DRAFT

AGENDA
Compliance & Quality Committee Meeting
Board of Governors

Thursday, October 17, 2024, 2:00 P.M.
1055 West 7th Street, Conference Room 100, 1st Floor
Los Angeles, CA 90017

To listen to the meeting via videoconference please register by using the link below:
https://lacare.webex.com/lacare/j.php?MTID=m272a6d07d7a7030e1e84ecf6145e7a5c

To listen to the meeting via teleconference please dial: +1-213-306-3065
Meeting Number: 2492 684 9918 Password: lacare

Teleconference Site

G. Michael Roybal, *MD*
Fairmont Hotel
950 Mason St
San Francisco, CA 94108

For those not attending the meeting in person, public comments on Agenda items can be submitted prior to the start of the meeting in writing by e-mail to BoardServices@lacare.org, or by sending a text or voicemail to (213) 628-6420. Due to time constraints, we are not able to transcribe and read public comment received by voice mail during the meeting. Public comment submitted by voice messages after the start of the meeting will be included in writing at the end of the meeting minutes.

The purpose of public comment is an opportunity for members of the public to inform the governing body 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 — Stephanie Booth, *MD, Chair*

1. Approve today's meeting Agenda — *Chair*
2. Public Comment (*please see instructions above)* — *Chair*
3. Approve September 19, 2024 Meeting Minutes ***P.4*** — *Chair*
4. Chairperson's Report — *Chair*
   - Education Topics
5. Chief Medical Officer Report ***P.15*** — Sameer Amin, *MD*, *Chief Medical Officer*

6. Chief Compliance Officer Report *P.29* — Todd Gower, *Chief Compliance Officer*
   - Compliance Report Out from Internal Compliance Committee "ICC" (Todd Gower)
   - Approve Revisions to the Committee Charter **(COM 100)** *P.33*
   - Special Investigations Unit Report Out
   - Issues Inventory
   - Staffing Management Action Plan

7. Quality Oversight Committee (QOC) Report — Edward Sheen, MD, *Senior Quality, Population Health, and Informatics Executive*

8. FSR Overview and Update (Quarter 1 to Quarter 2, 2024) & IHA Overview and Update *P.62* — Elaine Sadocchi-Smith, *Director, Facility Site Review Director, Population Health Management*

9. Approve UM Program Description & UM Program Evaluation **(COM 101)** *P.89* — Tara Nelson, *BSN, RN* *Senior Director, Utilization Management, Utilization Management*

10. Public Comment on Closed Session

ADJOURN TO CLOSED SESSION (Est. time 20 minutes)

11. PEER REVIEW
    Welfare & Institutions Code Section 14087.38(o)

12. 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

13. THREAT TO PUBLIC SERVICES OR FACILITIES
    Government Code Section 54957
    Consultation with: Tom MacDougall, Chief Information and Technology Officer

14. CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION
    Pursuant to Section 54956.9(d)(1) of the Ralph M. Brown Act
    - Department of Managed Health Care Enforcement Matter Numbers: 18-799, 20-063, 21-428, 21-509, 21-680
    - Department of Health Care Services, Office of Administrative Hearings and Appeals, In the matter of: L.A. Care Health Care Plan Appeal No. MCP22-0322-559-MF

RECONVENE IN OPEN SESSION

ADJOURNMENT

The next Compliance & Quality Committee meeting is scheduled on
Thursday, November 21, 2024 at 2:00 p.m.
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 COMPLIANCE & QUALITY 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.

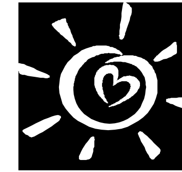
NOTE: THE COMPLIANCE & QUALITY COMMITTEE CURRENTLY MEETS ON THE THIRD THURSDAY OF MOST MONTHS AT 2:00 P.M. AGENDA and PRINTED MEETING MATERIALS ARE AVAILABLE FOR INSPECTION AT http://www.lacare.org/about-us/public-meetings/board-meetings and by email request to BoardServices@lacare.org

Any documents distributed to a majority of the Board Members regarding any agenda item for an open session after the agenda has been posted will be available for public inspection at 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.

BOARD OF GOVERNORS
Compliance & Quality Committee Meeting
Meeting Minutes – September 19, 2024



L.A. Care Health Plan CR 1017-1018, 1055 W. Seventh Street, Los Angeles, CA 90017

Members
Stephanie Booth, *MD, Chairperson*
Al Ballesteros, *MBA*
G. Michael Roybal, *MD*
Fatima Vazquez

Senior Management
Sameer Amin, *MD, Chief Medical Officer*
Terry Brown, *Chief of Human Resources*
Todd Gower*, Chief Compliance Officer*
Augustavia J. Haydel, *General Counsel*
Alex Li, *Chief Health Equity Officer*
Tom MacDougall, *Chief Information and Technology Officer, IT Executive Administration*
Noah Paley, *Chief of Staff*
Acacia Reed, *Chief Operations Officer*
Edward Sheen, MD, *Senior Quality, Population Health, and Informatics Executive*

** Absent ** Via Teleconference*

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
CALL TO ORDER	Chairperson Stephanie Booth, *MD*, called the L.A. Care Compliance & Quality Committee and the L.A. Care Health Plan Joint Powers Authority Compliance & Quality Committee meetings to order at 2:00 P.M. She announced that members of the public may address the Committee on each matter listed on the agenda before the Committee's consideration of the item by submitting their comments via text, voicemail, or email.	
APPROVAL OF MEETING AGENDA	**The meeting Agenda was approved as submitted.**	**Approved unanimously 4 AYES (Ballesteros, Booth, Roybal, and Vazquez)**
PUBLIC COMMENT	*There was no public comment.*	

DRAFT

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
APPROVAL OF MEETING MINUTES	**The August 15, 2024 meeting minutes were approved as submitted.**	**Approved unanimously. 4 AYES**
CHAIRPERSON REPORT	Chairperson Booth commended the committee for their hard work during a period of significant change. She noted that while the process involves considerable effort, the group is making meaningful progress beyond mere reorganization. Chairperson Booth stated that the system is maturing and expressed hope that Compliance will eventually become a natural part of their operations, where individuals will no longer resist it. She noted that audits should be viewed as beneficial opportunities for improvement rather than as punitive measures. Chairperson Booth noted the unique opportunity they have to receive expert advice on Compliance, which is not commonly found in similar organizations. She expressed pride in both the team's efforts and the contributions of Board committee members, who have been actively engaged in reviewing materials to ensure clarity and quality.	
CHIEF MEDICAL OFFICER REPORT	Sameer Amin, *MD, Chief Medical Officer*, gave a Chief Medical Officer report *(a copy of the materials can be obtaided from Board Services)*. Dr. Amin provided an update on key initiatives and progress within the health services department, emphasizing the importance of accountability for decisions and strategies made. Dr. Amin highlighted the success of Enhanced Care Management (ECM), noting a 25% increase in enrollment from February to August 2024. This growth was attributed to strategic recontracting efforts that incentivized providers to enroll new members and enhance patient interactions. He acknowledged the effective leadership of Noah Ng, *Director, Enhanced Care Management*, and his team, who have fostered positive relationships with providers, allowing for better service delivery. He discussed improvements in the Transitions of Care program, which aims to support high-risk patients during their transitions between care settings. Dr. Amin reported an increase in interactions related to transitions of care, rising from approximately 1,600 to 2,700. Dr. Amin addressed changes made to the prior authorization process, which resulted in a 10% reduction in overall authorization volume. These adjustments have reduced administrative burdens and improved the efficiency of the utilization management department. Collaboration with hospitals has also seen significant improvements, particularly with the establishment of a 24/7 hotline for urgent calls, which now boasts a response time of 40 seconds and a drop rate of less than 5%. Dr. Amin credited Tara Nelson, *RN, BSN, Senior Director, Utilization Management, Utilization Management*, for her outstanding leadership in enhancing operational performance and	

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	responsiveness to hospital needs. Dr. Amin expressed pride in the team's accomplishments and the ongoing efforts to create a more coordinated and efficient healthcare system for members. Member Roybal asked for clarification regarding the calls received through the hotline. He inquired whether the majority of these calls, specifically about 99%, were related to admissions from the emergency room. He assumed that a similar percentage of these calls likely resulted in approvals and sought confirmation on the actual approval rates for callers. Dr. Amin responded that at that point they are not calling for approval per se and they categorize all the calls that come in. the highest number is post stabilization. The next is transition to a higher level of care. Dr. Amin addressed the improvements in discharge planning and collaboration with hospitals. He noted that previously, the approach to engaging with hospitals was passive, relying on them to reach out for assistance with difficult-to-place patients. Recognizing the need for a more proactive strategy, Dr. Amin detailed the restructuring of the medical director division and the alignment of nursing staff with specific hospitals to enhance discharge processes. Dr. Amin noted the importance of actively rounding with hospital teams to discuss patients pending discharge. These efforts include connecting patients with necessary resources such as housing and community services, ensuring they are discharged to appropriate care settings rather than automatically to Skilled Nursing Facilities (SNFs). He pointed out that many patients were previously denied placement in SNFs because they were not suitable for that level of care. As a result of these strategic changes, the difficult-to-place patient list has been reduced by 25% month over month. He reported that patients are now being discharged to various care options beyond SNFs, including residential care and hospice services. Dr. Amin said that successful recontracting with skilled nursing facilities, noting that approximately 16% of the patients discharged are benefiting from a pilot program with Rockport, meeting expectations. Member Roybal noted that it isn't really a difficult to place patient population but more so it's the provider not knowing where to place them. Dr. Amin responded that it's a cry for help list. Dr. Amin explained that proactive engagement with hospitals around discharge planning has been instrumental in reducing the number of patients on this list. By addressing discharge needs before hospitals urgently request help, the team has been able to facilitate smoother transitions. He noted that a key factor in successfully paring down the list has been ensuring patients are directed to the appropriate care destinations. Dr. Amin noted that, previously, the common practice was to send patients to SNFs, even when that was not the most suitable option. He said that approximately 17% of the members on the difficult-to-place list were able to go home directly instead.	

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CHIEF COMPLIANCE OFFICER REPORT	Todd Gower, *Chief Compliance Officer*, and the Compliance Department staff presented the Chief Compliance Officer Report *(a copy of the full written report can be obtained from Board Services)*. Overview o Compliance Report from the Internal Compliance Committee (ICC) o Updates on the Enterprise Risk Assessment and Management Action Plans (MAPs) o Vendor Management and Contracting Process o Issues Inventory o Business Unit Report Out on Appeals and Grievances Key Highlights Compliance Report o The compliance report outlined the current status of various compliance initiatives and highlighted the importance of accountability within the organization. Michael Sobetzko, *Senior Director, Risk Management and Operations Support, Compliance*, presented updates on the Enterprise Risk Assessment, focusing on: o The lack of cross-functional third-party vendor management and oversight. o A remediation plan was developed, currently being assessed by a third-party consultant. Key actions include: - End-to-End Process Assessment: Completed in Q3 2024. - Leadership Review: Ongoing, with recommendations evaluated for implementation by Q2 2025. - Vendor Risk Committee: The charter is set to be presented for approval in September, with initial data gathering already in progress. Mr. Sobetzko provided an update on the Issues Inventory. o The current status included: - Reported Issues: Fluctuated over the past months, with a notable increase in July and August. - Open Issues: Currently at four. - Closed to Inventory: Issues resolved and removed from active tracking. - Deferred Issues: Waiting on regulatory guidance. Demetra Crandall, *Director, Customer Solution Center Appeals and Grievances, CSC Appeals & Grievances*, reported on the appeal and grievance volumes from July 2023 to June 2024. The data highlighted trends in complaints and the effectiveness of the response system. The report indicated that the system is undergoing improvements, including the implementation of a new system (i3vertical/Kiriworks) aimed at enhancing data reporting and compliance visibility by 2025.	

