L.A. CARE BOARD OF GOVERNORS MEETING

November 7, 2024 • 1:00 PM

Lobby Conference Room

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

L.A. Care offices have moved to 1200 W. 7th Street, Los Angeles, CA 90017. Public meetings will continue to be held in the Board Room at 1055 W. 7th Street until early 2025.

About L.A. Care Health Plan

Statement

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

Overview

Committed to the promotion of accessible, affordable and high quality health care, L.A. Care Health Plan (Local Initiative Health Authority of Los Angeles County) is an independent local public agency created by the State of California to provide health coverage to low-income Los Angeles County residents. Serving more than 2.6 million members in four product lines, L.A. Care is the nation's largest publicly operated health plan.

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

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

Programs

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

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

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

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

L.A. Care Membership by Product Line – As of October 2024	
Medi-Cal	**2,334,807**
L.A. Care Covered	**196,328**
D-SNP	**20,329**
PASC-SEIU	**49,613**
Total membership	**2,601,077**
L.A. Care Providers – As of April 2022	
Physicians	**5,709**
Specialists	**13,534**
Both	**364**
Hospitals, clinics and other health care professionals	**14,276**
Financial Performance (FY 2023-2024 budget)	
Revenue	**$11B**
Fund Equity	**$1,779,445**
Net Operating Surplus	**$103.9M**
Administrative cost ratio	**5.1%**
Staffing highlights	
Full-time employees (Actual as of September 2023)	**2,269**
Projected full-time employees (FY 2023-2024 budget)	**2,407**

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AGENDA
BOARD OF GOVERNORS MEETING
L.A. Care Health Plan
Thursday, November 7, 2024, 1:00 P.M.
1055 W. 7th Street, Lobby Conference Room 100, Los Angeles, CA 90017

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

To listen to the meeting via videoconference please register by using the link below:
https://lacare.webex.com/lacare/j.php?MTID=mb6a48900092c3e2d6d4c4f52cfc2d83f

To listen to the meeting via teleconference please dial: +1-213-306-3065
English Meeting Access Number: 2482 373 9517 Password: lacare
Spanish Meeting Access Number: 2496 844 9719 Password: lacare

George W. Greene, Esq.
515 S. Figueroa Street, Suite 1300
Los Angeles, CA 90071-3322

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

The purpose of public comment is an opportunity for members of the public to inform the governing body about their views. The Board of Governors appreciates hearing the input as it considers the business on the Agenda.
The process for public comment is evolving and may change at future meetings.
All votes in a teleconferenced meeting shall be conducted by roll call.

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

1. Welcome — Alvaro Ballesteros, MBA, *Chair*
2. Approve today's agenda — *Chair*
3. Public Comment *(Please read instructions above.)* — *Chair*
4. Approve Consent Agenda Items — *Chair*

(A consent agenda is a way the Board of Governors can approve many motions at the same time to improve efficiency at the meeting. Most motions on a consent agenda have already been discussed at a previous Board Committee meeting. According to the Brown Act [California Government Code Section 54954.3(a)], the agenda need not provide an opportunity for public comment on any item that has already been considered by a committee. Sometimes routine motions are placed on the consent agenda by staff, and those have motion numbers that start with "BOG".)

- October 3, 2024 meeting minutes p.17
- Annual Review of Investment Policy AFS 008 **(FIN 100)** p.48
- Revised Compliance & Quality Committee Charter **(COM 100)** p.75
- Children's Health Consultant Advisory Committee Membership **(CHC 100)** p.82
- Regional Community Advisory Committee Membership **(TTECA 100)** p.83

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5. Chairperson Report — *Chair*
   - Nominations of charitable organizations to receive donated Board member stipends.

6. Chief Executive Officer Report p.85 — John Baackes, *Chief Executive Officer*
   - Vision Progress Report p.89
   - Monthly Grants & Sponsorship Reports p.115 — Cherie Compartore, *Senior Director, Government Affairs*
   - Government Affairs Update p.118

7. Chief Medical Officer Report p.164 — Sameer Amin, MD, *Chief Medical Officer*
   - Health Services Strategy Update – Architectural Framework p.178 — John Anthony Madrigal, *Health Services Operations Project Manager III*

8. Chief Financial Officer Report p.204 — Afzal Shah, *Chief Financial Officer*
   - Financial Performance Report – August 2024 **(FIN 101)** p.213 — Jeff Ingram, *Deputy Chief Financial Officer*

9. Performance Monitoring - October 2024 p.223 — Sameer Amin, MD; Acacia Reed, *Chief Operating Officer*

10. Community Health Investment Fund Priorities FY 2024-25 **(BOG 100)** p.246 — Shavonda Webber-Christmas, *Director, Community Benefits*

Public Advisory Committee Reports

11. Temporary Transitional Executive Community Advisory Committee — Fatima Vazquez / Layla Gonzalez, *Consumer member / Advocate member*

12. Children's Health Consultant Advisory Committee — Tara Ficek, MPH, *Committee Chair*

13. Technical Advisory Committee — Alex Li, MD, *Chief Health Equity Officer/Committee Chair*

Board Committee Reports

14. Executive Committee — *Chair*
   - Recommend to the Board that Board Officers election be delayed to the February 2025 meeting. — *Chair*
   - Recommend to the Board that initiation of consideration of a nomination for the seat representing health plan/health insurance expertise be delayed to February 2025. — *Chair*
   - Los Angeles County Department of Public Health Medical Debt Project **(BOG 101)** p.290 — John Baackes, Alex Li, MD

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15. Finance & Budget Committee — G. Michael Roybal, MD, *Committee Member*

16. Compliance & Quality Committee — G. Michael Roybal, MD, *Committee Member*

17. Public Comment on Closed Session Items *(Please read instructions above.)* — *Chair*

ADJOURN TO CLOSED SESSION (Estimated time: 90 minutes) — *Chair*

18. REPORT INVOLVING TRADE SECRET
Pursuant to Welfare and Institutions Code Section 14087.38(n)
Discussion Concerning new Service, Program, Marketing Strategy, Business Plan or Technology
Estimated date of public disclosure: *November 2026*

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

20. CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION
Initiation of Litigation Pursuant to Paragraph (4) of Subdivision (d) of Section 54956.9 of the Ralph M. Brown Act
One Potential Case

21. CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION
Pursuant to paragraph 1 of subdivision (d) of Section 54956.9 of the Ralph M. Brown Act
HRRP Garland, LLC v. Local Initiative Health Authority for Los Angeles County
L.A.S.C. Case No. 21STCV47250

22. PUBLIC EMPLOYEE PERFORMANCE EVALUATION, PUBLIC EMPLOYMENT and CONFERENCE WITH LABOR NEGOTIATOR
Sections 54957 and 54957.6 of the Ralph M. Brown Act
Title: CEO
Agency Designated Representative: Alvaro Ballesteros, MBA

RECONVENE IN OPEN SESSION — *Chair*

23. Consideration of Chief Executive Officer's Compensation — *Chair*

ADJOURNMENT — *Chair*

The next meeting is scheduled on December 5, 2024 at 1 PM, it may be conducted as a teleconference meeting.
The order of items appearing on the agenda may change during the meeting.

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

ACTION MAY NOT BE TAKEN ON ANY MATTER RAISED DURING THE PUBLIC COMMENT PERIODS UNTIL THE MATTER IS SPECIFICALLY LISTED ON A FUTURE AGENDA, according to California Govt Code Section 54954.2 (a)(3) and Section 54954.3.
AGENDA and PRINTED MEETING MATERIALS ARE AVAILABLE FOR INSPECTION 72 HOURS BEFORE THE MEETING:
1. **At L.A. CARE'S Website:** http://www.lacare.org/about-us/public-meetings/board-meetings

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2. **L.A. Care's Reception Area, Lobby, at 1055 W. 7th Street, Los Angeles, CA 90017, or**
3. **by email request to BoardServices@lacare.org**

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

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

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

L.A. Care HEALTH PLAN

Schedule of Meetings
November 2024

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

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

Prepared by mbbalones/printed on 10/21/24

L.A. Care HEALTH PLAN
1200 W. 7th Street, Los Angeles, CA 90017
Tel. (213) 428.5500

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

	MEETING DAY, TIME & LOCATION	MEETING DATES	BOARD MEMBERS / STAFF CONTACT
BOARD OF GOVERNORS	**1st Thursday** 1:00 PM *(for approximately 3 hours)* Lobby Conference Room 100 1055 W. 7th Street Los Angeles, CA 90017	November 7 December 5	Alvaro Ballesteros, MBA, *Chairperson* Ilan Shapiro, MD, *Vice Chairperson* Stephanie Booth, MD, *Treasurer* John G. Raffoul, *Secretary* Jackie Contreras, PhD Hector De La Torre Christina R. Ghaly, MD Layla Gonzalez, George W. Greene, Esq. G. Michael Roybal, MD, MPH Supervisor Hilda L. Solis Nina Vaccaro, MPH Fatima Vazquez **Staff Contact:** John Baackes *Chief Executive Officer, x4102* Linda Merkens *Senior Manager, Board Services, x4050*
BOARD COMMITTEES			
EXECUTIVE COMMITTEE	**4th Wednesday of the month** 2:00 PM *(for approximately 2 hours)* Lobby Conference Room 100 1055 W. 7th Street Los Angeles, CA 90017 **3rd Wednesday due to Thanksgiving holiday*	November 20 * *No meeting in December*	Alvaro Ballesteros, MBA, *Chairperson* Ilan Shapiro, MD, *Vice Chairperson* Stephanie Booth, MD, *Treasurer* John G. Raffoul, *Secretary* G. Michael Roybal, MD, MPH *Governance Committee Chair* *Compliance & Quality Committee Chair* **Staff Contact:** Linda Merkens *Senior Manager, Board Services, x4050* Malou Balones *Board Specialist III, Board Services x4183*

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

	MEETING DAY, TIME & LOCATION	MEETING DATES	BOARD MEMBERS / STAFF CONTACT
COMPLIANCE & QUALITY COMMITTEE	**3rd Thursday of the month** 2:00 PM *(for approximately 2 hours)* Lobby Conference Room 100 1055 W. 7th Street Los Angeles, CA 90017	November 21 *No meeting in December*	Stephanie Booth, MD, *Chairperson* Alvaro Ballesteros, MBA G. Michael Roybal, MD, MPH Fatima Vazquez **Staff Contact:** Victor Rodriguez *Board Specialist II, Board Services x 5214*
FINANCE & BUDGET COMMITTEE	**4th Wednesday of the month** 1:00 PM *(for approximately 1 hour)* Lobby Conference Room 100 1055 W. 7th Street Los Angeles, CA 90017 **3rd Wednesday due to Thanksgiving holiday*	November 20 * *No meeting in December*	Stephanie Booth, MD, *Treasurer* Al Ballesteros, MBA G. Michael Roybal, MD, MPH Nina Vaccaro **Staff Contact:** Malou Balones *Board Specialist III, Board Services x4183*
PROVIDER RELATIONS ADVISORY COMMITTEE	**Meets Quarterly** **3rd Wednesday of meeting month** 9:30 AM *(for approximately 2 hours)* Lobby Conference Room 100 1055 W. 7th Street Los Angeles, CA 90017	November 20	George Greene, Esq., *Chairperson* **Staff Contact:** Linda Merkens *Senior Manager, Board Services, x4050*
AUDIT COMMITTEE	Lobby Conference Room 100 1055 W. 7th Street Los Angeles, CA 90017 **MEETS AS NEEDED**	December 16 10 – 11 am	Hector De La Torre, *Chairperson* Layla Gonzalez George Greene **Staff Contact** Malou Balones *Board Specialist III, Board Services, x 4183*

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

	MEETING DAY, TIME & LOCATION	MEETING DATES	BOARD MEMBERS / STAFF CONTACT
GOVERNANCE COMMITTEE	Lobby Conference Room 100 1055 W. 7th Street Los Angeles, CA 90017 **MEETS AS NEEDED**		Chairperson - **VACANT** Stephanie Booth, MD Layla Gonzalez Nina Vaccaro, MPH **Staff Contact:** Malou Balones *Board Specialist III, Board Services/x 4183*
SERVICE AGREEMENT COMMITTEE	Lobby Conference Room 100 1055 W. 7th Street Los Angeles, CA 90017 **MEETS AS NEEDED**		Layla Gonzalez, *Chairperson* George W. Greene **Staff Contact** Malou Balones *Board Specialist III, Board Services/x 4183*

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L.A. CARE COMMUNITY HEALTH PLAN	**Meets Annually or as needed** Lobby Conference Room 100 1055 W. 7th Street Los Angeles, CA 90017		Alvaro Ballesteros, MBA, *Chairperson* Ilan Shapiro, MD, *Vice Chairperson* Stephanie Booth, MD, *Treasurer* John G. Raffoul, *Secretary* Jackie Contreras, PhD Hector De La Torre Christina R. Ghaly, MD Layla Gonzalez, George W. Greene, Esq. G. Michael Roybal, MD, MPH Supervisor Hilda Solis Nina Vaccaro, MPH Fatima Vazquez **Staff Contact:** John Baackes, *Chief Executive Officer, x4102* Linda Merkens, *Senior Manager, Board Services, x4050*
L.A. CARE JOINT POWERS AUTHORITY	Lobby Conference Room 100 1055 W. 7th Street Los Angeles, CA 90017 **Placeholder meeting*	November 7 December 5	Alvaro Ballesteros, MBA, *Chairperson* Ilan Shapiro, MD, *Vice Chairperson* Stephanie Booth, MD, *Treasurer* John G. Raffoul, *Secretary* Jackie Contreras, PhD Hector De La Torre Christina R. Ghaly, MD Layla Gonzalez, George W. Greene, Esq. G. Michael Roybal, MD, MPH Supervisor Hilda Solis Nina Vaccaro, MPH Fatima Vazquez **Staff Contact:** John Baackes, *Chief Executive Officer, x4102* Linda Merkens, *Senior Manager, Board Services, x4050*

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

PUBLIC ADVISORY COMMITTEES			
CHILDREN'S HEALTH CONSULTANT ADVISORY COMMITTEE GENERAL MEETING	**3rd Tuesday of every other month** 8:30 AM *(for approximately 2 hours)* Lobby Conference Room 100 1055 W. 7th Street Los Angeles, CA 90017		**Tara Ficek, MPH,** *Chairperson* **Staff Contact:** Victor Rodriguez *Board Specialist II, Board Services/x 5214*
EXECUTIVE COMMUNITY ADVISORY COMMITTEE	**2nd Wednesday of the month** 10:00 AM *(for approximately 3 hours)* Lobby Conference Room 100 1055 W. 7th Street Los Angeles, CA 90017	November 13 December 11	**Ana Rodriguez,** *Chairperson* **Staff Contact:** Idalia Chitica**,** *Community Outreach & Education, Ext. 4420*
TECHNICAL ADVISORY COMMITTEE	**Meets Quarterly** **2nd Thursday of meeting month** 2:00 PM *(for approximately 2 hours)* Lobby Conference Room 100 1055 W. 7th Street Los Angeles, CA 90017		Alex Li, MD, *Chairperson* **Staff Contact:** Victor Rodriguez *Board Specialist II, Board Services/x 5214*

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

REGIONAL COMMUNITY ADVISORY COMMITTEES			
REGION 1	11 AM *(for approximately 2-1/2 hours)* L.A. Care Community Resource Center 2072 E. Palmdale Blvd. Palmdale, CA 93550 (213) 438-5580	Friday December 13, 2024	**Staff Contact:** Frank Meza (323) 541-7900 Ramon Garcia (213) 359-0086 *Community Outreach & Education*
REGION 2	10 AM *(for approximately 2-1/2 hours)* L.A. Care Community Resource Center 7868 Van Nuys Blvd. Panorama City CA 91402 (213) 438-5497	Monday November 18, 2024	**Staff Contact:** Martin Vicente (213) 503-6199 Tyonna Baker (213) 760-2050 *Community Outreach & Education*
REGION 3	3 PM *(for approximately 2-1/2 hours)* Community Resource Center in El Monte 3570 Santa Anita Ave. El Monte, CA 91731 (213) 428-1495	Wednesday November 20, 2024	**Staff Contact:** Frank Meza (323) 541-7900 Ramon Garcia (213) 359-0086 *Community Outreach & Education*
REGION 4	10:00 AM *(for approximately 2-1/2 hours)* Community Resource Center in Metro L.A. 11173 W. Pico Blvd. Los Angeles, CA 90064 (310) 231-3854	Tuesday November 19, 2024	**Staff Contact:** Christopher Maghar (213) 549-2146 Cindy Pozos (213) 545-4649 *Community Outreach & Education*
REGION 5	2:00 PM *(for approximately 2-1/2 hours)* Community Resource Center in West L.A. 1233 S. Western Ave. Los Angeles, CA 90006 (213) 428-1457	Thursday December 19, 2024	**Staff Contact:** Christopher Maghar (213) 549-2146 Cindy Pozos (213) 545-4649 *Community Outreach & Education*

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

REGION 6	10:00 AM *(for approximately 2-1/2 hours)* Community Resource Center in South Los Angeles 5710 Crenshaw Blvd. Los Angeles, CA 90043 Community Resource Center in Lynwood 3200 E. Imperial Highway Lynwood, CA 90262	Wednesday December 18, 2024 (South LA)	**Staff Contact:** Martin Vicente (213) 503-6199 Tyonna Baker (213) 760-2050 *Community Outreach & Education*
REGION 7	10:00 AM *(for approximately 2-1/2 hours)* Community Resource Center in East L.A. 4801 Whittier Blvd. Los Angeles, CA 90022 (213) 438-5570 Community Resource Center in Norwalk 11721 Rosecrans Ave. Norwalk, CA 90650 (562) 651-6060	Friday November 15, 2024 (Norwalk)	**Staff Contact:** Kristina Chung (213) 905-8502 Hilda Herrera (213) 605-4197 *Community Outreach & Education*
REGION 8	10:00 AM *(for approximately 2-1/2 hours)* Community Resource Center in Wilmington 911 N. Avalon Blvd. Wilmington, CA 90744 (213) 428-1490 Community Resource Center in Long Beach 5599 Atlantic Ave. Long Beach, CA 90805 (562) 256-9810	Monday December 16, 2024 (Long Beach)	**Staff Contact:** Kristina Chung (213) 905-8502 Hilda Herrera (213) 605-4197 *Community Outreach & Education*

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CONSENT AGENDA

Board of Governors
Regular Meeting Minutes #331
October 3, 2024

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

Members

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

Management

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

**Absent*

*** Via teleconference*

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
WELCOME	Alvaro Ballesteros, MBA, *Board Chairperson,* called the meetings to order at 1:05 pm, 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. Chairperson Ballesteros expressed condolences for the loss of life in the areas affected by Hurricane Helene and his hopes that those who survived will recover and the situation will improve quickly. He wished good health and a Happy New Year for those celebrating Rosh Hashanah. He welcomed everyone, recognizing the new Consumer Advisory Committee members and noting that the voice of the members is very important, and is appreciated by the Board. He outlined the information for public comment included on the meeting Agenda.	
APPROVAL OF MEETING AGENDA	**PUBLIC COMMENT** *Elizabeth Cooper would like to make a change regarding her public comment on page 35 of the September Board of Governors meeting minutes. She met with the Consular General of Israel, of Mexico at a public event. It said she got a letter from Her Majesty the Queen. She would have loved to sit with Her Majesty, but it was incorrect, she got a letter signed by her Lady in Waiting.* The meeting Agenda was approved.	**Unanimously approved.** **9 AYES (Ballesteros, Booth, Contreras, Ghaly, Gonzalez, Raffoul, Roybal, Vaccaro and Vazquez)**

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
PUBLIC COMMENTS	*Elizabeth Cooper commented that she is a consumer, she is not a Board Member. She hopes the Board understands that consumers might not know all the rules, but she tries to comply and respects each and every Board Member. First she would like to wish everyone well for all the holidays that will be celebrated in October. As a member she is concerned about the consumers, they're the ones who make the engine go. As a longtime member of the RCACs she has many issues and she respects all. Members make the engine go and are the ones the Board represents. She thank the human resources director, Mr. Lee, for a good suggestion on the sandwiches. She likes a little bit of humor. She has issues on the agenda, and hopes that the Board please consider the public who take their time to come here and give their public comment, and be a little bit more sensitive to them. They might not know all the rules, but they try to comply with them.*	
APPROVE CONSENT AGENDA ITEMS	**PUBLIC COMMENT** *Elizabeth Cooper commented that she got the Board Meeting materials late. She didn't have time to read it so she's at a disadvantage on the consent items. She would like clarification on some of them like the monthly grants, the Department of Managed Care and Regional Consumer Advisory Committee members. She feels she wasn't properly notified about that.* Chairperson Ballesteros read the items on the Consent Agenda. Board Member Booth noted that a report will be provided to the Board at a future meeting on the Ntooitive contract for marketing campaigns. • August 27, 2024 Special Meeting minutes and September 5, 2024 meeting minutes • Ratify the executed Amendment 03 to the 2024 Medi-Cal Contract 23-30232 between L.A. Care Health Plan and the California Department of Health Care Services **Motion BOG 100.1024*** **To ratify the executed Amendment A03 to the 2024 Medi-Cal Contract 23-30232 between L.A. Care Health Plan and the California Department of Health Care Services.** • Increase the existing purchase order with TRI Ventures (formerly known as Scout Exchange) for contingent worker vendor management services **Motion EXE 100.1024*** **To authorize staff to increase the spend of the existing purchase order, by an additional amount of $12,924,000 not to exceed a total spend of $76,388,908 with TRI Ventures (formerly known as Scout Exchange) for contingent worker vendor**	**Unanimously approved. 9 AYES**

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	management services rendered through the end of the contract term on December 31, 2025. • Authorized signatories for all L.A. Care Health Plan's and L.A. Care Health Plan Joint Powers Authority's (JPA) banking and investment accounts **Motion EXE 101.1024*** **To authorize the employees listed above as authorized signatories for all L.A. Care Health Plan and L.A. Care Health Plan Joint Powers Authority (JPA) banking and investment accounts.** • Ntooitive Contract for marketing campaigns for L.A. Care's direct lines of business, including the L.A. Care Covered (LACC) Shop and Compare Tool, and the Community Resource Centers **Motion EXE 102.1024*** **To authorize staff to execute a new statement of work with Ntooitive in the amount of $15,189,396 for marketing campaigns for L.A. Care's direct lines of business, including the LACC Shop and Compare Tool, and the Community Resource Centers for the period of October 1, 2024 through September 30, 2025.** • Edifecs, Inc. Contract to provide Software as a Service (SaaS) licensing and integration services **Motion EXE 103.1024*** **To authorize staff to execute a contract in the amount of $25,497,331 with Edifecs, Inc. to provide Software as a Service (SaaS) licensing and integration services for the period of October 2024 to September 2029.** • Regional Community Advisory Committee (RCAC) Membership **(ECA 100)** **Motion ECA 100.24*** **To approve the following candidate (s) to the Regional Community Advisory Committees (RCACs) as reviewed by the Temporary Transitional Executive Community Advisory Committee (TTECAC) at their September 11, 2024 meeting:** • **Fedelia Pineda, RCAC 1, Consumer** • **Yajaira Valdovinos, RCAC 1, Consumer** • **Tanya Lopez, RCAC 3, Consumer** • **Elmano Osorio, RCAC 3, Consumer** • **Eugene Beatty, RCAC 4, Consumer** • **Mallery Jena Robinson, RCAC 4, Consumer** • **Julia Wong, RCAC 4, Consumer** • **Diana Camacho, RCAC 5, Consumer**	

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	• **Ana Reyes, RCAC 5, Consumer** • **Lottie Cleveland, RCAC 6, Consumer** • **Daniel Navarro, RCAC 6, Consumer** • **Maria E. Rivas, RCAC 6, Consumer** • **Silvia Sosio, RCAC 6, Consumer** • **Aida Aguilar, RCAC 7, Consumer** • **Brynette Cruz, RCAC 7, Consumer** • **Luci Jeronimo, RCAC 7, Consumer**	
CHAIRPERSON'S REPORT	*Board Member and Supervisor Solis joined the meeting.* **PUBLIC COMMENT** *Elizabeth* Cooper commented that as a consumer member of the RCAC of long standing and a Vice Chair, she appreciates if the Board starts taking notice of the agenda and making sure more public comment is considered by the Board. It is so important because these items and these agendas and these motions are very important that the members of the Board vote on. As a member of the public and one who tries to read the board book as much as she can, please take notice of comments, she didn't come here just to sit on the seat. She came here because she appreciates what the Board is doing and it's very important now, especially in this time of year with our nation, is that we need these programs like healthcare, which is very vital. Chairperson Ballesteros reported that he had the opportunity to join Mr. Baackes, *Chief Executive Officer*, Francisco Oaxaca, *Chief of Communications and Community Outreach & Engagement*, and staff from various community resource centers to receive a special recognition that was organized by Supervisor Hilda Solis at the Board of Supervisors meeting on Tuesday. He thanked Supervisor Solis for recognizing L.A. Care and the Community Resource Centers (CRCs). He congratulated Mr. Baackes, Mr. Oaxaca and staff in all the CRCs across the County. Supervisor Solis commented that it was a great opportunity to recognize the CRCs. When she joined the Board in 2016, one of her first visits was in Pomona. She was really taken by the fact that L.A. Care was working to put resource centers in the community. Mr. Baackes certainly kept his word and the majority of them may be in the first district. She was pleased to meet staff from the CRCs. The celebration was about the invaluable strength, diversity and resources that CRCs provide for the community. She credits L.A. Care, the volunteers and staff at CRCs, and also the collaboration and partnerships with other organizations and the	

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	County. It was a privilege and honor to recognize L.A. Care. Mr. Baackes and Mr. Ballesteros spoke at the event, and it was very well done. She thanked everyone who came to the event. Mr. Baackes appreciated the recognition and not that anyone's counting, four out of the 14 resource centers are in her district. Chairperson Ballesteros thanked and congratulated the CRC staff. He appreciates their hard work in representing the health plan. They are the first line in working in the communities and providing information. Mr. Baackes noted that the ribbon cutting will be held for the new South LA CRC on Friday, October 11 at 10:00 A.M.	
CHIEF EXECUTIVE OFFICER REPORT **Department of Managed Health Care Enforcement Matter**	**PUBLIC COMMENT** *Elizabeth Cooper commented will be sad to see Mr. Baackes leave, and hopes she will still be here giving public comment. On a serious note, she thinks she must say this, she doesn't mean to say it, but how can people get awards when they've hurt so many people. She appreciates what he has done, but when a consumer brings an issue before the Board of Governors out of their heart, that makes a difference in how the awards should go. She is concerned about opening up so many CRCs when the RCACs need to be supported, because they're the ones who get out to the community. They're the ones who network with the people. And she thinks the awards should go to those dedicated RCAC members, all of those who have participated. One objection she has to the acknowledgement of one particular individual and she doesn't think they deserved it from her perspective. She thanked him for his leadership and the late Johnny Cash said, will you miss me when you're gone, and she will.* Mr. Baackes responded that he will miss her, and he will be here for two more meetings. John Baackes, *Chief Executive Officer,* reported a settlement was reached with the California Department of Managed Healthcare (DMHC) and Department of Health Care Services (DHCS) for enforcement actions. L.A. Care was cited in March 2022 on two violations L.A. Care had reported in June of 2021. L.A. Care discovered a trove of appeals and grievances that had not been properly closed. L.A. Care installed a new utilization management system, and within a month noticed it was slowing down the ability to provide authorizations in a timely manner. L.A. Care worked to remediate those as quickly as possible. In March 2022, DMHC and DHCS imposed a fine of $55 million, citing those two violations, an older issue from an audit about the use of the EConsult system at the Los Angeles County Department of Health Services and another old issue about paying interest on late claims. The fine was split between the two departments. L.A. Care objected at the time because it was unprecedented in the amount, five times larger than any prior fines. L.A. Care requested a review through the process outlined in the contract	

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	with each department and filed an appeal. Meanwhile, the remediation of the various items was completed and documented and L.A. Care sent reports to the DMHC and DHCS. Last December he proposed a settlement. DMHC and DHCS announced a fine of $55 million and L.A. Care had listed the fine as a liability in financial reports. He proposed that L.A. Care pay a smaller amount and the balance would be reinvested in the community. The settlement is for L.A. Care to pay $27 million in fines, split between the two departments, and $28 million would be held in a segregated reserve account, to be used over three years for community investments. It was agreed that the community investments would be in the areas of DHCS quality and health equity targets, CalAIM initiatives, and behavioral health integration and transformation. L.A. Care has 90 days to submit a plan for approval by the DMHC and DHCS. The agreement also includes a consultant, paid by L.A. Care, to monitor the areas that were the subject of the enforcement action and report to the two departments quarterly for two years. Mr. Baackes executed the settlement contract a week ago, the DMHC and DHCS officials executed it on Monday, so it is now a closed issue.	
• Monthly Grants and Sponsorships Reports	*Mr. Baackes referred Board Members to the written reports included in the meeting materials.*	
• Potential LA Care Distressed Hospital Financial Assistance	At the last meeting, Mr. Baackes had noted the potential for an L.A. Care distressed hospital financial assistance fund. The preliminary proposal needs more development and will be brought to the Board at a future meeting.	
• Government Affairs Update	Mr. Baackes reported on behalf of Cherie Compartore, Senior Director of Government Affairs. California's Legislative session has ended and the Governor finished signing bills. One new bill is going to shorten the time limit for payment of claims from 45 to 30 days and redefines "clean claims" as complete claims. The 30-day payment period begins in 2026. This is a big change for health care payers. L.A. Care has many business transformation projects underway and has further developments coming along that will support the change. At the federal level, Legislation is being introduced this month to extend the enhanced premium tax credits that are available to people who enroll in the individual health benefit exchange, known in our state as Covered California. This made coverage very affordable for many. Almost 80 % of L.A. Care members enrolled in Covered California pay little or no monthly premium, but are subject to copayments or deductibles. That assistance will expire at the end of 2025 unless legislation makes it permanent. It likely will not pass because of the current divided Congress, but it shows a desire in both houses to maintain health care coverage for millions of people.	

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	Board Member Gonzalez asked about L.A. Care's Community Health Investment Fund (CHIF) programs that provide assistance to providers to obtain accessible exam tables. Deaka McClain, a RCAC member, suggested that electronically operated patient lifts be available to providers who are not able to use the accessible exam tables, so patients who need assistance are able to get on and off of the table. Mr. Baackes responded that in past programs for patient accessibility, L.A. Care recognized that many practices did not have room for the accessible tables and the electronic lifts were part of the program. L.A. Care will continue to make the electronic lifts available. Board Member Gonzalez asked if training on the use of the electronic lifts will be included, because the availability of the equipment does not necessarily mean they will know how to use it. Mr. Baackes noted that in the previous grant funding program for accessible equipment, providers were invited to a demonstration of the equipment, and once installed, the manufacturers provide onsite training.	
• Community Benefits Community Health Investment Fund (CHIF) Summary	Shavonda Webber Christmas, *Director of Community Benefits*, reviewed the 2022-23 summary report (*a copy of her report can be obtained by contacting Board Services*). She noted that the accessible equipment fund will be in next year's report. This report includes grants that were active during 2022-23 with information on activities and objectives that have been completed for each grant. The grant portfolios are based on the priorities that the Board approved at the beginning of the fiscal year. She referred to the spreadsheet in the meeting materials that includes each active grant and the status as of the last available report from the grantee. Ms. Webber Christmas will be at a future Board meeting to discuss the proposed 2024-25 Grant Program. This report represents $29.3 million invested in 167 grants from 2021 to 2023, including the $9.6 million in grants made in 2022-23. The report shows the immense impact of the safety net infrastructure programs as more than 23,000 patients were positively impacted through the addition or advancement of 400 frontline and licensed clinical professionals that were hired or promoted in safety net clinics. In pursuing work on social determinants of health, nearly 100,000 lives were touched by L.A. Care investments to increase food, income, and housing security for marginalized populations. In the category for ending disparities, two years of investments in Generating African American Infant and Nurturers' Survival, the GAAINS Initiative has resulted in 116 live births to Black families and 115 out of 116 Black birthers surviving childbirth of those served by the organizations receiving funds from LA Care. L.A. Care expresses deep condolences to the family of the nurturer that did not survive. Lastly, staff drills down to the root causes of many of these issues by disrupting racism and finds that L.A. Care investments are restoring communities by empowering the organizations that serve them. More than 7,000 lives have been restored as we assist the latest group of BIPOC led and serving organizations to establish long-term and sustainable revenue strategies. She feels privileged to present this report to the Board and to champion the evolution of	

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	systems of care in partnership with each of these amazing and committed organizations that are ensuring the health and wellbeing of every life they touch. Board Member Booth thanked her for the report, noting it is really easy to tell where the money's going and it is nice to be able to read something and not have a lot of questions. Mr. Baackes noted that is a pretty high compliment, and Ms. Webber Christmas could not be a better representative of L.A. Care in the community. The CHIF is sought after as a source of grant funding. Ms. Webber Christmas and her staff are very diplomatic and professional in saying no to organizations that do not have a credible request. They also follow up and get reports on all the grants. That feeds into consideration when that grantee comes back to request more funding. They really do a great job. Board Member Vaccaro echoed Board Member Booth's comment. It is a really beautiful report and it was very heartening to see the impact of L.A. Care's programs. She recognized the team overseeing that and appreciates the responsive grant making. She was scrolling through the list of the organizations that have been funded and she observed that it is a very diverse group. On behalf of the federally qualified and community health centers, she appreciates that L.A. Care grant making funds have impacted the ability for the health centers to provide access to high quality and responsive care in a really holistic way. Board Member Contreras asked of the community reinvestment portion of the settlement referenced at the beginning of Mr. Baackes' report will be connected directly to this initiative, and what that process would look like. Mr. Baackes responded that it will be a separate process. L.A. Care will submit plans to the two departments for approval of the investments. The community health investment fund priorities and grants are made within L.A. Care. The community investments required by the settlement will be unique because they will be reviewed and approved by DHCS and DMHC as a condition of the settlement agreement. There will be three areas, behavioral health, supporting quality initiatives, and CalAIM support. L.A. Care has drafted some proposed community investments that will be refined before submission under the settlement. Chairperson Ballesteros thanked Mr. Baackes and congratulated him for getting that done. It took a while and the outcome is as good as it could be for L.A. Care. Mr. Baackes noted that there was concern about the size of the fine and that the funds would be taken out of the County and placed into the state general fund. The result is that a majority of the fine will be invested with organizations in Los Angeles County. Supervisor and Board Member Solis is excited with the flexibility, and there are joint initiatives underway right now with the county. There is a tremendous need for the unhoused population. She is certain that L.A. Care can align with the state agencies to complement ongoing projects. Mr. Baackes responded that L.A. Care will share with the Board the plans to be proposed for the community investments.	

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CHIEF MEDICAL OFFICER	**PUBLIC COMMENT** *Reginald Fagan is new here. He's very happy to see that L.A. Care was able to settle on the fine. He would also like to ensure resolution of the backlog of grievances. And so in lieu of completing grievances, he's finding as a member that it's just like they're running through the grievances. There's no back and forth with the members. Issues are not really being dealt with. So, he would hate to think that we're going to just eliminate any backlog, but not necessarily deal with the grievance issues.* Mr. Baackes commented that the backlog was cleared by June of 2022. L.A. Care went through every single grievance. Further improvements are being done and part of the consultant monitoring will be to report back to DHCS and DMHC on L.A. Care's progress. *Elizabeth Cooper would like the chief medical officer to be more available to the RCACs. Now that the RCACs have met, there are so many issues like with the COVID vaccine, where they would like to make an inquiry. She can only speak for herself as a RCAC member and have a family member who's a member of L.A. Care. But she would like him to be more accessible to the RCACs so they can have a question and answer. And she thinks he's doing an outstanding job in representing L.A. Care medically, but she thinks some of these concerns that are being addressed and now will be addressed with what he's doing in his relationship.* Sameer Amin, *Chief Medical Officer,* responded that he would love to attend more of the RCAC meetings. He has been to some, but always can do more. Not only attend, but get some staff from the medical side to those RCAC meetings. With the meetings restarted, it is an excellent opportunity to really understand the needs of the members. He will take that to heart and make sure that happens. Dr. Amin reported, following on from Ms. Webber Christmas' presentation, L.A. Care is unique because it is more than an insurance company. It is more than just paying claims or doing the work of an insurance company. Some of that is in how L.A. Care coordinates care for members and makes sure that members can understand the services available. He will ask two members of the health services leadership team to talk about a patient story and how L.A. Care has collaborated with the County to create a singular health care ecosystem.	
• Collaboration with Los Angeles County Fire Department's Advanced Provider	Dr. Amin introduced Noah Kaplan Ng, *Director, Enhanced Care Management* and Joycelyn Smart-Sanchez, *Director, Care Management*. Dr. Amin noted that the patient story actually ties back to a relationship developed with the Los Angeles County Fire Department (LACoFD) and its three advanced provider response units (APRUs). Each APRU covers 10-20 fire stations, and are staffed with a firefighter, a paramedic, and often with a nurse practitioner or LACoFD	

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Response Units (APRU)	physician assistant. The APRU responds to a 9-1-1 call from a patient who has been either consistently calling for help for a low risk issue, or when the main issue is not a health emergency for which the patient needs to be taken to the emergency room, but a call for help navigating the healthcare system. L.A. Care met with LACoFD about the APRUs to gather more information. A major issue was that when the APRU goes to the patient's home to provide access to health care, the APRU could not determine the patient's health care provider. They could not determine whether the person had insurance. L.A. Care has partnered with the LACoFD to get that information to them and work collaboratively to enable the patient to access programs like community supports and enhanced care management. Ms. Smart-Sanchez noted that L.A. Care leadership encourages partnerships and collaboration with organizations that provide support for the members. This story will speak to the power of continuing to reach out to organizations that are doing really great work. L.A. Care has many members, and it is likely that the members encounter various systems and organizations in LA County that are doing great work. It is a matter of finding synergies. L.A. Care wants members to be well and healthy, have access to care, and so do many of these organizations and entities. The APRU started in Arizona. Leadership in the LACoFD learned about the model and adapted it for LA County. It is currently a pilot project, and she hopes it will one day be the norm in supporting members and support their access to ongoing care. L.A. Care met with the medical director at LACoFD, and learned about the APRU. The aim is to reduce the number of low acuity members that are taken to the emergency departments (ED). There are alternative ways to support these individuals. Some have back pain or maybe a laceration. The EDs, especially during COVID, were very crowded. It is important to ensure that individuals with major medical issues are treated at EDs in a timely manner. LACoFD went outside the box to find alternative ways to support individuals who did not need ED treatment, without transporting them to the ED. LACoFD and L.A. Care have synergy in providing low risk care management and stabilize the member. The patient may be unhoused. L.A. Care has many unhoused members who do not know their primary care provider (PCP) nor how to access urgent care. The APRU team that respond to 9-1-1 includes firefighters, a nurse practitioner, a physician assistant, and a doctor. APRU meets with the members wherever they are, and provides interventions to support the patient, stabilizing them, getting them access to their PCP or access to an urgent care as needed. Transportation can be a barrier to care so transportation to medical appointments can be arranged for patients, along with any needed follow up care. L.A. Care has lots of synergies in its current care management for members, which includes a spectrum of services including enhanced care management (ECM). The opportunity for collaboration with LACoFD includes L.A. Care's care management and ECM staff. ECM	

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	supports member through external contracted providers that are in the community to serve members. The providers know the members. The providers are "boots on the ground" just like the APRU. Providers serve individuals that may have many medical and mental health needs. They go out and find people with these needs and offer care where the members are. Noah Ng, his team and the contracted providers do a lot of great work daily. She supports the internal care management team, which includes nurses and social workers that provide very intensive care coordination to ensure that members can successfully navigate the health care system. One major barrier for members is knowing what programs are available. The APRU team informed L.A. Care that often members don't have working phones. They may have contact with L.A. Care members many times every week, and APRU offered to support members with access to ongoing care and support for members. The APRU provides services in a low risk model. APRU responds to the member's call and addresses needs. They meet the member, take vital signs, and may apply stitches. APRU is able to refill prescriptions, especially to hold the member over until they are able to see their PCP or specialist, and arrange transportation. It is common for L.A. Care members to not know about transportation services and L.A. Care is always trying to spread the word. APRU leverages L.A. Care's transportation services. APRU learned about services offered by L.A. Care to support members and has been doing their best to tap into those services. APRU kept responding to the same members repeatedly, and is seeking a long term solution to support these members. Care management and enhanced care management staff provides ongoing support services for members, informs members about the benefits and services available to them and offers ongoing support. It was great to learn that APRU visits the actual members. L.A. Care also has a home visit aspect in care management, and ECM organizations are in the community to provide high-touch services to members. L.A. Care learned that APRU had a list of L.A. Care members lined up to discuss at the meeting. Some of the members had been referred to ECM or were active with ECM but L.A. Care lost contact for various reasons, and L.A. Care was trying to contact the member to provide the needed support. The list contained members active in care management as well. That was an opportunity to apply care coordination with the APRU and L.A. Care, and communicate with the member as well. Members are always at the center of care to ensure the best outcomes for members. Mr. Ng commented that it is an honor to be here with the Board and talk about this connection with APRU. Many things are happening in L.A. County and many people are involved in L.A. Care members' lives. Many people are trying to provide care and are trying to help, but it must be coordinated or it could have negative outcomes for the member. The story that he will share is about an L.A. Care member who was using 9-1-1 to access primary care and basic care needs. The member was calling four to five times a month. There is a cost associated with that and it pulls resources away from true emergencies for LACoFD. L.A.	

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	Care records showed that this member had over 80 ED visits in less than twelve months, going to the ED for care that could have been handled at the primary care office, at urgent care, through case management or even just having someone to talk to. The fire department gets the call and has to go to the member's location. If the member wants, the responders take the member to the ED. The challenge is in supporting the member with their immediate need, while responding in the right way with the right resources. With support from Dr. Amin and leadership in the fire department, L.A. Care staff met with APRU staff to review ways to support these members. The member who was calling more than once a week for assistance had an ECM provider and a case manager in charge of providing for all of the member's needs. Unfortunately, it happens that the member did not have a phone or it was not working. L.A. Care's collaboration with APRU allowed L.A. Care to help bridge the communication with the member. LACoFD was having too much contact with the member frequently calling 9-1-1, and L.A. Care wants to contact the member to encourage the member to connect with the lead care manager for ECM services. Through collaboration with APRU, L.A. Care and the ECM provider, and coordination with the nurse the member needs can be addressed and the member can be redirected to the right sources of care. What is also beautiful about this is that it allows people to help the member and to think about how to best coordinate fire department, ECM and providers. Because of CalAIM programs, such as ECM, the different services in the county can be coordinated to support members. The ECM provider and care management provider can help direct the services. The plan is to have a joint visit, so that the ECM provider and the fire department can go out together to support the member. The fire department now knows who the lead care manager is. If the member calls 9-1-1, the APRU could call the care manager to join them on a visit with the member. Bringing the ECM team into a 9-1-1 call is pretty revolutionary and he is really proud of that. The story may not end with a beautiful bow tie on it as members' lives are complicated and members face many challenges. The collaboration with APRU allows L.A. Care to step into a space that it normally would not be in delivery of care to members. L.A. Care looks forward to continuing this relationship and connecting more members in this way. Supervisor Solis commented she is impressed with the collaboration with the fire department, and she asked how the fire department can work with L.A. Care on the repeat calls, so more prevention can be done instead of reacting at the scene. She asked about potential privacy issues with data the fire department may be able to share. She also asked about determining the right care for patients when responders are not with the APRU. Mr. Ng responded that L.A. Care is looking forward to expanding the program to paramedics. The paramedics are great ambassadors because they are in the APRU and can get the information to others in the fire department. There is a knowledge gap among the paramedics, ED doctors and nurses. A member with Medi-Cal also has benefits that the providers should be able to access. His team	

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	is trying to get the message out that if a member has Medi-Cal, L.A. Care offers a range of services. Mr. Ng noted that L.A. Care uses data to identify members who would be eligible for ECM and send the information to ECM providers, who can reach out to the member by phone or go to the member's home. Two challenges are that data can be delayed as it comes through all of the different systems, and secondly, it is difficult to reach members that need the most help. The APRU relationship helps connect to the member through the care delivered, and the APRU or other responder needs to know that the patient has Medi-Cal through L.A. Care. L.A. Care has a whole team waiting to take on care management and the burden does not have to be on the fire department, so they can focus on the true emergencies. Ms. Smart-Sanchez noted that the APRU is really impressive. They educated themselves about ECM and care management before we met. They have sent a number of referrals to L.A. Care and other managed care plans for challenging cases when member will likely need additional support. L.A. Care will continue to work with APRU. Board Member Roybal thanked them for the presentation, and noted that he is concerned about sustaining the program. He asked if the fire department will be billing for the services or if L.A. Care could use ECM funds to support the program. He asked if the program was limited to areas in the LACoFD jurisdiction, and if other fire departments will be involved in areas where L.A. Care has members. He asked if L.A. Care is trying to make sure that members are aligned with the provider that can provide the best level of service and that providers have the resources and experience for the services the member will need. Mr. Ng responded that L.A. Care would love to have fire departments be contracted ECM providers for this work. L.A. Care started that conversation with the medical director at LACoFD to understand what the challenges may be. Supervisor Solis' support may be important at the Board of Supervisors level. He noted that engaging more county entities in contracts to deliver ECM would allow better coordination. Fewer people coming into member lives can be really valuable. L.A. Care has not yet approached other fire departments. L.A. Care would like to mirror the collaboration in other fire departments but APRU models many not exist yet in other fire departments. L.A. Care has ECM, care management and case management and could support them. With regard to alignment of providers, ECM assignment is not random. Much thought goes into assignment of a member to ECM provider. If L.A. Care is aware that a member has a previous relationship with an ECM provider, the member will be assigned there. Prior relationship is important to avoid too many people coming into the members' lives. L.A. Care also makes sure to assign members to providers that have experience serving the population needs, such as birth equity or homeless services. The location of the member and services available in that area are also important. The needs of the member are considered when making the assignment. Board Member Ghaly thanked them for the presentation, it's a great pilot. She noted that her	

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	understanding is that there are restrictions at the State EMS level for the number of units and the locations where APRUs can be deployed. There has been legislation, supported by Los Angeles County, looking at enhancing APRU deployment or other alternative destination policies, which ultimately have been defeated at the State level. The opposition is from the emergency medicine physician guilds. They oppose deployment of alternative models that result in lower volume of patients coming into the emergency departments, which is at odds with the reimbursement for ED physicians. The financial incentive is to maintain the volume in the EDs, even for low acuity volume for patients who are not best served in the ED. This shows the misalignment of financial incentives and interests of a subset of the physician population with the best interests of the health system and the individual patients. L.A. Care and other payers might want to consider advocacy with the state EMS agency to revive a legislative or regulatory change, or legislative tactics to enhance the APRU deployment or other alternative destinations, which are referred to as pilots because of the restrictions. She followed up on Board Member Roybal's comments with what is experienced in DHS hospitals and other EDs, noting that it is confusing for patients to understand where they are supposed to go for follow up care. The patient may know that L.A. Care managed their Medi-Cal benefits, or the patient may not know that they have L.A. Care. The EDs check to determine the patient's health coverage, their IPA and provider. It is really difficult in the course of a relatively short ED visit to be able to give the patient a specific phone number to call for follow up care because there are many levels of delegated PPGs, IPAs, and MSOs. It would be easier with a widespread education campaign for ED staff to educate them, for example have one phone number for any L.A. Care member regardless of the PPG or where the member is empaneled or which provider is assigned. There are only about 90 EDs in Los Angeles County. It is hard to navigate all the different levels of delegation. It would help to have one phone number for L.A. Care members where the patient can either secure the appropriate follow up, whether it's specialty care, primary care, or to let the patient know where the appropriate phone number is to call. The EDs cannot figure it out in that timeline, and the patient is sent out without the information, which contributes to the patient calling 9-1-1 again because they do not know where to go for care. Dr. Amin acknowledged that those are two important points and Board Member Ghaly is 100 % right about both. Dr. Amin has been working with the LACoFD on advocacy. The current State position is a reason why some of the other fire agencies do not have an APRU program. The medical director at LACoFD indicated that it almost killed the program. Dr. Amin has been discussing how L.A. Care can advocate at the state level, and there may be ways to support it. This relates to Board member Roybal's comment about funding as a community reinvestment, and L.A. Care can explore that. He asked Ms. Smart-Sanchez to respond about transitions of care, it is a segue into L.A. Care's work on transitions of care (TCS), which includes providing a single phone number for members to contact case management. L.A.	

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	Care has a transitions of care number for case management that has been given out to everybody, for whenever a member is leaving the hospital or leaving an ED so that they can call if they need help, and specific case managers are assigned to the highest risk members to ensure follow up care is provided. Ms. Smart Sanchez stated that L.A. Care has a dedicated central intake line for TCS. It is a new regulation as of last year for Medi Cal members in an inpatient setting, the members are considered high risk and must have a single point of contact at the health plan. L.A. Care shares the phone number with the inpatient facility for each member. While L.A. Care has shared that information with many facilities, there is more education needed. L.A. Care has held training sessions, and recognizes that not every facility knows about L.A. Care. She reached out to DHS facilities about ED visits. L.A. Care has a number of members who do not know about PCP follow up, and L.A. Care is working to close that gap. L.A. Care knows that conversation is needed with many more facilities. Board Member Ghaly commented that the limitation of the population health management (PHM) is that the eligibility criteria is inpatient, but that is not addressing the problem with ED visits. By the time a member is admitted, there is enough time to figure out how to connect them. The problem is the patients that are not admitted, and are discharged from the ED. They are technically never inpatients, they do not qualify for PHM, and there is not an eligible single phone number. She does not know if it is a different phone number or a different process, but in terms of targeting the issue of repeat calls to 9-1-1, a high acuity resource, it would be helpful to have a single point of contact for the outpatients as well. She noted that Los Angeles County Department of Health Services (DHS) operates the local EMS agency in Los Angeles County. DHS is a big supporter of the legislation and regulatory changes that were referred to, and DHS is happy to partner with L.A. Care in working with LACoFD. Dr. Amin thanked her for the offer and L.A. Care will look into extending the low risk TCS number to ED discharges. Board Member Booth asked if a discharge from the ED is considered a transition of care so the health plan could arrange services if the member wants it. Dr. Amin explained that high risk membership is considered by population of focus, lower risk populations are reflected in any transition of care. There is a number and a team set up to answer those calls. L.A. Care could extend the single call line to cover the larger populations of people who come out of the ED. It is a matter of education and making sure there is staff for it. Board Member Roybal acknowledged the barrier for implementing funding based on advocacy. He suggested exploring the potential to design "carrots" to help encourage APRUs everywhere. L.A. Care could explore the options to encourage these programs. Chairperson Ballesteros asked if care management staff is working with Housing4Health and with LAHSA on services for the homeless. Ms. Smart-Sanchez noted that homelessness is a population of focus for ECM. Mr. Ng responded that L.A. Care has a trio of community	

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	supports delivered through a contractor network that includes DHS Housing4Health and it is the subcontractor network, along with key stakeholders in the local coordinated entry system (CES) in Los Angeles County, so there is close collaboration. The homeless is one of the largest populations of focus in L.A. Care's ECM network, and many of the providers have dual contracts, offering housing navigation, tenancy support services, and ECM, to minimize the people coming into members' lives. Having one person to coordinate and support the member is the eventual goal.	
PERFORMANCE MONITORING – SEPTEMBER 2024	Dr. Amin reported that L.A. Care is committed to transparency and highlights of the performance dashboard metrics will continue to be reviewed with the Board. He reported that for authorization timelines and timeliness, L.A. Care is hitting 99.6, 99.8 and 99.9 % rates. The results are quite impressive and this excellent performance has continued throughout the year. The most current data for inpatient hospital admissions is from 2023. There is lower hospital admission rates throughout the majority of 2023. The excellent work by the case management team and L.A. Care providers likely contributes to the low rate. During the winter months last year, there was a large wave of respiratory viruses and COVID. He introduced diagrams that plots performance on a variety of metrics for delegated provider groups to show when the rate is outside of the normal. L.A. Care holds joint operating meetings for quality, enterprise level and medical management to discuss the rates outside of the norm and potential causes. L.A. Care also discusses with providers the issues and potential remediation. Throughout most of 2023, L.A. Care performed significantly better than the prior year in the inpatient hospital readmission rate. A lot of resources were used to make that happen. Emergency room visits have been generally tracking last year's performance. There is a plan to address potentially avoidable emergency department outpatient visits. A medical director was hired to work on this measure, and more analytics will be developed to determine next steps. A strategy summit with the entire health services team is planned next week to discuss ways to address issues. A scorecard was created for each provider group, including access, quality metrics, and medical management statistics. L.A. Care will have meetings with providers to go over how they're performing. These have been very informative conversations, in an effort to improve care for members. Noah Paley, *Chief of Staff,* commented that the integrated data sets are used in evaluating primary care practices in the direct network. The charts are helpful in evaluating member experience, utilization and quality metrics for each practice.	

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	Mr. Paley reported that the good news is, since a corrective action plan (CAP) was approved at the beginning of this year, performance by Call the Car (CTC) on telecom services, such as speed to answer and abandonment rate, are performing well above benchmarks. Missed pickups and member grievances are well below the benchmark. For scheduled trips, there is good news since the CAP implementation, CTC has met the 98% benchmark. Unscheduled trips are at 100%. Hospital discharges performance has increased one percentage point but is still 2% below the 100% benchmark. The performance level on hospital transfers has increased from 89% to 96%. Board Member Booth asked about the length of time the drivers are late. Mr. Paley responded that information on the length of time drivers arrive late can be provided. He noted that the volume of rides and calls are very high and increasing steadily. CTC is meeting the demand within performance benchmarks except for discharges and transfers, where it has substantially improved since the CAP was approved. Since July, L.A. Care has been evaluating four alternate vendors for transportation for capacity, willingness to act as a back-up. Two of the four evaluated will submit proposals next week and an alternate vendor will be selected by the end of the month, with service to begin before the end of 2024. Acacia Reed, *Chief Operating Officer,* reported there is little change in the claims received volume, August metric is identical to July. There is an increase in electronic claims received. L.A. Care receives claims electronically from two vendors since the Change Healthcare outage in February. She reviewed a graph showing the breakout of the volume by service type or bill type. There is a slight dip in payment processing for August but still relatively close to July results. At the last board meeting a dip in June results was discussed, with the investigation by claims and finance staff to understand that lower payment month. Interest paid on claims is declining, which is really good. It means that L.A. Care is timely on the majority of metrics, and that when claims are returned for a provider dispute, the outcome of that claim is not changed, which can cause interest payments to occur. For claims payment timeliness, last month the coordination of benefits dip on the 30 day metrics was discussed. She called attention to the 90 calendar day period, degradation will roll through for 90 calendar days and then there will be an uptick. When reported to regulators, these are reported in double digit integers. The scale is different in 90 days, it goes from 100 to 98% versus the other scales, which is why that dip looks so drastic, but March would have factored into a 99%, April actually is a 98%, as is May. The 45 business day volume is not a compliance metric but staff uses it to monitor interest paid on claims. Regarding denials and adjustments, first pass claim denial rate shows a slight uptick, but within the margin under 20%. For total volume processed, there is a new denial category called "Provider". This new category reflects providers not present in L.A. Care's system. Previously these claims would be pended until provider data was received and loaded into	

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	the system. Now they are denied, which triggers action for the provider to submit documentation (such as a TIN, W-9, and other information for credentialing) for L.A. Care to be able to reprocess the claim. The other categories are incorrect billing, benefits, and timely filing. The adjustments are declining, which is always great. Ms. Reed reviewed provider disputes, which is when providers don't agree with L.A. Care's payment of a claim either from an over- or underpayment perspective, and shows a reduced volume in June. As discussed last month that rate moved back up to 99%. Mr. Baackes asked how Ms. Reed feels about implementing the 30-day requirement in January 2026. She is confident in the implementation and noted that performance shows that 30 days is not a problem consistently.	
ADVISORY COMMITTEE REPORT		
Transitional Temporary Executive Community Advisory Committee	**PUBLIC COMMENT** *Elizabeth Cooper asked the Board to please take note of her comment. She doesn't object to the motion. She objects because the member of that committee never to the best of her knowledge, as a parent of a developmentally disabled son who has had issues, she never approaches anyone, it is her issue. She appreciates her, but she's there to represent all of us, not some of us, and sometimes members just direct for their concern. So that's why the ECAC needs to be more proactive. And number two, she would like to mention the RCAC selection committee for the new board chair to take Mr. Baackes' place. She hates to see him go, but she thinks there should be a member of the RCACs to be on that selection committee because his policies, and she's speaking from a point of authority from the enabling legislation where the consumers have points so she does have a point of authority. She would like to see a member of the selection committee to be able to give some advice on what they would like to see in the next CEO. She hopes they'll be like Mr. Baackes. But she does feel that there are some concerns she would like to address, and she would like a RCAC member to be on there so they can give input, because they are part of the enabling legislation, which is a part of the legislature. They didn't give us that responsibility just to be on there. They were part of that to advise the Board and through their elected representatives on the Board. She would like to be, and if you don't have anyone as a long time member she would certainly like to give her input on the next selection committee as one who's been here for many years, and don't take her comments negatively, she feels it's positive and she tries to be a positive role model and some of us won't always be here, but these policies would generate that. And I would like to see the RCACs, the ECAC be more proactive in response. We can't understand the big words you all use because they're very sophisticated,*	

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	but we know as persons, we have to live under the system and to decide the programs that you decide. So please take notice. She's not negative, but she thinks the Board needs to hear this. Please take notice from the bottom of her heart and Board members, please give some input. It's very important because when they come here, sometimes they feel like they're just here without being heard. Chairperson Ballesteros noted that Board Member Gonzalez, *Consumer Advocate*, is a member of the selection committee, and Board Member Vazquez is the consumer representative on the Board of Governors. (*Board Member Vazquez spoke in Spanish and below is a summary of her remarks translated into English.*) Board Member Vazquez reported that TTECAC met on September 11, 2024. She thanked the members that attended the TTECAC in person and those present today. 1. Roger Rabaja 2. Silvia Poz 3. Joyce Sales 4. Maritza Lebron 5. Ana Romo 6. Damares O Hernandez de Cordero 7. Tanya Lopez 8. Alicia Flores 9. Nereyda Ibarra 10. Elizabeth Cooper 11. Estela Lara 12. Myrra Bolla 13. Diana Camacho 14. Maria Montes 15. Lottie Cleveland • She thanked the members that attended the TTECAC meeting both virtually and in person. The comments and questions were greatly appreciated. • Dr. Amin reported on L.A. Care's commitment to the unhoused community, emphasizing a comprehensive approach that goes beyond insurance provision. L.A. Care has allocated $1.2 billion from 2022 to 2029 to support various initiatives, including establishing 10 new street medicine teams and a dedicated program in MacArthur Park, aimed at enhancing healthcare access and social services for vulnerable populations. Board Member Gonzalez, *Consumer Advocate,* reported:	

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	• Brigitte Bailey and Priscilla De La Torre discussed ongoing initiatives to enhance member experience within L.A. Care. They outlined strategies for improving appointment availability, reducing wait times, and increasing telehealth services, highlighting the correlation between positive member experiences and better clinical outcomes. • Dr. Eakins and Ms. De La Torre updated the committee on the reestablishment of the RCACs. "Welcome back" meetings are being held across all eight regions to grow member participation and discuss health care access, quality, and volunteer opportunities within L.A. Care initiatives.	
• Update on Automatic Push Door Request	Board Member Gonzalez noted that in response to a request during public comment from Deaka McClain, TTECAC Vice Chair, the Board will reconsider a motion to place push door buttons on any door accessible to the public at any site used by L.A. Care for public meetings. Chairperson Ballesteros invited a motion to reconsider the motion that was previously tabled. Board Member Booth asked why the Board is reconsidering. Chairperson Ballesteros responded that it is being reconsidered with information from staff on a road forward, so it seems like it's a good thing to do. **Motion to approve reconsideration of the Temporary Transitional Executive Community Advisory Committee's (TTECAC) motion requesting automated access for doors in public areas of L.A. Care offices and Community Resource Centers (CRCs).** Chairperson Ballesteros refereed to the information in the meeting materials. Mr. Baackes commented that he reviewed the information with staff and asked that the recommendation be revised to go above and beyond in response to the request from TTECAC. L.A. Care is currently in compliance with the Americans with Disabilities Act (ADA) access requirements in all facilities. The staff recommends that the Board allow implementation of additional improvements above and beyond what is required by statute or local ordinance, at a cost up to $1 million. The retrofitting costs in the current CRCs is over $500,000. There are other L.A. Care facilities that are not included in that estimate. L.A. Care will be creative about some solutions when the physical layout at some sites prevents installation of an automatic door, but there may be other potential ways to achieve improved access. Staff would report progress regularly to the Board. Board Member Booth asked how well these work. It makes access much easier for anybody that comes through the door. But when they do not work, access can be very difficult, and she is not sure it is worth the cost. She does not want automatic doors on restrooms.	**Unanimously approved.** **9 AYES (Ballesteros, Contreras, Ghaly, Gonzalez, Raffoul, Roybal, Solis, Vaccaro and Vazquez),** **1 ABSTENTION (Booth)**

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	Board Member Gonzalez commented that in her office approximately 50 employees use automatic doors every single day, multiple times a day, and she observed they have only broken down once in the last twelve years. She noted that depending on which vendor you use, they are pretty reliable. Terry Brown, *Chief of Human Resources,* noted that L.A. Care is looking into electric doors similar to a grocery store entrance, while exploring the possibility of using hydraulic doors in certain situations. L.A. Care will evaluate which is best for each environment. Neither can be used on restrooms, and L.A. Care is exploring acceptable alternatives to access, including things like door-less access, similar to airports. That type of access will work for large scale restrooms but not for small ones, and L.A. Care will be creative in an approach that preserves modesty and privacy. Each site may have a different solution to improve access. Supervisor Solis commented on the lease end dates, with the Pacoima site the lease has expired, and she asked what was done. Mr. Baackes responded that the Pacoima CRC now operates in Panorama City in a larger place. Supervisor Solis asked if there are automatic doors there. Mr. Brown responded that those will be retrofitted because that move happened within the last eight months. For future builds, including anything currently in progress, L.A. Care will update access. L.A. Care is looking for larger space for the Palmdale CRC next, it will likely be a full rebuild. Board Member Raffoul noted that L.A. Care buildings meet the regulations for access, so improvements would be above what is required. He asked Afzal Shah, *Chief Financial Officer,* to comment on the whether the financial cost would place undue burden on the financials of the organization. Mr. Shah asked for time to review it. Board Member Booth wondered if the recommended amount will be sufficient for all of the CRCs and doors in the new building. Mr. Baackes responded that the estimate includes retrofitting the 13 CRCs for approximately $513,000. The renovations at 1200 W 7th Street have not yet gotten underway, so an estimated total of $1 million would likely be sufficient. Board Member Vazquez commented that she would like to present the member point of view (*Board Member Vazquez spoke in Spanish and below is a summary of her remarks translated into English*). The members have those types of doors at small clinics. Our members consider this accessibility very important, as there are a lot of members with wheelchairs and walkers for assistance to access their medical services. As a health plan it is our responsibility is to provide the members everything that they require, as possible. The members consider it is very important to have this accessibility. She is here to represent the members and to see if we can reach agreement on this situation. Board Member Roybal commented that the cost is reasonable given the number of locations and the accessibility benefits for members. It is a large amount of money, but spread over many facilities it is a good investment in the sites.	

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	Board Member Booth asked if a particular type of door might become obsolete in a potential future law or regulation. Mr. Baackes responded that L.A. Care would install the state of the art solutions, which should be sufficient. Any new law would likely grandfather existing installations until the life cycle ends. Board Member Roybal noted that doors were installed in his clinic ten years ago and work great without any problems. The doors lock well and are secure, so the experience has been great. **To direct staff to go above applicable ordinance or other requirements in design of automated access in public areas, to be creative with solutions according to what is best for the individual environment with a broader view of improving access issues, and to allocate up to $1 million for retrofit of existing public areas.** *(Afzal Shah, Chief Financial Officer, added this comment later in the meeting and it is recorded here for relevancy.)* Mr. Shah noted that $1 million expenditure does not materially affect L.A. Care, especially because there is a $364 million surplus year-to-date for July. At the same time, L.A. Care continues to watch every dollar for administrative expense. This would not be an administrative expense, it is a non-operating cost, and more of an access and health equity issue. The Board already voted approval. Mr. Baackes commented that L.A. Care is in good hands with Mr. Shah as *Chief Financial Officer*. Mr. Shah noted that this year L.A. Care is challenging every single chief, including the CEO, to reduce overall spending for L.A. Care. There has been spending beyond revenue for administrative expense. He noted there was a good discussion with Board Member Ghaly about that at the last meeting.	**Unanimously approved.** **10 AYES (Ballesteros, Booth, Contreras, Ghaly, Gonzalez, Raffoul, Roybal, Solis, Vaccaro and Vazquez)**
BOARD COMMITTEE REPORTS		
Executive Committee	The Executive Committee met on September 25 *(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 to Delegate Authority to the CEO to execute a membership sponsorship agreement with the California Medical Association for up to 1,153 physicians in L.A. Care's provider network which does not require full Board approval. • The Committee also reviewed and approved a motion for approve revisions to Human Resources Policies: HR-205 (Dress Code), HR-225 (Standards of Employee Training), HR-502 (L.A. Care Employee Handbook and Human Resources Policies), and HR-710 (Reimbursement for Education Expenses), which does not require full Board approval. • The Committee reviewed and approved motions that were approved earlier on Consent Agenda. • The Committee received the Monthly Investment Transactions Reports for August 2024.	

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• Monthly Investments Transactions Report	*Board Member De La Torre joined the meeting.* Mr. Shah reported that the July 2024 financials were presented at the last board meeting, and the August financials will be presented at the next Board meeting. The investment reports for the month of July are in the meeting materials and are informational items with no Board action needed. The investment transactions reports are 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 L.A. Care's total investment market value as of August 31, 2024, was $3.5 billion. • $3.4 billion managed by Payden & Rygel and New England Asset Management (NEAM) • $125 million in BlackRock Liquidity T-Fund • $11 million in Los Angeles County Pooled Investment Fund • $6 million in Local Agency Investment Fund	
Compliance & Quality Committee	**PUBLIC COMMENT** *Elizabeth Cooper feels a little disappointed in how the Board just voted on an item which she appreciates, but when it comes to member issues, unless one is on the ECAC, she's saying this without prejudice, as a member of the RCAC, one does not get a voice brought before the Board. That's why she asked the local initiative, Hilda Solis and the Department of Managed Care, to hear her comments. She appreciates this, but she's looking at this, unless one is on the ECAC, she doesn't object, unless one is on the ECAC, as a member who's been here over 20 years and helped some of the issues that they support now are allow in effect. But unless one is on the ECAC, one does not get an issue brought before, you do not let it get brought before the Board. She doesn't feel they have equal representation whether it's diversity or not, but she does not feel that the L.A. Care is doing equal representation. It's something she does not want to do but the Department of Managed Care and the state legislature gave them the authority to give their point of view. But unless one is on these boards, you do not hear from our representation, in her opinion and others have said it. And that's why she's looking at this and that's why she would like to speak on public evaluation. And now please take notice of her comments, it's not out of madness, it's out of sadness because she just saw a motion presented. But when she brings up an issue as a member of the committee, a longtime member, an advocate for the disabled and*	

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	all, one does not get any input unless one is on the ECAC, and they are selective in what issues they bring. And I have to say that not out of madness, but as a member. The Compliance & Quality Committee met on September 19. The approved August 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: – Chief Compliance Officer Report The Chief Compliance Officer's report included updates from the Internal Compliance Committee, focusing on enterprise risk management and vendor management. L.A. Care is not only responsible for compliance but also for oversight of the compliance for any contracted providers. Key discussions revolved around action plans to enhance vendor oversight and ensure adherence to contractual requirements. – 2024 Enterprise Risk Management Assessment and Action Plans The report highlighted the current status of the enterprise risk management process, detailing actions such as ongoing assessments and leadership reviews of the contracting process. Efforts are underway to formalize vendor risk management and establish a Vendor Risk Committee. – Issues Inventory The Issues Inventory section provides a summary of reported issues over recent months, with a total of 65 open issues noted for 2024. It categorizes issues by status, including those that require oversight, remediation, and tracking, illustrating the organization's ongoing efforts to manage compliance risks effectively. – Appeal and Grievance Report This section reports on appeals and grievance volumes from July 2023 to June 2024, identifying trends in complaints and the highest volume categories. It also outlines the initiatives being implemented to improve data reporting and compliance visibility through a new appeals system expected in 2025. • The committee charter was distributed to the committee for review and will be placed on the October C&Q agenda for approval. • Dr. Amin presented the Chief Medical Officer report. He also gave a report earlier today. • Dr. Li's Quality Improvement and Health Equity Committee (QIHEC) report outlined various initiatives focused on enhancing health equity and addressing disparities within the community, including a gun violence awareness panel that distributed 163 gun locks. Other key findings indicate persistent disparities in clinical outcomes, particularly among Black/African American children in South L.A., with community health workers actively promoting well-child visits and colorectal cancer screening through home test kits. He	

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	noted the importance of data acquisition and demographic updates to better identify disparities, alongside plans to empower provider groups and collaborate with community organizations for culturally tailored outreach materials. • As part of the QOC report, Dr. Sheen said that the Cultural and Linguistic Services Utilization Report indicates that L.A. Care is effectively monitoring its language services, achieving high satisfaction levels among members for translation and interpreting services during the first two quarters of FY2023-24. While telephonic interpreting utilization increased significantly, there were some concerns regarding face-to-face interpreting satisfaction and connection times for telephonic services, primarily due to higher call volumes. • Priscilla Lopez presented the MY2023 survey on access to care. The report highlighted L.A. Care's commitment to maintaining a minimum compliance rate of 80% for appointment availability and after-hours access standards. The survey results revealed that several provider groups performed below expectations, particularly in urgent care and call-back appointments, which negatively impact patient access to timely care. To tackle the performance gaps, L.A. Care plans to implement a range of interventions, including enhanced analytics, targeted education, and proactive outreach efforts aimed at improving provider engagement. L.A. Care will adjust its webinar approach to share best practices and corrective actions, growing its collaboration among provider groups. • Thomas Mendez reported the MY2023 HEDIS results. The report indicates that L.A. Care successfully completed all HEDIS submissions for various lines of business by June 2024, maintaining a consistent 3.5 NCQA Health Plan Rating for Medi-Cal since MY2020. Overall, HEDIS rates have shown improvement since the COVID-19 pandemic, with 11 of 18 Managed Care Accountability Set measures meeting the minimum performance level, contributing to a projected $500,000 reduction in potential penalties from DHCS. Significant gains were noted in Controlling Blood Pressure, Colorectal Cancer Screening, and HbA1c for Diabetics, all exceeding last year's results. *At the conclusion of the Compliance & Quality Committee report Mr. Shah commented on the earlier report from ECAC, and his comments are included above at the end of the ECAC report on page 22.*	
ADJOURN TO CLOSED SESSION	**PUBLIC COMMENT** *Elizabeth Cooper commented that she's looking at the closed session and there are 13 anticipated litigation for LA Care. As a member, she's concerned about the litigation. As a member of the RCAC, when they go before, they get no answer if they have a concern. In fact, she brought up issues which cry out for the Board's attention and she got no response. She wonders if litigation is the only alternative for members. She looks at all the litigation, it is going to cost L.A. Care some money. But where are the consumers when they have a cries out for a concern and members have. Who responds to them? They don't get response*	

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	Who do they go to? This is litigation. Who do we go to? Because this is going to cost L.A. Care some money where maybe it could be put back in for the benefit of all the members. This is not something because it's not about longevity for her being on the committee, but she's looking at the future. And she just would like that when she addresses members of the board and the member of the local initiative, the Honorable Solis, she wants you to know that there are members who have issues, they have no alternative, but these members will have litigation, they will have to respond. And it might cost L.A. Care some money, big money, which can be used for the consumer. She would like the Board to do that, as a member and one who's concerned about the wellbeing, financially and wellbeing. *Joyce Sales is the Interim Chair of RCAC 6. Those who are celebrating the holiday, Happy Holidays. Be safe. Stay protected. She has a comment regarding item 7. The consolidation with the fire department and the advanced provider response unit. One thing that stuck out to her was that Ms. Smart's colleague mentioned that the ECM calls that the patients make are never responded to, but they're in abundant communication with the workers. She has been working and volunteering for the last almost ten years, eight to ten years, as a community advocate and helping the public consumers access health care services and any other services. When you call the agencies, the response is terrible, and this is something well before and beyond COVID. She doesn't know if it's budget or staff, or a lack of concern and people just coming to the office every day and doing the bare minimum and leaving, but how do they get to a point where people who are taking advantage of the ECM programs get a response from the workers, so that they won't have to utilize additional monies to collaborate with city and county agencies. It's very frustrating. She's experienced situations where one gets frustrated and if one has a health condition and it finally gets to a point where it becomes serious, then the last resort, or the only resort, becomes 911. So her comment, her concern, is how do we resolve it? She can complain, complain, and complain. She can be of the pessimistic attitude character, but she's not ever seeing any resolution. She read today billions of dollars, millions of dollars, several hundred millions of dollars, that state of California, Newsom, is delegating and nothing seems to get done. Every day one sees the money is being allocated, but the homeless, the underserved, the non-served, the numbers increase. So, where's the help? What do they do? It's not easy she knows, but it's a major problem and it's the frustration with people taking advantage because they already feel like there's no help and there's not going to be any help.* Dr. Amin understands her concern about agencies not picking up the phone. He feels there may be a misunderstanding with something that Ms. Smart said. The ECM program includes providers, nurses and social workers and case managers, and the issue that Ms. Smart raised was not about a patient calling the ECM provider and they're not picking up the phone. What she was trying to say was that the enhanced care manager, the nurses, and the social workers, are constantly trying to reach out to the patient and cannot reach that patient, but that patient is able to call 911 for assistance. The fire department is getting the call from the patient, and is going out to the patient's house. There is an opportunity to connect that member or that patient back to the enhanced care manager who has been desperately trying to get in contact with them. We're trying to say that there's a magical moment there where the fire department is in the home with that member	

and can call up the enhanced care manager to invite them to see the patient. As a health plan, L.A. Care works to connect the enhanced care manager, the fire department and the member.

Ms. Sales works with a nonprofit that has a licensed social worker and case managers. They are with Health Net, Molina, Aetna, and are in the process of contracting through the state with L.A. Care to provide the ECM program. The social workers are not responding, for whatever the case may be, to the calls that the patients are submitting to them. And that's where the frustration builds up. She may still be misinterpreting what he's said, but as a public individual, she's in agreement with Ms. Cooper that the language, this protocol is completely new to her, but the frustration is, as a public consumer, it's an ongoing thing, and it's extremely frustrating. She doesn't consider herself the smartest chick on the block, but she knows what she's experienced, and knows that it's not always the best service and the best response. And that goes across the board. T hat's not just the healthcare, that's all these systems that are in place that they're constantly giving these buzz names to and reorganizing and reallocating and moving here and moving there and nothing gets done. But the taxes continue to go up and the costs continue to rise, the service and the quality is worse. She's lived here her entire life. She is 65 years old and sees nothing good.

Board Member De La Torre apologized that he was late and missed the presentation. He sees something good with this program. The previous CMO was approached about this program and did not pursue it. He thanked the team for doing it now. This program is common sense. It was piloted in the high desert, had significant success, and it made sense for L.A. Care because there are many members that are high need. He is thankful that we're finally doing it and its starting to yield results. It is not a panacea, it is for a certain segment of the membership, but it will reduce costs and it will improve care for those who have a myriad of needs that aren't being met. They need the support and if it can be provided for pennies on the dollar, then it makes sense on both the care side and the fiscal side. He appreciates that LACoFD for doing this program, it was their initiative and L.A. Care just piled on.
Chairperson Ballesteros thanked Ms. Sales for bringing this up. It is good that she is involved with the RCACs, because discussion on these topics may lead to bringing ideas forward to ECAC and then to the Board.

