Board of Governors
Regular Meeting Minutes #325
March 7, 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

**Absent*

*** Via teleconference*

Management

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

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
WELCOME	Alvaro Ballesteros, *Board Chairperson,* called to order at 1:04 pm the regular and special meetings of L.A. Care Health Plan Board of Governors and the L.A. Care Health Plan Joint Powers Authority Board of Directors. The meetings were held simultaneously. Board Chairperson Ballesteros welcomed everyone. • Everyone's time is valuable. Recently, a few meetings have lasted more than three hours so L.A. Care will make some changes to improve meeting efficiency. • The public comment time may be adjusted to a shorter time limit during the meeting to keep the meeting on schedule and allow more people to comment. • Please be respectful of everyone at the meeting. Comments should end at 3 minutes. That's a lot of time – more time than is given for public comment at other meetings. Commenters do not have to use the full three minutes if their views can be expressed in less time. There is no need to wait for the clock to countdown the full 3 minutes. Get your points across quickly and step away from the microphone even if there is still time on the clock so others can be heard. Those attending the meeting in person who wish to submit a public comment should use the form provided. For those with access to the internet, the materials for today's meeting are available on the L.A. Care website. He thanked those who have submitted public comment by voice mail, text or email. He informed participants that for those using the video software during the meetings; the "chat"	

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	function will be available to provide live and direct public comment to everyone participating in the virtual meeting. The Chat feature will be open throughout the meeting for public comment. All are welcome to provide input.	
APPROVAL OF MEETING AGENDA	**The meeting Agendas were approved.**	**Unanimously approved by roll call. 10 AYES (Ballesteros, Booth, Contreras, De La Torre, Ghaly, Raffoul, Roybal, Solis, Vaccaro and Vazquez)**
PUBLIC COMMENTS	There were no public comments.	
ADJOURN TO CLOSED SESSION	The Joint Powers Authority Board of Directors meeting adjourned at 1:12 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 1:12 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: *March 2026* THREAT TO PUBLIC SERVICES OR FACILITIES Government Code Section 54957 Consultation with: Tom MacDougall, *Chief Technology and Information* CONTRACT RATES Pursuant to Welfare and Institutions Code Section 14087.38(m) • Plan Partner Rates • Provider Rates • DHCS Rates 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	

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	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: CEO Agency Designated Representative: Alvaro Ballesteros, MBA Unrepresented Employee: John Baackes CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION Pursuant to Section 54956.9(d)(1) of the Ralph M. Brown Act 1) *Glendale Adventist Medical Center dba Adventist Health Glendale v. Local Initiative Health Authority for Los Angeles County dba L.A. Care Health Plan,* JAMS 1220072832; 2) *Glendale Adventist Medical Center dba Adventist Health Glendale and White Memorial Center dba Adventist Health White Memorial v. Local Initiative Health Authority for Los Angeles County dba L.A. Care Health Plan,* JAMS 1220074035; 3) *Glendale Adventist Medical Center dba Adventist Health Glendale v. Local Initiative Health Authority for Los Angeles County dba L.A. Care Health Plan,* JAMS 1220074776; 4) *Glendale Adventist Medical Center dba Adventist Health Glendale and White Memorial Center dba Adventist Health White Memorial v. Local Initiative Health Authority for Los Angeles County dba L.A. Care Health Plan,* JAMS 1220075383; 5) *White Memorial Center dba Adventist Health White Memorial v. Local Initiative Health Authority for Los Angeles County dba L.A. Care Health Plan,* JAMS 1220072839; 6) *White Memorial Center dba Adventist Health White Memorial v. Local Initiative Health Authority for Los Angeles County dba L.A. Care Health Plan,* JAMS 1220072273; 7) *White Memorial Center dba Adventist Health White Memorial v. Local Initiative Health Authority for Los Angeles County dba L.A. Care Health Plan,* JAMS 1220074774; *8) San Joaquin Community Hospital dba Adventist Health Bakersfield; and Simi Valley Hospital and Health Care Services dba Adventist Health Simi Valley Hospital v. L.A. Care Health Plan,* L.A.S.C. case no. 22STCV30779*;* 9) *San Joaquin Community Hospital dba Adventist Health Bakersfield; Simi Valley Hospital and Health Care Services dba Adventist Health Simi Valley Hospital; Adventist Health Medical Center Tehachapi dba Adventist Health Tehachapi Valley; and Hanford Community Hospital dba Adventist Health Hanford v. L.A. Care Health Plan,* L.A.S.C. case no. 23STCV10175.	

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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 2:10 pm. There was no report from closed session.	
APPROVE CONSENT AGENDA ITEMS	• February 1, 2024 meeting minutes • Quarterly Investment Report **Motion FIN 100.0324** **To accept the Quarterly Investment Report for the quarter ending December 31, 2023, as submitted.** • Approve Accounting & Financial Services Policies AFS-027 (Travel Expenses and Other Expenses), and retirement of AFS-004 (Non-Travel & Other Related Expenses) **Motion FIN 101.0324** **To approve Accounting & Financial Services Policies AFS-027 (Travel Expenses and Other Expenses), and retirement of AFS-004 (Non-Travel & Other Related Expenses) as submitted.** • Contract Amendment with Metcalfe Security **Motion FIN 102.0324** **To authorize staff to amend Metcalfe Security contract and extend it for 5 years in an amount not to exceed $8,982,675.** • Contract Amendment with Solugenix, Infosys and Cognizant for Information Technology staff augmentation services through September 30, 2024 **Motion FIN 103.0324** **To authorize staff to amend a contract with Solugenix, Infosys and Cognizant in the amount of $6 million (total contract not to exceed $23,340,000) for Information Technology staff augmentation services through September 30, 2024.** • Delegation to Chief Executive Officer to enter into contractual agreements for professional services to perform tenant improvements in the 1200 W. 7th Street building **Motion FIN 104.0324** **To delegate to John Baackes, Chief Executive Officer, discretionary authority to approve vendors and enter into contractual agreements for certain professional services to perform capital improvements and purchase equipment to build-out floors 1, 5, 6 and 7 in the 1200 W. 7th Street building in an amount not to exceed $47,027,791 which includes a 10% contingency for potential unknown conditions.**	**Unanimously approved by roll call. 10 AYES**

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	• 2024 Compliance Program Work Plan **Motion COM 100.0324** **To approve the 2024 Compliance Work Plan, as submitted.**	
CHAIRPERSON'S REPORT	**PUBLIC COMMENT** *Andria McFerson wished everyone Happy March. She said it is very important that we address the homeless issue, so with the chair report, maybe for next month, we actually talk about how we can address the homeless issue. She wrote something down basically on how many homeless people are in L.A., 75,000 people are homeless on any given night per LA Times paper last year. L.A. Care can have RCAC members who are willing to volunteer of course, and in any given instance, help someone. Of course, to make sure it is safe to work around a shelter, work at your own risk. People are willing to do so much, they are ready. It would be great if we can talk about that next month about how the RCACs can give back. They have been together for 25 years, and do not want that opportunity to be taken away. Peer on peer communication is very important. It makes people feel welcomed. It makes people feel understood. And the people who are giving to the homeless, have been there. Whether it be health wise, financially or going through different instances - she guesses they are not instances, they affect you for the rest of your life. Domestic violence, rape, child rape, those are the topics that are not being discussed openly. That is why she is openly discussing it right now. If you have a volunteer, not just a focus group of people who are being talked at, but an open conversation with people who are just like them, would make it so that a lot of people help fight that homelessness and get people off the streets. It is not something that's just going to go away. It is something that we need to address openly. People who have been through it are just like the homeless people. We have RCAC members that are homeless now, she was homeless. She had epilepsy, had brain surgery, had a lot of different things going on with her, and she's willing to help. There are many other people who are willing to help and make it so that L.A. Care understands that RCACs have a purpose, and members are willing to give back as volunteers. It is not like hiring new staff and spending hundreds of thousands of dollars. A reimbursement for the time that they give to the community could be made. They will still do it, no matter what. There are people who are willing to be there for people in need, saving lives.* Chairperson Ballesteros commented that the Regional Community Advisory Committees (RCACs) and the involvement of the consumers is a tremendous asset for L.A. Care health plan. L.A. Care is doing a lot for homeless individuals now and has plans for future support. Mr. Baackes noted there are 40 to 50,000 L.A. Care members living in homelessness, whether they are in a car, a shelter, or on the street. Many of the efforts under the California Advancing and Innovating Medi-Cal (CalAIM) benefits provide new resources and tools to address that. L.A. Care is working with Los Angeles County on homelessness issues, and with LA Homeless	