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COMPLIANCE & QUALITY COMMITTEE CHARTER STATUS UPDATE	Todd Gower, *Chief Compliance Officer*, discussed the Compliance & Quality Committee Charter Process. Mr. Gower provided an update on the Compliance and Quality Charter, which has undergone a thorough review over the past year and a half. He pointed out a significant organizational change from the previous year: the separation of Internal Audit from the Compliance Department. This change necessitated clear documentation in the charter. He noted the importance of incorporating the Office of Inspector General seven elements into the charter, which serves as a framework for compliance. Mr. Gower also noted that the updated charter includes provisions for monitoring and auditing within the compliance area. He acknowledged the contributions of various team members, Mr. Gower expressed gratitude to Linda Merkens, *Senior Manager, Board Services*, and Augustavia J. Haydel, *General Counsel*, and Chairperson Booth for their collaboration on the charter. He said that the necessity of periodically reviewing charters every two to three years to ensure they align with the organization's current practices, noting that such a review had not occurred for some time. Mr. Gower indicated that changes made to the charter are highlighted in red for easy reference. He mentioned plans to seek a vote for the approval of the revised charter at the next meeting. He assured the Board that the essential legal requirements remain intact in the updated document, even as some legal jargon was streamlined for clarity. He also shared insights from comparisons with charters from other plans in California, noting that many only have compliance charters, while very few include both compliance and quality. He reiterated that the revisions reflect the best efforts to create a comprehensive charter that meets the needs of both compliance and quality for the committee. Member Roybal asked if there is a role for the Chief Medical Officer in the charter. Chairperson Booth stated that it's in the charter. Mr. Gower said that he will take it offline with Chairperson Booth and make sure there is wording in the charter regarding the Chief Medical Officer. Chairperson Booth said that they can also define CCO and CMO. She noted that there should also be an Internal Audit charter and remembers seeing one in the past. Maggie Marchese, *Senior Director, Audit Services*, responded that she'll be sure to get the charter to the committee for its review.	
QUALITY OVERSIGHT COMMITTEE (QOC) REPORT	Edward Sheen, *MD, Senior Quality, Population Health, and Informatics Executive*, *(a copy of the materials can be obtaidne from Board Services).* Cultural and Linguistic Services (C&L) Utilization Report Monitoring and Effectiveness: The C&L unit monitors its effectiveness through quarterly utilization reports, which analyze:	

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	o The utilization of language services. o Service levels and satisfaction with language services. o C&L-related grievances and complaints. Language Services Overview: o Services are provided uniformly across all product lines, including standard and rapid translations, alternative formats (large print, audio, braille), and both face-to-face and telephonic interpreting. o Key metrics included the number of documents translated and requests for interpreting services. Key Findings: o A slight decrease in standard translations and alternative formats (down 20.2%), while rapid translations increased by 11.7%. o Face-to-face interpreting requests increased by 5.1% for medical appointments and 8.8% for non-medical appointments. o Telephonic interpreting usage rose significantly, with a 37.4% increase in minutes used compared to previous quarters. Satisfaction Metrics: o Most goals related to member satisfaction with interpreting and translation services were met. For instance, 99.2% of members reported satisfaction with translation services. o Challenges were identified, including declining satisfaction regarding the ease of requesting an interpreter, which led to initiatives for improvement. Nurse Advice Line (NAL) Oversight Service Overview L.A. Care provides 24/7 access to a Nurse Advice Line where members can consult with Registered Nurse Health Coaches for medical concerns and referrals. Contract Extension: The contract with the vendor Health Dialog was extended for three years to ensure continuous service. Key Findings: o NAL met most performance metrics but struggled with average speed of answer during Q4 2023 and Q1 2024. o 35% of symptom check calls initially intended for the ER were redirected to appropriate lower levels of care. Corrective Action Plan: o Health Dialog was placed on a corrective action plan due to consistent performance issues. o The acquisition by Carenet is expected to improve service delivery, with an increase in available nursing staff. Teladoc Utilization Report	

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<tr><th>AGENDA ITEM/ PRESENTER</th><th>MOTIONS / MAJOR DISCUSSIONS</th><th>ACTION TAKEN</th></tr>
<tr><td></td><td>o Overview: This section summarized how members received care through Teladoc services, showcasing trends and utilization rates.
o Clinical Details: The report provided metrics on symptom check calls and identified common presenting symptoms, such as abdominal pain and respiratory issues.</td><td></td></tr>
<tr><td>QUALITY IMPROVEMENT AND HEALTH EQUITY COMMITTEE (QIHEC) REPORT</td><td>Alex Li, MD, Chief Health Equity Officer, gave a Quality Improvement and Health Equity Committee (QIHEC) report (a copy of the presentation can be obtained from Board Services).

Brief Summary of Key Equity and Disparities Findings and Program Focus and Interventions:
• Disparities in clinical outcomes persist across various domains and populations
• One of the main priorities is focused on improving the child health measures with Black/African American children and youth in Service Planning Area 6 (South LA):
- Community Health Workers provide assistance with scheduling well-child visits before the 15-month mark
- Offering at-home test kits
• Conducted member survey in text message campaign:
- Majority of members stated they did not see their doctor due to not feeling sick or not knowing who their doctor is.
Data Efforts:
• Efforts are under way to improve the quality and data collection of social determinants of health and race/ethnicity data points as well as scouring and scrubbing claims, encounters and supplemental data to capture the completion of our HEDIS measures.
Demographic Changes:
• Addressing the new Office of Management and Budget race/ethnicity changes in our system and talking with key community stakeholders (Los Angeles County Department of Public Health)
Correct and Updated Contact Information:
• Exploring alternative databases with member contact information.
• Working with enrollment services to continue to update and ensure that we have the accurate member contact information

Additional Work Planned for 2024-2025:
• Developing a disparities data dashboards to better identify disparities.
• Utilizing member councils and health promotoras for feedback on member outreach materials and programs</td><td></td></tr>
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AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• Empowering provider groups and clinics to analyze data and identify disparities in patient populations • Increasing the number of languages available for member outreach • Collaborating with community-based organizations and vendors in developing culturally tailored materials for a diverse membership Informational: Universal Provider Manual (UPM) Updates: • Legally binding document and serves as an extension of L.A. Care's contract with our network providers. • Updated on a regular cadence and posted on our website. • The Communications team seeks QIHEC input for the UPM on an annual basis.	
TIMELY ACCESS TO CARE UPDATE: MY2023 SURVEY RESULTS	Priscilla Lopez, *Manager, Quality Improvement Accreditation, Quality Improvement,* gave a Timely Access to Care Update: Measurement Year 2023 Survey Results *(a copy of the presentation can be obtained from Board Services).* Overview and Agenda: She provided insights into access to care survey results, performance goals, monitoring cycles, and interventions for improving provider performance. The annual survey is conducted from October to December, with results received by spring. Providers are given a report card and a corrective action plan (CAP) based on their performance, which they must respond to within 30 days. Performance Goals. L.A. Care sets a compliance rate goal of 80% for appointment availability and after-hours access, with the aim of achieving statistically significant improvement each year. She highlighted the compliance rates for various appointment types, comparing them against established performance goals: o Primary Care: Urgent appointments had a compliance rate of 73%, routine appointments 85%, and preventive care (adult) at 95%. o Specialty Care: Urgent appointments had a 69% compliance rate, routine appointments 75%, and prenatal appointments 100%. o After-Hours Care: Emergency room access showed 88%, but timeliness dropped to 66%. Provider Performance Analysis: Her analysis identified the lowest-performing provider groups based on urgent care appointments, call-back appointments, and after-hours care timeliness. Specific provider groups were highlighted, including those with high non-compliance rates. Interventions and Strategies:	

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	Ms. Lopez outlined ongoing remediation strategies for underperforming provider groups, including enhancing education about access to care requirements and collaborating to identify root causes for non-compliance. Ms. Lopez noted the importance of using data analytics to inform provider engagement and the need for adjusting training methods to address best practices effectively.	
MY2023 HEDIS RESULTS	Thomas Mendez, *Director, Quality Performance Informatics, Quality Performance Management,* presented the Measuremnet Year 2023 Healthcare Effectiveness Data and Information Set (HEDIS) Results *(a copy of the presentation can be obtained from Board Services).* Overview All HEDIS submissions for Measurement Year (MY) 2023 across all Lines of Business (LOB) were successfully completed in June 2024. L.A. Care maintained a 3.5 NCQA Health Plan Rating (HPR) for Medi-Cal, the same rating held since MY2020. The Dual Special Needs Plan (DSNP) HPR was not calculated due to the plan being new without eligible members for the CAHPS survey. The NCQA does not calculate Marketplace HPR. Key Findings: o HEDIS rates have generally improved year over year since the impact of COVID-19 (MY2020), with many measures returning to or exceeding pre-COVID levels. Summary of Improvements and Declines o Measures Improved: - DSNP Admin Measures: 45 - DSNP Hybrid Measures: 6 - LACC Admin Measures: 22 - LACC Hybrid Measures: 12 - Medi-Cal Admin Measures: 68 - Medi-Cal Hybrid Measures: 14 - Total Improvements: 167 Highlights and Goals Met Managed Care Accountability Set (MCAS): 11 out of 18 measures reached the Minimum Performance Level (MPL): o Lead Screening in Children (LSC), Topical Fluoride (TFL), and Well Visits for Children and Adolescents achieved MPL status, which they did not meet in MY2022. o Expected penalties from DHCS are projected to be approximately $500,000 less than the previous year due to these improvements.	

