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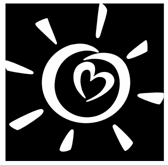

AGENDA
Provider Relations Advisory Committee Meeting
Board of Governors

Wednesday, December 6, 2023, 9:30 A.M.
L.A. Care Health Plan, Conference Room 100, 1st Floor
1055 West 7th Street, Los Angeles, CA 90017

Members of the Committee, 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=ma70d8927143c4c4797a71ce76be944e7

To listen to the meeting via teleconference please dial: +1-213-306-3065
Meeting Number: 2483 869 5941 Password: lacare

Teleconference Site

Hector Flores, MD	**Alice Kuo**	**Richard Ayoub**
1720 E. Cesar Chavez Avenue, Los Angeles, CA 90033	911 Broxton Ave. Los Angeles, CA 90024	922 Vine St, Los Angeles, CA 90038

For those not attending the meeting in person, public comments on Agenda items can be submitted in writing by e-mail to BoardServices@lacare.org, or by sending a text or voicemail to (213) 628-6420. Attendees who log on to lacare.webex using the URL above will be able to use "chat" during the meeting for public comment. You must be logged into WebEx to use the "chat" feature. The log in information is at the top of the meeting Agenda. The chat function will be available during the meeting so public comments can be made live and direct.

1. The "chat" will be available during the public comment periods before each item.
2. To use the "chat" during public comment periods, look at the bottom right of your screen for the icon that has the word, "chat" on it.
3. Click on the chat icon. It will open two small windows.
4. Select "Everyone" in the "To:" window,
5. The chat message must indicate if you wish to be identified or remain anonymous, and must also include the name of the item to which your comment relates.
6. Type your public comment in the box that says "Enter chat message here".
7. When you hit the enter key, your message is sent and everyone can see it.
8. L.A. Care staff will read the chat messages for up to three minutes during public comment so people who are on the phone can hear the comment.

You can also send your public comments by voicemail, email or text. If we receive your comments by 9:30 A.M. on December 6, 2023, it will be provided to the members of the Committee in writing at the beginning of the meeting. The chat message, text, voicemail, or email must indicate if you wish to be identified or remain anonymous, and must include the name of the item to which your comment relates.

Once the meeting has started, public comment submitted in writing must be received before the agenda item is called by the Chair. If your public comment is not related to any of the agenda item topics, it will be read in the general public comment agenda item.

Please note that there may be delay in the digital transmittal of emails, texts and voicemail. The Chair will announce when public comment period is over for each item. If your public comments are not received

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on time for the specific agenda item you want to address, your public comments will be read at the public comment section prior to the board going to closed session.

The purpose of public comment is an opportunity for members of the public to inform the Committee about their views. The Committee appreciates hearing the input as it considers the business on the Agenda. All public comments submitted will be read for up to 3 minutes during the meeting. The process for public comment is evolving and may change at future meetings. We thank you for your patience.

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.

Welcome — George Greene, Esq., *Chair*

1. Approve today's Agenda — *Chair*
2. Public Comment *(Please read instructions above.)* — *Chair*
3. Approve August 1, 2023 Meeting Minutes
4. Chairperson's Report — *Chair*
5. 2024 Meetings Schedule: February 21, May 15, August 21, November 20
6. Chief Executive Officer Report — John Baackes, *Chief Executive Officer*

Committee Issues

7. Discussion of Suggested Additional Member Categories — *Chair*
8. Open Forum

ADJOURNMENT — *Chair*

The next Committee meeting is scheduled on February 21, 2024 at 9:30 AM and 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 PROVIDER RELATIONS ADVISORY COMMITTEE 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.

NOTE: THE COMMITTEE schedule is not yet determined. AGENDA and PRINTED MEETING MATERIALS ARE AVAILABLE FOR INSPECTION AT http://www.lacare.org/about-us/public-meetings/board-meetings and by email request to BoardServices@lacare.org

Any documents distributed to a majority of the Board Members regarding any agenda item for an open session after the agenda has been posted will be available for public inspection at 1055 W. 7th Street, Los Angeles, CA, in the reception area in the main lobby or at http://www.lacare.org/about-us/public-meetings/board-meetings and can be requested by email to BoardServices@lacare.org.

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

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

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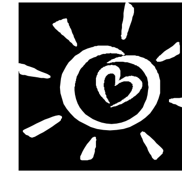
BOARD OF GOVERNORS
Provider Relations Advisory Committee
Meeting Minutes – August 1, 2023
1055 W. 7th Street, Los Angeles, CA 90017



L.A. Care HEALTH PLAN

Members
George Greene, Esq., *Chairperson*
Richard Ayoub
Stephanie Booth, MD
Warren Brodine
Hector Flores, MD **
Sabra Matovsky
Ashkan Moazzez, MD, MPH, FACS, CHCQM
Zahra Movaghar
John Raffoul
Amanda Ruiz, MD *
David Silver, MD
David Topper
Michelle Tyson, MD *
Haig Youredjian

Absent*   * *Via Teleconference*

Management/Staff
John Baackes, *Chief Executive Officer*
Sameer Amin, MD, *Chief Medical Officer*
Terry Brown, *Chief of Human Resources*
Augustavia Haydel, Esq., *General Counsel*
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	George Greene, Esq., *Committee Chairperson*, welcomed everyone and called the L.A. Care and JPA Provider Relations Advisory Committee (PRAC) meetings to order at 1:03 p.m. The meetings were held simultaneously. Chairperson Greene introduced himself. He is the President and Chief Executive Officer of the Hospital Association of Southern California for over 6-1/2 years. Prior to that, he was in the same role as the President and CEO of the Health Care Association of Hawaii for 7-1/2 years and has over 23 year's experience in the health care field. Chairperson Greene expressed his appreciation for the participation of Committee members in the Provider Relations Advisory Committee. He added that he is excited about the work that this committee is going to do. Committee Members and L.A. Care staff introduced themselves. Chairperson Greene summarized the process for public comment during this meeting. • For those who provided public comment for this meeting by voice message or in writing, L.A. Care is glad that they provided input today. The Committee will hear their comments and they also have to finish the business on the Agenda today.	

