BOARD OF GOVERNORS MEETING

June 4, 2020 • 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 $180 million throughout the years to support the health care safety net and expand health coverage. The patient-centered health plan has a robust system of consumer advisory groups, including 11 Regional Community Advisory Committees (governed by an Executive Community Advisory Committee), 35 health promoters and six Family Resource Centers and one Community Resource Center 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 April 2020	
Medi-Cal	**1,988,041**
L.A. Care Covered	**84,457**
Cal MediConnect	**16,624**
PASC-SEIU	**51,592**
Total membership	**2,140,714**
L.A. Care Providers – As of September 2018	
Physicians	**4,926**
Specialists	**19,024**
Both	**1,537**
Hospitals, clinics and other health care professionals	**8,778**
Financial Performance (FY 2019-2020 budget)	
Revenue	**$8B**
Fund Equity	**$1.2B**
Net Operating Surplus	**$152.9M**
Administrative cost ratio	**5.6%**
Staffing highlights	
Full-time employees (Actual as of November 2019)	**2,343**
Projected full-time employees (FY 2019-2020 budget)	**2,362**

AGENDA
BOARD OF GOVERNORS MEETING
L.A. Care Health Plan
Thursday, June 4, 2020, 2:00 PM
L.A. Care Health Plan, 1055 W. 7th Street, 10th Floor, Los Angeles, CA 90017

DRAFT

California Governor issued Executive Order N-25-20, N-29-20, which among other provisions amends the Ralph M. Brown Act and Executive Order N 33-20, ordering all residents to stay in their homes, except for specific essential functions. Accordingly, members of the public should now listen to this meeting via teleconference as follows:

Teleconference Call-In Information/Site
Call (844) 907-7272 or (213) 438-5597
Participant Access Code 73259739 (ENGLISH) / 990061589 (SPANISH)

Members of the Board of Governors or staff may also participate in this meeting via teleconference. *The public is encouraged to submit its public comments or comments on Agenda items in writing by e-mail to boardservices@lacare.org, or by sending a text or voicemail to 213 628 6420.*

The text, voicemail, or email should indicate if you wish to be identified or remain anonymous, and should also include the name of the item to which your comment relates.

Comments received by voicemail, email or text by 2:00 pm on June 4, 2020 will be provided in writing to the members of the Board of Governors at the meeting.
Once the meeting has started, emails and texts for public comment should be submitted before the item is called by the meeting Chair. If you wish to submit public comment on an item, you must submit it at any time prior to the time the Chair starts consideration of the item. The Chair will ask for public comment and will announce the item. The Chair will announce when public comment period is over.
Public comments will be read for up to 3 minutes at the meeting.
All votes in a teleconferenced meeting shall be conducted by roll call.

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

Welcome — Hector De La Torre, *Chair*

1. Approve today's Agenda — *Chair*
2. Public Comment *(Please read instructions above.)* — *Chair*
3. Consent Agenda Items — *Chair*
   - Minutes of May 7, 2020 Board of Governors meeting p.15
   - Covered California Contract Extension **(BOG 100)** p.47
   - Edifecs Contract Amendment **(FIN 100)** p.132
   - Change Healthcare Contract Amendment **(FIN 101)** p.134
   - Cognizant Contract Amendment **(FIN 102)** p.135
4. Chairperson's Report — *Chair*
5. Chief Executive Officer Report p.136 — John Baackes, *Chief Executive Officer*
   - 2020-21 Governor's May Budget Revise Summary p.138
   - COVID-19 Medicaid Relief Letter to Congress p.158
   - Grants & Sponsorships Reports p.163

6. Motion for Consideration: Revisions to Human Resources Policy for Employees who Volunteer to Help our Community **(BOG 101)** — Terry Brown, *Chief Human Resources Officer*

Committee Reports

7. Executive Committee — *Chair*
   - Government Affairs Update p.164 — Cherie Compartore, *Senior Director, Government Affairs*

8. Finance & Budget Committee — Robert H. Curry, *Committee Chair*
   - Financial Reports **(FIN 103)** p.216 — Marie Montgomery, *Chief Financial Officer*
   - Monthly Investments Transactions Report p.227

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

10. Audit Committee Report — Al Ballesteros, MD, *Committee Chair*

11. Public Comment — *Chair*

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

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

13. REPORT INVOLVING TRADE SECRET
    Pursuant to Welfare and Institutions Code Section 14087.38(n)
    Discussion Concerning new Service, Program, Technology, Business Plan
    Estimated date of public disclosure: *June 2022*

14. CONFERENCE WITH LABOR NEGOTIATOR
    Pursuant to Section 54957.6 of the Ralph M. Brown Act
    Agency Designated Representative: John Baackes
    Unrepresented Employee: All L.A. Care Employees

15. CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION
    Significant exposure to litigation pursuant to Section 54956.9(d) (2) of Ralph M. Brown Act
    One Potential Case

RECONVENE IN OPEN SESSION — *Chair*

Adjournment — *Chair*

The next meeting is scheduled on Thursday, July 30, 2020 at 2:00 PM
and may be conducted as a teleconference meeting.

Public comments will be read for up to three minutes.
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.

THE PUBLIC MAY SUBMIT COMMENTS TO THE BOARD OF GOVERNORS BEFORE DISCUSSION OF EACH ITEM LISTED ON THE AGENDA BY SUBMITTING THE COMMENT BY VOICE MESSAGE OR IN WRITING BY TEXT MESSAGE TO 213 628 6420, OR IN WRITING BY EMAIL TO boardservices@lacare.org. Please follow additional instructions on the first page of this Agenda.

ACTION MAY NOT BE TAKEN ON ANY MATTER RAISED DURING THE PUBLIC COMMENT PERIODS UNTIL THE MATTER IS SPECIFICALLY LISTED ON A FUTURE AGENDA, according to California Govt Code Section 54954.2 (a)(3) and Section 54954.3.

NOTE: THE BOARD OF GOVERNORS CURRENTLY MEETS ON THE FIRST THURSDAY OF MOST MONTHS AT 2:00 P.M. AGENDA and PRINTED MEETING MATERIALS ARE AVAILABLE FOR INSPECTION AT http://www.lacare.org/about-us/public-meetings/board-meetings **and by email request to boardservices@lacare.org**

Any documents distributed to a majority of the Board Members regarding any agenda item for an open session after the agenda has been posted will be available for public inspection at http://www.lacare.org/about-us/public-meetings/board-meetings **and can be requested by email to boardservices@lacare.org.**
An audio recording of the meeting is made to assist in writing the minutes and is retained for 30 days.

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

L.A. Care HEALTH PLAN

Schedule of Meetings
June 2020

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

Due to COVID 19 pandemic, California Governor issued Executive Order N-25-20, N-29-20, which among other provisions amends the Ralph M. Brown Act and Executive Order N 33-20, ordering all residents to stay in their homes, except for specific essential functions.

L.A. Care has temporarily suspended some of its public meetings.

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

Prepared by mhbalones/printed on 05/27/20

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
2020 MEETING SCHEDULE / MEMBER LISTING

	MEETING DAY, TIME & LOCATION	MEETING DATES	BOARD MEMBERS / STAFF CONTACT
BOARD OF GOVERNORS	**1st Thursday** 2:00 PM *(for approximately 3 hours)* L.A. Care Health Plan 1055 W. 7th Street, 1st Floor, Los Angeles, CA 90017 (213) 694-1250 **Offsite All Day Retreat at The California Endowment* ***Placeholder meeting date*	June 4 July 30 *No meeting in August* September 3 * October 1 ** November 5 December 3	Hector De La Torre, *Chairperson* Alvaro Ballesteros, MBA, *Vice Chairperson* Robert Curry, *Treasurer* Layla Gonzalez, *Secretary* Stephanie Booth, MD Christina R. Ghaly, MD George W. Greene, Esq. Antonia Jimenez Hilda Perez Honorable Mark Ridley-Thomas G. Michael Roybal, MD, MPH Ilan Shapiro, MD Nina Vaccaro **Staff Contact:** John Baackes *Chief Executive Officer, x4102* Linda Merkens *Senior Manager, Board Services, x4050*
BOARD COMMITTEES			
EXECUTIVE COMMITTEE	**4th Monday of the month** 2:00 PM *(for approximately 2 hours)* L.A. Care Health Plan 1055 W. 7th Street, 1st Floor, Los Angeles, CA 90017 (213) 694-1250	June 22 *No meeting in July* August 24 September 28 October 26 November 16 *No meeting in December*	Hector De La Torre, *Chairperson* Alvaro Ballesteros, MBA, *Vice Chairperson* Robert H. Curry, *Treasurer* Layla Gonzalez, *Secretary* Stephanie Booth, MD Hilda Perez **Staff Contact:** Linda Merkens *Senior Manager, Board Services, x4050* Malou Balones *Board Specialist III, Board Services x4183*

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BOARD OF GOVERNORS, BOARD COMMITTEES, PUBLIC ADVISORY COMMITTEES AND REGIONAL COMMUNITY ADVISORY COMMITTEES
2020 MEETING SCHEDULE / MEMBER LISTING

	MEETING DAY, TIME & LOCATION	MEETING DATES	BOARD MEMBERS / STAFF CONTACT
COMPLIANCE & QUALITY COMMITTEE	**3rd Thursday every 2 months** 2:00 PM *(for approximately 2 hours)* L.A. Care Health Plan 1055 W. 7th Street, 1st Floor, Los Angeles, CA 90017 (213) 694-1250	August 20 September 17 November 19 *No meeting in December*	Stephanie Booth, MD, *Chairperson* Alvaro Ballesteros, MBA Hilda Perez Ilan Shapiro, MD Nina Vaccaro **Staff Contact:** Victor Rodriguez *Board Specialist II, Board Services x 5214*
FINANCE & BUDGET COMMITTEE	**4th Monday of the month** 1:00 PM *(for approximately 1 hour)* L.A. Care Health Plan 1055 W. 7th Street, 1st Floor, Los Angeles, CA 90017 (213) 694-1250	June 22 *No meeting in July* August 24 September 28 October 26 November 16 *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 *Board Specialist III, Board Services x4183*
GOVERNANCE COMMITTEE	L.A. Care Health Plan 1055 W. 7th Street, 1st Floor, Los Angeles, CA 90017 (213) 694-1250 **MEETS AS NEEDED**		Hilda Perez, *Chairperson* Stephanie Booth, MD Layla Gonzalez Antonia Jimenez Nina Vaccaro **Staff Contact:** Malou Balones *Board Specialist III, Board Services/x 4183*
SERVICE AGREEMENT COMMITTEE	L.A. Care Health Plan 1055 W. 7th Street, 1st Floor, Los Angeles, CA 90017 (213) 694-1250 **MEETS AS NEEDED**		Layla Gonzalez, *Chairperson* George W. Greene Antonia Jimenez Hilda Perez **Staff Contact** Malou Balones *Board Specialist III, Board Services/x 4183*

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BOARD OF GOVERNORS, BOARD COMMITTEES, PUBLIC ADVISORY COMMITTEES AND REGIONAL COMMUNITY ADVISORY COMMITTEES
2020 MEETING SCHEDULE / MEMBER LISTING

	MEETING DAY, TIME & LOCATION	MEETING DATES	BOARD MEMBERS / STAFF CONTACT
AUDIT COMMITTEE	L.A. Care Health Plan 1055 W. 7th Street, 1st Floor, Los Angeles, CA 90017 (213) 694-1250 **MEETS AS NEEDED**		Alvaro Ballesteros, MBA, *Interim Chairperson* Stephanie Booth, MD, Layla Gonzalez **Staff Contact** Malou Balones *Board Specialist III, Board Services, x4183*
L.A. CARE COMMUNITY HEALTH PLAN	**Meets Annually or as needed** L.A. Care Health Plan 1055 W. 7th Street, 1st Floor, Los Angeles, CA 90017 (213) 694-1250		Hector De La Torre, *Chairperson* Alvaro Ballesteros, MBA, *Vice Chairperson* Robert Curry, *Treasurer* Layla Gonzalez, *Secretary* Stephanie Booth, MD Christina R. Ghaly, MD George W. Greene, Esq. Antonia Jimenez Hilda Perez Honorable Mark Ridley-Thomas G. Michael Roybal, MD, MPH Ilan Shapiro, MD Nina Vaccaro **Staff Contact:** John Baackes, *Chief Executive Officer, x4102* Linda Merkens, *Senior Manager, Board Services, x4050*
L.A. CARE JOINT POWERS AUTHORITY	**Meets as needed** L.A. Care Health Plan 1055 W. 7th Street, 1st Floor, Los Angeles, CA 90017 (213) 694-1250		Hector De La Torre, *Chairperson* Alvaro Ballesteros, MBA, *Vice Chairperson* Robert Curry, *Treasurer* Layla Gonzalez, *Secretary* Stephanie Booth, MD Christina R. Ghaly, MD George W. Greene, Esq. Antonia Jimenez Hilda Perez Honorable Mark Ridley-Thomas G. Michael Roybal, MD, MPH Ilan Shapiro, MD Nina Vaccaro **Staff Contact:** John Baackes, *Chief Executive Officer, x4102* Linda Merkens, *Senior Manager, Board Services, x4050*

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BOARD OF GOVERNORS, BOARD COMMITTEES, PUBLIC ADVISORY COMMITTEES AND REGIONAL COMMUNITY ADVISORY COMMITTEES
2020 MEETING SCHEDULE / MEMBER LISTING

	MEETING DAY, TIME & LOCATION	MEETING DATES	BOARD MEMBERS / STAFF CONTACT
PUBLIC ADVISORY COMMITTEES			
CHILDREN'S HEALTH CONSULTANT ADVISORY COMMITTEE GENERAL MEETING	**3rd Tuesday of every other month** 8:30 AM *(for approximately 2 hours)* L.A. Care Health Plan 1055 W. 7th Street, 1st Floor, Los Angeles, CA 90017 (213) 694-1250	August 18 September 15 November 19	**Tara Ficek, MPH,** *Chairperson* **Staff Contact:** Victor Rodriguez *Board Specialist II, Board Services/x 5214*
EXECUTIVE COMMUNITY ADVISORY COMMITTEE	**2nd Wednesday of the month** 10:00 AM *(for approximately 3 hours)* L.A. Care Health Plan 1055 W. 7th Street, 1st Floor, Los Angeles, CA 90017 (213) 694-1250	June 10* July 8 *No meeting in August* September 9 October 14 November 11 December 9 **1 pm*	**Fatima Vasquez,** *Chairperson* **Staff Contact:** Idalia Chitica, *Community Outreach & Education, Ext. 4420*
TECHNICAL ADVISORY COMMITTEE	L.A. Care Health Plan 1055 W. 7th Street, 1st Floor, Los Angeles, CA 90017 (213) 694-1250	July 9 October 8	*Chairperson – To be elected* **Staff Contact:** Victor Rodriguez *Board Specialist II, Board Services/x 5214*

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BOARD OF GOVERNORS, BOARD COMMITTEES, PUBLIC ADVISORY COMMITTEES AND REGIONAL COMMUNITY ADVISORY COMMITTEES
2020 MEETING SCHEDULE / MEMBER LISTING

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REGIONAL COMMUNITY ADVISORY COMMITTEES			
REGION 1 ANTELOPE VALLEY	**3rd Friday of every other month** 10:00 AM *(for approximately 2-1/2 hours)* L.A. Care Family Resource Center-Palmdale 2072 E. Palmdale Blvd. Palmdale, CA 93550 (213) 438-5580	June 19 August 21 October 16 December 18	**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 15 August 17 October 19 December 21	**Estela Lara,** *Chairperson* **Staff Contact:** Martin Vicente *Community Outreach & Education, x 4423*
REGION 3 ALHAMBRA, PASADENA AND FOOTHILL	**3rd Tuesday of every other month** 9:30 AM *(for approximately 2-1/2 hours)* Robinson Park Recreation Center 1081 N. Fair Oaks Avenue Pasadena, CA 91103 (626) 744-7330	June 16 August 18 October 20 December 15	**Cynthia Conteas-Wood,** *Chairperson* **Staff Contact:** Frank Meza *Community Outreach & Education, x4239*

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BOARD OF GOVERNORS, BOARD COMMITTEES, PUBLIC ADVISORY COMMITTEES AND REGIONAL COMMUNITY ADVISORY COMMITTEES
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REGION 4 HOLLYWOOD-WILSHIRE, CENTRAL L.A. AND GLENDALE	**3rd Wednesday of every other month** 9:30 AM *(for approximately 2-1/2 hours)* L.A. Care Health Plan Conference Room 100 1055 W. 7th Street Los Angeles, CA 90017 (213) 694-1250	July 15 September 16 November 18	**Sylvia Poz,** *Chairperson* **Staff Contact:** Kristina Chung *Community Outreach & Education, x5139*
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 15 August 17 October 19 December 21	**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 25* August 20 October 15 December 17 **date changed due to holiday or L.A. Care Special events*	**Andria McFerson,** *Chairperson* **Staff Contact:** Frank Meza *Community Outreach & Education, x4239*
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	July 16 September 17 November 19	**Fatima Vasquez,** *Chairperson* **Staff Contact:** Martin Vicente *Community Outreach & Education, x 4423*

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BOARD OF GOVERNORS, BOARD COMMITTEES, PUBLIC ADVISORY COMMITTEES AND REGIONAL COMMUNITY ADVISORY COMMITTEES
2020 MEETING SCHEDULE / MEMBER LISTING

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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	July 17 September 18 November 20	**Ana Romo – *Chairperson*** **Staff Contact:** Jose Rivas *Community Outreach & Education, x4090*
REGION 9 **LONG BEACH**	**3rd Monday of every other month** 10:00 AM *(for approximately 2-1/2 hours)* Albert Jewish Community Center 9801 E. Willow Street Long Beach, CA 90815 (562) 426-7601	July 20 September 21 November 16	**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** 2:00 PM *(for approximately 2-1/2 hours)* L.A. Care East L.A. Family Resource Center 4801 Whittier Blvd Los Angeles, CA 90022 (213) 438-5570	June 25* August 20 October 15 December 17 **date changed due to holiday or L.A. Care Special events*	**Damaris de Cordero,** *Chairperson* **Staff Contact:** Jose Rivas *Community Outreach & Education, x4090*
REGION 11 **POMONA AND EL MONTE**	**3rd Thursday of every other Month** 10:00 AM *(for approximately 2-1/2 hours)* Pomona Community Resource Center 696 W. Holt Street Pomona, CA 91768 (909) 620-1661	July 16 September 17 November 19	**Maria Angel Refugio,** *Chairperson* **Staff Contact:** Frank Meza *Community Outreach & Education, x4239*

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Board of Governors
Regular and Special Supplemental Meeting Minutes #287
May 7, 2020

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, *Secretary*
Stephanie Booth, MD
Christina R. Ghaly, MD *
George W. Greene, Esq.
Antonia Jimenez
Hilda Perez
Honorable Mark Ridley-Thomas *
G. Michael Roybal, MD, MPH
Ilan Shapiro, MD
Nina Vaccaro, MPH

**Absent **All via teleconference (COVID-19)*

Management/Staff

John Baackes, *Chief Executive Officer*
Terry Brown, *Chief of Human Resources*
Augustavia Haydel, *General Counsel*
Dino Kasdagly, *Chief Operating Officer*
Alex Li, MD, *Deputy Chief Medical Officer*
Thomas Mapp, *Chief Compliance Officer*
Marie Montgomery, *Chief Financial Officer*

California Governor issued Executive Order No. N-29-20, which among other provisions amends the Ralph M. Brown Act and Executive Order No. 33-20, ordering all residents to stay in their homes, except for specific essential functions.
Members of the public can listen to this meeting via teleconference, and can share their comments via voicemail, email, or text.

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
WELCOME	Hector De La Torre, *Chairperson,* called the meeting to order at 2:05 p.m. for the regular and Special Supplemental Agendas for L.A. Care and L.A. Care Health Plan Joint Powers Authority. The L.A. Care Board of Governors regular and special supplemental meetings and the L.A. Care Health Plan Joint Powers Authority regular and special supplemental meetings were held simultaneously. He welcomed members of the public and thanked those who have submitted public comment by voice mail, text or email. The process for public comment is new because of the extraordinary circumstances of the pandemic and adjustments are needed to be in compliance with the Governor Newsom's Executive Orders. You have the ability to submit your comments ahead of each item that you would like to speak on via text or email and we will read those at the appropriate time on the Agenda. As is done at the regular meeting, comments are taken before the item is discussed by the Board. Board Members have already received voice messages and written comments that were sent before the meeting. Comments that are sent during the meeting will also be read for up to three minutes. Just as at any other meeting, public comments on any topic that are not listed on the Agenda will be heard at the Public Comment section of the Agenda, and comments on the items listed on the Agenda will be heard before the item is discussed by the Board, just as we do in regular (in person) meetings.	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	For those with access to the internet, the materials for today's meeting are available on the L.A. Care website. If you have questions about where to locate the materials, please let us know. He asked for a moment of silence for those who are suffering from the effects of COVID-19, including those who have tested positive for the virus and especially for the more than 100 members who have lost their lives due to this pandemic.	
APPROVAL OF MEETING AGENDA	The agenda was approved as submitted.	**Unanimously approved by roll call. 8 AYES (Booth, De La Torre, Gonzalez, Jimenez, Perez, Roybal, Shapiro and Vaccaro)**
PUBLIC COMMENT	*Given current public health guidelines and orders, public comments received have been provided to Board Members in writing. Public comment received was read during the meeting for three minutes for each person submitting comments. Additional comments not read due to time will be printed as an addendum at the end of these minutes. Members Ballesteros and Greene joined the meeting.* **Text message received on April 11, 2020, 8:09 p.m., from Carolyn Navarro.** Public comment for May 2020 Board Meeting , will be verified from Carolyn Navarro for crime victim daughter Vanessa : after our repeated attempts to notify the state (public health and DMHC) and LA Care about Synermeds abuses going back to 2014 we now believe the state of Calif and LA Care are hiding the harm Synermed has done to patients who have the right to know they are crime/fraud victims, both agencies are carrying on like no one was actually harmed and not accepting responsibility for their lack of oversight, especially DMHC. LA Care , the state and the county have failed victims of Synermed who have the right to know, it is discrimination because of the disabilities many of these enrollees have and their advocates not being notified. I will also be verifying my April comments I'm within in my Brown Act rights making **Text message received on April 12, 2020, 8:53a.m., Carolyn Navarro,** Add to, to be verified public comment that the state and county don't want to acknowledge their own negligence, why would they have to when "helpless" people (such as Vanessa) can't defend themselves? State and county don't have a choice, Synermed abuses are an adverse event , my daughters preventable coma was adverse , it's against the law not to tell a patient they were adversely affected and they know it! Board members are liable for LA Cares conduct.	

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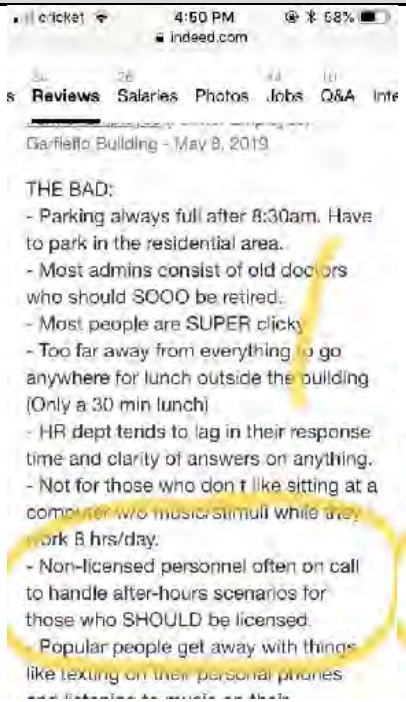
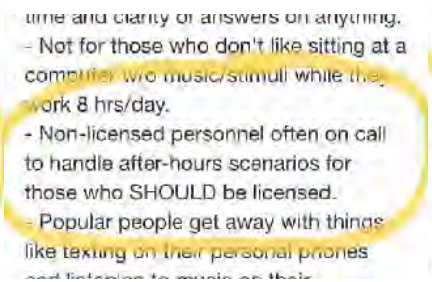
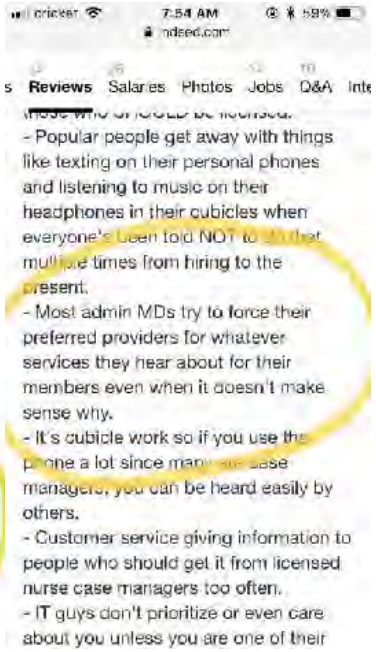
	We were lied to and told Vanessa had to go to Pacific Alliance when they had no right to force her telling us she was "capitated" to that *expletive* hole "hospital " as far as I'm concerned that is adverse and almost killed her then ,I intend to keep pursuing this indefinitely, Mr. Baackes even admitted to me there was a problem and nothing was done to help Vanessa even then in Nov 2015! I question Mr. Baackes's leadership of LA Care! I also don't believe LA Care really investigated what happened to Vanessa and think we were lied to! Mr. Baackes is not doing his job and needs to be kicked out, he knew all about Vanessa and turned a blind eye! It's suggested the doctors on LA Cares board look into what was done to Vanessa and Mr. Baackes and Dr. Carter handled it! They are on the hook for LA Cares conduct!  I do believe state and county people are covering up the abuses and I already know who they are , I intend to paint them into a corner so they can't just make it about me! I intend to report the doctors **Text message received on April 19, 2020, 4:37 p.m., from name not stated**. I located another MSO near Monterey Park and Alhambra and a person who works there states as of 2019 that non licensed people are making medical decisions about patients just like what caused Vanessa to be in a 9 day coma, it's suggested you look at what these losers are doing to enrollees instead of doling out carte blancs allowing them to abuse dependent adults, which I bet is going on even now because of your negligence. You need to watch what is going on instead of using these people to do your "dirty work"!	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN







Also being forwarded to DMHC that Synermed scams are still being perpetrated on disabled.

Message received on May 7, 2020, from Elizabeth Cooper, RCAC 2
To the Chairperson, Board of Governors, and Mr. John C. Baackes. As a member of L.A. Care I would like to thank you for your motion of support for the consumer advisory committees and staff, etc. at the April 2020 Board meeting. I would appreciate if the Board would consider a thank you to all the providers. Doctors and health care providers, etc. for their work helping L.A. County. And I would like to thank them for providing safety and support. I would also like to thank public officials for their support. I love California and I love L.A. Care.

Chairperson De La Torre announced that public comment period is closed. He also extended condolences to Mrs. Navarro, on his own behalf and on behalf of L.A. Care. He has a daughter who was hospitalized and moved around during her care, and was in the intensive care unit (ICU). She was in a coma. He feels very, very sorry and he extended to Mrs. Navarro and her family his deepest sympathy for the loss of her daughter. He understands that losing a child is a tragedy. He also thanked Mrs. Navarro for sharing her concerns. He asked that Mrs. Navarro please know that patient safety and access to quality health care services is our highest priority,

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	and she can be assured that L.A. Care has implemented quality assurance processes, including peer review, credentialing and grievance and delegation oversight processes in which all member concerns, like hers, are reviewed and addressed appropriately and in accordance with applicable rules and regulations. Specifically, with respect to Mrs. Navarro's concerns about EHS and Synermed, L.A. Care no longer contracts with EHS. Confidentiality requirements like Health Information Portability and Accountability Act (HIPAA), prevent us from commenting publicly about the care rendered to specific patients, however, at your discretion we can have members of our staff speak to you or other members about their concerns privately. Please let our Board Services staff know if there is a request to speak with an L.A. Care staff member regarding member concerns. He thanked Mrs. Navarro again for expressing her concerns. He noted that the Board hears her and appreciates her comments. He expressed his deepest sympathies, personally, and on behalf of the Board of Governors, for her loss.	
CONSENT AGENDA ITEMS APPROVED BY A COMMITTEE	The Chairperson read the items on the Consent Agenda to be considered by the Board: • Approve April 2, 2020 meeting minutes • Revised 2020 Board of Governors Meeting Schedule **Motion EXE 100.0520** **To approve the revised 2020 Board of Governors meeting schedule as submitted.** • Quarterly Investment Report **Motion FIN 100.0520** **To accept the Quarterly Investment Report for the quarter ending March 31, 2020, as submitted.** • WEX Health Contract Amendment **Motion FIN 101.0520** **To authorize staff to amend the contract in the amount of $3,520,000 with WEX Health to provide Covered California Premium Billing services through December 2021 for a total contract of $8,495,500.** • TransUnion Contract Amendment **Motion FIN 102.0520** **To authorize staff to amend a contract with TransUnion for the period of June 1, 2020 to May 31, 2021, to provide encounter processing services, in an amount not to exceed $1,300,000, for a total contract amount not to exceed $6,836,000.**	**The Consent Agenda items were unanimously approved by roll call. 10 AYES (Ballesteros, Booth, De La Torre, Gonzalez, Greene, Jimenez, Perez, Roybal, Shapiro and Vaccaro)** The Consent Agenda and Recommended Consent Agenda items were unanimously approved. 11 AYES (Ballesteros, Booth, De La Torre, Gonzalez, Greene, Jimenez, Perez, Ridley-Thomas, Roybal, Shapiro and Vaccaro)

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• SAP Contract Amendment **Motion FIN 103.0520** **To authorize staff to execute a contract in the amount of $6,278,311.28 with Systems, Applications, and Products (SAP) to provide Success Factors, Human Resources Information System for the period of May 20, 2020 to May 19, 2025.** • Healthx Contract Amendment **Motion FIN 104.0520** **To authorize staff to amend a contract with Healthx in the amount of $2,088,000 (total contract not to exceed $7,588,000) and extend the contact term for hosting services through February 28, 2021.** Member Perez asked why there are no committee meetings in July. Chairperson De La Torre noted that the committee meetings are in preparation for the Board Meetings. Since there is no Board meeting in August, committees will not meet in July. (*Committee meetings will resume in August in preparation for the Board Meeting in September*.)	
CHAIRPERSON'S REPORT	PUBLIC COMMENT **Text message received May 7, 2020, 1:56 p.m. from Cleo Clotill Ray**. How will L.A. Care address the disparities in its RCACs without Black African Americans as members on all of its committees? You can't provide equal access to medical care if we're not at the table to inform you of our needs. African Americans don't have enough Black doctors to provide the kind of service that we need. We live and die on the streets of LA everyday. At this rate will we as African Americans disappear, from lack of services, homes and health care. Thank you. Cleo Ray. The only black RCAC 5 member for the last 5 years! What about our health? Chairperson De La Torre thanked him for the comments. He noted that this issue has come up before, and requires volunteers to come forward to participate. He invited John Baackes, *Chief Executive Officer*, to add any additional comments during his CEO report. Chairperson De La Torre added that, in terms of the doctors, medical practitioners, he has spoken numerous times about the shortage, it is a problem not limited to L.A. Care, it is a problem throughout California and the United States. L.A. Care is doing everything it can to augment the students entering medical schools, through scholarship and loan repayment programs to practicing physicians, to keep physicians in California and in Los Angeles County, providing care for our members. But, he continued, we can't invent them, they have to be out there taking on the challenge themselves, and we can recruit them to serve our members.	

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	Chairperson De La Torre reported that at the Executive Committee meeting last week he thanked staff for their incredible work in this difficult transition. Most L.A. Care workers are now working from home, keeping track of L.A. Care's over 2 million covered members and providing services for them every single day under these extraordinary circumstances. We see in the media that people are acknowledging and praising nurses and doctors, janitors and medical assistants, who are providing care during this difficult time. He also wants to acknowledge L.A. Care staff members because they are the ones who are making sure that L.A. Care is functioning and members are getting the care that they need. L.A. Care is the "people's plan", and despite the difficult circumstances, we are trying to provide the best services we possibly can for our members. He is very, very proud of that.	
CHIEF EXECUTIVE OFFICER REPORT	PUBLIC COMMENT **Telephone call (not a recorded message) received** on April 29, 2020, 2:22 pm, from Elizabeth Cooper Thank you, Board Chairperson Mr. De La Torre and Members of the Board of Governors. I would like to thank you on my behalf and my son's behalf, regarding the issues of health care that you help address for all members and the community. In particular, I am deeply concerned about the issues of the Coronavirus and the impact it has on the African American community and people of color. My concern is about the data showing a high death rate among African Americans and people of color. I would like to see some strategy or concerns from the L.A. Care Board members. I would like to know what L.A. Care is doing to address that issue. To me this issue cries out for your concern. And finally I would like to say thank you to the Chairperson, members of the Board, and staff and also the organization for addressing health disparities. Thank you board members for giving me the opportunity to speak through public comment. And thank you to the Chief Executive Officer, John Baackes and staff. Your concern on this issue is welcome. Mr. Baackes commented that during the Chief Medical Officer report there will be a report on the special effort to reach out to the African American and Latino communities that are part of our membership because we recognize exactly the points that Mrs. Cooper has been making. People of color seem to have more deaths and more infections than the population as a whole. L.A. Care has the ability to help address that and there will be a report on this topic from James Kyle, MD, M.Div., *Medical Director, Quality Improvement*. Mr. Baackes referred to his written report in the meeting materials (*a copy of his report and related attachments is available by contacting Board Services)*. He thanked everyone for attending this meeting.	

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	• The Chairperson acknowledged earlier and it was reported at the last meeting in April that starting on March 20, within a week L.A. Care has deployed almost all staff to work from home. L.A. Care continues to have a skeleton crew of staff who come in to the office to maintain the information technology (IT) infrastructure, to open mail and to send out checks (L.A. Care still receives claims by mail and they have to be paid. L.A. Care still pays by check some providers that do not have electronic funds transfer). He complimented those staff that still come in to the office. • The important thing to note is that as a result of this redeployment of our staff and our responsibility to provide customer service and to pay providers on time and accurately all of the metrics or key business indicators are hitting highs. L.A. Care is doing extremely well with customer service, answering calls and dealing with their concerns, and in paying claims at a rapid rate. Care management staff is able to keep up with health assessments and other activities, all while working from home. • It has been noted that L.A. Care employees like working from home, and have made it quite clear that post-pandemic they would like to have more opportunity to work at home. L.A. Care is developing a post-pandemic work at home policy. • Interestingly, L.A. Care would have been reluctant to move customer service and claims to home environments because it was thought that it would be difficult to maintain production numbers, and yet it has proved wrong. L.A. Care definitely will have a totally different workplace when the pandemic passes and can begin to bring employees back into the work place. He will report more to the Board as that policy is developed. • A major health plan responsibility is to ensure that members have access to high quality providers and that those providers are financially compensated for those efforts. It has been noted in the press and as a stakeholder Board, many of the Board Members are aware that hospitals stopped taking elective procedures to make hospital bed space available for COVID-19 patients, and non COVID-19 patients were discharged as quickly and safely as possible to create bed spaces. While that was a good thing in preparing for the possibility of COVID-19 patients, in the absence of COVID-19 patients admitted for care, there was a loss of revenue for those institutions. • For L.A. Care providers and doctors working in their offices, with the stay at home order people are reluctant to go into the doctor's offices even though it would be considered an essential activity, and most providers are reporting cancellation of up to 50% of their normal appointment volume. This creates a deep financial problem, depending on how the provider is paid.	

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	• He reminded the Board and public that most L.A. Care providers are enrolled through delegated entities who are paid by capitation based on the population that they care for, which is unaffected by the volume of services provided. So for most L.A. Care providers, particularly primary care, capitated providers have continued to receive the same compensation as they received pre-pandemic. This provides a financial buffer that would not be there if the provider were contracted with L.A. Care on a fee-for-service basis. • The public hospitals in Los Angeles are also capitated with L.A. Care, meaning they are paid based on the number of people enrolled with the Los Angeles County Department of Health Services for primary care, and despite any diminution of a census, they have received the same compensation. • Many of L.A. Care's other hospitals are paid on a fee-for-service basis. L.A. Care has been working on this with the Hospital Association of Southern California. He thanked Member Greene for making his staff available to meet with L.A. Care and hear their concerns about operating under the current constraints. L.A. Care must make sure that any funds that are passed on will count in L.A. Care's medical cost base going forward. • L.A. Care has accelerated claims payments to hospitals by removing certain edits and business processes. As a result, in April L.A. Care paid out $80 million more in claims to hospitals than it normally would. A normal claims run in a month can be between $200 and $240 million. L.A. Care probably paid $300 million in April to hospitals in the provider network, and all of that will count in medical care costs to L.A. Care going forward. • For primary care providers and federally qualified health centers (FQHCs), L.A. Care has determined that even though many of them may be capitated, their practice still may be suffering because not all of the practice is in that payment methodology, so L.A. Care advanced $21 million in pay for performance incentive payments. All L.A. Care primary care doctors receive pay for performance incentives, which are usually paid in January. Last January they received the pay for performance incentives earned in 2019. The pay for performance incentive for 2020 would be paid in January 2021. By the end of April, 2020, primary care providers received an advance on the 2020 payment equally to what they had received in 2019. With this advance payment, providers were informed that if their ultimate pay for performance earned for 2020 was higher than what was advanced, they would receive the additional amount in January 2021. If the pay for performance incentive is lower than the amount advanced, L.A. Care will let them keep the additional amount. • The hospital claims payment of $80 million and the $21 million advanced to primary care providers represents over $100 million to assist the safety net in Los Angeles County.	

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	• L.A. Care also reviewed the Community Health Investment Fund (CHIF), which supports the safety net provider network through grant funding, and has accelerated grant payments awarded in prior years for a multi-year period. Around $7 million in CHIF funds will be advanced to clinics, community health centers and community based organizations. An additional $6 million in CHIF grants and targeted funding for the current fiscal year has been redirected to community based organizations and clinics to support L.A. Care's most vulnerable members. The grants will be awarded mainly to support programs that will address homelessness and food insecurity. There is a list in the CEO report describing the areas of funding. • These funding programs represent a significant step forward by L.A. Care. Providers and community service organizations are happy about L.A. Care's assistance. L.A. Care will be ready to provide additional support if it is needed. • As a Medi-Cal managed care plan, L.A. Care relies on financial help from California in combination with the federal government, since they split the cost of Medi-Cal. • As a result of skyrocketing unemployment, L.A. Care is expecting a surge in Medi-Cal enrollment. It has been generally agreed that enrollment in Medi-Cal in California may increase by 1.5 to 3 million. If L.A. Care's share of that increase is the same as its current market share, it could see new enrollment of between 230,000-400,000 people in the next few months. He thanked Board Member Antonia Jimenez, *Director, Los Angeles County Department of Public Social Services (DPSS)*, for alerting L.A. Care of any changes in Medi-Cal enrollment. She reported that to date, there has not been an increase in Medi-Cal applications at DPSS. It is expected that many people furloughed or laid off work may have continued health care coverage from their employer or may be considering using the Consolidated Omnibus Budget Reconciliation Act (COBRA) to continue health care coverage, before they would realize they are eligible for Medi-Cal. • Member Jimenez has previously informed Mr. Baackes that there has been a 75% increase in CalFresh applications, indicating that there is a need and a surge in Medi-Cal enrollment may be coming this summer. (CalFresh is a nutrition assistance program that can help people in low-income households purchase food by increasing their food-buying power.) • There was an increase in Medi-Cal enrollment for May 1, but that is probably because the redetermination of eligibility for Medi-Cal was suspended until June 1, to continue eligibility for some who may not have completed a re-enrolment application before the deadline. • In January, Mr. Baackes reviewed proposals by the California Department of Health Services (DHCS) to improve CalAIM. Nearly all of those proposed changes have been	

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	suspended because there were huge budget implications which the state is not going to be in a position to fund. • DHCS intends to proceed with the separation of prescription drug benefits from Medi-Cal on January 1, 2021 so that the State could seek additional cost savings. L.A. Care believes this could be troublesome given the expected number of new enrollees this year, who would then be subject to changes in their prescription drug program on January 1, 2021. • L.A. Care continues to be concerned that the California budget will be negatively impacted because of the looming economic recession due to the pandemic related economic shut down. This morning the California Department of Finance issued a directive that it is expected that for the California Budget beginning July 1, there will be a $53 billion deficit. As was discussed with Chairperson De La Torre prior to this meeting, during his term in the state legislature, the budget deficit during the last recession was between $20-$30 billion, so this will be a much more painful budget process, which will force an impact to Medicaid. The Governor is scheduled to release a detailed budget on May 14, which will provide a first glimpse of cuts to state programs. It is expected the cuts to Medi-Cal will be eligibility, benefits and, unfortunately, in reimbursement to providers. Mr. Baackes shares this with the Board, particularly the stakeholder Board members, to help them prepare for that issue when it comes up. • Ahead of discussions with Board Members and senior staff members, he suggested it would be prudent for L.A. Care to have a community meeting with providers to share information and gather their thoughts on how to approach this together. L.A. Care will have to figure out how to equally share the pain of cuts so that everybody can all get through this. The planning for funding cuts will need to be done even as L.A. Care experiences a surge in enrollment. • The state budget is being advanced without any of the COVID legislation that has been passed as stimulus or relief. At the federal level, four bills have been passed as economic stimulus, but none has provided long term support to keep Medicaid plans around the country solvent during the upcoming recession. The second bill included a 6.2% increase in the match under the Federal Medicaid Assistance Percentage (FMAP) for the duration of the pandemic, which is short term and wholly inadequate to cover the kind of budget deficits that were broadcast this morning. • It is somewhat disappointing that L.A. Care's trade associations have not been lobbying aggressively on its behalf for federal Medicaid support. • L.A. Care took the lead and garnered support from 14 other local initiative public entity health plans to sign a letter that was sent to the entire U.S. House of Representatives	

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	California Democratic delegation (which at 45 members is the largest state delegation in Congress and includes Speaker Pelosi). A copy of the letter is included in the CEO report. The letter calls for four specific things: 1. Increase the federal share of Medicaid spending and commit to at least a two-year period of federal Medicaid funding for states. Precedent was set in the last recession in the 2009 American Recovery and Reinvestment Act, which provided funding to the state for 27 months to keep Medicaid solvent. L.A. Care's strategy department developed a projection that Medicaid has 71 million beneficiaries and may grow further because of unemployment to an estimated 82-94 million beneficiaries. A procurement equal to the proportion in the 2009 Act would need to be between $168-$192 billion in funding to sustain the Medicaid program at the state level. 2. The Medicaid Fiscal Accountability Proposed Rule (MFAR) must not be finalized during the COVID-19 crisis. MFAR which would impact the amount of supplemental funding provided to states, particularly California. Reductions that would result from MFAR could unquestionably mean cuts in Medicaid program enrollment and covered services. L.A. Care objected to this rule because it would have a detrimental effect on hospitals and it is a disaster during a pandemic. L.A. Care requested that the rule be postponed indefinitely until we get to a more stable financial situation. 3. Deem presumptive eligibility (PE) for enrollment for Medi-Cal applicants. The usual time frame for an application for Medi-Cal is 30-60 days. During a pandemic, people need access to care for testing or treatment. 4. Halt changes to the public charge rules that make immigrants who receive non-cash public benefits, such as Medicaid, food assistance and housing assistance potentially ineligible for green cards and visas. Not surprisingly, the changes have created an environment of fear throughout immigrant communities already wary of accessing health care coverage. People should not be discouraged from seeking care during a pandemic. • The letter that was sent to the California delegation in the House of Representatives last month is now being distributed nationally to Medicaid managed care plans to encourage broad support for these four important matters. This is being done because the national trade association is going about this in a different way which is based on technical issues rather than the broader social aspects of the pandemic and the recession and how those affect people accessing care. • There was a Supreme Court decision in late April, in favor of health insurance plans which are owed $12 billion under the Affordable Care Act's (ACA) risk corridor program, which	

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	was a part of the ACA that protected insurers against adverse selection. The risk corridor program was suspended arbitrarily by the current administration, a lawsuit was filed, and the Supreme Court has now ruled against the government. It is not known when payment will be made. L.A. Care's portion of this is about $25 million. This is important because the Supreme Court is facing another case, which was discussed before, Texas vs. Azar, wherein some state Attorneys General sued for the ACA to be unconstitutional because in 2017 the mandatory coverage tax penalty was removed. This current ruling may be a harbinger that the Texas vs. Azar case will not succeed. The media reported this week that Attorney General Barr advised the administration to pull this back because it was not a good idea during a pandemic, but his advice was ignored, and it was announced this morning that the case will move forward. It will be heard by the Supreme Court but no decision is expected prior to the election in November, and probably not until 2021. • L.A. Care operates with a delegated model, where it contracts with delegated entities like independent practice associations (IPAs) and medical groups, which then take care of services like care management and utilization management. L.A. Care has endeavored, for a number of years, to increase the size of the direct network, where L.A. Care does not rely on third party entities, which requires that L.A. Care develop the ability to conduct the services that have been delegated. Dino Kasdagly, *Chief Operating Officer,* has reported on this process, which is coming along nicely. L.A. Care has made a decisive change with one group, Heritage, an IPA that has four subsidiaries, one of which is Regal. Regal has voluntarily agreed to reduce its footprint with L.A. Care. On April 1, 41,000 former Heritage members that had a primary care doctor who was also affiliated with another medical group, were transferred from Regal and placed with other medical groups, retaining their primary care doctor. This has lowered the number of members enrolled with Heritage. L.A. Care has had compliance issues with Heritage in the past. On June 1 and July 1, two groups of members totaling 15,000 will be moved. These members have primary care physicians who do not have affiliation with another medical group. Those doctors have agreed to directly contract with L.A. Care. It seems that L.A. Care is reaching a tipping point to increase providers in the directly contracted network. Other providers are enquiring about direct network enrollment with L.A. Care. • To address the public comment earlier about the composition of the Regional Community Advisory Committee (RCAC), it is a continuing problem to get volunteers who reflect the diversity of the geographic region of the RCAC. It is not for lack of trying but for lack of volunteers willing to join the RCAC. L.A. Care will be looking at more aggressive ways to	

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	bring volunteers into the RCACs. There is plenty of opportunity to bring in more volunteers. He asked RCAC members to have volunteers call L.A. Care if they want to join a RCAC. • L.A. Care has continued work on the Elevating the Safety Net (ESN) through the COVID-19 pandemic and Mr. Baackes is happy to report that 11 additional grants were awarded and 5 physicians were added. There is now a total of 120 grants awarded to clinics and private practices to bring new primary care physicians in to the community, and 79 physicians have been hired, credentialed and are in practice in Los Angeles County. Additionally, 4 more grants have been made for medical school loan repayment. The objective is to keep the safety net vibrant and to enable safety net providers to compete with other networks for the limited providers available. Member Perez noted that the ESN program addresses the concern expressed about the lack of African American physicians. She asked if there were plans to involve other universities with this program. With regard to the lack of brown and black physicians, she noted that the Chairperson De La Torre had indicated this is also a nationwide issue. She has raised the issue of diversity and representation of the RCAC members to the Executive Community Advisory Committee (ECAC) and to this Board many times in the past. She has also met with Francisco Oaxaca, *Senior Director, Communications Community Outreach and Education, Communications*, and with Auleria Eakins, Ed, *Manager, Community Outreach and Education*, and Idalia De La Torre, *Supervisor, Field Specialists, Community Outreach and Engagement*. Ms. Perez noted that her term is about to end, and not enough progress has been made with RCAC membership. She is glad to hear that L.A. Care will be more aggressive in recruiting more members because it works both ways, it is not only the members reaching out to the community. Members need guidance and help to recruit people. Whatever L.A. Care is doing now is not working. She would like to see more inclusiveness and people really willing to participate in the committee meetings. She would also like to hear ideas from the members so we can make it more attractive. Looking at the L.A. Care Facebook page to see what L.A. Care is telling the community. She sees that there are only one or two likes, and she would like to see more. There are different ways to reach out to the community and she finds this a very useful way to do it. She noted that the California Endowment released a paper on April 28 that said that young black Americans over presented when it comes to deaths from COVID-19. Inequality is not only in jobs but it is harmful to the community. She lives in Lynwood, and her community is made up of African American and Hispanic people. She would like to get rid of the denominator of race and provide support to people who are vulnerable and need help. She believes L.A. Care can do better in regard to this. She apologized if she took too much time but this is her only time to speak out. For example,	

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	regarding the Family Resource Centers (FRCs), she sees a lot of work to do. On May 1, there was a food drive through in Palmdale in partnership with Partners for Health. L.A. Care and the FRC staff participated in the event. There was another community event in Pomona in partnership with Sowing Seeds for Life. She would like to see if this could be done with all the FRCs. She will go and do it. She sees Supervisor Hilda Solis providing help everywhere. L.A. Care can do that too. We can show our membership that L.A. Care is for members and by members. It is in L.A. Care's best interest that members have food on the table and that they are healthy. Mr. Baackes thanked Member Perez for the comment. He agreed that once the pandemic is behind us, L.A. Care can increase efforts to recruit members to the RCACs to make sure that they represent their communities. One place to direct recruitment efforts is in the FRCs or the Community Resource Centers (CRCs). People who come to the CRCs already have an interest in the health plan and L.A. Care could be doing more to ask people using the CRCs if they would like to be part of the RCACs. Mr. Baackes mentioned that the 16 scholars in the ESN scholarship program that have been awarded scholarships to medical school are all people of color, and most are women. That was not a requirement for the program. L.A. Care did ask the medical schools that selected the scholars to select scholars that are appropriate for the communities in which they will serve. Mr. Baackes stated that he was part of the Palmdale food distribution event and the people there were representative of the local community. The Pomona event was organized in the community and L.A. Care came forward to participate. He also noted that one of the grants in the CHIF motion today is for grants for meals to be provided to 750 homebound L.A. Care members and support for Project Angel Food to feed 150 people for a year who are otherwise homebound and cannot get out and shop for themselves or prepare their own meals. L.A. Care is doing a lot and he is glad it is being recognized. L.A. Care will do more if it can. Member Perez noted that Assemblyman Tom Lackey, Senator Scott Wilk and Steve Hofbauer, Mayor of Palmdale were at the Palmdale FRC. She asked why L.A. Care is not working with City Councils and Los Angeles County Service Planning Area (SPA) representatives. Mr. Baackes responded that he would speak to Mr. Oaxaca about this. The manager of the Palmdale FRC helped organize the event because she knows and works with the community. He will follow up on her suggestion. Member Perez then noted that L.A. Care has worked with Project Angel Food for two years. She would like to see information showing their coverage area, and if there is any other agency doing the same thing so L.A. Care can look at more options spread over more area and reaching more people.	

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	Mr. Baackes responded that the new proposed grant for meals for 750 L.A. Care members uses a different agency (he did not have the name of the other agency). The Project Angel Food grant support is proposed because there was a waiting list for assistance and there are 75 L.A. Care members in the program. The other project which involves food is a study by the state to see if meals delivered for people with congestive heart failure will reduce hospitalizations. For this state study, L.A. Care provided funds so that Project Angel Food could meet the requirements of the program to deliver the meals in a refrigerated truck, but L.A. Care is not paying for the meals for that state study. He emphasized that L.A. Care is trying to spread its support around and is working with more than two agencies. He stated that it is a matter of finding good partners and spreading what resources L.A. Care has as far as possible. Richard Seidman, MD, MPH, *Chief Medical Officer,* added that L.A. Care has staff dedicated to identifying resources to assist members with non-medical needs including income, food and housing. The information about available resources is on the L.A. Care community link. Mr. Baackes indicated that the community link is seeing a big increase in use and more than 50% of the inquiries are related to food security issues. The community link helps people find resources that they can access. Member Jimenez reported that in April CalFresh applications increased 179% over those in March. She also mentioned that Medi-Cal patients who have not completed and returned the redetermination forms by June 1 will have their benefits terminated. Mr. Baackes reported that he has informed L.A. Care staff of the June 1 deadline so they can reach out to those members affected. Member Ballesteros asked Mr. Baackes how members are reaching out regarding food insecurity. He offered to assist with coordinating a response to food insecurities among health center CEOs. Mr. Baackes suggested working with Member Vaccaro at Community Clinics Association of Los Angeles County. Member Vaccaro welcomed the involvement and invited Mr. Baackes to reach out to her directly. Member Booth stated that she has been trying to get involved with companies that use serum to mix with antibodies and would like assistance with this. She has noted that donation agencies are not operating due to the pandemic. Mr. Baackes thanked her for the suggestion and noted that L.A. Care hosted a Red Cross donation event and another is scheduled. Dr. Seidman offered to assist Dr. Booth outside the meeting.	

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	Terry Brown, *Chief Human Resources Officer* confirmed that another Red Cross blood drive event will be held in June at L.A. Care.	
COVID-19 Update	PUBLIC COMMENT **Received by Text on May 7, 2020, 2:33 p.m. from Andria McFerson** My name is Andria McFerson I'm speaking as a public member of L.A. Care. While the BoG is addressing disparities I asked that L.A. Care allow future Emerging Strategies posted to involve not only celebrities but our own L.A. Care committees and community members. WE should join Public Services regarding prevention awareness education and overall Outreach to our own communities. Please allow us to practice what a lot of us already have many years of experience doing which is speaking to our own members like how the celebrities appointed to this task would. We could also join the phone call method posted to the members with updates and other information that adheres to the necessities of the members regarding the covid-19 virus. Also data of the high risk demographic states that Latinos and African Americans are the two most highrisk cases so instead of the Outreach Expanding to include ONE Community or race please involved the African American community due to that same high risk factor. Andria McFerson, Executive chair/Public Member, RCAC 6 **Received via email on May 7, 2020, 2:16 p.m. from Andria McFerson** As a member of each committee I need a chance or the freedom to speak and to talk about issues for many reasons because of 501 c (3), my civil rights, the freedom of speech and also my Ada Title 1 through 5 as a disabled person. This is all to benefit not only Services LA Care renders but also to save lives. However when I try to speak during a public meeting following proper protocol to do so, all the rights mentioned above has been violated by staff members at La care only a few members specifically by hindering my right to speak publicly for better access to care. Please refer to a write up I received while trying to talk about ADA title 4 rights for the disabled to have better access to the information and resources posted online. I got shut down the minute I started to speak by staff member during a public meeting when I was called on to speak about the topic at hand. Also I know of two other members who were wrote up by Francisco Oaxaca and all three of us have something in common. Black people are being shut out of a lot of things please investigate his actions and the validity of my harassment claim. I ask for justice and a formal apology. I do have the recording of the meeting that happened on September 11, 2019. The COVID-19 update was included in the Chief Executive Officer's report above.	

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2nd Quarter FY 2019-20 Vision 2021 Progress Report	Mr. Baackes referred Board Members to the report included in the meeting materials. *(Copy of the report may be requested by contacting Board Services.)* Member Booth commented that this is a huge step in aligning all the pieces of our fractured health care system to improve health care for low income and vulnerable communities. L.A. Care has made wonderful progress creating ways to support and partner with health care providers. This Vision 2021 Progress report does a great job of organizing all the tasks related to providers in a way that demonstrates L.A. Care's progress in support of the providers Having this expressly articulated as a priority, anybody who reads the progress report will conclude that partnering with health care providers is a serious endeavor at L.A. Care. She added this demonstrates that L.A. Care is a forward-looking health plan focusing on consensus-building and doing what is right. Member Booth believes the alignment L.A. Care is creating will be crucial to pulling together all parts of our fractured health-care system; this will not only improve health care for low income and vulnerable communities. L.A. Care will continue to lead health care in a direction that will work for America. Mr. Baackes thanked Member Booth for her diligence in reviewing and suggesting improvements to the Vision 2021 report.	
Grants & Sponsorship Report	Mr. Baackes referred Board Members to the report included in the meeting materials. *(Copy of the report may be requested by contacting Board Services.)*	
COMMITTEE REPORTS		
From the Supplemental Special Meeting Agenda **Technical Advisory Committee Report**	~~Attended RCAC & recognize the staff supporting the~~ PUBLIC COMMENT **Text message received May 7, 2020, 3:59 p.m. from Andria McFerson, RCAC 6 Chair,** Hi my name is Andria McFerson I'm a disabled LA Care member who hasn't been able to use my insurance subsidy with LA Care to cover my co-pays & for certain medications that the doctor deems an epilepsy medical necessity. 1st of all, my bill regarding my dental work after having a seizure on the concrete and hitting my face. When the tooth pain caused even more seizures LA Care insurance should covered the Medical Necessity Dental Care. But it dosent! Even if it's just covering the subsidized cost it could help save someone's life and avoid more brain damage. The overall tactics in this time of need should be expedited to avoid major situations like mine. Because over a week ago it took an insurmountable amount of time to get my medication approved that the brain specialist made a requirement and once it was I had a seizure in the middle of the street while going to go pick it up from the pharmacy. In this day and time of need LA Care needs to have more expedited methods for overall access to medication.	

