L.A. Care HEALTH PLAN

For All of L.A.

BOARD OF GOVERNORS MEETING

December 7, 2023 • 1:00 PM

L.A. Care Health Plan

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

PLEASE REVIEW: Augie Haydel

Please return to Board Services after review

Statement

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

Overview

Committed to the promotion of accessible, affordable and high quality health care, L.A. Care Health Plan (Local Initiative Health Authority of Los Angeles County) is an independent local public agency created by the State of California to provide health coverage to low-income Los Angeles County residents. Serving more than 2.9 million members in four product lines, L.A. Care is the nation's largest publicly operated health plan.

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

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

Programs

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

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

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

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

L.A. Care Membership by Product Line – As of November 2023	
Medi-Cal	**2,571,159**
L.A. Care Covered	**133,112**
D-SNP	**18,371**
PASC-SEIU	**48,368**
Total membership	**2,771,010**
L.A. Care Providers – As of April 2022	
Physicians	**5,709**
Specialists	**13,534**
Both	**364**
Hospitals, clinics and other health care professionals	**14,276**
Financial Performance (FY 2023-2024 budget)	
Revenue	**$11B**
Fund Equity	**$1,779,445**
Net Operating Surplus	**$103.9M**
Administrative cost ratio	**5.1%**
Staffing highlights	
Full-time employees (Actual as of September 2023)	**2,269**
Projected full-time employees (FY 2023-2024 budget)	**2,407**

AGENDA
BOARD OF GOVERNORS MEETING
L.A. Care Health Plan
Thursday, December 7, 2023, 1:00 P.M.

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

DRAFT

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

To listen to the meeting via videoconference please register by using the link below:
https://lacare.webex.com/lacare/j.php?MTID=m7741f4a969d320e80fdf5e001e2927dc

To listen to the meeting via teleconference please dial: +1-213-306-3065
English Meeting Access Number: 2498 961 0145 Password: lacare

Spanish Meeting Access Number: 2496 404 2206 Password: lacare

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

For those not attending the meeting in person, public comments on Agenda items can be submitted in writing by e-mail to BoardServices@lacare.org, or by sending a text or voicemail to (213) 628-6420.

Attendees who log on to lacare.webex using the URL above will be able to use "chat" during the meeting for public comment. You must be logged into WebEx to use the "chat" feature. The log in information is at the top of the meeting Agenda. The chat function will be available during the meeting so public comments can be made live and direct.

1. The "chat" will be available during the public comment periods before each item.
2. To use the "chat" during public comment periods, look at the bottom right of your screen for the icon that has the word, "chat" on it.
3. Click on the chat icon. It will open two small windows.
4. Select "Everyone" in the "To:" window,
5. The chat message must indicate if you wish to be identified or remain anonymous, and must also include the name of the item to which your comment relates.
6. Type your public comment in the box that says "Enter chat message here".
7. When you hit the enter key, your message is sent and everyone can see it.
8. L.A. Care staff will read the chat messages for up to three minutes during public comment so people who are on the phone can hear the comment.

You can send your public comments by voicemail, email or text. If we receive your comment by 1:00 P.M., December 7, 2023, it will be provided to the members of the Board of Governors in writing at the beginning of the meeting. The chat message, text, voicemail, or email must indicate if you wish to be identified or remain anonymous, and must include the name of the item to which your comment relates.

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

Please note that there may be delay in the digital transmittal of emails, texts and voicemail. The Chair will announce when public comment period is over for each item. If your public comments are not received on

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

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

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

Welcome Alvaro Ballesteros, MBA, *Chair*

1. Approve today's agenda *Chair*
2. Public Comment *(Please read instructions above.)* *Chair*
3. Approve Consent Agenda Items P.25 *Chair*
   (A consent agenda is a way the Board of Governors can approve many motions at the same time to improve efficiency at the meeting. Most motions on a consent agenda have already been discussed at a previous Board Committee meeting. According to the Brown Act [California Government Code Section 54954.3(a)], the agenda need not provide an opportunity for public comment on any item that has already been considered by a committee. Sometimes routine motions are placed on the consent agenda by staff, and those have motion numbers that start with "BOG".)

   - November 2, 2023 Board of Governors Meeting Minutes
   - Nomination for Charitable Organizations for donated Board Stipends **(BOG 100)**
   - Quarterly Investment Reports **(FIN 100)**
   - Annual Review of Accounting and Finance Policies: **(FIN 101)**
     - AFS-002 (Capital Assets)
     - AFS-027 (Travel Expenses), and
     - AFS-029 (Annual Budgets and Board of Governors Oversight)
   - Revision of Accounting and Finance Policy AFS-006 (Authorization and Approval Limits) **(FIN 102)**
   - InfoCrossing Contract Amendment to support regulatory enrollment requirements **(FIN 103)**
   - Infosys, Ltd. Contract Amendment to provide Quality Assurance services **(FIN 104)**
   - North Star Alliances, LLC Contract to provide event planning, logistics, staffing and execution services and community relations support **(FIN 105)**
   - Ratify the elected Chairperson and Vice Chairperson of the Technical Advisory Committee **(TAC 100)**
   - Ratify the selection by RCAC members of new and continuing members of the Temporary Transitional Executive Community Advisory Committee **(TTECA 100)**
   - Ratify the elected Chairperson and Vice Chairperson of the Temporary Transitional Executive Community Advisory Committee **(TTECA 101)**
4. Chairperson's Report *Chair*

5. Chief Executive Officer Report P.161 — John Baackes, *Chief Executive Officer*
   - Government Affairs Update — Cherie Compartore, *Senior Director, Government Affairs*
   - L.A. Care Medicare Plus Enrollee Advisory Committee Meeting Summary
   - Monthly Grants & Sponsorship Reports
6. Chief Medical Officer Report P.169 — Sameer Amin, MD, *Chief Medical Officer*
7. Motions for Consideration P.188
   - Hyland Contract (**BOG 101**) — Tom MacDougall, *Chief Information & Technology Officer*
   - SAP America Contract Amendment **(BOG 102)**
   - Plan Partner Services Agreements Amendments **(BOG 103)** — Augustavia Haydel, *General Counsel*
   - DHCS 2024 Contract **(BOG 104)**
8. 2024 Board Officer Elections — *Presider*

Public Advisory Committee Reports

9. Executive Community Advisory Committee — Fatima Vazquez / Layla Gonzalez, *Consumer member and Advocate member*
10. Children's Health Consultant Advisory Committee — Tara Ficek, MPH, *Committee Chair*
11. Technical Advisory Committee — Alex Li, MD, *Committee Chair / Chief Equity Officer*

Board Committee Reports

12. Executive Committee P.568 — *Chair*
    - Employee Annual Incentive Program FY 2022-23 **(EXE 100)** — Terry Brown, *Chief Human Resources Officer*
13. Finance & Budget Committee P.585 — Stephanie Booth, MD, *Committee Chair*
    - Chief Financial Officer Report — Afzal Shah, *Chief Financial Officer*
    - Financial Report – September 2023 **(FIN 106)** — Jeffrey Ingram, *Deputy Chief Financial Officer*
    - Monthly Investment Transactions Reports – September 2023
    - Quarterly/Annual Internal Policy Reports
14. Compliance & Quality Committee — Stephanie Booth, MD, *Committee Chair*
15. Provider Relations Advisory Committee — George Greene, Esq., *Committee Chair*
16. Public Comment on Closed Session Items *(Please read instructions above.)* — *Chair*

ADJOURN TO CLOSED SESSION (Estimated time: 70 minutes) — *Chair*

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

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

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

20. CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION
Pursuant to Section 54956.9(d)(1) of the Ralph M. Brown Act
HRRP Garland LLC v. Local Initiative Health Authority for Los Angeles County
(Los Angeles Superior Court, Case no. 21stcv47250)

21. CONFERENCE WITH REAL PROPERTY NEGOTIATORS
Pursuant to Section 54956.8 of the Ralph M. Brown Act
Property: 1200 West 7th Street, Los Angeles
Agency Negotiator: John Baackes
Negotiating Parties: City of Los Angeles, Municipal Facilities Committee and Rising Realty Partners, HRRP Garland, LLC.
Under Negotiation: Price, Terms of Payment

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

23. PUBLIC EMPLOYEE PERFORMANCE EVALUATION
Section 54957 of the Ralph M. Brown Act
Title: Chief Executive Officer

24. CONFERENCE WITH LABOR NEGOTIATOR
Section 54957.6 of the Ralph M. Brown Act
Agency Designated Representative: Alvaro Ballesteros, MBA
Unrepresented Employee: John Baackes

RECONVENE IN OPEN SESSION *Chair*

Adjournment *Chair*

There is no Board of Governors meeting in January 2024.
The next meeting is scheduled on February 1, 2024 at 1 PM, it may be conducted as a teleconference meeting.
The order of items appearing on the agenda may change during the meeting.

THE PUBLIC MAY SUBMIT COMMENTS TO THE BOARD OF GOVERNORS BEFORE DISCUSSION OF EACH ITEM LISTED ON THE AGENDA BY SUBMITTING THE COMMENT IN WRITING BY TEXT MESSAGE TO 213 628 6420, OR IN WRITING BY EMAIL TO BoardServices@lacare.org. Please follow additional instructions on the first page of this Agenda.
ACTION MAY NOT BE TAKEN ON ANY MATTER RAISED DURING THE PUBLIC COMMENT PERIODS UNTIL THE MATTER IS SPECIFICALLY LISTED ON A FUTURE AGENDA, according to California Govt Code Section 54954.2 (a)(3) and Section 54954.3.
AGENDA and PRINTED MEETING MATERIALS ARE AVAILABLE FOR INSPECTION 72 HOURS BEFORE THE MEETING:
1. **At L.A. CARE'S Website:** http://www.lacare.org/about-us/public-meetings/board-meetings
2. **L.A. Care's Offices at 1055 W. 7th Street, Los Angeles, CA 90017 through the Reception Area in the Building Lobby, or**
3. **by email request to BoardServices@lacare.org**

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

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

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

SCHEDULE OF MEETINGS

Schedule of Meetings
December 2023

Monday	Tuesday	Wednesday	Thursday	Friday
				1
4	5 ***CHCAC Meeting*** ***8:30 am*** *(for approx. 1-1/2 hours)*	6 ***Provider Relations Advisory Committee Meeting*** ***9:30 am*** *(for approx. 2 hours)*	7 ***Board of Governors Meeting*** ***1 pm*** *(for approx. 2-1/2 hours)*	8
11	12	13 ***ECAC Meeting*** *10 AM* *(for approx. 3 hours)*	14	15
18	19	20	21 ***Audit Committee Meeting*** ***2:30 pm*** *(for approx. 1hour)*	22
25	26	27	28	29

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

Prepared by mhbalones/printed on 11/28/23

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

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

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

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

	MEETING DAY, TIME & LOCATION	MEETING DATES	BOARD MEMBERS / STAFF CONTACT
COMPLIANCE & QUALITY COMMITTEE	**3rd Thursday of the month** 2:00 PM *(for approximately 2 hours)* L.A. Care Health Plan 1055 W. 7th Street Los Angeles, CA 90017 (213) 694-1250		Stephanie Booth, MD, *Chairperson* Alvaro Ballesteros, MBA G. Michael Roybal, MD, MPH **Staff Contact:** Victor Rodriguez *Board Specialist II, Board Services x 5214*
FINANCE & BUDGET COMMITTEE	**4th Wednesday of the month** 1:00 PM *(for approximately 1 hour)* L.A. Care Health Plan 1055 W. 7th Street Los Angeles, CA 90017 (213) 694-1250		Stephanie Booth, MD, *Treasurer* Al Ballesteros, MBA G. Michael Roybal, MD, MPH Nina Vaccaro **Staff Contact:** Malou Balones *Board Specialist III, Board Services x4183*
PROVIDER RELATIONS ADVISORY COMMITTEE	Quarterly, 2nd Wednesday at 9:30 am L.A. Care Health Plan 1055 W. 7th Street Los Angeles, CA 90017 (213) 694-1250	December 6 **Rescheduled due to conflict*	George Greene, Esq., *Chairperson* **Staff Contact:** Linda Merkens *Senior Manager, Board Services, x4050*
AUDIT COMMITTEE	L.A. Care Health Plan 1055 W. 7th Street Los Angeles, CA 90017 (213) 694-1250 **MEETS AS NEEDED**	Thursday December 21 2:30 PM	Hector De La Torre, *Chairperson* Layla Gonzalez George Greene **Staff Contact** Malou Balones *Board Specialist III, Board Services, x 4183*

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

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

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L.A. CARE COMMUNITY HEALTH PLAN	**Meets Annually or as needed** L.A. Care Health Plan 1055 W. 7th Street Los Angeles, CA 90017 (213) 694-1250		Alvaro Ballesteros, MBA, *Chairperson* Ilan Shapiro, MD, *Vice Chairperson* Stephanie Booth, MD, *Treasurer* John G. Raffoul, *Secretary* Jackie Contreras, PhD Hector De La Torre Christina R. Ghaly, MD Layla Gonzalez, George W. Greene, Esq. G. Michael Roybal, MD, MPH Supervisor Hilda L. Solis Nina Vaccaro, MPH Fatima Vazquez **Staff Contact:** John Baackes, *Chief Executive Officer, x4102* Linda Merkens, *Senior Manager, Board Services, x4050*
L.A. CARE JOINT POWERS AUTHORITY	L.A. Care Health Plan 1055 W. 7th Street Los Angeles, CA 90017 (213) 694-1250	December 7	Alvaro Ballesteros, MBA, *Chairperson* Ilan Shapiro, MD, *Vice Chairperson* Stephanie Booth, MD, *Treasurer* John G. Raffoul, *Secretary* Jackie Contreras, PhD Hector De La Torre Christina R. Ghaly, MD Layla Gonzalez, George W. Greene, Esq. G. Michael Roybal, MD, MPH Supervisor Hilda L. Solis Nina Vaccaro, MPH Fatima Vazquez **Staff Contact:** John Baackes, *Chief Executive Officer, x4102* Linda Merkens, *Senior Manager, Board Services, x4050*

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

PUBLIC ADVISORY COMMITTEES			
CHILDREN'S HEALTH CONSULTANT ADVISORY COMMITTEE GENERAL MEETING	**3rd Tuesday of every other month** 8:30 AM *(for approximately 2 hours)* L.A. Care Health Plan 1055 W. 7th Street Los Angeles, CA 90017 (213) 694-1250	December 5* **rescheduled from November meeting*	**Tara Ficek, MPH,** *Chairperson* **Staff Contact:** Victor Rodriguez *Board Specialist II, Board Services/x 5214*
EXECUTIVE COMMUNITY ADVISORY COMMITTEE	**2nd Wednesday of the month** 10:00 AM *(for approximately 3 hours)* L.A. Care Health Plan 1055 W. 7th Street Los Angeles, CA 90017 (213) 694-1250	December 13	**Ana Rodriguez,** *Chairperson* **Staff Contact:** Idalia De La Torre**,** *Community Outreach & Engagment, Ext. 4420*
TECHNICAL ADVISORY COMMITTEE	**Meets Quarterly** **2nd Thursday of meeting month** 2:00 PM *(for approximately 2 hours)* L.A. Care Health Plan 1055 W. 7th Street Los Angeles, CA 90017 (213) 694-1250		Alex Li, MD, *Chairperson* **Staff Contact:** Victor Rodriguez *Board Specialist II, Board Services/x 5214*

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

	MEETING DAY, TIME & LOCATION	MEETING DATES	BOARD MEMBERS / STAFF CONTACT
BOARD OF GOVERNORS	**1st Thursday** 1:00 PM *(for approximately 3 hours)* L.A. Care Health Plan 1055 W. 7th Street Los Angeles, CA 90017 (213) 694-1250 **Placeholder meeting* *** Offsite meeting. Location TBD* **** Meeting 4th Thursday due to summer holiday schedule* *****All Day Retreat. Location TBD*	*No meeting in January* February 1 March 7 * April 4 May 2 June 6 ** July 25 *** *No meeting in August* September 5 **** October 3 * November 7 December 5	Alvaro Ballesteros, MBA, *Chairperson* Ilan Shapiro, MD, *Vice Chairperson* Stephanie Booth, MD, *Treasurer* John G. Raffoul, *Secretary* Jackie Contreras, PhD Hector De La Torre Christina R. Ghaly, MD Layla Gonzalez, George W. Greene, Esq. G. Michael Roybal, MD, MPH Supervisor Hilda L. Solis Nina Vaccaro, MPH Fatima Vazquez **Staff Contact:** John Baackes *Chief Executive Officer, x4102* Linda Merkens *Senior Manager, Board Services, x4050*
BOARD COMMITTEES			
EXECUTIVE COMMITTEE	**4th Wednesday of the month** 2:00 PM *(for approximately 2 hours)* L.A. Care Health Plan 1055 W. 7th Street Los Angeles, CA 90017 (213) 694-1250 **3rd Wednesday due to Thanksgiving holiday*	January24 February 28 March 27 April 24 May 22 June 26 *No meeting in July* August 28 September 25 October 23 November 20 * *No meeting in December*	Alvaro Ballesteros, MBA, *Chairperson* Ilan Shapiro, MD, *Vice Chairperson* Stephanie Booth, MD, *Treasurer* John G. Raffoul, *Secretary* *Governance Committee Chair* *Compliance & Quality Committee Chair* **Staff Contact:** Linda Merkens *Senior Manager, Board Services, x4050* Malou Balones *Board Specialist III, Board Services x4183*

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

	MEETING DAY, TIME & LOCATION	MEETING DATES	BOARD MEMBERS / STAFF CONTACT
COMPLIANCE & QUALITY COMMITTEE	**3rd Thursday of the month** 2:00 PM *(for approximately 2 hours)* L.A. Care Health Plan 1055 W. 7th Street Los Angeles, CA 90017 (213) 694-1250	January 18 February 15 March 21 April 18 May 16 June 20 No meeting in July August 15 September 19 October 17 November 21 *No meeting in December*	Stephanie Booth, MD, *Chairperson* Alvaro Ballesteros, MBA G. Michael Roybal, MD, MPH **Staff Contact:** Victor Rodriguez *Board Specialist II, Board Services x 5214*
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PROVIDER RELATIONS ADVISORY COMMITTEE	**Meets Quarterly** **3rd Wednesday of meeting month** 9:30 AM *(for approximately 2 hours)* L.A. Care Health Plan 1055 W. 7th Street Los Angeles, CA 90017 (213) 694-1250	February 21 May 15 August 21 November 20	George Greene, Esq., *Chairperson* **Staff Contact:** Linda Merkens *Senior Manager, Board Services, x4050*
AUDIT COMMITTEE	L.A. Care Health Plan 1055 W. 7th Street Los Angeles, CA 90017 (213) 694-1250		Hector De La Torre Layla Gonzalez George Greene

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2024 MEETING SCHEDULE / MEMBER LISTING

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

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L.A. CARE COMMUNITY HEALTH PLAN	**Meets Annually or as needed** L.A. Care Health Plan 1055 W. 7th Street Los Angeles, CA 90017 (213) 694-1250		Alvaro Ballesteros, MBA, *Chairperson* Ilan Shapiro, MD, *Vice Chairperson* Stephanie Booth, MD, *Treasurer* John G. Raffoul, *Secretary* Jackie Contreras, PhD Hector De La Torre Christina R. Ghaly, MD Layla Gonzalez, George W. Greene, Esq. G. Michael Roybal, MD, MPH Supervisor Hilda Solis Nina Vaccaro, MPH Fatima Vazquez **Staff Contact:** John Baackes, *Chief Executive Officer, x4102* Linda Merkens, *Senior Manager, Board Services, x4050*
L.A. CARE JOINT POWERS AUTHORITY	L.A. Care Health Plan 1055 W. 7th Street Los Angeles, CA 90017 (213) 694-1250 **Placeholder meeting* *** Offsite meeting. Location TBD* **** Meeting 4th Thursday due to summer holiday schedule* *****All Day Retreat. Location TBD*	*No meeting in January* February 1 March 7 * April 4 May 2 June 6 ** July 25 *** *No meeting in August* September 5 **** October 3 * November 7 December 5	Alvaro Ballesteros, MBA, *Chairperson* Ilan Shapiro, MD, *Vice Chairperson* Stephanie Booth, MD, *Treasurer* John G. Raffoul, *Secretary* Jackie Contreras, PhD Hector De La Torre Christina R. Ghaly, MD Layla Gonzalez, George W. Greene, Esq. G. Michael Roybal, MD, MPH Supervisor Hilda Solis Nina Vaccaro, MPH Fatima Vazquez **Staff Contact:** John Baackes, *Chief Executive Officer, x4102* Linda Merkens, *Senior Manager, Board Services, x4050*

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

PUBLIC ADVISORY COMMITTEES			
CHILDREN'S HEALTH CONSULTANT ADVISORY COMMITTEE GENERAL MEETING	**3rd Tuesday of every other month** 8:30 AM *(for approximately 2 hours)* L.A. Care Health Plan 1055 W. 7th Street Los Angeles, CA 90017 (213) 694-1250	January 16 March 19 May 21 August 20 October 15	**Tara Ficek, MPH,** *Chairperson* **Staff Contact:** Victor Rodriguez *Board Specialist II, Board Services/x 5214*
EXECUTIVE COMMUNITY ADVISORY COMMITTEE	**2nd Wednesday of the month** 10:00 AM *(for approximately 3 hours)* L.A. Care Health Plan 1055 W. 7th Street Los Angeles, CA 90017 (213) 694-1250	*No meeting in January* February 14 March 13 April 10 May 8 June 12 July 10 *No meeting in August* September 11 October 9 November 13 December 11	**Ana Rodriguez,** *Chairperson* **Staff Contact:** Idalia De La Torre**,** *Community Outreach & Engagement, Ext. 4420*
TECHNICAL ADVISORY COMMITTEE	**Meets Quarterly 2nd Thursday of meeting month** 2:00 PM *(for approximately 2 hours)* L.A. Care Health Plan 1055 W. 7th Street Los Angeles, CA 90017 (213) 694-1250	January 11 April 11 August 8 October 10	Alex Li, MD, *Chairperson* **Staff Contact:** Victor Rodriguez *Board Specialist II, Board Services/x 5214*

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

REGIONAL COMMUNITY ADVISORY COMMITTEES			
REGION 1 **ANTELOPE VALLEY**	**3rd Friday of every other month** 10:30 AM *(for approximately 2-1/2 hours)* Community Resource Center Palmdale2072 E. Palmdale Blvd. Palmdale, CA 93550 (213) 438-5580		**Roger Rabaja,** *Chairperson* **Staff Contact:** Frank Meza, Field Specialist Cell Phone (213) 905-8502 *Community Outreach & Engagement*
REGION 2 **SAN FERNANDO VALLEY**	**3rd Monday of every other month** 10:00 AM *(for approximately 2-1/2 hours)* Community Resource Center Panorama City 7868 Van Nuys Blvd. Panorama City, CA 91402 (213) 438-5497		**Ana Rodriguez,** *Chairperson* **Staff Contact:** Martin Vicente, Field Specialist Cell Phone (213) 503-6199 Tyonna Baker, Field Specialist Cell Phone (213) 760-2050 *Community Outreach & Engagement*
REGION 3 **ALHAMBRA, PASADENA AND FOOTHILL**	**3rd Tuesday of every other month** 10:00 AM *(for approximately 2-1/2 hours)* TBD		**Lidia Parra,** *Chairperson* **Staff Contact:** Frank Meza, Field Specialist Cell Phone (323) 541-7900 *Community Outreach & Engagement*
REGION 4 **HOLLYWOOD-WILSHIRE, CENTRAL L.A. AND GLENDALE**	**3rd Tuesday of every other month** 10:00 AM *(for approximately 2-1/2 hours)* Community Resource Center Metro LA 1233 S. Western Ave. Los Angeles, CA 90006 (213) 428-1457		**Sylvia Poz,** *Chairperson* **Staff Contact:** Christopher Maghar, Field Specialist Cell Phone (213) 549-2146 Cindy Pozos, Field Specialist

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			Cell Phone (213) 545-4649 *Community Outreach & Engagement*
REGION 5 **CULVER CITY, VENICE, SANTA MONICA, MALIBU, WESTCHESTER**	**3rd Monday of every other month** 10:00 AM *(for approximately 2-1/2 hours)* Community Resource Center West Los Angeles 11173 W. Pico Blvd Los Angeles, CA 90064 (310) 231-3854	(310) 231-3854	**Maria Sanchez,** *Chairperson* **Staff Contact:** Christopher Maghar, Field Specialist Cell Phone (213) 549-2146 Cindy Pozos, Field Specialist Cell Phone (213) 545-4649 *Community Outreach & Engagement*
REGION 6 **COMPTON, INGLEWOOD, WATTS, GARDENA, HAWTHORNE**	**3rd Wednesday of every other month** 10:00 AM *(for approximately 2-1/2 hours)* Community Resource Center Inglewood 2864 W. Imperial Highway Inglewood, CA 90303 (310) 330-3130		**Joyce Sales,** *Chairperson* **Staff Contact:** Martin Vicente, Field Specialist Cell Phone (213) 503-6199 Tyonna Baker, Field Specialist Cell Phone (213) 760-2050 *Community Outreach & Engagement*
REGION 7 **HUNTINGTON PARK, BELLFLOWER, NORWALK, CUDAHY**	**3rd Tuesday of every other month** 10:00 AM *(for approximately 2-1/2 hours)* Community Resource Center Norwalk 11721 Rosecrans Ave. Norwalk, CA 90650 (562) 651-6060		**Maritza LeBron,** *Chairperson* **Staff Contact:** Martin Vicente, Field Specialist Cell Phone (213) 503-6199 Tyonna Baker, Field Specialist Cell Phone (213) 760-2050 *Community Outreach & Engagement*

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

REGION 8 **CARSON, TORRANCE, SAN PEDRO, WILMINGTON**	**3rd Friday of every other month** 10:30 AM *(for approximately 2-1/2 hours)* Community Resource Center Wilmington 911 N. Avalon Ave. Wilmington, CA 90744 (213) 428-1490		**Ana Romo** – *Chairperson* **<u>Staff Contact</u>:** Kristina Chung, Field Specialist Cell Phone (213) 905-8502 Hilda Herrera, *Field Specialist* Cell Phone (213) 605-4197 *Community Outreach & Engagement*
REGION 9 **LONG BEACH**	**3rd Wednesday of every other month** 11:00 AM *(for approximately 2-1/2 hours)* Community Resource Center Long Beach 5599 Atlantic Ave. Long Beach, CA 90805 (213) 905-8502		**Tonya Byrd**, *Chairperson* **<u>Staff Contact</u>:** Kristina Chung, Field Specialist Cell Phone (213) 905-8502 Hilda Herrera, Field Specialist Cell Phone (213) 605-4197 *Community Outreach & Engagement*
REGION 10 **EAST LOS ANGELES, WHITTIER AND HIGHLAND PARK**	**3rd Thursday of every other month** 2:00 PM *(for approximately 2-1/2 hours)* Community Resource Center East L.A. 4801 Whittier Blvd Los Angeles, CA 90022 (213) 438-5570		**Damares Hernández de Cordero,** *Chairperson* **<u>Staff Contact</u>:** Kristina Chung, Field Specialist Cell Phone (213) 905-8502 Hilda Herrera, *Field Specialist* Cell Phone (213) 605-4197 *Community Outreach & Engagement*
REGION 11 **POMONA AND EL MONTE**	**3rd Wednesday of every other Month** 10:00 AM		**Maria Angel Refugio,** *Chairperson*

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	(for approximately 2-1/2 hours) Community Resource Center Pomona 696 W. Holt Street Pomona, CA 91768 (909) 620-1661		**Staff Contact:** Frank Meza, Field Specialist Cell Phone (323) 541-7900 *Community Outreach & Engagement*

CONSENT AGENDA

Board of Governors
Regular Meeting Minutes #322
November 2, 2023

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

Members

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

**Absent*

*** Via teleconference*

Management

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

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
WELCOME	Alvaro Ballesteros, *Board Chairperson,* called to order the retreat and regular meeting of L.A. Care Health Plan Board of Governors and the L.A. Care Health Plan Joint Powers Authority Board of Directors meeting at 1:00 pm. The meetings were held simultaneously. He announced that those attending the meeting in person who wish to submit a public comment should use the form provided. For those with access to the internet, the materials for today's meeting are available on the L.A. Care website. He welcomed everyone and thanked those who have submitted public comment by voice mail, text or email. He informed participants that for those using the video software during the meetings; the "chat" function will be available to provide live and direct public comment to everyone participating in the virtual meeting. The Chat feature will be open throughout the meeting for public comment. All are welcome to provide input.	
APPROVAL OF MEETING AGENDA	**The meeting Agendas were approved.** *Board Member Gonzalez joined the meeting.*	**Unanimously approved by roll call. 8 AYES (Ballesteros, Booth, Contreras, Roybal, Shapiro, Solis, Vaccaro and Vazquez)**

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
PUBLIC COMMENTS	*Elizabeth Cooper commented that this is Thanksgiving season; there are many things that she is thankful for. She's thankful for being able to speak before the board. Our democracy is at risk and she believes in the Constitution, the First Amendment, and that is why she's glad to speak today. She has many concerns and what she's deeply concerned about, in a way she is saddened about, is sometimes the interaction we have with each other. She came here today to speak and she just feels a little sense of uncomfortableness about some things, as a long time member. She knows it's not about longevity for her but in participating in the board and participating in the RCACs. But she will leave a public comment there, but she's so glad, and her prayer today is about peace in the country and peace in the world. But the main thing is that we should value our freedom and value our public comment, and value how important it is to our democracy, because that's what's important. And she is thankful for the chief executive officer of the great State of California Governor Newsom, and all of those who make the laws and implement the laws - the legislature. But that's something. And she is thankful for this board, even though she doesn't always agree with some of the decisions, but she is thankful that she has the opportunity to speak today.* *Maritza Lebron appreciates the opportunity to speak to the board. She asked for a round of applause for all the hard work that RCAC members have been doing. She would like to comment that it would be good thing when you're leaving a message to just not forget to perhaps write down someone's cell phone number because the audio message can be very quick. And so we need to put again and again and again, and again, sometimes a number we cannot find what it is. And this is another thing, she's getting used to all of this. She is the president of RCAC 7 and she wants to thank you for this opportunity. And she's a little bit confused because she is also involved with the mental health department as well as she is a promotora. They say that the health promoters are going to change a little bit. And people don't know what is going to happen. She has kind of an idea but she doesn't know what will happen to the health promoters. She knows some health promoters with Hilda Solis, but she doesn't know if that is a different program. She asked if there is money put aside for the health promoters, and what are the new ideas for the health promoter program. Will the program be open or will there be promatoras brought over from another agency. She would like to know the dynamics of the program, because she hears talk about health promoters but she is not sure about it.* John Baackes, *Chief Executive Officer,* thanked her for the comment. He will ask Francisco Oaxaca, *Chief of Communications and Community Relations,* to contact her with an update on the health promoter program and what is planned for next year.	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
APPROVE CONSENT AGENDA ITEMS	PUBLIC COMMENT *Elizabeth Cooper is concerned about the consent items, it's so long. She is a RCAC member, but comes here as a public person. The consent item is too long. It should be on the item, it's very confusing. She is a layperson, not a lawyer. To look at the consent items, so many items are on the agenda and it gives her as a member who L.A. Care serves. You all are in power to make decisions. But there is too many items on the agenda on the consent item, so the consent item is very confusing. She wishes the board will please take notice and how you write the consent item. She has other items on the consent, which if you give me the opportunity to speak on this, a number of items. She had to itemize, and it was very confusing. That's why she comes a little earlier, so that she can look at the agenda. She came here not to look at you wonderful people but o speak about the agenda. To ask what are you doing for me lately, what are you doing for the public, and the RCAC members. So please look at the consent agenda because that is very important so we can keep involved for the time we are part of the RCACs. Please look at the consent item, don't make it so confusing because she was writing and writing it takes time to look at that and you all are aware of the consent item, but it should be itemized, not all on the consent.* Supervisor and Board Member Hilda Solis commented on the housing for homelessness initiative program investment agreement with United Way of Greater Los Angeles (UWGLA) and asked when the Board was notified about this funding opportunity, and when was a request for proposals sent out for the agreement. Mr. Baackes noted that the funding was provided through CalAIM, and he invited Michael Brodsky, MD, *Senior Medical Director, Community Health, Behavioral Health*. Mr. Baackes added that the funding received totals $100 million so far, and is being parsed out through various grants. Dr. Brodsky introduced Karl Calhoun, *Director of Housing Initiatives*. Mr. Calhoun responded that the workforce development arena that this investment supports is a priority issue for L.A. Care with the housing homeless incentive program. It was designated as such at the very early stages of the process, and the agreement began at that early stage because UWGLA was identified as a leader in that space and had done a great deal of work identifying the gaps that needed to be filled in the arena of workforce. Supervisor Solis asked if UWGLA originally received a part of the $100 million in funding, and is this an addition or is this a new effort. Mr. Calhoun responded that this is an entirely new agreement and is the only funding that UWGLA received to date as a portion of the overall HHIP funding. Supervisor Solis encouraged exploring other workforce programs available. She understands that there may be time constraints on this program. She hopes that Los Angeles County could work with L.A. Care, especially the Department of Economic Opportunity, and with Los	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Angeles County Homeless Initiative. She wanted to understand the process. Mr. Calhoun noted that the agreement provides for a leadership table that will include many of the key stakeholders in the workforce community throughout Los Angeles County. He would welcome any recommendations or entities and organizations you think should participate. Supervisor Solis commented that is the information she wanted to hear. She does not see a necessity to hold the item any further and she would support the item. • October 5, 2023 Board of Governors Meeting Minutes • Housing & Homelessness Incentive Program Investment agreement with United Way of Greater Los Angeles (UWGLA) **Motion EXE 100.1123*** **To authorize staff to execute an HHIP investment agreement in the amount of $3,500,000 with United Way of Greater Los Angeles to refine and reestablish the Workforce Development Leadership Team, launch priority pilot initiatives, provide stipends, and provide infrastructure funding to strengthen recruitment and retention of staff in agencies in Los Angeles County for the period of October 1, 2023 through October 1, 2025.** • I Color Printing and Mailing Inc. Contract Amendment FOR Premium Billing Unit services through June 30, 2025 **Motion FIN 100.1123*** **To authorize staff to amend contract to increase funds in the amount of $4,600,000 for a new total not to exceed $8,690,200 with I Color Printing and Mailing Inc. to provide L.A. Care MPSS Premium Billing Unit with printing, storage, postage/mailing, reporting, and order fulfillment services through June 30, 2025.** • MCG (Milliman) Contract provide clinical care guidelines for the period of November 10, 2023 to October 31, 2028 **Motion FIN 101.1123*** **To authorize staff to execute a five-year contract with MCG not to exceed $13,000,000 to provide clinical care guidelines for the period of November 10, 2023 to October 31, 2028.** • Accounts & Finance Services Policy AFS-008 (Annual Investment Policy Review) **Motion FIN 102.1123*** **To approve Accounting & Financial Services Policy AFS-008 (Annual Investment Policy) as submitted.**	**Unanimously approved by roll call. 8 AYES (Ballesteros, Booth, Contreras, Roybal, Shapiro, Solis, Vaccaro and Vazquez)**

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
Initiatives for L.A. Care's Unhoused and Housing Insecure Members	*(Board Member De La Torre joined the meeting.)* Dr. Brodsky and Charles Robinson**,** *Senior Director, Community Health Safety Net Initiatives*, provided information about L.A. Care's services for unhoused and housing insecure members. Dr. Brodsky noted that shortly after the arrival of Sameer Amin, MD, *Chief Medical Officer*, L.A. Care focused on social determinants of health, behavioral health, support for vulnerable communities and providing services in nontraditional settings. The services are being integrated across different teams. This presentation will focus on housing services and a field and street medicine proposal. Mr. Robinson reported that broad end-to-end services begin with members who are unhoused, and provides support for temporary housing, transition to permanent housing, and finally in-home support and addiction prevention for those who are able to move into permanent housing. L.A. Care is also making investments in communities, in L.A. Care services and in critical access to healthcare services at every point of the journey. This includes countywide investments in provider and community based organizations, making investments in community, and allocating care services, IT and data infrastructure. There is a combination of services related to California Advancing and Innovating Medi-Cal (CalAIM) and specifically related to the Community Supports program. L.A. Care will deliver services through a network of providers and countywide initiatives, through Housing and Homelessness Incentive Program (HHIP) and Incentive Payment Program (IPP) funds. This presentation will cover programs to support transition to permanent housing and in-home support and eviction prevention. The presentation will also provide insight into the development of a countywide network related to critical access for healthcare services for this population. L. A. Care's housing services that launched in 2022 are under the umbrella of the CalAIM Community Supports, has three parts: 1. Housing navigation, helping to connect members find housing and get a placement that leads to permanent supportive housing. 2. Housing deposits, helping people with first and last month's rent and other move in related expenses. 3. Once people are housed, provide tenancy-sustaining services to help with landlord relations, day-to-day assistance with managing the prospects of being a new tenant. Another service provided is recuperative care, also known as medical respite, which is another community support provided that is more focused on recovery after hospitalization or nursing	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	home stay, and short term post-hospitalization housing which will be available for members in July of next year. Since 2022, L.A. Care has helped 2,783 members transition into permanent housing. • 24% of the members engaged in housing navigation have transitioned to permanent housing. • 80% of those members have transitioned to permanent housing within 6 months. • Once members have found housing, L.A. Care is currently supporting 7,152 members through tenancy sustaining services. These services are provided through a robust network of 106 community-based providers countywide, both in L.A. Care's direct network and through a critical partnership with the Los Angeles County Department of Health Services (DHS). L.A. Care finds these services to be very successful and is trying to expand through increased referrals, increased eligibility and better training in the community to make sure that people who are eligible for these services are referred into the programs. There are challenges in the financial support for these programs. Over five years the overall cost to the health plan is projected to be $430 million through 2027. L.A. Care is currently analyzing the impact of these services on the overall cost of care. There is potential HHIP funding. At this time, it is not recommended to dedicate HHIP funds for these services. The projection represents about a $100 million loss with the health plan, even with projected savings in cost of care. Mr. Robinson introduced a countywide field medicine proposal. This proposal is not final. L.A. Care is seeking and soliciting feedback from key community stakeholders, providers in the county who are already providing Medi-Cal services to our members experiencing homelessness or providers who hope to provide those services in the future. Many have been talking about street medicine for quite some time, as has L.A. Care staff. Considerations include how best to provide access to care for members who are experiencing homelessness. L.A. Care has gathered feedback from critical partners countywide, including care facilities such as DHS, LA Christian, JWCH, St John's, UCLA, USC and Northeast Valley. Discussions have been about balancing two critical components in providing front-end care for this population. First is access to care. Most of the unhoused individuals in Los Angeles County are not receiving healthcare and do not have access to healthcare services despite that a majority of people are eligible for Medi-Cal. Second is pairing access with a medical home. We propose to solve both of those concerns with the full-fledged deployment of field medicine primary care providers. Field medicine includes street medicine, those basic clinical and social services delivered on foot in a member's environment. It will include longitudinal complex, primary care, coordinated specialty referrals within a defined network, and a care team that	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	serves members in the street, in shelters or contemporary housing, to make sure that we are providing access to care across that full continuum. They propose to do this through support for existing providers: • Coordinated, county-wide deployment of comprehensive services for members experiencing homelessness • The foundation is L.A. Care's existing network of primary care providers who are already serving this population, designating them as "Field Medicine Primary Care Providers", and growing that network of primary care providers • Targeted investment of HHIP and IPP funds to build the capabilities our "Field Medicine Primary Care Providers" will need to effectively take on member assignment for members experiencing homelessness under existing or new standard primary care contracts • Deployment of Street Medicine services to provide members with in-the-moment access to care with any Street Medicine provider they encounter, and *specifically supporting and facilitating full primary care assignment* • Network includes both designated regional anchors to ensure countywide coverage, as well as floating providers to offer choice for our members. L.A. Care proposes directed support for Field Medicine providers through HHIP and IPP funds. Feedback from core provider stakeholders indicates that current Medi-Cal rates for primary care do not cover all the services required nor the capabilities required to serve the unhoused population. L.A. Care believes that pairing HHIP and IPP funds with making other investments countywide through these programs is very effective in deploying the funds and making sure those funds are used for the population that most needs them. The funds intended to help providers field additional street medicine teams, provide incentives to encourage providers to begin to deliver street medicine services, which is a huge challenge for many providers, and incentivize providers to take on assignment for those individuals - to take on full responsibility for the care of those individuals. L.A. Care will make sure that providers are not only going into the street, serving members in shelters, but also serving members in short term housing, to ensure that as members move through the continuum of services, there is no disruption in care. Board Member Roybal asked if L.A. Care would integrate behavioral health and substance use disorder treatment into the field medicine specialty; because it is such a vital part of helping people deal with substance abuse and mental health disorders. He would like to know the plan for integrating the two so that members have good access to those services when they want them and we can provide them in a very efficient way. Dr. Brodsky responded that this is an important issue for him as he is a Psychiatrist by training. Medi-Cal has a bifurcated if not trifurcated system of managing behavioral health, with services	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	provided by a mental health agency in the county, a substance use focused division of an agency in the county, and L.A. Care. L.A. Care intends to support as much integration as possible. He and Mr. Robinson will have a meeting tomorrow on skid row with key county stakeholders on this exact question. L.A. Care supports both para-professional and assessment care happening in the field, in facilities, and in the anchor and floating providers as much as possible. Fortunately, many providers that L.A. Care contracts with have existing ways to provide services and assign to L.A. Care, or assign to county programs with L.A. Care paying for services as needed. Board Member Roybal commented that he feels passionate about making sure that we figure out an effective way to integrate the services. Part of the problem is with three silos, which do not communicate and are not funded the same way. This may be an opportunity to break down those silos and force integration to address the issues. From his perspective, these are barriers to helping patients deal with medical illness, homelessness, mental health and substance use disorder issues. He would support any effort to integrate the services robustly. Supervisor Solis commented that the Board could have a whole session just on this topic. She is excited about these programs and wants to make sure that we are really trying to integrate all the sources of support offered by Los Angeles County. She is sure there have been discussions with Dr. Ghaly of DHS, but wonders if Dr. Ferrer of Los Angeles County Department of Public Health and Dr. Wong of Los Angeles County Department of Mental Health (DMH) were also engaged. She feels it is important to talk about collaborating among the systems of care. Los Angeles County has teams in the street now, and those services are barely sufficiently growing. She has concerns about making sure that costs are not duplicated and that planners are being strategic. Case management is very important and may not be fully funded. Case management could be very helpful in integrating the services available. She wonders if there is opportunity to expand service providers while making sure that in addressing medical needs, those individuals are provided access to other services, perhaps through Los Angeles County Department of Public Social Services and including housing, and making sure that data is properly kept to make sure services are delivered appropriately. Mr. Baackes responded that L.A. Care is very conscious of the split that you have mentioned. One of the things for which L.A. Care has been advocating is to encourage participation for homeless or housed members in the Enhanced Care Management (ECM) program. ECM provides members with one point of contact to link services through contracts with community based organizations. A second item is that a proactive work group with DMH had looked at integrating services for members with serious and persistent mental illness, and L.A. Care's services for mild to moderate mental illness. A problem is that patients are in the middle and not receiving consistent care. L.A. Care is trying to find a way to operate an integrated mental	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	health system. L.A. Care has begun to work with Dr. Wong but the conversation is not at the level it needs to be. L.A. Care would like to resume that communication to prepare for when mental health money is going to come through the managed care plans and there would not be direct state support of the County mental health programs. The County mental health programs would need to contract with health plans, and L.A. Care is trying to get ahead of that direction. Dr. Brodsky commented that the health agency leaders have all sent their direct reports to participate in meetings. He feels like work is proceeding with a senior level of County engagement, and L.A. Care is excited to talk about ECM and other integration opportunities with them. Mr. Robinson commented that with the deployment of HHIP and IPP funds through the street medicine program, one of the key items we are working to incentivize is that every street medicine team also offers housing navigation and ECM services. There is a full package of care services for the teams supporting in the community. The other core component of the program still under development with feedback from key community stakeholders is the proposed regional anchor model. L.A. Care is hoping to create infrastructure for teams throughout the County from different organizations to know the default street medicine, field medicine provider in any region. When there is a need for co-management of services or for referrals, they will have information about the locations and availability of services. This will create infrastructure upon which additional levels of coordination of services for members can be built. Supervisor Solis appreciated the responses and offered to work with Dr. Wong on a meeting with Mr. Baackes and staff to work together. She noted that Los Angeles County teams are working with L.A. Care on much of what is being discussed here. She noted that coordination is needed to avoid any lapses in the systems of care. Mr. Baackes offered to contact the Supervisor's health deputy to restart the work group and discuss a proposal to Los Angeles City by L.A. Care related to the Inside Safe program. Chairperson Ballesteros commented that one of the biggest challenges in delivering both the clinical and the social services on the street team is that specifically for federally qualified health centers (FQHC) there's one billable visit allowed per day. With an integrated clinical team, the FQHC will be paid for only one visit, and that would be a disincentive to bring out multiple service providers. He has also heard from street teams that a big barrier is a lack of immediate access to emergency or interim housing. The team may reach a client that is ready to go right into housing, but the availability does not fit the timeframe. This can erode the client's trust in the service providers. L.A. Care has to figure out a way to across the county to provide immediate access to beds when needed. He further noted that the intent is to have coverage of	

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	the street teams across the County. However, in downtown skid row, there could be seven or eight different providers on the same day, and it can be very confusing to the clients. He suggested collaboration with DMH and DPH to combine some of the teams and resources to enable same day billable visits for different services. Supervisor Solis suggested a working group to address the issues that deserve a high level of attention. Chairperson Ballesteros commented that he understands that the funds do not pay for housing itself, and even if health plans provide the best possible services, the person is still on the streets. If a person wants to, they will need housing first. Some may not want housing, so the program is great for serving those people where they are. Housing is the chasm that needs to be bridged. The health plan is not providing the housing and must depend on other programs to make that chasm smaller. Mr. Baackes noted that Centers for Medicare and Medicaid Services (CMS) does not allow Medicaid funds to be used for housing. Health Plans can now use Medicaid funds for support services, which includes housing navigators, tenants' rights support and help with first month's rent. A problem has always been is that there is not enough permanent housing. A concern with Inside Safe is that it is temporary, and when the City stops paying and we have not been able to move any of the L.A. Care members into permanent supportive housing, they may end up unhoused. The complexity in resolving the challenges requires an extraordinary level of coordination. Chairperson Ballesteros noted it is wonderful that health plans have resources to help people with social services. Dr. Brodsky thanked the Board for the creativity in their comments. Chairperson Ballesteros commended Dr. Brodsky and Mr. Robinson for their work.	
CHAIRPERSON'S REPORT	**PUBLIC COMMENT** *Elizabeth Cooper commented that the information she is hearing is very helpful. She is concerned that it never gets to the RCACs. They don't hear this. They don't hear any of this and they can't comment on it. She knows board members do a wonderful job in the presentation, but the RCAC members are very vital part of L. A. Care. She would like to hear this presentation on a RCAC level in layman's terms. She wishes the chairperson would please take notice when all of these presentations come. He should direct Department of Consumer Engagement to have the RCAC membership participate. She comes here. She just feels so lost sometimes when she's hearing all this valuable information from very informed members of the Board. But what are the RCACs for if they can't get involved and give input through the Executive Consumer Advisory Committee? She hears nothing. She has been here a long time and they used to give input. There are so many people who are homeless. She networks as an advocate. She networks with people, and some of our L.A. Care members. What is Community Outreach doing to engage us? When you hear from the homeless, when you hear of this topic? Something needs to be done to engage the community outreach to engage us. They are members too.*	

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• Board Officers Election	*She is a member and she has engaged in these topics, homelessness and tenants' rights and et cetera. And we hear these outstanding people come and make a presentation. Please, Chairperson direct the staff to make sure that it comes down to the RCAC members, because there's no engagement, as far as she's concerned. She can only speak as Elizabeth Cooper and she comes here to listen and to learn, and not just to sit and be a potted plant. She would like the Chairperson to please help members be engaged too.* Chairperson Ballesteros summarized the officer election process: • L.A. Care will follow the usual process for the annual officer election for the 2024 calendar year. • Board Members can nominate a colleague for one of the four officer positions, renominate the current officers, or nominate a new slate of officers. • Nominations can be submitted at the December meeting and can be sent prior to the December meeting. At the December meeting, the board will consider a motion to close nomination and the board will consider voting to elect officers on a slate. • All Board members are eligible for nomination to an officer position.	
CHIEF EXECUTIVE OFFICER REPORT	**PUBLIC COMMENT** *Elizabeth Cooper asked to speak on the election of officers. She would like to see a consumer president. She will be honest; honesty is the best solution. She'd like to see one of the advocates president so they can set the agenda. Because, as a member, it's very important for community engagement. She sees so many intelligent people sitting on the Board and she listens to them and sometimes tries to talk like them. She tried to, but she can't talk like them. She asked the Chairperson to help the consumers get involved. She has never been asked to be on the board. She's never been asked to sit. One doesn't have to be at the seat, but one can talk to the seat. So, when you come up with this election, elect some of the consumers, and she wants the consumers to be more engaged with our representatives on the Board. Don't be just like a potted plant. She hears so many people being engaged. Let's hear the consumers because we are the ones who call their legislators, and they are the ones who listen to us. She is engaged nationwide with her legislators, from the Governor on down to the legislators. When she comes here, she can support the Board's agenda and she appreciates that. She would like to see more developmentally disabled engaged. That's a population that seems to be forgotten, the disability community, the developmentally disabled, not just disabled. She would like to see more engagement. She asked the Chairperson to let Mr. Baackes know her concerns.* Mr. Baackes reported: • Five months are complete of the twelve-month Medi-Cal eligibility redetermination process. Eligibility redetermination was suspended for Medi-Cal beneficiaries during the public	

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	health emergency. Approximately 75,000 L.A. Care members were placed on hold for the month of November. That means either the member mailed in their redetermination package and it has not been reviewed yet, or the member did not mail it in and it has not been received yet. In any event, those Medi-Cal beneficiaries on hold have 90 days to complete the paperwork and be reinstated. Since the beginning of this program, 283,000 members have been put on hold and 11,000 have been reinstated. Those members received the paperwork and about 4% completed it. The California Department of Health Care Services (DHCS) expects that 4% of the Medi-Cal members placed on hold will be reinstated. L.A. Care added 30,000 new members, resulting in a net loss in membership for November of about 48,000 members. Year to date, the net loss in Medi-Cal membership has been 153,000, which is about 5.6% of L.A. Care's total Medi-Cal enrollment. L.A. Care budgeted that after 12 months of eligibility redetermination, it would lose 13% of the Medi-Cal enrollment. Results are a little better than we thought, although January will be a big month because there are a lot of redetermination occurring. L.A. Care has requested DHCS to provide list of the anniversary dates for its Medi-Cal members so it could advise members when to expect the paperwork. L.A. Care is supposed to receive a list tomorrow from the DHCS that includes a complete file of the redetermination dates for its members. This will be a big step forward, because it will allow L.A. Care to be more targeted in messages to members who have a renewal date in a particular month and reinforce the importance of the mailing that package to continue to receive benefits. L.A. Care is very pleased with that development. There were comments in previous meetings about indigenous people in Los Angeles who are on Medi-Cal, and L.A. Care is working to have renewal information distributed to those communities. L.A. Care thanks Supervisor Solis for providing us with the connection to Comunidades Indígenas en liderazgo (CIELO), which is providing that information. Whenever indigenous people can be identified in the redetermination data, L.A. Care has not noticed any difference in the rate of renewals with that population, but L.A. Care will continue to monitor the data. Board Member Vaccaro asked if L.A. Care would share redetermination information within the provider networks. Mr. Baackes responded that is the intention to let them know when there is a patient on hold so the provider can support that patient in reinstating benefits. • Mr. Baackes reported that since 2015, L.A. Care has given providers a report card on the performance. The report card became the basis for performance incentives paid to those providers. Providers who made improvements in quality scores year over year are recognized annually. There is not a similar program for hospitals and skilled nursing facility (SNF) providers. L.A. Care has designed a program to be implemented in January 2024, and is discussing the program with some of the hospitals and SNFs and gathering their feedback. Information will be presented to the Board in February 2024. The program aims	

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	to measure quality outcomes. DHCS and the California Department of Managed Health Care (DMHC) have placed more emphasis on quality scores, and sanctions and corrective action plans are being linked to achievement of those quality goals. The program has been very helpful to the medical groups. It has helped L.A. Care improve its accreditation from the National Committee for Quality Assurance (NCQA). • RCAC members had brought to the Board an issue of accessible exam room equipment. A few years ago, L.A. Care implemented a program that outfitted many providers with accessible exam room equipment. L.A. Care would now like to make this a continuing part of the Community Health Investment Fund program. It is hoped to have a program in place by January 2024 so Providers can apply for funding for accessible equipment.	
• Vision 2024 Progress Report 4th Quarter	*Mr. Baackes referred Board Members to the written reports included in the meeting materials.*	
• Monthly Grants and Sponsorships Reports	*Mr. Baackes referred Board Members to the written reports included in the meeting materials.*	
• Government Affairs Update	Joanne Campbell, *Health Care Policy Specialist, Government Affairs,* reported the members of the US House of Representatives elected a new Speaker, Mike Johnson. Mr. Johnson is serving his fourth term representing the 4th District in Louisiana. The continuous resolution for federal funding runs out November 17. Speaker Johnson seeks to send dozens of funding bills to the floor for consideration before the stopgap measure expires. The House has passed over half of the 12 individual spending bills that historically received bipartisan support. This does not include the Health and Human Services funding bill. All of the individual funding bills must be passed to have a federal budget. She noted that the Speaker, as well as the Senate Majority Leader, might be open to supporting another stopgap funding measure. Neither have made a public statement, however experts across the board believe they will both be agreeable. On a similar topic late last week, President Biden sent Congress a $56 billion domestic aid package along with even larger foreign aid package. The domestic aid package includes childcare funding. Increased childcare funding was part of the COVID-19 recovery package and is in jeopardy if there is a government shutdown. The Speaker's priorities regarding the domestic and the foreign aid package do not match up with Senate leadership. The 12 individual spending bills and the domestic and foreign aid packages are not connected. This may cause friction between the two houses of Congress during negotiations.	

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	Board Member Booth asked about virtual specialty programs in the high quality network section of the Vision 2024 Progress Report for the 4th Quarter. At the one-year mark, it states that 82 eConsults were received and four visits. Since eConsult has had problems, she wonders what is being done differently. Mr. Baackes responded that DHS issue was that regulators determined eConsult was not a utilization management (UM) system. eConsult was very useful to DHS, but was not useful to L.A. Care, as a health plan, because it did not fit the UM definition used by DHCS. Amendments have been made so eConsult can be used as DHS intended, as the equivalent of hallway consultations between providers. Mr. Baackes introduced David Kagan, MD, *Senior Medical Director, Direct Network, Utilization Management,* who noted that a challenge for DHS is that no UM program seemed to be connected to eConsult. L.A. Care worked collaboratively with DHS to develop eConsult as a medical staffing and decision-making tool and a UM program for managed care. DHS is using the programs properly. Alex Li, MD, *Chief Health Equity Officer,* noted that this is for private doctors in L.A. Care's directly contracted network, and includes eConsult. It follows the rules and regulations for member choice for the provider based (initiated) decision, and the standard process will be followed if there are any Appeals or Grievances from members. Mr. Baackes acknowledged Phinney Ahn, *Executive Director, Medi-Cal*, who has been tracking and providing analysis for the redetermination activity. Board Member Contreras noted that there are waivers that will be effective October 1. The most impactful will be for individuals experiencing homelessness. Los Angeles County Department of Public Social Services (DPSS) can push the Medi-Cal redetermination forward without requiring a completed application for those with whom DPSS has had prior contact. There have been challenges with getting applications completed for these individuals. Another thing is that glitches in the automatic renewal system have been worked out. DPSS has been running at a 45% renewal rate for those eligible for automatic renewal, and that will increase to 73% by December. It will not be retroactive. This will be a significant increase in the processing rate.	

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CHIEF MEDICAL OFFICER	Dr. Kagan reported on behalf of Sameer Amin, MD, *Chief Medical Officer*. L.A. Care is working with SNFs and hospitals around transitions of care. L.A. Care held three roundtable events with hospitals and SNP representatives to identify, catalog and brainstorm solutions for patients whose complex medical and psycho-social needs contribute to challenges in achieving smooth hospital discharge and placement, particularly for those who are experiencing homelessness and unable to take care of themselves for a variety of reasons. This problem is not unique to L.A. Care or to Los Angeles County; and much has been written about the challenges nationwide. Los Angeles County has a large Medicaid population and it does affect L.A. Care. With the feedback from the hospitals and SNFs, a multi-step, comprehensive set of interdependent initiatives was developed to address the challenges: • First was developing a more personalized and simplified referral process between the hospitals and the SNFs. This is a successful pilot currently with a high volume providers and high volume hospitals. When people at the facilities are in direct communication to each other, referral documentation has been pared down to two pages of relevant information. This is helping place patients faster, as the SNFs understand what the patient needs. • L.A. Care has revised contracts to bring clinical needs and financial reimbursement into alignment. Dr. Kagan thanked the Finance team for their support in making that happen. The models are being tested with the SNFs to gather feedback, which has been positive and constructive. Efforts are also being made to curate the network, in terms of size and capability, so that the supply of SNF availability meets patient demand. L.A. Care is also working to expand professional ancillary services that it provides through SNFs, to ensure that we have alignment between the nursing home and the professional services. L.A. Care has expanded the internal case management team to support SNFs on discharges. As discussed earlier, there is aggressive expansion of Community Supports (CS) benefits and in 2024 there will be a continued focused effort to transition institutionalized patients out of custodial care and back into the community. • With regard to discharges, L.A. Care has made some tremendous efforts internally in how it supports and works with hospitals. Bed availability in Los Angeles County is very tight; there are not enough beds in Los Angeles County to support the members that need it, and L.A. Care is working with what is available. Effective November 1, L.A. Care's internal team was restructured to improve support for hospitals; the inpatient case management team has been assigned to specific hospitals. This will allow case managers to work together and develop a relationship as they communicate about what patients need, and conduct discharge planning earlier. Although there are some inefficiencies in the new model, we believe that the inherent value of people talking to each other is going to improve patient care. The discharge authorization team is achieving same day responses for patients who	

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	are ready to leave the hospital. L.A. Care is working with a wide selection of post-acute vendors and ancillary services on effective authorizations, to avoid any impediment to patient care. The hospitals tell us that the patient needs durable medical equipment or needs a place to go. The hospitals and the vendors work together, and L.A. Care works to reconcile the authorizations and the claims. This is working quite well. A substantial effort has been made to expand our difficult placement team by three-fold and L.A. Care now has three nurses focused on the most difficult and challenging patient placements. L.A. Care is able to support our hospitals more efficiently. L.A. Care has initiated standing weekly calls with high volume hospitals to discuss any potentially challenging patient discharges. Recurrent joint operations meetings are focused on operational metrics and large scale operational challenges that the hospitals and L.A. Care can work together as efficiently as possible. All of this will dovetail nicely with work done in transitional care services. The new CalAIM program includes ensuring that members are transitioned properly out of the hospital back into the community, and that the health plan provides the transitional care services. In 2023, the focus has been around high risk members and in 2024, it will be expanded to low risk members. Over the past five months, transitional care cases have increased tenfold. There is now 44% engagement of patients when L.A. Care is providing transitional care services. L.A. Care is able to reach out to the member within one day of being notified that the member is being discharged and the team includes a group of case managers, care coordinators and community health workers. Last week L.A. Care received significantly updated guidance from DHCS about changes in requirements in the management of low risk patients being discharged from the hospital. Historically, high risk and low risk members had the same requirements. DHCS has now made the requirements for low risk patients significantly less stringent, and L.A. Care members will now need to be seen by a primary care provider (PCP) within 30 days of a hospital discharge. Given the patient loads for L.A. Care providers, this will be difficult to manage. L.A. Care is working with the various large volume systems on how we can ensure that patients get the appropriate appointments they need within the required time frames. L.A. Care will coordinate with providers the on these efforts, because a substantial amount of the transitional care work for the low risk numbers is going to be done amongst the delegated network of providers. • Within the Appeals & Grievances (A&G) areas, there have been lots of discussion on how L.A. Care will process, adjudicate and act on Grievances in a more efficient and timely manner. He thanked Acacia Reed, *Chief Operating Officer,* for supporting his work with staff. Staffing, workflows and training materials have been redrafted to align within required compliance. A significant amount of medical director support has been dedicated to the A&G department. Peer review efforts have expanded across a much wider cast of physicians with much more diverse clinical backgrounds to ensure that members are getting	

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	the care they need at the best possible quality level. Metrics continue to improve in the performance of the direct network. He highlighted that all the internal utilization management (UM) metrics are within regulatory compliance, and continue to improve. They are actually the best ever in terms of the work that the internal medical management teams are doing. Call center wait times over the past 10 months internally in medical management have gone from 5 minutes wait time to 33 seconds' speed to answer. The abandonment rate has dropped from 60% to 4% with better training and better staffing. Like all health plans, L.A. Care is constantly adjusting the authorization requirements so as not to obstruct or delay care but to ensure authorization for care is effectuated well and members are getting the care that they need. More effort is going into case management; making sure that our members are connected with services. • With regard to medical director staffing, a decision was made to bring in a substantial amount of new physicians. Five physician medical directors are or will be on boarded since July, across a much wider array of specialties. This will allow expansion of peer view efforts and make a much larger impact on ensuring that our members are getting the care that they need. Board Member Booth asked if the physicians being in a broader spectrum of specialties is to match reviews by specialty. Dr. Kagan confirmed she is correct, and it brings a different brainpower. L.A. Care is creating care management under new requirements for pregnant individuals or children special health care needs, and having an OBGYN or pediatrician specialist allows the health plan to create those programs in a more appropriate way. Supervisor Solis is pleased to hear his report. She asked if the CEO has met with some of the hospitals that originally may have had some concerns and what feedback has been received. Mr. Baackes responded that since March he has met with the largest hospital systems, as they are the ones that had the most concerns. The changes made in L.A. Care's Health Services operations are recognized and feedback from those hospitals has been that L.A. Care is now the easiest plan to work with about placing a difficult patient, or in terms of a referral. It is a complete turnaround in terms of the hospitals' attitude. He hopes that Board Member Greene, if he were present, would support this statement. The Hospital Association of Southern California (HASC) is holding a hero's award dinner to recognize front-line workers and Mr. Baackes led an effort among local health plans to raise $100,000 for the benefit of those workers. A scholarship program was created through the generosity of health plans. Progress is being made in improving L.A. Care's relationships with the hospitals. Mr. Baackes noted that hospital representatives said to him that they always felt comfortable contacting him for assistance. Supervisor Solis thanked Mr. Baackes for the report.	

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	Mr. Baackes commented that Dr. Kagan reported on transitions of care and the regulations that the DHCS imposed, which L.A. Care found extremely onerous. L.A. Care and other health plans in Los Angeles County got together and figured out that if all health plans fully staffed up at least 600 new people would need to be hired to comply. The health plans would be competing for staff with hospitals, skilled nursing facilities and clinics. The group of five health plans went together to meet with DHCS representatives and successfully achieved significant modifications. Board Member Roybal noted that he is unsure if DHCS is aware how much the 30-day PCP visit after a hospital admission will impede access for all patients. For some hospitalizations, it makes no sense for a PCP to see that patient within 30 days. A patient experiencing a complication following surgery would need a surgeon. The requirement has a potential to decrease access, especially since there are not enough primary care providers. Mr. Baackes responded that is an important concern, and DHCS responded by modifying the requirement to narrow the spectrum of who has to be seen within 30 days. Dr. Kagan noted the requirement was originally 7 days. Mr. Baackes noted that one of the reasons for promoting the reinstatement of the managed care organization (MCO) tax was to generate additional funds for primary and specialty care services. Adding a regulation that does not have a clinical basis is only undoing the good that could be done with the additional funds. The health plans and providers need to speak with one voice. Board Member Booth asked if this was for regulators to have clear data on whether a patient complied with the 30-day post hospitalization requirement without allowing any room for judgement by physicians. She asked if there is clarity on the level of risk for the patient. Dr. Kagan responded that DHCS has determined what is considered high risk, and all the rest falls into lower risk categories. When asked if he feels this is reasonable, Dr. Kagan responded it is fair, but he does not necessarily agree that it makes sense clinically. Some patients do not need a 30-day follow up. Dr. Booth noted that some patients might look high risk because of the words on the paper, too.	
ADVISORY COMMITTEE REPORT		
Executive Community Advisory Committee (ECAC)	**PUBLIC COMMENT** *Elizabeth Cooper commented she first want to say she's speaking from participation over the years. Regarding the public advisory committee, she's deeply concerned, but she wants to hear more input from the two representatives who represent hundreds of L.A. Care members who are consumers. She listens to the very intelligent remarks of Board members. She rarely hears those two advisory members. There is a new chair, a new advisory*	

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	committee member, and she hopes she take notice. What she is concerned about as a public and a member of one of the advisory committee members, that they never say anything on the agenda that we, in the public, who they represent. For instance, she brings up many topics, but she doesn't hear, it's like silence. That means consent. Do you agree or do you disagree? We need our representatives just like you are members of the Board, and the Board of Supervisors gives comments, but she never hears anything from the advisory committee members who represent the consumers. She brought up many topics from the advisory committee members and it never gets on the agenda. And what is the advisory committee members for there? They're to represent them. What is the consumer enhancement department? It is to represent the consumers who have a voice. She can hear the intelligent remarks from the Board members. As one who once served as vice chair, we brought many issues before the board. But please, the two representatives, the consumer advocate and the consumer representative, it's not about longevity for her, but she's listening. Please do something, don't be a potted plant. You give your points of view too. She hears so many comments, and the consumers have a voice on this Board of Governors, we should. They should direct the consumer CEO and make sure they give us the input. Because she feels like she's just here talking. It takes a lot of time and sometimes a little bit of courage to speak, but I hope our two representatives, and she wants to welcome our new representative, and I hope that she speaks up, and the customer advocate, just like the Board members. So that's why she's here. She's not here to attack; she's here to offer suggestions. The consumer advisory committee used to be very powerful voice, but now she only hears silence. Where are the consumers who come before the Board? Encourage them to get involved. She would like to see, she knows this is a sensitive remark, but she has to say it, we need to see more diversity on that Board too. We need to hear some voices of those that are powerless. She hopes the two representatives make sure. She can address it to them because they are the ones who they were elected to serve. She would like to see our advisors; she'd like to see our representatives who represents the RCACs. That's something she hears all the time, but they do not talk. She asked the Chairperson to take notice during meetings. Board Member Booth asked all the members on the Board that feel they represent consumers, patients or are an advocate representative to raise their hands. [*Several Board Members raised a hand.] There were additional remarks from Ms. Cooper that were inaudible on the audio recording as she was too far from the microphone.* Board Member Vasquez thanked the members that attended the ECAC in person and those present today. [*Board Member Vazquez spoke in the Spanish language, and her remarks are written as translated into English.]* The Temporary Transitional Executive Community Advisory Committee (TTECAC) met on October 11.	

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	• Mr. Baackes gave a Chief Executive Officer update. He gave a report earlier in this meeting. • Dr. Amin discussed various structure changes and investments made in L.A. Care Health Plan's Health Services department over the past year. He emphasized the significant increase in resources allocated to case management and the expansion of the case management department by over 60%. The expansion includes employment of community health workers and care managers, focusing on treating complex conditions and ensuring the proper coordination of care for members transitioning in and out of healthcare facilities. Board Member Gonzalez continued the report: • Ms. Thanki and Ms. Campbell gave a Government Affairs update. • A federal judge ruled last month that the Deferred Action for Childhood Arrivals (DACA) program is unlawful. DACA started in 2012 by President Obama to protect from deportation young immigrants who had been brought to the United States as children. DACA holders can work legally in the United States and travel abroad with permission from the government. It is important to note existing DACA beneficiaries will not lose protection from deportation and they can still renew DACA status. This will affect those not already enrolled in DACA, as they will not be able to apply for DACA. Appeal of the decision is expected and it will be months or perhaps years before the federal courts render a final decision. Many had hoped that Congress would pass legislation that would provide a path to U.S. citizenship for DACA holders and other undocumented immigrants, but that is unlikely until at least 2025. • The committee held a TTECAC Chair/Vice-Chair Election. They congratulated Ana Rodriguez from RCAC 2 in the San Fernando Valley, on her election as Chairperson. Deaka McClain, Member At-Large, was elected Vice-Chairperson. Board Member Gonzalez noted that ECAC has not received any documentation as to what is mandated and what changes or recommendations were made for the restructuring of the advisory committees. She requested that a report be given to ECAC. She understood that a matrix would be provided to inform ECAC about the changes. But that is not the same as the actual document provided by the state. She asked that the actual document be provided rather than a paraphrased version of it. Board Member Vazquez commented [*Board Member Vazquez' remarks were in Spanish and are presented here translated into English.]* that she would also like to see a broader representation so they are able to give robust information to the members. That would be their greatest impact, and they are here to serve the members. Board Member Shapiro commented that it is very nice to meet Ms. Vazquez and he welcomed her to the Board.	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
BOARD COMMITTEE REPORTS		
Executive Committee	**PUBLIC COMMENT** *Elizabeth Cooper asked about the diversity on the committee for the Community Investment Priorities. She's concerned when these investments are made, that's where money comes in, and she looks at money. Who is on there? How does one get on the committee and what kind of investment is LA Care making? She knows these are challenging questions, but we the people have a right to know, because see these issues are not discussed. We have no RCAC meetings so she can't participate now with the fiscal year of 2023. No more RCAC meetings, she was informed. She would like to know what are the investments, who gets the investments, who's on the committee, is the committee made of diverse members; Afro Americans, native Americans, people who speak another language. These are the things that need to be brought to the attention of the Board. She asked that the answers because she needs to know who's on the committee, who's making the decisions. Because where the money goes, if there's no diversity then you don't know whether there's fairness and that its going to the total community of the great city of Los Angeles and Los Angeles County.* Mr. Baackes responded that there is no committee. The Community Health Investment Fund (CHIF) has been around almost since the beginning of the operation of the health plan, and is run within the administration of the organization. There will be a presentation by Shavonda Webber-Christmas, *Director of Community Benefits*, about the priorities for the CHIF in the 2023-24 fiscal year. This process invites community organizations to apply for grants and funding through the program. The selection of grantees is very rigorous. Ms. Webber-Christmas will go over that for the Board. A written report is provided to the Board every year on the grants made, the organizations receiving the grants and follow up activity. Chairperson Ballesteros noted that the grants are approved by the Board. There will be presentations for proposed grants brought to the Board for approval, there will be discussion by the Board when the presentations are made. Chairperson Ballesteros reported: • The Executive Committee met on October 25. • The approved meeting minutes can be obtained by contacting Board Services and will be available on the website. • The Committee reviewed and approved a motion at that meeting that was approved earlier today on the Consent Agenda. • The Committee approved a motion for Human Resources Policies HR 105 (Employee Benefit Plans), HR 109 (Jury Duty and Witness Subpoenas), and HR 709 (Language Proficiency Assessment). Those motions do not require full Board approval.	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
• Community Health Investment Fund (CHIF) Priorities FY 2023-24 **(BOG 100)**	Ms. Webber-Christmas presented the proposed priorities for the Community Health Investment Fund (CHIF) for FY 2023-24 (*a copy of her presentation can be obtained by contacting Board Services)*: Overview • As of October 1, 2023, the CHIF Program has supported more than 979 projects for 190 unique community entities, and invested more than $138 million in organizations caring for under-resourced communities. • CHIF awards improve clinics' workforce and infrastructure, access to care and improved health outcomes for members, and social determinants for under-resourced communities. All grant awards strengthen the health and social safety net. • Staff seeks Board approval to allocate the approved $10 million CHIF fund* across Community Benefits' Grant making Priorities for FY 2023-24 The awards improve clinic workforce and infrastructure, improve access to care, improve health outcomes for our members and address social determinants for under resourced communities. All of L.A. Care's grant awards strengthen the health and social safety net. The four proposed CHIF grant making priorities for FY 2023-24 are: **PRIORITIES PROJECTION SUMMARY** **PRIORITY/PORTFOLIO** / **ALLOCATION** **Support the health care safety net to improve infrastructure and address disparities** / **$4,450,000** **Advance solutions for social determinants of health to reduce inequities** / **$2,800,000** **Close pervasive health disparities gaps** / **$1,500,000** **Empower and invest in health and health related social service organizations that address systemic racism** / **$1,250,000** **Total CHIF Allocation** / **$10,000,000** Supervisor Solis commented that she is very pleased with the report, and especially pleased to see that justice involved communities are included in the last priority. That also helps us serve individuals that are coming out of the carceral system, whether it is youth or those coming out of jails, to receive some assistance through reentry programs and prevention. Many of them will end up on the street without that assistance. She hopes that L.A. Care will work with some of the new initiatives at LA County such as Justice, Care and Opportunities Department (JCOD),	

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	Department of Youth Development (DYD), and Care First Community Investment (CFCI). These are organized groups working with almost the same populations. She suggested that joint support could better expand some of this work to help sustain those groups doing hard work helping both L.A. Care members and LA County residents. Board Member Gonzalez asked if projects to provide accessible examination tables for health care sites would be included in the CHIF grant making. Ms. Webber-Christmas responded that it is included as part of the first CHIF priority, supporting health care safety net infrastructure. It will be included in annual planning for funding so that it would be accessible throughout the year. Ms. Webber-Christmas expressed her appreciation for the Executive Committee's discussion and reflection on the important impact that community health investments have on the health care system, social determinants of health, and the individuals that benefit from the services. *Board Members Ballesteros, Greene and Vaccaro may have financial interests in Plans, Plan Participating Providers or other programs and as such should consider refraining from the discussion of subsection c. to close pervasive health disparities gaps and/or d. to support the health care safety net to improve infrastructure and address racial inequities, and those Board Members' vote reflects a vote concerning the entire Motion excluding those items for which the member is abstaining.* Board Member Booth proposed an amendment to subsection d. in the motion to add, "health related" before social service organizations. **<u>Motion BOG 100.1123</u>** **1. Approve the recommended approach for the Community Health Investment Fund (CHIF) FY 2023-24 allocation of $10 million in the following priority categories:** **a. Support the health care safety net to improve infrastructure and address racial disparities, recommended at $4.45 million,** **b. Advance solutions for social determinants of health to reduce inequities recommended at $2.8 million,** **c. Close pervasive health disparities gaps, recommended at $1.5 million, and** d. **Empower and invest in health and health related social service organizations that address systemic racism, recommended at $1.25 million**. **2. Delegate authority to the CEO to adjust CHIF priority category amounts noted above to align with evolving community needs and requests. All other policies and procedures related to CHIF grant-making investments will remain.** **Shavonda Webber-Christmas thanked the Board of Governors for their approval of the 2023-24 CHIF Priorities.**	**Amended motion was unanimously approved by roll call.** **9 AYES (Ballesteros, Booth, Contreras, De La Torre, Gonzalez, Roybal, Solis, Vaccaro and Vazquez) with abstentions noted for portions of the motion.**

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Finance & Budget Committee	**PUBLIC COMMENT** *Elizabeth Cooper commented that the reason why she comes here is sometimes public comment on these issues need the public concern. You might or might not agree with the public, but it's important in a democracy that the public have a voice, and I appreciate the voice and that you've given me the opportunity. Regarding the chief financial report, she's concerned, she never thought about the budget, but we all have a budget in our home. Sometime we have sometimes not, but I would like to budget to consider, the Financial department, et cetera, she doesn't have the agenda in front of her, to consider more money for the RCAC's participation. It has not been discussed, but please put more money in the budget for the RCAC members so they can participate in all aspects of L.A. Care's decisions. Because it's very important. They are the ones that get the engine to go. They're the ones who you ladies and gentlemen are representing. She thanks each and every one of the Board Members for this holiday season and peace and goodwill. She feels these issues need to be discussed and the financial budget needs to be put in for consumer activity. And that's something that she's been very concerned about. She hopes that Board Members consider with the budget for the fiscal year of 24, not just for Elizabeth Cooper, but for those voices that do not say something. Put money in for more public engagement and for more public participation because I find that that's not too good, in her opinion, public comment, and please in the budget so that we can learn more about the system. For this year, I would like to thank you, ladies and gentlemen, and members of the Board of Governors, particularly the Chair and the Chief Executive Officer, for giving her the opportunity to speak about the budget. But that's so important. Congress has advisors. Sacramento has a budget, L.A. Care has a budget. But how you use that budget is very important for the good of all the members, regardless of their status, whether they're on a Board or whether they on a committee. So please put some more money in there for public engagement.* Treasurer Booth reported that the Committee met on October 25 *(a copy of approved minutes can be obtained by contacting Board Services)*. The Committee reviewed and approved motions at that meeting that were approved earlier today on the Consent Agenda. The Committee received written reports on Sponsorships & Grants and Monthly Investment transactions, which are also included in today's Board meeting materials (*copies of all the reports can be obtained by contacting Board Services*).	
Chief Financial Officer Report	Afzal Shah, *Chief Financial Officer*, reported on the August 2023 Financial Performance *(a copy of the report can be obtained by contacting Board Services)*. <u>Membership</u> Membership for August is 2.9 million members, which is almost 42,000 favorable to the forecast. This favorability is driven by Medi-Cal, with lower than expected disenrollment and higher than expected enrollment, with 32,000 members added. There were approximately	

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	20,000 terminations and 1200 retroactive disenrollments in August. The forecast assumed an overall 1% drop in membership for Medi-Cal across all categories of aid. There was a slight unfavorability in membership for L.A. Care Covered (LACC) of about 1800 members. <u>Consolidated Financial Performance for August 2023</u> Excluding financial performance for Housing and Homelessness Incentive Program (HHIP) and CalAIM Incentive Payment Program (IPP), financial results for the month of August reflect a net surplus of $32.9 million, about $8 million behind the 9+3 forecast. $66.5 million in revenue was recognized in August for IPP. L.A. Care has recognized only the revenue it has spent for IPP. Clarification has been received on performance and the remaining balance has been recognized in the year to date financials. <u>Consolidated Financial Performance Year to Date as of August 2023</u> Year to date excluding HHIP and IPP, financial results are $381,882 million surplus, which is about $56 million better than the 9+3 forecast. The biggest driver is incurred claims, which are favorable to forecast by about $62 million. There is also favorability related to Community Based Adult Services (CBAS), Enhanced Care Management (ECM), Major Organ Transplant (MOT) and Long Term Care (LTC). Offsetting these items are capitation and fee for service increases. Administrate expense had been favorable for at least the first seven to eight months, is unfavorable by $3.5 million. <u>Operating Margin by Segment</u> For the 11 months ended in August by line of business, the total revenue healthcare expenses, and the ratio between health care expenses and revenue overall, excluding HHIP and IPP, are performing about 0.4% better than forecast at 92.1% versus 92.5%. MCR for all segments is close to the 9+3 forecast, with some variation in DSNP. For the new fiscal year, Cal MediConnect (CMC) will no longer be reported separately as all of those members have transitioned into the Dual Eligible Special Needs Plans (DSNP). <u>Key Financial Ratios</u> The cash to claims ratio is higher than forecast because L.A. Care received capitation payments from DHCS on August 31 and payments were completed in early September. LA Care also received Medi-Cal Hospital Quality Assurance Fee Program (HQAF) payments for hospitals in August, which were paid in September. <u>Tangible Net Equity and Days of Cash on Hand</u> Fund balance is $1.6 billion, representing 700% of the tangible net equity (TNE) requirement. The fund balance is the net of the assets less liabilities. For the month of August, L.A. Care currently has enough cash to cover operating expenses for about 82 days.	

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	Motion FIN 103.1123 **To accept the Financial Reports for August 2023, as submitted.**	**Unanimously approved by roll call. 9 AYES**
• Monthly Investments Transactions Report	Mr. Shah referred to the investment transactions reports included in the meeting materials (a *copy of the reports can be obtained by contacting Board Services).* This report is provided to comply with the California Government Code and is presented as an informational item. L.A. Care's total investment market value as of August 31, 2023 was $2.1 billion. • $2 billion managed by Payden & Rygel and New England Asset Management (NEAM) • $35 million in Local Agency Investment Fund • $79 million in Los Angeles County Pooled Investment Fund	
Compliance & Quality Committee	Committee Chairperson Stephanie Booth reported that the Compliance & Quality Committee met on October 19. *The approved meeting minutes can be obtained by contacting Board Services.* Todd Gower, *Interim Chief Compliance Officer,* and the Compliance Department presented the Chief Compliance Officer report. • Michael Sobetzko, *Senior Director, Risk Management and Operations Support*, gave an Issues Inventory Update. He spoke about Part D auto forward for the coverage determination appeals report timeliness issues over a 5-month period. The issue has resulted in a cap request of Navitus. In all, there were 10 new issues created in August and two issues have been closed. • Mr. Sobetzko gave an update on top risks. One of the top risks pertains to the C2 - HRA Assessment / Reassessment Timeliness. When HRA assessments are not completed in a timely fashion, there is a potential that enrollees who need extensive care management interventions will not receive them. IT development team completed the D-SNP monitoring report on August 11, and the business unit completed post-production validation. A report to identify L.A. Care Medi-Cal members requiring an HRA was deployed and completed. • Magdalena Marchese, *Senior Director, Audit Services* and Mr. Gower gave an Internal Audit (IA) Update. The internal update outlines several key points regarding IA activities: – There are 27 project streams to support IA execution and Compliance Operations. – Ten projects are currently active, with one completed and three in the final report Quality Assurance (QA) phase. – One project has been divided into two phases to facilitate an IT Data Management Audit. – There are six projects in progress.	

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	– There are four projects specifically aimed at supporting Risk Management in Compliance, which include Annual Risk Assessment, Compliance Operations support, and IA Annual Planning. – Ten projects are being considered and four are on hold by a third party. *(The full written report can be obtained from Board Services.)* Dr. Amin presented the October 2023 Chief Medical Officer Report. Dr. Kagan gave a CMO report on his behalf earlier today. Ms. Martinez reported that DHCS issued all health plans in California two Performance Improvement Projects (PIPs) to begin in September of 2023 through 2026. The first PIP is based on disparity, specifically Black/African American Children who will be turning 15 months in 2023. The measure's focus is the Well-Child Visits in the First Thirty Months of Life: 0-15 months. The second non-clinical PIP will be focusing on behavioral health needs around Emergency Department Use for Substance Use and Mental Illness. DHCS is requesting plans choose an area of focus to improve the coordination of care with their provider for follow-up visit. One closed PIP was related to Improving Childhood Immunizations rates in SPA 6. L.A. Care conducted clinic-based outreach based on L.A. Care Health Plan custom missing vaccine report. A second closed PIP was related to Improving Diabetes A1C Control. The interventions conducted were health education outreach and text-messaging campaign. A third QI project from Medi-Cal that will close in 2023 is the Strengths, Weaknesses, Opportunities and Threats for both the Well-Child Visits in the First Thirty Months of Life and Childhood Immunization Combination – 10. The interventions included developing a custom W30 report and flu brochure encouraging Flu vaccine uptake in children 6 months and older. For Covered California, the QI project is a disparity-focused project on improving A1C levels among Black/African American and American Indian/Alaskan Native populations. Currently members are contacted to enroll into Medically Tailored Meals and offered the option to work with L.A. Care registered dieticians. Ms. Sadochi-Smith gave the following updates: • Facility Site Review (FSR): DHCS has agreed to give all health plans until December 31, 2023 to complete all FSR/Medical Record Review (MRR) backlog surveys. To date, the FSR team has completed 377 FSR/MRR backlog surveys out of 420, and has completed all current surveys and initial surveys due for 2022 (meaning we are not adding to the backlog.) The quarterly goal of 53 backlog FSR/MRR for each quarter from Q4 2021 to Q3 2023 has been exceeded. L.A. Care has assisted other health plans by taking on 29 of their backlog audits to conduct and complete the FSR/MRR. • Initial Health Assessment (IHA) and Annual Cognitive Health Assessment (ACHA) o IHA: DHCS had two findings in the March 2023 Audit.	

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	✓ 1-The Plan did not ensure the provision of a complete IHA to each new member. ✓ 2-The Plan did not ensure the provision of a complete IHA within the required timeframe. L.A. Care is waiting for the results. PHM, EPO, and Compliance have drafted a Corrective Action Plan (CAP) based on the preliminary findings. o ACHA: L.A. Care is operationalizing improvements now that the ACHA All Plan Letter has been thoroughly reviewed and implemented. It is too early to assess performance.	
PUBLIC COMMENT on Closed Session Items	*Joyce Sales commented that she is very new to this forum. She is a long time L.A. Care member. Through an unexpected situation, she has been asked to chair the RCAC 6. Her question is in regard, and correct her if she's out of line because she's not used to being in these type of environments, she's been self-employed her entire professional career, so she kind of does her own thing. With regard to Ms. Christmases' presentation, there's always the conversation about removing the systemic racism, increasing the diversity. But when she talked about the funds that were awarded, I noticed that the GAAINS, which her understanding is related to African American programs or funding, whatever, was reduced by $25,000, and then the overall dollar amount was reduced by another $250,000. She's trying to factor the funding that is granted, is it going to private entities? Is it going to nonprofits? Is it going to corporate entities? How is that money being dispersed? Why is it when we talk about the systematic racism, the diversity that the numbers, the need, is always reduced, when the areas that are most needed are always reduced, but we don't get the funding and the services?* Ms. Webber-Christmas responded that L.A. Care recognizes that the amount of funding is decreasing across priorities, however, the Generating African American Infant & Nurturers' Survival (GAAINS) initiative under Close Pervasive Health Disparities Gaps has been in place for two years. This will be the third year. Funding was allocated based on prior years' need. However, the motion also allows John Baackes, CEO, to make adjustments as necessary. If there is more interest in programs to be funded, staff will ask for his consideration. The organizations that are funded across the Community Health Investment Fund are all nonprofit organizations. Those that have been funded over the past two years for GAAINS have been reported. The smaller nonprofit organizations that provide birth worker services in the community, including doulas and midwives, and are part of this particular fund, which takes a village approach, and includes clinics and networks and a number of organizations that are thinking and working towards improving the real health outcomes and the issues within African American and infant and maternal mortality. Chairperson Ballesteros offered his assistance to Ms. Sales to help her feel comfortable participating in Board meetings. *Deaka McClain is the currently the member at large representing people with disabilities. She will try to do this quickly; she has more than one comment. First, she thanked her colleague Joyce for bringing up the issue about the funding for systematic racism. She just wanted to piggyback on that as well. As far as the funding being decreased, she appreciates the explanation. However, it was said that Mr. Baackes can use his discretion as needed. She appreciates that, but at the same time, how can she say this diplomatically, sometimes, as needed is not good enough. Sometimes, it needs to happen right then and there, because we can't wait to as needed. Because something has already happened, but we're waiting to as needed. If she's making sense. She doesn't know if shes saying it right.*	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	She hopes people understand what she's saying. Particularly because she can only speak for African Americans. When it comes to her people, her population, most of the time. She's not saying it doesn't affect other nationalities. That's not what she's saying. We watch the news and a majority of the time it's affecting her people, and then we're saying, as needed. Does that make sense? Okay. But she appreciates the clarification. Just wanted to put that out there and encourage with the funding that extensive training be done in this area when it comes to racism, because sometimes we have hinted racism. And then it doesn't come out until later. For example, the George Floyd incident, if that would have been critiqued or monitored a little bit more, we might not have that situation. The next thing she wants to highlight is more funding be placed on the RCAC work plans, or maybe just in general, for preventing intimate partner violence. She has been here a long time, and while she has been here, she mentions domestic violence many times as part of the work plan. It hasn't happened yet. She will continue to bring this up because she feels that domestic violence, or intimate partner violence is a public health issue, and it will cut down on some of the expense that has to be paid when a person comes into the emergency room for being beat up. But if we focus on intervention and prevention a little bit more often, and educate, bring awareness to this issue, she thinks it would cut down on some of the expense. She will bring it up at the temporary ECAC meeting about organizations that we are part of. We talk about these things for people that are on Medi-Cal to help prevent domestic violence and intimate partner violence. *Elizabeth Cooper commented first, the Thanksgiving season is coming in a couple of weeks. She is thankful that she can speak today. And she's thankful for her son, Jonathan, who encourages her to keep going. Sometime she gets discouraged. She's hearing some of the members talk. As an African American brought up in the South, born in the South, she knows how hard it is. She talks about voting and getting involved in this system, and the system can make it work. She also thinks about L.A. Care since many years ago she was part of some of the issues that are discussed today. She would like the Board to put on the agenda, and the Executive Committee, please put on the agenda some of the things for consumers. She only has a voice in the RCACs, but she hears the voices of the people who have spoken, and she hears the voices of some issues, but often times she's been a little discouraged. Maybe she gets discouraged because many of the things we the public speak about, never gets a part of the agenda. And there is such nice wonderful leadership here. She appreciates every member of the Board; she really does from the bottom of her heart, on behalf of Jonathan. She also appreciates the CEO, Mr. Baackes, who has been sensitive. She has come before here and cried and it's not about longevity for her, she's been here many years. What she would like to see the Board do is be more sensitive to consumer issues as they speak. They're the voices of the community. She feels there needs to be diversity and she appreciates her representation there* on the Board. *And she's not demeaning anyone, but it's very important. Listen to the voices. Don't just say, thank you, wham, bam, thank you. Ma'am. But please listen to them and their voices, because they go in the community. She lives in kind of a diverse community. Some of the people come with her with their voices, and it's been a privilege this year to be a part of L.A. Care. Another wonderful thing is her son, who's developmentally challenged, and you've seen him at the Board. He's just as interested now. When he watches TV, he doesn't want to watch the fun things. He listens to what the people are saying, maybe he got it from his mom, but when he watches television, he watches what is happening on the news. But may she say something to the Board before she closes: please consider all this concern is voting. You might think that's not an issue. But what is going to happen in 2024 is going to affect healthcare. Please encourage the members to start now, get involved, vote. As an African American, she knows the challenges we've had in voting and so that's one thing we are very compassionate about. She's not saying other groups aren't. But vote, vote, vote. Because*	

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	healthcare. She commented that she respects Mr. Baackes a lot, but on a funny note, will everybody here get a turkey? Will RCAC members get a turkey? They deserve a turkey; please don't forget to give them a turkey.	
ADJOURN TO CLOSED SESSION	The Joint Powers Authority Board of Directors meeting adjourned at 3:35 pm. Chairperson Ballesteros thanked the members that came to the meeting and wished everyone a Happy Thanksgiving. Augustavia J. Haydel, Esq., *General Counsel*, announced the following items to be discussed in closed session. The L.A. Care Board of Governors adjourned to closed session at 3:45 pm. No report was anticipated from the closed session. REPORT INVOLVING TRADE SECRET Pursuant to Welfare and Institutions Code Section 14087.38(n) Discussion Concerning New Service, Program, Business Plan Estimated date of public disclosure: *November 2025* CONTRACT RATES Pursuant to Welfare and Institutions Code Section 14087.38(m) • Plan Partner Rates • Provider Rates • DHCS Rates CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION Pursuant to Section 54956.9(d)(1) of the Ralph M. Brown Act *In re: UpHealth Holdings, Inc., et al., Case No. 23-11476 (LSS), pending in the United States Bankruptcy Court for the District of Delaware* CONFERENCE WITH LEGAL COUNSEL—ANTICIPATED LITIGATION Significant exposure to litigation pursuant to Section 54956.9(d)(2) of Ralph M. Brown Act: Four Potential Cases CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION Pursuant to Section 54956.9(d)(1) of the Ralph M. Brown Act • Department of Managed Health Care Enforcement Matter Numbers: 18-799, 20-063, 21-428, 21-509, 21-680 • Department of Health Care Services, Office of Administrative Hearings and Appeals, In the matter of: L.A. Care Health Care Plan Appeal No. MCP22-0322-559-MF CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION Pursuant to Section 54956.9(d)(1) of the Ralph M. Brown Act *MemorialCare Select Health Plan v. L.A. Care Health Plan* American Health Law Association, Case No. 7028, filed April 28, 2022	

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RECONVENE IN OPEN SESSION	The Board reconvened in open session at 4:32 pm. There was no report from closed session.	
ADJOURNMENT	The meeting was adjourned at 4:33 pm.	

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

APPROVED BY:

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

DRAFT

L.A. Care
HEALTH PLAN

Board of Governors
MOTION SUMMARY

Date: December 7, 2023 **Motion No. BOG 100.1223**

Committee: **Chairperson:** Alvaro Ballesteros, MD

Issue: Selection of two charitable organizations to receive Board members' stipend.

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

Background: L.A. Care Board members receive $100 stipend for each meeting, up to a maximum of $400 per month. For Board members who wish to contribute their stipend to charitable organizations, a random selection process was developed to comply with IRS guidance so Board members are not responsible for taxes on the value of the donated stipend.

In December 2017, the process for choosing the charitable organizations was updated.

1. L.A. Care staff will identify charitable organizations nominated to receive Board stipend based on nominations received from Board members.
2. The random selection of two charitable organizations will be conducted by staff prior to the Board meeting and a motion will be presented to the Board with the first two organizations drawn.

The two organizations listed in the motion below were randomly selected for this motion.

The following are the organizations that received donated Board member stipends in the past 10 years:

2023: Covenant House CA and Planned Parenthood Los Angeles
2022: Meet Each Need with Dignity (MEND) and National Alliance on Mental Illness, Greater Los Angeles County (NAMI GLA)
2021: Community Coalition and New Life Community Food Pantry Pomona
2020: Homeboy Industries and Housing Works for California
2019: Project Angel Food and Insure the Uninsured Project
2018: Kurka Children's Health Fund and The American Lung Association
2017: Strong Food/LA Kitchen and The American Lung Association
2016: Kurka Children's Health Fund and The American Lung Association
2015: Watts Willowbrook Boys and Girls Club and Downtown Women's Center Los Angeles
2014: Watts Willowbrook Boys and Girls Club and Downtown Women's Center Los Angeles

Member Impact: None.

Budget Impact: None.

Motion: **To designate St. Vincent Meals on Wheels and Door of Hope Pasadena as authorized recipients of funds from Board Member stipends according to Legal Services Policy 300 for the calendar year 2024.**

St. Vincent Meals on Wheels
2303 Miramar St.
Los Angeles, CA 90057
Phone: (213) 484-7775
Email: info@svmow.org

Delivering over 100,000 meals a month

Our mission is to prepare and deliver nutritious meals to homebound seniors and other vulnerable residents across Los Angeles, regardless of age, illness, disability, race, religion, or ability to pay.

We deliver over 100,000 meals a month to seniors who are at risk of hunger. **There are over 250,000 seniors facing hunger insecurity in Los Angeles and many of them are isolated and homebound.** For many seniors, St. Vincent Meals on Wheels is a lifeline.

The Food We Serve

St. Vincent Meals on Wheels provides nutritious meals, shelf-stable food, wellness checks, and pet food to seniors across Los Angeles.

- We cook with top-quality ingredients and all our meals meet or exceed federal and local nutritional standards, are high in fiber, and low in sugar.
- Clients receive customized meals tailored to specific medical protocols, including low sodium, renal for kidney patients and low Vitamin K for heart patients. We also provide pureed meals for seniors with difficulty chewing and swallowing.
- We cater to personal preferences, including no beef and vegetarian meals.
- Most importantly, our meals are healthy and delicious!

Our Impact

In 2020…

- We delivered nutritious meals to 2,557 individuals helping to alleviate food insecurity.
- We served 995,655 meals across Los Angeles making us the the largest privately funded Meals on Wheels program addressing hunger.
- We partnered with more than 20 local organizations to provide meals at-cost expanding our reach throughout Southern California.

- We worked with 190 volunteers to ensure that our clients receive food AND care.

Our History

"In the beginning, it was just us and a few pots of stew. But the response was tremendous…"

Sister Alice Marie Quinn, Daughter of Charity and Registered Dietitian, founded St. Vincent Meals on Wheels in 1977. Under her leadership, St. Vincent Meals on Wheels has become the largest Meals on Wheels program in America.

Door of Hope
211 E. Walnut St., Suite 112
Pasadena, CA 91101
(626) 304-9130 x120
Email: info@doorofhope.us
Tax I.D. 501©3 EIN: 95-4044568

Door of Hope is a Christian non-profit, based in Pasadena, serving Los Angeles County. Door of Hope is one of the only homeless providers that can shelter any kind of family together in their own private unit, including single moms, single dads, and two-parent families together with their children.

Homelessness Crisis

Los Angeles County reported 66,433 homeless individuals. Due to the ongoing COVID environment, the homeless numbers are expected to significantly increase. While statistics and numbers can feel sterile, they represent a person and sometimes a family without a home, exposed to all the dangers of homelessness.

Our Response and Our Impact

Homelessness Prevention
Preventing eviction for families at risk
96% Housed 1 year later
77% Increased income
36% Increased savings

Transitional Housing

Sheltering families in transition

92% Increased savings

88% Increased income

88% Improved mental health

Alumni Support

Support program graduates

97% Employed at 1 year

95% Housed at 1 year

87% Housed at 5+ years

Why Door of Hope?

The heartbreak of homelessness can't be solved by providing a bed for the night, a hot meal and shower, or financial assistance alone. **We address the root causes of homelessness** with our holistic approach, while simultaneously, **keeping families together**. We listen to our families, give them a voice, advocate for them, and **empower our families** with the tools they need to succeed. Listen to testimonies from our Transitional Housing and Homelessness Prevention families, and learn how **your investment can make an impact.**

L.A. Care
HEALTH PLAN

Board of Governors
MOTION SUMMARY

Date: December 7, 2023

Motion No. FIN 100.1223

Committee: Finance & Budget

Chairperson: Stephanie Booth, M.D.

Requesting Department: Finance Services

Issue: Accept the Investment Report for the quarter ended September 30, 2023

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

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

Member Impact: N/A

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

Motion: To accept the Quarterly Investment Report for the quarter ending September 30, 2023, as submitted.

DATE: November 15, 2023

TO: Finance & Budget Committee

FROM: Afzal Shah, *Chief Financial Officer*

SUBJECT: Quarterly Investment Report – September 2023

As of September 30 2023, L.A. Care's combined investments value was approximately $3.3 billion. Interest income, amortization, realized gains and losses was approximately $32 million for the quarter. Unrealized losses due to market price fluctuations was approximately $0.3 million for the quarter. The rate of return for the quarter was 1.15%. Based upon an independent compliance review performed as of September 30, 2023, LA Care is in compliance with its investment policy guidelines pursuant to the California Government Code and the California Insurance Code.

At quarter end $2.85 billion (or approx. 87% of total investments) and $0.3 billion (or approx. 10% of total investments) were under the management of Payden & Rygel and New England Asset Management, respectively. Both are external professional investment management firms. A list of the securities held under management of these two firms are attached. Below are the same securities grouped by investment type:

	Payden	NEAM	Combined
Cash and Money Market Mutual Fund	2%	0%	2%
U.S. Treasury Securities	82%	0%	73%
U.S. Agency & Municipal Securities	4%	4%	4%
Corporate bonds	0%	96%	10%
Asset Backed and Mortgage Backed Securities	7%	0%	6%
Negotiable CDs	3%	0%	2%
Other	2%	0%	3%
	100%	100%	100%
Average credit quality:	AA+	A1	
Average duration:	0.20 years	2.55 years	
Average yield to maturity:	5.33%	5.62%	

The funds managed by Payden & Rygel are managed as two separate portfolios based on investment style – 1) the short-term portfolio and 2) the extended term portfolio. The short-term portfolio had approximately $2,761 million invested as of September 30, 2023, and returned 1.32% for the quarter. The comparative benchmark returned 1.31% for the quarter. The extended term portfolio had approximately $90 million invested September 30, 2023, and returned 0.19% for the quarter. The comparative benchmark had a return of 0.19%.

PORTFOLIO RETURNS
Periods over one year annualized

Periods ended 9/30/2023

Performance	3rd Quarter	2023 YTD	Trailing 1 Year	Trailing 3 Year
LA Care - Short-Term Portfolio	**1.32**	**3.67**	**4.63**	**1.71**
Benchmark*	1.31	3.60	4.47	1.70
LA Care - Extended-Term Portfolio	**0.19**	**1.36**	**2.33**	**-1.21**
Benchmark**	0.19	1.12	2.07	-1.86
LA Care - Combined Portfolio	1.28	3.57	4.54	1.54

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

The $327 million portfolio managed by New England Asset Management, Inc (NEAM), focused on corporate fixed income bonds returned 0.26% for the quarter. The comparative benchmark returned 0.17% for the quarter.

LA Care also invests with 2 government pooled investment funds, the Local Agency Investment Fund (LAIF) and the Los Angeles County Pooled Investment Fund (LACPIF). L.A. Care's investment balances as of September 30, 2023 were $35 million in LAIF and $79 million in LACPIF.

The Local Agency Investment Fund (LAIF) yielded approximately 0.88% for the quarter. The fund's total portfolio market value as of September 30, 2023, was $156 billion, with a weighted average maturity of 256 days. LAIF is administered and overseen by the State Treasurer's office. The fund's investment holdings as of September 30, 2023 were as follows:

U.S. Treasury Securities	64%
Agencies	21%
CD's and bank notes	7%
Commercial paper	4%
Time deposits	3%
Other	1%
	100%

The Los Angeles County Pooled Investment Fund (LACPIF) yielded approximately 0.95% for the quarter. The fund's total market value as of August 31, 2023, was $46 billion, with a weighted average maturity of 815 days. LACPIF is administered and overseen by the Los Angeles County Treasurer. The fund's most recent published investment holdings (as of August 31, 2023) were as follows:

U.S. Govt. and Agency Securities	72%
Commercial paper	22%
CD's	6%
	100%

LA Care Securities Holdings
as of September 30, 2023

Porfolio	CUSIP/Identifier	Security	Type	Par	Maturity date
Payden	USD	NORTHERN INST GOVT MONEY MKT	Cash/Money Market Funds	47,837,609	NA
NEAM	USD	NORTHERN INST GOVT MONEY MKT	Cash/Money Market Funds	1,441,968	NA
Payden	912797GV3	U.S. TREASURY BILL	U.S. Treasury Security	270,000,000	10/3/2023
Payden	912796YJ2	U.S. TREASURY BILL	U.S. Treasury Security	790,000,000	10/5/2023
Payden	912797HA8	U.S. TREASURY BILL	U.S. Treasury Security	60,000,000	10/10/2023
Payden	912797FA0	U.S. TREASURY BILL	U.S. Treasury Security	190,000,000	10/12/2023
Payden	912797HB6	U.S. TREASURY BILL	U.S. Treasury Security	160,000,000	10/17/2023
Payden	912797FB8	U.S. TREASURY BILL	U.S. Treasury Security	50,000,000	10/19/2023
Payden	912797FC6	U.S. TREASURY BILL	U.S. Treasury Security	140,000,000	10/26/2023
Payden	912796YT0	U.S. TREASURY BILL	U.S. Treasury Security	100,000,000	11/2/2023
Payden	912797FJ1	U.S. TREASURY BILL	U.S. Treasury Security	7,000,000	11/9/2023
Payden	912797HK6	U.S. TREASURY BILL	U.S. Treasury Security	200,000,000	11/14/2023
Payden	91282CBA8	U.S. TREASURY NOTE	U.S. Treasury Security	12,000,000	12/15/2023
Payden	912797GC5	U.S. TREASURY BILL	U.S. Treasury Security	100,000,000	1/11/2024
Payden	912797GE1	U.S. TREASURY BILL	U.S. Treasury Security	150,000,000	2/1/2024
Payden	912796CX5	U.S. TREASURY BILL	U.S. Treasury Security	50,000,000	4/18/2024
Payden	912828ZL7	U.S. TREASURY NOTE	U.S. Treasury Security	935,000	4/30/2025
Payden	912828ZT0	U.S. TREASURY NOTE	U.S. Treasury Security	365,000	5/31/2025
Payden	91282CHS3	U.S. TREASURY FRN	U.S. Treasury Security	10,000,000	7/31/2025
Payden	91282CAJ0	U.S. TREASURY NOTE	U.S. Treasury Security	2,250,000	8/31/2025
Payden	91282CAM3	U.S. TREASURY NOTE	U.S. Treasury Security	500,000	9/30/2025
Payden	91282CAZ4	U.S. TREASURY NOTE	U.S. Treasury Security	4,365,000	11/30/2025
Payden	91282CBC4	U.S. TREASURY NOTE	U.S. Treasury Security	2,051,000	12/31/2025
Payden	91282CBH3	U.S. TREASURY NOTE	U.S. Treasury Security	1,410,000	1/31/2026
Payden	91282CBT7	U.S. TREASURY NOTE	U.S. Treasury Security	1,915,000	3/31/2026
Payden	91282CBW0	U.S. TREASURY NOTE	U.S. Treasury Security	1,595,000	4/30/2026
Payden	91282CCF6	U.S. TREASURY NOTE	U.S. Treasury Security	470,000	5/31/2026
Payden	91282CCJ8	U.S. TREASURY NOTE	U.S. Treasury Security	470,000	6/30/2026
Payden	91282CCP4	U.S. TREASURY NOTE	U.S. Treasury Security	2,350,000	7/31/2026
Payden	91282CCW9	U.S. TREASURY NOTE	U.S. Treasury Security	1,880,000	8/31/2026
Payden	91282CCZ2	U.S. TREASURY NOTE	U.S. Treasury Security	1,405,000	9/30/2026
Payden	91282CDQ1	U.S. TREASURY NOTE	U.S. Treasury Security	930,000	12/31/2026
Payden	91282CEF4	U.S. TREASURY NOTE	U.S. Treasury Security	1,350,000	3/31/2027
Payden	91282CEN7	U.S. TREASURY NOTE	U.S. Treasury Security	400,000	4/30/2027
Payden	91282CET4	U.S. TREASURY NOTE	U.S. Treasury Security	730,000	5/31/2027
Payden	91282CEW7	U.S. TREASURY NOTE	U.S. Treasury Security	2,470,000	6/30/2027
Payden	91282CFB2	U.S. TREASURY NOTE	U.S. Treasury Security	1,975,000	7/31/2027
Payden	91282CFH9	U.S. TREASURY NOTE	U.S. Treasury Security	1,325,000	8/31/2027
Payden	91282CFU0	U.S. TREASURY NOTE	U.S. Treasury Security	130,000	10/31/2027
Payden	91282CFZ9	U.S. TREASURY NOTE	U.S. Treasury Security	2,230,000	11/30/2027
Payden	91282CGH8	U.S. TREASURY NOTE	U.S. Treasury Security	1,950,000	1/31/2028
Payden	91282CGP0	U.S. TREASURY NOTE	U.S. Treasury Security	2,395,000	2/29/2028
Payden	91282CGT2	U.S. TREASURY NOTE	U.S. Treasury Security	11,105,000	3/31/2028
Payden	91282CHA2	U.S. TREASURY NOTE	U.S. Treasury Security	2,580,000	4/30/2028
Payden	91282CHE4	U.S. TREASURY NOTE	U.S. Treasury Security	680,000	5/31/2028
Payden	91282CHK0	U.S. TREASURY NOTE	U.S. Treasury Security	2,505,000	6/30/2028
Payden	91282CHQ7	U.S. TREASURY NOTE	U.S. Treasury Security	3,755,000	7/31/2028
Payden	91282CHX2	U.S. TREASURY NOTE	U.S. Treasury Security	2,030,000	8/31/2028
Payden	3130AUGN8	FHLB C 7/10/23 Q	U.S. Agency Security	7,500,000	1/10/2024
Payden	3135GADV0	FNMA C 7/25/23 1X	U.S. Agency Security	7,500,000	1/25/2024
Payden	3130AVR46	FHLB C 7/21/23 Q	U.S. Agency Security	12,800,000	5/17/2024
Payden	3134GYSH6	FHLMC C 8/18/23 Q	U.S. Agency Security	15,000,000	6/14/2024
Payden	3134GYFM9	FHLMC C 8/1/23 Q	U.S. Agency Security	5,000,000	8/1/2024
Payden	3134GXDZ4	FHLMC C 11/25/22 Q	U.S. Agency Security	510,000	11/25/2024
Payden	3135G0X24	FNMA	U.S. Agency Security	940,000	1/7/2025
Payden	3134GXS88	FHLMC C 02/28/23 Q	U.S. Agency Security	570,000	2/28/2025
Payden	3135G03U5	FNMA	U.S. Agency Security	960,000	4/22/2025
Payden	3137EAEU9	FHLMC	U.S. Agency Security	570,000	7/21/2025
Payden	3130AWYQ7	FHLB C 8/28/24 Q	U.S. Agency Security	4,500,000	8/28/2025
Payden	3134H1AZ6	FHLMC C 8/28/24 Q	U.S. Agency Security	5,000,000	8/28/2025
Payden	3134H1BG7	FHLMC C 2/28/24 Q	U.S. Agency Security	10,000,000	8/28/2025
Payden	3134GXR63	FHLMC C 11/28/22 Q	U.S. Agency Security	570,000	8/28/2025

LA Care Securities Holdings
as of September 30, 2023

Porfolio	CUSIP/Identifier	Security	Type	Par	Maturity date
Payden	3134GXS47	FHLMC C 11/28/2022 Q	U.S. Agency Security	570,000	8/28/2025
Payden	3134GX3A0	FHLMC C 12/30/2022 Q	U.S. Agency Security	610,000	9/30/2025
Payden	3135G06G3	FNMA	U.S. Agency Security	410,000	11/7/2025
Payden	3130AX4Y1	FHLB C 12/19/23 Q	U.S. Agency Security	8,300,000	12/19/2025
Payden	3130AKXQ4	FHLB C 05/12/21 Q	U.S. Agency Security	940,000	2/12/2026
Payden	3134H1BW2	FHLMC C 12/18/23 Q	U.S. Agency Security	10,000,000	9/18/2026
Payden	4581X0DP0	INTER-AMERICAN DEVELOPMENT BANK	Non U.S. Government Bond	560,000	11/15/2023
Payden	459058JM6	INTL BANK RECON & DEVELOP	Non U.S. Government Bond	580,000	11/24/2023
Payden	45950VQM1	INTL FINANCE CORP FRN SOFRRATE	Non U.S. Government Bond	7,500,000	4/3/2024
Payden	4581X0DT2	INTER-AMERICAN DEV BANK FRN SOFRINDX	Non U.S. Government Bond	15,000,000	2/10/2026
Payden	45906M4C2	IBRD C 09/15/2023 Q	Non U.S. Government Bond	4,200,000	6/15/2026
Payden	4581X0DY1	INTER-AMERICAN DEV BANK FRN SOFRINDX	Non U.S. Government Bond	15,000,000	9/16/2026
Payden	459058KK8	INTL BK RECON & DEVELOP FRN SOFRINDX	Non U.S. Government Bond	5,720,000	9/23/2026
Payden	23344NN85	DNB NOR BANK YCD	Negotiable CD	7,500,000	11/2/2023
Payden	06742T4S2	BARCLAYS YCD	Negotiable CD	7,500,000	11/10/2023
Payden	05966D4B5	BANCO SANTANDER YCD	Negotiable CD	7,500,000	11/13/2023
Payden	06417MT96	BANK OF NOVA SCOTIA FRN YCD SOFRRATE	Negotiable CD	7,500,000	11/20/2023
Payden	96130ASQ2	WESTPAC BANK YCD	Negotiable CD	7,500,000	11/27/2023
Payden	53947BN22	LLOYDS BANK YCD FRN SOFRRATE	Negotiable CD	10,000,000	12/11/2023
Payden	89115BRU6	TORONTO-DOMINION NY YCD FRN SOFRRATE	Negotiable CD	9,250,000	4/1/2024
Payden	87019WNH4	SWEDBANK NY YCD FRN SOFRRATE	Negotiable CD	10,000,000	4/12/2024
Payden	17330QFJ1	CITIBANK CD	Negotiable CD	10,000,000	6/17/2024
Payden	56453RAX2	CA MANTECA REDEV AGY TAB TXB	Municipal Securities	500,000	10/1/2023
Payden	80169BAL8	CA SANTA CLARA VLY WTR DIST CP TXB	Municipal Securities	5,000,000	10/17/2023
Payden	54473ERV8	CA LOS ANGELESX CNTY PUB WORKS TXB	Municipal Securities	425,000	12/1/2023
Payden	072024WP3	CA BAY AREA TOLL AUTH TOLL BRDG REV TXB	Municipal Securities	1,220,000	4/1/2024
Payden	13032UVB1	CA HEALTH FACS-NO PLACE LIKE HOME-TXB	Municipal Securities	380,000	6/1/2024
Payden	769036BL7	CA CITY OF RIVERSIDE POB TXB	Municipal Securities	320,000	6/1/2024
Payden	20772KJW0	CT STATE OF CONNECTICUT GO/ULT TXB	Municipal Securities	210,000	7/1/2024
Payden	284035AC6	CA CITY OF EL SEGUNDO POBS TXB	Municipal Securities	500,000	7/1/2024
Payden	664845EA8	CA NORTHERN CA PUB POWER TXB	Municipal Securities	410,000	7/1/2024
Payden	842475P66	CA SOUTHERN CA PUBLIC POWER TXB	Municipal Securities	900,000	7/1/2024
Payden	212204JE2	CA CONTRA COSTA CCD GO/ULT TXB	Municipal Securities	170,000	8/1/2024
Payden	223093VM4	CA COVINA-VALLEY USD GO/ULT TXB	Municipal Securities	250,000	8/1/2024
Payden	365298Y51	CA GARDEN GROVE USD GO/ULT TXB	Municipal Securities	395,000	8/1/2024
Payden	796720MG2	CA SAN BERNARDINO CCD TXB	Municipal Securities	570,000	8/1/2024
Payden	796720NQ9	CA SAN BERNARDINO CCD TXB	Municipal Securities	200,000	8/1/2024
NEAM	54438CYJ5	LOS ANGELES CA CMNTY CLG DIST	Municipal Securities	3,350,000	8/1/2024
Payden	378460YD5	CA GLENDALE USD GO/ULT TXB	Municipal Securities	250,000	9/1/2024
Payden	798736AW4	CA SAN LUIS WESTLANDS WTR DIST TXB	Municipal Securities	410,000	9/1/2024
Payden	544290JH3	CA LOS ALTOS SCH DIST GO BANS TXB	Municipal Securities	800,000	10/1/2024
Payden	861398CH6	CA STOCKTON PFA WTR REV-GREEN-TXB	Municipal Securities	300,000	10/1/2024
Payden	544587Y44	CA LOS ANGELES MUNI IMPT CORP LEASE TXB	Municipal Securities	500,000	11/1/2024
Payden	13080SZL1	CA STWD CMTY DEV AUTH REV-CAISO-TXB	Municipal Securities	750,000	2/1/2025
Payden	672211BM0	CA OAKLAND-ALAMEDA COLISEUM AUTH-TXBL	Municipal Securities	925,000	2/1/2025
Payden	64990FD43	NY STATE DORM AUTH PERS INC TAX TXB	Municipal Securities	680,000	3/15/2025
Payden	91412HFM0	CA UNIVERSITY OF CALIFORNIA TXB	Municipal Securities	750,000	5/15/2025
Payden	088006JZ5	CA BEVERLY HILLS PFA LEASE REV TXB	Municipal Securities	670,000	6/1/2025
Payden	13034AN55	CA INFRA & ECON BANK-SCRIPPS TXB	Municipal Securities	500,000	7/1/2025
Payden	3582326T8	CA FRESNO USD GO/ULT TXB	Municipal Securities	600,000	8/1/2025
Payden	672325M95	CA OAKLAND USD GO/ULT TXB	Municipal Securities	420,000	8/1/2025
NEAM	54438CYK2	LOS ANGELES CA CMNTY CLG DIST	Municipal Securities	1,100,000	8/1/2025
NEAM	969268DG3	WILLIAM S HART CA UNION HIGH S	Municipal Securities	2,350,000	8/1/2025
NEAM	576000ZE6	MASSACHUSETTS ST SCH BLDG AUTH	Municipal Securities	5,000,000	8/15/2025
Payden	5445872T4	CA LOS ANGELES MUNI IMPT CORP LEASE TXB	Municipal Securities	360,000	11/1/2025
Payden	20772KQJ1	CT STATE GO/ULT TXB	Municipal Securities	640,000	6/15/2026
NEAM	13063D3A4	CALIFORNIA ST	Municipal Securities	1,000,000	10/1/2026
Payden	576004HD0	MA ST SPL OBLG REV-SOCIAL TXB	Municipal Securities	440,000	7/15/2027
Payden	3137BWWE0	FHMS K725 AM CMBS	Mortgage-Backed Security	810,000	2/25/2024
Payden	3137BYPR5	FHMS K726 AM CMBS	Mortgage-Backed Security	570,000	4/25/2024
Payden	3137FBAR7	FHMS KF36 A	Mortgage-Backed Security	7,981	8/25/2024
Payden	3137FYUR5	FHMS Q015 A 1MOFRN CMBS	Mortgage-Backed Security	156,762	8/25/2024

LA Care Securities Holdings
as of September 30, 2023

Porfolio	CUSIP/Identifier	Security	Type	Par	Maturity date
Payden	3137FBUC8	FHMS KF38 A	Mortgage-Backed Security	224,407	9/25/2024
Payden	3137FVNA6	FHMS KI06 A 1MOFRN CMBS	Mortgage-Backed Security	101,572	3/25/2025
Payden	3137H3KA9	FHMS KI07 A SOFRFRN	Mortgage-Backed Security	6,950,000	9/25/2026
Payden	3137H4RC6	FHMS KI08 A 1MOFRN CMBS	Mortgage-Backed Security	2,779,094	10/25/2026
Payden	09659CX29	BNP PARIBAS NY CP	Commercial Paper	10,452,000	10/2/2023
Payden	22533UYA5	CREDIT AGRICOLE CP	Commercial Paper	7,500,000	11/10/2023
Payden	21687AC43	COOPERATIEVE RABOBANK CP	Commercial Paper	10,000,000	3/4/2024
Payden	09659BF70	BNP PARIBAS NY CP	Commercial Paper	10,000,000	6/7/2024
NEAM	05565EBH7	BMW US CAPITAL LLC	Corporate Security	6,000,000	4/18/2024
NEAM	14913Q2V0	CATERPILLAR FINL SERVICE	Corporate Security	2,000,000	5/17/2024
NEAM	14913Q2V0	CATERPILLAR FINL SERVICE	Corporate Security	500,000	5/17/2024
NEAM	24422ESP5	JOHN DEERE CAPITAL CORP	Corporate Security	2,000,000	6/12/2024
NEAM	02665WCZ2	AMERICAN HONDA FINANCE	Corporate Security	2,250,000	6/27/2024
NEAM	05531FBH5	TRUIST FINANCIAL CORP	Corporate Security	5,000,000	8/1/2024
NEAM	828807DG9	SIMON PROPERTY GROUP LP	Corporate Security	4,000,000	9/13/2024
NEAM	828807DG9	SIMON PROPERTY GROUP LP	Corporate Security	1,000,000	9/13/2024
NEAM	828807CS4	SIMON PROPERTY GROUP LP	Corporate Security	2,500,000	10/1/2024
NEAM	61761JVL0	MORGAN STANLEY	Corporate Security	3,000,000	10/23/2024
NEAM	05348EAU3	AVALONBAY COMMUNITIES	Corporate Security	5,000,000	11/15/2024
NEAM	07330NAT2	TRUIST BANK	Corporate Security	4,750,000	12/6/2024
NEAM	976656CL0	WISCONSIN ELECTRIC POWER	Corporate Security	1,500,000	12/15/2024
NEAM	57629WCG3	MASSMUTUAL GLOBAL FUNDIN	Corporate Security	2,500,000	1/11/2025
NEAM	89236TGT6	TOYOTA MOTOR CREDIT CORP	Corporate Security	3,000,000	2/13/2025
NEAM	384802AE4	WW GRAINGER INC	Corporate Security	1,000,000	2/15/2025
NEAM	69353REK0	PNC BANK NA	Corporate Security	2,000,000	2/23/2025
NEAM	57636QAN4	MASTERCARD INC	Corporate Security	1,000,000	3/3/2025
NEAM	57636QAN4	MASTERCARD INC	Corporate Security	2,000,000	3/3/2025
NEAM	30231GBH4	EXXON MOBIL CORPORATION	Corporate Security	2,000,000	3/19/2025
NEAM	254687FN1	WALT DISNEY COMPANY/THE	Corporate Security	3,000,000	3/24/2025
NEAM	458140BP4	INTEL CORP	Corporate Security	2,500,000	3/25/2025
NEAM	341081FZ5	FLORIDA POWER & LIGHT CO	Corporate Security	2,500,000	4/1/2025
NEAM	341081FZ5	FLORIDA POWER & LIGHT CO	Corporate Security	5,000,000	4/1/2025
NEAM	369550BK3	GENERAL DYNAMICS CORP	Corporate Security	5,000,000	4/1/2025
NEAM	911312BX3	UNITED PARCEL SERVICE	Corporate Security	5,000,000	4/1/2025
NEAM	438516CB0	HONEYWELL INTERNATIONAL	Corporate Security	5,000,000	6/1/2025
NEAM	29157TAC0	EMORY UNIVERSITY	Corporate Security	1,000,000	9/1/2025
NEAM	29157TAC0	EMORY UNIVERSITY	Corporate Security	3,305,000	9/1/2025
NEAM	68233JBZ6	ONCOR ELECTRIC DELIVERY	Corporate Security	3,000,000	10/1/2025
NEAM	64952WDW0	NEW YORK LIFE GLOBAL FDG	Corporate Security	5,000,000	1/15/2026
NEAM	64952WDW0	NEW YORK LIFE GLOBAL FDG	Corporate Security	5,000,000	1/15/2026
NEAM	927804FU3	VIRGINIA ELEC & POWER CO	Corporate Security	5,000,000	1/15/2026
NEAM	06406RAQ0	BANK OF NY MELLON CORP	Corporate Security	5,000,000	1/28/2026
NEAM	74005PBQ6	LINDE INC/CT	Corporate Security	2,250,000	1/30/2026
NEAM	037833BY5	APPLE INC	Corporate Security	1,500,000	2/23/2026
NEAM	20030NBS9	COMCAST CORP	Corporate Security	3,500,000	3/1/2026
NEAM	14913R2K2	CATERPILLAR FINL SERVICE	Corporate Security	5,000,000	3/2/2026
NEAM	74456QCF1	PUBLIC SERVICE ELECTRIC	Corporate Security	4,000,000	3/15/2026
NEAM	74456QCF1	PUBLIC SERVICE ELECTRIC	Corporate Security	5,000,000	3/15/2026
NEAM	90320WAF0	UPMC	Corporate Security	1,000,000	4/15/2026
NEAM	95000U2N2	WELLS FARGO & COMPANY	Corporate Security	2,000,000	4/30/2026
NEAM	95000U2N2	WELLS FARGO & COMPANY	Corporate Security	5,000,000	4/30/2026
NEAM	95000U2N2	WELLS FARGO & COMPANY	Corporate Security	3,000,000	4/30/2026
NEAM	459200JZ5	IBM CORP	Corporate Security	1,250,000	5/15/2026
NEAM	57629WDE7	MASSMUTUAL GLOBAL FUNDIN	Corporate Security	5,000,000	7/16/2026
NEAM	61761J3R8	MORGAN STANLEY	Corporate Security	3,000,000	7/27/2026
NEAM	931142ER0	WALMART INC	Corporate Security	5,000,000	9/17/2026
NEAM	46625HRV4	JPMORGAN CHASE & CO	Corporate Security	3,500,000	10/1/2026
NEAM	743756AB4	PROV ST JOSEPH HLTH OBL	Corporate Security	1,500,000	10/1/2026
NEAM	26884ABF9	ERP OPERATING LP	Corporate Security	1,252,000	11/1/2026
NEAM	025816CM9	AMERICAN EXPRESS CO	Corporate Security	5,000,000	11/4/2026
NEAM	641062AV6	NESTLE HOLDINGS INC	Corporate Security	5,000,000	1/14/2027
NEAM	756109AS3	REALTY INCOME CORP	Corporate Security	3,750,000	1/15/2027

LA Care Securities Holdings
as of September 30, 2023

Porfolio	CUSIP/Identifier	Security	Type	Par	Maturity date
NEAM	31677QBR9	FIFTH THIRD BANK	Corporate Security	5,000,000	2/1/2027
NEAM	771196BV3	ROCHE HOLDINGS INC	Corporate Security	5,000,000	3/10/2027
NEAM	771196BV3	ROCHE HOLDINGS INC	Corporate Security	2,500,000	3/10/2027
NEAM	29736RAJ9	ESTEE LAUDER CO INC	Corporate Security	1,500,000	3/15/2027
NEAM	20030NDK4	COMCAST CORP	Corporate Security	2,500,000	4/1/2027
NEAM	10373QAZ3	BP CAP MARKETS AMERICA	Corporate Security	5,000,000	4/14/2027
NEAM	437076CN0	HOME DEPOT INC	Corporate Security	2,750,000	4/15/2027
NEAM	437076CN0	HOME DEPOT INC	Corporate Security	2,000,000	4/15/2027
NEAM	907818EP9	UNION PACIFIC CORP	Corporate Security	1,000,000	4/15/2027
NEAM	46647PCB0	JPMORGAN CHASE & CO	Corporate Security	2,500,000	4/22/2027
NEAM	91159HHR4	US BANCORP	Corporate Security	7,000,000	4/27/2027
NEAM	904764AY3	UNILEVER CAPITAL CORP	Corporate Security	7,500,000	5/5/2027
NEAM	67021CAM9	NSTAR ELECTRIC CO	Corporate Security	1,000,000	5/15/2027
NEAM	67021CAM9	NSTAR ELECTRIC CO	Corporate Security	2,500,000	5/15/2027
NEAM	74456QBS4	PUBLIC SERVICE ELECTRIC	Corporate Security	1,500,000	5/15/2027
NEAM	927804GH1	VIRGINIA ELEC & POWER CO	Corporate Security	3,100,000	5/15/2027
NEAM	59217GFB0	MET LIFE GLOB FUNDING I	Corporate Security	3,500,000	6/30/2027
NEAM	61747YEC5	MORGAN STANLEY	Corporate Security	2,000,000	7/20/2027
NEAM	06051GJS9	BANK OF AMERICA CORP	Corporate Security	5,000,000	7/22/2027
NEAM	458140BY5	INTEL CORP	Corporate Security	5,000,000	8/5/2027
NEAM	14913R3A3	CATERPILLAR FINL SERVICE	Corporate Security	2,500,000	8/12/2027
NEAM	756109BG8	REALTY INCOME CORP	Corporate Security	5,000,000	8/15/2027
NEAM	010392FY9	ALABAMA POWER CO	Corporate Security	5,000,000	9/1/2027
NEAM	010392FY9	ALABAMA POWER CO	Corporate Security	2,000,000	9/1/2027
NEAM	89236TKJ3	TOYOTA MOTOR CREDIT CORP	Corporate Security	3,000,000	9/20/2027
NEAM	539830BV0	LOCKHEED MARTIN CORP	Corporate Security	5,000,000	11/15/2027
NEAM	278865BP4	ECOLAB INC	Corporate Security	5,000,000	1/15/2028
NEAM	756109BH6	REALTY INCOME CORP	Corporate Security	2,500,000	1/15/2028
NEAM	69353RFJ2	PNC BANK NA	Corporate Security	3,000,000	1/22/2028
NEAM	882508BV5	TEXAS INSTRUMENTS INC	Corporate Security	5,000,000	2/15/2028
NEAM	91324PEP3	UNITEDHEALTH GROUP INC	Corporate Security	5,000,000	2/15/2028
NEAM	210518DS2	CONSUMERS ENERGY CO	Corporate Security	3,000,000	3/1/2028
NEAM	210518DS2	CONSUMERS ENERGY CO	Corporate Security	1,650,000	3/1/2028
NEAM	04636NAF0	ASTRAZENECA FINANCE LLC	Corporate Security	5,000,000	3/3/2028
NEAM	49177JAE2	KENVUE INC	Corporate Security	1,000,000	3/22/2028
NEAM	49177JAE2	KENVUE INC	Corporate Security	1,000,000	3/22/2028
NEAM	035240AL4	ANHEUSER-BUSCH INBEV WOR	Corporate Security	2,500,000	4/13/2028
NEAM	02361DAS9	AMEREN ILLINOIS CO	Corporate Security	2,500,000	5/15/2028
NEAM	29736RAS9	ESTEE LAUDER CO INC	Corporate Security	3,000,000	5/15/2028
NEAM	29736RAS9	ESTEE LAUDER CO INC	Corporate Security	2,500,000	5/15/2028
NEAM	68233JCN2	ONCOR ELECTRIC DELIVERY	Corporate Security	1,000,000	5/15/2028
NEAM	74153WCS6	PRICOA GLOBAL FUNDING 1	Corporate Security	5,000,000	5/30/2028
NEAM	440452AH3	HORMEL FOODS CORP	Corporate Security	1,000,000	6/3/2028
NEAM	440452AH3	HORMEL FOODS CORP	Corporate Security	1,600,000	6/3/2028
NEAM	38141GWL4	GOLDMAN SACHS GROUP INC	Corporate Security	10,000,000	6/5/2028
NEAM	46647PDG8	JPMORGAN CHASE & CO	Corporate Security	5,000,000	7/25/2028
Payden	233258AA0	DLLAD 2023-1A A1 EQP 144A	Asset-Backed Security	2,962	2/20/2024
Payden	50117KAA8	KCOT 2023-1A A1 EQP 144A	Asset-Backed Security	1,522,057	3/15/2024
Payden	448979AA2	HART 2023-A A1 CAR	Asset-Backed Security	360,842	4/15/2024
Payden	98164QAA6	WOART 2023-B A1 CAR	Asset-Backed Security	1,472,195	4/15/2024
Payden	362583AA4	GMCAR 2023-2 A1 CAR	Asset-Backed Security	246,319	4/16/2024
Payden	12664QAA2	CNH 2023-A A1 EQP	Asset-Backed Security	3,739,029	5/15/2024
Payden	142921AA3	CARMX 2023-2 A1 CAR	Asset-Backed Security	1,675,354	5/15/2024
Payden	448980AA0	HALST 2023-B A1 LEASE 144A	Asset-Backed Security	534,043	5/15/2024
Payden	65480WAA9	NAROT 2023-A A1 CAR	Asset-Backed Security	2,391,735	5/15/2024
Payden	891941AA4	TAOT 2023-B A1 CAR	Asset-Backed Security	7,571,444	5/15/2024
Payden	232989AA1	DLLMT 2023-1A A1 EQP 144A	Asset-Backed Security	3,237,893	5/20/2024
Payden	362548AA7	GMALT 2023-2 A1 LEASE	Asset-Backed Security	653,989	5/20/2024
Payden	73328QAA2	PFAST 2023-1A A1 CAR 144A	Asset-Backed Security	950,342	5/22/2024
Payden	39154TCA4	GALC 2023-1 A1 EQP 144A	Asset-Backed Security	1,689,514	6/14/2024
Payden	29375NAA3	EFF 2023-2 A1 FLEET 144A	Asset-Backed Security	2,114,942	6/20/2024
Payden	24703GAA2	DEFT 2023-2 A1 EQP 144A	Asset-Backed Security	1,977,481	6/24/2024

LA Care Securities Holdings
as of September 30, 2023

Porfolio	CUSIP/Identifier	Security	Type	Par	Maturity date
Payden	14319BAA0	CARMX 2023-3 A1 CAR	Asset-Backed Security	2,932,330	7/15/2024
Payden	500945AA8	KCOT 2023-2A A1 EQP 144A	Asset-Backed Security	1,887,721	7/15/2024
Payden	78398AAA1	SFAST 2023-1 A1 CAR 144A	Asset-Backed Security	1,606,201	7/22/2024
Payden	80286TAC7	SRT 2021-A A3 LEASE 144A	Asset-Backed Security	646,988	7/22/2024
Payden	88167PAA6	TESLA 2023-A A1 LEASE 144A	Asset-Backed Security	1,733,189	7/22/2024
Payden	55317WAA9	MMAF 2023-A A1 EQP 144A	Asset-Backed Security	1,962,544	8/9/2024
Payden	14688GAA2	CRVNA 2023-P3 A1 CAR 144A	Asset-Backed Security	1,155,781	8/10/2024
Payden	98164FAA0	WOART 2023-C A1 CAR	Asset-Backed Security	4,908,092	8/15/2024
Payden	98163JAC9	WORLD OMNI 2021-A A3 LEASE	Asset-Backed Security	205,316	8/15/2024
Payden	88167QAA4	TESLA 2023-B A1 LEASE 144A	Asset-Backed Security	8,400,000	9/20/2024
Payden	34529NAA8	FORDL 2023-B A1 LEASE	Asset-Backed Security	7,700,000	10/15/2024
Payden	43815BAB6	HAROT 2022-1 A2 CAR	Asset-Backed Security	817,036	10/15/2024
Payden	98163NAB2	WOLS 2022-A A2 LEASE	Asset-Backed Security	280,576	10/15/2024
Payden	44328UAA4	HPEFS 2023-2A A1 EQP 144A	Asset-Backed Security	10,000,000	10/18/2024
Payden	89239CAC3	TLOT 2021-B A3 LEASE 144A	Asset-Backed Security	1,739,408	10/21/2024
Payden	47787NAC3	JOHN DEERE 2020-B A3 EQP	Asset-Backed Security	205,374	11/15/2024
Payden	65479QAB3	NAROT 2022-A A2 CAR	Asset-Backed Security	3,406,472	11/15/2024
Payden	58769KAD6	MERCEDES 2021-B A3 LEASE	Asset-Backed Security	235,080	11/15/2024
Payden	14315XAC2	CARMX 2020-1 A3 CAR	Asset-Backed Security	6,394	12/16/2024
Payden	09690AAC7	BMW 2021-2 A3 LEASE	Asset-Backed Security	413,501	12/26/2024
Payden	09690AAD5	BMWLT 2021-2 A4 LEASE	Asset-Backed Security	3,500,000	1/27/2025
Payden	89238LAC4	TLOT 2022-A A3 LEASE 144A	Asset-Backed Security	5,166,674	2/20/2025
Payden	92290BAA9	VERIZON 2020-B A PHONE	Asset-Backed Security	6,428	2/20/2025
Payden	80286CAC4	SRT 2021-C A3 LEASE 144A	Asset-Backed Security	1,761,287	3/20/2025
Payden	80286CAC4	SRT 2021-C A3 LEASE 144A	Asset-Backed Security	101,527	3/20/2025
Payden	34528LAD7	FORDL 2022-A A3 LEASE	Asset-Backed Security	2,940,266	5/15/2025
Payden	380144AD7	GMALT 2021-2 A LEASE	Asset-Backed Security	767,979	5/20/2025
Payden	362541AB0	GMALT 2023-1 A2A LEASE	Asset-Backed Security	2,195,984	6/20/2025
Payden	34533YAD2	FORDO 2020-C A3	Asset-Backed Security	3,806,599	7/15/2025
Payden	89231CAB3	TAOT 2022-C A2A CAR	Asset-Backed Security	2,986,243	8/15/2025
Payden	88161KAB1	TESLA 2021-B A2 LEASE 144A	Asset-Backed Security	159,993	9/22/2025
Payden	88161KAB1	TESLA 2021-B A2 LEASE 144A	Asset-Backed Security	20,983	9/22/2025
Payden	02008MAB5	ALLYA 2022-2 A2 CAR	Asset-Backed Security	2,052,076	10/15/2025
Payden	361886CM4	GM 2020-2 A FLOOR 144A	Asset-Backed Security	6,100,000	10/15/2025
Payden	98163QAB5	WOART 2022-B A2A CAR	Asset-Backed Security	1,655,285	10/15/2025
Payden	50117XAE2	KUBOTA 2021-2A A3 EQP 144A	Asset-Backed Security	773,800	11/17/2025
Payden	448979AB0	HART 2023-A A2A CAR	Asset-Backed Security	1,000,000	12/15/2025
Payden	14314QAC8	CARMX 2021-2 A3 AUTO	Asset-Backed Security	497,751	2/17/2026
Payden	437927AB2	HAROT 2023-2 A2 CAR	Asset-Backed Security	6,250,000	4/15/2026
Payden	380149AC8	GMCAR 2021-2 A3 CAR	Asset-Backed Security	116,594	4/16/2026
Payden	89239MAC1	TLOT 2023A A3 LEASE 144A	Asset-Backed Security	500,000	4/20/2026
Payden	05592XAB6	BMWOT 2023-A A2A CAR	Asset-Backed Security	5,000,000	4/27/2026
Payden	06428AAB4	BAAT 2023-1A A2 CAR 144A	Asset-Backed Security	5,000,000	5/15/2026
Payden	44933XAB3	HART 2023-B A2A CAR	Asset-Backed Security	3,400,000	5/15/2026
Payden	44935FAD6	HART 2021-C A3 CAR	Asset-Backed Security	4,112,963	5/15/2026
Payden	362583AB2	GMCAR 2023-2 A2A CAR	Asset-Backed Security	1,315,000	5/18/2026
Payden	14317DAC4	CARMX 2021-3 A3 CAR	Asset-Backed Security	5,277,729	6/15/2026
Payden	14317DAC4	CARMX 2021-3 A3 CAR	Asset-Backed Security	668,512	6/15/2026
Payden	98164JAB0	WOART 2023-A A2A CAR	Asset-Backed Security	5,006,383	7/15/2026
Payden	29375MAB3	ENTERPRISE 2020-2 A2 FLEET 144A	Asset-Backed Security	2,093,846	7/20/2026
Payden	362554AC1	GMCAR 2021-4 A3 CAR	Asset-Backed Security	4,311,275	9/16/2026
Payden	36267KAB3	GMCAR 2023-3 A2A CAR	Asset-Backed Security	2,800,000	9/16/2026
Payden	98163CAF7	WORLD OMNI 2020-C A4 CAR	Asset-Backed Security	5,000,000	10/15/2026
Payden	379929AD4	GMALT 2023-3 A3 LEASE	Asset-Backed Security	300,000	11/20/2026
Payden	29374EAB2	ENTERPRISE 2021-1 A2 FLEET 144A	Asset-Backed Security	2,603,563	12/21/2026
Payden	92867WAB4	VALET 2023-1 A2A CAR	Asset-Backed Security	1,600,000	12/21/2026
Payden	43813KAD4	HONDA 2020-3 A4 CAR	Asset-Backed Security	4,225,000	4/19/2027
Payden	500945AC4	KCOT 2023-2A A3 EQP 144A	Asset-Backed Security	500,000	1/18/2028
Payden	43815QAC1	HAROT 2023-3 A3 CAR	Asset-Backed Security	250,000	2/18/2028
Payden	477920AC6	JDOT 2023-B A3 EQP	Asset-Backed Security	750,000	3/15/2028
Payden	14319BAC6	CARMX 2023-3 A3 CAR	Asset-Backed Security	800,000	5/15/2028
Payden	344930AD4	FORDO 2023-B A3 CAR	Asset-Backed Security	600,000	5/15/2028

LA Care Securities Holdings
as of September 30, 2023

Porfolio	CUSIP/Identifier	Security	Type	Par	Maturity date
Payden	34528QHV9	FORDF 2023-1 A1 FLOOR 144A	Asset-Backed Security	900,000	5/15/2028
Payden	361886CR3	GFORT 2023-1 A1 FLOOR 144A	Asset-Backed Security	900,000	6/15/2028
Payden	63938PBU2	NAVMT 2023-1 A FLOOR 144A	Asset-Backed Security	200,000	8/25/2028

California State Treasurer
Fiona Ma, CPA

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

October 02, 2023

LAIF Home
PMIA Average Monthly Yields

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

Tran Type Definitions

September 2023 Statement

Account Summary

Total Deposit:	0.00	Beginning Balance:	34,551,230.94
Total Withdrawal:	0.00	Ending Balance:	34,551,230.94

KEITH KNOX
TREASURER AND TAX COLLECTOR

COUNTY OF LOS ANGELES
TREASURER AND TAX COLLECTOR

Kenneth Hahn Hall of Administration
500 West Temple Street, Room 462, Los Angeles, California 90012
Telephone: (213) 974-3385 Fax: (213) 626-1701
ttc.lacounty.gov and propertytax.lacounty.gov

October 5, 2023

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

MONTHLY eCAPS REPORT

Attached please find for your review and reference, the Balance Sheet Detail Activity by Fund report from eCAPS for the month ended September 30, 2023.

