BOARD OF GOVERNORS MEETING

May 2, 2019 • 2:00 PM

L.A. Care Health Plan

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

About L.A. Care Health Plan

Statement

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

Overview

Committed to the promotion of accessible, affordable and high quality health care, L.A. Care Health Plan (Local Initiative Health Authority of Los Angeles County) is an independent local public agency created by the State of California to provide health coverage to low-income Los Angeles County residents. Serving more than two million members in five 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 $170 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), four Coordinated Care Initiative Consumer Councils, 35 health promoters and five Family Resource Centers that offer free health education and exercise classes to the community, and has made significant investments in Health Information Technology for the benefit of the more than 10,000 doctors and other health care professionals who serve L.A. Care members.

Programs

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

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

- **L.A. Care Cal MediConnect Plan** – L.A. Care Cal MediConnect Plan provides coordinated care for Los Angeles County seniors and people with disabilities who are eligible for Medicare and Medi-Cal.

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

L.A. Care Membership by Product Line – As of March 2019	
Medi-Cal	**2,008,116**
L.A. Care Covered	**87,040**
Cal MediConnect	**16,339**
PASC-SEIU	**50,437**
Total membership	**2,161,932**
L.A. Care Providers	
Physicians	**4,926**
Specialists	**19,024**
Both	**1,537**
Hospitals, clinics and other health care professionals	**8,778**
Financial Performance (FY 2018-2019 budget)	
Revenue	**$7.7B**
Fund Equity	**$820.3M**
Net Operating Surplus	**$121.4M**
Administrative cost ratio	**5.5%**
Staffing highlights	
Full-time employees	**1,940**
Projected full-time employees (FY 2018-2019 budget)	**2,156**

AGENDA
BOARD OF GOVERNORS MEETING

Thursday, May 2, 2019, 2019, 2:00 PM

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

DRAFT

Teleconference Call-In Information/Site
Call (844) 907-7272 or (213) 438-5597
Participant Access Code #73259739

Stephanie Booth, MD
Hotel Villa Maria Via Trinità
84010 Ravello (SA), Italy

Robert H. Curry
Intercommunity Hospital
210 W. San Bernardino Rd, Covina, CA 91722.

Welcome — Alvaro Ballesteros, MBA, *Vice Chair*

1. Approve today's Agenda — *Vice Chair*
2. Public Comment — *Vice Chair*
3. Approve Consent Agenda Items — *Vice Chair*
   - Approve April 4, 2019 meeting minutes p.15
   - Alchemy Contract Amendment **(BOG 100)** p.36
   - Quarterly Investment Report **(FIN 100)** p.37
   - Marsh & McLennan Contract Renewal **(FIN 101)** p.69
   - HealthCare Fraud Shield Contract **(FIN 102)** p.70
   - RCAC Membership **(ECA 100)** p.71
   - Ratify Election of RCAC 7 Vice Chair **(ECA 101)** p.72
4. Chairperson's Report — *Vice Chair*
5. Chief Executive Officer Report p.73 — John Baackes, *Chief Executive Officer*
   - 2nd Quarter FY 2018-19 Vision 2021 Progress Report p.82
6. Executive Community Advisory Committee — Hilda Perez/Layla Gonzalez-Delgado, *Consumer member and Advocate member*
7. Executive Committee — *Vice Chair*
   - Government Affairs Update p.109 — Cherie Compartore, *Senior Director, Government Affairs*
8. Finance & Budget Committee — Robert H. Curry, *Chair*
   - Chief Financial Officer's Report — Marie Montgomery, *Chief Financial Officer*
     - Financial Reports **(FIN 103)** p.171
     - Monthly Investment Transactions Report p.182
9. Public Comment — *Vice Chair*

ADJOURN TO CLOSED SESSION (Estimated time: 30 minutes) — *Vice Chair*

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

11. 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: *May 2021*

12. CONFERENCE WITH REAL PROPERTY NEGOTIATORS
Section 54956.8 of the Ralph M. Brown Act
Property: 3101 W. Pico, Los Angeles, CA. 90019
Agency Negotiator: John Baackes
Negotiating Parties: Eurostar, Inc. DBA ("WSS"), William Argueta
Under Negotiation: Price and Terms of Payment

13. PEER REVIEW
Welfare & Institutions Code Section 14087.38(n)

14. CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION
Pursuant to Section 54956.9 (d) (2) of the Ralph M. Brown Act
Two potential cases

RECONVENE IN OPEN SESSION *Vice Chair*

Adjournment *Vice Chair*

The next meeting is scheduled on Thursday, June 6, 2019 at 2:00 PM

Please keep public comments to three minutes or less.

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

If a teleconference location is listed at the top of this agenda, the public can participate in the meeting at that location or by calling the teleconference call in number provided.
If teleconference arrangements are listed at the top of this Agenda, note that the arrangements may change prior to the meeting.
To confirm details with L.A. Care Board Services staff prior to the meeting call (213) 694-1250, extension 4183 or 4184.

THE PUBLIC MAY ADDRESS THE BOARD OF GOVERNORS BEFORE DISCUSSION OF EACH ITEM LISTED ON THE AGENDA BY FILLING OUT A "REQUEST TO ADDRESS" FORM AND SUBMITTING THE FORM TO L.A. CARE STAFF PRESENT AT THE MEETING BEFORE THE AGENDA ITEM IS ANNOUNCED. YOUR NAME WILL BE CALLED WHEN THE ITEM YOU ARE ADDRESSING WILL BE DISCUSSED. THE PUBLIC MAY ALSO ADDRESS THE BOARD ON OTHER L.A. CARE MATTERS DURING PUBLIC COMMENT.

NOTE: THE BOARD OF GOVERNORS CURRENTLY MEETS ON THE FIRST THURSDAY OF MOST MONTHS AT 2:00 P.M. POSTED AGENDA and PRINTED MEETING MATERIALS ARE AVAILABLE FOR INSPECTION AT Board Services, 1055 W. 7th Street – 10th Floor, Los Angeles, CA 90017.

Any documents distributed to a majority of the Board Members regarding any agenda item for an open session after the agenda has been posted will be available for public inspection at Board Services, L.A. Care Health Plan, 1055 W. 7th Street, 10th Floor, Los Angeles, CA 90017, during regular business hours, 8:00 a.m. to 5:00 p.m., Monday – Friday.

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) 694-1250. Notification at least one week before the meeting will enable us to make reasonable arrangements to ensure accessibility to the meetings and to the related materials.

L.A. Care HEALTH PLAN

Schedule of Meetings
May 2019

Monday	Tuesday	Wednesday	Thursday	Friday
		1	2 ***Board of Governors*** *2 pm* *(for approx. 3 hours)*	3
6	7	8 ***ECAC*** *10 am* *(for approx. 3 hours)*	9	10
13	14	15	16 ***RCAC 11*** *9:30 am* *(for approx. 2-1/2 hours)* ***RCAC 7*** *2:00 pm* *(for approx. 2-1/2 hours)*	17 ***RCAC 8*** *10:30 am* *(for approx. 2-1/2 hours)*
20 ***RCAC 9*** *9:30 am* *(for approx. 2-1/2 hours)*	21 ***RCAC 4*** *9:00 am* *(for approx. 2-1/2 hours)* ***CHCAC*** *8:30 am* *(for approx. 2 hours)*	22	23	24
27 ***Memorial Weekend Holiday***	28 ***Finance & Budget*** *1 pm* *(for approx. 1hour)* ***Executive Committee*** *2 pm* *(for approx. 2 hours)*	29	30	31

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Prepared by mhbalones/printed on 04/26/19

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
2019 Meeting Schedule / Member Listing

	MEETING DAY, TIME, & LOCATION	MEETING DATES	MEMBERS
Board of Governors General Meeting	**1st Thursday** 2:00 PM *(for approximately 3 hours)* 1055 W. 7th Street, 1st Floor, Los Angeles, CA 90017 *Offsite meeting - location TBA ** All Day Retreat at Joan Palevsky Center 281 S. Figueroa Street, Los Angeles, CA 90012 ***tentative (placeholder meeting)	May 2 June 6 * July 25 *No meeting in August* September 5 ** October 3 *** November 7 December 5	Hector De La Torre, *Chairperson* Alvaro Ballesteros, MBA, *Vice Chairperson* Robert Curry, *Treasurer* Layla Gonzalez-Delgado, *Secretary* Stephanie Booth, MD Christina R. Ghaly, MD George W. Greene, Esq. Antonia Jimenez Hilda Perez Courtney Powers, JD Honorable Mark Ridley-Thomas G. Michael Roybal, MD, MPH Ilan Shapiro, MD **Staff Contact:** John Baackes *Chief Executive Officer, x4102* Linda Merkens *Senior Manager, Board Services, x4050*

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BOARD OF GOVERNORS & PUBLIC ADVISORY COMMITTEES
2019 MEETING SCHEDULE / MEMBER LISTING

Board of Governors - Standing Committees

	MEETING DAY, TIME, & LOCATION	MEETING DATES	MEMBERS
Executive Committee	**4th Monday of the month** 2:00 PM *(for approximately 2 hours)* 1055 W. 7th Street, 1st Floor, Los Angeles, CA 90017 **meeting on a Tuesday due to holiday*	May 28 * June 24 *No meeting in July* August 26 September 23 October 28 November 18 *No meeting in December*	Hector De La Torre, *Chairperson* Alvaro Ballesteros, MBA, *Vice Chairperson* Robert H. Curry, *Treasurer* Layla Gonzalez-Delgado, *Secretary* Stephanie Booth, MD Hilda Perez **Staff Contact:** Linda Merkens *Senior Manager, Board Services, x4050*
Compliance & Quality Committee	**3rd Thursday every 2 months** 2:00 PM *(for approximately 2 hours)* 1055 W. 7th Street, 1st Floor, Los Angeles, CA 90017	May 16 *No meeting in July* August 15 September 19 November 21 *No meeting in December*	Stephanie Booth, MD, *Chairperson* Alvaro Ballesteros, MBA Christina Ghaly, MD Hilda Perez Courtney Powers, JD Ilan Shapiro, MD **Staff Contact:** Victor Rodriguez *Board Specialist, Board Services/x 5214*
Finance & Budget Committee	**4th Monday of the month** 1:00 PM *(for approximately 1 hour)* 1055 W. 7th Street, 1st Floor, Los Angeles, CA 90017 **meeting on a Tuesday due to holiday*	May 28 * June 24 *No meeting in July* August 26 September 23 October 28 November 18 *No meeting in December*	Robert H. Curry, *Chairperson* Stephanie Booth, MD Hector De La Torre Hilda Perez G. Michael Roybal, MD, MPH **Staff Contact:** Malou Balones *Senior Board Specialist, Board Services/x 4183*

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BOARD OF GOVERNORS & PUBLIC ADVISORY COMMITTEES
2019 MEETING SCHEDULE / MEMBER LISTING

	MEETING DAY, TIME, & LOCATION	MEETING DATES	MEMBERS
Governance Committee	1055 W. 7th Street, 1st Floor Los Angeles, CA 90017 **MEETS AS NEEDED**		Hilda Perez, *Chairperson* Stephanie Booth, MD Layla Gonzalez-Delgado Antonia Jimenez Courtney Powers, JD **Staff Contact:** Malou Balones *Senior Board Specialist, Board Services/x 4183*
Service Agreement Committee	1055 W. 7th Street, 1st Floor Los Angeles, CA 90017 **MEETS AS NEEDED**		Layla Gonzalez-Delgado, *Chairperson* Antonia Jimenez Hilda Perez Courtney Powers, JD **Staff Contact** Malou Balones *Senior Board Specialist, Board Services/x 4183*
Audit Committee	1055 W. 7th Street, 1st Floor Los Angeles, CA 90017 **MEETS AS NEEDED**		Stephanie Booth, MD, *Chairperson* Alvaro Ballesteros, MBA Layla Gonzalez-Delgado **Staff Contact** Malou Balones *Senior Board Specialist, Board Services, x 4183*

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BOARD OF GOVERNORS & PUBLIC ADVISORY COMMITTEES
2019 MEETING SCHEDULE / MEMBER LISTING

	MEETING DAY, TIME, & LOCATION	MEETING DATES	MEMBERS
L.A. Care Community Health	**Meets Annually or as needed** 1055 W. 7th Street, 1st Floor, Los Angeles, CA 90017		Hector De La Torre, *Chairperson* Alvaro Ballesteros, MBA*, Vice Chairperson* Robert Curry, *Treasurer* Layla Gonzalez-Delgado, *Secretary* Stephanie Booth, MD Christina R. Ghaly, MD George W. Greene, Esq. Antonia Jimenez Hilda Perez Courtney Powers, JD Honorable Mark Ridley-Thomas G. Michael Roybal, MD, MPH Ilan Shapiro, MD **Staff Contact:** John Baackes *Chief Executive Officer, x4102* Linda Merkens *Senior Manager, Board Services, x4050*
L.A. Care Joint Powers Authority	**Meets as needed** 1055 W. 7th Street, 1st Floor, Los Angeles, CA 90017		Hector De La Torre, *Chairperson* Alvaro Ballesteros, MBA*, Vice Chairperson* Robert Curry, *Treasurer* Layla Gonzalez-Delgado, *Secretary* Stephanie Booth, MD Christina R. Ghaly, MD George W. Greene, Esq. Antonia Jimenez Hilda Perez Courtney Powers, JD Honorable Mark Ridley-Thomas G. Michael Roybal, MD, MPH Ilan Shapiro, MD **Staff Contact:** John Baackes *Chief Executive Officer, x4102* Linda Merkens *Senior Manager, Board Services, x4050*

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BOARD OF GOVERNORS & PUBLIC ADVISORY COMMITTEES
2019 MEETING SCHEDULE / MEMBER LISTING

Public Advisory Committees

	MEETING DAY, TIME, & LOCATION	MEETING DATES	STAFF CONTACT
Children's Health Consultant Advisory Committee General Meeting	**3rd Tuesday of every other month** 8:30 AM *(for approximately 2 hours)* 1055 W. 7th Street, 1st Floor, Los Angeles, CA 90017	May 21 *No meeting in July* August 20 September 17 November 21	**Lyndee Knox, PhD,** *Chairperson* **Staff Contact:** Victor Rodriguez *Board Specialist, Board Services/x 5214*
Executive Community Advisory Committee	**2nd Wednesday of the month** 10:00 AM *(for approximately 3 hours)* 1055 W. 7th Street, 1st Floor, Los Angeles, CA 90017	May 8 June 12 July 10 *No meeting in August* September 11 October 9 November 13 December 11	**AnaRomo,** *Chairperson* **Staff Contact:** Idalia Chitica**,** *Community Outreach & Education, Ext. 4420*
Technical Advisory Committee	4th Thursdays every other month 9:00 AM *(for approximately 2 hours)* 1055 W. 7th Street, 1st Floor, Los Angeles, CA 90017	*This Committee is under restructure.*	**Staff Contact:** Victor Rodriguez *Board Specialist, Board Services/x 5214*

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BOARD OF GOVERNORS & PUBLIC ADVISORY COMMITTEES
2019 MEETING SCHEDULE / MEMBER LISTING

REGIONAL COMMUNITY ADVISORY COMMITTEES

REGION	MEETING DAY, TIME, & LOCATION	MEETING DATE	STAFF CONTACT
Region 1 **Antelope Valley**	**3rd Friday of every other month** 10:00 AM *(for approximately 2-1/2 hours)* L.A. Care Family Resource Center-Palmdale 2072 E. Palmdale Blvd. Palmdale, CA 93550 (213) 438-5580	June 21 August 16 October 18 December 20	**Russel Mahler,** *Chairperson* **Staff Contact:** Kristina Chung *Community Outreach & Education, x5139*
Region 2 **San Fernando Valley**	**3rd Monday of every other month** 10:00 AM *(for approximately 2-1/2 hours)* L.A. Care Family Resource Center-Pacoima 10807 San Fernando Road Pacoima, CA 91331 (844) 858-9942	June 17 August 19 October 21 December 16	**Estela Lara,** *Chairperson* **Staff Contact:** Kristina Chung *Community Outreach & Education, x5139*
Region 3 **Alhambra, Pasadena and Foothill**	**3rd Tuesday of every other month** 9:30 AM *(for approximately 2-1/2 hours)* Rosemead Community Center 3936 N. Muscatel Avenue, Room 3 Rosemead, CA 91770 (626) 569-2160	June 18 August 20 October 15 December 17	**Cynthia Conteas-Wood,** *Chairperson* **Staff Contact:** Frank Meza *Community Outreach & Education, x4239*
Region 4 **Hollywood-Wilshire, Central L.A. and Glendale**	**3rd Tuesday of every other month** 9:00 AM *(for approximately 2-1/2 hours)* Hope Street Family Center 1600 Hope Street, Rm 305 Los Angeles, CA 90015 (213) 742-6385	May 21 July 16 September 17 November 19	**Sylvia Poz,** *Chairperson* **Staff Contact:** Jose Rivas *Community Outreach & Education, x4090*

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BOARD OF GOVERNORS & PUBLIC ADVISORY COMMITTEES
2019 MEETING SCHEDULE / MEMBER LISTING

REGION	MEETING DAY, TIME, & LOCATION	MEETING DATE	STAFF CONTACT
Region 5 **Culver City, Venice, Santa Monica, Malibu, Westchester**	**3rd Monday of every other month** 2:00 PM *(for approximately 2-1/2 hours)* Veterans Memorial Building Garden Room 4117 Overland Avenue Culver City, CA 90230 (310) 253-6625	June 17 August 19 October 21 December 16	**Maria Sanchez,** *Chairperson* **Staff Contact:** Jose Rivas *Community Outreach & Education, x4090*
Region 6 **Compton, Inglewood, Watts, Gardena, Hawthorne**	**3rd Thursday of every other month** 3:00 PM *(for approximately 2-1/2 hours)* South LA Sports Activity Center 7020 S. Figueroa Street Los Angeles, CA 90003 (323) 758-8716	June 20 August 15 October 17 December 19	**Andria McFerson,** *Chairperson* **Staff Contact:** Jose Rivas *Community Outreach & Education, x4090*
Region 7 **Huntington Park, Bellflower, Norwalk, Cudahy**	**3rd Thursday of every other month** 2:00 PM *(for approximately 2-1/2 hours)* Community Empowerment Center 7515 Pacific Blvd. Walnut Park, CA 90255 (213) 516-3575	May 16 July 18 September 19 November 21	**Fatima Vasquez,** *Chairperson* **Staff Contact:** Martin Vicente *Community Outreach & Education, x 4423*
Region 8 **Carson, Torrance, San Pedro, Wilmington**	**3rd Friday of every other month** 10:30 AM *(for approximately 2-1/2 hours)* Providence Community Health Wellness and Activity Center 470 N. Hawaiian Ave. Wilmington, CA 90744 (424) 212-5699	May 17 July 19 September 20 November 15	**Ana Romo – *Chairperson*** **Staff Contact:** Martin Vicente *Community Outreach & Education, x 4423*

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BOARD OF GOVERNORS & PUBLIC ADVISORY COMMITTEES
2019 MEETING SCHEDULE / MEMBER LISTING

REGION	MEETING DAY, TIME, & LOCATION	MEETING DATE	STAFF CONTACT
Region 9 **Long Beach**	**3rd Monday of every other month** 9:30 AM *(for approximately 2-1/2 hours)* First Congressional Church of Long Beach 241 Cedar Avenue Long Beach, CA 90802 (562) 436-2256	May 20 July 15 September 16 November 18 **rescheduled due to holiday*	**Tonya Byrd**, *Chairperson* **Staff Contact:** Kristina Chung *Community Outreach & Education, x5139*
Region 10 **East Los Angeles, Whittier and Highland Park**	**3rd Thursday of every other month** 1:00 PM *(for approximately 2-1/2 hours)* L.A. Care East L.A. Family Resource Center 4801 Whittier Blvd Los Angeles, CA 90022 (213) 438-5570	June 20 August 15 October 17 December 19	**Damaris de Cordero,** *Chairperson* **Staff Contact:** Frank Meza *Community Outreach & Education, x4239*
Region 11 **Pomona and El Monte**	**3rd Thursday of every other Month** 9:30 AM *(for approximately 2-1/2 hours)* Pomona Catholic High School - Auditorium 533 W. Holt Ave. Pomona, CA 91768 (909) 623-5297	May 16 July 18 September 19 November 21	**Elda Sevilla,** *Chairperson* **Staff Contact:** Frank Meza *Community Outreach & Education, x4239*

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Board of Governors
Regular Meeting Minutes #278
April 4, 2019

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

Members

Hector De La Torre, *Chairperson*
Alvaro Ballesteros, MBA, *Vice Chairperson*
Robert H. Curry, *Treasurer* **
Layla Gonzalez-Delgado, *Secretary*
Stephanie Booth, MD
Christina R. Ghaly, MD *
George W. Greene, Esq. *
Antonia Jimenez
Hilda Perez
Courtney Powers, Esq.
Honorable Mark Ridley-Thomas *
G. Michael Roybal, MD, MPH
Ilan Shapiro, MD

**Absent **Via teleconference*

Management/Staff

John Baackes, *Chief Executive Officer*
Terry Brown, *Chief of Human Resources*
Augustavia Haydel, *General Counsel*
Marie Montgomery, *Chief Financial Officer*
Richard Seidman, MD, MPH, *Chief Medical Officer*

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
WELCOME Hector De La Torre	Hector De La Torre, *Chairperson*, called the meeting to order at 2:04 p.m. Rudy Martinez, *Safety & Security Specialist*, provided safety information. Chairperson De La Torre noted that everyone should be proud that L.A. Care celebrated the 22nd anniversary of its Knox Keene license on April 1. He welcomed everyone to the meeting. He announced that members of the public are welcome to introduce themselves or can remain anonymous. The public may address the Board on matters listed on the agenda before or during the Board's consideration of the item, and on any other topic in the public comment section on the agenda. He also announced that the Board is pleased that people are here to speak to the Board, and would like to ensure that everyone who would like to do so has the opportunity to speak today. He welcomed members of the CCIs and RCACs and informed them that members will be introduced later in this meeting during the ECAC report.	
APPROVAL OF MEETING AGENDA Hector De La Torre	The agenda was approved as submitted.	**Approved unanimously.** **9 AYES (Ballesteros, Booth, De La Torre, Gonzalez-Delgado, Jimenez, Perez, Powers, Roybal, and Shapiro)**

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
PUBLIC COMMENT	Stefanie Sunshine Mangone, *Shield HealthCare,* a medical supply company which has been in business since 1957. Shield currently serves about 5,000 L.A. Care members; about half of those members have Medicare health coverage. Shield Health Care serves Medicare beneficiaries who get nutrition through a gastric tube. Ms. Mangone stated that most assume Medicare would cover these types of supplies, but about 1/3 of these patients do not qualify for enteral services through Medicare. Medicare has very specific criteria to meet billing requirements. Examples of conditions which may require enteral services that are not covered by Medicare are end stage renal disease, dementia and aphasia. L.A. Care requires Shield HealthCare to obtain a denial from Medicare before it will approve an authorization for this coverage. For Shield HealthCare to obtain a denial, they have to provide care to the member first, then submit a claim to Medicare. A denial from Medicare takes six to eight weeks. L.A. Care does not retroactively authorize coverage after 30 days. Ms. Mangone requested that L.A. Care extend the retro-authorization period to 90 days or give Shield HealthCare an upfront authorization pending Medicare denial. An upfront authorization does not eliminate or supersede Shield HealthCare's requirement to submit documentation that Medicare has been billed. This process is in line with Medi-Cal's treatment authorization review policy. Enteral nutrition is life sustaining and can keep patients from getting malnourished and going back into hospital. She asked L.A. Care to consider changing its process so Shield HealthCare can better serve these members. John Baackes, *Chief Executive Officer,* asked Board Services to get Ms. Mangone's contact information so staff can follow up on the issues. Mr. Baackes also noted that L.A. Care has tens of thousands of dual eligible members (eligible for both Medicare and Medi-Cal) for whom L.A. Care provides coverage through Medi-Cal. Some of these patients may have another carrier for Medicare or are in the fee for service (FFS) program. L.A. Care processes these claims as a secondary payer. Mr. Baackes stated that L.A. Care would be happy to work with Shield HealthCare to try to streamline the process. Ms. Mangone thanked Mr. Baackes. She suggested that L.A. Care convene a vendor/provider advisory committee to bring these types of issues to the health plan. Mr. Baackes noted that L.A. Care will take her suggestion under advisement. Elizabeth Cooper, *RCAC 2 and CCI Member*, asked for moment of silence for victims of injustice, immigrants and others who may be suffering. Ms. Cooper congratulated L.A. Care and staff for the 20th Regional Community Advisory Committees anniversary. Ms. Cooper asked about the Coordinated Care Initiative (CCI) Councils restructure and asked to be a participant in the discussion on behalf of Jonathan Cooper. She commented that we are now seeing an attack on health care that will impact seniors, immigrants, persons with disabilities and others, and people need to join together. She asked Mr. Baackes to keep people informed on	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	ways they can get involved before 2020. Mr. Baackes noted that he will talk about this during his CEO report. Chris Arroyo, *State Council on Developmental Disabilities, Los Angeles office*, provided information about a listening session on April 18 in North Hills for the Assembly Select Committee. Assemblymembers Fraser and Nazarian will attend to hear comments about the Regional Centers. *(Member Curry joined the meeting by telephone.)* Andria McFerson, *RCAC 6 Chair*, commented that she is dually eligible and has had the same problems the first speaker described. Many people have asked her about her condition lately. She did not receive assistance or coverage that her neurologist prescribed. She went three weeks without epilepsy medication. She has had seizures and her health has suffered because of the lack of medication. She had to pay $80 a month for medication. The issue was life threatening. Something needs to be done about it. She had to sit in the doctor's office talking to Medicare and the doctor's assistant to get the medication she needs. She received no assistance from L.A. Care. She endorsed the idea of a committee to help resolve problems. Rachel Rose Luckey, *RCAC 4 Vice Chair*, commented that each RCAC is allocated $5,000 annually for community events. RCAC members do not weigh in on how to spend the money. She recommended that each RCAC receive a larger budget and representation so the members can plan the events and members have a vested interest in what is going on. Ms. Luckey commented that she asked their Field Specialist for a map of the geographic area served by the RCAC, and she was told there are no maps of RCAC areas. Ms. Luckey suggested that the RCAC areas be mapped. Third, she suggested that L.A. Care utilize the 99 neighboorhood councils to conduct outreach and communicate with community members. She advocated a pop up clinic to serve the many homeless people in her community.	
ADJOURN TO CLOSED SESSION Hector De La Torre	Chairperson De La Torre announced the following item to be discussed in closed session. A report is not expected in open session. The Board adjourned to closed session at 2:26 p.m. CONFERENCE WITH LABOR NEGOTIATOR Section 54957.6 of the Ralph M. Brown Act Agency Negotiator: Hector De La Torre Unrepresented Employee: Chief Executive Officer	
RECONVENE IN OPEN SESSION	The Board reconvened in open session at 3:05 p.m. There was no report from the closed session.	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
Executive Community Advisory Committee (ECAC) Hilda Perez/Layla Gonzalez-Delgado	Member Gonzalez-Delgado reported that ECAC met on March 13. • Mr. Baackes updated the committee on the new transportation vendor Call the Car (CTC) (that replaced Logisticare). o L.A. Care targeted members in two areas of the county, all Cal MediConnect (CMC) members, and members that were discharged or transferred from facilities throughout the county for the initial rollout. o All CMC members have been served by CTC since March 2019. By June 1, all member transportation for health services will be provided by CTC. o 50 CTC vehicles already have L.A. Care's branding and logos for easy identification. Eventually there will be 100 L.A. Care branded vehicles. o Members that had been receiving transportation services from Logisticare received the required letter informing them L.A. Care's new vendor is Call the Car (CTC) and a second letter informing them that L.A. Care is transitioning from Logisticare. o All members that used transportation services received both letters, which may have caused confusion for our members and drove a high volume of calls that outpaced call center capacity. o L.A. Care increased its call center staff and hold (wait) times are decreasing. • Francisco Oaxaca, *Senior Director of Communications & Community Relations,* provided the following updates: o Care Harbor will hold a new clinic at the Pomona County Fairgrounds on April 27-28. o L.A. Care will participate in the L.A. Times Festival of Books on April 13-14. o L.A. Care will partner with the Red Cross to host a program to install smoke alarm detectors in every home in the Pacoima and East L.A. areas for free. People can sign up at L.A. Care's Pacoima and East LA FRCs and the Red Cross website. • Inner City Law Center Attorney Ingrid Arriaga gave a presentation on tenants' rights in Los Angeles County. She covered topics such as lease agreements, how to pay rent, pets and companion animals, poor housing conditions, eviction under California Law, Section 8 vouchers, and provided resources for tenants to get help when they need it. • Regional Community Advisory Committees (RCAC's) Spring Conference, Elevating Advocay, was held on March 22. Very genuine and heartfelt meeting. Skit presenting difficulties people have in accessing health care. Members with more than 17 years of service were honored. Member Gonzalez-Delgado thanked Board members for attending. • Leadership training for RCAC Chairs and Vice Chairs were held on March 29. • The Health Promoters conducted a Colorectal Prevention and Screening at RCACs this month.	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Member Perez thanked the Commuity Outreach & Education staff for the RCAC's Spring Conference and for the promotional bags distributed at the Conference. Such incentives encourages members to keep working and giving to the community. With regard to the CCI restructure, a letter was sent to all CCI members. • The written information outlined the state requirements for the Cal MediConnect (CMC) contract, L.A. Care's demographic information and the process for the creation of a new Enrollee Advisory Committee (EAC). It also provided contact information for Mr. Oaxaca so that members will have the opportunity to express their concerns and provide their input. • There were discussions about the CCI restructure during the February and March 2019 RCAC and CCI meetings. • The final proposal will be presented to the Executive Committee on April 22 and to the full board at its May 2 meeting. • L.A. Care staff received input from all RCAC and CCI members on how to make the transition smooth and how to welcome the CCI members into the RCACs. • Ms. Perez asked to provide transportation for CCI members attending Board and Committee meetings. Staff will call CCI members to offer transportation. • The Board could also authorize staff to revise the Consumer Advisory Committee (CAC) Operating Rules and to implement the changes. • There are many questions and concerns regarding who will choose or select the members of the new EAC and when this committee will have its first official meeting. • Member Perez reminded all members that all meetings of L.A. Care are open to the public. PUBLIC COMMENTS Ms. Cooper commented that the process should be fair and asked board members to take notice of her comment. She understands that the recommendations will be reviewed by the Executive Committee and the Board. She will be providing recommendations at the Executive Committee and Board meetings. She asked Board members and the Chief Medical Officer to listen to her recommendations. She asked Mr. Baackes about her concern that she does not see too many independent doctors, and asked what L.A. Care is doing to support the independent doctors. Mr. Baackes responded that L.A. Care has many solo practice physicians in its network, located in many of the neighborhoods where members live. Mr. Baackes noted that many of these physicians are close to retirement. He added he has not seen a great rush of new physicians willing to work in those practices. The Elevating the Safety Net program grant funds will support clinics and private practices. L.A. Care could also help private physicians find	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	somebody to take their practice and serve in the L.A. Care network. Physicians come out of medical school with education debt. The easiest way to pay off the debt is to join a physician group or clinic at a salaried position. Chair De La Torre emphasized that this is a Medi-Cal problem in California, not just for L.A. Care. Only about one-half of the physicians practicing will accept patients with Medi-Cal coverage. L.A. Care is uniquely working hard to get more physicians in Medi-Cal. He asked Ms. Cooper to talk about her recommendations with the consumer board representatives as soon as possible. Andria McFerson, *RCAC 6 Chair*, noted that the ECAC report included the CCI structure and accommodations for disabled members. RCAC 6 has worked on a resolution to make the RCAC meetings longer, allow time for CCI members to speak, making the meeting longer and raising the RCAC member stipend. Members contribute to L.A. Care. She suggested there are other organizations that have higher stipends. L.A. Care has not raised the stipend in 20 years. RCAC 6 filed a motion, and she received a phone call that the motion did not have anything to do with the Agenda. They are doing everything they are supposed to do but this is the feedback they are getting. Wilma Ballew, *CCI Area 2 Chair,* is very comfortable with the transition of CCI members into the RCACs. She has attended all the CCI meetings and all the RCAC meetings. She does not see any reason for extending the meetings. A lot of members are saying that the meetings are too long. Her opinion is that it is amazing what L.A. Care does for its members. She recommended shortening the meetings.	
APPROVAL OF CONSENT AGENDA Hector De La Torre	*(Members Shapiro left the meeting.)* Member Booth asked to remove motions EXE 100.0419 and EXE 101.0419 from the Consent Agenda. PUBLIC COMMENTS Ms Cooper stated that she comes to serve, not for money. She appreciates the opportunity to speak to the Board and thanked the members for listening. She will speak with the two consumer representatives. No single person can speak for all of us. She believes in service and advocacy. • Approve February 7, 2019 meeting minutes • TransUnion Contract Amendment	**The February 7, 2019 Board meeting minutes and motions**

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Motion FIN 100.0419 **To authorize staff to amend a contract in the amount of $1,316,000 not to exceed $5,536,000 with TransUnion to provide encounter processing services for the period of July 1, 2019 to May 31, 2020.** • RCAC Membership **Motion ECA 100.0419** **To approve the following as members to the Regional Community Advisory Committee, as reviewed by the Executive Community Advisory Committee (ECAC) during its March 13, 2019 meeting:** o **Maria Carmen Gutierrez, Consumer, RCAC 1** o **Margarita Rodriguez, Consumer, RCAC 5** o **Socorro Moreno, Consumer, RCAC 10** Dorothy Lowery, *RCAC 8 Member*, stated that she met someone who lived next door to the RCAC meeting location who asked if L.A. Care has considered working people when scheduling the consumer advisory committee meetings so people who are available on weekends can help. Member Gonzalez-Delgado suggested that Ms. Lowery speak with the CO&E field specialists. Member Booth thanked the staff for the revisions to the policy as discussed at the March 25 Executive Committee meeting. Member Booth added that there are additional changes that can make it more useful to the Board of Governors. She added that she would like for the policy to include that a report to the Board be made monthly, on how much money was sent out from L.A. Care, the entity which got the money and the total amount of grants and sponsorships that entity has received from L.A. Care for the fiscal year. Chairperson De La Torre noted that at the March 24 Executive Committee meeting Board members requested a monthly report on all expenditures for grants and sponsorships. Member Booth recommended items to be included in the report to make them more useful to the Board: • For Sponsorships, the annual report needs to include information for each sponsorship that was awarded subsequent to the last annual report. o Name of the entity receiving sponsorship o Description of the event o Amount, date and timeframe	**FIN 100.0419 and ECA 100.0419 were approved unanimously by roll call. 9 AYES (Ballesteros, Booth, Curry, De La Torre, Gonzalez-Delgado, Jimenez, Perez, Powers, and Roybal)**

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• For Grants, all of the above information since the last annual report. In addition, the report should include reports to L.A. Care from the grantee or the entity that received the grant, that provides feedback to L.A. Care regarding the project progress, outcome and impact of the grant. Member Booth stated that the report should also contain provisions that further grant funding is contingent on the timely submission of progress reports by the grantee. A report shall also be made to the Finance & Budget Committee for any entity that receives grants totalling more than $150,000 in 12 months. Member Gonzalez Delgado noted that the Executive Committee requested a report on all entities receiving more than $300,000 in aggregate grants and sponsorships for the entire year. Chairperson De La Torre requested that the policies be amended with the items above. **Motion EXE 100.0419** **To approve changes to L.A. Care Policy 603 (Grants and Sponsorships), as submitted.** **Motion EXE 101.0419** **To approve changes to L.A. Care Policy 603.2 (Sponsorships), and renaming policy to COMM 006 (Sponsorship), as submitted**.	**Motions EXE 100.0419 and EXE 101.0419 were approved unanimously by roll call, as amended. 9 AYES**
Motion for Consideration: Authorization to Contract with Ntooitive for Traditional Media Buying services	Alex Gallegos, *Senior Director, Sales & Marketing,* presented a motion requesting approval to contract with Ntooitive for digital marketing and traditional media buying services for L.A. Care's lines of business, including Family Resource Centers (FRCs) and the Parent Brand Initiative. A Request for Proposal (RFP) process was conducted and Ntooitive was among eight agencies that responded. The funding allocation includes sustained product growth focused advertising for all Lines of Business. This funding is considered a "pass through" media cost that is managed by Ntooitive at the direction of L.A. Care. The funding would provide advertising resources for campaigns that would launch in the Spring and Summer of 2019 and lead into the Fall/Winter marketing period for L.A. Care Covered. In response to Member Curry's question about the expense and results for the campaign, Mr. Gallegos responded that L.A. Care has systems in place to monitor the effectiveness of the campaign in several areas. **Motion BOG 100.0419** **To authorize staff to create a new Master Service Agreement with Ntooitive in the amount of $4,117,000 (total contract amount not to exceed $4,117,000) for the period of May 1, 2019**	**Approved unanimously by roll call. 9 AYES**

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	through December 31, 2019.	
CHAIRPERSON'S REPORT	Chairperson De La Torre commented on recent news concerning the Affordable Care Act (ACA). He stated that because of the split in the Congress, a consensus on any action related to the ACA would be difficult to achieve and the public should not be concerned. There was a federal court ruling in Texas. There are two big steps, appeals court and supreme court, required to be taken which may take years. Lesser issues, like the work requirement, have been thrown out by the courts. There will be *noise* in the news but he encouraged peiple to not worry in the near term. He encouraged people not to worry or be stressed about it. Cherie Compartore, *Senior Director, Government Affairs*, added that President Trump announced today that he will not pursue activities to repeal and replace the ACA until after 2020 election. Member Ballesteros stated that he was in Washington, DC for a conference last week. He noted that individuals receiving services through the ACA may not be aware that the program they are using is Obamacare. He suggested it may be helpful to improve education in this area.	
CHIEF EXECUTIVE OFFICER REPORT John Baackes	Mr. Baackes reported: • He recognized the recent 22nd anniversary of L.A. Care and noted that it has evolved as an organization from the plan partner model to a health plan which also offers coverage through directly contracted providers. He thanked Dr. Greg Buchert, President CEO of Blue Shield Promise, one of L.A. Care's three current plan partners, for attending today's meeting. • In the last four years, L.A. Care strove to achieve improvements along two tracks. One is foundational improvements, normal operational improvements in customer service, paying claims, credentialing, etc. Great strides have been made in these areas, improving services to members and providers. The second is transformational, to take advantage of L.A. Care's size and its ability to impact delivery of health care services. This includes the Value Initiative for IPA Performance, a program to evaluate and incentivize excellence among providers. • The 20th anniversary of the formation of L.A. Care's RCACs was celebrated at a conference on March 22. Long serving RCAC members were recognized at the event. L.A. Care is the only plan that has multiple consumer committees that are focused on issues in their community related to member experience. L.A. Care has the largest consumer advisory committee participation of any plan in the country. These are hallmarks of L.A. Care that are truly unique and appreciated.	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• Mr. Baackes noted updates on transformational programs in the written CEO report included in the meeting materials. o 48 Grants have been made thorugh Elevating the Safety Net. o Elevating the Safety Net is supporting 29 physicians. 14 of them have applied for medical school tuition relief. o Housing for Health (H4H) has placed 228 people who were homeless into permanent housing. o In-Home Support Services training for CLTEC - 1525 people completed program and 1400 more are undergoing training. • L.A. Care has switched to Call The Car for the transportation needs of its members. The transition began rolling out in March. An RFP process was used to select this local firm. There were a flood of calls when the transition started so CTC has added staff and technology to meet the needs of our members. • L.A. Care won a lawsuit over a provision in the ACA for cost sharing reductions. It may be appealed to a higher court. L.A. Care will continue to pursue its case. The use of executive authority for regulatory changes is something for which L.A. Care will be on the alert at all times. Last Fall, changes were proposed in applying the Medicaid cost under the public charge provision in the citizenship application process. L.A. Care asked for input and more than 200,000 comments were submitted. There has not been an indication of action by the government. • L.A. Care will continue to work with consumer advisory committees when it is appropriate to speak out to support L.A. Care's members. • L.A. Care opened the East Los Angeles FRC a day after its last Board meeting. He described the care management services which will be located in the FRCs. PUBLIC COMMENT Ms. Cooper noted that she had asked to speak on a previous item on a motion related to sponsorship. Chairperson De La Torre indicated that he did not receive a written request for that, and she is welcome to speak about sponsorships and grants. She asked the Board to consider giving funds from the grants program to RCACs for a conference on grant funding. Ms. Cooper stated that the price of freedom is eternal vigilance. We cannot wait until something happens, but prevent it. She thanked Mr. Baackes for his report, it is important to her and she acts. As an advocate for her son, she applauds all the advocates of the world. She does not wait, she holds her representatives accountable. She encouraged others to be advocates and to carefully listen to Mr. Baackes and to Board Members.	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
Community Health Investment Fund Report	This agenda item was not discussed. The Community Health Investment Fund Report was included in the meeting materials. *(A copy of the report may be requested by contacting Board Services.)*	
CHIEF MEDICAL OFFICER REPORT Richard Seidman, MD, MPH	PUBLIC COMMENT Ms. McFerson proposed a resource guide proposal to make it easy for L.A. Care members, seniors and disabled to look up and contact community based organizations for assistance. She wrote it in simple terms so people could understand. The guide was also color coded so it would be easy to use for residents and community based organizations in Los Angeles County. She proposed a structured plan for RCACs to reach out to the community and bring the information back to the RCAC meetings. Richard Seidman, MD, MPH, *Chief Medical Officer,* referred to his written report *(a copy of the report can be requested from Board Services).* • L.A. Care is close to selecting an electronic platform for the functions that were just summarized to connect members and community based organizations. Member Perez invited Dr. Seidman to come to an ECAC meeting to provide them with the information. • L.A. Care is one of 29 federal grantees for the Transforming Clinical Practices Initiative (TCPI). L.A. Care ranks 3rd of the 29 grantees for cost savings and ranks 1st among helath plans across the nation in a measure of our ability to transform practices to higher performing and achieving better health outcomes. • Governor Newsom has a significant focus on health and has a particular interest in pediatric health care. He proposes to significantly expand the external accountability set. This is a set of clinical meansures that health plans are accountable for. The set was expanded to more than 60 items, with a minimum performance to the 50th percentile of the national Medicaid Performance Levels. This is a very high bar. L.A. Care is preparing to work hard to meet this challenge. • The Health Homes initiative is a state requirement with a launch date in July, 2019. L.A. Care has been preparing for this intense case management initiative and is contracting with community based care management entities. It is expected that L.A. Care will contract with 20 or more community based care management entities. Care management staff will be in L.A. Care FRCs. Member Booth noted that this provides an opportunity to work on improving communication among the primary care physicians and other people caring for patients.	
STANDING COMMITTEE REPORTS		

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
Executive Committee Hector De La Torre	The Executive Committee met on February 25 and March 25 *(a copy of the minutes of the meeting can be obtained by contacting Board Services).* The Executive Committee approved a motion to update human resources policies.	
Government Affairs Update Cherie Compartore	Cherie Compartore, Senior Director, Government Affairs, reported: Governor Newsom issued an Executive Order with a goal to reduce the cost of prescription drugs in government sponsored programs. The Governor's order would make the state the single purchaser of drugs for government sponsored health care programs. The Department of Health Care Services (DHCS) wants to carve out entirely the prescription drug coverage from Medi-Cal managed care plans and move it to a fee for service program by January 2021. This includes pharmacy purchase, utilization controls, and all administrative activities. DHCS desires to achieve several goals with a Medi-Cal carve out: • Obtain all rebates, including supplemental rebates. • DHCS believes its purchasing power will enable it to achieve more savings than the managed care plans. • Achieve cost savings through the 340B program, potentially ending the savings that health centers and hospitals experience. • Create a statewide single formulary that is consistent for all Medi-Cal enrollees, regardless of the health plan in which they are enrolled. L.A. Care supports the state's goal to lower pharmaceutical costs, but the Executive order for a managed care carve out could have negative impact on Medi-Cal beneficiaries with a full carve out. Plans need access to real time pharmacy data. Currently, it takes from one to three months for plans to get pharmacy data through the mental health drug carve out. • Managed care plans have extensive care coordination teams that work with physicians and pharmacists to manage pharmacy benefits to avoid harmful drug interactions, monitor opioid prescription misuse, avoid unnecessary hospitalizations and ensure that patients take their medications for chronic medical conditions. • Plans need real time pharmacy data to understand the needs of members enrolled in care coordination programs. L.A. Care has many members that have chronic conditions such as diabetes, asthma, cardiac illness, HIV/AIDS, and other complex conditions. • A carve out will negatively impact the Whole Person Care and Health Homes programs, which target fragile populations that experience homelessness, mental illness and substance abuse disorders.	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	According to DHCS, the proposal would not impact the current 340B managed care program until 2021. DHCS is willing to work with the health centers to find a solution that would continue to support health care services. L.A. Care is concerned that the community health centers will no longer have the means to provide services to underserved patients. The clinics rely on the 340B program savings to enhance their clinic services. The state likely will not achieve the savings through a carve out. The infrastructure to administer a carveout will need to be created. There is a potential negative impact to Medi-Cal enrollees and other vulnerable populations that rely on care coordination from health plans, community clinics and hospitals. L.A. Care staff has been meeting with the state, elected officials, Department of Finance, and other key stakeholders, independently and with our trade associations, so L.A. Care is very engaged on this issue. Mr. Baackes noted that this is a significant change, and L.A. Care is in an awkward spot, because it does not want to be seen as opposing a program that could result in cost savings for prescription drugs. There are other solutions to improve transparency. Member Powers stated that this is a huge concern for the Community Clinics Association of Los Angeles County (CCLAC). CCLAC is working closely with its state association to communicate the importance of the 340B program and the savings achieved. Savings are used to support services for community clinic patients. Member Ballesteros added that the association is also working on a statewide fiscal analysis. Enhanced infrastructure in health centers is funded through 340B. Member Ballesteros noted that there is a need for complex patient provider teams to join together over this issue to preserve infrastructure that allows health centers to support clinical activities and outcomes for patients. Mr. Baackes noted that L.A. Care is working with plan partners and trade associations to help stakeholders understand how the funding works. It is important to watch how any savings are used by the state. Member Booth asked if there is information that can be disseminated to explain the potential effects of this Executive Order. Mr. Baackes responded that the best thing will be to provide data to the legislature so it can intervene thorugh the budget. Member Ballesteros noted that health centers have constructed pharmacies to better serve the patients. These will be at risk, along with the opportunity to work directly with complex patients at the clinic where they receive medical services.	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
Finance & Budget Committee	Robert Curry, *Treasurer,* reported that the Finance & Budget Committee met on February 25 and March 25 (*Minutes of the March meeting are available by contacting Board Services, there were no Minutes for the February 25 meeting as there was not a quorum of members at that meeting*). The Committee approved the following motions that do not require Board approval: • Contract amendment with MarkLogic for Total Provider Management program, and • Tenant improvement expenses for 5th Floor, 1200 Building.	
Chief Financial Officer Report Marie Montgomery	Marie Montgomery, *Chief Financial Officer,* reported (*a copy of the report can be obtained by contacting Board Services)*: Highlights: • Membership continues to decrease each month. The decrease is likely linked to the audit findings of the discrepancies between the state Medi-Cal enrollment system and the County enrollment system. Enrollment is favorable for the month for L.A. Care Covered. In response to Member Curry's question about decreased enrollment, Ms. Montgomery indicated it likely is due to the improved economy and lower joblessness, leading to fewer Medi-Cal beneficiaries. • Consolidated financial performance shows positive effects from improved claims payment results and revised rates retroactively applied to July 2018 with an update in Proposition 56 revenue. • Net surplus year to date is $171 million, significantly favorable to budget mostly due to retroactive rate adjustments. • Administrative expenses are favorable by $1.6 million. Information Technology labor expense is unfavorable due to maintenance and support activites, which are generally not capitalized. Member Jimenez asked how much of the $171 million is related to one time cost savings. Ms. Montgomery estimated that $70 or $80 million reflects one time savings. • The overall medical cost ratio (MCR) is 89.8 % which is favorable to budget of 93.1%. • The Cash to Claims ratio will continue to be unfavorable until the In Home Supportive Services program reconciliation is complete. • Tangible Net Equity is at 611% of the state requirement. The updated average among health plans statewide is 600% so L.A. Care is updating its goal to that level.	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• The 4+8 forecast projects a 3% decrease in membership by year-end for MCLA and Plan Partner enrollment, based on the current trend. Cal MediConnect is assuming a slight decrease in enrollment in the forecast vs. budget as the brokers ramp up activities. Member Jimenez asked about the projected decrease in Medi-Cal membership. Ms. Montgomery noted that L.A. Care is seeing continued decreases in membership for this year. Mr. Baackes noted that Health Net is also experiencing decreases in Members. Ms. Jimenez indicated that Los Angeles County Department of Public Social Services is not experiencing a decrease in case load. Mr. Baackes suggested that Ms. Jimenez meet with him to discuss the discrepancy. • Some increases in administrative expenses are forecast for costs that were not anticipated in the original budget. • The revised 4+8 forecast projects increased overall year end net surplus revenue of $206 million. Ms. Montgomery presented pjotential risks and opportunities for surplus revenue for this fiscal year: **Opportunities** • Improvement in claims payment continues • Recovery activities for overpayment of claims to providers • Improvement in rates for 2019-20 **Risks** • Final reconciliation of IHSS program • CCI risk corridor methodology • Update in risk adjustment factor **<u>Motion FIN 101.0419</u>** **To accept the Financial Report for the period ended January and February 2019, as submitted.**	**Approved unanimously by roll call. 9 AYES**
Monthly Investment Transaction Report	Ms. Montgomery referred to the report on investment transactions included in the meeting materials for Board member review. (*A copy of the report can be obtained by contacting Board Services).* As of February 28, 2019, the market value of L.A. Care's investments was $1.4 billion. PUBLIC COMMENT:	

<table>
<tr><th>AGENDA ITEM/PRESENTER</th><th>MOTIONS / MAJOR DISCUSSIONS</th><th>ACTION TAKEN</th></tr>
<tr><td></td><td>Ms. Luckey asked if there was a breakdown of real money spent by RCAC region. Mr. Baackes indicated there is a RCAC budget, but there is not a report on expenditures for each RCAC region. Mr. Baackes responded that the MCR by itself would not provide complete information, it could be compiled on a per member per month basis.</td><td></td></tr>
<tr><td>Authorization to survey Family Resource Center (FRC) locations and delegation of authority to Finance & Budget Committee</td><td>Lance MacLean, Director, Facilities Services, presented a motion requesting authority to survey the real estate market in each of the remaining 6 RCAC regions to locate a Family Resource Center (FRC). L.A. Care leadership has prioritized and approved establishing a physical presence by opening and operating FRC's in communities where large numbers of our members reside. The plan is to establish 12 FRC's in select communities to deliver integrated health education and other services in each of our defined RCAC regions. L.A. Care has opened and is currently operating six FRC's with six new FRC's to be developed over the next two years. Below are the communities and RCAC regions that L.A. Care intends to establish an FRC:

FRC Schedule
<table><tr><td>Year</td><td>Location</td></tr><tr><td>2019</td><td>Pomona (RCAC 11) * already approved</td></tr><tr><td>2019</td><td>Metro L.A. (RCAC 4)</td></tr><tr><td>2019</td><td>Long Beach (RCAC 9)</td></tr><tr><td>2020</td><td>The Westside (RCAC 5)</td></tr><tr><td>2020</td><td>San Gabriel Valley (RCAC 3)</td></tr><tr><td>2020</td><td>Gateway Cities (RCAC 7)</td></tr><tr><td>2020</td><td>South Bay (RCAC 8)</td></tr></table>
Chair DeLaTorre informed the Board that Board Member Shapiro was incredibly excited about the new East LA FRC and possibilities for the members and for the community.

