Board of Governors
Regular Meeting Minutes #330
September 5, 2024

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

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Tom MacDougall, *Chief Technology & Information Officer*
Noah Paley, *Chief of Staff*
Acacia Reed, *Chief Operating Officer*
Afzal Shah, *Chief Financial Officer*

**Absent*

*** Via teleconference*

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WELCOME	Ilan Shapiro, MD, *Board Vice Chairperson,* called the meetings to order at 9:04 am, and noted that the regular meetings of L.A. Care Health Plan Board of Governors and the L.A. Care Health Plan Joint Powers Authority Board of Directors are held simultaneously. He welcomed everyone and outlined the information for public comment included on the meeting Agenda. He invited public comment.	
PUBLIC COMMENTS	**PUBLIC COMMENT** *Andria McFerson, RCAC 5 Member, commented she was a bit confused on the way that one can comment today, due to the fact that she's used to procedures, systematic type of thing that gives everyone an opportunity to speak their comments each item. Ms. McFerson asked if one can't make a comment for every item.* Vice Chairperson noted that some items have already been discussed during other public meetings. As provided by the Brown Act, topics that were discussed at a prior meeting where an opportunity for public comment was available are not open to public comment here. *Ms. McFerson said that the stakeholders have had a very detrimental important helpful information about their own conditions and the community. However, they were given new bylaws, a new system, to where it says you can't make a public comment anymore, and she thinks that's the reason why they're all here to make better decisions towards healthcare and make it so that they are the advisory committee. Hopefully the new bylaws would state*	

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	now that we can make public personal comments due to the fact that they are going through certain things that they may need to discuss with the Board in order to make proper decisions, in order to adhere to the necessities of people just like them, so that they can give proper funding to either the care providers or the shelters and just different places like organizations that the Board funds or gives money to and things like that. And an upkeep on the values of those services given to the community. She thinks it's very important that they are able to make a public comment on their own views, their own disparities that they have with the healthcare system and also the homeless, they have people who are going through it right now. A lot of people may not understand, particular instances where people have medical necessities that keep them homeless. So that's important too. The new bylaws for the RCACs and different things like that, please consider allowing them to make public comments. If they have RCAC meetings in the future, can someone discuss the new changes, well not changes, but, they talked about an unhoused program, it would be great to have information provided to the RCACs about the unhoused program. The measure, is it prop 35 or something like that? It would be great to have someone come and speak at RCAC meetings, the welcoming meetings this month, all RCACs have welcoming meetings. That would be so awesome because the RCAC members would be able to valley for certain types of voters decisions, to make it so that people understand that it is a value to vote for Proposition 35, to get more funding for their care providers and also to L.A. Care so that they can make the proper decisions as well regarding their health care plan. The RCACs could get out to the community like they used to, and they do have history in doing so. So they know exactly what they're doing and can do it if allowed to get that information during the welcome meetings this month and then use their budget that they have rolled over for the last past three years and go out to the community and do events, peer on peer, people are willing to listen more. And we'll get more votes towards that. *(Chairperson Ballesteros joined the meeting.)* *Elizabeth Cooper, RCAC 2 Member, said that first she would like to thank the Board for giving her the opportunity to talk. She is speaking about a different subject. She will use a little joy today. She tries to use a little joy, that's what it's all about. One of the things she would like to say, she's very thankful that L.A. Care is having this presentation today and inviting non-partisans speakers and she looks forward to hear them regarding how health care is going. It is very important as a longtime member of L.A. Care and one who has been very active. She is a registered voter. She communicates with her state, federal, and national elected officials. She thanked them for the presentation. But she is concerned. It is very Important members of the Board of Governors make sure the people who they represent, the RCAC members, get involved. Because that's where democracy is. She hopes and feels that members of the Board of Governors consider that when discussing propositions and have the honored guests today, what about voting? All these programs will exist depending on who gets in office and who doesn't get in office. So please be*	

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	advised members of the public. Voting is the democracy and on a non-partisan stand she's saying, it is very important. As she listens to the Board. Incidentally, Mr. John C Baackes, she brought an article in the LA Times, which she subscribes to. It was interesting and she found out a lot about L.A. Care, and it was a nice picture of him. She's interested in voting, Members of the Board. She is interested in issues. She comes here to learn and there are issues she would like to focus on. Please make sure the RCAC members are here to be informed, not to just receive, but to be informed. And hopefully those who have to make the decision. They are the people who the legislature is responding to, the people who receive the service, so all of this should be important to us. *Deaka McClain, RCAC 8 Member, is currently the TTECAC Vice Chair and Member at Large for Seniors and People with Disabilities. She comes before the Board speaking her truth of being very disheartened with the fact that at the June or July meeting, ECAC representatives brought to the Board an issue pertaining to push button doors in the buildings. And they were told that it was tabled and then she found out later that it was brought to the Executive Committee and not this Board, which was her understanding. And then it was voted on not to do it. So first of all, she's not happy to be told one thing and then something else happened, and she wasn't able to make a comment. Number two, she understands the concern about cost, but at the end of the day, it's about inclusion. It's about accessibility. It's about allowing people with disabilities to have access to these meetings. And when at these meetings, people need to be able to get through the door. So she would really like the Board to consider thinking along those lines because she knows we have money. We spend money on other things. She would like this to be a priority when it comes to accessibility, when it comes to inclusion, when it comes to equity.* Chairperson Ballesteros responded that there will be further discussion on this issue at a future meeting.	
APPROVAL OF MEETING AGENDA	*(Board Member Shapiro left the meeting.)* Board Member Booth informed Board Members she was not able to attend the meeting in person due to a medical emergency, and requested approval to participate remotely. She stated that no one over the age of 18 is in the room with her. The meeting Agenda was approved.	**Both items were Unanimously approved by roll call. 8 AYES (Ballesteros, Booth, Contreras, Ghaly, Gonzalez, Roybal, Vaccaro and Vazquez)**
Introduction of Speakers	**PUBLIC COMMENT** *Ms. Cooper commented regarding the two aforementioned speakers, she asked that they speak in lay terms, because she sees two distinguished, she read something about their background in the board book, but a lot of this*	

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○ Andy Slavitt, *Commissioner, National Academy of Medicine's Commission on Investment Imperatives for a Healthy Nation* ○ John Russell, *Partner, DGA Group Government Relations*	*stuff is so above her. What are they going to do for L.A. Care when they give their presentation? How will it benefit the consumers, not in a negative way? How will your comments benefit the members of the committee? She would hope that the Board in the future for the RCACs helps speakers come there and tell us, because we're the ones who have to receive the services. She read a lot about their background and she's very glad it's nonpartisan, and they will speak about how it will impact L.A. Care. She thanked the Board for that, but as a member, she's always concerned about how it would benefit the consumers, and please speak about that. She thanked them for their presentation. She looks forward to reading. She read in the board book about them but she wants to know how it would benefit the members of who have receive the services as well as the Board members.* John Baackes, *Chief Executive Officer,* introduced Andy Slavitt. Many may know Mr. Slavitt because of his very popular podcast, *In the Bubble with Andy Slavitt,* which was on for a couple of years. He was brought in by the Obama administration to lead turnaround efforts for the website, healthcare.gov. The website was set up to enroll people in the health care exchanges. There had been a series of technical issues that he helped solve, with the aid of Tom MacDougall, L.A. Care's *Chief Information and Technology Officer*. That was in 2013. In 2014 he was appointed deputy administrator of Centers for Medicare and Medicaid Services (CMS) and in 2015 he became the CMS administrator, which meant in layman's terms he was the head of Medicare and Medicaid for the nation. After the Obama administration, he did something very interesting called the town hall challenge, where he did 16 town halls across the United States attended by 35,000 people, the point of which was to explain the Affordable Care Act and overcome a lot of the disinformation that was circulating about it at the time. In 2021, he was named Senior Advisor on COVID-19 by the Biden Administration and served in that capacity for six months. He is now the General Partner and Founder of Town Hall Ventures, which invests in companies that transform access and equitable care for underserved Americans. He's a graduate of the Wharton School, and has a MBA from Harvard University.	
Fireside Chat & Discussion		
Federal Impacts on L.A. Care	Mr. Slavitt noted that he earlier entered two questions for an internet search, one was how many health insurance companies are there in America and the result was something like 1200. Then he asked how many health insurance companies take public comment? And it confused the search engine because it did not understand the question. Because nobody had asked it before, because it's an absurd question. So, L.A. Care may be among the only ones in the country that actually try to build that level of relationship with members. It is an imperfect process, and there are frustrations. It is incredibly admirable and affirming to sit in a room where relationships with the community are so primary. Mr. Baackes noted that it's been a hallmark of L.A. Care from the beginning. He noted that Mr. Slavitt was the CMS administrator for quite a while and is an expert. One of the things that those involved in the Medicaid business would like, particularly as a Medicaid managed care plan, is information about the funding level for Medicaid. It lags behind the reimbursement to providers who participate in Medicare or who take commercial reimbursement. For the context of the audience, the reason this is important is that the federal organization Medicaid and CHIP Payment and Access Commission (MACPAC), noted that 90 % of providers surveyed would accept new privately insured patients and 88% would accept new Medicare patients, only 74% said they would accept new Medicaid patients. It was an even lower	

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	percentage for specialty care, at 70%. He wondered if Medicaid reimbursement could be revised to be on par with Medicare. Mr. Slavitt commented that there is an abundance of resources in this country. There is an abundance of resources in healthcare, lots of institutions with lots of money. What they spend it on, however is not what serves the majority of Americans that are in need of care. At major institutions you will see amazing research, you will see amazing giant machines that probably cost millions of dollars, and you will see amazing diagnostics. If you walk into a pharmaceutical company in America as you get past the beautiful wood panel walls and the security guards, you will see big executive offices. He is not trying to villainize any of those people. It is fair to say that most of the people in the healthcare system intend to work toward making America healthier. The problem is resources go to waste; probably 30% more waste in the system than is needed. A lot of resources go to people who have an easy time accessing care. All you need to do is find the latest Apple watch, Fit Bit or Peloton to see the people with earnings in the top 1-2-3-4-5 % in this country have an abundance of things to make their lives 1% better. Alternatively, in parts of Los Angeles or indeed anywhere in the country, the basic infrastructure is missing, basic needs like mental health care, specialists, and way more, and how the money is spent doesn't reflect where the need is. Calling attention to this, as Proposition 35 does by suggesting that if we can afford all these amazing wonderful things at big research institutions, we should be able to afford to pay a physician, clinic, allergist, social worker or hospital, to deal with a child's asthma and to provide services for people who need help the most. He believes that most physicians, nurses and care teams want to take care of people. He would love to say that healthcare is strictly a relationship thing where all that matters is relationships. The truth is that sometimes money does stand in the way and money can be an enabler. With things like Prop 35, we have potential solutions to fix things. In his opinion, that's very important. If something is not done, we will just come back year after year and talk about the same challenges over and over, and we don't want to do that. Mr. Baackes commented that of institutions mentioned by Mr. Slavitt earlier, some of the institutions do not participate in L.A. Care's network of providers. Cedars Sinai, USC, nor City of Hope are not contracted providers. Access to services for L.A. Care members through those organizations requires negotiating a single contract every time there is a patient who really needs the services, which is hideously expensive. L.A. Care devotes legal time to writing Memorandums of Understanding. Aside from Prop 35, the national payment formula that exists now is the states put up about a third of the money and the federal government two thirds, and the total funding does not equal what is needed. He asked Mr. Slavitt what mechanically or legislatively could be done to fix funding as opposed to having to pass initiatives like Prop 35. Mr. Slavitt noted that institutions say they would love to participate, but just cannot afford to do it. If they really would love to do it, they would probably find a way to make it part of the core mission. If institutions want to be part of the community, they could be part of the community for everyone. Institutions participate in other programs that access federal funds, such as Medicare, National Institutes of Health grants for research, and graduate medical education. If the institutions take money from those sources, why is not it required to serve people from all government programs? He recognizes that it is not as simple as that, but at some level it really is as simple as that. Is there an obligation in this country to take care of the most vulnerable by the best institutions? Is it fair to say that a patient cannot go to City of Hope and has to go somewhere else that does not have the same quality, just because the patient does not have the income, assets or connections? It will require a lot of push or legislation, and change comes slowly, so it is not an	

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	overnight fix. At CMS when people would talk to him about their Medicare program, he would ask about their services through Medicaid. And they do not take Medicaid. Or they would tell him how great the quality of their programs were and how people were getting healthier in their hospitals, and he would ask if that is true for everybody? Is that as true for a patient who lives close by as it is for one who lives miles away? They do not look at equity that way. Interestingly, there are institutions that use the words, and while the words may be hollow, it is a form of progress. People feel an obligation to fulfill a community mission, to be seen as good people, they get tax benefits for doing that so it is time to tell them to stop making those words hollow and to start making them real. Mr. Baackes commented that we discriminate in healthcare in the United States by the plastic card in your wallet. If one has the right card, one can go anywhere for services. L.A. Care has a contract with UCLA and with Children's Hospital, which are tertiary care centers. L.A. Care motivated UCLA to accept enrollment of L.A. Care Members by pointing out that UCLA receives funding from the government as an educational institution and L.A. Care receives funding from the same source for the benefit of its members. Mr. Slavitt asked if Medi-Cal beneficiaries have the same access to expensive health care services that commercial patients can access at the institution. Mr. Baackes confirmed that Medi-Cal beneficiaries have access to all services at UCLA, however UCLA limits the enrollment number of Medi-Cal beneficiaries, but the number of L.A. Care Medi-Cal enrollees is consistently over that limit. Mr. Slavitt noted that public praise is as important as public scorn, and giving those who set a good example deserve recognition. Mr. Baackes noted that the contract signing was celebrated and photos of the event were sent it to the University of California headquarters and to all the other campuses with a message that L.A. Care wants a contract with each UC care facility. Mr. Slavitt noted that UCLA is among the top three institutions in the country, and L.A. Care members have access to that high level of care. That should be the expectation for Medi-Cal beneficiaries. Mr. Baackes noted that in the last year potential bankruptcy of Medicare Part A trust fund has been extended from 2031 from 2036. Unless there is a fundamental fix, that day will come. He asked Mr. Slavitt for his advice on how the long term fix for Medicare funding should be addressed, and if that would be an opportunity to also address Medicaid funding at the same time, since Medicare and Medicaid were created at the same time. Mr. Slavitt commented that when Medicare was set up in the 1960s, it was primarily a program to pay for hospital care for senior citizens. Back then, healthcare was a little different than it is today. Today, health care is more about people managing chronic diseases. People can stay out of the hospital, take medications and manage disease. That is what health care has become. But back then, the principal issue was that as people age, they would need hospitalization and Medicare would pay for that. Today, Medicare is funded by payroll deductions that go into to a fund to pay for hospital care. Anybody over 65 or anybody that qualifies for Medicare have paid for it. The question that Mr. Baackes is asking is about the future. Members of the baby boomer generation are now aged 70+ years old, and that number will peak in 2035. It is not accurate to say that Medicare will go bankrupt. It is projected that by 2035, $0.99 would come in for every dollar that goes out. This is about a very small difference between revenue and expenditure, not starting over with a new plan. That gap in funding is anticipated to grow over time and eventually the payroll tax level will need to be adjusted or the benefits of the Medicare program would be reduced. There have been efforts to reduce the cost of the Medicare program, not all of them have been very successful. In his opinion is that it is not going to be a crisis. If it did become a crisis, the U.S. Congress is not good at looking forward to resolve problems. But I do not think the Medicare system is in real jeopardy.	