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

Very truly yours,

KEITH KNOX
Treasurer and Tax Collector

Jennifer Koai
Operations Chief

JK:ML:en

Balance Sheet Detail Activity By Fund

September 1, 2023 - September 30, 2023

Fiscal Year: 2024 **Fiscal Period:** 3
Fund Class: TT15 TTC-ICG LAPIF **Fund:**

Balance Sheet Category	Balance Sheet Class	Balance Sheet Account	Record Date	Document	Description	Beginning Balance	Debits	Credits	Ending Balance
Asset									
1A Pooled Cash & Investments									
	100 Cash								
		1000 Cash							
						77,971,239.18	0.00	0.00	77,971,239.18
			09/01/2023	JVA AC IA082300030 16	INTEREST ALLOCATION FOR THE MONTH ENDING August 31, 2023	0.00	228,220.79	0.00	78,199,459.97
		Total for 1000 Cash				**$77,971,239.18**	**$228,220.79**	**$0.00**	**$78,199,459.97**
	Total for 100 Cash					**$77,971,239.18**	**$228,220.79**	**$0.00**	**$78,199,459.97**
Total for 1A Pooled Cash & Investments						**$77,971,239.18**	**$228,220.79**	**$0.00**	**$78,199,459.97**
Total for Asset						**$77,971,239.18**	**$228,220.79**	**$0.00**	**$78,199,459.97**
Total for T4P Los Angeles Care Health Plan						**$77,971,239.18**	**$228,220.79**	**$0.00**	**$78,199,459.97**
Total for TT15 TTC-ICG Los Angeles County Pool Investment Fund						**$77,971,239.18**	**$228,220.79**	**$0.00**	**$78,199,459.97**

L.A. Care Health Plan
Quarterly Investment Compliance Report
July 1, 2023 through September 30, 2023

OVERVIEW

The California Government Code requires the L.A. Care Treasurer to submit a quarterly report detailing its investment activity for the period. This investment report covers the three-month period from July 1, 2023 through September 30, 2023.

PORTFOLIO SUMMARY

As of September 30, 2023, the market values of the portfolios managed by Payden & Rygel and New England Asset Management are as follows:

Portfolios	Payden & Rygel
Cash Portfolio #2365	*$2,761,369,093.53*
Low Duration Portfolio #2367	*$90,378,588.94*
Total Combined Portfolio	**$2,851,747,682.47**

Portfolios	NEAM
Government and Corporate Debt	**$327,145,559.76**

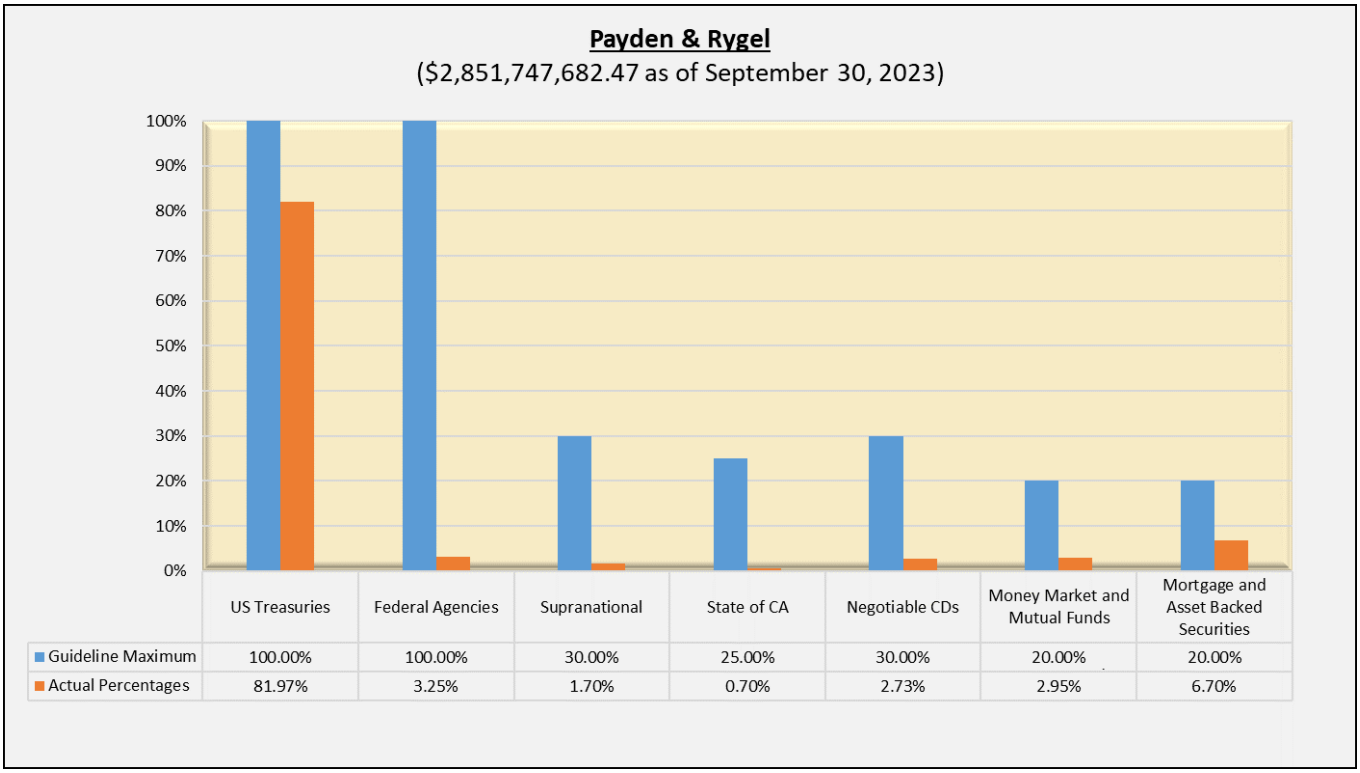
COMPLIANCE WITH ANNUAL INVESTMENT POLICY

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

L.A. Care has invested funds in California's Local Agency Investment Fund (LAIF) and the Los Angeles County Treasurer's Pooled Investment Fund (LACPIF). In a LAIF statement dated October 2, 2023, the September 30, 2023 balance is reported as $34,551,230.94 with accrued interest of $200,716. In the LACPIF statement dated October 5, 2023, the September 30, 2023 balance is reported as $78,199,459.97. The LACPIF account balance does not reflect accrued interest.

Payden & Rygel Compliance Verification

California Government Code Compliance Verification Detail as of September 30, 2023



	Maximum Permitted Maturity		Actual Maximum Maturity		Compliance
	#2365	#2367	#2365	#2367	
	Enhanced Cash	Low Duration	Enhanced Cash	Low Duration	
US Treasuries	5 Years	5 Years	1.84 Years	4.92 Years	YES
Federal Agencies	5 Years	5 Years	2.97 Years	2.37 Years	YES
Supranational	5 Years	5 Years	2.98 Years	0.15 Years	YES
State of CA	5 Years	5 Years	0.05 Years	3.79 Years	YES
Negotiable CDs	270 Days	270 Days	261 days	-	YES
Money Market and Mutual Funds	NA	NA	1 Day	1 Day	YES
Mortgage and Asset Backed Securities	5 Years	5 Years	3.55 Years	4.91 Years	YES

Payden & Rygel Compliance Verification

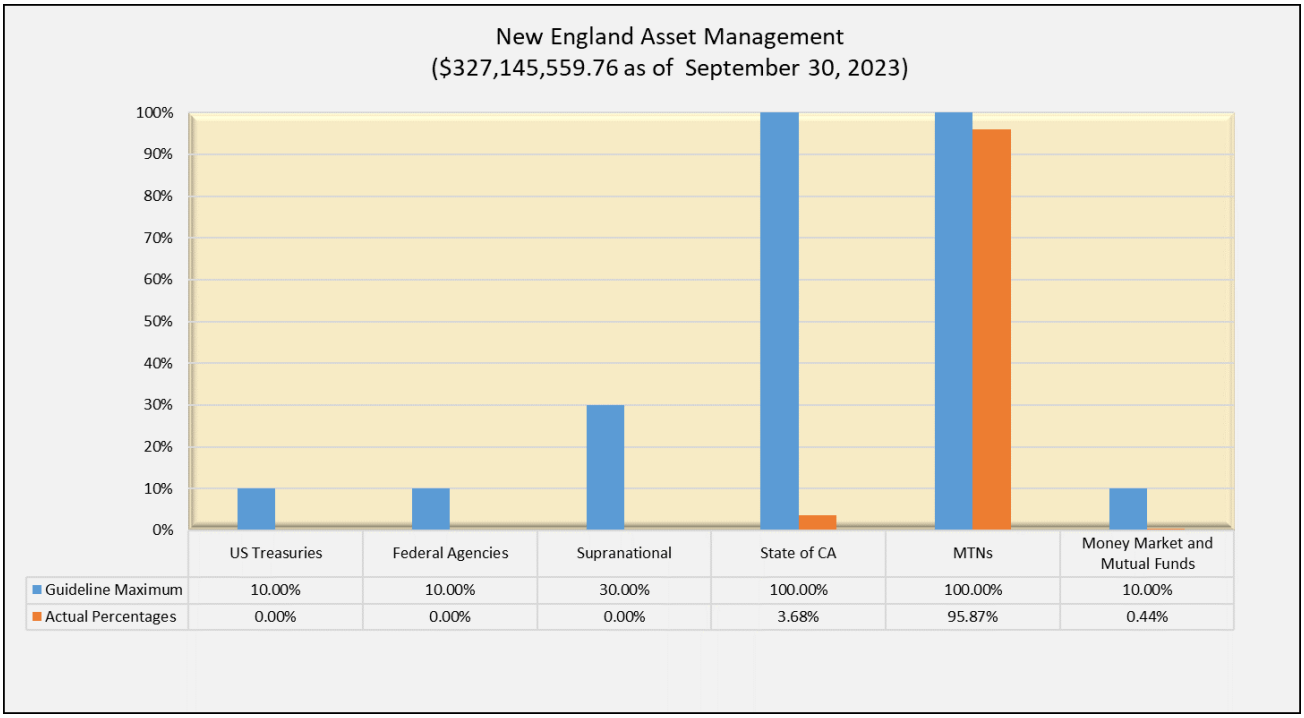
Combined #2365 and #2367 Portfolios as of September 30, 2023

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

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

New England Asset Management Compliance Verification

California Government Code Compliance Verification Detail as of September 30, 2023



	Maximum Permitted	Actual Maximum Maturity	Compliance
	NEAM	NEAM	
US Treasuries	5 Years	-	**YES**
Federal Agencies	5 Years	-	**YES**
Supranational	5 Years	-	**YES**
State of CA	5 Years	3.01 Years	**YES**
MTNs	5 Years	4.82 Years	**YES**
Money Market and Mutual Funds	NA	1 Day	**YES**

New England Asset Management Compliance Verification

As of September 30, 2023

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

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

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

MARKET COMMENTARY

Economic Highlights

- **GDP**: Real GDP growth has moderated this year, equaling 2.1% during the second quarter. After a strong Q1, consumer spending dropped and contributed just a half percent to overall growth. Private spending rebounded strongly during the quarter while government spending continues to grow. The Atlanta Federal Reserve's GDPNow forecast for the third quarter of 2023 currently stands at 4.9%.
  Source: Bureau of Economic Analysis.

- **Interest Rates**: The Treasury curve rose across all maturities during the third quarter. The 10-year Treasury closed at 4.57%, up 73 basis points. The 10-year real yield (i.e., net of inflation) rose 61 basis points to 2.23%. The Federal Open Market Committee (FOMC) increased their overnight rate by 0.25%, targeting a range of 5.25% to 5.50%. The committee's current median outlook is for a rate of approximately 5.6% by the end of 2023.
  Source: U.S. Treasury

- **Inflation**: Consumer price changes have ticked higher recently as the Consumer Price Index rose 1.0% for the three months ending August. For the one-year period, the CPI was up 3.7%. The 10-year breakeven inflation rate was up at 2.34% in September versus 2.23% in June.

- **Employment**: Jobs growth has been slowing, with an average of 150,000 jobs/month added during the three months ending in August. The unemployment rate ticked higher at 3.8%, up from 3.7% in May. Wage growth has been modest this year, up 0.2% in August, a likely welcome sign for the Fed.
  Source: Dept. of Labor (BLS)

U.S. Fixed Income Markets

The U.S. Treasury yield curve was up across the maturity spectrum during the quarter, and to a greater degree in the long end of the curve. The 10-year Treasury yield ended the quarter at 4.57%, up 73 basis points from June. Credit spreads were little changed during the quarter with investment grade down just 2 basis points and high yield bonds up 4 basis points. The FOMC met twice during the quarter, as scheduled, and increased the overnight rate by 0.25% in July, targeting a range of 5.25% to 5.50%, before again pausing increases in September. The Fed's "dot plot" is messaging that the current expectation is for another 25 basis point increase before the end of 2023 while markets are pricing a slightly lower year-end rate, approximately equal to the current effective rate. In late September, Fed Chair Jerome Powell said that inflation is currently the central bank's top priority, "the worst thing we can do is to fail to restore price stability, because the record is clear on that."

Payden&Rygel

QUARTERLY PORTFOLIO REVIEW

LA CARE HEALTH PLAN

3rd Quarter 2023

PAYDEN.COM
LOS ANGELES | BOSTON | LONDON | MILAN

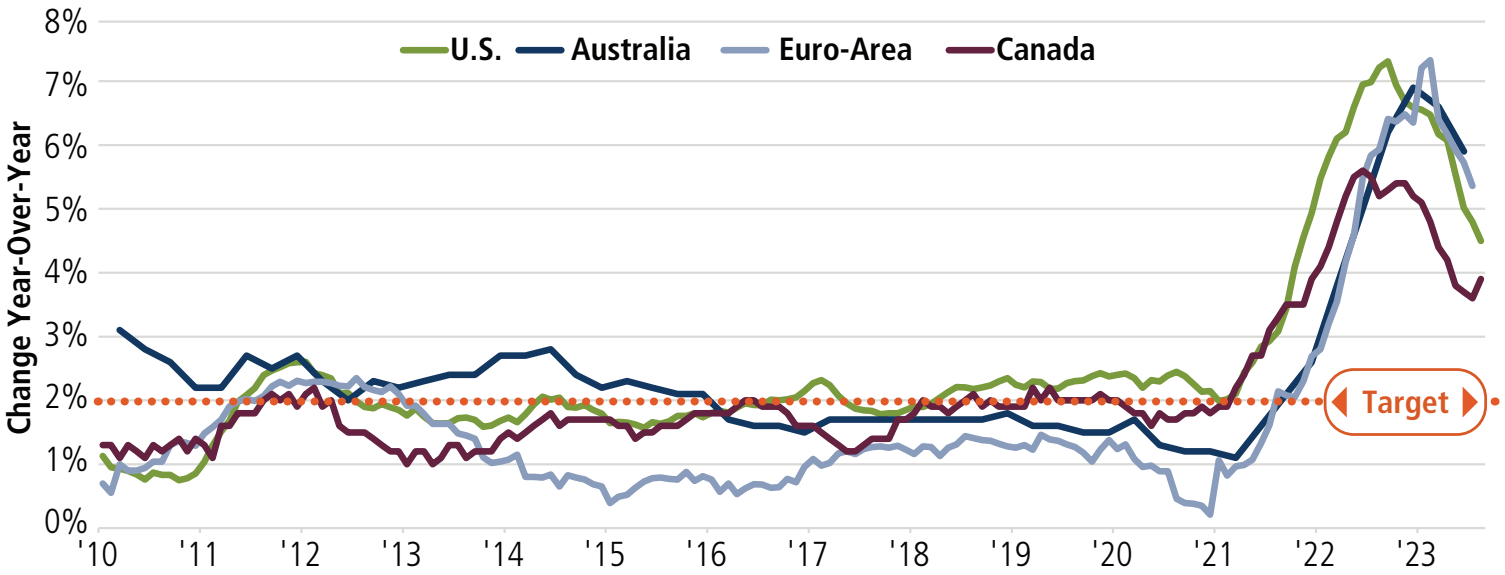
MARKET MEMO

From the desk of Joan Payden:

- Three key themes drove financial markets in Q3: **global inflation cooled, the U.S. labor market remained resilient, and global economic growth diverged.**
- First, the U.S. core personal consumption expenditures (PCE) **showed signs of progress this quarter**, down to 4.2% year-over-year but remaining well above the Fed's target, as risks of inflation acceleration still loom. **Globally, trimmed-mean measures of inflation have slowed considerably** (chart below).
- Second, **the U.S. economy proved surprisingly resilient** as consumer spending remains robust, and the unemployment rate remains low at 3.8%.
- Third, **global economies are not sharing the U.S. soft landing prospects**. Euro area GDP contracted, with manufacturing PMI falling into negative territory, while China continues to face growth headwinds.

GLOBALLY, UNDERLYING INFLATION REMAINS BROAD EVEN IF "THE WORST IS BEHIND US"

TRIMMED-MEAN MEASURES OF INFLATION FOR U.S., EURO AREA, AUSTRALIA, AND CANADA



Source: Federal Reserve Bank of Cleveland, Australian Bureau of Statistics, Bloomberg Economics, Statistics Canada

MARKET THEMES FOR Q3

- Bond yields rose as the Federal Reserve communicated its policy rate may have to remain elevated for longer to combat inflation.
- Despite robust domestic economic activity, credit spreads were mixed, and equity markets struggled as investors reassessed interest rate expectations.

OUTLOOK AND ACTIVITY

- Looking ahead to 2024, we foresee modest GDP growth, a steady U.S. unemployment rate, and a slow descent in core inflation. Central banks will likely remain restrictive for longer.
- Across strategies, we have modestly lengthened portfolio durations throughout the year. Sensitivity to credit has also broadly declined, as we maintain a preference towards quality and liquidity amid tight monetary conditions.

Portfolio Review and Market Update – 3rd Quarter 2023

PORTFOLIO CHARACTERISTICS (As of 9/30/2023)

Market Value	2,851,747,682
Avg Credit Quality	AA+
Avg Duration	0.20
Avg Yield to Maturity	5.33%

SECTOR ALLOCATION

Sector	Market Value	% of Port
Cash	47,837,609	1.68%
Money Market	115,119,608	4.04%
Treasury	2,336,535,637	81.93%
Agency	92,729,490	3.25%
Government Related	48,856,116	1.71%
Credit	-	0.00%
ABS/MBS	190,729,381	6.69%
Municipal	19,939,842	0.70%
Total	2,851,747,682	100.0%

MATURITY DISTRIBUTION

Sector	Market Value	% of Port
<90 day	2,260,038,321	79.3%
90 days - 1 Year	482,715,903	16.9%
1 - 2 Years	34,833,095	1.2%
2 - 5 years	74,160,364	2.6%
Total	2,851,747,682	100%

PORTFOLIO RETURNS

Periods over one year annualized

Periods ended 9/30/2023

Performance	3rd Quarter	2023 YTD	Trailing 1 Year	Trailing 3 Year
LA Care - Short-Term Portfolio	**1.32**	**3.67**	**4.63**	**1.71**
Benchmark*	1.31	3.60	4.47	1.70
LA Care - Extended-Term Portfolio	**0.19**	**1.36**	**2.33**	**-1.21**
Benchmark**	0.19	1.12	2.07	-1.86
LA Care - Combined Portfolio	1.28	3.57	4.54	1.54

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

L.A. CARE HEALTH PLAN SHORT TERM PORTFOLIO

Portfolio Review and Market Update – 3rd Quarter 2023

PORTFOLIO CHARACTERISTICS (As of 9/30/2023)

Market Value	2,761,369,094
Avg Credit Quality	AA+
Avg Duration	0.12
Avg Yield to Maturity	5.34%

SECTOR ALLOCATION

Sector	Market Value	% of Port
Cash	46,340,554	1.68%
Money Market	115,119,608	4.17%
Treasury	2,279,542,736	82.55%
Agency	86,421,032	3.13%
Government Related	47,722,708	1.73%
Corporate Credit	-	0.00%
ABS/MBS	181,145,303	6.56%
Municipal	5,077,153	0.18%
Total	2,761,369,094	100.0%

MATURITY DISTRIBUTION

Sector	Market Value	% of Port
<90 day	2,255,099,428	81.7%
90 days - 1 Year	474,124,665	17.2%
1 - 2 Years	19,581,371	0.7%
2 - 5 years	12,563,629	0.5%
Total	2,761,369,094	100.0%

PORTFOLIO RETURNS

Periods over one year annualized

Periods ended 9/30/2023

Performance	3rd Quarter	2023 YTD	Trailing 1 Year	Trailing 3 Year
L.A. Care - Short-Term Portfolio	**1.32**	**3.67**	**4.63**	**1.71**
Benchmark*	1.31	3.60	4.47	1.70

* ICE BofA 91 Day Treasury Index

L.A. CARE HEALTH PLAN EXTENDED TERM PORTFOLIO

Portfolio Review and Market Update – 3rd Quarter 2023

PORTFOLIO CHARACTERISTICS (As of 9/30/2023)

Market Value	90,378,589
Avg Credit Quality	AA+
Avg Duration	2.58
Avg Yield to Maturity	5.09%

SECTOR ALLOCATION

Sector	Market Value	% of Port
Cash	1,497,055	1.66%
Money Market	-	0.00%
Treasury	56,992,901	63.06%
Agency	6,308,458	6.98%
Government Related	1,133,408	1.25%
Credit	-	0.00%
ABS/MBS	9,584,077	10.60%
Municipal	14,862,690	16.44%
Total	90,378,589	100.0%

MATURITY DISTRIBUTION

Sector	Market Value	% of Port
<90 day	4,938,893	5.5%
90 days - 1 Year	8,591,238	9.5%
1 - 2 Years	15,251,723	16.9%
2 - 5 years	61,596,735	68.2%
Total	90,378,589	100%

PORTFOLIO RETURNS

Periods over one year annualized

Periods ended 9/30/2023

Performance	3rd Quarter	2023 YTD	Trailing 1 Year	Trailing 3 Year
LA Care - Extended-Term Portfolio	**0.19**	**1.36**	**2.33**	**-1.21**
Benchmark**	0.19	1.12	2.07	-1.86

** Bloomberg US Govt 1-5 Yr Bond Index

OUR STRATEGIES

Multi-Sector

Short Maturity Bonds

U.S. Core Bond

Absolute Return Fixed Income

Strategic Income

Global Fixed Income

Liability Driven Investing

Sector-Specific

Emerging Markets Debt

Government/Sovereign

High Yield Bonds & Loans

Inflation-Linked/TIPS

Investment Grade Corporate Bonds

Municipal Bonds (U.S.)

Securitized Bonds

Income-Focused Equities

Equity Income

L.A. Care Health Plan

NEAM's L.A. Care Board Report

Data as of September 30, 2023

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

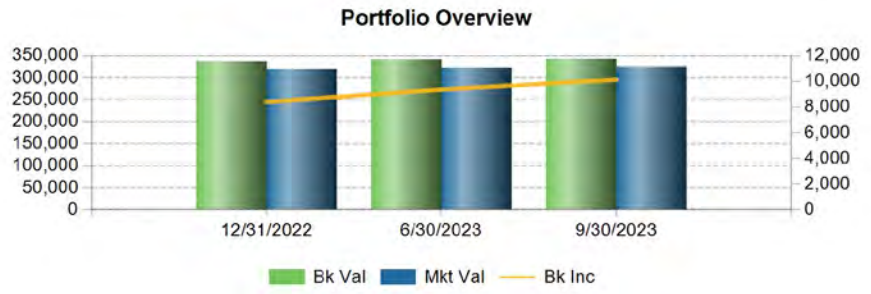
Table of Contents

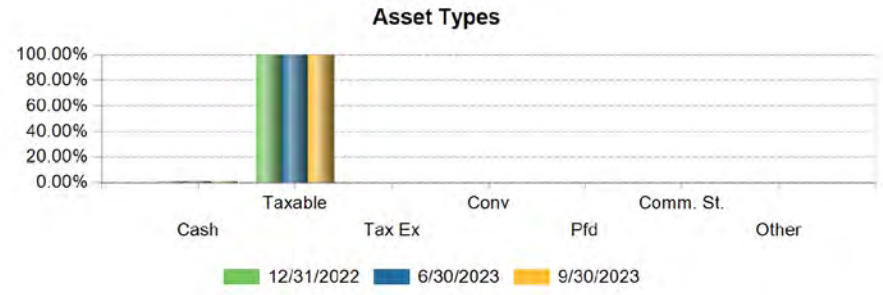
Portfolio Summary

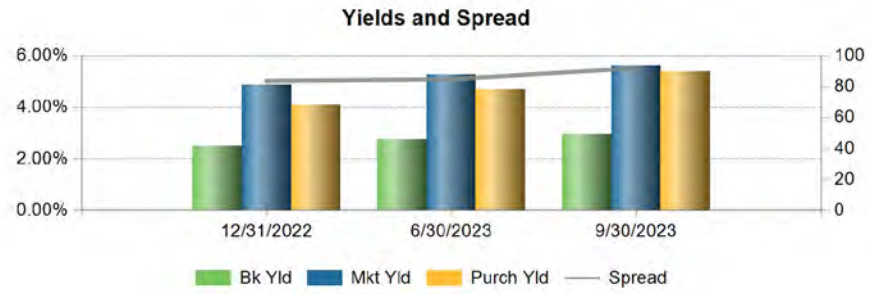
L.A. Care Health Plan - Comparative Overview

	12/31/2022	6/30/2023	9/30/2023	Change since 6/30/2023
Portfolio Overview (000's Omitted)				
Book Value	336,962	340,315	342,390	2,075
Market Value	319,103	323,571	324,536	965
Total Unrealized Gain/Loss	(17,859)	(16,744)	(17,854)	(1,110)
Net Gains	764	304	12	(291)
Net Losses	(18,622)	(17,048)	(17,866)	(819)
Realized Gain / Loss	(744)	(792)	(450)	
Annualized Book Income	8,399	9,361	10,135	774
After Tax Book Income	6,635	7,395	8,007	612
Asset Types				
Cash / Cash Equivalents	0.2%	0.1%	0.4%	0.3%
Taxable Fixed Income	99.8%	99.9%	99.6%	(0.3%)
Portfolio Yields				
Book Yield (Before Tax)	2.49%	2.75%	2.96%	0.21%
Book Yield (After Tax)	1.97%	2.17%	2.34%	0.17%
Market Yield	4.88%	5.27%	5.62%	0.35%
Fixed Income Analytics				
Average OAD	2.60	2.58	2.55	(0.03)
Average Life	2.86	2.86	2.87	0.01
Average OAC	8.71	8.46	8.34	(0.13)
Average Quality	A+	A+	A+	
144A %	11.35%	13.38%	13.58%	0.20%
Average Purchase Yield	4.09%	4.71%	5.40%	0.69%
Average Spread Over Tsy	84	85	92	7
5 Year US Govt On The Run	3.96%	4.12%	4.61%	0.49%

	12/31/22	03/31/23	06/30/23	09/30/23	Change since 06/30/2023
MV Excl. Acc. Int. Inc.	319,103,446	324,381,481	323,571,060	324,536,395	965,336
Acc. Int. Inc.	2,456,342	2,588,254	2,712,127	2,609,165	(102,963)
MV Inc. Acc. Int. Inc.	321,559,788	326,969,735	326,283,187	327,145,560	862,373



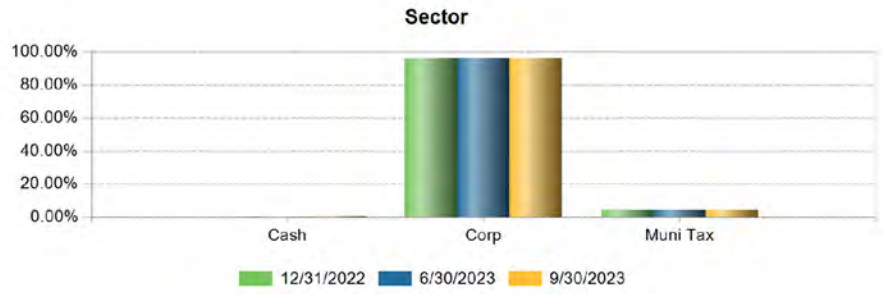


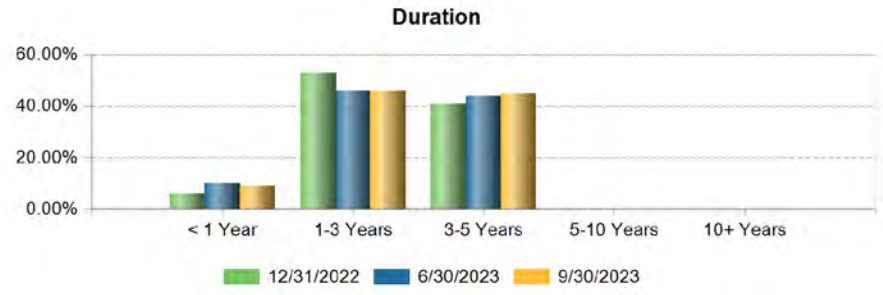


L.A. Care Health Plan - Fixed Income Summary

	12/31/2022	6/30/2023	9/30/2023	Change since 6/30/2023
Sector				
Cash & Cash Equivalents	< 1%	< 1%	< 1%	< 1%
Corporates	96%	96%	96%	-
Municipals - Taxable	4%	4%	4%	-
Fixed Income	100%	100%	100%	
Duration				
< 1 Year	6%	10%	9%	(1%)
1-3 Years	53%	46%	46%	-
3-5 Years	41%	44%	45%	1%
Average Duration	2.60	2.58	2.55	(0.03)
Quality				
AAA	6%	6%	6%	-
AA	26%	25%	23%	(2%)
A	68%	69%	71%	2%
Average Quality	A+	A+	A+	

	Average Portfolio Rating at 9/30/23				
	Moody	S&P	Fitch	Lowest	Highest
Average Rating	A1	A	A+	A	A+





Activity Report

L.A. Care Health Plan - Transaction Summary

(000's Omitted)

Purchases	Market Value	%	Spread (Bp)	Book Yld	High	Duration
Corporates	22,234	100.0	92	5.40	A+	3.74
Total Purchases	22,234	100.0	92	5.40	A+	3.74

Sales	Market Value	%	Realized G/L	Trade / Book Yld	High	Duration
Corporates	19,705	95.3	(415)	5.88 / 2.41	A+	0.65
Municipals - Taxables	965	4.7	(35)	5.54 / 0.43	AA+	0.73
Total Sales	20,669	100.0	(450)	5.86 / 2.32	A+	0.65

Performance Report

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

	Sep 2023 Market*	Sep 2023	Aug 2023	Jul 2023	Q3	YTD	12 Month	Annualized 3 Year	Annualized 5 Year	Annualized Inception	Inc Date
LA Care HealthPlan	327,146	(0.41)	0.16	0.52	0.26	1.74	3.33	(1.03)	1.69	1.51	Jan 2018
Barclay Bloomberg U.S. Credit: 1-5 Yr A- or better (Highest)		(0.50)	0.14	0.53	0.17	1.70	3.34	(1.39)	1.45	1.28	Jan 2018
Difference		0.09	0.02	(0.01)	0.09	0.04	(0.01)	0.36	0.24	0.23	

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

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

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

Disclosures

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

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

Appendix

Risk Reports

L.A. Care Health Plan - Profile Report

Distribution by Class

	Quantity	Book	Market	Unrealized Gain/ Loss	Book Yield	OAY	OAD	OAC	Avg Life	% of Portfolio
Cash & Cash Equivalents	1,441,968	1,441,968	1,441,968	-	5.14	5.14	0.08	0.05	0.08	0.44
Corporates	283,907,000	280,751,133	266,998,510	(13,752,624)	3.11	5.64	2.59	8.37	2.94	82.27
144A	47,500,000	47,335,771	44,078,101	(3,257,669)	2.58	5.60	2.64	9.67	2.85	13.58
Municipals - Taxable	12,800,000	12,861,273	12,017,815	(843,457)	0.94	5.40	1.61	3.72	1.68	3.70
Total Portfolio	**345,648,968**	**342,390,145**	**324,536,395**	**(17,853,750)**	**2.96**	**5.62**	**2.55**	**8.34**	**2.87**	**100.00**

Rating Analysis - Highest

	% of Portfolio
AAA	5.93
AA	23.25
A	70.82
BBB	-
Below BBB	-
NR	-
Total Fixed Income	**100.00**
Equity	-
Total	**100.00**

Average Rating: A+

Scenario Analysis - % of Market

	-300	-200	-100	-50	+50	+100	+200	+300
Cash & Cash Equivale	0.24	0.16	0.08	0.04	(0.04)	(0.08)	(0.16)	(0.24)
Corporates	8.13	5.34	2.63	1.30	(1.28)	(2.55)	(5.01)	(7.38)
144A	8.38	5.48	2.69	1.33	(1.31)	(2.59)	(5.10)	(7.51)
Municipals - Taxable	5.00	3.30	1.63	0.81	(0.80)	(1.59)	(3.15)	(4.67)
Total Portfolio	**8.01**	**5.26**	**2.59**	**1.28**	**(1.26)**	**(2.51)**	**(4.93)**	**(7.27)**

Key Rate Duration

	Market Value	1 Year	2 Year	3 Year	5 Year	7 Year	10 Year	15 Year	20 Year	30 Year
Cash & Cash Equival	1,441,968	0.08	-	-	-	-	-	-	-	-
Corporates	266,998,510	0.25	0.40	1.20	0.73	< 0.00	-	-	-	-
144A	44,078,101	0.14	0.42	1.31	0.77	< 0.00	-	-	-	-
Municipals - Taxable	12,017,815	0.39	1.01	0.21	< 0.01	-	-	-	-	-
Total Portfolio	**324,536,395**	**0.24**	**0.43**	**1.17**	**0.71**	**< 0.00**	**-**	**-**	**-**	**-**

Disclaimers

Disclaimers

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L.A. Care
HEALTH PLAN

Board of Governors

MOTION SUMMARY

Date: December 7, 2023 **Motion No. FIN 101.1223**

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

Requesting Department: Accounting & Finance Services

Issue: Annual Board Review and Approval of Accounting & Finance Services Policies AFS-002 (Capital Assets), AFS-027 (Travel Expenses), and AFS-029 (Annual Budgets and Board of Governors Oversight)

Background: On an annual basis, L.A. Care's Financial policies are brought to the Board for review, updates and approval. This year, we are bringing four policies to the Board for review which have minor updates to the policies. A summary of these policies is provided below:

AFS-002: Capital Assets:

- Policy defines the capitalization policy, fixed asset categorization, guidelines and procedures for acquisition, safeguarding and disposal. This policy assures that L.A. Care complies with the requirements of Generally Accepted Accounting Principles (GAAP) to ensure proper recording and control of the capital assets.
- The Policy is updated with reference to the new financial reporting system, SAP.
- Minor updates

AFS-027: Travel Expenses:

- Policy defines approvals and appropriate expenses related to travel.
- The Policy is updated with reference to the appropriate electronic signatures allowed for approval and updated mileage reimbursement guidelines for telecommuters.
- Minor updates

AFS-029: Annual Budgets & Board of Governors Oversight:

- Policy defines oversight responsibility of the Board and the process for the CFO and finance staff to prepare the annual budget for review by the Board.
- The Policy is updated with reference to the addition of the Deputy CFO reporting to the Finance & Budget Committee and Board of Governors
- Minor updates

Member Impact: None.

Budget Impact: None.

Motion: To approve Accounting & Financial Services Policies AFS-002 (Capital Assets), AFS-004 (Non-Travel & Other Related Expenses), AFS-027 (Travel Expenses), and AFS-029 (Annual Budgets & Board of Governors Oversight) as submitted.

	CAPITAL ASSETS	**AFS-002**
DEPARTMENT	FINANCE SERVICES	
Supersedes Policy Number(s)		

DATES					
Effective Date	4/1/2002	Review Date	~~11/18/2022~~11/15/2023	Next Annual Review Date	~~11/18/2023~~11/15/2024
Legal Review Date	~~10/23/202~~11/13/2023	Committee Review Date	~~10/26/2020~~11/15/2023		

LINES OF BUSINESS

☐ Medicare D-SNP ☐ L.A. Care Covered ☐ L.A. Care Covered Direct ☐ MCLA
☐ PASC-SEIU Plan ☒ Internal Operations

DELEGATED ENTITIES / EXTERNAL APPLICABILITY

☐ PP – Mandated ☐ PP – Non-Mandated ☐ PPGs/IPA ☐ Hospitals
☐ Specialty Health Plans ☐ Directly Contracted Providers ☐ Ancillaries ☐ Other External Entities

ACCOUNTABILITY MATRIX

Enter department here	Enter policy §§ here		
IT Operations & Infrastructure	ITOI-006, ITOI-010		

ATTACHMENTS

- Enter all attachments here (e.g., desktop procedures/job aids, templates, reports, letters)

ELECTRONICALLY APPROVED BY THE FOLLOWING

	OFFICER	**DIRECTOR**
NAME	~~Marie Montgomery~~Afzal Shah	Angela Bergman
DEPARTMENT	Finance Services	Accounting Services
TITLE	Chief Financial Officer	Controller

AUTHORITIES

- FASB Accounting Standards Codification (ASC) 105, Generally Accepted Accounting Principles
- FASB ASC 360, Property, Plant, and Equipment
- FASB ASC 350-40, Internal-Use software
- FASB Accounting Standards Updates (ASU) 2015-05, Intangibles – Goodwill and other Internal-Use Software
- Financial Accounting Standards (FAS) No. 142, Goodwill and Other Intangible Assets
- GASB Statement No. 42, Accounting and Financial Reporting for Impairment of Capital Assets and for Insurance Recoveries
- GASB Statement No. 51, Accounting and Financial Reporting for Intangible Assets
- GASB Statement No. 87. Leases

REFERENCES

- ITOI-006 "Asset Management Guidelines"
- ITOI-010 "Secure Data Disposal"

HISTORY

REVISION DATE	DESCRIPTION OF REVISIONS
05/11/09	Supersedes Policy #1503
06/11/14	Supersedes Policies AFS-003 and AFS-005
10/28/2019	Annual update of Policy; revised format and wordings
10/26/2020	Annual update of Policy; no material changes made
10/13/2021	Annual review of policy
11/18/2022	Annual review of policy; revised format
11/15/2023	Annual review of policy

1.0 OVERVIEW:

The objective is to establish L.A. Care Health Plan (L.A. Care)'s policy for capital assets and to clarify definitions of the capitalization policy, fixed asset categorization, guidelines and procedures for acquisition, safeguarding and disposal. This policy assures that L.A. Care complies with the requirements of Generally Accepted Accounting Principles (GAAP) referenced in Section 2.2316 below to ensure proper recording and control of the capital assets.

2.0 DEFINITIONS:

Whenever a word or term appears capitalized in this Policy and Procedure, the reader should refer to the "Definitions" below.

2.1 Account Systems Applications and Products (SAP)# 150100 (#10915) "Work in Progress": Includes costs associated with on-going projects related to software development, computer equipment, leasehold improvement or furniture purchases for office relocations.

2.2 Account SAP# 152200 (#10916) "Inventory – IT Equipment": Includes costs associated with inventories of computer equipment purchased at one time to take advantage of cost savings and deployed over several months.

2.3 Account SAP# 152210 (#10925) "Furniture - Sac": Includes all capitalized expenditures in L.A. Care's Sacramento office for office furniture, including desks, chairs, file cabinets, bookcases, and tables including modular furniture.

2.4 Account SAP# 152220 (#10927) "Furniture – 7th St": Includes all capitalized expenditures for office furniture, including desks, chairs, file cabinets, bookcases, and tables including modular furniture located in the buildings on 7th street in Los Angeles.

2.5 Account SAP# 152100 (#10931) "Furniture – CRC": Includes all capitalized expenditures for office furniture, including desks, chairs, file cabinets, bookcases, and tables including modular furniture located in the Community Resource Centers (CRC).

~~2.5~~

2.6 Account SAP# 152230 (#10928) "Office Equipment": Includes all capitalized expenditures for office equipment at all L.A Care's locations excluding ~~Community Resource Centers (~~CRC~~s)~~, including copiers, mailing machines, reproduction and graphics equipment, fax machines, video equipment, and projection machines.

2.7 **Account SAP# 152240 (#10929) "Office Equipment - CRC~~s~~":** Includes all capitalized expenditures for office equipment in ~~located at a Community Resource Center (~~CRC~~)~~, including copiers, mailing machines, reproduction and graphics equipment, fax machines, video equipment, and projection machines.

2.8 **Account SAP# 152250 (#10930) "Telephone Equipment":** Includes all capitalized expenditures for telephone equipment, including switches, reader boards, Private Branch Exchange System (PBX) and Star/conferencing equipment, and dedicated servers. Individual telephone units are not included.

2.9 **Account SAP# 152270 (#10935) "Personal Computers":** Includes all capitalized expenditures for individual workstation PCs, monitors, and printers. Networked, high-speed printers are included in other computer equipment. Expendable computer supplies, purchases of computer mouse, keyboards, pads, diskettes, and memory upgrades shall not be capitalized.

2.10 **Account SAP# 152280 (#10940) "Other Computer Equipment":** Includes all capitalized expenditures for network equipment at all L.A Care's locations excluding ~~Community Resource Centers (~~CRC~~s)~~. Includes~~such as~~ servers, racks, switches, and high-speed network printers, except those dedicated to the phone systems. ~~.~~

~~2.10~~2.11 **Account SAP# 152290 (#10940) "Other Computer Equipment - CRC":** Includes all capitalized expenditures for network equipment at ~~Community Resource Centers (~~CRC~~s)~~ including servers, racks, switches, and high-speed network printers, except those dedicated to the phone systems.

~~2.11~~2.12 **Account SAP# 152300 (#10945) "Computer Software":** This account category is intended for recording enterprise-wide systems and software-application implementations that are purchased by L.A. Care. Software licenses, maintenance agreements, upgrades, or additional user fees should not be capitalized.

2.13 **Account SAP# 151100 (#10951) "Leasehold Improvements 7th/Garland":** Includes expenditures greater than $10,000 for improving or reconfiguring the functional use of leased building/space located on 7th street HQ and Garland building.~~, Los Angeles~~.

2.14 **Account SAP# 151110 (#10951) "Leasehold Improvements - CRC":** Includes expenditures greater than $10,000 for improving or reconfiguring the functional use of leased building/space for L.A. Care's ~~Community Resource Centers (~~CRC~~s)~~.

2.15 **Account SAP# 157000 (#10960) "MIS Project"—:** Includes expenditures associated with the development of Management Information System (MIS) Project.

~~2.12~~2.16 **Account SAP# 157010 (#10961) "Data Mastery Repository (DMR"):** Includes expenditures associated with the development of a centralized data repository for L.A. Care's administrative personnel and management.

2.17 **Account SAP# 157100 (#10962) "CORE System":** Includes expenditures associated with the development of a centralized data system to standardize L.A. Care's business processes to serve the needs of members and providers.

Account SAP# 157030 (#10965) "EDS-Beneficiary Eligibility"-: Includes expenditures associated with the development of Ehlers-Danlos Syndrome (EDS)-Beneficiary Eligibility software.

2.18

2.19 **Account SAP# 151020 (#10952) "Right of Use (ROU) Asset"-:** Asset account to be used for L.A Care's right to use underlying leased asset balances in accordance with Government Accounting Standards Board (GASB) Statement No. 87 Leases.

~~2.14~~

~~2.15~~

~~2.16~~2.20 **Account SAP# 160000 (#10975) ~~(#10975)~~ "Capital Leases"-:** Asset account to be used when entering into equipment leases whose financial terms and conditions meet the criteria set forth in the Statement of Financial Accounting Standards (SFAS) No. 13, Accounting for Leases.

2.21 **Custodian:** The person to whom an asset is assigned for use or safekeeping.

~~2.17~~2.22 **SAP:** The Accounting & Financial Services software used to manage fixed assets.

~~**2.18 Fixed Asset System (FAS):** The Accounting & Financial Services software used to manage fixed assets.~~

~~2.19~~2.23 **Generally Accepted Accounting Principles (GAAP):** The common set of accounting principles, standards and procedures that companies use to compile their financial statements. GAAP are a combination of authoritative standards and requirements of Financial Accounting Standards Board (FASB) and Governmental Accounting Standards Board (GASB), which simply set the commonly accepted ways of recording and reporting accounting information.

~~2.20~~2.24 **Information Systems Assets:** For purposes of this policy, this includes items capitalized in the following general ledger accounts:

~~2.20.1~~2.24.1 SAP 152250 (10930) Telephone Equipment~~;~~
~~2.20.2~~2.24.2 SAP 152270 (10935) Personal Computers~~;~~
2.24.3 SAP 152280 (10940) Other Computer Equipment~~;~~
~~2.20.3~~2.24.4 SAP 152290 (10940) Other Computer Equipment-CRC~~;~~
2.24.5 SAP 152300 (10945) Computer Software~~;~~
~~2.20.4~~2.24.6 SAP 157000 (10960) MIS Project~~;~~
~~2.20.5~~2.24.7 SAP 157010 (10961) Data Master Repository (DMR)~~;~~
2.24.8 SAP 157100 (10962) CORE System~~;~~
~~2.20.6~~2.24.9 -SAP 157030 (10965) EDS-Beneficiary Eligibility~~.~~

~~2.21~~2.25 **Non-Information Systems Assets**: For purposes of this policy, this includes items capitalized in the following general ledger accounts:

~~2.21.1~~2.25.1 SAP 152210 (10925) Furniture - Sac;
2.25.2 SAP 152220 (10927) Furniture – 7th St;
~~2.21.2~~2.25.3 SAP 152100 (10931) Furniture – CRC;
~~2.21.3~~2.25.4 SAP 152230 (10928) Office Equipment;
~~2.21.4~~2.25.5 SAP 152240 (10929) Office Equipment – CRC~~s;~~
2.25.6 SAP 151100 (10951) Leasehold Improvements~~;~~~~.~~
2.25.7 SAP 151110 (10951) Leasehold Improvements-CRC~~s;~~
~~2.21.5~~2.25.8 SAP 151020 (10952) ROU Asset

~~2.22~~2.26 **Per Unit:** Consists of items, units or components that work together and are generally not separated during the life of the asset. The Accounting & Financial Services Department will determine the exact composition of the unit to be capitalized.

~~2.23~~2.27 **Designee(s):** A "Designee" is someone who is designated by the authorized approver to approve on their behalf when the authorized approver is not available or wishes to delegate this authority. A list of all authorized designees will be kept in Accounts Payable department as an internal document maintained on a regular basis.

3.0 POLICY:

Capitalization

3.1 L.A. Care records and capitalizes purchases of furniture, fixtures, office equipment, software, and computer equipment as capital assets, when cost (including freight and taxes), Per Unit, is $10,000 or greater effective October 1, 2017. The capitalization threshold was $5,000 effective June 1, 2014 and $2,000 prior to June 1, 2014. Assets that work together and generally are not separated during the life of the asset should be capitalized as one (1) asset (i.e., office furniture grouping, PC components).

3.2 For items less than $10,000 total value pPer uUnit, see policy ITOI-006 "Asset Management Guidelines".

3.3 For leasehold improvements, the capitalization threshold amount outlined in 3.1 .1 above applies, which shall be $10,000, and the financial standards criteria for definition and accounting for leasehold improvements in accordance with GAAP shall be met.

3.4 For intangible assets including internally developed software, only costs associated with the development stage are eligible for capitalization. Cloud-based application implementation with embedded license will be treated as software.

3.4.1 The software development costs may be capitalized if the software:
is an integral part of the IT system, or, identifiably enhances the functionality of the system because of its direct relationship to it;
requires substantial customized modifications to achieve expected level of performance;
is obtained through a long--term contractual arrangement.

3.4.2 Capitalized development costs are limited to:
(1) Fees paid to third parties (including travel expenses) to customize the software;
(2) Costs of obtaining software from third parties;
(3) Salaries, benefits and travel expenses of employees who devote their time to develop the software (must be supported by records);
(4) Interest costs, if applicable.

3.4.3 Indirect costs including senior manager's time, project management, training, overhead and data conversion are excluded.

~~**3.4.4**~~ Modification of computer software that is already in operation should be capitalized in the same manner as outlined above if the modification results in an increase in functionality, efficiency, or extension of the estimated useful life.

~~**3.4.5**~~

~~**3.4.6**~~**3.4.4**

Depreciation

3.5 L.A. Care will depreciate furniture over sixty (60) months and all other capital equipment and computer software over thirty-six (36) months.

3.6 Expenditures capitalized and charged to ~~the Account SAP 151100 and 151110 (#10951)~~ Leasehold Improvement will be amortized over the number of months remaining in the related building lease.

3.7 Capitalized software and development costs should be amortized over useful life not to exceed sixty (60) months.

3.8 The useful life should be determined by Information Technology (IT) Department of all pertinent factors impacting the estimated useful life, including the expected use, any legal, regulatory, or contractual provisions, and the effects of obsolescence, demand, competition, and the level of maintenance expenditures required.

4.0 PROCEDURES:

4.1 L.A. Care has established the following capital asset categories:

~~Account No.~~	~~Category~~
~~10915~~	~~Work in Progress (WIP)~~
~~10916~~	~~Work in Progress (WIP) – Inventory~~
~~10925~~	~~Furniture – Sac~~
~~10927~~	~~Furniture – 7th St/Garland~~
~~10928~~	~~Office Equipment~~
~~10929~~	~~Office Equipment – CRC's~~
~~10930~~	~~Telephone Equipment~~
~~10935~~	~~Personal Computers~~
~~10940~~	~~Other Computer Equipment~~
~~10945~~	~~Computer Software~~
~~10951~~	~~Leasehold Improvements~~
~~10960~~	~~MIS Project (inactive)~~
~~10961~~	~~DMR (Data Mastery Repository – inactive)~~
~~10962~~	~~CORE System~~
~~10965~~	~~EDS Beneficiary Eligibility (inactive)~~
~~10975~~	~~Capital Leases~~

Solomon Account No.	SAP Account No.	Category
10915	150100	Work in Progress - Renovations
10916	152200	Work in Progress - Inventory
10925	152210	Contra-Furniture - 5th & Olive/Sacramento
10927	152220	Contra-Furniture - HQ/Garland
10931	152100	Contra-Furniture - CRC
10928	152230	Contr-Office Equipment - 1055 W. 7th St.
10929	152240	Contra-Office Equipment - CRC
10930	152250	Contra-Telephone
10935	152270	Contr-Personal Computers
10940	152280	Contra-Oth Comp Equp
10940	152290	Contra-Oth Comp Equp CRC
10945	152300	Contra-Computer Software
10951	151110	Contra- LH Imprv-CRC
10951	151100	Contra- LH Imprv 7th
10960	157000	MIS Project (from WIP)
10961	157010	DMR-Data Warehouse
10962	157100	Contra- CORE System
10965	157030	EDS - Beneficiary Eligibility
10952	151020	ROU Asset

Acquisitions

4.2 Managers making the fixed asset purchases will notify Procurement and Accounting & Financial Services Departments in advance of delivery and request for an asset tag for each capital item.

4.3 An asset tag should be affixed to an accessible location on the asset upon arrival of the capital item.

4.3.1.1 For Information Services Assets, this procedure should be performed by the Help Desk, or m~~M~~anagers making the purchases in the I.T. Operations & Infrastructure Department.

4.3.1.2 For Non-Information Services Assets, this procedure should be performed by Facilities Services.

4.3.1.3 If an asset cannot be physically tagged, a tag number must still be assigned. The tag should be affixed to the invoice and filed in the permanent files.

4.4 Fixed assets, with the exception of laptop computers, should remain within L.A. Care premises.

4.44.5 In the case where assets must be removed from L.A. Care premises, the removal and return of the asset should be documented and approved by the Senior Director of Information Transformation Operations, Infrastructure & Security for Information

Services Assets and by the Senior Director of Facility Services for Non-Information Services Assets. Examples of such cases would be Information Systems assets used for disaster recovery tests or office equipment assigned to Community Advisory Committees (CAC~~'~~s) or the Executive Consumer Advisory Committee (ECAC).

~~4.5~~4.6 The c~~C~~ustodian, c~~C~~ustodian's department, location floor, and room number should be recorded in the ~~FAS System~~SAP at acquisition, and kept up to date for all fixed assets.

~~4.6~~4.7 The Accounting & Financial Services staff will determine the cost and useful life of the asset and enter all required information into the ~~FAS System~~SAP upon complete process of payment and validation against the invoice of all asset tags issued in Section 4.3 above.

~~4.6.1~~4.7.1 A copy of the information entered into the system, as well as any allocation worksheets, will be affixed to the documentation received from Accounts Payable and retained by the Accounting & Financial Services Department.

~~4.6.2~~4.7.2 The ~~FAS System~~SAP will be reconciled with the general ledger on a monthly basis to ensure that all acquisitions are recorded properly.

Disposal

~~4.7~~4.8 An asset may be disposed of if the asset is damaged, obsolete, or in rare cases lost or stolen. The disposal of assets for L.A. Care will strictly adhere to the procedures outlined in this policy.

~~4.8~~4.9 The Custodian should notify the department responsible for the asset:

~~4.8.1~~4.9.1 For Information Services assets, notify the Help Desk.

~~4.8.2~~4.9.2 For Non-Information Services assets, notify the Director of Facilities Services or Designee.

~~4.8.3~~4.9.3 If an asset is stolen, a police report should be provided as well.

~~4.8.4~~4.9.4 If an asset is lost, a written explanation and acknowledgement from the Custodian's department director should be provided as well.

4.10 The Help Desk or Facilities Services, as applicable, should retrieve the asset(s) to be disposed of and stored in a locked room while maintaining an asset log for all these items.

4.10.1 Accounting & Financial Services should be notified of the tag

number(s), method of disposal, and reason for disposal.

~~4.8.5~~4.10.2 The Accounting & Financial Services Staff will remove the tag from the asset and visually confirm that the item is safeguarded in the locked room for disposal.

~~4.9~~4.11 The responsible Accounting & Financial Services staff will complete a Fixed Asset Disposal Form for each asset to be disposed of and affix the asset tag to the disposal form.

~~4.9.1~~4.11.1 For stolen assets, a copy of the police report should be attached to the disposal form.

~~4.9.2~~4.11.2 For lost assets, a written explanation acknowledged by the Custodian's department Director should be attached.

~~4.10~~4.12 The Fixed Asset Disposal form(s) should be reviewed and approved:

~~4.10.1~~4.12.1 For Information Services Assets, the form should be reviewed and approved by the Controller, the Chief Information and Technology Officer and the Chief Financial Officer or respective designees.

~~4.10.2~~4.12.2 For Non-Information Services Assets, the form should be reviewed and approved by the Controller, the Senior Director of Facilities Services, and the Chief Financial Officer or designees.

~~4.11~~4.13 After approval is obtained, Accounting & Financial Services staff will notify the Help Desk or Senior Director of Facilities Services, as applicable, that the asset can be disposed of in the manner noted on the Fixed Asset Disposal form.

~~4.11.1~~4.13.1 All assets that contain Protected Health Information (PHI), as defined by the Health Insurance Portability and Accountability Act (HIPAA), must be disposed of in accordance with policy ITOI-010 “Secure Data Disposal”. This includes desktop and laptop computers, hard drives, media, flash drives, external hard drives, and any other devices that can store data and may contain PHI.

~~4.12~~4.14 Accounting & Financial Services staff will record the disposal date in ~~the FAS System~~SAP ~~and General Ledger~~. The original Fixed Asset Disposal form will be retained in the Accounting & Financial Services department.

Impairment

4.15 Impairment exists when the carrying amount of an intangible asset exceeds its fair value and is non-recoverable.

~~4.13~~4.16 ~~and the~~Impairment~~-~~ loss shall be recognized in accordance with GAAP.

~~4.14~~4.17 All capital assets, including software and development costs, shall be tested annually for impairment based on the evaluation by IT and Facility Services staff of all pertinent factors impacting the fair value, including any significant changes in the service potential (retired or no longer fulfilling the same purpose), the use of the software, costs of making necessary modifications, the effects of obsolescence, etc.

5.0 MONITORING:

5.1 To verify that fixed asset assignments are being kept up to date, Accounting & Financial Services will, at least every other year, conduct a full physical inventory of all fixed assets capitalized and recorded in ~~the FAS System~~SAP unless special circumstances exist which would delay this activity.

5.1.1 The inventory process will include verification of the fixed asset Custodian, department, location, and floor.

5.1.2 Accounting & Financial Services will correct any outdated information in ~~the FAS System~~SAP.

5.1.3 The Chief Financial Officer and Chief Information and Technology Officer or Designees will be notified of any fixed assets that cannot be located or are reported as lost or stolen at the time of inventory.

~~5.1.3~~5.1.4 The Controller approves special circumstances which would alter the scheduled inventory every other year.

6.0 REPORTING:

6.1 The Finance Department is responsible for presenting financial statements to the Board of Governors on a monthly basis. Capital assets are included within the financial statements on the balance sheet.

	TRAVEL EXPENSES	AFS-027
DEPARTMENT	ACCOUNTING AND FINANCIAL SERVICES	
Supersedes Policy Number(s)	1900	

DATES					
Effective Date	8/21/1997	Review Date	~~11/18/2022~~11/15/2023	Next Annual Review Date	~~11/18/2023~~11/15/2024
Legal Review Date	~~10/23/2020~~11/13/2023	Committee Review Date	10/25/2021		

LINES OF BUSINESS

☐ Medicare D-SNP ☐ L.A. Care Covered ☐ L.A. Care Covered Direct ☐ MCLA
☐ PASC-SEIU Plan ☒ Internal Operations

DELEGATED ENTITIES / EXTERNAL APPLICABILITY

☐ PP – Mandated ☐ PP – Non-Mandated ☐ PPGs/IPA ☐ Hospitals
☐ Specialty Health Plans ☐ Directly Contracted Providers ☐ Ancillaries ☐ Other External Entities

ACCOUNTABILITY MATRIX

Accounting	All sections		

ATTACHMENTS

- Enter all attachments here (e.g., desktop procedures/job aids, templates, reports, letters)

ELECTRONICALLY APPROVED BY THE FOLLOWING

	OFFICER	DIRECTOR
NAME	~~Marie Montgomery~~Afzal Shah	Angela Bergman
DEPARTMENT	Finance Services	Accounting Services
TITLE	Chief Financial Officer	Controller

AUTHORITIES

- California Welfare & Institutions Code §14087.96 et seq.

REFERENCES

- AFS-004 "Non-Travel Expenses"
- AFS-006 "Authorization and Approval Limits"
- HR-101 "Auto Allowance, Mileage Reimbursement, and Vehicle Damage Reimbursement"
- HR-122 "Transportation Incentive Allowance"
- HR-220 "Telecommuting"
- HR-322 "Relocation Expenses"
- LS-006 "Gifts and Donations"
- http://www.gsa.gov/travel
- https://www.gsa.gov/travel/plan-book/per-diem-rates

HISTORY

REVISION DATE	DESCRIPTION OF REVISIONS
05/11/2009	New policy; supersedes 1900
05/07/2015	Revised to include language from AFS-004 (split into two policies)
09/26/2018	Used latest policy template dated 2017-10-04; revised format and wordings
10/28/2019	Annual update of Policy; revised format and wordings
10/26/2020	Annual review of policy; revised wordings
10/13/2021	Annual review of policy; revised format and wordings
11/18/2022	Annual review of policy; revised format
11/15/2023	Annual review of policy; revised format

1.0 OVERVIEW:

1.1 This policy establishes L.A. Care Health Plan's (L.A. Care) policy for reimbursement of actual and necessary business-related travel expenses incurred by employees, members of the Board of Governors, Stakeholder Committees, and members of the Community Advisory Committees (CACs) on behalf of L.A. Care. Please refer to policy AFS-004 "Non-Travel Expenses" for information on reimbursable non-travel-related expenses.

2.0 DEFINITIONS:

Whenever a word or term appears capitalized in this policy and procedure, the reader should refer to the "Definitions" below.

2.1 **Designee(s):** A "Designee" is someone who is designated by the authorized approver to approve on their behalf when the authorized approver is not available or wishes to delegate this authority. A list of all authorized designees will be kept in Accounts Payable department as an internal document maintained on a regular basis.

~~**2.2** Please see the L.A. Care Intranet for the CMS Glossary of Terms for other definitions and acronyms that are designed mainly for the use of Medicare beneficiaries and the general public.~~

~~4.0~~3.0 POLICY:

~~4.1~~3.1 L.A. Care, as a public entity, has a fiduciary responsibility to utilize funds in a responsible and prudent manner. All employees, Board members, and Community Advisory Committees (CAC) members have a fiduciary role when requesting reimbursement for business-related expenditures, to provide adequate supporting documentation, rationale, and explanation for all reimbursable expenses.

~~4.2~~3.2 L.A. Care will reimburse certain travel expenses, for employees, Board members, CAC members, and Stakeholder Committee members, when such expenses are covered under this policy and approved through the procedures in Section 4.0.

~~4.3~~3.3 Reimbursable and Non-Reimbursable Travel Expenses

~~4.3.1~~3.3.1 Travel and Training Budget

~~4.3.1.1~~3.3.1.1 Travel expenses are reimbursable when incurred in connection with activities that are related to official L.A. Care business. All reasonable expenses, including the cost of transportation, lodging, and miscellaneous expenses for gratuities, transportation to and from airports, etc., incurred during an authorized trip are reimbursable as outlined herein and in Section 3.0.

~~4.3.1.2~~3.3.1.2 Expenses of a personal nature, such as entertainment, movies, sightseeing, health club fees, travel upgrades, cost of kennel fees and/or house-sitters etc., are not reimbursable.

~~4.3.2~~3.3.2 Airlines

~~4.3.2.1~~3.3.2.1 L.A. Care will reimburse acceptable air travel which is properly booked through L.A. Care's authorized travel application in accordance with procedures listed in Section 3.0.

~~4.3.2.2~~3.3.2.2 L.A. Care will not reimburse for the following charges, and the employee, Board member, CAC member, or Stakeholder Committee member will be held responsible for the charges:

~~4.3.2.2.1~~3.3.2.2.1 Membership fees for private clubs, air travel clubs, airline-sponsored lounges, and frequent flier clubs.

~~4.3.2.2.2~~3.3.2.2.2 The cost of any in-flight movies or other similar pay-per-view entertainment, or for any in-flight alcoholic drinks.

~~4.3.2.2.3~~3.3.2.2.3 Upgrades considered to be solely for the convenience or comfort of the traveler without a valid business justification.

~~4.3.2.2.4~~3.3.2.2.4 Any expenses due to the loss of your personal baggage.

~~4.3.2.2.5~~3.3.2.2.5 Flying personal aircraft while on L.A. Care business is strictly prohibited.

~~4.3.2.2.6 Cost of kennel fees and/or house-sitters.~~

~~4.3.3~~3.3.3 Out-of-Town Lodging

~~4.3.3.1~~3.3.3.1 L.A. Care will reimburse for out-of-town lodging with appropriate approval in accordance with this policy and procedures listed in Section 3.0.

~~4.3.3.2~~3.3.3.2 L.A. Care will not reimburse for:

~~4.3.3.2.1~~3.3.3.2.1 Charges for guaranteed reservations that the employee, Board member, CAC member, or Stakeholder Committee member fails to timely cancel, unless caused by L.A. Care conflicts. (Obtain a confirmation number from the hotel verifying the cancellation of the guaranteed reservation).

~~4.3.3.2.2~~3.3.3.2.2 Charges in-lieu of hotel accommodation when staying at the private residence of a friend, family member, etc.

~~4.3.3.2.3~~3.3.3.2.3 The cost of alcoholic beverages, television movies, mini-bar charges, personal toiletry needs, newspapers, or other incidentals.

~~4.3.3.2.4~~3.3.3.2.4 Costs incurred by a spouse, family member, or significant other who accompanies the employee, Board member, CAC member, or Stakeholder Committee member on the business trip.

~~4.3.4~~3.3.4 Parking

~~4.3.4.1~~3.3.4.1 Airport parking expenses incurred at the home airport are reimbursable. If parking is in excess of two days, reimbursement will be for long-term parking rates only. Employees, Board members, CAC members, and Stakeholder Committee members shall endeavor to obtain validated parking "stickers" from hosting locations whenever possible.

~~4.3.4.2~~3.3.4.2 Parking fees incurred in attendance of business meetings at locations other than L.A. Care's office are reimbursable.

~~4.3.5~~3.3.5 Mileage

~~4.3.5.1~~3.3.5.1 Mileage incurred in the use of a personal automobile while on L.A. Care business is reimbursable at the then-prevailing amounts allowed by the Internal Revenue Service (IRS). These rates are updated annually each January 1st, and will be utilized by L.A. Care as L.A. Care's mileage reimbursement rate. Please refer to Section 3.0 and HR-101, Auto Allowance, Mileage Reimbursement, and Vehicle Damage Reimbursement for more information.

3.3.5.2 Examples of reimbursable mileage include:

3.3.5.2.1 Miles from home or office to airport and return (less base mileage).

3.3.5.2.2 Miles from office to assigned worksite(s) (and return), as in the case of field workers (auditors; UM nurses; case workers).

3.3.5.2.3 Miles from office to offsite business meeting location(s) (and return).

3.3.5.2.4 Mileage in-lieu of airfare, if driving instead of flying to a meeting.

3.3.5.2.5 Business mileage incurred on non-scheduled work days, and holidays.

~~4.3.5.1.1~~3.3.5.2.6 With regard to mileage reimbursement while Telecommuting, please refer to ~~HR-101 and~~ HR-220, Telecommu~~n~~ting.

~~4.3.6~~3.3.6 Rental Cars

~~4.3.6.1~~3.3.6.1 The cost of rental cars on out-of-town travel assignments will be reimbursed only with advance approval by the responsible officer in accordance with this policy. Please refer to Section 3.0 for more information.

~~4.3.7~~3.3.7 Traffic/Parking Tickets

~~4.3.7.1~~3.3.7.1 Automobile traffic and/or parking tickets issued as fines are not reimbursable.

~~4.3.8~~3.3.8 Taxis, Transportation Network Companies (TNCs) and Other Public Transportation

~~4.3.8.1~~3.3.8.1 **Out-of-Town Travel**

Business-related taxis, TNCs (such as Uber or Lyft), train, and other public transportation costs while on out-of-town assignments or business are reimbursable, provided that a rental car has not been approved. However, employees, Board members, CAC members, and Stakeholder Committee members are discouraged from using taxis or TNCs unless necessary.

Examples of trips where taxis and TNCs are appropriate are trips to/from terminals and hotels when guest transportation services are not conveniently available, or when transporting heavy work papers.

~~4.3.8.2~~3.3.8.2 **In-town Travel**

While mileage is the preferred method of reimbursement for in-town travel, the costs of using taxis, TNC's (such as Uber or Lyft), train and other public transportation for in-town travel may be reimbursed if the travel is separate from normal commuting or the requester does not have access to a car. A valid business justification must be provided.

~~4.3.8.2.1~~3.3.8.2.1 The costs of using Taxis, TNCs, trains or other public transportation for in-town travel are not reimbursable for individuals receiving Auto Allowance per Policy HR-101.

~~4.3.8.2.2~~3.3.8.2.2 The costs of using Taxis, TNCs and Public transportation for normal commuting to and from L.A. Care's offices are not reimbursable.

~~4.3.9~~3.3.9 **Meals Related to Business Travel**

~~4.3.9.1~~3.3.9.1 L.A. Care reimburses employees, Board members, CAC members, and Stakeholder Committee members for actual reasonable costs incurred for out-of-town meals while traveling on L.A. Care business. Please refer to Section 3.0 for more information.

~~4.3.9.1.1~~3.3.9.1.1 Out-of-town is defined as over 50 miles from home, if telecommuting, or L.A. Care's office.

~~4.3.9.1.2~~3.3.9.1.2 Expenses incurred when meals are provided by the conference are not reimbursable.

~~4.3.9.2~~3.3.9.2 The purchase of alcoholic beverages with L.A. Care funds is prohibited.

~~4.3.9.3~~3.3.9.3 Please refer to AFS-004, "Non-Travel Expenses" for more information on non-travel meals.

~~5.0~~4.0 **PROCEDURES:**

4.1 Approval and Reimbursement Process

Prior to traveling, L.A. Care employees, Board members, CAC members, and Stakeholder Committee members must complete a travel authorization request and receive a Request ID Number. Employees wishing to be reimbursed for travel expenses can apply for applicable reimbursements by submitting Expense Reports through the Travel Reimbursement System (Concur).

4.1.1 PowerPoint instructions for using the Concur System are available on the L.A. Care intranet.

http://insidelac/sites/default/files/resources/ConcurTraining_022515.pdf

4.1.2 Travel Authorization Requests

4.1.2.1 Requests for reimbursement of airfare, hotel, and other expenses incurred beyond 50 miles from L.A. Care or home require a travel authorization request and shall be submitted on Concur and must be approved. No booking should be made until final approval is received from Finance Department. All employees must receive approval in advance for travel.

4.1.2.2 Travel authorizations grant approval to travel and are required for all business travel, however, ~~.~~ ~~p~~Payment does not occur upon approval of travel authorizations alone. Reimbursements for expenses are processed after the travel upon approval of the Expense Report, unless the employee is approved for a Travel Advance.

4.1.2.3 The traveler will use their own resources for travel, including personal credit cards. Travelers who have a personal credit card, but are unable to pay for the entire cost of approved travel up front may request a Travel Advance. Employees who are required to travel but are unable to use personal resources may apply for use of L.A. Care Procurement card for hotel and rental cars only through the Accounts Payable Department. (See section 4.3.4 for details).

4.1.2.4 **Approval.** The request is to be completed in full and approved by the employee's director, or senior director. Following this intermediate approval, each request is then forwarded to the responsible officer and Chief Financial O~~o~~fficer ("CFO") or Designee for final approval. The travel authorization requests will be assigned a travel authorization number (Request ID Number) for tracking purposes. The Request ID Number is then matched to invoices for direct payment, and/or used as supporting documentation for Expense Report reimbursement.

4.1.2.5 If travel expenses are incurred without pre-approval due to extenuating circumstances, the requestor must provide an

explanation of the circumstances and submit the request and appropriate documentation for retroactive approval in Concur. The request will be routed in Conucur for CFO, or Ddesignee approval, which will be required to process all reimbursements with retroactive approvals.

4.1.2.6 All international Travel Requests must be approved and authorized by Chief Executive Oofficer ("CEO").

4.1.2.7 Officers, Deputy Officers, and Executive Directors are exempt from attaining a Travel Authorization while traveling within California.

4.1.2.8 In-Town travels are travels less than 50 miles from the L.A. Care or home, if telecommuting.

4.1.3 Expense Reports

4.1.3.1 Requests for reimbursement of expenses shall be submitted through Expense Reports in Concur.

4.1.3.2 Only Expense Reports with direct manager's or director's electronic DocuSigned or "wet" approval will be processed and approved in accordance with Authorizations and Approvals policy (AFS-006).

4.1.3.3 Expense Report approvals for employees must be executed by direct managers and above.

4.1.3.4 No employee may approve his or her own Expense Report.

4.1.3.5 Expense Reports of the CEO shall be reviewed and approved by the CFO, or Designee, and Chair of the Board.

4.1.3.6 Expense report approvals for members of the Board of Governors and Community Advisory Committees (CAC) shall be reviewed and approved by the CFO and CEO or their respective Designees.

4.1.3.7 Expense report approvals for members of Stakeholder Committees shall be reviewed and approved by the CFO and CEO or their respective Designees.

4.1.3.8 The Expense Report information must be filled out completely, including business purpose and location of expense/meeting and participant names and affiliations.

4.1.3.9 Expense Reports are required to be submitted monthly, although there is an additional 30--day grace period for late submissions.

4.1.3.10 Expense Reports submitted after 60 calendar days will not be honored unless approved by the CFO or Designee.

4.1.3.11 Documentation Requirements:

4.1.3.11.1 Images of all required receipts should be uploaded into the electronic expense report for reimbursable expenses in excess of $25.

4.1.3.11.2 Receipts must demonstrate proof of payment.

4.1.3.11.3 See section 4.2.6.1.5 and 4.2.6.1.6 for information on when travelers will be reimbursed at Per Diem rates and receipts will not be required.

4.1.3.11.4 All reimbursable expenditures must be fully documented and supported on the Expense Report in conformity with IRS Guidelines and L.A. Care policy.

4.1.3.11.5 If receipts cannot be obtained or have been lost, a statement to that effect shall be made on the Expense Report, along with an appropriate explanation. In the absence of a satisfactory explanation, the amount involved shall not be allowed.

4.1.3.11.6 The business purpose of the expenditure, including applicable names, titles, etc., must be provided in all cases.

4.1.3.11.6.1 Providing initials instead of the name is insufficient.

4.1.3.11.6.2 If required receipts and/or required documentation of the business purpose are not provided, the expense will not be reimbursed.

4.1.3.11.6.3 All requests for reimbursement are subject to reasonability. The CFO or Designee shall make the final determination on disputed expenses.

4.1.3.11.7 An itemized statement for hotel, meal and rental car charges must be attached.

4.2 Specialized Travel Expenses

4.2.1 Airlines

4.2.1.1 All L.A. Care employees, Board members, CAC members, and Stakeholder Committee members must use Concur to book air travel for L.A. Care business.

4.2.1.1.1 **Exception for extenuating circumstances.** Airfare may be purchased outside of Concur only if prior approval is obtained from the CFO or Designee. In such cases, the purchaser will only be reimbursed for economy class accommodations.

4.2.1.1.2 Airfare purchased through the Cal-Travel Store without an approved Travel Authorization in Concur will require Business Justification and CFO approval for extenuating circumstances.

4.2.1.1.3 If the airfare is not purchased through Concur, then the purchaser must include an image of the receipt portion of the boarding pass for reimbursement. If using E-tickets, the employee, Board member, CAC member, or Stakeholder Committee member must request a passenger receipt when checking in at the ticket counter.

4.2.1.2 **Frequent Flyer Benefits**. Employees, Board members, CAC members, and Stakeholder Committee members may earn personal frequent flyer credit for flights taken on L.A. Care business. However, employees, Board members, CAC members, and Stakeholder Committee members may not incur abnormal travel time or incur any additional expenses for the purpose of acquiring frequent flyer mileage.— Employees, Board members, CAC members, and Stakeholder Committee members may not specify that an airline reservation must be made with a specific airline to gain frequent flyer credits.

4.2.2 Out-Of-Town Lodging

4.2.2.1 Out-of-town lodging is defined as lodging located over 50 miles from L.A. Care's office or home, if Telecommuting. Lodging within 50 miles from L.A. Care's office or home is considered as In-Town travels and is only reimbursable for multi-day conferences.

4.2.2.2 All hotel stays require an approved travel authorization request.

4.2.2.3 Hotels are to be booked by the traveler through Concur, and the reservation will be held by the L.A. Care Purchasing Card which may be accessed by submitting an approved check request with approved Request ID number to the Accounts Payable department. Employees will then use their personal credit card to pay for the

hotel upon arrival, and request reimbursement through Concur. If a personal credit card is not available, refer to section 4.3 for Travel Advances,

4.2.2.4 With advance approval by the CFO or Designee, L.A. Care will reimburse employees, Board members, CAC members, or Stakeholder Committee members for hotel and meal charges if early check-ins or staying over an extra day to save on airfare. (e.g., L.A. Care will reimburse for reasonable hotel, parking, meal expenses if arriving early at the work location to receive a discount "Saturday stay-over" airline rate.) This policy is designed to be a net benefit to both the individual and L.A. Care. If the cost of the hotel, parking, and meal expenses exceeds the savings on the Saturday stay-over, then the excess becomes a personal cost and is not subject to reimbursement.

4.2.2.5 The hotel folio must be attached to the Expense Report and the bill must be itemized on the Expense Report (e.g., business-related telephone calls, meals, and parking separated from the room charges).

4.2.2.5.1 Credit card receipts are not acceptable documentation for hotel expenses.

4.2.2.5.2 Personal items must be identified (movies, mini-bar, personal phone calls, etc.) and excluded from the reimbursement request.

4.2.2.5.3 Meal expenses reflected on the hotel bill must be claimed separately as part of meal expense and not part of the hotel expense. (See section 3.2.6 for details).

4.2.2.5.4 The hotel bill must show the name of the hotel, location of the hotel, date(s) registered at the hotel, room charges, and applicable taxes, laundry (reimbursable only if the stay exceeds four nights), telephone charges, and other charges (such as parking).

4.2.2.6 Hotel rates must be a reasonable amount based on the standards identified by Concur for the travel destination. Travelers should seek lodging rates at or below the federal government's Per Diem rate, found on the U.S. General Services Administration Website, www.gsa.gov. If these rates are not available, a hotel's discounted government rate will be acceptable.

4.2.2.7 If neither GSA nor government rates are available, additional justification should be provided. Exceptions to these maximum standards must be authorized by the CFO or Designee.

4.2.3 In-Town Lodging

4.2.3.1 Lodging within 50 miles from L.A. Care's office or home is considered as In-Town travels. In-Town Lodging is only reimbursable for multi-day conferences with prior approved Travel Authorization. Refer to section 3.2.2 for document requirements.

4.2.3.2 L.A. Care employees, Board members, CAC members, and Stakeholder Committee members attending a conference are allowed to stay at the host hotel, even if it exceeds the average hotel cost.

4.2.3.3 L.A. Care employees, Board members, CAC members, and Stakeholder Committee members may be reimbursed for their Local Business Travel (In-Town) expenses when attending a conference.

4.2.4 Mileage

4.2.4.1 When departing from or returning to home directly from a business meeting, the amount of reimbursement will be computed by indicating the number of business miles driven less base mileage (home to office, round trip), times the allowable IRS mileage rate except for telecommuters whose home is their principal place of employment. Documentation of the mileage traveled and base mileage must be electronically completed and submitted by the employee in Concur.

4.2.4.2 In order to obtain reimbursement for mileage, the business purpose for the trip must be stated on the Expense Report. In case of multiple employees, Board members or CAC members sharing a personal automobile, only the employee, Board member, CAC member, or Stakeholder Committee member incurring the usage cost, is allowed reimbursement.

4.2.4.3 Mileage reimbursement applies only to the use of an employee's, Board member's, CAC member's or Stakeholder Committee member's personal vehicle and not for any form of public transportation.

4.2.4.4 If the employee normally uses public transportation to commute to work, L.A. Care will not reimburse unused commuter fares if his/her personal auto is used for business.

4.2.4.5 All mileage reimbursements will deduct the mileage between the home and office of an employee's normal commute if they were to have driven, regardless ~~of~~ if the employee actually drives to the office on a regular basis if that employee's primary place of business is the L.A. Care office. For telecommuters, whose primary place of business is their home, there will be no deduction.~~.~~

4.2.4.6 Mileage incurred while receiving a Transportation Allowance is not reimbursable.

4.2.4.7 Mileage to attend volunteer activities is not reimbursable.

4.2.4.8 Travelers who use their personal vehicle on L.A. Care business are required to have adequate insurance coverage as required by state law (See HR-101).

4.2.4.9 L.A. Care shall compensate property damages to an individual's personal vehicle that occur during business travel when the individual is not at fault. L.A. Care will compensate up to ~~$250 or the amount of the deductible on the individual's insurance policy, whichever is the lesser amount, for each accident.~~ the amount allowed under HR-101 and approved by the Chief of Human Resources or designee.

4.2.4.10 L.A. Care shall not reimburse mileage for an employee's standard commute to work. A transportation incentive will be provided to eligible employees. Please refer to policy HR-122 "Transportation Allowance" for more information.

4.2.5 Rental Cars

4.2.5.1 If the rental car is used for business purposes, the employee, Board member, CAC member, or Stakeholder Committee member must purchase and will be reimbursed for the optional collision coverage and/or optional personal liability coverage offered by the rental car company.

4.2.5.2 If available, rental car companies should be selected from those listed in the Travel Reimbursement System to achieve the best rates possible.

4.2.5.3 When renting a car for business purposes, luxury and specialty car models are not authorized.

4.2.5.4 Economy Class vehicles should be selected whenever four or fewer individuals, including the driver, will be traveling in the rental automobile at any one time.

4.2.5.5 Mid-size Class vehicles may be selected in the event that more than four individuals will be riding in the rental automobile at any one time, or in the event that an economy class vehicle is not available and immediate departure is necessary.

4.2.5.6 If the rental car is used for business purposes, the employee, Board member, CAC member, or Stakeholder Committee member will be reimbursed for the additional expense of a Global Positioning System (GPS).

4.2.5.7 Whenever possible, an effort should be made to return the rental car with a full tank of gas and refueling options are to be declined from the rental agency.

4.2.5.8 Mileage will not be reimbursed for employees who opt to use a rental car rather than their personal vehicle. Receipts may be submitted for gas expense reimbursement through Concur.

4.2.6 Meals Related to Business Travel

4.2.6.1 For single day travel or In-Town travels, where the work day will extend beyond normal business hours, Meal reimbursement amount will be based on receipts of the actual costs of meals related to business travel with a maximum reimbursement not to exceed the Federal Daily (M& IE) GSA Per Diem limits.

4.2.6.1.1 Itemized receipts and appropriate explanations are required for all meals on single day travel, regardless of the amount.

4.2.6.1.2 Gratuities should be reasonable and not exceed 20% of the total bill, unless restaurant minimum charges/ restrictions are in place, in which case these circumstances must be documented.

4.2.6.1.3 The Expense Report should include employee names if the meal was for more than one individual. The employees in attendance should all have approved travel authorizations.

4.2.6.1.4 For meals not pertaining to travel, please follow the processes set forth in the Non-Travel Expense Policy AFS-004.

4.2.6.1.5 For multi-day travel, L.A. Care employees, Board members, CAC members, and Stakeholder Committee members will be reimbursed at the Federal Daily Per Diem (www.gsa.gov/perdiem) maximum allowable amount for meals expenses. Receipts will not be required in the

Expense Reports for these meals to be reimbursed at Per Diem rate.

~~4.2.6.1.5~~4.2.6.1.6 In accordance with the GSA guidelines, the meal expenses for first and last day of the travel is allowed at a rate of 75 % of the Federal Daily Per Diem.

~~4.2.6.1.6~~4.2.6.1.7 In lieu of Per Diem, receipts may be submitted for reimbursement less than Per Diem limits.

~~4.2.6.1.7~~4.2.6.1.8 Receipts for meals which exceed GSA Per Diem limits will be reimbursed only at GSA Per Diem limits.

4.3 Advances for Travel

4.3.1 L.A. Care employees should utilize their own financial resources (e.g., credit card) for authorized travel, meetings, conferences, etc., and obtain reimbursement after the event in accordance with this policy.

4.3.2 In cases where funding the entire cost of the travel from personal means is not feasible, employees may request a Travel Advance up to the amount requested in the Approved Travel Authorization.

4.3.3 Travel Advances may be used to cover the cost of reasonable travel expenses including lodging, meals and other expenses.

4.3.4 In cases where no personal credit card is available, arrangements can be made to have L.A. Care pay hotel costs in advance through the company Procurement Card. A check request should be submitted to the Accounts Payable department with the request.

4.3.5 The cost of airfare and a rental Car should be excluded from Travel Advance requests as the preferred method is to select the Enterprise Rental Car option for corporate account billing. Airfare booked through Concur upon authority of Approved Travel Authorization will be charged to the corporate Procurement card.

4.3.6 To receive an advance for travel, the employee should fill out an Advance Request in Concur and receive approval from the Controller or Designee.

4.3.7 Prior to travel, when requesting a Travel Advance, employees must complete the following steps:

4.3.7.1 Request and receive an approved Travel Authorization from Concur one month before the Travel date.

4.3.7.2 Travel Advance is not available for requests without a 30-day advance notice.

4.3.7.3 Complete the Travel Advance Request through Concur.

4.3.7.4 Receive approval for the Travel Advance from the Controller or Designee.

4.3.8 The receipts and unused cash from the Travel Advance must be returned to L.A. Care as an Expense Reimbursement Request within 30 days of the conclusion of the travel. Reconciliation Expense Forms and cash not returned within 60 days will be taxed as wages per IRS Guidelines.

4.4 Special Considerations

4.4.1 The purchase of any capitalized assets, small equipment, furniture, etc., by employees will not be reimbursed by L.A. Care. See Policy AFS-002 for Capital threshold limits.

4.4.2 Conferences, seminars, training for development and continuing education travel, which is travel to and from continuing education courses, is reimbursable for employees only if pre-approved by the responsible manager and officer.

4.4.3 The cost of the seminar or conference should be included in the travel authorization, but the payment can be processed through standard Procurement processes outside of Concur.

4.5 Pre-Employment and Telecommuting Travel

4.5.1 The Talent Acquisition department may request approval to reimburse travel expenses associated with recruiting (e.g. airfare for a candidate) by initiating a travel authorization in Concur.

4.5.2 The Human Resources Department must approve all receipts, which will be subject to the requirements set forth in this policy.

4.5.3 Once all approvals have been obtained, the Talent Acquisition department will submit a Check Request form, approved by the Human Resources Department, to Finance so that a reimbursement can be made to the candidate.

4.5.4 This policy provides guidelines on expense reimbursements for recruiting travel and pre-employment travel. Refer to policy HR-322, "Relocation Expenses" for guidelines on mileage and other expense reimbursements associated with relocation.

4.5.5 Employees who work remotely outside a Reasonable Community Distance of one of L.A. Care's on-site facilities will be reimbursed according to their signed agreement with Human Resources Department and Policy HR-220 "Telecommuting". In such instances, approval from the Chief of Human Resources or designee will be required.

4.6 Travel Paid for by Third Parties

4.6.1 All L.A. Care employees, Board and CAC members who have been offered and/or considering accepting a payment or reimbursement for travel, lodging/hotel, meals or conferences from a third party must consult with General Legal Services Unit of Legal Services Department prior to accepting such payments. General Legal Services Department can provide guidance on whether acceptance of such payments is permissible under applicable laws and policies relating to gifts. Please also refer to policy LS-006 "Gifts and Donations".

4.6.2 If traveling under a contract with a third party, the contract should be affixed to all reimbursement requests and provided to L.A. Care.

~~6.0~~5.0 MONITORING:

5.1 The Business Unit Manager or Designee is responsible for ensuring that all expenses are processed timely and coded correctly.

~~7.0~~6.0 REPORTING:

6.1 Variance reports between actual versus budgeted costs will be provided to Business Unit Managers on a monthly basis. Expenditures for expenses covered under this policy will be reported to the Board of Governors on a quarterly and annual basis.

	ANNUAL BUDGETS AND BOARD OF GOVERNORS' FINANCIAL OVERSIGHT	**AFS-029**

DEPARTMENT	FINANCE SERVICES
Supersedes Policy Number(s)	2100

DATES					
Effective Date	1/31/1997	Review Date	~~11/18/2022~~11/15/2023	Next Annual Review Date	~~11/18/2023~~11/15/2024
Legal Review Date	10/23/2020	Committee Review Date	10/26/2020		

LINES OF BUSINESS

☐ Medicare D-SNP ☐ L.A. Care Covered ☐ L.A. Care Covered Direct ☐ MCLA
☐ PASC-SEIU Plan ☒ Internal Operations

DELEGATED ENTITIES / EXTERNAL APPLICABILITY

☐ PP – Mandated ☐ PP – Non-Mandated ☐ PPGs/IPA ☐ Hospitals
☐ Specialty Health Plans ☐ Directly Contracted Providers ☐ Ancillaries ☐ Other External Entities

ACCOUNTABILITY MATRIX

ATTACHMENTS

ELECTRONICALLY APPROVED BY THE FOLLOWING

	OFFICER	**DIRECTOR**
NAME	~~Marie Montgomery~~Afzal Shah	Angela Bergman
DEPARTMENT	Finance Services	Accounting Services
TITLE	Chief Financial Officer	Controller

AUTHORITIES

- Government Accounting Standards Board (GASB) Codification Section P80 "Proprietary Fund Accounting and Financial Reporting"
- Government Accounting Standards Board (GASB) Codification Section 1800.141 "Reporting Restrictions in Proprietary Funds"
- Government Accounting Standards Board (GASB) Codification Section 150 "Accounting and Financial Reporting for Certain Investments and for External Investment Pools"
- Financial Accounting Standards Board (FASB) "Accounting Standards Codification (ASC)
- Generally Accepted Accounting Principles (GAAP)

REFERENCES

HISTORY

REVISION DATE	DESCRIPTION OF REVISIONS
10/25/2018	Supersedes Policy PO-2100
10/28/2019	Annual review of policy; revised format and wordings
10/26/2020	Annual review of policy
10/13/2021	Annual Review of Policy
11/18/2022	Annual review of policy; revised format
11/15/2023	Annual review of policy

1.0 OVERVIEW:

1.1 To ~~e~~insure the financial viability of L.A. Care Health Plan (L.A. Care), to charge the Board of Governors with the responsibility for the oversight of funds expended, and to provide the L.A. Care staff authorization to expend monies for budgeted and planned operational activities.

~~1.1~~1.2 To establish a process for the L.A. Care Chief Executive Officer (CEO), Chief Financial Officer (CFO), and ~~F~~finance staff to prepare the annual budget for review and approval by the Board of Governors. The approved budget will authorize the L.A. Care staff to expend funds included and planned in the budget in accordance with established L.A. Care policies and procedures.

2.0 DEFINITIONS:

~~**3.0** Please see the L.A. Care Intranet for the CMS Glossary of Terms for other definitions and acronyms that are designed mainly for the use of Medicare beneficiaries and the general public.~~

~~4.0~~3.0 POLICY:

~~4.1~~3.1 To ~~e~~insure the financial viability of -L.A. Care, the Board of Governors is charged with the responsibility for the oversight of funds expended, and provides ~~the~~ L.A. Care staff the authorization to expend monies for budgeted and planned operational activities.

~~5.0~~4.0 PROCEDURES:

IMPLEMENTATION GUIDELINES:

~~5.1~~4.1 Budget Preparation:

~~5.1.1~~4.1.1 **Planning**: At the direction of the CEO and the CFO, the L.A. Care finance staff will prepare an annual budget. Appropriate planning and forecasting will be incorporated into the budget process. The budget and planning process will incorporate:

~~5.1.1.1~~4.1.1.1 Regulatory required activities,

~~5.1.1.2~~4.1.1.2 Board of Governors organizational financial goals and objectives,

~~5.1.1.3~~4.1.1.3 Enrollment forecasts and revenue projections by segments,

~~5.1.1.4~~4.1.1.4 Healthcare Expense projections by segments,

~~5.1.1.6~~4.1.1.5 Administrative Expense projections for departmental functions and operational needs,

~~5.1.1.7~~4.1.1.6 Capital resource requirements,

~~5.1.1.8~~4.1.1.7 Outsourcing efficiency opportunities,

~~5.1.1.9~~4.1.1.8 State, federal, local and internal reporting requirements,

~~5.1.1.10~~4.1.1.9 Public Communication and member outreach,

~~5.1.1.11~~4.1.1.10 Contingencies and reserve requirements.

~~5.1.2~~4.1.2 **Budget Detail and Schedules:** The budget will be prepared by the L.A. Care Finance Department in sufficient detail so that planned expenditures will reflect projected operational activities, expected transactions, and specific departmental functions. The preliminary budget assumptions will be delivered to the Finance & Budget Committee in August for comments and suggestions and to the Board for approval at the September meeting. The budget will at a minimum include the following schedules:

~~5.1.2.1~~4.1.2.1 Projected balance sheet

~~5.1.2.2~~4.1.2.2 Forecast cash flow statement

~~5.1.2.3~~4.1.2.3 Financial statement of revenues and expenses

~~5.1.2.4~~4.1.2.4 Enrollment projections by segments

~~5.1.2.5~~4.1.2.5 Expenses by natural classification

~~5.1.2.6~~4.1.2.6 Capital expenditures and proposed projects

~~5.1.2.7~~4.1.2.7 Staffing and total cost of labor

~~5.1.2.8~~4.1.2.8 Discussion of budget assumptions

~~5.2~~4.2 Budget Review and Approval Process

~~5.2.1~~4.2.1 **Board Committee and Advisory Committee Input:** Appropriate sections of the budget will be reviewed with relevant Board Committees and Advisory Committees as communicated through Board member representatives for their input and council. Recommendations will be incorporated into the budget as appropriate.

~~5.2.2~~4.2.2 **Finance & Budget Committee Review:** The preliminary budget assumptions and budget will be presented to the Finance & Budget Committee for its review and approval in August.

~~5.2.3~~4.2.3 **Board of Governors Review and Approval:** Upon approval by the Finance & Budget Committee, the Committee Chairperson will present the budget to the Board of Governors for their review and approval. Upon Board approval, L.A. Care's finance staff will incorporate Board recommendations into the final budget.

~~5.2.4~~4.2.4 **Staff Authority to Expend Funds**: Board of Governors' approval of the budget will authorize the CEO, CFO, and L.A. Care staff to expend monies budgeted and planned on behalf of L.A. Care. All expenditures will be made in accordance with established L.A. Care financial and operational policies and procedures.

~~5.2.5~~4.2.5 **Policy, Procedure and Financial Safeguards**

~~5.2.5.1~~4.2.5.1 L.A. Care staff will develop and present to the Board of Governors policies and procedures which will include safeguards to insure that L.A. Care funds are expended effectively, efficiently and with Board approval. A Summary of Significant Accounting Policies will be included in the Notes to the Combines Financial Statements as appropriate. The Board will be involved in decisions regarding material cash transactions, significant non-budgeted expenditures, internal control procedures and capital purchases in excess of established amounts.

~~5.2.5.2~~4.2.5.2 Policies will be adopted in the following areas:

~~5.2.5.2.1~~4.2.5.2.1 Accounts Payable, disbursements and related areas

~~5.2.5.2.2~~4.2.5.2.2 Procurement and purchase authorization limits

~~5.2.5.2.3~~4.2.5.2.3 Banking, cash, and check signing limits

~~5.2.5.2.4~~4.2.5.2.4 Payroll and human resources

~~5.2.5.2.5~~4.2.5.2.5 Financial Statement preparation and supporting documentation

~~5.2.5.2.6~~4.2.5.2.6 Investments and cash management

~~5.2.5.2.7~~4.2.5.2.7 Revenue recognition and recording

~~5.2.5.2.8~~4.2.5.2.8 Fixed asset acquisition and control

~~6.0~~5.0 MONITORING:

~~6.1~~5.1 Annual Audit

~~5.1.1~~ Annually, the books and records supporting the Financial Statements of L.A. Care will be examined and analyzed by a public accounting firm whose selection will have been previously approved by the Audit Committee and the Board. Prior to commencement of the audit, the Audit Committee will meet with the appointed auditors to discuss scope of work to be performed.

~~6.1.1~~5.1.2 The results of the annual audit and accompanying reports of the auditors will be presented by the auditors to the Audit Committee, a committee of the Board of Governors, for review and acceptance.

~~6.1.2~~5.1.3 L.A. Care's finance staff will prepare a response and action plan to implement the operational findings and recommendations of the auditors. Prior to submitting the action plan to the Board, the audit findings will be reviewed with the Audit and Finance & Budget Committees.

~~6.1.3~~5.1.4 Subsequent to the Audit Committee review, the audited Financial Statements and accompanying reports of the auditors will be presented to the full Board of Governors for their review and action as required.

~~6.1.4~~5.1.5 The action plan will be presented to the Board of Governors for their review, input, revision and approval.

~~7.0~~6.0 REPORTING:

~~7.1~~6.1 Board of Governors and Finance & Budget Committee Oversight

~~7.1.1~~6.1.1 L.A. Care financial transactions and operational activities will be subject to the Board of Governors oversight on a regular basis as follows:

~~7.1.1.1~~6.1.1.1 Monthly Financial Statements – Finance & Budget Committee and Board Review.

~~7.1.1.1.1~~6.1.1.1.1 The Finance & Budget Committee, a committee of the Board of Governors, will review detailed monthly Financial Statements prepared by the L.A. Care F~~f~~inance staff.

~~7.1.1.1.2~~6.1.1.1.2 Financial Statements should properly reflect the operational activities, financial status and transactions of the organization.

~~7.1.1.1.3~~6.1.1.1.3 Financial statements will be prepared according to Generally Accepted Accounting Principles (GAAP), Government Accounting Standards Board (GASB) where applicable and Financial Accounting Standards Board (FASB) "Accounting Standards Codification (ASC).

~~7.1.2~~6.1.2 The CFO or Deputy CFO will present the Financial Statements to the Finance & Budget Committee and the Board of Governors according to the approved Board Schedule. Variances from Budget and/or recent forecast will be adequately explained by L.A. Care staff.

L.A. Care
HEALTH PLAN

Board of Governors
MOTION SUMMARY

Date: December 7, 2023 **Motion No. FIN 102.1223**

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

Requesting Department: Accounting & Finance Services

Issue: Revising Accounting and Finance Services Policy AFS-006 (Authorization and Approval Limits).

Background: L.A. Care periodically reviews and updates AFS-006 Authorization and Approval Limits policy to align with ongoing business needs while maintaining adequate oversight and transparency. The updates to the policy are summarized, below:

AFS-006: Authorization and Approval Limits:

- Updated exclusion section 3.2 to better define member benefits and state incentives.
- Updated policy to no longer require Finance & Budget and/or Board of Governor's approval for additional dollars if original contract satisfied authorization requirements.
- Added a requirement to report upcoming planned spend, by vendor, in the Annual Operating and Capital Budget presentation.
- Added Deputy Chiefs to the management level matrix.
- Removed the dollar thresholds to the exception list.
- Increased authorization limits for operating and capital expenditures.

Member Impact: None.

Budget Impact: None.

Motion: To approve Accounting and Finance Services Policy AFS-006 (Authorization and Approval Limits) as submitted.

	AUTHORIZATION AND APPROVAL LIMITS	**AFS-006**

DEPARTMENT	ACCOUNTING AND FINANCIAL SERVICES
Supersedes Policy Number(s)	

DATES					
Effective Date	1/10/2002	Review Date	~~2/8/2022~~11/15/2023	Next Annual Review Date	~~2/8/2023~~2/12/2024
Legal Review Date	11/09/2023	Committee Review Date	7/19/2017		

LINES OF BUSINESS

☐ Cal MediConnect	☐ L.A. Care Covered	☐ L.A. Care Covered Direct	☐ MCLA
☐ PASC-SEIU Plan	☒ Internal Operations		

DELEGATED ENTITIES / EXTERNAL APPLICABILITY

☐ PP – Mandated	☐ PP – Non-Mandated	☐ PPGs/IPA	☐ Hospitals
☐ Specialty Health Plans	☐ Directly Contracted Providers	☐ Ancillaries	☐ Other External Entities

ACCOUNTABILITY MATRIX

ATTACHMENTS

- Authorization and Approval Limits
- Authorizations and Approvals When Amount Exceeded
- Examples

ELECTRONICALLY APPROVED BY THE FOLLOWING			
	OFFICER	**DIRECTOR**	**COMMITTEE CHAIR**
NAME	~~Marie Montgomery~~Afzal Shah	~~JR Nino~~David Inglese	~~Ilan Shapiro~~Stephanie Booth, MD ~~MBA FAAP FACHE~~
DEPARTMENT	Financial Services	Financial Services	Finance and Budget Committee
TITLE	Chief Financial Officer	~~Senior~~ Director, Procurement	Treasurer of the Board of Governors

AUTHORITIES
➢ N/A

REFERENCES
➢ AFS-004, "Expense Policy" ➢ AFS-007, "Procurement Policy" ➢ AFS-027, "Travel Expense Policy" ➢ LS-009, "Government Claims Presentation and Delegation of Authority to Approve, Deny and/or Settle Certain Government Claims" ➢ LS-010, "Delegation of Authority to Approve, Compromise and/or Settle Certain Pre-Litigation Claims and Pending Litigation"

HISTORY	
REVISION DATE	**DESCRIPTION OF REVISIONS**
01/10/02	New Policy
02/10/10	Annual Review
06/24/2015	Annual Review with revisions
06/23/2017	Annual Review with revisions
08/14/2018	Annual Review
10/10/2019	Annual Review
12/14/2020	Annual review, no changes.

02/08/2021	Annual review with revisions on exclusions, reporting, and officer titles.
11/15/2023	Annual review with revisions

DEFINITIONS
Please visit the L.A. Care intranet for a comprehensive list of definitions used in policies: http://insidelac/ourtoolsandresources/departmentpoliciesandprocedures

1.0 OVERVIEW:

1.1 L.A. Care Health Plan (L.A. Care) expenditures shall only be made as authorized by designated management personnel. Designated management personnel have approval authority for expenditures as specified herein with oversight by supervisory levels. This policy seeks to balance the need for organizational efficiency and delegated decision making, with financial responsibility, oversight and accountability both internal to L.A. Care and consistent with L.A. Care's public entity status.

2.0 DEFINITIONS:

2.1 **Operating Expenditures:** Expenditures for goods and services required to conduct the day to day business operations of the organization. Examples are: advertising, consulting fees, IT or business hosting/cloud services, temporary labor, training, translation services, repair and maintenance, supplies, utilities, and all vendor services not related to providing medical care. For the purpose of this policy, operating expenditures excludes regulatory fees, legal fees from Section 2.2, medical services, and Capital Expenditures.

2.2 **Capital Expenditures:** Expenditures incurred for the purchase of tangible property, i.e. furniture, fixture, office equipment, computer equipment. Refer to Policy AFS-002-Capital Assets.

3.0 POLICY:

3.1 All purchases of Operating and Capital Expenditures must be made in accordance with AFS-007, "Procurement Policy" in order to comply with applicable legal, financial, compliance, privacy, and information security requirements prior to any contract (including without limitation amendments, new schedules or scope of work) execution.

3.2 This policy excludes the authorizations and approvals of all travel and expenses including all catering and meals from an L.A. Care meeting, training, recruiting, workplace meeting, provider relations, sales, or related purpose. For these expenditures, please refer to Expense Policy (AFS-004) and Travel and Other Expense Policy (AFS-027). This policy also excludes employee benefits; member benefits; medical claims; pharmacy claims; capitation; other health care expenses including member ~~and~~, provider and state incentives; and claims settlements covered by Government Claims Presentation and Delegation of Authority to Approve, Deny and/or Settle Certain Government Claims Policy (LS-009) and Delegation of Authority to Approve, Compromise and/or Settle Certain Pre-Litigation Claims and Pending Litigation Policy (LS-010).

3.3 Authorization and Approval Limits are subject to the review and approval by the Board of Governors, and L.A. Care management authorization in accordance with the authorization limits (see "Authorization and Approval Levels" attachment).

3.4 The Authorizations and Approval Limits are based on the total dollar amount of a purchase or contract. ~~If~~Once a purchase or contract receives Finance & Budget and/or Board of

Governor's approval, additional dollars ~~are~~ added to an existing purchase ~~order or contract already authorized, then the authorization limit is based on~~or contract will not need additional Finance & Budget and/or Board of Governor's approval if conducted in accordance with Policy AFS-007 "Procurement Policy" and the total ~~aggregate~~aggregated amount ~~of the~~ (original authorized dollar amount plus ~~the~~ additional added dollars ~~to~~) does not exceed the next Authorization and Approval Level. These purchases and contracts will be ~~added.~~included in the reporting required by Section 5.2 and included in the Annual Budget.

3.5 In addition to the approvers found in the "Authorization and Limits" attachment, there must be at least one other approver for purchases, contracts, or check requests. These approvers are accounting/budget ~~and/or,~~ procurement~~.~~ and/or as described in Policy (AFS-007). Exceptions to this are low dollar purchases for office supplies and IT peripherals directly from L.A. Care's electronic catalog procurement system.

3.6 Only authorized signers who have a current signatory card on file in Accounts Payable, as approved by their respective officer, and who have primary responsibility for managing the budget of one or more cost centers will be able to sign contracts, subject to the Authorizations and Approval Limits above.

3.7 Only the CEO or designee has the authority to execute contracts approved by the Finance & Budget Committee or the Board of Governors.

3.8 In a situation when time is of the essence and presenting a motion to Finance & Budget Committee is not possible, only the Chief Executive Officer (CEO) or designee may authorize an expenditure, not to exceed $5~~2~~,000,000, if prior approval is received from the Chairperson of the Executive Committee and the Chairperson of the Finance & Budget Committee.

3.9 In a situation when time is of the essence and when a motion must be presented to the Board of Governors prior to Finance & Budget Committee, the Chairperson of the Finance & Budget Committee must approve presenting of the said motion on behalf of the Finance & Budget Committee.

3.10 In the event that the actual expenditure or an approved invoice exceeds the original amount authorized, it will be handled in accordance with the attached procedure (see "Authorizations and Approvals When Amount Exceeded" attachment). Beyond these limits, the next management level authorization is required in accordance with Section 3.4 and 3.5.

3.11 All staff must adhere to these authorization limits and must not submit multiple purchase requisitions, check requests, or other payment requests that are under an authorization limit to avoid higher levels of management approvals.

3.12 Delegation of approvals and authorizations to a substitute approver when an approver is not available may be requested in writing via e-mail from the approver to Accounts Payable and Procurement. Delegation must be made at the same management level of the approver or higher.

3.13 In the event an officer needs to delegate approvals and authorizations to one formal designee to approve and sign contracts for an extended period of time other than for short-term unavailability, the following is required in writing:

3.13.1 Approval by officer who is requesting designee.

3.13.2 Designee must be at the equivalent level of the original requester or at a higher level.

~~**3.13.2**~~**3.13.3** Approval by CFO. If CFO is requesting officer, then approval by CEO.

~~**3.13.3**~~**3.13.4** Signatory card of designee on file in Accounts Payable.

3.14 The requesting officer, CFO, or CEO can revoke designee's approval and authorization at any time. The list of designees will be reviewed annually by CFO or designee.

3.15 In a situation when a management level individual is unable to authorize and approve expenditures, authorizations can be delegated temporarily in writing via e-mail to Accounts Payable and Procurement.

3.16 Examples of scenarios that apply to this policy's authorization and approval limits can be found in the "Examples" attachment.

3.17 Check requests can be used for disbursements that are not subject to the Procurement Policy including exceptions and infrequent purchases. The use of a check request for a disbursement must be approved by the Controller or designee. The check request approvals are required in accordance with the Authorization and Approval Limits except for the special exclusion listed below:

~~**3.18** The following are special authorizations and approvals for recurring expenditures which already have a previously authorized commitment (i.e., active and fully executed contract). A board motion is required when the following amounts are exceeded:~~

Recurring Expenditure	Delegated Approver	~~Up to the following amounts~~
Building lease payments from an active, fully executed lease contract	CFO or designee	~~$12,000,000 per year~~
Sales agency broker commissions from an active, fully executed contract	CFO or designee	~~$4,000,000 per year~~
L.A. Care insurance premiums from annual renewals (e.g., workers compensation, crime, fiduciary, managed errors and omissions, etc.)	CFO or designee	~~$4,000,000 per year~~
Investment fees	CFO or designee	~~$400,000 per month~~

Regulatory fee wire transfers (exclude Legal settlements and Provider payments)	CFO or designee	~~$15,000,000 per month~~

4.0 Monitoring:

4.1 List of substitute of approvers will be maintained by Accounts Payable and Procurement.

4.2 Accounts Payable will maintain the list of designees for special approvals and authorizations. The list of designees will be reviewed annually by CFO or designee.

5.0 Reporting:

5.1 Instances in which staff appears to unbundle purchases or split requirements to avoid scrutiny by higher levels of authority will be reported to senior management and could be subject to disciplinary action up to and including termination.

5.2 All executed vendor contracts for all expenditures will be reported to the Board of Governors on a quarterly basis.

5.3 Vendor budgets will be reported, in aggregate, for the upcoming fiscal year as part of the Annual Operating & Capital Budget materials.

Authorization and Approval Levels*

Management Level	Operating and Capital Expenditures Up to and including the following amounts
Department Managers*	$~~25~~,000
Directors / Senior Directors / Managing Directors /	$~~75~~100,000
Officers (CEO, COO, CFO, CHRO, Chief Information and Technology Officer, CMO, General Counsel, Chief of Staff Executive Services, Chief Product Officer, Executive Directors, Deputy Chiefs)	$~~300~~1,000,000
CEO plus CFO	$~~1~~3,000,000
Finance & Budget Committee	$~~25~~,000,000
Board of Governors	over $~~25~~,000,000

See Section 3.2 for exclusions.

*Manager level with direct reports.

Authorizations and Approvals When Amount Exceeded

Less than or equal to $250,000	Greater than $250,000 and up to $~~1~~3,000,000	Greater than $~~1~~3,000,000
Directors / Senior Directors / Managing Directors can approve up to the lesser of 10% or $15,000	Officers (CEO, COO, CFO, CHRO, CIO, CMO, General Counsel, Chief of Staff Executive Services, Executive Directors) can approve up to the lesser of 5% or $~~25,000~~37,500	CEO & CFO can approve up to the lesser of 5% or $~~75~~125,000

For purchases less than or equal to $250,000, if the additional amount of a final expenditure or a final approved invoice is the lesser of ten percent (10%) of the original amount authorized or $15,000, the additional amount may be approved by at least a director level approver or designee provided the cost overage is limited to the same goods and services originally authorized.

For purchases greater than $250,000 and up to $~~1~~3,000,000, if the additional amount of a final expenditure or a final approved invoice is the lesser of five percent (5%) of the original amount authorized or $~~25,000~~37,500, the additional amount may be approved by an officer level approver or designee provided the cost overage is limited to the same goods and services originally authorized.

For purchases greater than $~~1~~3,000,000 that have already been authorized by the Finance & Budget Committee or the Board of Governors, if the additional amount of a final expenditure or a final approved invoice is the lesser of five percent (5%) of the original amount authorized or $~~75~~125,000, the additional amount may be approved by the CEO and the CFO or respective designees provided the cost overage is limited to the same goods and services originally authorized; otherwise, Finance & Budget Committee and/or the Board of Governors authorization is required.

Section 3.12 applies to above.

Examples

Example	Scenario	Expenditure Type	Authorized Approver

1	$~~75~~100,000 Facility Services Contract	Operating	Director, Senior Director, Managing Director
2	$~~300~~51,000,000 Consulting Contract	Operating	Officers (CEO, COO, CFO, CHRO, Chief Information and Technology Officer, CMO, General Counsel, Chief Product Officer, Chief of Staff Executive Services, Executive Directors~~)~~, Deputy Chiefs)
3	$~~1M~~3M Translation Services	Operating	CEO plus CFO
4	$~~1~~4,999,999 Hardware Purchase	Capital	Finance & Budget Committee
5	$~~2~~5.5M Health Risk Assessment Contract	Operating	Board of Governors
6	Using Example #2, a $2,000 increase from a final invoice with a new total of $302,000	Operating	Officers (CEO, COO, CFO, CHRO, Chief Information and Technology Officer, CMO, General Counsel, Chief Product Officer, Chief of Staff Executive Services, Executive Directors~~)~~, Deputy Chiefs)
7	Using Example #3, a $40,000 increase from a final invoice with a new total of $~~1~~2,040,000	Operating	CEO plus CFO
8	$200 Catering Request	N/A	See Expense Policy AFS-004

Board of Governors
MOTION SUMMARY

Date: December 7, 2023 **Motion No. FIN 103.1223**

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

Requesting Department: Operations / Enrollment Services

Issue: Amend a contract with InfoCrossing, Inc. to provide additional funds for remainder of contract.

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

Background: The Enrollment Services department requests approval to execute a contract amendment, which will renew the existing InfoCrossing, LLC contract for two (2) years and provide additional funding in the amount of $1,200,000. The funds would cover anticipated costs from January 1, 2024 through December 31, 2025. Currently, InfoCrossing, LLC serves as the third-party submitter on behalf of L.A. Care for enrollment/disenrollment transactions and eligibility inquiries submitted to the Centers for Medicare and Medicaid Services (CMS) to support regulatory enrollment requirements. In addition, InfoCrossing, LLC manages the *WiPro Member360* platform (M360) for L.A. Care. This platform is the Medicare membership management system that focuses on membership enrollment & management, correspondence automation and generation, Transaction Reply Reporting (TRR) and CMS file reconciliation. L.A. Care has worked with InfoCrossing, LLC since 2007, and their services have been highly satisfactory.

Member Impact: L.A. Care members will benefit since the Member360 system will continue to timely send and receive member data and reporting to/from CMS; this will include enrollment and disenrollment transactions, all in accordance with CMS regulatory requirements.

Budget Impact: The costs were included in the approved budget for the Enrollment Services department for the current fiscal year (23/24).

Motion: **To authorize staff to amend the contract with InfoCrossing LLC, in the amount of $1,200,000, not to exceed $4,700,000. The funds would cover anticipated costs from January 1, 2024 through December 31, 2025, and allow InfoCrossing, LLC to continue their services with L.A. Care.**

Board of Governors
MOTION SUMMARY

Date: December 7, 2023 **Motion No. FIN 104.1223**

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

Requesting Department: Information Technology, Quality Assurance

Issue: Amend a contract with Infosys Limited to provide continuing Quality Assurance (QA) services for the Solutions Delivery and Architecture Teams.

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

Background: L.A. Care staff requests approval to amend an existing contract with Infosys Limited adding $3,175,000 for continued Quality Assurance (QA) Services for the SDM and Architecture teams. L.A. Care requires these services because QA is an integral part of the software development process and we need to deliver quality software to support L.A. care's daily operations. We have used this vendor for more than 10+ years and are pleased with their work. Other departments, including Architecture and Solutions Delivery use this vendor for Development projects.

Member Impact: L.A. Care members will benefit from this motion by delivering quality IT applications that enable staff to efficiently perform their job, utilizing new reliable software with minimal interruption of current operations to provide well-integrated health services.

Budget Impact: The cost was anticipated and included in the approved budget for the ITSD teams in this fiscal year. We will budget the balance in future fiscal years.

Motion: To authorize staff to amend a contract with Infosys Limited in the amount of $3,175,000 (total not to exceed amount of $11,175,000) to provide Quality Assurance services for the period of December 30, 2023 to September 30, 2024.

L.A. Care
HEALTH PLAN

Board of Governors
MOTION SUMMARY

Date: December 7, 2023 **Motion No. FIN 106.1223**

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

Requesting Department: Communications & Community Relations Department

Issue: Execute a contract with North Star Alliances, LLC to provide event planning, staffing, logistics and execution, community outreach services and support community marketing, sales and promotional activities.

☒ **New Contract** ☐ **Amendment** ☐ **Sole Source** ☒ **RFP/RFQ was conducted in 2023**

Background: L.A. Care staff requests approval to execute a 36-month contract with North Star Alliances, LLC (NSA) from January 1, 2024 to December 31, 2027 in the amount of $8,900,000. The vendor will provide all event planning, staffing, logistics, execution and community outreach services for L.A. Care. These services will include all event logistics support for health plan corporate events and for community marketing and sales efforts. The vendor will also provide staff augmentation services that allows the Marketing and Sales department and the Communications and Community Relations department to extend the reach of their efforts in the community. A competitive procurement process was conducted in 2023 to select a vendor for these services. NSA was one of three vendors that submitted proposals and was selected after written proposals were scored and interviews of two finalist bidders were conducted.

Member Impact: L.A. Care members will benefit from this motion through enhanced access to health care resources, information and services offered at an increased number of community events and at new Community Resource Centers and through enhanced local community relations support.

Budget Impact: The cost was anticipated and included in the approved FY 2023-24 budget for the Communications and Community Relations Department.

Motion: To authorize staff to execute a contract in the amount of $8,900,000 with North Star Alliances, LLC to provide event planning, logistics, staffing and execution services and community relations support for the period January 1, 2024 to December 31, 2027.

L.A. Care
HEALTH PLAN

Board of Governors
MOTION SUMMARY

Date: December 7, 2023 **Motion No. TAC 100.1223**

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

Issue: Ratification of elected Technical Advisory Committee (TAC) Chairperson and Vice-Chairperson.

Background: Per the Technical Advisory Committee Operating Rules, the TAC shall nominate a Chairperson and Vice-Chairperson for a one-year term.

Members Impact: N/A

Budget Impact: N/A

Motion: **To ratify the election of Alex Li, MD, as Chairperson and Paul Chung, MD, MS, as Vice Chairperson of the Technical Advisory Committee (TAC), a one year term.**

Board of Governors
MOTION SUMMARY

RECORD OF VOTING

Motion No. TAC 100.0323	Supported	Opposed	Abstained	Absent
Alvaro Ballesteros, MBA	☐	☐	☐	☒
Stephanie Booth, MD	☒	☐	☐	☐
Hector De La Torre	☒	☐	☐	☐
Christina R. Ghaly, MD	☒	☐	☐	☐
Layla Gonzalez	☒	☐	☐	☐
George W. Greene, Esq.	☐	☐	☐	☒ *
Honorable Hilda L. Solis	☒ ***	☐	☐	☐
Hilda Perez	☒ ***	☐	☐	☐
John G. Raffoul	☐	☐	☐	☒
G. Michael Roybal, MD, MPH	☒	☐	☐	☐
Ilan Shapiro, MD	☒	☐	☐	☐
Nina Vaccaro	☒	☐	☐	☐
VACANT	☐	☐	☐	☐
Total	9			3

**** Absent During Voting*** ****** Via Teleconference***

☒ **Motion Carried** ☐ **Motion Failed** ☐ **Motion Tabled**

Action/Follow-up/Comments (if applicable) *This motion was approved unanimously by roll call in Consent Agenda.*

_____
John Raffoul, *Board Secretary*
Date Signed: _____

Board of Governors
MOTION SUMMARY

Date: December 7, 2023

Motion No. TTECA 100.1223

Committee: Temporary Transitional Executive Community Advisory Committee (TTECAC)

Chairperson: Ana Rodriquez

Issue: Following a period of three years in a public health emergency, some members of L.A. Care's Regional Community Advisory Committees (RCAC) have moved their residence from the geographic area for their RCAC, which disqualified those members from participating in that RCAC.

A process was conducted for the remaining RCAC members to select replacement representatives on the Temporary Transitional Community Advisory Committee (TTECAC).

Background: TTECAC requests that the Board of Governors ratify the selection of representatives by the RCACs. Following is a list of current TTECAC members:

- Roger Rabaja, RCAC 1
- Ana Rodriguez, RCAC 2
- Lidia Parra, RCAC 3
- Silvia Poz, RCAC 4
- Maria Sanchez, RCAC 5
- Joyce Sales, RCAC 6
- Maritza Lebron, RCAC 7
- Ana Romo, RCAC 8
- Tonya Byrd, RCAC 9
- Damares Cordero de Hernandez, RCAC 10
- Maria Angel Refugio, RCAC 11
- Deaka McClain, At-Large Member
- Lluvia Salazar, At-Large Member

Motion: **A motion to request that the L.A. Care Board of Governors ratify the selection by Regional Community Advisory Committees (RCAC) members of new and continuing members of the Temporary Transitional Executive Community Advisory Committee (TTECAC):**

- **Roger Rabaja, RCAC 1**
- **Ana Rodriguez, RCAC 2**
- **Lidia Para, RCAC 3**
- **Silvia Poz, RCAC 4**
- **Maria Sanchez, RCAC 5**

- **Joyce Sales, RCAC 6**
- **Maritza Lebron, RCAC 7**
- **Ana Romo, RCAC 8**
- **Tonya Byrd, RCAC 9**
- **Damares Cordero de Hernandez, RCAC 10**
- **Maria Angel Refugio, RCAC 11**
- **Deak McClain, At-Large Member**
- **Lluvia Salazar, At-Large Member**

L.A. Care
HEALTH PLAN

Board of Governors
MOTION SUMMARY

Date: December 7, 2023

Motion No. TTECA 101.1223

Committee: Temporary Transitional Executive Community Advisory Committee (TTECAC)

Chairperson: N/A

Requesting Department: N/A

Issue: Ratification of elected Temporary Transitional Executive Community Advisory Committee (TTECAC) Chairperson and Vice-Chairperson from November 2023 to June 2024.

Background: The TTECAC shall nominate a Chairperson and Vice-Chairperson to serve from November 2023 to June 2024. The elections took place during the October 11, 2023 TTECAC meeting.

Members Impact: N/A

Budget Impact: N/A

Motion: **To ratify the election of Ana Rodriguez as Chairperson and Deaka McClain as Vice Chairperson of the Temporary Transitional Executive Community Advisory Committee (TTECAC) from November 2023 to June 2024.**

CHAIRPERSON'S REPORT

CHIEF EXECUTIVE OFFICER REPORT

November 27, 2023

TO: Board of Governors

FROM: John Baackes, *Chief Executive Officer*

SUBJECT: CEO Report – December 2023

This year has rushed by and it is hard to believe that we are already nearing 2024. L.A. Care continues to adapt and respond to the changing health care environment. Within all the change, our role is as paramount as ever as a public plan – to support the safety net and ensure that our members get high-quality care when they need it. This past month, we focused on many community events and partnerships, which have been highlighted below and are a good example of how we live our mission.