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	Especially medication deemed as a medical necessity! Imagine how many more people like me, who are out suffering in these crucial times? This is important information for LA Care to be informed about to take heed to.... Dr. Seidman reported that the Technical Advisory Committee (TAC) met on May 4. • Mr. Baackes reported on L.A. Care's COVID-19's activities as he did earlier today. • He reported on what L.A. Care is doing to help reach out to members, particularly those at high risk of infection. L.A. Care staff conducted targeted telephonic outreach to over 250,000 members to inform them that they may be in a high-risk group, provide guidance, and refer to resources. • Dr. Seidman reported on remote resources that are available to all members such as the nurse advice line, mail order pharmacy services, Teledoc which was launched in January, and the Community Link online resource platform. • James Kyle, *MD, Medical Director, Quality Improvement*, gave a presentation on the racial disparity for COVID-19 infections and mortality in Los Angeles County and how L.A. Care is addressing this issue. He will be presenting on that topic in a few moments. • Dr. Seidman was elected as Chair of the committee and Hector Flores, MD, was elected as Vice-Chair.	
Addressing Disparities	Dr. Seidman introduced Dr. Kyle who reported on a committee that L.A. Care formed in response to health disparities recognized among communities of color that arose in the pandemic. The internal team includes Thomas Mapp, *Compliance Officer,* and Alex Li, MD, *Deputy Chief Medical Officer,* and others. Dr. Kyle report on highlights of some of the activities to date. Dr. Kyle noted that L.A. Care is responding to COVID-19 health disparities that became evident on the local and national levels (*a copy of his presentation is available by contacting Board Services).* • In response to the mounting evidence on the national and local level, L.A. Care leadership moved quickly to address the racial disparity for COVID-19 infections and mortality in LA County. • L.A. Care has partnered with The California Endowment, the L.A. County Department of Public Health, the City of Los Angeles and local health care leaders collecting member data and observing County data. • Key leaders within L.A. Care have also volunteered to develop a plan to address this challenge. L.A. Care is developing a social media and radio campaign to reach "young	

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	invincibles" with tailored messages regarding prevention. L.A. Care is also looking to recruit entertainers and celebrities as spokespersons to produce public service announcements for L.A. Care. • There is planning for a virtual town hall with key community and political leaders to discuss a wider approach to COVID-19 racial disparity and to take action to limit the spread of the virus. • L.A. Care is looking to implement the Oakland model of reverse 911 calls and extensive neighborhood testing. The Customer Service Center (CSC) will make live calls to 32,000 high risk African American members and 110,000 low risk members, as well as identifying high risk members of the Hispanic community and conducting outreach in that community. • As of May 5, 2020, L.A. Care data showed: - 1,768 total confirmed cases - 847 members hospitalized - 101 reported deaths • Data from a number of L.A. Care sources including health information exchange (HIE), encounters, Costas Lab Data, QNXT, Compliance Reporting (including Plan Partner, participating provider groups (PPG), internal utilization management (UM), and CSC) • L.A. Care is collaborating with L.A. County Department of Public Health modeling and data sharing to monitor the spread of COVID-19. • L.A. Care has identified 18,276 high risk Latino members (disabled and diabetic) • L.A. County data as of April 26, 2020, is 19,516 confirmed cases: Latinos - 114 cases/per 100,000 African Americans - 102 cases/per 100,000 Whites - 78 cases/per 100,000 Asians - 73 cases/per 100,000 American Indian/Alaska Native - 50 cases/per 100,000 • Based on the data, L.A. Care is expanding its outreach to include the Latino community. The outreach will begin next week and will expand to others beyond that. Member Booth asked if L.A. Care has looked at data for compliance with social distancing. She has good friends who are Mexican, and they do not adhere to the guidelines. She wondered if this might be cultural and if there is any information about that. Dr. Kyle responded that L.A. Care is convinced that there are cultural issues as to compliance with the safer at home guidelines. A number are not just cultural, but stem from necessity. In the Latino and African American communities there are a number of people who are self-employed, under-employed or who are working in jobs that are not considered non-essential, so	

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	in order to earn their living they have to leave their home and go out. Compliance with social distancing guidelines becomes more difficult when people are out in the service type jobs. They have to go out to support their families and working from home is not an option for them. There are a lot of things to evaluate. This is part of why L.A. Care is planning Town Hall events, and will bring in people who are closer to these communities, community based organizations and their leaders, and converse with the leaders in these communities to determine how best to message and take into account factors such as culture and ethnicity, history and other factors that may play into this. The reason is not only compliance, but also addressing already existing underlying health disparities in these communities. COVID-19 has shined a brighter light in these communities where people are not as healthy because there were so many underlying medical conditions that have made these people more vulnerable to infection and death. Member Shapiro commented that he agrees completely with the assessment and added that a majority of Hispanics and communities of color are suffering and it is a reflection of social determinants of health (SDoH) that we have been fighting for the last couple of decades. More than a cultural aspect in Mexico and other countries, the reality is that they are already suffering and the health systems are saturated. It is trending similar to Italy, the things that are happening in Tijuana and Mexico City, and shortly it will happen in Guadalajara, it is coming everywhere. The reality on the ground is gruesome and horrible. The majority on both sides of the border are very concerned about what is happening. Understanding the SDoH is important, and social distancing is the only tool we have to protect ourselves. Chairperson De La Torre noted that a significant number of Latinos in Los Angeles County are not spending time in Mexico and would have no reason to know what is going on there. Mexico did not start implementing some of the controls in urban areas that we have, shelter in place, etc., until about two weeks ago. Mexico is way behind the United States in issuing public health safety guidelines and they are having trouble getting people to comply. There is a delay in Mexico. For those that do have interaction with relatives in Mexico, or maybe they themselves go back and forth (across the border), among that population, there may be those who did not understand the differences between the two countries. But a great majority of the population are not connected to Mexico and do not know what is going on there. What those people do here is more to Member Shapiro's and Dr. Kyle's point that it is the SDoH leading them to have more risk in this pandemic than other communities. Member Perez advocated for creating a task force to address the current pandemic situation for vulnerable communities and to seek long term solutions. She mentioned in particular mental health issues. *(Much of Member Perez' comment was not recorded due to technical problems.)*	

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	Dr. Seidman noted that L.A. Care has many activities addressing her concerns, but more can always be done because these are such difficult issues. Dr. Seidman offered to present to the Board a report on the SDoH task force, health equity committee and work being planned for FRC/CRCs. Member Booth noted that Dr. Seidman offered to provide a report for the Compliance & Quality Committee and that could be brought to the Board. She noted improvement in statistics for the pandemic is encouraging but it is important to address the problems going forward. Member Gonzalez noted that it is really easy for us to say you have to practice social distancing and wear a mask. When a family needs food, the mask is the last thing on one's mind. If we are going to address the issue and ask people to follow social distancing and wear masks, we need to find ways to supply people with what they need. Chairperson De La Torre commented that this is a nationwide challenge and we will keep addressing it. Input from the Board is important, and he asked Board Members to contact Mr. Baackes and Dr. Seidman so issues can be incorporated into what L.A. Care is doing. Mr. Baackes noted that Dr. Seidman leads a group of health plan medical directors and members of the departments of public health in Los Angeles County every week to address collective issues. The issue of personal protective equipment (PPE), testing and access has come up, and supplying PPE is a challenge for the entire community. The group of medical directors is trying to address this on a community basis. L.A. Care is trying to help find a way to address this.	
Executive Committee	The Executive Committee met on April 27 (*a copy of the minutes can be obtained by contacting Board Services*).	
Government Affairs Update	Mr. Baackes reported: • Implementation of the CalAIM program has been postponed indefinitely. • The state will continue to implement a carve out of pharmacy benefits for Medi-Cal. • California state budget proposals rolled out this morning and will take weeks to sort out. • The annual Governor's May Revise of the budget is due out May 14, and will provide a first look at potential cuts to the budget. L.A. Care will be working with providers and hospitals to determine ways to address the expected reduction in funds. • The state legislature is back in session, but will work on legislation only related to COVID and the state budget	

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	Chair De La Torre noted that legislative committee chairs were told to go through all of the bills in front of them and decide on which bills will be heard. Another culling process will happen when bills come out of committee. So two filtrations before bills come to the floor of either house, and probably less than 1/3 of the bills will survive. The state budget must be approved by mid-June. Mr. Baackes added that L.A. Care will be in high gear to get the U.S. Congress to pass a relief bill that will provide support for Medi-Cal through the expected economic recession, not just through the pandemic. Federal support for Medicaid (Medi-Cal in California) will be critical particularly with state budget cuts looming.	
Authorization of Expenditures for COVID-19 Related Program Funding	*Members Roybal, Vaccaro and Shapiro may have financial interests in Plans, Plan Participating Providers or other programs and as such refrained from the discussion and vote on this motion.* *(Member Greene left the meeting.)* Mr. Baackes summarized a motion to execute contracts and grants with entities not yet selected in an amount not to exceed $6 million. Funds will come from uncommitted Community Health Investment Fund (CHIF) funds, Strengthening Clinic Operations and Patient Experience (S.C.O.P.E) funds, and sponsorship funds. In addition, L.A. Care would like to request that the Chief Executive Officer be granted the authority to approve grants that will exceed the current $150,000 limit approval per grantee. The proposed grants will fund: • Up to 75 additional recuperative care beds for L.A. Care members • Phones, tents, and hygiene kits for up to 1,000 individuals experiencing homelessness to support social distancing and to stay in touch with their providers • Testing and telehealth support for members and other individuals in interim housing settings • Legal aid for community members facing eviction • Meal deliveries for up to 750 homebound members • Grants for safety net clinics serving high-need populations in support of COVID-19 efforts Member Perez asked about the application process for organizations to receive funding, and about reporting and monitoring of the grants. Mr. Baackes indicated that there is an application process for all CHIF grants and all requirements for reporting will apply to these grants. The Board receives a quarterly report on all grants made. Member Booth asked about a time limit for this authorization. Mr. Baackes suggested refreshing this at end of the current fiscal year on September 30.	

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	Member Perez asked about list of grant recipients for last three years. Staff will provide the information. **<u>Motion BOG 100.0520</u>** **To delegate authority for the Chief Executive Officer for:** **1. Expenditure of $6 million for COVID-19 related services for our most vulnerable members and community members.** **2. Redirection of budgeted Community Health Investment Fund (CHIF) funds, Strengthening Clinic Operations and Patient Experience (S.C.O.P.E) funds, and sponsorship funds for this purpose.** **3. Approval of contracts and grants that will exceed the current $150,000 limit approval per grantee.**	**Unanimously approved by roll call. 6 AYES (Ballesteros, Booth, De La Torre, Gonzalez, Jimenez, and Perez), 3 ABSTENTIONS (Roybal, Shapiro, Vaccaro)**
Authorization of Expenditures for Existing Programs under the Elevating the Safety Net (ESN) Initiative	*Member Perez may have financial interests in other programs and as such she refrained from discussion and vote on the Elevating Community Health program.* *(Members Jimenez and Shapiro left the meeting.)* On January 28, 2019, the Executive Committee approved motion EXE B.0119 authorizing an expenditure up to $18,200,000 in remaining funds for Elevating the Safety Net for existing programs, including the Provider Loan Repayment Program, Physician Recruitment Program and medical school scholarships. On April 2, 2020, the Executive Committee authorized a contract renewal (EXE 100.0420) in the amount of $8,711,339 with California Long Term Care Education Center (CLTCEC) to provide education and training for In-Home Supportive Services (IHSS) providers for dual-eligible beneficiaries for the period of May 15, 2020 through May 14, 2023. **Provider Loan Repayment Program (PLRP)** To continue the success of the program, the review committee would like to maintain support to providers being awarded PLRP funds and request an additional $6 million to continue loan repayment assistance to providers through the end of the fiscal year. The program is currently administered by Uncommon Good. The program has been successful with providing loan debt relief to nearly 50 providers since inception of the program, and up to 20 providers have applied and are awaiting funds to be approved for the program.	

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	Elevating Community Health The Elevating Community Health program currently consists of the Community Health Worker (CHW) training program approved last year by the Executive Committee. L.A. Care would like to expand this program to include other workforce development projects and training programs as part of a larger initiative to support non-clinical professionals in our network. L.A. Care would like to add In Home Support Services (IHSS) Home Care Integration Training Program to the existing L.A. Care program with California Long-Term Care Education Center (CLTCEC) to align the work to equip our non-clinical professionals with the tools and skills to serve members and work with providers. The work and training will continue under ESN with the current success of both programs. To date, 47 CHWs have successfully completed the training program as part of two groups of the CHW training program, and almost 2, 500 caregivers have graduated from the CLTCEC since the program launched in 2017. Member Gonzalez thanked Dr. Seidman for finding supplies for the recent graduates of the CLTCEC program. Dr. Seidman responded that he was glad to help out. Member Booth commented that she thinks they are a clinical arm of the care that patients receive and she thinks it is perfectly reasonable to include them and she supports having the program under Elevating Community Health. Mr. Baackes added that the CLTCEC program is now attracting national attention for its innovation and direct relationship between a managed care health plan and the work force that is caring for members. L.A. Care staff has been asked to present information about the program at various forums and conferences. L.A. Care is proud of this program and plans to expand the program for a couple of years and train 2500 more caregivers. **<u>Motion EXE 101.0520</u>** **To delegate authority to the Chief Executive Officer to:** **1. Authorize expenditures of up to $6 million to continue awarding providers in the Provider Loan Repayment Program, currently managed by Uncommon Good.** **2. Approve and authorize integrating the California Long-Term Care Education Center (CLTCEC) IHSS+ Home Care Integration Training Program under Elevating the Safety Net in the FY 2020-21.**	**Approved by roll call. 6 AYES (Ballesteros, Booth, De La Torre, Gonzalez, Roybal, and Vaccaro) ABSTENTION (Perez).**

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Finance & Budget Committee	The Finance & Budget Committee met on April 27 (*a copy of the minutes can be obtained by contacting Board Services*).	
Chief Financial Officer Report Financial Report for March 2020	*(Member Greene rejoined the meeting.)* Ms. Montgomery presented the highlights of the March 2020 financial reports included in the meeting materials. (*A copy of the report can be obtained by contacting Board Services)*: <u>Membership</u> Membership for the month is 2,146,643, favorable by 2,700 members; 14,379 member months unfavorable for the year versus the forecast. Membership is likely to increase significantly due to higher unemployment claims. The 4+8 forecast was done prior to the COVID-19 pandemic. The forecast assumed a 3.5% decrease in membership for Plan Partners and a 2.5% decrease for MCLA, with the exception of the enrollment expected to get from the expansion of coverage to undocumented young adults beginning in March, and the increase expected from our updated auto-assignment rate. Commercial is higher than forecast by approximately 3,300 members. There is a slight drop in membership for L.A. Care Covered (LACC) in March, but still ahead of the forecast for the year. An upward trend in membership is expected for the remainder of the year. <u>Consolidated Financial Performance</u> The net deficit for March 2020 is $9.8 million, bringing us to a net surplus of $45.8 million year to date, $19 million unfavorable to the forecast. Pharmacy expenses are unfavorable to the forecast by almost $13 million, $10 million year to date. This was due to lifting the "refill too soon" edit, given the regulatory guidance to relax this edit. L.A. Care changed that to a soft edit, which means that the pharmacist can override the edit without calling L.A. Care or the prescriber if the patient provides a reason for needing a refill earlier than the limit. Some medications are being filled at higher rates. The capitation deduct true-up is unfavorable at $10 million, retroactive to July 2019. L.A. Care experienced very high paid claims at $240 million for March 2020 due to accelerating payments to assist providers. As a result, L.A. Care has higher than forecast claims for months prior to March. For March 2020, staff is factoring in the impact of COVID-19 on elective medical procedures. Year to date it is slightly unfavorable to the forecast which is the net of higher prior periods and a lower March. The elective medical procedures are beginning to occur recently at the same time L.A. Care has accelerated claim payments.	

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	Member Booth asked about costs for telehealth services. Ms. Montgomery confirmed that costs have increased as telehealth use has increased and she can report on that at a future meeting. Ms. Montgomery noted that telehealth is not as significant a cost as increased emergency room visits. Dr. Seidman added that what L.A. Care pays for telehealth is relatively limited relative to the care provided in L.A. Care's contracted network. Most primary care providers are capitated, so their reimbursement may not change whether the care is provided in person or virtual. Specialists offering telehealth services are paid predominantly by the independent physician associations (IPA). There is a lot of care that has converted to telehealth, but L.A. Care's cost for urgent care services is a relatively small portion of that. Since January, when telehealth went "live", there were about 2,000 tests. This is important because it means that those members received care when they otherwise may not have been able to, but that is a small number when compared to all of the visits for L.A. Care's one million members (two million if we include members enrolled through Plan Partners). The administrative expenses are $700,000 favorable to budget. The non-operating revenue is $1.5 million unfavorable due to unrealized losses on investments. The unrealized gain position decreased from a $12.4 million gain to a $7.4 million gain. <u>Operating Margin by Segment</u> Overall medical care ratio (MCR) is 93.6% versus a forecast of 93.2%, higher than forecast due to the unfavorable $18 million variance. TANF/MCE MCR is behind the forecast driven by the $10 million capitation deduct true up discussed earlier. <u>Key Financial Ratios</u> Working Capital and Tangible Net Equity are ahead of benchmarks. Cash liquidity is fine, and cash to claims ratio is below the target due to the In Home Supportive Services (IHSS) program changes. The cash to claims ratio will not fully recover until the IHSS balances with the Department of Healthcare Services are settled. **<u>Motion FIN 105.0520</u>** **To accept the Financial Report as submitted, for March 2020, as submitted.**	**Unanimously approved by roll call. 10 AYES (Ballesteros, Booth, De La Torre, Gonzalez, Greene, Jimenez, Perez, Roybal, Shapiro and Vaccaro)**
Monthly Investments Transactions Report	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).* Total value of investments is $1.5 billion. This includes funds invested with the government pooled funds. L.A. Care has approximately $72 million invested with the statewide Local	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Agency Investment Fund and approximately $106 million invested with the Los Angeles County Pooled Investment Fund.	
Change Healthcare Contract	Mr. Kasdagly informed the Board that Change Healthcare is one of two L.A. Care claims clearinghouses which process claims submitted by providers. The motion is for a new five-year contract totaling $8.1 million ($1.6 million/year). Change Healthcare will be retiring the current solution that L.A. Care uses and will replace it with a new solution. Currently L.A. Care uses Advanced Claiming, and will move to Payer Conductivity Services (PCS). PCS will continue to provide electronic claims submissions, eligibility validation, and claims status. It will add pre-adjudicated claims validation, so it will add edits at the clearinghouse to make the claims process simpler and more efficient. L.A. Care will be able to have electronic attachments available. It is justifiably a sole source as we have been working with them for years and they are a very good partner in claims submission. They have a detailed understanding of L.A. Care's business operations. It is important to note the support for current advanced claiming solution diminishes at the end of this year so L.A. Care does not have a choice but to move forward. Funds for this contract are already budgeted. **Motion FIN 106.0520** **To authorize staff to execute a contract with Change Healthcare for the period of May 2020 to May 2025, for claims electronic data interchange services, in an amount not to exceed $8,100,000.**	**Unanimously approved by roll call. 10 AYES (Ballesteros, Booth, De La Torre, Gonzalez, Greene, Jimenez, Perez, Roybal, Shapiro and Vaccaro)**
Toney Healthcare Consulting Contract Amendment	Dr. Seidman summarized the motion summary included in the materials for this meeting to extend a contract with Toney that provides staff augmentation primarily for care management functions. The contract term is from June 2020 to the end of this calendar year at a cost of $2.3 million. Last April a notice of noncompliance was issued based on findings by the Centers for Medicare and Medicaid Services (CMS) in the CalMediConnect program. L.A. Care determined that the care management activities would be de-delegated for that delegated provider. L.A. Care acquired 16 full time equivalent positions and one supervisor for this work. The new contract amount for this request is a $383,000 per month rate. This contract will bridge staffing requirements through the transition of the care management functions back to the delegated provider. Member Booth noted that the Finance & Budget Committee asked for additional information regarding the cost of this motion. Member Gonzalez asked about the number of staff included in this motion. Dr. Seidman clarified that the motion provides for 17 staff members.	**Unanimously approved by roll call. 9 AYES (Ballesteros, Booth, De La Torre,**

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	<u>Motion FIN 107.0520</u> **To authorize an amendment extending the current contract with Toney Health Care Consulting through December 31, 2020, for care management and utilization management services, in an amount not to exceed $2,300,000, for a total contract not to exceed $5,800,000.**	**Greene, Jimenez, Perez, Roybal, Shapiro and Vaccaro), 1 ABSTENTION (Gonzalez)**
PUBLIC COMMENT	**Email received May 7, 2020, Ana Rodriguez, RCAC 2 member**, Me gustaria comentar en apoyo a la comunidad abarcar todas las areas y aqui en el Valle de San Fernando contactar. Los concejales Nury Martinez, Monica Rodriguez, senador Herzberg. Ya que ellos conocen miy bien nuestras atras de necesidad y aqui en el valle especialmente en el east, hay una gran necesidad almentaria en esta epoca de pandemia. I would like to comment in support of the community to cover all areas and here in the San Fernando Valley, contact Councilmembers Nury Martinez, Monica Rodriguez, Senator Herzberg. Since they know our areas of need very well and here in the valley especially in the east, there is a great food need in this time of pandemic. **Text message received May 4, 2020, 3:26 a.m., from Carolyn Navarro** All of this is my public comment, pursuant to the Brown Act. I also notice my words are not correctly noted when I addressed the Board in Feb, I said I may have part the part about the amount Pacific Alliance was fined by the OIG wrong, I never said I HAD it ALL wrong (everything I said)! At one point I saw Achievamed listed as "Synermed DOB as Achievamed" (that doesn't state a "different" company and then I see them as co defendants in a lawsuit, same people working there, same location, they should NEVER be allowed access to a patient or their Medi Cal info again! **Text message received May 4, 2020, 9:15 a.m., from Carolyn Navarro** This is proof you initiated a grievance process regarding the abuses against my disabled adult daughter and then turned a blind eye to the abuses, this is part of public comment and will be verified, I will pursue legal action if I'm not allowed my right to comment about the abuses against my child which I believe L.A. Care has covered up! Each and every comment is pursuant to Brown Act.	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	 Proof mentioned in last message. **Text Message Received May 6, 2020, 10:16 a.m. from Carolyn Navarro** Public comment, I also believe you brushed aside the harm to Vanessa and other victims because of an improper, biased relationship with Care 1st which has carried over into the improper merger between them and Blue Shield who continues Care 1sts abuses , poor service and I do believe Synermed people are still involved with LA Care and haven't faced "tangible " consequences as stated in DMHC enforcement action . All comments will be documented , you can't cherry pick what consumers and victims state. Carolyn Navarro Public comment , LA Care has assisted the doctors harmed by Synermed but is not notifying victims or their guardians of Synermed abuses and is carrying on like no one was actually harmed or died when I'm guess 1,000s in LA County were harmed. I actually spoke to Washington DC about this 2 days ago , they want to hear about it, the fact that patients were adversely affected and are not being told , Vanessa being on a coma caused by Synermeds abuses is an adverse event but I've never been notified , I did my own investigation, I believe people at LA Care have broken the law , board members are civilly and criminally liable for LA Cares conduct. More of 3 MINUTE comment , I don't believe LA Care did an investigation or peer review regarding Vanessa , I believe LA Care lied to us and wanted to cover up the abuses going on. I know you can't comment on individual patients but as a mother I CAN! **Email received May 7, 2020, 2:42 p.m. from Estela Lara, Chair, RCAC 2** This public comment is from Estela Lara, Chair RCAC 2, San Fernando Valley. Thank you to CEO John Baackes, Board of Governors and Community Outreach and Engagement department for approving the continuation of RCAC committee stipends. Our	

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	members depend on these funds to assist with their food security. It is essential and vital to access nutritious food for their families during this pandemic crisis. **Email received May 7, 2020, 4:30 p.m., Fresia Paz, Vice Chair, RCAC 10** Fresia Paz, RCAC 10 Vice-Chair. Is it possible that LA Care can contract with a fashion designer or house, to make cloth face masks for their RCAC members and workers? Is it possible to provide sample hand sanitizers or rubbing alcohol to the RCAC members? If so, it can be distributed through the Family Resource Center for the RCAC members. Also, food bags through the FRC's is a good idea and the RCAC members, that can help out to build the bags for the community. Thank you. Chairperson De La Torre noted that L.A. Care could do this with hand sanitizer. Mr. Baackes added that he will ask staff to look into it. L.A. Care will be preparing for employees to return to the office when guidance to that has been provided by the public health officials. As L.A. Care seeks to procure those supplies it can add sufficient additional supplies for RCAC members. Chairperson De La Torre announced that the Joint Powers Authority meetings are adjourned. Member Perez thanked all the members that provided comment for this meeting. She thanked Dr. Seidman for restarting the TAC.	
ADJOURN TO CLOSED SESSION	Augustavia J. Haydel, Esq., *General Counsel,* announced the following items to be discussed in closed session. She announced that John Baackes is the designated representative for labor negotiations for All L.A. Care Employees. The Board adjourned to closed session at 4:42 pm. CONTRACT RATES Pursuant to Welfare and Institutions Code Section 14087.38(m) • Plan Partner Rates • Provider Rates • DHCS Rates REPORT INVOLVING TRADE SECRET Pursuant to Welfare and Institutions Code Section 14087.38(n) Discussion Concerning New Service, Program, Business Plan Estimated date of public disclosure: *May 2022* PEER REVIEW Welfare & Institutions Code Section 14087.38(n)	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION Pursuant to Section 54956.9(d)(1) of Ralph M. Brown Act: Name of Case: Local Initiative Health Authority for Los Angeles County v. United States, Case No. 1:17-cv-1542-TCW (U.S. Court of Federal Claims) ***From the Supplemental Special Agenda*** CONFERENCE WITH LABOR NEGOTIATOR Pursuant to Section 54957.6 of the Ralph M. Brown Act Agency Designated Representative: John Baackes Unrepresented Employee: All L.A. Care Employees CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION Significant exposure to litigation pursuant to Section 54956.9(d) (2) of Ralph M. Brown Act One Potential Case 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 2022* CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION Significant exposure to litigation pursuant to Section 54956.9(d)(2) of the Ralph M. Brown At One Potential Case	
RECONVENE IN OPEN SESSION	The Board reconvened in open session at 5:59 p.m. There was no report from closed session.	
ADJOURNMENT	The meeting was adjourned at 6:00 p.m.	

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

APPROVED BY:

_____
Layla Gonzalez, *Board Secretary*
Date Signed _____

All public comments received were read at the meeting .

DRAFT

Board of Governors
MOTION SUMMARY

Date: June 4, 2020 **Motion No. BOG 100.0620**

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

Issue: Ratification of the Chief Executive Officer's execution of an amendment to the agreement with Covered California, the California Health Benefit Exchange, for L.A. Care to participate in the Exchange as a Qualified Health Plan through our L.A. Care Covered individual coverage program. The amendment 5 defines reporting requirements in compliance with AB 929.

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

Background: L.A. Care staff requests ratification of the CEO's execution of a contract with Covered California, the California Health Benefit Exchange (Exchange) for L.A. Care to participate in the Exchange as a Qualified Health Plan. L.A. Care has participated in the Exchange as a Qualified Health Plan (QHP) since 2014. L.A. Care previously executed amendment 4 to extend the contract term to 12/31/2020. This amendment 5 modifies the previous amendment 4 to define reporting requirements as required by AB 929.

Executive Committee approved the CEO's use of his discretionary authority to enter into and execute the Agreement, and to take any necessary actions to execute any necessary documents relating to the Agreement at the September 28, 2016 meeting (Motion EXE 100.0916).

All Qualified Health Plans are held to the same contractual standards and must adhere to the requirements outlined in the Agreement. The original deadline for providing an executed agreement amendment was May 14, 2020.

Member Impact: L.A. Care members will benefit from the continued availability of L.A. Care as a QHP choice on the Exchange. Members who lose Medi-Cal eligibility can enroll through the Exchange and continue to receive care through the L.A. Care provider network.

Budget Impact: Sufficient funds are budgeted in the Commercial and Group Product Management budget for this fiscal year. For plan year 2020, Participation Fees are paid to the Exchange on a per-member/per-month basis at 3.5% of premium.

Motion: To ratify the Chief Executive Officer's execution of an amendment to the contract with Covered California, the California Health Benefit Exchange, to define reporting requirements as required by AB 929.

STATE OF CALIFORNIA
STANDARD AGREEMENT AMENDMENT
STD. 213 A (Rev 6/03)

x **CHECK HERE IF ADDITIONAL PAGES ARE ATTACHED** 42 **Pages**	AGREEMENT NUMBER **16-C-045**	AMENDMENT NUMBER **A5**
	REGISTRATION NUMBER	

1. This Agreement is entered into between the State Agency and Contractor named below:
STATE AGENCY'S NAME
California Health Benefit Exchange
CONTRACTOR'S NAME
Local Initiative Health Authority for Los Angeles County dba L.A. Care Health Plan
2. The term of this Agreement is October 1, 2016 through December 31, 2020
3. The maximum amount of this Agreement after this amendment is: Reimbursement is specified in the contract.
4. The parties mutually agree to this amendment as follows. All actions noted below are by this reference made a part of the Agreement and incorporated herein:

I. **Purpose of Amendment:** The 2017 -2020 Qualified Health Plan Issuer Contract is hereby amended with this Amendment Number 5, attached and incorporated herein, with substantive changes necessary due to the passage of Assembly Bill 929 (2019-2020) and which makes the following specific changes to the aforementioned Qualified Health Plan Issuer Contract as well as Attachment 7— Quality, Network Management, Delivery System Standards and Improvement Strategy, for the Individual market:

- Section 2.02 to Attachment 7 — Quality, Network Management, Delivery System Standards and Improvement Strategy — Data Submission Requirements
- Section 2.2.5 to the 2017 – 2020 Qualified Health Plan Issuer Contract — Notice to Provider Regarding Enrollee's Grace Period Status
- Section 3.5.4 to the 2017 – 2020 Qualified Health Plan Issuer Contract — Provider Rates, deleted in its entirety.

II. This Amendment Number 5 shall be effective on October 1, 2019.

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

CONTRACTOR

CONTRACTOR'S NAME *(If other than an individual, state whether a corporation, partnership, etc.)*

BY *(Authorized Signature)* ✍ | DATE SIGNED *(Do not type)*

PRINTED NAME AND TITLE OF PERSON SIGNING
John Baackes, Chief Executive Officer

ADDRESS
1055 West 7th Street, 10th Floor, Los Angeles, CA 90017

STATE OF CALIFORNIA

AGENCY NAME
California Health Benefit Exchange

BY *(Authorized Signature)* ✍ | DATE SIGNED *(Do not type)*

PRINTED NAME AND TITLE OF PERSON SIGNING
Lisa Lassetter, Deputy Chief Operations Officer

ADDRESS
1601 Exposition Blvd., Sacramento, CA 95815

CALIFORNIA
Department of General Services
Use Only

☒ Exempt per:GC Sec 100505

AMENDMENT NO. 5 TO
COVERED CALIFORNIA
QUALIFIED HEALTH PLAN ISSUER CONTRACT FOR 2017 – 2020

This AMENDMENT NO. 5 TO COVERED CALIFORNIA QUALIFIED HEALTH PLAN ISSUER CONTRACT FOR 2017 - 2020 ("Amendment") is made and entered into as of the date specified in the STD 213a. This Amendment amends the Covered California Qualified Health Plan Issuer Contract for 2017 – 2020 ("Agreement"). Capitalized terms used in this Amendment without definition are used as defined in the Agreement.

WHEREAS, the parties hereto desire to amend the Agreement to change certain obligations and requirements in the Agreement; and

WHEREAS, Section 12.4 b) of the Agreement provides for the amendment of the Agreement upon mutual consent of the parties.

NOW THEREFORE, the parties agree:

I. The sections referenced below shall be amended and replaced in their entirety to read as follows:

1. Section 3.5.4 Provider Rates

   "Intentionally deleted."

2. Section 2.2.5 Notice to Provider Regarding Enrollee's Grace Period Status

   a) In the event of nonpayment of premium by an individual Exchange Enrollee receiving advance payments of the premium tax credit, Contractor shall provide notice to its network providers in accordance with the applicable State and Federal law.

   b) Notwithstanding (a) above, this notice obligation does not relieve the QHP Issuer from compliance with existing state laws governing claims payment.

II. Attachment 7 is hereby amended and replaced in its entirety as attached hereto.

Attachment 7 to Covered California 2017 Individual Market QHP Issuer Contract: Quality, Network Management, Delivery System Standards and Improvement Strategy

Preamble

PROMOTING HIGHER QUALITY AND BETTER VALUE

Covered California's "Triple Aim" framework seeks to lower costs, improve quality, and improve health outcomes, while ensuring a good choice of plans for consumers. Covered California and Contractor recognize that promoting better quality and value will be contingent upon supporting Providers and strategic, collaborative efforts to align with other major purchasers and payors to support delivery system reform. Health Insurance Issuers contracting with Covered California to offer Qualified Health Plans (QHP) are integral to Covered California achieving its mission:

> *The mission of the California Health Benefit Exchange is to increase the number of insured Californians, improve health care quality, lower costs, and reduce health disparities through an innovative, competitive marketplace that empowers consumers to choose the health plan and Providers that give them the best value.*

By entering into this Agreement with Covered California, Contractor agrees to work with Covered California the Exchange to develop and implement policies and practices that will promote the Triple Aim, impacting not just the Enrollees of Covered California but Contractor's entire California membership. All QHP Issuers have the opportunity to take a leading role in helping Covered California support new models of care which promote the vision of the Affordable Care Act and meet consumer needs and expectations. At the same time, the Contractor and Covered California can promote improvements in the entire care delivery system. Covered California will seek to promote care that reduces excessive costs, minimizes unpredictable quality, and reduces inefficiencies of the current system. In addition, Covered California expects all QHP Issuers to balance the need for accountability and transparency at the Provider-level with the need to reduce administrative burdens on Providers as much as possible. For there to be a meaningful impact on overall healthcare cost and quality, solutions and successes need to be sustainable, scalable, and expand beyond local markets or specific groups of individuals. Covered California expects its QHP Issuers to support their Providers to engage in a culture of continuous quality and value improvement, which will benefit both Covered California Enrollees and all individuals covered by the QHP Issuers.

This Quality, Network Management, Delivery System Standards and Improvement Strategy outlines the ways that Covered California and the Contractor will focus on the promotion of better care and higher value for Enrollees and for other California health care consumers. This focus will require both Covered California and Contractor to coordinate with and promote alignment with other organizations and groups that seek to deliver better care and higher value. By entering into this Agreement with Covered California, Contractor affirms its commitment to be an active and engaged partner with Covered California and to work collaboratively to define and implement additional initiatives and programs to continuously improve quality and value.

Covered California and Contractor recognize that driving the significant improvements needed to ensure better quality care is delivered at lower cost will require tactics and strategies that extend beyond the term

of this agreement. Success will depend on establishing targets based on current performance, national benchmarks, and the best improvement science conducting rigorous evaluation of progress and adjusting goals annually based on experience. This Attachment 7 contains numerous reports that will be required as part of the annual certification and contracting process with QHP Issuers. Contractor shall submit all required reports as defined in this Attachment and listed in the annual "Contract Reporting Requirements" table found on Covered California's Extranet site (Plan Home, in the Resources folder, Contract Reporting Compliance subfolder). This information will be used for negotiation and evaluation purposes regarding any extension of this Agreement and will be reported as required in the annual application for certification.

ARTICLE 1
IMPROVING CARE, PROMOTING BETTER HEALTH AND LOWERING COSTS

1.01 Coordination and Cooperation

Contractor and Covered California agree that the Quality, Network Management, Delivery System Standards and Improvement Strategy serve as a starting point for what must be ongoing, refined, and expanded efforts to promote improvements in care for Enrollees and across Contractor's California members. Improving and building on these efforts to improve care and reduce administrative burdens will require active partnership between Covered California and Contractor, but also with Providers, consumers, and other important stakeholders.

1) Covered California shall facilitate ongoing discussions with Contractor and other stakeholders through Covered California's Plan Management and Delivery System Reform Advisory Group and through other forums as may be appropriate to work with Contractors to assess the elements of this section and their impact, and ways to improve upon them, on:

   (a) Enrollees and other consumers;

   (b) Providers in terms of burden, changes in payment and rewarding the Triple Aim of improving care, promoting better health, and lowering costs; and

   (c) Contractors in terms of the burden of reporting and participating in quality or delivery system efforts.

2) Contractor agrees to participate in Covered California advisory and planning processes, including participating in the Plan Management and Delivery System Reform Advisory Group.

1.02 Ensuring Networks are Based on Value

Central to its contractual requirements of its QHP Issuers, Covered California requirements include multiple elements related to ensuring that QHP Issuers' plans and networks provide quality care, including Network Design (Section 3.3.2), the inclusion of Essential Community Providers (Section 3.3.3) and a wide range of elements detailed in this Attachment. To complement these provisions and to promote accountability and transparency of Covered California's expectation that network design and Provider selection considers quality and patient experience in addition to cost and efficiency, the Contractor shall:

1) Include quality, which may include clinical quality, patient safety and patient experience, and cost in all Provider and facility selection criteria when designing and composing networks for inclusion in Covered California products.

2) Contractor will be required to report to Covered California as part of its annual application for certification for purposes of negotiations, how it meets this requirement and the basis for the selection of Providers or facilities in networks available to Enrollees. This will include a detailed description of how cost, clinical quality, patient reported experience or other factors are considered in network design and Provider or facility selection. Information submitted in the application for certification for 2021 may be made publicly available by Covered California.

3) Covered California expects Contractor to only contract with Providers and hospitals that demonstrate they provide quality care and promote the safety of Enrollees at a reasonable price. To meet this expectation, by year end 2019, Covered California will work with Cal Hospital Compare and its QHP Issuers to identify areas of "outlier poor performance" for hospitals based on variation analysis. As part of this process, Covered California will engage experts in quality and cost variation and shall consult with Providers throughout California. By year end 2020 QHP Issuers will be expected to either exclude those Providers that are "outlier poor performers" on either cost or quality from Covered California Provider networks or to document each year in its application for certification the rationale for continued contracting with each Provider that is identified as a "poor performing outlier" and efforts the Provider is undertaking to improve performance. Rationales for continued inclusion of Providers may include the impact on consumers in terms of geographical access and their out-of-pocket costs, or other justification provided by the QHP Issuers. QHP Issuers rationale for inclusion of outliers on cost or quality will be released to the public by Covered California. Selection of specific measures of cost and quality, as well as criteria for defining "outlier poor performance" in a way that can be implemented consistently across Contractors will be established by Covered California based on national benchmarks, analysis of variation in California performance which shall include consideration of hospital case mix and services provided, best existing science of quality improvement, and effective engagement of stakeholders. Covered California does not expect Contractor to base outlier performance, and potential network removal decisions, on one quality or cost measure alone. Contractor agrees to participate in these collaborative processes to establish definitions. Reports from Contractor must detail implementation of such criteria through contractual requirements and enforcement, monitoring and evaluation of performance, consequences of noncompliance, corrective action and improvement plans if appropriate, and plans to transition patients from the care of Providers with poor performance. Such information may be made publicly available by Covered California.

4) Contractor will report as requested how Enrollees with conditions that require highly specialized management (e.g. transplant patients and burn patients) are managed by Providers with documented special experience and proficiency based on volume and outcome data, such as Centers of Excellence. In addition, to the extent that the Contractor uses Centers of Excellence more broadly, it will report as requested, the basis for inclusion of such Centers of Excellence, the method used to promote consumers' usage of these Centers, and the utilization of these Centers by Enrollees.

5) While Covered California welcomes QHP Issuers' use of Centers of Excellence, which may include design incentives for consumers, the current standard benefit designs do not envision or allow for "tiered" in-network Providers.

1.03 Demonstrating Action on High Cost Providers

Affordability is core to Covered California's mission to expand the availability of insurance coverage and promoting the Triple Aim. The wide variation in unit price and total costs of care charged by Providers, with some Providers charging far more for care irrespective of quality, is one of the biggest contributors to high costs of medical services.

1) Contractor will be required to report to Covered California as part of its annual application for certification, which will be used for negotiation purposes:

   (a) The factors it considers in assessing the relative unit prices and total costs of care;

   (b) The extent to which it adjusts or analyzes the reasons for cost factors based on elements such as area of service, population served, market dominance, services provided by the facility (e.g., trauma or tertiary care), or other factors;

   (c) How such factors are used in the selection of Providers or facilities in networks available to Enrollees; and

   (d) The identification of specific hospitals and their distribution by cost deciles or describe other ways Providers and facilities are grouped by costs such as comparison of costs as a percentage of Medicare costs and the percentage of costs for Contractor that are expended in each cost decile. Contractor understands that it is the desire and intention of Covered California to expand this identification process to include other Providers and facilities in future years.

2) In its annual application for certification, which will be used for negotiation purposes, Contractor will be required to report on its strategies to ensure that contracted Providers are not charging unduly high prices, and for what portions of its entire enrolled population it applies each strategy, which may include:

   (a) Telehealth;

   (b) Use of Centers of Excellence;

   (c) Design of Networks (see Article 1.02);

   (d) Reference Pricing; and

   (e) Efforts to make variation in Provider or facility cost transparent to consumers and the use of such tools by consumers.

3) By year end 2019, Contractor will be expected to exclude hospitals and other facilities that demonstrate outlier high cost from Provider networks serving Covered California or to document each year in its application for certification the rationale for continued contracting with each hospital that is identified as a high cost outlier and efforts that the hospital or facility is undertaking to lower its costs. Covered California does not expect Contractor to base outlier performance, and potential network removal decisions, on one quality or cost measure alone.

1.04 Demonstrating Action on High Cost Pharmaceuticals

Appropriate treatment with pharmaceuticals is often the best clinical strategy to treating conditions, as well as managing chronic and life-threatening conditions. Covered California expects its Contractor to ensure that its Enrollees get timely access to appropriate prescription medications. At the same time, Covered California is concerned with the trend in rising prescription drug costs, including those in specialty pharmacy, and compounding increases in costs of generic drugs, which reflect a growing driver of total cost of care.

Contractor will be required to report in its annual application for certification for negotiation purposes, a description of its approach to achieving value in delivery of pharmacy services, which should include a strategy in each of the following areas:

1) Contractor must describe how it considers value in its selection of medications for use in its formulary, including the extent to which it applies value assessment methodology developed by independent groups or uses independent drug assessment reports on comparative effectiveness and value to design benefits, negotiate prices, develop pricing for consumers, and determine formulary placement and tiering within Covered California standard benefit designs. Contractor shall report the specific ways they use a value assessment methodology or independent reports to improve value in pharmacy services and indicate which of the following sources it relies upon:

    (a) Drug Effectiveness Review Project (DERP)

    (b) NCCN Resource Stratification Framework (NCCN-RF)

    (c) NCCN Evidence Blocks (NCCN-EB)

    (d) ASCO Value of Cancer Treatment Options (ASCO-VF)

    (e) ACC/AHA Cost/Value Methodology in Clinical Practice Guidelines

    (f) Oregon State Health Evidence Review Commission Prioritization Methodology

    (g) Premera Value-Based Drug Formulary (Premera VBF)

    (h) DrugAbacus (MSKCC) (DAbacus)

    (i) The ICER Value Assessment Framework (ICER-VF)

    (j) Real Endpoints

    (k) Blue Cross/Blue Shield Technology Evaluation Center

    (l) International Assessment Processes (e.g., United Kingdom's National Institute for Health and Care Excellence – "NICE")

    (m) Other (please identify)

2) Contractor shall describe how its construction of formularies is based on total cost of care rather than on drug cost alone;

3) Contractor shall describe its process for managing specialty pharmacy and biologics management;

4) Contractor must describe how it provides decision support for prescribers and consumers related to the clinical efficacy and cost impact of treatments and their alternatives.

1.05 Quality Improvement Strategy

Starting with the application for certification for 2017, Contractor is required under the Affordable Care Act and regulations from CMS to implement a Quality Improvement Strategy (QIS). The core CMS requirement for the QIS is to align Provider and Enrollee market-based incentives with delivery system and quality targets.

Contractor agrees to align its QIS with the contractual requirements and initiatives of Covered California and to report on its multi-year strategy and first-year plan for implementing each initiative through the annual certification application submitted to Covered California, which will be used for negotiation purposes during the application process. Contractor understands that the application serves as the reporting mechanism and measurement tool for assessing Contractor QIS work plans and progress in achieving improvement targets with respect to each of Covered California quality and delivery system reform initiatives.

Contractor understands that Covered California will seek increasingly detailed reports over time that will facilitate the assessment of the impacts of each initiative which will include:

(a) The percentage, number, and performance of total participating Providers;

(b) The number and percent of Enrollees participating in the initiative;

(c) The number and percent of all the Contractor's covered lives participating in the initiative; and

(d) The results of Contractor's participation in this initiative, including clinical, patient experience, and cost impacts.

1.06 Participation in Collaborative Quality Initiatives

Covered California believes that improving health care quality and reducing costs can only be done over the long-term through collaborative efforts that effectively engage and support clinicians and other Providers of care. There are many established statewide and national collaborative initiatives for quality improvement that are aligned with priorities established by Covered California with requirements specified below.

1) Effective January 1, 2017, Contractor must participate in:

(a) Smart Care California: Sponsored by Covered California, DHCS, and CalPERS, this multi-stakeholder work group facilitated by the Integrated Healthcare Association (IHA), will provide guidance and steer the delivery system to drive appropriate use of C-sections, prescription of opioids, and low back pain. https://www.iha.org/our-work/insights/smart-care-california

i. The C-section work aligns with activities underway through the California Maternal Quality Care Collaborative (CMQCC) which provides statewide

analysis of variation and promotes the appropriate use of C-sections with associated reductions in maternal and newborn mortality and morbidity. https://www.cmqcc.org/ (See Article 5, Section 5.03)

ii. A key element of the change for all three focus areas is promoting best practices through provider and consumer decision support, for example through the Choosing Wisely campaign from Consumer Reports. https://www.iha.org/our-work/insights/smart-care-california (See Article 7, Section 7.04)

2) Covered California is interested in Contractors' participation in other collaborative initiatives. As part of the annual application for certification for negotiation purposes, Contractor will be required to report to Covered California its participation in any of the following collaboratives, or other similar activities not listed:

(a) CMMI's Transforming Clinical Practices, administered by:

i. Children's Hospital of Orange County,

ii. LA Care,

iii. National Rural Accountable Care Consortium,

iv. California Quality Collaborative of PBGH, and

v. VHA/UHC Alliance NewCo, Inc.

All five of these collaboratives are coaching accessible, data-driven, team-based care over the course of the grant 2015-2019. https://innovation.cms.gov/initiatives/Transforming-Clinical-Practices/ (See Article 4, Section 4.02)

(b) Partnership for Patients: The CMS Innovation Center (CMMI) implemented this program focused on hospital patient safety, which between 2012 and 2014 resulted in 87,000 fewer deaths, mostly in 2013-14. The 2017 grants to build on this work have been distributed to Hospital Improvement Innovation Networks (HIINs) around the country including several in California. https://partnershipforpatients.cms.gov/ (See Article 5, Section 5.02)

Awardees working with California hospitals for 2017 are:

i. Health Services Advisory Group (HSAG),

ii. Dignity Hospitals,

iii. VHA/UHC,

iv. Children's Hospitals' Solutions for Patient Safety, and

v. Premiere, Inc.

(c) 1115 Medicaid Waiver Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program

(d) California Joint Replacement Registry developed by the California Healthcare Foundation (CHCF), California Orthopedic Association (COA) and PBGH

(e) California Immunization Registry (CAIR)

(f) Any IHA or CMMI sponsored payment reform program

(g) CMMI ACO Program (including Pioneer, Savings Sharing, Next Gen ACO, and other models)

(h) California Perinatal Quality Care Collaborative

(i) California Quality Collaborative

(j) Leapfrog

(k) A Federally Qualified Patient Safety Organization such as CHPSO

(l) The IHA Encounter Standardization Project

3) When reporting this information to Covered California, such information shall be in a form that is mutually agreed upon by the Contractor and may include copies of reports used by Contractor for other purposes. Contractor understands that Covered California will seek increasingly detailed reports over time that will facilitate the assessment of the impacts of these programs which will include: (1) the percentage of total Participating Providers, as well as the percentage of Covered California specific Providers participating in the programs; (2) the number and percentage of potentially eligible Plan Enrollees who participate through the Contractor in the Quality Initiative; (3) the results of Contractors' participation in each program, including clinical, patient experience and cost impacts; and (4) such other information as Covered California and the Contractor identify as important to identify programs worth expanding.

4) Covered California and Contractor will collaboratively identify and evaluate the most effective programs for improving care for Enrollees and Covered California may require participation in specific collaboratives in future years.

1.07 Data Exchange with Providers

Covered California and Contractor recognize the critical role of sharing data across specialties and institutional boundaries as well as between health plans and contracted Providers in improving quality of care and successfully managing total costs of care.

1) Contractor will be required to report in its annual application for certification for negotiation purposes, the initiatives Contractor has undertaken to improve routine exchange of timely information with Providers to support their delivery of high quality care. Examples that could impact the Contractor's success under this contract may include:

(a) Notifying Primary Care clinicians when one of their empaneled patients is admitted to a hospital, a critical event that often occurs without the knowledge of either the primary care or specialty Providers who have been managing the patient on an ambulatory basis.

(b) Developing systems to collect clinical data as a supplement to the annual HEDIS process, such as HbA1c lab results and blood pressure readings which are important under Article 3 below.

(c) Racial and ethnic self-reported identity collected at every patient contact.

2) Contractor will be required to describe its participation in statewide or regional initiatives that seek to make data exchange routine, including, but not limited to the following Health Information Exchanges:

(a) Inland Empire Health Information Exchange (IEHIE)

(b) Los Angeles Network for Enhanced Services (LANES)

(c) Orange County Partnership Regional Health Information Organization (OCPRHIO)

(d) San Diego Health Connect

(e) Santa Cruz Health Information Exchange

(f) Manifest MedEx (formerly CalIndex)

3) By June 30, 2018 Contractor must use standard processes for encounter data exchange with its contracted providers, which include:

(a) The use of the 837-P and 837-I industry standard transaction sets for encounter data intake. These standard transaction sets must include appropriate cost sharing and member out of pocket information.

(b) The use of the 277 CA transaction set and industry standard code sets to communicate encounter data that was successfully processed, as well as any encounter data that was rejected and requires resubmission. If Contractor uses a clearing house to process encounter data and the 277 CA is not utilized, the Contractor must provide a daily detailed file to the clearing house of all rejected records and corresponding reasons for rejections. Contractor must ensure its contracted providers receive visibility to the specific reasons the encounter data was rejected to allow for both successful resubmissions and any process improvement needed to minimize future rejections.

4) By June 30, 2018 Contractor agrees to participate in industry collaborative initiatives for improving encounter data exchange processes in California, which include:

(a) The Integrated Healthcare Association Encounter Data Work Group; and

(b) The Industry Collaborative Efforts (ICE) Encounter Data Work Group.

1.08 Data Aggregation Across Health Plans

Covered California and Contractor recognize the importance of aggregating data across purchasers and payors to more accurately understand the performance of Providers that have contracts with multiple health plans. Such aggregated data reflecting a larger portion of a

Provider, group, or facility's practice can potentially be used to support performance improvement, contracting and public reporting.

1) Contractor will be required to report in its annual application for certification for negotiation purposes, its participation in initiatives to support the aggregation of claims and clinical data. Contractor must include its assessment of additional opportunities to improve measurement and reduce the burden of data collection on Providers through such proposals as a statewide All Payor Claims Database.

   Examples include but are not limited to:

   (a) The Integrated Health Association (IHA)

   (b) The CMS Physician Quality Reporting System

   (c) CMS Hospital Compare

   (d) CalHospital Compare

ARTICLE 2
PROVISION AND USE OF DATA AND INFORMATION FOR QUALITY OF CARE

2.01 HEDIS and CAHPS Reporting

Contractor shall annually collect and report to Covered California, for each QHP Issuer product type, its Quality Rating System HEDIS, CAHPS and other performance data (numerators, denominators, and rates). Contractor must provide such data to Covered California each year regardless of the extent to which CMS uses the data for public reporting or other purposes.

Contractor shall submit to Covered California HEDIS and CAHPS scores to include the measure numerator, denominator, and rate for the required measures set that is reported to the National Committee for Quality Assurance (NCQA) Quality Compass and DHCS, for each Product Type for which it collects data in California. The timeline for Contractor's HEDIS and CAHPS quality data must be submitted at the same time as Contractor submits this to the NCQA Quality Compass and DHCS. Covered California reserves the right to use the Contractor-reported measures to construct Contractor summary quality ratings that Covered California may use for such purposes as supporting consumer choice and Covered California's oversight of Contractor's QHPs.

2.02 Data Submission Requirements

1) General

(a) The parties mutually agree that California law requires Contractor to provide Covered California with information on cost, quality, and disparities to evaluate the impact of Covered California on the health delivery system and health coverage in California, including information from qualified health plan issuers since the inception of Covered California, both inside and outside of the Exchange.

(b) The parties also mutually agree that California law requires Contractor to provide Covered California with data needed to conduct audits, investigations, inspections, evaluations, analyses, and other activities needed to oversee the operation of the Exchange. California law likewise requires that such data be provided in a form, manner, and frequency which Covered California shall specify, which may include but need not be limited to financial and other data pertaining to Covered California's oversight obligations.

(c) The data which Contractor is required to provide ("HEI Data") may include, but need not be limited to, data and other information pertaining to quality measures affecting enrollee health and improvements in healthcare care coordination and patient safety. This data may likewise include enrollee claims and encounter data needed to monitor compliance with applicable provisions of this Agreement pertaining to improvements in health equity and disparity reductions, performance improvement strategies, individual payment methods, as well as enrollee-specific financial data needed to evaluate enrollee costs and utilization experiences.

(d) The Parties mutually agree and acknowledge that financial and other data needed to evaluate enrollee costs and utilization experiences shall include, but need not be limited to information pertaining to contracted provider

reimbursement rates and historical data for consumers who have obtained healthcare coverage both through and outside of the Exchange.

(e) As detailed below, certain HEI Data submissions shall initially be transmitted to Covered California through a vendor which has been authorized by Covered California to receive and collect such data on Covered California's behalf. Notwithstanding the foregoing, the parties mutually agree and acknowledge that the form, manner, and frequency wherein Covered California may require the submission of HEI Data may, in Covered California's discretion, require the use of alternative methods for the submission of any such data. Such alternative methods may include but need not be limited to data provided indirectly through a vendor or directly to Covered California either via the terms of this Agreement or the certification process for Exchange participation.

(f) The parties further mutually agree that the aforementioned data may include information which represents Protected Health Information ("PHI") for purposes of the HIPAA Privacy Rule (45 CFR §160.103).

2) Disclosures to Healthcare Evidence Initiative Vendor (HEI Vendor):

(a) Covered California has entered into a contract with an HEI Vendor to assist with its health oversight functions and activities. Under the terms of its contract with Covered California, HEI Vendor has been authorized to collect, store, and process HEI Data which Contractor is required to provide on Covered California's behalf.

(b) To facilitate the submission of HEI Data to HEI Vendor, Contractor shall execute a data use or other similar agreement ("DUA") with HEI Vendor, which shall at all times govern the submission of HEI Data from Contractor to HEI Vendor. Prior to execution, Contractor shall provide a draft copy of the DUA for review and approval to the Covered California Privacy Office at privacyofficer@covered.ca.gov. Contractor shall at all times ensure that the DUA is current, up-to-date, and consistent with the terms and conditions of this Agreement and shall provide the Privacy Office with draft copies of any revisions, modifications, or amendments to the DUA prior to execution.

3) HEI Vendor Designation:

(a) As of the date of this Agreement, Covered California has selected IBM Watson to serve as its HEI Vendor. Should Covered California terminate its contract with HEI Vendor, Covered California shall provide written notice to Contractor in accordance with the terms and conditions of this Agreement.

(b) Upon receipt of the aforementioned written notice from Covered California, Contractor shall terminate its DUA with IBM Watson in accordance with the terms and conditions specified therein and shall discontinue the provision of HEI Data to IBM Watson.

(c) Covered California shall notify Contractor of the selection of an alternative HEI Vendor as soon as reasonably practicable and the parties shall at all times cooperate in good faith to ensure the timely execution of a new DUA between

Contractor and the new HEI Vendor which shall govern the provision of HEI Data to the new HEI Vendor.

4) HIPAA Privacy Rule:

(a) PHI Disclosures Required by California law:

i) California law requires Contractor to provide HEI Data in a form, manner, and frequency determined by Covered California. Covered California has retained and designated HEI Vendor to collect and receive certain HEI Data information on its behalf.

ii) Accordingly, the parties mutually agree and acknowledge that the disclosure of any HEI Data information to Covered California or to HEI Vendor which represents PHI is permissible and consistent with applicable provisions of the HIPAA Privacy Rule which permit Contractor to disclose PHI when such disclosures are required by law (45 CFR §164.512(a)(1)).

(b) PHI Disclosures For Health Oversight Activities:

i) The parties mutually agree and acknowledge that applicable California law (CA Gov Code §100503.8) requires Contractor to provide Covered California with HEI Data for the purpose of engaging in health oversight activities and declares Covered California to be a health oversight agency for purposes of the HIPAA Privacy Rule (CA Gov Code §100503.8).

ii) The HIPAA Privacy Rule defines a “health oversight agency” to consist of a person or entity acting under a legal grant of authority from a health oversight agency (45 CFR §164.501) and HEI Vendor has been granted legal authority to collect and receive HEI Data from Contractor on Covered California’s behalf.

iii) Accordingly, the parties mutually acknowledge and agree that the provision of any HEI Data by Contractor to Covered California or HEI Vendor is permissible under applicable provisions of the HIPAA Privacy Rule which permit the disclosure of PHI for health oversight purposes (45 CFR §164.512(d).

5) Publication of Data and Public Records Act Disclosures:

(a) The parties mutually acknowledge and agree that California law requires Covered California to publish certain HEI Data provided by Contractor pertaining to its cost-reduction efforts, quality improvements, and disparity reductions.

(b) Notwithstanding the foregoing, the parties mutually acknowledge and agree that data shall at all times be disclosed in a manner which protects the Personally-Identifiable Information of Contractor’s enrollees.

(c) The parties further acknowledge and agree that records which reveal contracted rates paid by Contractor to health care providers, as well as any enrollee cost

share, claims or encounter data, cost detail, or information pertaining to enrollee payment methods, which can be used to determine contracted rates paid by Contractor to health care providers shall not at any time be subject to public disclosure and shall at all times be deemed to be exempt from compulsory disclosure under the Public Records Act.

2.03 Quality and Delivery System Reform Reporting

Contractor will be required to respond to questions identified and required by the Exchange in the annual certification application related to quality and delivery system reform requirements in this Attachment 7.

Such information will be used by Covered California to evaluate Contractor's performance under the terms of the Quality, Network Management, Delivery System Standards and Improvement Strategy and in connection with the evaluation regarding any extension of this Agreement and the certification process for subsequent years. The timing, nature and extent of such responses will be established by Covered California based on its evaluation of various quality-related factors.

2.04 Data Measurement Specifications

Contractor shall report metrics specified herein, as mutually agreed upon by both parties, and as requested by Covered California. Covered California and Contractor agree to work collaboratively during the term of this Agreement to enhance the data specifications and further define the requirements.

ARTICLE 3
REDUCING HEALTH DISPARITIES AND ENSURING HEALTH EQUITY

Mitigation of health disparities is central to the mission of Covered California, and the California Language Assistance Act adopted as SB 853 in 2003. In alignment with these principles, Covered California and Contractor recognize that promoting better health requires a focus on addressing health disparities and health equity. Covered California will require Contractor to track, trend and reduce health disparities with the phased approach outlined below.

3.01 Measuring Care to Address Health Equity

Contractor must track and trend quality measures by racial or ethnic group, or both, and by gender for the Contractor's full book of business, excluding Medicare.

1) Identification:

   (a) By year end 2019 and annually thereafter, Contractor must achieve eighty percent (80%) self-identification of racial or ethnic identity for Covered California enrollees.

   (b) In the annual application for certification, Contractor will be required to report the percent of self-reported racial or ethnic identity for Covered California enrollees.

   (c) To the extent Contractor does not have self-reported information on racial or ethnic identity, or both, it shall use a standardized tool for proxy identification through the use of zip code and surname to fill any gaps in information.

2) Measures for Improvement:

   (a) Disparities in care by racial and ethnic identity and by gender will be reported annually by QHP Issuers based on its Enrollees. The tool for proxy identification shall be used to supplement self-reported racial or ethnic identity. Contractor agrees to work with Covered California to provide comparison reporting for its other lines of business where comparative data can offer meaningful reference points.

   (b) Measures selected for improvement beginning in plan year 2017 include Diabetes, Hypertension, Asthma (control plus hospital admission rates), and Depression (HEDIS appropriate use of medications).

   (c) Covered California will consider adding additional measures for plan year 2021 and beyond.

3.02 Narrowing Disparities

While Covered California and Contractor recognize that some level of disparity is determined by social and economic factors beyond the control of the health care delivery system, there is agreement that health care disparities can be narrowed through quality improvement activities tailored to specific populations and targeting select measures at the health plan level. Covered California and the Contractor agree that collection of data on clinical measures for the purpose of population health improvement requires development and adoption of systems for enhanced information exchange (see Section 1.07).

1) Contractor reported baseline measurements from plan years 2015, 2016, 2017, and 2018, on the measures listed in the Measurement Specifications document, based either on self-reported identity or on proxy identification on its Enrollees. Covered California anticipates that this baseline data may be incomplete. The Measurement Specifications document is posted on the Contractors extranet website provided by Covered California (Plan Home, in the Resources folder, Health Disparities Reduction – Measurement Specifications folder).

2) Targets for year end 2020 and for annual intermediate milestones in reduction of disparities will be established by Covered California based on national benchmarks, analysis of variation in California performance, best existing science of quality improvement, and effective engagement of stakeholders.

3.03 Expanded Measurement

Contractor and Covered California will work together to assess the feasibility and impact of extending the disparity identification and improvement program over time. Areas for consideration include:

1) Income

2) Disability status

3) Sexual orientation

4) Gender identity

5) Limited English Proficiency (LEP)

3.04 NCQA Certification

Meeting the standards for Multicultural Health Care Distinction by NCQA is encouraged as a way to build a program to reduce documented disparities and to develop culturally and linguistically appropriate communication strategies. To the extent Contractor has applied for or received NCQA Certification, Contractor must provide this information with its annual application for certification. Covered California may publicly recognize this achievement and include it in information provided to consumers.