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	Mr. Baackes acknowledged that the question was sensationalized. It is being said that Medicare Part A and benefits could be cut 11% in 2036, so it could be manageable. He thought of it as an opportunity to bring together the gap between Medicare and Medicaid funding. Mr. Slavitt answered that building consensus for Medicaid and Medi-Cal needs to be done. One never knows when the opportunity for action will arise, either at the federal level or in Sacramento. That action will happen best when we have educated the public and build public support. That needs to be done over the course of years not days and weeks when something comes up. In 2017, there was an attempt to repeal Medicaid expansion. The popularity of Medicaid was not known, while Medicare was and is very popular. Medicaid has been belittled and demeaned, and over time it was thought people would look at it more negatively. As it turned out, when the repeal effort on Medicaid expansion began, there was an incredible outpouring across the country, and incredible support of how important the program is. There are a few things that are just important to know, Medicaid pays for 50% of all births in the country, 50% of all pediatric care, nursing homes and retirement homes, care for people with disabilities, and there was an opportunity to educate people who did not know all that. The perception of Medicaid was that people probably would never need it, it is for people that do not look like me, and so I'm not going to bother to worry about it. When it was explained that one may need it, your neighbors may need it and your neighbor's kids definitely need it, people responded really positively. There may be a core there, but it is a core that is about talking about people, not the program. Talking about people who benefit from the program brought a different response. Mr. Baackes recalls in 2017, Susan Collins, the Senator from Maine, challenged the repeal by saying how economically important Medicaid was for many communities in the country, including in her own state. That was the first time he had heard Medicaid discussed positively in national media. That was a significant change in the perception of Medicaid. Stories started coming out about families that had Medicaid back in the day and it was a significant benefit for them. Stories that followed were about how Medicaid supported the local economy because people were able to receive care at the local hospital paid by Medicaid. Mr. Slavitt noted that in prior presidential elections, it was clear that one party was for Medicaid and the other party would do something to alter it in a way that put a cap on it, a budget, a cost pressure that took away some of the guarantees. In the current presidential race, Medicaid is not being discussed. One interpretation of that could be that it has become more politically powerful as an idea, not powerful as in political lobby. People support Medicaid more because they understand it better and there is no political mileage in attacking it as there was before. There are other interpretations, including more cynical ones, that candidates are not forthcoming with their real agendas. He is not suggesting which way it should be interpreted, one should interpret it anyway they want. It is notable that attacking Medicaid as a program is not happening now as it did in the past. Mr. Baackes noted that Proposition 35 will be on the ballot this November. It is about a provider tax. He did a little research and found that every state has multiple provider taxes except Alaska. He invited Mr. Slavitt to explain the role of provider taxes as a fundamental part of the income stream to Medicaid. Mr. Slavitt commented that usually one can discern opposition to legislative initiatives. He cannot think of opposition to Prop 35. His understanding is that it is a good idea. It is good for states, people, communities, hospitals, insurance companies, and doctors, and appears to be a clear and legitimate way to increase funding, with a real benefit. If it passes, and his personal opinion is that it should, the job would not be done. There is a social and cultural element to this that people do not like: it is easier to treat people who have easy access to transportation and can take the day off to come in for an appointment whenever they want, and who have the ability to go home with all the resources they need. Progress is made but one needs to continue to move	

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	forward or the situation can revert. His experience with equity in his oversight of elements in vaccinating the public is that only when one pays attention can one actually solve a problem. Large vaccination clinics opened in South Central Los Angeles and in Oakland, and the goal was to vaccinate the people in those communities. The first day those clinics opened the workers realized that people were coming from other areas of the city for vaccines. It is a perfect illustration of a system that does not recognize the difference that having more resources makes in the ability to access care. The vaccination clinics managed access by limiting services during certain hours by zip code, and vaccination levels by race closed from about ten points to about zero. This happened because people worked hard, specifically focused on access, put more energy and attention toward it, and made changes. Mr. Baackes commented that a lot of that work was done by some of the organizations represented on this Board, who went the extra mile to make sure vaccinations were available in the most convenient way for as many people as possible. Mr. Baackes noted that L.A. Care is a public entity that participates in Covered California, the health benefit exchange created in the Affordable Care Act (ACA). L.A. Care was the only public plan in California to do so until this year when Inland Empire Health Plan joined. Mr. Baackes makes the bold statement, which no one ever contradicts, that L.A. Care is the only functioning public option in the United States. In the original ACA legislation that passed the U.S. House, it was proposed that there would be a public entity in every state to compete in the individual market with commercial insurers. That provision was dropped in the Senate version. He asked Mr. Slavitt his opinion on the potential to reconsider the public option nationally. Mr. Slavitt commented that Colorado, Washington (state), New Mexico, Connecticut have had legislation for public options. He thinks we ought to be buoyed by state victories, because that's how methods can be proven to work. His read of the situation is that getting to a national consensus on health care changes is that about once a decade there is an opportunity to reform the health care system in a major transformational way. The stars and moon have to line up perfectly. What is needed is either a bi-partisan consensus or one party or the other to have a 60 vote majority in the U.S. Senate, and legislation that has elements that aren't just budget related. The system cannot tolerate big changes like this as often as every couple of years. The years in between those opportunities must be spent working to build national consensus, getting local Congress people and Senators to make the issues priorities by pointing out the effects on people who live in their districts. Local politicians ultimately care about that. There has been a change for the better in how Washington, D.C. works. Over the last few years something new is emerging, which is that legislators started to vote based not solely on what powerful lobbyists wanted them to do, but based on the organizing power of people behind issues. He noted three very powerful lobbies, the pharmaceutical lobby, the gun lobby, and the oil and gas lobby. No doubt three of the most powerful lobbies in Washington, DC. For decades attempts were blocked to pass legislation that those three lobbies didn't like, such as allowing the federal government to negotiate prescription drugs, background checks to improve gun safety, and climate legislation. In the last few years, legislation passed in all three of those areas. It felt a little bit like people seizing back the government from the lobbyists. Though it is only one sign, it's only one small thing, but it tells him to encourage people who may feel like, why bother? Why even try to make a point heard in Washington? Why fight it when there are people with lined up with all this power and money against it? It can be done by shaping and driving public consensus. There is nothing more personal to people than healthcare. It is more personal than climate, as personal as safety. The prescription drug legislation is wildly popular. He encouraged Mr. Baackes to continue to be a voice for health care because while it may not feel on a day to day basis like people are listening, if you look at it over the course of years, things are changing in a positive way.	

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Presidential Election Possibilities	Mr. Baackes introduced L.A. Care's lobbyist, John Russell. Mr. Russell is a partner in DGA group in Washington, D.C. since 2021. He is an attorney and was with Denton from 2006 to 2020, the largest law firm in the world. Prior to that he had a career in service with various U.Ss. House members. He had the distinction of being the youngest Chief of Staff on Capitol Hill. The national election is 63 days away. Mr. Baackes invited Mr. Russell to comment on what can be expected for health care from the administration of the candidate elected. Mr. Russell commented that the Republican party of ten years ago no longer exists. He spent time in Milwaukee at the Republican convention. He has been going to conventions since Philadelphia in 2000. This was the first convention that the words Medicare or Medicaid were not heard, and usually cutting Medicaid is heard at those events. To look at where the Republicans may be, one can look at a populist president, Donald Trump. He has said he would repeal and replace Obamacare but it was not well-received, and he thinks Trump has turned off that side of the Republican party that was pushing for that and has a much more populist agenda. He is not certain how that translates to health care or where the Republican party is going on it. He agrees with Mr. Slavitt that healthcare reform is the type of thing that arises every ten years. He wondered if passage of the Inflation Reduction Act in 2022 with prescription drug negotiations reset the clock, and we will wait another ten years, or will healthcare legislation be stagnant? He does not think healthcare is in the top five issues that former president Trump wants to talk about, let alone congressional Republicans. Mr. Slavitt commented that there is one clear legislative priority if Trump wins, which is extending the tax cuts, at least as a Democrat would say it, he thinks probably factually, are largely for corporations and favored people at the high end of the income brackets. One could disagree with that. He thinks that Trump's priority is to make the tax cuts permanent, and how he makes them permanent. It depends somewhat on whether Trump controls Congress or not. If he controls Congress, one way to do it is that generally speaking it is considered a good policy to pay for programs that are funded. There need to be cuts somewhere. Mr. Slavitt thinks high on the list is the ACA, subsidies and Medicaid. Although the Parliamentarian, who decides what can go into a bill, may have something to say about this. His assumption is that, though he will not run his campaign on this, if looking for places to cut, Trump will try to find places that will include Medicare and Medicaid though that's not a policy priority for him. Mr. Slavitt thinks he is more populist, and thinks there's ways to cut without looking like its cutting, and ways that Democrats will make it appear that it's cutting. If Trump becomes president and one of the Houses of Congress is controlled by the Democrats, and it is no sure thing that will happen, then there is more of a negotiation and more of a conversation. There is more of a possibility that legislators actually do something that gets everybody what they want but cuts nothing. There must be a compromise when government is divided. Mr. Slavitt is friendly with people who served in his previous role during Republican and Democrat administrations. One thing is true in any Cabinet, for Health and Human Services, the EPA or any department, there are a set of issues that the President, Vice President and the White House care about and they get to make the call. Everything else is left up to the Departments, the Secretary and so forth. The question becomes less about what the President believes, and more about which issues they really care about. The first Trump team told me the issues the White House cared deeply about were LGBTQ rights, abortion, pro-family and religious groups, so do not do anything that	

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	favors any of the groups. But pretty much everything else is your playground. For Democrats, health equity is probably high on the list, covering more people, et cetera. When you get past that, you go to the Secretary, which might be Bobby Jindal, who as Governor cut Medicaid in Louisiana. If cuts could not be done through Congress, there are lots of ways to disadvantage the program. Based on statements Jindal has made, he believes in pull yourself up by the bootstraps, giving people access to health care keeps people poor, those sorts of things. On the Democrat side Mr. Slavitt thinks we will see the opposite. Secretary Becerra would be replaced by probably another governor, someone who would be in favor of the same types of issues as the White House. Despite differences there is agreement among Democrats and Republicans on issues like mental health care, value based care, and making programs more efficient. It is unknown if Medicaid would be saved. It depends on who becomes Secretary. Mr. Russell commented that a Harris administration would likely try and solidify the gains that have been made on health care issues, and look to ways to expand those gains. He believes that equity will be a driving issue in a Harris administration. With the Becerra team leaving, a lot of the Biden staff slips out. There are potentially Obama era staff coming back, and Obama had some great wins. He agrees with Mr. Slavitt that it matters how the Congress is set. For one of the first times in history, both chambers may flip in the opposite direction; House becomes Democratic and the Senate becomes Republican. He is not quite sure exactly who the President will be, but with a divided Congress, there will likely not be a lot of movement on big things. Mr. Slavitt commented that Republican's historically have a lot more interest in tax and fiscal policy although things are changing. On the Democratic side, there are some but not many people who are interested in tax and economic policy, but the passion of the Democratic party is in healthcare. Healthcare has typically been a winning political issue. It is an issue Democrats care about from a policy and people standpoint, and has been a winning issue politically. This is a long way of saying there are more people for healthcare policy jobs among Democrats. He hopes that if Harris wins, there are more people on the Democratic side who look like the makeup of these programs, that there are more people of color. He has been arguing that person living with a disability should run CMS. There is a need for people who have a lived experience to know what the most challenged situations are like, who has the humanity and the empathy to extend to everybody. He has explicitly encouraged Democratic administrations to do that. The more that can be done, and there are some incredibly qualified people who could run those agencies or departments, the more he thinks the agency and the country will live up to its mission. Hubert Humphrey said that these programs are for people at the earliest stages and the latest stages of life, at the poorest moments of their life and at the most infirm moments of their life, and who live with disabilities. That is what these programs are for. He has not had this explicit conversation with Vice President Harris, but he has had lots of healthcare conversations with her. He knows, or at least has an impression of how she thinks and what she values. She likes to get to the bottom of things, she likes to know how it affects real people, and she likes to know how things affect equity. She does not have tolerance for situations where people are getting screwed, without understanding why. She likes to take a lot of opinions in mind, she likes diversity of thought, but she likes to push the decisions. She basically is a prosecutor. She is comfortable when she is interrogating someone, which is her natural zone. He also thinks, and this may not sound as positive, she likes to judge which way the political winds are blowing. She likes to know what the consensus is and what people think before she makes up her mind. Biden is more, this is what I think is right, we need to do this. Obama, to his experience, had a real intellectual approach to everything. He thinks Harris will	

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	look for a decision the majority of people would like, and she will look to have the voice heard of the minority who do not like something. That is why she sometimes comes across as equivocal. It is in her nature to try to assess the politics of a situation as she makes a decision. The people that presidents and elected officials put around them really matter, whether it is the advisors in the White House or people in the Cabinet. He thinks she will work really hard, at least in the health arena, to make sure that people who are talking to her every day are people who know what it's like in the real world. That is one thing he feels pretty good about. Mr. Russell commented that the events of January 6 impacted a significant amount of staffers at Health and Human Services, they got up and left and have pledged that they are not coming back. That is institutional knowledge that the Republicans had that they could have been able to bring back in for the next administration. The Trump administration is not looking for those people. They are not looking at D.C. folks, to Bobby Jindal's point in Louisiana. You are going to see folks coming from the "hinterlands". They will pull people from states, predominantly red states, to work in these in these departments. They will have some experience, limited experience, and they will probably not have a lot of Washington D.C. experience. One can translate state level experience into the federal government but not all of it translates. Mr. Slavitt asked Mr. Russell to comment on the potential impact of the endorsement by Bobby Kennedy, Jr. and what that would mean to the Trump administration? Mr. Russell opined that Donald Trump is not going after regular Republican voters, and he is not looking to get anybody in the middle. That is clear. Bobby Kennedy has some very strongly held beliefs that up until about four months ago, seemingly Donald Trump was putting aside, and now, should Donald Trump get elected, Kennedy will serve a role in the administration. Last week it was said that Kennedy wants to explore the link between autism and vaccines. The populist issues will find a way into this administration, should it happen, in ways that you have not seen before in the Republican party. So, he thinks Kennedy will have one or two issues, with a budget and a plane to go talk about the issues. It is unknown the actions that will be taken.	
Questions and discussion from the Board of Governors	A comment from Board Member Booth was submitted in the chat and read aloud by staff: Mr. Slavitt, the resources you were talking about for up to 5% of the population as far as they're concerned, belong to them. I am not that lucky and I wait for my medical care longer than they do, but not as long as many people, they must wait. Some of those people are in the room with you today. If we really wanted to make the system equitable, we will need to have federal and state support for making it equitable. However, please try to imagine trying to convince our politicians that they need to share their wonderful and complete health care system with everyone. Your words all sound good. Oh, so good. I wish I could make it so, but there are words and not actions and people like you, Mr. Baackes and me have been saying for decades that the words have not translated into action. We talk about raising taxes and lowering payments in the same sentence. Both are ways to fund the system so that health care might be more equitable, but it hasn't resulted in improvements. Some facts are not given the weight they deserve. For example, I certainly don't see us flush with money in California at the health plan level or the provider level. I wonder if anyone in the room would disagree with me. You mentioned the research being done at money-flush institutions. That money cannot be cut in order to boost Medicaid, eventually Medicare coverage. So many of our medical advances are people cheer that Medicaid will be just fine as long as it gets paid at 87.5% of Medicare, but Medicare is getting cut. Medicare is no longer a gold standard and private insurance follows right along with similar cuts. That	

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	5% you spoke of already pay a huge amount of taxes towards making the rest of the U.S. function properly. Can they put in just a bit more to create equity in healthcare? Yes. Can we require that? No. It is not the best way for the 5% to behave, but its human nature that we take care of ourselves and our families first. The hospitals that do not see Medicaid. Patients do not get back what they put in. Mr. Slavitt cannot think of anything he heard that he does not agree with in that great comment. The question it leaves us with, is there reason for hope? Is there a reason to think that things could change? He will leave that to everybody individually to decide how to think about that. He personally thinks there are signs of hope. There are always things that are wrong, things that are broken, they're all the things that were called out today. So that is a reason for one to choose to not be optimistic. But the case for hope is actually just the case for work. It is a case for working on the issue. It is a case for building consensus. It is the case that was made in the attempt to repeal the ACA. It was said to be a disaster for Trump, but Mr. Slavitt will tell you it was considered a done deal that they would get rid of the ACA. He called governors and senators and they all said, do not waste your energy, this is a done deal. All the power was in taking further steps back, that today there would be 20 million or more uninsured people than already exist. People would have lost rights to protections for preexisting conditions. Well, something happened and the repeal did not happen automatically. He is not here to suggest that is easily replicable, but to observe that there were a number of people, not leaders, but people who did not want to see that change. Real people who just said they would not let it happen. He knows many moms who have kids that are medically fragile, with tracheotomies that would drive to Washington every weekend and wheel their kids around the halls of D.C. to advocate for health care coverage. He thinks sometimes one is optimistic because there's no other choice. Sometimes one is optimistic because one knows it is right. But sadly, even when optimistic, it can take a long time and happen incrementally changing minds one at a time. That is what he has come to believe. He will not stop saying what he believes, but we ought to be very cognizant of all the points that were made in that comment, because that's the reason why it's so difficult. Mr. Russell quoted from the Vice President's campaign, we won't go back. He recalled that he and Mr. Baackes were in the halls of the Senate the day of the vote, and Mr. Baackes was on the plane returning to California with the delegation. The way to sustain the gains and push for more is you just do not leave the field. You keep coming back, you keep talking, and personalize the issue. He remembers the mothers and they were incredibly effective, and but for Senator John McCain, with his thumb down gesture, we'd have a very different world. He thinks that was the high-water mark of this effort. A lesson has been learned, and a Republican representing a suburban community anywhere in the country is seeing that when something is taken away from people, they get kind of upset, they will hold you to account. Taking things away gets harder and harder to do. He would argue that is not where Mr. Trump's head is at. Mr. Slavitt related a story about the John McCain vote. He was in Arizona a number of times. The Governor of Arizona was Doug Ducey, who's a conservative Republican. Senator McCain had let his staff know that morning that he would vote the way Ducey wanted him to vote. And Mr. Slavitt received word of that at around noon, the day of the vote. Everyone wondered what Ducey was telling McCain. Ducey did not want to lose Medicaid expansion, largely for financial reasons and fiscal reasons, and it is a program that worked, that made sense, that federal government was funding a lot of, and even though it was part of Obamacare, Ducey was able to make the decision that it would be really bad for Arizona. Ducey talked to McCain that day and McCain may have voted that way anyway but that cinched it for McCain. Mr. Slavitt received word that about an	

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hour before the press conference. Medicaid was the story that stopped what Trump was trying to do. He thinks that is pretty powerful.