Ms. Sales noted as she said earlier, there's no result, there's no resolve, and the deficit and the activity, and when she says deficit it's for lack of a better word, she's not referring to money, but the service and the need don't get any better, it tends to get worse. She doesn't know, it's above and beyond what can happen in this room, but it's very frustrating. It's extremely frustrating.
Chairperson Ballesteros suggested that she talk with Dr. Amin directly.
Ms. Sales responded that it's not about being spoken to directly. It's about figuring out the powers that be. It's about figuring out how to really make and see a difference. Even yesterday she was on the phone with AT&T. They transferred her to five different people and she still didn't get a result. So it's not just health care, it's overall services that we're paying for, and there's no benefit. She never feels good about having to pick up the phone and call an agency with the hope that she will get an answer or a result without all the time involved. But yet every day she gets an email from Urban LA which talks about all the development and the state millions and billions of dollars that are coming this way. And there's no improvement. There's

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	absolutely no improvement. She's lived here her entire life, in the same West Adams neighborhood for 20 years. She grew up in the Crenshaw district. She is not impressed with this city. Yet people thankfully keep coming here. But for her, if there was somewhere where she could go and feel like she's living a comfortable life, if she feels like if she has a need, it's will be given attention, there will be a result, then that's where she would be. But that's not the case. We hear the reports, it's <expletive>. It's not about having private conversations to express my same frustration. It's about the powers that be supervisors, politicians, presidents. It's about coming to some kind of resolve to make life better. These Jewish holidays are here and the Jewish community is afraid to celebrate the holidays. Where are we? Who are we? What have we become? *Reginald Fagan Okay thank you for this opportunity. And I'm listening to Ms. Cooper and this lady right here. And kind of in the same spirit, it's almost like you have to consider possibly a lawsuit or going to a state agency to file some type of grievances on another level because you got all these systems and they sound real good, and this just think tank right here. He's checking everybody's credentials and there are heavy people here. But it's still like the lady's saying here, it's the spirit of mediocracy. People doing just enough. He's in a housing program that L.A. Care put him through. But when we talk about social determinants of health, it's a big gap there. L.A. Care has an allergy program. For the last six months, he's been trying to get the pulmonologists to just fill out the form. Six months. A community worker wrote the provider up because every time the form would be faxed, a week later, they called to get the application back and they never acknowledged getting it. This went on about five times. Meanwhile, he's in a place that's just covered with mold, dust and everything else. Talking about social determinants of health, you have a housing component, you have an adaptive organization that deals with coming out, modification, and it just seems like at some point a community worker would say, wait a minute, this provider dropped the ball and let's try to get somebody out there to do an evaluation because we don't want our member in a contaminated facility. But it just seems like it's the hardest thing. So he's sitting back thinking does he call Sacramento? Does he get an attorney? Because he's tired of playing. And so he understands Ms. Cooper's spirit, do they have to sue to get attention. He grew up here. He'll be 67 in two months, he's a LA product. He grew up in Los Angeles, California and is proud of it. He is disappointed in the mediocre attitude. He wants all of you to go back and figure out how to take that extra mile. Go that extra mile. Don't just be concerned to do just the minimum. Because what they're all trying to say is they need you folks, our leadership, to step up and do more. He asked to please forgive him because he doesn't mean to come here, talking in such a manner as disrespectful, but he's tired. At 66 years old he has something to offer to his community and he doesn't want to be stuck. He wants to be well.* Mr. Baackes responded to Mr. Fagan, the same frustration he is talking about, L.A. Care experiences as an organization trying to work with other organizations. He has heard talk about collaboration over and over again because as a health plan, L.A. Care cannot solve all the issues or address all the social determinants of health. And it shows in how L.A. Care is exercising CalAIM. L.A. Care has 85 contractors working on CalAIM. There are more contractors providing	

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	Community Support services. And there are opportunities to use some of the money that's coming through CalAIM working with other city and county agencies. Getting through the years of bureaucratic silos is very difficult. Mr. Baackes doesn't accept mediocrity, and L.A. Care is working very hard to break down the barriers. Proposition 35 is collaboration. He suggested that people read about it and figure out how to vote. It came about because everybody got on the same page and put forward a solution that they think will solve a lot of issues. He understands exactly what they are saying and he asked them not to think the comments have fallen on deaf ears. Board Member Booth asked about Proposition 35. Mr. Baackes noted that Proposition 35 is about an existing tax that has been around since 2009 and lapsed for one year in 2022. The tax is on managed care organizations, it is called the MCO tax. The tax collected is eligible for matching funds from the federal government. In the past, the matching funds have gone into the State's general fund. The proposition would require that the substantial matching funds go to support supplemental reimbursement for providers to participate in Medi-Cal. This is an attempt to close the gap of reimbursement between what a provider receives for Medi-Cal and the amount received for Medicare. Right now Medi-Cal is the lowest reimbursement and the desire is to bring Medi-Cal closer to Medicare. *Elizabeth Cooper commented for the future RCAC members, there's a culture issue there she feels, that she hopes that the Board can address through evaluation. She hopes that the evaluation would include consumer issues and not just those who sit on a different Board. Make sure that the Board gets input, whether it is a list of questions to the RCAC members about what they appreciate and that can be brought before the ECAC. Because other than that, they do not have representation. We have participation, but no member has asked the RCACs, nor the ECAC. There's no objection to the RCACs. She appreciates all the committees that work on their behalf, and she appreciates Board members, but there is a deficit and she thinks that's where making sure that a list of concerns that the members would like to see in the new CEO, and also how they can give input rather than output.* 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: *October 2026* CONTRACT RATES Pursuant to Welfare and Institutions Code Section 14087.38(m) • Plan Partner Rates • Provider Rates	

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	• DHCS Rates • Plan Partner Services Agreement 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 1) *Lakewood Regional Med. Ctr., Inc., et al. v L.A. Care* (JAMS Case No. 1220075422) 2) *Lakewood Regional Med. Ctr., Inc., et al. v L.A. Care* (JAMS Case No. 1220074758) CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION Pursuant to Section 54956.9(d)(1) of the Ralph M. Brown Act 1) *University of Southern California on behalf of its Keck Hospital of USC v. Local Initiative Health Authority for Los Angeles County*, L.A.S.C. Case No. 22STCV02659 2) *University of Southern California on behalf of its USC Verdugo Hills Hospital v. Local Initiative Health Authority for Los Angeles County*, L.A.S.C. Case No. 22STCV15865 3) *University of Southern California on behalf of its Keck Hospital of USC v. Local Initiative Health Authority for Los Angeles County*, L.A.S.C. Case No. 22STCV33996 4) *University of Southern California on behalf of its Keck Hospital of USC and on behalf of its USC Norris Comprehensive Cancer Center v. Local Initiative Health Authority for Los Angeles County*, L.A.S.C. Case No. 23STCV22700 5) *University of Southern California on behalf of its USC Verdugo Hills Hospital v. Local Initiative Health Authority for Los Angeles County*, L.A.S.C. Case No. 23STCV25633 6) *University of Southern California on behalf of its Keck Hospital of USC v. Local Initiative Health Authority for Los Angeles County*, L.A.S.C. Case No. and Norris 23STCV25875 7) *University of Southern California on behalf of its USC Verdugo Hills Hospital v. Local Initiative Health Authority for Los Angeles County*, L.A.S.C. Case No. 24STCV21495 8) *University of Southern California on behalf of its Keck Hospital of USC v. Local Initiative Health Authority for Los Angeles County*, L.A.S.C. Case No. 24STCV20537 9) *University of Southern California on behalf of its Keck Hospital of USC and on behalf of its USC Verdugo Hills Hospital v. Local Initiative Health Authority for Los Angeles County, L.A.S.C. Case No. 23STCV13310*	

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	10) *University of Southern California on behalf of its Keck Hospital of USC, on behalf of its USC Verdugo Hills Hospital, and on behalf of its USC Norris Comprehensive Cancer Center v. Local Initiative Health Authority for Los Angeles County, L.A.S.C. Case No. 24STCV13333* 11) *University of Southern California on behalf of its Keck Hospital of USC v. Local Initiative Health Authority for Los Angeles County*, L.A.S.C. Case No. 24STCV17654 12) *University of Southern California on behalf of its USC Verdugo Hills Hospital v. Local Initiative Health Authority for Los Angeles County*, L.A.S.C. Case No. 22STCV02072	
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 5:28 pm. There was no report from closed session.	
ADJOURNMENT	The meeting was adjourned at 5:28 pm.	

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

APPROVED BY:

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

Board of Governors
MOTION SUMMARY

Date: November 7, 2024 **Motion No. FIN 100.1124**

Committee: Finance & Budget **Chairperson:** Stephanie Booth, M.D.

Issue: Annual Board Review and Approval of the Investment Policy.

Background: L.A. Care policy and procedure requires annual review and approval by the Finance & Budget Committee of the Accounting & Financial Services Policy AFS-008 (Annual Investment Policy). Policy AFS-008 was last reviewed in November 2023. L.A. Care follows the California Government Code. Due to changes and clarifications made in the California Government Code, L.A. Care is putting in those same changes and clarifications in the policy AFS-008.

1. Investment policy section 2.25 & 3.7.15.2 – The term, SOFR (Secured Overnight Financing rate), has been added to the glossary, and, further clarified as an allowed reference rate for variable and floating rate securities.

2. Investment policy section 3.7.13.1.6 – Prohibits the purchase of exchange-traded funds (ETFs) for LA Care investment portfolio. Government code sections 53601 (l) and 53601.6(b) now includes statements regarding the impermissibility of exchange traded funds for public investment portfolios.

3. Investment policy section 3.7.4.1 – Further clarifies allowed issuers and guarantors of federal agency and US government related agencies debt securities.

4. Investment policy section 6.1.1 and 6.2.1 – To more closely match the wording used in the California Government Code, the wording "Finance and Budget Committee" is being replaced with "L.A. Care's legislative body."

Member Impact: None.

Budget Impact: None.

Motion: To approve Accounting & Financial Services Policy AFS-008 (Annual Investment Policy) as submitted.

	ANNUAL INVESTMENT POLICY	**AFS-008**

DEPARTMENT	ACCOUNTING AND FINANCIAL SERVICES
Supersedes Policy Number(s)	

DATES					
Effective Date	1/1/1996	Review Date	~~11/2/2023~~11/7/2024	Next Annual Review Date	~~11/2/2024~~11/6/2025
Legal Review Date	~~10/2/202X/X/2024~~10/7/2024	Committee Review Date	~~XX/10/25/2023/XX/2024~~10/23/2024		

LINES OF BUSINESS

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

DELEGATED ENTITIES / EXTERNAL APPLICABILITY

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

ACCOUNTABILITY MATRIX

Finance and Accounting Services	AFS-008		

ATTACHMENTS

- N/A

ELECTRONICALLY APPROVED BY THE FOLLOWING		
	OFFICER	**DIRECTOR**
NAME	Afzal Shah	Angela Bergman
DEPARTMENT	Finance Services	Accounting and Finance Services
TITLE	Chief Financial Officer	Controller

AUTHORITIES
➢ California Government Code ~~of Regulations (CCR),~~ §§53600-53609 and 53646 ➢ Title 31, Code of Federal Regulations (CFR), §§306.1 et seq. and 350.0 et seq. ➢ L.A. Care Conflict of Interest Code ➢ L.A. Care Code of Conduct ➢ California Health & Safety Code §§1346(a)(11), 1375.1, and 1376 ➢ Knox Keene Health Care Service Plan Act of 1975, Ch. 2.2, §1340 et seq. of Div. 3 of the Health & Safety Code, including the Rules of the DMHC

REFERENCES
➢ NA

HISTORY	
REVISION DATE	**DESCRIPTION OF REVISIONS**
~~X/XX/XX~~11/7/24	Annual Review
11/2/23	Annual review
10/25/22	Annual review
10/25/21	Annual review
10/26/20	Annual review (adding Public bank debt and obligations (Government code section 53601(r))
11/7/19	Annual review
11/1/18	Annual review
10/5/17	Annual review
4/6/2017	Revision; primarily clarification of existing government code sections
11/3/2016	Annual review
11/05/2015	Annual review; primarily format changes
09/11/2014	Annual review
02/28/2013	Annual review; primarily format changes
04/01/2012	Annual review; primarily format changes
01/01/1996	New Policy

1.0 OVERVIEW:

1.1 To establish the investment guidelines for all operating funds and Board designated reserve funds of L.A. Care Health Plan (L.A. Care) invested on and after November ~~2~~1, 202~~3~~4. The objective is to ensure L.A. Care's funds are prudently invested in compliance with applicable requirements and according to the Board of Governors'

objectives to preserve capital, provide necessary liquidity, and to achieve a market average rate of return through economic cycles.

1.2 This Policy only applies to L.A. Care's investment funds. The Policy does not include retirement, retiree health care savings/trust/plan(s), or deferred compensation plans.

2.0 DEFINITIONS:

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

2.1 **Agent:** An independent third party acting for the Custodian. The Investment Manager may act as Agent.

2.2 **Approved NRSRO:** Approved NRSROs consists of the following NRSROs: 1) Standard and Poor's, 2) Moody's, and 3) Fitch Ratings.

2.3 **Bankers' Acceptance:** Time drafts which a bank "accepts" as its financial responsibility as a part of trade finance process.

2.4 **Commercial Paper:** Unsecured promissory notes issued by companies and government entities at a discount.

2.5 **Credit Risk:** The risk of principal loss due to the failure of the issuer of the security.

2.6 **Custodian:** A financial institution that holds securities for the benefit of L.A. Care and has legal responsibility for those securities.

2.7 **Delivery vs. Payment**: A settlement system that stipulates that payment for security must be made at the time the security is delivered to the purchaser or purchaser's agent.

2.8 **Diversification:** The reduction of risk by investing in a variety of assets ~~which~~ to ensure~~s~~ that a portfolio is not concentrated in securities of any one type, industry, or entity.

2.9 **Federal Agencies and U.S. Government Sponsored Enterprises:** Investments which are obligations, participations, and other instruments of, or issued by, a federal agency or a United States government sponsored enterprise, including instruments issued by, or fully guaranteed as to principal and interest by the issuers.

2.10 **Floating Rate Securities:** Securities that provide for the automatic adjustments of its interest rate whenever a specified interest rate changes.

2.11 **Government Pooled Funds:** Funds of various governmental agencies that are pooled together for investment purposes.

2.12 **Investment Manager:** An individual designated by the Chief Financial Officer (CFO) to manage all or any part of ~~the~~ L.A. Care's investment portfolio.

2.13 **Liquidity**: The ability to convert an asset into cash quickly.

2.14 **London Interbank Offered Rate (LIBOR):** The average interest rate that leading banks in London charge when lending to other banks and used as a benchmark for Finance.

2.15 **Market Risk:** The risk of market value fluctuations due to economic change in the interest rate markets.

2.16 **Maturity**: The stated final date at which the principal of the security must be paid, or the unconditional put option date, if the security contains such a provision.

2.17 **Medium Term Maturity Corporate Securities:** Notes issued by a corporation organized and operating within the United States or by depository institutions licensed by the United States, or by any state and are operating within the United States.

2.18 **Money Markets:** A component of financial markets for assets involved in short-term borrowing and lending with original maturities of one year or shorter time frames.

2.19 **Mortgage or Asset Backed Securities:** Securities whereby cash flow from the mortgages, receivables and other assets underlying the security are passed-through as principal and interest payments to the investor.

2.20 **Mutual Funds:** A type of professionally managed investment scheme which pools money from many investors.

2.21 **Nationally Recognized Statistical Rating Organization (NRSRO):** A credit rating agency that issues credit ratings that the U.S. Securities and Exchange Commission (SEC) permits other financial firms to use for certain regulatory purposes. The SEC's Office of Credit Ratings administers the SEC's rules relating to NRSROs, in addition to performing various other functions with respect to NRSROs.

2.22 **Negotiable Certificates of Deposit/Time Deposits:** A negotiable receipt for a time deposit at a bank or other financial institution for a fixed time and interest rate.

2.23 **Public bank**: A corporation, organized under the Nonprofit Mutual Benefit Corporation Law or the Nonprofit Public Benefit Corporation Law for the purpose

of engaging in the commercial banking business or industrial banking business, that is wholly owned by a local agency, local agencies, or a joint powers authority formed pursuant to the Joint Exercise of Powers Act that is composed only of local agencies.

2.24 **Repurchase Agreements:** A purchase of securities under simultaneous agreement to sell these securities back at a fixed price on some future date.

~~2.24~~2.25 **Secured Overnight Financing Rate (SOFR):** Represents a broad measure of the cost of borrowing cash overnight collateralized by Treasury securities.

~~2.25~~2.26 **State of California and Local Agency Obligations:** Registered state warrants, treasury notes or bonds of the State of California and bonds, notes and warrants or other evidence of indebtedness of any local agency of the state including bonds payable solely out of the revenue from a revenue producing property owned, controlled, or operated by the State or local agency or by a department, board, agency, or authority of the State or local agency.

~~2.26~~2.27 **Term**: The remaining time to Maturity when the asset is purchased. Investment Term or remaining maturity shall be measured from the settlement date to final maturity.

~~2.27~~2.28 **U.S. Treasuries:** Direct obligations of the United States government and securities which are fully and unconditionally guaranteed as to the timely payment of principal and interest by the full faith and credit of the United States.

~~2.28~~2.29 **Variable Rate Securities:** Securities that provide for the automatic establishment of a new interest rate on set dates.

3.0 POLICY:

3.1 General

Investment of funds may only be made as authorized by this policy, which conforms to California Government Code (the Code) §53600 et seq., and complies with §1346(a)(11) and §1375.1 et seq. of the California Health & Safety Code, specifically §1376, related to the operations of L.A. Care as a health care service plan licensed pursuant to Health and Safety Code Section 1340, et. seq. and engaged in Medi-Cal, Medicare, and other programs, as well as to customary standards of prudent investment management. Should the provisions of the Code become more restrictive than those contained herein, such provisions will be considered immediately, incorporated into this policy, and appropriately adopted by the Board of Governors and L.A. Care management.

3.2 Investment Objectives

In accordance with the regulations cited herein, L.A. Care's primary annual investment objectives are in order of priority as follows:

3.2.1 Safety and Preservation of Capital

Each investment transaction shall seek to ensure that the capital losses are avoided due to market erosion of security value and institutional default or broker-dealer default. L.A. Care shall seek to preserve capital by mitigating the two types of risk, Credit Risk and Market Risk, as follows:

3.2.1.1 Credit Risk will be mitigated through diversification of the investment portfolio.

3.2.1.2 Market Risk will be mitigated by matching Maturity dates to coincide, as much as possible, with L.A. Care's cash flow requirements. It is explicitly recognized herein, however, that in a diversified portfolio, occasional capital losses are inevitable and must be considered within the context of the overall investment return.

3.2.2 Liquidity and Flexibility

The portfolio investments need to be comprised of investments for which there is a secondary market and which offer the flexibility to be sold at any time at prevailing market values with minimal risk of loss of principal and interest.

3.2.3 Total Return

L.A. Care's portfolio will be designed to achieve a market average rate of return similar to other authorized instruments and securities which have similar security, maturities and levels of risk.

3.3 Authority to Invest

3.3.1 The CFO shall have the authority to invest L.A. Care funds and manage the investment portfolio. Such authority is derived by order from the Board of Governors.

3.3.2 The CFO may designate an Investment Manager(s) to manage all or such portions of L.A. Care's funds as the CFO shall determine from time to time. Such Investment Manager(s) shall be subject to this policy and investment guidelines and any directions provided by the CFO. The CFO will be responsible for all actions undertaken and shall establish a system on internal controls to regulate the activities of subordinate officials, including

the Investment Manager(s). Additional information regarding Investment Manager(s) can be found in Paragraph 3.6.

3.3.3 No person may engage in an investment transaction except as provided herein and in the procedures established by the CFO and/or Board of Governors.

3.4 Prudence

L.A. Care's Board of Governors, CFO, and persons authorized to make investment decisions on behalf of L.A. Care are trustees and fiduciaries subject to the Prudent Investor Standard, defined as follows:

3.4.1 The Prudent Investor Standard, as defined in Government Code §53600.3, requires that when investment officials are investing, reinvesting, purchasing, acquiring, exchanging, selling, or managing funds on behalf of L.A. Care, the investment officials shall act with care, skill, prudence, and diligence under the circumstances then prevailing, including, but not limited to, the general economic conditions and the anticipated needs of L.A. Care that a prudent person acting in a like capacity and familiarity with those matters would use in the conduct of funds of a like character and with like aims, to safeguard the principal and maintain the liquidity needs of L.A. Care. The Prudent Investor Standard shall be applied in the context of managing an overall portfolio.

3.4.2 L.A. Care's investment trustees and fiduciaries as mentioned in Paragraph 3.4 acting in accordance with this policy and any applicable written procedures shall be relieved of personal responsibility for an individual security's credit risk or market risk.

3.5 Ethics and Conflict of Interest

3.5.1 L.A. Care's officers and employees involved in the investment process or having authority or influence over such activities are not permitted to have any material financial interests in financial institutions that conduct business with L.A. Care, and they are not permitted to have any personal financial investment holdings that could be materially related to the performance of L.A. Care's investments.

3.5.2 L.A. Care officers and employees involved in the investment of funds will follow applicable compliance policies related to disclosure of potential conflicts to the extent the personal business activity or material financial interest is one capable of being known.

3.6 Investment Manager

3.6.1 Any designated Investment Manager(s) shall be a fiduciary subject to the Prudent Investor Standard in **Section 3.4.1** with respect to the funds under management.

If outside professional investment management firms are engaged, such firms must be registered investment advisors with the U.S. Security Exchange Commission (the "SEC"), or be appropriately exempt from registration under the SEC Investment Advisers Act of 1940, as amended.

3.6.2 The CFO will:

3.6.2.1 Evaluate candidates for the role of Investment Manager(s). The selected candidates will be reviewed and approved by the Chief Executive Officer (CEO), and Finance and Budget Committee and the Board of Governors.

3.6.2.2 Obtain certification from outside Investment Managers that they will purchase securities from broker-dealers (other than themselves) or financial institutions in compliance with Government Code Section 53601.5 and the Annual Investment Policy.

3.6.2.3 Provide all Investment Manager(s) with a copy of the Annual Investment Policy which will be included in the Investment Manager's contract.

3.6.2.4 Establish and review the targeted average maturities periodically with the Investment Manager(s).

3.6.2.5 Review the investment diversification and portfolio performance monthly to ensure that the Investment Manager's compliance with this policy, risk levels and returns are reasonable, and that investments are diversified according to the policy.

3.6.2.6 Investigate any investment made by the Investment Manager(s) which is not authorized by the policy for possible cause for termination of contract.

3.7 Authorized Investments

3.7.1 Maturity and Term

All investments are subject to a maximum five (5) year Maturity or Term.

For purposes of specified maturity and compliance with this policy:

3.7.1.1 Investments term or remaining maturity shall be measured from the settlement date to final maturity.

3.7.1.2 The purchase of a security with a forward settlement date exceeding 45 days from the time of investment is prohibited.

3.7.2 Eligible Instruments

L.A. Care's Policy is to invest in the high quality instruments as permitted by the Government Code, subject to the limitations of **the Annual Investment Policy.**

3.7.3 U.S. Treasuries (Government Code Section 53601(b))

Types of US Treasuries	***Description***
Treasury Bills	3 months, 6 months, and one year securities and traded at a discount. 3 months, 6 months, and one year securities and traded at a premium or at par value are allowed until 1/1/2026.
Treasury Notes and Bonds	Interest bearing instruments issued with maturities of 2 to 5 years. Non-interest bearing and negative interest rate instruments issued with maturities of 2 to 5 years are allowed until 1/1/2026.
Treasury STRIPS	US Treasury securities that have been separated into their component parts of principal and interest payments and recorded as such in the Federal Reserve book-entry record keeping system.
US Treasury coupon and principal STRIPS	These are not to be considered to be derivatives for the purpose of the **Annual Investment Policy** and are permitted investments.

3.7.3.1 Maximum Term: Five (5) Years

3.7.4 Federal Agencies and US Government Sponsored Enterprises (Government Code Section 53601(f))

3.7.4.1 These are U.S. Government related organizations, the largest of which are federal intermediaries assisting credit markets, and are often simply referred to as "Agencies." ~~Any Federal Agency and U.S. Government Sponsored Enterprise security not specifically listed below is not a permitted investment instrument~~ Only Federal Agency securities issued by one of the agencies specifically listed below, or U.S. Government Sponsored Enterprise (GSE) securities issued and guaranteed by one of the agencies specifically listed below, are permitted investment instruments.

"Agencies" are limited to:	
Federal Agricultural[JC1] Mortgage Association	FRMDN
Federal Home Loan Banks	FHLB
Federal Home Loan Mortgage Corporation	FHLMC
Federal National Mortgage Association	FNMA
Federal Farm Credit Banks	FFCB
~~Student Loan Marketing Association~~	~~SLMA~~[JC2]
Government National Mortgage Association	GNMA
Small Business Administration	SBA
Export-Import Bank of the United States	Ex-Im Bank
U.S. Maritime Administration	MARAD
U.S. Department of Housing and Urban Developments	HUD
Tennessee Valley Authority	TVA

3.7.4.2 Maximum Term: Five (5) Years

3.7.5 State of California and Local Agency Obligations (Government Code Sections 53601(a), (c), (e))

3.7.5.1 Such obligations must be rated A-1, P-1, or equivalent or better short term; or /A-, or equivalent or better long term, by an Approved NRSRO. Public agency bonds issued for private purposes (industrial development bonds) are specifically excluded as permitted investments.

3.7.5.2 Maximum Term: Five (5) Years

3.7.6 Other States' Obligations (Government Code Section 53601(d))

3.7.6.1 Other states' obligations are permitted provided that:

3.7.6.1.1 Registered treasury notes or bonds of any of the other 49 states in addition to California, including bonds payable solely out of the revenues from a revenue-producing property owned, controlled, or operated by a state or by a department, board, agency, or authority of any of the other 49 states, in addition to California. However, ownership of out of state local agency bonds is not allowed.

3.7.6.1.2 Such obligations must be rated A-1, P-1, or equivalent or better short term; or A- /A3, or equivalent or better long term, by an Approved NRSRO.

3.7.6.2 Maximum Term: Five (5) Years

3.7.7 Bankers' Acceptances (BA) (Government Code Section 53601(g))

3.7.7.1 These short term notes are sold at a discount, and are obligations of the drawer (the bank's trade finance client) as well as the bank. Once accepted, the bank is irrevocably obligated to pay the BA upon Maturity if the drawer does not pay.

3.7.7.2 Eligible Bankers' Acceptances are Bankers' Acceptances that are eligible for purchase by the Federal Reserve System, and

3.7.7.3 Drawn on and accepted by a bank rated F1 or better by Fitch, or are rated A-1 for short-term deposits by Standard and Poor's or P-1 for short-term deposits by Moody's.

3.7.7.4 No more than five percent (5%) of L.A. Care's investment funds may be invested in any one commercial bank.

3.7.7.5 Maximum Term: 180 days

3.7.8 Commercial Paper (Government Code Section 53601(h))

3.7.8.1 Commercial Paper is negotiable, although it is usually held to Maturity. The maximum Maturity is 270 days with most Commercial Paper issued for terms of less than 30 days.

3.7.8.2 Investments in Commercial Paper must be:

3.7.8.2.1 Rated A-1, or equivalent, or higher by an Approved NRSRO.

3.7.8.2.2 Issued by corporations rated A-3, or equivalent, or higher by an Approved NRSRO on long term debt, if any, and

3.7.8.2.3 Issued by U.S. corporations or non-U.S. corporations organized and operating within the United States and having total assets in excess of five hundred million dollars ($500,000,000).

3.7.8.2.4 Asset backed Commercial Paper issued by special purpose vehicles (structure investment vehicles) are prohibited.

3.7.8.3 L.A. Care's investment funds may not be used to purchase more than ten percent (10%) of the outstanding Commercial Paper issued by any single issuer.

3.7.8.4 Represent no more than 5% of the portfolio for both Medium Term Maturity Corporate Securities and Commercial Paper combined of any one corporate issuer.

3.7.8.5 Maximum Term: 270 days

3.7.9 Negotiable Certificates of Deposit (CD) (Government Code Section 53601(i))

3.7.9.1 Negotiable Certificates of Deposit must be issued by a nationally or state chartered bank or savings association, state or federal credit unions or by a state-licensed branch of a foreign bank, which have been rated as F1 or better by Fitch, or rated as A-1 for short-term deposits by Standard & Poor's or P-1 for short-term deposits by Moody's. No investment shall be made in Negotiable Certificates of Deposit issued by a state or federal credit union if an Investment Official also serves on the board of directors, or any committee appointed by the board of directors, or the credit committee or the supervisory committee of the state or federal credit union issuing the Negotiable Certificates of Deposit.

3.7.9.2 Maximum Term: 270 days

3.7.10 Non-Negotiable Certificates of Deposit (CD) (Government Code Sections 53601.8 & 53635.8)

3.7.10.1 Investment funds managed by an external Investment Manager may not invest in Non-Negotiable Certificates of Deposit.

3.7.10.2 L.A. Care must choose a nationally or state chartered commercial bank, savings bank, savings and loan association, or credit union in this state to invest the funds, which shall be known as the "selected" depository institution, and the funds shall be known as “Placement Service Deposits.”

3.7.10.3 The selected depository institution may submit the funds to a private sector entity that assists in the placement of certificates of deposit with one or more commercial banks, savings banks, savings and loan associations, or credit unions that are located in the United States, for the local agency's account.

3.7.10.4 The full amount of the principal and the interest that may be accrued during the maximum term of each certificate of deposit shall at all times be insured by the Federal Deposit Insurance Corporation or the National Credit Union Administration.

3.7.10.5 Maximum Term: Five (5) years

3.7.11 Repurchase Agreements (Government Code Section 53601(j))

3.7.11.1 Repurchase Agreements are permitted provided that:

3.7.11.1.1 The terms of the agreement do not exceed one year.

3.7.11.1.2 Repurchase Agreements are permitted if collateralized by U.S. Agencies or U.S. Treasuries with any registered broker-dealer or commercial bank insured by the FDIC so long as at the time of the investment:

3.7.11.1.2.1 Such registered broker-dealer is a recognized primary dealer, and

3.7.11.1.2.2 Such primary broker-dealer (or its parent) has an uninsured, unsecured and unguaranteed obligation rated A-1 short term or A long term, or equivalent or better by an Approved NRSRO.

3.7.11.2 A broker dealer master Repurchase Agreement must be signed by the Investment Manager (acting as “Agent”) and approved by

the Investment Professional prior to entering into any repurchase transaction.

3.7.11.3 The securities are held free and clear of any lien by L.A. Care's Custodian or Agent for the Custodian, and such third party is a:

3.7.11.3.1 Federal Reserve Bank, or

3.7.11.3.2 A bank which is a member of the Federal Deposit Insurance Corporation (FDIC) and which has a combined capital surplus and undivided profits of not less than $50 million and the Custodian shall have received written confirmation from such third party that it holds such securities, free and clear of any lien, as Agent for L.A. Care's Custodian, and

3.7.11.3.3 A perfected first security interest under the Uniform Commercial Code, or book entry procedures prescribed at 31 C.F.R. 306.1 et seq., or 31 C.F.R 350.0 et seq. in such securities is created for the benefit of L.A. Care's Custodian.

3.7.11.4 The Agent must provide L.A. Care's Custodian and Investment Professionals with a valuation of the collateral securities value no less frequently than weekly and shall liquidate the collateral securities if any deficiency in the required one hundred and two percent (102%) collateral percentage is not restored within two business days of such valuation.

3.7.11.5 Maximum Term: One (1) year.

3.7.11.6 Reverse Repurchase Agreements are not allowed.

3.7.12 Medium Term Maturity Corporate Securities (Government Code Section 53601(k))

3.7.12.1 Medium Term Maturity Corporate Securities are corporate and depository institution debt securities with a maximum remaining maturity of five years (5) or less. Medium Term Maturity Corporate Securities must:

3.7.12.1.1 Be Corporate Securities that have a rating of A- or equivalent or better by an Approved NRSROs with a Maturity of five (5) years or less,

3.7.12.1.2 Be issued by corporations organized and operating within the United States or by depository institutions licensed by the United States or by any state and are operating within the United States that have total assets in excess of five hundred million dollars ($500,000,000),

3.7.12.1.3 Represent no more than five percent (5%) of the issue in the case of a specific public offering. This limitation does not apply to debt that is "continuously offered" in a mode similar to Commercial Paper (i.e., medium term notes (MTN's)), and

3.7.12.1.4 Represent no more than 5% of the portfolio for both MTN's and Commercial Paper combined of any one corporate issuer.

3.7.12.2 Maximum Term: Five (5) years

3.7.13 Money Market and Mutual Funds (Government Code Section 53601(l))

3.7.13.1 Investments in shares of beneficial interest issued by diversified management companies (Money Market Funds or Mutual Funds) must be with a company that:

3.7.13.1.1 Attained the highest ranking or the highest letter and numerical rating provided by not less than two nationally recognized rating services, or

3.7.13.1.2 If unrated, all funds must be invested 100% in government securities or securities backed by government collateral.

3.7.13.1.3 Any investments in a Mutual Fund must be with a Mutual Fund that invests in the securities and obligations authorized by Government Code Sections 53601(a) to (r), inclusive.

3.7.13.1.4 Any investments in a Money Market Fund must be with a Money Mutual Fund that follows regulations specified by the SEC under the Investment Company Act of 1940.

3.7.13.1.5 Not more than ten percent (10%) of L.A. Care's investment funds may be invested in any one Mutual

Fund. However, Money Market Funds are not subject to a maximum investment limitation per fund.

3.7.13.1.6 Investment in Exchange Traded Funds (ETFs) are not allowed.

3.7.14 Mortgage or Asset Backed Securities (Government Code Section 53601(o))

3.7.14.1 Though these securities may contain a third-party guarantee, they are a package of assets being sold by a trust, not a debt obligation of the sponsor. Other types of "backed" debt instruments have assets (such as leases or consumer receivables) pledged to support the debt service. However, Mortgage Backed Securities primarily backed by sub-prime collateral are not allowed.

3.7.14.2 Investments in any Mortgage Pass-Through Securities, collateralized Mortgage Obligations, Mortgage Backed or other pay through bond, equipment lease backed certificate, consumer receivable pass through certificate, or consumer receivable backed bonds must be:

3.7.14.2.1 Rated AA-, or its equivalent or better by an Approved NRSRO.

3.7.14.3 Maximum Term: Five (5) years

3.7.15 Variable and Floating Rate Securities

3.7.15.1 Variable and Floating Rate Securities are an appropriate investment when used to enhance yield and reduce risk. They should have the same stability, liquidity and quality as traditional market securities.

3.7.15.2 Variable and Floating Rate Securities with a final Maturity not to exceed five (5) years as described above, must utilize Money Market asset indices such as U.S. Treasury Bills, Federal Funds, Commercial Paper, Secured Overnight Financing Rate (SOFR) ~~LIBOR~~ or a LIBOR alternative reference rate ~~SOFR~~. Investment in Floating Rate Securities whose reset is calculated

using more than one of the above indices are not permitted, i.e., dual index notes.

3.7.15.3 No investments shall be made in inverse floaters, range notes, interest-only strips derived from mortgage pools, and securities that could result in zero-interest accrual if held to maturity. Zero-interest accrual means the security has the potential to realize zero interest depending upon the structure of the security.

3.7.15.3.1 Zero coupon bonds and similar investments that start at a level below the face value are permissible because the value does increase.

3.7.15.3.2 Securities issued by, or backed by, the United States government, in the event of, and for the duration of, a period of negative market interest rates are allowed until 1/1/2026.

3.7.15.4 Maximum term is determined by the underlying security type

3.7.16 Government Pooled Funds (Government Code Section 53601(p))

3.7.16.1 Investments are permitted in Government Pooled Funds including, but not limited to, County Pooled Investment Funds, Joint Powers Authority Pools, the Local Agency Investment Fund, and the Voluntary Investment Program Fund.

3.7.16.2 A Joint Powers Authority Pool must retain an investment advisor who is registered with the SEC (or exempt from registration), has assets under management in excess of $500 million, and has at least five years of experience investing in instruments authorized by Government Code Sections 53601(a) to (r).

3.7.16.3 Any investments in the Voluntary Investment Program Fund must be between $200 million and $10 billion dollars and must be approved by the Board of Governors.

3.7.16.4 For any investments in the Local Agency Investment Fund or County Pooled Investment Fund, the CFO may provide to the Board of Governors and the auditor the most recent statement or statements received from those institutions in lieu of the information otherwise required to be provided in the quarterly reports pursuant to Paragraph 6.2.

3.7.16.5 Maximum Term: Five (5) years (per Government Code Section 53601)

3.7.17 Supranational Obligations (Government Code Section 53601(q))

3.7.17.1 Certain supranational obligations are permitted provided that the obligations are:

3.7.17.1.1 U.S. Dollar denominated,

3.7.17.1.2 Senior Obligations,

3.7.17.1.3 Issued or unconditionally guaranteed by the International Bank for Reconstruction and Development, International Finance Corporation, or Inter-American Development Bank,

3.7.17.1.4 Represent no more than 10% of the portfolio for any one allowed issuer

3.7.17.1.5 Eligible for purchase and sale within the United States, and

3.7.17.1.6 Rated AA-, or equivalent or better by an Approved NRSRO.

3.7.18 Public bank debt and obligations (Government code section 53601(r))

3.7.18.1 A public bank is as defined under section 2.23 of this policy and must be wholly owned by a local agency, local agencies, or a joint powers authority in California.

3.7.18.2 Certain Public bank debt and obligations are permitted as follows:

3.7.18.2.1 Medium Term Maturity Debt Securities. Medium Term Maturity Securities must:

3.7.18.2.1.1 Be rated A- or equivalent or better by an Approved NRSROs with a Maturity of five (5) years or less,

3.7.18.2.1.2 Represent no more than five percent (5%) of the issue in the case of a specific public offering.

3.7.18.2.1.3 L.A. Care's investment funds may not be used to purchase more than five percent (5%) of the outstanding debt securities issued by any single public bank issuer.

3.7.18.2.2 Commercial Paper. Investments in public bank Commercial Paper must be:

3.7.18.2.2.1 Rated A-1, or equivalent, or higher by an Approved NRSRO.

3.7.18.2.2.2 Issued by public banks rated A-3, or equivalent, or higher by an Approved NRSRO on long term debt, if any, and

3.7.18.2.2.3 L.A. Care's investment funds may not be used to purchase more than five percent (5%) of the outstanding Commercial Paper issued by any single public bank issuer.

3.7.18.2.2.4 Maximum Term: 270 days

3.7.19 Securities & Exchange Commission (SEC) Rule 144A Securities

The Securities and Exchange Commission adopted amendments to update and improve the definition of "accredited investor" in the Commission's rules and the definition of "qualified institutional buyer" in Rule 144A under the Securities Act of 1933. The list of entities that are eligible to qualify as QIB in Rule 144A under the Securities Act was expanded to include all institutional investors (including governmental entities) with $100 million or more in their investment portfolio.

3.7.19.1 Rule 144A securities that are consistent with all other sections of the investment policy are permitted.

3.7.20 Securities Lending

3.7.20.1 Securities lending is allowed but are subject to the conditions and restrictions in the California Government Code Sections 53601(j) and 53601(l).

3.7.21 Derivatives

3.7.21.1 Investments in derivative securities are not allowed, except as permitted by this Annual Investment Policy, including but not limited to, US Treasury STRIPS as discussed in Section 3.7.3.

3.8 Diversification Guidelines

3.8.1 Investment Security Diversification at the time of purchase:

Type of Security	***Maximum Portfolio %***
US Treasuries, including STRIPS	100%
Federal Agencies, and US Government Enterprises	100%
State Obligations (CA and others) and CA Local Agency Obligations	30%
Bankers' Acceptances	40%
Commercial Paper	25%
Negotiable Certificates of Deposit	30%
Non-Negotiable Certificates of Deposit	100%
Placement Service Deposits	30%
Repurchase Agreements	100%
Medium Term Maturity Corporate Securities	30%
Money Market Funds and Mutual Funds Combined	20%
Mortgage and Asset Backed Securities	20%
Variable and Floating Rate Securities	*
Government Pooled Funds	100%
Certain Supranational Obligations	30%
Public Bank Obligations	30%
SEC Rule 144A securities	*

* Maximum holding percentage is based on underlying security type limits listed.

3.8.2 Issuer / Counterparty Diversification Guidelines:

Issuer / Counterparty	***Maximum Portfolio %***

Any one Federal Agency or Government Sponsored Enterprise	100%
Any one of the allowed Supranational obligation issuer	10%
The combined Medium Term Maturity Corporate Securities and/or Commercial Paper of any single issuer	5%
Any one Repurchase Agreement counterparty name:	
If Maturity / Term is less than or equal to 7 days	50%
If Maturity / Term is greater than 7 days	25%

3.8.3 For all other securities described under Authorized Investments that are permitted investments, no more than two percent (2%) of L.A. Care's funds may be invested with any one issuer, unless otherwise stated.

3.8.4 L.A. Care's CFO and Investment Manager(s) (if any) must review the portfolio he/she manages to ensure compliance with L.A. Care's Diversification guidelines at the time of each purchase.

3.9 Leverage

3.9.1 The investment portfolio, or investment portfolios managed by an Investment Manager, cannot be used as collateral to obtain additional investment funds.

3.10 Underlying Nature of Investments

3.10.1 L.A. Care and its Investment Manager(s) shall not make investments in organizations which have a line business that is visibly in conflict with public health or the mission of L.A. Care.

3.10.2 L.A. Care and its Investment Manager(s) shall not make investments in Negotiable Certificates of Deposit of a state or federal credit union if a member of its Board or Executive Officers also serves on the Board of Governors of that credit union.

3.10.3 L.A. Care will provide the Investment Manager(s) with a list of corporations that do not comply with the Annual Investment Policy and shall notify its Investment Manager(s) of any changes.

3.10.4 Investment Manager(s) will not enter into any investments with any institutions with which the Investment Manager is affiliated.

3.11 Rating Downgrades

3.11.1 L.A. Care may from time to time be invested in a security whose rating is downgraded below the quality permitted in this Annual Investment Policy.

3.11.2 For any security, whose credit rating falls below the minimum required rating required as per the California Government Code and the Investment Policy, the CFO will make the decision whether to continue to hold the security. For all other security rating downgrades, the decision as to whether L.A. Care will continue to hold that security will be left to the Investment Manager.

3.12 Rating Guidelines

3.12.1 A security must be rated by one or more of the following Approved NRSROs: 1) Standard and Poor's 2) Moody's, or 3) Fitch Ratings. Unless specifically stated otherwise for a specific asset class, if a security is rated at different rating levels by two or more Approved NRSRO's, the highest rating will apply.

3.12.2 All investments must adhere to rating requirements outlined under the sections authorizing their purchase under section 3.7.

3.12.3 Notwithstanding Section 3.7.16, L.A. Care may invest in Government Pooled Funds that invest only in high grade securities or obligations.

4.0 PROCEDURES:

4.1 Safekeeping and Delivery

4.1.1 Investments purchased shall be held by a Custodian bank acting as agent for L.A. Care and such custody agreement shall be in compliance with Government Code Section 53608.

4.1.2 All security transactions, including collateral for repurchase agreements, shall be conducted on a Delivery vs. Payment (DVP) basis. Any exception to this standard delivery practice, e.g., DVP failure necessitating delivery other than by simultaneous exchange, shall require written procedural approval by the CFO.

4.1.3 The CFO shall have the authority to appoint the Custodian and execute the custody agreement.

4.2 Authorized Financial Dealers and Institutions

4.2.1 In compliance with Government Code Section 53601.5, investment transactions initiated by or on behalf of L.A. Care may only be transacted with the following,

4.2.1.1 Banks and securities broker dealers designated as "Primary Dealers" defined by the Federal Reserve Bank of New York.

4.2.1.2 An institution licensed by the state as a broker dealer as defined in section 25004 of the California Corporations Code.

4.2.1.3 A member of a federally regulated securities exchange.

4.2.1.4 A national or State Chartered Bank.

4.2.1.5 A savings association or federal association as defined by section 5102 of the California Financial Code.

5.0 MONITORING:

5.1 Board of Governors

5.1.1 The CFO is responsible for providing the Board of Governors with an Annual Investment Policy, and the Board of Governors is responsible for adopting the Annual Investment Policy and ensuring investments are made in compliance with the AFS-008, Annual Investment Policy. Investments will be made in recognition of L.A. Care's need to comply with tangible net equity (Title 28 California Code of Regulations Section 1300.76) and other solvency and financial reporting requirements set forth by the Department of Managed Health Care. This Annual Investment Policy shall be reviewed and approved annually by the Board of Governors at a public meeting pursuant to Section 53646(a) (2) of the California Government Code.

5.1.2 The CFO is responsible for directing L.A. Care's investment program and for compliance with this policy pursuant to the delegation of authority to invest funds or to sell or exchange securities. The CFO shall provide a quarterly report to the Board of Governors. The CFO shall also provide the Board of Governors with a monthly report of investment transactions.

5.2 Finance and Budget Committee

5.2.1 Duties and responsibilities of the Finance and Budget Committee are distinct from those of the CFO as follows:

5.2.1.1 The CFO and staff are responsible for the day-to-day management of L.A. Care's investment portfolio and the making of specific investments.

5.2.1.2 The Board of Governors is responsible for the Annual Investment Policy. The Finance and Budget Committee shall not make or direct L.A. Care management to make any particular investment, purchase any particular investment product, or do business with any particular investment companies or brokers. It shall not be the purpose of the Finance and Budget Committee to provide advice to the CFO on particular investment decisions of L.A. Care.

5.2.2 The duties and responsibilities of the Finance and Budget Committee shall consist of the following:

5.2.2.1 Review of the Annual Investment Policy annually before its consideration by the Board of Governors and recommend revisions.

5.2.2.2 Review L.A. Care's investment portfolio quarterly to confirm compliance with the Annual Investment Policy, including its diversification and maturity guidelines.

5.2.2.3 Provide comments to the CFO regarding potential investments and potential investment strategies.

5.2.2.4 Periodically review investment security diversification and investment strategies with Investment Manager(s).

5.2.2.5 Perform such additional duties and responsibilities as may be required from time to time by specific action and direction of the Board of Governors.

5.3 Internal Control and Audit

5.3.1 The CFO shall establish internal controls to provide reasonable assurance of compliance with the Annual Investment Policy and the California Government Code. The controls shall also be designed to prevent theft and misuse of funds.

5.3.2 Internal controls should include, but are not limited to:

5.3.2.1 Segregation of duties (e.g., the purchaser of investments is different than the person recording the transaction),
5.3.2.2 Reconciliation of investment report and cash balances, and
5.3.2.3 Authorization of transactions.

5.3.3 To ensure compliance with the Annual Investment Policy, the investment portfolio holdings shall be reviewed monthly by the CFO and staff, and the portion of the investment portfolio that each investment Manager is responsible for shall be reviewed by the respective Investment Manager(s).

5.3.4 An independent review shall be performed on LA Care's investment holdings on a quarterly basis. This review will provide internal control by assuring compliance with investment portfolio requirements established by the Annual Investment Policy.

5.3.5 Investment transactions of L.A. Care may be reviewed during the annual audit performed by the public accounting firm selected by the Audit Committee. The results of the audit of the investment transactions shall be presented in a report prepared by the auditors to the Audit Committee and the Board of Governors for their review, acceptance, and action as the Board of Governors deems necessary. A full audit of the investment of L.A. Care may be requested by the Finance and Budget Committee or Board of Governors at any time.

5.4 Performance Benchmarks

5.4.1 L.A. Care's investment portfolio shall be designed to achieve a market-average rate of return through economic cycles similar to authorized investment instruments, which have similar security maturities and levels of risk.

5.4.2 The performance benchmarks for the investment portfolio will be based upon the market indices for short term investments of comparable risk and duration. These performance benchmarks will be agreed to by the CFO and the Investment Manager(s) and the relative performance of the investment portfolio will be reviewed with the Finance and Budget Committee quarterly.

6.0 REPORTING:

6.1 Monthly (Government Code Section 53607)

6.1.1 The CFO shall submit a monthly report of investment transactions to L.A. Care's legislative body ~~to the Finance and Budget Committee~~ as outlined under Government Code Section 53607.

6.2 Quarterly (Government Code Section 53646)

6.2.1 At a minimum, the CFO shall present a quarterly report with the following information to L.A. Care's legislative body ~~to the Finance and Budget Committee~~:

6.2.1.1 Type of investment;

6.2.1.2 Issuer name;

6.2.1.3 Date of maturity;

6.2.1.4 Par amount;

6.2.1.5 Dollar amount invested in all securities and investments and monies held by L.A. Care;

6.2.1.6 A description of the funds, investments, and programs (including lending programs) managed by contracted parties (i.e., LAIF, investment pools, outside money managers, and securities lending agents);

6.2.1.7 Current market value as of the date of the report of all funds held by L.A. Care and under management of any outside party that is not also a local agency or LAIF and the source of the valuation;

6.2.1.8 A statement of compliance with the investment policy or an explanation for non-compliance; For funds that have been placed in a county investment pool, LAIF, or FDIC insured bank deposit, the CFO may substitute the most recent account statement received from those entities in lieu of the information on these investments that is otherwise required by Section 53646.

6.2.1.9 Return on investments on the total portfolio made by L.A. Care.

L.A. Care
HEALTH PLAN

Board of Governors
MOTION SUMMARY

Date: November 7, 2024

Motion No. COM 100.1124

Committee: Compliance and Quality

Chairperson: Stephanie Booth, MD

Issue: Approval of Revisions to the Compliance and Quality Committee Charter

Background:

Member Impact: None

Budget Impact: None

Motion: **To approve the Revisions to the Compliance and Quality Committee Charter, as presented.**

L.A. Care Health Plan
Board of Governors
Compliance & Quality Committee

CHARTER

I. *General.*

The Compliance & Quality Committee ~~("~~("the ~~committee~~"Committee") of the L.A. Care Health Plan Board of Governors ~~("~~("the ~~board")~~"Board") shall assist the Board in fulfilling its oversight responsibilities concerning the review of L.A. Care Health Plan's compliance with applicable federal and state laws and regulations, policies relating to healthcare-related regulatory compliance and quality issues, and the delivery of quality medical care to the members it serves.

The Committee shall be comprised of Board members, none of whom is an employee of L.A. Care Health Plan. ~~-~~The number of Committee members shall be determined by the Board.~~-~~ Committee members should be independent of management and free of any relationship that, in the opinion of the Board, would interfere with the exercise of independent judgment as a Committee member.

The Committee shall elect one of its members to act as Chairperson of the Committee. The Chairperson shall preside at each Committee meeting. The Chairperson, in consultation with the other Committee members, shall set the agenda of items to be addressed at each meeting.

The Committee shall meet at least ~~four times annually~~quarterly and more frequently, as necessary.~~-~~ It shall make recommendations to the Board periodically, in consultation with the Chief Executive Officer ("CEO") or ~~his~~their designee, ~~and~~ the Chief Compliance Officer ~~of Regulatory Affairs & Compliance,~~("CCO"), and the Chief Medical Officer ("CMO") on those findings and matters within the scope of its responsibility. ~~The~~The CCO leads the Compliance Program and reports directly to the CEO and the Committee~~ shall maintain minutes of all its meetings to document its activities and recommendations.~~. The CMO leads the Quality Program and reports directly to the CEO and the Committee.

L.A. Care Health Plan's compliance framework is informed by the Seven Elements of an Effective Compliance Program, as set forth by the Office of Inspector General ("OIG") of the U.S. Department of Health and Human Services ("HHS"). As indicated in L.A. Care Health Plan's Compliance Program, the Committee shall comply with OIG requirements and guidance, and compliance reports will be aligned with OIG guidance.

II. *Committee Goals.*
~~II.~~
The Committee is committed to helping L.A. Care Health Plan achieve its mission to provide access to quality health care for Los Angeles County's vulnerable and low-income communities and residents and to support the safety net required to achieve that purpose. To that end, the Committee's goal is to foster a culture that strives to enhance L.A. Care Health Plan's value to members and its employees, health care providers, and all other entities with which L.A. Care Health Plan has contracted or subcontracted. The Committee envisions a culture where everyone involved understands compliance and acts to maximize the prevention, detection, reporting, and resolution of all instances of noncompliance. The Committee aspires to a culture that values quality and promotes continuous

quality improvement related to member health care and service at all levels, both inside and outside L.A. Care Health Plan. The primary goals of the Committee are to:

1. Monitor and oversee the quality management of L.A. Care Health Plan, its ~~plan~~Plan Partners, and any contracted or subcontracted entities~~.~~;

2. Assist the Board in fulfilling its fiduciary responsibilities relating to L.A. Care Health Plan's ~~legal and financial~~ compliance with applicable laws, regulatory requirements, ~~industry guidelines,~~ and policies;

3. Ensure that all applicable solvency standards are met with respect to L.A. Care Health Plan's Plan Partners and any contracted or subcontracted entities;

4. Monitor the solvency and claims payment timeliness of any organization that is contracted or ~~sub-contracted~~subcontracted with L.A. Care Health Plan; and

5. Provide a vehicle for communication between the Board and management of L.A. Care Health Plan to ensure proper operations and performance of L.A. Care Health Plan ~~and its stakeholders.~~ , its Plan Partners, and any contracted or subcontracted entities.

III. *Committee Responsibilities.*
~~III.~~
The responsibilities of the Committee, on behalf of the Board, shall include:

1. Ensuring L.A. Care Health Plan ~~–~~adopts and monitors the implementation of policies and procedures and performance standards that require L.A. Care Health Plan and its employees, ~~the~~its Plan Partners, and the providers to act in full compliance with all applicable laws, regulations, and contractual requirements~~; and .~~

2. Receiving and reviewing information necessary to understand L.A. Care Health Plan's compliance risks, including receiving and reviewing policies and procedures and other compliance-related documents.

~~2.~~3. Maintaining communication between the Board, the internal or external compliance auditors, and management of L.A. Care Health Plan.

~~3.~~4. Ensuring ~~that~~ L.A. Care Health Plan addresses and reviews matters concerning or relating to L.A. Care Health Plan's Compliance Program and Plan Partner performance.

IV. *Committee Duties.*
~~IV.~~
In carrying out its responsibilities, the ~~Compliance & Quality~~ Committee shall include, but not limit performance of its duties~~,~~ to, the following:

~~*Compliance*~~*General Duties*~~:~~

Committee members are encouraged to ask questions and relate concerns about any matter they believe relates to the compliance and quality responsibilities of the Board.

Compliance Duties

1. Provide oversight of the implementation ~~and~~, continuance, and effectiveness of L.A. Care Health Plan's Compliance Program (and recommend any revisions thereto, as appropriate) relating to the conduct of business to ensure adherence to L.A. Care Health Plan's Compliance Program policies, the Code of Conduct, governmental rules, regulations ~~and contractual agreements~~, and contractual agreements. Committee members must remain aware that such oversight extends to all other entities with which L.A. Care Health Plan has contracted or subcontracted, as applicable.

2. ~~Ensure that L.A. Care Health Plan's~~Ensure that L.A. Care Health Plan has in place policies and procedures, reporting systems, and programs to provide reasonable assurance that: (a) the operations of L.A. Care Health Plan comply with all applicable federal and state laws and regulations; (b) L.A. Care Health Plan ensures the delivery of quality medical care to its members and promotes member safety; and (c) L.A. Care Health Plan is addressing its regulatory-extended obligations (for compliance and quality accountability) to its providers and vendors.

~~2.~~3. Ensure that L.A. Care Health Plan's mission, values, and Code of Conduct are properly communicated to all employees on an annual basis.

4. ~~Review, revise as necessary,~~Execute the authority delegated by the Board to the Committee to review and ~~recommend approval, at least annually, of~~approve biennially the Code of Conduct.

5. Review and ~~submit it to~~ approve a biennial assessment of compliance. The scope will be based on fulfilling the requirements of an effective compliance program. This must be conducted by a 3rd Party and or L.A. Care Audit Services.

~~3.~~6. Receive reports from the CCO about reportable items from L.A. Care Health Plan's ~~Board for approval~~Internal Compliance Committee.

7. Report at least quarterly to the Board, and as requested by the Board, on its activities, findings, and any recommendations it may have related to the duties delegated to the Committee.

~~4.~~8. Present to L.A. Care Health ~~Plan's~~Plan's Board, as appropriate, such measures and recommend such actions as may be necessary or desirable to assist L.A. Care Health Plan in conducting its activities in full compliance with all applicable laws, regulations, contractual requirements, policies, performance standards, and L.A. Care Health Plan's Code of Conduct. Further, the Committee shall present to the Board, as appropriate, recommendations to establish policies and procedures and performance standards.

9. Receive annual reports on the completeness and timeliness of employee training, the effectiveness of L.A. Care Health Plan's education and training programs, and the challenges associated with the education and training programs.

~~5.~~10. Regularly review reports to assess and monitor the operational performance of each of the Plan Partners to ensure they maintain the standards and requirements set forth in their contracts with L.A. Care Health Plan and set forth in all other applicable laws, procedures, and standards.

~~6.~~11. Make recommendations to the ~~full~~ Board to impose appropriate sanctions, extend or renew contracts, establish policies, procedures and performance standards, impose additional conditions of participation, and review corrective action plans for any organization that is either directly or indirectly contracted with L.A. Care Health Plan.

~~7.~~12. Serve as a hearing committee in connection with recommendations to impose sanctions on any individual or organization that is either directly or indirectly contracted with L.A. Care Health Plan, if required under applicable law or L.A. ~~Care's~~Care Health Plan's policies and procedures.

13. Require management to do the following: conduct audits on healthcare-related compliance, regulatory, or legal concerns and, where appropriate, direct management to provide the results of such audits directly to the Committee or Board; commission such other studies, analyses, reviews, or surveys it deems appropriate to ensure L.A. Care Health Plan's compliance with healthcare-related regulatory requirements; and evaluate the quality of the personnel, committees, and entities providing healthcare-related compliance and regulatory services for L.A. Care Health Plan, subject to the procurement policies and the Board's approval.

14. Receive reports of material and substantiated concerns that one or more entities is not complying with applicable laws or regulations related to compliance, payment integrity, patient safety, or the quality of patient care. Such concerns may include subpoenas, search warrants, or similar requests to L.A. Care Health Plan from the United States Department of Justice ("DOJ"), HHS, the Department of Health Care Services ("DHCS"), or any State Attorney General, or external complaints such as qui tam actions.

15. Receive from staff transparent reporting on material enforcement matters and, upon request, access to communications from monitors and/or consultants required under the enforcement matter.

16. Receive reports of investigations that are occurring, including findings as they become available, mitigation and remedial measures, and the implementation of such mitigation and remedial measures.

Monitoring & Audit Duties~~:~~

1. Provide sufficient opportunity for the ~~Compliance Officer~~CCO and leader of Internal Audits to meet with the ~~Compliance & Quality~~ Committee to provide the Committee with appropriate evaluations of L.A. Care Health ~~Plan~~Plan's Plan Partners' and other contracted or subcontracted entities' compliance with legal, regulatory, and financial solvency standards.

2. Provide oversight of the internal ~~compliance~~ audit functions of L.A. Care Health Plan and external compliance audit functions in connection with the Plan Partners and those entities for which L.A. Care Health Plan has oversight responsibilities, including reporting obligations, the proposed annual audit plans, and the coordination of such plans.

3. Receive and review, as appropriate, reports on compliance issues and risks including but not limited to: compliance and quality; exclusion and sanction monitoring; concerns or cases of

fraud, waste, and abuse; internal and external audit results; clinical risk; patient safety and privacy; operational performance; and corrective action plans and performance improvement. The CCO and CMO will provide, at a minimum, quarterly written reports. For additional Committee meetings, the CCO and CMO (or their approved designee(s)) may provide an oral or written report.

4. Receive in-person reports from any of L.A. Care Health Plan's officers or their designee(s); employees of L.A. Care Health Plan or any other entity with which L.A. Care Health Plan has contracted or subcontracted; or any representative of outside legal, accounting, or other advisors. The Committee, or the Chairperson on behalf of the Committee, may request any of these individuals to attend a Committee meeting. The Committee may request and meet privately with any officer or employee of L.A. Care Health Plan.

Quality Assurance Duties~~:~~

1. Provide oversight of the quality management activities of L.A. Care Health Plan and its contracted and subcontracted entities ~~including~~. Such oversight includes review of the ~~QM~~Quality Management Program, monitoring activities, corrective action plans, and improvement activities.

~~2. Quality Improvement Plan (QIP) and the QIP Annual Work Plan for submission to L.A. Care Health Plan's Board of Governors for approval.~~

2. Execute the authority delegated by the Board to the ~~Compliance & Quality~~ Committee to review and approve the following ~~annual~~ Quality Improvement ~~(~~("QI~~) and~~"), Utilization Management ~~(~~("UM~~)~~"), Compliance, and Internal Audit program documents:

~~• QI Program Document~~

- Annual QI Workplan
- ~~QI~~ Annual QI Report/Evaluation
- Annual UM Program Document
- Annual UM ~~Annual~~ Report/Evaluation
- Annual Compliance Program Report/Evaluation
- Annual Compliance Program Workplan
- Biennial Internal Audit Assessment
- Annual Internal and External Audit Plans

Executive summaries, with key findings and highlights from the documents, shall be submitted to the Board for its information and pursuant to requirements by ~~the State Department of Health Services~~ DHCS and other regulatory bodies.

~~3. Receive periodic reports from the Chief Medical Officer and the Quality Assurance/Quality Improvement Committee~~

3. Receive and review data provided by Centers for Medicare and Medicaid Services ("CMS") to compare L.A. Care Health Plan's quality performance with CMS standards and requirements.

General Duties:

Perform other duties as assigned by the Board ~~of Governors~~.

Amendment of the Compliance and Quality Committee Charter

At a minimum, on a biennial basis, the Committee shall review the Committee Charter, make changes as needed, and approve the amended Charter. The Committee shall then forward it to the Board for approval. Any amendment must be reported and disclosed as required by and in accordance with applicable laws, rules, and regulations.

Reviewed and Approved by:

L.A. Care Health Plan
Board of Governors

John G. Raffoul, DPA, FACHE, Secretary ~~Alexander K. Li, MD, Board Secretary~~
Date: _____

L.A. Care
HEALTH PLAN

Board of Governors
MOTION SUMMARY

Date: November 7, 2024 **Motion No. CHC 100.1124**

Committee: Children's Health Consultant Advisory Committee **Chairperson:** Tara Ficek, MPH

Issue: Approval of Children's Health Consultant Advisory Committee (CHCAC) members

Background:

Member Impact: None

Budget Impact: None

Motion: **To appoint the following candidates on the Children's Health Consultant Advisory Committee (CHCAC):**

- **Alex Li, MD, Chief Health Equity Officer, as member for the Ex-Officio L.A. Care Chief Health Equity Officer Seat**
- **Mona Patel, MD, as member for the Adolescent Health Seat**
- **Smita Malhotra, MD, as member for the Los Angeles Unified School District (LAUSD) Seat**
- **Ankit Shah, MD, as member for the Los Angeles County Department of Health Services (DHS) / California Children's Services (CCS) Seat**

Board of Governors
MOTION SUMMARY

Date: November 7, 2024 **Motion No. TTECA 100.1124**

Committee: Temporary Transitional Executive Community Advisory Committee (TTECAC) **Chairperson:** Ana Rodriguez

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

Background: Senate Bill 2092 requires that L.A. Care Health Plan ensure community involvement through a Community Advisory Committee. L.A. Care's Regional Community Advisory Committee (RCAC) structure is composed of up to 35 members per RCAC. RCAC member recruitment is ongoing to ensure the highest possible community involvement.

Budget Impact: None.

Motion

- **To approve the following candidate (s) to the Regional Community Advisory Committees (RCACs) as reviewed by the Temporary Transitional Executive Community Advisory Committee (TTECAC) at their October 9, 2024, meeting:**
    - **Diane Chavez, RCAC 2, Consumer**
    - **Bolla Myrra, RCAC 2, Consumer**
    - **Troyette Magee Cano, RCAC 4, Consumer**
    - **Martha Perez, RCAC 4, Consumer**
    - **Erki Castro, RCAC 5, Consumer**

CHIEF EXECUTIVE OFFICER REPORT

October 28, 2024

TO: Board of Governors

FROM: John Baackes, *Chief Executive Officer*

SUBJECT: CEO Report – November 2024

The 2025 Open Enrollment Period for the Covered California Exchange is quickly approaching (it begins on November 1). We are proud that L.A. Care has maintained its ability to keep rates affordable while continuing to offer access to high-quality care for our members. This is also the first year that some Deferred Action for Childhood Arrival (DACA) recipients are eligible to apply for coverage through Covered California. We are here to support DACA recipients by offering the most affordable rates across all metal levels in Los Angeles County and access to one of the largest provider networks among Covered California HMO plans.

This month we also celebrated the grand opening of our 13th Community Resource Center in South Los Angeles. One year ago, the South Los Angeles Community Resource Center team surveyed more than 400 residents from the community to learn more about the type of programming they would like offered at the center. A common request was mental health classes for people of all ages. We know that a healthy life depends on more than just medical check-ups, and we are excited to bring South Los Angeles residents a variety of practical resources that enhance both the physical and mental well-being, which ultimately leads to a better quality of life. The South Los Angeles Community Resource Center will offer a variety of classes that support mental health, exercise, healthy cooking, and health education, as well as Medi-Cal and CalFresh enrollment services.

Following are the cumulative totals for some of our community- and provider-focused work.

	Since Last CEO Report	As of 10/28/24
Provider Recruitment Program Physicians hired under PRP[1]	2	194
Provider Loan Repayment Program Active grants for medical school loan repayment[1]	—	192
Medical School Scholarships Grants for medical school scholarships[2]	—	56
Elevating Community Health Home care worker graduates from CCA's IHSS training program	—	7,373

Notes:
1. Effective January 2024, this table will provide cumulative (since program inception) award counts, and will no longer provide "active" award counts.
2. The count includes scholarships that have been awarded and announced, not prospective scholar seats.

Below please find organizational updates for October.

L.A. Care Commits Nearly $2.1 Million to Address Social Factors that Affect Health
We are proud to announce our fifteenth round of Robert E. Tranquada Safety Net Initiative grants totaling $2,075,000, which will support the work of 14 community clinics addressing common social factors impacting their patients' health. Grantee partners will receive up to $150,000 each and will use the funding to implement multidisciplinary strategies to support patient care outside of a clinical setting to improve their overall health and well-being. Through this initiative, it is expected that more than 25,000 people will be reached.

L.A. Care Commits More Than $1.2 Million to Reduce Barriers to Dental Care
We have committed $1.22 million to our Oral Health Initiative which will support ten organizations addressing barriers to oral health care in low-income communities. It is extremely important that we take steps to improve oral health, as it is critical to overall health. Our funding will help these ten award recipients implement projects that will provide outreach, increase engagement and services, and connect patients to necessary community and social resources to improve oral health outcomes.

Westside Family Center Awards L.A. Care Health Plan
Westside Family Center presented L.A. Care with its Healthcare Hero Award, crediting the role L.A Care has played in the success of the center. Westside Family is a Federally Qualified Health Center in Culver City, and they provide care to 13,000 Los Angeles County residents ranging from prenatal to seniors.

MEND Names L.A. Care 2024 Community Champion
Meet Each Need with Dignity, also known as MEND, presented L.A. Care with its Community Champion Award for helping to meet the nutrition needs of tens of thousands of vulnerable residents in the San Fernando Valley. This award is not just a recognition of our efforts, but also the powerful partnership between L.A. Care and Mend, and our shared commitment to uplift those in need by providing essential services that foster health, dignity, and hope.

Clínica Romero Honors L.A. Care CEO with Health Equity Award
Clínica Monseñor Oscar A. Romero has honored me with the Health Equity Award at their 41st Anniversary Gala for contributing to the elevation of the clinic's services within the communities they serve. The Health Equity Award recognizes leadership in the health industry as well as an unwavering commitment to the underserved in Los Angeles. I am honored to receive this recognition and grateful for the opportunity to lead L.A. Care.

Attachments
Los Angeles Sentinel – L.A. Care Commits $1.2 Million+ to Reduce Barriers to Dental Care for Angelenos

L.A. Care Commits $1.2 Million to Reduce Barriers to Dental Care for Angelenos

Oral health diseases such as cavities and gum disease are largely preventable. However, factors such as chronic medical conditions, access to care, cultural norms and attitudes, and socioeconomic status can influence these outcomes and create additional barriers to care. Addressing these barriers is essential to ensuring that community members have the necessary access to maintain and improve their oral health. L.A. Care Health Plan announced a new $1.22 million commitment to its Oral Health Initiative to support 10 organizations that are addressing the barriers to oral health care in low-income communities.

"Oral health is critical to overall health. Poor oral health in children can have a devastating impact on quality of life and their performance in school, which ultimately can impact their success as an adult," said John Baackes, L.A. Care CEO. "In adults, poor oral health can lead to complications for those with cardiovascular disease, diabetes, or even those who are pregnant, so it is extremely important that we take steps to improve oral health."

The Center for Disease Control and Prevention (CDC) reports tooth decay in children aged 2 to 5 from low-income households is about three times higher than that of children from higher income households. And 33% of Latino children and 28% Black children aged 2 to 5 have had cavities in their primary teeth, compared with just 18% of non-Hispanic White children.

The L.A. Care funding will help the 10 awardees implement strategies that address the barriers contributing to oral health disparities. To improve oral health outcomes, projects will include providing outreach and oral health screenings at local schools and community events, increasing engagement and services for hypertensive persons experiencing homelessness, and implementing Social Determinants of Health screenings to connect patients to necessary community and social resources.

Herald Christian Health Center, a Federally Qualified Health Center (FQHC) with facilities across the San Gabriel Valley, is one of the awardees in this 15th round of Oral Health Initiative grants.

"L.A. Care's grant will greatly enhance our efforts to support the community, helping us guide patients through the health system and promote both medical and dental preventative care," said Carolin Eng, CEO of Herald Christian Health Center. "Our comprehensive approach is designed to reduce health disparities and ensure that underserved communities receive the essential care they need, ultimately fostering better health outcomes for all."

Via Care Community Health Center, an FQHC with a network of clinics throughout Los Angeles County, is another of the awardees.

"Via Care is thrilled to be an L.A. Care Oral Health Initiative (OHI XV) grantee. This important grant will increase access to pediatric dental services, which are extremely hard to find in the East L.A. area," said Deborah Villar, CEO of Via Care Community Health Center. "This grant project will strengthen our dental program by enabling us to offer comprehensive dental care for all members of the family at low or no-cost."

The 10 awardees in this 15th round of the Oral Health Initiative grants are Garfield Health Center, Gracelight Community Health, Herald Christian Health Center, JWCH Institute Inc., Northeast Valley Health Corporation, Eisner Health, T.H.E. Health and Wellness Centers, Via Care Community Health Center, Watts Healthcare Corporation, and White Memorial Community Health Center.

Since 2003, L.A. Care, through its Oral Health Initiative, has awarded more than more than $19 million for 195 projects that provide oral health infrastructure, education, prevention, and treatment services to low-income communities.

Introduction

Vision 2024

L.A. Care's strategic plan, Vision 2024, outlines our major goals for 2021-2024. Vision 2024 guides us towards continued growth and success using the framework offered by the four strategic directions that remain our guideposts—Operational Excellence, High Quality Network, Member Centric Care, and Health Leader. The Vision 2024 document is available upon request.

Progress Reports

L.A. Care reports to the Board of Governors regarding the progress made towards the goals in Vision 2024 on a quarterly basis. Each quarterly report is retrospective and captures a high-level summary of activities from the previous quarter. **The following report covers the fourth quarter of our fiscal year, from July 1 through September 30.**

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

Operational Excellence

Achieve operational excellence by improving health plan functionality.

Goals	Q4: July – September 2024 Highlights
Build out information technology systems that support improved health plan functionality.	• IBM Consulting was selected to help with the implementation of Ariba Procurement, a cloud-based procurement management solution. • L.A. Care's modernization and system improvement efforts include two technical go-lives for a new Utilization Management (UM) system and a new Appeals and Grievance (A&G) system. There was also a full go-live for the new Potential Quality of Care Issues (PQI) system.
Support and sustain a diverse and skilled workforce and plan for future needs.	• Succession planning for senior leadership roles in IT and Provider Data Management is underway. • Cohort two of the Management Certificate Program graduated in July, with a total of 23 graduates. Seven participants from different cohorts have been promoted to supervisor or manager roles.
Ensure long-term financial sustainability.	• FY23-24 Q3 administrative expenses were higher by $10.7M vs 4+8 Forecast. Finance continues to monitor the targeted spend.
Mature L.A. Care's family of product lines, taking an "all products" approach whenever possible.	• L.A. Care Covered membership exceeded 195,000 members. • Medicare Plus (D-SNP) Special Election Period (SEP) net membership continues to grow, with current membership at 20,322. • The addition of a Medi-Cal Direct Enrollment Team is currently under consideration. • L.A. Care successfully launched its inaugural quarterly regional Joint Operation Meetings with directly contracted Primary Care Providers.

High Quality Network

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

Goals	Q4: July – September 2024 Highlights
Mature and grow our Direct Network.	• L.A. Care is developing an express protocol to address ongoing claims issues impacting directly contracted professional providers. • L.A. Care is automating key performance indicators (KPIs) to measure and assess direct network performance. • L.A. Care is expanding its provider directory to include additional contracted clinic locations and specifying the subspecialties offered at each site.
Improve our quality across products and providers.	• The mid-year update to the Measurement Year (MY) 2024 Direct Network P4P program will be distributed in October. Updates include newly released MY 2023 NCQA Quality Compass National Medicaid benchmarks for HEDIS and Utilization Management measures, as well as a modification to the Social Determinants of Health measure. • A new Lead Screening text message campaign launched in July for parents and guardians of members ages five and under with no lead test on record.
Invest in providers and practices serving our members and the L.A. County safety net.	• Five Help Me Grow L.A. participating practices are testing and/or implementing electronic screening tools. Their referral and IT departments are also building standard data fields into their systems for Regional Center referrals. • L.A. Care introduced the eight new Elevating the Safety Net scholarship recipients from Charles R. Drew University of Medicine and Science and UCLA David Geffen School of Medicine in July, at L.A. Care's annual White Coat Ceremony and Celebration. • The final Community Health Investment Fund docket for the fiscal year includes 52 grants to enhance quality service delivery through the safety net.

Member Centric Care

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

Goals	Q4: July – September 2024 Highlights
Operate all components of California Advancing and Innovating Medi-Cal (CalAIM) as they are launched.	• L.A. Care launched all 14 CalAIM Community Supports (CS) services as of July 1, 2024. • The Enhanced Care Management team finalized contracts and processes to support the go-live of the new ECM payment model, transitioning from a prospective capitation to a three-tiered Per Utilizer Per Month (PUPM) structure in October 2024.
Establish and implement a strategy for a high-touch care management approach.	• New Community Health Workers have been hired at CRC locations that previously did not have permanent CHW representation, such as the Wilmington and South L.A. CRC locations.
Ensure that the services we provide to members promote equity and are free of implicit and explicit bias.	• CHIF awards totaling more than $2.6 million were provided to seventeen community organizations to address food, income, and housing security for marginalized communities. • The Member Equity Council closed out its FY23-24 goals, meeting 11 out of the 16 goals established, with work continuing on the remaining goals. • L.A. Care has completed embedding vendor diversity into the procurement process. • L.A. Care created and distributed a social determinants of health resource sheet for providers and members, highlighting the CRCs, Community Link, and L.A. Care-specific social needs programs. Providers also received diagnostic codes and provider referral sheets for L.A. Care programs.

Health Leader

Serve as a national leader in promoting equitable healthcare to our members and the community and act as a catalyst for community change.

Goals	Q4: July – September 2024 Highlights
Drive improvements to the Affordable Care Act by serving as a model of a successful public option.	• L.A. Care leaders will participate on a Local Health Plans of California panel discussion, where they will share with other sister plans the experiences and challenges of participating in the Covered California marketplace. The panel is scheduled for November 2024.
Optimize members' use of Community Resource Centers and expand our member and community offerings.	• Construction was completed for the South L.A. CRC. • Contracts with the National Health Foundation and community-based organizations that provide CalFresh and Medi-Cal enrollment assistance respectively at all CRCs have been extended through 2025.
Drive change to advance health and social services for our members and the community.	• L.A. Care hosted a Continuing Medical Education webinar on Promoting Safe Firearm Storage in Primary Care in September. • L.A. Care's Housing Initiatives has increased enrollment to 13,661 unhoused members. • The first Field Medicine Provider Summit was completed, and the Provider Care Pods initiative was rolled out. The goal of Provider Care Pods is to increase collaboration and coordination among interim housing providers, CBOs, and other agencies providing services to members.

APPENDIX

Detailed Vision 2024 Progress Report
Fiscal Year Quarter 4
July – September 2024

Operational Excellence

Achieve operational excellence by improving health plan functionality.

Build out information technology systems that support improved health plan functionality.	
Tactics	**Update**
Improve customer service through the Voice of the Customer (VOICE) initiative, our customer service information technology system.	L.A. Care completed the development phase for the agent console. Gaps were identified during user testing, and deployment was delayed towards the end of Q1 of 2025. Planning for the agent training program and organizational change management activities are underway in preparation for business operations. Member and Provider portal requirements continue to be developed and tested, and scheduling is reconsidered when quality gaps are identified during testing. Additional functionality is being explored for the Interactive Voice Response (IVR) to improve quality monitoring to provide targeted feedback to agents and support customer service experience strategies. Project plans for the portals and IVR are under review. Approvals are anticipated by end of Q1 2025.
Improve efficiency and effectiveness of financial management functions with the implementation of the additional phases of the SAP Enterprise Resource Planning (ERP).	Callidus (the SAP cloud-based commission software solution for managing incentives and compensation programs for brokers) is in the testing phase of implementation and projected to be deployed in Q2 2025. SAP's (the financial system software solution for accounting and reporting) migration to the RISE platform planning is underway, with the anticipated project kick-off in Q2 2025. IBM Consulting was selected to be the Ariba procurement system implementation partner. The system is expected to be deployed in Q3 2025.
Modernize provider data management by defining and creating a roadmap for achieving our target state for our provider data ecosystem.	L.A. Care continued work towards implementing the Provider Target State by: • Collaborative Workshops: Conducting collaborative workshops with Infosys to finalize the configuration documentation for Helix—a cloud-based SaaS platform that will streamline the Provider Network Management and Provider Data Management team's performance of all provider enrollment and provider maintenance tasks. • Workflow Optimization: Mapping future-state provider enrollment and provider maintenance workflows in Helix, with a focus on optimizing automation to minimize manual tasks.

Build out information technology systems that support improved health plan functionality.	
Tactics	**Update**

	• Integration Blueprint: Developing a comprehensive blueprint detailing the steps required to integrate Helix with all upstream and downstream systems.
	• Data Migration Strategy: Finalizing the data migration strategy, which will ensure a seamless transition of data into the new platform.
	• Single Domain Database Development: Continuing the development of a single domain database (SDD), which remains on track for completion in Q4 2024. The SDD will:
	  ○ Interface with and be continuously updated by provider enrollment and maintenance tasks performed on Helix.
	  ○ Supply validated and up-to-date network data to all downstream functions and systems.
	  ○ Enable L.A. Care to retire its currently fragmented provider data management systems.
	• Recalibrated Project Plan: Ensuring adherence to the recalibrated project plan milestones, with full implementation scheduled for Q2 2025.

Refine and implement our three-year technology roadmap and ensure that the reference architecture serves as a blueprint that evolves with L.A. Care's needs.	In the past quarter there have been several accomplishments that support L.A. Care's modernization and system improvement efforts. We had two technical go-lives for a new Utilization Management (UM) system and a new Appeals and Grievance (A&G) system. We did a full go-live for the new Potential Quality of Care Issues (PQI) system. The VOICE Program continues in its efforts to implement a new Agent Console, a new Provider Portal, and new Member Portal by the end of 2024/Q1(CY) 2025. Our Provider Target State Program continues to work on implementing a new solution to manage provider data and create a source of truth. That work will continue through 2025.
Develop real-time interoperability capabilities to share data with providers and members.	This tactic has been completed.