We're also still in the enrollment season for L.A. Care Covered and Medicare Plus (D-SNP) products, and we are preparing for the expansion of Medi-Cal to undocumented adults age 26-49 in January. This marks the final phase of enrollment for undocumented adults into Medi-Cal, with other age groups being eligible in 2020 and 2022. Medi-Cal Product has been working hard to ensure L.A. Care is ready to receive and serve this new membership.

To our hardworking staff, our tireless providers, our valued members, and to you, our trusted Board of Governors, thank you. I am grateful for every one of you and honored to be the CEO of this organization.

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

	Since Last CEO Report (10/23/23)	As of 11/27/23
Provider Recruitment Program Physicians hired under PRP[1]	7	160
Provider Loan Repayment Program Active grants for medical school loan repayment[2]	13	122
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 November:

Public Comment on Proposed Rule to Advance Health Equity and Bolster Protections for People with Disabilities

The Department of Health and Human Services (HHS) has proposed a new rule that updates, clarifies, and strengthens the Rehabilitation Act of 1973. The rule strengthens prohibitions against discrimination on the basis of a disability in health care and human services programs that receive federal funding. As the

CEO of L.A. Care, I submitted a public comment expressing support for the proposed rule. I agree with the HHS Secretary's assessment that this update is needed to advance justice for people with disabilities. My comment letter is attached to this report.

L.A. Care and the L.A. County Office of Violence Prevention to Help Health Care Professionals Address Gun Violence
L.A. Care and the Los Angeles County Office of Violence Prevention hosted a training titled, "Prioritizing Patient Safety by Reducing Firearm Injury and Death." L.A. Care prioritized Gun Safety last summer when we approved a resolution for Gun Safety Legislation. This training is one example from our recent efforts to address gun safety and violence prevention locally. By the end of the training, attendees will have the information and tools to start taking steps to prevent gun violence.

L.A. Care Presented with Health Excellence Award by UMMA Community Clinic
During a weekend celebration of the 25th anniversary of its first free clinic staffed by volunteers, the UMMA Community Clinic presented L.A. Care with its Health Excellence Award, in recognition of our quarter century partnership with them. They have participated as a provider for L.A. Care members since their inception. L.A. Care and UMMA have partnered together and L.A. Care has provided over $1.1 M in support through our Community Health Investment Fund, and Elevating the Safety Net. I was honored to accept the award on behalf of L.A. Care.

L.A. Care and Children's Hospital Los Angeles Host Roundtable to Identify Actionable Solutions to Children's Health Disparities
L.A. Care and Children's Hospital Los Angeles hosted a Children's Health Disparities Roundtable, which brought together experts from various disciplines, to find actionable solutions to address the wide-ranging issues that lead to health disparities for children in Los Angeles County. The discussions focused on four areas: building resilience in schools, child welfare gaps, post-pandemic vaccine catch-up, and rethinking the pediatric medical home. Roundtable participants also developed a child health disparity framework to inform policy and create actionable next steps.

L.A. Care Commits $1.25 Million to Help Organizations that Serve BIPOC Communities Find Sustainable Funding Sources
L.A. Care announced our fourth round of Equity & Resilience Initiative grants, which aim to further enhance the impact of Black, Indigenous and other people of color (BIPOC)-led nonprofits in Los Angeles County. We awarded a total of $1.25 M to 12 BIPOC-led organizations that have been working to mitigate the impact of historic oppression and marginalization of their communities. The grantees will receive technical assistance to help them identify and secure sustainable funding sources and heighten their readiness for such funding.

Speaking Events
November 15 – Health Exec Wire Webinar; *The Return of the Public Option and Its Implications for Healthcare's Future.*

Attachments
Public Comment: Nondiscrimination on the Basis of Disability
Meeting Summary L.A. Care Medicare Plus Enrollee Advisory Committee

November 13, 2023

Submitted electronically via: www.regulations.gov

RE: RIN 1190–AA79, Nondiscrimination on the Basis of Disability; Accessibility of Web Information and Services of State and Local Government Entities

John Baackes
Chief Executive Officer

L.A. Care Health Plan, the nation's largest public plan with nearly 2.9 million Medicaid, Medicare D-SNP (Medicaid/Medicare Dual Eligibles), PASC- SEIU Homecare Workers, and Covered California (Marketplace) enrollees, respectfully submits comments in response to the proposed rule regarding clarification of the Americans with Disabilities Act (ADA) and Rehabilitation Act of 1973 (Rehabilitation Act).

L.A. Care wishes to express our strong support for the Administration's proposed rule to prevent discrimination on the basis of disability in health and human service programs or activities by clarifying the obligations of entities receiving federal assistance. It is L.A. Care's mission is to provide access to quality health care for Los Angeles County's vulnerable and low-income communities and residents and to support the safety net required to achieve that purpose – this includes individuals with a disability.

The Department of Health and Human Services (HHS) has issued a proposed rule designed to ensure that individuals with disabilities have equal access to healthcare and social services mandated by the Rehabilitation Act and the ADA. The Rehabilitation Act prohibits discrimination against individuals with disabilities in federally funded programs and activities, and the ADA extends these protections to employment, public accommodations, transportation, and telecommunications, promoting equal opportunities and access for individuals with disabilities.

The proposed rule addresses discrimination against people with disabilities when they need medical care. The changes ensure that decisions about medical treatment cannot be based on unfair beliefs or biases about disabilities and stops unfair methods that undervalue extending the lives of people with disabilities when deciding on medical treatments or services.

With more health services online, protections are needed to ensure websites and mobile apps are easily accessible for people with disabilities. The proposed rule defines what accessibility means for web and mobile apps and sets forth specific technical standards for compliance.

Additionally, the rule establishes enforceable standards for accessible medical diagnostic equipment, a significant and concrete step toward addressing health disparities experienced by people with disabilities. The proposed rule requires provider recipients of federal funds that use an examination table in their program or activity have at least one accessible exam table,

and recipients that use a weight scale in their program or activity have at least one accessible weight scale. The accessible equipment is required within two years of the rule's effective date. These requirements have been scattered throughout case law over the history of the ADA and Rehabilitation Act– consolidating and clarifying regulations will increase protections for individuals with disabilities and simplify requirements for providers who serve the safety net.

Our vision is a healthy community where everyone, regardless of their background, has equitable access to healthcare. L.A. Care has been at the forefront of addressing health disparities and social barriers, playing a significant role in promoting health equity, diversity, inclusion, and social justice. We work with our members, community partners, and providers to make Los Angeles County a leader in ensuring a fair and just opportunity for optimal health. Guaranteeing equal access for individuals with disabilities is vital, but it comes with challenges. Standards for accessible medical equipment, like adjustable exam tables and wheelchair-friendly scales, are essential; however, these costs can strain safety net providers with tight budgets. Ensuring our safety net providers have the resources they need is crucial for them to serve our community effectively.

L.A. Care supports the safety net in L.A County by collaborating with individual and community health providers through a variety of targeted activities including a Community Health Investment Fund (CHIF). As of October 1, 2023, CHIF has supported more than 979 projects for 190 unique community entities, and invested more than $138 million in organizations caring for under-resourced communities. We support community-based strategies and policy efforts to reduce health inequities associated with social determinants, which will help improve the health and wellbeing of marginalized community members. As a specific example, L.A. Care's CHIF will provide grant funding for accessible exam tables, starting in 2024, which happens to be part of the rule requirement.

This is not the first time that L.A. Care has stepped up to support safety net providers serving individuals with a disability. In 2008, L.A. Care invested $1.5 million in an initiative that improved access to care for approximately 228,000 seniors and persons with disabilities by providing wheelchair-accessible scales and height adjustable exam tables to more than 60% of Los Angeles County's community clinics. In 2017, L.A. Care funded 82 additional clinic sites for the purchase of accessible exam tables and wheelchair-accessible scales for patients. These sites received at least one type of accessible equipment – in total 75 sites received adaptable exam tables and 82 received accessible scales. L.A. Care has worked to address health disparities and the social barriers that impede a person's equitable access to health care since our inception 26 years ago.

However, there must be adequate federal funding for the safety net providers. Adding requirements to already burdened providers will not fix the problem; providers need the resources to transform their practices into accessible sites for all. The federal government is in the perfect position to protect those most vulnerable, while not overburdening the safety net, by providing adequate funding.

L.A. Care supports the proposed amendments to the HHS regulations on discrimination on the basis of disability in health and human service programs or activities. These are common sense and necessary protections for the most vulnerable in our communities. This proposed rule will play a vital role in ensuring that individuals with disabilities have equitable access to essential services and employment opportunities. These regulations underscore the government's commitment to upholding the rights and dignity of all individuals, regardless of their disability status. However, the safety net providers need our support and cannot be left grappling with these requirements without proper funding provided by the federal government.

Sincerely,

John Baackes

L.A. Care Medicare Plus Enrollee Advisory Committee (CMC EAC) Meeting Summary

Meeting Date: November 14, 2023, Time: 2:00pm-3:30pm
Attendees: 6 L.A. Care Medicare Plus members via conference call

Meeting Summary

I. L.A. Care Updates

a. Susan Ma, Community Relations Specialist III, informed the attendees about the following:
   i. Medi-Cal Renewals/Redetermination: Staff reminded committee members that Medi-Cal renewals have begun. The local Med-Cal office will send them a letter or a renewal form to complete. Complete your renewal by the due date printed on the form. If you don't, you could lose your Medi-Cal coverage. Go to benefitscal.com or call DPSS at 1-866-613-3777.
   ii. Covered California Open Enrollment – L.A. Care Covered is L.A. Care's health coverage option on the Covered California exchange. L.A. Care Covered has the most affordable rates in Los Angeles County. Open Enrollment runs from November 1, 2023 through January 31, 2024.
   iii. L.A. Care was presented the Health Excellence Award by UMMA Community Clinic
   iv. Updates on Community Resource Center (CRC) programming: offering free in-person classes and services to help keep participants active, healthy and informed. Upcoming locations: West L.A. had a soft opening in October and Pacoima is relocating to Panorama City

II. L.A. Care At-Home Test Kits

a. A presentation was shared regarding at-home test kits for members. L.A. Care is partnering with ixlayer and Walgreens to provide at-home test kits for members that meet the criteria for testing. The test kits include Colorectal Cancer Screening, Hemoglobin A1c and Kidney Health Evaluation. Ixlayer will be responsible for mailing the at-home test kits to members, distribution of test kit results, and call center support.

III. Overview of the changes of Dual Eligible Special Needs Plan (D-SNP) and Survey

a. Staff reviewed benefit changes of the 2024 L.A. Care Medicare Plus D-SNP plan and asked members for feedback. The survey includes questions regarding Annual Notice of Changes (ANOC), robocalls, Over-the-Counter (OTC) benefits, etc. Members reviewed the survey and provided feedback.

IV. Close-Out

a. Members got instructions on how to contact L.A. Care Member Relations staff for help with member issues.
b. The next L.A. Care Medicare Plus Enrollee Advisory Committee meeting will be Tuesday, February 20, 2024, from 2:00 pm - 3:30 pm, via conference call.

October 2023
Grants & Sponsorships Report
December 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	San Pedro Chamber of Commerce	2023 State of the County with Supervisor Janice Hahn	10/27/2023	Sponsorship	$ -	$ 1,250	$ 1,250
2	Los Angeles Business Journal	Book of Lists 2024	10/30/2023	Sponsorship	$ -	$ 4,500	$ 4,500
3	United Friends of the Children	United Friends of the Children: An Autumn Affair	10/5/2023	Sponsorship	$ -	$ 5,000	$ 5,000
4	Ability First	AbilityFirst Stroll & Roll	10/10/2023	Sponsorship	$ -	$ 5,000	$ 5,000
5	UMMA - University Muslim Medical Association Community Clinic	UMMA 25th Anniversary Celebration Gala	10/10/2023	Sponsorship	$ -	$ 5,000	$ 5,000
6	The African American Male Wellness Agency	African American Male Wellness Walk & screening hub	10/10/2023	Sponsorship	$ -	$ 5,000	$ 5,000
7	California State University Long Beach Bob Murphy Access Center	BMAC 50th Anniversary Celebration	10/11/2023	Sponsorship	$ -	$ 5,000	$ 5,000
8	Valley Presbyterian Hospital	Valley Presbyterian Hospital 13th Annual Golf Classic	10/19/2023	Sponsorship	$ -	$ 6,000	$ 6,000
10	Voices of Our Youth	I Solemnly Swear That I Am Up To Some Good Resource fair and food distribution	10/5/2023	Sponsorship	$ -	$ 7,500	$ 7,500
11	Adventist Health White Memorial Charitable Foundation	Adventist Health White Memorial Charitable Foundation Gala 2023	10/10/2023	Sponsorship	$ -	$ 10,000	$ 10,000
12	Care Harbor	Veterans' Care	10/10/2023	Sponsorship	$ -	$ 10,000	$ 10,000
13	Los Angeles County Department of Public Health	2023 Department of Public Health Giving Thanks Event	10/25/2023	Sponsorship	$ -	$ 12,500	$ 12,500
14	Heart of Compassion Distribution	Thanksgiving Giveaway Event	10/10/2023	Sponsorship	$ -	$ 13,000	$ 13,000
15	Community Health Alliance of Pasadena (CHAP)	ChapCare 25th Anniversary Gala	10/5/2023	Sponsorship	$ -	$ 15,000	$ 15,000
16	Martin Luther King Jr. Community Health Foundation - Medical Group (MLKCHF)	The Dream Show 2024: Power of Purpose	10/25/2023	Sponsorship	$ -	$ 25,000	$ 25,000
17	Urban Voices Project	A Holiday Called Home Celebration	10/25/2023	Sponsorship	$ -	$ 25,000	$ 25,000
18	Oaks of Righteousness Ministry	Meals on Jesus	10/10/2023	Sponsorship	$ -	$ 30,000	$ 30,000
19	Patient Care Foundation	11th Annual LA Healthcare Awards	10/25/2023	Sponsorship	$ -	$ 30,000	$ 30,000
20	Hospital Association of Southern California	MySoCal Hospital Heroes Awards Gala	10/19/2023	Sponsorship	$ -	$ 46,660	$ 46,660
21	Leonard Nimoy Foundation	Remembering Leonard Nimoy COVID and Flu Vaccine Campaign	10/10/2023	Sponsorship	$ -	$ 50,000	$ 50,000
22	iHeart Media	Youth Community Skill Clinics	10/11/2023	Sponsorship	$ -	$ 75,000	$ 75,000
		Total of grants and sponsorships approved in September 2023			**$ -**	**$ 386,410**	**$ 386,410**

* No grants approved in October 2023.

CHIEF MEDICAL OFFICER REPORT

CMO Report
December 2023

Care Management/Utilization Management/MLTSS Departments

Care Management

Enhanced Care Management (ECM)

ECM leaders continue to implement quality improvement activities related to staff roles, technology, and processes to align with the DHCS ECM Policy Guide.

- **Data Integrity**
  - Coordinators from the CM team completed corrections of thousands of enrollments
  - Continued creating code sets to assist with accuracy and completeness of enrollment data
  - Developed Referral and Enrollment KPIs for internal use and for DHCS reporting

- **Payment Model**
  - Conducted a full payment reconciliation on CY 2022 and Q1 2023. Complete and accurate numbers are now available for reporting and payment recovery amounts validated to claims/encounters.
  - Worked with Actuary to develop a fee-for-service (FFS) rate structure. We are anticipating moving forward with this change once we have obtained additional feedback from our network with likely implementation April 2024.
  - Updated the ECM provider contract to include compensation for outreach services to offer members ECM. This change in payment is retro to July 2023 and covers all outreach including unsuccessful attempts at reaching members.

- **Clinical Oversight**
  - Team is testing the new audit tool with a few providers. Concurrently, the ECM team is communicating standards and expectations to all providers in advance of launching full-scale audits during Q1 2024.
  - Developing reports to assess provider performance such as average time from referral to enrollment and rates of face-to-face interventions.

- **Network**
  - Working with IT to develop a dashboard to overlay the provider network expertise and capacity with our ECM eligible membership.
  - Numerous factors will likely prompt changes to network as providers respond to changes in the payment model, contract and oversight activities described above.
  - Developed the LA County ECM provider capacity report with partnership from the local MCPs. This will support capacity planning and DHCS reporting requirements.
  - In collaboration with local MCPs the team sent out the Justice Involved (JI) ECM provider survey to assess how many of our current providers can meet the DHCS JI Provider requirements. The survey results along with follow up meetings helped finalize the LA County JI ECM provider network, which will serve our members upon release from incarceration.

- **Staffing**
  - Continue to add and update job aids. Reference guides have been developed to standardize compliant processes.
  - Team building
    - Current: 6 FTEs +1 Consultant
      - In recruitment: 10 positions (4 backfills, 6 new positions)
    - Future: 4 new positions pending approval
- **Enrollment**
  - Plan to increase its ECM Enrollment from the current ~10k to 30k members for Q3 2024. This goal will require significant cross-functional efforts and the ECM provider network to achieve.

Transitional Care Services (TCS)

- CM team began implementing the TCS program in Q1 2023 using Care Managers (CM) and Community Health Workers (CHWs). With 16 new staff hired in August and September and finishing training, we have been able to increase monthly outreach to hospitalized members dramatically: 147 in July 224 in August and 554 in September – a remarkable 377% increase in only two months. As of mid-October, year-to-date 1,929 members have been outreached for TCS. We anticipate that with the additional planned hiring and training that by end of Q2 2024 we will reach the goal of outreaching to 3K high-risk admissions per month.
- So far, we have had a high engagement rate, with about 44% of members we outreach to participating in part or all of the TCS process. While difficult to measures outcomes at this point in the program, there is intrinsic value in engaging with our members in the critical period post-transition to help with follow-up visits, medications and other services critical to members in their most vulnerable time after hospitalization.
- The CM team is working with other departments
  - CM is collaborating with the MLTSS team in the development of plans for new populations of focus that will also need TCS starting in 2024, primarily the long term care population residing in skilled nursing facilities (SNF) and in Intermediate Care Facilities for the Developmentally Disabled (ICF-DD). In partnership with CM, MLTSS is creating workflows, assessing staffing needs, testing tools, drafting letters, determining documentation standards and creating training schedule and materials.
  - In addition, Network is working to ensure PPGs are aware of, and are performing, TCS for the high-risk populations for which they are responsible.
- In response to LAC and other health plans' feedback, DHCS issued updated guidance late-October for the TCS requirements for 2024 related to low-risk members.
  - Plans no longer have to assign all members with a transition to a care coordinator. However, hospitals, SNFs etc. will need to inform each member that TCS services are available through their health plan and inform members about how to reach out to the health plan to start the process.
  - We are adjusting our plans accordingly. LAC will have a centralized intake line to the TCS team that take the requests and then assign staff.
  - We will need to build system and process to establish responsibilities and hand-offs between LAC, PPGs, hospitals and potential vendors.

General CM

- CM had no audit findings in the reports from the recent DHCS and DMHC Preliminary reports. Despite that, the team continues to work on improvements in areas identified as potential findings during the on-site portion of the audits such as California Childrens' Services (CCS) (see below).
- CM continues to work on adopting and implementing new PHM requirements from DHCS (not covered in above sections).
    - These efforts include significant IT work such as:
        - Configuring IPRO (analytic stratification tool) to account for newly introduced DHCS high-risk populations, including those meeting definitions for SMHS/SUD, those transitioning into or out of SNFs, and individuals within 12 months post-partum.
        - Implementing an effective system of tracking members in CM and TCS across the PPGs so case transfers, assignments, and coordination are seamless.
        - Integration of DHCS's PHM Service risk stratification and segmentation logic into IPRO and CCA (Case Management documentation platform) upon its release in CY2024.
        - Transitioning to the new version of CCA.
    - Headwinds
        - DHCS expectations have shifted throughout the year. While some of the changes are welcome, the changes hold challenges in planning and implementation.
        - High-risk populations are more fluid than DHCS is accounting for. These populations have associated expectations for assessment, care coordination, TCS, and formal care management that do not divide cleanly between the PPGs and LAC's internal CM team because the stratifications do not necessarily account for clinical or utilization risk.
    - Team Building
        - Hiring remains a focus as we build capacity to meet the new requirements. Bringing on experienced and/or skilled staff at a pace that matches the pipeline of new work for DSNP and PHM has been difficult.
        - Attrition in recent months is higher than the department's multi-year trend due to both the demands of the work itself as well as the current volume of attractive job prospects outside of the organization.
        - As of 10/31/23: 53 new staff have started (including staff for ECM and TCS) during CY2023.
        - With the expanded requirements and populations of focus, recruitment continues for numerous positions. Examples include: Coordinators (9 + 2 Supervisors); Program Manager (1); Care Managers (12 + 5 Supervisors + 1 Manager); Data analyst (1).
- DSNP
    - CM continues to work on adopting and implementing new DSNP requirements. These efforts include significant IT work such as:
        - Configuring a new Health Risk Assessment (HRA) into CCA to account for new required DSNP elements. The HRA is the foundation for nearly all care coordination processes. Consequently, in addition to the HRA, all current operational and regulatory reports as well as related operational processes will need revisions to account for the new HRA.
        - Updating note templates and modules in CCA in order to track and report face-to-face activities in accordance with new DSNP program expectations.
    - LAC's CM team is performing well on DSNP metrics and is advising EPO on the audit and oversight of PPG performance.

- CM staff audit process was selected for review in the recent Medicare mock Compliance Program Effectiveness audit and received positive feedback on their monitoring processes.

Utilization Management

Timeliness Corrective Action Plans (relates to June 2021 regulatory disclosure, 2021 DHCS Audit and 2022 Enforcement Action. The DMHC Preliminary Report for the 2021 Routine Survey also listed two timeliness findings.) UM continues to make extraordinary progress in this area. We have made incremental improvements quarter over quarter for the past year.

Compliance Scorecard measures – Q3 2023 most recent available

- Overall performance for all Lines of Business
  - 50/52 measures > 95%
  - 50/50 measures > 90%
- Direct Network only (Medi-Cal subset)
  - 20/20 measures > 95%
  - LAC continues to submit Direct Network scores and narratives on process enhancements and staffing levels to DMHC via quarterly reports.

UM Team Development

Since 1/1/23, 42 new FTEs have been hired

- As of 10/31/23 multiple positions were open
- Note: UM expectations/standards have been made clear, and are being enforced with the team leading to an increased turnover rate. Anticipate this will level-off with the latest round of resignations
  - 2 new Supervisor positions to support the growth of the Quality Team (in recruitment)
  - 4 Medical Directors (two hired with start dates in November, one in December, one in January.)
  - Quality Manager (resignation, filled with internal candidate early November)
  - Director, Outpatient (resignation, in recruitment for external candidate)
  - Manager, Inpatient (resignation, filled, start date 11/20/23)
  - Supervisor, Inpatient (internal transfer, subsequently filled with start date 11/6/23)
  - Supervisor, Outpatient (internal transfer, in recruitment)
- The Quality team now has seven auditors (five clinical, two nonclinical), four trainers (two clinical, two nonclinical), and one policy nurse. These positions are critical to ensure staff are trained for compliance and quality and to conduct monitoring and oversight of the team that will help us sustain the demonstrated improvements as well as ensure implementation of corrective action plans from regulatory audits (described below).
- The ER/Admit team phone queue went live in mid-May, but has three openings that have been difficult to fill as they are evening and night shifts. This has also been a tough team to keep staffed as the calls can be challenging. Maintaining management coverage for nights and weekends has been difficult.
- The Discharge Planning team has been sluggish to staff but has 5/6 positions filled. Progress also slowed when the Supervisor for the team was on a leave during all of October. A P&P was developed to set standards for phone queue management and customer service.
- The data analyst has been assisting with tracking productivity and projecting staff capacity. As a result, in early November the Inpatient clinical teams restructured to a pod system to better distribute work based on hospital volume and contract type (DRG and per diem). The inpatient team was also able to significantly reduce the inventory of aging concurrent review cases.

Systems

- SyntraNet – enhancements have been on schedule for deployment since September and are scheduled to continue to the end of the year. The system is now displaying member ages and correct due dates for decisions and notifications, which will assist the team in prioritizing cases for completion, thus maintaining the high timeliness metrics. The post-stabilization log for tracking and monitoring was also added.
- QXNT UM – Plans are in full swing for a conversion from Syntranet to QNXT in 2024. UM team is working with LAC IT and Cognizant staff to develop and execute an extensive workplan. Currently the team is building specifications for work queues and planning for user acceptance testing to start in mid-December. While these planning stages heavily impact the leadership on multiple teams (UM, ECM, MLTSS, CS), we look forward to the future flexibility and improved speed of configuration as regulatory requirements and business-needs change. In addition, we welcome the integration with QNXT claims that is expected to reduce abrasion that impacts our day-to-day relationships with our providers.

UM Cross-Functional Collaborations

- Coordination between UM and Grievance & Appeals and Quality
    - The three teams have increased their meeting frequency to weekly.
    - A new processes and leveling for medical directors to review grievances that appear to have quality of care (QOC) concerns ASAP after receipt continues to be developed and refined. Findings from the recent audit reports as well as updated guidance from DHCS regarding timeliness and peer protection are being accounted for. The new clinical grievances workflow is expected to be completed by the first week in December, and receiving sign-off from Compliance by mid-December. Once regulatory compliance isvalidated, all relevant policies and procedural documentation will be updated to reflect the substantive changes and Health Services and Operations leadership will convene to plan and implement a clinical staff model designed to support this new process.
    - The Medical Directors received training in the PCT system in October and are now documenting directly in the A&G system rather than by email.
    - A framework for metrics and reporting was developed to track denials rates, appeal rates, uphold/overturn rates and break down by entity (e.g. LAC, PPG). The business case is under review with IT.
    - The Appeals nurses participated in the 2023 MCG IRR, all with passing scores. Discussion is occurring to establish MCG training course of action.
- California Children's' Services (CCS)
    - SyntraNet now displays dates of birth in the work queues allowing easy identification of members under 21.
    - We created and filled a UM Supervisor position that will oversee inpatient and outpatient UM staff who will review all pediatric authorization requests to determine whether the member is already enrolled in CCS or needs to be referred to CCS. All complex kids with CCS or CCS eligible diagnoses will be referred to CM/ECM/PPG.
    - Our medical director Dr. Lina Shah has experience with CCS and is working with both UM and CM teams in building processes to ensure kids with complex medical needs are connected with the services they need through formal CCS program enrollment and/or collaboration with other specialty providers.
    - The UM CCS UM Supervisor, and CM leadership have established a CCS workgroup which meets routinely to ensure continued collaboration and process progression.

  - In October, DHCS released the final new MOU template with an All Plan Letter. The team is reviewing the new requirements and working with their counterparts at LA County CCS Office to implement it.
- Hospital and SNF
  - UM, MLTSS, PNM, Finance and AAL continue to work on updating contracts with particular focus on ensuring rate allowances that will facilitate timely discharges from hospitals by offering greater access to SNF beds.
  - UM inpatient team continues to meet weekly with multiple hospitals to assist with complex discharge planning needs. While new contracts are pending, Finance has allowed PNM to work with UM on member specific Letters of Agreements to move complex members out of acute beds.
  - Developed a template for hospitals to use in seeking skilled nursing placements to meet the member's needs. The template pilot has been going well with one hospital system and one SNF system working with LAC to expedite discharges. We continue to streamline more targeted referral processes with other large SNF chains.

Managed Long Term Services & Supports (MLTSS)

Since January 2022, the MLTSS team has grown from administering six categories of benefits and services to 15 by 2024. In order to maintain current operations and implement new ones from CalAim, 19 additional staff were approved in June and all of the new positions have been filled as of November.

Community Based Adult Services (CBAS)

- New staff are in training and are expected to take on full time review of new requests for 5-day/week services early in 2024. The staff will focus on reviewing requests to determine the appropriate visit frequency for the member's condition and prevent avoidable over-utilization.
- Team is also working with AAL to quantify the impact of prior efforts to appropriately reduce CBAS frequency requests of 6 and 7 days per week and estimate the savings from UM activities.
- MLTSS leaders are working with AAL on a claims recovery project in which providers were paid inappropriately despite lack of authorization, incorrect codes and incorrect dates/frequency of services. The second part of this effort will use all findings to work with claims team to ensure controls are established to prevent erroneous payments going forward.

CalAIM & Community Supports (CS)

- The MLTSS team is currently administering the following CS services: Personal Care and Homemaker Services; Caregiver Respite; Environmental Accessibility Adaptations
  - Each of these CS have low referrals and approvals.
    - Personal Care and Homemaker Services: while referrals have steadily increased, the highest month so far was August 2023 with 112
    - Caregiver Respite: the average monthly referrals remains in the low double digits with the highest month at 21 in July 2023
    - Environmental Accessibility Adaptations: only two months so far this year have seen double digit referrals
  - LAC is not unique in low uptake of the CS services. DHCS believes that these CS services are underutilized statewide. The Department has provided updated guidance to plans about benefit and eligibility standardization along with expectations that plans increase member access and uptake of these services in 2024.

  - In collaboration with the Community Health team, MLTSS is promoting the CS offerings in numerous forums including the JOMs (Joint Operating Meetings) occurring with PPGs (Provider Groups), hospitals and SNFs (Skilled Nursing Facilities). The MLTSS team offers separate more detailed training sessions on the services, eligibility criteria, and referral/approval processes. The team has been conducting an average of two trainings per month and also promotes the services during the quarterly webinars with CBAS centers and SNFs.
- MLTSS is preparing for additional CS services becoming effective 1/1/24.
  - Intermediate Care Facility For Developmentally Disabled (ICF-DD) Long-Term Care Carve-In from FFS Medi-Cal (benefits are administered by Regional Centers).
  - Nursing Facility Transitions/Diversions to Assisted Living Facilities (Transitioning members who meet program and medical criteria for transition out of LTC) and Community Transition Services/Nursing Facility Transition to a Home.

New Populations/Benefits Standardization

- MLTSS continues to prepare for the 1/1/24 effective date for members residing in Intermediate Care Facilities for the Developmentally Disabled (ICF-DD)
  - Webinar held in October with Regional Centers and ICF-DDs with 73 external participants
  - MLTSS continues to collaborate in regular workgroups with other health plans on operational process alignment for this new population.
  - LAC has provided feedback to DHCS on their proposed ICF-DD Carve-in Resource Policy Guide.
  - Syntranet updates are in progress and user acceptance testing is being set up
- Pediatric Sub-Acute Carve In 1/1/2024. Though the DHCS APL is still in draft form and pending publication, planning progresses
  - System readiness: Codes are in process of being loaded with the new heading
  - Provider readiness: working with PNM and CRM to contract all three pediatric sub-acute facilities in LA County. Drafting letter to providers.
  - Working with PNM on PCP/PPG assignment – likely to follow the methodology of other long-term care members
  - Provider training – planning in progress
  - Updating existing policies/procedures and referral forms to add Pediatric subacute as appropriate

Palliative Care

- Palliative Care SB 1004 (APLs 17-015 and 18-020) benefit is currently for full-benefit-only Medi-Cal members (excludes partial and full duals). Benefit expands to full duals in DSNP (under Medi-Cal) on 1/1/24.
- Despite steady increases, referrals and enrollment are low for this benefit, averaging around 50 per month with a current census of 224. MLTSS team is using the PPG, hospital and SNF JOMs to promote the service's benefits and availability. They will also be providing an in-service to ECM providers. Additionally, UM and CM are redirecting members ineligible for hospice for palliative care where appropriate. We are looking at ways we can use our IPRO risk stratification data to further increase referrals as the program has previously shown to positively affect utilization.

<u>Community Health</u>

Community Supports Operations & Reporting:

- CS staff worked alongside ECM team to resubmit revisions to DHCS for the Quarterly Implementation Monitoring Report (QIMR) for 2022 Q1, 2022 Q2, and 2022 Q3. Plan partner data changed and L.A. Care had more claims to support the reporting of Services Received.
- DHCS Member Information Sharing - CS staff are working with internal IT to build out the CS Authorization Status File (ASF) and prepare for processing CS Return Transmission Files (RTFs) in accordance to DHCS requirements
- Developed draft of DHCS Supplement Data Request for Q1 2023 to give them information needed to create provider payment rates

Community Supports - SyntraNet:

- CS staff outreached to Excell HCA/UpHealth to specify assistance required with ASF development, and plan for SyntraNet ingestion of RTF data.
- CS staff are continuing to work with IT and Excell HCA/UpHealth on several data discrepancies and issues on both Daily Scrum meetings and Technical CalAIM issue calls

Social Services

- Provided an in-person training at a CRC (Community Resource Center) to showcase our Community Link and engage Community Based Organizations to collaborate through our Community Link.
- Our Community Health Coordinators attended various community events and health fairs to provide information to the community about our Community Resource Centers and the Community Health Worker Benefit.
- Our Recuperative Care Staff continues to provide on-site visits to Recuperative Care Centers in our network. This last month our staff worked with our Communications Department on a success story of a homeless members that entered into permanent supportive housing out of a recuperative care center.

HHSS:

- Members Enrolled (as of 11/15/2023): 11,024 members enrolled in HHSS
- Provider Network:
    - Currently 28 contracted for HHSS: Includes 4 new providers, 15 also contracted for HD
    - January 2024 provider load: 9 new providers in process
- Provider Capacity Report:
    - Q3 2023 Quarterly Provider Staffing and Report (reported as of 9/3/2023)
        - Total: 29,063
        - DHS: 26,034
        - Non-DHS: 3,029
- Claims Needed Report: CS staff have prepared October Claims Needed Report for HHSS Providers. This report will help HHSS providers be more compliant and timely in submission of HHSS claims

HHIP:

- Metric 1.6 - Housing Equity: Awards for infrastructure/capacity and innovation
    - Max earnings: $6.9M
    - Applications are under review
- Metric 2.1 - 10% Increase from MP1 (Measurement Period 1): Relationships with SM (Street Medicine) providers to meet MP2 increase
    - Max earnings: $13.8M
    - Request for Applicant submissions received and being reviewed
- Metric 3.2 – Screening for high utilizers

  - Max earnings: $6.9M
  - Engaging with MLK and DHS: DHCS has approved partial points and we are likely to achieve the 2% threshold. Pursuing max 5%.
- Metric 3.3 – ECM enrollment: Increase ECM enrollment for HHSS eligible members from MP1 to MP2
  - Max earnings: $6.6M
  - Reporting of ECM enrollment sent to eligible HHSS providers
- Metric 3.6 – Eviction Prevention: Execute agreement for 2nd installment of funds
  - Max earnings: $13.8M
  - Investment in Mayor's Fund Eviction Prevention
  - Exploring coinciding investment in County's eviction prevention services

Street Medicine (SM):

- Development of SM network contract in progress
- SM network service structure: Developing a regional structure for service delivery based on anchor providers
- SM rates are in development
  - We are currently analyzing potential SM provider rates and exploring supplemental HHIP-funded rates for anchor providers
- Development of geo mapping of SM providers
- Conducting individual meetings with SM providers to preview proposed operational model

Pharmacy

Star Rating Metrics

- **Medication Adherence:** Our medication adherence STAR measures continue to trend higher than the same time last year. We are on track to meet our goal for CY2023.
  - Comprehensive Adherence Solutions Program (CASP): After evaluating the adherence call programs offered by Navitus and L.A. Care Pharmacy department, we have determined that our program is superior in both call connection and member engagement rates. The quality of calls made by L.A. Care Pharmacy also surpasses those of Navitus. As a result, L.A. Care Pharmacy intends to transition all adherence call efforts in-house for 2024. Pharmacy continues to pursue the implementation of Salesforce Intelligent Desktop (IDT) to further strengthen our in-house adherence call program, ultimately improving our STAR performance across 3 triple-weighted adherence measures.
  - CVS Medication Adherence Program: Launched 11/1/23.
  - Participating Physician Group (PPG) Collaboration: Pharmacy is proactively pursuing collaboration opportunities with PPGs to improve medication adherence and statin measures. We will leverage PPG clinical pharmacists to facilitate timely initiation of refills and statin therapy. Successful initial meetings have been held with Optum and Altamed.
  - Formulary Team Expanded Rejected Claim & Transition Fill Outreach: Formulary team reviews daily rejected claims and transition fill reports and conducts outreach to providers and members. Outreach is conducted to ensure appropriateness of rejections, resolve rejections, encourage utilization of preferred alternatives, and submission of coverage determinations as needed. As of 11/6/23, 388 claims identified for outreach were successfully reached by the prescriber, member, or pharmacy.

- **Medication Therapy Management (MTM) Program**: CMS requires health plans to offer MTM services to Medicare members, including an annual comprehensive medication review (CMR). Pharmacy, in collaboration with Navitus Clinical Engagement Center (MTM vendor), OutcomesMTM, and CustomHealth pilot program, achieved 73% completion rate of eligible members in 2023 Q3, a notable improvement from 2022 Q2 at 60%. Pharmacy has implemented a hybrid model with MTM vendor starting on 11/1. L.A. Care pharmacists are conducting CMRs alongside MTM vendor for additional assistance to boost CMR completion rate.

- **Care for Older Adults (COA)**: Medication reviews completed by summer interns have been reviewed by L.A. Care pharmacists and sent to STARS team for dissemination. PPGs will be educated at upcoming Joint Operations Meetings (JOMs) on how to close the gap for their members. Pharmacy is also submitting MTM comprehensive medication reviews for this measure. We are projected to achieve a 4 star rating based on the medication reviews that have already been completed by Pharmacy and Navitus (2,671 as of 10/25/2023), in addition to the number of reviews anticipated to be completed by the PPGs.

- **Statin Use in Persons with Diabetes (SUPD)/Statin Therapy for Patients with Cardiovascular Disease (SPC):** Pharmacy, in collaboration with Navitus Clinical Engagement Center, has launched a new provider-facing intervention in late-September 2023. Pharmacy is also collaborating with PPGs to facilitate appropriate initiation of statin therapy. Outcomes will be provided in future reports.

California Right Meds Collaborative (CRMC)

- CRMC is an initiative with USC to establish a network of community pharmacies that provide comprehensive medication management (CMM) to members with chronic diseases, such as diabetes and cardiovascular disease. As of October 2023, an average A1c reduction of 2.7% from an A1c baseline of 11.5% is observed in patients who complete at least 5 visits with a pharmacist. In addition, an average reduction in systolic blood pressure (SBP) of 18.4 in patients with baseline blood pressure >140/90 mmHg with 3 or more visits with the pharmacist.
- Multiple CRMC pharmacies have submitted interest forms to contract with LA Care for the Community Health Worker (CHW) benefit to expand current services.

Clinical Pharmacy Pilot Program (Ambulatory Care)

- A clinical pharmacist participates as part of the healthcare team once weekly at various FQHCs to improve medication use and safety for L.A. Care members with uncontrolled diabetes and/or uncontrolled hypertension.
- Clinical pharmacist will also be assisting in closing out gaps for COA Medication Review and Transitions of Care (TRC) for DSNP members.
- Current clinics include Wilmington Community Clinic and Harbor Community Clinic.

Community Resource Center (CRC) Flu Clinics

- Pharmacy in collaboration with Health Education, CRC leadership, and North Star Alliances planned and hosted 10 successful flu clinics. USC Medical Plaza Pharmacy offered health screenings (blood pressure and blood glucose), in addition to flu and COVID vaccines. All Pharmacy Team members have volunteered to attend ≥2 events. The number of vaccines and health screenings administered are listed below:
    - Flu shots administered: 1,061

- COVID shots administered: 347
- Members with either blood pressure or blood glucose health screening: 56
- Members with both health screenings: 798

Quality Improvement

Executive Summary

- NCQA Health Plan Accreditation Survey results have been received. L.A. Care's status is **Accredited** for Medicaid and Medicare. Our Exchange line of business is Accredited, but under a Corrective Action Plan requiring a written response within 30 days and onsite survey in May 2024.
- A Direct Network Physician Advisory Collaborative meeting was held in September.
- The first Provider Engagement Event was held successfully at the Lynwood CRC on 10/26/23.
- DHCS Equity and Practice Transformation (EPT) Grant announced that 133 practices have selected LA Care as their managed care plan. This includes 83 small/medium-sized independent practices and 50 FQHCs. We are now reviewing these applicants to submit our concurrence for their participation in EPT to DHCS.

Health Education & Cultural Linguistic Services (HECLS)

- Maternal health texting campaigns, PPC1 (Prenatal), and PPC2 (Post-partum) received the Activate 2023 Award for Achieving Health Equity from mPulse at their annual conference. The two campaigns were recognized for content, strong member engagement, and successful results.
- Multimodal Fight the Flu campaign activities underway: texting campaign launched on 9/22 with 439,027 members enrolled in the flu texting campaign. Additionally, end-of-call flu script, flu postcards, social media campaign, automated flu message, newsletter articles, provider email, and fax blast are additional initiatives in flight.
- The Diabetes Prevention Program (DPP) under the new vendor (Diabetes Care Partners) reached highest enrollment to date with 197 members enrolled in FY 22-23. This was a 42% increase from FY 21-22 under the previous vendor Solera, and the highest number of members (n=46) who achieved a weight loss goal of at least 5% reduction in body weight.
- Meals As Medicine program has completed most activities related to the Medically Tailored Meals DHCS-required alignment within MCPs. This includes eligibility criteria expansion and documentation uniformity. New criteria going into effect on 1/1/2024 will add an extensive list of diet responsive conditions to the current eligible conditions and eliminate any age restrictions.
- First Pediatric Healthy Lifestyle program for ages 6 to 13 years were completed at Lynwood CRC with seven initial participants and five who completed the three-session pilot. The program is expanding to Inglewood, Metro and El Monte CRCs with the support of Registered Dietitians.
- Three trainings on "Writing in Plain Language and Readability using Health Literacy Advisor" were conducted during the months of October and November with approximately 180 participants. These trainings aim to train and educate staff from departments that develop member letters and materials.
- The Adult Weight Management program, a six week skills based series of workshops, will be piloted at the Inglewood CRC in January. Efforts are underway to expand to other CRCs and develop a virtual option.

Initiatives

- The Managed Care Accountability Set (MSCAS) Performance and Sanctions:-DHCS recently released their new methodology for determining sanctions. The new methodology takes into consideration state and regional benchmarks along with national benchmarks. Based on this new methodology, L.A. Care is

in the Green Tier and has no financial sanction for Measurement Year (MY) 2022. L.A. Care will need to complete one project due to low performance in the Child Health domain.

- The Department of Health Care Services also released new benchmarks for the MY 2023 MCAS. While some benchmarks were lowered, some increased substantially such as the Follow-Up After Emergency Department Visit for Mental Illness (FUA) 30-Day Follow-Up. This increases the total number of measures at risk to meet the minimum performance level (MPL) to eight measures.
- The at-home test kit contract with ixLayer was accelerated, signed, and executed on 10/13/2023. Plans are underway to mail out the test kits in December. Notification to providers is scheduled to go out mid-November through various channels to ensure that providers are aware of this new resource for members.
- Clinical initiatives team hosted "Q4 push" meetings to discuss specific interventions and measures that L.A. Care will be focused on through the remainder of year. The team is also supporting discussions with Participating Provider Groups (PPGs) on their efforts to close out the measurement year.
- A chase list of noncompliant members for specific measures (BCS, CIS, LSC, CBP, COA, EED, HBC >9%, W30) was curated for each PPG to support closing gaps and distributed on October 13, 2023 with requests for follow-up. Additionally, initiatives shared W30 and CIS incentive program information along with a list of eligible members for PPGs to outreach. Meetings were conducted with: AltaMed Health Services, Allied Pacific IPA, Optum Care Network/Apple Care Select, Community Family Care, Exceptional Care Medical Group, Global Care IPA, Health Care LA IPA, Prospect, and Preferred.
- Retinal-Eye Exam (EED) outreach conducted by Vision Service Plan continues. A Q4 priority is to focus on Dual Eligible Special Needs Plan (D-SNP) populations. Member outreach (04/03/23-08/10/23) statistics are as follows: 2,259 MCLA members, 400 members scheduled to date, 181 gaps closed. Provider outreach (04/08/2023-08/10/2013) statistics are as follows: 17,123 noncompliant members sent to assigned eye-care providers, 3,650 gaps closed.
- All seven text messaging campaigns to improve preventive care are now live:
    - **Comprehensive Diabetes Care (CDC)**
    - **Well-Child Visits in the First 30 Months of Life (W30A&B)**
    - **Adults Access to Preventive and Ambulatory Care (AAP)**
    - **Colorectal Cancer Screening (COL)**
    - **Controlling Blood Pressure (CBP)**
    - **Breast Cancer Screening (BCS)**

Quality Improvement- Practice Transformation Programs

First 5LA/HMG LA

- Cohort 1 practices (APHCV + Kids & Teens MCG) are screening 51.9% of our members aged 0-5 years old, realizing a 38% increase in screenings over baseline (14%) through September.
- Cohort 2 practices (T.H.E., Bartz-Altadonna, Palmdale Pediatrics, and White Memorial CMC) have generated a 12.6% increase over baseline for completed screenings through September.
- Completed 50 out of 60 early childhood development classes for members through November.

Transform L.A.-Direct Network

- Current program enrollment: 19 practices, 102 providers, 12,095 DN members (29% of total DN members).
- One new practice has enrolled in the program.
- A1C <9%: 7% improvement over baseline and Controlling Blood Pressure: 10% improvement over baseline

EQuIP LA – Direct Network

- Baseline data for four practices have been successfully submitted. Practices have completed their baseline assessments of quality improvement capabilities. Development of health equity based program goals under way.

Equity & Practice Transformation Payments Program

- Enrollment has concluded. Total number of practices that selected LA Care: 133: 83 small/medium sized independent practices and 50 FQHCs/look-alikes/large practices. Exceeded enrollment goal (60) by 122%.
- A review of applications is underway.

Provider Quality Review (PQR)/Potential Quality of Care Issues (PQI)

- **Total PQI Reviewed**
  - FY 2022/2023 (October 2022 - September 2023) the PQR team reviewed and closed 7,337 cases. 2,165 (30%) were classified as duplicates or triage zero, meaning that they did not meet the PQI referral criteria. The remaining 5,172 cases were reviewed for quality of care or service issues. 339 had actions taken to address the PQI findings. The PQI actions included communication to inform provider of quality review findings (no response required), provider response required for quality review findings, and corrective action plans required for quality review findings. As of April 2023, the monthly rate for timely closure has averaged above 99%.

- **Aging PQI Cases:** As of October 31st, 2023, there were 3,734 cases open. 3,358 cases in green (0-151 days), 300 cases in yellow (152-183 days), 75 cases in orange (184-213 days), and one case entered the untimely aging category of 214+ days.

- **PQR – Critical Incident (CI) Reporting**
  - The PQR department is currently undertaking the reinstatement of Critical Incident (CI) Reporting. Under the new guidelines from DHCS, Critical Incident reporting will now include DSNP and MCLA members. The team is consulting Compliance and Legal team to understand regulatory reporting to ensure we require the impacted facilities to report CI. We will finalize the requirement and P&P by 11/20/2023.

- **PQR – Staffing Updates**
  PQI referrals remain high. A&G and PQR leadership continue to work together to enhance the end-to-end process. Meanwhile, the PQR team staff up to ensure timely processing of referrals. As of November 6, 2023, all approved positions are filled.

Accreditation

National Committee for Quality Assurance (NCQA): Health Plan Accreditation

L.A. Care's status is **Accredited** for Medicaid and Medicare. Our Exchange line of business is **Accredited** but under a Corrective Action Plan requiring a written response within 30 days and onsite survey in May 2024.

CATEGORY SCORING THRESHOLDS

STANDARD CATEGORY	CATEGORY RESULT	POINTS RECEIVED AND PERCENTAGE	TOTAL APPLICABLE POINTS (TOTAL POSSIBLE)	≥80% THRESHOLD POINTS (ACCREDITED)	< 80% - ≥ 55% THRESHOLD POINTS (PROVISIONAL)	< 55% THRESHOLD POINTS (DENIED)	MUST-PASS REQUIREMENTS
QI - Quality Management and Improvement	ACCREDITED	14.00 (82.35 %)	17.00	13.60	9.35	9.18	
PHM - Population Health Management	ACCREDITED	18.00 (85.71 %)	21.00	16.80	11.55	11.34	
NET - Network Management	ACCREDITED	28.00 (100.00 %)	28.00	22.40	15.40	15.12	
UM - Utilization Management	ACCREDITED	43.50 (94.57 %)	46.00	36.80	25.30	24.84	1 Failed Must-Pass Elements
CR - Credentialing	ACCREDITED	17.00 (100.00 %)	17.00	13.60	9.35	9.18	0 Failed Must-Pass Elements
ME - Member Experience	ACCREDITED	26.00 (100.00 %)	26.00	20.80	14.30	14.04	

- The CAP is for **UM 7B: Written Notification of Nonbehavioral Healthcare Denials**. During the file review, 15 out of the 30 files did not include a statement that members and their treating physicians can obtain a copy of the actual benefit provision, guideline, protocol, or other similar criterion on which the denial decision was based.
    - Please note, this letter was corrected and implemented prior to the survey. However, half of the selected files were for dates prior to the issue being corrected.
    - Next Steps: QI will coordinate CAP completion with EPO and our consultants. The CAP response due date is December 3, 2023.
        - QI will also coordinate a mock file review by our consultants in February 2024 in preparation for the CAP survey.

- **Discretionary Review – UM 13 Elements C: Review of UM Program and D: Opportunities for Improvement**
    - Part of the evidence for the DHS discretionary survey did not meet all standards and will therefore also be included in the CAP survey.
    - Next Steps: QI will coordinate an **internal CAP** completion with EPO and our consultants.
        - QI will also coordinate a mock file review by our consultants in February 2024 as preparation for the CAP survey.

- **Near Misses:**
    - The requirements for the elements listed below were not fully met, although similar evidence was accepted in a prior survey. A one-time exception was granted and full points have been awarded for this survey only. Compliance will be evaluated during our next survey in 2026. Regardless, QI is actively working with the accountable business units on completing an **internal CAP** to ensure these gaps are addressed.

Health Equity Accreditation (HEA)

- NCQA survey submission will be 12/5/2023.

- Health Equity Evidence Updates
    - The minimum passing score to achieve accreditation is 80%
        - QI Accreditation estimates a **worst-case scenario score of 84%** once all evidence is reviewed
    - The survey holds 2 critical (must pass) factors.
        - We have no concerns about meeting requirements for either of these elements.

- HE 7 Standard: Delegation of Health Equity Activities
    - NCQA Selected Delegates:
        - Anthem: HEA Accredited, however, still pending agreement
        - Teladoc: Pending discussion
        - Carelon: Pending response
        - Liberty: Agreed to delegation

Access to Care

- MY2022: CAP responses- 32 of 33 received. Past-due follow-up notifications have been sent to the remaining provider groups. DHS Pending CAP submission
    - DHS reached out to L.A. Care on 9/8 concerning appointment availability survey and corrective action plan concerns. DHS has shared five areas of concern. Investigation of concerns have resulted in a minor edit to DHS's report card and CAP regarding PCP routine and urgent appointments.
    - All other issues were related to provider contact list issues which have been resolved for MY2023
    - QI Accreditation is finalizing follow-up communication with DHS.

STARS/HEDIS

- MY2023 performance continues to project to 3.0 (rounding down). Most HEDIS measure performance is still projected to perform lower year over year. The overall performance is projected to improve from a 2.44 to 2.94 despite substantial increases in cut-points. Both the Operations and Pharmacy measure performance are performing higher with overall domain performance improving from 2.28 to 2.96 (Operations) and from 2.31 to 2.85 (Pharmacy) despite huge increases in cut-points.
- HEDIS Q4 recovery effort continues which includes 1) reconciliation between PPG performance tracking vs. LAC received encounter information; 2) review of PPG Q4 improvement plans and areas LAC can assist and 3) review of supplemental data submission (and potential under-submissions).
- For the High Touch HEDIS Outreach RFP, AdhereHealth was selected as the vendor of choice. The contract is currently in redline review between L.A. Care legal and AdhereHealth Legal with the goal to have the contract approved prior to 12/31/23 and implementation kicking off early Q1 2024.

Surveys: (CAHPS (Consumer Assessment of Healthcare Providers and Systems)/HOS (Healthcare Outcomes Survey)/QHP (Quality Health Plan)/Off Season

- Surveys were deployed late September/October 2023
    - MAPD(Medicare Advantage Part D)/HOS Offseason
    - TAR (Timely Access Reporting) QHP Offseason (LACC(Covered CA) population)
    - LACC-D (Direct)
    - PASC (Personal Assistance Services Council) (Using Commercial CAHPS survey – in anticipation of potential accreditation decision in the future)
    - Provider Satisfaction Survey (PSS)
- Identify methods for improving member services and experience for this composite to count positively towards CAHPS performance
    - Identify consistently poor performing providers
    - Identify consistently poor performing office locations
    - Identify lower rated PCPs

Population Health Management (PHM)

- For Enterprise Goals, the PHM team is tracking the 2022-2023 PHM index and is currently on track to meet the mid-goal, with 13/16 of the goals met for at least one line of business.
- The 2023-2024 PHMI is in development and work is in progress across the enterprise to update goals for the next cycle.
- The PHM team will develop the 2023 PHM Program Description in Q4 2023 and will include the CalAIM requirements.
- CalAIM Strategy document was submitted to Compliance and will be passed forward to DHCS.
- L.A. Care submitted the CalAIM Key Performance Indicators (KPIs) report to DHCS.

Initial Health Assessment (IHA) transitioning to Initial Health Appointment

- The QI-047 IHA Policy and all related materials have been updated per APL 22-030.
- Further IHA provider training is in development.
- The IHA workgroup has drafted documentation on root causes of poor IHA completion rates and has created a corrective action plan (CAP). Next steps include enhancing reporting and monitoring tools, and strengthening the PPG accountability process.
- All Network Providers (PPG and Direct Network) have access to monthly IHA due reports on the provider portal to support IHA completion for members within 120 days of enrollment. Soon they will also receive monthly (currently quarterly) reporting on members who have not had their IHA.

Annual Cognitive Health Assessment (ACHA) APL 22-025

- The Policy for APL 22-025 developed by the PHM team and approved by DHCS will go to QOC for internal approval in November after the process is more established.
- DHCS is sending the reports on providers completing the Dementia Aware training and L.A. Care has notified all providers of the new APL requirements.

Facility Site Review (FSR)

- The total Public Health Emergency (PHE) related backlog spanning 3/15/2020-12/31/2021 is now down to **20**. To date **377** audits have been completed from the backlog.
- In Q3 2023, **6** FSR/MRR audits were conducted and completed from the backlog.
- L.A. Care FSR is working with the LA County Collaborative (According to APL 22-017, all health plans operating in the LA County area must collaborate to establish systems and implement procedures for the coordination, consolidation, and data sharing of site reviews for mutually contracted PCPs. All health plans within a county have equal responsibility and accountability for participation in the site review collaborative processes) on the FSR/MRR backlog audits to be completed by 12/31/2023.
- FSR is working with the LA County Collaborative on a combined mobile unit tool and condensed street medicine tool. All MCP's are currently piloting this tool. Feedback still pending.

Population Health Informatics

Health Information Management (HIM) Analytics

- The Population Health Assessment, which is a document submitted to NCQA annually showing the different health profiles of LA Care (Member Demographics, Utilization Rates, Top Diagnoses, etc.) has begun and is on track to be completed in early January 2024.
- Preliminary data research is being conducted for the upcoming SNF and Hospital Incentive Programs and the availability and usability of each measures' rates from publically available data sources (such as Nursing Home Compare) are being evaluated.
- Continued development of the Hospital Performance Dashboard is ongoing. This Dashboard is updated on an annual basis (may change to quarterly) which reports the performance of Hospitals

based on CMS quality metrics. This Dashboard is used by various teams when meeting with Hospitals.

- The first phase of a new STARS Dashboard has been published. HIM is working alongside the STARS Team for phase 2 which will include Operations and Member Experience metrics. Discussions are also in progress to develop a LACC Dashboard for MY 2024.
- A Social Determinants of Health/Initial Health Assessment/Health Information Exchange Report is currently being developed to distribute to PPGs that will inform provider groups of their performance in these three domains. This report will be distributed quarterly.
- Given the recent spike in COVID cases, HIM has been tasked with ingesting all available vaccination data streams to identify the uptake of vaccine boosters in the L.A. Care population. The ingestion code has been completed and will be run on a monthly basis.
- HIM continues analytic support for Annual Cognitive Health Screening and IHAs for elderly and new members.
- HIM continues its analytic work on the CalAIM project. Measures are currently being developed which monitor PCP visits and ambulatory care.
- HIM is working alongside Community Health to identify the homeless population with greater accuracy for the HHIP program.

Health Information Exchange Ecosystem (HIEc)

- L.A. Care is revising the Hospital Services Agreement (HSA) to mandate hospital participation in Health Information Exchanges (HIEs). This revision will enforce compliance with CMS 9115 standards for Hospital ADT notifications and require participation in the CalHHS Data Exchange Framework (DXF).
- A similar directive is underway for Skilled Nursing Facilities (SNFs), obligating them to engage in DXF and facilitate information exchange with HIEs.
- Effective January 1, 2024, involvement in Health Information Exchanges (HIEs) will become part of the Hospital Pay-for-Performance (P4P) program. Hospitals will be eligible for incentives upon achieving set milestones in HIE participation.
- Likewise, beginning January 1, 2024, Skilled Nursing Facilities' (SNFs) engagement in HIEs will be incorporated into SNF Pay-for-Performance (P4P) program, offering incentives for SNFs that reach specific HIE participation milestones.
- Edifecs has been selected as the Clinical Data Repository (CDR) vendor, tasked with managing real-time ADT data ingestion via FHIR from LANES and CMT.
- The One-Time HIE Adoption Incentive Program has been successfully launched, offering incentives from October 1, 2023, to September 30, 2026, for providers, particularly aimed at FQHCs and small or solo group providers, to enhance HIE adoption and DXF participation.
- The California Health and Human Services Agency (CalHHS) has designated LANES as a Qualified Health Information Organization (QHIO). In this capacity, LANES is set to serve as the QHIO for L.A. Care and is actively working on the implementation of the Data Exchange Framework (DXF) to enable the exchange of health and social services information in alignment with the established DXF policies and procedures.

Incentives

- Final 2022 HEDIS and other domain data are being processed for use in the P4P Programs. We are aiming to complete all six program reports and payments between Thanksgiving and Christmas.

- The 2023 Update Action Plans have been sent to L.A. Care from the PPGs. L.A. Care and Plan Partner subject matter experts have provided feedback on the PPG projects. Final action plan results are expected from the PPGs in January 2024.
- A new Hospital P4P Program is close to being finalized. The program will be previewed with hospital leadership in November/December. The goal is to launch the program in January 2024.
- A new SNF P4P Program is close to being finalized. The program will be previewed with SNF leadership in November/December. The goal is to launch the program in January 2024.
- 2023 Provider Opportunity Report (POR)/Gap in Care (GIC) reports are being produced monthly. Plans for report enhancements are under way alongside efforts towards more effective use of the Cozeva platform.

MOTIONS FOR CONSIDERATION

Board of Governors
MOTION SUMMARY

Date: December 7, 2023 **Motion No. BOG 101.1223**

Committee: **Chairperson:** Al Ballesteros

Requesting Department: Information Technology / Appeals & Grievances

Issue: To execute a contract with Hyland (i3/Kiriworks) to provide Appeals & Grievances (A&G) solution and QNXT FAX Ingestion/Hyland Intelligent Document Processing platform.

☒ **New Contract** ☐ **Amendment** ☐ **Sole Source** ☒ **RFP/RFQ was conducted in** July 2023

Background: L.A. Care staff requests approval to execute a contract with Hyland (i3/Kiriworks) from January 1, 2024 to December 31, 2026 in an amount not to exceed $2,699,118. The vendor will provide:

1. Appeals & Grievances (A&G) solution platform, which will replace the existing PCT platform provided by EJA. This will enable L.A. Care business unit to automate A&G workflows, enhance letters configuration and reporting and enable case intake from various systems. Additionally, the platform will include Department of Managed Health Care (DMHC), Department of Health Care Services (DHCS) and Centers for Medicaid and Medicare Services (CMS) requirements and will automate this creation, file transfer and increase efficiency of information lookup. L.A. Care requires these services because they improve productivity and monitoring of the review process and will reduce chances of information between teams being delayed, lost, or having incongruent data.
2. QNXT FAX Ingestion/Hyland Intelligent Document Processing platform.

A competitive request for proposal process was conducted in July 2023. Six vendors responded to the request, and Hyland was selected because of their strong technical fit, having the strongest A&G solution and meeting L.A. Care business needs. Hyland partners with i3/Kiriworks content services platform OnBase, which allows them to offer streamlined workflows and seamless document management.

1. A&G Implementation (one-time fee) 2. QNXT/FAX Ingestion (one-time fee)	$412,225 $216,750
QNXT FAX Ingestion/Hyland Intelligent Document Processing platform licenses	$2,070,143

Member Impact: The A&G services and the QNXT/FAX Ingestion capabilities for UM purchased under this contract will improve L.A. Care's turnaround response time to members concerns and result in improved member satisfaction.

Budget Impact: The cost was anticipated and included in the approved budget for the IT Department in this fiscal year. Staff will budget the balance in future fiscal years.

Motion: **To authorize staff to execute a contract with Hyland (i3/Kiriworks) in an amount not exceed $2,699,118 to provide Appeals & Grievances (A&G) services and QNXT FAX Ingestion/Hyland Intelligent Document Processing platform for the period of January 1, 2024 to December 31, 2026.**

Board of Governors
MOTION SUMMARY

Date: December 7, 2023 **Motion No. BOG 102.1223**

Committee: **Chairperson: Al Ballesteros**

Issue: To amend contracts with SAP America to continue to provide cloud services to support L.A. Care in the following services: Premium Billing, Claims/Capitation payments, Budget/Forecast, Financial Reporting, Contracts, Sourcing and Enterprise Resource Planning (ERP).

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

Background: L.A. Care staff previously received approval in 2018 to execute contracts with SAP America for $8.2 million to provide cloud services to support Finance Services core functions. SAP currently provides L.A. Care with the following services:

- S4/HANA Financial Services-Collections and Disbursements (FSCD) - Billing/Collections – Payment Disbursements
- S4/HANA Enterprise Edition ERP
- S4/HANA Analytics Cloud (SAC) – Budget/Forecast/Reporting
- SAP Ariba Contracts
- SAP Ariba Supplier Risks and Sourcing
- SAP Data Services, Process Orchestration

L.A. Care staff is requesting approval to amend contracts to add funds and extend time with SAP America for continued services which support activities including LACC/ Members Billing, Claims (providers) & Cap (PPG & plan partners) payments, Medical and Medicare revenue calculations, General Ledgers, Procurement, Accounts Payable and Financial Reporting and other accounting related functions.

Services	Amount	Amendment	New Total	Term Date
SAP Hana/Ariba Cloud Services	$5,101,368	$3,176,000	$8,277,368	12/31/2026
SAP License & Support	$3,087,000	$970,200	$4,057,200	12/31/2026
Total	**$8,188,368**	**$4,146,200**	**$12,334,568**	

L.A. Care has used this vendor since 2019 and their applications and services are meeting expectations and compliance requirements. The Finance Department relies on SAP HANA Cloud for the majority of their functions.

Member Impact: L.A. Care members will benefit from this motion, as L.A. Care relies on SAP HANA Cloud to correctly bill and process payments for LACC members. SAP also is the foundation for the Member Payment Application (MPAL). Members (LACC) utilize MPAL to make payments and view the payment history as well as an overview of their health plan.

Budget Impact: The cost was anticipated and included in the approved budget for the IT Department in this fiscal year. Staff will budget the balance in future fiscal years.

Motion: **To authorize staff to amend contracts to increase funds in the amount of $4,146,200 for a new total not to exceed amount of $12,334,568 with SAP America to provide cloud services through December 31, 2026.**

Board of Governors
MOTION SUMMARY

Date: December 7, 2023 **Motion No. BOG 103.1223**

Committee: **Chairperson: Ballesteros**

Issue: Staff requests the Board of Governors' approval of the following attached Amendments to the Plan Partner Services Agreements (PPSA):

(1) Amendments which consist of the 2022 National Committee for Quality Assurance delegation standards for Blue Shield Promise Health Plan (Amendment No. 58) and Kaiser Foundation Health Plan (Amendment No. 47) (the amendment for Anthem Blue Cross is still pending).

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

Background: The delegation standards exhibit of the PPSA is being revised to incorporate 2022 National Committee for Quality Assurance criteria.

Member Impact: This action will not directly affect L.A. Care members.

Budget Impact: None (already factored into the relevant budget).

Motion:

(1) To approve Amendment No. 57 and Amendment No. 46 to the Plan Partner Services Agreements which update the 2022 National Committee for Quality Assurance delegation standards for Blue Shield Promise Health Plan and Kaiser Foundation Health Plan, respectively, and to authorize the Chief Executive Officer, or his designate, to execute such amendments and to authorize staff to make non-substantive revisions to the amendments.

Amendment No. 58
to
Services Agreement
between
Local Initiative Health Authority for Los Angeles County
and
Blue Shield of California Promise Health Plan

This Amendment No. 58 is effective as of July 1, 2022, as indicated herein by and between the Local Initiative Health Authority for Los Angeles County, a local public agency operating as L.A. Care Health Plan ("Local Initiative") and ***Blue Shield of California Promise Health Plan***, a California health care service plan ("Plan").

RECITALS

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

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

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

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

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

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

IN WITNESS WHEREOF, the parties have entered into this Amendment No. 58 as of the date set forth below.

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

By: _____
John Baackes
Chief Executive Officer

Date: _____, 2023

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

By: _____
Kristen Cerf
President and Chief Executive Officer

Date: _____, 2023

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

Date: _____, 2023

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

Exhibit 8
Delegation Agreement
[Attachment A]

Delegated Activities Effective July 1, 2022-June 30, 2023
Responsibilities of Plan and Local Initiative

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

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

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

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

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

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

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

Standard	Delegated Activities	Retained by L.A. Care
	4. How member programs are coordinated. 5. How members are informed about available PHM programs. 6. How the organization promotes health equity. **<u>CalAIM Program Strategy</u>** Delegates must complete DHCS required annual strategy documents and share with L.A. Care for review. **<u>NCQA Informing Members</u>** The organization informs members eligible for programs that include interactive contact: 1. How members become eligible to participate 2. How to use program services. 3. How to opt in or opt out of the program	activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care. L.A. Care to coordinate collaborative shared SMART goal development included in all delegates' CalAIM Strategy submission.
Population Identification (NCQA PHM 2)	**<u>NCQA Data Integration</u>** The organization integrates the following data to use for population health management functions: 1. Medical and Behavioral claims or encounters 2. Pharmacy claim 3. Laboratory results 4. Health appraisal results 5. Electronic health records 6. Health Services programs within the organization 7. Advanced data sources **<u>NCQA Population Assessment</u>** The organization annually: 1. Assesses the characteristics and needs, including social determinants of health, of its member population. 2. Assesses the needs of child and adolescent members. 3. Assesses the needs of members with disabilities. 4. Assesses the needs of members with serious and persistent mental illness (SPMI). 5. Assesses the needs of members of racial or ethnic groups. 6. Assesses the needs of members with limited English proficiency. 7. Identifies and assesses the needs of relevant member subpopulations. **<u>CalAIM Population Needs Assessment</u>** The organization every three years completes the Population Needs Assessment per the DHCS requirements as detailed in APL 23-021. **<u>Activities and Resources</u>**	

Standard	Delegated Activities	Retained by L.A. Care
	The organization annually uses the population assessment to: 1. Review and update its PHM activities to address member needs 2. Review and update its PHM resources to address member need 3. Review and update activities or resources to address health care disparities for at least one identified population. 4. Review community resources for integration into program offerings to address member needs. **Segmentation** At least annually, the organization segments or stratifies its entire population into subsets for targeted intervention: 1. Segments or stratifies its entire population into subset for targeted intervention. 2. Assesses for racial bias in its segmentation or stratification methodology.	
Delivery System Supports (NCQA PHM 3)	**Practitioner or Provider Support** The organization supports practitioners or providers in its network to achieve population health management goals by: 1. Sharing data 2. Offering evidence-based or certified shared-decision making aids 3. Providing practice transformation support to primary care practitioners 4. Providing comparative quality information on selected specialties 5. Providing comparative pricing information for selected services 6. Providing training on equity, cultural competency, bias, diversity or inclusion	**Value-Based Payment Arrangements** The organization demonstrates that it has a value-based payment (VBP) arrangement(s) and reports the percentages of total payments tied to VBP.
Wellness and Prevention (NCQA PHM 4)	**Frequency of Health Appraisal Completion** This standard is required for the first survey under NCQA guidelines. Plans are still required to maintain compliance with this standard. NCQA only removed this requirement to submit documentation for renewal surveys. The organization has the capability to administer a health appraisal (HA) annually. **Topics of Self-Management Tools** The organization offers self-management tools derived from available evidence, that provide members with information on at least the following wellness and health promotion areas: 1. Healthy weight (BMI) maintenance. 2. Smoking and tobacco use cessation.	

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

Standard	Delegated Activities	Retained by L.A. Care
	12. Development of an individualized case management plan, including prioritized goals and considers member and caregiver goals, preferences and desired level of involvement in the case management plan 13. Identification of barriers to the member meeting goals or complying with the case management plan 14. Facilitation of member referrals to resources and follow-up process to determine whether members act on referral 15. Development of a schedule for follow-up and communication with the member 16. Development and communication of self-management plans. 17. A process to assess members' progress against case management plans. **Initial Assessment** An NCQA review of a sample of the organization's complex case management files demonstrates that the organization follows its documented processes for completing the following within 60 calendar days: 1. Initial assessment of members' health status, including condition-specific issues 2. Documentation of clinical history, including medications 3. Initial assessment of activities of daily living (ADL) 4. Initial assessment of behavioral health status, including cognitive functions 5. Initial assessment of social determinants of health 6. Evaluation of cultural and linguistic needs, preferences or limitations 7. Evaluation of visual and hearing needs, preferences or limitations 8. Evaluation of caregiver resources and involvement 9. Evaluation of available benefits 10. Evaluation of available community resources 11. Assessment of life planning activities. 12. Beginning the assessment for at least one factor within 30 calendar days of identifying a member for complex case management. **Case Management Ongoing Management** The NCQA review of a sample of the organization's case management files that demonstrates the Plan Partner follows its documented processes for: 1. Development of case management plans, including prioritized goals, that take into account member and caregiver goals, preferences and desired level	

Standard	Delegated Activities	Retained by L.A. Care
	of involvement in the complex case management program 2. Identification of barriers to meeting goals and complying with the case management plan 3. Development of a schedule for follow-up and communication with members. 4. Development and communication of member self-management plans. 5. Assessment of progress against case management plans and goals and modification as needed.	
Population Health Management Impact (NCQA PHM 6)	**Measuring Effectiveness** At least annually, the organization conducts a comprehensive analysis of the impact of its PHM strategy that includes the following: 1. Quantitative results for relevant clinical, cost/utilization and experience measures. 2. Comparison of results with a benchmark or goal. 3. Interpretation of results. **Improvement and Action** The organization uses results from the PHM impact analysis to annually: 1. Identify opportunities for improvement. 2. Act on one opportunity for improvement.	
Sub-Delegation of PHM (NCQA PHM 7)	**Sub-Delegation Agreement** **(LAC will ask Delegate of its sub-delegate during the annual audit)** The written sub-delegation agreement: 1. Is mutually agreed upon 2. Describes the sub-delegated activities and the responsibilities of the delegate and the sub-delegated entity 3. Requires at least semiannual reporting by the sub-delegated entity to the delegate 4. Describes the process by which the delegate evaluates the sub-delegated entity's performance 5. Describes the process for providing member experience and clinical performance data to its delegates when requested. 6. Describes the remedies available to the delegate if the sub-delegated entity does not fulfill its obligations, including revocation of the sub-delegation agreement **Predelegation Evaluation** For new sub-delegation agreements initiated in the look-back period, the delegated entity evaluates sub-delegate capacity to meet NCQA requirements before sub-delegation begins.	

Standard	Delegated Activities	Retained by L.A. Care
	Review of PHM Program For arrangements in effect for 12 months or longer, the delegate: 1. Annually reviews its sub-delegate's PHM program 2. Annually audits complex case management files against NCQA standards for each year that sub-delegation has been in effect, if applicable 3. Annually evaluates sub-delegate performance against NCQA standards for sub-delegated activities 4. Semiannually evaluates regular reports, as specified in the sub-delegation agreement **Opportunities for Improvement** For sub-delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that sub-delegation has been in effect, the delegate identified and followed up on opportunities for improvement, if applicable.	
	NETWORK MANAGEMENT	
Availability of Practitioners (NCQA NET 1)	**Cultural Needs and Preferences** The organization annually: 1. Assessing the cultural, ethnic, racial, and linguistic needs of members 2. Adjusts the availability of practitioners within its network if necessary. **Practitioners Providing Primary Care** To evaluate the availability of practitioners who provide primary care services, including general medicine or family practice, internal medicine and pediatrics, the organization: 1. Establishes measurable standards for the number of each type of practitioners providing primary care 2. Establishes measurable standards for the geographic distribution of each type of practitioner providing primary care. 3. Annually analyzes performance against the standards for the number of each type of practitioner providing primary care 4. Annually analyzes performance against the standards for the geographic distribution of each type of practitioner providing primary care. **Practitioners Providing Specialty Care** To evaluate the availability of specialists in its delivery system, the organization: 1. Defines the types of high-volume and high-impact specialists	

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

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

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

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

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

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

Standard	Delegated Activities	Retained by L.A. Care
	3. Has written policies for applying the criteria based on an assessment of the local delivery system 4. Involves appropriate practitioners in developing, adopting and reviewing criteria. 5. Annually reviews UM criteria and the procedures for applying them and updating them, and updates the criteria when appropriate. **Availability of Criteria** The organization: 1. States in writing how practitioners can obtain the UM criteria 2. Makes the criteria available to practitioners upon request. **Consistency in Applying Criteria** At least annually, the organization: 1. Evaluates the consistency with which health care professionals involved in UM apply criteria in decision making 2. Acts on opportunities to improve consistency, if applicable.	activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.
Communication Services (NCQA UM 3)	**Access to Staff** The organization provides the following communication services for members and practitioners: 1. Staff are available at least eight (8) hours a day during normal business hours for inbound collect or toll-free calls regarding UM issues 2. Staff can receive inbound communication regarding UM issues after normal business hours 3. Staff are identified by name, title, and organization name when initiating or returning calls regarding UM issues 4. TDD/TTY services for members who need them 5. Language assistance for members to discuss UM issues.	
Appropriate Professionals (NCQA UM 4)	**Licensed health Professionals** The organization has written procedures: 1. Requiring appropriately licensed professionals to supervise all medical necessity decisions 2. Specifying the type of personnel responsible for each level of UM decision-making. **Use of Practitioners for UM Decisions** The organization has a written job description with qualifications for practitioners who review denials of care based on medical necessity. Practitioners are required to have: 1. Education, training and professional experience in medical or clinical practice	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

Standard	Delegated Activities	Retained by L.A. Care
	2. A current clincial license to practice or an administrative license to review UM cases without restriction. **Practitioner Review of Nonbehavioral healthcare Denials** The organization uses a physician, or other healthcare professional as appropriate, reviews any non-behavioral healthcare denial of coverage based on medical necessity. **Practitioner Review of Behavioral Healthcare Denials** The organization uses that a physician or appropriate behavioral healthcare practitioner, to review any behavioral healthcare denial of care based on medical necessity. **Practitioner Review of Pharmacy Denials** The organization uses a physician or a pharmacist reviews pharmacy denials based on medical necessity. Note: This only applies to pharmaceuticals (Physician Administered Drugs) covered under the medical benefit. **Use of Board Certified Consultants** The organization: 1. Has written procedures for using board certified consultants to assist in making medical necessity determinations 2. Provides evidence that it uses board-certified consultants for medical necessity determinations	
Timeliness of UM Decisions (NCQA UM 5)	**Notification of Nonbehavioral Decisions** The organization adheres to the following time frames for notification of non-behavioral healthcare UM Decisions: 1. N/A Marketplace 2. For Medicaid urgent concurrent decisions, the organization gives electronic or written notification of the decision to members and practitioners within 72 hours of the request. 3. For Medicaid urgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 72 hours of the request. 4. For Medicaid nonurgent preservice decisions the organization gives electronic or written notification of the decision to members and practitioners within 14 calendar days of the request.	

Standard	Delegated Activities	Retained by L.A. Care
	5. For Medicaid postservice decisions the organization gives electronic or written notification of the decision to members and practitioners within 30 calendar days of the request. 6. For postservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 30 calendar days of the request. **Notification of Behavioral Healthcare Decisions** The organization adheres to the following time frames for notification of behavioral healthcare UM decisions: 1. N/A (Marketplace) 2. For Medicaid urgent concurrent decisions, the organization gives electronic or written notification of the decision to members and practitioners within 72 hours of the request. 3. For Medicaidurgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 15 calendar days of the request. 4. For Medicaid nonurgent preservice decisions the organization gives electronic or written notification of the decision to members and practitioners within 14 calendar days of the request. 5. For Medicaid post service decisions, the organization gives electronic or written notification of the decision to practitioners and members within 30 calendar days of the request. **Notification of Pharmacy Decisions** The organization adheres to the following time frames for notifying members and practitioners of pharmacy UM decisions: 1. For Medicaid urgent concurrent decisions electronic or written notification of the decision to members and practitioners within 24 hours of the request. 2. For Medicaid urgent preservice decisions electronic or written notification of the decision to members and practitioners within 72 hours of the request. 3. For Medicaid nonurgent preservice decisions electronic or written notification of the decision to members and practitioners within 15 calendar days of the request.	

Standard	Delegated Activities	Retained by L.A. Care
	4. For Medicaid postservice decisions electronic or written notification of the decision to members and practitioners within 30 calendar days of the request. 5. N/A (Medicare and Marketplace) **Timeliness Report** The organization monitors and submits a report for timeliness of: 1. Notification of non-behavioral UM decisions 2. 3. Notification of behavioral UM decisions 4. Notification of pharmacy UM decisions Note: This only applies to pharmaceuticals (Physician Administered Drugs) covered under the medical benefit. ***Note: L.A. Care and Plan must adhere to the applicable standards identified in the California Health and Safety Code and DHCS Contract, all current regulatory notifications (such as APLs), as well as the most recent NCQA HP Standards***	
Clinical Information (NCQA UM 6)	**Relevant Information for Nonbehavioral Healthcare Decisions** There is documentation that the organization gathers relevant clinical information consistently to support nonbehavioral healthcare UM decision making. **Relevant Information for Behavioral Healthcare Decisions** There is documentation that the organization gathers relevant clinical information consistently to support behavioral healthcare UM decision making. **Relevant Information for Pharmacy Decisions** The organization documents that it consistently gathers relevant information to support pharmacy UM decision making. Note: This only applies to pharmaceuticals (Physician Administered Drugs) covered under the medical benefit.	
Denial Notices (NCQA UM 7)	**Discussing a Denial With a Nonbehavioral Healthcare Reviewer** The organization gives practitioners the opportunity to discuss nonbehavioral healthcare UM denial decisions with a physician or other appropriate reviewer.	

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

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

	3. A description of the expedited appeal process for urgent preservice or urgent concurrent denials. 4. Notification that expedited external review can occur concurrently with the internal appeal process for urgent care Note: This only applies to pharmaceuticals (Physician Administered Drugs) covered under the medical benefit.	
Policies for Appeals (NCQA UM 7 NCQA UM 8)	**<u>Internal Appeals</u>** The organization's written policies and procedures for registering and responding to written internal appeals include the following: 1. Allowing at least sixty (60) calendar days after notification of the denial for the member to file the appeal. 2. Documenting the substance of the appeal and any actions taken 3. Full investigation of the substance of the appeal, including any aspects of clinical care involved 4. The opportunity for the member to submit written comments, documents or other information relating to the appeal 5. Appointment of a new person to review an appeal, who was not involved in the initial determination and who is not the subordinate of any person involved in the initial determination 6. Appointment of at least one person to review an appeal who is a practitioner in the same or similar specialty The decision for a pre-service appeal and notification to the member within 30 calendar days of receipt of the request. 7. For Medicaid only, the decisions for postservice appeals and notifications to the members must be within 30 calendar days of receipt of the request. 8. The decision for an expedited appeal and notification to the member within 72 hours of receipt of the request. 9. Notification to the member about further appeal rights. 10. Referencing the benefit provision, guideline, protocol or other similar criterion on which the appeal decision is based 11. Giving members reasonable access to and copies of all documents relevant to the appeal, free of charge, upon request. 12. Including a list of titles and qualifications, including specialties, of individuals participating in the appeal review 13. Allowing an authorized representative to act on behalf of the member	Members have the option to appeal directly to L.A. Care. Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

	14. Continued coverage pending the outcome of an appeal.	
Appropriate Handling of Appeals (NCQA UM 9)	**<u>Preservice and Postservice Appeals</u>** An NCQA review of the organization's appeal files indicates that they contain the following information: 1. Documenting the substance of appeals 2. Investigating appeals 3. Appropriate response to the substance of the appeal. **<u>Timeliness of the Appeal Process</u>** The organization adheres to the following time frames for notification of preservice, postservice and expedited appeal decisions.: 1. For preservice appeals, the organization gives electronic or written notification within thirty (30) calendar days of receipt of the request 2. For Medicaid postservice appeals, the organization gives electronic or written notification within thirty (30) calendar days of receipt of the request 3. For expedited appeals, the organization gives electronic or written notification within seventy-two (72) hours of receipt of the request. **<u>Appeal Reviewers</u>** The organization provides non-subordinate reviewers who were not involved in the previous determination and same or similar specialist review, as appropriate. **<u>Notification of Appeal Decision/Rights</u>** An NCQA review of the organization's internal appeal files indicates notification to members of the following: 1. Specific reasons for the appeal decision in easily understandable language 2. A reference to the benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based 3. Notification that the member can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based, upon request. 4. Notification that the member is entitled to receive reasonable access to and copies of all documents free of charge upon request. 5. The list of titles and qualifications, including specialties, of individuals participating in the appeal review 6. A description of the next level of appeal, either within the organization or to an independent external organization, as applicable, along with relevant written procedures.	Members have the option to appeal directly to L.A. Care. Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

	Final Internal and External Appeal Files N/A **Appeals Overturned by the IRO** N/A	
Evaluation of New Technology (NCQA UM 10)		**Written Process** Evaluates the inclusion of new technology and the new application of existing technology in the benefits plan, including medical and behavioral health procedures, physician administered drugs effective January 2022 and devices. This element is Not Applicable for Medicaid product lines if the state mandates all benefits and new technology determinations. L.A. Care will provide the state's language. **Description of the Evaluation Process** This element is Not Applicable for Medicaid product lines if the state mandates all benefits and new technology determinations. L.A. Care will produce documentation that demonstrates this.
Procedures for Pharmaceutical Management (NCQA UM 11)	**Pharmaceutical Management Procedures** The organization's policies and procedures for pharmaceutical management include the following: 1. The criteria used to adopt pharmaceutical management procedures 2. A process that uses clinical evidence from appropriate external organizations 3. A process to include pharmacists and appropriate practitioners in the development of procedures 4. A process to provide procedures to practitioners annually and when it makes changes. **Pharmaceutical Restrictions/Preferences** Annually and after updates, the organization communicate to members and prescribing practitioners: 1. A list of pharmaceuticals including restrictions, updates and preferences to post on its Internet	

	website and update that posting with changes on a monthly basis (SB1052) 2. How to use the pharmaceutical management procedures 3. An explanation of limits or quotas 4. How prescribing practitioners must provide information to support an exception request 5. The process for generic substitution, therapeutic interchange and step-therapy protocols. **Pharmaceutical Patient Safety Issues** The organization's pharmaceutical procedures include: 1. Identifying and notifying members and prescribing practitioners affected by Class II recalls or voluntary drug withdrawals from the market for safety reasons within thirty (30) calendar days of the FDA notification 2. An expedited process for prompt identification and notification of members and prescribing practitioners affected by a Class I recall. **Reviewing and Updating Procedures** With the participation of physicians and pharmacists the organization annually: 1. Reviews the procedures 2. Reviews the list of pharmaceuticals 3. Updates the procedures as appropriate 4. Updates the list of pharmaceuticals, as appropriate, and 5. Post the list with changes on its Internet website on a monthly basis. (SB1052) **Considering Exceptions** The organization has exceptions policies and procedures that describe the process for: 1. Making exception requests based on medical necessity 2. Obtaining medical necessity information from prescribing practitioners 3. Using appropriate pharmacists and practitioners to consider exception requests 4. Timely handling of request 5. Communicating the reason for denial and explanation of the appeal process when it does not approve an exception request. Note: This only applies to pharmaceuticals (Physician Administered Drugs) covered under the medical benefit.	
UM System Controls (NCQA UM 12)	**UM Denial System Controls**	

	The organization has policies and procedures describing its system controls specific to UM denial notification dates that: 1. Define the date of receipt consistent with NCQA requirements. 2. Define the date of written notification consistent with NCQA requirements. 3. Describe the process for recording dates in systems. 4. Specify titles or roles of staff who are authorized to modify dates once initially recorded and circumstances when modification is appropriate. 5. Specify how the system tracks modified dates. 6. Describe system security controls in place to protect data from unauthorized modification. 7. Describe how the organization monitors its compliance with the policies and procedures in factors 1–6 at least annually and takes appropriate action, when applicable. **UM Denial System Controls Oversight** At least annually, the organization demonstrates that it monitors compliance with its UM denial controls, as described in Element A, factor 7, by: 1. Identifying all modifications to receipt and decision notification dates that did not meet the organization's policies and procedures for date modifications. 2. Analyzing all instances of date modifications that did not meet the organization's policies and procedures for date modifications. 3. Acting on all findings and implementing a quarterly monitoring process until it demonstrates improvement for one finding over three consecutive quarters. **UM Appeal System Controls** The organization has policies and procedures describing its system controls specific to UM appeal dates that: 1. Define the date of receipt consistent with NCQA requirements. 2. Define the date of written notification consistent with NCQA requirements. 3. Describe the process for recording dates in systems.	

	4. Specify titles or roles of staff who are authorized to modify dates once initially recorded and circumstances when modification is appropriate. 5. Specify how the system tracks modified dates. 6. Describe system security controls in place to protect data from authorized modification. 7. Describe how the organization monitors its compliance with the policies and procedures in factors 1-6 at least annually and takes appropriate action, when applicable. **UM Appeal System Control Oversight** At least annually, the organization demonstrates that it monitors compliance with its UM appeal controls, as described in Element C, factor 7, by: 1. Identifying all modifications to receipt and decision notification dates that did not meet the organization's policies and procedures for date modifications. 2. Analyzing all instances of date modifications that did not meet the organization's policies and procedures for date modifications. 3. Acting on all findings and implementing a quarterly monitoring process until it demonstrates improvement for one finding over three consecutive quarters.	
Sub-Delegation of UM (NCQA UM 13)	**Sub-Delegation Agreement** The written delegation agreement: 1. Is mutually agreed upon 2. Describes the delegated activities and the responsibilities of the organization and the delegated entity. 3. Requires at least semiannual reporting by the delegated entity to the organization. 4. Describes the process by which the organization evaluates the delegated entity's performance. 5. Describes the process for providing member experience and clinical performance data to its delegates when request. 6. Describes the remedies available to the organization if the delegated entity does not fulfill its obligations including revocation of the delegation agreement. **Predelegation Evaluation** For new delegation agreements initiated in the look-back period, the organization evaluated delegate	

	capacity to meet NCQA requirements before delegation began. **Review of the UM Program** For arrangements in effect for 12 months or longer, the organization: 1. Annually reviews its delegate's UM program. 2. Annually audits UM denials and appeals files against NCQA standards for each year that delegation has been in effect. 3. Annually evaluates delegate performance against NCQA standards for delegated activities. 4. Semiannually evaluates regular reports, as specified in Element A. 5. At least annually monitors the delegate's UM denial and appeal system security controls to ensure that the delegate monitors its compliance with the delegation agreement or with the delegate's policies and procedures 6. At least annually acts on all findings from factor 5 for each delegate and implements a quarterly monitoring process until each delegate demonstrates improvement for one finding over three consecutive quarters. **Opportunities for Improvement** For delegation arrangements that have been in effect for more than 12 months at least once in each of the past 2 years the organization identified and followed up on opportunities for improvement if applicable.	
	CREDENTIALING	
Credentialing Policies (NCQA CR 1) DMHC, DHCS, CMS	The Delegate has a well-defined credentialing and recredentialing process for evaluating licensed independent practitioners, non-physician medical practitioners (NMPs) and non-medical/clinical providers (NCPs) to provide care to its members by developing and implementing credentialing policies and procedures which specify: **Practitioner Credentialing Guidelines** The organization has a rigorous process to select and evaluate practitioners: 1. The types of practitioners to credential and re-credential, to also include all administrative physician reviewers responsible for making medical decisions. 2. The verification sources used. 3. The criteria for credentialing and re-credentialing. 4. The policies must explicitly define the process and criteria used for making credentialing and re-credentialing decisions.	L.A. Care retains the right based on quality issues to approve, suspend and terminate individual practitioners, providers and sites at all times. Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' credentialing activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

	5. The process for managing credentialing files that meet Delegate's established criteria. Policies must describe the process it uses to determine and approve clean files or the Delegate may present all files to the Credentialing Committee, including clean files, or it may designate approval authority to the medical director or to an equally qualified practitioner. 6. The process for requiring that credentialing and recredentialing are conducted in a nondiscriminatory manner. Policies must specify that the Delegate does not base credentialing decisions on an applicant's race, ethnic/national identity, gender, age, sexual orientation or patient type in which the practitioner specializes. Has a process for preventing and monitoring discriminatory practices and monitors the credentialing and recredentialing processes for discriminatory practices, at least annually and maintain a heterogeneous credentialing committee to sign a statement affirming that they do not discriminate when they make decisions. 7. The process for notifying practitioners about any information obtained during the credentialing process that varies substantially from the information provided to Delegate by the practitioner. 8. The process to ensure that practitioners are notified of initial and recredentialing decisions within sixty (60) calendar days of the committee's decision. 9. The medical director or other designated physician's direct responsibility for, and participation in, the credentialing program. 10. The process for securing the confidentiality of all information obtained in the credentialing process except as otherwise provided by law. 11. The process for confirming that listings in practitioner directories and other materials for members are consistent with credentialing data including education training board certification and specialty. **<u>Practitioner Rights</u>** The organization notifies practitioners about: 1. The right of practitioners to review information submitted to support their credentialing or recredentialing application 2. The right of practitioners to correct erroneous information including: • The timeframe for making corrections. • The format for submitting corrections.	

(DHCS APL22-013)	• The person to whom the corrections must be submitted. 3. The right of practitioners to be informed of the status of their credentialing or re-credentialing application, upon request. **<u>Credentialing System Controls</u>** The Delegate must have policies and procedures for its CR system security controls. If the Organization outsources storage of credentialing information to an external entity, the contract between the Delegate and the external entity will be part of the oversight review. The organization's credentialing process describes: 1. How primary source verification information is received, stored, reviewed, tracked and dated. 2. How modified information is tracked and dated from its initial verification. 3. Titles or roles of staff who are authorized to review, modify and delete information, and circumstances when modification or deletion is appropriate. 4. The security controls in place to protect the information from unauthorized modification. 5. How the organization monitors its compliance with the processes and procedures in factors 1–4 at least annually and takes appropriate action when applicable. **<u>Credentialing System Controls Oversight</u>** At least annually, the organization demonstrates that it monitors compliance with its credentialing controls, as described in Element C, factor 5, by: 1. Identifying all modifications to credentialing and recredentialing information that did not meet the organization's policies and procedures for modifications. 2. Analyzing all instances of modifications that did not meet the organization's policies and procedures for modifications. 3. Acting on all findings and implementing a quarterly monitoring process until it demonstrates improvement for one finding over three consecutive quarters. **Medi-Cal FFS Enrollment** Developing and implementing policies and procedures for Medi-Cal enrollment. Policy must clearly specify enrollment process including, but not limited to: 1. All practitioners that have a FFS enrollment pathway must enroll in the Medi-Cal	

	program.process for ensuring and verifying Medi-Cal enrollment prior to contracting. 2. The process for ensuring and verifying Medi-Cal enrollment prior to contracting. 3. The process for practitioners whose enrollment application is in process. 4. The process for monitoring between recredentialing cycles to validate continued enrollment. 5. Process for practitioners not currently enrolled in the Medi-Cal program. 6. Process for practitioners deactivated, suspended or denied from the Medi-Cal program. During the annual oversight review, the Delegate is subject to a CAP (Corrective Action Plan) if their documented process does not align with policies. In addition, if the Delegate demonstrates reoccurring deficiencies that were identified in previous audits, the Delegate is subject to additional point deductions.	
Credentialing Committee (NCQA CR 2) DHCS, DMHC, CMS	Designating a credentialing committee that uses a peer review process to make recommendations regarding credentialing and recredentialing decisions such that: The committee: a. Includes representation from a range of participating practitioners to provide advice and expertise for credentialing decisions. b. Has the opportunity to review the credentials of all practitioners being credentialed or re-credentialed who do not meet Delegate's established criteria and to offer advice, which Delegate considers appropriate under the circumstances. c. The Medical Director, designated physician or credentialing committee reviews and approves files that meet the Delegate's established criteria. d. Ensures that all license accusations, sanctions or restrictions are reviewed by the credentialing committee for action.	

Credentialing Verification (NCQA CR 3) DHCS, DMHC, CMS	Primary source verification and credentialing and recredentialing decision-making, which includes verification of information to ensure that practitioners have the legal authority and relevant training and experience to provide quality care, within the regulatory and NCQA prescribed time limits, through primary or other regulatory and NCQA-approved sources prior to credentialing and recredentialing by: Verifying that the following are within the prescribed time limits: 1. Current, valid license to practice (develop a process to ensure providers licenses are kept current at all times). 2. A valid DEA or CDS, with schedules 2 thru 5, if applicable; or the Delegate has a documented process for practitioners: • Allowing a practitioner with a valid DEA certificate to write all prescriptions for a practitioner with a pending DEA certificate. • Require an explanation from a qualified practitioner who does not prescribe medications and provide arrangements for the practitioner's patients who need prescriptions for medications. 3. For physicians, verification of the highest of the following three levels of education and training obtained by the practitioners as appropriate: • Board certification if practitioner stated on the application that he/she is board certified, as well as expiration date of certification. • Completion of a residency program. • Graduation from medical or professional school. 4. For Non-Physician Medical Practitioners (NMPs) and Non-Clinical Providers (NCPs), the Delegate verifies the provider has met the qualifications to render services based on the provider type including but not limited to, a current and valid license, registration, certification or the education/training equivalent. 5. Work history. 6. Current malpractice insurance coverage ($1 million/$3 million). 7. A history of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner.	

	8. Clinical Privileges in good standing at a Plan contracted facility designated by the physician as the primary admitting facility. 9. Current, valid FSR/MRR of primary care physician (PCP) offices within 3 years prior to credentialing decision. 10. CLIA Certifications, if applicable. 11. NPI number. 12. Medicare number, if applicable 13. Medi-Cal FFS enrollment. All certifications and expiration dates must be made part of the practitioner's file and kept current. Delegate shall maintain credentialing and/or other monitoring processes to assure that licensure and professional status of each Participating Provider is verified on an ongoing basis. Pursuant to the performance of its credentialing, recredentialing, auditing, monitoring and/or other processed, which include confirmation relating to the following: ▪ Each Participating Provider/Practitioner is and shall remain duly licensed, registered or certified, as required by the laws of this State, and such licensure is free from restrictions that would restrict or limit the ability of Participating provider/practitioner to provide Health Care Services to LAC members as required under the Agreement. ▪ Each Delegate shall maintain professional liability insurance, either independently or through Contractor or some other entity, in a dollar amount that is sufficient for his/her/its practice and as may be required by law or accrediting entities. The Delegate's participating providers must also have general liability insurance in a dollar amount appropriate for their business practice. The Delegate must notify L.A. Care immediately when a practitioner's license has expired for removal from the network.	
CR Sanction Information (NCQA CR 3) DHCS, DMHC, CMS	Primary source verification and credentialing and recredentialing decision-making, which includes verifying, within the NCQA prescribed time limits, through primary or other NCQA-approved sources, the following prior to credentialing and recredentialing. a. State sanctions, restrictions on licensure, or limitations on scope of practice. Review of information must cover the most recent 5-year period available. If a practitioner is licensed in	

	more than one state, in the most recent 5-year period, the query must include all states in which they worked b. Medicare and Medicaid sanctions. c. *Medicare Opt-out. d. SAM. e. CMS Preclusion. f. Debarment g. Decertification Providers must not be terminated, sanctioned, suspended, debarred, disenrolled/decertified, convicted of a felony related to healthcare program fraud or excluded from participation in any federal or state funded programs. L.A. Care does not contract, credential, refer, or pay claims to Practitioners or Providers who have opted out of participation in the Medicare and Medicaid programs; or with individuals or businesses that have been convicted of a felony related to healthcare program fraud, federally or state terminated, sanctioned, suspended, debarred, disenrolled/decertified, excluded, or have appeared on any sanction reports, or on any order issued by judicial authority. Such Practitioners, Providers, individuals, or businesses are ineligible from participation in Medi-Cal, Medicare, federal or state funded programs. The Delegate must notify L.A. Care immediately when practitioners are identified on any sanctions or reports for removal from the network.	
CR Application and Attestation (NCQA CR 3) DHCS, DMHC, CMS	Applications for credentialing and recredentialing include the following: a. Reasons for inability to perform the essential functions of the position, with or without accommodation. b. Lack of present illegal drug use. c. History of loss of license and felony convictions. d. History of loss or limitation of privileges or disciplinary action. e. Current malpractice insurance coverage. ($1million/$3 million). f. g. Current and signed attestation confirming the correctness and completeness of the application.	
Re-credentialing Cycle Length (NCQA CR 4) DHCS, DMHC, CMS	Recredentialing all practitioners at least every 36 months. For PCPs only, must confirm provider has a valid FSR at least every 36 months as part of the recredentialing process.	

CR Ongoing Monitoring and Interventions (NCQA CR 5) DHCS, DMHC, CMS	Developing and implementing policies and procedures for ongoing monitoring of practitioner sanctions, complaints and quality issues and takes appropriate action against practitioners when it identifies occurrences of poor quality between recredentialing cycles by: 1. Collecting and reviewing Medicare and Medicaid sanctions within 30 calendar days of its release. In areas where reporting entities do not publish sanction information on a set schedule, the Delegate must query for this information at least every 6 months 2. Collecting and reviewing accusations, sanctions or limitations on licensure and report actions taken against any identified practitioners to Plan. 3. Collecting and reviewing complaints. 4. Collecting and reviewing information from identified adverse events. 5. Implementing appropriate interventions when delegate identifies instances of poor quality. a. The Delegate's Credentialing committee may vote to flag a practitioner for ongoing monitoring. b. The Delegate must make clear the types of monitoring it imposes, the timeframe used, the intervention, and the outcome, which must be fully demonstrated in the Delegate's credentialing committee minutes. c. The Delegate's credentialing committee can: • Request a practitioner be placed on a watch list. Any list must be clearly defined and monitored. • Request that the practitioner demonstrate compliance with probation that has been imposed by the State and monitor completion. • Impose upon the practitioner to demonstrate steps they have taken to improve processes and/or chart review, if applicable. d. Delegated entities who fail to comply with the requested information within the specified timeframe are subject to sanctions as described in L.A. Care's policies and procedures. e. The Plan will clearly delineate what is expected from the Delegate regarding the Adverse Event that has been	Upon notification of any Adverse Event, L.A. Care will notify the Delegate of their responsibility with respect to delegation of credentialing/re-credentialing activity. The notification will clearly delineate what is expected from the Adverse Event that has been identified. The notice will include, but is not limited to: a. Requesting what actions will be taken by the Delegate. b. What type of monitoring is being performed. c. What interventions are being implemented including closing panel, moving members, or removal of practitioner from the network. d. The notification will include a timeframe for responding to L.A. Care to ensure L.A. Care's members receive the highest level of quality care.

	identified. The notification may include performing the following: • Requesting what action will be taken by the Delegate. • What type of monitoring is being performed. • What interventions are being implemented, including closing panel, moving members, or removal of practitioner from the network. • The notification will include a timeframe for responding to L.A. Care to ensure L.A. Care members receive the highest level of quality care. 6. In the event that the Delegate fails to respond as required, L.A. Care will perform the oversight functions of the Adverse Event and the Delegate will be subject to L.A. Care's credentialing committee's outcome of the adverse events. 7. The Delegate must notify L.A. Care immediately when practitioners are identified on any sanctions or reports for removal from the network. 8. The above are samples, but not limited to, the steps the Delegate can take.	
Notification to Authorities and Practitioner Appeal Rights (NCQA CR 6) DHCS, DMHC, CMS	The Delegate uses objective evidence and patient care considerations when deciding on a course of action for dealing with a practitioner who does not meet its quality standards, including: 1. Developing and implementing policies and procedures that specify: a. The range of actions available to Delegate. b. That the Delegate reviews participation of practitioners whose conduct could adversely affect members' health or welfare. c. The range of actions that may be taken to improve practitioner performance before termination. d. That the Delegate reports its actions to the appropriate authorities. e. Making the appeal process known to practitioners. All final adverse actions determined to be reportable pursuant to applicable law, must be reported by the Delegate to the National Practitioner Data Bank (NPBD) and the appropriate State Medical Boards. Upon the filing of NPBD reports and 805 reporting, the Delegate must notify the Plan within 5 business days from the date the reports are filed. Providers must notify the Delegate, in writing, of any adverse or criminal action taken against them	L.A. Care retains accountability for procedural components and will oversee Delegate's adherence to these standards through pre-delegation, routine monitoring and annual oversight review or more frequently, as required, per changes in contract, Federal and State regulatory guidelines and accreditation standards.

	promptly and no later than fourteen (14) calendar days from the occurrence of any adverse event, criminal action, changes in privileges, accusation, probation, or other disciplinary action of practitioners. Failure to do so may result in the removal of the practitioner from L.A. Care's network as referenced in the California Participating Physician Application Information Release Acknowledgments. Upon notification from a contracted or employed provider, the PPG must notify the Healthplan immediately or no later than 5 business days from the date when practitioners are identified on any ongoing monitoring reports. Within 14 days from criminal action taken against any contracted practitioner, Delegate shall notify L.A. Care in writing.	
CR Assessment of Organizational Providers (NCQA CR 7) DHCS, DMHC, CMS	The Delegate's policy for assessing a health care delivery provider specifies that before it contracts with a provider, and for at least every 36 months thereafter it: 1. Confirms that the provider is in good standing with state and federal regulatory bodies. 2. Confirms that the provider has been reviewed and approved by an accrediting body acceptable to Delegate, including which accrediting bodies are acceptable. 3. Conducts an onsite quality assessment if the provider is not accredited. 4. At least every three years that the provider continues to be in good standing with state and federal regulatory bodies and, if applicable, is reviewed and approved by an accrediting body acceptable to Delegate. Maintaining a tracking log that includes names of the organization, type of organization, a prior validation date, a current validation date for licensure, accreditation status (if applicable), CMS or state reviews conducted within 3 years at time of verification (if applicable), CLIA certificate (if applicable), NPI number for each organizational provider. The Delegate includes at least the following medical providers in its assessment: a. Hospitals. b. Home health agencies. c. Skilled nursing facilities. d. Freestanding surgical centers. e. Federally Qualified Health Center (FQHCs). f. Federally Qualified Health Center (FQHCs).	

	g. Any other ancillary provider types outlined in the delegate's contract with the Plan The Delegate includes behavioral healthcare facilities providing mental health or substance abuse services in the following setting: a. Inpatient. b. Residential. c. Ambulatory. The Delegate assesses contracted medical health care providers. The Delegate assesses contracted behavioral healthcare providers.	
Sub-Delegation of CR (NCQA CR 8) DHCS, DMHC, CMS	**<u>Subdelegation Agreement:</u>** If Delegate sub-delegates any NCQA required credentialing activities, there must be evidence of oversight of the delegated activities, including a written sub-delegation agreement that: 1. Is mutually agreed upon. 2. Describes the sub-delegated activities and the responsibilities of the organization and the delegated entity. 3. Requires at least quarterly reporting to Delegate. 4. Describes the process by which Delegate evaluates sub-delegate's performance. 5. Specifies that the delegate retains the right to approve, suspend and terminate individual practitioners, providers and sites, even if the organization delegates decision making. 6. Describes the remedies available to Delegate if sub-delegate does not fulfill its obligations, including revocation of the delegation agreement. Retention of the right by Delegate and LA Care, based on quality issues, to approve, suspend, and terminate individual practitioners, providers, and sites. **<u>Presubdelegation Evaluation:</u>** For new sub-delegation agreements initiated in the look-back period, the Delegate evaluated sub-delegate capacity to meet NCQA requirements before sub-delegation begins **<u>Review of Subdelegates Credentialing Activities:</u>** For sub-delegation arrangements in effect for 12 months or longer, the Delegate: a. Annually reviews its sub-delegate's credentialing policies and procedures.	L.A. Care retains the right to perform a pre-delegation audit of any entity to which the Plan sub-delegates delegated credentialing activities and approve any such sub-delegation audit of any sub-delegate. Prior to entering into an agreement to sub-delegate delegated credentialing activities, Delegated Plan shall provide L.A. Care with reasonable prior notice of Plan's intent to sub-delegate.

	b. Annually audits credentialing and recredentialing files against NCQA standards for each year that sub-delegation has been in effect. c. Annually evaluates the sub-delegate's performance against relevant regulatory requirements; NCQA standards and Delegate's expectations annually d. Evaluates regular reports from sub-delegate at least quarterly or more frequently based on the reporting schedule described in the sub-delegation document. e. Annually monitors the delegate's credentialing system security controls to ensure that the delegate monitors its compliance with the delegation agreement or with the delegate's policies and procedures at least annually. f. Annually acts on all findings from factor 5 for each delegate and implements a quarterly monitoring process until each delegate demonstrates improvement for one finding over three consecutive quarters. **Opportunities for Improvement:**For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years, the organization identifies and follows up on opportunities for improvement, if applicable. If a Delegate fails to complete the corrective action plan and has gone through the exigent process which results in de-delegation, the Delegate cannot appeal and must wait one year to reapply for a pre-delegation audit. If the pre-delegation audit reveals deficiencies identified are the same as those from previous audits, delegation will be at the sole discretion of the Credentialing Committee regardless of score.	
MEMBER EXPERIENCE		
Statement of Members' Rights and Responsibilities (NCQA ME 1)	**Distribution of Rights Statement** The organization distributes its member rights and responsibilities statement to the following groups: 1. New members, upon enrollment. 2. Existing members, if requested. 3. New practitioners, when they join the network. 4. Existing practitioners, if requested.	**Rights and Responsibilities Statement** The organization's member rights and responsibilities statement specifies that members have: 1. A right to receive information about the organization its services its practitioners and providers and member rights and responsibilities. 2. A right to be treated with respect and recognition of their dignity and their right to privacy.

		3. A right to participate with practitioners in making decisions about their health care. 4. A right to a candid discussion of appropriate or medically necessary treatment options for their conditions regardless of cost or benefit coverage. 5. A right to voice complaints or appeals about the organization or the care it provides. 6. A right to make recommendations regarding the organization's member rights and responsibilities policy. 7. A responsibility to supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care. 8. A responsibility to follow plans and instructions for care that they have agreed to with their practitioners. 9. A responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goals to the degree possible. L.A. Care adheres to the most current NCQA standards to comply with these requirements.
Subscriber Information (NCQA ME 2)		**<u>Subscriber Information</u>** L.A. Care informs its subscribers upon enrollment and annually thereafter about benefits and access to medical services. **<u>Distribution of Subscriber Information</u>** The organization distributes its subscriber information to the following groups: 1. New members, upon enrollment. 2. Existing members, annually.

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

		3. Acts on opportunities for improvement, if applicable.
Functionality of Claims Processing (NCQA ME 4)	**Functionality-Website** Members can track the status of their claims in the claims process and obtain the following information on the organization's website in one attempt or contact: 1. The stage in the process. 2. The amount approved. 3. The amount paid. 4. The member's cost. 5. The date paid **Functionality-Telephone Requests** Members can track the status of their claims in the claims process and obtain the following information over the telephone in one attempt or contact: 1. The stage in the process. 2. The amount approved. 3. The amount paid. 4. Member cost. 5. The date paid	
Personalized Information on Health Plan Services (NCQA ME 6)	**Functionality-Website** Members can complete each of the following activities on the organization's website in one attempt or contact: 1. Change a primary care practitioner, as applicable. 2. Determine how and when to obtain referrals and authorizations for specific services, as applicable 3. Determine benefit and financial responsibility for a specific service or treatment from a specified provider or institution, if applicable. **Functionality Telephone** To support financial decision making, members can complete each of the following activities over the telephone within one business day: 1. Determine how and when to obtain referrals and authorizations for specific services, as applicable. 2. Determine benefit and financial responsibility for a specific service or treatment from a specified provider or institution. **Quality and Accuracy of Information** At least annually, the organization must evaluate the quality and accuracy of the information provided to members via the website and telephone must be evaluated by: 1. Collecting data on quality and accuracy of information provided. 2. Analyzing data against standards or goals.	

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

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

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

	a. Flyers b. Informational mailers c. ID Cards d. Evidence of Coverage (EOC)	
Potential Quality of Care Issue Review (Title 28 California Code of Regulations Section 1300.70)	The Quality Improvement program must document that the quality of care is being reviewed, that problems are being identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated. The Quality Improvement program must include continuous review of the quality of care provided; quality of care problems are identified and corrected for all provider entities.	L.A. Care retains accountability for procedural components and will oversee Delegate's adherence to these standards through pre-delegation and annual oversight review and more frequently, as required, per changes in contract, Federal and State regulatory guidelines and accreditation standards.
Critical Incident Reporting and Tracking: (California Code of Regulations Title 22 §72541)	The Quality Improvement program must include implementation of a defined policy and procedures to identify, report, and track Critical Incidents under the following categories: abuse, neglect, exploitation, a serious, life threatening medical event requiring immediate emergency evaluation by a medical professional, disappearance (missing person), suicide attempt, restraint and/or seclusion, unexpected death, or other (such as catastrophes and unusual occurrences that threaten the member's wellbeing). Training shall be made available to network providers on identifying and reporting Critical Incidents to the appropriate authorities in a timely manner to ensure patient safety	L.A. Care retains accountability for procedural components and will oversee Delegate's adherence to these standards through pre-delegation, annual oversight review. More frequent oversight measures may be taken if needed to ensure delegate compliance. L.A. Care is responsible for submitting quarterly Critical Incident reports to DHCS using the data received from delegates.
Quality Improvement Performance: Applicable L.A. Care Policy: QI-0008 APL 19-017	1. Annually measures performance and meets the NCQA 50th percentile benchmark for the Medi-Cal Managed Care Accountability Set established by DHCS and NCQA required Medi-Cal accreditation measures. 2. Opportunity for Improvement When the 50th percentile is not met the plan will identify and follow up on opportunities for improvement.	L.A. Care will still retain the PIP and PDSA reporting process with DHCS for the Medi-Cal line of business.
Blood Lead Screening of Young Children Applicable L.A. Care Policy: QI-048 APL 20-016	1. Ensure network providers follow the blood lead anticipatory guidance and screening requirements in accordance with APL 20-016 2. Identify, on at least a quarterly basis (i.e. January – March, April – June, July – September, October – December), all child members under the age of six years (i.e. 72 months) who have any record of receiving a blood lead screening test as required Note: L.A. Care will send delegate CLPPB data when they receive from DHCS on a quarterly basis.	Annual Submission to DHCS data for all child members under the age of six years (i.e. 72 months) who have no record of receiving a blood lead screening
HEALTH EDUCATION		

DHCS Policy Letter 02-004 DHCS Policy Letter 16-014 DHCS Policy Letter 18-018 DHCS Policy Letter 13-001 DHCS Policy Letter 10-012 DHCS Policy Letter 16-005	1. Maintenance of a health education program description and work plan 2. Availability and promotion of member health education services in DHCS language and topic requirements including implementation of a closed-loop referral process. 3. Implementation of comprehensive tobacco cessation/prevention services including: a. individual, group, and telephone counseling b. Provider tobacco cessation trainings c. Tobacco user identification system d. Tracking individual utilization data of tobacco cessation interventions 4. Availability of a diabetes prevention program (DPP) that complies with CDC DPP guidelines and is delivered by a CDC recognized provider 5. Availability of written member health education materials in English and Spanish in DHCS required health topics including: a. a system for providers to order materials and informing providers how to do so b. Adherence to all regulatory requirements as dictated per the Readability & Suitability Checklist 6. Implementation of an Individual Health Education Behavioral Assessment (IHEBA), preferably the Staying Healthy Assessment (SHA) including a method of making the assessments available to providers and provider education 7. Employment of a full-time Health Education Director, or the equivalent, with a Master's Degree in Public Health (MPH) responsible for the direction, management and supervision of the health education system. 8. Integration between health education activities and QI activities 9. Provision of provider education on health education requirements and resources 10. Adherence to all requirements regarding Non-Monetary Member Incentives including submission of Request for Approval and Annual Update/End of Program Evaluation forms to L.A. Care's Compliance Unit on an on-going basis.\ 11. Should Plan Partner delegate any or all health education requirements to a sub-delegate, Plan Partner must monitor sub-delegate's performance and ensure continued compliance.	L.A. Care retains responsibility for providing written health education materials in DHCS required health topics for non-English/Spanish threshold languages. L.A. Care retains responsibility for conducting the Health Education, Cultural & Linguistics Population Needs Assessment (PNA) annually but retains the right to request Plan Partner assistance as needed.
CULTURAL & LINGUISTIC REQUIREMENTS		
Civil Rights Act of 1964, Title VI Code of California Regulations (CCR), Title 28, §1300.67.04(c) CCR, Title 22, §53876	**Cultural & Linguistic Program Description and Staffing** 1. Plan maintains an approved written program description of its C&L services program that	

DHCS Agreement Exhibit A Attachment 9, (12)& (13)(A) Federal Guidelines: OMH CLAS Standards, Standards 1-4 & 9	complies with all applicable regulations, includes, at minimum, the following elements (or its equivalent): a. Organizational commitment to deliver culturally and linguistically appropriate health care services. b. Goals and objectives with timetable for implementation. c. Standards and performance requirements for the delivery of culturally and linguistically appropriate health care services. 2. Plan centralizes coordination and monitoring of C&L services. The department and/or staff responsible for such services are documented in an organizational chart. 3. Plan has written description(s) of position(s) and qualifications of the staff involved in the C&L services program.	
Civil Rights Act of 1964, Title VI Code of California Regulations (CCR), Title 22, §53876 CCR, Title 28, §1300.67.04, (c)(2)(G) & (H) Code of Federal Regulations (CFR), Title28, §35.160-25.164 CFR, Title 45 §92.4 & §92.201 DHCS Agreement Exhibit A, Attachment 9(12) & (14) DHCS All Plan Letter 21-004 Federal Guidelines: OMH CLAS Standards, Standard 5-7	**Access to Interpreting Services** 1. Plan has approved policies and procedures which include, at minimum, the following items: a. Provision of timely 24-hour, 7 days a week interpreting services from a qualified interpreter at all key points of contact, in any language requested, including American Sign Language, at no cost to members. b. Discouraging use of friends, family, and particularly minors as interpreters, unless specifically requested by the member after she/he was being informed of the right and availability of no-cost interpreting services. c. Availability of auxiliary aids and services, such as TTY, video relay services, remote interpreting services, etc., to ensure effective communication with individuals with disabilities. Plan has a sound method to ensure qualifications of interpreters and quality of interpreting services. Qualified interpreter must have demonstrated: 2. a. Proficiency in speaking and understanding both spoken English and at least one other spoken language; and b. Ability to interpret effectively, accurately, and impartially, both receptively and expressly, to and from such language(s) and English, using necessary specialized vocabulary and a fundamental knowledge in both languages of health care terminology	

	and phraseology concepts relevant to health care delivery systems. c. Adherence to generally accepted interpreter ethics principles, including client confidentiality (such as the standards promulgated by the California Healthcare Interpreters Association and the National Council on Interpreting in Healthcare) 3. Plan makes available translated signage (tagline) on availability of no-cost language assistance services and how to access such services to providers. Tagline must be in English and all 18 non-English languages specified by DHCS 4. Plan posts non-discrimination notice and translated taglines in English and 18 non-English languages specified by DHCS at physical location where the plan interacts with the public and on plan's website. 5. Plan maintains utilization reports for face-to-face and telephonic interpreting services.	
Civil Rights Act of 1964, Title VI Code of California Regulations (CCR), Title 28, §1300.67.04(c)(2)(H) Code of Federal Regulations (CFR), Title 45 §92.4 & §92.201(e)(4) DHCS Agreement Exhibit A, Attachment 9(13)(B) & (F) DHCS All Plan Letter 22-04 Federal Guidelines: OMH CLAS Standards, Standards - 7	**Assessment of Linguistic Capabilities of Bilingual** 1. Plan has approved policies and procedures related to identifying, assessing, and tracking oral and/or written language proficiency of clinical and non-clinical bilingual employees who communicate directly with members in a language other than English. 2. Plan has a sound method to assess bilingual employees' oral and/or written language proficiency, including appropriate criteria for ensuring the proficiency. Qualified bilingual staff must have demonstrated: a. Proficiency in speaking and understanding both spoken English and at least one other spoken language, including any necessary specialized vocabulary, terminology, and phraseology. b. Ability to effectively, accurately, and impartially communicate directly with Limited English Proficiency Members in their preferred language. 3. Plan maintains a current list of assessed and qualified bilingual employees, who communicate directly with members, including the following information at minimum, name, position, department, language, level of proficiency.	
Civil Rights Act of 1964, Title VI Code of California Regulations (CCR), Title 28, §1300.67.04(d)(9) DHCS Agreement Exhibit A,	**Linguistic Capabilities of Provider Network** 1. Plan has approved policies and procedures related to identifying and monitoring language capabilities of providers and provider staff	

Attachment 6(11)(B)(2) & Attachment 18 (6)(K) DHCS Policy Letter 98-12 Federal Guidelines: OMH CLAS Standards, Standard 7	ensuring provider network is reflective of membership demographics. 2. Plan lists language spoken by providers and provider staff in the provider directory. 3. Plan updates language spoken by providers and provider staff in the provider directory. 4. Plan annually assesses the provider network language capabilities meet the members' needs.	
California Health and Safety Code, §1367.04(b)(1)(A)-(C) Civil Rights Act of 1964, Title VI Code of California Regulations (CCR), Title 22, §53876 (a)(2)&(3) CCR, Title 28, §1300.67.04, (b)(7), (c)(2)(F) & (e)(2)(i)-(ii) Code of Federal Regulations (CFR), Title28, §35.160-25.164 CFR, Title 45 §92.4 & §92.8 DHCS Agreement, Exhibit A, Attachment 9(14)(B)(2), (14)(C), Attachment 13(4)(C) DHCS All Plan Letter 21-011 DHCS All Plan Letter 21-004 DHCS All Plan Letter 22-002 Federal Guidelines: OMH CLAS Standards, Standard 5-	**Access to Written Member Informing Materials in Threshold Languages & Alternative Formats** 1. Plan has approved policies and procedures documenting the process to: a. Translate Written Member Informing Materials, including the non-template individualized verbiage in Notice of Action (NOA) letters, accurately using a qualified translator in all Los Angeles County threshold languages and alternative formats (large print 20pt, audio, Braille, accessible data) according to the required timelines. b. Track member's standing requests for Written Member Informing Materials in their preferred threshold language and alternative format. c. Submit newly captured members' alternative format selection data directly to the DHCS Alternate Format website d. Distribute fully translated Written Member Informing Materials in their identified Los Angeles County threshold language and alternative format to members on a routine basis based on the standing requests and DHCS alternative format selection (AFS) data. e. Attach the appropriate non-discrimination notice and translated tagline (a written language assistance notice) in English and required all 18 non-English required by DHCS to Member Informing Materials publications). Threshold Languages for Los Angeles County: English, Spanish, Arabic, Armenian, Chinese, Farsi, Khmer, Korean, Russian, Tagalog, and Vietnamese. Taglines (Language assistance notice) Languages: English, Spanish, Arabic, Armenian, Chinese, Farsi, Khmer, Korean, Russian, Tagalog, Vietnamese,	L.A. Care provides Plan with: 1. Any changes to threshold and tagline languages. 2. Weekly DHCS alternative format selection data

	Hindi, Hmong, Japanese, Lao, Mien, Punjabi, Thai and Ukrainian. 2. Plan has a sound method to ensure qualifications of translators and quality of translated Written Member Informing Materials. Qualified translators must have demonstrated: a. Adherence to generally accepted translator ethics principles, including client confidentiality to protect the privacy and independence of LEP Members. b. Proficiency reading, writing, and understanding both English and the other non-English target language. c. Ability to translate effectively, accurately, and impartially to and such language(s) and English, using necessary specialized vocabulary, terminology and phraseology. Plan maintains: a. Translated Written Member Informing materials on file along with attestations which affirm qualifications of the translators and translated document is an accurate rendition of the English version. b. Evidence of the distribution of Written Member Informing Materials to members in their identified Los Angeles County threshold language and alternative format on a routine basis. c. Evidence of reporting newly captured AFS data to DHCS	
Code of California Regulations (CCR), Title 28, §1300.67.04(c)(2)(C) DHCS Agreement, Exhibit A, Attachment 13(1)(A) DHCS All Plan 21-004 Federal Guidelines: OMH CLAS Standards, Standard 6	**Member Education** 1. Plan informs members annually of their right to no-cost interpreting services 24-hour, 7 days a week, including American Sign Language and axillary aids/services and how to access these services. 2. Plan informs members annually about the importance of not using friends, family members and particularly minors, as interpreters. 3. Plan informs members annually of their right to receive Written Member Informing Materials in their preferred language and alternative format at no cost and how to access these services. 4. Plan informs members annually of their right to file complaints and grievances if their cultural or linguistic needs are not met and how to file them.	

	5. Plan informs members annually that Plan does not discriminate on the basis of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental disability or identification with any other persons or group identified in Penal Code 422.56 in its health programs and activities.	
Code of California Regulations (CCR), Title 28, §1300.67.04(c)(2)(E) & (3) DHCS Agreement Exhibit A, Attachment 7(5)(B), Attachment 9 (13)(E), Attachment 18(7)(F) & (9)(M) DHCS All Plan Letter 99-005 Federal Guidelines: OMH CLAS Standards, Standard 4	**Provider Education & Training** 1. Plan has approved policies and procedures related to education/training on C&L requirements, cultural competency, sensitivity or diversity training for providers. 2. Plan provides initial orientation training/education on cultural and linguistic requirements to new providers within first ten business days of active status and annual education/training thereafter, which includes the following items: a. Availability of no-cost language assistance services, including: i) 24-hour, 7 days a week interpreting services, including American Sign Language\ ii) Written Member Informing Materials in their identified Los Angeles threshold language and preferred alternative format iii) Auxiliary aids and services, such as TTY, video relay services, remote interpreting services, etc. b. How to access language assistance services. c. Discouraging the use of friends, family, and particularly minors as interpreters. d. Not relying on staff other than qualified bilingual staff to communicate directly in a non-English language with members. e. Documenting the member's language and the request/refusal of interpreting services in the medical record. f. Posting translated taglines in English and 18 non-English languages required by DHCS at key points of contact with members. g. Working effectively with members using in-person or telephonic interpreters and using other media such as TTY and remote interpreting services. h. Referring members to culturally and linguistically appropriate community services.	

	3. Plan provides initial and annual cultural competency, sensitivity or diversity training to providers, which includes topics that are relevant to the cultural groups in Los Angeles County, such as: a. Promote access and the delivery of services in a culturally competent manner to all Members, regardless of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental, disability, or identification with any other persons or groups defined in Penal Code 422. b. Awareness that culture and cultural beliefs may influence health and health care delivery. c. Knowledge about diverse attitudes, beliefs, behaviors, practices, and methods regarding preventive health, illnesses, diseases, traditional home remedies, and interaction with providers and health care systems. d. Skills to communicate effectively with diverse populations e. Language and literacy needs.	
Code of California Regulations (CCR), Title 28, §1300.67.04(c)(3) DHCS Agreement Exhibit A, Attachment 9(13)(E) DHCS All Plan Letter 99-005 Federal Guidelines: OMH CLAS Standards, Standard 4	**Plan Employee Education & Training** 1. Plan has approved policies and procedures related to education/training on C&L requirements, cultural competency sensitivity or diversity training for Plan employees. 2. Plan provides initial and annual education/training on cultural and linguistic requirements and language assistance services to plan staff, which includes the following items: a. The availability of Plan's no-cost language assistance services to members, including: i. 24-hour, 7 days a week interpreting services, including American Sign Language. ii. Written Member Informing Materials in their identified Los Angeles threshold language and preferred alternative format. iii. Auxiliary aids and services, such as TTY, video relay services, remote interpreting services, etc. b. How to access these language assistance services.	

	c. Discouraging the use of friends, family, and particularly minors, as interpreters. d. Not relying on staff other than qualified bilingual staff to communicate directly in a non-English language with members. e. Working effectively with members using in-person or telephonic interpreters and using other media such as TTY and remote interpreting services f. Referring members to culturally and linguistically appropriate community services. 3. Plan has cultural competency, sensitivity or diversity training material(s) for Plan employees, which includes topics that are relevant to the cultural groups in Los Angeles County, such as: a. Promote access and the delivery of services in a culturally competent manner to all Members, regardless of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental, disability, or identification with any other per-sons or groups defined in Penal Code 422. b. c. Knowledge about diverse attitudes, beliefs, behaviors, practices, and methods regarding preventive health, illnesses, diseases, traditional home remedies, and interaction with providers and health care system. d. Skills to communicate effectively with diverse populations. e. Language and literacy needs	
DHCS Agreement Exhibit A, Attachment 9(13)(F) DHCS All Plan Letter 99-005 Federal Guidelines: OMH CLAS Standards, Standard 10	**C&L and Quality Improvement** 1. Plan has approved policies and procedures related to C&L program evaluation, at minimum, including: a. Review and monitoring of C&L program that has a direct link to Plan's quality improvement processes. b. Procedures for continuous evaluation. 2. Plan analyzes C&L services performance and evaluates the overall effectiveness of the C&L program to identify barriers and deficiencies. For example: a. Grievances and complaints regarding C&L issues b. Trending of interpreting and translation utilization	

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

	community service programs for members and how to access them.	
FINANCIAL SOLVENCY AND CLAIMS PROCESSING REQUIREMENTS		
Financial Solvency (Title 28 California Code of Regulations Sections 1300.75.1, 1300.75.4.1(a)(5) & (6), 1300.75.4.2(a), 1300.76, 1300.76.1, 1300.77.1 & 2, 1300.78, and 1300.76.3).	**Financial Solvency** 1. Maintain a cash-to-claims ratio > 0.75. 2. Maintain positive working capital. 3. Maintain a minimum Tangible Net Equity (TNE). 4. Document and record the liability for incurred but not reported (IBNR) claims on a monthly basis. 5. Submit the quarterly financial statements no later than 45 calendar days after the close of each quarter end to L.A Care. 6. Submit the annual financial statements audited by an independent Certified Public Accounting firm no later than 120 calendar days after each fiscal year end to L.A. Care. **Administrative Costs** 1. Maintain administrative costs no greater than 15% of the revenue. **Commissioner Deposits** 1. Maintain at least $300,000 deposit with the Commissioner, with any FDIC insured bank. **Quarterly Risk-Sharing Reports** i. Distribute the quarterly risk-sharing report detailing the amounts allocated to the Plan Participating Providers (PPPs) under each risk-sharing arrangement no later than 45 calendar days after each quarter end. i. Distribute the annual preliminary payment risk-sharing report detailing the amounts allocated to the PPPs under each risk-sharing arrangement no later than 150 calendar days after the contract year. i. Remit payment due under risk-sharing arrangements to the PPPs no later than 180 days after the contract year. **Risk Management** Maintain the following insurance at all times: 1. Reinsurance or Stop-Loss 2. Malpractice or Professional Liability 3. General Liability 4. Errors & Omissions 5. Workers Compensation 6. Fidelity Bond **Policies and Procedures**	

	Maintain approved policies and procedures that describe the process and requirements for each of the sections mentioned above.	
	Financial Viability Oversight of the Plan Participating Providers (PPPs) 1. Obtain and analyze quarterly financial statements and annual audited financial statements of the PPPs. 2. Perform financial audit of the PPPs at least once a year including the issuance of audit reports. 3. Request a written corrective action plan (CAP) from PPPs that do not meet the financial solvency requirements. **Claims Processing Oversight of the PPPs** 1. Perform claims processing audit of the PPPs at least once a year including the issuance of audit reports. 2. Perform annual ER claims and applicable ER follow-up audits for the PPPs that are delegated for the ER claims payment functions. 3. Request a written corrective action plan (CAP) from PPPs that do not meet the claims processing requirements. **Policies and Procedures** Maintain approved policies and procedures that describe the process and requirements for each of the sections mentioned above.	
Claims Processing (Title 28 California Code of Regulations Section 1300.71)	**Timely Claims Processing** 7. Process at a minimum ninety percent (90%) of claims within 30 calendar days of the claim receipt date, 8. Process at a minimum ninety-five percent (95%) of claims within 45 working days of the claim receipt date, **and** 9. Process at a minimum ninety-nine percent (99%) of claims within 90 calendar days of the claim receipt date. **Accurate Claims Payments** 1. Pay claims at the Medi-Cal rates or contracted rates at a minimum of 95% of the time. 2. All modified claims are reviewed and approved by a physician and medical records are reviewed. 3. Calculate and pay interest automatically for claims paid beyond 45 workings days from date of receipt at a minimum 95% of the time.	