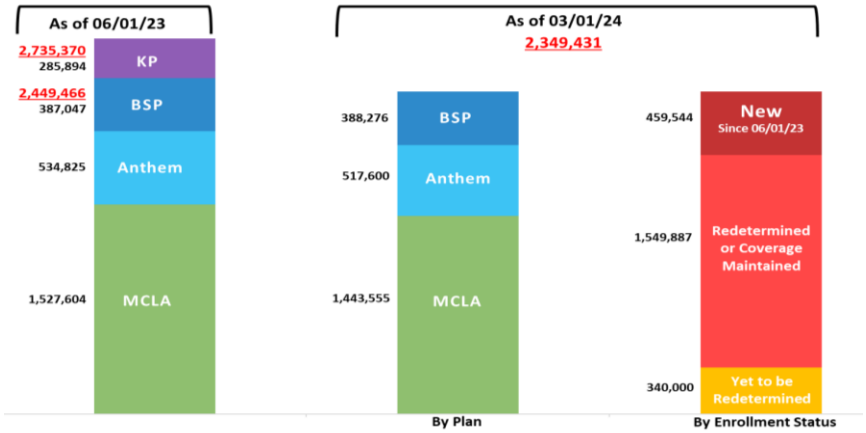
AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Services Agency (LHASA). L.A. Care also works with Los Angeles City on the Inside Safe program, bringing people from encampments into hotels. L.A. Care is identifying members or members of the other health plans, and works to get them into enhanced care management as quickly as possible. That is launching now and L.A. Care is excited about the program. Feedback on the efforts addressing homelessness can be presented, and then perhaps talk about how to incorporate volunteers. L.A. Care has an initiative on supporting street medicine, which is an important thing. At an L.A. Care Community Resource Center (CRC) recently, the manager told him that people walk in who are homeless. If the person is an L.A. Care member, the CRC works on helping that person go to a primary care physician. Sometimes, the person does not want to go. It could be better to have street medicine capabilities to serve members in this situation. *Ms. McFerson noted that she brought a motion about this at one of her first ECAC meetings and it would be good for L.A. Care to get involved for example with Med-Tents in different areas with RCAC members would be great.* *Joyce Sales is RCAC 6 co-chair, and she asked about Proposition 1 on the March 5 ballot.* Board member De La Torre responded that the votes are still being counted and the results are too close to call. *Ms. Sales would like to find out what the procedure is to make a motion or a vote or however, it goes to get this meeting returned to the public attendance at 1:00 p.m.* Augustavia Haydel, *General Counsel,* responded that a RCAC member can take the idea to a RCAC, and the RCAC could bring it forward, or a member can bring it forward to the Executive Community Advisory Committee (ECAC) as a motion for the Board to consider. The Community Outreach & Engagement (CO&E) staff can help you with that. *Ms. Sales noted that unfortunately they are not having the RCAC meetings at this time, so she could bring it to ECAC.* Ms. Haydel indicated that a member could take the item to the ECAC. ECAC would have to vote to bring it as a motion to the Board. Then the Board would consider it, they might take a vote or they might take some other action. John Baackes, *Chief Executive Officer,* added that there is an ECAC meeting on Wednesday, March 13. Board Chairperson Ballesteros reported that he attended the last ECAC meeting. He appreciated the invitation. He noted there was a lot of discussion, and he took many notes. He understands things a little bit more. He has shared the notes with management and he will continue to do so. He met the members that attend the meetings and he appreciates that experience.	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	He has a tremendous group of consumer members participating, they are very engaged, very passionate and care about the health plan and care about the community. He wants to thank members for allowing him to be there and learn from the members.	
CHIEF EXECUTIVE OFFICER REPORT	**PUBLIC COMMENT** *Andria McFerson thinks it is important to comment on the RCAC meetings, how they are giving back to the public and let people know specifically what is going on with RCACs post-COVID. It is important to give information to everyone here, along with the Board of Supervisors, on better ways to reach out to people and make it so that people are not scared to go back to the doctors. A lot of people lost people, so that counseling and different things having to do with outreach and engagement is very important. It is more important than a lot of other things. Someone she knows, a family member, died 10 years ago today. But it still hurts. Every time she gets to this point, and it is her brother. Then she found out that a family member tried to kill themselves today. They had a long conversation over the phone. She hopes that people understand that they are important. There is a right way of conversating with someone who has been there, that you love, that you have a lot of things they're familiar with. There is absolutely no way we should go without making sure that we have that outreach and engagement. It's been here for 25 years, more than that, actually. RCACs helped L.A. Care grow into the largest public insurance company in the nation. But now, when she talks to people, they are not happy with their coverage because they feel as though they are being treated as someone that's a beggar on the street. They would rather not even go to the doctor at this point. When the doctor's office finds out that they have public insurance, they treat them differently. The Board would find out way more if it heard from the people who are suffering from that. She thinks it is very important that the Board talk about that, bring the RCACs back and let them have a voice. It is more than just important. It is life saving.* Chairperson Ballesteros expressed his sympathy for her pain in the loss of a family member. Mr. Baackes reported that on February 21 there was a cyberattack on L.A. Care's claims processor, Change Healthcare. Change Healthcare is the largest clearinghouse for medical claims in the United States, processing $15 billion claims a year. Claims could not be processed through Change Healthcare as of February 21. Most medical expenses are paid by L.A. Care to providers through monthly capitation payments that do not require the submission of claims by providers to be reimbursed. L.A. Care immediately notified the provider network and provided a pathway to submit paper claims, which are quickly scanned and digitally processed. L.A. Care has been working with the Change Healthcare, owned by Optum. United Healthcare, one of the largest medical conglomerates in the United States, owns Optum. L.A. Care is	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	working with Optum on a bridge to another clearinghouse and it is expected that within a week electronic claims submissions can again be received from many hospitals. During the COVID pandemic, L.A. Care began advancing hundreds of millions of dollars to providers. Those advances were based on quality payments to which the providers would be entitled. The smaller community based organizations who do not have cash reserves are a major concern for L.A. Care now, as those may be unable to meet payroll. L.A. Care is working through the various trade associations to offer cash advances to the providers that are going to have a problem meeting payroll in the next month. Cash advances sound great but can be difficult to reconcile and L.A. Care is working to enable electronic claims again. L.A. Care has not been asked to do many advances yet, but is prepared to do as many as necessary. L.A. Care is preparing to examine carefully Change Healthcare's capacity and reliability once it is back online, and is reviewing alternative clearinghouse entities to build redundancy for the future. Tom MacDougall, *Chief Information and Technology Officer,* reported that L.A. Care's cyber defense operations center is a team of staff working 7 days a week, 24 hours a day, looking at all incoming and outgoing traffic to block any attempts to break in to L.A. Care's systems. After notification from Change Healthcare, L.A. Care immediately cut all connections with their systems, scanned all services to look for an indicator of compromise (IOC), and found no IOCs. L.A. Care is diligently watching all endpoints, making sure that there is no aberrant traffic. Unfortunately, in today's electronic world, there are constant attempts to compromise systems, and it is important to be constantly vigilant. L.A. Care updated its technology in the last year to make sure it is as current as possible. There have been attempts discovered and repelled. L.A. Care will continue to protect its systems. Mr. Baackes noted that L.A. Care is responding to all inquiries from parties impacted by the cyberattack. He recommended a March 6, 2024 article in the *Atlantic* (The U.S. Health System's Single Point of Failure - The Atlantic) regarding the vulnerability of the US healthcare system. An email from the California Department of Health Care Services (DHCS) was received on February 2, informing L.A. Care that the 2023 revenue from Medi-Cal would be retroactively reduced by 1.5%, total of $84 million. The rationale was explained as decreased acuity among the Medi-Cal members dis-enrolled through the eligibility redetermination process, which indicates Medi-Cal health plans were paid for services that were not necessary, and that the distribution of members had been more favorable to health plans than was anticipated. DHCS also indicated that, while not an explicit driver of the retroactive adjustment, the financial reports from health plans for calendar year 2023 show strong profit margins. Mr. Baackes stated that L.A. Care would not retroactively adjust its payments to health care providers in 2023 even after the DHCS claw-back, despite L.A. Care's deficit budget in 2024. He acknowledged that L.A. Care financial reports showed a positive performance in 2023,	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	following three years of very poor financial performance. L.A. Care has sufficient reserves for the retroactive adjustment in rates, which will affect 2024 financial performance. He restated that L.A. Care would not retroactively adjust the 2023 payments to health care services providers. In response to a comment from Board Member Roybal, Mr. Baackes noted that the retroactive negative adjustments to 2023 by DHCS would apply to all health plans, for-profit and non-profit. Mr. Baackes reported that the managed care organization (MCO) tax was reinstated in the California State Budget and revenue will begin accruing in 2024. DHCS has announced the revenue will be allocated to providers through the health plans to providers in a targeted rate increase (TRI) for care and services limited to at least 791 specific aid codes for primary care, behavioral health and obstetrics and gynecology (OB/GYN). L.A. Care and other health plans with a highly capitated model have not received guidance about distribution of TRI to providers. L.A. Care has received many provider inquiries about TRI payments. Town hall meetings with providers have been scheduled to address questions about the Change Healthcare cyber-attack and interim electronic claims processes, retroactive adjustments to rates and TRI. Similar meetings were held with providers in 2020 after the public health emergency was declared. Afzal Shah, *Chief Financial Officer,* commented that L.A. Care has received some draft rate information and funds from DHCS. DHCS requested supplemental data from health plans for all provider contracts and payments made in prior periods and has not responded to a request from health plans for information about the calculation of rates. DHCS will provide revised rates to health plans in April.	