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	• For people who have access to the internet, the meeting materials are available at the lacare.org website. If anyone needs information about how to locate the meeting materials, they can reach out to L.A. Care staff. • Information for public comment is on the Agenda available on the web site. Staff will read the comment from each person for up to three minutes. • Public comment will be made before the Committee starts to discuss an item. If the comment is not for a specific agenda item, it will be read at the general Public Comment. • Chairperson Greene provided information on how to submit a comment in-person, or live and directly using the "chat" feature.	
APPROVE MEETING AGENDA	The Agenda for today's meeting was approved.	**Approved unanimously by roll call. 11 AYES (Booth, Brodine, Flores, Greene, Matovsky, Moazzez, Movaghar, Raffoul, Silver, Topper, and Youredjian)**
PUBLIC COMMENTS	Chairperson Greene stated that this Committee will work together to provide support and information to L.A. Care and all participants can be part of supporting the beneficiaries of this organization. Fostering collaboration will take a lot of effort by individuals and the organizations represented.	
Approval of Membership	On May 4, 2023, the Board of Governors approved the establishment of the Provider Relations Advisory Committee (PRAC) as an advisory committee to the Board of Governors. The Board directed that PRAC members represent the following provider constituencies, including but not limited to: • Hospitals, Community and Tertiary or Quaternary Facilities • Federally Qualified Health Centers, Community Clinics or Public Clinics • Independent physicians • Independent Practice Associations or similar third party entities • Skilled Nursing Facilities • Transportation Providers	

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	• Durable Medical Equipment Providers • Behavioral Health Providers • Community Based Organization Chairperson Greene noted that the membership of this Committee includes a variety of organizations in the provider community associated with L.A. Care. He invited feedback from Committee members about the membership. L.A. Care staff will regularly participate in the Committee meetings. **<u>Motion PRC 100.0923</u>** **To approve the membership of the Provider Relations Advisory Committee, as submitted.**	**Approved unanimously by roll call. 11 AYES**
CHAIRPERSON'S REPORT	Chairperson Greene expressed his appreciation for the Committee Members' commitment and willingness to participate. Their engagement and dedication have been instrumental in fostering an environment where they can collaboratively address systemic issues and enhance services for the benefit of the valued providers and beneficiaries. He expressed gratitude to L.A. Care for listening to the needs of providers in establishing this Committee. Chairperson Greene thanked L.A. Care Board Member and Los Angeles County Supervisor Hilda Solis, who was instrumental in recommending the establishment of this committee. This Committee demonstrates L.A. Care's commitment to continuously improve the process, foster transparency and enhancing the partnership between L.A. Care and its network providers. L.A. Care has displayed leadership and commitment to listen to the concerns and suggestions of hospitals and providers in the network. It is essential to acknowledge that there are many variables, some of which might have caused tension between L.A. Care and providers in the past. The issues were acknowledged and recognized, presenting opportunities for growth and improvement. With the commitment to transparency, an open dialogue will be vital in unravelling complex issues and finding collaborative solutions. Some of the critical and operational financial issues to be addressed include claims processing, accounts receivable and prior authorization delays. There is need for increased communication on new policies, benefits, and workflows, and addressing long wait times in verifying patient eligibility and/or claims status. Chairperson Greene noted the need to prioritize issues and seek collaborative input on ways to improve and mitigate operational and financial challenges. This committee will provide a	

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AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	forum for open communication, constructive discussion and proactive problem solving. Systemic issues may have led to challenges such as delayed reimbursements, administrative issues and communication gaps. This Committee will aim to foster a culture of understanding and action ensuring that the concerns of the providers are acknowledged and addressed. He urged Committee members to use this platform to engage in meaningful dialogue, appreciating diverse perspectives and work toward collectively arriving at solutions that will elevate the quality of care provided to beneficiaries. The Committee can create a positive change and foster a collaborative partnership that stands as a shining example in the health care industry. Chairperson Greene extended his sincere gratitude to the committee participants for devoting their time, expertise, and passion to this endeavor. Their contribution is vital to the success of the Provider Relations Advisory Committee, and ultimately, to L.A. Care's mission to provide accessible high quality care to the most vulnerable communities. He is looking forward to the upcoming meetings and the positive impact of this group.	
CHIEF EXECUTIVE OFFICER'S REPORT • **California Safety Net Coalition and Elevating the Safety Net**	Sameer Amin, MD, *Chief Medical Officer*, provided the CEO Report. Dr. Amin thanked everyone for their participation in the Committee. He noted the roles, responsibilities, and accountability of public trust organizations to make sure that it functions efficiently for the members coming to the hospital and to the nursing facilities to get health care. Everybody has parts to play as can be seen in the composition of this group, and all are coming from a different standpoint. Dr. Amin hopes that it will bring different perspectives to enrich the discussions. Dr. Amin is hoping to foster a conversation about how this Committee can improve the delivery of care to the members, and to support the people of L.A. Care, who come to work each day dedicated to serving the members. L.A. Care is among the most mission driven organizations he has experienced. He added that L.A. Care staff are not in every provider office or every hospital room, to see every member's face. Having the representatives of health care providers on this Committee is critical to giving L.A. Care perspective and assistance in improving health care for LA Care members. Dr. Amin added that he looks forward to sharing L.A. Care's plans and gather feedback to improve services. He hopes for a collaborative conversation that is not just about hospitals and providers, but also includes other perspectives. Dr. Amin informed the Committee that John Baackes, *Chief Executive Officer,* cannot be here today. He reported on the two important things for Mr. Baackes: the California Safety Net	