<u>Motion FIN 102.0419</u>
1. To authorize L.A. Care staff to survey the real estate market for the remaining six Family Resource Centers (FRCs) in the Regional Community Advisory Committee (RCAC) regions, negotiate lease terms and perform leasehold improvement design and construction.
2. To delegate authority to the Finance & Budget Committee approval of final lease terms and approval of capital improvement design and construction budgets.</td><td>Approved unanimously by roll call. 9 AYES</td></tr>
<tr><td>Compliance & Quality Committee</td><td>PUBLIC COMMENT:
Ms. McFerson suggested that the Compliance department make sure that seniors participate in all the programs. She made that suggestion and she has been taking flack for speaking up and</td><td></td></tr>
</table>

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	speaking out. She wants to make sure that everyone has an opportunity to participate in the program, for the seniors, disabled or whatever race you are. The Health Promotor program was shut down. The new members are 16 Latinos and two Black people. L.A. Care has a statement on its website that it does not discriminate. But there is no diversity in the Health Promoter program. She speaks up and she received a warning letter. She had a meeting with compliance department and received a response yesterday. She read a portion of the letter regarding L.A. Care's ability to expand the Health Promoter program. Chairperson De La Torre asked about the warning and responded that Ms. McFerson's concerns about the warning she received from Francisco Oaxaca will be looked into. Ms. McFerson stated that three African American women received warnings for speaking up and speaking out. Chairperson De La Torre stated that L.A. Care will always draw a line on comments that are perceived to be racially focused. Board Member Booth, *Committee Chair*, reported that the Committee met on March 21. *(A copy of the minutes may be requested by contacting Board Services.)* • Member Booth was elected the Chair of the Committee. • Dr. Seidman provided updates during his CMO report earlier today. Elysse Palomo, *Director of Regulatory Affairs,* reported on the 2018 CMS Program Audit • L.A. Care received a score of 1.93 (0 is the best score possible). • Findings during the audit included misclassification of coverage determinations, appeals and grievances, inappropriate denials, denial letter language, grievance resolution letters, and misclassification of service authorization requests. There were 218 members affected and L.A. Care was fined $200 for each, resulting in a $43,600 fine. L.A. Care is conducting ongoing monitoring and remediation of these findings. The Committee received and approved the 2018 Quality Improvement Program Annual Report and Evaluation and 2019 Program description and work plan.	
ADVISORY COMMITTEE REPORT		
Children's Health Consultant Advisory Committee	Dr. Seidman reported that the Children's Health Consultant Advisory Committee (CHCAC) met on March 19. • The CMO report was presented at the CHCAC meeting.	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
Richard Seidman, MD, MPH	• Aligned with the Governor's health agenda and pushed further by recent legislative audit findings, the Department of Health Care Services (DHCS) hosted a call with all of the Medi-Cal Managed Care Plans earlier this month to announce an increased focus on pediatric screening and adult and pediatric prevention services. • The Board discussed earlier in this meeting about the Governor's proposal to manage pharmacy benefits at the state level. L.A. Care is working with clinic and pharmacy networks to ensure that there are no unintended consequences. • In February 2019, the Quality Performance Management team hosted an onsite HEDIS compliance audit by NCQA and the state. L.A. Care passed all phases of the audit. Results will be reported when available. PUBLIC COMMENT Nesima Estrefi, *CCI 4 Chair,* stated that womens and children's health are both very important things, and asked what about the teenagers. Dr. Seidman responded that the CHCAC often discusses adolescent health. Many of the measures included in the existing external accountability set and the new additional measures are focused on adolescents. A lot of time was spent at the last meeting about how to improve screening for sexually transmitted infections. Another item in the written CMO report today is the effort to help with the transition to adult medical care for children who age out of pediatric medical care.	
PUBLIC COMMENT	Ms. Luckey commented that the Chair was about to admonish her earlier. She stated if one puts in a public comment card ahead of time, how can they actually have input into the discussion that's going on, especially if public comment is before any of the discussion. Chairperson De La Torre responded that is the way the Ralph Brown Act works. He's been doing this for over 20 years now, working under these rules, and that's the way the rules are laid out. The idea is to have people be able to comment about a subject, not necessarily about the debate or discussion that takes place among the body in front of them, whether it is a city council or county supervisors meeting. Any public entity in the state of California is able to have their discussion, their debate, after the public has given their input. The idea is that the public has given input that the Board hears before they have a debate. It's not meant to be an ongoing back and forth between the board and the public. That's not the point of that structure. The point is for decision makers to make decisions with input from the public. Ms. Luckey noted that that's a great explanation for everybody else in the room. She is intimately familiar with the Brown Act, being an elected government official. At least when a	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	motion is put forward, it is seconded, then in the course of things public comment is required, then board discussion would be required, and then vote. That's her understanding of how things are to happen. Since a lot of this stuff did not fall under a motion she can understand where he is coming from as well. She wanted to make that clarification. Recently L.A. Care signed a contract with UCLA, and Ms. Luckey commented on an event planned as a protest because Dignity Health, a Catholic Charities orgnaization is partnering with UCLA Health. Because of its religious beliefs, Dignity denies services for women's reproductive rights and services for transgender people. She asked about L.A. Care's relationship with Dignity and as L.A. Care has a relationship with UCLA, it could undermine what L.A. Care stands for. Mr. Baackes responded that he doesn't have details about the upcoming event. There are four Dignity hospitals in Los Angeles and L.A. Care contracts with three of them: California Downtown, Long Beach and Glendale. In those contracts, L.A. Care members are protected from discrimination in health care access. Mr. Baackes does not know about the partnership between UCLA and Dignity. L.A. Care members are protected against any discrimination in services provided. Russel Mahler, *RCAC 1 Chair,* thanked Mr. Baackes for his report on CTC. He has seen the vans in the Antelope Valley recently. He also thanked L.A. Care for 20 years of service through the RCACs. He thanked the Board for letting the public come and speak on their health issues. Ms. Lowery stated that she went through so many hurdles but finally found an advocate that helped her. The advocate connected her to a case manager that really did a professional job. She is pleased with the assistance from a case manager nurse. She thanked the Board for letting her speak.	
ADJOURN TO CLOSED SESSION Hector De La Torre	Ms. Haydel announced the following items to be discussed in closed session. A motion will be considered in open session after this closed session. The Board adjourned to closed session at 5:10 p.m. CONTRACT RATES Pursuant to Welfare and Institutions Code Section 14087.38(m) • Plan Partner Rates • Provider Rates • DHCS Rates • Plan Partner Services Agreement REPORT INVOLVING TRADE SECRET	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Pursuant to Welfare and Institutions Code Section 14087.38(n) Discussion Concerning new Service, Program, Business Plan Estimated date of public disclosure: *April 2021* CONFERENCE WITH REAL PROPERTY NEGOTIATORS Section 54956.8 of the Ralph M. Brown Act Property: 3101 W. Pico, Los Angeles, CA. 90019 Agency Negotiator: John Baackes Negotiating Parties: Eurostar, Inc. DBA ("WSS"), William Argueta Under Negotiation: Price and Terms of Payment CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION Pursuant to Section 54956.9 (d) (2) of the Ralph M. Brown Act Two potential cases PEER REVIEW Welfare & Institutions Code Section 14087.38(n) CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION Section 54956.9(d)(1) of Ralph M. Brown Act Case name is unspecified - disclosure of the case name would jeopardize service of process PUBLIC EMPLOYEE PERFORMANCE EVALUATION Section 54957 of the Ralph M. Brown Act Title: Chief Executive Officer CONFERENCE WITH LABOR NEGOTIATOR Section 54957.6 of the Ralph M. Brown Act Agency Negotiator: Hector De La Torre Unrepresented Employee: Chief Executive Officer	
RECONVENE IN OPEN SESSION	The Board reconvened in open session at 6:12 p.m. There was no report from the closed session.	
Consideration of Chief Executive Officer's Compensation	**Motion BOG 101.0419** **To approve the payment of the following compensation amounts for Chief Executive Officer, John Baackes:** **1. A salary increase of 8% of base salary for a total base salary of approximately $598,417.93.**	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	2. A performance based incentive opportunity for the performance period of October 1, 2017 thru March 22, 2018 of 35 %, and **3. A performance based incentive opportunity for the performance period of March 23, 2018 thru March 22, 2019 of 50 % (adjusted by 10% similarly as other executives for the same period [45% *]).** ***Phrase in parentheses was added for clarity.**	**Approved unanimously by roll call. 9 AYES**
ADJOURNMENT	The meeting was adjourned at 6:13 p.m.	

Respectfully submitted by:

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

APPROVED BY:

_____
Layla Delgado-Gonzalez, *Board Secretary*
Date Signed _____

Board of Governors

MOTION SUMMARY

Date: May 2, 2019 **Motion No. BOG 100.0519**

Committee: **Chairperson:** Hector De La Torre

Issue: Approval to lease additional datacenter cage space for three more server racks and upgrade electric power supply to further support L.A. Care's network infrastructure.

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

Background: The Board of Governors approved motion (BOG 106.0916) authorizing L.A. Care staff to relocate its datacenter from the 1055 W 7th building to the Alchemy Data center located in the 1200 W. 7th building in February 2017. This strategic move provides continuity for computer system operation in the case of utility outage. The Alchemy datacenter provides redundancy in electrical supply with battery UPS systems, back-up generators, standby air conditioning, expansion space capacity, a higher level of physical security, fire protection systems and real-time system monitoring.

L.A Care staff recommends further reinforcing the datacenter infrastructure by leasing additional datacenter cage space to accommodate three more server racks (for a total of 35 racks) and upgrading electric power service to 30A/208V. The expansion will accommodate new initiatives like the Qnxt/CCA de-hosting of lower environments, increased demand for Edifec, and M360 as well as additional capacity for other future enterprise wide IT projects.

L.A. Care staff requests approval to amend the service contract with Alchemy Communications Inc. datacenter to add funds to lease additional datacenter cage space, procure three server racks and upgrade the power supply. The three-year total cost for this upgrade is projected to be:

Alchemy Service order	# of Months	Cost/Month	Annual Total
Non Recurring + 1st month	1	$ 6,919.74	$ 6,919.74
7/1/19 through 6/30/20	12	$ 5,569.74	$ 66,836.88
7/1/20 through 6/30/21	12	$ 5,736.83	$ 68,841.96
7/1/21 through 4/30/22	9	$ 5,908.94	$ 53,180.46
		TOTAL	$ 195,779.04

Member Impact: Datacenter disruption even for a short period would have substantial adverse effects on L.A Care's business continuity, revenue and reputation. Having an efficient datacenter infrastructure will ensure seamless support services for L.A. Care members.

Budget Impact: Funds are budgeted under Facility Services budget for FY 2018-19 and the remaining agreement term will be budgeted in future fiscal years.

Motion: To authorize staff to procure three server racks, upgrade electric power and amend the lease service agreement with Alchemy Communications Inc. for additional datacenter cage space in an amount not to exceed $200,000 for a grand total not to exceed amount of $3,444,282 to upgrade and strengthen L.A. Care's datacenter infrastructure.

L.A. Care
HEALTH PLAN

Board of Governors
MOTION SUMMARY

Date: May 2, 2019 **Motion No. FIN 100.0519**

Committee: Finance & Budget **Chairperson:** Robert H. Curry

Issue: Accept the Investment Report for the quarter ended March 31, 2019.

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

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

Member Impact: N/A

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

Motion: To accept the Quarterly Investment Report for the quarter ending March 31, 2019, as submitted.

DATE: April 22, 2019

TO: Finance & Budget Committee

FROM: Marie Montgomery, *Chief Financial Officer*

SUBJECT: Quarterly Investment Report – March 2019

As of March 31, 2019, L.A. Care's combined investments market value was approximately $2.3 billion. Interest income, amortization, realized gains and losses was approximately $8.7 million for the quarter. Unrealized gain due to market price fluctuations was approximately $5.2 million for the quarter. Based upon an independent compliance review performed as of March 31, 2019, LA Care is in compliance with its investment policy guidelines pursuant to the California Government Code and the California Insurance Code.

At quarter end $1.9 billion (or approx. 80% of total investments) and $0.3 billion (or approx. 13% of total investments) were under the management of Payden & Rygel and New England Asset Management, respectively. Both are external professional asset management companies. The holdings of these invested funds were as follows:

	Payden	NEAM	Combined
U.S. Treasury Securities	77%	0%	66%
U.S. Agency & Municipal Securities	17%	0%	15%
Corporate bonds	0%	96%	14%
Asset Backed and Mortgage Backed Securities	3%	0%	3%
Other	3%	4%	2%
	100%	100%	100%
Average credit quality:	AAA	A1	
Average duration:	0.14 years	2.39 years	
Average yield to maturity:	1.98%	2.52%	

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 $1,772 million invested as of March 31, 2019, and returned 0.61% for the quarter. The comparative benchmark returned 0.60% for the quarter. The extended term portfolio had approximately $87 million invested March 31, 2019, and returned 1.16% for the quarter. The comparative benchmark had a return of 1.22%.

PORTFOLIO RETURNS
Periods over one year annualized

Periods ended 3/31/2019

Performance	1st Quarter	Trailing 1 Year	Trailing 3 Year
LA Care - Short-Term Portfolio	**0.61**	**2.22**	**1.38**
Benchmark*	0.60	2.12	1.09
LA Care - Extended-Term Portfolio	**1.16**	**3.01**	**1.37**
Benchmark**	1.22	3.17	1.14
LA Care - Combined Portfolio	**0.65**	**2.28**	**1.38**

*iMoneyNet DTaxable Money Market Avg. from inception to 10/31/2017; BofAML 91 Day Tsy thereafter.
** BofAML 1-Yr Tsy to 10/31/2017; Bloomberg Barclays US Govt 1-5 Yr thereafter.

The $0.3 billion portfolio managed by New England Asset Management, Inc (NEAM), focused on corporate fixed income bonds returned 2.03% for the quarter. The comparative benchmark returned 2.14% for the quarter.

LA Care also invests with 2 government pooled investment funds, the Local Agency Investment Fund (LAIF) and the Los Angeles County Pooled Investment Fund (LACPIF). L.A. Care's investment balances as of March 31, 2019 were $61 million in LAIF and $104 million in LACPIF.

The Local Agency Investment Fund (LAIF) yielded approximately 2.39% annualized for the quarter. The fund's total portfolio market value as of February 28, 2019, was $89.5 billion, with a weighted average maturity of 192 days. LAIF is administered and overseen by the State Treasurer's office. The fund's investment holdings as of February 28, 2019 were as follows:

U.S. Treasury Securities	50%
Agencies	21%
CD's and bank notes	16%
Commercial paper	7%
Time deposits	5%
Loans	1%
	100%

The Los Angeles County Pooled Investment Fund (LACPIF) yielded approximately 2.26% annualized for the quarter. The fund's market value as of February 28, 2019, was $30.4 billion, with a weighted average maturity of 555 days. LACPIF is administered and overseen by the Los Angeles County Treasurer. The fund's most recent published investment holdings (February 28, 2019) were as follows:

U.S. Govt. and Agency Securities	68%
Commercial paper	25%
CD's	7%
	100%

L.A. Care Health Plan
Quarterly Investment Compliance Report
January 1, 2019 through March 31, 2019

OVERVIEW

The California Government Code requires the L.A. Care Treasurer to submit a quarterly report detailing its investment activity for the period. This investment report covers the three-month period from January 1, 2019 through March 31, 2019.

PORTFOLIO SUMMARY

As of March 31, 2019, the market values of the portfolios managed by Payden & Rygel and New England Asset Management are as follows:

Portfolios	Payden & Rygel
Cash Portfolio #2365	*$1,772,014,167.37*
Low Duration Portfolio #2367	*$87,177,502.79*
Total Combined Portfolio	**$1,859,191,670.16**

Portfolios	NEAM
Government and Corporate Debt	**$309,640,385.70**

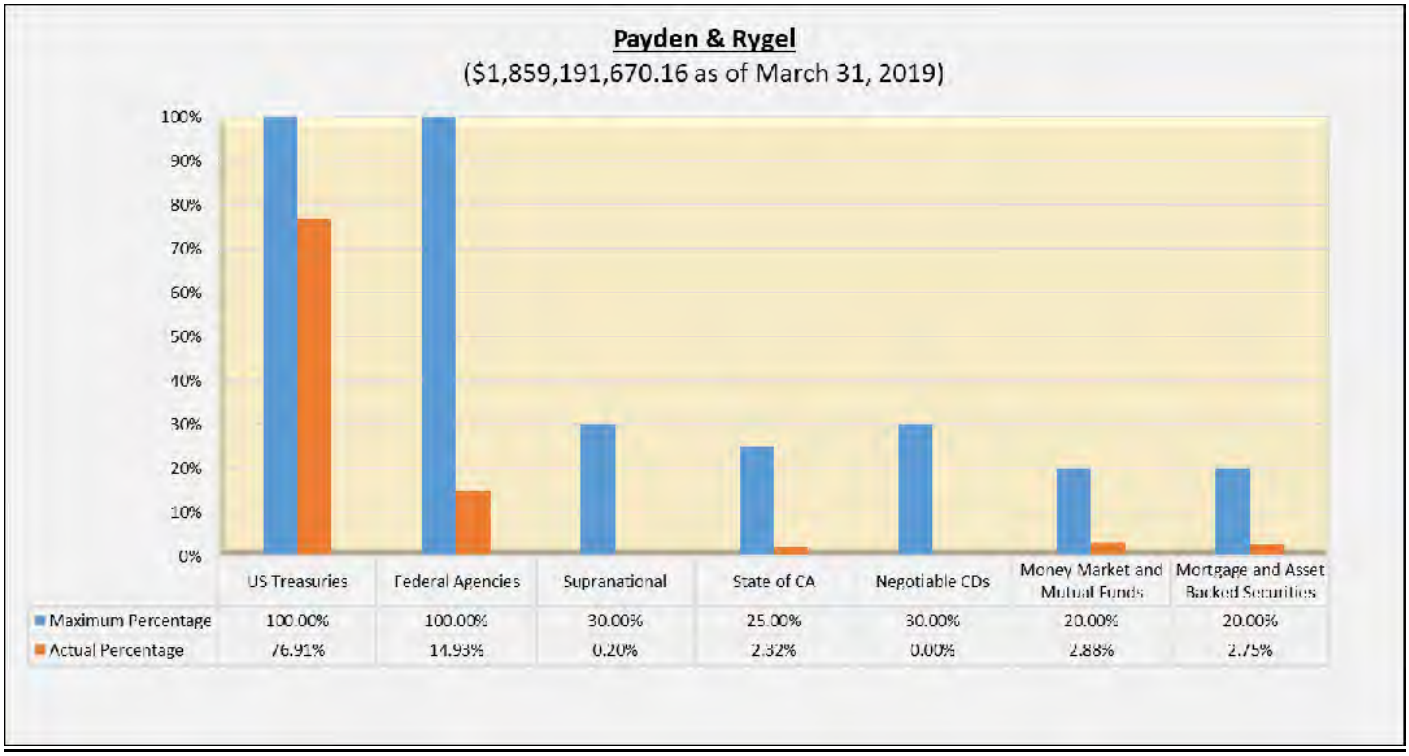
COMPLIANCE WITH ANNUAL INVESTMENT POLICY

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

L.A. Care has invested funds in California's Local Agency Investment Fund (LAIF) and the Los Angeles County Treasurer's Pooled Investment Fund (LACPIF). In a LAIF statement dated April 2, 2019, the March 31, 2019 balance is reported as $60,262,993.93 with accrued interest of $354.828.00. In the LACPIF statement dated March 22, 2019, the February 28, 2019 balance was $103,101,936.50. The LACPIF account balance does not reflect accrued interest.

Payden & Rygel Compliance Verification

California Government Code Compliance Verification Detail as of March 31, 2019



	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	1.09 Years	4.92 Years	YES
Federal Agencies	5 Years	5 Years	0.34 Years	4.34 Years	YES
Supranational	5 Years	5 Years	1.40 Years	2.32 Years	YES
State of CA	5 Years	5 Years	1.13 Years	4.43 Years	YES
Negotiable CDs	270 Days	270 Days	-	-	YES
Money Market and Mutual Funds	NA	NA	1 Day	1 Day	YES
Mortgage and Asset Backed Securities	5 Years	5 Years	2.55 Years	4.55 Years	YES

Payden & Rygel Compliance Verification

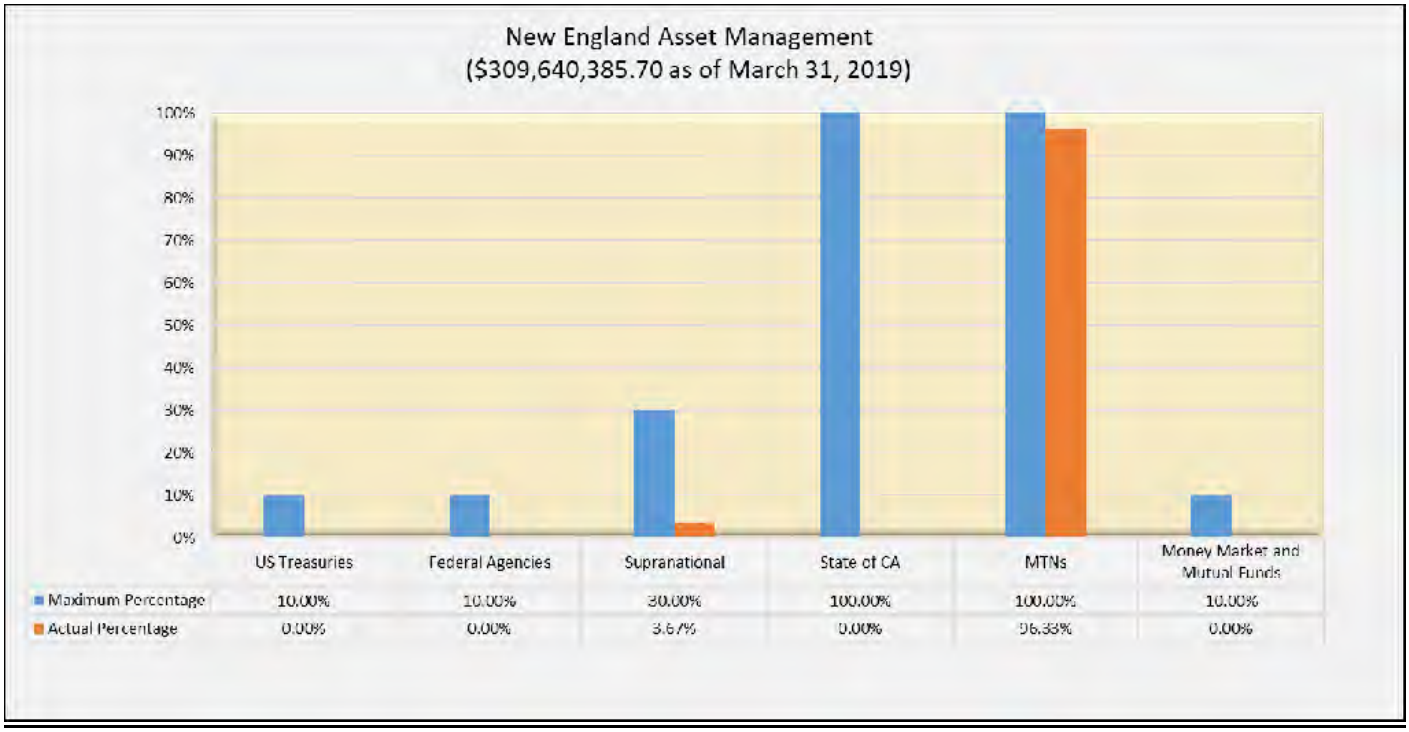
Combined #2365 and #2367 Portfolios as of March 31, 2019

	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)*
MTNs	*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 March 31, 2019



	Maximum Permitted Maturity	Actual Maximum Maturity	Compliance
	NEAM	NEAM	
US Treasuries	5 Years	-	**YES**
Federal Agencies	5 Years	-	**YES**
Supranational	5 Years	0.55 Years	**YES**
State of CA	5 Years	-	**YES**
MTNs	5 Years	4.94 Years	**YES**
Money Market and Mutual Funds	NA	-	**YES**

New England Asset Management Compliance Verification

As of March 31, 2019

	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 Associates, 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 slowed during the fourth quarter of 2018, at 2.2% annualized. Real growth for the year was the strongest since 2015 at 2.9%. Consumer spending was the main driver of growth for the quarter. Private investment was also a positive contributor due to both business and inventory investment. Housing investment, however, was down. A change in net exports was a minor detractor and government spending was down slightly.
  Source: Dept. of Commerce (BEA)

- **Interest Rates:** The Treasury curve fell across all maturities during the quarter while its inversion worsened. The largest negative slope in the curve was from the 3-year to 1-month range with a difference of -22 basis points. The 10-year Treasury was down 28 basis points during the quarter, finishing at 2.41%. The Federal Reserve left the Fed-funds rate unchanged during the quarter after a 0.25% increase in December. However, they did change their projection for 2019 from two rate increases to zero.
  Source: US Treasury

- **Inflation**: Consumer price increases have slowed recently with very little growth during the past six months. The Consumer Price Index was up 0.1% for the three months ending February and 1.5% for the one-year period. The 10-year breakeven inflation rate increased modestly during the first quarter to 1.88% in March versus 1.71% to begin the new year.
  Source: Dept. of Labor (BLS), US Treasury

- **Employment**: Jobs growth continued to be solid with total nonfarm employment increasing an average of 186,000 jobs per month during the three months ending February 2019. The unemployment rate remains below 4%, the first time beneath that mark since 2000.
  Source: Dept. of Labor (BLS)

U.S. Fixed Income Markets

The U.S. Treasury yield curve fell across most maturities during the quarter with the biggest decreases occurring in the 5 to 10-year portion of the curve. The bellwether 10-year Treasury yield ended the quarter at 2.41%, down 28 basis points from December. The Federal Open Market Committee left its overnight rate unchanged during the quarter at a range of 2.25% to 2.50%. The committee adjusted their forecast for future rates, communicated through their "dot plot," from two rate increases in 2019 to zero. The FOMC also adopted a more dovish position on unwinding their balance sheet. Credit spreads tightened during the quarter within both the investment grade and high yield markets.

Payden&Rygel

QUARTERLY PORTFOLIO REVIEW

LA CARE HEALTH PLAN

1st Quarter 2019

PAYDEN.COM

LOS ANGELES | BOSTON | LONDON | MILAN

LETTER FROM THE CEO

April 2019

What a difference one quarter makes! Since our last letter, risk appetite has returned to financial markets. In retrospect, the decline in nearly all market segments in the last quarter of 2018 proved temporary. In part, the reversal was supported by changes in monetary policy and in part by continued robust economic data.

Looking ahead, the U.S. economy remains on decent footing. While we cannot expect to repeat last year's stellar performance, there are still reasons to be optimistic. The services-oriented nature of the U.S. economy and a strong labor market have helped us achieve the longest business cycle expansion in the post-war era.

On a global basis, weaker data in Europe and China dominated headlines in the first quarter. Additionally, coming to terms with the U.K./EU Brexit situation, there is still no conclusion in sight. Investors should stay tuned, however, as there may be scope for acceleration through 2019.

We recognize that risks often arrive unannounced, at times when investors least expect them. On a very practical front, we are managing your portfolio mindful of maintaining liquidity and diversification to ensure changes can be made efficiently.

We are grateful for your continued trust.

Sincerely,

Joan A. Payden

President & CEO

Portfolio Review and Market Update – 1st Quarter 2019

PORTFOLIO CHARACTERISTICS (As of 3/31/2019)

Market Value	$ 1,859,191,670
Avg Credit Quality	AAA
Avg Duration	0.14
Avg YTM	1.98%

SECTOR ALLOCATION

Sector	Market Value	% of Port
Cash	30,303,064	1.63%
Money Market	23,317,223	1.25%
Treasury	1,429,924,660	76.91%
Agency	277,641,729	14.93%
Government Related	3,671,655	0.20%
Credit	-	0.00%
ABS/MBS	51,148,532	2.75%
Municipal	43,184,807	2.32%
Total	$1,859,191,670	100.0%

MATURITY DISTRIBUTION

Sector	Market Value	% of Port
<90 day	1,738,610,051	93.5%
90 days - 1 Year	54,879,685	3.0%
1 - 2 Years	24,305,507	1.3%
2 - 5 years	41,396,427	2.2%
Total	$1,859,191,670	100%

PORTFOLIO RETURNS
Periods over one year annualized

Periods ended 3/31/2019

Performance	1St Quarter	Trailing 1 Year	Trailing 3 Year
LA Care - Short-Term Portfolio	**0.61**	**2.22**	**1.38**
Benchmark*	0.60	2.12	1.09
LA Care - Extended-Term Portfolio	**1.16**	**3.01**	**1.37**
Benchmark**	1.22	3.17	1.14
LA Care - Combined Portfolio	**0.65**	**2.28**	**1.38**

*iMoneyNet DTaxable Money Market Avg. from inception to 10/31/2017; BofAML 91 Day Tsy thereafter.
** BofAML 1-Yr Tsy to 10/31/2017; Bloomberg Barclays US Govt 1-5 Yr thereafter.

Portfolio Review and Market Update – 1st Quarter 2019

PORTFOLIO CHARACTERISTICS (As of 3/31/2019)

Market Value	$1,772,014,167
Avg Credit Quality	AAA
Avg Duration	0.05
Avg YTM	1.96%

SECTOR ALLOCATION

Sector	Market Value	% of Port
Cash	29,646,649	1.67%
Money Market	23,317,223	1.32%
Treasury	1,379,401,501	77.84%
Agency	275,430,120	15.54%
Government Related	1,188,815	0.07%
Corporate Credit	-	0.00%
ABS/MBS	33,923,408	1.91%
Municipal	29,106,452	1.64%
Total	$1,772,014,167	100.0%

MATURITY DISTRIBUTION

Sector	Market Value	% of Port
<90 day	1,731,098,113	97.7%
90 days - 1 Year	38,883,095	2.2%
1 - 2 Years	2,032,960	0.1%
2 - 5 years	-	0.0%
Total	$1,772,014,167	100.0%

PORTFOLIO RETURNS

Periods over one year annualized

Periods ended 3/31/2019

Performance	1st Quarter	Trailing 1 Year	Trailing 3 Year
L.A. Care - Short-Term Portfolio	**0.61**	**2.22**	**1.38**
Benchmark*	0.60	2.12	1.09

* iMoneyNet DTaxable Money Market Avg. from inception to 10/31/2017; BofAML 91 Day Tsy thereafter.

Portfolio Review and Market Update – 1st Quarter 2019

PORTFOLIO CHARACTERISTICS (As of 3/31/2019)

Market Value	$87,177,503
Avg Credit Quality	AAA
Avg Duration	1.89
Avg YTM	2.44%

SECTOR ALLOCATION

Sector	Market Value	% of Port
Cash	656,415	0.75%
Money Market	-	0.00%
Treasury	50,523,160	57.95%
Agency	2,211,610	2.54%
Government Related	2,482,840	2.85%
Credit	-	0.00%
ABS/MBS	17,225,124	19.76%
Municipal	14,078,354	16.15%
Total	$87,177,503	100.0%

MATURITY DISTRIBUTION

Sector	Market Value	% of Port
<90 day	7,511,938	8.6%
90 days - 1 Year	15,996,590	18.3%
1 - 2 Years	22,272,548	25.5%
2 - 5 years	41,396,427	47.5%
Total	$87,177,503	100%

PORTFOLIO RETURNS

Periods over one year annualized

Periods ended 3/31/2019

Performance	1st Quarter	Trailing 1 Year	Trailing 3 Year
L.A. Care - Extended-Term Portfolio	**1.16**	**3.01**	**1.37**
Benchmark**	1.22	3.17	1.14

** BofAML 1-Yr Tsy to 10/31/2017; Bloomberg Barclays US Govt 1-5 Yr thereafter.

MARKET THEMES

The first quarter started off with an abrupt shift in Fed messaging following a volatile 4th quarter, easing concerns of a Fed induced slowdown. The FOMC maintained its target range for the Fed Funds rate at 2.25% - 2.50% in January and March and indicated that they are unlikely to hike until global headwinds and downward pressure on inflation abate. The easier policy stance was supportive for credit: spreads reversed their Q4 widening, and yields continued to fall. The yield curve inverted as markets shifted from an expectation of future rate hikes to rate cuts. Geopolitical risks remain as uncertainty over the U.S./China relationship, concerns surrounding emerging markets, populism in Europe, and Brexit are persistent headwinds. Treasury yields declined, credit risk premiums shrank, and equity prices rebounded sharply providing an environment for strong returns in the front end of the yield curve.

STRATEGY

- The portfolio continued to hold a diversified mix of non-government sectors to increase income.
- We maintain a bias toward a shorter average maturity profile in credit sectors to limit the portfolio's sensitivity to changes in credit risk premiums while maintaining a yield advantage.
- We continue holding securitized bonds, which serve as a diversifier and source of high-quality income.
- We maintained a conservative allocation to short maturity taxable muni bonds as a high quality, low beta alternative to corporate credit and for the added spread and carry over government bonds

INTEREST RATES

- Front-end interest rates shifted as the three-month U.S. Treasury bill yield moved higher by 0.03% to 2.38% while the two-year note fell by 0.23% to 2.26%. The slope between two- and five-year maturities remained tight over the quarter, at -0.03%. The five-year note ended the quarter at 2.23%.
- Longer duration positions benefited the portfolio through price performance over the quarter.
- One-month LIBOR was unchanged at 2.50%, while three-month LIBOR decreased 0.22% to 2.59%.

SECTORS

- High-quality asset-backed securities outperformed Treasuries as spreads tightened.
- Floating-rate bonds benefited from elevated rates and spread compression.
- The portfolio's allocation to taxable muni bonds benefited the portfolio, as taxable munis outperformed Treasuries over the course of the quarter.

MARKET PERSPECTIVE

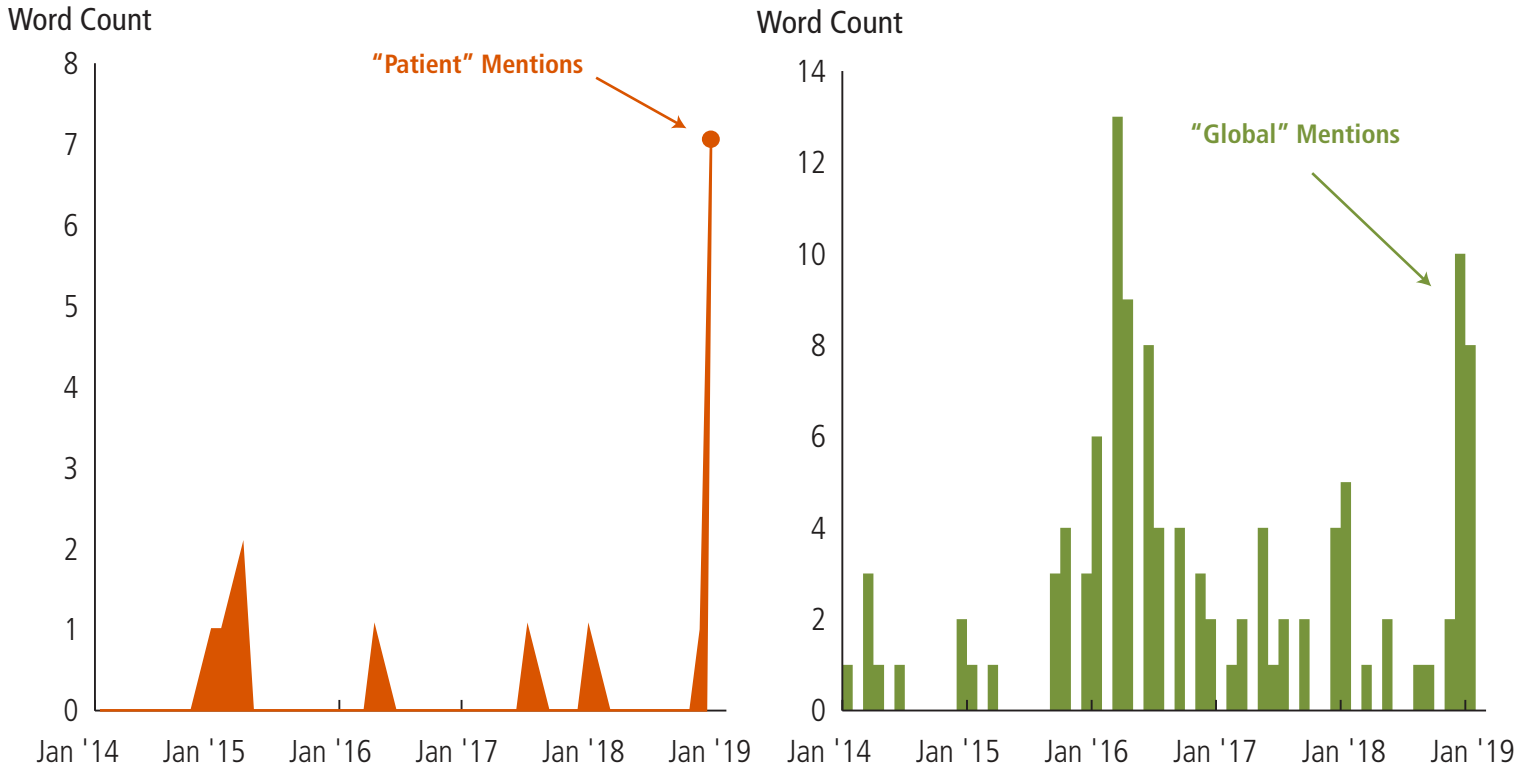
Call us U.S.-centric if you must, but the Fed has been the most important driver of global financial markets in 2019. Global stocks, bonds, oil, and gold, among a host of other assets, have been affected by the shift in the U.S. central bank's policy trajectory to start the year.

Use of the word "patient" by policymakers spiked at the January FOMC meeting (left chart), based on our text mining of the minutes released in the first quarter. We've seen the word before: "patient" appeared twice in the March 2015 meeting minutes, precipitating a nine-month-long wait for the first rate hike of the cycle. The recent re-emphasis of the word "patient" presages an extended pause from the U.S. central bank. At their March meeting, policymakers maintained a dovish stance and message.

As global economic woes increase, the Fed's mentions of "Global" have increased commensurately (see right chart). Similarly, these woes have led to global central banks going on hold. So far in 2019, not only is the European Central Bank (ECB) on hold, they have also returned with stimulus through long-term refinancing operations (LTROs). The Bank of England is also on hold, dealing with the uncertainty of Brexit. The People's Bank of China is also easing, cutting their required deposit reserve ratio for banks, one of many policy rates in their arsenal, by 1% in Q1. Even the Reserve Bank of India cut its key policy rate at its February meeting!

We think the global central banks' dovish tailwind could continue to fuel markets until the global and U.S. economic data improve later in the year, as we expect. This could prompt another rethink by the monetary wonks of the world.

Global Central Banks Go On Hold:
Number of Mentions of the Words "Patient" and "Global" in the FOMC Meeting Minutes*



Source: Federal Reserve, Payden Calculations

**Only includes text from the "Participants' Views on Current Conditions and the Economic Outlook" section*

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U.S. DOMICILED MUTUAL FUNDS

CASH BALANCE
Payden/Kravitz Cash Balance Plan Fund

EQUITY
Equity Income Fund

GLOBAL FIXED INCOME
Emerging Markets Bond Fund
Emerging Markets Corporate Bond Fund
Emerging Markets Local Bond Fund
Global Fixed Income Fund
Global Low Duration Fund

TAX-EXEMPT FIXED INCOME
California Municipal Income Fund

U.S. FIXED INCOME
Absolute Return Bond Fund
Cash Reserves Money Market Fund
Core Bond Fund
Corporate Bond Fund
Floating Rate Fund
GNMA Fund
High Income Fund
Limited Maturity Fund
Low Duration Fund
Strategic Income Fund
U.S. Government Fund

DUBLIN DOMICILED UCITS FUNDS

EQUITY
Global Equity Income Fund
U.S. Equity Income Fund

LIQUIDITY FUNDS
Euro Liquidity Fund
Sterling Reserve Fund
U.S. Dollar Liquidity Fund

FIXED INCOME
Absolute Return Bond Fund
Global Bond Fund
Global Emerging Markets Bond Fund
Global Emerging Markets Corporate Bond Fund
Global Government Bond Index Fund
Global High Yield Bond Fund
Global Inflation-Linked Bond Fund
Global Short Bond Fund
Sterling Corporate Bond Fund
U.S. Core Bond Fund
USD Low Duration Credit Fund

For more information about Payden & Rygel's funds, contact us at a location listed below.