Mr. Baackes displayed a chart showing the results of Medi-Cal eligibility redetermination as of March 1, 2024:



The left column shows L.A. Care Medi-Cal enrollment by plan partner at the start of the redetermination in June 2023. The changes as of March 1, 2024 are in the middle column. He noted that the DHCS direct contract with Kaiser was effective on January 1, 2024, and members in Kaiser were removed from L.A. Care's enrollment. Over the nine months of redetermination, L.A. Care Medi-Cal enrollment is down 4%, or approximately 100,000 members. The right column shows the distribution of L.A. Care's enrollment, with almost 460,000 new members since June 2023, including 155,000 members eligible through the expansion of eligibility to undocumented adults 26-49 years old. 1,549,887 L.A. Care members have had eligibility for Medi-Cal confirmed, and they continue as L.A. Care members. There are approximately 340,000 Medi-Cal members remaining to have eligibility redetermined in April and May. There is a 90-day grace period for submission of the eligibility redetermination paperwork. It is estimated that about 6% of those will remain covered by Medi-Cal and enrolled with L.A. Care.

L.A. Care is working with Los Angeles County Department of Public and Social Services (DPSS) to determine if the new Medi-Cal members previously had Medi-Cal coverage and completed new paperwork instead of using the eligibility redetermination process.

Overall, the enrollment information indicates that L.A. Care may have a lower financial impact than previously estimated. There may be a financial impact to L.A. Care from new membership rate categories for satisfactory immigration status (SIS) and unsatisfactory immigration status (UIS). Health plans will receive lower rates from DHCS for the UIS category. Mr. Shah will provide more information in the financial report later in this meeting.

Mr. Baackes reported that under the direction of Phinney Ahn, *Executive Director for Medi-Cal*, L.A. Care follows up with members in the 90-day grace period to make sure that every effort is made to get to keep those members enrolled if still eligible for Medi-Cal benefits. He noted that