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	Quality Transformation Initiative (QTI): o 3 out of 4 measures were above MY2022 results o Controlling Blood Pressure (CBP) reached the 50th percentile, increasing by 5.19% compared to last year. o Colorectal Cancer Screening (COL) improved by 5.03%, and HbA1c for Diabetics (HBD) improved by 5.84%. Areas of Poor Performance For the MCAS MPL measures, concerns include: o Childhood Immunization Status (CIS): The rate for the influenza vaccine continues to decline. o Cervical Cancer Screening (CCS): The rate has been trending downward since COVID-19, remaining a challenge due to its five-year measurement cycle. For the QTI measures, despite improvements, all four measures still fall well below the required 67th percentile, indicating substantial penalties are expected. Root Cause Analysis Access to care remains an issue for several measures, particularly those requiring in-person visits or multiple appointments for compliance, such as cervical cancer screenings, well-child visits, and colorectal cancer screenings. Notable challenges include delays in scheduling necessary procedures like colonoscopies and a rise in late immunizations.	
PUBLIC COMMENT ON CLOSED SESSION ITEMS	*There was no public comment.*	
ADJOURN TO CLOSED SESSION	Augustavia J. Haydel, Esq., *General Counsel*, announced the following items to be discussed in closed session. The JPA Compliance and Quality Committee meeting adjourned and the Compliance and Quality Committee adjourned to closed session at 4:51 P.M. PEER REVIEW Welfare & Institutions Code Section 14087.38(o) CONFERENCE WITH LEGAL COUNSEL—ANTICIPATED LITIGATION Significant exposure to litigation pursuant to Section 54956.9(d)(2) of Ralph M. Brown Act: Four potential cases THREAT TO PUBLIC SERVICES OR FACILITIES Government Code Section 54957	

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	Consultation with: Tom MacDougall, Chief Information and Technology Officer, IT Executive Administration CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION Pursuant to Section 54956.9(d)(1) of the Ralph M. Brown Act • Department of Managed Health Care Enforcement Matter Numbers: 18-799, 20-063, 21-428, 21-509, 21-680 • Department of Health Care Services, Office of Administrative Hearings and Appeals, In the matter of: L.A. Care Health Care Plan Appeal No. MCP22-0322-559-MF	
RECONVENE IN OPEN SESSION	The Committee reconvened in open session at 5:10 p.m. There was no report from closed session.	
ADJOURNMENT	The meeting adjourned at 5:15 p.m.	

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

APPROVED BY:

____
Stephanie Booth, MD, *Chairperson*
Date Signed: ______________________________

CMO Report: October 2024

Health Services Division Update

Medical Management
Quality Management
Community Health
Pharmacy

Sameer Amin, MD
Chief Medical Officer, Health Services

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Strategy Management

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

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

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

- **Optimizing Population Health Management (PHM):** The Health Services Division will adopt a PHM-based integration framework that will enable all departments to coordinate on key success drivers that are fundamental to the implementation of PHM. The drivers will be embedded in all subsequent strategic initiatives:
    - Data Analytics and Technology
    - Aligned Incentive Contracting
    - Network Development and Optimization
    - Robust Provider Engagement
    - Effective Member Engagement
    - Value-Based Practice Transformation
    - Care Coordination and Integration

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

Medical Management

Enhanced Care Management (ECM)

Enrollment

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

Contracting and Network

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

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

Care Management (CM) for MCLA Members

Case Volumes

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

Transitional Care Services (TCS)

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

members who fall under the "DHCS High Risk" category for TCS purposes. Low risk TCS members began receiving post discharge notification of their ability to access TCS services. To date, a total of 82 low risk members have contacted the TCS Central Intake Line to request TCS support.

Utilization Management (UM)

Timeliness of UM Decisions and Notifications

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

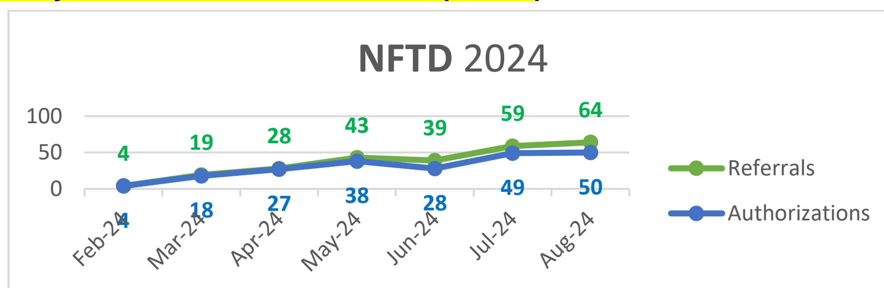
Managed Long Term Services and Supports (MLTSS)

Community-Based Adult Services (CBAS)

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

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

Nursing Facility Transition or Diversion (NFTD)



Quality Management

Health Education, Cultural, and Linguistic Services (HECLS)

Meals as Medicine Program

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

DHCS Transitional Care Services (TCS) for Birthing Individuals

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

Maternal Health Programs

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

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

Initiatives

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

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

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

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

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

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

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

Provider Quality Review (PQR)

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

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

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

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

- **PQR – PQI Platform:** Development for the new PQI system (“Kaizen”) is on track with end-to-end UAT and regression testing. The IT and the PQR teams have successfully deployed the Kaizen Phase 1 release into production as of September 27, 2024. All technical and business validations have been completed, and all functionalities work as expected. The successful deployment of Kaizen is a testament to the hard work and

dedication of the project teams. Their collective efforts will significantly improve L.A. Care's Provider Quality Review process. Phase 2 development will soon follow.

Population Health Management (PHM)

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

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

Population Health Informatics

Health Information Management (HIM) Analytics

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

Health Information Ecosystem (HIEc)

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

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

Community Health

Community Supports (CS) Operations & Reporting

CS Provider Network

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

Latest in CS Implementation and Member Engagement

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

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

Systems IT: SyntraNet and QNXT

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

Behavioral Health Services (BH)

Spotlight: Year's End Telehealth Summary with Hazel Health

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

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

Care Coordination

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

Grievances

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

Justice-Involved ECM (Enhanced Care Management) Populations

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

Social Services (SS)

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

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

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

Housing Initiatives

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

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

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

Day Habilitation Community Support

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

Housing and Homelessness Incentive Program

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

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

Field and Street Medicine: Launch and Operations

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

Pharmacy Department

Medication Adherence Programs

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

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

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

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

Medication Therapy Management (MTM) Program

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

Additional Pharmacy Programs

Asthma Medication Ratio (AMR):

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

Community Resource Center (CRC) Vaccine Clinics:

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

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

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

Compliance & Quality Committee (C&Q) Meeting

Compliance Department
October 17, 2024

Chief Compliance Officer Report Out

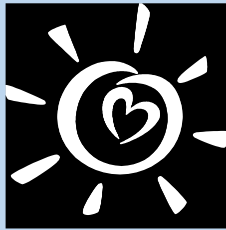
Todd Gower

Chief Compliance Report & Agenda

1. Compliance Report Out from Internal Compliance Committee “ICC” (Todd Gower)
2. Compliance & Quality Committee Charter Review (Todd Gower)
3. Special Investigations Unit Report Out (Michael Devine)
4. Issues Inventory (Mike Sobetzko)
5. Staffing Management Action Plan (Jyl Russell)

Compliance & Quality Committee Charter Review
(Attached doc)

Todd Gower



Board of Governors

MOTION SUMMARY

Date: October 17, 2024

Motion No. COM 100.1124

Committee: Compliance and Quality

Chairperson: Stephanie Booth, MD

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

Background:

Member Impact: None

Budget Impact: None

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

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

CHARTER

I. *General.*

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

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

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

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

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

II. *Committee Goals.*
~~II.~~

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

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

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

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

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

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

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

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

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

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

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

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

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

ComplianceGeneral Duties:

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

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Compliance Duties

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Monitoring & Audit Duties:

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

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

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

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

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

Quality Assurance Duties~~:~~

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

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

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

- ~~QI Program Document~~

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

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

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

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

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General Duties:

Perform other duties as assigned by the Board of Governors.

Amendment of the Compliance and Quality Committee Charter

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

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Reviewed and Approved by:

L.A. Care Health Plan
Board of Governors

John G. Raffoul, DPA, FACHE, SecretaryAlexander K. Li, MD, Board Secretary
Date: ______________________________

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

CHARTER

I. *General.*

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

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

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

The Committee shall meet at least quarterly and more frequently, as necessary. It shall make recommendations to the Board periodically, in consultation with the Chief Executive Officer ("CEO") or their designee, the Chief Compliance Officer ("CCO"), and the Chief Medical Officer ("CMO") on those findings and matters within the scope of its responsibility. The CCO leads the Compliance Program and reports directly to the CEO and the Committee. The CMO leads the Quality Program and reports directly to the CEO and the Committee.

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

II. *Committee Goals.*

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

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

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

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

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

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

III. *Committee Responsibilities.*

The responsibilities of the Committee, on behalf of the Board, shall include:

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

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

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

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

IV. *Committee Duties.*

In carrying out its responsibilities, the Committee shall include, but not limit performance of its duties to, the following:

General Duties

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

Compliance Duties

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

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

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

4. Execute the authority delegated by the Board to the Committee to review and approve biennially the Code of Conduct.

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

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

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

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

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

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

11. Make recommendations to the Board to impose appropriate sanctions, extend or renew contracts, establish policies, procedures and performance standards, impose additional

conditions of participation, and review corrective action plans for any organization that is either directly or indirectly contracted with L.A. Care Health Plan.

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

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

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

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

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

Monitoring & Audit Duties

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

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

3. Receive and review, as appropriate, reports on compliance issues and risks including but not limited to: compliance and quality; exclusion and sanction monitoring; concerns or cases of fraud, waste, and abuse; internal and external audit results; clinical risk; patient safety and privacy; operational performance; and corrective action plans and performance improvement. The CCO and CMO will provide, at a minimum, quarterly written reports. For additional Committee

meetings, the CCO and CMO (or their approved designee(s)) may provide an oral or written report.

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

Quality Assurance Duties

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

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

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

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

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

General Duties

Perform other duties as assigned by the Board.

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Reviewed and Approved by:

L.A. Care Health Plan
Board of Governors

John G. Raffoul, DPA, FACHE, Secretary

Date: ________________________

Special Investigations Unit Report Out

Michael Devine

Compliance Unit – SIU Update

Presenter: Michael Devine, Ph.D., Director, Special Investigations Unit

FY 23/24 Year-to-Date Recoveries & Savings Dashboard

	June - Sept 2024	FY 23/24
Recoveries	$1.1M	$4.7M
Savings	$2.6M	$9.4M
Totals	$3.7M	**$14.1M**

Law Enforcement

Active Criminal Investigations (FBI, CA DOJ, LASD HALT)	58
Undercover Operations	0
Arrests	2
Pending Prosecution	11
Convictions	3

Compliance Unit - SIU Update

Comparative Analysis FY-23/FY-24

	FY-23	FY-24	% Change
Recoveries	$2.3M	$4.7M	86% Increase
Savings	$5.7M	$9.4M	65% Increase
Total	$8.0M	$14.1M	75% Increase

Compliance Unit - SIU Update

SIU current open case inventory is 404

Month	Year	New Leads	Cases Opened	Cases Closed
6	2024	82	34	8
7	2024	102	37	50
8	2024	98	38	30
9	2024	89	31	26

100% compliance with Regulatory Reporting

Compliance Unit - SIU Update

2024 Lead Source

Lead Source	Count
Internal	353
Plan Partner	196
Law Enforcement	164
Hotline	101
PPG	88
PostShield	47
L.A. Care Website	38
Other	15
Navitus	7

2024 Primary Allegations - Top 10

Allegation	Count
Services not rendered/documented	179
Ineligible Provider	153
Identity Theft	132
Not Fraud	102
Questionable Billing Patterns	99
Transportation	79
Not medically necessary	58
Ineligible Member	21
Pharmacy	21
Request for Information	16
*All Others	149

**All Others is the combined amount from all the other allegation categories that are not part of the top ten.*

Compliance Unit - SIU Update

Special Investigations Unit (SIU)

- Home Health Settlement ($1.5M)
- Hospital Case ($203K lettered)
- Labs Case ($200K+ recovered)
- (2) Wound Care Cases ($660K lettered)
- Dialysis Center ($215K lettered)
- Behavioral Health case ($1.1M lettered)
- Hospice Case ($211K lettered)
- ADHC Case ($150K lettered)

Compliance Unit - SIU Update

- Michael Devine and Frank Arteaga were selected to present at the National Health Care Anti-Fraud Association Annual Conference and will speak on Hospice Fraud.