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NEAM New England Asset Management

L.A. Care Health Plan

NEAM's L.A. Care Board Report

L.A. Care HEALTH PLAN

Data as of March 31, 2019

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

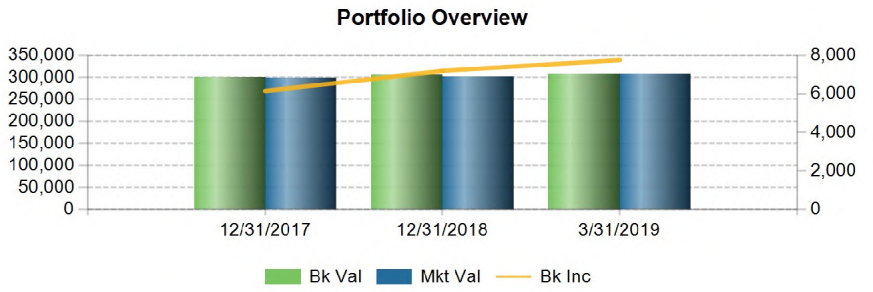
Table of Contents

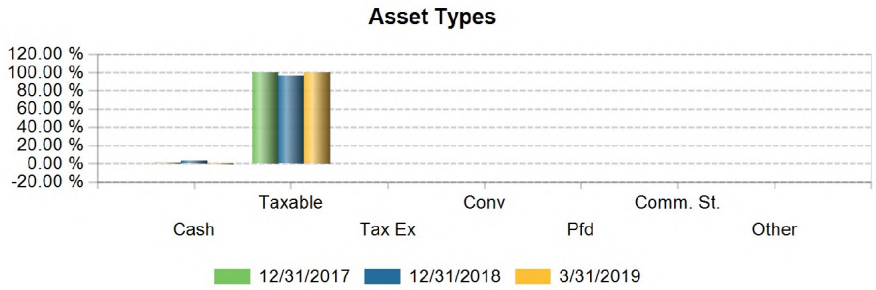
Portfolio Summary

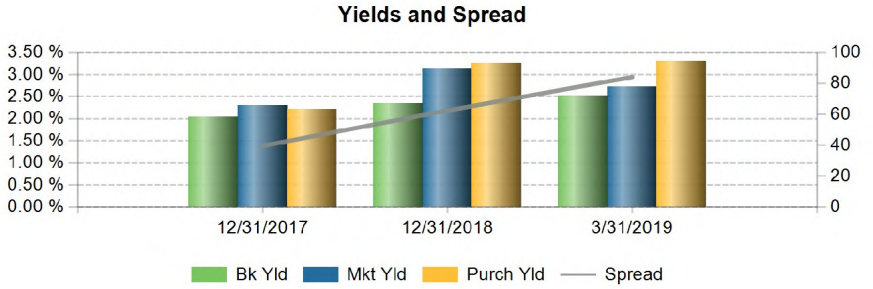
L.A. Care Health Plan - Comparative Overview

	12/31/2017	12/31/2018	3/31/2019	Change since 12/31/2018
Portfolio Overview (000's Omitted)				
Book Value	300,148	306,480	307,771	1,291
Market Value	298,558	301,672	307,393	5,721
Total Unrealized Gain/Loss	(1,590)	(4,808)	(378)	4,430
Gross Gains	21	134	1,445	1,310
Gross Losses	(1,611)	(4,943)	(1,823)	3,119
Realized Gain / Loss	(5)	(116)	(139)	
Annualized Book Income	6,143	7,188	7,759	572
After Tax Book Income	3,993	5,678	6,130	452
Asset Types				
Cash / Cash Equivalents	0.2%	3.6%	-	(3.6%)
Taxable Fixed Income	99.8%	96.4%	100.0%	3.6%
Portfolio Yields				
Book Yield (Before Tax)	2.05%	2.35%	2.52%	0.18%
Book Yield (After Tax)	1.33%	1.85%	1.99%	0.14%
Market Yield	2.30%	3.13%	2.72%	(0.41%)
Fixed Income Analytics				
Average OAD	2.58	2.08	2.39	0.31
Average Life	2.73	2.19	2.57	0.38
Average OAC	7.49	5.14	5.32	0.18
Average Quality	AA-	A+	A+	
Average Purchase Yield	2.22%	3.27%	3.30%	0.04%
Average Spread Over Tsy	40	62	84	22
5 Year NEAM US Govt On The Run	2.21%	2.51%	2.23%	(0.28%)

	09/30/18	12/31/18	03/31/19	Change since 12/31/2018
MV Inc. Acc. Int. Inc.	298,772,635	301,671,972	307,392,551	5,720,580
Acc. Int. Inc.	2,058,024	1,808,311	2,247,834	439,523
MV Inc. Acc. Int. Inc.	300,830,659	303,480,283	309,640,386	6,160,102





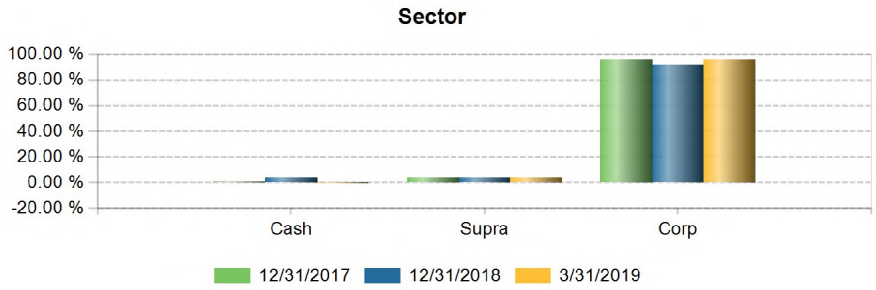


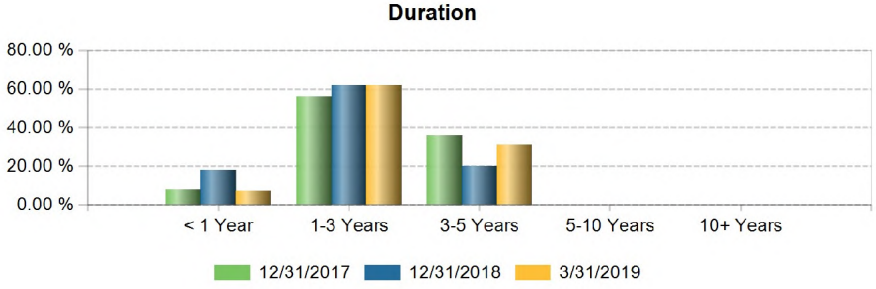
For historical comparison purposes, prior to 1/1/2018 a 35% effective tax rate was applied. Effective 1/1/2018, 21% is being used.

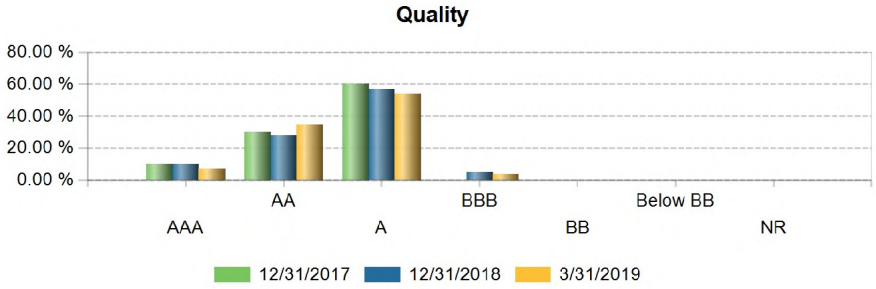
L.A. Care Health Plan - Fixed Income Summary

	12/31/2017	12/31/2018	3/31/2019	Change since 12/31/2018
Sector				
Cash & Cash Equivalents	< 1%	4%	-	(4%)
Supranationals	4%	4%	4%	-
Corporates	96%	92%	96%	4%
Fixed Income	100%	100%	100%	
Duration				
< 1 Year	8%	18%	7%	(11%)
1-3 Years	56%	62%	62%	-
3-5 Years	36%	20%	31%	11%
Average Duration	2.58	2.08	2.39	0.31
Quality				
AAA	10%	10%	7%	(3%)
AA	30%	28%	35%	7%
A	60%	57%	54%	(3%)
BBB	-	5%	4%	(1%)
Average Quality	AA-	A+	A+	

	Average Portfolio Rating at 3/31/19				
	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	44,441	100.0	84	3.30	A+	4.37
Total Purchases	44,441	100.0	84	3.30	A+	4.37

Sales	Market Value	%	Realized G/L	Trade / Book Yld	High	Duration
Corporates	31,884	100.0	(139)	2.76 / 1.96	A	0.70
Total Sales	31,884	100.0	(139)	2.76 / 1.96	A	0.70

Other Transactions	Market Value	%	Realized G/L	Book Yld	High	Duration
Maturities	150	100.0	-	1.13	-	< 0.01
Total Other Transactions	150	100.0	-	1.13	-	< 0.01

A Foreign Exchange Rate as of 03/31/2019 was used to convert amounts to USD.

Performance Report

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

						Annualized			
	Mar 2019	Feb 2019	Jan 2019	Q1	12 Month	3 Year	5 Year	Inception	Inc Date
LA Care HealthPlan	0.87	0.27	0.87	2.03	3.95			2.53	Jan 2018
Barclay Bloomberg U.S. Credit: 1-5 Yr A- or better (Highest)	0.95	0.24	0.93	2.14	4.16			2.73	Jan 2018
Difference	(0.08)	0.03	(0.06)	(0.12)	(0.22)			(0.20)	

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	(4,671)	(4,671)	(4,671)	-	2.32	2.35	0.08	0.05	0.09	< 0.00
Supranationals	11,350,000	11,338,818	11,296,386	(42,432)	1.74	2.46	0.52	0.53	0.53	3.67
Corporates	294,788,000	296,436,827	296,100,836	(335,991)	2.55	2.74	2.46	5.50	2.65	96.33
Total Portfolio	**306,133,329**	**307,770,974**	**307,392,551**	**(378,423)**	**2.52**	**2.73**	**2.39**	**5.32**	**2.57**	**100.00**

Rating Analysis - Highest

	% of Portfolio
AAA	6.71
AA	35.05
A	54.68
BBB	3.56
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	0.21	0.17	0.08	0.04	(0.04)	(0.08)	(0.17)	(0.25)
Supranationals	1.34	1.05	0.52	0.26	(0.26)	(0.52)	(1.03)	(1.54)
Corporates	5.93	5.03	2.48	1.24	(1.22)	(2.43)	(4.78)	(7.06)
Total Portfolio	**5.76**	**4.88**	**2.41**	**1.20**	**(1.19)**	**(2.36)**	**(4.64)**	**(6.86)**

Key Rate Duration

	Market Value	1 Year	2 Year	3 Year	5 Year	7 Year	10 Year	15 Year	30 Year
Cash & Cash Equivale	(4,671)	0.08	-	-	-	-	-	-	-
Supranationals	11,296,386	0.52	-	-	-	-	-	-	-
Corporates	296,100,836	0.25	0.67	0.90	0.64	< 0.00	-	-	-
Total Portfolio	**307,392,551**	**0.26**	**0.65**	**0.87**	**0.61**	**< 0.00**	**-**	**-**	**-**

Disclaimers

Disclaimers

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Board of Governors
MOTION SUMMARY

Date: May 2, 2019 **Motion No. FIN 101.0519**

Committee: Finance & Budget **Chairperson:** Robert H. Curry

Issue: Approval annual corporate insurance renewal with insurance broker Marsh and McLennan.

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

Background: L.A. Care staff requests the approval to renew the annual corporate insurance renewal for April 1, 2019 to April 1, 2020 in the amount of $3,275,973. The corporate insurance provides coverage for the following:

- Crime
- Cyber Risk
- Difference in Conditions (Earthquake and Flood)
- Directors and Officers Liability
- Employment Practices Liability
- Fiduciary Liability
- General Liability, Property, Automobile
- Managed Care Errors and Omissions
- Workers' Compensation

L.A. Care worked with insurance broker Marsh and McLennan who has been L.A. Care's insurance broker for over three years and was selected from an RFP in 2016. Marsh and McLennan reviewed L.A. Care's insurance needs and then marketed them via quotes from several leading insurance carriers.

Member Impact: None.

Budget Impact: The cost was anticipated and included in the approved budget for the Accounting and Financial Services department in this fiscal year. We will budget the balance in future fiscal years.

Motion: **To authorize staff to approve the corporate insurance renewal in the amount of $3,275,973 with insurance broker Marsh and McLennan to provide insurance coverage for the period of April 1, 2019 to April 1, 2020.**

Board of Governors
MOTION SUMMARY

Date: May 2, 2019 **Motion No. FIN 102.0519**

Committee: Finance & Budget **Chairperson:** Robert H. Curry

Issue: Execute a contract with HealthCare Fraud Shield (HCFS) to provide Fraud & Abuse analytics

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

Background: L.A. Care staff requests approval to execute a contract with HCFS from May 1, 2019 to December 31, 2022 in the estimated amount of $2,335,000 over the term of the contract. The pricing structure includes: licensing fees of $1,715,000 for the analytics and case management solutions, implementation fee of $95,000, and variable costs of $525,000 for medical records reviews to support SIU investigations for cases requiring clinical/coding expertise.

The vendor will provide a web-based application comprising of L.A. Care data (including professional claims, facility claims, Rx claims, and encounter data) to identify aberrant or suspect provider billing behavior and quickly identify fraud & abuse trends for further investigation by the Special Investigations Unit (SIU). The fraud analytics solution is projected to generate $6M-$12M of medical expense savings over the term of the contract. (Annual recoveries of $2M-$4M once fully deployed).

An RFP was conducted with multiple vendor proposals received and evaluated. HCFS was selected due to 1) the depth and breadth of analytics 2) testimonials from other payers using the application to identify fraud & abuse, and 3) competitive pricing relative to other solutions available in the market.

Member Impact: L.A. Care members will not be impacted.

Budget Impact: Vendor fees are included in the FY 2018-2019 budget.

Motion: **To authorize staff to execute a contract in the amount estimated at $2,335,000 with HealthCare Fraud Shield to provide Fraud & Abuse analytics for the period of May 1, 2019 to December 31, 2022.**

L.A. Care
HEALTH PLAN

Board of Governors
MOTION SUMMARY

Date: May 2, 2019 **Motion No. ECA 100.0519**

Committee: Executive Community Advisory Committee **Chairperson:** Ana Romo

Issue: Approval of members to the Regional Community Advisory Committees (RCACs).

Background: Senate Bill 2092 requires that L.A. Care Health Plan ensure community involvement through a Community Advisory Committee.

Member Impact: None

Budget Impact: None.

Motion: **To approve the following as members to the Regional Community Advisory Committee, as reviewed by the Executive Community Advisory Committee (ECAC) during its April 10, 2019 meeting:**

- **Scott Clapson RCAC 4**
- **Ana Maria Uc-Batum RCAC 8**
- **Maribel Vizcarra RCAC 11**

Board of Governors
MOTION SUMMARY

Date: May 2, 2019

Motion No. ECA 101.0519

Committee: Executive Community Advisory

Chairperson: Ana Romo

Issue: Ratification of elected Regional Community Advisory Committee (RCAC) Region 10 Vice-Chairperson for calendar year 2019.

Background: Per the Community Advisory Committee Operating Rules, the RCAC shall nominate a Chairperson and Vice-Chairperson for a one-year term at their first meeting in December each year.

Budget Impact: N/A

Motion: **To ratify the election of Norma Angelica Alvarez as Vice Chairperson of Regional Community Advisory Committee (RCAC) Region 7 for the calendar year 2019.**

April 25, 2019

TO: Board of Governors

FROM: John Baackes, *Chief Executive Officer*

SUBJECT: CEO Report – May 2019

As we head into May, the transformational work we are doing at L.A. Care is moving at full speed. As many of you know from attending a recent board reception, there are a number of major initiatives we are pushing forward simultaneously. It is a major lift, but our members deserve nothing less.

At the same time, we are reaping the rewards of our efforts to provide quality health care as demonstrated by our most recent recognitions – a sure sign that we are on the right track. I look forward to continued success – and I thank you for being a part of this journey as we shape the future of health care.

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

	Since last CEO report on 3/29/19	As of 4/25/19
Elevating the Safety Net Grants for primary care physicians	1	49
Elevating the Safety Net Grants for medical school loan repayment	4	18
Elevating the Safety Net Grants for medical school	_	8
Housing for Health Housing secured for homeless individuals	4	232
IHSS+ Home Care Training IHSS worker graduates from CLTCEC program	_	1,525

Below please find an update on organizational activities for the month of April.

April 2019

1. L.A. Care Earns NCQA Distinction
   I am proud to report that, for the fourth time, L.A. Care has received the Multicultural Health Care Distinction from the National Committee for Quality Assurance (NCQA). The distinction was for our Medi-Cal, Cal MediConnect and L.A. Care Covered product lines. The Multicultural Health Care Distinction recognizes organizations that engage in efforts to improve culturally and linguistically appropriate services and reduce health care disparities. Additionally, NCQA recognized the strong, knowledgeable, and dedicated staff of L.A. Care's Cultural and Linguistic (C&L) Program which

provides translation and interpreting services for members, conducts cultural competency training for staff, and provides technical assistance to plan partners, among other things. L.A. Care was among 48 health plans across the country to receive the Multicultural Health Care Distinction.

2. L.A. Care Leadership Convenes Current and Former L.A. Care Board Members
   On April 22, the L.A. Care leadership team hosted a gathering of current and former board members for an evening of reconnecting and learning about the organization's major initiatives and transformational improvements to further our leadership role in shaping the future of health. As the health care landscape continues to be impacted by a range of factors and issues – ongoing threats to the Affordable Care Act, health reform proposals happening at the state and federal levels, etc. – there is an even greater need to know the tremendous value of existing public health plans like L.A. Care. It is my hope that those who attended will help disseminate information about the great work we are doing to deliver high quality care to our members and added value for our providers.

3. South Bay Family Health Care Honors L.A. Care
   I am pleased to share that South Bay Family Health Care (SBFHC) honored L.A. Care at its annual gala with the Leader in Health Care award. The award recognizes L.A. Care's ongoing commitment and support of SBFHC – one of Los Angeles County's largest safety net providers – offering high quality, low- and no cost-health care, dental, and mental health services throughout the South Bay and Harbor Gateway communities.

4. L.A. Care Launches Internet Radio Station to Better Serve Providers
   As part of our ongoing efforts to create added value for our providers, L.A. Care has launched a new provider communication vehicle – an internet radio station. Providers of all types can tune in and listen to exclusive interviews with L.A. Care physicians and leaders on topics related to HEDIS® measures and care coordination, as well as quick segments on the latest clinical guidelines. It also aims to break down issues like claims and coding, customer service and staff development through quality improvement tips that support provider practice success and patient satisfaction. Content is looped every two hours, and will be updated once a quarter. To our knowledge, this is the first-ever internet radio station launched by a health plan and hope it becomes a welcome and useful addition to the wide range of resources we offer our providers.

Attachments:

- April 2019 sponsorship list
- Modern Healthcare op-ed
- Modern Health care article

April 2019 Sponsorship List

Date	Organization	Event	Amount	Target Audience
4/1/2019	Community Clinic Association of Los Angeles County	Policy Café	$7,000	Providers/ Advocates
4/6/2019	St. Barnabas Senior Services	Aging Into the Future/ Los Angeles Aging Advocacy Coalition	$7,500	Providers/ Advocates
4/8/2019	Southern California Grantmakers	Public Policy Conference	$2,500	Advocates
4/11/2019	America's Physician Groups	Annual Conference	$8,590	Providers/ Advocates
4/18/2019	Charles Drew University School of Medicine GRANTEE	Legacy Leaders Spring Gala: A Tribute to Legends	$3,500	Providers/ Advocates
4/23/2019	El Nido Family Centers	Teen and Young Families Program	$3,000	Members/ Potential Members
4/24/2019	Farmworker Justice	Farmworker Justice Awards	$1,500	Advocates
4/25/2019	CADRE	CADRE Annual Spring Fundraiser	$5,000	Advocates
4/25/2019	Los Angeles Family Housing GRANTEE	LAFH Awards	$0	Advocates
4/25/2019	Pacoima Beautiful	Environmental Justice Awards	$1,500	Advocates
4/27/2019	Care Harbor	Care Harbor LA Healthcare Clinic	$30,000	Members/ Potential Members
4/27/2019	Positive Results Corporation	Promoting Healthy Manhood	$2,500	Advocates

Modern Healthcare

Commentary: Don’t scrap Obamacare. Fix it

By John Baackes
April 13, 2019

Healthcare is the political issue with nine lives. After failing to kill the Affordable Care Act legislatively in 2017, the Trump administration is trying again, while Democratic presidential hopefuls are trying to kill it as well by proposing a single-payer system, Medicare for All, in its place.

The administration reversed its previous position not to defend a lawsuit brought by 18 Republican attorneys general and two GOP governors that got a U.S. District Court judge in Texas to declare the ACA unconstitutional. Now it will join the states in trying to get the ACA scrapped. Yet the GOP has no replacement plan.

Meanwhile those of us who work every day to make our healthcare system more responsive, affordable and comprehensible are shaking our heads in disbelief that people who know nothing about how healthcare works in the U.S. are rolling the dice on creating chaos for millions of Americans by repealing the ACA with no alternative or swapping the ACA for a single-payer system for which there are no details on how it would operate.

So let’s consider another idea. Fix what we have so everyone—consumers, providers, payers and even politicians—can understand how it works and what to expect.

The ACA is a good framework, but it certainly needs fixing. I offer several changes—including restoring some effective provisions—that would make the law work better, cover more people and continue the cost containment that has started since major provisions of the law went into effect five years ago:

Restore the tax penalty for not having insurance. Removing the penalty let people without access to employer-based insurance, Medicare or Medicaid off the hook. If you’re young and feel invincible, why bother with health insurance? They are exactly the people we need to keep the pool of insureds balanced and keep costs reasonable.

Restore the cost-sharing reduction provision, which is still in the law. CSRs were an inexpensive way to help make plans offered in the individual market exchange affordable.

Provide a government-sponsored reinsurance pool for those individual markets with only one or two plans available to keep those insurers in place.

Introduce a public option everywhere. In the original 2010 ACA legislation that passed the House, a provision for public health plans in every state was included to compete in the individual market exchanges with commercial insurers. The Senate dropped it and the House agreed in order to get the ACA over the finish line. Public entities without the need to reward shareholders would provide a lower-

cost competitor. In Los Angeles there is a functioning public option plan doing just that, L.A. Care Health Plan.

Eliminate short-term health insurance policies. They expose buyers to ruinous copayment and lifetime limits should they become seriously ill.

Provide federal support for medical education. Most First World countries subsidize the costs of medical education. In the U.S. the students are on their own and almost all incur crushing loan debt to become a doctor. This drives many students into specialty care instead of primary care, where the need is greatest but compensation is the lowest.

Create a new plan for the 10 million people who are dually eligible for both Medicare and Medicaid. We spend $400 billion a year of taxpayer money on their healthcare making this the most expensive cohort. The new plan would consolidate Medicare, Medicaid and Part D prescription drug benefits into a single comprehensive plan eliminating wasteful duplication of government administration and lack of coordination. The new plan should be an option that the states would administer, or if a state did not want that responsibility, the plan would default to a federally administered program.

Healthcare is not rocket science. It's actually more complicated. To get to a simpler, less costly system we have to carefully parse the elements of our current system to understand what is leaving 29 million Americans still uninsured even after five years of the ACA.

The American people deserve a more balanced discussion on healthcare that goes beyond sloganeering.

Modern Healthcare

CMS may start cracking down on dual-eligible 'look-alike' plans

By Shelby Livingston
April 11, 2019

As the federal government sets about promoting more integrated care for patients eligible for both Medicare and Medicaid, it is also considering cracking down on a type of health plan that could complicate that goal.

These plans, referred to as dual-eligible special needs (D-SNP) plan "look-alikes," are designed and marketed to attract dual-eligible patients, who may enroll thinking they will receive integrated Medicare and Medicaid benefits and extra care coordination. Instead, they find themselves in general Medicare Advantage plans without the ability to integrate with Medicaid and miss out on benefits they could receive elsewhere, critics argue.

D-SNP look-alikes have drawn the wrath of health insurers that offer true D-SNPs, which hold contracts with both the CMS and a state Medicaid agency, as well as advocates who worry the look-alikes confuse vulnerable patients. The issue was a topic at this week's spring meeting of the Special Needs Plan Alliance, which is partnering with several insurers, including L.A. Care Health Plan, to encourage the CMS to curb look-alike plans.

"Dually eligible individuals may be enrolling in plans that do not provide any integration on the Medicaid side when in fact they could benefit from it," said Dr. Cheryl Phillips, CEO of the SNP Alliance. "Yes, they have the right to choose (their health plan), and we support that, but we want to make sure that choice is transparent."

The CMS seems to be listening to those concerns. While the agency isn't acting yet, it is considering various ways to curb enrollment in look-alike plans in future regulation, from better educating dual-eligible individuals on their options or even rejecting applications for Medicare Advantage insurers to offer non-integrated plans that appear to target dual-eligible patients, as the Medicare Payment Advisory Commission has suggested.

D-SNPs, which were first offered in 2006, are Medicare Advantage plans that limit enrollment to dual-eligible patients. These contracts allow states to encourage or require the D-SNPs to integrate Medicare and Medicaid benefits for their members. For example, a patient may receive hospital and physician services from Medicare Advantage, while Medicaid may pay for that patient's Medicare cost-sharing, behavioral health services or long-term care benefits.

Of the more than 10 million dually eligible individuals in the United States, 1.7 million were enrolled in D-SNPs in 40 states and the District of Columbia as of January 2018, according to MedPAC. Dual-eligibles, who are generally very poor with complex health needs, represented a fifth of Medicare

beneficiaries but accounted for 34% of total Medicare spending in 2013, and made up 15% of Medicaid beneficiaries but accounted for 32% of total Medicaid spending, according to MedPAC.

While they are meant to offer integrated benefits, oftentimes D-SNPs have little integration because of administrative and operational challenges, MedPAC has noted. The Bipartisan Budget Act of 2018 sought to address that by laying out a "road map" to improve integration between Medicaid and Medicare in D-SNPs and streamline the grievance and appeals process for dual-eligible members, explained Alex Shekhdar, a Medicaid managed-care expert.

In theory, having dual-eligibles receive integrated Medicare Advantage, Part D and Medicaid benefits from one organization should eliminate those inefficiencies, provide more coordinated care, improve quality and lower the cost of that care. But comprehensive data on D-SNP quality and spending is lacking, several sources said.

The CMS is starting to put the budget act's requirements into motion by holding D-SNPs to a stricter standard of showing they are integrated with a state Medicaid agency, effective in 2021.

But D-SNP look-alikes get in the way of those goals, critics say.

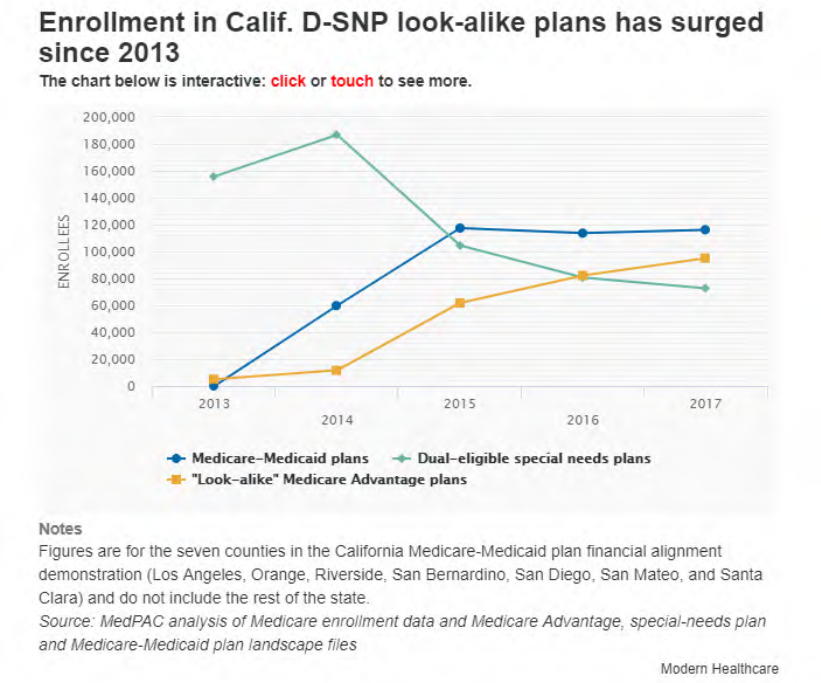
"Members are not going to get the same level of care; they are not going to get the care coordination that they get in the fully integrated plan," said John Baackes, CEO of L.A. Care, which serves 16,000 dual-eligible members in California's Medicare-Medicaid demonstration plans. "So we are very concerned about them and looking for ways we can advise CMS and the state on ways they can isolate these programs so they are sold for what they are and not what they pretend to be."

The CMS also noted in its final call letter that the look-alike plans may undermine state integration efforts and impede goals of lowering cost and improving quality of care.

Still, some insurers say there are situations in which D-SNP look-alikes have a place.

Blue Shield of California, which offers a D-SNP look-alike, said in a statement: "While we wholeheartedly support integrated programs, our (D-SNP look-alike) plan makes managed care available to those members who choose not to enroll in our Cal MediConnect product and don't have the option to enroll in a D-SNP."

Look-alike plans have proliferated in recent years for various reasons. They started in California, but the SNP Alliance's Phillips said look-alike plans are now offered in an estimated 34 states. The latest data from MedPAC shows that in 2017, there were 19 look-alike plans with 95,000 combined enrollees in seven counties of California alone, compared with just four plans with 5,000 members in those areas in 2013. Enrollment in look-alike plans has surpassed enrollment in true D-SNPs, which served 72,700 members in those seven California counties in 2017.



The jump happened after the state began encouraging dual-eligible patients to enroll in the state's Medicare-Medicaid plan financial alignment demonstration, called Cal MediConnect, which launched in 2014 in those seven counties. The state limited enrollment in regular D-SNPs and barred brokers from getting commissions on the new Medicare-Medicaid plans. So insurers and brokers pivoted to offering look-alike plans.

"It's clearly a natural response to the program rules that have been put on this state, which has basically limited the ability of Medicare Advantage organizations to offer D-SNPs," said Erin Trish, associate director of the Schaeffer Center for Health Policy & Economics at the University of Southern California.

Health insurers, unable to grow their D-SNP business, built other plans that looked a lot like D-SNPs, in terms of the types of benefits they offer. For instance, they may have the highest allowable maximum out-of-pocket threshold for hospital and physician services and a beneficiary premium for prescription drugs. Those characteristics wouldn't be attractive to a member who isn't dually eligible, but they don't matter to dual-eligible members because all of them receive a low-income subsidy that covers their premiums and Medicaid covers their cost-sharing.

Health insurers also may want to offer a look-alike plan to avoid having to win a state Medicaid contract, which can be difficult. Look-alike plans also don't have to submit a model of care or report quality metrics to the CMS. Moreover, look-alike plans nab health insurers higher payments from Medicare Advantage because those payments are risk-adjusted for the dual-eligible patient's health status.

"They get paid more for these dual eligibles, who are higher cost and higher acuity of care. So the revenue is up there for taking care of these beneficiaries," said Jeff Fox, president of Gorman Health Group, a consultant firm for Medicare Advantage plans.

But Fox said the quality of care that patients get in D-SNP look-alike plans is on par with integrated plans; it's just that care coordination with Medicaid benefits is missing.

There has not yet been an evaluation of the Medicare-Medicaid plan demonstration in California, so it's hard to say whether D-SNP look-alike plans are truly a problem, according to Trish. It's also hard to know if patients in look-alike plans would have enrolled in an integrated Medicare-Medicaid plan if look-alike plans were not an option, she said.

But the SNP Alliance insists patients would be better off in an integrated plan. Phillips said it's unclear if the CMS has the ability to prohibit the creation of look-alike D-SNPs. But stakeholders would like to see a way to ensure dual-eligible members at least understand their options and don't enroll in a non-integrated plan because of misleading marketing tactics, she said.

They have some ideas, such as requiring outbound calls to beneficiaries to verify they want to enroll in a plan that does not coordinate benefits with Medicaid. The SNP Alliance also recommended that the CMS: address broker incentives that drive enrollment into look-alikes; allow high-quality D-SNPs to market year-round; and require brokers to disclose the full menu of plan options for a beneficiary.

April 15, 2019

TO: Board of Governors

FROM : John Baackes, *CEO*

SUBJECT: 2nd Quarter FY 2018-19 Vision 2021 Progress Report

This report summarizes the progress made on the activities outlined in Vision 2021, L.A. Care's Strategic Plan. This is the second report for the 2018-19 fiscal year, which represents the first year of the three-year plan.

L.A. Care's second quarter notable activities include:

- On January 30, L.A. Care held its first (hopefully annual) Provider Recognition Awards Dinner. We awarded the Top Performing and Most Improved Practitioner, Clinic, and IPA.

- L.A. Care executed a contract with CVS Minute Clinic to enhance member access to an alternative for urgent care for all products.

- The Business Needs Assessment has been finalized for Member 360, a tool to assess member needs and utilization.

- Health Homes project is underway and we have 41 potential Community-Based Care Management Entities - the strongest showing of any local health plan.

- Cal Medi-Connect will proceed with commitment to the demonstration project, based on the state signaling that they will continue efforts.

1 High Performing Enterprise

A high functioning health plan with clear lines of accountability, processes, and people that drive efficiency and excellence.

Goal 1.1

Members and providers get what they need from L.A. Care, accurately and consistently.

Key Activities	• Document and integrate health services processes. *Lead: Health Services*		• The Identification, Stratification, Enrollment, Interventions, Outcomes (ISEIO) Population Health Management Program Structure grids and Future State Utilization Management Processes are underway. • Future State Process list has been cross-walked with Knox Keene and PHM NCQA regulatory requirements complete.	Update

Color Indicator Legend

Green – On target, no issues
Yellow – Some issues, probable risks, concerns
Red – Major issues, high risk
Blue – Complete

Key Activities	• Maintain focus on VOICE (Value Our Individual Customers Everyday), Total Provider Management, enrollment reengineering, claims/authorization stabilization, and IT (Information Technology) architecture. *Lead: Operations*		• Focus remains on multi-year transformative projects like VOICE, a multi-year plan that will transform the way its customers navigate to find information and self-serve; and Total Provider Management, another multi-year program focused on improving L.A. Care's intake, validation and quality of provider data. • Focus remains on work to reengineer membership enrollment and improve the processes that enable the claims processing of authorized services. • An Enterprise IT Delivery Roadmap has been completed and identifies approximately 150 efforts to be completed over the next 3 years to establish Vision 2021.	Update
Goal 1.2 **Members across all products receive all the benefits they're entitled to, accurately and consistently.**				
Key Activities	• Refine and maintain benefit grids. *Lead: Product*		• With a cross functional team from Provider Network Management (PNM), Health Services, and Product, a standardized division of financial responsibility (DOFR) for provider contracts was developed for all lines of business based on common sources of grievances and industry best practices. A DOFR hierarchy was developed to establish business rules for payment. • A Medi-Cal Benefits Administration process and meeting series was launched.	Update

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Key Activities	(cont. from previous) • Refine and maintain benefit grids. *Lead: Product*		• LACC (L.A. Care Covered)/LACCD (L.A. Care Covered Direct) benefit grids have been updated with the 2020 plan benefit changes. All metal level plan grids have been submitted (4/1) to the DMHC for review and approval o PASC (Personal Assistance Services Council) benefit grids are reviewed and updated as part of an annual cycle. Will begin May 2019. Completion is targeted for 2020 Cycle. • Cal Medi-Connect (CMC) will proceed with commitment to the demonstration project, although the State and CMS have not fully executed the 3-year extension. Benefits are being created to support the 2020 bid process.	Update
	• Use product segment data to analyze trends and design interventions to optimize health and utilization. *Lead: Product*		• The Medi-Cal team provided material content and requirements for the Member 360 (member and provider analytics tool) business needs assessment document and provided subject-specific guidance on specific attributes of member enrollment. • LACC data is being compiled to support: o Risk Pool Stratification o Churn Opportunity o 2020 Go-To Market Strategy o Member 360 requirements o Invented Future opportunities • The CMC team continues to leverage a monthly report to identify and follow trends related to member health and utilization, now with new line of sight from the medical cost drivers report.	

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Goal 1.3

Providers receive the individualized information and resources they need to provide high-quality care with low administrative burden.

Key Activities			Update
• Provide practices with actionable performance reports and support in improving quality. *Lead: Health Services*		• We continue to try to improve the Provider Opportunity Report and Gap in Care Lists. The final reports for 2018 were sent in February. This is a very complex process from start to finish. We hope to evolve to an online report monthly as soon as possible.	
• Celebrate top providers and improved performance. *Lead: Health Services*		• On January 30, L.A. Care held its first (hopefully annual) Provider Recognition Awards Dinner. We awarded the Top Performing and Most Improved Practitioner, Clinic, and IPA. It was a great success. Planning for the next event will start in June.	
• Offer access to loan repayment and recruitment assistance for new physicians (Elevating the Safety Net). *Lead: Safety Net*		• The Elevating the Safety Net Physician Loan Repayment Program continues to grow with 16 providers awarded to date (4/1/2019) and many others under review for future awards. We are also working to disburse another $3 million for funding more physicians through the program. • Twenty-eight new providers have been hired through the Provider Recruitment Program. We received 25 applicants for Cycle 3 and awards will be announced in late May.	

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Key Activities	• Support practice transformation and use of electronic resources such as Electronic Health Records (EHRs) and virtual care. *Lead: Health Services, HIT*		• LA Practice Transformation Network continues to overachieve in quality, cost, and transformation with current focus on clinical exchange, utilization reduction, A1c control, and medication management. • California Technical Assistance Program helped providers achieve 5,600 adopt, implement, upgrade (AIU) and meaningful use milestones which earned $6.8M towards the $10.8M goal. • eManagement with 142 providers serving 155,000 MCLA members with over 22,000 receiving behavioral health screenings and 39% of PCPs in eConsults with psychiatric specialists. • eConnect is live with 44 hospital sites representing 18 hospital organizations which capture 50% of L.A. Care inpatient admits. • L.A. Care was one of 59 organizations chosen for Network of Quality Improvement and Innovation Contractors, a CMS $25B initiative to support data-driven health care quality improvement efforts across various settings and programs. The contract is for five years with an option for five more. CMS plans to release task orders in coming months which contractors can bid on. • L.A. Care and First 5 are pursuing a partnership to help medical practices improve child development by implementing screening tools and facilitating access to community resources. • TransformLA offers direct network practices quality improvement support through a tailored coaching model similar to TCPI. The program engaged 7 practices and started active coaching.	Update

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2 High Quality Network

A network that aligns reimbursement with member risk and provider performance to support high quality, cost efficient care.

Goal 2.1

Develop a contracting strategy with rates that support access to high-quality, cost efficient care.

Key Activities			Update
• Conduct pricing analysis for hospital re-contracting efforts. *Lead: Operations/Finance*		• Identified hospital contracts to renegotiate for improved internal operations and external partnerships. Pricing analysis is underway.	
• Define provider network requirements by product. *Lead: Product*		• L.A. Care executed a contract with CVS Minute Clinic to enhance member access to urgent care for all products. • Medi-Cal staff continued to work on business processes to support assignment of Medi-Cal members with complex health needs and who meet established clinical criteria to UCLA primary care physicians under the new contract with UCLA Medical Group. • LACC network expansion include: o Retail clinics/telehealth o UCLA Network o Other strategic expansion • The CMC team closely follows the required network adequacy guidelines for Medicare members, and regularly reviews and submits its adherence to meeting provider guidelines to CMS.	

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	• Analyze and report monthly hospital utilization changes. *Lead: Health Services*		• Overall, hospital utilization has remained controlled. Efforts have been implemented to re-direct elective procedures away from non-contracted hospitals and towards contracted hospitals, when appropriate. An additional initiative has been implemented to assess the appropriateness of hospital sepsis charges.	
Goal 2.2 **Administer benefits at the level that ensures the best outcome, whether through high quality delegated providers or directly.**				
Key Activities	• Optimize oversight of delegated functions. *Lead: Operations/Compliance/HS*		• Compliance has scheduled the Sanctions committee for the rest of the year to review poor delegate performance and hold them accountable. • Ongoing delegate audit readiness to prepare for upcoming regulatory audits.	**Update**
	• Factor VIIP scores into member assignment and network composition. *Lead: Operations, Health Services*		• The VIIP team shared comments with participating IPAs on submitted action plans (improvement efforts on specific performance measures) and established a schedule of dates for ongoing monitoring. • Staff also began reassessing measures and domain weighting for future program enhancements.	

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Goal 2.3

Build foundational capabilities to support expansion of the L.A. Care Direct Network.

Key Activities	• Add primary and specialty providers to the direct network. *Lead: Operations*		• Strategic recruiting in LA County for the Direct Network continues and is incorporated as part of daily operations. • We are continuing to work towards building our infrastructure to ensure there is appropriate support for a countywide Direct Network.	Update
	• Improve administrative and health services support to enable the direct network to scale up. *Lead: Operations, Health Services*		• L.A. Care remains focused on the expansion of the Direct Network, and will focus on scaling and enhancing key Health Service, Finance, and Ops functionality to meet the needs of the growing number of providers contracted directly with L.A. Care.	
	• Convert contracts to capitation when membership reaches an appropriate level. *Lead: Operations*		• A committee has been convened to address all internal business operations (Health Services, Finance, Ops) to support the continued expansion of the Direct Network. As membership assigned to directly contracted PCPs increases, L.A. Care will implement the process necessary to change the reimbursement methodology accordingly.	

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3 Member Centric Care

Member-centric services and care, tailored to the needs of our varied populations.

Goal 3.1

Understand our member needs so we can respond more meaningfully and plan for the future.

Key Activities	• Implement Member360 analytics. *Lead: Operations*		• The Business Needs Assessment has been finalized and communicated with L.A. Care's business stakeholders. Data transformation has been completed, and the team is finalizing input validation analysis with Optum.	Update
	• Develop a view of the member by product segment to assess needs, utilization, and costs *Lead: Product*	(aid codes)	• The Medi-Cal team provided material content and requirements for the Member 360 (member and provider analytics tool) business needs assessment document and provided subject-specific guidance on specific attributes of member enrollment. • The Medi-Cal team is leading a cross functional team in the implementation and operationalization of new Medi-Cal aid codes and changes in existing aid codes that impact the roll up by segment. • The LACC team is developing a baseline through Member360 and member demographic profiling: o "Face of the member"; new membership o Requirements for Member360 o Partner with Risk Adjustment & Health Services to identify the high risk pool and create the applicable programs to encourage appropriate utilization	

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			• The CMC team continues to utilize the Member360 system to better identify medical trends in place. Member data can now be produced by PPG through the medical cost drivers report, which helps to more closely manage member care and cost of care.	

Goal 3.2

Address members' unmet social needs and make care accessible in the right way, at the right place, at the right time.

Key Activities	• Implement care management platform, and integrate with other health services functions over time. *Lead: Health Services*		• Final vendor has been selected and we are currently in the middle of contract negotiations.	Update
	• Implement alternative approaches for urgent care, offsetting ED utilization. *Lead: Health Services*		• Negotiations are still in progress for the final telehealth vendor.	
	• Expand care management at Family Resource Centers (FRCs) *Lead: Health Services*		• New Care Management (CM) nurses have completed onboarding and training and are now beginning work on cases. • Disease Management nurses will undergo cross training for CM in April, and will begin working high/complex CM cases thereafter. • Ongoing activities include: hiring and training of community health workers, operational planning in preparation for launch of field based CM services in two additional FRCs on July 1.	
	• Assess members' social needs that affect health and establish pathways to programs and resources that meet those needs. *Lead: Health Services*		• Developed a Social Determinants of Health (SDoH) work plan that identifies progress of the approved SDoH Strategic Plan milestones. • Communication plan is beginning to be developed in order to inform L.A. Care staff of enterprise-wide social determinants of health priorities.	

Color Indicator Legend

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			• Final vendor candidates have been selected for the community-based resource platform.	

Color Indicator Legend

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Red – Major issues, high risk
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4 Health Leader

Recognized leader in improving health for low income and vulnerable communities.

Goal 4.1

Be a local, state, and national leader to advance health and social services for low income and vulnerable communities.

Key Activities	• Advocate for policies that improve access to care and quality of life for low income communities *Lead: Strategy Council*		• J. Baackes met with Deputy Cabinet Secretary to Governor Newsom, Richard Figueroa. Issues discussed included value of Two Plan Model, L.A. Care as a local initiative, safety net protection, and various L.A. Care Initiatives. • Held 13 state assembly and senate legislative office meetings to update key LA delegation offices with L.A. Care issues and updates (e.g., Two Plan Model, Medi-Cal Pharmacy Carve-out, Elevating the Safety Net Initiative, Housing Initiative, etc.). • Held 17 congressional office visits in DC to discuss key L.A. Care and safety net issues. • Presented at Local Health Plans of California legislative briefing. J. Baackes presented on L.A. Care's Elevating the Safety Net program. Capitol staff, DHCS, Legislative Analyst's Office, and DMHC staff were in attendance at the briefing.	Update
	• Demonstrate the value of a public option *Lead: Strategy Council*		• Actively monitoring the health reform proposals and the role that a public option could play.	

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Red – Major issues, high risk
Blue – Complete

Goal 4.2

Implement initiatives that improve the health and wellbeing of those served by safety net providers.

Key Activities	• Implement the Elevating the Safety Net initiative *Lead: Health Services*		• The Elevating the Safety Net Physician Loan Repayment Program continues to grow with 16 providers awarded to date (4/1/2019) and many others under review for future awards. We are also working on a second grant contract to disburse another $3 million for funding more physicians through the program. • Granted provider groups have hired 28 new providers to their networks. Twenty-five applicants have been received for Cycle 3 and awards will be announced in late May. • Preliminary selection is underway for our second cohort of medical school scholars, four students from UCLA and four students from Charles Drew University. The confirmed list will be available in early to mid-May. • We are also in the final stages of the development of our RFP and application for the Residency Support Program which will fund slots at institutions that have a vested interest in training providers at community health centers. We have identified six institutions that have expressed a strong interest in participating in this program.	Update
	• Launch FRCs (Family Resource Centers) in every RCAC (Regional Community Advisory Committees) *Lead: Strategy Council*		• Initial lease for Metro L.A. location was approved and negotiations for additional space have begun. Plans for Pomona being prepared for submission for city review. Property search in Long Beach has begun. Preparation of new	

Color Indicator Legend

Green – On target, no issues
Yellow – Some issues, probable risks, concerns
Red – Major issues, high risk
Blue – Complete

			occupancy agreement for Boyle Heights including additional space in progress. New letter of interest for relocation of Inglewood location in progress.	
	• Implement Health Homes *Lead: Health Services*		• Multiple activities were held with external stakeholders to raise awareness and educate about the Health Homes launch. Activities include: biweekly webinars, one-one-one calls with potential Community-Based Care Management Entities (CB-CMEs), and the unveiling of a new L.A. Care Health Homes website. Efforts resulted in 41 potential CB-CMEs - the strongest showing of any local health plan. • Partnered with Health Net, Plan Partners, and Molina to streamline CB-CME certification process, including development of a joint application and CB-CME certification review process. Next steps include CB-CME contracting and training. • Continued focus on internal cross-functional collaboration to ensure infrastructure and organizational processes are in place to enable successful program launch on July 1.	