ARTICLE 4
PROMOTING DEVELOPMENT AND USE OF EFFECTIVE CARE MODELS

Covered California and Contractor agree that promoting the Triple Aim requires a foundation of effectively delivered primary care and integrated services for patients that is data driven, team based and crosses specialties and institutional boundaries. Contractor agrees to actively promote the development and use of care models that promote access, care coordination, and early identification of at-risk enrollees and consideration of total costs of care. Contractor agrees to design networks and payment models for Providers serving Enrollees to reflect these priorities.

In particular, Covered California's priority models which align with the CMS requirements under the QIS, are:

1) Effective primary care services, including ensuring that all enrollees have a Primary Care clinician,

2) Promotion of Patient-Centered Medical Homes (PCMH), which use a patient-centered, accessible, team-based approach to care delivery, member engagement, and data-driven improvement as well as integration of care management for patients with complex conditions, and

3) Accountable Care Organizations (ACOs) are integrated, coordinated, and accountable systems of care including multi-discipline physician practices, hospitals, and ancillary Providers with combined risk sharing arrangements and incentives between Contractor and Providers.

4.01 Primary Care

Contractor must ensure that all Enrollees either select or be provisionally assigned to a Primary Care clinician within sixty (60) days of effectuation into the plan. If an Enrollee does not select a Primary Care clinician, Contractor must provisionally assign the Enrollee to a Primary Care clinician, inform the Enrollee of the assignment, and provide the enrollee with an opportunity to select a different Primary Care clinician. When assigning a Primary Care clinician, Contractor shall use commercially reasonable efforts to assign a Primary Care clinician consistent with an Enrollee's stated gender, language, ethnic and cultural preferences, geographic accessibility, existing family member assignment, and any prior Primary Care clinician. Contractor will be required to report on this requirement annually in the application for certification for negotiation and evaluation purposes regarding any extension of this Agreement. The Exchange will evaluate the effectiveness of this policy based on criteria mutually agreed upon between the Exchange and Contractor. If requested, Contractor agrees to provide the Exchange with data and other information to perform this evaluation.

4.02 Patient-Centered Medical Homes

A growing body of evidence shows that advanced models of primary care, often called Patient-Centered Medical Homes (PCMH), greatly improve the care delivered to patients and support Triple Aim goals. Contractor must provide this information with its annual application for certification.

1) Covered California will provide Contractor with necessary data for Contractor to perform analysis on their networks to assess the adoption and growth of advanced primary care

among providers. Contractor agrees to use any of the following recognition programs to determine which network providers meet standards for redesigned primary care:

(a) NCQA Patient-Centered Medical Home recognition

(b) The Joint Commission Primary Care Medical Home certification

(c) Accreditation Association for Ambulatory Health Care, Inc. (AAAHC) Medical Home accreditation

(d) URAC Patient-Centered Medical Home (PCMH) Certification

2) Contractor will be required to describe in its application for certification a payment strategy for adoption and progressive expansion among Providers caring for Enrollees that creates a business case for Primary Care Providers to adopt accessible, data-driven, team-based care (alternatives to face-to-face visits and care provided by non-MDs) with accountability for meeting the goals of the Triple Aim, including total cost of care.

3) Contractor will be required to report annually:

(a) The number and percent of Covered California enrollees who obtain their primary care in a PCMH.

(b) Covered California will establish targets for year end 2019 and annually thereafter for the percent of Covered California enrollees obtaining primary care in a PCMH based on national benchmarks, analysis of variation in California performance, and best existing science of quality improvement and effective engagement of stakeholders.

(c) A baseline of the percent of Primary Care clinicians whose contracts for Covered California Enrollees are based on the payment strategy defined in 4.02(2) for primary care services.

(d) Methods for enrolling or attributing members to a PCMH including whether the plan engages in formal enrollment and or outreach to members based on a risk algorithm.

(e) How Contractor's payment to PCMH practices differs from those payments made to practices that have not met PCMH standards.

(f) If Contractor participates in primary care improvement collaboratives like the California Quality Collaborative or the California Improvement Network.

(g) If or how Contractor supports providers in primary care practice transformation through efforts such as providing practice coaches or investments in information technology.

4) Contractor agrees to work with Covered California to provide comparison reporting for its other lines of business to compare performance and inform future Covered California requirements where comparative data can offer meaningful reference points. The non-Covered California lines of business data are to support contract negotiations in setting targets and requirements for Covered California-only business and any required data will be submitted as part of Contractor's annual application for certification, which will be used for negotiation and evaluation purposes regarding any extension of this Agreement.

4.03 Accountable Care Organizations (ACO)

Covered California places great importance on the adoption and expansion of integrated, coordinated, and accountable systems of care such as Accountable Care Organizations (ACOs):

1) The ACO is defined as:

   (a) A system of population-based care coordinated across the continuum including multi-discipline physician practices, hospitals, and ancillary Providers.

   (b) Having combined risk sharing arrangements and incentives between Contractor and Providers, and among Providers across specialties and institutional boundaries, holding the ACO accountable for nationally recognized evidence-based clinical, financial, and operational performance, as well as incentives for improvements in population outcomes. As Providers accept more accountability under this provision, Contractors shall ensure that Providers have the capacity to manage the risk.

2) Contractor must provide Covered California with details on its existing or planned integrated systems of care describing how the systems meet the criteria in Article 4.03(1), including the number and percent of Enrollees who are managed under ACOs in its response to the annual application for certification, which will be used for negotiation and evaluation purposes regarding any extension of this Agreement.

3) Target for year end 2019 and annually thereafter for the percentage of Enrollees who select or are attributed to ACOs will be established by Covered California based on national benchmarks, analysis of variation in California performance, best existing science of quality improvement, and effective engagement of stakeholders.

4) Contractor agrees to work with Covered California to provide comparison reporting for all lines of business to compare performance and inform future Covered California requirements where comparative data can offer meaningful reference points, starting with the 2018 plan year data. The non-Covered California lines of business data are to support contract negotiations in setting targets and requirements for Covered California-only business and any required data will be required as part of Contractor's annual application for certification.

   (a) The basis for analysis of variation in performance of different ACO models shall be the Commercial ACO Measure Set as updated by the Integrated Healthcare Association (IHA) and published at: http://www.iha.org/our-work/accountability/commercial-aco.

(b) Comparison reporting using the Commercial ACO Measure Set will begin once data becomes available for plan year 2018.

4.04 Behavioral Health

Covered California and Contractor recognize the critical importance of behavioral health services, including mental health and substance use disorder services, as part of the broader set of medical services provided to Enrollees.

Contractor will be required to report in its annual application for certification on the strategies Contractor has implemented and its progress in:

1) Making behavioral health services available to Enrollees;

2) Measuring access and quality to ensure Enrollees receive appropriate, evidence-based treatment, and provide the outcomes for these measures;

3) Improving accessibility and quality of behavioral health services; and

4) Integrating behavioral health services with Medical Services.

Reports must include documenting the percent of services provided under an integrated behavioral health-medical model for Enrollees and the reports should include the percent for Contractor's overall covered lives, where such information is useful for comparison purposes and informing future Covered California requirements. These reports should also include whether these models are implemented in association with PCMH and ACO models or are independently implemented and will be used for negotiation and evaluation purposes regarding any extension of this Agreement and reported in the annual application for certification.

Contractor agrees to actively participate in the statewide effort through Smart Care California to promote the appropriate use of opioids and lower opioid overdose deaths (https://www.iha.org/our-work/insights/smart-care-california/focus-area-opioids). To the extent possible, Contractor agrees to implement policies and programs that align with the Smart Care California priority areas:

1) Prevent: decrease the number of new starts: fewer prescriptions, lower doses, shorter durations;

2) Manage: identify patients on risky regimens (high-dose, or opioids and sedatives) and develop individualized treatment plans, avoiding mandatory tapers;

3) Treat: streamline access to evidence-based treatment for substance use disorder at all points in the health care system; and

4) Stop deaths: promote data-driven harm reduction strategies, such as naloxone access and syringe exchange.

4.05 Telehealth and Remote Monitoring

In the annual application for certification, Contractor will be required to report the extent to which the Contractor is supporting and using technology to assist in higher quality, accessible, patient-centered care, and the utilization for Enrollees on the number of unique patients and number of separate servicing provided for telehealth and remote home monitoring. Contractor agrees to

work with Covered California to provide comparison reporting for its other lines of business to compare performance and inform future requirements for the Exchange where comparative data can offer meaningful reference points. Such information will be used for negotiation and evaluation purposes regarding any extension of this Agreement and the annual certification process for subsequent years.

Reporting requirements will be met through completing the annual application for certification, but contractor may supplement such reports with data on the efficacy and impact of such utilization. These reports must include whether these models are implemented in association with PCMH and ACO models or are independently implemented.

ARTICLE 5
HOSPITAL QUALITY

Covered California and Contractor recognize that hospitals have contracts with multiple health plans and are engaged in an array of quality improvement and efficiency initiatives. Hospitals play a pivotal role in providing critical care to those in the highest need and should be supported with coordinated efforts across health plans and purchasers.

5.01 Hospital Payments to Promote Quality and Value

Covered California expects its Contractors to pay differently to promote and reward better quality care rather than pay for volume. Contractor shall:

1) Adopt a hospital payment methodology that incrementally places at least six percent (6%) of reimbursement to hospitals for Contractor's Covered California business with each general acute care hospital at-risk or subject to a bonus payment for quality performance. At minimum, this methodology shall include two percent (2%) of reimbursement by year end 2019 with a plan for satisfying future increases in reimbursement, four percent (4%) of reimbursement by year end 2021, and six percent (6%) by year end 2023. Contractor may structure this strategy according to its own priorities such as:

   (a) The extent to which the payments "at risk" take the form of bonuses, withholds, or other penalties; or

   (b) The selection of specific metrics upon which performance based payments are made may include, but are not limited to, Hospital Acquired Conditions (HACs) including Hospital Acquired Infections (HAIs), readmissions, or satisfaction measured through the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAPS), but Contractor must use standard measures commonly in use in hospitals and that are endorsed by the National Quality Forum – with the goal of limiting measurement burden on hospitals.

   (c) Contract arrangements with hospitals that participate in Accountable Care Organizations, whether sponsored by the Contractor or by Provider organizations, which include accountability or shared risk for total cost of care shall be considered to have met this requirement.

2) Because there is some evidence that readmissions may be influenced by social determinants beyond the control of the health care system or social supports that a hospital can provide at discharge, if Contractor includes readmissions as a measure under this provision, it shall not be the only measure. Additionally, Contractor must adopt balancing measures to track, address, and prevent unintended consequences from at-risk payments including exacerbation of health care disparities. Contractor shall report what strategies it is implementing to support hospitals serving at-risk populations in achieving target performance. In alignment with CMS rules on payments to hospitals for inpatient hospital services, Critical Access Hospitals as defined by the Centers for Medicare and Medicaid, are excluded from this requirement. In addition, the following types of hospitals are excluded from this requirement:

   (a) Long Term Care hospitals

   (b) Inpatient Psychiatric hospitals

(c) Rehabilitation hospitals

(d) Children's hospitals

Contractor shall still be accountable for the quality of care and safety of Covered California members receiving care in the aforementioned hospitals. Implementation of this requirement may differ for integrated delivery systems and require alternative mechanisms for tying payment to performance.

3) Report in its annual application for certification for negotiation purposes, for Enrollees, the:

(a) Amount, structure, and metrics for its hospital payment strategy;

(b) The percent of network hospitals operating under contracts reflecting this payment methodology;

(c) The total dollars and percent or best estimate of hospital payments that are tied to this strategy; and

(d) The dollars and percent, or best estimate that is respectively paid or withheld to reflect value. The hospital payments to promote value must be distinct from shared-risk and performance payments to hospitalization related to participation in ACOs as described in Article 4.03.

Additionally, Contractor agrees to work with Covered California to provide comparison reporting for Contractor's entire book of business where comparative data can offer meaningful reference points. Such information will be used for negotiation and evaluation purposes regarding any extension of this Agreement.

5.02 Hospital Patient Safety

1) Contractor agrees to work with Covered California to support and enhance acute general hospitals' efforts to promote safety for their patients. Exclusions for this requirement include CMS Critical Access Hospitals as defined by the Centers for Medicare and Medicaid. In addition, the following types of hospitals are excluded:

(a) Long Term Care hospitals

(b) Inpatient Psychiatric hospitals

(c) Rehabilitation hospitals

(d) Children's hospitals

2) Contractor will annually report strategy to improve safety in network hospitals, informed by review of specified HAC rates in all network hospitals. HAC rates will be provided by Covered California from established sources of clinical data such as rates reported by hospitals to the National Healthcare Safety Network (NHSN), or the California Department of Public Health (CDPH). Such information will be used for negotiation and evaluation purposes regarding any extension of this Agreement.

3) Covered California has identified an initial set of HACs for focus. Certain HACs may be substituted for others if a common data source cannot be found. The decision to

substitute HACs would be made transparently and collaboratively through the advisory process. The HACs that are currently the subject of the hospital safety initiatives are listed below:

(a) Catheter Associated Urinary Tract Infection (CAUTI);

(b) Central Line Associated Blood Stream Infection (CLABSI);

(c) Surgical Site Infection (SSI) with focus on colon;

(d) Methicillin-resistant Staphylococcus aureus (MRSA); and

(e) Clostridium difficile colitis (C. Diff) infection.

Contractor agrees to work with its contracted hospitals to continuously pursue a standardized infection ratio (SIR) of 1.5 or lower for each of the specified HAIs prioritizing hospitals that care for a high-volume of the Contractor's Enrollees.

4) The subject HACs may be revised in future years. Covered California expects to include adverse drug events (ADEs) including inappropriate use of opioids and blood thinners, hypoglycemia, and Sepsis Mortality when standardized definitions and measurement strategies have been adopted by CMS or by a coalition of Partnership for Patients grantees in California.

5) Covered California expects Contractor to only contract with hospitals that demonstrate they provide quality care and promote the safety of Enrollees. To meet this expectation Covered California will work with QHP Issuers and with California's hospitals to identify areas of "outlier poor performance" based on variation analysis of HAC rates. By year end 2020, as detailed in Article 1, 1.02(3), Contractors must either exclude hospitals that demonstrate outlier poor performance on safety from Provider networks serving Covered California or to document each year in its application for certification the rationale for continued contracting with each hospital that is identified as a poor performing outlier on safety and efforts the hospital is undertaking to improve its performance. Covered California does not expect Contractor to base outlier performance, and potential network removal decisions, on one HAC measure alone.

5.03 Appropriate Use of C-sections

Contractor agrees to actively participate in the statewide effort through Smart Care California to promote the appropriate use of C-sections. This ongoing initiative sponsored by Covered California, DHCS, and CalPERS as well as major employers has adopted the goal of reducing Nulliparous, Term Singleton, Vertex (NTSV) C-section rates to meet or exceed the national Healthy People 2020 target of twenty-three-point nine percent (23.9%) for each hospital in the state by year end 2019. In addition to actively participating in this collaborative, Contractor shall:

1) Work collaboratively with Covered California to promote and encourage all in-network hospitals that provide maternity services to use the resources provided by California Maternity Quality Care Collaborative (CMQCC) and enroll in the CMQCC Maternal Data Center (MDC).

2) Review information on C-section rate for NTSV deliveries and use it to inform hospital engagement strategy to reduce NTSV C-sections. Such information will also be used for negotiation and evaluation purposes regarding any extension of this Agreement.

3) Adopt a payment methodology progressively to include all contracted physicians and hospitals serving Enrollees, such that by year end 2019, payment is structured to support only medically necessary care and there is no financial incentive to perform C-sections. Smart Care California has outlined three payment strategies to align payment with medically necessary use of C-sections:

   (a) Adopt a blended case rate payment for both physicians and hospitals

   (b) Include a NTSV C-section metric in existing hospital and physician quality incentive programs

   (c) Adopt population-based payment models, such as ACO-like arrangements.

   Contractor must report on its payment methodology, how this methodology aligns with the Smart Care California payment strategies, and either the number or percent of hospitals contracted, as applicable, under this model in its annual application for certification.

4) Covered California expects Contractor to only contract with hospitals that demonstrate they provide quality care and promote the safety of Enrollees. Though Covered California does not expect Contractor to base outlier performance, and potential network removal decisions, on one measure alone, it is expected that Contractor will encourage providers with high rates of NTSV C-section delivery to pursue CMQCC coaching. Covered California expects Contractor to consider NTSV C-section rate, improvement trajectory, and willingness to engage in coaching as part of its maternity hospital contracting decisions and terms by year end 2019 and annually thereafter.

ARTICLE 6
POPULATION HEALTH: PREVENTIVE HEALTH, WELLNESS AND AT-RISK ENROLLEE SUPPORT

Covered California and Contractor recognize that access to care, timely preventive care, coordination of care, and early identification of high risk enrollees are central to the improvement of Enrollee health. Contractor and Covered California shall identify ways to increase access and coordination of care and work collaboratively to achieve these objectives.

6.01 Health and Wellness Services

Contractor shall ensure Enrollees have access to preventive health and wellness services. For the services described below, Contractor must identify Enrollees who are eligible, notify Enrollees of their availability, and report utilization.

1) Necessary preventive services appropriate for each Enrollee. Contractor must report to Covered California the number and percent of Enrollees who utilize preventive services.

2) Tobacco cessation intervention, inclusive of evidenced-based counseling and appropriate pharmacotherapy, if applicable. Contractor must report to Covered California the number and percent of Enrollees who take advantage of the tobacco cessation benefit.

3) Obesity management, if applicable. Contractor must report to Covered California the number and percent of its Enrollees who take advantage of the obesity benefit.

4) To ensure the Enrollee health and wellness process is supported, Contractor must report on its:

   (a) Health and wellness communication processes delivered to its Enrollees and applicable Participating Providers, that take into account cultural and linguistic diversity; and

   (b) Processes to incorporate Enrollee's health and wellness information into Contractor's data and information specific to each individual Enrollee. This Enrollee's data is Contractor's most complete information on each Enrollee and is distinct from the Enrollee's medical record maintained by the Providers.

Contractor will be required to report on each of these four service categories in its annual application for certification. Additionally, Contractor agrees to work with Covered California to provide comparison reporting for its other lines of business to compare performance and inform future requirements for the Exchange where comparative data can offer meaningful reference points. The non-exchange line of business data is to support contract negotiations in setting targets and requirements for Exchange-only business and any required data will be submitted as part of Contractor's annual application for certification.

For each of the four service categories described above, Covered California working with appropriate stakeholders and the Contractor, will develop a measurement strategy based on national benchmarks, analysis of variation in California performance, best existing science of quality improvement, and effective engagement of stakeholders.

6.02 Community Health and Wellness Promotion

Covered California and Contractor recognize that promoting better health for Enrollees also requires engagement and promotion of community-wide initiatives that foster better health,

healthier environments, and the promotion of healthy behaviors across the community. Contractor is encouraged to support community health initiatives that have undergone or are being piloted through systematic review to determine effectiveness in promoting health and preventing disease, injury, or disability and have been recommended by the Community Preventive Services Task Force.

Contractor will be required to report annually in its application for certification the initiatives, programs and projects that it supports that promote wellness and better community health for Enrollees, and is encouraged to report on such initiatives for Contractor's overall population. Such reports must include available results of evaluations of these community programs for Enrollees, including clinical or other health impacts and efficacy and will be used for negotiation and evaluation purposes regarding any extension of this Agreement.

Such programs may include:

1) Partnerships with local, state, or federal public health departments such as Let's Get Healthy California;

2) CMS Accountable Health Communities;

3) Voluntary health organizations which operate preventive and other health programs such as CalFresh; and

4) Hospital activities undertaken under the Community Health Needs Assessment required every three years under the Affordable Care Act.

6.03 Determining Enrollee Health Status and Use of Health Assessments

Contractor shall demonstrate the capacity and systems to collect, maintain, use, and protect from disclosure individual information about Enrollees' health status and behaviors in order to promote better health and to better manage Enrollees' health conditions.

To the extent the Contractor uses or relies upon Health Assessments to determine health status, Contractor shall offer, upon initial enrollment and on a regular basis thereafter, a Health Assessment in all threshold languages to all Enrollees over the age of 18, including those Enrollees that have previously completed such an assessment. If a Health Assessment tool is used, Contractor should select a tool that adequately evaluates Enrollees current health status and provides a mechanism to conduct ongoing monitoring for future intervention(s). In addition, Health Assessments should advise policyholders at the outset on how the information collected may be used, and explain that the member is opting in to receive information from the Contractor, and that participating in the assessment is optional.

6.04 Reporting to and Collaborating with Covered California Regarding Health Status

Contractor shall provide to Covered California, in a format that shall be mutually agreed upon, information on how it collects and reports, at both individual and aggregate levels, changes in Enrollees' health status. Reporting may include a comparative analysis of health status improvements across geographic regions and demographics.

Contractor shall report to Covered California its process to monitor and track Enrollees' health status, which may include its process for identifying individuals who show a decline in health status, and referral of such Enrollees to Contractor care management and chronic condition program(s) as defined in Section 6.05, for the necessary intervention. Contractor shall annually report to Covered California the number of Enrollees who are identified through their selected mechanism and the results of their referral to receive additional services.

6.05 Supporting At-Risk Enrollees Requiring Transition

Contractor shall be able to facilitate transitions of care with minimal disruption for Enrollees who are switching from one QHP Issuer to another or into or out of the Exchange marketplace. The Exchange is particularly concerned about QHP Issuer transitions of enrollment for At-Risk Enrollees, which includes Enrollees who are: 1) in the middle of acute treatment, third trimester pregnancy, or those who would otherwise qualify for Continuity of Care under California law, 2) in case management programs, 3) in disease management programs, or 4) on maintenance prescription drugs for a chronic condition.

In the event of a future service area reduction, the Exchange may automatically transition Contractor's Enrollees into a different QHP Issuer to avoid gaps in coverage.

If this occurs, the Contractor terminating Enrollees shall do the following:

1) Conduct outreach to alert all impacted Enrollees that their QHP with Contractor will be ending. Outreach will include instructions, timing, and options for enrolling with a new QHP Issuer.

2) Conduct outreach to At-Risk Enrollees with sensitive diagnosis, giving them the option to authorize Contractor to send their personal health information to the Enrollee's new QHP Issuer with the goal of improving the transition of care.

3) Send Enrollee health information relevant to creating transitions of care with minimal disruption to the Enrollee's new QHP Issuer for those Enrollees who have provided authorization to do so, as follows:

    (a) For all terminating Enrollees, send PCP on record.

    (b) For At-Risk Enrollees, send relevant personal health information to new QHP Issuer on behalf of those who authorize.

4) Conduct outreach to providers in impacted service areas to create Enrollee transitions with minimal disruption.

Contractors receiving terminating Enrollees from a Contractor under a service area withdrawal must do the following:

1) Identify At-Risk Enrollees, either through existing contractor practices, or through receipt of both health information from prior Contractor and the data file with transitioning enrollment information from Covered California (which would occur after these Enrollees have effectuated coverage).

2) Ensure At-Risk Enrollee care transition accounts for the Enrollee's medical situation; including participation in case or disease management programs, locating in-network Providers with appropriate clinical expertise, or any alternative therapies including specific drugs;

3) Establish internal processes to ensure all parties involved in the transition of care for At-Risk Enrollees are aware of their responsibilities. This includes anyone within or outside of the Contractor's organization who are needed to ensure the transition of prescriptions or provision of care;

4) Provide information on continuity of care program, including alternatives for transitioning to an in-network provider; and

5) Ensure terminating Enrollees have access to Contractor's formulary information prior to enrollment.

6.06 Identification and Services for At-Risk Enrollees

Contractor agrees to identify and proactively manage Enrollees with existing and newly diagnosed chronic conditions, including, diabetes, asthma, heart disease, or hypertension, and who are most likely to benefit from well-coordinated care ("At-Risk Enrollees"). Contractor agrees to support disease management activities at the plan or health care Provider level that meet standards of accrediting programs such as NCQA. Contractor shall provide Covered California with a documented process, care management plan and strategy for targeting and managing At-Risk Enrollees. Such documentation may include the following:

1) Methods to identify and target At-Risk Enrollees;

2) Description of Contractor's predictive analytic capabilities to assist in identifying At-Risk Enrollees who would benefit from early, proactive intervention;

3) Communication plan for known At-Risk Enrollees to receive information prior to Provider visit, including the provision of culturally and linguistically appropriate communication;

4) Process to update At-Risk Enrollee medical history in Contractor's maintained Enrollee health profile;

5) Process for sharing registries of Enrollees with their identified risk, as permitted by state and federal law, with appropriate accountable Providers, especially the enrollee's PCP;

6) Mechanisms to evaluate access within the Provider network on an ongoing basis, to ensure that an adequate network is in place to support a proactive intervention and care management program for At-Risk Enrollees;

7) Care and network strategies that focus on supporting a proactive approach to At-Risk Enrollee intervention and care management. Contractor agrees to provide Covered California with a documented plan and include “tools” and strategies to supplement or expand care management and Provider network capabilities, including an expansion or reconfiguration of specialties or health care professionals to meet clinical needs of At-Risk Enrollees;

8) Data on number of Enrollees identified and types of services provided.

6.07 Diabetes Prevention Programs

Starting January 1, 2018, Contractor must offer a CDC-recognized Diabetes Prevention Lifestyle Change Program, also known as a Diabetes Prevention Program (DPP), to all Enrollees ages 18 and older who meet the participation criteria. The DPP shall be available to all Enrollees in the geographic service area and covered under the $0 preventive services benefit or diabetes education benefit in the Patient-Centered Benefit Design Plans. Contractor’s DPP must have pending or full recognition by CDC as a DPP and be accessed either online or in person. A list of recognized programs in California can be found at https://nccd.cdc.gov/DDT_DPRP/Programs.aspx.

ARTICLE 7
PATIENT-CENTERED INFORMATION AND SUPPORT

Empowering consumers with knowledge to support healthcare decision-making is a crucial part of Covered California's mission and naturally promotes the Triple Aim by supporting decisions consistent with the Enrollee's values and preferences and fostering consumer access to care.

Covered California and Contractor agree that valid, reliable, and actionable information relating to the cost and quality of healthcare services is important to Enrollees, Covered California, and Providers.

Thus, Covered California expects that Contractor will participate in activities necessary to provide this information to consumers. The specifics of this phased approach are described in Section 7.01 below.

7.01 Enrollee Healthcare Services Price and Quality Transparency Plan

1) In the annual application for certification, Contractor will have reported for negotiation and certification purposes, its planned approach to providing healthcare shopping cost and quality information available to all Enrollees. Covered California does not require using a specific form or format and recognizes that the timeline and expectations will differ, based on variables such as Contractor's membership size and current tool offerings. Regardless of how the requirement is fulfilled, the common elements at the end point of each Contractor planned approach must include:

   (a) Cost information:

      i. That enables Enrollees to understand their exposure to out-of-pocket costs based on their benefit design, including real time information on member accumulation toward deductibles, when applicable, and out of pocket maximums. Health Savings Account (HSA) user information shall include account deposit and withdrawal/payment amounts.

      ii. That enables Enrollees to understand Provider-specific consumer cost shares for prescription drugs and for care delivered in the inpatient, outpatient, and ambulatory surgery/facility settings. Such information must include the facility name, address, and other contact information and be based on the contracting rates to give the Enrollee estimates of out of pocket costs that are as accurate as possible.

      iii. Commonly used service information should be organized in ways that are useful and meaningful for consumers to understand.

   (b) Quality information:

      i. That enables Enrollees to compare Providers based on quality performance in selecting a Primary Care clinician or common elective specialty and hospital Providers.

      ii. That is based on quality measurement consistent with nationally-endorsed quality information in accordance with the principles of the Patient Charter for Physician Performance Measurement.

      iii. That, as an interim step prior to integrating quality measurement into Provider chooser tools, can be provided by linking to:

a. The California Office of the Patient Advocate (www.opa.ca.gov/)

b. CMS Hospital Compare Program (https://www.medicare.gov/hospitalcompare/search.html)

c. CMS Physician Compare Program (https://www.medicare.gov/physiciancompare/)

iv. In addition, Contractor must recognize California hospitals that have achieved target rates for HACs and NTSV C-section utilization as defined in Article 5, Sections 5.02 and 5.03.

(c) Health Insurance Benefit Information. Contractor shall make available personalized benefit-specific information to all enrollees that includes accumulations of expenses applicable to deductible and out-of-pocket maximums.

(d) Contractor agrees to monitor care provided out of network to ensure that consumers understand that their cost share will be higher and are choosing care out of network intentionally.

(e) If Contractor product enrollment exceeds 100,000 for Covered California business, the cost and quality information shall be provided through an online tool easily accessible across a variety of platforms and made available by 2018. If Contractor enrollment is under 100,000 for Covered California business, the information may be provided by alternative means such as a call center.

2) Contractor will be required in its annual application for certification to:

(a) Report the number and percent of unique Enrollees for each of the consumer tools offered for the reporting period of the plan year.

(b) Report user experience with the tool (or equivalent service such as a call center) from a representative sample of users who respond to a survey which includes a user overall satisfaction with rating.

(c) Provide access and log-in credentials for Covered California staff per mutually agreeable terms to safeguard Contractor proprietary information and services.

Contractor agrees to work with Covered California to provide comparison reporting for its other lines of business to compare performance and inform future requirements for the Exchange where comparative data can offer meaningful reference points. The non-exchange line of business data is to support contract negotiations in setting targets and requirements for Exchange-only business and any required data will be submitted as part of Contractor's annual application for certification.

7.02 Enrollee Personalized Health Record Information

1) In its annual application for certification, Contractor will report for negotiation and certification purposes, the extent to which Enrollees can easily access personal health information or have reported its plan to provide such access through such tools as a Personal Health Record (PHR) or other "patient portal".

2) The content of such PHRs includes: medical records, billing and payment records, insurance information, clinical laboratory test results, medical images such as X-rays, wellness and disease management program files, clinical case notes, and other information used to make decisions about individuals.

3) Covered California, working with appropriate stakeholders and the Contractor, will develop a measurement strategy for tracking the use of personal health information based on national benchmarks, analysis of variation in California performance, best existing science of quality improvement, and effective engagement of stakeholders.

4) Contractor will provide access and log-in credentials for Covered California staff per mutually agreeable terms to safeguard Contractor proprietary information and services.

7.03 Enrollee Shared Decision-Making

Covered California requires deployment of decision-making tools to support Enrollees in understanding their medical diagnosis and treatment options to aid in discussion with their Provider. Educating Enrollees on their diagnosis and alternative treatment options is a powerful evidence-based approach to reducing overuse or misuse of clinical interventions.

Contractor agrees to promote and encourage patient engagement in shared decision-making with contracted Providers.

1) Contractor will be required to report in its annual application for certification specific information regarding the number of Enrollees who have accessed consumer information or have participated in a shared decision-making process prior to reaching an agreement on a treatment plan. For example, Contractor may adopt shared-decision-making practices for preference-sensitive conditions, including breast cancer, prostate cancer, and knee and hip replacements, that feature patient-decision-making aids in addition to physician opinions and present trade-offs regarding quality or length of life.

2) Contractor will be required to report in its annual application for certification the percentage of Enrollees with identified health conditions above who received information that allowed the Enrollee to share in the decision-making process prior to agreeing to a treatment plan.

3) Contractor will be required to report in its annual application for certification participation in these programs and their results, including clinical, patient experience and costs impacts.

4) These reports will be used for negotiation and evaluation purposes regarding any extension of this Agreement.

7.04 Reducing Overuse through Smart Care California

Contractor shall participate in Smart Care California. This multi-stakeholder work group facilitated by IHA, will leverage Choosing Wisely decision aids to support efforts to drive appropriate use of:

1) C-sections for NTSV deliveries;

2) Opioids; and

3) Evidence-based treatment for low back pain.

The mechanism for reduction of NTSV C-sections will be participation in Smart Care California, with the target of ensuring all network hospitals achieve rates of twenty-three-point nine percent (23.9%) or less by year end 2019 (see Section 5.03).

Improvement strategies and targets for 2020 as well as for annual intermediate milestones for the appropriate use of opioids and evidence-based treatment for low back pain will be established by Covered California in collaboration with other stakeholders participating in the workgroup based on national benchmarks, analysis of variation in California performance, and best existing science of quality improvement and effective engagement of stakeholders.

ARTICLE 8
PAYMENT INCENTIVES TO PROMOTE HIGHER VALUE CARE

8.01 Reward-based Consumer Incentive Programs

Contractor may, to the extent permitted by law, maintain or develop a Reward-based Consumer Incentive Program to promote evidence-based, optimal care for Enrollees with identified chronic conditions. To the extent Contractor implements such a program and to the extent such information is known, Contractor shall report participation rates and outcomes results, including clinical, patient experience, and cost impacts, to Covered California annually.

8.02 Value-Based Reimbursement Inventory and Performance

Contractor agrees to implement value-based reimbursement methodologies to Providers within networks contracted to serve Covered California. Value-based reimbursement methodologies must include those payments to hospitals and physicians that are linked to quality metrics, performance, costs and value measures, and must include the Contractor's entire book of business with the Provider.

1) Among the strategies for which Covered California has established requirements for payment strategies to support delivery system reforms are:

   (a) Advanced Primary Care or Patient-Centered Medical Homes (Section 4.02)

   (b) Accountable Care Organizations (Section 4.03)

   (c) Appropriate use of C-sections (Section 5.03)

   (d) Hospital Patient Safety (Section 5.02)

2) In addition to the required payment strategies above, Contractor will be required to report in its annual application for certification an inventory and evaluation of the impact of other value-based payment models it is implementing including, but not limited to:

   (a) Direct participation or alignment with CMMI innovative payment models such as the Oncology or Joint Replacement model; and

   (b) Adoption of new Alternative Payment Models associated with the implementation of the Medicare Access & CHIP Reauthorization Act of 2015 (MACRA).

8.03 Value-Pricing Programs

Contractor agrees to provide Covered California with the details of any value-pricing programs for procedures or in-service areas that have the potential to improve care and generate savings for Enrollees. Contractor agrees to share with Covered California, the results of programs that may focus on high cost regions or those with the greatest cost variation(s). These programs may include payment bundling pilots for specific procedures where wide cost variations exist.

8.04 Payment Reform and Data Submission

1) Contractor agrees to provide information to Covered California pursuant to this Article 8, understanding that Covered California will provide such information to the Catalyst for Payment Reform's (CPR) National Scorecard on Payment Reform and National Compendium on Payment Reform.

2) The CPR National Scorecard will provide a view of progress on payment reform at the national level and then at the market level as the methodology and data collection mechanisms allow.

3) The CPR National Compendium will be an up-to-date resource regarding payment reforms being tested in the marketplace and their available results. The Compendium will be publicly available for use by all health care stakeholders working to increase value in the system.

4) Contractor must annually report on the progress and impact of value-oriented payment initiatives imputed to the Purchaser's annual spend for the preceding calendar year, using both the format and calculation methodology in the annual certification application, and CPR's Payment Reform Evaluation Framework.

QUALITY, NETWORK MANAGEMENT, AND DELIVERY SYSTEM STANDARDS

GLOSSARY OF KEY TERMS

Accountable Care Organization (ACO) - A system of population-based care coordinated across the continuum including multi-discipline physician practices, hospitals, and ancillary Providers with combined risk sharing arrangements and incentives between health plans and Providers, and among Providers across specialties and institutional boundaries. The ACO is held accountable for nationally recognized evidence-based clinical, financial, and operational performance, as well as incentives for improvements in population outcomes. As Providers accept more accountability under this provision, health plans shall be aware of their obligations.

Bundled Payments (also known as Global Payment Bundles, episode-of-care payment, or global case rates) - An alternative payment method to reimburse healthcare Providers for services that provides a single payment for all physician, hospital, and ancillary services that a patient uses in the course of an overall treatment for a specific, defined condition, or care episode. These services may span multiple Providers in multiple settings over a period of time, and are reimbursed individually under typical fee-for-service models. The Payment Bundle may cover all inpatient/outpatient costs related to the care episode, including physician services, hospital services, ancillary services, procedures, lab tests, and medical devices/implants. Using Payment Bundles, Providers assume financial risk for the cost of services for a particular treatment or condition, as well as costs associated with preventable complications, but not the insurance risk (that is, the risk that a patient will acquire that condition, as is the case under capitation).

Care Management - Healthcare services, programs, and technologies designed to help individuals with certain long-term conditions better manage their overall care and treatment. Care management typically encompasses Utilization Management (UM), Disease Management (DM), and Case Management (CM). Care Management's primary goal is to prevent the sick from getting sicker, and avoiding acute care events. Care Management is usually considered a subset of Population Health Management.

Complex Conditions - Clinical conditions that are of a complex nature that typically involve ongoing case management support from appropriately trained clinical staff. Frequently, individuals have multiple chronic clinical conditions that complicate management ("polychronic") or may have a complex, infrequent specialty condition that requires specialized expertise for optimal management.

Contractor - The Health Insurance Issuer contracting with the Exchange under this Agreement to offer a QHP and perform in accordance with the terms set forth in this Agreement.

Delivery System Transformation - A set of initiatives taken by purchasers, employers, health plans, or Providers, together or individually, to drive the creation and preferred use of care delivery models that are designed to deliver higher value aligned with the "Triple Aim" goals of patient care experience including quality and satisfaction, improve the health of the populations, and reduce the per capita cost of Covered Services. Generally these models require improved care coordination, Provider and payor information sharing, and programs that identify and manage populations of individuals through care delivery and payment models.

Enrollees – Enrollee means each and every individual enrolled in a QHP offered through the Exchange for the purpose of receiving health benefits.

The Exchange – The California Health Benefit Exchange, doing business as Covered California and an independent entity within the Government of the State.

Health Disparities - Healthy People 2020 defines a health disparity as "a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion."9 Racial and ethnic disparities populations include persons with Limited English Proficiency. (LEP).

Health Equity - Healthy People 2020 defines health equity as the "attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities."

Health Insurance Issuer - Health Insurance Issuer has the same meaning as that term is defined in 42 U.S.C. § 300gg-91 and 45 C.F.R. § 144.103.

Patient Centered Medical Home - A health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family. Care is facilitated by registries, information technology, health information exchange, and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner. The medical home is best described as a model or philosophy of primary care that is patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety.

Primary Care - The provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health needs, developing a sustained partnership with patients, and practicing in the context of family and community. (IOM, 1978) Contractors may allow enrollees to select Nurse Practitioners and Physician Assistants to serve as their Primary Care clinician. Covered California does not require that Primary Care clinicians serve as a "gatekeeper" or the source of referral and access to specialty care. Covered California recognizes Internal Medicine, OBGYN, Pediatrics, General Practice, and Family Medicine as primary care specialties.

Population Health Management - A management process that strives to address health needs at all points along the continuum of health and wellbeing, through participation of, engagement with and targeted interventions for the population. The goal of a Population Health Management program is to maintain and/or improve the physical and psychosocial wellbeing of individuals through cost-effective and tailored health solutions.

Preventive Health and Wellness Services - The provision of specified preventive and wellness services and chronic disease management services, including preventive care, screening and immunizations, set forth under Section 1302 of the Affordable Care Act (42 U.S.C. Section 18022) under the Section 2713 of the Affordable Care Act (42 U.S.C. Section 300gg-13), to the extent that such services are required under the California Affordable Care Act.

Qualified Health Plan or QHP– A health care service plan contract or policy of insurance offered by a QHP Issuer and certified by Covered California.

Qualified Health Plan Issuer or QHP Issuer - means a licensed health care service plan or insurer that has been selected and certified by Covered California to offer QHPs through the Exchange.

Reference Pricing - A payor contracting, network management and enrollee information process that identifies and differentially promotes delivery system options for care based on transparent display of

comparative costs for identical services or procedures, typically after each Provider has passed a quality assessment screen. In some cases, value pricing will identify the individual enrollee's out-of-pocket costs accounting for plan design and deductible status. While quality is incorporated in the process, typically there is no differentiation based on comparative quality once a threshold performance level is achieved.

Remote Patient Monitoring - A technology or set of technologies to enable monitoring of patients outside of conventional clinical settings (e.g. in the home), which may increase access to care and decrease healthcare delivery costs.

Reward Based Consumer Incentive Program - (aka: Value-Based Insurance Design) individualizes the benefits and claims adjudication to the specific clinical conditions of each high risk member and to reward participation in appropriate disease management & wellness programs. Positive Consumer Incentive programs help align employee incentives with the use of high-value services and medications, offering an opportunity for quality improvement, cost savings and reduction in unnecessary and ineffective care.

Shared Decision Making - The process of making decisions regarding health care diagnosis and treatment that are shared by doctors and patients, informed by the best evidence available and weighted according to the specific characteristics and values of the patient. Shared decision making combines the measurement of patient preferences with evidence-based practice.

Team Care - A plan for patient care that is based on philosophy in which groups of professional and non-professional personnel work together and share the work to identify, plan, implement and evaluate comprehensive client-centered care. The key concept is a group that works together toward a common goal, providing qualitative comprehensive care. The team care concept has its roots in team nursing concepts developed in the 1950's.

Telehealth – A mode of delivering professional health care and public health services to a patient through information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site and the health care provider is at a distant site.

Value Pricing - A payor contracting, network management and enrollee information process that identifies and differentially promotes delivery system options for care that provide better value through the identification and transparent display of comparative total cost, out-of-pocket cost for enrollees and standardized quality performance to allow for informed consumer choice and Provider referrals for individual services and bundles of services.

Value-Based Reimbursement - Payment models that rewards physicians and Providers for taking a broader, more active role in the management of patient health, and provides for a reimbursement rate that reflects results and quality instead of solely for specific visits or procedures.

In all other respects, the Agreement remains in full force and effect.

Attachment 7 to Covered California 2017 Individual Market QHP Issuer Contract: Quality, Network Management, Delivery System Standards and Improvement Strategy

Preamble

PROMOTING HIGHER QUALITY AND BETTER VALUE

Covered California's "Triple Aim" framework seeks to lower costs, improve quality, and improve health outcomes, while ensuring a good choice of plans for consumers. Covered California and Contractor recognize that promoting better quality and value will be contingent upon supporting Providers and strategic, collaborative efforts to align with other major purchasers and payors to support delivery system reform. Health Insurance Issuers contracting with Covered California to offer Qualified Health Plans (QHP) are integral to Covered California achieving its mission:

> *The mission of the California Health Benefit Exchange is to increase the number of insured Californians, improve health care quality, lower costs, and reduce health disparities through an innovative, competitive marketplace that empowers consumers to choose the health plan and Providers that give them the best value.*

By entering into this Agreement with Covered California, Contractor agrees to work with Covered California the Exchange to develop and implement policies and practices that will promote the Triple Aim, impacting not just the Enrollees of Covered California but Contractor's entire California membership. All QHP Issuers have the opportunity to take a leading role in helping Covered California support new models of care which promote the vision of the Affordable Care Act and meet consumer needs and expectations. At the same time, the Contractor and Covered California can promote improvements in the entire care delivery system. Covered California will seek to promote care that reduces excessive costs, minimizes unpredictable quality, and reduces inefficiencies of the current system. In addition, Covered California expects all QHP Issuers to balance the need for accountability and transparency at the Provider-level with the need to reduce administrative burdens on Providers as much as possible. For there to be a meaningful impact on overall healthcare cost and quality, solutions and successes need to be sustainable, scalable, and expand beyond local markets or specific groups of individuals. Covered California expects its QHP Issuers to support their Providers to engage in a culture of continuous quality and value improvement, which will benefit both Covered California Enrollees and all individuals covered by the QHP Issuers.

This Quality, Network Management, Delivery System Standards and Improvement Strategy outlines the ways that Covered California and the Contractor will focus on the promotion of better care and higher value for Enrollees and for other California health care consumers. This focus will require both Covered California and Contractor to coordinate with and promote alignment with other organizations and groups that seek to deliver better care and higher value. By entering into this Agreement with Covered California, Contractor affirms its commitment to be an active and engaged partner with Covered California and to work collaboratively to define and implement additional initiatives and programs to continuously improve quality and value.

Covered California and Contractor recognize that driving the significant improvements needed to ensure better quality care is delivered at lower cost will require tactics and strategies that extend beyond the term of this agreement. Success will depend on establishing targets based on current performance, national benchmarks, and the best improvement science conducting rigorous evaluation of progress and adjusting goals annually based on experience. This Attachment 7 contains numerous reports that will be required as part of the annual certification and contracting process with QHP Issuers. Contractor shall submit all required reports as defined in this Attachment and listed in the annual "Contract Reporting Requirements" table found on Covered California's Extranet site (Plan Home, in the Resources folder, Contract Reporting Compliance subfolder). This information will be used for negotiation and evaluation purposes regarding any extension of this Agreement and will be reported as required in the annual application for certification.

ARTICLE 1
IMPROVING CARE, PROMOTING BETTER HEALTH AND LOWERING COSTS

1.01 Coordination and Cooperation

Contractor and Covered California agree that the Quality, Network Management, Delivery System Standards and Improvement Strategy serve as a starting point for what must be ongoing, refined, and expanded efforts to promote improvements in care for Enrollees and across Contractor's California members. Improving and building on these efforts to improve care and reduce administrative burdens will require active partnership between Covered California and Contractor, but also with Providers, consumers, and other important stakeholders.

1) Covered California shall facilitate ongoing discussions with Contractor and other stakeholders through Covered California's Plan Management and Delivery System Reform Advisory Group and through other forums as may be appropriate to work with Contractors to assess the elements of this section and their impact, and ways to improve upon them, on:

   (a) Enrollees and other consumers;

   (b) Providers in terms of burden, changes in payment and rewarding the Triple Aim of improving care, promoting better health, and lowering costs; and

   (c) Contractors in terms of the burden of reporting and participating in quality or delivery system efforts.

2) Contractor agrees to participate in Covered California advisory and planning processes, including participating in the Plan Management and Delivery System Reform Advisory Group.

1.02 Ensuring Networks are Based on Value

Central to its contractual requirements of its QHP Issuers, Covered California requirements include multiple elements related to ensuring that QHP Issuers' plans and networks provide quality care, including Network Design (Section 3.3.2), the inclusion of Essential Community Providers (Section 3.3.3) and a wide range of elements detailed in this Attachment. To complement these provisions and to promote accountability and transparency of Covered California's expectation that network design and Provider selection considers quality and patient experience in addition to cost and efficiency, the Contractor shall:

1) Include quality, which may include clinical quality, patient safety and patient experience, and cost in all Provider and facility selection criteria when designing and composing networks for inclusion in Covered California products.

2) Contractor will be required to report to Covered California as part of its annual application for certification for purposes of negotiations, how it meets this requirement and the basis for the selection of Providers or facilities in networks available to Enrollees. This will include a detailed description of how cost, clinical quality, patient reported experience or other factors are considered in network design and Provider or facility selection. Information submitted in the application for certification for 2021 may be made publicly available by Covered California.

3) Covered California expects Contractor to only contract with Providers and hospitals that demonstrate they provide quality care and promote the safety of Enrollees at a reasonable price. To meet this expectation, by year end 2019, Covered California will work with Cal Hospital Compare and its QHP Issuers to identify areas of "outlier poor performance" for hospitals based on variation analysis. As part of this process, Covered California will engage experts in quality and cost variation and shall consult with Providers throughout California. By year end 2020 QHP Issuers will be expected to either exclude those Providers that are "outlier poor performers" on either cost or quality from Covered California Provider networks or to document each year in its application for certification the rationale for continued contracting with each Provider that is identified as a "poor performing outlier" and efforts the Provider is undertaking to improve performance. Rationales for continued inclusion of Providers may include the impact on consumers in terms of geographical access and their out-of-pocket costs, or other justification provided by the QHP Issuers. QHP Issuers rationale for inclusion of outliers on cost or quality will be released to the public by Covered California. Selection of specific measures of cost and quality, as well as criteria for defining "outlier poor performance" in a way that can be implemented consistently across Contractors will be established by Covered California based on national benchmarks, analysis of variation in California performance which shall include consideration of hospital case mix and services provided, best existing science of quality improvement, and effective engagement of stakeholders. Covered California does not expect Contractor to base outlier performance, and potential network removal decisions, on one quality or cost measure alone. Contractor agrees to participate in these collaborative processes to establish definitions. Reports from Contractor must detail implementation of such criteria through contractual requirements and enforcement, monitoring and evaluation of performance, consequences of noncompliance, corrective action and improvement plans if appropriate, and plans to transition patients from the care of Providers with poor performance. Such information may be made publicly available by Covered California.

4) Contractor will report as requested how Enrollees with conditions that require highly specialized management (e.g. transplant patients and burn patients) are managed by Providers with documented special experience and proficiency based on volume and outcome data, such as Centers of Excellence. In addition, to the extent that the Contractor uses Centers of Excellence more broadly, it will report as requested, the basis for inclusion of such Centers of Excellence, the method used to promote consumers' usage of these Centers, and the utilization of these Centers by Enrollees.

5) While Covered California welcomes QHP Issuers' use of Centers of Excellence, which may include design incentives for consumers, the current standard benefit designs do not envision or allow for "tiered" in-network Providers.

1.03 Demonstrating Action on High Cost Providers

Affordability is core to Covered California's mission to expand the availability of insurance coverage and promoting the Triple Aim. The wide variation in unit price and total costs of care charged by Providers, with some Providers charging far more for care irrespective of quality, is one of the biggest contributors to high costs of medical services.

1) Contractor will be required to report to Covered California as part of its annual application for certification, which will be used for negotiation purposes:

   (a) The factors it considers in assessing the relative unit prices and total costs of care;

   (b) The extent to which it adjusts or analyzes the reasons for cost factors based on elements such as area of service, population served, market dominance, services provided by the facility (e.g., trauma or tertiary care), or other factors;

   (c) How such factors are used in the selection of Providers or facilities in networks available to Enrollees; and

   (d) The identification of specific hospitals and their distribution by cost deciles or describe other ways Providers and facilities are grouped by costs such as comparison of costs as a percentage of Medicare costs and the percentage of costs for Contractor that are expended in each cost decile. Contractor understands that it is the desire and intention of Covered California to expand this identification process to include other Providers and facilities in future years.

2) In its annual application for certification, which will be used for negotiation purposes, Contractor will be required to report on its strategies to ensure that contracted Providers are not charging unduly high prices, and for what portions of its entire enrolled population it applies each strategy, which may include:

   (a) Telehealth;

   (b) Use of Centers of Excellence;

   (c) Design of Networks (see Article 1.02);

   (d) Reference Pricing; and

   (e) Efforts to make variation in Provider or facility cost transparent to consumers and the use of such tools by consumers.

3) By year end 2019, Contractor will be expected to exclude hospitals and other facilities that demonstrate outlier high cost from Provider networks serving Covered California or to document each year in its application for certification the rationale for continued contracting with each hospital that is identified as a high cost outlier and efforts that the hospital or facility is undertaking to lower its costs. Covered California does not expect Contractor to base outlier performance, and potential network removal decisions, on one quality or cost measure alone.

1.04 Demonstrating Action on High Cost Pharmaceuticals

Appropriate treatment with pharmaceuticals is often the best clinical strategy to treating conditions, as well as managing chronic and life-threatening conditions. Covered California expects its Contractor to ensure that its Enrollees get timely access to appropriate prescription medications. At the same time, Covered California is concerned with the trend in rising prescription drug costs, including those in specialty pharmacy, and compounding increases in costs of generic drugs, which reflect a growing driver of total cost of care.

Contractor will be required to report in its annual application for certification for negotiation purposes, a description of its approach to achieving value in delivery of pharmacy services, which should include a strategy in each of the following areas:

1) Contractor must describe how it considers value in its selection of medications for use in its formulary, including the extent to which it applies value assessment methodology developed by independent groups or uses independent drug assessment reports on comparative effectiveness and value to design benefits, negotiate prices, develop pricing for consumers, and determine formulary placement and tiering within Covered California standard benefit designs. Contractor shall report the specific ways they use a value assessment methodology or independent reports to improve value in pharmacy services and indicate which of the following sources it relies upon:

    (a) Drug Effectiveness Review Project (DERP)

    (b) NCCN Resource Stratification Framework (NCCN-RF)

    (c) NCCN Evidence Blocks (NCCN-EB)

    (d) ASCO Value of Cancer Treatment Options (ASCO-VF)

    (e) ACC/AHA Cost/Value Methodology in Clinical Practice Guidelines

    (f) Oregon State Health Evidence Review Commission Prioritization Methodology

    (g) Premera Value-Based Drug Formulary (Premera VBF)

    (h) DrugAbacus (MSKCC) (DAbacus)

    (i) The ICER Value Assessment Framework (ICER-VF)

    (j) Real Endpoints

    (k) Blue Cross/Blue Shield Technology Evaluation Center

    (l) International Assessment Processes (e.g., United Kingdom's National Institute for Health and Care Excellence – "NICE")

    (m) Other (please identify)

2) Contractor shall describe how its construction of formularies is based on total cost of care rather than on drug cost alone;

3) Contractor shall describe its process for managing specialty pharmacy and biologics management;

4) Contractor must describe how it provides decision support for prescribers and consumers related to the clinical efficacy and cost impact of treatments and their alternatives.

1.05 Quality Improvement Strategy

Starting with the application for certification for 2017, Contractor is required under the Affordable Care Act and regulations from CMS to implement a Quality Improvement Strategy (QIS). The core CMS requirement for the QIS is to align Provider and Enrollee market-based incentives with delivery system and quality targets.

Contractor agrees to align its QIS with the contractual requirements and initiatives of Covered California and to report on its multi-year strategy and first-year plan for implementing each initiative through the annual certification application submitted to Covered California, which will be used for negotiation purposes during the application process. Contractor understands that the application serves as the reporting mechanism and measurement tool for assessing Contractor QIS work plans and progress in achieving improvement targets with respect to each of Covered California quality and delivery system reform initiatives.

Contractor understands that Covered California will seek increasingly detailed reports over time that will facilitate the assessment of the impacts of each initiative which will include:

(a) The percentage, number, and performance of total participating Providers;

(b) The number and percent of Enrollees participating in the initiative;

(c) The number and percent of all the Contractor's covered lives participating in the initiative; and

(d) The results of Contractor's participation in this initiative, including clinical, patient experience, and cost impacts.

1.06 Participation in Collaborative Quality Initiatives

Covered California believes that improving health care quality and reducing costs can only be done over the long-term through collaborative efforts that effectively engage and support clinicians and other Providers of care. There are many established statewide and national collaborative initiatives for quality improvement that are aligned with priorities established by Covered California with requirements specified below.

1) Effective January 1, 2017, Contractor must participate in:

(a) Smart Care California: Sponsored by Covered California, DHCS, and CalPERS, this multi-stakeholder work group facilitated by the Integrated Healthcare Association (IHA), will provide guidance and steer the delivery system to drive appropriate use of C-sections, prescription of opioids, and low back pain. https://www.iha.org/our-work/insights/smart-care-california

i. The C-section work aligns with activities underway through the California

Maternal Quality Care Collaborative (CMQCC) which provides statewide analysis of variation and promotes the appropriate use of C-sections with associated reductions in maternal and newborn mortality and morbidity. https://www.cmqcc.org/ (See Article 5, Section 5.03)

ii. A key element of the change for all three focus areas is promoting best practices through provider and consumer decision support, for example through the Choosing Wisely campaign from Consumer Reports. https://www.iha.org/our-work/insights/smart-care-california (See Article 7, Section 7.04)

2) Covered California is interested in Contractors' participation in other collaborative initiatives. As part of the annual application for certification for negotiation purposes, Contractor will be required to report to Covered California its participation in any of the following collaboratives, or other similar activities not listed:

(a) CMMI's Transforming Clinical Practices, administered by:

i. Children's Hospital of Orange County,

ii. LA Care,

iii. National Rural Accountable Care Consortium,

iv. California Quality Collaborative of PBGH, and

v. VHA/UHC Alliance NewCo, Inc.

All five of these collaboratives are coaching accessible, data-driven, team-based care over the course of the grant 2015-2019. https://innovation.cms.gov/initiatives/Transforming-Clinical-Practices/ (See Article 4, Section 4.02)

(b) Partnership for Patients: The CMS Innovation Center (CMMI) implemented this program focused on hospital patient safety, which between 2012 and 2014 resulted in 87,000 fewer deaths, mostly in 2013-14. The 2017 grants to build on this work have been distributed to Hospital Improvement Innovation Networks (HIINs) around the country including several in California. https://partnershipforpatients.cms.gov/ (See Article 5, Section 5.02)

Awardees working with California hospitals for 2017 are:

i. Health Services Advisory Group (HSAG),

ii. Dignity Hospitals,

iii. VHA/UHC,

iv. Children's Hospitals' Solutions for Patient Safety, and

v. Premiere, Inc.

(c) 1115 Medicaid Waiver Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program

(d) California Joint Replacement Registry developed by the California Healthcare Foundation (CHCF), California Orthopedic Association (COA) and PBGH

(e) California Immunization Registry (CAIR)

(f) Any IHA or CMMI sponsored payment reform program

(g) CMMI ACO Program (including Pioneer, Savings Sharing, Next Gen ACO, and other models)

(h) California Perinatal Quality Care Collaborative

(i) California Quality Collaborative

(j) Leapfrog

(k) A Federally Qualified Patient Safety Organization such as CHPSO

(l) The IHA Encounter Standardization Project

3) When reporting this information to Covered California, such information shall be in a form that is mutually agreed upon by the Contractor and may include copies of reports used by Contractor for other purposes. Contractor understands that Covered California will seek increasingly detailed reports over time that will facilitate the assessment of the impacts of these programs which will include: (1) the percentage of total Participating Providers, as well as the percentage of Covered California specific Providers participating in the programs; (2) the number and percentage of potentially eligible Plan Enrollees who participate through the Contractor in the Quality Initiative; (3) the results of Contractors' participation in each program, including clinical, patient experience and cost impacts; and (4) such other information as Covered California and the Contractor identify as important to identify programs worth expanding.

4) Covered California and Contractor will collaboratively identify and evaluate the most effective programs for improving care for Enrollees and Covered California may require participation in specific collaboratives in future years.

1.07 Data Exchange with Providers

Covered California and Contractor recognize the critical role of sharing data across specialties and institutional boundaries as well as between health plans and contracted Providers in improving quality of care and successfully managing total costs of care.

1) Contractor will be required to report in its annual application for certification for negotiation purposes, the initiatives Contractor has undertaken to improve routine exchange of timely information with Providers to support their delivery of high quality care. Examples that could impact the Contractor's success under this contract may include:

(a) Notifying Primary Care clinicians when one of their empaneled patients is admitted to a hospital, a critical event that often occurs without the knowledge of either the primary care or specialty Providers who have been managing the patient on an ambulatory basis.

(b) Developing systems to collect clinical data as a supplement to the annual HEDIS process, such as HbA1c lab results and blood pressure readings which are important under Article 3 below.

(c) Racial and ethnic self-reported identity collected at every patient contact.

2) Contractor will be required to describe its participation in statewide or regional initiatives that seek to make data exchange routine, including, but not limited to the following Health Information Exchanges:

(a) Inland Empire Health Information Exchange (IEHIE)

(b) Los Angeles Network for Enhanced Services (LANES)

(c) Orange County Partnership Regional Health Information Organization (OCPRHIO)

(d) San Diego Health Connect

(e) Santa Cruz Health Information Exchange

(f) Manifest MedEx (formerly CalIndex)

3) By June 30, 2018 Contractor must use standard processes for encounter data exchange with its contracted providers, which include:

(a) The use of the 837-P and 837-I industry standard transaction sets for encounter data intake. These standard transaction sets must include appropriate cost sharing and member out of pocket information.