Support and sustain a diverse and skilled workforce and plan for future needs.	
Tactics	**Update**
Conduct succession planning, particularly at the leadership level.	We have been working with IT and Provider Data Management departments on succession planning. Succession planning will be conducted with the Communications, Provider Network and Government Relations departments.
Maintain a diverse and inclusive workforce, validated by data analysis, to model L.A. Care's commitment to Diversity, Equity, and Inclusion.	We continue to monitor current employee demographics, and remain an ethnically diverse organization with only minor variations in demographics over the last quarter. Our employees are: 37.42% Hispanic or Latino; 21.97% Asian; 15.07% Black or African American; 10.91% White; 4.47% Native Hawaiian or Other Pacific Islander; 0.24% American Indian/Alaskan Native; 2.95% two or more races; 6.96% non-applicable. Additionally, our employees are 69.37% Female and 30.63% Male.
Improve managed care and Management Services Organization (MSO) acumen among staff.	L.A. Care continues to partner with Local Health Plans of California (LHPC) to help educate our employees on Managed Care services. In Q4, employees attended the following educational sessions: • Medi-Cal Managed Care Finance 201 (attended by 48 employees) • Medi-Cal Managed Care Back to Basics Fundamentals (attended by 53 employees) • History of California's Local Health Plans Webinar (attended by 5 employees) During the course of the fiscal year, at least 106 employees have attended LHPC classes.
Promote retention of staff in an evolving work environment.	Cohort two of the Management Certificate Program graduated in July. There were 23 graduates out of 31 initial participants. Cohort one had one graduate promoted to manager and one promoted to supervisor in July. Cohort two had two graduates promoted to manager and two promoted to supervisor in August. One participant from cohort three was promoted to supervisor in July.

Ensure long-term financial sustainability.	
Tactics	**Update**
Implement recommendations from the administrative expense benchmarking study and update the administrative expense target in the revised forecasts.	*Providing FY23-24 Q3 results as Q4 financials won't be available until next month* FY23-24 Q3 administrative expenses were higher by $10.7M vs 4+8 Forecast. The unfavorable variance will likely persist for the final quarter. Finance continues to closely monitor the targeted spend while utilizing higher than anticipated investment income to offset expense overages. Management implemented an administrative spend cap as part of the FY 2024-25 annual budget development. The overall administrative expense ratio was determined based on an analysis of the risk adjusted revenue and assumed administrative funding from DHCS. All levels of management are working to revise operational plans and adjust spend to meet targets.

Mature L.A. Care's family of product lines, taking an "all products" approach whenever possible.	
Tactics	**Update**
Launch a D-SNP to serve the dually-eligible Medicare and Medi-Cal population and transition members from Cal MediConnect (CMC) to the D-SNP.	This tactic has been completed.
Increase membership across all products by implementing member recruitment and retention strategies.	**Sales** **L.A. Care Covered (LACC):** Membership continues to grow (exceeds 195k effective members which is over 5%+ above forecast) through the Special Enrollment Period (SEP) mainly due to continued effectuation of new members through the SB 260 process. • In Q4, community outreach strategies targeting Deferred Action for Childhood Arrivals (DACA) recipients eligible for ACA coverage beginning November 2024 were created. • Overall Open Enrollment Period (November 1, 2024 – January 31, 2025) Growth Plans are in place with key partners, including Broker General Agencies and Preferred Provider Groups (PPGs).

Mature L.A. Care's family of product lines, taking an "all products" approach whenever possible.	
Tactics	**Update**
	Medicare Plus (D-SNP): Special Election Period (goes through end of calendar year 2024) net membership continues to grow, surpassing the 20,000 milestone at 20,322 (above forecast target) • Plan Year-to-Date Enrollments are currently nearing a new L.A. Care milestone of 8,000 at 7,930, 15%+ year over year increase. • Annual Election Period (October 1, 2024 forward marketing of new Plan Year 2025 Benefits) growth Initiatives Implemented during Q4 for an October 1, 2024 kick-off. **Medi-Cal (MCLA):** • Secured preliminary approval to build a "pilot" Medi-Cal Direct Enrollment Team ○ This will allow for enrollment assistance and oversight, which is projected to increase L.A. Care's "choice rate." **Marketing** **L.A. Care Covered (LACC):** Developed strategies that broadened advertising and outreach to target and enroll DACA recipients, who will be newly eligible to sign-up for health plans through Covered California. **Medicare Plus (D-SNP):** Created a robust strategy for the D-SNP Annual Enrollment Period (AEP) campaign, which successfully launched on October 1st and employed a comprehensive multi-channel approach. We leveraged out-of-home advertising, radio, TV, hyperlocal marketing, and digital channels to reach our target audience. Additionally, we implemented new direct-to-consumer campaigns via email and text messaging to address specific segments. Our multicultural outreach efforts focused on all three-target demographics: Hispanic, African American, and Asian communities. However, we made a more concerted effort to increase our outreach and engagement within the African American and Asian communities through an increase spend in media and community partnerships. All campaign materials were finalized and launched in time for the AEP launch, and English and Spanish enrollment kits were distributed to brokers to support enrollment.

Mature L.A. Care's family of product lines, taking an "all products" approach whenever possible.	
Tactics	**Update**
	Medi-Cal (MCLA): A new Medi-Cal brochure was created and will be launched in partnership with Sales. In preparation for 2025, we've developed both the overall messaging strategy and creative approach, while also creating member profiles and conducting focus groups to better understand member needs. We've produced educational videos about our Medi-Cal product and enrollment process, and will be sharing them across social media and digital platforms. Additionally, our 2024 campaigns, including Redetermination, Adult Expansion, Product Branding, and Plan Partners, have increased visibility and built trust through partnerships with local media such as iHeart Radio, KTLA, and the L.A. Dodgers.
Engage in a provider network strategy that meets distinct business and competitive needs of all products and ensures that members receive high-value care.	L.A. Care successfully launched its inaugural quarterly regional Joint Operation Meetings (JOMs) with directly contracted Primary Care Providers (PCPs). During these meetings, performance scorecards aggregated at the regional level were reviewed, and L.A. Care's programs, services, and incentives to support PCPs in managing the care of their assigned members were discussed. The JOMs were well-attended and received positive feedback from providers. Following the meetings, L.A. Care staff have been working closely with individual, directly contracted primary care practices to identify the root causes of performance deficiencies and help develop action plans to improve performance. L.A. Care is sponsoring memberships in the Los Angeles County Medical Association (LACMA) and the California Medical Association (CMA) for select Primary Care Providers (PCPs) within both its direct and delegated Participating Physician Group (PPG) networks. This initiative provides PCPs with valuable educational benefits, including access to physician education, practice management support, health information technology resources, physician wellness programs, legal and regulatory compliance assistance, and community resource connections. By offering these advantages, L.A. Care ensures that providers have the tools necessary to deliver the highest quality of care to their assigned members. L.A. Care also continues to host monthly Provider Engagement Events at Community Resource Centers, as well as quarterly Physician Advisory Collaborative events for providers in both its direct and delegated PPG networks.

High Quality Network

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

Mature and grow our Direct Network.	
Tactics	**Update**
Insource delegation functions that are currently outsourced, as appropriate and cost effective.	This tactic has been completed.
Improve the operations of all L.A. Care functions necessary to support and scale up the Direct Network.	L.A. Care is actively working to enhance Direct Network operations by developing an express protocol to address ongoing claims issues impacting directly contracted professional providers. This initiative aims to streamline issue resolution, improve service delivery, and increase provider satisfaction. Additionally, L.A. Care is automating key performance indicators (KPIs) to measure and assess direct network performance. While KPIs are already in production for the MCLA network, new queries are being developed to generate direct network-specific reporting. L.A. Care is also establishing a performance threshold for direct contracting and identifying primary care practices for targeted direct contracting. This selection is based on membership volume, specialty network adequacy, and scores related to quality, utilization, and member experience. By directly contracting with high-performing practices, L.A. Care ensures members in the direct network receive the highest quality of care.
Strategically address gaps in the Direct Network to meet all member needs countywide.	L.A. Care is expanding its provider directory to include additional contracted clinic locations and specifying the subspecialties offered at each site. This improvement will make it easier for members to locate the services they need while enhancing transparency and access within the network. L.A. Care is also actively collaborating with regulators, providing documentation to support a filing for approval to increase membership in the Direct Network.

Mature and grow our Direct Network.	
Tactics	**Update**
	Additionally, L.A. Care continues to ensure sufficient network adequacy and addresses any gaps as they arise, maintaining a robust network that meets the needs of its members.
Increase access to virtual care by implementing L.A. Care's Virtual Specialty Care Program (V-SCP).	Since the start of the pilot V-SCP program for our high-volume Direct Network primary care providers (PCPs) began in July 2023: • We have received a total of 132 eConsults submitted and five telehealth visits; • The eConsult specialists have responded back to the primary care provider with an average response time of 1.6 days and around 63.1% of the eConsults needed an in-person visit.

Improve our quality across products and providers.	
Tactics	**Update**
Achieve quality scores for the Direct Network that are commensurate with the median IPA network scores.	• A new metric to measure the volume of accepted versus rejected service claims has been developed for Direct Network primary care providers. The measure is modeled on a new encounter measure for the Value Initiative for IPA Performance + Pay-for-Performance (VIIP+P4P) programs, called Percentage of Encounter Rejections. The report will include the top 5 claims denial reasons, including: Invalid CPT Modifier; Duplicate; Non-Payable Service for Medi-Cal; Missing or Invalid Diagnosis; and Default Fee-for-Service Percent Not Defined. This new report will be used by Direct Network Account Managers to follow-up with directly contracted primary care practices to improve claims submission performance. The measure will also be introduced in the MY 2025 Direct Network P4P Program. • The mid-year update to the Measurement Year (MY) 2024 Direct Network P4P Program will be distributed in October. Updates include newly released MY 2023 NCQA Quality Compass National Medicaid benchmarks for HEDIS and Utilization Management measures, as well as a modification to the Social Determinants of Health measure to include screenings that do not identify any social determinants of health or insecurities.

Improve our quality across products and providers.	
Tactics	**Update**
	• MY 2023 Direct Network P4P data preparation and quality assurance are underway. Payments and reports are expected to go out this winter.

Exceed the DHCS Minimum Performance Level for all measures for Medi-Cal, achieve a four-star quality rating for L.A. Care Covered, and build the infrastructure to achieve a four-star quality rating for our D-SNP.	• L.A. Care deployed an additional round of various text message campaigns and continues distributing health reminders through mailers. We are also executing automated calls and social media campaigns.
	• L.A. Care continues monthly joint operations meetings with provider groups and plan partners to address quality performance and improvement.
	• For Measurement Year (MY) 2023 on the 18 Medi-Cal Accountability Set (MCAS) measures held to the Minimum Performance Level (MPL):
	  ○ 11 measures met or exceeded the DHCS MPL 50TH threshold
	  ○ 14 measures improved compared to MY2022
	  ○ 7 measures had significant improvements compared to MY2022
	  ○ 7 measures missed MPL
	• L.A. Care deployed second rounds of various text messages in Q4 that were previously sent out earlier in the year. This second round aims to capture members who are newly eligible for a health screening or have still not completed one. These campaigns deliver health education and encourage members to schedule services like mammograms and colorectal cancer screenings as well as see their doctor for well-baby visits. Over 550,000 non-unique members have received text messages so far in CY 2024.

Improve clinical data integration and data governance, starting with race, ethnicity, language, sexual orientation, and gender identity data, in order to achieve the NCQA Health Equity Accreditation.	This tactic is completed.

Improve our quality across products and providers.	
Tactics	**Update**
Improve clinical performance for children's care.	• Well care visit reminder postcards were mailed to the parents/guardians of members, ages 0-17 years old, and members, ages 18-21 years old, describing the importance of health screenings and immunizations. Reminder postcards were mailed in the following languages: English, Spanish, Chinese, Armenian, Russian, and Vietnamese. • A new Lead Screening text message campaign launched in July. Parents/guardians of members ages five and under with no lead test on record were texted a lead screening reminder. A new campaign included an educational fotonovela, a small booklet that portrays a story using photographs and captions. • The well-child visit text message campaign was revised and launched in September. Revised campaign included fotonovelas, Spanish & Chinese versions, and a member feedback survey.

Invest in providers and practices serving our members and the L.A. County safety net.	
Tactics	**Update**
Assist our providers in adopting and using Health Information Technology (HIT) resources.	**Transform L.A.**: The Transform L.A. program is supporting practices' use of Provider Opportunity Reports (POR) and Cozeva as alternative data sources for their monthly measure reports in CIS-10 and well-child visits. All participating practices who see pediatric patients up to 3 years of age are now reporting their baseline and year-to-date performances for both measures. The team is continuing work with the practices to improve their HEDIS performances by standardizing the use of the POR and Cozeva in the practices' monthly QI meetings. **Help Me Grow LA:** Practice coaches reviewed sustainability plans that incorporated investment plans for Mini Grant funds in software enhancements or purchasing the Ages & Stages Questionnaire portal to streamline the administration of the screening tool and reporting data. Five out of the six practices are testing/implementing electronic screening tools; practices' referral and IT departments are building standard data fields into their systems for

Invest in providers and practices serving our members and the L.A. County safety net.	
Tactics	**Update**
	Regional Center referrals; and ongoing use of now multiple practice data sources (EHRs, Cozeva, IPA dashboards) will be used to conduct data analysis. **EQuIP-LA:** We continue to collaborate with the Quality Performance Management team which prepares the rolling 12-month HEDIS measures reports (Controlling Blood Pressure, A1c Poor Control, and Colorectal Cancer Screening) to ensure that we meet program deliverables in a timely fashion. Two out of the four practices completed participation in the Race, Ethnicity, and Language (REaL) Data Accelerator training course, offered through the California Quality Collaborative (CQC)/Purchaser Business Group on Health (PBGH) program office. The 12-week, online program equips practices to improve REaL data collection to strengthen equity-focused primary care. Practices are currently working to improve workflows to improve REaL Data collection. **Equity & Practice Transformation:** Practices are in process of submitting seven milestones for the November 1st deliverables. The milestones include Empanelment & Access milestones – Assessment and P&P; Data to Enable PHM milestones – Assessment and P&P; and Empanelment & Access KPIs focusing on percentage of patients empaneled, Continuity, and Third Next Available Appointment (TNAA). Practices that are enrolled in the PHMI program are eligible to attest out of the Empanelment & Access milestones.
Provide practice coaching to support patient-centered care.	**Transform L.A.:** As of August 2024, program practices have achieved improvements of 31% for Glycemic Assessment in Patients with Diabetes (>9%) against the Minimum Performance Level (MPL) of 38%, and 69% in Controlling High Blood Pressure against the MPL of 61%. Transform L.A. has worked with practices who are seeing pediatric patients under three years of age to report their baseline performance in Well-Child Visits (W30). The program practices are reporting a 2023 baseline of 52% in W30a (“a” stands for 6 visits from 0 to 15 months) and 68% in W30b (“b” stands for 2 visits from 15 to 30 months). As of August 2024, practices have achieved improvements of 78% for W30b against the MPL 67%. **Help Me Grow LA:** The provider pilot concluded on September 30th, 2024. Participants included Asian Pacific Health Care Venture, White Memorial Community Health Center, Bartz-Altadonna, Palmdale Pediatrics, Kids & Teens and T.H.E. Health and Wellness. Each practice

Invest in providers and practices serving our members and the L.A. County safety net.	
Tactics	**Update**
	received a Certificate of Recognition for their successful participation. Cohorts One and Two achieved overall increases of 51% and 23% respectively over their baselines. Final program partnership reports will be submitted to First 5 by December 2024. **EQuIP-LA:** Quality improvement work continues. Practices continue to focus on patient outreach, identifying patients due or overdue for screening tests as well as developing tools to improve their QI capacity. HEDIS measures reported through April 2024 as follows: Colorectal Cancer Screening: 25%, no MPL established for MCLA; Controlling Blood Pressure: 25% vs. MPL 62%; Glycemic Status Assessment for Patient w/Diabetes>9%: 65% vs. MPL 38% (inverse measure). **Equity & Practice Transformation:** As of September 2024, forty-four practices are actively enrolled in the program. Two private practices withdrew from the program due to reduced Directed Payments. L.A. Care completed recruitment of five additional practice coaches, with a full complement of seven coaches, including the two coaches already on staff. Practice coaches have begun meeting with their assigned practices. L.A. Care will advance the first Directed Payment to all originally enrolled 46 practices in October 2024 for the completion of the phmCAT (assessment tool) deliverable this past April.

Invest in providers and practices serving our members and the L.A. County safety net.	
Tactics	**Update**
Implement innovative programs to train, recruit, and retain highly qualified providers through the Elevating the Safety Net initiative.	**Provider Recruitment Program:** We continue to grow this program, with 173 active providers totaling slightly more than $23.1 million in investment. There are currently 21 vacancies. **Provider Loan Repayment Program:** Of the 192 physicians awarded, we have 95 active awards, including 77 new awardees and 18 award extensions. **Medical School Scholarship Program:** L.A. Care has awarded a total of 56 scholars, 28 at CDU and 28 at UCLA, with full-tuition scholarships. In July 2024, CDU and UCLA confirmed the eight new scholars who were introduced during L.A. Care's annual White Coat Ceremony and Celebration. **IHSS Program:** Three hundred sixty-seven students graduated from the Trimester 22nd cohort. CCA's Trimester 23 cohort is currently underway. Overall, 7,373 students have completed the L.A. Care training course as of September 2024.
Utilize the Community Health Investment Fund (CHIF) to leverage opportunities for providers to increase quality and access to care.	The final Community Health Investment Fund docket for the fiscal year includes 52 grants to enhance quality service delivery through the safety net. Twenty-four community clinics were provided adaptive exam tables and accessible scales through the new Accessible Equipment Fund (AEF) Initiative implemented to ensure thorough and accurate exams can be received by L.A. Care and other community members who are seniors, people with disabilities and other differently-abled individuals. Four additional grants were awarded to community agencies to support CalAIM engagement, equitable public health program planning, and reduction in high-cost care following hospitalization and Emergency Department use.

Member Centric Care

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

Operate all components of California Advancing and Innovating Medi-Cal (CalAIM) as they are launched.	
Tactics	**Update**
Maximize care for L.A. Care members, within funding constraints, through successful implementation of Enhanced Care Management (ECM) and Community Supports (CS) for specified populations of focus.	**Enhanced Care Management (ECM):** L.A. Care saw an increase in ECM enrollment, which is a result of the recently launched incentive payment program and improvements to our processes. The ECM team finalized contracts and processes to support the go-live of the new ECM payment model, transitioning from a prospective capitation to a three-tiered Per Utilizer Per Month (PUPM) structure in October 2024. The ECM network continues to grow, with 84 providers currently onboarded to meet the needs of our members. Additionally, in Q4, we engaged with the Department of Child and Family Services (DCFS) to explore ways to coordinate care for our members involved in the child welfare system. **Community Supports:** L.A. Care has launched all 14 CalAIM Community Supports (CS) services as of July 1, 2024. The CS provider network continues to expand to support increased CS member engagement, and work is in progress to develop targeted incentives to increase enrollment and engagement. Activities are ongoing to support cohesive and efficient CS program operations across the various CS service areas related to data and reporting, provider network management, member engagement, and compliance. Furthermore, efforts are underway to coordinate CS services with Field Medicine services for members experiencing homelessness.
Ensure CalAIM Population Health Management (PHM) requirements are met.	The Population Health department continues to lead the community partnership with all the Health Plan and Local Health Jurisdictions working together to develop a strategy due in November 2024 to meet the CalAIM SMART goal of reducing maternal and infant mortality. The partnership now has three sub-groups including finance, data, and planning that report up to a steering committee. Initial Health Appointment (IHA) updates: • **IHA Data Enhancements:** The monthly IHA compliance reports have been enhanced to include a scorecard, and the top and bottom five providers per PPG. These are posted in the provider portal and shared with Account Manager and Corporate Compliance Monitoring (CCM) teams for follow-up monitoring and auditing. These reports and scorecards are also shared in the Quality Improvement (QI) Joint Operations Meetings (JOMs).

Operate all components of California Advancing and Innovating Medi-Cal (CalAIM) as they are launched.	
Tactics	**Update**

	• **IHA Provider Enhancements:** L.A. Care is developing a template for documenting provider outreach/scheduling and member refusals for IHAs.
	• **IHA Member Enhancements:**
	  ○ L.A. Care has executed a contract for a monthly member text campaign for IHAs that will kick off in October 2024.
	  ○ L.A. Care has approved a reminder robo-call campaign for IHAs and a live-call campaign, targeting members due for an IHA who have been to the Emergency Department or Urgent Care. These campaigns will kick-off in October 2024.

Monitor and establish infrastructure for longer-term CalAIM initiatives.	Under CalAIM, as of January 1, 2024, Medi-Cal Managed Care Plans (MCPs) became responsible for the full Long Term Care benefit, including Intermediate Care Facility – Developmentally Disabled (ICF-DD), and Pediatric Sub-Acute Care benefits. These programs are administered under the Managed Long Term Services and Supports (MLTSS) department. The MLTSS team became the liaison for the ICF-DD Homes and Sub-Acute Care Facilities. Both programs were implemented successfully through collaborative work with internal stakeholders such as Provider Network Management (PNM), Utilization Management (UM), Claims and Credentialing. MLTSS, along with other internal stakeholders, actively participated in DHCS stakeholder forums to share best practices. In addition, MLTSS facilitates bimonthly meetings with other L.A. County MCPs to ensure alignment of key processes and share best practices. Internally, MLTSS meets with other business partners to discuss processes, provider feedback, challenges and solutions as it relates to these new carve-in benefits. Several communications and trainings with Regional Centers and ICF-DD Homes took place to support providers with the implementation of the ICF-DD Carve-In. MLTSS continues these efforts by hosting quarterly webinars. There have been 349 members authorized for ICF-DD and 28 members for Pediatric Sub-Acute Care YTD (Jan - Sept.). PNM continues their diligent work on establishing contracts with ICF-DD Homes and partner with Claims to ensure all billing and payment concerns are addressed. MLTSS Liaisons continue to provide support and closely assist ICF-DD Homes with any questions or concerns.

Establish and implement a strategy for a high-touch care management approach.	
Tactics	**Update**
Maximize use of care managers and community health workers within our care management model.	In Q4 (July-September 2024), there was an increase in the number of members who successfully achieved care plan goals, compared to the previous quarter. Care Management also had an increase in overall members that received support during the quarter. Care Managers continued to provide discharge planning support to members who recently experienced a care transition, and based on a member's risk of readmission, connected the member to various CalAIM services such as Enhanced Care Management, Recuperative Care, and Meals as Medicine. The Care Management Community Health Worker team has grown and expanded their reach by hiring new CHWs for CRC locations that previously did not have permanent CHW representation. This includes the Wilmington and South LA locations while also providing additional support to the West LA, Panorama City and Metro LA areas due to increased need. Efforts have been made to continue and grow the partnership with training provider, El Sol, to support capacity building and help grow continuing education for CHWs. As a result, by Q4 2024, all CHWs have been trained and received the Community Health Worker certification.
Expand upon our progress with palliative care and add other end-of-life services.	Palliative Care is a specialized form of care that is offered to our members with serious illnesses who meet the criteria. The Managed Long Term Services and Supports (MLTSS) team and the Senior Medical Director continue to facilitate ongoing educational webinars and partner with internal and external stakeholders, in order to increase awareness of this important benefit. The Palliative Care team also participates in Interdisciplinary Care Team (ICT) meetings to improve the care of our members and bring awareness to this great program. As of January 1, 2024, this benefit also became eligible to Dual Special Needs Plan (D-SNP) members. Through partnership with Provider Network Management, the palliative care providers have expanded, and we are working on adding more palliative care providers to support our pediatrics population. Referrals increased this fiscal year by compared to last fiscal year. The census also increased this fiscal year compared to last fiscal year.

Ensure that the services we provide to members promote equity and are free of implicit and explicit bias.	
Tactics	**Update**
Leverage external partnerships, grantmaking, and sponsorships to implement programs that address the root causes of inequity, including racism and poverty.	CHIF awards totaling more than $2.6 million were provided to seventeen community organizations to address food, income and housing security for marginalized communities. Strategies employed by grantee partners include CalFresh outreach, medically tailored meals, workforce training and pipeline programs, as well as, eviction prevention services. Another $700,000 was invested in organizations led by and serving BIPOC and other divested communities to achieve systemic justice through the fifth Equity & Resilience Initiative. Generating African American Infant and Nurturers' Survival (GAAINS) Initiative grantee partners continue to impact successful birth outcomes through culturally congruent interventions that enhance prenatal experiences and reduce the toxic stress of systemic racism. GAAINS partners' reports during this quarter revealed 438 live births of a total 444 births (98.6%) for Black birthing program participants. The Member Equity Council closed out its FY23-24 goals. Eleven out of 16 goals were met. Three goals will be met next fiscal year, and one goal is ongoing because it is the collection of social determinants of health data. The Consumer Health Equity Council (CHEC) met in September. The Chief Health Equity Officer presented on Health Equity One Year Progress Update and about our transportation metrics. Most of the members have asked to continue to serve on the CHEC for another year.
Identify and reduce health disparities among our members by implementing targeted quality improvement programs.	L.A. Care focuses on disparities in prenatal and postpartum care, diabetes, and hypertension: • The following member touchpoints were finalized in design: A refrigerator magnet emphasizing at-home blood pressure management, text messaging campaigns for both blood pressure and diabetes care, and a diabetes care letter. All touchpoints will be sent to populations experiencing disparities in these clinical areas. • A social media campaign emphasizing kidney health among people with diabetes launched in September outreaching to the L.A. Care community.

Ensure that the services we provide to members promote equity and are free of implicit and explicit bias.	
Tactics	**Update**
Implement initiatives to promote diversity among providers, vendors, and purchased services.	We have completed embedding vendor diversity into the procurement process, so our efforts since then have been to sustain the program. The Provider Equity Council remains committed to the initiatives to help healthcare providers better understand the unique needs of their patients and community. We celebrated the awardees of the Provider Equity Awards earlier this year who demonstrated creating value in the community and will look to continue these efforts for 2025. We continue to evaluate data and work with internal partners to develop our roadmap and work plan for Phase one of the Provider Equity Photos pilot, which we hope to launch in conjunction with efforts to support Open Enrollment 2026.
Offer providers Diversity, Equity, and Inclusion resources to promote bias-free care.	L.A. Care is on track to submit the training curriculum for DHCS all plan letter (APL), 23-025, Diversity Equity and Inclusion (DEI) and Health Equity curriculum and training plan. L.A. Care continues to lead and collaborate the L.A. County-wide effort along with our Plan Partners and other local health plans. In September, communications went out to stakeholders and providers about the required DEI training scheduled for January 2025. L.A. Care has created and distributed a social determinants of health resource sheet for providers and members. The resource sheet highlights L.A. Care's Community Resources Centers, Community Link and L.A. Care-specific social needs programs. The provider resource sheet includes information about preferred screeners, diagnostic codes as well as provider referral sheets for L.A. Care programs. Additionally, on L.A. Care's website, there are curated Community Link folders based on input from our CRC staff for food, housing, transportation, maternal health services, and social needs organizations and programs.

Health Leader

Serve as a national leader in promoting equitable healthcare to our members and the community and act as a catalyst for community change.

Drive improvements to the Affordable Care Act by serving as a model of a successful public option.	
Tactics	**Update**
Play a leading role in advocating for a public option at the state and national levels.	No new action this quarter.
Provide expertise and assistance to other public plans interested in participating in state exchanges.	L.A. Care leaders will participate on a Local Health Plans of California panel discussion, where they will share with other sister plans the experiences and challenges of participating in the Covered California marketplace. The panel is scheduled for November 2024.

Optimize members' use of Community Resource Centers and expand our member and community offerings.	
Tactics	**Update**
Increase the number of Community Resource Centers to 14, in partnership with Blue Shield of California Promise Health Plan and increase number of annual visits to 70,000 by Q2 2024.	Construction at the South L.A. CRC was completed. L.A. Care took over final construction from the landlord at the Lincoln Heights site. The opening of our last CRC location is expected mid-February 2025.
Partner with community-based organizations to offer a range of services onsite.	Contracts with the National Health Foundation and community-based organizations that provide CalFresh and Medi-Cal enrollment assistance respectively at all CRCs have been extended through 2025.

Drive change to advance health and social services for our members and the community.	
Tactics	**Update**
Identify and prioritize actions, interventions, and programs to promote equity and social justice.	L.A. Care hosted a Continuing Medical Education webinar on Promoting Safe Firearm Storage in Primary Care in September. Forty-three individuals attended the webinar.

Drive change to advance health and social services for our members and the community.	
Tactics	**Update**
Support regional Health Information Exchanges (HIE).	L.A. Care is preparing to launch the third round of its Health Information Exchange (HIE) Adoption Incentive in October 2024, targeting 15 hospitals and 80 skilled nursing facilities (SNFs) that have yet to be onboarded to HIEs. We have allocated $2.2 million towards this effort, and to-date, we have funded 30 SNFs and eight hospitals. Furthermore, we plan to introduce another one-time HIE adoption incentive in November 2024, aimed at increasing adoption among hospitals and SNFs contracted with plan partners. This initiative will specifically focus on improving Plan Partner HIE metrics within the Incentive Payment Program (IPP).
Create a deliberate and tailored strategy to address homelessness among our members.	Housing Initiatives continues to evolve and expand services to LA Care's unhoused members. Over the last quarter we've grown to a current enrollment of 13,661 members (5,947 Housing Navigation and 7,714 Tenancy Sustaining Services), which represents a 26% increase from October 2023. We've also completed our first Field Medicine Provider Summit, at which we rolled out our newest initiative, Provider Care Pods. The goal of our Care Pods program is to increase collaboration and coordination among interim housing providers, CBO's, and other agencies providing services to members. We hope to connect members to the appropriate care and services they need and to reduce the number of touch points for members when receiving services.

September 2024
Grants & Sponsorships Report
November 2024 Board of Governors Meeting

#	Organization Name	Project Description	Grant/ Sponsorship Approval Date	Grant Category/ Sponsorship	Grant Amount*	Sponsorship Amount	FY CHIF & Sponsorships Cumulative Total
1	Adventist Health White Memorial Charitable Foundation	Adventist Health White Memorial Charitable Foundation Gala: Supports primary care services and improving health outcomes, fostering equity and lowering healthcare costs for East LA, Boyle Heights, Montebello and surrounding areas to have access to comprehensive primary care.	9/24/2024	Sponsorship	$ -	$ 7,500	$ 7,500
2	AltaMed	Support the expansion of access to care for seniors and people with disabilities and other differently abled individuals in Los Angeles County through the utilization of adaptive equipment.	9/18/2024	Grant/ Accessible Equipment Fund	$ 34,506	$ -	$ 34,506
3	AltaMed Foundation	55th Anniversary Gala, Noche de Salud y Arte: This event supports the work AltaMed does within the community to provide access to quality healthcare for Angelenos. John Baackes will be honored during this fundraising event.	9/25/2024	Sponsorship	$ -	$ 25,000	$ 50,000
	AltaMed	**Cumulative Total Line**		**Grants/Sponsorships**			**$ 84,506**
4	AME Medical Group	Support the expansion of access to care for seniors and people with disabilities and other differently abled individuals in Los Angeles County through the utilization of adaptive equipment.	9/18/2024	Grant/ Accessible Equipment Fund	$ 20,419	$ -	$ 20,419
5	Angeles Community Health Center	Support the expansion of access to care for seniors and people with disabilities and other differently abled individuals in Los Angeles County through the utilization of adaptive equipment.	9/18/2024	Grant/ Accessible Equipment Fund	$ 15,195	$ -	$ 15,195
6	Antelope Valley Partners for Health	AVPH 25th Anniversary Masquerade Ball: This sponsorship supports the work done in SPA 1 by the Antelope Valley Partners for Health.	9/4/2024	Sponsorship	$ -	$ 5,000	$ 5,000
7	Anti-Recidivism Coalition	Under the guidance of the Director of Youth Development, TAY Life Coaches will coordinate with TAY Workforce and Education Coordinator to enroll youth participants into programming. They will be identifying career opportunities, job readiness, resume skills, and field trips. Provide workforce development services via the Emergent Adults Community of Learning project to 12 unduplicated TAY clients.	9/16/2024	Grant/Advancing Economic Mobility	$ 150,000	$ -	$ 150,000
8	Association of Black Women Physicians	ABWP 43rd Annual Charity Scholarship Benefit: This sponsorship supports ABWP whose work strengthens the medical industry and promotes diverse medical professionals that represent L.A. Care's beneficiaries.	9/4/2024	Sponsorship	$ -	$ 5,000	$ 5,000
9	Bartz-Altadonna	Support the expansion of access to care for seniors and people with disabilities and other differently abled individuals in Los Angeles County through the utilization of adaptive equipment.	9/18/2024	Grant/ Accessible Equipment Fund	$ 11,502	$ -	$ 11,502
10	Be Social Productions	Health Fair + Wellness Conference: This community event will offer health screenings (blood pressure, fibro-liver scan, cholesterol, etc.), insurance information; while also providing resources such as boxes of food, and haircuts; and important information such as child education and after-school programs, legal consulting, life insurance, etc.; and also fun activities for all the family.	9/24/2024	Sponsorship	$ -	$ 4,000	$ 8,000
11	Buddhist Tzu Chi	Support the expansion of access to care for seniors and people with disabilities and other differently abled individuals in Los Angeles County through the utilization of adaptive equipment.	9/18/2024	Grant/ Accessible Equipment Fund	$ 14,419	$ -	$ 14,419
12	Central Neighborhood Health Foundation	Support the expansion of access to care for seniors and people with disabilities and other differently abled individuals in Los Angeles County through the utilization of adaptive equipment.	9/18/2024	Grant/ Accessible Equipment Fund	$ 14,486	$ -	$ 14,486
13	Clinica del Socorro Medical Group	Support the expansion of access to care for seniors and people with disabilities and other differently abled individuals in Los Angeles County through the utilization of adaptive equipment.	9/18/2024	Grant/ Accessible Equipment Fund	$ 15,065	$ -	$ 15,065
14	Clinica Msgr. Oscar A. Romero	Clinica Monseñor Oscar A. Romero's 41st Anniversary Gala: This sponsorship supports Clinica Romero's effort to provide quality access to healthcare throughout Los Angeles County. John Baackes will be honored.	9/4/2024	Sponsorship	$ -	$ 25,000	$ 25,000
15	Coalition for Responsible Community Development (CRCD)	To provide workforce development training and apprenticeship opportunities to 60 low-income clients, with an emphasis on justice system-involved individuals. Funding will cover salary for a new Placement Coordinator position that will be responsible for connecting clients to post-apprenticeship career opportunities At least 36 clients who complete the program will be placed in building and construction trades union jobs and earn a livable wage.	9/16/2024	Grant/Advancing Economic Mobility	$ 125,000	$ -	$ 125,000
16	Comprehensive Community Health Centers	Support the expansion of access to care for seniors and people with disabilities and other differently abled individuals in Los Angeles County through the utilization of adaptive equipment.	9/18/2024	Grant/ Accessible Equipment Fund	$ 24,273	$ -	$ 29,273
17	Crenshaw Family Medical Group	Support the expansion of access to care for seniors and people with disabilities and other differently abled individuals in Los Angeles County through the utilization of adaptive equipment.	9/18/2024	Grant/ Accessible Equipment Fund	$ 14,616	$ -	$ 14,616

18	Doula Hub	The Los Angeles County Medi-Cal Doula Hub will ensure the new Medi-Cal doula benefit is equitably implemented in Los Angeles County and jointly shouldered by Medi-Cal health plans, the County, community partners, and doulas, to enable doulas to prioritize and serve those most at risk of adverse birth outcomes. The work of the Hub will complement the ongoing efforts of direct service doula programs, statewide benefit implementation workgroups, maternal health advocates, and health plans/regulators.	9/12/2024	Grant/Ad Hoc	$ 200,000	$ -	$ 250,000
19	Eisner Health	Support the expansion of access to care for seniors and people with disabilities and other differently abled individuals in Los Angeles County through the utilization of adaptive equipment.	9/18/2024	Grant/ Accessible Equipment Fund	$ 17,730	$ -	$ 299,230
20	Erick A Garcia You Are Enough Foundation	3rd Mental Health Awareness Day: This fundraising event supports the Antelope Valley/Palmdale community and highlights mental health awareness and suicide prevention.	9/24/2024	Sponsorship	$ -	$ 1,000	$ 1,000
21	Family Focus Resource Center	All Abilities Resource Fair: This sponsorship supports the disability community in SPA 2.	9/25/2024	Sponsorship	$ -	$ 1,000	$ 1,000
22	GRID Alternatives Greater Los Angeles	Provide solar panel installation training for 120 clients through its 13-week Installation Basics Training (IBT) program. Participants will complete a total of 280 program hours and receive a stipend of $17.00 per hour. Funding will cover contracted training staff (professors), trainee stipends, program equipment, and sector-based certificates for trainees. At least 96 clients will be placed in solar panel installation jobs and earn a livable wage.	9/16/2024	Grant/Advancing Economic Mobility	$ 150,000	$ -	$ 150,000
23	LA Partnership for Early Childhood Investment - CCF	AAIMM seeks to finalize and disseminate a Request for Proposals (RFP) that will identify a qualified community entity to join the operational leadership of AAIMM, alongside DPH and First 5 LA, as a critical step in implementing a more inclusive leadership model within AAIMM.	9/12/2024	Grant/Ad Hoc	$ 150,000	$ -	$ 150,000
24	Liberty Hill Foundation	To develop and implement an optimized data collection and reporting system for the community-based organizations (CBOs) who are part of the Stay Housed L.A. (SHLA) Coalition.	9/12/2024	Grant/Ad Hoc	$ 200,000	$ -	$ 200,000
25	Mass Liberation	Mass Liberation will educate and empower up to 250 individuals preparing to return and recently returned from incarceration through life-skills courses on healthy relationships, personal finance, wellness, and responsible citizenship. Maintain temporary and permanent housing for 75 clients and assist other clients with housing navigation. In partnership with Southwest Community College, provide courses on essential technology and employment preparation, and prepare at least 40% of clients for specific career paths to ensure successful transition to society	9/16/2024	Grant/Equity and Resilience V	$ 150,000	$ -	$ 150,000
26	MEND - Meet Each Need with Dignity	Annual Dignity Awards Gala: This sponsorship supports MEND's work in the SPA 2 community to bring quality wrap around services to individuals experiencing homelessness or poverty. John Baackes will receive an award on behalf of L.A. Care's contribution to Los Angeles residents.	9/4/2024	Sponsorship	$ -	$ 15,000	$ 15,000
27	National Alliance on Mental Illness Greater Los Angeles County	NAMI Walks Greater LA County Conference: The National Alliance on Mental Illness Greater Los Angeles County (NAMI GLAC) and the NAMI Los Angeles community will convene to provide information on the state of mental health treatment, advocacy, and innovations.	9/24/2024	Sponsorship	$ -	$ 2,500	$ 7,500
28	North East Valley Health Corporation	Support the expansion of access to care for seniors and people with disabilities and other differently abled individuals in Los Angeles County through the utilization of adaptive equipment.	9/18/2024	Grant/ Accessible Equipment Fund	$ 34,506	$ -	$ 34,506
29	PATH (People Assisting the Homeless)	PATH 40th Anniversary Gala: This sponsorship supports the fundraising efforts for PATH to continue serving the homeless population.	9/17/2024	Sponsorship	$ -	$ 5,000	$ 5,000
30	Saban Community Clinic	Support the expansion of access to care for seniors and people with disabilities and other differently abled individuals in Los Angeles County through the utilization of adaptive equipment.	9/18/2024	Grant/ Accessible Equipment Fund	$ 23,004	$ -	$ 173,004
31	Social Impact Fund, fiscal sponsor for Accelerate Impact	Accelerate will cultivate and maintain authentic multiracial relationships between twenty Black and Brown-led grassroots organizations (The Beloved Community) to develop leadership and strengthen solidarity among organizations' leaders, their teams, and community members through healing circles, leadership development training, and mini-grants to member organizations. Impact 15,000 existing and 5,000 new individuals through communitywide events and shared policy campaigns, and direct service.	9/16/2024	Grant/Equity and Resilience V	$ 150,000	$ -	$ 150,000
31	SoLA Foundation	To provide a six-month program for 60 BIPOC emerging entrepreneurs through its SoLa Entrepreneurship Accelerator that will train and equip clients from underinvested communities of South Los Angeles to launch or grow their businesses. Funding will cover two new program assistant positions, field trips, program marketing, course materials, software, and technical assistance for clients. Thirty-two (32) clients will successfully launch or expand their businesses upon completion of the SoLa Tech Center Entrepreneurship program. New businesses will generate at least $5,000 in gross revenues and existing businesses will earn at least a 25% increase in gross revenues after one year post-program participation	9/16/2024	Grant/Advancing Economic Mobility	$ 150,000	$ -	$ 150,000
33	St Anthony's Medical Center	Support the expansion of access to care for seniors and people with disabilities and other differently abled individuals in Los Angeles County through the utilization of adaptive equipment.	9/18/2024	Grant/ Accessible Equipment Fund	$ 11,372	$ -	$ 11,372

34	Sunnyside Baptist Church fiscal sponsor for Sunnyside 5	Sunny side aims to provide personalized intensive education coaching and career development workshops and for up to 40 transition-age Black and Latino youth, including 14 youth living onsite in container homes, to complete post-secondary education or a trade. Provide each client with case management, work training/internships, and financial management through partner organizations, and evaluate individualized growth plan achievement at least semi-annually.	9/16/2024	Grant/Equity and Resilience V	$ 125,000	$ -	$ 125,000
35	Taxi Productions,Inc	Taste of Soul: This sponsorship brings brand awareness to L.A. Care's brand and boosts our community engagement in Inglewood and surrounding areas.	9/27/2024	Sponsorship	$ -	$ 15,000	$ 35,000
36	Ten Toes In (NEW)	Ten Toes will provide health and human services systems' navigation, case management, advocacy and support, and coordinate access to safety net resources, including mental health and SUD treatment, for up to 100 parolees and their families to address the complex challenges of reentry. Provide job training and placement, financial literacy, and family reunification support for 60 parolees and prevent recidivism among 35% of clients.	9/16/2024	Grant/Equity and Resilience V	$ 125,000	$ -	$ 125,000
37	The Chrysalis Center	To provide paid job training that provides career pathway opportunities for 240 justice system involved individuals who have experienced substance use disorders and/or have mental health needs through its SECTOR (Skills + Experience for the Careers of Tomorrow) program. All clients will receive at least 150 hours of paid job training.	9/16/2024	Grant/Advancing Economic Mobility	$ 125,000	$ -	$ 125,000
38	The Los Angeles City College Foundation	2024 LACC Gala: This sponsorship supports raising funds for college students to continue higher education and increase income stability. Our Board Chair will be honored during this event.	9/4/2024	Sponsorship	$ -	$ 10,000	$ 10,000
39	Tides Foundation, fiscal sponsor for (A) La Defensa	Org will provide advocacy and media spokesperson training for up to 600 systems impacted people; incite at least 1,400 residents to engage in civic activities to implement Measure J; and facilitate Re-Imagine LA Coalition partners' and independent members' attendance at key county meetings and workgroups.	9/16/2024	Grant/Equity and Resilience V	$ 150,000	$ -	$ 150,000
40	UCLA Foundation	Women's Health and the Environment Conference: The conference aims to address racial and ethnic disparities relating to the impact of environmental toxins on breast cancer and reproductive health.	9/27/2024	Sponsorship	$ -	$ 3,000	$ 272,000
41	Valley Presbyterian Hospital	Valley Presbyterian Hospital Golf Classic: This fundraising event supports access to care for the underserved community.	9/25/2024	Sponsorship	$ -	$ 6,000	$ 6,000
42	Valley Renal Medical Group	Support the expansion of access to care for seniors and people with disabilities and other differently abled individuals in Los Angeles County through the utilization of adaptive equipment.	9/18/2024	Grant/ Accessible Equipment Fund	$ 14,486	$ -	$ 14,486
43	Venice Family Clinic	Support the expansion of access to care for seniors and people with disabilities and other differently abled individuals in Los Angeles County through the utilization of adaptive equipment.	9/18/2024	Grant/ Accessible Equipment Fund	$ 15,195	$ -	$ 165,195
44	Via Care	Support the expansion of access to care for seniors and people with disabilities and other differently abled individuals in Los Angeles County through the utilization of adaptive equipment.	9/18/2024	Grant/ Accessible Equipment Fund	$ 34,506	$ -	$ 309,506
45	Vision y Compromiso	Vision y Compromiso 22nd Annual Conference: This annual community health workers conference is an opportunity to learn, network, and celebrate important work and contributions to the community.	9/4/2024	Sponsorship	$ -	$ 14,800	$ 14,800
46	Voices of Our Youth	Voices For Change Gala: Voices of our youth event is meant to support the Streets to Suites program offering a lifeline to individuals without a safe place to spend the night.	9/24/2024	Sponsorship	$ -	$ 3,000	$ 3,000
47	Westside Family Health Center	Westside Family Health Center's Fiftieth Birthday Party: WFHC's Fiftieth Birthday Party will be a celebration of its history of advancing health equity in Los Angeles and a fundraising event for the organization as it continues to provide services to patients from underserved communities facing Social Determinants of Health (SDOH).	9/24/2024	Sponsorship	$ -	$ 2,500	$ 2,500
48	Westside Infant-Family Network	Advancing Equity in Early Childhood: A half-day conference aimed at addressing racial and socioeconomic disparities in early childhood and driving transformative change in our systems.	9/27/2024	Sponsorship	$ -	$ 5,000	$ 5,000
Total of grants and sponsorships approved in September 2024					**$ 2,265,283**	**$ 155,300**	**$ 3,739,586**

Final Legislative Matrix

Last Updated: October 14, 2024

Bills by Issue

2024 Legislation (46)

Bill Number
AB 106

Status
Enacted

Title
Budget Acts of 2022 and 2023.

Description
AB106, Gabriel . Budget Acts of 2022 and 2023. The Budget Act of 2022 and the Budget Act of 2023 made appropriations for the support of state government for the 2022–23 and 2023–24 fiscal years. This bill would amend the Budget Act of 2022 and the Budget Act of 2023 by amending, adding, and repealing items of appropriation and making other changes. This bill would declare that it is to take effect immediately as a Budget Bill.

Primary Sponsors
Jesse Gabriel

Bill Number
AB 157

Status
Enacted

Title
Budget Act of 2024.

Description
AB157, Gabriel . Budget Act of 2024. The Budget Act of 2024 made appropriations for the support of state government for the 2024–25 fiscal year. This bill would amend the Budget Act of 2024 by amending, adding, and repealing items of appropriation and making other changes. This bill would declare that it is to take effect immediately as a Budget Bill.

Primary Sponsors
Jesse Gabriel

Bill Number
AB 158

Status
Enacted

Title
Budget Acts of 2022 and 2023.

Description
AB158, Gabriel . Budget Acts of 2022 and 2023. The Budget Act of 2022 and the Budget Act of 2023 made appropriations for the support of state government for the 2022–23 and 2023–24 fiscal years. This bill would amend the Budget Act of 2022 and the Budget Act of 2023 by amending and repealing items of appropriation and making other changes. This bill would declare that it is to take effect immediately as a Budget Bill.

Primary Sponsors
Jesse Gabriel

Bill Number
AB 177

Status
Enacted

Title
Health.

Description
AB 177, Committee on Budget. Health. (1) The California Hospice Licensure Act of 1990 requires a person, political subdivision of the state, or other governmental agency to obtain a license from the State Department of Public Health to provide hospice services to an individual who is experiencing the last phase of life due to a terminal disease, as defined, and their family, except as provided. Existing law requires the department, by January 1, 2025, to adopt emergency regulations to implement the recommendations in a specified report of the California State Auditor. Existing law requires the department to maintain the general moratorium on new hospice agency licenses until the department adopts the regulations. Existing law requires the moratorium to end the date the emergency regulations are adopted.This bill would extend the deadline by which the department is required to adopt those regulations to January 1, 2026, and would require the moratorium to end January 1, 2027, or one year after the date the emergency regulations are adopted.(2) Existing law requires a disability insurance policy issued, amended, renewed, or delivered on or after January 1, 2024, to provide coverage for medically necessary treatment of mental health and substance use disorders and cover services identified in a fee-for-service reimbursement schedule published by the State Department of Health Care Services when those services are delivered at schoolsites, regardless of the network status of the local educational agency, institution of higher education, or health care provider. Existing law requires the Insurance Commissioner to issue guidance to disability insurers regarding compliance with these provisions. Existing law, as part of the Children and Youth Behavioral Health Initiative, requires the State Department of Health Care Services to develop and maintain a school-linked statewide provider network of schoolsite behavior health counselors and requires a health care service plan, insurer, or Medi-Cal managed care plan that covers necessary schoolsite services, as specified, to comply with all administrative requirements to cover and reimburse the services set forth by the network administrator.This bill would require the commissioner to additionally issue guidance to disability insurers regarding compliance with provisions regarding administrative requirements to cover and reimburse services under the school-linked statewide behavioral health provider network.(3) Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program p... (click bill link to see more).

Primary Sponsors
House Budget Committee

Bill Number
AB 1282

Status
Enacted

Title
Mental health: impacts of social media.

Description
AB 1282, Lowenthal. Mental health: impacts of social media. Existing law, the Mental Health Services Act, an initiative measure enacted by the voters as Proposition 63 at the November 2, 2004, statewide general election, establishes the Mental Health Services Oversight and Accountability Commission, and authorizes the commission to take specified actions, including advising the Governor or the Legislature regarding actions the state may take to improve care and services for people with mental illness. Existing law authorizes the State Department of Public Health to, among other things, enforce its regulations and protect and preserve the public health.This bill would require the department, in consultation with the commission, to report to specified policy committees of the Legislature, on or before December 31, 2026, a statewide strategy to understand, communicate, and mitigate mental health risks associated with the use of social media by children and youth. The bill would require the report to include, among other things, (1) the degree to which the mental health of children and youth is positively, negatively, or neutrally impacted by use of social media and (2) recommendations to strengthen children and youth resiliency strategies and California’s use of mental health services related to social media use. The bill would require the department to explore, among other things, the child and youth populations that use social media, including disproportionate rates and impacts among specific groups, and the negative behavioral health risks, as specified, associated with social media use and misuse among children and youth. The bill would require the department to additionally consult with certain communities in preparing the report, and prior to publication. The bill would repeal these provisions on January 1, 2030.

Primary Sponsors
Josh Lowenthal

Bill Number
AB 1316

Status
Enacted

Title
Emergency services: psychiatric emergency medical conditions.

Description
AB 1316, Irwin. Emergency services: psychiatric emergency medical conditions. Existing law, the Lanterman-Petris-Short Act, provides for the involuntary commitment and treatment of a person who is a danger to themselves or others or who is gravely disabled, as defined. Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Pursuant to a schedule of covered benefits, existing law requires Medi-Cal coverage for inpatient hospital services, subject to utilization controls, and with respect to fee-for service beneficiaries, coverage for emergency services and care necessary for the treatment of an emergency medical condition and medical care directly related to the emergency medical condition, as specified.Existing law provides for the licensing and regulation of health facilities by the State Department of Public Health and makes a violation of those provisions a crime. Existing law defines “psychiatric emergency medical condition,” for purposes of providing treatment for emergency conditions, as a mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either an immediate danger to the patient or to others, or immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental disorder. Existing law includes various circumstances under which a patient is required to be treated by, or may be transferred to, specified health facilities for treatment that is solely necessary to relieve or eliminate a psychiatric emergency medical condition.This bill would revise the definition of “psychiatric emergency medical condition” to make that definition applicable regardless of whether the patient is voluntary, or is involuntarily detained for assessment, evaluation, and crisis intervention, or placement for evaluation and treatment, under prescribed circumstances. The bill would make conforming and clarifying changes to provisions requiring facilities to provide that treatment. By expanding the definition of a crime with respect to those facilities, the bill would impose a state-mandated local program.The bill would require the Medi-Cal program to cover emergency services and care necessary to treat an emergency medical condition, as defined, including poststabilization care services required under specified federal law, emergency room professional services, and facility charges for emergency room visits. The bill would require coverage for emergency services necessary to relieve or eliminate a psychiatric emergency m... (click bill link to see more).

Primary Sponsors
Jacqui Irwin, Chris Ward

Bill Number
AB 1842

Status
Enacted

Title
Health care coverage: Medication-assisted treatment.

Description
AB 1842, Reyes. Health care coverage: Medication-assisted treatment. Existing law, the Knox–Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law authorizes health care service plans and health insurers that cover prescription drugs to utilize reasonable medical management practices, including prior authorization and step therapy, consistent with applicable law. This bill would require a group or individual health care service plan or health insurer offering an outpatient prescription drug benefit to provide coverage without prior authorization, step therapy, or utilization review for at least one medication approved by the United States Food and Drug Administration in each of 4 designated categories, including medication for the reversal of opioid overdose, including a naloxone product or another opioid antagonist. Because a willful violation of these provisions by a health care service plan would be a crime, this bill would impose a state-mandated local program.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Reyes

Organizational Notes

Last edited by Joanne Campbell at Mar 22, 2024, 6:00 PM
California Association of Health Plans - Oppose America’s Health Insurance Plans - Oppose Association of California Life and Health Insurance Companies - Oppose Support: California Academy of Child and Adolescent Psychiatry - Support California Black Health Network - Support California Hospital Association - Support California State Association of Psychiatrists (CSAP) - Support County Behavioral Health Directors Association of California - Support Ella Baker Center for Human Rights - Support Health Access California - Support Steinberg Institute - Support

Bill Number
AB 1936

Status
Enacted

Title
Maternal mental health screenings.

Description
AB 1936, Cervantes. Maternal mental health screenings. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan or health insurer to develop a maternal mental health program designed to promote quality and cost-effective outcomes, as specified.This bill would require the program to consist of at least one maternal mental health screening during pregnancy, at least one additional screening during the first 6 weeks of the postpartum period, and additional postpartum screenings, if determined medically necessary and clinically appropriate in the judgment of the treating provider. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Sabrina Cervantes, Susan Rubio

Bill Number
AB 2105

Status
Enacted

Title
Coverage for PANDAS and PANS.

Description
AB 2105, Lowenthal. Coverage for PANDAS and PANS. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law sets forth specified coverage requirements for health care service plan contracts and health insurance policies, and limits the copayment, coinsurance, deductible, and other cost sharing that may be imposed for specified health care services.This bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2025, to provide coverage for the prophylaxis, diagnosis, and treatment of Pediatric Autoimmune Neuropsychiatric Disorder Associated with Streptococcal Infections (PANDAS) and Pediatric Acute-onset Neuropsychiatric Syndrome (PANS) that is prescribed or ordered by the treating physician and surgeon and is medically necessary, as specified. The bill would prohibit coverage for PANDAS and PANS from being subject to a copayment, coinsurance, deductible, or other cost sharing that is greater than that applied to other benefits. The bill would prohibit a plan or insurer from denying or delaying coverage for PANDAS or PANS therapies because the enrollee or insured previously received treatment for PANDAS or PANS or was diagnosed with or received treatment for the condition under a different diagnostic name. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Josh Lowenthal

Organizational Notes

Last edited by Cherie Compartore at May 14, 2024, 3:54 PM
Oppose: California Association of Health Plans

Bill Number
AB 2129

Status
Enacted

Title
Immediate postpartum contraception.

Description
AB 2129, Petrie-Norris. Immediate postpartum contraception. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law generally regulates contractual provisions between health care service plans and health insurers and their contracting health care providers.This bill would require a contract between a health care service plan or health insurer and a health care provider issued, amended, or renewed on or after January 1, 2025, to authorize a provider to separately bill for devices, implants, or professional services, or a combination thereof, associated with immediate postpartum contraception if the birth takes place in a general acute care hospital or licensed birth center. The bill would prohibit that provider contract from considering those devices, implants, or services to be part of a payment for a general obstetric procedure. Because a violation of the bill’s requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Cottie Petrie-Norris

Bill Number
AB 2132

Status
Enacted

Title
Health care services: tuberculosis.

Description
AB 2132, Low. Health care services: tuberculosis. Existing law provides for the licensure and regulation of health facilities and clinics, including primary care clinics, by the State Department of Public Health. A violation of these provisions is generally a crime. Existing law requires an adult patient receiving primary care services in certain health care settings to be offered a screening test for hepatitis B and hepatitis C, as specified.This bill would require a patient who is 18 years of age or older receiving health care services in a facility, clinic, center, office, or other setting, where primary care services are provided, to be offered tuberculosis screening, if tuberculosis risk factors are identified, to the extent these services are covered under the patient's health care coverage, except as specified. The bill would also require the health care provider to offer the patient followup health care or refer the patient to a health care provider who can provide followup health care if a screening test is positive. The bill would prohibit a health care provider that fails to comply with these provisions from being subject to any disciplinary action related to their licensure or certification, or to any civil or criminal liability, for that failure. The bill would make related findings and declarations.Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services through managed care or fee-for-service delivery systems. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law requires the department to adopt an option made available under federal Medicaid law to pay allowable tuberculosis-related services for persons infected with tuberculosis, as specified.This bill would require a Medi-Cal managed care plan to ensure access to care for latent tuberculosis infection and active tuberculosis disease and coordination with local health department tuberculosis control programs for plan enrollees with active tuberculosis disease, as specified.

Primary Sponsors
Evan Low

Bill Number
AB 2198

Status
Enacted

Title
Health information.

Description
AB 2198, Flora. Health information. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act’s requirements a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires health care service plans and health insurers, commencing January 1, 2024, to establish and maintain specified application programming interfaces (API), including patient access API, for the benefit of enrollees, insureds, and contracted providers. Existing law authorizes the departments to require health care service plans or health insurers, as applicable, to establish and maintain provider access API and prior authorization support API if and when final federal rules are published .This bill would instead require the departments, commencing January 1, 2027, or when final federal rules are implemented, whichever occurs later, to require health care service plans and health insurers to establish and maintain patient access API, provider access API, payer-to-payer API, and prior authorization API. The bill, until January 1, 2027, would authorize the departments to issue guidance relating to these provisions not subject to the Administrative Procedure Act, as specified. Because a violation of these requirements by a health care service plan would be a crime, this bill would impose a state-mandated local program.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Heath Flora

Bill Number
AB 2258

Status
Enacted

Title
Health care coverage: cost sharing.

Description
AB 2258, Zbur. Health care coverage: cost sharing. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a group or individual nongrandfathered health care service plan contract or health insurance policy to provide coverage for, and prohibits a contract or policy from imposing cost-sharing requirements for, specified preventive care services and screenings.This bill would prohibit a group or individual nongrandfathered health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2025, from imposing a cost-sharing requirement for items or services that are integral to the provision of the above-described preventive care services and screenings. The bill would require those contracts and policies to cover items and services for those preventive care services and screenings, including home test kits for sexually transmitted diseases and specified cancer screenings. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program. The bill would authorize the Insurance Commissioner to impose a civil penalty of not more than $5,000 against an insurer for each violation of these provisions, or not more than $10,000 per violation if the violation was willful.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Rick Zbur

Organizational Notes

Last edited by Joanne Campbell at Mar 7, 2024, 9:18 PM
California Association of Health Plans - Oppose

Bill Number
AB 2293

Status
Enacted

Title
Joint powers agreements: health care services.

Description
AB 2293, Mathis. Joint powers agreements: health care services. (1) Existing law, the Joint Exercise of Powers Act, authorizes 2 or more public agencies by agreement to exercise any power common to the contracting parties, subject to meeting certain conditions with respect to that agreement. Existing law authorizes a private, nonprofit corporation, until January 1, 2032, formed for the purposes of providing services to zero-emission transportation systems or facilities, to join a joint powers authority or enter into a joint powers agreement with a public agency to facilitate the development, construction, and operation of zero-emission transportation systems or facilities that lower greenhouse gases, reduce vehicle congestion and vehicle miles traveled, and improve public transit connections.This bill, until January 1, 2034, would authorize one or more private, nonprofit mutual benefit corporations formed for purposes of providing health care services to join a joint powers authority or enter into a joint powers agreement with one or more public entities established under the act, as specified. The bill would deem any joint powers authority formed pursuant to this provision to be a public entity, except that the authority would not have the power to incur debt or to engage in specified other acts, including employing physicians and surgeons or charging for professional services rendered by physicians and surgeons. The bill would require an authority formed to be governed by a board of directors, composed as determined by the participating public agency or agencies. The bill would prohibit the representation of private, nonprofit mutual benefit corporations on the board of directors from exceeding 50%. The bill would define terms for its purposes. (2) Existing law sets forth requirements for the solicitation and evaluation of bids and the awarding of contracts by public entities, including requirements applicable if the public entity is required by statute or regulation to obtain an enforceable commitment that a bidder, contractor, or other entity will use a skilled and trained workforce, as defined, to complete a contract or project. Except as specified, existing law requires that, for workers employed on public works, as defined, not less than the general prevailing rate of per diem wages, determined as provided by the Director of Industrial Relations, for work of a similar character in the locality in which the public work is performed be paid to those workers, as provided. This bill, except as specified, would require a joint powers authority formed pursuant to the bill, when undertaking a project applicable to the construction or refurbishment of health facilities, to obtain an enforceable commitment that any... (click bill link to see more).

Primary Sponsors
Devon Mathis

Bill Number
AB 2297

Status
Enacted

Title
Hospital and Emergency Physician Fair Pricing Policies.

Description
AB 2297, Friedman. Hospital and Emergency Physician Fair Pricing Policies. Existing law requires a hospital to maintain a written charity care policy and a discount payment policy for uninsured patients or patients with high medical costs who are at or below 400 percent of the federal poverty level. Existing law requires the written policy regarding discount payments to also include a statement that an emergency physician who provides emergency medical services in a hospital that provides emergency care is also required by law to provide discounts to uninsured patients or patients with high medical costs who are at or below 400 percent of the federal poverty level. Existing law authorizes an emergency physician to choose to grant eligibility for a discount payment policy to patients with incomes over 350% of the federal poverty level. Existing law defines “high medical costs” for these purposes to mean, among other things, specified annual out-of-pocket costs incurred by the individual at the hospital or a hospital that provided emergency care.This bill would authorize an emergency physician to choose to grant eligibility for a discount payment policy to patients with incomes over 400% of the federal poverty level. The bill would also clarify that out-of-pocket costs for the above-described definition of “high medical costs” means any expenses for medical care that are not reimbursed by insurance or a health coverage program, such as Medicare copays or Medi-Cal cost sharing.Existing law requires a hospital’s discount payment policy to clearly state the eligibility criteria based upon income, and authorizes a hospital to consider the income and monetary assets of the patient or the patient’s family, as defined, in determining eligibility under its charity care policy.This bill would prohibit a hospital from considering the monetary assets of the patient in determining eligibility for both the charity care and the discount payment policies, but would authorize the hospital to consider the availability of a patient’s health savings account held by the patient or the patient’s family, as specified. The bill would revise the definition of patient’s family, as specified. The bill would instead require that the eligibility for charity care or discounted payments be determined at any time the hospital is in receipt of, among other things, recent pay stubs or income tax returns. The bill would prohibit a hospital or an emergency physician from imposing time limits for applying for charity care or discounted payments, and would prohibit a hospital or emergency physician from denying eligibility based on the timing of a patient’s application. The bill would authorize a hospital or emergency physician to waive or reduce Medi... (click bill link to see more).

Primary Sponsors
Laura Friedman

Bill Number
AB 2302

Status
Enacted

Title
Open meetings: local agencies: teleconferences.

Description
AB 2302, Addis. Open meetings: local agencies: teleconferences. Existing law, the Ralph M. Brown Act, requires, with specified exceptions, that all meetings of a legislative body, as defined, of a local agency be open and public and that all persons be permitted to attend and participate. The act generally requires for teleconferencing that the legislative body of a local agency that elects to use teleconferencing post agendas at all teleconference locations, identify each teleconference location in the notice and agenda of the meeting or proceeding, and have each teleconference location be accessible to the public. Existing law also requires that, during the teleconference, at least a quorum of the members of the legislative body participate from locations within the boundaries of the territory over which the local agency exercises jurisdiction. The act provides an exemption to the jurisdictional requirement for health authorities, as defined.Existing law, until January 1, 2026, authorizes the legislative body of a local agency to use alternative teleconferencing in specified circumstances if, during the teleconference meeting, at least a quorum of the members of the legislative body participates in person from a singular physical location clearly identified on the agenda that is open to the public and situated within the boundaries of the territory over which the local agency exercises jurisdiction, and the legislative body complies with prescribed requirements. Existing law imposes prescribed restrictions on remote participation by a member under these alternative teleconferencing provisions, including establishing limits on the number of meetings a member may participate in solely by teleconference from a remote location, prohibiting such participation for a period of more than 3 consecutive months or 20% of the regular meetings for the local agency within a calendar year, or more than 2 meetings if the legislative body regularly meets fewer than 10 times per calendar year.This bill would revise those limits, instead prohibiting such participation for more than a specified number of meetings per year, based on how frequently the legislative body regularly meets. The bill, for the purpose of counting meetings attended by teleconference, would define a “meeting” as any number of meetings of the legislative body of a local agency that begin on the same calendar day.The California Constitution requires local agencies, for the purpose of ensuring public access to the meetings of public bodies and the writings of public officials and agencies, to comply with a statutory enactment that amends or enacts laws relating to public records or open meetings and contains findings demonstrating that the enactment furthers the constitu… (click bill link to see more).

Primary Sponsors
Dawn Addis

Bill Number
AB 2319

Status
Enacted

Title
California Dignity in Pregnancy and Childbirth Act.

Description
AB 2319, Wilson. California Dignity in Pregnancy and Childbirth Act. Existing law requires the State Department of Public Health to maintain a program of maternal and child health, which may include, among other things, facilitating services directed toward reducing infant mortality and improving the health of mothers and children. Existing law requires the Office of Health Equity within the department to serve as a resource for ensuring that programs collect and keep data and information regarding ethnic and racial health statistics, and strategies and programs that address multicultural health issues, including, but not limited to, infant and maternal mortality. Existing law makes legislative findings relating to implicit bias and racial disparities in maternal mortality rates. Existing law requires a hospital that provides perinatal care, and an alternative birth center or a primary clinic that provides services as an alternative birth center, to implement an evidence-based implicit bias program, as specified, for all health care providers involved in perinatal care of patients within those facilities. Existing law requires the health care provider to complete initial basic training through the program and a refresher course every 2 years thereafter, or on a more frequent basis if deemed necessary by the facility. Existing law requires the facility to provide a certificate of training completion upon request, to accept certificates of completion from other facilities, and to offer training to physicians not directly employed by the facility. Existing law requires the department to track and publish data on pregnancy-related death and severe maternal morbidity, as specified.This bill would make a legislative finding that the Legislature recognizes all birthing people, including nonbinary persons and persons of transgender experience. The bill would extend the evidence-based implicit bias training requirements to specified health care providers at hospitals that provide perinatal care, alternative birth centers, or primary care clinics, as specified. The bill would require an implicit bias program to include recognition of intersecting identities and the potential associated biases. The bill would require initial basic training for the implicit bias program to be completed by June 1, 2025, for current health care providers, and within 6 months of their start date for new health care providers, unless exempted. The bill would require specified facilities to, by February 1 of each year, commencing in 2026, provide the Attorney General with proof of compliance with these provisions, as specified. The bill would authorize the Attorney General to pursue civil penalties for violations of these provisions, as specified. Th... (click bill link to see more).

Primary Sponsors
Lori Wilson, Akilah Weber, Mia Bonta, Steve Bradford, Isaac Bryan, Mike Gipson, Chris Holden

Bill Number
AB 2327

Status
Enacted

Title
Optometry: mobile optometric offices.

Description
AB 2327, Wendy Carrillo. Optometry: mobile optometric offices. Existing law, the Optometry Practice Act, establishes the State Board of Optometry within the Department of Consumer Affairs and sets forth the powers and duties of the board relating to the licensure and regulation of the practice of optometry. Existing law regulates the ownership and operation of mobile optometric offices, as defined, including, among other things, requiring the owner and operator of a mobile optometric office to file a quarterly report containing specified information. Existing law requires the board, by January 1, 2023, to adopt regulations establishing a registry for the owners and operators of mobile optometric offices, as specified. Existing law prohibits the board, before January 1, 2023, from bringing an enforcement action against an owner and operator of a mobile optometric office based solely on its affiliation status with an approved optometry school in California for remotely providing optometric service. Existing law makes these and other provisions related to the permitting and regulation of mobile optometric offices effective only until July 1, 2025, and repeals them as of that date.This bill would authorize the owner and operator of a mobile optometric office to instead file the above-described quarterly reports as a single, annual report during the first renewal period of 2 years, as specified. The bill would also extend the deadline for the board to adopt the above-described regulations to January 1, 2026. The bill would prohibit the board from bringing the above-described enforcement action before January 1, 2026, or before the board adopts those regulations, whichever is earlier. The bill would extend the repeal date of the provisions related to the permitting and regulation of mobile optometric clinics to July 1, 2035.

Primary Sponsors
Wendy Carrillo

Bill Number
AB 2340

Status
Enacted

Title
Medi-Cal: EPSDT services: informational materials.

Description
AB 2340, Bonta. Medi-Cal: EPSDT services: informational materials. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive medically necessary health care services, through fee-for-service or managed care delivery systems. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under existing law, early and periodic screening, diagnostic, and treatment (EPSDT) services are covered under Medi-Cal for an individual under 21 years of age in accordance with certain federal provisions.Existing federal regulations require the state to provide for a combination of written and oral methods designed to inform individuals eligible for EPSDT services, or their families, about the EPSDT program, within 60 days of the individual's initial Medicaid eligibility determination and, in the case of families that have not utilized EPSDT services, annually thereafter, as specified. Under those regulations, required information includes, among other components, the benefits of preventive health care and the services available under the EPSDT program and where and how to obtain those services.This bill would require the department to prepare written informational materials that effectively explain and clarify the scope and nature of EPSDT services, as defined, that are available under the Medi-Cal program. Under the bill, the materials would include, but would not be limited to, the information required in the above-described federal regulations or their successor. Under the bill, the informational materials would also include content designed for youth, for purposes of delivery of that content to a beneficiary who is 12 years of age or older but under 21 years of age.The bill would authorize the department to standardize the materials, as specified, and would require the department to regularly review the materials to ensure that they are up to date. The bill would require the department to test the quality, clarity, and cultural concordance of translations of the informational materials with Medi-Cal beneficiaries, in order to ensure that the materials use clear and nontechnical language that effectively informs beneficiaries.The bill would require the department or a Medi-Cal managed care plan, to provide to a beneficiary who is eligible for EPSDT services, or to the parent or other authorized representative of that beneficiary, as applicable, the informational materials within a maximum number of calendar days after that beneficiary's enrollment in a managed care plan or initial Medi-Cal eligibility determination and annually thereafter, as specified by the department.

Primary Sponsors
Mia Bonta

Bill Number
AB 2435

Status
Enacted

Title
California Health Benefit Exchange.

Description
AB 2435, Maienschein. California Health Benefit Exchange. Existing federal law, the Patient Protection and Affordable Care Act (PPACA), requires each state to establish an American Health Benefit Exchange to facilitate the purchase of qualified health benefit plans by qualified individuals and qualified small employers. Existing state law creates the California Health Benefit Exchange, also known as Covered California, governed by an executive board, to facilitate the enrollment of qualified individuals and qualified small employers in qualified health plans as required under PPACA. Existing law specifies the powers of the executive board. Existing law authorizes the executive board to adopt necessary rules and regulations by emergency regulations until January 1, 2025, with the exception of regulations implementing prescribed provisions relating to criminal background history checks for persons with access to confidential, personal, or financial information. Existing law authorizes the Office of Administrative Law to approve more than 2 readoptions of emergency regulations until January 1, 2030. Existing law provides that these extensions apply to a regulation adopted before January 1, 2022.This bill would extend the authority of the executive board to adopt necessary rules and regulations by emergency regulations until January 1, 2030, and would extend the authority of the Office of Administrative Law to approve more than 2 readoptions of emergency regulations until January 1, 2035. The bill would provide that these prescribed time extensions apply to a regulation adopted before January 1, 2025.

Primary Sponsors
Brian Maienschein

Bill Number
AB 2556

Status
Enacted

Title
Behavioral health and wellness screenings: notice.

Description
AB 2556, Jackson. Behavioral health and wellness screenings: notice. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. This bill would require a health care service plan, except as specified, or health insurer to provide to enrollees and insureds a written or electronic notice regarding the benefits of a behavioral health and wellness screening, as defined, for children and adolescents 8 to 18 years of age. The bill would require a health care service plan or insurer to provide the notice annually. Because a violation of the bill's requirements relative to a health care service plan would be crimes, the bill would impose a state-mandated local program. The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Corey Jackson

Organizational Notes

Last edited by Joanne Campbell at Mar 18, 2024, 5:29 PM
California Association of Health Plans - Oppose

Bill Number
AB 2630

Status
Enacted

Title
Pupil health: oral health assessment.

Description
AB 2630, Bonta. Pupil health: oral health assessment. Existing law requires a pupil, while enrolled in kindergarten in a public school, or while enrolled in first grade in a public school if the pupil was not previously enrolled in kindergarten in a public school, to present proof of having received an oral health assessment by a licensed dentist, or other licensed or registered dental health professional operating within the professional’s scope of practice, that was performed no earlier than 12 months before the date of the initial enrollment of the pupil, as provided.This bill would define “kindergarten” for these purposes as including both transitional kindergarten and kindergarten, and would require the above-described proof only once during a 2-year kindergarten program. To the extent the bill would impose additional duties on public schools, the bill would impose a state-mandated local program.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.

Primary Sponsors
Mia Bonta

Bill Number
AB 2703

Status
Enacted

Title
Federally qualified health centers and rural health clinics: psychological associates.

Description
AB 2703, Aguiar-Curry. Federally qualified health centers and rural health clinics: psychological associates. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services, including federally qualified health center (FQHC) services and rural health clinic (RHC) services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.Existing law requires that FQHC services and RHC services be reimbursed on a per-visit basis and defines a visit as a face-to-face encounter, or other modality of interaction, as specified, between a patient and specified practitioners.This bill would add to that list of practitioners a licensed professional clinical counselor.Existing law authorizes an FQHC or RHC to apply for an adjustment to its per-visit rate based on a change in the scope of services provided by the FQHC or RHC and includes in the definition of a change in the scope of services any changes in any of the federally defined FQHC services or RHC services, among other things. Existing law requires an FQHC or RHC that does not provide certain services, including marriage and family therapist services, and later elects to add those services and bill them as a separate visit to process the addition of the services as a change in scope of service, as specified.This bill would remove the requirement for an FQHC or RHC that does not provide marriage and family therapist services, but later elects to add those services and bill them as a separate visit, to file for a change in scope of service.Existing law requires the department to seek any necessary federal approvals and issue appropriate guidance to allow an FQHC or RHC to bill, under a supervising licensed behavioral health practitioner, for an encounter between an FQHC or RHC patient and an associate clinical social worker or associate marriage and family therapist when certain conditions are met, including, among others, that the FQHC or RHC is otherwise authorized to bill for services provided by the supervising practitioner as a separate visit.This bill would add a psychological associate or associate professional clinical counselor to those provisions, requiring the department to seek any necessary federal approvals and issue appropriate guidance to allow an FQHC or RHC to bill for an encounter between a patient and a psychological associate or associate professional clinical counselor under those conditions. The bill would make conforming changes with regard to supervision by a licensed behavioral health practitioner, as required by the associate’s applicable clinical licensing board.

Primary Sponsors
Cecilia Aguiar-Curry

Organizational Notes

Last edited by Cherie Compartore at Jul 29, 2024, 9:07 PM
Support: Local Health Plans of California

Bill Number
AB 2715

Status
Enacted

Title
Ralph M. Brown Act: closed sessions.

Description
AB 2715, Boerner. Ralph M. Brown Act: closed sessions.
Existing law, the Ralph M. Brown Act, generally requires that all meetings of a legislative body of a local agency be open and public and that all persons be permitted to attend and participate. Existing law authorizes a legislative body to hold a closed session with specified individuals on, among other things, matters posing a threat to the security of essential public services, as specified.This bill would additionally authorize a legislative body to hold a closed session with other law enforcement or security personnel and to hold a closed session on a threat to critical infrastructure controls or critical infrastructure information, as defined, relating to cybersecurity.Existing constitutional provisions require that a statute that limits the right of access to the meetings of public bodies or the writings of public officials and agencies be adopted with findings demonstrating the interest protected by the limitation and the need for protecting that interest.This bill would make legislative findings to that effect.The California Constitution requires local agencies, for the purpose of ensuring public access to the meetings of public bodies and the writings of public officials and agencies, to comply with a statutory enactment that amends or enacts laws relating to public records or open meetings and contains findings demonstrating that the enactment furthers the constitutional requirements relating to this purpose.This bill would make legislative findings to that effect.

Primary Sponsors
Tasha Boerner

Bill Number
AB 2749

Status
Enacted

Title
California Health Benefit Exchange: financial assistance.

Description
AB 2749, Wood. California Health Benefit Exchange: financial assistance. Existing federal law, the federal Patient Protection and Affordable Care Act (PPACA), requires each state to establish an American Health Benefit Exchange to facilitate the purchase of qualified health benefit plans by qualified individuals and qualified small employers. PPACA authorizes a state to apply to the United States Department of Health and Human Services for a state innovation waiver of any or all PPACA requirements, if certain criteria are met, including that the state has enacted a law that provides for state actions under a waiver. Existing state law creates the California Health Benefit Exchange (Exchange), also known as Covered California, to facilitate the enrollment of qualified individuals and qualified small employers in qualified health plans as required under PPACA. Existing law requires the Exchange, upon appropriation by the Legislature, to administer a program of financial assistance beginning July 1, 2023, to help Californians obtain and maintain health benefits through the Exchange if they lose employer-provided health care coverage as a result of a labor dispute, as specified. Under existing law, if specified eligibility requirements are met, an individual who has lost minimum essential coverage from an employer or joint labor management trust fund as a result of a strike, lockout, or other labor dispute receives the same premium assistance and cost-sharing reductions as an individual with a household income of 138.1% of the federal poverty level, and is also not required to pay a deductible for any covered benefit if the standard benefit design for a household income of 138.1% of the federal poverty level has zero deductibles. Existing law excludes from gross income any subsidy amount received pursuant to that program of financial assistance.This bill would revise various provisions of the financial assistance program, including deleting the exclusion of financial assistance received under the program from gross income, and specifying the criteria required for an individual to be qualified to receive coverage under the program. The bill would specify that an individual would no longer be eligible for financial assistance under the program when the Exchange verifies that employer-provided minimum essential coverage from the employer has been reinstated for the individual and dependents, as specified. The bill would require an employer or labor organization to notify the Exchange before employer-provided coverage is affected by a strike, lockout, or labor dispute, and would authorize the Exchange to contact the employer, labor organization, or other appropriate representative to determine information necessary to determ... (click bill link to see more).