Color Indicator Legend

Green – On target, no issues
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Board of Governors
Executive Community Advisory Committee
Meeting Minutes – March 13, 2019

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

ECAC Members	RCAC Members/Public	L.A. Care Board of Governors/Staff
Russell Mahler, *RCAC 1 Chair* Estela Lara, *RCAC 2 Chair* Cynthia Conteas-Wood, *RCAC 3 Chair* Silvia Poz, *RCAC 4 Chair* Maria Sanchez, *RCAC 5 Chair* Andria McFerson, *RCAC 6 Chair* Fátima Vázquez, *RCAC 7 Chair* Ana Romo, *RCAC 8 Chair* Tonya Byrd, *RCAC 9 Chair* Damares O Hernandez de Cordero, *RCAC 10 Chair* Elda Sevilla, *RCAC 11 Chair* Lluvia Salazar, *At-Large Member* Deaka McClain, *At Large Member* Demetria Saffore, *CCI Area 1 Chair* Wilma Ballew, *CCI Area 2 Chair* Brenda White, *CCI Area 3 Chair* Nesima Istrefi, *CCi Area 4 Chair* * *Excused Absent* **Absent* *** *Via teleconference*	Amanda Calzada, *RCAC 1* Daisy Torres, *RCAC 1* Maricruz Alvarez, *RCAC 2* Micheal Choe, *RCAC 2* Gabriela Quintanilla, *RCAC 5* Romalda Meza, *RCAC 5* Rita Montes, *RCAC 8* Dorothy Lowery, *RCAC 8* Arun Tes Yang, *RCAC 9* Martha Perez, *RCAC 10* Sandra Aramburo, *RCAC 11* Maria Angel Refugio, *RCAC 11* Ismael Maldonado, *CCI Area 2* Elizabeth Cooper, *CCI Area 2* Tina Johnson, *CCI Area 4* Ingrid Arriaga, *Senior Staff Attorney,* *Inner City Law Center* Eduardo Kogan, *Interpreter* Ruth Nuno, *Interpreter* Bo Uce, *Interpreter* Samedy chhum, *Interpreter*	Hilda Pérez, *Member, Board of Governors* Layla Gonzalez-Delgado, *Member Advocate, Board of Governors* John Baackes, *Chief Executive Officer* Hector Andrade, *External Relations Manager, Executive Services* Idalia De La Torre, *Field Specialist Supervisor, CO&E* Auleria Eakins, *Manager, CO&E* Felicia Gray, *Community Outreach Liaison, CO&E* Susan Ma, *CCI Field Specialist, Communication and Community Relations* Francisco Oaxaca, *Senior Director, Communications, Community Education and Outreach* Frank Meza, *Community Outreach Field Specialist, CO&E* Candace Nafissi, *Senior Communication Specialist, Communication and Community Relations* Jose Ricardo Rivas, *Community Outreach Field Specialist, CO&E* Manuel Vizcarra, *Community Outreach Liaison CO&E* Victor Rodriguez, *Board Specialist, Board Services* Malou Balones, *Senior Board Specialist, Board Services* Sylvia Gochuico, *Member Advocate, Customer Solution Center* Gracia Rojas, *Member Advocate, Customer Solution Center*

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
CALL TO ORDER Ana Romo	Ana Romo, *ECAC Chairperson*, called the meeting to order at 10:08 a.m. She reviewed the ECAC meeting guidelines. Elizabeth Cooper, *RCAC 2 Member*, stated that the 1st amendment of the Constitution gives the public the right to speak.	

APPROVE MEETING AGENDA Ana Romo	**The Agenda for today's meeting was approved as submitted.**	**Approved.** **17 AYES (Ballew, Conteas-Wood, Byrd, Hernandez de Cordero, Istrefi, Lara, McClain, McFerson, Mahler, Poz, Romo, Saffore, Salazar, Sanchez, Sevilla, White and Vazquez)**
APPROVE MEETING MINUTES Ana Romo	Estela Lara, *RCAC 2 Chair*, stated that a person from RCAC 2, Socrates Rodriguez, attended the last meeting but is not listed on the February 2019 ECAC meeting minutes. Idalia De La Torre, *Field Specialist Supervisor, CO&E*, responded that only the people who sign in on the public sign in sheet will be listed on the meeting minutes. People can attend the meeting and remain anonymous. Socrates Rodriguez will be included on the meeting minutes. **The meeting minutes for February 13, 2019 were approved, noting the above amendments.**	**Approved.** **16 AYES (Ballew, Conteas-Wood, Byrd, Hernandez de Cordero, Istrefi, Lara, McClain, Mahler, Poz, Romo, Saffore, Salazar, Sanchez, Sevilla, White and Vazquez)** **1 ABSTENTION (McFerson)**
STANDING ITEMS		
ECAC CHAIR REPORT Ana Romo	Ms. Romo presented the following motion for approval: **To recommend the approval of Maria Carmen Gutierrez RCAC 1, Margarita Rodriguez RCAC 5, Socorro Moreno RCAC 10, as members of the Regional Community Advisory Committee (RCAC).**	**Approved.** **17 AYES (Ballew, Conteas-Wood, Byrd, Hernandez de Cordero, Istrefi, Lara, McClain, McFerson, Mahler, Poz, Romo, Saffore, Salazar, Sanchez, Sevilla, White and Vazquez)**

UPDATE FROM THE CHIEF EXECUTIVE OFFICER John Baackes	John Baackes, *Chief Executive Officer,* provided an update on L.A. Care's new transportation vendor, Call the Car. *(A copy of the presentation can be obtained from CO&E department)* **<u>Transition Plan</u>** • For the initial rollout of Call the Car (CTC), L.A. Care targeted Regions 1 and 3, all Cal MediConnect (CMC) members, and discharged patients and transfers across the county. • Members that used Logisticare for transportation were sent two separate letters. o A letter informing them the new vendor is CTC o Another letter informing them that L.A. Care is transitioning from Logisticare. o The letters were sent to all members that used transportation services and this may have caused confusion for our members. • As a result of these letters calls were received from members in all regions, which quickly outpaced call center capacity • L.A. Care has increased its call center staffing and hold times are going down. • Staff will continue to monitor CTC performance and drive the call wait time down. • Staff is actively adjusting staffing and technology to manage the transportation needs of members. CTC is a countywide transportation vendor currently providing transportation services for Care 1st Health Plan members. CTC has been getting test calls and members have provided good reviews. All CMC members have been served by CTC since March 2019. By June 1 all medical transportation services will be provided by CTC. Vehicles will have L.A. Care's branding and logos for easy identification. Ms. Lara thanked Mr. Baackes for his transportation update and asked if it applies only to medical transportation needs. Gracia Rojas, *Member Advocate, Customer Solution Center,* responded that CTC will be providing transportation to appointments for medical care. Special transportation for people who are in a gurney will require a written request from their doctor. Silvia Poz, *RCAC 4 Chair*, stated that she has heard some parents say that their children are having trouble getting transportation to their mental health appointments. Mr. Baackes stated that there shouldn't be any discrimination based on the patient's medical needs. Nesima Istrefi, *CCI Area 4 Chair*, stated she received a letter stating she has a new transportation vendor in Pasadena.	

Mr. Baackes responded that CTC is based in Pasadena and will be providing transportation services to members throughout Los Angeles County.

Andria McFerson, *RCAC 6 Chair,* asked for an example of non-emergency medical transportation.

Ms. Rojas responded that transportation to doctor offices, pharmacies and specialist visits count as non-emergency transportation.

Lluvia Salazar, *At-Large Member* asked if the services will be similar to Access services.

Francisco Oaxaca, *Senior Director, Communications, Community Education and Outreach* responded that Access provides services to certain locations and for certain distances. There is a small charge to use Access. Mr. Baackes stated that L.A. Care does not contract with Access.

Deaka McClain, *At Large Member,* pointed out that Access will also provide transportation to doctor offices.

Ms. Salazar asked a question on behalf of Ms. McClain. Ms. McClain would like to know if it will require a new authorization for CTC even if there is already one in place.

Ms. Rojas responded that if there is an authorization already in place with Logisticare, a new authorization does not need to be submitted or approved unless the patient has a wheelchair or is in a gurney.

Ms. Cooper asked if her comment has to be in regards to transportation.

Ms. De La Torre responded that her question or comment has to be in regards to the CTC presentation. She stated that Ms. Baackes was not finished answering questions from the public about CTC and asked her to wait.

Ms. Cooper stated she will wait for Ms. Baackes to finish so she can ask him a question.

Ismael Maldonado, *CCI Area 2 Member,* stated he went to an appointment at USC Keck Hospital and used Call the Car. The driver did not arrive for over five hours. He also pointed out that a Lyft driver was sent to pick him and the driver did not have the proper etiquette to serve people with disability.

Dorothy Lowery, *RCAC 8 Member,* stated she has a number on the back of her card and would like to know if she can call that number to get transportation. She asked if she needs transportation to a doctor appointment does she require an authorization beforehand.

	Ms. Rojas stated that CTC is going to replace Logisticare. Outpatient services, doctor appointments and pharmacies will also qualify for transportation. Transportation will not be provided to the market or the emergency room. Mr. Baackes noted that he was asked good questions. Ms. Romo asked Mr. Baackes if he had anything else to say. Mr. Baackes responded that he did not.	
COMMUNICATION AND COMMUNITY RELATIONS UPDATE Francisco Oaxaca	Mr. Oaxaca provided the following updates: <u>Sponsorship</u> Care Harbor will be holding a new event at the Pomona County Fairgrounds. L.A. Care is working with event organizers to help with planning. The event will be on April 27-28. More details will be provided as they become available. Mr. Oaxaca added that L.A. Care is establishing its presence in Pomona to coincide with the opening of the new Family Resource Center (FRC) in Pomona. L.A. Care will also participate in the L.A. Times Festival of Books on April 13-14. <u>Red Cross: Sound The Alarm Program</u> L.A. Care is going to partner with the Red Cross to host an event to install smoke detectors in every home in Pacoima. They will be signing up people to get them installed for free at the FRCs in Pacoima and East L.A. People can also sign up using the Red Cross website. <u>Mission Statement</u> A company's mission statement is what defines an organization and helps it achieve its vision. A mission statement is not meant to be all inclusive. L.A. Care's mission statement includes the majority of the members that it serves that includes members who are vulnerable and low income. L.A. Care looks at the mission statement on a three-year cycle. The following presentations will be scheduled in the future for all the RCACs: • Tenants' rights and rights of renters. • The new Step Program which will be conducting new detailed assessments of members needs to help avoid over prescribing and unnecessary medications. • Elevating the Safety Net program, and • A presentation to be given Compliance regarding L.A. Care members' rights have when receiving services at a doctor's office. Ms. McClain thanked Mr. Oaxaca for his report. She clarified that the mission statement conversation started because of the word "vulnerable" being included in the statement. She pointed out that the topic came up during her CCI Council meeting.	

Brenda White, *CCI Area 3 Chair,* stated that the word vulnerable makes her feel uneasy.

Mr. Oaxaca responded that mission and vision statements are revisited and updated as organizations evolve and change, and the Board would like to hear their comments on this issue.

Ms. Lara stated that she and Elda Sevilla, *RCAC 11 Chair,* sent out an email to the Valley Care Community Consortium about Care Harbor in Pomona asking for wristbands for RCAC members. She stated that she and Ms. Sevilla have taken an active stance. She asked Mr. Oaxaca if he can provide information in regard to installation of smoke detectors before the next RCAC 2 meeting in April.

Mr. Oaxaca responded that the information will be provided at a later time before the next RCAC 2 meeting.

Hilda Pérez, *Member, Board of Governors,* asked if members are allowed to attend the Executive Committee on March 25 to share their concerns in regards to the CCI Council restructure and if they will be provided transportation.

Mr. Oaxaca responded that the Executive committee meeting is open to the public and a decision on whether there will be transportation provided to the meeting has not been made.

Ms. McFerson asked if she can get the address to the Care Harbor event in Pomona and she would like to know if the Red Cross would also hold a Sound the Alarm event in the West L.A.

Mr. Oaxaca stated that it is at the Pomona Fairplex. He does not have the address, but it may be held in one of the larger buildings. The Red Cross is testing out this event and there may be other similar events held in other parts of L.A. County.

Mr. Maldonado stated that the month of May is Mental Health Awareness Month. He requested promotional items to pass out at a Mental Health event. He stated that there needs to be more communication between L.A. Care and regional center clients so that L.A. Care can participate in their events.

Ms. Cooper stated that it is not fair that she was not able to ask Mr. Baackes a question after he finished presenting. She would like the record to reflect that she objects to that treatment.

Ms. Lowery asked Mr. Oaxaca to clarify his comments in regards to member's rights.

Mr. Oaxaca responded that Compliance department will be giving a presentation on the rights that members have at their doctors' offices at a future ECAC meeting.

GLOBAL MEMBER ISSUES	Ms. Lara stated that there was a motion passed at RCAC 2 requesting that L.A. Care look into the cost of epilepsy medicine for dually eligible members. A second motion was proposed to ECAC the following month asking L.A. Care to look into reducing Olive View Medical Center wait times. Ms. Istrefi stated that an authorization for electrical wheelchair repairs are very difficult to obtain. When an authorization is finally obtained the process to get the repairs can take several months. Ms. McClain requested that a motion be put forth to have L.A. Care look into the wait time to get electric wheelchair repairs. Layla Gonzalez-Delgado, *Member Advocate, Board of Governors,* suggested that the motion instead request that L.A. Care procure more vendors to shorten the wait times. Ms. De La Torre stated the wording for the motion will be worked on by staff. L.A. Care's internal departments will first look into the global member issue to find ways to address it. If a solution can't be found, a motion can be presented at the following ECAC. Fátima Vázquez, *RCAC 7 Chair,* stated that RCAC 7 members are having difficulty getting referrals for services at Crown City Medical Center. The staff working at the front desk are causing delays in service. Ms. Lara asked if ECAC will be voting on the two motions she presented. Ms. De La Torre stated she will ask Auleria Eakins, *Manager, CO&E,* what the outcome of the motion that RCAC 2 passed before moving forward with a vote. Ms. McFerson stated there was a discussion at RCAC 6 to provide more time for the disabled CCI members who will be joining the RCACs. She added that stipends should be raised for all RCAC members and RCAC Chairs. She noted that the Resource Guide she proposed was approved by the Board. Ms. Cooper stated she would like to request that Legal Counsel be present when she asks a question, because she does not feel her rights are being respected. Tina Johnson, *CCI Area 4,* stated she uses an electric scooter and it is currently in the process of getting the battery fixed. It is taking longer than expected to get it fixed, but it is being addressed by L.A. Care. Elizabeth Rita Montes, *RCAC 8 Member,* stated she took her daughter to the emergency room when she fell and hurt herself. She received two bills for the services that were rendered. One bill was higher because her daughter received services at night. She would like someone to look into this.	

	Ms. De La Torre responded that Ms. Montes will need speak to a Member Advocate with regard to her concerns.	
OLD BUSINESS		
ECAC Ad-Hoc Committee – Meeting Guidelines Idalia De La Torre	Ms. De La Torre reported that the ECAC will hold an Ad-Hoc committee to revisit the ECAC meeting guidelines as requested by the committee. The committee will meet after the Spring Conference. The following members volunteered: Wilma Ballew, Nessima Istrefi, Andria McFerson, Sylvia Poz, and Demetria Saffore.	
NEW BUSINESS		
L.A. Care Tenants' Rights Presentation Ingrid Arriaga, Senior Staff Attorney, Inner City Law Center	Ingrid Arriaga, Senior Staff Attorney, Inner City Law Center, gave a presentation on tenants' rights in Los Angeles County: <u>LEASE AGREEMENTS</u> • Written Lease Agreements–Note: Number of occupants, Pets, Parking spots • Oral Lease Agreement still guarantee tenants' rights • Do not sign anything that you do not understand • Do not sign a substantially different lease agreement renewal <u>HOW TO PAY YOUR RENT</u> • Pay on the first of the month • Never pay in cash • Use a money order and keep stubs • Use personal checks. Make sure there are sufficient funds in your bank account. • Method of Payment: By Certified Mail and if paid in person, ask for receipt • Take a picture of the money order or check and save it on your phone or email before paying. Add the month and year you are paying rent for <u>PETS AND COMPANION ANIMALS</u> If pets are not allowed, a medical documentation that states the tenant needs an emotional support animal can be obtained and presented to the landlord • Notify the landlord in writing and send medical documentation before bringing the pet onto the property • Visit PAWSLA.ORG or reach out to Omar Olivares, PAWS/LA Client Services at 213.741.1950 Extension 106 <u>ADDING NEW TENANTS</u>	

Get written permission from the landlord before a new tenant moves in and get the person added to the lease.

POOR HOUSING CONDITIONS

- Document any request for repairs
- Bug infestation complaints can be made to the Department of Health
- Complaints in regards to other issues can be made with the Department of Building & Safety or the L.A. Housing Department (1-866-577-RENT)

BASIS FOR EVICTION UNDER CALIFORNIA LAW

- Expiration of lease
- Failure to pay rent
- Waste, nuisance, unlawful purpose
- The tenant is served with a 30-day or a 60-day notice to vacate and has lived on the property for more than one year.
- The tenant is served with a 90-day notice and has a section 8 voucher.

LOS ANGELES RENT STABILIZATION ORDINANCE (LARSO)

Properties subject to rent control include properties built within L.A. City Limits, buildings built before October 1, 1978 and properties with two or more dwellings

SIX COMMON REASONS FOR EVICTION UNDER RENT CONTROL

- Failure to pay rent
- A violation of a lawful obligation or covenant and failed to cure that violation
- Committing a nuisance or causing damage
- Refusing reasonable access to unit
- Landlord seeking possession of unit for themselves or family member or a resident manager
- Seeking possession to comply with a government order

SECTION 8 VOUCHERS

- Report all household changes to the housing authority
- Report changes in income and in household
- An eviction is basis to terminate voucher

NOTICE TO PAY RENT OR QUIT

The notice may be served upon the tenant in one of three ways:

- In person
- Leaving a copy with a person of suitable age and sending a copy by mail

- A notice can be left on the tenants' door

WHERE TO GET HELP

- Eviction assistance center: Stanley Mosk Courthouse 111 N. Hill Street 1st floor, Los Angeles, Ca 90012
- Assistance in answering an eviction lawsuit: Legal Aid Foundation of Los Angeles Housing helpline: 800-399-4529. Walk-In for assistance in answering an eviction lawsuit at 1550 W. 8th Street
- L.A. Tenants Union: www.latenantsunion.org
- Eviction Defense Network: 1930 Wilshire Blvd., #208, Los Angeles, CA 90057 213-385-8112

Russell Mahler, *RCAC 1 Chair,* stated his roommate is owed back pay for being over charged and would like to know how she can get her money back. Ms. Arriaga recommended that his roommate file a claim with the L.A. Housing & Community Investment Department.

Ms. Poz asked why Ms. Arriaga's office can't help people who are not under rent control.

Ms. Arriaga responded that her office accepts cases from people who are and are not under rent control. It depends on how the case is referred to her office. Her office has taken cases from residents in Norwalk, Pomona, and Inglewood.

Ms. McFerson asked Ms. Arriaga who is looking into the cases that are not following the law. She stated that judges can evict families and get away with it, because the landlords are wealthy.

Ms. Arriaga responded that it depends on the facts that are presented to the court. She stated that most cases are fought without an attorney. She added that it is an unfair system and people should seek legal advice or legal counsel before going to court.

Ms. McFerson stated that people in her apartment complex were sick, because of mold. Eventually the mold was found and nothing was done about it.

Ms. Arriaga recommended that she seek legal counsel to get assistance with addressing that issue.

Ms. Vasquez asked if her office serves all of L.A. county.

Ms. Arriaga stated that her office serves all of L.A. county, but the individual must have an AIDS diagnosis.

	Ms. Gonzalez -Delgado asked if tenants' who are in Section 8 housing can get evicted during a government shutdown. Ms. Arriaga responded that they can be evicted, because landlords are not being paid. Ms. Johnson stated that there are planks of wood coming up from the floor and they were covered up with a rug, but it did not solve the problem. Ms. Arriaga recommended that she submit her complaints in writing and if it is not addressed she should seek legal counsel. Ms. Cooper asked that the presentation be given to every RCAC. She stated there is not enough cultural sensitivity when it comes to tenants' rights. Ms. De La Torre responded that it is not under L.A. Care's authority to have Ms. Arriaga present at every RCAC and added she will follow up with the agency to check their availability. Ms. Lowery stated she has been an onsite property manager for 20 years and she has always recommended to her tenants that they submit everything in writing and mail it by certified mail to ensure that the landlord receives it. Ms. Arriaga concurred that it is very important to document all issues that the tenant is having with their apartment and submit everything to the landlord as the issues arise.	
FUTURE AGENDA ITEMS	Ms. Gonzalez-Delgado asked if Ms. Obeidi can provide an update on the issues members are having with urgent cares. Ms. De La Torre responded that Ms. Obeidi gives presentations to ECAC quarterly and she will notify them when she is due to give another presentation.	
PUBLIC COMMENTS	Ms. Cooper thanked Ms. Arriaga for her presentation. She stated that she does not think it is fair that her RCAC representative had nothing to say about the way she was treated earlier. Ms. Perez thanked Ms. McFerson for her Black History Month display at RCAC 6. She also thanked Ms. Saffore for her comments and questions in regards to the services she receives in the Antelope Valley. Ms. McFerson thanked Mr. Rivas for recognizing RCAC 6 at their previous meeting. Ms. Vasquez stated that she received a resource book that provides information on the L.A. County Board of Supervisors at the previous Care Harbor clinic.	

	Ms. Eakins stated that Ms. Lara's RCAC 2 motions will be addressed by staff and an update will be provided at the next ECAC meeting. She also reminded the committee about the Spring Conference on Friday March 22.	
ADJOURNMENT	The meeting adjourned at 1:09 pm.	

RESPECTFULLY SUBMITTED BY:
Victor Rodriguez, *Board Specialist, Board Services*
Malou Balones, *Senior Board Specialist, Board Services*
Linda Merkens, *Senior Manager, Board Services*

APPROVED BY Elda Sevilla

ELDA DEVILLA VICE
A~~na Romo~~, *ECAC Chair*
Date 4/10/19

2019 Legislative Matrix

Last Updated: April 22, 2019

Legislative Matrix

The following is a list of the priority legislation currently tracked by Government Affairs that has been introduced during the 2019-2020 Legislative Session and is on interest to L.A. Care. These top priority bills, if passed, could have a direct impact on L.A. Care. If there are any questions, please contact Cherie Compartore, Senior Director of Government Affairs at ccompartore@lacare.org or extension 5481.

Please note, Government Affairs also has a list of all the bills that may not have a direct impact, but do have the possibility to be amended in the future to do so. Some of the bills included are spot bills, legislative place holders, in code sections that could have a policy impact on L.A. Care. If you would like a copy of this list please contact Cherie Compartore.

This year Government Affairs has transitioned to a new legislative tracking system so please feel free to reach out to us with any questions. To access the bill language, click n the bill number listed at the top left corner of each bill section. One of the changes to note is that the bill author is listed as "Primary Sponsor' - the same terminology as is used in Congress. If there is an organizational sponsor for the bill they are listed under "Organizational Notes." Additionally, each bill has a "Description" which is the legal summary of the bill drafted when the bill was written. Some of the bills on the matrix may also have a "Bill Summary," this has been created by staff to simplify or clarify the bill. Lastly, the "Lables" section is used to identify which product area the bill is likely to impact and topic(s) of the bill.

Direct Impact Bills

Bill State: CA (56)

State	Bill Number	Status	Position
CA	**AB 4**	**In Assembly**	**Support**

Title
Medi-Cal: eligibility.

Description
AB 4, as amended, Bonta. Medi-Cal: eligibility. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Federal law prohibits payment to a state for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law.Existing law requires that individuals under 19 years of age enrolled in restricted-scope Medi-Cal at the time the Director of Health Care Services makes a determination that systems have been programmed for implementation of these provisions, provisions to be enrolled in the full scope of Medi-Cal benefits, if otherwise eligible, pursuant to an eligibility and enrollment plan. plan, which includes outreach strategies. Existing law makes the effective date of enrollment for those individuals the same day that systems are operational to begin processing new applications pursuant to the director's determination. determination, and requires the department to seek necessary federal approvals to obtain federal financial participation for purposes of implementing the requirements. Existing law requires the department, until the

Bill Summary: Last edited by Joanne Campbell at Feb 27, 2019, 5:39 PM
Expands Medi-Cal eligibility regardless of immigration status.

Labels: Care4All Medi-Cal

director makes the above-described determination, to provide monthly updates to specified legislative committees on the status of the implementation of these provisions.This bill would additionally extend eligibility for full-scope Medi-Cal benefits to individuals of all ages, if otherwise eligible for those benefits, but for their immigration status. The bill status, and would delete provisions delaying eligibility and enrollment until the director makes the determination described above. The bill would require the department to provide, indefinitely, the above-described monthly updates to the legislative committees. The bill would expand the requirements of the eligibility and enrollment plan, such as ensuring that an individual maintains their primary care provider without disruption to their continuity of care. The bill would require the department to collaborate with the counties and designated public hospitals to maximize federal financial participation, and to work with designated public hospitals to mitigate financial losses related to the implementation of these requirements. Because counties are required to make Medi-Cal eligibility determinations and this bill would expand Medi-Cal eligibility, the bill would impose a state-mandated local program.The California Constitution requires the state to reimburse local agencies and school districts for certain ... (click bill link to see more).

Primary Sponsors
Rob Bonta, David Chiu, Miguel Santiago

Organizational Notes

Last edited by Joanne Campbell at Feb 21, 2019, 6:24 PM
Organizational Sponsor: California Immigrant Policy Center Local Health Plans of California - Support California Association of Health Plans - Support

State	Bill Number	Status	Position
CA	AB 174	In Assembly	Monitor

Labels: Affordability | Care4All | Commercial

Title
Health care coverage: financial assistance.

Description
AB 174, as amended, Wood. Personal income taxes: credits: health insurance premiums. Health care coverage: financial assistance. Existing federal law, the Patient Protection and Affordable Care Act (PPACA), requires each state to establish an American Health Benefit Exchange to facilitate the purchase of qualified health benefit plans by qualified individuals and qualified small employers. PPACA defines a "qualified health plan" as a plan that, among other requirements, provides an essential health benefits package. Existing state law creates the California Health Benefit Exchange, also known as Covered California, to facilitate the enrollment of qualified individuals and qualified small employers in qualified health plans as required under PPACA. Existing law specifies the powers of the Exchange's executive board, including the power to assist in the administration of subsidies for individuals with coverage made available through the Exchange.This bill would require the board to administer enhanced premium assistance to individuals with household incomes below 400% of the federal poverty level, reduce premiums to zero for individuals with household incomes at or below 138% of the federal poverty level, reduce premiums for individuals with household incomes at or between 401% and 800% of the federal poverty level and who are ineligible for federal advanced premium tax credits so their premiums do not exceed a specified percentage of their household incomes, and administer specified additional cost-sharing financial assistance for individuals with household incomes below 400% of the federal poverty level and who are eligible for premium tax credits.The Personal Income Tax Law allows various credits against the taxes imposed by that law.This bill, for each taxable year beginning on or after January 1, 2020, would allow a credit under the Personal Income Tax Law in an amount equal to the cost of health insurance premiums of the lowest cost bronze plan for the qualified individual, certified by the board of Covered California, or the qualified individual's dependent that exceeds 8%, but no more than ____%, of the qualified individual's modified adjusted gross income, as specified. The bill would, for a taxpayer with an allowable credit in excess of tax liability, allow a payment to the taxpayer in excess of that credit amount, upon appropriation by the Legislature, subject to the annual Budget Act or a bill providing for appropriations related to the Budget Act, as provided. The bill would require, on or before January 1, 2024, the Legislative Analyst's Office to report on the number of qualified individuals who claimed the credit, the average and median credit amounts claimed, and the effectiveness of the credit in reducing health car... (click bill link to see more).

Primary Sponsors
Jim Wood

Organizational Notes

Last edited by Joanne Campbell at Mar 28, 2019, 5:09 PM
Local Health Plans of California - Support

State	Bill Number	Status	Position
CA	AB 290	In Assembly	Support

Title
Health care service plans and health insurance: third-party payments.

Description
AB 290, as amended, Wood. Health care service plans and health insurance: third-party payments. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. These provisions govern, among other things, procedures by health care service plans and insurers with respect to premium payments.This bill would require a health care service plan or an insurer that provides a policy of health insurance to accept payments from specified third-party entities, including an Indian tribe or a local, state, or federal government program. The bill would also require a financially interested entity, as defined, other than those entities, that is making a third-party premium payment to provide that assistance in a specified manner and to perform other related duties, including disclosing to the plan or the insurer the name of the enrollee or insured, as applicable, for each plan or policy on whose behalf a third-party premium payment will be made. The bill would require each plan or insurer to provide to the department information regarding premium payments by financially interested entities and reimbursement for services to providers, and would set forth standards governing the reimbursement of financially interested third parties. The bill would not alter existing obligations and requirements applicable to a health care service plan or health insurer relating to offering, marketing, selling, and issuing a health benefit plan, and cancellation or nonrenewal, as specified.Because a willful violation of these requirements by a health care service plan would be a crime, this bill would impose a state-mandated local program.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Jim Wood

Organizational Notes

Last edited by Joanne Campbell at Mar 26, 2019, 7:58 PM
California Association of Health Plans - Support

Bill Summary: Last edited by Joanne Campbell at Mar 11, 2019, 8:50 PM Requires a financially interested entity that is making a third-party premium payment to provide assistance in a specified manner including disclosing to the plan the name of the enrollee for each plan on whose behalf a third-party premium payment will be made.

Labels: Commercial Third Party Payer

State	Bill Number	Status	Position
CA	AB 316	In Assembly	Monitor

Labels: Denti-Cal, Medi-Cal

Title
Medi-Cal: benefits: beneficiaries with special dental care needs.

Description
AB 316, as amended, Ramos. Medi-Cal: benefits: beneficiaries with special dental care needs. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law provides for a schedule of benefits under the Medi-Cal program, including certain dental services, and dental managed care plans.This bill would require the department to implement a special needs treatment and management benefit, which benefit that would be provided for 4 visits in a 12-month period for a Medi-Cal dental program beneficiary with special dental care needs, as defined. The bill would require a Medi-Cal dental program provider to document specified information, including the need for additional time to treat a Medi-Cal dental program beneficiary with special dental care needs. needs, for purposes of reimbursement. The bill would not limit the provision or scope of Medi-Cal benefits covered under existing law. The bill would require the department to seek any necessary approvals from the federal Centers for Medicare and Medicaid Services to implement the bill. The bill would authorize the department to implement these provisions, by means of all-county letters, plan letters, various means, including plan or provider bulletins, or similar instructions, without taking regulatory action, and would require the department department, by July 1, 2022, to subsequently adopt regulations, as specified, by July 1, 2022. regulations. The bill would require the department, commencing January 1, 2020, to provide the Legislature with semiannual status reports to the Legislature until regulations have been adopted.

Primary Sponsors
James Ramos, Robert Rivas

Organizational Notes

Last edited by Joanne Campbell at Mar 26, 2019, 7:33 PM
Organizational Sponsor: West Health Institute

State	Bill Number	Status	Position
CA	**AB 318**	**In Assembly**	**Monitor**

Labels translation

Title
Medi-Cal materials: readability.

Description
AB 318, as amended, Chu. Medi-Cal materials: readability. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.Existing law requires the department to notify Medi-Cal beneficiaries, prospective beneficiaries, and members of the public of the availability of language assistance services free of charge and in a timely manner, when those services are necessary to provide meaningful access to individuals with limited English proficiency (LEP). Existing law requires the department to require all managed care plans contracting with the department to provide Medi-Cal services to provide language assistance services to LEP Medi-Cal beneficiaries who are mandatorily enrolled in managed care.This bill would require the department and managed care plans, commencing January 1, 2020, to require field testing of all translated materials released by the department or the managed care plans, respectively, to Medi-Cal beneficiaries, except as specified. The bill would define "field testing" as a review of translations for accuracy, cultural appropriateness, and readability. The bill would also define a "managed care plan" for these purposes. The bill would also require the department to establish a readability workgroup to identify at least 10 documents that are released to Medi-Cal beneficiaries, including certain documents, and to designate a readability expert to revise those documents, as specified. The bill would require the readability expert and workgroup to provide the department with specific recommendations for revising the selected documents to improve the readability of the documents. The bill would require the department to rerelease the documents with revisions based on those recommendations, and would require the translation and field testing of those documents. The bill would require the implementation of these provisions no later than January 1, 2021.

Primary Sponsors
Kansen Chu

Organizational Notes

Last edited by Joanne Campbell at Mar 26, 2019, 7:40 PM
Organizational Sponsor: California Pan-Ethnic Health Network and Western Center on Law & Poverty Local Health Plans of California - Oppose California Association of Health Plans - Oppose

State	Bill Number	Status	Position
CA	AB 319	In Assembly	Monitor

Labels: Behavioral Health | MAT | Medi-Cal | Pharmacy

Title
Narcotic treatment: medication-assisted treatment: Drug Medi-Cal.

Description
AB 319, as amended, Blanca Rubio. Narcotic treatment: medication-assisted treatment. treatment: Drug Medi-Cal. Existing law requires the State Department of Health Care Services to license narcotic treatment programs to use narcotic replacement therapy and medication-assisted treatment in the treatment of addicted persons. Existing law specifies the medications a licensed narcotic treatment program may use for narcotic replacement therapy and medication-assisted treatment by licensed narcotic treatment programs.Existing law establishes the Medi-Cal program, administered by the State Department of Health Care Services and under which qualified low-income persons receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law establishes the Drug Medi-Cal Treatment Program (Drug Medi-Cal), under which the department is authorized to enter into contracts with each county, or enter into contracts directly with certified providers, for the provision of various alcohol and drug use treatment services to Medi-Cal beneficiaries. Existing law limits reimbursement for narcotic treatment program services to services specified in state and federal regulations governing the licensing and administration of narcotic treatment programs, as specified.This bill would require the department to create reimbursement rates and rate billing codes for use by authorized medications that are provided by licensed narcotic treatment programs providing medication-assisted treatment using electing to provide noncontrolled medications approved by the United States Food and Drug Administration for patients with a substance use disorder.

Primary Sponsors
Blanca Rubio, Marie Waldron

State	Bill Number	Status	Position
CA	AB 341	In Assembly	Monitor

Title
CalHEERS: application for CalFresh.

Description
AB 341, as amended, Maienschein. CalHEERS: application for CalFresh. Existing federal law provides for the federal Supplemental Nutrition Assistance Program (SNAP), known in California as CalFresh, under which supplemental nutrition assistance benefits allocated to the state by the federal government are distributed to eligible individuals by each county. Existing law requires the eligibility of households to be determined to the extent permitted by federal law. Existing law, if a county has entered into a memorandum of understanding, requires the county to determine CalFresh program eligibility for children whose information is shared with the county on the National School Lunch Program application and to treat that application as an application for CalFresh if the pupil is not already enrolled in CalFresh.Existing law, the Health Care Reform Eligibility, Enrollment, and Retention

Bill Summary: Last edited by Joanne Campbell at Mar 11, 2019, 8:55 PM
Requires applicant information from the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS) used at Covered California to be transferred to the county CalFresh systems for eligibility determinations for the CalFresh food program.

Labels:

Planning Act, requires the State Department of Health Care Services to develop a single, accessible, standardized electronic application for insurance affordability programs, now known as the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS), and would require, if CalHEERS has the ability to prepopulate an application form for insurance affordability programs with personal information from available electronic databases, an applicant to be given the option, with his or her their informed consent, to have the application form prepopulated.Existing law establishes the Office of Systems Integration within the California Health and Human Services Agency and specifies the duties of that office, including implementing a statewide automated welfare system.This bill would require the Office of Systems Integration to ensure that CalHEERS transfers an individual's individual's application for health care benefits that is processed by CalHEERS to the county of residence of the individual if that individual is determined by CalHEERS to be potentially eligible for CalFresh benefits and the individual opts into applying for CalFresh benefits, as specified. The bill would require the office to collaborate with the State Department of Social Services to ensure that the application transferred via CalHEERS to a county for purposes of treatment as a CalFresh application meets all state and federal requirements necessary to qualify as a CalFresh application. The bill would require the county, upon receipt of the application received from CalHEERS, to treat the application as an application for CalFresh benefits and to process the application, as specified. To the extent that the bill would impose new duties on counties, the bill would impose a state-mandated local program. The bill would also require the department to issue guidance to county... (click bill link to see more).

Primary Sponsors
Brian Maienschein

Organizational Notes

Last edited by Joanne Campbell at Mar 11, 2019, 8:55 PM
Organizational Sponsor: Coalition of California Welfare Rights Organizations (CCWRO)

State	Bill Number	Status	Position
CA	AB 384	In Assembly	Monitor

Labels: Data Privacy

Title
Information privacy: digital health feedback systems.

Description
AB 384, as introduced, Chau. Information privacy: digital health feedback systems. Existing law, the Confidentiality of Medical Information Act, generally prohibits a provider of health care, a health care service plan, or a contractor from disclosing medical information regarding a patient of the provider of health care or an enrollee or subscriber of a health care service plan without first obtaining an authorization, except as otherwise specified. Existing law defines "medical information" for purposes of these provisions to mean certain individually identifiable health information in possession of or derived from a provider of health care, among others. Existing law makes a violation of these provisions that results in economic loss or personal injury to a patient punishable as a misdemeanor.This bill would expand the definition of "medical information" for purposes of the act to include any information in possession of, or derived from, a digital health feedback system, which the bill would define. The bill would also require a manufacturer or operator that sells or offers to sell a device or software application that may be used with a digital health feedback system to a consumer in California to equip the device or software application, and the system, with reasonable security features that meet certain requirements, including that the measures be appropriate to the nature of the device, software application, or system. Because this bill would expand the definition of a crime, it would impose a state-mandated local program. The bill would make other related conforming changes.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Ed Chau

State	Bill Number	Status	Position
CA	AB 385	In Assembly	Monitor

Labels: Behavioral Health | EPSDT | Medi-Cal

Title

Medi-Cal: Early and Periodic Screening, Diagnosis, and Treatment mental health services: performance outcome system platform.

Description

AB 385, as introduced, Calderon. Medi-Cal: Early and Periodic Screening, Diagnosis, and Treatment mental health services: performance outcome system platform. Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive healthcare services, including Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services for an individual under 21 years of age. The Medi-Cal program is, in part, governed by, and funded pursuant to, federal Medicaid Program provisions. Existing law requires the department, in collaboration with the California Health and Human Services Agency and in consultation with the Mental Health Services Oversight and Accountability Commission, to create a plan for a performance outcome system for EPSDT mental health services, as specified.This bill would require the department to develop a platform, or integrate with an existing platform, to support the performance outcome system that will improve outcomes at the individual and system levels and will inform fiscal decision making related to the purchase of services. The bill would require the platform to, at a minimum, be capable of automating the collection of the required data, provide for secure access via a web-based system, and allow authorized individuals to complete the data collection and to retrieve up-to-date customized multi-rater reports.

Primary Sponsors

Ian Calderon

State	Bill Number	Status	Position
CA	AB 414	In Assembly	Monitor

Title
Healthcare coverage: minimum essential coverage.

Description
AB 414, as introduced, Bonta. Healthcare coverage: minimum essential coverage. Existing law establishes the Medi-Cal program, administered by the State Department of Health Care Services and under which healthcare services are provided to qualified, low-income persons. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions. Existing law provides for the regulation of health care service plans by the Department of Managed Health Care and health insurers by the Department of Insurance. Existing law establishes the California Health Benefit Exchange (Exchange), also known as Covered California, for the purpose of facilitating the purchase of qualified health plans by qualified individuals and qualified small employers.Existing federal law, the Patient Protection and Affordable Care Act (PPACA), enacts various healthcare coverage market reforms as of January 1, 2014. PPACA generally requires individuals, and any dependents of the individual, to maintain minimum essential coverage, as defined, and, if an individual fails to maintain minimum essential coverage, PPACA imposes on the individual taxpayer a penalty. This provision is referred to as the individual mandate.This bill would require a California resident to ensure that the resident and the resident's dependents are covered under minimum essential coverage for each month beginning after 2019. The bill would impose a penalty for the failure to maintain minimum essential coverage. The bill would require the Exchange to determine the penalty, if any, for a resident and would require the Franchise Tax Board to collect the penalty. The bill would require the Exchange to determine whether to grant a certification that a resident is exempt from the requirement to maintain minimum essential coverage, the penalty, or both, and would require the Exchange to notify the resident and the Franchise Tax Board of its determination.The bill would also establish the Health Care Coverage Penalty Fund, into which moneys collected from the above-described penalty would be deposited. Subject to an appropriation by the Legislature, the bill would require that moneys in the fund be used to improve the affordability of healthcare coverage for Californians.

Primary Sponsors
Rob Bonta

Bill Summary: Last edited by Joanne Campbell at Mar 7, 2019, 11:10 PM
Requires a California resident to ensure that the resident and the resident's dependents are covered under minimum essential coverage for each month beginning after 2019. The bill would impose a penalty for the failure to maintain minimum essential coverage.

Labels: Care4All | Commercial | Individual Mandate

State	Bill Number	Status	Position
CA	AB 537	In Assembly	Monitor

Title
Medi-Cal managed care: quality improvement and value-based financial incentive program.

Description
AB 537, as introduced, Wood. Medi-Cal managed care: quality improvement and value-based financial incentive program. Existing law establishes the Medi-Cal program, administered by the State Department of Health Care Services and under which health care services are provided to qualified, low-income persons. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under existing law, one of the methods by which Medi-Cal services are provided is pursuant to contracts with various types of managed care health plans, including through a county organized health system and geographic managed care.This bill would require, commencing January 1, 2022, a Medi-Cal managed care plan to meet a minimum performance level (MPL) that improves the quality of health care and reduces health disparities for enrollees, as specified. The bill would require the department to establish both a quality assessment and performance improvement program and a value-based financial incentive program to ensure that a Med-Cal managed care plan achieves an MPL. The bill would, among other things, require the department to establish a public stakeholder process in the planning, development, and ongoing oversight of the programs. The bill would require the department to annually and publicly report the results of the quality assessment and performance improvement program on the department's internet website. The bill would require the department to utilize the results of the quality improvement and value-based financial incentive program to inform a publicly reported Quality Rating System for Medi-Cal managed care plans, subject to federal approval.

Primary Sponsors
Jim Wood

Organizational Notes

Last edited by Joanne Campbell at Mar 26, 2019, 7:41 PM
Organizational Sponsor: California Pan-Ethnic Health Network and Western Center on Law & Poverty

Bill Summary: Last edited by Joanne Campbell at Mar 28, 2019, 8:39 PM Adds WIC Section 14310.1 and contains the following key provisions: i. Requires the Department to establish a quality assessment and performance improvement program. ii. Requires managed care plans to meet a specified MPL by January 1, 2022 that is developed by the Department and which improves quality and decreases disparities. iii. When creating and establishing the MPL, the Department must consult with stakeholders and consider the performance of various other products in California and national performance of Medicaid plans. iv. Requires the Department to establish quality improvement performance targets that improve quality of care and reduce disparities. Permits financial incentive payments to plans that meet performance targets. v. Requires plans to annually collect and report data based on established measures to be applied to the MPL and performance targets. vi. Requires the Department to provide validated translations of the CAHPS survey in all threshold languages and requires the Department to deem CAHPS survey data for NCQA accredited plans if the data meets specified requirements. vii. Requires the Department to develop a value-based financial incentive program to reward plans that meet targets. viii. Requires annual public reporting by the Department on plan performance.

Labels: Medi-Cal Quality

State	Bill Number	Status	Position
CA	AB 577	In Assembly	Monitor

Title
Medi-Cal: maternal mental health.

Description
AB 577, as amended, Eggman. Medi-Cal: maternal mental health. Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive healthcare health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under existing law, an individual is eligible for Medi-Cal benefits, to the extent required by federal law, as though the individual was pregnant, for all pregnancy-related and postpartum services for a 60-day period beginning on the last day of pregnancy. This bill would extend Medi-Cal postpartum care for up to one year beginning on the last day of the pregnancy for an eligible individual eligibility for a pregnant individual who is receiving health care coverage under the Medi-Cal program, or another specified program, and who has been diagnosed with a maternal mental health condition. condition, for a period of one year following the last day of the individual's pregnancy if the individual complies with certain requirements. The bill would define maternal "maternal mental health condition condition" for purposes of the bill. bill.

Primary Sponsors
Susan Eggman, Anthony Portantino

Bill Summary: Last edited by Joanne Campbell at Mar 8, 2019, 5:27 PM
This bill would extend Medi-Cal postpartum coverage from 60 days to one-year. The bill specifically: Amends WIC Section 14005.18 to extend postpartum Medi-Cal eligibility from 60 days to up to one year for individuals diagnosed with a maternal mental health condition (definition includes, but is not limited to, postpartum depression).

Labels: Behavioral Health

State	Bill Number	Status	Position
CA	AB 598	In Assembly	Monitor

Title
Hearing aids: minors.

Description
AB 598, as introduced, Bloom. Hearing aids: minors. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law requires health care service plan contracts and health insurance policies to provide coverage for specified benefits.This bill would require a health care service plan contract or a health insurance policy issued, amended, or renewed on or after January 1, 2020, to include coverage for hearing aids, as defined, for an enrollee or insured under 18 years of age, as specified. Because a willful violation of these requirements by a health care service plan would be a crime, this bill would impose a state-mandated local program. The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Richard Bloom

Bill Summary: Last edited by Joanne Campbell at Mar 11, 2019, 9:00 PM
Mandates coverage for a hearing aid for individuals up to 18 years of age beginning January 1, 2020.

Labels: Commercial, Medi-Cal

State	Bill Number	Status	Position
CA	AB 648	In Assembly	Monitor

Labels: Commercial, Data, Medi-Cal

Title
Wellness programs.

Description
AB 648, as amended, Nazarian. Wellness programs. (1) Existing federal law, the federal Patient Protection and Affordable Care Act (PPACA), enacted various health care coverage market reforms that took effect January 1, 2014. Among other things, PPACA sets forth various requirements related to wellness programs, which encompass programs of health promotion or disease prevention.Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care (department) and makes a willful violation of the act a crime. Existing law also provides for the regulation of various insurers by the Department of Insurance, headed by the Insurance Commissioner. Existing law authorizes the director of the department and the commissioner to adopt regulations for purposes of implementing various provisions of law, as specified.This bill would, among other things, would prohibit health care service plans and insurers from offering an incentive or reward to an enrollee or member, or insured ("individual"), based on adherence to sharing any personal information or data collected through a wellness program, and would prohibit health care service plans or insurers from taking any adverse action, as defined, against an enrollee or member, or insured ("individual"), if

the action of the health care service plans or insurers is in response to a matter related to a wellness program, such as an individual's election to not participate in a wellness program. The bill would establish and impose upon health care service plans and insurers various requirements related to a wellness programs, such as requiring a health care service plan or insurer to provide an individual information concerning its policies and practices pertaining to wellness programs, as specified. The bill would require a health care service plan or insurer, for purposes of administering and operating a wellness program, to limit its collection, dissemination, retention, and use of any personal information of an individual to only information that is reasonably necessary to operate a wellness program, and would extend various requirements, to the extent that they are applicable, to any entity that the health care service plan or insurer contracts with for purposes of administering or operating a wellness program on their behalf. The bill would authorize the commissioner to assess penalties on an insurer for any violation of these provisions, as specified. The bill would authorize the director and commissioner to adopt regulations to conform to federal law in the event that the provisions conflict with federal law.Because a willful violation of these requirements relative to health care s... (click bill link to see more).