Mr. Baackes is optimistic because the only reason Prop 35 is on the ballot is through a disparate group of providers that came together and agreed something needs to be done. And that coalition is how Prop 35 got to where it is today, with no opposition submitted that will appear on the ballot.

PUBLIC COMMENT

Ms. McFerson thinks the two speakers are awesome. She is a former chair with a Regional Community Advisory Committee and also a stakeholder member now of RCAC 5. She thinks they have made some detrimental comments and she's not quite sure whether they're familiar with the RCACs, but they have been giving back for almost 27 years, maybe over that, don't quote her on it. But with that, at the very beginning, they helped reach out to the community and made LA Care the largest public insurance company in the nation. She says they made it because they went out peer to peer, eye to eye, to talk to people and let people know that they have options as far as health care goes. And they have not ended that fight. They still need to fight for that peer on peer, eye to eye contact, letting people know specifically how they need to take care of their bodies and get options for their health care. And with that, that Prop 35 is so important. So with that, she believes the RCACs could actually have some great information to give to the community and to the public about that. And the information that they receive today is so very detrimental and we need to be able to give that to our RCACs as well. She is glad they gave them this information. She will give it back to the RCACs and just different things like that and talk about it. And then maybe they can go out to the community and speak eye to eye to people just like them. But with that being said, she spoke to Kamala Harris, herself, eye to eye. She does listen. She does listen about the disparities that people go through and how her decisions would make an impact on that, a positive impact, not corporate or anything else having to do with that. So with that being said, Ms. McFerson wants to make sure that they receive the information, whether it be something that they have written down or whatever the case, may be so that they can hand this out to the community and give them more information about why they should vote yes on Proposition 35.

Mr. Baackes responded that, as he mentioned at the meeting at the end of August with the new Community Advisory Committees, information will be provided to the RCACs in September.

Board Member Ghaly commented that the desire to enhance coverage, increase benefits and focus on health equity would be easier if cost of care wasn't so high. She represents the Department of Health Services (DHS), the largest public hospital system in California. The cost of providing care as a provider is astronomical. She thinks both Republicans and Democrats have a part of that and they don't see eye to eye on how to solve the problem, which leads to very little focus on solving that problem. Because of that the focus is on more valid measures, bringing in more money and on the revenue side of the equation without any attention paid to the costs. Multiple studies show that the cost of healthcare in America is much higher than in any other developed nation with far fewer and poorer outcomes, whether one looks at the inputs of labor or pharmaceutical, the utilization rates, the infrastructure that's needed, the amount of administrative complexity that's required to run some of these operations. She asked if there is any hope in either the federal or the state context, trying to get to any sort of meaningful consensus about how to control costs in a way that is material and might change that equation and allow people to ultimately get what ideally both sides want, which is better health care with less

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	money, allowing that money, depending on who's in charge, to go to whatever people want it to go to. But to stop what is ultimately a lot of poor value and waste in the system. Mr. Slavitt commented that it is a fantastic question, and he thanked Board Member Ghaly for all she does. The core premise of Board Member Ghaly's question is correct. We have difficulty controlling costs in this country and Congress has prohibited the evaluation of costs when considering whether or not to approve or even evaluate new medications. It is different in other parts of the country and other parts of the world. When he would travel overseas, his peers in other countries would jokingly thank the U.S. for subsidizing prescription medicine, because drugs that would sell for thousands of dollars in the U.S. sell for hundreds of dollars in England. These are the same drugs and factory. The prescription drug area is easier to attack on the cost side but hasn't been successful until recently. Because it is a product, there's margins, it's already in the market, and there are things you can do to create substitutions such as biosimilar alternatives and other things. The cost of medical care has been a very difficult conundrum to tackle. Mechanisms are forced, such as by limiting payment, and it is left to providers to figure out. The cost for emergency room care is high, and if one is in the hospital for two or three days the cost can be $40-, $50- or $60,000. There is a lot that goes into that, but much of that is that it is largely a labor-driven business. It is challenging because healthcare can be the largest employer in communities, and people have to be paid. In many respects, there's a dependency on the job creation, which can artificially inflate prices in all communities. Where price is an issue, in rural America and other places, a lot of the pressure is to maintain employment. When hospital care is so expensive, there are ways for people to receive care without going to a hospital. When a better choice is available, people prefer to be treated at home or in the community rather than in a hospital. There are options coming, not just technology, telemedicine, AI, et cetera, but also local community centers, home care, all these different ways, to make it more convenient for people to get care other than at a hospital. Hospitals can become more efficient, and as great as hospitals are, most of them are extremely inefficient. He would frequently meet with hospital CEOs who told him they need to get paid more money. He would listen, and not necessarily disagree with them. He asked the CEOs if hospitals were fully capitated, if revenue was guaranteed and profits came from managing cost, how much money would be taken out of the system, how much waste is there. And every time the hospital CEO will respond between 20% and 33%, but there's no motivation to get it because they can bill for it, and because of the political issue. There are efforts such as paying for value, paying for outcomes, which are good ideas but are not proven to reduce costs. Hospitals are in a challenging position because they both want to reduce costs but they also need sources of revenue, and those new sources of revenue will add more costs. There have not been serious conversations about cost and cost of care in this country, there is an attitude to let free enterprise reign so we do not get the waste out. There are things that could be done such as two-sided risks and capitation. This is a complex set of issues that extend far beyond even the health care issues. Mr. Russell commented that hospital board members are among the lobbyists in Washington D.C. Members of the hospital board in a local community are accomplished and have reach with their Members of Congress, who know who these hospital board members are and more often than not those board members are contributors at a pretty significant level. The board members are part of the economic engine, certainly in rural communities. Every time a hospital starts to get squeezed a little bit, the American Hospital's Association calls a couple board members in specific states. Mr. Slavitt added that when a member of Congress or a family member becomes ill, they contact the local hospital CEO. Many	

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	hospitals are in very challenging circumstances. Hospitals do not do the hard job of restructuring which other industries had to do. There is not a villain in the U.S. healthcare system, people want to do the right thing. There are narrow interests, and it is tough to make the bottom line work. The pressure needs to be put on all: hospitals to reduce costs, Congress to take care of things, insurance companies to manage the situation. Every entity needs to own up to some part of it. Board Member Roybal stated he is a general internist and a medical administrator, and represents the Department of Health Services. He has noticed pre and post ACA that the face of Medicaid has changed to a new demographic including younger people who are working, and for whatever reason their employer does not provide employer-based health care. He asked if any states or other models where there's an employer-based payroll tax to fund Medicaid. So many of the patients are working, even for large companies, and the employers don't provide health insurance but depend on Medicaid to help their employees receive healthcare. Mr. Slavitt has a family member on Medi Cal, in his thirties. He noted that the nature of employment is different. People work for multiple different employers at different times of the year, it's the gig economy. Tying medical costs to employers may be tricky as the nature of employment changes. Large employers that keep employees to 29.5 hours a week to avoid providing benefits need to be called out, and find a way to make employers pay for that. There was a time when large retailers had a lot of employees on Medicaid across the country. That is less the case today because employers are acting more responsibly, but may still be the case in many situations. Many employees are contractors or work for small businesses. The idea of taxing a small business for medical costs is hard to do. The question of where to spread the cost is interesting and important. What is true is that there is a different group of people, who are younger and coming of age, and their employment status and situation is inherently more unstable. These programs help them get health care. Mr. Russell is watching carefully how the Department of Labor treats the gig economy at the federal and the state levels. That will be a first step to forcing companies to throw a little skin into the game. Mr. Russell noted that a major talking point for L.A. Care is that the plan members have direct input at the Board level, which is unique. Board Member Roybal noted that California employers pay disability and other taxes, and that is the employer's contribution for the employee. If the employee is hurt while working it's hopefully not as big a drain on the system as a whole. Mr. Russell suggested that changes may be coming for companies who hire independent contractors. Mr. Baackes noted he encountered an employee with one of the richest corporations in America who had Medi-Cal, and it was because she wasn't given enough hours to get full time benefits. He would like to see something done about that. Mr. Baackes asked each guest for a final comment. Mr. Slavitt recognized what a tremendous service Mr. Baackes has done in this state, in this nation. As a public service official, he was frequently called by CEOs. Usually, it was about something that they want to go their way. He always felt Mr. Baackes wanted to talk to him about what's good for the system and good for the community. Even things that may not serve L.A. Care's interest in the small picture, he always felt that he was talking to someone who felt a really unblemished commitment to what was right. It always made him listen to Mr. Baackes, respect him. He realizes how fortunate the community is to have Mr. Baackes, he will really be missed. Mr. Slavitt is grateful for all of Mr. Baackes' service. Mr. Russell commented that it is really wonderful to represent Mr. Baackes in Washington D.C. It is an honor and a pleasure because Mr. Russell doesn't get to wear a lot of white hats when he goes into legislative offices. L.A. Care	

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	is a white hat, probably one of the whitest you can get in Washington D.C., because of its goals, because of the people it serves, and because of the issues it pushes. Mr. Baackes has been able to push the legislative delegation through his persistence. Looking back to where things were ten years ago compared to today, two thirds of the knowledge that the members of Congress gained is because of what L.A. Care is providing. It is a pleasure and an honor to carry the work of L.A. Care members in Washington. Mr. Russell thanked Mr. Baackes and the Board for their work. Mr. Baackes responded that he is humbled by the comments and he thanked Mr. Slavitt and Mr. Russell. **PUBLIC COMMENT** *Ms. McClain thanked Mr. Slavitt for mentioning people with disabilities, because they are often an afterthought and not a before thought, and they should be at the table. She noted that when it comes to health care for all, sometimes to her, that's just words. She is thankful for Prop 35, she still doesn't know a lot about it, but it sounds good. Her concern is, can we ever get to the point where everybody gets the same care no matter what insurance they have. Because right now they are not the same, some are being economically discriminated against. And she's one of them.* Mr. Slavitt sees many problems deeply embedded in the way people think and in what people care about. He would love to tell her that he knows a way to keep the disabled as a forethought, not an afterthought. He would love to tell her that there's a national consensus and that things will happen quickly. What he can tell her is he has seen incremental progress over the course of his career, but it is been little and hard fought. Much of it falls on the backs of the disabled in having to tell their story so people see it. He encouraged her to keep doing that. Earlier there was a comment by a person who had talked to Vice President Harris. Having a Vice President who cares and has those conversations is not just good, it often repeats, and people mirror people in high positions who indicate what they care about, and it represents progress. There may be small steps and occasionally a big step. Hopefully there are big steps in her near future. **PUBLIC COMMENT** *Estela Lara, RCAC 2 Member, commented that it is important for Board Members to know that Community Advisory Committee members have been the backbone of this plan. They have insight because they have at least 25 years of experience in telling the Board how to how improve the medical plan. And the reason that is happening is because they were included in the very beginning to be an advisory group to this plan. They can be available for the podcast so their stories are directly heard. Because they have tons of experience in letting people know what we are and what we represent, 2.5 million members. That's who we represent. And they influence this Board. They recently had a restructure because of the agency that oversees them, and they got the restructuring plan approved with their input, and they got double the stipend for the members. Small little thing, but for the members it means a lot. This is what they have in this plan and that's why they are successful in giving that information.*	
CEO Presentation		
• **2015-2024 Retrospective** • **2024-2027 Plan**	**PUBLIC COMMENT** *Ms. McFerson wanted to speak about the retrospective, plan and the Plan that we have set up for the future. Retrospectively, they actually had a process. The public would come and speak about different motions that would*	

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	be presented beforehand, they would hear about the motions and then they would vote on them. They would talk, they would have a conversation during the RCAC meetings to let L.A. Care know specifically how it would affect them in a positive or negative way. And then it was given to the ECAC. The ECAC would discuss those things on behalf of the people that they represent. Then it would be sent to the BOG and the two representatives would come and vote accordingly. With that, they also had comments first and foremost before anything else, and they would have a presentation, first and foremost before anything else and then their comments. She thinks that that would be better communication for people with disabilities, seniors and people who may be developmentally delayed to go through that process, to adhere to better communication. *Ms. Cooper commented that she is so proud of the outstanding leadership from Mr. Baackes. She brought the LA Times paper today. She wants to say something before Mr. Baackes leaves, on a more serious note. As a RCAC member of long standing, and one who has advocated for the RCACs and for L.A. Care and through the legislative agenda, which is very important. She is concerned about sometimes, as members of the RCACs, how they interact with each other. She noticed how board members interact with people, but they have a problem with in the RCACs in how people interact. If they take little personal items and some of them are not very courteous to each other. That's something that needs to be looked at from the cultural as well as the linguistic. Particularly if one is in a leadership role, one should act like a leader. A person might disagree with someone, but can respect someone and say, hello, how do you do? And she thinks Mr. Baackes has done a fantastic job. But the next CEO needs to look at the ECAC and the RCACs, how they interact. Because they represent the people. She has done it before, and she interacts with people of all different cultures. In fact, she was very pleased so many years ago, she had the opportunity to sit next to the Consul General of Mexico, the Consul General of Israel and the Queen of England and all that, so she will try to be international in her end point. But the RCAC members need to interact and be caring toward each other because they are all in this health care together. And that's one issue she feels is very important. She hopes the next CEO will be just as fantastic as Mr. Baackes, but there needs to be more focus on the ECAC and the RCAC who represent us.* Mr. Baackes reported that when he started at L.A. Care he informed management staff that he wanted to learn as quickly as possible about the value added by L.A. Care for members and providers that participated in the plan (*a copy of his presentation can be obtained by contacting Board Services).* He wanted to know also about the value added for staff and for the community. Those conversations resulted in a strategic plan, which he presented at the Board Retreat nine years ago. The strategic plan was based on four aspirational directions for L.A. Care: achieve operational excellence, a high quality network, member centric care, and be a health leader in the community. • To achieve operational excellence, a matrix management structure introduced nine years ago established clear accountability for product lines. At that time, L.A. Care was operating Medi-Cal, Medicare, and participated in the health benefit exchange in Los Angeles County under the ACA. The matrix management structure placed senior management responsible for each product. He realized that he was doing something right when one of the senior managers told him that they used to have to talk to everybody, but now knows who to talk to. L.A. Care was making progress. L.A. Care expanded health services with increased staff, particularly in the utilization management (UM) and care management areas, and dedicated resources for specific provider needs. Most recently L.A. Care addressed the subacute transitions of care. Among the most important accomplishments has been a series of core business	

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	transformations, a new claims processing system and other state of the art industry standard processes. An artificial intelligence chat box was produced for internal communications, to answer how to questions, provide knowledge articles, locate items in a support catalog, open, manage and close technology improvement tickets and provide real time ticket update notifications. The QNXT transformation has been updated to the latest version, and a UM platform will be implemented this month. Rollout of an Appeals & Grievances (A&G) platform will be done in phases starting this month. The VOICE transformation program is a big improvement in L.A. Care's customer service experience for members. Though it is not visible to the members or the providers, L.A. Care is moving to a single source of data for providers. Keeping the provider directory current with the data in one place as a single source of truth is a problem for every health plan. L.A. Care is in the execution phase right now and it is expected to be available by March 2025. L.A. Care is in a different position than it was nine years ago with operational excellence. • L.A. Care has invested in building a quality provider network for the future. Achievements in the high quality network include credentialing and addressing problems immediately. The provider recruitment program, which provides grants to clinics and practices, resulted in the addition of 192 primary care physicians in the Los Angeles County safety net since 2017, and 192 physicians (not all the same) participate in a medical school loan repayment program for those who agree to stay for three years in a safety net practice. It is fulfilling when one of those doctors tell him that the loan repayment transformed their life because the doctor could practice as preferred and where the doctor feels they could do the most good. L.A. Care provided 56 medical school scholarships through Charles Drew and UCLA medical schools for students of color with lived experience. The first cohort of scholarship students are now finishing their residency programs and are practicing medicine in the community. • L.A. Care supports member centric care. It has conducted important training for over 7000 In Home Supportive Services (IHSS) workers. During the COVID pandemic, the result of having better trained IHSS workers helped keep people out of institutions and probably saved lives. L.A. Care was an early adopter of community health workers (CHW), hired CHW staff and supported training for both L.A. Care and staff working at some of the federally qualified health centers. CHWs are now recognized and can be billed as a professional category. L.A. Care launched a Health Equity Department with a Chief Health Equity Officer, Alex Li, MD. L.A. Care has a community link with social needs resources and referral tools and participated in the Health Homes initiative. L.A. Care fully supports the California Advancing and Innovating Medi-Cal (CalAIM) initiatives. 32,000 members have received Community Support (CS) services, and 45,000 members participated in Enhanced Care Management (ECM) since January 2022 through the end of June. L.A. Care implemented all 14 CS programs and is receiving financial reimbursement from California Department of Health Care Services (DHCS). • L.A. Care is a health leader. The Community Health Investment Fund (CHIF) annual budget has increased from $5 to $10 million, and grant-making has broadened to address many of the social needs faced by L.A. Care members, including Housing for Health, CS, and street medicine. The health leader role is most tangible in the Community Resource Centers (CRC), which have expanded from 4 to 14 to cover all of Los Angeles County. Programming at CRCs has expanded beyond health education classes to include member services, and L.A. Care also hosts social service agencies at the clinics. CRCs have technology bars for high speed internet connectivity. Community activities include food distribution, vaccine clinics and back to school backpack distributions. L.A. Care's partnership with Blue Shield Promise since 2018 has provided additional $74 million of revenue to support those efforts.	