APPROVED

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	L.A. Care's Covered California enrollment is up 36%, which could indicate that some of those members determined to be ineligible for Medi-Cal may have enrolled in Covered California, particularly if their incomes rose above the ceiling of 138% of the federal poverty level for Medi-Cal eligibility. He commended everyone who is working to provide health care benefits for all who are eligible. Board Member and Supervisor Solis asked about trends in the information about Latino members who are disenrolled. Mr. Baackes responded that L.A. Care could provide detailed information for her. He noted that in Los Angeles County' First District, 53,000 enrolled in Medi-Cal under the expansion, which is 35% of the total enrollment for L.A. Care. Supervisor Solis asked about the two new rate categories. Mr. Baackes reported that prior to 2024, health plans were paid for actual Medi-Cal enrollment. Going forward, the rate methodology was changed. Mr. Shah responded that the Centers for Medicare and Medicaid Services (CMS) issued a corrective action plan to DHCS for not differentiating between UIS and SIS members, because federal regulations apply to funding mechanisms for Medicaid. CMS funds support the cost for SIS members. Costs for UIS members are paid by the State of California as federal funds cannot be used for UIS. DHCS began paying separate rates in 2023. There have been issues in correctly identifying UIS and SIS members. DHCS decreased the rates for UIS in 2024, and many health plans contested the severity of the decrease. DHCS has agreed to use a risk corridor on the UIS members and rates will be adjusted based on actual experience of health plans for those members. Mr. Baackes noted that California expanded benefits for UIS and is responsible for all of the costs. DHCS is therefore watching the cost more carefully for those newly eligible for Medi-Cal and differentiating between SIS and UIS. Chairperson Ballesteros asked about DHCS rates based on experience for members previously enrolled through My Health LA. Mr. Baackes responded that the data was not shared with health plans, the health plans objected and DHCS created a risk corridor. Chairperson Ballesteros asked If the projections for lower utilization for those members will there be adjustments if it is not confirmed by data on actual utilization. Mr. Shah noted that DHCS may have some data on emergency care or pregnancy-related care, DHCS is making some assumptions and many health plans challenged those assumptions. The rates will be adjusted through a risk corridor for the first year. The challenge is that health plans pay capitation without differentiating between UIS and SIS, except for Plan Partners. When there is a risk corridor, health plans pay capitation to providers for both categories. Health plans have questions on how the payment methodology will work. Health plans do not provide member-level information to providers to protect member privacy. Mr. Baackes noted that if there were a differentiation in payments to providers it could reduce provider revenue. Sameer Amin, MD, *Chief Medical Officer*, commented that as time goes on and these members become more	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	comfortable in seeking care, utilization may increase. The new members may only be accessing services for acute care, which can be more expensive. This may be the reason health plans requested a risk corridor until actual utilization could be established. Board Member Booth noted that there should be data in Medi-Cal for mothers and children in this category. Reportedly, pregnant women immigrate prior to birth so the child will be a US citizen, and there should be sufficient related data. Chairperson Ballesteros noted that he is informed by staff in health centers that some individuals are not enrolling in Medi-Cal for fear of potential consequences related to immigration. He thinks that it is sad because those who are eligible could benefit from health coverage, and he would like to see efforts to make them more comfortable with enrollment. Mr. Baackes noted that this issue also arose after changes in the public charge regulations. A problem may be that even though health plans were assured enrollment in Medicaid was shielded from reporting to the Immigration and Naturalization Service (INS), the trust factor is not an issue that health plans alone can overcome. Health plans need to partner with government agencies to try and help people become more comfortable in enrolling in programs for which they are eligible, so they can seek health care services without retribution. Supervisor Solis noted that trends indicate that there are fewer males, Latino males in this case, coming forward. She thinks that we are not reaching them. If these men are working two or three jobs, they have limited time to review information that may not be provided to them in an accessible manner. L.A. Care should be using the CRCs with health navigators, and working alongside Los Angeles County to reach potential members. These programs are made available for them and underutilization should be addressed. Mr. Baackes commented that L.A. Care saw reluctance during the vaccination program when the uptake was under 70%. Distrust must be overcome. L.A. Care is working to ensure that CRCs become a reliable place for people to have questions answered and act on that information. Board Member Vaccaro asked about the extent L.A. Care is utilizing the network Promotoras to help community members learn about enrollment and immigration. Mr. Baackes responded that L.A. Care would grow the Promotoras program, which currently has about 35 members. Community Outreach & Engagement staff is working on how it can begin to expand Promotoras. (*Board Member Vazquez' commented in Spanish and this summary is the professional simultaneous English interpretation of her comments.*) Board Member Vazquez commented regarding the information that goes to the community. Culturally speaking, we know that men tend not to participate in their own healthcare, as was mentioned, due to the work that they do. Probably L.A. Care could do some events to address	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	these working people. The health promoters are effectively working in their communities. The CRCs are providing different types of events to the community and these events could add elements specifically to reach the men, and also teenagers or adolescents, to encourage them to attend doctor visits as they go through the process of growing up. L.A. Care should continue sharing about all of these changes. Board Member de La Torre noted that a relevant experience was when Massachusetts launched a health care program called Romney Care (before Obama Care) it was discovered that men were not signing up. Research was conducted using focus groups, and it was proposed that Tom Brady narrate commercials to encourage men to enroll. It was found that none of that worked. The only thing that worked was to encourage moms to get men to enroll. If L.A. Care is going to do something, it needs to target the moms, not the wives or the sisters. The strategy should be to get moms to be the intermediary. Chairperson Ballesteros stated that Ms. Sales wanted him to communicate that the RCACs could be a mechanism of getting information out once RCAC meetings are held more regularly.	
• Monthly Grants and Sponsorships Reports	*Mr. Baackes referred Board Members to the written reports included in the meeting materials.* Board Member Booth asked about L.A. Care's sponsorship of Angel City Football Club. Mr. Baackes responded that additional information would be provided.	
• Government Affairs Update	Cherie Compartore, *Senior Director, Government Affairs*, reported: • The US House of Representatives passed a package of six pieces of legislation on March 6, and one of those does concern some health related items. The deadline for this part of the continuing resolution expires March 8 at midnight. A continuing resolution was passed in the House and it appears that the Senate will also pass the continuing resolution, funding the government through 2024. • The reconciliation package includes impacts to Health and Human Services with a deadline of March 22 for passage. Last year, a 3.34% physician payment reduction was proposed for Medicare providers and was implemented on January 1, 2024. The legislation expected to pass contains a prospective rate cut that will actually be 1.69%. It will increase funding for the Women, Infants and Children (WIC) by $1 billion with total funding at $7 billion under the Federal Drug Administration. There is additional funding for community health centers. A Disproportionate Share Hospital (DSH) cut in funding will be delayed until January 2025. • In California, Proposition 1 on the March 5 ballot contains changes in mental health services; the vote is at nearly a 50-50 split now, too close to call. The Secretary of State has until April 12 to finalize the vote. It will likely be a couple of weeks before results are announced. Earlier today, Ms. Compartore checked on past failed ballot initiatives that	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	were placed on a subsequent ballot and found that there is no will among legislators to do that. Board member De La Torre noted that there are two bond measures on the November ballot, so Proposition 1 probably would not be added to the November ballot if it fails. • The deadline for submitting bills has passed, and L.A. Care staff is monitoring over 150 state bills. When the content of spot bills becomes clear, there will be fewer bills. The Legislature is at the end of a two-year cycle and some bills remain from last year. • Staff will report on some of the bills at the Board's May meeting. • California's Legislative Analyst Office projects the state budget deficit is $73 billion, which is significantly more than projected in January and a far cry from the Governor's estimated budget deficit. That is not stopping the Legislature from entering and passing spending bills. • Budget hearings are at a high level at this point, and no action will be taken until after the Governor's May Budget Revise is released. • There is going to be a hearing on Monday regarding hospital financing and closures, and maternity board issues. L.A. Care will not be on the panel. Trade association representatives from Local Health Plans of California and the California Association of Health Plans will be on the panel, as well as representatives for individual hospitals. • The Assembly Budget Subcommittee held a high-level hearing on the MCO tax last week. The hearing went through the information and heard public comment. Hearings will continue on hospitals as well as MCO tax issues. Board Member Booth asked about AB815, credentialing of providers. It suggests making private and public entities, instead of the health plans, responsible for credentialing. It appears to be another carve-out that has been tried before. The intent is to have a central credentialing system. It sounds great in concept but in practice it is more difficult because of the variation among providers. Staff will continue to monitor this. Joanne Campbell, *Health Care Policy Specialist*, commented that amendments are expected on this bill, which currently seems to be a spot bill. Board Member Booth asked about AB2200, Guaranteed Health Care for All. Ms. Compartore responded that bill is not expected to progress due to a lack of funding.	
CHIEF MEDICAL OFFICER	Dr. Amin presented a health services retrospective overview of 2023, reviewing six items (*a copy of his presentation can be obtained by contacting Board Services*): • Redesigning the Health Services department • Enhancing employee engagement	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• Accelerating operational excellence • Reaching strategic milestones • Strengthening relationships with regulators. • 2024 focus areas Health services has been redesigned with a new organizational framework that: • Creates a robust Medical Management vertical by absorbing Utilization Management (UM) and Care Management (CM) into Health Services that includes informatics, accreditation, practice transformation and facility site review. • Pharmacy is a third department • Community health is a new department with a whole person care approach to manage our member behavioral and social health needs, bringing housing and community support services under one vertical. • Forms a new leadership and strategy team and fills it with new and existing top-talent. The new structure 1. Empowers staff to take responsibility and draws clearer lines of accountability to reduce wasted time and effort 2. Fosters partnership between the clinical and operational experts within functional areas 3. Promotes cross-functional collaboration across the department and with external business units 4. Reinforces communication and transparency through a refined cadence of internal leadership meetings After the redesign was done, health services includes • 738 total FTEs, about 31% of L.A. Care's total employee base • $126 million dollar budget, which is about 23% of total budget • 18 health services cost centers. Enhancing Employee Engagement • Achieved a 4.22/5 in Employee Engagement Indicator Score • Measuring intent to stay, willingness to recommend, and overall pride and satisfaction in the organization • +0.13 over the overall organizational score • +0.04 over the National Corporate Healthcare Average • A vast majority of HS staff are engaged or highly engaged • Leaders are effective at driving trust, productivity and improvement; teams are equipped to take accountability, execute on responsibilities, and support improvement efforts	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN

Accelerating Operational Excellence

- 33% improvement in our urgent hospital care decisions
- 60% faster than regular regulatory timelines by the end of 2023
- 80% faster in terms of the decisions for our skilled nursing facility (SNF) referrals

Overall performance measures above 95% for Medi-Cal, L.A. Care Covered (LACC) and the In-Home Supportive Services Workers healthcare coverage through PASC. For L.A. Care's Direct Network only (Medi-Cal): 20/20 measures above 95%. For the Dual Special Needs Plan (DSNP):

- Two measures at 100%; and two measures at 99%
- Two measures above 90% (93.6% and 91.8%, both of which improved from November to December)

L.A. Care has expanded UM and CM auditing, training, and quality assurance, vastly improving performance and are meeting goals in over 100 measured categories including appeals adjudication and notification letters.

Reaching Strategic Milestones

	Challenge	Solution
IT Systems	Unstable partnership with IT vendor UpHealth contributed to 2021 DMHC Enforcement Action and hindered critical system improvements	• Revamped UpHealth relationship for 2023 SyntraNet compliance enhancements. • Developed long-term UM solution, transitioning to QNXT by 2024.
Field Medicine	Unhoused in LA struggle accessing care due to fragmented services, uneven provider distribution, and limited street medicine.	• Created a county-wide field medicine program. • Operational framework for service coordination among providers. • Member-focused infrastructure supporting City and County flagship programs and housing initiatives.
Inpatient UM	High volume of UM cases needing additional resources. High #'s of difficult to place patients seeking lower levels of care. SNF contracts offered insufficient incentives to accept complex patients.	• Increased UM staff by 40% and CM staff by 60%, while adding auditing and training processes, and a focus on inpatient care. • Introduced tiered SNF rates for complex members and a SNF P4P, facilitating timely hospital discharge.
Provider Quality	High PQI referral volumes and labor-intensive processes, reliant on challenging medical record retrieval, caused a compliance-affecting backlog.	• Revamped multidisciplinary A&G-UM-PQI process • Increased staffing for case closure support • Strengthened monitoring of case aging and risk • Achieved 99% compliance for timely closure in Q1, a 14% increase from last year

Dr. Amin showed details of L.A. Care achievements in the CalAIM programs. There are 18,692 L.A. Care members receiving CalAIM community support (CS) services. L.A. Care provided over $80.9 million in community support services over the past year and the CS programs will be fully implemented by July 2024. There are 35,000 L.A. Care members who received