(b) The use of the 277 CA transaction set and industry standard code sets to communicate encounter data that was successfully processed, as well as any encounter data that was rejected and requires resubmission. If Contractor uses a clearing house to process encounter data and the 277 CA is not utilized, the Contractor must provide a daily detailed file to the clearing house of all rejected records and corresponding reasons for rejections. Contractor must ensure its contracted providers receive visibility to the specific reasons the encounter data was rejected to allow for both successful resubmissions and any process improvement needed to minimize future rejections.

4) By June 30, 2018 Contractor agrees to participate in industry collaborative initiatives for improving encounter data exchange processes in California, which include:

(a) The Integrated Healthcare Association Encounter Data Work Group; and

(b) The Industry Collaborative Efforts (ICE) Encounter Data Work Group.

1.08 Data Aggregation Across Health Plans

Covered California and Contractor recognize the importance of aggregating data across purchasers and payors to more accurately understand the performance of Providers that have contracts with multiple health plans. Such aggregated data reflecting a larger portion of a Provider, group, or facility's practice can potentially be used to support performance improvement, contracting and public reporting.

1) Contractor will be required to report in its annual application for certification for negotiation purposes, its participation in initiatives to support the aggregation of claims and clinical data. Contractor must include its assessment of additional opportunities to improve measurement and reduce the burden of data collection on Providers through such proposals as a statewide All Payor Claims Database.

   Examples include but are not limited to:

   (a) The Integrated Health Association (IHA)

   (b) The CMS Physician Quality Reporting System

   (c) CMS Hospital Compare

   (d) CalHospital Compare

ARTICLE 2
PROVISION AND USE OF DATA AND INFORMATION FOR QUALITY OF CARE

2.01 HEDIS and CAHPS Reporting

Contractor shall annually collect and report to Covered California, for each QHP Issuer product type, its Quality Rating System HEDIS, CAHPS and other performance data (numerators, denominators, and rates). Contractor must provide such data to Covered California each year regardless of the extent to which CMS uses the data for public reporting or other purposes.

Contractor shall submit to Covered California HEDIS and CAHPS scores to include the measure numerator, denominator, and rate for the required measures set that is reported to the National Committee for Quality Assurance (NCQA) Quality Compass and DHCS, for each Product Type for which it collects data in California. The timeline for Contractor's HEDIS and CAHPS quality data must be submitted at the same time as Contractor submits this to the NCQA Quality Compass and DHCS. Covered California reserves the right to use the Contractor-reported measures to construct Contractor summary quality ratings that Covered California may use for such purposes as supporting consumer choice and Covered California's oversight of Contractor's QHPs.

2.02 Data Submission Requirements

1) General

(a) The parties mutually agree that California law requires Contractor to provide Covered California with information on cost, quality, and disparities to evaluate the impact of Covered California on the health delivery system and health coverage in California, including information from qualified health plan issuers since the inception of Covered California, both inside and outside of the Exchange.

(b) The parties also mutually agree that California law requires Contractor to provide Covered California with data needed to conduct audits, investigations, inspections, evaluations, analyses, and other activities needed to oversee the operation of the Exchange. California law likewise requires that such data be provided in a form, manner, and frequency which Covered California shall specify, which may include but need not be limited to financial and other data pertaining to Covered California's oversight obligations.

(c) The data which Contractor is required to provide ("HEI Data") may include, but need not be limited to, data and other information pertaining to quality measures affecting enrollee health and improvements in healthcare care coordination and patient safety. This data may likewise include enrollee claims and encounter data needed to monitor compliance with applicable provisions of this Agreement pertaining to improvements in health equity and disparity reductions, performance improvement strategies, individual payment methods, as well as enrollee-specific financial data needed to evaluate enrollee costs and utilization experiences.

(d) The Parties mutually agree and acknowledge that financial and other data needed to evaluate enrollee costs and utilization experiences shall include, but

need not be limited to information pertaining to contracted provider reimbursement rates and historical data for consumers who have obtained healthcare coverage both through and outside of the Exchange.

(e) As detailed below, certain HEI Data submissions shall initially be transmitted to Covered California through a vendor which has been authorized by Covered California to receive and collect such data on Covered California's behalf. Notwithstanding the foregoing, the parties mutually agree and acknowledge that the form, manner, and frequency wherein Covered California may require the submission of HEI Data may, in Covered California's discretion, require the use of alternative methods for the submission of any such data. Such alternative methods may include but need not be limited to data provided indirectly through a vendor or directly to Covered California either via the terms of this Agreement or the certification process for Exchange participation.

(f) The parties further mutually agree that the aforementioned data may include information which represents Protected Health Information ("PHI") for purposes of the HIPAA Privacy Rule (45 CFR §160.103).

2) Disclosures to Healthcare Evidence Initiative Vendor (HEI Vendor):

(a) Covered California has entered into a contract with an HEI Vendor to assist with its health oversight functions and activities. Under the terms of its contract with Covered California, HEI Vendor has been authorized to collect, store, and process HEI Data which Contractor is required to provide on Covered California's behalf.

(b) To facilitate the submission of HEI Data to HEI Vendor, Contractor shall execute a data use or other similar agreement ("DUA") with HEI Vendor, which shall at all times govern the submission of HEI Data from Contractor to HEI Vendor. Prior to execution, Contractor shall provide a draft copy of the DUA for review and approval to the Covered California Privacy Office at privacyofficer@covered.ca.gov. Contractor shall at all times ensure that the DUA is current, up-to-date, and consistent with the terms and conditions of this Agreement and shall provide the Privacy Office with draft copies of any revisions, modifications, or amendments to the DUA prior to execution.

3) HEI Vendor Designation:

(a) As of the date of this Agreement, Covered California has selected IBM Watson to serve as its HEI Vendor. Should Covered California terminate its contract with HEI Vendor, Covered California shall provide written notice to Contractor in accordance with the terms and conditions of this Agreement.

(b) Upon receipt of the aforementioned written notice from Covered California, Contractor shall terminate its DUA with IBM Watson in accordance with the terms and conditions specified therein and shall discontinue the provision of HEI Data to IBM Watson.

(c) Covered California shall notify Contractor of the selection of an alternative HEI Vendor as soon as reasonably practicable and the parties shall at all times cooperate in good faith to ensure the timely execution of a new DUA between

Contractor and the new HEI Vendor which shall govern the provision of HEI Data to the new HEI Vendor.

4) HIPAA Privacy Rule:

(a) PHI Disclosures Required by California law:

i) California law requires Contractor to provide HEI Data in a form, manner, and frequency determined by Covered California. Covered California has retained and designated HEI Vendor to collect and receive certain HEI Data information on its behalf.

ii) Accordingly, the parties mutually agree and acknowledge that the disclosure of any HEI Data information to Covered California or to HEI Vendor which represents PHI is permissible and consistent with applicable provisions of the HIPAA Privacy Rule which permit Contractor to disclose PHI when such disclosures are required by law (45 CFR §164.512(a)(1)).

(b) PHI Disclosures For Health Oversight Activities:

i) The parties mutually agree and acknowledge that applicable California law (CA Gov Code §100503.8) requires Contractor to provide Covered California with HEI Data for the purpose of engaging in health oversight activities and declares Covered California to be a health oversight agency for purposes of the HIPAA Privacy Rule (CA Gov Code §100503.8).

ii) The HIPAA Privacy Rule defines a "health oversight agency" to consist of a person or entity acting under a legal grant of authority from a health oversight agency (45 CFR §164.501) and HEI Vendor has been granted legal authority to collect and receive HEI Data from Contractor on Covered California's behalf.

iii) Accordingly, the parties mutually acknowledge and agree that the provision of any HEI Data by Contractor to Covered California or HEI Vendor is permissible under applicable provisions of the HIPAA Privacy Rule which permit the disclosure of PHI for health oversight purposes (45 CFR §164.512(d).

5) Publication of Data and Public Records Act Disclosures:

(a) The parties mutually acknowledge and agree that California law requires Covered California to publish certain HEI Data provided by Contractor pertaining to its cost-reduction efforts, quality improvements, and disparity reductions.

(b) Notwithstanding the foregoing, the parties mutually acknowledge and agree that data shall at all times be disclosed in a manner which protects the Personally-Identifiable Information of Contractor's enrollees.

(c) The parties further acknowledge and agree that records which reveal contracted rates paid by Contractor to health care providers, as well as any enrollee cost share, claims or encounter data, cost detail, or information pertaining to enrollee

payment methods, which can be used to determine contracted rates paid by Contractor to health care providers shall not at any time be subject to public disclosure and shall at all times be deemed to be exempt from compulsory disclosure under the Public Records Act.

~~Contractor and Covered California agree that the assessment of quality and value offered by a QHP to Enrollees is dependent on consistent, normalized data, so that the Contractor and Covered California can evaluate the experience of Contractor's membership, and compare that experience to the experience of Enrollees covered by other QHP Issuers, and to the Covered California population as a whole. In order to conduct this assessment, the Contractor shall provide certain information currently captured in contractor's information systems related to its participation in the Exchange to the EAS Vendor in a manner consistent to that which Contractor currently provides to its major purchasers.~~

~~1) Disclosures to Enterprise Analytics Vendor:~~

~~(a) Covered California has entered into a contract with an Enterprise Analytics Solution Vendor ("EAS Vendor") to support its oversight and management of the Exchange. The EAS Vendor has provided Contractor with a written list of data elements ("EAS Dataset") and a data submission template that defines the data elements and format for transmitting the data. Contractor shall provide EAS Vendor with the data identified in the EAS Dataset on a monthly basis, which is attached as Appendix 1 to this Attachment 7. The parties may modify the data fields in Appendix 1 to Attachment 7 upon mutual agreement of the parties, and without formal amendment to this Agreement.~~

~~(b) To enable the submission of the EAS Dataset to EAS Vendor, Contractor has executed a Business Associate Agreement ("BAA"), and any other agreements that Contractor determines are required for the submission of the EAS Dataset to EAS Vendor. Contractor's obligation to provide any data to EAS Vendor is contingent on a BAA being in force at the time information is to be provided to EAS Vendor. Covered California may, upon request to Contractor, review such BAA and any other agreements between Contractor and EAS Vendor related to the submission of the EAS Dataset.~~

~~2) Disclosures to Covered California:~~

~~(a) EAS Vendor must protect the EAS Dataset submitted to it by Contractor pursuant to the BAA and any other agreements entered into with Contractor, applicable federal and state laws, rules and regulations, including the HIPAA Privacy and Security Rules.~~

~~(b) Any data extract or report ("EAS Output") provided to Covered California and generated from the EAS Dataset shall at all times be limited to de-identified data. Covered California shall not request any Personally Identifiable Health Information from EAS Vendor or attempt to use the de-identified data it receives from EAS Vendor to re-identify any person.~~

~~3) EAS Vendor Designation:~~

~~(a) IBM Watson Health is Covered California's current EAS Vendor. In the event that Covered California terminates its contract with IBM Watson Health during the term of this Agreement, Covered California shall provide notice to Contractor pursuant to Section 12.3 of the Agreement.~~

~~(b) Any such termination of the agreement with IBM Watson Health shall excuse any performance of Contractor under this Section 2.02 effective on the date of termination of the agreement with IBM Watson Health until a replacement EAS Vendor is designated.~~

~~4) Covered California is a Health Oversight Agency:~~

~~(a) Covered California continues to maintain that it operates as a Health Oversight Agency as described by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended. As such, Contractor may disclose protected health information to Covered California, or its vendor, in order for Covered California to perform its mandated oversight activities. At such time that Covered California receives technical assistance from the Office for Civil Rights, or otherwise receives guidance from the federal government, that reasonably confirms Covered California's status as a Health Oversight Agency, Contractor shall provide Covered California, or its vendor, with the necessary data elements, including protected health information as permitted by state and federal laws, in order for Covered California to perform its mandated oversight activities.~~

2.03 Quality and Delivery System Reform Reporting

Contractor will be required to respond to questions identified and required by the Exchange in the annual certification application related to quality and delivery system reform requirements in this Attachment 7.

Such information will be used by Covered California to evaluate Contractor's performance under the terms of the Quality, Network Management, Delivery System Standards and Improvement Strategy and in connection with the evaluation regarding any extension of this Agreement and the certification process for subsequent years. The timing, nature and extent of such responses will be established by Covered California based on its evaluation of various quality-related factors.

2.04 Data Measurement Specifications

Contractor shall report metrics specified herein, as mutually agreed upon by both parties, and as requested by Covered California. Covered California and Contractor agree to work collaboratively during the term of this Agreement to enhance the data specifications and further define the requirements.

ARTICLE 3
REDUCING HEALTH DISPARITIES AND ENSURING HEALTH EQUITY

Mitigation of health disparities is central to the mission of Covered California, and the California Language Assistance Act adopted as SB 853 in 2003. In alignment with these principles, Covered California and Contractor recognize that promoting better health requires a focus on addressing health disparities and health equity. Covered California will require Contractor to track, trend and reduce health disparities with the phased approach outlined below.

3.01 Measuring Care to Address Health Equity

Contractor must track and trend quality measures by racial or ethnic group, or both, and by gender for the Contractor's full book of business, excluding Medicare.

1) Identification:

   (a) By year end 2019 and annually thereafter, Contractor must achieve eighty percent (80%) self-identification of racial or ethnic identity for Covered California enrollees.

   (b) In the annual application for certification, Contractor will be required to report the percent of self-reported racial or ethnic identity for Covered California enrollees.

   (c) To the extent Contractor does not have self-reported information on racial or ethnic identity, or both, it shall use a standardized tool for proxy identification through the use of zip code and surname to fill any gaps in information.

2) Measures for Improvement:

   (a) Disparities in care by racial and ethnic identity and by gender will be reported annually by QHP Issuers based on its Enrollees. The tool for proxy identification shall be used to supplement self-reported racial or ethnic identity. Contractor agrees to work with Covered California to provide comparison reporting for its other lines of business where comparative data can offer meaningful reference points.

   (b) Measures selected for improvement beginning in plan year 2017 include Diabetes, Hypertension, Asthma (control plus hospital admission rates), and Depression (HEDIS appropriate use of medications).

   (c) Covered California will consider adding additional measures for plan year 2021 and beyond.

3.02 Narrowing Disparities

While Covered California and Contractor recognize that some level of disparity is determined by social and economic factors beyond the control of the health care delivery system, there is agreement that health care disparities can be narrowed through quality improvement activities tailored to specific populations and targeting select measures at the health plan level. Covered California and the Contractor agree that collection of data on clinical measures for the purpose of

population health improvement requires development and adoption of systems for enhanced information exchange (see Section 1.07).

1) Contractor reported baseline measurements from plan years 2015, 2016, 2017, and 2018, on the measures listed in the Measurement Specifications document, based either on self-reported identity or on proxy identification on its Enrollees. Covered California anticipates that this baseline data may be incomplete. The Measurement Specifications document is posted on the Contractors extranet website provided by Covered California (Plan Home, in the Resources folder, Health Disparities Reduction – Measurement Specifications folder).

2) Targets for year end 2020 and for annual intermediate milestones in reduction of disparities will be established by Covered California based on national benchmarks, analysis of variation in California performance, best existing science of quality improvement, and effective engagement of stakeholders.

3.03 Expanded Measurement

Contractor and Covered California will work together to assess the feasibility and impact of extending the disparity identification and improvement program over time. Areas for consideration include:

1) Income

2) Disability status

3) Sexual orientation

4) Gender identity

5) Limited English Proficiency (LEP)

3.04 NCQA Certification

Meeting the standards for Multicultural Health Care Distinction by NCQA is encouraged as a way to build a program to reduce documented disparities and to develop culturally and linguistically appropriate communication strategies. To the extent Contractor has applied for or received NCQA Certification, Contractor must provide this information with its annual application for certification. Covered California may publicly recognize this achievement and include it in information provided to consumers.

ARTICLE 4
PROMOTING DEVELOPMENT AND USE OF EFFECTIVE CARE MODELS

Covered California and Contractor agree that promoting the Triple Aim requires a foundation of effectively delivered primary care and integrated services for patients that is data driven, team based and crosses specialties and institutional boundaries. Contractor agrees to actively promote the development and use of care models that promote access, care coordination, and early identification of at-risk enrollees and consideration of total costs of care. Contractor agrees to design networks and payment models for Providers serving Enrollees to reflect these priorities.

In particular, Covered California's priority models which align with the CMS requirements under the QIS, are:

1) Effective primary care services, including ensuring that all enrollees have a Primary Care clinician,

2) Promotion of Patient-Centered Medical Homes (PCMH), which use a patient-centered, accessible, team-based approach to care delivery, member engagement, and data-driven improvement as well as integration of care management for patients with complex conditions, and

3) Accountable Care Organizations (ACOs) are integrated, coordinated, and accountable systems of care including multi-discipline physician practices, hospitals, and ancillary Providers with combined risk sharing arrangements and incentives between Contractor and Providers.

4.01 Primary Care

Contractor must ensure that all Enrollees either select or be provisionally assigned to a Primary Care clinician within sixty (60) days of effectuation into the plan. If an Enrollee does not select a Primary Care clinician, Contractor must provisionally assign the Enrollee to a Primary Care clinician, inform the Enrollee of the assignment, and provide the enrollee with an opportunity to select a different Primary Care clinician. When assigning a Primary Care clinician, Contractor shall use commercially reasonable efforts to assign a Primary Care clinician consistent with an Enrollee's stated gender, language, ethnic and cultural preferences, geographic accessibility, existing family member assignment, and any prior Primary Care clinician. Contractor will be required to report on this requirement annually in the application for certification for negotiation and evaluation purposes regarding any extension of this Agreement. The Exchange will evaluate the effectiveness of this policy based on criteria mutually agreed upon between the Exchange and Contractor. If requested, Contractor agrees to provide the Exchange with data and other information to perform this evaluation.

4.02 Patient-Centered Medical Homes

A growing body of evidence shows that advanced models of primary care, often called Patient-Centered Medical Homes (PCMH), greatly improve the care delivered to patients and support Triple Aim goals. Contractor must provide this information with its annual application for certification.

1) Covered California will provide Contractor with necessary data for Contractor to perform analysis on their networks to assess the adoption and growth of advanced primary care among providers. Contractor agrees to use any of the following recognition programs to determine which network providers meet standards for redesigned primary care:

   (a) NCQA Patient-Centered Medical Home recognition

   (b) The Joint Commission Primary Care Medical Home certification

   (c) Accreditation Association for Ambulatory Health Care, Inc. (AAAHC) Medical Home accreditation

   (d) URAC Patient-Centered Medical Home (PCMH) Certification

2) Contractor will be required to describe in its application for certification a payment strategy for adoption and progressive expansion among Providers caring for Enrollees that creates a business case for Primary Care Providers to adopt accessible, data-driven, team-based care (alternatives to face-to-face visits and care provided by non-MDs) with accountability for meeting the goals of the Triple Aim, including total cost of care.

3) Contractor will be required to report annually:

   (a) The number and percent of Covered California enrollees who obtain their primary care in a PCMH.

   (b) Covered California will establish targets for year end 2019 and annually thereafter for the percent of Covered California enrollees obtaining primary care in a PCMH based on national benchmarks, analysis of variation in California performance, and best existing science of quality improvement and effective engagement of stakeholders.

   (c) A baseline of the percent of Primary Care clinicians whose contracts for Covered California Enrollees are based on the payment strategy defined in 4.02(2) for primary care services.

   (d) Methods for enrolling or attributing members to a PCMH including whether the plan engages in formal enrollment and or outreach to members based on a risk algorithm.

   (e) How Contractor's payment to PCMH practices differs from those payments made to practices that have not met PCMH standards.

   (f) If Contractor participates in primary care improvement collaboratives like the California Quality Collaborative or the California Improvement Network.

   (g) If or how Contractor supports providers in primary care practice transformation through efforts such as providing practice coaches or investments in information technology.

4) Contractor agrees to work with Covered California to provide comparison reporting for its other lines of business to compare performance and inform future Covered California requirements where comparative data can offer meaningful reference points. The non-Covered California lines of business data are to support contract negotiations in setting targets and requirements for Covered California-only business and any required data will be submitted as part of Contractor's annual application for certification, which will be used for negotiation and evaluation purposes regarding any extension of this Agreement.

4.03 Accountable Care Organizations (ACO)

Covered California places great importance on the adoption and expansion of integrated, coordinated, and accountable systems of care such as Accountable Care Organizations (ACOs):

1) The ACO is defined as:

   (a) A system of population-based care coordinated across the continuum including multi-discipline physician practices, hospitals, and ancillary Providers.

   (b) Having combined risk sharing arrangements and incentives between Contractor and Providers, and among Providers across specialties and institutional boundaries, holding the ACO accountable for nationally recognized evidence-based clinical, financial, and operational performance, as well as incentives for improvements in population outcomes. As Providers accept more accountability under this provision, Contractors shall ensure that Providers have the capacity to manage the risk.

2) Contractor must provide Covered California with details on its existing or planned integrated systems of care describing how the systems meet the criteria in Article 4.03(1), including the number and percent of Enrollees who are managed under ACOs in its response to the annual application for certification, which will be used for negotiation and evaluation purposes regarding any extension of this Agreement.

3) Target for year end 2019 and annually thereafter for the percentage of Enrollees who select or are attributed to ACOs will be established by Covered California based on national benchmarks, analysis of variation in California performance, best existing science of quality improvement, and effective engagement of stakeholders.

4) Contractor agrees to work with Covered California to provide comparison reporting for all lines of business to compare performance and inform future Covered California requirements where comparative data can offer meaningful reference points, starting with the 2018 plan year data. The non-Covered California lines of business data are to support contract negotiations in setting targets and requirements for Covered California-only business and any required data will be required as part of Contractor's annual application for certification.

   (a) The basis for analysis of variation in performance of different ACO models shall be the Commercial ACO Measure Set as updated by the Integrated Healthcare Association (IHA) and published at: http://www.iha.org/our-work/accountability/commercial-aco.

(b) Comparison reporting using the Commercial ACO Measure Set will begin once data becomes available for plan year 2018.

4.04 Behavioral Health

Covered California and Contractor recognize the critical importance of behavioral health services, including mental health and substance use disorder services, as part of the broader set of medical services provided to Enrollees.

Contractor will be required to report in its annual application for certification on the strategies Contractor has implemented and its progress in:

1) Making behavioral health services available to Enrollees;

2) Measuring access and quality to ensure Enrollees receive appropriate, evidence-based treatment, and provide the outcomes for these measures;

3) Improving accessibility and quality of behavioral health services; and

4) Integrating behavioral health services with Medical Services.

Reports must include documenting the percent of services provided under an integrated behavioral health-medical model for Enrollees and the reports should include the percent for Contractor's overall covered lives, where such information is useful for comparison purposes and informing future Covered California requirements. These reports should also include whether these models are implemented in association with PCMH and ACO models or are independently implemented and will be used for negotiation and evaluation purposes regarding any extension of this Agreement and reported in the annual application for certification.

Contractor agrees to actively participate in the statewide effort through Smart Care California to promote the appropriate use of opioids and lower opioid overdose deaths (https://www.iha.org/our-work/insights/smart-care-california/focus-area-opioids). To the extent possible, Contractor agrees to implement policies and programs that align with the Smart Care California priority areas:

1) Prevent: decrease the number of new starts: fewer prescriptions, lower doses, shorter durations;

2) Manage: identify patients on risky regimens (high-dose, or opioids and sedatives) and develop individualized treatment plans, avoiding mandatory tapers;

3) Treat: streamline access to evidence-based treatment for substance use disorder at all points in the health care system; and

4) Stop deaths: promote data-driven harm reduction strategies, such as naloxone access and syringe exchange.

4.05 Telehealth and Remote Monitoring

In the annual application for certification, Contractor will be required to report the extent to which the Contractor is supporting and using technology to assist in higher quality, accessible, patient-centered care, and the utilization for Enrollees on the number of unique patients and number of separate servicing provided for telehealth and remote home monitoring. Contractor agrees to

work with Covered California to provide comparison reporting for its other lines of business to compare performance and inform future requirements for the Exchange where comparative data can offer meaningful reference points. Such information will be used for negotiation and evaluation purposes regarding any extension of this Agreement and the annual certification process for subsequent years.

Reporting requirements will be met through completing the annual application for certification, but contractor may supplement such reports with data on the efficacy and impact of such utilization. These reports must include whether these models are implemented in association with PCMH and ACO models or are independently implemented.

ARTICLE 5
HOSPITAL QUALITY

Covered California and Contractor recognize that hospitals have contracts with multiple health plans and are engaged in an array of quality improvement and efficiency initiatives. Hospitals play a pivotal role in providing critical care to those in the highest need and should be supported with coordinated efforts across health plans and purchasers.

5.01 Hospital Payments to Promote Quality and Value

Covered California expects its Contractors to pay differently to promote and reward better quality care rather than pay for volume. Contractor shall:

1) Adopt a hospital payment methodology that incrementally places at least six percent (6%) of reimbursement to hospitals for Contractor's Covered California business with each general acute care hospital at-risk or subject to a bonus payment for quality performance. At minimum, this methodology shall include two percent (2%) of reimbursement by year end 2019 with a plan for satisfying future increases in reimbursement, four percent (4%) of reimbursement by year end 2021, and six percent (6%) by year end 2023. Contractor may structure this strategy according to its own priorities such as:

   (a) The extent to which the payments "at risk" take the form of bonuses, withholds, or other penalties; or

   (b) The selection of specific metrics upon which performance based payments are made may include, but are not limited to, Hospital Acquired Conditions (HACs) including Hospital Acquired Infections (HAIs), readmissions, or satisfaction measured through the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAPS), but Contractor must use standard measures commonly in use in hospitals and that are endorsed by the National Quality Forum – with the goal of limiting measurement burden on hospitals.

   (c) Contract arrangements with hospitals that participate in Accountable Care Organizations, whether sponsored by the Contractor or by Provider organizations, which include accountability or shared risk for total cost of care shall be considered to have met this requirement.

2) Because there is some evidence that readmissions may be influenced by social determinants beyond the control of the health care system or social supports that a hospital can provide at discharge, if Contractor includes readmissions as a measure under this provision, it shall not be the only measure. Additionally, Contractor must adopt balancing measures to track, address, and prevent unintended consequences from at-risk payments including exacerbation of health care disparities. Contractor shall report what strategies it is implementing to support hospitals serving at-risk populations in achieving target performance. In alignment with CMS rules on payments to hospitals for inpatient hospital services, Critical Access Hospitals as defined by the Centers for Medicare and Medicaid, are excluded from this requirement. In addition, the following types of hospitals are excluded from this requirement:

   (a) Long Term Care hospitals

(b) Inpatient Psychiatric hospitals

(c) Rehabilitation hospitals

(d) Children's hospitals

Contractor shall still be accountable for the quality of care and safety of Covered California members receiving care in the aforementioned hospitals. Implementation of this requirement may differ for integrated delivery systems and require alternative mechanisms for tying payment to performance.

3) Report in its annual application for certification for negotiation purposes, for Enrollees, the:

(a) Amount, structure, and metrics for its hospital payment strategy;

(b) The percent of network hospitals operating under contracts reflecting this payment methodology;

(c) The total dollars and percent or best estimate of hospital payments that are tied to this strategy; and

(d) The dollars and percent, or best estimate that is respectively paid or withheld to reflect value. The hospital payments to promote value must be distinct from shared-risk and performance payments to hospitalization related to participation in ACOs as described in Article 4.03.

Additionally, Contractor agrees to work with Covered California to provide comparison reporting for Contractor's entire book of business where comparative data can offer meaningful reference points. Such information will be used for negotiation and evaluation purposes regarding any extension of this Agreement.

5.02 Hospital Patient Safety

1) Contractor agrees to work with Covered California to support and enhance acute general hospitals' efforts to promote safety for their patients. Exclusions for this requirement include CMS Critical Access Hospitals as defined by the Centers for Medicare and Medicaid. In addition, the following types of hospitals are excluded:

(a) Long Term Care hospitals

(b) Inpatient Psychiatric hospitals

(c) Rehabilitation hospitals

(d) Children's hospitals

2) Contractor will annually report strategy to improve safety in network hospitals, informed by review of specified HAC rates in all network hospitals. HAC rates will be provided by Covered California from established sources of clinical data such as rates reported by hospitals to the National Healthcare Safety Network (NHSN), or the California Department of Public Health (CDPH). Such information will be used for negotiation and evaluation purposes regarding any extension of this Agreement.

3) Covered California has identified an initial set of HACs for focus. Certain HACs may be substituted for others if a common data source cannot be found. The decision to substitute HACs would be made transparently and collaboratively through the advisory process. The HACs that are currently the subject of the hospital safety initiatives are listed below:

(a) Catheter Associated Urinary Tract Infection (CAUTI);

(b) Central Line Associated Blood Stream Infection (CLABSI);

(c) Surgical Site Infection (SSI) with focus on colon;

(d) Methicillin-resistant Staphylococcus aureus (MRSA); and

(e) Clostridium difficile colitis (C. Diff) infection.

Contractor agrees to work with its contracted hospitals to continuously pursue a standardized infection ratio (SIR) of 1.5 or lower for each of the specified HAIs prioritizing hospitals that care for a high-volume of the Contractor's Enrollees.

4) The subject HACs may be revised in future years. Covered California expects to include adverse drug events (ADEs) including inappropriate use of opioids and blood thinners, hypoglycemia, and Sepsis Mortality when standardized definitions and measurement strategies have been adopted by CMS or by a coalition of Partnership for Patients grantees in California.

5) Covered California expects Contractor to only contract with hospitals that demonstrate they provide quality care and promote the safety of Enrollees. To meet this expectation Covered California will work with QHP Issuers and with California's hospitals to identify areas of "outlier poor performance" based on variation analysis of HAC rates. By year end 2020, as detailed in Article 1, 1.02(3), Contractors must either exclude hospitals that demonstrate outlier poor performance on safety from Provider networks serving Covered California or to document each year in its application for certification the rationale for continued contracting with each hospital that is identified as a poor performing outlier on safety and efforts the hospital is undertaking to improve its performance. Covered California does not expect Contractor to base outlier performance, and potential network removal decisions, on one HAC measure alone.

5.03 Appropriate Use of C-sections

Contractor agrees to actively participate in the statewide effort through Smart Care California to promote the appropriate use of C-sections. This ongoing initiative sponsored by Covered California, DHCS, and CalPERS as well as major employers has adopted the goal of reducing Nulliparous, Term Singleton, Vertex (NTSV) C-section rates to meet or exceed the national Healthy People 2020 target of twenty-three-point nine percent (23.9%) for each hospital in the state by year end 2019. In addition to actively participating in this collaborative, Contractor shall:

1) Work collaboratively with Covered California to promote and encourage all in-network hospitals that provide maternity services to use the resources provided by California Maternity Quality Care Collaborative (CMQCC) and enroll in the CMQCC Maternal Data Center (MDC).

2) Review information on C-section rate for NTSV deliveries and use it to inform hospital engagement strategy to reduce NTSV C-sections. Such information will also be used for negotiation and evaluation purposes regarding any extension of this Agreement.

3) Adopt a payment methodology progressively to include all contracted physicians and hospitals serving Enrollees, such that by year end 2019, payment is structured to support only medically necessary care and there is no financial incentive to perform C-sections. Smart Care California has outlined three payment strategies to align payment with medically necessary use of C-sections:

   (a) Adopt a blended case rate payment for both physicians and hospitals

   (b) Include a NTSV C-section metric in existing hospital and physician quality incentive programs

   (c) Adopt population-based payment models, such as ACO-like arrangements.

   Contractor must report on its payment methodology, how this methodology aligns with the Smart Care California payment strategies, and either the number or percent of hospitals contracted, as applicable, under this model in its annual application for certification.

4) Covered California expects Contractor to only contract with hospitals that demonstrate they provide quality care and promote the safety of Enrollees. Though Covered California does not expect Contractor to base outlier performance, and potential network removal decisions, on one measure alone, it is expected that Contractor will encourage providers with high rates of NTSV C-section delivery to pursue CMQCC coaching. Covered California expects Contractor to consider NTSV C-section rate, improvement trajectory, and willingness to engage in coaching as part of its maternity hospital contracting decisions and terms by year end 2019 and annually thereafter.

ARTICLE 6
POPULATION HEALTH: PREVENTIVE HEALTH, WELLNESS AND AT-RISK ENROLLEE SUPPORT

Covered California and Contractor recognize that access to care, timely preventive care, coordination of care, and early identification of high risk enrollees are central to the improvement of Enrollee health. Contractor and Covered California shall identify ways to increase access and coordination of care and work collaboratively to achieve these objectives.

6.01 Health and Wellness Services

Contractor shall ensure Enrollees have access to preventive health and wellness services. For the services described below, Contractor must identify Enrollees who are eligible, notify Enrollees of their availability, and report utilization.

1) Necessary preventive services appropriate for each Enrollee. Contractor must report to Covered California the number and percent of Enrollees who utilize preventive services.

2) Tobacco cessation intervention, inclusive of evidenced-based counseling and appropriate pharmacotherapy, if applicable. Contractor must report to Covered California the number and percent of Enrollees who take advantage of the tobacco cessation benefit.

3) Obesity management, if applicable. Contractor must report to Covered California the number and percent of its Enrollees who take advantage of the obesity benefit.

4) To ensure the Enrollee health and wellness process is supported, Contractor must report on its:

   (a) Health and wellness communication processes delivered to its Enrollees and applicable Participating Providers, that take into account cultural and linguistic diversity; and

   (b) Processes to incorporate Enrollee's health and wellness information into Contractor's data and information specific to each individual Enrollee. This Enrollee's data is Contractor's most complete information on each Enrollee and is distinct from the Enrollee's medical record maintained by the Providers.

Contractor will be required to report on each of these four service categories in its annual application for certification. Additionally, Contractor agrees to work with Covered California to provide comparison reporting for its other lines of business to compare performance and inform future requirements for the Exchange where comparative data can offer meaningful reference points. The non-exchange line of business data is to support contract negotiations in setting targets and requirements for Exchange-only business and any required data will be submitted as part of Contractor's annual application for certification.

For each of the four service categories described above, Covered California working with appropriate stakeholders and the Contractor, will develop a measurement strategy based on national benchmarks, analysis of variation in California performance, best existing science of quality improvement, and effective engagement of stakeholders.

6.02 Community Health and Wellness Promotion

Covered California and Contractor recognize that promoting better health for Enrollees also requires engagement and promotion of community-wide initiatives that foster better health, healthier environments, and the promotion of healthy behaviors across the community. Contractor is encouraged to support community health initiatives that have undergone or are being piloted through systematic review to determine effectiveness in promoting health and preventing disease, injury, or disability and have been recommended by the Community Preventive Services Task Force.

Contractor will be required to report annually in its application for certification the initiatives, programs and projects that it supports that promote wellness and better community health for Enrollees, and is encouraged to report on such initiatives for Contractor's overall population. Such reports must include available results of evaluations of these community programs for Enrollees, including clinical or other health impacts and efficacy and will be used for negotiation and evaluation purposes regarding any extension of this Agreement.

Such programs may include:

1) Partnerships with local, state, or federal public health departments such as Let's Get Healthy California;

2) CMS Accountable Health Communities;

3) Voluntary health organizations which operate preventive and other health programs such as CalFresh; and

4) Hospital activities undertaken under the Community Health Needs Assessment required every three years under the Affordable Care Act.

6.03 Determining Enrollee Health Status and Use of Health Assessments

Contractor shall demonstrate the capacity and systems to collect, maintain, use, and protect from disclosure individual information about Enrollees' health status and behaviors in order to promote better health and to better manage Enrollees' health conditions.

To the extent the Contractor uses or relies upon Health Assessments to determine health status, Contractor shall offer, upon initial enrollment and on a regular basis thereafter, a Health Assessment in all threshold languages to all Enrollees over the age of 18, including those Enrollees that have previously completed such an assessment. If a Health Assessment tool is used, Contractor should select a tool that adequately evaluates Enrollees current health status and provides a mechanism to conduct ongoing monitoring for future intervention(s). In addition, Health Assessments should advise policyholders at the outset on how the information collected may be used, and explain that the member is opting in to receive information from the Contractor, and that participating in the assessment is optional.

6.04 Reporting to and Collaborating with Covered California Regarding Health Status

Contractor shall provide to Covered California, in a format that shall be mutually agreed upon, information on how it collects and reports, at both individual and aggregate levels, changes in Enrollees' health status. Reporting may include a comparative analysis of health status improvements across geographic regions and demographics.

Contractor shall report to Covered California its process to monitor and track Enrollees' health status, which may include its process for identifying individuals who show a decline in health status, and referral of such Enrollees to Contractor care management and chronic condition program(s) as defined in Section 6.05, for the necessary intervention. Contractor shall annually report to Covered California the number of Enrollees who are identified through their selected mechanism and the results of their referral to receive additional services.

6.05 Supporting At-Risk Enrollees Requiring Transition

Contractor shall be able to facilitate transitions of care with minimal disruption for Enrollees who are switching from one QHP Issuer to another or into or out of the Exchange marketplace. The Exchange is particularly concerned about QHP Issuer transitions of enrollment for At-Risk Enrollees, which includes Enrollees who are: 1) in the middle of acute treatment, third trimester pregnancy, or those who would otherwise qualify for Continuity of Care under California law, 2) in case management programs, 3) in disease management programs, or 4) on maintenance prescription drugs for a chronic condition.

In the event of a future service area reduction, the Exchange may automatically transition Contractor's Enrollees into a different QHP Issuer to avoid gaps in coverage.

If this occurs, the Contractor terminating Enrollees shall do the following:

1) Conduct outreach to alert all impacted Enrollees that their QHP with Contractor will be ending. Outreach will include instructions, timing, and options for enrolling with a new QHP Issuer.

2) Conduct outreach to At-Risk Enrollees with sensitive diagnosis, giving them the option to authorize Contractor to send their personal health information to the Enrollee's new QHP Issuer with the goal of improving the transition of care.

3) Send Enrollee health information relevant to creating transitions of care with minimal disruption to the Enrollee's new QHP Issuer for those Enrollees who have provided authorization to do so, as follows:

    (a) For all terminating Enrollees, send PCP on record.

    (b) For At-Risk Enrollees, send relevant personal health information to new QHP Issuer on behalf of those who authorize.

4) Conduct outreach to providers in impacted service areas to create Enrollee transitions with minimal disruption.

Contractors receiving terminating Enrollees from a Contractor under a service area withdrawal must do the following:

1) Identify At-Risk Enrollees, either through existing contractor practices, or through receipt of both health information from prior Contractor and the data file with transitioning enrollment information from Covered California (which would occur after these Enrollees have effectuated coverage).

2) Ensure At-Risk Enrollee care transition accounts for the Enrollee's medical situation; including participation in case or disease management programs, locating in-network Providers with appropriate clinical expertise, or any alternative therapies including specific drugs;

3) Establish internal processes to ensure all parties involved in the transition of care for At-Risk Enrollees are aware of their responsibilities. This includes anyone within or outside of the Contractor's organization who are needed to ensure the transition of prescriptions or provision of care;

4) Provide information on continuity of care program, including alternatives for transitioning to an in-network provider; and

5) Ensure terminating Enrollees have access to Contractor's formulary information prior to enrollment.

6.06 Identification and Services for At-Risk Enrollees

Contractor agrees to identify and proactively manage Enrollees with existing and newly diagnosed chronic conditions, including, diabetes, asthma, heart disease, or hypertension, and who are most likely to benefit from well-coordinated care ("At-Risk Enrollees"). Contractor agrees to support disease management activities at the plan or health care Provider level that meet standards of accrediting programs such as NCQA. Contractor shall provide Covered California with a documented process, care management plan and strategy for targeting and managing At-Risk Enrollees. Such documentation may include the following:

1) Methods to identify and target At-Risk Enrollees;

2) Description of Contractor's predictive analytic capabilities to assist in identifying At-Risk Enrollees who would benefit from early, proactive intervention;

3) Communication plan for known At-Risk Enrollees to receive information prior to Provider visit, including the provision of culturally and linguistically appropriate communication;

4) Process to update At-Risk Enrollee medical history in Contractor's maintained Enrollee health profile;

5) Process for sharing registries of Enrollees with their identified risk, as permitted by state and federal law, with appropriate accountable Providers, especially the enrollee's PCP;

6) Mechanisms to evaluate access within the Provider network on an ongoing basis, to ensure that an adequate network is in place to support a proactive intervention and care management program for At-Risk Enrollees;

7) Care and network strategies that focus on supporting a proactive approach to At-Risk Enrollee intervention and care management. Contractor agrees to provide Covered California with a documented plan and include "tools" and strategies to supplement or expand care management and Provider network capabilities, including an expansion or reconfiguration of specialties or health care professionals to meet clinical needs of At-Risk Enrollees;

8) Data on number of Enrollees identified and types of services provided.

6.07 Diabetes Prevention Programs

Starting January 1, 2018, Contractor must offer a CDC-recognized Diabetes Prevention Lifestyle Change Program, also known as a Diabetes Prevention Program (DPP), to all Enrollees ages 18 and older who meet the participation criteria. The DPP shall be available to all Enrollees in the geographic service area and covered under the $0 preventive services benefit or diabetes education benefit in the Patient-Centered Benefit Design Plans. Contractor's DPP must have pending or full recognition by CDC as a DPP and be accessed either online or in person. A list of recognized programs in California can be found at https://nccd.cdc.gov/DDT_DPRP/Programs.aspx.

ARTICLE 7
PATIENT-CENTERED INFORMATION AND SUPPORT

Empowering consumers with knowledge to support healthcare decision-making is a crucial part of Covered California's mission and naturally promotes the Triple Aim by supporting decisions consistent with the Enrollee's values and preferences and fostering consumer access to care.

Covered California and Contractor agree that valid, reliable, and actionable information relating to the cost and quality of healthcare services is important to Enrollees, Covered California, and Providers.

Thus, Covered California expects that Contractor will participate in activities necessary to provide this information to consumers. The specifics of this phased approach are described in Section 7.01 below.

7.01 Enrollee Healthcare Services Price and Quality Transparency Plan

1) In the annual application for certification, Contractor will have reported for negotiation and certification purposes, its planned approach to providing healthcare shopping cost and quality information available to all Enrollees. Covered California does not require using a specific form or format and recognizes that the timeline and expectations will differ, based on variables such as Contractor's membership size and current tool offerings. Regardless of how the requirement is fulfilled, the common elements at the end point of each Contractor planned approach must include:

   (a) Cost information:

      i. That enables Enrollees to understand their exposure to out-of-pocket costs based on their benefit design, including real time information on member accumulation toward deductibles, when applicable, and out of pocket maximums. Health Savings Account (HSA) user information shall include account deposit and withdrawal/payment amounts.

      ii. That enables Enrollees to understand Provider-specific consumer cost shares for prescription drugs and for care delivered in the inpatient, outpatient, and ambulatory surgery/facility settings. Such information must include the facility name, address, and other contact information and be based on the contracting rates to give the Enrollee estimates of out of pocket costs that are as accurate as possible.

      iii. Commonly used service information should be organized in ways that are useful and meaningful for consumers to understand.

   (b) Quality information:

      i. That enables Enrollees to compare Providers based on quality performance in selecting a Primary Care clinician or common elective specialty and hospital Providers.

      ii. That is based on quality measurement consistent with nationally-endorsed quality information in accordance with the principles of the Patient Charter for Physician Performance Measurement.

iii. That, as an interim step prior to integrating quality measurement into Provider chooser tools, can be provided by linking to:

a. The California Office of the Patient Advocate (www.opa.ca.gov/)

b. CMS Hospital Compare Program (https://www.medicare.gov/hospitalcompare/search.html)

c. CMS Physician Compare Program (https://www.medicare.gov/physiciancompare/)

iv. In addition, Contractor must recognize California hospitals that have achieved target rates for HACs and NTSV C-section utilization as defined in Article 5, Sections 5.02 and 5.03.

(c) Health Insurance Benefit Information. Contractor shall make available personalized benefit-specific information to all enrollees that includes accumulations of expenses applicable to deductible and out-of-pocket maximums.

(d) Contractor agrees to monitor care provided out of network to ensure that consumers understand that their cost share will be higher and are choosing care out of network intentionally.

(e) If Contractor product enrollment exceeds 100,000 for Covered California business, the cost and quality information shall be provided through an online tool easily accessible across a variety of platforms and made available by 2018. If Contractor enrollment is under 100,000 for Covered California business, the information may be provided by alternative means such as a call center.

2) Contractor will be required in its annual application for certification to:

(a) Report the number and percent of unique Enrollees for each of the consumer tools offered for the reporting period of the plan year.

(b) Report user experience with the tool (or equivalent service such as a call center) from a representative sample of users who respond to a survey which includes a user overall satisfaction with rating.

(c) Provide access and log-in credentials for Covered California staff per mutually agreeable terms to safeguard Contractor proprietary information and services.

Contractor agrees to work with Covered California to provide comparison reporting for its other lines of business to compare performance and inform future requirements for the Exchange where comparative data can offer meaningful reference points. The non-exchange line of business data is to support contract negotiations in setting targets and requirements for Exchange-only business and any required data will be submitted as part of Contractor's annual application for certification.

7.02 Enrollee Personalized Health Record Information

1) In its annual application for certification, Contractor will report for negotiation and certification purposes, the extent to which Enrollees can easily access personal health information or have reported its plan to provide such access through such tools as a Personal Health Record (PHR) or other "patient portal".

2) The content of such PHRs includes: medical records, billing and payment records, insurance information, clinical laboratory test results, medical images such as X-rays, wellness and disease management program files, clinical case notes, and other information used to make decisions about individuals.

3) Covered California, working with appropriate stakeholders and the Contractor, will develop a measurement strategy for tracking the use of personal health information based on national benchmarks, analysis of variation in California performance, best existing science of quality improvement, and effective engagement of stakeholders.

4) Contractor will provide access and log-in credentials for Covered California staff per mutually agreeable terms to safeguard Contractor proprietary information and services.

7.03 Enrollee Shared Decision-Making

Covered California requires deployment of decision-making tools to support Enrollees in understanding their medical diagnosis and treatment options to aid in discussion with their Provider. Educating Enrollees on their diagnosis and alternative treatment options is a powerful evidence-based approach to reducing overuse or misuse of clinical interventions.

Contractor agrees to promote and encourage patient engagement in shared decision-making with contracted Providers.

1) Contractor will be required to report in its annual application for certification specific information regarding the number of Enrollees who have accessed consumer information or have participated in a shared decision-making process prior to reaching an agreement on a treatment plan. For example, Contractor may adopt shared-decision-making practices for preference-sensitive conditions, including breast cancer, prostate cancer, and knee and hip replacements, that feature patient-decision-making aids in addition to physician opinions and present trade-offs regarding quality or length of life.

2) Contractor will be required to report in its annual application for certification the percentage of Enrollees with identified health conditions above who received information that allowed the Enrollee to share in the decision-making process prior to agreeing to a treatment plan.

3) Contractor will be required to report in its annual application for certification participation in these programs and their results, including clinical, patient experience and costs impacts.

4) These reports will be used for negotiation and evaluation purposes regarding any extension of this Agreement.

7.04 Reducing Overuse through Smart Care California

Contractor shall participate in Smart Care California. This multi-stakeholder work group facilitated by IHA, will leverage Choosing Wisely decision aids to support efforts to drive appropriate use of:

1) C-sections for NTSV deliveries;

2) Opioids; and

3) Evidence-based treatment for low back pain.

The mechanism for reduction of NTSV C-sections will be participation in Smart Care California, with the target of ensuring all network hospitals achieve rates of twenty-three-point nine percent (23.9%) or less by year end 2019 (see Section 5.03).

Improvement strategies and targets for 2020 as well as for annual intermediate milestones for the appropriate use of opioids and evidence-based treatment for low back pain will be established by Covered California in collaboration with other stakeholders participating in the workgroup based on national benchmarks, analysis of variation in California performance, and best existing science of quality improvement and effective engagement of stakeholders.

ARTICLE 8
PAYMENT INCENTIVES TO PROMOTE HIGHER VALUE CARE

8.01 Reward-based Consumer Incentive Programs

Contractor may, to the extent permitted by law, maintain or develop a Reward-based Consumer Incentive Program to promote evidence-based, optimal care for Enrollees with identified chronic conditions. To the extent Contractor implements such a program and to the extent such information is known, Contractor shall report participation rates and outcomes results, including clinical, patient experience, and cost impacts, to Covered California annually.

8.02 Value-Based Reimbursement Inventory and Performance

Contractor agrees to implement value-based reimbursement methodologies to Providers within networks contracted to serve Covered California. Value-based reimbursement methodologies must include those payments to hospitals and physicians that are linked to quality metrics, performance, costs and value measures, and must include the Contractor's entire book of business with the Provider.

1) Among the strategies for which Covered California has established requirements for payment strategies to support delivery system reforms are:

   (a) Advanced Primary Care or Patient-Centered Medical Homes (Section 4.02)

   (b) Accountable Care Organizations (Section 4.03)

   (c) Appropriate use of C-sections (Section 5.03)

   (d) Hospital Patient Safety (Section 5.02)

2) In addition to the required payment strategies above, Contractor will be required to report in its annual application for certification an inventory and evaluation of the impact of other value-based payment models it is implementing including, but not limited to:

   (a) Direct participation or alignment with CMMI innovative payment models such as the Oncology or Joint Replacement model; and

   (b) Adoption of new Alternative Payment Models associated with the implementation of the Medicare Access & CHIP Reauthorization Act of 2015 (MACRA).

8.03 Value-Pricing Programs

Contractor agrees to provide Covered California with the details of any value-pricing programs for procedures or in-service areas that have the potential to improve care and generate savings for Enrollees. Contractor agrees to share with Covered California, the results of programs that may focus on high cost regions or those with the greatest cost variation(s). These programs may include payment bundling pilots for specific procedures where wide cost variations exist.

8.04 Payment Reform and Data Submission

1) Contractor agrees to provide information to Covered California pursuant to this Article 8, understanding that Covered California will provide such information to the Catalyst for Payment Reform's (CPR) National Scorecard on Payment Reform and National Compendium on Payment Reform.

2) The CPR National Scorecard will provide a view of progress on payment reform at the national level and then at the market level as the methodology and data collection mechanisms allow.

3) The CPR National Compendium will be an up-to-date resource regarding payment reforms being tested in the marketplace and their available results. The Compendium will be publicly available for use by all health care stakeholders working to increase value in the system.

4) Contractor must annually report on the progress and impact of value-oriented payment initiatives imputed to the Purchaser's annual spend for the preceding calendar year, using both the format and calculation methodology in the annual certification application, and CPR's Payment Reform Evaluation Framework.

QUALITY, NETWORK MANAGEMENT, AND DELIVERY SYSTEM STANDARDS

GLOSSARY OF KEY TERMS

Accountable Care Organization (ACO) - A system of population-based care coordinated across the continuum including multi-discipline physician practices, hospitals, and ancillary Providers with combined risk sharing arrangements and incentives between health plans and Providers, and among Providers across specialties and institutional boundaries. The ACO is held accountable for nationally recognized evidence-based clinical, financial, and operational performance, as well as incentives for improvements in population outcomes. As Providers accept more accountability under this provision, health plans shall be aware of their obligations.

Bundled Payments (also known as Global Payment Bundles, episode-of-care payment, or global case rates) - An alternative payment method to reimburse healthcare Providers for services that provides a single payment for all physician, hospital, and ancillary services that a patient uses in the course of an overall treatment for a specific, defined condition, or care episode. These services may span multiple Providers in multiple settings over a period of time, and are reimbursed individually under typical fee-for-service models. The Payment Bundle may cover all inpatient/outpatient costs related to the care episode, including physician services, hospital services, ancillary services, procedures, lab tests, and medical devices/implants. Using Payment Bundles, Providers assume financial risk for the cost of services for a particular treatment or condition, as well as costs associated with preventable complications, but not the insurance risk (that is, the risk that a patient will acquire that condition, as is the case under capitation).

Care Management - Healthcare services, programs, and technologies designed to help individuals with certain long-term conditions better manage their overall care and treatment. Care management typically encompasses Utilization Management (UM), Disease Management (DM), and Case Management (CM). Care Management's primary goal is to prevent the sick from getting sicker, and avoiding acute care events. Care Management is usually considered a subset of Population Health Management.

Complex Conditions - Clinical conditions that are of a complex nature that typically involve ongoing case management support from appropriately trained clinical staff. Frequently, individuals have multiple chronic clinical conditions that complicate management ("polychronic") or may have a complex, infrequent specialty condition that requires specialized expertise for optimal management.

Contractor - The Health Insurance Issuer contracting with the Exchange under this Agreement to offer a QHP and perform in accordance with the terms set forth in this Agreement.

Delivery System Transformation - A set of initiatives taken by purchasers, employers, health plans, or Providers, together or individually, to drive the creation and preferred use of care delivery models that are designed to deliver higher value aligned with the "Triple Aim" goals of patient care experience including quality and satisfaction, improve the health of the populations, and reduce the per capita cost of Covered Services. Generally these models require improved care coordination, Provider and payor information sharing, and programs that identify and manage populations of individuals through care delivery and payment models.

Enrollees – Enrollee means each and every individual enrolled in a QHP offered through the Exchange for the purpose of receiving health benefits.

The Exchange – The California Health Benefit Exchange, doing business as Covered California and an independent entity within the Government of the State.

Health Disparities - Healthy People 2020 defines a health disparity as "a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion."9 Racial and ethnic disparities populations include persons with Limited English Proficiency. (LEP).

Health Equity - Healthy People 2020 defines health equity as the "attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities."

Health Insurance Issuer - Health Insurance Issuer has the same meaning as that term is defined in 42 U.S.C. § 300gg-91 and 45 C.F.R. § 144.103.

Patient Centered Medical Home - A health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family. Care is facilitated by registries, information technology, health information exchange, and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner. The medical home is best described as a model or philosophy of primary care that is patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety.

Primary Care - The provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health needs, developing a sustained partnership with patients, and practicing in the context of family and community. (IOM, 1978) Contractors may allow enrollees to select Nurse Practitioners and Physician Assistants to serve as their Primary Care clinician. Covered California does not require that Primary Care clinicians serve as a "gatekeeper" or the source of referral and access to specialty care. Covered California recognizes Internal Medicine, OBGYN, Pediatrics, General Practice, and Family Medicine as primary care specialties.

Population Health Management - A management process that strives to address health needs at all points along the continuum of health and wellbeing, through participation of, engagement with and targeted interventions for the population. The goal of a Population Health Management program is to maintain and/or improve the physical and psychosocial wellbeing of individuals through cost-effective and tailored health solutions.

Preventive Health and Wellness Services - The provision of specified preventive and wellness services and chronic disease management services, including preventive care, screening and immunizations, set forth under Section 1302 of the Affordable Care Act (42 U.S.C. Section 18022) under the Section 2713 of the Affordable Care Act (42 U.S.C. Section 300gg-13), to the extent that such services are required under the California Affordable Care Act.

Qualified Health Plan or QHP– A health care service plan contract or policy of insurance offered by a QHP Issuer and certified by Covered California.

Qualified Health Plan Issuer or QHP Issuer - means a licensed health care service plan or insurer that has been selected and certified by Covered California to offer QHPs through the Exchange.

Reference Pricing - A payor contracting, network management and enrollee information process that identifies and differentially promotes delivery system options for care based on transparent display of comparative costs for identical services or procedures, typically after each Provider has passed a quality assessment screen. In some cases, value pricing will identify the individual enrollee's out-of-pocket costs accounting for plan design and deductible status. While quality is incorporated in the process, typically there is no differentiation based on comparative quality once a threshold performance level is achieved.

Remote Patient Monitoring - A technology or set of technologies to enable monitoring of patients outside of conventional clinical settings (e.g. in the home), which may increase access to care and decrease healthcare delivery costs.

Reward Based Consumer Incentive Program - (aka: Value-Based Insurance Design) individualizes the benefits and claims adjudication to the specific clinical conditions of each high risk member and to reward participation in appropriate disease management & wellness programs. Positive Consumer Incentive programs help align employee incentives with the use of high-value services and medications, offering an opportunity for quality improvement, cost savings and reduction in unnecessary and ineffective care.

Shared Decision Making - The process of making decisions regarding health care diagnosis and treatment that are shared by doctors and patients, informed by the best evidence available and weighted according to the specific characteristics and values of the patient. Shared decision making combines the measurement of patient preferences with evidence-based practice.

Team Care - A plan for patient care that is based on philosophy in which groups of professional and non-professional personnel work together and share the work to identify, plan, implement and evaluate comprehensive client-centered care. The key concept is a group that works together toward a common goal, providing qualitative comprehensive care. The team care concept has its roots in team nursing concepts developed in the 1950's.

Telehealth – A mode of delivering professional health care and public health services to a patient through information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site and the health care provider is at a distant site.

Value Pricing - A payor contracting, network management and enrollee information process that identifies and differentially promotes delivery system options for care that provide better value through the identification and transparent display of comparative total cost, out-of-pocket cost for enrollees and standardized quality performance to allow for informed consumer choice and Provider referrals for individual services and bundles of services.

Value-Based Reimbursement - Payment models that rewards physicians and Providers for taking a broader, more active role in the management of patient health, and provides for a reimbursement rate that reflects results and quality instead of solely for specific visits or procedures.

L.A. Care
HEALTH PLAN

Board of Governors
MOTION SUMMARY

Date: June 4, 2020 **Motion No. FIN 100.0620**

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

Issue: Execute new contracts with Edifecs in the amount of $5,500,000 for risk adjustment data management and processing for Cal MediConnect (CMC) and L.A. Care Covered (LACC) lines of business.

☒ **New Contract** ☐ **Amendment** ☒ **Sole Source** ☐ **RFP/RFQ on** _____

Background: In 2017, the Board approved the funding of the first phase of modernization of L.A. Care's 20-year-old encounters processing system. This approval allowed L.A. Care to implement an encounters processing system by Edifecs. The improvements provide increased processing capabilities on an integrated platform, and replaced an older system that required a patchwork of solutions to keep it operational in an environment of ever changing business demands.

The next proposed function of the processing platform is the risk adjustment data management and processing for the CMC and LACC lines of business. Currently these processes are disjointed under various owners using a wide array of tools that are highly dependent on staff expertise and availability. This creates ongoing issues of quality and timeliness for deliverables. Although well-defined procedures help protect the processing, it requires significant ongoing resources to maintain. By utilizing the Edifecs platform for the risk adjustment data processing and management we will be able to take advantage of modern processing technology and provide better visibility to the data, end to end, and standardized approaches to delivering solutions and maintenance.

This project work will include a series of contracts. The contracts will include: External Data Gathering Environment (EDGE) server licenses and implementation ($800,000), Smart Encounters module licenses and implementation ($2,300,000), and the XPM licenses and implementation ($2,400,000). No request for proposal was conducted for this vendor because we are leveraging our investment in the new encounter processing platform and all the advantages it presents.

The current budget impact is projected to save approximately $1.4 million annually when all project components are fully operational. Moreover, better data management for current risk adjustment functions protects and enhances the $100 million in revenue for our CMC line of business and seeks to control our current expenditure of $80 million in risk adjustment transfer costs for the LACC line of business.

Member Impact: L.A. Care members will benefit from this motion through improvement in the financial performance of our CMC and LACC lines of business. This is accomplished through better alignment of the cost of needed care and the finances to support the delivery of this care.

Budget Impact: The cost of this strategic project was anticipated and part of the current Strategic Projects budget. The funding will take the project through to the end of 2022.

Board of Governors
MOTION SUMMARY

Motion: **To authorize staff to execute on the extension of additional capabilities of the Edifecs platform to address risk adjustment data processing modernization. This will include contracts totaling $5,500,000. This will include new software modules, licensing, implementation services, and maintenance for the period June 15, 2020 to September 30, 2022.**

Board of Governors
MOTION SUMMARY

Date: June 4, 2020 **Motion No. FIN 101.0620**

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

Issue: Amend a current contract with Change Healthcare Resources for additional $1,250,000 to provide Risk Adjustment analytics for the L.A. Care Covered (LACC) line of business through 2021.