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	The three-year focus and those four attributes are supported by tasks that are refreshed annually for each area and have guided L.A. Care in making improvements. Three cycles have been completed and the next three-year strategic planning process has been engaged through Wendy Schiffer, *Senior Director, Strategic Planning*, and staff in that department who conduct research on state and federal policies, competitors and market pressures. Senior L.A. Care staff is involved and feedback was provided by employees, leadership and the Board of Governors. The four strategic vision areas provide aspirational direction and will remain the same. L.A. Care will continue to focus on improved operational efficiency. Mr. MacDougall can confirm that new activities happen every day. L.A. Care will continue to focus attention on cyber security. We continue to support a robust provider and partner network to ensure capacity and access. L.A. Care's directly contracted network started in 2016 and offers physicians an opportunity to participate in L.A. Care network without a third party entity like an IPA. There are about 300 primary care physicians and 1200 specialists in that network that is now serving over 47,000 L.A. Care members. There were some technical or regulatory roadblocks by the Department of Managed Health Care which have largely been addressed and there is a more relaxed attitude. There is a pathway for doctors who wish to contract with L.A. Care directly without a third party to do so without any prohibition. L.A. Care will continue to focus on improving the member experience, the VOICE system will provide members and providers a better way to communicate with and get timely responses from L.A. Care. L.A. Care will continue to be a national leader in promoting equitable health care. Alex Li, *Chief Health Equity Officer*, will agree that addressing health disparities is a key function for members that have disability issues or health status issues. L.A. Care is working to eliminate health disparity for its members. The rest of L.A. Care's work to improve access and get the right compensation for the providers is to level the playing field so that everyone has equal access and address those particular disparities with special programs. Progress reports will be provided at future meetings. Mr. Baackes referred to the written report included in the materials for this meeting.	
ADJOURN TO CLOSED SESSION	Chairperson Ballesteros, with no objection from Board Members, revised the order of the items on the Agenda. **PUBLIC COMMENT** *Ms. Cooper asked about the change in presider at the meeting.* Chairperson Ballesteros responded that as the Vice Chairperson, Board Member Shapiro is helping with today's meeting. *Ms. Cooper commented that she knows there are many items that you cannot discuss with the closed session, she asked that the Board talk about some of the things that the members talk about. She respects every Board Member. And one thing she sees, in closed session, she likes the professionalism of each of the Board Members. She really appreciates that, and is trying to emulate that. She asked the Board to talk about some of these closed sessions that the public respond to, and maybe talk about it in private.* *Demetria Saffore, RCAC 4 Member, said she wanted to address the situation with how we interact with one another. And first and foremost, they need to stop classifying ourselves by the color of their skin. She would like to see more*	

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	unity among staff and the committee members. Because if we don't have that, it will interfere with their ability to serve their communities effectively. *Ms. McFerson commented on the report involving Trade Secrets, discussion concerning new services, business plan or technology. She wants to speak about the service that L.A. Care has toward the homeless, she's not sure whether the Board will go from closed back into open session. As far as the business plan or technology, they do have classes for AI and computer virtual classes and different things like that for seniors, for people with learning disabilities and who are developmentally delayed. Because we did go into this technical world now to where people like them are being left behind. There's an automatic assumption that they know how to communicate via email with links and all kinds of different things having to do with zoom. Actually we need to be able to make it easier for people who may need assistance. The LA County Department of Mental Health has a program teaching people how to use the virtual world, in layman's terms. It breaks it down to where it makes it understandable to all people and not just people who are familiar with that whole process. It would be great if L.A. Care invited them or got information about what they do so that the Board can adhere to the necessities of the members of L.A. Care.* *Reginald Fagan is a member of the Consumer Health Equity Council. He wanted to comment on the CEO's report pertaining to housing for health.* Chairperson Ballesteros suggested that Mr. Fagan make his comment when the item comes up on the Agenda. The Joint Powers Authority Board of Directors meeting adjourned at 11:30 am and it will reconvene after the Closed Session items. Augustavia J. Haydel, Esq., *General Counsel*, announced the following items to be discussed in closed session. The L.A. Care Board of Governors adjourned to closed session at 11:30 am No report was anticipated from the closed session. REPORT INVOLVING TRADE SECRET Pursuant to Welfare and Institutions Code Section 14087.38(n) Discussion Concerning New Service, Program, Business Plan Estimated date of public disclosure: *September 2026* CONTRACT RATES Pursuant to Welfare and Institutions Code Section 14087.38(m) • Plan Partner Rates • Provider Rates • DHCS Rates CONFERENCE WITH REAL PROPERTY NEGOTIATORS Section 54956.8 of the Ralph M. Brown Act Property: 1055 W. 7th St., Los Angeles Agency Negotiator: John Baackes Negotiating Parties: Jamison Services, Inc.	

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	Under Negotiation: Price and Terms of Payment THREAT TO PUBLIC SERVICES OR FACILITIES Government Code Section 54957 Consultation with: Tom MacDougall, *Chief Information & Technology Officer* and Gene Magerr, *Chief Information Security Officer* CONFERENCE WITH LEGAL COUNSEL—ANTICIPATED LITIGATION Significant exposure to litigation pursuant to Section 54956.9(d)(2) of Ralph M. Brown Act: Four Potential Cases CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION Pursuant to Section 54956.9(d)(1) of the Ralph M. Brown Act L.A. Care Health Plan's Notice of Contract Dispute under Contract No. 04-36069 Department of Health Care Services (Case No. Unavailable) CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION Pursuant to Section 54956.9(d)(1) of the Ralph M. Brown Act Department of Managed Health Care Enforcement Matter Numbers: 23-725, 21-855 CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION Pursuant to Section 54956.9(d)(1) of the Ralph M. Brown Act • Department of Managed Health Care Enforcement Matter Numbers: 18-799, 20-063, 21-428, 21-509, 21-680 • Department of Health Care Services, Office of Administrative Hearings and Appeals, In the matter of: L.A. Care Health Care Plan Appeal No. MCP22-0322-559-MF	
RECONVENE IN OPEN SESSION	The Joint Powers Authority Board of Directors and the L.A. Care Board of Governors meetings reconvened in open session at 12:50 pm.	
BUSINESS MEETING		
APPROVE CONSENT AGENDA ITEMS	**PUBLIC COMMENT** *Ms. Cooper commented there's so many items here that she would like to comment on, so she has to be brief. As a lawyer said, keep it brief. On the housing and homelessness, she really appreciates the work L.A. Care has done on homelessness. She speaks to many tenants as a tenant herself. Many tenants are having the issue now with first and last. And she sees so many, when they have to move and being evicted with their little worldly goods on the sidewalks. Is there something one can do to bring that issue, helping tenants save their little worldly goods, some who are evicted and mostly parents, and I hear the pleas of some of them. As a tenant herself, she's concerned. And she feels that LA Care has done a lot, but not just doing work on homelessness, but to prevent homelessness. She hopes the members of the Board hear her plea. She speaks to people who are at risk now of being homeless. But we need to focus on having someone*	

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	encourage people working with the landlord, the apartment association, being a little more lenient toward tenants now so they wouldn't be homeless. And that affects all economic humans. She asked the Board to take notice of the homeless issue. She asked about the motion with Chief Executive Officer and DHCS. Mr. Baackes responded that is a contract with the Department of Healthcare Services. It is a routine contract amendment. *Ms. Cooper asked why some of these speakers are not invited to the RCAC meetings. She feels that they listen, and they do a fantastic job, but like the speaker who spoke today, and she learned so much by just listening to the two speakers today and she thanked the Board for that. She asked the Board to please do something about having the RCACs, directly with the people who you represent, having some speakers. Finally, they talked about voting. That's her issue.* *Mr. Fagan is not sure how much time is allowed for speakers, but he wanted to kind of dovetail off of what the lady was saying with the homeless programs. There's a serious issue with a lot of the housing stock in LA County getting old and needing a lot of structural upgrades. And it seems to him, he's a tenant himself, he came through the Housing for Health program. But it's kind of like an oxymoron in the sense that they are thankful to get housing, but then it's the social determinants of health, which we all know is 50% of the puzzle, only 25% is health care. So when there is indoor pollution, issues with materials that have asbestos so then LA Care is part of a consortium, Brilliant Corners and various other stakeholders, but there's no enforcement of the social determinants of health. So it puts one in a situation if one pushes too hard, then find oneself like the lady was saying, out on the streets with all ones belongings. And I would like to see LA Care put emphasis on social determinants of health within the contracts. You have an organization, environmental accessibility adaptation which is set up to do modifications. There has to be some type of enforcement, getting people in the housing is great, but getting people into housing that does not damage their health is even better.* *Ms. McFerson wanted to speak about the unhoused issue and let people know that it is still disparity that a lot of people that she knows, specifically, go through and it's not just people who may have a disability or a mental illness, its people who actually lost their jobs due to COVID-19. They could not have a business anymore, so now they couldn't pay their rent so now they're homeless and different issues like that as well. We need to address all issues having to do with that by our public meetings with the RCAC. She showed a video of herself, making spaghetti at home, and giving that pan of spaghetti to a shelter right down the street from her house. She sees it all the time. It's not because she wants some sort of … she doesn't want anyone to say, Andria, you're doing a good job. She's just used to doing that because she's from Chicago. If you see someone on the street, if you don't*	

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	help them up, then that's almost like, something that you're doing wrong cause they're going to pass away. So that's why she's used to making sure that if it's people outside and they need assistance, she's going to make sure that she does the best she possibly can in order to do that. We need a general consensus with all of the RCACs that are coming up. Unfortunately, a change was made to the RCACs. That was according to the staff and what they had decided that they needed to do. The ECAC, the TTECAC approved state changes specifically, and if you look at the motion, it says state changes. But it was changed completely to the to the point where they don't have a whole lot of time to speak on different options beforehand, before we take it to the Board of Governors meeting and hear their information. She just went and walked down the street twice and gave food to someone who was homeless in 90 degree weather, so excuse her if she sounds a little tired right now, but she's doing the best that she can. Board Member Gonzalez asked if there will be any strategies or any way to get more doctors for the Dual Special Needs Plan (DSNP) contract. She received comments from members who do not want to join this plan because they want to keep the fee-for-service Medicare doctor. Mr. Baackes responded that L.A. Care tries to get all doctors to sign contracts for all products so that if they are with Medi-Cal, they are also with Medicare and Covered California. L.A. Care does not have every doctor in Los Angeles County in the programs. The match is above 90% for Medicare compared to our Medi-Cal schedule, and L.A. Care can review it on an individual basis. This contract does not address that, other than requiring an adequate network to meet the minimum requirement of the Department of Health Care Services (DHCS). He invited Noah Paley, *Chief of Staff*, to comment on the number of doctors in the DSNP product versus Medi -Cal. Mr. Paley stated he does not have the exact number. Mr. Baackes is exactly correct in terms of the overlap that L.A. Care tries to achieve in the network with all contracts. L.A. Care has professional providers contracted in all lines of business and relative to the adequacy of our network and the capacity of the doctors, L.A. Care is constantly checking both internally. It is being evaluated and L.A. Care identifies pockets where there is a need to undertake additional contracting efforts. Board Member Gonzalez asked if there will be feedback from them regarding the appropriate use of the funds and changes made by Pacifica Hospital. Mr. Baackes responded that the Board may recall that with approval of support for Catalina Island Hospital, the grant required periodic reports. Catalina filed the first report last month which described steps being taken to stabilize the financial situation. A similar requirement will be included in the Pacifica grant. Pacifica is a community-based high volume safety net provider hospital serving a disproportionate share of Medi-Cal beneficiaries. L.A. Care has provided advances on the directed payments for probably four or five years, which has been done for dozens of other hospitals. Pacifica seems to have difficulty in getting out of that cycle. At the end of Mr. Baackes' CEO report he will discuss another issue addressing this. L.A. Care has made it clear	

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	that these are one time grants to provide breathing space so the Hospital can work toward being able to fashion an affiliation with a larger chain, which has happened with other safety net hospitals. L.A. Care hopes Pacifica is able to adjust their financial situation and find a pathway to the future. Board Member Booth asked if Mr. Baackes could discuss the organizational support for Proposition 35. Mr. Baackes responded that as a public health entity, L.A. Care can provide information about a proposition like this, it cannot campaign for votes for or against it. L.A. Care is signaling that that people learn about this proposition so they can make their own independent decision. Earlier, Andy Slavitt spoke about the role of the provider taxes. It is important to know that this is an existing tax, it would not increase taxes. Proposition 35 specifies that proceeds of the tax will increase reimbursement to Medi-Cal providers. *Board Members Ballesteros, Ghaly and Roybal may have financial interests Motion BOG 100.0924*. In order to expedite the process Members Ghaly, Roybal and Ballesteros abstained from voting on item BOG 100. Their vote for the entire consent agenda excludes vote for BOG 100.* • June 6, 2024 Meeting Minutes • Housing and Homelessness Incentive Program (HHIP) Investment Agreements with the Los Angeles County Department of Health Services Housing for Health & Harm Reduction Division and JWCH Institute to provide access to critical healthcare and social services for the Skid Row community from July 1, 2024 to June 30, 2027. **Motion BOG 100.0924*** **To authorize staff to execute two (2) Housing and Homelessness Incentive Program (HHIP) investment agreements for a combined amount of up to $20,723,100 with the Los Angeles County Department of Health Services Housing for Health & Harm Reduction Division and JWCH Institute to provide access to critical healthcare and social services for the Skid Row community from July 1, 2024 to June 30, 2027.** • Ratify L.A. Care Chief Executive Officer's, John Baackes, execution of Amendment A04 to L.A. Care's Exclusively Aligned Enrollment (EAE) D-SNP Contract Number 22-20236 with the Department of Health Care Services (DHCS) **Motion EXE 100.0924*** **To ratify L.A. Care Chief Executive Officer's, John Baackes, execution of Amendment A04 to L.A. Care's Exclusively Aligned Enrollment (EAE) D-SNP Contract Number 22-20236 with the Department of Health Care Services (DHCS).** • 2025 Board and Committee Meeting Schedule **Motion EXE 101.0924***	