Primary Sponsors
Jim Wood

Bill Number
AB 2767

Status
Enacted

Title
Financial Solvency Standards Board: membership.

Description
AB 2767, Santiago. Financial Solvency Standards Board: membership. Existing law establishes the Department of Managed Health Care, which, among other duties, ensures the financial stability of managed care plans. Existing law establishes within the department the Financial Solvency Standards Board for the purpose of, among other things, developing and recommending to the director of the department financial solvency requirements and standards relating to health care service plan operations. Existing law requires the board to be composed of the director, or their designee, and 7 members appointed by the director, and authorizes the director to appoint individuals with training and experience in specified subject areas or fields.This bill would instead require the director to appoint 10 members to the board, and would additionally authorize the director to appoint health care consumer advocates and individuals with training and experience in large group health insurance purchasing.

Primary Sponsors
Miguel Santiago

Bill Number
AB 2843

Status
Enacted

Title
Health care coverage: rape and sexual assault.

Description
AB 2843, Petrie-Norris. Health care coverage: rape and sexual assault. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance.Existing law requires a victim of sexual assault who seeks a medical evidentiary examination to be provided with one, as specified. Existing law prohibits costs incurred by a qualified health care professional, hospital, clinic, sexual assault forensic examination team, or other emergency medical facility for the medical evidentiary examination portion of the examination of the victim of a sexual assault, as described in a specified protocol, when the examination is performed as specified, from being charged directly or indirectly to the victim of the assault. This bill would require a health care service plan or health insurance policy that is issued, amended, renewed, or delivered on or after July 1, 2025, to provide coverage without cost sharing for emergency room medical care and followup health care treatment for an enrollee or insured who is treated following a rape or sexual assault for the first 9 months after the enrollee initiates treatment, as specified. The bill would prohibit a health care service plan or health insurer from requiring, as a condition of providing coverage, (1) an enrollee or insured to file a police report, (2) charges to be brought against an assailant, (3) or an assailant to be convicted of rape or sexual assault. Because a violation of the bill by a health care service plan would be a crime, the bill would impose a state-mandated local program. The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Cottie Petrie-Norris

Bill Number
AB 2860

Status
Enacted

Title
Licensed Physicians and Dentists from Mexico programs.

Description
AB 2860, Garcia. Licensed Physicians and Dentists from Mexico programs. Existing law, the Licensed Physicians and Dentists from Mexico Pilot Program, allows up to 30 licensed physicians and up to 30 licensed dentists from Mexico to practice medicine or dentistry in California for a period not to exceed 3 years, in accordance with certain requirements. Existing law requires the Medical Board of California and the Dental Board of California to provide oversight pursuant to these provisions. Existing law requires appropriate funding to be secured from nonprofit philanthropic entities before implementation of the pilot program may proceed.Existing law requires physicians participating in the Licensed Physicians and Dentists from Mexico Pilot Program to be enrolled in English as a second language classes, to have satisfactorily completed a 6-month orientation program, and to have satisfactorily completed a 6-month externship at the applicant’s place of employment, among various other requirements.This bill would repeal the provisions regarding the Licensed Physicians and Dentists from Mexico Pilot Program, and would instead establish two bifurcated programs, the Licensed Physicians from Mexico Program and the Licensed Dentists from Mexico Pilot Program. Within these 2 programs, the bill would generally revise and recast certain requirements pertaining to the Licensed Physicians and Dentists from Mexico Pilot Program, including deleting the above-described requirement that Mexican physicians participating in the program enroll in adult English as a second language classes. The bill would instead require those physicians to have satisfactorily completed the Test of English as a Foreign Language or the Occupational English Test, as specified. The bill would remove the requirement that the orientation program be 6 months, and would further require the orientation program to include electronic medical records systems utilized by federally qualified health centers and standards for medical chart notations. The bill would also delete the requirement that the physicians participate in a 6-month externship. The bill would further delete provisions requiring an evaluation of the pilot program to be undertaken with funds provided from philanthropic foundations, and would make various other related changes to the program. The bill would require the Dental Board of California to, notwithstanding existing requirements to provide specified federal taxpayer information, issue a 3-year nonrenewable permit to an applicant who has not provided an individual taxpayer identification number or social security number if the applicant meets specified conditions.Commencing January 1, 2025, the bill would authorize the Medical Board of Califor... (click bill link to see more).

Primary Sponsors
Eduardo Garcia

Organizational Notes

Last edited by Cherie Compartore at May 29, 2024, 7:01 PM
Support: Local Health Plans of California, California Primary Care Association (Co-Sponsor), Clinica De Salud Del Valle De Salinas (Co-Sponsor)

Bill Number
AB 2998

Status
Enacted

Title
Opioid overdose reversal medications: pupil administration.

Description
AB 2998, McKinnor. Opioid overdose reversal medications: pupil administration. Existing law authorizes a public or private elementary or secondary school to determine whether or not to make emergency naloxone hydrochloride or another opioid antagonist and trained personnel available at its school, and to designate one or more volunteers to receive related training to address an opioid overdose, as specified. Existing law prohibits a person who has completed that training and who administers, in good faith and not for compensation, naloxone hydrochloride or another opioid antagonist to a person who appears to be experiencing an opioid overdose from being subject to professional review, liable in a civil action, or subject to criminal prosecution for the person’s acts or omissions in administering the naloxone hydrochloride or another opioid antagonist, unless the person’s acts or omissions constituted gross negligence or willful and wanton misconduct, as provided.This bill would prohibit a school district, county office of education, or charter school from prohibiting a pupil 12 years of age or older, while on a schoolsite or participating in school activities, from carrying or administering, for the purposes of providing emergency treatment to persons who are suffering, or reasonably believed to be suffering, from an opioid overdose, a naloxone hydrochloride nasal spray or any other opioid overdose reversal medication that is federally approved for over-the-counter, nonprescription use, as provided. The bill would prohibit a pupil 12 years of age or older of those local educational agencies who administers those opioid antagonists on a schoolsite or while participating in school activities to a person who appears to be experiencing an opioid overdose, from being held liable in a civil action or being subject to criminal prosecution for their acts or omissions, unless the pupil’s acts or omissions constitute gross negligence or willful and wanton misconduct, as provided. The bill would also prohibit those local educational agencies, or an employee of those local educational agencies, from being subject to professional review, liable in a civil action, or subject to criminal prosecution for a pupil’s acts or omissions in administering those opioid antagonists, unless an act or omission of the local educational agency, or the employee of the local educational agency, constitutes gross negligence or willful and wanton misconduct connected to the administration of those opioid antagonists.

Primary Sponsors
Tina McKinnor

Bill Number
AB 3059

Status
Enacted

Title
Human milk.

Description
AB 3059, Weber. Human milk. Existing law licenses and regulates tissue banks and generally makes a violation of the requirements applicable to tissue banks a crime.This bill would specify that a general acute care hospital is not required to have a license to operate a tissue bank to store or distribute pasteurized donor human milk that was obtained from a tissue bank licensed by the State Department of Public Health. The bill would exempt from licensing requirements a hospital storing or distributing human milk obtained from a licensed tissue bank. The bill would require hospitals that collect, process, store, or distribute human milk in any other circumstance to obtain a tissue bank license. To the extent that the bill would expand the class of hospitals subject to tissue bank licensing requirements, thereby expanding a crime, the bill would impose a state-mandated local program.Existing law, the Knox-Keene Health Care Service Plan Act of 1975, requires the Department of Managed Health Care to license and regulate health care service plans and makes a willful violation of the act a crime. Other existing law requires the Department of Insurance to regulate health insurers. Existing law requires health care service plans and health insurers, as specified, to provide certain health benefits and services, including, among others, maternity hospital stays, inpatient hospital and ambulatory maternity services, and maternal mental health programs. Existing law generally requires a health care service plan or health insurance policy to provide an enrollee or insured with basic health care services, as specified.This bill would include, in the above-described basic health care services, medically necessary pasteurized donor human milk obtained from a tissue bank licensed by the State Department of Public Health.Because a violation of the bill’s provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Akilah Weber

Organizational Notes

Last edited by Joanne Campbell at Apr 19, 2024, 8:10 PM
California Association of Health Plans - Opposed

Bill Number
AB 3221

Status
Enacted

Title
Department of Managed Health Care: review of records.

Description
AB 3221, Pellerin. Department of Managed Health Care: review of records. Existing law, the Knox-Keene Health Care Service Plan Act of 1975 (hereafter the act), provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law requires the records, books, and papers of a health care service plan and other specified entities to be open to inspection by the director of the department during normal business hours.This bill would instead require the records, books, and papers of a health care service plan and other specified entities to be open to inspection by the director, including through electronic means. The bill would require a plan and other specified entities to furnish in electronic media records, books, and papers that are possessed in electronic media and to conduct a diligent review of records, books, and papers and make every effort to furnish those responsive to the director’s request. The bill would require records, books, and papers to be furnished in a format that is digitally searchable, to the greatest extent feasible. The bill would require records, books, and papers to be preserved until furnished, if requested by the department. The bill would authorize the director to inspect and copy these records, books, and papers, and to seek relief in an administrative law proceeding if, in the director’s determination, a plan or other specified entity fails to fully or timely respond to a duly authorized request for production of records, books, and papers. Because a willful violation of these requirements would be a crime, the bill would impose a state-mandated local program.Existing law requires the department to conduct periodically an onsite medical survey of the health delivery system of each plan. Existing law requires the director to publicly report survey results no later than 180 days following the completion of the survey, and requires a final report to be issued after public review of the survey. Existing law requires the department to conduct a followup review to determine and report on the status of the plan’s efforts to correct deficiencies no later than 18 months following release of the final report.This bill would state that nothing in those provisions prohibits the director from taking any action permitted or required under the act in response to the survey results before the followup review is initiated or completed, including, but not limited to, taking enforcement actions and opening further investigations. The bill would declare that these provisions are declaratory of and clarify existing law with regard to the director’s enforcement authority.Existing law enumerates acts or omis... (click bill link to see more).

Primary Sponsors
Gail Pellerin

Organizational Notes

Last edited by Joanne Campbell at Feb 28, 2024, 9:06 PM
National Union of Healthcare Workers, Sponsor

Bill Number
AB 3275

Status
Enacted

Title
Health care coverage: claim reimbursement.

Description
AB 3275, Soria. Health care coverage: claim reimbursement. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health insurer or health care service plan, including a specialized health care service plan, to reimburse a claim or portion of a claim no later than 30 working days after receipt of the claim, unless the plan contests or denies the claim, in which case the plan is required to notify the claimant within 30 working days that the claim is contested or denied. Under existing law, if a claim or portion thereof is contested on the basis that a health insurer or health care service plan has not received all information necessary to determine payer liability for the claim or portion thereof and notice has been provided, the health insurer or health care service plan has 30 working days after receipt of the additional information to complete reconsideration of the claim. Existing law extends these timelines to 45 working days for a health care service plan that is a health maintenance organization. Under existing law, if a claim is not reimbursed, contested, or denied pursuant to these timelines, as specified, interest accrues at a rate of 15% per annum for a health care service plan and 10% per annum for a health insurer. Commencing January 1, 2026, this bill instead would require a health care service plan, including a Medi-Cal managed care plan, or health insurer to reimburse a complete claim or a portion thereof within 30 calendar days after receipt of the claim, or, if a claim or portion thereof does not meet the criteria for a complete claim or portion thereof, to notify the claimant as soon as practicable, but no later than 30 calendar days that the claim or portion thereof is contested or denied. The bill would authorize the departments to issue guidance and regulations related to these provisions. The bill would exempt the guidance and amendments from the Administrative Procedure Act until December 31, 2027. Existing law requires health care service plans to establish a grievance process, as specified. This bill would require a complaint made by an enrollee to a health care service plan about a delay or denial of a payment of a claim to be treated as a grievance subject to that grievance process. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program. The California Constitution requires the state to reimburse local a... (click bill link to see more).

Primary Sponsors
Esmeralda Soria, Robert Rivas

Organizational Notes

Last edited by Cherie Compartore at May 14, 2024, 4:03 PM
Oppose: Local Health Plans of California, California Association of Health Plans

Bill Number
SB 136

Status
Enacted

Title
Medi-Cal: managed care organization provider tax.

Description
SB 136, Committee on Budget and Fiscal Review. Medi-Cal: managed care organization provider tax. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under existing law, one of the methods by which Medi-Cal services are provided is pursuant to contracts with various types of managed care plans.Existing law imposes a managed care organization (MCO) provider tax, administered and assessed by the department, on licensed health care service plans and managed care plans contracted with the department. Under existing law, all revenues, less refunds, derived from the taxes are deposited into the Managed Care Enrollment Fund, to be available to the department, upon appropriation, for the purpose of funding specified subcomponents to support the Medi-Cal program.Existing law sets forth certain taxing tiers and tax amounts for purposes of the tax periods of April 1, 2023, to December 31, 2023, inclusive, and the 2024, 2025, and 2026 calendar years. Under existing law, the Medi-Cal per enrollee tax amount for Medi-Cal taxing tier II, as defined, is $182.50 for the 2024 calendar year, $187.50 for the 2025 calendar year, and $192.50 for the 2026 calendar year.This bill would raise that tax amount for that tier to $205 for all 3 of those calendar years.This bill would declare that it is to take effect immediately as an urgency statute.

Primary Sponsors
Senate Budget and Fiscal Review Committee

Organizational Notes

Last edited by Joanne Campbell at Mar 18, 2024, 5:17 PM
California Association of Health Plans - Support

Bill Number
SB 339

Status
Enacted

Title
HIV preexposure prophylaxis and postexposure prophylaxis.

Description
SB 339, Wiener. HIV preexposure prophylaxis and postexposure prophylaxis. Existing law, the Pharmacy Law, provides for the licensure and regulation of pharmacists by the California State Board of Pharmacy. Existing law authorizes a pharmacist to furnish at least a 30-day supply of HIV preexposure prophylaxis, and up to a 60-day supply of those drugs if certain conditions are met. Existing law also authorizes a pharmacist to furnish postexposure prophylaxis to a patient if certain conditions are met.This bill would authorize a pharmacist to furnish up to a 90-day course of preexposure prophylaxis, or preexposure prophylaxis beyond a 90-day course, if specified conditions are met. The bill would require the California State Board of Pharmacy to adopt emergency regulations to implement these provisions by October 31, 2024.Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law prohibits a health care service plan or health insurer from covering preexposure prophylaxis that has been furnished by a pharmacist in excess of a 60-day supply once every 2 years, except as specified.Existing law provides for the Medi-Cal program administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services pursuant to a schedule of benefits. The existing schedule of benefits includes coverage for preexposure prophylaxis as pharmacist services, limited to no more than a 60-day supply furnished by a pharmacist once every 2 years, and includes coverage for postexposure prophylaxis, subject to approval by the federal Centers for Medicare and Medicaid Services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.This bill would require a health care service plan and health insurer to cover preexposure prophylaxis and postexposure prophylaxis furnished by a pharmacist, including the pharmacist’s services and related testing ordered by the pharmacist, and to pay or reimburse for the service performed by a pharmacist at an in-network pharmacy or a pharmacist at an out-of-network pharmacy if the health care service plan or health insurer has an out-of-network pharmacy benefit, except as specified. The bill would include preexposure prophylaxis furnished by a pharmacist as pharmacist services on the Medi-Cal schedule of benefits. Because a willful violation of these provisions by a health care service plan would be a crime, this bill would impose a state-mandated l... (click bill link to see more).

Primary Sponsors
Scott Wiener, Mike Gipson

Organizational Notes

Last edited by Joanne Campbell at Jan 11, 2024, 5:48 PM
California Association of Health Plans: Oppose Unless Amended

Bill Number
SB 729

Status
Enacted

Title
Health care coverage: treatment for infertility and fertility services.

Description
SB 729, Menjivar. Health care coverage: treatment for infertility and fertility services. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law provides for the regulation of disability insurers by the Department of Insurance. Existing law imposes various requirements and restrictions on health care service plans and disability insurers, including, among other things, a requirement that every group health care service plan contract or disability insurance policy that is issued, amended, or renewed on or after January 1, 1990, offer coverage for the treatment of infertility, except in vitro fertilization.This bill would require large and small group health care service plan contracts and disability insurance policies issued, amended, or renewed on or after July 1, 2025, to provide coverage for the diagnosis and treatment of infertility and fertility services. With respect to large group health care service plan contracts and disability insurance policies, the bill would require coverage for a maximum of 3 completed oocyte retrievals, as specified. The bill would revise the definition of infertility, and would remove the exclusion of in vitro fertilization from coverage. The bill would also delete a requirement that a health care service plan contract and disability insurance policy provide infertility treatment under agreed-upon terms that are communicated to all group contractholders and policyholders. The bill would prohibit a health care service plan or disability insurer from placing different conditions or coverage limitations on fertility medications or services, or the diagnosis and treatment of infertility and fertility services, than would apply to other conditions, as specified. The bill would make these requirements inapplicable to a religious employer, as defined, and specified contracts and policies.Because the violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Caroline Menjivar, Buffy Wicks

Organizational Notes

Last edited by Joanne Campbell at Mar 27, 2023, 6:01 PM
California Association of Health Plans: Oppose

Bill Number
SB 819

Status
Enacted

Title
Medi-Cal: certification.

Description
SB 819, Eggman. Medi-Cal: certification. Existing law requires the State Department of Public Health to license and regulate clinics. Existing law exempts from those licensing provisions certain clinics that are directly conducted, maintained, or operated by federal, state, or local governmental entities, as specified. Existing law also exempts from those licensing provisions a clinic that is operated by a primary care community or free clinic, that is operated on separate premises from the licensed clinic, and that is only open for limited services of no more than 40 hours per week.Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services (department) and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.Existing law sets forth various procedures, including the submission of an application package, for providers to enroll in the Medi-Cal program. Under existing law, an applicant or provider that is a government-run license-exempt clinic as described above is required to comply with those Medi-Cal enrollment procedures.Under existing law, an applicant or provider that is operated on separate premises and is license exempt, including an intermittent site or mobile health care unit that is operated by a licensed primary care clinic that provides all staffing, protocols, equipment, supplies, and billing services, is not required to enroll in the Medi-Cal program as a separate provider or comply with the above-described enrollment procedures, if the licensed primary care clinic has notified the department of its separate locations, premises, intermittent sites, or mobile health care units.This bill would additionally exempt from the Medi-Cal enrollment procedures an intermittent site or mobile health care unit that is operated by the above-described government-run license-exempt clinic if that clinic has notified the department of its separate locations, premises, sites, or units.The bill would make legislative findings stating that this bill is declaratory of existing law, as specified.

Primary Sponsors
Susan Eggman

Bill Number
SB 1120

Status
Enacted

Title
Health care coverage: utilization review.

Description
SB 1120, Becker. Health care coverage: utilization review. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of disability insurers by the Department of Insurance. Existing law generally authorizes a health care service plan or disability insurer to use prior authorization and other utilization review or utilization management functions, under which a licensed physician or a licensed health care professional who is competent to evaluate specific clinical issues may approve, modify, delay, or deny requests for health care services based on medical necessity. Existing law requires a health care service plan or disability insurer, including those plans or insurers that delegate utilization review or utilization management functions to medical groups, independent practice associations, or to other contracting providers, to comply with specified requirements and limitations on their utilization review or utilization management functions. Existing law authorizes the Director of the Department of Managed Health Care or the Insurance Commissioner to assess an administrative penalty to a health care service plan or disability insurer, as applicable, for failure to comply with those requirements. This bill would require a health care service plan or disability insurer, including a specialized health care service plan or specialized health insurer, that uses an artificial intelligence, algorithm, or other software tool for the purpose of utilization review or utilization management functions, or that contracts with or otherwise works through an entity that uses that type of tool, to ensure compliance with specified requirements, including that the artificial intelligence, algorithm, or other software tool bases its determination on specified information and is fairly and equitably applied, as specified. Because a willful violation of these provisions by a health care service plan would be a crime, this bill would impose a state-mandated local program.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Josh Becker

Organizational Notes

Last edited by Cherie Compartore at Jul 9, 2024, 5:26 PM
Oppose Unless Amended: California Association of Health Plans

Bill Number
SB 1131

Status
Enacted

Title
Medi-Cal providers: family planning.

Description
SB 1131, Gonzalez. Medi-Cal providers: family planning. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.Existing law establishes, under the Medi-Cal program, the Family Planning, Access, Care, and Treatment (Family PACT) Program, administered by the Office of Family Planning within the department. Under Family PACT, comprehensive clinical family planning services are provided to a person who has a family income at or below 200% of the federal poverty level and who meets other eligibility criteria to receive those services.Existing law makes the Family PACT Program inoperative if the program is determined to no longer be cost effective, as specified. If the program becomes inoperative, existing law requires all persons who have received, or are eligible to receive, comprehensive clinical family planning services pursuant to Family PACT to receive family planning services under other specified provisions of the Medi-Cal program or under the State-Only Family Planning Program, which is also established within the department.Existing law requires enrolled providers in the Family PACT Program or the State-Only Family Planning Program to attend a specific orientation approved by the department and requires providers who conduct certain services to have prior training in those services.This bill would, for the Family PACT Program, require a site certifier of a primary care clinic or affiliate primary care clinic, as those terms are defined, to be a clinician who oversees the provision of Family PACT services and would authorize certain clinic corporations to enroll multiple, but no more than 10, service addresses under one site certifier. The bill would require any orientation or training that the department requires of a site certifier to comply with specified requirements, including, among others, being offered through a virtual platform and being offered at least once every other month.For purposes of both of the above-described programs, existing law requires the program to disenroll as a program provider any individual who, or any entity that, has a license, certificate, or other approval to provide health care that is revoked or suspended by a federal, California, or other state’s licensing, certification, or other approval authority, that is otherwise lost, or that is surrendered while a disciplinary hearing is pending, as specified.This bill would authorize the department to elect to not disenroll an individual or entity as a program provider if the revocation, suspension, loss,... (click bill link to see more).

Primary Sponsors
Lena Gonzalez

Bill Number
SB 1180

Status
Enacted

Title
Health care coverage: emergency medical services.

Description
SB 1180, Ashby. Health care coverage: emergency medical services. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law requires health care service plan contracts and health insurance policies to provide coverage for certain services and treatments, including medical transportation services. Existing law establishes the Medi-Cal program, administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services, including emergency medical transport. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.Existing law, until January 1, 2031, authorizes a local emergency medical services (EMS) agency to develop a community paramedicine or triage to alternate destination program that, among other things, provides case management services to frequent EMS users or triage paramedic assessments, respectively.This bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after July 1, 2025, to establish a process to reimburse for services provided by a community paramedicine program, a triage to alternate destination program, and a mobile integrated health program, as defined.The bill would require those contracts and policies to require an enrollee or insured who receives covered services from a noncontracting program to pay no more than the same cost-sharing amount that they would pay for the same covered services received from a contracting program. The bill would prohibit reimbursement rates adopted pursuant to this provision from exceeding the health care service plan’s or health insurer’s usual and customary charges for services rendered.Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.The bill would also make services provided by these programs covered benefits under the Medi-Cal program. The bill would condition this Medi-Cal coverage on an appropriation, receipt of any necessary federal approvals, and the availability of federal financial participation.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Angelique Ashby

Organizational Notes

Last edited by Joanne Campbell at Apr 19, 2024, 8:14 PM
California Association of Health Plans - Oppose

Bill Number
SB 1238

Status
Enacted

Title
Health facilities.

Description
SB 1238, Eggman. Health facilities. (1) Existing law defines “health facility” to include a “psychiatric health facility” that is licensed by the State Department of Health Care Services and provides 24-hour inpatient care for people with mental health disorders. Existing law requires that such care include, but is not limited to, psychiatry, clinical psychology, psychiatric nursing, social work, rehabilitation, drug administration, and food services for persons whose physical health needs can be met in an affiliated hospital or in outpatient settings.This bill would expand the definition of “psychiatric health facility” to also include a facility that provides 24-hour inpatient care for people with severe substance use disorders, or cooccurring mental health and substance use disorders. The bill would expand that 24-hour inpatient care also include substance use disorder services, as medically necessary and appropriate. The bill would specify that psychiatric health facilities to only admit persons with stand-alone severe substance use disorders involuntarily pursuant to specified requirements.The bill would authorize a psychiatric health facility to admit persons diagnosed only with a severe substance use disorder when specified conditions are met. The bill would authorize the department to implement, interpret, or make specific these provisions, in whole or in part, by means of plan or county letters, information notices, plan or provider bulletins, or other similar instructions, until the time when regulations are adopted no later than December 31, 2027.(2) Under existing law, regulations adopted by the department are to include standards appropriate for 2 levels of disorder: (1) involuntary ambulatory psychiatric patients, and (2) voluntary ambulatory psychiatric patients.This bill would instead require regulations to include standards appropriate for 3 levels of disorder: (1) involuntary ambulatory patients receiving treatment for a mental health disorder, (2) voluntary ambulatory patients receiving treatment for a mental health disorder, and (3) involuntary ambulatory patients receiving treatment for a severe substance use disorder.(3) Existing law requires the program aspects of a psychiatric health facility to be reviewed and approved by the department to include, among others, activities programs, interdisciplinary treatment teams, and rehabilitation services. Existing law requires proposed changes in the standards or regulations affecting health facilities that serve persons with mental health disorders to be effected only with review and coordination of the California Health and Human Services Agency.This bill would expand these program aspects to also include substance use disorder services, if the psych... (click bill link to see more).

Primary Sponsors
Susan Eggman

Bill Number
SB 1289

Status
Enacted

Title
Medi-Cal: call centers: standards and data.

Description
SB 1289, Roth. Medi-Cal: call centers: standards and data. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law sets forth various responsibilities for counties relating to eligibility determinations and enrollment functions under the Medi-Cal program.Existing federal law sets forth Medicaid reporting requirements for each state during the period between April 1, 2023, and June 30, 2024, inclusive, relating to eligibility redeterminations, including, among other information, the total call-center volume, average wait times, and average abandonment rate for each call center of the state agency responsible for administering the state plan, as specified.The bill would require a county with a call center as described above, commencing on January 1, 2026, and each month thereafter, to collect and submit to the department call-center data metrics, including, among other information, total call volume, average call wait times by language, and average call abandonment rate. By creating new duties for counties relating to call-center data, the bill would impose a state-mandated local program.The bill would require the department to prepare a report, excluding any personally identifiable information, on call-center data. The bill would require the department to post the report on its internet website on a quarterly basis no later than 45 calendar days after the conclusion of each quarter, with the initial report due on May 15, 2026.The bill would require the department to implement these provisions, without taking any regulatory action, by means of an all-county letter or similar instruction. The bill would require the department to adopt regulations thereafter in accordance with certain provisions.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.

Primary Sponsors
Richard Roth

Bill Number
SB 1300

Status
Enacted

Title
Health facility closure: public notice: inpatient psychiatric and perinatal services.

Description
SB 1300, Cortese. Health facility closure: public notice: inpatient psychiatric and perinatal services. Existing law requires the State Department of Public Health to license, regulate, and inspect health facilities, as specified, including general acute care hospitals. A violation of these provisions is a crime. Under existing law, a general acute care hospital is required to provide certain basic services, including medical, nursing, surgical, anesthesia, laboratory, radiology, pharmacy, and dietary services. Existing law authorizes a general acute care hospital to provide various special or supplemental services if certain conditions are met. Existing regulations define a supplemental service as an organized inpatient or outpatient service that is not required to be provided by law or regulation. Existing law requires a health facility to provide 90 days of public notice of the proposed closure or elimination of a supplemental service, and 120 days of public notice of the proposed closure or elimination of an acute psychiatric hospital.This bill would change the notice period required before proposed closure or elimination of the supplemental service of inpatient psychiatric unit or a perinatal unit from 90 days to 120 days. By changing the definition of a crime, this bill would impose a state-mandated local program. The bill would require the health facility to provide public notice of the proposed elimination of the supplemental service of either inpatient psychiatric unit or perinatal unit, as specified. The bill would require the health facility to conduct at least one noticed public hearing within 60 days of providing public notice of the proposed elimination of the inpatient psychiatric unit or perinatal unit and would require the health facility to accept public comment. The bill would require the health facility to post the public hearing notice and the agenda along with the public notice. The bill would require the health facility holding the public hearing to meet prescribed requirements, including notifying the board of supervisors of the county in which the health facility is located when a public hearing is scheduled and inviting the board of supervisors to provide testimony on the impacts of the elimination of the services to the county and community health systems.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Dave Cortese

Bill Number
SB 1320

Status
Enacted

Title
Mental health and substance use disorder treatment.

Description
SB 1320, Wahab. Mental health and substance use disorder treatment. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law provides for the regulation of disability insurers by the Department of Insurance. Existing law requires a health care service plan contract or disability insurance policy issued, amended, or renewed on or after January 1, 2021, to provide coverage for medically necessary treatment of mental health and substance use disorders, as defined, under the same terms and conditions applied to other medical conditions.This bill would require a plan or insurer subject to the above-described coverage requirement, and its delegates, to establish a process to reimburse providers for mental health and substance use disorder treatment services that are integrated with primary care services and provided under a contract or policy issued, amended, or renewed on or after July 1, 2025. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Aisha Wahab

Bill Number
SB 1354

Status
Enacted

Title
Long-term health care facilities: payment source and resident census.

Description
SB 1354, Wahab. Long-term health care facilities: payment source and resident census. Existing law provides for the licensing and regulation of long-term health care facilities, including, among others, skilled nursing facilities and intermediate care facilities, by the State Department of Public Health. A violation of those provisions is generally a crime. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.Existing law prohibits a long-term health care facility that participates as a provider under the Medi-Cal program from discriminating against a Medi-Cal patient on the basis of the source of payment for the facility's services that are required to be provided to individuals entitled to services under the Medi-Cal program. Existing law prohibits that facility from seeking to evict out of the facility, or transfer within the facility, any resident as a result of the resident changing their manner of purchasing the services from private payment or Medicare to Medi-Cal, except as specified.This bill would require the facility to provide aid, care, service, and other benefits available under Medi-Cal to Medi-Cal beneficiaries in the same manner, by the same methods, and at the same scope, level, and quality as provided to the general public, regardless of payment source. The bill would find and declare that this requirement is declaratory of existing law and thus not reimbursable under the Medi-Cal Long-Term Care Reimbursement Act or any other Medi-Cal ratesetting provisions, as specified. The bill would specify that if reimbursement is found to be required by state or federal law or regulation, as specified, the above requirement shall only become operative upon appropriation by the Legislature. The bill would also provide that this requirement and the above-described prohibition against discrimination on the basis of payment source be implemented only to the extent that these provisions do not conflict with federal law, that any necessary federal approvals are obtained, and that federal financial participation for the Medi-Cal program is available and is not otherwise jeopardized.Existing federal regulations require certain nursing facilities to post their resident census and specified nurse staffing data on a daily basis.This bill would require a skilled nursing facility that participates as a provider under the Medi-Cal program to make publicly available its current daily resident census and nurse staffing data, as defined. The bill would require the facility to make the information a... (click bill link to see more).

Primary Sponsors
Aisha Wahab

Bill Number
SB 1385

Status
Enacted

Title
Medi-Cal: community health workers: supervising providers.

Description
SB 1385, Roth. Medi-Cal: community health workers: supervising providers. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services through various delivery systems, including fee-for-service and managed care. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.Under existing law, community health worker services are a covered Medi-Cal benefit subject to any necessary federal approvals. Under existing law, a community health worker is a liaison, link, or intermediary between health and social services and the community to facilitate access to services and to improve the access and cultural competence of service delivery. Existing law requires a Medi-Cal managed care plan to engage in outreach and education efforts to enrollees, and to notify providers, about the community health worker services benefit, as specified.This bill would require a Medi-Cal managed care plan, no later than July 1, 2025, to adopt policies and procedures to effectuate a billing pathway for supervising providers to claim for the provision of community health worker services to enrollees during an emergency department visit and as an outpatient followup to an emergency department visit. The bill would require that the policies and procedures be consistent with guidance developed by the department for use by supervising providers to claim for community health worker services to Medi-Cal members in the fee-for-service delivery system in the settings described above.The bill would define a “supervising provider” for purposes of these provisions as an enrolled Medi-Cal provider that is authorized to supervise a community health worker pursuant to the federally approved Medicaid state plan amendment and that ensures that a community health worker meets the qualifications as required by the department, as specified.

Primary Sponsors
Richard Roth

Bill Number
SB 1511

Status
Enacted

Title
Health omnibus.

Description
SB 1511, Committee on Health. Health omnibus. (1) Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. Existing law defines a “group contract,” for purposes of the act, as a contract that by its terms limits the eligibility of subscribers and enrollees to a specified group.This bill would clarify that reference to a “group” in the act does not include a Medi-Cal managed care contract between a health care service plan and the State Department of Health Care Services to provide benefits to beneficiaries of the Medi-Cal program.(2) Existing law, the Compassionate Access to Medical Cannabis Act or Ryan’s Law, requires specified health care facilities to allow a terminally ill patient’s use of medicinal cannabis within the health care facility, as defined, subject to certain restrictions. Existing law requires the State Department of Public Health to enforce the act. Existing law prohibits a general acute care hospital, as specified, from permitting a patient with a chronic disease to use medicinal cannabis.This bill would authorize a general acute care hospital to allow a terminally ill patient, as defined, to use medicinal cannabis.(3) Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed by, and funded pursuant to, federal Medicaid program provisions. Existing law establishes the Administrative Claiming process under which the department is authorized to contract with local governmental agencies and local educational consortia for the purpose of obtaining federal matching funds to assist with the performance of administrative activities relating to the Medi-Cal program that are provided by a local governmental agency or local educational agency (LEA).Existing law requires the department to engage in specified activities relating to the LEA Medi-Cal Billing Option, including amending the Medicaid state plan to ensure that schools are reimbursed for all eligible services, consulting with specified entities in formulating state plan amendments, examining methodologies for increasing school participation in the LEA Medi-Cal Billing Option, and conducting an audit of a Medi-Cal Billing Option claim consistent with prescribed requirements, such as generally accepted accounting principles. Existing law requires the department to issue and regularly maintain a program guide for the LEA Medi-Cal Billing Option program. Existing law requires the department to file an annual report with the Legislature that includes, among other... (click bill link to see more).

Primary Sponsors
Senate Health Committee

CHIEF MEDICAL OFFICER'S REPORT

L.A. Care HEALTH PLAN
For All of L.A.

CMO Report: October 2024

Health Services Division Update

Medical Management
Quality Management
Community Health
Pharmacy

Sameer Amin, MD
Chief Medical Officer, Health Services

ELEVATING HEALTHCARE IN LOS ANGELES COUNTY SINCE 1997

Contents

Strategy Management

*As part of our annual strategic planning efforts, L.A. Care's Health Services (HS) Division held a two-day **Strategy Summit** on October 7-8, 2024, engaging senior leadership across all HS functional areas to plan the 2025 Health Services Program Strategy. This document is a first of its kind living strategic guide designed to promote alignment to enterprise goals and objectives, integration across all Health Services departments and underlying operational teams, and cross-divisional partnerships.*

In addition to mapping out the Health Services strategic goals and objectives for the upcoming year in alignment with the enterprise strategic vision and goals, we are generating a list of strategic initiatives meant to address the following priority areas:

- **Streamlining Authorizations and Care Coordination**: Identifying interdependencies between the teams of the Medical Management department to ensure seamless authorizations and referrals for new, policy-driven, programs and services, e.g., CalAIM Enhanced Care Management (ECM), Transitional Care Services (TCS), and Community Supports (CS).

- **Optimizing Population Health Management (PHM):** The Health Services Division will adopt a PHM-based integration framework that will enable all departments to coordinate on key success drivers that are fundamental to the implementation of PHM. The drivers will be embedded in all subsequent strategic initiatives:

    - Data Analytics and Technology
    - Aligned Incentive Contracting
    - Network Development and Optimization
    - Robust Provider Engagement
    - Effective Member Engagement
    - Value-Based Practice Transformation
    - Care Coordination and Integration

- **Clearing Pathways for Collaboration with other Divisions:** Enhancing the ways in which the Health Services team engages with critical enterprise teams like Finance, Operations, Compliance, and IT to maintain operational stability and achieve alignment.

Medical Management

Enhanced Care Management (ECM)

Enrollment

L.A. Care continues to work towards the goal of enrolling 30,000 members in ECM. The initial Q2 2024 enrollment data, including Plan Partners, shows 16,725 members enrolled, reflecting a 7% increase from the previous quarter (15,759). This growth in Q2 2024 was driven almost entirely by L.A. Care, facilitated by new incentive payments and improved referral and lead processes. In terms of enrollment distribution, 53% of members have been enrolled in the last year; 47% have been enrolled for over a year, while 36% of members have been enrolled for over 2 years.

Contracting and Network

Our top 5 providers include St. John's Well Child & Family Health Center, Los Angeles County Department of Health Services (DHS), Healthcare in Action, Central Neighborhood Health Foundation, and Titanium. 17 of our 84 ECM providers are Justice-Involved providers. A total of 9 new providers were contracted in 2024.

A total of 21 providers have been in the contracting process; 3 of which were recently added including Adventist Health, AltaMed Health Services, and Didi Hirsch Mental Health Services.

Care Management (CM) for MCLA Members

Case Volumes

During August 2024, the L.A. Care CM team created 542 MCLA CM cases and conducted initial outreach to offer members CM support. Of these cases, 427 were considered high risk cases, 73 were California Children's Services (CCS) care management, 24 were low risk cases, 15 were medium risk cases, and 3 were complex care management (CCM) cases.

Transitional Care Services (TCS)

The TCS program sustained an increase in the number of high-risk TCS cases outreached through August. During that month, over 2,717 members were contacted and offered TCS support. The team is collaborating with the Analytics Team to enhance and expand real-time admission notifications via Health Information Exchanges (HIEs). Currently, all but two contracted hospitals in Los Angeles County (West Hills and Lakewood) are on an HIE platform. Our data algorithms help immediately identify members who fall under the "DHCS High Risk" category for TCS purposes. Low risk TCS members began receiving post discharge notification

of their ability to access TCS services. To date, a total of 82 low risk members have contacted the TCS Central Intake Line to request TCS support.

Utilization Management (UM)

Timeliness of UM Decisions and Notifications

The UM department continues to show exceptional operational compliance from January to June 2024, with nearly all quantitative compliance measures for timeliness of decisions and notifications consistently exceeding 95% across multiple lines of business, including MCLA, LACC, PASC, and D-SNP. This improvement is particularly notable considering the updated measures for commercial lines of business, which now account for extensions and have contributed to the enhanced compliance rates. Not a single measure fell below 95%, underscoring the department's commitment to maintaining high standards of timeliness and accuracy in UM processes.

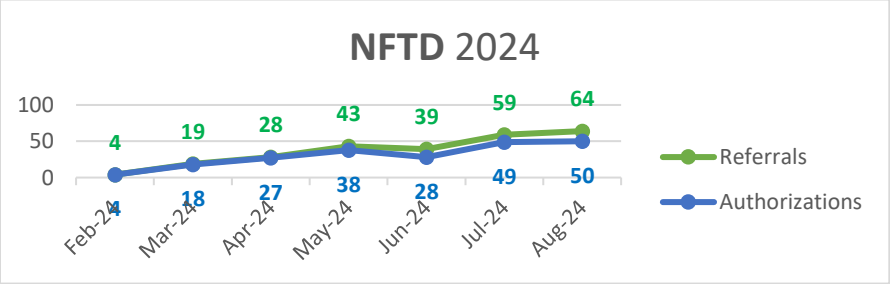
Managed Long Term Services and Supports (MLTSS)

Community-Based Adult Services (CBAS)

There are a total of 181 contracted CBAS providers, with 2 new entrants since the last report: Regal Center in Arcadia and Monte del Sol in El Monte. A total of 3 providers were terminated due to administrative issues regarding re-credentialing, or center closure.

The current CBAS census stands at 10,393 thru the end of August, which is a total increase of 93 members since the previous month. 10,248 are Medi-Cal members, while the remaining 145 are D-SNP.

Nursing Facility Transition or Diversion (NFTD)



Quality Management

Health Education, Cultural, and Linguistic Services (HECLS)

Meals as Medicine Program

The Community Supports Meals as Medicine (MAM) program has been experiencing steady growth. In August, the program hit 636 service authorization requests, the highest number since the program's inception in January 2022, compared to the latest record of ~500+ requests in the last reporting term for July 2024.

DHCS Transitional Care Services (TCS) for Birthing Individuals

As a reminder, every pregnant member who has had a hospital discharge is contacted by a Community Health Worker/Case Manager, who connects them to relevant resources and facilitates scheduling of provider follow-up visits. The TCS program for Birthing Individuals is onboarding eight new staff members this month to support the program and the high volume of members eligible for this program.

Maternal Health Programs

Health Education is continuing to work with Plan Partners regarding LA County Department of Public Health (DPH) Doula Hub funding. Plan Partners will work directly with DPH on funding proposals. L.A. Care's Community Benefits team will finalize L.A. Care's Doula Hub sponsorship.

Health Education partnered with Birth Workers of Color Collective to support the Inglewood Community Resource Center Baby Shower, attended by 15 participants. Perinatal resources, including the Doula Benefit, were shared with attendees.

Initiatives

- L.A. Care has contracted with Quality Health Partners (QHP) to co-host mobile clinic events with Blue Shield Promise at the Community Resource Centers (CRCs). The first mobile clinic event will take place on October 19 at the Panorama City CRC. This event is by appointment only and will close gaps for Well Child Visits, Lead Screening, Social Determinants of Health Screening, and Topical Fluoride Application.

- MCLA and LACC Pediatric Flu Vaccine Member Incentive is expected to launch in October. The MCLA version has been approved by the Department of Health Care Services (DHCS). Member materials are awaiting final approval before being distributed.

- The new Fall 2024 Patient Experience Training webinar series *Optimizing the Clinical Experience for All* launched on September 24. The fall series will include 10 sessions in

total and will run through December 3. Additional efforts were made this season to help improve attendance rates.

- After the 3rd non-compliant Blood Lead Attestation was sent out to applicable providers, we still have 29 direct network providers who have not signed and returned the attestation. These notifications were sent by email and fax. The attestations were escalated to delegation and monitoring with Provider Relations. They will contact these PCP offices in an attempt to have the attestations signed.

- The Clinical Initiatives team will distribute fluoride varnish materials/kits to clinics in practice transformation programs. Transform L.A. has identified 15 clinics that are interested.

- L.A. Care hosted 3 provider webinars in September: *Documenting DSF-E (Depression Screening and Follow-Up for Adolescents and Adults) and SNS-E (Social Need Screening and Intervention) Codes Refresher* webinar with Quality Performance Management, *Promoting Safe Firearm Storage in Primary Care* with Dr. Robert Riewerts a Pediatrician at Keck Medicine USC, and *Building Vaccine Confidence and Addressing Vaccine Hesitancy* with Dr. Reena Gulati, Regional Medical Director at Merck.

Provider Quality Review (PQR)

- Total Potential Quality Issue (PQI) Processed/PQI Processing Timeliness. The PQR team's timely closure rate has remained above 99% for FY2023-2024.

- **PQR- Audits and Oversight:** PQR has completed all Annual Audits for Plan Partners and Specialty Health Plans. No corrective action plans were needed. PQR continues to monitor Anthem for low-volume trends; however, their PQI policies are noted to be in alignment with other health plans.

- **PQR Collaboration with A&G:** PQR continues to monitor incoming PQI referral cases under the new A&G workflow, provide collaborative feedback to the A&G team, and identify potential areas for additional PQI training, as needed.

- **PQR has completed A&G oversight** through August 2024 with 3 cases being identified for potential quality of care issues. The PQR team continues to work with both A&G and Customer Solution Center (CSC) teams to drive process improvements.

- **PQR – PQI Platform:** Development for the new PQI system (“Kaizen”) is on track with end-to-end UAT and regression testing. The IT and the PQR teams have successfully deployed the Kaizen Phase 1 release into production as of September 27, 2024. All technical and business validations have been completed, and all functionalities work as expected. The successful deployment of Kaizen is a testament to the hard work and dedication of the project teams. Their collective efforts will significantly improve L.A. Care’s Provider Quality Review process. Phase 2 development will soon follow.

Population Health Management (PHM)

- The PHM team finalized the 2024 PHM Program Description, which included the CalAIM requirements and intervention updates.

- PHM and other business units are participating in strategic planning on PHM across the enterprise. Business units completed a survey of the current state and gaps and have been meeting bi-weekly to strategize how to enhance PHM.

Population Health Informatics

Health Information Management (HIM) Analytics

We have been tasked to investigate the low rates we're seeing for KED, AMR, and PCR (Kidney Health Evalution for Patients with Diabetes, Asthma Medication Ratio, and Plan All-cause Readmission) measures. The HIM team is looking into L.A. Care's data, and applying HEDIS specifications to that data, to glean any information on strategies to improve those critical HEDIS rates.

Health Information Ecosystem (HIEc)

Clinical Data Repository (CDR) Program: Real-time ADT (Admission Discharge Transfer) data integration into downstream applications (CCA) is expected to be completed by November 10, 2024. The CCD (Continuity of Care Documents) project is currently undergoing IT estimation and architecture review. This project aims to develop a real-time FHIR (Fast Healthcare Interoperabilty Resources) CCD data ingestion pipeline, with implementation scheduled to begin around November 2024.

CMT Amendments: A one-time HIE Adoption Incentive program has been successfully launched, targeting hospitals and Skilled Nursing Facilities (SNFs) with a total budget of $2.1 million. The first two rounds of funding have been completed, resulting in the onboarding of 31 SNFs and 7 hospitals. Planning for the third round is currently underway, with the onboarding of the remaining facilities scheduled to launch in October 2024.

Community Health

Community Supports (CS) Operations & Reporting

CS Provider Network

Contracting in progress for providers selected for contracting for Community Supports services as part of the July 2024 and January 2025 contracting cycles.

Latest in CS Implementation and Member Engagement

The Community Health Department is working to increase member engagement and CS utilization. Strategies include provider opportunity reports, provider and stakeholder engagement, provider incentives, member engagement, and referral monitoring and reporting.

A review of preliminary DHCS guidance related to revised CS service descriptions, a new proposed Community Supports service (Transitional Rent), and Closed Loop Referral (CLR) requirements has been completed to identify impacts to operations, identify areas that require clarification, and suggest changes to the preliminary guidance.

Systems IT: SyntraNet and QNXT

Work is ongoing to resolve CS data issues in SyntraNet such as accurate reflection of Provider Return Transmission File (RTF) updates (i.e. discontinuation of services). Certain CS related Housing Initiatives and Social Services (i.e., Recuperative Care and Short Term Post Hospitalization Housing) will remain in SyntraNet with a plan to transition them to the QNXT platform in early 2025.

Behavioral Health Services (BH)

Spotlight: Year's End Telehealth Summary with Hazel Health

63 Local Education Agencies (LEAs) with 703 schools are currently referring members for BH services though Hazel Health.

- **Utilization:** 3k students served, 20k visits, and 30k hours delivered.
- **School Level Visit breakdown:** 43% Elementary, 30% Middle, & 26% High School.
- **Insurance Coverage by type:** 45% Commercial, 55% Medi-Cal
- **Hazel is reaching a highly diverse population of students:** 54.5% Hispanic/ Latino, 13.5% White, 8.6% Black, 2.4% 2+ Races, 4.4% Asian, 0.1% Pacific Islander, 0.3% American Indian, 16.3% Unknown.

Care Coordination

Actively working on evaluating and refining the Closed Loop Referral process for members transitioning between delivery systems, Carelon Behavioral Health and Department of Mental Health (DMH), to ensure compliance with DHCS regulations.

Grievances

BH team is analyzing the individual grievances that are filed by members accessing or attempting to access BH services to develop a root cause analysis as well as an action plan to help decrease the number of grievances filed. BH is also working closely with the A&G department to improve the resolution process for behavioral health related grievances.

Justice-Involved ECM (Enhanced Care Management) Populations

BH team is preparing for this new ECM population to go live as of October 1, 2024. We will ensure that members being released from correctional facilities can be connected to behavioral health services when they do not meet criteria for specialty services through the County.

Social Services (SS)

The department has initiated services at the Tiny Homes campus in Montebello effective September 13, 2024.

Our director of Social Services attended the Gateway Cities Council of Governments Network Meeting to talk about L.A. Care's Community Supports programs, particularly the Homeless Navigation, Tenancy Support Services, Housing Deposits, and Recuperative Care programs.

Our Social Services Recuperative Care Manager attended the Recuperative Care Symposium in Sacramento to talk about our Recuperative Care Program.

Housing Initiatives

Housing Community Supports: Housing Navigation (HN), Tenancy Sustaining Services (TSS) and Housing Deposits (HD).

Financial Restructure Planning: HN/TSS will transition from a pre-emptive monthly capitation structure to a 2 claims per month (paid at half the cap rate each) structure. Implementation is in progress.

Members Enrolled (as of 9/23/2024): 13,321 members were enrolled in L.A. Care's housing programs (of which 9,344 are assigned to DHS). This is a 27% increase in enrollment from 1/1/2024 (2,823 additional members).

Day Habilitation Community Support

This community support program launched on July 1, 2024. Currently, 5 providers are part pf the July 2024 cycle (4 are pending, and 1 is onboarded). There is 1 provider approved for the January 2025 cycle.

Housing and Homelessness Incentive Program

- The Skid Row Care Collaborative HHIP Investment agreement is near execution. DHS completed legal review and final review by L.A.'s legal team is underway. The JWCH (Wesley Health Centers) agreement is complete and moving towards final approvals and execution.
- The HHIP team is working to analyze HMIS (Homelessness Management Information System) data and create reports and dashboards that will support identification of members experiencing homelessness.

- HHIP Core Stakeholder and Community Forum meetings will be scheduled for fall 2024 to provide updates on existing initiatives and new initiatives including the Skid Row Care Collaborative and Field Medicine Program.

Field and Street Medicine: Launch and Operations

- The capacity-building grant investment and reporting templates are being finalized. The applicable metrics have been finalized and distributions will occur annually for selected for FM provider.
- Measurement Period 1 of the Field Medicine Performance Incentive program began July 1, 2024.
- Legal and Contracting & Relationship Management finalized a Field Medicine amendment that will go out alongside the Primary Care Provider (PCP) contracts.
- We are continuing to refine operations for fee-for-service claims for unassigned members, time-limited direct access to specialty care and durable medical equipment, member assignment, etc.
- Field Medicine Provider Care Pods
    - Contracted providers of HN, TSS, ECM, and Recuperative Care have been identified to serve as care pod providers assigned to each of the 15 Field Medicine regions.
    - Regionally assigned Care Pod providers will receive referrals from: Field Medicine providers, Interim Housing sites, MDT (Multidisciplinary) teams, transitional housing sites, and eventually LAHSA outreach, DPH's CHOI (Children's Health Outreach Initiatives) teams, and DMH's HOME (Homeless Outreach and Mobile Engagement) teams operating in each region.
    - Meetings with selected providers will be scheduled between now and October 10 to introduce the Care Pod concept and secure buy-in
    - Care Pod concept will be rolled out at the 10/16 Field Medicine In-Person meeting.

Pharmacy Department

Medication Adherence Programs

Comprehensive Adherence Solutions Program (CASP): Earlier this year, we introduced a series of interventions and enhancements to address declining performance. We are now seeing positive results, having surpassed adherence rates for statin and hypertension measures compared to this time last year, with diabetes adherence trailing by less than 0.5%. We will continue to track performance and explore additional avenues for improvement.

Pharmaco-adherence Mailers: Pharmacy has been collaborating with Facilities to launch the adherence mailers. As of 9/23/24, a total of 1,575 DSNP and 1,998 LACC provider mailers have been sent out, alongside 3,200 DSNP and 8,521 LACC member mailers. Looking ahead, we plan to gather feedback from members at the upcoming Enrollee Advisory Committee (EAC) meeting on 11/12/24 to further improve these mailers.

Refill Reminder Robocalls: The robocalls identify and call members who are overdue for a medication refill. As of 10/1/24, 21,456 total robocall attempts have been made to DSNP and LACC members. Of these, 6,567 calls successfully connected with the members.

AdhereHealth Vendor Collaboration: Medication adherence outreach began and 953 active members were enrolled as of 9/27/24.

Medication Therapy Management (MTM) Program

As a reminder, CMS requires health plans to offer MTM services to Medicare members, including an annual comprehensive medication review (CMR). L.A. Care Pharmacy, in collaboration with Navitus Clinical Engagement Center (MTM vendor), has achieved a 71% completion rate of eligible members as of 9/23/24, a significant improvement from this time last year at 69%.

Additional Pharmacy Programs

Asthma Medication Ratio (AMR):

Pharmacy identified incorrect drug quantities in the pharmacy claim data used by the HEDIS engine, resulting in an increase in the number of rescue inhalers and a lower AMR rate. Quality Performance Management (QPM) is investigating the issue and hoping to correct it by the next data refresh. Additionally, 12,788 prescribers were sent a general notice to prescribe inhaled corticosteroid (ICS)-formoterol as the preferred reliever therapy per clinical guidelines, accompanied by an asthma remediation flyer in collaboration with Social Services.

Community Resource Center (CRC) Vaccine Clinics:

Pharmacy worked closely with Health Education, CRC leadership, and North Star Alliances to plan 7 vaccine clinics for the upcoming flu season between September and November 2024. USC Medical Plaza Pharmacy will offer health screenings (blood pressure and blood glucose) in addition to flu and COVID-19 vaccines. Pharmacy is collaborating with USC and QPM to ingest blood pressure screening results as supplemental data to fill any gaps in care.

All pharmacists (along with many technicians and other staff) from our team have volunteered to attend the events.

Date	Time	Location
Friday, 9/13/2024	10AM-4PM	Norwalk CRC
Saturday, 9/28/2024	10AM-2PM	West LA CRC
Friday, 10/4/2024	10AM-2PM	Lynwood CRC
Saturday, 10/5/2024	9AM-2PM	El Monte CRC
Monday, 10/7/2024	12PM-4PM	Long Beach CRC
Friday, 10/11/2024	12PM-4PM	East LA CRC
Friday, 11/8/2024	10AM-2PM	Panorama City CRC

Health Services Division

2024 Strategy Summit

Executive Summary Report: 2025 Strategic Priorities

L.A. Care HEALTH PLAN

For All of L.A.

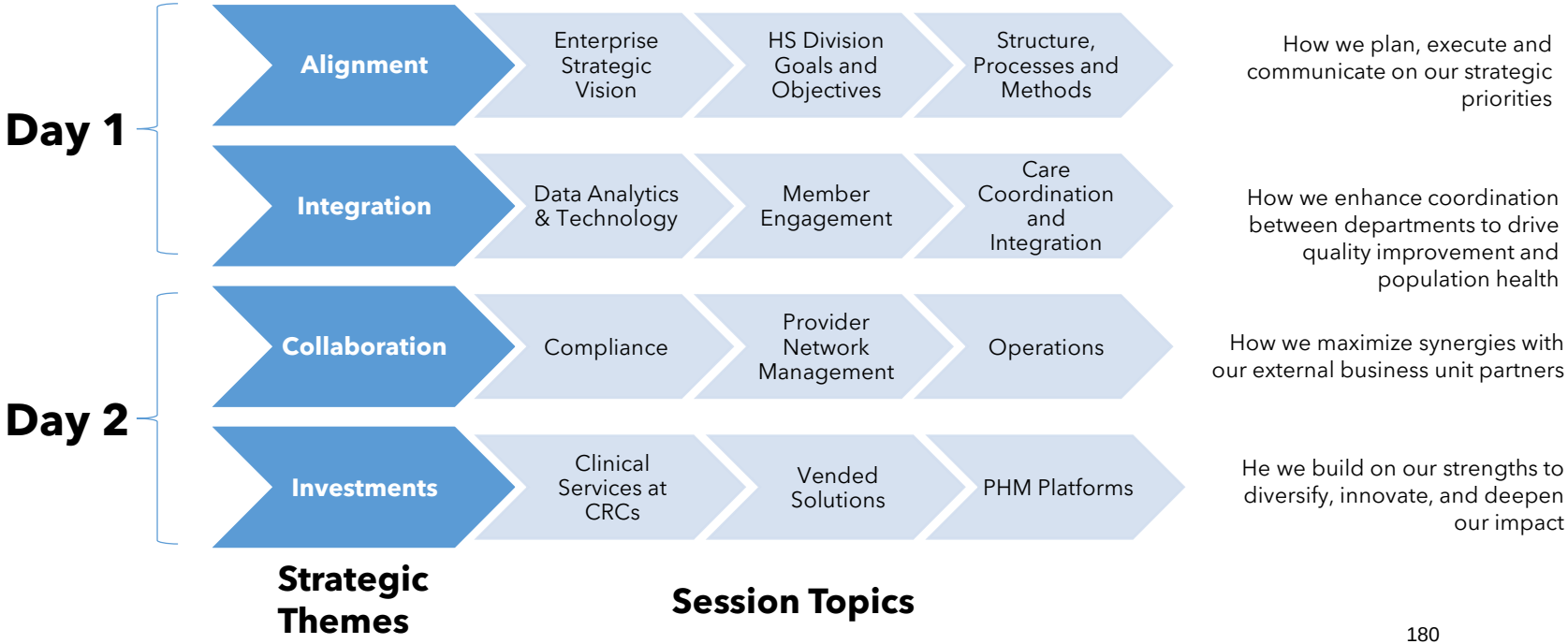
ELEVATING HEALTHCARE IN LOS ANGELES COUNTY SINCE 1997

Overview

Intent and Purpose of the HS Strategy Summit

2024 Health Services Strategy Summit

Figure 1. Framework for the Health Services Strategy Summit. The Summit aims to address fundamental questions about the nature of our work and operations, establishing alignment within the team to set the foundation for a focused strategic planning phase in Q4 of 2024.



Identifying Drivers of Success in HS Operations

Adopting a Strategy Architecture Based on Population Health Management

A unified strategy aligning Medical Management, Quality, Community Health, and Pharmacy, emphasizing collaboration and interdependencies.

Key Focus Areas:

- **Data & Technology:** Data-driven decisions for quality and efficiency
- **Aligned Incentives:** Partnering with providers at system and individual levels to improve outcomes
- **Network Optimization:** Building and curating a high-performing provider network and strategic contracts to align with enterprise goals
- **Provider Engagement:** Deepening provider collaboration
- **Member Engagement:** Growing and sustaining member participation
- **Value-based Improvement:** Driving value-based care improvements
- **Care Coordination:** Seamless, integrated member-centered care

Critical Success Drivers: Mutually Interdependent and Reinforcing

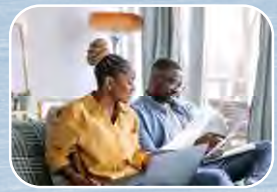
Data Analytics and Technology

Aligned Incentive Contracting: LAC with Provider Groups

Aligned Incentive Contracting: Provider Groups with Individual Providers

Network Development and Optimization

Robust Provider Engagement



Effective Member Engagement

Practice Transformation and Value-Based Improvement

Care Coordination and Integration

Figure 2. Strategic Integration Framework. This approach fosters high-quality, efficient care, promoting positive health outcomes across our member population.

A Division Level Strategy

Enabling Alignment, Integration, and Collaboration

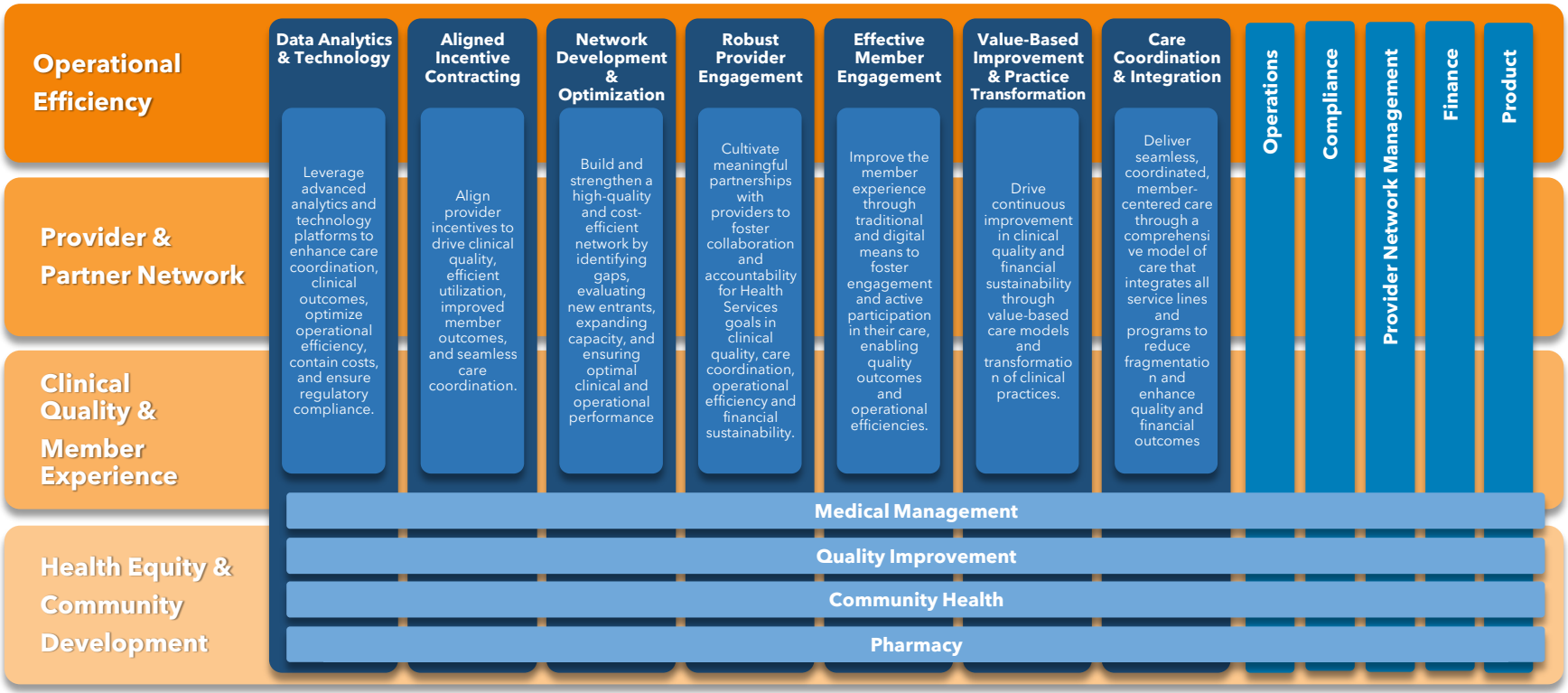


Figure 3. Health Services Strategic Architecture. This conceptual model demonstrates how the division-level strategy in Health Services in designed to align to enterprise goals, integrate operations in the four primary functional area departments, and enable collaboration with division partners across the enterprise.

HS Partnership with Enterprise Strategy

An Advisory Relationship for Strategic Planning and Implementation

	Milestone Activity	Purpose	Finish	Status
1	Identify the Enterprise Strategy themes and goals	Anchoring the HS Division Strategy to the key priorities of the Enterprise strategy	October 31	✅
2	Breakdown the scope of the Health Services Division	Understanding each department's contributions to the division, and how that translates to the Enterprise strategy	October 31	✅
3	Identify strategic alignment opportunities	Aligning HS initiatives to the Enterprise priorities	October 31	✅
4	Develop strategic themes for the HS Division and department objectives	Each pillar will align with the enterprise strategy while integrating departmental objectives	October 31	⏳
5	Define metrics and KPIs	Understanding how we will define success and demonstrate the effectiveness of the strategy	November 15	⏳
6	Identify interdependencies and collaboration points	Ensures the departments work cohesively to achieve shared goals. Some initiatives may overlap, requiring alignment between different teams.	November 30	⛔
7	Develop the Strategic Action Plan	Outline specific initiatives and actions, ongoing and future state, to under each strategic theme and by department objectives	December 20	⛔
8	Develop Communication and Governance Plans	Support a clearly communicated strategy to stakeholders and backed by an accountability framework.	January 15	⛔
9	Implement, Monitor Progress and Risk, Evaluate and Continuously Improve	Ensure that strategies are effectively executed, tracked for performance, and adapted as needed.	January 31	⛔

✅ Complete ⏳ In Progress ⛔ Not Started

Key Outcomes

Tactical Directions to Operationalize our Strategic Plan

Selected Directions for Alignment

A Centralized Strategy Management Team to Execute the Division Strategy

Adopting a matrixed model by establishing **dotted-line relationships between resources and a centralized strategic unit**, scaling resources for flexible and efficient strategy management.

- Cross-functional collaboration
- Shared Responsibilities
- Optimized Resource Allocation
- Increased Agility and Flexibility
- Enhanced Skill Utilization
- Cost-efficiency
- Improved knowledge sharing

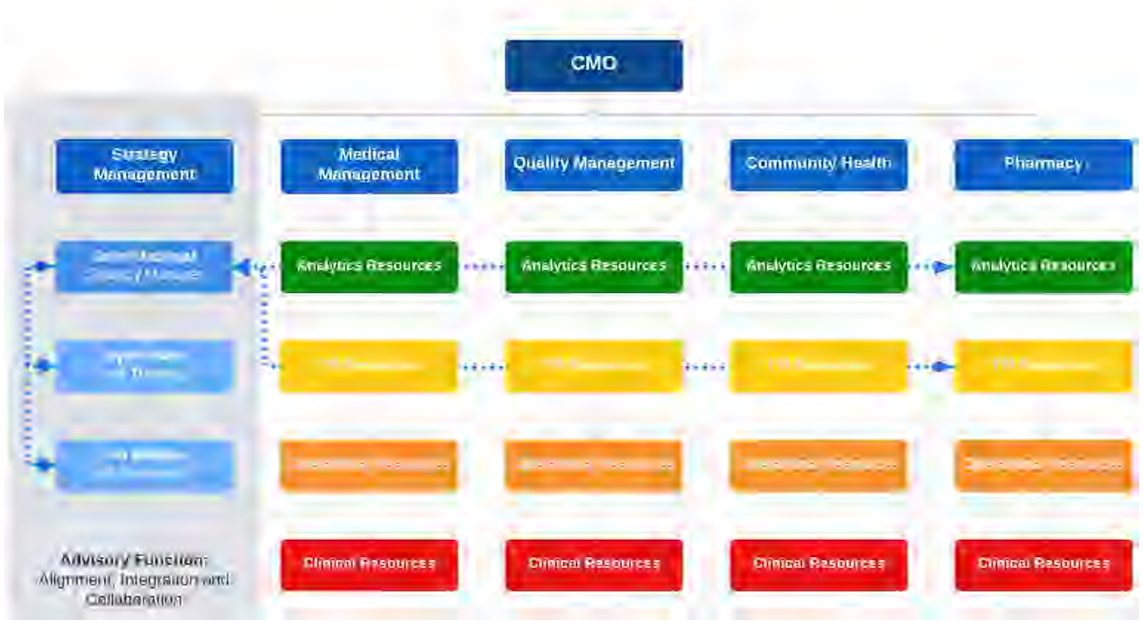


Figure 4. Conceptual Model for Strategy Management Team. Establishing dotted-line relationships between analytics and project management resources across the HS division and a centralized strategy unit to enhance and scale strategic impact.

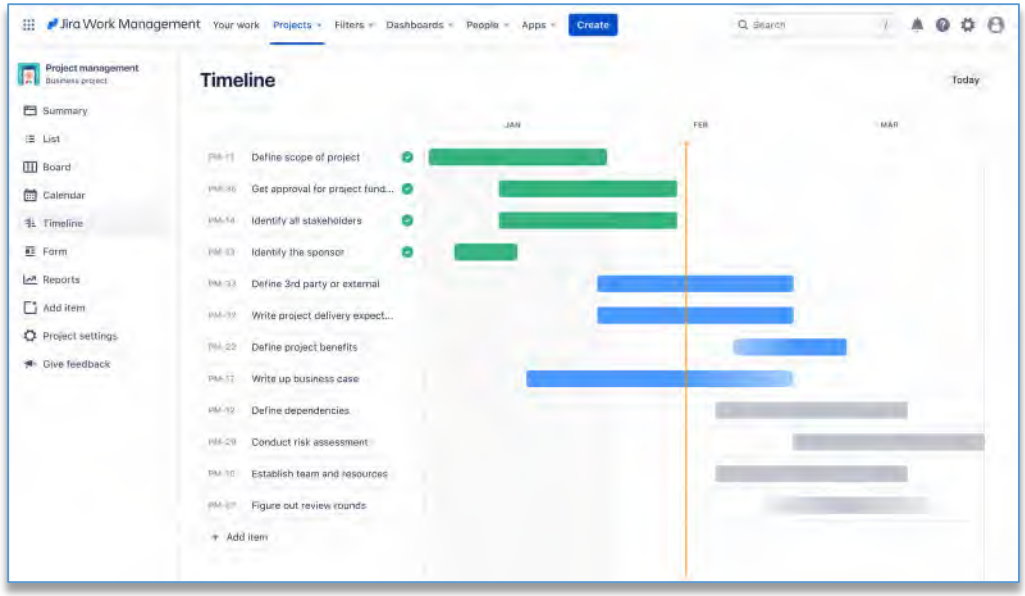
Selected Directions for Alignment

A Centralized Strategy Management Team to Execute the Division Strategy

Leveraging a digital platform like **Jira for project management** to enhance overall management of the division strategy.

- Centralized Planning and Tracking
- Enhanced Collaboration and Cross-Functional Integration
- Real-time Status Updates and Dashboards
- Efficient Resource Management
- Data-Driven Decision-Making
- Facilitates agile strategy execution
- Clear accountability and Transparency
- Customizable Workflows and Processes
- Facilitates Risk Management
- Enhanced Reporting and Stakeholder Communication

Figure 5. Jira Board for Project Management. Various digital, real-time, and project-based features will enable forward momentum in all phases of the strategy program lifecycle.



Selected Directions for Alignment

Communications and Governance Plan to Support Monitoring and Reporting

Improved strategic focus by aligning meetings with project lifecycle phases

- **Streamlined communication** across the team with fewer redundant meetings
- **Enhanced decision-making** with timely data at key lifecycle stages
- **Clearer progress monitoring** at each project phase
- **Greater accountability** as teams regularly report on lifecycle progress
- **Increased agility** to respond to challenges during project execution
- **Efficient use of time**, leading to more productive meetings

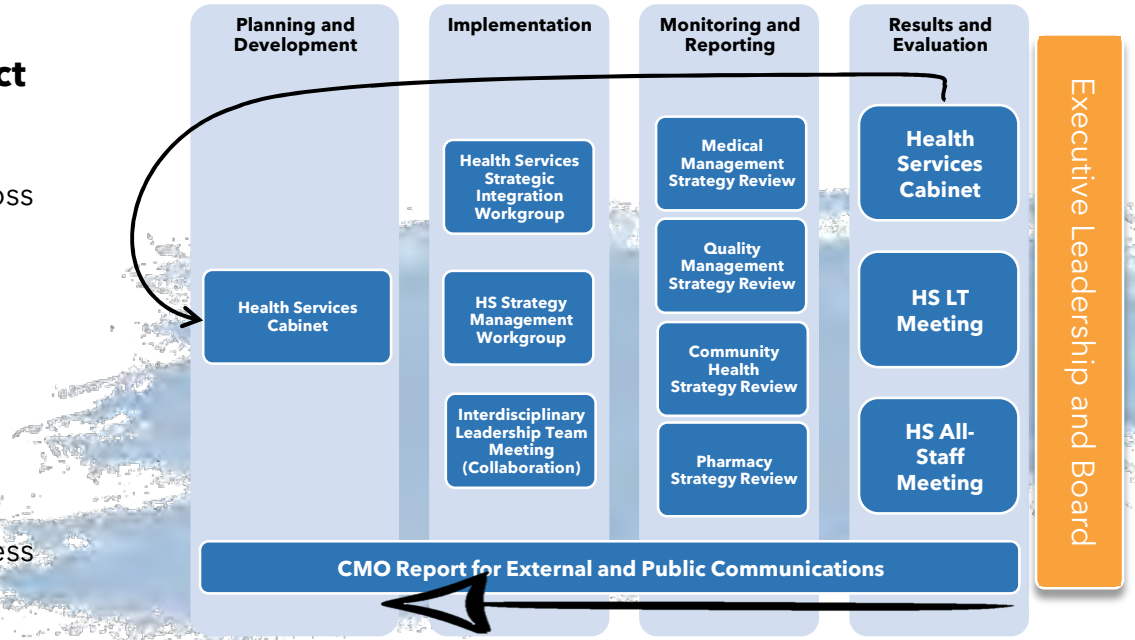


Figure 6. Conceptual Model for a Health Services Communications Plan. Contextualizing our meetings within the project lifecycle provides a clear framework for communication. By implementing this structured approach, we foster a more focused, strategic, and agile environment that drives projects forward and keeps all stakeholders aligned.

Selected Directions for Alignment

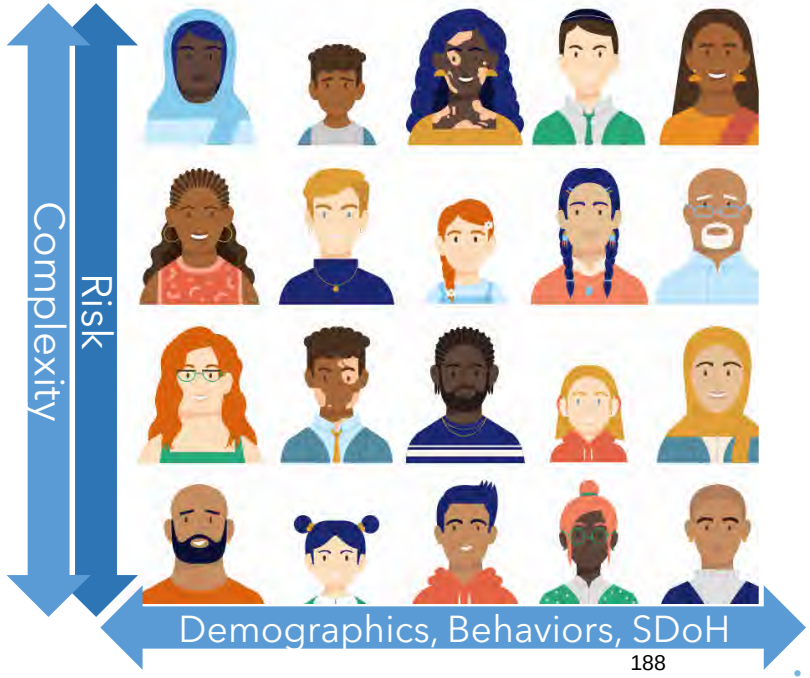
Member Personas to Support Accountability, Problem Solving and Collaboration

The use of member personas as a heuristic for problem-solving and decision-making offers several benefits:

- **Focuses problem-solving** efforts on real-life member experiences.
- **Improves accountability** by clearly tying roles and responsibilities to specific challenges and outcomes.
- **Enhances integration and collaboration** between cross-functional leaders.
- **Streamlines decision-making** by simplifying complex issues.
- **Supports continuous improvement** through iterative evaluation.
- **Aligns decisions with broader strategic goals** and member-centric outcomes.

By leveraging personas, our teams can solve emerging problems more efficiently, foster collaboration, and make faster, better-informed decisions.

Figure 7. Conceptual Model for Member Personas.



Selected Directions for Integration

Strategies in Data Analytics and Technology: Executive Summary

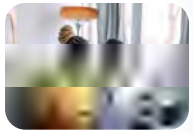
Technology, Data Platforms, and Analytics

Aligned Incentive Contracting: LAC with Provider Groups

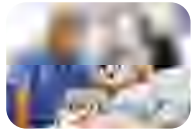
Aligned Incentive Contracting: Provider Groups with Individual Care Providers

Balanced Network Development and Optimization

Robust Provider Engagement



Effective Member Engagement



Practice Transformation and Value-Based Improvement

Care Coordination and Integration

Data Analytics

Knowledge Management
- **Robust Training Opportunities**
- Analytics Policies for Standardization
- **Shared Data Processes Workflows**

Process Efficiency
- **Centralized Intake and Triage Process in Jira**
- Self-Service Access and Utilization

Quality Oversight
- **HS-Engagement in Enterprise Data Governance Implementation**
- Federated Analytics Model

Strategic Execution
- **Central Data Analytics Strategy**
- Enhance Usage of HIE Ecosystem
- Risk Stratification for All

Technology

Population Health Platforms
- RFP Process for Foundational population health data platforms
  - Cozeva
  - Epic Payer Platform

Digital Member Engagement Vendors
- Optimizing Existing Member Experience Capabilities like VOICE CRM
- Digital Health Orchestration and Engagement Platforms
- Incentive and Patient Motivator Solutions
- Digital Care Delivery Solutions

Figure 8. Data Analytics and Technology Priorities.

Selected Directions for Integration

Strategies for Effective Member Engagement

Technology, Data Platforms, and Analytics

Aligned Incentive Contracting: LAC with Provider Groups

Aligned Incentive Contracting: Provider Groups with Individual Care Providers

Balanced Network Development and Optimization

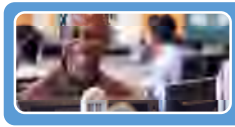
Robust Provider Engagement

Effective Member Engagement

Practice Transformation and Value-Based Improvement

Care Coordination and Integration

Digital Strategy



Optimizing Existing Member Experience Capabilities

- **Example:** Strengthening the VOICE Program driving improvement in the Customer Solutions Center

Delegated Primary and Complex Care Partners

- **Example:** CareMore, Aledade, Apree, Oak Street

Community Care Delivery Partners

- **Example:** Food Banks, Homeless Shelters, Family Care Centers

Community & Neighborhood Health Connectors

- **Example:** Pair Team, Wider Circle

Digital Health Orchestration and Engagement Platforms

- **Example:** League, Pager Health, and Salesforce

Digital Incentive and Patient Motivator Solutions

- **Example:** Wellth and Soda Health

Digital Care Delivery Solutions

- **Example:** Teladoc (PCP), Tailor Care (MSK), Lyra Health (BH), Livongo (Diabetes), Omada (Chronic Disease Management)

Figure 9. Member Engagement Priorities.