APPROVED

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	enhanced care management (ECM) services. L.A. Care has 75 contracted ECM providers. L.A. Care is the leader in implementing CalAIM programs. Earlier during this meeting, there was discussion about housing and the homeless population, or unhoused population. In housing navigation and tenancy support services, L.A. Care has served 14,939 members, has given out 276 housing deposits, which average over $2,000 each. Strengthening Relationships with Regulators • L.A. Care achieved "Accredited" health plan status for Medicaid, Medicare and LACC lines of business; and predicts a 94% assessment score, meeting the 80% minimum pass threshold for Health Equity Accreditation • Health Services leadership worked collaboratively with DHCS to promote the adoption of a new, accurate methodology, effectively shifting default member enrollment rates from 52% to 64% and maintaining a competitive market share in Los Angeles County. • We clarified transitional care services (TCS) requirements with DHCS, leading to revisions of the Population Health Management Policy Guide. Health plans no longer need to fulfill all TCS requirements directly but can coordinate with discharging facilities. We also standardized the rule for addressing TCS Low Risk Members through a centralized TCS phone number, instead of individually assigning care managers. In line with 2024 guidance, LAC launched a new TCS Central Line for referrals from any member experiencing a care transition, including low-risk members seeking extra support. Planning for the near term with a focus in 2024 • Compliance: ensure regulatory audit engagement and minimize future operational findings, applying best practices in project management and process improvement to implement corrective action plans and streamline cross-functional collaboration to achieve common goals. • Delegation oversight: collaborating closely with Delegation Oversight to enhance delegate reporting, scorecards, and feedback mechanisms to improve communication with delegates. We are also conducting Quality Improvement meetings for both the direct network and PPGs, implementing a new process for Over/Under Utilization, and enhancing communication regarding available Plan resources. • Information technology: advancing technology to enhance operational performance by transitioning UM from Syntranet to Cognizant, developing a new provider portal, creating a PQI platform, and upgrading the case management platform. Board Member Booth commented that in redesigning health services, there should specifically be arrows to Compliance and IT. Dr. Amin responded that staff has close connections with all other departments, including IT, Compliance and Finance. There are frequent meetings. Board Member Booth noted that his report made her very proud to be on the Board.	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Board Member De La Torre asked about an update on field medicine. Dr. Amin noted that the Agenda includes an item that was carried over from the last meeting, and he will provide an update on field medicine. Board Member De La Torre commented on the field medicine effort in Montebello, where there is a tiny home complex for transitional housing. Most of the people in that transition housing have been there over a year, and that is not transitional. Those individuals need services. L.A. Care collaborated with the provider in the tiny home complex, and they are launching an initiative to work with those members, get them the services they need and once they are stable, get them into permanent supportive housing or permanent housing. That is a unique model that can be replicated in other places. He acknowledged this is a promising path to help folks stuck in transitional housing. Dr. Amin thanked him and reported that the field medicine program is a much larger program. He highlighted three elements: 1. At the Montebello tiny homes, L.A. Care is sending social workers out to help unhoused member or members in temporary housing, to make sure they are getting ECM and CS services and are enrolled in Medicaid. This is being done for L.A. Care members residing in temporary housing in hotels through Los Angeles Homeless Services Authority (LAHSA). 2. L.A. Care started sending assistance for the first time earlier this week. It was a huge achievement to enroll people for the right services, including housing deposits, ensuring that they are on a pathway to permanent housing and intense case management resources. 3. L.A. Care is working with the care collaborative on skid row, to make sure that we are having allies working together to deliver resources. L.A. Care is planning to make a significant financial contribution to that project that is moving along quite well. Chairperson Ballesteros appreciates the staff Health Services division Charles Robinson and Michael Brodsky. Dr. Amin noted that Mr. Robinson and Dr. Brodsky are leaders of the Community Health department in Health Services. Chairperson Ballesteros noted that they have invested a lot of time to understand the needs downtown, to understand the needs in the new Los Angeles County Department of Health Services (DHS) project on Crocker Street and the collective efforts of other organizations working in the area. Chairperson Ballesteros expressed his appreciation for the time invested. Dr. Amin will inform them about those kind words. Dr. Amin noted that he has emphasized that staff learns about members. He has encouraged team members to visit the community resource centers, go to skid row and walk the streets, go into the clinics and meet L.A. Care members and talk to them to see what their needs are. He credited staff that has been doing that, and it is one of the key cultural elements in health services. Supervisor Solis thanked Dr. Amin for the presentation. She is excited about all the things that are being done with CalAIM funding. She knows L.A. Care is working closely with DHS and	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Los Angeles County Department of Mental Health (DMH). She is interested in street medicine, not just at the Crocker Center that Los Angeles County is going to be transposing, she looks forward to seeing more support there and collaboration with all of our partners. She noted the restorative care village concept and the program ongoing at LA General Hospital and programs that are coming up for the unhoused treatment and recuperative care beds. She is wondering what else can be done to utilize CalAIM funds to help with the recuperative beds that are being created, as well as subacute beds, and trying to figure out how to more cooperatively enhance services there. That is something that is missing and could help get people who become self-sufficient to step down to other housing, jobs and assistance for rentals, so they can leave the more intensive facilities and go to a permanent setting. Dr. Amin noted L.A. Care has the ability to support these programs through CalAIM and he highlighted other programs in line to contribute to the system. 1. Short term post-hospitalization housing will come online at L.A. Care in July 2024. In initial conversations with Mr. Baackes, to his credit, he decided it was a moral obligation to develop programs for all community supports elements. L.A. Care implemented every community support program in CalAIM. Short-term post hospitalization housing provides services to get people into temporary housing, particularly after a hospital visit. 2. There is also recuperative care, and L.A. Care has served about 2000 members, and provided about 37,000 days in recuperative care beds. L.A. Care would be happy to increase that number, and the number is increasing each month. That is part of the $81 million dollars used to support these services. L.A. Care plans to continue to support these programs. Supervisor Solis spoke about an initiative that Los Angeles County and L.A. Care are working on, as well around the Justice Involved Initiative (JI) proposed by DHCS, a prerelease initiative intended to provide incarcerated individuals with medical coverage for 90 days before release from jails. Dr. Amin noted that this is a complicated program because there are data gaps, but L.A. Care is involved. Board Member Ghaly thanked Supervisor Solis for raising this topic. This complicated program has a broader mandated scope by DHCS than what Counties initially anticipated. The JI program was envisioned as a transition from whole person care. DHS, DMH, Los Angeles County Department of Public Health (DPH) and likely probation and sheriff departments are struggling with how to implement JI within the broad scope that is now mandated to be implemented by the County. There is uncertainty about the timeline for implementation and the funding path for the broad set of services and supports for JI. To name one of multiple problems with the program, no rates have been released by DHCS despite an implementation plan now due in three weeks. It is impossible to develop any sort of an implementation plan for	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	a program for which we do not know the funding. DHS appreciates the collaboration with L.A. Care and other health plans on this. It is not clear among other partners in the County, which are really struggling with this right now, what a pathway to implementation may look like. Dr. Amin responded that DHCS has been at L.A. Care for the last three days in conversations around the ECM, CS and transitions of care. This is one point that he brought up in those meetings, and L.A. Care discussed it with the statewide trade association. It is a major issue, and the program will be very hard to implement without understanding the funding streams. Another area of concern is the expansive view of the potential population. He does not know that the program could be implemented as proposed. Dr. Ghaly thinks that originally it was anticipated that the 90-day prerelease was going to provide an additional revenue source for services that were already being supplied in the jail, and would replace the whole person care revenue and sustain those services. However, it is clear that the scope of services is much broader than those that existed in the whole person care program. This is a fundamental disconnect, as we have seen in CS programs. DHS is struggling on the sustainability of ECM and trying to cover costs, given some of the rules. She asked if L.A. Care has heard from other providers, or if you feel like you have a stable network for ECM. CS is a different topic. She thanked L.A. Care for the partnership on homelessness and support for the Crocker project. DHS is grateful for the support that L.A. Care has provided to help get the Crocker project off the ground on Skid Row. For those not familiar with the project, it is part of DHS' Skid Row Action Plan to bring a host of supportive services to the community. There is so much potential, and so much engagement among residents of Skid Row and residents want to build it up as a place that can support their lives, livelihoods, health and wellness. Regarding ECM, Dr. Amin noted there was a lengthy conversation specifically around payments regarding ECM in the lobby during closed session. L.A. Care is working through the issues with its provider network and will gather more information. There is a lot of regulatory pressure for L.A. Care to expand the population receiving ECM services. That is a great idea, but ECM is supposed to be a very intense service for the sickest of the sick. There is an expansion of the number of people receiving services. Providers need to be supported financially to care for a huge influx of members. At the same time, L.A. Care is receiving signals that the finances will be more tightly controlled by DHCS. L.A. Care is working to develop a financial model that will allow both those diametrically opposite things. Dr. Amin noted that as part of developing tighter regulatory relationships, he actually went up to the chief medical officer of DHCS and asked her to meet with providers in person to have a conversation about the struggle and the conflicting signals on ECM and she committed to return for that. We hope to schedule that soon.	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Mr. Baackes noted that L.A. Care's 75 ECM providers are not equal in ability to provide services. DHCS wants the program to grow faster. Half of the ECM cases in the state are L.A. Care members. DHCS wants services to be more intensive and face-to-face. Many providers were serving members with a phone call. L.A. Care needs to encourage providers to do more intense work, which will require more resources than a phone call. L.A. Care is developing a reimbursement model to incentivize providers to provide more intense contact, within the funding provided by DHCS. Dr. Amin agreed that DHCS asks for more intense care from licensed individuals, meaning less community health workers (CHWs) and more licensed nurses (RNs) and doctors in that program. DHCS wants fewer phone calls and more in-person care. DHCS also wants the program to expand dramatically, although L.A. Care provides care for more than half of the states Medi-Cal members in ECM. It is anticipated that DHCS will cut rates. Not all of those things line up into a sensible plan. Dr. Ghaly agrees and DHS has struggled with some of that. The DHCS expectations fly in the face of other messaging or pressure that comes from the state regulators. DHS believes the providers are well-intentioned in shifting toward the use of less licensed staff, a licensed individual is not always needed to perform services for patients; CHWs, Promotoras and other unlicensed staff could be effective. That is not the direction from DHCS. Providers will be able to use CHWs and Promotoras less, despite conversations with some of the same people about a desire to use CHWs and Promotoras more. The model does not support that. The face-to-face services become another challenge. There are fewer individuals actually signing up than might be eligible for ECM and are willing to be part of the program. It is a challenge to get people to understand and engage. Many hours of time from providers and teams go into enrollment. Medical homes try to conduct outreach and engagement with members, but reimbursement is not associated with the outreach and engagement effort. That is where a huge portion of losses is. Dr. Amin noted that L.A. Care had that discussion too, and stated it would like to be able to pay providers an administrative rate for engagement and outreach costs in order to enroll more people. DHCS has not provided the ability to do that. L.A. Care has asked for a code to be able to provide reimbursement and was given a code that was relatively useless. It is a challenge. Mr. Baackes stated that this is an area where collaboration would be very important, particularly with the federally qualified health centers (FQHCs) and community clinics that are ECM providers. He suggested a joint team to describe for DHCS what providers are asking for. If DHCS wants more licensed clinicians, there will be entities competing with providers to hire those licensed individuals. Regulators need to recognize that the CHWs should be considered clinical providers so their services can be counted as an intervention.	