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	Coalition and L.A. Care's work with Elevating the Safety Net. L.A. Care has done a substantial amount of work in the community to not only improve reimbursements to providers and facilities, but has helped the safety net providers form a Los Angeles Safety Net Coalition. Mr. Baackes speaks passionately about the lack of sufficient reimbursement for providers; that the regulations imposed are causing provider burn out; how we can encourage physicians to participate in serving the members. Mr. Baackes had brought together a coalition of representatives from hospitals and provider groups to lobby in Sacramento for improved reimbursements overall for everyone in Medi-Cal. In that meeting, The name of the Los Angeles Safety Net Coalition was changed to California Safety Net Coalition (CSNC) to expand the reach to include representatives from different healthcare communities. Legislators in Sacramento said they were stunned that such a wide variety of representatives came together to talk about Medi-Cal reimbursements. Legislators are used to seeing stakeholders separately and hearing individual complaints. When representatives come to them together, it has a big impact. CSNC achieved the reinstatement of the managed care organization (MCO) tax and is working to make it permanent. Another L.A. Care initiative, Elevating the Safety Net (ESN) is supporting medical school scholars to increase the number of physicians practicing in the safety net. L.A. Care welcomed new medical student scholars who have a desire to practice in their community as primary care doctors. L.A. Care supports not only their movement from high school to college to medical school, but also supports their movement from medical school to residency and into practice. Many have seen that work in ESN and support the movement of providers into the safety net to serve their communities. L.A. Care has provided millions of dollars to make that a reality. There are over 100 physicians in the community today because of the financial support from L.A. Care. Chairperson Greene thanked Dr. Amin, and commended the collaborative effort to get the MCO tax approved. He expressed his appreciation for Mr. Baackes' leadership and added that more of that collaborative effort is needed moving forward.	
COMMITTEE ISSUES		
Election of Vice Chairperson	Chairperson Greene opened the nomination for the election of PRAC Vice Chairperson. Stephanie Booth, MD and Sabra Matovsky were nominated to the position of Vice Chairperson. Dr. Booth withdrew her nomination. **Sabra Matovsky was unanimously elected as PRAC Vice Chairperson.**	**Approved unanimously by roll call. 11 AYES (Ayoub, Booth, Brodine, Flores, Greene, Moazzez, Movaghar,**

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
		Raffoul, Silver, Topper, and Youredjian) **1 ABSTENTION Matovsky**
Schedule of meetings	The Committee agreed to meet quarterly on the third Wednesday of the meeting month at 9:30 AM, or as soon thereafter as possible for the convenience of members.	
Review of Committee Charter	Chairperson Greene referred to the written Committee Charter included in the meeting materials. Chairperson Greene, Mr. Baackes and his team spent a significant amount of time working on this Charter. Committee Member Booth noted the Charter indicates 16 members. There are only 14 members on the list, and not all of them have accepted the nomination. Chairperson Greene noted that he and Mr. Baackes support 16 members on PRAC. **<u>Motion PRC 101.0923</u>** **To approve the attached Charter of the Provider Relations Advisory Committee.**	**Approved unanimously by roll call. 12 AYES (Ayoub, Booth, Brodine, Flores, Greene, Matovsky, Moazzez, Movaghar, Raffoul, Silver, Topper, and Youredjian)**

Report on Hospital/SNF Brainstorming Forums	Eddie Calles, *Senior Director, Provider Network Development and Operations*, A.J. Lopez III, *Director, Provider Contract and Relationship Management*, and Afzal Shah, *Chief Financial Officer*, provided a report on Hospitals/Skilled Nursing Facilities (SNF) Brainstorming Forums. *(A copy of the report may be requested by contacting Board Services.)*
	
	• L.A. Care hosted brainstorming sessions in April, May, and July 2023 with Hospital Association of Southern California (HASC) and Skilled Nursing Facilities (SNF) leadership to provide updates and identify mutual opportunities for operational improvements.
	• Focused Transportation Webinars for Non-Emergency Medical Transportation (NEMT)/Non Medical Transportation (NMT)
	    o L.A. Care conducted training with Call the Car and HASC leaders on June 7
	    o SNF training will be scheduled in August
	    o Follow up session with HASC is tentatively scheduled in October 2023
	• SNF Contract Restructuring
	    o Phase I: Rate adjustments where applicable
	    o Phase II: Contract and network redesign, Carve Outs/Add-ons, Leveraging Pay-for-Performance	

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	• L.A. Care hired four additional Account Managers to develop regularly scheduled SNF Joint Operations Meeting (JOMs). This improved L.A. Care's Account Manager to SNF Ratio from 1:313 to 1:75. L.A. Care will continue regular meetings with California Association of Health Facilities (CAHF) on behalf of the SNFs they represent.
	• SNF Network Update
	  o Using feedback received at brainstorming sessions, L.A. Care will evaluate SNF contracts aimed to restructure the template, including rate adjustments where applicable, by the end of August.
	  o L.A. Care is in the process of collecting an inventory of SNF services by facility to help improve member placement.
	• Phase II (Pay-for-Performance, contract adjustments, carve-outs) will follow thereafter, with tentative schedule forthcoming.
	