☐ **New Contract** ☒ **Amendment** ☒ **Sole Source** ☐ **RFP/RFQ on** _____

Background: L.A. Care staff requests approval to amend a contract with Change Healthcare Resources from January 1, 2021 to December 31, 2021 in the amount of $1,250,000. This extension of budget covers the extended term and covers the additional funds required to complete the existing term. L.A. Care engaged Change Healthcare Resources in January 2018 for risk adjustment analytics services when the LACC membership was approximately 24,000. The original contract total amounts were based on a forecast of 50% growth in membership by the end of the contract term (December 31, 2020). However, due to market changes impacting the 2019 membership, LACC membership grew to 90,000. Since our contract with Change Healthcare Resources is based on fees using a per member, per month (PMPM) calculation, projected total cost to the end of the contract period, December 31, 2020, will exceed the contract's amount.

The vendor will provide us with ongoing analytics required to manage the risk adjustment functions for the LACC line of business. L.A. Care requires these services to ensure financial obligations to the Accountable Care Act (ACA) marketplace are properly aligned with the level of care needed by our members.

No request for proposal was conducted for this vendor because of the need to only extend the existing contract one additional year and because the services are under the existing contract. We have used this vendor since January 2018 and are pleased with their work. This function will be addressed by the Edifecs platform project (phase 3) that will be in production in 2021.

Member Impact: L.A. Care members will benefit from the continued availability of L.A. Care as a Qualified Health Plan (QHP) choice on the Exchange. The continued participation of L.A. Care on the health benefit exchange provides members who lose Medi-Cal eligibility continuity of care by enabling enrollment in the L.A. Care provider network through LACC.

Budget Impact: The cost was anticipated and included in the approved budget for the Enterprise Risk Adjustment Department in this fiscal year. We will budget the balance in future fiscal years.

Motion: **To authorize staff to amend a contract with Change Healthcare Resources for Affordable Care Act risk adjustment functions in the amount of $1,250,000 for a new contract total of $3,520,000 and to extend the contract through December 31, 2021.**

Board of Governors
MOTION SUMMARY

Date: June 4, 2020 **Motion No. FIN 102.0620**

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

Issue: Execute an amendment with Cognizant to extend the term for one year to continue providing Healthcare Effectiveness Data and Information Set (HEDIS) & The Align. Measure. Perform (AMP) services.

☐ **New Contract** ☒ **Amendment** ☐ **Sole Source** ☒ **RFP/RFQ was conducted in 2020**

Background: HEDIS reporting is required by Center for Medicare and Medicaid Services (CMS), Department of Health Care Services (DHCS), National Commission on Quality Assurance (NCQA), and Covered California. The Align. Measure. Perform (AMP) Program is administered by the Integrated Healthcare Association. Participation in the AMP Program is the primary way L.A. Care meets the Covered California requirement to offer some portion of reimbursement to our network using a value based payment methodology. Utilization of certified HEDIS software is required to complete the audit and submission process to these entities.

L.A. Care executed a 3-year agreement with Cognizant to provide HEDIS and AMP services in 2017, in the amount of $3,043,761. Since that agreement is due to expire in 2020, a request for proposal process was conducted from December 2019 through May 2020. Five vendors were evaluated, including our current vendor, Cognizant. Staff has concluded that it is best to delay implementation of a new HEDIS engine given current competing priorities and the additional challenges we are facing with the COVID-19 pandemic. Therefore, staff is requesting approval to extend the existing contract with Cognizant from September 2020 to September 2021 in the amount of $1,050,000.

L.A. Care will continue to work with Cognizant to improve its services and will re-evaluate its decision to change vendors within the next 6-12 months. Staff would also like to inform the Board that it is not uncommon, when changing HEDIS vendors, to run 2 systems in parallel during the transition to assure that the new system is developing valid rates.

Member Impact: The HEDIS engine, in addition to producing HEDIS rates for the plan, also drives services to members by identifying gaps in care for recommended services that are used to inform providers and PPGs to spur improvement in care for L.A. Care members.

Budget Impact: The cost is budgeted in FY 2019-2020, and anticipated for FY 2020-2021.

Motion: **To authorize staff to amend the existing contract with Cognizant to continue providing Healthcare Effectiveness Data and Information Set (HEDIS) & The Align. Measure. Perform (AMP) software and services for the period of September 2020 through September 2021 with fees not to exceed $1,050,000 for a contract total of $4,093,761.**

May 29, 2020

TO: Board of Governors

FROM: John Baackes, *Chief Executive Officer*

SUBJECT: CEO Report – June 2020

With about 10 stay-at-home weeks under our belt, I can confidently and proudly say that L.A. Care is not only surviving, but it is thriving and growing. This is truly a remarkable accomplishment that speaks volumes about the staff's dedication and perseverance amid the uncertainty we face. While many of my colleagues miss the regular face-to-face interactions, they have adapted to new ways of communicating. Even I have become accustomed to taking video calls and participating in virtual panels. This is the new normal – for now.

As you know, the economic and political fronts have also continued to evolve. We are now confronted with a pandemic-induced recession of epic proportions. The sheer number of job losses will undoubtedly bring a wave of new Medi-Cal enrollees. Rather than waiting to see how things unfold, L.A. Care has taken the lead among public and commercial plans in urging Congressional leaders to implement critical measures necessary to stabilize the Medicaid program. On a local level, we are working closely with our health care providers to figure out the best path forward in light of the imminent budget cuts to Medi-Cal.

There are many unknowns today but, as always, we will do everything in our control to ensure the best possible outcome for our members and providers.

Be well and be safe.

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

	Since last CEO report on 5/1/20	As of 5/29/20
Elevating the Safety Net Grants for primary care physicians	__	120 grants awarded
	7	86 physicians hired
Elevating the Safety Net Grants for medical school loan repayment	10	55
Elevating the Safety Net Grants for medical school scholarships	__	16
Housing for Health Housing secured for homeless households	__	255
IHSS+ Home Care Training IHSS worker graduates from CLTCEC program	311	2,780

Below please find updates for the month of May.

California's Latest Budget Proposal
Earlier this month, Governor Gavin Newsom unveiled a revision of the state budget that was initially presented in January, before the widespread outbreak of COVID-19. As a result of the economic damage from the pandemic, the state now projects an unprecedented $54 billion budget deficit. Given that health care spending accounts for a significant part of the state budget, it is not surprising the Governor is proposing massive cuts to the Medi-Cal program. Attached to this report you will find a summary from our Government Affairs team outlining the current budget proposals pertinent to LA. Care. As you will see, many of the cuts stand to negatively impact Medi-Cal health plans and safety net providers. The state legislature is expected to finalize the budget by June 15.

Provider Town Halls
In anticipation of the deep cuts to Medi-Cal, I believe it is our responsibility as a partner to our network of providers to share the latest information on Governor Newsom's proposed budget and its potential impact. As such, L.A. Care has quickly mobilized to organize five virtual town halls, one for each of our provider groups (hospitals, FQHCs, IPAs, SNFs and Direct Network). This platform will also allow L.A. Care leadership to answer our providers' most pressing questions and solicit input on how they plan to manage under these circumstances – and explore ways we can help. The town halls will take place from May 29 through June 5. Attached to this report you will find a copy of the presentation we are sharing with our providers. Again, I consider this to be part of our commitment to working with our providers as partners – and I look forward to sharing the outcome of these meetings.

Federal Medicaid Funding
While the federal government continues to debate about the details of the next economic relief package, L.A. Care continues to push Congress to stabilize Medicaid in the wake of the crushing COVID-19 job losses that are certain to mean a flood of new Medicaid enrollees across the country. Earlier in May, L.A. Care and 26 other health plans from across the country submitted a letter to congressional leadership calling for legislation to ensure Medicaid can continue to give the most vulnerable people in the country access to health care. Congress shored up the Medicaid system after the 2008 financial crisis and it is critical that lawmakers do the same now. The pandemic has resulted in even more jobs losses than during the last recession, and state budgets cannot handle the expected influx of Medicaid enrollees. Attached to this report you will find the most recent letter we sent to Congressional leadership.

Attachments:

- L.A. Care Provider Town Halls Presentation
- California Budget Proposal – May Revise Highlights
- Medicaid Relief Letter to Congress

State Budget
Proposed Medi-Cal Budget

Budget Summary

- The Administration projects a $54B budget deficit.
- In accordance with state law, the Legislature has until June 15th to submit its budget to the Governor for final review and enactment by July 1st.
- The Administration has proposed substantial cuts to the Medi-Cal program to accommodate the budget deficit.
- The cuts are categorized in two buckets:
  - Some cuts are ‘triggered’ - in the event of federal aid in another COVID related stimulus or relief package directed to states, these cuts will be restored.
  - Cuts not labeled as ‘triggered’ are assumed to be unaffected by any federal aid related to COVID.
- The Medi-Cal budget is $99.5B in 2019-20 and $112.1B in 2020-21.

Medi-Cal Budget Proposal Highlights

- Expansion of Medi-Cal enrollment
  - Pre pandemic 12.9M enrollees
  - July 2020 estimate 14.5M - *this is highly unlikely until later based on Medi-Cal applications at County DPSS offices.*
- Medi-Cal rate reductions
  - 1.5% reduction in Medi-Cal Managed Care Plans (MMP) rates retroactive to July 2019 through December 2020 - the bridge period. CA is moving to a calendar fiscal year for Medi-Cal rating from a July to June fiscal year.
  - Reduction applies to **major** aid categories - Adult, Child, Optional Expansion, and SPD. Maternity, behavioral health, and Hepatitis C supplemental payments are not impacted. Also, CCI is not impacted.
  - The State is implementing a risk corridor, both upside and downside, for the entire bridge period across all categories of aid excluding CMC. It will be symmetrical with tiered risk bands calculated using the medical portion of the rate.
  - Beginning 1/2021, the profit/risk margin in the DHCS capitation rates will be reduced from 2% to 1.5%.
- L.A. Care has determined there will be no retroactive provider reimbursement cuts to accommodate the 1.5% plan retroactive rate reduction

Future Rate Calculation Changes

Hospitals: *the following cuts are NOT triggered*

- Beginning 1/1/2021 implementation of an inpatient maximum fee schedule for Managed Care Plans equal to FFS inpatient rates (APR DRG).
  - Applicable to all private and district municipal hospitals
  - Does not apply to County or UC hospitals
  - No impact on directed payments or IGTs
- Implement a Low Acuity Non-Emergent (LANE) Services Efficiency Adjustment - focus is on ER visits that could have been avoided if effective outreach, care coordination, and access to preventive care, had been available.
- Healthcare Common Procedure Coding System (HCPCS) Efficiency Adjustment
  - The HCPCS efficiency adjustment identifies opportunities for MCP savings by identifying historical contracting/payment levels that can be reduced in future prospective periods. This efficiency adjustment promotes improved contracting with providers for clinician-administered drugs billed via HCPCS codes. Medicare payment rates serve as the benchmark.

Future Rate Calculation Changes

Doctors: *The following cuts are triggered*

- Redirection of Prop 56 supplemental payments and programs
  - Eliminates $1.2B in Prop 56 supplemental payments for physician, dental, family health services, developmental screenings, non emergency medical transportation, value based payments and loan repayments for physicians and dentists.
  - Funds will be shifted to fund increased Medi-Cal enrollment from high unemployment.
  - Maintains $67M for home health providers, pediatric day health care facilities, pediatric sub acute facilities, AIDS waiver supplemental payments, already awarded physician and dental loan repayments and trauma screenings.
- Certain specialty services are entirely eliminated (see slide 10)

Future Rate Calculation Changes

- **Skilled Nursing Facilities**
  - Effective 3/1/2020, a 10% rate increase for SNFs and ICF-DDs during the pandemic.
  - Increase will apply to all contracted SNF providers whose payment rates are currently paid as a percent of Medi-Cal FFS.
  - We are expecting increased revenue from DHCS to cover the FFS rate increase for the duals, but not for the non-duals.
- **FQHCs**
  - ***this cut is NOT triggered:*** Withdraw of supplemental payment pool for non-hospital 340B clinics
  - ***this cut is triggered:*** Eliminate the FQHC's ability to carve out some services such as dental and pharmacy out of their rates.
- **IHSS:** ***this cut is triggered***
  - Service hours to IHSS beneficiaries will be cut by 7%.

Community Based Adult Services (CBAS) & Multipurpose Senior Services (MSSP) Programs

These cuts are triggered

- CBAS eliminated 1/1/2021
  - CBAS offers services to eligible older adults and/or adults with disabilities to restore or maintain their optimal capacity for self-care and delay or prevent inappropriate or undesirable institutionalization.
- MSSP eliminated 7/1/2020
  - MSSP provides Home and Community-Based Services to Medi-Cal eligible individuals who are 65 years or older and disabled as an alternative to nursing facility placement.

Benefits Eliminated For Adult Medi-Cal Beneficiaries

These cuts are triggered

- Physical therapy
- Occupational therapy
- Speech therapy
- Audiology
- Optometry
- Incontinence supplies
- Podiatry
- Acupuncture
- Diabetes prevention program
- Nurse anesthetist services
- Intervention and referrals for opioid treatment
- Some dental services

- These do NOT apply to children, beneficiaries in long term care, beneficiaries receiving pregnancy related services, or those who receive services in FQHC or RC settings.

CalAIM

This proposal is NOT triggered

- The ambitious program proposed to begin 2021 has been postponed indefinitely. New benefits on hold:
  - Enhanced care management
  - In Lieu of Services
  - Population Health Management
- California is seeking a one year extension on current 1115 Waiver. Requires CMS approval.
- Health Homes and Whole Person Care set to expire on 12/31/20 will be continued through 2021 pending approval of CMS for a 1135 emergency waiver.
- The Prescription Drug Carve Out will be implemented as planned 1/1/2021

L.A. Care Action To Date

- Accelerated claims payments to hospitals and Skilled Nursing Facilities
- Advanced incentive payments to providers for P4P for 2020
- Community Health Investment Fund (CHIF)
  - Advanced payments for previously awarded grants to clinics and CBOs
  - Targeted grants to support programs for homelessness and hunger
- L.A. Care has determined there will be no retroactive provider reimbursement cuts to accommodate the 1.5% plan retroactive rate reduction
- L.A. Care has taken a leadership role in advocating for another federal stimulus or relief funding advocating for:
  - Up to $190B in funding to State Medicaid programs for recession relief
  - Elimination of Medicaid Fiscal Accountability Regulation (MFAR) proposed rules
  - Presumptive eligibility for Medi-Cal enrollees at point of application
  - Rollback of Public Charge rules that went into effect 2/24/20

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  - Rollback of Public Charge rules that went into effect 2/24/20

May 11, 2020

The Honorable Mitch McConnell
Senate Majority Leader
U.S. Senate
Washington, DC 20515

The Honorable Charles Schumer
Senate Minority Leader
U.S. Senate
Washington, DC 20515

The Honorable Nancy Pelosi
Speaker of the House
U.S. House of Representatives
Washington, DC 20515

The Honorable Kevin McCarthy
House Minority Leader
U.S. House of Representatives
Washington, DC 20515

Dear Leaders:

Thank you for your leadership to help overcome the COVID-19 crisis. The magnitude of the crisis is extraordinary and sadly, more must be done. The undersigned 27 Managed Care Organizations represent over 16 million Medicaid beneficiaries across the country who rely on Medicaid for their health and well-being. We stand united in our commitment to work with you and to work together.

As a result of this national emergency, we know the impacts of the pandemic will result in a significant increase in Medicaid enrollment, further straining every state's budget over the next two years, if not longer.

Our experience during the financial crisis of 2008-2011, where over the two-and-a half-year period, the American Recovery and Reinvestment Act provided for $98 Billion in direct fiscal relief, leads us to believe that the following steps, taken in concert will help Medicaid beneficiaries, Managed Care Organizations, and the safety net throughout the country.

Stable Medicaid Funding

Increase the federal share of Medicaid spending and to commit to at least a two-year period of federal Medicaid funding for states.

Because of COVID-19, states will experience large declines in revenue as the needs for services, including Medicaid, will significantly increase. As we learned from the last recession, state revenues dropped significantly while spending growth continued, resulting in large budget gaps. Not surprisingly, states are already estimating significant revenue declines and unemployment estimates that could easily exceed those experienced during the last recession.

Based on analysis of the provisions included in the 2009 American Recovery and Reinvestment Act (ARRA) to fund a temporary increase in the Federal share of Medicaid costs, as well as Medicaid enrollment trends, we calculated an inflation-adjusted, per-enrollee amount of funding currently needed. We then applied this to recent estimates from Health Management Associates (HMA) that predict a national increase in Medicaid enrollment from the current 71 million beneficiaries to 82 to 94 million beneficiaries as a result of growth in unemployment[i]. We found that between $167.6 billion and $192.1 billion in funding is needed to sustain the Medicaid program at the state level in the midst of the COVID-19 pandemic and the resulting recession.

The COVID-19 health crisis will increase demands on Medicaid. By picking up a larger share of the costs of Medicaid, the federal government can make sure that state budget decisions do not constrain the health response by the states and ensure that increased Medicaid costs do not force states to cut spending in other areas (e.g., education or public safety) in ways that could contribute to a further economic downturn or even cause a delay of economic recovery.

Medicaid Fiscal Accountability Proposed Rule (MFAR)

The Medicaid Fiscal Accountability Proposed Rule must not be finalized during the COVID-19 crisis. In fact, due to the devastating financial impact on states that the Rule would have, we contend the proposed rule be suspended until more analysis is done by CMS to understand the policy and financial impacts the proposed rule would have on states and in particular, the Medicaid delivery system and beneficiaries.

In November, 2019 CMS released the MFAR which would reduce the amount of funding provided to states as part of their Medicaid matching funds when the funding is generated through various supplemental means (e.g., provider taxes, intergovernmental transfers). Many states use supplemental funding mechanisms to provide the non-federal share of some of its Medicaid funding.

Moving forward without this information is dangerous to the efficiency and operation of any Medicaid program, and jeopardizes beneficiary services. Prior to the COVID-19 crisis, it was estimated that millions of patients could lose access to care in public health care systems alone, and project that many public health care systems could not be financially stable and thus would have to close.

For nearly all states, the reductions that would result from MFAR could unquestionably mean cuts in Medicaid program enrollment and covered services. The impact in some states could be catastrophic on state Medicaid funding and ultimately reduce access to critically needed health services for Medicaid beneficiaries.

Presumptive Eligibility

Extend Presumptive Eligibility (PE) to all applicants that appear to be Medicaid eligible (based on initial income screening by a qualified entity); expand the types of entities qualified to perform PE screening; allow qualified entities to utilize online/telephonic applications and online/telephonic signatures for PE applications; and disallow any maximum limitation amounts that would prohibit a person from applying for PE more than once in a twelve-month period.

Presumptive Eligibility (PE) is a Medicaid policy option allowing states to authorize specific types of entities (e.g., federally qualified health centers, hospitals, and schools) to screen eligibility based on income and temporarily enroll them in Medicaid coverage while their full enrollment application is being considered. The goal of PE is to provide short-term coverage of health care services for those with limited incomes, who appear to be eligible for Medicaid, but not currently enrolled. This allows those individuals to receive much needed medical care, while they complete the full Medicaid application and allow counties to conduct the enrollment process. Because of the potential Medicaid application backlog, we believe counties may experience challenges with processing all of the applications in a timely manner. Thus, we are asking that the federal government allow PE for a period of 90 days while counties and the Medicaid applicants complete the enrollment process, and to allow for extensions if counties are experiencing delays in processing Medicaid applications.

Presumptive Eligibility is a powerful tool in ensuring that, as people lose individual or employer coverage during this pandemic and appear to be income-eligible, they are able to receive services via Medicaid without having to wait weeks or even months to complete the Medicaid enrollment process before receiving services.

Cease Implementation of the Public Charge Rule (Rule)

The Public Charge Rule should be fully suspended until the COVD-19 emergency has subsided.

On February 23, 2020 the U.S. Supreme Court removed the remaining Public Charge injunctions, allowing the policy to go into full effect on February 24, 2020. As you know, the Public Charge rule makes immigrants who receive non-cash public benefits, such as Medicaid, food assistance, and housing assistance potentially ineligible for green cards and visas.

Not surprisingly, the Public Charge has created an environment of fear throughout immigrant communities who were already wary of accessing health care coverage, long before the Rule went into place. In December 2018, the Urban Institute conducted a survey on non-elderly adults in immigrant families and found that one in seven did not participate in non-cash government benefit programs because of their fear of harming their or their families green card application.

As an effective public health response, it is vital that the federal government fully suspend the Public Charge rule for the duration of the emergency, at a minimum.

The undersigned managed care plans are prepared to provide expertise, data and ideas as you consider various issues to be addressed in the next relief package. We stand ready to work with you to craft solutions that will ensure the solvency of the Medicaid program during and after this national emergency. These are trying and uncertain times for all Americans,

and more so for our most vulnerable. Taking the above steps will result in better health care outcomes for the members of our communities and for the nation as a whole.

Sincerely,

John Baackes
Chief Executive Officer
L.A. Care Health Plan

Paul Markovich
President & Chief Executive Officer
Blue Shield of California

Scott E. Coffin
Chief Executive Officer
Alameda Alliance for Health

Paul A. Tufano
Chairman & Chief Executive Officer
AmeriHealth Caritas

Bob Freeman
Chief Executive Officer
CenCal Health

Stephanie Sonnenshine
Chief Executive Officer
Central California Alliance for Health

Margaret Tatar
Interim Chief Executive Officer
Gold Coast Health Plan

Brian Ternan
President & Chief Executive Officer
Health Net of California & California Health & Wellness

Maya Altman
Chief Executive Officer
Health Plan of San Mateo

Jarrod B. McNaughton
Chief Executive Officer
Inland Empire Health Plan

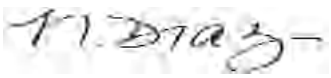
Douglas A. Hayward
Chief Executive Officer

Gregory Hund
CalViva Health

Kern Health Systems

Elizabeth Gibboney
Chief Executive Officer
Partnership HealthPlan of California

Christine M. Tomcala
Chief Executive Officer
Santa Clara Family Health Plan



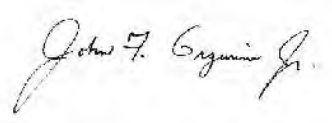
Norma Diaz
Chief Executive Officer
Community Health Group

Erhardt Preitauer
Chief Executive Officer
CareSource

James Kiamos
Chief Executive Officer
CountyCare Health Plan, CCH

Christopher D. Palmieri
President & Chief Executive Officer
Commonwealth Care Alliance

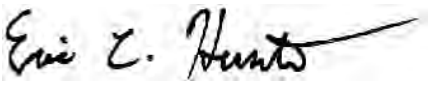
Fresno-Kings-Madera Regional Health Authority



John F. Grgurina, Jr.
Chief Executive Officer
San Francisco Health Plan

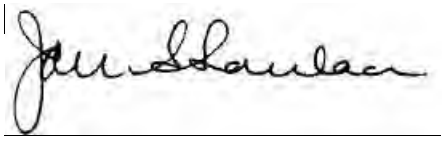
Michelle Tetreault
Interim Chief Executive Officer
Health Plan of San Joaquin

Sharron Mackey
Chief Executive Officer
Contra Costa Health Plan



Eric C. Hunter
President & Chief Executive Officer
CareOregon

Edward Kumian
Chief Executive Officer
Priority Partners



John Lovelace
Chief Executive Officer
UPMC For You, Inc.

Leanne Berge
Chief Executive Officer
Community Health Network of Washington
Community Health Plan of Washington

Doug Wirth
President & Chief Executive Officer
Amida Care

Peter Marino
President & CEO
Neighborhood Health Plan of Rhode Island

[i] https://www.healthmanagement.com/wp-content/uploads/HMA-Estimates-of-COVID-Impact-on-Coverage-public-version-for-April-3-830-CT.pdf

April 2020
Grants & Sponsorships Report
June 2020 Board of Governors Meeting

#	Organization Name	Project Description	Grant/ Sponsorship Aproval Date	Grant Category/ Sponsorship	April Grant Amount*	April Sponsorship Amount	FY CHIF & Sponsorships Cummulative Total
1	Eviction Defense Network	COVID19 Response: To support and educate residents and defend eviction cases using on-line and telephonic resources.	4/15/2020	Sponsorship	$ -	$ 20,000	$ 20,000
2	Get Together Foundation	COVID19 Response: Provide handwashing kits (soap, water, paper towels) for families and individuals experiencing homelessness.	4/15/2020	Sponsorship	$ -	$ 5,000	$ 5,000
3	Hope of the Valley Rescue Mission	COVID19 Response: Support a total of 9 COVID19 shelters for homeless individuals and a 140-bed emergency shelter.	4/15/2020	Sponsorship	$ -	$ 20,000	$ 20,000
4	Southern California Resource Services for Independent Living (SCRS-IL)	COVID19 Response: Deliver bags filled with food and toiletries to 600 individuals with disabilities that are experiencing food insecurity as a result of COVID 19.	4/15/2020	Sponsorship	$ -	$ 10,000	$ 10,000
5	Star View Children and Family Services	COVID 19 Response: Provide diapers to 200 families in need, as a result of COVID 19 unemployment.	4/15/2020	Sponsorship	$ -	$ 5,000	$ 5,000
				Total of grants and sponsorships approved in April 2020	**$ -**	**$ 60,000**	

* No grants were approved in the month of April.

2020 Legislative Matrix

Last Updated: May 27, 2020

The following is a list of priority legislation currently tracked by Government Affairs that has been introduced during the 2020-2021 Legislative Session and is of interest to L.A. Care. If there are any questions, please contact Cherie Compartore, Senior Director of Government Affairs at ccompartore@lacare.org or extension 5481.

In response to COVID-19, the state legislature voted to recess in order to allow members and staff to observe social distancing until May, resulting in a compressed legislative calendar. Additionally, COVID-19 has reduced the state's 2020-2021 revenues and increased emergency spending the budget will be “slimmed down” since the state’s needs, resources and available time have changed. As a result, the Assembly and Senate leadership have directed their members to only carry bills that directly relate to COVID-19 and to drop all other bills that do not directly relate to the crisis and to run them next year. However, there has been no official direction from Senate and Assembly leadership on what bills will move through the process; and members have are justifying their bill packages even though some of the issues are only tangentially related to COVID-19. The legislative matrix includes the bills that could directly impact L.A. Care and have not been confirmed dropped by the author.

Direct Impact Bills

Bill State: CA (54)

State	Bill Number	Status	Position
CA	AB 648	In Senate	Oppose

Title
Wellness programs.

Introduction Date: 2019-02-15

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.This bill would prohibit health care service plans and insurers from sharing any personal information or data collected through a wellness program, except as specified, 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 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 program, such as requiring a health care service plan or insurer to post a written explanation that is reasonably likely to be understood by an individual on its internet website 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, except as specified, 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.Because a willful violation of these 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 Division of Labor Standards Enforcement, headed by the Labor Commissioner, within the Department of Industrial Relations, for the purpose of enforcing labor laws, including those relating to employer retaliation.This bill would, among other things, prohibit... (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 713	In Senate	Monitor

Title
California Consumer Privacy Act of 2018.

Introduction Date: 2019-02-19

Description
AB 713, as amended, Mullin. California Consumer Privacy Act of 2018. (1) Existing law, the California Consumer Privacy Act of 2018 (CCPA), grants a consumer various rights with regard to personal information relating to that consumer collected by a business, including the right to know the categories and the specific pieces of personal information that have been collected and to opt out of the sale of personal information. The act also grants a consumer the right to request a business to delete any personal information about the consumer collected by the business and requires a business to do so upon receipt of a verified request, except as specified. The act excepts certain categories of personal information and entities from its provisions, including medical information, as specified.This bill would except from the CCPA information that was deidentified in accordance with specified federal law, was derived from protected health information, individually identifiable health information, or identifiable private information, consistent with specified federal policy, as provided. The bill also would except from the CCPA a business associate of a covered entity, as defined, that is governed by federal privacy, security, and data breach notification rules if the business associate maintains, uses, and discloses patient information in accordance with specified requirements.This bill would additionally except personal information that is collected for, or used in, biomedical research subject to institutional review board standards and the ethics and privacy laws of an identified federal policy, specified clinical practice guidelines, or human subject protection requirements of the United States Food and Drug Administration (FDA). The bill would further except personal information of certain types that is collected for, or used in, research, as defined, and, as specified, personal information collected by a business for purposes of product registration and tracking regulated by the FDA, specified public health activities, or quality, safety, or effectiveness compliance regulated by the FDA. The bill would define terms for these purposes.(2) The CCPA requires a business to make certain disclosures to consumers, in a specified form, in its online privacy policy, if the business has an online privacy policy, and in any California-specific description of consumers' privacy rights, or, if the business does not maintain an online privacy policy or policies, on its internet website, and to update that information at least once every 12 months.This bill would require a business that sells or discloses information that was deidentified in accordance with specified federal law, was derived from protected health information, individua... (click bill link to see more).

Primary Sponsors
Kevin Mullin

State	Bill Number	Status	Position
CA	AB 890	In Senate	Monitor

Title
Nurse practitioners: scope of practice: practice without

Introduction Date: 2019-02-20

standardized procedures.

Description

AB 890, as amended, Wood. Nurse practitioners: scope of practice: practice without standardized procedures. Existing law, the Nursing Practice Act, provides for the certification and regulation of nurse practitioners by the Board of Registered Nursing. Existing law authorizes the implementation of standardized procedures that authorize a nurse practitioner to perform certain acts that are in addition to other authorized practices, including certifying disability after performing a physical examination and collaboration with a physician and surgeon. A violation of the act is a misdemeanor.This bill, until January 1, 2026, would establish the Advanced Practice Registered Nursing Board within the Department of Consumer Affairs, which would consist of 9 members. The bill would require the board, by regulation, to define minimum standards for a nurse practitioner to transition to practice without the routine presence of a physician and surgeon. The bill would authorize a nurse practitioner who meets certain education, experience, and certification requirements to perform, in certain settings or organizations, specified functions without standardized procedures, including ordering, performing, and interpreting diagnostic procedures, certifying disability, and prescribing, administering, dispensing, and furnishing controlled substances. The bill would also authorize a nurse practitioner to perform those functions without standardized procedures outside of specified settings or organizations in accordance with specified conditions and requirements if the nurse practitioner holds an active certification issued by the board. The bill would require the board to issue that certification to a nurse practitioner who meets additional specified education and experience requirements.The bill would also require the board to request the department's Office of Professional Examination Services, or an equivalent organization, to perform an occupational analysis of nurse practitioners performing certain functions. The bill would require the board to take specified measures to identify and assess competencies. The bill would require the board to identify and develop a supplemental examination for licensees if needed based on the assessment, as provided.Existing law makes it unlawful for specified healing arts practitioners, including physicians and surgeons, psychologists, and acupuncturists, to refer a person for certain services, including laboratory, diagnostic nuclear medicine, and physical therapy, if the physician and surgeon or their immediate family has a financial interest with the person or in the entity that receives the referral. A violation of those provisions is a misdemeanor and subject to specified civil penalties a... (click bill link to see more).

Primary Sponsors

Jim Wood

Organizational Notes

Last edited by Joanne Campbell at May 27, 2020, 3:40 PM
LHPC - Support

State	Bill Number	Status	Position
CA	AB 1124	In Senate	Monitor

Title
Health care service plans: regulations: exemptions.

Introduction Date: 2019-02-21

Description
AB 1124, as amended, Maienschein. Health care service plans: regulations: exemptions. Existing federal law defines a voluntary employees' beneficiary association as an organization composed of a voluntary association of employees that provides for the payment of life, sick, accident, or similar benefits to members, their dependents, or designated beneficiaries. Existing federal law defines a welfare plan as any plan, fund, or program established or maintained by an employer or employee organization, or both, for the purpose of providing participants or their beneficiaries specified benefits, such as medical, surgical, or hospital care or benefits. Existing law further defines a multiemployer plan as a plan to which more than one employer is required to contribute, that is maintained pursuant to one or more collective bargaining agreements between one or more employee organizations and more than one employer, and that meets other specified requirements.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 the willful violation of the act a crime. Existing law exempts specified persons or plans from the requirements of the act and authorizes the Director of the Department of Managed Health Care (director) to exempt additional specified persons or plans if the director finds, among other things, that the exemption is in the public interest. Under existing law, upon the request of the Director of Health Care Services, the director must exempt a county-operated pilot program contracting with the State Department of Health Care Services, and may exempt a noncounty-operated pilot program, subject to any conditions the Director of Health Care Services deems appropriate. Existing law also exempts a health care service plan operated by a city, county, city and county, public entity, political subdivision, or public joint labor management trust that satisfies certain criteria, including that the plan requires providers to be reimbursed solely on a fee-for-service basis.This bill would authorize the director, no later than an unspecified date, to authorize 2 pilot programs, one in northern California and one in southern California, under which providers approved by the department may undertake risk-bearing arrangements with a voluntary employees' beneficiary association with enrollment of more than 100,000 lives, notwithstanding the fee-for-service requirement described above, or a trust fund that is a welfare plan and a multiemployer plan with enrollment of more than 25,000 lives, if certain criteria are met, including that each risk-bearing provider is registered with the department as a r... (click bill link to see more).

Primary Sponsors
Brian Maienschein

State	Bill Number	Status	Position
CA	AB 1909	In Assembly	Monitor

Title
Healing arts licensees: virginity examinations or tests.

Description
AB 1909, as introduced, Gonzalez. Healing arts licensees: virginity examinations or tests. Existing law establishes the Department of Consumer Affairs in the Business, Consumer Services, and Housing Agency. The department is composed of boards for purposes of licensing and regulating various professions and vocations, including healing arts licensees. The boards are established for the purpose of ensuring that those private businesses and professions deemed to engage in activities that have potential impact upon the public health, safety, and welfare are adequately regulated in order to protect the people of California. Existing law makes certain acts by a healing arts licensee, including, but not limited to, sexual abuse, misconduct, or relations with a patient, unprofessional conduct and grounds for disciplinary action.This bill would prohibit a healing arts licensee, as defined, from performing an examination or test on a patient for the purpose of determining whether the patient is a virgin. The bill would also make a violation of its provisions unprofessional conduct and grounds for disciplinary action by the licensing board for the healing arts licensee.

Primary Sponsors
Lorena Gonzalez Fletcher

Introduction Date: 2020-01-08

State	Bill Number	Status	Position
CA	AB 1938	In Assembly	Monitor

Title
Prescription drugs: 340B discount drug purchasing program.

Introduction Date: 2020-01-16

Description
AB 1938, as amended, Low. Prescription drugs: 340B discount drug purchasing 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 federal law requires the United States Secretary of Health and Human Services to enter into an agreement with each manufacturer of covered drugs that are not subject to a rebate under an agreement between the state Medicaid program and the manufacturer under which the amount required to be paid to the manufacturer for covered drugs purchased by a covered entity does not exceed an amount equal to the average manufacturer price for the drug under the federal Medicaid program in the preceding calendar quarter, reduced by the rebate received pursuant to the Medicaid agreement. This program is commonly referred to as the 340B Drug Pricing program or 340B program.Existing state law requires a covered entity to dispense only the above-described drugs to Medi-Cal beneficiaries, authorizes a covered entity that is unable to purchase the above-described drugs to dispense a drug purchased at regular drug wholesale rates to a Medi-Cal beneficiary if the covered entity maintains documentation of their inability to obtain the drugs, and requires a not-for-profit hospital that participates in the drug discount program established under federal law to enter into an agreement with the department that includes specified terms, including that the not-for-profit hospital continues its historic commitment to the provision of charity care.This bill would define a “designated entity” as a nonprofit organization, including any subsidiary of that organization, that individually or collectively with one or more of its subsidiaries meets specified requirements, including that the designated entity is a licensed managed care organization that has previously contracted with the department as a primary care case management organization, contracts with the federal Centers for Medicare and Medicaid Services to provide services in the Medicare Program as a Medicare special needs plan, and participates in the 340B program. The bill would prohibit a designated entity from using any revenue from a contract with the department, a contract with the federal Centers for Medicare and Medicaid Services, and from the 340B program on specified activity, such as funding litigation under the California Environmental Quality Act. The bill would require a designated entity, and any subsidiary of that entity, to annually report on its internet website specified information, including the amou... (click bill link to see more).

Primary Sponsors
Evan Low, Susan Eggman, Scott Wiener

State	Bill Number	Status	Position
CA	AB 1965	In Assembly	Monitor

Title
Family Planning, Access, Care, and Treatment (Family PACT) Program.

Description
AB 1965, as introduced, Aguiar-Curry. Family Planning, Access, Care, and Treatment (Family PACT) Program. 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 law also establishes the Family Planning, Access, Care, and Treatment (Family PACT) Program, administered by the Office of Family Planning within the department, under which comprehensive clinical family planning services are provided to a person who has a family income at or below 200% of the federal poverty level, and who is eligible to receive these services. Existing law provides that comprehensive clinical family planning services under the program includes preconception counseling, maternal and fetal health counseling, and general reproductive health care, among other things.This bill would expand comprehensive clinical family planning services under the program to include the human papillomavirus (HPV) vaccine for persons of reproductive age.

Primary Sponsors
Cecilia Aguiar-Curry

Introduction Date: 2020-01-21

State	Bill Number	Status	Position
CA	AB 1973	In Assembly	Monitor

Title
Health care coverage: abortion services: cost sharing.

Introduction Date: 2020-01-22

Description
AB 1973, as amended, Kamlager. Health care coverage: abortion services: cost sharing. Existing law, the Reproductive Privacy Act, provides that the state may not deny or interfere with a person's right to choose or obtain an abortion prior to viability of the fetus, or when the abortion is necessary to protect the life or health of the person. The act defines "abortion" as a medical treatment intended to induce the termination of a pregnancy except for the purpose of producing a live birth.Existing law also 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 through, among other things, managed care plans licensed under the act that contract with the State Department of Health Care Services.Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law requires group and individual health care service plan contracts and disability insurance policies to cover contraceptives, without cost sharing, as specified.This bill would prohibit a health care service plan or an individual or group policy of disability insurance that is issued, amended, renewed, or delivered on or after January 1, 2021, from imposing a deductible, coinsurance, copayment, or any other cost-sharing requirement on coverage for all abortion services, as specified, and additionally would prohibit cost sharing from being imposed on a Medi-Cal beneficiary for those services. The bill would apply the same benefits with respect to an enrollee's or insured's covered spouse and covered nonspouse dependents. The bill would not require an individual or group health care service plan contract or disability insurance policy to cover an experimental or investigational treatment.Because a violation of the bill by a health care service plan would be a crime, the bill would impose a state-mandated local program.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Sydney Kamlager

State	Bill Number	Status	Position
CA	AB 1994	In Assembly	Monitor

Title
Eligibility.

Introduction Date: 2020-01-27

Description
AB 1994, as amended, Holden. Eligibility. Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law provides for the suspension of Medi-Cal benefits to an inmate of a public institution, which ends on the date they are 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 requires county welfare departments to notify the department within 10 days of receiving information that an individual who is receiving Medi-Cal is or will be an inmate of a public institution. 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.Existing federal law, the SUPPORT for Patients and Communities Act, prohibits a state from terminating Medi-Cal eligibility for an eligible juvenile if they are an inmate of a public institution, authorizes the suspension of Medicaid benefits to that eligible juvenile, and requires a state to conduct a redetermination of Medicaid eligibility or process an application for medical assistance under the Medicaid program for an eligible juvenile who is an inmate of a public institution.This bill would instead require the suspension of Medi-Cal benefits to an inmate of a public institution to end on the date they are no longer an inmate of a public institution or 3 years from the date they become an inmate of a public institution, whichever is sooner. The bill would conform state law with those specified federal provisions, and would impose those responsibilities on county welfare departments. The bill would require the county welfare department to suspend Medi-Cal benefits to an eligible juvenile in conformity with the above-specified suspension standard. Because counties are required to make Medi-Cal eligibility determinations, and the bill would expand Medi-Cal determinations of eligibility for eligible juveniles 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... (click bill link to see more).

Primary Sponsors
Chris Holden, Blanca Rubio

State	Bill Number	Status	Position
CA	AB 2007	In Assembly	Monitor

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

Introduction Date: 2020-01-28

Description
AB 2007, as introduced, Salas. Medi-Cal: federally qualified health center: rural health clinic: 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 health care services, including federally qualified health center (FQHC) services and rural health clinic (RHC) services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. FQHC and RHC services are reimbursed, to the extent that federal financial participation is obtained, to providers on a per-visit basis, and a “visit” is defined as a face-to-face encounter between a patient of an FQHC or RHC and specified health care professionals, including dental providers.Existing law prohibits a requirement of in-person contact between a health care provider and a Medi-Cal patient when the service may be provided by telehealth, and, for purposes of telehealth, prohibits the department from limiting the type of setting where Medi-Cal services are provided. Existing law authorizes, to the extent that federal financial participation is available, the use of health care services by store and forward under the Medi-Cal program, subject to billing and reimbursement policies developed by the department, and prohibits a requirement of in-person contact between a health care provider and a Medi-Cal patient when these services are provided by store and forward.This bill would provide that an FQHC or RHC “visit” includes an encounter between an FQHC or RHC patient and a health care provider using telehealth by synchronous real time or asynchronous store and forward. The bill would clarify, for purposes of an FQHC or RHC visit, that face-to-face contact between a health care provider and a patient is not required for an FQHC or RHC to bill for telehealth by synchronous real time or asynchronous store and forward if specified requirements are met, including that a billable provider in the Medi-Cal program, and who is employed by the FQHC or RHC, supervises or provides the services for that patient via telehealth by synchronous real time or asynchronous store and forward.

Primary Sponsors
Rudy Salas

Organizational Notes

Last edited by Cherie Compartore at Mar 10, 2020, 9:23 PM
Organization Sponsor: California Primary Care Association, Children's Partnership, Children Now, and CaliforniaHealth + Advocates, California Dental Assoc.

State	Bill Number	Status	Position
CA	AB 2025	In Assembly	Monitor

Title
Mental illness and substance use disorder: restorative care program: pilot projects.

Description
AB 2025, as amended, Gipson. Mental illness and substance use disorder: restorative care program: pilot projects. Existing law, the Bronzan-McCorquodale Act, governs the organization and financing of community mental health services for persons with mental disorders in every county through locally administered and locally controlled community mental health programs. Existing law authorizes the State Department of Health Care Services, in its discretion, to permit new programs to be developed and implemented without complying with licensure requirements established pursuant to existing state law, except for requirements relating to fire and life safety of persons with mental illness.This bill would also include within that exception requirements relating to fire and life safety of persons with alcohol or substance use disorder. The bill would, subject to the above licensing provisions, authorize the County of Los Angeles to establish a pilot project for up to 6 years to develop a restorative care program for community-based care and treatment that addresses the interrelated and complex needs of individuals suffering from mental illness and substance use disorder, along with other medical comorbidities, and homelessness. The bill would require the department, in conjunction with the Los Angeles County Director of Mental Health, to report to the Legislature within 2 years of the commencement of the operation of the initial facility regarding the progress and cost-effectiveness demonstrated by the pilot project. Under the bill, authorization for the pilot projects would be repealed as of January 1, 2026.This bill would declare that it is to take effect immediately as an urgency statute.

Primary Sponsors
Mike Gipson

Introduction Date: 2020-01-30

State	Bill Number	Status	Position
CA	AB 2032	In Assembly	Monitor

Title
Medi-Cal: medically necessary services.

Introduction Date: 2020-01-30

Description
AB 2032, as amended, Wood. Medi-Cal: medically necessary services. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive medically necessary health care services, including specified mental health and substance use disorder services, pursuant to a schedule of benefits. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.Under existing law, for individuals 21 years of age and older, a service is “medically necessary” if it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain. Existing law provides that for individuals under 21 years of age, “medically necessary” or “medical necessity” standards are governed by the definition in federal law. This bill would provide that the above-specified medical necessity standards do not preclude coverage for, and reimbursement of, a clinically appropriate and covered mental health or substance use disorder assessment, screening, or treatment service before a provider renders a diagnosis.

Primary Sponsors
Jim Wood

State	Bill Number	Status	Position
CA	AB 2055	In Assembly	Monitor

Title
Specialty mental health services and substance use disorder treatment.

Introduction Date: 2020-02-03

Description
AB 2055, as amended, Wood. Specialty mental health services and substance use disorder treatment. (1) Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services, including behavioral health services, which encompass specialty mental health services and substance use disorder treatment that are provided under the Medi-Cal Specialty Mental Health Services Program, the Drug Medi-Cal Treatment Program, and the Drug Medi-Cal organized delivery system, respectively. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions, and specialty mental health services and substance use disorder treatment are funded through certified public expenditures. Existing law requires the department to implement managed mental health care for purposes of delivering specialty mental health services to Medi-Cal beneficiaries through contracts with county mental health plans.Existing law, the Medi-Cal 2020 Demonstration Project Act, requires the department to implement specified components of a Medi-Cal demonstration project, including the Global Payment Program, the Whole Person Care pilot program, and the Dental Transformation Initiative, consistent with the Special Terms and Conditions approved by the federal Centers for Medicare and Medicaid Services. Pursuant to existing law, the department has created a multiyear initiative, the Medi-Cal Healthier California for All initiative, for purposes of building upon the outcomes of various Medi-Cal pilots and demonstration projects, including the Medi-Cal 2020 demonstration project.This bill would require the department to establish, implement, and administer the Behavioral Health Quality Improvement Program to assist county mental health plans and counties that administer the Drug Medi-Cal Treatment Program or the Drug Medi-Cal organized delivery system for purposes of preparing those entities for implementation of the behavioral health components included in the Medi-Cal Healthier California for All initiative, and would establish in the State Treasury the Behavioral Health Quality Improvement Account to fund those efforts. The bill would require the department to determine the methodology and distribution of funds appropriated to those entities. The bill would authorize the department to implement these provisions by various means, including provider bulletin, without taking regulatory action, and to enter into contracts that would be exempt from specified provisions of state contracting requirements. The bill would condition the implementation of these provisions to the extent that the department determines that federal fin... (click bill link to see more).

Primary Sponsors
Jim Wood

State	Bill Number	Status	Position
CA	AB 2100	In Assembly	Monitor

Title
Medi-Cal: pharmacy benefits.

Introduction Date: 2020-02-05

Description
AB 2100, as amended, Wood. Medi-Cal: pharmacy benefits.
(1) 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 pursuant to a schedule of benefits, which includes pharmacy benefits, through various health care delivery systems, including fee-for-service and managed care. 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 a managed care plan. Existing law generally requires Medi-Cal managed care plan contractors to be licensed pursuant to the Knox-Keene Health Care Service Plan Act of 1975. The Knox-Keene Health Care Service Plan Act provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. Under this act, a health care service plan is required to provide an external, independent review process, which meets prescribed standards, to examine the plan's coverage decisions on experimental or investigational therapies for an enrollee who meets specified criteria, including that the enrollee was denied coverage by the plan for a drug, device, procedure, or other therapy recommended or requested. Existing law requires the Department of Managed Health Care to establish the Independent Medical Review System, which generally serves to address grievances involving disputed health care services.By executive order, the Governor directed the department to transition pharmacy services for Medi-Cal managed care to a fee-for-service benefit by January 1, 2021. Existing law requires the department to convene an advisory group to receive feedback on the changes, modifications, and operational timeframes on the implementation of pharmacy benefits offered in the Medi-Cal program, and to provide regular updates on the pharmacy transition, including a description of changes in the division of responsibilities between the department and managed care plans relating to the transition of the outpatient pharmacy benefit to fee-for-service.This bill would require the department to establish the Independent Prescription Drug Medical Review System (IPDMRS), commencing on January 1, 2021, which generally models the above-described requirements of the Knox-Keene Health Care Service Plan Act. The bill would provide that any Medi-Cal beneficiary grievance involving a disputed health care service is eligible for review under the IPDMRS, and would define "disputed health care service" as any outpatient prescription drug eligible for coverage and payment by the Medi-Cal program ... (click bill link to see more).

Primary Sponsors
Jim Wood

Organizational Notes

Last edited by Cherie Compartore at Mar 3, 2020, 7:07 PM
Organization Sponsor: CA Pharmacists Association, Western Center on Law & Poverty

State	Bill Number	Status	Position
CA	AB 2118	In Assembly	Monitor

Title
Health care service plans and health insurers: reporting requirements.

Introduction Date: 2020-02-06

Description
AB 2118, as amended, Kalra. Health care service plans and health insurers: reporting requirements. 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 offering a contract or policy in the individual, small, and large group markets to file specified information, including total earned premiums and total incurred claims for each contract or policy form, with the appropriate department at least 120 days before implementing a rate change. Existing law requires a large group market health care service plan or insurer to report additional information relating to cost sharing and specified aggregate rate information. Existing law requires the Department of Managed Health Care and the Department of Insurance to conduct an annual public meeting regarding large group rates.This bill would expand reporting requirements for health care service plans and health insurers, for products in the individual and small group markets to include, for rates effective during the 12-month period ending January 1 of the following year, specified information on premiums, cost sharing, benefits, enrollment, and trend factors as reported in all rate filings for the health care service plan or insurer, including both price and utilization. The bill would exclude specified information from the reporting requirements until January 1, 2023. The bill would require each department, beginning in 2022, to annually present the information required by the bill at the meeting regarding large group rates and at a public meeting of the board of Covered California, as specified.Because a violation of the bill by a health care service plan would be a crime, the bill would impose a state-mandated local program.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Ash Kalra

Organizational Notes

Last edited by Joanne Campbell at May 18, 2020, 9:16 PM
Organization Sponsor: Health Access CAHP: Opposed Unless Amended

State	Bill Number	Status	Position
CA	AB 2144	In Assembly	Monitor

Title
Health care coverage: step therapy.

Introduction Date: 2020-02-10

Description
AB 2144, as amended, Arambula. Health care coverage: step therapy. Existing law, the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene), provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law authorizes a health insurer to require step therapy if there is more than one drug that is appropriate for the treatment of a medical condition, and authorizes a health care service plan to utilize step therapy consistent with Knox-Keene. Under existing law, if a health care service plan, health insurer, or contracted physician group fails to respond to a completed prior authorization request from a prescribing provider within a specified timeframe, the prior authorization request is deemed to have been granted.This bill would clarify that a health care service plan may require step therapy if there is more than one drug that is appropriate for the treatment of a medical condition. The bill would require a health care service plan or health insurer to expeditiously grant a step therapy exception if specified criteria are met. The bill would authorize an enrollee or insured or their designee, guardian, primary care physician, or health care provider to file an appeal of a prior authorization or the denial of a step therapy exception request, and would require a health care service plan or health insurer to designate a clinical peer to review those appeals. The bill would require a health care service plan, health insurer, or utilization review organization to annually report specified information about their step therapy exception requests and prior authorization requests to the Department of Managed Health Care or the Department of Insurance, as appropriate. The bill would require a prior authorization request or step therapy exception request to be deemed to have been granted if a health care service plan, health insurer, or contracted physician group fails to send an approval or denial within a specified timeframe. 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
Joaquin Arambula

Organizational Notes

Last edited by Cherie Compartore at Mar 3, 2020, 7:11 PM
Organization Note: Arthritis Foundation, CA Rheumatology Alliance

State	Bill Number	Status	Position
CA	AB 2157	In Assembly	Monitor

Title
Health care coverage: independent dispute resolution process.

Introduction Date: 2020-02-10

Description
AB 2157, as introduced, Wood. Health care coverage: independent dispute resolution process. Existing law provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and provides for the regulation of health insurers by the Department of Insurance. Existing law requires each department to establish an independent dispute resolution process to resolve a claim dispute between a health care service plan or health insurer, as appropriate, and a noncontracting individual health professional, and sets forth requirements and guidelines for that process, including contracting with an independent organization for the purpose of conducting the review process. Existing law requires each department to establish uniform written procedures for the submission, receipt, processing, and resolution of these disputes, as specified. Existing law requires the independent organization, in deciding the dispute, to base its decision regarding the appropriate reimbursement on all relevant information.This bill would require the procedures established by each department to include a process for each party to submit into evidence information that will be kept confidential from the other party, in order to preserve the confidentiality of the source contract. The bill would specifically require the independent organization to conduct a de novo review of the claim dispute, based solely on the information and documents timely submitted into evidence by the parties. The bill would require the independent organization to assign reviewers to each case based on their relevant education, background, and medical claims payment and clinical experience.

Primary Sponsors
Jim Wood

State	Bill Number	Status	Position
CA	AB 2158	In Assembly	Monitor

Title
Health care coverage.

Description
AB 2158, as introduced, Wood. Health care coverage. Existing federal law, the Patient Protection and Affordable Care Act (PPACA), enacts various health care market reforms. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a group or individual health care policy issued, amended, renewed, or delivered on or after September 23, 2010, to comply with the requirements of the PPACA, and any rules or regulations issued under the PPACA, that require a group health plan and health insurance issuer offering group or individual health insurance coverage to, at a minimum, provide coverage for specified preventive services, and prohibits the plan or health insurance issuer from imposing any cost-sharing requirements for those preventive services. Existing law requires a health insurer to comply with those provisions to the extent required by federal law.This bill would delete the requirement that a health insurer comply with the requirement to cover preventive health services without cost sharing to the extent required by federal law, and would instead require a group or individual health insurance policy to, at a minimum, provide coverage for specified preventive services without any cost-sharing requirements for those preventive services, thereby indefinitely extending those requirements.

Primary Sponsors
Jim Wood

Introduction Date: 2020-02-10

State	Bill Number	Status	Position
CA	AB 2159	In Assembly	Monitor

Title
Health care coverage.

Introduction Date: 2020-02-10

Description
AB 2159, as introduced, Wood. Health care coverage. The federal Patient Protection and Affordable Care Act (PPACA) enacts various health care market reforms. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health insurer that issues, sells, renews, or offers plan contracts for health care coverage in the state to comply with the requirements of the PPACA, and any rules or regulations issued under the PPACA, that generally prohibit a health insurer offering group or individual coverage from imposing lifetime or annual limits on the dollar value of benefits for an insured. Existing law requires an insurer to comply with those provisions to the extent required by federal law. This bill would delete the requirement that a health insurer comply with the prohibition on lifetime or annual limits to the extent required by federal law, and would instead prohibit an individual or group health insurance policy from establishing lifetime or annual limits on the dollar value of benefits for an insured, thereby indefinitely extending the prohibitions on lifetime or annual limits.

Primary Sponsors
Jim Wood

State	Bill Number	Status	Position
CA	AB 2170	In Assembly	Monitor

Title
Eligibility: redetermination.

Introduction Date: 2020-02-11

Description
AB 2170, as introduced, Blanca Rubio. Eligibility: redetermination. 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 the suspension of Medi-Cal benefits to an inmate of a public institution, and requires county welfare departments to notify the department within 10 days of receiving information that an individual who is receiving Medi-Cal is or will be an inmate of a public institution. 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 require a county welfare department to conduct a redetermination of eligibility for the Medi-Cal program for any juvenile who is either detained at a juvenile detention center or an inmate of a public institution, and would provide that Medi-Cal eligibility be restored upon their release from that facility if they meet eligibility requirements. Because counties are required to make Medi-Cal eligibility determinations, and the bill would expand Medi-Cal determinations of eligibility for eligible juveniles in 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.

Primary Sponsors
Blanca Rubio

State	Bill Number	Status	Position
CA	AB 2203	In Assembly	Monitor

Title
Insulin cost-sharing cap.

Introduction Date: 2020-02-12

Description
AB 2203, as amended, Nazarian. Insulin cost-sharing cap. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act's requirements a crime. Existing law requires every health care service plan contract that covers hospital, medical, or surgical expenses to include coverage for specified equipment and supplies for the management and treatment of diabetes.Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health insurance policy issued, amended, delivered, or renewed on or after January 1, 2000, to include coverage for specified equipment and supplies for the management and treatment of insulin-using diabetes, non-insulin-using diabetes, and gestational diabetes as medically necessary, even if the items are available without a prescription. Existing law requires a health insurance policy issued, amended, delivered, or renewed on or after January 1, 2000, that covers prescription benefits to include coverage for specified diabetes management prescription items, including insulin and glucagon.This bill would prohibit a health care service plan contract or a health insurance policy that is issued, amended, delivered, or renewed on or after January 1, 2021, from imposing cost sharing on a covered insulin prescription, except for a copayment not to exceed $50 per 30-day supply of insulin, and no more than $100 total per month, regardless of the amount or type of insulin. The bill would apply these cost-sharing limitations until January 1, 2024.The bill would also authorize the Attorney General to investigate pricing of prescription insulin drugs to ensure adequate pricing protections for consumers, and would authorize the Attorney General, by November 1, 2022, to issue and make publicly available a report detailing its findings from any insulin pricing investigations. The bill would exempt trade secret or proprietary business information submitted to the Attorney General pursuant to these provisions from specified disclosure requirements. The bill would make these provisions applicable until January 1, 2024.Existing constitutional provisions require that a statute that limits the right of access to the meetings of public bodies or the writings of public officials and agencies be adopted with findings demonstrating the interest protected by the limitation and the need for protecting that interest.This bill would make legislative findings to that effect.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provis... (click bill link to see more).

Primary Sponsors
Adrin Nazarian

Organizational Notes

Last edited by Joanne Campbell at May 18, 2020, 9:15 PM
Organization Sponsor: American Diabetes Association CAHP: Opposed

State	Bill Number	Status	Position
CA	AB 2218	In Assembly	Support

Title
Transgender Wellness and Equity Fund.

Introduction Date: 2020-02-12

Description
AB 2218, as amended, Santiago. Transgender Wellness and Equity Fund. Existing law establishes an Office of Health Equity in the State Department of Public Health for purposes of aligning state resources, decisionmaking, and programs to accomplish certain goals related to health equity and protecting vulnerable communities. Existing law requires the office to develop department-wide plans to close the gaps in health status and access to care among the state's diverse racial and ethnic communities, women, persons with disabilities, and the lesbian, gay, bisexual, transgender, queer, and questioning communities, as specified.This bill would establish the Transgender Wellness and Equity Fund, under the administration of the office, for grants to transgender-led (Trans-led) organizations and hospitals, health care clinics, and other medical providers that provide gender-conforming health care services and have an established partnership with a Trans-led organization, to create, or fund existing, programs focused on coordinating trans-inclusive health care, as defined, for people that identify as transgender, gender nonconforming, or intersex.The bill would appropriate $15,000,000 from the General Fund to the Transgender Wellness and Equity Fund, established pursuant to this bill, for these purposes.

Primary Sponsors
Miguel Santiago, Scott Wiener

State	Bill Number	Status	Position
CA	AB 2276	In Assembly	Monitor

Title
Medi-Cal: Blood lead screening tests.

Introduction Date: 2020-02-14

Description
AB 2276, as amended, Reyes. Medi-Cal: Blood lead screening tests. 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 authorizes the department to enter contracts with managed care plans to provide Medi-Cal services, and imposes requirements on the Medi-Cal managed care plans, including network adequacy standards. Under existing law, Medi-Cal covers early and periodic screening, diagnostic, and treatment for individuals under 21 years of age, consistent with federal law.This bill would require the department to ensure that a Medi-Cal beneficiary who is a child receives blood lead screening tests at specified ages consistent with state regulatory standards, and would require a contract between the department and a Medi-Cal managed care plan to ensure that the Medi-Cal managed care plan and its contracting health care providers who are responsible for performing a periodic health assessment of a child meet specified standard of care requirements relating to blood lead testing. The bill would require the department to report its progress toward blood lead screening tests for Medi-Cal beneficiaries who are children, as specified, annually on its internet website. The bill would require each Medi-Cal managed care plan to establish a monitoring system related to blood lead screening tests, to require its contracting health care providers who are responsible for performing a periodic health assessment of a child to test each child pursuant to specified standards of care for lead testing, to inform a child’s parent, parents, guardian, or other person charged with their support and maintenance with specified information, including the risks and effects of lead exposure, and to notify a child’s health care provider when that child has missed a required blood lead screening test. The bill would provide that it is the goal of the state that children at risk of lead exposure receive blood lead screening tests.