APPROVED

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Dr. Ghaly worries about L.A. Care's ability to maintain a network. DHS is not unique in not being able to continue as a provider because of financial concerns, and DHS can take a loss on it for a while because it is in the best interest of patients. At some point, DHS will not be able to continue operating the program at a loss. If other providers are experiencing something similar and cannot continue to participate there will be a smaller network. Dr. Amin stated that L.A. Care would engage with providers before making any big changes to the financial model. It will be a partnership between Health Services and Finance departments to make sure that L.A. Care does it in the right way. The conversation is ongoing and it is going to be tough. Finance is getting a completely different answer from DHCS than what Dr. Ghaly and he are getting. DHCS actuaries are saying the payments to health plans include using licensed providers for ECM. Mr. Shah reported that the capitated rates division and Mercer actuaries at DHCS have communicated that payment needs to be related to encounters per member per month (PMPM) or encounters per member per year (PMPY). An example of paying rates per utilizer per month (PUPM) is that if there was a $400 dollar PUPM and the member has only one visit for 15 minutes or a phone call, DHCS would not consider that an ECM service for the member. L.A. Care will work to align a model with feedback received from the provider community. Board Member Ghaly thanked L.A. Care for implementing a post-short term hospitalization community support. DHS advocated for this. She would like a presentation with information about how acute care providers can use eligible unlicensed lower levels of care and move non-acute patients out of the hospital. There is a list of different services, such as Medi-Cal Managed Long-Term Services & Supports (MLTSS) or short-term hospitalization or recuperative care, which have overlapping eligibility, rules and regulations, and it can be confusing to determine where there are gaps or opportunities. When the program goes live in July it would help to outline ways that providers can maximize the benefits for patients at the appropriate level of care. Dr. Amin responded that a presentation would be done, and he has spoken with L.A. Care's community health department. It is a great idea to target information for acute care facilities. There will be a menu of step down options for discharged unhoused members. L.A. Care is committed to getting the short term housing post-hospitalization community supports benefit online, and it will be a significant cost for the health plan. L.A. Care is discussing the funding with DHCS, and will continue to advocate for the benefit. DHCS has not provided clarity on the benefit. Mr. Baackes commented regarding the ability to maintain a provider network. He advocates for L.A. Care to do some of this work in house, because there is a tremendous amount of administrative time and money spent in recruiting, monitoring and assisting the small community based organizations (CBOs) in becoming a contractor. L.A. Care has enough	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	overhead and could absorb more of that cost than they can. DHCS has said L.A. Care must use CBOs and cannot bring services in-house. L.A. Care would love to have DHS support in advocating for internal services. Dr. Amin added that he also spoke with DHCS, and although he thought the negotiation went well, the final response from DHCS was No. He responded to DHCS that another local health plan had gotten an authorization to do a pilot program, and DHCS shut down the pilot program. If health plans and providers work together, it could yet become a possibility. Board Member Contreras echoed Dr. Booth's earlier comments. The focus on progress in Health Services is very impressive, and she thanked Dr. Amin. She asked about the 4.22 out of 5 on employee engagement that Dr. Amin said was better than the organization as a whole, what's the rating for the organization as a whole. Dr. Amin responded that the organization as a whole was 4.13, and he noted the significance of every decimal. Dr. Contreras commented that a vast majority of children and youth in the child welfare system are in fee for service (FFS) Medi-Cal. Los Angeles County Department of Public and Social Services (DPSS) and child welfare have received information around the potential for CalAIM benefits. She asked if there have been conversations with Los Angeles County Department of Child and Family Services (DFCS) in that regard for beneficiaries in out of home care, the vast majority of whom are enrolled in FFS Medi-Cal. She noted that decision was made years ago to offer flexibility in medical services for children coming in and out of care or changing residence. She thinks the environment has changed. She is wondering if there have been conversations with DCFS about CalAIM benefits. Alex Li, *Chief Health Equity Officer*, responded that L.A. Care recently hosted a round table attended by DCFS and DPSS staff and other participants. This is a conundrum around whether the children should be in managed care or FFS. He noted that foster youth was given an option to have the children enrolled in FFS in part because their residence changes. In a managed care model, the children could be too far away from the providers and services network. The group is trying to figure out the next best step to signal to the community. Dr. Contreras commented that it has come up in that space because in talking about individuals who are higher need, and need more intensive services, that population always comes up. Dr. Li noted there are disadvantages in not being able to benefit from DHS services as well.	
ADVISORY COMMITTEE REPORT		
Executive Community Advisory Committee (ECAC)	**PUBLIC COMMENT** *Andria McFerson when she first became a chair of ECAC she filed a motion. The motion basically stated housing and other homeless solutions, and that shelters should have standards and better housing opportunities. These certain reasonable and important things should be a part of every single shelter. And with that, she said that definitely she would still*	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	be in her car if she did not speak up and speak out. The board of supervisor at that particular point in time, heard her and bettered the services in Santa Monica. She came up with a motion. Basically she has seen many different situations, but overall homeless people need to find a housing program that will help keep them housed, because there are a lot of homeless people that have received housing, but are back now on the street because they were misunderstood. If a program specifically has a mental evaluation from a medical professional, a psychiatrist, psychologist, whatever the case may be. If they are evaluated mentally to see their life and their capabilities, then put them in a program. That program should adhere to their necessities and what they are capable of doing. That was her motion. It was almost as if that whole program could not only help house them. It would house the developmentally delayed and receive services while they are housed to make sure that they pay bills and pay their rent, keep their house together and themselves. Everyone does not have family. Then, she said that if there are people who lost their job they can have training, CNA training, forklift training, anything having to do with training for people who may not be educated enough to finish college. And also people who are domestic violence victims, molestation victims, and all kinds of different things like that to have support for them in one tier. First the mental evaluation, second the housing according to their own necessities. Then you have the program that best suits them, and then housing. Housing would be a great opportunity if it adhered to that person and what they are capable of doing. Also, of course, you can have training, job training, that they are capable of doing. Sometimes people do not have family and some people have mental disparities that keep them from their own capabilities. She had a motion. Francisco Oaxaca, she is talked about him before, he basically said for 20 minutes, how it was a bad idea, and people should just call 211. But with that, please understand that they do have great ways of giving back to the community and great ideas for the Board. *Joyce Sales doesn't know when the opportunity for questions come, that's why she asserts herself. It is all very confusing. Dr. Amin's presentation was extremely well put together, quite informational, but speaking for herself, not being in the medical industry using the acronyms misses the mark with her as a layman. She came in contact, not more than maybe about three days ago with a woman, single parent of 3 or 4 year old twins. She is on the verge of losing her housing and she knows that Ms. Sales is a community advocate. She came to Ms. Sales asking about financial support in getting her kids another home. Dr. Amin mentioned the $2000 financial housing deposits. Ms. Sales asked if one has to be an L.A. Care member and how can Ms. Sales get information to her to see if she qualifies for the help that she needs.