Primary Sponsors
Adrin Nazarian

Organizational Notes

Last edited by Joanne Campbell at Mar 26, 2019, 7:22 PM
Organizational Sponsor: Consumer Reports California Association of Health Plans - Oppose

State	Bill Number	Status	Position
CA	AB 651	In Assembly	Monitor

Title
Air ambulance services.

Description
AB 651, as amended, Grayson. Air ambulance services. (1) Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law requires that health care service plans plan contracts and health insurance policies, as specified, policies provide coverage for certain services and treatments, including emergency medical transportation services.This bill would require a health care service plan contract or a health insurance policy issued, amended, or renewed on or after January 1, 2020, to provide that if an enrollee, insured, or subscriber, as applicable, subscriber (individual) receives covered services from a noncontracting air ambulance provider, the enrollee, insured, or subscriber individual shall pay no more than the same cost sharing that the enrollee, insured, or subscriber individual would pay for the same covered services received from a contracting air ambulance provider, referred to as the in-network cost-sharing amount. The bill would specify provide that an enrollee, subscriber, or insured individual would not owe the noncontracting provider more than the in-network cost-sharing amount for services subject to the bill, as specified. services. The bill would allow authorize a noncontracting provider to advance to collections only the in-network cost-sharing amount, as determined by the health care service plan or insurer, that the enrollee, insured, or subscriber amount that the individual has failed to pay. The bill would authorize a health care service plan, health insurer, or provider to seek relief in any court for the purpose of resolving a payment dispute, and would not prohibit a provider from using a health care service plan's or health insurer's existing dispute resolution processes. Because a willful violation of the bill's requirements relative to health care service plans would be a crime, the bill would impose a state-mandated local program. (2) Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive healthcare services. health care services, including medical transportation services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law authorizes the Director of Health Care Services to limit rates of payment for health care services, and requires the director to adopt regulations as are necessary for carrying out these provisions. Existing regulations provide for the maxim... (click bill link to see more).

Primary Sponsors
Tim Grayson

Bill Summary: Last edited by Joanne Campbell at Feb 19, 2019, 9:13 PM
Limits a health plan enrollee out of network air ambulance costs to an enrollee's out of pocket expenses for in-network providers. Also includes language regarding the Medi-Cal rate setting for air ambulance services.

Labels: Commercial Medi-Cal

Organizational Notes

Last edited by Joanne Campbell at Mar 11, 2019, 10:15 PM
Organizational Sponsor: California Association of Air Medical Services (Cal-AAMS) California Association of Health Plans - Support

State	Bill Number	Status	Position
CA	AB 678	In Assembly	Monitor

Title
Medi-Cal: podiatric services.

Description
AB 678, as amended, Flora. Medi-Cal: podiatric services. Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law excludes certain optional Medi-Cal benefits, including, among others, podiatric services and chiropractic services, from coverage under the Medi-Cal program, except for specified beneficiaries.This bill would provide that the exclusion of podiatric services is effective only through December 31, 2019, and would restore podiatric services as a covered benefit of the Medi-Cal program as of January 1, 2020, or the effective date of federal approvals as specified.Existing law provides that prior authorization for podiatric services provided on an outpatient or inpatient basis is not required if specified conditions are met, including an urgent or emergency need for services at the time of service.This bill would repeal these provisions, and would instead prohibit the requirement of prior authorization for podiatric services provided by a doctor of podiatric medicine if a physician and surgeon rendering the same services would not be required to provide prior authorization. The bill would clarify that a doctor of podiatric medicine acting within their scope of practice and providing specified services is subject to the same Medi-Cal billing and services policies as required for a physician and surgeon. surgeon, including a maximum numerical service limitation in any one calendar month.

Primary Sponsors
Heath Flora

Organizational Notes

Last edited by Joanne Campbell at Mar 26, 2019, 7:33 PM
Organizational Sponsor: California Podiatric Medical Association

Bill Summary: Last edited by Joanne Campbell at Feb 19, 2019, 9:14 PM
Provides that the exclusion of podiatric services is effective only through December 31, 2019, and would restore podiatric services as a covered benefit of the Medi-Cal program as of January 1, 2020, or the effective date of federal approvals as specified.

Labels: Medi-Cal

State	Bill Number	Status	Position
CA	AB 714	In Assembly	Monitor

Title
Opioid prescription drugs: prescribers.

Description
AB 714, as amended, Wood. Opioid prescription drugs: prescribers. Existing law requires a prescriber, as defined, to offer to a patient a prescription for naloxone hydrochloride or another drug approved by the United States Food and Drug Administration for the complete or partial reversal of opioid depression when certain conditions are present, including if the patient presents with an increased risk for overdose or a history of substance use disorder, and to provide education on overdose prevention to patients receiving a prescription and specified other persons. This bill would make those provisions applicable only to a patient receiving a prescription for an opioid or benzodiazepine medication, and would make the provisions specific to opioid-induced respiratory depression, opioid overdose, opioid use disorder, and opioid overdose prevention, as specified. The bill bill, among other exclusions, would exclude from the above-specified provisions requiring prescribers to offer a prescription and provide education prescribers when prescribing, ordering, or administering ordering medications to be administered to a patient in an inpatient health facility and prescribers prescribing to a patient in outpatient-based hospice care. or outpatient setting. The bill would define terms for purposes of those provisions.This bill would declare that it is to take effect immediately as an urgency statute.

Primary Sponsors
Jim Wood

Bill Summary: Last edited by Joanne Campbell at Feb 20, 2019, 6:45 PM Current law requires a prescriber to offer to a patient a prescription for naloxone hydrochloride or another drug approved by the United States Food and Drug Administration for the complete or partial reversal of opioid depression when certain conditions are present. This bill would make those provisions applicable only to a patient receiving a prescription for an opioid or benzodiazepine medication, and would make the provisions specific to opioid-induced respiratory depression, opioid overdose, opioid use disorder, and opioid overdose prevention.

Labels: Behavioral Health, Commercial, Medi-Cal, Opioids, Pharmacy

State	Bill Number	Status	Position
CA	AB 715	In Assembly	Support

Title
Medi-Cal: program for aged and disabled persons.

Description
AB 715, as introduced, Wood. Medi-Cal: program for aged and disabled persons. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive healthcare services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law requires the department to exercise its option under federal law to implement a program for aged and disabled persons, as described. Existing law requires an individual under these provisions to satisfy certain financial eligibility requirements, including, among other things, that the individual's countable income does not exceed an income standard equal to 100% of the applicable federal poverty level, plus an income disregard of $230 for an individual, or $310 in the case of a couple, except that the income standard determined shall not be less than the SSI/SSP payment level for a disabled individual or couple, as applicable. Existing law requires the department to implement this program by means of all-county letters or similar instructions without taking regulatory action and thereafter requires the department to adopt regulations.This bill

Bill Summary: Last edited by Joanne Campbell at Feb 20, 2019, 6:46 PM Requires, upon receipt of federal approval, all countable income over 100% of the federal poverty level, up to 138% of the federal poverty level, to be disregarded, after taking all other disregards, deductions, and exclusions into account for those persons eligible under the program for aged and disabled persons.

Labels:

would instead require, upon receipt of federal approval, all countable income over 100% of the federal poverty level, up to 138% of the federal poverty level, to be disregarded, after taking all other disregards, deductions, and exclusions into account for those persons eligible under the program for aged and disabled persons. The bill would require that provision to be implemented after the Director of Health Care Services determines, and communicates that determination in writing to the Department of Finance, that systems have been programmed for implementation of that provision, but no sooner than January 1, 2020.The bill would require the department to implement, interpret, or make specific the above-described program for aged and disabled persons by means of all-county letters, plan or provider bulletins, or similar instructions until regulations are adopted, and would require the department to adopt regulations by July 1, 2023. The bill would require the department to provide a status report on a semiannual basis to the Legislature until regulations are adopted. The bill would require the implementation of the program only if and to the extent that any necessary federal approvals have been obtained.Because counties are required to make Medi-Cal eligibility determinations, and this bill would expand Medi-Cal eligibility by increasing the income disregard amounts and would increase the responsibility of counties in determining Medi-Cal eligibility, the bill would impose a state-mandated local program.The California Cons... (click bill link to see more).

Primary Sponsors
Jim Wood, Melissa Hurtado

Organizational Notes

Last edited by Joanne Campbell at Mar 8, 2019, 4:54 PM
Organizational Sponsor: Western Center on Law and Poverty, Disability Rights, Justice and Aging Local Health Plans of California - Support California Association of Health Plans - Support

State	Bill Number	Status	Position
CA	AB 744	In Assembly	Monitor

Title
Healthcare coverage: telehealth.

Description
AB 744, as introduced, Aguiar-Curry. Healthcare coverage: telehealth. Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive healthcare services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under existing law, face-to-face contact between a health care provider and a patient is not required under the Medi-Cal program for teleophthalmology, teledermatology, and teledentistry by store and forward. Existing law requires a Medi-Cal patient receiving teleophthalmology, teledermatology, or teledentistry by store and forward to be notified of the right to receive interactive communication with a distant specialist physician, optometrist, or dentist, and authorizes a patient to request that interactive communication.This bill would delete those interactive communication provisions.Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law prohibits a health care service plan or health insurer from requiring that in-person contact occur between a healthcare provider and a patient, and from limiting the type of setting where services are provided, before payment is made for covered services provided appropriately through telehealth services.This bill would require a contract issued, amended, or renewed on or after January 1, 2020, between a health care service plan and a healthcare provider for the provision of healthcare services to an enrollee or subscriber, or a contract issued, amended, or renewed on or after January 1, 2020, between a health insurer and a healthcare provider for an alternative rate of payment to specify that the health care service plan or health insurer reimburse a healthcare provider for the diagnosis, consultation, or treatment of an enrollee, subscriber, insured, or policyholder delivered through telehealth services on the same basis and to the same extent that the health care service plan or health insurer is responsible for reimbursement for the same service through in-person diagnosis, consultation, or treatment. The bill would authorize a health care service plan or health insurer to offer a contract or policy containing a deductible, copayment, or coinsurance requirement for a healthcare service delivered through telehealth services, subject to specified limitations. The bill would prohibit a health care service plan contract or policy or health insurance issued, amended, or ren... (click bill link to see more).

Primary Sponsors
Cecilia Aguiar-Curry

Organizational Notes

Last edited by Joanne Campbell at Mar 11, 2019, 9:01 PM
Organizational Sponsor: CA Medical Association (CMA)

Bill Summary: Last edited by Joanne Campbell at Feb 20, 2019, 6:49 PM Requires a contract between a health care service plan and a healthcare provider for the provision of healthcare services to an enrollee for an alternative rate of payment to specify that the plan reimburse a healthcare provider for the diagnosis, consultation, or treatment delivered through telehealth services on the same basis and to the same extent that the health care service plan is responsible for reimbursement for the same service through in-person diagnosis, consultation, or treatment. The bill authorizes a plan to offer a contract or policy containing a deductible, copayment, or coinsurance requirement for a healthcare service delivered through telehealth services, subject to specified limitations. The bill would prohibit a health care service plan contract from imposing an annual or lifetime dollar maximum for telehealth services, and would prohibit those contracts and policies from imposing a deductible, copayment, or coinsurance, or a plan year, calendar year, lifetime, or other durational benefit limitation or maximum for benefits or services that is not equally imposed on all terms and services covered under the contract.

Labels: Commercial | Medi-Cal | Telehealth

State	Bill Number	Status	Position
CA	AB 767	In Assembly	Monitor

Title
Health care coverage: infertility.

Description
AB 767, as amended, Wicks. Healthcare Health care coverage: infertility. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, 1975 (Knox-Keene Act), provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law imposes various requirements and restrictions on health care service plans and health insurers, including, among other things, a requirement that every group health care service plan contract or health insurance policy that is issued, amended, or renewed on or after January 1, 1990, offers coverage for the treatment of infertility, except in vitro fertilization, under those terms and conditions as may be agreed upon between the group subscriber or the group policyholder and the health care service plans or the health insurers. The Knox-Keene Act specifies that a health care service plan that is a health maintenance organization (HMO) is required to provide this coverage to a group contractholder with at least 20 employees. Existing law provides that any employer that is a religious organization or health care service plans and health insurers which are a subsidiary of an entity whose owner or corporate member is a religious organization shall not be required to offer coverage for forms of treatment of infertility in a manner inconsistent with the religious organization's religious and ethical principles, as specified.This bill would require every all health care service plan contract contracts, including every HMO contract, or health insurance policy that is issued, amended, or renewed on or after January 1, 2020, to provide coverage for in vitro fertilization, as a treatment of infertility, and mature oocyte cryopreservation. The bill would delete the exemption for religiously affiliated employers, health care service plans, and health insurance policies, from the requirements relating to coverage for the treatment of infertility, thereby imposing these requirements on these employers, plans, and policies. The bill would also delete the requirement that a health care service plan contract and health insurance policy provide infertility treatment under agreed upon terms that are communicated to all group contractholders and prospective group contractholders. By expanding the duties of health care service plans, the bill would expand the scope of an existing crime, thereby imposing a state-mandated local program.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that r... (click bill link to see more).

Primary Sponsors
Buffy Wicks, Autumn Burke, Evan Low, Henry Stern

Organizational Notes

Last edited by Joanne Campbell at Mar 11, 2019, 9:02 PM
Organizational Sponsor: Equality California and Planned Parenthood

Bill Summary: Last edited by Joanne Campbell at Feb 20, 2019, 6:50 PM
Requires health care service plan contract to provide coverage for in vitro fertilization, as a treatment of infertility, and mature oocyte cryopreservation. The bill would delete the exemption for health care service plans from the requirements relating to coverage for the treatment of infertility.

Labels: Commercial | Mandate | Medi-Ca

State	Bill Number	Status	Position
CA	AB 769	In Assembly	Monitor

Labels: Commercial FQHC Medi-Cal Scope

Title
Federally qualified health centers and rural health clinics: licensed professional clinical counselor.

Description
AB 769, as introduced, Smith. Federally qualified health centers and rural health clinics: licensed professional clinical counselor. Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive healthcare services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law provides that federally qualified health center (FQHC) services and rural health clinic (RHC) services, as defined, are covered benefits under the Medi-Cal program, to be reimbursed, to the extent that federal financial participation is obtained, to providers on a per-visit basis. "Visit" is defined as a face-to-face encounter between a patient of an FQHC or RHC and specified health care professionals. Existing law allows an FQHC or RHC to apply for an adjustment to its per-visit rate based on a change in the scope of service it provides.This bill would additionally include a licensed professional clinical counselor within those health care professionals covered under that definition. The bill would require an FQHC or RHC that currently includes the cost of the services of a licensed professional clinical counselor for the purposes of establishing its FQHC or RHC rate to apply to the department for an adjustment to its per-visit rate, and, after the rate adjustment has been approved by the department, would require the FQHC or RHC to bill for these services as a separate visit, as specified. The bill would require an FQHC or RHC that does not provide the services of a licensed professional clinical counselor, and later elects to add this service and bill these services as a separate visit, to process the addition of these services as a change in scope of service.

Primary Sponsors
Christy Smith

State	Bill Number	Status	Position
CA	AB 770	In Assembly	Monitor

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

Description
AB 770, as introduced, Eduardo Garcia. Medi-Cal: federally qualified health clinics: rural health clinics. Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law provides that federally qualified health center (FQHC) services and rural health clinic (RHC) services, as defined, are covered benefits under the Medi-Cal program, to be reimbursed, in accordance with Medicare reasonable cost principles, and to the extent that federal financial participation is obtained, to providers on a per-visit basis that is unique to each facility. Existing law prescribes the reimbursement rate methodology for both establishing and adjusting the per-visit rate. Under existing law, if an FQHC or RHC is partially reimbursed by a 3rd-party payer, such as a managed care entity, the department is required to reimburse the FQHC or RHC for the difference between its per-visit rate programs on a contract-by-contract basis, as specified. Existing law authorizes an FQHC or RHC to apply for an adjustment to its rate based on a change in the scope of service that it provides within 150 days following the beginning of the FQHC's or RHC's fiscal year, and authorizes an FQHC or RHC to appeal a grievance of complaint concerning various matters, including ratesetting and scope of service change, as described. Existing law provides that the department's implementation of FQHC and RHC services is subject to federal approval and the availability of federal financial participation.This bill would require the methodology of the adjusted per-visit rate to exclude, among other things, a per-visit payment limitation, and a provider productivity standard. The bill would authorize an FQHC or RHC to apply for a rate adjustment for the adoption, implementation, or upgrade of a certified electronic health record system as a change in the scope of service. The bill would clarify, among other terms, the meaning of "scope of service." The bill would expand the meaning of "visit" to include FQHC and RHC services rendered outside of the facility location, as specified. The bill would modify how the department reimburses an FQHC or RHC that is partially reimbursed by a 3rd-party payer, as described. The bill would repeal the provisions authorizing an FQHC or RHC to apply for an adjustment to its rate based on a change in the scope of service that it provides within 150 days following the beginning of the FQHC's or RHC's fiscal year, and would instead extend the time frame for an FQHC or RHC to file a scope of service rate change to anytime durin... (click bill link to see more).

Primary Sponsors
Eduardo Garcia, Devon Mathis

Bill Summary: Last edited by Joanne Campbell at Feb 20, 2019, 6:51 PM Current law provides that federally qualified health center (FQHC) services and rural health clinic (RHC) servicesare covered benefits under the Medi-Cal program, to be reimbursed, in accordance with Medicare reasonable cost principles, and to the extent that federal financial participation is obtained, to providers on a per-visit basis that is unique to each facility. Current law prescribes the reimbursement rate methodology for both establishing and adjusting the per-visit rate. This bill would require the methodology of the adjusted per-visit rate to exclude, among other things, a per-visit payment limitation, and a provider productivity standard.

Labels: FQHC Medi-Cal

State	Bill Number	Status	Position
CA	AB 848	In Assembly	Monitor

Labels: Medi-Cal

Title
Medi-Cal: covered benefits: continuous glucose monitors.

Description
AB 848, as introduced, Gray. Medi-Cal: covered benefits: continuous glucose monitors. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive healthcare services. The Medi-Cal program is, in part, governed by, and funded pursuant to, federal Medicaid program provisions. Existing law establishes a schedule of covered benefits under the Medi-Cal program. Existing law also generally requires pharmaceutical manufacturers to provide to the department a state rebate for certain drug products that have been added to the Medi-Cal list of contract drugs, that are approved for the treatment of acquired immunodeficiency syndrome (AIDS), or an AIDS-related condition, or cancer, and that are reimbursed through the Medi-Cal outpatient fee-for-service drug program, as specified.This bill would, to the extent that federal financial participation is available and any necessary federal approvals have been obtained, add continuous glucose monitors and related supplies required for use with those monitors to the schedule of benefits under the Medi-Cal program for the treatment of diabetes mellitus when medically necessary, subject to utilization controls. The bill would also authorize the department to require the manufacturer of a continuous glucose monitor to enter into a rebate agreement with the department.

Primary Sponsors
Adam Gray

State	Bill Number	Status	Position
CA	AB 914	In Assembly	Support

Labels: Medi-Cal

Title
Medi-Cal: inmates: eligibility.

Description
AB 914, as amended, Holden. Medi-Cal: inmates: eligibility. Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive healthcare health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law requires Medi-Cal benefits of an individual who is an inmate of a public institution to be suspended effective the date the individual becomes an inmate of a public institution. Existing law requires the suspension to end on the date that the individual is no longer an inmate of a public institution or one year from the date they become an inmate of a public institution, whichever is sooner. Existing law generally requires a county to redetermine a Medi-Cal beneficiary's eligibility to receive Medi-Cal benefits every 12 months and whenever the county receives information about changes in a beneficiary's circumstances that may affect their eligibility for Medi-Cal benefits.This bill would, subject to federal approval, instead require the suspension of Medi-Cal eligibility to end either on the date that the individual is no longer an inmate of the public institution or is no longer otherwise eligible for benefits under the Medi-Cal program, whichever is sooner, and would require the department, in consultation with specified stakeholders, to develop and implement a simplified annual redetermination of eligibility for individuals whose eligibility is suspended pursuant to these provisions. Because counties are required to make Medi-Cal eligibility determinations, and the bill would expand Medi-Cal annual redetermination of eligibility for inmates of public institutions, the bill would impose a state-mandated local program.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.This bill would make technical, nonsubstantive changes to that provision.

Primary Sponsors
Chris Holden

State	Bill Number	Status	Position
CA	AB 990	In Assembly	Monitor

Labels: Medi-Cal

Title
Medi-Cal managed care plans: financial incentives.

Description
AB 990, as amended, Gallagher. Medi-Cal: Medi-Cal managed care plans: financial incentives. Existing law provides for establishes the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under existing law, one of the methods by which Medi-Cal services are provided is pursuant to contracts with various types of managed care health plans. Existing law authorizes a Medi-cal Medi-Cal managed care contractor to offer nonmonetary incentives to promote good health practices by its Medi-cal Medi-Cal enrollees.This bill would express the intent of the Legislature to enact legislation that would require Medi-Cal managed care plans to offer financial incentives to enrollees for their improved wellness activities, as specified.This bill would require a Medi-Cal managed care plan contract entered into, or amended, on or after January 1, 2021, to require the contracting Medi-Cal managed care plan to offer financial incentives to its existing enrollees for the purpose of promoting participation in preventive health or wellness activities, as specified, for a value of at least $100 annually per participating enrollee.The bill would require the Medi-Cal managed care plan to annually evaluate its financial incentive programs and to submit an annual report to the department. The bill would require the department to submit a report to the Legislature detailing those financial incentive programs, as specified.The bill would require that its provisions be implemented only if all necessary federal approvals have been obtained, and only to the extent permitted by federal law.The bill would repeal these provisions on January 1, 2026.

Primary Sponsors
James Gallagher

State	Bill Number	Status	Position
CA	AB 993	In Assembly	Monitor

Title
Health care coverage: HIV specialists.

Description
AB 993, as amended, Nazarian. Health care coverage: HIV specialists. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. A willful violation of the act is a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires the Department of Managed Health Care to adopt regulations to ensure that enrollees have access to needed health care services in a timely manner. Existing law requires the Department of Managed Health Care to develop indicators of timeliness of access to care, including waiting times for appointments with physicians, including primary care and specialty physicians. Existing law requires health care service plans to report annually to the Department of Managed Health Care on compliance with the standards developed pursuant to these provisions. Existing law also requires the Insurance Commissioner to promulgate regulations applicable to health insurers that contract with providers for alternative rates to ensure that insureds have the opportunity to access needed health care services in a timely manner.This bill would require a health care service plan contract or health insurance policy that is issued, amended, or renewed on or after January 1, 2019, 2020, to permit an HIV specialist, as defined, to be an eligible primary care provider, as defined, if the provider requests primary care provider status and meets the plan's or the health insurer's eligibility criteria for all specialists seeking primary care provider status. The bill would provide that these provisions do not apply to a health insurance policy that does not require an insured to obtain a referral from his or her the primary care physician prior to seeking covered health care services from a specialist. The bill would provide that these provisions do not include an HIV specialist as a primary care physician for the purposes of network adequacy requirements. Because a willful violation of these requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Adrin Nazarian

Organizational Notes

Last edited by Joanne Campbell at Mar 11, 2019, 10:18 PM
Organizational Sponsor: AIDS Healthcare Foundation (AHF)

Bill Summary: Last edited by Joanne Campbell at Mar 11, 2019, 10:18 PM
Requires a health care service plan contract to permit an HIV specialist, as defined, to be an eligible primary care provider, as defined, if the provider requests primary care provider status and meets the plan's eligibility criteria for all specialists seeking primary care provider status.

Labels: Commercial Medi-Cal

State	Bill Number	Status	Position
CA	AB 1004	In Assembly	Monitor

Title
Developmental screening services.

Description
AB 1004, as introduced, McCarty. Developmental screening services. Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services, including Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services for any individual under 21 years of age who is covered under Medi-Cal consistent with the requirements under federal law. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under existing law, one of the methods by which Medi-Cal services are provided is pursuant to contracts with various types of managed care plans.Existing federal law provides that EPSDT services include periodic screening services, vision services, dental services, hearing services, and other necessary services to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not the services are covered under the state plan.This bill would require, consistent with federal law, that screening services provided as an EPSDT benefit include developmental screening services for individuals zero to 3 years of age, inclusive. The bill would require the department to ensure a Medi-Cal managed care plan's ability and readiness to perform these developmental screening services, and would require the department to adjust a Medi-Cal managed care plan's capitation rate, as specified. Until July 1, 2023, the bill would require an external quality review organization entity to annually review, survey, and report on managed care plan reporting and compliance with specified developmental screening tools and schedules. The bill would also make legislative findings and declarations relating to child development.

Primary Sponsors
Kevin McCarty

Organizational Notes

Last edited by Joanne Campbell at Mar 26, 2019, 7:34 PM
Organizational Sponsor: First 5 LA

Bill Summary: Last edited by Joanne Campbell at Mar 11, 2019, 8:49 PM Requires that screening services provided as an EPSDT benefit include developmental screening services for individuals zero to 3 years of age, inclusive. Until July 1, 2023, the bill would require an external quality review organization entity to annually review, survey, and report on managed care plan reporting and compliance with specified developmental screening tools and schedules.

Labels: EPSDT Medi-Cal Quality

State	Bill Number	Status	Position
CA	AB 1035	In Assembly	Monitor

Labels: Data Privacy

Title
Personal information: data breaches.

Description
AB 1035, as introduced, Mayes. Personal information: data breaches. Existing law defines and regulates the use of personal information by businesses. Existing law requires a person or business, as defined, that owns or licenses computerized data that includes personal information to disclose, as specified, any breach of the security of the system following discovery or notification of the breach. Existing law requires the disclosure to be made in the most expedient time possible and without unreasonable delay consistent with the legitimate needs of law enforcement, as provided, and other security and investigative measures.This bill would, instead, require a person or business, as defined, that owns or licenses computerized data that includes personal information to disclose any breach of the security of the system within 72 hours following discovery or notification of the breach, subject to the legitimate needs of law enforcement, as provided.The bill would also make nonsubstantive changes.

Primary Sponsors
Chad Mayes

State	Bill Number	Status	Position
CA	AB 1088	In Assembly	Support

Title
Medi-Cal: eligibility.

Description
AB 1088, as amended, Wood. Medi-Cal: eligibility. Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive healthcare health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law requires the department to exercise its option under federal law to implement a program for aged and disabled persons, as described. Existing law requires an individual under these provisions to satisfy certain financial eligibility requirements. Existing law requires the department, to the extent required by federal law, to implement for Medi-Cal recipients who are qualified Medicare beneficiaries, the payment of Medicare premiums, deductibles, and coinsurance for elderly and disabled persons whose income does not exceed the federal poverty level or 200% of a specified Supplemental Security Income program standard.This bill would provide that an aged, blind, or disabled individual who would otherwise be eligible for Medi-Cal benefits, as described, but for the state's contribution to their Medicare premium, would be eligible for Medi-Cal without a share of cost if their income and resources they otherwise meet eligibility requirements. The bill would authorize the department to implement this provision by provider bulletins or similar instructions until regulations are adopted. The bill would require the department to adopt regulations by July 1, 2021, and to provide a status report to the Legislature on a semiannual basis until regulations have been adopted.

Primary Sponsors
Jim Wood

Bill Summary: Last edited by Joanne Campbell at Mar 11, 2019, 8:54 PM
Provides that an aged, blind, or disabled individual who would otherwise be eligible for Medi-Cal benefits under Section 14005.40, if not for the state buy-in of their Medicare Part B premiums, shall be eligible for Medi-Cal without a share of cost if their income and resources otherwise meet all eligibility requirements.

Labels: Coverage Expansion

Organizational Notes

Last edited by Joanne Campbell at Mar 11, 2019, 8:55 PM
Organizational Sponsor: Disability Rights CA Local Health Plans of California - Support California Association of Health Plans - Support

State	Bill Number	Status	Position
CA	AB 1174	In Assembly	Monitor

Title
Health care: anesthesia services.

Description
AB 1174, as amended, Wood. Health care: anesthesia services. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan contract or policy of health insurance to cover services provided at an in-network health facility by a noncontracting health professional with the same cost sharing as if the services were provided by a contracting health professional. Existing law creates the Managed Care Administrative Fines and Penalties Fund, into which certain health care service plans' fines and penalties are deposited.This bill would require a health care service plan, its delegated entity, or a health insurer to notify the Department of Managed Health Care or the Insurance Commissioner before the expiration or plan-, entity-, or insurer-initiated termination of a contract pursuant to which anesthesia services are provided. The bill would require the Department of Managed Health Care or the Insurance Commissioner to issue a finding that, at the expiration or termination of an anesthesia services contract initiated by a health care service plan, its delegated entity, or a health insurer, contracts are required to be in place with anesthesiologists individual health professionals who are licensed by the state to deliver or furnish anesthesia services so that specified requirements are met.This bill would authorize the Director of the Department of Managed Health Care or the Insurance Commissioner to assess an administrative penalty by order, after appropriate notice and opportunity for hearing, if the director or commissioner determines that a health care service plan, its delegated entity, or a health insurer has failed to comply with a finding. The bill would create the Managed Care Penalty Account, within the Managed Care Administrative Fines and Penalties Fund, which would be subject to appropriation by the Legislature, and into which administrative penalties for a health care service plan's noncompliance would be deposited. The bill would specify that administrative penalties assessed against a health insurer be deposited into the Insurance Fund. Because a willful violation of the bill's requirements relative to health care service plans would be a crime, the bill would impose a state-mandated local program.Existing constitutional provisions require that a statute that limits the right of access to the meetings of public bodies or the writings of public officials and agencies be adopted with findings demonstrating the intere... (click bill link to see more).

Primary Sponsors
Jim Wood

Organizational Notes

Last edited by Joanne Campbell at Mar 28, 2019, 9:30 PM
California Association of Health Plans - Oppose

Bill Summary: Last edited by Joanne Campbell at Mar 11, 2019, 10:19 PM
Requires health plans to maintain contracts for anesthesia services and report contract changes to the Department of Managed Healthcare. Allows for fines of health plans that do not have contracts.

Labels: Commercial Medi-Cal

State	Bill Number	Status	Position
CA	AB 1268	In Assembly	Monitor

Labels: Commercial

Title
Health care coverage: prospective review.

Description
AB 1268, as introduced, Rodriguez. Health care coverage: prospective review. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of its provisions a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan or health insurer to have written policies and procedures establishing the process by which the plan or insurer approves, modifies, delays, or denies requests for health care services based in whole or in part on medical necessity, including those plans or insurers that delegate these functions to medical groups, independent practice associations, or to other contracting providers. Existing law requires a plan or insurer to evaluate its criteria used to authorize, modify, or deny health care services at least annually.This bill would require a health care service plan or health insurer, on or before July 1, 2020, and annually on July 1 thereafter, to report to the appropriate department the number of times in the preceding calendar year that each health care service was prospectively approved, modified, delayed, or denied. The bill would require a plan or insurer to take the reported information into account when evaluating its criteria used to authorize, modify, or deny health care services. The bill would require each department to determine the form and manner of that reporting. Because a willful violation of the bill's requirements relative to health care service plans would be a crime, the bill would impose a state-mandated local program.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Freddie Rodriguez

Organizational Notes

Last edited by Joanne Campbell at Mar 26, 2019, 7:31 PM
California Medical Association

State	Bill Number	Status	Position
CA	AB 1309	In Assembly	Monitor

Title
Health care coverage: enrollment periods.

Description
AB 1309, as introduced, Bauer-Kahan. Health care coverage: enrollment periods. Existing federal law, the Patient Protection and Affordable Care Act (PPACA), requires each state to establish an American Health Benefit Exchange to facilitate the purchase of qualified health benefit plans by qualified individuals and qualified small employers. PPACA requires an American Health Benefit Exchange to provide for an annual open enrollment period for the individual market for policy years beginning on or after January 1, 2018, to begin on November 1 and extend through December 15 of the calendar year preceding the benefit year. Existing federal law establishes special enrollment periods during which a qualified individual may enroll in a qualified health plan when specified triggering events occur, such as when the qualified individual loses minimum essential coverage, as defined. Existing federal regulatory authority authorizes a state to establish additional special enrollment periods to supplement these special enrollment periods provided for under federal law under certain circumstances.Existing state law creates the California Health Benefit Exchange (Exchange), also known as Covered California, to facilitate the enrollment of qualified individuals and qualified small employers in qualified health plans as required under PPACA. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan and a health insurer, for policy years beginning on or after January 1, 2019, to provide a special enrollment period to allow individuals to enroll in individual health benefit plans through the Exchange from October 15 to October 31 of the preceding calendar year, inclusive, and from December 16 of the preceding calendar year, to January 15 of the benefit year, inclusive. Existing law requires, with respect to individual health benefit plans offered outside of the Exchange, that the annual open enrollment period for policy years beginning on or after January 1, 2019, extend from October 15 of the preceding calendar year, to January 15 of the benefit year, inclusive.This bill would additionally require a health care service plan and a health insurer, for policy years beginning on or after January 1, 2020, to provide a special enrollment period to allow individuals to enroll in individual health benefit plans through the Exchange from December 16 of the preceding calendar year, to January 31 of the benefit year, inclusive. The bill would also addition... (click bill link to see more).

Primary Sponsors
Rebecca Bauer-Kahan

Organizational Notes

Last edited by Joanne Campbell at Mar 8, 2019, 5:16 PM
Organizational Sponsor: Health Access CA

Bill Summary: Last edited by Joanne Campbell at Feb 25, 2019, 10:23 PM Requires a health care service plan for policy years beginning on or after January 1, 2020, to provide a special enrollment period to allow individuals to enroll in individual health benefit plans through the Exchange from December 16 of the preceding calendar year, to January 31 of the benefit year, inclusive.

Labels: Care4All Commercial Exchange

State	Bill Number	Status	Position
CA	AB 1494	In Assembly	Monitor

Title
Medi-Cal: telehealth: state of emergency.

Description
AB 1494, as amended, Aguiar-Curry. Medi-Cal: telehealth: state of emergency. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.Under existing law, in-person contact between a health care provider and a patient is not required under the Medi-Cal program for services appropriately provided through telehealth, as defined, subject to reimbursement policies adopted by the department to compensate a licensed health care provider who provides health care services through telehealth that are otherwise reimbursed pursuant to the Medi-Cal program. Existing law, for purposes of payment for covered treatment or services provided through telehealth, prohibits the department from limiting the type of setting where services are provided for the patient or by the health care provider.This bill would provide, only to the extent that federal financial participation is available, available and federal approval is obtained, that neither face-to-face contact nor a patient's physical presence on the premises of an enrolled community clinic, is required for services provided by the clinic to a Medi-Cal beneficiary during or immediately following a state of emergency, as specified. proclamation declaring a state of emergency. The bill would authorize the department to apply this provision to services provided by another enrolled fee-for-service Medi-Cal provider, clinic, or facility. The bill would require that telehealth services, telephonic services, and other specified services be reimbursable when provided by one of those entities during or immediately following a state of emergency, as specified. emergency.The bill would require the department, on or before March 1, 2020, to establish a stakeholder process to assist the department in developing guidance for those entities in order to facilitate reimbursement for the above-described services. The bill would require the department services, and, on or before July 1, 2020, to issue the guidance on or before July 1, 2020, and would require the guidance to include, among other things, specified guidance, including certain instructions on the submission of claims for telehealth or telephonic services, and identification of certain services and devices. This bill would require the department to seek federal approval of any necessary state plan amendments or waivers to implement these provisions, and would services. The bill would authorize the department to implement the provisions by all-county letters, provider bulletins, or similar instructions. The bill various means... (click bill link to see more).

Primary Sponsors
Cecilia Aguiar-Curry

Bill Summary: Last edited by Joanne Campbell at Feb 25, 2019, 10:25 PM Provides, only to the extent that federal financial participation is available, that neither face-to-face contact nor a patient's physical presence on the premises of an enrolled community clinic, is required for services provided by the clinic to a Medi-Cal beneficiary during or immediately following a state of emergency. The bill would authorize the department to apply this provision to services provided by another enrolled fee-for-service Medi-Cal provider, clinic, or facility.

Labels: FQHC Medi-Cal Telehealth

State	Bill Number	Status	Position
CA	AB 1611	In Assembly	Monitor

Title
Emergency hospital services: costs.

Description
AB 1611, as introduced, Chiu. Emergency hospital services: costs. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, requires the Department of Managed Health Care to license and regulate health care service plans and makes a willful violation of the act a crime. Existing law requires the Department of Insurance to regulate health insurers. Existing law requires a health care service plan or health insurer offering a contract or policy to provide coverage for emergency services. Existing law prohibits a hospital from transferring a person needing emergency services and care to another hospital for any nonmedical reason unless prescribed conditions are met and makes a willful violation of this requirement a crime.This bill would require a health care service plan contract or insurance policy issued, amended, or renewed on or after January 1, 2020, to provide that if an enrollee or insured receives covered services from a noncontracting hospital, the enrollee or insured is prohibited from paying more than the same cost sharing that the enrollee or insured would pay for the same covered services received from a contracting hospital. The bill would require a health care service plan or insurer to pay a noncontracting hospital for emergency services rendered to an enrollee or insured pursuant to a specified formula, would require a noncontracting hospital to bill, collect, and make refunds in a specified manner, and would provide a dispute resolution procedure if any party is dissatisfied with payment. The bill would require health care service plans and insurers to document cost savings pursuant to these provisions. By expanding the duties of health care services plans and hospitals, this bill would expand existing crimes, thereby imposing a state-mandated local program.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
David Chiu, Scott Wiener

Organizational Notes

Last edited by Joanne Campbell at Mar 26, 2019, 7:27 PM
Organizational Sponsor: California Labor Federation and Health Access

Bill Summary: Last edited by Joanne Campbell at Feb 25, 2019, 10:34 PM Requires a health care service plan to provide that if an enrollee receives covered services from a noncontracting hospital, the enrollee is prohibited from paying more than the same cost sharing that the enrollee would pay for the same covered services received from a contracting hospital. The bill would require a health care service plan to pay a noncontracting hospital for emergency services rendered to an enrollee pursuant to a specified formula (average contracted rate or 150 percent of the amount Medicare reimburses on a fee-for-service basis for the same or similar services in the general geographic region), would require a noncontracting hospital to bill, collect, and make refunds in a specified manner, and would provide a dispute resolution procedure if any party is dissatisfied with payment.

Labels: Commercial

State	Bill Number	Status	Position
CA	AB 1642	In Assembly	Monitor

Title
Medi-Cal: managed care plans.

Description
AB 1642, as amended, Wood. Medi-Cal: managed care plans. Existing(1) Existing law establishes the Medi-Cal program, administered by the State Department of Health Care Services, under which health care services are provided to qualified, low-income persons through various health care delivery systems, including managed care pursuant to Medi-Cal managed care plan contracts. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing federal regulations require a state that contracts with specified Medicaid managed care plans to develop and enforce network adequacy standards, require each state to ensure that services covered under the Medicaid state plan are available and accessible to enrollees of specified Medicaid managed care plans in a timely manner, and require each state to contract with a qualified external quality review organization (EQRO) to annually produce an external quality review technical report that summarizes findings on access and quality of care. Existing state law establishes, until January 1, 2022, certain time and distance and appointment time standards for specified services consistent with those federal regulations to ensure that Medi-Cal managed care covered services are available and accessible to enrollees of Medi-Cal managed care plans in a timely manner, and manner, and authorizes a Medi-Cal managed care plan to request approval from the department to use alternative access standards for the time and distance standards if specified conditions are met, including that the Medi-Cal managed care plan has exhausted all reasonable options to obtain providers to meet the applicable standard. Existing state law requires a Medi-Cal managed care plan to annually provide to the department, or upon the department's request, a report that demonstrates the Medi-Cal managed care plan's compliance with time and distance standards, and requires the EQRO to compile various data, by plan and by county, related to time and distance standards, including the number of requests for alternative access standards in the plan service area for time and distance.This bill would require a Medi-Cal managed care plan to provide to the department additional information in its request for the alternative access standards, including a description of the reasons justifying the alternative access standards, and to report to the department on how the Medi-Cal managed care plan arranged for the delivery of Medi-Cal covered services to Medi-Cal enrollees, such as through the use of nonemergency medical transportation. The bill would require a Medi-Cal managed care plan that has received approval from the department to utilize an alternative access standard to assist an enrollee who would t... (click bill link to see more).

Primary Sponsors
Jim Wood

Bill Summary: Last edited by Joanne Campbell at Apr 4, 2019, 7:46 PM

Labels: EPSDT Medi-Cal Quality Telehealth

State	Bill Number	Status	Position
CA	AB 1670	In Assembly	Monitor

Title
Health care coverage.

Description
AB 1670, as amended, Holden. Health care coverage. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Under existing law, if a health care service plan or insurer, or one of its contracting providers, denies, modifies, or delays a health care service because the proposed service is not a covered benefit, the statement of that decision is to clearly specify the provision in the policy or contract that excludes that coverage.This bill would authorize a provider that contracts with a health care service plan or health insurer to bill an enrollee or insured for a service that is not a covered benefit if the enrollee or insured consents in writing and that written consent meets specified criteria. The bill would require a contracting provider to provide an enrollee or insured with a written estimate of the person's total cost, based on the standard rate the provider would charge for the service, if the service sought is not a covered benefit under the person's health care service plan contract or health insurance policy. The bill would require these written consent and estimate documents to be in the language spoken by the enrollee or insured, if the language is a primary language of a limited-English-proficient population group meeting a specified numeric threshold. Because a willful violation of the bill's requirements relative to health care service plans would be a crime, the bill would impose a state-mandated local program.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified reason.Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of its provisions a crime. Existing law requires a health care service plan to have written policies and procedures establishing the process by which the plan approves, modifies, delays, or denies requests for health care services based in whole or in part on medical necessity, including those plans that delegate these functions to medical groups, independent practice associations, or to other contracting providers. As part of that process, existing law requires health care service plans to communicate decisions to approve, modify, or deny request... (click bill link to see more).

Primary Sponsors
Chris Holden

Bill Summary: Last edited by Joanne Campbell at Feb 25, 2019, 11:01 PM
Spot bill regarding procedures by which the plan approves, modifies, delays, or denies requests for health care services based in whole or in part on medical necessity.

Labels: Commercial Medi-Cal

State	Bill Number	Status	Position
CA	AB 1676	In Assembly	Monitor

Title
Health care: mental health.

Description
AB 1676, as introduced, Maienschein. Health care: mental health. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of that act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law requires health care service plan contracts and health insurance policies that provide hospital, medical, or surgical coverage to provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses, as defined, of a person of any age. Existing law also requires health care service plans and health insurers, by July 1, 2019, to develop maternal mental health programs, as specified.This bill would require health care service plans and health insurers, by January 1, 2021, to establish a telehealth consultation program that provides providers who treat children and pregnant and postpartum persons with access to a psychiatrist, as specified, in order to more quickly diagnose and treat children and pregnant and postpartum persons suffering from mental illness. The bill would require health care service plans and insurers to communicate information relating to the telehealth program at least twice a year in writing. The bill would require health care service plans and health insurers to maintain records and data pertaining to the utilization of the program and the availability of psychiatrists in order to facilitate ongoing changes and improvements, as necessary. The bill would exempt certain specialized health care service plans and health insurers from these provisions. Because a willful violation of the bill's requirement by a health care service plan would be a crime, the bill would impose a state-mandated local program.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Brian Maienschein

Organizational Notes

Last edited by Joanne Campbell at Mar 11, 2019, 9:58 PM
Organizational Sponsor: 2020 Mom

Bill Summary: Last edited by Joanne Campbell at Feb 25, 2019, 11:03 PM Requires health care service plans to establish a telehealth consultation program that provides providers who treat children and pregnant and postpartum persons with access to a psychiatrist in order to more quickly diagnose and treat children and pregnant and postpartum persons suffering from mental illness. The bill would require health care service plans to communicate information relating to the telehealth program at least twice a year in writing.

Labels: Behavioral Health | Commercial | Medi-Cal | Telehealth

State	Bill Number	Status	Position
CA	SB 11	In Senate	Monitor

Labels: Behavioral Health | MAT

Title

Health care coverage: mental health parity.

Description

SB 11, as introduced, Beall. Health care coverage: mental health parity. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires health care service plan contracts or health insurance policies issued, amended, or renewed on or after July 1, 2000, to provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses, as defined, and of serious emotional disturbances of a child, as specified, under the same terms and conditions applied to other medical conditions.Existing federal law, the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), requires group health plans and health insurance issuers that provides both medical and surgical benefits and mental health or substance use disorder benefits to ensure that financial requirements and treatment limitations applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical and surgical benefits. Existing state law subjects nongrandfathered individual and small group health care service plan contracts and health insurance policies that provide coverage for essential health benefits to those provisions of the MHPAEA.This bill would require a health care service plan and a health insurer to submit an annual report to the Department of Managed Health Care or the Department of Insurance, as appropriate, certifying compliance with state and federal mental health parity laws, as specified. The bill would require the departments to review the reports submitted by health care service plans to ensure compliance with state and federal mental health parity laws, and would require the departments to make the reports and the results of the reviews available upon request and to post the reports and the results of the reviews on the departments' Internet Web site. The bill would also require the departments to report to the Legislature the information obtained through the reports and the results of the review of the reports and on all other activities taken to enforce state and federal mental health parity laws.Existing law authorizes a health care service plan and a health insurer to utilize formularies, prior authorization, step therapy, or other reasonable medical management practices, as specified, in the provision of outpatient prescription drug coverage.The bill would prohibit a health care service plan and a health insurer that... (click bill link to see more).

Primary Sponsors

Jim Beall

State	Bill Number	Status	Position
CA	SB 29	In Senate	Support

Title
Medi-Cal: eligibility.