	Improved Structure of SNF JOMs
	• Standardized agenda focused on priority topics identified in brainstorming sessions such as, most common bi-directional placement issues, capacity, transportation, and turnaround times.
	• Include key L.A. Care stakeholders to appropriately, timely and thoroughly discuss business items for decision making, such as point personnel for various Health Plan functional areas.
	• Enhanced focus on quality metrics and overall Quality Improvement (QI).
	• Create bi-directional communication pathways that are clear, thus improving potential for collaboration and decision-making, while ensuring key information is dispersed in a consistent way to contracted facilities, including enhanced portal options focused on reduced wait times.
	• L.A. Care Account Managers working with SNF's to update contact information by August 15.
	
	Dr. Amin noted the forums brought together hospitals, SNFs and ancillary services, with about 150 people participating in each event. The holistic conversation around the flow from the emergency rooms and hospital inpatient beds to SNFs included discussion of issues unique to Los Angeles County Medi-Cal patients. Dr. Amin noted that these patients have complex cases with many comorbidities. L.A. Care is dedicated to support these patients who are young and have bariatric issues, are experiencing homelessness; or have substance abuse issues; and it is very difficult to find good discharge locations. It is difficult for	

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	hospitals because these patients are waiting for transfer after the acute phase care is completed. Dr. Amin noted that in working to transfer them to a SNF, the SNFs are reviewing the patient history to arrange the right services. A need was identified for streamlining the transfer with a one page discharge template. A pilot program was developed by a hospital to see if this could work. The one page discharge template will include information about the patient. SNFs were asked to provide information on the number and types of vacancies available. That was an important step toward working together to help these members. L.A. Care is addressing underlying issues related to rates, helping with carve-outs and a pay for performance plan for the school nurse facilities to get more money and promote high quality of care. L.A. Care will work collaboratively with the hospitals and service providers to bring patients to the facilities that can provide them with the best care. L.A. Care is developing contracting and pay for performance measures with help from the provider network management team. L.A. Care will support a distribution of patients among the SNFs and post-acute care providers, bringing case management services to the forefront. Community Supports (CS) and Enhanced Care Management (ECM) programs, as well as L.A. Care's homelessness initiatives, will provide structure to take care of these members as they are leaving the hospitals. Steven Chang, *Senior Director, Care Management*, did a great job of explaining that during the last of the SNF meetings. In terms of community health, L.A. Care will make sure that communication is strong among the providers of care to facilitate transfers. There have been communication issues. Through L.A. Care's delegation oversight, efforts will be made to ensure that providers have the information they need. Committee Member Hector Flores noted the meeting packet did not have any information on this initiative. Dr. Amin responded that the presentation will be distributed to PRAC members. Dr. Amin noted that the most important thing is a really good quality of care and the right network of providers supporting members. L.A. Care is expanding its contracting network to make sure that it has the right providers in the network. The challenges are not unique. One of the many things that came out of the forum sessions is a need to collaborate in providing care.	

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	Los Angeles County SNF occupancy rates are in the high to mid-80%, which is obviously not a lot of capacity. There are people who need long term care and SNFs want to make sure to accommodate them. Many representatives were not familiar with all the services L.A. Care could provide. CS and ECM, as well as L.A. Care's homeless initiatives are about getting patients to an appropriate level of care. The housing initiatives represent opportunities to build programs together. L.A. Care is part of a pilot project with the facility to expedite services in the initial process, which is remarkably better in serving members than it was several years ago. Dr. Stone noted that she has worked with Rockport over the last year to bring palliative care and other support services to long term care to help members making that transition. The care management team is committed to working with facilities. Dr. Amin commented on long-term care and custodial care. He formed an entire department around community health, which now includes behavioral health services, social services, housing initiatives, and CS. The department is led by Michael Brodsky, MD, and Charlie Robinson. They will communicate what resources are available. There will be a lot outreach to provide these members with community health and with housing programs, such as housing sustaining services, which involves intensive case management. Chairperson Greene commented it is very encouraging to see the collaborative work going on but he asked, how do we know if we are making progress? Will there a dashboard report for members that needed to be transitioned, how many are placed or were not? For those that were placed, how long did that take? He thinks it is critical to have this information. Dr. Amin responded that L. A. Care has an internal team to handle difficult to place members. Analytics will be forthcoming. L.A. Care is working at capacity. With lower acuity patients, the process will move faster. Some of the analytics are difficult to report. L.A. Care is tracking metrics, some of which are reported to the Board of Governors on a dashboard of metrics. It is planned to provide the individual metrics to facilities during joint operating meetings, specifically tailored to that facility and the members in their service area. Chairperson Greene thanked the Committee members for the discussion and their comments.	
Transitional Care Services	Susan Stone, MD, *Senior Medical Director, Medical Management* and Steven Chang, *Senior Director, Care Management*, provided a report on Transitional Care Services. *(A copy of the report may be requested by contacting Board Services.)*	

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	<u>Transitional Care Services (TCS) Coordination</u> Parties involved in a Transitional Care event • Hospital / Facility Staff • Caregiver • Primary Care Physician • TCS Care Manager • Health Plan Utilization Management (UM) A complex coordination to determine what members need after their discharge. • Enhanced and Complex Care Management • PCP Appointment • Social Services, Long Term Care Services & Supports • Community Supports • Behavioural Health <u>Department of Healthcare Services (DHCS) Requirements</u> <u>Managed Care Plan (MCP) Responsibilities</u> • Knowing when Member is Admitted/Discharged /Transferred • Processing Authorizations in Timely Manner • Assigning/Notifying Care Manager <u>Care Manager Responsibilities</u> • Discharge Risk Assessment – Coordination with Discharging Facility • Information Sharing/Discharge Planning Document – Shared with Patient, PCP and providers • Follow up with doctor appointment / medication reconciliation / closed loop referrals • End Services/Assessment for further Care Management or other needs <u>Transitional Care Services Coordination: Facility and L.A. Care</u> Activities at the Facility: • Documents: Risk Assessment / Discharge Plan • Information Sharing: Patient/PCP/Providers • Support and Follow up: Appointments / Medications / Referrals • Ending Service and Hand-offs: Care Management / Enhanced Care Management	