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

	service in good faith and pursuant to the authorization on three (3) or more occasions over the course of any three-month period. **Request for Medical Records** 1. **Emergency services claims:** Medical records shall not be requested more frequently than twenty percent (20%) of the claims submitted by all providers for emergency services over any 12-month period. 2. **All other claims:** Medical records shall not be requested more frequently than three percent (3%) of the claims submitted by all providers, excluding claims involving unauthorized services over any 12-month period. **Exception:** The thresholds and limitations on requests for medical records as stated above should not apply to claims where reasonable grounds for suspecting possible fraud, misrepresentation or unfair billing practices are being demonstrated. **Policies and Procedures** Maintain approved policies and procedures that describe the process and requirements for each of the sections mentioned above.	
Provider Dispute Resolution (PDR) Processing and Payments requirement. (Title 28 California Code of Regulations Section 1300.71.38)	**Acknowledgement of Provider Disputes** Acknowledgement of received disputes is performed in a timely manner at a minimum of 95% of the time. a. 15 working days for paper disputes. b. 2 working days for electronic disputes. **Timely Dispute Determinations** Dispute determinations are made in a timely manner, at a minimum of 95% of the time. a. 45 working days from receipt of the dispute. b. 45 working days from receipt of additional information. **Clear Explanation of NOA Letter** Rationale for decision is clear, accurate and specific in NOA Letter, at a minimum of 95% of the time. a. Written determination stating the pertinent facts and explaining the reasons for the determination **Accurate Provider Dispute Payments** 1. Appropriately paying any outstanding monies determined to be due if the dispute is determined in whole or in part in favor of the provider.	

	2. Interest payments are paid correctly when dispute determination is in favor of provider, at a minimum of 95% of the time. Accrual of interest of payment on resolved provider disputes begin on the day after the expiration of forty-five (45) working days from the original claim receipt date. **Acceptance of Late Claims** The organization must accept and adjudicate disputes that were originally filed beyond the claim filing deadline and the provider was able to demonstrate good cause for the delay, at a minimum of 95% of the time. **Policies and Procedures** Maintain approved policies and procedures that describe the process and requirements for each of the sections mentioned above.	
Annual Plan Claims Payment and Dispute Resolution Mechanism Report" Cal. Code Regs. tit. 28 § 1300.71.38(k) Cal. Code Regs. tit. 28 § 1300.71.38(k)(1) Cal. Code Regs. tit. 28 § 1300.71.38(k)(2) Cal. Code Regs. tit. 28 § 1300.71.38(k)(3)	1. "Information on the number and types of providers using the dispute resolution mechanism. 2. "A summary of the disposition of all provider disputes, which shall include an informative description of the types, terms and resolution. Disputes contained in a bundled submission shall be reported separately as individual disputes. Information may be submitted in an aggregate format so long as all data entries are appropriately footnoted to provide full and fair disclosure; and… 3. A detailed, informative statement disclosing any emerging or established patterns of provider disputes and how that information has been used to improve the plan's administrative capacity, plan-provider relations, claim payment procedures, quality assurance system (process) and quality of patient care (results) and how the information has been used in the development of appropriate corrective action plans.[1]	
DMHC Provider Disputes Document/Information Requests	Plan Partner to respond to document\information requests from LA Care for DMHC provider disputes within 5 days, urgent requests within 2 days.	
PROVIDER NETWORK REQUIREMENTS		
DHCS Agreement Exhibit A, Attachment 7 (5)(A)(B)	**Provider Education & Training**	

[1] Cal. Code Regs. tit. 28 § 1300.71.38(k)(3)

	1. Plan has approved policies and procedures for training newly contracted/hired providers within ten (10) business days of the effective date of contract/hire. The training must include, but is not limited to: (DHCS Agreement, Exhibit A, Attachment 7, Provision 5; DHCS Agreement, Exhibit A, Attachment 13, Provision 1), and the NCQA 2017 Standards and Guidelines (NCQA, Element A), NCQA RR 1. a. 1. Federal and State statutes and regulations to ensure providers' full compliance b. 2. Medi-Cal Managed Care services c. 3. Applicable policies and procedures d. 4. Medi-Cal marketing guidelines e. 5. Member rights and responsibilities f. 6. Member services, including the member's right to full disclosure of health care information and the member's right to participate actively in health care decisions education/training on C&L requirements, for providers. 2. Plan Partner must evidence a process to provide information to and train providers on a continuing basis regarding clinical protocols and evidence-based practice guidelines for Seniors and Persons with Disabilities or chronic conditions a. 1. Process includes an educational program for providers regarding health needs specific to Seniors and Persons with Disabilities or chronic conditions population b. 2. Educational program uses a variety of educational strategies, including, but not limited to, posting information on websites and other methods of educational outreach to providers	

Exhibit 8
Delegation Agreement
[Attachment B]

Plan's Reporting Requirements

Report	Due Date	Submit To	Required Format
QUALITY IMPROVEMENT			
NET 1A **Cultural Needs and Preferences Assessment** **NET 1B** Practitioners Providing Primary Care **NET 1C** Practitioners Providing Specialty Care **NET 1D** Practitioners Providing Behavioral Healthcare	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
NET 2A **Access to Primary Care** **NET 2B** Access to Behavioral Healthcare **NET 2C** Access to Specialty Care	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
NET 3A Assessment of Member Experience Accessing the Network **NET 3B** Opportunities to Improve Access to Nonbehavioral Healthcare Services **NET 3C** Opportunities to Improve Access to Behavioral Healthcare Services	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
QI 2A Practitioner Contracts	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission

QI 3A Identifying Opportunities **QI 3B** Acting on Opportunities **QI 3C** Measuring Effectiveness	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Annual data collection analysis that identify and acts on opportunities for improvement for Continuity of Care as outlined by NCQA guidelines for Continuity Coordination of Care of Medical Care and Continuity and Coordination Between Medical Care and Behavioral HealthCare
QI 4A Data Collection **QI 4B** Collaborative Activities **QI 4C** Measuring Effectiveness	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
QI 5A **Sub-Delegation Agreement** **QI 5B** Sub- Delegation Predelegation Evaluation **QI 5C** Sub-Delegation Review of QI Program **QI 5D** **Sub-Delegation** Opportunities for Improvement	Annually during PP audit	home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
<u>Quality Improvement Quarterly reporting requirements</u> 1. **QI Workplan Update** **2. Potential Quality of Care Issues (PQIs)** a. Number of PQIs b. Number of closed PQIs c. Number of closed PQIs within 6 months d. PQI Detail Report with final PQI severity level	QI Workplan Update - Quarterly 1st Qtr – Jun 30 2nd Qtr – Sep 30 3rd Qtr – Dec 30 4th Qtr – Mar 30 2. PQI Report - Quarterly 1st Qtr – April 25 2nd Qtr – July 25 3rd Qtr – Oct 25 4th Qtr – Jan 25	1-3. L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	1 – 3. Acceptable formats: • Quarterly Workplan Updates • ICE Reporting Format **Naming convention for PQI Reports** *Plan Partner Name YYYY Q# PQI Report*

<u>Critical Incidents Tracking Log</u> **1. Critical Incident Tracking Log** **Naming convention:** *YYYY Q# LA Care CI Tracking Report* **Description:** Includes a tracking log of critical incidents specific to each member. - Abuse - Neglect - Exploitation - Disappearance/Missing Member - Suicide Attempt - Unexpected Death - A Serious Life Threatening Medical Event that requires immediate emergency evaluation by a Medical Professional - Restraints or seclusion - Other **2.Critical Incident Report in DHCS required format** - Number of LTSS users - Number of Critical Incidents Filed - Number of Critical Incidents Filed with Grievances Previously Filed - Number of Critical Incidents Filed with Appeals Previously Filed Blue Shield of California Promise Health Plan shall keep track of all Critical Incidents and ensure appropriate reporting and resolution of the incidents in a timely fashion.	**Quarterly** 1st Qtr. – April 15 2nd Qtr. – July 15 3rd Qtr. – Oct 15 4th Qtr. – Jan 15	Submit to L.A. Care Critical Incident inbox CI@lacare.org	1. The Critical Incident Tracking Log with Health Plan Report Format, which includes but not limited to member information, specific information about the incident (date, time, location, entity/person involved in the incident, etc.) 2. Quarterly Critical Incident Report with DHCS required format
<u>Quality Improvement Annual reporting requirements</u> 1. **QI 1A:** QM Program Description 2. **QI 1C:** QM Program Evaluation 3. QI Workplan 4. PHM Work plan (if the activities are not included in the QI Workplan)	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Acceptable formats: • Quarterly • ICE Reporting Format
ME 1B: Distribution of Member Rights & Responsibilities Statement	Semi-Annually: Jan 15th (Reporting period Q3 & Q4) July 15th (Reporting period Q1 &Q2)	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Mutually agreed upon format  ME 1B_Distribution of Rights Statement
ME 7C Element C: Annual Assessment of Nonbehavioral Healthcare Complaints and Appeals **ME 7E** Element E: Annual Assessment of Behavioral Healthcare and Services	Annually during PP audit	home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission

Element F: Behavioral Healthcare Opportunities			
PHM 1A Strategy Description **PHM 1B** Informing Members	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
PHM 2A Data Integration **PHM 2B** Population Assessment **PHM 2C** Activities and Resources **PHM 2D** Segmentation	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
PHM 3 A Practitioner or Provider Support	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
PHM 6A Measuring Effectiveness **PHM 6B** Improvement and Action	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
PHM 7A Sub-Delegation Agreement **PHM 7B** Sub-Delegate Pre-Delegation Agreement **PHM 7C** Sub-Delegate Review of PHM Program **PHM 7D** Opportunities for Improvement	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
Title 28 California Code of Regulations Section 1300.67.2.2 **California Health and Safety Code Section 1348.8** **Assessment of Nurse Advice Line** 1. Nurse Advice Line monitoring for: a. Telephone statistics at least quarterly • Average abandonment rate within 5 percent • Average speed of answer within 30 seconds	1. Quarterly 1st Qtr – May 18 2nd Qtr – August 18 3rd Qtr – November 18 4th Qtr – February 18	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Health Education/ Plan will also have the option to submit via email to remain compliant with due date.	Mutually agreed upon format

2. Annual analysis of Nurse Advice Line statistics (telephone, use, and calls), identify opportunities and establish priorities for improvement.	2. Annually during PP Audit		
Quality Improvement Performance A PDSA tool will be required when the plan does not meet the 50th percentile for the Managed Care Accountability Set and the 50th percentile for the Medicaid NCQA Accreditation Measures as established by both regulatory entities.	Annually during PP Audit. The PDSA tool is due 90 calendar days after findings are received.	L.A. Care's Secure File Transfer Protocol (SFTP)/ home/ucfst/infile/Quality Improvement/ Plan will also have the option to submit via email to remain compliant	The PDSA tool provided by DHCS or L.A. Care
DELEGATION OVERSIGHT - UTILIZATION MANAGEMENT AND MEMBER RIGHTS			
APPEALS & GRIEVANCES Member complaints and Appeals Log	Monthly 15th Calendar Day of Each Month	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Delegation Oversight	Format as defined in the L.A. Care Technical Bulletin MS 005
ME 7 A, B, C, E, F **Analysis of Member Experience, if delegated, to include:** 1. Policies and Procedures for Complaints 2. Policies and Procedures for Appeals 3. Annual Assessment of Nonbehavioral Healthcare Complaints and Appeals for each of 5 categories: a. Quality of Care b. Access c. Attitude and Service d. Billing and Financial Issues e. Quality of Practitioner Office Site 4. Annual Assessment of Behavioral Healthcare Complaints and Appeals and Services for each of 5 categories along with opportunities for improvement: a. Quality of Care b. Access c. Attitude and Service d. Billing and Financial Issue e. Quality of Practitioner Office Site	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/greivance/	Compliant with NCQA in accordance to Plan's accreditation submission
Service Authorizations and Utilization Review			
UM 1 1. UM Program Description 2. UM Program Evaluation 3. UM Program Work Plan	1. Delegation Oversight to review. Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Clinical Assurance_CFST/	1. Narrative 2. HICE Quarterly Reporting format 3. HICE Quarterly Format

	2-3. Due to Clinical Assurance on May 31st via the SFTP Site		
Quarterly UM Activity Report **All elements outlined within L.A. Care Quarterly UM Activity Health Industry Collaboration Effort (HICE) reporting format including but not limited to:** 1. UM Summary – Inpatient Activity a. Average monthly membership b. Acute Admissions/K c. Acute Bed days/K d. Acute LOS e. Acute Readmits/K f. SNF Admissions/K g. SNF Bed days/K h. SNF LOS i. SNF Readmits/K 2. UM Activities Summary a. Referral Management Tracking of the number of Approvals/Modifications/Denials/ Deferrals (Routine/Urgent) b. Referral Denial Rate c. Appeals/K d. Overturn Rate 3. **PHM 5:** CCM Complex Case Management CM Reports and Statistics	Quarterly 1st Qtr –May 31 2nd Qtr – Aug 31 3rd Qtr – Nov 30 4th Qtr – Feb 28	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Clinical Assurance_CFST/	HICE Quarterly Reporting Format
NET 4B: Continued Access to Care 1. Continued Access to Practitioners If a practitioner's contract is discontinued, the organization allows affected members continued access to the practitioner, as follows: a. Continuation of treatment through the current period of active treatment for members undergoing active treatment for a chronic or acute medical condition b. Continuation of care through the postpartum period for members in their second or third trimester of pregnancy	Quarterly 1st Qtr – May 31 2nd Qtr – Aug 31 3rd Qtr – Nov 30 4th Qtr – Feb 28	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Clinical Assurance_CFST/	L.A. Care Quarterly Reporting Format
PHM 5: CCM Log of Case Management Cases (CCM) for members who have been in CCM for at least 60 days to include both open and closed cases.	Quarterly 1st Qtr – May 25 2nd Qtr – Aug 25 3rd Qtr – Nov 25 4th Qtr – Feb 25	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Clinical Assurance_CFST/	Acceptable formats: L.A. Care Format

Medi-Cal Provider Preventable Reportable Conditions	Quarterly 1st Qtr – May 25 2nd Qtr – Aug 25 3rd Qtr – Nov 25 4th Qtr – Feb 25	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Clinical Assurance_CFST/	Acceptable formats: DHCS Required Reporting Format
QI 3D: Transition to Other Care--member transition to other care, **a.** When their benefits end, if necessary **b.** During transition from pediatric care to adult care.	Quarterly 1st Qtr – May 31 2nd Qtr – Aug 31 3rd Qtr – Nov 30 4th Qtr – Feb 28	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Clinical Assurance_CFST/	L.A. Care Quarterly Reporting Format
CREDENTIALING			
1. Initial Credentialed practitioner list containing Credentialing Date, Last Name, First Name, MI, Title, Address, City, State, Zip, Group Name. 2. Re-credentialed practitioner list containing Re-credentialing Date, Last Name, First Name, MI, Title, Address, City, State, Zip, Group Name. 3. Voluntary Practitioner Termination list containing Termination Date, Last Name, First Name, MI, Title, Address, City, State, Zip, Group Name. 4. Involuntary Practitioner Termination list containing Termination Date, Last Name, First Name, MI, Title, Address, City, State, Zip, Group Name	Quarterly 1st Qtr – May15 2nd Qtr – Aug 15 3rd Qtr – Nov 15 4th Qtr – Feb 15	credinfo@lacare.org	Current L.A. Care Health Plan Delegated Credentialing Quarterly Credentialing Submission Form (ICE Format)
DMHC SURVEYS			
1. DMHC Timely Access and Network Reporting (TAR) a. Exhibit A-1 Timely Access Time-Elapsed Standards Policies and Procedures b. Exhibit A-2 Alternative Access Timely Access Time-Elapsed Standards Policies and Procedures c. Exhibit A-3 Oversight of Plan-to-Plan Contracts Policy and Procedures d. Exhibit B-1 Quality Assurance Monitoring related to Time-Elapsed Standards Policies and Procedures e. Exhibit B-2 Quality Assurance Monitoring related to All Other Time-	Due Date: 4/17/2023	L.A. Care's Secure File Transfer Protocol (SFTP) /ucfst/infile/compliance	

Elapsed Standards Policies and Procedures f. g. h. Exhibit D-4 Prior Incidents or Patterns of Non-Compliance not Previously Submitted i. Exhibit E-1 Policies and Procedures for Advanced Access Program j. Exhibit F-1 Triage k. l. Exhibit F-3 Health I.T. m. Exhibit G-1 Provider Satisfaction Survey Methodology n. Exhibit G-2 Provider Staisfaction Survey Results o. Exhibit G-2 Enrollment Staisfaction Survey Methodology p. Exhibit G-4- Enrollee Satisfaction Survey q. Exhibit H-1 Quality Assurance Report r. Exhibit C-1 Contact List Report Forms for each Provider Survey Type s. Exhibit C-2 Raw Data Report Forms for each applicable Provider Survey Type t. Exhibit C-3 Results Report Form u. APNR Form PCP v. APNR Form Specialists w. APNR Form Mental Health x. APNR Form Hospitals and Clinics y. APNR Form Other Outpatient Provider z. APNR Form Grievances aa. APNR Form Third Party Telehealth (if applicable) i.	Due Date: 9/1/2022 Due Date: 2/6/2023		
2. DMHC Provider Appointment Availability Survey (PAAS) a. Provider Contact Lists i. PCP ii. Specialists iii. Psychiatry	Annually - July	L.A. Care's Secure File Transfer Protocol (SFTP)/ home/ucfst/infile/Quality Improvement/	

iv. Non-Physician Mental Health v. Ancillary			
COMPLIANCE			
1. 274 EDI File Mandated by APL 16-019	Monthly – Due to L.A. Care by the 4th of each month	L.A. Care's Secure File Transfer Protocol (SFTP) /home/ucfst/infile/274	DHCS required formatting.
2. Data Certification Statements Mandated by APL 17-005	Monthly – Due to L.A. Care 3 business days prior to submission to DHCS	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	Word Document, Non-specific template. Utilize own template; however, all state reports submitted to L.A. Care within the month MUST be listed and CEO MUST sign off attesting to ALL data submissions.
3. Non-Medical Transportation & Non-Emergency Medical Transportation (NMT-NEMT) Report Mandated by APL 17-010	Monthly - Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	DHCS approved template
4. **Health Industry Collaboration Effort** AB1455 Quarterly Reports a. M/Q Medi-Cal Claims Timeliness Report b. Disclosure of Emerging Claims Payment Deficiencies (DoECPD)	Quarterly – Due to L.A. Care within specified deadline set by L.A. Care	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/AB1455	HICE Approved Documents
5. Call Center Report	Quarterly – Due to L.A. care 30 days after the end of each quarter of the calendar year. When due date falls on the weekend (Sunday or Saturday, data must be submitted by COB on the Friday before the due date. • Q1 – January, February, and March • Q2 – April, May, and June • Q3 – July, August, and September • Q4 – October, November, and December	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	Format as specified by L.A. Care

6. Community Based Adult Services (CBAS) Report	Quarterly - Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	DHCS approved templates
7. Dental General Anesthesia Report Mandated by APL 15-012	Quarterly - Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	DHCS approved templates
8. Medi-Cal Managed Long-Term Services & Supports (MLTSS) Report Mandated by APL 17-012	Quarterly - Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	DHCS approved templates
9. Medi-Cal Managed Care Survey – Disproportionate State Hospitals (MMCS-DSH) Survey	Annually - Due to L.A. Care 7 business days prior to submission to DHCS	BSCPHP has the option to submit report directly to DHCS Or Via L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	DHCS approved templates
10. Health Homes Program DHCS Required Reporting (Sunset CY 2022)	Quarterly, Bi-Annually, & Annually, according to schedule in DHCS template -Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care Regulatory / Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	DHCS approved template, plus attestation of data and brief written summary of oversight and monitoring activity for the reporting period
11. Enhanced Care Management DHCS Required Reporting	Quarterly, Bi-Annually, & Annually, according to schedule in DHCS template -Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care Regulatory / Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	DHCS approved template, plus attestation of data and brief written summary of oversight and monitoring activity for the reporting period
12. Community Supports DHCS Required Reporting	Quarterly, Bi-Annually, & Annually, according to schedule in DHCS template -Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care Regulatory / Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	DHCS approved template, plus attestation of data and brief written summary of oversight and monitoring activity for the reporting period
13. CBAS Monthly Wavier Report	Monthly - Due to L.A. Care every 4th day of the month	L.A. Care Regulatory / Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	DHCS approved template

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

through APL 20-017. The MCPD file replaces the following reporting requirements, as this data is now incorporated into the MCPD file in .json format: • Grievances and appeals data in an Excel template, as specified in APL 14-013 ***(previously submitted by your plan as the Grievance Report Mandated by APL 14-013)*** • Monthly MERs and other continuity of care records data in an Excel template, as specified in Attachment B of APL 17-007 ***(previously submitted by your plan as the MMDR Report)*** • Other types of continuity of care data in ad-hoc Excel templates • Out-of-Network request data in a variety of ad-hoc Excel templates ***(previously submitted by your plan as the OON Report)***			
21. Cost Avoidance & Post Payment (CAPP) Recovery Mandated by APL 21-002	Monthly – Due to L.A. Care 6th business day of every month	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports/	DHCS Approved Template
22. Provider Network Termination Mandated by APL 21-003	Quarterly - Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports/	DHCS Approved Template
23. Third Party Liability APL 21-007	15 days from the date LA Care submits case file.	L.A. Care via its Secure File Transfer Protocol (SFTP) – home/ucfst/infile/Regulatory Reports/	DHCS approved templates
24. New and or revised reports as released by DHCS	Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	DHCS approved templates
25. Disaster and Recovery Plan Disaster Recovery Test Results L.A. Care will request all elements outlined below including but not limited to:	Annually during PP audit and ad-hoc;	L.A. Care's Secure File Transfer Protocol (SFTP) EnterpriseRiskManagement@lacare.org	Word Document, Non-Specific template

LA Care may require additional information on Business Continuity efforts based off current event. In the event there are any additional requests from regulators for individual instances, such as, an emergency declared by the governor; 26. L.A. Care will send out an ad hoc written request asking to respond with the requested information should it be an element outside of what is already being requested and another mobile contact mechanism when outside of regular business hours.	Ad-Hoc	home/PPName/infile/Regulatory Reports/ EnterpriseRiskManagement@lacare.org ; RegulatoryReports@lacare.org	Template may change upon regulators request.
27. Encounter Data	Monthly, at a minimum	L.A. Care's Secure File Transfer Protocol (SFTP)	
DELEGATED FINANCIAL AND DELEGATED CLAIMS COMPLIANCE			
1. a) Oversight Summary on Financial Solvency Monitoring of Delegates' Quarterly Unaudited Financial Statements b) Data elements that are from Delegates' Quarterly Timeliness Reporting will be included in 1(a) above Note: Delegates consist of PPGs and capitated hospitals.	Quarterly – Due to L.A. Care 75 calendar days after each quarter end	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Financial_Compliance/ Plan will also have the option to submit via email to remain compliant	Excel/PDF
2. Oversight Summary on Financial Solvency Monitoring of Delegates' Annual Independent Audited Financial Statements ***Note: 2) does not apply to Oversight reporting of claims processing audits of delegates*** Note: Delegates consist of PPGs and capitated hospitals.	Annually – Due to L.A. Care 180 calendar days after delegates' fiscal year end	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Financial_Compliance Plan will also have the option to submit via email to remain compliant	Excel/PDF
3. a) Oversight Summary on Annual Financial Solvency Audits of Delegates. b) Oversight Summary on Annual & Follow-Up Claims Processing Audit of Delegates Note: Delegates consist of PPGs and capitated hospitals.	Quarterly – Due to L.A. Care 60 calendar days after each calendar quarter end for the delegate audits conducted[1] in the reporting quarter [1]the date of delegate audit is based on the first date of	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Financial_Compliance Plan will also have the option to submit via email to remain compliant	Excel/PDF

	fieldwork conducted by BSC PHP.		
4. Policy 2305 Medi-Cal Allocation	Annually – Due to L.A. Care 120 calendar year end (April 30)	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Financial_Compliance Plan will also have the option to submit via email to remain compliant	
DELEGATION OVERSIGHT			
New Member Welcome Kit Mailing Reports	Quarterly – Due to L.A. Care the 15th day of each quarter end Q1 due 4/15 Q2 due 7/15 Q3 due 9/15 Q4 due 1/15	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Delegation Oversight	Format as specified by L.A. Care
HEALTH EDUCATION			
1. Health Education Referral Report	Quarterly – Due to L.A. Care the 25th day of the month following the end of the quarter: • Q1 due 4/25 • Q2 due 7/25 • Q3 due 10/25 • Q4 due 1/25	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Health Education/	Format as specified by LA. Care or mutually agreed upon per Plan Partner process.
2. Health Education Material Distribution Report	Quarterly – Due to L.A. Care the 25th day of the month following the end of the quarter: • Q1 due 4/25 • Q2 due 7/25 • Q3 due 10/25 • Q4 due 1/25	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Health Education/	Format as specified by LA. Care or mutually agreed upon per Plan Partner process.
3. Health Education Program Description and Work Plan	Annually – due to L.A. Care January 31st of each year	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Health Education/	As appropriate per Plan Partner model.
CULTURAL AND LINGUISTC SERVICES			
1. C&L Program Description and Work Plan	Annually – due to L.A. Care January 31st of each year	L.A. Care's Secure File Transfer Protocol (SFTP) *OR* Via email to CL_Reports_Mailbox@lacare.org	Plan Partner can submit their own format of C&L PD and work Plan. Requirement is in reference to Policy and Procedure CL-008 and C&L Program Description delegated

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

7. C&L Referral Report	Quarterly – Due to L.A. Care the 25th day of the month following the end of the quarter: • Q1 due 4/25 • Q2 due 7/25 • Q3 due 10/25 Q4 due 1/25	L.A. Care's Secure File Transfer Protocol (SFTP) *OR* Via email to CL_Reports_Mailbox@lacare.org	Format as specified by LA. Care or mutually agreed upon per Plan Partner process.

[Signature block appears on the following page]

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

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

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

By: _____
John Baackes
Chief Executive Officer

Date: _____, 2023

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

Date: _____, 2023

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

By: _____
Kristen Cerf
President and Chief Executive Officer

Date: _____, 2023

Amendment No. 58
to
Services Agreement
between
Local Initiative Health Authority for Los Angeles County
and
Blue Shield of California Promise Health Plan

This Amendment No. 58 is effective as of July 1, 2022, as indicated herein by and between the Local Initiative Health Authority for Los Angeles County, a local public agency operating as L.A. Care Health Plan ("Local Initiative") and ***Blue Shield of California Promise Health Plan***, a California health care service plan ("Plan").

RECITALS

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

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

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

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

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

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

IN WITNESS WHEREOF, the parties have entered into this Amendment No. 58 as of the date set forth below.

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

By: _____
John Baackes
Chief Executive Officer

Date: _____, 2023

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

By: _____
Kristen Cerf
President and Chief Executive Officer

Date: _____, 2023

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

Date: _____, 2023

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

Exhibit 8
Delegation Agreement
[Attachment A]

Delegated Activities Effective July 1, 2022-June 30, 2023
Responsibilities of Plan and Local Initiative

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

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

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

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

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

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

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

Standard	Delegated Activities	Retained by L.A. Care
	4. How member programs are coordinated. 5. How members are informed about available PHM programs. 6. How the organization promotes health equity. **CalAIM Program Strategy** Delegates must complete DHCS required annual strategy documents and share with L.A. Care for review. **NCQA Informing Members** The organization informs members eligible for programs that include interactive contact: 1. How members become eligible to participate 2. How to use program services. 3. How to opt in or opt out of the program	activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care. L.A. Care to coordinate collaborative shared SMART goal development included in all delegates' CalAIM Strategy submission.
Population Identification (NCQA PHM 2)	**NCQA Data Integration** The organization integrates the following data to use for population health management functions: 1. Medical and Behavioral claims or encounters 2. Pharmacy claim 3. Laboratory results 4. Health appraisal results 5. Electronic health records 6. Health Services programs within the organization 7. Advanced data sources **NCQA Population Assessment** The organization annually: 1. Assesses the characteristics and needs, including social determinants of health, of its member population. 2. Assesses the needs of child and adolescent members. 3. Assesses the needs of members with disabilities. 4. Assesses the needs of members with serious and persistent mental illness (SPMI). 5. Assesses the needs of members of racial or ethnic groups. 6. Assesses the needs of members with limited English proficiency. 7. Identifies and assesses the needs of relevant member subpopulations. **CalAIM Population Needs Assessment** The organization every three years completes the Population Needs Assessment per the DHCS requirements as detailed in APL 23-021. **Activities and Resources**	

Standard	Delegated Activities	Retained by L.A. Care
	The organization annually uses the population assessment to: 1. Review and update its PHM activities to address member needs 2. Review and update its PHM resources to address member need 3. Review and update activities or resources to address health care disparities for at least one identified population. 4. Review community resources for integration into program offerings to address member needs. **Segmentation** At least annually, the organization segments or stratifies its entire population into subsets for targeted intervention: 1. Segments or stratifies its entire population into subset for targeted intervention. 2. Assesses for racial bias in its segmentation or stratification methodology.	
Delivery System Supports (NCQA PHM 3)	**Practitioner or Provider Support** The organization supports practitioners or providers in its network to achieve population health management goals by: 1. Sharing data 2. Offering evidence-based or certified shared-decision making aids 3. Providing practice transformation support to primary care practitioners 4. Providing comparative quality information on selected specialties 5. Providing comparative pricing information for selected services 6. Providing training on equity, cultural competency, bias, diversity or inclusion	**Value-Based Payment Arrangements** The organization demonstrates that it has a value-based payment (VBP) arrangement(s) and reports the percentages of total payments tied to VBP.
Wellness and Prevention (NCQA PHM 4)	**Frequency of Health Appraisal Completion** This standard is required for the first survey under NCQA guidelines. Plans are still required to maintain compliance with this standard. NCQA only removed this requirement to submit documentation for renewal surveys. The organization has the capability to administer a health appraisal (HA) annually. **Topics of Self-Management Tools** The organization offers self-management tools derived from available evidence, that provide members with information on at least the following wellness and health promotion areas: 1. Healthy weight (BMI) maintenance. 2. Smoking and tobacco use cessation.	

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

Standard	Delegated Activities	Retained by L.A. Care
	12. Development of an individualized case management plan, including prioritized goals and considers member and caregiver goals, preferences and desired level of involvement in the case management plan 13. Identification of barriers to the member meeting goals or complying with the case management plan 14. Facilitation of member referrals to resources and follow-up process to determine whether members act on referral 15. Development of a schedule for follow-up and communication with the member 16. Development and communication of self-management plans. 17. A process to assess members' progress against case management plans. **Initial Assessment** An NCQA review of a sample of the organization's complex case management files demonstrates that the organization follows its documented processes for completing the following within 60 calendar days: 1. Initial assessment of members' health status, including condition-specific issues 2. Documentation of clinical history, including medications 3. Initial assessment of activities of daily living (ADL) 4. Initial assessment of behavioral health status, including cognitive functions 5. Initial assessment of social determinants of health 6. Evaluation of cultural and linguistic needs, preferences or limitations 7. Evaluation of visual and hearing needs, preferences or limitations 8. Evaluation of caregiver resources and involvement 9. Evaluation of available benefits 10. Evaluation of available community resources 11. Assessment of life planning activities. 12. Beginning the assessment for at least one factor within 30 calendar days of identifying a member for complex case management. **Case Management Ongoing Management** The NCQA review of a sample of the organization's case management files that demonstrates the Plan Partner follows its documented processes for: 1. Development of case management plans, including prioritized goals, that take into account member and caregiver goals, preferences and desired level	

Standard	Delegated Activities	Retained by L.A. Care
	of involvement in the complex case management program 2. Identification of barriers to meeting goals and complying with the case management plan 3. Development of a schedule for follow-up and communication with members. 4. Development and communication of member self-management plans. 5. Assessment of progress against case management plans and goals and modification as needed.	
Population Health Management Impact (NCQA PHM 6)	**<u>Measuring Effectiveness</u>** At least annually, the organization conducts a comprehensive analysis of the impact of its PHM strategy that includes the following: 1. Quantitative results for relevant clinical, cost/utilization and experience measures. 2. Comparison of results with a benchmark or goal. 3. Interpretation of results. **<u>Improvement and Action</u>** The organization uses results from the PHM impact analysis to annually: 1. Identify opportunities for improvement. 2. Act on one opportunity for improvement.	
Sub-Delegation of PHM (NCQA PHM 7)	**<u>Sub-Delegation Agreement</u>** **(LAC will ask Delegate of its sub-delegate during the annual audit)** The written sub-delegation agreement: 1. Is mutually agreed upon 2. Describes the sub-delegated activities and the responsibilities of the delegate and the sub-delegated entity 3. Requires at least semiannual reporting by the sub-delegated entity to the delegate 4. Describes the process by which the delegate evaluates the sub-delegated entity's performance 5. Describes the process for providing member experience and clinical performance data to its delegates when requested. 6. Describes the remedies available to the delegate if the sub-delegated entity does not fulfill its obligations, including revocation of the sub-delegation agreement **<u>Predelegation Evaluation</u>** For new sub-delegation agreements initiated in the look-back period, the delegated entity evaluates sub-delegate capacity to meet NCQA requirements before sub-delegation begins.	

Standard	Delegated Activities	Retained by L.A. Care
	Review of PHM Program For arrangements in effect for 12 months or longer, the delegate: 1. Annually reviews its sub-delegate's PHM program 2. Annually audits complex case management files against NCQA standards for each year that sub-delegation has been in effect, if applicable 3. Annually evaluates sub-delegate performance against NCQA standards for sub-delegated activities 4. Semiannually evaluates regular reports, as specified in the sub-delegation agreement **Opportunities for Improvement** For sub-delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that sub-delegation has been in effect, the delegate identified and followed up on opportunities for improvement, if applicable.	
	NETWORK MANAGEMENT	
Availability of Practitioners (NCQA NET 1)	**Cultural Needs and Preferences** The organization annually: 1. Assessing the cultural, ethnic, racial, and linguistic needs of members 2. Adjusts the availability of practitioners within its network if necessary. **Practitioners Providing Primary Care** To evaluate the availability of practitioners who provide primary care services, including general medicine or family practice, internal medicine and pediatrics, the organization: 1. Establishes measurable standards for the number of each type of practitioners providing primary care 2. Establishes measurable standards for the geographic distribution of each type of practitioner providing primary care. 3. Annually analyzes performance against the standards for the number of each type of practitioner providing primary care 4. Annually analyzes performance against the standards for the geographic distribution of each type of practitioner providing primary care. **Practitioners Providing Specialty Care** To evaluate the availability of specialists in its delivery system, the organization: 1. Defines the types of high-volume and high-impact specialists	

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

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

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

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

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

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

Standard	Delegated Activities	Retained by L.A. Care
	3. Has written policies for applying the criteria based on an assessment of the local delivery system 4. Involves appropriate practitioners in developing, adopting and reviewing criteria. 5. Annually reviews UM criteria and the procedures for applying them and updating them, and updates the criteria when appropriate. **Availability of Criteria** The organization: 1. States in writing how practitioners can obtain the UM criteria 2. Makes the criteria available to practitioners upon request. **Consistency in Applying Criteria** At least annually, the organization: 1. Evaluates the consistency with which health care professionals involved in UM apply criteria in decision making 2. Acts on opportunities to improve consistency, if applicable.	activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.
Communication Services (NCQA UM 3)	**Access to Staff** The organization provides the following communication services for members and practitioners: 1. Staff are available at least eight (8) hours a day during normal business hours for inbound collect or toll-free calls regarding UM issues 2. Staff can receive inbound communication regarding UM issues after normal business hours 3. Staff are identified by name, title, and organization name when initiating or returning calls regarding UM issues 4. TDD/TTY services for members who need them 5. Language assistance for members to discuss UM issues.	
Appropriate Professionals (NCQA UM 4)	**Licensed health Professionals** The organization has written procedures: 1. Requiring appropriately licensed professionals to supervise all medical necessity decisions 2. Specifying the type of personnel responsible for each level of UM decision-making. **Use of Practitioners for UM Decisions** The organization has a written job description with qualifications for practitioners who review denials of care based on medical necessity. Practitioners are required to have: 1. Education, training and professional experience in medical or clinical practice	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

Standard	Delegated Activities	Retained by L.A. Care
	2. A current clincial license to practice or an administrative license to review UM cases without restriction. **Practitioner Review of Nonbehavioral healthcare Denials** The organization uses a physician, or other healthcare professional as appropriate, reviews any non-behavioral healthcare denial of coverage based on medical necessity. **Practitioner Review of Behavioral Healthcare Denials** The organization uses that a physician or appropriate behavioral healthcare practitioner, to review any behavioral healthcare denial of care based on medical necessity. **Practitioner Review of Pharmacy Denials** The organization uses a physician or a pharmacist reviews pharmacy denials based on medical necessity. Note: This only applies to pharmaceuticals (Physician Administered Drugs) covered under the medical benefit. **Use of Board Certified Consultants** The organization: 1. Has written procedures for using board certified consultants to assist in making medical necessity determinations 2. Provides evidence that it uses board-certified consultants for medical necessity determinations	
Timeliness of UM Decisions (NCQA UM 5)	**Notification of Nonbehavioral Decisions** The organization adheres to the following time frames for notification of non-behavioral healthcare UM Decisions: 1. N/A Marketplace 2. For Medicaid urgent concurrent decisions, the organization gives electronic or written notification of the decision to members and practitioners within 72 hours of the request. 3. For Medicaid urgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 72 hours of the request. 4. For Medicaid nonurgent preservice decisions the organization gives electronic or written notification of the decision to members and practitioners within 14 calendar days of the request.	

Standard	Delegated Activities	Retained by L.A. Care
	5. For Medicaid postservice decisions the organization gives electronic or written notification of the decision to members and practitioners within 30 calendar days of the request. 6. For postservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 30 calendar days of the request. **Notification of Behavioral Healthcare Decisions** The organization adheres to the following time frames for notification of behavioral healthcare UM decisions: 1. N/A (Marketplace) 2. For Medicaid urgent concurrent decisions, the organization gives electronic or written notification of the decision to members and practitioners within 72 hours of the request. 3. For Medicaidurgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 15 calendar days of the request. 4. For Medicaid nonurgent preservice decisions the organization gives electronic or written notification of the decision to members and practitioners within 14 calendar days of the request. 5. For Medicaid post service decisions, the organization gives electronic or written notification of the decision to practitioners and members within 30 calendar days of the request. **Notification of Pharmacy Decisions** The organization adheres to the following time frames for notifying members and practitioners of pharmacy UM decisions: 1. For Medicaid urgent concurrent decisions electronic or written notification of the decision to members and practitioners within 24 hours of the request. 2. For Medicaid urgent preservice decisions electronic or written notification of the decision to members and practitioners within 72 hours of the request. 3. For Medicaid nonurgent preservice decisions electronic or written notification of the decision to members and practitioners within 15 calendar days of the request.	

Standard	Delegated Activities	Retained by L.A. Care
	4. For Medicaid postservice decisions electronic or written notification of the decision to members and practitioners within 30 calendar days of the request. 5. N/A (Medicare and Marketplace) **Timeliness Report** The organization monitors and submits a report for timeliness of: 1. Notification of non-behavioral UM decisions 2. 3. Notification of behavioral UM decisions 4. Notification of pharmacy UM decisions Note: This only applies to pharmaceuticals (Physician Administered Drugs) covered under the medical benefit. ***Note: L.A. Care and Plan must adhere to the applicable standards identified in the California Health and Safety Code and DHCS Contract, all current regulatory notifications (such as APLs), as well as the most recent NCQA HP Standards***	
Clinical Information (NCQA UM 6)	**Relevant Information for Nonbehavioral Healthcare Decisions** There is documentation that the organization gathers relevant clinical information consistently to support nonbehavioral healthcare UM decision making. **Relevant Information for Behavioral Healthcare Decisions** There is documentation that the organization gathers relevant clinical information consistently to support behavioral healthcare UM decision making. **Relevant Information for Pharmacy Decisions** The organization documents that it consistently gathers relevant information to support pharmacy UM decision making. Note: This only applies to pharmaceuticals (Physician Administered Drugs) covered under the medical benefit.	
Denial Notices (NCQA UM 7)	**Discussing a Denial With a Nonbehavioral Healthcare Reviewer** The organization gives practitioners the opportunity to discuss nonbehavioral healthcare UM denial decisions with a physician or other appropriate reviewer.	

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

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

Standard	Delegated Activities	Retained by L.A. Care
	2. An explanation of the appeal process including the member's right to representation and the appeal time frames. 3. A description of the expedited appeal process for urgent preservice or urgent concurrent denials. 4. Notification that expedited external review can occur concurrently with the internal appeal process for urgent care Note: This only applies to pharmaceuticals (Physician Administered Drugs) covered under the medical benefit.	
Policies for Appeals (NCQA UM 7 NCQA UM 8)	**<u>Internal Appeals</u>** The organization's written policies and procedures for registering and responding to written internal appeals include the following: 1. Allowing at least sixty (60) calendar days after notification of the denial for the member to file the appeal. 2. Documenting the substance of the appeal and any actions taken 3. Full investigation of the substance of the appeal, including any aspects of clinical care involved 4. The opportunity for the member to submit written comments, documents or other information relating to the appeal 5. Appointment of a new person to review an appeal, who was not involved in the initial determination and who is not the subordinate of any person involved in the initial determination 6. Appointment of at least one person to review an appeal who is a practitioner in the same or similar specialty The decision for a pre-service appeal and notification to the member within 30 calendar days of receipt of the request. 7. For Medicaid only, the decisions for postservice appeals and notifications to the members must be within 30 calendar days of receipt of the request. 8. The decision for an expedited appeal and notification to the member within 72 hours of receipt of the request. 9. Notification to the member about further appeal rights. 10. Referencing the benefit provision, guideline, protocol or other similar criterion on which the appeal decision is based 11. Giving members reasonable access to and copies of all documents relevant to the appeal, free of charge, upon request.	Members have the option to appeal directly to L.A. Care. Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

Standard	Delegated Activities	Retained by L.A. Care
	12. Including a list of titles and qualifications, including specialties, of individuals participating in the appeal review 13. Allowing an authorized representative to act on behalf of the member 14. Continued coverage pending the outcome of an appeal.	
Appropriate Handling of Appeals (NCQA UM 9)	**<u>Preservice and Postservice Appeals</u>** An NCQA review of the organization's appeal files indicates that they contain the following information: 1. Documenting the substance of appeals 2. Investigating appeals 3. Appropriate response to the substance of the appeal. **<u>Timeliness of the Appeal Process</u>** The organization adheres to the following time frames for notification of preservice, postservice and expedited appeal decisions.: 1. For preservice appeals, the organization gives electronic or written notification within thirty (30) calendar days of receipt of the request 2. For Medicaid postservice appeals, the organization gives electronic or written notification within thirty (30) calendar days of receipt of the request 3. For expedited appeals, the organization gives electronic or written notification within seventy-two (72) hours of receipt of the request. **<u>Appeal Reviewers</u>** The organization provides non-subordinate reviewers who were not involved in the previous determination and same or similar specialist review, as appropriate. **<u>Notification of Appeal Decision/Rights</u>** An NCQA review of the organization's internal appeal files indicates notification to members of the following: 1. Specific reasons for the appeal decision in easily understandable language 2. A reference to the benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based 3. Notification that the member can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based, upon request. 4. Notification that the member is entitled to receive reasonable access to and copies of all documents free of charge upon request.	Members have the option to appeal directly to L.A. Care. Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

Standard	Delegated Activities	Retained by L.A. Care
	5. The list of titles and qualifications, including specialties, of individuals participating in the appeal review 6. A description of the next level of appeal, either within the organization or to an independent external organization, as applicable, along with relevant written procedures. **Final Internal and External Appeal Files** N/A **Appeals Overturned by the IRO** N/A	
Evaluation of New Technology (NCQA UM 10)		**Written Process** Evaluates the inclusion of new technology and the new application of existing technology in the benefits plan, including medical and behavioral health procedures, physician administered drugs effective January 2022 and devices. This element is Not Applicable for Medicaid product lines if the state mandates all benefits and new technology determinations. L.A. Care will provide the state's language. **Description of the Evaluation Process** This element is Not Applicable for Medicaid product lines if the state mandates all benefits and new technology determinations. L.A. Care will produce documentation that demonstrates this.
Procedures for Pharmaceutical Management (NCQA UM 11)	**Pharmaceutical Management Procedures** The organization's policies and procedures for pharmaceutical management include the following: 1. The criteria used to adopt pharmaceutical management procedures 2. A process that uses clinical evidence from appropriate external organizations 3. A process to include pharmacists and appropriate practitioners in the development of procedures	

Standard	Delegated Activities	Retained by L.A. Care
	4. A process to provide procedures to practitioners annually and when it makes changes. **Pharmaceutical Restrictions/Preferences** Annually and after updates, the organization communicate to members and prescribing practitioners: 1. A list of pharmaceuticals including restrictions, updates and preferences to post on its Internet website and update that posting with changes on a monthly basis (SB1052) 2. How to use the pharmaceutical management procedures 3. An explanation of limits or quotas 4. How prescribing practitioners must provide information to support an exception request 5. The process for generic substitution, therapeutic interchange and step-therapy protocols. **Pharmaceutical Patient Safety Issues** The organization's pharmaceutical procedures include: 1. Identifying and notifying members and prescribing practitioners affected by Class II recalls or voluntary drug withdrawals from the market for safety reasons within thirty (30) calendar days of the FDA notification 2. An expedited process for prompt identification and notification of members and prescribing practitioners affected by a Class I recall. **Reviewing and Updating Procedures** With the participation of physicians and pharmacists the organization annually: 1. Reviews the procedures 2. Reviews the list of pharmaceuticals 3. Updates the procedures as appropriate 4. Updates the list of pharmaceuticals, as appropriate, and 5. Post the list with changes on its Internet website on a monthly basis. (SB1052) **Considering Exceptions** The organization has exceptions policies and procedures that describe the process for: 1. Making exception requests based on medical necessity 2. Obtaining medical necessity information from prescribing practitioners 3. Using appropriate pharmacists and practitioners to consider exception requests	

Standard	Delegated Activities	Retained by L.A. Care
	4. Timely handling of request 5. Communicating the reason for denial and explanation of the appeal process when it does not approve an exception request. Note: This only applies to pharmaceuticals (Physician Administered Drugs) covered under the medical benefit.	
UM System Controls (NCQA UM 12)	**<u>UM Denial System Controls</u>** The organization has policies and procedures describing its system controls specific to UM denial notification dates that: 1. Define the date of receipt consistent with NCQA requirements. 2. Define the date of written notification consistent with NCQA requirements. 3. Describe the process for recording dates in systems. 4. Specify titles or roles of staff who are authorized to modify dates once initially recorded and circumstances when modification is appropriate. 5. Specify how the system tracks modified dates. 6. Describe system security controls in place to protect data from unauthorized modification. 7. Describe how the organization monitors its compliance with the policies and procedures in factors 1–6 at least annually and takes appropriate action, when applicable. **<u>UM Denial System Controls Oversight</u>** At least annually, the organization demonstrates that it monitors compliance with its UM denial controls, as described in Element A, factor 7, by: 1. Identifying all modifications to receipt and decision notification dates that did not meet the organization's policies and procedures for date modifications. 2. Analyzing all instances of date modifications that did not meet the organization's policies and procedures for date modifications. 3. Acting on all findings and implementing a quarterly monitoring process until it demonstrates improvement for one finding over three consecutive quarters. **<u>UM Appeal System Controls</u>**	

Standard	Delegated Activities	Retained by L.A. Care
	The organization has policies and procedures describing its system controls specific to UM appeal dates that: 1. Define the date of receipt consistent with NCQA requirements. 2. Define the date of written notification consistent with NCQA requirements. 3. Describe the process for recording dates in systems. 4. Specify titles or roles of staff who are authorized to modify dates once initially recorded and circumstances when modification is appropriate. 5. Specify how the system tracks modified dates. 6. Describe system security controls in place to protect data from authorized modification. 7. Describe how the organization monitors its compliance with the policies and procedures in factors 1-6 at least annually and takes appropriate action, when applicable. **UM Appeal System Control Oversight** At least annually, the organization demonstrates that it monitors compliance with its UM appeal controls, as described in Element C, factor 7, by: 1. Identifying all modifications to receipt and decision notification dates that did not meet the organization's policies and procedures for date modifications. 2. Analyzing all instances of date modifications that did not meet the organization's policies and procedures for date modifications. 3. Acting on all findings and implementing a quarterly monitoring process until it demonstrates improvement for one finding over three consecutive quarters.	
Sub-Delegation of UM (NCQA UM 13)	**Sub-Delegation Agreement** The written delegation agreement: 1. Is mutually agreed upon 2. Describes the delegated activities and the responsibilities of the organization and the delegated entity.	

Standard	Delegated Activities	Retained by L.A. Care
	3. Requires at least semiannual reporting by the delegated entity to the organization. 4. Describes the process by which the organization evaluates the delegated entity's performance. 5. Describes the process for providing member experience and clinical performance data to its delegates when request. 6. Describes the remedies available to the organization if the delegated entity does not fulfill its obligations including revocation of the delegation agreement. **Predelegation Evaluation** For new delegation agreements initiated in the look-back period, the organization evaluated delegate capacity to meet NCQA requirements before delegation began. **Review of the UM Program** For arrangements in effect for 12 months or longer, the organization: 1. Annually reviews its delegate's UM program. 2. Annually audits UM denials and appeals files against NCQA standards for each year that delegation has been in effect. 3. Annually evaluates delegate performance against NCQA standards for delegated activities. 4. Semiannually evaluates regular reports, as specified in Element A. 5. At least annually monitors the delegate's UM denial and appeal system security controls to ensure that the delegate monitors its compliance with the delegation agreement or with the delegate's policies and procedures 6. At least annually acts on all findings from factor 5 for each delegate and implements a quarterly monitoring process until each delegate demonstrates improvement for one finding over three consecutive quarters. **Opportunities for Improvement** For delegation arrangements that have been in effect for more than 12 months at least once in each of the past 2 years the organization identified and followed up on opportunities for improvement if applicable.	
	CREDENTIALING	

Standard	Delegated Activities	Retained by L.A. Care
Credentialing Policies (NCQA CR 1) DMHC, DHCS, CMS	The Delegate has a well-defined credentialing and recredentialing process for evaluating licensed independent practitioners, non-physician medical practitioners (NMPs) and non-medical/clinical providers (NCPs) to provide care to its members by developing and implementing credentialing policies and procedures which specify: **<u>Practitioner Credentialing Guidelines</u>** The organization has a rigorous process to select and evaluate practitioners: 1. The types of practitioners to credential and re-credential, to also include all administrative physician reviewers responsible for making medical decisions. 2. The verification sources used. 3. The criteria for credentialing and re-credentialing. 4. The policies must explicitly define the process and criteria used for making credentialing and re-credentialing decisions. 5. The process for managing credentialing files that meet Delegate's established criteria. Policies must describe the process it uses to determine and approve clean files or the Delegate may present all files to the Credentialing Committee, including clean files, or it may designate approval authority to the medical director or to an equally qualified practitioner. 6. The process for requiring that credentialing and recredentialing are conducted in a nondiscriminatory manner. Policies must specify that the Delegate does not base credentialing decisions on an applicant's race, ethnic/national identity, gender, age, sexual orientation or patient type in which the practitioner specializes. Has a process for preventing and monitoring discriminatory practices and monitors the credentialing and recredentialing processes for discriminatory practices, at least annually and maintain a heterogeneous credentialing committee to sign a statement affirming that they do not discriminate when they make decisions. 7. The process for notifying practitioners about any information obtained during the credentialing process that varies substantially from the information provided to Delegate by the practitioner. 8. The process to ensure that practitioners are notified of initial and recredentialing decisions	L.A. Care retains the right based on quality issues to approve, suspend and terminate individual practitioners, providers and sites at all times. Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' credentialing activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

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

Standard	Delegated Activities	Retained by L.A. Care
(DHCS APL22-013)	**<u>Credentialing System Controls Oversight</u>** At least annually, the organization demonstrates that it monitors compliance with its credentialing controls, as described in Element C, factor 5, by: 1. Identifying all modifications to credentialing and recredentialing information that did not meet the organization's policies and procedures for modifications. 2. Analyzing all instances of modifications that did not meet the organization's policies and procedures for modifications. 3. Acting on all findings and implementing a quarterly monitoring process until it demonstrates improvement for one finding over three consecutive quarters. **Medi-Cal FFS Enrollment** Developing and implementing policies and procedures for Medi-Cal enrollment. Policy must clearly specify enrollment process including, but not limited to: 1. All practitioners that have a FFS enrollment pathway must enroll in the Medi-Cal program.process for ensuring and verifying Medi-Cal enrollment prior to contracting. 2. The process for ensuring and verifying Medi-Cal enrollment prior to contracting. 3. The process for practitioners whose enrollment application is in process. 4. The process for monitoring between recredentialing cycles to validate continued enrollment. 5. Process for practitioners not currently enrolled in the Medi-Cal program. 6. Process for practitioners deactivated, suspended or denied from the Medi-Cal program. During the annual oversight review, the Delegate is subject to a CAP (Corrective Action Plan) if their documented process does not align with policies. In addition, if the Delegate demonstrates reoccurring deficiencies that were identified in previous audits, the Delegate is subject to additional point deductions.	
Credentialing Committee (NCQA CR 2) DHCS, DMHC, CMS	Designating a credentialing committee that uses a peer review process to make recommendations regarding credentialing and recredentialing decisions such that: The committee:	

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

Standard	Delegated Activities	Retained by L.A. Care
	• Completion of a residency program. • Graduation from medical or professional school. 4. For Non-Physician Medical Practitioners (NMPs) and Non-Clinical Providers (NCPs), the Delegate verifies the provider has met the qualifications to render services based on the provider type including but not limited to, a current and valid license, registration, certification or the education/training equivalent. 5. Work history. 6. Current malpractice insurance coverage ($1 million/$3 million). 7. A history of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner. 8. Clinical Privileges in good standing at a Plan contracted facility designated by the physician as the primary admitting facility. 9. Current, valid FSR/MRR of primary care physician (PCP) offices within 3 years prior to credentialing decision. 10. CLIA Certifications, if applicable. 11. NPI number. 12. Medicare number, if applicable 13. Medi-Cal FFS enrollment. All certifications and expiration dates must be made part of the practitioner's file and kept current. Delegate shall maintain credentialing and/or other monitoring processes to assure that licensure and professional status of each Participating Provider is verified on an ongoing basis. Pursuant to the performance of its credentialing, recredentialing, auditing, monitoring and/or other processed, which include confirmation relating to the following: ▪ Each Participating Provider/Practitioner is and shall remain duly licensed, registered or certified, as required by the laws of this State, and such licensure is free from restrictions that would restrict or limit the ability of Participating provider/practitioner to provide Health Care Services to LAC members as required under the Agreement. ▪ Each Delegate shall maintain professional liability insurance, either independently or through Contractor or some other entity, in a dollar amount that is sufficient for his/her/its practice and as may be required	

Standard	Delegated Activities	Retained by L.A. Care
	by law or accrediting entities. The Delegate's participating providers must also have general liability insurance in a dollar amount appropriate for their business practice. The Delegate must notify L.A. Care immediately when a practitioner's license has expired for removal from the network.	
CR Sanction Information (NCQA CR 3) DHCS, DMHC, CMS	Primary source verification and credentialing and recredentialing decision-making, which includes verifying, within the NCQA prescribed time limits, through primary or other NCQA-approved sources, the following prior to credentialing and recredentialing. a. State sanctions, restrictions on licensure, or limitations on scope of practice. Review of information must cover the most recent 5-year period available. If a practitioner is licensed in more than one state, in the most recent 5-year period, the query must include all states in which they worked b. Medicare and Medicaid sanctions. c. *Medicare Opt-out. d. SAM. e. CMS Preclusion. f. Debarment g. Decertification Providers must not be terminated, sanctioned, suspended, debarred, disenrolled/decertified, convicted of a felony related to healthcare program fraud or excluded from participation in any federal or state funded programs. L.A. Care does not contract, credential, refer, or pay claims to Practitioners or Providers who have opted out of participation in the Medicare and Medicaid programs; or with individuals or businesses that have been convicted of a felony related to healthcare program fraud, federally or state terminated, sanctioned, suspended, debarred, disenrolled/decertified, excluded, or have appeared on any sanction reports, or on any order issued by judicial authority. Such Practitioners, Providers, individuals, or businesses are ineligible from participation in Medi-Cal, Medicare, federal or state funded programs.	

Standard	Delegated Activities	Retained by L.A. Care
	The Delegate must notify L.A. Care immediately when practitioners are identified on any sanctions or reports for removal from the network.	
CR Application and Attestation (NCQA CR 3) DHCS, DMHC, CMS	Applications for credentialing and recredentialing include the following: a. Reasons for inability to perform the essential functions of the position, with or without accommodation. b. Lack of present illegal drug use. c. History of loss of license and felony convictions. d. History of loss or limitation of privileges or disciplinary action. e. Current malpractice insurance coverage. ($1million/$3 million). f. g. Current and signed attestation confirming the correctness and completeness of the application.	
Re-credentialing Cycle Length (NCQA CR 4) DHCS, DMHC, CMS	Recredentialing all practitioners at least every 36 months. For PCPs only, must confirm provider has a valid FSR at least every 36 months as part of the recredentialing process.	
CR Ongoing Monitoring and Interventions (NCQA CR 5) DHCS, DMHC, CMS	Developing and implementing policies and procedures for ongoing monitoring of practitioner sanctions, complaints and quality issues and takes appropriate action against practitioners when it identifies occurrences of poor quality between recredentialing cycles by: 1. Collecting and reviewing Medicare and Medicaid sanctions within 30 calendar days of its release. In areas where reporting entities do not publish sanction information on a set schedule, the Delegate must query for this information at least every 6 months 2. Collecting and reviewing accusations, sanctions or limitations on licensure and report actions taken against any identified practitioners to Plan. 3. Collecting and reviewing complaints. 4. Collecting and reviewing information from identified adverse events. 5. Implementing appropriate interventions when delegate identifies instances of poor quality. a. The Delegate's Credentialing committee may vote to flag a practitioner for ongoing monitoring.	Upon notification of any Adverse Event, L.A. Care will notify the Delegate of their responsibility with respect to delegation of credentialing/re-credentialing activity. The notification will clearly delineate what is expected from the Adverse Event that has been identified. The notice will include, but is not limited to: a. Requesting what actions will be taken by the Delegate. b. What type of monitoring is being performed. c. What interventions are being implemented including closing panel, moving members, or removal of practitioner from the network. d. The notification will include a timeframe for responding to L.A. Care to ensure L.A. Care's members receive the highest level of quality care.

Standard	Delegated Activities	Retained by L.A. Care
	b. The Delegate must make clear the types of monitoring it imposes, the timeframe used, the intervention, and the outcome, which must be fully demonstrated in the Delegate's credentialing committee minutes. c. The Delegate's credentialing committee can: • Request a practitioner be placed on a watch list. Any list must be clearly defined and monitored. • Request that the practitioner demonstrate compliance with probation that has been imposed by the State and monitor completion. • Impose upon the practitioner to demonstrate steps they have taken to improve processes and/or chart review, if applicable. d. Delegated entities who fail to comply with the requested information within the specified timeframe are subject to sanctions as described in L.A. Care's policies and procedures. e. The Plan will clearly delineate what is expected from the Delegate regarding the Adverse Event that has been identified. The notification may include performing the following: • Requesting what action will be taken by the Delegate. • What type of monitoring is being performed. • What interventions are being implemented, including closing panel, moving members, or removal of practitioner from the network. • The notification will include a timeframe for responding to L.A. Care to ensure L.A. Care members receive the highest level of quality care. 6. In the event that the Delegate fails to respond as required, L.A. Care will perform the oversight functions of the Adverse Event and the Delegate will be subject to L.A. Care's credentialing committee's outcome of the adverse events. 7. The Delegate must notify L.A. Care immediately when practitioners are identified on any sanctions or reports for removal from the network.	

Standard	Delegated Activities	Retained by L.A. Care
	8. The above are samples, but not limited to, the steps the Delegate can take.	
Notification to Authorities and Practitioner Appeal Rights (NCQA CR 6) DHCS, DMHC, CMS	The Delegate uses objective evidence and patient care considerations when deciding on a course of action for dealing with a practitioner who does not meet its quality standards, including: 1. Developing and implementing policies and procedures that specify: a. The range of actions available to Delegate. b. That the Delegate reviews participation of practitioners whose conduct could adversely affect members' health or welfare. c. The range of actions that may be taken to improve practitioner performance before termination. d. That the Delegate reports its actions to the appropriate authorities. e. Making the appeal process known to practitioners. All final adverse actions determined to be reportable pursuant to applicable law, must be reported by the Delegate to the National Practitioner Data Bank (NPBD) and the appropriate State Medical Boards. Upon the filing of NPBD reports and 805 reporting, the Delegate must notify the Plan within 5 business days from the date the reports are filed. Providers must notify the Delegate, in writing, of any adverse or criminal action taken against them promptly and no later than fourteen (14) calendar days from the occurrence of any adverse event, criminal action, changes in privileges, accusation, probation, or other disciplinary action of practitioners. Failure to do so may result in the removal of the practitioner from L.A. Care's network as referenced in the California Participating Physician Application Information Release Acknowledgments. Upon notification from a contracted or employed provider, the PPG must notify the Healthplan immediately or no later than 5 business days from the date when practitioners are identified on any ongoing monitoring reports.	L.A. Care retains accountability for procedural components and will oversee Delegate's adherence to these standards through pre-delegation, routine monitoring and annual oversight review or more frequently, as required, per changes in contract, Federal and State regulatory guidelines and accreditation standards.

Standard	Delegated Activities	Retained by L.A. Care
	Within 14 days from criminal action taken against any contracted practitioner, Delegate shall notify L.A. Care in writing.	
CR Assessment of Organizational Providers (NCQA CR 7) DHCS, DMHC, CMS	The Delegate's policy for assessing a health care delivery provider specifies that before it contracts with a provider, and for at least every 36 months thereafter it: 1. Confirms that the provider is in good standing with state and federal regulatory bodies. 2. Confirms that the provider has been reviewed and approved by an accrediting body acceptable to Delegate, including which accrediting bodies are acceptable. 3. Conducts an onsite quality assessment if the provider is not accredited. 4. At least every three years that the provider continues to be in good standing with state and federal regulatory bodies and, if applicable, is reviewed and approved by an accrediting body acceptable to Delegate. Maintaining a tracking log that includes names of the organization, type of organization, a prior validation date, a current validation date for licensure, accreditation status (if applicable), CMS or state reviews conducted within 3 years at time of verification (if applicable), CLIA certificate (if applicable), NPI number for each organizational provider. The Delegate includes at least the following medical providers in its assessment: a. Hospitals. b. Home health agencies. c. Skilled nursing facilities. d. Freestanding surgical centers. e. Federally Qualified Health Center (FQHCs). f. Federally Qualified Health Center (FQHCs). g. Any other ancillary provider types outlined in the delegate's contract with the Plan The Delegate includes behavioral healthcare facilities providing mental health or substance abuse services in the following setting: a. Inpatient. b. Residential. c. Ambulatory. The Delegate assesses contracted medical health care providers.	

Standard	Delegated Activities	Retained by L.A. Care
	The Delegate assesses contracted behavioral healthcare providers.	
Sub-Delegation of CR (NCQA CR 8) DHCS, DMHC, CMS	**<u>Subdelegation Agreement:</u>** If Delegate sub-delegates any NCQA required credentialing activities, there must be evidence of oversight of the delegated activities, including a written sub-delegation agreement that: 1. Is mutually agreed upon. 2. Describes the sub-delegated activities and the responsibilities of the organization and the delegated entity. 3. Requires at least quarterly reporting to Delegate. 4. Describes the process by which Delegate evaluates sub-delegate's performance. 5. Specifies that the delegate retains the right to approve, suspend and terminate individual practitioners, providers and sites, even if the organization delegates decision making. 6. Describes the remedies available to Delegate if sub-delegate does not fulfill its obligations, including revocation of the delegation agreement. Retention of the right by Delegate and LA Care, based on quality issues, to approve, suspend, and terminate individual practitioners, providers, and sites. **<u>Presubdelegation Evaluation:</u>** For new sub-delegation agreements initiated in the look-back period, the Delegate evaluated sub-delegate capacity to meet NCQA requirements before sub-delegation begins **<u>Review of Subdelegates Credentialing Activities:</u>** For sub-delegation arrangements in effect for 12 months or longer, the Delegate: a. Annually reviews its sub-delegate's credentialing policies and procedures. b. Annually audits credentialing and recredentialing files against NCQA standards for each year that sub-delegation has been in effect. c. Annually evaluates the sub-delegate's performance against relevant regulatory requirements; NCQA standards and Delegate's expectations annually d. Evaluates regular reports from sub-delegate at least quarterly or more frequently based on the	L.A. Care retains the right to perform a pre-delegation audit of any entity to which the Plan sub-delegates delegated credentialing activities and approve any such sub-delegation audit of any sub-delegate. Prior to entering into an agreement to sub-delegate delegated credentialing activities, Delegated Plan shall provide L.A. Care with reasonable prior notice of Plan's intent to sub-delegate.

Standard	Delegated Activities	Retained by L.A. Care
	reporting schedule described in the sub-delegation document. e. Annually monitors the delegate's credentialing system security controls to ensure that the delegate monitors its compliance with the delegation agreement or with the delegate's policies and procedures at least annually. f. Annually acts on all findings from factor 5 for each delegate and implements a quarterly monitoring process until each delegate demonstrates improvement for one finding over three consecutive quarters. **Opportunities for Improvement:**For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years, the organization identifies and follows up on opportunities for improvement, if applicable. If a Delegate fails to complete the corrective action plan and has gone through the exigent process which results in de-delegation, the Delegate cannot appeal and must wait one year to reapply for a pre-delegation audit. If the pre-delegation audit reveals deficiencies identified are the same as those from previous audits, delegation will be at the sole discretion of the Credentialing Committee regardless of score.	
MEMBER EXPERIENCE		
Statement of Members' Rights and Responsibilities (NCQA ME 1)	**Distribution of Rights Statement** The organization distributes its member rights and responsibilities statement to the following groups: 1. New members, upon enrollment. 2. Existing members, if requested. 3. New practitioners, when they join the network. 4. Existing practitioners, if requested.	**Rights and Responsibilities Statement** The organization's member rights and responsibilities statement specifies that members have: 1. A right to receive information about the organization its services its practitioners and providers and member rights and responsibilities. 2. A right to be treated with respect and recognition of their dignity and their right to privacy. 3. A right to participate with practitioners in making decisions about their health care. 4. A right to a candid discussion of appropriate or medically necessary treatment options

Standard	Delegated Activities	Retained by L.A. Care
		for their conditions regardless of cost or benefit coverage. 5. A right to voice complaints or appeals about the organization or the care it provides. 6. A right to make recommendations regarding the organization's member rights and responsibilities policy. 7. A responsibility to supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care. 8. A responsibility to follow plans and instructions for care that they have agreed to with their practitioners. 9. A responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goals to the degree possible. L.A. Care adheres to the most current NCQA standards to comply with these requirements.
Subscriber Information (NCQA ME 2)		**<u>Subscriber Information</u>** L.A. Care informs its subscribers upon enrollment and annually thereafter about benefits and access to medical services. **<u>Distribution of Subscriber Information</u>** The organization distributes its subscriber information to the following groups: 1. New members, upon enrollment. 2. Existing members, annually. **<u>Interpreter Services</u>** L.A. Care provides interpreter or bilingual services in its Member Services Department and

Standard	Delegated Activities	Retained by L.A. Care
		telephone functions based on linguistic needs of its subscribers. L.A. Care adheres to the most current NCQA standards to comply with these requirements.
Marketing Information (NCQA ME 3)		**<u>Materials and Presentations</u>** L.A. Care's prospective members receive an accurate description of the organization's benefits and operating procedures. L.A. Care adheres to the most current NCQA standards to comply with these requirements. **<u>Communicating with Prospective Members</u>** The organization uses easy-to-understand language in communications to prospective members about its policies and practices regarding collection, use and disclosure of PHI: 1. In routine notification of privacy practices 2. The right to approve the release of information (use of authorizations) 3. Access to Medical Records 4. Protection of oral, written, and electronic information across the organization 5. Information for employers **<u>Assessing Member Understanding</u>** The organization systematically takes the following steps: 1. Assesses how well new members understand policies and procedures. The right to approve the release of information (use of authorizations) 2. Implements procedures to maintain accuracy of marketing communication. Protection of oral, written, and electronic information across the organization 3. Acts on opportunities for improvement, if applicable.

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Functionality of Claims Processing (NCQA ME 4)	**Functionality-Website** Members can track the status of their claims in the claims process and obtain the following information on the organization's website in one attempt or contact: 1. The stage in the process. 2. The amount approved. 3. The amount paid. 4. The member's cost. 5. The date paid **Functionality-Telephone Requests** Members can track the status of their claims in the claims process and obtain the following information over the telephone in one attempt or contact: 1. The stage in the process. 2. The amount approved. 3. The amount paid. 4. Member cost. 5. The date paid	
Personalized Information on Health Plan Services (NCQA ME 6)	**Functionality-Website** Members can complete each of the following activities on the organization's website in one attempt or contact: 1. Change a primary care practitioner, as applicable. 2. Determine how and when to obtain referrals and authorizations for specific services, as applicable 3. Determine benefit and financial responsibility for a specific service or treatment from a specified provider or institution, if applicable. **Functionality Telephone** To support financial decision making, members can complete each of the following activities over the telephone within one business day: 1. Determine how and when to obtain referrals and authorizations for specific services, as applicable. 2. Determine benefit and financial responsibility for a specific service or treatment from a specified provider or institution. **Quality and Accuracy of Information** At least annually, the organization must evaluate the quality and accuracy of the information provided to members via the website and telephone must be evaluated by: 1. Collecting data on quality and accuracy of information provided. 2. Analyzing data against standards or goals.	

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

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

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

Standard	Delegated Activities	Retained by L.A. Care
	E. Promotion 1. Promote the availability of Nurse Advice Line services in materials that are approved in accordance with the Plan Partner Services Agreement and L.A. Care policies and procedures. 2. In the form of, but not limited to: a. Flyers b. Informational mailers c. ID Cards d. Evidence of Coverage (EOC)	
Potential Quality of Care Issue Review (Title 28 California Code of Regulations Section 1300.70)	The Quality Improvement program must document that the quality of care is being reviewed, that problems are being identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated. The Quality Improvement program must include continuous review of the quality of care provided; quality of care problems are identified and corrected for all provider entities.	L.A. Care retains accountability for procedural components and will oversee Delegate's adherence to these standards through pre-delegation and annual oversight review and more frequently, as required, per changes in contract, Federal and State regulatory guidelines and accreditation standards.
Critical Incident Reporting and Tracking: (California Code of Regulations Title 22 §72541)	The Quality Improvement program must include implementation of a defined policy and procedures to identify, report, and track Critical Incidents under the following categories: abuse, neglect, exploitation, a serious, life threatening medical event requiring immediate emergency evaluation by a medical professional, disappearance (missing person), suicide attempt, restraint and/or seclusion, unexpected death, or other (such as catastrophes and unusual occurrences that threaten the member's wellbeing). Training shall be made available to network providers on identifying and reporting Critical Incidents to the appropriate authorities in a timely manner to ensure patient safety	L.A. Care retains accountability for procedural components and will oversee Delegate's adherence to these standards through pre-delegation, annual oversight review. More frequent oversight measures may be taken if needed to ensure delegate compliance. L.A. Care is responsible for submitting quarterly Critical Incident reports to DHCS using the data received from delegates.
Quality Improvement Performance: Applicable L.A. Care Policy: QI-0008 APL 19-017	1. Annually measures performance and meets the NCQA 50th percentile benchmark for the Medi-Cal Managed Care Accountability Set established by DHCS and NCQA required Medi-Cal accreditation measures. 2. Opportunity for Improvement When the 50th percentile is not met the plan will identify and follow up on opportunities for improvement.	L.A. Care will still retain the PIP and PDSA reporting process with DHCS for the Medi-Cal line of business.
Blood Lead Screening of Young Children Applicable L.A. Care Policy: QI-048 APL 20-016	1. Ensure network providers follow the blood lead anticipatory guidance and screening requirements in accordance with APL 20-016 2. Identify, on at least a quarterly basis (i.e. January – March, April – June, July – September, October – December), all child members under the age of six years (i.e. 72	Annual Submission to DHCS data for all child members under the age of six years (i.e. 72 months) who have no record of receiving a blood lead screening

Standard	Delegated Activities	Retained by L.A. Care
	months) who have any record of receiving a blood lead screening test as required Note: L.A. Care will send delegate CLPPB data when they receive from DHCS on a quarterly basis.	
HEALTH EDUCATION		
DHCS Policy Letter 02-004 DHCS Policy Letter 16-014 DHCS Policy Letter 18-018 DHCS Policy Letter 13-001 DHCS Policy Letter 10-012 DHCS Policy Letter 16-005	1. Maintenance of a health education program description and work plan 2. Availability and promotion of member health education services in DHCS language and topic requirements including implementation of a closed-loop referral process. 3. Implementation of comprehensive tobacco cessation/prevention services including: a. individual, group, and telephone counseling b. Provider tobacco cessation trainings c. Tobacco user identification system d. Tracking individual utilization data of tobacco cessation interventions 4. Availability of a diabetes prevention program (DPP) that complies with CDC DPP guidelines and is delivered by a CDC recognized provider 5. Availability of written member health education materials in English and Spanish in DHCS required health topics including: a. a system for providers to order materials and informing providers how to do so b. Adherence to all regulatory requirements as dictated per the Readability & Suitability Checklist 6. Implementation of an Individual Health Education Behavioral Assessment (IHEBA), preferably the Staying Healthy Assessment (SHA) including a method of making the assessments available to providers and provider education 7. Employment of a full-time Health Education Director, or the equivalent, with a Master's Degree in Public Health (MPH) responsible for the direction, management and supervision of the health education system. 8. Integration between health education activities and QI activities 9. Provision of provider education on health education requirements and resources 10. Adherence to all requirements regarding Non-Monetary Member Incentives including submission of Request for Approval and Annual Update/End of Program Evaluation forms to L.A. Care's Compliance Unit on an on-going basis.\	L.A. Care retains responsibility for providing written health education materials in DHCS required health topics for non-English/Spanish threshold languages. L.A. Care retains responsibility for conducting the Health Education, Cultural & Linguistics Population Needs Assessment (PNA) annually but retains the right to request Plan Partner assistance as needed.

Standard	Delegated Activities	Retained by L.A. Care
	11. Should Plan Partner delegate any or all health education requirements to a sub-delegate, Plan Partner must monitor sub-delegate's performance and ensure continued compliance.	
CULTURAL & LINGUISTIC REQUIREMENTS		
Civil Rights Act of 1964, Title VI Code of California Regulations (CCR), Title 28, §1300.67.04(c) CCR, Title 22, §53876 DHCS Agreement Exhibit A Attachment 9, (12)& (13)(A) Federal Guidelines: OMH CLAS Standards, Standards 1-4 & 9	**Cultural & Linguistic Program Description and Staffing** 1. Plan maintains an approved written program description of its C&L services program that complies with all applicable regulations, includes, at minimum, the following elements (or its equivalent): a. Organizational commitment to deliver culturally and linguistically appropriate health care services. b. Goals and objectives with timetable for implementation. c. Standards and performance requirements for the delivery of culturally and linguistically appropriate health care services. 2. Plan centralizes coordination and monitoring of C&L services. The department and/or staff responsible for such services are documented in an organizational chart. 3. Plan has written description(s) of position(s) and qualifications of the staff involved in the C&L services program.	
Civil Rights Act of 1964, Title VI Code of California Regulations (CCR), Title 22, §53876 CCR, Title 28, §1300.67.04, (c)(2)(G) & (H) Code of Federal Regulations (CFR), Title28, §35.160-25.164 CFR, Title 45 §92.4 & §92.201 DHCS Agreement Exhibit A, Attachment 9(12) & (14) DHCS All Plan Letter 21-004 Federal Guidelines: OMH CLAS Standards, Standard 5-7	**Access to Interpreting Services** 1. Plan has approved policies and procedures which include, at minimum, the following items: a. Provision of timely 24-hour, 7 days a week interpreting services from a qualified interpreter at all key points of contact, in any language requested, including American Sign Language, at no cost to members. b. Discouraging use of friends, family, and particularly minors as interpreters, unless specifically requested by the member after she/he was being informed of the right and availability of no-cost interpreting services. c. Availability of auxiliary aids and services, such as TTY, video relay services, remote interpreting services, etc., to ensure effective communication with individuals with disabilities. Plan has a sound method to ensure qualifications of interpreters and quality of	

Standard	Delegated Activities	Retained by L.A. Care
	interpreting services. Qualified interpreter must have demonstrated: 2. a. Proficiency in speaking and understanding both spoken English and at least one other spoken language; and b. Ability to interpret effectively, accurately, and impartially, both receptively and expressly, to and from such language(s) and English, using necessary specialized vocabulary and a fundamental knowledge in both languages of health care terminology and phraseology concepts relevant to health care delivery systems. c. Adherence to generally accepted interpreter ethics principles, including client confidentiality (such as the standards promulgated by the California Healthcare Interpreters Association and the National Council on Interpreting in Healthcare) 3. Plan makes available translated signage (tagline) on availability of no-cost language assistance services and how to access such services to providers. Tagline must be in English and all 18 non-English languages specified by DHCS 4. Plan posts non-discrimination notice and translated taglines in English and 18 non-English languages specified by DHCS at physical location where the plan interacts with the public and on plan's website. 5. Plan maintains utilization reports for face-to-face and telephonic interpreting services.	
Civil Rights Act of 1964, Title VI Code of California Regulations (CCR), Title 28, §1300.67.04(c)(2)(H) Code of Federal Regulations (CFR), Title 45 §92.4 & §92.201(e)(4) DHCS Agreement Exhibit A, Attachment 9(13)(B) & (F) DHCS All Plan Letter 22-04 Federal Guidelines: OMH CLAS Standards, Standards - 7	**Assessment of Linguistic Capabilities of Bilingual** 1. Plan has approved policies and procedures related to identifying, assessing, and tracking oral and/or written language proficiency of clinical and non-clinical bilingual employees who communicate directly with members in a language other than English. 2. Plan has a sound method to assess bilingual employees' oral and/or written language proficiency, including appropriate criteria for ensuring the proficiency. Qualified bilingual staff must have demonstrated: a. Proficiency in speaking and understanding both spoken English and at least one other spoken language, including any necessary	

Standard	Delegated Activities	Retained by L.A. Care
	specialized vocabulary, terminology, and phraseology. b. Ability to effectively, accurately, and impartially communicate directly with Limited English Proficiency Members in their preferred language. 3. Plan maintains a current list of assessed and qualified bilingual employees, who communicate directly with members, including the following information at minimum, name, position, department, language, level of proficiency.	
Civil Rights Act of 1964, Title VI Code of California Regulations (CCR), Title 28, §1300.67.04(d)(9) DHCS Agreement Exhibit A, Attachment 6(11)(B)(2) & Attachment 18 (6)(K) DHCS Policy Letter 98-12 Federal Guidelines: OMH CLAS Standards, Standard 7	**Linguistic Capabilities of Provider Network** 1. Plan has approved policies and procedures related to identifying and monitoring language capabilities of providers and provider staff ensuring provider network is reflective of membership demographics. 2. Plan lists language spoken by providers and provider staff in the provider directory. 3. Plan updates language spoken by providers and provider staff in the provider directory. 4. Plan annually assesses the provider network language capabilities meet the members' needs.	
California Health and Safety Code, §1367.04(b)(1)(A)-(C) Civil Rights Act of 1964, Title VI Code of California Regulations (CCR), Title 22, §53876 (a)(2)&(3) CCR, Title 28, §1300.67.04, (b)(7), (c)(2)(F) & (e)(2)(i)-(ii) Code of Federal Regulations (CFR), Title28, §35.160-25.164 CFR, Title 45 §92.4 & §92.8 DHCS Agreement, Exhibit A, Attachment 9(14)(B)(2), (14)(C), Attachment 13(4)(C) DHCS All Plan Letter 21-011 DHCS All Plan Letter 21-004 DHCS All Plan Letter 22-002 Federal Guidelines: OMH CLAS Standards, Standard 5-	**Access to Written Member Informing Materials in Threshold Languages & Alternative Formats** 1. Plan has approved policies and procedures documenting the process to: a. Translate Written Member Informing Materials, including the non-template individualized verbiage in Notice of Action (NOA) letters, accurately using a qualified translator in all Los Angeles County threshold languages and alternative formats (large print 20pt, audio, Braille, accessible data) according to the required timelines. b. Track member's standing requests for Written Member Informing Materials in their preferred threshold language and alternative format. c. Submit newly captured members' alternative format selection data directly to the DHCS Alternate Format website d. Distribute fully translated Written Member Informing Materials in their identified Los Angeles County threshold language and alternative format to members on a routine basis based on the standing requests and	L.A. Care provides Plan with: 1. Any changes to threshold and tagline languages. 2. Weekly DHCS alternative format selection data

Standard	Delegated Activities	Retained by L.A. Care
	DHCS alternative format selection (AFS) data. e. Attach the appropriate non-discrimination notice and translated tagline (a written language assistance notice) in English and required all 18 non-English required by DHCS to Member Informing Materials publications). Threshold Languages for Los Angeles County: English, Spanish, Arabic, Armenian, Chinese, Farsi, Khmer, Korean, Russian, Tagalog, and Vietnamese. Taglines (Language assistance notice) Languages: English, Spanish, Arabic, Armenian, Chinese, Farsi, Khmer, Korean, Russian, Tagalog, Vietnamese, Hindi, Hmong, Japanese, Lao, Mien, Punjabi, Thai and Ukrainian. 2. Plan has a sound method to ensure qualifications of translators and quality of translated Written Member Informing Materials. Qualified translators must have demonstrated: a. Adherence to generally accepted translator ethics principles, including client confidentiality to protect the privacy and independence of LEP Members. b. Proficiency reading, writing, and understanding both English and the other non-English target language. c. Ability to translate effectively, accurately, and impartially to and such language(s) and English, using necessary specialized vocabulary, terminology and phraseology. Plan maintains: a. Translated Written Member Informing materials on file along with attestations which affirm qualifications of the translators and translated document is an accurate rendition of the English version. b. Evidence of the distribution of Written Member Informing Materials to members in their identified Los Angeles County threshold language and alternative format on a routine basis.	

Standard	Delegated Activities	Retained by L.A. Care
	c. Evidence of reporting newly captured AFS data to DHCS	
Code of California Regulations (CCR), Title 28, §1300.67.04(c)(2)(C) DHCS Agreement, Exhibit A, Attachment 13(1)(A) DHCS All Plan 21-004 Federal Guidelines: OMH CLAS Standards, Standard 6	**Member Education** 1. Plan informs members annually of their right to no-cost interpreting services 24-hour, 7 days a week, including American Sign Language and axillary aids/services and how to access these services. 2. Plan informs members annually about the importance of not using friends, family members and particularly minors, as interpreters. 3. Plan informs members annually of their right to receive Written Member Informing Materials in their preferred language and alternative format at no cost and how to access these services. 4. Plan informs members annually of their right to file complaints and grievances if their cultural or linguistic needs are not met and how to file them. 5. Plan informs members annually that Plan does not discriminate on the basis of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental disability or identification with any other persons or group identified in Penal Code 422.56 in its health programs and activities.	
Code of California Regulations (CCR), Title 28, §1300.67.04(c)(2)(E) & (3) DHCS Agreement Exhibit A, Attachment 7(5)(B), Attachment 9 (13)(E), Attachment 18(7)(F) & (9)(M) DHCS All Plan Letter 99-005 Federal Guidelines: OMH CLAS Standards, Standard 4	**Provider Education & Training** 1. Plan has approved policies and procedures related to education/training on C&L requirements, cultural competency, sensitivity or diversity training for providers. 2. Plan provides initial orientation training/education on cultural and linguistic requirements to new providers within first ten business days of active status and annual education/training thereafter, which includes the following items: a. Availability of no-cost language assistance services, including: i) 24-hour, 7 days a week interpreting services, including American Sign Language\ ii) Written Member Informing Materials in their identified Los Angeles threshold language and preferred alternative format	

Standard	Delegated Activities	Retained by L.A. Care
	iii) Auxiliary aids and services, such as TTY, video relay services, remote interpreting services, etc. b. How to access language assistance services. c. Discouraging the use of friends, family, and particularly minors as interpreters. d. Not relying on staff other than qualified bilingual staff to communicate directly in a non-English language with members. e. Documenting the member's language and the request/refusal of interpreting services in the medical record. f. Posting translated taglines in English and 18 non-English languages required by DHCS at key points of contact with members. g. Working effectively with members using in-person or telephonic interpreters and using other media such as TTY and remote interpreting services. h. Referring members to culturally and linguistically appropriate community services. 3. Plan provides initial and annual cultural competency, sensitivity or diversity training to providers, which includes topics that are relevant to the cultural groups in Los Angeles County, such as: a. Promote access and the delivery of services in a culturally competent manner to all Members, regardless of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental, disability, or identification with any other persons or groups defined in Penal Code 422. b. Awareness that culture and cultural beliefs may influence health and health care delivery. c. Knowledge about diverse attitudes, beliefs, behaviors, practices, and methods regarding preventive health, illnesses, diseases, traditional home remedies, and interaction with providers and health care systems. d. Skills to communicate effectively with diverse populations	

Standard	Delegated Activities	Retained by L.A. Care
	e. Language and literacy needs.	
Code of California Regulations (CCR), Title 28, §1300.67.04(c)(3) DHCS Agreement Exhibit A, Attachment 9(13)(E) DHCS All Plan Letter 99-005 Federal Guidelines: OMH CLAS Standards, Standard 4	**Plan Employee Education & Training** 1. Plan has approved policies and procedures related to education/training on C&L requirements, cultural competency sensitivity or diversity training for Plan employees. 2. Plan provides initial and annual education/training on cultural and linguistic requirements and language assistance services to plan staff, which includes the following items: a. The availability of Plan's no-cost language assistance services to members, including: i. 24-hour, 7 days a week interpreting services, including American Sign Language. ii. Written Member Informing Materials in their identified Los Angeles threshold language and preferred alternative format. iii. Auxiliary aids and services, such as TTY, video relay services, remote interpreting services, etc. b. How to access these language assistance services. c. Discouraging the use of friends, family, and particularly minors, as interpreters. d. Not relying on staff other than qualified bilingual staff to communicate directly in a non-English language with members. e. Working effectively with members using in-person or telephonic interpreters and using other media such as TTY and remote interpreting services f. Referring members to culturally and linguistically appropriate community services. 3. Plan has cultural competency, sensitivity or diversity training material(s) for Plan employees, which includes topics that are relevant to the cultural groups in Los Angeles County, such as: a. Promote access and the delivery of services in a culturally competent manner to all Members, regardless of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation,	

Standard	Delegated Activities	Retained by L.A. Care
	gender identity, health status, physical or mental, disability, or identification with any other per-sons or groups defined in Penal Code 422. b. c. Knowledge about diverse attitudes, beliefs, behaviors, practices, and methods regarding preventive health, illnesses, diseases, traditional home remedies, and interaction with providers and health care system. d. Skills to communicate effectively with diverse populations. e. Language and literacy needs	
DHCS Agreement Exhibit A, Attachment 9(13)(F) DHCS All Plan Letter 99-005 Federal Guidelines: OMH CLAS Standards, Standard 10	**C&L and Quality Improvement** 1. Plan has approved policies and procedures related to C&L program evaluation, at minimum, including: a. Review and monitoring of C&L program that has a direct link to Plan's quality improvement processes. b. Procedures for continuous evaluation. 2. Plan analyzes C&L services performance and evaluates the overall effectiveness of the C&L program to identify barriers and deficiencies. For example: a. Grievances and complaints regarding C&L issues b. Trending of interpreting and translation utilization c. Member satisfaction with the quality and availability of language assistance services and culturally competent care d. Plan staff and providers' feedback on C&L services 3. Plan takes actions to correct identified barriers and deficiencies related to C&L services.	
Authority: Code of California Regulations (CCR), Title 28, §1300.67.04 (c)(4) DHCS Agreement, Exhibit A, Attachment 4(6)(A), (B) & Attachment 6(14)(B) DHCS All Plan Letter 99-005 DHCS All Plan Letter 17-004DHCS All Plan Letter 21-004	**Oversight of Subcontractors for Cultural & Linguistic Services and Requirements** 1. Plan has a contract and/or other written agreement with its network providers and subcontractor(s) regarding: a. C&L requirements (e.g., documentation of preferred language and refusal/request for interpreting services in the medical record, posting of translated tagline in English and 18 non-English languages) b. Delegated C&L services (e.g., language assistance services)	

Standard	Delegated Activities	Retained by L.A. Care
	2. Plan has approved policies and procedures related to oversight and monitoring of its network providers and subcontractors to ensure compliance with the contract/agreement terms and applicable federal and state laws and regulations that are related to C&L requirements and/or delegated C&L services. 3. Plan has a mechanism to monitor network providers and subcontractors to ensure compliance with the contract terms and applicable federal and state laws and regulations that are related to C&L requirements and/or delegated C&L services. 4. Plan monitors network providers and subcontractors with regular frequency to ensure compliance with the contract terms and applicable federal and state laws and regulations that are related to C&L requirements and/or delegated C&L services.	
Code of California Regulations (CCR), Title 22, §53876 DHCS Agreement Exhibit A, Attachment 9(5) & (14)(B)(3)	**Cultural & Linguistic Service Referral*** 1. Plan has approved policies and procedures related to referring members to culturally and linguistically appropriate community services and providers who can meet the members' religious and ethical needs. 2. Plan has a process and/or mechanism to refer members to culturally and linguistically appropriate community services. **3.** Plan informs providers of the availability of culturally and linguistically appropriate community service programs for members and how to access them.	
FINANCIAL SOLVENCY AND CLAIMS PROCESSING REQUIREMENTS		
Financial Solvency (Title 28 California Code of Regulations Sections 1300.75.1, 1300.75.4.1(a)(5) & (6), 1300.75.4.2(a), 1300.76, 1300.76.1, 1300.77.1 & 2, 1300.78, and 1300.76.3).	**Financial Solvency** 1. Maintain a cash-to-claims ratio > 0.75. 2. Maintain positive working capital. 3. Maintain a minimum Tangible Net Equity (TNE). 4. Document and record the liability for incurred but not reported (IBNR) claims on a monthly basis. 5. Submit the quarterly financial statements no later than 45 calendar days after the close of each quarter end to L.A Care. 6. Submit the annual financial statements audited by an independent Certified Public Accounting firm no later than 120 calendar days after each fiscal year end to L.A. Care.	

Standard	Delegated Activities	Retained by L.A. Care
	Administrative Costs 1. Maintain administrative costs no greater than 15% of the revenue. **Commissioner Deposits** 1. Maintain at least $300,000 deposit with the Commissioner, with any FDIC insured bank. **Quarterly Risk-Sharing Reports** i. Distribute the quarterly risk-sharing report detailing the amounts allocated to the Plan Participating Providers (PPPs) under each risk-sharing arrangement no later than 45 calendar days after each quarter end. i. Distribute the annual preliminary payment risk-sharing report detailing the amounts allocated to the PPPs under each risk-sharing arrangement no later than 150 calendar days after the contract year. i. Remit payment due under risk-sharing arrangements to the PPPs no later than 180 days after the contract year. **Risk Management** Maintain the following insurance at all times: 1. Reinsurance or Stop-Loss 2. Malpractice or Professional Liability 3. General Liability 4. Errors & Omissions 5. Workers Compensation 6. Fidelity Bond **Policies and Procedures** Maintain approved policies and procedures that describe the process and requirements for each of the sections mentioned above.	
	Financial Viability Oversight of the Plan Participating Providers (PPPs) 1. Obtain and analyze quarterly financial statements and annual audited financial statements of the PPPs. 2. Perform financial audit of the PPPs at least once a year including the issuance of audit reports. 3. Request a written corrective action plan (CAP) from PPPs that do not meet the financial solvency requirements. **Claims Processing Oversight of the PPPs**	

Standard	Delegated Activities	Retained by L.A. Care
	1. Perform claims processing audit of the PPPs at least once a year including the issuance of audit reports. 2. Perform annual ER claims and applicable ER follow-up audits for the PPPs that are delegated for the ER claims payment functions. 3. Request a written corrective action plan (CAP) from PPPs that do not meet the claims processing requirements. **Policies and Procedures** Maintain approved policies and procedures that describe the process and requirements for each of the sections mentioned above.	
Claims Processing (Title 28 California Code of Regulations Section 1300.71)	**Timely Claims Processing** 7. Process at a minimum ninety percent (90%) of claims within 30 calendar days of the claim receipt date, 8. Process at a minimum ninety-five percent (95%) of claims within 45 working days of the claim receipt date, **and** 9. Process at a minimum ninety-nine percent (99%) of claims within 90 calendar days of the claim receipt date. **Accurate Claims Payments** 1. Pay claims at the Medi-Cal rates or contracted rates at a minimum of 95% of the time. 2. All modified claims are reviewed and approved by a physician and medical records are reviewed. 3. Calculate and pay interest automatically for claims paid beyond 45 workings days from date of receipt at a minimum 95% of the time. a. **Emergency services claims:** Late payment on a complete claim which is not contested or denied will automatically include the greater of $15 or 15% rate per annum applied to the payment amount for the time period the payment is late. b. **All other service claims**: Late payments on a complete claim will automatically include interest at a 15% rate per annum applied to the payment amount for the time period payment is late. **Penalty:** Failure to automatically include the interest due on the late claims regardless of	

Standard	Delegated Activities	Retained by L.A. Care
	service is $10 per late claim in addition to the interest amount. **Forwarding of Misdirected Claims** Forward misdirected claims within 10 working days of the claim receipt date at a minimum of 95% of the time. **Acknowledgement of Claims** Acknowledge the receipt of electronic claims within 2 working days and paper claims within 15 working days at a minimum of 95% of the time. **Dispute Resolution Mechanism** Provide written notice of a dispute resolution mechanism for all denied and modified claims at a minimum 95% of the time. **Accurate and Clear Written Explanation** Provide written notice of a dispute resolution mechanism for all denied and modified claims at a minimum 95% of the time. **Deadline for Claims Submission** Shall not impose a claims filing deadline less than 90 days after the date of service for contracted providers and less than 180 days after the date of service for non-contracted providers on three or more occasions. **Request for Reimbursement of Overpayment** Reimbursement for overpayment request shall be in writing and clearly identifying the claim and reason why the claim is believed to be overpaid within 365 days from the payment date, for at least 95% of the time. **Rescind or Modify an Authorization** An authorization shall not be rescinded or modified for health care services after the provider renders the service in good faith and pursuant to the authorization on three (3) or more occasions over the course of any three-month period. **Request for Medical Records** 1. **Emergency services claims:** Medical records shall not be requested more frequently than twenty percent (20%) of the claims submitted by all providers for emergency services over any 12-month period.	

Standard	Delegated Activities	Retained by L.A. Care
	2. **All other claims:** Medical records shall not be requested more frequently than three percent (3%) of the claims submitted by all providers, excluding claims involving unauthorized services over any 12-month period. **Exception:** The thresholds and limitations on requests for medical records as stated above should not apply to claims where reasonable grounds for suspecting possible fraud, misrepresentation or unfair billing practices are being demonstrated. **Policies and Procedures** Maintain approved policies and procedures that describe the process and requirements for each of the sections mentioned above.	
Provider Dispute Resolution (PDR) Processing and Payments requirement. (Title 28 California Code of Regulations Section 1300.71.38)	**Acknowledgement of Provider Disputes** Acknowledgement of received disputes is performed in a timely manner at a minimum of 95% of the time. a. 15 working days for paper disputes. b. 2 working days for electronic disputes. **Timely Dispute Determinations** Dispute determinations are made in a timely manner, at a minimum of 95% of the time. a. 45 working days from receipt of the dispute. b. 45 working days from receipt of additional information. **Clear Explanation of NOA Letter** Rationale for decision is clear, accurate and specific in NOA Letter, at a minimum of 95% of the time. a. Written determination stating the pertinent facts and explaining the reasons for the determination **Accurate Provider Dispute Payments** 1. Appropriately paying any outstanding monies determined to be due if the dispute is determined in whole or in part in favor of the provider. 2. Interest payments are paid correctly when dispute determination is in favor of provider, at a minimum of 95% of the time. Accrual of interest of payment on resolved provider disputes begin on the day after the expiration of forty-five (45) working days from the original claim receipt date.	

Standard	Delegated Activities	Retained by L.A. Care
	Acceptance of Late Claims The organization must accept and adjudicate disputes that were originally filed beyond the claim filing deadline and the provider was able to demonstrate good cause for the delay, at a minimum of 95% of the time. **Policies and Procedures** Maintain approved policies and procedures that describe the process and requirements for each of the sections mentioned above.	
Annual Plan Claims Payment and Dispute Resolution Mechanism Report" Cal. Code Regs. tit. 28 § 1300.71.38(k) Cal. Code Regs. tit. 28 § 1300.71.38(k)(1) Cal. Code Regs. tit. 28 § 1300.71.38(k)(2) Cal. Code Regs. tit. 28 § 1300.71.38(k)(3)	1. "Information on the number and types of providers using the dispute resolution mechanism. 2. "A summary of the disposition of all provider disputes, which shall include an informative description of the types, terms and resolution. Disputes contained in a bundled submission shall be reported separately as individual disputes. Information may be submitted in an aggregate format so long as all data entries are appropriately footnoted to provide full and fair disclosure; and… 3. A detailed, informative statement disclosing any emerging or established patterns of provider disputes and how that information has been used to improve the plan's administrative capacity, plan-provider relations, claim payment procedures, quality assurance system (process) and quality of patient care (results) and how the information has been used in the development of appropriate corrective action plans.1	
DMHC Provider Disputes Document/Information Requests	Plan Partner to respond to document\information requests from LA Care for DMHC provider disputes within 5 days, urgent requests within 2 days.	
PROVIDER NETWORK REQUIREMENTS		
DHCS Agreement Exhibit A, Attachment 7 (5)(A)(B)	**Provider Education & Training** 1. Plan has approved policies and procedures for training newly contracted/hired providers within ten (10) business days of the effective date of contract/hire. The training must include, but is not limited to: (DHCS Agreement, Exhibit A, Attachment 7, Provision 5; DHCS Agreement, Exhibit A, Attachment 13, Provision 1), and the	

[1] Cal. Code Regs. tit. 28 § 1300.71.38(k)(3)

Standard	Delegated Activities	Retained by L.A. Care
	NCQA 2017 Standards and Guidelines (NCQA, Element A), NCQA RR 1. a. 1. Federal and State statutes and regulations to ensure providers' full compliance b. 2. Medi-Cal Managed Care services c. 3. Applicable policies and procedures d. 4. Medi-Cal marketing guidelines e. 5. Member rights and responsibilities f. 6. Member services, including the member's right to full disclosure of health care information and the member's right to participate actively in health care decisions education/training on C&L requirements, for providers. 2. Plan Partner must evidence a process to provide information to and train providers on a continuing basis regarding clinical protocols and evidence-based practice guidelines for Seniors and Persons with Disabilities or chronic conditions a. 1. Process includes an educational program for providers regarding health needs specific to Seniors and Persons with Disabilities or chronic conditions population b. 2. Educational program uses a variety of educational strategies, including, but not limited to, posting information on websites and other methods of educational outreach to providers	

Exhibit 8
Delegation Agreement
[Attachment B]

Plan's Reporting Requirements

Report	Due Date	Submit To	Required Format
QUALITY IMPROVEMENT			
NET 1A **Cultural Needs and Preferences Assessment** **NET 1B** Practitioners Providing Primary Care **NET 1C** Practitioners Providing Specialty Care **NET 1D** Practitioners Providing Behavioral Healthcare	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
NET 2A **Access to Primary Care** **NET 2B** Access to Behavioral Healthcare **NET 2C** Access to Specialty Care	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
NET 3A Assessment of Member Experience Accessing the Network **NET 3B** Opportunities to Improve Access to Nonbehavioral Healthcare Services **NET 3C** Opportunities to Improve Access to Behavioral Healthcare Services	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
QI 2A Practitioner Contracts	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission

QI 3A Identifying Opportunities **QI 3B** Acting on Opportunities **QI 3C** Measuring Effectiveness	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Annual data collection analysis that identify and acts on opportunities for improvement for Continuity of Care as outlined by NCQA guidelines for Continuity Coordination of Care of Medical Care and Continuity and Coordination Between Medical Care and Behavioral HealthCare
QI 4A Data Collection **QI 4B** Collaborative Activities **QI 4C** Measuring Effectiveness	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
QI 5A **Sub-Delegation Agreement** **QI 5B** Sub- Delegation Predelegation Evaluation **QI 5C** Sub-Delegation Review of QI Program **QI 5D** **Sub-Delegation** Opportunities for Improvement	Annually during PP audit	home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
<u>Quality Improvement Quarterly reporting requirements</u> 1. **QI Workplan Update** **2. Potential Quality of Care Issues (PQIs)** a. Number of PQIs b. Number of closed PQIs c. Number of closed PQIs within 6 months d. PQI Detail Report with final PQI severity level	QI Workplan Update - Quarterly 1st Qtr – Jun 30 2nd Qtr – Sep 30 3rd Qtr – Dec 30 4th Qtr – Mar 30 2. PQI Report - Quarterly 1st Qtr – April 25 2nd Qtr – July 25 3rd Qtr – Oct 25 4th Qtr – Jan 25	1-3. L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	1 – 3. Acceptable formats: • Quarterly Workplan Updates • ICE Reporting Format **Naming convention for PQI Reports** *Plan Partner Name YYYY Q# PQI Report*

<u>Critical Incidents Tracking Log</u> **1. Critical Incident Tracking Log** **Naming convention:** *YYYY Q# LA Care CI Tracking Report* **Description:** Includes a tracking log of critical incidents specific to each member. - Abuse - Neglect - Exploitation - Disappearance/Missing Member - Suicide Attempt - Unexpected Death - A Serious Life Threatening Medical Event that requires immediate emergency evaluation by a Medical Professional - Restraints or seclusion - Other **2.Critical Incident Report in DHCS required format** - Number of LTSS users - Number of Critical Incidents Filed - Number of Critical Incidents Filed with Grievances Previously Filed - Number of Critical Incidents Filed with Appeals Previously Filed Blue Shield of California Promise Health Plan shall keep track of all Critical Incidents and ensure appropriate reporting and resolution of the incidents in a timely fashion.	**Quarterly** 1st Qtr. – April 15 2nd Qtr. – July 15 3rd Qtr. – Oct 15 4th Qtr. – Jan 15	Submit to L.A. Care Critical Incident inbox CI@lacare.org	1. The Critical Incident Tracking Log with Health Plan Report Format, which includes but not limited to member information, specific information about the incident (date, time, location, entity/person involved in the incident, etc.) 2. Quarterly Critical Incident Report with DHCS required format
<u>Quality Improvement Annual reporting requirements</u> 1. **QI 1A:** QM Program Description 2. **QI 1C:** QM Program Evaluation 3. QI Workplan 4. PHM Work plan (if the activities are not included in the QI Workplan)	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Acceptable formats: • Quarterly • ICE Reporting Format
ME 1B: Distribution of Member Rights & Responsibilities Statement	Semi-Annually: Jan 15th (Reporting period Q3 & Q4) July 15th (Reporting period Q1 &Q2)	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Mutually agreed upon format  ME 1B_Distribution of Rights Statement
ME 7C Element C: Annual Assessment of Nonbehavioral Healthcare Complaints and Appeals **ME 7E** Element E: Annual Assessment of Behavioral Healthcare and Services	Annually during PP audit	home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission

ME 7F Element F: Behavioral Healthcare Opportunities			
PHM 1A Strategy Description **PHM 1B** Informing Members	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
PHM 2A Data Integration **PHM 2B** Population Assessment **PHM 2C** Activities and Resources **PHM 2D** Segmentation	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
PHM 3 A Practitioner or Provider Support	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
PHM 6A Measuring Effectiveness **PHM 6B** Improvement and Action	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
PHM 7A Sub-Delegation Agreement **PHM 7B** Sub-Delegate Pre-Delegation Agreement **PHM 7C** Sub-Delegate Review of PHM Program **PHM 7D** Opportunities for Improvement	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
Title 28 California Code of Regulations Section 1300.67.2.2 **California Health and Safety Code Section 1348.8** **Assessment of Nurse Advice Line** 1. Nurse Advice Line monitoring for: a. Telephone statistics at least quarterly • Average abandonment rate within 5 percent • Average speed of answer within 30 seconds	1. Quarterly 1st Qtr – May 18 2nd Qtr – August 18 3rd Qtr – November 18 4th Qtr – February 18	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Health Education/ Plan will also have the option to submit via email to remain compliant with due date.	Mutually agreed upon format

2. Annual analysis of Nurse Advice Line statistics (telephone, use, and calls), identify opportunities and establish priorities for improvement.	2. Annually during PP Audit		
Quality Improvement Performance A PDSA tool will be required when the plan does not meet the 50th percentile for the Managed Care Accountability Set and the 50th percentile for the Medicaid NCQA Accreditation Measures as established by both regulatory entities.	Annually during PP Audit. The PDSA tool is due 90 calendar days after findings are received.	L.A. Care's Secure File Transfer Protocol (SFTP)/ home/ucfst/infile/Quality Improvement/ Plan will also have the option to submit via email to remain compliant	The PDSA tool provided by DHCS or L.A. Care
DELEGATION OVERSIGHT - UTILIZATION MANAGEMENT AND MEMBER RIGHTS			
APPEALS & GRIEVANCES Member complaints and Appeals Log	Monthly 15th Calendar Day of Each Month	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Delegation Oversight	Format as defined in the L.A. Care Technical Bulletin MS 005
ME 7 A, B, C, E, F **Analysis of Member Experience, if delegated, to include:** 1. Policies and Procedures for Complaints 2. Policies and Procedures for Appeals 3. Annual Assessment of Nonbehavioral Healthcare Complaints and Appeals for each of 5 categories: a. Quality of Care b. Access c. Attitude and Service d. Billing and Financial Issues e. Quality of Practitioner Office Site 4. Annual Assessment of Behavioral Healthcare Complaints and Appeals and Services for each of 5 categories along with opportunities for improvement: a. Quality of Care b. Access c. Attitude and Service d. Billing and Financial Issue e. Quality of Practitioner Office Site	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/greivance/	Compliant with NCQA in accordance to Plan's accreditation submission
Service Authorizations and Utilization Review			
UM 1 1. UM Program Description 2. UM Program Evaluation 3. UM Program Work Plan	1. Delegation Oversight to review. Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Clinical Assurance_CFST/	1. Narrative 2. HICE Quarterly Reporting format 3. HICE Quarterly Format

	2-3. Due to Clinical Assurance on May 31st via the SFTP Site		
Quarterly UM Activity Report **All elements outlined within L.A. Care Quarterly UM Activity Health Industry Collaboration Effort (HICE) reporting format including but not limited to:** 1. UM Summary – Inpatient Activity a. Average monthly membership b. Acute Admissions/K c. Acute Bed days/K d. Acute LOS e. Acute Readmits/K f. SNF Admissions/K g. SNF Bed days/K h. SNF LOS i. SNF Readmits/K 2. UM Activities Summary a. Referral Management Tracking of the number of Approvals/Modifications/Denials/ Deferrals (Routine/Urgent) b. Referral Denial Rate c. Appeals/K d. Overturn Rate 3. **PHM 5:** CCM Complex Case Management CM Reports and Statistics	Quarterly 1st Qtr –May 31 2nd Qtr – Aug 31 3rd Qtr – Nov 30 4th Qtr – Feb 28	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Clinical Assurance_CFST/	HICE Quarterly Reporting Format
NET 4B: Continued Access to Care 1. Continued Access to Practitioners If a practitioner's contract is discontinued, the organization allows affected members continued access to the practitioner, as follows: a. Continuation of treatment through the current period of active treatment for members undergoing active treatment for a chronic or acute medical condition b. Continuation of care through the postpartum period for members in their second or third trimester of pregnancy	Quarterly 1st Qtr – May 31 2nd Qtr – Aug 31 3rd Qtr – Nov 30 4th Qtr – Feb 28	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Clinical Assurance_CFST/	L.A. Care Quarterly Reporting Format
PHM 5: CCM Log of Case Management Cases (CCM) for members who have been in CCM for at least 60 days to include both open and closed cases.	Quarterly 1st Qtr – May 25 2nd Qtr – Aug 25 3rd Qtr – Nov 25 4th Qtr – Feb 25	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Clinical Assurance_CFST/	Acceptable formats: L.A. Care Format

Medi-Cal Provider Preventable Reportable Conditions	Quarterly 1st Qtr – May 25 2nd Qtr – Aug 25 3rd Qtr – Nov 25 4th Qtr – Feb 25	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Clinical Assurance_CFST/	Acceptable formats: DHCS Required Reporting Format
QI 3D: Transition to Other Care--member transition to other care, **a.** When their benefits end, if necessary **b.** During transition from pediatric care to adult care.	Quarterly 1st Qtr – May 31 2nd Qtr – Aug 31 3rd Qtr – Nov 30 4th Qtr – Feb 28	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Clinical Assurance_CFST/	L.A. Care Quarterly Reporting Format
CREDENTIALING			
1. Initial Credentialed practitioner list containing Credentialing Date, Last Name, First Name, MI, Title, Address, City, State, Zip, Group Name. 2. Re-credentialed practitioner list containing Re-credentialing Date, Last Name, First Name, MI, Title, Address, City, State, Zip, Group Name. 3. Voluntary Practitioner Termination list containing Termination Date, Last Name, First Name, MI, Title, Address, City, State, Zip, Group Name. 4. Involuntary Practitioner Termination list containing Termination Date, Last Name, First Name, MI, Title, Address, City, State, Zip, Group Name	Quarterly 1st Qtr – May15 2nd Qtr – Aug 15 3rd Qtr – Nov 15 4th Qtr – Feb 15	credinfo@lacare.org	Current L.A. Care Health Plan Delegated Credentialing Quarterly Credentialing Submission Form (ICE Format)
DMHC SURVEYS			
1. DMHC Timely Access and Network Reporting (TAR) a. Exhibit A-1 Timely Access Time-Elapsed Standards Policies and Procedures b. Exhibit A-2 Alternative Access Timely Access Time-Elapsed Standards Policies and Procedures c. Exhibit A-3 Oversight of Plan-to-Plan Contracts Policy and Procedures d. Exhibit B-1 Quality Assurance Monitoring related to Time-Elapsed Standards Policies and Procedures e. Exhibit B-2 Quality Assurance Monitoring related to All Other Time-	Due Date: 4/17/2023	L.A. Care's Secure File Transfer Protocol (SFTP) /ucfst/infile/compliance	

Elapsed Standards Policies and Procedures f. g. Exhibit D-1 Non-Compliance Policies and Procedures Exhibit D-2 Incidents of Non-Compliance Resulting in Substantial Harm to an Enrollee Exhibit D-3 Patterns of Non-Compliance h. Exhibit D-4 Prior Incidents or Patterns of Non-Compliance not Previously Submitted i. Exhibit E-1 Policies and Procedures for Advanced Access Program j. Exhibit F-1 Triage k. Exhibit F-2 Telemedicine l. Exhibit F-3 Health I.T. m. Exhibit G-1 Provider Satisfaction Survey Methodology n. Exhibit G-2 Provider Staisfaction Survey Results o. Exhibit G-2 Enrollment Staisfaction Survey Methodology p. Exhibit G-4- Enrollee Satisfaction Survey q. Exhibit H-1 Quality Assurance Report r. Exhibit C-1 Contact List Report Forms for each Provider Survey Type s. Exhibit C-2 Raw Data Report Forms for each applicable Provider Survey Type t. Exhibit C-3 Results Report Form	Due Date: 9/1/2022		
u. APNR Form PCP v. APNR Form Specialists w. APNR Form Mental Health x. APNR Form Hospitals and Clinics y. APNR Form Other Outpatient Provider z. APNR Form Grievances aa. APNR Form Third Party Telehealth (if applicable) i.	Due Date: 2/6/2023		

2. DMHC Provider Appointment Availability Survey (PAAS) a. Provider Contact Lists i. PCP ii. Specialists iii. Psychiatry iv. Non-Physician Mental Health v. Ancillary	Annually - July	L.A. Care's Secure File Transfer Protocol (SFTP)/ home/ucfst/infile/Quality Improvement/	
COMPLIANCE			
1. 274 EDI File Mandated by APL 16-019	Monthly – Due to L.A. Care by the 4th of each month	L.A. Care's Secure File Transfer Protocol (SFTP) /home/ucfst/infile/274	DHCS required formatting.
2. Data Certification Statements Mandated by APL 17-005	Monthly – Due to L.A. Care 3 business days prior to submission to DHCS	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	Word Document, Non-specific template. Utilize own template; however, all state reports submitted to L.A. Care within the month MUST be listed and CEO MUST sign off attesting to ALL data submissions.
3. Non-Medical Transportation & Non-Emergency Medical Transportation (NMT-NEMT) Report Mandated by APL 17-010	Monthly - Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	DHCS approved template
4. **Health Industry Collaboration Effort** AB1455 Quarterly Reports a. M/Q Medi-Cal Claims Timeliness ReportQuarterly Provider Dispute Resolution (PDR) Report b. Disclosure of Emerging Claims Payment Deficiencies (DoECPD)	Quarterly – Due to L.A. Care within specified deadline set by L.A. Care	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/AB1455	HICE Approved Documents
5. Call Center Report	Quarterly – Due to L.A. care 30 days after the end of each quarter of the calendar year. When due date falls on the weekend (Sunday or Saturday, data must be submitted by COB on the Friday before the due date. • Q1 – January, February, and March • Q2 – April, May, and June	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	Format as specified by L.A. Care

	• Q3 – July, August, and September • Q4 – October, November, and December		
6. Community Based Adult Services (CBAS) Report	Quarterly - Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	DHCS approved templates
7. Dental General Anesthesia Report Mandated by APL 15-012	Quarterly - Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	DHCS approved templates
8. Medi-Cal Managed Long-Term Services & Supports (MLTSS) Report Mandated by APL 17-012	Quarterly - Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	DHCS approved templates
9. Medi-Cal Managed Care Survey – Disproportionate State Hospitals (MMCS-DSH) Survey	Annually - Due to L.A. Care 7 business days prior to submission to DHCS	BSCPHP has the option to submit report directly to DHCS Or Via L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	DHCS approved templates
10. Health Homes Program DHCS Required Reporting (Sunset CY 2022)	Quarterly, Bi-Annually, & Annually, according to schedule in DHCS template -Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care Regulatory / Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	DHCS approved template, plus attestation of data and brief written summary of oversight and monitoring activity for the reporting period
11. Enhanced Care Management DHCS Required Reporting	Quarterly, Bi-Annually, & Annually, according to schedule in DHCS template -Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care Regulatory / Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	DHCS approved template, plus attestation of data and brief written summary of oversight and monitoring activity for the reporting period
12. Community Supports DHCS Required Reporting	Quarterly, Bi-Annually, & Annually, according to schedule in DHCS template -Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care Regulatory / Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	DHCS approved template, plus attestation of data and brief written summary of oversight and monitoring activity for the reporting period

13. CBAS Monthly Wavier Report	Monthly - Due to L.A. Care every 4th day of the month	L.A. Care Regulatory / Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	DHCS approved template
14. MOT Post Transitional Monitoring	Quarterly -Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care Regulatory / Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	DHCS approved template
15. Prop 56 Directed Payment for Physician Services Mandated by APL 19-015	Quarterly-Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care Regulatory / Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	Financial Compliance provided Template based on APL reporting requirements
16. Prop 56 Hyde Reimbursement Requirements for specific Services Mandated by APL 19-013	Quarterly-Due to L.A. Care 7 business days prior to submission to DHCS	LA Care Regulatory/Secure File Transfer Protocol (sFTP) home/ucfst/infile/Regulatory	Regulatory Reports provided Template based on APL reporting requirements
17. Prop 56 Directed Payments for Developmental Screening Services Mandated by APL 19-016	Quarterly-Due to L.A. Care 7 business days prior to submission to DHCS	LA Care Regulatory/Secure File Transfer Protocol (sFTP) home/ucfst/infile/Regulatory	Regulatory Reports provided Template based on APL reporting requirements
Prop 56 Directed Payments for Valued Base Payment Program Mandated by APL 20-014	Quarterly-Due to L.A. Care 7 business days prior to submission to DHCS	LA Care Regulatory/Secure File Transfer Protocol (sFTP) home/ucfst/infile/Regulatory	Regulatory Reports provided Template based on APL reporting requirements
18. Prop 56 Directed Payments for Family Planning Mandated by APL 20-013	Quarterly-Due to L.A. Care 7 business days prior to submission to DHCS	LA Care Regulatory/Secure File Transfer Protocol (sFTP) home/ucfst/infile/Regulatory	Regulatory Reports provided Template based on APL reporting requirements
19. Prop 56 Directed Payment for Adverse Childhood Experiences Screening Services Mandated by AP-19-018	Quarterly-Due to L.A. Care 7 business days prior to submission to DHCS	LA Care Regulatory/Secure File Transfer Protocol (sFTP) home/ucfst/infile/Regulatory	Regulatory Reports provided Template based on APL reporting requirements

20. MCPD and PCPA Managed Care Program Date (MCPD) and Primary Care Provider Alignment (PCPA) Mandated by APL 20-017 The Managed Care Program Data (MCPD) report is a consolidated reporting requirement which DHCS introduced through APL 20-017. The MCPD file replaces the following reporting requirements, as this data is now incorporated into the MCPD file in .json format: • Grievances and appeals data in an Excel template, as specified in APL 14-013 ***(previously submitted by your plan as the Grievance Report Mandated by APL 14-013)*** • Monthly MERs and other continuity of care records data in an Excel template, as specified in Attachment B of APL 17-007 ***(previously submitted by your plan as the MMDR Report)*** • Other types of continuity of care data in ad-hoc Excel templates • Out-of-Network request data in a variety of ad-hoc Excel templates ***(previously submitted by your plan as the OON Report)***	Monthly - Due to L.A. Care every 4th day of the month	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports/	Regulatory Reports provided Template based on APL reporting requirements
21. Cost Avoidance & Post Payment (CAPP) Recovery Mandated by APL 21-002	Monthly – Due to L.A. Care 6th business day of every month	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports/	DHCS Approved Template
22. Provider Network Termination Mandated by APL 21-003	Quarterly - Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports/	DHCS Approved Template
23. Third Party Liability APL 21-007	15 days from the date LA Care submits case file.	L.A. Care via its Secure File Transfer Protocol (SFTP) – home/ucfst/infile/Regulatory Reports/	DHCS approved templates
24. New and or revised reports as released by DHCS	Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care's Secure File Transfer Protocol (SFTP)	DHCS approved templates

		home/ucfst/infile/Regulatory Reports	
25. Disaster and Recovery Plan Disaster Recovery Test Results L.A. Care will request all elements outlined below including but not limited to: LA Care may require additional information on Business Continuity efforts based off current event. In the event there are any additional requests from regulators for individual instances, such as, an emergency declared by the governor; 26. L.A. Care will send out an ad hoc written request asking to respond with the requested information should it be an element outside of what is already being requested and another mobile contact mechanism when outside of regular business hours.	Annually during PP audit and ad-hoc; Ad-Hoc	L.A. Care's Secure File Transfer Protocol (SFTP) EnterpriseRiskManagement@lacare.org home/PPName/infile/Regulatory Reports/ EnterpriseRiskManagement@lacare.org ; RegulatoryReports@lacare.org	Word Document, Non-Specific template Template may change upon regulators request.
27. Encounter Data	Monthly, at a minimum	L.A. Care's Secure File Transfer Protocol (SFTP)	
DELEGATED FINANCIAL AND DELEGATED CLAIMS COMPLIANCE			
1. a) Oversight Summary on Financial Solvency Monitoring of Delegates' Quarterly Unaudited Financial Statements b) Data elements that are from Delegates' Quarterly Timeliness Reporting will be included in 1(a) above Note: Delegates consist of PPGs and capitated hospitals.	Quarterly – Due to L.A. Care 75 calendar days after each quarter end	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Financial_Compliance/ Plan will also have the option to submit via email to remain compliant	Excel/PDF
2. Oversight Summary on Financial Solvency Monitoring of Delegates' Annual Independent Audited Financial Statements ***Note: 2) does not apply to Oversight reporting of claims processing audits of delegates***	Annually – Due to L.A. Care 180 calendar days after delegates' fiscal year end	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Financial_Compliance Plan will also have the option to submit via email to remain compliant	Excel/PDF

Note: Delegates consist of PPGs and capitated hospitals.			
3. a) Oversight Summary on Annual Financial Solvency Audits of Delegates. b) Oversight Summary on Annual & Follow-Up Claims Processing Audit of Delegates Note: Delegates consist of PPGs and capitated hospitals.	Quarterly – Due to L.A. Care 60 calendar days after each calendar quarter end for the delegate audits conducted[1] in the reporting quarter [1]the date of delegate audit is based on the first date of fieldwork conducted by BSC PHP.	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Financial_Compliance Plan will also have the option to submit via email to remain compliant	Excel/PDF
4. Policy 2305 Medi-Cal Allocation	Annually – Due to L.A. Care 120 calendar year end (April 30)	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Financial_Compliance Plan will also have the option to submit via email to remain compliant	
DELEGATION OVERSIGHT			
New Member Welcome Kit Mailing Reports	Quarterly – Due to L.A. Care the 15th day of each quarter end Q1 due 4/15 Q2 due 7/15 Q3 due 9/15 Q4 due 1/15	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Delegation Oversight	Format as specified by L.A. Care
HEALTH EDUCATION			
1. Health Education Referral Report	Quarterly – Due to L.A. Care the 25th day of the month following the end of the quarter: • Q1 due 4/25 • Q2 due 7/25 • Q3 due 10/25 • Q4 due 1/25	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Health Education/	Format as specified by LA. Care or mutually agreed upon per Plan Partner process.
2. Health Education Material Distribution Report	Quarterly – Due to L.A. Care the 25th day of the month following the end of the quarter: • Q1 due 4/25 • Q2 due 7/25 • Q3 due 10/25 • Q4 due 1/25	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Health Education/	Format as specified by LA. Care or mutually agreed upon per Plan Partner process.

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

6. Interpreting Utilization Report (Face-to-face and Telephonic interpreting)	Quarterly – Due to L.A. Care the 25th day of the month following the end of the quarter: • Q1 due 4/25 • Q2 due 7/25 • Q3 due 10/25 Q4 due 1/25	L.A. Care's Secure File Transfer Protocol (SFTP) *OR* Via email to CulturalandLinguisticServices_Mailbox@lacare.org	L.A. Care report template *OR* Mutually agreed upon report format
7. C&L Referral Report	Quarterly – Due to L.A. Care the 25th day of the month following the end of the quarter: • Q1 due 4/25 • Q2 due 7/25 • Q3 due 10/25 Q4 due 1/25	L.A. Care's Secure File Transfer Protocol (SFTP) *OR* Via email to CL_Reports_Mailbox@lacare.org	Format as specified by LA. Care or mutually agreed upon per Plan Partner process.

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

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

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

By: _____
John Baackes
Chief Executive Officer

Date: _____, 2023

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

By: _____
Kristen Cerf
President and Chief Executive Officer

Date: _____, 2023

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

Date: _____, 2023

Amendment No. 47
to
Services Agreement
between
Local Initiative Health Authority for Los Angeles County
and
Kaiser Foundation Health Plan, Inc.

This Amendment No. 47 is effective as of July 1, 2022, as indicated herein by and between the Local Initiative Health Authority for Los Angeles County, a local public agency operating as L.A. Care Health Plan ("Local Initiative") and ***Kaiser Foundation Health Plan, Inc.,*** a California health care service plan ("Plan").

RECITALS

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

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

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

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

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

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

IN WITNESS WHEREOF, the parties have entered into this Amendment No. 47 as of the date set forth below.

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

By: _____
John Baackes
Chief Executive Officer

Date: _____, 2023

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

By: _____
Marcus J. Hoffman
Senior Vice President, Chief Financial Officer, Southern California and Hawai'i Market

Date: _____, 2023

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

Date: _____, 2023

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

Exhibit 8
Delegation Agreement
[Attachment A]

Delegated Activities
Responsibilities of Plan and Local Initiative

The purpose of the following grid is to specify the activities delegated by Local Initiative ("L.A. Care") to Kaiser Foundation Health Plan (individually and collectively "Plan" and/or "Delegate") under the Delegation Agreement with respect to: (i) quality management and improvement, (ii) population health management, (iii) network management, (iv) utilization management, (v) credentialing and re-credentialing, (vi) member experience, (viii) financial solvency and claims processing compliance. All Delegated Activities are to be performed in accordance with currently applicable NCQA accreditation standards and State and Federal regulatory requirements, as modified from time to time. Kaiser Foundation Health Plan agrees to be accountable for all responsibilities delegated by L.A. Care and will not further delegate (sub-delegate) any such responsibilities without prior written approval by L.A. Ct as outlined in the Delegation Agreement. Kaiser Foundation Health Plan is responsible for sub-delegation oversight of any sub-delegated activities. Kaiser Foundation Health Plan will provide periodic reports to L.A. Care as described elsewhere in the Delegation Agreement. L.A. Care will oversee the delegation to Kaiser

Foundation Health Plan as described elsewhere in the Services Agreement. Due to the Medi-Cal Rx Transition where the pharmacy benefit will be managed by DHCS starting January 1,2022 , standard and reporting requirements as related to Pharmacy items will no longer be required for data period beginning the transition date identified by DHCS. This would apply to all standard requirements and reports listed under "Pharmacy". The final monitoring and quarterly reporting requirement would be up to the data period until the transition date. However, while the monitoring and quarterly reporting will discontinue after the transition date, any reports required for regulatory or NCQA purposes mainly as it relates to any data up to the actual transition date would be still required upon request. In the event deficiencies are identified through this oversight, Kaiser Foundation Health Plan will provide a specific corrective action plan acceptable to L.A. Care. If Kaiser Foundation Health Plan does not comply with the corrective action plan within the specified time frame, L.A. Care may revoke the delegation to Kaiser Foundation Health Plan, in whole or in part, in accordance with Exhibit 5, herein. L.A. Care will provide Plan Partner with the data necessary to determine member experience and clinical performance, when requested and as applicable. Request shall be sent to the L.A. Care business unit which maintains the data and/or L.A. Care's Plan Partner Business Unit. The request must be precise and contain sufficient details so it is clear what minimum data needs to be provided to fulfill the request. The L.A. Care business unit responsible for the requested data shall respond timely and ensure that data is sent in compliance with L.A. Care's Policies and Procedures securing PHI through applicable protections, e.g., encryption

Standard	Delegated Activities	Retained by L.A. Care
	QI	
Program Structure and Operations (NCQA QI 1) QI	**QI Program Structure** The organization's QI program description specifies: 1. The QI Program Structure 2. The behavioral healthcare aspects of the program 3. Involvement of a designated physician in the QI program 4. Involvement of a behavioral healthcare practitioner in the behavioral aspects of the program 5. Oversight of QI functions of the organization by the QI Committee **<u>Annual Work Plan</u>** The organization documents and executes a QI annual work plan that reflects ongoing activities throughout the year and addresses: 1. Yearly planned QI activities and objectives. 2. Time frame for each activity's completion. 3. Staff members responsible for each activity. 4. Monitoring of previously identified issues. 5. Evaluation of the QI program. **Annual Evaluation** The organization conducts an annual written evaluation of the QI program that includes the following information: 1. A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of service 2. Trending of measures of performance in the quality and safety of clinical care and quality of service	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs, including review, evaluation, and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

Standard	Delegated Activities	Retained by L.A. Care
	3. evaluation of the overall effectiveness of the QI program and of its progress toward influencing network-wide safe clinical practices **<u>QI Committee Responsibilities</u>** The organization's QI Committee: 1. Recommends policy decisions. 2. Analyzes and evaluates the results of QI activities. 3. Ensures practitioner participation in the QI program through planning, design, implementation or review. 4. Identifies needed actions. 5. Ensures follow-up, as appropriate. **<u>Promoting Organizational Diversity, Equity and Inclusion</u>** The organization: 1. Promotes diversity in recruiting and hiring. 2. Offers training to employees on cultural competency, bias or inclusion.	
Health Services Contracting (NCQA QI 2)	**Practitioner Contracts** Contracts with practitioners specifically require that: 1. Practitioners cooperate with QI activities; 2. Practitioners allow the organization to use their performance data.	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs, including review, evaluation, and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.
Continuity and Coordination of Medical Care (NCQA QI 3)	**Identifying Opportunities** The organization annually identifies opportunities to improve coordination of medical care by: 1. Collecting data on member movement between practitioners 2. Collecting data on member movement across settings 3. Conducting quantitative and causal analysis of data to identify improvement opportunities 4. Identifying and selecting one opportunity for improvement 5. Identifying and selecting a second opportunity for improvement 6. Identifying and selecting a third opportunity for improvement 7. Identifying and selecting a fourth opportunity for improvement **Acting of Opportunities** The organization annually acts to improve coordination of medical care by:	

Standard	Delegated Activities	Retained by L.A. Care
	1. Acting on the first opportunity identified in Element A, factors 4-7 2. Acting on the second opportunity identified in Element A, factors 4-7 3. Acting on the third opportunity identified in Element A, factors 4-7 **Measuring Effectiveness** The organization annually measures the effectiveness of improvement actions taken for: 1. The first opportunity in Element B. 2. The second opportunity in Element B. 3. The third opportunity in Element B. **Transition to other care** Refer to Utilization Management Delegated Activities Section	
Continuity and Coordination between Medical and Behavioral Healthcare (NCQA QI 4)	**Data Collection** The organization annually collects data about opportunities for collaboration between medical care and behavioral healthcare in the following areas: 1. Exchange of information 2. Appropriate diagnosis, treatment and referral of behavioral healthcare disorders commonly seen in primary care 3. Appropriate use of psychotropic medications 4. Management of treatment access and follow-up for members with coexisting medical and behavioral disorders. 5. Primary or secondary preventive behavioral healthcare program implementation. 6. Special needs of members with severe and persistent mental illness or serious emotional disturbance. **Collaborative Activities** The organization annually conducts activities to improve the coordination of behavioral healthcare and general medical care including: 1. Collaborating with behavioral healthcare practitioners 2. Quantitative and qualitative analysis of data to identify improvement opportunities 3. Identifying and selecting one opportunity for improvement from Element A 4. Identifying and selecting a second opportunity for improvement from Element A	

Standard	Delegated Activities	Retained by L.A. Care
	5. Taking collaborative action to address one identified opportunities for improvement from Element A 6. Taking collaborative action to address a second identified opportunity for improvement from Element A. **Measuring Effectiveness** The organization annually measures the effectiveness of improvement actions taken for: 1. The first opportunity in Element B. 2. The second opportunity in Element B.	
Standards for Medical Record Documentation (DHCS)	Establishing medical record standards which require medical records to be maintained in a manner that is current, detailed, and organized, and which permits effective and confidential patient care and quality review, including: 1. Developing and distributing to practice sites: a. Policies and procedures for the confidentiality of medical records b. Medical record documentation standards i. Requirements for an organized medical record c. Standards for the availability of medical records	

Standard	Delegated Activities	Retained by L.A. Care
Sub--delegation Delegation of QI (NCQA QI 5)	**Sub-delegation Delegation Agreement** The written sub-delegation agreement: 1. Is mutually agreed upon 2. Describes the sub-delegated activities and the responsibilities of the delegate and the sub-delegated entity 3. Requires at least semiannual reporting by the sub-delegated entity to the delegate 4. Describes the process by which the delegate evaluates the sub-delegated entity's performance 5. Describes the process for providing member experience and clinical performance data to its sub-delegates when requested 6. Describes the remedies available to the delegate if the sub-delegated entity does not fulfill its obligations, including revocation of the sub-delegation agreement **Predelegation Evaluation** For new sub-delegation agreements initiated in the look-back period, the delegated entity evaluates sub-delegate capacity to meet NCQA requirements before sub-delegation begins. **Review of QI Program** For arrangements in effect for 12 months or longer, the organization: 1. Annually reviews its sub-delegate's QI program 2. Annually evaluates sub-delegate performance against NCQA standards for sub-delegated activities 3. Semiannually evaluates regular reports, as specified in Element Athe sub-delegation agreement. **Opportunities for Improvement** For sub-delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that sub-delegation has been in effect, the delegate identified and followed up on opportunities for improvement, if applicable.	
	POPULATION HEALTH MANAGEMENT	

Standard	Delegated Activities	Retained by L.A. Care
PHM Strategy (NCQA PHM 1) (CalAIM PHM Strategy)	**NCQA Strategy Description** The strategy describes: 1. Goals and populations targeted for each of the four areas of focus 2. Programs or Services offered to members. 3. Activities that are not direct member interventions, 4. How member programs are coordinated. 5. How members are informed about available PHM programs. 6. How the organization promotes health equity. **CalAIM Strategy** Delegates must complete DHCS required annual strategy documents and share with L.A. Care for review. **NCQA Informing Members** The organization informs members eligible for programs that include interactive contact: 1. How members become eligible to participate 2. How to use program services 3. How to opt in or opt out of the program	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care. L.A. Care to coordinate collaborative shared SMART goal development included in all delegates' CalAIM Strategy submission.