- Michael Devine and Eric Renteria were speakers at the Healthcare Payment & Revenue Integrity Congress in Las Vegas.

Issues Inventory

Michael Sobetzko

Issues Inventory Update – Summary

Status	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Reported	5	6	7	10	4	6	27	5	1				
Open	2	4	1	2	0	1		3	1				
Closed to inventory	1		2	3	2	3							
Deferred													
Remediated		1	3	1	1			1					
Tracking Only	2	1	1	4	1	2	27	1					
Monitoring Only													

- **Open** – Issues confirmed by Compliance Risk Operations that require oversight and monitoring with business units.
- **Closed to Inventory** – Issues in which business units' are seeking guidance about a regulation or best practice process.
- **Deferred** – Issues in which regulatory guidance (DHCS, DMHC, or CMS) is pending to resolve or issue resolution is dependent on another business units' implementation of a system or process.
- **Remediated** – Issues that require formal or informal corrective action plans for resolution.
- **Tracking Only** – Issues managed by other Compliance areas (such as Regulatory Affairs, Audits, Analysis, Communication and Internal Audit In which the risk management staff is following up for current status updates to closure.
- **Monitoring Only** – Issues in which corrective action plans are completed and monitoring is to be done by Compliance.

Issues Inventory Years 2019 - 2024

OPEN
DEFERRED
TRACKING ONLY

Year	2019	2020	2021	2022	2023	2024
Total	6	134	32	105	212	66
Open				2	15	12
Closed to Inventory					126	10
Deferred			3	21	2	
Remediated	6	134	29	82	50	7
Tracking Only					19	37
Monitoring Only						

Issues Inventory Update – Open

Issue Name and Description	Date Reported	Business Unit	Status
Non Compliance with SB 855 Explanation of Coverage (EOC) Missing Offered Services Two Service types indicated in Final Rule 1300.74.72.01 are missing from the (EOC). 1. Intensive community-based treatment, including assertive community treatment and intensive case management. 2. Intensive home-based treatment. (1609)	8/23/2024	Commercial Products	Open

Issues Inventory Update – Remediation

Issue Name and Description	Date Reported	Accountable Exec./Business Unit	Remediation Description	Date Remediated
D-SNP Special Supplemental Benefit for the Chronically ILL Decommission 2025 Business Unit is seeking regulatory guidance for addressing the members impacted by decommissioning of D-SNP Special Supplemental Benefit for the Chronically ILL (SSBCI) benefit in 2025. (1606)	7/30/2024	Medicare Product, Appeals & Grievances	The D-SNP Special Supplemental Benefit for the Chronically ILL (SSBCI) data for active members who qualify will be uploaded as an alert on their member profile and visible to the agents when they pull up the members' 360 after the effective decommissioning date of 12/31/2024.	8/30/2024
Call Center D-SNP Performance Metric Not Met Q12024 The plan did not meet the D-SNP internal enterprise performance target goals for call center service level >80% and abandonment <3% for the Q12024. (1569)	4/18/2024	Lilian Bravo, Customer Call Center	D-SNP met internal enterprise performance target goals for parts of the 2Q2024 and is being monitored by Corporate Compliance Monitoring.	8/29/2024

2024 Enterprise Risk Assessment Management Action Plan ("MAP")

Staffing MAP

Jyl Russell

Human Resources – Talent Management

Presenter: Jyl Russell

RISK DESCRIPTION AND ACTIVITY	STATUS	START DATE	END DATE
Risk Description: L.A. Care is like other health plans, with risks in recruiting and retaining skilled talent. L.A. Care's process can be perceived as cumbersome and may contain longer cycle times to recruit, promote, and receive approvals for hires. Additionally, L.A. Care has difficulty in timely performance management of staff.			
Human Resources Talent Management Process Remediation Plan and Timeline – Timely Performance Management			
Complete Revisions of P&P HR-214: Employee Conduct and Discipline • Review and approval process – Chief, Legal, Executive team • Finalize documents and post to GRC Policy Manager • Send for Employee Attestations	In progress	9/2/2024 10/1/2024	2/28/25
Updated Manager Training • Create training documentation (include policy and templates) • Pilot training to select group • Launch Training	Not started	10/7/2024	Q2 2025
Provide ongoing coaching and support	In Progress		

Human Resources – Talent Management

Presenter: Jyl Russell

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Human Resources Staffing Process Remediation Plan and Timeline – Improve Recruitment Process			
Address Hard To Fill Positions • Create reporting for hard to fill positions (every other week) • Standardize Review for Talent Acquisition Advisors/Hiring Managers/HR Business Partners • Process for optimization of job postings, grades and department needs • Communicate all ongoing efforts to hiring managers • Ongoing review and appropriate improvements to process	In progress	10/1/2024	Ongoing
Training for managers on L.A. Care's hiring process • Identify and document top issues that delay hiring process (e.g. candidates must meet the Basic Qualifications (BQs)). • Create plan to train managers on recruiting processes so that they may improve the cycle time of their portion of the process. • Determine most effective delivery system • Deliver training	In progress	10/1/2024	TBD
Provide ongoing coaching and support to hiring managers	Ongoing		Ongoing

Questions??

Facility Site Review (FSR)

Compliance & Quality Committee (C&Q)
October 2024
Elaine Sadocchi-Smith FNP, MPH, CHES
Director, Facility Site Review

Report Content & Background

Department of Health Care Services (DHCS) requires Managed Care Health Plans (MCP) to conduct site reviews, which include a Facility Site Review (FSR), Medical Record Review (MRR), and Physical Accessibility Review Survey (PARS) to ensure that all primary care provider (PCP) sites, contracted by health plans to deliver primary care services to their members, have sufficient capacity to:

- Provide appropriate and safe primary health care services.
- Carry out processes that support continuity and coordination of care.
- Maintain patient safety standards and practices.
- Operate in compliance with all applicable local, state, and federal laws and regulations.

Report Content & Background

Health plans must complete initial site reviews and subsequent periodic site reviews of all PCP sites participating in their provider networks.

A site periodic review consists of the Facility Site Review (FSR), Medical Record Review (MRR) and a Physically Accessibility Review (PARS).

Health plans must use and apply the standardized DHCS *FSR/MRR/PARS* survey tools and standards to conduct site reviews at each PCP site. Each health plan is responsible for tracking the survey status of all of its contracted provider sites.

Report Content & Background

HEALTH PLANS MUST COLLABORATE LOCALLY WITH OTHER HEALTH PLANS TO DETERMINE HOW THEY WILL NOTIFY EACH OTHER OF THE SURVEY STATUS AND RESULTS FOR THEIR SHARED PROVIDERS. THE L.A. COUNTY COLLABORATIVE MEETS QUARTERLY WITH OTHER HEALTH PLANS TO ESTABLISH SYSTEMS AND IMPLEMENT PROCEDURES FOR COORDINATING AND CONSOLIDATING SITE AUDITS FOR MUTUALLY SHARED PCPS AND DISCUSS INTERPRETATION OF STANDARDS AND TOOLS.

IN JULY 2020, L. A CARE'S FSR MIGRATED TO HEALTHY DATA SYSTEMS (HDS), THE APPLICATION THAT 17 DIFFERENT CALIFORNIA HEALTH PLANS UTILIZE. ALL FSR/MRR/PARS REVIEWS ARE ENTERED INTO HDS AT THE PROVIDER'S OFFICE. THIS DECREASES DUPLICATION FOR THE NURSES AND STAFF AND ALLOWS US TO RUN REPORTS FOR L.A. CARE AND OUR PLAN PARTNERS.

IN JANUARY OF 2024 DHCS ADDED LANGUAGE TO THE FACILITY SITE REVIEW AND MEDICAL RECORD REVIEW STANDARDS. THE LANGUAGE IN THE TOOL CHANGED HOWEVER, THE TOOL REQUIREMENTS/CRITERIA TO CONDUCT THESE SERVICES DID NOT CHANGE.

Key Findings

Audits completed January –June of 2024

Total audits completed: **136 completed**

Initial Audits: **22 completed**

Periodic Audits: **51 completed**

Annual Audits: **34 completed**

Initial MRR: **22 completed**

Medical Record Review: **3 completed**

Educational visits: **6 completed**

Number of pending audits for the rest of 2024:

- **51** Periodic Audits
- **18** Annual Audits

317 PARS [PARS/ANCL/CBAS] completed for Jan-June 2024

FSR Summary Q1- Q2 2024

156 Criteria, Passing Score ≥ 80%

Facility Site Review Criteria Sections	Q1-Q2 2024
Access/Safety	
A. Site is accessible and useable by individuals with physical disabilities. Sites must have the following safety accommodations for physically disabled persons:	97%
B. Site environment is maintained in a clean and sanitary condition.	97%
C. Site environment is safe for all patients, visitors, and personnel.	94%
D. Emergency health care services are available and accessible 24 hours a day, 7 days a week.	88%
E. Emergency medical equipment appropriate to practice/patient population is available on site:	77%
There is a process in place on site to:	92%
F. Medical and lab equipment used for patient care is properly maintained.	90%
Personnel	
A. Professional health care personnel have current California licenses and certifications.	91%
B. Health care personnel are properly identified.	91%
C. Site personnel are qualified and trained for assigned responsibilities.	92%
D. Scope of practice for non-physician medical practitioners (NPMP) is clearly defined.	85%
E. NPMPs are supervised according to established standards.	97%
F. Site personnel receive safety training annually	68%
G. Site personnel receive training on member rights.	81%
Office Management	
A. Physician coverage is available 24 hours a day, 7 days a week.	95%
B. There is sufficient health care personnel to provide timely, appropriate health care services.	97%
C. Health care services are readily available.	98%
D. There is 24-hour access to interpreter services for non- or limited-English proficient (LEP) members.	95%
E. Procedures for timely referral/consultative services are established on site.	89%
F. Member Grievance/Complaint processes are established on site.	94%
G. Medical records are available for the practitioner at each scheduled patient encounter.	100%
H. Confidentiality of personal medical information is protected according to State and federal guidelines.	93%