Description
SB 29, as amended, LaraDurazo. Medi-Cal: eligibility. Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. The federal Medicaid program provisions prohibit payment to a state for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law.Existing law requires individuals under 19 years of age enrolled in restricted-scope Medi-Cal at the time the Director of Health Care Services makes a determination that systems have been programmed for implementation of these provisions, provisions to be enrolled in the full scope of Medi-Cal benefits, if otherwise eligible, pursuant to an eligibility and enrollment plan, as specified. plan, which includes outreach strategies. Existing law makes the effective date of enrollment for those individuals the same day that systems are operational to begin processing new applications pursuant to the director's determination. determination, and requires the department to seek necessary federal approvals to obtain federal financial participation for purposes of implementing the requirements.This bill would extend eligibility for full-scope Medi-Cal benefits to individuals of all ages who are otherwise eligible for those benefits but for their immigration status. The bill would also status, and would delete provisions delaying implementation until the director makes the determination described above. The bill would expand the requirements of the eligibility and enrollment plan, such as ensuring that an individual maintains their primary care provider without disruption to their continuity of care, would require the department to collaborate with the counties and designated public hospitals to maximize federal financial participation, and would require the department to work with designated public hospitals to mitigate financial losses related to the implementation of these requirements. Because counties are required to make Medi-Cal eligibility determinations and this bill would expand Medi-Cal eligibility, the bill would impose a state-mandated local program.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to the statutory prov... (click bill link to see more).

Primary Sponsors
Maria Durazo

Organizational Notes

Last edited by Joanne Campbell at Mar 26, 2019, 7:20 PM
Organizational Sponsor: California Immigrant Policy Center and Health Access

Bill Summary: Last edited by Joanne Campbell at Feb 27, 2019, 5:39 PM
Expands Medi-Cal eligibility regardless of immigration status.

Labels: Care4All Medi-Cal

State	Bill Number	Status	Position
CA	SB 65	In Senate	Monitor

Title
Health care coverage: financial assistance.

Description
SB 65, as amended, Pan. California Health Benefit Exchange: Health care coverage: financial assistance. Existing federal law, the federal Patient Protection and Affordable Care Act (PPACA), enacts various healthcare coverage market reforms. Among other things, the PPACA requires each state to establish an American Health Benefit Exchange that facilitates the purchase of qualified health plans by qualified individuals and qualified small employers and requires that state entity to meet certain other requirements. Existing law creates the California Health Benefit Exchange (the Exchange), also known as Covered California, for the purpose of facilitating the enrollment of qualified individuals and qualified small employers in qualified health plans as required under the PPACA. Existing law requires the Exchange, among other duties, to develop options for providing financial assistance to help low-income and middle-income Californians access healthcare coverage. Existing law also establishes the California Health Trust Fund, a continuously appropriated fund, in the State Treasury for purposes of providing funding for the duties carried out by the Exchange.This bill would require the Exchange, notwithstanding the provision establishing the California Health Trust Fund and only to the extent that the Legislature appropriates funding for these purposes, to administer a program of financial assistance assistance, to be known as the Affordable Care Access Plus Program, to help low-income and middle-income Californians access affordable healthcare coverage by requiring the Exchange to implement specified maximum premium contributions and to reduce copays and deductibles for individuals who meet specified income requirements. The bill would also require the Exchange to administer financial assistance in a manner that maximizes federally funded subsidies. health care coverage with respect to individual coverage that is made available through the Exchange. The bill would require the program to provide financial assistance to California residents with household incomes below 600% of the federal poverty level, and would authorize the program to provide other appropriate subsidies designed to make health care more accessible and affordable for individuals and households. The bill would require the Exchange to adopt a program design to implement these provisions by resolution of the board of the Exchange, as specified. The bill would require the Exchange to promulgate rules and regulations to implement these provisions, and would authorize any rules and regulations necessary to implement these provisions to be adopted as emergency regulations, as specified.

Primary Sponsors
Richard Pan

Bill Summary: Last edited by Joanne Campbell at Mar 11, 2019, 8:51 PM
Requires the California Health Benefit Exchange, to administer financial assistance to help low-income and middle-income Californians access affordable healthcare coverage by requiring the Exchange to implement specified maximum premium contributions and to reduce copays and deductibles for individuals who meet specified income requirements.

Labels: Affordability Care4All Exchange

State	Bill Number	Status	Position
CA	SB 66	In Senate	Support

Labels: FQHC Medi-Cal

Title
Medi-Cal: federally qualified health center and rural health clinic services.

Description
SB 66, as amended, Atkins. Medi-Cal: federally qualified health center and rural health clinic services. Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law provides that federally qualified health center (FQHC) services and rural health clinic (RHC) services, as defined, are covered benefits under the Medi-Cal program, to be reimbursed, to the extent that federal financial participation is obtained, to providers on a per-visit basis. "Visit" is defined as a face-to-face encounter between a patient of an FQHC or RHC and specified health care professionals, including a physician. physician and marriage and family therapist. Under existing law, "physician," for these purposes, includes, but is not limited to, a physician and surgeon, an osteopath, and a podiatrist.This bill would authorize reimbursement for a maximum of 2 visits taking place on the same day at a single location if after the first visit the patient suffers illness or injury requiring additional diagnosis or treatment, or if the patient has a medical visit and a mental health visit or a dental visit, as defined. The bill would authorize an FQHC or RHC that currently includes the cost of a medical visit and a mental health visit that take place on the same day at a single location as a single visit for purposes of establishing the FQHC's or RHC's rate to apply for an adjustment to its per-visit rate, and after the department has approved that rate adjustment, to bill a medical visit and a mental health visit that take place on the same day at a single location as separate visits, in accordance with the bill.This bill would also make an FQHC or RHC visit to a licensed acupuncturist reimbursable on a per-visit basis. The include a licensed acupuncturist within those health care professionals covered under the definition of "visit." The bill would require the department, by July 1, 2020, to submit a state plan amendment to the federal Centers for Medicare and Medicaid Services to reflect certain changes described in the bill, and to seek necessary federal approvals. The bill would also make conforming and technical changes.

Primary Sponsors
Toni Atkins, Mike McGuire

Organizational Notes

Last edited by Joanne Campbell at Jan 29, 2019, 6:48 PM
Organizational Sponsor: Local Health Plans of California, California Association of Public Hospitals and Health Systems, California Health + Advocates, and Steinberg Institute California Association of Health Plans - Support

State	Bill Number	Status	Position
CA	SB 159	In Senate	Monitor

Title
HIV: preexposure and postexposure prophylaxis.

Description
SB 159, as amended, Wiener. HIV: preexposure and postexposure prophylaxis. Existing law, the Pharmacy Law, provides for the licensure and regulation of pharmacists by the California State Board of Pharmacy, and makes a violation of these requirements a crime. Existing law generally authorizes a pharmacist to dispense or furnish drugs only pursuant to a valid prescription, except as provided, such as furnishing emergency contraceptives, hormonal contraceptives, and naloxone hydrochloride, pursuant to standardized procedures.This bill would authorize a pharmacist to furnish preexposure prophylaxis and postexposure prophylaxis, in specified amounts, if the pharmacist completes a training program approved by the board and complies with specified requirements, such as assessing a patient and providing a patient with counseling and tests, if those services can be provided in a private and sanitary location. tests. Because a violation of these requirements would be a crime, this bill would impose a state-mandated local program.Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services pursuant to a schedule of benefits, including pharmacist services, which are subject to approval by the federal Centers for Medicare and Medicaid Services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.This bill would expand the Medi-Cal schedule of benefits to include preexposure prophylaxis and postexposure prophylaxis as pharmacist services.Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law authorizes health care service plans and health insurers that cover prescription drugs to utilize reasonable medical management practices, including prior authorization and step therapy, consistent with applicable law. For combination antiretroviral drug treatments medically necessary for the prevention of AIDS/HIV, existing law prohibits plans and insurers, until January 1, 2023, from having utilization management policies or procedures that rely on a multitablet drug regimen instead of a single-tablet drug regimen, except as specified.This bill would additionally prohibit plans and insurers from subjecting those drug treatments, including preexposure prophylaxis or postexposure prophylaxis, to prior authorization or step therapy. Because a willful violation of these provisions would be a crime, this b... (click bill link to see more).

Primary Sponsors
Scott Wiener, Mike Gipson, Todd Gloria

Organizational Notes

Last edited by Joanne Campbell at Mar 26, 2019, 7:24 PM
Organizational Sponsor: APLA Health, California Pharmacists Association, Equality CA, Los Angeles LGBT Center, and San Francisco AIDS Foundation

Bill Summary: Last edited by Joanne Campbell at Mar 11, 2019, 10:07 PM
Prohibits plans from subjecting drug treatments, including preexposure prophylaxis or postexposure prophylaxis, to prior authorization or step therapy.

Labels: Medi-Cal

State	Bill Number	Status	Position
CA	SB 163	In Senate	Monitor

Title
Healthcare coverage: pervasive developmental disorder or autism.

Description
SB 163, as amended, Portantino. Healthcare coverage: pervasive developmental disorder or autism. Existing law, the Lanterman Developmental Disabilities Services Act, requires the State Department of Developmental Services to contract with regional centers to provide services and supports to individuals with developmental disabilities and their families. Existing law defines developmental disability for these purposes to include, among other things, autism.Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan contract or a health insurance policy to provide coverage for behavioral health treatment for pervasive developmental disorder or autism, and defines "behavioral health treatment" to mean specified services and treatment programs, including treatment provided pursuant to a treatment plan that is prescribed by a qualified autism service provider and administered either by a qualified autism service provider or by a qualified autism service professional or qualified autism service paraprofessional who is supervised as specified. Existing law defines a "qualified autism service provider" to refer to a person who is certified or licensed and a "qualified autism service professional" to refer to a person who meets specified educational, training, and other requirements and is supervised and employed by a qualified autism service provider. Existing law defines a "qualified autism service paraprofessional" to mean an unlicensed and uncertified individual who meets specified educational, training, and other criteria, is supervised by a qualified autism service provider or a qualified autism service professional, and is employed by the qualified autism service provider. Existing law also requires a qualified autism service provider to design, in connection with the treatment plan, an intervention plan that describes, among other information, the parent participation needed to achieve the plan's goals and objectives, as specified. Under existing law, these coverage requirements provide an exception for specialized health care service plans or health insurance policies that do not cover mental health or behavioral health services, accident only, specified disease, hospital indemnity, or Medicare supplement health insurance policies, and health care service plans and health insurance policies in the Medi-Cal program.Existing federal law, the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity... (click bill link to see more).

Primary Sponsors
Anthony Portantino

Bill Summary: Last edited by Joanne Campbell at Mar 11, 2019, 10:07 PM
Would revise the definition of behavioral health treatment to require the services and treatment programs provided to be based on behavioral, developmental, behavior-based, or other evidence-based models. The bill would remove the exception for health care service plans and health insurance policies in the Medi-Cal program, consistent with the MHPAEA.

Labels: Behavioral Health Commercial Medi-Cal

Organizational Notes

Last edited by Joanne Campbell at Mar 11, 2019, 10:08 PM
Organizational Sponsor: Autism Behavior Services California Association of Health Plans - Oppose

State	Bill Number	Status	Position
CA	SB 175	In Senate	Monitor

Title
Health care coverage: minimum essential coverage.

Description
SB 175, as amended, Pan. Healthcare Health care coverage: minimum essential coverage. Existing law establishes the Medi-Cal program, administered by the State Department of Health Care Services and under which healthcare health care services are provided to qualified, qualified low-income persons. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program program provisions. Existing law provides for the regulation of health care service plans by the Department of Managed Health Care and health insurers by the Department of Insurance. Existing law establishes the California Health Benefit Exchange (Exchange), also known as Covered California, for the purpose of facilitating the purchase of qualified health plans by qualified individuals and qualified small employers. Existing law establishes the California Health Trust Fund and continuously appropriates moneys in the fund for these purposes. Existing federal law, the Patient Protection and Affordable Care Act (PPACA), enacts various healthcare health care coverage market reforms as of January 1, 2014. PPACA generally requires individuals, an individual, and any dependents of the individual, to maintain minimum essential coverage, as defined, and, if an individual fails to maintain minimum essential coverage, PPACA imposes on the individual taxpayer a penalty. This provision is referred to as the individual mandate.This bill would require a California resident to ensure that the resident, and any dependent of the resident, is covered under minimum essential coverage for each month beginning after 2019. The bill would impose a penalty for the failure to maintain minimum essential coverage. The bill would require the Exchange to determine the penalty, if any, for a resident and would require the Franchise Tax Board to collect the penalty. The bill would require the Exchange to determine whether to grant a certification that a resident is exempt from the requirement to maintain minimum essential coverage, the penalty, or both, and would require the Exchange to notify the resident and the Franchise Tax Board of its determination.The bill would also establish the Health Care Coverage Penalty Fund, into which moneys collected from the above-described penalty would be deposited. Subject to an appropriation by the Legislature, the bill would require that moneys in the fund be used to improve the affordability of healthcare coverage for Californians.This bill would create the Minimum Essential Coverage Individual Mandate to require a California resident to ensure that the resident, and any dependent of the resident, is covered under minimum essential coverage, as defined, for each month beginning on January 1, 2020, except as specified. The bill would require the E... (click bill link to see more).

Primary Sponsors
Richard Pan

Bill Summary: Last edited by Joanne Campbell at Mar 7, 2019, 11:10 PM
Requires a California resident to ensure that the resident, and any dependent of the resident, is covered under minimum essential coverage for each month beginning after 2019. The bill would impose a penalty for the failure to maintain minimum essential coverage.

Labels: Care4All | Commercial | Individual Mandate

Organizational Notes

Last edited by Joanne Campbell at Mar 28, 2019, 5:11 PM
Local Health Plans of California - Support California Association of Health Plans - Support

State	Bill Number	Status	Position
CA	SB 207	In Senate	Monitor

Title
Medi-Cal: asthma preventive services.

Description
SB 207, as amended, Hurtado. Medi-Cal: asthma preventive services. Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income persons receive health care benefits. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing federal law authorizes, at the option of the state, preventive services, as defined, to be provided by practitioners other than physicians or other licensed practitioners.This bill would include asthma preventive services, as defined, as a covered benefit under the Medi-Cal program. The bill would require the department, in consultation with external stakeholders, to approve 2 accrediting bodies with expertise in asthma to review and approve training curricula for asthma preventive services providers, and would require the curricula to be consistent with specified federal and clinically appropriate guidelines. The bill would require a supervising licensed Medi-Cal provider and the Medi-Cal asthma preventive services provider to satisfy specified requirements, including the Medi-Cal asthma preventive services provider's completion of a training program approved by one of the accrediting bodies. The bill would authorize the department to implement, interpret, or make specific these provisions without taking regulatory action until regulations are adopted. The bill would require the department to adopt regulations by July 1, 2020, 2023, and to provide semiannual status reports to the Legislature until regulations have been adopted. The bill would require the department to seek any federal waivers or other state plan amendments as necessary, and would require these provisions to be implemented if federal approvals are obtained, as specified.

Primary Sponsors
Melissa Hurtado, David Chiu

Bill Summary: Last edited by Joanne Campbell at Feb 19, 2019, 9:23 PM a. Adds WIC Section 14132.08 which includes the following key previsions: i. Instructs DHCS to develop and implement asthma preventive services in Medi-Cal which shall be a covered benefit by July 1, 2020. ii. Requires that an asthma preventive services provider provide asthma education, environmental trigger assessments, and minor to moderate environmental asthma trigger remediation to Medi-Cal beneficiaries. b. Adds WIC Section 14132.085 which requires the Department to approve at least two accrediting bodies to review and approve training curricula for asthma preventive services. The curricula shall align with the NIH 2007 Guidelines for Dx and Management of Asthma and be a minimum of 16 hours. Requires specific elements to be included in the curricula. c. Adds WIC Section 14132.09 which includes the following key provisions: i. Requires supervision of asthma prevention services providers to ensure the provider complies with outlined requirements and includes requirements for entities or providers that employ or contract with asthma prevention services providers to maintain specified documentation of services. ii. Requires DHCS to pursue funding opportunities to develop payment methodologies for minor and moderate remediation, seek any required federal approvals, and adopt regulations by July 1, 2020.

Label

Organizational Notes

Last edited by Joanne Campbell at Mar 26, 2019, 7:39 PM
Organizational Sponsor: California Pan-Ethnic Health Network, Children Now, Regional Asthma Management and Prevention

State	Bill Number	Status	Position
CA	SB 260	In Senate	Monitor

Title
Automatic health care coverage enrollment.

Description
SB 260, as amended, Hurtado. Automatic health care coverage enrollment. Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing state law creates the

Bill Summary: Last edited by Joanne Campbell at Mar 11, 2019, 8:59 PM Beginning January 1, 2021, a health plan shall provide to the Exchange the name, address, and other contact information of a policyholder or certificate holder who ceased to be enrolled in coverage and who did not opt out of the information transfer.

Labels: Care4All Commercial Exchange Medi-Cal

California Health Benefit Exchange (Exchange), also known as Covered California, to facilitate the enrollment of qualified individuals and qualified small employers in qualified health plans as required under the federal Patient Protection and Affordable Care Act. Existing law requires a county to perform redeterminations of eligibility for Medi-Cal beneficiaries every 12 months. Under existing law, if a county determines that an individual is ineligible for Medi-Cal, the county is required to determine the individual's eligibility for other insurance affordability programs and transfer the individual's electronic account to insurance affordability programs, including the Exchange, for which the individual is eligible.This bill would require the Exchange Exchange, beginning no later than July 1, 2020, to enroll an individual in the lowest cost silver plan or another plan, as specified, upon receiving the individual's electronic account from a county, or upon receiving information from the State Department of Health Care Services regarding an individual terminated from department-administered health coverage. The bill would require enrollment to occur before Medi-Cal coverage or coverage administered by the State Department of Health Care Services is terminated, and would prohibit the premium due date from being sooner than the 30th last day of the first month of enrollment. The bill would require the Exchange to provide an individual who is automatically enrolled in the lowest cost silver plan with a notice that includes specified information, including the individual's right to select another available plan or to not enroll in the plan.Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan providing individual or group health care coverage or a health insurer to notify an enrollee, subscriber, policyholder, or certificate holder who ceases to be enrolled in coverage that the individual may be eligible for coverage through the Exchange or Medi-Cal.This bill would require a health care service plan providing individual or group healt... (click bill link to see more).

Primary Sponsors
Melissa Hurtado

Organizational Notes

Last edited by Joanne Campbell at Mar 8, 2019, 5:14 PM
Organizational Sponsor: Health Access of California and Western Center on Law and Poverty

State	Bill Number	Status	Position
CA	SB 276	In Senate	Support

Title
Immunizations: medical exemptions.

Description
SB 276, as amended, Pan. Immunizations: medical exemptions. Existing law prohibits the governing authority of a school or other institution from admitting for attendance any pupil who fails to obtain required immunizations within the time limits prescribed by the State Department of Public Health. Existing law exempts from those requirements a pupil whose parents have filed with the governing authority a written statement by a licensed physician to the effect that immunization is not considered safe for that child, indicating the specific nature and probable duration of their medical condition or circumstances, including, but not limited to, family medical history.This bill would instead require the State Department of Public Health to develop and make available for use by licensed physicians and surgeons a statewide standardized medical exemption request form, which would be the only medical exemption documentation that a governing authority may accept. The bill would require the State Public Health Officer or the public health officer's designee to approve or deny a medical exemption request, upon determining that the request provides sufficient medical evidence that the immunization is contraindicated by guidelines of the federal Centers of Disease Control and Prevention (CDC). The bill would specify the information to be included in the medical exemption form. The bill would require a physician and surgeon to inform a parent or guardian of the bill's requirements and to examine the child and submit a completed medical exemption request form to the department, as specified. The bill would require the State Public Health Officer or designee to review the completed exemption request form and notify the physician and surgeon of the approval or denial of the request. The bill would require the reason for denial of a request to be included in the notification, and would authorize the physician and surgeon to submit additional information to the department for further review, as specified.This bill would require the department to create and maintain a database of approved medical exemption requests, and to make the database accessible to local health officers. The bill would require a copy of a medical exemption granted prior to the availability of the standardized form to be submitted to the department for inclusion in the database by July 1, 2020, in order for the medical exemption to remain valid after the statewide standardized form has been adopted. The bill would authorize the State Public Health Officer or a local public health officer to revoke a medical exemption if the State Public Health Officer or local public health officer determines that the medical exemption is fraudulent or inconsistent with applicable CDC guideline... (click bill link to see more).

Primary Sponsors
Richard Pan, Lorena Gonzalez Fletcher

State	Bill Number	Status	Position
CA	SB 361	In Senate	Monitor

Title
Medi-Cal: Health Home Program.

Description
SB 361, as amended, Mitchell. Medi-Cal: Health Home Program. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law authorizes the department to create the Health Home Program (program) for enrollees with chronic conditions, as authorized under federal law. Existing law conditions the implementation of the program on federal approval and the availability of federal financial participation.Existing law prohibits the implementation of the program using if additional General Fund moneys are used to fund the administration and costs of services, unless the department projects, as specified, that no projects that the implementation of the program would not result in any net increase in ongoing General Fund costs for the Medi-Cal program would result. program. Existing law requires the nonfederal share for the program to be provided by funds from local governments, private foundations, or any other source permitted under state and federal law. specified entities, including local governments.This bill would remove the prohibition on the use of General Fund moneys for the implementation of the program. The bill would limit the above restriction on sources for the nonfederal share only to the first 8 quarters of implementation of each phase of the program.Existing law authorizes the department to revise or terminate the program any time after the first 8 quarters of implementation if the department finds that the program fails to demonstrate certain results.This bill would remove the department's authority to revise or terminate the program as described above.Existing law requires the department to select providers with a viable plan to reach out to and engage frequent hospital or emergency department users and chronically homeless eligible individuals.This bill would require the outreach and engagement to be in person.The bill would require the department to require administering Medi-Cal managed care plans to take specified actions, relating to provider rates, partnerships, and reports, for purposes of adult beneficiaries who have a level of severity in certain conditions based on chronic homelessness, to achieve the goal of 13 of program participants being increase program participation from that population.

Primary Sponsors
Holly Mitchell

Organizational Notes

Last edited by Joanne Campbell at Feb 25, 2019, 10:05 PM
Organizational Sponsor: Corporation for Supportive Housing and the Western Center on Law and Poverty

Bill Summary: Last edited by Joanne Campbell at Feb 25, 2019, 10:05 PM Expands the Health Home program to include outreach and engagement for homeless population. Removes existing general fund spending restrictions. i. Tier payment rates to health homes providers, using the highest rate for providers that serve the homeless HHP participants ii. Partner with local homeless Continuums of care or agencies to identify members experiencing homelessness and design a process for referring homeless members HHP eligibility assessment iii. Offer health homes providers an outreach rate that requires providers to outreach to the homeless population in person iv. Report to the department member-level data on the homeless population Removes conditions for extending HHP beyond eight quarters by striking subdivisions (b), (c), and (f) of WIC Section 14127.6 i. Removes requirement that HHP shall only continue beyond the first eight quarters if no additional GF is used. ii. Removes requirement that if program does not result in a net increase of ongoing GF costs in Medi-Cal, the department may use state funds for HHP. iii. Removes the authority for the department to revise or terminate HHP after the first eight quarters if it finds the program fails to meet certain requirements (e.g., reduce inpatient stays).

Labels: Medi-Cal

State	Bill Number	Status	Position
CA	SB 388	In Senate	Monitor

Title
Breast feeding.

Description
SB 388, as introduced, Galgiani. Breast feeding. Existing law requires the State Department of Public Health to promote the breastfeeding of infants in its public service campaign. Existing law vests authority for enforcing state laws governing health care service plans in the Department of Managed Health Care.This bill would express the intent of the Legislature to enact legislation that would provide that infant feeding of breast milk should be encouraged and that would require health care service plans to provide reimbursement for the widest variety of choices and styles of breast milk pumps to facilitate their use and acceptance. The bill would express the further intent of the Legislature to enact legislation that would give the Department of Managed Health Care the authority to require health care service plans to provide that reimbursement under a specified condition.

Primary Sponsors
Cathleen Galgiani

Bill Summary: Last edited by Joanne Campbell at Feb 21, 2019, 7:01 PM
Intent bill to require health care service plans to provide reimbursement for the widest variety of choices and styles of breast milk pumps to facilitate their use and acceptance.

Labels: Commercial Medi-Cal

State	Bill Number	Status	Position
CA	SB 446	In Senate	Monitor

Labels:

Title
Medi-Cal: hypertension medication management services.

Description
SB 446, as amended, Stone. Medi-Cal: hypertension medication management services. Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law provides for a schedule of benefits under the Medi-Cal program, which includes pharmacist services, subject to approval by the federal Centers for Medicare and Medicaid Services. Under existing law, covered pharmacist services include, but are not limited to, furnishing travel medications, initiating and administering immunizations, providing tobacco cessation counseling, and furnishing nicotine replacement therapy.This bill would additionally provide that hypertension medication management services are a covered pharmacist service under the Medi-Cal program, as specified.

Primary Sponsors
Jeff Stone

State	Bill Number	Status	Position
CA	SB 503	In Senate	Monitor

Title
Medi-Cal: managed care plan: subcontracts.

Description
SB 503, as amended, Pan. Medi-Cal: managed care plan: subcontracts. Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services either through a fee-for-service or managed care delivery system. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law authorizes the department to enter into various types of contracts for the provision of services to beneficiaries, including contracts with prepaid health plans. Existing law requires the Director of Health Care Services, in accordance with specified procedures, to either terminate a contract with or impose one or more specified sanctions, including civil penalties pursuant to federal law, on a prepaid health plan or Medi-Cal managed care plan if the department makes a finding of noncompliance or for other good cause. Existing law defines "good cause" to include 3 repeated and uncorrected findings of serious deficiencies, which potentially endanger patient care and are identified in medical audits conducted by the department.This bill would instead authorize "good cause" to be based on findings of serious deficiencies that have the potential to endanger patient care and are identified in the specified medical audits, and would conform the civil penalties to federal law.Existing law requires subcontracts entered into by a prepaid health plan to contain the amount of compensation or other consideration that a subcontractor will receive under the terms of the subcontract with the prepaid health plan, and to meet specified requirements, including compliance with the Knox-Keene Health Care Service Plan Act of 1975.This bill would extend these requirements to all other types of Medi-Cal managed care plans. The bill would state that a Medi-Cal managed care plan contractor bears the ultimate responsibility for adherence to the contract, even if the contractor subcontracts with or delegates any duties to another entity.This bill would require a Medi-Cal managed care plan to conduct specified audits of its subcontractors, including an annual medical audit of any subcontract involving medical or administrative services. The bill would authorize a Medi-Cal managed care plan to conduct additional medical audits of a subcontract, for good cause, and to contract with a professional organization to perform medical audits. The bill would require a Medi-Cal managed care plan to report to the department the findings of the finalized annual medical audit, and would require the department to post the annual medical report on its internet website.

Primary Sponsors
Richard Pan

Organizational Notes

Last edited by Joanne Campbell at Mar 26, 2019, 6:02 PM
Organizational Sponsor: Western Center on Law & Poverty and the National Health Law Program

Bill Summary: Last edited by Joanne Campbell at Feb 25, 2019, 9:54 PM a. This is Senator Pan's bill on delegation oversight b. Amends WIC Sections 14304 & 14452 c. Redefines "good cause" in subdivision (a) i. When defining grounds on which the director may terminate a managed care plan contract, redefines good cause as the following: "Good cause includes any findings of serious deficiencies that have the potential to endanger patient care...identified in the medical audits conducted by the department." ii. Previous definition stated "three repeated and uncorrected findings..." d. Subdivision (b) outlines the director's authority to implement sanctions in lieu of contract termination. New subparagraph (b)(A)(iv) adds failure to "comply with the requirements for physician incentive plans" (as set forth in federal regulations) as a fourth finding that may be subject to a fine of up to $25,000. e. Adds subparagraph (a)(2) which states that the managed care plan must comply with applicable requirements in WIC and that this requirement is not waived under subcontracting or delegated arrangements. Also states that a plan "bears the ultimate responsibility for adherence to, and compliance with, the terms and conditions of the Medi-Cal managed care plan contract." f. Adds subdivision (f) to state that the requirements in this section apply to all Medi-Cal managed care plans

Labels Sub-Delegation

State	Bill Number	Status	Position
CA	SB 583	In Senate	Monitor

Title
Clinical trials.

Description
SB 583, as introduced, Jackson. Clinical trials. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan or health insurer to provide coverage for routine patient care costs related to a clinical trial for cancer, including, among other things, health care services required for the clinically appropriate monitoring of the investigational item or service. Existing law requires the clinical trial to either be exempt from a federal new drug application or be approved by a specified federal agency.This bill would expand required coverage for clinical trials under a plan contract or insurance policy to include a clinical trial relating to the prevention, detection, or treatment of a life-threatening disease or condition, as defined, and include a trial funded by, among others, a qualified nongovernmental research entity. The bill would prohibit a plan contract or insurance policy from, among other things, discriminating against an enrollee or insured for participating in an approved clinical trial. The bill would authorize a plan or insurer to require a qualified enrollee or insured to participate in a clinical trial, as specified, and to restrict coverage to an approved clinical trial in this state, unless the clinical trial is not offered or available through a provider in this state. Because a willful violation of the bill's requirements relative to health care service plans would be a crime, the bill would impose a state-mandated local program.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Hannah-Beth Jackson

Bill Summary: Last edited by Joanne Campbell at Mar 7, 2019, 11:43 PM The bill expands required coverage for clinical trials under a plan contract to include a clinical trial relating to the prevention, detection, or treatment of a life-threatening disease or condition and include a trial funded by, among others, a qualified nongovernmental research entity. The bill would prohibit a plan contract from discriminating against an enrollee for participating in an approved clinical trial.

Labels: Commercial Medi-Cal

State	Bill Number	Status	Position
CA	SB 600	In Senate	Monitor

Title
Healthcare coverage: fertility preservation.

Description
SB 600, as introduced, Portantino. Healthcare coverage: fertility preservation. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law requires every group health care service plan contract and health insurance policy issued, amended, or renewed on or after January 1, 2017, to include, at a minimum, coverage for essential health benefits, including medically necessary basic health care services, as defined.This bill would clarify that an individual or group health care service plan contract or health insurance policy that covers hospital, medical, or surgical expenses includes coverage for standard fertility preservation services when a medically necessary treatment may cause iatrogenic infertility to an enrollee or insured. The bill would state that these provisions are declaratory of existing law.This bill would also prohibit a health care service plan or health insurer from denying coverage for standard fertility preservation services based on medical necessity when a provider of a treatment of a medical condition authorized by the plan or policy states that the treatment may cause iatrogenic infertility to an enrollee or insured. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Anthony Portantino

Bill Summary: Last edited by Joanne Campbell at Feb 25, 2019, 11:14 PM Clarifies that an individual or group health care service plan contract that covers hospital, medical, or surgical expenses includes coverage for standard fertility preservation services when a medically necessary treatment may cause iatrogenic infertility to an enrollee. The bill would state that these provisions are declaratory of existing law.

Labels: Commercial, Medi-Cal

Organizational Notes

Last edited by Joanne Campbell at Mar 11, 2019, 10:10 PM
Organizational Sponsor: Alliance for Fertility Preservation, American Society for Reproductive Medicine and Fertile Action

State	Bill Number	Status	Position
CA	**SB 642**	**In Senate**	**None**

Labels: Pharmacy

Title
Public health.

Description
SB 642, as introduced, Stone. Public health. Existing law establishes the State Department of Public Health within the California Health and Human Services Agency, and requires the appointment of a State Public Health Officer to serve as the director of the State Department of Public Health, as prescribed.This bill would make technical, nonsubstantive changes to that provision.

Primary Sponsors
Jeff Stone

State	Bill Number	Status	Position
CA	SB 740	In Senate	Monitor

Title
Insurance: unclaimed life insurance.

Description
SB 740, as amended, Mitchell. Insurance: health care coverage: notice of termination. unclaimed life insurance. Existing law generally regulates the business of insurance in the state, including life insurance. Existing law provides for the escheat to the state of unclaimed personal property, including funds owed under a life insurance policy or annuity contract if the funds are unclaimed and unpaid for more than 3 years after the funds became payable.This bill, the Unclaimed Life Insurance and Annuities Act, would provide standards for identifying a deceased individual whose death may require an insurer to pay benefits or proceeds to beneficiaries in accordance with the terms of a life insurance policy, annuity contract, or retained asset account, for locating those beneficiaries, and for providing those beneficiaries with appropriate claims forms or instructions to make a claim. The bill would require an insurer to match its insureds with deceased individuals in the United States Social Security Administration's Death Master File by complying with specified requirements, including searching exact matches and variations of insureds' names, social security numbers, individual taxpayer identification numbers, and dates of birth. If an insurer is not contacted by a beneficiary within 120 days of the insurer's establishing its knowledge of death of an insured, the bill would require the insurer to conduct a thorough search for a beneficiary, to be completed within one year. The bill would require an insurer to provide appropriate claims forms or instructions to a beneficiary within 15 days of locating the beneficiary. The bill would require an insurer to escheat the proceeds of a policy, annuity contract, or retained asset account to the state if a beneficiary cannot be found after a thorough search. A failure to meet the bill's requirements knowingly or with the frequency to constitute a general practice would be an unfair and deceptive act, punishable by civil penalty.Existing law prohibits an insurer or nonprofit hospital service plan from terminating a group master policy or contract providing hospital, medical, or surgical benefits, increasing premiums or charges, reducing or eliminating benefits, or restricting eligibility for coverage without providing prior notice of that action.This bill would make technical, nonsubstantive changes to that prohibition.

Primary Sponsors
Holly Mitchell

Organizational Notes

Last edited by Joanne Campbell at Mar 26, 2019, 7:47 PM
Organizational Sponsor: California Insurance Commissioner

Bill Summary: Last edited by Joanne Campbell at Feb 25, 2019, 11:23 PM
Intent bill regarding private notice of action.

Labels: Commercial Medi-Cal

State	Bill Number	Status	Position
CA	SB 746	In Senate	Monitor

Title
Health care coverage: anticancer medical devices.

Description
SB 746, as introduced, Bates. Health care coverage: anticancer medical devices. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law requires health care service plan contracts and health insurance policies to cover certain medical services for particular types of cancer, including the screening, diagnosis, and treatment of breast cancer, and the screening and diagnosis of prostate cancer, if the contract or policy was issued, amended, or renewed after the applicable date.This bill would require health care service plan contracts and health insurance policies issued, amended, or renewed on or after January 1, 2020, that cover chemotherapy or radiation therapy for the treatment of cancer to also cover anticancer medical devices. The bill would define "anticancer medical device" as a medical device that has been approved for marketing by the federal Food and Drug Administration or is exempt from that approval, is primarily designed to be used outside of a medical facility, and has been prescribed by an authorized provider upon the provider's determination that the device is medically reasonable and necessary for the treatment of the patient's cancer. Because a violation of this bill's provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Pat Bates

Organizational Notes

Last edited by Joanne Campbell at Mar 11, 2019, 10:10 PM
Organizational Sponsor: Novocure

Bill Summary: Last edited by Joanne Campbell at Feb 25, 2019, 11:24 PM Mandates coverage for chemotherapy or radiation therapy for the treatment of cancer to also cover anticancer medical devices. The bill would define "anticancer medical device" as a medical device that has been approved for marketing by the federal Food and Drug Administration and is primarily designed to be used outside of a medical facility, and has been prescribed by an authorized provider upon the provider's determination that the device is medically reasonable and necessary for the treatment of the patient's cancer.

Labels: Commercial | Medi-Cal | Pharmacy

BOARD OF GOVERNORS
Executive Committee
Meeting Minutes – March 25, 2019
1055 West 7th Street, Los Angeles, CA 90017

L.A. Care HEALTH PLAN

Members
Hector De La Torre, *Chairperson*
Al Ballesteros, *Vice Chairperson* *
Robert H. Curry, *Treasurer*
Layla Gonzalez-Delgado, *Secretary*
Stephanie Booth, MD
Hilda Perez

Management/Staff
John Baackes, *Chief Executive Officer*
Terry Brown, *Chief Human Resources Officer*
Augustavia J. Haydel, Esq., *General Counsel*
Marie Montgomery, *Chief Financial Officer*
Richard Seidman, MD, MPH, *Chief Medical Officer*
Absent* * Via Teleconference*

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
CALL TO ORDER Hector De La Torre	Hector De La Torre, *Board Chairperson*, called the meeting to order at 2:37 pm. He welcomed Dr. Booth to the Committee and welcomed everyone to the meeting and invited the members of the Executive Committee, staff and guests to introduce themselves. He announced that members of the public may address the Committee on each matter listed on the agenda before or during the Committee's consideration of the item, or on any other topic at the Public Comment section.	
APPROVE MEETING AGENDA Hector De La Torre	The Agenda for today's meeting was approved as amended.	**Approved unanimously. 5 AYES (Booth, Curry, De La Torre, Gonzalez-Delgado, and Perez)**
PUBLIC COMMENTS	There were no public comments.	
APPROVE MEETING MINUTES Hector De La Torre	The minutes of the February 25, 2019 meeting were approved as submitted.	**Approved unanimously. 5 AYES**
CHAIRPERSON'S REPORT	There was no Chairperson report.	

APPROVED

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
CHIEF EXECUTIVE OFFICER REPORT John Baackes	John Baackes, *Chief Executive Officer,* provided a CEO and a Government Affairs update: Governor Newsom has proposed four things: 1. Create individual mandate to mimic the tax penalty in the original Affordable Care Act. 2. Increase subsidies for exchange participants, paid for by tax penalty revenue. 3. Extend eligibility to age 26 for undocumented persons not eligible for Medi-Cal. 4. Centralize pharmacy formulary and purchase to reduce cost. Mr. Baackes noted that health plans already use Pharmacy Benefit Managers to aggregate purchasing power. Health plans who are eligible for 340B pass along the benefit to the State. Providers eligible for 340B need to have the extra revenue to support health care for the uninsured. Medi-Cal beneficiaries will be affected, and it could affect care management for the most vulnerable patients. Mr. Baackes added that it may be difficult for the State to handle the administrative requirements. This is a very controversial executive order. The Local Health Plans of California will continue to raise serious questions around the execution of this proposal to shed light on the issues. <u>Grants and Sponsorship Policies</u> Francisco Oaxaca, *Senior Director, Communications and Community Outreach & Education,* summarized revisions to the policies that the Committee requested at the last meeting to reflect additional oversight and transparency. Staff reviewed the potential impacts. Staff looked back 18-months; board approval would have been needed for about 30 grants. He also noted that sponsorship requests are received 5 or 6 weeks before events, and if there was not a meeting within that time frame, the sponsorship request would have been denied. There may also have been conflicts of interest for board members. There was a request by the committee for increased frequency in reports. Member Booth expressed that she feels her point was missed and noted that what the Board wants is to look at the equity of the distribution of the funds, the recommendations to ensure the money is spent well, and to make sure that the Board gets sufficient and more immediate feedback. Chairperson De La Torre added that the Board did not need to vote on every sponsorship, but wanted to receive relevant information. Mr. Baackes noted that staff can do a report every month.	

APPROVED

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Chairperson De La Torre also suggested a lower threshold for grants, to $150,000 for reporting only, not for approval. If it goes over threshold, notification would be triggered. He asked that the report list high funding amounts (six figures) at the top and the rest at the bottom, with flags for repeat requests.	
ADJOURN TO CLOSED SESSION	Augustavia J. Haydel, Esq., *General Counsel,* announced the items to be discussed in closed session. He announced there is no report anticipated from the closed session. There was no public comment on the closed session items, and the meeting adjourned to closed session at 3:45 p.m. PUBLIC EMPLOYEE PERFORMANCE EVALUATION Section 54957 of the Ralph M. Brown Act Title: Chief Executive Officer CONFERENCE WITH LABOR NEGOTIATOR Section 54957.6 of the Ralph M. Brown Act Agency Negotiator: Hector De La Torre Unrepresented Employee: Chief Executive Officer	
RECONVENIE IN OPEN SESSION	The meeting reconvened in open session at 3:38 pm. No reportable actions were taken during the closed session.	
Government Affairs Update	The Government Affairs update were covered in the CEO report earlier in the meeting.	
Annual Disclosure of Broker Fees	Terry Brown, *Chief Human Resources Officer,* referred members to the report included in the meeting packet. The base commissions are the same as disclosed in 2018 and have been reviewed and found to be within normal ranges for such commissions. Member Curry asked how often is the rebid. Mr. Brown reported that a broker goes out every year to review underlying policies and L.A. Care conducts request for proposal every three years. Chairperson De La Torre asked who determines the offerings. Mr. Brown reported that L.A. Care determines the offering, with recommendations of the broker.	
Human Resources Policies	Mr. Brown presented the revisions to the Human Resources (HR) policies below. L.A. Care Policy HR-501 requires that the Executive Committee review the substantial changes to the HR Policies. In 2006, the Executive Committee was delegated the task of annual review of the Human Resource Policies. Policies are revised or written to reflect	

<table>
<tr><th>AGENDA ITEM/PRESENTER</th><th>MOTIONS / MAJOR DISCUSSIONS</th><th>ACTION TAKEN</th></tr>
<tr><td></td><td>desired changes to L.A. Care's practices, and to incorporate any changes necessitated by law.

Note that a doctor's note is required for taking off unscheduled paid time off just one day prior or past the holiday.

<table>
<tr><th>Policy Number</th><th>Policy</th><th>Section</th><th>Description of Modification or Reason for Creation</th></tr>
<tr><td>HR-108</td><td>Holidays</td><td>Benefits</td><td>1) Eligible Employees defined.
2) Procedure added for taking unscheduled PTO adjacent to a holiday.
3) Holiday pay for alternative work schedule added.</td></tr>
<tr><td>HR-205</td><td>Dress Code</td><td>Employee Relations</td><td>1) Dress code changed to include casual dress attire.
2) Dress attire definitions updated.</td></tr>
</table>

<u>Motion EXE A.0319</u>
To approve the revisions to Human Resources Policies: HR-108 (Holidays); HR-205 (Dress Code).</td><td>Approved unanimously.
5 AYES</td></tr>
<tr><td>Approve Consent Agenda for the Board of Governors Meeting</td><td>The Committee approved the following motions to be added to the Consent Agenda for the Board of Governors meeting on April 4, 2019 (the revised policies for grants and sponsorships will be revised):
• Revised Policy 603 (Grants)
• Policy COMM 006 (Sponsorships) (old Policy 603.2)
• RCAC Membership</td><td>Approved unanimously.
5 AYES</td></tr>
<tr><td>ADJOURN TO CLOSED SESSION</td><td>Ms. Haydel announced the items to be discussed in closed session. She announced there is no report anticipated from the closed session. There was no public comment on the closed session items, and the meeting adjourned to closed session at 3:45 p.m.

CONTRACT RATES
Pursuant to Welfare and Institutions Code Section 14087.38(m)
• Plan Partner Rates</td><td></td></tr>
</table>

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• Provider Rates • DHCS Rates REPORT INVOLVING TRADE SECRET Pursuant to Welfare and Institutions Code Section 14087.38(n) Discussion Concerning New Product Lines Estimated date of public disclosure: *March 2021* CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION Pursuant to Section 54956.9 (d) (2) of the Ralph M. Brown Act Two potential cases PEER REVIEW Welfare & Institutions Code Section 14087.38(n) PUBLIC EMPLOYEE PERFORMANCE EVALUATION Section 54957 of the Ralph M. Brown Act Title: Chief Executive Officer CONFERENCE WITH LABOR NEGOTIATOR Section 54957.6 of the Ralph M. Brown Act Agency Negotiator: Hector De La Torre Unrepresented Employee: Chief Executive Officer	
RECONVENIE IN OPEN SESSION	The meeting reconvened in open session at 4:15 pm. No reportable actions were taken during the closed session.	
ADJOURNMENT	The meeting adjourned at 4:15 pm.	

Respectfully submitted by:

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

APPROVED BY:

Hector De La Torre

Hector De La Torre, *Chair*
Date: 4-22-19

APPROVED

L.A. Care
HEALTH PLAN

Board of Governors
MOTION SUMMARY

Date: May 2, 2019 **Motion No. FIN 103.0519**

Committee: Finance & Budget **Chairperson:** Robert H. Curry

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

Issue: Acceptance of the Financial Reports.

Background: N/A

Member Impact: N/A

Budget Impact: N/A

Motion: **To accept the Financial Report as submitted, for the period ended March 2019, as submitted.**

Financial Performance
March 2019

Overall

The combined member months are 13.2 million year-to-date, which is 8,512 member months favorable to forecast. The year-to-date performance is a surplus of $199.5 million or 5% of revenue and is $36.7 million favorable to forecast.

MediCal Plan Partners

The member months are 6.0 million, which is 1,561 member months unfavorable to forecast. The performance is a surplus of $59.3 million and is $0.1 million favorable to forecast.

MediCal SPD-CCI

The member months are 1.3 million, which is 2,242 member months favorable to forecast. The performance is a surplus of $67.9 million, which is $19.8 million favorable to forecast driven by higher revenues and lower healthcare and operating expenses.

MediCal TANF-MCE

The member months are 5 million, which is 2,702 member months favorable to forecast. The performance is a surplus of $45.0 million and is $2.2 million favorable to forecast. The favorable variance is driven primarily by lower than expected operating expenses.

Cal MediConnect (CMC)

The member months are 98,272 which is 200 member months unfavorable to forecast. The performance is a deficit of $1.2 million, which is $0.8 million unfavorable to forecast driven by higher than expected healthcare expenses.

Commercial

L.A. Care Commercial consists of LACC and PASC-SEIU. The member months are 755,453, which is 5,329 member months favorable to forecast. The performance is a surplus of $34.8 million and is $6.7 million favorable to forecast driven primarily by increased revenue as a result of favorable membership.