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	To approve the attached 2025 Board of Governors & Committees meeting schedule. • Pacifica Hospital of the Valley Grant **Motion EXE 102.0924*** **To approve delegated authority to Chief Executive Officer, John Baackes, to issue up to a $1 million award to Pacifica Hospital of the Valley to support safety net access to health care for L.A. Care members with behavioral health needs.** • L.A. Care's organizational support for California Proposition 35 **Motion EXE 103.0924*** **To approve L.A. Care's organizational support for California Proposition 35.** • Quarterly Investment Report **Motion FIN 100.0924*** **To accept the Quarterly Investment Report for the quarter ending June 30, 2024, as submitted.** • Infosys Contract to provide Information Technology (IT) testing services **Motion FIN 101.0924*** **To authorize staff to execute a contract in the amount of $18,515,760 with Infosys to provide Information Technology (IT) testing services for the period of October 1, 2024 to September 30, 2027.** • Children's Health Consultant Advisory Committee (CHCAC) Membership **Motion CHC 100.0924*** **To appoint Lina Shah, MD, Medical Director, Medical Management, Utilization Management, as member of the Children's Health Consultant Advisory Committee (CHCAC), for the Medical Director for Quality Management of L.A. Care Health Plan seat.** • Children's Health Consultant Advisory Committee (CHCAC) Revised Charter **Motion CHC 101.0924*** **To approve the Revisions to the Children's Health Consultants Advisory Committee (CHCAC) Charter, as presented.**	**Unanimously Approved by roll call. 12 AYES (Ballesteros, Booth, Ghaly, Gonzalez, Roybal, Shapiro, Solis, Vaccaro, and Vazquez), with partial ABSTENTION: Members Ballesteros, Ghaly and Roybal for motion BOG 100.**
CHAIRPERSON'S REPORT	Chairperson Ballesteros thanked Board Member Roybal for accepting an appointment to the Executive Committee. Chairperson Ballesteros commented that he went to the meeting of the Regional Community Advisory Committee (RCAC) for the technical training and it was the first time for RCAC members to meet together. He thanked the RCAC members and Chairs for inviting him. It	

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	was a wonderful group of people and very diverse. There were many new faces and individuals representing different communities. He thought that it was a good start together with all the RCACs. He commended the Community Outreach & Engagement (CO&E) staff, because they did a really good job. Auleria Eakins, Ed D, *Manager, CO&E*, is a wonderful employee of L.A. Care Health Plan, and she went above and beyond to make sure the community felt comfortable. All of the staff dedicated to the RCACs spoke in front of the meeting and they each represented L.A. Care in the best possible light. He thanked Mr. Baackes, Francisco Oaxaca, *Chief of Communications and CO&E*, Acacia Reed, *Chief Operating Officer*, Samir Amin, MD, *Chief Medical Officer*, and everybody that had anything to do with that meeting. He thanked the RCAC members for welcoming him. He appreciates hearing all of their comments. Their time and energy is appreciated, and RCAC members want L.A. Care be the best. He sees it and knows that this Board values it very much.	
CHIEF EXECUTIVE OFFICER REPORT	**PUBLIC COMMENT** *Ms. McClain commented that the Chairperson said that members want L.A. Care to be the best. She wants to add to that and say they don't want it to be the best. L.A. Care is the best. Her question pertains to proposition 35. She's not very educated on it, forgive her. Mr. Baackes will share a report. In the past, she has brought a concern about benefits for those with Medi-Medi, and the difference in benefits and access to care compared to people with a Medicare Advantage plan. And they deal with doctors saying they're not going to take it, as stated earlier. She asked if there is any progress on this issue and if Proposition 35 will help with it.* Mr. Baackes stated that Proposition 35 does not address the issue, which is that those who are dually eligible for Medi-Cal and Medicare may have different benefits in the Dual Special Needs Plans compared with beneficiaries enrolled in a Medicare Advantage plan. He offered assistance in understanding the differences among the plans. In Los Angeles County there are about eight DSNP plans, with 19 insurance companies offering 108 different Medicare advantage products. It is impossible for a consumer to absorb the information and make an informed decision to enroll in a plan. L.A. Care uses brokers, not every broker, but select brokers who are professional in making sure to match the client to the right plan. There are likely cases where that does not happen. That is a big issue that L.A. Care has addressed with CMS, challenging the number of plans because it is not helping the consumers to have so many choices to sort through. • Mr. Baackes reported that L.A. Care has taken a bold step in reducing the number of prior authorizations required. Prior authorizations are a keystone in managed care to limit unnecessary or duplicative tests and procedures. Prior authorizations have become a source of irritation for both patients and providers over time. In 2010 there was a change	

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	in the international coding list. In ICD-10, there are 70,000 procedure codes, and providers are required to note each code in a request for authorization. L.A. Care had 56,000 codes on the prior authorization list. L.A. Care has reduced the number of codes requiring prior authorization by 24 % by eliminating 14,000 codes. Under ICD-9, there were 3,800 procedure codes and ICD-10 greatly increased the number of codes. He is not aware of any other health plan in Los Angeles County that has done this. Dr. Amin will monitor the prior authorization codes on an annual basis to be sure there are no unintended consequences. L.A. Care is out in front of other plans on this issue. This is a big issue in Congress and it is the number one issue among the members of America's Health Insurance Plans, a national trade association. L.A. Care is the only plan that has taken this step to reduce the number of prior authorizations required. • The last time this Board met, Proposition 35 had not yet been accepted for the ballot by the Secretary of State. That happened later in June, and we have the ballot label, which is in the booklet with all the other propositions and explains the measure in 25 words or less and it lists the organizations in favor and opposing. Those in favor are all the providers. The coalition that united for Proposition 35 includes hospitals, doctors, clinics, health plans and others. The list for the opposition reads, none submitted. The proposition has an excellent chance of passing. The managed care organization (MCO) tax exists currently. Managed care plans are taxed very heavily, the commercial plans not as much. The money collected goes into a pool. That pool of funds is used to draw down an equal match from the federal government. In the nine years that the MCO tax was in place in California, that drawdown of around $30 billion went to the state's general fund. Last year when the MCO tax was reinstated, the proceeds were directed mostly to Medi-Cal to increase reimbursement and a portion to the general fund. This year, there is a large state deficit and it was announced that all the proceeds of the tax would be swept into the state's general fund. If voters approve Proposition 35, the original intent will be restored and the bulk of the money will to go into Medi-Cal to increase reimbursement to providers and a small portion will go to the state's general fund. If the Proposition is not approved, every year the legislature can decide what they want to do with the money. There is precedent in that most of the education funding in California was approved through a similar ballot proposition. • Mr. Baackes reported that there was a two-day session for RCAC members in August. Chairperson Ballesteros attended the first day and Mr. Baackes attended the last one. The purpose of the sessions was to inform existing and the 24 new RCAC members in the eight RCACs. New members were selected through the selection committee process, a requirement of the DHCS contract. RCAC members met on two days at St. Ann's conference center. Regular meetings of the eight regional advisory committees will begin in September. RCAC members will elect a Chairperson for each committee. Those eight	

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	Chairpersons will form the ECAC. Mr. Baackes joined Chairperson Ballesteros in saluting Dr. Eakins and Idalia De La Torre, *Supervisor of CO&E*. They did an excellent job arranging a fun and informational event. They included the entire CO&E staff members. The members were able to really understand who does what and where for RCACs. Mr. Baackes thanked the advisory committee members. It has been a long haul getting through the pandemic and this reorganization, and he thanked them for their input and engagement. He looks forward to the new series of RCAC meetings that start this month. • Since the last Board meeting, other events have occurred. L.A. Care awarded eight more scholarships, four to UCLA Medical School, and four to the Charles R. Drew University of Medicine and Science. At the ceremony, held in this room, white coats and stethoscopes were presented to the scholarship winners. Assemblyman Gibson and former Mayor Villaraigosa were guest speakers. As usual, many of the family members thanked him and said the award has been transformational in the student's life. L.A. Care is doing good stuff. The first group of students who were awarded scholarships have graduated and are finishing their residencies. They will be coming back to work here in Los Angeles County. • L.A. Care held the annual back to school backpack distribution events, which provide a backpack with school supplies to everybody who shows up. This year 18,000 backpacks were distributed in 16 different events. • Mr. Baackes noted there is an article in the meeting materials about a program with the school districts for student mental health. L.A. Care has engaged Hazel Health, which has introduced online and telephonic counseling for students. It has been a huge hit. The school districts are pleased, the students that participate are pleased, and it is one of the better stories about addressing the chronic and rising behavioral health diagnosis. It is one tool, and may not solve everything, but it is a step in the right direction.	
• Vision 2024 Progress Report	*Mr. Baackes referred Board Members to the written reports included in the meeting materials.*	
• Monthly Grants and Sponsorships Reports	*Mr. Baackes referred Board Members to the written reports included in the meeting materials.*	
• Government Affairs Update o 2024-25 State Budget Update	Cherie Compartore, *Senior Director, Government Affairs,* reported: • On August 31, 2024, the California Legislature ended its session. Governor Newson will have until September 30 to either sign or veto the legislative bills. • The Governor called California lawmakers into a special session related to gas and oil issues in California. The Assembly has called a legislative session but the state Senate has not.	

APPROVED

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	• There is a matrix of legislation in the materials for this meeting. The legislative matrix will be updated for the October meeting. • SB 516 was not passed by the legislature. This was a bill sponsored by the California Medical Association that to ensure patients get treatments they urgently need without unnecessary delays, and stopped health plans from requiring prior authorization for health care providers. This bill will likely be brought back next year. L.A. Care will have an opportunity to participate in discussion.	
• One-Year Health Equity Impact Report: Health Equity Disparities Mitigation Plan 2023-25	Mr. Baackes introduced Alex Li, MD, Chief Health Equity Officer. Every Medi-Cal health plan in California now has a health equity leader. L.A. Care's Health Equity leader is an officer of the corporation and a member of the CEO Cabinet. His instruction to Dr. Li is that he wants health disparities mitigation to be about solving problems and not the study of problems. The health equity team should be a guiding force at L.A. Care and identify areas that will help solve the disparity gaps. Dr. Li thanked the Board, Mr. Baackes, his colleagues and staff for supporting him and team in making this an amazing role and opportunity to serve our members and providers through a health equity framework (a copy of his presentation can be obtained by contacting Board Services). Since this job is new, there a few fundamental strategic questions that we need to ask as we approach a problem: is this a disparity that is core to a large number of our members; what and how does L.A. Care proceed in addressing the disparity; what role and actions should we take; and how do we build community alliance and translate the partnership and L.A. Care resources into action and positive outcomes. Currently, L.A. Care is in the midst of its two year 2023-2025 Health Equity and Disparities Mitigation (HEDM) plan. The HEDM plan is available on the website. Much of the work has been laying the foundation and "ground game" (e.g. building trust and relationships). We have identified clear areas of focus and priorities which help guide us in who we are seeking to engage with. Some key efforts include a focus to improve Black and African American Maternal Health, improve physical health and mental wellness for youth. For example, we heard from our public health and community colleagues state that there has been inconsistent capacity building of L.A. County's community assets and efforts to address Black maternal and infant health. Thus, over the last two years, our Community Benefits team and others have identified organizations to help support and expand their infrastructure and capacity. Now we are leveraging and forming regional clinical and social service coalitions in three areas: Inglewood/West LA, South LA and Antelope Valley. We are also working with LA County Departments of Public Health (DPH) and Public and Social Services (DPSS) to identify pregnant individuals early. A challenge or problem that we need to solve is that while L.A.	

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	Care provides health care coverage for pregnant women, most pregnant women are not made aware of who their OB provider is or know what L.A. Care resources are available to them until the enrollment information is first processed and worked its way from the local DPSS office to the State and then L.A. Care. This time lag means that we may not know that someone is pregnant till around 45 days or more before we can actively engage that individual. L.A. Care is looking at how we can reduce the lag time and engage our pregnant members to provide access and information about services as quickly as we can. Another partnership example involves our relationship with our school systems. Schools are a great place for us to address the health and wellness of youth because that is where they are for most of the day. Going through our framework and process, we thought that it would be good place to invest in wellness programs for middle school students for a population where physical and social habits are still being developed. We are currently looking into investing in improving the physical and social wellness programs in 5 middle schools and our aim is to impact thousands of or more students a year. In November 2023, we convened key advocates, academics, practicing providers and County staff to address: 1) vaccine catch up/misinformation, 2) building resiliency in school age children and youth, 3) supporting foster youths and 4) helping youths with complex health conditions transition into adult systems of care. We took a lead to organize and bring people together, thereby, creating the space for people to share and make recommendations that are L.A. County specific. Another focus area that the Board has directed L.A. Care to take action on is to reduce gun injuries in our community. We have taken a multi-pronged approach by offering a series of provider trainings; organized member community education and informational panels and promoted gun lock distributions. We have also tried to raise awareness by partnering with the LA County DPH's Office of Violence Prevention and the Los Angeles County Medical Association (LACMA). Billboard space was rented for display of key messages, reminding people about the importance of gun safety. Noting that no health equity work is done without involving L.A. Care staff, he thanked the Human Resources team. We have increased the practice of Diversity Equity, Inclusion and Belonging (DEIB) by developing employee affinity groups which seek to serve as a safe space for social, educational and professional venues and discourse. A clear validation that our health equity and DEIB and health equity efforts are moving in the right direction is when L.A. Care received its first National Committee on Quality Assurance (NCQA) Health Equity Accreditation score of 98%. L.A. Care is among the 15% of health plans nationwide to have received NCQA Health Equity Accreditation status and this status is valid from March 2024-2027.	

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	For this coming year, our plan is to focus on implementing the required DHCS DEI Health Equity Training requirements, creating and publishing an L.A. Care Health Disparities Dashboard and continuing to work closely with our key community partners on addressing disparities. Board Member and Supervisor Hilda Solis commended the accomplishments. She asked how the school programs will be expanded, especially with respect to mental health services needs and what are the plans moving forward to support Native Americans and immigrant groups, particularly Latino Hispanic, and Asian American and Pacific Islander (AAPI). Dr. Li responded that there is an incredible amount of work led by Dr. Brodsky and Health Services team that are collaborating with school systems to implement school based mental health services. Many of these behavioral health services are focused in schools with a high number of students of color and who are new immigrants. Supervisor Solis noted that it is also useful to collaborate with existing programs at the schools and community partners like Planned Parenthood who are also providing mental health services and to think not only about the child/student, but also family members or guardians. She also reminded everyone that due to language barriers, immigrant communities often do not receive much mental health services; they experience and express their mental illnesses differently or indigenous communities such as Guatemala Mixtec, often are not getting the right information because we don't have the right interpreters. Dr. Amin also shared that the school-based behavioral health program led by Dr. Brodsky show that more than 2800 students were assessed and referred from over 600 schools. This program has offered over 17,000 counseling sessions and greater than two out of three served by the program are BIPOC students. Additionally, 50% of the therapists being hired are BIPOC with ten languages spoken. Dr. Amin invited Michael Brodsky, MD, *Senior Medical Director, Community Health, Behavioral Health* to share more. Dr. Brodsky noted in addition to what was shared by Drs. Li and Amin, he acknowledged that about a month ago, many ECAC members shared similar concerns (that were raised by Supervisor Solis). He noted that in order for the school based mental health programs to be sustainable, there is an on-going effort to implement a fee schedule so that the school mental health services can have a funding source from health plans and move away from a grant model. Board Member Ghaly thanked Dr. Li for the presentation and the equity and the gun violence prevention work that he is leading at L.A. Care. Board Member Ghaly noted that there are many screening tools and programs that are coming out of L.A. Care and other health plans because they are prescribed by DHCS or CMS. A challenge the Department of Health Services (DHS) and other providers experience are that the health plans are requiring different assessment tools for the same DHCS or CMS requirements. She noted that this can be both confusing and frustrating for the providers and staff. She also noted that DHS is a firm,	

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	wholehearted believer in the assessments to help their patients optimize and access resources. But she wonders if it would be possible for the health plans to require the same tools when there are requirements from DHCS or CMS to minimize the administrative burden for all providers. Dr. Li responded that he leads the statewide as well as the local L.A. County Chief Health Equity Officer roundtables. He will raise this challenge at future meetings. He asked if Board Member Ghaly's team can provide some examples. Board Member Ghaly noted that there are unique alcohol screening tools and homelessness prevention tools required by health plans, and those are just two examples from a long list. The tools are more or less the same but are different in the details, and require multiple programming in the electronic health record and requires training on the multiple subsets of questions. She appreciates the continued work on alignment of the tools and re-emphasized that DHS providers support this work. Mr. Baackes noted that it will be great to start with our Plan Partners and involve HealthNet and Molina. Board Member Gonzalez thanked Dr. Li for his report. She feels the Doula program is underused. She asked whether L.A. Care is collaborating with Planned Parenthood. Dr. Li responded the Doula Program is relatively new and is a growing program. At last internal review, there are around 140 pregnant woman who have been referred and used the doula service. L.A. Care is working with obstetrics and gynecology (OB) physician groups to encourage doula referrals. He would need to check with the L.A. Care team on whether we are contracted and contracted with and partnering with Planned Parenthood. Mr. Baackes added that the Los Angeles County DPH has requested that health plans fund a Los Angeles County Doula hub. L.A. Care is part of that effort and will contribute to the doula hub. The idea is to provide training for doulas to gain expertise on how to engage with health plans and other providers in the community.	
CHIEF EXECUTIVE OFFICER REPORT	Mr. Baackes continued his report, noting that there are a number of safety net hospitals that are struggling financially. A distressed hospital loan fund was created in last year's State Budget, which was assigned $300 million, and that was immediately gone. There were many more applicants than funds, and only 18 hospitals received funding. He believes that L.A. Care could start a distressed safety net hospital revolving loan fund of $30 to $50 million with its reserves. He is researching the mechanism for that funding and has connected with the California's Department of Health Care Access and Information (HCAI), which administers the state's Distressed Hospital Loan program, to align the financial and community needs criteria. He consulted with Board Member George W. Greene, Esq., who is President and Chief Executive Officer of the Hospital Association of Southern California, and more details will be provided at a future Board meeting.	