Primary Sponsors
Eloise Reyes, Cristina Garcia, Bill Quirk, Rudy Salas, Connie Leyva

State	Bill Number	Status	Position
CA	AB 2277	In Assembly	Monitor

Title
Medi-Cal: Blood lead screening tests.

Introduction Date: 2020-02-14

Description
AB 2277, as amended, Salas. Medi-Cal: Blood lead screening tests. 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 authorizes the department to enter contracts with managed care plans to provide Medi-Cal services. Under existing law, Medi-Cal covers early and periodic screening, diagnostic, and treatment services for individuals under 21 years of age, consistent with federal law.This bill would require any contract between the department and a Medi-Cal managed care plan to impose requirements on the Medi-Cal managed care plan to identify every enrollee who does not have a record of completing those tests at 12 and 24 months of age, and to remind the contracting health care provider who is responsible for performing a periodic health assessment of a child of the need to perform those tests. The bill would require the department to develop and implement procedures, and take enforcement action, as prescribed, to ensure that a Medi-Cal managed care plan performs those duties. If a Medi-Cal managed care plan enrollee who is a child misses a required blood lead screening test at 12 and 24 months of age, the bill would require the Medi-Cal managed care plan to notify specified individuals responsible for that child, including the parent or guardian, about those missed blood lead screening tests, and would require that notification to be included as part of an annual notification on preventive services.

Primary Sponsors
Rudy Salas, Cristina Garcia, Bill Quirk, Eloise Reyes, Connie Leyva

State	Bill Number	Status	Position
CA	AB 2278	In Assembly	Monitor

Title
Lead screening.

Introduction Date: 2020-02-14

Description
AB 2278, as amended, Quirk. Lead screening. Existing law requires the State Department of Public Health to maintain an electronic database to support electronic laboratory reporting of blood lead tests, management of lead-exposed children, and assessment of sources of lead exposures. Existing law requires a laboratory that performs a blood lead analysis on human blood drawn in California to report specified information, including the test results and the name, birth date, and address of the person tested, to the department for each analysis on every person tested. Existing law authorizes the department to share the information reported by a laboratory with, among other entities, the State Department of Health Care Services for the purpose of determining whether children enrolled in Medi-Cal are being screened for lead poisoning and receiving appropriate related services. This bill also would additionally require a laboratory that performs a blood lead analysis to report to the department, among other things, the Medi-Cal identification number and medical plan identification number, if available, for each analysis on every person tested.

Primary Sponsors
Bill Quirk, Cristina Garcia, Tim Grayson, Eloise Reyes, Rudy Salas, Connie Leyva

State	Bill Number	Status	Position
CA	AB 2280	In Assembly	Monitor

Title
Information privacy: digital health feedback systems.

Introduction Date: 2020-02-14

Description
AB 2280, 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 define “personal health record information” for purposes of the act to mean individually identifiable information, in electronic or physical form, about an individual’s mental or physical condition that is collected by an FDA-approved commercial internet website, online service, or product that is used by an individual at the direction of a provider of health care with the primary purpose of collecting the individual’s individually identifiable personal health record information through a direct measurement of an individual’s mental or physical condition or through user input regarding an individual’s mental or physical condition. The bill would provide that a business that offers personal health record software or hardware to a consumer, in order to make information available to an individual or provider of health care at the request of the individual or provider of health care, for purposes of allowing the individual to manage their information, or for the diagnosis, treatment, or management of a medical condition of the individual, shall be deemed to be a provider of health care subject to the requirements of the Confidentiality of Medical Information Act. Because the bill would expand the definition of a crime, it would impose a state-mandated local program.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Ed Chau

State	Bill Number	Status	Position
CA	AB 2288	In Assembly	Monitor

Title
Nursing programs: state of emergency.

Description
AB 2288, as amended, Low. Nursing programs: state of emergency. Existing law, the Nursing Practice Act, provides for the licensure and regulation of the practice of nursing by the Board of Registered Nursing and requires an applicant for licensure to have completed a nursing program at a school of nursing that is approved by the board. Existing regulatory law sets forth curriculum requirements for nursing programs, including preceptorships and clinical practice hours, and also requirements for clinical facilities that may be used for clinical experience. This bill would authorize the director of an approved nursing program to use a clinical setting without meeting specified requirements, including approval by the board, when the Governor declares a state of emergency in the county in which the facility is located. The bill would also authorize the director to use preceptorships without having to maintain written policies on specified matters that would otherwise be required, and to request that the approved nursing program be allowed to substitute up to an additional 25% of clinical practice hours in a course not in direct patient care, subject to specified conditions and requirements. The bill would make those provisions subject to approval by a board nurse education consultant and would require the board nurse education consultant to use a uniform standard for granting approvals.

Primary Sponsors
Evan Low

Introduction Date: 2020-02-14

State	Bill Number	Status	Position
CA	AB 2347	In Assembly	Monitor

Title
Health care coverage: financial assistance.

Introduction Date: 2020-02-18

Description
AB 2347, as amended, Wood. 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. 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. Until January 1, 2023, existing law requires the Exchange to administer a program of financial assistance, and authorizes the program to provide assistance, including premium assistance subsidies, to program participants with household incomes at or below 600% of the federal poverty level.This bill, contingent upon an appropriation by the Legislature, would reduce premiums to zero for program participants with household incomes at or below 138% of the federal poverty level, and would scale the premium assistance subsidy amount for program participants with household incomes of 139% to 600%, inclusive, of the federal poverty level pursuant to the program design adopted by the board of the Exchange.

Primary Sponsors
Jim Wood

Organizational Notes

Last edited by Cherie Compartore at Feb 20, 2020, 9:50 PM
Organization Sponsor: Health Access

State	Bill Number	Status	Position
CA	AB 2348	In Assembly	Monitor

Title
Pharmacy benefit management.

Introduction Date: 2020-02-18

Description
AB 2348, as amended, Wood. Pharmacy benefit management. Existing law provides for the regulation of health care service plans by the Department of Managed Health Care. A willful violation of those provisions is a crime. Existing law requires health care service plans that cover prescription drug benefits and contract with pharmacy providers and pharmacy benefit managers to meet specified requirements, including requiring pharmacy benefit managers with whom they contract to register with the department and exercise good faith and fair dealing, among other requirements.Existing law provides for the registration and regulation of pharmacy benefit managers, as defined, that contract with health care service plans to manage their prescription drug coverage. Under existing law, a pharmacy benefit manager is required to submit specified information to the department to apply to register with the department.This bill would require a pharmacy benefit manager to, beginning October 1, 2021, annually report specified information to the department regarding the covered drugs dispensed at a pharmacy and specified information about the pharmacy benefit manager's revenue, expenses, health care service plan contracts, the scope of services provided to the health care service plan, and the number of enrollees that the pharmacy benefit manager serves. The bill would require the department to compile this reported information and make the report publicly available, as specified, but would exempt records other than the report from public disclosure. The bill would include in the requirements that health care service plans are required to impose on a pharmacy benefit manager with which they contract, the requirement that the pharmacy benefit manager comply with these reporting requirements. Because a willful violation of these provisions by a health care service plan would be a crime, this bill would impose a state-mandated local program.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified reason.Existing constitutional provisions require that a statute that limits the right of access to the meetings of public bodies or the writings of public officials and agencies be adopted with findings demonstrating the interest protected by the limitation and the need for protecting that interest.This bill would make legislative findings to that effect.

Primary Sponsors
Jim Wood

State	Bill Number	Status	Position
CA	AB 2360	In Assembly	Monitor

Title
Telehealth: mental health.

Introduction Date: 2020-02-18

Description
AB 2360, as amended, Maienschein. Telehealth: 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 the consultation to be done by telephone or telehealth video, and would authorize the consultation to include guidance on providing triage services and referrals to evidence based treatment options, including psychotherapy. 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 May 18, 2020, 9:15 PM
Organization Sponsor: 2020 Mom CAHP: Opposed

State	Bill Number	Status	Position
CA	AB 2422	In Assembly	Monitor

Title
Lead testing.

Introduction Date: 2020-02-19

Description
AB 2422, as introduced, Grayson. Lead testing. Existing law, the Childhood Lead Poisoning Prevention Act of 1991, requires the State Department of Public Health to adopt regulations establishing a standard of care at least as stringent as the most recent United States Centers for Disease Control and Prevention screening guidelines, whereby all children are evaluated for risk of lead poisoning by health care providers during each child's periodic health assessment. Existing law requires the standard of care for a child who is determined to be "at risk" for lead poisoning to include the screening of that child. Existing regulations require every health care provider who performs a periodic health assessment of a child to order a child who receives services from a publicly funded program for low-income children to be screened for lead poisoning.Existing law requires a laboratory that performs a blood lead analysis on a specimen of human blood drawn in California to report specified information to the department for each analysis on every person tested. Existing law requires that all information reported be confidential, except that the department is authorized to share the information for the purpose of surveillance, case management, investigation, environmental assessment, environmental remediation, or abatement with the local health department, environmental health agency, or building department, so long as the entity receiving the information otherwise maintains the confidentiality of the information, as specified.Existing law requires the State Department of Public Health to implement and administer a program to meet the requirements of the federal Residential Lead-Based Paint Hazard Reduction Act of 1992. Among other things, the program requires the department to establish certification requirements for persons conducting lead-related construction work, abatement, or lead hazard evaluation. Existing regulations require specified information relating to hazard evaluations for public and residential buildings to be provided to the department.This bill would add to the information that a laboratory is required to provide the Medi-Cal identification number, or other equivalent medical identification number of the person tested. The bill would require, if the person tested is a minor, that the laboratory include the person's contact information and a unique identifier, in a form to be determined by the department, as specified.This bill would require the department to develop and maintain on its internet website a public registry of lead-contaminated locations reported to the department pursuant to the provisions relating to lead hazards in buildings. The bill would require the department to ensure that personally identifia... (click bill link to see more).

Primary Sponsors
Tim Grayson

State	Bill Number	Status	Position
CA	AB 2625	In Assembly	Monitor

Title
Emergency ground medical transportation.

Introduction Date: 2020-02-20

Description
AB 2625, as introduced, Boerner Horvath. Emergency ground medical transportation. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law requires that health care service plan contracts and health insurance policies provide coverage for certain services and treatments, including emergency medical transportation services.This bill would require a health care service plan contract or a health insurance policy issued, amended, or renewed on or after January 1, 2021, that offers coverage for emergency ground medical transportation services to include those services as in-network services and would require the plan or insurer to pay those services at the contracted rate pursuant to the plan contract or policy. Because a willful violation of the bill's requirements relative to a health care service plan would be a crime, the bill would impose a state-mandated local program.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Tasha Boerner Horvath

State	Bill Number	Status	Position
CA	AB 2729	In Assembly	Monitor

Title
Medi-Cal: presumptive eligibility.

Introduction Date: 2020-02-20

Description
AB 2729, as introduced, Bauer-Kahan. Medi-Cal: presumptive eligibility. Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions. Existing federal law, as a condition of receiving federal Medicaid funds, requires states to provide health care services to specified individuals. Existing federal law authorizes states to provide presumptive eligibility to pregnant women or children, and existing state law requires the department to provide presumptive eligibility to pregnant women and children, as specified.Under existing law, a minor may consent to pregnancy prevention or treatment services without parental consent. Under existing law, an individual under 21 years of age who qualifies for presumptive eligibility is required to go to a county welfare department office to obtain approval for presumptive eligibility.This bill would expand the presumptive eligibility for pregnant women to all pregnant people, renaming the program “Presumptive Eligibility for Pregnant People” (PE4PP). The bill would make a presumptively eligible pregnant person eligible for coverage of all medical care, services, prescriptions, and supplies available under the Medi-Cal program, except for inpatient services and institutional long-term care. The bill would also require the department to ensure that a pregnant person receiving coverage under PE4PP who applies for full-scope Medi-Cal benefits within 60 days receives coverage under PE4PP until their full-scope Medi-Cal application is approved or denied, as specified.The bill would allow a pregnant individual under 26 years of age who can consent to services without parental approval to receive presumptive eligibility by a qualified hospital. The bill would also make conforming changes. Because counties are required to make eligibility determinations, and this bill would expand Medicaid eligibility, the bill would impose a state-mandated local program.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.

Primary Sponsors
Rebecca Bauer-Kahan

State	Bill Number	Status	Position
CA	AB 2775	In Assembly	Monitor

Title
Timely access to health care.

Introduction Date: 2020-02-20

Description
AB 2775, as introduced, Ting. Timely access to health care. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law requires each department to develop and adopt regulations to ensure that enrollees and insureds have access to needed health care services in a timely manner, and existing regulations set forth these timely access standards for specified health care appointments.This bill would declare the intent of the Legislature to ensure that patients receive timely access to health care services, including nonemergency followup appointments with mental health care providers within 10 business days.

Primary Sponsors
Phil Ting

Organizational Notes

Last edited by Cherie Compartore at Mar 3, 2020, 7:41 PM
Organization Sponsor: National Union of Healthcare Workers

State	Bill Number	Status	Position
CA	AB 2830	In Assembly	Monitor

Title
Health Care Payments Data Program.

Introduction Date: 2020-02-20

Description
AB 2830, as amended, Wood. Health Care Payments Data Program. Existing law, the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene), 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 provides for the regulation of health insurers by the Department of Insurance. Existing law, the Information Practices Act of 1977, regulates the collection and disclosure of personal information regarding individuals by state agencies, except as specified. Under existing law, a person who willfully requests or obtains a record containing personal information from an agency under false pretenses or a person who intentionally discloses medical, psychiatric, or psychological information held by an agency is guilty of a misdemeanor.Existing law states the intent of the Legislature to establish the Health Care Cost Transparency Database to collect information on the cost of health care, and requires the Office of Statewide Health Planning and Development to convene a review committee to advise the office on the establishment and implementation of the database. Existing law requires, subject to appropriation, the office to establish, implement, and administer the database by July 1, 2023. Existing law requires certain health care entities, including a health care service plan, to provide specified information to the office for collection in the database.This bill would delete those provisions relative to the Health Care Cost Transparency Database and would instead require the office to establish the Health Care Payments Data Program to implement and administer the Health Care Payments Data System, which would include health care data submitted by health care service plans, health insurers, a city or county that offers self-insured or multiemployer-insured plans, and other specified mandatory submitters. The bill would require the Department of Managed Health care and the Department of Insurance to take appropriate action to bring a plan or insurer into compliance if the office notifies the appropriate department of a plan or insurer's failure to submit required data, and would specify that the failure of a health care service plan to submit required data is a violation of Knox-Keene. Because a willful violation of these provisions by a health care service plan would be a crime, and because a city or county that offers self-insured or multiemployer-insured plans would be required to submit health care data to the office, the bill would impose a state-mandated local program.This bill would require the office to use the above-described data to produce publicly available information, including data products, summaries... (click bill link to see more).

Primary Sponsors
Jim Wood

Organizational Notes

Last edited by Joanne Campbell at May 18, 2020, 9:17 PM
CAHP: Opposed Unless Amended

State	Bill Number	Status	Position
CA	AB 2871	In Assembly	Monitor

Title
Medi-Cal: substance use disorder services: reimbursement rates.

Introduction Date: 2020-02-21

Description
AB 2871, as introduced, Fong. Medi-Cal: substance use disorder services: reimbursement rates. 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 specialty mental health services and substance use disorder services that are delivered through the Medi-Cal Specialty Mental Health Services Program, the Drug Medi-Cal Treatment Program (Drug Medi-Cal), and the Drug Medi-Cal organized delivery system (DMC-ODS). The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.Under Drug Medi-Cal, the department is authorized to enter into contracts with counties for various drug treatment services to Medi-Cal recipients, or is required to directly arrange for these services if a county elects not to do so. Existing law specifies the method of determining the maximum allowable reimbursement rates for Drug Medi-Cal and group outpatient drug free services.Existing law requires the department to implement the Medi-Cal 2020 demonstration project, including the DMC-ODS that provides alcohol and drug use services to eligible persons and authorizes the department to enter into a DMC-ODS contract with a county for the provision of those services within a county service area.This bill would require the department, in establishing reimbursement rates for services under Drug Medi-Cal and capitated rates for a Medi-Cal managed care plan contract that covers substance use disorder services to ensure that those rates are equal to the reimbursement rates for similar services provided under the Medi-Cal Specialty Mental Health Services Program.The bill would also require the department to require its managed care contractors that cover substance use disorder services to set reimbursement rates for those services at equal rates to similar services provided under the Medi-Cal Specialty Mental Health Services Program.

Primary Sponsors
Vince Fong

State	Bill Number	Status	Position
CA	AB 2983	In Assembly	Monitor

Title
Pharmacies: automatic refills.

Introduction Date: 2020-02-21

Description
AB 2983, as amended, Holden. Pharmacies: automatic refills.
Existing law, the Pharmacy Law, provides for the licensure and regulation of pharmacists and pharmacies by the California State Board of Pharmacy, and makes a willful violation of those provisions a misdemeanor. Existing law prohibits a prescription for any dangerous drug or dangerous device to be refilled except upon authorization of the prescriber.This bill would prohibit a pharmacy from automatically contacting a prescriber to authorize a prescription for any dangerous drug or device to be refilled for more than a 7-day supply unless the prescriber or patient has expressly authorized the pharmacy to automatically contact the prescriber to refill that prescription. The bill would require a pharmacy to obtain separate written authorization for each prescription and would prohibit a pharmacy from requesting more than the number of refills authorized in the original prescription. The bill would require the pharmacy to retain a record of the authorization for at least 3 years. The bill would exempt certain pharmacies owned or operated by a nonprofit health care service plan, as specified. Because the bill would expand the scope of a crime, the bill would impose a state-mandated local program.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Chris Holden

State	Bill Number	Status	Position
CA	AB 2984	In Assembly	Monitor

Title
Prescription drug cost sharing.

Introduction Date: 2020-02-21

Description
AB 2984, as amended, Daly. Prescription drug cost sharing. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law limits the maximum amount an enrollee or insured may be required to pay at the point of sale for a covered prescription drug to the lesser of the applicable cost-sharing amount or the retail price.This bill would require an enrollee's or insured's defined cost sharing for each prescription drug to be calculated at the point of sale based on a price that is reduced by an amount equal to 90% of all rebates received, or to be received, in connection with the dispensing or administration of the drug. The bill would prohibit a health care service plan, health insurer, or a plan's or insurer's agents from publishing or otherwise revealing information regarding the actual amount of rebates the health care service plan or health insurer receives on a product-specific, manufacturer-specific, or pharmacy-specific basis. 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
Tom Daly

State	Bill Number	Status	Position
CA	AB 3118	In Assembly	Support

Title
Medically supportive food.

Introduction Date: 2020-02-21

Description
AB 3118, as amended, Bonta. Medically supportive food. 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 enteral nutrition products, pursuant to a schedule of benefits, and subject to utilization controls, such as prior authorization. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law, until January 1, 2021, or as otherwise specified, requires the department to establish a 3-year pilot program in specified counties, including the Counties of Alameda and Sonoma, to provide medically tailored meals, as defined, to Medi-Cal participants with specified health conditions, such as cancer and renal disease.This bill would require the department to establish, no earlier than January 1, 2021, a pilot program for a 3-year period in the County of Alameda to provide medically supportive food, such as healthy food vouchers or renewable food prescriptions, as a covered benefit for a Medi-Cal beneficiary who has a specified chronic health condition, including diabetes or heart disease, when utilizing evidence-based practices that demonstrate the prevention, reduction, or reversal of those specified diseases. The bill would authorize the department, in consultation with stakeholders, to establish utilization controls, including the limitation on the number of services, and to enter into contracts for purposes of implementing the pilot program. The bill would require the department to evaluate the pilot program upon its conclusion, to report to the Legislature on those findings, and to implement these provisions by various means, including provider bulletins, without taking regulatory action. The bill would condition the implementation of these provisions to the extent permitted by federal law, the availability of federal financial participation, and the department securing federal approval, and would repeal these provisions on January 1, 2026.This bill would make legislative findings and declarations as to the necessity of a special statute for the County of Alameda.

Primary Sponsors
Rob Bonta

State	Bill Number	Status	Position
CA	AB 3285	In Assembly	Monitor

Title
Medi-Cal: antipsychotic drugs.

Introduction Date: 2020-02-21

Description
AB 3285, as introduced, Irwin. Medi-Cal: antipsychotic drugs. 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 pursuant to a schedule of benefits. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law provides for the provision of prescription drugs as a Medi-Cal benefit, subject to the list of contract drugs and utilization controls. Existing law limits prescribed drugs under the Medi-Cal program to 6 drugs per month, unless prior authorization is obtained, and except under specified circumstances.This bill would prohibit requiring prior authorization for an antipsychotic drug to treat the serious mental illness of a Medi-Cal enrollee for 365 days after the initial prescription has been dispensed, and would require automatic approval of an antipsychotic drug to treat the serious mental illness of a Medi-Cal enrollee if the department verifies a paid claim that documents a diagnosis of a serious mental illness within 365 days before the date of that prescription. The bill would exclude an antipsychotic drug to treat serious mental illness from the Medi-Cal program's limit of 6 drugs per month. The bill would require the department to allow a pharmacist to dispense a 90-day supply or early refill of a prescribed antipsychotic drug if specified criteria are met.

Primary Sponsors
Jacqui Irwin

State	Bill Number	Status	Position
CA	AB 3300	In Assembly	Monitor

Title
Homelessness: California Access to Housing and Services Act.

Introduction Date: 2020-02-21

Description
AB 3300, as amended, Santiago. Homelessness: California Access to Housing and Services Act. Existing law establishes the Homeless Housing, Assistance, and Prevention program for the purpose of providing jurisdictions with one-time grant funds to support regional coordination and expand or develop local capacity to address their immediate homelessness challenges informed by a best-practices framework focused on moving homeless individuals and families into permanent housing and supporting the efforts of those individuals and families to maintain their permanent housing. Upon appropriation, existing law requires the Business, Consumer Services, and Housing Agency to distribute $650,000,000 among continuums of care, cities, and counties pursuant to the program. By executive order, the Governor required the Department of Finance to establish the California Access to Housing and Services Fund, administered by the State Department of Social Services, to provide funding for additional affordable housing units, providing rental and operating subsidies, and stabilizing board and care homes. This bill, the California Access to Housing and Services Act, would establish the California Access to Housing and Services Fund in the State Treasury and continuously appropriate moneys in the fund solely for the purpose of implementing and administering the bill's provisions. The bill, for the 2020–21 fiscal year and each fiscal year thereafter, would require the Controller to transfer $2,000,000,000 from the General Fund to the fund and require the Department of Housing and Community Development and the State Department of Social Services to jointly administer the fund pursuant to a memorandum of understanding, as provided. The bill would require the departments, in collaboration with the California Health and Human Services Agency and after deduction for administrative costs and certain allocations to the Governor's Office to End Homelessness, if the bill establishing that office is enacted, to allocate 55% of the moneys in the fund to counties and continuums of care that apply jointly, 45% to large cities, and 5% to developers operating in unincorporated areas and cities that are not eligible for an allocation. The bill would define various terms for these purposes. The bill would require that recipients and subrecipients ensure that any expenditure of moneys allocated to them serve the eligible population, as defined, unless otherwise expressly provided in the bill.The bill would require eligible recipients to apply for allocations and require the departments to evaluate those applications based on specified criteria and make annual allocations, as provided. The bill would require recipients to contractually obligate 100% of the ... (click bill link to see more).

Primary Sponsors
Miguel Santiago, Richard Bloom, Rob Bonta, Mike Gipson, Sharon Quirk-Silva, Buffy Wicks, Wendy Carrillo, Todd Gloria, Ash Kalra, Adrin Nazarian

State	Bill Number	Status	Position
CA	AB 3344	In Assembly	Monitor

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

Description
AB 3344, as introduced, Gloria. Medi-Cal: federally qualified health centers and 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, to the extent that federal financial participation is obtained, to providers on a per-visit basis.This bill would make technical, nonsubstantive changes to those provisions.

Primary Sponsors
Todd Gloria

Introduction Date: 2020-02-21

State	Bill Number	Status	Position
CA	SB 65	In Assembly	Support

Title
Health care coverage: financial assistance.

Introduction Date: 2019-01-08

Description
SB 65, as amended, Pan. 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. Until January 1, 2023, existing law requires the Exchange, among other duties, to administer an individual market assistance program to provide assistance, including premium assistance subsidies, to program participants with household incomes at or below 600% of the federal poverty level.This bill would reduce premiums to zero for program participants with household incomes at or below 138% of the federal poverty level, and would specify the premium assistance subsidy amount for program participants with household incomes of 139% to 600%, inclusive, of the federal poverty level. The bill would require the financial assistance administered by the Exchange to include cost-sharing reduction assistance to reduce the copays, deductibles, coinsurance, out-of-pocket maximums, and other cost sharing of a program participant with a household income of 200% to 400%, inclusive, of the federal poverty level.

Primary Sponsors
Richard Pan

Organizational Notes

Last edited by Joanne Campbell at May 27, 2020, 4:09 PM
Organization Sponsor: Health Access Support - California Association of Health Plans, Local Health Plans of California

BOARD OF GOVERNORS
Executive Committee
Meeting Minutes – April 27, 2020
1055 West 7th Street, Los Angeles, CA 90017

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

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*

California Governor issued Executive Order No. N-29-20, which among other provisions amends the Ralph M. Brown Act and Executive Order No. 33-20, ordering all residents to stay in their homes, except for specific essential functions. Members of the public can listen to this meeting via teleconference.

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
CALL TO ORDER	Hector De La Torre, *Chairperson,* called the meetings to order for L.A. Care Executive Committee and L.A. Care's Joint Powers Authority Executive Committee at 2:25 p.m. The meetings were held simultaneously. He welcomed everyone to the meetings and invited the members of the Committees, staff and guests to introduce themselves. Chair De La Torre summarized the process for this teleconference meetings as reflected on the meeting agenda. • Public comments received by voicemail, email or text received by 2:00 p.m. today were provided in writing to the Executive Committee members. Public comments will be read for 3 minutes during the meeting. • Once the meeting has started, emails and texts for public comment should be submitted before the item is called by the meeting Chair. If you wish to submit public comment on an item, you must submit it at any time prior to the time the Chair starts consideration of the item. The Chair will ask for public comment and will announce the item. The Chair will announce when public comment period is over.	

APPROVED

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
APPROVE MEETING AGENDA	The Agenda for today's meeting was approved.	**Approved unanimously by roll call. 5 AYES (Ballesteros, Booth, De La Torre, Gonzalez, and Perez)**
PUBLIC COMMENTS	There were no public comments.	
APPROVE MEETING MINUTES	The minutes of the March 24, 2020 meeting were approved, as submitted.	**Approved unanimously by roll call. 5 AYES**
CHAIRPERSON'S REPORT	Chairperson De La Torre thanked staff for their work and assistance to the Board for continuing L.A. Care's operations. The Leadership Team is the backbone of this operation. He added that he is proud of L.A. Care for stepping up in assisting the providers to assure access to care for and to assist L.A. Care members.	
CHIEF EXECUTIVE OFFICER REPORT	John Baackes, *Chief Executive Officer*, reported: Recap of COVID crisis • Staff has been working from home since March 16. On the weekend preceding March 16, Information Technology (IT) staff put together equipment to distribute to employees setting up a home office. IT has maintained a command center, which keeps everyone functioning. All key business indicators are being met by L.A. Care staff. Employees are remarkably upbeat and many are grateful to work from home. • Post pandemic, L.A. Care employees will want to continue to work from home. Mr. Baackes has asked Human Resources to come up with a work from home policy, and will continue to update this Committee. • He thanked IT and Facility department staff for their remarkable support during the transition to working from home. • L.A. Care's main role is to provide access to care for members, and we will continue to support the providers who care for L.A. Care members. • L.A. Care will advance Pay for Performance (P4P) incentive payments to Federally Qualified Health Centers (FQHCs) and other providers equal to what they received last year. The payments were scheduled to be paid in January 2021. $20 million was disbursed to providers last week. If a provider earns more incentive than we have paid, they get more in January 2021. If they earn less they keep the difference.	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• To help many members with social needs, L.A. Care has repurposed budgeted Community Health Investment Fund (CHIF) grants to direct $6 million in grants to various agencies. Staff will present a motion at the May 7 Board of Governors meeting. Projects to be funded will include: o More recuperative care beds o Tents and supplies for homeless o Testing for congregate living o Telehealth o Eviction prevention o Meal delivery o Support for safety net clinics o Advanced payments for CHIF grants o For hospitals who have not seen CARES act funds. o Advanced payment of claims to hospitals (accelerated $50 million) Dino Kasdagly, *Chief Operating Officer,* added that prior timing for claims payments was 20 days for electronic and 25 days for paper. That has been reduced to 10 days and 15 days to support the providers. The reduction was accomplished by temporarily loosening quality assurance and payment integrity processes, which is not a best practice, but the goal was to get funds to providers quickly in the current emergency situation. Mr. Baackes asked Marie Montgomery, *Chief Financial Officer,* to report on Proposition 56 and other funds L.A. Care is responsible for distributing. Ms. Montgomery reported that in March L.A. Care sent out over $550 million in hospital directed payment and quality assurance funds, and Cost Based Reimbursement Clinics (CBRC) funds to Los Angeles County Department of Health Services of about $97 million. Staff is focused on distributing existing Proposition 56 and family planning funds that were received by L.A. Care in mid-April. Mr. Baackes noted that L.A. Care doing as much as possible so providers are not lacking funds and can continue to serve members. L.A. Care is also working with the Community Clinics Association of Los Angeles County, the Private Essential Access Community Hospitals and the Hospital Association of Southern California to coordinate aid for providers that need it most. • In California, the unprecedented high level of unemployment will likely lead to additional enrollment in Medi-Cal. L.A. Care is working with a model developed by	

APPROVED

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Health Management Associates that predicts Medi-Cal will increase by more than 1 million, which could be an additional 230,000-460,000 gain in members for L.A. Care. This is significant, but will not be a permanent gain in members. The challenge will be not to inflate infrastructure, so that when enrollment returns to pre pandemic levels, L.A. Care is not left with too much overhead. • California Department of Health Care Services (DHCS) has announced that the current federal waiver, Cal AIM, is suspended for at least a year, and is instead asking that existing waivers be extended for Whole Person Care and Housing4Health programs. • Unfortunately, DHCS is pressing on with a proposed carve out of Prescription drugs from Medi-Cal benefits. L.A. Care and a coalition of health plans has submitted a letter asking that this proposal is delayed. A delay appears unlikely. • Cuts in the Medi-Cal program are likely due to lower federal payments which will likely lead to reductions in benefits, determining that categories of members are ineligible and lowering rates paid to providers of care. • L.A. Care has joined with 14 other plans in asking for federal support for the duration of the recession: o Seeking funds to maintain existing benefits through the Coronavirus Aid, Relief, and Economic Security (CARES) Act o With increased enrollment, asking for additional funds to keep Medicaid (Medi-Cal) programs whole o indefinitely suspend Medicaid Fiscal Accountability Proposed Rule (MFAR) regulations, which determine how hospitals receive directed payments o Amend the Medicaid regulations to allow presumptive eligibility o Suspend public charge rules • L.A. Care is also working with other health plans around the country on continued funding and benefits during the looming recession • This morning, the Supreme Court in unprecedented 8-1 decision, ruled in favor of insurance companies on the constitutional legality of the risk sharing payments due to plans through the Affordable Care Act. L.A. Care's potential share is about $23 million. Member Perez asked if there is a written CEO report. Mr. Baackes responded that this will be included in his written CEO report for the May 7 board meeting. He will provide copies of letters sent to U.S. Congress California legislative delegation.	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Member Ballesteros commended L.A. Care's support for community health centers and FQHCs, which he has announced at several local meetings, and clinics are very appreciative. Patient visits to facilities are down 20-50%, and L.A. Care's advanced claims payment arrived at the right time to maintain cash flow amid the current level of operations. He expressed his and the clinics' appreciation to the Board and Mr. Baackes for the support. As of April 1, through a cooperative agreement with Heritage IPA, L.A. Care moved 41,000 members to different IPAs (away from Heritage) because of quality concerns. An additional 15,000 members will move with their primary care physicians (PCPs) into L.A. Care's directly contracted provider network. There will be announcements in the next few months about increases in L.A. Care's directly contracted provider network. Member Booth commented that many of the doctor visits were postponed because of the stay at home order, and in keeping a health equity action plan in mind, this may be a good time to provide resources and training to assist providers with chronic disease management, such as diabetes and asthma care. Richard Seidman, *Chief Medical Officer,* responded that L.A. Care continues to provide information about telehealth, encouraging PCPs to use telehealth and on how to bill for those services. In-person visits are down but telehealth use is increasing. Member Ballesteros noted that many providers are providing services more than 50% of the time in telehealth and chronic disease management is ongoing, however, there are certain visits that cannot be done by telephone.	
2nd Quarter FY 2019-20 Vision 2021 Progress Report	Mr. Baackes referred to the report included in the meeting materials *(a copy of the report may be requested by contacting Board Services).* Member Booth commented that the improved report now clearly demonstrates how L.A. Care is a leader and role model for the community. Mr. Baackes thanked Member Booth for her comments and suggestions to improve the report.	
Government Affairs Update	Cherie Compartore, *Senior Director, Government Affairs,* reported that Governor Newsom announced on Friday that effective immediately, additional food services would be provided for seniors. The state in partnership with Federal Emergency Management Agency (FEMA) will contract with independent restaurants to provide seniors with three	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	meals daily. The cost of these services will be shared 75% by the state and 25% by local governments.	
Revise 2020 Board & Committee Meeting Schedule (EX	Linda Merkens, *Senior Manager, Board Services,* presented a motion to revise the Board meeting schedule to hold the June 4, 2020 at L.A. Care Health Plan, 1055 W. 7th Street, Los Angeles, CA 90017. The meeting was originally scheduled to be held offsite, but because of the public health orders related to the COVID-19 pandemic, that meeting will now be rescheduled to be held at L.A. Care's offices. **Motion EXE 100.0520** **To approve the revised 2020 Board of Governors meeting schedule as submitted.**	**Approved unanimously by roll call. 5 AYES** **The Committee approved including this motion on the Consent Agenda for the May 7 Board of Governors meeting**
Annual Disclosure of Broker Fees	Terry Brown, *Chief Human Resources Officer,* referred Committee members to the report included in the meeting packet *(a copy of the report may be requested by contacting Board Services).* This is to comply with the requirements of AB 2589 in reporting insurance broker fees associated with the various benefits L.A. Care offers to its employees. It is the disclosure of the commissions earned by Woodruff Sawyer, L.A. Care's broker of record for the majority of various health and wellness insurers providing L.A. Care employee benefits for the last two fiscal years (2018-19 and 2019-20). Commissions are paid to Woodruff Sawyer on a monthly or annual basis, and the amount is based on the number of participants in the benefit program. This disclosure also includes commissions paid to LTC Solutions, Inc., the writing agent for the Genworth policy.	
Authorization of Expenditures for existing programs under the Elevating the Safety Net (ESN) Initiative	Mr. Baackes summarized a motion requesting authorization to add In Home Support Services (IHSS) Home Care Integration Training Program to the existing L.A. Care program with California Long-Term Care Education Center (CLTCEC), to align the work L.A. Care is doing to equip our non-clinical professionals with the tools and skills to serve members and work with providers. Member Gonzalez noted that the CLTCEC graduations are going on now. Given the current resources available, they do not have the right personal protective equipment (PPE) to continue. She asked if L.A. Care will try to provide PPE to the graduates. Mr. Baackes asked Dr. Seidman to make a request to the Los Angeles County Medicaid group that meets weekly, to try to source the PPE. Dr. Seidman will work on the request and will forward to the Office of Emergency Medical Services in Los Angeles County. He noted that everybody needs PPE, and medical practitioners are priority.	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Mr. Baackes reported that SoCal Transformation is a group looking for ideas about mitigating effects of the pandemic and pending recession. Mr. Baackes commented that he has proposed an idea to enhance local pandemic preparation that seeks resources from local businesses, to help the local economy. Dr. Seidman noted that there are good resources specific to IHSS workers for recommended practical everyday precautions. Member Booth added that she supports adding IHSS to the Elevating the Safety Net (ESN) program. She asked if payments would be made directly to doctors or to providers. Mr. Baackes responded that L.A. Care uses a vendor who administers direct payments to doctors for the ESN program. **<u>Motion EXE 101.0520</u>** **To delegate authority to the Chief Executive Officer to:** **1. Authorize expenditures of up to $6 million to continue awarding providers in the Provider Loan Repayment Program, currently managed by Uncommon Good.** **2. Approve and authorize integrating the California Long-Term Care Education Center (CLTCEC) IHSS+ Home Care Integration Training Program under Elevating the Safety Net in the FY 2020-21.**	**Approved unanimously by roll call. 5 AYES**
Approve the Consent Agenda for May 7, 2020 Board of Governors meeting	• Minutes of April 2, 2020 Board of Governors meeting • Revised 2020 Board of Governors Meeting Schedule • Quarterly Investment Report • WEX Health Contract Amendment • ~~Toney Health Care Consulting Contract Amendment~~ • TransUnion Contract Amendment • SAP Contract Amendment	**Approved unanimously by roll call. 6 AYES (Ballesteros, Booth, Curry, De La Torre, Gonzalez, and Perez)**
PUBLIC COMMENTS	There were no public comments.	
ADJOURN TO CLOSED SESSION	Augustavia J. Haydel, Esq., *General Counsel,* announced the items to be discussed in closed session. She announced there is no report anticipated from the closed session. The meeting adjourned to closed session at 3:29 p.m.	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	CONTRACT RATES Pursuant to Welfare and Institutions Code Section 14087.38(m) • Plan Partner Rates • Provider Rates • DHCS Rates CONFERENCE WITH REAL PROPERTY NEGOTIATORS Pursuant to Section 54956.8 of the Ralph M. Brown Act Property: 11725 Rosecrans Ave., Norwalk, CA. 90650 Agency Negotiator: John Baackes Negotiating Parties: Hekmatravan Family Norwalk, LLC, and Levian Family Norwalk, LLC. Under Negotiation: Price and Terms of Payment REPORT INVOLVING TRADE SECRET Pursuant to Welfare and Institutions Code Section 14087.38(n) Discussion Concerning New Service, Program, Business Plan Estimated date of public disclosure: *April 2022* CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION Significant exposure to litigation pursuant to Section 54956.9(d) (2) of Ralph M. Brown Act One Potential Case	
RECONVENE IN OPEN SESSION	The meeting reconvened in open session at 4:16 pm. No reportable actions were taken during the closed session.	
ADJOURNMENT	The meeting adjourned at 4:17p.m.	

Respectfully submitted by:

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

APPROVED BY:

_____
Hector De La Torre, *Chair*
Date: _____

APPROVED

L.A. Care HEALTH PLAN

Board of Governors
MOTION SUMMARY

Date: June 4, 2020 **Motion No. FIN 103.0620**

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

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

Issue: Acceptance of the Financial Reports for April 2020.

Background: N/A

Member Impact: N/A

Budget Impact: N/A

Motion: **To accept the Financial Report as submitted for April 2020.**

Financial Performance
April 2020 - Final
(Unaudited)

Overall

The combined member months are 15.1 million year-to-date, which is 12,435 member months favorable to the 4+8 forecast. The year-to-date performance is a surplus of $87.8 million or 1.8% of revenue and is $34.0 million favorable to the 4+8 forecast. The favorable variance is driven by lower outpatient claims and timing in provider incentive accrual, but partially offset by higher pharmacy costs.

MediCal Plan Partners

The member months are 6.7 million, which is 8,555 member months unfavorable to the 4+8 forecast. The performance is a surplus of $57.8 million and is $1.9 million unfavorable to the 4+8 forecast. The unfavorable variance is primarily due to lower revenue net of healthcare costs, but partially offset by timing in provider incentive accrual.

MediCal SPD-CCI

The member months are 1.5 million, which is 547 member months favorable to the 4+8 forecast. The performance is a deficit of $23.7 million and is $9.8 million favorable to the 4+8 forecast. The favorable variance is due to lower outpatient claims but partially offset by higher skilled nursing facility costs and provider shared risks.

MediCal TANF-MCE

The member months are 5.8 million, which is 2,869 member months favorable to the 4+8 forecast. The performance is a surplus of $59.3 million and is $13.8 million favorable to the 4+8 forecast. The favorable variance is due to lower skilled nursing facility costs, lower inpatient claims and timing in provider incentive accrual; but partially offset by a provider reconciliation adjustment.

Cal MediConnect (CMC)

The member months are 114,326, which is 526 member months favorable to the 4+8 forecast. The performance is a surplus of $2.5 million and is $12.5 million favorable to the 4+8 forecast. The favorable variance is driven by higher Medicare risk adjustment and lower inpatient claims.

Commercial

L.A. Care Commercial consists of LACC and PASC-SEIU. The member months are 915,474, which is 17,048 member months favorable to the 4+8 forecast. The performance is a surplus of $13.7 million and is $3.8 million unfavorable to the 4+8 forecast. The unfavorable variance is due to higher inpatient claims but partially offset by provider shared risk.

L.A. Care HEALTH PLAN

Consolidated Operations Income Statement ($ in thousands)

April 2020

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						
2,173,570		2,146,756		26,814		Member Months	15,067,129		15,054,694		12,435	
						Revenue						
$ 698,909	$ 321.55	$ 688,274	$ 320.61	$ 10,635	$ 0.94	Capitation	$ 4,865,048	$ 322.89	$ 4,864,796	$ 323.14	$ 251	$ (0.25)
$ 698,909	**$ 321.55**	**$ 688,274**	**$ 320.61**	**$ 10,635**	**$ 0.94**	**Total Revenues**	**$ 4,865,048**	**$ 322.89**	**$ 4,864,796**	**$ 323.14**	**$ 251**	**$ (0.25)**
						Healthcare Expenses						
$ 373,033	$ 171.62	$ 373,742	$ 174.10	$ 709	$ 2.47	Capitation	$ 2,610,492	$ 173.26	$ 2,614,312	$ 173.65	$ 3,820	$ 0.40
$ 75,703	$ 34.83	$ 78,346	$ 36.50	$ 2,643	$ 1.67	Inpatient Claims	$ 556,679	$ 36.95	$ 557,410	$ 37.03	$ 732	$ 0.08
$ 40,312	$ 18.55	$ 63,480	$ 29.57	$ 23,168	$ 11.02	Outpatient Claims	$ 430,707	$ 28.59	$ 450,898	$ 29.95	$ 20,191	$ 1.36
$ 69,006	$ 31.75	$ 64,240	$ 29.92	$ (4,766)	$ (1.82)	Skilled Nursing Facility	$ 454,476	$ 30.16	$ 453,966	$ 30.15	$ (510)	$ (0.01)
$ 54,343	$ 25.00	$ 58,220	$ 27.12	$ 3,878	$ 2.12	Pharmacy	$ 409,839	$ 27.20	$ 403,379	$ 26.79	$ (6,460)	$ (0.41)
$ 2,772	$ 1.28	$ 15,512	$ 7.23	$ 12,740	$ 5.95	Provider Incentives and Shared Risk	$ 17,796	$ 1.18	$ 28,945	$ 1.92	$ 11,149	$ 0.74
$ 6,196	$ 2.85	$ 6,642	$ 3.09	$ 446	$ 0.24	Medical Administrative Expenses	$ 40,175	$ 2.67	$ 42,225	$ 2.80	$ 2,050	$ 0.14
$ 621,364	**$ 285.87**	**$ 660,182**	**$ 307.53**	**$ 38,818**	**$ 21.65**	**Total Healthcare Expenses**	**$ 4,520,163**	**$ 300.00**	**$ 4,551,136**	**$ 302.31**	**$ 30,972**	**$ 2.31**
88.9%		*95.9%*		*7.0%*		*MCR(%)*	*92.9%*		*93.6%*		*0.6%*	
$ 77,545	**$ 35.68**	**$ 28,091**	**$ 13.09**	**$ 49,454**	**$ 22.59**	**Operating Margin**	**$ 344,885**	**$ 22.89**	**$ 313,661**	**$ 20.83**	**$ 31,224**	**$ 2.06**
$ 41,199	$ 18.95	$ 37,105	$ 17.28	$ (4,094)	$ (1.67)	**Total Operating Expenses**	$ 264,831	$ 17.58	$ 261,430	$ 17.37	$ (3,402)	$ (0.21)
5.9%		*5.4%*		*-0.5%*		*Admin Ratio(%)*	*5.4%*		*5.4%*		*-0.1%*	
$ 36,346	**$ 16.72**	**$ (9,014)**	**$ (4.20)**	**$ 45,359**	**$ 20.92**	**Income (Loss) from Operations**	**$ 80,053**	**$ 5.31**	**$ 52,231**	**$ 3.47**	**$ 27,822**	**$ 1.84**
$ (3,007)	$ (1.38)	$ (4,368)	$ (2.03)	$ 1,362	$ 0.65	Other Income/(Expense), net	$ (20,815)	$ (1.38)	$ (23,855)	$ (1.58)	$ 3,040	$ 0.20
$ 1,868	$ 0.86	$ 2,313	$ 1.08	$ (445)	$ (0.22)	Interest Income, net	$ 19,367	$ 1.29	$ 19,828	$ 1.32	$ (461)	$ (0.03)
$ 174	$ 0.08	$ -	$ -	$ 174	$ 0.08	Realized Gain / Loss	$ 953	$ 0.06	$ 216	$ 0.01	$ 737	$ 0.05
$ 6,609	$ 3.04	$ -	$ -	$ 6,609	$ 3.04	Unrealized Gain / Loss	$ 8,200	$ 0.54	$ 5,321	$ 0.35	$ 2,879	$ 0.19
$ 5,645	**$ 2.60**	**$ (2,055)**	**$ (0.96)**	**$ 7,700**	**$ 3.55**	**Total Non-Operating Income (Expense)**	**$ 7,705**	**$ 0.51**	**$ 1,508**	**$ 0.10**	**$ 6,196**	**$ 0.41**
$ 41,991	**$ 19.32**	**$ (11,069)**	**$ (5.16)**	**$ 53,059**	**$ 24.47**	**Net Surplus (Deficit)**	**$ 87,758**	**$ 5.82**	**$ 53,739**	**$ 3.57**	**$ 34,019**	**$ 2.25**
6.0%		*-1.6%*		*7.6%*		*Margin(%)*	*1.8%*		*1.1%*		*0.7%*	

L.A. Care HEALTH PLAN

MediCal Plan Partners Income Statement ($ in thousands)

April 2020

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						
962,910		958,887		4,023		Member Months	6,734,883		6,743,438		(8,555)	
						Revenue						
$ 252,959	$ 262.70	$ 253,833	$ 264.72	$ (874)	$ (2.01)	Capitation	$ 1,754,540	$ 260.52	$ 1,771,356	$ 262.68	$ (16,815)	$ (2.16)
$ 252,959	**$ 262.70**	**$ 253,833**	**$ 264.72**	**$ (874)**	**$ (2.01)**	**Total Revenues**	**$ 1,754,540**	**$ 260.52**	**$ 1,771,356**	**$ 262.68**	**$ (16,815)**	**$ (2.16)**
						Healthcare Expenses						
$ 239,306	$ 248.52	$ 237,846	$ 248.04	$ (1,460)	$ (0.48)	Capitation	$ 1,662,784	$ 246.89	$ 1,670,783	$ 247.76	$ 7,999	$ 0.87
$ 6	$ 0.01	$ -	$ -	$ (6)	$ (0.01)	Inpatient Claims	$ 85	$ 0.01	$ (0)	$ (0.00)	$ (85)	$ (0.01)
$ 1	$ 0.00	$ -	$ -	$ (1)	$ (0.00)	Outpatient Claims	$ (21)	$ (0.00)	$ (16)	$ (0.00)	$ 5	$ 0.00
$ -	$ -	$ 5,602	$ 5.84	$ 5,602	$ 5.84	Provider Incentives and Shared Risk	$ (32)	$ (0.00)	$ 5,570	$ 0.83	$ 5,602	$ 0.83
$ 1,026	$ 1.07	$ 885	$ 0.92	$ (141)	$ (0.14)	Medical Administrative Expenses	$ 6,601	$ 0.98	$ 6,740	$ 1.00	$ 139	$ 0.02
$ 240,340	**$ 249.60**	**$ 244,333**	**$ 254.81**	**$ 3,993**	**$ 5.21**	**Total Healthcare Expenses**	**$ 1,669,419**	**$ 247.88**	**$ 1,683,077**	**$ 249.59**	**$ 13,658**	**$ 1.71**
95.0%		*96.3%*		*1.2%*		*MCR(%)*	*95.1%*		*95.0%*		*-0.1%*	
$ 12,619	**$ 13.11**	**$ 9,500**	**$ 9.91**	**$ 3,120**	**$ 3.20**	**Operating Margin**	**$ 85,122**	**$ 12.64**	**$ 88,279**	**$ 13.09**	**$ (3,157)**	**$ (0.45)**
$ 6,346	$ 6.59	$ 5,588	$ 5.83	$ (758)	$ (0.76)	**Total Operating Expenses**	$ 40,184	$ 5.97	$ 39,920	$ 5.92	$ (264)	$ (0.05)
2.5%		*2.2%*		*-0.3%*		*Admin Ratio(%)*	*2.3%*		*2.3%*		*0.0%*	
$ 6,274	**$ 6.52**	**$ 3,912**	**$ 4.08**	**$ 2,362**	**$ 2.44**	**Income (Loss) from Operations**	**$ 44,937**	**$ 6.67**	**$ 48,358**	**$ 7.17**	**$ (3,421)**	**$ (0.50)**
$ 3,703	**$ 3.85**	**$ 1,036**	**$ 1.08**	**$ 2,667**	**$ 2.77**	**Total Non-Operating Income (Expense)**	**$ 12,845**	**$ 1.91**	**$ 11,369**	**$ 1.69**	**$ 1,477**	**$ 0.22**
$ 9,977	**$ 10.36**	**$ 4,948**	**$ 5.16**	**$ 5,029**	**$ 5.20**	**Net Surplus (Deficit)**	**$ 57,783**	**$ 8.58**	**$ 59,727**	**$ 8.86**	**$ (1,944)**	**$ (0.28)**
3.9%		*1.9%*		*2.0%*		*Margin(%)*	*3.3%*		*3.4%*		*-0.1%*	

L.A. Care HEALTH PLAN

MediCal SPD-CCI Income Statement ($ in thousands)

April 2020

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						
224,134		219,614		4,520		Member Months	1,544,683		1,544,136		547	
						Revenue						
$ 168,348	$ 751.10	$ 166,914	$ 760.04	$ 1,433	$ (8.93)	Capitation	$ 1,197,090	$ 774.97	$ 1,191,835	$ 771.85	$ 5,254	$ 3.13
$ 168,348	**$ 751.10**	**$ 166,914**	**$ 760.04**	**$ 1,433**	**$ (8.93)**	**Total Revenues**	**$ 1,197,090**	**$ 774.97**	**$ 1,191,835**	**$ 771.85**	**$ 5,254**	**$ 3.13**
						Healthcare Expenses						
$ 17,515	$ 78.14	$ 19,012	$ 86.57	$ 1,497	$ 8.43	Capitation	$ 125,258	$ 81.09	$ 128,334	$ 83.11	$ 3,076	$ 2.02
$ 34,566	$ 154.22	$ 31,207	$ 142.10	$ (3,359)	$ (12.12)	Inpatient Claims	$ 235,087	$ 152.19	$ 230,960	$ 149.57	$ (4,127)	$ (2.62)
$ 19,066	$ 85.07	$ 33,762	$ 153.73	$ 14,696	$ 68.67	Outpatient Claims	$ 222,026	$ 143.74	$ 238,407	$ 154.39	$ 16,380	$ 10.66
$ 60,165	$ 268.44	$ 55,581	$ 253.08	$ (4,585)	$ (15.35)	Skilled Nursing Facility	$ 409,296	$ 264.97	$ 405,318	$ 262.49	$ (3,977)	$ (2.48)
$ 17,867	$ 79.72	$ 17,980	$ 81.87	$ 113	$ 2.16	Pharmacy	$ 126,183	$ 81.69	$ 123,882	$ 80.23	$ (2,301)	$ (1.46)
$ (1,227)	$ (5.47)	$ (608)	$ (2.77)	$ 619	$ 2.71	Provider Incentives and Shared Risk	$ 2,825	$ 1.83	$ (481)	$ (0.31)	$ (3,306)	$ (2.14)
$ 1,993	$ 8.89	$ 2,146	$ 9.77	$ 152	$ 0.88	Medical Administrative Expenses	$ 12,920	$ 8.36	$ 13,503	$ 8.74	$ 582	$ 0.38
$ 149,946	**$ 669.00**	**$ 159,079**	**$ 724.36**	**$ 9,134**	**$ 55.36**	**Total Healthcare Expenses**	**$ 1,133,595**	**$ 733.87**	**$ 1,139,923**	**$ 738.23**	**$ 6,328**	**$ 4.36**
89.1%		*95.3%*		*6.2%*		*MCR(%)*	*94.7%*		*95.6%*		*0.9%*	
$ 18,402	**$ 82.10**	**$ 7,835**	**$ 35.68**	**$ 10,567**	**$ 46.42**	**Operating Margin**	**$ 63,495**	**$ 41.11**	**$ 51,913**	**$ 33.62**	**$ 11,582**	**$ 7.49**
$ 13,822	$ 61.67	$ 12,358	$ 56.27	$ (1,464)	$ (5.40)	**Total Operating Expenses**	$ 94,935	$ 61.46	$ 92,183	$ 59.70	$ (2,751)	$ (1.76)
8.2%		*7.4%*		*-0.8%*		*Admin Ratio(%)*	*7.9%*		*7.7%*		*-0.2%*	
$ 4,580	**$ 20.43**	**$ (4,523)**	**$ (20.59)**	**$ 9,103**	**$ 41.03**	**Income (Loss) from Operations**	**$ (31,440)**	**$ (20.35)**	**$ (40,271)**	**$ (26.08)**	**$ 8,831**	**$ 5.73**
$ 2,246	**$ 10.02**	**$ 617**	**$ 2.81**	**$ 1,628**	**$ 7.21**	**Total Non-Operating Income (Expense)**	**$ 7,747**	**$ 5.02**	**$ 6,753**	**$ 4.37**	**$ 994**	**$ 0.64**
$ 6,825	**$ 30.45**	**$ (3,905)**	**$ (17.78)**	**$ 10,731**	**$ 48.23**	**Net Surplus (Deficit)**	**$ (23,693)**	**$ (15.34)**	**$ (33,518)**	**$ (21.71)**	**$ 9,826**	**$ 6.37**
4.1%		*-2.3%*		*6.4%*		*Margin(%)*	*-2.0%*		*-2.8%*		*0.8%*	

L.A. Care HEALTH PLAN

MediCal TANF-MCE Income Statement ($ in thousands)

April 2020

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						
831,146		820,776		10,370		Member Months	5,757,763		5,754,894		2,869	
						Revenue						
$ 205,872	$ 247.70	$ 200,268	$ 244.00	$ 5,604	$ 3.70	Capitation	$ 1,447,311	$ 251.37	$ 1,440,537	$ 250.32	$ 6,773	$ 1.05
$ 205,872	**$ 247.70**	**$ 200,268**	**$ 244.00**	**$ 5,604**	**$ 3.70**	**Total Revenues**	**$ 1,447,311**	**$ 251.37**	**$ 1,440,537**	**$ 250.32**	**$ 6,773**	**$ 1.05**
						Healthcare Expenses						
$ 82,971	$ 99.83	$ 84,431	$ 102.87	$ 1,460	$ 3.04	Capitation	$ 598,661	$ 103.97	$ 590,372	$ 102.59	$ (8,289)	$ (1.39)
$ 30,947	$ 37.23	$ 36,071	$ 43.95	$ 5,124	$ 6.71	Inpatient Claims	$ 244,462	$ 42.46	$ 248,213	$ 43.13	$ 3,751	$ 0.67
$ 17,510	$ 21.07	$ 24,407	$ 29.74	$ 6,896	$ 8.67	Outpatient Claims	$ 175,629	$ 30.50	$ 176,634	$ 30.69	$ 1,005	$ 0.19
$ 6,224	$ 7.49	$ 7,428	$ 9.05	$ 1,204	$ 1.56	Skilled Nursing Facility	$ 32,408	$ 5.63	$ 38,781	$ 6.74	$ 6,373	$ 1.11
$ 29,979	$ 36.07	$ 32,844	$ 40.02	$ 2,865	$ 3.95	Pharmacy	$ 230,518	$ 40.04	$ 228,468	$ 39.70	$ (2,050)	$ (0.34)
$ 869	$ 1.05	$ 6,119	$ 7.46	$ 5,250	$ 6.41	Provider Incentives and Shared Risk	$ 2,285	$ 0.40	$ 9,414	$ 1.64	$ 7,128	$ 1.24
$ 2,839	$ 3.42	$ 3,026	$ 3.69	$ 187	$ 0.27	Medical Administrative Expenses	$ 18,271	$ 3.17	$ 19,404	$ 3.37	$ 1,133	$ 0.20
$ 171,340	**$ 206.15**	**$ 194,326**	**$ 236.76**	**$ 22,986**	**$ 30.61**	**Total Healthcare Expenses**	**$ 1,302,235**	**$ 226.17**	**$ 1,311,286**	**$ 227.86**	**$ 9,051**	**$ 1.69**
83.2%		*97.0%*		*13.8%*		*MCR(%)*	*90.0%*		*91.0%*		*1.1%*	
$ 34,532	**$ 41.55**	**$ 5,942**	**$ 7.24**	**$ 28,590**	**$ 34.31**	**Operating Margin**	**$ 145,076**	**$ 25.20**	**$ 129,252**	**$ 22.46**	**$ 15,824**	**$ 2.74**
$ 15,514	$ 18.67	$ 13,516	$ 16.47	$ (1,998)	$ (2.20)	**Total Operating Expenses**	$ 93,819	$ 16.29	$ 90,800	$ 15.78	$ (3,019)	$ (0.52)
7.5%		*6.7%*		*-0.8%*		*Admin Ratio(%)*	*6.5%*		*6.3%*		*-0.2%*	
$ 19,018	**$ 22.88**	**$ (7,574)**	**$ (9.23)**	**$ 26,592**	**$ 32.11**	**Income (Loss) from Operations**	**$ 51,257**	**$ 8.90**	**$ 38,452**	**$ 6.68**	**$ 12,805**	**$ 2.22**
$ 2,337	**$ 2.81**	**$ 645**	**$ 0.79**	**$ 1,692**	**$ 2.03**	**Total Non-Operating Income (Expense)**	**$ 8,081**	**$ 1.40**	**$ 7,097**	**$ 1.23**	**$ 984**	**$ 0.17**
$ 21,355	**$ 25.69**	**$ (6,929)**	**$ (8.44)**	**$ 28,284**	**$ 34.14**	**Net Surplus (Deficit)**	**$ 59,338**	**$ 10.31**	**$ 45,549**	**$ 7.91**	**$ 13,789**	**$ 2.39**
10.4%		*-3.5%*		*13.8%*		*Margin(%)*	*4.1%*		*3.2%*		*0.9%*	

L.A. Care HEALTH PLAN

CMC Income Statement ($ in thousands)