Population Identification (NCQA 2021-2022 PHM 2) (CalAIM Population Needs Assessment)	**NCQA Data Integration** The organization integrates the following data to use for population health management functions: 1. Medical and Behavioral claims or encounters 2. Pharmacy claims 3. Laboratory results 4. Health appraisal results 5. Electronic health records 6. Health Services programs within the organization 7. Advanced data sources **NCQA Population Assessment** The organization annually: 1. Assesses the characteristics and needs, including social determinants of health, of its member population 2. Identifies and assesses the needs of relevant member subpopulations. 3. Assesses the needs of child and adolescent members 4. Assesses the needs of members with disabilities 5. Needs of members with serious and persistent mental illness (SPMI) 6. Assesses the needs of members of racial or ethnic groups. 7. Assesses the needs of members with limited English proficiency. **CalAIM Population Needs Assessment** The organization every three years completes the Population Needs Assessment per the DHCS requirements as detailed in APL 23-021. **NCQA Activities and Resources** The organization annually uses the population assessment to: 1. Review and update its PHM activities to address member needs 2. Review and update its PHM resources to address member needs 3. Review and update activities or resources to address health care disparities for at least one identified populations. 4. Review community resources for integration into program offerings to address member needs **Segmentation** At least annually, the organization segments or stratifies its entire population into subset for targeted intervention.	

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

Standard	Delegated Activities	Retained by L.A. Care
Complex Case Management (NCQA PHM 5)	**Access to Case Management** The organization has multiple avenues for members to be considered for complex case management services, including: 1. Medical management program referral 2. Discharge planner referral 3. Member or caregiver referral 4. Practitioner referral. **Case Management Systems** The organization uses case management systems that support: 1. Evidence-based clinical guidelines or algorithms to conduct assessment and management; 2. Automatic documentation of staff ID, and the date and time of action on the case or when interaction with the member occurred 3. Automated prompts for follow-up, as required by the case management plan.	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

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

Standard	Delegated Activities	Retained by L.A. Care
	5. Initial assessment of social determinants of health 6. Evaluation of cultural and linguistic needs, preferences or limitations 7. Evaluation of visual and hearing needs, preferences or limitations 8. Evaluation of caregiver resources and involvement 9. Evaluation of available benefits 10. Evaluation of available community resources 11. Assessment of life planning activities. 12. Beginning the assessment for at least one factor within 30 calendar days of identifying a member for complex case management. **Case Management Ongoing Management** The NCQA review of a sample of the organization's case management files that demonstrates the Plan Partner follows its documented processes for: 1. Development of case management plans, including prioritized goals, that take into account member and caregiver goals, preferences and desired level of involvement in the complex case management program 2. Identification of barriers to meeting goals and complying with the plan 3. Development of a schedule for follow-up and communication with members. 4. Development and communication of member self-management plans 5. Assessment of progress against the case management plans and goals and modification as needed.	
Population Health Management Impact (NCQA PHM 6)	**Measuring Effectiveness** At least annually, the organization conducts a comprehensive analysis of the impact of its PHM strategy that includes the following: 1. Quantitative results for relevant clinical, cost/utilization and experience measures. 2. Comparison of results with a benchmark or goal. 3. Interpretation of results. **Improvement and Action** The organization uses results from the PHM impact analysis to annually: 1. Identify opportunities for improvement. 2. Act on one opportunity for improvement.	

Standard	Delegated Activities	Retained by L.A. Care
Sub-delegation Delegation of PHM (NCQA PHM 7)	**Sub-delegation Delegation Agreement** The written sub-delegation agreement: 1. Is mutually agreed upon 2. Describes the sub-delegated activities and the responsibilities of the delegate and the sub-delegated entity 3. Requires at least semiannual reporting by the sub-delegated entity to the delegate 4. Describes the process by which the delegate evaluates the sub-delegated entity's performance 5. Describes the process for providing member experience and clinical performance data to its sub-delegates when requested 6. Describes the remedies available to the delegate if the sub-delegated entity does not fulfill its obligations, including revocation of the sub-delegation agreement **Predelegation Evaluation** For new sub-delegation agreements initiated in the look-back period, the delegated entity evaluates sub-delegate capacity to meet NCQA requirements before sub-delegation begins. **Review of PHM Program** For arrangements in effect for 12 months or longer, the organization: 1. Annually reviews its sub-delegate's PHM program 2. Annually audits complex case management files against NCQA standards for each year that sub-delegation has been in effect, if applicable 3. Annually evaluates sub-delegate performance against NCQA standards for sub-delegated activities 4. Semiannually evaluates regular reports, as specified in Element of the sub-delegation agreement. **Opportunities for Improvement** For sub-delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that sub-delegation has been in effect, the delegate identified and followed up on opportunities for improvement, if applicable.	
	NETWORK MANAGEMENT	
Availability of Practitioners (NCQA NET 1)	**Cultural Needs and Preferences** The organization: 1. Assesses the cultural, ethnic, racial, and linguistic needs of its members	

Standard	Delegated Activities	Retained by L.A. Care
	2. Adjusts the availability of practitioners within its network, if necessary. **Practitioners Providing Primary Care** To evaluate the availability of practitioners who provide primary care services, including general medicine or family practice, internal medicine and pediatrics by: 1. Establishes measurable standards for the number of each type of practitioner providing primary care 2. Establishes measurable standards for the geographic distribution of each type of practitioner providing primary care 3. Annually analyzes performance against the standards for the number of each type of practitioner providing primary care 4. Annually analyzes performance against the standards for the geographic distribution of each type of practitioner providing primary care. **Practitioners Providing Specialty Care** To evaluate the availability of specialists in its delivery system, the organization: 1. Defines the type of practitioners who serve as high volume and high impact specialists 2. Establishes measurable standards for the number of each type of high volume specialists 3. Establishes measurable standards for the geographic distribution of each type of high-volume specialist 4. Establishes measureable standards for the geographic distribution of each type of high-impact specialist 5. Analyzes its performance against the established standards at least annually **Practitioners Providing Behavioral Healthcare** To evaluate the availability of high-volume behavioral healthcare practitioners in its delivery system, the organization: 1. Defines the types of high volume behavioral healthcare practitioners 2. Establishes measurable standards for the number of each type of high volume behavioral healthcare practitioner 3. Establishes measurable standards for the geographic distribution of each type of high-volume behavioral healthcare practitioner	

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

Standard	Delegated Activities	Retained by L.A. Care
	1. Prioritizes opportunities for improvement identified from analyses of availability,. **(NET 1, Elements A, B and C), accessibility (NET 2, Elements A and C) and member experience accessing the network (NET 3, Element A, factors 1 and 3).** 2. Implements interventions on at least one opportunity, if applicable. 3. Measures the effectiveness of interventions, if applicable. **Opportunities to Improve Access to Behavioral Healthcare Services** The organization annually: 1. 1. Prioritizes opportunities for improvement identified from analyses of availability (NET 1, Elements A, B and C), accessibility (NET 2, Elements A and C) and member experience accessing the network (NET 3, Element A, factors 1 and 3). 2. Implements interventions on at least one opportunity, if applicable. 3. Measures the effectiveness of interventions, if applicable.	
Continued Access to Care (NCQA NET 4)	**Notification of Termination** Refer to Utilization Management Delegated Activities Section **Continued Access to Practitioners** Refer to Utilization Management Delegated Activities Section	
Physician and Hospital Directories (NCQA NET 5)	**Physician Directory Data** The organization has a web-based physician directory that includes the following physician information: 1. Name 2. Gender 3. Specialty 4. Hospital affiliations 5. Medical group affiliations 6. Board certification 7. Accepting new patients 8. Language spoken by the physician or clinical staff 9. Office locations and phone numbers **Physician Directory Updates**	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

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

Standard	Delegated Activities	Retained by L.A. Care
	Hospital Directory Updates The organization updates its web-based hospital directory information within 30 calendar days of receiving new information from the network hospital. **Searchable Hospital Web-Based Directory** The organization's web-based directory includes search functions for specific data types and instructions for searching for the following information: 1. Hospital name 2. Hospital location **Usability Testing** The organization evaluates its web-based physician and hospital directories for understandability and usefulness to members and prospective members at least every three years, and considers the following: 1. Reading level 2. Intuitive content organization 3. Ease of navigation 4. Directories in additional languages, if applicable to membership **Availability of Directories** The organization makes web-based physician and hospital directory information available to members and prospective members through alternative media, including: 1. Print 2. Telephone	
Sub-Delegation of NET (NCQA NET 6)	**Sub-delegation Agreement** The written sub-delegation agreement: 1. Is mutually agreed upon 2. Describes the sub-delegated activities and the responsibilities of the delegate and the sub-delegated entity 3. Requires at least semiannual reporting by the sub-delegated entity to the delegate 4. Describes the process by which the delegate evaluates the sub-delegated entity's performance 5. Describes the process for providing member experience and clinical performance data to its sub-delegates when requested	

Standard	Delegated Activities	Retained by L.A. Care
	6. Describes the remedies available to the delegate if the sub-delegated entity does not fulfill its obligations, including revocation of the sub-delegation agreement **Predelegation Evaluation** For new sub-delegation agreements initiated in the look-back period, the delegated entity evaluates sub-delegate capacity to meet NCQA requirements before sub-delegation begins. **Review of Sub-Delegated Activities** 1. For arrangements in effect for 12 months or longer, the organization: Annually reviews its sub-delegate's network management procedures 2. Annually evaluates sub-delegate performance against NCQA standards for sub-delegated activities 3. Semiannually evaluates regular reports, as specified in Element A the sub-delegation agreement. **Opportunities for Improvement** For sub-delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that sub-delegation has been in effect, the delegate identified and followed up on opportunities for improvement, if applicable.	
	UTILIZATION MANAGEMENT	
Continued Access to Care and Continuity and Coordination of Medical Care (NCQA NET 4and QI 3)	**Notification of Termination** The organization notifies members affected by the termination of a practitioner or practice group in general, family, and internal medicine or pediatrics, at least thirty (30) calendar days prior to the effective termination date and helping the member select a new practitioner. **Continued Access to Practitioners** If a practitioner's contract is discontinued, the organization allows affected members continued access to the practitioner, as follows: 1. Continuation of treatment through the current period of active treatment or for up to ninety (90) calendar days, whichever is less, for members undergoing active treatment for a chronic or acute medical condition 2. Continuation of care through the postpartum period for members in their second or third trimester of pregnancy.	

Standard	Delegated Activities	Retained by L.A. Care
	Transition to Other Care The organization helps with members' transition to other care when their benefits end, if necessary.	
Program Structure (NCQA UM 1)	**Written Program Description** The organization's UM program description includes the following: 1. A written description of the program structure 2. The behavioral healthcare aspects of the program 3. Involvement of a designated senior-level physician in UM program implementation 4. Involvement of a designated behavioral healthcare practitioner in the implementation of the behavioral healthcare aspects of the UM program 5. The program scope and processes to determine benefit coverage and medical necessity 6. Information sources used to determine benefit coverage and medical necessity. **Annual Evaluation** The organization annually evaluates and updates the UM program, as necessary.	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs, including review, evaluation, and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.
Clinical Criteria for UM Decisions (NCQA UM 2)	**UM Criteria** The organization: 1. Has written UM decision-making criteria that are objective and based on medical evidence 2. Has written policies for applying the criteria based on individual needs 3. Has written policies for applying the criteria based on an assessment of the local delivery system 4. Involves appropriate practitioners in developing, adopting, and reviewing criteria 5. Annually reviews the UM criteria and the procedures for applying them, and updates the criteria when appropriate **Availability of Criteria** The organization: 1. States in writing how practitioners can obtain the UM criteria 2. Makes the criteria available to practitioners upon request. **Consistency in Applying Criteria** At least annually, the organization:	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs, including review, evaluation, and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

Standard	Delegated Activities	Retained by L.A. Care
	1. Evaluates the consistency with which health care professionals involved in UM apply criteria in decision making 2. Acts on opportunities to improve consistency, if applicable.	
Communication Services (NCQA UM 3)	**Access to Staff** The organization provides the following communication services for members and practitioners including: 1. Staff are available at least eight (8) hours a day during normal business hours for inbound collect or toll-free calls regarding UM issues 2. Staff can receive inbound communication regarding UM issues after normal business hours 3. Staff are identified by name, title, and organization name when initiating or returning calls regarding UM issues 4. TDD/TTY services for members who need them 5. Language assistance for members to discuss UM issues.	
Appropriate Professionals* (NCQA UM 4)	**Licensed Health Professionals** The organization has written procedures: 1. Requiring appropriately licensed professionals to supervise all medical necessity decisions 2. Specifying the type of personnel responsible for each level of UM decision-making **Use of Practitioners for UM Decisions** The organization has a written job description with qualifications for practitioners who review denials of care based on medical necessity. Practitioners are required to have: 1. Education, training, or professional experience in medical or clinical practice 2. A current clinical license to practice or an administrative license to review UM cases **Practitioner Review of Nonbehavioral Healthcare Denials** The organization uses a physician or other healthcare professional, as appropriate, to review any non-behavioral healthcare denial based on medical necessity. **Practitioner Review of Behavioral Healthcare Denials** The organization uses a physician, appropriate behavioral healthcare practitioners, as appropriate,	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs, including review, evaluation, and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

Standard	Delegated Activities	Retained by L.A. Care
	to review any behavioral healthcare denial of care based on medical necessity. **Practitioner Review of Pharmacy Denials** The organization uses a physician or a pharmacist to review pharmacy denials based on medical necessity. **Use of Board-Certified Consultants** The organization: 1. Has written procedures for using board-certified consultants to assist in making medical necessity determinations 2. Provides evidence that it uses board-certified consultants for medical necessity determinations.	
Timeliness of UM Decisions (NCQA UM 5)	**Notification of Nonbehavioral Decisions** The organization adheres to the following time frames for notification of non-behavioral healthcare UM decisions: 1. N/A (Marketplace) 2. For Medicaid urgent concurrent decisions, the organization gives electronic or written notification of the decision to practitioners and members within seventy-two (72) hours of the request 3. For Medicaid urgent pre-service decisions, the organization gives electronic or written notification of the decision to practitioners and members within seventy-two (72) hours of the request 4. For Medicaid non-urgent pre-service decisions, the organization gives electronic or written notification of the decision to practitioners and members within fourteen (14) calendar days of the request 5. For Medicaid postservice decisions, the organization gives electronic or written notification of the decision to practitioners and members within thirty (30) calendar days of the request. **Notification of Behavioral Healthcare Decisions** The organization adheres to the following time frames for notification of behavioral healthcare UM decisions: 1. N/A (Marketplace) 2. For Medicaid urgent concurrent decisions, the organization gives electronic or written notification of the decision to practitioners and members within seventy-two (72) hours of the request	

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

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

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

Standard	Delegated Activities	Retained by L.A. Care
	representation and time frames for deciding appeals 3. A description of the expedited appeals process for urgent pre-service or urgent concurrent denials 4. Notification that expedited external review can occur concurrently with the internal appeals process for urgent care **Discussing a Pharmacy Denial With a Reviewer** The organization gives practitioners the opportunity to discuss pharmacy UM denial decisions with a physician or pharmacist. **Written Notification of Pharmacy Denials** The organization's written notification of pharmacy denials to members and their treating practitioners contains the following information: 1. The specific reasons for the denial, in language that is easy to understand 2. A reference to the benefit provision, guideline, protocol or similar criterion on which the denial decision is based A statement that members can obtain a copy of the actual benefit provision, guideline, protocol or similar criterion on which the denial decision was based, upon request. **Written Notification of Pharmacy Appeals Rights/Process** The organization's written notification of pharmacy denials to members and their treating practitioners contains the following information: 1. A description of appeal rights, including the right to submit written comments, documents or other information relevant to the appeal 2. An explanation of the appeal process, including the right to member representation and time frames for deciding appeals 3. A description of the expedited appeals process for urgent pre-service or urgent concurrent denials 4. Notification that expedited external review can occur concurrently with the internal appeal process for urgent care	
Policies for Appeals (NCQA UM 8)	**Internal Appeals** The organization's written policies and procedures for registering and responding to written internal appeals must follow all current regulations and include but not limited toto the following:	Members have the option to appeal directly to L.A. Care. Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs,

Standard	Delegated Activities	Retained by L.A. Care
	1. Allowing at least sixty (60) calendar days after notification of the denial for the member to file the appeal 2. Documenting the substance of the appeal and any actions taken 3. Full investigation of the substance of the appeal, including any aspects of clinical care involved 4. The opportunity for the member to submit written comments, documents or other information relating to the appeal 5. Appointment of a new person to review an appeal, who was not involved in the initial determination and who is not the subordinate of any person involved in the initial determination 6. Appointment of at least one person to review an appeal who is a practitioner in the same (defined as a practitioner with similar credentials and licensure as those who typically treat the condition or health problem in question in the appeal) or a similar (defined as a practitioner who has experience treating the same problems as those in question in the appeal, in addition to experience treating similar complications of those problems) specialty. 7. The decision for a pre-service appeal and notification to the member within thirty (30) calendar days of receipt of the request. 8. The decision for a post-service appeal and notification to the member within sixty (60) calendar days of receipt of the request. For Medicaid only, decisions for postservice appeals and notifications to members must be within 30 calendar days of receipt of the request. 9. The decision for an expedited appeal and notification to the member within seventy-two (72) hours of receipt of the request 10. Notification to the member about further appeal rights 11. Referencing the benefit provision guideline, protocol or other similar criterion on which the appeal decision is based 12. Giving members reasonable access to and copies of all documents relevant to the appeal, free of charge, upon request	including review, evaluation, and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care. Delegate will supply L.A. with requested documentation for processing and investigating appeals and grievances filed by the member. Timeframes for supplying the requested information will be 7 calendar days for standard appeals or grievances and 24 hour or less for expedited appeal or grievances. Part B appeals 24 hours. The Delegate will assist L.A. Care in remaining in compliance with all regulatory guidelines and requests. The Delegate will supply L.A. Care with any requested documentation required to conduct research for any Regulatory inquires made by our Regulators within 24 hours or less contingent upon the turnaround times established by the Regulator.

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

Standard	Delegated Activities	Retained by L.A. Care
	guideline, protocol or other similar criterion on which the appeal decision was based, upon request 4. Notification that the member is entitled to receive reasonable access to, and copies of all documents relevant to their appeal, free of charge, upon request 5. A list of titles and qualifications, including specialties, of individuals participating in the appeal review 6. A description of the next level of appeal, either within the organization or to an independent external organization, as applicable, along with any relevant written procedures. **Final Internal and External Appeal Files** N/A **Appeals Overturned by the IRO** N/A	
Evaluation of New Technology (NCQA UM 10)		**Written Process** Evaluates the inclusion of new technology and the new application of existing technology in the benefits plan, including medical and behavioral health procedures, pharmaceuticals, and devices. This element is Not Applicable for Medicaid product lines if the state mandates all benefits and new technology determinations. L.A. Care will provide the state's language. **Description of the Evaluation Process** This element is Not Applicable for Medicaid product lines if the state mandates all benefits and new technology determinations. L.A. Care will produce documentation that demonstrates this.
UM System Controls (NCQA UM 12)	**UM Denial System Controls** The organization has policies and procedures describing its system controls specific to UM denial notification dates that: 1. Define the date of receipt consistent with NCQA requirements. 2. Define the date of written notification consistent with NCQA requirements.	

Standard	Delegated Activities	Retained by L.A. Care
	3. Describe the process for recording dates in systems. 4. Specify staff who are authorized to modify dates once initially recorded and circumstances when modification is appropriate. 5. Specify how the system tracks modified dates. 6. Describe system security controls in place to protect data from unauthorized modification. 7. Describe how the organization audits the processes and procedures in factors 1-6. **UM Denial System Controls Oversight** At least annually, the organization demonstrates that it monitors compliance with its UM denial controls, as described in Element A, factor 7, by: 1. Identifying all modifications to receipt and decision notification dates that did not meet the organization's policies and procedures for date modifications. 2. Analyzing all instances of date modifications that did not meet the organization's policies and procedures for date modifications. 3. Acting on all findings and implementing a quarterly monitoring process until it demonstrates improvement for one finding over three consecutive quarters. **UM Appeal System Controls** The organization has policies and procedures describing its system controls specific to UM appeal dates that: 1. Define the date of receipt consistent with NCQA requirements. 2. Define the date of written notification consistent with NCQA requirements. 3. Describe the process for recording dates in systems. 4. Specify staff who are authorized to modify dates once initially recorded and circumstances when modification is appropriate. 5. Specify how the system tracks modified dates. 6. Describe system security controls in place to protect data from unauthorized modification. 7. Describe how the organization audits the processes and procedures in factors 1-6. **UM Appeal System Controls Oversight** At least annually, the organization demonstrates that it monitors compliance with its UM appeal controls, as described in Element C, factor 7, by: 1. Identifying all modifications to receipt and decision notification dates that did not	

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

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

Standard	Delegated Activities	Retained by L.A. Care
	for discriminatory practices, at least annually. 7. The process for notifying practitioners about any information obtained during the credentialing process that varies substantially from the information provided to Delegate by the practitioner. 8. The process for notifying practitioners of the credentialing and recredentialing decisions within sixty (60) calendar days of the committee's decision 9. The medical director or other designated physician's direct responsibility for, and participation in, the credentialing program 10. The process for securing the confidentiality of all information obtained in the credentialing process, except as otherwise provided by law 11. The process for confirming that listings in practitioner directories and other materials for members are consistent with credentialing data, including education, training, board certification, and specialty. **Practitioner Rights** The organization notifies practitioners about: 1. The right of practitioners to review information submitted to support their credentialing application, including: 2. The right of practitioners to correct erroneous information: i. The timeframe for making corrections. ii. The format for submitting corrections. iii. The person to whom the corrections must be submitted. 3. The right of practitioners to be informed of the status of their credentialing or re-credentialing application, upon request. **Credentialing System Control** The Delegate must have policies and procedures for its CR system security controls. If the Organization outsources storage of credentialing information to an external entity, the contract between the Delegate and the external entity will be part of the oversight review. The organization's credentialing process describes: 1. How primary source verification information is received, stored, reviewed, and dated.	

Standard	Delegated Activities	Retained by L.A. Care
(DHCS APL 19-004)	2. How modified information is tracked and dated from its initial verification. 3. Titles or roles of staff who are authorized to review, modify and delete information, and circumstances when modification or deletion is appropriate. 4. The security controls in place to protect the information from unauthorized modification 5. How the organization monitors its compliance with the processes and procedures in factors 1–4at least annually and takes appropriate action when applicable. **Credentialing System Controls Oversight** At least annually, the organization demonstrates that it monitors compliance with its CR controls by: 1. Identifying all modifications to credentialing and recredentialing information that did not meet the organization's policies and procedures for modifications. 2. Analyzing all instances of modifications that did not meet the organization's policies and procedures for modifications. 3. Acting on all findings and implementing a quarterly monitoring process until it demonstrates improvement from one finding over three consecutive quarters. **Medi-Cal FFS Enrollment** Developing and implementing policies and procedures for Medi-Cal enrollment. Policy must clearly specify enrollment process including, but not limited to: 1. All practitioners that have a FFS enrollment pathway must enroll in the Medi-Cal program. 2. The process for ensuring and verifying Medi-Cal enrollment. 3. The process for practitioners whose enrollment application is in process. 4. The process for monitoring between recredentialing cycles to validate continued enrollment. 5. The process for practitioners not currently enrolled in the Medi-Cal program. 6. The process for practitioners deactivated or suspended from the Medi-Cal program.	

Standard	Delegated Activities	Retained by L.A. Care
	During the annual oversight review, the Delegate is subject to a CAP (Corrective Action Plan) if their process does not match their policies. In addition, if the Delegate demonstrates reoccurring deficiencies that were identified in previous audits, the Delegate is subject to additional point deductions.	
Credentialing Committee (NCQA CR 2) DMHC, DHCS, CMS	Designating a credentialing committee that uses a peer review process to make recommendations regarding credentialing and re-credentialing decisions such that the organization's Credentialing Committee: 1. Includes representation from a range of participating practitioners, and provides advice and expertise for credentialing decisions 2. Has the opportunity to review the credentials of all practitioners being credentialed or recredentialed who do not meet Delegate's established criteria and to offer advice, which Delegate considers appropriate under the circumstances. 3. The Medical Director, designated physician or credentialing committee reviews and approves files that meet the Delegate's established criteria. 4. Ensures that all license accusations, sanctions or restrictions are reviewed by the credentialing committee for action.	
Credentialing Verification (NCQA CR 3) DMHC, DHCS, CMS	Primary source verification and credentialing and recredentialing decision-making, which includes verification of information to ensure that practitioners have the legal authority and relevant training and experience to provide quality care, within the regulatory and NCQA prescribed time limits, through primary or other regulatory and NCQA-approved sources, prior to credentialing and recredentialing The organization verifies that the following are within the prescribed time limits: 1. Current, valid license to practice (Develop a process to ensure providers' licenses are kept current at all times). 2. A valid DEA or CDS, with schedules 2 thru 5, if applicable; or the Delegate has a documented process for practitioners: a. Allowing a practitioner with a valid DEA certificate to write all prescriptions for a practitioner with a pending DEA certificate b. Requiring an explanation from a qualified practitioner who does not prescribe	

Standard	Delegated Activities	Retained by L.A. Care
	medications and provides arrangements for the practitioner's patients who need prescriptions for medications. 3. For physicians, verification of the highest of the following three levels of education and training obtained by the practitioner as appropriate: a. Board certified if practitioner stated on the application that he/she is board certified, as well as expiration date of certification. b. Completion of a residency program. c. Graduation from medical or professional school. 4. For Non-Physician Medical Practitioners (NMPs) and Non-Clinical Providers (NCPs), the Delegate verifies the provider has met the qualifications to render services based on the provider type including but not limited to, a current and valid license, registration, certification or the education/training equivalent. 5. Work history. 6. Current malpractice insurance coverage ($1 million/$3 million). 7. A history of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner. 8. Clinical Privileges in good standing at a Plan contracted facility designated by the physician as the primary admitting facility. 9. Current, valid FSR/MRR of primary care physician offices within 3 years prior to credentialing decision. 10. CLIA Certifications, if applicable. 11. NPI number. 12. Medicare number, if applicable. 13. Medi-Cal FFS enrollment All certifications and expiration dates must be made part of the practitioner's file and kept current. Delegate shall maintain credentialing and/or other monitoring processes to assure that licensure and professional status of each Participating Provider is verified on an ongoing basis. Pursuant to the performance of its credentialing, recredentialing, auditing, monitoring and/or other processed, which include confirmation relating to the following: ▪ Each Participating Provider/Practitioner is and shall remain duly licensed, registered or certified, as required by the laws of this State, and such licensure is free from restrictions that would restrict or limit the	

Standard	Delegated Activities	Retained by L.A. Care
	ability of Participating provider/practitioner to provide Health Care Services to LAC members as required under the Agreement. ▪ Each Delegate shall maintain professional liability insurance, either independently or through Contractor or some other entity, in a dollar amount that is sufficient for his/her/its practice and as may be required by law or accrediting entities. The Delegate's participating providers must also have general liability insurance in a dollar amount appropriate for their business practice. The Delegate must notify L.A. Care immediately when a practitioner's license has expired for removal from the network.	
CR Sanction Information (NCQA CR 3) DMHC, DHCS, CMS	The organization verifies the following sanction information for credentialing: 1. State sanctions, restrictions on licensure, or limitations on scope of practice. Review of information must cover the most recent 5-year period available. If a practitioner is licensed in more than one state, in the most recent 5-year period, the query must include all states in which they worked. 2. Medicare and Medicaid sanctions. 3. *Medicare Opt-out. 4. SAM. 5. CMS Preclusion 6. Debarment. 7. Decertification. Providers must not be terminated, sanctioned, suspended, debarred, disenrolled/decertified, convicted of a felony related to healthcare program fraud or excluded from participation in any federal or state funded programs. L.A. Care does not contract, credential, refer, or pay claims to Practitioners or Providers who have opted out of participation in the Medicare and Medicaid programs; or with individuals or businesses that have been convicted of a felony related to healthcare program fraud, federally or state terminated, sanctioned, suspended, debarred, disenrolled/decertified, excluded, or have appeared on any sanction reports, or on any order issued by judicial authority. Such Practitioners, Providers, individuals, or businesses are ineligible from participation in Medi-Cal, Medicare, federal or state funded programs.	

Standard	Delegated Activities	Retained by L.A. Care
	The Delegate must notify L.A. Care immediately when practitioners are identified on any sanctions or reports for removal from the network.	
CR Application and Attestation (NCQA CR 3) DMHC, DHCS, CMS	Applications for credentialing and recredentialing include the following: 1. Reasons for inability to perform the essential functions of the position, with or without accommodation 2. Lack of present illegal drug use 3. History of loss of license and felony convictions 4. History of loss or limitation of privileges or disciplinary action 5. Current malpractice insurance coverage ($1million/$3 million). 6. Current and signed attestation confirming the correctness and completeness of the application.	
Re-credentialing Cycle Length (NCQA CR 4) DMHC, DHCS, CMS	The length of the recredentialing cycle is within the required 36-month time frame. For PCPs only, must confirm provider has a valid FSR at least every 36 months as part of the recredentialing process.	
CR Ongoing Monitoring and Interventions (NCQA CR 5) DMHC, DHCS, CMS	Developing and implementing policies and procedures for ongoing monitoring of practitioner sanctions, complaints and quality issues and takes appropriate action against practitioners when it identifies occurrences of poor quality between recredentialing cycles by: 1. Collecting and reviewing Medicare and Medicaid sanctions within 30 calendar days of its release. In areas where reporting entities do not publish sanction information on a set schedule, the Delegate must query for this information at least every 6 months. 2. Collecting and reviewing sanctions, restrictions or limitations on licensure and report actions taken against any identified practitioners to Plan. 3. Collecting and reviewing complaints. The delegate must set a threshold to evaluate the specific complaint and the practitioners history of issues. 4. Collecting and reviewing information from identified adverse events. a. Implementing appropriate interventions when Delegate identifies instances of poor quality.	Upon notification of any Adverse Event, L.A. Care will notify the Delegate of their responsibility with respect to delegation of credentialing/re-credentialing activity. The notification will clearly delineate what is expected from the Adverse Event that has been identified. The notice will include, but is not limited to: a. Requesting what actions will be taken by the Delegate b. What type of monitoring is being performed c. What interventions are being implemented, including closing panel, moving members, or removal of practitioner from the network d. The notification will include a timeframe for responding to Plan to ensure Plan's members receive the highest level of quality care.

Standard	Delegated Activities	Retained by L.A. Care
	The Delegate's Credentialing committee may vote to flag a practitioner for ongoing monitoring 1. The Delegate must make clear the types of monitoring it imposes, the timeframe used, the intervention, and the outcome, which must be fully demonstrated in the Delegate's credentialing committee minutes 2. The Delegate's credentialing committee can: a. Request a practitioner be placed on a watch list. Any list must be clearly defined and monitored. b. Request that the practitioner demonstrate compliance with probation that has been imposed by the State and monitor completion c. Impose upon the practitioner to demonstrate steps they have taken to improve processes and/or chart review, if applicable. Delegated entities who fail to comply with the requested information within the specified timeframe are subject to sanctions as described in Plan's policies and procedures The Plan will clearly delineate what is expected from the Delegate regarding the Adverse Event that has been identified. The notification may include performing the following: 1. Requesting what action will be taken by the Delegate. 2. What type of monitoring is being performed. 3. What interventions are being implemented, including closing panel, moving members, or removal of practitioner from the network. 4. The notification will include a timeframe for responding to L.A. Care to ensure L.A. Care members receive the highest level of quality care. a. In the event that the Delegate fails to respond as required, the Plan will perform the oversight functions of the Adverse Event and the Delegate will be subject to Plan's credentialing committee's outcome of the adverse events. b. The Delegate must notify L.A. Care immediately when practitioners are identified on any sanctions or reports for removal from the network	

Standard	Delegated Activities	Retained by L.A. Care
	c. The above are samples, but not limited to, the steps the Delegate can take.	
Credentialing: Notification to Authorities and Practitioner Appeal Rights (NCQA 2022 CR 6) DMHC, DHCS, CMS	The Delegate uses objective evidence and patient care consideration when deciding on a course of action for dealing with a practitioner who does not meet its quality standards. The organization has policies and procedures specify for: 1. The range of actions available to Delegate 2. That the Delegate reviews participation of practitioners whose conduct could adversely affect members' health or welfare. 3. The range of actions that may be taken to improve practitioner performance before termination. b. That the Delegate reports its actions to the appropriate authorities. 4. Making the appeal process known to practitioners. All final adverse actions determined to be reportable pursuant to applicable law, must be reported by the Delegate to the National Practitioner Data Bank (NPBD) and the appropriate State Medical Boards. Upon the filing of NPBD reports and 805 reporting, the Delegate must notify the Plan within 5 business days from the date the reports are filed. Providers must notify the Delegate, in writing, of any adverse or criminal action taken against them promptly and no later than fourteen (14) calendar days from the occurrence of any adverse event, criminal action, changes in privileges, accusation, probation, or other disciplinary action of practitioners. Failure to do so may result in the removal of the practitioner from L.A. Care's network as referenced in the California Participating Physician Application Information Release Acknowledgments. Upon notification from a contracted or employed provider, the PPG must notify the Healthplan immediately or no later than 5 business days from the date when practitioners are identified on any ongoing monitoring reports. Within 14 days from criminal action taken against any contracted practitioner, Delegate shall notify L.A. Care in writing.	L.A. Care retains accountability for procedural components and will oversee Delegate's adherence to these standards through pre-delegation, routine monitoring and annual oversight review or more frequently, as required, per changes in contract, Federal and State regulatory guidelines, and accreditation standards.

Standard	Delegated Activities	Retained by L.A. Care
CR Assessment of Organizational Providers (NCQA CR 7) DMHC, DHCS, CMS	The delegate's organization's policy for assessing a health care delivery provider specifies that before it contracts with a provider, and for at least every 36 months thereafter, it: 1. Confirms that the provider organization is in good standing with state and federal regulatory bodies. 2. Confirms that the provider organization has been reviewed and approved by an accrediting body acceptable to Delegate, including which accrediting bodies are acceptable. 3. Conducts an onsite quality assessment is conducted if the provider organization is not accredited by an accrediting body acceptable to Delegate, including which accredited bodies are acceptable. 4. At least every three years that the provider organization continues to be in good standing with state and federal regulatory bodies and, if applicable, is reviewed and approved by an accrediting body acceptable to Delegate. Maintaining a tracking log that includes names of the organization, type of organization, a prior validation date, a current validation date for licensure, accreditation status (if applicable), CMS or state reviews conducted within 3 years at time of verification (if applicable), CLIA certificate (if applicable), NPI number for each organizational provider. The organization includes at least the following medical providers in its assessment: 1. Hospitals. 2. Home health agencies. 3. Skilled nursing facilities. 4. Freestanding surgical centers. 5. *Hospices. 6. *Clinical Laboratories (A CMS issued CLIA certificate or a hospital based exemption from CLIA). 7. *Comprehensive Rehabilitation Facilities (CORFs). 8. *Outpatient Physical Therapy and Speech Pathology Providers. 9. *Providers of end-stage renal disease services. 10. *Providers of outpatient diabetes self-management training. 11. *Portable X-Ray Suppliers.	

Standard	Delegated Activities	Retained by L.A. Care
	12. *Rural Health Clinic (RHCs). 13. Federally Qualified Health Center (FQHCs).e 14. Any other ancillary provider types outlined in the delegate's contract with the Plan The organization includes behavioral healthcare facilities providing mental health or substance abuse services in the following settings: 1. Inpatient. 2. Residential. 3. Ambulatory. The delegate assesses contracted medical health care providers. The delegate assesses contracted behavioral healthcare providers.	
Sub-Delegation of CR (NCQA CR 8) DMHC, DHCS, CMS	**Subdelegation Agreement** If Delegate sub-delegates any NCQA required credentialing activities, there must be evidence of oversight of the delegated activities, including the written sub-delegation agreement that: 1. Is mutually agreed upon. 2. Describes the sub-delegated activities and the responsibilities of the organization and the delegated entity. 3. Requires at least quarterly reporting to Delegate. 4. Describes the process by which Delegate evaluates Sub-delegated entity's performance. 5. Specifies that the delegate retains the right to approve, suspend and terminate individual practitioners, providers and sites, even if the organization delegates decision making. 6. Describes the remedies available to Delegate if Sub-delegate does not fulfill its obligations including revocation of the sub-delegation agreement. **Presubdelegation Evaluation** Retention of the right by Delegate and L.A. Care, based on quality issues, to approve, suspend, and terminate individual practitioners, providers, and sites. **Review of Subdeelgate's Credentialing Activities** For new sub-delegation agreements initiated in the look-back period, the delegate evaluated sub-	L.A. Care retains the right to perform a pre-delegation audit of any entity to which the Plan sub-delegates delegated credentialing activities and approve any such sub-delegation audit of any sub-delegate. Prior to entering into an agreement to sub-delegate delegated credentialing activities, Delegated Plan shall provide L.A. Care with reasonable prior notice of Plan's intent to sub-delegate.

Standard	Delegated Activities	Retained by L.A. Care
	delegate capacity to meet NCQA requirements before sub-delegation begins. For sub-delegation arrangements in effect for 12 months or longer, the Delegate: 1. Annually reviews its sub-delegate's credentialing policies and procedures. 2. Annually audits credentialing and recredentialing files against NCQA standards for each year that sub-delegation has been in effect. 3. Annually evaluates the sub-delegate's performance against relevant regulatory requirements, NCQA standards, and Delegate's expectations annually. 4. Evaluates regular reports from sub-delegate at least quarterly or more frequently based on the reporting schedule described in the sub-delegation document. 5. Annually monitors the delegate's credentialing system security controls to ensure that the delegate monitors its compliance with the delegation agreement or with the delegate's policies and procedures at least annually. 6. Annually acts on all findings from factor 5 for each delegate and implements a quarterly monitoring process until each delegate demonstrates improvement for one finding over three consecutive quarters. **Opportunities for Improvement** For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years, the organization identifies and follows up on opportunities for improvement, if applicable If a Delegate fails to complete the corrective action plan and has gone through the exigent process which results in de-delegation, the Delegate cannot appeal and must wait one year to reapply for a pre-delegation audit. If the pre-delegation audit reveals deficiencies identified are the same as those from previous audits, delegation will be at the sole discretion of the Credentialing Committee regardless of score.	
MEMBER EXPERIENCE		

Standard	Delegated Activities	Retained by L.A. Care
Statement of Members' Rights and Responsibilities (NCQA ME 1)	**Distribution of Rights Statement** The organization distributes its member rights and responsibilities statement to the following groups: 1. New members, upon enrollment. 2. Existing members, if requested. 3. New practitioners, when they join the network. 4. Existing practitioners, if requested.	**Rights and Responsibilities Statement** The organization's member rights and responsibilities statement specifies that members have: 1. A right to receive information about the organization, its services, its practitioners and providers and member rights and responsibilities 2. A right to be treated with respect and recognition of their dignity and right to privacy 3. A right to participate with practitioners in making decisions about their health care4. A right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage 5. A right to voice complaints or appeals about the organization or the care it provides6. A right to make recommendations regarding the organization's member rights and responsibilities policy 7. A responsibility to supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care 8. A responsibility to follow plans and instructions for care that they have agreed to with their practitioners9. A responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goal, to the degree possible L.A. Care adheres to the most current NCQA standards to comply with these requirements.
Subscriber Information (NCQA 2020 ME 2)		**Subscriber Information:** L.A. Care informs its subscribers upon enrollment and annually thereafter about benefits and access to medical services. 1. Benefits and services included in, and excluded from, coverage. 2. Pharmaceutical management procedures, if they exist. 3. Copayments and other charges for which members are responsible. 4. Benefit restrictions that apply to services obtained outside the

Standard	Delegated Activities	Retained by L.A. Care
		organization's system or service area. 5. How to obtain language assistance. 6. How to submit claim for covered services, if applicable. 7. How to obtain information about practitioners who participate in the organization. 8. How to obtain primary care services, including points of access. 9. How to obtain specialty care and behavioral healthcare services and hospital services. 10. How to obtain care after normal business hours. 11. How to obtain emergency care, including the organization's policy on when to directly access emergency care or use of 911 services. 12. How to obtain care and coverage when subscribers are out of the organization's service area. 13. How to submit a complaint. 14. How to appeal a decision that adversely affects coverage, benefits or a subscriber's relationship with the organization. 15. Availability of independent, external review of internal UM final determinations. 16. How the organization evaluates new technology for inclusion as a covered benefit. **Distribution of Subscriber Information** The organization distributes its subscriber information to the following groups: 1. New members, upon enrollment. 2. Existing members, annually **Interpreter Services** L.A. Care provides interpreter or bilingual services in its Member Services Department and telephone functions based on linguistic needs of its subscribers. L.A. Care adheres to the most current NCQA standards to comply with these requirements.

Standard	Delegated Activities	Retained by L.A. Care
Marketing Information (NCQA ME 3)		**Materials and Presentations** All organizational materials and presentations accurately describe the following information: 1. Covered benefits. 2. Noncovered benefits. 3. Practitioner and provider availability. 4. Key UM procedures the organization uses. 5. Potential network, service or benefit restrictions. 6. Pharmaceutical management procedures. L.A. Care's prospective members receive an accurate description of the organization's benefits and operating procedures. L.A. Care adheres to the most current NCQA standards to comply with these requirements. **Communicating with Prospective Members** The organization uses easy-to-understand language in communications to prospective members about its policies and practices regarding collection, use and disclosure of PHI: 1. In routine notification of privacy practices 2. The right to approve the release of information (use of authorizations) 3. Access to Medical Records4. Protection of oral, written, and electronic information across the organization 4. Information for employers **Assessing Member Understanding** 1. Assesses how well new members understand policies and procedures. The right to approve the release of information (use of authorizations) 2. Implements procedures to maintain accuracy of marketing communication. Protection of oral, written, and electronic information across the organization 3. Acts on opportunities for improvement, if applicable

Standard	Delegated Activities	Retained by L.A. Care
Functionality of Claims Processing (NCQA ME 4)	**Functionality-Website** Members can track the status of their claims in the claims process and obtain the following information on the organization's website in one attempt or contact: 1. The stage in the process. 2. The amount approved. 3. The amount paid. 4. Member cost. 5. The date paid **Functionality-Telephone Requests** Members can track the status of their claims in the claims process and obtain the following information over the telephone in one attempt or contact: 1. The stage in the process. 2. The amount approved. 3. The amount paid. 4. Member cost. 5. The date paid	
Personalized Information on Health Plan Services (NCQA ME 6)	**Functionality Website** Members can complete each of the following activities on the organization's website in one attempt or contact: 1. Change a primary care practitioner, as applicable. 2. Determine how and when to obtain referrals and authorizations for specific services, as applicable 3. N/A **Functionality Telephone** To support financial decision making, members can complete each of the following activities over the telephone within one business day: 1. Determine how and when to obtain referrals and authorizations for specific services, as applicable. 2. Determine benefit and financial responsibility for a specific service or treatment from a specified provider or institution. **Quality and Accuracy of Information** At least annually, the organization must evaluate the quality and accuracy of the information provided to members via the website and telephone must be evaluated by: 1. Collecting data on quality and accuracy of information provided. 2. Analyzing data against standards or goals. 3. Determining causes of deficiencies, as applicable.	

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

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

Standard	Delegated Activities	Retained by L.A. Care
	1. Semiannually evaluates regular reports, as specified in the sub-delegation agreement 2. Annually evaluates sub-delegate performance against NCQA standards for sub-delegated activities **Opportunities for Improvement** For sub-delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that sub-delegation has been in effect, the delegate identified and followed up on opportunities for improvement, if applicable.	
Nurse Advice Line (Title 28 California Code of Regulations Section 1300.67.2.2; California Health and Safety Code Section 1348.8)	A Nurse Advice Line is offered to members to assist members with wellness and prevention **A. Access to Nurse Advice Line** A Nurse Advice Line that is staffed by licensed nurses or clinicians and meets the following factors: 1. Is available 24 hours a day, 7 days a week by telephone. 2. Provides secure transmission of electronic communication, with safeguards, and a 24-hour turnaround time. 3. Provides interpretation services for members by telephone. 4. Provide telephone triage or screening services in a timely manner appropriate to the enrollee's condition. The triage and screening wait time shall not exceed 30 minutes. **B. Nurse Advice Line Capabilities** The nurse advice line gives staff the ability to: 1. Follow up on specified cases and contact members. 2. Link member contacts to a contact history. **C. Monitoring the Nurse Advice Line** The following shall be conducted: 1. Track telephone and website statistics at least quarterly. 2. Track member use of the nurse advice line at least quarterly. 3. Evaluate member satisfaction with the nurse advice line at least annually. 4. Monitors call periodically. 5. Analyze data at least annually and, if applicable, identify opportunities and establish priorities for improvement. D. **Policies and Procedures**	L.A. Care retains accountability for procedural components and will oversee Delegate's adherence to these standards through pre-delegation and annual oversight review and more frequently, as required, per changes in contract, Federal and State regulatory guidelines and accreditation standards.

Standard	Delegated Activities	Retained by L.A. Care
	1.Establish and maintain an operational policy for operating and maintaining a Telephone Nurse Advice Service. E. **Promotion** 1. Promote the availability of Nurse Advice Line services in materials that are approved in accordance with the Plan Partner Services Agreement and L.A. Care policies and procedures. 2. In the form of, but not limited to: a. Flyers b. Informational mailers c. ID Cards d. Evidence of Coverage (EOC)	
Potential Quality of Care Issue Review (Title 28 California Code of Regulations Section 1300.70)	The Quality Improvement program must document that the quality of care is being reviewed, that problems are being identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated. The Quality Improvement program must include continuous review of the quality of care provided; quality of care problems are identified and corrected for all provider entities.	L.A. Care retains accountability for procedural components and will oversee Delegate's adherence to these standards through pre-delegation and annual oversight review and more frequently, as required, per changes in contract, Federal and State regulatory guidelines and accreditation standards.
Critical Incident Reporting and Tracking (California Code of Regulations Title 22 §72541)	The Quality Improvement program must include implementation of a defined policy and procedures to identify, report, and track Critical Incidents under the following categories: abuse, neglect, exploitation, a serious, life threatening medical event requiring immediate emergency evaluation by a medical professional, disappearance (missing person), suicide attempt, restraint and/or seclusion, unexpected death, or other (such as catastrophes and unusual occurrences that threaten the member's wellbeing). Training shall be made available to network providers on identifying and reporting Critical Incidents to the appropriate authorities in a timely manner to ensure patient safety.	L.A. Care retains accountability for procedural components and will oversee Delegate's adherence to these standards through pre-delegation, annual oversight review. More frequent oversight measures may be taken if needed to ensure delegate compliance. L.A. Care is responsible for submitting quarterly Critical Incident reports to DHCS using the data received from delegates.
HEDIS Performance Benchmark APL 19-017	1. Annually measures performance and meets the NCQA 50th percentile benchmark for the Medi-Cal Managed Care Accountability Set established by DHCS and NCQA required Medi-Cal accreditation measures. 2. Opportunity for Improvement When the 50th percentile is not met the plan will identify and follow up on opportunities for improvement.	L.A. Care will still retain the PIP and PDSA reporting process with DHCS for the Medi-Cal line of business.

Standard	Delegated Activities	Retained by L.A. Care
Blood Lead Screening of Young Children Applicable L.A. Care Policy: QI-048 APL 20-016	1. Ensure network providers follow the blood lead anticipatory guidance and screening requirements in accordance with APL 20-016 2. Identify, on at least a quarterly basis (i.e. January – March, April – June, July – September, October – December), all child members under the age of six years (i.e. 72 months) who have any record of receiving a blood lead screening test as required 3. Note: L.A. Care will send delegate CLPPB data when they receive from DHCS on a quarterly basis.	Annual Submission to DHCS data for all child members under the age of six years (i.e. 72 months) who have no record of receiving a blood lead screening
FINANCIAL SOLVENCY AND CLAIMS PROCESSING REQUIRMENTS		
Financial Solvency (Title 28 California Code of Regulations Sections 1300.75.1, 1300.75.4.2(a), 1300.76, 1300.76.1, 1300.77.1 & 2, 1300.78, and 1300.76.3).	**Financial Solvency** 1. Maintain a cash-to-claims ratio > 0.75. 2. Maintain positive working capital. 3. Maintain a minimum Tangible Net Equity (TNE). 4. Document and record the liability for incurred but not reported (IBNR) claims on a monthly basis. 5. Submit the quarterly financial statements no later than 45 calendar days after the close of each quarter end to L.A Care. 6. Submit the annual financial statements audited by an independent Certified Public Accounting firm no later than 120 calendar days after each fiscal year end to L.A. Care. **Administrative Costs** 1. Maintain administrative costs no greater than 15% of the revenue. **Commissioner Deposits** 1. Maintain at least $300,000 deposit with the Commissioner, with any FDIC insured bank. **Risk Management** Maintain the following insurance at all times: 1. Reinsurance or Stop-Loss 2. Malpractice or Professional Liability 3. General Liability 4. Errors & Omissions 5. Workers Compensation 6. Fidelity Bond **Policies and Procedures** Maintain approved policies and procedures that describe the process and requirements for each of the sections mentioned above.	

Standard	Delegated Activities	Retained by L.A. Care
Claims Processing (Title 28 California Code of Regulations Section 1300.71)	**Timely Claims Processing** 7. Process at a minimum ninety percent (90%) of claims within 30 calendar days of the claim receipt date, 8. Process at a minimum ninety-five percent (95%) of claims within 45 working days of the claim receipt date, **and** 9. Process at a minimum ninety-nine percent (99%) of claims within 90 calendar days of the claim receipt date. **Accurate Claims Payments** 1. Pay claims at the Medi-Cal rates or contracted rates at a minimum of 95% of the time. 2. All modified claims are reviewed and approved by a physician and medical records are reviewed. 3. Calculate and pay interest automatically for claims paid beyond 45 workings days from date of receipt at a minimum 95% of the time. a. **Emergency services claims:** Late payment on a complete claim which is not contested or denied will automatically include the greater of $15 or 15% rate per annum applied to the payment amount for the time period the payment is late. b. **All other service claims:** Late payments on a complete claim will automatically include interest at a 15% rate per annum applied to the payment amount for the time period payment is late. c. **Penalty:** Failure to automatically include the interest due on the late claims regardless of service is $10 per late claim in addition to the interest amount. **Forwarding of Misdirected Claims** Forward misdirected claims within 10 working days of the claim receipt date at a minimum of 95% of the time. **Acknowledgement of Claims** Acknowledge the receipt of electronic claims within 2 working days and paper claims within 15 working days at a minimum of 95% of the time. **Dispute Resolution Mechanism** Provide written notice of a dispute resolution mechanism for all denied and modified claims at a minimum 95% of the time. **Accurate and Clear Written Explanation**	

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

Standard	Delegated Activities	Retained by L.A. Care
(Title 28 California Code of Regulations Section 1300.71.38)	b. 2 working days for electronic disputes. **Timely Dispute Determinations** Dispute determinations are made in a timely manner, at a minimum of 95% of the time. a. 45 working days from receipt of the dispute. b. 45 working days from receipt of additional information. **Clear Explanation of NOA Letter** Rationale for decision is clear, accurate and specific in NOA Letter, at a minimum of 95% of the time. a. Written determination stating the pertinent facts and explaining the reasons for the determination **Accurate Provider Dispute Payments** 1. Appropriately paying any outstanding monies determined to be due if the dispute is determined in whole or in part in favor of the provider. 2. Interest payments are paid correctly when dispute determination is in favor of provider, at a minimum of 95% of the time. Accrual of interest of payment on resolved provider disputes begin on the day after the expiration of forty-five (45) working days from the original claim receipt date. **Acceptance of Late Claims** The organization must accept and adjudicate disputes that were originally filed beyond the claim filing deadline and the provider was able to demonstrate good cause for the delay, at a minimum of 95% of the time. **Policies and Procedures** Maintain approved policies and procedures that describe the process and requirements for each of the sections mentioned above.	
Annual Plan Claims Payment and Dispute Resolution Mechanism Report" Cal. Code Regs. tit. 28 § 1300.71.38(k) Cal. Code Regs. tit. 28 § 1300.71.38(k)(1) Cal. Code Regs. tit. 28 § 1300.71.38(k)(2)	1. "Information on the number and types of providers using the dispute resolution mechanism. 2. "A summary of the disposition of all provider disputes, which shall include an informative description of the types, terms and resolution. Disputes contained in a bundled submission shall be reported separately as individual disputes. Information may be submitted in an	

Standard	Delegated Activities	Retained by L.A. Care
Cal. Code Regs. tit. 28 § 1300.71.38(k)(3)	aggregate format so long as all data entries are appropriately footnoted to provide full and fair disclosure; and… 3. A detailed, informative statement disclosing any emerging or established patterns of provider disputes and how that information has been used to improve the plan's administrative capacity, plan-provider relations, claim payment procedures, quality assurance system (process) and quality of patient care (results) and how the information has been used in the development of appropriate corrective action plans.[1]	
DMHC Provider Disputes Document/Information Requests	Plan Partner to respond to document\information requests from LA Care for DMHC provider disputes within 5 days, urgent requests within 2 days.	
HEALTH EDUCATION		
DHCS Policy Letter 02-004 DHCS Policy Letter 16-014 DHCS Policy Letter 18-018 DHCS Policy Letter 13-001 DHCS Policy Letter 10-012 DHCS Policy Letter 16-005	1. Maintenance of a health education program description and work plan 2. Availability and promotion of member health education services in DHCS language and topic requirements including implementation of a closed-loop referral process. 3. Implementation of comprehensive tobacco cessation/prevention services including: a. individual, group, and telephone counseling b. Provider tobacco cessation trainings c. Tobacco user identification system d. Tracking individual utilization data of tobacco cessation interventions 4. Availability of a diabetes prevention program (DPP) that complies with CDC DPP guidelines and is delivered by a CDC recognized provider 5. Availability of written member health education materials in English and Spanish in DHCS required health topics including: a. a system for providers to order materials and informing providers how to do so b. Adherence to all regulatory requirements as dictated per the Readability & Suitability Checklist 6. Implementation of an Individual Health Education Behavioral Assessment (IHEBA), preferably the Staying Healthy Assessment (SHA) including a method of making the assessments available to providers and provider education	L.A. Care retains responsibility for providing written health education materials in DHCS required health topics for non-English/Spanish threshold languages. L.A. Care retains responsibility for conducting the Health Education, Cultural & Linguistics Population Needs Assessment (PNA) annually but retains the right to request Plan Partner assistance as needed.

[1] Cal. Code Regs. tit. 28 § 1300.71.38(k)(3)

Standard	Delegated Activities	Retained by L.A. Care
	7. Employment of a full-time Health Education Director, or the equivalent, with a Master's Degree in Public Health (MPH) responsible for the direction, management and supervision of the health education system. 8. Integration between health education activities and QI activities 9. Provision of provider education on health education requirements and resources 10. Adherence to all requirements regarding Non-Monetary Member Incentives including submission of Request for Approval and Annual Update/End of Program Evaluation forms to L.A. Care's Compliance Unit on an on-going basis.\ Should Plan Partner delegate any or all health education requirements to a sub-delegate, Plan Partner must monitor sub-delegate's performance and ensure continued compliance.	
CULTURAL & LINGUISTIC SERVICES		
Civil Rights Act of 1964, Title VI Code of California Regulations (CCR), Title 28, §1300.67.04(c) CCR, Title 22, §53876 DHCS Agreement Exhibit A Attachment 9, (12)& (13)(A) Federal Guidelines: OMH CLAS Standards, Standards 1-4 & 9	**Cultural & Linguistic Program Description and Staffing** 1. Plan maintains an approved written program description of its C&L services program that complies with all applicable regulations. It must include, at minimum, the following elements (or its equivalent): a. Organizational commitment to deliver culturally and linguistically appropriate health care services. b. Goals and objectives with timetable for implementation. c. Standards and performance requirements for the delivery of culturally and linguistically appropriate health care services. 2. Plan centralizes coordination and monitoring of C&L services. The department and/or staff responsible for such services are documented in an organizational chart. 3. Plan has written description(s) of position(s) and qualifications of the staff involved in the C&L services program. 11.	
Civil Rights Act of 1964, Title VI Code of California Regulations (CCR), Title 22, §53876 CCR, Title 28, §1300.67.04, (c)(2)(G) & (H)	**Access to Interpreting Services** 1. Plan has approved policies and procedures which include, at minimum, the following items: a. Provision of timely 24-hour, 7 days a week interpreting services from a qualified interpreter at all key points of contact, in any language requested, including	

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

Standard	Delegated Activities	Retained by L.A. Care
Civil Rights Act of 1964, Title VI Code of California Regulations (CCR), Title 28, §1300.67.04(c)(2)(H) Code of Federal Regulations (CFR), Title 45 §92.4 & §92.201(e)(4) DHCS Agreement Exhibit A, Attachment 9(13)(B) & (F) DHCS All Plan Letter 22-04 Federal Guidelines: OMH CLAS Standards, Standards - 7	**Assessment of Linguistic Capabilities of Bilingual** 1. Plan has approved policies and procedures related to identifying, assessing, and tracking oral and/or written language proficiency of clinical and non-clinical bilingual employees who communicate directly with members in a language other than English. 2. Plan has a sound method to assess bilingual employees' oral and/or written language proficiency, including appropriate criteria for ensuring the proficiency. Qualified bilingual staff must have demonstrated: a. Proficiency in speaking and understanding both spoken English and at least one other spoken language, including any necessary specialized vocabulary, terminology, and phraseology. b. Ability to effectively, accurately, and impartially communicate directly with Limited English Proficiency Members in their preferred language. 3. Plan maintains a current list of assessed and qualified bilingual employees, who communicate directly with members, including the following information at minimum, name, position, department, language, level of proficiency.	
Civil Rights Act of 1964, Title VI Code of California Regulations (CCR), Title 28, §1300.67.04(d)(9) DHCS Agreement Exhibit A, Attachment 6(11)(B)(2) & Attachment 18 (6)(K) DHCS Policy Letter 98-12 Federal Guidelines: OMH CLAS Standards, Standard 7	**Linguistic Capabilities of Provider Network** 1. Plan has approved policies and procedures related to identifying and monitoring language capabilities of providers and provider staff ensuring provider network is reflective of membership demographics. 2. Plan lists language spoken by providers and provider staff in the provider directory. 3. Plan updates language spoken by providers and provider staff in the provider directory. Plan annually assesses the provider network language capabilities to meet the members' needs.	
California Health and Safety Code, §1367.04(b)(1)(A)-(C) Civil Rights Act of 1964, Title VI Code of California	**Access to Written Member Informing Materials in Threshold Languages & Alternative Formats** 1. Plan has approved policies and procedures documenting the process to: a. Translate Written Member Informing Materials, including the non-template	

Standard	Delegated Activities	Retained by L.A. Care
Regulations (CCR), Title 22, §53876 (a)(2)&(3) CCR, Title 28, §1300.67.04, (b)(7), (c)(2)(F) & (e)(2)(i)-(ii) Code of Federal Regulations (CFR), Title28, §35.160-25.164 CFR, Title 45 §92.4 & §92.8 DHCS Agreement, Exhibit A, Attachment 9(14)(B)(2), (14)(C), Attachment 13(4)(C) DHCS All Plan Letter 21-011 DHCS All Plan Letter 21-004 DHCS All Plan Letter 22-002 Federal Guidelines: OMH CLAS Standards, Standard 5- 8	individualized verbiage in Notice of Action (NOA) letters, accurately using a qualified translator in all Los Angeles County threshold languages and alternative formats (large print 20pt, audio, Braille, accessible data) according to the required timelines. b. Track member's standing requests for Written Member Informing Materials in their preferred threshold language and alternative format. c. Submit newly captured members' alternative format selection data directly to the DHCS Alternate Format website. d. Distribute fully translated Written Member Informing Materials in their identified Los Angeles County threshold language and alternative format to members on a routine basis based on the standing requests and DHCS alternative format selection (AFS) data. e. Attach the appropriate non-discrimination notice and translated tagline (a written language assistance notice) in English and 18 non-English required by DHCS to Member Informing Materials. Threshold Languages for Los Angeles County: English, Spanish, Arabic, Armenian, Chinese, Farsi, Khmer, Korean, Russian, Tagalog, and Vietnamese. Taglines (Language assistance notice) Languages: English, Spanish, Arabic, Armenian, Chinese, Farsi, Khmer, Korean, Russian, Tagalog, Vietnamese, Hindi, Hmong, Japanese, Lao, Mien, Punjabi, Thai and Ukrainian. 2. Plan has a sound method to ensure qualifications of translators and quality of translated Written Member Informing Materials. Qualified translators must have demonstrated: a. Adherence to generally accepted translator ethics principles, including client confidentiality to protect the privacy and independence of LEP Members.	

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

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

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

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

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

Exhibit 8
NCQA Delegation Agreement
[Attachment B]

Plan's Reporting Requirements

Report	Due Date	Submit To	Required Format
QUALITY IMPROVEMENT			
NET 1A **Cultural Needs and Preferences Assessment** **NET 1B** Practitioners Providing Primary Care **NET 1C** Practitioners Providing Specialty Care **NET 1D** Practitioners Providing Behavioral Healthcare	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
NET 2A **Access to Primary Care** **NET 2B** Access to Behavioral Healthcare **NET 2C** Access to Specialty Care	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
NET 3A Assessment of Member Experience Accessing the Network **NET 3B** Opportunities to Improve Access to Nonbehavioral Healthcare Services **NET 3C** Opportunities to Improve Access to Behavioral Healthcare Services	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
ME 7C Element C: Annual Assessment of Nonbehavioral Healthcare Complaints and Appeals **ME 7E** Element E: Annual Assessment of Behavioral Healthcare and Services	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Member Services/	Compliant with NCQA in accordance to Plan's accreditation submission

ME 7F Element F: Behavioral Healthcare Opportunities for Improvement			
QI 2A Practitioner Contracts	Annually during PP audit	home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
QI 3 A Identifying Opportunities **QI 3B** Acting on Opportunities **QI 3C** Measuring Effectiveness **1.**	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Quality Improvement/	Annual data collection analysis that identifies and acts on opportunities for improvement for Continuity of Care as outlined by NCQA guidelines for Continuity Coordination of Care of Medical Care and Continuity and Coordination Between Medical Care and Behavioral HealthCare
QI 4A Data Collection **QI 4B** Collaborative Activities **QI 4C** Measuring Effectiveness	Annually during PP audit	home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
QI 5A **Sub-Delegation Agreement** **QI 5B** Sub- Delegation Predelegation Evaluation **QI 5C** Sub-Delegation Review of QI Program **QI 5D** **Sub-Delegation** Opportunities for Improvement	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
<u>Quality Improvement Quarterly Reporting Requirements</u> 1. **Clinical Strategic Goals (CSG)** with MCAS Measures for L.A Care Medical Members ONLY: 2. **Potential Quality of Care Issues (PQIs)** a. Number of PQIs b. Number of closed PQIs	Quarterly Clinical Strategic Goals 1st Qtr – Jun 30 2nd Qtr – Sep 30 3rd Qtr – Dec 30 4th Qtr – Mar 30 **Quarterly PQI Report**	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Quality Improvement/	Acceptable formats: • Clinical Strategic Goals (CSG) Report with L.A. Care member rates included.

c. Number of closed PQIs within 6 months	1st Qtr – April 25 2nd Qtr – July 25 3rd Qtr – Oct 25 4th Qtr – Jan 25		• Potential Quality of Care Issues (PQIs)
<u>Critical Incidents Tracking Log</u> **1. Critical Incident Tracking Log** **Naming convention:** *YYYY Q# LA Care CI Tracking Report* **Description:** Includes a tracking log of critical incidents specific to each member. - Abuse - Neglect - Exploitation - Disappearance/Missing Member - Suicide Attempt - Unexpected Death - A Serious Life Threatening Medical Event that requires immediate emergency evaluation by a Medical Professional - Restraints or seclusion - Other **2.Critical Incident Report in DHCS required format** - Number of LTSS users - Number of Critical Incidents Filed - Number of Critical Incidents Filed with Grievances Previously Filed - Number of Critical Incidents Filed with Appeals Previously Filed Kaiser shall keep track of all Critical Incidents and ensure appropriate reporting and resolution of the incidents in a timely fashion.	**Quarterly** 1st Qtr. – April 15 2nd Qtr. – July 15 3rd Qtr. – Oct 15 4th Qtr. – Jan 15	L.A. Care Critical Incident inbox CI@lacare.org	1. The Critical Incident Tracking Log with Health Plan Report Format, which includes but not limited to member information, specific information about the incident (date, time, location, entity/person involved in the incident, etc.) 2. Quarterly Critical Incident Report with DHCS required format
<u>Quality Improvement Annual reporting requirements</u> 1. **QI 1A:** QM Program Description 2. **QI 1C:** QM Program Evaluation 3. QI Workplan 4. PHM Work plan (if the activities are not included in the annual QI Workplan)	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Quality Improvement/	Acceptable formats: • Quarterly
ME 1B: Distribution of Member Rights & Responsibilities Statement 1. KP will randomly select 20 providers for each Reporting period and will complete the New Provider Training Tracking Sheet for the selected physicians each Reporting period.	Semi-Annually: **Jan 15th (Reporting period Q3 & Q4)** **July 15th (Reporting period Q1 & Q2)** KP to submit the New Provider Training	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Quality Improvement/	New Provider Training Tracking Sheet (KP document)

	Tracking Sheet to LA Care		ME 1B_Distribution of Rights Statement
PHM 1A Strategy Description **PHM 1B** Informing Members	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
PHM 2A Data Integration **PHM 2B** Population Assessment **PHM 2C** Activities and Resources **PHM 2D** Segmentation	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
PHM 3 A Practitioner or Provider Support	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
PHM 6A Measuring Effectiveness **PHM 6B** Improvement and Action	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
PHM 7A Sub-Delegation Agreement **PHM 7B** Sub-Delegate Pre-Delegation Agreement **PHM 7C** Sub-Delegate Review of PHM Program **PHM 7D** Opportunities for Improvement	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
Title 28 California Code of Regulations Section 1300.67.2.2		L.A. Care's Secure File Transfer Protocol (SFTP)	Mutually agreed upon format

California Health and Safety Code Section 1348.8 **Assessment of Nurse Advice Line** 1. Nurse Advice Line monitoring for: a. Telephone statistics at least quarterly • Average speed of answer within 30 minutes ~~(goal)~~ 2. Annual analysis of Nurse Advice Line statistics (website, telephone, use, and calls), identify opportunities and establish priorities for improvement.	1. Quarterly 1st Qtr – April 25 2nd Qtr – July 25 3rd Qtr – Oct 25 4th Qtr – Jan 25 2. Annually during PP Audit	home/ukais-cr/infile/Health Education/ Plan will also have the option to submit via email to remain compliant with due date.	
HEDIS Performance Benchmark A PDSA tool will be required when the plan does not meet the 50th percentile for the Managed Care Accountability Set and the 50th percentile for the Medicaid NCQA Accreditation Measures as established by both regulatory entities.	Annually during PP Audit. The PDSA tool is due 90 calendar days after final validated HEDIS results are available.	L.A. Care's Secure File Transfer Protocol (SFTP)/ home/ukais-cr/infile/Quality Improvement/ Plan will also have the option to submit via email to remain compliant	The PDSA tool provided by DHCS or L.A. Care
UTILIZATION MANAGEMENT			
Service Authorizations and Utilization Review			
UM 1 1. UM Program Description 2. UM Program Evaluation 3. UM Program Work Plan	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Clinical_Assurance/	1. Narrative 2. ICE Quarterly Reporting format 3. ICE Quarterly Format
Quarterly UM Activity Report **All elements outlined within L.A. Care Quarterly UM Activity (ICE) report including but not limited to:** 1. UM Summary – Inpatient Activity a. Average monthly membership b. Acute Admissions/K c. Acute Bed days/K d. Acute LOS e. Acute Readmits/K f. SNF Admissions/K g. SNF Bed days/K 2. SNF LOS a) SNF Readmits/K 3. UM Activities Summary a) Referral Management Tracking of the number of Approvals/Modifications/Denials/ Deferrals (Routine/Urgent)	Quarterly 1st Qtr –May 31 2nd Qtr – Aug 31 3rd Qtr – Nov 30 4th Qtr – Feb 28	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Clinical_Assurance/	ICE Quarterly Reporting Format

b) Referral Denial Rate c) Appeals/K d) Overturn Rate 2. **PHM 5:** CCM Complex Case Management CM Reports and Statistics			
NET 4B: Continued Access to Care 1. Continued Access to Practitioners If a practitioner's contract is discontinued, the organization allows affected members continued access to the practitioner, as follows: a. Continuation of treatment through the current period of active treatment for members undergoing active treatment for a chronic or acute medical condition b. Continuation of care through the postpartum period for members in their second or third trimester of pregnancy	Quarterly 1st Qtr – May 31 2nd Qtr – Aug 31 3rd Qtr – Nov 30 4th Qtr – Feb 28	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Clinical_Assurance/	L.A. Care Quarterly Reporting Format
Medi-Cal Provider Preventable Reportable Conditions	Monthly 15th of Each Month	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Clinical_Assurance/	Acceptable formats: DHCS Required Reporting Format
QI 3D: Transition to Other Care—member transition to other care, a. When their benefits end.	Quarterly 1st Qtr – May 31 2nd Qtr – Aug 31 3rd Qtr – Nov 30 4th Qtr – Feb 28	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Clinical_Assurance/	L.A. Care TOC Reporting Format
CREDENTIALING			
1. Initial Credentialed practitioner list containing Credentialing Date, Last Name, First Name, MI, Title, Address, City, State, Zip, Group Name. 2. Re-credentialed practitioner list containing Re-credentialing Date, Last Name, First Name, MI, Title, Address, City, State, Zip, Group Name. 3. Voluntary Practitioner Termination list containing Termination Date, Last Name, First Name, MI, Title, Address, City, State, Zip, Group Name. 4. Involuntary Practitioner Termination list containing Termination Date, Last Name, First Name, MI, Title, Address, City, State, Zip, Group Name	Quarterly 1st Qtr – May 15 2nd Qtr – Aug 15 3rd Qtr – Nov 15 4th Qtr – Feb 15	credinfo@lacare.org	Current L.A. Care Health Plan Delegated Credentialing Quarterly Credentialing Submission Form (ICE Format)
COMPLIANCE			

1. 274 EDI File Mandated by APL 16-019	Monthly – Due to L.A. Care by the 4th of each month	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Regulatory Reports/	DHCS required formatting.
2. Data Certification Statements Mandated by APL 17-005	Monthly – Due to L.A. Care 3 business days prior to submission to DHCS	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Regulatory Reports/	Word Document, Non-specific template. Utilize own template; however, all state reports submitted to L.A. Care within the month MUST be listed and CEO MUST sign off attesting to ALL data submissions.
3. Non-Medical Transportation & Non-Emergency Medical Transportation (NMT-NEMT) Report Mandated by APL 17-010	Monthly - Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Regulatory Reports/	DHCS approved template
4. Health Industry Collaboration Effort AB1455 Quarterly Reports a. M/Q Medi-Cal Claims Timeliness Report b. Quarterly 5 Provider Dispute Resolution (PDR) Report 5. c) Disclosure of Emerging Claims Payment Deficiencies (DoECPD)	Quarterly – Due to L.A. Care within specified deadline set by L.A. Care	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/ AB1455	HICE approved templates
6. Call Center Report	Quarterly – Due to L.A. care 30 days after the end of each quarter of the calendar year. When due date falls on the weekend (Sunday or Saturday, data must be submitted by COB on the Friday before the due date. • Q1 – January, February, and March • Q2 – April, May, and June • Q3 – July, August, and September Q4 – October, November, and December	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Regulatory Reports/	Format as specified by L.A. Care

7. Community Based Adult Services (CBAS) Report	Quarterly - Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Regulatory Reports/	DHCS approved templates
8. Medi-Cal Managed Long-Term Services & Supports (MLTSS) Report Mandated by APL 14-010	Quarterly - Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Regulatory Reports/	DHCS approved templates
9. Medi-Cal Managed Care Survey – Disproportionate State Hospitals (MMCS-DSH) Survey	Annually - Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Regulatory Reports/	DHCS approved templates
10. Enhanced Care Management DHCS Required Reporting	Quarterly, according to schedule in DHCS template -Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care Regulatory / Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Regulatory Reports	DHCS approved template, plus attestation of data and brief written summary of oversight and monitoring activity for the reporting period
11. Community Supports DHCS Required Reporting	Quarterly, according to schedule in DHCS template -Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care Regulatory / Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Regulatory Reports	DHCS approved template, plus attestation of data and brief written summary of oversight and monitoring activity for the reporting period
12. CBAS Monthly Wavier Report	Monthly -Due to L.A. Care on the specified dates stated below: January 5 February 3 March 2 April 2 May 3 June 2 July 2 August 3 September 2	L.A. Care Regulatory / Secure File Transfer Protocol (SFTP) home/ ukais-cr /infile/Regulatory Reports	DHCS approved template

	October 4 November 2 December 2		
13. Prop 56 Directed Payment for Physician Services (APL 19-015)	Quarterly-Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care Regulatory / Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Regulatory Reports/	DHCS approved template
14. Prop 56 Hyde Reimbursement Requirements for specific Services (APL 19-013)	Quarterly-Due to L.A. Care 7 business days prior to submission to DHCS	LA Care Regulatory/Secure File Transfer Protocol (sFTP) home/ ukais-cr /infile/Regulatory	Regulatory Reports provided Template based on APL reporting requirements
15. Prop 56 Directed Payments for Developmental Screening Services (APL 19-016)	Quarterly-Due to L.A. Care 7 business days prior to submission to DHCS	LA Care Regulatory/Secure File Transfer Protocol (sFTP) home/ ukais-cr infile/Regulatory	Regulatory Reports provided Template based on APL reporting requirements
16. Prop 56 Directed Payments for Family Planning (APL 20-013)	Quarterly-Due to L.A. Care 7 business days prior to submission to DHCS	LA Care Regulatory/Secure File Transfer Protocol (sFTP) home/ ukais-cr /infile/Regulatory	Regulatory Reports provided Template based on APL reporting requirements
17. Prop 56 Directed Payment for Adverse Childhood Experiences Screening Services (AP-19-018)	Quarterly-Due to L.A. Care 7 business days prior to submission to DHCS	LA Care Regulatory/Secure File Transfer Protocol (sFTP) home/ ukais-cr /infile/Regulatory	Regulatory Reports provided Template based on APL reporting requirements
18. Third Party Liability (TPL) (APL 19-018)	15 days from the date LA Care submits case file.	L.A. Care via its Secure File Transfer Protocol (SFTP) – home/ ukais-cr /infile/Regulatory Reports/	DHCS approved templates
19. MCPD and PCPA Managed Care Program Date (MCPD) and Primary Care Provider Alignment (PCPA) The Managed Care Program Data (MCPD) report is a consolidated reporting	Monthly - Due to L.A. Care every 4th day of the month	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Regulatory Reports/	Regulatory Reports provided Template based on APL reporting requirements

requirement which DHCS introduced through APL 20-017. The MCPD file replaces the following reporting requirements, as this data is now incorporated into the MCPD file in .json format: • Grievances and appeals data in an Excel template, as specified in APL 14-013 ***(previously submitted by your plan as the Grievance Report Mandated by APL 14-013)*** • Monthly MERs and other continuity of care records data in an Excel template, as specified in Attachment B of APL 17-007 ***(previously submitted by your plan as the MMDR Report)*** • Other types of continuity of care data in ad-hoc Excel templates • Out-of-Network request data in a variety of ad-hoc Excel templates ***(previously submitted by your plan as the OON Report)***			
20. New and or revised reports as released by DHCS	Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Regulatory Reports/	DHCS approved templates
21. Disaster and Recovery Plan Disaster Recovery Test Results L.A. Care will request all elements outlined below including but not limited to: 1. LA Care may require additional information on Business Continuity efforts based off current event. In the event there are any additional requests from regulators for individual instances, such as, an emergency declared by the governor; L.A. Care will send out an ad hoc written request asking to respond with the requested information should it be an element outside of what is already being requested and another mobile contact	Annually during PP audit and ad-hoc; Ad-Hoc	L.A. Care's Secure File Transfer Protocol (SFTP) EnterpriseRiskManagement@lacare.org home/ukais-cr/infile/Regulatory Reports/ EnterpriseRiskManagement@lacare.org ;	Word Document, Non-Specific template Template may change upon regulators request.

mechanism when outside of regular business hours.		RegulatoryReports@lacare.org	
22. Supplemental Payments (American Indian Health, BHT, Maternity Kicks, LTCC)	Monthly by the 10th	L.A. Care Regulatory / (SFTP) home/ ukais-cr /infile/Regulatory Reports	Format as specified by L.A. Care
23. DMHC Pending/Unresolved Grievances	Quarterly Jan 23 Apr 23 July 23 Oct 23	L.A. Care Regulatory / (SFTP) home/ ukais-cr /infile/Regulatory Reports	Format as specified by L.A. Care
24. Grievance Volumes Report DMHC Title 28, CCR, Section 1300.68 (F)1	Quarterly Feb 8 May 8 Aug 8 Nov 8	L.A. Care Regulatory / (SFTP) home/ ukais-cr /infile/Regulatory Reports	Format as specified by L.A. Care
25. Quarterly Network Report (Terminations)	Quarterly Jan 23 Apr 23 July 23 Oct 23	L.A. Care Regulatory / (SFTP) home/ ukais-cr /infile/Regulatory Reports	Format as specified by L.A. Care
26. Major Organ Transplant	Quarterly Jan 23 Apr 23 July 23 Oct 23	L.A. Care Regulatory / (SFTP) home/ ukais-cr /infile/Regulatory Reports	
27. Encounter Data	Monthly, at a minimum	L.A. Care Regulatory / (SFTP) home/ ukais-cr /infile/Regulatory Reports	
28. Cost Avoidance & Post Payment (CAPP) Recovery Mandated by APL 21-002	Monthly – Due to L.A. Care 6th business day of every month	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports/	DHCS Approved Template

DELEGATION OVERSIGHT			
New Member Welcome Kit Mailing Reports	Quarterly Jan 15 April 15 July 15 October 15	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Delegation Oversight	Format as specified by L.A. Care
HEALTH EDUCATION			
Health Education Reports (Referrals, Material Distribution Report, Individual Encounters, Other Language Encounters)	Quarterly – Due to L.A. Care the 25th day of the month following the end of the quarter: • Q1 due 4/25 • Q2 due 7/25 • Q3 due 10/25 • Q4 due 1/25	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Health Education/	Format as specified by L.A. Care or as mutually agreed upon per Plan Partner process.
Health Education (Workplan and Program Description)	Annual Jan 31	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Health Education/	Format as specified by L.A. Care or as mutually agreed upon per Plan Partner process.
DMHC SURVEYS			
DMHC Timely Access and Network Reporting (TAR) a. Exhibit A-1 Timely Access Time-Elapsed Standards Policies and Procedures b. Exhibit A-2 Alternative Access Timely Access Time-Elapsed Standards Policies and Procedures (if applicable) c. Exhibit A-3 Oversight of Plan-to-Plan Contracts Policy and Procedures d. Exhibit B-1 Quality Assurance Monitoring related to Time-Elapsed Standards Policies and Procedures e. Exhibit B-2 Quality Assurance Monitoring related to All Other Time-Elapsed Standards Policies and Procedures f. Exhibit C-1 Contact List Report Forms for each Provider Survey Type g. Exhibit C-2 Raw Data Report Forms for each applicable Provider Survey Type h. Exhibit C-3 Results Report Form	Annually April 17, 2023	L.A. Care's Secure File Transfer Protocol (SFTP) /ukais/infile/compliance	

i. Exhibit D-1 Non-Compliance Policies and Procedures j. Exhibit D-2 Incidents of Non-Compliance Resulting in Substantial Harm to an Enrollee k. Exhibit D-3 Patterns of Non-Compliance l. Exhibit D-4 Prior Incidents or Patterns of Non-Compliance not Previously Submitted m. Exhibit E-1 Policies and Procedures for Advanced Access Program n. Exhibit F-1 Triage o. Exhibit F-2 Telemedicine p. Exhibit F-3 Health I.T. q. Exhibit G-1 Provider Satisfaction Survey Methodology r. Exhibit G-2 Provider Satisfaction Survey Results s. Exhibit G-3 Enrollee Satisfaction Survey Methodology t. Exhibit G-4 Enrollee Satisfaction Survey Results u. Exhibit H-1 Quality Assurance Report v. APNR Form PCP w. APNR Form Specialists x. APNR Form Mental Health y. APNR Form Hospitals and Clinics z. APNR Form Other Outpatient Provider aa. APNR Form Greivances			
DMHC Financial Statement	Quarterly Feb 15 May 15 Aug 15 Nov 15	FTP	DMHC Template
CULTURAL AND LINGUISTC SERVICES			
C&L Program Description and Work Plan	Annually – due to L.A. Care January 31st of each year	L.A. Care's Secure File Transfer Protocol (SFTP) *OR* Via email to CL_Reports_Mailbox@lacare.org	Plan Partner can submit their own format of C&L PD and work Plan. Requirement is in reference to Policy and Procedure CL-008 and C&L Program Description delegated Subcontractor

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

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

[Signature block appears on the following page]

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

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

By: _____
John Baackes
Chief Executive Officer

Date: _____, 2023

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

Date: _____, 2023

Kaiser Foundation Health Plan
A California health care services plan

By: _____
Marcus J. Hoffman
Senior Vice President, Chief Financial Officer, Southern California and Hawai'i Market

Date: _____, 2023

Amendment No. 47
to
Services Agreement
between
Local Initiative Health Authority for Los Angeles County
and
Kaiser Foundation Health Plan, Inc.

This Amendment No. 47 is effective as of July 1, 2022, as indicated herein by and between the Local Initiative Health Authority for Los Angeles County, a local public agency operating as L.A. Care Health Plan ("Local Initiative") and ***Kaiser Foundation Health Plan, Inc.,*** a California health care service plan ("Plan").

RECITALS

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

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

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

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

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

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

IN WITNESS WHEREOF, the parties have entered into this Amendment No. 47 as of the date set forth below.

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

By: _____
John Baackes
Chief Executive Officer

Date: _____, 2023

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

Date: _____, 2023

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

By: _____
Marcus J. Hoffman
Senior Vice President, Chief Financial Officer, Southern California and Hawai'i Market

Date: _____, 2023

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

Exhibit 8
Delegation Agreement
[Attachment A]

Delegated Activities
Responsibilities of Plan and Local Initiative

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

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

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

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

Standard	Delegated Activities	Retained by L.A. Care
	4. Management of treatment access and follow-up for members with coexisting medical and behavioral disorders. 5. Primary or secondary preventive behavioral healthcare program implementation. 6. Special needs of members with severe and persistent mental illness or serious emotional disturbance. **Collaborative Activities** The organization annually conducts activities to improve the coordination of behavioral healthcare and general medical care including: 1. Collaborating with behavioral healthcare practitioners 2. Quantitative and qualitative analysis of data to identify improvement opportunities 3. Identifying and selecting one opportunity for improvement from Element A 4. Identifying and selecting a second opportunity for improvement from Element A 5. Taking collaborative action to address one identified opportunities for improvement from Element A 6. Taking collaborative action to address a second identified opportunity for improvement from Element A. **Measuring Effectiveness** The organization annually measures the effectiveness of improvement actions taken for: 1. The first opportunity in Element B. 2. The second opportunity in Element B.	
Standards for Medical Record Documentation (DHCS)	Establishing medical record standards which require medical records to be maintained in a manner that is current, detailed, and organized, and which permits effective and confidential patient care and quality review, including: 1. Developing and distributing to practice sites: a. Policies and procedures for the confidentiality of medical records b. Medical record documentation standards i. Requirements for an organized medical record c. Standards for the availability of medical records	

Standard	Delegated Activities	Retained by L.A. Care
Sub--delegation Delegation of QI (NCQA QI 5)	**Sub-delegation Delegation Agreement** The written sub-delegation agreement: 1. Is mutually agreed upon 2. Describes the sub-delegated activities and the responsibilities of the delegate and the sub-delegated entity 3. Requires at least semiannual reporting by the sub-delegated entity to the delegate 4. Describes the process by which the delegate evaluates the sub-delegated entity's performance 5. Describes the process for providing member experience and clinical performance data to its sub-delegates when requested 6. Describes the remedies available to the delegate if the sub-delegated entity does not fulfill its obligations, including revocation of the sub-delegation agreement **Predelegation Evaluation** For new sub-delegation agreements initiated in the look-back period, the delegated entity evaluates sub-delegate capacity to meet NCQA requirements before sub-delegation begins. **Review of QI Program** For arrangements in effect for 12 months or longer, the organization: 1. Annually reviews its sub-delegate's QI program 2. Annually evaluates sub-delegate performance against NCQA standards for sub-delegated activities 3. Semiannually evaluates regular reports, as specified in Element Athe sub-delegation agreement. **Opportunities for Improvement** For sub-delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that sub-delegation has been in effect, the delegate identified and followed up on opportunities for improvement, if applicable.	
	POPULATION HEALTH MANAGEMENT	

Standard	Delegated Activities	Retained by L.A. Care
PHM Strategy (NCQA PHM 1) (CalAIM PHM Strategy)	**NCQA Strategy Description** The strategy describes: 1. Goals and populations targeted for each of the four areas of focus 2. Programs or Services offered to members. 3. Activities that are not direct member interventions, 4. How member programs are coordinated. 5. How members are informed about available PHM programs. 6. How the organization promotes health equity. **CalAIM Strategy** Delegates must complete DHCS required annual strategy documents and share with L.A. Care for review. **NCQA Informing Members** The organization informs members eligible for programs that include interactive contact: 1. How members become eligible to participate 2. How to use program services 3. How to opt in or opt out of the program	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care. L.A. Care to coordinate collaborative shared SMART goal development included in all delegates' CalAIM Strategy submission.

Population Identification (NCQA 2021-2022 PHM 2) (CalAIM Population Needs Assessment)	**NCQA Data Integration** The organization integrates the following data to use for population health management functions: 1. Medical and Behavioral claims or encounters 2. Pharmacy claims 3. Laboratory results 4. Health appraisal results 5. Electronic health records 6. Health Services programs within the organization 7. Advanced data sources **NCQA Population Assessment** The organization annually: 1. Assesses the characteristics and needs, including social determinants of health, of its member population 2. Identifies and assesses the needs of relevant member subpopulations. 3. Assesses the needs of child and adolescent members 4. Assesses the needs of members with disabilities 5. Needs of members with serious and persistent mental illness (SPMI) 6. Assesses the needs of members of racial or ethnic groups. 7. Assesses the needs of members with limited English proficiency. **CalAIM Population Needs Assessment** The organization every three years completes the Population Needs Assessment per the DHCS requirements as detailed in APL 23-021. **NCQA Activities and Resources** The organization annually uses the population assessment to: 1. Review and update its PHM activities to address member needs 2. Review and update its PHM resources to address member needs 3. Review and update activities or resources to address health care disparities for at least one identified populations. 4. Review community resources for integration into program offerings to address member needs **Segmentation** At least annually, the organization segments or stratifies its entire population into subset for targeted intervention.	

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

Standard	Delegated Activities	Retained by L.A. Care
Complex Case Management (NCQA PHM 5)	**Access to Case Management** The organization has multiple avenues for members to be considered for complex case management services, including: 1. Medical management program referral 2. Discharge planner referral 3. Member or caregiver referral 4. Practitioner referral. **Case Management Systems** The organization uses case management systems that support: 1. Evidence-based clinical guidelines or algorithms to conduct assessment and management; 2. Automatic documentation of staff ID, and the date and time of action on the case or when interaction with the member occurred 3. Automated prompts for follow-up, as required by the case management plan.	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

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

Standard	Delegated Activities	Retained by L.A. Care
	5. Initial assessment of social determinants of health 6. Evaluation of cultural and linguistic needs, preferences or limitations 7. Evaluation of visual and hearing needs, preferences or limitations 8. Evaluation of caregiver resources and involvement 9. Evaluation of available benefits 10. Evaluation of available community resources 11. Assessment of life planning activities. 12. Beginning the assessment for at least one factor within 30 calendar days of identifying a member for complex case management. **Case Management Ongoing Management** The NCQA review of a sample of the organization's case management files that demonstrates the Plan Partner follows its documented processes for: 1. Development of case management plans, including prioritized goals, that take into account member and caregiver goals, preferences and desired level of involvement in the complex case management program 2. Identification of barriers to meeting goals and complying with the plan 3. Development of a schedule for follow-up and communication with members. 4. Development and communication of member self-management plans 5. Assessment of progress against the case management plans and goals and modification as needed.	
Population Health Management Impact (NCQA PHM 6)	**Measuring Effectiveness** At least annually, the organization conducts a comprehensive analysis of the impact of its PHM strategy that includes the following: 1. Quantitative results for relevant clinical, cost/utilization and experience measures. 2. Comparison of results with a benchmark or goal. 3. Interpretation of results. **Improvement and Action** The organization uses results from the PHM impact analysis to annually: 1. Identify opportunities for improvement. 2. Act on one opportunity for improvement.	

Standard	Delegated Activities	Retained by L.A. Care
Sub-delegation Delegation of PHM (NCQA PHM 7)	**Sub-delegation Delegation Agreement** The written sub-delegation agreement: 1. Is mutually agreed upon 2. Describes the sub-delegated activities and the responsibilities of the delegate and the sub-delegated entity 3. Requires at least semiannual reporting by the sub-delegated entity to the delegate 4. Describes the process by which the delegate evaluates the sub-delegated entity's performance 5. Describes the process for providing member experience and clinical performance data to its sub-delegates when requested 6. Describes the remedies available to the delegate if the sub-delegated entity does not fulfill its obligations, including revocation of the sub-delegation agreement **Predelegation Evaluation** For new sub-delegation agreements initiated in the look-back period, the delegated entity evaluates sub-delegate capacity to meet NCQA requirements before sub-delegation begins. **Review of PHM Program** For arrangements in effect for 12 months or longer, the organization: 1. Annually reviews its sub-delegate's PHM program 2. Annually audits complex case management files against NCQA standards for each year that sub-delegation has been in effect, if applicable 3. Annually evaluates sub-delegate performance against NCQA standards for sub-delegated activities 4. Semiannually evaluates regular reports, as specified in Element of the sub-delegation agreement. **Opportunities for Improvement** For sub-delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that sub-delegation has been in effect, the delegate identified and followed up on opportunities for improvement, if applicable.	
	NETWORK MANAGEMENT	
Availability of Practitioners (NCQA NET 1)	**Cultural Needs and Preferences** The organization: 1. Assesses the cultural, ethnic, racial, and linguistic needs of its members	

Standard	Delegated Activities	Retained by L.A. Care
	2. Adjusts the availability of practitioners within its network, if necessary. **Practitioners Providing Primary Care** To evaluate the availability of practitioners who provide primary care services, including general medicine or family practice, internal medicine and pediatrics by: 1. Establishes measurable standards for the number of each type of practitioner providing primary care 2. Establishes measurable standards for the geographic distribution of each type of practitioner providing primary care 3. Annually analyzes performance against the standards for the number of each type of practitioner providing primary care 4. Annually analyzes performance against the standards for the geographic distribution of each type of practitioner providing primary care. **Practitioners Providing Specialty Care** To evaluate the availability of specialists in its delivery system, the organization: 1. Defines the type of practitioners who serve as high volume and high impact specialists 2. Establishes measurable standards for the number of each type of high volume specialists 3. Establishes measurable standards for the geographic distribution of each type of high-volume specialist 4. Establishes measureable standards for the geographic distribution of each type of high-impact specialist 5. Analyzes its performance against the established standards at least annually **Practitioners Providing Behavioral Healthcare** To evaluate the availability of high-volume behavioral healthcare practitioners in its delivery system, the organization: 1. Defines the types of high volume behavioral healthcare practitioners 2. Establishes measurable standards for the number of each type of high volume behavioral healthcare practitioner 3. Establishes measurable standards for the geographic distribution of each type of high-volume behavioral healthcare practitioner	

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

Standard	Delegated Activities	Retained by L.A. Care
	1. Prioritizes opportunities for improvement identified from analyses of availability,. **(NET 1, Elements A, B and C), accessibility (NET 2, Elements A and C) and member experience accessing the network (NET 3, Element A, factors 1 and 3).** 2. Implements interventions on at least one opportunity, if applicable. 3. Measures the effectiveness of interventions, if applicable. **Opportunities to Improve Access to Behavioral Healthcare Services** The organization annually: 1. 1. Prioritizes opportunities for improvement identified from analyses of availability (NET 1, Elements A, B and C), accessibility (NET 2, Elements A and C) and member experience accessing the network (NET 3, Element A, factors 1 and 3). 2. Implements interventions on at least one opportunity, if applicable. 3. Measures the effectiveness of interventions, if applicable.	
Continued Access to Care (NCQA NET 4)	**Notification of Termination** Refer to Utilization Management Delegated Activities Section **Continued Access to Practitioners** Refer to Utilization Management Delegated Activities Section	
Physician and Hospital Directories (NCQA NET 5)	**Physician Directory Data** The organization has a web-based physician directory that includes the following physician information: 1. Name 2. Gender 3. Specialty 4. Hospital affiliations 5. Medical group affiliations 6. Board certification 7. Accepting new patients 8. Language spoken by the physician or clinical staff 9. Office locations and phone numbers **Physician Directory Updates**	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

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

Standard	Delegated Activities	Retained by L.A. Care
	Hospital Directory Updates The organization updates its web-based hospital directory information within 30 calendar days of receiving new information from the network hospital. **Searchable Hospital Web-Based Directory** The organization's web-based directory includes search functions for specific data types and instructions for searching for the following information: 1. Hospital name 2. Hospital location **Usability Testing** The organization evaluates its web-based physician and hospital directories for understandability and usefulness to members and prospective members at least every three years, and considers the following: 1. Reading level 2. Intuitive content organization 3. Ease of navigation 4. Directories in additional languages, if applicable to membership **Availability of Directories** The organization makes web-based physician and hospital directory information available to members and prospective members through alternative media, including: 1. Print 2. Telephone	
Sub-Delegation of NET (NCQA NET 6)	**Sub-delegation Agreement** The written sub-delegation agreement: 1. Is mutually agreed upon 2. Describes the sub-delegated activities and the responsibilities of the delegate and the sub-delegated entity 3. Requires at least semiannual reporting by the sub-delegated entity to the delegate 4. Describes the process by which the delegate evaluates the sub-delegated entity's performance 5. Describes the process for providing member experience and clinical performance data to its sub-delegates when requested	

Standard	Delegated Activities	Retained by L.A. Care
	6. Describes the remedies available to the delegate if the sub-delegated entity does not fulfill its obligations, including revocation of the sub-delegation agreement **Predelegation Evaluation** For new sub-delegation agreements initiated in the look-back period, the delegated entity evaluates sub-delegate capacity to meet NCQA requirements before sub-delegation begins. **Review of Sub-Delegated Activities** 1. For arrangements in effect for 12 months or longer, the organization: Annually reviews its sub-delegate's network management procedures 2. Annually evaluates sub-delegate performance against NCQA standards for sub-delegated activities 3. Semiannually evaluates regular reports, as specified in Element A the sub-delegation agreement. **Opportunities for Improvement** For sub-delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that sub-delegation has been in effect, the delegate identified and followed up on opportunities for improvement, if applicable.	
	UTILIZATION MANAGEMENT	
Continued Access to Care and Continuity and Coordination of Medical Care (NCQA NET 4and QI 3)	**Notification of Termination** The organization notifies members affected by the termination of a practitioner or practice group in general, family, and internal medicine or pediatrics, at least thirty (30) calendar days prior to the effective termination date and helping the member select a new practitioner. **Continued Access to Practitioners** If a practitioner's contract is discontinued, the organization allows affected members continued access to the practitioner, as follows: 1. Continuation of treatment through the current period of active treatment or for up to ninety (90) calendar days, whichever is less, for members undergoing active treatment for a chronic or acute medical condition 2. Continuation of care through the postpartum period for members in their second or third trimester of pregnancy.	

Standard	Delegated Activities	Retained by L.A. Care
	Transition to Other Care The organization helps with members' transition to other care when their benefits end, if necessary.	
Program Structure (NCQA UM 1)	**Written Program Description** The organization's UM program description includes the following: 1. A written description of the program structure 2. The behavioral healthcare aspects of the program 3. Involvement of a designated senior-level physician in UM program implementation 4. Involvement of a designated behavioral healthcare practitioner in the implementation of the behavioral healthcare aspects of the UM program 5. The program scope and processes to determine benefit coverage and medical necessity 6. Information sources used to determine benefit coverage and medical necessity. **Annual Evaluation** The organization annually evaluates and updates the UM program, as necessary.	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs, including review, evaluation, and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.
Clinical Criteria for UM Decisions (NCQA UM 2)	**UM Criteria** The organization: 1. Has written UM decision-making criteria that are objective and based on medical evidence 2. Has written policies for applying the criteria based on individual needs 3. Has written policies for applying the criteria based on an assessment of the local delivery system 4. Involves appropriate practitioners in developing, adopting, and reviewing criteria 5. Annually reviews the UM criteria and the procedures for applying them, and updates the criteria when appropriate **Availability of Criteria** The organization: 1. States in writing how practitioners can obtain the UM criteria 2. Makes the criteria available to practitioners upon request. **Consistency in Applying Criteria** At least annually, the organization:	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs, including review, evaluation, and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

Standard	Delegated Activities	Retained by L.A. Care
	1. Evaluates the consistency with which health care professionals involved in UM apply criteria in decision making 2. Acts on opportunities to improve consistency, if applicable.	
Communication Services (NCQA UM 3)	**Access to Staff** The organization provides the following communication services for members and practitioners including: 1. Staff are available at least eight (8) hours a day during normal business hours for inbound collect or toll-free calls regarding UM issues 2. Staff can receive inbound communication regarding UM issues after normal business hours 3. Staff are identified by name, title, and organization name when initiating or returning calls regarding UM issues 4. TDD/TTY services for members who need them 5. Language assistance for members to discuss UM issues.	
Appropriate Professionals* (NCQA UM 4)	**Licensed Health Professionals** The organization has written procedures: 1. Requiring appropriately licensed professionals to supervise all medical necessity decisions 2. Specifying the type of personnel responsible for each level of UM decision-making **Use of Practitioners for UM Decisions** The organization has a written job description with qualifications for practitioners who review denials of care based on medical necessity. Practitioners are required to have: 1. Education, training, or professional experience in medical or clinical practice 2. A current clinical license to practice or an administrative license to review UM cases **Practitioner Review of Nonbehavioral Healthcare Denials** The organization uses a physician or other healthcare professional, as appropriate, to review any non-behavioral healthcare denial based on medical necessity. **Practitioner Review of Behavioral Healthcare Denials** The organization uses a physician, appropriate behavioral healthcare practitioners, as appropriate,	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs, including review, evaluation, and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

Standard	Delegated Activities	Retained by L.A. Care
	to review any behavioral healthcare denial of care based on medical necessity. **Practitioner Review of Pharmacy Denials** The organization uses a physician or a pharmacist to review pharmacy denials based on medical necessity. **Use of Board-Certified Consultants** The organization: 1. Has written procedures for using board-certified consultants to assist in making medical necessity determinations 2. Provides evidence that it uses board-certified consultants for medical necessity determinations.	
Timeliness of UM Decisions (NCQA UM 5)	**Notification of Nonbehavioral Decisions** The organization adheres to the following time frames for notification of non-behavioral healthcare UM decisions: 1. N/A (Marketplace) 2. For Medicaid urgent concurrent decisions, the organization gives electronic or written notification of the decision to practitioners and members within seventy-two (72) hours of the request 3. For Medicaid urgent pre-service decisions, the organization gives electronic or written notification of the decision to practitioners and members within seventy-two (72) hours of the request 4. For Medicaid non-urgent pre-service decisions, the organization gives electronic or written notification of the decision to practitioners and members within fourteen (14) calendar days of the request 5. For Medicaid postservice decisions, the organization gives electronic or written notification of the decision to practitioners and members within thirty (30) calendar days of the request. **Notification of Behavioral Healthcare Decisions** The organization adheres to the following time frames for notification of behavioral healthcare UM decisions: 1. N/A (Marketplace) 2. For Medicaid urgent concurrent decisions, the organization gives electronic or written notification of the decision to practitioners and members within seventy-two (72) hours of the request	

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

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

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

Standard	Delegated Activities	Retained by L.A. Care
	representation and time frames for deciding appeals 3. A description of the expedited appeals process for urgent pre-service or urgent concurrent denials 4. Notification that expedited external review can occur concurrently with the internal appeals process for urgent care **Discussing a Pharmacy Denial With a Reviewer** The organization gives practitioners the opportunity to discuss pharmacy UM denial decisions with a physician or pharmacist. **Written Notification of Pharmacy Denials** The organization's written notification of pharmacy denials to members and their treating practitioners contains the following information: 1. The specific reasons for the denial, in language that is easy to understand 2. A reference to the benefit provision, guideline, protocol or similar criterion on which the denial decision is based A statement that members can obtain a copy of the actual benefit provision, guideline, protocol or similar criterion on which the denial decision was based, upon request. **Written Notification of Pharmacy Appeals Rights/Process** The organization's written notification of pharmacy denials to members and their treating practitioners contains the following information: 1. A description of appeal rights, including the right to submit written comments, documents or other information relevant to the appeal 2. An explanation of the appeal process, including the right to member representation and time frames for deciding appeals 3. A description of the expedited appeals process for urgent pre-service or urgent concurrent denials 4. Notification that expedited external review can occur concurrently with the internal appeal process for urgent care	
Policies for Appeals (NCQA UM 8)	**Internal Appeals** The organization's written policies and procedures for registering and responding to written internal appeals must follow all current regulations and include but not limited toto the following:	Members have the option to appeal directly to L.A. Care. Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs,

Standard	Delegated Activities	Retained by L.A. Care
	1. Allowing at least sixty (60) calendar days after notification of the denial for the member to file the appeal 2. Documenting the substance of the appeal and any actions taken 3. Full investigation of the substance of the appeal, including any aspects of clinical care involved 4. The opportunity for the member to submit written comments, documents or other information relating to the appeal 5. Appointment of a new person to review an appeal, who was not involved in the initial determination and who is not the subordinate of any person involved in the initial determination 6. Appointment of at least one person to review an appeal who is a practitioner in the same (defined as a practitioner with similar credentials and licensure as those who typically treat the condition or health problem in question in the appeal) or a similar (defined as a practitioner who has experience treating the same problems as those in question in the appeal, in addition to experience treating similar complications of those problems) specialty. 7. The decision for a pre-service appeal and notification to the member within thirty (30) calendar days of receipt of the request. 8. The decision for a post-service appeal and notification to the member within sixty (60) calendar days of receipt of the request. For Medicaid only, decisions for postservice appeals and notifications to members must be within 30 calendar days of receipt of the request. 9. The decision for an expedited appeal and notification to the member within seventy-two (72) hours of receipt of the request 10. Notification to the member about further appeal rights 11. Referencing the benefit provision guideline, protocol or other similar criterion on which the appeal decision is based 12. Giving members reasonable access to and copies of all documents relevant to the appeal, free of charge, upon request	including review, evaluation, and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care. Delegate will supply L.A. with requested documentation for processing and investigating appeals and grievances filed by the member. Timeframes for supplying the requested information will be 7 calendar days for standard appeals or grievances and 24 hour or less for expedited appeal or grievances. Part B appeals 24 hours. The Delegate will assist L.A. Care in remaining in compliance with all regulatory guidelines and requests. The Delegate will supply L.A. Care with any requested documentation required to conduct research for any Regulatory inquires made by our Regulators within 24 hours or less contingent upon the turnaround times established by the Regulator.

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

Standard	Delegated Activities	Retained by L.A. Care
	guideline, protocol or other similar criterion on which the appeal decision was based, upon request 4. Notification that the member is entitled to receive reasonable access to, and copies of all documents relevant to their appeal, free of charge, upon request 5. A list of titles and qualifications, including specialties, of individuals participating in the appeal review 6. A description of the next level of appeal, either within the organization or to an independent external organization, as applicable, along with any relevant written procedures. **Final Internal and External Appeal Files** N/A **Appeals Overturned by the IRO** N/A	
Evaluation of New Technology (NCQA UM 10)		**Written Process** Evaluates the inclusion of new technology and the new application of existing technology in the benefits plan, including medical and behavioral health procedures, pharmaceuticals, and devices. This element is Not Applicable for Medicaid product lines if the state mandates all benefits and new technology determinations. L.A. Care will provide the state's language. **Description of the Evaluation Process** This element is Not Applicable for Medicaid product lines if the state mandates all benefits and new technology determinations. L.A. Care will produce documentation that demonstrates this.
UM System Controls (NCQA UM 12)	**UM Denial System Controls** The organization has policies and procedures describing its system controls specific to UM denial notification dates that: 1. Define the date of receipt consistent with NCQA requirements. 2. Define the date of written notification consistent with NCQA requirements.	

Standard	Delegated Activities	Retained by L.A. Care
	3. Describe the process for recording dates in systems. 4. Specify staff who are authorized to modify dates once initially recorded and circumstances when modification is appropriate. 5. Specify how the system tracks modified dates. 6. Describe system security controls in place to protect data from unauthorized modification. 7. Describe how the organization audits the processes and procedures in factors 1-6. **UM Denial System Controls Oversight** At least annually, the organization demonstrates that it monitors compliance with its UM denial controls, as described in Element A, factor 7, by: 1. Identifying all modifications to receipt and decision notification dates that did not meet the organization's policies and procedures for date modifications. 2. Analyzing all instances of date modifications that did not meet the organization's policies and procedures for date modifications. 3. Acting on all findings and implementing a quarterly monitoring process until it demonstrates improvement for one finding over three consecutive quarters. **UM Appeal System Controls** The organization has policies and procedures describing its system controls specific to UM appeal dates that: 1. Define the date of receipt consistent with NCQA requirements. 2. Define the date of written notification consistent with NCQA requirements. 3. Describe the process for recording dates in systems. 4. Specify staff who are authorized to modify dates once initially recorded and circumstances when modification is appropriate. 5. Specify how the system tracks modified dates. 6. Describe system security controls in place to protect data from unauthorized modification. 7. Describe how the organization audits the processes and procedures in factors 1-6. **UM Appeal System Controls Oversight** At least annually, the organization demonstrates that it monitors compliance with its UM appeal controls, as described in Element C, factor 7, by: 1. Identifying all modifications to receipt and decision notification dates that did not	

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

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

Standard	Delegated Activities	Retained by L.A. Care
	for discriminatory practices, at least annually. 7. The process for notifying practitioners about any information obtained during the credentialing process that varies substantially from the information provided to Delegate by the practitioner. 8. The process for notifying practitioners of the credentialing and recredentialing decisions within sixty (60) calendar days of the committee's decision 9. The medical director or other designated physician's direct responsibility for, and participation in, the credentialing program 10. The process for securing the confidentiality of all information obtained in the credentialing process, except as otherwise provided by law 11. The process for confirming that listings in practitioner directories and other materials for members are consistent with credentialing data, including education, training, board certification, and specialty. **Practitioner Rights** The organization notifies practitioners about: 1. The right of practitioners to review information submitted to support their credentialing application, including: 2. The right of practitioners to correct erroneous information: i. The timeframe for making corrections. ii. The format for submitting corrections. iii. The person to whom the corrections must be submitted. 3. The right of practitioners to be informed of the status of their credentialing or re-credentialing application, upon request. **Credentialing System Control** The Delegate must have policies and procedures for its CR system security controls. If the Organization outsources storage of credentialing information to an external entity, the contract between the Delegate and the external entity will be part of the oversight review. The organization's credentialing process describes: 1. How primary source verification information is received, stored, reviewed, and dated.	

Standard	Delegated Activities	Retained by L.A. Care
(DHCS APL 19-004)	2. How modified information is tracked and dated from its initial verification. 3. Titles or roles of staff who are authorized to review, modify and delete information, and circumstances when modification or deletion is appropriate. 4. The security controls in place to protect the information from unauthorized modification 5. How the organization monitors its compliance with the processes and procedures in factors 1–4at least annually and takes appropriate action when applicable. **Credentialing System Controls Oversight** At least annually, the organization demonstrates that it monitors compliance with its CR controls by: 1. Identifying all modifications to credentialing and recredentialing information that did not meet the organization's policies and procedures for modifications. 2. Analyzing all instances of modifications that did not meet the organization's policies and procedures for modifications. 3. Acting on all findings and implementing a quarterly monitoring process until it demonstrates improvement from one finding over three consecutive quarters. **Medi-Cal FFS Enrollment** Developing and implementing policies and procedures for Medi-Cal enrollment. Policy must clearly specify enrollment process including, but not limited to: 1. All practitioners that have a FFS enrollment pathway must enroll in the Medi-Cal program. 2. The process for ensuring and verifying Medi-Cal enrollment. 3. The process for practitioners whose enrollment application is in process. 4. The process for monitoring between recredentialing cycles to validate continued enrollment. 5. The process for practitioners not currently enrolled in the Medi-Cal program. 6. The process for practitioners deactivated or suspended from the Medi-Cal program.	

Standard	Delegated Activities	Retained by L.A. Care
	During the annual oversight review, the Delegate is subject to a CAP (Corrective Action Plan) if their process does not match their policies. In addition, if the Delegate demonstrates reoccurring deficiencies that were identified in previous audits, the Delegate is subject to additional point deductions.	
Credentialing Committee (NCQA CR 2) DMHC, DHCS, CMS	Designating a credentialing committee that uses a peer review process to make recommendations regarding credentialing and re-credentialing decisions such that the organization's Credentialing Committee: 1. Includes representation from a range of participating practitioners, and provides advice and expertise for credentialing decisions 2. Has the opportunity to review the credentials of all practitioners being credentialed or recredentialed who do not meet Delegate's established criteria and to offer advice, which Delegate considers appropriate under the circumstances. 3. The Medical Director, designated physician or credentialing committee reviews and approves files that meet the Delegate's established criteria. 4. Ensures that all license accusations, sanctions or restrictions are reviewed by the credentialing committee for action.	
Credentialing Verification (NCQA CR 3) DMHC, DHCS, CMS	Primary source verification and credentialing and recredentialing decision-making, which includes verification of information to ensure that practitioners have the legal authority and relevant training and experience to provide quality care, within the regulatory and NCQA prescribed time limits, through primary or other regulatory and NCQA-approved sources, prior to credentialing and recredentialing The organization verifies that the following are within the prescribed time limits: 1. Current, valid license to practice (Develop a process to ensure providers' licenses are kept current at all times). 2. A valid DEA or CDS, with schedules 2 thru 5, if applicable; or the Delegate has a documented process for practitioners: a. Allowing a practitioner with a valid DEA certificate to write all prescriptions for a practitioner with a pending DEA certificate b. Requiring an explanation from a qualified practitioner who does not prescribe	

Standard	Delegated Activities	Retained by L.A. Care
	medications and provides arrangements for the practitioner's patients who need prescriptions for medications. 3. For physicians, verification of the highest of the following three levels of education and training obtained by the practitioner as appropriate: a. Board certified if practitioner stated on the application that he/she is board certified, as well as expiration date of certification. b. Completion of a residency program. c. Graduation from medical or professional school. 4. For Non-Physician Medical Practitioners (NMPs) and Non-Clinical Providers (NCPs), the Delegate verifies the provider has met the qualifications to render services based on the provider type including but not limited to, a current and valid license, registration, certification or the education/training equivalent. 5. Work history. 6. Current malpractice insurance coverage ($1 million/$3 million). 7. A history of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner. 8. Clinical Privileges in good standing at a Plan contracted facility designated by the physician as the primary admitting facility. 9. Current, valid FSR/MRR of primary care physician offices within 3 years prior to credentialing decision. 10. CLIA Certifications, if applicable. 11. NPI number. 12. Medicare number, if applicable. 13. Medi-Cal FFS enrollment All certifications and expiration dates must be made part of the practitioner's file and kept current. Delegate shall maintain credentialing and/or other monitoring processes to assure that licensure and professional status of each Participating Provider is verified on an ongoing basis. Pursuant to the performance of its credentialing, recredentialing, auditing, monitoring and/or other processed, which include confirmation relating to the following: ▪ Each Participating Provider/Practitioner is and shall remain duly licensed, registered or certified, as required by the laws of this State, and such licensure is free from restrictions that would restrict or limit the	

Standard	Delegated Activities	Retained by L.A. Care
	ability of Participating provider/practitioner to provide Health Care Services to LAC members as required under the Agreement. ▪ Each Delegate shall maintain professional liability insurance, either independently or through Contractor or some other entity, in a dollar amount that is sufficient for his/her/its practice and as may be required by law or accrediting entities. The Delegate's participating providers must also have general liability insurance in a dollar amount appropriate for their business practice. The Delegate must notify L.A. Care immediately when a practitioner's license has expired for removal from the network.	
CR Sanction Information (NCQA CR 3) DMHC, DHCS, CMS	The organization verifies the following sanction information for credentialing: 1. State sanctions, restrictions on licensure, or limitations on scope of practice. Review of information must cover the most recent 5-year period available. If a practitioner is licensed in more than one state, in the most recent 5-year period, the query must include all states in which they worked. 2. Medicare and Medicaid sanctions. 3. *Medicare Opt-out. 4. SAM. 5. CMS Preclusion 6. Debarment. 7. Decertification. Providers must not be terminated, sanctioned, suspended, debarred, disenrolled/decertified, convicted of a felony related to healthcare program fraud or excluded from participation in any federal or state funded programs. L.A. Care does not contract, credential, refer, or pay claims to Practitioners or Providers who have opted out of participation in the Medicare and Medicaid programs; or with individuals or businesses that have been convicted of a felony related to healthcare program fraud, federally or state terminated, sanctioned, suspended, debarred, disenrolled/decertified, excluded, or have appeared on any sanction reports, or on any order issued by judicial authority. Such Practitioners, Providers, individuals, or businesses are ineligible from participation in Medi-Cal, Medicare, federal or state funded programs.	

Standard	Delegated Activities	Retained by L.A. Care
	The Delegate must notify L.A. Care immediately when practitioners are identified on any sanctions or reports for removal from the network.	
CR Application and Attestation (NCQA CR 3) DMHC, DHCS, CMS	Applications for credentialing and recredentialing include the following: 1. Reasons for inability to perform the essential functions of the position, with or without accommodation 2. Lack of present illegal drug use 3. History of loss of license and felony convictions 4. History of loss or limitation of privileges or disciplinary action 5. Current malpractice insurance coverage ($1million/$3 million). 6. Current and signed attestation confirming the correctness and completeness of the application.	
Re-credentialing Cycle Length (NCQA CR 4) DMHC, DHCS, CMS	The length of the recredentialing cycle is within the required 36-month time frame. For PCPs only, must confirm provider has a valid FSR at least every 36 months as part of the recredentialing process.	
CR Ongoing Monitoring and Interventions (NCQA CR 5) DMHC, DHCS, CMS	Developing and implementing policies and procedures for ongoing monitoring of practitioner sanctions, complaints and quality issues and takes appropriate action against practitioners when it identifies occurrences of poor quality between recredentialing cycles by: 1. Collecting and reviewing Medicare and Medicaid sanctions within 30 calendar days of its release. In areas where reporting entities do not publish sanction information on a set schedule, the Delegate must query for this information at least every 6 months. 2. Collecting and reviewing sanctions, restrictions or limitations on licensure and report actions taken against any identified practitioners to Plan. 3. Collecting and reviewing complaints. The delegate must set a threshold to evaluate the specific complaint and the practitioners history of issues. 4. Collecting and reviewing information from identified adverse events. a. Implementing appropriate interventions when Delegate identifies instances of poor quality.	Upon notification of any Adverse Event, L.A. Care will notify the Delegate of their responsibility with respect to delegation of credentialing/re-credentialing activity. The notification will clearly delineate what is expected from the Adverse Event that has been identified. The notice will include, but is not limited to: a. Requesting what actions will be taken by the Delegate b. What type of monitoring is being performed c. What interventions are being implemented, including closing panel, moving members, or removal of practitioner from the network d. The notification will include a timeframe for responding to Plan to ensure Plan's members receive the highest level of quality care.

Standard	Delegated Activities	Retained by L.A. Care
	The Delegate's Credentialing committee may vote to flag a practitioner for ongoing monitoring 1. The Delegate must make clear the types of monitoring it imposes, the timeframe used, the intervention, and the outcome, which must be fully demonstrated in the Delegate's credentialing committee minutes 2. The Delegate's credentialing committee can: a. Request a practitioner be placed on a watch list. Any list must be clearly defined and monitored. b. Request that the practitioner demonstrate compliance with probation that has been imposed by the State and monitor completion c. Impose upon the practitioner to demonstrate steps they have taken to improve processes and/or chart review, if applicable. Delegated entities who fail to comply with the requested information within the specified timeframe are subject to sanctions as described in Plan's policies and procedures The Plan will clearly delineate what is expected from the Delegate regarding the Adverse Event that has been identified. The notification may include performing the following: 1. Requesting what action will be taken by the Delegate. 2. What type of monitoring is being performed. 3. What interventions are being implemented, including closing panel, moving members, or removal of practitioner from the network. 4. The notification will include a timeframe for responding to L.A. Care to ensure L.A. Care members receive the highest level of quality care. a. In the event that the Delegate fails to respond as required, the Plan will perform the oversight functions of the Adverse Event and the Delegate will be subject to Plan's credentialing committee's outcome of the adverse events. b. The Delegate must notify L.A. Care immediately when practitioners are identified on any sanctions or reports for removal from the network	

Standard	Delegated Activities	Retained by L.A. Care
	c. The above are samples, but not limited to, the steps the Delegate can take.	
Credentialing: Notification to Authorities and Practitioner Appeal Rights (NCQA 2022 CR 6) DMHC, DHCS, CMS	The Delegate uses objective evidence and patient care consideration when deciding on a course of action for dealing with a practitioner who does not meet its quality standards. The organization has policies and procedures specify for: 1. The range of actions available to Delegate 2. That the Delegate reviews participation of practitioners whose conduct could adversely affect members' health or welfare. 3. The range of actions that may be taken to improve practitioner performance before termination. b. That the Delegate reports its actions to the appropriate authorities. 4. Making the appeal process known to practitioners. All final adverse actions determined to be reportable pursuant to applicable law, must be reported by the Delegate to the National Practitioner Data Bank (NPBD) and the appropriate State Medical Boards. Upon the filing of NPBD reports and 805 reporting, the Delegate must notify the Plan within 5 business days from the date the reports are filed. Providers must notify the Delegate, in writing, of any adverse or criminal action taken against them promptly and no later than fourteen (14) calendar days from the occurrence of any adverse event, criminal action, changes in privileges, accusation, probation, or other disciplinary action of practitioners. Failure to do so may result in the removal of the practitioner from L.A. Care's network as referenced in the California Participating Physician Application Information Release Acknowledgments. Upon notification from a contracted or employed provider, the PPG must notify the Healthplan immediately or no later than 5 business days from the date when practitioners are identified on any ongoing monitoring reports. Within 14 days from criminal action taken against any contracted practitioner, Delegate shall notify L.A. Care in writing.	L.A. Care retains accountability for procedural components and will oversee Delegate's adherence to these standards through pre-delegation, routine monitoring and annual oversight review or more frequently, as required, per changes in contract, Federal and State regulatory guidelines, and accreditation standards.

Standard	Delegated Activities	Retained by L.A. Care
CR Assessment of Organizational Providers (NCQA CR 7) DMHC, DHCS, CMS	The delegate's organization's policy for assessing a health care delivery provider specifies that before it contracts with a provider, and for at least every 36 months thereafter, it: 1. Confirms that the provider organization is in good standing with state and federal regulatory bodies. 2. Confirms that the provider organization has been reviewed and approved by an accrediting body acceptable to Delegate, including which accrediting bodies are acceptable. 3. Conducts an onsite quality assessment is conducted if the provider organization is not accredited by an accrediting body acceptable to Delegate, including which accredited bodies are acceptable. 4. At least every three years that the provider organization continues to be in good standing with state and federal regulatory bodies and, if applicable, is reviewed and approved by an accrediting body acceptable to Delegate. Maintaining a tracking log that includes names of the organization, type of organization, a prior validation date, a current validation date for licensure, accreditation status (if applicable), CMS or state reviews conducted within 3 years at time of verification (if applicable), CLIA certificate (if applicable), NPI number for each organizational provider. The organization includes at least the following medical providers in its assessment: 1. Hospitals. 2. Home health agencies. 3. Skilled nursing facilities. 4. Freestanding surgical centers. 5. *Hospices. 6. *Clinical Laboratories (A CMS issued CLIA certificate or a hospital based exemption from CLIA). 7. *Comprehensive Rehabilitation Facilities (CORFs). 8. *Outpatient Physical Therapy and Speech Pathology Providers. 9. *Providers of end-stage renal disease services. 10. *Providers of outpatient diabetes self-management training. 11. *Portable X-Ray Suppliers.	

Standard	Delegated Activities	Retained by L.A. Care
	12. *Rural Health Clinic (RHCs). 13. Federally Qualified Health Center (FQHCs).e 14. Any other ancillary provider types outlined in the delegate's contract with the Plan The organization includes behavioral healthcare facilities providing mental health or substance abuse services in the following settings: 1. Inpatient. 2. Residential. 3. Ambulatory. The delegate assesses contracted medical health care providers. The delegate assesses contracted behavioral healthcare providers.	
Sub-Delegation of CR (NCQA CR 8) DMHC, DHCS, CMS	**Subdelegation Agreement** If Delegate sub-delegates any NCQA required credentialing activities, there must be evidence of oversight of the delegated activities, including the written sub-delegation agreement that: 1. Is mutually agreed upon. 2. Describes the sub-delegated activities and the responsibilities of the organization and the delegated entity. 3. Requires at least quarterly reporting to Delegate. 4. Describes the process by which Delegate evaluates Sub-delegated entity's performance. 5. Specifies that the delegate retains the right to approve, suspend and terminate individual practitioners, providers and sites, even if the organization delegates decision making. 6. Describes the remedies available to Delegate if Sub-delegate does not fulfill its obligations including revocation of the sub-delegation agreement. **Presubdelegation Evaluation** Retention of the right by Delegate and L.A. Care, based on quality issues, to approve, suspend, and terminate individual practitioners, providers, and sites. **Review of Subdeelgate's Credentialing Activities** For new sub-delegation agreements initiated in the look-back period, the delegate evaluated sub-	L.A. Care retains the right to perform a pre-delegation audit of any entity to which the Plan sub-delegates delegated credentialing activities and approve any such sub-delegation audit of any sub-delegate. Prior to entering into an agreement to sub-delegate delegated credentialing activities, Delegated Plan shall provide L.A. Care with reasonable prior notice of Plan's intent to sub-delegate.

Standard	Delegated Activities	Retained by L.A. Care
	delegate capacity to meet NCQA requirements before sub-delegation begins. For sub-delegation arrangements in effect for 12 months or longer, the Delegate: 1. Annually reviews its sub-delegate's credentialing policies and procedures. 2. Annually audits credentialing and recredentialing files against NCQA standards for each year that sub-delegation has been in effect. 3. Annually evaluates the sub-delegate's performance against relevant regulatory requirements, NCQA standards, and Delegate's expectations annually. 4. Evaluates regular reports from sub-delegate at least quarterly or more frequently based on the reporting schedule described in the sub-delegation document. 5. Annually monitors the delegate's credentialing system security controls to ensure that the delegate monitors its compliance with the delegation agreement or with the delegate's policies and procedures at least annually. 6. Annually acts on all findings from factor 5 for each delegate and implements a quarterly monitoring process until each delegate demonstrates improvement for one finding over three consecutive quarters. **Opportunities for Improvement** For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years, the organization identifies and follows up on opportunities for improvement, if applicable If a Delegate fails to complete the corrective action plan and has gone through the exigent process which results in de-delegation, the Delegate cannot appeal and must wait one year to reapply for a pre-delegation audit. If the pre-delegation audit reveals deficiencies identified are the same as those from previous audits, delegation will be at the sole discretion of the Credentialing Committee regardless of score.	
MEMBER EXPERIENCE		

Standard	Delegated Activities	Retained by L.A. Care
Statement of Members' Rights and Responsibilities (NCQA ME 1)	**Distribution of Rights Statement** The organization distributes its member rights and responsibilities statement to the following groups: 1. New members, upon enrollment. 2. Existing members, if requested. 3. New practitioners, when they join the network. 4. Existing practitioners, if requested.	**Rights and Responsibilities Statement** The organization's member rights and responsibilities statement specifies that members have: 1. A right to receive information about the organization, its services, its practitioners and providers and member rights and responsibilities 2. A right to be treated with respect and recognition of their dignity and right to privacy 3. A right to participate with practitioners in making decisions about their health care4. A right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage 5. A right to voice complaints or appeals about the organization or the care it provides6. A right to make recommendations regarding the organization's member rights and responsibilities policy 7. A responsibility to supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care 8. A responsibility to follow plans and instructions for care that they have agreed to with their practitioners9. A responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goal, to the degree possible L.A. Care adheres to the most current NCQA standards to comply with these requirements.
Subscriber Information (NCQA 2020 ME 2)		**Subscriber Information:** L.A. Care informs its subscribers upon enrollment and annually thereafter about benefits and access to medical services. 1. Benefits and services included in, and excluded from, coverage. 2. Pharmaceutical management procedures, if they exist. 3. Copayments and other charges for which members are responsible. 4. Benefit restrictions that apply to services obtained outside the

Standard	Delegated Activities	Retained by L.A. Care
		organization's system or service area. 5. How to obtain language assistance. 6. How to submit claim for covered services, if applicable. 7. How to obtain information about practitioners who participate in the organization. 8. How to obtain primary care services, including points of access. 9. How to obtain specialty care and behavioral healthcare services and hospital services. 10. How to obtain care after normal business hours. 11. How to obtain emergency care, including the organization's policy on when to directly access emergency care or use of 911 services. 12. How to obtain care and coverage when subscribers are out of the organization's service area. 13. How to submit a complaint. 14. How to appeal a decision that adversely affects coverage, benefits or a subscriber's relationship with the organization. 15. Availability of independent, external review of internal UM final determinations. 16. How the organization evaluates new technology for inclusion as a covered benefit. **Distribution of Subscriber Information** The organization distributes its subscriber information to the following groups: 1. New members, upon enrollment. 2. Existing members, annually **Interpreter Services** L.A. Care provides interpreter or bilingual services in its Member Services Department and telephone functions based on linguistic needs of its subscribers. L.A. Care adheres to the most current NCQA standards to comply with these requirements.