FSR Summary Q1- Q2 2024

156 Criteria, Passing Score ≥ 80%

Facility Site Review Criteria Sections	Q1-Q2 2024
Clinical	
A. Drugs and medication supplies are maintained secure to prevent unauthorized access.	79%
B. Drugs are handled safely and stored appropriately.	92%
C. Drugs are dispensed according to State and federal drug distribution laws and regulations.	93%
D. Site is compliant with Clinical Laboratory Improvement Amendment (CLIA) regulations	84%
E. Site meets CDPH Radiological inspection and safety regulations.	100%
The following documents are posted on site:	99%
The following radiological protective equipment is present on site:	100%
Preventive	
A. Preventive health care services and health appraisal examinations are provided on a periodic basis for the detection of asymptomatic diseases.	91%
B. Health education services are available to Plan members.	95%
Infection	
A. Infection control procedures for Standard/Universal precautions are followed.	90%
	88%
C. Contaminated surfaces are decontaminated according to Cal-OSHA Standards.	96%
Disinfectant solutions used on site are:	93%
D. Reusable medical instruments are properly sterilized after each use.	83%
Staff adheres to site-specific policy and/or manufacturer/product label directions for the following procedures:	86%
3) Cold chemical sterilization/high level disinfection:	89%
4) Autoclave/steam sterilization.	83%

MRR Summary Q1- Q2 2024

147 Criteria, Passing Score ≥ 80%

Medical Record Review Criteria Sections	Q1-Q2 2024
Format	**91%**
Individual Medical Record is established for each member.	
A. Member identification is on each page.	
B. Individual personal biographical information is documented.	
C. Emergency "contact" is identified.	
D. Medical records are maintained and organized.	
E. Member's assigned and/or rendering primary care physician (PCP) is identified.	
F. Primary language and linguistic service needs of non-or limited-English proficient (LEP) or hearing/speech-impaired persons are prominently noted.	
G. Person or entity providing medical interpretation is identified.	
H. Signed Copy of the Notice of Privacy.	
Documentation	**98%**
A. Allergies are prominently noted.	
B. Chronic problems and/or significant conditions are listed.	
C. Current *continuous* medications are listed	
D. Appropriate consents are present:	
1) Release of Medical Records	
2) Informed Consent for invasive procedures	
E. Advance Health Care Directive Information is offered.	
F. All entries are signed, dated, and legible.	
G. Errors are corrected according to legal medical documentation standards.	

MRR Summary Q1- Q2 2024

147 Criteria, Passing Score ≥ 80%

Coordination	92%
A. History of present illness or reason for visit is documented.	
B. Working diagnoses are consistent with findings.	
C. Treatment plans are consistent with diagnoses.	
D. Instruction for follow-up care is documented.	
E. Unresolved/continuing problems are addressed in subsequent visit(s).	
F. There is evidence of practitioner *review* of specialty/consult/referral reports and diagnostic test results.	
G. There is evidence of *follow-up* of specialty/consult/referrals made, and results/reports of diagnostic tests, when appropriate.	
H. Missed primary care appointments and outreach efforts/follow-up contacts are documented.	
Pediatric	
A. Initial Health Appointment (IHA) Includes H&P and Risk Assessment	89%
1) Comprehensive History and Physical	
2) Member Risk Assessment	
B. Subsequent Comprehensive Health Assessment	87%
1) Comprehensive History and Physical exam completed at age-appropriate frequency	
2) Subsequent Risk Assessment	
C. Well-child visit	77%
1) Alcohol Use Disorder Screening and Behavioral Counseling	
2) Anemia Screening	
3) Anthropometric Measurements	
4) Anticipatory Guidance	
5) Autism Spectrum Disorder Screening	
6) Blood Lead Screening	
7) Blood Pressure Screening	
8) Dental/Oral Health Assessment	
a) Fluoride Supplementation	
b) Fluoride Varnish	
9) Depression Screening	
a) Suicide-Risk Screening	
b) Maternal Depression Screening	
10) Developmental Disorder Screening	

MRR Summary Q1- Q2 2024

147 Criteria, Passing Score ≥ 80%

11) Developmental Surveillance	
12) Drug Use Disorder Screening and Behavioral Counseling	
13) Dyslipidemia Screening	
14) Hearing Screening	
15) Hepatitis B Virus Infection Screening	
16) Hepatitis C Virus Infection Screening	
17) Human Immunodeficiency Virus (HIV) Infection Screening	
18) Psychosocial/Behavioral Assessment	
19) Sexually Transmitted Infections (STIs) Screening and Counseling	
20) Sudden Cardiac Arrest and Sudden Cardiac Death Screening	
21) Tobacco Use Screening, Prevention, and Cessation Services	
22) Tuberculosis Screening	
23) Vision Screening	
D. Childhood Immunizations	**90%**
1) Given according to Advisory Committee on Immunization Practices (ACIP) guidelines	
2) Vaccine administration documentation	
3) Vaccine Information Statement (VIS) documentation	
Adult	
A. Initial Health Appointment (IHA): Includes H&P and Risk Assessment	**84%**
1) Comprehensive History and Physical	
2) Member Risk Assessment	
B. Periodic Health Evaluation according to most recent United States Preventive Services Taskforce (USPSTF) Guidelines	**79%**
1) Comprehensive History and Physical Exam completed at age-appropriate frequency	
2. Subsequent Risk Assessment	

MRR Summary Q1- Q2 2024

147 Criteria, Passing Score ≥ 80%

C. Adult Preventive Care Screenings	73%
1) Abdominal Aneurysm Screening	
2) Alcohol Use Disorder Screening and Behavioral Counseling	
3) Breast Cancer Screening	
4) Cervical Cancer Screening	
5) Colorectal Cancer Screening	
6) Depression Screening	
7) Diabetic Screening	
a. Comprehensive Diabetic Care	
8) Drug Use Disorder Screening and Behavioral Counseling	
9) Dyslipidemia Screening	
10) Folic Acid Supplementation	
11) Hepatitis B Virus Screening	
12) Hepatitis C Virus Screening	
13) High Blood Pressure Screening	
14) HIV Screening	
15) Intimate Partner Violence Screening for Women of Reproductive Age	
16) Lung Cancer Screening	
17) Obesity Screening and Counseling	
18) Osteoporosis Screening	
19) Sexually Transmitted Infection (STI) Screening and Counseling	
20) Skin cancer Behavioral Counseling	
21) Tobacco Use Screening, Counseling, and Intervention	
22) Tuberculosis Screening	
D. Adult Immunizations	66%
1) Given according to ACIP guidelines	
2) Vaccine administration documentation	
3) Vaccine Information Statement (VIS) documentation	

FSR/MRR Q1- Q2 Challenges

Lack of knowledge and training regarding medical record review standards by site staff and physician

Increase in use of telehealth for episodic visits

PCP site does not maintain corrective actions taken upon completion of the site review process

EMR systems do not provide a field to document certain criteria and will incur additional costs to PCP sites if implemented

Some offices indicate they are understaffed and don't have time to review packets we send pre-audit to prepare for on-site visit

Recent updates to FSR/MRR standards have increased non-passing scores among PCP sites. This is primarily due to a lack of full awareness and understanding of new changes by PCP sites.

Enhanced medical record criteria requiring PCPs to complete additional tools not previously mandated

Increase in the number of vaccinations assessed, contributing significantly to a higher failure rate

FSR/MRR Q1- Q2 Actions Taken

All provider sites receive the pre-audit packet with informational material on each area of criteria for FSR/MRR

Continue to provide technical assistance, resources, and on-site support and guidance as necessary

Continue to discuss with L.A. Care FSR Task Force low-scoring criteria and opportunities to improve compliance rates

Continue to reinforce education and training for PCP sites. FSR/MRR video training for providers and office staff have been uploaded to provider portal. Annual review of all materials to ensure up to date information is posted.

We are readily available to answer all questions and provide coaching

Facilitate access to medical record templates and documents ensuring sites have necessary information

Sharing multiple strategies and explanations on how to meet and comply with updated criteria effectively

Policy and Procedure Implementation: Providing sample policy and procedure documents for PCPs to implement

In-Depth CAP Review and Best Practice Education: While on-site, FSR staff meticulously review CAPs with providers, offering detailed education on best practices and ensuring a thorough understanding of steps required for compliance.

Future Vision and Strategy for FSR

Expansion of Training Services	• FSR to mange Child Health and Disability Prevention (CHDP) program education and information • Enhanced Training offerings – Provide PCP offices with online trainings for required CHDP
CPSP Auditing	• FSR to take over Comprehensive Perinatal Services Program (CPSP) • Ensuring compliance and quality standards are met
Integration with MSRP State Data System	• FSR to continue to submit required data through MSRP to streamline data submission for efficiency
Professional Development	• Continuous training and upskilling of CSRs • Working with HR to develop career pathway and retention strategies • Continue seeking ways to improve and ensure fairness and accuracy in our auditing practices

Committee Recommendations & Feedback

- Committee Feedback and Approval

Questions?

Initial Health Appointment (IHA)

Overview and Updates

Compliance & Quality Committee (C&Q)
Date: October 17, 2024
Presenter: Elaine Sadocchi-Smith FNP, MPH, CHES
Director Population Health Management

Report Content & Background

Initial Health Appointment (IHA) is a Medi-Cal requirement (APL 22-030) for all newly enrolled members to complete with their provider within 120 days of enrollment

The IHA is **NOT** a single assessment form but includes the following important components:

- Physical and mental medical history
- Identification of risks
- Assessment of need for preventive screens or services (e.g. Immunizations)
- Health Education
- Diagnosis and plan for treatment of any diseases

L.A. Care has implemented a **wide-range of interventions** to encourage members to schedule and complete their IHA and for providers to get valuable data to schedule and complete their patients' IHA.

Key Findings: IHA

L.A. Care has implemented and enhanced member and provider outreach to educate and provide actionable resources for members to schedule and providers to complete the IHA with their newly enrolled members.

"Potential" IHA Completion Rates continue to be low, with a 32% compliance rate for MCLA year to date (September 2024):

L.A. Care's Population Health Management (PHM) and Corporate Compliance Monitoring (CCM) teams have reached out to compliance to setup a meeting with DHCS to understand best practices and what aside from 100% compliance could close this finding. DHCS denied the meeting

Line of Business	2024 Rate (YTD)	2023 Rate	2022 Rate	2021 Rate
MCLA	32.27%	30.63%	35.8%	26.9%

Highlights/Goals Met

- Per DHCS APL regulations, L.A. Care has all IHA processes fully operationalized and up to date, including:
  - IHA Policy and Procedures
  - Training
  - Provider reports and notifications
  - Member reminders
  - Monitoring Program
  - IHA completion including in the Pay for Performance (P4P) Program

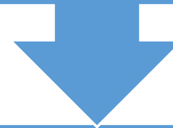
- The PHM team enhanced the IHA Compliance Reports to provide **useful actionable data** for internal compliance and for provider outreach including top and bottom providers and an overall scorecard
  - L.A. Care shares the reports monthly in the provider portal and sends a monthly notification
  - Reports are reviewed in QI JOMs and shared with account managers

Any Areas of Poor Performance

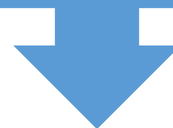
- **IHA**: DHCS has one potential finding from the June 2024 Audit. L.A. Care is waiting on the final results. However, PHM, Corporate Compliance Monitoring, and Compliance have drafted a Corrective Action Plan (CAP) based on the preliminary findings.
  - *The Plan did not ensure that each new member received a complete IHA within the required timeframe.*

Root Cause Analysis: IHA

Participating Physician Groups (PPGs) and providers do not have sufficient time, do not follow the process thoroughly, and/or do not have the incentive to complete the IHA in a timely manner and document appropriately.