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	Dr. Stone noted that social determinants of health are central to health outcomes. There are medically vulnerable groups with higher risk for adverse events after a hospital discharge. Literature shows that members who are medically underserved or in a lower socio-economic status have differences in transitions of care across the country. California is doing a lot better than some other states. This work is important in that context of making sure that when transitioning to another level of care that medication needed is available, the patient understands the discharge instructions and there is transportation available for a follow up appointment. There can be health literacy issues. These are key features in helping people succeed in achieving a reasonable health status. Mr. Chang continued the presentation and commented there are a lot of different parties involved in transitions of care. For each transition, there is the hospital, the primary care physician, the health plan, medical groups, and the member. California Department of Health Care Services (DHCS) is addressing the different parts and different teams to make sure that the member is supported. Dr. Amin referenced earlier that there are a lot of new services, teams and programs available for members when being discharged from the hospital to a nursing facility. DHCS wants services brought together for the member so that they get everything that they need. Dr. Chang explained the different services and activities to be provided for the member upon discharge. The services are robust and a little bit burdensome for one person to everything for every admission. L.A. Care wants to be sure that the services are valuable to the hospitals, facilities, and to the member. LA Care may ask this committee to review and provide feedback on any adjustments to processes. DHCS wants to make sure that health plans have a designated point of contact for every discharge, regardless of acuity. L.A. Care gathered other plans in Los Angeles County, Health Net, Molina, Blue Shield and Anthem, and approached DHCS about the process. Mr. Baackes noted that L.A. Care advocates for providers because if it is going to be a burden, everything they do is a burden that trickles down to our providers. We have to be looking at pushing back on that and so this was the first time we have been able to get them to listen to your feedback here will be helpful in our further communications. Chairperson Greene thanked Mr. Baackes and expressed his appreciation for L.A. Care's advocacy on this issue. We do try with every health plan when we are delegated for discharge planning to have that patient lead with a PCP appointment. And then we do follow up to make sure that that patient actually had that appointment and track. How many show and no	

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	show. It is a huge amount of work to do that and have another agency that is doing that. It creates more administrative burden that is not fruitful. Chairperson Greene also expressed his appreciation for any effort to coordinate and be clear about circumstances and responsibility. There are not enough resources in the medical system for duplicating efforts. For every transition of a patient includes activities for compliance and to ensure continued care. Hospitals are good at the acute phase, but may not follow the member actively to make sure they show up to their appointments and all ancillary care arrangements were made. Primary care physicians may believe that the hospital will take responsibility for follow up. The idea that there needs to be a coordinator for the entire spectrum of care could result in duplication of effort and could create a tug of war between the hospitals and the PCPs for resources. Case managers and care coordinators in great numbers would be needed to oversee this work. We have tried to bring a common sense approach, bring everybody together and speak with one voice to help regulators form a workable system of care. Committee Member Zarah Movaghar noted that in a delegated arrangement, there is a team to arrange the discharge planning. With the health data exchange information can be shared and accessed. A single entity coordinates the care for these members if they need to be in an SNF facility. Most patients are extraordinarily confused by this, and they call their PCP. That is why the PCP fields calls from the patients and their families when they do not understand the system. She urged that patient education is important. There happens to be an L.A. Care member who calls her directly about care. She says she is the Uber at the institution for this patient. The insight is important, as she hears about every outreach from L.A. Care, hospitals, and ancillary care providers. It is hard to keep it straight, and she does this for a living. It is critical to think about how this ends up. More touch points onto these transitions may not yield the desired result. The patient is confused on the outpatient side when we call them, and they ask us who are you and why are you calling. We call people still in the hospital asking about medication reconciliation. The hospitals and the patient are asking why we are calling. It gets back to the famous quote, just because you can do something, doesn't necessarily mean that you should do it. Throwing resources at it may not be the right idea. It is important to focus on upgrading a provider portal that includes information about the chart note, the referral, an authorization process, and the finance process. Something that binds care providers together. An access that would	

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	eliminate a lot of repetition. It can reduce a lot of the operational procedures on the back end that could be explored and could make a big dent in that process. Dr. Amin noted that there can be an offline conversation about the complications, and have been actively working on that for some time. As Mr. Calles had mentioned it is not as robust as it needs to be yet. There have been a lot of hoops and hurdles in setting of coverage, getting that out, but we are committed to doing so and I think we are as close as we have ever been to get this out of this. It was noted that there is so much information that the patient needs to hear, and different messages come from different providers. It is important to have all patient files accessible online. We help the patients get to the point where they need to be, so that they can follow up and stay healthy. Committee Member Hector Flores commented that the idea of vertical integration that Mr. Calles and Dr. Amin talked about applies to everything that we do if we are patient-centered. We have to be the problem solvers for the patient. That includes PCPs, hospitals, doctors, and whoever else is going to interact with that patient. There are some good models available for delegation that minimize length of stay and reduce readmissions - all the things that the DHCS is interested in, and include a description of how the model applies for those particular delegated models. We have our own hospital model that promotes improved communication, because we know the patient's family is going to call us in the clinic. For example, A mom got admitted on Sunday night, and the assigned PCP is notified on Monday morning that a patient is in the hospital. The PCP can actually look what is going on in the hospital and answer questions for the patient because they are going to trust their PCP, because the hospital physician often is a stranger. There should be a way to identify personnel that will manage the patient on discharge. Follow up care is planned in advance of discharge. There are models that address all of this. Dr. Amin noted that he likes the idea, and suggested working with the staff to identify areas for best practices. He noted also that there are regulatory guidelines for providing services in a timely fashion, depending on whether it is an urgent or non-urgent service. There are definitions that are laid out by the regulators. L.A. Care begins addressing the needs as early as possible. If you look at the data, the timing is dramatically faster than the deadline. For example, SNF approvals is required within 72 hours. L.A. Care gets most approvals done in less than 24 hours. L.A. Care does not wait to do it according to regulatory guidelines.	