Selected Directions for Integration

Centralizing Operations in Medical Management

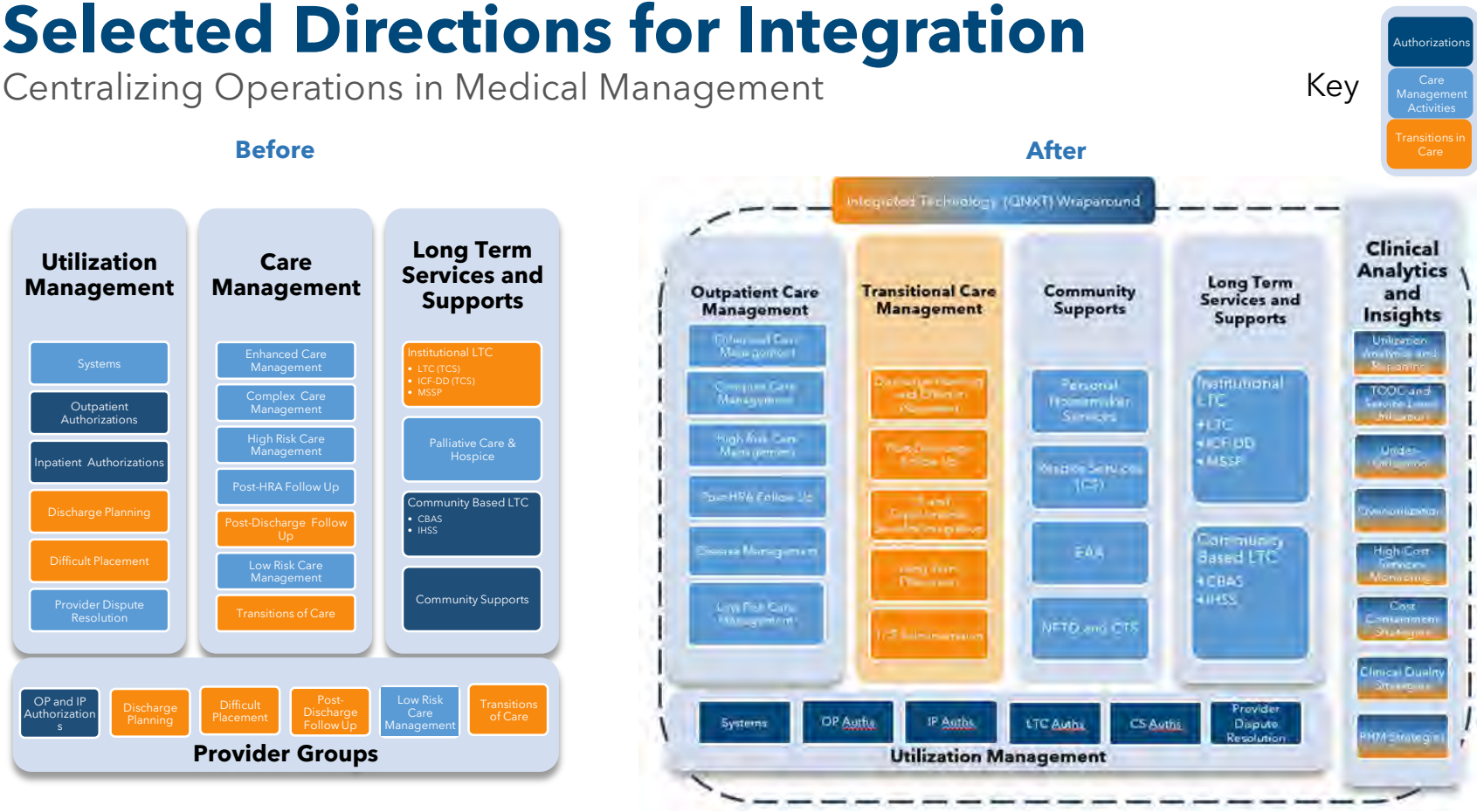


Figure 10. Conceptual Model of Initiative to Centralize Operations in Medical Management. In the "Before" state, authorization, and outpatient and transitional care management activities are disseminated across the department. In the "After" state, they are centralized under new operational departments to reduce fragmentation and promote streamlined care coordination.

Selected Directions for Collaboration

Cross-Division Collaboration Strategy for Network Development and Optimization

Enterprise Goal. Support a robust provider and partner network to ensure capacity to address out members' health and social needs.

HS Objective. Build and strengthen a high-quality and cost-efficient network by identifying gaps, evaluating new entrants, expanding capacity, and ensuring optimal clinical and operational performance.

HS and Finance

Collaborative Focus: Collaborate with Finance to align network strategies with financial compliance, provider finance, and actuarial services. Use risk adjustment analytics and financial reporting to optimize reimbursement models, manage provider risk, and ensure sustainable care delivery through cost-effective, value-based partnerships.

HS and Systems IT

Collaborative Focus: Enable real-time data synchronization and system alignment to reduce network leakage, streamline operational workflows, and implement advanced analytics tools for monitoring performance and ensuring smooth, automated operations.

HS and Product

Collaborative Focus: Align network optimization efforts with the operational needs of Medi-Cal, Medicare, and Commercial & Group products to support seamless member transitions and product continuity. Collaborate with Strategic Planning, Sales, and Marketing to ensure network readiness and enhance the member experience, promoting high-quality, cost-effective care across all product lines.

HS and PNM

Collaborative Focus: Utilize clinical data and analytics to ensure network adequacy, guide provider onboarding and performance management, and align the network with quality initiatives to meet member needs for access, specialized care, and improved outcomes.

HS and Compliance

Collaborative Focus: Ensure regulatory compliance for delegated utilization. care management, and quality functions while optimizing provider operations, reducing administrative burden, and maintaining alignment with health plan standards.

HS and Operations

Collaborative Focus:

Enable Health Services to deliver coordinated, high-quality care by aligning authorizations, claims, call center operations, and A&G functions around provider- and member-centric processes, ensuring operational efficiency, timely QOC grievance resolution, and seamless information flow.

Figure 11. Conceptual Model of Cross-Division Strategy for Network Optimization. By adopting this integrated strategy, your health plan can foster collaboration, break down silos between divisions, and drive improvements in network optimization, regulatory compliance, and operational processes to enhance member care.

Appendix

Selected Directions for Integration

Data Analytics: Robust Trainings and Opportunities for Knowledge Management

Impact Intelligence

- A tool that gives LA Care a retrospective view of member data and comprehensively shows us **trends in the member's care** and the **efficacy of implemented programs/decisions** made for the member.

Impact Pro

- This tool is geared towards a prospective view, giving us **predictions into what could be** the outcome if certain decisions are made or not, as members are identified.

Optum

Optum's Impact Intelligence (I.I.) and Impact Pro (IPro) empower L.A. Care to:

- Enhance health plan quality and performance as we transition to a managed care model.
- Improve the health and well-being of our members.
- Optimize our facility and physician network.
- Add value, efficiency, and quality to our managed care organization and client relationships.
- Detect cost, utilization, and quality trends.
- Integrate patient satisfaction data and HRA results to elevate patient care and physician performance.
- Facilitate Health Information Exchange (HIE) to enhance continuity and coordination of care through access to EHR systems.

Selected Directions for Integration

Data Analytics: Robust Trainings and Opportunities for Knowledge Management

Self-service training is available on L.A. Care University for Health Services staff who want to learn more about LANES and PointClickCare HIEs and the information that's available in the portals.

- **LANES Smart Alerts Patient Synopsis Overview**
- **Collective Medical Technology and Post-Acute Management Overview Training**

LANES and PointClickCare offer real-time access to comprehensive clinical information and medical records from hospitals, skilled nursing facilities, ambulatory facilities, county agencies, and more:

- Encounter details
- Medications
- Active Problems
- Social History
- Last Filled Vitals Signs
- Functional Status
- Progress Notes
- Plan of Treatment
- Medical Devices
- Results
- Visit Diagnoses
- Additional Health Concerns
- Insurance
- Advance Directives
- Care Teams

Selected Directions for Integration

Data Analytics: Centralized Intake Process in Jira for Process Efficiency

Enterprise Reporting Process Overview and Goals

Purpose

- Develop a centralized process for handling enterprise reporting to enhance efficiency and consistency
  - Promotes efficiency by avoiding duplication of effort, increasing knowledge sharing, and aligning all teams with organizational goals
  - By streamlining information access and establishing a robust triage system, it ensures visibility into ongoing analytics efforts across the enterprise and facilitates a smooth transition from analytics to production IT.

Objectives	Description
Develop Centralized Reporting Intake Process	• A centralized intake process and tool (Jira) providing a one-stop shop for reporting.
Identify Cross-functional Stakeholders and Develop Decision-making Matrix.	• Identification of cross-functional stakeholders for collaborative decision-making. • Implementation of an automated decision matrix for self-service decision-making.
Develop Report Distribution Process	• An established process for efficient report distribution to end users.
Federated Governance Model	• Define standards, policies, and guidelines for how data is reported. This ensures consistency in reporting across the organization while respecting the autonomy of different business units.

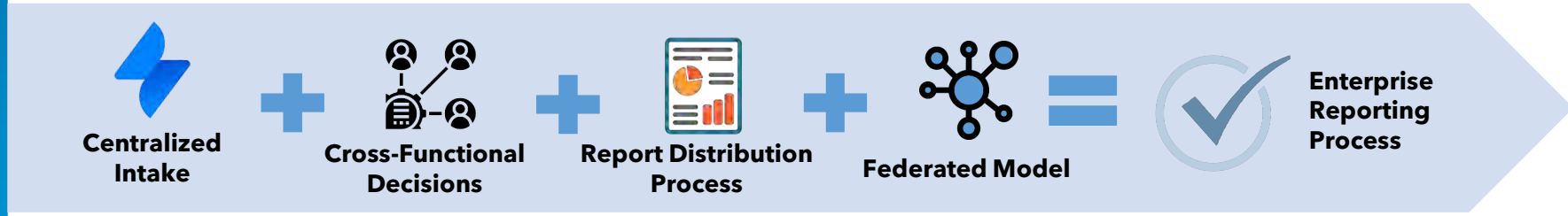


Figure 12. Conceptual Model of Enterprise Reporting Process.

Selected Directions for Integration

Data Analytics: HS-Engagement in Enterprise Data Governance Implementation for Quality Oversight

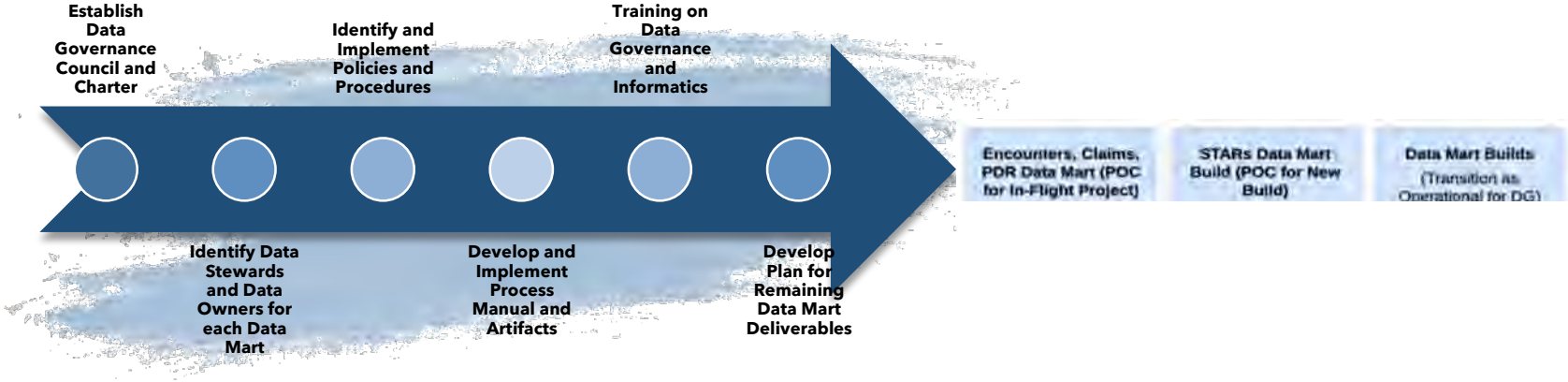


Figure 13. Conceptual Model of Enterprise Level Data Governance Implementation Work Plan Milestones. (Above)

Figure 14. Ongoing and Upcoming Data Mart Builds. (Right)

Health Services Challenges

Disseminated Authorizations, Care Management and Care Transitions Activities

Current State

Utilization Management

- Functional fragmentation of authorizations across MM units, LOB, service level or type and significant PPG delegation with resultant inefficiency and inconsistent oversight
- IP discharge planning/DPT sits within UM vs. CM/TCS resulting in lack of direct member engagement, delayed referrals, planning and discharge, high readmission rates and frustrated providers
- Appropriate management of the utilization of LA Care services rests in cross functional areas and requires strategic collaboration amongst many departments: AAL, QI, PHM, PNM, etc.

Transitions of Care and Care Management

- Fragmented accountability across internal and external parties by organizational structure, LOB, etc., resulting in fragmented outcome monitoring
- Lack of standard CM protocols and DM approaches to care
- Inconsistent longitudinal care planning for optimal member-centric care delivery
- Inconsistent approaches to vendor strategy and engagement to optimize member outcomes

Systems Disparate systems contribute to effective and efficient program delivery

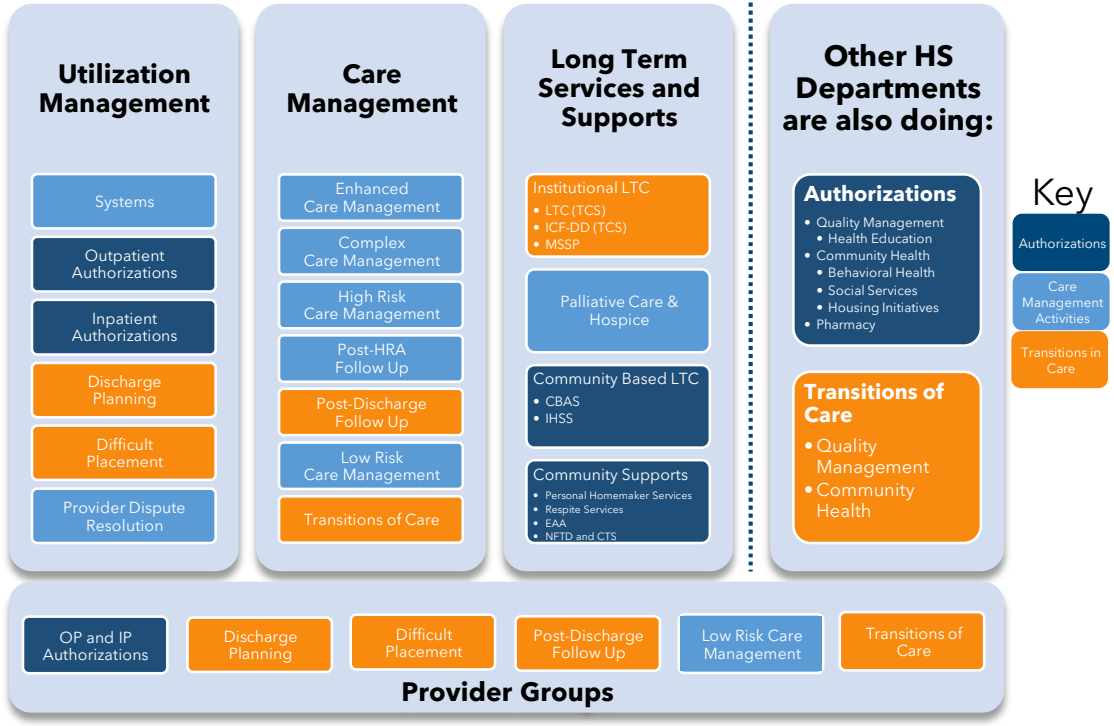


Figure 15. Conceptual Model of Disseminated Processes in the Medical Management Department. Focus is on authorizations, care management and transitional care activities.

Selected Directions for Integration

An Integrated Medical Management Model Based on Severity and Need

A Path Forward in Medical Management:

1. Centralize authorizations and utilization review in Utilization Management
2. Organize care management activities along the continuum of care delivery based on severity and need, with established protocols and evidence based practice interventions.
3. Incorporate selected QI measures in CM/TCS activities such as closing gaps in care.
4. Develop disease management programs and CM DM specific interventions.
5. Organize all transitions-related activities into a clearly defined transitional care management focus.
6. Align data analytics resources into a new operational focus generating clinical business insights on total cost of care, service level utilization and over/under utilization, to inform cost containment and PHM strategies.

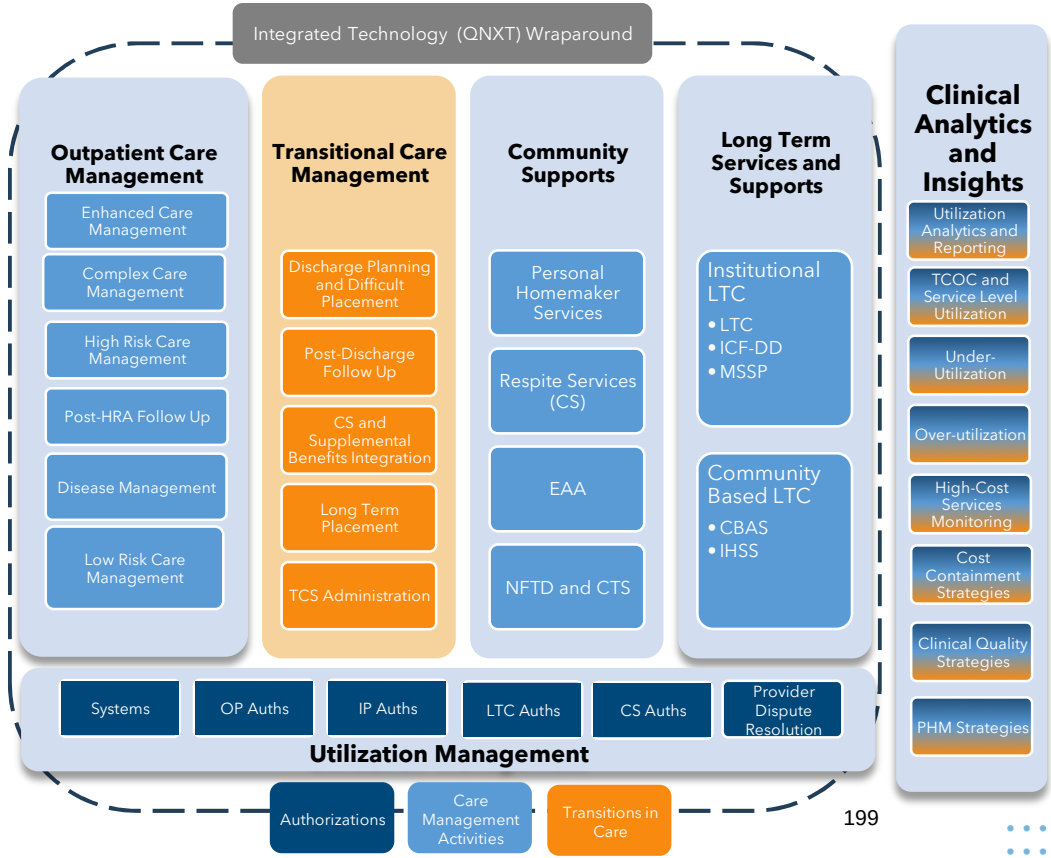


Figure 16. Conceptual Model of Disseminated Processes in the Medical Management Department. Focus is on authorizations, care management and transitional care activities.

Selected Directions for Collaboration

Enhanced Delegation Oversight: Advancing Clinical Coordination in the Network

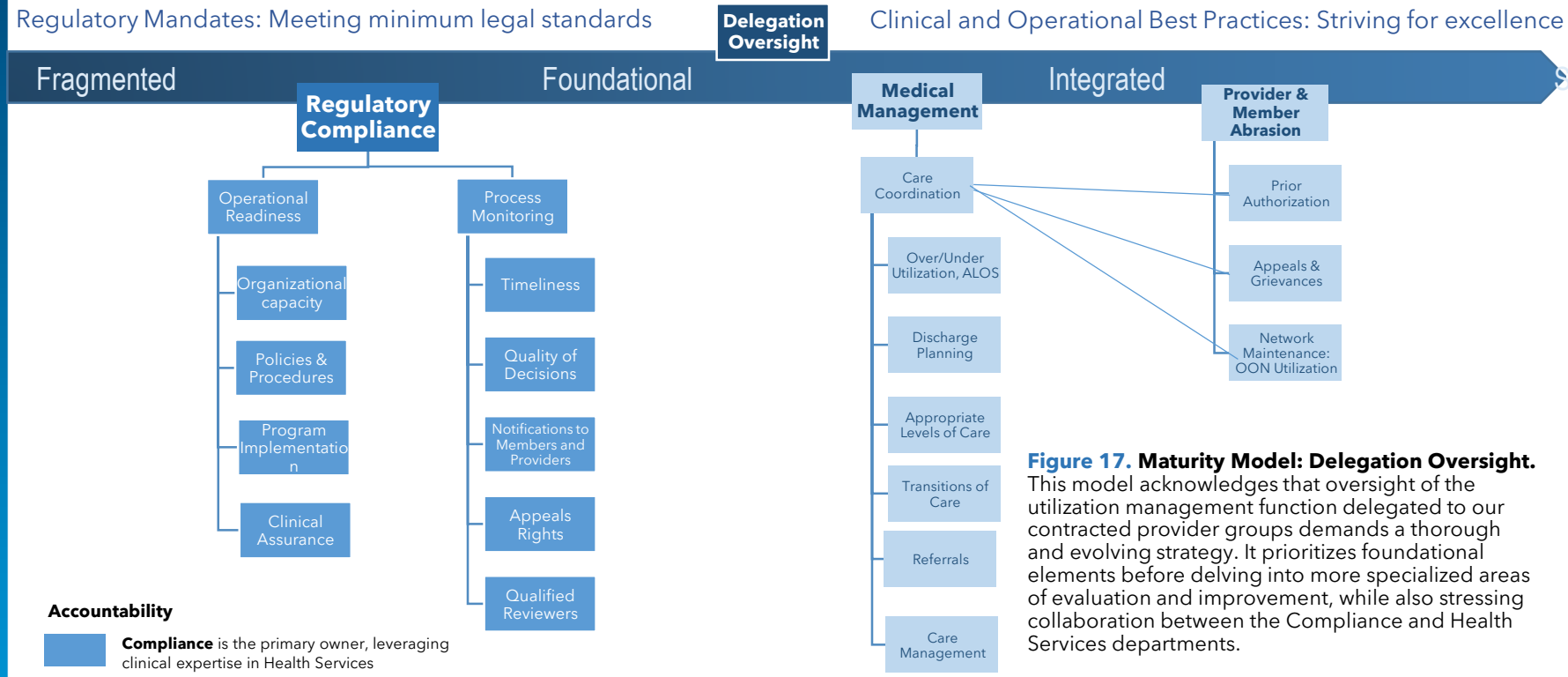


Figure 17. Maturity Model: Delegation Oversight. This model acknowledges that oversight of the utilization management function delegated to our contracted provider groups demands a thorough and evolving strategy. It prioritizes foundational elements before delving into more specialized areas of evaluation and improvement, while also stressing collaboration between the Compliance and Health Services departments.

Selected Directions for Collaboration

Enhanced Delegation Oversight: Advancing Care Coordination in the Network

Care Coordination Evaluation Domains

Adverse Utilization and Inpatient Authorizations

- Ensure that delegates' handling of inpatient authorization decisions for our members is consistently supported by evidence-based guidelines, reflecting appropriate clinical judgments and alignment with L.A. Care's standards.

Lengths of Stay

- Optimize the lengths of stay for our members managed by our delegates by ensuring that stays are clinically appropriate, neither excessively long nor prematurely short, and are justified based on best practices and the specific needs of each member.

Discharge Dispositions

- Improve the discharge planning practices of our delegates by ensuring that our members are discharged to the most suitable care levels and settings, with comprehensive discharge plans that include necessary follow-up care and resources to support recovery and reduce the likelihood of readmissions.

Transitions of Care

- Enhance the quality of care transitions managed by our delegates on behalf of our members by promoting robust communication between inpatient and outpatient providers, ensuring care management teams are effectively integrated to support seamless transitions and minimize risk of readmission.

Referrals to LTSS, Community Supports and Supplementary Services

- Strengthen the referral process managed by our delegates by ensuring that our members are appropriately and timely connected to LTSS and CS, and Medicare Supplemental Services facilitating access to essential resources that support their long-term health and well-being.

Care Management: Individual Care Plans

- Evaluate the effectiveness care management practices during and after hospitalization by assessing the quality and relevance of ICPs and the thoroughness of care coordination across different care settings.

Selected Directions for Collaboration

Enhanced Delegation Oversight: Advancing Care Coordination in the Network

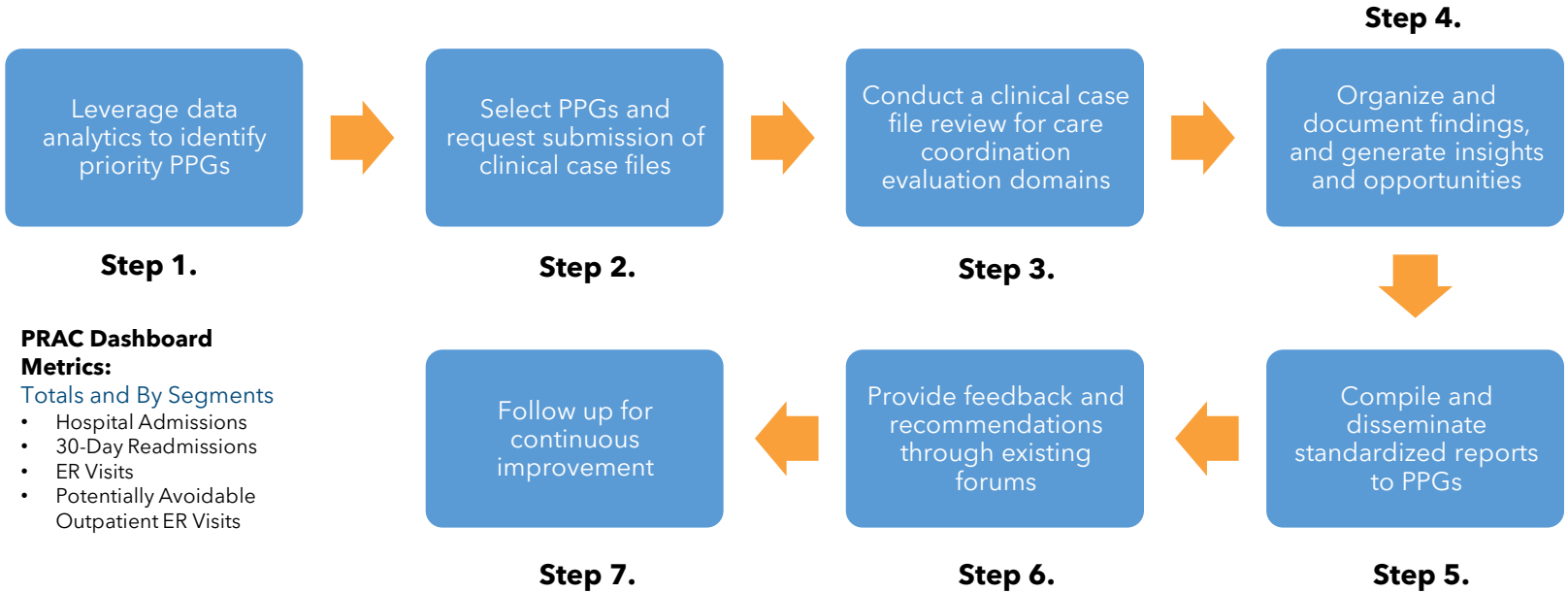


Figure 19. Mockup of the End-to-End Process: Targeted Evaluation of Care Coordination in Prioritized Provider Groups.

CHIEF FINANCIAL OFFICER REPORT

Board of Governors Meeting

L.A. Care HEALTH PLAN®

For All of L.A.

August 2024 YTD Financials

November 7, 2024

Agenda

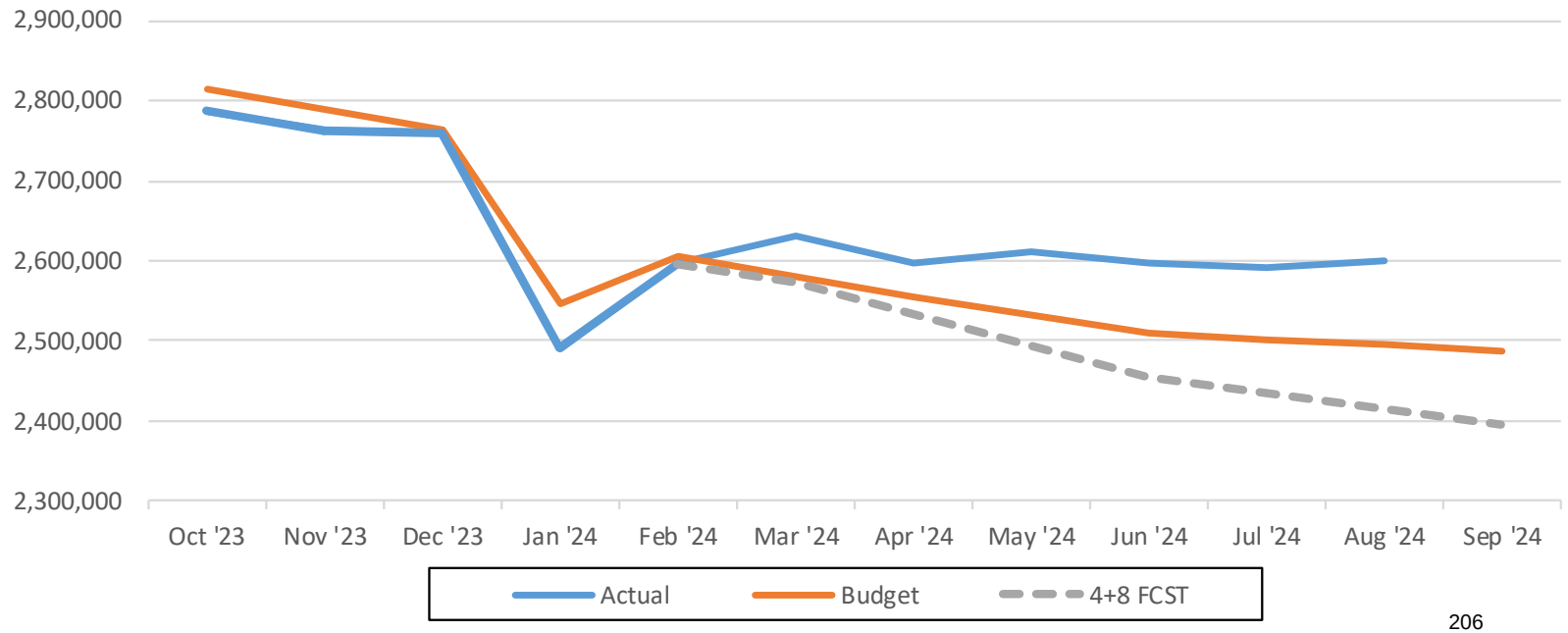
Financial Performance – August 2024 & YTD

- Membership
- Consolidated Financial Performance
- Operating Margins by Segment
- Key Financial Ratios
- Tangible Net Equity & Days of Cash On-Hand Comparison

Membership – August 2024 YTD

	August 2024			Year-to-Date		
Sub-Segment	**Actual**	**4+8 FCST**	**Variance**	**Actual**	**4+8 FCST**	**Variance**
Medi-Cal	2,359,052	2,197,450	161,602	26,664,551	26,027,456	637,095
D-SNP	19,945	19,735	210	211,563	210,444	1,119
LACC	190,859	171,398	19,461	1,827,172	1,750,008	77,165
PASC	49,381	47,513	1,868	536,125	528,418	7,707
***Elimination**	(19,945)	(19,735)	(210)	(211,563)	(210,444)	(1,119)
Consolidated	**2,599,292**	**2,416,361**	**182,931**	**29,027,848**	**28,305,882**	**721,966**

***D-SNP members included in MCLA membership under CCI.**



Consolidated Financial Performance – August 2024

($ in Thousands)	Actual	4+8 FCST	Variance
Member Months	2,599,292	2,416,361	182,931
Total Revenues	$841,392	$862,839	($21,447)
Total Healthcare Expenses	$873,188	$830,210	($42,978)
Operating Margin	($31,796)	$32,629	($64,425)
Operating Margin (excl HHIP/IPP)	*($30,769)*	*$24,600*	*($55,369)*
Total Admin Expenses	$59,310	$55,804	($3,506)
Income/(Loss) from Operations	($91,106)	($23,175)	($67,931)
Non-Operating Income (Expense)	$6,166	$10,925	($4,759)
Net Surplus/(Deficit)	**($84,939)**	**($12,250)**	**($72,689)**
Net Surplus/(Deficit) (excl HHIP/IPP)	***($83,713)***	***($20,078)***	***($63,634)***

Consolidated Financial Performance – Aug 2024 YTD

($ in Thousands)	Actual	4+8 FCST	Variance
Member Months	29,027,848	28,305,882	721,966
Total Revenues	$9,935,481	$9,834,762	$100,719
Total Healthcare Expenses	$9,117,309	$9,100,906	($16,404)
Operating Margin	$818,171	$733,856	$84,315
Operating Margin (excl HHIP/IPP)	*$704,459*	*$639,405*	*$65,054*
Total Admin Expenses	$594,682	$579,871	($14,811)
Income/(Loss) from Operations	$223,489	$153,985	$69,504
Non-Operating Income (Expense)	$172,103	$153,512	$18,591
Net Surplus/(Deficit)	**$395,592**	**$307,497**	**$88,095**
Net Surplus/(Deficit) (excl HHIP/IPP)	***$284,563***	***$215,388***	***$69,175***

Operating Margin by Segment – August 2024 YTD

($ in Thousands)

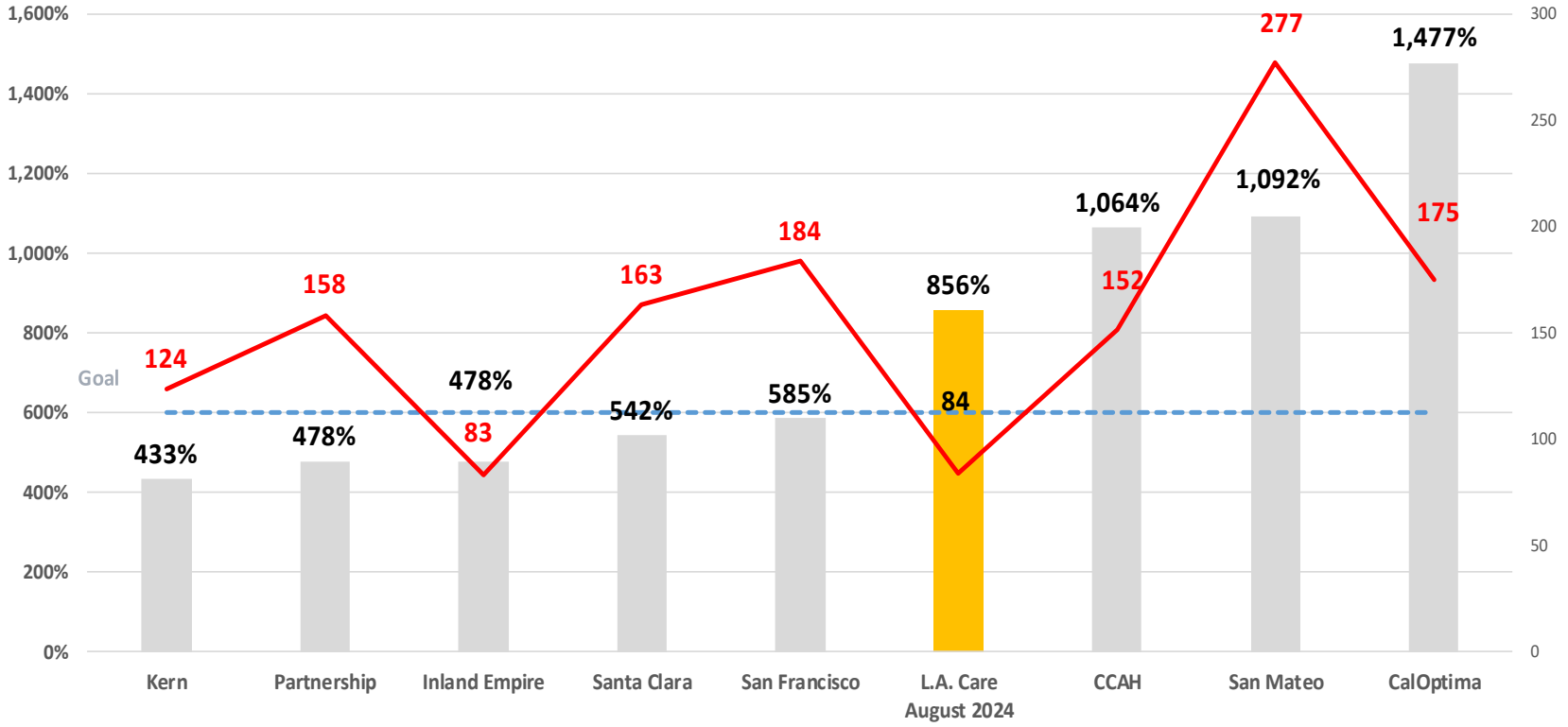
	Medi-Cal	D-SNP	LACC	PASC	Other	Total	Total *(excl HHIP/IPP)*
Revenue	$8,791,580	$316,969	$516,156	$169,404	$141,371	$9,935,481	$9,792,254
Healthcare Exp.	$8,212,490	$273,486	$434,173	$171,020	$26,141	$9,117,309	$9,087,795
Operating Margin	$579,090	$43,483	$81,984	($1,616)	$115,231	$818,171	$704,459
Actual MCR %	93.4%	86.3%	84.1%	101.0%	N/A	91.8%	92.8%
4+8 FCST MCR%	94.2%	90.3%	79.0%	100.7%	N/A	92.5%	93.4%

Operating Margin by Segment – August 2024 YTD

(Excl. HHIP/IPP)	Actual		4+8 FCST	
MCR	92.8%	vs.	93.4%	✓
Admin Ratio	6.0%	vs.	5.9%	✗

	Actual		Benchmark	
Working Capital	1.47	vs.	1.00+	✓
Cash to Claims	0.98	vs.	0.75+	✓
Tangible Net Equity	8.56	vs.	1.30+	✓

Tangible Net Equity & Days of Cash On-Hand



• As of June 2024 Quarterly filings, unless noted otherwise.

Questions & Considerations

Motion

- To accept the Financial Report for the eleven months ended August 31, 2024.

L.A. Care
HEALTH PLAN

Board of Governors
MOTION SUMMARY

Date: November 7, 2024 **Motion No. FIN 101.1124**

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

Requesting Department: Accounts & Finance Services

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

Issue: Acceptance of the Financial Reports for August 2024.

Background: N/A

Member Impact: N/A

Budget Impact: N/A

Motion: To accept the Financial Reports for August, 2024, as submitted.

Financial Performance
August 2024
(Unaudited)

Financial Performance Highlights - Year-to-Date

August 2024

Overall (incl. HHIP/IPP)

L.A. Care total YTD combined member months are 29.0M, +722K favorable to forecast. August YTD financial performance resulted in a surplus of +$396M or 4.0% margin and is +$88M/+85bps favorable to forecast. The YTD favorability is driven by lower capitation expense +$117.7M, higher revenue +$100.7M, timing of provider incentives and shared risk +$34.4M, higher net unrealized/realized gains +$6.9M, higher net other income +$6.4M, and higher interest income +$5.2M; partially offset by higher skilled nursing ($66.2M), inpatient ($52.1M) and outpatient ($51.7M) claims, and higher operating expenses ($14.8M).

Medi-Cal

Medi-Cal consists of members through our contracted providers and our contracted health plans ("Plan Partners"). August YTD member months are 26.7M, +637K favorable to forecast. August YTD financial performance resulted in a surplus of +$349.6M or 4.0% margin, +$138.2M/+155bps favorable to forecast, driven by lower capitation expense +$119.6M, higher revenue +$95.4M, lower operating expenses +$25.9M, higher interest income +$15.2M, higher net other income +$14.4M, timing of provider incentives and shared risk +$13.4M, and net unrealized/realized gains +$6.9M; partially offset by higher outpatient ($67.9M), skilled nursing ($60.6M), and inpatient ($33.1M) claims.

D-SNP

Effective January 1, 2023, members enrolled in CMC have been transitioned to our D-SNP plan. August YTD member months are 212K, +1.1K favorable to forecast. August YTD financial performance resulted in a surplus of +$13.9M or 4.4% margin, $7.8M/238bps favorable to forecast, primarily driven by higher revenue +$13.7M, lower outpatient +$9.2M, inpatient +$7.2M, and pharmacy +$2.0M claims; partially offset by timing of provider incentives and shared risk ($7.2M), higher operating expenses ($6.3M), higher skilled nursing claims ($5.1M), and higher capitation expense ($4.3M).

Commercial

L.A. Care Commercial consists of LACC and PASC-SEIU. August YTD member months are 2.4M, favorable +85K to forecast. August YTD financial performance resulted in a deficit of ($39.1M) or (5.7%) margin, ($65.4M)/(960bps) unfavorable to forecast, driven by higher operating expenses ($31.6M), higher inpatient ($26.4M) and pharmacy ($11.8M) claims, lower net interest income ($8.4M), and timing of provider incentives and shared risk ($2.8M); partially offset by higher revenue +$10.4M and lower outpatient claims +$1.4M

Incentive Programs

L.A. Care Incentive Programs consist of CalAIM Incentive Payment Program (IPP) and Housing and Homelessness Incentive Program (HHIP). August YTD financial performance resulted in a surplus of +$111.0M, +$18.9M favorable to forecast, primarily driven by the timing of healthcare expenses +$35.9M; partially offset by the timing of revenue ($16.7M).

Consolidated Operations Income Statement ($ in thousands)

August 2024

Current Actual	PMPM	Current 4+8 Forecast	PMPM	Current Fav/(Unfav)	PMPM		YTD Actual	PMPM	YTD 4+8 Forecast	PMPM	YTD Fav/(Unfav)	PMPM
						Membership						
2,599,292		2,416,361		182,931		Member Months	29,027,848		28,305,882		721,966	
						Revenue						
$ 841,392	$ 323.70	$ 862,839	$ 357.08	$ (21,447)	$ (33.38)	Capitation Revenue	$ 9,935,481	$ 342.27	$ 9,834,762	$ 347.45	$ 100,719	$ (5.17)
$ 841,392	**$ 323.70**	**$ 862,839**	**$ 357.08**	**$ (21,447)**	**$ (33.38)**	**Total Revenues**	**$ 9,935,481**	**$ 342.27**	**$ 9,834,762**	**$ 347.45**	**$ 100,719**	**$ (5.17)**
						Healthcare Expenses						
$ 429,406	$ 165.20	$ 442,819	$ 183.26	$ 13,413	$ 18.06	Capitation	$ 4,938,665	$ 170.14	$ 5,056,400	$ 178.63	$ 117,735	$ 8.50
$ 128,272	$ 49.35	$ 116,212	$ 48.09	$ (12,061)	$ (1.26)	Inpatient Claims	$ 1,262,335	$ 43.49	$ 1,210,238	$ 42.76	$ (52,097)	$ (0.73)
$ 158,251	$ 60.88	$ 124,740	$ 51.62	$ (33,510)	$ (9.26)	Outpatient Claims	$ 1,294,107	$ 44.58	$ 1,242,412	$ 43.89	$ (51,695)	$ (0.69)
$ 110,142	$ 42.37	$ 98,190	$ 40.64	$ (11,952)	$ (1.74)	Skilled Nurse Facility	$ 1,148,764	$ 39.57	$ 1,082,589	$ 38.25	$ (66,175)	$ (1.33)
$ 18,554	$ 7.14	$ 15,670	$ 6.48	$ (2,884)	$ (0.65)	Pharmacy	$ 174,109	$ 6.00	$ 164,338	$ 5.81	$ (9,771)	$ (0.19)
$ 16,598	$ 6.39	$ 21,229	$ 8.79	$ 4,631	$ 2.40	Provider Incentive and Shared Risk	$ 181,438	$ 6.25	$ 215,817	$ 7.62	$ 34,379	$ 1.37
$ 11,965	$ 4.60	$ 11,351	$ 4.70	$ (614)	$ 0.09	Medical Administrative Expenses	$ 117,891	$ 4.06	$ 129,113	$ 4.56	$ 11,221	$ 0.50
$ 873,188	**$ 335.93**	**$ 830,210**	**$ 343.58**	**$ (42,978)**	**$ 7.65**	**Total Healthcare Expenses**	**$ 9,117,309**	**$ 314.09**	**$ 9,100,906**	**$ 321.52**	**$ (16,404)**	**$ 7.43**
103.8%		*96.2%*		*(7.6%)*		*MCR (%)*	*91.8%*		*92.5%*		*0.8%*	
$ (31,796)	**$ (12.23)**	**$ 32,629**	**$ 13.50**	**$ (64,425)**	**$ (25.74)**	**Operating Margin**	**$ 818,171**	**$ 28.19**	**$ 733,856**	**$ 25.93**	**$ 84,315**	**$ 2.26**
$ 59,310	**$ 22.82**	**$ 55,804**	**$ 23.09**	**$ (3,506)**	**$ 0.28**	**Total Operating Expenses**	**$ 594,682**	**$ 20.49**	**$ 579,871**	**$ 20.49**	**$ (14,811)**	**$ (0.00)**
7.0%		*6.5%*		*(0.6%)*		*Admin Ratio (%)*	*6.0%*		*5.9%*		*(0.1%)*	
$ (91,106)	**$ (35.05)**	**$ (23,175)**	**$ (9.59)**	**$ (67,931)**	**$ (25.46)**	**Income (Loss) from Operations**	**$ 223,489**	**$ 7.70**	**$ 153,985**	**$ 5.44**	**$ 69,504**	**$ 2.26**
(10.8%)		*(2.7%)*		*(8.1%)*		*Margin before Non-Operating Inc/(Exp) Ratio (%)*	*2.2%*		*1.6%*		*0.7%*	
$ 15,035	$ 5.78	$ 15,774	$ 6.53	$ (739)	$ (0.74)	Interest Income,Net	$ 174,095	$ 6.00	$ 168,875	$ 5.97	$ 5,221	$ 0.03
$ (12,386)	$ (4.77)	$ (4,849)	$ (2.01)	$ (7,536)	$ (2.76)	Other Income (Expense),Net	$ (22,872)	$ (0.79)	$ (29,300)	$ (1.04)	$ 6,428	$ 0.25
$ 493	$ 0.19	$ -	$ -	$ (493)	$ (0.19)	Realized Gain/Loss	$ 2,866	$ 0.10	$ 987	$ 0.03	$ (1,880)	$ (0.06)
$ 4,010	$ 1.54	$ -	$ -	$ 4,010	$ 1.54	Unrealized Gain/Loss	$ 23,726	$ 0.82	$ 14,904	$ 0.53	$ 8,822	$ 0.29
$ 6,166	**$ 2.37**	**$ 10,925**	**$ 4.52**	**$ (4,759)**	**(2.15)**	**Total Non-Operating Income/(Expense)**	**$ 172,103**	**$ 5.93**	**$ 153,512**	**$ 5.42**	**$ 18,591**	**$ 0.51**
$ (84,939)	**$ (32.68)**	**$ (12,250)**	**$ (5.07)**	**$ (72,689)**	**$ (27.61)**	**Net Surplus/(Deficit)**	**$ 395,592**	**$ 13.63**	**$ 307,497**	**$ 10.86**	**$ 88,095**	**$ 2.76**
(10.1%)		*(1.4%)*		*(8.7%)*		*Margin (%)*	*4.0%*		*3.1%*		*0.9%*	

Total Medi-Cal Income Statement ($ in thousands)

August 2024

Current Actual	PMPM	Current 4+8 Forecast	PMPM	Current Fav/(Unfav)	PMPM		YTD Actual	PMPM	YTD 4+8 Forecast	PMPM	YTD Fav/(Unfav)	PMPM
						Membership						
2,359,052		2,197,450		161,602		Member Months	26,664,551		26,027,456		637,095	
						Revenue						
$ 752,817	$ 319.12	$ 750,078	$ 341.34	$ 2,739	$ (22.20)	Capitation Revenue	$ 8,791,580	$ 329.71	$ 8,696,192	$ 334.12	$ 95,388	$ (4.41)
$ 752,817	**$ 319.12**	**$ 750,078**	**$ 341.34**	**$ 2,739**	**$ (22.22)**	**Total Revenues**	**$ 8,791,580**	**$ 329.71**	**$ 8,696,192**	**$ 334.12**	**$ 95,388**	**$ (4.41)**
						Healthcare Expenses						
$ 397,040	$ 168.31	$ 413,142	$ 188.01	$ 16,102	$ 19.70	Capitation	$ 4,628,719	$ 173.59	$ 4,748,294	$ 182.43	$ 119,575	$ 8.84
$ 110,046	$ 46.65	$ 97,405	$ 44.33	$ (12,641)	$ (2.32)	Inpatient Claims	$ 1,065,900	$ 39.97	$ 1,032,772	$ 39.68	$ (33,128)	$ (0.29)
$ 143,039	$ 60.63	$ 107,513	$ 48.93	$ (35,525)	$ (11.71)	Outpatient Claims	$ 1,159,431	$ 43.48	$ 1,091,510	$ 41.94	$ (67,921)	$ (1.55)
$ 109,466	$ 46.40	$ 98,190	$ 44.68	$ (11,276)	$ (1.72)	Skilled Nurse Facility	$ 1,139,911	$ 42.75	$ 1,079,306	$ 41.47	$ (60,606)	$ (1.28)
$ 2	$ 0.00	$ -	$ -	$ (2)	$ (0.00)	Pharmacy	$ 178	$ 0.01	$ 141	$ 0.01	$ (38)	$ (0.00)
$ 12,536	$ 5.31	$ 9,956	$ 4.53	$ (2,579)	$ (0.78)	Provider Incentive and Shared Risk	$ 111,161	$ 4.17	$ 124,599	$ 4.79	$ 13,438	$ 0.62
$ 9,958	$ 4.22	$ 10,095	$ 4.59	$ 137	$ 0.37	Medical Administrative Expenses	$ 107,190	$ 4.02	$ 116,265	$ 4.47	$ 9,075	$ 0.45
$ 782,086	**$ 331.53**	**$ 736,302**	**$ 335.07**	**$ (45,784)**	**$ 3.55**	**Total Healthcare Expenses**	**$ 8,212,490**	**$ 307.99**	**$ 8,192,886**	**$ 314.78**	**$ (19,604)**	**$ 6.79**
103.9%		*98.2%*		*(5.7%)*		*MCR (%)*	*93.4%*		*94.2%*		*0.8%*	
$ (29,269)	**$ (12.41)**	**$ 13,775**	**$ 6.27**	**$ (43,045)**	**$ (18.68)**	**Operating Margin**	**$ 579,090**	**$ 21.72**	**$ 503,306**	**$ 19.34**	**$ 75,784**	**$ 2.38**
$ 43,709	**$ 18.53**	**$ 42,577**	**$ 19.38**	**$ (1,132)**	**$ 0.85**	**Total Operating Expenses**	**$ 433,887**	**$ 16.27**	**$ 459,794**	**$ 17.67**	**$ 25,906**	**$ 1.39**
5.8%		*5.7%*		*(0.1%)*		*Admin Ratio (%)*	*4.9%*		*5.3%*		*0.4%*	
$ (72,978)	**$ (30.94)**	**$ (28,802)**	**$ (13.11)**	**$ (44,177)**	**$ (17.83)**	**Income (Loss) from Operations**	**$ 145,202**	**$ 5.45**	**$ 43,512**	**$ 1.67**	**$ 101,690**	**$ 3.77**
(9.7%)		*(3.8%)*		*(5.9%)*		*Margin before Non-Operating Inc/(Exp) Ratio (%)*	*1.7%*		*0.5%*		*1.2%*	
$ 14,687	$ 6.23	$ 14,191	$ 6.46	$ 496	$ (0.23)	Interest Income,Net	$ 170,001	$ 6.38	$ 154,825	$ 5.95	$ 15,176	$ 0.43
$ 1,494	$ 0.63	$ (1,840)	$ (0.84)	$ 3,334	$ 1.47	Other Income (Expense),Net	$ 14,014	$ 0.53	$ (421)	$ (0.02)	$ 14,435	$ 0.54
$ 482	$ 0.20	$ -	$ -	$ (482)	$ (0.20)	Realized Gain/Loss	$ 2,799	$ 0.10	$ 940	$ 0.04	$ (1,860)	$ (0.07)
$ 3,917	$ 1.66	$ -	$ -	$ 3,917	$ 1.66	Unrealized Gain/Loss	$ 23,185	$ 0.87	$ 14,460	$ 0.56	$ 8,725	$ 0.31
$ 19,618	**$ 8.32**	**$ 12,351**	**$ 5.62**	**$ 7,267**	**2.70**	**Total Non-Operating Income/(Expense)**	**$ 204,420**	**$ 7.67**	**$ 167,943**	**$ 6.45**	**$ 36,477**	**$ 1.21**
$ (53,361)	**$ (22.62)**	**$ (16,451)**	**$ (7.49)**	**$ (36,910)**	**$ (15.13)**	**Net Surplus/(Deficit)**	**$ 349,622**	**$ 13.11**	**$ 211,455**	**$ 8.12**	**$ 138,167**	**$ 4.99**
(7.1%)		*(2.2%)*		*(4.9%)*		*Margin (%)*	*4.0%*		*2.4%*		*1.5%*	

DSNP Income Statement ($ in thousands) **August 2024**

Current Actual	PMPM	Current 4+8 Forecast	PMPM	Current Fav/(Unfav)	PMPM		YTD Actual	PMPM	YTD 4+8 Forecast	PMPM	YTD Fav/(Unfav)	PMPM
						Membership						
19,945		19,735		210		Member Months	211,563		210,444		1,119	
						Revenue						
$ 29,089	$ 1,458.47	$ 28,596	$ 1,448.99	$ 493	$ 9.48	Capitation Revenue	$ 316,969	$ 1,498.23	$ 303,234	$ 1,440.93	$ 13,735	$ 57.30
$ 29,089	**$ 1,458.47**	**$ 28,596**	**$ 1,448.99**	**$ 493**	**$ 9.48**	**Total Revenues**	**$ 316,969**	**$ 1,498.23**	**$ 303,234**	**$ 1,440.93**	**$ 13,735**	**$ 57.30**
						Healthcare Expenses						
$ 10,875	$ 545.23	$ 10,779	$ 546.20	$ (95)	$ 0.97	Capitation	$ 117,542	$ 555.59	$ 113,280	$ 538.29	$ (4,261)	$ (17.30)
$ 6,277	$ 314.69	$ 7,694	$ 389.88	$ 1,418	$ 75.19	Inpatient Claims	$ 67,018	$ 316.78	$ 74,240	$ 352.78	$ 7,223	$ 36.00
$ 3,581	$ 179.52	$ 5,285	$ 267.81	$ 1,705	$ 88.29	Outpatient Claims	$ 36,914	$ 174.48	$ 46,134	$ 219.22	$ 9,220	$ 44.74
$ 610	$ 30.60	$ -	$ -	$ (610)	$ (30.60)	Skilled Nurse Facility	$ 7,875	$ 37.22	$ 2,808	$ 13.35	$ (5,067)	$ (23.88)
$ 468	$ 23.46	$ 1,281	$ 64.91	$ 813	$ 41.46	Pharmacy	$ 12,183	$ 57.58	$ 14,229	$ 67.62	$ 2,047	$ 10.03
$ 1,980	$ 99.25	$ 2,315	$ 117.29	$ 335	$ 18.04	Provider Incentive and Shared Risk	$ 27,721	$ 131.03	$ 20,550	$ 97.65	$ (7,171)	$ (33.38)
$ 807	$ 40.45	$ 184	$ 9.31	$ (623)	$ (31.15)	Medical Administrative Expenses	$ 4,234	$ 20.01	$ 2,469	$ 11.73	$ (1,765)	$ (8.28)
$ 24,596	**$ 1,233.21**	**$ 27,538**	**$ 1,395.40**	**$ 2,942**	**$ 162.20**	**Total Healthcare Expenses**	**$ 273,486**	**$ 1,292.69**	**$ 273,711**	**$ 1,300.64**	**$ 225**	**$ 7.94**
84.6%		*96.3%*		*11.7%*		*MCR (%)*	*86.3%*		*90.3%*		*4.0%*	
$ 4,493	**$ 225.27**	**$ 1,058**	**$ 53.59**	**$ 3,435**	**$ 171.68**	**Operating Margin**	**$ 43,483**	**$ 205.53**	**$ 29,523**	**$ 140.29**	**$ 13,960**	**$ 65.24**
$ 2,843	**$ 142.56**	**$ 2,827**	**$ 143.24**	**$ (16)**	**$ 0.68**	**Total Operating Expenses**	**$ 34,120**	**$ 161.28**	**$ 27,784**	**$ 132.03**	**$ (6,336)**	**$ (29.25)**
9.8%		*9.9%*		*0.1%*		*Admin Ratio (%)*	*10.8%*		*9.2%*		*(1.6%)*	
$ 1,650	**$ 82.71**	**$ (1,769)**	**$ (89.65)**	**$ 3,419**	**$ 172.36**	**Income (Loss) from Operations**	**$ 9,363**	**$ 44.26**	**$ 1,739**	**$ 8.27**	**$ 7,624**	**$ 35.99**
5.7%		*(6.2%)*		*11.9%*		*Margin before Non-Operating Inc/(Exp) Ratio (%)*	*3.0%*		*0.6%*		*2.4%*	
$ 347	$ 17.41	$ 385	$ 19.52	$ (38)	$ (2.11)	Interest Income,Net	$ 4,090	$ 19.33	$ 4,051	$ 19.25	$ 40	$ 0.09
$ -	$ -	$ -	$ -	$ -	$ -	Other Income (Expense),Net	$ 16	$ 0.07	$ 0	$ 0.00	$ 16	$ 0.07
$ 11	$ 0.57	$ -	$ -	$ (11)	$ (0.57)	Realized Gain/Loss	$ 67	$ 0.32	$ 23	$ 0.11	$ (44)	$ (0.21)
$ 93	$ 4.64	$ -	$ -	$ 93	$ 4.64	Unrealized Gain/Loss	$ 541	$ 2.56	$ 344	$ 1.64	$ 197	$ 0.92
$ 429	**$ 21.49**	**$ 385**	**$ 19.52**	**$ 43**	**1.97**	**Total Non-Operating Income/(Expense)**	**$ 4,581**	**$ 21.65**	**$ 4,373**	**$ 20.78**	**$ 208**	**$ 0.87**
$ 2,078	**$ 104.19**	**$ (1,384)**	**$ (70.13)**	**$ 3,462**	**$ 174.33**	**Net Surplus/(Deficit)**	**$ 13,944**	**$ 65.91**	**$ 6,112**	**$ 29.04**	**$ 7,832**	**$ 36.87**
7.1%		*(4.8%)*		*12.0%*		*Margin (%)*	*4.4%*		*2.0%*		*2.4%*	

Commercial Income Statement ($ in thousands)

August 2024

Current Actual	PMPM	Current 4+8 Forecast	PMPM	Current Fav/(Unfav)	PMPM		YTD Actual	PMPM	YTD 4+8 Forecast	PMPM	YTD Fav/(Unfav)	PMPM
						Membership						
240,240		218,911		21,329		Member Months	2,363,297		2,278,425		84,872	
						Revenue						
$ 59,486	$ 247.61	$ 67,609	$ 308.84	$ (8,123)	$ (61.23)	Capitation Revenue	$ 685,560	$ 290.09	$ 675,111	$ 296.31	$ 10,449	$ (6.22)
$ 59,486	**$ 247.61**	**$ 67,609**	**$ 308.84**	**$ (8,123)**	**$ (61.23)**	**Total Revenues**	**$ 685,560**	**$ 290.09**	**$ 675,111**	**$ 296.31**	**$ 10,449**	**$ (6.22)**
						Healthcare Expenses						
$ 21,491	$ 89.46	$ 18,897	$ 86.32	$ (2,594)	$ (3.13)	Capitation	$ 194,039	$ 82.11	$ 194,575	$ 85.40	$ 536	$ 3.29
$ 11,915	$ 49.60	$ 11,112	$ 50.76	$ (803)	$ 1.16	Inpatient Claims	$ 130,523	$ 55.23	$ 104,075	$ 45.68	$ (26,448)	$ (9.55)
$ 11,649	$ 48.49	$ 11,108	$ 50.74	$ (540)	$ 2.26	Outpatient Claims	$ 97,711	$ 41.35	$ 99,090	$ 43.49	$ 1,379	$ 2.15
$ 75	$ 0.31	$ -	$ -	$ (75)	$ (0.31)	Skilled Nurse Facility	$ 1,197	$ 0.51	$ 581	$ 0.25	$ (616)	$ (0.25)
$ 18,084	$ 75.28	$ 14,389	$ 65.73	$ (3,695)	$ (9.55)	Pharmacy	$ 161,385	$ 68.29	$ 149,614	$ 65.67	$ (11,771)	$ (2.62)
$ 1,055	$ 4.39	$ 1,263	$ 5.77	$ 208	$ 1.38	Provider Incentive and Shared Risk	$ 13,870	$ 5.87	$ 11,059	$ 4.85	$ (2,811)	$ (1.02)
$ 1,200	$ 5.00	$ 1,072	$ 4.90	$ (128)	$ (0.10)	Medical Administrative Expenses	$ 6,468	$ 2.74	$ 10,378	$ 4.56	$ 3,911	$ 1.82
$ 65,469	**$ 272.52**	**$ 57,842**	**$ 264.23**	**$ (7,627)**	**$ (8.29)**	**Total Healthcare Expenses**	**$ 605,193**	**$ 256.08**	**$ 569,372**	**$ 249.90**	**$ (35,820)**	**$ (6.18)**
110.1%		*85.6%*		*(24.5%)*		*MCR (%)*	*88.3%*		*84.3%*		*(3.9%)*	
$ (5,983)	**$ (24.91)**	**$ 9,767**	**$ 44.62**	**$ (15,750)**	**$ (69.52)**	**Operating Margin**	**$ 80,367**	**$ 34.01**	**$ 105,739**	**$ 46.41**	**$ (25,372)**	**$ (12.40)**
$ 12,569	**$ 52.32**	**$ 9,963**	**$ 45.51**	**$ (2,606)**	**$ (6.81)**	**Total Operating Expenses**	**$ 119,200**	**$ 50.44**	**$ 87,582**	**$ 38.44**	**$ (31,618)**	**$ (12.00)**
21.1%		*14.7%*		*(6.4%)*		*Admin Ratio (%)*	*17.4%*		*13.0%*		*(4.4%)*	
$ (18,552)	**$ (77.22)**	**$ (196)**	**$ (0.89)**	**$ (18,357)**	**$ (76.33)**	**Income (Loss) from Operations**	**$ (38,832)**	**$ (16.43)**	**$ 18,158**	**$ 7.97**	**$ (56,990)**	**$ (24.40)**
(31.2%)		*(0.3%)*		*(30.9%)*		*Margin before Non-Operating Inc/(Exp) Ratio (%)*	*(5.7%)*		*2.7%*		*(8.4%)*	
$ 1	$ 0.00	$ 1,198	$ 5.47	$ (1,198)	$ (5.47)	Interest Income,Net	$ 5	$ 0.00	$ 8,382	$ 3.68	$ (8,377)	$ (3.68)
$ (17)	$ (0.07)	$ (17)	$ (0.08)	$ -	$ 0.01	Other Income (Expense),Net	$ (296)	$ (0.13)	$ (296)	$ (0.13)	$ -	$ 0.00
$ -	$ -	$ -	$ -	$ -	$ -	Realized Gain/Loss	$ -	$ -	$ -	$ -	$ -	$ -
$ -	$ -	$ -	$ -	$ -	$ -	Unrealized Gain/Loss	$ -	$ -	$ -	$ -	$ -	$ -
$ (17)	**$ (0.07)**	**$ 1,181**	**$ 5.39**	**$ (1,198)**	**(5.46)**	**Total Non-Operating Income/(Expense)**	**$ (292)**	**$ (0.12)**	**$ 8,086**	**$ 3.55**	**$ (8,377)**	**$ (3.67)**
$ (18,569)	**$ (77.29)**	**$ 985**	**$ 4.50**	**$ (19,554)**	**$ (81.79)**	**Net Surplus/(Deficit)**	**$ (39,124)**	**$ (16.55)**	**$ 26,243**	**$ 11.52**	**$ (65,367)**	**$ (28.07)**
(31.2%)		*1.5%*		*(32.7%)*		*Margin (%)*	*(5.7%)*		*3.9%*		*(9.6%)*	

Incentive Programs Income Statement ($ in thousands)

August 2024

Current Actual	PMPM	Current 4+8 Forecast	PMPM	Current Fav/(Unfav)	PMPM		YTD Actual	PMPM	YTD 4+8 Forecast	PMPM	YTD Fav/(Unfav)	PMPM
						Membership						
-		-		-		Member Months	-		-		-	
						Revenue						
$ -	$ -	$ 16,556	$ -	$ (16,556)	$ -	Capitation Revenue	$ 143,226	$ -	$ 159,893	$ -	$ (16,667)	$ -
$ -	**$ -**	**$ 16,556**	**$ -**	**$ (16,556)**	**$ -**	**Total Revenues**	**$ 143,226**	**$ -**	**$ 159,893**	**$ -**	**$ (16,667)**	**$ -**
						Healthcare Expenses						
$ -	$ -	$ -	$ -	$ -	$ -	Capitation	$ -	$ -	$ -	$ -	$ -	$ -
$ -	$ -	$ -	$ -	$ -	$ -	Inpatient Claims	$ -	$ -	$ -	$ -	$ -	$ -
$ -	$ -	$ 833	$ -	$ 833	$ -	Outpatient Claims	$ -	$ -	$ 5,833	$ -	$ 5,833	$ -
$ -	$ -	$ -	$ -	$ -	$ -	Skilled Nurse Facility	$ -	$ -	$ -	$ -	$ -	$ -
$ -	$ -	$ -	$ -	$ -	$ -	Pharmacy	$ -	$ -	$ -	$ -	$ -	$ -
$ 1,028	$ -	$ 7,694	$ -	$ 6,667	$ -	Provider Incentive and Shared Risk	$ 29,515	$ -	$ 59,609	$ -	$ 30,094	$ -
$ -	$ -	$ -	$ -	$ -	$ -	Medical Administrative Expenses	$ -	$ -	$ -	$ -	$ -	$ -
$ 1,028	**$ -**	**$ 8,528**	**$ -**	**$ 7,500**	**$ -**	**Total Healthcare Expenses**	**$ 29,515**	**$ -**	**$ 65,442**	**$ -**	**$ 35,927**	**$ -**
0.0%		*51.5%*		*51.5%*		*MCR (%)*	*20.6%*		*40.9%*		*20.3%*	
$ (1,028)	**$ -**	**$ 8,029**	**$ -**	**$ (9,056)**	**$ -**	**Operating Margin**	**$ 113,712**	**$ -**	**$ 94,451**	**$ -**	**$ 19,261**	**$ -**
$ 199	**$ -**	**$ 201**	**$ -**	**$ 2**	**$ -**	**Total Operating Expenses**	**$ 2,683**	**$ -**	**$ 2,342**	**$ -**	**$ (341)**	**$ -**
0.0%		*1.2%*		*1.2%*		*Admin Ratio (%)*	*1.9%*		*1.5%*		*(0.4%)*	
$ (1,227)	**$ -**	**$ 7,828**	**$ -**	**$ (9,055)**	**$ -**	**Income (Loss) from Operations**	**$ 111,029**	**$ -**	**$ 92,109**	**$ -**	**$ 18,920**	**$ -**
0.0%		*47.3%*		*(47.3%)*		*Margin before Non-Operating Inc/(Exp) Ratio (%)*	*77.5%*		*57.6%*		*19.9%*	
$ -	$ -	$ -	$ -	$ -	$ -	Interest Income,Net	$ -	$ -	$ -	$ -	$ -	$ -
$ -	$ -	$ -	$ -	$ -	$ -	Other Income (Expense),Net	$ -	$ -	$ -	$ -	$ -	$ -
$ -	$ -	$ -	$ -	$ -	$ -	Realized Gain/Loss	$ -	$ -	$ -	$ -	$ -	$ -
$ -	$ -	$ -	$ -	$ -	$ -	Unrealized Gain/Loss	$ -	$ -	$ -	$ -	$ -	$ -
$ -	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**Total Non-Operating Income/(Expense)**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
$ (1,227)	**$ -**	**$ 7,828**	**$ -**	**$ (9,055)**	**$ -**	**Net Surplus/(Deficit)**	**$ 111,029**	**$ -**	**$ 92,109**	**$ -**	**$ 18,920**	**$ -**
0.0%		*47.3%*		*(47.3%)*		*Margin (%)*	*77.5%*		*57.6%*		*19.9%*	

Balance Sheet ($ in thousands)

August 2024

	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24
Assets											
Cash and Cash Equivalents	$ 1,215,928	$ 1,164,685	$ 1,050,823	$ 1,300,559	$ 1,457,922	$ 1,724,269	$ 1,543,191	$ 1,159,185	$ 867,797	$ 880,576	$ 820,164
Short Term Investments, at fair value	$ 1,858,223	$ 2,006,373	$ 2,298,594	$ 2,203,165	$ 2,494,863	$ 2,799,085	$ 2,568,822	$ 2,555,603	$ 2,799,586	$ 2,675,073	$ 2,584,837
Capitation Receivable	$ 3,182,445	$ 3,233,165	$ 3,152,661	$ 2,907,187	$ 3,022,046	$ 2,587,481	$ 2,525,481	$ 2,587,709	$ 2,693,894	$ 2,690,751	$ 2,621,974
Interest and Non-Operating Receivables	$ 40,813	$ 6,752	$ 423,494	$ 472,216	$ 515,539	$ 567,924	$ 239,392	$ 110,212	$ 104,680	$ 87,213	$ 72,474
Prepaids and Other Current Assets	$ 18,325	$ 16,145	$ 27,978	$ 33,486	$ 33,847	$ 63,688	$ 63,007	$ 43,180	$ 43,476	$ 33,730	$ 52,883
Current Assets	**$ 6,315,735**	**$ 6,427,120**	**$ 6,953,551**	**$ 6,916,612**	**$ 7,524,217**	**$ 7,742,447**	**$ 6,939,893**	**$ 6,455,888**	**$ 6,509,433**	**$ 6,367,344**	**$ 6,152,332**
Capitalized Assets - net	$ 168,137	$ 166,800	$ 163,264	$ 160,379	$ 161,628	$ 161,758	$ 160,634	$ 157,917	$ 156,927	$ 157,512	$ 208,303
Non-Current Assets	$ 3,071	$ 2,901	$ 2,744	$ 1,744	$ 1,765	$ 2,917	$ 2,769	$ 5,229	$ 27,725	$ 27,495	$ 27,317
Total Assets	**$ 6,486,942**	**$ 6,596,822**	**$ 7,119,560**	**$ 7,078,735**	**$ 7,687,611**	**$ 7,907,122**	**$ 7,103,296**	**$ 6,619,034**	**$ 6,694,086**	**$ 6,552,351**	**$ 6,387,953**
Liabilities & Equity											
Liabilities											
Accounts Payable and Accrued Liabilities	$ 175,928	$ 187,262	$ 551,099	$ 598,049	$ 489,004	$ 398,097	$ 316,924	$ 241,720	$ 285,992	$ 205,098	$ 229,628
Subcapitation Payable	$ 3,110,125	$ 3,153,507	$ 3,258,876	$ 3,194,511	$ 3,214,279	$ 3,130,550	$ 3,009,663	$ 2,978,540	$ 2,925,553	$ 2,941,454	$ 2,785,753
Accts Receivable - PP	$ 2	$ 2	$ 1	$ 1	$ 1	$ 1	$ 1	$ 1	$ 1	$ 1	$ 1
Reserve for Claims	$ 819,965	$ 827,368	$ 867,307	$ 851,802	$ 809,922	$ 829,146	$ 769,022	$ 733,127	$ 788,631	$ 718,477	$ 701,882
Accrued Medical Expenses	$ 271,671	$ 266,999	$ 269,172	$ 211,542	$ 212,239	$ 199,114	$ 188,898	$ 195,703	$ 185,086	$ 190,115	$ 154,949
Deferred Revenue	$ 69,446	$ 64,958	$ 38,107	$ 76,179	$ 138,196	$ 131,722	$ 156,957	$ 123,676	$ 71,999	$ 92,004	$ 116,666
Reserve for Provider Incentives	$ 109,889	$ 114,474	$ 78,126	$ 67,785	$ 60,283	$ 60,905	$ 68,956	$ 99,527	$ 108,272	$ 115,768	$ 128,247
Non-Operating Payables	$ 33,097	$ 29,341	$ 9,667	$ (19,112)	$ 645,902	$ 998,941	$ 379,332	$ 46,155	$ 44,440	$ 27,469	$ 40,644
Grants Payable	$ 18,094	$ 16,769	$ 17,968	$ 17,443	$ 16,955	$ 17,855	$ 17,143	$ 18,381	$ 16,318	$ 16,232	$ 21,389
Deferred Rent	$ 48,456	$ 45,243	$ 43,553	$ 41,868	$ 40,104	$ 38,434	$ 36,768	$ 35,108	$ 33,467	$ 31,909	$ 79,908
Total Current Liabilities	**$ 4,656,673**	**$ 4,705,923**	**$ 5,133,874**	**$ 5,040,067**	**$ 5,626,885**	**$ 5,804,764**	**$ 4,943,664**	**$ 4,471,938**	**$ 4,459,759**	**$ 4,338,527**	**$ 4,259,067**
Equity											
Invested in Capital Assets, Net of related dep	$ 99,218	$ 99,259	$ 97,349	$ 99,507	$ 103,953	$ 105,544	$ 105,848	$ 104,546	$ 104,659	$ 106,745	$ 107,621
Restricted Equity	$ 600	$ 600	$ 600	$ 600	$ 600	$ 600	$ 600	$ 600	$ 23,327	$ 23,327	$ 23,380
Minimum Tangible Net Equity	$ 235,945	$ 235,089	$ 238,050	$ 236,840	$ 238,550	$ 240,896	$ 242,796	$ 240,282	$ 238,065	$ 243,760	$ 248,710
Board Designated Funds	$ 143,902	$ 142,476	$ 147,962	$ 145,172	$ 143,248	$ 141,795	$ 140,281	$ 136,265	$ 134,842	$ 131,525	$ 119,639
Unrestricted Net Assets	$ 1,350,604	$ 1,413,475	$ 1,501,725	$ 1,556,550	$ 1,574,375	$ 1,613,522	$ 1,670,106	$ 1,665,402	$ 1,733,435	$ 1,708,467	$ 1,629,536
Total Equity	**$ 1,830,268**	**$ 1,890,899**	**$ 1,985,685**	**$ 2,038,668**	**$ 2,060,725**	**$ 2,102,358**	**$ 2,159,631**	**$ 2,147,096**	**$ 2,234,328**	**$ 2,213,824**	**$ 2,128,885**
Total Liabilities & Equity	**$ 6,486,942**	**$ 6,596,822**	**$ 7,119,560**	**$ 7,078,735**	**$ 7,687,611**	**$ 7,907,122**	**$ 7,103,296**	**$ 6,619,034**	**$ 6,694,086**	**$ 6,552,351**	**$ 6,387,953**
Solvency Ratios											
Working Capital Ratio	1.37	1.38	1.37	1.38	1.35	1.34	1.41	1.46	1.47	1.48	1.47
Cash to Claims Ratio	0.78	0.80	0.81	0.87	0.98	1.14	1.09	1.00	0.99	0.97	0.98
Tangible Net Equity Ratio	7.76	8.04	8.34	8.61	8.64	8.73	8.89	8.94	9.39	9.08	8.56

L.A. Care HEALTH PLAN®

Cash Flows Statement ($ in thousands)