Insufficient corrective action of PPGs not completing of IHAs.



Members are not aware or encouraged sufficiently to schedule and complete the IHA.

Reoccurring Issue(s) - IHA

Low Compliance: Despite member and provider outreach, L.A. Care continues to have low IHA compliance rates and continues to receive a finding from DHCS.

Provider Challenges: Providers have competing priorities, and outreach/tracking/ documenting and ensuring IHA completion continues to be a challenge for many providers and provider groups.

Small Sample for Monitoring: Corporate Compliance Monitoring (CCM) only monitors a small portion of the providers through quarterly case file review.

Sample volume per delegate

– PPGs with 500 or less assigned members - two cases

_ PPG with greater than 500 assigned members – five cases

Actions Taken: IHA

IHA Cross-functional Team

- Developed **training** available for providers and internal staff
- Added IHA performance to L.A. Care's **incentive** P4P program

IHA Cross-functional Team

- Updated IHA Due Reports to be IHA Compliance Reports to include an **overall scorecard** and top and bottom provider compliance with IHA.
- Scorecards are delivered monthly to Direct Network providers and PPGs for down streaming through provider portal
- Scorecards are used by Account Mangers and CCM, shared at QI JOMs and Enterprise JOMS

IHA Cross-functional Team

- Developing **member reminder call campaigns and member text campaign** (launching October 2024)

Follow-up/Next Steps: IHA

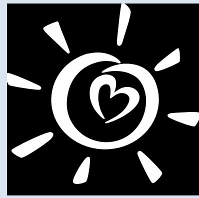
- **Finalize CAP** once findings are released by DHCS (already drafted and starting actions proactively).
- Annual **review of IHA P&P** at Nov Quality of Care (QOC) meeting
- Initiating the following updated interventions:
  - Member IHA **text campaign**
  - Member IHA **reminder robocalls**
  - **Live outreach member calls** for members due for an IHA who have visited the ER or Urgent Care
  - Developing a **provider tip sheet** at lacare.org
  - Developing a **provider template for documenting outreach** to schedule IHAs, member refusals, and no-shows

- IHA is a **cross-functional effort**. We need everyone's input! Any questions/ideas. Please join the IHA Workgroup or reach out: IHA@lacare.org

C&Q Committee Recommendations & Feedback

- C&Q Committee approval

Questions?



Board of Governors
MOTION SUMMARY

Date: October 17, 2024 **Motion No.** COM 100.1124

Committee: Compliance & Quality **Chairperson:** Stephanie Booth, MD

Requesting Department: Utilization Management

Issue: Approval of 2023 UM Program Evaluation and 2024 UM Program Description

Background: The Utilization Management documents must be reviewed and approved annually by the plan's governing board in accordance with regulatory, contractual and accreditation standards.

The 2023 UM Program Evaluation covers accomplishments in our Medi-Cal, PASC-SEIU, L.A. Care Covered and Dual Special Needs Plans (D-SNP) lines of business.

The 2024 UM Program Description describe 2024 activities for our Medi-Cal, PASC-SEIU, L.A. Care Covered and Dual Special Needs Plans (D-SNP) lines of business.

The documents referenced above are attached for review. A copy of both documents will be available at the Compliance and Quality meeting on October 17, 2024.

Member Impact: The 2023 UM Program Evaluation documents that the organization annually evaluates and updates the UM program as necessary to determine if it remains current and appropriate. Member and practitioner experience data is considered and the UM program is updated based on its evaluation. The intent of the 2024 UM Program Description is to document that the organization has a well-structured UM program and makes utilization decisions affecting the health care of members in a fair, impartial and consistent manner.

Budget Impact: None.

Motion: **To approve the following documents:**

- **2023 UM Program Evaluation**
- **2024 UM Program Description**

LA Care

Utilization Management

2024 Program Description

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History and Company Overview

L.A. Care is an independent local public entity created by the State of California to serve Los Angeles County residents. L.A. Care is a federally qualified health maintenance organization and a California-licensed Knox-Keene health care service plan. In 1992, the State Department of Health Services established a Two-Plan Model for Medi-Cal Managed Care in Los Angeles County, in which they would contract with a locally developed public health plan and a commercial health plan to serve the Medi-Cal population. Originally known as the Local Initiative Health Authority for Los Angeles County, L.A. Care was created in 1994 by the State of California. L.A. Care, the locally developed public health plan of this Two Plan Model, is a tax-exempt public entity pursuant to IRS Code Section 170(b)(1)(A)(v).

L.A. Care's initial mission was to ensure the provision of health care to the vulnerable and low-income communities and residents and to support the safety net. This has greatly improved access to healthcare for hundreds of thousands of Los Angeles County residents. At its inception, the organization's primary focus was serving the health care needs of Los Angeles County's Medi-Cal beneficiaries under the Temporary Assistance for Needy Families Aid Codes. Over the years, L.A. Care has expanded to provide access to quality healthcare for Los Angeles County's Healthy Families, Healthy Kids, PASC-SEIU members, and Medicare beneficiaries. In 2014, Healthy Families members transitioned into Medi-Cal and L.A. Care Covered and Dual Special Needs Plans (D-SNPs) members were added as new product lines. At the end of 2016, the Healthy Kids program was terminated. L.A. Care has carefully evaluated the membership for assistance with transition to other coverage as well as continued care needs for those who were unable to coordinate active coverage on 1/1/2017. For those members, L.A. Care has extended coverage for chronic medications and care. Essentially, all of the Healthy Kids membership has transitioned successfully into Medi-Cal.

L.A. Care has delegated the provision of health services to members to various Plan Partners and Participating Provider Groups (PPGs)/Independent Provider Agreements (IPAs) through various contractual arrangements. In 2016, L.A Care began developing a directly contracted provider network and continues to do so. Today L.A. Care maintains four key lines of business: Medi-Cal, Covered California, Dual Special Needs Plans (D-SNPs) and PASC-SIEU. L.A. Care Health Plan's mission is to provide access to quality health care for Los Angeles County's vulnerable and low-income communities and residents; and to support the safety net required to achieve that purpose. Our vision is to build "a healthy community where all residents have access to the health care they need, when it is needed."

Program Purpose and Overview

L.A. Care has program descriptions along with policies and procedures to describe the structures needed to provide high quality health care while being stewards of taxpayer resources. The Utilization Management (UM) Program Description outlines the structure of our management and measurement of utilization of health care services within our system. Of note, L.A Care financially capitates various delegates for specific services, depending on the contractual relationship, and those delegates reserve the right to establish their own authorization rules and processes for those services with close delegation oversight. The UM Program Description does not outline the authorization processes for each of those delegated entities.

The L.A. Care UM program serves to implement a comprehensive integrated process that actively evaluates and manages utilization of health care resources delivered to all members and to actively pursue identified opportunities for improvement.

The UM program is housed within the Health Services Department that consists of the following teams:

- Utilization Management
- Care Management
- Social Work
- Behavioral Health
- Managed Long Term Support Services (LTSS)
- Pharmacy
- Quality Improvement
- Safety Net Initiatives
- Clinical Assurance

The L.A Care UM program serves to accomplish the following:

- Ensure that members receive the appropriate quality and quantity of healthcare service
- Ensure that members receive care from the appropriate provider
- Ensure that healthcare service is delivered at the appropriate time
- Ensure that the setting in which the service is delivered is consistent with the medical care needs of the individual
- Ensure that the network of providers, facilities, vendors and subcontractors is adequate to serve the needs of our members

Each department within Health Services plays a critical role in ensuring these are fulfilled.

L.A. Care recognizes the potential for under-utilization and over-utilization of health care services and takes appropriate steps and actions to monitor for this. The processes for UM decision-making are based solely on the appropriateness of the care and services and the existence of coverage. There is a separation of medical decisions from fiscal and administrative management to assure that fiscal and administrative management will not unduly influence medical decisions. L.A Care does not specifically reward practitioners or other individuals for issuing denials of coverage. Financial incentives for UM decision makers do not encourage decisions that result in inappropriate utilization of resources and L.A. Care does not use incentives to encourage barriers to care and service. This does not preclude the use of appropriate incentives for fostering efficient, appropriate care.

The UM program provides a reliable mechanism to review, monitor, evaluate, recommend and implement actions on identification and correction of potential and actual utilization and resource allocation issues. While each year L.A Care will undergo a formal complete UM Program Evaluation to ensure all goals and objectives are met and identify areas of opportunity for improvement, the program aims to be continuously improved in real-time based on feedback, benefit changes, authorization changes and network changes.

Program Goals and Objectives

The L.A Care UM program serves to ensure that appropriate, high quality cost-effective utilization of health care resources, including medical and behavioral, are available to all members in a timely

manner. This is accomplished in a fair, impartial, and consistent manner void of discrimination through the systematic and consistent application of utilization management processes based on current, relevant medical review criteria and expert clinical opinion when needed. The UM process provides a system that ensures equitable access to high quality health care across the network of providers for all eligible members by:

- Ensuring that requested services delivered are medically needed and consistent with diagnosis and level of care required for each individual taking into account any co-morbid condition that exists and the ability of the local delivery system to meet the need
- Defining the methods by which utilization criteria and clinical practice guidelines are selected, developed, reviewed, and modified based upon appropriate and current standards of practice and professional review
- Ensuring authorized services are covered under contract with the State of California Department of Health Services (DHCS) California Code of Regulations (CCR) Title 22 or CMS for Medi-Cal and Dual Special Needs Plans (D-SNPs) members respectively.
- Coordinating thorough and timely investigations and responses to member and provider reconsiderations, disputes, appeals and grievances associated with utilization issues
- Monitoring utilization practice patterns of practitioners, PPGs, Specialty Vendors, and Planned Partners to identify trends and opportunities for improvement.
- Monitoring both inpatient and outpatient care for possible quality of care deficiencies, and utilize indicator screening criteria, documenting and submitting all potential deficiencies to the Quality Improvement (QI) Department
- Identifying and addressing known or potential quality of care issues (PQIs) and trends that affect the health care and safety of members and implement corrective action plans as needed.
- Optimizing the member's health benefits by linking and coordinating services with the appropriate county/state sponsored programs
- Educating practitioners, providers and internal staff about L.A. Care's goals for providing quality, cost-effective managed health care on the utilization management policies and procedures to ensure alignment with the UM Program and Practices established by L.A. Care, as well as compliance with contractual, regulatory and accreditation requirements as well as assisting in achieving the goals and objectives of the Program
- Promoting and ensuring the integration of utilization management with quality monitoring and improvement, risk management, behavioral health and case management activities
- Improving physician and member satisfaction by analyzing member and practitioner experience data and complaints, regarding the UM program, to identify opportunities and implement appropriate interventions for continuous improvement of services.
- Ensuring a process for critical review and assessment of the UM program and plan on, at minimum, an annual basis, with updates occurring more frequently if needed. The process incorporates practitioner and member input along with any regulatory changes, changes to current standards of care, and technological advances
- Evaluating the ability of delegates to perform UM activities and to monitor performance

Program Structure

Delegation

Various UM activities are delegated to different contracted providers through contractual arrangements, including but not limited to:

- Plan Partners
- Participating Provider Groups (PPGs)/Independent Practice Associations (IPAs)
- Carelon Behavioral Health
- Navitus

The scope of delegated functions varies based on each entity and L.A. Care maintains responsibility for providing authorization and coordination of services for all non-delegated functions. A delegation agreement, including a detailed list of activities delegated and reporting requirements, is signed by both the delegate and L.A Care.