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	Dr. Amin stated that this may be an opportunity for educating the community to take a look at what some of the regulatory requirements are, because there was an earlier comment about what sorts of dashboards this group might look at as far as establishing opportunities for improvement, metrics and benchmarks that can be agreed to. Jennifer Rasmussen, *Clinical Operations Executive, UM*, noted that the regulatory timeframe is not always going to meet the patient needs. L.A. Care is able to process authorizations much more quickly for discharges from the acute setting, and has a dedicated a fax line for discharge requests. That oftentimes results in a turnaround within a couple of hours. It depends on identifying a bed, which can be delayed by a need to call multiple facilities to find the one that will meet the needs of the member. We are well versed on the complications when there is behavioral health involved, there are specific wound care needs, and not every facility can accommodate those patients. L.A. Care continues to staff up the teams that will support this area, and is building a dedicated discharge team and staffing for 24/7 teams to get as close to real time decisions and authorizations as possible. She noted that all providers and health plans share the same struggles around staffing.	
Provider Funding Issues	Chairperson Greene noted that this agenda item titled, Hospital Funding Issues, is changed to Provider Funding Issues. He mentioned that as the committee moves forward, opportunities to collaborate will be created. It is important that this group understands each other and learns from the challenges, understand what circumstance creates the challenges and work together. He noted there are ways to work better as a provider community in order to share resources and share best practices to overcome the challenges. Chairperson Greene would like to bring back this agenda item back because we did not ask everyone to be prepared today. Prior to the pandemic, 39% of hospitals in Los Angeles County were experiencing operating losses. For the first quarter of 2023, 55% of those hospitals are now in the red, and losses are growing in the greater Los Angeles area. Inpatient admissions have not returned to pre-pandemic levels and inpatient days are greater. The average length of stay has increased from 5.9 to 6.4 days. Operating expenses outstripped revenues by 5% during the past three years. Expenses, led by labor and supply costs, are up 22% versus revenue increasing by 17%. Patient revenue has fallen from covering 98% of operating expenses to 93%. Medicare and Medicaid account for 61.5% of patient revenue and 80% of total hospital days.	

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	Hospitals that are shutting their doors, for the first time in a very long time. This leaves patients and communities at risk. It is not just about hospitals. Some of the systemic issues that lead to hospitals closures includes the cessation of some services. Generally, the first to go is OB. That is a vital service, and its absence in the communities means that people have to drive miles and miles to get those services. This is not a unique situation, and among committee members in this room, there is no industry that would attest that it is financially strong. Each has its own set of challenges. He is interested to hear some of the financial challenges that organizations are facing. Mr. Baackes apologized for not being present at the start of the meeting. He understands here was a brief discussion about the new managed care organization (MCO) tax. The main motivation for MCO was to increase revenue to medical providers. There has not been a base rate increase in 25 years. It was great to see the California Safety Net Coalition (CSNC) succeed with the MCO tax. Mr. Baackes provided an update on the 2023-2027 Distribution of the Managed Care Organization (MCO) Tax.	

MCO Tax Renewal – Cash Basis by Fiscal Year

(dollars in thousands)	2023-24	2024-25	2025-26	2026-27	Total
Total Revenue[1]	$8,269,212	$8,526,680	$8,761,784	$6,703,584	$32,261,260
Medi-Cal Capitation Rates[2]	$3,859,656	$3,414,943	$3,507,447	$2,077,488	$12,859,534
State's Net Benefit[3]	$4,409,556	$5,111,737	$5,254,337	$4,626,096	$19,401,726
General Fund Backfill[4]	$3,388,600	$1,857,914	$2,019,341	$1,050,027	$8,315,882
Medi-Cal Provider Payment Reserve Funds[5]	$1,020,956	$3,253,823	$3,234,996	$3,576,069	$11,085,844

The managed care organization (MCO) tax expired last year when the State had a $100 billion surplus. This year the surplus was $30 billion. An idea was put together to resurrect that tax. In the past, the tax was used to draw down federal matching funds that went into the California general fund. The biggest portion of the tax is levied on the Medi-Cal Managed Care Plans (MCPs). The MCPs get the tax back in the capitation payment. Because L.A. Care is bound by Centers for Medicaid and Medicare Services (CMS) rules, L.A. Care does not pay taxes. The MCO tax is used to draw on federal matching funds. The amount of federal matching funds goes to the general fund.