* Dr. Amin noted he is happy to define acronyms that may have been in his report and he apologized for not making it more layperson friendly. He offered to speak with Ms. Sales outside of the Board meeting *(Board Member Ghaly left the meeting.)*	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Board Member Fatima Vazquez, *Consumer Representative*, reported that TTECAC met on February 14, 2024. She thanked members that attended the TTECAC in person and to those present today: 1. Elizabeth Cooper (R2) 2. Ana Rodriguez (R2) 3. Silvia Poz (R4) 4. Joyce Sales (R6) 5. Ana Romo (R8) 6. Deaka McClain (R9) 7. Damares O Hernandez de Cordero (R10) • Mr. Ballesteros attended TTECAC as a Special Guest. He talked about the importance of the Board's connection with the members and the public and recognized the unique aspect of RCAC member involvement at L.A. Care. He apologized for the long closed session at the Board meeting. He assured members that future meetings would strictly adhere to the posted agenda time. He shared his personal involvement with a nonprofit health organization serving L.A. Care members, the under- and un-insured. He shares a background with other board members, and he emphasized the valuable perspectives they bring to their role. He spoke about his belief that L.A. Care provides opportunities for meeting the needs of members and Los Angeles County residents. Mr. Ballesteros expressed a commitment to integrating community ideas, suggestions, and issues into board-level discussions and stressed the importance of community involvement to improve services for members. He committed to engaging with the community and dedicating time to listen to and support their needs. • Mr. Baackes provided an update to ECAC members, highlighting progress in Medi-Cal eligibility redetermination and support for individuals during the process. He announced initiation of a $450,000 accessibility equipment fund to supply clinics with tables and scales for individuals with disabilities, expected to launch by month-end. Addressing member concerns about changes to RCACs under a new state contract, he outlined a comprehensive engagement plan with presentations, getting member feedback, and consideration of recommendations to ensure stakeholder input in decisions, despite a potential delay in meeting the state's deadline. • Dr. Amin gave an update on COVID-19. He spoke about the importance of booster shots and highlighted a surge in cases between November and December 2023, followed by a gradual decrease in infection rates in January and February. He noted L.A. Care's health education efforts and the integration of COVID-19 information into L.A. Care's flu campaign across various platforms, including community resource centers.	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• Mr. Oaxaca provided an update on the scheduling of RCAC meetings through March and April. These meetings will be held primarily at local community resource centers, with an aim to engage members and their representatives. • Rudy Martinez led TTECAC on L.A. Care's Emergency Preparedness Training. Board Member Vazquez reported that ECAC members were happy to have Mr. Ballesteros at the meeting, and members appreciate how he started and everything he has done for the community. He was invited to come back at a future meeting. Chairperson Ballesteros allowed additional public comment. **PUBLIC COMMENT** *Andria McFerson attended a RCAC meeting and it was uneventful just due to the fact that they were told that the funding that they had or that the state is mandating the new rules that they have as RCAC members. And they were told that focus groups are better and the RCACs would be better with a smaller population. She does not think that that's okay, to be told that each RCAC meeting needs Brown Act, Robert's Rules of Order, and they were being told that the changes were going to happen. So with that, she thinks that they need to be able to vote on things. They need to be able to make sure that they have a right to speak up and speak out. And then, the Agendas are premade. They are not made by the public, they are not made by the RCAC members and that's kind of frustrating. Just due to the fact that you feel as though you are going there just to sit down and listen to Francisco Oaxaca. She does not know why he is still here. He needs to be able to go to another department that is not Outreach and Engagement, because they are doing the opposite. They do not need any segregation, they need to stay together. With that she knows she sounds redundant. But it is worth more to her and to the people that she speaks to about how they need to voice their disparities. And there was someone there and she didn't understand why she couldn't speak up and speak out. She felt horrible. But with that, that's how we help save people's lives. Doing things like that. But neither here nor there, she even had someone talk about whistleblowing, because they have a budget and for years now they have not used that budget. She asked where is that budget for the fiscal year. It is hard for her to speak about it but she participates as a stakeholder for a major county stakeholder group. And they use their budget to outreach and to do necessary stuff and not just look like they're on the outside looking in. They are on the inside looking out, helping people. And she thinks that needs to be evaluated. Where is our budget before the end of the fiscal year.* Mr. Baackes stated that he went to the RCAC 5 meeting on Monday and presented the plan to be compliant with the state. He introduced concepts for the RCAC members to consider. Mr. Oaxaca only participated by answering questions in Spanish, since Mr. Baackes is not fluent in	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Spanish. He offered to share the presentation with the Board at another time, as this meeting is running late.	
BOARD COMMITTEE REPORTS		
Executive Committee	Chairperson Ballesteros reported that the Executive committee met on February 28, 2024 (*approved minutes can be obtained by contacting Board Services and will be available on the L.A. Care website).*	
Finance & Budget Committee	**PUBLIC COMMENT** *Andria McFerson stated she wants to be compliant. Definitely. And with that, she just wants to follow proper protocol. She does not want to seem as though she is being defiant or confrontational. She just want to make sure that we use the funding for the stakeholder groups properly. And so that they can have a voice, legally, and all the different things that are back us up as stakeholders to make it so that they can have RCAC meetings. They had two months of RCAC meetings, that is it. So, with that being said, are there any other RCAC meetings throughout the year? Will they be smaller, or still have 11 RCACs or whatever the case may be, or will there be a smaller number of people. Why ca not they have focus and RCAC at the same time?* Mr. Baackes responded that as was stated the meeting last Monday for RCAC 5, and was repeated at other meetings, the budget allocation for each RCAC that was not spent during the pandemic has accumulated. RCAC members will decide how to spend that money in their regions when RCACs resume a regular schedule. It was explained that once the realignment process is completed and compliant with the new state contract, there would be a regular schedule of RCAC meetings. Board Treasurer Booth reported that the Committee met on February 28, 2024 (*approved minutes can be obtained by contacting Board Services).* The Committee reviewed and approved motions for Broadcom (VMware) Contract to provide product support services and Toney Healthcare Consulting Contract for Utilization Management Services. These motions do not require full Board approval.	
Chief Financial Officer Report	Mr. Shah reported on the December 2023 Financial Performance reports *(a copy of the report can be obtained by contacting Board Services).* The reports include results for the month of December and for December year to date, which is combined information for October, November and December Overall, L.A. Care is 2000 members under budget, which is less than 0.01% variance. He noted that earlier Mr. Baackes presented membership for 2024, but these numbers are as of December 2023. A drop in membership is expected, driven primarily by removing the Kaiser members. There will be a smaller increase in enrollment for the expansion of Medi-Cal to undocumented adults ages 26 to 49.	