- Providers to whom UM activities have been delegated are responsible for reporting results and analyses to L.A Care on a quarterly or annual basis. Reports are summarized for review and evaluation by the UM Committee (UMC).
- Evaluation includes a review of both the processes applied in carrying out delegated UM activities, and the outcome achieved in accordance with the respective policy(s) and agreement governing the delegated responsibility.
- The UMC reviews delegate performance and make recommendations regarding opportunities for improvement and continuation of delegated functions.

A pre-delegation evaluation is conducted when delegation of functions to providers is being considered.

Internal Structure

This section outlines the individual program staff, its' assigned activities, including approval authority and the involvement of the designated physician, and the committee governance structure.

Senior UM Leadership

Chief Medical Officer (CMO)

The CMO is a physician with an active, unrestricted license to practice in the State of California. The CMO, or his/her equivalently licensed designee, is responsible for providing leadership, policy direction, clinical support and implementation, and oversight of the UM Program. This includes monitoring and oversight of the results of program activities and services, and ensuring that fiscal and administrative management decisions do not compromise the quality of care and service provided to L.A. Care members. The CMO may delegate the program implementation and oversight responsibilities to a delegate whose responsibilities encompass the care and service needs of the respective programs.

Senior Medical Director, Utilization Management and Care Management

The Senior Medical Director is a physician with an active, unrestricted license to practice in the State of California who acts as a liaison in the resolution of UM issues with practicing physicians. The Senior Medical Director:

- Assists the DCMO in the implementation, supervision, oversight, evaluation, and assuring compliance with all UM Program requirements.

- Interfaces with the UM staff daily and is a resource to them when evaluating cases, including reviewing denials.
- Is available 24 hours per day, seven days each week to assist with utilization issues.
- Supports the promotion of managed care systems and offers education to the providers to facilitate appropriate utilization.
- Chairs UM Committee.
- Assures compliance with regulatory requirements.
- Oversees the UM Program, which may include:
    - Reviewing UM cases
    - Ensuring that medical decisions are:
        - Rendered by qualified medical personnel.
        - Not influenced by fiscal or administrative management considerations.
        - Reviewers to ensure UM decision criteria are consistently applied and implementing corrective actions when needed.
        - Ensuring that medical care provided meets the standard for acceptable medical care.
        - Ensuring that medical protocols and rules of conduct for plan medical personnel are followed.
        - Leading, advising, educating and/or auditing the team of physicians functioning as physician reviewers
- Develops and implements medical policy.
- Participates in the function of L.A. Care's grievance processes
    - Ensures department processes are maintained to identify and refer grievances related to medical quality of care.
- Is directly involved in the implementation of process and quality improvement activities.
- Ensures second opinions are available for all members from a qualified health professional at no cost to the member.
- Reports UM activities to designated committees on a quarterly basis.

Senior Medical Director, Behavioral Health

The Medical Director, Behavioral Health provides leadership and program development and systems ensuring the integration of physical, behavioral and substance use health care services for L.A. Care members. The Medical Director, Behavioral Health:

- Is a physician with an active, unrestricted license to practice in the State of California.
- Provides clinical and operational oversight for behavioral health benefits and services provided to L.A. Care members.
- Ensures that a psychiatrist or clinical psychologist reviews any denials of behavioral health care that are based on medical necessity.
- Works closely with all departments to ensure appropriate access and coordination of behavioral healthcare services, improves member and provider satisfaction with services and ensures quality behavioral health outcomes.
- Serves on the Quality Improvement and UM Committees

Clinical Operations Executive

The Clinical Operations Executive (COE) of L.A. Care Health Plan is a senior leader focused on streamlining operations within Health Services to improve clinical outcomes for its members. This individual reports directly to the Chief Medical Officer (CMO) and is responsible for the following activities:

- Overseeing the operational, clinical and administrative management and implementation of Health Services functions in L.A. Care
- Managing the planning, organization, direction, staffing and development of L.A. Care's Utilization Management, Care Management, Managed Long Term Supportive Services and Clinical Assurance functions
- Working with the Chief Operating Officer (COO) to receive non-clinical operational functional guidance to ensure end-to-end operational integration
- Overseeing the process of measuring and analyzing effectiveness of Plan Partners and delegated PPG functions
- Monitoring operational compliance with organizational standards, policies and procedures, and regulatory requirements for all areas of responsibility
- Working collaboratively with Health Services leadership, as well as other Senior Leaders and management across the organization

Sr. Director and Directors of Utilization Management

The Sr. Director and Directors of Utilization Management have day-to-day responsibilities for the operation of the UM Program under the direction of the Chief Operations Executive. The Sr. Director and Director of Utilization Management:

- Oversee the UM units consisting of an adequate number of UM staff with the required qualifications to perform UM in a managed care environment.
- Ensures staff receives direction and supervision by the Supervisors and Leads of the Utilization Management Department.
- Provides supervisory oversight and administration of the Utilization Management Program.
- Supports UM medical management decisions, provides oversight, and is also responsible for planning, implementing, and directing utilization management.
- Partners with internal stakeholders to develop and implement short- and long-term strategies to improve health outcomes.
- Interfaces with public entities, leaders of regulatory agencies, and the community as a delegate and ambassador of L.A. Care
- Maintain an operationally compliant UM Department that ensures services are completed in the required timeframe and patient and provider services are delivered appropriately.
- Assures departmental compliance with all contracts, Centers for Medicare and Medicaid Services (CMS), California Department of Health Care Services (DHCS), California Department of Managed Health Care (DMHC) regulations and other applicable state and federal regulations.
- Oversees and monitors operational compliance with organizational standards, policies and procedures and regulatory requirements. Assures department meets all regulatory time frames on UM and appeals determinations.
- Develops and implements departmental policies and procedures, desk procedures and workflows. Develops and maintains departmental statistical performance reports. Develops, implements and monitors performance standards.

- Performs ongoing monitoring and evaluation of departmental operations to assure optimal efficiency and effectiveness.

The Sr. Director and Directors of Utilization Management also serves on the UM Committee and:

- Assists in development and implementation of the Utilization Management Program
- Assists in the development and implementation of policies and procedures and
- Ensures that appropriate UM Committee functions are supported by qualified and appropriate staff
- Collects and screens UM data input from various sources to identify utilization trends for presentation to the UM Committees for information, recommendations or actions
- Facilitates the comprehensive centralized review of utilization trends by the UM Committees and periodically by the QA/QIC committee
- Assures data security and confidentiality of all utilization and committee information
- Oversees results of delegate oversight activities and reporting of trends or issues to appropriate committees
- Oversees coordination of care and services related to UM referral management.

Chief Pharmacy Executive

The Chief Pharmacy Executive is directly responsible on all business aspects related to pharmacy operations UM decision-making and significantly contribute to the strategic direction of the organization by integrating pharmaceutical care delivery with medical care and operational delivery strategy. The Chief Pharmacy Executive is responsible in providing pharmacy business and clinical forecast assessments to contribute to good decision-making on the strategic direction of the organization to achieve its positive outcomes. Key responsibilities include:

- Leading the development and enforcement of all policies & procedures
- Overseeing regulatory and compliance of plan partners' related operations, Pharmacy Benefit Management (PBM) functions and performance, clinical pharmacy service operations for direct lines of business, and vendor service agreements/RFPs
- Ensuring that a licensed pharmacist conducts reviews on cases that do not meet review criteria/guidelines for any potential adverse determinations (medication denials)
- Providing supervision of the coordination of Pharmacy-related clinical affairs
- Overseeing all medication use decision policies and monitor for inappropriate utilization
- Devising new clinical guidelines for medications

UM Program Staff

Medical Directors / Physician Reviewers

Under the direction of the UM Medical Director, physician reviewers perform daily case review. Their responsibilities include:

- Interfacing with the UM staff daily and serving as a resource to them when evaluating cases
- Reviewing all escalated cases for potential adverse determinations
- Assisting nurses in discharge planning of all complicated inpatient admissions
- Performing timely reviews of all member and provider appeals

UM Nurse Specialist

UM Nurse Specialists are responsible for assessing the medical appropriateness and quality of proposed services in accordance with established criteria. This activity may be conducted prospectively, concurrently, or retrospectively. Assigned activities may include:

- Reviewing and authorizing Durable Medical Equipment (DME), Ancillary and Medical Treatment Authorization Requests (TARs) based on established guidelines
- Reviewing and authorizing Long Term Care TARs based on established guidelines
- Reviewing and authorizing inpatient Hospital TARs based on established guidelines
- Retrospective review of services to determine medical necessity
- Referring cases to a peer reviewer for requests that may not appear to meet evidence-based medical necessity criteria
- Determining if requested services are part of the members benefit package
- Initiating Letters of Agreement (LOAs) as needed with out of network providers
- Requesting/obtaining additional medical information as needed from physician offices
- Working collaboratively with the Care Coordination, Pharmacy and Quality Improvement staff on UM issues.