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CHIEF MEDICAL OFFICER	**PUBLIC COMMENT** *Ms. Cooper asked if the housing issue is in the CMO report. She would like more emphasis placed on housing issue, which is part of health. And so often that is not addressed as well as should be. But housing and tenants issues are important because housing is going to always be an issue and housing is part of health. She hopes that the chief medical officer will address that more before the Board and make it a priority issue. Tenant's issues, not just homeless, tenants become homeless and so she would appreciate that.* *Mr. Fagan asked Dr. Li if there is a strategy set up to address second hand smoke in the schools. Back in the 1970s that was something that was talked about, secondhand smoke needs to be brought back up. And then Mr. Fagan also wanted to talk in terms of root cause medicine being incorporated into the provider database. There needs to be some kind of way where the members can have access to providers that provide functional medicine.* Dr. Li suggested that they can discuss more about secondhand smoke and functional medicine offline. Dr. Amin referred Board members to the written Chief Medical Officer report in the board packet, with some highlights on the important details. Dr. Amin noted that Health Services is engaged in planning for the next year to five years. Health Services has work groups meeting and it will culminate in a strategy summit over two days in October. The senior leadership and management across all the health services functional areas will discuss plans and create a guiding document with a timeline and metrics associated with providing services. Major topics to be discussed are how the programs relate to one another, including CalAIM programs like Enhanced Care Management, Community Supports and transitional care services. There will be discussion on how programs are tied together so that they are not a disparate menu of items, but are part of a holistic program to treat our members. There will be discussion about how each area of health services connects with others, to make sure that members eligible to access multiple programs have that access. Streamlining and making sense of medical management is a primary topic, and number two is making sure that the path is clear for collaboration outside of Health Services divisions and that Health Services staff are working properly with staff in finance, operations, compliance, and information technology departments. A few topics are population health management, program management within Health Services, and taking on technology as part of medical management. There will be a full description of the strategy at a future Board Meeting. It will guide Health Services toward the future.	

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• MacArthur Park Care Collaborative	Dr. Amin invited Dr. Brodsky and Charlie Robinson, *Senior Director, Community Health*, to present information about the MacArthur Park Care Collaborative. Dr. Amin reviewed the components of L.A. Care's strategy to address the housing crisis: • Finding housing and staying housed • Short term housing solutions • Increasing the availability of permanent housing and • Access to healthcare and social services. Field Medicine supports access to health care and social services. It has now rolled out across the County. The community health team has developed L.A. Care's field medicine program in a very innovative way. A map of the county was created and separated into regions that have the right number of providers to treat people in the street who are unhoused, as well as ensure that longitudinal primary care is provided. There are a lot of operational details to that. High density regions are areas where there are multiple providers and a very large unhoused population. This would include areas like Skid Row, where there are a lot of very well intentioned providers who L.A. Care needs to make sure are working together in a coordinated fashion to keep those people healthy. L.A. Care has done that in Skid Row, by supporting the Crocker Street initiative and by creating a care collaborative between multiple providers in the area. But that is not where L.A. Care is going to leave it. There are multiple high density regions across the County. L.A. Care Field Medicine will assist with as many areas as possible. Dr. Amin thanked Supervisor Solis for prompting at a prior meeting regarding MacArthur Park, which is a high density region. Dr. Amin introduced Charlie Robinson, the operational leader behind Community Health, and Michael Brodsky, MD, who is the clinical leader of Community Health. L.A. Care has elevated talent and brought in new talent, and one of the benefits is creation of these very innovative solutions. Community Health has team including Karl Calhoun, Delia Mojarro, and Matilde Gonzalez-Flores, who have contributed dramatically to these projects. Mr. Robinson reviewed the regional structure, and the general construct is actually tried and true in complex environments. Mr. Robinson spent eight years as a commissioned officer in the United States Navy, including a year in Afghanistan. The genesis for the geographic structure that we have applied to organize care across the county is aligned with the way that NATO nations were deployed in Afghanistan. The anchor nations managed airfields and bases in regions, and others floated through those regions. It was a flexible way for multiple different entities to operate in a complex environment with some taking regional control and some accountability for certain regions, and included the flexibility to have other providers float through the regions. For the high density regions, the care collaborative concept was born from that general organization. It is how the care collaborative concept is structured in	

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	Skid Row. L.A. Care is continuing to use that collaborative structure for the high density region in MacArthur Park. Each region is unique. There are 15 distinct regions across Los Angeles County. Fourteen regions have a regional anchor provider, but Skid Row has a care collaborative to cover that high density area and to provide resources for providers to coordinate care. Based on feedback from key stakeholders in the community, MacArthur Park is another area that needs additional support for care coordination. L.A. Care plans to carve out MacArthur Park from the Alvarado/Glendale Corridor region and go from 15 to 16 regions. The MacArthur Park care collaborative will be created to meet specific health and social services needs in that specific neighborhood. The needs in MacArthur Park are acute and are being served by multiple different providers, and are markedly different from the needs in Skid Row. Dr. Brodsky will review the unique needs of MacArthur Park and the proposed care model. The Department of Health Care Services model of care describes how people move through engagement and treatment depending on their needs. For MacArthur Park, psychosocial stressors and the social determinants look slightly different. Macarthur Park has a different environment than does Skid Row. There was great benefit in reviewing some detail the Skid Row action plan proposed by Supervisor Solis in 2022 and the Skid Row action plan implementation reports recently delivered to the Board by Board Member Ghaly's DHS staff ago. Reading the comments and feedback line by line was quite helpful. In MacArthur Park, the clinical model and clinical goal are to reduce overdose deaths (it is the second highest site of overdose fatalities in L.A. City), to increase access and linkage to housing, and to create a runway for people to engage in care for substance use. Underlying principles include coordination between stakeholders with L.A. Care planning to provide navigation as needed between the various stakeholders in the care collaborative. Similar to the skid row action plan, there will be transportation. Resources will be needed for people who may not be able to easily walk between drop-in centers, the federally qualified health centers, and the Department of Health Services facilities that are in the area. Providing transportation between Skid Row and MacArthur Park is being considered to take advantage of services being built at Skid Row. There are enhanced field medicine services and look forward to having an additional field medicine team bring medical care, sometimes called backpack medicine, and ideally to reconnect people to the primary care they need. Similar to the action plan, there will be harm reduction services to keep people as safe as we can in the context of fairly significant substance use. We want to make it safer to use drugs, and definitely want it safer for people who come to the point where they are interested in stopping using drugs. As the Department of Public Health says, substance use treatment does	

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	not have a supply problem, it has a demand problem. The demand is too low. Many people are not ready to enter treatment yet, so harm reduction is the lowest level of engagement where people feel welcome, they can take a shower, get a snack, or do laundry, and we can provide both safe services and counseling, particularly using the modality called motivational interviewing. This is the lowest level of engagement. A higher level of engagement is when some people who pass by and encounter field medicine teams or come to the DHS operated health and harm reduction center, will be ready for treatment. We want to be prepared for the days people are ready for treatment and have a range of services available. There is a local community clinic, a Federally Qualified Health Center called Clinica Romero quite nearby with an extensive program that is like the lowest level of outpatient substance used treatment. Other people who may need more support than that will be referred to partners in the Department Public Health, which has a spectrum of services including integrated housing and substance use services. This has been a significant education opportunity and staff is very grateful, particularly to the Los Angeles County entities. The Department of Health Services, including Housing for Health and Harm Reduction Division, the Department of Public health, notably the Substance Use Prevention and Control Division have been the principal planning partners. Supervisorial District 1, and he thanked these organizations. He thanked Supervisor Solis for an introduction to the Office of Los Angeles City Council District 1 Council Member, Eunisses Hernandez. Dr. Brodsky reviewed a partial list of potential providers, the Department of Public Health is a planning partner and has knowledge to contribute, and although it does not have field medicine teams, they been very helpful. The Department of Health Services is very involved in the work on harm reduction as well as coordination, not to mention serving as a Skid Row and field medicine primary care provider, as well as a Skid Row primary care provider. Clinica Romero has extensive outpatient substance use treatment co-located with primary care. Healthcare in Action is the first street medicine provider L.A. Care contracted with. UCLA and USC are academic cousins and provider contracts with L.A. Care are pending, and we look forward to their participation in the MacArthur Park care collaborative. Next steps will be to review the services in detail, meet with partners and work on a budget, and discuss the project governance. Finally, we will look at provider selection and develop methodology and process. Dr. Amin commented that L.A. Care prides itself in putting money where its mouth is. With the Skid Row care collaborative and field medicine, L.A. Care is prepared to make a significant investment in the MacArthur Park care collaborative to make a difference in for those residents. L.A. Care will be financially supporting this effort. Supervisor Solis is proud to see this effort, the report and the deep thought and in integrating	

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	services. She is glad the staff collaborated with the Skid Row Action Plan because much has been learned and continues to be learned. She knows that Board Member Ghaly has been very involved with the Crocker Street project and she'll be involved here. Supervisor Solis encouraged involving other Los Angeles County departments that work with the unhoused. Dr. Amin responded that there will be reports at future Board of Governors meetings. Board Member Ghaly offered thanks to Dr. Amin, Mr. Robinson and Dr. Brodsky for the work on this. DHS is excited to participate. Hopefully it will be an expansion of DHS' achievements MacArthur Park. She thanked other partners among the Board Members. Chairperson Ballesteros echoed the appreciation expressed by Supervisor Solis and Board Member Ghaly. It is so important to collaborate with Los Angeles County DHS, DPH and DMH because it will take many resources to bring this collaborative to the robustness that it will need to address the needs of people in that area requires partnerships from different entities. He would like to add that down the road when ready, LAHSA needs to also be engaged. LAHSA brings housing stock to the Skid Row area for interim housing and even permanent housing, but at least interim housing solutions are very much needed. Dr. Amin noted that L.A. Care has the blessing of a Board of Governors with deep connections in the community, and that can drive care for L.A. Care members. Dr. Amin stated that the community health team has connections with LAHSA and has worked with them quite a bit on Pathway to Home and Inside Safe. L.A. Care will engage them on this project, and there are other entities in the community that we will collaborate with, perhaps with contacts provided by Board Members. *(Board Member Vazquez spoke in Spanish and her remarks were translated to English by a professional interpreter.)* Board Member Vazquez would like to know more about the professionals that are participating. She would like to ask whether these professionals have experience with homelessness. She believes it is important for the professionals that will be providing this help to have some experience to advise people who are going through the same situation. They can better identify and serve the needs of the people who are currently in the situation. Dr. Brodsky responded that he completely agrees with the comment. A benefit being in Los Angeles is that many organizations have worked with individuals who have lived experience and learned a great deal. DHS in particular, for the previous five year period, built an entire infrastructure of service delivery using the expertise of those in the community and those with lived experience and the DHCS was so inspired by that there now is a community health worker benefit, which L.A. Care helps pay for and is eager to pay for, with regard to these projects.	

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Performance Monitoring May 2024	**PUBLIC COMMENT** *Ms. Cooper deferred her remarks.* *Ms. McFerson asked that everyone excuse the way she is speaking. She did a couple walks in the heat and when one has epilepsy, that's what happens. So love her for who she is. Please read ADA information in its totality before each meeting, if at all possible performance monitoring, having a genuine connection with the members of whom, these meetings affect the most. We were talking about the homeless and effective procedural dedication to the disabled members. Unfortunately many care providers, the organizations and things like that, they don't give good access to care for people who may not be able to mentally take care of themselves and describe their disparities so they're left not even receiving proper care because they are reluctant to even go up to someone who is treating them in a bad way. So with that homeless situation, can we please have performance monitoring towards the programs that we have for the unhoused, to give empathy training to the people.* Dr. Amin presented the Performance Monitoring report *(a copy of the report may be obtained by contacting Board Services)* and noted the dashboard has been reviewed in the Provider Relations Advisory Committee and by this Board. Updates will be included in the Board meeting packet. Instead of going over an exhaustive detail each time, he will go over any major changes. L.A. Care continues to perform well in utilization management, within regulatory timelines at the 99.8% to 100% timeliness. This will be carefully monitored as L.A. Care moves to a new platform in November 2024. With regard to inpatient hospital admissions. PTM PM means *per thousand members per month*. Over the course of 2023 the measures tracked better than the previous year, meaning admissions to the hospital are lower and patients are hopefully getting better care, and getting care in a less urgent and emergent fashion. There was an increase between November and January which occurred because of a bump in respiratory viruses. The graphs for various delegated provider groups indicates outliers; those above are doing worse than others, those below are doing better. L.A. Care meets with outliers in joint operating meetings to discuss performance and suggest ways to collaborate with L.A. Care and improve. The line in between is the medium line. Hospital readmission rates have generally been tracking lower, which is positive news. Data on emergency room visits shows a big change from November to January period due to the increase in respiratory viruses which sent patients to the hospital for emergency room care. The data on potentially avoidable emergency room visits are the core of discussions during joint operating meetings, along with the phase sheet with data that is actually coming down to their personal performance. L.A. Care has discussions with direct network providers and reviews the data. That has been helpful in moving the network forward.	