Standard	Delegated Activities	Retained by L.A. Care
Marketing Information (NCQA ME 3)		**Materials and Presentations** All organizational materials and presentations accurately describe the following information: 1. Covered benefits. 2. Noncovered benefits. 3. Practitioner and provider availability. 4. Key UM procedures the organization uses. 5. Potential network, service or benefit restrictions. 6. Pharmaceutical management procedures. L.A. Care's prospective members receive an accurate description of the organization's benefits and operating procedures. L.A. Care adheres to the most current NCQA standards to comply with these requirements. **Communicating with Prospective Members** The organization uses easy-to-understand language in communications to prospective members about its policies and practices regarding collection, use and disclosure of PHI: 1. In routine notification of privacy practices 2. The right to approve the release of information (use of authorizations) 3. Access to Medical Records4. Protection of oral, written, and electronic information across the organization 4. Information for employers **Assessing Member Understanding** 1. Assesses how well new members understand policies and procedures. The right to approve the release of information (use of authorizations) 2. Implements procedures to maintain accuracy of marketing communication. Protection of oral, written, and electronic information across the organization 3. Acts on opportunities for improvement, if applicable

Standard	Delegated Activities	Retained by L.A. Care
Functionality of Claims Processing (NCQA ME 4)	**Functionality-Website** Members can track the status of their claims in the claims process and obtain the following information on the organization's website in one attempt or contact: 1. The stage in the process. 2. The amount approved. 3. The amount paid. 4. Member cost. 5. The date paid **Functionality-Telephone Requests** Members can track the status of their claims in the claims process and obtain the following information over the telephone in one attempt or contact: 1. The stage in the process. 2. The amount approved. 3. The amount paid. 4. Member cost. 5. The date paid	
Personalized Information on Health Plan Services (NCQA ME 6)	**Functionality Website** Members can complete each of the following activities on the organization's website in one attempt or contact: 1. Change a primary care practitioner, as applicable. 2. Determine how and when to obtain referrals and authorizations for specific services, as applicable 3. N/A **Functionality Telephone** To support financial decision making, members can complete each of the following activities over the telephone within one business day: 1. Determine how and when to obtain referrals and authorizations for specific services, as applicable. 2. Determine benefit and financial responsibility for a specific service or treatment from a specified provider or institution. **Quality and Accuracy of Information** At least annually, the organization must evaluate the quality and accuracy of the information provided to members via the website and telephone must be evaluated by: 1. Collecting data on quality and accuracy of information provided. 2. Analyzing data against standards or goals. 3. Determining causes of deficiencies, as applicable.	

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

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

Standard	Delegated Activities	Retained by L.A. Care
	1. Semiannually evaluates regular reports, as specified in the sub-delegation agreement 2. Annually evaluates sub-delegate performance against NCQA standards for sub-delegated activities **Opportunities for Improvement** For sub-delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that sub-delegation has been in effect, the delegate identified and followed up on opportunities for improvement, if applicable.	
Nurse Advice Line (Title 28 California Code of Regulations Section 1300.67.2.2; California Health and Safety Code Section 1348.8)	A Nurse Advice Line is offered to members to assist members with wellness and prevention **A. Access to Nurse Advice Line** A Nurse Advice Line that is staffed by licensed nurses or clinicians and meets the following factors: 1. Is available 24 hours a day, 7 days a week by telephone. 2. Provides secure transmission of electronic communication, with safeguards, and a 24-hour turnaround time. 3. Provides interpretation services for members by telephone. 4. Provide telephone triage or screening services in a timely manner appropriate to the enrollee's condition. The triage and screening wait time shall not exceed 30 minutes. **B. Nurse Advice Line Capabilities** The nurse advice line gives staff the ability to: 1. Follow up on specified cases and contact members. 2. Link member contacts to a contact history. **C. Monitoring the Nurse Advice Line** The following shall be conducted: 1. Track telephone and website statistics at least quarterly. 2. Track member use of the nurse advice line at least quarterly. 3. Evaluate member satisfaction with the nurse advice line at least annually. 4. Monitors call periodically. 5. Analyze data at least annually and, if applicable, identify opportunities and establish priorities for improvement. D. **Policies and Procedures**	L.A. Care retains accountability for procedural components and will oversee Delegate's adherence to these standards through pre-delegation and annual oversight review and more frequently, as required, per changes in contract, Federal and State regulatory guidelines and accreditation standards.

Standard	Delegated Activities	Retained by L.A. Care
	1.Establish and maintain an operational policy for operating and maintaining a Telephone Nurse Advice Service. E. **Promotion** 1. Promote the availability of Nurse Advice Line services in materials that are approved in accordance with the Plan Partner Services Agreement and L.A. Care policies and procedures. 2. In the form of, but not limited to: a. Flyers b. Informational mailers c. ID Cards d. Evidence of Coverage (EOC)	
Potential Quality of Care Issue Review (Title 28 California Code of Regulations Section 1300.70)	The Quality Improvement program must document that the quality of care is being reviewed, that problems are being identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated. The Quality Improvement program must include continuous review of the quality of care provided; quality of care problems are identified and corrected for all provider entities.	L.A. Care retains accountability for procedural components and will oversee Delegate's adherence to these standards through pre-delegation and annual oversight review and more frequently, as required, per changes in contract, Federal and State regulatory guidelines and accreditation standards.
Critical Incident Reporting and Tracking (California Code of Regulations Title 22 §72541)	The Quality Improvement program must include implementation of a defined policy and procedures to identify, report, and track Critical Incidents under the following categories: abuse, neglect, exploitation, a serious, life threatening medical event requiring immediate emergency evaluation by a medical professional, disappearance (missing person), suicide attempt, restraint and/or seclusion, unexpected death, or other (such as catastrophes and unusual occurrences that threaten the member's wellbeing). Training shall be made available to network providers on identifying and reporting Critical Incidents to the appropriate authorities in a timely manner to ensure patient safety.	L.A. Care retains accountability for procedural components and will oversee Delegate's adherence to these standards through pre-delegation, annual oversight review. More frequent oversight measures may be taken if needed to ensure delegate compliance. L.A. Care is responsible for submitting quarterly Critical Incident reports to DHCS using the data received from delegates.
HEDIS Performance Benchmark APL 19-017	1. Annually measures performance and meets the NCQA 50th percentile benchmark for the Medi-Cal Managed Care Accountability Set established by DHCS and NCQA required Medi-Cal accreditation measures. 2. Opportunity for Improvement When the 50th percentile is not met the plan will identify and follow up on opportunities for improvement.	L.A. Care will still retain the PIP and PDSA reporting process with DHCS for the Medi-Cal line of business.

Standard	Delegated Activities	Retained by L.A. Care
Blood Lead Screening of Young Children Applicable L.A. Care Policy: QI-048 APL 20-016	1. Ensure network providers follow the blood lead anticipatory guidance and screening requirements in accordance with APL 20-016 2. Identify, on at least a quarterly basis (i.e. January – March, April – June, July – September, October – December), all child members under the age of six years (i.e. 72 months) who have any record of receiving a blood lead screening test as required 3. Note: L.A. Care will send delegate CLPPB data when they receive from DHCS on a quarterly basis.	Annual Submission to DHCS data for all child members under the age of six years (i.e. 72 months) who have no record of receiving a blood lead screening
FINANCIAL SOLVENCY AND CLAIMS PROCESSING REQUIRMENTS		
Financial Solvency (Title 28 California Code of Regulations Sections 1300.75.1, 1300.75.4.2(a), 1300.76, 1300.76.1, 1300.77.1 & 2, 1300.78, and 1300.76.3).	**Financial Solvency** 1. Maintain a cash-to-claims ratio > 0.75. 2. Maintain positive working capital. 3. Maintain a minimum Tangible Net Equity (TNE). 4. Document and record the liability for incurred but not reported (IBNR) claims on a monthly basis. 5. Submit the quarterly financial statements no later than 45 calendar days after the close of each quarter end to L.A Care. 6. Submit the annual financial statements audited by an independent Certified Public Accounting firm no later than 120 calendar days after each fiscal year end to L.A. Care. **Administrative Costs** 1. Maintain administrative costs no greater than 15% of the revenue. **Commissioner Deposits** 1. Maintain at least $300,000 deposit with the Commissioner, with any FDIC insured bank. **Risk Management** Maintain the following insurance at all times: 1. Reinsurance or Stop-Loss 2. Malpractice or Professional Liability 3. General Liability 4. Errors & Omissions 5. Workers Compensation 6. Fidelity Bond **Policies and Procedures** Maintain approved policies and procedures that describe the process and requirements for each of the sections mentioned above.	

Standard	Delegated Activities	Retained by L.A. Care
Claims Processing (Title 28 California Code of Regulations Section 1300.71)	**Timely Claims Processing** 7. Process at a minimum ninety percent (90%) of claims within 30 calendar days of the claim receipt date, 8. Process at a minimum ninety-five percent (95%) of claims within 45 working days of the claim receipt date, **and** 9. Process at a minimum ninety-nine percent (99%) of claims within 90 calendar days of the claim receipt date. **Accurate Claims Payments** 1. Pay claims at the Medi-Cal rates or contracted rates at a minimum of 95% of the time. 2. All modified claims are reviewed and approved by a physician and medical records are reviewed. 3. Calculate and pay interest automatically for claims paid beyond 45 workings days from date of receipt at a minimum 95% of the time. a. **Emergency services claims:** Late payment on a complete claim which is not contested or denied will automatically include the greater of $15 or 15% rate per annum applied to the payment amount for the time period the payment is late. b. **All other service claims:** Late payments on a complete claim will automatically include interest at a 15% rate per annum applied to the payment amount for the time period payment is late. c. **Penalty:** Failure to automatically include the interest due on the late claims regardless of service is $10 per late claim in addition to the interest amount. **Forwarding of Misdirected Claims** Forward misdirected claims within 10 working days of the claim receipt date at a minimum of 95% of the time. **Acknowledgement of Claims** Acknowledge the receipt of electronic claims within 2 working days and paper claims within 15 working days at a minimum of 95% of the time. **Dispute Resolution Mechanism** Provide written notice of a dispute resolution mechanism for all denied and modified claims at a minimum 95% of the time. **Accurate and Clear Written Explanation**	

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

Standard	Delegated Activities	Retained by L.A. Care
(Title 28 California Code of Regulations Section 1300.71.38)	b. 2 working days for electronic disputes. **Timely Dispute Determinations** Dispute determinations are made in a timely manner, at a minimum of 95% of the time. a. 45 working days from receipt of the dispute. b. 45 working days from receipt of additional information. **Clear Explanation of NOA Letter** Rationale for decision is clear, accurate and specific in NOA Letter, at a minimum of 95% of the time. a. Written determination stating the pertinent facts and explaining the reasons for the determination **Accurate Provider Dispute Payments** 1. Appropriately paying any outstanding monies determined to be due if the dispute is determined in whole or in part in favor of the provider. 2. Interest payments are paid correctly when dispute determination is in favor of provider, at a minimum of 95% of the time. Accrual of interest of payment on resolved provider disputes begin on the day after the expiration of forty-five (45) working days from the original claim receipt date. **Acceptance of Late Claims** The organization must accept and adjudicate disputes that were originally filed beyond the claim filing deadline and the provider was able to demonstrate good cause for the delay, at a minimum of 95% of the time. **Policies and Procedures** Maintain approved policies and procedures that describe the process and requirements for each of the sections mentioned above.	
Annual Plan Claims Payment and Dispute Resolution Mechanism Report" Cal. Code Regs. tit. 28 § 1300.71.38(k) Cal. Code Regs. tit. 28 § 1300.71.38(k)(1) Cal. Code Regs. tit. 28 § 1300.71.38(k)(2)	1. "Information on the number and types of providers using the dispute resolution mechanism. 2. "A summary of the disposition of all provider disputes, which shall include an informative description of the types, terms and resolution. Disputes contained in a bundled submission shall be reported separately as individual disputes. Information may be submitted in an	

Standard	Delegated Activities	Retained by L.A. Care
Cal. Code Regs. tit. 28 § 1300.71.38(k)(3)	aggregate format so long as all data entries are appropriately footnoted to provide full and fair disclosure; and… 3. A detailed, informative statement disclosing any emerging or established patterns of provider disputes and how that information has been used to improve the plan's administrative capacity, plan-provider relations, claim payment procedures, quality assurance system (process) and quality of patient care (results) and how the information has been used in the development of appropriate corrective action plans.1	
DMHC Provider Disputes Document/Information Requests	Plan Partner to respond to document\information requests from LA Care for DMHC provider disputes within 5 days, urgent requests within 2 days.	
HEALTH EDUCATION		
DHCS Policy Letter 02-004 DHCS Policy Letter 16-014 DHCS Policy Letter 18-018 DHCS Policy Letter 13-001 DHCS Policy Letter 10-012 DHCS Policy Letter 16-005	1. Maintenance of a health education program description and work plan 2. Availability and promotion of member health education services in DHCS language and topic requirements including implementation of a closed-loop referral process. 3. Implementation of comprehensive tobacco cessation/prevention services including: a. individual, group, and telephone counseling b. Provider tobacco cessation trainings c. Tobacco user identification system d. Tracking individual utilization data of tobacco cessation interventions 4. Availability of a diabetes prevention program (DPP) that complies with CDC DPP guidelines and is delivered by a CDC recognized provider 5. Availability of written member health education materials in English and Spanish in DHCS required health topics including: a. a system for providers to order materials and informing providers how to do so b. Adherence to all regulatory requirements as dictated per the Readability & Suitability Checklist 6. Implementation of an Individual Health Education Behavioral Assessment (IHEBA), preferably the Staying Healthy Assessment (SHA) including a method of making the assessments available to providers and provider education	L.A. Care retains responsibility for providing written health education materials in DHCS required health topics for non-English/Spanish threshold languages. L.A. Care retains responsibility for conducting the Health Education, Cultural & Linguistics Population Needs Assessment (PNA) annually but retains the right to request Plan Partner assistance as needed.

[1] Cal. Code Regs. tit. 28 § 1300.71.38(k)(3)

Standard	Delegated Activities	Retained by L.A. Care
	7. Employment of a full-time Health Education Director, or the equivalent, with a Master's Degree in Public Health (MPH) responsible for the direction, management and supervision of the health education system. 8. Integration between health education activities and QI activities 9. Provision of provider education on health education requirements and resources 10. Adherence to all requirements regarding Non-Monetary Member Incentives including submission of Request for Approval and Annual Update/End of Program Evaluation forms to L.A. Care's Compliance Unit on an on-going basis.\ Should Plan Partner delegate any or all health education requirements to a sub-delegate, Plan Partner must monitor sub-delegate's performance and ensure continued compliance.	
CULTURAL & LINGUISTIC SERVICES		
Civil Rights Act of 1964, Title VI Code of California Regulations (CCR), Title 28, §1300.67.04(c) CCR, Title 22, §53876 DHCS Agreement Exhibit A Attachment 9, (12)& (13)(A) Federal Guidelines: OMH CLAS Standards, Standards 1-4 & 9	**Cultural & Linguistic Program Description and Staffing** 1. Plan maintains an approved written program description of its C&L services program that complies with all applicable regulations. It must include, at minimum, the following elements (or its equivalent): a. Organizational commitment to deliver culturally and linguistically appropriate health care services. b. Goals and objectives with timetable for implementation. c. Standards and performance requirements for the delivery of culturally and linguistically appropriate health care services. 2. Plan centralizes coordination and monitoring of C&L services. The department and/or staff responsible for such services are documented in an organizational chart. 3. Plan has written description(s) of position(s) and qualifications of the staff involved in the C&L services program. 11.	
Civil Rights Act of 1964, Title VI Code of California Regulations (CCR), Title 22, §53876 CCR, Title 28, §1300.67.04, (c)(2)(G) & (H)	**Access to Interpreting Services** 1. Plan has approved policies and procedures which include, at minimum, the following items: a. Provision of timely 24-hour, 7 days a week interpreting services from a qualified interpreter at all key points of contact, in any language requested, including	

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

Standard	Delegated Activities	Retained by L.A. Care
Civil Rights Act of 1964, Title VI Code of California Regulations (CCR), Title 28, §1300.67.04(c)(2)(H) Code of Federal Regulations (CFR), Title 45 §92.4 & §92.201(e)(4) DHCS Agreement Exhibit A, Attachment 9(13)(B) & (F) DHCS All Plan Letter 22-04 Federal Guidelines: OMH CLAS Standards, Standards - 7	**Assessment of Linguistic Capabilities of Bilingual** 1. Plan has approved policies and procedures related to identifying, assessing, and tracking oral and/or written language proficiency of clinical and non-clinical bilingual employees who communicate directly with members in a language other than English. 2. Plan has a sound method to assess bilingual employees' oral and/or written language proficiency, including appropriate criteria for ensuring the proficiency. Qualified bilingual staff must have demonstrated: a. Proficiency in speaking and understanding both spoken English and at least one other spoken language, including any necessary specialized vocabulary, terminology, and phraseology. b. Ability to effectively, accurately, and impartially communicate directly with Limited English Proficiency Members in their preferred language. 3. Plan maintains a current list of assessed and qualified bilingual employees, who communicate directly with members, including the following information at minimum, name, position, department, language, level of proficiency.	
Civil Rights Act of 1964, Title VI Code of California Regulations (CCR), Title 28, §1300.67.04(d)(9) DHCS Agreement Exhibit A, Attachment 6(11)(B)(2) & Attachment 18 (6)(K) DHCS Policy Letter 98-12 Federal Guidelines: OMH CLAS Standards, Standard 7	**Linguistic Capabilities of Provider Network** 1. Plan has approved policies and procedures related to identifying and monitoring language capabilities of providers and provider staff ensuring provider network is reflective of membership demographics. 2. Plan lists language spoken by providers and provider staff in the provider directory. 3. Plan updates language spoken by providers and provider staff in the provider directory. Plan annually assesses the provider network language capabilities to meet the members' needs.	
California Health and Safety Code, §1367.04(b)(1)(A)-(C) Civil Rights Act of 1964, Title VI Code of California	**Access to Written Member Informing Materials in Threshold Languages & Alternative Formats** 1. Plan has approved policies and procedures documenting the process to: a. Translate Written Member Informing Materials, including the non-template	

Standard	Delegated Activities	Retained by L.A. Care
Regulations (CCR), Title 22, §53876 (a)(2)&(3) CCR, Title 28, §1300.67.04, (b)(7), (c)(2)(F) & (e)(2)(i)-(ii) Code of Federal Regulations (CFR), Title28, §35.160-25.164 CFR, Title 45 §92.4 & §92.8 DHCS Agreement, Exhibit A, Attachment 9(14)(B)(2), (14)(C), Attachment 13(4)(C) DHCS All Plan Letter 21-011 DHCS All Plan Letter 21-004 DHCS All Plan Letter 22-002 Federal Guidelines: OMH CLAS Standards, Standard 5- 8	individualized verbiage in Notice of Action (NOA) letters, accurately using a qualified translator in all Los Angeles County threshold languages and alternative formats (large print 20pt, audio, Braille, accessible data) according to the required timelines. b. Track member's standing requests for Written Member Informing Materials in their preferred threshold language and alternative format. c. Submit newly captured members' alternative format selection data directly to the DHCS Alternate Format website. d. Distribute fully translated Written Member Informing Materials in their identified Los Angeles County threshold language and alternative format to members on a routine basis based on the standing requests and DHCS alternative format selection (AFS) data. e. Attach the appropriate non-discrimination notice and translated tagline (a written language assistance notice) in English and 18 non-English required by DHCS to Member Informing Materials. Threshold Languages for Los Angeles County: English, Spanish, Arabic, Armenian, Chinese, Farsi, Khmer, Korean, Russian, Tagalog, and Vietnamese. Taglines (Language assistance notice) Languages: English, Spanish, Arabic, Armenian, Chinese, Farsi, Khmer, Korean, Russian, Tagalog, Vietnamese, Hindi, Hmong, Japanese, Lao, Mien, Punjabi, Thai and Ukrainian. 2. Plan has a sound method to ensure qualifications of translators and quality of translated Written Member Informing Materials. Qualified translators must have demonstrated: a. Adherence to generally accepted translator ethics principles, including client confidentiality to protect the privacy and independence of LEP Members.	

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

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

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

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

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

Exhibit 8
NCQA Delegation Agreement
[Attachment B]

Plan's Reporting Requirements

Report	Due Date	Submit To	Required Format
QUALITY IMPROVEMENT			
NET 1A **Cultural Needs and Preferences Assessment** **NET 1B** Practitioners Providing Primary Care **NET 1C** Practitioners Providing Specialty Care **NET 1D** Practitioners Providing Behavioral Healthcare	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
NET 2A **Access to Primary Care** **NET 2B** Access to Behavioral Healthcare **NET 2C** Access to Specialty Care	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
NET 3A Assessment of Member Experience Accessing the Network **NET 3B** Opportunities to Improve Access to Nonbehavioral Healthcare Services **NET 3C** Opportunities to Improve Access to Behavioral Healthcare Services	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
ME 7C Element C: Annual Assessment of Nonbehavioral Healthcare Complaints and Appeals **ME 7E** Element E: Annual Assessment of Behavioral Healthcare and Services	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Member Services/	Compliant with NCQA in accordance to Plan's accreditation submission

ME 7F Element F: Behavioral Healthcare Opportunities for Improvement			
QI 2A Practitioner Contracts	Annually during PP audit	home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
QI 3 A Identifying Opportunities **QI 3B** Acting on Opportunities **QI 3C** Measuring Effectiveness **1.**	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Quality Improvement/	Annual data collection analysis that identifies and acts on opportunities for improvement for Continuity of Care as outlined by NCQA guidelines for Continuity Coordination of Care of Medical Care and Continuity and Coordination Between Medical Care and Behavioral HealthCare
QI 4A Data Collection **QI 4B** Collaborative Activities **QI 4C** Measuring Effectiveness	Annually during PP audit	home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
QI 5A **Sub-Delegation Agreement** **QI 5B** Sub- Delegation Predelegation Evaluation **QI 5C** Sub-Delegation Review of QI Program **QI 5D** **Sub-Delegation** Opportunities for Improvement	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
<u>Quality Improvement Quarterly Reporting Requirements</u> 1. **Clinical Strategic Goals (CSG)** with MCAS Measures for L.A Care Medical Members ONLY: 2. **Potential Quality of Care Issues (PQIs)** a. Number of PQIs b. Number of closed PQIs	Quarterly Clinical Strategic Goals 1st Qtr – Jun 30 2nd Qtr – Sep 30 3rd Qtr – Dec 30 4th Qtr – Mar 30 **Quarterly PQI Report**	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Quality Improvement/	Acceptable formats: • Clinical Strategic Goals (CSG) Report with L.A. Care member rates included.

c. Number of closed PQIs within 6 months	1st Qtr – April 25 2nd Qtr – July 25 3rd Qtr – Oct 25 4th Qtr – Jan 25		• Potential Quality of Care Issues (PQIs)
Critical Incidents Tracking Log **1. Critical Incident Tracking Log** **Naming convention:** *YYYY Q# LA Care CI Tracking Report* **Description:** Includes a tracking log of critical incidents specific to each member. - Abuse - Neglect - Exploitation - Disappearance/Missing Member - Suicide Attempt - Unexpected Death - A Serious Life Threatening Medical Event that requires immediate emergency evaluation by a Medical Professional - Restraints or seclusion - Other **2.Critical Incident Report in DHCS required format** - Number of LTSS users - Number of Critical Incidents Filed - Number of Critical Incidents Filed with Grievances Previously Filed - Number of Critical Incidents Filed with Appeals Previously Filed Kaiser shall keep track of all Critical Incidents and ensure appropriate reporting and resolution of the incidents in a timely fashion.	**Quarterly** 1st Qtr. – April 15 2nd Qtr. – July 15 3rd Qtr. – Oct 15 4th Qtr. – Jan 15	L.A. Care Critical Incident inbox CI@lacare.org	1. The Critical Incident Tracking Log with Health Plan Report Format, which includes but not limited to member information, specific information about the incident (date, time, location, entity/person involved in the incident, etc.) 2. Quarterly Critical Incident Report with DHCS required format
Quality Improvement Annual reporting requirements 1. **QI 1A:** QM Program Description 2. **QI 1C:** QM Program Evaluation 3. QI Workplan 4. PHM Work plan (if the activities are not included in the annual QI Workplan)	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Quality Improvement/	Acceptable formats: • Quarterly
ME 1B: Distribution of Member Rights & Responsibilities Statement 1. KP will randomly select 20 providers for each Reporting period and will complete the New Provider Training Tracking Sheet for the selected physicians each Reporting period.	Semi-Annually: **Jan 15th (Reporting period Q3 & Q4)** **July 15th (Reporting period Q1 & Q2)** KP to submit the New Provider Training	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Quality Improvement/	New Provider Training Tracking Sheet (KP document)

	Tracking Sheet to LA Care		ME 1B_Distribution of Rights Statement
PHM 1A Strategy Description **PHM 1B** Informing Members	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
PHM 2A Data Integration **PHM 2B** Population Assessment **PHM 2C** Activities and Resources **PHM 2D** Segmentation	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
PHM 3 A Practitioner or Provider Support	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
PHM 6A Measuring Effectiveness **PHM 6B** Improvement and Action	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
PHM 7A Sub-Delegation Agreement **PHM 7B** Sub-Delegate Pre-Delegation Agreement **PHM 7C** Sub-Delegate Review of PHM Program **PHM 7D** Opportunities for Improvement	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
Title 28 California Code of Regulations Section 1300.67.2.2		L.A. Care's Secure File Transfer Protocol (SFTP)	Mutually agreed upon format

California Health and Safety Code Section 1348.8 **Assessment of Nurse Advice Line** 1. Nurse Advice Line monitoring for: a. Telephone statistics at least quarterly • Average speed of answer within 30 minutes ~~(goal)~~ 2. Annual analysis of Nurse Advice Line statistics (website, telephone, use, and calls), identify opportunities and establish priorities for improvement.	1. Quarterly 1st Qtr – April 25 2nd Qtr – July 25 3rd Qtr – Oct 25 4th Qtr – Jan 25 2. Annually during PP Audit	home/ukais-cr/infile/Health Education/ Plan will also have the option to submit via email to remain compliant with due date.	
HEDIS Performance Benchmark A PDSA tool will be required when the plan does not meet the 50th percentile for the Managed Care Accountability Set and the 50th percentile for the Medicaid NCQA Accreditation Measures as established by both regulatory entities.	Annually during PP Audit. The PDSA tool is due 90 calendar days after final validated HEDIS results are available.	L.A. Care's Secure File Transfer Protocol (SFTP)/ home/ukais-cr/infile/Quality Improvement/ Plan will also have the option to submit via email to remain compliant	The PDSA tool provided by DHCS or L.A. Care
UTILIZATION MANAGEMENT			
Service Authorizations and Utilization Review			
UM 1 1. UM Program Description 2. UM Program Evaluation 3. UM Program Work Plan	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Clinical_Assurance/	1. Narrative 2. ICE Quarterly Reporting format 3. ICE Quarterly Format
Quarterly UM Activity Report **All elements outlined within L.A. Care Quarterly UM Activity (ICE) report including but not limited to:** 1. UM Summary – Inpatient Activity a. Average monthly membership b. Acute Admissions/K c. Acute Bed days/K d. Acute LOS e. Acute Readmits/K f. SNF Admissions/K g. SNF Bed days/K 2. SNF LOS a) SNF Readmits/K 3. UM Activities Summary a) Referral Management Tracking of the number of Approvals/Modifications/Denials/ Deferrals (Routine/Urgent)	Quarterly 1st Qtr –May 31 2nd Qtr – Aug 31 3rd Qtr – Nov 30 4th Qtr – Feb 28	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Clinical_Assurance/	ICE Quarterly Reporting Format

b) Referral Denial Rate c) Appeals/K d) Overturn Rate 2. **PHM 5:** CCM Complex Case Management CM Reports and Statistics			
NET 4B: Continued Access to Care 1. Continued Access to Practitioners If a practitioner's contract is discontinued, the organization allows affected members continued access to the practitioner, as follows: a. Continuation of treatment through the current period of active treatment for members undergoing active treatment for a chronic or acute medical condition b. Continuation of care through the postpartum period for members in their second or third trimester of pregnancy	Quarterly 1st Qtr – May 31 2nd Qtr – Aug 31 3rd Qtr – Nov 30 4th Qtr – Feb 28	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Clinical_Assurance/	L.A. Care Quarterly Reporting Format
Medi-Cal Provider Preventable Reportable Conditions	Monthly 15th of Each Month	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Clinical_Assurance/	Acceptable formats: DHCS Required Reporting Format
QI 3D: Transition to Other Care—member transition to other care, a. When their benefits end.	Quarterly 1st Qtr – May 31 2nd Qtr – Aug 31 3rd Qtr – Nov 30 4th Qtr – Feb 28	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Clinical_Assurance/	L.A. Care TOC Reporting Format
CREDENTIALING			
1. Initial Credentialed practitioner list containing Credentialing Date, Last Name, First Name, MI, Title, Address, City, State, Zip, Group Name. 2. Re-credentialed practitioner list containing Re-credentialing Date, Last Name, First Name, MI, Title, Address, City, State, Zip, Group Name. 3. Voluntary Practitioner Termination list containing Termination Date, Last Name, First Name, MI, Title, Address, City, State, Zip, Group Name. 4. Involuntary Practitioner Termination list containing Termination Date, Last Name, First Name, MI, Title, Address, City, State, Zip, Group Name	Quarterly 1st Qtr – May 15 2nd Qtr – Aug 15 3rd Qtr – Nov 15 4th Qtr – Feb 15	credinfo@lacare.org	Current L.A. Care Health Plan Delegated Credentialing Quarterly Credentialing Submission Form (ICE Format)
COMPLIANCE			

1. 274 EDI File Mandated by APL 16-019	Monthly – Due to L.A. Care by the 4th of each month	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Regulatory Reports/	DHCS required formatting.
2. Data Certification Statements Mandated by APL 17-005	Monthly – Due to L.A. Care 3 business days prior to submission to DHCS	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Regulatory Reports/	Word Document, Non-specific template. Utilize own template; however, all state reports submitted to L.A. Care within the month MUST be listed and CEO MUST sign off attesting to ALL data submissions.
3. Non-Medical Transportation & Non-Emergency Medical Transportation (NMT-NEMT) Report Mandated by APL 17-010	Monthly - Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Regulatory Reports/	DHCS approved template
4. Health Industry Collaboration Effort AB1455 Quarterly Reports a. M/Q Medi-Cal Claims Timeliness Report b. Quarterly 5 Provider Dispute Resolution (PDR) Report 5. c) Disclosure of Emerging Claims Payment Deficiencies (DoECPD)	Quarterly – Due to L.A. Care within specified deadline set by L.A. Care	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/ AB1455	HICE approved templates
6. Call Center Report	Quarterly – Due to L.A. care 30 days after the end of each quarter of the calendar year. When due date falls on the weekend (Sunday or Saturday, data must be submitted by COB on the Friday before the due date. • Q1 – January, February, and March • Q2 – April, May, and June • Q3 – July, August, and September Q4 – October, November, and December	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Regulatory Reports/	Format as specified by L.A. Care

7. Community Based Adult Services (CBAS) Report	Quarterly - Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Regulatory Reports/	DHCS approved templates
8. Medi-Cal Managed Long-Term Services & Supports (MLTSS) Report Mandated by APL 14-010	Quarterly - Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Regulatory Reports/	DHCS approved templates
9. Medi-Cal Managed Care Survey – Disproportionate State Hospitals (MMCS-DSH) Survey	Annually - Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Regulatory Reports/	DHCS approved templates
10. Enhanced Care Management DHCS Required Reporting	Quarterly, according to schedule in DHCS template -Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care Regulatory / Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Regulatory Reports	DHCS approved template, plus attestation of data and brief written summary of oversight and monitoring activity for the reporting period
11. Community Supports DHCS Required Reporting	Quarterly, according to schedule in DHCS template -Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care Regulatory / Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Regulatory Reports	DHCS approved template, plus attestation of data and brief written summary of oversight and monitoring activity for the reporting period
12. CBAS Monthly Wavier Report	Monthly -Due to L.A. Care on the specified dates stated below: January 5 February 3 March 2 April 2 May 3 June 2 July 2 August 3 September 2	L.A. Care Regulatory / Secure File Transfer Protocol (SFTP) home/ ukais-cr /infile/Regulatory Reports	DHCS approved template

	October 4 November 2 December 2		
13. Prop 56 Directed Payment for Physician Services (APL 19-015)	Quarterly-Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care Regulatory / Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Regulatory Reports/	DHCS approved template
14. Prop 56 Hyde Reimbursement Requirements for specific Services (APL 19-013)	Quarterly-Due to L.A. Care 7 business days prior to submission to DHCS	LA Care Regulatory/Secure File Transfer Protocol (sFTP) home/ ukais-cr /infile/Regulatory	Regulatory Reports provided Template based on APL reporting requirements
15. Prop 56 Directed Payments for Developmental Screening Services (APL 19-016)	Quarterly-Due to L.A. Care 7 business days prior to submission to DHCS	LA Care Regulatory/Secure File Transfer Protocol (sFTP) home/ ukais-cr infile/Regulatory	Regulatory Reports provided Template based on APL reporting requirements
16. Prop 56 Directed Payments for Family Planning (APL 20-013)	Quarterly-Due to L.A. Care 7 business days prior to submission to DHCS	LA Care Regulatory/Secure File Transfer Protocol (sFTP) home/ ukais-cr /infile/Regulatory	Regulatory Reports provided Template based on APL reporting requirements
17. Prop 56 Directed Payment for Adverse Childhood Experiences Screening Services (AP-19-018)	Quarterly-Due to L.A. Care 7 business days prior to submission to DHCS	LA Care Regulatory/Secure File Transfer Protocol (sFTP) home/ ukais-cr /infile/Regulatory	Regulatory Reports provided Template based on APL reporting requirements
18. Third Party Liability (TPL) (APL 19-018)	15 days from the date LA Care submits case file.	L.A. Care via its Secure File Transfer Protocol (SFTP) – home/ ukais-cr /infile/Regulatory Reports/	DHCS approved templates
19. MCPD and PCPA Managed Care Program Date (MCPD) and Primary Care Provider Alignment (PCPA) The Managed Care Program Data (MCPD) report is a consolidated reporting	Monthly - Due to L.A. Care every 4th day of the month	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Regulatory Reports/	Regulatory Reports provided Template based on APL reporting requirements

requirement which DHCS introduced through APL 20-017. The MCPD file replaces the following reporting requirements, as this data is now incorporated into the MCPD file in .json format: • Grievances and appeals data in an Excel template, as specified in APL 14-013 ***(previously submitted by your plan as the Grievance Report Mandated by APL 14-013)*** • Monthly MERs and other continuity of care records data in an Excel template, as specified in Attachment B of APL 17-007 ***(previously submitted by your plan as the MMDR Report)*** • Other types of continuity of care data in ad-hoc Excel templates • Out-of-Network request data in a variety of ad-hoc Excel templates ***(previously submitted by your plan as the OON Report)***			
20. New and or revised reports as released by DHCS	Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Regulatory Reports/	DHCS approved templates
21. Disaster and Recovery Plan Disaster Recovery Test Results L.A. Care will request all elements outlined below including but not limited to: 1. LA Care may require additional information on Business Continuity efforts based off current event. In the event there are any additional requests from regulators for individual instances, such as, an emergency declared by the governor; L.A. Care will send out an ad hoc written request asking to respond with the requested information should it be an element outside of what is already being requested and another mobile contact	Annually during PP audit and ad-hoc; Ad-Hoc	L.A. Care's Secure File Transfer Protocol (SFTP) EnterpriseRiskManagement@lacare.org home/ukais-cr/infile/Regulatory Reports/ EnterpriseRiskManagement@lacare.org ;	Word Document, Non-Specific template Template may change upon regulators request.

mechanism when outside of regular business hours.		RegulatoryReports @lacare.org	
22. Supplemental Payments (American Indian Health, BHT, Maternity Kicks, LTCC)	Monthly by the 10th	L.A. Care Regulatory / (SFTP) home/ ukais-cr /infile/Regulatory Reports	Format as specified by L.A. Care
23. DMHC Pending/Unresolved Grievances	Quarterly Jan 23 Apr 23 July 23 Oct 23	L.A. Care Regulatory / (SFTP) home/ ukais-cr /infile/Regulatory Reports	Format as specified by L.A. Care
24. Grievance Volumes Report DMHC Title 28, CCR, Section 1300.68 (F)1	Quarterly Feb 8 May 8 Aug 8 Nov 8	L.A. Care Regulatory / (SFTP) home/ ukais-cr /infile/Regulatory Reports	Format as specified by L.A. Care
25. Quarterly Network Report (Terminations)	Quarterly Jan 23 Apr 23 July 23 Oct 23	L.A. Care Regulatory / (SFTP) home/ ukais-cr /infile/Regulatory Reports	Format as specified by L.A. Care
26. Major Organ Transplant	Quarterly Jan 23 Apr 23 July 23 Oct 23	L.A. Care Regulatory / (SFTP) home/ ukais-cr /infile/Regulatory Reports	
27. Encounter Data	Monthly, at a minimum	L.A. Care Regulatory / (SFTP) home/ ukais-cr /infile/Regulatory Reports	
28. Cost Avoidance & Post Payment (CAPP) Recovery Mandated by APL 21-002	Monthly – Due to L.A. Care 6th business day of every month	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports/	DHCS Approved Template

DELEGATION OVERSIGHT			
New Member Welcome Kit Mailing Reports	Quarterly Jan 15 April 15 July 15 October 15	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Delegation Oversight	Format as specified by L.A. Care
HEALTH EDUCATION			
Health Education Reports (Referrals, Material Distribution Report, Individual Encounters, Other Language Encounters)	Quarterly – Due to L.A. Care the 25th day of the month following the end of the quarter: • Q1 due 4/25 • Q2 due 7/25 • Q3 due 10/25 • Q4 due 1/25	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Health Education/	Format as specified by L.A. Care or as mutually agreed upon per Plan Partner process.
Health Education (Workplan and Program Description)	Annual Jan 31	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Health Education/	Format as specified by L.A. Care or as mutually agreed upon per Plan Partner process.
DMHC SURVEYS			
DMHC Timely Access and Network Reporting (TAR) a. Exhibit A-1 Timely Access Time-Elapsed Standards Policies and Procedures b. Exhibit A-2 Alternative Access Timely Access Time-Elapsed Standards Policies and Procedures (if applicable) c. Exhibit A-3 Oversight of Plan-to-Plan Contracts Policy and Procedures d. Exhibit B-1 Quality Assurance Monitoring related to Time-Elapsed Standards Policies and Procedures e. Exhibit B-2 Quality Assurance Monitoring related to All Other Time-Elapsed Standards Policies and Procedures f. Exhibit C-1 Contact List Report Forms for each Provider Survey Type g. Exhibit C-2 Raw Data Report Forms for each applicable Provider Survey Type h. Exhibit C-3 Results Report Form	Annually April 17, 2023	L.A. Care's Secure File Transfer Protocol (SFTP) /ukais/infile/compliance	

i. Exhibit D-1 Non-Compliance Policies and Procedures j. Exhibit D-2 Incidents of Non-Compliance Resulting in Substantial Harm to an Enrollee k. Exhibit D-3 Patterns of Non-Compliance l. Exhibit D-4 Prior Incidents or Patterns of Non-Compliance not Previously Submitted m. Exhibit E-1 Policies and Procedures for Advanced Access Program n. Exhibit F-1 Triage o. Exhibit F-2 Telemedicine p. Exhibit F-3 Health I.T. q. Exhibit G-1 Provider Satisfaction Survey Methodology r. Exhibit G-2 Provider Satisfaction Survey Results s. Exhibit G-3 Enrollee Satisfaction Survey Methodology t. Exhibit G-4 Enrollee Satisfaction Survey Results u. Exhibit H-1 Quality Assurance Report v. APNR Form PCP w. APNR Form Specialists x. APNR Form Mental Health y. APNR Form Hospitals and Clinics z. APNR Form Other Outpatient Provider aa. APNR Form Greivances			
DMHC Financial Statement	Quarterly Feb 15 May 15 Aug 15 Nov 15	FTP	DMHC Template
CULTURAL AND LINGUISTC SERVICES			
C&L Program Description and Work Plan	Annually – due to L.A. Care January 31st of each year	L.A. Care's Secure File Transfer Protocol (SFTP) *OR* Via email to CL_Reports_Mailbox@lacare.org	Plan Partner can submit their own format of C&L PD and work Plan. Requirement is in reference to Policy and Procedure CL-008 and C&L Program Description delegated Subcontractor

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

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

[Signature block appears on the following page]

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

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

By: _____
John Baackes
Chief Executive Officer

Date: _____, 2023

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

Date: _____, 2023

Kaiser Foundation Health Plan
A California health care services plan

By: _____
Marcus J. Hoffman
Senior Vice President, Chief Financial Officer, Southern California and Hawai'i Market

Date: _____, 2023

Board of Governors
MOTION SUMMARY

Date: December 7, 2023 **Motion No. BOG 104.1223**

Committee: **Chairperson: Al Ballesteros**

Issue: Request to delegate authority to negotiate and execute L.A. Care's 2024 Medi-Cal contract (contract number 23-30232 (Primary)) with the Department of Health Care Services (DHCS). *The Contract document is too large to include in the meeting materials and for those with access to the internet, a copy can be accessed here* 2024 DHCS Contract *until December 30. It can also be obtained by contacting Board Services.*

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

Background: L.A. Care received the draft version of the 2024 Medi-Cal contract from DHCS on July 7, 2023; all relevant business units reviewed and approved or were deemed to have approved the terms in the draft version. This final version of the contract has been revised to include contract requirements from prior amendments for calendar years 2021, 2022, and 2023, which the MCPs have previously executed. The Plan received the final version of the 2024 Medi-Cal contract on November 1, 2023, along with a list of changes which all relevant business units reviewed and approved or were deemed to have approved. Note that Contract 23-30232 replaces Contract 04-36069 which expires effective December 31, 2023.

The 2024 Medi-Cal contract was developed following the issuance of the Medi-Cal Managed Care request for proposal (RFP) for commercial plans which was released on February 9, 2022. The RFP included new managed care contract requirements for all Medi-Cal plans which were to be implemented as of January 1, 2024. In June 2022, DHCS kicked off an operational readiness assessment for Medi-Cal managed care plans. On September 1, 2023, DHCS approved L.A. Care to go live effective January 1, 2024.

The 2024 Medi-Cal contract integrates CalAIM requirements (including Enhanced Care Management and Population Health Management), and there is a strong focus on oversight, training, and monitoring of delegated entities. The contract also contains more specific requirements including, but not limited to, the following: Structure and duties of Community Advisory Committees; Memorandum of Understanding (MOU)/agreements with third parties (DHCS is providing plans with MOU templates and guidance); Quality improvement and health equity activities, including NCQA health equity accreditation; and Emergency preparedness and response.

The due date for submission of the executed amendment to DHCS is December 12, 2023.

Member Impact: Member impact has been and continues to be assessed by relevant business units.

Budget Impact: Finance has been reviewing for impact on relevant budgets.

Motion: **To delegate authority to L.A. Care Chief Executive Officer, John Baackes, to negotiate and execute the 2024 Medi-Cal Contract 23-30232, between L.A. Care Health Plan and the California Department of Health Care Services.**

2024 Medi-Cal Managed Care Contract

Overview & Motion

Phinney Ahn, MPH

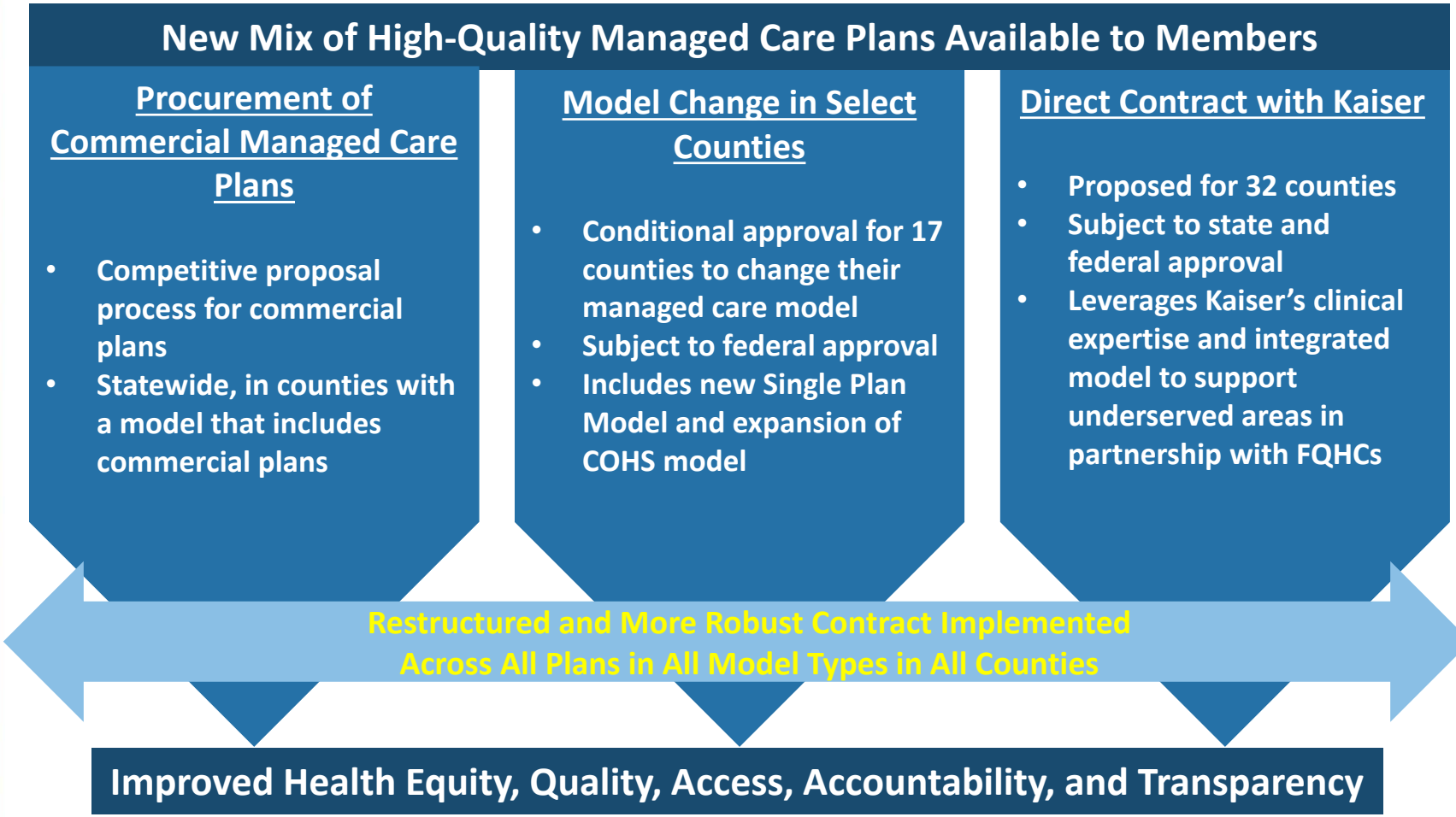
Medi-Cal Product Management

December 2023

Introduction

- Today's presentation will include:
  - Highlights of changes in the new 2024 Medi-Cal managed care contract
  - Motion to request delegated authority to execute contract with DHCS for 2024 Medi-Cal Contract 23-30232

DHCS: Transforming Medi-Cal Managed Care Through Multiple Channels



**Slide adapted from DHCS webinar on Medi-Cal Managed Care Procurement – 2/15/22*

New 2024 Contract Requirements - Overview

- **Will amplify ongoing investments in DHCS' vision/priorities for Medi-Cal**
  - CalAIM
  - Medi-Cal Expansion for All
  - Children and Youth Behavioral Health Initiative
  - Behavioral Health Continuum Infrastructure Program
  - Home and Community-Based Services Spending Plan
  - New Benefits to Support Culturally Competent Services
  - Comprehensive Quality Strategy & Equity Roadmap

- **Major Themes**
  - Transparency
  - High-Quality Care
  - Access to Care & Continuum of Care
  - Coordinated & Integrated Care
  - Increasing Health Equity & Reducing Disparities
  - Addressing SDOH
  - Local Presence & Engagement
  - Enhanced Children's Services
  - Behavioral Health Services Expansion
  - Accountability, Compliance & Administrative Efficiency
  - Emergency Preparedness & Essential Services
  - Value-Based Payment

Highlights of 2024 Contract Changes

- Increased references to plan's accountability for oversight, training, and monitoring of delegated entities
  - Newly defined terms to include subcontractor, downstream subcontractor, fully-delegated subcontractor, and partially-delegated subcontractor
  - More plan transparency to include posting of content on website (e.g., compliance program, CAPs, QI/health equity activities, selected P&Ps, delegation model)
- Inclusion of CalAIM requirements (e.g., ECM, CS, PHM)
- Community Reinvestment Plan for plan and delegates
- Development of a detailed delegation reporting and compliance plan
- More specific requirements for:
  - MOUs with third parties
  - Structure and duties of Community Advisory Committees
  - Quality and health equity activities including NCQA health equity accreditation
  - Emergency preparedness planning

Motion

- L.A. Care is requesting delegated authority for the CEO to negotiate and execute the 2024 Medi-Cal Contract 23-30232 between L.A. Care and DHCS
  - Term – 1/1/24 – 12/31/24
  - Financial Impact – There is no revenue associated with this contract
  - Scope – Agree to the terms and conditions outlined in the 2024 Medi-Cal managed care contract

2024 BOARD OFFICER ELECTIONS

Date: December 7, 2023

To: Board of Governors

From: Board Services

Subject: Nominations for 2024 Officers

Nominations for 2024 Officers were received and below is a summary. (Individuals who declined the nomination are not shown.)

Chairperson	Vice Chairperson	Treasurer	Secretary
Ballesteros Booth	Booth Gonzalez Shapiro	Booth Raffoul	Raffoul Vazquez

The process can be conducted for each office separately or for a slate of officers:

1. Chairperson appoints a Presider (who is not a candidate) for the election process.
2. Presider asks for any more nominations.
3. Presider asks for a motion to close nominations and a vote.
4. Announce the number of affirmative votes required for election (50% of members present and voting + 1 vote).
5. As appropriate, the Presider can ask for a motion or any Board member can make a motion to:
    a. Elect a proposed slate, the Presider then calls for a motion to elect the proposed slate, or
    b. Elect each officer separately, the Presider then calls for a motion for each officer.
6. If there are Board Members participating remotely, all votes shall be conducted by roll call.
7. Presider announces the winner for each officer position.

TEMPORARY TRANSITIONAL EXECUTIVE COMMUNITY ADVISORY

Board of Governors

Executive Community Advisory Committee

Meeting Minutes – September 13, 2023

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

1st

L.A. Care HEALTH PLAN

ECAC Members	RCAC Members/Public	L.A. Care Board of Governors/Senior Staff
Roger Rabaja, RCAC 1 Chair	Izmir Coello, Interpreter	Hilda Pérez, Member, Board of Governors ***
Ana Rodriguez, RCAC 2 Chair	Isaac Ibarlucea, Interpreter	Layla Gonzalez, Advocate, Board of Governors
Lidia Parra, RCAC 3 Chair *	Eduardo Kogan, Interpreter	John Baackes, Chief Executive Office, L.A. Care
Silvia Poz, RCAC 4 Chair **	Alex Mendez, Interpreter	Alex Li, MD, Chief Health Equity Officer, L.A. Care ***
Maria Sanchez, RCAC 5 Chair	Estefanie Mendez, Interpreter	Tyonna Baker, Community Outreach Field Specialist, CO&E
Joyce Sales, RCAC 6 Chair	Andrew Yates, Interpreter	Idalia De La Torre, Field Specialist Supervisor, CO&E
Fátima Vázquez, RCAC 7 Chair, ECAC Chair	Deb Bowen, Closed Caption	Hilda Herrera, Community Outreach Field Specialist, CO&E
Ana Romo, RCAC 8 Chair **		Rudy Martinez, Safety & Security Program Manager III, Facilities Services0
Tonya Byrd, RCAC 9 Chair		Christopher Maghar, Community Outreach Field Specialist, CO&E
Damares O Hernández de Cordero, RCAC 10 Chair		Joshua Mendoza, Community Outreach Field Specialist, CO&E
Maria Angel Refugio, RCAC 11 Chair	Russel Mahler, Public	Linda Merkens, Senior Manager, Board Services
Lluvia Salazar, At-Large Member	Andria McFerson, Public ***	Frank Meza, Community Outreach Field Specialist, CO&E
Deaka McClain, At Large Member	Demetria Saffore, Public	Alison Patsy, Quality Improvement Project Manager, Quality Improvement Department ***
		Cindy Pozos, Community Outreach Field Specialist, CO&E
* Excused Absent ** Absent		Victor Rodriquez, Board Specialist, Board Services ***
*** Via teleconference		Martin Vicente, Community Outreach Field Specialist, CO&E

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
CALL TO ORDER	Members of the Temporary Transitional Executive Community Advisory Committee (TTECAC), L.A. Care staff, and the public can attend the meeting in-person at the address listed above. Public comment can be made live and in-person at the meeting. A form will be available to submit public comments. Accordingly, members of the public should join this meeting via teleconference as follows: https://us06web.zoom.us/j/88204459295	

Teleconference Call –In information/Site
Call-in number: 1-415-655-0002 Participants Access Code: 2483 725 0054 (English)
Call-in number: 1-415-655-0002 Participants Access Code: 2490 076 1317 (Spanish)

For those not attending the meeting in person, public comments on Agenda items can be submitted in writing by email to COEpubliccomments@lacare.org or by calling the CO&E toll- free line at 1-888-522-2732 and leaving a voicemail.
Attendees who log on to lacare.zoom using the URL above will be able to use "chat" during the meeting for public comment. You must be logged into Zoom to use the "chat" feature. The log in information is at the top of the meeting Agenda. This is a new function during the meeting so public comments can be made live and direct.

1. The "chat" will be available during the public comment periods before each item.
2. To use the "chat" during public comment periods, look at the bottom of your screen for the icon that has the word, "chat" on it.
3. Click on the chat icon. It will open a window.
4. Select "Everyone" in the to: window.
5. Type your public comment in the box.
6. When you hit the enter key, your message is sent and everyone can see it.
7. The chat message, text, voicemail, or email must indicate if you wish to be identified or remain anonymous, and must also include the name of the item to which your comment relates.
8. L.A. Care staff will read the chat messages for up to three minutes during public comment so people who are on the phone can hear the comment.

Your comments can also be sent by voicemail or email. If we receive your comments by 10:00 a.m. on September 13, 2023, it will be provided to the members of the Temporary Transitional Executive Community Advisory Committee at the beginning of the meeting. The chat message, voicemail, or email must indicate if you wish to be identified or remain anonymous, and must also include the name of the item to which your comment relates. Once the meeting has started, public comments should be submitted prior to the time the Chair announces public comments for each agenda item and staff will read those public comments for up to three (3) minutes. Chat messages submitted during the public comment period for each agenda item will be read for up to three (3) minutes. If your public comment agenda is not related to any of the agenda item topics, your public comment will be read for up to three (3) minutes at item IX Public Comments on the agenda.
Please note that there may be a delay in the digital transmittal of emails and voicemails. The Chair will announce when the public comment period is over for each item. If your public

	comments are not received on time for the specific agenda item you want to address, your public comments will be read at the public comment section of the agenda. The purpose of public comment is that it is an opportunity for members of the public to inform the governing body about their views. The Temporary Transitional Executive Community Advisory Committee appreciates hearing the input as it considers the business on the Agenda. The process for public comment is evolving and may change at future meetings. We thank you for your patience. All votes in a teleconferenced meeting shall be conducted by roll call. If you are an individual with a disability and need a reasonable modification or accommodation pursuant to the Americans with Disabilities Act please contact the Community Outreach & Engagement staff prior to the meeting for assistance by calling our toll-free line at 1-888-522-2732 or by email to COEpubliccomments@lacare.org. SB 1100 was signed by Governor in August 2022, and added a short section to the Brown Act as Govt Code Section 54957.95 to supplement language already part of the Brown Act : (a) In addition to authority exercised pursuant to Sections 54954.3 and 54957.9, the presiding member of the legislative body conducting a meeting may remove an individual for disrupting the meeting. (b) As used in this section, "disrupting" means engaging in behavior during a meeting of a legislative body that actually disrupts, disturbs, impedes, or renders infeasible the orderly conduct of the meeting and includes, but is not limited to, both of the following: (1) A failure to comply with reasonable and lawful regulations adopted by a legislative body pursuant to Section 54954.3 or 54957.9 or any other law. (2) Engaging in behavior that includes use of force or true threats of force. (54954.3 contains provisions related to public comment time restrictions, and 54957.9 allows the presider to clear the room if the meeting can't continue.) AGENDA and PRINTED MEETING MATERIALS ARE AVAILABLE FOR INSPECTION BEFORE THE MEETING AT L.A. Care's Offices at 1055 W. 7th Street, Los Angeles, CA 90017 through the Reception Area in the Building Lobby.	
APPROVE MEETING AGENDA	Member McClain stated that she would like the committee to know that she is amending the motion on the agenda today and it is reflecting properly on the agenda. **The Agenda for today's meeting was approved with the changes mentioned above.**	**Approved by roll call. 9 AYES (Byrd, Cordero, Rabaja, Refugio, Rodriguez, Sales, Sanchez, Vazquez, McClain)**

APPROVE MEETING MINUTES	**The May 10, 2023 and June 14, 2023 Minutes were approved as submitted.**	**Approved by roll call. 10 AYES (Byrd, Cordero, Rabaja, Refugio, Rodriguez, Salazar, Sales, Sanchez, Vazquez, McClain)**
STANDING ITEMS		
UPDATE FROM CHIEF EXECUTIVE OFFICER	John Baackes, *Chief Executive Officer*, reported on the redetermination process for Medi-Cal members in California. During the COVID-19 health emergency, redeterminations were suspended to ensure uninterrupted access to care. However, after the public health emergency ended in April, California initiated a 12-month process to redetermine eligibility for Medi-Cal beneficiaries. Notably, the state did not announce which beneficiaries would undergo redetermination each month, causing some uncertainty. So far, approximately 40% of beneficiaries had the redetermination done automatically using available data, some from other programs. Those automatic redetermination beneficiaries received a letter confirming eligibility for another year. The remaining beneficiaries received a 20-page form by mail, with the option to complete it online, by phone (with lengthy wait times), or at community resource centers with enroller assistance. Over the first three months of the process, nearly 700,000 individuals participated. About 120,000 did not complete the form, likely due to moving, ignoring it, or having incorrect address. These individuals have a 90-day grace period to complete the form and retain coverage. Outreach efforts are underway to contact them. After 90 days, those who have not completed the form will lose coverage and need to restart the application process. Despite the redetermination process, nearly 96,000 new members were enrolled over three months. The total net decrease in enrollment for L.A. Care during this period was only 24,000 out of 2.7 million, less than 1%. Interestingly, there have not been a significant volume of calls from individuals losing coverage, suggesting that many who didn't complete the form may have moved or experienced other changes in their circumstances. Mr. Baackes emphasized the importance of being informed about this process, as it may impact individuals in the community. He encouraged people to reach out with any questions or concerns. PUBLIC COMMENT **Submitted by Andria McFerson, RCAC 5 Member via chat:** *Madam Chair can I ask a question to Mr. John Baackus if we are allowed to vote or just mandate that we have RCAC meetings for the rest of the year and Will Francisco Oaxaca be investigated for any actions he made of harassment? Mr. Baackes I would like to suggest that the agenda be systematically planned so that those who may have a comment towards each topic (a, b,& c) can separately comment. RCAC's need have*	

	more input during the planning process so is there going to be anymore TTECAC or ECAC or RCAC meetings this year, and if so can it be more accessible for those who may have difficulty commenting on all items listed within 2 or 3 minutes? Can RCAC members help people find out about this redetermenation? Mr. Baackes stated that he cannot comment on an employee, because it is confidential. He stated that the listening sessions are considered RCAC meetings so he does not see a need for a resolution on that. He will ask Legal Services for a determination on that. He said that if RCAC members know of neighbors or family members that have questions about the redetermination process that they do not have the answers to, he asked that they be referred to L.A. Care. Member Byrd said she received a text from the Department of Public Social Services (DPSS) about her redeterminations and it has already been submitted. She asked how often should members submit a redetermination. Mr. Baackes responded that the redetermination is done once a year. Member Refugio asked about the people that help members with redetermination at L.A. Care Community Resource Centers. She asked if they are DPSS workers and if they are redetermined on the spot. Mr. Baackes responded that they are certified enrollers by the State and can help members complete the form. L.A. Care hired them to help members with the paperwork.	
L.A. CARE EQUITY STEERING COMMITTEE UPDATE • **Health Equity and Disparities Mitigation Plan**	Alex Li, *Chief Health Equity Officer*, gave a L.A. Care Equity Steering Committee Update. Part of L.A. Care's DNA (Mission) • Explicitly calling out and addressing "Health Equity and Disparities" - Statement of Principles on Social Justice and Systemic Racism (2020) • Established an Equity Steering Committee and three sub-committees: Members/Consumer Health Equity Council, 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 • Measure impact • Ensure compliance* • Many people have their own definitions of "health equity" or specific disparities that they focus or work on.	

- Target rich environment
- Changes and impact will take time

- Many disparities initiatives are not connected or coordinated.
  - Work needs to be synergistic and coordinated and not territorial; Can't do it alone!
  - Many L.A. Care Departments work on health equity:
- E.g. Community Resource Centers, Community Health, Community Benefits, Health Education, Quality Improvement etc.

- "Health Equity" requirements are written into L.A. Care's DHCS and Covered California contracts and for our future NCQA accreditation.
- CHEO for the health plans are not all physicians or have worked at a health plan.
  - Best to be familiar with the health plan resources and align with the mission
- 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, "Food as Medicine," closing technical/digital divide
  - Optimize health plan and community resources for our members and the community
- The What? (Focus Area)
  - Use a public health and community focus framework
  - Support and work with L.A. Care service areas and initiatives that impact health equity
  - Target and when possible work with programs that are sustainable
- 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 Equity Coordinator" when needed
- Example: Black Infant and Women's Health
  - Measure impact
  - Ensure Compliance

Health Equity Zone 1: Close racial and ethnic gaps in health outcomes among our member.

- Implement interventions to increase vaccination rates for children 2 and younger
- Implements initiatives to address health for Black birthing individuals and infants
- Strengthen provider network for unhoused community
- Expand physical and behavioral wellness programs for school age youth
- Address disparities for Black, Latino/Hispanic, AIAN communities with chronic disease

Health Equity Zone 2: Provide leadership and be an active ally for key community partners to promote health equity and social justice.

- Create partnerships and shared agendas with internal and external partners
- Promote gun violence education and prevention
- Explore and identify additional areas for advocacy
  - Community Health Investment Fund, Elevating the Safety Net
  - Medical Debt Relief
  - Community generated and drive improvements

Health Equity Zone 3: Ensure that our members have access to care and services that are free of bias and that our providers are supported in delivering equitable, culturally tailored care.

- Improve data collection and analysis
  - REaL and SOGI
- Strengthen SDOH data collection
- Promote patient and provider concordance
- Promote health equity through Provider Equity Award
- Health Equity in Appeals and Grievances and Utilization Management and other key health plan processes

Health Equity Zone 4: Serve as a model in supporting an equitable and inclusive work environment, as reflected in our workforce and business practices.

- DEI training plan
- Compliance for all regulatory, contractual, and accreditation health equity requirements
- Support diverse employees and allow equitable opportunity to advance and thrive
- Promote health equity through Provider Equity Award
- Provide employees with training and tools they need to provide bias-free services and care

PUBLIC COMMENT

Submitted by Elizabeth Cooper, RCAC 2 Member, via voicemail:

Elizabeth Cooper: Dr. Alex Li, I would like to make an inquiry: Who are the members of the equity council and how are they selected? What programs and services do they

	address? How will it affect RCAC members and how will RCAC members be considered to attend CHEC because I think it's needed. Ms. De La Torre responded that people that are interested must fill out an application. It is reviewed and selected depending on what demographic they represent. **Submitted by Andria McFerson, RCAC 5 Member, via email:** *During the BOG meeting, I also expressed the need for art classes with music for all ages as well, there are many people who have certain restrictions. So classes with incentives like the winner receiving an art kit or a gift card would be great as well as emotional support for seniors and children for example;* *- Art classes/contests of all ages with peer-on-peer support for* *• PTSD* *• Domestic Violence* *• Personal Violation victims of all ages* *• Developmentally Delayed* *• Mental Distressed/Illness* *• Seniors* *• Disabled (paraplegic, death, autistic, etc)* Dr. Li responded that those are great suggestions and programs, and there are organizations that are already doing that, like the Regional Centers that help children and adults with autism and disabilities. It is best to do these programs in partnership instead of doing it alone. He thanked her for her suggestions. **Submitted by Demetria Saffore, RCAC 4 Member:** *They have been having the same conversation for the last 19 years that she has been volunteer. She said they need to stop talking about and be about it and begin to address the problems. She doesn't think that they should tie race to health care. If the health plan just provided better services there wouldn't be any problems.* Member Byrd said that the system is broken. She hates the racial thing. She had no idea until the first African American program that African American women were being treated in health care. She has visited her doctor many times and he always made the same comment about her foot fungus. She stated that doctors aren't paid on time and patients suffer. Dr. Li said that he hears what she and Ms. Saffore are saying, race should not be tied to health care, but it is. The health care system is a business and is tied to money. People will make their choices based on economics. If they do not speak English, they may be poor or have other issues. Part of it is people and part of it is the system. Medi-Cal only pays 40 cents to the dollar compared to commercial Medi-Cal.	

BOARD MEMBERS REPORT	Ms. Gonzalez and Ms. Perez gave their Board Report. They warmly welcomed newly appointed Board member Fatima Vazquez to the Board. The Board of Governors held its annual retreat and meeting on September 7 at Valley Presbyterian Hospital. Approved meeting minutes can be obtained by contacting Board Services and meeting materials are available on L.A. Care's website. The list of motions approved at that board meeting can be obtained from CO&E. Ms. Gonzalez thanked the RCAC members that joined the Board Retreat in person or virtually. These members attended in person: 1. Deaka McClain (RCAC 9) 2. Damares O Hernandez de Cordero (RCAC 10) 3. Elizabeth Cooper (RCAC 2) 4. Andria McFerson (RCAC 5) The guest speaker was Dr. Naqi Khan, Physician Lead for Analytics & Machine Learning Amazon Web Services (AWS). Dr. Khan discussed the potential of artificial intelligence and machine learning in healthcare while emphasizing the importance of responsible and ethical use. He highlighted the need for transparency in AI systems, sharing data and models openly, and collaborating across diverse groups to ensure fairness and inclusivity. Dr. Khan also mentioned the challenges and risks associated with AI, such as biases and a generation of incorrect information, and called for vigilance in addressing these issues. He presented examples of both the positive impact of AI in healthcare like predictive interventions, and the negative consequences, such as bias in algorithms. Dr. Khan encouraged broader engagement and expanding the diversity of perspectives in AI development for healthcare. In his Chairperson's report, Mr. Ballesteros recognized Hilda Perez, Member Representative. The Board Retreat was her last Board meeting as a Board member. Since 2007, Hilda has served as a volunteer, RCAC 7 Chair, ECAC Chair, Health Promoter, Board Member, and on every Board committee. Hilda has been an important contributor to and voice for L.A. Care's Consumer Advisory Committees and L.A. Care members. While sharing her extensive knowledge and experience during this time, Hilda has significantly affected the unique way in which the Board listens to members' voices. Mr. Baackes gave a CEO Report. He gave an update earlier today. In his Chief Medical Officer Report, Dr. Amin discussed successful collaboration with state regulators to continue to improve transitions of care with more efficient processes. He highlighted efforts to ensure that valuable ideas are implemented rather than left unused, with specific initiatives related to patient care, skilled nursing facilities, and delegation oversight. He also spoke about improved communication and collaboration with the Hospital Association of Southern California and efforts to continue to systematically and effectively address grievances.	

	PUBLIC COMMENT **Submitted by Elizabeth Cooper, RCAC 2 Member, via voicemail:** *I would like more fairness concerning Hilda Perez and Layla Gonzalez for member issues. I do hope you will make sure that the new Consumer Board Member knows that she needs to represent all RCAC members not just some of the members.* **Submitted by Andria McFerson, RCAC 5 Member, via chat:** *Love Hilda and we'll miss you I appreciate Layla's follow-up. I have been speaking about the opportunity for the community to receive help with the internet for a long time and officially requesting it for over 2 years during ECAC & BOG. The first time was at an ECAC meeting in 2021, I never got a response. But, Layla forwarded me information about the CRCs now having classes, and my request was carried out. Chair allow me to tell Layla thank you for following up.* Member Salazar thanked Ms. Perez for her service on the Board and said that she will miss her very much. Member McClain thanked Ms. Perez for her encouragement to run in the Board Seat election and said that she will be missed at ECAC.	
MEMBER ISSUES	PUBLIC COMMENT **Submitted by Andria McFerson, RCAC 5 Member, via chat:** *Chair I want to let people know we are allowed to have RCAC meetings this month and throughout 2023 the state has not mandated anything for this year and these are recommendations only so for all ECAC chairs please officially state that we can have RCAC's for the rest of the year including this month. I think we would be more productive, we could also consist of a more diverse perspective and have an equal opportunity to speak if we then continued are RCAC meetings you all are allowed the right to do so, and a lot of budget money needs to be spent so even Dr. Li was saying he needed information from the community to come up with a feasible plan so why can't that be us? We have people of all races with different disparities let's work together and tell stories like my neighbor was given 6 months to live he needs many different medical apparatuses but he gave up because of discrimination he needs a wheelchair and oxygen tank but after calling LA Care 5 times waiting for 45 mins he has given up completely* **Submitted by Demetria Saffore, RCAC 4 Member:** *She said that L.A. Care needs to examine how it is giving care to members. She does not think it is acceptable for anyone to be told they can't see a cancer doctor for 9 months. She was referred back in October was not able to see a doctor until July 31 of this year. She was sent to Olive View knowing that they do not accept insurance. When*	

	she engages members services they try to lie to members about what is going on. They wanted her to file a grievance against her doctor, but it was actually L.A. Care. She told member services that she is recording the man changed his voice. She said to address disparities they have to look on the inside. It is not always going on on the outside. Member Byrd said that RCAC 9 Khmer speaking members have expressed frustration in the translation of materials and are asking to seek another vendor. Translation does not make sense to the member. Members have expressed that having accurate information is vital especially in trying to understand the restructure. It is embarrassing to recruit new Cambodian members with these materials. They have discussed this with C&L and there have been no changes. Member Byrd said that she is speechless and the people being paid to translate documents are not doing their job. This has been going on for over a year. Ms. De La Torre responded that CO&E has been made aware of the issue. They will be having a meeting in regard to translation of documents. Khmer speaking members have been invited to the meeting to address the issue. She encouraged Member Byrd to speak to those members after their meeting.	
OLD BUSINESS		
DIABETES AWARENESS AND INTERVENTION UPDATE	Alison Patsy, *Quality Improvement Project Manager, Quality Improvement Department,* gave a presentation about Diabetes Awareness & Prevention *(a copy of the presentation can be obtained from CO&E.)* Objectives • Discuss L.A. Care's Diabetes Intervention objectives and barriers. • Update the committee on Diabetes Interventions. • Ask the committees advice for other ways to encourage and empower members to manage their diabetes. • Empowering diabetes patients to take control of their health outcome: - Understanding diabetes and diabetes treatment through health education. - Healthy eating, being physically active - Taking medication - Checking blood sugar (self-monitoring) - Regular visits to the doctor for diabetic screenings - Participate in Diabetes Self-Management Education and support programs Barriers in Managing Diabetes • Lack of provider-patient engagement • Medication adherence • Lifestyle changes • Negative emotions about diabetes	

	• Lack of social support L.A. Care does the following to encourage members to visit their doctor regularly and manage their diabetes: • California Right Meds Collaborative (CRMC) • IVR Calls • Text-Message Campaigns • L.A. Cares About Diabetes® Program Member Letters • Diabetes Magnet Mailer PUBLIC COMMENT **Submitted by Elizabeth Cooper, RCAC 2 Member, via voicemail:** *I ask to be considered to be part of that but I got no response. There should be more opportunities for RCAC members to be part of the diabetes awareness and intervention. Members should be considered to join the Diabetes Awareness and Intervention Update* Ms. Patsy stated that she will take note of that and it will be considered. Ms. Gonzalez thanked Ms. Patsy for being patient. She noted that she asked for other ideas in regards to managing diabetes. She thinks it should be open to more members and not just 30. She asked if she has been able to speak to the community resource centers, because it is also about all the exercise that someone can get in order to manage diabetes and noted that the community resource centers officer exercise classes. She suggested to incentivize members to go into the resource centers. Ms. Perez noted that L.A. Care conducts outbound calls regarding getting exams. She said that some members like it and others don't. She suggested using phone calls to remind members and providing education to make doctor visits more effective.	
NEW BUSINESS		
TTECAC CHAIR/VICE-CHAIR NOMINATION AND ELECTION PROCESS	Ms. De La Torre reported that a nomination process is underway for the chair and vice chair positions of the Temporary Transitional Executive Committee Advisory Committee. This committee was established during the transition of the rack and the implementation of a new structure in preparation for the reconvening of the RCACs. In this process, chairs who were continuing their roles or at-large members with existing posts will retain their positions. However, chairs who were no longer representing their regions and did not have a vice chair have the opportunity to nominate someone for these positions. The nominations are open to all committee members. The temporary chair and vice chair will serve until June, and detailed information about the nomination process can be found in a provided letter. Members can either self-nominate or nominate someone from the list of committee members. Ms. De La Torre encouraged members to submit their nominations	

	by the end of the meeting, or they could contact her before October 6 if they needed more time. The actual elections for these positions will take place at the next committee meeting in October. PUBLIC COMMENT **Submitted by Andria McFerson, RCAC 5 Member, via chat:** *Please excuse all comments I officially make during this meeting because I didn't physically receive the agenda at home yet so I'm trying to go online on 2 phones at the same time while still commenting within the proper amount of time. Now we need to Please allow there to be an official RCAC meeting to vote on the election for TTECAC meeting Chair and Vice-Chair first this would honor the agreement we made as stakeholders and the Browne act and Robert's rule of order* **Submitted by Elizabeth Cooper, RCAC 2 Member, via voicemail:** *I am concerned about the election process and fairness. I am concerned that the new Chair will make sure will just represent her own RCAC and not all RCAC members.* Ms. Perez stated that community members will be the only ones with voting privileges in a discussion regarding an unspecified topic. She thanked Ms. De La Torre for providing information and raised a question related to changes in chair assignments for RCAC meetings. She mentioned that some chairs had been reassigned to other RCAC meetings due to address changes or no longer representing other areas' interests. Ms. Perez explained that the process of having members select their chair to represent a specific RCAC occurred because there were no official RCAC meetings and no way to conduct official nominations for that particular RCAC. Ms. De La Torre responded to clarify the process regarding RCAC chairs who were no longer representing their regions. In cases where the chair was no longer in the region, and there was a vice chair available, the vice chair was given the opportunity to take their place at the table. For RACs that didn't have a vice chair and experienced changes due to members moving out of the RCAC area, information was sent to the committee about the process that would be implemented and recommendations provided. Ms. De La Torre explained that the reason for the process was due to the temporary transitional nature of the committee. She noted that although the current chairs couldn't vote due to these changes, the committee would eventually vote when it was at full membership, allowing them to select their chair and vice chair to represent them at the ECAC (Executive Committee Advisory Committee).	
PRESENT A MOTION TO TTECAC	Member McClain presented the following motion to ECAC: ***Motion: For L.A Care to allocate funds yearly for exam tables to assist providers in serving seniors and the disables populations. A request is made to provide a report on***	

	how previous funding was distributed and if the motion passes, an annual report is requested on the distribution of funds. Member McClain commented on the importance of providing examination tables accessible for seniors and individuals with disabilities. She emphasized that these tables can benefit everyone and proposed revisiting the issue for a vote. She wanted to continue the process of obtaining these tables and requested data regarding past grant applications for providers to acquire them. She expressed the need for this data to ensure accountability for funding and ensure that this vital need is met. Ms. McClain hoped for swift action on this matter. Member Sales asked where the funding comes from and who determines which providers receive them. Ms. Gonzalez responded to Ms. Sales, explaining the process related to the distribution of Community Health Investment Funds money by L.A. Care. She mentioned that in the past, these funds were used to address community needs, including purchasing exam tables. However, there were challenges in implementing these changes due to issues such as room size and inventory constraints. She noted that there have been new resolutions from Centers for Medicare & Medicaid Services (CMS) that will require providers to change the way they conduct examinations and provide accessibility for people with disabilities. This could potentially lead to an expansion of efforts to more providers. However, the specific details of these changes are yet to be clarified. Ms. Gonzalez mentioned that she had requested a presentation from the Government Affairs department to provide more information about these changes. She anticipated that the presentation would help shed light on the implications of the new CMS requirements in the coming months.	**Approved by roll call. 10 AYES (Byrd, Cordero, Rabaja, Refugio, Rodriguez, Salazar, Sales, Sanchez, Vazquez, McClain)**
	FUTURE AGENDA ITEMS	
	PUBLIC COMMENT **Submitted by Andria McFerson, RCAC 5 Member, via chat:** *discuss data input with ad-hoc's and public forum meetings with our community for us to collaborate with Dr. Li the suggestions I made before about support group with music and art were only to reach out to the community while also collecting data to find out about health disparities and why it might be happening from a different perspectives and some people aren't able to give necessary information because they don't feel comfortable expressing themselves* Member Refugio said that it occurred to her while Mr. Baackes gave his update on redeterminations, if someone can go to someone's home and provide help to fill out their paperwork. This would be helpful to people that are disabled or don't have internet. Member Cordero if there will be training for new Health Promoters.	

	Member McClain asked if the CMS report can be shared at the next meeting. She would like to see the recommendation being made by the state in regards to the RCAC restructure. She asked if there can be an updated disaster preparedness scenario.	
	PUBLIC COMMENTS	
	Submitted by Elizabeth Cooper, RCAC 2 Member, via voicemail: *I want to extend my best wishes to Hilda Perez. How are these changes being implemented since there was no conversation on the changes in the last BOG meeting? How is the input going to be taken into account by the Board before the changes are approved?* **Submitted by Andria McFerson, RCAC 5 Member, via chat:** *Please know that my comments are only advocacy for our community we have not had access to the public and their disparities so that we can talk and vote on answers so we can present information to the BOG which includes chairs from different healthcare services and a member from the Board of Supervisors they all make daily life changing decisions that change and save lives. I may not come across as productive or relevant but I am glad we have the RCAC's back to have an official curriculum and a future RCAC Agenda officially approved by the members with much more time to talk more amongst each other about topics like diabetes, cancer, senior outreach that I have spoken about before. So please allow the chairs to make an agenda during our upcoming RCAC's and with ADA rights and time for everyone including people with asperger syndrome or any other developmental delays as well and lastly I would like to honor National suicide awareness month and Latino Heritage month.* *The Staff is not allowed to mandate the ECAC decisions who what where and when things can change so is it considered fraudulent for the staff to mandate all rules? The staff cannot dictate any changes so I myself am tyring investigate something and we are defiantly working on a lot of different topics that are now practiced by staff members and taking over a meeting dictating what we do from now on \is not*	
ADJOURNMENT	Chairperson Vazquez thanked the interpreters, L.A. Care staff, and the public for attending. The meeting was adjourned at 1:22 p.m.	

RESPECTFULLY SUBMITTED BY:
Victor Rodriguez, *Board Specialist II, Board Services*
Malou Balones, *Board Specialist III, Board Services*
Linda Merkens, *Senior Manager, Board Services*

APPROVED BY

Ana Rodriguez, TTECAC *Chair* _____
Date 11/8/2023

Board of Governors

Temporary Transitional Executive Community Advisory Committee (TTECAC)

Meeting Minutes – October 11, 2023

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

ECAC Members	RCAC Members/Public	L.A. Care Board of Governors/Senior Staff
Roger Rabaja, RCAC 1 Chair	Izmir Coello, Interpreter	Hilda Pérez, Member, Board of Governors ***
Ana Rodriguez, RCAC 2 Chair	Isaac Ibarlucea, Interpreter	Layla Gonzalez, Advocate, Board of Governors
Lidia Parra, RCAC 3 Chair *	Eduardo Kogan, Interpreter	John Baackes, Chief Executive Office, L.A. Care
Silvia Poz, RCAC 4 Chair **	Alex Mendez, Interpreter	Alex Li, MD, Chief Health Equity Officer, L.A. Care ***
Maria Sanchez, RCAC 5 Chair	Estefanie Mendez, Interpreter	Tyonna Baker, Community Outreach Field Specialist, CO&E
Joyce Sales, RCAC 6 Chair	Andrew Yates, Interpreter	Idalia De La Torre, Field Specialist Supervisor, CO&E
Fátima Vázquez, RCAC 7 Chair, ECAC Chair	Deb Bowen, Closed Caption	Hilda Herrera, Community Outreach Field Specialist, CO&E
Ana Romo, RCAC 8 Chair **		Rudy Martinez, Safety & Security Program Manager III, Facilities Services
Tonya Byrd, RCAC 9 Chair		Christopher Maghar, Community Outreach Field Specialist, CO&E
Damares O Hernández de Cordero, RCAC 10 Chair		Joshua Mendoza, Community Outreach Field Specialist, CO&E
Maria Angel Refugio, RCAC 11 Chair	Russel Mahler, Public	Linda Merkens, Senior Manager, Board Services
Lluvia Salazar, At-Large Member	Andria McFerson, Public ***	Frank Meza, Community Outreach Field Specialist, CO&E
Deaka McClain, At Large Member	Demetria Saffore, Public	Alison Patsy, Quality Improvement Project Manager, Quality Improvement Department ***
	Maritza Lebron, Public	Cindy Pozos, Community Outreach Field Specialist, CO&E
* Excused Absent ** Absent		Victor Rodriquez, Board Specialist, Board Services ***
*** Via teleconference		Martin Vicente, Community Outreach Field Specialist, CO&E

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
CALL TO ORDER	Ms. De La Torre, the Field Specialist Supervisor for the Community Outreach and Engagement Department of L.A. Care Health Plan, welcomed everyone and apologized for technical difficulties. She explained the process for making public comments via Zoom chat and a toll-free line for WebEx bridge line listeners. She also mentioned that public members could submit comment cards and that they would be allowed time to speak during the	

	appropriate agenda items. Ms. De La Torre welcomed L.A. Care staff and the public to the meeting and encouraged L.A. Care members with healthcare issues to contact the Member Services Department. Ms. De La Torre called the meeting to order at 10:18am Members of the Temporary Transitional Executive Community Advisory Committee (TTECAC), L.A. Care staff, and the public can attend the meeting in-person at the address listed above. Public comment can be made live and in-person at the meeting. A form will be available to submit public comments. Accordingly, members of the public should join this meeting via teleconference as follows: https://us06web.zoom.us/j/88204459295 Teleconference Call –In information/Site Call-in number: 1-415-655-0002 Participants Access Code: 2483 111 5817 (English) Call-in number: 1-415-655-0002 Participants Access Code: 2494 102 0094 (Spanish) For those not attending the meeting in person, public comments on Agenda items can be submitted in writing by email to COEpubliccomments@lacare.org or by calling the CO&E toll- free line at 1-888-522-2732 and leaving a voicemail. Attendees who log on to lacare.zoom using the URL above will be able to use "chat" during the meeting for public comment. You must be logged into Zoom to use the "chat" feature. The log in information is at the top of the meeting Agenda. This is a new function during the meeting so public comments can be made live and direct. 1. The "chat" will be available during the public comment periods before each item. 2. To use the "chat" during public comment periods, look at the bottom of your screen for the icon that has the word, "chat" on it. 3. Click on the chat icon. It will open a window. 4. Select "Everyone" in the to: window. 5. Type your public comment in the box. 6. When you hit the enter key, your message is sent and everyone can see it. 7. The chat message, text, voicemail, or email must indicate if you wish to be identified or remain anonymous, and must also include the name of the item to which your comment relates. 8. L.A. Care staff will read the chat messages for up to three minutes during public comment so people who are on the phone can hear the comment. Your comments can also be sent by voicemail or email. If we receive your comments by 10:00 a.m. on October 11, 2023, it will be provided to the members of the Temporary Transitional Executive Community Advisory Committee at the beginning of the meeting.	

	The chat message, voicemail, or email must indicate if you wish to be identified or remain anonymous, and must also include the name of the item to which your comment relates. Once the meeting has started, public comments should be submitted prior to the time the Chair announces public comments for each agenda item and staff will read those public comments for up to three (3) minutes. Chat messages submitted during the public comment period for each agenda item will be read for up to three (3) minutes. If your public comment agenda is not related to any of the agenda item topics, your public comment will be read for up to three (3) minutes at item IX Public Comments on the agenda. Please note that there may be a delay in the digital transmittal of emails and voicemails. The Chair will announce when the public comment period is over for each item. If your public comments are not received on time for the specific agenda item you want to address, your public comments will be read at the public comment section of the agenda. The purpose of public comment is that it is an opportunity for members of the public to inform the governing body about their views. The Temporary Transitional Executive Community Advisory Committee appreciates hearing the input as it considers the business on the Agenda. The process for public comment is evolving and may change at future meetings. We thank you for your patience. All votes in a teleconferenced meeting shall be conducted by roll call. If you are an individual with a disability and need a reasonable modification or accommodation pursuant to the Americans with Disabilities Act please contact the Community Outreach & Engagement staff prior to the meeting for assistance by calling our toll-free line at 1-888-522-2732 or by email to COEpubliccomments@lacare.org. SB 1100 was signed by Governor in August 2022, and added a short section to the Brown Act as Govt Code Section 54957.95 to supplement language already part of the Brown Act : (a) In addition to authority exercised pursuant to Sections 54954.3 and 54957.9, the presiding member of the legislative body conducting a meeting may remove an individual for disrupting the meeting. (b) As used in this section, "disrupting" means engaging in behavior during a meeting of a legislative body that actually disrupts, disturbs, impedes, or renders infeasible the orderly conduct of the meeting and includes, but is not limited to, both of the following: (1) A failure to comply with reasonable and lawful regulations adopted by a legislative body pursuant to Section 54954.3 or 54957.9 or any other law. (2) Engaging in behavior that includes use of force or true threats of force. (54954.3 contains provisions related to public comment time restrictions, and 54957.9 allows the presider to clear the room if the meeting can't continue.)	

	AGENDA and PRINTED MEETING MATERIALS ARE AVAILABLE FOR INSPECTION BEFORE THE MEETING AT L.A. Care's Offices at 1055 W. 7th Street, Los Angeles, CA 90017 through the Reception Area in the Building Lobby.	
APPROVE MEETING AGENDA	**The Agenda for today's meeting was approved with the changes mentioned above.**	**Approved by roll call. 9 AYES (Byrd, Cordero, Rabaja, Refugio, Rodriguez, Sales, Sanchez, Vazquez, McClain)**
ELECT TTECAC CHAIR PRO TEMPORE	By consensus the Committee determined to allow Ms. De La Torre to preside at this meeting.	
APPROVE MEETING MINUTES	**The September 13, 2023 Minutes will be considered for approval in November.**	
	STANDING ITEMS	
UPDATE FROM CHIEF EXECUTIVE OFFICER	John Baackes, *Chief Executive Officer,* reported: Mr. Baackes provided information about the redetermination process for Medi-Cal. He mentioned that approximately 38% of eligible individuals were automatically redetermined due to state and county access to data verifying the information. Those individuals received a letter confirming continued Medi-Cal eligibility for another year, while others received a 20-page packet for redetermination. To assist those who received the packet, L.A. Care continues to have certified enrollers available at the community resource centers (CRC) to help Medi-Cal members complete the eligibility redetermination process, and the services are available for new enrollees seeking healthcare coverage. This outreach resulted in the enrollment of approximately 101,000 in Medi-Cal. Mr. Baackes noted that the level of new enrollment of newly eligible members. Mr. Baackes mentioned that the call center had experienced a significant decrease in the number of calls received, possibly due to people not getting through the redetermination process, potentially because of pandemic-related relocations. He encouraged the audience to reach out to individuals who lost coverage, and have them call the Los Angeles County Department of Public Social Services (DPSS) so they could be reinstated. Mr. Baackes congratulated Member McClain for receiving an honor from Cal State University Long Beach for outstanding community service, and reported that L.A. Care was	

sponsoring the event in support of this achievement. He mentioned that he would personally attend the event to witness Member McClain's honor.

PUBLIC COMMENT

Andria McFerson, RCAC 5 Member:
Ms. McFerson expressed gratitude towards Mr. Baackes for his efforts to help individuals with physical illnesses who may avoid seeking medical care due to lack of coverage. She emphasized that when people discover their coverage has lapsed due to not redetermining, their conditions worsen. She appreciated the encouragement provided by Member McClain and noted that Member McClain has served as a source of inspiration, especially considering she herself has a disability. Ms. McFerson also highlighted the importance of public events for encouraging people to apply for or redetermine their coverage. She suggested that these events, combined with encouragement, could effectively reach individuals who may not be aware of their options. She called for the RCACs to hold meetings where they can discuss various ongoing issues. Additionally, she recommended having tables at events to provide information about available resources, including coverage options, and to help answer questions about coverage. She stressed the importance of making these resources accessible to those who may not have access to the virtual world or may not be able to afford such resources. Ms. McFerson also asked Mr. Baackes if there would be RCAC meetings in the future. Mr. Baackes responded that he believes the RCACs are meeting bimonthly. He stated that L.A. Care attends community events with information for people to check on redeterminations in California. Other community organizations had booths as well. He also attends back-to-school backpack distribution events.

Member McClain raised concerns about the disparities between individuals on Medicare and on Medi-Cal. She noted that there is a distinct difference in the way they are treated and stigmatized, especially when it is apparent that someone is on Medicare. Member McClain highlighted that those on Medicare receive additional benefits, such as extra funds to purchase supplements, and this practice has been ongoing. She expressed uncertainty about whether this issue is related to L.A. Care but emphasized that it is unfair and noticeable when individuals face stigma in their healthcare treatment. Member McClain mentioned recent perceptions that Medicare is not viewed as proper health insurance and that it may not provide adequate access to care. She called for efforts to address the disparities and improve the situation. Mr. Baackes explained the difference between Medicare and Medi-Cal program benefits. He clarified that Medicare Plus is a program for individuals who qualify for both Medi-Cal benefits due to their income and Medicare due to age or disability. The program is a combination of federal and state funding. Mr. Baackes explained that for the Medicare Plus program, LA Care anticipates sufficient funds to provide additional benefits for members.

	For Medi-Cal beneficiaries who do not also qualify for Medicare, there is not capacity to provide the same level of benefits as Medicare Plus. There are advantages to each program. Mr. Baackes offered to provide a written explanation of the specific benefits associated with each program. He attributed the disparities to the structure of the federal Medicare program, which is beyond L.A. Care's control. Mr. Baackes thanked Member Rodriguez for helping out at L.A. Care events. He witnessed Ms. Perez helping as well. That is the power of the beat of the regional advisory committees. RCAC Members are ambassadors and people rely on what they tell them as the truth.	
CHIEF MEDICAL OFFICER UPDATE	Sameer Amin, MD, *Chief Medical Officer,* reported: Dr. Amin discussed various changes and investments made in L.A. Care Health Plan's Health Services department over the past year. He emphasized the significant increase in resources allocated to case management and the expansion of the case management department by over 60%. The expansion includes employment of community health workers and care managers, focusing on treating complex conditions and ensuring the proper coordination of care for members transitioning in and out of healthcare facilities. Dr. Amin reported that the Utilization Management Department is responsible for managing prior authorizations and making sure members receive the right care at the right place and time. The teams work closely with care managers in hospitals to facilitate smooth transitions for members, whether to acute care facilities, rehabilitation centers, or back home. The resources for utilization management have increased over 40% in the last year. Another key focus is on managed long-term services and supports (MLTSS), where staff numbers have increased by over 40% as well. The expansion aims to better support community programs and coordinate MLTSS care in skilled nursing facilities, effectively addressing the needs of both members and the community. Dr. Amin discussed L.A. Care's commitment to enhancing care management through a holistic approach, taking patients from general care management in providers' offices to complex case management by the health plan. Enhanced Care Management (ECM) often occurs within the community, where members are most comfortable. Dr. Amin mentioned the importance of auditing and providing the necessary resources to ensure that care management is effective and technologically sophisticated. The second major focus Dr. Amin mentioned was the California Advancing and Innovating Medi-Cal program (Cal-AIM) efforts. Cal-AIM comprises two central pillars: enhanced care management (ECM) and community support (CS) programs. CS programs encompass various initiatives aimed at improving access to healthcare, housing, and more for members. L.A. Care has committed to actively participating in all of these programs and has established a department dedicated to effectively coordinating and organizing these efforts. Dr. Amin highlighted the department's role in making sure these programs are well-	

organized, coordinated, and holistic, ultimately improving community health. Clinical audits are conducted to ensure program effectiveness. The second pillar, ECM, involves case management and focuses on a holistic approach, requiring close connections with community providers and allocation of resources to enhance technology and operations.

PUBLIC COMMENT

Andria McFerson, RCAC 5 Member:

Ms. Andria McFerson expressed concern about individuals, including her friends, who have medical conditions like diabetes and poor blood flow that can lead to dental issues such as tooth decay. She asked whether conditions like anemia could be contributing to these problems. She noted that these individuals have been unable to access dental services approved by L.A. Care. Ms. McFerson also shared her personal experience, mentioning that she has epilepsy, which occasionally leads to falls and facial injuries, including cracked teeth. She highlighted the need to visit the dentist more frequently than the average person due to her medical condition. She mentioned that she receives the same amount of dental coverage as others, even though her doctor deems dental care a medical necessity, as her pain can trigger seizures. She discussed her recent approval to see a dentist and the evaluation that followed, which revealed the need for a root canal and other dental work. However, she pointed out that she was informed she must undergo a tooth cleaning first, which is only allowed every three years. She emphasized that, given her chronic illness and the life-threatening potential of untreated dental issues triggering seizures, she was in urgent need of dental care. Ms. McFerson sought guidance on how individuals in similar situations, needing special dental coverage due to chronic illnesses, can navigate the process when standard procedures often involve long waiting periods. She was particularly concerned about the extended waiting times for essential dental care when her medical condition required more immediate attention.

Dr. Sameer Amin appreciated the question from Ms. McFerson and explained that providing a specific response was challenging without full details. He noted that the question seemed to revolve around how they could collaborate to address coverage issues within the scope of Medi-Cal, which is a broader issue. Dr. Amin then clarified that there were certain aspects under L.A. Care's control that they could manage, such as requests for in-patient visits, skilled nursing facilities, and complex procedures covered by Medi-Cal. The decision-making process for these cases often goes through utilization management, which can be confused with issues of coverage. He emphasized the importance of distinguishing between utilization management and coverage. Dr. Amin explained that when members face difficulties accessing services they believe should be covered, it is not necessarily due to L.A. Care denying the services. Instead, it may be because the services are not within the coverage benefits provided by Medi-Cal. L.A. Care's role is to inform members that certain

	services are beyond its control because they are not covered by Medi-Cal. Services like dental and pharmaceuticals are typically carved out of Medi-Cal and are not within L.A. Care's scope of control. Dr. Amin expressed a desire to have a broader scope of control, as L.A. Care is committed to ensuring that members receive the necessary care. However, when it comes to expanding these benefits, the best approach is for L.A. Care to stand with its members, support their needs, and advocate on their behalf. He mentioned that L.A. Care has a government affairs department dedicated to addressing members' concerns and representing them in Sacramento. Dr. Amin acknowledged the challenges some members face in obtaining the care they need and emphasized the need to differentiate between what L.A. Care deems inappropriate and what is simply not covered as a Medi-Cal benefit. Member McClain expressed her appreciation to Dr. Amin for providing valuable information and addressing Ms. McFerson's concerns, suggesting that such information should be made accessible to members through the website or other means for better understanding. She raised another question regarding holistic medicine within the coverage provided by L.A. Medi-Cal. Member McClain inquired whether L.A. Care could ensure an adequate number of providers offering holistic medicine. She highlighted the preference of some individuals to explore holistic care rather than conventional medical approaches, as they seek to address the root causes of health issues rather than relying solely on medications. Member McClain would like to understand whether L.A. Care had the capacity to address this within their coverage or if it was an issue that should be taken to government affairs to advocate for potential changes or increased access to holistic care providers in the network. Dr. Amin responded that the information regarding what is covered under Medi-Cal benefits is accessible on the website, acknowledging that it is a lengthy document. He recommended referring to the website for a breakdown that simplifies the information for better understanding. Dr. Amin highlighted that L.A. Care has a network department responsible for ensuring access to the necessary services. He emphasized the importance of not only having providers within the network but also making sure they are available in real-time to serve the members. He mentioned an ongoing effort to improve specialty access over the coming months to address concerns in this area. Dr. Amin acknowledged the complexity of holistic medicine due to the wide range of services it encompasses, such as acupuncture, Eastern medicine, and herbal medication. He explained that what is covered or not covered in this context is outside L.A. Care's control but expressed a willingness to work on advocating for expanded coverage in holistic therapeutics, as he is interested in providing more options beyond pharmaceuticals. Member Rodriguez asked who identifies the patient's necessities. Dr. Amin explained that L.A. Care, as a health plan, offers various wrap-around resources, such as case management	

	and care coordination. He emphasized that the core decisions about what is necessary for a member and how care is delivered, including prescription medications and durable medical equipment, are primarily the choices of the healthcare providers. Dr. Amin stressed that L.A. Care's role is not to interfere with the autonomy of healthcare providers in delivering care but to facilitate the process and address any concerns. While L.A. Care can step in when a provider's actions might be deemed inappropriate, the fundamental responsibility for patient care remains with the healthcare provider. He clarified that L.A. Care's role includes ensuring a network of providers, including specialists, hospitals, and skilled nursing facilities, to offer various options for care. Dr. Amin emphasized the importance of respecting the doctor-patient, nurse-patient, and social worker-patient relationships, and L.A. Care aims to support these relationships rather than dictating orders. The decisions about patient necessities are primarily the result of a collaborative conversation between patients and their healthcare providers. Member Byrd expressed her concerns about patients being released from the hospital without proper care and support. She emphasized the lack of assistance and gaps in the system, sharing her observations of patients being left in their gowns and wheelchairs without proper arrangements. While she clarified that she wasn't blaming Dr. Amin, she voiced her frustration about the situations she had witnessed, highlighting the absence of social workers or responsible individuals when patients were discharged from healthcare facilities. Member Byrd also mentioned instances where patients had to find their own way home, although it is expected that hospitals should arrange transportation. She thanked Dr. Amin and expressed hope that the discussed initiatives would address these issues. Additionally, Member Byrd seemed relieved that the individuals responsible for such gaps were no longer in charge, and she expressed her concerns for patients who faced difficulties after being discharged from hospitals. Dr. Amin acknowledged the challenges in ensuring seamless transitions of care for patients. He conveyed a commitment to improving the situation and noted the complexities involved in managing such transitions effectively. Dr. Amin described ongoing efforts within L.A. Care to enhance transition of care processes. He explained that the organization had established a dedicated department responsible for overseeing patient movements from hospitals to various healthcare settings. He further mentioned that this transition of care department was working to improve the infrastructure and coordinate care more effectively. He emphasized that achieving perfection in these processes was a monumental effort and would take time. Dr. Amin expressed a strong determination to continually work on these issues, even if perfection could not be guaranteed immediately. He reassured that L.A. Care would persist in its efforts to get things right and provide the necessary resources to achieve this goal.	

GOVERNMENT AFFAIRS DEPARTMENT UPDATE	Ms. Thanki and Ms. Campbell gave the following Government Affairs update *(a copy of the written report can be obtained from CO&E)*: Legal Setback for DACA • A federal judge ruled last month that the Deferred Action for Childhood Arrivals (DACA) program is unlawful. DACA was started in 2012 by President Obama to protect young immigrants who were brought to the United States as children from deportation. DACA holders can also work legally in the United States and travel abroad with permission from the government. • The legal battle stems from Texas and eight other states suing to stop DACA, arguing that it violated federal regulatory law and imposed additional costs on the states including education, healthcare, and law enforcement. This recent order by the federal judge extends the injunction already in place against DACA, which prevents the government from processing new applications. However, it maintains the program for current beneficiaries as the legal review continues. • DACA has been a critical issue for many years. Former President Donald Trump sought to end DACA during his tenure, but the U.S. Supreme Court rejected his efforts. The judge's decision prolongs the uncertainty that has surrounded the DACA program for the past two years. • It is important to note existing DACA beneficiaries will not lose their protection from deportation. They can still renew their DACA status. However, new applicants will not be able to apply for DACA. • Appeals are expected and it will be months or perhaps a few years before the federal courts make a final decision on the lawfulness of DACA. Many had hoped that Congress would pass legislation that would provide a path to U.S. citizenship for DACA holders and other undocumented immigrants, but that is unlikely until at least 2025. Proposed Rule Regarding Clarification of ADA and Rehabilitation Act of 1973 • Last month, the U.S. Department of Health and Human Services (HHS) proposed a rule that would update provisions in Section 504 of the Rehabilitation Act of 1973 and effectively bolster disability protections that were outlined in federal law 50 years ago. • Section 504 of the Rehabilitation Act of 1973 is a landmark civil rights law that prohibits disability discrimination in any program or activity that receives federal funding or that is conducted by a federal agency, such as public schools, hospitals and nursing homes. Section 504, was championed by disability advocates and served as a foundation for the Americans with Disabilities Act of 1990 (ADA). • HHS's new proposed rule would update and clarify obligations to provide nondiscriminatory health care and social services to disabled people, which are not explicitly stated in the current version of Section 504.	

Here are the key points:

- Medical Treatment: The proposed rule addresses discrimination against people with disabilities when they need medical care. It ensures that decisions about medical treatment cannot be based on unfair beliefs or biases about disabilities.
- Value Assessment Methods: The rule stops unfair methods that undervalue extending the lives of people with disabilities when deciding on medical treatments or services.
- Child Welfare Programs: It sets strict rules to prevent discrimination in child welfare programs, making sure children, parents, caregivers, and others are treated fairly by setting detailed requirements including parent-child visitation, reunification services, child removals and child placements, guardianship, parenting skills programs, foster and adoptive parent assessments, and in and out-of-home services.
- Web and Mobile Accessibility: With more health services online, the rule aims to ensure websites and apps are easy to use for people with disabilities. The proposed rule defines what accessibility means for web and mobile applications and sets forth specific technical standards for compliance.
- Accessible Medical Equipment: The rule sets standards for medical equipment that must be easy to use for people with disabilities, like adjustable exam tables and wheelchair-friendly scales. The proposed rule establishes enforceable standards for accessible medical diagnostic equipment, a significant and concrete step toward addressing health disparities experienced by people with disabilities. It also requires that within two years of the rule's effective date, recipients that use an examination table in their program or activity have at least one accessible exam table, and recipients that use a weight scale in their program or activity have at least one accessible weight scale.
- Integration: The rule emphasizes that providing community-based services for people with disabilities when it is suitable, and the person agrees is the best option.
- While HHS is undertaking this rulemaking, the current version of Section 504 is in effect. HHS is taking public comments on this proposed rule and are encouraging all interested stakeholders to submit comments through http://www.regulations.gov.
- A fact sheet on the rule is available in both English and Spanish and is attached for your information. It can also be found at https://www.hhs.gov/civil-rights/for-individuals/disability/section-504-rehabilitation-act-of-1973/fact-sheet/index.html.

PUBLIC COMMENT

Andria McFerson, RCAC 5 Member:

Ms. McFerson commended the discussion regarding provisions for individuals with disabilities, particularly in the context of dental coverage. She highlighted the importance of ensuring expedited coverage due to physical limitations faced by people with disabilities. Ms. McFerson expressed concerns that a lack of adequate coverage could worsen their

	conditions, ultimately leading to increased costs for addressing related health issues. She also provided her email address for further contact. **Elizabeth Cooper, RCAC 2 Member:** Ms. Cooper shared her disappointment with how she was treated as an ECAC member. She mentioned receiving the agenda only a day before the meeting, making it challenging for her to prepare her comments. Ms. Cooper emphasized the need for oversight of the Community Outreach and Engagement Department to ensure that public comments are given the importance they deserve. She stressed the importance of board representatives advocating for issues that truly impact the members they represent and to avoid giving undue accolades. Member McClain said that she represents seniors and individuals with disabilities, and expressed her gratitude for the presence of the attendees and highlighted the importance of listening to the discussions during the meeting. She pointed out a concern regarding medical treatment for individuals with disabilities and seniors. Specifically, she mentioned the limited time doctors have with patients, which can be insufficient, given the time it takes for patients to understand and process medical information. She suggested that the new proposal should allow doctors to have more time with these individuals and make it more inclusive for everyone. Ms. McClain also raised issues related to wheelchairs and medical appointments, stating that insurance only covers big, bulky power wheelchairs and not smaller, lightweight ones. She questioned the fairness of this practice. She mentioned that she would document these concerns and include them in her letter or seek assistance to further elaborate on these issues. Ms. Campbell said that she made a note of her comments.	
BOARD MEMBERS REPORT	Ms. Gonzalez and Ms. Vazquez gave a Board Report. They thanked all the RCAC members that are at the meeting today. The Board of Governors met on October 5. Approved meeting minutes for previous Board meetings can be obtained by contacting Board Services and meeting materials are available on L.A. Care's website. • The list of motions approved at that board meeting can be obtained from CO&E. • She thanked the RCAC members that joined the Board Meeting in person or virtually. They were happy to see members there in person and appreciated their public comments. Public comment gives Board Members the opportunity to hear from members and helps improve services for members. • These members attended in person: 1. Deaka McClain (RCAC 9) 2. Ana Rodriguez (RCAC 2)	

3. Maritza Lebron (RCAC 7)
4. Roger Rabaja (RCAC 1)
5. Damares O Hernandez de Cordero (RCAC 10)
6. Elizabeth Cooper (RCAC 2)
7. Andria McFerson (RCAC 5)

- Mr. Baackes gave a CEO Report. He gave an update earlier today.
- In his Chief Medical Officer Report, Dr. Amin discussed the progress made with skilled nursing facilities, outlining a phased approach. Phase 1 involves conversations with over 100 facilities regarding their rates, and proposals were issued to many of them. This approach aimed to increase help for hospitals in moving patients to the correct facility patients need to continue care. Phase 2 is a reimagining of contracts with skilled nursing facilities, with a focus on more holistic patient care and integrating services. He gave an update earlier today.
- The meeting was adjourned in memory of Senator Dianne Feinstein, who had a tremendous impact on many Californians, in particular on health care issues and domestic violence.

PUBLIC COMMENT

Andria McFerson, RCAC 5 Member:

Andria McFerson thanked the Board members for their report and welcomed Ms. Vazquez, the Member Representative of the RCACs. She emphasized the importance of addressing the need for the RCACs. Ms. McFerson urged both Chairs to take action when attending Board meetings, as the RCACs had not convened since the beginning of the year. She requested that they ensure that the meetings on the calendar are carried out and encouraged a general conversation with the staff about the matter. Ms. McFerson also highlighted her previous discussion at the Board meeting regarding formal skill set training for L.A. Care staff and organizations funded by L.A. Care. She proposed the creation of an official empathy certification, focusing on addressing systemic disparities in healthcare services. This certification would be mandatory for all parties providing services to L.A. Care members, including contract agencies and community-based organizations. She explained that this certification would hold these parties accountable for the services they provide, and if recipients were unsatisfied, they could report to L.A. Care or the state, which might result in funding consequences. She emphasized the need for more accountability from primary care providers, community-based organizations, and various service providers, and stressed that certification and satisfaction surveys were essential for achieving this goal.

MEMBER ISSUES	PUBLIC COMMENT **Andria McFerson, RCAC 5 Member:** Ms. McFerson shared her insights during the meeting. She began by discussing a proposal she presented at the Board meeting. The proposal involves implementing a recertification process for homeless individuals, emphasizing the need for redetermination. She suggested collaborating with shelters, community-based organizations, and other relevant entities to set up information tables at various locations. Andria highlighted the importance of having these tables at places like the DPSS offices, Electronic Benefit Transfer (EBT) offices, and outside family resource centers. She explained that homeless individuals might not feel comfortable going inside some facilities due to their specific circumstances, including their appearance. This discomfort can lead to communication barriers that contribute to homelessness. The proposal aims to provide homeless individuals with necessary information about the redetermination process to maintain their coverage. She stressed that because many homeless people lack a fixed mailing address, they might not receive notices about coverage ending. She emphasized the necessity of reaching out to unhoused individuals, drawing from her personal experiences with homelessness. Member Parra raised concerns about the increasing cost of living due to inflation. They pointed out that many people are forced to take on additional jobs to make ends meet, which, in turn, can result in losing their coverage through Medicaid (Medi-Cal in California). The member noted that the monthly rates for plans like Obamacare (Affordable Care Act) can be prohibitively expensive for some individuals. The member's primary question revolved around the possibility of increasing the income thresholds for eligibility in programs like Medicaid, as many people are struggling to afford the rising costs of living. This concern highlighted the financial challenges faced by many individuals, and they sought solutions to address these issues. Member McClain said she is concerned about meeting in this building. She has been advocating for evacuation chairs for people with disabilities. She would like evacuation chairs to be available at L.A. Care. Evacuation chairs are used when elevators are not working. PUBLIC COMMENT **Maritza Lebron, RCAC 7 Member:** Ms. Lebron expressed concerns about a person in her area, specifically in the RCAC 7 area, who is in need of an electric wheelchair due to mobility issues. She shared that the individual has experienced multiple falls and chronic pain, but she was informed that approval for an electric wheelchair had been denied. She emphasized the importance of considering and planning for accessible electric wheelchairs for individuals with limited mobility. Ms. Lebron also addressed the issue of providing resources and information to the homeless population.	

	She mentioned the importance of distributing flyers with relevant community resources, taking into account the diverse needs of people facing physical trauma, mental health issues, or other challenges. She highlighted a case involving a mother who has a child with severe behavioral problems. The child's aggressive behavior has made it difficult for the mother to attend medical appointments, and she has faced accusations from healthcare providers. Ms. Lebron stressed the importance of approving services that allow mothers to take children with disabilities to appointments, as well as the necessity of providing in-home services and better understanding individuals' disabilities.	
COMMUNICATIONS AND COMMUNITY RELATIONS DEPARTMENT UPDATE	**The Communication and Community Relations Department Update will be given at the November 2023 TTECAC meeting.**	
OLD BUSINESS		
TTECAC CHAIR/VICE-CHAIR NOMINATION AND ELECTION PROCESS	Ms. De La Torre presided over the Chair and Vice Chair election. Chairperson Candidates: Ana Rodriguez, RCAC 2 Chair Ana Romo, RCAC 8 Chair Damares O Hernández de Cordero, RCAC 10 Chair Deaka McClain, At Large Member The candidates each made their statements and took questions from members. <u>PUBLIC COMMENT</u> **Andria McFerson, RCAC 5 Member:** Ms. McFerson inquired about their opinions regarding the potential reduction of RCACs from the current number, specifically if they believed that having only eight RCACs would be appropriate. She asked them about their commitment to ensuring that the RCACs continue to meet for the remainder of the year. She sought assurance that the candidates would take steps to facilitate and maintain regular RCAC meetings for the benefit of the community members they represent. Member Cordero responded that she believes that eight RCACs are insufficient. She thinks there should be more RCACs so they can cover more communities. Member McClain responded that she does not feel that the number of RCACs should be reduced if it will reduce representation of members. She said that they have been hearing all these different things. It is under the community engagement that is going to make the decision and they have access to be able to play a part in that, then yes. She will advocate to continue to have the RCACs. However, if it is come down and they have proven to	

	members that that is out of their control then She will accept that and advocate to make sure that they are able to give input of some kind of way even if they have to do it within their town. Member Rodriguez expressed her perspective on the number of RCACs. She mentioned that having more RCACs could potentially allow them to reach and serve a broader audience. She also mentioned that they are currently in the process of assessing the power and influence they will have and that if they gain more decision-making power, it might make sense to create additional RCACs rather than reducing their number. Member Romo expressed her concerns about potentially reducing the number of RCACs. She questioned what would happen to the population served by the RCACs if some were removed. She also pointed out that with only eight RCACs covering the entire LA county, it would mean more work for the presidents of each RCAC. She emphasized the importance of quality over quantity and suggested that any changes should be made carefully to ensure that the public's needs are still met effectively. Member Romo expressed her belief that removing RCACs might not be the right solution and that a thoughtful approach should be taken to address the issues. Ms. De La Torre stated that the majority vote means that in order for a candidate to win the position they need to receive six votes, as there are 11 committee members present.. The ballots are distributed in English and Spanish and must be signed and dated. <u>Result of first round of Voting for Chairperson</u>: Damares O Hernández De Cordero – 1 Deaka McClain – 4 Ana Rodriguez – 5 Ana Romo – 1 Member Cordero and Member Romo removed their names from the ballot. <u>Result of second round of Voting for Chairperson</u>: Damares O Hernández De Cordero – 3 Deaka McClain – 1 Ana Rodriguez – 6 **Ana Rodriguez received 6 vote and was elected as Chairperson.** <u>Result of first round of Voting for Vice Chairperson</u>: Damares O Hernández De Cordero – 3 Ana Romo – 2 Deaka McClain – 6 **Deaka McClain received 6 votes and was elected as Vice Chairperson.**	

	FUTURE AGENDA ITEMS	
	Member McClain would like an update on the reconstruction of the RCACs and a follow up on the procurement of evacuation chairs for providers. She would also like to revisit the meeting guidelines, specifically the time allotted for committee members to comment. Ms. Gonzalez would like someone from C&L to speak to Khmer speaking members regarding translated materials. Khmer speaking members have expressed that they do not understand the materials that are being translated. Member Sales said she is new to the committee. She would like to increase income levels for Medi-Cal recipients. Ms. De La Torre responded that she will reach out to Government Affairs, but it is a decision federal government. She said it can be part of the advocacy day topics.	
	PUBLIC COMMENTS	
	Andria McFerson, RCAC 5 Member: Ms. McFerson spoke about the rules of engagement and stakeholder meetings. They have recommendations and state and they are not mandates. They are suggestions of how they can change things but they are not mandate. They still have a voice and can say no. Whatever is presented in a listening session doesn't necessarily make it so the rules changes completely. Different things like RCAC members. What they go through, they talk about those things. And it makes it plausible for people that are making million dollar decisions that help saves lives. She wants to talk about a fellow RCAC member, Bridgette Green, RCAC 6 Member. She was reluctant to even speak. They have that overall feeling and they don't want to speak anymore. They don't even want to speak to each other. Everything is timed and organized and they are not allowed to talk to anyone. With that being said, Bridgette Green lost her life. She was trying to get care from L.A. Care to get help. It was hard for the family to pay for the funeral. She has a go fund me at this point. She asked for a moment of silence for Bridgette Green.	
ADJOURNMENT	The meeting was adjourned at 1:20 p.m.	

RESPECTFULLY SUBMITTED BY:
Victor Rodriguez, *Board Specialist II, Board Services*

APPROVED BY

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

Ana Rodriguez, TTECAC Chair _____

Date 11/8/23

EXECUTIVE COMMITTEE

Board of Governors
MOTION SUMMARY

Date: December 7, 2023 **Motion No**. **EXE 100.1223**

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

Requesting Department: Human Resources

Issue: Approve the disbursement of funds for the Annual Incentive Plan, based on the results of individual performance goals and organizational targets for FY 2022-23.

Background:

Currently, employees are eligible to participate based upon job classification, and under one of the following components of the Annual Incentive Program:

- Monthly Production Incentives Program based on predetermined criteria;
- Individual Annual Incentives Program based on predetermined goals; and,

The Production Incentive Program was budgeted and paid monthly according to policy.

This request is for authorization to payout for the Annual Incentives Program, not to exceed $10.12 million.

Budget Impact: The Annual Incentive Program budget previously approved by the Board of Governors for FY 2022-2023, no more than 4.5% of budgeted Salaries and Benefits. The projected amount for a potential incentive for the Chief Executive Officer has a separate budget.

Motion: To authorize the disbursement of funds not to exceed $10.12 million for the Individual Annual Incentive Program, based on the completion of pre-determined individual goals and targets in support of L.A. Care's FY 2022-23 Organizational Goals. Distribution of the annual incentive payout shall be guided by Human Resource Policy No. 602, Annual Organizational Incentive Program.

BOARD OF GOVERNORS
Executive Committee
Meeting Minutes – October 25, 2023
1055 West 7th Street, 10th Floor, Los Angeles, CA 90017

Members
Al Ballesteros, *Chairperson*
Ilan Shapiro MD, MBA, FAAP, FACHE, *Vice Chairperson*
Stephanie Booth, MD, *Treasurer*
John G. Raffoul, *Secretary**

** Absent*
*** Via Teleconference*

Management/Staff
John Baackes, *Chief Executive Officer*
Sameer Amin, MD, *Chief Medical Officer*
Terry Brown, *Chief of Human Resources*
Todd Gower, *Interim Chief Compliance Officer*
Linda Greenfeld, *Chief Product Officer*
Augustavia Haydel, *General Counsel*
Tom MacDougall, *Chief Technology & Information Officer*
Noah Paley, *Chief of Staff*
Acacia Reed, *Chief Operating Officer*

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
CALL TO ORDER	Alvaro Ballesteros, MBA, *Chairperson,* called to order the regular meetings of the L.A. Care Executive Committee and the L.A. Care Joint Powers Authority Executive Committee regular meetings at 2:02 p.m. The meetings were held simultaneously. He welcomed everyone to the meetings. • For those who provided public comment for this meeting by voice message or in writing, L.A. Care is glad that they provided input today. The Committee will hear their comments and the Committee also needs to finish the business on the Agenda today. • For people who have access to the internet, the meeting materials are available at the lacare.org website. If anyone needs information about how to locate the meeting materials, they can reach out to L.A. Care staff. • Information for public comment is on the Agenda available on the web site. Staff will read the comment received in writing from each person for up to three minutes. • Public comment will be heard before the Committee discusses an item. If the comment is not on a specific agenda item, it will be read at the general Public Comment. He provided information on how to submit a comment in-person, or using the "chat" feature.	

APPROVED

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
APPROVE MEETING AGENDA	The Agenda for today's meeting was approved.	**Approved unanimously. 3 AYES (Ballesteros, Booth and Shapiro)**
PUBLIC COMMENT	There were no public comments.	
APPROVE MEETING MINUTES	The minutes of the September 27, 2023 meeting were approved as submitted.	**Approved unanimously. 3 AYES**
CHAIRPERSON'S REPORT	There was no report from the Chairperson.	
CHIEF EXECUTIVE OFFICER REPORT	John Baackes, *Chief Executive Officer*, reported there are four months of data for the redetermination process and L.A. Care has a net loss of about a 100,000 Medi-Cal members. Over 200,000 did not make it through the process. Of those, some were determined to be no longer eligible and a vast majority are people that have not returned the redetermination package. L.A. Care added 132,000 Medi-Cal members in four months. If we were to project this forward for the remainder of the process, L.A. Care would lose about 300,000 lives, which would be slightly less than forecast. All of the health plans in California are reporting significant new enrollment. L.A. Care has enrolled a number of people eligible for L.A. Care Covered. L.A. Care Covered has 133,000 paid members with about 20,000 in the queue. Not all of the new enrollment will become members; people have 60 days to decide to accept the enrollment. Any premium due must be paid within 60 days. About half of the people who have enrolled will not have to pay any premium because the federal and state subsidies will cover the premium. Those members will need to pay the co-payments and the deductible for health care services. From an enrollment standpoint, L.A. Care is in good shape so far. In January 2024, several things will happen in Medi-Cal. • L.A. Care will be severing the 275,000 Kaiser members, as Kaiser will have its own Medi-Cal contract. All of the preparation is moving very smoothly and work with Kaiser is ongoing to make that happen as easily as possible for members. There have been no glitches whatsoever. L.A. Care does not anticipate that this will have a significant financial impact because of the contract terms L.A. Care had with Kaiser.	

APPROVED

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• Medi-Cal eligibility will be extended to undocumented residents between the ages of 26 and 49 as of January. 1, 2024. Many in this demographic are already partially covered by Medi-Cal and the transition will be seamless for them. Others who will become eligible will likely enroll within three or four months. A big challenge will be to match the primary care physician with the members who have federally qualified health centers (FQHC) as a primary provider under discounted programs or are using clinics at Los Angeles County Department of Health Services (DHS) sites through My Health LA. The member may be used to seeing a primary care physician, and L.A. Care will work to match them with that same physician, assuming the physician is in L.A. Care's network. DHS physicians will be in L.A. Care's network. The information provided to L.A. Care from California Department of Health Care Services (DHCS) will not include any previous primary care affiliation. It will be a lot of work. This group is expected to be more than 150,000 members. • The last event in January does not directly affect L.A. Care but it will crowd the environment L.A. Care is working in. Health Net will be assigning half of its 1.1 million lives to Molina Health. DHCS has not announced how that will happen. Notices should be sent in November to those members, and that will be during the ongoing redetermination process. A Medi-Cal member could receive a letter that informs them that as of January 1 the member will be enrolled with Molina. The next day the member could receive a redetermination package to continue eligibility for Medi-Cal. There could be some fallout from the resulting confusion among members. • At the November 2 Board meeting there may be more information about the rate development for 2024. The initial estimates were not good for L.A. Care or for any of the health plans. Many health plans are concerned, and a lot of pushback is expected in terms of the actuarial soundness of these rates. Chairperson Ballesteros noted that L.A. Care is seeing increases in enrollment of new members coming in. That is offsetting those that are dropping off. He asked if there is any sense of the new member demographics. Are there members that did not know about it, or recently qualified or maybe did not know about the benefit? Mr. Baackes responded that L.A. Care is researching this, and it appears they are coming in across all categories. It seems not to be a concentration of moms and kids or childless adults; it is across the board. People may also have moved their residence to Los Angeles County, or perhaps all of the awareness around the eligibility redetermination prompted	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	enrollment. He reported at the October Board Meeting that L.A. Care has Certified enrollers at the Community Resource Centers to help people with the enrollment process, and many are new enrollees. He hears from health plans across California that there is significant new enrollment. Every plan is seeing new membership. Chairperson Ballesteros commented that it is great that they are coming in, but were these new members out there and they did not know they were eligible? That is a concern because we want folks to be able to get benefits for which they are eligible. Mr. Baackes noted that that anytime LA Care had open enrollment for Covered California, there would also be a spike in Medical enrollment, because people did not know they were eligible for Medi-Cal and had enrolled through Covered California.	
• Government Affairs Update	Joanne Campbell*, Government Affairs,* reported: • Congress had passed a continuing resolution for the federal budget, because federal legislators were unable to come to an agreement about the budget before the deadline. The deadline for the continuing resolution is November 17, 2023 • The Speaker of the House was removed in early October. Noah Paley, *Chief of Staff* noted that a new Speaker, Mike Johnson, was elected this morning. Staff will continue to update the Board on new developments. • The most recent estimate for California state revenue was released last week. California has collected $17.3 billion in taxes, far below the estimated $44.9 billion projected. Last week, the IRS and California delayed the filing date for taxes until November 16. There are outstanding filings. It is unlikely that the extended deadline will significantly affect California's tax revenue. This does not mean immediate cuts, California's rainy-day fund including a specifically targeted health fund, are full and there are other funding mechanisms that could be utilized. The revenue shortfall will complicate negotiations for next year's budget.	
COMMITTEE ISSUES		
Presentation on Community Health Investment Fund (CHIF) Priorities for FY 2023-24	Shavonda Webber-Christmas, *Director, Community Benefits,* reviewed the priorities for the 2023-24 fiscal year. Overview: • As of October 1, 2023, the CHIF Program has supported more than 979 projects for 190 unique community entities, and invested more than $138 million in organizations caring for under-resourced communities.	

APPROVED

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• CHIF awards improved clinic workforce and infrastructure, access to care and improved health outcomes for members and social determinants for under-resourced communities, all in an effort to strengthen the safety net of providers in Los Angeles County. • A motion will be presented on November 2 seeking Board approval to allocate the CHIF fund already approved in the current budget for $10 million, across Community Benefits' Grant Making Priorities for FY 2023-24 The CHIF grants improve clinics, workforce, infrastructure and access to care, allowing organizations to pilot various programs for care coordination, improve health outcomes for our members, and advance solutions for social determinants of health to reduce inequities in under-resourced communities. Categories in which CHIF initiatives and ad hoc awards are allocated: • Support the health care safety net to improve infrastructure and address disparities • Advance solutions for social determinants of health to reduce inequities • Close pervasive health disparities gaps • Empower and invest in health and health related social service organizations that address systemic racism Ms. Webber-Christmas reviewed the grant making priorities in each category. **Support the health care safety net to improve infrastructure and address disparities** • Supports projects that address the infrastructure needs of safety net providers, including technological, personnel, and care coordination methods that enable healthcare providers to resolve broad structural and racial inequities in the health care system, and to ensure quality and equitable care and improve client outcomes. • Portfolio may be distributed through initiatives such as the Robert E. Tranquada, MD Safety Net Initiative, and community initiated ad hoc projects, including major healthcare investments. • Budget - $4.45 million • Grants starting at $100,000 each **Advance solutions for social determinants of health to reduce inequities** • Supports community based strategies and policy efforts to reduce health inequities associated with social determinants and improve health and wellbeing for	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	marginalized community members. Projects affecting food and housing security, economic empowerment, and education are prioritized. • Portfolio may be distributed through initiatives such as a pilot Advancing Economic Mobility and community initiated ad hoc projects that improve areas related to social determinants of health. • Budget - $2.8 million • Grants starting at $125,000 each **Close pervasive health disparities gaps** • Uplifts projects that directly address health disparities among under resourced populations due to race or ethnicity, sex, gender identity, age, ability, socioeconomic status, geographic location, and especially coexistent or intersectional characteristics. L.A. Care will address opportunities revealed through analysis of available data. • Portfolio may be distributed through initiatives such as Generating African American Infant & Nurturers' Survival (GAAINS), and community initiated ad hoc grants aligned with reducing health disparities, including data surveillance. • Budget - $1.5 million • Grants starting at $125,000 each **Empower and invest in health and health-related social service organizations that address systemic racism.** • Supports trusted BIPOC-led and serving organizations that provide services to meet community health and social needs and address root causes of systemic injustices. Focuses on building infrastructure and capacity among agencies historically underfunded by philanthropy to resource community driven solutions to systemic racism. • Portfolio may be organized around initiatives, such as the Equity & Resilience Initiative, and community initiated ad hoc grants aligned with eliminating systemic racism. • Budget - $1.25 million • Grant average $125,000 each In response to a question from Board Member Booth, (*the question was inaudible)* Ms. Webber Christmas responded that workforce partners are focused on health care and technology workforce sectors.	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Board Member Shapiro appreciates the information; this is important and creates hope, especially for organizations that have never had a grant, helping them in that process is extremely important. He stressed the importance of outcomes to learn from projects that may not have worked, but also the projects that can be replicated. It will be interesting, after all these projects have a year of operation, to see the results. Those stories are powerful and are untold, and need to be replicated. Ms. Webber-Christmas responded that a summary report is presented annually to the Board. Chairperson Ballesteros thanked her on behalf of the clinics; he hears good feedback about the CHIF program. He thanked Ms. Webber-Christmas for her hard work. Her reports provide important information for the Board. Ms. Webber-Christmas responded that it is a privilege to work with the Board and the opportunity is very much appreciated. Mr. Baackes noted that Ms. Webber Christmas has done a wonderful job. He reported that in a meeting with Mary Watanabe, *Director*, California Department of Managed Health Care (DMHC), and the CEOs of the Local Health Plans of California. There were concerns expressed about the DMHC imposing quality requirements on health plans. DMHC will be coming out with a set of quality metrics arranged around health disparities and health inequity. Ms. Watanabe commented that the state administration is asking for accountability, and raising the number of measures and the sanctions that go with them. Mr. Baackes responded that it seems accountability should go both ways. If health plans are going to work on moving improving quality and removing health disparities. Health plans will need the resources to do it; piling on more metrics and higher sanctions is not going to move the needle. Health plans do not have the resources to place providers in the communities that need them. He commented that all the health plans are doing the kinds of projects that the Committee just heard about. Health plans are using unassigned revenue to invest in the community to address the inequities that are leading to the low quality scores, and on which the administration is not taking action. The Director is not aware about good things the health plans are doing and Mr. Baackes will meet with her to review these community programs sponsored by the health plans. Mr. Baackes and Sameer Amin, MD, *Chief Medical Officer,* will inform her about the CHIF programs including Elevating the Safety Net, and Community Resource Centers. These programs are doing more to improve quality and access to care and remove disparities than the increasing number of quality measures on health plans, which come with financial sanctions on top of corrective action plans. He	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	mentions this because it really struck him that DMHC is not measuring the quality improvement programs underway; it measures other transactional areas. Board Member Booth commended Mr. Baackes and expressed hope that the Director heard his words and was honest with him. She thanked Mr. Baackes. Dr. Amin commented that in addition to that, in conversations with some of the regulators, he raises the question, why keep ramping up penalties to remove money from the system when health plans could invest the money in the system. A quality withhold includes financial penalties on Managed Care Accountability Sets (MCAS) measures, the auto assignment of members is being adjusted based on the same quality metrics. These are detrimental to a health plan's ability to invest in the community. It just does not make sense. Ultimately, that money coming out of the community is not helping anything. The issues Mr. Baackes is talking about are exactly what we need To do to try to reinvest. Board Member Shapiro noted that one of the metrics that can be pointed out is that whenever people have clean water, affordable food, green spaces - safe spaces and people actually have a home, other metrics can be involved that promote positive things on behalf of the community. Dr. Amin responded that they apply metrics from other programs like Medicare, to a population that is very different, and some of it is coming from lack of understanding. If people do not have a roof over their head, do not have any green spaces and are in a violent area, it is hard to worry about Colonoscopy as the first and foremost thing. Getting folks settled so that they can think about health care and become part of the ecosystem is a positive first step. A lot of what L.A. Care is doing through Elevating the Safety Net is to strengthen the safety net of providers. L.A. Care is trying to reinvest into the community to address at least the basic issues. That is first. After that, we can make sure everyone who needs to, gets a colonoscopy. Mr. Baackes commented that in that conversation the Director described a two-year journey, as she put it, that she went through to come up with these quality measures. The issues are really coming from advocates who complain about a lack of progress on these measures related to child immunization and so forth. The advocates play a big role in promoting the quality measure. Some of the advocates are self-appointed and may not be advocates because they have been in the system and want to change it. They are self-appointed and driving this, and they get the ear of the regulators, get the	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	ear of the media. Health plans have yet to figure out a way to work with the advocates, educate them and encourage advocacy based on real data and real life experience, rather than aspirational goals. Board Member Booth suggested this topic for a small group discussion among providers. She asked if it would be possible to urge the California Department of Health Care Services (DHCS) and DMHC to work together about their separate duties. Dr. Amin noted it would be great if DHCS and DMHC could articulate that separation. Mr. Baackes noted that around the particular issue where DMHC is getting into quality metrics and penalties, a question was posed to Ms. Watanabe if DMHC and DHCS communicate. Communication has also been an issue for L.A. Care between Covered California, DHCS and CalPERS. These are three entities that health plans have to deal with and each has set up different quality standards and measures and separate data collection and reporting from health plans. Health Plans have asked for alignment of the data collection and standards. There are opportunities for the bureaucratic structure in which health plans operate to consolidate and streamline reporting. Mr. Baackes will be asking for accountability by aligning the structure. Chairperson Ballesteros commented that the topic of metrics and sanctions has come up often. He noted that for 25-30% of the members assigned to providers, no contact information is provided when the member is assigned. A great deal of resources must be expended in locating and contacting newly assigned members. Those resources could be directed to the care of members who are engaged with the providers. It does not make sense to hold health plan or the provider accountable for patients delegated to them with no contact information, but this has not been reconciled. Dr. Amin commented that from a regulatory standpoint, the patients for which the plan or the provider have no contact information and no engagement with health care are considered healthy. Those 30-40% of members who do not see a provider are actually among the sickest and may have the most co-morbidity, and are choosing not to be part of the health care system. They have other concerns, possibly with social determinants of health that prevent engagement with health care providers. This is an area where regulators and government could help members by building a better infrastructure that provides for their social needs and draws them into the health care system. Chairperson Ballesteros agreed with Dr. Amin, but payments to clinics are affected by the inability to reach these patients. There may be ways to contact patients through other means such as housing programs. Regulators need to address this.	