August 2024

	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	YTD
Cash Flows from Operating Activities:												
Capitation Revenue	$ 841,537	$ 878,375	$ 1,020,197	$ 1,056,193	$ 814,382	$ 1,358,785	$ 951,617	$ 816,743	$ 767,921	$ 954,143	$ 934,316	$ 10,394,209
Other Income (Expense), net	$ 19,423	$ 8,321	$ 3,604	$ 13,760	$ 11,212	$ 8,470	$ 24,067	$ 14,830	$ 10,554	$ 13,754	$ 9,981	$ 137,976
Healthcare Expenses	$ (846,331)	$ (796,846)	$ (739,718)	$ (808,174)	$ (835,771)	$ (935,164)	$ (949,577)	$ (906,580)	$ (801,437)	$ (956,252)	$ (1,067,655)	$ (9,643,505)
Operating Expenses	$ (36,472)	$ (29,715)	$ (75,466)	$ (48,204)	$ (51,472)	$ (83,534)	$ (48,528)	$ (35,942)	$ (49,877)	$ (40,567)	$ (69,196)	$ (568,973)
Net Cash Provided By Operating Activities	**$ (21,843)**	**$ 60,135**	**$ 208,617**	**$ 213,575**	**$ (61,649)**	**$ 348,557**	**$ (22,421)**	**$ (110,949)**	**$ (72,839)**	**$ (28,922)**	**$ (192,554)**	**$ 319,707**
Cash Flows from Investing Activities												
Purchase of investments - Net	$ (67,389)	$ (137,165)	$ (285,931)	$ 96,186	$ (295,798)	$ (303,696)	$ 226,577	$ 16,064	$ (264,816)	$ 130,457	$ 93,701	$ (791,810)
Purchase of Capital Assets	$ (3,065)	$ (2,368)	$ (161)	$ (4,646)	$ (5,605)	$ (4,599)	$ (3,071)	$ (1,554)	$ (2,771)	$ (4,476)	$ (67,796)	$ (100,112)
Net Cash Provided By Investing Activities	**$ (70,454)**	**$ (139,533)**	**$ (286,092)**	**$ 91,540**	**$ (301,403)**	**$ (308,295)**	**$ 223,506**	**$ 14,510**	**$ (267,587)**	**$ 125,981**	**$ 25,905**	**$ (891,922)**
Cash Flows from Financing Activities:												
Lease Payment - Capital & ROU	$ (1,546)	$ (1,377)	$ (1,505)	$ (1,502)	$ (1,367)	$ (1,462)	$ (1,428)	$ (1,415)	$ (1,389)	$ (1,520)	$ 4,600	$ (9,911)
SBITA Liabilty Increase / (Decrease)	$ -	$ -	$ -	$ -	$ 188	$ 29	$ 26	$ 23	$ 21	$ 19	$ 45,315	$ 45,621
Gross Premium Tax (MCO Sales Tax) - Net		$ 33,288	$ (15,208)	$ (25,099)	$ (143,420)	$ (125,521)	$ 238,848	$ 47,001	$ 52,121	$ (82,437)	$ 43,148	$ 22,721
Pass through transactions (AB 85, IGT, etc.)	$ (269,155)	$ (3,756)	$ (19,674)	$ (28,779)	$ 665,014	$ 353,039	$ (619,609)	$ (333,176)	$ (1,715)	$ (342)	$ 13,174	$ (244,979)
Net Cash Provided By Financing Activities	**$ (270,701)**	**$ 28,155**	**$ (36,387)**	**$ (55,380)**	**$ 520,415**	**$ 226,085**	**$ (382,163)**	**$ (287,567)**	**$ 49,038**	**$ (84,280)**	**$ 106,237**	**$ (186,548)**
Net Increase in Cash and Cash Equivalents	**$ (362,998)**	**$ (51,243)**	**$ (113,862)**	**$ 249,735**	**$ 157,363**	**$ 266,347**	**$ (181,078)**	**$ (384,006)**	**$ (291,388)**	**$ 12,779**	**$ (60,412)**	**$ (758,763)**
Cash and Cash Equivalents, Beginning	$ 1,578,927	$ 1,215,929	$ 1,164,686	$ 1,050,824	$ 1,300,559	$ 1,457,922	$ 1,724,269	$ 1,543,191	$ 1,159,185	$ 867,797	$ 880,576	$ 1,578,927
Cash and Cash Equivalents, Ending	**$ 1,215,929**	**$ 1,164,686**	**$ 1,050,824**	**$ 1,300,559**	**$ 1,457,922**	**$ 1,724,269**	**$ 1,543,191**	**$ 1,159,185**	**$ 867,797**	**$ 880,576**	**$ 820,164**	**$ 820,164**
Reconciliation of Income from Operations to Net Cash Provided By (Used In) Operating Activities:												
			3									
Excess of Revenues over Expenses	**$ 96,976**	**$ 60,630**	**$ 94,786**	**$ 52,983**	**$ 22,057**	**$ 41,633**	**$ 57,273**	**$ (12,536)**	**$ 87,232**	**$ (20,503)**	**$ (84,939)**	**$ 395,592**
Adjustments to Excess of Revenues Over Expenses:												
Depreciation	$ 4,181	$ 3,715	$ 3,697	$ 7,531	$ 4,356	$ 4,469	$ 4,196	$ 4,271	$ 3,760	$ 3,892	$ 17,004	$ 61,072
Realized and Unrealized (Gain)/Loss on Investments	$ 868	$ (7,749)	$ (6,291)	$ (756)	$ 4,099	$ (525)	$ 3,685	$ (3,146)	$ (1,593)	$ (5,944)	$ (3,517)	$ (20,869)
Deferred Rent	$ 50	$ (6)	$ 50	$ 50		$ -	$ -			$ -	$ -	$ 144
Gross Premium Tax provision	$ (1)	$ (2)	$ 2	$ (1,187)	$ (1,765)	$ (2,330)	$ (2,339)	$ (1,559)	$ (1,531)	$ (1,460)	$ (277)	$ (12,449)
Loss on Disposal of Capital Assets		$ (10)	$ -	$ -	$ -	$ -	$ -	$ -			$ -	$ (10)
Total Adjustments to Excess of Revenues over Expenses	**$ 5,098**	**$ (4,052)**	**$ (2,542)**	**$ 5,638**	**$ 6,690**	**$ 1,614**	**$ 5,542**	**$ (434)**	**$ 636**	**$ (3,512)**	**$ 13,210**	**$ 27,888**
Changes in Operating Assets and Liabilities:												
Capitation Receivable	$ (92,525)	$ (53,272)	$ (1,340,639)	$ 1,635,640	$ (120,052)	$ 445,473	$ 38,669	$ (56,954)	$ (102,379)	$ 6,986	$ 68,507	$ 429,454
Interest and Non-Operating Receivables	$ 4,753	$ (2,462)	$ (7,465)	$ 1,386	$ 321	$ (8,149)	$ 8,342	$ 359	$ (3,479)	$ 1,055	$ (231)	$ (5,570)
Prepaid and Other Current Assets	$ 4,508	$ 4,901	$ (12,882)	$ (5,512)	$ 4,812	$ (41,969)	$ 24,161	$ 12,094	$ (3,913)	$ 6,132	$ (18,651)	$ (26,319)
Accounts Payable and Accrued Liabilities	$ 4,634	$ 9,503	$ (12,961)	$ 4,877	$ (8,089)	$ (7,463)	$ 2,245	$ 8,208	$ 2,159	$ 2,729	$ (5,288)	$ 554
Subcapitation Payable	$ (13,634)	$ 43,487	$ 105,367	$ (30,666)	$ 19,768	$ (83,730)	$ (120,887)	$ (31,123)	$ (52,987)	$ 15,900	$ (155,690)	$ (304,195)
MediCal Adult Expansion Payable		$ (104)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1	$ (10)	$ (113)
Deferred Capitation Revenue	$ (18,967)	$ (3,952)	$ 1,377,508	$ (1,366,774)	$ 62,024	$ (6,481)	$ 25,242	$ (32,779)	$ (52,211)	$ 21,246	$ 24,418	$ 29,274
Accrued Medical Expenses	$ 6,124	$ (5,208)	$ 2,656	$ (57,626)	$ 690	$ (13,118)	$ (10,223)	$ 6,303	$ (10,083)	$ 3,788	$ (34,922)	$ (111,619)
Reserve for Claims	$ (22,643)	$ 7,403	$ 39,939	$ (15,505)	$ (41,880)	$ 19,225	$ (60,124)	$ (35,896)	$ 55,504	$ (70,154)	$ (16,594)	$ (140,725)
Reserve for Provider Incentives	$ 5,038	$ 4,586	$ (36,349)	$ (10,341)	$ (7,502)	$ 622	$ 8,051	$ 30,571	$ 8,745	$ 7,496	$ 12,479	$ 23,396
Grants Payable	$ (1,205)	$ (1,325)	$ 1,199	$ (525)	$ (488)	$ 900	$ (712)	$ 1,238	$ (2,063)	$ (86)	$ 5,157	$ 2,090
Net Changes in Operating Assets and Liabilities	**$ (123,917)**	**$ 3,557**	**$ 116,373**	**$ 154,954**	**$ (90,396)**	**$ 305,310**	**$ (85,236)**	**$ (97,979)**	**$ (160,707)**	**$ (4,907)**	**$ (120,825)**	**$ (103,773)**
Net Cash Provided By Operating Activities	**$ (21,843)**	**$ 60,135**	**$ 208,617**	**$ 213,575**	**$ (61,649)**	**$ 348,557**	**$ (22,421)**	**$ (110,949)**	**$ (72,839)**	**$ (28,922)**	**$ (192,554)**	**$ 319,707**

Board of Governors Monthly Meeting

Performance Monitoring
October 2024

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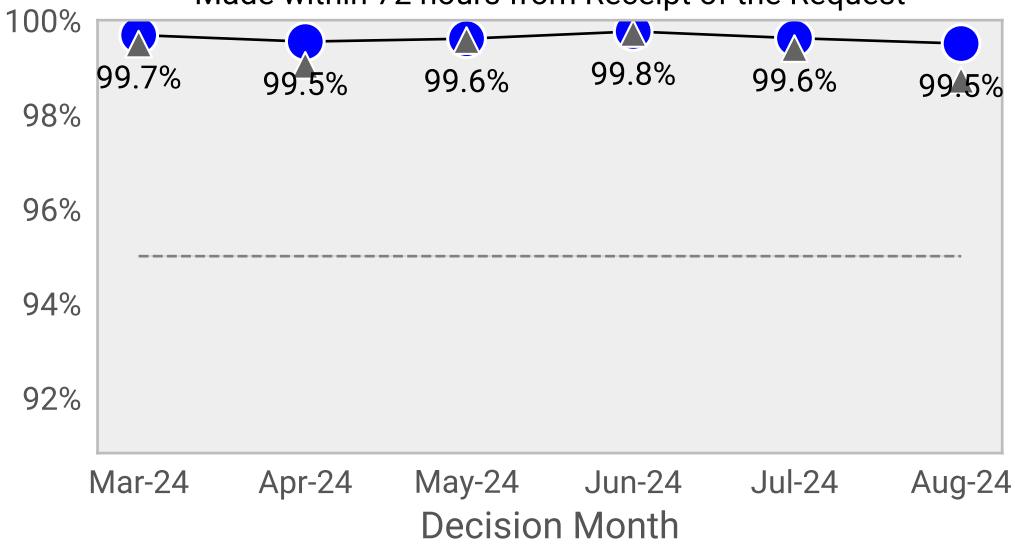
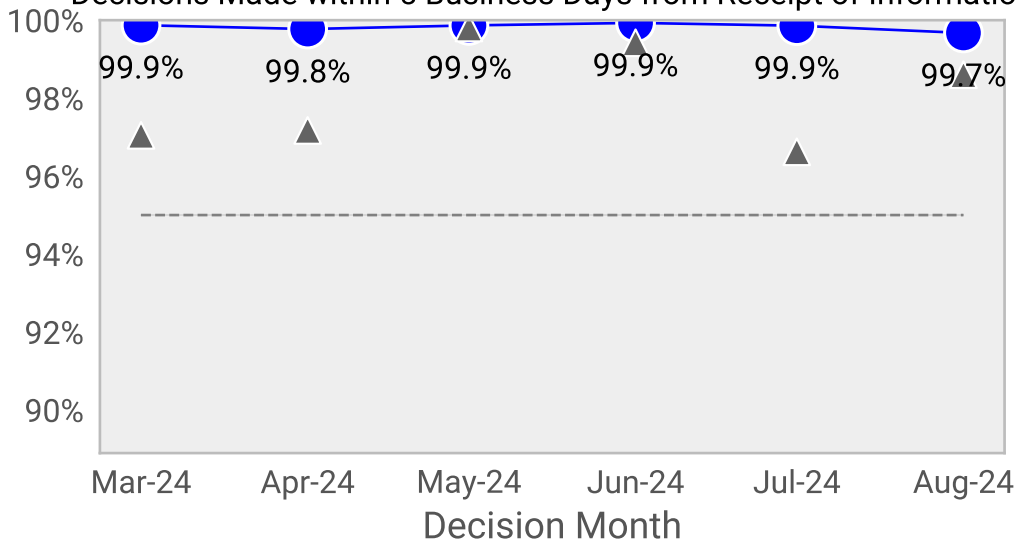
Medical Management

MCLA Authorization Processing Timeliness

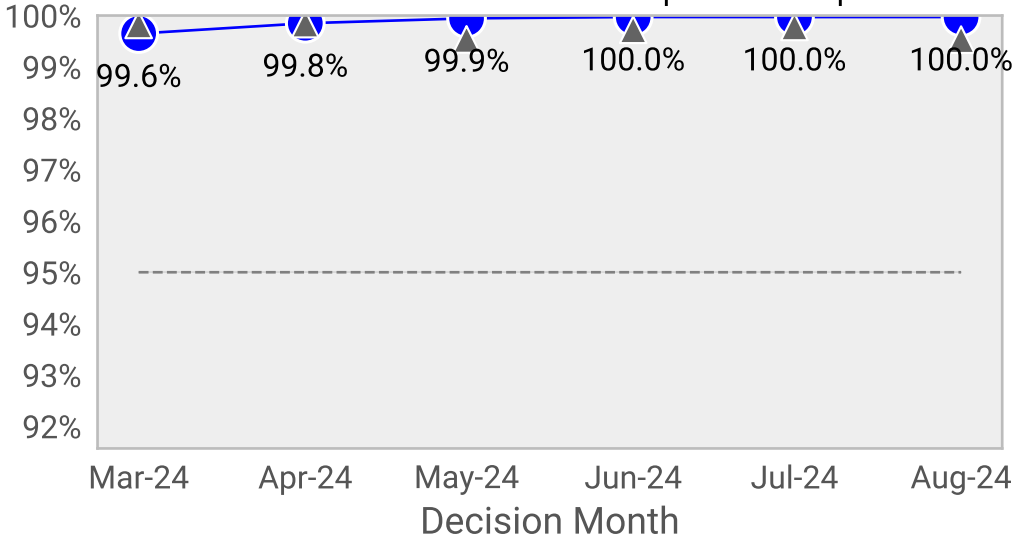
Expedited/Urgent Preservice Service Requests Decisions Made within 72 hours from Receipt of the Request



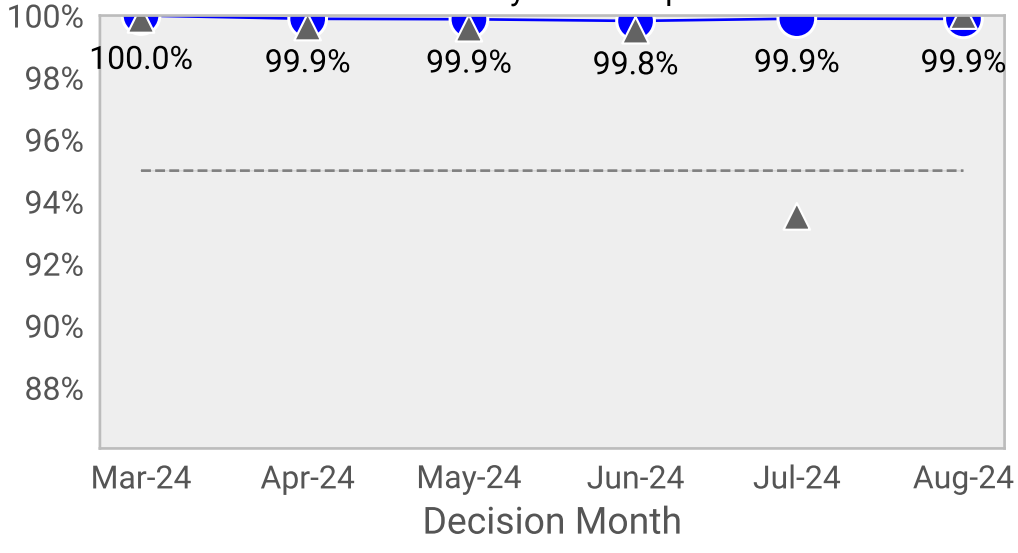
Standard/Routine Preservice Service Request Decisions Made within 5 Business Days from Receipt of Information



Expedited/Urgent Concurrent Service Request Decisions Made within 72 hours from Receipt of the Request



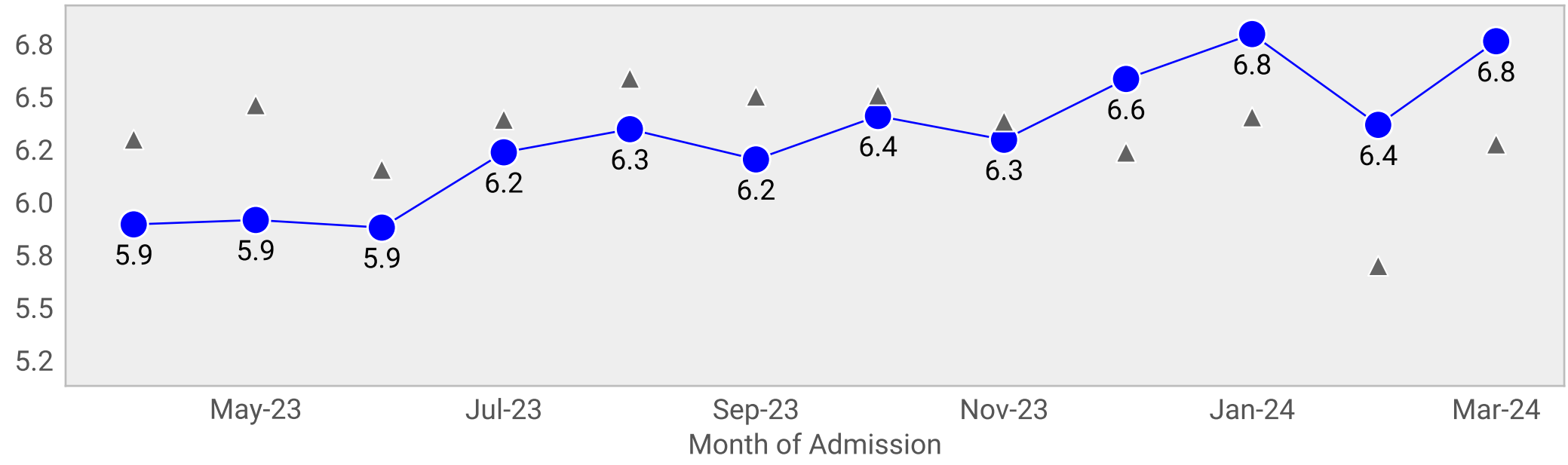
Post Service Request Decisions within 30 Calendar Days of Receipt of Information



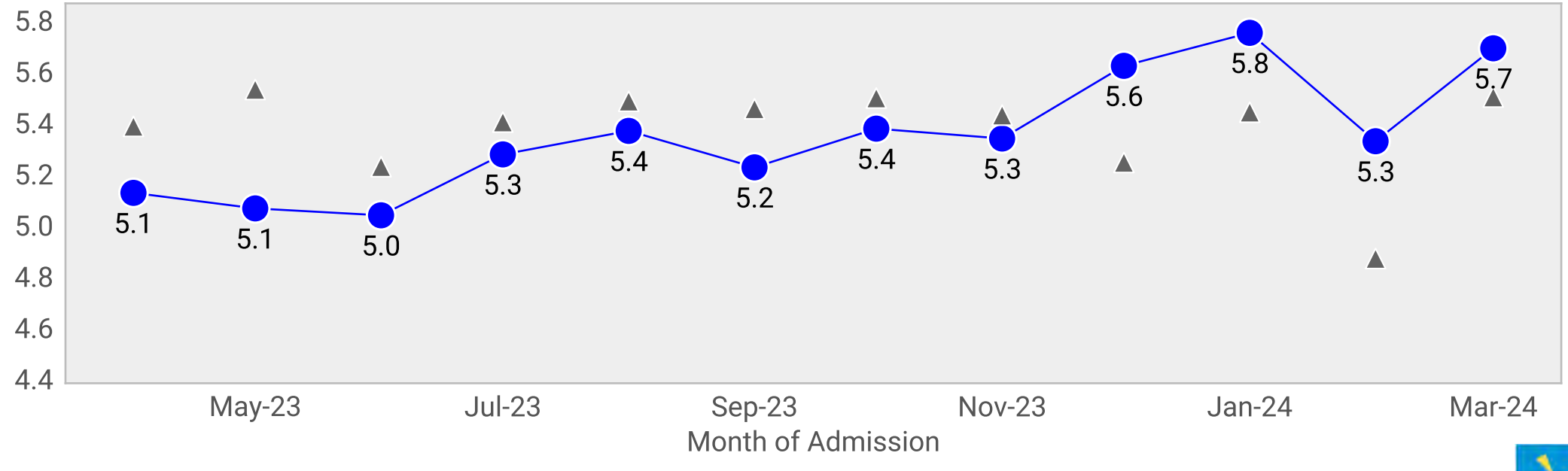
Triangles display the previous year's performance for the same month.

Only includes authorizations processed directly by L.A. Care.

Total MCLA In-Patient Hospital Admissions PTMPM



Non-Obstetrics MCLA In-Patient Hospital Admissions PTMPM

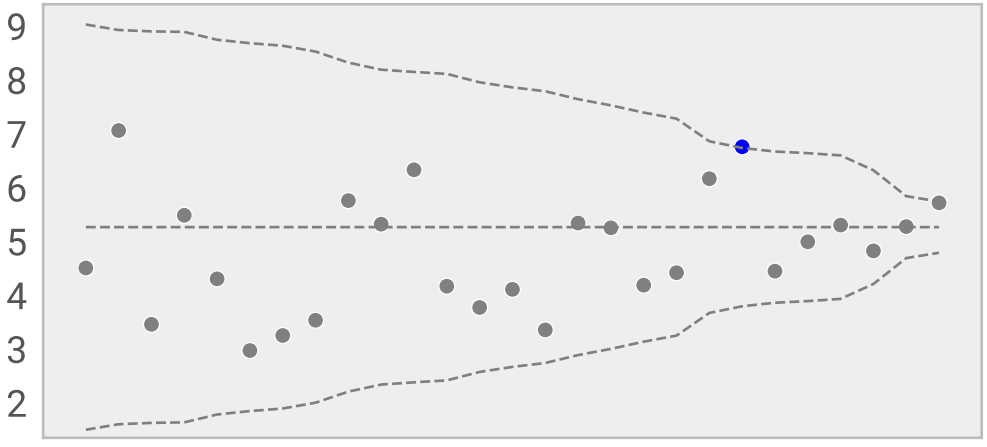


Triangles display the previous year's performance for the same month.

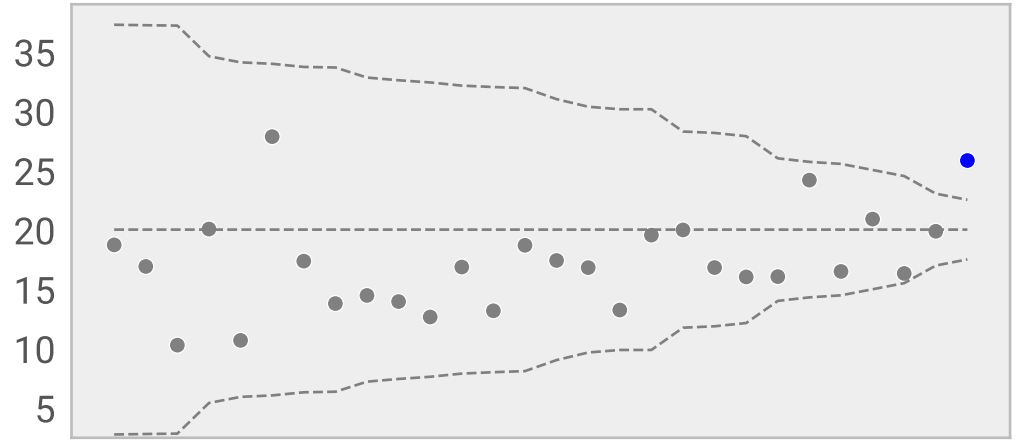
L.A. Care HEALTH PLAN

MCLA Non-Obstetrics In-Patient Admissions PMTPM by Segment and PPG
U' Charts
Assessment Period: Apr 2023 through Mar 2024

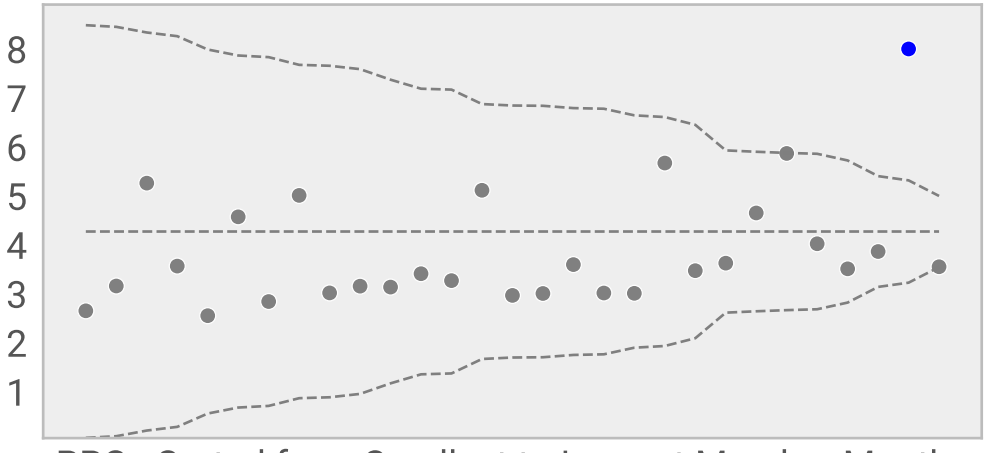
MCE



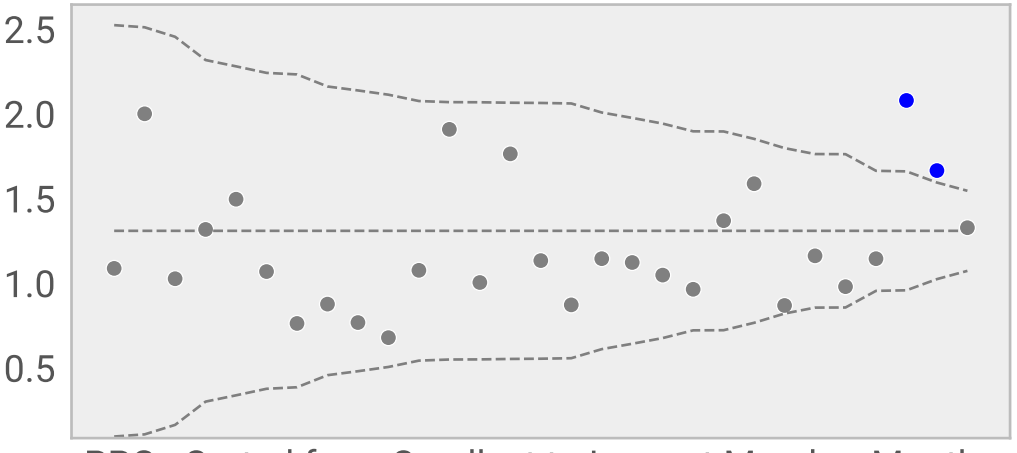
SPD

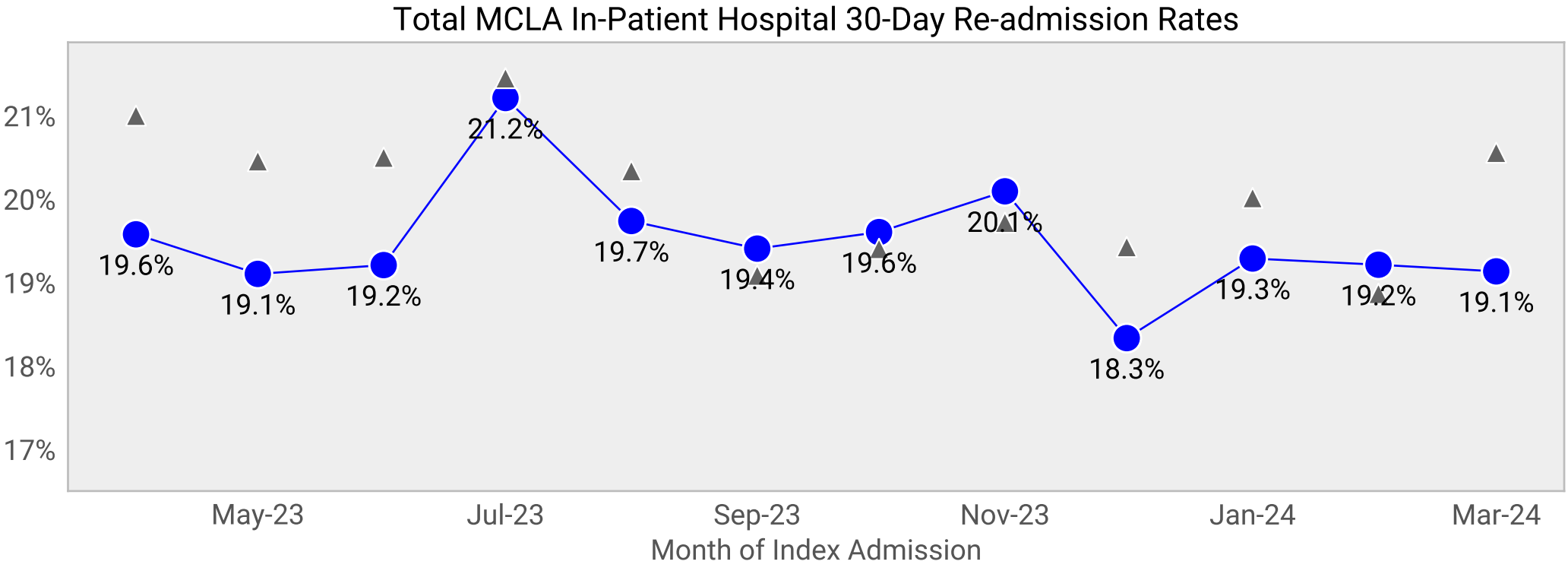


TANF - Adult



TANF - Child

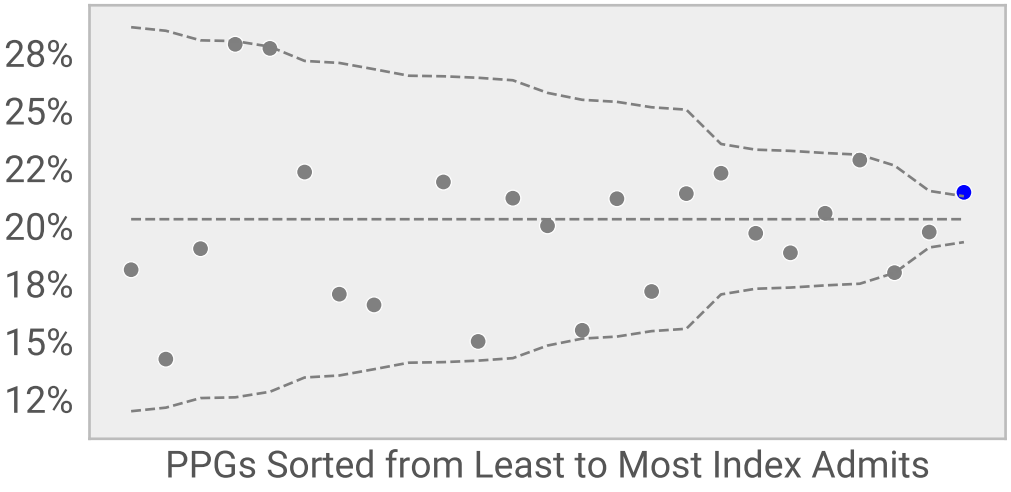




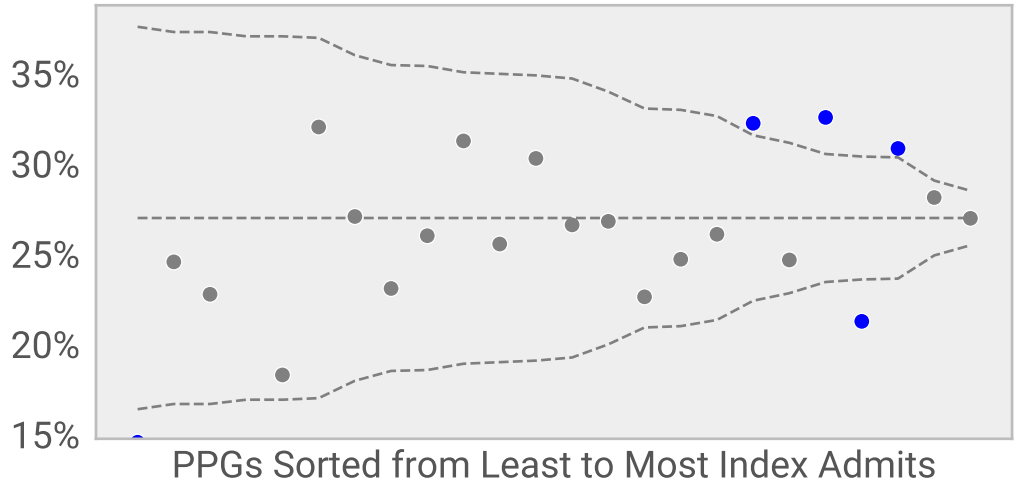
Triangles display the previous year's performance for the same month.

MCLA In-Patient Hospital 30-Day Readmission Rates by Segment and PPG
P Charts
Assessment Period: Apr 2023 through Mar 2024

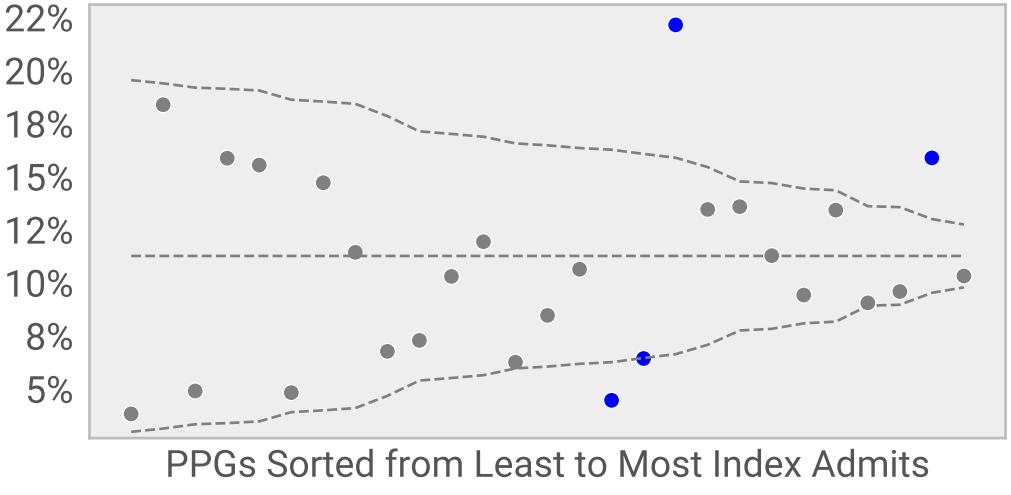
MCE



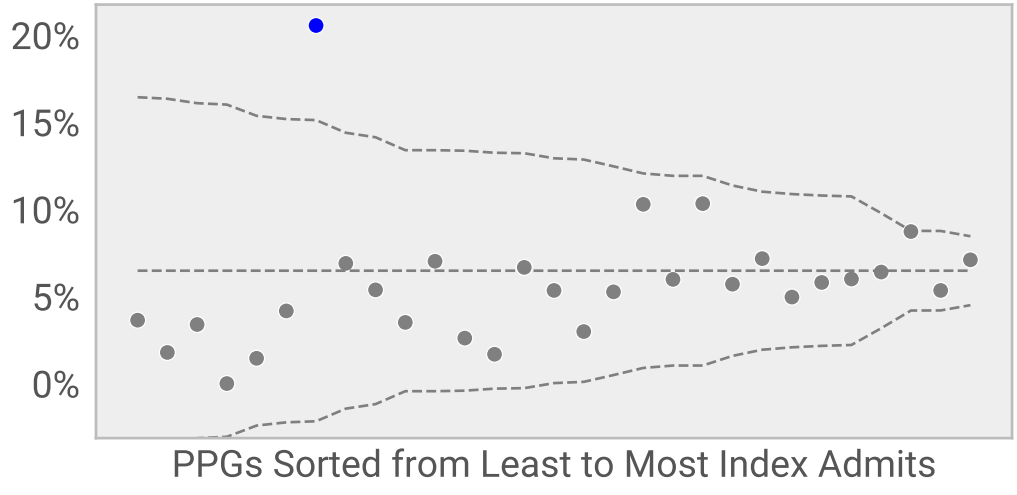
SPD

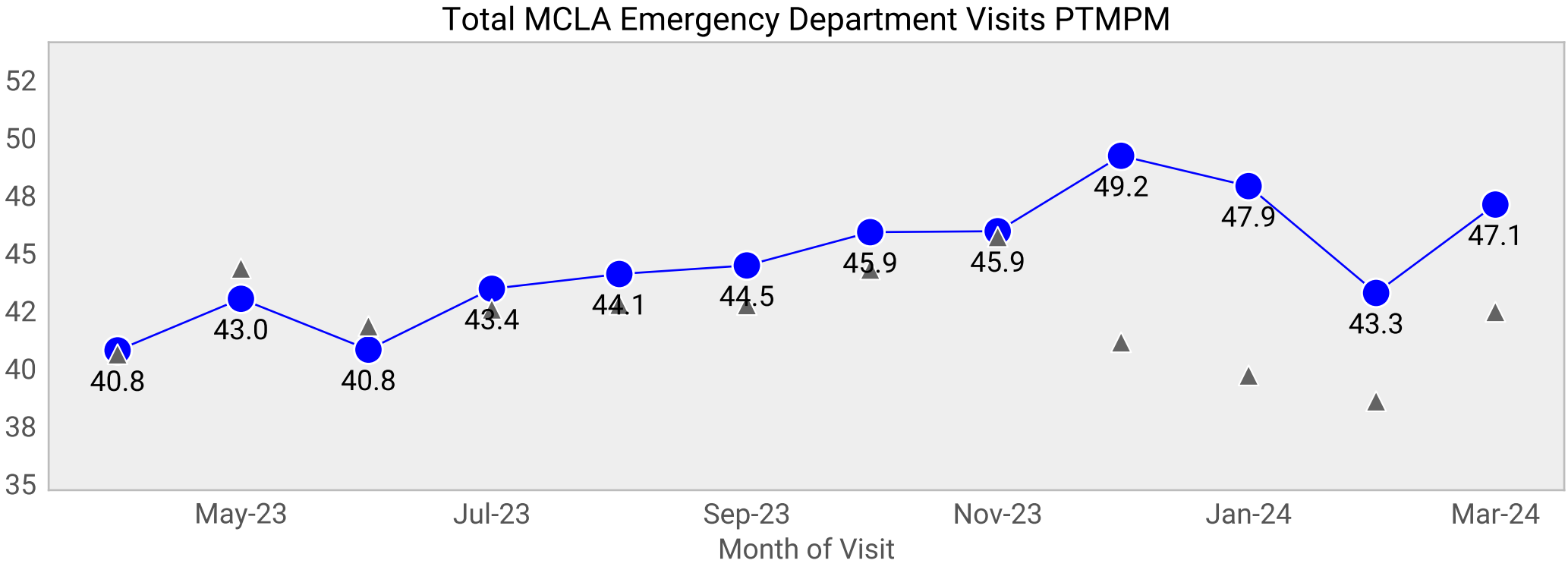


TANF - Adult



TANF - Child

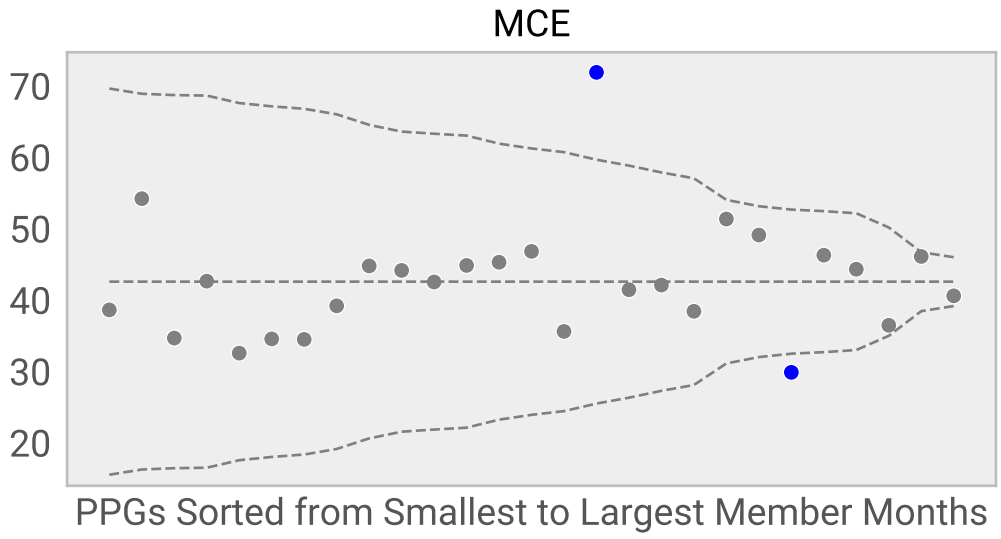


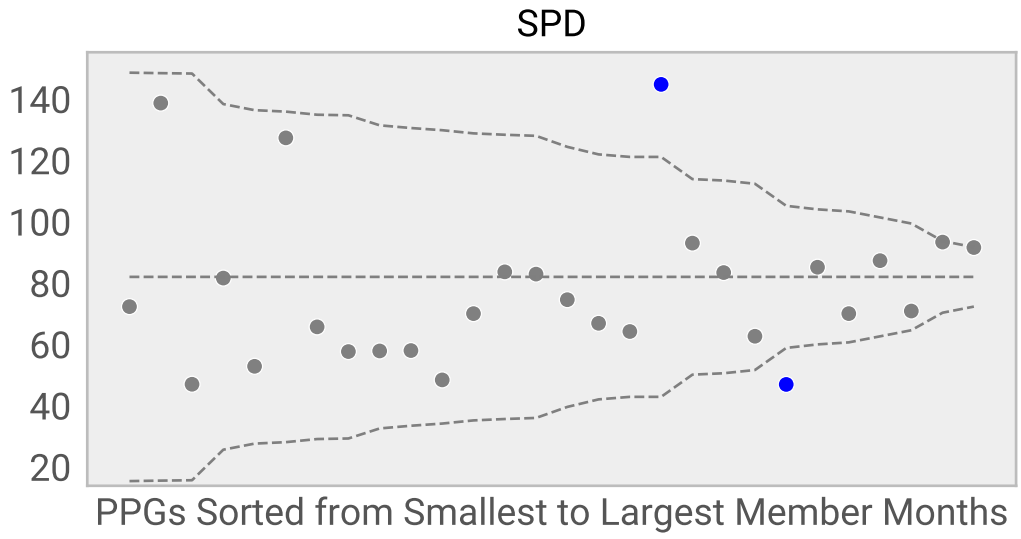


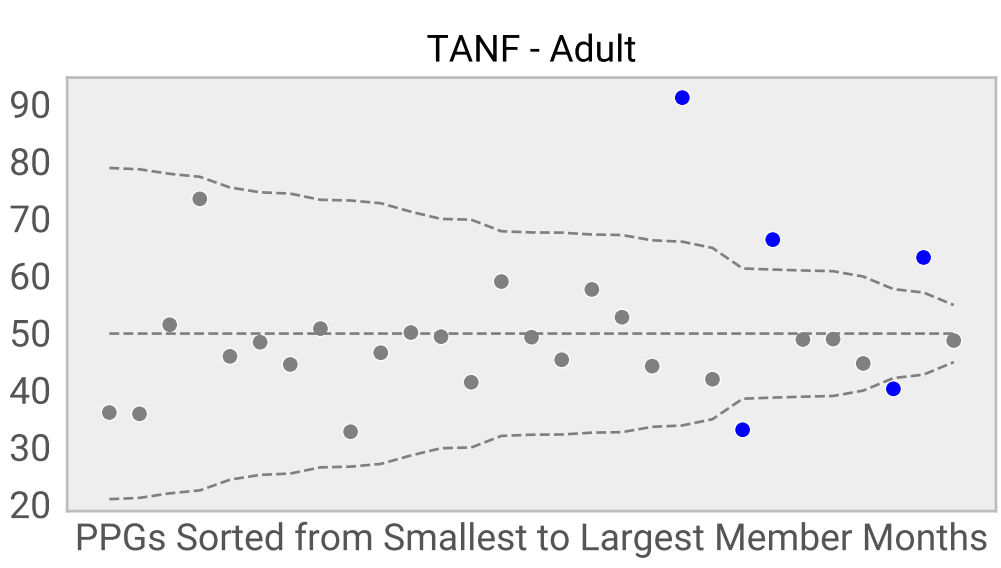
Emergency Department Visits include both Out-Patient visits and visits that result in an In-Patient admission.

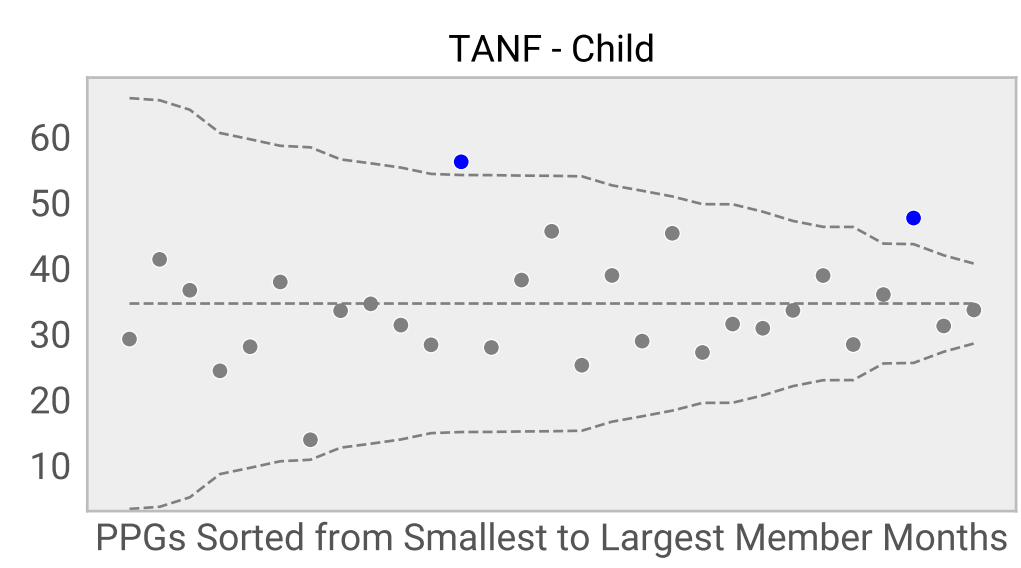
Triangles display the previous year's performance for the same month.

Total MCLA Emergency Department Visits PTMPM by Segment and PPG
U' Charts
Assessment Period: Apr 2023 through Mar 2024

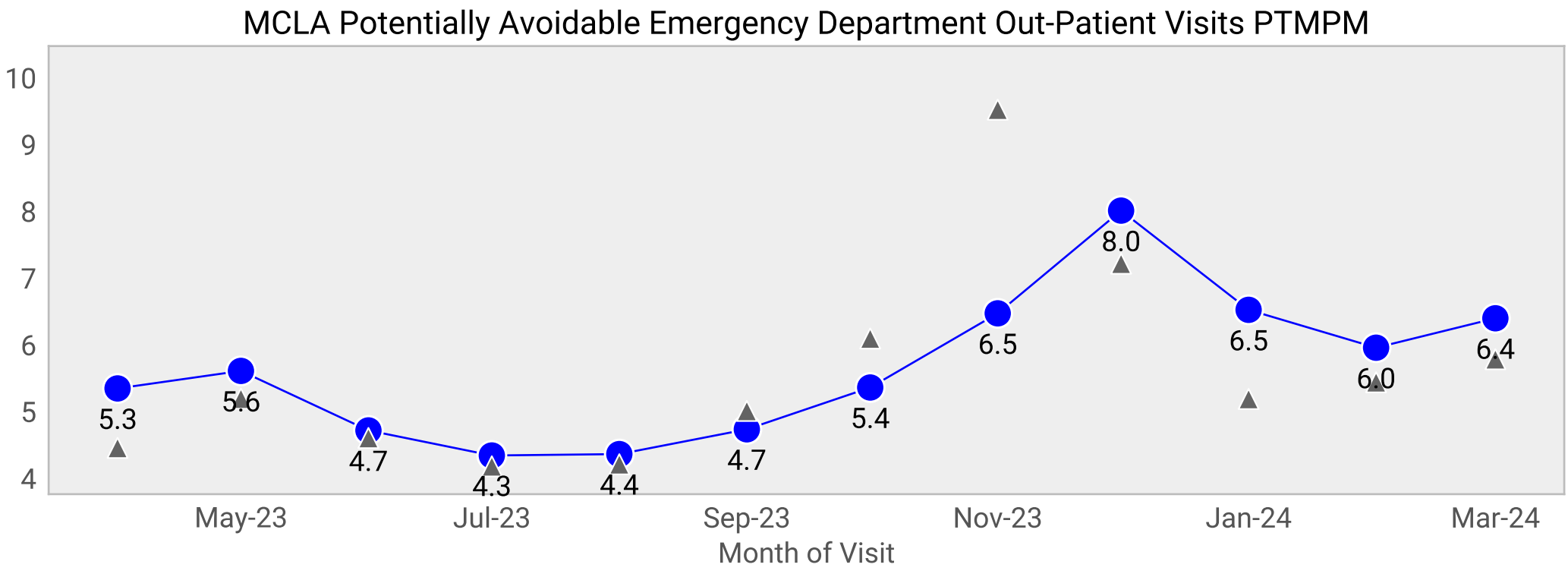








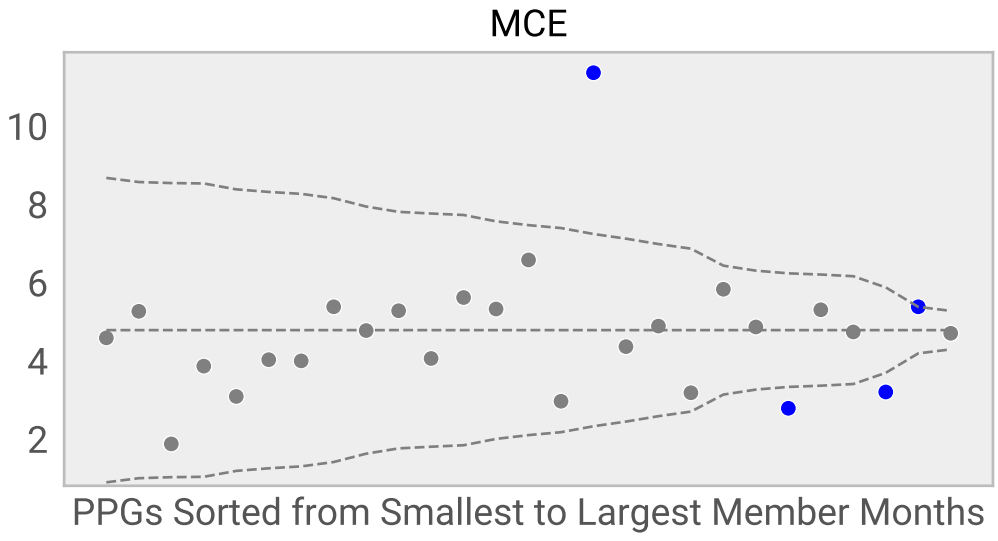
Emergency Department Visits include both Out-Patient visits and visits that result in an In-Patient admission.

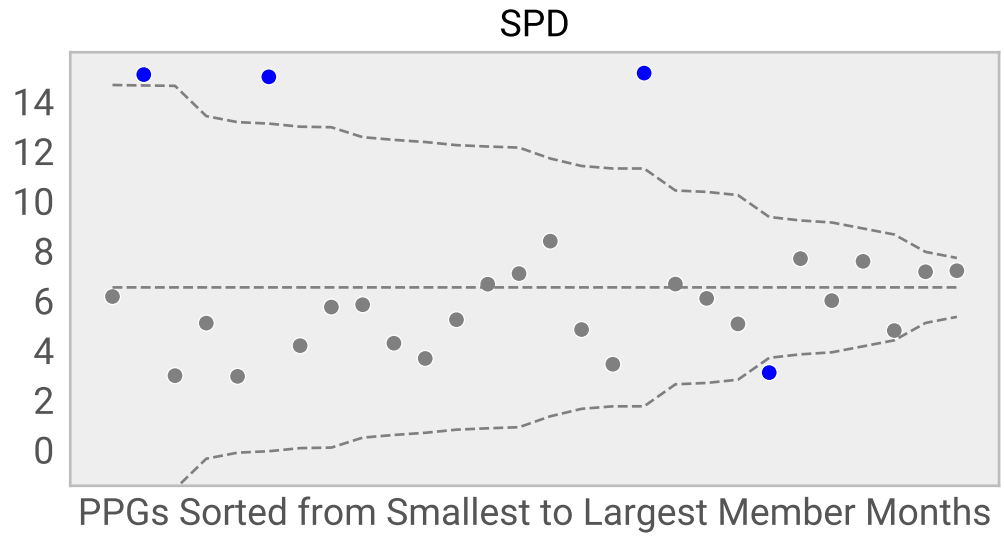


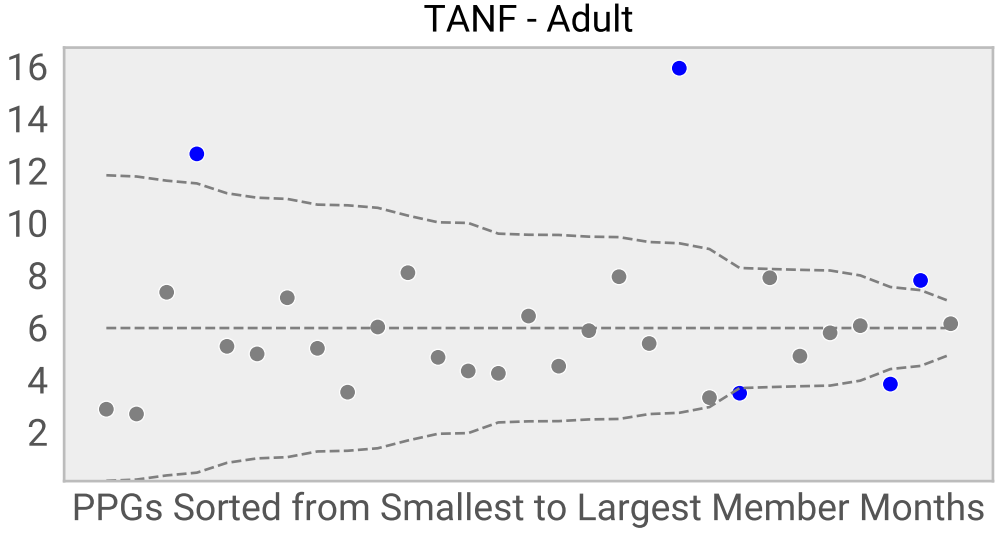
"Potentially Avoidable" identification uses the Agency for Health Research and Quality's Emergency Department Prevention Quality Indicator logic.

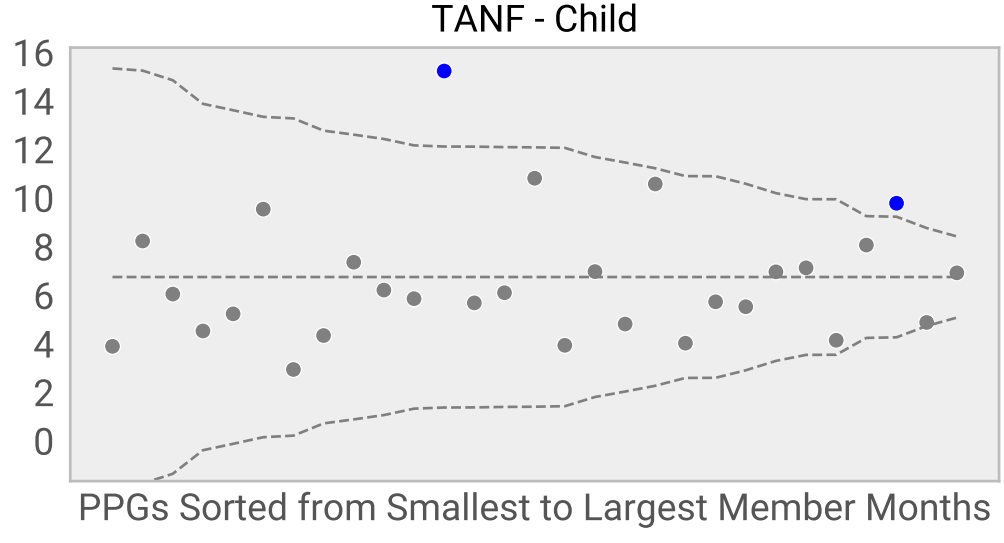
Triangles display the previous year's performance for the same month.

MCLA Potentially Avoidable Emergency Department Visits PTMPM by Segment and PPG
U' Charts
Assessment Period: Apr 2023 through Mar 2024









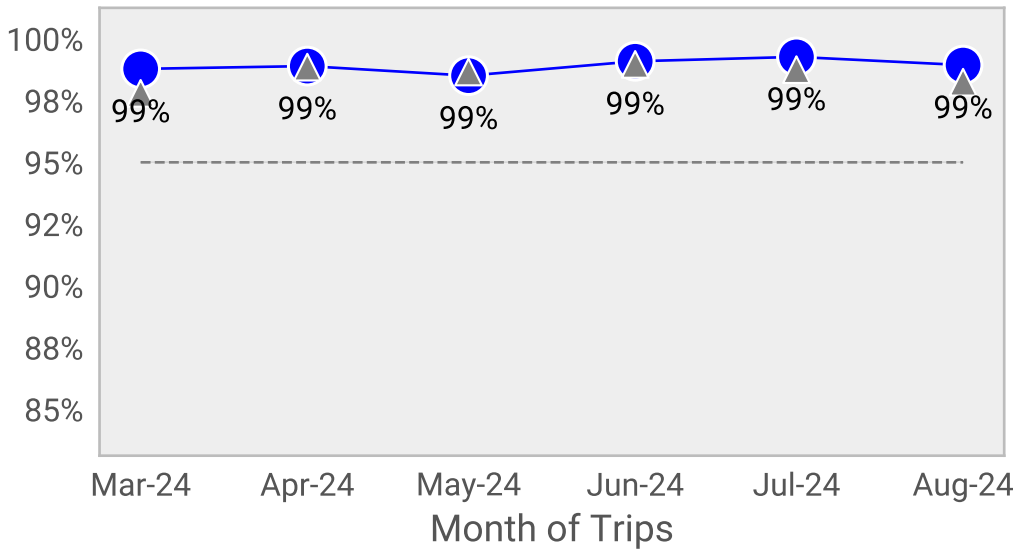
"Potentially Avoidable" identification uses the Agency for Health Research and Quality's Emergency Department Prevention Quality Indicator logic.

Total Members Receiving CalAIM Community Support Services from January 2024 to June 2024: 19,473

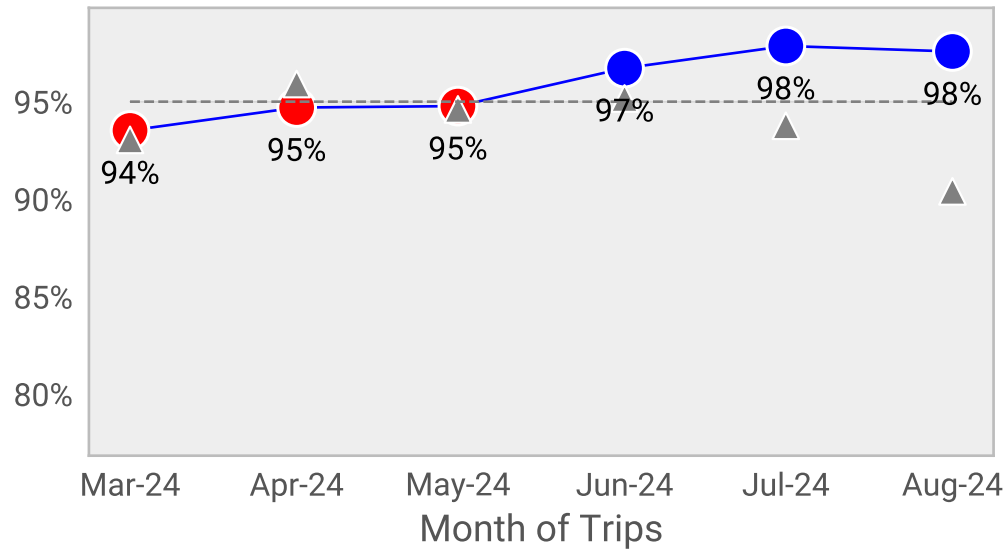
Call the Car

Call the Car On-Time Pick-Up Performance

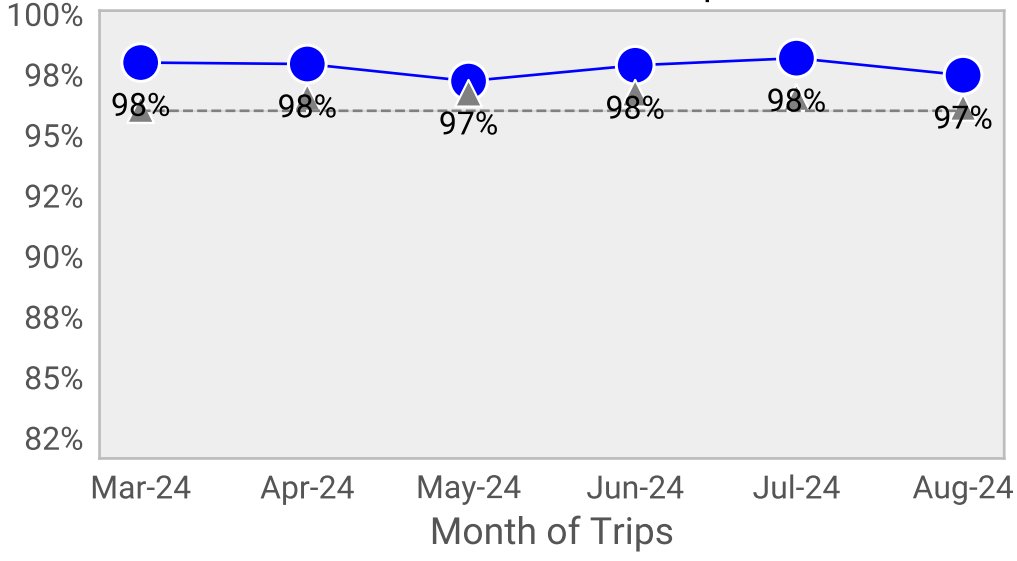
Call the Car Discharge Trips Rate



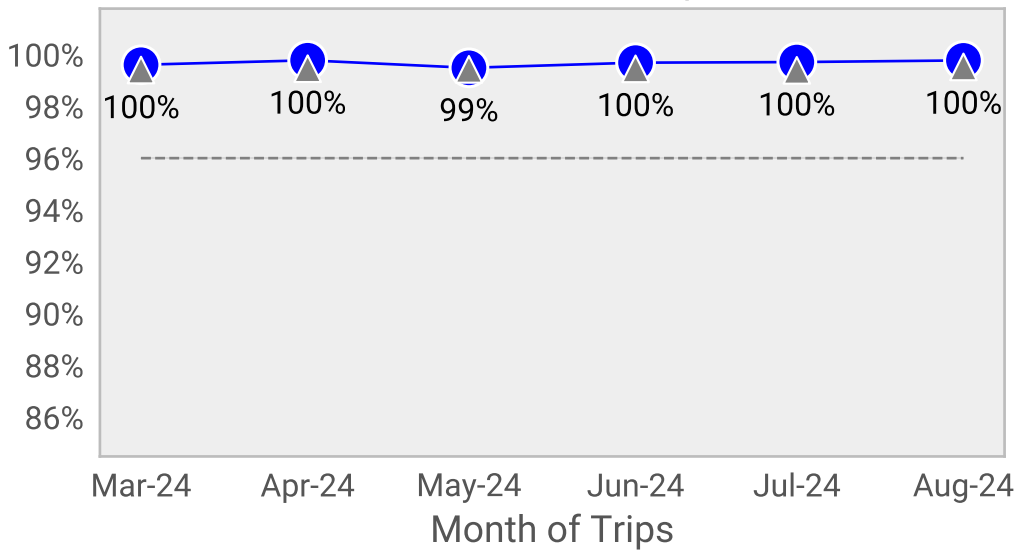
Call the Car Transfer Trips Rate



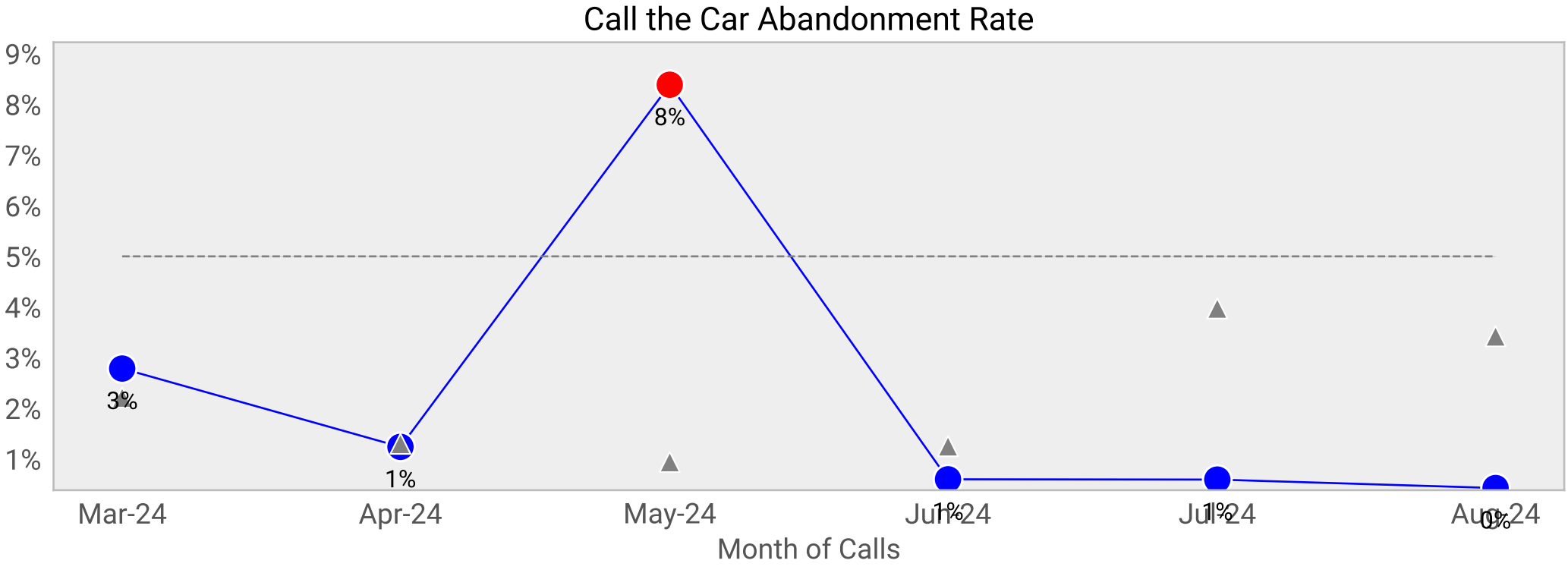
Call the Car Scheduled Trips Rate



Call the Car Will Call Trips Rate



Triangles display the previous year's performance for the same month.



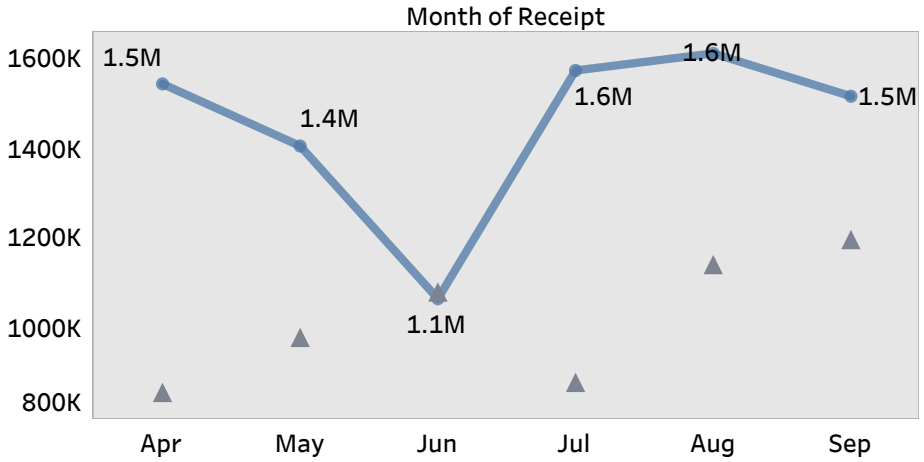
Triangles display the previous year's performance for the same month.

Claims Operations

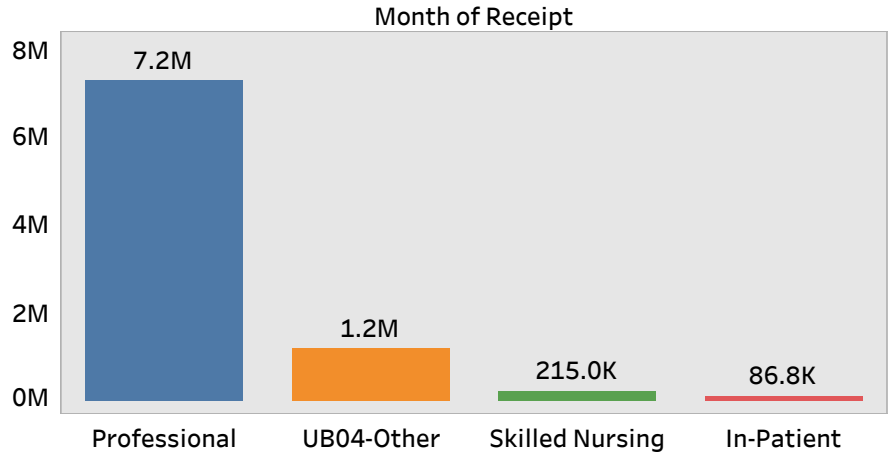
MCLA Claims Received

Line of Business	Assigned Provider Group	Pay to Provider Name
MCLA	All	All

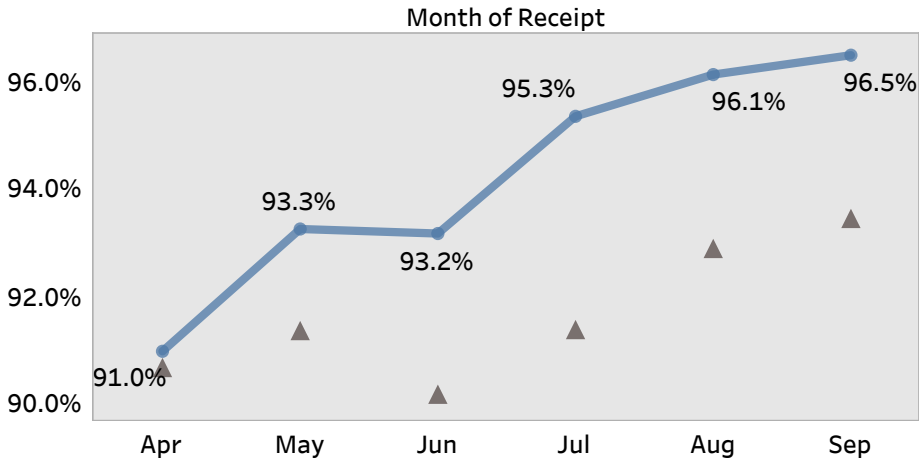
Total Claims Volume Received: **Apr-2024 to Sep-2024**



Most Recent 6 months' Volume by Service Type: **Apr-2024 to Sep-2024**



% of Claims Submitted Electronically: **Apr-2024 to Sep-2024**

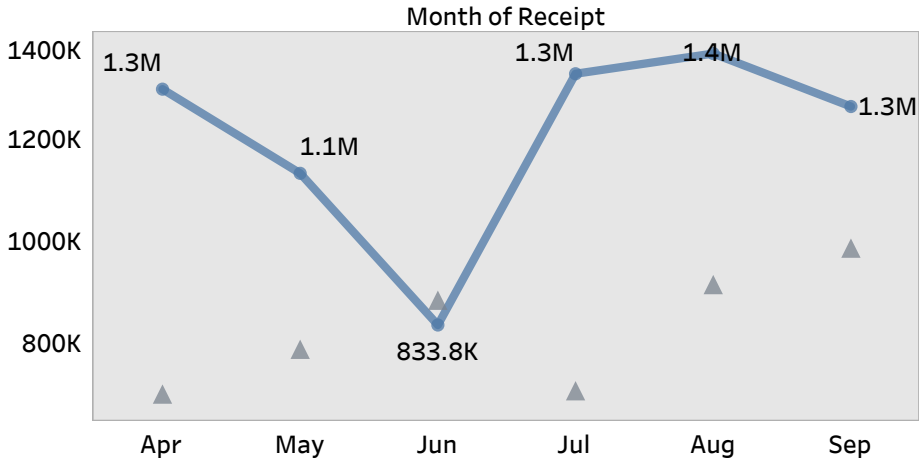


Triangles display the previous year's performance for the same month.

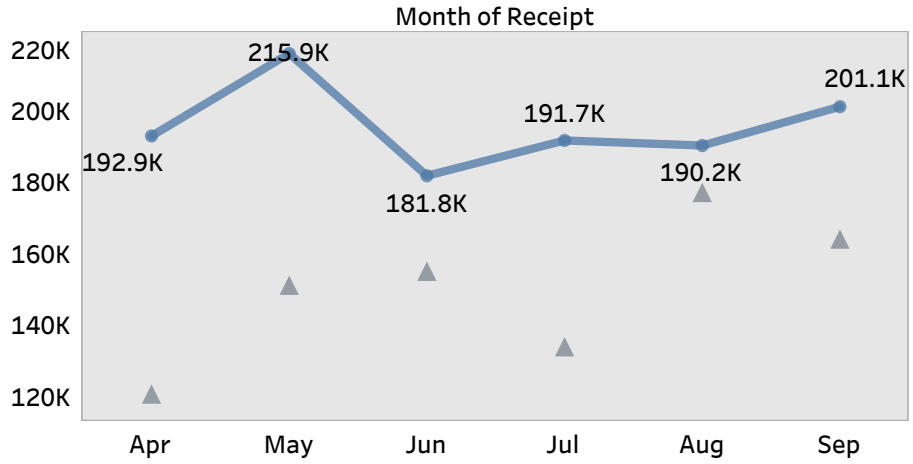
MCLA Claims Volume Received by Service Type

Line of Business	Assigned Provider Group	Pay to Provider Name
MCLA	All	All

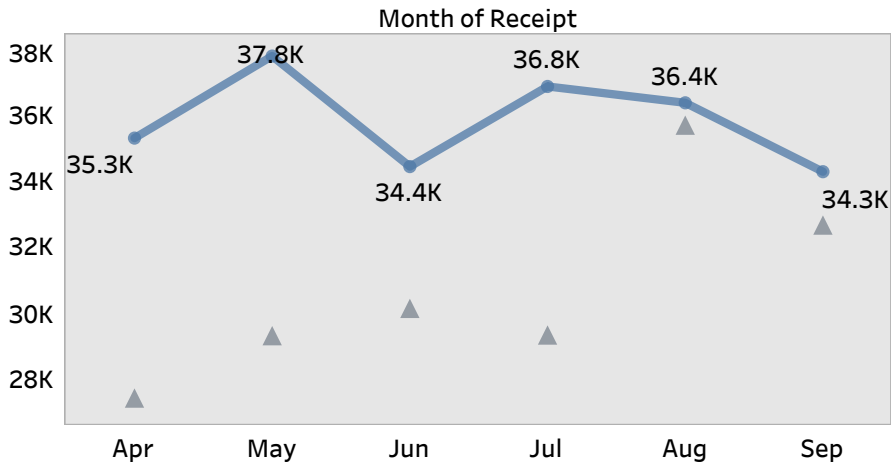
Professional - Apr-2024 to Sep-2024



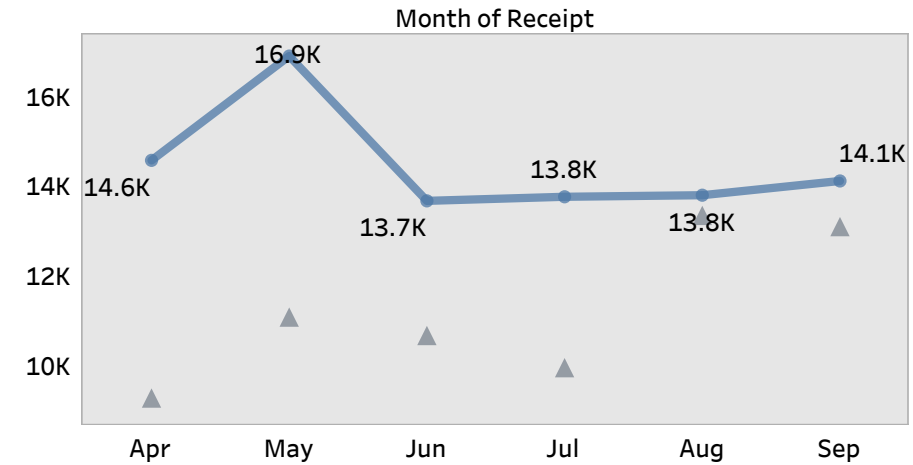
UB04 Other - Apr-2024 to Sep-2024



Skilled Nursing - Apr-2024 to Sep-2024



In-Patient - Apr-2024 to Sep-2024

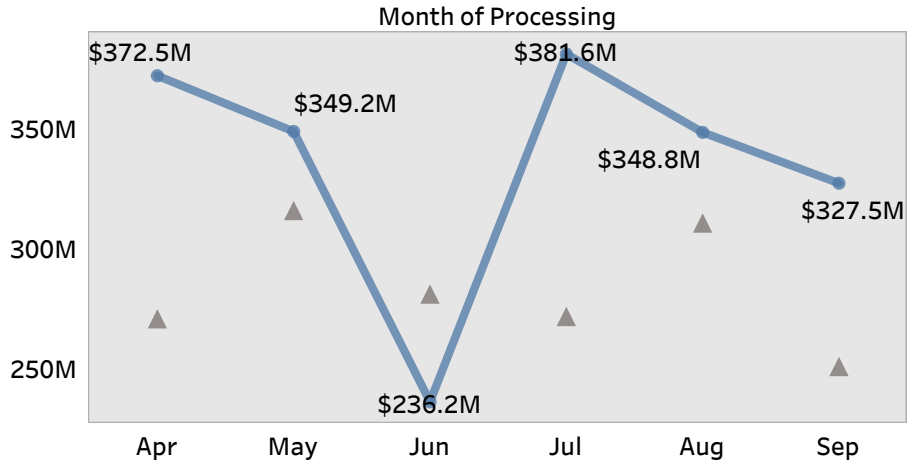


Triangles display the previous year's performance for the same month.