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AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	For the month of December, L.A. Care has a $52.8 million net surplus, which is $31 million favorable to budget forecast. Healthcare cost are favorable, driven by incurred claims, which were favorable by $25 million. Results for three months ended December 2023 show an overall net surplus of $212 million, and $153 million favorable to the budget. There was $53 million net surplus for December 2023, when funds for Housing and Homelessness Incentive Program (HHIP) and Incentive Payment Program (IPP) were excluded. Results for medical care ratios (MCR) by line of business include Medi-Cal performing better than budget by 300 basis points, primarily due to favorable 2023 rates. DSNP and LACC show favorability but these MCRs are expected to increase. There will be a breakeven for LACC because of high administrative expense driven partly by commissions. Administrative expense is the high 77-78 range, for DSNP and Medi-Cal, the percentages are much higher, and the overall performance at 89.1% is about 4 percentage points better than budgeted. The only ratio that is higher than budget is administrative expense ratio, driven by a variety of factors including the hiring rate, adding a new employees faster and at higher cost than what was anticipated in the budget. Drivers of administrative expense will be discussed in the coming months. Staff will monitor the administrative expense ratio and look carefully at the administrative expenses by the various departments. The tangible net equity continues to build due to strong surplus positions and is now at 834% of required TNE, and there are 92 days' cash on hand. **<u>Motion FIN 105.0324</u>** **To accept the Financial Reports for December 2023, as submitted.**	**Unanimously approved by roll call. 9 AYES (Ballesteros, Booth, Contreras, DeLaTorre, Raffoul, Roybal, Solis, Vaccaro and Vazquez)**
• Monthly Investments Transactions Report	Mr. Shah referred to the investment transactions reports included in the meeting materials (a *copy of the reports can be obtained by contacting Board Services).* This report is provided to comply with the California Government Code and is presented as an informational item. L.A. Care's total investment market value as of December 31, 2023 was $3.4 billion. • $3.3 billion managed by Payden & Rygel and New England Asset Management (NEAM) • $35 million in Local Agency Investment Fund • $79 million in Los Angeles County Pooled Investment Fund	
Compliance & Quality Committee	**PUBLIC COMMENT** *Andria McFerson referred to her written comment regarding legal Title 11 section 312.1 and Chapter 15, section 999.5 of Government Code. Just basically, if a person or entity subject to the supervision of trustees and fundraisers, and for charitable purposes, submit false misleading information or fail Provide required information it's not okay. She thinks that*	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	John Baackes is doing a great job, but under him, as far as outreach and engagement goes, I think we need to do better. Committee Chairperson Booth reported that the Compliance & Quality Committee met on February 15. Approved meeting minutes from the January meeting can be obtained by contacting Board Services and are also available on L.A. Care's website. Mr. Gower and the Compliance Department presented the Chief Compliance Officer report. The report provided an overview of the compliance activities including the 2023 year in review, 2024 compliance work plan, training updates, delegation oversight, and auditing. The report outlined changes in the compliance structure, including a reconstitution of enterprise process optimization as well as the separation of internal audit from compliance. There is an excellent written report, 2023 year-end review that describes the functions of compliance departments very thoroughly. She invited interested Board members to read that. The report emphasized a focus on stabilizing and maturing compliance processes, especially Medicare awareness and delegation oversight in 2024. The committee approved the 2024 Compliance Work Plan. Dr. Amin presented the Chief Medical Officer report. He gave an overview of quality initiatives related to compliance along with the caps that were working on in their programs provider, quality review and regarding case timeliness issues, and how the whole grievances and appeals and potential quality issues process has been improved markedly. We also reviewed the new DHCS policies and the financial risks inherently associated with them. We heard updates on the DHCS and DMHC audit findings (DMHCfindings included both the local initiative and JPA). Details are in the C&Q meeting packet. Dr. Li gave a Quality Improvement Health Equity Committee (QIHEC) Update. The committee is part of the new 2024 DHCS and California Managed Care Plan Contracts and reports to the Board or its appropriate delegate. • The committee held the first meeting and approved a charter on November 1, 2023. • The committee is not only oriented to quality, but it is also oriented to the 2023-25 L.A. Care Health Equity and Disparities Mitigation Plan. For example, the committee will work to identify opportunities to address disparities by stratifying L.A. Care's performance measures and other key reports by race/ethnicity and geography	
Provider Relations Advisory Committee	*The report was postponed to the April Board meeting.*	

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ADJOURN TO CLOSED SESSION	The Joint Powers Authority Board of Directors meeting adjourned at 4:35 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 4:35 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: *March 2026* THREAT TO PUBLIC SERVICES OR FACILITIES Government Code Section 54957 Consultation with: Tom MacDougall, *Chief Technology and Information* CONTRACT RATES Pursuant to Welfare and Institutions Code Section 14087.38(m) • Plan Partner Rates • Provider Rates • DHCS Rates CONFERENCE WITH LEGAL COUNSEL—ANTICIPATED LITIGATION Significant exposure to litigation pursuant to Section 54956.9(d)(2) of Ralph M. Brown Act: Four Potential Cases CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION Pursuant to Section 54956.9(d)(1) of the Ralph M. Brown Act L.A. Care Health Plan's Notice of Contract Dispute under Contract No. 04-36069 Department of Health Care Services (Case No. Unavailable) CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION Pursuant to Section 54956.9(d)(1) of the Ralph M. Brown Act • Department of Managed Health Care Enforcement Matter Numbers: 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: CEO Agency Designated Representative: Alvaro Ballesteros, MBA Unrepresented Employee: John Baackes	

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AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION Pursuant to Section 54956.9(d)(1) of the Ralph M. Brown Act 10) *Glendale Adventist Medical Center dba Adventist Health Glendale v. Local Initiative Health Authority for Los Angeles County dba L.A. Care Health Plan,* JAMS 1220072832; 11) *Glendale Adventist Medical Center dba Adventist Health Glendale and White Memorial Center dba Adventist Health White Memorial v. Local Initiative Health Authority for Los Angeles County dba L.A. Care Health Plan,* JAMS 1220074035; 12) *Glendale Adventist Medical Center dba Adventist Health Glendale v. Local Initiative Health Authority for Los Angeles County dba L.A. Care Health Plan,* JAMS 1220074776; 13) *Glendale Adventist Medical Center dba Adventist Health Glendale and White Memorial Center dba Adventist Health White Memorial v. Local Initiative Health Authority for Los Angeles County dba L.A. Care Health Plan,* JAMS 1220075383; 14) *White Memorial Center dba Adventist Health White Memorial v. Local Initiative Health Authority for Los Angeles County dba L.A. Care Health Plan,* JAMS 1220072839; 15) *White Memorial Center dba Adventist Health White Memorial v. Local Initiative Health Authority for Los Angeles County dba L.A. Care Health Plan,* JAMS 1220072273; 16) *White Memorial Center dba Adventist Health White Memorial v. Local Initiative Health Authority for Los Angeles County dba L.A. Care Health Plan,* JAMS 1220074774; *17) San Joaquin Community Hospital dba Adventist Health Bakersfield; and Simi Valley Hospital and Health Care Services dba Adventist Health Simi Valley Hospital v. L.A. Care Health Plan,* L.A.S.C. case no. 22STCV30779*;* 18) *San Joaquin Community Hospital dba Adventist Health Bakersfield; Simi Valley Hospital and Health Care Services dba Adventist Health Simi Valley Hospital; Adventist Health Medical Center Tehachapi dba Adventist Health Tehachapi Valley; and Hanford Community Hospital dba Adventist Health Hanford v. L.A. Care Health Plan,* L.A.S.C. case no. 23STCV10175.	
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 5:21 pm. There was no report from closed session.	
ADJOURNMENT	The meeting was adjourned at 5:21 pm.	

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

APPROVED BY:
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John Raffoul
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John G. Raffoul, *Board Secretary*
Date Signed 4/5/2024 | 11:19 AM PDT

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