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	Acacia Reed, *Chief Operating Officer*, reviewed claims data, noting there was a dip in June in the total claims volume received. A low volume of Call the Car claims were received in June when compared to the significant volume of 300,000 claims received in July. The total paid claims including interest, is anomalous in June - lower than average and lower than last year. There were some timing issues with the holiday and the number of working days in the month of June compared to July, and other issues being analyzed that led to a lower payment volume in June versus July. Last year L.A. Care discussed with the Board and Provider Relations Advisory Committee about the coordination of benefits agreement, or COBA. In November, December, and January, there was an inordinate volume of incremental claims received, which degraded performance at the 30-calendar day and eventually 90-calendar day metrics. L.A. Care monitors the 45-days claims payment rate to continue to drive down interest paid on claims after 45 days. First pass claims denial rate was a hot topic last year, but not this year, and the rate is normalizing around 16%. The Provider Dispute Resolution rate degraded in May due to an issue that was identified in the claims processing system. L.A. Care is remediating that and other issues tied to that. Mr. Paley reported that Call the Car is collaborating with L.A. Care on a corrective action plan and performance continues to improve. The transportation team is working with Call the Car and other vendors to onboard an alternate vendor for overflow. In a previous meeting there was a question about whether members who utilize Call the Car can provide contemporaneous feedback, and the answer is yes. L.A. Care monitors the survey results and feedback from members in monthly joint operating meetings with Call the Car.	
ADVISORY COMMITTEE REPORT		
Transitional Temporary Executive Community Advisory Committee	**PUBLIC COMMENT** *Ms. Cooper commented that she feels a little saddened. The reason she said that she wouldn't have to be coming to this meeting. We have not seen one Item. She's been a RCAC member for years. They work very well together. But as an Afro American, she's going to have to be honest. When she go to the meetings, when a motion is made or a concern expressed, one can only get anything done if a member of the executive committee. And some Sometimes she feels isolated because she tried to bring up issues, not by herself, by others. But they have not seen one item and they do not see a program. She asked that he come to the RCAC meetings and see they do not have a voice. Those who have a voice seem like we are silenced. She came here to work for all the members, diversity. She helps work, but she feels the Board needs to have more oversight over the executive committee, those who represent them, those who are supposed to be*	

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	representing them, but they ignore them and in fact, particularly if one is a minority such as African American, they need to be more culturally sensitive and have a healthy altitude, and she feels very sadness. Sometimes she feels like just giving up, not being on a RCAC, but she feels the people like, who ran for president and all who said don't give up. But there needs to be oversight with the ECAC and their representatives who represent them. She tries to be a good steward. She has letters from former board members, RCAC members, board members, and from some of the RCAC members of different cultures, but she doesn't feel comfortable in her RCAC. The incident that happened today it made her feel very uncomfortable. An experience she had today with people who supposed to be representing her. She appreciates all the comments she made, but the Board members, you need to come to the RCACs and put some oversight on the ECAC. And the Board representatives need to represent all of them, not just some of them, because they all have great ideas and she appreciates that, but please take notice of her comment. She felt like writing to Sacramento. Chairperson Ballesteros apologized that she feels that way. He will talk with her after the meeting and they can have more dialogue. *Ms. McFerson feels a general consensus in what she was saying actually, and that's from everyone from, their representatives to the providers who don't give good access to care, mentally, physically, leaving L.A. Care members sick and unwilling to receive care because they believe it would be uneventful to speak up and please better communication, of course, with the services by having a genuine survey, and either eye to eye or peer on peer during events that the RCAC members can do, and it would be able body, people who are willing to be out there giving eye to eye, person to person, information to the members and receiving personal performance data from that, to all kinds of other opportunities to give ideas to L.A. Care to have better statistics and data and things like that. And then also we need to discuss the 504 planning for all of the disabled members to give an emergency contact to everyone, if they become impaled with their chronic illness.* *Mr. Fagan commented he's in agreement, he's in solidarity with the last two comments. He feels the same frustrations that they have brought up and it needs to be addressed. It really does. In addition to Call the Car, if they're going to allow a third vendor, then we should make sure it's an American vendor. Because what we have now is two vendors that are out of the country and it makes it very difficult for English speakers.* Mr. Baackes commented that L.A. Care currently has one transportation vendor, Call the Car, which is based in Los Angeles County. He is not aware that there is any foreign ownership. Mr. Paley stated he is not aware of any foreign ownership.	

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	Mr. Fagan commented that Call the Car contracts with call centers not located in the United States. Mr. Paley will follow up and provide details for the caller. Board Member Booth noted that Compliance & Quality Committee should also receive that information because the Committee was reassured that there are no vendors outside the United States. Board Member Vazquez reported that TTECAC met on July 10, 2024 *(Board Member Vazquez spoke in Spanish and her remarks were translated to English by a professional interpreter).* She thanked the members that attended the meeting in virtually and in person, the comments and questions were greatly appreciated. She recognized members present at this meeting, including those not on this list: Ana Rodriguez (R2) Maritza Lebron (R7) Ana Romo (R8) Deaka McClain (R9) Damares O Hernandez de Cordero (R10) Elizabeth Cooper (R2) Joyce Sales (R6) Silvia Poz (R4) Estela Lara (R4) Silvia Sosio (R6) • Mr. Baackes gave a CEO update at TTECAC and he also gave a CEO earlier today. • Dr. Michael Brodsky presented information about increasing access to mental health treatment in Los Angeles County schools. Dr. Brodsky highlighted the successful rollout of telehealth mental health services in over 600 Los Angeles County schools under Student Behavioral Health Incentive Program (SBHIP), improving access for students, especially in BIPOC communities. The initiative addresses mental health challenges exacerbated by COVID-19, reducing school absences and positively impacting student well-being and school funding. The program's success includes the hiring of 50 culturally and linguistically matched therapists, capable of serving over a thousand students weekly. Board Member Gonzalez continued the report: • Mr. Oaxaca gave a communications and community relations Departments update. He reported that South LA and Lincoln Heights Community Resource Centers are progressing well. A grand opening event is planned in October for the South LA Center. The Lincoln Heights CRC should be ready for a grand opening by November or	

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	December. Invitations to the events will be sent to ECAC and RCAC members representing those areas. The CO&E team is scheduling RCAC meetings at Community Resource Centers allowing members to experience the Centers and interact with the programs and staff. • A RCAC conference was held in August, as Mr. Baackes and Chair Ballesteros related earlier. Members came together and new RCAC structure and operations were introduced. The member selection committee is working to interview and select new RCAC members. There has been significant interest in joining the RCACs, and new members will be added in the coming weeks. • Ryan Bowen, Account Manager and Transportation Experience Manager for Call the Car presented information about the transportation services. Board Member Gonzalez commented that the meetings in August were wonderful. It was a chance for Members to get together as they had not met in over three years. The members were delighted to see each other. Board Member Vazquez commented on her activities since the last meeting *(Board Member Vazquez spoke in Spanish and her remarks were translated to English by a professional interpreter).* • On July 16 2024, L.A. Care recognized eight new scholars accepted in the L.A. Care medical school scholarship program through Elevating the Safety Net. The excitement of the families and the students was very contagious. • On August 3 she attended an event on Catalina Island to raise funds for Catalina Island Hospital. L.A. Care was recognized for its support of the only hospital on Catalina Island. • August 15 and 23 way we were at a conference for RCAC members. Members appreciated the opportunity to participate in the "Celebration of the Community Voices". The RCAC meeting schedule was announced: RCAC 1 Tuesday September 17, 10 A.M to 12:30 P.M. RCAC 2 Wednesday September 18, 10 A.M. to 12:30 P.M. RCAC 3 Thursday, September 19, 10:00 A.M. to 12:30 P.M. RCAC 4 Friday, September 20, at 10:00 A.M. to 1230 P.M. RCAC 5 Thursday, September 26, 02:00 P.M. to 4:30 P.M. RCAC 6 Wednesday September 25, 10 A.M. to 12:30 P.M. RCAC 7 Tuesday, September 24, 10 A.M. to 12:30 P.M. RCAC 8 Monday, September 23, 10 A.M. to 12:30 P.M. Board Member Vázquez thanked L.A. Care for the opportunity to participate as a member of the Consumer Health Equity Committee and the Compliance & Quality Committee. Board Member Booth commented that she is glad that RCAC members continue to participate and provide input to the Board. She thanked members for working through the process.	

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The next report, from the Finance & Budget Committee, was moved up on the Agenda with no objection by Board members.		
Finance & Budget Committee	**PUBLIC COMMENT** *Ms. Cooper opted to not provide public comment at this item.* Board Member Booth reported that the committee met on June 26 and August 28. Please ask Board Services staff if you would like to obtain a copy of the approved meeting minutes. The Committee reviewed and approved a motion for contract amendments with Hyland Contract for Salesforce Integration, Appeals & Grievances, QNXT Integration (Utilization Management) and NTT America which do not require full Board approval. The Committee reviewed and approved motions that were approved earlier today on the consent agenda. Afzal Shah, *Chief Financial Officer*, reported on the July 2024 financials: <u>Membership</u> Total membership for July 2024 was approximately 2.6 million members, around 155,000 favorable to the 4+8 forecast due to higher than expected enrollment post-redeterminations. L.A. Care Covered (LACC) is approximately 17,000 members favorable to the 4+8 forecast. <u>Consolidated Financial Performance</u> There was a $7 million net loss, for the month of July driven primarily by GEMT, directed payment program payments, L.A. Care did implement close to $31 million in GEMT payments, and $5 million in associated interest. YTD results for the 10 months ending in July were $368 million net surplus, $132 million favorable to the forecast, excluding Housing and Homelessness Incentive Program (HHIP)/Incentive Payment Program (IPP). Excluding investment income, the surplus is around 2% of the revenue. For Medi Cal, rates are set at about a 2% risk margin, so L.A. Care has ended ten months of 2023-24 fiscal year in line with Medi-Cal margin expectations aligned with the State, though these financial results include Medi-Cal, DSNP and Covered California. Due to the meeting schedule, financial results for April, May and June financials are included in these results although they have not been reported separately. *(Board Member Ghaly left the meeting.)* Board Member Booth suggested an amendment to include April, May, June and July.	

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	<u>Motion FIN 102.0924</u> **To accept the Financial Reports for the 10 months including April, May, June and July 2024, as submitted.**	**Unanimously Approved as amended. 8 AYES (Ballesteros, Booth, Del La Torre, Gonzalez, Roybal, Shapiro, Vaccaro, Vazquez),**
Fiscal Year 2024-25 Operating and Capital Budget	Mr. Shah recognized the hundreds, if not thousands of hours spent by Jeff Ingram, *Deputy Chief Financial Officer*, Neil Bedwell, *Director, Financial Planning and Analysis*, and Nancy Pham, *Manager, Financial Planning and Analysis,* and the Finance staff. They put in a lot of effort and created a robust budget process for 2024-25, with internal controls and changes in the process. The assumptions for 2024-25, include a 3.9% decline in membership for Medi-Cal, and increases in members for DSNP and LACC. L.A. Care has the lowest price plan for LACC. He reviewed the overall forecast by month compared to the variance in member months from the prior year. The October 2024 projection is shown compared to the variance from October 2023. L.A. Care doesn't have draft rates yet from DHCS for 2025. Assumptions are based on the best information available. We used assumptions from the actuarial team on Medi-Cal revenue, while LACC and DSNP forecast assumptions are consistent with the DSNP and LACC rate filings. Mr. Shah reviewed high level assumptions for global sub capitation, capitation, and fee for service costs. The projections are preliminary and could change based on the actual rates. Final 2024 rates are expected in September, draft 2025 rates in October and final 2025 rates in November. L.A. Care is projected to have a net increase in revenue, driven by LACC and DSNP (not by Medi-Cal) with a 1% decrease in the medical care ratio. For administrative expense, an increase of $60 million is projected, which is about a 9.5% increase. The majority of that increase is in two line items, salaries and benefits and purchased services. Increases in salaries and benefits are due to increased staff through 2023-24. Business fees and leases are increasing primarily due to LACC and DMHC participation. Finance staff continues to develop a sustainable long-term administrative budget. Board Member Ghaly commented that the increases in administrative expense seem to be large, with a huge increase in salaries and benefits, depreciation and amortization and business fees and insurance, which exceed the increase on purchased services. She asked about the driving factors, are they in line with expectations, or with what other health plans are experiencing?	

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	Mr. Shah noted that L.A. Care exceeded the 2023-24 budget for administrative expense, primarily because of staffing investments that were needed to comply with DHCS CalAIM requirements. For 2024-25, the salaries and benefits line item increase is primarily driven by annualized salary for staff hired during 2023-24. With support from Mr. Baackes and the Chief Officers, the finance team is developing a more sustainable budget with a goal that the administrative expense increase is not higher than the revenue increase. The revenue increase at best will be 2 to 3%. Mr. Shah invited Mr. Ingram to respond to her question about depreciation, occupancy and leases. Mr. Ingram noted that some of the increase is related to changes, based on GASB, in where expenses are shown. The expense for accounting software licenses had to move from business fees and insurance to depreciation amortization. A challenge is the cost increases associated with growth in commercial product lines. Broker commissions and participation fees increased as more membership enrolls in those lines of business. He noted for reference that last year's budget started with a $20 million increase from 2022-23, and the forecast update increased by over $70 million. That was almost a $100 million increase from last year to this fiscal year. The current budget has the increase at $60 million, so growth of the administrative expense is slowing. L.A. Care moves into each budget season with close to 500 open positions. The progress in hiring over the last year added pressure to salary & benefits expense. Finance is working on leveling the growth in future years. There is a three-year plan to stay in line with an administrative percentage in line with rates of reimbursement. In future iterations there will be more separation among lines of business to show the differences in participation fees. Board Member Ghaly noted that slowing down growth is different than aligning cost growth with revenue, and she asked if the emphasis is slowing down the cost growth so that in the future it's in line with the revenue growth or is the goal to reverse one time operating expense increases. Mr. Shah responded that the goal, within each of the lines of business, Medi-Cal, DSNP, and LACC, is to align administrative expense for each program. Medi-Cal rates include roughly 7% for administrative expense. Adding administrative expense for Plan Partners, L.A. Care's admin expenses are projected to be closer to 8%. The three-year goal is to move closer to 7% annually. Additional staffing was required in 2023-24 to meet requirements from DHCS. Mr. Baackes noted that the expense is a concern to him. The work added, particularly by CalAIM programs such as Enhanced Care Management (ECM), has been substantial and has driven much of the hiring. L.A. Care is not allowed to do ECM work in house and has to contract with 75 community based organizations. The cost for contracting and oversight of the contracts is substantial. There are efforts, through Local Health Plans of California, to push on DHCS for review of the requirements. L.A. Care has implemented with transitions of care, but the way DHCS wanted implementation for health plans would have collectively	

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	required hiring 600 people. It was explained to DHCS that it would have led to competition for limited employees among health plans and providers. It is not a sustainable trend as has been pointed out. The laundry list of business transformation projects that he mentioned in his report earlier in the meeting showed that when fully operational by the middle of next year, the demand to replace people will slow down, because efficiencies will emerge in some operations. Mr. Baackes commended Mr. Shah and Mr. Ingram for the long-term and strategic planning for future budgets and the preparation that is needed now. Board Member Booth noted that several years ago it was difficult for L.A. Care to fill important positions. To a certain extent there may be a time for catching up. Right now it is important to predict the best balance of expense and income. Mr. Shah reviewed the overall decrease in medical cost ratios (MCR) although Medi-Cal is higher than desired at 94%; DHCS estimates 91.5% in our Medi-Cal rates. L.A. Care will have additional medical cost savings initiatives to help reduce the MCR. Mr. Shah reviewed opportunities: • CY 2025 Revenue Rates: Continued rate advocacy efforts with DHCS related to a safety net adjustment and acknowledging acuity of remaining members post redeterminations. • Membership: Reduce dis-enrollment rates, increase renewals along with overall higher new sales growth for LACC and DSNP segments. • Business Transformation/Sunset Legacy Systems & Processes: Driving cost savings via administrative value based procurement, selective workforce conversions and realizing efficiency gains due to new systems and processes. • Headcount Management: Evaluate the effectiveness of incremental staffing on operational metrics and expected cost savings. Resource management relative to like-sized plans, accounting for percentage of delegation. and risks: • CY 2025 Rates: Additional pressure due to overall acuity assumptions, risk adjustment, county-wide averaging, administrative adjustments and/or negative economic development adding pressure to CA general fund. • Medi-Cal TRI Rates: TRI Rates from DHCS less than what L.A. Care's obligations for payment. There is also a risk of providers not agreeing to the Medi-Cal TRI payments, provider disputes, and L.A. Care not able to attest by Dec 31, 2024. • Covid Testing: Covid Testing costs are continuing to increase this summer with an uptick in covid cases.	

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	• Utilization and Unit Cost Trends: FFS and Capitation trends higher than what is assumed in the budget. • Admin Costs: Exceeding budgetary assumptions due to unplanned/uncontrolled cost. Mr. Shah reviewed presented information about Board designated funds. He reviewed the projected tangible net equity with a small decrease. Mr. MacDougall reviewed capital investments in projects included in the budget: • Appeals & Grievance (A&G) System Replacement. The current A&G legacy system (PCT) is outdated, resulting in inefficiencies and reliability issues. To address these challenges, the initiative replaces PCT with a new system that will automate A&G processes, integrate with UM and Claims systems, comply with DMHC, DHCS, and CMS requirements, and eliminate manual processes deficiencies. The new system will enhance workflow controls, productivity, and monitoring, improve information accuracy and timeliness, and support better case intake, letter configuration, and reporting. • Care Catalyst – New Health Services Clinical System. This final component of the Care Catalyst program focuses on ensuring the continued accessibility of historical data from the SyntraNet Utilization Management platform for operational, compliance, audit, and reporting uses. These investments complement functionality being deployed in the QNXT Upgrade & Transformation effort (below), which transform L.A. Care's Utilization Management tools and processes. • Clinical Data Repository (CDR) Phase 2. CDR Phase 2 will be a continued investment in modern data exchange functionality to include Continuity of Care Document (CCD) data. The objective is to develop a real-time CCD data ingestion pipeline from LANES and HIEs to meet regulatory compliance, enhance health plan performance, and improve quality of care for members. • Clinic Based Assignment and FQHC APM. With the recent, successful implementation of Clinic Based Assignment, L.A. Care can not only assign members directly to specific categories of community clinics, but also gained the necessary infrastructure to participate in the DHCS-mandated Alternative Payment Methodology (APM). Under APM, L.A. Care will change how it pays participating FQHC community clinics to include the Prospective Payment System (PPS) rate for Medi-Cal services that has previously been paid to clinics by the State. • CMS Interoperability Mandate. L.A. Care continues its multi-phase investment in electronic provider and member data portability in accordance with CMS requirements. Investments in 2025 and 2026 focus on payer-to-payer interfaces to ensure timely and efficient benefits coordination and transitions, as well as functionality for electronic prior authorizations.	