APPROVED

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Dr. Amin noted that L.A. Care is creating infrastructure around field medicine and street medicine. L.A. Care noted that there were requirements without any infrastructure or any organization, and stepped in to build it. The LA Care Community Health team has been working with providers and a number of other entities to gather input, and a plan will be presented at the Board of Governors meeting on November 2. Mr. Baackes noted that L.A. Care also operates CRCs and those can be places people come for care without having to be contacted. Chairperson Ballesteros stated that the resource centers contain a wonderful opportunity. Mr. Baackes commented that Medicaid was created in 1965, and was to be operated by the states. The states were to do the claims and operate the systems. After about 20 or 30 years, almost 40 of the 50 states turned to managed care to operate the programs, because states found it was hard. Now the states do not have to be held responsible, but became a regulator and hold health plans responsible. It was a changing dynamic over the history of this program. He thinks that is worth noting. States have become more entrenched in the regulatory side than in the actual provision of care. Health plans bear the responsibility of providing care. Chairperson Ballesteros commented that the community is going to be thankful that DMHC is willing to have the conversation, because there is a perception that there is a wall blocking them from hearing the information.	
Housing & Homelessness Incentive Program Investment agreement with United Way of Greater Los Angeles (UWGLA) **(EXE 100)**	Dr. Amin commented that this motion dovetails nicely with the previous conversation around L.A. Care's investments in the community to build infrastructure. He introduced Karl Calhoun, *Director, Housing Initiatives,* to present the motion. Mr. Calhoun stated that the Housing and Homelessness Incentive Program (HHIP) goals are to reduce and prevent homelessness, to provide access to L.A. Care members and to the greater Los Angeles County community, for those who are experiencing homelessness, to provide them access to the services they need to end their homelessness. All of that is dependent on the ability of the service community, largely community based organizations, to provide that support. L.A. Care has listed housing services, workforce development as a key priority initiative for HHIP. The workforce development aspect of homeless services is in dire need of support. This is in the investment plan with budget approval for $3 to 4 million dollars focused on housing related workforce development.	

APPROVED

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	This motion presents the agreement to utilize that funding. Further support is in study from KPMG that projected in the next 3 to 5 years, there will be 31% shortfall in staff at organizations who provide homeless services in Los Angeles County. That equates to about 67 to 70 people doing the work of a 100 people. One can imagine what that will do to staff retention and to the quality of the services provided. L.A. Care's efforts in many areas around homelessness experience obvious gaps. Homeless services workforce is a gap that is less obvious to many, but is equally as important as other gaps. In addressing the needs, staff recommends funding for United Way of Greater Los Angeles (UWGLA) through two primary initiatives, at $1.75 million each. This investment addresses immediate needs; it addresses ways to prevent this problem from getting worse in the future. The first phase of the investment addresses the practical reality of staff leaving the housing service industry by funding up to $500,000 for 15 different agencies to provide direct staff stipends to improve staff retention at those agencies. All of those agencies are contracted with L.A. Care. This phase of the investment will directly benefit L.A. Care members using services at those agencies. The Agency needs to be directly contracted with L.A. Care for housing related community supports or indirectly contracted with L.A. Care in a subcontracting relationship with Los Angeles County Department of Health Services (DHS) which is one of L.A. Care's largest homeless service providers. The second initiative involves a leadership round table led by UWGLA to develop 2-4 pilot initiatives to address identify people in the homeless space who have lived experience and bring them into the industry to benefit from their knowledge of the struggles of those experiencing homelessness. It will also identify newer generations that can work in this industry, particularly Transitional Age Youth program (TAY) individuals, because they bring lived experience and knowledge of homelessness issues. The initiative will support work to develop ways that may target that community. It will also develop pilot programs that create a career track within the homeless service community that is much more tangible and obtainable then what is available now. L.A. Care will have a seat at the round table, and will be shaping these pilot programs and the policies that the round table recommends.	

APPROVED

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	In order to align with HHIP goals and to help meet HHIP metrics and thus draw down funds, L.A. Care staff requests approval to execute a contract with United Way of Greater Los Angeles (UWGLA) from October 1, 2023 to October 1, 2025 of up to $3.5 million. **Motion EXE 100.1123** **To authorize staff to execute an HHIP investment agreement in the amount of $3,500,000 with United Way of Greater Los Angeles to refine and reestablish the Workforce Development Leadership Team, launch priority pilot initiatives, provide stipends, and provide infrastructure funding to strengthen recruitment and retention of staff in agencies in Los Angeles County for the period of October 1, 2023 through October 1, 2025.** Board Member Booth asked about other organizations involved in similar work in Los Angeles County. Mr. Calhoun responded that United Way is the leader in addressing the workforce shortfall crisis. This is part of the larger work underway in support of the entire community addressing homelessness issues, because without appropriate staffing, it will be very difficult to achieve the goals in reducing and preventing homelessness. L.A. Care is very consistently and, ardently working to connect HHIP funding to strategic initiatives, particularly within community health and CalAIM programming. This funding will directly benefit the community based organizations that are contracted with us to provide homeless services Chairperson Ballesteros noted that L.A. Care funding a program through community benefits years ago for staff retention in nonprofit health clinics, and it was the first time he had seen it done. Member Booth enquired if the HHIP will allow L.A. Care to be creative in funding programs. Dr. Amin responded that this did not require LA Care to get too creative because it was within the bounds of allowable funding. There are some ideas for programs he is discussing with Mr. Baackes that may be a little bit more outside of the box. Fortunately, this is very much in the HHIP box.	**Approved unanimously.** **3 AYES** **The Committee approved to include EXE 100 on the Consent Agenda for the November 2, 2023 Board of Governors meeting.**
Human Resources Policies HR 105 (Employee Benefit Plans), HR 109 (Jury Duty and Witness Subpoenas), and HR 709 (Language	Terry Brown, *Chief Human Resources Officer*, presented a motion to approve revisions to three L.A. Care HR policies. For two of the policies, the revision is updating the definition of eligible employees make sure that all of our policies are fully aligned and to make sure that they are aligned with the definitions in the benefit plan. There are benefit plans that individuals can and cannot participate in based upon their employment status.	

<table>
<tr><th>AGENDA ITEM/PRESENTER</th><th>MOTIONS / MAJOR DISCUSSIONS</th><th>ACTION TAKEN</th></tr>
<tr><td>Proficiency Assessment)
(EXE A)</td><td>The third policy contains changes in the language proficiency assessment, and the major change is to add a second chance for an employee to take and pass the verbal language proficiency test.

The revised policies are written to comply with changes to Regulatory, Legislative and Judicial changes, or reflect changes in L.A. Care's practices.

<table>
<tr><th>Policy Number</th><th>Policy</th><th>Section</th><th>Description of Modification</th></tr>
<tr><td>HR-105</td><td>Employee Benefit Plans</td><td>Benefits</td><td>Revision – clarified definitions and specific processes; update Reporting and Monitoring sections using standard verbiage; removed age requirement under 3.2.7.1 as plan docs do not contain a min age requirement</td></tr>
<tr><td>HR-109</td><td>Jury Duty and Witness Subpoenas</td><td>Benefits</td><td>Updated definition of Eligible Employees</td></tr>
<tr><td>HR-709</td><td>Language Proficiency Assessment</td><td>Learning and Development</td><td>Policy Review</td></tr>
</table>

<u>Motion EXE A.1023</u>
To approve revisions to Human Resources Policies HR 105 (Employee Benefit Plans), HR 109 (Jury Duty and Witness Subpoenas), and HR 709 (Language Proficiency Assessment), as presented.</td><td>Approved unanimously.
3 AYES</td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td>Approve Consent Agenda</td><td>Approve the list of items that will be considered on a Consent Agenda for November 2, 2023 Board of Governors Meeting.
• October 5, 2023 Board of Governors Meeting Minutes
• Housing & Homelessness Incentive Program Investment agreement with United Way of Greater Los Angeles (UWGLA)
• I Color Printing and Mailing Inc. Contract Amendment Premium Billing Unit with printing, storage, postage/mailing, reporting, and order fulfillment services through June 30, 2025</td><td>Approved unanimously.
3 AYES</td></tr>
</table>

APPROVED

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• MCG (Milliman) Contract provide clinical care guidelines for the period of November 10, 2023 to October 31, 2028 • Accounts & Finance Services Policy AFS-008 (Annual Investment Policy Review)	
PUBLIC COMMENTS	There were no public comments.	
ADJOURN TO CLOSED SESSION	The Joint Powers Authority Executive Committee meeting adjourned at 2:54 pm. Augustavia J. Haydel, Esq., *General Counsel* announced the items to be discussed in closed session. She announced there is no report anticipated from the closed session. The meeting adjourned to closed session at 3:00 pm. REPORT INVOLVING TRADE SECRET Pursuant to Welfare and Institutions Code Section 14087.38(n) Discussion Concerning New Service, Program, Business Plan Estimated date of public disclosure: *October 2025* CONTRACT RATES Pursuant to Welfare and Institutions Code Section 14087.38(m) • Plan Partner Rates • Provider Rates • DHCS Rates CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION Pursuant to Section 54956.9(d)(1) of the Ralph M. Brown Act *MemorialCare Select Health Plan v. L.A. Care Health Plan* American Health Law Association, Case No. 7028, filed April 28, 2022 CONFERENCE WITH LEGAL COUNSEL—ANTICIPATED LITIGATION Significant exposure to litigation pursuant to Section 54956.9(d)(2) of Ralph M. Brown Act: Four Potential Cases CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION Pursuant to Section 54956.9(d)(1) of the Ralph M. Brown Act • Department of Managed Health Care Enforcement Matter Numbers: 18-799, 20-063, 21-428, 21-509, 21-680 • Department of Health Care Services, Office of Administrative Hearings and Appeals, In the matter of: L.A. Care Health Care Plan Appeal No. MCP22-0322-559-MF	

APPROVED

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
RECONVENE IN OPEN SESSION	The meeting reconvened in open session at 3:07 pm. No reportable actions were taken during the closed session.	
ADJOURNMENT	The meeting adjourned at 3:08 pm.	

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

APPROVED BY:

_____
Alvaro Ballesteros, MBA, *Board Chairperson*
Date: _____

APPROVED

FINANCE
&
BUDGET
COMMITTEE

Financial Update

Board of Governors Meeting

December 7, 2023

Agenda

Financial Performance – September 2023 YTD

- Membership
- Consolidated Financial Performance
  - Forecast vs Actuals
  - Financial Trend
  - Budget vs. Actuals
  - Variance Walk
- Operating Margins by Segment
- Key Financial Ratios
- Tangible Net Equity & Days of Cash On-Hand Comparison

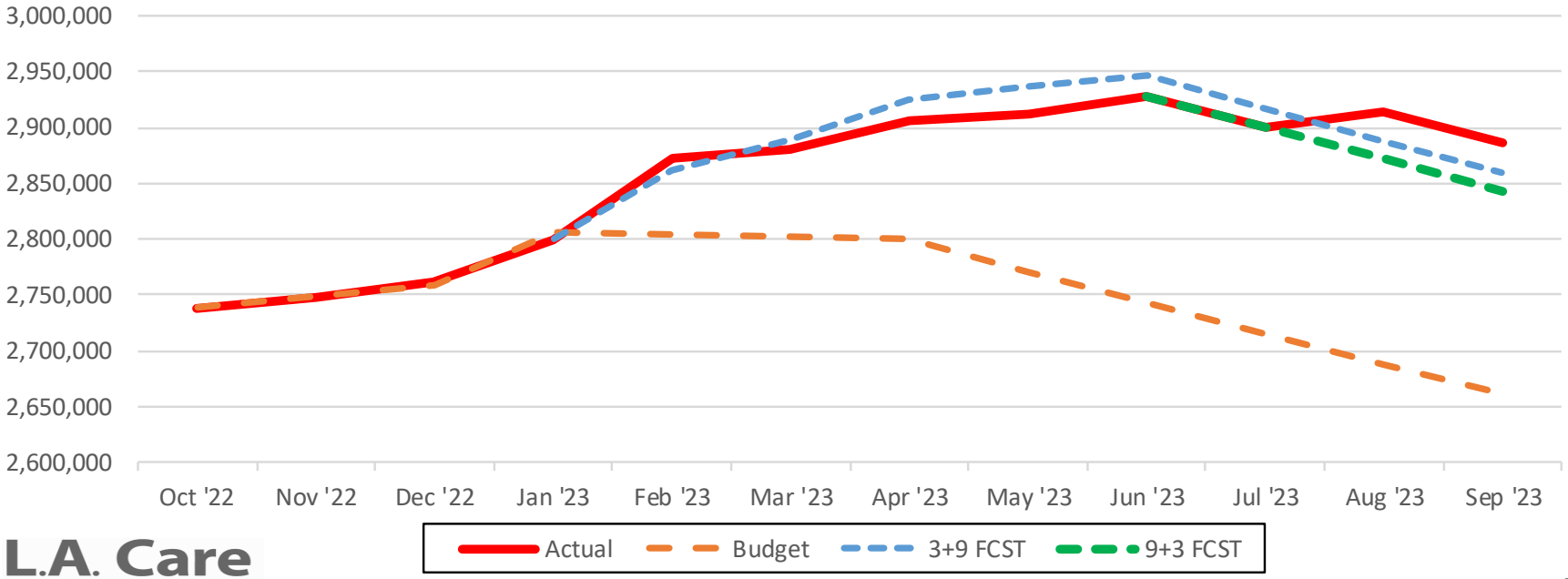
Financial Informational Updates

- Investment Transactions
- Quarterly/Annual Internal Policies Reports

Membership
for the 12 months ended September 2023

	September 2023			Year-to-Date		
Sub-Segment	**Actual**	**9+3 FCST**	**Variance**	**Actual**	**9+3 FCST**	**Variance**
Medi-Cal	2,706,816	2,664,523	42,293	32,128,986	32,042,206	86,780
CMC	-	-	-	51,321	51,321	-
D-SNP	18,446	18,369	77	162,354	162,213	141
LACC	130,265	129,514	751	1,476,298	1,479,324	(3,026)
PASC	48,636	48,954	(318)	591,869	592,246	(377)
***Elimination**	(18,446)	(18,369)	(77)	(162,354)	(162,213)	(141)
Consolidated	**2,885,717**	**2,842,991**	**42,726**	**34,248,474**	**34,165,096**	**83,378**

***D-SNP members included in MCLA membership under CCI beginning in January 2023**



L.A. Care HEALTH PLAN

Consolidated Financial Performance

for the month of September 2023

($ in Thousands)	Actual	9+3 FCST	Variance
Member Months	2,885,717	2,842,991	42,726
Total Revenues	$853,874	$948,883	($95,010)
Total Healthcare Expenses	$731,510	$920,038	$188,528
Operating Margin	$122,364	$28,846	$93,518
Operating Margin (excl HHIP/IPP)	$122,943	$33,096	$89,847
Total Admin Expenses	$50,509	$44,747	($5,762)
Income/(Loss) from Operations	$71,854	($15,901)	$87,756
Non-Operating Income (Expense)	$18,737	($20,037)	$38,774
Net Surplus	**$90,592**	**($35,938)**	**$126,530**
Net Surplus (excl HHIP/IPP)	***$92,066***	***($31,535)***	***$123,601***

L.A. Care HEALTH PLAN

Consolidated Financial Performance – Actuals vs. Forecast

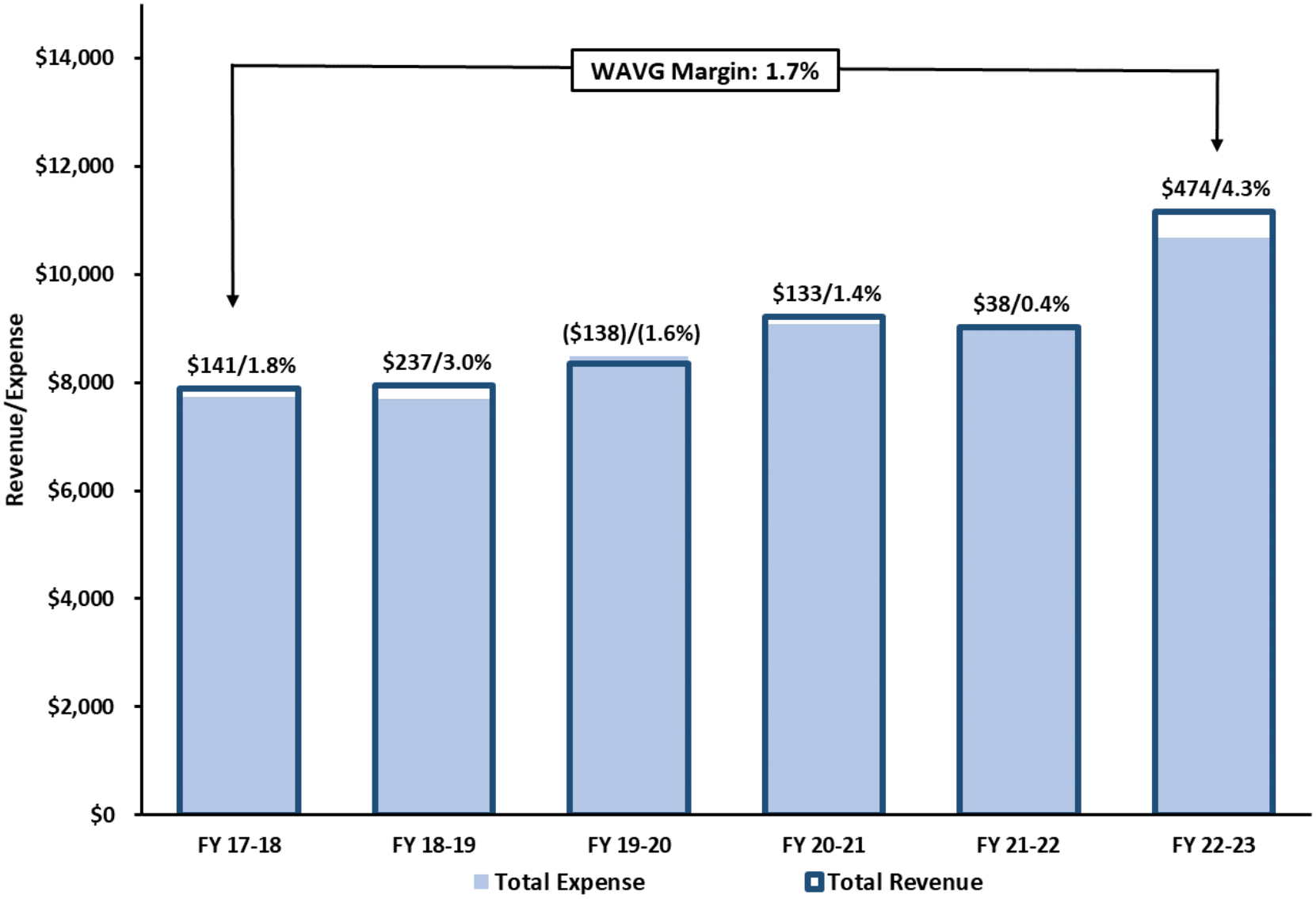
for the 12 months ended September 2023

($ in Thousands)	Actual	9+3 FCST	Variance
Member Months	34,248,474	34,165,096	83,378
Total Revenues	$11,290,839	$11,297,646	($6,807)
Total Healthcare Expenses	$10,182,852	$10,404,292	$221,440
Operating Margin	$1,107,987	$893,354	$214,633
Operating Margin (excl HHIP/IPP)	$934,171	$796,169	$138,002
Total Admin Expenses	$532,026	$522,720	($9,307)
Income/(Loss) from Operations	$575,960	$370,635	$205,326
Non-Operating Income (Expense)	$69,978	$19,542	$50,436
Net Surplus	**$645,939**	**$390,177**	**$255,762**
Net Surplus (excl HHIP/IPP)	***$473,757***	***$294,077***	***$179,680***

L.A. Care HEALTH PLAN

Consolidated Financial Performance ($M) – Six Year Trend

excl. IPP/HHIP



L.A. Care HEALTH PLAN

Consolidated Financial Performance – Actuals vs. Budget

for the 12 months ended September 2023

($ in Thousands)	Actual	Budget	Variance
Member Months	34,248,474	33,036,235	1,212,239
Total Revenues	$11,290,839	$10,165,331	$1,125,507
Total Healthcare Expenses	$10,182,852	$9,574,526	($608,326)
Operating Margin	$1,107,987	$590,806	$517,181
Operating Margin (excl HHIP/IPP)	$934,171	$590,806	$343,365
Total Admin Expenses	$532,026	$510,090	($21,936)
Income/(Loss) from Operations	$575,960	$80,716	$495,245
Non-Operating Income (Expense)	$69,978	($634)	$70,612
Net Surplus	**$645,939**	**$80,082**	**$565,857**
Net Surplus (excl HHIP/IPP)	***$473,757***	***$80,082***	***$393,675***

Variance Walk – Budget vs. Actuals

for the 12 months ended September 2023

	Revenue	Healthcare Costs	Admin	Non-Ops	Net Surplus
FY 2022-2023 Budget	**$10,165,331**	**$9,574,526**	**$510,090**	**($634)**	**$80,082**
CY 2022 & 2023 Rate Adjustments	$849,557	($116,240)		$24,594	$757,911
Non-Operating Income/(Expense)				$46,018	$46,018
Provider Incentives (excl IPP & HHIP)	$14,669	$6,764			$21,433
IHSS Reconciliation (CY 2014 - 2017)	($17,386)	$32,942			$15,556
Volume Impact on Operating Margin	$320,275	($305,098)			$15,177
RAF and Risk Sharing Adjustments	($21,177)	$2,660			($18,517)
Administrative Expenses			($20,302)		($20,302)
Risk Corridor Updates	($222,346)	$84,272			($138,074)
Incurred Claims		($276,313)			($276,313)
Other	($4,741)	($4,472)			($9,213)
Total Variance (excl HHIP & IPP)	**$918,850**	**($575,485)**	**($20,302)**	**$70,612**	**$393,675**
FY 2022-2023 Actuals (excl HHIP & IPP)	**$11,084,181**	**$10,150,010**	**$530,392**	**$69,978**	**$473,757**
HHIP & IPP	$206,658	($32,842)	($1,634)	$0	$172,182
Total Variance	**$1,125,508**	**($608,327)**	**($21,936)**	**$70,612**	**$565,857**
FY 2022-2023 Actuals	**$11,290,839**	**$10,182,852**	**$532,026**	**$69,978**	**$645,939**

Operating Margin by Segment

for the 12 months ended September 2023

($ in Thousands)

	Medi-Cal	CMC	D-SNP	LACC	PASC	Total	Total *(excl HHIP/IPP)*
Revenue	$10,115,404	$77,231	$239,433	$465,093	$187,020	$11,290,839	$11,084,181
Healthcare Exp.	$9,288,480	$80,583	$202,681	$407,270	$180,463	$10,182,852	$10,150,010
Operating Margin	$826,924	($3,351)	$36,752	$57,823	$6,557	$1,107,987	$934,171
MCR %	91.8%	104.3%	84.7%	87.6%	96.5%	90.2%	91.6%
9+3 FCST	93.2%	108.2%	84.2%	87.8%	96.2%	92.1%	92.9%

L.A. Care HEALTH PLAN

Key Financial Ratios

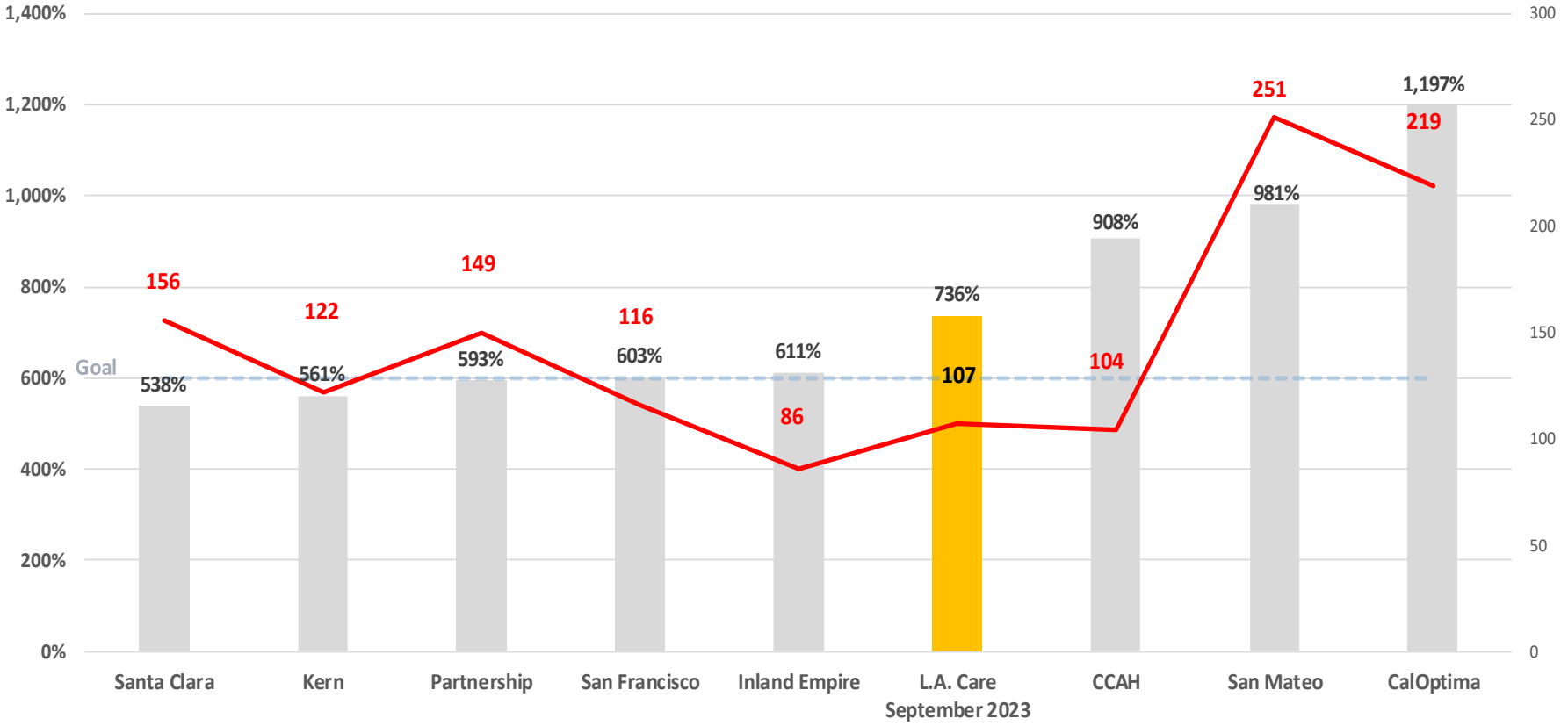
for the 12 months ended September 2023

(Excl. HHIP/IPP)	Actual		9+3 FCST	
MCR	91.6%	vs.	92.9%	✓
Admin Ratio	4.8%	vs.	4.7%	✗

	Actual		Benchmark	
Working Capital	1.32	vs.	1.00+	✓
Cash to Claims	0.85	vs.	0.75+	✓
Tangible Net Equity	7.36	vs.	1.30+	✓

Tangible Net Equity & Days of Cash On-Hand

for the 12 months ended September 2023



• As of June 2023 Quarterly filings, unless noted otherwise.

L.A. Care HEALTH PLAN

Questions & Consideration

Motion

- To accept the Financial Reports for the twelve months ended September 30, 2023, as submitted.

Informational Items

Investment Transactions

- As of September 30, 2023, L.A. Care's total investment market value was $3.3B
  - $3.2B managed by Payden & Rygel and New England Asset Management (NEAM)
  - $35M in Local Agency Investment Fund
  - $79M in Los Angeles County Pooled Investment Fund

Quarterly/Annual Internal Policy Reports

L.A. Care
HEALTH PLAN

Board of Governors
MOTION SUMMARY

Date: December 7, 2023 **Motion No. FIN 107.1223**

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

Requesting Department: Accounts & Finance Services

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

Issue: Acceptance of the Financial Reports for September 2023.

Background: N/A

Member Impact: N/A

Budget Impact: N/A

Motion: To accept the Financial Reports for September 2023, as submitted.

Financial Performance
September 2023
(Unaudited)

Financial Performance Results Highlights - Year-to-Date

September 2023

Overall

The combined September YTD member months are 34.2M, +83.4K favorable to the 9+3 forecast. YTD financial performance resulted in a surplus of +$645.9M or 5.7% margin and is +$255.8M/+227bps favorable to forecast. YTD forecast favorability is driven by lower capitation expenses +$132.2M, lower inpatient +$59.2M and outpatient +$30.5M claims, lower skilled nursing facility costs +$21.3M, and higher net interest income +$16.5M; partially offset by higher operating expenses ($9.3M), lower revenue ($6.8M), and higher pharmacy costs ($6.3M).

Medi-Cal

Medi-Cal consists of members through our contracted providers and our contracted health plans ("Plan Partners"). September YTD member months are 32.1M, +86.8K favorable to forecast. YTD financial performance resulted in a surplus of +$508.3M, +$183M favorable to forecast, driven by lower healthcare expense including lower capitation expenses +$121.3M, lower inpatient +$52.0M and outpatient +$37.0M claims, lower skilled nursing facility costs +$23.8M, and higher net interest income +$16.8M; partially offset by lower revenue ($86.8M) impacted by Prop 56 Risk Corridor of $173M which covered the Bridge Period 2019-20, CY 2021, and CY 2022 and UIS estimates of $63M that were booked in September.

Cal MediConnect (CMC)

Effective January 1, 2023, members enrolled in CMC have been transitioned to our D-SNP plan. September YTD member months are 51.3K, flat to forecast. YTD financial performance resulted in a deficit of ($3.8M), +$5.6M favorable to forecast, primarily driven by lower outpatient +$2.3M and inpatient +$1.4M claims as these expenses have been transitioned to D-SNP plan. CMC YTD favorability also benefited from higher net interest income +$1.2M.

D-SNP

January 2023 was the first month of the D-SNP plan as the CMC members were transitioned into this product. The September YTD member months are 162.4K, flat to forecast. YTD financial performance resulted in a surplus of +$21.7M, ($1.9M) unfavorable to forecast, driven by increased pharmacy costs ($2.7M), higher inpatient claims ($2.4M), and higher skilled nursing facility costs ($2.1M); partially offset by higher revenue +$5.0M due to 2023 RAF and risk share adjustments of $3.6M.

Commercial

L.A. Care Commercial consists of LACC and PASC-SEIU. The September YTD member months are 2.1M, unfavorable (3.4K) to forecast. YTD financial performance resulted in a deficit of ($18.4M), +$0.9M favorable to forecast, driven by lower inpatient claims +$8.8M and capitation expenses +$8.2M; partially offset by higher outpatient claims ($11.8M) and pharmacy costs ($3.5M).

Incentive Programs

L.A. Care Incentive Programs consist of CalAIM Incentive Payment Program (IPP) and Housing and Homelessness Incentive Program (HHIP). The September YTD surplus of +$172.2M, +$76.1M favorable to forecast, and is primarily driven by revenue recognition related to the DHCS investment plan submission. L.A. Care received an overall revenue total of $110M for IPP and $135M for HHIP.

L.A. Care HEALTH PLAN®

Consolidated Operations Income Statement ($ in thousands)

September 2023

Current Actual $	Current Actual PMPM	Current Forecast $	Current Forecast PMPM	Fav(Unfav) Forecast $	Fav(Unfav) Forecast PMPM		YTD Actual $	YTD Actual PMPM	YTD Forecast $	YTD Forecast PMPM	Fav(Unfav) Forecast $	Fav(Unfav) Forecast PMPM
						Membership						
2,885,717		2,842,991		42,726		Member Months	34,248,474		34,165,096		83,378	
						Revenue						
$ 853,874	$ 295.90	$ 948,883	$ 333.76	$ (95,010)	$ (37.87)	Capitation	$ 11,290,839	$ 329.67	$ 11,297,646	$ 330.68	$ (6,807)	$ (1.00)
$ 853,874	**$ 295.90**	**$ 948,883**	**$ 333.76**	**$ (95,010)**	**$ (37.87)**	**Total Revenues**	**$ 11,290,839**	**$ 329.67**	**$ 11,297,646**	**$ 330.68**	**$ (6,807)**	**$ (1.00)**
						Healthcare Expenses						
$ 401,066	$ 138.98	$ 555,932	$ 195.54	$ 154,866	$ 56.56	Capitation	$ 5,911,183	$ 172.60	$ 6,043,364	$ 176.89	$ 132,181	$ 4.29
$ 103,671	$ 35.93	$ 123,673	$ 43.50	$ 20,002	$ 7.58	Inpatient Claims	$ 1,444,767	$ 42.18	$ 1,503,972	$ 44.02	$ 59,205	$ 1.84
$ 95,715	$ 33.17	$ 112,000	$ 39.40	$ 16,285	$ 6.23	Outpatient Claims	$ 1,327,776	$ 38.77	$ 1,358,310	$ 39.76	$ 30,534	$ 0.99
$ 86,991	$ 30.15	$ 95,801	$ 33.70	$ 8,810	$ 3.55	Skilled Nursing Facility	$ 1,109,176	$ 32.39	$ 1,130,509	$ 33.09	$ 21,333	$ 0.70
$ 12,177	$ 4.22	$ 12,168	$ 4.28	$ (10)	$ 0.06	Pharmacy	$ 145,181	$ 4.24	$ 138,920	$ 4.07	$ (6,261)	$ (0.17)
$ 21,391	$ 7.41	$ 11,292	$ 3.97	$ (10,099)	$ (3.44)	Provider Incentives and Shared Risk	$ 138,963	$ 4.06	$ 128,091	$ 3.75	$ (10,872)	$ (0.31)
$ 10,500	$ 3.64	$ 9,172	$ 3.23	$ (1,328)	$ (0.41)	Medical Administrative Expenses	$ 105,805	$ 3.09	$ 101,126	$ 2.96	$ (4,679)	$ (0.13)
$ 731,510	**$ 253.49**	**$ 920,038**	**$ 323.62**	**$ 188,528**	**$ 70.12**	**Total Healthcare Expenses**	**$ 10,182,852**	**$ 297.32**	**$ 10,404,292**	**$ 304.53**	**$ 221,440**	**$ 7.21**
85.7%		*97.0%*		*11.3%*		*MCR(%)*	*90.2%*		*92.1%*		*1.9%*	
$ 122,364	**$ 42.40**	**$ 28,846**	**$ 10.15**	**$ 93,518**	**$ 32.26**	**Operating Margin**	**$ 1,107,987**	**$ 32.35**	**$ 893,354**	**$ 26.15**	**$ 214,633**	**$ 6.20**
$ 50,509	$ 17.50	$ 44,747	$ 15.74	$ (5,762)	$ (1.76)	**Total Operating Expenses**	$ 532,026	$ 15.53	$ 522,720	$ 15.30	$ (9,307)	$ (0.23)
5.9%		*4.7%*		*-1.2%*		*Admin Ratio(%)*	*4.7%*		*4.6%*		*-0.1%*	
$ 71,854	**$ 24.90**	**$ (15,901)**	**$ (5.59)**	**$ 87,756**	**$ 30.49**	**Income (Loss) from Operations**	**$ 575,960**	**$ 16.82**	**$ 370,635**	**$ 10.85**	**$ 205,326**	**$ 5.97**
$ 9,569	$ 3.32	$ (25,150)	$ (8.85)	$ 34,720	$ 12.16	Other Income/(Expense), net	$ (32,573)	$ (0.95)	$ (67,349)	$ (1.97)	$ 34,776	$ 1.02
$ 11,547	$ 4.00	$ 5,113	$ 1.80	$ 6,434	$ 2.20	Interest Income, net	$ 98,277	$ 2.87	$ 81,778	$ 2.39	$ 16,499	$ 0.48
$ (37)	$ (0.01)	$ -	$ -	$ (37)	$ (0.01)	Realized Gain / Loss	$ (2,099)	$ (0.06)	$ (1,562)	$ (0.05)	$ (537)	$ (0.02)
$ (2,342)	$ (0.81)	$ -	$ -	$ (2,342)	$ (0.81)	Unrealized Gain / Loss	$ 6,373	$ 0.19	$ 6,675	$ 0.20	$ (302)	$ (0.01)
$ 18,737	**$ 6.49**	**$ (20,037)**	**$ (7.05)**	**$ 38,774**	**$ 13.54**	**Total Non-Operating Income (Expense)**	**$ 69,978**	**$ 2.04**	**$ 19,542**	**$ 0.57**	**$ 50,436**	**$ 1.47**
$ 90,592	**$ 31.39**	**$ (35,938)**	**$ (12.64)**	**$ 126,530**	**$ 44.03**	**Net Surplus (Deficit)**	**$ 645,939**	**$ 18.86**	**$ 390,177**	**$ 11.42**	**$ 255,762**	**$ 7.44**
10.6%		*-3.8%*		*14.4%*		*Margin(%)*	*5.7%*		*3.5%*		*2.3%*	

L.A. Care HEALTH PLAN

Total Medi-Cal Income Statement ($ in thousands)

September 2023

Current Actual $	Current Actual PMPM	Current Forecast $	Current Forecast PMPM	Fav(Unfav) Forecast $	Fav(Unfav) Forecast PMPM		YTD Actual $	YTD Actual PMPM	YTD Forecast $	YTD Forecast PMPM	Fav(Unfav) Forecast $	Fav(Unfav) Forecast PMPM
						Membership						
2,706,816		2,664,523		42,293		Member Months	32,128,986		32,042,206		86,780	
						Revenue						
$ 768,302	$ 283.84	$ 867,015	$ 325.39	$ (98,713)	$ (41.55)	Capitation	$ 10,115,404	$ 314.84	$ 10,202,155	$ 318.40	$ (86,751)	$ (3.56)
$ 768,302	**$ 283.84**	**$ 867,015**	**$ 325.39**	**$ (98,713)**	**$ (41.55)**	**Total Revenues**	**$ 10,115,404**	**$ 314.84**	**$ 10,202,155**	**$ 318.40**	**$ (86,751)**	**$ (3.56)**
						Healthcare Expenses						
$ 373,250	$ 137.89	$ 522,960	$ 196.27	$ 149,709	$ 58.37	Capitation	$ 5,561,876	$ 173.11	$ 5,683,208	$ 177.37	$ 121,332	$ 4.26
$ 89,417	$ 33.03	$ 108,094	$ 40.57	$ 18,677	$ 7.53	Inpatient Claims	$ 1,253,928	$ 39.03	$ 1,305,975	$ 40.76	$ 52,047	$ 1.73
$ 85,162	$ 31.46	$ 100,782	$ 37.82	$ 15,620	$ 6.36	Outpatient Claims	$ 1,185,624	$ 36.90	$ 1,222,661	$ 38.16	$ 37,037	$ 1.26
$ 86,170	$ 31.83	$ 95,801	$ 35.95	$ 9,631	$ 4.12	Skilled Nursing Facility	$ 1,095,500	$ 34.10	$ 1,119,292	$ 34.93	$ 23,792	$ 0.83
$ 4	$ 0.00	$ -	$ -	$ (4)	$ (0.00)	Pharmacy	$ 403	$ 0.01	$ 401	$ 0.01	$ (2)	$ (0.00)
$ 13,636	$ 5.04	$ 5,226	$ 1.96	$ (8,409)	$ (3.08)	Provider Incentives and Shared Risk	$ 92,367	$ 2.87	$ 85,473	$ 2.67	$ (6,895)	$ (0.21)
$ 9,709	$ 3.59	$ 8,163	$ 3.06	$ (1,546)	$ (0.52)	Medical Administrative Expenses	$ 98,781	$ 3.07	$ 93,615	$ 2.92	$ (5,166)	$ (0.15)
$ 657,348	**$ 242.85**	**$ 841,027**	**$ 315.64**	**$ 183,679**	**$ 72.79**	**Total Healthcare Expenses**	**$ 9,288,480**	**$ 289.10**	**$ 9,510,626**	**$ 296.82**	**$ 222,146**	**$ 7.72**
85.6%		*97.0%*		*11.4%*		*MCR(%)*	*91.8%*		*93.2%*		*1.4%*	
$ 110,954	**$ 40.99**	**$ 25,988**	**$ 9.75**	**$ 84,966**	**$ 31.24**	**Operating Margin**	**$ 826,924**	**$ 25.74**	**$ 691,529**	**$ 21.58**	**$ 135,395**	**$ 4.16**
$ 41,092	$ 15.18	$ 35,827	$ 13.45	$ (5,265)	$ (1.73)	**Total Operating Expenses**	$ 426,360	$ 13.27	$ 417,434	$ 13.03	$ (8,926)	$ (0.24)
5.3%		*4.1%*		*-1.2%*		*Admin Ratio(%)*	*4.2%*		*4.1%*		*-0.1%*	
$ 69,862	**$ 25.81**	**$ (9,839)**	**$ (3.69)**	**$ 79,701**	**$ 29.50**	**Income (Loss) from Operations**	**$ 400,564**	**$ 12.47**	**$ 274,095**	**$ 8.55**	**$ 126,469**	**$ 3.91**
$ 28,139	**$ 10.40**	**$ (16,734)**	**$ (6.28)**	**$ 44,873**	**$ 16.68**	**Total Non-Operating Income (Expense)**	**$ 107,738**	**$ 3.35**	**$ 51,235**	**$ 1.60**	**$ 56,503**	**$ 1.75**
$ 98,001	**$ 36.21**	**$ (26,572)**	**$ (9.97)**	**$ 124,574**	**$ 46.18**	**Net Surplus (Deficit)**	**$ 508,302**	**$ 15.82**	**$ 325,330**	**$ 10.15**	**$ 182,972**	**$ 5.67**
12.8%		*-3.1%*		*15.8%*		*Margin(%)*	*5.0%*		*3.2%*		*1.8%*	

CMC Income Statement ($ in thousands)

September 2023

Current Actual $	Current Actual PMPM	Current Forecast $	Current Forecast PMPM	Fav(Unfav) Forecast $	Fav(Unfav) Forecast PMPM		YTD Actual $	YTD Actual PMPM	YTD Forecast $	YTD Forecast PMPM	Fav(Unfav) Forecast $	Fav(Unfav) Forecast PMPM
						Membership						
-				-		Member Months	51,321		51,321		-	
						Revenue						
$ (43)	N/A	$ -	N/A	$ (43)	N/A	Capitation	$ 77,231	$ 1,504.86	$ 77,319	$ 1,506.57	$ (88)	$ (1.71)
$ (43)	**$ -**	**$ -**	**$ -**	**$ (43)**	**$ -**	**Total Revenues**	**$ 77,231**	**$ 1,504.86**	**$ 77,319**	**$ 1,506.57**	**$ (88)**	**$ (1.71)**
						Healthcare Expenses						
$ (20)	N/A	$ -	N/A	$ 20	N/A	Capitation	$ 31,383	$ 611.50	$ 31,439	$ 612.60	$ 56	$ 1.10
$ (538)	N/A	$ -	N/A	$ 538	N/A	Inpatient Claims	$ 23,492	$ 457.74	$ 24,909	$ 485.36	$ 1,418	$ 27.62
$ (1,921)	N/A	$ -	N/A	$ 1,921	N/A	Outpatient Claims	$ 8,622	$ 167.99	$ 10,904	$ 212.46	$ 2,282	$ 44.47
$ (26)	N/A	$ -	N/A	$ 26	N/A	Skilled Nursing Facility	$ 7,297	$ 142.18	$ 7,208	$ 140.44	$ (89)	$ (1.74)
$ (2)	N/A	$ -	N/A	$ 2	N/A	Pharmacy	$ (3,737)	$ (72.82)	$ (3,775)	$ (73.55)	$ (38)	$ (0.73)
$ -	N/A	$ -	N/A	$ -	N/A	Provider Incentives and Shared Risk	$ 11,174	$ 217.72	$ 11,174	$ 217.72	$ -	$ -
$ 180	N/A	$ -	N/A	$ (180)	N/A	Medical Administrative Expenses	$ 2,353	$ 45.86	$ 1,795	$ 34.97	$ (559)	$ (10.89)
$ (2,327)	**$ -**	**$ -**	**$ -**	**$ 2,327**	**$ -**	**Total Healthcare Expenses**	**$ 80,583**	**$ 1,570.17**	**$ 83,653**	**$ 1,630.00**	**$ 3,071**	**$ 59.83**
5352.3%		*0.0%*		*-5352.3%*		*MCR(%)*	*104.3%*		*108.2%*		*3.9%*	
$ 2,283	**$ -**	**$ -**	**$ -**	**$ 2,283**	**$ -**	**Operating Margin**	**$ (3,351)**	**$ (65.30)**	**$ (6,334)**	**$ (123.43)**	**$ 2,983**	**$ 58.12**
$ (864)	$ -	$ -	$ -	$ 864	$ -	**Total Operating Expenses**	$ 4,992	$ 97.27	$ 5,628	$ 109.67	$ 636	$ 12.40
1988.0%		*0.0%*		*-1988.0%*		*Admin Ratio(%)*	*6.5%*		*7.3%*		*0.8%*	
$ 3,147	**$ -**	**$ -**	**$ -**	**$ 3,147**	**$ -**	**Income (Loss) from Operations**	**$ (8,343)**	**$ (162.57)**	**$ (11,963)**	**$ (233.10)**	**$ 3,619**	**$ 70.53**
$ 1,063	**N/A**	**$ (146)**	**N/A**	**$ 1,209**	**N/A**	**Total Non-Operating Income (Expense)**	**$ 4,503**	**$ 87.74**	**$ 2,499**	**$ 48.70**	**$ 2,004**	**$ 39.04**
$ 4,210	**N/A**	**$ (146)**	**N/A**	**$ 4,357**	**N/A**	**Net Surplus (Deficit)**	**$ (3,841)**	**$ (74.83)**	**$ (9,464)**	**$ (184.40)**	**$ 5,623**	**$ 109.57**
-9686.0%		*0.0%*		*-9686.0%*		*Margin(%)*	*-5.0%*		*-12.2%*		*7.3%*	

L.A. Care HEALTH PLAN

D-SNP Income Statement ($ in thousands)

September 2023

Current Actual $	Current Actual PMPM	Current Forecast $	Current Forecast PMPM	Fav(Unfav) Forecast $	Fav(Unfav) Forecast PMPM		YTD Actual $	YTD Actual PMPM	YTD Forecast $	YTD Forecast PMPM	Fav(Unfav) Forecast $	Fav(Unfav) Forecast PMPM
						Membership						
18,446		18,369		77		Member Months	162,354		162,213		141	
						Revenue						
$ 25,069	$ 1,359.07	$ 25,465	$ 1,386.34	$ (396)	$ (27.26)	Capitation	$ 239,433	$ 1,474.76	$ 234,431	$ 1,445.21	$ 5,002	$ 29.55
$ 25,069	**$ 1,359.07**	**$ 25,465**	**$ 1,386.34**	**$ (396)**	**$ (27.26)**	**Total Revenues**	**$ 239,433**	**$ 1,474.76**	**$ 234,431**	**$ 1,445.21**	**$ 5,002**	**$ 29.55**
						Healthcare Expenses						
$ 11,484	$ 622.59	$ 11,112	$ 604.94	$ (372)	$ (17.65)	Capitation	$ 92,565	$ 570.14	$ 92,719	$ 571.59	$ 155	$ 1.45
$ 5,964	$ 323.31	$ 6,442	$ 350.72	$ 478	$ 27.41	Inpatient Claims	$ 60,340	$ 371.66	$ 57,934	$ 357.15	$ (2,407)	$ (14.51)
$ (1,358)	$ (73.62)	$ 2,760	$ 150.24	$ 4,118	$ 223.86	Outpatient Claims	$ 23,984	$ 147.73	$ 24,382	$ 150.31	$ 398	$ 2.58
$ 765	$ 41.47	$ -	$ -	$ (765)	$ (41.47)	Skilled Nursing Facility	$ 4,996	$ 30.77	$ 2,914	$ 17.96	$ (2,082)	$ (12.81)
$ 712	$ 38.57	$ 1,291	$ 70.27	$ 579	$ 31.69	Pharmacy	$ 12,875	$ 79.30	$ 10,141	$ 62.52	$ (2,734)	$ (16.78)
$ 745	$ 40.38	$ 929	$ 50.60	$ 185	$ 10.21	Provider Incentives and Shared Risk	$ 6,356	$ 39.15	$ 6,907	$ 42.58	$ 552	$ 3.44
$ 306	$ 16.58	$ 482	$ 26.22	$ 176	$ 9.64	Medical Administrative Expenses	$ 1,565	$ 9.64	$ 2,464	$ 15.19	$ 898	$ 5.55
$ 18,618	**$ 1,009.30**	**$ 23,016**	**$ 1,252.99**	**$ 4,398**	**$ 243.69**	**Total Healthcare Expenses**	**$ 202,681**	**$ 1,248.39**	**$ 197,461**	**$ 1,217.30**	**$ (5,221)**	**$ (31.10)**
74.3%		*90.4%*		*16.1%*		*MCR(%)*	*84.7%*		*84.2%*		*-0.4%*	
$ 6,452	**$ 349.78**	**$ 2,449**	**$ 133.34**	**$ 4,003**	**$ 216.43**	**Operating Margin**	**$ 36,752**	**$ 226.37**	**$ 36,970**	**$ 227.91**	**$ (218)**	**$ (1.54)**
$ 2,503	$ 135.71	$ 1,530	$ 83.27	$ (974)	$ (52.44)	**Total Operating Expenses**	$ 15,059	$ 92.75	$ 13,844	$ 85.34	$ (1,216)	$ (7.41)
10.0%		*6.0%*		*-4.0%*		*Admin Ratio(%)*	*6.3%*		*5.9%*		*-0.4%*	
$ 3,949	**$ 214.06**	**$ 920**	**$ 50.07**	**$ 3,029**	**$ 163.99**	**Income (Loss) from Operations**	**$ 21,692**	**$ 133.61**	**$ 23,126**	**$ 142.57**	**$ (1,434)**	**$ (8.96)**
$ -	**$ -**	**$ 163**	**$ 8.88**	**$ (163)**	**$ (8.88)**	**Total Non-Operating Income (Expense)**	**$ -**	**$ -**	**$ 489**	**$ 3.01**	**$ (489)**	**$ (3.01)**
$ 3,949	**$ 214.06**	**$ 1,083**	**$ 58.95**	**$ 2,866**	**$ 155.11**	**Net Surplus (Deficit)**	**$ 21,692**	**$ 133.61**	**$ 23,615**	**$ 145.58**	**$ (1,923)**	**$ (11.97)**
15.8%		*4.3%*		*11.5%*		*Margin(%)*	*9.1%*		*10.1%*		*-1.0%*	

L.A. Care HEALTH PLAN

Commercial Income Statement ($ in thousands)

September 2023

Current Actual $	Current Actual PMPM	Current Forecast $	Current Forecast PMPM	Fav(Unfav) Forecast $	Fav(Unfav) Forecast PMPM		YTD Actual $	YTD Actual PMPM	YTD Forecast $	YTD Forecast PMPM	Fav(Unfav) Forecast $	Fav(Unfav) Forecast PMPM
						Membership						
178,901		178,468		433		Member Months	2,068,167		2,071,569		(3,402)	
						Revenue						
$ 55,222	$ 308.67	$ 54,979	$ 308.06	$ 243	$ 0.61	Capitation	$ 652,113	$ 315.31	$ 653,087	$ 315.26	$ (974)	$ 0.05
$ 55,222	**$ 308.67**	**$ 54,979**	**$ 308.06**	**$ 243**	**$ 0.61**	**Total Revenues**	**$ 652,113**	**$ 315.31**	**$ 653,087**	**$ 315.26**	**$ (974)**	**$ 0.05**
						Healthcare Expenses						
$ 16,351	$ 91.40	$ 21,042	$ 117.90	$ 4,691	$ 26.50	Capitation	$ 225,360	$ 108.97	$ 233,516	$ 112.72	$ 8,156	$ 3.76
$ 8,828	$ 49.35	$ 9,137	$ 51.20	$ 309	$ 1.85	Inpatient Claims	$ 105,885	$ 51.20	$ 114,679	$ 55.36	$ 8,794	$ 4.16
$ 13,832	$ 77.32	$ 7,571	$ 42.42	$ (6,261)	$ (34.90)	Outpatient Claims	$ 109,537	$ 52.96	$ 97,696	$ 47.16	$ (11,840)	$ (5.80)
$ 82	$ 0.46	$ -	$ -	$ (82)	$ (0.46)	Skilled Nursing Facility	$ 1,382	$ 0.67	$ 1,095	$ 0.53	$ (288)	$ (0.14)
$ 11,463	$ 64.08	$ 10,877	$ 60.95	$ (587)	$ (3.13)	Pharmacy	$ 135,637	$ 65.58	$ 132,149	$ 63.79	$ (3,488)	$ (1.79)
$ 1,107	$ 6.19	$ 1,226	$ 6.87	$ 119	$ 0.68	Provider Incentives and Shared Risk	$ 6,863	$ 3.32	$ 7,030	$ 3.39	$ 167	$ 0.08
$ 304	$ 1.70	$ 467	$ 2.62	$ 163	$ 0.92	Medical Administrative Expenses	$ 3,069	$ 1.48	$ 3,037	$ 1.47	$ (32)	$ (0.02)
$ 51,968	**$ 290.49**	**$ 50,320**	**$ 281.96**	**$ (1,648)**	**$ (8.53)**	**Total Healthcare Expenses**	**$ 587,733**	**$ 284.18**	**$ 589,201**	**$ 284.42**	**$ 1,469**	**$ 0.24**
94.1%		*91.5%*		*-2.6%*		*MCR(%)*	*90.1%*		*90.2%*		*0.1%*	
$ 3,253	**$ 18.19**	**$ 4,659**	**$ 26.10**	**$ (1,405)**	**$ (7.92)**	**Operating Margin**	**$ 64,380**	**$ 31.13**	**$ 63,885**	**$ 30.84**	**$ 495**	**$ 0.29**
$ 6,273	$ 35.06	$ 7,010	$ 39.28	$ 737	$ 4.21	**Total Operating Expenses**	$ 83,645	$ 40.44	$ 85,012	$ 41.04	$ 1,367	$ 0.59
11.4%		*12.8%*		*1.4%*		*Admin Ratio(%)*	*12.8%*		*13.0%*		*0.2%*	
$ (3,020)	**$ (16.88)**	**$ (2,351)**	**$ (13.17)**	**$ (668)**	**$ (3.70)**	**Income (Loss) from Operations**	**$ (19,265)**	**$ (9.31)**	**$ (21,126)**	**$ (10.20)**	**$ 1,862**	**$ 0.88**
$ 0	**$ 0.00**	**$ 318**	**$ 1.78**	**$ (317)**	**$ (1.78)**	**Total Non-Operating Income (Expense)**	**$ 848**	**$ 0.41**	**$ 1,799**	**$ 0.87**	**$ (951)**	**$ (0.46)**
$ (3,019)	**$ (16.88)**	**$ (2,034)**	**$ (11.39)**	**$ (986)**	**$ (5.48)**	**Net Surplus (Deficit)**	**$ (18,416)**	**$ (8.90)**	**$ (19,327)**	**$ (9.33)**	**$ 910**	**$ 0.42**
-5.5%		*-3.7%*		*-1.8%*		*Margin(%)*	*-2.8%*		*-3.0%*		*0.1%*	

L.A. Care HEALTH PLAN

Incentive Programs (IPP & HHIP) Income Statement ($ in thousands)

September 2023

Current Actual $	Current Actual PMPM	Current Forecast $	Current Forecast PMPM	Fav(Unfav) Forecast $	Fav(Unfav) Forecast PMPM		YTD Actual $	YTD Actual PMPM	YTD Forecast $	YTD Forecast PMPM	Fav(Unfav) Forecast $	Fav(Unfav) Forecast PMPM
				-		**Membership** Member Months					-	
						Revenue						
$ 5,324	$ -	$ 1,424	$ -	$ 3,900	$ -	Capitation	$ 206,658	$ -	$ 130,654	$ -	$ 76,004	$ -
$ 5,324	**$ -**	**$ 1,424**	**$ -**	**$ 3,900**	**$ -**	**Total Revenues**	**$ 206,658**	**$ -**	**$ 130,654**	**$ -**	**$ 76,004**	**$ -**
						Healthcare Expenses						
$ -	$ -	$ 818	$ -	$ 818	$ -	Capitation	$ -	$ -	$ 2,482	$ -	$ 2,482	$ -
$ -	$ -	$ 888	$ -	$ 888	$ -	Outpatient Claims	$ -	$ -	$ 2,663	$ -	$ 2,663	$ -
$ 5,903	$ -	$ 3,910	$ -	$ (1,994)	$ -	Provider Incentives and Shared Risk	$ 32,842	$ -	$ 28,145	$ -	$ (4,697)	$ -
$ -	$ -	$ 60	$ -	$ 60	$ -	Medical Administrative Expenses	$ 0	$ -	$ 180	$ -	$ 180	$ -
$ 5,903	**$ -**	**$ 5,675**	**$ -**	**$ (228)**	**$ -**	**Total Healthcare Expenses**	**$ 32,842**	**$ -**	**$ 33,469**	**$ -**	**$ 627**	**$ -**
110.9%		*398.5%*		*287.6%*		*MCR(%)*	*15.9%*		*25.6%*		*9.7%*	
$ (579)	**$ -**	**$ (4,251)**	**$ -**	**$ 3,671**	**$ -**	**Operating Margin**	**$ 173,816**	**$ -**	**$ 97,185**	**$ -**	**$ 76,631**	**$ -**
$ 895	$ -	$ 152	$ -	$ (743)	$ -	**Total Operating Expenses**	$ 1,634	$ -	$ 1,085	$ -	$ (549)	$ -
16.8%		*10.7%*		*-6.1%*		*Admin Ratio(%)*	*0.8%*		*0.8%*		*0.0%*	
$ (1,474)	**$ -**	**$ (4,403)**	**$ -**	**$ 2,929**	**$ -**	**Income (Loss) from Operations**	**$ 172,182**	**$ -**	**$ 96,100**	**$ -**	**$ 76,081**	**$ -**
$ -	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**Total Non-Operating Income (Expense)**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
$ (1,474)	**$ -**	**$ (4,403)**	**$ -**	**$ 2,929**	**$ -**	**Net Surplus (Deficit)**	**$ 172,182**	**$ -**	**$ 96,100**	**$ -**	**$ 76,081**	**$ -**
-27.7%		*-309.2%*		*281.5%*		*Margin(%)*	*83.3%*		*73.6%*		*9.8%*	

DATE: November 15, 2023

TO: Finance & Budget Committee

FROM: Afzal Shah, *Chief Financial Officer*

SUBJECT: Monthly Investment Portfolio Securities Transaction Report for September, 2023

To keep the Committee apprised of L.A. Care's investment portfolios and to comply with California Government Code Section 53607, attached are the monthly investment transaction details from September 1 to Septmber 30, 2023.

L.A. Care's investment market value as of September 30, 2023, was $3.3 billion. This includes our funds invested with the government pooled funds. L.A. Care has approximately $35 million invested with the statewide Local Agency Investment Fund (LAIF), and approximately $79 million invested with the Los Angeles County Pooled Investment Fund (LACPIF).

The remainder as of September 30, 2023, of $3.2 billion is managed by two independent asset managers, 1) Payden & Rygel and 2) New England Asset Management (NEAM) and is divided into three portfolios based on investment style,

1. Payden & Rygel - Short-term portfolio
2. Payden & Rygel - Extended term portfolio
3. New England Asset Management - Corporate notes extended term portfolio

The transactions within these three portfolios are included in the attached reports.

LA Care, as a California government entity, only makes investments in bonds/fixed income, as per the California Government Code. The entries on the Investment Securities Portfolio Transaction Report reflect transactions undertaken by financial management companies on L.A. Care's behalf. L.A. Care does not direct these individual transactions. The firms, managing investments on behalf of L.A. Care, conduct the transactions based on L.A. Care's investment guidelines.

Account Name: L.A. CARE HEALTH PLAN

09/01/2023 through 09/30/2023

Tr Date	St Date	Transaction Type	Units	Description		Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
09/01/23	09/01/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 09/07/23 Cpn	912796YH6	(49,956,500.00)		0.00	0.00	(49,956,500.00)
09/01/23	09/01/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 09/07/23 Cpn	912796YH6	(49,956,500.00)		0.00	0.00	(49,956,500.00)
09/01/23	09/01/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 09/07/23 Cpn	912796YH6	(49,956,500.00)		0.00	0.00	(49,956,500.00)
09/01/23	09/01/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 09/07/23 Cpn	912796YH6	(49,956,500.00)		0.00	0.00	(49,956,500.00)
09/01/23	09/01/23	Buy	20,000,000.000	U.S. TREASURY BILL MAT 09/07/23 Cpn	912796YH6	(19,982,600.00)		0.00	0.00	(19,982,600.00)
09/01/23	09/01/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 09/21/23 Cpn	912796CR8	(49,853,888.89)		0.00	0.00	(49,853,888.89)
09/01/23	09/01/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 09/21/23 Cpn	912796CR8	(49,853,888.89)		0.00	0.00	(49,853,888.89)
09/01/23	09/01/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 09/21/23 Cpn	912796CR8	(49,853,888.89)		0.00	0.00	(49,853,888.89)
09/01/23	09/01/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 09/21/23 Cpn	912796CR8	(49,853,888.89)		0.00	0.00	(49,853,888.89)
09/01/23	09/01/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 11/14/23 Cpn	912797HK6	(49,459,131.94)		0.00	0.00	(49,459,131.94)
09/01/23	09/01/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 11/14/23 Cpn	912797HK6	(49,459,131.94)		0.00	0.00	(49,459,131.94)
09/01/23	09/01/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 11/14/23 Cpn	912797HK6	(49,459,131.94)		0.00	0.00	(49,459,131.94)
09/01/23	09/01/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 11/14/23 Cpn	912797HK6	(49,459,131.94)		0.00	0.00	(49,459,131.94)

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Tr Date	St Date	Transaction Type	Units	Description		Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
09/01/23	09/01/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 09/19/23 Cpn	912797GT8	(49,868,250.00)		0.00	0.00	(49,868,250.00)
09/01/23	09/01/23	Buy	40,000,000.000	U.S. TREASURY BILL MAT 09/19/23 Cpn	912797GT8	(39,894,600.00)		0.00	0.00	(39,894,600.00)
09/01/23	09/01/23	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/05/23 Cpn	313384LH0	(49,970,944.44)		0.00	0.00	(49,970,944.44)
09/01/23	09/01/23	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/05/23 Cpn	313384LH0	(49,970,944.44)		0.00	0.00	(49,970,944.44)
09/01/23	09/01/23	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/05/23 Cpn	313384LH0	(49,970,944.44)		0.00	0.00	(49,970,944.44)
09/01/23	09/01/23	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/05/23 Cpn	313384LH0	(49,970,944.44)		0.00	0.00	(49,970,944.44)
09/01/23	09/01/23	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/05/23 Cpn	313384LH0	(49,970,944.44)		0.00	0.00	(49,970,944.44)
09/01/23	09/01/23	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/05/23 Cpn	313384LH0	(49,970,944.44)		0.00	0.00	(49,970,944.44)
09/01/23	09/01/23	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/05/23 Cpn	313384LH0	(49,970,944.44)		0.00	0.00	(49,970,944.44)
09/05/23	09/05/23	Buy	22,500,000.000	CREDIT AGRICOLE CP MAT 09/12/23 Cpn	22533UWC3	(22,476,856.25)		0.00	0.00	(22,476,856.25)
09/05/23	09/05/23	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/06/23 Cpn	313384LJ6	(49,992,708.33)		0.00	0.00	(49,992,708.33)
09/05/23	09/05/23	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/06/23 Cpn	313384LJ6	(49,992,708.33)		0.00	0.00	(49,992,708.33)
09/05/23	09/05/23	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/06/23 Cpn	313384LJ6	(49,992,708.33)		0.00	0.00	(49,992,708.33)

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Tr Date	St Date	Transaction Type	Units	Description		Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
09/05/23	09/05/23	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/06/23 Cpn	313384LJ6	(49,992,708.33)		0.00	0.00	(49,992,708.33)
09/05/23	09/05/23	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/06/23 Cpn	313384LJ6	(49,992,708.33)		0.00	0.00	(49,992,708.33)
09/05/23	09/05/23	Buy	10,000,000.000	SOUTHERN CALIF GAS CP 144A MAT 09/12/23 Cpn	84243MWC	(9,989,655.56)		0.00	0.00	(9,989,655.56)
09/06/23	09/06/23	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/07/23 Cpn	313384LK3	(49,992,708.33)		0.00	0.00	(49,992,708.33)
09/06/23	09/06/23	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/07/23 Cpn	313384LK3	(49,992,708.33)		0.00	0.00	(49,992,708.33)
09/06/23	09/06/23	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/07/23 Cpn	313384LK3	(49,992,708.33)		0.00	0.00	(49,992,708.33)
09/06/23	09/06/23	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/07/23 Cpn	313384LK3	(49,992,708.33)		0.00	0.00	(49,992,708.33)
09/06/23	09/06/23	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/07/23 Cpn	313384LK3	(49,992,708.33)		0.00	0.00	(49,992,708.33)
09/06/23	09/06/23	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/07/23 Cpn	313384LK3	(49,992,708.33)		0.00	0.00	(49,992,708.33)
09/05/23	09/06/23	Buy	20,000,000.000	NATL SEC CLEARING CP 144A MAT 09/28/23 Cpn	63763QWU	(19,935,100.00)		0.00	0.00	(19,935,100.00)
09/06/23	09/07/23	Buy	20,000,000.000	U.S. TREASURY BILL MAT 09/14/23 Cpn	912796CQ0	(19,979,719.44)		0.00	0.00	(19,979,719.44)
09/06/23	09/07/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 09/14/23 Cpn	912796CQ0	(49,949,298.61)		0.00	0.00	(49,949,298.61)
09/06/23	09/07/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 09/14/23 Cpn	912796CQ0	(49,949,298.61)		0.00	0.00	(49,949,298.61)

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Tr Date	St Date	Transaction Type	Units	Description	Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
09/06/23	09/07/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 09/14/23 Cpn 912796CQ0	(49,949,298.61)		0.00	0.00	(49,949,298.61)
09/06/23	09/07/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 09/14/23 Cpn 912796CQ0	(49,949,298.61)		0.00	0.00	(49,949,298.61)
09/07/23	09/07/23	Buy	25,000,000.000	FHLB DISCOUNT NOTE MAT 09/08/23 Cpn 313384LL1	(24,996,354.17)		0.00	0.00	(24,996,354.17)
09/05/23	09/07/23	Buy	5,069,850.060	NAROT 2022-A A2 CAR MAT 11/15/24 Cpn 1.32 65479QAB3	(5,047,669.48)	(4,089.68)	0.00	0.00	(5,051,759.16)
09/07/23	09/07/23	Buy	25,000,000.000	UNITEDHEALTH GROUP CP 144A MAT 09/08/23 Cpn 91058UW82	(24,996,312.50)		0.00	0.00	(24,996,312.50)
09/08/23	09/08/23	Buy	40,000,000.000	FHLB DISCOUNT NOTE MAT 09/11/23 Cpn 313384LP2	(39,982,500.00)		0.00	0.00	(39,982,500.00)
09/06/23	09/08/23	Buy	5,000,000.000	INTER-AMERICAN DEV BANK FRN MAT 02/10/26 Cpn 5.54 4581X0DT2	(4,998,500.00)	(22,193.86)	0.00	0.00	(5,020,693.86)
09/07/23	09/08/23	Buy	10,000,000.000	U.S. TREASURY FRN MAT 07/31/25 Cpn 5.53 91282CHS3	(9,991,908.50)	(59,573.48)	0.00	0.00	(10,051,481.98)
09/11/23	09/11/23	Buy	30,000,000.000	AUTOMATIC DATA CP 144A MAT 09/12/23 Cpn 0530A3WC8	(29,995,583.33)		0.00	0.00	(29,995,583.33)
09/11/23	09/11/23	Buy	12,500,000.000	FHLB DISCOUNT NOTE MAT 09/12/23 Cpn 313384LQ0	(12,498,184.03)		0.00	0.00	(12,498,184.03)
09/07/23	09/11/23	Buy	1,100,000.000	GM 2020-2 A FLOOR 144A MAT 10/15/25 Cpn 0.69 361886CM4	(1,094,886.72)	(548.17)	0.00	0.00	(1,095,434.89)
09/12/23	09/12/23	Buy	30,000,000.000	AUTOMATIC DATA CP 144A MAT 09/13/23 Cpn 0530A3WD6	(29,995,583.33)		0.00	0.00	(29,995,583.33)
09/12/23	09/12/23	Buy	8,000,000.000	SC SOUTH CAROLINA PUB SVC CP MAT 09/21/23 Cpn 5.40 83708BCE4	(8,000,000.00)		0.00	0.00	(8,000,000.00)

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09/12/23	09/13/23	Buy	10,000,000.000	BNP PARIBAS NY CP MAT 06/07/24 Cpn	09659BF70	(9,579,388.89)		0.00	0.00	(9,579,388.89)
09/13/23	09/13/23	Buy	24,000,000.000	FHLB DISCOUNT NOTE MAT 09/14/23 Cpn	313384LS6	(23,996,513.33)		0.00	0.00	(23,996,513.33)
09/11/23	09/13/23	Buy	4,370,869.490	FORDO 2020-C A3 MAT 07/15/25 Cpn 0.41	34533YAD2	(4,302,675.18)	(1,393.82)	0.00	0.00	(4,304,069.00)
09/14/23	09/14/23	Buy	22,500,000.000	CATERPILLAR FIN CP MAT 09/28/23 Cpn	14912EWU7	(22,453,625.00)		0.00	0.00	(22,453,625.00)
09/14/23	09/14/23	Buy	28,000,000.000	FHLB DISCOUNT NOTE MAT 09/15/23 Cpn	313384LT4	(27,995,932.22)		0.00	0.00	(27,995,932.22)
09/14/23	09/14/23	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/15/23 Cpn	313384LT4	(49,992,736.11)		0.00	0.00	(49,992,736.11)
09/14/23	09/14/23	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/15/23 Cpn	313384LT4	(49,992,736.11)		0.00	0.00	(49,992,736.11)
09/15/23	09/15/23	Buy	10,452,000.000	BNP PARIBAS NY CP MAT 10/02/23 Cpn	09659CX29	(10,425,742.25)		0.00	0.00	(10,425,742.25)
09/15/23	09/15/23	Buy	20,000,000.000	FHLB DISCOUNT NOTE MAT 09/18/23 Cpn	313384LW7	(19,991,250.00)		0.00	0.00	(19,991,250.00)
09/15/23	09/15/23	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/18/23 Cpn	313384LW7	(49,978,125.00)		0.00	0.00	(49,978,125.00)
09/15/23	09/15/23	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/18/23 Cpn	313384LW7	(49,978,125.00)		0.00	0.00	(49,978,125.00)
09/15/23	09/15/23	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/18/23 Cpn	313384LW7	(49,978,125.00)		0.00	0.00	(49,978,125.00)
09/14/23	09/15/23	Buy	7,000,000.000	SUMITOMO MITSUI CP 144A MAT 09/25/23 Cpn	86563HWR7	(6,989,616.67)		0.00	0.00	(6,989,616.67)

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09/18/23	09/18/23	Buy	30,000,000.000	FHLB DISCOUNT NOTE MAT 09/19/23 Cpn	313384LX5	(29,995,625.00)		0.00	0.00	(29,995,625.00)
09/07/23	09/18/23	Buy	10,000,000.000	FHLMC C 12/18/23 Q MAT 09/18/26 Cpn 6.00	3134H1BW2	(10,000,000.00)		0.00	0.00	(10,000,000.00)
09/06/23	09/19/23	Buy	8,300,000.000	FHLB C 12/19/23 Q MAT 12/19/25 Cpn 5.75	3130AX4Y1	(8,300,000.00)		0.00	0.00	(8,300,000.00)
09/19/23	09/19/23	Buy	15,000,000.000	FHLB DISCOUNT NOTE MAT 09/20/23 Cpn	313384LY3	(14,997,812.50)		0.00	0.00	(14,997,812.50)
09/14/23	09/19/23	Buy	7,700,000.000	FORDL 2023-B A1 LEASE MAT 10/15/24 Cpn 5.69	34529NAA8	(7,700,000.00)		0.00	0.00	(7,700,000.00)
09/20/23	09/20/23	Buy	5,000,000.000	FHLB DISCOUNT NOTE MAT 09/21/23 Cpn	313384LZ0	(4,999,270.83)		0.00	0.00	(4,999,270.83)
09/20/23	09/20/23	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/21/23 Cpn	313384LZ0	(49,992,708.33)		0.00	0.00	(49,992,708.33)
09/19/23	09/21/23	Buy	3,500,000.000	BMWLT 2021-2 A4 LEASE MAT 01/27/25 Cpn 0.43	09690AAD5	(3,438,339.84)	(1,086.94)	0.00	0.00	(3,439,426.78)
09/21/23	09/21/23	Buy	20,000,000.000	FHLB DISCOUNT NOTE MAT 09/22/23 Cpn	313384MA4	(19,997,083.33)		0.00	0.00	(19,997,083.33)
09/21/23	09/21/23	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/22/23 Cpn	313384MA4	(49,992,708.33)		0.00	0.00	(49,992,708.33)
09/21/23	09/21/23	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/22/23 Cpn	313384MA4	(49,992,708.33)		0.00	0.00	(49,992,708.33)
09/21/23	09/21/23	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/22/23 Cpn	313384MA4	(49,992,708.33)		0.00	0.00	(49,992,708.33)
09/21/23	09/21/23	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/22/23 Cpn	313384MA4	(49,992,708.33)		0.00	0.00	(49,992,708.33)

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09/21/23	09/21/23	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/22/23 Cpn	313384MA4	(49,992,708.33)		0.00	0.00	(49,992,708.33)
09/22/23	09/22/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 10/05/23 Cpn	912796YJ2	(49,904,648.61)		0.00	0.00	(49,904,648.61)
09/22/23	09/22/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 10/05/23 Cpn	912796YJ2	(49,904,648.61)		0.00	0.00	(49,904,648.61)
09/22/23	09/22/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 10/05/23 Cpn	912796YJ2	(49,904,648.61)		0.00	0.00	(49,904,648.61)
09/21/23	09/22/23	Buy	10,000,000.000	CITIBANK CD MAT 06/17/24 Cpn 5.92	17330QFJ1	(10,000,000.00)		0.00	0.00	(10,000,000.00)
09/22/23	09/22/23	Buy	5,000,000.000	FHLB DISCOUNT NOTE MAT 09/25/23 Cpn	313384MD8	(4,997,812.50)		0.00	0.00	(4,997,812.50)
09/22/23	09/22/23	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/25/23 Cpn	313384MD8	(49,978,125.00)		0.00	0.00	(49,978,125.00)
09/22/23	09/22/23	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/25/23 Cpn	313384MD8	(49,978,125.00)		0.00	0.00	(49,978,125.00)
09/22/23	09/22/23	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/25/23 Cpn	313384MD8	(49,978,125.00)		0.00	0.00	(49,978,125.00)
09/22/23	09/22/23	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/25/23 Cpn	313384MD8	(49,978,125.00)		0.00	0.00	(49,978,125.00)
09/22/23	09/22/23	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/25/23 Cpn	313384MD8	(49,978,125.00)		0.00	0.00	(49,978,125.00)
09/22/23	09/22/23	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/25/23 Cpn	313384MD8	(49,978,125.00)		0.00	0.00	(49,978,125.00)
09/22/23	09/22/23	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/25/23 Cpn	313384MD8	(49,978,125.00)		0.00	0.00	(49,978,125.00)

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09/22/23	09/22/23	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/25/23 Cpn 313384MD8	(49,978,125.00)		0.00	0.00	(49,978,125.00)
09/22/23	09/22/23	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/25/23 Cpn 313384MD8	(49,978,125.00)		0.00	0.00	(49,978,125.00)
09/22/23	09/22/23	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/25/23 Cpn 313384MD8	(49,978,125.00)		0.00	0.00	(49,978,125.00)
09/22/23	09/22/23	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/25/23 Cpn 313384MD8	(49,978,125.00)		0.00	0.00	(49,978,125.00)
09/20/23	09/22/23	Buy	4,783,957.360	TLOT 2022-A A3 LEASE 144A MAT 02/20/25 Cpn 1.96 89238LAC4	(4,719,112.31)	(520.92)	0.00	0.00	(4,719,633.23)
09/20/23	09/22/23	Buy	382,716.590	TLOT 2022-A A3 LEASE 144A MAT 02/20/25 Cpn 1.96 89238LAC4	(377,484.14)	(41.67)	0.00	0.00	(377,525.81)
09/22/23	09/25/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 09/26/23 Cpn 912797GU5	(49,992,750.00)		0.00	0.00	(49,992,750.00)
09/22/23	09/25/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 09/26/23 Cpn 912797GU5	(49,992,750.00)		0.00	0.00	(49,992,750.00)
09/22/23	09/25/23	Buy	30,000,000.000	U.S. TREASURY BILL MAT 09/28/23 Cpn 912796CS6	(29,986,887.50)		0.00	0.00	(29,986,887.50)
09/22/23	09/25/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 09/28/23 Cpn 912796CS6	(49,978,145.83)		0.00	0.00	(49,978,145.83)
09/22/23	09/25/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 10/03/23 Cpn 912797GV3	(49,941,472.22)		0.00	0.00	(49,941,472.22)
09/22/23	09/25/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 10/03/23 Cpn 912797GV3	(49,941,472.22)		0.00	0.00	(49,941,472.22)
09/22/23	09/25/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 10/03/23 Cpn 912797GV3	(49,941,472.22)		0.00	0.00	(49,941,472.22)

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09/22/23	09/25/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 10/03/23 Cpn	912797GV3	(49,941,472.22)		0.00	0.00	(49,941,472.22)
09/22/23	09/25/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 10/03/23 Cpn	912797GV3	(49,941,472.22)		0.00	0.00	(49,941,472.22)
09/22/23	09/25/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 10/03/23 Cpn	912797GV3	(49,941,472.22)		0.00	0.00	(49,941,472.22)
09/25/23	09/25/23	Buy	10,000,000.000	U.S. TREASURY BILL MAT 10/10/23 Cpn	912797HA8	(9,978,035.42)		0.00	0.00	(9,978,035.42)
09/25/23	09/25/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 10/10/23 Cpn	912797HA8	(49,890,177.08)		0.00	0.00	(49,890,177.08)
09/25/23	09/25/23	Buy	10,000,000.000	U.S. TREASURY BILL MAT 10/17/23 Cpn	912797HB6	(9,967,733.33)		0.00	0.00	(9,967,733.33)
09/25/23	09/25/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 10/17/23 Cpn	912797HB6	(49,838,666.67)		0.00	0.00	(49,838,666.67)
09/25/23	09/25/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 10/17/23 Cpn	912797HB6	(49,838,666.67)		0.00	0.00	(49,838,666.67)
09/25/23	09/25/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 10/17/23 Cpn	912797HB6	(49,838,666.67)		0.00	0.00	(49,838,666.67)
09/25/23	09/25/23	Buy	40,000,000.000	U.S. TREASURY BILL MAT 10/26/23 Cpn	912797FC6	(39,818,443.33)		0.00	0.00	(39,818,443.33)
09/25/23	09/25/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 10/26/23 Cpn	912797FC6	(49,773,054.17)		0.00	0.00	(49,773,054.17)
09/22/23	09/25/23	Buy	40,000,000.000	U.S. TREASURY BILL MAT 10/05/23 Cpn	912796YJ2	(39,941,555.56)		0.00	0.00	(39,941,555.56)
09/22/23	09/25/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 10/05/23 Cpn	912796YJ2	(49,926,944.44)		0.00	0.00	(49,926,944.44)

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09/22/23	09/25/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 10/05/23 Cpn	912796YJ2	(49,926,944.44)		0.00	0.00	(49,926,944.44)
09/22/23	09/25/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 10/05/23 Cpn	912796YJ2	(49,926,944.44)		0.00	0.00	(49,926,944.44)
09/22/23	09/25/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 10/05/23 Cpn	912796YJ2	(49,926,944.44)		0.00	0.00	(49,926,944.44)
09/22/23	09/25/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 10/05/23 Cpn	912796YJ2	(49,926,944.44)		0.00	0.00	(49,926,944.44)
09/21/23	09/25/23	Buy	413,500.610	BMW 2021-2 A3 LEASE MAT 12/26/24 Cpn 0.33	09690AAC7	(410,722.40)		0.00	0.00	(410,722.40)
09/25/23	09/25/23	Buy	45,000,000.000	FHLB DISCOUNT NOTE MAT 09/26/23 Cpn	313384ME6	(44,993,412.50)		0.00	0.00	(44,993,412.50)
09/25/23	09/25/23	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/26/23 Cpn	313384ME6	(49,992,680.56)		0.00	0.00	(49,992,680.56)
09/25/23	09/25/23	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/26/23 Cpn	313384ME6	(49,992,680.56)		0.00	0.00	(49,992,680.56)
09/25/23	09/25/23	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/26/23 Cpn	313384ME6	(49,992,680.56)		0.00	0.00	(49,992,680.56)
09/25/23	09/25/23	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/26/23 Cpn	313384ME6	(49,992,680.56)		0.00	0.00	(49,992,680.56)
09/25/23	09/25/23	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/26/23 Cpn	313384ME6	(49,992,680.56)		0.00	0.00	(49,992,680.56)
09/25/23	09/25/23	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/26/23 Cpn	313384ME6	(49,992,680.56)		0.00	0.00	(49,992,680.56)
09/25/23	09/25/23	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/26/23 Cpn	313384ME6	(49,992,680.56)		0.00	0.00	(49,992,680.56)

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Tr Date	St Date	Transaction Type	Units	Description		Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
09/25/23	09/25/23	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/26/23 Cpn	313384ME6	(49,992,680.56)		0.00	0.00	(49,992,680.56)
09/25/23	09/25/23	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/26/23 Cpn	313384ME6	(49,992,680.56)		0.00	0.00	(49,992,680.56)
09/25/23	09/25/23	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/26/23 Cpn	313384ME6	(49,992,680.56)		0.00	0.00	(49,992,680.56)
09/25/23	09/25/23	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/26/23 Cpn	313384ME6	(49,992,680.56)		0.00	0.00	(49,992,680.56)
09/25/23	09/25/23	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/26/23 Cpn	313384ME6	(49,992,680.56)		0.00	0.00	(49,992,680.56)
09/21/23	09/25/23	Buy	4,842,995.400	TAOT 2023-B A1 CAR MAT 05/15/24 Cpn 5.23	891941AA4	(4,841,481.95)	(7,029.07)	0.00	0.00	(4,848,511.02)
09/25/23	09/26/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 10/03/23 Cpn	912797GV3	(49,948,861.11)		0.00	0.00	(49,948,861.11)
09/25/23	09/26/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 10/03/23 Cpn	912797GV3	(49,948,861.11)		0.00	0.00	(49,948,861.11)
09/25/23	09/26/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 10/03/23 Cpn	912797GV3	(49,948,861.11)		0.00	0.00	(49,948,861.11)
09/25/23	09/26/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 10/03/23 Cpn	912797GV3	(49,948,861.11)		0.00	0.00	(49,948,861.11)
09/25/23	09/26/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 10/03/23 Cpn	912797GV3	(49,948,861.11)		0.00	0.00	(49,948,861.11)
09/25/23	09/26/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 10/05/23 Cpn	912796YJ2	(49,934,187.50)		0.00	0.00	(49,934,187.50)
09/25/23	09/26/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 10/05/23 Cpn	912796YJ2	(49,934,187.50)		0.00	0.00	(49,934,187.50)

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09/25/23	09/26/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 10/05/23 Cpn	912796YJ2	(49,934,187.50)		0.00	0.00	(49,934,187.50)
09/25/23	09/26/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 10/05/23 Cpn	912796YJ2	(49,934,187.50)		0.00	0.00	(49,934,187.50)
09/26/23	09/26/23	Buy	33,000,000.000	FHLB DISCOUNT NOTE MAT 09/27/23 Cpn	313384MF3	(32,995,169.17)		0.00	0.00	(32,995,169.17)
09/26/23	09/26/23	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/27/23 Cpn	313384MF3	(49,992,680.56)		0.00	0.00	(49,992,680.56)
09/26/23	09/26/23	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/27/23 Cpn	313384MF3	(49,992,680.56)		0.00	0.00	(49,992,680.56)
09/26/23	09/26/23	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/27/23 Cpn	313384MF3	(49,992,680.56)		0.00	0.00	(49,992,680.56)
09/26/23	09/26/23	Buy	40,000,000.000	FHLB DISCOUNT NOTE MAT 09/27/23 Cpn	313384MF3	(39,994,144.44)		0.00	0.00	(39,994,144.44)
09/25/23	09/26/23	Buy	10,000,000.000	FHLMC C 2/28/24 Q MAT 08/28/25 Cpn 5.75	3134H1BG7	(10,000,000.00)	(41,527.78)	0.00	0.00	(10,041,527.78)
09/22/23	09/26/23	Buy	15,000,000.000	INTER-AMERICAN DEV BANK FRN MAT 09/16/26 Cpn 5.51	4581X0DY1	(14,976,196.80)	(18,258.33)	0.00	0.00	(14,994,455.13)
09/27/23	09/27/23	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/28/23 Cpn	313384MG1	(49,992,708.33)		0.00	0.00	(49,992,708.33)
09/27/23	09/27/23	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/28/23 Cpn	313384MG1	(49,992,708.33)		0.00	0.00	(49,992,708.33)
09/27/23	09/27/23	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/28/23 Cpn	313384MG1	(49,992,708.33)		0.00	0.00	(49,992,708.33)
09/27/23	09/27/23	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/28/23 Cpn	313384MG1	(49,992,708.33)		0.00	0.00	(49,992,708.33)

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09/19/23	09/27/23	Buy	10,000,000.000	HPEFS 2023-2A A1 EQP 144A MAT 10/18/24 Cpn 5.76 44328UAA4	(10,000,000.00)		0.00	0.00	(10,000,000.00)
09/20/23	09/27/23	Buy	8,400,000.000	TESLA 2023-B A1 LEASE 144A MAT 09/20/24 Cpn 5.68 88167QAA4	(8,400,000.00)		0.00	0.00	(8,400,000.00)
09/28/23	09/28/23	Buy	50,000,000.000	FNM DISCOUNT NOTE MAT 09/29/23 Cpn 313588MH5	(49,992,847.22)		0.00	0.00	(49,992,847.22)
09/28/23	09/28/23	Buy	50,000,000.000	FNM DISCOUNT NOTE MAT 09/29/23 Cpn 313588MH5	(49,992,847.22)		0.00	0.00	(49,992,847.22)
09/28/23	09/28/23	Buy	50,000,000.000	FNM DISCOUNT NOTE MAT 09/29/23 Cpn 313588MH5	(49,992,847.22)		0.00	0.00	(49,992,847.22)
09/28/23	09/28/23	Buy	50,000,000.000	FNM DISCOUNT NOTE MAT 09/29/23 Cpn 313588MH5	(49,992,847.22)		0.00	0.00	(49,992,847.22)
			6,416,815,889.510		(6,408,966,346.96)	(156,263.72)	0.00	0.00	(6,409,122,610.68)
09/07/23	09/07/23	Coupon		NY LONG ISLAND POWER AUTH CP MAT 09/07/23 Cpn 5.38 54270XCU9		70,537.78	0.00	0.00	70,537.78
09/11/23	09/11/23	Coupon		CRVNA 2023-P2 A1 CAR 144A MAT 06/10/24 Cpn 5.59 14686TAA6		1,650.40	0.00	0.00	1,650.40
09/11/23	09/11/23	Coupon		CRVNA 2023-P3 A1 CAR 144A MAT 08/10/24 Cpn 5.66 14688GAA2		7,645.05	0.00	0.00	7,645.05
09/11/23	09/11/23	Coupon		LLOYDS BANK YCD FRN SOFRRAT MAT 12/11/23 Cpn 5.76 53947BN22		190,891.67	0.00	0.00	190,891.67
09/12/23	09/12/23	Coupon		SC SOUTH CAROLINA PUB SVC CP MAT 09/12/23 Cpn 5.42 83708BCB0		73,350.67	0.00	0.00	73,350.67
09/13/23	09/13/23	Coupon		MMAF 2023-A A1 EQP 144A MAT 08/09/24 Cpn 5.71 55317WAA9		11,051.91	0.00	0.00	11,051.91

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09/15/23	09/15/23	Coupon		ALLYA 2022-2 A2 CAR MAT 10/15/25 Cpn 4.62 02008MAB5		9,017.13	0.00	0.00	9,017.13
09/15/23	09/15/23	Coupon		BAAT 2023-1A A2 CAR 144A MAT 05/15/26 Cpn 5.83 06428AAB4		24,291.67	0.00	0.00	24,291.67
09/15/23	09/15/23	Coupon		CARMX 2021-3 A3 CAR MAT 06/15/26 Cpn 0.55 14317DAC4		2,580.64	0.00	0.00	2,580.64
09/15/23	09/15/23	Coupon		CARMX 2023-2 A1 CAR MAT 05/15/24 Cpn 5.51 142921AA3		14,086.84	0.00	0.00	14,086.84
09/15/23	09/15/23	Coupon		CARMX 2023-3 A1 CAR MAT 07/15/24 Cpn 5.63 14319BAA0		17,568.43	0.00	0.00	17,568.43
09/15/23	09/15/23	Coupon		CNH 2023-A A1 EQP MAT 05/15/24 Cpn 5.43 12664QAA2		19,975.55	0.00	0.00	19,975.55
09/15/23	09/15/23	Coupon		FORDL 2022-A A3 LEASE MAT 05/15/25 Cpn 3.23 34528LAD7		8,344.17	0.00	0.00	8,344.17
09/15/23	09/15/23	Coupon		FORDO 2020-C A3 MAT 07/15/25 Cpn 0.41 34533YAD2		1,493.38	0.00	0.00	1,493.38
09/15/23	09/15/23	Coupon		GALC 2023-1 A1 EQP 144A MAT 06/14/24 Cpn 5.52 39154TCA4		9,746.96	0.00	0.00	9,746.96
09/15/23	09/15/23	Coupon		GM 2020-2 A FLOOR 144A MAT 10/15/25 Cpn 0.69 361886CM4		2,875.00	0.00	0.00	2,875.00
09/15/23	09/15/23	Coupon		GM 2020-2 A FLOOR 144A MAT 10/15/25 Cpn 0.69 361886CM4		632.50	0.00	0.00	632.50
09/15/23	09/15/23	Coupon		HALST 2023-B A1 LEASE 144A MAT 05/15/24 Cpn 5.25 448980AA0		6,682.11	0.00	0.00	6,682.11
09/15/23	09/15/23	Coupon		HAROT 2022-1 A2 CAR MAT 10/15/24 Cpn 1.44 43815BAB6		1,388.59	0.00	0.00	1,388.59

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09/15/23	09/15/23	Coupon		HAROT 2023-2 A2 CAR MAT 04/15/26 Cpn 5.41 437927AB2		28,177.08	0.00	0.00	28,177.08
09/15/23	09/15/23	Coupon		HART 2019-B A4 CAR MAT 04/15/25 Cpn 2.00 44891JAD0		308.97	0.00	0.00	308.97
09/15/23	09/15/23	Coupon		HART 2021-C A3 CAR MAT 05/15/26 Cpn 0.74 44935FAD6		2,714.87	0.00	0.00	2,714.87
09/15/23	09/15/23	Coupon		HART 2023-A A1 CAR MAT 04/15/24 Cpn 5.17 448979AA2		4,975.79	0.00	0.00	4,975.79
09/15/23	09/15/23	Coupon		HART 2023-A A2A CAR MAT 12/15/25 Cpn 5.19 448979AB0		4,325.00	0.00	0.00	4,325.00
09/15/23	09/15/23	Coupon		HART 2023-B A2A CAR MAT 05/15/26 Cpn 5.77 44933XAB3		16,348.33	0.00	0.00	16,348.33
09/15/23	09/15/23	Coupon		JOHN DEERE 2020-B A3 EQP MAT 11/15/24 Cpn 0.51 47787NAC3		165.79	0.00	0.00	165.79
09/15/23	09/15/23	Coupon		KCOT 2023-1A A1 EQP 144A MAT 03/15/24 Cpn 5.29 50117KAA8		10,564.87	0.00	0.00	10,564.87
09/15/23	09/15/23	Coupon		KCOT 2023-2A A1 EQP 144A MAT 07/15/24 Cpn 5.62 500945AA8		10,828.85	0.00	0.00	10,828.85
09/15/23	09/15/23	Coupon		NALT 2023-A A1 LEASE MAT 02/15/24 Cpn 4.97 65480VAA1		238.43	0.00	0.00	238.43
09/15/23	09/15/23	Coupon		NAROT 2022-A A2 CAR MAT 11/15/24 Cpn 1.32 65479QAB3		5,576.84	0.00	0.00	5,576.84
09/15/23	09/15/23	Coupon		NAROT 2023-A A1 CAR MAT 05/15/24 Cpn 5.42 65480WAA9		15,839.42	0.00	0.00	15,839.42
09/15/23	09/15/23	Coupon		TAOT 2022-C A2A CAR MAT 08/15/25 Cpn 4.19 89231CAB3		11,649.64	0.00	0.00	11,649.64

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09/15/23	09/15/23	Coupon		TAOT 2023-B A1 CAR MAT 05/15/24 Cpn 5.23 891941AA4		18,212.87	0.00	0.00	18,212.87
09/15/23	09/15/23	Coupon		WORLD OMNI 2020-C A4 CAR MAT 10/15/26 Cpn 0.61 98163CAF7		2,541.67	0.00	0.00	2,541.67
09/15/23	09/15/23	Coupon		WOART 2022-B A2A CAR MAT 10/15/25 Cpn 2.77 98163QAB5		4,445.95	0.00	0.00	4,445.95
09/15/23	09/15/23	Coupon		WOART 2023-A A2A CAR MAT 07/15/26 Cpn 5.18 98164JAB0		23,317.79	0.00	0.00	23,317.79
09/15/23	09/15/23	Coupon		WOART 2023-B A1 CAR MAT 04/15/24 Cpn 5.32 98164QAA6		14,332.73	0.00	0.00	14,332.73
09/15/23	09/15/23	Coupon		WOART 2023-C A1 CAR MAT 08/15/24 Cpn 5.61 98164FAA0		34,576.50	0.00	0.00	34,576.50
09/15/23	09/15/23	Coupon		WOLS 2022-A A2 LEASE MAT 10/15/24 Cpn 2.63 98163NAB2		951.45	0.00	0.00	951.45
09/15/23	09/15/23	Coupon		WOLS 2023-A A1 LEASE MAT 05/15/24 Cpn 5.22 981944AA9		1,752.97	0.00	0.00	1,752.97
09/16/23	09/16/23	Coupon		GMCAR 2021-4 A3 CAR MAT 09/16/26 Cpn 0.68 362554AC1		2,591.65	0.00	0.00	2,591.65
09/16/23	09/16/23	Coupon		GMCAR 2023-2 A2A CAR MAT 05/18/26 Cpn 5.10 362583AB2		4,250.00	0.00	0.00	4,250.00
09/16/23	09/16/23	Coupon		GMCAR 2023-2 A2A CAR MAT 05/18/26 Cpn 5.10 362583AB2		1,338.75	0.00	0.00	1,338.75
09/16/23	09/16/23	Coupon		GMCAR 2023-3 A2A CAR MAT 09/16/26 Cpn 5.74 36267KAB3		13,393.33	0.00	0.00	13,393.33
09/18/23	09/18/23	Coupon		GMCAR 2023-2 A1 CAR MAT 04/16/24 Cpn 5.19 362583AA4		7,303.30	0.00	0.00	7,303.30

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Tr Date	St Date	Transaction Type	Units	Description	Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
09/18/23	09/18/23	Coupon		HONDA 2020-3 A4 CAR MAT 04/19/27 Cpn 0.46 43813KAD4		1,619.58	0.00	0.00	1,619.58
09/18/23	09/18/23	Coupon		SWEDBANK NY YCD FRN SOFRRA MAT 04/12/24 Cpn 5.84 87019WNH4		50,213.89	0.00	0.00	50,213.89
09/20/23	09/20/23	Coupon		DLLAD 2023-1A A1 EQP 144A MAT 02/20/24 Cpn 5.01 233258AA0		1,038.79	0.00	0.00	1,038.79
09/20/23	09/20/23	Coupon		DLLMT 2023-1A A1 EQP 144A MAT 05/20/24 Cpn 5.53 232989AA1		18,289.60	0.00	0.00	18,289.60
09/20/23	09/20/23	Coupon		ENTERPRISE 2020-2 A2 FLEET 144 MAT 07/20/26 Cpn 0.61 29375MAB3		804.25	0.00	0.00	804.25
09/20/23	09/20/23	Coupon		ENTERPRISE 2020-2 A2 FLEET 144 MAT 07/20/26 Cpn 0.61 29375MAB3		535.53	0.00	0.00	535.53
09/20/23	09/20/23	Coupon		ENTERPRISE 2021-1 A2 FLEET 144 MAT 12/21/26 Cpn 0.44 29374EAB2		1,008.01	0.00	0.00	1,008.01
09/20/23	09/20/23	Coupon		ENTERPRISE 2021-1 A2 FLEET 144 MAT 12/21/26 Cpn 0.44 29374EAB2		118.78	0.00	0.00	118.78
09/20/23	09/20/23	Coupon		EFF 2022-4 A1 FLEET 144A MAT 11/20/23 Cpn 5.15 29374GAA9		1,468.02	0.00	0.00	1,468.02
09/20/23	09/20/23	Coupon		EFF 2022-4 A1 FLEET 144A MAT 11/20/23 Cpn 5.15 29374GAA9		1,490.60	0.00	0.00	1,490.60
09/20/23	09/20/23	Coupon		EFF 2023-2 A1 FLEET 144A MAT 06/20/24 Cpn 5.79 29375NAA3		12,308.27	0.00	0.00	12,308.27
09/20/23	09/20/23	Coupon		GMALT 2021-2 A LEASE MAT 05/20/25 Cpn 0.41 380144AD7		463.61	0.00	0.00	463.61
09/20/23	09/20/23	Coupon		GMALT 2021-2 A LEASE MAT 05/20/25 Cpn 0.41 380144AD7		287.00	0.00	0.00	287.00

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Tr Date	St Date	Transaction Type	Units	Description	Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
09/20/23	09/20/23	Coupon		GMALT 2023-1 A2A LEASE MAT 06/20/25 Cpn 5.27 362541AB0		10,508.59	0.00	0.00	10,508.59
09/20/23	09/20/23	Coupon		GMALT 2023-2 A1 LEASE MAT 05/20/24 Cpn 5.45 362548AA7		9,567.85	0.00	0.00	9,567.85
09/20/23	09/20/23	Coupon		SFAST 2023-1 A1 CAR 144A MAT 07/22/24 Cpn 5.57 78398AAA1		12,753.18	0.00	0.00	12,753.18
09/20/23	09/20/23	Coupon		SRT 2021-A A3 LEASE 144A MAT 07/22/24 Cpn 0.51 80286TAC7		472.95	0.00	0.00	472.95
09/20/23	09/20/23	Coupon		SRT 2021-C A3 LEASE 144A MAT 03/20/25 Cpn 0.50 80286CAC4		1,114.32	0.00	0.00	1,114.32
09/20/23	09/20/23	Coupon		TESLA 2021-B A2 LEASE 144A MAT 09/22/25 Cpn 0.36 88161KAB1		100.83	0.00	0.00	100.83
09/20/23	09/20/23	Coupon		TESLA 2023-A A1 LEASE 144A MAT 07/22/24 Cpn 5.63 88167PAA6		10,558.31	0.00	0.00	10,558.31
09/20/23	09/20/23	Coupon		TLOT 2021-B A3 LEASE 144A MAT 10/21/24 Cpn 0.42 89239CAC3		352.44	0.00	0.00	352.44
09/20/23	09/20/23	Coupon		TLOT 2021-B A3 LEASE 144A MAT 10/21/24 Cpn 0.42 89239CAC3		515.97	0.00	0.00	515.97
09/20/23	09/20/23	Coupon		VALET 2023-1 A2A CAR MAT 12/21/26 Cpn 5.50 92867WAB4		7,333.33	0.00	0.00	7,333.33
09/21/23	09/21/23	Coupon		SC SOUTH CAROLINA PUB SVC CP MAT 09/21/23 Cpn 5.40 83708BCE4		10,800.00	0.00	0.00	10,800.00
09/22/23	09/22/23	Coupon		DEFT 2023-2 A1 EQP 144A MAT 06/24/24 Cpn 5.64 24703GAA2		11,045.07	0.00	0.00	11,045.07
09/22/23	09/22/23	Coupon		PFAST 2023-1A A1 CAR 144A MAT 05/22/24 Cpn 5.37 73328QAA2		10,297.15	0.00	0.00	10,297.15

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Tr Date	St Date	Transaction Type	Units	Description	Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
09/25/23	09/25/23	Coupon		BMWLT 2021-2 A4 LEASE MAT 01/27/25 Cpn 0.43 09690AAD5		1,254.17	0.00	0.00	1,254.17
09/25/23	09/25/23	Coupon		BMWOT 2023-A A2A CAR MAT 04/27/26 Cpn 5.72 05592XAB6		23,833.33	0.00	0.00	23,833.33
09/25/23	09/25/23	Coupon		FHMS KF36 A MAT 08/25/24 Cpn 5.77 3137FBAR7		38.18	0.00	0.00	38.18
09/25/23	09/25/23	Coupon		FHMS KF38 A MAT 09/25/24 Cpn 5.76 3137FBUC8		1,072.25	0.00	0.00	1,072.25
09/25/23	09/25/23	Coupon		FHMS KI06 A 1MOFRN CMBS MAT 03/25/25 Cpn 5.65 3137FVNA6		2,550.42	0.00	0.00	2,550.42
09/25/23	09/25/23	Coupon		FHMS KI07 A SOFRFRN MAT 09/25/26 Cpn 5.48 3137H3KA9		31,548.16	0.00	0.00	31,548.16
09/25/23	09/25/23	Coupon		FHMS KI08 A 1MOFRN CMBS MAT 10/25/26 Cpn 5.51 3137H4RC6		12,686.95	0.00	0.00	12,686.95
09/25/23	09/25/23	Coupon		FHMS Q015 A 1MOFRN CMBS MAT 08/25/24 Cpn 5.51 3137FYUR5		725.22	0.00	0.00	725.22
09/25/23	09/25/23	Coupon		INTL BK RECON & DEVELOP FRN S MAT 09/23/26 Cpn 5.65 459058KK8		19,151.75	0.00	0.00	19,151.75
09/25/23	09/25/23	Coupon		INTL BK RECON & DEVELOP FRN S MAT 09/23/26 Cpn 5.65 459058KK8		61,398.24	0.00	0.00	61,398.24
09/28/23	09/28/23	Coupon		CA SAN JOSE FIN AUTH CP TXB MAT 09/28/23 Cpn 5.40 79815WDN5		60,894.25	0.00	0.00	60,894.25
						1,104,752.13	0.00	0.00	1,104,752.13

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Tr Date	St Date	Transaction Type	Units	Description			Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
09/01/23	09/01/23	Income	3,873.330	ADJ NET INT MAT	Cpn	USD		3,873.33	0.00	0.00	3,873.33
09/01/23	09/01/23	Income	542,512.130	STIF INT MAT	Cpn	USD		542,512.13	0.00	0.00	542,512.13
			546,385.460					546,385.46	0.00	0.00	546,385.46
09/01/23	09/01/23	Contributn	745,000,000.000	NM MAT	Cpn	USD	745,000,000.00		0.00	0.00	745,000,000.00
09/18/23	09/18/23	Contributn	100,000,000.000	NM MAT	Cpn	USD	100,000,000.00		0.00	0.00	100,000,000.00
09/22/23	09/22/23	Contributn	450,000,000.000	NM MAT	Cpn	USD	450,000,000.00		0.00	0.00	450,000,000.00
09/22/23	09/22/23	Contributn	500,000,000.000	NM MAT	Cpn	USD	500,000,000.00		0.00	0.00	500,000,000.00
09/25/23	09/25/23	Contributn	915,000,000.000	NM MAT	Cpn	USD	915,000,000.00		0.00	0.00	915,000,000.00
			2,710,000,000.000				2,710,000,000.00		0.00	0.00	2,710,000,000.00
09/12/23	09/12/23	Sell Long	3,250,000.000	U.S. TREASURY BILL MAT 09/14/23	Cpn	912796CQ0	3,246,712.00	2,353.99	7.59	0.00	3,249,065.99
09/12/23	09/13/23	Sell Long	7,500,000.000	BNP PARIBAS NY CP MAT 10/26/23	Cpn	09659CXS2	7,219,772.92	232,031.25	(3,852.08)	0.00	7,451,804.17
09/28/23	09/29/23	Sell Long	30,000,000.000	U.S. TREASURY BILL MAT 10/03/23	Cpn	912797GV3	29,964,920.00	17,558.33	36.66	0.00	29,982,478.33
09/28/23	09/29/23	Sell Long	20,000,000.000	U.S. TREASURY BILL MAT 10/03/23	Cpn	912797GV3	19,976,613.33	11,705.56	24.45	0.00	19,988,318.89

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Tr Date	St Date	Transaction Type	Units	Description	Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
09/28/23	09/29/23	Sell Long	30,000,000.000	U.S. TREASURY BILL MAT 10/03/23 Cpn 912797GV3	29,964,920.00	17,558.33	36.66	0.00	29,982,478.33
09/28/23	09/29/23	Sell Long	20,000,000.000	U.S. TREASURY BILL MAT 10/03/23 Cpn 912797GV3	19,976,613.33	11,705.56	24.45	0.00	19,988,318.89
09/28/23	09/29/23	Sell Long	30,000,000.000	U.S. TREASURY BILL MAT 10/03/23 Cpn 912797GV3	29,964,920.00	17,558.33	36.66	0.00	29,982,478.33
09/28/23	09/29/23	Sell Long	20,000,000.000	U.S. TREASURY BILL MAT 10/03/23 Cpn 912797GV3	19,976,613.33	11,705.56	24.45	0.00	19,988,318.89
09/28/23	09/29/23	Sell Long	30,000,000.000	U.S. TREASURY BILL MAT 10/03/23 Cpn 912797GV3	29,964,920.00	17,558.33	36.66	0.00	29,982,478.33
09/28/23	09/29/23	Sell Long	20,000,000.000	U.S. TREASURY BILL MAT 10/03/23 Cpn 912797GV3	19,976,613.33	11,705.56	24.45	0.00	19,988,318.89
09/28/23	09/29/23	Sell Long	30,000,000.000	U.S. TREASURY BILL MAT 10/03/23 Cpn 912797GV3	29,964,920.00	17,558.33	36.66	0.00	29,982,478.33
09/28/23	09/29/23	Sell Long	20,000,000.000	U.S. TREASURY BILL MAT 10/03/23 Cpn 912797GV3	19,976,613.33	11,705.56	24.45	0.00	19,988,318.89
09/28/23	09/29/23	Sell Long	30,000,000.000	U.S. TREASURY BILL MAT 10/03/23 Cpn 912797GV3	29,964,920.00	17,558.33	36.66	0.00	29,982,478.33
			290,750,000.000		290,139,071.56	398,263.03	(3,502.28)	0.00	290,537,334.59
09/11/23	09/11/23	Pay Princpl	332,266.533	CRVNA 2023-P2 A1 CAR 144A MAT 06/10/24 Cpn 5.59 14686TAA6	332,266.53		(0.00)	0.00	332,266.53
09/11/23	09/11/23	Pay Princpl	644,219.192	CRVNA 2023-P3 A1 CAR 144A MAT 08/10/24 Cpn 5.66 14688GAA2	644,219.19		(0.00)	0.00	644,219.19
09/13/23	09/13/23	Pay Princpl	358,878.676	MMAF 2023-A A1 EQP 144A MAT 08/09/24 Cpn 5.71 55317WAA9	358,878.68		0.00	0.00	358,878.68

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09/15/23	09/15/23	Pay Princpl	290,036.372	ALLYA 2022-2 A2 CAR MAT 10/15/25 Cpn 4.62 02008MAB5	290,036.37		10.92	0.00	290,036.37
09/15/23	09/15/23	Pay Princpl	352,759.369	CARMX 2021-3 A3 CAR MAT 06/15/26 Cpn 0.55 14317DAC4	352,759.37		12,176.21	0.00	352,759.37
09/15/23	09/15/23	Pay Princpl	1,294,674.713	CARMX 2023-2 A1 CAR MAT 05/15/24 Cpn 5.51 142921AA3	1,294,674.71		(0.00)	0.00	1,294,674.71
09/15/23	09/15/23	Pay Princpl	690,835.527	CARMX 2023-3 A1 CAR MAT 07/15/24 Cpn 5.63 14319BAA0	690,835.53		0.00	0.00	690,835.53
09/15/23	09/15/23	Pay Princpl	536,992.621	CNH 2023-A A1 EQP MAT 05/15/24 Cpn 5.43 12664QAA2	536,992.62		(0.00)	0.00	536,992.62
09/15/23	09/15/23	Pay Princpl	159,734.345	FORDL 2022-A A3 LEASE MAT 05/15/25 Cpn 3.23 34528LAD7	159,734.35		1,859.63	0.00	159,734.35
09/15/23	09/15/23	Pay Princpl	564,270.409	FORDO 2020-C A3 MAT 07/15/25 Cpn 0.41 34533YAD2	564,270.41		8,751.50	0.00	564,270.41
09/15/23	09/15/23	Pay Princpl	361,411.090	GALC 2023-1 A1 EQP 144A MAT 06/14/24 Cpn 5.52 39154TCA4	361,411.09		(0.00)	0.00	361,411.09
09/15/23	09/15/23	Pay Princpl	944,026.800	HALST 2023-B A1 LEASE 144A MAT 05/15/24 Cpn 5.25 448980AA0	944,026.80		0.00	0.00	944,026.80
09/15/23	09/15/23	Pay Princpl	340,123.719	HAROT 2022-1 A2 CAR MAT 10/15/24 Cpn 1.44 43815BAB6	340,123.72		0.00	5.05	340,123.72
09/15/23	09/15/23	Pay Princpl	185,384.632	HART 2019-B A4 CAR MAT 04/15/25 Cpn 2.00 44891JAD0	185,384.63		(0.00)	0.00	185,384.63
09/15/23	09/15/23	Pay Princpl	289,526.972	HART 2021-C A3 CAR MAT 05/15/26 Cpn 0.74 44935FAD6	289,526.97		10,349.41	0.00	289,526.97
09/15/23	09/15/23	Pay Princpl	757,473.160	HART 2023-A A1 CAR MAT 04/15/24 Cpn 5.17 448979AA2	757,473.16		(0.00)	0.00	757,473.16

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Tr Date	St Date	Transaction Type	Units	Description	Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
09/15/23	09/15/23	Pay Princpl	184,724.973	JOHN DEERE 2020-B A3 EQP MAT 11/15/24 Cpn 0.51 47787NAC3	184,724.97		1,228.90	0.00	184,724.97
09/15/23	09/15/23	Pay Princpl	796,325.854	KCOT 2023-1A A1 EQP 144A MAT 03/15/24 Cpn 5.29 50117KAA8	796,325.85		(16.46)	0.00	796,325.85
09/15/23	09/15/23	Pay Princpl	349,105.585	KCOT 2023-2A A1 EQP 144A MAT 07/15/24 Cpn 5.62 500945AA8	349,105.59		0.00	0.00	349,105.59
09/15/23	09/15/23	Pay Princpl	55,732.855	NALT 2023-A A1 LEASE MAT 02/15/24 Cpn 4.97 65480VAA1	55,732.86		0.00	0.00	55,732.86
09/15/23	09/15/23	Pay Princpl	1,663,378.432	NAROT 2022-A A2 CAR MAT 11/15/24 Cpn 1.32 65479QAB3	1,663,378.43		6,915.67	0.00	1,663,378.43
09/15/23	09/15/23	Pay Princpl	999,519.298	NAROT 2023-A A1 CAR MAT 05/15/24 Cpn 5.42 65480WAA9	999,519.30		0.00	0.00	999,519.30
09/15/23	09/15/23	Pay Princpl	350,170.312	TAOT 2022-C A2A CAR MAT 08/15/25 Cpn 4.19 89231CAB3	350,170.31		0.00	14.37	350,170.31
09/15/23	09/15/23	Pay Princpl	1,319,480.380	TAOT 2023-B A1 CAR MAT 05/15/24 Cpn 5.23 891941AA4	1,319,480.38		0.00	0.00	1,319,480.38
09/15/23	09/15/23	Pay Princpl	270,756.196	WOART 2022-B A2A CAR MAT 10/15/25 Cpn 2.77 98163QAB5	270,756.20		0.00	9.61	270,756.20
09/15/23	09/15/23	Pay Princpl	395,422.353	WOART 2023-A A2A CAR MAT 07/15/26 Cpn 5.18 98164JAB0	395,422.35		2.33	0.00	395,422.35
09/15/23	09/15/23	Pay Princpl	1,658,817.281	WOART 2023-B A1 CAR MAT 04/15/24 Cpn 5.32 98164QAA6	1,658,817.28		(0.00)	0.00	1,658,817.28
09/15/23	09/15/23	Pay Princpl	2,491,908.297	WOART 2023-C A1 CAR MAT 08/15/24 Cpn 5.61 98164FAA0	2,491,908.30		0.00	0.00	2,491,908.30
09/15/23	09/15/23	Pay Princpl	153,544.028	WOLS 2022-A A2 LEASE MAT 10/15/24 Cpn 2.63 98163NAB2	153,544.03		0.00	1.09	153,544.03

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Tr Date	St Date	Transaction Type	Units	Description	Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
09/15/23	09/15/23	Pay Princpl	390,206.578	WOLS 2023-A A1 LEASE MAT 05/15/24 Cpn 5.22 981944AA9	390,206.58		0.00	0.00	390,206.58
09/16/23	09/16/23	Pay Princpl	262,223.614	GMCAR 2021-4 A3 CAR MAT 09/16/26 Cpn 0.68 362554AC1	262,223.61		10,784.81	0.00	262,223.61
09/18/23	09/18/23	Pay Princpl	1,289,978.096	GMCAR 2023-2 A1 CAR MAT 04/16/24 Cpn 5.19 362583AA4	1,289,978.10		0.00	0.00	1,289,978.10
09/20/23	09/20/23	Pay Princpl	245,651.281	DLLAD 2023-1A A1 EQP 144A MAT 02/20/24 Cpn 5.01 233258AA0	245,651.28		(0.00)	0.00	245,651.28
09/20/23	09/20/23	Pay Princpl	728,764.528	DLLMT 2023-1A A1 EQP 144A MAT 05/20/24 Cpn 5.53 232989AA1	728,764.53		0.00	0.00	728,764.53
09/20/23	09/20/23	Pay Princpl	325,217.070	ENTERPRISE 2020-2 A2 FLEET 144 MAT 07/20/26 Cpn 0.61 29375MAB3	325,217.07		3,408.42	0.00	325,217.07
09/20/23	09/20/23	Pay Princpl	216,553.271	ENTERPRISE 2020-2 A2 FLEET 144 MAT 07/20/26 Cpn 0.61 29375MAB3	216,553.27		2,216.73	0.00	216,553.27
09/20/23	09/20/23	Pay Princpl	420,008.573	ENTERPRISE 2021-1 A2 FLEET 144 MAT 12/21/26 Cpn 0.44 29374EAB2	420,008.57		6,933.66	0.00	420,008.57
09/20/23	09/20/23	Pay Princpl	49,492.173	ENTERPRISE 2021-1 A2 FLEET 144 MAT 12/21/26 Cpn 0.44 29374EAB2	49,492.17		817.03	0.00	49,492.17
09/20/23	09/20/23	Pay Princpl	342,195.031	EFF 2022-4 A1 FLEET 144A MAT 11/20/23 Cpn 5.15 29374GAA9	342,195.03		(0.00)	0.00	342,195.03
09/20/23	09/20/23	Pay Princpl	347,459.563	EFF 2022-4 A1 FLEET 144A MAT 11/20/23 Cpn 5.15 29374GAA9	347,459.56		75.71	0.00	347,459.56
09/20/23	09/20/23	Pay Princpl	352,428.615	EFF 2023-2 A1 FLEET 144A MAT 06/20/24 Cpn 5.79 29375NAA3	352,428.61		(0.00)	0.00	352,428.61
09/20/23	09/20/23	Pay Princpl	882,579.267	GMALT 2021-2 A LEASE MAT 05/20/25 Cpn 0.41 380144AD7	882,579.27		9,504.26	0.00	882,579.27

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Tr Date	St Date	Transaction Type	Units	Description	Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
09/20/23	09/20/23	Pay Princpl	546,358.594	GMALT 2021-2 A LEASE MAT 05/20/25 Cpn 0.41 380144AD7	546,358.59		2,166.75	0.00	546,358.59
09/20/23	09/20/23	Pay Princpl	196,863.102	GMALT 2023-1 A2A LEASE MAT 06/20/25 Cpn 5.27 362541AB0	196,863.10		10.68	0.00	196,863.10
09/20/23	09/20/23	Pay Princpl	1,451,920.087	GMALT 2023-2 A1 LEASE MAT 05/20/24 Cpn 5.45 362548AA7	1,451,920.09		0.00	0.00	1,451,920.09
09/20/23	09/20/23	Pay Princpl	1,143,317.106	SFAST 2023-1 A1 CAR 144A MAT 07/22/24 Cpn 5.57 78398AAA1	1,143,317.11		0.00	0.00	1,143,317.11
09/20/23	09/20/23	Pay Princpl	465,824.829	SRT 2021-A A3 LEASE 144A MAT 07/22/24 Cpn 0.51 80286TAC7	465,824.83		4,669.37	0.00	465,824.83
09/20/23	09/20/23	Pay Princpl	913,090.540	SRT 2021-C A3 LEASE 144A MAT 03/20/25 Cpn 0.50 80286CAC4	913,090.54		5,908.93	0.00	913,090.54
09/20/23	09/20/23	Pay Princpl	176,095.810	TESLA 2021-B A2 LEASE 144A MAT 09/22/25 Cpn 0.36 88161KAB1	176,095.81		0.00	3.01	176,095.81
09/20/23	09/20/23	Pay Princpl	515,651.593	TESLA 2023-A A1 LEASE 144A MAT 07/22/24 Cpn 5.63 88167PAA6	515,651.59		(0.00)	0.00	515,651.59
09/20/23	09/20/23	Pay Princpl	301,038.194	TLOT 2021-B A3 LEASE 144A MAT 10/21/24 Cpn 0.42 89239CAC3	301,038.19		6,654.88	0.00	301,038.19
09/20/23	09/20/23	Pay Princpl	440,719.916	TLOT 2021-B A3 LEASE 144A MAT 10/21/24 Cpn 0.42 89239CAC3	440,719.92		5,625.15	0.00	440,719.92
09/22/23	09/22/23	Pay Princpl	371,284.951	DEFT 2023-2 A1 EQP 144A MAT 06/24/24 Cpn 5.64 24703GAA2	371,284.95		(0.00)	0.00	371,284.95
09/22/23	09/22/23	Pay Princpl	1,278,544.662	PFAST 2023-1A A1 CAR 144A MAT 05/22/24 Cpn 5.37 73328QAA2	1,278,544.66		(0.00)	0.00	1,278,544.66
09/25/23	09/25/23	Pay Princpl	117.120	FHMS KF38 A MAT 09/25/24 Cpn 5.76 3137FBUC8	117.12		0.00	0.03	117.12

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Tr Date	St Date	Transaction Type	Units	Description	Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
09/25/23	09/25/23	Pay Princpl	443,279.619	FHMS KI06 A 1MOFRN CMBS MAT 03/25/25 Cpn 5.65 3137FVNA6	443,279.62		0.00	0.00	443,279.62
			32,888,363.756		32,888,363.75		100,054.52	33.16	32,888,363.75
09/05/23	09/05/23	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/05/23 Cpn 313384LH0	49,970,944.44	29,055.56	0.00	0.00	50,000,000.00
09/05/23	09/05/23	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/05/23 Cpn 313384LH0	49,970,944.44	29,055.56	0.00	0.00	50,000,000.00
09/05/23	09/05/23	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/05/23 Cpn 313384LH0	49,970,944.44	29,055.56	0.00	0.00	50,000,000.00
09/05/23	09/05/23	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/05/23 Cpn 313384LH0	49,970,944.44	29,055.56	0.00	0.00	50,000,000.00
09/05/23	09/05/23	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/05/23 Cpn 313384LH0	49,970,944.44	29,055.56	0.00	0.00	50,000,000.00
09/05/23	09/05/23	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/05/23 Cpn 313384LH0	49,970,944.44	29,055.56	0.00	0.00	50,000,000.00
09/05/23	09/05/23	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/05/23 Cpn 313384LH0	49,970,944.44	29,055.56	0.00	0.00	50,000,000.00
09/06/23	09/06/23	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/06/23 Cpn 313384LJ6	49,992,708.33	7,291.67	0.00	0.00	50,000,000.00
09/06/23	09/06/23	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/06/23 Cpn 313384LJ6	49,992,708.33	7,291.67	0.00	0.00	50,000,000.00
09/06/23	09/06/23	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/06/23 Cpn 313384LJ6	49,992,708.33	7,291.67	0.00	0.00	50,000,000.00
09/06/23	09/06/23	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/06/23 Cpn 313384LJ6	49,992,708.33	7,291.67	0.00	0.00	50,000,000.00

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Tr Date	St Date	Transaction Type	Units	Description	Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
09/06/23	09/06/23	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/06/23 Cpn 313384LJ6	49,992,708.33	7,291.67	0.00	0.00	50,000,000.00
09/07/23	09/07/23	Mature Long	50,000,000.000	U.S. TREASURY BILL MAT 09/07/23 Cpn 912796YH6	49,956,500.00	43,500.00	0.00	0.00	50,000,000.00
09/07/23	09/07/23	Mature Long	50,000,000.000	U.S. TREASURY BILL MAT 09/07/23 Cpn 912796YH6	49,956,500.00	43,500.00	0.00	0.00	50,000,000.00
09/07/23	09/07/23	Mature Long	50,000,000.000	U.S. TREASURY BILL MAT 09/07/23 Cpn 912796YH6	49,956,500.00	43,500.00	0.00	0.00	50,000,000.00
09/07/23	09/07/23	Mature Long	50,000,000.000	U.S. TREASURY BILL MAT 09/07/23 Cpn 912796YH6	49,956,500.00	43,500.00	0.00	0.00	50,000,000.00
09/07/23	09/07/23	Mature Long	20,000,000.000	U.S. TREASURY BILL MAT 09/07/23 Cpn 912796YH6	19,982,600.00	17,400.00	0.00	0.00	20,000,000.00
09/07/23	09/07/23	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/07/23 Cpn 313384LK3	49,992,708.33	7,291.67	0.00	0.00	50,000,000.00
09/07/23	09/07/23	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/07/23 Cpn 313384LK3	49,992,708.33	7,291.67	0.00	0.00	50,000,000.00
09/07/23	09/07/23	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/07/23 Cpn 313384LK3	49,992,708.33	7,291.67	0.00	0.00	50,000,000.00
09/07/23	09/07/23	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/07/23 Cpn 313384LK3	49,992,708.33	7,291.67	0.00	0.00	50,000,000.00
09/07/23	09/07/23	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/07/23 Cpn 313384LK3	49,992,708.33	7,291.67	0.00	0.00	50,000,000.00
09/07/23	09/07/23	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/07/23 Cpn 313384LK3	49,992,708.33	7,291.67	0.00	0.00	50,000,000.00
09/07/23	09/07/23	Mature Long	8,000,000.000	NY LONG ISLAND POWER AUTH CP MAT 09/07/23 Cpn 5.38 54270XCU9	8,000,000.00		0.00	0.00	8,000,000.00

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09/08/23	09/08/23	Mature Long	25,000,000.000	FHLB DISCOUNT NOTE MAT 09/08/23 Cpn 313384LL1	24,996,354.17	3,645.83	0.00	0.00	25,000,000.00
09/08/23	09/08/23	Mature Long	25,000,000.000	UNITEDHEALTH GROUP CP 144A MAT 09/08/23 Cpn 91058UW82	24,996,312.50	3,687.50	0.00	0.00	25,000,000.00
09/11/23	09/11/23	Mature Long	40,000,000.000	FHLB DISCOUNT NOTE MAT 09/11/23 Cpn 313384LP2	39,982,500.00	17,500.00	0.00	0.00	40,000,000.00
09/12/23	09/12/23	Mature Long	30,000,000.000	AUTOMATIC DATA CP 144A MAT 09/12/23 Cpn 0530A3WC8	29,995,583.33	4,416.67	0.00	0.00	30,000,000.00
09/12/23	09/12/23	Mature Long	22,500,000.000	CREDIT AGRICOLE CP MAT 09/12/23 Cpn 22533UWC3	22,476,856.25	23,143.75	0.00	0.00	22,500,000.00
09/12/23	09/12/23	Mature Long	12,500,000.000	FHLB DISCOUNT NOTE MAT 09/12/23 Cpn 313384LQ0	12,498,184.03	1,815.97	0.00	0.00	12,500,000.00
09/12/23	09/12/23	Mature Long	10,000,000.000	SOUTHERN CALIF GAS CP 144A MAT 09/12/23 Cpn 84243MWC	9,989,655.56	10,344.44	0.00	0.00	10,000,000.00
09/12/23	09/12/23	Mature Long	8,700,000.000	SC SOUTH CAROLINA PUB SVC CP MAT 09/12/23 Cpn 5.42 83708BCB0	8,700,000.00		0.00	0.00	8,700,000.00
09/13/23	09/13/23	Mature Long	30,000,000.000	AUTOMATIC DATA CP 144A MAT 09/13/23 Cpn 0530A3WD6	29,995,583.33	4,416.67	0.00	0.00	30,000,000.00
09/14/23	09/14/23	Mature Long	16,750,000.000	U.S. TREASURY BILL MAT 09/14/23 Cpn 912796CQ0	16,733,015.03	16,984.97	(0.00)	0.00	16,750,000.00
09/14/23	09/14/23	Mature Long	50,000,000.000	U.S. TREASURY BILL MAT 09/14/23 Cpn 912796CQ0	49,949,298.61	50,701.39	0.00	0.00	50,000,000.00
09/14/23	09/14/23	Mature Long	50,000,000.000	U.S. TREASURY BILL MAT 09/14/23 Cpn 912796CQ0	49,949,298.61	50,701.39	0.00	0.00	50,000,000.00
09/14/23	09/14/23	Mature Long	50,000,000.000	U.S. TREASURY BILL MAT 09/14/23 Cpn 912796CQ0	49,949,298.61	50,701.39	0.00	0.00	50,000,000.00

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Tr Date	St Date	Transaction Type	Units	Description		Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
09/14/23	09/14/23	Mature Long	50,000,000.000	U.S. TREASURY BILL MAT 09/14/23 Cpn	912796CQ0	49,949,298.61	50,701.39	0.00	0.00	50,000,000.00
09/14/23	09/14/23	Mature Long	24,000,000.000	FHLB DISCOUNT NOTE MAT 09/14/23 Cpn	313384LS6	23,996,513.33	3,486.67	0.00	0.00	24,000,000.00
09/15/23	09/15/23	Mature Long	28,000,000.000	FHLB DISCOUNT NOTE MAT 09/15/23 Cpn	313384LT4	27,995,932.22	4,067.78	0.00	0.00	28,000,000.00
09/15/23	09/15/23	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/15/23 Cpn	313384LT4	49,992,736.11	7,263.89	0.00	0.00	50,000,000.00
09/15/23	09/15/23	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/15/23 Cpn	313384LT4	49,992,736.11	7,263.89	0.00	0.00	50,000,000.00
09/18/23	09/18/23	Mature Long	20,000,000.000	FHLB DISCOUNT NOTE MAT 09/18/23 Cpn	313384LW7	19,991,250.00	8,750.00	0.00	0.00	20,000,000.00
09/18/23	09/18/23	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/18/23 Cpn	313384LW7	49,978,125.00	21,875.00	0.00	0.00	50,000,000.00
09/18/23	09/18/23	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/18/23 Cpn	313384LW7	49,978,125.00	21,875.00	0.00	0.00	50,000,000.00
09/18/23	09/18/23	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/18/23 Cpn	313384LW7	49,978,125.00	21,875.00	0.00	0.00	50,000,000.00
09/19/23	09/19/23	Mature Long	50,000,000.000	U.S. TREASURY BILL MAT 09/19/23 Cpn	912797GT8	49,868,250.00	131,750.00	0.00	0.00	50,000,000.00
09/19/23	09/19/23	Mature Long	40,000,000.000	U.S. TREASURY BILL MAT 09/19/23 Cpn	912797GT8	39,894,600.00	105,400.00	0.00	0.00	40,000,000.00
09/19/23	09/19/23	Mature Long	30,000,000.000	FHLB DISCOUNT NOTE MAT 09/19/23 Cpn	313384LX5	29,995,625.00	4,375.00	0.00	0.00	30,000,000.00
09/20/23	09/20/23	Mature Long	15,000,000.000	FHLB DISCOUNT NOTE MAT 09/20/23 Cpn	313384LY3	14,997,812.50	2,187.50	0.00	0.00	15,000,000.00