L.A. Care HEALTH PLAN

Consolidated Operations Income Statement ($ in thousands)

March 2019

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						
2,182,532		2,177,371		5,161		Member Months	13,153,317		13,144,805		8,512	
						Revenue						
$ 649,883	$ 297.77	$ 645,607	$ 296.51	$ 4,277	$ 1.26	Capitation	$ 3,968,460	$ 301.71	$ 3,940,187	$ 299.75	$ 28,273	$ 1.96
$ 410	$ 0.19	$ 401	$ 0.18	$ 9	$ 0.00	Pay for Performance	$ 3,608	$ 0.27	$ 2,317	$ 0.18	$ 1,291	$ 0.10
$ 650,293	**$ 297.95**	**$ 646,008**	**$ 296.69**	**$ 4,286**	**$ 1.26**	**Total Revenues**	**$ 3,972,068**	**$ 301.98**	**$ 3,942,504**	**$ 299.93**	**$ 29,564**	**$ 2.05**
						Healthcare Expenses						
$ 341,785	$ 156.60	$ 343,949	$ 157.97	$ 2,164	$ 1.37	Capitation	$ 2,090,150	$ 158.91	$ 2,083,400	$ 158.50	$ (6,751)	$ (0.41)
$ 97,586	$ 44.71	$ 77,218	$ 35.46	$ (20,368)	$ (9.25)	Inpatient Claims	$ 470,490	$ 35.77	$ 448,048	$ 34.09	$ (22,442)	$ (1.68)
$ 58,261	$ 26.69	$ 57,918	$ 26.60	$ (344)	$ (0.09)	Outpatient Claims	$ 326,839	$ 24.85	$ 326,684	$ 24.85	$ (155)	$ 0.00
$ 31,525	$ 14.44	$ 50,962	$ 23.41	$ 19,437	$ 8.96	Skilled Nursing Facility	$ 296,159	$ 22.52	$ 315,254	$ 23.98	$ 19,094	$ 1.47
$ 63,030	$ 28.88	$ 55,033	$ 25.27	$ (7,997)	$ (3.60)	Pharmacy	$ 341,705	$ 25.98	$ 333,888	$ 25.40	$ (7,818)	$ (0.58)
$ 3,047	$ 1.40	$ 1,993	$ 0.92	$ (1,054)	$ (0.48)	Provider Incentives and Shared Risk	$ 27,298	$ 2.08	$ 25,535	$ 1.94	$ (1,763)	$ (0.13)
$ 4,820	$ 2.21	$ 5,462	$ 2.51	$ 642	$ 0.30	Medical Administrative Expenses	$ 29,304	$ 2.23	$ 30,149	$ 2.29	$ 845	$ 0.07
$ 600,055	**$ 274.94**	**$ 592,534**	**$ 272.13**	**$ (7,521)**	**$ (2.80)**	**Total Healthcare Expenses**	**$ 3,581,946**	**$ 272.32**	**$ 3,562,957**	**$ 271.05**	**$ (18,989)**	**$ (1.27)**
92.3%		*91.7%*		*-0.6%*		*MCR(%)*	*90.2%*		*90.4%*		*0.2%*	
$ 50,238	**$ 23.02**	**$ 53,473**	**$ 24.56**	**$ (3,235)**	**$ (1.54)**	**Operating Margin**	**$ 390,122**	**$ 29.66**	**$ 379,547**	**$ 28.87**	**$ 10,575**	**$ 0.79**
$ 26,758	$ 12.26	$ 37,433	$ 17.19	$ 10,675	$ 4.93	**Total Operating Expenses**	$ 204,371	$ 15.54	$ 218,753	$ 16.64	$ 14,382	$ 1.10
4.1%		*5.8%*		*1.7%*		*Admin Ratio(%)*	*5.1%*		*5.5%*		*0.4%*	
$ 23,480	**$ 10.76**	**$ 16,040**	**$ 7.37**	**$ 7,440**	**$ 3.39**	**Income (Loss) from Operations**	**$ 185,751**	**$ 14.12**	**$ 160,794**	**$ 12.23**	**$ 24,957**	**$ 1.89**
$ (990)	$ (0.45)	$ (4,323)	$ (1.99)	$ 3,332	$ 1.53	Other Income/(Expense), net	$ (8,747)	$ (0.66)	$ (15,308)	$ (1.16)	$ 6,561	$ 0.50
$ 3,613	$ 1.66	$ 2,393	$ 1.10	$ 1,220	$ 0.56	Interest Income, net	$ 15,541	$ 1.18	$ 14,214	$ 1.08	$ 1,327	$ 0.10
$ (50)	$ (0.02)	$ -	$ -	$ (50)	$ (0.02)	Realized Gain / Loss	$ (177)	$ (0.01)	$ (82)	$ (0.01)	$ (95)	$ (0.01)
$ 2,540	$ 1.16	$ (533)	$ (0.24)	$ 3,073	$ 1.41	Unrealized Gain / Loss	$ 7,180	$ 0.55	$ 3,197	$ 0.24	$ 3,984	$ 0.30
$ 5,112	**$ 2.34**	**$ (2,463)**	**$ (1.13)**	**$ 7,575**	**$ 3.47**	**Total Non-Operating Income (Expense)**	**$ 13,797**	**$ 1.05**	**$ 2,020**	**$ 0.15**	**$ 11,777**	**$ 0.90**
$ 28,592	**$ 13.10**	**$ 13,577**	**$ 6.24**	**$ 15,015**	**$ 6.86**	**Net Surplus (Deficit)**	**$ 199,548**	**$ 15.17**	**$ 162,815**	**$ 12.39**	**$ 36,734**	**$ 2.78**
4.4%		*2.1%*		*2.3%*		*Margin(%)*	*5.0%*		*4.1%*		*0.9%*	

MediCal Plan Partners Income Statement ($ in thousands)

March 2019

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						
990,217		991,778		(1,561)		Member Months	6,013,239		6,014,800		(1,561)	
						Revenue						
$ 236,024	$ 238.36	$ 240,572	$ 242.57	$ (4,548)	$ (4.21)	Capitation	$ 1,451,585	$ 241.40	$ 1,445,457	$ 240.32	$ 6,127	$ 1.08
$ 236,024	**$ 238.36**	**$ 240,572**	**$ 242.57**	**$ (4,548)**	**$ (4.21)**	**Total Revenues**	**$ 1,451,585**	**$ 241.40**	**$ 1,445,457**	**$ 240.32**	**$ 6,127**	**$ 1.08**
						Healthcare Expenses						
$ 220,490	$ 222.67	$ 223,230	$ 225.08	$ 2,740	$ 2.41	Capitation	$ 1,361,054	$ 226.34	$ 1,350,703	$ 224.56	$ (10,351)	$ (1.78)
$ -	$ -	$ -	$ -	$ -	$ -	Inpatient Claims	$ 7	$ 0.00	$ (1)	$ (0.00)	$ (8)	$ (0.00)
$ (2)	$ (0.00)	$ -	$ -	$ 2	$ 0.00	Outpatient Claims	$ 536	$ 0.09	$ 140	$ 0.02	$ (396)	$ (0.07)
$ 211	$ 0.21	$ -	$ -	$ (211)	$ (0.21)	Provider Incentives and Shared Risk	$ 6,973	$ 1.16	$ 6,763	$ 1.12	$ (211)	$ (0.04)
$ 648	$ 0.65	$ 796	$ 0.80	$ 149	$ 0.15	Medical Administrative Expenses	$ 3,994	$ 0.66	$ 4,235	$ 0.70	$ 240	$ 0.04
$ 221,346	**$ 223.53**	**$ 224,027**	**$ 225.88**	**$ 2,680**	**$ 2.35**	**Total Healthcare Expenses**	**$ 1,372,564**	**$ 228.26**	**$ 1,361,839**	**$ 226.41**	**$ (10,725)**	**$ (1.84)**
93.8%		*93.1%*		*-0.7%*		*MCR(%)*	*94.6%*		*94.2%*		*-0.3%*	
$ 14,678	**$ 14.82**	**$ 16,545**	**$ 16.68**	**$ (1,867)**	**$ (1.86)**	**Operating Margin**	**$ 79,021**	**$ 13.14**	**$ 83,618**	**$ 13.90**	**$ (4,598)**	**$ (0.76)**
$ 3,785	$ 3.82	$ 5,501	$ 5.55	$ 1,716	$ 1.72	**Total Operating Expenses**	$ 29,914	$ 4.97	$ 32,193	$ 5.35	$ 2,279	$ 0.38
1.6%		*2.3%*		*0.7%*		*Admin Ratio(%)*	*2.1%*		*2.2%*		*0.2%*	
$ 10,893	**$ 11.00**	**$ 11,044**	**$ 11.14**	**$ (151)**	**$ (0.14)**	**Income (Loss) from Operations**	**$ 49,106**	**$ 8.17**	**$ 51,425**	**$ 8.55**	**$ (2,318)**	**$ (0.38)**
$ 2,726	**$ 2.75**	**$ 773**	**$ 0.78**	**$ 1,953**	**$ 1.97**	**Total Non-Operating Income (Expense)**	**$ 10,201**	**$ 1.70**	**$ 7,747**	**$ 1.29**	**$ 2,454**	**$ 0.41**
$ 13,619	**$ 13.75**	**$ 11,817**	**$ 11.92**	**$ 1,801**	**$ 1.84**	**Net Surplus (Deficit)**	**$ 59,307**	**$ 9.86**	**$ 59,172**	**$ 9.84**	**$ 135**	**$ 0.03**
5.8%		*4.9%*		*0.9%*		*Margin(%)*	*4.1%*		*4.1%*		*0.0%*	

MediCal SPD-CCI Income Statement ($ in thousands)

March 2019

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						
219,620		217,378		2,242		Member Months	1,322,256		1,320,014		2,242	
						Revenue						
$ 155,683	$ 708.87	$ 150,653	$ 693.05	$ 5,030	$ 15.83	Capitation	$ 960,489	$ 726.40	$ 956,466	$ 724.59	$ 4,023	$ 1.81
$ 155,683	**$ 708.87**	**$ 150,653**	**$ 693.05**	**$ 5,030**	**$ 15.83**	**Total Revenues**	**$ 960,489**	**$ 726.40**	**$ 956,466**	**$ 724.59**	**$ 4,023**	**$ 1.81**
						Healthcare Expenses						
$ 15,983	$ 72.77	$ 14,910	$ 68.59	$ (1,072)	$ (4.18)	Capitation	$ 98,420	$ 74.43	$ 96,818	$ 73.35	$ (1,602)	$ (1.09)
$ 36,831	$ 167.70	$ 29,362	$ 135.07	$ (7,469)	$ (32.63)	Inpatient Claims	$ 175,861	$ 133.00	$ 166,918	$ 126.45	$ (8,943)	$ (6.55)
$ 31,118	$ 141.69	$ 30,274	$ 139.27	$ (845)	$ (2.42)	Outpatient Claims	$ 175,119	$ 132.44	$ 174,002	$ 131.82	$ (1,117)	$ (0.62)
$ 27,439	$ 124.94	$ 45,159	$ 207.75	$ 17,720	$ 82.81	Skilled Nursing Facility	$ 266,777	$ 201.76	$ 284,542	$ 215.56	$ 17,765	$ 13.80
$ 18,358	$ 83.59	$ 17,700	$ 81.42	$ (658)	$ (2.17)	Pharmacy	$ 103,202	$ 78.05	$ 103,975	$ 78.77	$ 774	$ 0.72
$ (679)	$ (3.09)	$ (791)	$ (3.64)	$ (112)	$ (0.55)	Provider Incentives and Shared Risk	$ 1,828	$ 1.38	$ 1,681	$ 1.27	$ (147)	$ (0.11)
$ 1,647	$ 7.50	$ 1,803	$ 8.29	$ 156	$ 0.79	Medical Administrative Expenses	$ 9,300	$ 7.03	$ 9,437	$ 7.15	$ 137	$ 0.12
$ 130,697	**$ 595.10**	**$ 138,417**	**$ 636.75**	**$ 7,720**	**$ 41.65**	**Total Healthcare Expenses**	**$ 830,507**	**$ 628.10**	**$ 837,374**	**$ 634.37**	**$ 6,867**	**$ 6.27**
84.0%		*91.9%*		*7.9%*		*MCR(%)*	*86.5%*		*87.5%*		*1.1%*	
$ 24,986	**$ 113.77**	**$ 12,236**	**$ 56.29**	**$ 12,750**	**$ 57.48**	**Operating Margin**	**$ 129,982**	**$ 98.30**	**$ 119,092**	**$ 90.22**	**$ 10,890**	**$ 8.08**
$ 8,373	$ 38.12	$ 13,061	$ 60.09	$ 4,688	$ 21.96	**Total Operating Expenses**	$ 68,253	$ 51.62	$ 75,866	$ 57.47	$ 7,614	$ 5.86
5.4%		*8.7%*		*3.3%*		*Admin Ratio(%)*	*7.1%*		*7.9%*		*0.8%*	
$ 16,613	**$ 75.65**	**$ (825)**	**$ (3.79)**	**$ 17,438**	**$ 79.44**	**Income (Loss) from Operations**	**$ 61,729**	**$ 46.68**	**$ 43,226**	**$ 32.75**	**$ 18,503**	**$ 13.94**
$ 1,633	**$ 7.43**	**$ 553**	**$ 2.55**	**$ 1,079**	**$ 4.89**	**Total Non-Operating Income (Expense)**	**$ 6,189**	**$ 4.68**	**$ 4,905**	**$ 3.72**	**$ 1,284**	**$ 0.96**
$ 18,246	**$ 83.08**	**$ (271)**	**$ (1.25)**	**$ 18,517**	**$ 84.33**	**Net Surplus (Deficit)**	**$ 67,918**	**$ 51.37**	**$ 48,131**	**$ 36.46**	**$ 19,787**	**$ 14.90**
11.7%		*-0.2%*		*11.9%*		*Margin(%)*	*7.1%*		*5.0%*		*2.0%*	

MediCal TANF-MCE Income Statement ($ in thousands)

March 2019

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						
823,579		820,877		2,702		Member Months	4,964,097		4,961,395		2,702	
						Revenue						
$ 189,610	$ 230.23	$ 188,372	$ 229.48	$ 1,238	$ 0.75	Capitation	$ 1,168,836	$ 235.46	$ 1,157,395	$ 233.28	$ 11,441	$ 2.18
$ 189,610	**$ 230.23**	**$ 188,372**	**$ 229.48**	**$ 1,238**	**$ 0.75**	**Total Revenues**	**$ 1,168,836**	**$ 235.46**	**$ 1,157,395**	**$ 233.28**	**$ 11,441**	**$ 2.18**
						Healthcare Expenses						
$ 73,891	$ 89.72	$ 74,262	$ 90.47	$ 372	$ 0.75	Capitation	$ 445,298	$ 89.70	$ 451,279	$ 90.96	$ 5,982	$ 1.25
$ 48,855	$ 59.32	$ 39,290	$ 47.86	$ (9,565)	$ (11.46)	Inpatient Claims	$ 243,593	$ 49.07	$ 232,122	$ 46.79	$ (11,471)	$ (2.29)
$ 22,952	$ 27.87	$ 23,727	$ 28.90	$ 775	$ 1.04	Outpatient Claims	$ 131,183	$ 26.43	$ 131,795	$ 26.56	$ 612	$ 0.14
$ 2,683	$ 3.26	$ 4,322	$ 5.26	$ 1,638	$ 2.01	Skilled Nursing Facility	$ 19,731	$ 3.97	$ 21,412	$ 4.32	$ 1,681	$ 0.34
$ 37,103	$ 45.05	$ 30,340	$ 36.96	$ (6,762)	$ (8.09)	Pharmacy	$ 198,618	$ 40.01	$ 190,537	$ 38.40	$ (8,081)	$ (1.61)
$ 2,201	$ 2.67	$ 681	$ 0.83	$ (1,520)	$ (1.84)	Provider Incentives and Shared Risk	$ 9,695	$ 1.95	$ 6,750	$ 1.36	$ (2,945)	$ (0.59)
$ 2,135	$ 2.59	$ 2,420	$ 2.95	$ 284	$ 0.35	Medical Administrative Expenses	$ 12,823	$ 2.58	$ 13,356	$ 2.69	$ 533	$ 0.11
$ 189,821	**$ 230.48**	**$ 175,042**	**$ 213.24**	**$ (14,778)**	**$ (17.24)**	**Total Healthcare Expenses**	**$ 1,060,940**	**$ 213.72**	**$ 1,047,251**	**$ 211.08**	**$ (13,689)**	**$ (2.64)**
100.1%		*92.9%*		*-7.2%*		*MCR(%)*	*90.8%*		*90.5%*		*-0.3%*	
$ (211)	**$ (0.26)**	**$ 13,330**	**$ 16.24**	**$ (13,541)**	**$ (16.49)**	**Operating Margin**	**$ 107,896**	**$ 21.74**	**$ 110,144**	**$ 22.20**	**$ (2,248)**	**$ (0.47)**
$ 9,923	$ 12.05	$ 13,044	$ 15.89	$ 3,121	$ 3.84	**Total Operating Expenses**	$ 69,193	$ 13.94	$ 72,236	$ 14.56	$ 3,043	$ 0.62
5.2%		*6.9%*		*1.7%*		*Admin Ratio(%)*	*5.9%*		*6.2%*		*0.3%*	
$ (10,134)	**$ (12.30)**	**$ 286**	**$ 0.35**	**$ (10,419)**	**$ (12.65)**	**Income (Loss) from Operations**	**$ 38,703**	**$ 7.80**	**$ 37,908**	**$ 7.64**	**$ 795**	**$ 0.16**
$ 1,708	**$ 2.07**	**$ 533**	**$ 0.65**	**$ 1,175**	**$ 1.42**	**Total Non-Operating Income (Expense)**	**$ 6,325**	**$ 1.27**	**$ 4,901**	**$ 0.99**	**$ 1,425**	**$ 0.29**
$ (8,426)	**$ (10.23)**	**$ 819**	**$ 1.00**	**$ (9,244)**	**$ (11.23)**	**Net Surplus (Deficit)**	**$ 45,028**	**$ 9.07**	**$ 42,809**	**$ 8.63**	**$ 2,219**	**$ 0.44**
-4.4%		*0.4%*		*-4.9%*		*Margin(%)*	*3.9%*		*3.7%*		*0.2%*	

L.A. Care HEALTH PLAN

CMC Income Statement ($ in thousands)

March 2019

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						
16,330		16,530		(200)		Member Months	98,272		98,472		(200)	
						Revenue						
$ 20,755	$ 1,270.96	$ 20,124	$ 1,217.43	$ 631	$ 53.53	Capitation	$ 122,322	$ 1,244.73	$ 120,228	$ 1,220.94	$ 2,095	$ 23.80
$ 20,755	**$ 1,270.96**	**$ 20,124**	**$ 1,217.43**	**$ 631**	**$ 53.53**	**Total Revenues**	**$ 122,322**	**$ 1,244.73**	**$ 120,228**	**$ 1,220.94**	**$ 2,095**	**$ 23.80**
						Healthcare Expenses						
$ 9,431	$ 577.54	$ 9,363	$ 566.44	$ (68)	$ (11.10)	Capitation	$ 57,024	$ 580.27	$ 55,868	$ 567.35	$ (1,156)	$ (12.92)
$ 5,638	$ 345.24	$ 4,221	$ 255.33	$ (1,417)	$ (89.91)	Inpatient Claims	$ 23,346	$ 237.57	$ 22,778	$ 231.31	$ (569)	$ (6.26)
$ 1,481	$ 90.70	$ 1,786	$ 108.08	$ 305	$ 17.38	Outpatient Claims	$ 8,765	$ 89.19	$ 9,245	$ 93.88	$ 480	$ 4.69
$ 1,307	$ 80.02	$ 1,481	$ 89.58	$ 174	$ 9.55	Skilled Nursing Facility	$ 9,229	$ 93.91	$ 9,008	$ 91.48	$ (221)	$ (2.43)
$ 1,852	$ 113.42	$ 1,281	$ 77.51	$ (571)	$ (35.92)	Pharmacy	$ 10,613	$ 107.99	$ 8,304	$ 84.33	$ (2,309)	$ (23.67)
$ 604	$ 36.96	$ 301	$ 18.19	$ (303)	$ (18.77)	Provider Incentives and Shared Risk	$ 4,374	$ 44.51	$ 3,732	$ 37.90	$ (642)	$ (6.61)
$ 251	$ 15.38	$ 425	$ 25.71	$ 174	$ 10.33	Medical Administrative Expenses	$ 2,094	$ 21.31	$ 2,266	$ 23.02	$ 173	$ 1.71
$ 20,564	**$ 1,259.27**	**$ 18,858**	**$ 1,140.82**	**$ (1,706)**	**$ (118.45)**	**Total Healthcare Expenses**	**$ 115,445**	**$ 1,174.75**	**$ 111,201**	**$ 1,129.27**	**$ (4,244)**	**$ (45.49)**
99.1%		*93.7%*		*-5.4%*		*MCR(%)*	*94.4%*		*92.5%*		*-1.9%*	
$ 191	**$ 11.68**	**$ 1,266**	**$ 76.61**	**$ (1,075)**	**$ (64.92)**	**Operating Margin**	**$ 6,877**	**$ 69.98**	**$ 9,027**	**$ 91.67**	**$ (2,150)**	**$ (21.69)**
$ 763	$ 46.75	$ 1,757	$ 106.29	$ 994	$ 59.55	**Total Operating Expenses**	$ 8,234	$ 83.79	$ 9,557	$ 97.05	$ 1,323	$ 13.26
3.7%		*8.7%*		*5.1%*		*Admin Ratio(%)*	*6.7%*		*7.9%*		*1.2%*	
$ (573)	**$ (35.06)**	**$ (491)**	**$ (29.69)**	**$ (82)**	**$ (5.38)**	**Income (Loss) from Operations**	**$ (1,357)**	**$ (13.81)**	**$ (530)**	**$ (5.39)**	**$ (827)**	**$ (8.42)**
$ 38	**$ 2.31**	**$ (4)**	**$ (0.22)**	**$ 41**	**$ 2.53**	**Total Non-Operating Income (Expense)**	**$ 145**	**$ 1.47**	**$ 82**	**$ 0.83**	**$ 63**	**$ 0.64**
$ (535)	**$ (32.75)**	**$ (494)**	**$ (29.91)**	**$ (41)**	**$ (2.85)**	**Net Surplus (Deficit)**	**$ (1,212)**	**$ (12.34)**	**$ (448)**	**$ (4.55)**	**$ (764)**	**$ (7.78)**
-2.6%		*-2.5%*		*-0.1%*		*Margin(%)*	*-1.0%*		*-0.4%*		*-0.6%*	

Commercial Income Statement ($ in thousands)

March 2019

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						
132,786		130,808		1,978		Member Months	755,453		750,124		5,329	
						Revenue						
$ 47,812	$ 360.07	$ 45,886	$ 350.79	$ 1,926	$ 9.28	Capitation	$ 265,228	$ 351.09	$ 260,640	$ 347.46	$ 4,588	$ 3.62
$ 47,812	**$ 360.07**	**$ 45,886**	**$ 350.79**	**$ 1,926**	**$ 9.28**	**Total Revenues**	**$ 265,228**	**$ 351.09**	**$ 260,640**	**$ 347.46**	**$ 4,588**	**$ 3.62**
						Healthcare Expenses						
$ 21,991	$ 165.61	$ 22,183	$ 169.58	$ 192	$ 3.97	Capitation	$ 128,355	$ 169.90	$ 128,731	$ 171.61	$ 376	$ 1.71
$ 6,262	$ 47.16	$ 4,346	$ 33.22	$ (1,916)	$ (13.94)	Inpatient Claims	$ 27,683	$ 36.64	$ 26,231	$ 34.97	$ (1,452)	$ (1.67)
$ 2,712	$ 20.42	$ 2,130	$ 16.28	$ (581)	$ (4.14)	Outpatient Claims	$ 11,237	$ 14.87	$ 11,503	$ 15.33	$ 266	$ 0.46
$ 96	$ 0.72	$ -	$ -	$ (96)	$ (0.72)	Skilled Nursing Facility	$ 423	$ 0.56	$ 292	$ 0.39	$ (131)	$ (0.17)
$ 5,718	$ 43.06	$ 5,712	$ 43.66	$ (6)	$ 0.61	Pharmacy	$ 29,273	$ 38.75	$ 31,071	$ 41.42	$ 1,798	$ 2.67
$ 711	$ 5.36	$ 1,802	$ 13.78	$ 1,091	$ 8.42	Provider Incentives and Shared Risk	$ 4,428	$ 5.86	$ 6,609	$ 8.81	$ 2,182	$ 2.95
$ 139	$ 1.04	$ 18	$ 0.14	$ (120)	$ (0.90)	Medical Administrative Expenses	$ 1,092	$ 1.45	$ 855	$ 1.14	$ (238)	$ (0.31)
$ 37,628	**$ 283.37**	**$ 36,191**	**$ 276.67**	**$ (1,437)**	**$ (6.70)**	**Total Healthcare Expenses**	**$ 202,490**	**$ 268.04**	**$ 205,292**	**$ 273.68**	**$ 2,802**	**$ 5.64**
78.7%		*78.9%*		*0.2%*		*MCR(%)*	*76.3%*		*78.8%*		*2.4%*	
$ 10,185	**$ 76.70**	**$ 9,695**	**$ 74.11**	**$ 490**	**$ 2.58**	**Operating Margin**	**$ 62,739**	**$ 83.05**	**$ 55,348**	**$ 73.79**	**$ 7,390**	**$ 9.26**
$ 3,786	$ 28.51	$ 3,349	$ 25.60	$ (436)	$ (2.91)	**Total Operating Expenses**	$ 24,492	$ 32.42	$ 23,848	$ 31.79	$ (644)	$ (0.63)
7.9%		*7.3%*		*-0.6%*		*Admin Ratio(%)*	*9.2%*		*9.1%*		*-0.1%*	
$ 6,399	**$ 48.19**	**$ 6,346**	**$ 48.51**	**$ 53**	**$ (0.32)**	**Income (Loss) from Operations**	**$ 38,247**	**$ 50.63**	**$ 31,500**	**$ 41.99**	**$ 6,746**	**$ 8.63**
$ (577)	**$ (4.34)**	**$ (575)**	**$ (4.40)**	**$ (1)**	**$ 0.05**	**Total Non-Operating Income (Expense)**	**$ (3,492)**	**$ (4.62)**	**$ (3,489)**	**$ (4.65)**	**$ (3)**	**$ 0.03**
$ 5,822	**$ 43.85**	**$ 5,771**	**$ 44.11**	**$ 52**	**$ (0.27)**	**Net Surplus (Deficit)**	**$ 34,755**	**$ 46.01**	**$ 28,011**	**$ 37.34**	**$ 6,744**	**$ 8.66**
12.2%		*12.6%*		*-0.4%*		*Margin(%)*	*13.1%*		*10.7%*		*2.4%*	

Comparative Balance Sheet

March 2019

(Dollars in thousands)	Mar-18	Jun-18	Sep-18	Dec-18	Jan-19	Feb-19	Mar-19
ASSETS							
CURRENT ASSETS							
Total Current Assets	4,422,273	4,357,889	4,015,955	3,828,181	3,809,146	4,055,003	4,745,141
Capitalized Assets - net	95,837	101,440	105,599	108,055	109,126	108,229	110,451
NON-CURRENT ASSETS	1,803	2,147	1,721	1,902	2,861	2,701	2,578
TOTAL ASSETS	**$4,519,913**	**$4,461,476**	**$4,123,276**	**$3,938,138**	**$3,921,133**	**$4,165,933**	**$4,858,170**
LIABILITIES AND FUND EQUITY							
CURRENT LIABILITIES							
Total Current Liability	3,711,164	3,679,923	3,302,934	3,059,560	2,992,769	3,174,780	3,838,394
Long Term Liability	3,167	2,980	2,855	2,767	2,647	2,710	2,742
Total Liabilities	**$3,714,330**	**$3,682,903**	**$3,305,790**	**$3,062,327**	**$2,995,416**	**$3,177,491**	**$3,841,136**
FUND EQUITY							
Invested in Capital Assets, net of related debt	95,837	101,440	105,599	108,055	109,126	108,229	110,451
Restricted Equity	300	300	300	300	300	300	300
Minimum Tangible Net Equity	195,011	186,868	174,088	164,287	163,320	161,904	161,811
Board Designated Funds	3,106	43,356	35,992	63,795	63,720	63,720	73,720
Unrestricted Net Assets	511,329	446,609	501,506	539,373	589,250	654,289	670,753
Total Fund Equity	**$805,583**	**$778,573**	**$817,486**	**$875,810**	**$925,717**	**$988,442**	**$1,017,034**
TOTAL LIABILITIES AND FUND EQUITY	**$4,519,913**	**$4,461,476**	**$4,123,276**	**$3,938,138**	**$3,921,133**	**$4,165,933**	**$4,858,170**
Solvency Ratios							
Working Capital Ratio	1.19	1.18	1.22	1.25	1.27	1.28	1.24
Cash to Claims Ratio	0.51	0.49	0.51	0.45	0.48	0.52	0.85
Tangible Net Equity Ratio	4.13	4.17	4.70	5.33	5.67	6.11	6.29

L.A. Care HEALTH PLAN

Cash Flows Statement ($ in thousands)

March 2019

	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	YTD
	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	
Cash Flows from Operating Activities:							
Capitation Revenue	$ 638,407	$ 406,972	$ 596,708	$ 713,150	$ 745,293	$ 926,643	$ 4,027,173
Other Income (Expense), net	$ 3,682	$ (90)	$ 241	$ 1,254	$ 2,286	$ 3,149	$ 10,522
Healthcare Expenses	$ (566,253)	$ (640,460)	$ (462,734)	$ (615,151)	$ (508,155)	$ (547,646)	$ (3,340,399)
Operating Expenses	$ (32,471)	$ (41,276)	$ (38,812)	$ (29,411)	$ (30,246)	$ (29,377)	$ (201,593)
Net Cash Provided By Operating Activities	**$ 43,365**	**$ (274,854)**	**$ 95,403**	**$ 69,842**	**$ 209,178**	**$ 352,769**	**$ 495,703**
Cash Flows from Investing Activities							
Purchase of investments - Net	$ 149,067	$ (179,656)	$ 52,077	$ 13,073	$ 26,570	$ 66,471	$ 127,602
Purchase of Capital Assets	$ (4,355)	$ (1,591)	$ (1,984)	$ (2,892)	$ (1,319)	$ (4,347)	$ (16,488)
Net Cash Provided By Investing Activities	**$ 144,712**	**$ (181,247)**	**$ 50,093**	**$ 10,181**	**$ 25,251**	**$ 62,124**	**$ 111,114**
Cash Flows from Financing Activities:							
Gross Premium Tax (MCO Sales Tax) - Net	$ (26,802)	$ 11,908	$ 11,770	$ (26,959)	$ 11,719	$ 11,998	$ (6,366)
Pass through transactions (AB 85, IGT, etc.)	$ -	$ -	$ -	$ -	$ (92)	$ 587,558	$ 587,466
Net Cash Provided By Financing Activities	**$ (26,802)**	**$ 11,908**	**$ 11,770**	**$ (26,959)**	**$ 11,627**	**$ 599,556**	**$ 581,100**
Net Increase in Cash and Cash Equivalents	**$ 161,275**	**$ (444,193)**	**$ 157,266**	**$ 53,064**	**$ 246,055**	**$ 1,014,449**	**$ 1,187,916**
Cash and Cash Equivalents, Beginning	$ 598,403	$ 759,678	$ 315,485	$ 472,751	$ 525,815	$ 771,870	$ 598,403
Cash and Cash Equivalents, Ending	**$ 759,678**	**$ 315,485**	**$ 472,751**	**$ 525,815**	**$ 771,870**	**$ 1,786,319**	**$ 771,870**
Reconciliation of Income from Operations to Net Cash Provided By (Used In) Operating Activities:							
Excess of Revenues over Expenses	**$ 14,215**	**$ (802)**	**$ 44,912**	**$ 49,906**	**$ 62,725**	**$ 28,592**	**$ 199,548**
Adjustments to Excess of Revenues Over Expenses:							
Depreciation	$ 1,789	$ 1,494	$ 2,191	$ 1,822	$ 2,216	$ 2,124	$ 11,636
Realized and Unrealized (Gain)/Loss on Investments	$ 639	$ 7	$ (2,567)	$ (2,259)	$ (334)	$ (2,489)	$ (7,003)
Deferred Rent	$ (62)	$ (71)	$ 45	$ (120)	$ 63	$ 32	$ (113)
Gross Premium Tax provision	$ 263	$ 768	$ 577	$ 419	$ 577	$ 576	$ 3,180
Total Adjustments to Excess of Revenues over Expenses	**$ 2,629**	**$ 2,198**	**$ 246**	**$ (138)**	**$ 2,522**	**$ 243**	**$ 7,700**
Changes in Operating Assets and Liabilities:							
Capitation Receivable	$ 1,122	$ (12,349)	$ (39,884)	$ 77,849	$ (13,645)	$ 275,361	$ 288,454
Interest and Non-Operating Receivables	$ 1,325	$ (406)	$ (1,068)	$ (1,062)	$ 91	$ (460)	$ (1,580)
Prepaid and Other Current Assets	$ (3,196)	$ (2,402)	$ 99,860	$ (14,521)	$ (10,600)	$ (9,817)	$ 59,324
Accounts Payable and Accrued Liabilities	$ 3,602	$ (5,923)	$ (7,631)	$ 7,420	$ 1,022	$ (7,273)	$ (8,783)
Subcapitation Payable	$ 23,118	$ (39,060)	$ 30,434	$ (38,957)	$ 121,337	$ 22,025	$ 118,897
MediCal Adult Expansion Payable	$ (5,829)	$ (244,519)	$ (18,702)	$ (4,221)	$ 70,388	$ 10,133	$ (192,750)
Deferred Capitation Revenue	$ 1,894	$ 13,256	$ (17,419)	$ (1,761)	$ (896)	$ 1,398	$ (3,528)
Accrued Medical Expenses	$ 7,611	$ 441	$ 4,411	$ 2,455	$ (1,667)	$ 5,006	$ 18,257
Reserve for Claims	$ 1,236	$ 24,664	$ 18,110	$ (6,994)	$ (20,490)	$ 27,161	$ 43,687
Reserve for Provider Incentives	$ (4,177)	$ (10,567)	$ (17,643)	$ (46)	$ (10)	$ 400	$ (32,043)
Grants Payable	$ (185)	$ 615	$ (223)	$ (88)	$ (1,599)		$ (1,480)
Net Changes in Operating Assets and Liabilities	**$ 26,521**	**$ (276,250)**	**$ 50,245**	**$ 20,074**	**$ 143,931**	**$ 323,934**	**$ 288,455**
Net Cash Provided By Operating Activities	**$ 43,365**	**$ (274,854)**	**$ 95,403**	**$ 69,842**	**$ 209,178**	**$ 352,769**	**$ 495,703**

DATE: April 22, 2019

TO: Finance & Budget Committee

FROM: Marie Montgomery, *Chief Financial Officer*

SUBJECT: Monthly Investment Transaction Report for March 2019

To keep the Committee apprised of L.A. Care's investment portfolios and to comply with California Government Code Section 53607, attached are the monthly investment transaction details from March 1 to March 31, 2019.

L.A. Care's investment market value as of March 31, 2019 was $2.3 billion. This includes our funds invested with the government pooled funds. L.A. Care has approximately $61 million invested with the statewide Local Agency Investment Fund (LAIF), and approximately $104 million invested with the Los Angeles County Pooled Investment Fund (LACPIF).

The remainder as of March 31, 2019, $2.2 billion, respectively, 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.

Account Name: L.A. CARE HEALTH PLAN
Account Number:

03/01/2019
through 03/31/2019

Tr Date	St Date	Transaction Type	Units	Description	Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
03/01/19	03/01/19	Buy	1,200,000.000	CA LOS ANGELES MUNI IMPT CP T MAT 05/01/19 Cpn 2.58 54459L4U7	(1,200,000.00)		0.00	0.00	(1,200,000.00)
03/01/19	03/05/19	Buy	2,035,000.000	CA NEWARK USD GO/ULT MAT 08/01/19 Cpn 2.14 650264TC8	(2,030,502.65)	(4,107.20)	0.00	0.00	(2,034,609.85)
03/06/19	03/06/19	Buy	10,000,000.000	WISCONSIN GAS CP MAT 03/28/19 Cpn 97670SQU0	(9,984,111.11)		0.00	0.00	(9,984,111.11)
03/07/19	03/07/19	Buy	3,480,000.000	SAN JOSE FIN AUTH CP TXB MAT 06/13/19 Cpn 2.57 79815WCD8	(3,480,000.00)		0.00	0.00	(3,480,000.00)
03/12/19	03/12/19	Buy	30,000,000.000	U.S. TREASURY BILL MAT 03/21/19 Cpn 912796RC5	(29,982,453.00)		0.00	0.00	(29,982,453.00)
03/12/19	03/12/19	Buy	50,000,000.000	U.S. TREASURY BILL MAT 04/09/19 Cpn 912796UW7	(49,907,133.33)		0.00	0.00	(49,907,133.33)
03/12/19	03/12/19	Buy	50,000,000.000	U.S. TREASURY BILL MAT 04/09/19 Cpn 912796UW7	(49,907,133.33)		0.00	0.00	(49,907,133.33)
03/12/19	03/12/19	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 03/18/19 Cpn 313384DE6	(49,980,833.33)		0.00	0.00	(49,980,833.33)
03/12/19	03/12/19	Buy	30,000,000.000	FHLB DISCOUNT NOTE MAT 03/18/19 Cpn 313384DE6	(29,988,500.00)		0.00	0.00	(29,988,500.00)
03/05/19	03/13/19	Buy	2,500,000.000	JOHN DEERE 2019-A A1 EQP MAT 03/16/20 Cpn 2.63 47789JAA4	(2,500,000.00)		0.00	0.00	(2,500,000.00)
03/14/19	03/14/19	Buy	50,000,000.000	U.S. TREASURY BILL MAT 04/09/19 Cpn 912796UW7	(49,913,856.94)		0.00	0.00	(49,913,856.94)
03/14/19	03/14/19	Buy	50,000,000.000	U.S. TREASURY BILL MAT 04/09/19 Cpn 912796UW7	(49,913,856.94)		0.00	0.00	(49,913,856.94)
03/14/19	03/14/19	Buy	50,000,000.000	U.S. TREASURY BILL MAT 04/09/19 Cpn 912796UW7	(49,913,856.94)		0.00	0.00	(49,913,856.94)

Account Name: L.A. CARE HEALTH PLAN
Account Number:

03/01/2019
through 03/31/2019

Tr Date	St Date	Transaction Type	Units	Description		Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
03/14/19	03/14/19	Buy	50,000,000.000	U.S. TREASURY BILL MAT 04/09/19 Cpn	912796UW7	(49,913,856.94)		0.00	0.00	(49,913,856.94)
03/15/19	03/15/19	Buy	50,000,000.000	U.S. TREASURY BILL MAT 04/11/19 Cpn	912796RG6	(49,910,693.75)		0.00	0.00	(49,910,693.75)
03/15/19	03/15/19	Buy	50,000,000.000	U.S. TREASURY BILL MAT 04/11/19 Cpn	912796RG6	(49,910,693.75)		0.00	0.00	(49,910,693.75)
03/15/19	03/15/19	Buy	50,000,000.000	U.S. TREASURY BILL MAT 04/11/19 Cpn	912796RG6	(49,910,693.75)		0.00	0.00	(49,910,693.75)
03/15/19	03/15/19	Buy	50,000,000.000	U.S. TREASURY BILL MAT 04/11/19 Cpn	912796RG6	(49,910,693.75)		0.00	0.00	(49,910,693.75)
03/15/19	03/15/19	Buy	50,000,000.000	U.S. TREASURY BILL MAT 04/11/19 Cpn	912796RG6	(49,910,693.75)		0.00	0.00	(49,910,693.75)
03/15/19	03/15/19	Buy	50,000,000.000	U.S. TREASURY BILL MAT 04/11/19 Cpn	912796RG6	(49,910,693.75)		0.00	0.00	(49,910,693.75)
03/15/19	03/15/19	Buy	50,000,000.000	U.S. TREASURY BILL MAT 04/11/19 Cpn	912796RG6	(49,910,693.75)		0.00	0.00	(49,910,693.75)
03/15/19	03/15/19	Buy	50,000,000.000	U.S. TREASURY BILL MAT 04/11/19 Cpn	912796RG6	(49,910,693.75)		0.00	0.00	(49,910,693.75)
03/15/19	03/15/19	Buy	50,000,000.000	U.S. TREASURY BILL MAT 04/11/19 Cpn	912796RG6	(49,910,693.75)		0.00	0.00	(49,910,693.75)
03/15/19	03/15/19	Buy	50,000,000.000	U.S. TREASURY BILL MAT 04/11/19 Cpn	912796RG6	(49,910,693.75)		0.00	0.00	(49,910,693.75)
03/15/19	03/15/19	Buy	50,000,000.000	U.S. TREASURY BILL MAT 04/11/19 Cpn	912796RG6	(49,910,693.75)		0.00	0.00	(49,910,693.75)
03/15/19	03/15/19	Buy	50,000,000.000	U.S. TREASURY BILL MAT 04/11/19 Cpn	912796RG6	(49,910,693.75)		0.00	0.00	(49,910,693.75)

Account Name: L.A. CARE HEALTH PLAN
Account Number:

03/01/2019
through 03/31/2019

Tr Date	St Date	Transaction Type	Units	Description		Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
03/18/19	03/18/19	Buy	1,880,000.000	BNP PARIBAS YCD FRN MAT 09/18/19 Cpn 2.62	05586FYA9	(1,880,000.00)		0.00	0.00	(1,880,000.00)
03/18/19	03/18/19	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 03/21/19 Cpn	313384DH9	(49,990,229.17)		0.00	0.00	(49,990,229.17)
03/18/19	03/18/19	Buy	30,000,000.000	FHLB DISCOUNT NOTE MAT 03/21/19 Cpn	313384DH9	(29,994,137.50)		0.00	0.00	(29,994,137.50)
03/12/19	03/20/19	Buy	1,620,000.000	BMW 2019-1 A2 LEASE MAT 03/22/21 Cpn 3.16	05586VAB8	(1,619,957.07)		0.00	0.00	(1,619,957.07)
03/25/19	03/25/19	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 03/26/19 Cpn	313384DN6	(49,996,736.11)		0.00	0.00	(49,996,736.11)
03/25/19	03/25/19	Buy	30,000,000.000	FHLB DISCOUNT NOTE MAT 03/26/19 Cpn	313384DN6	(29,998,041.67)		0.00	0.00	(29,998,041.67)
03/20/19	03/28/19	Buy	640,000.000	HOUSING URBAN DEVELOPMENT MAT 08/01/19 Cpn 2.54	911759MS4	(640,000.00)		0.00	0.00	(640,000.00)
03/28/19	03/28/19	Buy	4,900,000.000	WISCONSIN GAS CP MAT 04/04/19 Cpn	97670SR47	(4,897,541.83)		0.00	0.00	(4,897,541.83)
03/28/19	03/29/19	Buy	50,000,000.000	U.S. TREASURY BILL MAT 04/04/19 Cpn	912796RD3	(49,980,491.67)		0.00	0.00	(49,980,491.67)
03/28/19	03/29/19	Buy	50,000,000.000	U.S. TREASURY BILL MAT 04/04/19 Cpn	912796RD3	(49,980,491.67)		0.00	0.00	(49,980,491.67)
03/28/19	03/29/19	Buy	50,000,000.000	U.S. TREASURY BILL MAT 04/04/19 Cpn	912796RD3	(49,980,491.67)		0.00	0.00	(49,980,491.67)
03/28/19	03/29/19	Buy	50,000,000.000	U.S. TREASURY BILL MAT 04/04/19 Cpn	912796RD3	(49,980,491.67)		0.00	0.00	(49,980,491.67)
03/28/19	03/29/19	Buy	50,000,000.000	U.S. TREASURY BILL MAT 04/04/19 Cpn	912796RD3	(49,980,491.67)		0.00	0.00	(49,980,491.67)

Account Name: L.A. CARE HEALTH PLAN
Account Number:

03/01/2019
through 03/31/2019

Tr Date	St Date	Transaction Type	Units	Description	Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
03/28/19	03/29/19	Buy	50,000,000.000	U.S. TREASURY BILL MAT 04/04/19 Cpn 912796RD3	(49,980,491.67)		0.00	0.00	(49,980,491.67)
03/28/19	03/29/19	Buy	50,000,000.000	U.S. TREASURY BILL MAT 04/04/19 Cpn 912796RD3	(49,980,491.67)		0.00	0.00	(49,980,491.67)
03/29/19	03/29/19	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 04/15/19 Cpn 313384EJ4	(49,948,055.56)		0.00	0.00	(49,948,055.56)
03/29/19	03/29/19	Buy	30,000,000.000	FHLB DISCOUNT NOTE MAT 04/15/19 Cpn 313384EJ4	(29,968,833.33)		0.00	0.00	(29,968,833.33)
03/29/19	03/29/19	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 04/22/19 Cpn 313384ER6	(49,920,666.67)		0.00	0.00	(49,920,666.67)
03/29/19	03/29/19	Buy	30,000,000.000	FHLB DISCOUNT NOTE MAT 04/22/19 Cpn 313384ER6	(29,952,400.00)		0.00	0.00	(29,952,400.00)
03/29/19	03/29/19	Buy	45,000,000.000	FHLB DISCOUNT NOTE MAT 04/01/19 Cpn 313384DU0	(44,991,750.00)		0.00	0.00	(44,991,750.00)
			1,753,255,000.000		(1,751,206,210.11)	(4,107.20)	0.00	0.00	(1,751,210,317.31)
03/01/19	03/01/19	Coupon		CA LOS ANGELES MUNI IMPT BOA MAT 03/01/19 Cpn 2.54 54459L4S2		2,338.19	0.00	0.00	2,338.19
03/07/19	03/07/19	Coupon		NGN 2010-R3 2A 1MOFRN NCUA G MAT 12/08/20 Cpn 3.04 62888WAB2		6,696.57	0.00	0.00	6,696.57
03/07/19	03/07/19	Coupon		NGN 2011-R1 1A 1MOFRN NCUA G MAT 01/08/20 Cpn 2.93 62888YAA0		3,395.17	0.00	0.00	3,395.17
03/07/19	03/07/19	Coupon		CA SAN JOSE FIN AUTH CP TXB MAT 03/07/19 Cpn 2.80 79815WCC0		20,555.84	0.00	0.00	20,555.84
03/13/19	03/13/19	Coupon		US BANK CINCINNATI FRN CD MAT 05/13/19 Cpn 2.65 90333VYD6		5,148.66	0.00	0.00	5,148.66

Account Name: L.A. CARE HEALTH PLAN
Account Number:

03/01/2019
through 03/31/2019

Tr Date	St Date	Transaction Type	Units	Description	Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
03/01/19	03/15/19	Coupon		FHLMC #G15842 15YR MAT 04/01/19 Cpn 4.50 3128MEWB		6.02	0.00	0.00	6.02
03/01/19	03/15/19	Coupon		FHLMC #G15842 15YR MAT 04/01/19 Cpn 4.50 3128MEWB		0.44	0.00	0.00	0.44
03/15/19	03/15/19	Coupon		MERCEDES 2019-A A2 LEASE MAT 02/16/21 Cpn 3.01 58772TAB6		5,794.25	0.00	0.00	5,794.25
03/15/19	03/15/19	Coupon		NISSAN 2017-B A2A LEASE MAT 12/16/19 Cpn 1.83 65479BAB6		5,647.33	0.00	0.00	5,647.33
03/15/19	03/15/19	Coupon		NISSAN 2018-A A2A LEASE MAT 02/16/21 Cpn 3.03 65478BAB7		4,620.75	0.00	0.00	4,620.75
03/15/19	03/15/19	Coupon		NISSAN 2019-A A1 CAR MAT 02/18/20 Cpn 2.71 65479KAA8		5,415.72	0.00	0.00	5,415.72
03/15/19	03/15/19	Coupon		TOYOTA 2018-A A2A CAR MAT 10/15/20 Cpn 2.10 89238BAB8		9,221.62	0.00	0.00	9,221.62
03/15/19	03/15/19	Coupon		TOYOTA 2019-A A2A CAR MAT 10/15/21 Cpn 2.83 89239AAB9		2,918.04	0.00	0.00	2,918.04
03/15/19	03/15/19	Coupon		USAA 2017-1 A3 CAR MAT 05/17/21 Cpn 1.70 90290AAC1		5,069.42	0.00	0.00	5,069.42
03/18/19	03/18/19	Coupon		HONDA 2017-3 A2 CAR MAT 01/21/20 Cpn 1.57 43814PAB6		1,704.69	0.00	0.00	1,704.69
03/20/19	03/20/19	Coupon		BMW 2017-2 A2A LEASE MAT 02/20/20 Cpn 1.80 05584PAB3		2,896.95	0.00	0.00	2,896.95
03/20/19	03/20/19	Coupon		CANADIAN IMPERIAL BANK YCD FR MAT 09/20/19 Cpn 3.04 13606BUG9		16,010.00	0.00	0.00	16,010.00
03/01/19	03/25/19	Coupon		FHMS K504 A2 CMBS MAT 09/25/20 Cpn 2.57 3137BMLC8		3,243.37	0.00	0.00	3,243.37