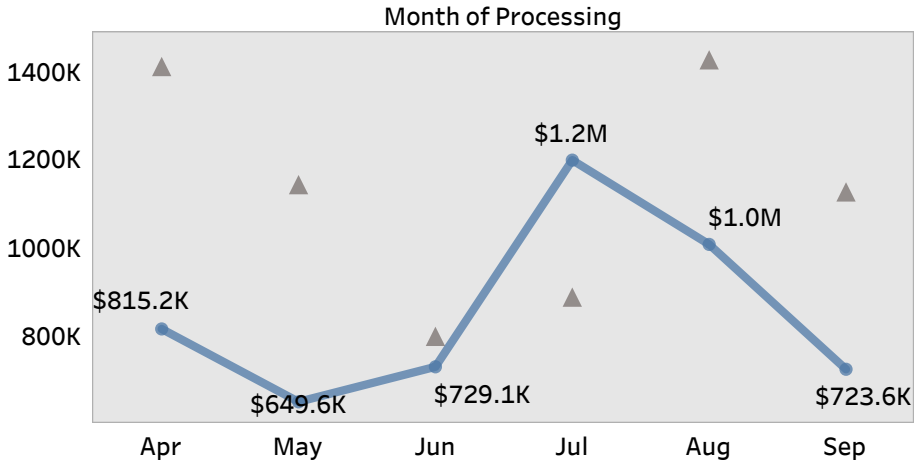
MCLA Payment Processing

Line of Business	Assigned Provider Group	Pay to Provider Name
MCLA	All	All

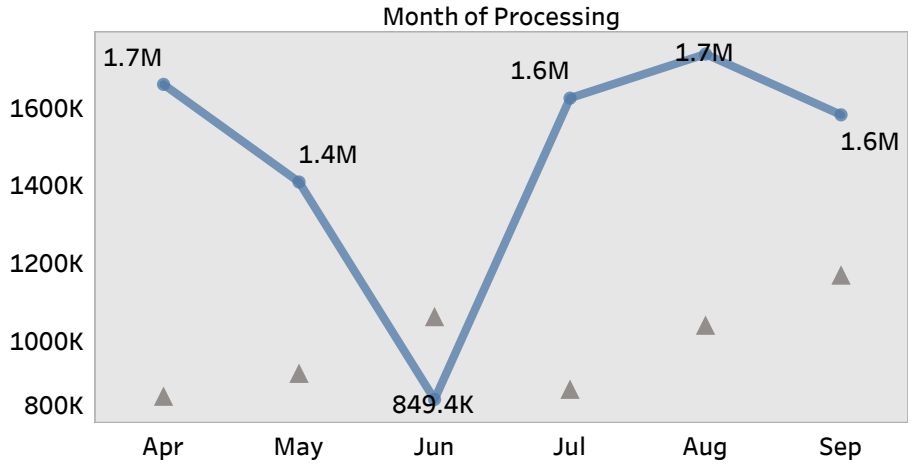
Total Paid (including Interest) - Apr-2024 to Sep-2024



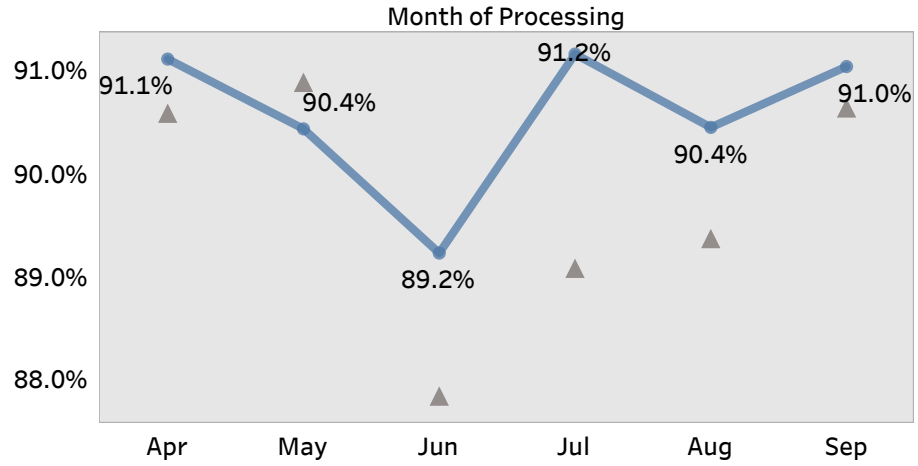
Total Interest Paid - Apr-2024 to Sep-2024



Total First-Pass Adjudicated Claims Volume - Apr-2024 to Sep-2024



% of First-Pass Claims Auto-Adjudicated - Apr-2024 to Sep-2024

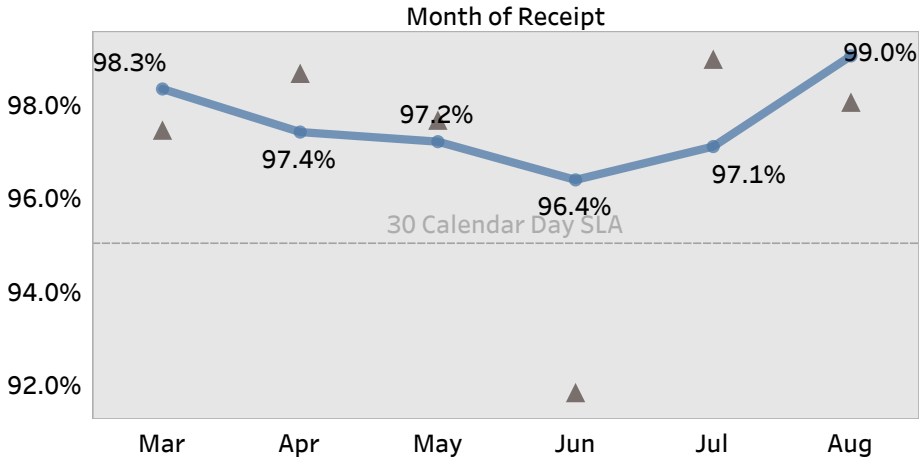


Triangles display the previous year's performance for the same month.

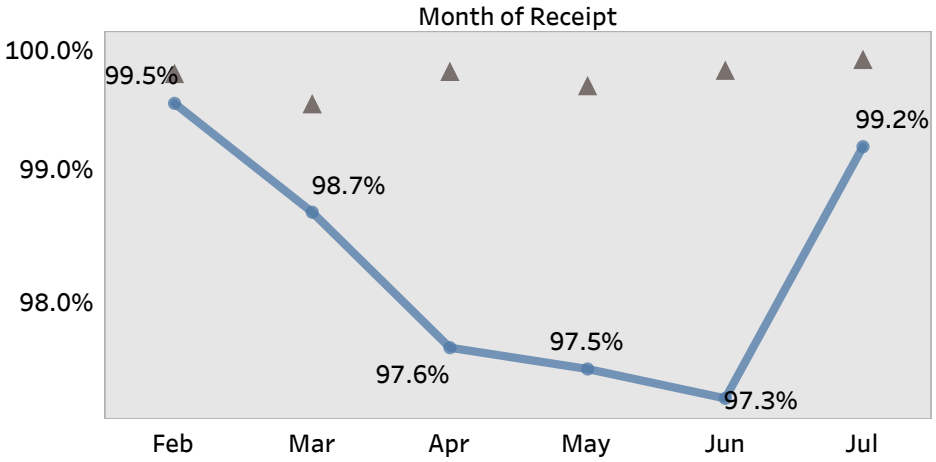
MCLA Claims Processing Timeliness

Line of Business	Assigned Provider Group	Pay to Provider Name
MCLA	All	All

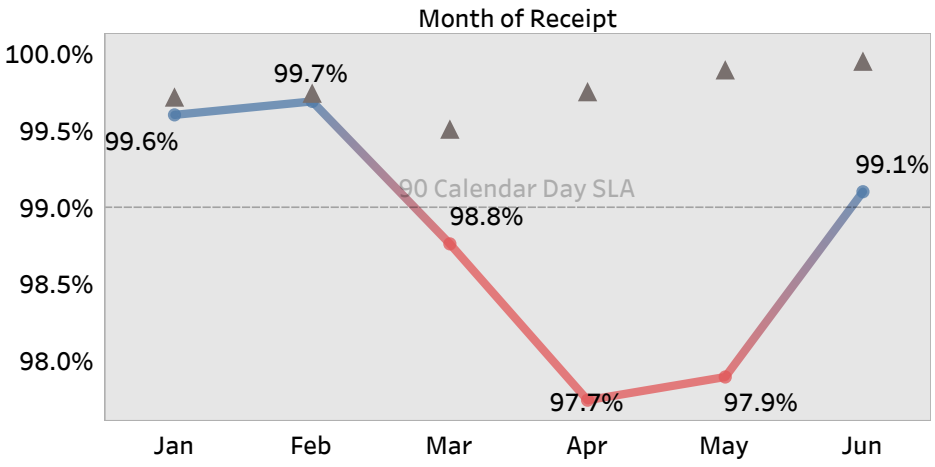
% Processed within 30 Calendar Days - Mar-2024 to Aug-2024



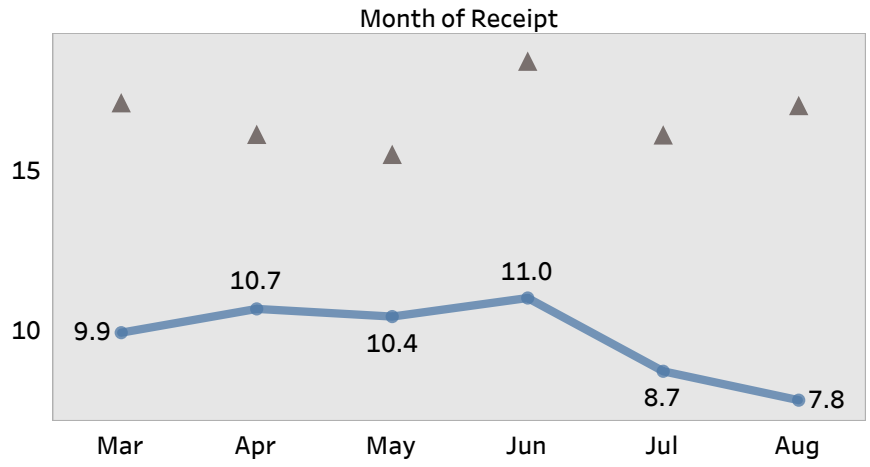
% Processed within 45 Business Days - Feb-2024 to Jul-2024



% Processed within 90 Calendar Days - Jan-2024 to Jun-2024



Average Calendar Days to Process - Mar-2024 to Aug-2024



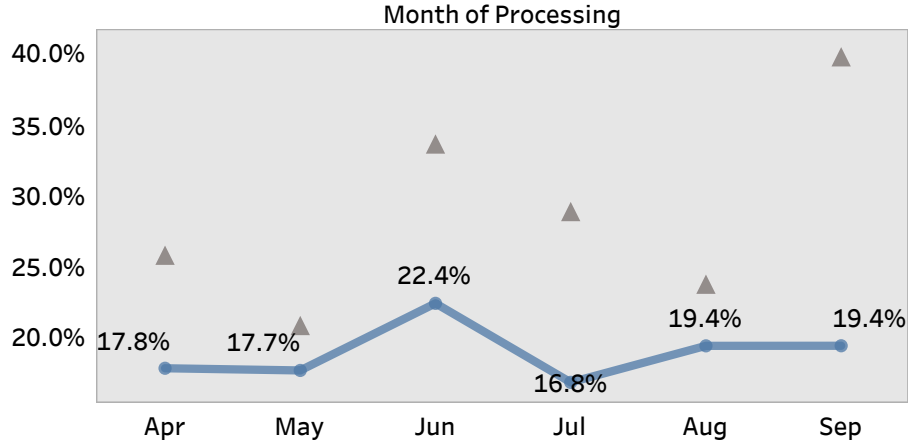
Triangles display the previous year's performance for the same month.

The most recent 6 months displayed is different for each plot, accounting for the time needed to maturely report each measure.

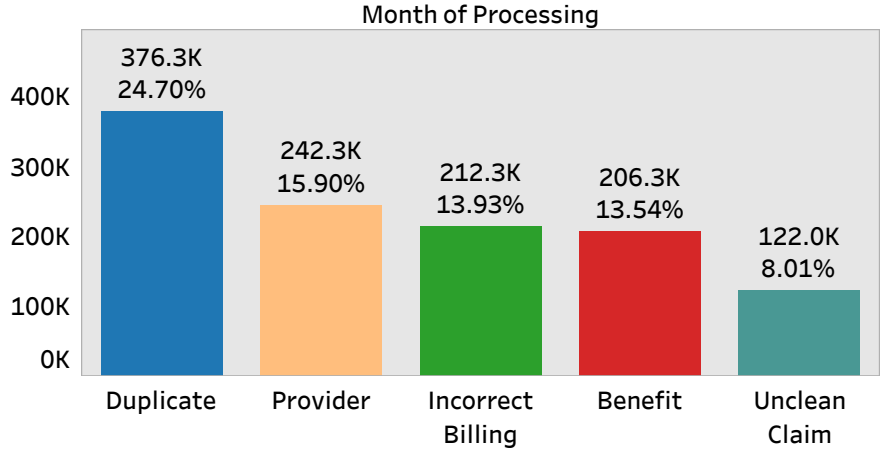
MCLA Claims Denials and Adjustments

Line of Business	Assigned Provider Group	Pay to Provider Name
MCLA	All	All

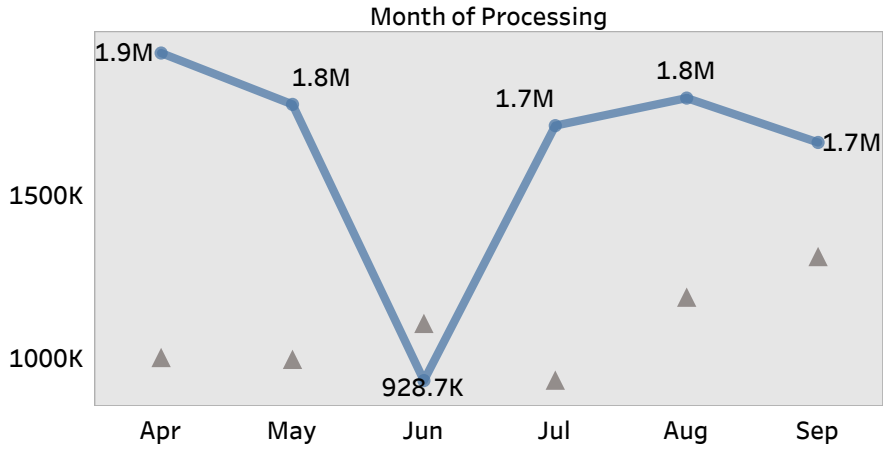
First-Pass Claims Denial Rate - Apr-2024 to Sep-2024



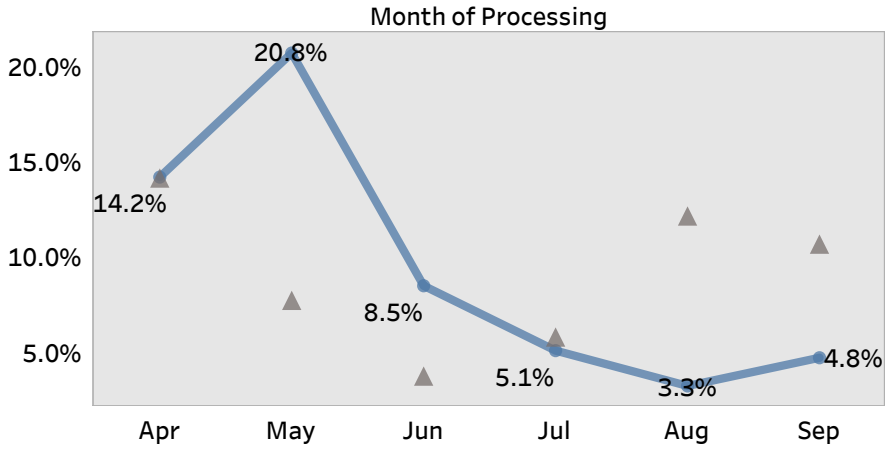
Most Recent 6 months' Denial Volume by Reason: Apr-2024 to Sep-2024



Total Claims Processed (Originals + Adjustments) - Apr-2024 to Sep-2024



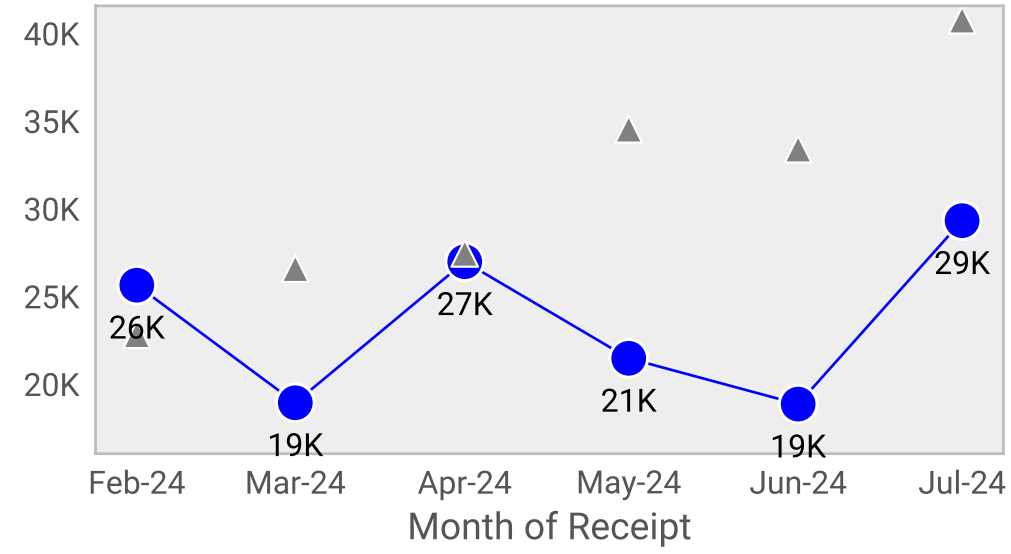
% of Total Claims Processed that are Adjustments - Apr-2024 to Sep-2024



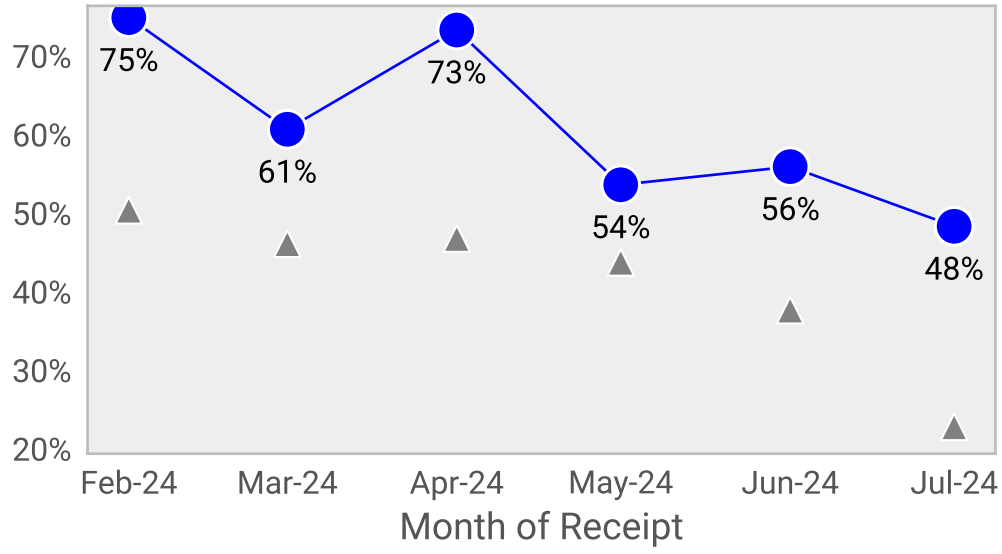
Triangles display the previous year's performance for the same month.

MCLA Provider Dispute Resolution Processing

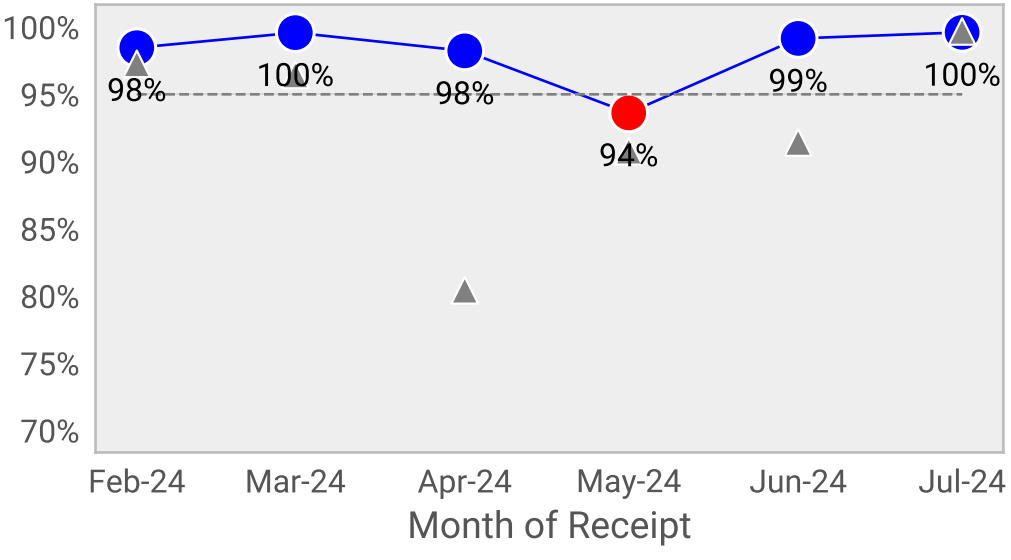
PDR Volumes Received



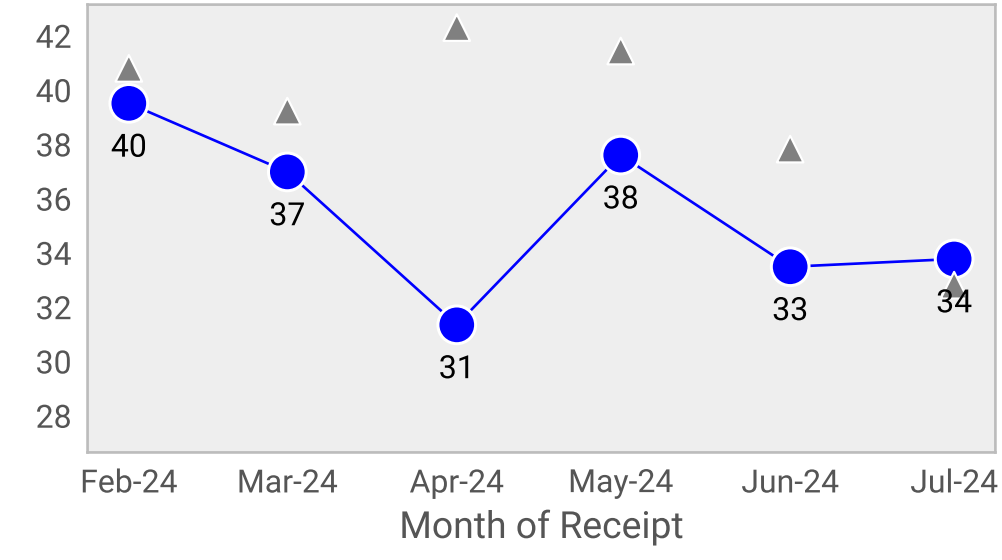
% of Closed PDR Cases that are Upheld



% of PDR Cases Closed within 45 Business Days



Average Business Days to Process PDRs



Triangles display the previous year's performance for the same month.

L.A. Care
HEALTH PLAN

Board of Governors
MOTION SUMMARY

Date: November 7, 2024

Motion No. BOG 100.1124

Committee:

Chairperson: Alvaro Ballesteros, MBA

Issue: This motion seeks approval for the FY 2024-25 Community Health Investment Fund (CHIF) priorities. Funding awards will align with the following CHIF priorities:

1. Support the health care safety net to improve infrastructure and address disparities
2. Advance solutions for social determinants of health to reduce inequities
3. Close pervasive health disparities gaps
4. Empower and invest in health and health related social service organizations that address systemic racism.

Background: On September 5, 2024, the L.A. Care Board of Governors approved a CHIF funding allocation of $10 million for fiscal year 2025 as part of the general organizational budget.

CHIF grantmaking priorities are aligned with efforts across the enterprise to ensure non-duplicative funding. Funding strategies have been vetted by internal and external organizations to determine the most appropriate strategy to impact community health and social needs. All CHIF grant applications will be rigorously examined by Community Benefits staff, a review committee composed of internal staff and/or external subject matter experts, and the Senior Director of Strategic Planning before approval is sought. T he CEO's approval will be obtained prior to execution of a grant within his authority. Grant requests over $500,000 will be brought to the Board for approval. Upon approval, a binding grant agreement will be executed with the agency to ratify the scope of work, deliverables, and terms of funding. Staff will report approved grants to the Board monthly and provide an annual summary of CHIF grants.

Member Impact: L.A. Care members will benefit from CHIF grants, which work to improve the health and wellbeing of L.A. Care's target population, including prospective members, through support to safety net providers and social service agencies. As a result of this motion, members will gain greater access to innovative, high quality, and culturally congruent care. Ultimately, FY 2025 CHIF grants will improve health outcomes, reduce health disparities, and minimize health and racial inequities.

Budget Impact: There is no budget impact from this motion as the $10 million allocation was approved by the Board of Governors on September 5, 2024, as part of the general organizational budget.

Motion:

1. **Approve the recommended approach for the Community Health Investment Fund (CHIF) FY 2024-25 $10 million allocation as designated across the following priorities:**
   a. **support the health care safety net to improve infrastructure and address racial disparities, recommended at $5 million,**
   b. **advance solutions for social determinants of health to reduce inequities recommended at $2.2 million,**
   c. **close pervasive health disparities gaps, recommended at $1.6 million, and**
   d. **empower and invest in health and health related social service organizations that address systemic racism, recommended at $1.2 million.**
2. **Delegate authority to the CEO to adjust CHIF priority designations above to align with evolving community needs and requests. All other policies and procedures related to CHIF grant making investments will remain.**

Community Benefits

2024-25 Community Health Investment Fund (CHIF) Grantmaking Priorities

Board of Governors Meeting
November 7, 2024
Shavonda Webber-Christmas, Director
Community Benefits Department

ELEVATING HEALTHCARE IN LOS ANGELES COUNTY SINCE 1996

L.A. Care

Community Health Investment Fund (CHIF)

- Leverage partnerships to strengthen healthcare and social service systems since 2000

- As of October 1, 2024, the CHIF Program has
  - Supported 1,061 projects
  - Engaged 213 unique community entities from various sectors
  - Invested more than $147.9 million through grant awards
  - Impacted critical metrics, including BP/HbA1c control, care integration, healthy food access, permanent housing, birth survival, & power building
  - Sustained prominent recognition of L.A. Care Health Plan

Grantmaking Priorities

Support the health care safety net to improve infrastructure and address disparities

Advance solutions for social determinants of health to reduce inequities

Close pervasive health disparities gaps

Empower and invest in health and health related social service organizations that address systemic racism

Grantmaking Portfolios

Healthcare Infrastructure & Innovation

Tranquada XVI

Oral Health XVI

Accessible Equipment II

Clinical Ad Hocs

SDOH Solutions

Community Wellness VIII

Adv. Economic Mobility III

SDOH Ad Hocs

End Disparities

GAAINS III

Disparities Ad Hocs

Systemic Justice & Reparations

Equity & Resilience VI

Systemic Justice Ad Hocs

Priorities Motion

1. Approve the recommended approach for the Community Health Investment Fund (CHIF) FY 2024-25 $10 million allocation as designated across the following priorities:

Priority	Allocation
Support the health care safety net to improve infrastructure and address disparities	$5,050,000
Advance solutions for social determinants of health to reduce inequities	$2,225,000
Close pervasive health disparities gaps	$1,550,000
Empower and invest in health and health related social service organizations that address systemic racism	$1,175,000
Total Allocation	$10,000,000

2. Delegate authority to the CEO to adjust CHIF priority designations above to align with evolving community needs and requests.

PUBLIC ADVISORY COMMITTEES

- Temporary Transitional Consumer Advisory Committee

- Children's Health Consultant Advisory Committee

- Technical Advisory Committee

Board of Governors

Temporary Transitional Executive Community Advisory Committee (TTECAC)

Meeting Minutes – September 11, 2024

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

ECAC Members	RCAC Members/Public	L.A. Care Board of Governors/Senior Staff
Roger Rabaja, RCAC 1 Chair	Izmir Coello, Interpreter	Layla Gonzalez, *Advocate, Board of Governors*
Ana Rodriguez, TTECAC Chair and	Pablo De La Puente, Interpreter	Fatima Vazquez, *Member, Board of Governors*
RCAC 2 Chair	Sonia Hernandez, Interpreter	Sameer Amin, MD, *Chief Medical Officer, L.A. Care*
Silvia Poz, RCAC 4 Chair	Isaac Ibarlucea, Interpreter	Todd Gower, *Chief Compliance Officer, L.A. Care* ***
Maria Sanchez, RCAC 5 Chair	Eduardo Kogan, Interpreter	Brigitte Baily, *Supervisor, Quality Improvement Department* ***
Joyce Sales, RCAC 6 Chair	Katelynn Mory, Captioner	Tyonna Baker, *Community Outreach Field Specialist, CO&E*
Martiza Lebron, RCAC 7 Chair	Andrew Yates, Interpreter	Malou Balones, *Board Specialist, Board Services* ***
Ana Romo, RCAC 8 Chair		Idalia De La Torre, *Field Specialist Supervisor, CO&E*
Tonya Byrd, RCAC 9 Chair		Priscilla De La Torre, *Project Manager, Quality Manager* ***
Damares O Hernández de Cordero,	Norma Angélica Álvarez, Public	Auleria Eakins, *Manager, CO&E*
RCAC 10 Chair	Elizabeth Cooper, Public ***	Ramon Garcia, *Community Outreach Field Specialist, CO&E*
Maria Angel Refugio, RCAC 11 Chair *	Silvia Sosio, Public	Hilda Herrera, *Community Outreach Field Specialist, CO&E*
Lluvia Salazar, At-Large Member	Nereyda Ibarra, Public ***	Christopher Maghar, *Community Outreach Field Specialist, CO&E*
Deaka McClain, TTECAC Vice-Chair	Estela Lara, Public	Linda Merkens, *Senior Manager, Board Services* ***
and At Large Member	Russel Mahler, Public	Frank Meza, *Community Outreach Field Specialist, CO&E*
	Kimberly Martinez, Public	Alfredo Mora, *Staff Augmentation, Facilities Services*
	Andrea McFerson, Public	Cindy Pozos, *Community Outreach Field Specialist, CO&E*
	Maria Montes, Public ***	Victor Rodriquez, *Board Specialist, Board Services* ***
* Excused Absent ** Absent	Demetria Saffore, Public	Farid Seyed, *Lead Unified Communication Mobility Engineer, IT*
*** Via teleconference	Dazzling Sanchez, Public	*Operations & Infrastructure*

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
CALL TO ORDER	Ana Rodriguez, *TTECAC Chairperson*, explained the meeting rules guidelines and process for making public comments via Zoom chat and a toll-free line for WebEx bridge line listeners. She also mentioned that public members could submit comment cards and that they would be allowed time to speak during the appropriate agenda items. Chairperson Rodriguez welcomed L.A. Care staff and the public to the meeting and encouraged L.A. Care members with healthcare issues to contact the Member Services Department.	

	Chairperson Rodriguez called the meeting to order at 10:02 A.M.	
APPROVE MEETING AGENDA	Vice Chair McClain advised the members of the public that one minute will be allotted for public comment on each agenda item and asked that their comments be related to the agenda item. **PUBLIC COMMENT** ***Andria McFerson, RCAC 5 Member, stated that unless there's a motion on the floor to take the minutes away, then there should not be less than, it states 3 minutes on the agenda but there should not be less minutes allotted. She said she needs ADA compensation or some sort of ADA rights so that she can have a little bit more time and she is in a lot of pain right now and it's debilitating. Unless there's a motion on the floor to take the minutes away, then there should not be less than, it states 3 minutes on the agenda but there should not be. But I need ADA compensation, I guess you can say, some sort of ADA rights so that I can have a little bit more time and I'm in a lot of pain right now and it's debilitating. But with that said, there must be a motion on the floor or approval of the depreciation of time.*** Chairperson Rodriguez responded that as the chair she can reduce the time allotted for public comment. ***Ms. McFerson responded that as the Chair, she is saying for the public record that she can depreciate the minutes even if they're not behind on time.*** Chairperson Rodriguez responded that she can do so. ***Ms. McFerson said that as far as the agenda goes, that should be discussed. And also with the budget sent to her should also be discussed on the agenda so she does not approve of this agenda today and it needs to be investigated if they are taking away minutes for public comment and there is no ADA provision.*** Ms. De La Torre stated that for clarity for everyone including TTECAC members, the Chair has authority to reduce the public comment time and she will determine if accommodations will be made for those individuals that need extra time. The Chair has that authority. **The Agenda for today's meeting was approved.** Ms. De La Torre advised the committee that Lidia Parra, *RCAC 3 Chair*, resigned from the committee and membership now stands at 12 members.	**Approved.** **8 AYES** **(Byrd, Cordero, McClain, Poz, Rabaja, Rodriguez, Salazar, and Sanchez)** **3 Abstention** **(Lebron, Romo, and Sales)**
APPROVE MEETING MINUTES	Member Salazar would like Francisco Oaxaca, *MBA, Chief, Communications and Community Relations*, to invite the TTECAC to the grand opening of the South L.A. Community Resource Center. Ms. De La Torre stated that everyone will be receiving an invitation.	**Approved.**

	Member Lebron stated that on page 19, it looks strange. She suggested an agenda item regarding the Health Promoters program. She would like to see what L.A. Care is doing, if it's going to recruit, or if there will be spaces available. Ms. De La Torre stated that Board Services is taking note of corrections and comments. **The July 10, 2024 Meeting minutes were approved with corrections.**	**8 AYES (Byrd, Cordero, McClain, Poz, Rabaja, Rodriguez, Salazar, Lebron, and Romo), 3 Absentions (Sanchez, Salazar, and Sales)**
STANDING ITEM		
UPDATE FROM CHIEF EXECUTIVE OFFICER	Sameer Amin, MD, *Chief Medical Officer*, reported on behalf of John Baackes, *Chief Executive Officer*: Dr. Amin provided an update on L.A. Care's work with the unhoused community. He emphasized the organization's commitment to serving the community beyond being just an insurance provider, noting that L.A. Care reinvests funds into the community. Dr. Amin outlined the four key areas of focus for their unhoused program: 1. Helping members find and stay in housing. 2. Providing short-term housing solutions. 3. Increasing the availability of permanent housing. 4. Ensuring access to healthcare and social services. He highlighted the importance of field medicine. The county has been divided geographically into 15 regions, each with dedicated medical teams to provide care to the unhoused on the streets. These regions also have anchor providers for brick-and-mortar healthcare services. L.A. Care has committed $1.2 billion from 2022 to 2029 for these efforts, including $30 million to create 10 new street medicine teams and $40 million in incentive payments to sustain healthcare providers. Dr. Amin discussed L.A. Care's initiatives in Skid Row, where $90 million has been allocated for services including harm reduction, mental health, and substance use treatment, as well as extending urgent care and transportation services. He also introduced plans for a new initiative in the community around MacArthur Park, a high-density area of unhoused individuals. L.A. Care will create a 16th region specifically for this area, with specialized services including field medicine, overdose response teams, behavioral health services, and a harm reduction health hub with respite care, hygiene, and nutrition support in collaboration with the Department of Mental Health, the Department of Public Health, and local city and county councils. Dr. Amin outlined plans for transit services and expanded clinical-based	

services. He emphasized the speed and commitment to implement these initiatives, similar to the Skid Row effort.

PUBLIC COMMENT

Andria McFerson, RCAC 5 Member, thanked the Chair for being given the opportunity to speak, and mentioned that her ADA rights were not fully accommodated. She thanked Dr. Amin for his presentation and referred to the recent approval of the housing initiative incentive program by the Board of Governors. She spoke about her motion aimed at ensuring that L.A. Care provides not only housing but also healthcare for the unhoused. Ms. McFerson emphasized the importance of conducting a mental health evaluation to identify specific challenges individuals face, such as learning disabilities, job loss, disabilities, veteran status or domestic violence. She asked if there are specific programs tailored to address these various needs. She said that disabled individuals, those without family support, often require 24-hour assistance from service workers. The workers would help manage essential tasks like paying bills, maintaining hygiene and ensure access to food, as those are often neglected when someone is facing mental health issues. She asked if these services are available to the unhoused population.

Dr. Sameer Amin confirmed that L.A. Care is indeed providing the services Ms. McFerson inquired about. He affirmed that the programs include mental health assessments, social workers, and community health workers, many of whom come from similar life experiences and are familiar with the community's needs. These services are designed to ensure that individuals receive temporary or permanent housing and the care management necessary to maintain stability. Dr. Amin highlighted Enhanced Care Management (ECM) as a key approach, emphasizing that street teams and ECM are central to delivering comprehensive services.

Russel Mahler, RCAC 4 Member, asked if the RCACs can get involved with helping this project.

Dr. Amin responded that RCACs can be involved and he will brainstorm with Dr. Eakins on how to do this. This is a community-based problem. It's not something an insurance plan will be able to do on its own and L.A. Care is not trying to go solo on this. L.A. Care involves multiple partners from the county, the city, the Department of Mental Health, the Department of Public Health and the community, which includes the RCACs. He noted that the program is for the community and supported by the community and L.A. Care is going to need their help.

Member Poz expressed concern about the diversity of the population at MacArthur Park, highlighting the presence of many immigrants, possibly without legal status. She noted that

	harm reduction is relatively new in the area and might be misunderstood by some. She spoke about the need for co-located Department of Mental Health (DMH) clinics, similar to those in Skid Row, to provide long-term health services. Based on her experience living in the area 22 years ago, the addiction issue is linked to minor drug dealing and street gangs contribute to anxiety among the residents. Dr. Amin thanked Ms. Poz for her comments. He agreed that the problems at MacArthur Park are multifactorial, meaning they stem from multiple causes layered together. He explained that solving such issues requires a multifaceted approach and can't be resolved quickly or with a single solution. Dr. Amin highlighted the need for responsible harm reduction, acknowledging arguments on all sides of the debate, and emphasized that solutions should prioritize community involvement. He agreed that MacArthur Park has distinct challenges compared to Skid Row, particularly in terms of safety and substance abuse, and mentioned the ongoing discussion with DMH about developing long-term care solutions for the area. Member Salazar asked for a printed copy of his presentation. Dr. Amin noted that the slide deck was finished earlier today and will be forwarded to the committee after the meeting. Member Salazar asked Dr. Amin if he is speaking about a new housing program. Dr. Amin explained that efforts to address housing and staying housed are linked to community support programs under CalAIM. Specifically, finding housing is part of the housing navigation program, while staying housed is tied to housing-sustaining services. He also mentioned significant efforts related to housing deposits, grouping all these initiatives under the broader goal of helping individuals find and maintain stable housing. Member Salazar asked about the plan for hygiene, nutrition, and laundry, will there be mobile services. Dr. Amin responded that L.A. Care is trying to determine the best method. There are some services which L.A. Care may try to bring to the area. It's still under discussion, and he has spoken to the team quite a bit about this, it is needed for these folks to get back up on their feet. Some of the services are not truly healthcare but healthcare adjacent, and those need to be addressed. Two of those are laundry and a clean place to shower. Member Joyce Sales mentioned the unpleasant conditions at MacArthur Park, including the stench. She then asked about the boundaries of the 15 regions, wondering if there are specific offices people could visit. Sales also inquired about the source of the $90 million in funding and whether the programs were already in progress or would begin soon. She referenced previous discussions about RCAC members wanting to get involved, particularly regarding the health promotion program and expressed frustration over delayed responses from Mr. Baackes, especially concerning the orientation at St. Anne and services like mobile laundry. Sales supports the idea of mobile laundry and suggested helping people become more independent with supervised assistance. Lastly, she highlighted concerns about gangs, drugs, and dealing in the area and urged for greater involvement from the Los Angeles Police Department (LAPD) to address crime. Dr. Amin responded that the Department of	

	Health, the housing division specifically works with the unhoused. They have been dealing with this issue for a long time, L.A. Care works closely with them that is where the providers that deal with the unhoused specifically sit with them. The question with LAPD, the answer is yes, L.A. Care is actively considering the LAPD's role in the MacArthur Park collaborative. The $90 million in funding includes $30 million for Skid Row, $30 million for incentives for Medi-Cal payment and providers providing care and $30 million to add street teams where L.A. Care does not have enough capacity. The funding is coming from L.A. Care reserves, because L.A. Care doesn't give the money to shareholders that are sitting across the country by way of a stock price. And so the money is coming from within and it is putting it out there into the community where it belongs. Dr. Eakins raised two points. First, she asked how the County collaborates with the City, particularly for services like mobile showers, and suggested that greater collaboration between the City and County could expand available resources. She mentioned that libraries, such as the public library downtown, now dispense Narcan to help homeless individuals. She wondered if there could be a partnership with libraries to connect people who receive Narcan with medical services offered at nearby clinics. Dr. Amin responded that that he will take the suggestion into account. With regard to City and County programs, L.A. City District One and County District One are involved. L.A. Care works with the Supervisor and the City Councilperson in those districts to coordinate and work together and a meeting was held last week with District representatives, and a couple of days ago with the Mayor's Office. Member Romo thanked Dr. Amin for the information and she would like to reinforce what Member Salazar mentioned about prevention, because some people don't have social security, they cannot work, but they have children born here and they have not been given many months of rent. She would like more information about prevention. She also thanked him for helping the homeless. She thinks it's important to help them become self-sufficient. She would like also to help them understand that people are the architects of their own destiny, if they don't want to get out of the hole, nobody will be able to help them all the time. Dr. Amin expressed appreciation for the comments, acknowledging the idea of personal responsibility. He noted that intensive care management services that they provide are designed to support helping individuals with practical skills such as paying bills on time, avoiding substance abuse, and securing more permanent employment. He noted that the housing-sustaining services aim to foster independence. Amin reiterated his commitment to advocating for these ideas in other settings. Vice Chair McClain asked if they will need training to help with this program. Dr. Amin responded that he will work on ways that RCAC members can be involved. He suggested that the training health workers receive would be helpful. He needs a more concrete	

	understanding of what the intentions are and how to best incorporate RCAC members. Vice Chair McClain asked about data to support statements about the high density of Skid Row and MacArthur Park and differences between the two communities. She noted at the end of the day, both areas need help. Dr. Amin responded that certain high-density areas, such as Skid Row and MacArthur Park, have large populations of unhoused individuals and many service providers that are not fully coordinated. There is an opportunity to better organize the providers and services, inject additional funding, and address the needs of large populations in these regions. Each area has unique challenges, such as greater issues with substance abuse or safety, which are informed by data and input from people on the ground. Dr. Amin said that many individuals and organizations are already providing support, and emphasized that L.A. Care's role is to offer care management, additional funding, and to help coordinate efforts, rather than be a sole solution. Member Lebron stated her concerns about the challenges in accessing housing and health services, particularly for people with mental health issues. She noted that while some individuals receive help, others who genuinely want assistance struggle to qualify. She emphasized that housing alone is insufficient if mental health support is lacking, as people may end up in the same situation without proper therapy and care. Member Lebron called for a comprehensive approach that integrates mental health services with housing programs and urged for stronger advocacy to ensure that these projects work effectively for those in need. Dr. Amin spoke about the significant investments L.A. Care has made in increasing both short-term housing solutions and the availability of permanent housing, and while the focus of the current discussion is on addressing the needs of the unhoused, L.A. Care is also dedicating substantial resources to other populations, such as veterans, disabled children, and individuals with various health conditions. Amin emphasized that L.A. Care is actively working across a range of health issues, including behavioral health and medical management, and that the efforts are not limited to the unhoused population.	
Board Members Report	Ms. Gonzalez and Ms. Vazquez presented the September 2024 Board Member Report *(a copy of the report can be obtained from CO&E).* **PUBLIC COMMENT** ***Andria McFerson thanked the Board Members for their report. She noted the importance of Proposition 35, which supports managed care organizations and healthcare funding. She said that the measure would improve healthcare services, particularly for L.A. Care members. She shared a personal experience where she received inadequate care after being injured, which led to ongoing pain and challenges with transportation. Ms. McFerson urged the Board to enhance outreach and provide better information to RCAC members so they can***	

	advocate for important measures like Proposition 35 that impact healthcare services.	
ECAC CHAIRPERSON'S REPORT • **Motion**	Chairperson Rodriguez presented the following motion: **MOTION ECA 100.1003** ***Motion to recommend approval of the following candidate(s) for RCAC membership.*** *(A copy of the list of RCAC members can be obtained from CO&E.)* **PUBLIC COMMENT** ***Ms. McFerson spoke about the importance of diverse representation in the RCACs to inform the Board on significant financial decisions related to community needs. She advocated for including a wide range of personal stories from various racial and demographic backgrounds, including seniors and individuals with disabilities. Ms. McFerson pointed out that participation in the RCACs has declined, partly due to the COVID-19 pandemic which made some members feel their voices were not heard. She called for improved public communication about RCAC options and a more inclusive approach to recruiting members, stressing the need for diversity and equity. She urged for a fresh start in building a more representative RCAC membership through motions from the TTECAC.*** Member Sales said she did not attend the last Board meeting and would like to know what the motion is about. Member Romo responded that the motion is to approve new RCAC members, and if approved, it will be on the agenda at the next Board meeting.	**Approved.** **9 AYES (Byrd, Cordero, McClain, Poz, Rabaja, Rodriguez, Salazar, Sanchez, Salazar, and Sales)** *(Member Lebron and Member Romo stepped out of the room during voting.)*
MEMBER ISSUES	**PUBLIC COMMENT** ***Ms. McFerson shared her concerns regarding recent bylaws that discourage RCAC members from sharing personal stories, arguing that this restriction undermines their role as stakeholders. She claimed it could violate ADA rights and other legislative protections. McFerson emphasized the importance of members being able to share their experiences related to healthcare issues, including treatment, homelessness, and discrimination, to foster a more inclusive environment. She urged the board to clarify this policy to ensure new and existing RCAC members feel comfortable expressing themselves. Additionally, she highlighted the discrimination faced by low-income L.A. Care members, suggesting that this issue should be addressed as a specific agenda item in future meetings.***	

	Member Poz suggested that L.A. Care enhance support for dual members facing difficulties accessing medications, particularly in light of current shortages of diabetic medications at pharmacies. She expressed frustration that when members contact L.A. Care for assistance, they often do not receive helpful information. Poz urged the organization to collaborate with pharmacies to provide clearer guidance on where members can obtain the necessary medications. Vice Chair McClain spoke about the need for better communication regarding L.A. Care transportation services after being informed by a disabled community member who was unaware of these options. The individual, who uses a wheelchair, had been taking the bus to medical appointments. She mentioned that the member faced issues with accessible transportation, particularly regarding the availability of equipment and training for proper use. She proposed adding this topic to future agenda items to explore potential grants for accessible equipment or separate funding specifically for this purpose. Ms. Vazquez noted the importance of addressing issues related to pharmacy service coupons or vouchers during upcoming RCAC meetings. She noted that many members face out-of-pocket costs for medications not fully covered by insurance and often rely on these coupons to help with expenses. Vazquez expressed concern that pharmacies might mishandle these coupons or charge extra fees, resulting in members not receiving the intended benefits. She suggested sharing information with members about how to effectively use these coupons and encouraged them to report any issues they encounter at pharmacies. Member Salazar spoke about a lack of awareness regarding a program that provides assistance with cleaning tools, specifically for families dealing with asthma, like her own. She expressed interest in having information about this program shared within the resource center in Pomona, emphasizing the need for better communication from L.A. Care. Salazar also shared her personal approach to managing medication costs, suggesting that members could request generic prescriptions from their doctors and consider using pharmacies like Costco or Sam's Club, where medications can be more affordable. She urged for greater dissemination of such helpful information to ensure members can access available resources.	
OLD BUSINESS		
IMPROVING THE EXPERIENCE OF L.A. CARE MEMBERS	Brigitte Bailey, *MPH, CHES, Supervisor, Quality Improvement*, and Priscilla De La Torre, Project Manager, Quality Improvement, gave a presentation on Improving the Experience of L.A. Care Members *(a copy of the presentation can be obtained from Board Services).* Ms. Bailey defined member experience as the overall interaction members have with the healthcare system, including the health plan, doctors, and healthcare facilities. She spoke	

about the importance of a positive member experience, noting the correlation with better clinical outcomes. She outlined various factors contributing to member experience, such as appointment availability, respect from healthcare staff, and timely responses to questions. She highlighted common issues faced by members, including long wait times, lack of available appointments, and inadequate time spent with providers.
To enhance member experience, L.A. Care is implementing several initiatives, including increasing provider availability, expanding telehealth services, and offering comprehensive training for healthcare staff. Ms. Bailey encouraged members to provide feedback through surveys and report both positive and negative experiences to help identify areas for improvement. She concluded by inviting questions and suggestions from the audience.

PUBLIC COMMENT

Ms. McFerson spoke about communication between L.A. Care, service providers, and members. She emphasized that members should be treated with respect and highlighted the importance of staff following up on feedback from RCAC members. Ms. McFerson pointed out that there is a need for better internal communication among service providers to assist members effectively, especially those who may not know how to access the necessary resources for their healthcare needs. She expressed concern about the challenges faced by low-income providers and the lack of accountability for poor service. She also questioned how members can receive feedback regarding their care to ensure they are not being taken advantage of. She concluded by asking what steps can be taken if L.A. Care fails to follow through on addressing these issues.

Member Sales asked how many providers have been added to offer healthcare services at community centers. She is asked if training is required or voluntary. She would like to know what rewards are in highlighting the highest surveys and improvements made at the call centers. Ms. Bailey acknowledged the need for information on how many providers have been added to offer healthcare services at community centers and mentioned that this falls under the provider network management team, and she would research it further. She clarified that training is voluntary, not required, and offered to compile a list of clinics and provider groups with which they have collaborated over the years. She highlighted that L.A. Care conducts webinars and various training sessions throughout the year. She noted that high-performing providers are typically recognized at the annual provider award ceremony, though she does not manage that program directly. With regard to improvements at the call centers, Ms. Bailey suggested that the relevant team should provide a detailed overview, as she is not an expert in that area.

Member Lebron commented on the importance of language when discussing culture and feedback, emphasizing that terms like "positive" and "negative" can stigmatize individuals.

	She suggested using the phrase "constructive comments" instead, as it promotes a more supportive approach and avoids placing a stigma on those providing feedback. Ms. Bailey thank her for her comments and stated that she wholeheartedly agrees.	
LAUNCH OF THE NEW REGIONAL COMMUNITY ADVISORY COMMITTEES (RCACs) MEETINGS	Dr. Eakins and Ms. De La Torre gave a Regional Community Advisory Committee (RCAC) update *(a copy of the report can be obtained from CO&E).* Dr. Eakins spoke about the importance of reestablishing the Regional Community Advisory Committees (RCACs) as a key opportunity for engagement and communication. She outlined that effective September, all eight regions will hold "welcome back" meetings, aiming to generate excitement and gather insights from members. Dr. Eakins highlighted plans for broader member inclusion in discussions about health care access and quality, as well as increased volunteer opportunities tied to L.A. Care initiatives. She stressed the importance of accountability between staff and committee members, advocating for actionable items on meeting agendas to ensure meaningful outcomes. Overall, her section aimed to set a collaborative tone and encourage members to actively participate in shaping the RCAC experience. Ms. De La Torre reiterated the importance of member experience and emphasized the need for RCAC members to share insights at meetings. She outlined plans for a revised, more community-friendly agenda that includes a clear mission for the RCACs and the CO&E department, as well as guidelines for meetings. Ms. De La Torre stressed the need for in-depth discussion to provide opportunities for members to voice concerns and suggestions, which will then be communicated to the ECAC and ultimately to the Board of Governors. Acknowledging the hiatus in RCAC meetings, she noted that there would be opportunities for education and training to enhance member engagement. Overall, her report focused on fostering collaboration between L.A. Care staff and advisory members to ensure that their voices are heard and valued in the decision-making process. Dr. Eakins expressed enthusiasm for the discussions and emphasized the importance of accountability and transparency as they move forward with the reimplementation of the RCACs. She noted the shift from a meeting format where chairs read talking points to a more engaging and interactive process, encouraging members to actively participate in creating agendas tailored to their specific regional needs. Dr. Eakins noted the importance of fostering a welcoming environment where members feel comfortable sharing their experiences. She encouraged chairs to arrive early and set a positive tone for meetings, aiming to transform silent participants into vocal contributors. She introduced the concept of "interim chairs," as the RCACs will undergo elections for new chairs due to the integration of regions, shifting from 11 to 8. This new model will allow for co-interim chairs who can alternate meeting responsibilities, ensuring equity in leadership roles. Eakins reassured members that the stipends would remain unchanged and emphasized the goal of building a collaborative atmosphere as they adopt this new operational model. She	

concluded by handing the presentation over to Ms. De La Torre for further details on upcoming meetings.
Ms. De La Torre outlined the schedule and objectives for the upcoming welcome meetings for the RCACs, starting with RCAC 1 next Tuesday and continuing through the following week for all eight RCACs. She emphasized the importance of these meetings as an opportunity for returning and new members to feel included and engaged in the advisory committee process. A focus of the welcome meetings will be on developing group agreements tailored to each region, with a significant portion of the agenda dedicated to this discussion. Additionally, updates will be provided on the Chair and Vice Chair election process and a review of a revised, more community-friendly RCAC agenda. This agenda will reflect the mission of the CO&E department and include essential meeting materials. Ms. De La Torre mentioned the need to cover the Ralph M. Brown Act to ensure all members understand their responsibilities regarding public meetings. Member discussion issues will remain a component of the agenda, with opportunity for members to voice their concerns. To encourage participation, a raffle will be held for those who complete the evaluations, and each member will receive a volunteer polo shirt at the welcome meetings. Time will be allotted for members to tour the Community Resource Center (CRC) to familiarize themselves with its services. She encouraged members to connect with their assigned field specialists to prepare adequately for the meetings.
Dr. Eakins discussed what to expect in October as the RCACs transition from welcome meetings to official business meetings. She emphasized the importance of grounding the meetings in the mission, which focuses on empowering L.A. Care members to advocate for healthcare issues affecting their communities. Dr. Eakins presented a new mission statement for the CO&E department, which aims to improve healthcare delivery through advocacy, education, and resources. She introduced the concept of an "RCAC Promise," which serves to remind members of their shared commitment to diversity and collaboration in addressing health disparities. The promise reflects the strength of their diverse community and reinforces the importance of including varied voices in their discussions. Moving forward, she assured members that advocacy education would consistently be a component of every meeting, with a focus on relevant aspects of the Brown Act. Eakins mentioned the intent to streamline the consensus-building process and emphasized that education would be tailored to the specific needs of the members. Additionally, she noted the importance of developing a work plan that aligns with the organization's fiscal year, starting October 1, to effectively share resources with community-based organizations. She encouraged members to actively seek out diverse perspectives to enrich their discussions and enhance the RCAC experience.

PUBLIC COMMENT

Ms. McFerson questioned the election process, specifically whether it is governed by TTECAC and the associated timelines, emphasizing the importance

	of their rights in making provisions. Ms. McFerson also inquired about the new structural changes and whether decisions regarding votes and motions are determined by members or dictated by staff. She expressed concerns regarding the budgeting process, requesting a detailed history of the budget allocations, particularly highlighting a reported $300,000 expenditure for food without specific breakdowns. She asserted that all discussions should facilitate open dialogue within the RCAC, stressing that members have the right to express their views without being disruptive. McFerson concluded by asking whether the RCAC meeting schedules for September are public record, noting that only the date for RCAC 1 is currently listed on the website. Dr. Eakins addressed Andria McFerson's concerns regarding the elections, stating that the elections for Chair and Vice Chair must occur according to the established processes and operating rules, particularly due to the new RCAC structure. She emphasized the importance of expediting the election process to avoid unnecessary delays. Regarding the new RCAC structure, Eakins explained that it was designed to enhance dialogue with consumer members, aligning with recommendations from the Department of Health Care Services. She assured that the RCAC budget will be discussed in upcoming meetings, clarifying that the staff is working to ensure agendas are posted at least 72 hours in advance of meetings, affirming that welcome meetings are public events. Member Sales asked if the meeting dates and time will change and if they can attend other welcoming RCAC meetings. Dr. Eakins responded that the schedule will be shared, the meetings are scheduled the third week of the month. They are working with the availability of the community resource centers. Member Salazar asked for clarification on transportation. She would like to know if it will be provided. Ms. De La Torre responded that transportation will be provided to anybody that needs transportation for their assigned RCACs. When the field specialist calls to confirm attendance, they will ask for that information. In reference for attending other RCACs, she highly recommends they speak to their field specialist and they will try to make those accommodations.	
FUTURE AGENDA ITEM SUGGESTIONS		
	Member Salazar asked for a presentation about Asthma.	
PUBLIC COMMENTS		
	PUBLIC COMMENT *(This public comment was submitted by voicemail and read by staff)* ***Elizabeth Cooper, RCAC 2 member, was unable to attend the meeting in person but wants the Chair and staff members to know that meetings should be more friendly***	

	when calling in and she filed a grievance toward that and ADA rights should be considered and given the opportunity to those members requested and like to bring notice to both members that they should be helping members as well when these types of issues occur. *Ms. McFerson noted the importance of filing motions in the RCAC to influence decisions regarding agendas, election times, and other community matters, asserting their right to ensure public access to RCAC meetings for all stakeholders involved in the L.A. Care system. She noted the legal obligations L.A. Care has concerning stakeholder rights and stressed the need for transparency in budget discussions. Ms. McFerson called for the budget to be included in future agenda items, mentioning that audits by the Department of Justice are a serious concern when budget information is not accessible to stakeholders. She noted her request for a complete record of past fiscal year expenditures was not fulfilled, warning that lack of transparency could lead to public corruption.*	
ADJOURNMENT		
ADJOURNMENT	The meeting was adjourned at 1:19 P.M.	

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

APPROVED BY

Ana Rodriguez, TTECAC Chair _____

Date 10/9/2024

BOARD OF GOVERNORS
Children's Health Consultant Advisory Committee
Meeting Summary – August 20, 2024

1055 W. Seventh Street, Los Angeles, CA 90017

Members

Tara Ficek, *MPH, Chair*
Sameer Amin, *MD*
Edward Bloch, *MD**
Maria Chandler, *MD, MBA**
Rebecca Dudovitz, *MD, MS*
Rosina Franco, *MD*
Toni Frederick, *PhD**
Gwendolyn Ross Jordan
Lynda Knox, *PhD*
Hilda Perez
Maryjane Puffer, *BSN, MPH**
Diana Ramos, *MD**
Ilan Shapiro, *MD, FAAP**

**Absent **Present, but not quorum*

Management

Alex Li, *MD, Chief Health Equity Officer*
Cherie Compartore, *Senior Director, Government Affairs, Government Affairs*
Laura Gunn, *Quality Improvement Project Manager II, Quality Improvement*
Tamara Ataiwi, *Quality Management Nurse Specialist RN II, Quality Improvement*
Caroline Margaret Basil, *Quality Improvement Project Manager II, Quality Improvement*

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
CALL TO ORDER	Tara Ficek, *MPH, Chairperson*, called the meeting to order at 8:36 A.M. **without quorum**	
APPROVAL OF MEETING AGENDA	The Agenda for today's meeting was approved as submitted.	**Approved Unanimously. 7 AYES (Amin, Dudovitz, Ficek, Franco, Jordan, Knox, Perez)**
PUBLIC COMMENT	*No public comment was submitted.*	
APPROVAL OF THE MEETING MINUTES	The March 26, 2024 meeting minutes were approved as submitted.	**Approved Unanimously. 7 AYES**
CHAIRPERSON'S REPORT	Chairperson Ficek gave the following report	

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Chair Ficek expressed her enthusiasm for resuming meetings after the summer break, hoping everyone had an enjoyable and COVID-19-free summer. She acknowledged the back-to-school season, noting the significant policy changes in Los Angeles Unified School District (LAUSD), particularly the implementation of a student cell phone ban aimed at improving mental health. Chair Ficek pointed out the importance of this shift and expressed interest in tracking its impact on children's mental health. She encouraged the committee to prioritize mental health in their agenda, highlighting her organization, First 5 LA's, focus on maternal mental health in their new strategic plan. She stressed the significance of mental health for both parents and children, particularly its long-term effects on health, learning, and family well-being. She invited committee members to share their insights, progress, and challenges related to children's and youth mental health, citing previous presentations on the DHCS Children's Youth Behavioral Health Initiative. Chair Ficek called for the committee's support in spotlighting mental health over the coming year, emphasizing the need to address remaining gaps and ensure the issue receives the attention it deserves.	
CHIEF MEDICAL OFFICER REPORT	Sameer Amin, *MD*, *Chief Medical Officer*, gave a Chief Medical Officer update. Dr. Amin provided an update on increasing access to mental health treatment in Los Angeles County schools, emphasizing the importance of addressing the mental health needs of adolescents. He noted that California ranks low in Medicaid spending per child and highlighted the concerning statistic that approximately 64% of adolescents needing depression treatment are not receiving it, particularly affecting teenage girls. He explained the establishment of the Student Behavioral Health Incentive Program (SB HIP) in August 2021, aimed at enhancing mental health services in schools. A survey revealed that only 46% of the responding school districts had fully operational mental health services, underscoring the need for improvement. Dr. Amin described the implementation of a school telehealth process that facilitates referral, evaluation, treatment, and linkage to community resources, with the assistance of Hazel Health. He shared positive results from the program, noting that over 2,800 students were assessed, leading to significant counseling sessions, predominantly initiated by school staff. He spoke about the improvements in school attendance among students referred to the program, indicating that students were feeling well enough to attend school regularly. Dr. Amin spoke about plans for 2024 and 2025, including expanding the therapist network, expediting the consent process, and enhancing long-term treatment pathways to ensure continuous support for those needing ongoing care. He expressed excitement for the work being done and offered to have Michael Brodsky, *MD, Senior Medical Director, Community Health, Behavioral Health*, give an update on this.	

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Member Dudovitz inquired about the racial and ethnic breakdown of the users of the mental health services, specifically how it compares to the overall school population across the various districts involved in the program. She noted that in the Los Angeles Unified School District (LAUSD), students of color might be underrepresented in the user sample and sought clarification on how the data aligned with the broader demographic trends in the schools from which the data was collected. She also asked Dr. Amin to elaborate on the challenges related to streamlining the consent process. Dudovitz was interested in understanding the number of students who expressed interest in the services or were referred but ultimately did not connect with the program. This inquiry aimed to identify potential barriers that may prevent students from accessing the mental health support they need. Member Amin addressed the racial and ethnic breakdown of students receiving mental health care. He reported that approximately 55% of those referred for care identify as Latinx, while around 7.5% are African American. Member Amin noted that this distribution aligns well with the student populations in the schools served, although he acknowledged that African American youth might still be underrepresented given the significant mental health needs in that demographic. He spoke about L.A. Care's commitment to increasing referrals for this group, especially in light of rising suicide rates among young African American women. Regarding the challenges of streamlining the consent process, Dr. Amin emphasized the importance of establishing a sustainable program beyond the initial incentive funding. He highlighted the need to transition to a fee schedule that allows schools to bill Medi-Cal effectively. He pointed out that many school districts are not currently set up for this billing process, creating a gap that needs to be addressed. To overcome this challenge, the state plans to employ a third-party administrator to facilitate billing and ensure funds are appropriately allocated back to the schools. Amin acknowledged that this process might be complicated and initially challenging, but he expressed confidence in successfully navigating these obstacles.	
MEMBERSHIP (CHC 100)	Sameer Amin, *MD, Chief Medical Officer,* presented the following motion for approval. **<u>Motion CHC 100.0924</u>** **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.**	**Approved Unanimously. 7 AYES**

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
PROPOSED COMMITTEE PURPOSE AND OTHER HOUSEKEEPING ACTIVITIES	Chairperson Ficek and Alex Li, *MD, Chief Health Equity Officer,* gave the following presentation about the Proposed Committee Purpose and Other Housekeeping Activities *(a copy of the presentation can be obtained from Board Services).* Dr. Li began by speaking about the importance of revisiting the committee's mission and purpose, particularly in relation to how L.A. Care can impact children's healthcare for 2024 and beyond. He noted that the discussion was initiated by Chair Ficek, who invited feedback from committee members. Dr. Li stated that the core mission of the Children Health Consultant Advisory Committee (CHCAC) is to ensure that young children and teenagers in the community have access to necessary healthcare. He discussed the need for collaboration among managed care plans and community stakeholders to improve healthcare delivery. He stressed the significance of creating strong relationships between the healthcare system, public health entities, and social services that support children and youth. Dr. Li addressed the importance of committee diversity, stating that it should reflect the varied communities served. He affirmed that the committee's recommendations should advocate for children and youth at board meetings, especially as L.A. Care refreshes its vision and strategy for the next three years. Dr. Li reminded the committee to incorporate themes of health equity and quality into their discussions, he said that serving vulnerable communities requires a comprehensive approach. He invited feedback on the clarified purpose of the committee and encouraged a collaborative effort in making impactful decisions for the benefit of children and youth. Chair Ficek spoke about the importance of aligning the committee's activities with the needs and services available for children and youth across Los Angeles County. She said that the committee could better reflect these needs and provide valuable insights to L.A. Care. Chair Ficek noted the challenge of creating relationships among various entities and organizations within a virtual meeting environment. She said that the need for more engaging meetings that promote relationship-building among members and other stakeholders involved in the welfare of children and youth. She also mentioned the current membership roster, indicating a desire to ensure it represents the diverse demographics of L.A. County. Chair Ficek invited feedback on potential gaps in membership and encouraged committee members to nominate individuals who could add value to the committee. Regarding the structure of future meetings, Chair Ficek proposed maintaining bi-monthly meetings but also suggested an annual in-person meeting. This would provide an opportunity for agenda planning and facilitate relationship-building among members. She proposed holding committee retreat, noted the benefits of face-to-face engagement. She indicated that there would be an action	

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	item on the agenda to review and approve an updated committee charter, which would incorporate the ideas and suggestions discussed during the meeting. Member Knox proposed the idea of involving young people as guest speakers during committee meetings, particularly to provide firsthand insights about their experiences. She suggested this could be done every other session or at the proposed annual retreat, potentially featuring young individuals and pregnant mothers to facilitate meaningful discussions about their needs. She stated that she can assist with organizing the youth participation if there was capacity for it. She recommended starting with scheduling a young guest speaker, allowing the committee to prepare questions in advance to guide the conversation. This approach could create a more structured yet open dialogue, lasting about 15 to 20 minutes, where young speakers could share their perspectives on issues like access to school-based clinics or other relevant topics. She noted the limitations imposed by the Brown Act but believed that even with these constraints, engaging with young voices could provide feedback for the committee. Member Knox stated that she is open for a retreat, meeting face-to-face. Chair Ficek responded that she would be happy to bring in members that are within their population. Member Franco stated that she is the Senior Physician for Student Medical Services at LAUSD, outlined her role in managing 13 school-based clinics within the district, previously classified as CHDP clinics. She noted that with the sunset of the CHDP program, her staff no longer receives the guidance and training previously provided by public health nurses from the county. Member Franco mentioned her discussions with Felix Aguilar-Henriquez, *MD, Medical Director, Quality, Quality Improvement*, and noted his helpfulness in addressing these concerns. She inquired whether L.A. Care could take on the responsibility of conducting facility site reviews, as the county public health nurses would no longer perform these audits. She requested support from L.A. Care in providing educational resources and training for her staff. Member Franco specifically mentioned the need for training in areas such as immunizations, Body Mass Index readings, and audiology to ensure that medical assistants and providers are equipped to continue delivering quality care to students. Member Amin responded that he can ask Dr. Aguilar and Edward Sheen, MD, Senior Quality, Population Health and Informatics Executive, speak a little bit to that. Yep. Okay, that'd be great. Dr. Li stated that this could be part of future agenda items.	

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Member Perez thanked Member Knox for her suggestion to include the voices of patients and consumers in discussions. She suggested that the committee could enhance this approach by conducting focus groups tailored to specific populations, such as pregnant women or children in foster care. These focus groups would gather insights on how these groups prefer to receive information and access healthcare services. Member Perez noted the constraints of short meetings and busy schedules but emphasized the importance of creating opportunities for direct feedback from these communities. She also supported the idea of an annual retreat, viewing it as a valuable opportunity for strategic planning and fostering deeper discussions about incorporating these insights into the committee's work. Chair Ficek stated that she can work with Victor Rodriguez, *Board Services*, to figure out a demographic and figure out a way to engage members. Member Perez stated that they can connect with the Community Resource Centers so they know what services are offered. She noted that they do not have medical appointments but do offer education and classes.They have a diversity of all different classes, workshops, educational facilitation of health topics, and also there's case management from the community health workers at LA care. They do follow ups with patients.	
DISCUSSION AND CONSIDERATION OF APPROVAL OF REVISIONS TO THE COMMITTTE CHARTER (**CHC 101**)	Alex Li, *MD, Chief Health Equity Officer*, presented Motion CHC 101.0924 for approval. Dr. Li presented a motion to approve revisions to the committee charter, noting that the proposed changes were straightforward and outlined in the packet provided to committee members. He said that the revisions primarily focused on recognizing his role as the Chief Health Equity Officer, who will have an increased responsibility in supporting the committee. Dr. Li also mentioned that outdated language and references to committees or councils no longer in existence were revised for clarity. He also updated references to L.A. Care and its Board of Governors.. **<u>Motion CHC 101.0924</u>** **To approve the Revisions to the Children's Health Consultants Advisory Committee (CHCAC) Charter.**	**Approved Unanimously.** **7 AYES**

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
CALIFORNIA BUDGET UPDATE AND IMPACT ON CHILDREN AND YOUTH	Cherie Compartore, *Senior Director, Government Affairs,* and Erica Whitt, , gave a California Budget update and its impact on children and youth. Budget Updates • California State Budget: The final budget for 2024-2025, totaling $297.9 billion, was approved on June 29, 2024. This budget aims to address a significant deficit through fund shifts and early actions. • Key Changes: o Elimination of the Los Angeles County Child Welfare Services Public Health Nursing Program, resulting in a $8.3 million reduction. o A six-month delay in the implementation of a rate increase for developmental services, now starting January 1, 2025. o Introduction of a $9 million allocation for diaper and wipe distributions for low-income families. Managed Care Organization (MCO) Tax • MCO Tax Renewal: The MCO tax has been renewed through December 31, 2026. This renewal includes provider rate increases for various specialties and the implementation of continuous Medi-Cal eligibility for children aged 0-5, effective January 1, 2026. • Potential Changes: The funding for these new programs may be affected if Proposition 35, a ballot measure set for November, passes. Legislative Updates • Legislative Priorities: The presentation highlighted several key bills: o SB 1289: This bill focuses on improving Medi-Cal call center standards and metrics. o AB 2630: Mandates oral health assessments for transitional kindergarten students. o AB 2319: Updates the California Dignity in Pregnancy and Childbirth Act, aiming to address implicit bias in healthcare settings. o SB 1396: Addresses changes to the CalWORKs Home Visiting Program but is currently held in suspense. Legislative Calendar • Important upcoming deadlines were noted, including the last day for each house to pass bills (August 31) and the governor's deadline to sign or veto bills (September 30).	

APPROVED

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
ADJOURNMENT	The meeting was adjourned at 9:55 a.m.	

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

APPROVED BY:
Tara Ficek, *MPH*, *Chairperson* _____

Date Signed: _____

BOARD OF GOVERNORS
Technical Advisory Committee
Meeting Summary – August 8, 2024

1055 W. Seventh Street, Los Angeles, CA 90017

Members

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

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

Management

Noah Paley, *Chief of Staff, Executive Services*
Wendy Schiffer, *Senior Director, Strategic Planning, Strategy*

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
CALL TO ORDER	Alex Li, *MD*, *Chief Health Equity Officer,* called the meeting to order at 2:02 p.m. without a quorum. *The committee reached a quorum at 2:11 p.m.*	
APPROVAL OF MEETING AGENDA	The Agenda for today's meeting was approved.	**Approved Unanimously by roll call. 6 AYES (Batchlor, Chung, Li, Manchanda, Munoz, and Shultz)**
PUBLIC COMMENT	There were no public comments.	
APPROVAL OF MEETING MINUTES	The April 11, 2024 meeting minutes were approved as submitted.	**Approved Unanimously by roll call. 6 AYES**

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
CHAIRPERSON'S REPORT • **Chief Health Equity Update**	Member Alex Li, *MD*, *Chief Health Equity Officer,* gave a Chief Health Equity Officer Update as part of the Chairperson's Report. • Targeted Rate Increase for Medi-Cal/Medicaid Providers: Dr. Li discussed a statewide initiative aimed at increasing payment parity for primary care providers, particularly those in behavioral health and OB. He noted that this is a significant effort, especially in the context of the delegated and capitated market, which adds complexity. • Equity Practice Transformation Program: Originally a $700 million state investment to improve primary care provider performance, the budget was reduced to $350 million due to budget challenges. Despite the cutbacks, L.A. Care retained all 46 partner providers and remains committed to expediting payments upon milestone completion and enhancing the program by adding practice coaches. The program has been shortened to three years, reducing required milestones from 40+ to 25. • One-Year Reflection as Chief Health Equity Officer: Dr. Li marked his one-year anniversary in his role, reflecting on the lessons learned from working with the TAC committee, L.A. Care staff, and community partners. He shared that health equity disparity mitigation plans span over two years and stated that progress is in the "yellow" zone, indicating room for improvement but moving forward steadily. • Dr. Li indicated that a one-year update on his work would be presented to the Board of Governors in September.	
L.A. CARE'S PROGRAM IMPACT ASSESSMENT PRACTICE	Francisco Perez-Chavez, *Data Scientist III, Advanced Analytics Lab*, gave a presentation on L.A. Care's Program Impact Assessment Practice (IAP) *(a copy of the presentation can be obtained from Board Services).* Overview • Impact Assessments are all about tying the effect of a program to an outcome of interest Impact assessments come from various different scientific disciplines such as public policy and public health and is part of a broader program evaluation process. Wanted to make sure our work is grounded in statistical rigor backed by peer reviewed scholarship • LA Care's implementation called Impact Assessment Program (IAP) Based on existing work delivered to Department of Health Care Services (DHCS) • Causal analysis methodologies: - How we provide evidence of a casual link - existing and future directions • Open discussion	

APPROVED

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	How do we evaluate a program's impact with a focus on evidence based policies? Key Idea: What is the impact (or causal effect) of a program on a specific outcome of interest? • Impact assessments are a particular type of evaluation that seeks to answer cause-and-effect questions - Use statistical tools and methods to account for other factors to that impact the observed outcome • A periodic assessment of the effectiveness, relevance and sustainability of a program or policy Program Evaluations: A complementary suite of evaluations both qualitative and quantitative needed for "demonstrating the results of resource investments": • Needs assessment • Process evaluation and monitoring • Design and theory assessment • Efficiency evaluation (cost benefit analysis) How the IAP was designed? Final Evaluation of California's Whole Person Care (WPC) Program (December 2022) • WPC was a $3 billion five-year statewide pilot with ~250,000 participants • UCLA Center for Health Policy Research was selected to evaluate WPC • Developed a conceptual framework for evaluation with a mixed methods approach An impact assessment is part of a very thorough full program evaluation Member Manchanda inquired whether the tracked outcomes include changes in both adverse utilization and increases in appropriate utilization, such as preferred use of primary care over emergency department or urgent care visits. He asked for clarification on whether the metrics being used to evaluate outcomes also account for positive shifts in appropriate service use, not just reductions in inappropriate use. Member Manchanda spoke about the importance of considering balancing measures, which would track the increase in preferred utilization alongside any decrease in inappropriate utilization, to ensure that the overall impact on healthcare access and usage is fully understood. Mr. Perez-Chavez acknowledged that while they can analyze various outcomes, the current focus is on three main metrics: inpatient admissions, outpatient utilization, and primary care provider (PCP) visits. These outcomes are carryovers from an earlier version of the program. The emphasis on adverse utilization measures (like emergency department utilization) is because they can be directly linked to	

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	costs. In contrast, tracking changes in PCP utilization, while beneficial, does not easily correlate with cost, which is why it is less emphasized in the current outcome targets. Member Manchanda responded that that sounds great. He thinks that maybe if there a discussion element afterwards, he would love to come back to that point about defining the kind of outcomes of interest and seeing how easy it is or not to be able to assign monetary value including costs to that He asked if the IAP methodology that L.A. Care is using to define outcomes for meeting the disparities reduction targets as well. Mr. Perez-Chavez responded he is not familiar with that program. Member Manchanda said that the work, goals and the disparities reduction targets that. The targets demonstrate that there are improvement plans to reduce the disparities. He asked if L.A. Care will be using this methodology to help demonstrate, not only the impact on closing disparities, but also the economic impact. Mr. Perez-Chavez responded that is not something he is familiar with, and he suggested that Dr. Li would know more. L.A. Care is currently focused on specific programs and measuring the changes to adverse utilization in the aggregate. Chairperson Li stated that the team held its first kick off meeting last week to discuss that, and the discussion can be brought back to this committee in the future. What is the IAP? • The goal is to apply an iterative and systematic accounting, with a focus on results that can help inform policy and program guidelines. • Consultative process to help define the operational characteristics of the program with the institutional knowledge of the people administering the program - Empower program managers to help define parameters of the study - It is our job to help them define the problem so that it can be examined with these tools • The specific outcomes are changes in adverse utilization as well as the costs associated with those changes - Translate these parameters into statistical outcomes • The code is the definitive source of the methodology - Outcomes are determined and reviewed by the code • Software design principals - Computational statistics - Efficient, scalable, and reproducible code • We must transform statistical outcomes into a language that is accessible and intuitive so that stakeholders understand and feel empowered to participate	

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	- Outcomes from the studies are typically in a very specific specialized language. • Communicate the process and the outcomes in a way that is transparent, accessible and effective - Helps our customers in building confidence in our outcomes - Encourages building meaningful two-way discussion Methodology • Estimating a counterfactual - Randomized Control Trails in medical literature - Natural experiments in econometrics - Quasi-experimental in social sciences • Design based approaches - Difference in differences - Regression discontinuity Heterogeneous Treatment Effects • "Individuals differ not only in their background characteristics but also in how they respond to a particular treatment" • How effects vary based on a member's background characteristics - What groups see greater effect - Useful for equity analysis Methodology • Structural Causal Modeling - Cause and effect - Represent a more logical flow for business processes • Making the assumptions very clear, explicit and transparent - Validating those assumptions with subject matter experts - Testing those assumptions • Helps identify: - Downstream impacts - Confounding variables Interesting points about Lyft's causal model: How sessions has two paths to the rides and one is independent of price	

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AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	- Members enrolled in multiple programs With limited resources, these confounders have unintended consequences Member Chung noted that choosing the analytic methodology is a subtle approach and much of the validity of the analysis depends on choices that are made - it is not always clear. He asked what L.A. Care is using to guide its decision. Mr. Perez-Chavez responded that L.A. Care is using established approaches rather than developing new methods. Specifically, employing a difference-in-difference methodology, following the model used by the UCLA School of Public Health for a study commissioned by the DHCS. He explained that by aligning with a methodology already accepted by DHCS and validated in similar populations, they aim to avoid the complexities and debates over which analytic approach is best. He acknowledged that various disciplines have different methodologies, but L.A. Care is following a well-recognized, validated path. Member Chung pointed out that certain situations call for specific methods . He noted that a difference-in-difference may be more appropriate in some cases than in others and there are alternative approaches that might be better suited depending on the situation. He asked about whether L.A. Care is employing various techniques based on specific contexts and suggested that this topic could be discussed further offline. Mr. Perez-Chavez responded that L.A. Care is using a generalizable framework across different programs, applying the same methods because the panel data format allows for it. The methodology is checked to be appropriate for the data by performing validity tests, which are documented in an application called Confluence. This documentation tracks all outcomes and verifies that the chosen method fits the data and assumptions. He emphasized the importance of making validity tests interpretable for non-technical stakeholders, ensuring the results are clearly understood and valid. All results and methodologies are memorialized for future reference.	
L.A. CARE'S STRATEGIC PLAN	Wendy Schiffer, *Senior Director, Strategic Planning, Strategy,* gave a report about L.A. Care's Strategic Plan *(a copy of the materials can be obtained from Board Services).* Ms. Schiffer provided an overview of the draft three-year strategic plan. The plan builds upon the successes of the previous plan and is informed by leadership interviews, community advisory committees, and broader healthcare trends. Key highlights: • Mission and Vision: The mission and vision remain unchanged, focusing on providing access to quality healthcare for vulnerable communities and promoting a healthy, inclusive society. • Four Strategic Directions:	

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AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	- Improving Operational Efficiency: Focus on strong leadership, enhancing IT systems (appeals, claims), and modernizing the data ecosystem. - Supporting a Robust Provider Network: Ensuring providers can meet both health and social needs, improving provider portals, expanding the direct network, and enhancing field medicine and care management programs. - Improving Member Experience and Care Quality: Utilizing community resource centers, improving customer service, expanding member outreach, and addressing quality ratings and health disparities. - National Leadership in Equitable Healthcare: Advocating for equity, addressing AI integration, and investing in safety net providers. • The plan will be presented at the September 5 Board of Governors retreat after finalizing goals and wording with leadership. Member Shultz suggested clarifying L.A. Care's Role in serving homeless populations. He emphasized the need for L.A. Care to articulate its specific responsibilities for the Medi-Cal population experiencing homelessness. He noted the confusion and debate within the County about which agencies are responsible for different aspects of care, particularly in behavioral health. He suggested L.A. Care create an internal consensus document that clearly defines its role in addressing homelessness, complementing the strategic plan. Member Shultz encouraged L.A. Care to take a stronger leadership role in expanding and strengthening the behavioral health care continuum for Medi-Cal managed care populations. He acknowledged that there may be challenges in partnering with the Department of Mental Health (DMH) along with an opportunity for L.A. Care to demonstrate what a public plan can do in addressing behavioral health needs and ensuring continuity of care, similar to how the organization has been a leader in other areas under John Baackes' leadership. Chairperson Li responded that the vision is crucial, and the practical aspects of execution and operations are equally critical. He thanked Member Shultz for his thoughtful points. Member Shultz urged L.A. Care to be more assertive in demanding stronger partnerships from the County, particularly in the area of behavioral health. Member Shultz encouraged L.A. Care to feel comfortable publicly pushing the County to better collaborate, especially regarding behavioral health services. Member Munoz wondered if Ms. Schiffer could speak to the ways L.A. Care is measuring success in all these categories. It was a great presentation really thoughtful, and he appreciates it. He asked if there is a scorecard that the committee will able to look at. He asked if the Board will be adopting the actual measures.	