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	• Edifecs Enhancements. L.A. Care is continuing its iterative improvements of the Edifecs platform, which enables the organization's encounter data management and related regulatory reporting, and that supports risk adjustment activities. Upcoming enhancements target both operational optimizations, as well as compliance with evolving regulatory requirements. Planned investments include the processing of chart review records in Edifecs that do not have correlates in our electronic encounter data received from trading partners; the ability to unbundle mother/infant claims and encounters for the LACC line of business; processing of supplemental dental, vision, chiropractic, and acupuncture data for submission to CMS; inclusion of pharmacy data in outbound encounter reports to CMS; and enhancing the ability to process multi-payer encounter data. The organization is also exploring changes to the hosting arrangement for Edifecs software to maximize operational savings. • Medicare Advantage Prescription Drug (MA-PD) Product Launch. L.A. Care will be offering a new Medicare Advantage Prescription Drug (MA-PD) Plan, with enrollment starting in the fall of 2025, and plan benefits starting January 1, 2026. The MA-PD Product aims to provide continuity of managed care services for members transitioning into Medicare, as well as provide an option for Medicare beneficiaries in Los Angeles County who do not qualify for the D-SNP Plan. L.A. Care's business and technical teams will be preparing technology systems and business processes throughout the FY 24-25 fiscal year to ensure operational readiness. • PQI System Replacement for Provider Quality Review. The team responsible for Provider Quality Review has lacked a central repository and modern system to support its work. L.A. Care has been building system with modern workflow controls to improve productivity and monitoring of the review process; to reduce delayed, lost, or incongruent information between teams; and to ensure integration with other enterprise systems. With the initial deployment targeted for fall 2024, L.A. Care intends to iteratively enhance the system's capabilities through FY 24-25 to meet the needs of Health Services. • Provider Roadmap. This multi-year initiative centers on the implementation of a holistic provider network management system for L.A. Care's provider business functions. The scope includes improved provider data ingestion, validation, and management, as well as workflow tools and refined business processes. The initiative will enable improved provider data quality, and more efficient operations in contracting, credentialing, network management, provider relations, member assignment, and regulatory reporting. • SAP/ERP. L.A. Care is continuing its implementation of SAP for financial management functions. The upcoming phase will concentrate on finalizing the deployment of Callidus, a commission software solution that manages incentives and compensation programs for brokers. Additionally, the program will implement Arriba, a spend management tool designed to integration seamlessly with existing SAP procurement solutions. Arriba will	

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	enhance electronic order and invoice routing, user and role management functionalities, and contract and vendor management processes. • VOICE - CRM & Telecom. This multi-year program aims to create a robust and integrated Enterprise Customer Relationship Management (CRM) solution that improves the experience of L.A. Care's members and providers. Recent investments have focused on the implementation of a new agent console ('intelligent desktop') for the Call Center and other enterprise users; a new member portal with self-service capabilities; and a new provider portal with self-service capabilities. Following this implementation a subsequent phase will add enhancements across the CRM platform, including the integration of the agent console with our telephony systems, and the onboarding of additional areas of the organization with tailored CRM tools. These tools are expected to include Provider Dispute Resolution (PDR), Quality Improvement, and Pharmacy medication management. The initiative is also making investments in capturing and managing member demographic data aligned with regulatory requirements, such as Race and Ethnicity, Sexual Orientation and Gender Identity, and Alternative Format Selection. • I.T. Member Experience Program. This initiative is composed of two multi-year, cross-functional programs to modernize data systems and I.T. tools to support an optimized member experience. These foundational technology efforts enable L.A. Care to more proactively manage the member life cycle (from enrollment through care delivery). Work streams in this initiative include Data Architecture Modernization, which improves how enterprise data is organized, managed, and stored; and a Clinical Data Repository (CDR) to better organize clinical experience data in support of care coordination, operational planning, and regulatory reporting. These continued investments will enable L.A. Care to deliver future technology initiatives more effectively, and significantly improve the ability of business areas inside L.A. Care to serve member needs. • Performance Optimization Program (Enterprise & Network). This multi-year initiative is building data management tools and dashboard reporting tailored to L.A. Care's oversight activities. These investments improve monitoring of the performance of non-delegated enterprise functions, as well as entities in L.A. Care's extended service delivery model across lines of business. This initiative is improving data sources and reporting for numerous Key Performance Indicators (KPIs) for L.A. Care. • QNXT Upgrade & Transformation. L.A. Care is making progressive investments in its core claims platform (QNXT), with current work focused on the implementation of new UM capabilities, as well as meeting Transparency in Coverage requirements. L.A. Care is also laying the foundation for a future move to a cloud implementation, with related efforts to reduce dependence on custom code, as well as completing an incremental upgrade of the software to meet business needs.	

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	Mr. Shah noted the leasehold improvements capital investments will be at the 1200 W. 7th Street offices. • Leasehold Improvements. The capital budget includes funds to support construction associated with two Community Resource Centers (CRC), Lincoln Heights (new), Palmdale (relocation), miscellaneous upgrades to existing CRCs and a budget for the build-out of the 1200 W. 7th Street lease space to support the return to work/hybrid office configuration effective January 2025. *Board Members Ballesteros and Vaccaro may have financial interests in Plans, Plan Participating Providers or other programs and as such should consider refraining from the discussion of such issues. In order to expedite the process, those Board Members' vote on the Budget reflects a vote concerning the entire budget excluding those items for which the member is abstaining, as identified below:* *For the Community Health Improvement Programs:* *Board Members Ballesteros and Vaccaro* *Community Health Investment Fund* *SCOPE Fund* *Board Members Ballesteros* *Work Force Development Initiative Provider Recruitment Program* **Motion FIN 103.0924** **To approve the Fiscal Year 2024-25 Operating and Capital Budget, as submitted.**	**Unanimously Approved. 8 AYES**
• Monthly Investments Transactions Report	Mr. Shah referred to the investment transactions reports included in the meeting materials (a *copy of the reports can be obtained by contacting Board Services).* This report is provided to comply with the California Government Code and is presented as an informational item. L.A. Care's total investment market value as of July 31, 2024, L.A. Care's total investment market value was $3.7 billion. • $3.6 billion managed by Payden & Rygel and New England Asset Management (NEAM) • $88 million in BlackRock Liquidity T-Fund • $11 million in Los Angeles County Pooled Investment Fund • $6 million in Local Agency Investment Fund	
• Quarterly Internal Policy Reports	Mr. Shah referred to the expenditure reports pursuant to internal policies that are included in the meeting materials. The reports relate to business travel and non-travel related expenses and authorization and approval policies and purchases over $250,000, and sole source purchases over $250,000.	
Technical Advisory Committee	Dr. Li reported that the Technical Advisory Committee met on August 8. • He provided a Chief Health Equity Officer update with a focus on the equity practice	

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	transformation program, which has been modified by the state from a five year to a three year program, as well as some of the milestones and goals. There were 48 practices originally that were interested or signed up for participation, two have opted to opt out in part because of a reduction in payment as well as changes in the rules. • The Committee members shared their expertise on assessment of the impact and success of programs developed and implemented. Some areas of discussion were around missing data, outcomes and thinking through are causal or inference with regards to the interventions. The group provided supportive information on the methods. • Ms. Schiffer discussed the strategic plan with opportunity for committee members to provide feedback. • One of L.A. Care's data scientists shared L.A. Care's approach to categorize and report on race and ethnicity data. The Office of Management and Budget (OMB) updated the race and ethnicity approach in the collection of data.	
Children's Health Consultant Advisory Committee	Dr. Li reported on behalf of Committee Chair Tara Ficek. The Children's Health Consultant Advisory Committee met on August 20. • There was discussion about the rise in anxiety and concern for mental health, and concerns were expressed earlier today as well. LAUSD is one of the first to adopt a policy of no cell phones at schools. • Dr. Amin shared an update on school based mental health programs, including statistics. • The Committee reviewed its Charter, including the purpose of the Committee, and key impact areas. Dr. Li invited the Board and public to share discussion topics. • There are changes in Committee membership. Dr. Lena Shaw, a pediatrician and an expert on California Children's Services, joined the Committee. • Cheri Compartore reported on the 2025 California budget and impacts on the children and youth.	
BOARD COMMITTEE REPORTS		
Executive Committee	**PUBLIC COMMENT** *Ms. Cooper appreciates the new RCAC members and their new input. She is concerned that the executive committee take notice of the RCACs and the ECAC because she feels there needs to be oversight. If one are not on the ECAC, you do not get your agenda. In her opinion, if they get an item on there, it just looked like they're personal agenda, it affects other members. She asks that the Executive Committee start taking notice of the RCACs, because they are the ones who provide the membership. That's very important, and she appreciates the new members. She appreciates all she's hearing from board members, but please take notice. This is her honest and sincere request of the board of governors and executive committee.*	

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	Mr. Fagan wanted to make sure within that budget for the technical upgrades, which sound really great, sounds like a good plan to integrate, you know, healthcare is going digital, but is there a provision of finance being set aside for training at the community centers where the members can get up to speed on the new technology, and would it be available on the website. The Executive Committee met on August 28 (*copies of approved minutes can be obtained by contacting Board Services and will be available on L.A. Care's website*). The Committee reviewed and approved a motion for approve revisions to Human Resources Policies: HR- 628 (Use of Sign on and Retention Bonuses) which does not require full Board approval.	
ADJOURN TO CLOSED SESSION	The Joint Powers Authority Board of Directors meeting adjourned at 3:47 pm. Augustavia J. Haydel, Esq., *General Counsel*, announced the following items to be discussed in closed session. The L.A. Care Board of Governors adjourned to closed session at 3:48 pm. No report was anticipated from the closed session. REPORT INVOLVING TRADE SECRET Pursuant to Welfare and Institutions Code Section 14087.38(n) Discussion Concerning New Service, Program, Business Plan Estimated date of public disclosure: *September 2026* CONTRACT RATES Pursuant to Welfare and Institutions Code Section 14087.38(m) • Plan Partner Rates • Provider Rates • DHCS Rates CONFERENCE WITH REAL PROPERTY NEGOTIATORS Section 54956.8 of the Ralph M. Brown Act Property: 1055 W. 7th St., Los Angeles Agency Negotiator: John Baackes Negotiating Parties: Jamison Services, Inc. Under Negotiation: Price and Terms of Payment THREAT TO PUBLIC SERVICES OR FACILITIES Government Code Section 54957 Consultation with: Tom MacDougall, *Chief Information & Technology Officer* and Gene Magerr, *Chief Information Security Officer*	

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	CONFERENCE WITH LEGAL COUNSEL—ANTICIPATED LITIGATION Significant exposure to litigation pursuant to Section 54956.9(d)(2) of Ralph M. Brown Act: Four Potential Cases CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION Pursuant to Section 54956.9(d)(1) of the Ralph M. Brown Act L.A. Care Health Plan's Notice of Contract Dispute under Contract No. 04-36069 Department of Health Care Services (Case No. Unavailable) CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION Pursuant to Section 54956.9(d)(1) of the Ralph M. Brown Act Department of Managed Health Care Enforcement Matter Numbers: 23-725, 21-855 CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION Pursuant to Section 54956.9(d)(1) of the Ralph M. Brown Act • Department of Managed Health Care Enforcement Matter Numbers: 18-799, 20-063, 21-428, 21-509, 21-680 • Department of Health Care Services, Office of Administrative Hearings and Appeals, In the matter of: L.A. Care Health Care Plan Appeal No. MCP22-0322-559-MF	
RECONVENE IN OPEN SESSION	The L.A. Care Board of Governors and the L.A. Care Health Plan Joint Powers Authority Board of Directors reconvened in open session at 4:09 pm. There was no report from closed session.	

Compliance & Quality Committee	Committee Chairperson Booth reported that the Compliance & Quality Committee met on August 15. Approved meeting minutes can be obtained by contacting Board Services.
	• Todd Gower, *Chief Compliance Officer,* and the Compliance Department gave an update on the following items from the Chief Compliance Officer report:
	  o Risk Committee Report
	  o Enterprise Risk Assessment
	  o Information Technology Risk Report
	  o Delegation Oversight Monitoring Update
	  o Issues Inventory
	  o Internal Audit and Delegation Oversight Auditing
	  o Internal Audit and Delegation Oversight Auditing
	• Compliance continues to strive for continued clarity for the Board on required Compliance matters. Additionally, the draft Compliance and Quality Charter was provided to the C&Q Chair.
	• Dr. Amin presented the Chief Medical Officer report. He gave a report earlier today.
	• Joycelyn Smart-Sanchez provided an overview of the Transitional Care Services (TCS) program, which supports members transitioning between different levels of care, focusing	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	on high-risk populations. She described the phased rollout, starting with high-risk members in January 2023 and extending to all Medi-Cal members by January 2024, highlighting new responsibilities for care managers and the importance of care coordination. Despite challenges in data reporting, the TCS program has served nearly 17,000 members and continues to grow, with efforts underway to expand staffing and improve service delivery. • Rachel Martinez reported on four types of regulatory projects: Quality Improvement Projects (QIPs), Performance Improvement Projects (PIPs), Plan-Do-Study-Act (PDSA) cycles, and Strengths Weaknesses Opportunities and Threats (SWOT) analyses. These projects vary in duration and scope, with PDSAs and SWOTs typically initiated by Medi-Cal when minimum performance levels are not met, such as the 2022 SWOT for Well-Child Visits and Childhood Immunization, which closed in 2023. She highlighted upcoming PIPs for 2023-2026 focusing on disparities in well-child visits for Black/African American children and behavioral health needs related to emergency department use. • Donna Sutton provided an overview of the D-SNP (Dual Eligible Special Needs Plans) program, explaining the purpose of the Star Quality Program, which serves as a tool for CMS to implement federal policy, provide oversight on health plan performance, and offer consumers information to make informed decisions. She outlined the program's timeline, emphasizing that it takes up to three years to receive payment based on performance, and described the 39 metrics across five domains that determine the star rating. Additionally, she discussed new evaluation measures for improvement in Part C and Part D, the impact of the Categorical Adjustment Index (CAI) for plans serving higher-risk populations, and the significance of maintaining high star ratings for financial incentives and industry positioning.	
Provider Relations Advisory Committee	Board Member Booth reported that the Provider relations advisory Committee met on August 21, 2024. Committee received a report on participating physician group scorecards and internal performance metrics. There were discussions regarding prior authorizations, after-hours urgent care and evening clinics.	
Audit Committee	Committee Chairperson De La Torre reported that the audit committee met on August 19 to discuss the audit plan for FY 2023-24 (*contact board services to obtain a copy of approved meeting minutes.)* • The Board has previously delegated authority to the Audit Committee for overseeing the work of the external independent financial audit firm. • The FY 2022-23 audit went smoothly. Deloitte was able to accelerate the audit timeline through expanded interim procedures, implementation of new procedures and claims and other medical expenses and increased use of data analytics and other audit technology.	

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AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• Deloitte and Touch presented the audit plan for FY 2023-24. Planned procedures for this year's audit will be basically the same. It includes engaging in fraud prevention discussions with certain members of senior management and others. Deloitte will evaluate whether L.A. Care has entered into any significant unusual transactions, and if so, the nature, terms and business purpose of those transactions, whether those transactions involved related parties, and evaluate L.A. Care's fraud risk assessment and controls over financial reporting. • The proposed audit fee for 2024 is $476,000 excluding expenses. • The committee approved Deloitte's proposed audit plan. For FY 2324 board approval is not required.	
ADJOURNMENT	The meeting was adjourned at 4:13 pm.	

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

APPROVED BY:
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John Raffoul
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John G. Raffoul, *Board Secretary*
Date Signed 10/7/2024 | 2:26 PM PDT

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