Account Name: L.A. CARE HEALTH PLAN
Account Number:

03/01/2019
through 03/31/2019

Tr Date	St Date	Transaction Type	Units	Description	Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
03/01/19	03/25/19	Coupon		FHMS K710 A2 CMBS MAT 05/25/19 Cpn 1.88 3137ARPY6		1,629.69	0.00	0.00	1,629.69
03/01/19	03/25/19	Coupon		FHMS K710 A2 CMBS MAT 05/25/19 Cpn 1.88 3137ARPY6		187.71	0.00	0.00	187.71
03/25/19	03/25/19	Coupon		FHMS KI03 A 1MOFRN CMBS MAT 02/25/23 Cpn 2.74 3137FJXN4		4,084.21	0.00	0.00	4,084.21
03/25/19	03/25/19	Coupon		FHMS KI03 A 1MOFRN CMBS MAT 02/25/23 Cpn 2.74 3137FJXN4		1,676.68	0.00	0.00	1,676.68
03/01/19	03/25/19	Coupon		FNA 2015-M13 ASQ2 CMBS MAT 09/25/19 Cpn 1.65 3136AQDQ		301.30	0.00	0.00	301.30
03/01/19	03/25/19	Coupon		FNA 2016-M6 ASQ2 CMBS MAT 06/25/19 Cpn 1.79 3136ASPX8		56.39	0.00	0.00	56.39
						108,619.01	0.00	0.00	108,619.01
03/01/19	03/01/19	Income	1,188.320	ADJ NET P&I MAT Cpn USD		1,188.32	0.00	0.00	1,188.32
03/01/19	03/01/19	Income	48,203.260	STIF INT MAT Cpn USD		48,203.26	0.00	0.00	48,203.26
			49,391.580			49,391.58	0.00	0.00	49,391.58
03/14/19	03/14/19	Contributn	225,000,000.000	NM MAT Cpn USD	225,000,000.00		0.00	0.00	225,000,000.00
03/15/19	03/15/19	Contributn	640,000,000.000	NM MAT Cpn USD	640,000,000.00		0.00	0.00	640,000,000.00
03/28/19	03/28/19	Contributn	390,000,000.000	NM MAT Cpn USD	390,000,000.00		0.00	0.00	390,000,000.00

Account Name: L.A. CARE HEALTH PLAN
Account Number:

03/01/2019
through 03/31/2019

Tr Date	St Date	Transaction Type	Units	Description	Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
03/29/19	03/29/19	Contributn	185,000,000.000	NM MAT Cpn USD	185,000,000.00		0.00	0.00	185,000,000.00
			1,440,000,000.000		1,440,000,000.00		0.00	0.00	1,440,000,000.00
03/04/19	03/05/19	Sell Long	1,640,000.000	U.S. TREASURY NOTE MAT 03/15/19 Cpn 1.00 912828P95	1,639,353.88	7,746.96	0.00	(687.94)	1,647,100.84
03/20/19	03/21/19	Sell Long	50,000,000.000	U.S. TREASURY BILL MAT 04/02/19 Cpn 912796UV9	49,848,572.23	111,444.45	(649.99)	0.00	49,960,016.67
03/20/19	03/21/19	Sell Long	10,000,000.000	U.S. TREASURY BILL MAT 04/02/19 Cpn 912796UV9	9,969,714.44	22,288.89	(130.00)	0.00	9,992,003.33
03/22/19	03/25/19	Sell Long	40,000,000.000	U.S. TREASURY BILL MAT 04/02/19 Cpn 912796UV9	39,879,342.22	99,644.44	(35.56)	0.00	39,978,986.66
03/22/19	03/25/19	Sell Long	10,000,000.000	U.S. TREASURY BILL MAT 04/02/19 Cpn 912796UV9	9,969,835.56	24,911.11	(8.88)	0.00	9,994,746.67
03/22/19	03/25/19	Sell Long	30,000,000.000	U.S. TREASURY BILL MAT 04/02/19 Cpn 912796UV9	29,909,506.67	74,733.33	(26.67)	0.00	29,984,240.00
			141,640,000.000		141,216,324.99	340,769.18	(851.11)	(687.94)	141,557,094.17
03/07/19	03/07/19	Pay Princpl	70,676.609	NGN 2010-R3 2A 1MOFRN NCUA G MAT 12/08/20 Cpn 3.04 62888WAB2	70,676.61		(199.53)	0.00	70,676.61
03/07/19	03/07/19	Pay Princpl	38,465.550	NGN 2011-R1 1A 1MOFRN NCUA G MAT 01/08/20 Cpn 2.93 62888YAA0	38,465.55		(23.79)	0.00	38,465.55
03/01/19	03/15/19	Pay Princpl	1,269.470	FHLMC #G15842 15YR MAT 04/01/19 Cpn 4.50 3128MEWB	1,269.47		0.00	(1.15)	1,269.47
03/01/19	03/15/19	Pay Princpl	93.270	FHLMC #G15842 15YR MAT 04/01/19 Cpn 4.50 3128MEWB	93.27		0.00	(0.08)	93.27

Account Name: L.A. CARE HEALTH PLAN
Account Number:

03/01/2019
through 03/31/2019

Tr Date	St Date	Transaction Type	Units	Description	Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
03/15/19	03/15/19	Pay Princpl	694,398.741	NISSAN 2017-B A2A LEASE MAT 12/16/19 Cpn 1.83 65479BAB6	694,398.74		0.00	(0.00)	694,398.74
03/15/19	03/15/19	Pay Princpl	336,699.627	NISSAN 2019-A A1 CAR MAT 02/18/20 Cpn 2.71 65479KAA8	336,699.63		0.00	0.00	336,699.63
03/15/19	03/15/19	Pay Princpl	588,901.232	TOYOTA 2018-A A2A CAR MAT 10/15/20 Cpn 2.10 89238BAB8	588,901.23		0.00	22.58	588,901.23
03/15/19	03/15/19	Pay Princpl	340,005.776	USAA 2017-1 A3 CAR MAT 05/17/21 Cpn 1.70 90290AAC1	340,005.78		0.00	15.17	340,005.78
03/18/19	03/18/19	Pay Princpl	612,340.836	HONDA 2017-3 A2 CAR MAT 01/21/20 Cpn 1.57 43814PAB6	612,340.84		0.00	2.99	612,340.84
03/20/19	03/20/19	Pay Princpl	463,406.786	BMW 2017-2 A2A LEASE MAT 02/20/20 Cpn 1.80 05584PAB3	463,406.79		0.00	7.55	463,406.79
03/01/19	03/25/19	Pay Princpl	2,097.808	FHMS K504 A2 CMBS MAT 09/25/20 Cpn 2.57 3137BMLC8	2,097.81		11.18	0.00	2,097.81
03/01/19	03/25/19	Pay Princpl	238,730.120	FHMS K710 A2 CMBS MAT 05/25/19 Cpn 1.88 3137ARPY6	238,730.12		0.00	(172.81)	238,730.12
03/01/19	03/25/19	Pay Princpl	27,497.710	FHMS K710 A2 CMBS MAT 05/25/19 Cpn 1.88 3137ARPY6	27,497.71		0.00	(35.43)	27,497.71
03/01/19	03/25/19	Pay Princpl	36,489.780	FNA 2015-M13 ASQ2 CMBS MAT 09/25/19 Cpn 1.65 3136AQDQ	36,489.78		0.00	(53.30)	36,489.78
03/01/19	03/25/19	Pay Princpl	66.160	FNA 2016-M6 ASQ2 CMBS MAT 06/25/19 Cpn 1.79 3136ASPX8	66.16		0.00	(0.08)	66.16
			3,451,139.475		3,451,139.49		(212.14)	(214.57)	3,451,139.49

Account Name: L.A. CARE HEALTH PLAN
Account Number:

03/01/2019
through 03/31/2019

Tr Date	St Date	Transaction Type	Units	Description	Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
03/01/19	03/01/19	Mature Long	1,200,000.000	CA LOS ANGELES MUNI IMPT BOA MAT 03/01/19 Cpn 2.54 54459L4S2	1,200,000.00		0.00	0.00	1,200,000.00
03/04/19	03/04/19	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 03/04/19 Cpn 313384CQ0	49,944,750.00	55,250.00	0.00	0.00	50,000,000.00
03/04/19	03/04/19	Mature Long	20,000,000.000	FHLB DISCOUNT NOTE MAT 03/04/19 Cpn 313384CQ0	19,977,900.00	22,100.00	0.00	0.00	20,000,000.00
03/06/19	03/06/19	Mature Long	10,000,000.000	WISCONSIN GAS CP MAT 03/06/19 Cpn 97670SQ63	9,994,377.78	5,622.22	0.00	0.00	10,000,000.00
03/07/19	03/07/19	Mature Long	3,480,000.000	CA SAN JOSE FIN AUTH CP TXB MAT 03/07/19 Cpn 2.80 79815WCC0	3,480,000.00		0.00	0.00	3,480,000.00
03/11/19	03/11/19	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 03/11/19 Cpn 313384CX5	49,922,000.00	78,000.00	0.00	0.00	50,000,000.00
03/11/19	03/11/19	Mature Long	30,000,000.000	FHLB DISCOUNT NOTE MAT 03/11/19 Cpn 313384CX5	29,953,200.00	46,800.00	0.00	0.00	30,000,000.00
03/12/19	03/12/19	Mature Long	50,000,000.000	U.S. TREASURY BILL MAT 03/12/19 Cpn 912796US6	49,917,500.00	82,500.00	0.00	0.00	50,000,000.00
03/12/19	03/12/19	Mature Long	50,000,000.000	U.S. TREASURY BILL MAT 03/12/19 Cpn 912796US6	49,917,500.00	82,500.00	0.00	0.00	50,000,000.00
03/12/19	03/12/19	Mature Long	50,000,000.000	U.S. TREASURY BILL MAT 03/12/19 Cpn 912796US6	49,917,500.00	82,500.00	0.00	0.00	50,000,000.00
03/12/19	03/12/19	Mature Long	50,000,000.000	U.S. TREASURY BILL MAT 03/12/19 Cpn 912796US6	49,917,500.00	82,500.00	0.00	0.00	50,000,000.00
03/12/19	03/12/19	Mature Long	30,000,000.000	U.S. TREASURY BILL MAT 03/12/19 Cpn 912796US6	29,950,500.00	49,500.00	0.00	0.00	30,000,000.00
03/18/19	03/18/19	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 03/18/19 Cpn 313384DE6	49,980,833.33	19,166.67	0.00	0.00	50,000,000.00

Account Name: L.A. CARE HEALTH PLAN
Account Number:

03/01/2019
through 03/31/2019

Tr Date	St Date	Transaction Type	Units	Description			Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
03/18/19	03/18/19	Mature Long	30,000,000.000	FHLB DISCOUNT NOTE MAT 03/18/19	Cpn	313384DE6	29,988,500.00	11,500.00	0.00	0.00	30,000,000.00
03/21/19	03/21/19	Mature Long	50,000,000.000	U.S. TREASURY BILL MAT 03/21/19	Cpn	912796RC5	49,419,495.83	580,504.17	0.00	0.00	50,000,000.00
03/21/19	03/21/19	Mature Long	30,000,000.000	U.S. TREASURY BILL MAT 03/21/19	Cpn	912796RC5	29,982,453.00	17,547.00	0.00	0.00	30,000,000.00
03/21/19	03/21/19	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 03/21/19	Cpn	313384DH9	49,990,229.17	9,770.83	0.00	0.00	50,000,000.00
03/21/19	03/21/19	Mature Long	30,000,000.000	FHLB DISCOUNT NOTE MAT 03/21/19	Cpn	313384DH9	29,994,137.50	5,862.50	0.00	0.00	30,000,000.00
03/26/19	03/26/19	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 03/26/19	Cpn	313384DN6	49,996,736.11	3,263.89	0.00	0.00	50,000,000.00
03/26/19	03/26/19	Mature Long	30,000,000.000	FHLB DISCOUNT NOTE MAT 03/26/19	Cpn	313384DN6	29,998,041.67	1,958.33	0.00	0.00	30,000,000.00
03/28/19	03/28/19	Mature Long	10,000,000.000	WISCONSIN GAS CP MAT 03/28/19	Cpn	97670SQU0	9,984,111.11	15,888.89	0.00	0.00	10,000,000.00
			724,680,000.000				723,427,265.50	1,252,734.50	0.00	0.00	724,680,000.00
03/01/19	03/01/19	Withdrawal	(25,000,000.000)	WD MAT	Cpn	USD	(25,000,000.00)		(25,000,000.00)	0.00	(25,000,000.00)
03/01/19	03/01/19	Withdrawal	(145.410)	ADJ CUSTODY FEE 1/1/19 MAT	Cpn	USD	(145.41)		(145.41)	0.00	(145.41)
03/01/19	03/01/19	Withdrawal	(2,168.960)	CUSTODY FEE MAT	Cpn	USD	(2,168.96)		(2,168.96)	0.00	(2,168.96)
03/04/19	03/04/19	Withdrawal	(70,000,000.000)	WD MAT	Cpn	USD	(70,000,000.00)		(70,000,000.00)	0.00	(70,000,000.00)

Account Name: L.A. CARE HEALTH PLAN
Account Number:

03/01/2019
through 03/31/2019

Tr Date	*St Date*	*Transaction Type*	*Units*	*Description*			*Proceeds / (Cost)*	*Accrued Interest (Purch) or Sold*	*G/L < 1 Yr Amort Cost*	*G/L > 1 Yr Amort Cost*	*Total Amount*
03/11/19	03/11/19	Withdrawal	(80,000,000.000)	WD MAT	Cpn	USD	(80,000,000.00)		(80,000,000.00)	0.00	(80,000,000.00)
03/18/19	03/18/19	Withdrawal	(80,000,000.000)	WD MAT	Cpn	USD	(80,000,000.00)		(80,000,000.00)	0.00	(80,000,000.00)
03/21/19	03/21/19	Withdrawal	(220,000,000.000)	WD MAT	Cpn	USD	(220,000,000.00)		(220,000,000.00)	0.00	(220,000,000.00)
03/26/19	03/26/19	Withdrawal	(80,000,000.000)	WD MAT	Cpn	USD	(80,000,000.00)		(80,000,000.00)	0.00	(80,000,000.00)
			(555,002,314.370)				(555,002,314.37)		(555,002,314.37)	0.00	(555,002,314.37)

Account Name: L.A. CARE HEALTH PLAN-LOW DURATION PORT
Account Number:

03/01/2019
through 03/31/2019

Tr Date	St Date	Transaction Type	Units	Description	Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
03/04/19	03/06/19	Buy	1,567,000.000	U.S. TREASURY NOTE MAT 02/28/21 Cpn 2.50 9128286D7	(1,565,775.78)	(638.72)	0.00	0.00	(1,566,414.50)
03/25/19	03/26/19	Buy	430,000.000	U.S. TREASURY NOTE MAT 02/29/24 Cpn 2.38 9128286G0	(434,066.28)	(721.54)	0.00	0.00	(434,787.82)
03/20/19	03/28/19	Buy	140,000.000	HOUSING URBAN DEVELOPMENT MAT 08/01/23 Cpn 2.62 911759MW5	(140,000.00)		0.00	0.00	(140,000.00)
			2,137,000.000		(2,139,842.06)	(1,360.26)	0.00	0.00	(2,141,202.32)
03/01/19	03/01/19	Coupon		CA HESPERIA REDEV AGY SUCCE MAT 09/01/23 Cpn 3.13 42806KAS2		10,217.88	0.00	0.00	10,217.88
03/01/19	03/01/19	Coupon		CA OAKLAND REDEV AGY TXB MAT 09/01/22 Cpn 3.78 67232TAT2		8,606.33	0.00	0.00	8,606.33
03/01/19	03/01/19	Coupon		CA RIALTO REDEV AGENCY TAB-T MAT 09/01/22 Cpn 4.00 76246PBC1		13,200.00	0.00	0.00	13,200.00
03/01/19	03/01/19	Coupon		CA SANTA ANA CMNTY REDEV AG MAT 09/01/23 Cpn 3.57 801096AR9		5,038.39	0.00	0.00	5,038.39
03/15/19	03/15/19	Coupon		AMEX 2017-1 A CDT MAT 09/15/22 Cpn 1.93 02587AAJ3		2,412.50	0.00	0.00	2,412.50
03/15/19	03/15/19	Coupon		BACCT 2017-A1 A1 CDT MAT 08/15/22 Cpn 1.95 05522RCW6		1,950.00	0.00	0.00	1,950.00
03/15/19	03/15/19	Coupon		CHASE 2016-A2 A CDT MAT 06/15/21 Cpn 1.37 161571HC1		1,141.67	0.00	0.00	1,141.67
03/15/19	03/15/19	Coupon		CHASE 2016-A2 A CDT MAT 06/15/21 Cpn 1.37 161571HC1		570.83	0.00	0.00	570.83
03/15/19	03/15/19	Coupon		CAPITAL ONE 2016-A3 A3 CDT MAT 04/15/22 Cpn 1.34 14041NFE6		558.33	0.00	0.00	558.33

Account Name: L.A. CARE HEALTH PLAN-LOW DURATION PORT
Account Number:

03/01/2019
through 03/31/2019

Tr Date	St Date	Transaction Type	Units	Description	Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
03/15/19	03/15/19	Coupon		CAPITAL ONE 2016-A6 A6 CDT MAT 09/15/22 Cpn 1.82 14041NFH9		1,506.05	0.00	0.00	1,506.05
03/15/19	03/15/19	Coupon		JOHN DEERE 2017-A A3 EQP MAT 04/15/21 Cpn 1.78 47787XAC1		1,067.23	0.00	0.00	1,067.23
03/15/19	03/15/19	Coupon		JOHN DEERE 2017-B A2A EQP MAT 04/15/20 Cpn 1.59 47788BAB0		53.45	0.00	0.00	53.45
03/15/19	03/15/19	Coupon		JOHN DEERE 2017-B A2A EQP MAT 04/15/20 Cpn 1.59 47788BAB0		76.35	0.00	0.00	76.35
03/15/19	03/15/19	Coupon		NISSAN 2017-B A3 LEASE MAT 09/15/20 Cpn 2.05 65479BAD2		632.08	0.00	0.00	632.08
03/15/19	03/15/19	Coupon		NISSAN 2017-B A3 LEASE MAT 09/15/20 Cpn 2.05 65479BAD2		854.17	0.00	0.00	854.17
03/15/19	03/15/19	Coupon		NISSAN 2018-A A3 LEASE MAT 09/15/21 Cpn 3.25 65478BAD3		893.75	0.00	0.00	893.75
03/15/19	03/15/19	Coupon		NISSAN 2018-C A3 CAR MAT 06/15/23 Cpn 3.22 65478NAD7		2,012.50	0.00	0.00	2,012.50
03/15/19	03/15/19	Coupon		NISSAN 2019-A A3 CAR MAT 10/16/23 Cpn 2.90 65479KAD2		1,392.00	0.00	0.00	1,392.00
03/15/19	03/15/19	Coupon		NY STATE URBAN DEV CORP TXB MAT 03/15/22 Cpn 2.10 6500354S4		2,362.50	0.00	0.00	2,362.50
03/15/19	03/15/19	Coupon		TOYOTA 2017-A A3 CAR MAT 02/16/21 Cpn 1.73 89238MAD0		686.28	0.00	0.00	686.28
03/15/19	03/15/19	Coupon		TOYOTA 2017-B A3 CAR MAT 07/15/21 Cpn 1.76 89190BAD0		1,266.24	0.00	0.00	1,266.24
03/15/19	03/15/19	Coupon		TOYOTA 2018-A A3 CAR MAT 05/16/22 Cpn 2.35 89238BAD4		822.50	0.00	0.00	822.50

Account Name: L.A. CARE HEALTH PLAN-LOW DURATION PORT
Account Number:

03/01/2019
through 03/31/2019

Tr Date	St Date	Transaction Type	Units	Description	Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
03/15/19	03/15/19	Coupon		TOYOTA 2019-A A3 CAR MAT 07/17/23 Cpn 2.91 89239AAD5		1,448.53	0.00	0.00	1,448.53
03/15/19	03/15/19	Coupon		U.S. TREASURY NOTE MAT 09/15/20 Cpn 1.38 9128282V1		27,706.25	0.00	0.00	27,706.25
03/15/19	03/15/19	Coupon		U.S. TREASURY NOTE MAT 09/15/20 Cpn 1.38 9128282V1		14,437.50	0.00	0.00	14,437.50
03/15/19	03/15/19	Coupon		USAA 2016-1 A3 CAR MAT 06/15/20 Cpn 1.20 90327CAC4		42.38	0.00	0.00	42.38
03/15/19	03/15/19	Coupon		USAA 2016-1 A3 CAR MAT 06/15/20 Cpn 1.20 90327CAC4		49.44	0.00	0.00	49.44
03/15/19	03/15/19	Coupon		USAA 2017-1 A3 CAR MAT 05/17/21 Cpn 1.70 90290AAC1		306.46	0.00	0.00	306.46
03/20/19	03/20/19	Coupon		BMW 2017-2 A2A LEASE MAT 02/20/20 Cpn 1.80 05584PAB3		223.97	0.00	0.00	223.97
03/25/19	03/25/19	Coupon		BMW 2016-A A3 CAR MAT 11/25/20 Cpn 1.16 05582QAD9		270.92	0.00	0.00	270.92
03/01/19	03/25/19	Coupon		FHMS J22F A1 CMBS MAT 05/25/23 Cpn 3.45 3137FJYA1		1,707.40	0.00	0.00	1,707.40
03/01/19	03/25/19	Coupon		FHMS K504 A2 CMBS MAT 09/25/20 Cpn 2.57 3137BMLC8		1,165.92	0.00	0.00	1,165.92
03/25/19	03/25/19	Coupon		FHMS KI03 A 1MOFRN CMBS MAT 02/25/23 Cpn 2.74 3137FJXN4		1,397.23	0.00	0.00	1,397.23
03/25/19	03/25/19	Coupon		FHMS KI02 A 1MOFRN CMBS MAT 02/25/23 Cpn 2.69 3137FGZN8		652.18	0.00	0.00	652.18
03/25/19	03/25/19	Coupon		FHMS KP04 AG1 1MOFRN CMBS MAT 07/25/20 Cpn 2.71 3137FBUV6		2,062.46	0.00	0.00	2,062.46

Account Name: L.A. CARE HEALTH PLAN-LOW DURATION PORT
Account Number:

03/01/2019 through 03/31/2019

Tr Date	St Date	Transaction Type	Units	Description	Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
03/25/19	03/25/19	Coupon		FMPRE 2017-KT01 A 1MOFRN CMB MAT 02/25/20 Cpn 2.81 30258EAA3		1,481.49	0.00	0.00	1,481.49
03/01/19	03/25/19	Coupon		FNA 2011-M5 A2 CMBS MAT 07/25/21 Cpn 2.94 3136A07H4		386.99	0.00	0.00	386.99
03/01/19	03/25/19	Coupon		FNA 2015-M13 ASQ2 CMBS MAT 09/25/19 Cpn 1.65 3136AQDQ		28.70	0.00	0.00	28.70
03/31/19	03/31/19	Coupon		U.S. TREASURY NOTE MAT 09/30/22 Cpn 1.88 9128282W9		12,796.88	0.00	0.00	12,796.88
03/31/19	03/31/19	Coupon		U.S. TREASURY NOTE MAT 09/30/22 Cpn 1.88 9128282W9		10,171.88	0.00	0.00	10,171.88
03/31/19	03/31/19	Coupon		U.S. TREASURY NOTE MAT 09/30/21 Cpn 1.13 912828T34		8,746.88	0.00	0.00	8,746.88
						142,404.49	0.00	0.00	142,404.49
03/01/19	03/01/19	Income	918.810	STIF INT MAT Cpn USD		918.81	0.00	0.00	918.81
03/04/19	03/06/19	Sell Long	1,567,000.000	U.S. TREASURY NOTE MAT 12/31/20 Cpn 2.50 9128285S5	1,565,044.49	7,034.19	581.58	0.00	1,572,078.68
03/13/19	03/15/19	Call	55,000.000	NY STATE URBAN DEV CORP TXB MAT 03/15/22 Cpn 2.10 6500354S4	55,000.00		0.00	102.35	55,000.00
			1,622,000.000		1,620,044.49	7,034.19	581.58	102.35	1,627,078.68

Account Name: L.A. CARE HEALTH PLAN-LOW DURATION PORT
Account Number:

03/01/2019
through 03/31/2019

Tr Date	St Date	Transaction Type	Units	Description	Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
03/15/19	03/15/19	Pay Princpl	52,452.127	JOHN DEERE 2017-A A3 EQP MAT 04/15/21 Cpn 1.78 47787XAC1	52,452.13		0.00	84.23	52,452.13
03/15/19	03/15/19	Pay Princpl	22,312.424	JOHN DEERE 2017-B A2A EQP MAT 04/15/20 Cpn 1.59 47788BAB0	22,312.42		0.00	(0.00)	22,312.42
03/15/19	03/15/19	Pay Princpl	31,874.891	JOHN DEERE 2017-B A2A EQP MAT 04/15/20 Cpn 1.59 47788BAB0	31,874.89		0.00	(0.00)	31,874.89
03/15/19	03/15/19	Pay Princpl	40,366.539	TOYOTA 2017-A A3 CAR MAT 02/16/21 Cpn 1.73 89238MAD0	40,366.54		0.00	1.59	40,366.54
03/15/19	03/15/19	Pay Princpl	57,767.239	TOYOTA 2017-B A3 CAR MAT 07/15/21 Cpn 1.76 89190BAD0	57,767.24		0.00	1.94	57,767.24
03/15/19	03/15/19	Pay Princpl	29,641.969	USAA 2016-1 A3 CAR MAT 06/15/20 Cpn 1.20 90327CAC4	29,641.97		0.00	0.31	29,641.97
03/15/19	03/15/19	Pay Princpl	34,582.298	USAA 2016-1 A3 CAR MAT 06/15/20 Cpn 1.20 90327CAC4	34,582.30		0.00	11.88	34,582.30
03/15/19	03/15/19	Pay Princpl	20,554.505	USAA 2017-1 A3 CAR MAT 05/17/21 Cpn 1.70 90290AAC1	20,554.51		0.00	0.92	20,554.51
03/20/19	03/20/19	Pay Princpl	35,826.407	BMW 2017-2 A2A LEASE MAT 02/20/20 Cpn 1.80 05584PAB3	35,826.41		0.00	0.59	35,826.41
03/25/19	03/25/19	Pay Princpl	39,886.822	BMW 2016-A A3 CAR MAT 11/25/20 Cpn 1.16 05582QAD9	39,886.82		0.00	86.15	39,886.82
03/01/19	03/25/19	Pay Princpl	11,936.515	FHMS J22F A1 CMBS MAT 05/25/23 Cpn 3.45 3137FJYA1	11,936.51		0.30	0.00	11,936.51
03/01/19	03/25/19	Pay Princpl	754.114	FHMS K504 A2 CMBS MAT 09/25/20 Cpn 2.57 3137BMLC8	754.11		0.32	0.00	754.11
03/01/19	03/25/19	Pay Princpl	4,341.580	FNA 2011-M5 A2 CMBS MAT 07/25/21 Cpn 2.94 3136A07H4	4,341.58		20.77	0.00	4,341.58

Account Name: L.A. CARE HEALTH PLAN-LOW DURATION PORT
Account Number:

03/01/2019
through 03/31/2019

Tr Date	*St Date*	*Transaction Type*	*Units*	*Description*	*Proceeds / (Cost)*	*Accrued Interest (Purch) or Sold*	*G/L < 1 Yr Amort Cost*	*G/L > 1 Yr Amort Cost*	*Total Amount*
03/01/19	03/25/19	Pay Princpl	3,475.217	FNA 2015-M13 ASQ2 CMBS MAT 09/25/19 Cpn 1.65 3136AQDQ	3,475.22		0.00	(5.07)	3,475.22
			385,772.647		385,772.65		21.39	182.53	385,772.65

LA CARE

Cash Activity by Transaction Type GAAP Basis

Accounting Period From 03/01/2019 To 03/31/2019

Cash Date	Trade/Ex-Date	Settle/Pay Date	Custodian	Cusip	Description	Quantity	Income Amount	Principal Amount	Contributions/ Withdrawals	Total Amount
BUY										
03/18/19	03/14/19	03/18/19	BKAMER19	741531FA0	PRICOA GLOBAL FUNDING 1	3,500,000.00	(5,702.08)	(3,559,745.00)	0.00	(3,565,447.08)
03/22/19	03/22/19	03/22/19	BKAMER19	09248U718	BLACKROCK LIQ FUND T-FD-IN	6,767,873.34	0.00	(6,767,873.34)	0.00	(6,767,873.34)
TOTAL BUY						10,267,873.34	(5,702.08)	(10,327,618.34)	0.00	(10,333,320.42)
DIVIDEND										
03/01/19	03/01/19	03/01/19	BKAMER19	09248U718	BLACKROCK LIQ FUND T-FD-IN	3,810,271.51	12,029.10	0.00	0.00	12,029.10
TOTAL DIVIDEND						3,810,271.51	12,029.10	0.00	0.00	12,029.10
INTEREST										
03/01/19	03/01/19	03/01/19	BKAMER19	46625HQJ2	JPMORGAN CHASE & CO	0.00	31,875.00	0.00	0.00	31,875.00
03/01/19	03/01/19	03/01/19	BKAMER19	478160BR4	JOHNSON & JOHNSON	0.00	843.75	0.00	0.00	843.75
03/01/19	03/01/19	03/01/19	BKAMER19	741531FA0	PRICOA GLOBAL FUNDING 1	0.00	35,266.67	0.00	0.00	35,266.67
03/01/19	03/01/19	03/01/19	BKAMER19	828807CU9	SIMON PROPERTY GROUP LP	0.00	62,500.00	0.00	0.00	62,500.00
03/03/19	03/03/19	03/03/19	BKAMER19	0258M0EG0	AMERICAN EXPRESS CREDIT	0.00	87,750.00	0.00	0.00	87,750.00
03/05/19	03/05/19	03/05/19	BKAMER19	40428HPR7	HSBC USA INC	0.00	11,750.00	0.00	0.00	11,750.00
03/07/19	03/07/19	03/07/19	BKAMER19	14913Q2N8	CATERPILLAR FINL SERVICE	0.00	27,562.50	0.00	0.00	27,562.50
03/07/19	03/07/19	03/07/19	BKAMER19	857477AG8	STATE STREET CORP	0.00	109,375.00	0.00	0.00	109,375.00
03/07/19	03/07/19	03/07/19	BKAMER19	904764BF3	UNILEVER CAPITAL CORP	0.00	22,500.00	0.00	0.00	22,500.00
03/08/19	03/08/19	03/08/19	BKAMER19	44932HAC7	IBM CREDIT LLC	0.00	55,000.00	0.00	0.00	55,000.00
03/15/19	03/15/19	03/15/19	BKAMER19	053015AD5	AUTOMATIC DATA PROCESSNG	0.00	49,500.00	0.00	0.00	49,500.00
03/15/19	03/15/19	03/15/19	BKAMER19	235851AP7	DANAHER CORP	0.00	52,800.00	0.00	0.00	52,800.00
03/15/19	03/15/19	03/15/19	BKAMER19	585055BR6	MEDTRONIC INC	0.00	78,750.00	0.00	0.00	78,750.00
03/20/19	03/20/19	03/20/19	BKAMER19	17275RBJ0	CISCO SYSTEMS INC	0.00	46,250.00	0.00	0.00	46,250.00
03/21/19	03/21/19	03/21/19	BKAMER19	74153WCN7	PRICOA GLOBAL FUNDING 1	0.00	61,250.00	0.00	0.00	61,250.00
03/22/19	03/22/19	03/22/19	BKAMER19	904764BA4	UNILEVER CAPITAL CORP	0.00	78,125.00	0.00	0.00	78,125.00
TOTAL INTEREST						0.00	811,097.92	0.00	0.00	811,097.92
MATURITY										
03/01/19	03/01/19	03/01/19	BKAMER19	478160BR4	JOHNSON & JOHNSON	150,000.00	0.00	150,000.00	0.00	150,000.00
TOTAL MATURITY						150,000.00	0.00	150,000.00	0.00	150,000.00

LA CARE

Cash Activity by Transaction Type GAAP Basis

Accounting Period From 03/01/2019 To 03/31/2019

Cash Date	Trade/Ex-Date	Settle/Pay Date	Custodian	Cusip	Description	Quantity	Income Amount	Principal Amount	Contributions/ Withdrawals	Total Amount
SELL										
03/22/19	03/22/19	03/22/19	BKAMER19	09248U718	BLACKROCK LIQ FUND T-FD-IN	3,810,271.51	0.00	3,810,271.51	0.00	3,810,271.51
03/29/19	03/27/19	03/29/19	BKAMER19	06051GFT1	BANK OF AMERICA CORP	5,500,000.00	64,166.67	5,486,470.00	0.00	5,550,636.67
TOTAL SELL						9,310,271.51	64,166.67	9,296,741.51	0.00	9,360,908.18
WITHDRAW										
03/07/19	03/07/19	03/07/19	BKAMER19	CASHCASH6	C-04 BANK FEES	0.00	0.00	0.00	(714.78)	(714.78)
TOTAL WITHDRAW						0.00	0.00	0.00	(714.78)	(714.78)
GRAND TOTAL						23,538,416.36	881,591.61	(880,876.83)	(714.78)	0.00

Avg Date 23

BOARD OF GOVERNORS

Finance & Budget Committee

Meeting Minutes – March 25, 2019

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

Members

Robert H. Curry, *Chairperson*
Stephanie Booth, MD
Hector De La Torre
Hilda Perez
G. Michael Roybal, MD

Absent* * Via Teleconference*

Management/Staff

John Baackes, *Chief Executive Officer*
Terry Brown, *Chief Human Resources Officer*
Augustavia J. Haydel, Esq., *General Counsel*
Dino Kasdagly, *Chief Operating Officer*
Marie Montgomery, *Chief Financial Officer*
Tom Schwaninger, *Chief Information Officer*

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
CALL TO ORDER Robert H. Curry	Robert H. Curry, *Chairperson,* called the meeting to order at 1:05 p.m. He welcomed Stephanie Booth, MD, to the Committee. He announced that members of the public may address the Committee on each matter listed on the agenda before or during the Committee's consideration of the item, or on any other topic at the Public Comment section.	
APPROVE MEETING AGENDA Robert H. Curry	The Agenda for today's meeting was approved.	**Approved unanimously. 4 AYES (Booth, Curry, De La Torre, and Roybal)**
PUBLIC COMMENTS	There were no public comments.	
APPROVE MEETING MINUTES Robert H. Curry	The minutes of the January 28, 2019 meeting were approved as submitted. *(There was not a quorum for the February 25, 2019 meeting, so there are no minutes.)*	**Approved unanimously. 4 AYES**
CHAIRPERSON'S REPORT	Chair Curry noted that the Private Essential Access Community Hospitals (PEACH) is a statewide association of California's disproportionate share (DSH) hospitals. Proposition 55 was passed two years ago and supports education and Medicaid, although no money came to health care. PEACH estimates $700 million could be funded. They are lobbying to get funding freed up.	

APPROVED

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	John Baackes, *Chief Executive Officer,* responded that he will raise the issue at the Local Health Plans of California (LHPC).	
CHIEF EXECUTIVE OFFICER REPORT	Mr. Baackes reported that Governor Newsome issued an executive order that will carve pharmacy benefits out of Medi-Cal. The effective date of this proposal is January 1, 2021. It is thought that, as a centralized purchaser for all Medi-Cal beneficiaries, the state will get better pharmacy pricing than the health plans. Some non-profit health plans receive rebates for pharmacy purchases through the 340B program currently in place, and those rebates support the safety net. A source of significant funding for Medicaid is the subsidization from commercial plans through programs like the 340B. The new structure proposed by the Governor allows the state to change the 340B program which may disrupt current services by limiting programs that support the safety net and could potentially interrupt care management for the neediest patients. *(Member Perez joined the meeting.)* The process of appeals for pharmacy and formulary require a response in 24 hours, and plans are not confident that the state would be able to comply. The Department of Health Care Services (DHCS) is charged with administering pharmacy benefits. L.A. Care advocates for pharmacy cost savings with the health plans administering the program. L.A. Care's pharmacy benefit is currently about $800 million, and removal of this revenue will affect the financial reports for health plans and would be a significant change in Medi-Cal. L.A. Care supports cost savings but does not want to upset a program that is working well. The Centers for Medicare & Medicaid Services (CMS) recent audit of L.A. Care's CMC product found no issues in pharmacy benefits administration. Chair Curry noted that the hospitals support the health plans and health centers in preserving funding for Medi-Cal beneficiaries. Member Booth noted that there may be other standards that the state could not meet, other than the inability to respond to an appeal in formulary within 24 hours. Mr. Baackes noted that the main issue is to get rid of rebates and have an actual price for pharmaceuticals. The proposal seems designed to improve transparency. A national legislation to replace rebates with appropriate price reductions will provide better transparency. Member Roybal noted that the County relies on 340B as a funding stream for clinics and hospitals. The change could adversely affect how the County provides care for the	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	uninsured. When states have done this in the past it has not reduced pharmacy cost. Any changes should focus on improved care, with cost savings secondary. Mr. Baackes added that the improvement of care is questionable because pharmacy will be centralized. DHCS has advised that a comparison to similar changes in other states does not work because it is argued that California is different. Member Roybal noted that there will likely be winners and losers for pharmacy formulary. Any loss in variety will not help patients. Mr. Baackes noted that Planned Parenthood, the Federally Qualified Health Clinics and the County will have good arguments against the centralization of pharmacy benefits in California. Mr. Baackes is also concerned that the Managed Care Organization Tax will end on June 30. Board Chair De La Torre noted that it makes sense to get economies of scale for state purchasers but it should not be done to the detriment in care for the beneficiaries.	
COMMITTEE ITEMS		
Chief Financial Officer's Report Marie Montgomery	Marie Montgomery, Chief Financial Officer, referred to the reports included in the meeting material. *(A copy of her report may be requested by contacting Board Service)* Highlights: • A flattening in the enrollment rate was assumed for the current budget, but a decrease continues in membership each month. The decrease is likely linked to the audit findings of the discrepancies between the state Medi-Cal enrollment system and the County enrollment system. Enrollment is favorable for the month for L.A. Care Covered. In response to Chair Curry's question about decreased enrollment, Ms. Montgomery thinks it is due to the improved economy and lower joblessness, which has led to fewer Medi-Cal beneficiaries. Chair Curry noted the hospitals are seeing growth in uncompensated care potentially due to lower enrollment and fear of deportation and application of the public charge rule on immigration processes. Mr. Baackes noted that approximately 25,000 undocumented children are enrolled under Medi-Cal with L.A. Care. Undocumented adults are not eligible to enroll in Medi-Cal.	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Member Roybal added that those eligible for enrollment may be worried that their undocumented relatives could suffer adverse consequences if the person enrolls in government health care benefit programs. Mr. Baackes added that the Covered California enrollment may also reflect these concerns. • Consolidated financial performance shows a positive effect from revised Proposition 56 rates, retroactively applied back to July 2018. • The overall medical cost ratio (MCR) is 89.8 % which is favorable to budget of 93.1%. Member Booth asked about the lower commercial MCR. Ms. Montgomery responded that it is due to higher administrative costs, including the MCO tax, advertising, and broker fees. There is a risk pool, and L.A. Care will transfer revenue into the pool if the MCR reaches a certain level. • Tangible Net Equity is at 611%. The updated average is 600% so L.A. Care is updating its goal to that level. • The 4+8 forecast assumes a 3% decrease in membership by year-end for MCLA and Plan Partner enrollment, based on the trend in the first five months of the year. Cal MediConnect is assuming a slight decrease in enrollment in the forecast vs. budget as the brokers ramp up activities. Member Booth asked about member satisfaction ratings. Mr. Baackes noted that L.A. Care's satisfaction ratings are not segmented by type of enrollment. **Motion FIN 100.0419** **To accept the Financial Report for the periods ended January and February 2019, as submitted.**	Approved unanimously. 5 AYES (Booth, Curry, De La Torre, Perez, and Roybal)
Investment Monthly Transactions Report Marie Montgomery	Ms. Montgomery referred to the report on investment transactions included in the meeting materials for Committee member review. (*A copy of the report can be obtained by contacting Board Services).* As of February 28, 2019, the market value of L.A. Care's investments was $1.4 billion. • $1.3 billion managed by Paydel & Rygel and New England Asset Management • $60 million in Local Agency Investment Fund • $103 million in Los Angeles County Pooled Investment Fund	

APPROVED

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
Real Property Motions **Authorization to survey Family Resource Center (FRC) locations and delegation of authority to the Finance & Budget Committee**	Lance MacLean, *Director, Facilities Services*, presented the motion requesting authorization to survey locations for future Family Resource Center (FRC) and delegation of authority for final approval of leases to the Finance & Budget Committee. L.A. Care has prioritized establishing a physical presence by opening and operating FRCs in communities where L.A. Care members reside. The plan is to establish 12 FRCs in select communities to deliver integrated health education and other services in each of the defined RCAC regions. L.A. Care has opened and is currently operating six FRCs with six new FRCs to be developed over the next two years. L.A. Care intends to establish the remaining six FRCs in the following RCAC regions:	

Year	Location
2019	Pomona (RCAC 11) * already approved
2019	Metro L.A. (RCAC 4)
2019	Long Beach (RCAC 9)
2020	The Westside (RCAC 5)
2020	San Gabriel Valley (RCAC 3)
2020	Gateway Cities (RCAC 7)
2020	South Bay (RCAC 8)

Mr. MacLean added that staff will present final lease terms to the F&B Committee for approval.

Member Booth asked if the 2019 sites were budgeted. Mr. MacLean responded that the Pomona and Metro LA FRC sites were budgeted. The remaining planned FRCs will be budgeted in the next fiscal year.

In response to Member Perez' question about the locations for the remaining FRCs, Mr. MacLean responded that the location of the Pomona FRC has been identified.

Motion FIN 101.0419

1. **To authorize L.A. Care staff to survey the real estate market for the remaining six Family Resource Centers (FRCs) in the Regional Community Advisory Committee (RCAC) regions, negotiate lease terms and perform leasehold improvement design and construction.**
2. **To delegate authority to the Finance & Budget Committee for approval of final lease terms and approval of capital improvement design and construction budgets.**

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
Tenant Improvement Budget for the 5th Floor, 1200 7th Street Building	Mr. MacLean presented a motion requesting authority for the Chief Executive Officer to enter into contracts for capital improvements, office furniture and other required equipment, fees or services to renovate the 5th floor of 1200 W. 7th Street building. The Board of Governors authorized staff to extend the lease of L.A. Care's space in this building on floors 1, 2, 3 and 5 (Motion BOG 114.1216-CS). Staff executed the first amendment to the lease dated February 15, 2017, that extends L.A. Care occupancy to March 2024 and adds the 5th floor consisting of 43,292 sq./ft. of space beginning in August 2019. **Motion FIN A.0319** **To delegate to John Baackes, Chief Executive Officer, discretionary authority to approve vendors and enter into contractual agreements for certain professional services, capital improvements, furniture and equipment to renovate the 5th floor 1200 W. 7th Street building in an amount not to exceed $3,974,885.00 which includes a 5% contingency for potential unknown conditions.**	**Motions FIN 101.0419 and FIN A.0319 were simultaneously approved unanimously. 5 AYES**
TransUnion Contract Amendment	Dino Kasdagly, *Chief Operating Officer,* presented a motion requesting an added $1.3 million for an existing contract with TransUnion for encounter data processing. Trans Union collects and processes provider encounter data for all L.A. Care lines of business. The data is used to determine health plan rates. **Motion FIN 103.0419** **To authorize staff to amend a contract in the amount of $1,316,000 not to exceed $5,536,000 with TransUnion to provide encounter processing services for the period of July 1, 2019 to May 31, 2020.**	**Approved unanimously. 5 AYES**
MarkLogic Contract Amendment	Tom Schwaninger, *Chief Information Officer,* presented a motion requesting approval to amend the contract with MarkLogic. MarkLogic provides professional and consulting services to manage provider data for L.A. Care's Total Provider Management strategic project. Member Booth asked about phase 2. Mr. Schwaninger responded that MarkLogic receives data from providers, adjusts it and compares to other data sources, and matches the data against existing data. MarkLogic also will do a data cleansing process to enable L.A. Care to use the data. In response to Member Perez' question about the extension to August 31, 2019, instead of the fiscal year end, Mr. Schwaninger responded that August 31, 2019 is the expected date for completion of the work.	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Motion FIN B.0319 **To authorize staff to amend a contract with MarkLogic in the amount of $285,880 total contract not to exceed $1,285,760 to provide Information Technology Development Services through August 31, 2019.**	**Approved unanimously. 5 AYES**
ADJOURN TO CLOSED SESSION	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 2:00 pm. CONTRACT RATES Pursuant to Welfare and Institutions Code Section 14087.38(m) • Plan Partner Rates • Provider Rates • DHCS Rate REPORT INVOLVING TRADE SECRET Pursuant to Welfare and Institutions Code Section 14087.38(n) Discussion Concerning New Product Lines Estimated date of public disclosure: *March 2021* CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION Pursuant to Section 54956.9 (d) (2) of the Ralph M. Brown Act Two potential cases PEER REVIEW Welfare & Institutions Code Section 14087.38(n)	
RECONVENE IN OPEN SESSION	The meeting reconvened in open session at 2:05 pm. No reportable actions were taken during the closed session.	
ADJOURNMENT	The meeting was adjourned at 2:05 pm.	

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

APPROVED BY:

Robert H. Curry, *Chair*
Date Signed 4/22/19

APPROVED