April 2020

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						
16,531		16,336		195		Member Months	114,326		113,800		526	
						Revenue						
$ 24,681	$ 1,492.99	$ 21,461	$ 1,313.70	$ 3,220	$ 179.29	Capitation	$ 155,778	$ 1,362.57	$ 152,333	$ 1,338.60	$ 3,445	$ 23.97
$ 24,681	**$ 1,492.99**	**$ 21,461**	**$ 1,313.70**	**$ 3,220**	**$ 179.29**	**Total Revenues**	**$ 155,778**	**$ 1,362.57**	**$ 152,333**	**$ 1,338.60**	**$ 3,445**	**$ 23.97**
						Healthcare Expenses						
$ 10,580	$ 640.01	$ 10,293	$ 630.07	$ (287)	$ (9.94)	Capitation	$ 70,375	$ 615.56	$ 72,066	$ 633.27	$ 1,691	$ 17.71
$ 534	$ 32.28	$ 5,728	$ 350.66	$ 5,195	$ 318.38	Inpatient Claims	$ 31,628	$ 276.65	$ 41,466	$ 364.37	$ 9,837	$ 87.72
$ 1,026	$ 62.07	$ 2,081	$ 127.37	$ 1,055	$ 65.30	Outpatient Claims	$ 12,551	$ 109.78	$ 14,143	$ 124.28	$ 1,592	$ 14.50
$ 2,526	$ 152.82	$ 1,231	$ 75.33	$ (1,296)	$ (77.49)	Skilled Nursing Facility	$ 12,061	$ 105.50	$ 9,481	$ 83.31	$ (2,580)	$ (22.19)
$ 619	$ 37.44	$ 1,339	$ 81.97	$ 720	$ 44.53	Pharmacy	$ 9,312	$ 81.45	$ 7,995	$ 70.25	$ (1,317)	$ (11.19)
$ 430	$ 26.01	$ 789	$ 48.32	$ 359	$ 22.30	Provider Incentives and Shared Risk	$ 4,680	$ 40.94	$ 2,635	$ 23.16	$ (2,045)	$ (17.78)
$ 198	$ 11.99	$ 501	$ 30.70	$ 303	$ 18.71	Medical Administrative Expenses	$ 1,468	$ 12.84	$ 1,994	$ 17.52	$ 526	$ 4.68
$ 15,913	**$ 962.63**	**$ 21,962**	**$ 1,344.41**	**$ 6,049**	**$ 381.78**	**Total Healthcare Expenses**	**$ 142,075**	**$ 1,242.72**	**$ 149,780**	**$ 1,316.17**	**$ 7,705**	**$ 73.45**
64.5%		*102.3%*		*37.9%*		*MCR(%)*	*91.2%*		*98.3%*		*7.1%*	
$ 8,767	**$ 530.36**	**$ (502)**	**$ (30.72)**	**$ 9,269**	**$ 561.07**	**Operating Margin**	**$ 13,702**	**$ 119.85**	**$ 2,553**	**$ 22.43**	**$ 11,150**	**$ 97.42**
$ 1,700	$ 102.87	$ 1,756	$ 107.52	$ 56	$ 4.66	**Total Operating Expenses**	$ 11,390	$ 99.63	$ 12,752	$ 112.05	$ 1,362	$ 12.43
6.9%		*8.2%*		*1.3%*		*Admin Ratio(%)*	*7.3%*		*8.4%*		*1.1%*	
$ 7,067	**$ 427.49**	**$ (2,258)**	**$ (138.24)**	**$ 9,325**	**$ 565.73**	**Income (Loss) from Operations**	**$ 2,312**	**$ 20.23**	**$ (10,199)**	**$ (89.62)**	**$ 12,512**	**$ 109.85**
$ 40	**$ 2.43**	**$ 14**	**$ 0.88**	**$ 26**	**$ 1.55**	**Total Non-Operating Income (Expense)**	**$ 143**	**$ 1.25**	**$ 144**	**$ 1.27**	**$ (1)**	**$ (0.02)**
$ 7,107	**$ 429.92**	**$ (2,244)**	**$ (137.36)**	**$ 9,351**	**$ 567.28**	**Net Surplus (Deficit)**	**$ 2,456**	**$ 21.48**	**$ (10,055)**	**$ (88.35)**	**$ 12,510**	**$ 109.83**
28.8%		*-10.5%*		*39.3%*		*Margin(%)*	*1.6%*		*-6.6%*		*8.2%*	

L.A. Care HEALTH PLAN

Commercial Income Statement ($ in thousands)

April 2020

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						
138,849		131,143		7,706		Member Months	915,474		898,426		17,048	
						Revenue						
$ 47,050	$ 338.85	$ 45,798	$ 349.22	$ 1,252	$ (10.37)	Capitation	$ 310,329	$ 338.98	$ 308,735	$ 343.64	$ 1,594	$ (4.66)
$ 47,050	**$ 338.85**	**$ 45,798**	**$ 349.22**	**$ 1,252**	**$ (10.37)**	**Total Revenues**	**$ 310,329**	**$ 338.98**	**$ 308,735**	**$ 343.64**	**$ 1,594**	**$ (4.66)**
						Healthcare Expenses						
$ 22,661	$ 163.21	$ 22,161	$ 168.98	$ (500)	$ 5.77	Capitation	$ 153,413	$ 167.58	$ 152,756	$ 170.03	$ (657)	$ 2.45
$ 9,649	$ 69.49	$ 5,339	$ 40.71	$ (4,310)	$ (28.78)	Inpatient Claims	$ 45,416	$ 49.61	$ 36,772	$ 40.93	$ (8,644)	$ (8.68)
$ 2,708	$ 19.51	$ 3,231	$ 24.64	$ 523	$ 5.13	Outpatient Claims	$ 20,521	$ 22.42	$ 21,730	$ 24.19	$ 1,209	$ 1.77
$ 90	$ 0.65	$ -	$ -	$ (90)	$ (0.65)	Skilled Nursing Facility	$ 711	$ 0.78	$ 385	$ 0.43	$ (325)	$ (0.35)
$ 5,878	$ 42.33	$ 6,057	$ 46.19	$ 179	$ 3.85	Pharmacy	$ 43,827	$ 47.87	$ 43,034	$ 47.90	$ (792)	$ 0.03
$ 2,699	$ 19.44	$ 3,609	$ 27.52	$ 910	$ 8.08	Provider Incentives and Shared Risk	$ 8,037	$ 8.78	$ 11,807	$ 13.14	$ 3,770	$ 4.36
$ 140	$ 1.01	$ 84	$ 0.64	$ (56)	$ (0.37)	Medical Administrative Expenses	$ 915	$ 1.00	$ 585	$ 0.65	$ (330)	$ (0.35)
$ 43,825	**$ 315.63**	**$ 40,481**	**$ 308.68**	**$ (3,344)**	**$ (6.95)**	**Total Healthcare Expenses**	**$ 272,840**	**$ 298.03**	**$ 267,070**	**$ 297.26**	**$ (5,770)**	**$ (0.77)**
93.1%		*88.4%*		*-4.8%*		*MCR(%)*	*87.9%*		*86.5%*		*-1.4%*	
$ 3,224	**$ 23.22**	**$ 5,317**	**$ 40.54**	**$ (2,092)**	**$ (17.32)**	**Operating Margin**	**$ 37,489**	**$ 40.95**	**$ 41,665**	**$ 46.38**	**$ (4,176)**	**$ (5.42)**
$ 3,700	$ 26.64	$ 3,676	$ 28.03	$ (23)	$ 1.39	**Total Operating Expenses**	$ 23,561	$ 25.74	$ 24,192	$ 26.93	$ 631	$ 1.19
7.9%		*8.0%*		*0.2%*		*Admin Ratio(%)*	*7.6%*		*7.8%*		*0.2%*	
$ (475)	**$ (3.42)**	**$ 1,640**	**$ 12.51**	**$ (2,115)**	**$ (15.93)**	**Income (Loss) from Operations**	**$ 13,929**	**$ 15.21**	**$ 17,473**	**$ 19.45**	**$ (3,544)**	**$ (4.23)**
$ (63)	**$ (0.45)**	**$ -**	**$ -**	**$ (63)**	**$ (0.45)**	**Total Non-Operating Income (Expense)**	**$ (252)**	**$ (0.28)**	**$ -**	**$ -**	**$ (252)**	**$ (0.28)**
$ (538)	**$ (3.88)**	**$ 1,640**	**$ 12.51**	**$ (2,178)**	**$ (16.38)**	**Net Surplus (Deficit)**	**$ 13,677**	**$ 14.94**	**$ 17,473**	**$ 19.45**	**$ (3,797)**	**$ (4.51)**
-1.1%		*3.6%*		*-4.7%*		*Margin(%)*	*4.4%*		*5.7%*		*-1.3%*	

L.A. Care HEALTH PLAN

Comparative Balance Sheet

April 2020

(Dollars in thousands)	Apr-19	Jul-19	Oct-19	Jan-20	Feb-20	Mar-20	Apr-20
ASSETS							
CURRENT ASSETS							
Total Current Assets	4,607,521	4,308,965	4,315,443	4,284,356	4,833,097	4,369,491	4,628,256
Capitalized Assets - net	110,181	110,730	113,464	111,784	110,416	109,758	109,899
NON-CURRENT ASSETS	2,468	2,890	2,601	2,262	2,152	2,042	1,931
TOTAL ASSETS	**$4,720,171**	**$4,422,585**	**$4,431,508**	**$4,398,402**	**$4,945,664**	**$4,481,291**	**$4,740,087**
LIABILITIES AND FUND EQUITY							
CURRENT LIABILITIES							
Total Current Liability	3,685,387	3,349,878	3,396,056	3,300,940	3,832,752	3,378,212	3,595,155
Long Term Liability	2,764	3,521	3,602	3,357	3,207	3,196	3,058
Total Liabilities	**$3,688,151**	**$3,353,399**	**$3,399,658**	**$3,304,296**	**$3,835,959**	**$3,381,408**	**$3,598,213**
FUND EQUITY							
Invested in Capital Assets, net of related debt	110,181	110,730	113,464	111,784	110,416	109,758	109,899
Restricted Equity	300	300	300	300	300	300	300
Minimum Tangible Net Equity	160,510	159,816	171,185	173,549	175,817	177,579	176,764
Board Designated Funds	72,595	65,340	58,575	59,845	57,868	101,259	98,650
Unrestricted Net Assets	688,434	732,999	688,325	748,627	765,304	710,987	756,260
Total Fund Equity	**$1,032,020**	**$1,069,186**	**$1,031,850**	**$1,094,106**	**$1,109,705**	**$1,099,883**	**$1,141,874**
TOTAL LIABILITIES AND FUND EQUITY	**$4,720,171**	**$4,422,585**	**$4,431,508**	**$4,398,402**	**$4,945,664**	**$4,481,291**	**$4,740,087**
Solvency Ratios							
Working Capital Ratio	1.25	1.29	1.27	1.30	1.26	1.29	1.29
Cash to Claims Ratio	0.77	0.63	0.63	0.58	0.71	0.53	0.71
Tangible Net Equity Ratio	6.43	6.69	6.03	6.30	6.31	6.19	6.46

L.A. Care HEALTH PLAN

Cash Flows Statement ($ in thousands)

April 2020

	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	YTD
Cash Flows from Operating Activities:								
Capitation Revenue	$ 663,527	$ 692,673	$ 665,196	$ 659,921	$ 554,891	$ 600,316	$ 922,985	$ 4,759,509
Other Income (Expense), net	$ 3,842	$ (794)	$ (275)	$ 343	$ (477)	$ 754	$ (237)	$ 3,156
Healthcare Expenses	$ (624,044)	$ (791,884)	$ (648,703)	$ (608,026)	$ (543,266)	$ (638,218)	$ (802,674)	$ (4,656,815)
Operating Expenses	$ (33,459)	$ (31,902)	$ (46,800)	$ (35,145)	$ (35,264)	$ (29,022)	$ (40,820)	$ (252,412)
Net Cash Provided By Operating Activities	**$ 9,866**	**$ (131,907)**	**$ (30,582)**	**$ 17,093**	**$ (24,116)**	**$ (66,170)**	**$ 79,254**	**$ (146,562)**
Cash Flows from Investing Activities								
Purchase of investments - Net	$ (19,378)	$ (67,742)	$ 156,462	$ (265,654)	$ (99,222)	$ 15,193	$ 59,063	$ (221,278)
Purchase of Capital Assets	$ (3,403)	$ (69)	$ (3,187)	$ (1,950)	$ (1,039)	$ (1,751)	$ (2,549)	$ (13,948)
Net Cash Provided By Investing Activities	**$ (22,781)**	**$ (67,811)**	**$ 153,275**	**$ (267,604)**	**$ (100,261)**	**$ 13,442**	**$ 56,514**	**$ (235,226)**
Cash Flows from Financing Activities:								
Gross Premium Tax (MCO Sales Tax) - Net	$ 36	$ 17	$ (434)	$ 88	$ 618	$ 2	$ 3	$ 330
Pass through transactions (AB 85, IGT, etc.)	$ (672,615)	$ (7,520)	$ (1,452)	$ 1,528	$ 440,518	$ (456,490)	$ 265,754	$ (430,277)
Net Cash Provided By Financing Activities	**$ (672,579)**	**$ (7,503)**	**$ (1,886)**	**$ 1,616**	**$ 441,136**	**$ (456,488)**	**$ 265,757**	**$ (429,947)**
Net Increase in Cash and Cash Equivalents	**$ (685,494)**	**$ (207,221)**	**$ 120,807**	**$ (248,895)**	**$ 316,759**	**$ (509,216)**	**$ 401,525**	**$ (811,735)**
Cash and Cash Equivalents, Beginning	$ 1,634,374	$ 948,880	$ 741,659	$ 862,466	$ 613,571	$ 930,330	$ 421,114	$ 1,634,374
Cash and Cash Equivalents, Ending	**$ 948,880**	**$ 741,659**	**$ 862,466**	**$ 613,571**	**$ 930,330**	**$ 421,114**	**$ 822,639**	**$ 822,639**
Reconciliation of Income from Operations to Net Cash Provided By (Used In) Operating Activities:								
Excess of Revenues over Expenses	**$ (22,266)**	**$ (8,013)**	**$ 59,436**	**$ 10,833**	**$ 15,600**	**$ (9,822)**	**$ 41,991**	**$ 87,759**
Adjustments to Excess of Revenues Over Expenses:								
Depreciation	$ 2,261	$ 2,250	$ 2,313	$ 2,324	$ 2,407	$ 2,408	$ 2,408	$ 16,371
Realized and Unrealized (Gain)/Loss on Investments	$ (1,145)	$ 1,052	$ (88)	$ (2,999)	$ (3,796)	$ 4,606	$ (6,783)	$ (9,153)
Deferred Rent	$ 21	$ (196)	$ 93	$ (142)	$ (149)	$ (11)	$ (138)	$ (522)
Gross Premium Tax provision	$ -	$ 4	$ 11	$ (10)	$ (681)	$ 247	$ 389	$ (40)
Total Adjustments to Excess of Revenues over Expenses	**$ 1,137**	**$ 3,110**	**$ 2,329**	**$ (827)**	**$ (2,219)**	**$ 7,250**	**$ (4,124)**	**$ 6,656**
Changes in Operating Assets and Liabilities:								
Capitation Receivable	$ (2,235)	$ 8,298	$ (96,596)	$ (24,231)	$ (123,955)	$ (63,607)	$ 225,048	$ (77,278)
Interest and Non-Operating Receivables	$ 945	$ 860	$ (1,047)	$ 904	$ (837)	$ 162	$ (26)	$ 961
Prepaid and Other Current Assets	$ 3,341	$ 17	$ 930	$ 628	$ (2,098)	$ 15,187	$ (18,324)	$ (319)
Accounts Payable and Accrued Liabilities	$ (4,040)	$ 2,682	$ (9,307)	$ (2,142)	$ 3,793	$ 4,086	$ 1,822	$ (3,106)
Subcapitation Payable	$ 20,423	$ (125,860)	$ 75,705	$ 62,474	$ 49,656	$ 44,823	$ (19,090)	$ 108,131
MediCal Adult Expansion Payable	$ (10,417)	$ (47,619)	$ (32,682)	$ (14,564)	$ 97,114	$ (20,929)	$ (84)	$ (29,181)
Deferred Capitation Revenue	$ (138)	$ 17,451	$ (20,897)	$ 17,768	$ (715)	$ (19,664)	$ (973)	$ (7,168)
Accrued Medical Expenses	$ 2,155	$ (12,666)	$ (669)	$ 3,124	$ (44,033)	$ 11,336	$ (5,758)	$ (46,511)
Reserve for Claims	$ 16,290	$ 23,630	$ 2,280	$ (3,810)	$ (17,178)	$ (35,393)	$ (120,459)	$ (134,640)
Reserve for Provider Incentives	$ 4,211	$ 4,063	$ (10,006)	$ (32,160)	$ -	$ (344)	$ (21,307)	$ (55,543)
Grants Payable	$ 460	$ 2,140	$ (58)	$ (904)	$ 756	$ 745	$ 538	$ 3,677
Net Changes in Operating Assets and Liabilities	**$ 30,995**	**$ (127,004)**	**$ (92,347)**	**$ 7,087**	**$ (37,497)**	**$ (63,598)**	**$ 41,387**	**$ (240,977)**
Net Cash Provided By Operating Activities	**$ 9,866**	**$ (131,907)**	**$ (30,582)**	**$ 17,093**	**$ (24,116)**	**$ (66,170)**	**$ 79,254**	**$ (146,562)**

DATE: May 26, 2020

TO: Finance & Budget Committee

FROM: Marie Montgomery, *Chief Financial Officer*

SUBJECT: Monthly Investment Transaction Report for April 2020

To keep the Committee apprised of L.A. Care's investment portfolios and to comply with California Government Code Section 53607, attached are the monthly investment transaction details from April 1 to April 30, 2020.

L.A. Care's investment market value as of April 30, 2020 was $2.0 billion. This includes our funds invested with the government pooled funds. L.A. Care has approximately $72 million invested with the statewide Local Agency Investment Fund (LAIF), and approximately $176 million invested with the Los Angeles County Pooled Investment Fund (LACPIF).

The remainder as of April 30, 2020, of $1.7 billion is managed by two independent asset managers, 1) Payden & Rygel and 2) New England Asset Management (NEAM) and is divided into three portfolios based on investment style,

1. Payden & Rygel - Short-term portfolio
2. Payden & Rygel - Extended term portfolio
3. New England Asset Management - Corporate notes extended term portfolio

The transactions within these three portfolios are included in the attached reports.

Account Name: L.A. CARE HEALTH PLAN

04/01/2020 through 04/30/2020

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
04/03/20	04/06/20	Buy	7,500,000.000	NATL RURAL UTILITIES CP MAT 05/04/20 Cpn 63743CE41	(7,494,166.67)		0.00	0.00	(7,494,166.67)
04/08/20	04/08/20	Buy	5,000,000.000	CA STATE GO/ULT CP TXB MAT 07/07/20 Cpn 1.50 13068BFH5	(5,000,000.00)		0.00	0.00	(5,000,000.00)
04/08/20	04/08/20	Buy	7,500,000.000	CA SAN JOSE FIN AUTH CP TXB MAT 05/04/20 Cpn 1.30 79815WCH9	(7,500,000.00)		0.00	0.00	(7,500,000.00)
04/07/20	04/09/20	Buy	4,595,722.480	FNA 2011-M3 A2 CMBS MAT 07/25/21 Cpn 3.64 31397UL49	(4,637,371.22)	(3,720.49)	0.00	0.00	(4,641,091.71)
04/09/20	04/09/20	Buy	4,250,000.000	CA LOS ANGELES MTA CP TXB MAT 05/13/20 Cpn 1.25 54531HBF3	(4,250,000.00)		0.00	0.00	(4,250,000.00)
04/17/20	04/17/20	Buy	30,000,000.000	U.S. TREASURY BILL MAT 04/28/20 Cpn 9127962D0	(29,999,908.33)		0.00	0.00	(29,999,908.33)
04/17/20	04/17/20	Buy	50,000,000.000	U.S. TREASURY BILL MAT 04/28/20 Cpn 9127962D0	(49,999,847.22)		0.00	0.00	(49,999,847.22)
04/17/20	04/17/20	Buy	50,000,000.000	U.S. TREASURY BILL MAT 05/12/20 Cpn 9127962L2	(49,998,784.72)		0.00	0.00	(49,998,784.72)
04/17/20	04/17/20	Buy	50,000,000.000	U.S. TREASURY BILL MAT 05/12/20 Cpn 9127962L2	(49,998,784.72)		0.00	0.00	(49,998,784.72)
04/17/20	04/17/20	Buy	50,000,000.000	U.S. TREASURY BILL MAT 05/12/20 Cpn 9127962L2	(49,998,784.72)		0.00	0.00	(49,998,784.72)
04/17/20	04/17/20	Buy	50,000,000.000	U.S. TREASURY BILL MAT 05/05/20 Cpn 9127962K4	(49,999,750.00)		0.00	0.00	(49,999,750.00)
04/17/20	04/17/20	Buy	50,000,000.000	U.S. TREASURY BILL MAT 05/07/20 Cpn 912796TT6	(49,999,722.22)		0.00	0.00	(49,999,722.22)
04/17/20	04/20/20	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 04/29/20 Cpn 313384WE5	(49,999,750.00)		0.00	0.00	(49,999,750.00)

Account Name: L.A. CARE HEALTH PLAN

04/01/2020 through 04/30/2020

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
04/17/20	04/20/20	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 04/29/20 Cpn	313384WE5	(49,999,750.00)		0.00	0.00	(49,999,750.00)
04/17/20	04/20/20	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 04/29/20 Cpn	313384WE5	(49,999,750.00)		0.00	0.00	(49,999,750.00)
04/17/20	04/20/20	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 05/04/20 Cpn	313384WK1	(49,999,027.78)		0.00	0.00	(49,999,027.78)
04/17/20	04/20/20	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 05/04/20 Cpn	313384WK1	(49,999,027.78)		0.00	0.00	(49,999,027.78)
04/17/20	04/20/20	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 05/04/20 Cpn	313384WK1	(49,999,027.78)		0.00	0.00	(49,999,027.78)
04/27/20	04/28/20	Buy	3,140,000.000	PACCAR FINANCIAL CP MAT 07/27/20 Cpn	69372AGT3	(3,137,645.00)		0.00	0.00	(3,137,645.00)
04/28/20	04/29/20	Buy	40,000,000.000	U.S. TREASURY BILL MAT 04/30/20 Cpn	912796TS8	(39,999,976.67)		0.00	0.00	(39,999,976.67)
04/28/20	04/29/20	Buy	50,000,000.000	U.S. TREASURY BILL MAT 04/30/20 Cpn	912796TS8	(49,999,970.83)		0.00	0.00	(49,999,970.83)
04/28/20	04/29/20	Buy	50,000,000.000	U.S. TREASURY BILL MAT 04/30/20 Cpn	912796TS8	(49,999,970.83)		0.00	0.00	(49,999,970.83)
04/20/20	04/29/20	Buy	4,530,000.000	TOYOTA 2020-B A1 CAR MAT 05/17/21 Cpn 1.14	89239RAA4	(4,530,000.00)		0.00	0.00	(4,530,000.00)
04/29/20	04/30/20	Buy	15,000,000.000	U.S. TREASURY BILL MAT 05/07/20 Cpn	912796TT6	(14,999,905.21)		0.00	0.00	(14,999,905.21)
04/29/20	04/30/20	Buy	50,000,000.000	U.S. TREASURY BILL MAT 05/07/20 Cpn	912796TT6	(49,999,684.03)		0.00	0.00	(49,999,684.03)
04/29/20	04/30/20	Buy	50,000,000.000	U.S. TREASURY BILL MAT 05/07/20 Cpn	912796TT6	(49,999,684.03)		0.00	0.00	(49,999,684.03)

Account Name: L.A. CARE HEALTH PLAN

04/01/2020 through 04/30/2020

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
04/29/20	04/30/20	Buy	50,000,000.000	U.S. TREASURY BILL MAT 05/07/20 Cpn 912796TT6	(49,999,684.03)		0.00	0.00	(49,999,684.03)
04/24/20	04/30/20	Buy	3,250,000.000	CA LOS ANGELES USD GO/ULT TX MAT 07/01/20 Cpn 2.38 544647BY5	(3,254,517.50)		0.00	0.00	(3,254,517.50)
04/29/20	05/01/20	Buy	1,680,000.000	TOYOTA 2019-D A2 CAR MAT 07/15/22 Cpn 1.92 89233MAB9	(1,689,909.38)	(1,433.60)	0.00	0.00	(1,691,342.98)
04/30/20	05/04/20	Buy	35,000,000.000	U.S. TREASURY BILL MAT 05/07/20 Cpn 912796TT6	(34,999,921.25)		0.00	0.00	(34,999,921.25)
04/30/20	05/04/20	Buy	50,000,000.000	U.S. TREASURY BILL MAT 05/07/20 Cpn 912796TT6	(49,999,887.50)		0.00	0.00	(49,999,887.50)
04/30/20	05/04/20	Buy	7,177,000.000	CHAIT 2014-A2 A2 CDT MAT 03/15/23 Cpn 2.77 161571GK4	(7,309,045.59)	(10,492.38)	0.00	0.00	(7,319,537.97)
04/23/20	05/05/20	Buy	4,080,000.000	CA PERALTA CCD GO/ULT TXB MAT 08/01/20 Cpn 2.25 713575XC7	(4,080,000.00)		0.00	0.00	(4,080,000.00)
04/23/20	05/06/20	Buy	1,930,000.000	CA RIVERSIDE CNTY PENSN OBLG MAT 02/15/21 Cpn 2.17 76913CAV1	(1,930,000.00)		0.00	0.00	(1,930,000.00)
04/30/20	05/11/20	Buy	1,000,000.000	CA SAN DIEGO PUBLIC FACS WTR MAT 08/01/21 Cpn 1.13 79730CJE5	(1,000,000.00)		0.00	0.00	(1,000,000.00)
			1,075,632,722.480		**(1,075,803,255.01)**	**(15,646.47)**	**0.00**	**0.00**	**(1,075,818,901.48)**
04/01/20	04/01/20	Coupon		CA STATE GO/ULT TXB MAT 04/01/20 Cpn 2.60 13063DFZ6		57,590.00	0.00	0.00	57,590.00
04/01/20	04/01/20	Coupon		CANADIAN IMPERIAL BANK YCD FR MAT 05/01/20 Cpn 1.16 13606BX68		7,338.04	0.00	0.00	7,338.04
04/01/20	04/01/20	Coupon		CANADIAN IMPERIAL BANK YCD FR MAT 05/01/20 Cpn 1.16 13606BX68		2,715.08	0.00	0.00	2,715.08

Account Name: L.A. CARE HEALTH PLAN

04/01/2020 through 04/30/2020

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
04/01/20	04/01/20	Coupon		CA SAN BERNARDINO CNTY COPS MAT 10/01/20 Cpn 2.00 796815ZE1		23,450.00	0.00	0.00	23,450.00
04/02/20	04/02/20	Coupon		SUMITOMO MITSUI BANK YCD FRN MAT 04/02/20 Cpn 86565BT27		3,627.42	0.00	0.00	3,627.42
04/06/20	04/06/20	Coupon		NGN 2010-R1 1A 1MOFRN NCUA G MAT 10/07/20 Cpn 1.43 62888VAA6		1,747.63	0.00	0.00	1,747.63
04/06/20	04/06/20	Coupon		NGN 2010-R2 2A 1MOFRN NCUA G MAT 11/05/20 Cpn 1.45 62888UAB6		5,198.60	0.00	0.00	5,198.60
04/06/20	04/06/20	Coupon		NGN 2010-R3 2A 1MOFRN NCUA G MAT 12/08/20 Cpn 1.54 62888WAB2		3,119.29	0.00	0.00	3,119.29
04/06/20	04/06/20	Coupon		NGN 2011-C1 2A 1MOFRN NCUA G MAT 03/09/21 Cpn 1.51 62889DAB3		1,583.41	0.00	0.00	1,583.41
04/07/20	04/07/20	Coupon		CITI 2017-A3 A3 CDT MAT 04/07/22 Cpn 1.92 17305EGB5		48,000.00	0.00	0.00	48,000.00
04/07/20	04/07/20	Coupon		CITI 2017-A3 A3 CDT MAT 04/07/22 Cpn 1.92 17305EGB5		1,200.00	0.00	0.00	1,200.00
04/07/20	04/07/20	Coupon		CITI 2017-A3 A3 CDT MAT 04/07/22 Cpn 1.92 17305EGB5		20,736.00	0.00	0.00	20,736.00
04/07/20	04/07/20	Coupon		CITI 2017-A3 A3 CDT MAT 04/07/22 Cpn 1.92 17305EGB5		17,040.00	0.00	0.00	17,040.00
04/08/20	04/08/20	Coupon		CREDIT AGRICOLE YCD FRN MAT 05/08/20 Cpn 1.13 22532XNH7		6,987.00	0.00	0.00	6,987.00
04/08/20	04/08/20	Coupon		CA STATE GO/ULT CP TXB MAT 04/08/20 Cpn 1.90 13068BEU7		23,827.87	0.00	0.00	23,827.87
04/08/20	04/08/20	Coupon		CA SAN JOSE FIN AUTH CP TXB MAT 04/08/20 Cpn 1.75 79815WCG		46,306.82	0.00	0.00	46,306.82

Account Name: L.A. CARE HEALTH PLAN

04/01/2020 through 04/30/2020

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
04/15/20	04/15/20	Coupon		CAPITAL ONE 2020-1 CAR MAT 02/16/21 Cpn 1.64 14043MAA9		7,577.99	0.00	0.00	7,577.99
04/15/20	04/15/20	Coupon		DRYROCK 2017-1 A CDT 1MOFRN MAT 03/15/23 Cpn 1.14 06742LAN3		12,932.88	0.00	0.00	12,932.88
04/15/20	04/15/20	Coupon		HONDA 2017-2 A3 CAR MAT 08/16/21 Cpn 1.68 43811BAC8		214.80	0.00	0.00	214.80
04/15/20	04/15/20	Coupon		HONDA 2017-2 A3 CAR MAT 08/16/21 Cpn 1.68 43811BAC8		184.28	0.00	0.00	184.28
04/15/20	04/15/20	Coupon		HONDA 2019-3 A2 CAR MAT 04/15/22 Cpn 1.90 43815NAB0		6,903.33	0.00	0.00	6,903.33
04/15/20	04/15/20	Coupon		HARLEY 2019-A A2 CYCLE MAT 05/15/22 Cpn 2.37 41284WAB6		7,408.69	0.00	0.00	7,408.69
04/15/20	04/15/20	Coupon		INTER-AMERICAN DEVELPMNT BK MAT 04/15/20 Cpn 45818WBK1		10,875.76	0.00	0.00	10,875.76
04/15/20	04/15/20	Coupon		INTER-AMERICAN DEVELOPMENT MAT 01/15/22 Cpn 1.22 45818WBA3		50,918.92	0.00	0.00	50,918.92
04/15/20	04/15/20	Coupon		JOHN DEERE 2017-B A3 EQP MAT 10/15/21 Cpn 1.82 47788BAD6		1,043.22	0.00	0.00	1,043.22
04/15/20	04/15/20	Coupon		JOHN DEERE 2018-A A3 EQP MAT 04/18/22 Cpn 2.66 47788CAC6		1,788.69	0.00	0.00	1,788.69
04/15/20	04/15/20	Coupon		JOHN DEERE 2020-A A1 EQP MAT 03/15/21 Cpn 1.10 47789KAA1		6,234.86	0.00	0.00	6,234.86
04/15/20	04/15/20	Coupon		MERCEDES 2018-A A4 LEASE MAT 10/16/23 Cpn 2.51 58772QAE6		1,568.75	0.00	0.00	1,568.75
04/15/20	04/15/20	Coupon		MERCEDES 2018-A A4 LEASE MAT 10/16/23 Cpn 2.51 58772QAE6		2,583.21	0.00	0.00	2,583.21

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Tr Date	St Date	Transaction Type	Units	Description	Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
04/15/20	04/15/20	Coupon		MERCEDES 2019-A A2 LEASE MAT 02/16/21 Cpn 3.01 58772TAB6		1,554.84	0.00	0.00	1,554.84
04/15/20	04/15/20	Coupon		MERCEDES 2019-A A2 LEASE MAT 02/16/21 Cpn 3.01 58772TAB6		269.24	0.00	0.00	269.24
04/15/20	04/15/20	Coupon		MERCEDES 2019-A A2 LEASE MAT 02/16/21 Cpn 3.01 58772TAB6		706.75	0.00	0.00	706.75
04/15/20	04/15/20	Coupon		MERCEDES 2019-A A2 LEASE MAT 02/16/21 Cpn 3.01 58772TAB6		1,076.95	0.00	0.00	1,076.95
04/15/20	04/15/20	Coupon		MERCEDES 2019-B A2 LEASE MAT 12/15/21 Cpn 2.01 58769QAB7		4,505.75	0.00	0.00	4,505.75
04/15/20	04/15/20	Coupon		MERCEDES 2020-A A2 CAR LEASE MAT 03/15/22 Cpn 1.82 58770FAB8		6,430.67	0.00	0.00	6,430.67
04/15/20	04/15/20	Coupon		MERCEDES 2019-1 A2A CAR MAT 06/15/22 Cpn 2.04 58769TAB1		4,352.00	0.00	0.00	4,352.00
04/15/20	04/15/20	Coupon		NISSAN 2018-A A2A LEASE MAT 02/16/21 Cpn 3.03 65478BAB7		764.67	0.00	0.00	764.67
04/15/20	04/15/20	Coupon		NISSAN 2018-A A2A LEASE MAT 02/16/21 Cpn 3.03 65478BAB7		459.64	0.00	0.00	459.64
04/15/20	04/15/20	Coupon		NISSAN 2019-A A2A LEASE MAT 07/15/21 Cpn 2.71 65479PAB5		5,144.67	0.00	0.00	5,144.67
04/15/20	04/15/20	Coupon		NISSAN 2019-A A2A LEASE MAT 07/15/21 Cpn 2.71 65479PAB5		6,681.38	0.00	0.00	6,681.38
04/15/20	04/15/20	Coupon		NISSAN 2019-B A2B LEASE 1MOFR MAT 10/15/21 Cpn 1.08 65478LAC3		2,564.86	0.00	0.00	2,564.86
04/15/20	04/15/20	Coupon		NISSAN 2020-A A1 LEASE MAT 02/16/21 Cpn 1.72 65479NAA2		3,429.85	0.00	0.00	3,429.85

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Tr Date	St Date	Transaction Type	Units	Description	Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
04/15/20	04/15/20	Coupon		NISSAN 2020-A A2A LEASE MAT 05/16/22 Cpn 1.80 65479NAB0		5,325.00	0.00	0.00	5,325.00
04/15/20	04/15/20	Coupon		NISSAN 2019-A A2A CAR MAT 01/18/22 Cpn 2.82 65479KAB6		6,742.74	0.00	0.00	6,742.74
04/15/20	04/15/20	Coupon		TOYOTA 2018-A A3 CAR MAT 05/16/22 Cpn 2.35 89238BAD4		5,422.22	0.00	0.00	5,422.22
04/15/20	04/15/20	Coupon		TOYOTA 2019-A A2A CAR MAT 10/15/21 Cpn 2.83 89239AAB9		1,467.09	0.00	0.00	1,467.09
04/15/20	04/15/20	Coupon		TOYOTA 2019-A A2A CAR MAT 10/15/21 Cpn 2.83 89239AAB9		2,282.84	0.00	0.00	2,282.84
04/15/20	04/15/20	Coupon		TOYOTA 2019-C A2A CAR MAT 04/15/22 Cpn 2.00 89238UAB6		5,150.00	0.00	0.00	5,150.00
04/15/20	04/15/20	Coupon		TOYOTA 2019-D A2 CAR MAT 07/15/22 Cpn 1.92 89233MAB9		7,360.00	0.00	0.00	7,360.00
04/15/20	04/15/20	Coupon		USAA 2019-1 A2 CAR MAT 02/15/22 Cpn 2.26 90290EAB5		3,654.72	0.00	0.00	3,654.72
04/16/20	04/16/20	Coupon		SKANDINAV ENSKILDA BK YCD FR MAT 10/16/20 Cpn 1.35 83050PEX3		13,481.83	0.00	0.00	13,481.83
04/18/20	04/18/20	Coupon		HONDA 2017-3 A3 CAR MAT 09/20/21 Cpn 1.79 43814PAC4		375.11	0.00	0.00	375.11
04/18/20	04/18/20	Coupon		HONDA 2017-3 A3 CAR MAT 09/20/21 Cpn 1.79 43814PAC4		1,467.58	0.00	0.00	1,467.58
04/20/20	04/20/20	Coupon		BMW 2018-1 A3 LEASE MAT 07/20/21 Cpn 3.26 05586CAC8		7,688.17	0.00	0.00	7,688.17
04/20/20	04/20/20	Coupon		BMW 2018-1 A3 LEASE MAT 07/20/21 Cpn 3.26 05586CAC8		624.83	0.00	0.00	624.83

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Tr Date	St Date	Transaction Type	Units	Description	Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
04/20/20	04/20/20	Coupon		BMW 2019-1 A2 LEASE MAT 03/22/21 Cpn 2.79 05586VAB8		1,913.74	0.00	0.00	1,913.74
04/20/20	04/20/20	Coupon		VOLKSWAGEN 2019-A A2A LEASE MAT 03/21/22 Cpn 2.00 92867XAB2		2,483.33	0.00	0.00	2,483.33
04/21/20	04/21/20	Coupon		OVERSEA-CHINESE BANKING NY F MAT 08/21/20 Cpn 0.71 69033MMY0		5,239.74	0.00	0.00	5,239.74
04/23/20	04/23/20	Coupon		INTL FINANCE CORP FRN MAT 08/23/21 Cpn 0.75 45950VNE2		8,846.10	0.00	0.00	8,846.10
04/01/20	04/25/20	Coupon		FHMS K504 A2 CMBS MAT 09/25/20 Cpn 2.57 3137BMLC8		1,104.02	0.00	0.00	1,104.02
04/25/20	04/25/20	Coupon		FHMS KI03 A 1MOFRN CMBS MAT 02/25/23 Cpn 1.24 3137FJXN4		287.68	0.00	0.00	287.68
04/25/20	04/25/20	Coupon		FHMS KI03 A 1MOFRN CMBS MAT 02/25/23 Cpn 1.24 3137FJXN4		118.10	0.00	0.00	118.10
04/25/20	04/25/20	Coupon		FHMS KI04 A 1MOFRN CMBS MAT 07/25/24 Cpn 0.85 3137FNAV2		4,954.25	0.00	0.00	4,954.25
04/25/20	04/25/20	Coupon		FHMS Q009 A 1MOFRN CMBS MAT 04/25/24 Cpn 1.34 3137FMTW		7,046.60	0.00	0.00	7,046.60
04/01/20	04/25/20	Coupon		FNA 2012-M2 A2 CMBS MAT 02/25/22 Cpn 2.72 3136A4TX7		4,805.99	0.00	0.00	4,805.99
04/27/20	04/27/20	Coupon		FHMS KF36 A MAT 08/25/24 Cpn 0.78 3137FBAR7		5,076.07	0.00	0.00	5,076.07
04/27/20	04/27/20	Coupon		FHMS KF38 A MAT 09/25/24 Cpn 1.32 3137FBUC8		2,155.67	0.00	0.00	2,155.67
04/27/20	04/27/20	Coupon		FHMS KI05 A MAT 07/25/24 Cpn 0.83 3137FQXG3		6,958.52	0.00	0.00	6,958.52

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04/29/20	04/29/20	Coupon		FFCB 1ML+7.5 FRN MAT 03/29/21	Cpn 0.51	3133EKEX0		4,373.93	0.00	0.00	4,373.93
04/30/20	04/30/20	Coupon		U.S. TREASURY FRN MAT 10/31/20	Cpn 0.17	9128285H9		49,220.13	0.00	0.00	49,220.13
04/30/20	04/30/20	Coupon		U.S. TREASURY FRN MAT 10/31/21	Cpn 0.43	912828YN4		65,157.63	0.00	0.00	65,157.63
04/30/20	04/30/20	Coupon		U.S. TREASURY FRN MAT 04/30/20	Cpn	9128284K3		48,470.13	0.00	0.00	48,470.13
								697,897.57	**0.00**	**0.00**	**697,897.57**
04/01/20	04/01/20	Income	398.100	ADJ NET P&I MAT	Cpn	USD		398.10	0.00	0.00	398.10
04/01/20	04/01/20	Income	127,526.820	STIF INT MAT	Cpn	USD		127,526.82	0.00	0.00	127,526.82
			127,924.920					**127,924.92**	**0.00**	**0.00**	**127,924.92**
04/16/20	04/16/20	Contributn	230,000,000.000	NM MAT	Cpn	USD	230,000,000.00		0.00	0.00	230,000,000.00
04/17/20	04/17/20	Contributn	550,000,000.000	NM MAT	Cpn	USD	550,000,000.00		0.00	0.00	550,000,000.00
			780,000,000.000				**780,000,000.00**		**0.00**	**0.00**	**780,000,000.00**

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04/06/20	04/06/20	Sell Long	10,000,000.000	U.S. TREASURY BILL MAT 04/14/20 Cpn 9127962B4	9,999,475.56	480.00	115.56	0.00	9,999,955.56
04/06/20	04/06/20	Sell Long	30,000,000.000	U.S. TREASURY BILL MAT 04/14/20 Cpn 9127962B4	29,998,426.66	1,440.00	346.66	0.00	29,999,866.66
04/09/20	04/09/20	Sell Long	20,000,000.000	U.S. TREASURY BILL MAT 04/14/20 Cpn 9127962B4	19,998,781.11	1,080.00	61.11	0.00	19,999,861.11
04/09/20	04/09/20	Sell Long	30,000,000.000	U.S. TREASURY BILL MAT 04/14/20 Cpn 9127962B4	29,998,171.67	1,620.00	91.67	0.00	29,999,791.67
04/13/20	04/13/20	Sell Long	20,000,000.000	U.S. TREASURY BILL MAT 04/14/20 Cpn 9127962B4	19,998,760.00	1,240.00	40.00	0.00	20,000,000.00
04/24/20	04/27/20	Sell Long	30,000,000.000	U.S. TREASURY BILL MAT 04/28/20 Cpn 9127962D0	29,999,884.16	83.34	(24.17)	0.00	29,999,967.50
04/24/20	04/27/20	Sell Long	50,000,000.000	U.S. TREASURY BILL MAT 04/28/20 Cpn 9127962D0	49,999,806.94	138.89	(40.28)	0.00	49,999,945.83
04/24/20	04/27/20	Sell Long	1,000,000.000	LLOYDS BANK FRN YCD MAT 09/24/20 Cpn 1.70 53947BAC4	1,000,240.00	1,609.46	(1,152.37)	0.00	1,001,849.46
04/28/20	04/29/20	Sell Long	5,000,000.000	U.S. TREASURY BILL MAT 05/14/20 Cpn 912796TV1	4,964,464.86	35,401.81	3,065.63	0.00	4,999,866.67
04/30/20	04/30/20	Sell Long	35,000,000.000	FHLB DISCOUNT NOTE MAT 05/04/20 Cpn 313384WK1	34,999,513.89	486.11	194.45	0.00	35,000,000.00
			231,000,000.000		**230,957,524.86**	**43,579.60**	**2,698.26**	**0.00**	**231,001,104.46**
04/06/20	04/06/20	Pay Princpl	49,114.036	NGN 2010-R1 1A 1MOFRN NCUA G MAT 10/07/20 Cpn 1.43 62888VAA6	49,114.04		(29.23)	0.00	49,114.04
04/06/20	04/06/20	Pay Princpl	73,785.595	NGN 2010-R2 2A 1MOFRN NCUA G MAT 11/05/20 Cpn 1.45 62888UAB6	73,785.60		(69.72)	0.00	73,785.60

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04/06/20	04/06/20	Pay Princpl	23,416.886	NGN 2010-R3 2A 1MOFRN NCUA G MAT 12/08/20 Cpn 1.54 62888WAB2	23,416.89		0.00	(25.33)	23,416.89
04/06/20	04/06/20	Pay Princpl	54,796.366	NGN 2011-C1 2A 1MOFRN NCUA G MAT 03/09/21 Cpn 1.51 62889DAB3	54,796.37		(31.88)	0.00	54,796.37
04/07/20	04/07/20	Pay Princpl	5,000,000.000	CITI 2017-A3 A3 CDT MAT 04/07/22 Cpn 1.92 17305EGB5	5,000,000.00		692.47	0.00	5,000,000.00
04/07/20	04/07/20	Pay Princpl	125,000.000	CITI 2017-A3 A3 CDT MAT 04/07/22 Cpn 1.92 17305EGB5	125,000.00		0.00	0.00	125,000.00
04/07/20	04/07/20	Pay Princpl	2,160,000.000	CITI 2017-A3 A3 CDT MAT 04/07/22 Cpn 1.92 17305EGB5	2,160,000.00		0.00	0.00	2,160,000.00
04/07/20	04/07/20	Pay Princpl	1,775,000.000	CITI 2017-A3 A3 CDT MAT 04/07/22 Cpn 1.92 17305EGB5	1,775,000.00		0.00	0.00	1,775,000.00
04/15/20	04/15/20	Pay Princpl	1,158,917.426	CAPITAL ONE 2020-1 CAR MAT 02/16/21 Cpn 1.64 14043MAA9	1,158,917.43		0.00	0.00	1,158,917.43
04/15/20	04/15/20	Pay Princpl	21,109.275	HONDA 2017-2 A3 CAR MAT 08/16/21 Cpn 1.68 43811BAC8	21,109.28		27.87	0.00	21,109.28
04/15/20	04/15/20	Pay Princpl	18,110.143	HONDA 2017-2 A3 CAR MAT 08/16/21 Cpn 1.68 43811BAC8	18,110.14		27.74	0.00	18,110.14
04/15/20	04/15/20	Pay Princpl	459,518.456	HARLEY 2019-A A2 CYCLE MAT 05/15/22 Cpn 2.37 41284WAB6	459,518.46		3.06	0.00	459,518.46
04/15/20	04/15/20	Pay Princpl	145,188.705	JOHN DEERE 2017-B A3 EQP MAT 10/15/21 Cpn 1.82 47788BAD6	145,188.71		222.63	0.00	145,188.71
04/15/20	04/15/20	Pay Princpl	75,777.970	JOHN DEERE 2018-A A3 EQP MAT 04/18/22 Cpn 2.66 47788CAC6	75,777.97		(198.28)	0.00	75,777.97
04/15/20	04/15/20	Pay Princpl	1,324,664.762	JOHN DEERE 2020-A A1 EQP MAT 03/15/21 Cpn 1.10 47789KAA1	1,324,664.76		(0.00)	0.00	1,324,664.76

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04/15/20	04/15/20	Pay Princpl	189,206.183	MERCEDES 2019-A A2 LEASE MAT 02/16/21 Cpn 3.01 58772TAB6	189,206.18		0.00	0.18	189,206.18
04/15/20	04/15/20	Pay Princpl	32,762.975	MERCEDES 2019-A A2 LEASE MAT 02/16/21 Cpn 3.01 58772TAB6	32,762.98		(12.01)	0.00	32,762.98
04/15/20	04/15/20	Pay Princpl	86,002.810	MERCEDES 2019-A A2 LEASE MAT 02/16/21 Cpn 3.01 58772TAB6	86,002.81		(37.16)	0.00	86,002.81
04/15/20	04/15/20	Pay Princpl	131,051.901	MERCEDES 2019-A A2 LEASE MAT 02/16/21 Cpn 3.01 58772TAB6	131,051.90		(53.34)	0.00	131,051.90
04/15/20	04/15/20	Pay Princpl	77,404.446	MERCEDES 2019-B A2 LEASE MAT 12/15/21 Cpn 2.01 58769QAB7	77,404.45		2.91	0.00	77,404.45
04/15/20	04/15/20	Pay Princpl	102,114.383	MERCEDES 2019-1 A2A CAR MAT 06/15/22 Cpn 2.04 58769TAB1	102,114.38		6.75	0.00	102,114.38
04/15/20	04/15/20	Pay Princpl	188,925.968	NISSAN 2018-A A2A LEASE MAT 02/16/21 Cpn 3.03 65478BAB7	188,925.97		0.00	0.52	188,925.97
04/15/20	04/15/20	Pay Princpl	113,562.057	NISSAN 2018-A A2A LEASE MAT 02/16/21 Cpn 3.03 65478BAB7	113,562.06		(102.23)	0.00	113,562.06
04/15/20	04/15/20	Pay Princpl	250,978.932	NISSAN 2019-A A2A LEASE MAT 07/15/21 Cpn 2.71 65479PAB5	250,978.93		(342.99)	0.00	250,978.93
04/15/20	04/15/20	Pay Princpl	325,946.665	NISSAN 2019-A A2A LEASE MAT 07/15/21 Cpn 2.71 65479PAB5	325,946.67		(661.60)	0.00	325,946.67
04/15/20	04/15/20	Pay Princpl	200,804.920	NISSAN 2019-B A2B LEASE 1MOFR MAT 10/15/21 Cpn 1.08 65478LAC3	200,804.92		(0.00)	0.00	200,804.92
04/15/20	04/15/20	Pay Princpl	479,743.302	NISSAN 2020-A A1 LEASE MAT 02/16/21 Cpn 1.72 65479NAA2	479,743.30		(0.00)	0.00	479,743.30
04/15/20	04/15/20	Pay Princpl	379,520.683	NISSAN 2019-A A2A CAR MAT 01/18/22 Cpn 2.82 65479KAB6	379,520.68		(711.04)	0.00	379,520.68

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04/15/20	04/15/20	Pay Princpl	236,328.223	TOYOTA 2018-A A3 CAR MAT 05/16/22 Cpn 2.35 89238BAD4	236,328.22		(326.25)	0.00	236,328.22
04/15/20	04/15/20	Pay Princpl	86,855.803	TOYOTA 2019-A A2A CAR MAT 10/15/21 Cpn 2.83 89239AAB9	86,855.80		0.00	2.36	86,855.80
04/15/20	04/15/20	Pay Princpl	135,150.625	TOYOTA 2019-A A2A CAR MAT 10/15/21 Cpn 2.83 89239AAB9	135,150.63		(190.83)	0.00	135,150.63
04/15/20	04/15/20	Pay Princpl	241,100.856	TOYOTA 2019-C A2A CAR MAT 04/15/22 Cpn 2.00 89238UAB6	241,100.86		6.92	0.00	241,100.86
04/15/20	04/15/20	Pay Princpl	252,745.449	USAA 2019-1 A2 CAR MAT 02/15/22 Cpn 2.26 90290EAB5	252,745.45		7.72	0.00	252,745.45
04/18/20	04/18/20	Pay Princpl	32,324.011	HONDA 2017-3 A3 CAR MAT 09/20/21 Cpn 1.79 43814PAC4	32,324.01		41.89	0.00	32,324.01
04/18/20	04/18/20	Pay Princpl	126,464.742	HONDA 2017-3 A3 CAR MAT 09/20/21 Cpn 1.79 43814PAC4	126,464.74		142.07	0.00	126,464.74
04/20/20	04/20/20	Pay Princpl	148,467.864	BMW 2019-1 A2 LEASE MAT 03/22/21 Cpn 2.79 05586VAB8	148,467.86		0.00	1.06	148,467.86
04/01/20	04/25/20	Pay Princpl	84,526.264	FHMS K504 A2 CMBS MAT 09/25/20 Cpn 2.57 3137BMLC8	84,526.26		0.00	138.85	84,526.26
04/25/20	04/25/20	Pay Princpl	920.007	FHMS KF36 A MAT 08/25/24 Cpn 0.78 3137FBAR7	920.01		0.70	0.00	920.01
04/25/20	04/25/20	Pay Princpl	629.527	FHMS KF38 A MAT 09/25/24 Cpn 1.32 3137FBUC8	629.53		0.77	0.00	629.53
04/25/20	04/25/20	Pay Princpl	9,906.694	FHMS Q009 A 1MOFRN CMBS MAT 04/25/24 Cpn 1.34 3137FMTW	9,906.69		(0.00)	0.00	9,906.69

Account Name: L.A. CARE HEALTH PLAN

04/01/2020 through 04/30/2020

Tr Date	St Date	Transaction Type	Units	Description	Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
Fixed Income - cont.									
04/01/20	04/25/20	Pay Princpl	21,319.068	FNA 2012-M2 A2 CMBS MAT 02/25/22 Cpn 2.72 3136A4TX7	21,319.07		(483.26)	0.00	21,319.07
			16,399,163.979		**16,399,164.01**		**(2,066.33)**	**117.65**	**16,399,164.01**
04/01/20	04/01/20	Mature Long	4,430,000.000	CA STATE GO/ULT TXB MAT 04/01/20 Cpn 2.60 13063DFZ6	4,430,000.00		0.00	0.00	4,430,000.00
04/02/20	04/02/20	Mature Long	4,350,000.000	SUMITOMO MITSUI BANK YCD FRN MAT 04/02/20 Cpn 86565BT27	4,350,000.00		0.00	0.00	4,350,000.00
04/03/20	04/03/20	Mature Long	9,200,000.000	FHLB DISCOUNT NOTE MAT 04/03/20 Cpn 313384VC0	9,196,613.89	3,386.11	0.00	0.00	9,200,000.00
04/08/20	04/08/20	Mature Long	5,100,000.000	CA STATE GO/ULT CP TXB MAT 04/08/20 Cpn 1.90 13068BEU7	5,100,000.00		0.00	0.00	5,100,000.00
04/08/20	04/08/20	Mature Long	10,852,000.000	CA SAN JOSE FIN AUTH CP TXB MAT 04/08/20 Cpn 1.75 79815WCG	10,852,000.00		0.00	0.00	10,852,000.00
04/14/20	04/14/20	Mature Long	50,000,000.000	U.S. TREASURY BILL MAT 04/14/20 Cpn 9127962B4	49,996,800.00	3,200.00	0.00	0.00	50,000,000.00
04/14/20	04/14/20	Mature Long	50,000,000.000	U.S. TREASURY BILL MAT 04/14/20 Cpn 9127962B4	49,996,800.00	3,200.00	0.00	0.00	50,000,000.00
04/14/20	04/14/20	Mature Long	50,000,000.000	U.S. TREASURY BILL MAT 04/14/20 Cpn 9127962B4	49,996,800.00	3,200.00	0.00	0.00	50,000,000.00
04/15/20	04/15/20	Mature Long	2,000,000.000	INTER-AMERICAN DEVELPMNT BK MAT 04/15/20 Cpn 45818WBK1	2,000,000.00		0.00	0.00	2,000,000.00
04/16/20	04/16/20	Mature Long	4,950,000.000	PACCAR FINANCIAL CP MAT 04/16/20 Cpn 69372ADG4	4,944,555.00	5,445.00	0.00	0.00	4,950,000.00

Account Name: L.A. CARE HEALTH PLAN

04/01/2020 through 04/30/2020

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
04/29/20	04/29/20	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 04/29/20 Cpn 313384WE5	49,999,750.00	250.00	0.00	0.00	50,000,000.00
04/29/20	04/29/20	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 04/29/20 Cpn 313384WE5	49,999,750.00	250.00	0.00	0.00	50,000,000.00
04/29/20	04/29/20	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 04/29/20 Cpn 313384WE5	49,999,750.00	250.00	0.00	0.00	50,000,000.00
04/30/20	04/30/20	Mature Long	40,000,000.000	U.S. TREASURY BILL MAT 04/30/20 Cpn 912796TS8	39,999,976.67	23.33	0.00	0.00	40,000,000.00
04/30/20	04/30/20	Mature Long	50,000,000.000	U.S. TREASURY BILL MAT 04/30/20 Cpn 912796TS8	49,999,970.83	29.17	0.00	0.00	50,000,000.00
04/30/20	04/30/20	Mature Long	50,000,000.000	U.S. TREASURY BILL MAT 04/30/20 Cpn 912796TS8	49,999,970.83	29.17	0.00	0.00	50,000,000.00
04/30/20	04/30/20	Mature Long	25,000,000.000	U.S. TREASURY FRN MAT 04/30/20 Cpn 9128284K3	25,000,000.00		0.00	0.00	25,000,000.00
			505,882,000.000		**505,862,737.22**	**19,262.78**	**0.00**	**0.00**	**505,882,000.00**
04/01/20	04/01/20	Withdrawal	(3,859.960)	CUSTODY FEES MAT Cpn USD	(3,859.96)		(3,859.96)	0.00	(3,859.96)
04/02/20	04/02/20	Withdrawal	(20,000,000.000)	WD MAT Cpn USD	(20,000,000.00)		(20,000,000.00)	0.00	(20,000,000.00)
04/06/20	04/06/20	Withdrawal	(35,000,000.000)	WD MAT Cpn USD	(35,000,000.00)		(35,000,000.00)	0.00	(35,000,000.00)
04/09/20	04/09/20	Withdrawal	(40,000,000.000)	WD MAT Cpn USD	(40,000,000.00)		(40,000,000.00)	0.00	(40,000,000.00)
04/13/20	04/13/20	Withdrawal	(30,000,000.000)	WD MAT Cpn USD	(30,000,000.00)		(30,000,000.00)	0.00	(30,000,000.00)

Account Name: L.A. CARE HEALTH PLAN

04/01/2020 through 04/30/2020

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
04/14/20	04/14/20	Withdrawal	(70,000,000.000)	WD MAT	Cpn	USD	(70,000,000.00)		(70,000,000.00)	0.00	(70,000,000.00)
04/15/20	04/15/20	Withdrawal	(35,000,000.000)	WD MAT	Cpn	USD	(35,000,000.00)		(35,000,000.00)	0.00	(35,000,000.00)
04/16/20	04/16/20	Withdrawal	(60,000,000.000)	WD MAT	Cpn	USD	(60,000,000.00)		(60,000,000.00)	0.00	(60,000,000.00)
04/17/20	04/17/20	Withdrawal	(75,000,000.000)	WD MAT	Cpn	USD	(75,000,000.00)		(75,000,000.00)	0.00	(75,000,000.00)
04/23/20	04/23/20	Withdrawal	(50,000,000.000)	WD MAT	Cpn	USD	(50,000,000.00)		(50,000,000.00)	0.00	(50,000,000.00)
04/27/20	04/27/20	Withdrawal	(60,000,000.000)	WD MAT	Cpn	USD	(60,000,000.00)		(60,000,000.00)	0.00	(60,000,000.00)
04/30/20	04/30/20	Withdrawal	(40,000,000.000)	WD MAT	Cpn	USD	(40,000,000.00)		(40,000,000.00)	0.00	(40,000,000.00)
			(515,003,859.960)				**(515,003,859.96)**		**(515,003,859.96)**	**0.00**	**(515,003,859.96)**