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	CSNC members met with state representatives and showed them they could draw down five times as much money. The administration adopted a financing model in the State Budget. Revenue of $8.3 million will go into the general fund, and a total of $11 billion of new money will go into Medi-Cal. This will go mostly to providers. CSNC is going ahead with the ballot initiative in 2024. It has achieved a 70% approval rating in market testing of a potential initiative to take the existing tax and redirect the proceeds to Medi-Cal to reduce emergency room crowding. If the ballot initiative is effective, it would start in 2025. The bulk of the money received would go to Medi-Cal and not to the state's general fund. The Governor does not oppose the ballot proposition. The reimbursement rates for primary care physicians, obstetricians, and behavioral health services are at least 87.5% of the Medicare fee schedule. They are also doing this to eliminate Proposition 56 as a directed payment. The money coming through Proposition 56 will now be added to the base rates. CSNC would like that to be 87.5% for all providers. Committee Member David Topper noted that the hospital industry across the United States, particularly in California, are facing funding shortfalls. More and more regulations are imposed along with the shrinking of the health care dollar. In discussions with L.A. Care about authorization and utilization issues, these issues would go away if the health care dollar could increase. For hospitals, having a patient stay another day or two is not as big of an issue as getting an increase in funding. Within a highly regulated state, and now a minimum wage and more regulations will be placed upon the industry, a lot more facilities will shut down. A lot of these issues would go away if the healthcare dollar was level with increased expenses. There is no additional revenue and admissions are up; hospitals are running a very high occupancy rate. Other providers are also suffering in the shrinking of the healthcare dollar, and face the same pressure: high operating expenses, labor shortage and increased labor costs of 27%. The reimbursements would not be able to rise to anywhere near that level just to cover the basics on the Medi-Cal program. Funding increases lag about four years behind increased expenses. We are always behind one of the things; what we can do in the interim is just a band aid. It may help the cash flow, but it is not going to cover costs. The problem that they have made the directed payments part of the base rate. They thought of that because it is such a pain to administer. The directed payments come after the fact and are still not enough to cover	

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	expenses. It would be more preferable to have a base rate that is. Mr. Baackes invited feedback on whether 87.5% of Medicare rates is sufficient. Committee Member Flores noted equity starts with patients first, especially for the most vulnerable, then it goes to those who serve those patients. We do not have equity, but this is a first step in the right direction. He added that the global cost of care should be considered, and where the funds are spent. California spends $500 billion a year on healthcare, which is more than enough to take care of everyone living in California including the undocumented. Safety net providers take indigent patients far more than Kaiser, but it is a good model to emulate in terms of the efficiency of hospitals and alternatives to hospitalization. The great experiment will be when Kaiser begins serving Medi-Cal next year. Committee Member Flores was appointed to the advisory committee for the office of health care affordability, and is working with people to come up with a way to address sufficiency of funding. The worst would be to disrupt providers; lose them and the patients suffer. Transparency and equity must be the compass used in addressing sufficiency of funding. Providers and solo small practices in particular are struggling to transform practices around requirements for value-based performance.	
Managed Care Accountability Sets	Matthew Pirritano, PhD, MPH, *Director, Population Health Informatics*, and Bettsy Santana, MPH, *Senior Manager, Quality Improvement Initiatives*, presented information about the Managed Care Accountability Sets (MCAS). *(A copy of the presentation may be requested by contacting Board Services.)* <u>Clinical Initiatives Background</u> • Develop health campaigns targeting Healthcare Effectiveness Data and Information Set (HEDIS) and other quality measures with the aim of improving health outcomes that covers direct lines of business: Medi-Cal (MCLA), Covered California (LACC), and Medicare (D-SNP). • Each product line has its own unique set of performance metrics—most use HEDIS but can use other quality indicators. • Medi-Cal uses HEDIS and CMS core measure sets to measure performance – known as the Managed Care Accountability Set (MCAS). • MCAS is a HUGE focus because those measures overlap in Medicare and for Covered California. • DHCS is moving toward increasing sanctions and penalties for low performance <u>Medi-Cal Managed Care Accountability Sets (MCAS)</u>	

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	• Top priority measures set to a Minimum Performance Level (MPL), the national National Committee on Quality Assurance (NCQA) 50th percentile.
	• This year there are 18 measures held to the MPL, plus 24 reportable measures that may be added in subsequent years.
	• DHCS has proposed increasing measures held to MPL to 25 in 2024.
	• Two new measures come from the CMS Core Set of measures and are now held to MPL for MY 2023: 1) Developmental Screening in the First Three Years of Life and 2) Topical Fluoride for Children
	
	<u>Current Performance</u>
	• 15 measures are held to the Minimum Performance Level (MPL) or 50th percentile
	• Six out of 15 measures did not meet the minimum performance level
	• Initiative is investigating root causes and is working on various initiatives to drive care
	• Four measures that fell below the MPL were in Children's Health
	  o The others were Cervical Cancer Screenings, and Follow up After and ED visit for Mental Illness -30 days
	
	<u>Areas of Low Performance & Recurring Issues</u>
	• Did not meet MPL in Measure Year (MY) 2022
	• Children's Health measure performance continues to be a recurring issue
	
	<u>Root Cause Analysis for Areas of Poor Performance</u>
	• Members are unaware of the care needed to take control of their health outcomes
	• Providers do not maximize the use of gap-in-care reports
	• Intervention design need to align with the member audience and incentivize.
	• Lack of customization in data analysis and segmentation
	• Access to care for members, e.g., MY 2022 tridemic, recalls to blood lead testing machines, staffing post COVID impacted care
	
	<u>Follow up and Next steps: Top Strategies Underway</u>
	• Increased member touch points and incentives on the need for care and services
	  o Texting, social, mail, live agent via Community Health Workers (CHWs)
	• Increased provider outreach on care gaps via meetings
	  o Regular meetings with IPAs, medical groups, and providers
	• Involving more members and providers in the design of interventions	