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09/21/23	09/21/23	Mature Long	50,000,000.000	U.S. TREASURY BILL MAT 09/21/23 Cpn	912796CR8	49,853,888.89	146,111.11	0.00	0.00	50,000,000.00
09/21/23	09/21/23	Mature Long	50,000,000.000	U.S. TREASURY BILL MAT 09/21/23 Cpn	912796CR8	49,853,888.89	146,111.11	0.00	0.00	50,000,000.00
09/21/23	09/21/23	Mature Long	50,000,000.000	U.S. TREASURY BILL MAT 09/21/23 Cpn	912796CR8	49,853,888.89	146,111.11	0.00	0.00	50,000,000.00
09/21/23	09/21/23	Mature Long	50,000,000.000	U.S. TREASURY BILL MAT 09/21/23 Cpn	912796CR8	49,853,888.89	146,111.11	0.00	0.00	50,000,000.00
09/21/23	09/21/23	Mature Long	5,000,000.000	FHLB DISCOUNT NOTE MAT 09/21/23 Cpn	313384LZ0	4,999,270.83	729.17	0.00	0.00	5,000,000.00
09/21/23	09/21/23	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/21/23 Cpn	313384LZ0	49,992,708.33	7,291.67	0.00	0.00	50,000,000.00
09/21/23	09/21/23	Mature Long	8,000,000.000	SC SOUTH CAROLINA PUB SVC CP MAT 09/21/23 Cpn 5.40	83708BCE4	8,000,000.00		0.00	0.00	8,000,000.00
09/22/23	09/22/23	Mature Long	20,000,000.000	FHLB DISCOUNT NOTE MAT 09/22/23 Cpn	313384MA4	19,997,083.33	2,916.67	0.00	0.00	20,000,000.00
09/22/23	09/22/23	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/22/23 Cpn	313384MA4	49,992,708.33	7,291.67	0.00	0.00	50,000,000.00
09/22/23	09/22/23	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/22/23 Cpn	313384MA4	49,992,708.33	7,291.67	0.00	0.00	50,000,000.00
09/22/23	09/22/23	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/22/23 Cpn	313384MA4	49,992,708.33	7,291.67	0.00	0.00	50,000,000.00
09/22/23	09/22/23	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/22/23 Cpn	313384MA4	49,992,708.33	7,291.67	0.00	0.00	50,000,000.00
09/22/23	09/22/23	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/22/23 Cpn	313384MA4	49,992,708.33	7,291.67	0.00	0.00	50,000,000.00

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09/25/23	09/25/23	Mature Long	5,000,000.000	FHLB DISCOUNT NOTE MAT 09/25/23 Cpn 313384MD8	4,997,812.50	2,187.50	0.00	0.00	5,000,000.00
09/25/23	09/25/23	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/25/23 Cpn 313384MD8	49,978,125.00	21,875.00	0.00	0.00	50,000,000.00
09/25/23	09/25/23	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/25/23 Cpn 313384MD8	49,978,125.00	21,875.00	0.00	0.00	50,000,000.00
09/25/23	09/25/23	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/25/23 Cpn 313384MD8	49,978,125.00	21,875.00	0.00	0.00	50,000,000.00
09/25/23	09/25/23	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/25/23 Cpn 313384MD8	49,978,125.00	21,875.00	0.00	0.00	50,000,000.00
09/25/23	09/25/23	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/25/23 Cpn 313384MD8	49,978,125.00	21,875.00	0.00	0.00	50,000,000.00
09/25/23	09/25/23	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/25/23 Cpn 313384MD8	49,978,125.00	21,875.00	0.00	0.00	50,000,000.00
09/25/23	09/25/23	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/25/23 Cpn 313384MD8	49,978,125.00	21,875.00	0.00	0.00	50,000,000.00
09/25/23	09/25/23	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/25/23 Cpn 313384MD8	49,978,125.00	21,875.00	0.00	0.00	50,000,000.00
09/25/23	09/25/23	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/25/23 Cpn 313384MD8	49,978,125.00	21,875.00	0.00	0.00	50,000,000.00
09/25/23	09/25/23	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/25/23 Cpn 313384MD8	49,978,125.00	21,875.00	0.00	0.00	50,000,000.00
09/25/23	09/25/23	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/25/23 Cpn 313384MD8	49,978,125.00	21,875.00	0.00	0.00	50,000,000.00
09/25/23	09/25/23	Mature Long	7,000,000.000	SUMITOMO MITSUI CP 144A MAT 09/25/23 Cpn 86563HWR7	6,989,616.67	10,383.33	0.00	0.00	7,000,000.00

Account Name: L.A. CARE HEALTH PLAN

09/01/2023 through 09/30/2023

Tr Date	St Date	Transaction Type	Units	Description		Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
09/26/23	09/26/23	Mature Long	50,000,000.000	U.S. TREASURY BILL MAT 09/26/23 Cpn	912797GU5	49,992,750.00	7,250.00	0.00	0.00	50,000,000.00
09/26/23	09/26/23	Mature Long	50,000,000.000	U.S. TREASURY BILL MAT 09/26/23 Cpn	912797GU5	49,992,750.00	7,250.00	0.00	0.00	50,000,000.00
09/26/23	09/26/23	Mature Long	45,000,000.000	FHLB DISCOUNT NOTE MAT 09/26/23 Cpn	313384ME6	44,993,412.50	6,587.50	0.00	0.00	45,000,000.00
09/26/23	09/26/23	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/26/23 Cpn	313384ME6	49,992,680.56	7,319.44	0.00	0.00	50,000,000.00
09/26/23	09/26/23	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/26/23 Cpn	313384ME6	49,992,680.56	7,319.44	0.00	0.00	50,000,000.00
09/26/23	09/26/23	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/26/23 Cpn	313384ME6	49,992,680.56	7,319.44	0.00	0.00	50,000,000.00
09/26/23	09/26/23	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/26/23 Cpn	313384ME6	49,992,680.56	7,319.44	0.00	0.00	50,000,000.00
09/26/23	09/26/23	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/26/23 Cpn	313384ME6	49,992,680.56	7,319.44	0.00	0.00	50,000,000.00
09/26/23	09/26/23	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/26/23 Cpn	313384ME6	49,992,680.56	7,319.44	0.00	0.00	50,000,000.00
09/26/23	09/26/23	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/26/23 Cpn	313384ME6	49,992,680.56	7,319.44	0.00	0.00	50,000,000.00
09/26/23	09/26/23	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/26/23 Cpn	313384ME6	49,992,680.56	7,319.44	0.00	0.00	50,000,000.00
09/26/23	09/26/23	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/26/23 Cpn	313384ME6	49,992,680.56	7,319.44	0.00	0.00	50,000,000.00
09/26/23	09/26/23	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/26/23 Cpn	313384ME6	49,992,680.56	7,319.44	0.00	0.00	50,000,000.00

Account Name: L.A. CARE HEALTH PLAN

09/01/2023 through 09/30/2023

Tr Date	St Date	Transaction Type	Units	Description		Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
09/26/23	09/26/23	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/26/23 Cpn	313384ME6	49,992,680.56	7,319.44	0.00	0.00	50,000,000.00
09/26/23	09/26/23	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/26/23 Cpn	313384ME6	49,992,680.56	7,319.44	0.00	0.00	50,000,000.00
09/27/23	09/27/23	Mature Long	33,000,000.000	FHLB DISCOUNT NOTE MAT 09/27/23 Cpn	313384MF3	32,995,169.17	4,830.83	0.00	0.00	33,000,000.00
09/27/23	09/27/23	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/27/23 Cpn	313384MF3	49,992,680.56	7,319.44	0.00	0.00	50,000,000.00
09/27/23	09/27/23	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/27/23 Cpn	313384MF3	49,992,680.56	7,319.44	0.00	0.00	50,000,000.00
09/27/23	09/27/23	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/27/23 Cpn	313384MF3	49,992,680.56	7,319.44	0.00	0.00	50,000,000.00
09/27/23	09/27/23	Mature Long	40,000,000.000	FHLB DISCOUNT NOTE MAT 09/27/23 Cpn	313384MF3	39,994,144.44	5,855.56	0.00	0.00	40,000,000.00
09/28/23	09/28/23	Mature Long	30,000,000.000	U.S. TREASURY BILL MAT 09/28/23 Cpn	912796CS6	29,986,887.50	13,112.50	0.00	0.00	30,000,000.00
09/28/23	09/28/23	Mature Long	50,000,000.000	U.S. TREASURY BILL MAT 09/28/23 Cpn	912796CS6	49,978,145.83	21,854.17	0.00	0.00	50,000,000.00
09/28/23	09/28/23	Mature Long	22,500,000.000	CATERPILLAR FIN CP MAT 09/28/23 Cpn	14912EWU7	22,453,625.00	46,375.00	0.00	0.00	22,500,000.00
09/28/23	09/28/23	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/28/23 Cpn	313384MG1	49,992,708.33	7,291.67	0.00	0.00	50,000,000.00
09/28/23	09/28/23	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/28/23 Cpn	313384MG1	49,992,708.33	7,291.67	0.00	0.00	50,000,000.00
09/28/23	09/28/23	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/28/23 Cpn	313384MG1	49,992,708.33	7,291.67	0.00	0.00	50,000,000.00

Account Name: L.A. CARE HEALTH PLAN

09/01/2023 through 09/30/2023

Tr Date	St Date	Transaction Type	Units	Description	Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
09/28/23	09/28/23	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 09/28/23 Cpn 313384MG1	49,992,708.33	7,291.67	0.00	0.00	50,000,000.00
09/28/23	09/28/23	Mature Long	20,000,000.000	NATL SEC CLEARING CP 144A MAT 09/28/23 Cpn 63763QWU	19,935,100.00	64,900.00	0.00	0.00	20,000,000.00
09/28/23	09/28/23	Mature Long	4,200,000.000	CA SAN JOSE FIN AUTH CP TXB MAT 09/28/23 Cpn 5.40 79815WDN5	4,200,000.00		0.00	0.00	4,200,000.00
09/29/23	09/29/23	Mature Long	50,000,000.000	FNM DISCOUNT NOTE MAT 09/29/23 Cpn 313588MH5	49,992,847.22	7,152.78	0.00	0.00	50,000,000.00
09/29/23	09/29/23	Mature Long	50,000,000.000	FNM DISCOUNT NOTE MAT 09/29/23 Cpn 313588MH5	49,992,847.22	7,152.78	0.00	0.00	50,000,000.00
09/29/23	09/29/23	Mature Long	50,000,000.000	FNM DISCOUNT NOTE MAT 09/29/23 Cpn 313588MH5	49,992,847.22	7,152.78	0.00	0.00	50,000,000.00
09/29/23	09/29/23	Mature Long	50,000,000.000	FNM DISCOUNT NOTE MAT 09/29/23 Cpn 313588MH5	49,992,847.22	7,152.78	0.00	0.00	50,000,000.00
			4,595,150,000.000		4,592,815,450.53	2,334,549.48	(0.00)	0.00	4,595,150,000.00
09/01/23	09/01/23	Withdrawal	(40,148.610)	CUSTODY FEE MAT Cpn USD	(40,148.61)		(40,148.61)	0.00	(40,148.61)
09/07/23	09/07/23	Withdrawal	(250,000,000.000)	WD MAT Cpn USD	(250,000,000.00)		(250,000,000.00)	0.00	(250,000,000.00)
09/12/23	09/12/23	Withdrawal	(50,000,000.000)	WD MAT Cpn USD	(50,000,000.00)		(50,000,000.00)	0.00	(50,000,000.00)
09/18/23	09/18/23	Withdrawal	(150,000,000.000)	WD MAT Cpn USD	(150,000,000.00)		(150,000,000.00)	0.00	(150,000,000.00)
09/19/23	09/19/23	Withdrawal	(150,000,000.000)	WD MAT Cpn USD	(150,000,000.00)		(150,000,000.00)	0.00	(150,000,000.00)

Account Name: L.A. CARE HEALTH PLAN

09/01/2023 through 09/30/2023

Tr Date	St Date	Transaction Type	Units	Description			Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
09/20/23	09/20/23	Withdrawal	(50,000,000.000)	WD MAT	Cpn	USD	(50,000,000.00)		(50,000,000.00)	0.00	(50,000,000.00)
09/26/23	09/26/23	Withdrawal	(50,000,000.000)	WD MAT	Cpn	USD	(50,000,000.00)		(50,000,000.00)	0.00	(50,000,000.00)
09/27/23	09/27/23	Withdrawal	(150,000,000.000)	WD MAT	Cpn	USD	(150,000,000.00)		(150,000,000.00)	0.00	(150,000,000.00)
09/28/23	09/28/23	Withdrawal	(120,000,000.000)	WD MAT	Cpn	USD	(120,000,000.00)		(120,000,000.00)	0.00	(120,000,000.00)
09/29/23	09/29/23	Withdrawal	(595,000,000.000)	WD MAT	Cpn	USD	(595,000,000.00)		(595,000,000.00)	0.00	(595,000,000.00)
			(1,565,040,148.610)				(1,565,040,148.61)		(1,565,040,148.61)	0.00	(1,565,040,148.61)

Account Name: L.A. CARE HEALTH PLAN-LOW DURATION PORT

09/01/2023 through 09/30/2023

Tr Date	St Date	Transaction Type	Units	Description	Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
09/12/23	09/20/23	Buy	200,000.000	NAVMT 2023-1 A FLOOR 144A MAT 08/25/28 Cpn 6.18 63938PBU2	(199,971.58)		0.00	0.00	(199,971.58)
09/28/23	09/29/23	Buy	2,030,000.000	U.S. TREASURY NOTE MAT 08/31/28 Cpn 4.38 91282CHX2	(2,007,638.28)	(7,075.72)	0.00	0.00	(2,014,714.00)
			2,230,000.000		(2,207,609.86)	(7,075.72)	0.00	0.00	(2,214,685.58)
09/01/23	09/01/23	Coupon		CA GLENDALE USD GO/ULT TXB MAT 09/01/24 Cpn 1.46 378460YD5		1,821.25	0.00	0.00	1,821.25
09/01/23	09/01/23	Coupon		CA SAN DIEGO REDEV AGY TAB T MAT 09/01/23 Cpn 3.38 79730WAZ3		7,593.75	0.00	0.00	7,593.75
09/01/23	09/01/23	Coupon		CA SAN JOSE-EVERGREEN CCD T MAT 09/01/23 Cpn 3.50 798189RE8		6,825.00	0.00	0.00	6,825.00
09/01/23	09/01/23	Coupon		CA SAN LUIS WESTLANDS WTR DI MAT 09/01/24 Cpn 1.45 798736AW4		2,970.45	0.00	0.00	2,970.45
09/15/23	09/15/23	Coupon		CARMX 2020-1 A3 CAR MAT 12/16/24 Cpn 1.89 14315XAC2		36.44	0.00	0.00	36.44
09/15/23	09/15/23	Coupon		CARMX 2021-2 A3 AUTO MAT 02/17/26 Cpn 0.52 14314QAC8		234.98	0.00	0.00	234.98
09/15/23	09/15/23	Coupon		CARMX 2021-3 A3 CAR MAT 06/15/26 Cpn 0.55 14317DAC4		326.88	0.00	0.00	326.88
09/15/23	09/15/23	Coupon		CARMX 2023-3 A3 CAR MAT 05/15/28 Cpn 5.28 14319BAC6		3,520.00	0.00	0.00	3,520.00
09/15/23	09/15/23	Coupon		FORDF 2023-1 A1 FLOOR 144A MAT 05/15/28 Cpn 4.92 34528QHV9		2,870.00	0.00	0.00	2,870.00
09/15/23	09/15/23	Coupon		FORDF 2023-1 A1 FLOOR 144A MAT 05/15/28 Cpn 4.92 34528QHV9		820.00	0.00	0.00	820.00

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09/01/2023 through 09/30/2023

Tr Date	St Date	Transaction Type	Units	Description	Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
09/15/23	09/15/23	Coupon		FORDO 2023-B A3 CAR MAT 05/15/28 Cpn 5.23 344930AD4		2,615.00	0.00	0.00	2,615.00
09/15/23	09/15/23	Coupon		GFORT 2023-1 A1 FLOOR 144A MAT 06/15/28 Cpn 5.34 361886CR3		4,005.00	0.00	0.00	4,005.00
09/15/23	09/15/23	Coupon		JDOT 2023-B A3 EQP MAT 03/15/28 Cpn 5.18 477920AC6		3,237.50	0.00	0.00	3,237.50
09/15/23	09/15/23	Coupon		KUBOTA 2021-2A A3 EQP 144A MAT 11/17/25 Cpn 0.56 50117XAE2		387.78	0.00	0.00	387.78
09/15/23	09/15/23	Coupon		KCOT 2023-2A A3 EQP 144A MAT 01/18/28 Cpn 5.28 500945AC4		2,200.00	0.00	0.00	2,200.00
09/15/23	09/15/23	Coupon		MERCEDES 2021-B A3 LEASE MAT 11/15/24 Cpn 0.40 58769KAD6		97.56	0.00	0.00	97.56
09/15/23	09/15/23	Coupon		NY STATE DORM AUTH PERS INC T MAT 03/15/25 Cpn 0.89 64990FD43		3,015.80	0.00	0.00	3,015.80
09/15/23	09/15/23	Coupon		WORLD OMNI 2021-A A3 LEASE MAT 08/15/24 Cpn 0.42 98163JAC9		108.37	0.00	0.00	108.37
09/16/23	09/16/23	Coupon		GMCAR 2021-2 A3 CAR MAT 04/16/26 Cpn 0.51 380149AC8		53.81	0.00	0.00	53.81
09/18/23	09/18/23	Coupon		HAROT 2023-3 A3 CAR MAT 02/18/28 Cpn 5.41 43815QAC1		976.81	0.00	0.00	976.81
09/20/23	09/20/23	Coupon		GMALT 2023-3 A3 LEASE MAT 11/20/26 Cpn 5.38 379929AD4		1,524.33	0.00	0.00	1,524.33
09/20/23	09/20/23	Coupon		SRT 2021-C A3 LEASE 144A MAT 03/20/25 Cpn 0.50 80286CAC4		64.23	0.00	0.00	64.23
09/20/23	09/20/23	Coupon		TESLA 2021-B A2 LEASE 144A MAT 09/22/25 Cpn 0.36 88161KAB1		13.22	0.00	0.00	13.22

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Tr Date	St Date	Transaction Type	Units	Description	Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
09/20/23	09/20/23	Coupon		TLOT 2023A A3 LEASE 144A MAT 04/20/26 Cpn 4.93 89239MAC1		2,054.17	0.00	0.00	2,054.17
09/20/23	09/20/23	Coupon		VERIZON 2020-B A PHONE MAT 02/20/25 Cpn 0.47 92290BAA9		16.26	0.00	0.00	16.26
09/01/23	09/25/23	Coupon		FHMS K725 AM CMBS MAT 02/25/24 Cpn 3.10 3137BWWE		2,095.20	0.00	0.00	2,095.20
09/01/23	09/25/23	Coupon		FHMS K726 AM CMBS MAT 04/25/24 Cpn 2.99 3137BYPR5		1,417.88	0.00	0.00	1,417.88
09/30/23	09/30/23	Coupon		FHLMC C 12/30/2022 Q MAT 09/30/25 Cpn 4.75 3134GX3A0		14,487.50	0.00	0.00	14,487.50
09/30/23	09/30/23	Coupon		U.S. TREASURY NOTE MAT 09/30/25 Cpn 0.25 91282CAM3		625.00	0.00	0.00	625.00
09/30/23	09/30/23	Coupon		U.S. TREASURY NOTE MAT 03/31/26 Cpn 0.75 91282CBT7		2,006.25	0.00	0.00	2,006.25
09/30/23	09/30/23	Coupon		U.S. TREASURY NOTE MAT 03/31/26 Cpn 0.75 91282CBT7		3,412.50	0.00	0.00	3,412.50
09/30/23	09/30/23	Coupon		U.S. TREASURY NOTE MAT 03/31/26 Cpn 0.75 91282CBT7		1,762.50	0.00	0.00	1,762.50
09/30/23	09/30/23	Coupon		U.S. TREASURY NOTE MAT 09/30/26 Cpn 0.88 91282CCZ2		6,146.88	0.00	0.00	6,146.88
09/30/23	09/30/23	Coupon		U.S. TREASURY NOTE MAT 03/31/27 Cpn 2.50 91282CEF4		5,625.00	0.00	0.00	5,625.00
09/30/23	09/30/23	Coupon		U.S. TREASURY NOTE MAT 03/31/27 Cpn 2.50 91282CEF4		11,250.00	0.00	0.00	11,250.00
09/30/23	09/30/23	Coupon		U.S. TREASURY NOTE MAT 03/31/28 Cpn 3.63 91282CGT2		64,343.75	0.00	0.00	64,343.75

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Tr Date	St Date	Transaction Type	Units	Description	Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
09/30/23	09/30/23	Coupon		U.S. TREASURY NOTE MAT 03/31/28 Cpn 3.63 91282CGT2		28,818.75	0.00	0.00	28,818.75
09/30/23	09/30/23	Coupon		U.S. TREASURY NOTE MAT 03/31/28 Cpn 3.63 91282CGT2		37,065.63	0.00	0.00	37,065.63
09/30/23	09/30/23	Coupon		U.S. TREASURY NOTE MAT 03/31/28 Cpn 3.63 91282CGT2		71,050.00	0.00	0.00	71,050.00
						297,495.43	0.00	0.00	297,495.43
09/01/23	09/01/23	Income	3,057.250	STIF INT MAT Cpn USD		3,057.25	0.00	0.00	3,057.25
09/28/23	09/29/23	Sell Long	1,686,000.000	U.S. TREASURY NOTE MAT 03/31/25 Cpn 0.50 912828ZF0	1,570,746.09	4,191.97	0.00	(119,824.75)	1,574,938.06
09/28/23	09/29/23	Sell Long	230,000.000	U.S. TREASURY NOTE MAT 02/28/25 Cpn 1.13 912828ZC7	216,981.64	206.15	0.00	(13,714.92)	217,187.79
			1,916,000.000		1,787,727.73	4,398.12	0.00	(133,539.67)	1,792,125.85
09/15/23	09/15/23	Pay Princpl	16,744.666	CARMX 2020-1 A3 CAR MAT 12/16/24 Cpn 1.89 14315XAC2	16,744.67		0.00	(33.97)	16,744.67
09/15/23	09/15/23	Pay Princpl	44,512.865	CARMX 2021-2 A3 AUTO MAT 02/17/26 Cpn 0.52 14314QAC8	44,512.87		0.00	3.43	44,512.87
09/15/23	09/15/23	Pay Princpl	44,682.853	CARMX 2021-3 A3 CAR MAT 06/15/26 Cpn 0.55 14317DAC4	44,682.85		0.00	3.31	44,682.85
09/15/23	09/15/23	Pay Princpl	57,155.129	KUBOTA 2021-2A A3 EQP 144A MAT 11/17/25 Cpn 0.56 50117XAE2	57,155.13		0.00	0.97	57,155.13

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09/01/2023 through 09/30/2023

Tr Date	St Date	Transaction Type	Units	Description	Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
09/15/23	09/15/23	Pay Princpl	57,606.537	MERCEDES 2021-B A3 LEASE MAT 11/15/24 Cpn 0.40 58769KAD6	57,606.54		0.00	0.91	57,606.54
09/15/23	09/15/23	Pay Princpl	104,315.125	WORLD OMNI 2021-A A3 LEASE MAT 08/15/24 Cpn 0.42 98163JAC9	104,315.13		0.00	2.02	104,315.13
09/16/23	09/16/23	Pay Princpl	10,024.843	GMCAR 2021-2 A3 CAR MAT 04/16/26 Cpn 0.51 380149AC8	10,024.84		0.00	0.31	10,024.84
09/20/23	09/20/23	Pay Princpl	52,633.764	SRT 2021-C A3 LEASE 144A MAT 03/20/25 Cpn 0.50 80286CAC4	52,633.76		0.00	0.56	52,633.76
09/20/23	09/20/23	Pay Princpl	23,094.532	TESLA 2021-B A2 LEASE 144A MAT 09/22/25 Cpn 0.36 88161KAB1	23,094.53		0.00	0.39	23,094.53
09/20/23	09/20/23	Pay Princpl	35,086.576	VERIZON 2020-B A PHONE MAT 02/20/25 Cpn 0.47 92290BAA9	35,086.58		0.00	(5.59)	35,086.58
			445,856.890		445,856.90		0.00	(27.64)	445,856.90
09/01/23	09/01/23	Mature Long	450,000.000	CA SAN DIEGO REDEV AGY TAB T MAT 09/01/23 Cpn 3.38 79730WAZ3	450,000.00		0.00	0.00	450,000.00
09/01/23	09/01/23	Mature Long	390,000.000	CA SAN JOSE-EVERGREEN CCD T MAT 09/01/23 Cpn 3.50 798189RE8	390,000.00		0.00	0.00	390,000.00
			840,000.000		840,000.00		0.00	0.00	840,000.00

LA CARE

Cash Activity by Transaction Type GAAP Basis

Accounting Period From 09/01/2023 To 09/30/2023

Cash Date	Trade/Ex-Date	Settle/Pay Date	Custodian	Cusip	Description	Quantity	Income Amount	Principal Amount	Contributions/ Withdrawals	Total Amount
BUY										
09/01/23	08/30/23	09/01/23	TNT77	02361DAS9	AMEREN ILLINOIS CO	2,500,000.00	(27,972.22)	(2,382,900.00)	0.00	(2,410,872.22)
09/14/23	09/12/23	09/14/23	TNT77	29736RAS9	ESTEE LAUDER CO INC	2,500,000.00	(37,065.97)	(2,422,750.00)	0.00	(2,459,815.97)
09/14/23	09/14/23	09/14/23	TNT77	665278404	NORTHERN INST GOVT MONEY MKT	1,441,968.36	0.00	(1,441,968.36)	0.00	(1,441,968.36)
09/28/23	09/26/23	09/28/23	TNT77	440452AH3	HORMEL FOODS CORP	1,000,000.00	(5,430.55)	(855,080.00)	0.00	(860,510.55)
09/29/23	09/27/23	09/29/23	TNT77	440452AH3	HORMEL FOODS CORP	1,600,000.00	(8,764.44)	(1,364,176.00)	0.00	(1,372,940.44)
TOTAL BUY						9,041,968.36	(79,233.18)	(8,466,874.36)	0.00	(8,546,107.54)
DIVIDEND										
09/01/23	09/01/23	09/01/23	TNT77	665278404	NORTHERN INST GOVT MONEY MKT	7,522,580.18	19,504.83	0.00	0.00	19,504.83
TOTAL DIVIDEND						7,522,580.18	19,504.83	0.00	0.00	19,504.83
INTEREST										
09/01/23	09/01/23	09/01/23	TNT77	010392FY9	ALABAMA POWER CO	7,000,000.00	131,250.00	0.00	0.00	131,250.00
09/01/23	09/01/23	09/01/23	TNT77	20030NBS9	COMCAST CORP	3,500,000.00	55,125.00	0.00	0.00	55,125.00
09/01/23	09/01/23	09/01/23	TNT77	210518DS2	CONSUMERS ENERGY CO	4,650,000.00	138,744.38	0.00	0.00	138,744.38
09/01/23	09/01/23	09/01/23	TNT77	29157TAC0	EMORY UNIVERSITY	4,305,000.00	33,708.15	0.00	0.00	33,708.15
09/02/23	09/02/23	09/02/23	TNT77	14913R2K2	CATERPILLAR FINL SERVICE	5,000,000.00	22,500.00	0.00	0.00	22,500.00
09/03/23	09/03/23	09/03/23	TNT77	04636NAF0	ASTRAZENECA FINANCE LLC	5,000,000.00	121,875.00	0.00	0.00	121,875.00
09/03/23	09/03/23	09/03/23	TNT77	57636QAN4	MASTERCARD INC	3,000,000.00	30,000.00	0.00	0.00	30,000.00
09/10/23	09/10/23	09/10/23	TNT77	771196BV3	ROCHE HOLDINGS INC	7,500,000.00	86,775.00	0.00	0.00	86,775.00
09/13/23	09/13/23	09/13/23	TNT77	828807DG9	SIMON PROPERTY GROUP LP	5,000,000.00	50,000.00	0.00	0.00	50,000.00
09/15/23	09/15/23	09/15/23	TNT77	29736RAJ9	ESTEE LAUDER CO INC	1,500,000.00	23,625.00	0.00	0.00	23,625.00
09/15/23	09/15/23	09/15/23	TNT77	74456QCF1	PUBLIC SERVICE ELECTRIC	9,000,000.00	42,750.00	0.00	0.00	42,750.00
09/17/23	09/17/23	09/17/23	TNT77	931142ER0	WALMART INC	5,000,000.00	26,250.00	0.00	0.00	26,250.00
09/19/23	09/19/23	09/19/23	TNT77	30231GBH4	EXXON MOBIL CORPORATION	2,000,000.00	29,920.00	0.00	0.00	29,920.00
09/20/23	09/20/23	09/20/23	TNT77	89236TKJ3	TOYOTA MOTOR CREDIT CORP	3,000,000.00	68,250.00	0.00	0.00	68,250.00
09/22/23	09/22/23	09/22/23	TNT77	49177JAE2	KENVUE INC	2,000,000.00	50,500.00	0.00	0.00	50,500.00
09/24/23	09/24/23	09/24/23	TNT77	254687FN1	WALT DISNEY COMPANY/THE	3,000,000.00	50,250.00	0.00	0.00	50,250.00
09/25/23	09/25/23	09/25/23	TNT77	458140BP4	INTEL CORP	2,500,000.00	42,500.00	0.00	0.00	42,500.00
TOTAL INTEREST						72,955,000.00	1,004,022.53	0.00	0.00	1,004,022.53
SELL										

LA CARE

Cash Activity by Transaction Type GAAP Basis

Accounting Period From 09/01/2023 To 09/30/2023

Cash Date	Trade/Ex-Date	Settle/Pay Date	Custodian	Cusip	Description	Quantity	Income Amount	Principal Amount	Contributions/ Withdrawals	Total Amount
09/14/23	09/14/23	09/14/23	TNT77	665278404	NORTHERN INST GOVT MONEY MKT	7,522,580.18	0.00	7,522,580.18	0.00	7,522,580.18
TOTAL SELL						7,522,580.18	0.00	7,522,580.18	0.00	7,522,580.18
GRAND TOTAL						97,042,128.72	944,294.18	(944,294.18)	0.00	0.00

Avg Date 14

November 15, 2023

TO: Finance & Budget Committee

FROM: Afzal Shah, *Chief Financial Officer*

SUBJECT: AFS-006 (Authorization and Approval Limits) and AFS-007 (Procurement Policy) 4th Quarter and Annual Reports for FY 2022-23

The below Accounting & Financial Services (AFS) policies are required to be reported to the Finance & Budget Committee:

1. Policy AFS-006 (Authorization and Approval Limits) requires reports for executed vendor contracts for all expenditures.

2. Policy AFS-007 (Procurement Policy) requires reports for all sole source purchases over $250,000.

Attached are the reports for 4th Quarter and Annual Reports for FY 2022-23.

L.A. Care Health Plan
AFS-006 Authorization and Approval Limits Quarterly Report
July 2023 - September 2023

New POs and Contracts	
Vendor Name	**PO and Contract Total**
County Superintendent of Schools	$ 39,901,074.50
Cognizant TriZetto Software Group, Inc.	$ 7,478,186.24
NTT America Solutions, Inc.	$ 5,217,724.63
Thrasys, Inc.	$ 4,050,000.00
Delphix Corp.	$ 4,025,548.80
Uncommon Good, A California Nonprofit Corporation (Grantee)	$ 4,000,000.00
I Color Printing & Mailing Inc	$ 3,562,354.88
Los Angeles Homeless Service Authority (Grantee)	$ 2,820,324.73
Sheppard Mullin Richter & Hampton LLP	$ 1,600,000.00
MediKeeper, Inc.	$ 1,510,000.00
Edifecs, Inc.	$ 1,427,849.96
Infosys Limited	$ 1,387,924.00
Mayor's Fund for Los Angeles (Grantee)	$ 1,078,000.02
Optiv Security, Inc.	$ 996,450.00
SHI International Corp	$ 994,437.90
Language Line Services, Inc.	$ 990,000.00
Arent Fox LLP	$ 800,000.00
Seyfarth Shaw LLP	$ 800,000.00
Fivetran Inc.	$ 722,600.00
Hanson Bridgett LLP	$ 700,000.00
Isaacs | Friedberg LLP	$ 600,000.00
Earth Print, Inc.	$ 539,135.40
Datavail Corporation	$ 519,984.00
JWCH Institute, Inc. (Grantee)	$ 500,000.00
Liberty Hill Foundation (Grantee)	$ 500,000.00
Venice Family Clinic (Grantee)	$ 475,000.00
Community Clinic Association of Los Angeles County	$ 457,409.40
Health Management Associates, Inc. (dba Wakely Consulting Group, L	$ 450,850.00
Los Angeles Christian Health Centers (Grantee)	$ 425,000.00
Canon Solutions America Inc	$ 416,348.00
SAI360 Inc.	$ 414,882.16
Marie Montgomery	$ 400,400.00
Daponde Simpson Rowe PC	$ 400,000.00
Mintz, Levin, Cohn, Ferris, Glovsky and Popeo P.C.	$ 400,000.00
Health Management Associates Inc.	$ 396,720.00
Oracle America, Inc.	$ 395,388.00
Absolute Ops LLC	$ 336,072.00
BrandFuse, inc.	$ 315,890.00
PillarRx Consulting, LLC	$ 302,400.00
St. John's Well Child & Family Center (Grantee)	$ 300,000.00
Escape Velocity Holdings, Inc.	$ 249,820.00
Microsoft Corporation	$ 234,576.00
Deloitte & Touche LLP	$ 225,000.00

New POs and Contracts	
Vendor Name	**PO and Contract Total**
Andrues/Podberesky, APLC	$ 200,000.00
Larson LLP	$ 200,000.00
Orbach, Huff, Suarez & Henderson LLP	$ 200,000.00
CrowdStrike, Inc.	$ 189,600.00
SKKN, INC.	$ 184,350.90
Garfield Health Center (Grantee)	$ 175,000.00
Harbor Community Clinic, Inc. (Grantee)	$ 175,000.00
Northeast Valley Health Corporation (Grantee)	$ 175,000.00
QueensCare Health Centers (Grantee)	$ 175,000.00
San Fernando Community Hospital (Grantee)	$ 175,000.00
Via Care Community Health Center (Grantee)	$ 175,000.00
DocuSign Inc	$ 167,140.00
salesforce.com, inc.	$ 165,371.80
Asian Pacific Health Care Venture, Inc. (Grantee)	$ 160,000.00
phData, Inc.	$ 159,780.00
UL Verification Services	$ 158,874.17
Sonia P. Guzman	$ 153,820.00
Analysis Prime, Inc.	$ 150,000.00
Community Partners (Grantee)	$ 150,000.00
National Medical Fellowships, Inc. (Grantee)	$ 150,000.00
Public Health Foundation Enterprises, Inc. (Grantee)	$ 150,000.00
Public Health Institute (Grantee)	$ 150,000.00
Advize Health LLC	$ 146,000.00
HALO BRANDED SOLUTIONS, INC.	$ 143,210.30
The Achievable Foundation (Grantee)	$ 140,000.00
Herald Christian Health Center (Grantee)	$ 125,000.00
Healthcare Informatics LLC	$ 111,900.00
Moveworks, Inc.	$ 100,000.00
Antelope Valley Partners for Health (Grantee)	$ 100,000.00
Franklin Covey Client Sales, Inc.	$ 87,023.73
SAP America, Inc.	$ 85,185.20
Critical Care Training Center	$ 84,000.00
Beauty for Ashes Maternal Wellness Inc. (Grantee)	$ 75,000.00
ApiSec.ai Inc	$ 71,250.00
Kensington Consulting Group LLC	$ 70,000.00
Solarwinds, Inc.	$ 68,757.00
Tony Lopez International	$ 66,576.60
ePlus Technology, inc.	$ 62,244.40
JeffersonLarsonSmith LLC	$ 56,250.00
Brent Powell	$ 52,500.00
Prompt Delivery, Inc.	$ 50,000.00
Southern California Grantmakers (Grantee)	$ 50,000.00
Robert M. Taylor, Jr.	$ 49,920.00
Zena B. Meeks	$ 47,200.00
Angie Gomez	$ 45,880.00
Embarcadero Technologies Inc	$ 45,550.00
Milliman Inc	$ 45,000.00

New POs and Contracts	
Vendor Name	**PO and Contract Total**
Office Depot, Inc.	$ 40,366.79
God's Pantry	$ 36,000.00
SonBern LLC.	$ 34,320.00
VideoGuard, LLC	$ 32,400.00
Faith Tramples Fear LLC	$ 31,450.00
Yesenia Andrade	$ 29,750.00
Ricky L. Davis	$ 26,250.00
ABF Data Systems, Inc	$ 25,920.00
Digicert, Inc.	$ 25,685.00
Verizon Business Network Services Inc	$ 25,000.00
SALVA	$ 24,740.00
Lands' End, Inc	$ 24,100.48
Well Rounded Fitness LLC	$ 23,390.00
Amazon Capital Services, Inc.	$ 22,317.25
ATTAC Consulting Group, LLC	$ 21,800.00
Arakelian Enterprises, Inc.	$ 19,898.00
Unidos Por La Musica	$ 18,720.00
Melissa Data Corporation	$ 18,000.00
MG Dance Foundation	$ 17,140.00
Blackbaud, Inc.	$ 14,283.00
Lakeshore Equipment Company	$ 12,946.33
Laura Roman Cadena	$ 12,040.00
CenturyLink Communications, LLC	$ 12,000.00
Self-Help Graphics and Art, Inc	$ 10,787.00
Toddler Tings! Paint.Play.Create	$ 10,775.00
Khavarian Enterprises, Inc.	$ 10,760.00
RLG Enterprises, Inc	$ 10,000.00
Aunt Flow Corp.	$ 9,665.00
One Ring Networks, Inc.	$ 9,375.00
FanelliPM	$ 7,500.00
Worksite Wellness LA	$ 7,200.00
Mercer (US) Inc.	$ 7,000.00
EPI-USE Labs, LLC.	$ 6,286.38
Uline, Inc.	$ 5,524.20
Altec Products, Inc.	$ 4,245.75
Metalcraft, Inc	$ 3,347.20
Training Connection LLC	$ 3,180.00
RightStar, Inc.	$ 3,024.67
Serra Community Medical Clinic, Inc.	$ 2,175.00
Charter Communications Holdings, LLC	$ 1,726.00
Ollivier Corporation	$ 1,620.00
Blue Ribbon Technologies, LLC	$ 1,560.00
Luxury Glass Tinting Inc.	$ 1,275.00
ABMS Solutions, LLC	$ 975.00
Wistia, Inc	$ 950.40
OnDemand, Inc.	$ 898.00
Your Glass Connection, Inc.	$ 885.00

New POs and Contracts	
Vendor Name	**PO and Contract Total**
Samuel Roman	$ 700.00
Sovos Compliance, LLC	$ 689.85
American Registry for Internet Numbers, LTD	$ 500.00
Norm's Refrigeration, LLC.	$ 335.00
Optum360 LLC	$ 296.96
Total	**$ 99,706,507.98**

L.A. Care Health Plan
AFS-006 Authorization and Approval Limits Quarterly Report
July 2023 - September 2023

Amended Vendor Contracts

Vendor Name	Current Contract Total	Amendment	New Contract Total	Term Date
Center for Caregiver Advancement	$ 15,311,339.00	$ 11,640,388.00	$ 26,951,727.00	5/14/2026
Health Dialog Services Corporation	$ 2,000,000.00	$ 8,400,000.00	$ 15,400,000.00	8/31/2026
Infosys Limited	$ 8,564,883.00	$ 800,000.00	$ 9,364,883.00	10/31/2023
BIG Language Solutions LLC	$ 670,937.00	$ 3,600,000.00	$ 7,100,000.00	7/31/2026
Payspan, Inc.	$ 3,600,000.00	$ 1,000,000.00	$ 3,875,000.00	12/31/2024
Imagenet LLC	$ 3,150,000.00	$ 600,000.00	$ 3,750,000.00	6/30/2024
O'Neil Digital Solutions LLC	$ 2,000,000.00	$ 1,000,000.00	$ 3,000,000.00	6/30/2026
North Star Alliances, LLC	$ 1,950,000.00	$ 815,000.00	$ 2,765,000.00	12/31/2023
Language Select, LLC	$ 22,000,000.00	$ 1,200,000.00	$ 2,406,000.00	1/31/2026
Health Dialog Services Corporation	$ 2,000,000.00	$ 320,000.00	$ 2,320,000.00	12/31/2023
Corporate Translation Services, LLC	$ 640,000.00	$ 1,329,000.00	$ 1,969,000.00	2/28/2026
Infosys Limited	$ 1,271,936.00	$ 161,784.00	$ 1,433,720.00	9/30/2023
Health Management Associates Inc.	$ 842,690.00	$ 306,000.00	$ 1,148,690.00	12/31/2023
Health Management Associates Inc.	$ 476,000.00	$ 452,200.00	$ 928,200.00	12/31/2023
LA Net Community Health Research and R	$ 625,000.00	$ 220,000.00	$ 845,000.00	9/30/2024
Cognizant Technology Solutions U.S. Corp	$ 75,944,611.22	$ 85,776.00	$ 702,376.00	12/31/2023
Imagenet LLC	$ 400,000.00	$ 200,000.00	$ 600,000.00	6/30/2024
Datavail Corporation	$ 395,448.00	$ 124,536.00	$ 519,984.00	8/2/2024
Toney HealthCare Consulting, LLC	$ 325,000.00	$ 150,000.00	$ 475,000.00	12/31/2023
Axis Technology, LLC	$ 646,016.00	$ 28,000.00	$ 471,000.00	12/31/2023
A&M Healthcare Industry Group, LLC (a WH	$ 465,000.00	Time	$ 465,000.00	12/31/2023
NexTec Operating Corp.	$ 300,000.00	$ 100,000.00	$ 400,000.00	6/1/2024
The Mihalik Group, LLC	$ 208,320.00	$ 185,200.00	$ 393,520.00	11/30/2024
Integrated Healthcare Association	$ 273,354.35	$ 89,071.00	$ 362,425.35	No Expiration Date
Infosys Limited	$ 289,623.36	$ 69,060.00	$ 358,683.36	7/31/2023
WTI Holdings LLC	$ 283,520.00	$ 68,442.00	$ 351,962.00	6/30/2026
EPI-USE America Inc	$ 408,506.00	$ 100,000.00	$ 340,000.00	12/31/2023
Infosys Limited	$ 318,119.09	$ (17,568.00)	$ 300,551.09	8/31/2023
Shah Health LLC	$ 150,000.00	$ 150,000.00	$ 300,000.00	3/31/2024
Edifecs, Inc.	$ 110,000.00	$ 99,303.00	$ 209,303.00	7/1/2026
Therma Holdings, LLC	$ 154,615.00	$ 24,504.00	$ 179,119.00	10/31/2024
Canon Solutions America Inc	$ 43,800.00	$ 88,000.00	$ 163,600.00	7/31/2025
iXerv Americas Inc	$ 112,888.00	$ 50,000.00	$ 162,888.00	3/31/2024
Advent Advisory Group LLC	$ 101,700.00	$ 19,500.00	$ 121,200.00	12/30/2023
Cognisight, LLC	$ 75,000.00	$ 19,175.00	$ 94,175.00	7/31/2023
Gomez Research Inc.	$ 60,000.00	Time	$ 60,000.00	9/30/2024
Cactus Software LLC	$ 130,080.00	$ (70,429.00)	$ 59,651.00	4/30/2023
Antelope Valley Partners for Health	$ 50,290.00	$ 5,200.00	$ 55,490.00	12/31/2023
Acts93, Inc.	$ 2,335,000.00	$ 19,250.00	$ 54,250.00	12/31/2023
Council for Affordable Quality Healthcare, In	$ 2,700,000.00	$ 6,000.00	$ 49,800.00	4/22/2024
Parent, Family Engagement and Community	$ 39,000.00	$ 4,800.00	$ 43,800.00	10/31/2023
LexisNexis Risk Solutions FL Inc	$ 36,000.00	$ 6,900.00	$ 42,900.00	11/1/2023
Gasol Foundation	$ 20,800.00	Time	$ 20,800.00	11/30/2023
Martin Scholl Consulting, Inc.	$ 4,900.00	$ 2,100.00	$ 7,000.00	10/4/2026
Total	**$ 151,484,376.02**			

L.A. Care Health Plan
AFS-007 Authorization and Approval Limits Quarterly Report
July 2023 - September 2023

Vendor Selection - Sole Source

Vendor Name	Contract Total	Paid As Of 10/16/23	Vendor Selection
Shah Health LLC	$ 300,000.00	$ 162,126.00	Sole Source
CVS Pharmacy, Inc.	$ 450,000.00	N/A	Sole Source
Metcalfe Security Inc.	$ 950,000.00	N/A	Sole Source

L.A. Care Health Plan
AFS-006 Authorization and Approval Limits Annual Report
October 2022 - September 2023

New POs and Contracts

Vendor Name	PO and Contract Total
County Superintendent of Schools	$ 57,038,189.50
I Color Printing & Mailing Inc	$ 25,709,945.58
Cognizant TriZetto Software Group, Inc.	$ 14,537,131.50
Ntooitive Digital LLC	$ 11,215,332.00
Uncommon Good, A California Nonprofit Corporation (Grantee)	$ 8,000,000.00
Sierra Pacific Constructors, Inc.	$ 6,275,663.00
NTT America Solutions, Inc.	$ 5,390,719.63
SHI International Corp	$ 5,124,080.02
Delphix Corp.	$ 4,583,513.09
Thrasys, Inc.	$ 4,050,000.00
TransUnion Healthcare, Inc	$ 3,900,000.00
Daponde Simpson Rowe PC	$ 3,500,000.00
Arent Fox LLP	$ 3,400,000.00
Sheppard Mullin Richter & Hampton LLP	$ 3,149,119.57
Salesforce.com, Inc.	$ 3,108,567.61
ePlus Technology, inc.	$ 2,922,288.20
Infosys Limited	$ 2,859,318.45
Los Angeles Homeless Service Authority (Grantee)	$ 2,820,324.73
North Star Alliances, LLC	$ 2,765,000.00
Q-PERIOR Inc.	$ 2,672,000.00
California Association of Food Banks (Grantee)	$ 2,600,000.00
Optiv Security, Inc.	$ 2,453,602.89
Center for the Study of Services	$ 1,929,713.49
Health Management Associates Inc.	$ 1,862,790.00
Informatica LLC	$ 1,793,508.37
Charles R. Drew University of Medicine and Science (Grantee)	$ 1,738,387.00
UCLA Foundation, The (Grantee)	$ 1,613,387.00
MediKeeper, Inc.	$ 1,510,000.00
Iron Mountain Inc	$ 1,500,000.00
SAP America, Inc.	$ 1,472,703.50
Edifecs, Inc.	$ 1,427,849.96
Earth Print, Inc.	$ 1,408,134.96
Instant InfoSystems	$ 1,318,904.58
Isaacs | Friedberg LLP	$ 1,200,000.00
JWCH Institute, Inc. (Grantee)	$ 1,150,000.00
Seyfarth Shaw LLP	$ 1,100,000.00
Transform Health LLC	$ 1,098,910.29
Verizon Business Network Services Inc	$ 1,087,727.78
Canon Solutions America Inc	$ 1,079,645.85
Mayor's Fund for Los Angeles (Grantee)	$ 1,078,000.02
Change Healthcare Resources Holdings Inc.	$ 1,000,000.00
Liberty Hill Foundation (Grantee)	$ 1,000,000.00
Language Line Services, Inc.	$ 990,000.00
SKKN, INC.	$ 968,529.92

New POs and Contracts

Vendor Name	PO and Contract Total
CenturyLink Communications, LLC	$ 912,000.00
California Medical Association	$ 896,688.00
Hanson Bridgett LLP	$ 800,000.00
Fivetran Inc.	$ 722,600.00
Meyers, Nave, Riback, Silver & Wilson	$ 700,000.00
Los Angeles Christian Health Centers (Grantee)	$ 700,000.00
BrandFuse, inc.	$ 693,889.65
NICE Systems Inc	$ 682,445.56
Salesforce.com, Inc. (Parent Company of MuleSoft, LLC)	$ 680,194.80
HALO BRANDED SOLUTIONS, INC.	$ 677,199.95
Deloitte & Touche LLP	$ 668,300.00
mPulse Mobile, Inc.	$ 655,093.00
Collective Medical Technologies, Inc.	$ 655,000.00
Absolute Ops LLC	$ 643,962.00
Analysis Prime, Inc.	$ 622,472.40
Andrues/Podberesky, APLC	$ 600,000.00
MetaSoftTech Solutions LLC	$ 597,600.00
Applied Research Works, Inc.	$ 588,000.00
Venice Family Clinic (Grantee)	$ 575,000.00
Garfield Health Center (Grantee)	$ 550,000.00
St. John's Well Child & Family Center (Grantee)	$ 550,000.00
National Committee for Quality Assurance	$ 545,788.00
Via Care Community Health Center (Grantee)	$ 520,000.00
Datavail Corporation	$ 519,984.00
Health Data Vision, Inc.	$ 505,550.00
GTT LLC	$ 500,000.00
Reed Smith LLP	$ 500,000.00
Plunum Health (Grantee)	$ 500,000.00
Public Health Foundation Enterprises, Inc. (Grantee)	$ 500,000.00
M. Arthur Gensler, Jr. & Associates, Inc	$ 495,187.50
Advantmed, LLC	$ 488,000.00
Lista Design Studio, Inc.	$ 475,000.00
Axis Technology, LLC	$ 471,000.00
A&M Healthcare Industry Group, LLC (a Wholly Owned Subsidiary of A&	$ 465,000.00
Community Clinic Association of Los Angeles County	$ 457,409.40
Health Management Associates, Inc. (dba Wakely Consulting Group, LL	$ 450,850.00
Northeast Valley Health Corporation (Grantee)	$ 425,000.00
SAI360 Inc.	$ 414,882.16
Marie Montgomery	$ 400,400.00
Mintz, Levin, Cohn, Ferris, Glovsky and Popeo P.C.	$ 400,000.00
Orbach, Huff, Suarez & Henderson LLP	$ 400,000.00
The Berman Law Firm, APC	$ 400,000.00
Oracle America, Inc.	$ 395,388.00
Micro-Dyn Medical Systems, Inc.	$ 386,595.00
Pediatric & Family Medical Center (Grantee)	$ 375,000.00
Quest Analytics, Inc. (Parent Company of Quest Analytics L.L.C.)	$ 373,036.40
FanelliPM	$ 370,949.00
Optum360 LLC	$ 339,077.21

New POs and Contracts

Vendor Name	PO and Contract Total
Chinatown Service Center (Grantee)	$ 325,000.00
Harbor Community Clinic, Inc. (Grantee)	$ 325,000.00
City of Los Angeles, Department of Water and Power	$ 318,198.12
Asian Pacific Health Care Venture, Inc. (Grantee)	$ 310,000.00
PillarRx Consulting, LLC	$ 302,400.00
Actum II, LLC	$ 300,000.00
Barber Ranen LLP	$ 300,000.00
Best Best & Krieger LLP	$ 300,000.00
Mitchell Martin Inc.	$ 300,000.00
Richards, Watson & Gershon A Professional Corporation	$ 300,000.00
Wilson Elser Moskowitz Edelman and Dicker LLP	$ 300,000.00
Diversity Uplifts, Inc. (Grantee)	$ 300,000.00
Public Health Institute (Grantee)	$ 300,000.00
Ex Novo, Inc	$ 299,899.09
The Achievable Foundation (Grantee)	$ 290,000.00
God's Pantry	$ 280,176.00
Amplifi Group, LLC	$ 280,000.00
Korean Health, Education, Information and Research Center (Grantee)	$ 275,000.00
San Fernando Community Hospital (Grantee)	$ 275,000.00
National Health Foundation	$ 270,284.40
Alison Klurfeld	$ 267,400.00
Worksite Wellness LA	$ 266,400.00
Saviynt, Inc.	$ 250,541.79
Public Health Foundation Enterprises, Inc. (Grantee)	$ 250,000.00
Valley Community Healthcare (Grantee)	$ 250,000.00
Escape Velocity Holdings, Inc.	$ 249,820.00
Fierce Software Corporation	$ 248,954.84
Microsoft Corporation	$ 234,576.00
Sonia P. Guzman	$ 231,025.00
Skillsoft Corporation	$ 230,852.03
SciQuest, Inc.	$ 229,209.75
Breastfeeding Task Force of Greater Los Angeles (Grantee)	$ 225,000.00
JeffersonLarsonSmith LLC	$ 208,000.00
Burke, Williams & Sorrensen, LLP	$ 200,000.00
Hogan Lovells US LLP	$ 200,000.00
Jenner & Block LLP	$ 200,000.00
Larson LLP	$ 200,000.00
Morgan, Lewis & Bockius, LLP	$ 200,000.00
Sanders Roberts, LLP	$ 200,000.00
SSI (US) Inc	$ 200,000.00
Wilshire Advisors LLC	$ 200,000.00
Zones, LLC (Wholly Owned by Zones IT Solutions Inc.)	$ 193,470.29
CrowdStrike, Inc.	$ 189,600.00
GHA Technologies Inc	$ 188,229.75
Moss Adams LLP	$ 186,903.00
Cynthia ReedCarmona	$ 182,000.00
Green Management Consulting Group, Inc.	$ 180,000.00
RightStar, Inc.	$ 177,203.51

New POs and Contracts

Vendor Name	PO and Contract Total
QueensCare Health Centers (Grantee)	$ 175,000.00
Southern California Medical Center, Inc. (Grantee)	$ 175,000.00
DocuSign Inc	$ 167,140.00
11:11 Systems, Inc.	$ 161,586.60
phData, Inc.	$ 159,780.00
UL VERIFICATION SERVICES INC	$ 158,874.17
Qualtrics, LLC	$ 151,998.00
Critical Care Training Center	$ 151,200.00
Alliance for a Better Community (Grantee)	$ 150,000.00
AltaMed Health Services Corporation (Grantee)	$ 150,000.00
Communities Lifting Communities (Grantee)	$ 150,000.00
Community Partners (Grantee)	$ 150,000.00
Comprehensive Community Health Centers, Inc. (Grantee)	$ 150,000.00
DIY Girls (Grantee)	$ 150,000.00
East Valley Community Health Center, Inc. (Grantee)	$ 150,000.00
Fathers and Mothers Who Care, Inc. (Grantee)	$ 150,000.00
Gente Organizada (Grantee)	$ 150,000.00
Health Access for All Inc. (Grantee)	$ 150,000.00
National Medical Fellowships, Inc. (Grantee)	$ 150,000.00
Pomona Community Health Center (Grantee)	$ 150,000.00
Saahas For Cause (Grantee)	$ 150,000.00
St. Anthony Medical Centers (Grantee)	$ 150,000.00
Universal Community Health Center (Grantee)	$ 150,000.00
Gartner Inc.	$ 148,045.00
Citrix Systems, Inc.	$ 147,561.75
Advize Health LLC	$ 146,000.00
Office Depot, Inc.	$ 135,916.70
Aunt Bertha, a Public Benefit Corporation	$ 132,000.00
SAS Institute, Inc.	$ 128,438.00
Asian Pacific Community Fund of Southern California (Grantee)	$ 125,000.00
BeverlyCare (Grantee)	$ 125,000.00
Herald Christian Health Center (Grantee)	$ 125,000.00
The Los Angeles Free Clinic (Grantee)	$ 125,000.00
The R.O.A.D.S. Foundation, Inc. (Grantee)	$ 125,000.00
Gloria S. Nuestro	$ 124,800.00
Healthy Cooking LLC	$ 123,060.00
ABF Data Systems, Inc	$ 121,086.00
Brent Powell	$ 119,000.00
Live Art Plantscapes, Inc.	$ 118,941.00
Kinema Fitness, Inc.	$ 117,360.00
Healthcare Informatics LLC	$ 111,900.00
Bhive Holdings, LLC	$ 111,250.00
Aurora Systems Consulting, Inc	$ 109,350.00
Tony Lopez International	$ 104,312.95
Korn Ferry Hay Group, Inc.	$ 104,127.00
Nielsen Merksamer Parrinello Gross & Leoni, LLP	$ 102,526.00
PPT Holdings I, LLC	$ 100,432.86
Moveworks, Inc.	$ 100,000.00

New POs and Contracts

Vendor Name	PO and Contract Total
Musick, Peeler & Garrett LLP	$ 100,000.00
Antelope Valley Partners for Health (Grantee)	$ 100,000.00
California Black Women's Health Project (Grantee)	$ 100,000.00
California Safety Net Coalition (Grantee)	$ 100,000.00
Children's Dental Foundation (Grantee)	$ 100,000.00
Community Medical Wellness Centers USA (Grantee)	$ 100,000.00
Family Health Care Centers of Greater Los Angeles, Inc. (Grantee)	$ 100,000.00
Project Joy, Inc. (Grantee)	$ 100,000.00
Social Justice Learning Institute (Grantee)	$ 100,000.00
South Central Family Health Center (Grantee)	$ 100,000.00
T.H.E. Clinic, Inc. (Grantee)	$ 100,000.00
Westside Family Health Center (Grantee)	$ 100,000.00
White Memorial Community Health Center (Grantee)	$ 100,000.00
Wilmington Community Clinic (Grantee)	$ 100,000.00
Blackbaud, Inc.	$ 95,605.11
Purchaser Business Group on Health	$ 94,736.42
NAVEX Global, Inc.	$ 91,527.18
Edmund Jung & Associates, Inc.	$ 90,000.00
Franklin Covey Client Sales, Inc.	$ 87,023.73
Kimberley Carruthers	$ 85,800.00
Access Books	$ 85,000.00
Herald Christian Health Center	$ 83,200.00
Harvard Business School Publishing Corporation	$ 81,795.04
Solarwinds, Inc.	$ 81,777.00
VideoGuard, LLC	$ 80,400.00
Amazon Capital Services, Inc.	$ 80,352.45
Beauty for Ashes Maternal Wellness Inc. (Grantee)	$ 75,000.00
Tham & Associates LTD	$ 71,355.00
ApiSec.ai Inc	$ 71,250.00
Zipari, Inc.	$ 70,600.00
Kensington Consulting Group LLC	$ 70,000.00
Level 3 Financing, Inc.	$ 70,000.00
MEND- Meet Each Need with Dignity	$ 67,500.00
Cactus Software LLC	$ 67,435.55
Aquent LLC	$ 66,960.00
Lands' End, Inc	$ 62,407.44
Merito Solutions, Inc	$ 59,562.40
MG Dance Foundation	$ 57,470.00
DLT Solutions, LLC.	$ 56,038.45
Ollivier Corporation	$ 55,637.10
Rebecca E. Lynch	$ 52,000.00
Sovos Compliance, LLC	$ 51,203.19
Antelope Valley Partners for Health	$ 50,290.00
SonBern LLC.	$ 50,160.00
Customer Motivators, LLC	$ 50,000.00
Prompt Delivery, Inc.	$ 50,000.00
University of Southern California	$ 50,000.00
Positive Results Center (Grantee)	$ 50,000.00

New POs and Contracts

Vendor Name	PO and Contract Total
Southern California Grantmakers (Grantee)	$ 50,000.00
Robert M. Taylor, Jr.	$ 49,920.00
Politico LLC	$ 49,180.00
Yesenia Andrade	$ 48,500.00
Prevalent, Inc.	$ 47,714.07
Zena B. Meeks	$ 47,200.00
Uline, Inc.	$ 46,105.21
Angie Gomez	$ 45,880.00
Providence Little Company of Mary Foundation	$ 45,600.00
Embarcadero Technologies Inc	$ 45,550.00
California Hospital Assessment and Reporting Task Force (CHA	$ 45,000.00
Milliman Inc	$ 45,000.00
Arakelian Enterprises, Inc.	$ 44,248.00
Digicert, Inc.	$ 44,187.20
Parent, Family Engagement and Community Services, Inc.	$ 43,800.00
Momentive Inc.	$ 42,500.20
Partners In Care Foundation Inc.	$ 41,880.00
Advantage Mailing, LLC	$ 40,944.92
AEGIS.net, Inc.	$ 40,000.00
HRRP Garland LLC	$ 39,528.00
Jennifer Baez	$ 34,320.00
Laura Roman Cadena	$ 34,260.00
LPS Holdco LLC	$ 33,790.00
FiscalNote, Inc	$ 33,700.00
Faith Tramples Fear LLC	$ 31,450.00
Safe and Sound Surveillance Solutions Inc	$ 30,728.13
Vendor Credentialing Service LLC	$ 30,224.34
Maternal and Child Health Access Project	$ 30,000.00
Melissa Data Corporation	$ 29,185.00
Rubi Ruiz	$ 26,550.00
Ricky L. Davis	$ 26,250.00
Gallup, Inc.	$ 25,494.50
Posit Software, PBC	$ 24,995.00
Johnathan Madrigal	$ 24,912.00
SALVA	$ 24,740.00
Lakeshore Equipment Company	$ 24,426.19
Elizabeth Barnett	$ 24,000.00
Freeman-Thomas Early Education Consulting, LLC	$ 23,820.00
Well Rounded Fitness LLC	$ 23,390.00
Casa Bella Foundation	$ 23,000.00
FEAST	$ 22,400.00
ATTAC Consulting Group, LLC	$ 21,800.00
Victoria Serna Garcia	$ 20,800.00
Costas Healthcare Solutions, LLC	$ 20,700.00
GM Voices, Inc.	$ 20,000.00
Mayra Selene Sosa	$ 19,725.00
Golden State Water Company	$ 19,498.76
Training Connection LLC	$ 19,430.00

New POs and Contracts

Vendor Name	PO and Contract Total
Peoples Yoga	$ 19,000.00
Therapeutic Bridges Inc.	$ 19,000.00
Unidos Por La Musica	$ 18,720.00
Juan Andres lara	$ 17,880.00
Mercer (US) Inc.	$ 17,075.00
Luxor Printing Inc.	$ 16,877.43
Ana Maria Delgado	$ 16,840.00
Meltwater News US Inc.	$ 15,950.00
Miriam Patricia Perez	$ 15,800.00
Footage Firm, Inc	$ 15,500.00
Galan Cultural Center Inc.	$ 15,200.00
ComponentSource, Inc.	$ 14,283.36
Voices of Our Youth	$ 13,600.00
TurningWest, Inc.	$ 13,560.00
Homeboy Industries	$ 13,013.00
RLG Enterprises, Inc	$ 13,000.00
Acts93, Inc.	$ 12,655.50
Black Velveteen Yoga	$ 12,600.00
Sculpt Fitness Long Beach LLC	$ 12,600.00
Ashley Celine Maldonado	$ 12,240.00
Direct Technology Group, Inc.	$ 11,760.00
B&H Foto & Electronics, Corp.	$ 11,440.05
Zoom Video Communications, Inc.	$ 11,294.00
America's Health Insurance Plans, Inc.	$ 11,125.00
Rainbow Services, Ltd.	$ 10,800.00
Self-Help Graphics and Art, Inc	$ 10,787.00
Toddler Tings! Paint.Play.Create	$ 10,775.00
Khavarian Enterprises, Inc.	$ 10,760.00
Nneoma Duruhesie	$ 10,600.00
AHN Foundation	$ 10,400.00
Plunet Inc	$ 10,178.78
PhotoShelter, Inc.	$ 9,999.00
Dewey Pest Control	$ 9,915.00
Omar Sanchez Barreras	$ 9,800.00
Aunt Flow Corp.	$ 9,665.00
Stella Ilran Han	$ 9,600.00
One Ring Networks, Inc.	$ 9,375.00
ISI Telemanagement Solutions, LLC	$ 9,000.00
Michael Moldofsky	$ 8,500.00
Angela P. Ahmu	$ 8,320.00
Getty Images (US), Inc.	$ 8,200.00
Blue Ribbon Technologies, LLC	$ 7,800.00
LexisNexis Risk Solutions FL Inc	$ 7,200.00
Bootstrap Software Partners, LLC	$ 7,180.65
Christopher Lopez	$ 7,020.00
GOANIMATE, INC.	$ 6,594.00
Metalcraft, Inc	$ 6,536.40
EPI-USE Labs, LLC.	$ 6,286.38

New POs and Contracts

Vendor Name	PO and Contract Total
Altec Products, Inc.	$ 5,172.75
Lee Hecht Harrison LLC	$ 5,150.00
Q:SIS Los Angeles	$ 4,613.75
Sage Software, Inc.	$ 4,261.50
ABMS Solutions, LLC	$ 4,020.00
Alzheimer's Greater Los Angeles	$ 4,000.00
Smartsheet.com, Inc.	$ 3,600.00
LifeLabs Group, Inc.	$ 3,200.00
Majestic Marketing, Inc.	$ 3,086.25
Articulate Global, Inc.	$ 2,798.00
I.D. Systems & Supplies, Inc.	$ 2,632.99
All Day AcquisitionCo LLC	$ 2,500.00
WW North America Holdings LLC	$ 2,500.00
Your Glass Connection, Inc.	$ 2,435.00
Public Health Foundation Enterprises, Inc.	$ 2,400.00
Serra Community Medical Clinic, Inc.	$ 2,175.00
Luxury Glass Tinting Inc.	$ 2,145.00
Zoll Medical Corp	$ 2,076.00
Wistia, Inc	$ 1,900.80
Charter Communications Holdings, LLC	$ 1,726.00
Norm's Refrigeration, LLC.	$ 1,210.00
SJS Partnership	$ 1,090.00
Fitness International, LLC	$ 1,000.00
OnDemand, Inc.	$ 898.00
Playcore Wisconsin, Inc.	$ 891.90
Audio Visual Innovations, Inc.	$ 710.00
Samuel Roman	$ 700.00
Richard Ehrlinspiel	$ 540.00
American Registry for Internet Numbers, LTD	$ 500.00
Total	**$ 258,244,011.19**

L.A. Care Health Plan
AFS-006 Authorization and Approval Limits Annual Report
October 2022 - September 2023

Amended Vendor Contracts

Vendor Name	Current Contract Total	Amendment	New Contract Total	Term Date
Cognizant TriZetto Software Group, Inc.	$ 78,864,351.22	$ 1,614,946.00	$ 77,249,405.22	9/29/2027
Cognizant TriZetto Software Group, Inc.	$ 76,254,763.22	$ 310,152.00	$ 75,944,611.22	9/30/2027
Cognizant TriZetto Software Group, Inc.	$ 75,944,611.22	Scope	$ 75,944,611.22	9/30/2027
Cognizant TriZetto Software Group, Inc.	$ 56,542,519.41	$ 134,400.00	$ 56,408,119.41	9/30/2027
Scout Exchange LLC	$ 62,964,908.00	$ 14,500,000.00	$ 48,464,908.00	12/31/2023
Health Management Systems, Inc.	$ 63,645,332.00	$ 20,822,666.00	$ 42,822,666.00	12/31/2025
Scout Exchange LLC	$ 40,464,908.00	$ 6,500,000.00	$ 33,964,908.00	12/31/2023
Center for Caregiver Advancement	$ 38,592,115.00	$ 11,640,388.00	$ 26,951,727.00	5/14/2026
Faneuil, Inc.	$ 22,000,000.00	Scope	$ 22,000,000.00	3/31/2025
Solugenix Corporation	$ 32,101,240.00	$ 12,819,718.00	$ 19,281,522.00	6/30/2023
Payden & Rygel	$ 18,000,000.00	Scope	$ 18,000,000.00	10/31/2023
Health Dialog Services Corporation	$ 23,800,000.00	$ 8,400,000.00	$ 15,400,000.00	8/31/2026
OptumInsight, Inc.	$ 22,415,000.00	$ 7,457,500.00	$ 14,957,500.00	12/31/2026
Toney HealthCare Consulting, LLC	$ 14,392,571.00	$ 1,232,000.00	$ 13,160,571.00	9/30/2023
Infosys Limited	$ 10,164,883.00	$ 800,000.00	$ 9,364,883.00	10/31/2023
Infosys Limited	$ 10,164,883.00	$ 800,000.00	$ 9,364,883.00	10/31/2023
Health Dialog Services Corporation	$ 9,000,000.00	Scope	$ 9,000,000.00	8/31/2023
Health Dialog Services Corporation	$ 9,000,000.00	Scope	$ 9,000,000.00	8/31/2023
Infosys Limited	$ 8,564,883.00	Time	$ 8,564,883.00	6/30/2023
BIG Language Solutions LLC	$ 10,700,000.00	$ 3,600,000.00	$ 7,100,000.00	7/31/2026
Solugenix Corporation	$ 9,721,247.00	$ 3,259,443.00	$ 6,461,804.00	3/31/2023
OptumInsight, Inc.	$ 9,607,308.85	$ 3,147,712.00	$ 6,459,596.85	12/31/2025
Cognizant Technology Solutions U.S. Corporation	$ 6,743,359.00	$ 292,000.00	$ 6,451,359.00	12/31/2023
Cognizant Technology Solutions U.S. Corporation	$ 6,496,440.20	$ 337,081.20	$ 6,159,359.00	5/31/2023
Change Healthcare Resources Holdings Inc.	$ 7,100,000.00	$ 1,000,000.00	$ 6,100,000.00	1/1/2024
Cognizant TriZetto Software Group, Inc.	$ 11,820,923.54	$ 5,910,461.77	$ 5,910,461.77	7/31/2026
Cognizant Technology Solutions U.S. Corporation	$ 6,321,486.60	$ 499,208.80	$ 5,822,277.80	11/30/2022
Language Line Services, Inc.	$ 6,675,000.00	$ 2,100,000.00	$ 4,575,000.00	3/31/2026
OptumInsight, Inc.	$ 7,665,774.00	$ 3,142,887.00	$ 4,522,887.00	12/31/2025
Imagenet LLC	$ 6,802,466.00	$ 2,701,233.00	$ 4,101,233.00	9/30/2025
I Color Printing & Mailing Inc	$ 5,885,400.00	$ 1,795,200.00	$ 4,090,200.00	6/30/2025
Payspan, Inc.	$ 4,875,000.00	$ 1,000,000.00	$ 3,875,000.00	12/31/2024
Imagenet LLC	$ 4,350,000.00	$ 600,000.00	$ 3,750,000.00	6/30/2024
Centauri Health Solutions Inc	$ 3,600,000.00	Time	$ 3,600,000.00	12/31/2023
Prove Em Investments LLC	$ 3,483,873.00	Time	$ 3,483,873.00	8/1/2023
Infocrossing, LLC	$ 4,177,949.00	$ 715,000.00	$ 3,462,949.00	12/31/2023
HCL America Inc.	$ 4,278,374.00	$ 855,104.00	$ 3,423,270.00	6/30/2023
O'Neil Digital Solutions LLC	$ 4,000,000.00	$ 1,000,000.00	$ 3,000,000.00	6/30/2026
Customer Motivators, LLC	$ 4,999,998.00	$ 1,999,999.00	$ 2,999,999.00	6/30/2026
Customer Motivators, LLC	$ 2,999,999.00	Scope	$ 2,999,999.00	6/30/2026
Avantpage Inc.	$ 3,950,000.00	$ 1,000,000.00	$ 2,950,000.00	2/7/2026
North Star Alliances, LLC	$ 3,580,000.00	$ 815,000.00	$ 2,765,000.00	12/31/2023
BIG Language Solutions LLC	$ 2,700,000.00	Time	$ 2,700,000.00	2/28/2026
HCL America Inc.	$ 3,756,674.00	$ 1,188,508.00	$ 2,568,166.00	4/20/2023
Resources Connection Inc.	$ 3,205,000.00	$ 700,000.00	$ 2,505,000.00	12/31/2023
Lorenzo Campos-Marquez	$ 3,070,052.44	$ 600,631.94	$ 2,469,420.50	12/31/2024
Lorenzo Campos-Marquez	$ 2,469,420.50	Scope	$ 2,469,420.50	12/31/2024
Language Select, LLC	$ 3,606,000.00	$ 1,200,000.00	$ 2,406,000.00	1/31/2026
Cloud Technology Innovations LLC	$ 2,335,000.00	Time	$ 2,335,000.00	12/31/2025
Health Dialog Services Corporation	$ 2,640,000.00	$ 320,000.00	$ 2,320,000.00	12/31/2023
NTT America Solutions, Inc.	$ 2,275,680.00	Time	$ 2,275,680.00	1/25/2027
Cognizant TriZetto Software Group, Inc.	$ 2,500,000.00	$ 300,000.00	$ 2,200,000.00	7/31/2023
Toney HealthCare Consulting, LLC	$ 2,026,000.00	Time	$ 2,026,000.00	3/31/2024
Toney HealthCare Consulting, LLC	$ 2,303,200.00	$ 277,200.00	$ 2,026,000.00	9/30/2023
O'Neil Digital Solutions LLC	$ 2,000,000.00	Scope	$ 2,000,000.00	6/30/2023
O'Neil Digital Solutions LLC	$ 2,450,000.00	$ 450,000.00	$ 2,000,000.00	6/30/2023
Corporate Translation Services, LLC	$ 3,298,000.00	$ 1,329,000.00	$ 1,969,000.00	2/28/2026
California Coverage and Health Initiatives	$ 1,948,404.48	Time	$ 1,948,404.48	12/31/2022
Cognizant TriZetto Software Group, Inc.	$ 2,700,000.00	$ 800,000.00	$ 1,900,000.00	7/31/2023
Resources Connection Inc.	$ 2,205,000.00	$ 400,000.00	$ 1,805,000.00	4/30/2023
Milliman Inc	$ 2,050,000.00	$ 400,000.00	$ 1,650,000.00	12/31/2023
Milliman Inc	$ 1,899,000.00	$ 300,000.00	$ 1,599,000.00	12/31/2023
Infosys Limited	$ 1,595,504.00	$ 161,784.00	$ 1,433,720.00	9/30/2023
NetCentric Technologies Inc.	$ 1,415,000.00	Time	$ 1,415,000.00	9/30/2025
Infosys Limited	$ 1,424,620.00	$ 152,684.00	$ 1,271,936.00	3/31/2023
Health Management Associates Inc.	$ 1,454,690.00	$ 306,000.00	$ 1,148,690.00	12/31/2023
Infosys Limited	$ 1,240,144.00	$ 120,892.00	$ 1,119,252.00	10/31/2022
Toney HealthCare Consulting, LLC	$ 1,600,000.00	$ 600,000.00	$ 1,000,000.00	10/31/2023
Miller Geer & Associates, Inc.	$ 1,336,000.00	$ 370,000.00	$ 966,000.00	2/28/2025
Health Management Associates Inc.	$ 1,380,400.00	$ 452,200.00	$ 928,200.00	12/31/2023
Sullivan/Luallin, Inc.	$ 849,711.12	Scope	$ 849,711.12	7/31/2024
LA Net Community Health Research and Resource Network	$ 1,065,000.00	$ 220,000.00	$ 845,000.00	9/30/2024
Oliver Tate Brooks	$ 990,000.00	$ 150,000.00	$ 840,000.00	12/31/2023
NTT America Solutions, Inc.	$ 943,138.44	$ 119,406.72	$ 823,731.72	6/27/2025

Amended Vendor Contracts

Vendor Name	Current Contract Total	Amendment	New Contract Total	Term Date
Toney HealthCare Consulting, LLC	$ 800,000.00	Time	$ 800,000.00	9/30/2023
Cognizant Technology Solutions U.S. Corporation	$ 788,152.00	$ 85,776.00	$ 702,376.00	12/31/2023
Edifecs, Inc.	$ 670,937.00	Time	$ 670,937.00	9/30/2023
Bayard Advertising Agency, Inc.	$ 828,000.00	$ 170,000.00	$ 658,000.00	9/30/2024
Infosys Limited	$ 646,016.00	Time	$ 646,016.00	6/15/2023
Bloom Insurance Agency, LLC	$ 916,425.00	$ 285,475.00	$ 630,950.00	5/5/2023
Cognizant Technology Solutions U.S. Corporation	$ 683,432.00	$ 66,832.00	$ 616,600.00	6/30/2023
Alliant Insurance Services, Inc.	$ 900,000.00	$ 300,000.00	$ 600,000.00	9/30/2025
Imagenet LLC	$ 800,000.00	$ 200,000.00	$ 600,000.00	6/30/2024
MetaSoftTech Solutions LLC	$ 900,000.00	$ 300,000.00	$ 600,000.00	4/21/2024
CDA Rotunda Partners, LLC	$ 893,700.00	$ 297,900.00	$ 595,800.00	2/28/2028
Health Management Associates Inc.	$ 955,000.00	$ 382,000.00	$ 573,000.00	9/30/2024
Mazars USA LLP	$ 630,140.00	$ 65,570.00	$ 564,570.00	3/31/2023
OptumInsight, Inc.	$ 550,000.00	Time	$ 550,000.00	4/30/2025
Cognizant Technology Solutions U.S. Corporation	$ 711,320.00	$ 161,552.00	$ 549,768.00	3/31/2023
Datavail Corporation	$ 644,520.00	$ 124,536.00	$ 519,984.00	8/2/2024
C3 Enterprises, Inc	$ 500,000.00	Scope	$ 500,000.00	9/30/2024
Bayard Advertising Agency, Inc.	$ 668,000.00	$ 180,000.00	$ 488,000.00	9/30/2023
Toney HealthCare Consulting, LLC	$ 625,000.00	$ 150,000.00	$ 475,000.00	12/31/2023
Analysis Prime, Inc.	$ 639,394.80	$ 166,922.40	$ 472,472.40	12/31/2023
Axis Technology, LLC	$ 499,000.00	$ 28,000.00	$ 471,000.00	12/31/2023
A&M Healthcare Industry Group, LLC (a Wholly Owned Subsidiary of A&M Ho	$ 465,000.00	Time	$ 465,000.00	12/31/2023
Advanced Medical Reviews LLC	$ 599,000.00	$ 150,000.00	$ 449,000.00	12/31/2023
Axis Technology, LLC	$ 601,000.00	$ 158,000.00	$ 443,000.00	12/31/2023
FRASCO, Inc	$ 514,000.00	$ 100,000.00	$ 414,000.00	9/30/2024
Microsoft Corporation	$ 408,506.00	Time	$ 408,506.00	7/14/2023
Jemmott Rollins Group	$ 550,000.00	$ 150,000.00	$ 400,000.00	12/31/2023
LCG Services LLC	$ 600,000.00	$ 200,000.00	$ 400,000.00	8/14/2024
NexTec Operating Corp.	$ 500,000.00	$ 100,000.00	$ 400,000.00	6/1/2024
Panhealth Inc.	$ 640,000.00	$ 245,000.00	$ 395,000.00	12/31/2023
The Mihalik Group, LLC	$ 578,720.00	$ 185,200.00	$ 393,520.00	11/30/2024
Pearl Meyer & Partners LLC	$ 464,500.00	$ 75,000.00	$ 389,500.00	12/31/2023
Alison Klurfeld	$ 504,800.00	$ 118,700.00	$ 386,100.00	4/17/2024
Integrated Healthcare Association	$ 451,496.35	$ 89,071.00	$ 362,425.35	No Expiration
Infosys Limited	$ 427,743.36	$ 69,060.00	$ 358,683.36	7/31/2023
Scout Exchange LLC	$ 454,000.00	$ 100,000.00	$ 354,000.00	No Expiration
WTI Holdings LLC	$ 420,404.00	$ 68,442.00	$ 351,962.00	6/30/2026
Firstsource Group USA, Inc.	$ 425,000.00	$ 75,000.00	$ 350,000.00	12/31/2022
EPI-USE America Inc	$ 440,000.00	$ 100,000.00	$ 340,000.00	12/31/2023
Cognizant TriZetto Software Group, Inc.	$ 375,424.15	$ 41,373.00	$ 334,051.15	10/31/2023
Cognizant TriZetto Software Group, Inc.	$ 375,424.15	$ 41,373.00	$ 334,051.15	10/31/2023
Toney HealthCare Consulting, LLC	$ 475,000.00	$ 150,000.00	$ 325,000.00	6/30/2023
Health Management Associates Inc.	$ 320,080.00	Time	$ 320,080.00	12/31/2023
Infosys Limited	$ 375,543.18	$ 57,424.09	$ 318,119.09	6/30/2023
FRASCO, Inc	$ 414,000.00	$ 100,000.00	$ 314,000.00	9/30/2023
Krishaunda Hampton	$ 391,520.00	$ 84,835.00	$ 306,685.00	9/30/2023
Infosys Limited	$ 282,983.09	$ (17,568.00)	$ 300,551.09	8/31/2023
Shah Health LLC	$ 450,000.00	$ 150,000.00	$ 300,000.00	3/31/2024
California Safety Net Coalition	$ 500,000.00	$ 200,000.00	$ 300,000.00	12/31/2024
Infosys Limited	$ 360,123.36	$ 70,500.00	$ 289,623.36	4/30/2023
salesforce.com, inc. (Parent Company of MuleSoft, LLC)	$ 300,427.96	$ 21,459.14	$ 278,968.82	4/30/2023
Scout Exchange LLC	$ 354,000.00	$ 100,000.00	$ 254,000.00	No Expiration
Microsoft Corporation	$ 234,576.00	Time	$ 234,576.00	7/14/2024
The Messina Group, Inc.	$ 315,000.00	$ 90,000.00	$ 225,000.00	5/10/2024
Health Management Associates, Inc. (dba Wakely Consulting Group, LLC)	$ 290,723.75	$ 75,000.00	$ 215,723.75	7/31/2024
SSI (US) Inc	$ 230,000.00	$ 15,000.00	$ 215,000.00	5/4/2023
Scott Ash	$ 259,500.00	$ 50,000.00	$ 209,500.00	10/31/2023
Scott Ash	$ 259,500.00	$ 50,000.00	$ 209,500.00	10/31/2023
Edifecs, Inc.	$ 308,606.00	$ 99,303.00	$ 209,303.00	7/1/2026
Health Management Associates, Inc. (dba Leavitt Partners, LLC)	$ 220,800.00	$ 33,000.00	$ 187,800.00	12/31/2023
Therma Holdings, LLC	$ 203,623.00	$ 24,504.00	$ 179,119.00	10/31/2024
Toney HealthCare Consulting, LLC	$ 250,000.00	$ 75,000.00	$ 175,000.00	6/30/2023
Canon Solutions America Inc	$ 251,600.00	$ 88,000.00	$ 163,600.00	7/31/2025
UptoDate, Inc.	$ 179,514.33	$ 19,080.00	$ 160,434.33	2/28/2024
Advent Advisory Group LLC	$ 140,700.00	$ 19,500.00	$ 121,200.00	12/30/2023
HRchitect, Inc.	$ 152,000.00	$ 34,000.00	$ 118,000.00	10/31/2023
Patient & Family Centered Care Partners, Inc.	$ 198,000.00	$ 80,000.00	$ 118,000.00	6/30/2024
HRchitect, Inc.	$ 152,000.00	$ 34,000.00	$ 118,000.00	10/31/2023
Control Air Holdings Inc	$ 120,068.00	$ 18,136.00	$ 101,932.00	3/31/2025
Infosys Limited	$ 97,187.00	Time	$ 97,187.00	11/11/2022
Cognizant TriZetto Software Group, Inc.	$ 132,028.00	$ 36,930.00	$ 95,098.00	9/16/2025
Cognisight, LLC	$ 113,350.00	$ 19,175.00	$ 94,175.00	7/31/2023
Healthcare Informatics LLC	$ 105,600.00	$ 19,200.00	$ 86,400.00	6/25/2023
FanelliPM	$ 91,994.00	$ 9,716.00	$ 82,278.00	11/30/2024
Sonia P. Guzman	$ 98,400.00	$ 16,400.00	$ 82,000.00	7/31/2024
Gartner Inc.	$ 76,795.00	Time	$ 76,795.00	1/31/2026
Milliman Inc	$ 100,000.00	$ 25,000.00	$ 75,000.00	2/28/2024
EVERFI INC.	$ 125,760.00	$ 50,880.00	$ 74,880.00	3/5/2025
ALTA Language Services, Inc.	$ 81,920.00	$ 15,000.00	$ 66,920.00	9/30/2024

Amended Vendor Contracts

Vendor Name	Current Contract Total	Amendment	New Contract Total	Term Date
Brent Powell	$ 84,000.00	$ 20,800.00	$ 63,200.00	8/31/2023
Gomez Research Inc.	$ 60,000.00	Time	$ 60,000.00	9/30/2024
Cactus Software LLC	$ (10,778.00)	$ (70,429.00)	$ 59,651.00	4/30/2023
Traliant Holdings, LLC	$ 78,695.00	$ 19,680.00	$ 59,015.00	1/14/2024
Antelope Valley Partners for Health	$ 60,690.00	$ 5,200.00	$ 55,490.00	12/31/2023
Acts93, Inc.	$ 73,500.00	$ 19,250.00	$ 54,250.00	12/31/2023
ALTA Language Services, Inc.	$ 51,920.00	Time	$ 51,920.00	5/1/2023
Infosys Limited	$ 92,406.00	$ 41,133.00	$ 51,273.00	12/31/2022
Karen Escalante-Dalton	$ 65,000.00	$ 15,000.00	$ 50,000.00	12/31/2023
UNUM Life Insurance Company of America	$ 50,000.00	Time	$ 50,000.00	12/31/2023
Council for Affordable Quality Healthcare, Inc.	$ 55,800.00	$ 6,000.00	$ 49,800.00	4/22/2024
Whitney Lawrence Consulting LLC	$ 70,000.00	$ 25,000.00	$ 45,000.00	10/31/2023
Whitney Lawrence Consulting LLC	$ 70,000.00	$ 25,000.00	$ 45,000.00	10/31/2023
ATTAC Consulting Group, LLC	$ 43,800.00	Time	$ 43,800.00	3/31/2024
Parent, Family Engagement and Community Services, Inc.	$ 48,600.00	$ 4,800.00	$ 43,800.00	10/31/2023
Parent, Family Engagement and Community Services, Inc.	$ 48,600.00	$ 4,800.00	$ 43,800.00	10/31/2023
LexisNexis Risk Solutions FL Inc	$ 49,800.00	$ 6,900.00	$ 42,900.00	11/1/2023
LexisNexis Risk Solutions FL Inc	$ 49,800.00	$ 6,900.00	$ 42,900.00	11/1/2023
Vendor Credentialing Service LLC	$ 38,025.00	Time	$ 38,025.00	3/31/2023
Infosys Limited	$ 18,366.60	$ (16,453.20)	$ 34,819.80	1/31/2023
Urban Voices Project	$ 32,240.00	Scope	$ 32,240.00	6/30/2024
Gallup, Inc.	$ 39,491.00	$ 13,996.50	$ 25,494.50	12/31/2023
Gasol Foundation	$ 20,800.00	Time	$ 20,800.00	11/30/2023
Yesenia Andrade	$ 21,150.00	$ 2,400.00	$ 18,750.00	8/31/2023
Juan Andres Iara	$ 25,440.00	$ 7,560.00	$ 17,880.00	8/31/2023
Angie Gomez	$ 20,360.00	$ 3,380.00	$ 16,980.00	6/30/2023
Rubi Ruiz	$ 21,300.00	$ 5,400.00	$ 15,900.00	9/30/2023
LexisNexis Risk Solutions FL Inc	$ 7,200.00	Time	$ 7,200.00	5/31/2025
Martin Scholl Consulting, Inc.	$ 9,100.00	$ 2,100.00	$ 7,000.00	10/4/2026
Total	**$ 914,795,488.32**			

L.A. Care Health Plan
AFS-007 Authorization and Approval Limits Quarterly Report
October 2022 - September 2023

Vendor Selection - Sole Source

Vendor Name	Contract Total	Paid As Of 10/16/23	Vendor Selection
Center for Caregiver Advancement	$ 26,951,727.00	N/A	Sole Source
Metcalfe Security Inc.	$ 950,000.00	$236,585.45	Sole Source
County Superintendent of Schools	$ 839,497.00	$ 839,497.00	Sole Source
Applied Research Works, Inc.	$ 588,000.00	$ 588,000.00	Sole Source
GTT LLC	$ 500,000.00	$ 500,000.00	Sole Source
CVS Pharmacy, Inc.	$ 450,000.00	$ 450,000.00	Sole Source
Krishaunda Hampton	$ 306,685.00	N/A	Sole Source
Analysis Prime, Inc.	$ 305,550.00	$ 472,472.40	Sole Source
Actum II, LLC	$ 300,000.00	300,000	Sole Source
Shah Health LLC	$ 300,000.00	N/A	Sole Source
Axis Technology, LLC	$ 285,000.00	$ 471,000.00	Sole Source
Amplifi Group, LLC	$ 280,000.00	$ 277,000.00	Sole Source
National Health Foundation	$ 270,284.00	$ 61,178.00	Sole Source
Alison Klurfeld	$ 267,400.00	$ 119,227.49	Sole Source

DATE: November 15, 2023

TO: Finance & Budget Committee

FROM: Afzal Shah, *Chief Financial Officer*

SUBJECT: AFS-027 Travel Expense Report & AFS-004 Non-Travel Expense Report

L.A. Care's internal policies, AFS-027 Travel Related Expenses and AFS-004 Non-Travel Expenses, for business related travel and non-travel expenses incurred by employees, members of the Board of Governors, Stakeholder Committees, and members of the Public Advisory Committees (PACs), require that all expenditures covered under these policies are to be reported to the Board of Governors on a quarterly basis.

Expenses covered under the Travel Related Expenses policy:

Travel and training expenditures, such as:

- Airlines
- Out-of-Town Lodging
- Parking
- Mileage
- Rental Cars
- Taxis and Other Public Transportation
- Meals Related to Business Travel

Expenses covered under the Non-Travel Expenses policy:

Any lunch, event, or gathering at which stakeholders are in attendance, such as:

- Board of Governors' meetings
- Stakeholder relationship events and outreach
- Education events

Any lunch, event, or gathering for internal staff only, such as:

- Recruitment, On-boarding, or Orientation Events
- Extenuating circumstances
- Discretionary staff spending for recognition and retention efforts

In order to keep the Committee apprised of L.A. Care's necessary expenditures and to comply with internal policy, presented herein are the travel and non-travel related expenses for the fourth quarter of Fiscal Year 2022-2023, July through September 2023, and for the fiscal year 2022-2023, October 2022 through September 2023.

AFS-004 Non-Travel Expense Report Q4 FY 22-23

Division	July - Sept 2023	Description
Health Services	$ 16,788	Expenses are related to in-person CME/CE Opioid Use Disorder, Geriatric Care, and Maternal Mental Health Conferences.
Human Resources	$ 6,845	Expenses are related to refreshments for New Hire Orientation events and PHM Job Fair.
Legal Services	$ 3,617	Expenses are related to refreshments for the committee meetings.
Strategic Services	$ 14,270	Expenses are related to refreshments for RCAC, ECAC, and TTECAC meetings in July, Aug, and Sept.
Total Non-Travel Expenses	**$ 41,520**	

AFS-027 Travel Expense Report Q4 FY 22-23

Division	July - Sept 2023	Description
Chief Product Officer	$ 13,939	Expenses are related to attendance of SNP Board Meeting and L.A. Care staff mileage reimbursement.
Clinical Operations	$ 11,104	Expenses are related to L.A. Care Community Health Worker (CHW) staff mileage reimbursement and nursing license renewals.
Compliance	$ 226	Expenses are related to attendance of staff mileage reimbursement.
Executive Services	$ 1,295	Expenses are related to attendance of America's Health Insurance Plans (AHIP) conference, Managed Care Organization (MCO) Principal's meeting, and Local Health Plans of California (LHPC) Board Meeting.
Finance Services	$ 6,523	Expenses are related to attendance of Society of Actuaries (SOA) Health meeting, California Health Information Association (CHIA) Conference, and RISE Health National Conference.
Health Services	$ 19,855	Expenses are related to attendance of Institute of Medicaid Innovation subcommittee meeting, PointClickCare Summit, continuing education fees, license renewals, and staff expense and mileage reimbursement for clinics.
Human Resources	$ 6,871	Expenses are related to attendance of Association for Talent Development (ATD) conference and L.A. Care staff mileage reimbursement.
Information Technology	$ 11,293	Expenses are related to attendance of Cognizant QUser Fall conference, Cisco LIVE training, and LA Care staff mileage reimbursement for CRC visits.
Legal Services	$ 317	Expenses are related to approved L.A. Care staff education and travel.
Operations	$ 7,344	Expenses are related to attendance of Global Leadership Conference, approved L.A. Care staff education and travel, and staff transportation for CRC visits.
Strategic Services	$ 15,560	Expenses are related to support fees for CRC workshops and Outreach events, and approved L.A. Care staff transportation for site visits and meetings.
Total Travel Expenses	**$ 94,328**	

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AFS-004 Non-Travel Expense Report Year-End FY 22-23

Division	FY 2022-2023	Description
Compliance	$ 920	Expenses are related to retreat and planning meetings.
Executive Services	$ 2,588	Expenses are related to refreshments for leadership retreat, safety net coalition meetings, and executive team meetings.
Finance Services	$ 632	Expenses are related to refreshments for in-person meeting with Milliman.
Health Services	$ 79,340	Expenses are related to Transform LA appreciation day, Quality Improvement's provider performance improvement plan, in-person CME/CE Psychotherapy for Substance Use Disorder, Opioid Use Disorder, Geriatric Care, and Maternal Mental Health Conferences.
Human Resources	$ 49,391	Expenses are related to refreshments for New Hire Orientation events, Anti-Racism and Cultural Humility workshops, 2022-23 Service Awards, Social Worker Month luncheon, Admin Professionals Day, and Job Fair events
Information Technology	$ 1,139	Expenses are related to in-person meeting with Local Health Plans of California (LHPC)
Legal Services	$ 15,438	Expenses are related to refreshments for the committee meetings.
Strategic Services	$ 26,558	Expenses are related to refreshments for professional development retreat, CHEC New Member Orientation, RCAC Meeting and Training, ECAC special meeting and RCAC, ECAC, and TTECAC meetings throughout the year.
Total Non-Travel Expenses	**$ 176,007**	

AFS-027 Travel Expense Report Year-End FY 22-23

Division	FY 2022-2023	Description
Chief Product Officer	$ 47,519	Expenses are related to attendance of SNP Alliance Leadership Forum, California Primary Care Association (CPCA) Conference, SNP Board Meeting, Sales Outreach events and L.A. Care staff mileage reimbursement.
Clinical Operations	$ 41,146	Expenses are related to attendance of California Association of Health Plans (CAHP) conference, L.A. Care Community Health Worker (CHW) staff mileage reimbursement, and nursing license renewals.
Compliance	$ 23,520	Expenses are related to attendance of Compliance Retreat and Planning meetings, California Association of Health Plans (CAHP) and National Health Care Anti-Fraud Association (NHCAA) conferences, and staff mileage reimbursement.
Executive Services	$ 19,273	Expenses are related to attendance of California Association of Health Plans (CAHP) conference and America's Health Insurance Plans (AHIP) Board meeting and conference, Managed Care Organization (MCO) Coalition meeting, California Health and Human Services (CHHS) Agency conference, Hospital Association of California (HASC) conference, MCO Principal's meeting, Medi-Cal Ballot Measure Meeting, American College of Healthcare Executives conference, and Local Health Plans of California (LHPC) Board Meeting and conference.
Finance Services	$ 27,743	Expenses are related to attendance of Government Investment Officers Association (GIOA) conference, California Municipal Treasurers Association (CMTA) conference, and America's SAP Users Group conference, Society of Actuaries (SOA) Health meeting, California Health Information Association (CHIA) conference, RISE Health National conference, actuarial licenses and dues, and approved L.A Care staff travel.
Health Services	$ 119,724	Expenses are related to attendance of Healthcare Information and Management Systems Society (HIMSS) conference, Western Pharmacy Exchange (WPE) conference, Association for Talent Development (ATD) conference, Academy of Managed Care Pharmacy (AMCP) conference, California Association of Health Plans (CAHP) conference, NCQA Health Innovation Summit, American Academy of Family Physicians (AAFP) conference, Cozeva conference, American Society of Health-System Pharmacists conference, American Society of Health-System Pharmacists (ASHP) conference, College of Healthcare Information Management Executives (CHIME) Fall Forum, Institute of Medicaid Innovation subcommittee meeting, PointClickCare Summit, continuing education fees, license renewals, and staff expense and mileage reimbursement for clinics.
Human Resources	$ 18,411	Expenses are related to attendance of 2022 SAP SuccessConnect conference, Association for Talent Development (ATD) conference and L.A. Care staff mileage reimbursement.
Information Technology	$ 34,325	Expenses are related to attendance of Local Health Plans of California (LHPC) meeting, Gartner IT Symposium, HLTH 2022 Conference, Cognizant QUser Fall conference, Cisco LIVE training, Gartner CIO Leadership Forum, and LA Care staff mileage reimbursement for CRC visits.
Legal Services	$ 3,218	Expenses are related to attendance of California Association of Health Plans (CAHP) conference, and approved L.A. Care staff education and travel.
Operations	$ 36,384	Expenses are related to attendance of Claris Health POP Conference, National Health Care Anti-Fraud Association (NHCAA) conference, Cognizant/Trizetto conference , Global Leadership Conference, nursing license renewals, and staff transportation for CRC visits.
Strategic Services	$ 61,348	Expenses are related to attendance of California Association of Health Plans (CAHP) conference, Ragan Social Media Conference, Association of Community Affiliated Plans (ACAP) membership, Social Determinants of Health (SDOH) Summit, Association for Community Affiliated Plans (ACAP) member meeting, support fees for CRC workshops and Outreach events, and approved L.A. Care staff transportation for site visits and meetings.
Total Travel Expenses	**$ 432,612**	

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BOARD OF GOVERNORS

Finance & Budget Committee

Meeting Minutes – October 25, 2023

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

Members

Stephanie Booth, MD, *Chairperson*
Alvaro Ballesteros, MBA
G. Michael Roybal, MD **
Nina Vaccaro **

Management/Staff

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

**Absent ** Via Teleconference*

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
CALL TO ORDER	Stephanie Booth, MD*, Committee Chairperson*, called the L.A. Care and JPA Finance & Budget Committee meetings to order at 1:05 p.m. The meetings were held simultaneously. She welcomed everyone and summarized the process for public comment during this meeting. • For those who provided public comment for this meeting by voice message or in writing, L.A. Care is glad that they provided input today. The Committee will hear their comments and they also have to finish the business on the Agenda today. • For people who have access to the internet, the meeting materials are available at the lacare.org website. If anyone needs information about how to locate the meeting materials, they can reach out to L.A. Care staff. • Information for public comment is on the Agenda available on the web site. Staff will read the comment from each person for up to three minutes. • Public comment will be made before the Committee starts to discuss an item. If the comment is not for a specific agenda item, it will be read at the general Public Comment. • Chairperson Booth provided information on how to submit a comment in-person, or live and directly using the "chat" feature.	
APPROVE MEETING AGENDA	The Agenda for today's meeting was approved.	**Approved unanimously by roll call. 3 AYES (Booth, Roybal, and Vaccaro)**

APPROVED

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
PUBLIC COMMENTS	There were no public comments.	
APPROVE CONSENT AGENDA	• September 27, 2023 meeting minutes • I Color Printing and Mailing Inc. Contract Amendment Premium Billing Unit with printing, storage, postage/mailing, reporting, and order fulfillment services through June 30, 2025 **Motion FIN 100.1123*** **To authorize staff to amend contract to increase funds in the amount of $4,600,000 for a new total not to exceed $8,690,200 with I Color Printing and Mailing Inc. to provide L.A. Care MPSS Premium Billing Unit with printing, storage, postage/mailing, reporting, and order fulfillment services through June 30, 2025.** • MCG (Milliman) Contract provide clinical care guidelines for the period of November 10, 2023 to October 31, 2028 **Motion FIN 101.1123*** **To authorize staff to execute a five-year contract with MCG not to exceed $13,000,000 to provide clinical care guidelines for the period of November 10, 2023 to October 31, 2028.**	**Approved unanimously by roll call. 3 AYES** **The Committee approved to include FIN 100 and FIN 101 to the Consent Agenda for the November 2, 2023 Board of Governors meeting.**
CHAIRPERSON'S REPORT	Committee Chairperson Booth commented about the administration of the Centers for Medicaid and Medicare Services (CMS) and Department of Health Care Services (DHCS). She read an article about that subject over the weekend and mentioned that it correlates with the legislative branches and the level of detail because the affected industries will be regulated. There are cases before the Supreme Court, so we will see what happens.	
CHIEF EXECUTIVE OFFICER'S REPORT • Sponsorships & Grants Reports	There was no CEO Report. The written Sponsorships and Grants Reports was included in the meeting packet.	
COMMITTEE ITEMS		
Chief Financial Officer's Report • Financial Report	Jeffrey Ingram, *Deputy Chief Financial Officer,* reported on the August 2023 Financial Performance**.** *(A copy of the report can be obtained by contacting Board Services.)* *(Committee Member Ballesteros joined the meeting.)*	

Membership

Membership for August 2023 is just over 2.9 million members, slightly more than forecast. There will likely be an update at the Executive Committee meeting, but for the financial statements, it will take a few months to see the impacts of Medi-Cal eligibility redetermination. Some issues to watch:

- There is a three month grace period for Medi-Cal members who were disenrolled
- The rate algorithm used by California Department of Health Care Services may face challenges in implementing the Unsatisfactory Immigration Status (UIS)/Satisfactory Immigration Status (SIS) rates. There were delays which complicated the process further.

Consolidated Financial Performance

Surplus revenue for the month was $98 million, $33 million when adjusted for Housing and Homelessness Incentive Program/Incentive Payment Program (HHIP/IPP).

Mr. Ingram reported that L.A. Care recognized the $66.5 million in revenue for Incentive Payment Program (IPP) in August. To date, L.A. Care has only been recognizing spent funds. L.A. Care received final clarification on performance and the full funding is L.A. Care's to keep, so it recognized the remaining balance. Other items for revenue include $17 million unfavorable due to the Enhanced Care Management (ECM) risk corridor (with the offset in cap expense), $3 million favorable due to Major Organ Transplant (MOT) risk corridor (with the offset in claims expense) and $9 million favorable due to volume.

In healthcare costs, there is the favorable offset in the ECM risk corridor from the revenue adjustment. There were also increases in capitation and fee-for-service expenses due to contract changes which bring back closer to forecast.

Administrative was unfavorable to the forecast by $1.3 million. L.A. Care expects to be slightly over forecast for the remainder of the year because there was favorability for much of the year due to timing. Non-operating is favorable $2.6 million. This is the same variance explanation all year; higher interest rates are generating more investment income. This month there was a slight offset in realized losses due to a planned loss harvesting program.

The year to date (YTD) surplus was $555 million, $382 million when adjusted for HHIP/IPP. This is a surplus margin of 3.7% on the $10.2 billion in revenue thus far.

Most plans have been realizing higher surpluses than anticipated for the CY 2023 rate cycle, but L.A. Care does not anticipate this trend to carry forward in the new CY with sustained pressure on healthcare and administrative costs and expected rate reductions on revenue.

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Operating Margin by Segment The higher revenue improves the medical cost ratio. Overall, L.A. Care has an MCR of 92.1%, slightly ahead of the forecast of 92.5%. Reported vs. Paid Claims Trend Cash to claims is ahead of target this month but this is not due to the completion of the In-Home Support Services (IHSS) reconciliation. Rather, it is due to receiving the capitation payment on August 31 and the capitation payments went out in early September. Tangible Net Equity (TNE) L.A. Care is in the same position as last month relative to the other plans. TNE is 700% and there are 85 days of cash on hand. **Motion FIN 102.1123** **To accept the Financial Reports for August 2023, as submitted.**	**Approved unanimously by roll call. 4 AYES (Ballesteros, Booth, Roybal, and Vaccaro)**
• Monthly Investment Transactions Reports	Mr. Ingram referred to the investment transactions reports included in the meeting materials (*a copy of the report is available by contacting Board Services)*. This report is to comply with the California Government Code as an informational item. L.A. Care's total investment market value as of August 31, 2023 was $2.1 billion. • $2 billion managed by Payden & Rygel and New England Asset Management (NEAM) • $35 million in Local Agency Investment Fund • $79 million in Los Angeles County Pooled Investment Fund	
• Accounts & Finance Services Policy AFS-008 (Annual Investment Policy Review)	L.A. Care policy and procedure requires annual review and approval by the Finance & Budget Committee of the Accounting & Finance Services Policy AFS-008 (Annual Investment Policy). Policy AFS-008 was reviewed last in October 2022. The Policy follows the California Government Code. There were changes and clarifications made in the California Government Code, and L.A. Care is aligning the Policy with those changes and clarifications: 1. Investment policy section 2.26 & 3.7.1.1 – Clarification added to specify that the start date of an investment term is the settlement date. 2. Investment policy section 3.7.1.2 – Prohibits the purchase of any security that has a forward settlement date exceeding 45 days from the time of investment. **Motion FIN 103.1123** **To approve Accounting & Financial Services Policy AFS-008 (Annual Investment Policy) as submitted.**	**Approved unanimously by roll call. 4 AYES** **The Committee approved to include FIN 103 to the Consent Agenda for the November 2, 2023 Board of Governors meeting.**

APPROVED

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
Public Comments on the Closed Session agenda items.	There were no public comments.	
ADJOURN TO CLOSED SESSION	The Joint Powers Authority Finance & Budget Committee meeting adjourned at 1:23 p.m. Augustavia J. Haydel, Esq., *General Counsel*, announced the items that the Committee will discuss in closed session. There was no public comment on the Closed Session items, and the meeting adjourned to closed session at 1:24 p.m. REPORT INVOLVING TRADE SECRET Pursuant to Welfare and Institutions Code Section 14087.38(n) Discussion Concerning New Service, Program, Technology, Business Plan Estimated date of public disclosure: *October 2025* CONTRACT RATES Pursuant to Welfare and Institutions Code Section 14087.38(m) • Plan Partner Rates • Provider Rates • DHCS Rates	
RECONVENE IN OPEN SESSION	The meeting reconvened in open session at 1:33 pm. Augustavia J. Haydel, Esq., *General Counsel*, advised the public that no reportable action from the closed session.	
ADJOURNMENT	The meeting adjourned at 1:33 p.m.	

Respectfully submitted by:

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

APPROVED BY:

DocuSigned by:
Stephanie Booth, MD
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Stephanie Booth, MD, *Chairperson*
Date Signed 11/22/2023 | 9:57 AM PST

APPROVED

COMPLIANCE & QUALITY COMMITTEE

BOARD OF GOVERNORS

Compliance & Quality Committee Meeting

Meeting Minutes – October 19, 2023

L.A. Care Health Plan CR 1017-1018, 1055 W. Seventh Street, Los Angeles, CA 90017

Members
Stephanie Booth, *MD, Chairperson*
Al Ballesteros, *MBA*
G. Michael Roybal, *MD***

Senior Management
John Baackes, *Chief Executive Officer*
Augustavia J. Haydel, *General Counsel*
Sameer Amin, *MD, Chief Medical Officer*
Terry Brown, *Chief of Human Resources*
Todd Gower, *Interim Chief Compliance Officer*
Linda Greenfield, *Chief Product Officer*

** Absent ** Via Teleconference*

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
CALL TO ORDER	Chairperson Stephanie Booth, *MD*, called the L.A. Care Compliance & Quality Committee and the L.A. Care Health Plan Joint Powers Authority Compliance & Quality Committee meetings to order at 2:02 p.m. She announced that members of the public may address the Committee on each matter listed on the agenda before the Committee's consideration of the item by submitting their comments via text, voicemail, or email.	
APPROVAL OF MEETING AGENDA	**The meeting Agenda was approved as submitted.**	**Approved unanimously by roll call. 3 AYES (Ballesteros, Booth, and Roybal)**
PUBLIC COMMENT	There was no public comment.	
APPROVAL OF MEETING MINUTES	**The September 21, 2023 meeting minutes were approved as submitted.**	**Approved unanimously by roll call.**

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
CHAIRPERSON REPORT • **Education Topics**	Chairperson Booth gave the following report: She said it has been wonderful to approach Compliance from a different angle for the last few months. She went over documentation and how to present information that is important to the Board. There are many changes being made. Some fo them are still in progress. She would like Committee Members to reach out to Board Services if they are finding meeting materials difficult to read or whatever their comments are as long as they are contrcutive. There have been a couple of times when she has offered to provide some perspective from her point of view, obviously that's going to be from her point of view and offer some perspective about what the committee needs to see and everyone is really open to hearing. Staff might not be able to do what she asks, but they'll always give her a reason or they tell her why they can't when they can't. It has been going on now and she really appreciates that.	
CHIEF COMPLIANCE OFFICER REPORT	Todd Gower, *Interim Chief Compliance Officer*, and Compliance Department staff presented the Chief Compliance Officer Report *(a copy of the full written report can be obtained from Board Services).* Mr. Gower stated that there will be five units responsible for reporting in Chief Compliance Officer report on their respective areas. He also informed the committee about receiving an exit conference recently from the Department of Health Care Services (DHCS), where they received some observations and information, which they are adjusting and planning to follow up on. He noted that once they receive the final report, there will be a 15-day window to respond with necessary information and address findings and observations. Additionally, there will be about four weeks to review the received information, and by January, they expect to have the final report ready. Michael Sobetzko, *Senior Director, Risk Management and Operations Support*, gave an Issues Inventory Update. Mr. Sobetzko provided an issues inventory report, focusing on matters from August. He mentioned that there are currently three open issues, all of which have been reviewed. These issues revolve around call center metrics and the line of business's performance, which has faced some challenges due to a phone line that was kept open after a conversion on January 1. After conversing with the contact center, it was decided that this matter would be closed, as the line of business no longer needed it to meet regulatory requirements. Part D Auto-Forwards Timelines The Part-D Auto-Forwards for Coverage Determination Appeals report has had timeliness reporting issues for five consecutive months. The root cause revolves around high Prior Authorizations volume and limited staff available at Navitus due to their staffing turnovers. Item is still open. Long Term Care Discharge Process Letter Usage	

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Long Term Care area inquired about regulatory guidance for the usage of the Last covered day (LCD) and Notice of Medicare Non-Coverage (NOMNC) letters to members when they no longer qualify for skilled services. Issue is still open. Direct Network Utilization Management (UM) Decision Notification Timeliness Report The UM decision notification timeliness July scorecard had an internal calculation issue. The issue was fixed prior to publishing the report. The error was, the last provider notification letter for in patient concurrent admissions was reported instead of the initial notification letter to provider. Closed on August 25, No issue to remediate; regulatory guidance only. UM authorizations quality controls Special Investigation Unit's (SIU) feedback of UM referral cases for potential Fraud Waste and Abuse (FWA) review. This issue was closed on August 2. The SIU cases identified were researched by UM Quality Assurance. The staff were trained on the quality deficiencies findings. Member Roybal said that he has a general question involving the street medicine member, access, and the provider network. He said he can see where this could be an area where there could have some FWA by people trying to recruit folks who are homeless and providing things that they shouldn't be in efforts to bill for that. He asked if L.A. Care credentials folks specifically for street medicine? Or is that something that anyone who's in the L.A. Care provider network can do. Dr. Amin responded that he is glad that he brought that up. He would actually tell him that only L.A. Care is leading on this issue. It is actually creating this within its Community Health Department. That's the department led by Charlie Robinson*, Senior Director, Community Health, Safety Net Initiatives,* and Michael Brodsky, *Senior Medical Director, Community Health, Behavioral Health*, they are working together on social services, behavioral health housing initiatives, and community supports as part of the CalAIM initiatives that are aligned to community health. One of the things they're working on is street medicine. They have actually created a framework around street medicine called field medicine that he thinks incorporates a lot of the concern they have. It's not just how to do street medicine, by appropriately credential people make sure there's not FWA occurring, but also tie those people back to longitudinal care with their primary care doctor, to whom they were originally assigned or attributed and so there is a system by which they have broken out the county into regions. They've got anchor providers that are the Primary Care Provider group that could take new assignment. They also have the traditional provider that could get the patient back to to ongitudinal care. L.A. Care has a street medicine sort of Main Street medicine person for that region. Along the lines of people providing street medicine as an urgent care, they would just bill on a fee-for-service basis. There's a very intense plan around this. L.A. Care has got Health Net on board and a number of other health plans that they've talked to about it so they are coordinating and leading on this topic. It's the first real infrastructure built around on street medicine	

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN

	in the county, and he is extraordinarily proud of what they've been doing and he believes, at some point either during the Board of Governors meeting or an Executive Committee meeting, they're going to have a whole presentation on this. Mr. Gower stated that they will be monitoring this closely.
	
	Mr. Sobetzko gave a Risk Assessment update *(a copy of the written report can be obtained from Board Services.)*.
	C13 - Compliance Program Effectiveness
	With the Plan winning new contracts and past CAP, the need to have strong monitoring and auditing is key. Not having a robust Compliance Program could put the new and current products at Risk.
	Mitigation Activites
	• Engage third-party to conduct Annual Compliance Program Effectiveness (CPE) assessment
	• Reorganize Compliance department (Implemented June 2023)
	• Complete Corrective Action Plan (CAP) Validation after CPE assessment
	Status Update
	• 2023 CPE Audit Kickoff September 2023; Material Collection and Field work scheduled through November 2023.
	• Regarding the findings from the 2021 CPE Audit:
	  – Additional CAPs accepted for a portion of Condition three (concerning the delegation oversight (DO) program)-the remaining portion is under review with Compliance, Observation two (concerning SIU reporting structure/specialized training), and Observation four (concerning the formal FWA risk assessment and risk rating).
	  – Compliance is coordinating with other units in the reorganized Compliance Department to finalize additional responses and CAPs for Conditions third – four and Observations three and five, ahead of the 2023 CPE Audit.
	
	Maggie Marches, *Senior Director, Audit Services, Executive Services*, gave an Internal Audit (IA) Plan Update.
	She began by announcing that the Internal Audit team now reports to Mr. Baackes to ensure some independence from some of the work that is being done. They will still continue to work with Compliance.
	• Ten Active projects with 1 completed and three in final report QA, with 6 in progress. One project was split into two phases to support IT Data Management Audit
	• 10 other Projects are either being considered, on hold or being assessed by a 3rd party.
	• Four Projects that relate to support Risk Management in Compliance, Annual Risk Assessment, Compliance Operations support and IA Annual Planning
	• Two Prior Year Follow-up Reviews. Moved 1 to the 2024 IA Plan due to other priority audits and support for Risk and Compliance.	

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Member Booth asked if the second item related to the Health Risk Assessment was on hold, because of D-SNP and now it's status is "further notice." Mr. Gower responded the focus is on the corrective mitigation activities related to the audit process. He mentioned that they were working on assessing risk mitigation and ensuring that controls are in place and effective. Their goal is to have a good understanding of their processes and have an aligned plan for risk assessment. They are also looking at a 2023 year outlook for their internal audit plan to gain a comprehensive understanding of their operations. Member Booth asked if it would be good to see an explanation as to why it was on hold and it isn't any longer. Mr. Gower highlighted their efforts to improve the audit and assessment process. They are working on transitioning from manual methods to a more streamlined digital system that can store decisions and audit plans effectively. Their goal is to retain this valuable information for reference, ensuring that it remains accessible and serves a purpose for their operations. Marita Nazarian, *Director, Delegation Oversight, Executive Services*, gave Delegation Oversight Audit Update. • Total of 42 Delegates Audited - All 42 audits completed = CAPs Accepted • 2022 Audit Areas included: - Credentialing - Compliance Program Effectiveness - Cultural & Linguistic - Health Education - Provider Network - Critical Incidents - Utilization Management - Special Investigation Unit - Quality Improvements 2022 Delegation Oversight CAP Validation • CAP Validation occurs 60 days after CAPs are accepted. • CAP Validation from 42 Annual Audits: - Completed/closed: 33 - To occur/or in progress: 9 2023 Delegation Oversight Annual Audits • What entities will be audited? - Plan Partners	

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	- Participating Physician Groups (PPGs) - Specialty Health Plans (SHPs)/Vendors 33 Audits are scheduled from April 2023 - January 2024. - Audit areas will be the same as 2022 audits with exception of Credentialing (CR). Credentialing Department will conduct CR audits of delegates. 2023 Delegation Oversight Pre-Delegation Assessments Completed Pre-Delegation Assessments: • Serra Community Medical Clinic (MCLA, LACC) • Western Dental (DSNP) • Liberty Dental (DSNP) In-Progress: • Serra Community Medical Clinic (DSNP) • Exceptional Care Medical Group (DSNP) • Family Care Specialist (DSNP) • Superior Choice Medical Group (DSNP) Pending Contracting: • Welcome Health- (New PPG) • Full Circle (Enhanced Care Management Provider) Member Booth asked what the items listed are Medicare. Ms. Nazarian responded that four items are contracted with L.A. Care through Medi-Cal lines of business, but are trying to contract through D-SNP. Mr. Baackes stated that they may have not been contracted with the Cal-MediConnect line of business. Richard Rice, Jr., *Director, Delegation Oversight Performance Monitoring and Account Management, Enterprise Performance Optimization,* gave a Notice of Non- Compliance/CAP Tracker Oversight Monitoring-update. • Enterprise Performance Optimization (EPO) Department has added the tracking of any CAPs issued to delegates by LA Care Business Units to our current process of tracking Notices of Non-Compliance issued by LA Care. • EPO is still working with all Business Units to pull in any CAPs that have been sent out to the delegates. • The tracker is being updated and will be sent out at the next C&Q. • Summary:	

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	- Corrective Action Plans (CAPs)Total – 16 - Notices of Non-Compliance (NONCs) Total – 28 - Total: 44	
CHIEF MEDICAL OFFICER REPORT • **Quality Oversight Committee**	Dr. Amin gave a Chief Medical Officer Report. Dr. Amin expressed his gratitude for the opportunity to address topics close to his heart in his Chief Medical Officer report. The report was divided into two parts: the first part focused on preliminary audit results and ongoing work, while the second part addressed over and underutilization. He discussed the need for improvements in the appeals and grievances process. He acknowledged the effectiveness of the current system but emphasized the importance of making it even better. This includes detailed categorization of grievances for better analytics, expedited review by medical directors, and closing agreements within 30 days, particularly for quality of care issues. The process of thorough investigation and notification to members to prevent systemic issues was also a key focus. Collaborative efforts with Acacia Reed, *Chief Operating Officer*, were underway to enhance this process. He highlighted efforts to tackle over and underutilization. Dr. Amin mentioned the collaboration between various departments, including operations, finance, and fraud waste and abuse. Advanced analytics and a dedicated medical director were being incorporated into the team. He shared a successful case in the hospice space where claims and authorization data analysis revealed concerns of fraud. Investigations, recovery letters, site visits, and member outreach were some of the measures taken. Dr. Amin mentioned that findings aligned with the 2022 California auditor report, and efforts were made to engage with law enforcement to address issues. He highlighted that more work would be carried out with the integration of a medical director and advanced analytics in 2024 to identify both overutilization and underutilization issues and ensure that members receive appropriate care. Dr. Amin introduced Edward Sheen, *MD*, to the committee. Dr. Sheen provided a comprehensive update on the Quality Oversight Committee meeting held on July 25, 2023. While he was not present at the meeting, he focused on four major highlights from the meeting. • There was presentation on potential quality issue updates for 2022-2023. The presentation highlighted significant backlogs in grievance cases, with a backlog of 1560 cases from August 2021 to March 2022, which was closed in March. Another backlog of 500 cases from grievance referred in February was closed in September. The monthly volume of cases remained high, averaging about 700 cases per month, which raised concerns about timely review. Dr. Sheen emphasized the need to address the root causes of this issue, such as evaluating high volume causes, hiring additional staff, improving coordination between different departments, and enhancing training to reduce inappropriate referrals.	

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• There was a report on the utilization of language services. The report showed an increasing trend in the utilization of all language services, with a nearly 15% increase in translation requests compared to the previous year. Face-to-face interpreting requests exceeded pre-pandemic levels by approximately 25% for medical appointments and increased by 68% for non-medical appointments. Telephonic interpreting utilization was 43% higher than the previous year. Member grievances related to language services were discussed, including concerns about providers not having staff who speak the members' language, members not being offered interpreting services, and member dissatisfaction with material received. Dr. Sheen highlighted the overall small number of staff complaints and the high member satisfaction levels with language services. • There was information presented about the 2023-2025 Health Equity and Disparities Mitigation Plan. The plan aims to address health disparities and promote health equity. It is organized into four health equity zones, each with specific objectives and performance metrics. These zones focus on addressing key health disparities, leading change in the community, moving towards equitable care, and embracing diversity, equity, and inclusion. The plan seeks input from members, providers, and the community, align resources with community initiatives, and evaluate efforts to advance equitable health for all. • Dr. Sheen concluded the meeting by accepting the minutes and reports from various committees, including the Credentialiang , Utilization Management , Pharmacy , Population Health Management, Quality Performance Management, and additional committees.. He encouraged the committee members to access the detailed minutes from each committee meeting for reference.	
QUALITY IMPROVEMENT PROJECTS UPDATE	Rachel Martinez, *Supervisor, Quality Improvement,* gave a Quality Improvement Projects Update *(a copy of the full written report can be obtained from Board Services).* There are four types of quality improvement projects that can be required of us by our regulators: • Quality Improvement Projects (QIPs): These have unique, product line specific, requirements and last from 9 months to 3 years. All product lines may issue a QIP but typically Medi-Cal does not. • Performance Improvement Projects (PIPs): PIPs are typically 18-month long projects with the first half spent on identifying areas of need, causal analysis, and planning interventions then followed by testing of interventions. • Plan-Do-Study Act (PDSA). PDSA projects are done in much shorter timeframes with interventions being tested in 30-90 day cycles. Typically these have two cycles of interventions and are required by our regulators due to low performance on a measure. • Strengths Weakness Opportunities and Threats (SWOTS) An analysis project of strengths, weakness, opportunities and threats among existing resources for a particular area of focus.	

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	* PDSAs or SWOTs are issued by Medi-Cal only when L.A. Care does not meet the minimum performance level (MPL) for Managed Care Accountability Sets (MCAS) measures. SWOT & PIPs from DHCS for 2023-2026 • DHCS issued all health plans in California two PIPs to begin in September of 2023 through 2026. • The first PIP is based on disparity, specifically Black/ African American Children who will be turning 15 months in 2023. The measure's focus is the Well-Child Visits in the First Thirty Months of Life: 0-15 months (W30 6+). • The second non-clinical PIP will be focusing on behavioral health needs around Emergency Department Use for Substance Use Disorder and Sever Mental Illness. DHCS is requesting plans choose an area of focus to improve the coordination of care with their provider for follow-up visit. • One active SWOT issued in the prior year in the Children's Health Domain. • Two PIPs closed this year. Member Roybal acknowledged that healthcare organizations, including his own, have encountered significant challenges in recruiting and retaining medical assistants and nurses. He noted the difficulties faced in hiring these essential staff members. He explained that many medical professionals have chosen to work as travelers due to the lucrative opportunities they offer. This trend has made it tough for healthcare facilities to attract and retain their workforce, as these traveling professionals often receive higher pay. Member Roybal pointed out that the rates offered to traveling professionals have risen dramatically. Hospitals are willing to pay higher rates to secure the services of these professionals, making it challenging for healthcare organizations to compete. He mentioned that this recruitment and retention challenge has been ongoing for an extended period, persisting for at least a year, and possibly up to 18 months. Member Roybal emphasized the importance of making healthcare operations as efficient as possible. He suggested that healthcare facilities should minimize their reliance on nurses and medical professionals for tasks that can be delegated to other staff or automated processes. Mr. Baackes emphasized that the staffing challenges discussed by Member Roybal have significant implications for the organization's interactions with state authorities. He pointed out that these challenges have led to specific feedback provided to the state. He mentioned that the state has been introducing additional requirements for healthcare organizations, which include mandates for increased staffing. Mr. Baackes explained that the requirement for additional staffing puts healthcare organizations, including his own, in direct competition with others, referring to "you guys," likely indicating other healthcare providers or facilities. He noted that the organization has been requesting the state to provide clearer justifications for these additional staffing requirements. The intention behind this request is to gain a better understanding of the necessity and rationale behind the imposed	

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	rules. Mr. Baackes emphasized that these requirements not only result in increased expenses but also hinder the organization's ability to effectively staff its operations due to the competition for qualified personnel. Dr. Booth stated that they already knew that staffing was going to be an issue. She said that she can't think of anything that L.A. Care can choose in terms of PIPs that already has an answer. She said Ms. Martinez and her team do a great job of putting them together. It's very frustrating to see efforts that she feels are a waste. Ms. Martinez mentioned that they had previously built a custom report for PIP several years ago, which they are currently using in the enhanced version. She highlighted that the team's work may not always result in immediate, tangible changes, but it's essential to note that they have been consistently working on improving various aspects. Ms. Martinez discussed recent projects such as the development of Flu Vaccine brochure and the vaccine uptake project for young kids. These initiatives demonstrate the team's commitment to addressing important healthcare issues. She agreed with Member Booth's perspective on the significant workload but emphasized that they are actively trying to enhance their efforts. The team is expecting to take on six more projects on top of the two existing Pip projects, further demonstrating their commitment to improvement. Ms. Martinez pointed out that the projects involve various components that come together over time. She shared that they are hoping to gain some flexibility with the two upcoming projects. She expressed her desire to share what they have learned and how it can be applied in the future, indicating a commitment to continuous learning and improvement. Dr. Amin mentioned that there are two components to their work, one being the interventions they implement, and the other being the lessons they learn. He acknowledged that some of the lessons learned were already known, but this doesn't diminish the value of the interventions being carried out. He emphasized that even though the patient populations affected by these interventions might be small, the outcomes of these efforts often lead to the development of more efficient processes that can benefit a much larger member base in the future. These broader improvements may not be immediately reflected in the specific performance improvement project (PIP) under discussion. Dr. Amin mentioned the challenges they face in terms of the administrative burden imposed on their provider network and the competition for nurses and other healthcare staff. This competition has been significant. He shared a positive development in their advocacy efforts with the Department of Health Services (DHS). A new Public Health Management (PHM) guide was published to address concerns raised by their organization. This guide eases some requirements, particularly for lower and medium-risk populations, allowing for a more member-centric approach. Dr. Amin highlighted that the changes in the PHM guide mean less pulling away from medical practices, with more services housed at L.A. Care. This shift aims to reduce duplicative work and promote better coordination, which aligns with their objectives. Dr. Amin suggested that their organization played a role in helping craft some of the	

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	language and content in the new PHM guide, indicating their active participation in shaping the guidelines. Mr. Baackes emphasized that the dialogue with DHS was led by clinicians, with Dr. Amin representing all the medical plans for Los Angeles County. This approach involved medical directors and clinicians, rather than non-clinical personnel engaging in clinical discussions. The interaction between clinicians, both from the medical plans and the DHS medical director, was instrumental. This clinician-to-clinician communication made a substantial difference in the outcome and contributed to the success of their advocacy efforts. Mr. Baackes noted that, in many instances with other agencies, discussions on clinical issues often involve non-clinicians. In this case, having clinicians at the forefront of the dialogue was a key factor contributing to their success.	
FACILITY SITE REVIEW	Elaine Sadocchi-Smith, *Director, Facility Site Review, Director, Population Health Management*, gave a presentation on Facility Site Review *(a copy of the full presentation can be obtained from Board Services.)*.	
INITIAL HEALTH APPOINTMENT (IHA), ANNUAL COGNITIVE HEALTH ASSESSMENT (ACHA) OVERVIEW AND UPDATES	Elaine Sadocchi-Smith, *Director, Facility Site Review, Director, Population Health Management*, gave a presentatiom about Initial Health Appointment (IHA), Annual Cognitive Health Assessment (ACHA) Overview and Updates *(a copy of the full presentation can be obtained from Board Services.).* Member Roybal stated that for the IHA he knows that there are certain labortatory tests that they want done. He asked if that was correct. Ms. Sadocchi-Smith responded that she does believe so. Member Roybal stated that L.A. Care sends out children to see their doctor to get credit for the HEDIS (Healthcare Effectiveness Data and Information Set) survey, he asked if the same thing was being done for IHA. Ms. Sadocchi-Smith responded that Quality Performance Management (QPM) team does gaps in care report. She is not sure how often that report goes to the provider, but can provide update at the next meeting. Dr. Amin clarified that the health plan's primary focus has been on facilitating and ensuring that people attend their healthcare visits. The plan tracks various elements related to quality metrics, with a particular emphasis on measures like HEDIS and STAR ratings, which are critical in Medicare. Specifically, they monitor getting members into these visits. Dr. Amin also mentioned that the information provided to the provider portal centers more on whether the appointment was scheduled or not. He implied that the system's tracking might focus on the completion of the appointment. He asked that Ms. Sadocchi-Smith provide a more accurate update at the next meeting. Ms Sadocchi-Smith said she will confirm and provide an update at a future meeting.	
ADJOURN TO CLOSED SESSION	Augustavia J. Haydel, Esq., *General Counsel*, announced the following items to be discussed in closed session. The JPA Compliance and Quality Committee meeting adjourned and the Compliance and Quality Committee adjourned to closed	

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	session at 3:35 P.M. PEER REVIEW Welfare & Institutions Code Section 14087.38(o) CONFERENCE WITH LEGAL COUNSEL—ANTICIPATED LITIGATION Significant exposure to litigation pursuant to Section 54956.9(d)(2) of Ralph M. Brown Act: Four potential cases THREAT TO PUBLIC SERVICES OR FACILITIES Government Code Section 54957 Consultation with: Thomas Mapp, Chief Compliance Officer, Serge Herrera, Privacy Director and Gene Magerr, Chief Information Security Officer CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION Pursuant to Section 54956.9(d)(1) of the Ralph M. Brown Act • Department of Managed Health Care Enforcement Matter Numbers: 18-799, 20-063, 21-428, 21-509, 21-680 • Department of Health Care Services, Office of Administrative Hearings and Appeals, In the matter of: L.A. Care Health Care Plan Appeal No. MCP22-0322-559-MF	
RECONVENE IN OPEN SESSION	The Committee reconvened in open session at 4:20 p.m. There was no report from closed session.	
ADJOURNMENT	The meeting adjourned at 4:20 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:

DocuSigned by:
Stephanie Booth
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Stephanie Booth, MD, *Chairperson*
Date Signed: 11/22/2023 | 8:47 AM PS