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

04/01/2020 through 04/30/2020

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
04/17/20	04/20/20	Buy	950,000.000	FHLMC MAT 04/20/23 Cpn 0.38 3137EAEQ8	(947,625.00)		0.00	0.00	(947,625.00)
04/20/20	04/22/20	Buy	450,000.000	CA SAN DIEGO REDEV AGY TAB T MAT 09/01/23 Cpn 3.38 79730WAZ3	(476,766.00)	(2,151.56)	0.00	0.00	(478,917.56)
04/22/20	04/24/20	Buy	960,000.000	FNMA MAT 04/22/25 Cpn 0.63 3135G03U5	(958,022.40)		0.00	0.00	(958,022.40)
04/17/20	04/24/20	Buy	300,000.000	INTER-AMERICAN DEVELOPMENT MAT 05/24/23 Cpn 0.50 4581X0DM7	(299,898.00)		0.00	0.00	(299,898.00)
04/30/20	05/01/20	Buy	2,315,000.000	U.S. TREASURY NOTE MAT 03/31/25 Cpn 0.50 912828ZF0	(2,332,362.50)	(980.40)	0.00	0.00	(2,333,342.90)
04/23/20	05/06/20	Buy	280,000.000	CA RIVERSIDE CNTY PENSN OBLG MAT 02/15/23 Cpn 2.36 76913CAX7	(280,000.00)		0.00	0.00	(280,000.00)
04/30/20	05/11/20	Buy	130,000.000	CA SAN DIEGO PUBLIC FACS WTR MAT 08/01/24 Cpn 1.53 79730CJH8	(130,000.00)		0.00	0.00	(130,000.00)
			5,385,000.000		**(5,424,673.90)**	**(3,131.96)**	**0.00**	**0.00**	**(5,427,805.86)**
04/01/20	04/01/20	Coupon		CA BAY AREA TOLL AUTH TOLL BR MAT 04/01/24 Cpn 2.25 072024WP3		14,131.33	0.00	0.00	14,131.33
04/01/20	04/01/20	Coupon		CA STATE GO/ULT-TXB MAT 04/01/22 Cpn 2.37 13063DAD0		5,680.80	0.00	0.00	5,680.80
04/01/20	04/01/20	Coupon		CA STATE GO/ULT TXBL MAT 04/01/21 Cpn 2.80 13063DGA0		11,200.00	0.00	0.00	11,200.00
04/01/20	04/01/20	Coupon		CA SAN MARCOS REDEV AGY TAB MAT 10/01/22 Cpn 2.25 79876CBS6		5,793.75	0.00	0.00	5,793.75
04/01/20	04/01/20	Coupon		CA STOCKTON PFA WTR REV-GRE MAT 10/01/24 Cpn 2.37 861398CH6		2,294.87	0.00	0.00	2,294.87

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

04/01/2020 through 04/30/2020

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
04/07/20	04/07/20	Coupon		CITI 2017-A3 A3 CDT MAT 04/07/22 Cpn 1.92 17305EGB5		4,800.00	0.00	0.00	4,800.00
04/15/20	04/15/20	Coupon		CAPTAIL ONE 2020-1 A3 AUTO MAT 11/15/24 Cpn 1.60 14043MAC5		640.00	0.00	0.00	640.00
04/15/20	04/15/20	Coupon		FIFTH THIRD 2019-1 A3 CAR MAT 12/15/23 Cpn 2.64 31680YAD9		704.00	0.00	0.00	704.00
04/15/20	04/15/20	Coupon		HONDA 2019-3 A3 CAR MAT 08/15/23 Cpn 1.78 43815NAC8		623.00	0.00	0.00	623.00
04/15/20	04/15/20	Coupon		JOHN DEERE 2017-A A3 EQP MAT 04/15/21 Cpn 1.78 47787XAC1		25.62	0.00	0.00	25.62
04/15/20	04/15/20	Coupon		JOHN DEERE 2020-A A3 EQP MAT 08/15/24 Cpn 1.10 47789KAC7		748.00	0.00	0.00	748.00
04/15/20	04/15/20	Coupon		MERCEDES 2020-A A3 CAR LEASE MAT 12/15/22 Cpn 1.84 58770FAC6		352.67	0.00	0.00	352.67
04/15/20	04/15/20	Coupon		NISSAN 2018-A A3 LEASE MAT 09/15/21 Cpn 3.25 65478BAD3		893.75	0.00	0.00	893.75
04/15/20	04/15/20	Coupon		NISSAN 2018-C A3 CAR MAT 06/15/23 Cpn 3.22 65478NAD7		2,012.50	0.00	0.00	2,012.50
04/15/20	04/15/20	Coupon		NISSAN 2019-A A3 CAR MAT 10/16/23 Cpn 2.90 65479KAD2		1,305.00	0.00	0.00	1,305.00
04/15/20	04/15/20	Coupon		CA SAN DIEGO CITY PUB FACS LE MAT 10/15/22 Cpn 3.23 797299LU6		13,731.75	0.00	0.00	13,731.75
04/15/20	04/15/20	Coupon		TOYOTA 2017-A A3 CAR MAT 02/16/21 Cpn 1.73 89238MAD0		32.95	0.00	0.00	32.95
04/15/20	04/15/20	Coupon		TOYOTA 2017-B A3 CAR MAT 07/15/21 Cpn 1.76 89190BAD0		317.08	0.00	0.00	317.08

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04/01/2020 through 04/30/2020

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
04/15/20	04/15/20	Coupon		TOYOTA 2018-A A3 CAR MAT 05/16/22 Cpn 2.35 89238BAD4		613.51	0.00	0.00	613.51
04/15/20	04/15/20	Coupon		TOYOTA 2019-A A3 CAR MAT 07/17/23 Cpn 2.91 89239AAD5		1,358.00	0.00	0.00	1,358.00
04/15/20	04/15/20	Coupon		TOYOTA 2019-C A3 CAR MAT 09/15/23 Cpn 1.91 89238UAD2		668.50	0.00	0.00	668.50
04/15/20	04/15/20	Coupon		TOYOTA 2019-D A3 CAR MAT 01/16/24 Cpn 1.92 89233MAD5		1,376.00	0.00	0.00	1,376.00
04/19/20	04/19/20	Coupon		INTER-AMERICAN DEVELOPMENT MAT 04/19/21 Cpn 2.63 4581X0DB1		6,168.75	0.00	0.00	6,168.75
04/20/20	04/20/20	Coupon		VOLKSWAGEN 2019-A A4 LEASE MAT 08/20/24 Cpn 2.02 92867XAE6		538.67	0.00	0.00	538.67
04/20/20	04/20/20	Coupon		VERIZON 2019-C A1A PHONE MAT 04/22/24 Cpn 1.94 92348AAA3		808.33	0.00	0.00	808.33
04/25/20	04/25/20	Coupon		BMW 2019-A A3 CAR MAT 01/25/24 Cpn 1.92 05588CAC6		880.00	0.00	0.00	880.00
04/01/20	04/25/20	Coupon		FHMS J22F A1 CMBS MAT 05/25/23 Cpn 3.45 3137FJYA1		462.67	0.00	0.00	462.67
04/01/20	04/25/20	Coupon		FHMS K020 A2 CMBS MAT 05/25/22 Cpn 2.37 3137ATRW		613.03	0.00	0.00	613.03
04/01/20	04/25/20	Coupon		FHMS K020 A2 CMBS MAT 05/25/22 Cpn 2.37 3137ATRW		751.45	0.00	0.00	751.45
04/01/20	04/25/20	Coupon		FHMS K029 A2 CMBS MAT 02/25/23 Cpn 3.32 3137B36J2		664.00	0.00	0.00	664.00
04/01/20	04/25/20	Coupon		FHMS K029 A2 CMBS MAT 02/25/23 Cpn 3.32 3137B36J2		1,051.33	0.00	0.00	1,051.33

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

04/01/2020 through 04/30/2020

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
04/01/20	04/25/20	Coupon		FHMS K029 A2 CMBS MAT 02/25/23 Cpn 3.32 3137B36J2		498.00	0.00	0.00	498.00
04/01/20	04/25/20	Coupon		FHMS K031 A2 MAT 04/25/23 Cpn 3.30 3137B3NX2		2,200.00	0.00	0.00	2,200.00
04/01/20	04/25/20	Coupon		FHMS K033 A2 MAT 07/25/23 Cpn 3.06 3137B4WB8		2,091.00	0.00	0.00	2,091.00
04/01/20	04/25/20	Coupon		FHMS K034 A2 MAT 07/25/23 Cpn 3.53 3137B5JM6		1,412.40	0.00	0.00	1,412.40
04/01/20	04/25/20	Coupon		FHMS K504 A2 CMBS MAT 09/25/20 Cpn 2.57 3137BMLC8		396.87	0.00	0.00	396.87
04/01/20	04/25/20	Coupon		FHMS K725 AM CMBS MAT 02/25/24 Cpn 3.10 3137BWWE		2,095.20	0.00	0.00	2,095.20
04/01/20	04/25/20	Coupon		FHMS K726 AM CMBS MAT 04/25/24 Cpn 2.99 3137BYPR5		1,417.88	0.00	0.00	1,417.88
04/01/20	04/25/20	Coupon		FHMS KJ06 A CMBS MAT 01/25/23 Cpn 2.27 3137BQR90		795.20	0.00	0.00	795.20
04/01/20	04/25/20	Coupon		FHMS KJ28 A1 MAT 02/25/25 Cpn 1.77 3137FREB3		675.52	0.00	0.00	675.52
04/01/20	04/25/20	Coupon		FHMS KS01 A2 CMBS MAT 01/25/23 Cpn 2.52 3137B1U75		766.57	0.00	0.00	766.57
04/01/20	04/25/20	Coupon		FHMS KSMC A2 CMBS MAT 01/25/23 Cpn 2.62 3137B04Y7		1,939.46	0.00	0.00	1,939.46
04/01/20	04/25/20	Coupon		FNA 2011-M5 A2 CMBS MAT 07/25/21 Cpn 2.94 3136A07H4		263.05	0.00	0.00	263.05
04/27/20	04/27/20	Coupon		FHMS KI05 A MAT 07/25/24 Cpn 0.83 3137FQXG3		471.76	0.00	0.00	471.76

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

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Tr Date	St Date	Transaction Type	Units	Description	Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
04/30/20	04/30/20	Coupon		U.S. TREASURY NOTE MAT 10/31/24 Cpn 1.50 912828YM6		300.00	0.00	0.00	300.00
04/30/20	04/30/20	Coupon		U.S. TREASURY NOTE MAT 10/31/22 Cpn 2.00 9128283C2		4,350.00	0.00	0.00	4,350.00
						100,914.22	**0.00**	**0.00**	**100,914.22**
04/01/20	04/01/20	Income	601.060	STIF INT MAT Cpn USD		601.06	0.00	0.00	601.06
04/17/20	04/20/20	Sell Long	950,000.000	U.S. TREASURY NOTE MAT 11/15/22 Cpn 1.63 912828TY6	983,917.97	6,658.48	34,712.08	0.00	990,576.45
04/22/20	04/22/20	Call	880,000.000	FFCB MAT 07/13/23 Cpn 1.78 3133ELGR9	880,000.00	4,307.60	205.51	0.00	884,307.60
04/22/20	04/24/20	Sell Long	885,000.000	U.S. TREASURY NOTE MAT 01/31/25 Cpn 1.38 912828Z52	927,037.50	2,808.17	42,533.57	0.00	929,845.67
04/17/20	04/24/20	Sell Long	300,000.000	U.S. TREASURY NOTE MAT 02/15/23 Cpn 1.38 912828Z86	309,703.13	781.94	5,312.53	0.00	310,485.07
04/30/20	05/01/20	Sell Long	405,000.000	U.S. TREASURY NOTE MAT 05/15/22 Cpn 2.13 9128286U9	420,741.21	3,972.12	13,154.73	0.00	424,713.33
			3,420,000.000		**3,521,399.81**	**18,528.31**	**95,918.42**	**0.00**	**3,539,928.12**
04/07/20	04/07/20	Pay Princpl	500,000.000	CITI 2017-A3 A3 CDT MAT 04/07/22 Cpn 1.92 17305EGB5	500,000.00		0.00	8.87	500,000.00
04/15/20	04/15/20	Pay Princpl	17,270.416	JOHN DEERE 2017-A A3 EQP MAT 04/15/21 Cpn 1.78 47787XAC1	17,270.42		0.00	13.29	17,270.42

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

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Tr Date	St Date	Transaction Type	Units	Description		Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
04/15/20	04/15/20	Pay Princpl	22,856.522	TOYOTA 2017-A A3 CAR MAT 02/16/21 Cpn 1.73	89238MAD0	22,856.52		0.00	(0.00)	22,856.52
04/15/20	04/15/20	Pay Princpl	38,928.998	TOYOTA 2017-B A3 CAR MAT 07/15/21 Cpn 1.76	89190BAD0	38,929.00		0.00	0.31	38,929.00
04/15/20	04/15/20	Pay Princpl	26,739.724	TOYOTA 2018-A A3 CAR MAT 05/16/22 Cpn 2.35	89238BAD4	26,739.72		0.00	0.09	26,739.72
04/01/20	04/25/20	Pay Princpl	1,083.561	FHMS J22F A1 CMBS MAT 05/25/23 Cpn 3.45	3137FJYA1	1,083.56		0.00	0.02	1,083.56
04/01/20	04/25/20	Pay Princpl	30,385.258	FHMS K504 A2 CMBS MAT 09/25/20 Cpn 2.57	3137BMLC8	30,385.26		0.00	3.97	30,385.26
04/01/20	04/25/20	Pay Princpl	790.366	FHMS KJ28 A1 MAT 02/25/25 Cpn 1.77	3137FREB3	790.37		0.01	0.00	790.37
04/01/20	04/25/20	Pay Princpl	1,006.001	FHMS KS01 A2 CMBS MAT 01/25/23 Cpn 2.52	3137B1U75	1,006.00		(10.71)	0.00	1,006.00
04/01/20	04/25/20	Pay Princpl	207.980	FNA 2011-M5 A2 CMBS MAT 07/25/21 Cpn 2.94	3136A07H4	207.98		0.00	0.54	207.98
			639,268.826			**639,268.83**		**(10.71)**	**27.10**	**639,268.83**

LA CARE

Cash Activity by Transaction Type GAAP Basis

Accounting Period From 04/01/2020 To 04/30/2020

Cash Date	Trade/Ex-Date	Settle/Pay Date	Custodian	Cusip	Description	Quantity	Income Amount	Principal Amount	Contributions/ Withdrawals	Total Amount
BUY										
04/06/20	04/02/20	04/06/20	BKAMER19	341081FZ5	FLORIDA POWER & LIGHT CO	2,500,000.00	(1,781.25)	(2,636,275.00)	0.00	(2,638,056.25)
04/06/20	04/06/20	04/06/20	BKAMER19	09248U718	BLACKROCK TREASURY TRUST	634,899.46	0.00	(634,899.46)	0.00	(634,899.46)
TOTAL BUY						3,134,899.46	(1,781.25)	(3,271,174.46)	0.00	(3,272,955.71)
DIVIDEND										
04/01/20	04/01/20	04/01/20	BKAMER19	09248U718	BLACKROCK TREASURY TRUST	58,370.64	2,921.32	0.00	0.00	2,921.32
TOTAL DIVIDEND						58,370.64	2,921.32	0.00	0.00	2,921.32
INTEREST										
04/01/20	04/01/20	04/01/20	BKAMER19	375558AW3	GILEAD SCIENCES INC	0.00	111,000.00	0.00	0.00	111,000.00
04/01/20	04/01/20	04/01/20	BKAMER19	677415CP4	OHIO POWER COMPANY	0.00	53,750.00	0.00	0.00	53,750.00
04/01/20	04/01/20	04/01/20	BKAMER19	911312BP0	UNITED PARCEL SERVICE	0.00	92,250.00	0.00	0.00	92,250.00
04/08/20	04/08/20	04/08/20	BKAMER19	89236TCZ6	TOYOTA MOTOR CREDIT CORP	0.00	47,500.00	0.00	0.00	47,500.00
04/12/20	04/12/20	04/12/20	BKAMER19	05565EAW5	BMW US CAPITAL LLC	0.00	51,750.00	0.00	0.00	51,750.00
04/13/20	04/13/20	04/13/20	BKAMER19	64952WCE1	NEW YORK LIFE GLOBAL FDG	0.00	45,000.00	0.00	0.00	45,000.00
04/15/20	04/15/20	04/15/20	BKAMER19	67021CAG2	NSTAR ELECTRIC CO	0.00	59,375.00	0.00	0.00	59,375.00
04/15/20	04/15/20	04/15/20	BKAMER19	91324PDD1	UNITEDHEALTH GROUP INC	0.00	57,593.75	0.00	0.00	57,593.75
04/17/20	04/17/20	04/17/20	BKAMER19	36962G5J9	GENERAL ELECTRIC CO	0.00	201,112.50	0.00	0.00	201,112.50
04/18/20	04/18/20	04/18/20	BKAMER19	05565EBH7	BMW US CAPITAL LLC	0.00	94,500.00	0.00	0.00	94,500.00
04/23/20	04/23/20	04/23/20	BKAMER19	61761JVL0	MORGAN STANLEY	0.00	55,500.00	0.00	0.00	55,500.00
TOTAL INTEREST						0.00	869,331.25	0.00	0.00	869,331.25
SELL										
04/06/20	04/03/20	04/06/20	BKAMER19	912828TY6	UNITED STATES TREASURY NOTE	2,250,000.00	14,363.84	2,328,742.46	0.00	2,343,106.30
04/06/20	04/06/20	04/06/20	BKAMER19	09248U718	BLACKROCK TREASURY TRUST	58,370.64	0.00	58,370.64	0.00	58,370.64
TOTAL SELL						2,308,370.64	14,363.84	2,387,113.10	0.00	2,401,476.94
WITHDRAW										
04/07/20	04/07/20	04/07/20	BKAMER19	CASHCASH6	C-04 CUSTODY FEE	0.00	0.00	0.00	(773.80)	(773.80)
TOTAL WITHDRAW						0.00	0.00	0.00	(773.80)	(773.80)

LA CARE

Cash Activity by Transaction Type GAAP Basis

Accounting Period From 04/01/2020 To 04/30/2020

Cash Date	Trade/Ex-Date	Settle/Pay Date	Custodian	Cusip	Description	Quantity	Income Amount	Principal Amount	Contributions/ Withdrawals	Total Amount
GRAND TOTAL						5,501,640.74	884,835.16	(884,061.36)	(773.80)	0.00
Avg Date 7										

BOARD OF GOVERNORS

Finance & Budget Committee

Meeting Minutes – April 27, 2020

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

Management/Staff

John Baackes, *Chief Executive Officer*
Terry Brown, *Chief Human Resource Officer*
Augustavia J. Haydel, Esq., *General Counsel*
Dino Kasdagly, *Chief Operating Officer*
Marie Montgomery, *Chief Financial Officer*
Tom MacDougall, *Chief Information & Technology Officer*
Richard Seidman, MD, MPH, *Chief Medical Officer*

Absent* * Via Teleconference*

California Governor issued Executive Order No. N-29-20, which among other provisions amends the Ralph M. Brown Act and Executive Order No. 33-20, ordering all residents to stay in their homes, except for specific essential functions. Members of the public can listen to this meeting via teleconference.

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
CALL TO ORDER	Robert H. Curry, *Chairperson,* called the meeting to order at 1:03 p.m. He welcomed everyone to the meeting and invited the members of the Committee, staff and guests to introduce themselves. Chairperson Curry summarized the process for public comment during this teleconference meeting as reflected on the meeting agenda. • Public comments received by voicemail, email or text received by 2pm today were provided to the Finance & Budget Committee members. Public comments will be read for 3 minutes during the meeting. • Once the meeting has started, emails and texts for public comment should be submitted before the item is called by the meeting Chair. If you wish to submit public comment on an item, you must submit it at any time prior to the time the Chair starts consideration of the item. The Chair will ask for public comment and will announce the item. The Chair will announce when public comment period is over.	

APPROVED

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
APPROVE MEETING AGENDA	The Agenda for today's meeting was approved.	**Approved unanimously by roll call. 4 AYES (Curry, De La Torre, Perez and Roybal)**
PUBLIC COMMENTS	There were no public comments.	
MEETING MINUTES	*The February 24, 2020 F&B meeting minutes were approved by the Executive Committee on March 23, 2020.*	
CHAIRPERSON'S REPORT	Chairperson Curry commented on the unique natures of the current public health situation. He is pleased and proud of L.A. Care's response. He thanked everyone in health care who is treating people with this deadly and horrible disease. He complimented those who work to get personal protective equipment (PPE) to health care staff. He appreciates the overall response from front line staff who are working hard to help patients.	
CHIEF EXECUTIVE OFFICER'S REPORT	John Baackes, *Chief Executive Officer,* thanked the front line health providers. • All of L.A. Care staff are working remotely since as of March 16. A handful of staff does go in to the office: IT staff, staff that checks mail, and staff that receive claims or sending checks to providers. • L.A. Care recognizes its role as a health plan is to make sure members have access to care and providers have resources to operate. Leadership is looking carefully at all that L.A. Care can do to help them. • Hospital space is set aside to treat COVID-19 patients. Doctors whose offices are closed are using telephone visits. • Last week, L.A. Care announced an effort to advance funds to providers with cash flow problems. There is incomplete data on the needs of hospitals and clinics. Hospitals are still waiting for Coronavirus Aid, Relief, and Economic Security (CARES) Act funding. L.A. Care has allocated $20 million in advance incentive payment to hospitals, federally qualified health centers (FQHCs), clinics and independent physician associations (IPAs) based on past performance incentive earned. • L.A. Care is also involved with the meal delivery with Project Angel Food. More details will be provided at the May 7 Board meeting. *(Member Booth joined the meeting.)*	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Health plans are expecting sharp increases in enrollment because of the expected economic recession, and L.A. Care is leading an effort with 14 other health plans to ask for federal financial support for Medicaid through the CARES Act, to: o Indefinitely suspend the Medicaid Fiscal Accountability Regulations (MFAR) o Amend Medicaid rules to allow presumptive eligibility for enrollment o Suspend changes to public charge rules • This morning the Supreme Court, in an unprecedented 8-1 decision, ruled against the US government and supported the case for health insurance companies to recover funds that were to be paid through the Affordable Care Act. L.A. Care's share of the payment is estimated to be $23 million.	
COMMITTEE ITEMS		
Chief Financial Officer's Report Financial Performance Report	Marie Montgomery, *Chief Financial Officer,* provided an update on financial performance for March 2020. *(A copy of her presentation may be requested by contacting Board Services.)* <u>Membership</u> Membership for the month is 2,146,643, favorable by 2,700 members; 14,379 member months unfavorable for the year versus the forecast. Membership is likely to increase significantly due to an increase in unemployment claims. The 4+8 forecast was done pre COVID-19. The forecast assumed a 3.5% decrease in membership for Plan Partners and a 2.5% decrease for MCLA, with the exception of the enrollment expected to get from the expansion of coverage to undocumented young adults beginning in March, and the increase expected from our updated auto-assignment rate. Commercial is higher than forecast by approximately 3,300 members. There is a slight drop in membership for L.A. Care Covered (LACC) in March, but still ahead of the forecast for the year. Board Chairperson De La Torre asked how L.A. Care can help the unemployed having difficulties with Employment Development Department. He also asked about eligibility for Medi-Cal. Member Roybal suggested that L.A. Care run advertising to let people know their options. Mr. Baackes will check with Antonia Jimenez, *Director of Department of Public Social Services*, on the question and will ask staff to explore the advertising.	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Member Booth asked the enrollment for PASC and LACC. Ms. Montgomery responded that PASC membership is approximately 50,000 and L.A. care Covered (LACC) is approximately 85,000. <u>Consolidated Financial Performance</u> The net deficit for March 2020 is $9.8 million, with a year to date net surplus of $45.8 million which is $19 million unfavorable to forecast. Pharmacy expenses are unfavorable to the forecast by almost $13 million. This was because of regulatory guidance to change the early refill limit. L.A. Care changed the early refill restriction to a soft edit, which means that the pharmacist can override the rejection without calling L.A. Care or the prescriber if the patient provides a valid reason. The capitation deduct true-up is unfavorable to L.A. Care by $10 million, retroactive to July 2019. L.A. Care experienced very high paid claims in March at $241 million. L.A. Care is accelerating claims payments to assist providers. As a result, claims incurred for months prior to March are higher than forecasted. For the incurred month of March 2020, staff is factoring in the impact of COVID-19 on cancelled elective medical procedures. The elective procedures are beginning to occur only recently at the same time L.A. Care has accelerated claim payments. YTD Administrative expenses are $700,000 favorable to forecast. Non-operating revenue is $1.5 million unfavorable to forecast due to unrealized losses on investments. The unrealized gain position went from a $12.4 million gain down to a $7.4 million gain. <u>Operating Margin by Segment</u> Overall medical care ratio (MCR) is 93.6% versus a forecast of 93.2%, resulted in an unfavorable variance of $18 million in operating margin.. MCR for the Temporary Assistance to Needy Families (TANF)/Medi-Cal Expansion (MCE) segment is behind the forecast driven by the $10 million capitation deduct true up discussed earlier. <u>Key Financial Ratios</u> Working Capital and Tangible Net Equity are ahead of benchmarks. Cash to claims ratio is below the target. The cash to claims ratio will not fully recover until the In Home Supportive Services program balance with the Department of Health Care Services is settled.	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Motion FIN 100.0520 **To accept the Financial Report for March 2020, as submitted.**	**Approved unanimously by roll call. 5 AYES**
Quarterly Investment Report	Ms. Montgomery noted that the Quarterly Investment Report for the quarter ending March 31, 2020, is included in meeting materials. Per Wilshire's report, L.A Care is in compliance with its investment guidelines. Investment yields have decreased significantly for the short-term duration investments and L.A. Care is moving funds to the Los Angeles County pooled fund to improve its yield. **Motion FIN 101.0520** **To accept the Quarterly Investment Report for the quarter ending March 31, 2020, as submitted.**	**Approved unanimously by roll call. 5 AYES** **The Committee approved including this motion on the Consent Agenda for the May 7, 2020, Board of Governors meeting.**
Investment Monthly Transactions Report	Ms. Montgomery referred to the investment transactions reports included in the meeting materials. (*A copy of the report can be obtained by contacting Board Services).* As of March 31, 2020, L.A. Care's total investment market value was $1.5 billion. • $1.3 billion managed by Payden & Rygel and New England Asset Management (NEAM) • $72 million in Local Agency Investment Fund • $106 million in Los Angeles County Pooled Investment Fund	
Quarterly Reports Required by Internal Policies	Ms. Montgomery referred to reports required by L.A. Care's internal policies for the FY 2019-20, included in the meeting materials. (*A copy of the reports can be obtained by contacting Board Services)*: • Policy AFS-004 (Non-Travel Expense Report) • Policy AFS-027 (Travel Expense Report) • Policy AFS-006 (Authorization and Approval Limits) • Policy AFS-007 (Procurement) Member Booth noted that it is difficult to compare non-travel expenses to the budget. Ms. Montgomery noted that staff is tracking these expenses, and will report expenses higher than budgeted.	
PaySpan Contract Amendment	Ms. Montgomery presented a motion requesting a contract amendment with PaySpan. L.A. Care partnered with PaySpan for an EDI System that includes Electronic Funds Transfer (EFT), file processing, Electronic Remittance Advice (ERA), and an online archive. A competitive bid was conducted in 2013. The EDI System enables L.A. Care to be compliant	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	with the Department of Health & Human Services regulation regarding Adoption of Operating Rules for Health Care EFTs and ERA transactions, including Provider Enrollment in EFT and ERA. L.A. Care requires these services because of an increase in EFT Claims Payments. **<u>Motion FIN A.0420</u>** **To authorize staff to amend a contract in the amount of $1,000,000 with PaySpan to provide Electronic Funds Transfer services through its Electronic Data Interchange System through September 30, 2022 for a new contract total of $1,875,000.**	**Approved unanimously by roll call. 5 AYES**
WEX Health Contract Amendment	Ms. Montgomery presented a motion requesting approval to amend the contract with WEX Health. WEX Health was selected through a competitive bidding process in 2014 for L.A. Care Covered (LACC) Premium Billing services. WEX Health services include invoice billing, processing of premium payments (through ACH, recurring, credit/debit card and lockbox), and will provide a secured platform for LACC members to submit payments, view payments, and download premium invoices. Member Booth asked about the calculation of the increase. Ms. Montgomery responded that this request is to get through the end of the time period and additional work. Member Booth asked about the request for proposal (RFP) check box on the motion summary form. Ms. Montgomery responded that the RFP is described in the background summary. Chair Curry suggested adding the year the RFP was conducted next to the check box. **<u>Motion FIN 102.0520</u>** **To authorize staff to amend the contract in the amount of $3,520,000 with WEX Health to provide Covered California Premium Billing services through December 2021 for a total contract of $8,495,500.**	**Approved unanimously by roll call. 5 AYES** **The Committee approved including this motion on the Consent Agenda for the May 7, 2020, Board of Governors meeting.**
Toney Healthcare Consulting Contract Amendment	Richard Seidman, MD, *Chief Medical Officer,* summarized a motion requesting approval of a contract amendment with Toney Healthcare Consulting through December 31, 2020. Member Booth asked about full time equivalent staff (FTEs) and the increase in the contract amount. Staff will revise the motion summary to be presented to the full board on May 7 to address Member Booth's questions. This motion was taken off the Consent Agenda for May 7, 2020 Board of Governors meeting. **<u>Motion FIN 103.0520</u>**	**The motion summary will be revised and the motion will be presented**

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	To authorize an amendment extending the current contract with Toney Health Care Consulting through December 31, 2020, for care management and utilization management services, in an amount not to exceed $2,300,000, for a total contract not to exceed $5,800,000.	**at the May 7 Board meeting.**
TransUnion Contract Amendment	Dino Kasdagly, *Chief Operating Officer,* summarized a motion requesting approval to amend the contract with Trans Union for additional funding and extension through May 31, 2021. Trans Union collects and processes provider encounter data for Medi-Cal, In Home Supportive Services (IHSS), LACC, and CalMediConnect lines of business, and the data is used to determine health plan rates. Trans Union was originally selected through an RFP process in 2017. It is the industry leader for Medi-Cal encounter data processing in the Los Angeles region. **Motion FIN 104.0520** **To authorize staff to amend a contract with TransUnion for the period of June 1, 2020 to May 31, 2021, to provide encounter processing services, in an amount not to exceed $1,300,000, for a total contract amount not to exceed $6,836,000.**	**Approved unanimously by roll call. 5 AYES** **The Committee approved including this motion on the Consent Agenda for the May 7, 2020, Board of Governors meeting.**
Change Healthcare Contract	Mr. Kasdagly summarized a motion requesting approval to contract with Change Healthcare (CHC). As part of the new contract, L.A. Care will implement Change Healthcare's Payer Connectivity Services (PCS) platform and will convert all providers currently submitting electronic claims utilizing CHC's Advanced Claiming platform to the new PCS platform. The vendor has notified L.A. Care that Advanced Claiming will no longer be supported. The PCS platform will continue to provide L.A. Care's providers with the ability to submit electronic claims, validate eligibility, and lookup claims status. The implementation of the PCS platform will allow L.A. Care to take advantage of reduced per-claim service rates due to volume based tiered pricing which decreases per-claim cost as the claims processing volume increases. This is a sole source vendor according to L.A. Care Policy AFS-007 because Change Healthcare is already familiar with L.A. Care systems and processes and there would be a significant learning curve and disruption if a new vendor unfamiliar with L.A. Care is selected. Chair Curry asked if this system will track authorizations. Mr. Kasdagly responded that this will not track authorizations. **Motion FIN 105.0520**	**Approved unanimously by roll call. 5 AYES**

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	To authorize staff to execute a contract with Change Healthcare for the period of May 2020 to May 2025, for claims electronic data interchange services, in an amount not to exceed $8,100,000.	
Systems, Applications, and Products (SAP) Contract Renewal	Terry Brown *Chief Human Resources Officer,* summarized a motion requesting approval to execute a contract renewal with Systems, Applications, and Products (SAP). The vendor currently provides L.A. Care with a Human Resources Information System (HRIS) which includes, but is not limited to, storing employee data, Applicant Tracking System, Learning Management System and Talent Management System. L.A. Care has used this vendor since 2015 and is pleased with their work. SAP Successfactors also fits within the footprint of other SAP solutions in use at L.A. Care. A competitive request for proposal was conducted in 2014. Chair Curry asked if L.A. Care is pleased with the utility. Mr. Brown responded that L.A. Care is pleased with their work. **Motion FIN 106.0520** **To authorize staff to execute a contract in the amount of $6,278,311.28 with Systems, Applications, and Products (SAP) to provide SuccessFactors, Human Resources Information System for the period of May 20, 2020 to May 19, 2025.**	**Approved unanimously by roll call. 5 AYES** **The Committee approved including this motion on the Consent Agenda for the May 7, 2020, Board of Governors meeting.**
Healthx Contract Amendment	Tom MacDougall, *Chief Information & Technology Office,* summarized a motion requesting to amend a contract with Healthx, through February 2021. In February 2015, the Board of Governors authorized staff to contract with one or more existing key vendors for L.A. Care's Member and Provider Portal Strategic implementation services. L.A. Care conducted a competitive request for proposal (RFP) process in 2015 and selected Healthx as the vendor of choice given its proven expertise, health plan experience, and fit with L.A. Care's strategic goals. Member Booth asked why there is an increase in monthly cost. Mr. McDougall responded that there are additional functions which significantly upgrade the provider portal. **Motion FIN 107.0520** **To authorize staff to amend a contract with Healthx in the amount of $2,088,000 (total contract not to exceed $7,588,000) and extend the contact term for hosting services through February 28, 2021.**	**Approved unanimously by roll call. 5 AYES** **The Committee approved including this motion on the Consent Agenda for the May 7, 2020, Board of Governors meeting.**

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
Rebranding of the existing Family / Community Resource Centers (Lynwood, East LA, Palmdale) to incorporate the Blue Shield partnership	Lance MacLean, *Senior Director, Facilities Services*, reported that while L.A. Care's Family and Community Resource Centers are closed due to public health guidelines, L.A. Care is taking the opportunity to upgrade the facilities with the rebranded Blue Shield partnership. The cost falls within the authority for the CEO/CFO to approve. Chair Curry asked about health care services at the resource centers. Mr. Baackes responded that there are no direct health care services provided at the resource centers.	
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 2:12 pm. CONTRACT RATES Pursuant to Welfare and Institutions Code Section 14087.38(m) • Plan Partner Rates • Provider Rates • DHCS Rates REPORT INVOLVING TRADE SECRET Pursuant to Welfare and Institutions Code Section 14087.38(n) Discussion Concerning New Service, Program, Technology, Business Plan Estimated date of public disclosure: *April 2022* CONFERENCE WITH REAL PROPERTY NEGOTIATORS Pursuant to Section 54956.8 of the Ralph M. Brown Act Property: 11725 Rosecrans Ave., Norwalk, CA. 90650 Agency Negotiator: John Baackes Negotiating Parties: Hekmatravan Family Norwalk, LLC, and Levian Family Norwalk, LLC. Under Negotiation: Price and Terms of Payment	

APPROVED

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
RECONVENE IN OPEN SESSION	The meeting reconvened in open session at 2:22 pm. No reportable actions were taken during the closed session.	
ADJOURNMENT	The meeting was adjourned at 2:23 pm.	

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

APPROVED BY:

_____
Robert H. Curry, *Chair*
Date Signed _____

APPROVED

BOARD OF GOVERNORS

Compliance & Quality Committee Meeting

Meeting Minutes – March 19, 2020

L.A. Care Health Plan CR 100, 1055 W. Seventh Street, Los Angeles, CA 90017

Members

Stephanie Booth, MD, *Chairperson*
Al Ballesteros, MBA **
Hilda Perez **
Ilan Shapiro, MD *
Nina Vaccaro **
** Absent ** Teleconference*

Management

Richard Seidman, *MD, MPH Chief Medical Officer*
Augustavia J. Haydel, *General Counsel*
Thomas Mapp, *Chief Compliance Officer*
James Kyle, MD, *Medical Director, Quality, Quality Improvement*
Katrina miller Parrish, *MD, FAAFP, Chief Quality and Information Executive*
Maria Casias, RN, BSN, MPH, *Director, Quality Improvement Accreditation*
Yasamin Hafid, *Senior Director, Compliance Risk Management and Operations Oversight*
Lisa Marie Golden, *Director, CSC Appeals & Grievance*

California Governor Newsom issued Executive Order No. N-29-20, which among other provisions amends the Ralph M. Brown Act and Executive Order No. 33-20, ordering all residents to stay in their homes, except for specific essential functions. Members of the public can hear and observe this meeting via teleconference, and can share their comments via voicemail, email, or text.

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
CALL TO ORDER	Stephanie Booth, MD, *Committee Chairperson*, called the meeting to order at 2:06 pm. She announced that members of the public may address the Committee on each matter listed on the agenda before the Committee's consideration of the item, or on any other topic at the Public Comment section.	
APPROVAL OF MEETING AGENDA	The Agenda was approved as submitted.	**Approved unanimously. 4 AYES (Ballesteros, Booth, Perez, and Vaccaro)**
PUBLIC COMMENT	There was no public comment.	
APPROVAL OF MEETING MINUTES	The January 16, 2020 meeting minutes were approved as submitted.	**Approved unanimously. 4 AYES**

APPROVED

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
CHAIRPERSON REPORT	There was no chairperson report.	
CHIEF MEDICAL OFFICER REPORT	Richard Seidman, MD, MPH, *Chief Medical Officer,* referred to his written report *(a copy of the report can be requested from Board Services)*: <u>Coronavirus Update (COVID-19)</u> The World Health Organization (WHO) declared the coronavirus outbreak as a Public Health Emergency of International Concern on January 30, followed by the United States declaration of a Public Health Emergency on January 31. As of March 7, there are over 100,000 cases, now representing less than 80% of cases worldwide, with more than 20,000 cases in more than 90 countries outside of China. There have been over 3,000 deaths. While cases in China have been declining since early February, cases throughout the rest of the world are increasing, and are expected to increase further as the outbreak spreads and the availability of testing increases. The WHO now believes it is likely that the outbreak will ultimately be declared a pandemic once widespread community transmission is established on all of the world's non-polar continents. In California, Governor Gavin Newsom declared a State of Emergency on March 5, 2020, as did the Cities of Los Angeles, Long Beach and Pasadena. Emergency declarations are intended to help California prepare for and contain the spread of the outbreak by allowing state and local agencies to more easily access funds, equipment and services. In Los Angeles County, as of March 6 there were 13 known cases, notably all individuals with known travel to high-risk countries, in their known contacts, and two cases in airport passenger screeners at the Los Angeles International Airport. He stated that currently there are no known cases of community transmission, although that can change at any time as it has in other parts of the United States and in other parts of the world. This would mark a significant change in the status of the outbreak. L.A. Care has a plan in place and is taking proactive steps to ensure that our employees are protected and business operations continue to operate as efficiently as possible to provide services to the members of L.A. Care as the coronavirus outbreak evolves. At this time in Los Angeles County, the risk to the general public is low and public health authorities have not called for schools or businesses to close. L.A. Care is preparing to enable its employees to work remotely as the need arises.	

APPROVED

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	L.A. Care took an additional proactive intervention to collaborate with the Los Angeles County Department of Public Health, which sends priority notifications via email through the Los Angeles Health Alert Network (LAHAN), on topics such as local disease outbreaks and emerging health risks. Each notification is clearly marked with an alert level directed to the intended audience. He noted that the first cohort of L.A. Care network providers were welcomed to LAHAN on February 13. A total of 3,165 new emails were added to LAHAN. At least 1,139 (36%) of people opened and interacted with the email and only 23 people opted out (0.7%). A nice thank you for being added email was sent directly to LAHAN. The following is taken from the Center for Disease Control's (CDC) website: *There is currently no vaccine to prevent coronavirus disease 2019 (COVID-19). The best way to prevent illness is to avoid being exposed to this virus.* <u>Influenza Season</u> The CDC estimates of the total number of cases during the 2019-20 flu season are as high as 50 million cases, with the number of deaths as high as 50,000. In Los Angeles County, emergency room (ER) visits for influenza-like illness has been declining for the last several weeks, but the number of deaths increased over prior weeks. Influenza activity in Los Angeles should continue to decline now over the next several months until it begins to pick up again in the late summer and fall. <u>National Committee for Quality Accreditation (NCQA) Update</u> L.A. Care will host its triennial onsite survey for the NCQA Accreditation this year. Our file submission is due to NCQA in early April, and NCQA representatives will be onsite in June for the file review portion of the survey process. Our Quality Performance Management (QPM) team that manages our Healthcare Efficiency Data Information Set (HEDIS) efforts recently passed the annual HEDIS audit. The auditor was extremely complimentary of L.A. Care's team and processes. The QPM team and others across the organization are managing the selection process for the HEDIS application used to determine and report HEDIS scores. Member Perez asked, is a member is feeling symptoms, is that person advised to call the nurse advice line instead of their primary care doctor? Dr. Seidman responded that if people are feeling the need to seek medical services he suggests that members first call the nurse advice line. Dr. Seidman stated that members can also call their doctor's office.	

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Member Perez asked Thomas Mapp, *Chief Compliance Officer*, if employees working from home have the necessary resources to do their jobs? She would like to know if it is challenging for employees to work from home and how they are coping. Mr. Mapp responded that L.A. Care employees are coping well. Dr. Seidman pointed out that L.A. Care has posted information on its website reminding members to call their doctor or the nurse advice line before going in person for services. There are links on the website to COVID-19 related messages and to Teledoc. Members can register to become Teledoc users and to schedule virtual visits. Prescription mail order is also an underutilized service that is available to members. He pointed out that members are becoming used to getting prescriptions by mail, which enhances adherence and compliance, and assures availability of medications which may not be in stock at the pharmacy. Member Vaccaro asked if the Teledoc program has a panel of physicians to serve patients? Dr Seidman responded that it is a virtual doctor visit, and the scope of service is for urgent care services. About 80% of the calls have been by audio only. If a face-to-face visit to a doctor is warranted the Teledoc physician will make that recomendation. Dr. Seidman stated that he has been asked about continuity of care and getting documentation to the member's doctor's office. When people have gone to get services at a hospital the member's doctor may not receive a report via fax. Hospitals only provide members with discharge papers. They do not send it to the patient's doctor. The expectation is that Telehealth quality and speed will improve member experience by providing follow up information to the primary care provider. Member Perez stated that she has been watching the L.A. Care's social media accounts and she wasn't able to find information about the nurse advice line. She suggested to have someone respond "live" to people on the social media accounts. Dr. Seidman responded that he will forward her suggestion to Communications staff. He noted that the nurse advice line phone number is printed on the back of Member ID cards.	
APPROVE QUALITY IMPROVEMENT DOCUMENTS	Maria Casias, RN, BSN, MPH, *Director, Quality Improvement Accreditation,* summarized the 2019 Quality Improvement (QI) Program Evaluation and 2020 QI Program Description and Work Plan *(a copy of the presentations can be requested from Board Services)*: <u>2019 QI Program Evaluation</u>	

APPROVED

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Results of Major Audits: • Regulatory Audits managed/supported 16 audits • Centers for Medicare and Medicaid Services (CMS) Services Validation Audit cleared 9 of 16 findings • Department of Health Care Services Medical Audit findings increased from 3 to 14 - Findings are attributed to a new focus on pharmacy, initial health assessments, and California Children's Services - Corrective Action Plans have been developed and will be monitored prior to the 2020 audit • For the first time, L.A. Care received 100% in two data validation audits confirming the accuracy of care management, health risk assessment, grievance, appeal, pharmacy, and utiliztion management data • Monitoring framework was developed to monitor internal business units and delegates for the Cal MediConnect (CMC) line of business NCQA Accreditation Status • Medi-Cal-maintained "Commendable" status • CMC and L.A. Care Covered (LACC) maintained "Accredited" status Consumer Assessment of Healthcare Providers and Systems (CAHPS) Performance: Medi-Cal • Adult scores remained low in 2019, and NCQA Accreditation points: 4.08 • Pediatric scores were statistically unchanged from 2019, and NCQA Accreditation points: 7.65 LACC • Enrollee Experience: 1 star, unchanged from 2018 CMC • NCQA Accreditation points: 6.24, improved by 3 points New Interventions: • Customer Service training for network providers Clinical HEDIS Performance RY 2019 • DHCS Auto- Assignment: L.A. Care scored higher than Health Net in 3 out of the six auto-assignment measures (Childhood Immunizations, Well Child Visits 3-6 years of age, Prenatal)	

APPROVED

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	- Prenatal care resulted in a three-point increase (one point for improvement and two points for the statistically significant difference over Health Net). - Increase from 54% to 67% + 9% rate adjustment due to DHCS calculation error in 2017. Total allocation 76%. • Medicaid: NCQA total Accreditation points: 82.1 (HEDIS: 24.98 & CAHPS: 7.65) • Medicare: NCQA total Accreditation points: 75.4 (HEDIS: 25.94 & CAHPS: 6.24) • NCQA Health Insurance Plan Ratings - Medi-Cal: L.A. Care is the highest rated Medi-Cal managed care plan in Los Angeles with a rating of 4.0 stars - CMC: maintained a score of 3.0 stars - LACC Marketplace Quality Rating System: maintained a score of 3.0 stars <u>2020 QI Program Description & Work Plan</u> General Revisions • Updated Strategic Priorities (Vision 2021), Goals, and Objectives. Program Structure Revisions: • The Medi-Cal, LACC , and CMC lines of business language now reflects the current membership and changes that were effective January 2020: - Medi-Cal expansion for undocumented immigrants - CMC extended until 2022 - LACC qualifying criteria for California Premium Subsidy • Included language to describe how the Quality improvement and Population Health Management (PHM) programs are related in terms of operation and oversight. The PHM program uses both the QI workplan to monitor PHM activities and the QI annual evaluation as part of the PHM impact report. • QI Program Goals and Objectives were updated. Program Changes Quality of Care • HEDIS measures updated; they will be prioritized for interventions and/or monitored in 2020. • The Health Equity program was revised to clarify health equity vs. health disparities and to update the program goals.	

APPROVED

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Quality of Service: • Hospital safety and use of California Hospital Compare data in assessing performance of L.A. Care network hospitals was added. • MinuteClinic information was included. This became effective June 1, 2019 for our direct line of business members. • Included new telehealth service effective January 1, 2020, for L.A. Care's direct line of business members to improve access to care when their primary care doctor is not available. **<u>Motion COM A.0420</u>** **To approve the following documents:** • **2019 Quality Improvement Annual Report and Program Evaluation – All Lines of Business** • **2020 Quality Improvement Program Description and Work Plan – All Lines of Business**	**Approved unanimously. 4 AYES**
CHIEF COMPLIANCE OFFICER REPORT	Mr. Mapp referred to the written report included in the meeting packet (*a copy of the written report can be obtained from Board Services*). <u>COVID-19 Preparedness Plan</u> In response to the Local Public Health Emergency declared on March 4, 2020, the Compliance - Business Continuity team convened a workgroup to activate L.A. Care's emergency response protocols and develop a focused COVID-19 preparedness plan. The workgroup is meeting regularly to track business decisions, regulatory requests/requirements, and staff, member and operational impacts. Governing Regulatory Guidance: • Department of Managed Health Care (DMHC) APL 20-006 • Department of Health Care Service (DHCS) COVID-19 Memo to Managed Care Plans • CMS Health Plan Management System Memo: Reminder of Pharmacy and Provider Access during a Federal Disaster or Other Public Health Emergency Declaration Access to Facilitites In alignment with guidelines set forth by the CDC, sick employees have been urged to stay home. Managers were instructed to send employees home who come to work ill. Family and Community Resource Centers have been advised to ask visibly ill	

APPROVED

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	visitors to go home. Additional cleaning procedures have been put in place for Headquarters and Garland facilities. L.A. Care has not cancelled any meetings or events onsite and is asking employees who are representing the organization at upcoming internal or community meetings/events to use their best judgement. Communication Strategy Regular updates are provided to management, staff, members and providers through L.A. Care's internal and external facing websites, in alignment with the CDC and the WHO recommendations. A Frequently Asked Question (FAQ) document was provided to staff and providers to provide guidance in responding to member's questions. The Facilities and Communications Departments have also provided guidance and resource materials to the Family Resource Centers FRCs on how to operate during this time. Serving Members Call Center is tracking COVID-19 related calls and issues; volume remains under ten per day. Per standard CMS protocol, prior authorization requirements for prescriptions, medically necessary services and transportation have been waived for members impacted by COVID-19. Special Investigations Unit is on alert to monitor potential fraud, waste and abuse. Members are encouraged to pursue telehealth service options. FAQ guides were distributed to Call Center representatives, nurses on the Nurse Advice Line and Pharmacy Department staff, for consistent communication to members. Providers L.A. Care requested and received business continuity plans from our Plan Partners and vendors focused on COVID-19 preparedness. Additional communications for medical groups, Direct Network providers and facilities are completing internal review, and will be distributed on March 10. Sales and Marketing Department suspended all large scale CMC and LACC sales events until further notice. Next Steps • Request sent to Appeals and Grievances Department to develop a process to track appeals and grievances related to COVID-19. • Deploy L.A. Care's requirement for staff returning from any Level 3 travel advisory country, to remain outside of any L.A. Care facility for 14 days.	

APPROVED

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• A memo will be released to all staff on March 10 regarding potential school closures. • Human Resources, IT and Legal staff are discussing a larger scale remote work strategy that can be deployed quickly, if needed. • Health Services is discussing a strategy/communication for community health workers and home visits. • Critical business units are finalizing business continuity plans that address potential COVID-19 impact to operations. Yasamin Hafid, *Senior Director, Compliance Risk Management and Operations Oversight*, stated tht L.A. Care is tracking and logging member calls related to COVID-19. Ms. Hafid presented information in the Compliance Issues Log. (*A copy of the meeting materials can be obtained from Board Services*). Chairperson Booth asked about delegated entities. Mr. Mapp responded that Compliance staff is responsible for delegation oversight and will report on activities to the committee. Member Vaccaro asked about the anticipated duration L.A. Care staff will be working remotely? Terry Brown, *Chief Human Resources Officer*, responded that L.A. Care is following the advice of public health officals. Los Angeles Unified School District is out for two weeks, and it is anticipated that will extend beyond Spring vacation. He thinks it might be that long for L.A. Care employees. Dr. Seidman agreed with Mr. Brown's comments and Governor Newsom's comments earlier this week. Things are changing dramatically, and it is useful take things in small increments. He noted that the CDC has noted that it is not expected that schools will be back this school year. Mr. Mapp added that L.A. Care is very capable and well set up to serve its members for a long period of time.	
APPEALS & GRIEVANCE UPDATE	Mr. Mapp introduced Lisa Marie Golden, *Director, Customer Solution Center Appeals and Grievances, CSC Appeals & Grievance*. Ms. Golden presented information in regards L.A. Care Appeals & Grievance (*A copy of the presentation can be obtained from Board Services*). Medi-Cal Grievances Quantitative Analysis	

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• Grievances related to attitude and service delivered by network providers and health plan staff are the top categories during this measurement period. The percentage rate for this category increased by 6% based on the previous measurement period. - 29% of grievances in these categories are related to transportation services • Grievances related to access issues increased by 3% based on the percentage rate reported for the previous measurement period • Grievances related to billing and financial issues decreased by 7% based on the percentage rate reported for the previous measurement period Qualitative Analysis The data supports the top two reasons for dissatisfaction in these categories are related to the following: • Dissatisfaction with their transportation services • Dissatisfaction with their primary care physician and/or office staff Medi-Cal Appeals Quantitative Analysis • Rate of appeals per 1,000 members decreased for appeals related to billing and financial issues when compared to the previous measurement period • Access issues represent the highest percentage rate for appeals. The rate per thousand did not experience a significant increase. • 34% of all appeals are related to pharmacy. Qualitative Analysis - The top category for appeals filed are related to access issues. Upon review, 48% of the overturns are related to pharmacy services. This can be attributed to prescribers which failed to respond to a request for additional information within the allotted timeframe. As a result the request is denied due to lack of sufficient evidence to support approval of the initial request. Upon receipt of the denial notice the prescriber submits supporting documentation and an appeal will often result in an overturn. Mr. Mapp asked if there are any grievances related to COVID-19? Ms. Golden responded that none have been submitted that are directly related to COVID-19.	

APPROVED

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Chairperson Booth asked about the chart on page 180 of the meeting packet. She would like to see the number value changed to over 1,000. She noted that following through on grivances is important and it is a way to improve services. Member Perez asked about the many grivances related to billing. Ms. Golden responded that members mistakenly use the state-issued card or an expired membership card, which causes the provider to directly bill the member for services. Member Perez suggested that L.A. Care find a way to make it less confusing for members. Chairperson Booth suggested that L.A. Care ask consumer advisory committee members for suggestions. Member Perez asked Ms. Golden if she can attend advisory committee meetings. Ms. Golden stated that she attended ECAC twice last year to inform members and take suggestions, and she will continue to attend as needed.	
COMMITTEE ISSUES		
REVIEW COMMITTEE CHARTER	This agenda item has been postponed for a future meeting.	
ADJOURNMENT	The meeting was adjourned at 3:45 p.m.	

Respectfully submitted by:

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

APPROVED BY:

_____
Stephanie Booth, MD, *Chairperson*
Date Signed: _____

APPROVED

BOARD OF GOVERNORS

Audit Committee Meeting Minutes – January 21, 2020

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

Members
Alvaro Ballesteros, *Interim Chairperson*
Layla Gonzalez
Stephanie Booth*, MD

Management/Staff
John Baackes, *Chief Executive Officer*
Augustavia J. Haydel, Esq., *General Counsel*
Marie Montgomery**, *Chief Financial Officer*

Guests
Khurram Siddiqui, *Partner, Deloitte & Touche*
Angelica Kocharova, *Audit Sr. Manager, Deloitte & Touche*

** Absent ** Teleconference*

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
CALL TO ORDER Alvaro Ballesteros	Alvaro Ballesteros, *Committee Chair,* called the meeting to order at 1:04 pm. 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.	
PUBLIC COMMENT	There were no public comments.	
APPROVE MEETING AGENDA Alvaro Ballesteros	Today's Agenda was approved as submitted.	**Approved unanimously. 2 AYES (Ballesteros and Gonzalez)**
APPROVE MEETING MINUTES Alvaro Ballesteros	The August 20, 2019 meeting minutes were approved as submitted.	**Approved unanimously. 2 AYES**
CHAIRPERSON'S REPORT	There was no report from the Chairperson.	
CHIEF EXECUTIVE OFFICER/CHIEF FINANCIAL OFFICER REPORT	Marie Montgomery, *Chief Financial Officer,* summarized the materials sent to the Committee prior to the meeting.	

APPROVED

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
COMMITTEE ISSUES		
Review of Audit Report for FY 2017-18	Khurram Siddiqui and Angelica Kocharova, of *Deloitte & Touche (D&T),* referenced the documents provided in the meeting packet. There were no significant changes to accounting policies. The incurred but not reported (IBNR) claims were reviewed by D&T actuary and L.A. Care estimates were close to the mid-point. D&T also closely reviewed provider claim settlements and talked to legal counsel. An estimated $30 million has been set aside. A review of the fair value of investments and revenue assumptions was also conducted and the resulting estimates were agreed to by D&T and L.A. Care. There were no disagreements, no questions with management regarding the financial statements. D&T received full cooperation and appreciated the easy availability of L.A. Care management. **<u>Motion AUD A.0119</u>** **To accept the findings of the Deloitte & Touches' audit of L.A. Care's financial statements for the fiscal year ended September 30, 2019, as presented.**	**Approved unanimously. 3 AYES (Ballesteros, Booth and Gonzalez-Delgado)**
2020-21 Audit Planning	Ms. Montgomery reported that the committee has previously directed staff to conduct a competitive bidding (RFP) process to invite other firms to propose providing audit services to L.A. Care. Staff has agreed to go forward with an RFP, but due to unique circumstances in 2019, Deloitte continued as the outside auditor for one more year. An RFP will be conducted for the 2019-20 Fiscal Year audit. Ms. Montgomery also noted that this committee typically would have planning meeting in July but may need to be earlier with a new firm. Finance will put together a timeline in order to complete the audit on time.	
COMMITTEE CHAIR ELECTION Augustavia J. Haydel, Esq.	The election was tabled to a future meeting.	

APPROVED

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
ADJOURNMENT	The Chair adjourned the meeting at 11:30 am.	

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

APPROVED BY:

_____
Al Ballesteros, MBA, *Interim Chairperson*
Date Signed: _____

APPROVED

BOARD OF GOVERNORS

Audit Committee Meeting Minutes – January 22, 2018

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

Members
Hector De La Torre, *Chairperson*
Alvaro Ballesteros, MBA
Stephanie Booth, MD *

Management/Staff
John Baackes, *Chief Executive Officer*
Augustavia J. Haydel, Esq., *General Counsel*
Marie Montgomery, *Chief Financial Officer*

Guests
Khurram Siddiqui, *Partner, Deloitte & Touche*
Angelica Kocharova, *Audit Sr. Manager, Deloitte & Touche*

** Absent ** Teleconference*

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
CALL TO ORDER Hector De La Torre	Hector De La Torre, *Committee Chair,* called the meeting to order at 10:10 am. 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	Today's Agenda was approved as submitted.	**Approved unanimously. 2 AYES (Ballesteros and De La Torre)**
PUBLIC COMMENTS	There were no public comments.	
APPROVE MEETING MINUTES Hector De La Torre	The July 20, 2017 meeting minutes were approved as submitted.	**Approved unanimously. 2 AYES**
CHAIRPERSON'S REPORT	There was no report from the Chairperson.	
CHIEF EXECUTIVE OFFICER/CHIEF FINANCIAL OFFICER REPORT	John Baackes, *Chief Executive Officer*, provided an update regarding the termination of ~~SynerMed~~* *Employee Health Systems (EHS)* contract with L.A. Care. • L.A. Care's contract with EHS and 2 other IPAs were also terminated because they have the same ownership as SynerMed. **A factual error was brought to our attention in May, 2020, through public comment and the text above was corrected. Additional clarifying corrections were also made below.*	

APPROVED

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• The Department of Managed Health Care (DMHC) and Department of Health Care Services (DHCS) has revised their Corrective Action Plan (CAP) to include cease and desist order. • A whistleblower has reported an additional fraud, that SynerMed suppressed access to ~~through SynerMedm that EHS has removed~~ certain "high-cost" EHS providers which is a violation of the Knox-Keene Act's prohibition against "economic profiling". No additional action is required from L.A. Care. • Affected members will be migrated to IPAs/providers contracted with L.A. Care. • L.A. Care is also discussing with providers who were in the SynerMed/EHS network, to contract with L.A. Care or with IPAs in L.A. Care's network. • This is an opportunity for L.A. Care and other health plans to reinforce their oversight of delegated authority. • Updates will be provided at the next Board meeting.	
COMMITTEE ISSUES		
Review of Audit Report FY 2016-17	Khurram Siddiqui, Partner, for Deloitte & Touche presented the results of the onsite audit of L.A. Care's FY 2017-18 financial statements. *(A copy of the report may be requested by contacting Board Services.)* • No significant changes in previously adopted accounting policies during the year ended September 30, 2017. • Significant accounting estimates reflected in the Organization's 2017 financial statements include 1) Reserves for Incurred but not Reported Claims, 2) Provider Settlement Liability, and 3) Collectability Assessment related to Risk Corridor Receivables. There are no significant changes in accounting estimates, except for the changes in prior year IBNR estimates as disclosed in the combined financial statements. Favorable development of approximately $141 million, net of provision for adverse development and negative provider settlement recast is primarily due to: o Certain provider settlement successfully negotiated during the year contained "cliff date" provision, which reduced the payout compared to the estimated reserves, with an impact on the reserves estimated at $80 million. o The remaining difference is due to a change in estimate resulting from the inpatient and outpatient costs emerging at lower than estimated levels.	

APPROVED

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• No material weaknesses or deficiencies were found in L.A. Care's financial operations or internal controls, • The audit went smoothly and, • There were no material adjustments to the financial statements reviewed. Committee members briefly met with the Auditors without L.A. Care management and staff present. **Motion AUD A.0118** **To accept the findings of the Deloitte & Touche audit of L.A. Care's financial statements for the fiscal year ended September 30, 2017, as presented.**	**Approved unanimously.** **2 AYES**
ADJOURNMENT	The Chair adjourned the meeting at 10:50 am.	

Respectfully submitted by:
Malou Balones, *Committee Liaison*
Linda Merkens, *Manager, Board Services*

APPROVED BY:

_____
Hector De La Torre, *Chairperson*
Date Signed: _____

APPROVED