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	○ Increase member/provider feedback session ○ Established an incentive for clinics to launch their own interventions • Data and Reporting Enhancements ○ Conducting more deep dives, customized care gap list ○ Segmenting our population by engagement • Increasing access to care via mobile or at home services ○ Lead Screening Community events, Test kits, mobile mammography <u>Quality Withhold in Medi-Cal Rates</u> <u>Program Design</u> • Starting in Calendar Year (CY) 2023, DHCS implemented a quality component in rating. For CY 23, this led to an increase in L.A. Care's rates • For CY 24, DHCS is moving to a 0.5% of revenue Quality Withhold program. The withhold % is expected to increase in subsequent years • L.A. Care's estimate of the Quality Withhold for CY 24 is $35 million • L.A Care will be able to earn back the quality withhold, and potentially more, based on performance against national benchmarks • For CY 24, L.A. Care's score will be the higher of its improvement score or its achievement score • The final earn-back amount for CY 24 will not be known until at least mid CY 25 • Statewide, there will be no new money added for this program <u>CY 2024 Program Measures</u> • Controlling High Blood Pressure (CBP) • Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%) (CDC-H9) • Prenatal and Postpartum Care: Postpartum Care (PPC-Pst) • Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-Pre) • Child and Adolescent Well-Care Visits (WCV) • Well-Child Visits in the First 30 Months of Life (W30) • Childhood Immunization Status: Combination 10 (CIS-10) • Immunizations for Adolescents: Combination 2 (IMA-2) • CAHPS - Rating of Health Plans: Adult & Child • CAHPS - Getting Needed Care: Adult & Child	

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	Pay-for-Performance (P4): • A platform for provider engagement & accountability • Tool for meaningful performance measurement and progress reporting to support provider clinical quality efforts • Peer group benchmarking & definition of performance targets: Value-based revenue • P4P is one part of a complete QI solution and an amplifier for other QI interventions to foster durable change in provider behavior and business practice, systematic process improvements and better care coordination *(not just about HEDIS hits)*. It helps identify reporting gaps. Value Initiative for IPA Performance (VIIP) Overview • P4P program for participating provider groups (PPGs), also known as IPAs or medical groups. VIIP measures, reports, and provides significant financial rewards for performance across multiple domains and measures for Medi-Cal, LACC, and D-SNP. • Scoring Methodology: Provider groups are rewarded for both outstanding performance and year-over-year improvement. • Measurement Year 2022 payments and performance reports will go out during the 4th quarter of 2023 MY 2021 Medi-Cal VIIP+P4P Payment Stats L.A. Care reimbursed $15.5 million in incentive payments to 53 eligible provider groups. Median incentive paid was $0.87 per member per month (PMPM). The highest performers receiving $1.80 PMPM. MY 2022 data is being processed now! LACC VIIP+P4P Program L.A. Care is collaborating with the Integrated Healthcare Association (IHA) on their Align. Measure. Perform. (AMP) performance measurement program for L.A. Care Covered (LACC). Data submission is not run in-house. L.A. Care submits data to Transunion and OnPoint (IHA's data vendors): Onpoint, Eligibility, Medical Claims, Pharmacy Claims, Member Identifier, Cost, Lab, TransUnion and HEDIS MY 2023 Medicare Plus VIIP Cal MediConnect (CMC) sun-set after MY 2022, and Medicare Advantage Plus took its place in MY 2023. A new VIIP has been developed to replace CMC VIIP, called Medicare Plus VIIP. PPG's will have a percentage of capitation withheld that can be earned back incrementally. There will be a 3-Tier composite score system for the PPGs to earn back their withholdings. Incentive payments will be made once, annually	

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	Physician P4P Program: Overview P4P program for solo and small group physicians and community clinic organizations. Eligible practices can receive *significant revenue above capitation* for outstanding performance and year-over-year improvement on multiple HEDIS measures. Payout for MY 2021 was $20.6 million & MY 2022 was approximately $22 million. Measurement Year 2022 payments will be sent out in Q4 of 2023. Direct Network (DN) P4P Mirrors the Physician P4P. Providers can be eligible for both Physician P4P and DN P4P. Eligible providers can receive annual incentive payments up to $8.00 PMPM for outstanding performance. Dr. Pirritano noted that patient care is a shared responsibility. Provider groups work with Medi-Cal managed care plans to achieve the required levels of care. Health plans are held to a national percentage for performance. There are differences among states on the qualifications for Medicaid eligibility and in how a patient is assigned to a PCP. There should be some adjustment factor in the system when measuring health plans across the country. It is discouraging how much work happens in California on improving the measures without an appreciation for the distinctions between States. There are great differences in performance of health plans even within the state. In response to a comment on the quality initiatives and how L.A. Care accounts for the gaps in care, Ms. Santana noted that because of redetermination, there were population who have sought health insurance through other means. These will not be automatically re-enrolled. L.A. Care only has one month of data on eligibility redetermination. The process will not be completed until the end of August next year. It appears that so far, there is probability of 21% disenrollment rate in Los Angeles County. For comparison, in Ventura County, the disenrollment rate is 33% after the first month.	

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ADJOURNMENT	Chairperson Greene noted that there are opportunities for new agenda items from this meeting. He encouraged Committee members to reach out to him if they have any agenda items. This will be a collaborative process. Chairperson Greene thanked everyone for the participating. The meeting adjourned at 3:20 p.m.	

Respectfully submitted by:
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Malou Balones, *Board Specialist III, Board Services*
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APPROVED BY:

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George Greene, Esq., *Chairperson*
Date Signed ___________________________

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