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Ms. Schiffer noted the challenge of making strategic planning measurable, noting that this is a common struggle. She explained that when possible, L.A. Care tries to identify metrics, in areas such as workforce diversity, where clear metrics exist . However, when metrics are not available, the organization relies on qualitative reporting. Ms. Schiffer emphasized that L.A. Care regularly provides quarterly reports to the board to ensure accountability and track progress, even when the data is more qualitative than quantitative. Noah Paley, *Chief of Staff*, added that L.A. Care consistently shares a variety of performance metrics, such as claims and call center data, with the Board of Governors and the Provider Relations Advisory Committee. Over the past year, the Quality, Health Informatics, and Advanced Analytics teams have collaborated to improve the data sets shared with the provider network. These data sets now integrate quality metrics like Managed Care Accountability Set (MCAS), Healthcare Effectiveness Data and Information Set (HEDIS), and compliance data with member grievances and utilization data. This integrated approach allows L.A. Care to track the effectiveness of infrastructure and workflow enhancements, ensuring that operational improvements are reflected in performance outcomes.	
APPROACH ON RACE AND ETHNICITY DATA	Melinda Mata, *Clinical Data Analyst III, Health Equity*, reported on L.A. Care's Approach to Categorize and Report on Race Ethnicity Data *(a copy of the presentation can be obtained from Board Services).* Federal Office of Management and Budget's (OMB) Race/Ethnicity (R/E) Standards Overview • The OMB Statistical Policy Directive No. 15 (SPD 15) guidance has not changed since 1997. • Since 1997 there has been one: - Increasing racial and ethnic diversity and rise in number of people who identify as more than one race and/or ethnicity. • This requires data to be captured accurately, which can lead to more opportunities to reflect communities with diverse experiences and needs. Increasing accuracy in counts could help lead to more opportunities for communities of color who have diverse experiences, not only at the minimum R/E categories but within the detailed R/E categories as well. Previously there was no requirement to collect detailed race or detailed ethnicities categories. The latest SPD 15 revision now requires it. Detailed data helps: • Identify important differences that exist across subgroups who may have previously been "statistically invisible." • Accurately count some communities that may have been undercounted using previous methods.	

APPROVED

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• Distinguish with-in group disparities which will help identify specific community needs. SPD 15 recent revisions include: • Using a single combined race and ethnicity question for data collection. • Allowing respondents to have multiple responses in that single question. • Adding the Middle Eastern or North African (MENA) category, as a minimum reporting category - Separate and distinct from the White category • Requiring the collection of more detail beyond the minimum race and ethnicity reporting categories. • Updated terminology. • Requiring agency Action Plans on Race and Ethnicity Data and timely compliance with revisions. Supporting Evidence • Census Bureau research suggests this change would lead more people to declaring both their racial and ethnic identities. • The decennial census, the American Community Survey (ACS), and the 2015 NCT Research Study found that a combined race and ethnicity question reduces confusion and reduces the use of the "some other race" category by Hispanic or Latino respondents. • The 2020 Census found that 43.5% of respondents who self-identified as Hispanic or Latino either did not report a race or were classified as `Some Other Race' (SOR) alone (over 23 million people). Concerns regarding combining R/E • Some presenters advised against a combined race and ethnicity question, expressing concern that race data for the Hispanic or Latino population may be lost. • E.g., some presenters worried that the Black or African American population in Puerto Rico may only select "Hispanic or Latino" and not "Black or African American" in a combined question format, even with the instruction of "Select all that apply") [2] Working Group's Response to Concerns • The 2015 NCT Research Study compared Afro-Latino population estimates when using a combined question format versus a separate questions format and did not find a significant difference between the approaches. In fact, Afro-Latino population estimates were slightly higher when using a combined question with detailed checkboxes and write-in fields. • However, during cognitive interviews the working group conducted, respondents only selected the Hispanic or Latino response when shown the combined question, this resulted in the working groups recommendation for future research in the 2024 revision to the SPD 15.	

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	OMB's Guidance on R/E Categorization	

Approach #1	Approach #2	Approach #3
Approach consists of **double counting** respondents in several categories depending on what they report.	Approach defines a category as **every possible combination** of Race and Ethnicity.	Approach aggregates to the **Multiracial and Multiethnic** category which obscures specific race and ethnicity details.
Percentages do **not** sum to **100%**	Percentages sum to **100%**	Percentages sum to **100%**
Example: If respondent reported being both 'Black or African American' and 'White' then they would fall into both the '**Black or African American alone or in combination**' category and the '**White alone or in combination**' category.	*Example:* If respondent reported being both 'Black or African American' and 'White' then they would fall into the '**Black or African American and White**' category.	*Example:* If respondent reported being both 'Black or African American' and 'White' then they would fall into the '**Multiracial**' category.

L.A. Care is considering a combination of OMB's suggested Approach #2 and Approach #3. Implement this approach with the understanding that we may want to shift more toward Approach #2 if the data supports this.

- As we learn more about our member population we may want to include additional categories (similar to the permutations seen in Approach #2) such as 'Hispanic or Latino and Black or African American and White'.

Percentages sum to 100 percent. Response categories to be mutually exclusive.

L.A. Care's Consideration for Tabulation – 1 Question Roll Up

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN

Ethnicity	Rate	OMB One-Question Roll-up Draft
Not Hispanic or Latino	American Indian or Alaska Native	Not Hispanic or Latino and American Indian or Alaska Native
	Asian	Not Hispanic or Latino and Asian
	Black or African American	Not Hispanic or Latino and Black or African American
	Native Hawaiian or Other Pacific Islander	Not Hispanic or Latino and Native Hawaiian or Other Pacific Islander
	White	Not Hispanic or Latino and White
	Two or more races *(If a respondent has any combinations of the five race categories - **American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, White**)*	Not Hispanic or Latino and Two or more races *Must maintain the ability to drill into two or more races*
	Other	Not Hispanic or Latino and Other Race
	Asked but no answer	Not Hispanic or Latino and Unknown
	Unknown	Not Hispanic or Latino and Unknown
Hispanic or Latino	American Indian or Alaska Native	Hispanic or Latino and American Indian or Alaska Native
	Asian	Hispanic or Latino and Asian
	Black or African American	Hispanic or Latino and Black or African American
	Native Hawaiian or Other Pacific Islander	Hispanic or Latino and Native Hawaiian or Other Pacific Islander
	White	Hispanic or Latino and White
	Two or more races *(If a respondent has any combinations of the five race categories - **American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, White**)*	Hispanic or Latino and Two or more races *Must maintain the ability to drill into two or more races*
	Other	Hispanic or Latino and Other Race
	Asked but no answer	Hispanic or Latino and Unknown
	Unknown	Hispanic or Latino and Unknown

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L.A. Care's Consideration for Tabulation – 2 Question Roll Up

Race (OMB Categories)	OMB Two-Question Roll-up Draft
American Indian or Alaska Native	American Indian or Alaska Native
Asian	One or any combinations of granular Asian categories: ***Asian Indian, Cambodian, Chinese, Filipino, Hmong, Japanese, Korean, Laotian, Vietnamese, Other Asian***
Black or African American	Black or African American
Native Hawaiian or Other Pacific Islander	One or any combinations of granular Native Hawaiian or Other Pacific Islander categories: ***Native Hawaiian, Samoan, Guamanian or Chamorro, Other Pacific Islander***
White	White
2 or more races	Any combinations of the five race categories: ***American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, White***
Asked but no answer	Asked but no answer
Unknown	Unknown

Ethnicity (OMB Categories)	OMB Two-Question Roll-up Draft
Hispanic or Latino	One *or* any combinations of granular Hispanic or Latino categories: ***Mexican, Guatemalan, Salvadoran, Puerto Rican, Cuban, Other Hispanic/Latino***
Not Hispanic or Latino	Not Hispanic or Latino
Asked but no answer	I choose not to answer
Unknown	Unknown

Potential Limitations

834 Files - Health Plan benefit enrollment files

- Each Line of Business manages their own race and ethnicity codes.
- Race and Ethnicity codes are not consistent across Lines of Business.

Potential Future Opportunities

- Health Information Exchange Data
- Call Center Data
  - Expand the race and ethnicity values to include the minimum 7 race and ethnicity categories as well as the minimum detailed race and ethnicity values.
  - Ensure we are capturing the both race and ethnicity details for our members. This may include additional detailed values than what is seen in the SPD 15.

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
ADJOURNMENT	The meeting was adjourned at 4:01 P.M.	

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

APPROVED BY: _____
Alex Li, MD, *Chairperson*

_____
Date Signed

APPROVED

EXECUTIVE COMMITTEE

Board of Governors
MOTION SUMMARY

Date: November 7, 2024 **Motion No. BOG 101.1124**

Committee: Executive **Chairperson:** Alvaro Ballesteros, MBA

Issue: To approve delegated authority to the Chief Executive Officer, John Baackes, to utilize $2,000,000 in unassigned reserve funds to: 1) aid Los Angeles County hospitals (via Hospital Association of Southern California) in identifying a patient assistance program/platform. The program/platform will be used to match hospitalized patients to programs that will reduce and cancel medical debts and 2) utilize the remaining funds to support Los Angeles County's Coalition on Medical Debt (Coalition) effort to retire medical debt. The funds to retire the medical debt for low-income individuals will run through Los Angeles County Department of Public Health's contracted non-profit, Undue Medical Debt (formerly RIP Medical Deb). The Coalition is comprised of 40+ stakeholders including: Los Angeles County agencies, medical debt stakeholders (e.g. hospitals, medical groups), community based organizations, policy experts and health care leaders (i.e. L.A. Care's Chief Health Equity Officer is a participant).

☐ **New Contract** ☐ **Amendment** ☐ **Sole Source** ☐ **RFP/RFQ** ☒ **N/A**

Background: L.A. Care's mission is to serve low income and vulnerable populations. Currently around 785,000 Los Angeles County's adults are burdened with ~$3 billion in medical debt that are serviced by debt collection agencies. Data analyses and research conducted by the Coalition shows that nearly half of those with medical debt live below 200% of Federal Poverty Level; disproportionate number of these individuals are people of color and most of the medical debt are a result of one or more hospitalizations.

This past Summer, Los Angeles County Board of Supervisors committed $5 million in County funds to purchase and retire ~$500 million in medical debt for ~150,000 individuals. The Board of Supervisors also passed an ordinance that will require hospitals to report out on their financial assistance data and debt collection activities. Currently, there are state and federal legislation that will attempt to protect patients from the undue burden of medical debt.

Additionally, Los Angeles County have also contracted with the nationally recognized non-profit Undue Medical Debt to help manage the Los Angeles County medical debt reduction pilot program. Because medical debt can be purchased for pennies on the dollars, the aim of the Coalition is to raise around $24 million to retire ~$2 billion of medical debt.

Member Impact: L.A. Care's support of Los Angeles County's medical debt prevention and relief efforts. This is a unique opportunity to bolster our hospital partners and ensure that people who receive great hospital care are not then adversely burdened with medical debt. Simultaneously, there is now a program in place to reduce the number of individuals experiencing the on-going deleterious effects of chronic medical debt-as it contributes to financial, mental and physical health, food and housing instability etc. This overall motion is consistent with L.A. Care's mission to serve vulnerable and low-income Los Angeles County residents.

Budget Impact: The request for this fund will be from our unassigned reserves.

Motion: **To approve delegated authority to Chief Executive Officer, John Baackes, to utilize to $2,000,000 to identify a patient financial assistance program and reduce the medical debt of low-income Los Angeles County residents.**

Retiring and Preventing Medical Debt for Angelenos

Alex Li, MD
John Baackes

L.A. Care HEALTH PLAN
For All of L.A.

ELEVATING HEALTHCARE IN LOS ANGELES COUNTY SINCE 1997

Medical Debt Is Everywhere in the U.S.


KFF Health News

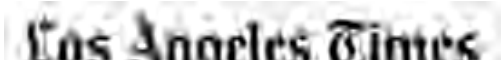
DIAGNOSIS: DEBT

100 Million People in America Are Saddled With Health Care Debt

By Noam N. Levey

JUNE 16, 2022

….more than 100 million people in America — including 41% of adults — beset by a health care system that is systematically pushing patients into debt on a mass scale, an investigation bv KHN and NPR shows.


Los Angeles Times

Op-Ed: The debt crisis that sick Americans can't avoid


BUSINESS

Medical bills pushed a Santa Monica family into poverty. They're not alone

By Carly Dixon

Staff Writer

Medical Debt In LA County

- Affects approximately 785,000 LA County Adults (unchanged since 2017) where the medical debt are now with debt collection agencies.
  - ~46% of this debt are with individuals who are below the 200% federal poverty level (~$29K/year for household of 1)
  - Disproportionately impacts low-income, people of color and those with chronic illnesses.

- Medical debt in LA County rose from ~$2.6 billion in 2021 to ~$3 billion in 2022

- ~10% of L.A. Care member grievances are related to financial disputes
  - E.g. many are co-pay related, issues with out of network or certain loop holes with private ambulance billing.

LA County Efforts

- LA County DPH led and formed a LA County Medical Debt Coalition consisting of community based organizations, hospitals, public agencies, provider groups and L.A. Care.
  - Met from 2023-24 and provided a set of recommendations.

Plan and Action:

- LA County Board of Supervisors adopted an ordinance on September 10, 2024 that require hospitals to report out on medical debt and financial assistance provided.
- LA County contracted with a national non-profit Undue Medical Debt (formerly Rip Medical Debt) to manage the retirement of the debt at collection agencies.
  - Aim is to raise $24 Million to relieve $2 billion in medical debt.
    - L.A. County has committed $5M (eliminate $500M for ~150K individuals)
- Invest and use financial assistance programs and tools at the hospital setting.

Recommendation/Proposal

LA County Request

- Allocate $2M to support LA County Medical Debt Coalition recommendations:
  - Investigate and work with hospitals to identify software/technology that will help patients qualify for programs that will reduce or cancel medical debts
  - Use the remaining balance to provide medical debt relief for L.A. Care members.

BOARD OF GOVERNORS
Executive Committee
Meeting Minutes – September 25, 2024

1055 West 7th Street, 1st Floor, Los Angeles, CA 90017

Members
Alvaro Ballesteros, MBA, *Chairperson*
Ilan Shapiro MD, MBA, FAAP, FACHE, *Vice Chairperson*
Stephanie Booth, MD, *Treasurer*
John G. Raffoul, *Secretary* *
G. Michael Roybal, MD

Management/Staff
John Baackes, *Chief Executive Officer*
Sameer Amin, MD, *Chief Medical Officer*
Augustavia J. Haydel, Esq., *General Counsel*
Todd Gower, *Interim Chief Compliance Officer*
Linda Greenfeld, *Chief Products Officer*
Alex Li, MD, *Chief Health Equity Officer*
Noah Paley, *Chief of Staff*
Acacia Reed, *Chief Operating Officer*
Afzal Shah, *Chief Financial Officer*

**Absent*

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
CALL TO ORDER	Stephanie Booth, *Treasurer,* called to order the regular meetings of the L.A. Care Executive Committee and the L.A. Care Joint Powers Authority Executive Committee at 1:02 p.m. The meetings were held simultaneously. She welcomed everyone to the meetings. She provided information on how to submit public comments.	
APPROVE MEETING AGENDA	The Agenda for today's meeting was approved.	**Approved unanimously.** **3 AYES (Booth, Raffoul, and Roybal)**
PUBLIC COMMENT		
APPROVE MEETING MINUTES	The minutes of the August 28, 2024 meeting were approved. *Agenda items were heard out of the order on the Agenda with no objection from Committee Members.*	**Approved unanimously.** **3 AYES**
COMMITTEE ISSUES		
Increase the existing purchase order with TRI Ventures (formerly known as Scout Exchange) for contingent	Terry Brown, *Chief Human Resources Officer,* summarized a request for approval to execute Amendment VII to the contract with Scout Exchange adding $12,924,000 to the maximum compensation.	

<table>
<tr><th>AGENDA ITEM/PRESENTER</th><th>MOTIONS / MAJOR DISCUSSIONS</th><th>ACTION TAKEN</th></tr>
<tr><td>worker vendor management services</td><td>Scout provides L.A. Care with software to assist in the management of contingent workers (temporary labor). Using Scout streamlines the contingent workforce management process, including timecards, staffing requests, and vendor management.

Approval of this motion would authorize staff to extend the contract for temporary labor needs through December 31, 2025 with an additional $12,924,000 (for a total cost not to exceed $76,388,908).

<u>Motion EXE 100.1025</u>
To authorize staff to increase the spend of the existing purchase order, by an additional amount of $12,924,000 not to exceed a total spend of $76,388,908 with TRI Ventures (formerly known as Scout Exchange) for contingent worker vendor management services rendered through the end of the contract term on December 31, 2025.</td><td>Approved unanimously.
3 AYES

The Committee approved placing EXE 100 on the Consent Agenda for October 3, 2024 Board of Governors meeting.</td></tr>
<tr><td>Approve Human Resources Policies HR-205 (Dress Code), HR-225 (Standards of Employee Training), HR-502 (L.A. Care Employee Handbook and Human Resources Policies), and HR-710 (Reimbursement for Education Expenses)</td><td>Mr. Brown explained that these are standard updates to existing policies. The revised policies are written to comply with changes to Regulatory, Legislative and Judicial changes, and reflect changes in L.A. Care’s practices.

<table>
<tr><th>Policy Number</th><th>Policy</th><th>Section</th><th>Description of Modification</th></tr>
<tr><td>HR-205</td><td>Dress Code</td><td>Employee Relations</td><td>Revised for gender inclusivity</td></tr>
<tr><td>HR-225</td><td>Standards of Employee Training</td><td>Learning & Development</td><td>Transitioned policy into new template. Rewrote 4.1 and 4.3 to align with current practices</td></tr>
<tr><td>HR-502</td><td>L.A. Care Employee Handbook and Human Resources Policies</td><td>Preface</td><td>Transfer to new template and removed reference to procedure manual to the title of policy</td></tr>
<tr><td>HR-710</td><td>Reimbursement for Educational Expenses</td><td>Learning & Development</td><td>Added verbiage to 4.2.3.2 and added 4.2.3.4.3 to exclude reimbursement for courses that are available in L.A. Care University, unless required for a degree program; added 4.2.3.4.4. to exclude subscriptions to online universities</td></tr>
</table></td><td></td></tr>
</table>

APPROVED

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Motion EXE A.0924 **To approve the Human Resources Policies HR-205 (Dress Code), HR-225 (Standards of Employee Training), HR-502 (L.A. Care Employee Handbook and Human Resources Policies), and HR-710 (Reimbursement for Education Expenses), as presented.** *(Chairperson Ballesteros and Vice Chairperson Shapiro joined the meeting.)*	**Approved unanimously.** **3 AYES** **This motion does not require full Board approval.**
CHAIRPERSON'S REPORT	There was no report from the Chairperson.	
CHIEF EXECUTIVE OFFICER REPORT	John Baackes, *Chief Executive Officer,* reported that the California Department of Health Care Services (DHCS) is issuing new all plan letters (APLs) elaborating on requirements in the new Medi-Cal contract for managed Medi-Cal plans to invest 5-7.5% of operating income in the community. When he signed the contract with that 89-word provision, he conducted an assessment of L.A. Care's community investments, which are 20% of our operating income on average. A 23-page draft APL was recently issued clarifying the community investments provision. If the APL draft becomes permanent, the current investments will not count toward the 20% community investment requirement. The APL requires new investments over and above current community investments, and is very specific in describing the required investment areas. The draft APL proposes shared governance with L.A. Care's Board of Governors on how the community investments are spent. L.A. Care is objecting, along with other health plans, through the Local Health Plans of California. A very detailed letter will be submitted to DHCS on behalf of all 17 local health plans in California. There is another clause in the new contract that requires health plans to report administrative expenses including delegated providers. The combined administrative expense of L.A. Care, the delegates, including Independent Physician Associations (IPAs), cannot exceed 7%. This is challenging because L.A. Care and other health plans have experienced a significant increase in administrative expenses over the last 2 to 3 years to meet the requirements of newly mandated DHCS programs, including California Advancing and Improving Medi-Cal (CalAIM). With a limit on administrative expense along with additional oversight and reporting, it will be very difficult for a health plan to reach the required administrative expense level.	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	The California state budget is in obviously poor financial condition. DHCS has exercised three acuity adjustments reducing Medi-Cal rates. Afzal Shah, *Chief Financial Officer*, reported that 2024 final rates were received the previous evening and staff is reviewing the information, there is a third acuity adjustment for 2024 rates. Mr. Baackes reported that adjustment will "claw back" $199 million. It will continue to be a very difficult environment, with an aggressive reach into the operations of the health plans by the regulator who is also L.A. Care's customer. The pressure on California's finances will ultimately be reflected in the Medi-Cal rates. During the previous recession, reimbursement and benefits for Medi-Cal were cut. Cuts have not been discussed yet, the tactic seems to be financial pressure on the health plans. He is bringing awareness to the Board as these factors will color the relationship with DHCS in the remaining time of the Newsom administration. Board Member Booth noted that these regulatory actions may reflect the California administration's displeasure with health plan support of Proposition 35. Board Member Roybal asked if L.A. Care currently is able to review the administrative expense of its delegated providers. Mr. Baackes responded that L.A. Care's oversight of delegated providers does not currently include a detailed review of administrative expenses nor an accounting of the level of administrative expense. L.A. Care's administrative expenses have historically been about 5.5%. The APL has not been finalized because delegated providers are pushing back based on the established "four part rule". Mr. Shah noted that L.A. Care collects data on medical loss ratio (MLR) from its delegated (subcontracted) providers. DHCS and Centers for Medicare and Medicaid Services (CMS), make a distinction between services that delegates provide directly providing versus services that they purchase. If the MLR is less than 85%, funds will be deducted by regulators from future reimbursement. This year, L.A. Care will have line of sight into the administrative expenses related to the services that delegated providers are purchasing. Regulators are moving towards one set of administrative expense among health plans, plan partners and delegated providers. He anticipates continued collective financial pressure on the administrative expense ratio in 2025 and 2026. Board Member Roybal commented that it will be challenging to meet the required administrative expense level. Mr. Baackes agreed, and noted that almost all IPAs purchase services through managed service organizations (MSOs) and the cost of those purchased services will be added to	

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AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	administrative expenses. There was a severe disruption in services in 2017 because of an MSO failure in Los Angeles County. Board Member Roybal asked if the community investment level of 7.5% has to be new investments and would not include L.A. Care's current community investments such as Community Resource Centers, Elevating the Safety Net and others. Mr. Baackes noted that is in the draft APL and health plans are challenging that provision. L.A. Care is included in the LHPC objection and will write to DHCS with L.A. Care objections. L.A. Care leads the industry with community investments and its current level of investment should be included in the APL provisions. Other health plans also have community investment programs, and have informed DHCS that requirements for new community investments will force them to discontinue current community investments that are not included in meeting the regulatory requirement. Mr. Baackes noted that when he started at L.A. Care he felt the regulators were partners with L.A. Care, but now he feels the relationship has changed into a more contentious one. Board Member Roybal noted that this happened to health plans during the last State budget problems. Sameer Amin, MD, *Chief Medical Officer,* commented that it's not only that the community investments have to be new programs, the program must also be acceptable according to requirements delineated in the draft APL, and the detail about unacceptable community reinvestments is very concerning, because a lot of them are programs that L.A. Care thinks are important for its community. Board Member Booth asked about acceptable and unacceptable community investments. Mr. Baackes responded that L.A. Care has requested discussion about the community investment requirements. L.A. Care's funding for workforce development is essential for the safety net. It appears that DHCS wants investment in programs for which DHCS does not have the funds to invest, which seems to be a reason for DHCS being so directive and particularly for the shared governance over health plan funds. L.A. Care currently funds programs to recruit doctors, supplement salaries for primary care providers and facilities, safety net doctors, medical school scholarships, and more. DHCS does not have similar programs. Board Member Booth asked if CMS has imposed requirements on DHCS, and DHCS is imposing those on health plans. Mr. Baackes has not studied this. Health plans are never informed about CMS communication with DHCS about Medicaid. This is an issue he raised with Chiquita Brooks-LaSure, the Administrator who runs the Medicaid side of CMS.	

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AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Board Member Booth asked about communication at the state level about the community investments. Mr. Baackes responded that L.A. Care could probably ask the director of DHCS for an opinion, she is likely to decline because DHCS has not wanted to interfere in health plan contracting with providers. But this is a new contract provision. The APL indicates what areas health plans should invest in.	
• Government Affairs Update	Cherie Compartore, *Senior Director, Government Affairs*, reported: • The Governor has until September 30 to take action on legislation passed by the Legislature, and has signed several high profile bills relating to retail theft, artificial intelligence and housing initiatives. He has not yet acted on bills of significant interest to L.A. Care. One reason is that at the end of the legislative session he convened a special session on gas and oil pricing and to establish additional regulations on oil refinery inventory. The California Assembly agreed to hold a special session but the Senate did not agree to the special session, indicating it would await meaningful action by the Assembly. The special session seems to be politically driven rather than focused on real policy. It is likely the Governor will wait until the last minute on some of the bills that L.A. Care is tracking. • L.A. Care is working with its trade associations including LHPC, America's Health Insurance Plans (AHIP) and the California Association of Health Plans (CAHP) in advocating for priority health care bills that await the Governor's action. • The general election voter guide has been mailed to voters and includes Proposition 35, related to the managed care organization (MCO) tax. There is no argument against Prop 35 in the voter guide. However, the Governor has been privately trying to pressure organizations to not outwardly support Prop 35 nor verbally oppose it. Some organizations have publicly opposed Prop 35, including the California Pan-Ethnic Health Network and the Children's Partnership. L.A. Care's Board of Governors approved a support position on Prop 35. The opposition affirms a need for Prop 35 in not allowing the Legislature or the Governor to use Medi-Cal funds to backfill the general fund nor take away important Medi Cal provider rate increases. Prop 35 will permanently guard those funds as long as CMS continues to approve MCO taxes. • At the federal level, Congressional leaders approved a continuing resolution on funding for the federal budget through December 20, 2024. Final budget action will be taken up after the November election.	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Mr. Baackes commented that the coalition formed around the MCO tax met this morning. There are about a half a dozen organizations that have opposed but there are 300 organizations that are supporting prop 35, including trade associations and the health plan associations. Both the Democratic and the Republican parties have endorsed Prop 35. The opposition is fairly thin and has not mounted a paid media campaign in opposition. The Vote Yes Prop 35 media campaign began earlier this week. Board Member Booth asked about the potential for action to reverse the provisions of Prop 35 in the future. Ms. Compartore noted that a 3/4ths majority affirmative vote of the Legislature is required to change or repeal the initiative. The Department could make changes to comply with federal regulation. Voters could also change or repeal it with another initiative. Board Member Roybal asked about the arguments against Prop 35. The opposition is that Prop 35 would divert funds from the opposition's interests, and would take money away from other programs. There is no credible connection because this is new money directed at specific programs for primary care, special care and other health care. Prop 35 does not infringe on funding for other programs. Mr. Baackes noted that the taxes raised would supplement and would not supplant existing revenue sources. Ms. Compartore noted that the coalition established the categories of the specialties to be funded. The administration wanted control of the general fund and used that to their advantage. It created specific special deals for some provider groups or specialties that weren't originally included in the coalition. If Prop 35 is approved by voters, those specific areas of funding will end. Advocates of those specific funding areas are using the end of that additional exclusive funding as a negative against Prop 35. Chair Ballesteros asked about active opposition to Prop 35. Mr. Baackes responded that the Governor is silent in public on this, but behind the scenes he is not happy about it. Indications are that he will not go public in his opposition, there are too many in favor of it and no resources to conduct an effective opposition campaign. If he publicly opposed it and it was passed, he would be losing face and his reputation. Remaining silent is better for him. There are a lot of leaders in the coalition supporting Prop 35 who have been champions and allies of the Governor throughout his career. It is a watermark event that Prop 35 is so important to those leaders that they would differ with the Governor on this issue.	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
Chief Financial Officer Report • Monthly Investments Transactions Report	Afzal Shah, *Chief Financial Officer,* reported that August financial reports will be presented at the October 23, 2024 Finance & Budget Committee. He referred to the investment transactions reports included in the meeting materials (*a copy of the report is available by contacting Board Services).* This report is to comply with the California Government Code as an informational item. L.A. Care's total investment market value as of as of August 31, 2024, was $3.5 billion. • $3.4 billion managed by Payden & Rygel and New England Asset Management (NEAM) • $125 million in BlackRock Liquidity T-Fund • $11 million in Los Angeles County Pooled Investment Fund • $6 million in Local Agency Investment Fund	
• Authorized signatories for all L.A. Care Health Plan's and L.A. Care Health Plan Joint Powers Authority's (JPA) banking and investment accounts	Mr. Shah summarized the motion requesting an update to L.A. Care and L.A. Care Joint Powers Authority signatories. The three signatories will have authority to approve financial transactions, create accounts, and make investment decisions on behalf of the organization. The motion will provide authority over all L.A. Care Health Plan's and L.A. Care Health Plan Joint Powers Authority's (JPA) banking and investment accounts to the following three employees: 1. Afzal Shah, *Chief Financial Officer,* 2. Jeff Ingram, *Deputy Chief Financial Officer*, and 3. Radiah Campbell, *Controller* This authority will be renewed when the investment policy is brought for approval by the Board, which is approximately annually, or as updates are needed. **<u>Motion EXE 101.1024</u>** **To authorize the employees listed above as authorized signatories for all L.A. Care Health Plan and L.A. Care Health Plan Joint Powers Authority (JPA) banking and investment accounts.** Mr. Shah introduced Radiah Campbell, *Controller*. She greeted the Committee members and noted she is excited to join L.A. Care.	**Approved unanimously.** **5 AYES (Ballesteros, Booth, Raffoul, Roybal and Shapiro)** **The Committee approved placing EXE 101 on the Consent Agenda for October 3, 2024 Board of Governors meeting.**
Ntooitive Contract for marketing campaigns for L.A. Care's direct lines of	John Cota, *Senior Director, Creative and Marketing,* presented a motion to approve a contract with Ntooitive, the agency that supports L.A. Care with all marketing and	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
business, including the L.A. Care Covered (LACC) Shop and Compare Tool, and the Community Resource Centers	advertising needs. He noted a correction to the contract amount to $15.1 million due to an error in the original draft of this motion. Board Member Booth noted the contract is expensive and the cost has increased over the five years or so that Ntooitive has provided services for L.A. Care. She would like to better understand why this is a good company to keep and the funds are spent appropriately for these services so the Executive Committee knows the funds are well spent. She asked about data or reports on new member enrollment generated by Ntooitive services. She asked if the LACC shop and compare tool, which was first mentioned in 2021, requires ongoing development and management. Mr. Cota responded that the calculator requires ongoing development and management of the LACC shop and compare tool is required to reflect the current pricing model. Board Member Booth noted that between 2019 and 2024, the price increased from $5.3 million roughly to $12.3 million, a 135% increase. She asked if that is due to inflation or additional services and if L.A. Care receives value in those services. Mr. Cota noted that up to 95% of the funds are for procurement by Ntooitive of contracts with media for TV, radio and other outlets where L.A. Care advertising appears. Board Member Raffoul suggested a report on L.A. Care's marketing plan at a future Board meeting. Board Member Booth suggested adding data on the enrollment increase reflected in the marketing plan. Mr. Cota commented that L.A. Care added a layer into the contract to be able to provide de-identified new membership data to correlate media impressions with the marketing. In the next year it is hoped that the return on investment will be more accurate in reflecting the tactics that are executed. Board Member Raffoul suggested identifying funding used to create awareness and growth, and identify the goals for growth. **<u>Motion EXE 102.1024</u>** **To authorize staff to execute a new statement of work with Ntooitive in the amount of $15,189,396 for marketing campaigns for L.A. Care's direct lines of business, including the LACC Shop and Compare Tool, and the Community Resource Centers for the period of October 1, 2024 through September 30, 2025.**	**Approved unanimously.** **5 AYES (Ballesteros, Booth, Raffoul, Roybal and Shapiro)** **The Committee approved placing EXE 102 on the Consent Agenda for October 3, 2024 Board of Governors meeting.**
Edifecs, Inc. Contract to provide Software as a	Tom MacDougall, *Chief Information and Technology Officer*, introduced a motion requesting approval to execute a five-year contract with Edifecs, Inc. from October 2024 to September 2029 in the amount of $25,497,331, reflecting an increase of $5 million in	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
Service (SaaS) licensing and integration services	licensing fees over five years. The contract will support L.A. Care's internal infrastructure to manage encounter data and make sure that the data quality is good. There will be an initial increase and costs will decrease over the contract term. The vendor will assume responsibility for maintaining the software. Board Member Booth asked about statements of work (SOW) in contracting with this vendor. Mr. MacDougall stated there are four SOWs over the next few years for additional services with discounts already negotiated. **<u>Motion EXE 103.1024</u>** **To authorize staff to execute a contract in the amount of $25,497,331 with Edifecs, Inc. to provide Software as a Service (SaaS) licensing and integration services for the period of October 2024 to September 2029.**	**Approved unanimously. 5 AYES** **The Committee approved placing EXE 103 on the Consent Agenda for October 3, 2024 Board of Governors meeting.**
Delegate Authority for CEO to execute a membership sponsorship agreement with the California Medical Association (CMA)	*Board Member Booth may have financial interests in Plans, Plan Participating Providers or other programs and as such she refrained from the discussion and vote on this motion.* Mr. Baackes stated that in 2022, L.A. Care entered into a pilot group membership program (Pilot Program) with California Medical Association (CMA) whereby L.A. Care paid the membership expenses to CMA and the Los Angeles County Medical Association (LACMA) for 312 physicians participating in L.A. Care's Direct Network. The goal was to increase L.A. Care's direct network participation. Benefits of CMA and LACMA membership include physician education and training, practice management support, health information technology, physician wellness, legal and regulatory compliance support, financial and insurance benefits, recruitment and office staffing assistance, and community-directed resources. Given the success of the pilot program, L.A. Care would like to expand the group membership program by up to an additional 841 physicians. The proposed expansion will begin October 1, 2024 and will cease on September 30, 2027. Board Member Shapiro commented that membership in these organizations is a great benefit for physicians and this will include some physicians that would otherwise not get involved. He suggested a program to help guide new members with participation and advocacy for important community programs. He suggested that L.A. Care negotiate access to the resources offered by the two organizations.	

APPROVED

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Motion EXE B.0924 **To delegate authority to the CEO to execute the CMA group membership program agreement in the amount of $3,461,700 in order to provide three years of membership in California Medical Association (CMA) and Los Angeles County Medical Association (LACMA) for up to 1,153 physicians participating in L.A. Care's provider network.**	**Approved unanimously.** **3 AYES (Ballesteros, Raffoul, and Roybal),** **2 ABSTENTIONS (Booth and Shapiro)**
Approve Consent Agenda	Approve the list of items that will be considered on a Consent Agenda for October 3, 2024 Board of Governors Meeting. • September 5, 2024 meeting minutes • TRI Ventures (formerly known as Scout Exchange) Contract • Authorized signatories for all L.A. Care Health Plan's and L.A. Care Health Plan Joint Powers Authority's (JPA) banking and investment accounts • Ntooitive Contract • Edifecs, Inc. Contract • Delegate Authority for CEO to execute a membership sponsorship agreement with the California Medical Association (CMA) for up to 1,153 physicians in L.A. Care's provider network • RCAC Membership	**Approved unanimously.** **5 AYES (Ballesteros, Booth, Raffoul, Roybal and Shapiro)**
PUBLIC COMMENTS ON CLOSED SESSION ITEMS		
ADJOURN TO CLOSED SESSION	The Joint Powers Authority Executive Committee meeting adjourned at 2:08 pm. Augustavia J. Haydel, Esq., *General Counsel* announced the items for discussion in closed session. She announced there is no report anticipated from the closed session. The meeting adjourned to closed session at 2:08 pm. REPORT INVOLVING TRADE SECRET Pursuant to Welfare and Institutions Code Section 14087.38(n) Discussion Concerning New Service, Program, Business Plan Estimated date of public disclosure: *September 2026*	

	CONTRACT RATES Pursuant to Welfare and Institutions Code Section 14087.38(m) • Plan Partner Rates • Provider Rates • DHCS Rates 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: Three Potential Cases CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION Pursuant to Section 54956.9(d)(1) of the Ralph M. Brown Act 1) *Lakewood Regional Med. Ctr., Inc., et al. v L.A. Care* (JAMS Case No. 1220075422) 2) *Lakewood Regional Med. Ctr., Inc., et al. v L.A. Care* (JAMS Case No. 1220074758) CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION Pursuant to Section 54956.9(d)(1) of the Ralph M. Brown Act 1) *University of Southern California on behalf of its Keck Hospital of USC v. Local Initiative Health Authority for Los Angeles County*, L.A.S.C. Case No. 22STCV02659 2) *University of Southern California on behalf of its USC Verdugo Hills Hospital v. Local Initiative Health Authority for Los Angeles County*, L.A.S.C. Case No. 22STCV15865 3) *University of Southern California on behalf of its Keck Hospital of USC v. Local Initiative Health Authority for Los Angeles County*, L.A.S.C. Case No. 22STCV33996 4) *University of Southern California on behalf of its Keck Hospital of USC and on behalf of its USC Norris Comprehensive Cancer Center v. Local Initiative Health Authority for Los Angeles County*, L.A.S.C. Case No. 23STCV22700 5) *University of Southern California on behalf of its USC Verdugo Hills Hospital v. Local Initiative Health Authority for Los Angeles County*, L.A.S.C. Case No. 23STCV25633 6) *University of Southern California on behalf of its Keck Hospital of USC v. Local Initiative Health Authority for Los Angeles County*, L.A.S.C. Case No. and Norris 23STCV25875 7) *University of Southern California on behalf of its USC Verdugo Hills Hospital v. Local Initiative Health Authority for Los Angeles County*, L.A.S.C. Case No. 24STCV21495 8) *University of Southern California on behalf of its Keck Hospital of USC v. Local Initiative Health Authority for Los Angeles County*, L.A.S.C. Case No. 24STCV20537

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AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	9) *University of Southern California on behalf of its Keck Hospital of USC and on behalf of its USC Verdugo Hills Hospital v. Local Initiative Health Authority for Los Angeles County, L.A.S.C. Case No. 23STCV13310* 10) *University of Southern California on behalf of its Keck Hospital of USC, on behalf of its USC Verdugo Hills Hospital, and on behalf of its USC Norris Comprehensive Cancer Center v. Local Initiative Health Authority for Los Angeles County, L.A.S.C. Case No. 24STCV13333* 11) *University of Southern California on behalf of its Keck Hospital of USC v. Local Initiative Health Authority for Los Angeles County*, L.A.S.C. Case No. 24STCV17654 12) *University of Southern California on behalf of its USC Verdugo Hills Hospital v. Local Initiative Health Authority for Los Angeles County*, L.A.S.C. Case No. 22STCV02072 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: 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 PUBLIC EMPLOYEE PERFORMANCE EVALUATION, PUBLIC EMPLOYMENT and CONFERENCE WITH LABOR NEGOTIATOR Sections 54957 and 54957.6 of the Ralph M. Brown Act Title: Chief Executive Officer Agency Designated Representative: Alvaro Ballesteros, MBA Unrepresented Employee: John Baackes	
RECONVENE IN OPEN SESSION	The meeting reconvened in open session at 2:38 pm. No reportable actions were taken during the closed session.	

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AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
ADJOURNMENT	The meeting adjourned at 2:38 pm	

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

APPROVED BY:

_____
Alvaro Ballesteros, MBA, *Board Chairperson*
Date: _____

APPROVED

FINANCE
&
BUDGET
COMMITTEE

BOARD OF GOVERNORS

Finance & Budget Committee

Meeting Minutes – August 28, 2024

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

Members

Stephanie Booth, MD, *Chairperson*
Alvaro Ballesteros, MBA
G. Michael Roybal, MD **
Nina Vaccaro **

**Absent ** Via Teleconference*

Management/Staff

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

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
CALL TO ORDER	Stephanie Booth, MD, *Committee Chairperson*, called the L.A. Care and JPA Finance & Budget Committee meetings to order at 1:01 p.m. The meetings were held simultaneously. She welcomed everyone and summarized the process for public comment during this meeting.	
APPROVE MEETING AGENDA	The Agenda for today's meeting was approved.	**Approved unanimously by roll call. 3 AYES (Ballesteros, Booth, and Vaccaro)**
PUBLIC COMMENTS	There were no public comments.	
APPROVE CONSENT AGENDA	• June 26 2024 Meeting Minutes • Quarterly Investment Report **Motion FIN 100.0924** **To accept the Quarterly Investment Report for the quarter ending June 30, 2024, as submitted.** • Hyland Contract for Salesforce Integration, Appeals & Grievances, QNXT Integration (Utilization Management) **Motion FIN A.0824** **To authorize staff to execute a contract with Hyland (i3/Kiriworks) in an amount of $ 1,319,160 (total not to exceed amount of $4,018,278) to provide Appeals &**	**Approved unanimously by roll call. 3 AYES** **The Committee approved placing FIN 100 on the Consent Agenda for September 5, 2024 Board of Governors meeting.**

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Grievances (A&G) services and QNXT FAX Ingestion/Hyland Intelligent Document Processing platform for the period thru December 31, 2026. • Contract with NTT America Contract Amendment **(FIN B)** **<u>Motion FIN B.0824</u>** **To authorize staff to amend the contract with NTT America, in an amount not to exceed $3,300,000 for the purpose of amending NTT America's Cisco Enterprise Agreement contract thru April 2026.**	**FIN A and FIN B do not require full Board approval.**
CHAIRPERSON'S REPORT	There was no report from the Chairperson.	
CHIEF EXECUTIVE OFFICER'S REPORT	There was no report from the CEO.	
COMMITTEE ITEMS		
Chief Financial Officer's Report • Financial Report	*(Board Member Roybal joined the meeting.)* Jeffrey Ingram, *Deputy Chief Financial Officer,* reported on the Financial Performance as of July 2024 *(a copy of the report can be obtained by contacting Board Services).* <u>Membership</u> Total membership for July 2024 was approximately 2.6 million members, around 155,000 favorable to the 4+8 forecast. Year-to-date (YTD) member months was approximately 26 million; 539,000 favorable to the 4+8 forecast. The majority of favorability is coming from Medi-Cal as higher than expected enrollment has been reported post-redeterminations. L.A. Care Covered (LACC) has also been a main driver in favorability primarily due to SB260 and its competitive price position. <u>Consolidated Financial Performance</u> There was a $7.6 million net loss for July 2024, excluding Housing and Homelessness Incentive Program (HHIP)/Incentive Payment Program (IPP) which was $5 million favorable to forecast. Revenue was favorable to forecast $57.9 million, primarily driven by membership, +$52.5 million. Medical Expense was unfavorable to forecast $82.3 million. Higher membership brings higher capitation costs ($50.5 million). There was also a $31 million adjustment to Ground Emergency Medical Transportation (GEMT) covering 2018-	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	2024, with $5 million in associated interest. Operating Expense was flat to forecast. Non-Operating was $8.9 million favorable, driven by unrealized gains and other income. YTD, there was $368 million net surplus, $133 million favorable to the forecast when HHIP and IPP are excluded. That was an income percentage of 4.1%, however, that drops to 2.1% when investment income is removed. Revenue was favorable $122.2 million which includes a final acuity adjustment of ($118 million) to CY 2023 rates. Offsetting that was higher membership, which accounts for $185 million. There is favorability in LACC and Dual Eligible Special Needs Plan (DNSP) as well. Medical Expense is favorable to forecast by $26.6 million. Drivers include (*parentheses indicate negative impacts, +indicates positive impacts*): • ($171 million) Membership • ($41 million) Incurred Claims • ($31 million) GEMT 2018-2024 • ($23 million) Hospital & Skilled Nursing Facility (SNF) Pay for Performance (P4P) Incentives • ($19 million) CY 2023 Shared Risk True-Up • +$168 million Capitation • +$43 million Provider Incentives (excl. SBHIP, P4P & IPP) • +$36 million CY 2023 Rates • +$28 million HHIP/IPP • +11 million Medical Admin • +$7 million SBHIP Incentive • +$6 million Shared Risk • +$4 million Retro ECM/HHSS cleanup Operating Expense was $11.3 million unfavorable driven by $11 million in Medical Administrative costs. There was an equivalent offset within the healthcare costs. Non-Operating was $23.4 million favorable, driven by higher interest income, unrealized gains and lower non-operating expenses than forecasted. The YTD key financial metrics are all good. • Medical Cost Ratio: 91.8% vs 93% • Administration Ratio: 6.0% vs 5.9%	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Working Capital, Cash to claims, and Tangible Net Equity (TNE) were all ahead of benchmarks. **<u>Motion FIN 101.0924</u>** **To accept the Financial Reports as of July 2024, as submitted.**	**Approved unanimously by roll call. 4 AYES (Ballesteros, Booth, Roybal, and Vaccaro)**
• Fiscal Year 2024-25 Operating and Capital Budget	Afzal Shah, *Chief Financial Officer,* presented the Fiscal Year 2024-25 Operating and Capital Budget. *(A copy of the report can be obtained by contacting Board Services).* <u>Membership Assumptions</u> • FY 2024-25 Budget assumes 3.9% annual decline in Medi-Cal membership from previous year (0.33% p/month). This accounts for post unwinding activity after the end of the redetermination period as well as ongoing renewal processing delays. • The California State budget projects a 4.38% decrease in the statewide Medi-Cal caseload for FY 2024-25. Nearly 1.5 million outstanding Medi-Cal renewals statewide were not completed during the unwinding period as of July 2024. L.A. Care believes it has about 240,000 of those outstanding renewals. • D-SNP assumes 6% member growth from previous year. • LACC assumes growth of 11% over previous year. This assumes #1 price position and retention rate of 90%. • The projected membership gain for FY 2024-25 Budget vs FY 2023-24 4+8 Forecast is expected to be 69,000 members or 2.9 %, with member months falling approximately 720,000 or 2.3 %. D-SNP and LACC growth is expected to offset moderate losses in Medi-Cal, which gets net September 2024 vs September 2025 increase of 2.9%. <u>Revenue Assumptions</u> • Medi-Cal - CY 2024 aligned with current Department of Healthcare Services (DHCS) rates. CY 2025 based on preliminary actuarial assumption, pending DHCS draft release. • LACC & D-SNP - CY 2024 consistent with CY 2024 rates. CY 2025 aligns with respective bids. • PASC - CY 2025 projected to continue at current rates. <u>Healthcare Cost Assumptions</u> • Global Sub Capitation - CY 2024 in line with current draft rates. CY 2025 rate methodology based on preliminary actuarial assumptions.	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN

	• Capitation
	  o Medi-Cal - CY 2024 aligns with June '24 capitation. CY 2025 trend consistent with historical increases.
	  o LACC
	  • Risk Adjustment Factor (RAF) of 0.64
	  • CY 2024 uses June 2024 rates
	  • CY 2025 trend consistent with historical increases
	  o D-SNP - Aligns with June 2024 Capitation
	  o Fee-for-Service (FFS) Cost
	  • Incurred But Not Reported (IBNR) files from May 2024 and CY 2023 trends
	  • FFS trends were developed using a base period of CY 2023 and projected using actuarial assumptions
	
	<u>FY24-25 Budget vs. FY23-24 4+8 Forecast P&L – Total L.A. Care (excl. HHIP/IPP)</u>
	• Revenue is $278 million higher than prior year forecast. The primary driver of the increases are tied to the growth in LACC and D-SNP
	• Healthcare Costs (HCC) are $168 million higher than the 4+8 forecast.
	  o Lower capitation tied to lower member months.
	  o FFS trend discussed earlier accounts for increase in FFS claims.
	  o Provider incentives favorability includes Student Behavioral Health Incentive Program (SBHIP) timing in current fiscal year.
	  o Medical Administrative increase is associated with administrative increases tied to activities within Health Services
	• Operating margin is projected to improve $109 million
	• MCR of 93.2% vs 94.1% forecast
	• Overall Administrative is increasing $60 million from the 4+8 forecast
	• Administrative ratio of 6.5% vs 6.1%
	• Salaries & Benefits increasing $36 million due to primarily carrying existing staff - Temporary labor increasing $6 million. This is more of a difference on where it was accounted for in the forecast.
	• Professional & Purchased Services increasing $2.7 million
	  o Increase in printing/contracted services
	  o Broker commissions tied to higher LACC enrollment
	  o Pharmacy and Behavioral Health (BH) administrative fees	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	○ Offset by reduced staff augmentation spend • Advertising decreasing $6 million. The 4+8 forecast was too high. • Business Fees & Occupancy/Leases increasing $17.7 million ○ DMHC and LACC participation fees ○ Software licenses/maintenance • Medical Administrative increasing $4.8 million ○ Reduces administrative amount ○ Increases to Health Services-related activities • Depreciation and Amortization increasing $16.8 million ○ Subscription-Based Information Technology Arrangement (SBITA) geography changes ($15 Million) ○ Assets placed in service • Non-Operating – a slight decrease in interest income because the Federal Reserve is expected begin to cut rates in September. • Overall Surplus of 1.5%. If interest income is removed, there would have a slight loss. <u>FY 2024-25 Budget – Margin by Segment</u> • Most segments are showing an improvement over the 4+8 forecast. <u>FY 2024-25 Budget – Opportunities</u> • 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. <u>FY 2024-25 Budget – Risks</u> • 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.	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• Medi-Cal Targeted Rate Increase (TRI) Rates - TRI Rates from DHCS less than 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 December 31, 2024. • Covid Testing - Costs are continuing to increase this summer with an uptick in Covid cases. • Utilization and Unit Cost Trends - FFS and Capitation trends higher than assumed in the budget. • Administrative Costs - Exceeding budgetary assumptions due to unplanned/uncontrolled cost. <u>FY 2024-25 Budget – Balance Sheet Comparison</u> The balance sheet continues to be a source of strength for L.A. Care. Investments at fair value could increase by more than projected if the Federal Reserve aggressively cuts rates throughout next calendar year. <u>Board Designated Funds</u> The Community Health Investment Fund is projected to have $37.7 million at fiscal year-end. Staff is projecting $98.6 million for the Workforce Development Initiative or Elevating the Safety Net and $0 remaining for Community Resource Centers (CRCs) maintenance and expansion. <u>Tangible Net Equity (TNE)</u> TNE is showing a slight drop next year with the fund balance increasing. Days of cash on hand decreasing slightly but still in good shape. <u>FY 2024-25 Capital Projects and Programs</u> Staff is proposing total project spend of $88.7 million with $78.3 million in capital and $10.4 million in operating. It is 33% less than what was spent last fiscal year. The 2023-24 Budget was $129 million. It covers strategic projects and leasehold improvements. The leasehold improvements are primarily for the CRCs. Tom McDougall, *Chief Information and Technology Officer*, presented and summarized the following L.A. Care's Strategic Programs. • Appeals & Grievance (A&G) System Replacement. • Care Catalyst – New Health Services Clinical System. • Clinical Data Repository (CDR) Phase 2	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• Clinic Based Assignment and FQHC APM • CMS Interoperability Mandate • Edifecs Enhancements • Medicare Advantage Prescription Drug (MA-PD) Product Launch • PQI System Replacement for Provider Quality Review • Provider Roadmap • SAP/ERP • VOICE - Customer Relationship Management (CRM) & Telecom • I.T. Member Experience Program • Performance Optimization Program (Enterprise & Network) • QNXT Upgrade & Transformation • Leasehold Improvements *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 102.0924** **To approve the Fiscal Year 2024-25 Operating and Capital Budget, as submitted.**	**Approved unanimously by roll call with potential conflicts noted. 4 AYES**
• Monthly Investment Transactions Reports	Mr. Ingram referred to the investment transactions reports included in the meeting materials (*a copy of the report is available by contacting Board Services).* This report is to comply with the California Government Code as an informational item. L.A. Care's total investment market value as of 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	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• $11 million in Los Angeles County Pooled Investment Fund • $6 million in Local Agency Investment Fund	
• Quarterly Internal Policy Reports	Mr. Ingram referred to the 3rd Quarter Expenditure Reports required by L.A. Care Internal Policies for FY 2023-24 included in the meeting materials. (*A copy of the report is available by contacting Board Services).* L.A. Care internal policies require reports on expenditures for business related travel expenses incurred by employees, members of the Board of Governors, Stakeholder Committees, and members of the Public Advisory Committees. The Authorization and Approval Limits policy requires reports for executed vendor contracts for all expenditures and the Procurement Policy requires reports for all sole source purchases over $250,000. These are informational items, and do not require approval. • Policy AFS-004 (Non-Travel Expense Report) • Policy AFS-027 (Travel Expense Report) • Policy AFS-006 (Authorization and Approval Limits) • Policy AFS-007 (Procurement)	
Infosys Contract (FIN 103)	Mr. MacDougall presented a motion requesting approval of contract with Infosys for Quality Assurance testing (QA Test), totaling $23,715,760 and yielding a savings of $5,200,000. The new 3-year total contract with Infosys (FY25 to FY27) would cost $18,515,760 for Solutions Delivery and EDM combined. **<u>Motion FIN 103.0924</u>** **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.**	**Approved unanimously by roll call. 4 AYES** **The Committee approved placing FIN 103 on the Consent Agenda for September 5, 2024 Board of Governors meeting.**
Public Comments on the Closed Session agenda items.	There were no public comments.	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
ADJOURN TO CLOSED SESSION	The Joint Powers Authority Finance & Budget Committee meeting adjourned at 1:55 p.m. Augustavia J. Haydel, Esq., *General Counsel*, announced the items that the Committee will discuss in closed session. There was no public comment on the Closed Session items, and the meeting adjourned to closed session at 1:55 p.m. REPORT INVOLVING TRADE SECRET Pursuant to Welfare and Institutions Code Section 14087.38(n) Discussion Concerning New Service, Program, Technology, Business Plan Estimated date of public disclosure *August 2026* CONTRACT RATES Pursuant to Welfare and Institutions Code Section 14087.38(m) • Plan Partner Rates • Provider Rates • DHCS Rates	
RECONVENE IN OPEN SESSION	The meeting reconvened in open session at 2:24 pm. Ms. Haydel advised the public that no reportable action from the closed session.	
ADJOURNMENT	The meeting adjourned at 2:25 p.m.	

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

APPROVED BY:
Signed by:
Stephanie Booth, MD
084B48A20E5F499...
Stephanie Booth, MD, *Chairperson*
Date Signed 10/24/2024 | 6:55 PM PDT

APPROVED

COMPLIANCE & QUALITY COMMITTEE

BOARD OF GOVERNORS
Compliance & Quality Committee Meeting
Meeting Minutes – September 19, 2024

L.A. Care Health Plan CR 1017-1018, 1055 W. Seventh Street, Los Angeles, CA 90017

Members
Stephanie Booth, *MD, Chairperson*
Al Ballesteros, *MBA*
G. Michael Roybal, *MD*
Fatima Vazquez

Senior Management
Sameer Amin, *MD, Chief Medical Officer*
Terry Brown, *Chief of Human Resources*
Todd Gower, *Chief Compliance Officer*
Augustavia J. Haydel, *General Counsel*
Alex Li, *Chief Health Equity Officer*
Tom MacDougall, *Chief Information and Technology Officer, IT Executive Administration*
Noah Paley, *Chief of Staff*
Acacia Reed, *Chief Operations Officer*
Edward Sheen, MD, *Senior Quality, Population Health, and Informatics Executive*

** Absent ** Via Teleconference*

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
CALL TO ORDER	Chairperson Stephanie Booth, *MD*, called the L.A. Care Compliance & Quality Committee and the L.A. Care Health Plan Joint Powers Authority Compliance & Quality Committee meetings to order at 2:00 P.M. She announced that members of the public may address the Committee on each matter listed on the agenda before the Committee's consideration of the item by submitting their comments via text, voicemail, or email.	
APPROVAL OF MEETING AGENDA	**The meeting Agenda was approved as submitted.**	**Approved unanimously 4 AYES (Ballesteros, Booth, Roybal, and Vazquez)**
PUBLIC COMMENT	*There was no public comment.*	

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
APPROVAL OF MEETING MINUTES	**The August 15, 2024 meeting minutes were approved as submitted.**	**Approved unanimously. 4 AYES**
CHAIRPERSON REPORT	Chairperson Booth commended the committee for their hard work during a period of significant change. She noted that while the process involves considerable effort, the group is making meaningful progress beyond mere reorganization. Chairperson Booth stated that the system is maturing and expressed hope that Compliance will eventually become a natural part of their operations, where individuals will no longer resist it. She noted that audits should be viewed as beneficial opportunities for improvement rather than as punitive measures. Chairperson Booth noted the unique opportunity they have to receive expert advice on Compliance, which is not commonly found in similar organizations. She expressed pride in both the team's efforts and the contributions of Board committee members, who have been actively engaged in reviewing materials to ensure clarity and quality.	
CHIEF MEDICAL OFFICER REPORT	Sameer Amin, *MD, Chief Medical Officer*, gave a Chief Medical Officer report *(a copy of the materials can be obtaided from Board Services).* Dr. Amin provided an update on key initiatives and progress within the health services department, emphasizing the importance of accountability for decisions and strategies made. Dr. Amin highlighted the success of Enhanced Care Management (ECM), noting a 25% increase in enrollment from February to August 2024. This growth was attributed to strategic recontracting efforts that incentivized providers to enroll new members and enhance patient interactions. He acknowledged the effective leadership of Noah Ng, *Director, Enhanced Care Management*, and his team, who have fostered positive relationships with providers, allowing for better service delivery. He discussed improvements in the Transitions of Care program, which aims to support high-risk patients during their transitions between care settings. Dr. Amin reported an increase in interactions related to transitions of care, rising from approximately 1,600 to 2,700. Dr. Amin addressed changes made to the prior authorization process, which resulted in a 10% reduction in overall authorization volume. These adjustments have reduced administrative burdens and improved the efficiency of the utilization management department. Collaboration with hospitals has also seen significant improvements, particularly with the establishment of a 24/7 hotline for urgent calls, which now boasts a response time of 40 seconds and a drop rate of less than 5%. Dr. Amin credited Tara Nelson, *RN, BSN, Senior Director, Utilization Management, Utilization Management*, for her outstanding leadership in enhancing operational performance and	

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	responsiveness to hospital needs. Dr. Amin expressed pride in the team's accomplishments and the ongoing efforts to create a more coordinated and efficient healthcare system for members. Member Roybal asked for clarification regarding the calls received through the hotline. He inquired whether the majority of these calls, specifically about 99%, were related to admissions from the emergency room. He assumed that a similar percentage of these calls likely resulted in approvals and sought confirmation on the actual approval rates for callers. Dr. Amin responded that at that point they are not calling for approval per se and they categorize all the calls that come in. the highest number is post stabilization. The next is transition to a higher level of care. Dr. Amin addressed the improvements in discharge planning and collaboration with hospitals. He noted that previously, the approach to engaging with hospitals was passive, relying on them to reach out for assistance with difficult-to-place patients. Recognizing the need for a more proactive strategy, Dr. Amin detailed the restructuring of the medical director division and the alignment of nursing staff with specific hospitals to enhance discharge processes. Dr. Amin noted the importance of actively rounding with hospital teams to discuss patients pending discharge. These efforts include connecting patients with necessary resources such as housing and community services, ensuring they are discharged to appropriate care settings rather than automatically to Skilled Nursing Facilities (SNFs). He pointed out that many patients were previously denied placement in SNFs because they were not suitable for that level of care. As a result of these strategic changes, the difficult-to-place patient list has been reduced by 25% month over month. He reported that patients are now being discharged to various care options beyond SNFs, including residential care and hospice services. Dr. Amin said that successful recontracting with skilled nursing facilities, noting that approximately 16% of the patients discharged are benefiting from a pilot program with Rockport, meeting expectations. Member Roybal noted that it isn't really a difficult to place patient population but more so it's the provider not knowing where to place them. Dr. Amin responded that it's a cry for help list. Dr. Amin explained that proactive engagement with hospitals around discharge planning has been instrumental in reducing the number of patients on this list. By addressing discharge needs before hospitals urgently request help, the team has been able to facilitate smoother transitions. He noted that a key factor in successfully paring down the list has been ensuring patients are directed to the appropriate care destinations. Dr. Amin noted that, previously, the common practice was to send patients to SNFs, even when that was not the most suitable option. He said that approximately 17% of the members on the difficult-to-place list were able to go home directly instead.	

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
CHIEF COMPLIANCE OFFICER REPORT	Todd Gower, *Chief Compliance Officer*, and the Compliance Department staff presented the Chief Compliance Officer Report *(a copy of the full written report can be obtained from Board Services).* Overview o Compliance Report from the Internal Compliance Committee (ICC) o Updates on the Enterprise Risk Assessment and Management Action Plans (MAPs) o Vendor Management and Contracting Process o Issues Inventory o Business Unit Report Out on Appeals and Grievances Key Highlights Compliance Report o The compliance report outlined the current status of various compliance initiatives and highlighted the importance of accountability within the organization. Michael Sobetzko, *Senior Director, Risk Management and Operations Support, Compliance*, presented updates on the Enterprise Risk Assessment, focusing on: o The lack of cross-functional third-party vendor management and oversight. o A remediation plan was developed, currently being assessed by a third-party consultant. Key actions include: - End-to-End Process Assessment: Completed in Q3 2024. - Leadership Review: Ongoing, with recommendations evaluated for implementation by Q2 2025. - Vendor Risk Committee: The charter is set to be presented for approval in September, with initial data gathering already in progress. Mr. Sobetzko provided an update on the Issues Inventory. o The current status included: - Reported Issues: Fluctuated over the past months, with a notable increase in July and August. - Open Issues: Currently at four. - Closed to Inventory: Issues resolved and removed from active tracking. - Deferred Issues: Waiting on regulatory guidance. Demetra Crandall, *Director, Customer Solution Center Appeals and Grievances, CSC Appeals & Grievances*, reported on the appeal and grievance volumes from July 2023 to June 2024. The data highlighted trends in complaints and the effectiveness of the response system. The report indicated that the system is undergoing improvements, including the implementation of a new system (i3vertical/Kiriworks) aimed at enhancing data reporting and compliance visibility by 2025.	

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
COMPLIANCE & QUALITY COMMITTEE CHARTER STATUS UPDATE	Todd Gower, *Chief Compliance Officer*, discussed the Compliance & Quality Committee Charter Process. Mr. Gower provided an update on the Compliance and Quality Charter, which has undergone a thorough review over the past year and a half. He pointed out a significant organizational change from the previous year: the separation of Internal Audit from the Compliance Department. This change necessitated clear documentation in the charter. He noted the importance of incorporating the Office of Inspector General seven elements into the charter, which serves as a framework for compliance. Mr. Gower also noted that the updated charter includes provisions for monitoring and auditing within the compliance area. He acknowledged the contributions of various team members, Mr. Gower expressed gratitude to Linda Merkens, *Senior Manager, Board Services*, and Augustavia J. Haydel, *General Counsel*, and Chairperson Booth for their collaboration on the charter. He said that the necessity of periodically reviewing charters every two to three years to ensure they align with the organization's current practices, noting that such a review had not occurred for some time. Mr. Gower indicated that changes made to the charter are highlighted in red for easy reference. He mentioned plans to seek a vote for the approval of the revised charter at the next meeting. He assured the Board that the essential legal requirements remain intact in the updated document, even as some legal jargon was streamlined for clarity. He also shared insights from comparisons with charters from other plans in California, noting that many only have compliance charters, while very few include both compliance and quality. He reiterated that the revisions reflect the best efforts to create a comprehensive charter that meets the needs of both compliance and quality for the committee. Member Roybal asked if there is a role for the Chief Medical Officer in the charter. Chairperson Booth stated that it's in the charter. Mr. Gower said that he will take it offline with Chairperson Booth and make sure there is wording in the charter regarding the Chief Medical Officer. Chairperson Booth said that they can also define CCO and CMO. She noted that there should also be an Internal Audit charter and remembers seeing one in the past. Maggie Marchese, *Senior Director, Audit Services*, responded that she'll be sure to get the charter to the committee for its review.	
QUALITY OVERSIGHT COMMITTEE (QOC) REPORT	Edward Sheen, *MD, Senior Quality, Population Health, and Informatics Executive*, *(a copy of the materials can be obtaidne from Board Services).* Cultural and Linguistic Services (C&L) Utilization Report Monitoring and Effectiveness: The C&L unit monitors its effectiveness through quarterly utilization reports, which analyze:	

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	o The utilization of language services. o Service levels and satisfaction with language services. o C&L-related grievances and complaints. Language Services Overview: o Services are provided uniformly across all product lines, including standard and rapid translations, alternative formats (large print, audio, braille), and both face-to-face and telephonic interpreting. o Key metrics included the number of documents translated and requests for interpreting services. Key Findings: o A slight decrease in standard translations and alternative formats (down 20.2%), while rapid translations increased by 11.7%. o Face-to-face interpreting requests increased by 5.1% for medical appointments and 8.8% for non-medical appointments. o Telephonic interpreting usage rose significantly, with a 37.4% increase in minutes used compared to previous quarters. Satisfaction Metrics: o Most goals related to member satisfaction with interpreting and translation services were met. For instance, 99.2% of members reported satisfaction with translation services. o Challenges were identified, including declining satisfaction regarding the ease of requesting an interpreter, which led to initiatives for improvement. Nurse Advice Line (NAL) Oversight Service Overview L.A. Care provides 24/7 access to a Nurse Advice Line where members can consult with Registered Nurse Health Coaches for medical concerns and referrals. Contract Extension: The contract with the vendor Health Dialog was extended for three years to ensure continuous service. Key Findings: o NAL met most performance metrics but struggled with average speed of answer during Q4 2023 and Q1 2024. o 35% of symptom check calls initially intended for the ER were redirected to appropriate lower levels of care. Corrective Action Plan: o Health Dialog was placed on a corrective action plan due to consistent performance issues. o The acquisition by Carenet is expected to improve service delivery, with an increase in available nursing staff. Teladoc Utilization Report	

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AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	o Overview: This section summarized how members received care through Teladoc services, showcasing trends and utilization rates. o Clinical Details: The report provided metrics on symptom check calls and identified common presenting symptoms, such as abdominal pain and respiratory issues.	
QUALITY IMPROVEMENT AND HEALTH EQUITY COMMITTEE (QIHEC) REPORT	Alex Li, *MD, Chief Health Equity Officer,* gave a Quality Improvement and Health Equity Committee (QIHEC) report *(a copy of the presentation can be obtained from Board Services).* Brief Summary of Key Equity and Disparities Findings and Program Focus and Interventions: • Disparities in clinical outcomes persist across various domains and populations • One of the main priorities is focused on improving the child health measures with Black/African American children and youth in Service Planning Area 6 (South LA): - Community Health Workers provide assistance with scheduling well-child visits before the 15-month mark - Offering at-home test kits • Conducted member survey in text message campaign: - Majority of members stated they did not see their doctor due to not feeling sick or not knowing who their doctor is. Data Efforts: • Efforts are under way to improve the quality and data collection of social determinants of health and race/ethnicity data points as well as scouring and scrubbing claims, encounters and supplemental data to capture the completion of our HEDIS measures. Demographic Changes: • Addressing the new Office of Management and Budget race/ethnicity changes in our system and talking with key community stakeholders (Los Angeles County Department of Public Health) Correct and Updated Contact Information: • Exploring alternative databases with member contact information. • Working with enrollment services to continue to update and ensure that we have the accurate member contact information Additional Work Planned for 2024-2025: • Developing a disparities data dashboards to better identify disparities. • Utilizing member councils and health promotoras for feedback on member outreach materials and programs	

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• Empowering provider groups and clinics to analyze data and identify disparities in patient populations • Increasing the number of languages available for member outreach • Collaborating with community-based organizations and vendors in developing culturally tailored materials for a diverse membership Informational: Universal Provider Manual (UPM) Updates: • Legally binding document and serves as an extension of L.A. Care's contract with our network providers. • Updated on a regular cadence and posted on our website. • The Communications team seeks QIHEC input for the UPM on an annual basis.	
TIMELY ACCESS TO CARE UPDATE: MY2023 SURVEY RESULTS	Priscilla Lopez, *Manager, Quality Improvement Accreditation, Quality Improvement,* gave a Timely Access to Care Update: Measurement Year 2023 Survey Results *(a copy of the presentation can be obtained from Board Services).* Overview and Agenda: She provided insights into access to care survey results, performance goals, monitoring cycles, and interventions for improving provider performance. The annual survey is conducted from October to December, with results received by spring. Providers are given a report card and a corrective action plan (CAP) based on their performance, which they must respond to within 30 days. Performance Goals. L.A. Care sets a compliance rate goal of 80% for appointment availability and after-hours access, with the aim of achieving statistically significant improvement each year. She highlighted the compliance rates for various appointment types, comparing them against established performance goals: o Primary Care: Urgent appointments had a compliance rate of 73%, routine appointments 85%, and preventive care (adult) at 95%. o Specialty Care: Urgent appointments had a 69% compliance rate, routine appointments 75%, and prenatal appointments 100%. o After-Hours Care: Emergency room access showed 88%, but timeliness dropped to 66%. Provider Performance Analysis: Her analysis identified the lowest-performing provider groups based on urgent care appointments, call-back appointments, and after-hours care timeliness. Specific provider groups were highlighted, including those with high non-compliance rates. Interventions and Strategies:	

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Ms. Lopez outlined ongoing remediation strategies for underperforming provider groups, including enhancing education about access to care requirements and collaborating to identify root causes for non-compliance. Ms. Lopez noted the importance of using data analytics to inform provider engagement and the need for adjusting training methods to address best practices effectively.	
MY2023 HEDIS RESULTS	Thomas Mendez, *Director, Quality Performance Informatics, Quality Performance Management,* presented the Measuremnet Year 2023 Healthcare Effectiveness Data and Information Set (HEDIS) Results *(a copy of the presentation can be obtained from Board Services).* Overview All HEDIS submissions for Measurement Year (MY) 2023 across all Lines of Business (LOB) were successfully completed in June 2024. L.A. Care maintained a 3.5 NCQA Health Plan Rating (HPR) for Medi-Cal, the same rating held since MY2020. The Dual Special Needs Plan (DSNP) HPR was not calculated due to the plan being new without eligible members for the CAHPS survey. The NCQA does not calculate Marketplace HPR. Key Findings: o HEDIS rates have generally improved year over year since the impact of COVID-19 (MY2020), with many measures returning to or exceeding pre-COVID levels. Summary of Improvements and Declines o Measures Improved: - DSNP Admin Measures: 45 - DSNP Hybrid Measures: 6 - LACC Admin Measures: 22 - LACC Hybrid Measures: 12 - Medi-Cal Admin Measures: 68 - Medi-Cal Hybrid Measures: 14 - Total Improvements: 167 Highlights and Goals Met Managed Care Accountability Set (MCAS): 11 out of 18 measures reached the Minimum Performance Level (MPL): o Lead Screening in Children (LSC), Topical Fluoride (TFL), and Well Visits for Children and Adolescents achieved MPL status, which they did not meet in MY2022. o Expected penalties from DHCS are projected to be approximately $500,000 less than the previous year due to these improvements.	

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Quality Transformation Initiative (QTI): o 3 out of 4 measures were above MY2022 results o Controlling Blood Pressure (CBP) reached the 50th percentile, increasing by 5.19% compared to last year. o Colorectal Cancer Screening (COL) improved by 5.03%, and HbA1c for Diabetics (HBD) improved by 5.84%. Areas of Poor Performance For the MCAS MPL measures, concerns include: o Childhood Immunization Status (CIS): The rate for the influenza vaccine continues to decline. o Cervical Cancer Screening (CCS): The rate has been trending downward since COVID-19, remaining a challenge due to its five-year measurement cycle. For the QTI measures, despite improvements, all four measures still fall well below the required 67th percentile, indicating substantial penalties are expected. Root Cause Analysis Access to care remains an issue for several measures, particularly those requiring in-person visits or multiple appointments for compliance, such as cervical cancer screenings, well-child visits, and colorectal cancer screenings. Notable challenges include delays in scheduling necessary procedures like colonoscopies and a rise in late immunizations.	
PUBLIC COMMENT ON CLOSED SESSION ITEMS	*There was no public comment.*	
ADJOURN TO CLOSED SESSION	Augustavia J. Haydel, Esq., *General Counsel*, announced the following items to be discussed in closed session. The JPA Compliance and Quality Committee meeting adjourned and the Compliance and Quality Committee adjourned to closed session at 4:51 P.M. PEER REVIEW Welfare & Institutions Code Section 14087.38(o) CONFERENCE WITH LEGAL COUNSEL—ANTICIPATED LITIGATION Significant exposure to litigation pursuant to Section 54956.9(d)(2) of Ralph M. Brown Act: Four potential cases THREAT TO PUBLIC SERVICES OR FACILITIES Government Code Section 54957	

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Consultation with: Tom MacDougall, Chief Information and Technology Officer, IT Executive Administration CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION Pursuant to Section 54956.9(d)(1) of the Ralph M. Brown Act • Department of Managed Health Care Enforcement Matter Numbers: 18-799, 20-063, 21-428, 21-509, 21-680 • Department of Health Care Services, Office of Administrative Hearings and Appeals, In the matter of: L.A. Care Health Care Plan Appeal No. MCP22-0322-559-MF	
RECONVENE IN OPEN SESSION	The Committee reconvened in open session at 5:10 p.m. There was no report from closed session.	
ADJOURNMENT	The meeting adjourned at 5:15 p.m.	

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

APPROVED BY:

_____
Stephanie Booth, MD, *Chairperson*
Date Signed: _____

APPROVED