UM Nurse Supervisor

UM Nurse Supervisors are responsible for the daily mentorship and oversight of the nursing staff. This position has the authority to make decisions on coverage not relating to medical necessity. The assigned activities include:

- Working collaboratively with all levels of leadership within the department to efficiently coordinate workflow and individual staff assignments
- Providing day to day supervision to the assigned team, overseeing daily operation of all inpatient and outpatient review processes
- Participating in staff trainings and continuing education and conducts annual performance evaluations for assigned UM staff
- Auditing medical records as appropriate and monitors for consistent application of UM Criteria by UM staff, for each level and type of UM decision.
- Supporting clinical staff in matters of escalation

This position, in addition to his/her own case load, may be assigned cases in the area of oversight as deemed necessary to provide coverage

UM Nurse Educator

The UM Nurse Educations is responsible for ensuring all clinical staff is adequately trained and mentored. The responsibilities include:

- Providing training for all new nurse hires and retraining of identified topics as deemed necessary.
- Coordinating monthly nurse education sessions on implementation of clinical guidelines
- Creating and maintaining current training materials including assessing eligibility, managing reviews processes and effectuating UM policy and procedures.
- Conducting the annual inter-rater reliability assessment and performing remediation as needed.
- Acting on recommendations from the UM Quality Nurse, other qualified clinicians, and/or regulatory audit findings to provide individual training/remediation

UM Quality Nurse Manager

The quality nurse is responsible for ensuring the accuracy of clinical decision making and adhering to state, federal, and local regulatory requirements for the department. Responsibilities include:

- Reviewing all decisions made by clinical staff, including nurses and physicians
- Reviewing regulatory compliance of all denial letters and providing feedback
- Conducting monthly audits and coordinating the UM Nurse Education re-trainings and remediation

UM Operations Manager

The Utilization Management (UM) Operations Manager is responsible for the overall day-to-day operations of non-clinical staff and activities that do not require clinical licensure in the UM department. This role will work closely with the UM Director, UM Medical Director, and UM Nurse Leaders to:

- Manage a team of Operations personnel to orchestrate and oversee the completion of Operations-related tasks
- Develop and organize the department's work priorities and deliverables
- Establish, maintain, and execute workflows, tools, processes, and strategies for his or her team to consistently and successfully provide deliverables
- Assess operational needs of the business unit and develops actionable plans to mitigate those needs
- Collaborate with interfacing departments to ensure that productivity including, but not limited to, timeliness and accuracy, is maximized

UM Authorization Technicians (ATs)

ATs are non-licensed staff responsible for effective, efficient and courteous interaction with practitioners. Assigned activities include:

- Performing
- Reviewing and making eligibility determinations
- Reviewing referral forms for completeness
- Interfacing with physician offices to obtain any needed non-medical information
- Providing technical support in the form of call screening, authorization and pre-certification data entry.
- Authorizing specific referral request listed in authorization matrix

UM Authorization Technician (AT) Supervisors

UM AT Supervisors are responsible for the daily mentorship and oversight of the AT staff. Assigned activities include:

- Working collaboratively with all levels of leadership within the department to efficiently coordinate workflow and individual staff assignments
- Providing day to day supervision to the assigned team, overseeing daily operation of all inpatient and outpatient intake and review processes
- Participating in staff trainings and continuing education and conducts annual performance evaluations for assigned UM staff
- Auditing cases as appropriate and monitors for consistent and appropriate build type and decision making

- Supporting non-clinical staff in matters of escalation

This position, in addition to his/her own case load, may be assigned cases in the area of oversight as deemed necessary to provide coverage

UM Authorization Technician (AT) Leads

UM AT Leads are responsible for assisting the AT Supervisors, as well as the UM Operations Manager, in developing a successful and cohesive unit with high-level productivity to achieve the department's overall performance metrics. Assigned activities include:

- Serving as a department and staff resource in managing day to day referral management, information system/technology and operational issues
- Monitoring the daily UM inventory of reports/staff queues and ensuring cases are processed within the established timeframe requirements
- Triaging identified issues, resolving applicable issues, and escalating appropriate issues to UM AT Supervisors

Community Health Worker (CHW)

Under the direction of the Operations Manager, the CHW:

- Collaborates with interdisciplinary team to assist in care management and transition of care for complex member population
- Utilizes social work skills and techniques to attempt to motivate individual and family towards self-support, self-care
- Reviews discharge plan to determine eligibility for social programs and community assistance from a variety of funds, agencies, and or programs.
- Participates in staff trainings and on-site continuing education

Health Services Quality Manager

This individual is responsible is responsible for all internal quality control. This includes:

- Ensuring L.A. Care's UM department is able to achieve and maintain accuracy in meeting reporting requirements
- Monitoring all compliance functions, including turn around time and letter compliance, in real time and providing feedback
- Summarizing compliance reports and presents at various committees as appropriate
- Working with leadership team and staff to provide support in meeting requirements of various oversight agencies
- Prepares and submits all required reports timely and accurately

UM Administrative Assistant

Provides administrative support to the UM Director and Medical Director. Responsible for maintaining and updating policy and procedure manuals, managing appointment calendars, and working closely with the Information Technology Department to ensure appropriate electronic functioning for the Health Services Department. This individual supports additional operational needs including, but not limited to, logistical coordination of activities directly impacting the UM department.

Behavioral Health Specialist (BHT)

The BHT is a board certified behavior analyst whose primary responsibility is to provide assistance to the department in identifying, developing, and implementing initiatives/projects that supports an integrated health delivery system for all lines of business to meet the needs of vulnerable populations, such as individuals who are experiencing homelessness, suffer from Severe and Persistent Mental Illness (SPMI), or identify with the LGBTQ communities. This individual also:

- Serves as a liaison to the community stakeholders, providers, governmental agencies, and other contracted providers
- Analyzes data and provides analytic output to the department and the leadership team to help manage the projects service delivery
- Provides comprehensive diagnostic evaluations and review/approve Behavioral Health Treatment plans for the 13 APL mandated elements.

Pharmacists

Clinical Pharmacists are responsible for assessing the medical appropriateness and quality of proposed pharmaceutical services in accordance with established criteria. This activity may be conducted prospectively, concurrently, or retrospectively. Assigned activities may include:

- Leading the research, development and maintenance of clinical pharmacy programs within LA Care, such as the clinical initiatives that impact drug utilization, clinical education and staff development, management of appropriate drug utilization, and drug spend analysis
- Oversight of the medical daily operations of the Pharmacy & Formulary department to ensure regulatory compliance
- Review of pharmacy claims, after-hour calls, and formulary maintenance
- Decision-making on pharmacy authorizations requests and appeals
- Participation in the medical reviews and pharmacy coordination with case management regarding Medical eligible members.

Authority and Accountability

Board of Governors (BoG)

The L.A. Care Board of Governors (Board) promotes and supports, and has ultimate accountability, authority and responsibility for a comprehensive and integrated UM program and the quality of care and service provided to L.A. Care members. The board consists of 13 members representing specific stakeholder groups, including consumer members, physicians, federally qualified health centers, children's health care providers, local hospitals and the Los Angeles County Department of Health Services. This ensures that the broad spectrum of those who make up and participate in the L.A. County safety net guide this organization's direction and investments. The Board delegates more in-depth supervision and oversight to its Compliance and Quality Committee.

The Board has delegated authority for oversight of health services functions to the Chief Medical Officer (CMO). The CMO has the authority and responsibility to ensure that effective Utilization Management Programs are conducted, supported, implemented, and maintained.

Board of Governors Compliance and Quality Committee (C&Q)

The Board of Governors appoints the Board Compliance & Quality Committee (C&Q) and is responsible for reviewing, evaluating, and reporting to the BoG on quality improvement (QI) and utilization management (UM) activities. The C&Q approves the QI and UM Program Documents, Work Plans and

annual evaluations. It makes recommendations to the Board periodically, in consultation with the Chief Executive Officer or designee, the CMO and the Compliance Officer, on the findings and matters within the scope of its responsibility. C&Q receives regular reports from the CMO, the Chief Compliance Officer, and the Quality Oversight Committee. L.A. Care is required under California's open meeting law, the Ralph M. Brown Act, Government Code §54950 et seq., to hold public meetings, except under circumstances specified in the Act. The QOC is a public meeting under the Brown Act.

Quality Oversight Committee (QOC)

The Quality Oversight Committee (QOC) is an internal committee of L.A. Care that reports to the Board of Governors through the Quality and Compliance Committee. The QOC meeting minutes are submitted to the Department of Health Care Services (DHCS) on no less than on a quarterly basis. The QOC is charged with aligning organization-wide quality improvement goals and efforts prior to program implementation and monitoring the overall performance of L.A. Care quality improvement infrastructure. The Quality Oversight Committee is responsible for the overall direction and development of strategies of the UM program including, but not limited to, reviewing all recommendations and actions taken by the UM Committee.

The Quality Oversight Committee has delegated authority to the UM Committee for certain UM oversight functions. This delegation of authority is pursuant to the annual review and approval of the UM Program, UM Policies/Procedures, UM Criteria, and other pertinent UM documents such as the UM Delegation Oversight Plan, UM Notice of Action Templates, and Case/ Care Management Program and Policies/ Procedures.

Behavioral Health Quality Improvement Committee (BHQIC)

The Behavioral Health Quality Improvement Committee (BHQIC) is responsible for collecting and reviewing data, as well as prioritizing, developing, implementing, and monitoring interventions based on the analysis of data to improve continuity and coordination of medical and behavioral health care. L.A. Care delegates Behavioral Health services for Medi-Cal, Medicare, PASC-SEIU, and Covered California to a Managed Behavioral Health Organization (MBHO). L.A. Care works closely with the MBHO in order to collaborate with behavioral health practitioners (BHPs) and use information collected to coordinate medical and behavioral health care. This committee reports to the Quality Oversight Committee and meets quarterly.

The functions of the Behavioral Health Quality Improvement Committee include:

- Assess exchange of information between BHPs, medical/surgical specialists, organization providers or other relevant medical delivery systems.
- Assess appropriate diagnosis, treatment, and referral of behavioral health disorders commonly seen in primary care settings.
- Assess appropriate use of psychopharmacological medications and consistent guidelines for prescribing by behavioral and medical practitioners.
- Assess the screening and managing of patients with coexisting medical and behavioral health conditions.
- Discuss, develop, prioritize, and evaluate interventions to measure effectiveness and evaluate member experience data.

- Collaboratively develop and adopt primary or secondary prevention programs for behavioral health and evaluate effectiveness of program through process or outcomes data.
- Identify opportunities for improvement across all measures.
- Develop training seminars and conferences to educate primary care providers on screening, diagnosis and treatment of mental health and substance uses disorders in the primary care settings.
- Facilitate discussion between primary care physician network and behavioral health practitioner network including LA County DMH and DPH/SAPC as it relates to coordination of care and opportunities for improvement.

Pharmacy Quality Oversight Committee (PQOC) and Pharmacy and Therapeutics (P & T)

The Pharmacy Quality Oversight Committee (PQOC) is responsible for oversight of the Pharmacy and Therapeutics process administered by the existing Pharmacy Benefit Manager (PBM). The committee's role is to review and evaluate drugs and drug therapies to be added to, or deleted from, the formulary and to review new medical technologies or new applications of existing technologies and recommend for benefit coverage, based on medical necessity. The PQOC develops utilization management criteria for all direct product lines of L.A. Care. Additionally, the PQOC provides a peer review forum for L.A. Care's clinical policies and programs, provider communication strategies, pharmaceutical quality programs/outcomes, and specialty drug distribution options. The P&T Committee meets quarterly to review and make pharmaceutical management procedures with consideration to:

- Drug Formulary
- Drug Utilization Review - Step Therapy Review, Quantity Limits Review,
- Generic Substitution and Therapeutic Interchanges or Other Management Methods to which the Practitioner's Prescribing Decision Are Subject
- Coverage Determination (Prior Authorization) criteria
- Coverage Determination – Exceptions criteria
- Pharmaceutical Class Review

The P&T Committee is composed of clinicians who serve as the clinical oversight body for all clinical criteria to ensure promotion of rational, clinically appropriate, and safe drug therapy. Members of the P&T Committee include a broad range of specialists and general practitioners, which may include but is not limited to medical doctors, doctors of pharmacy, registered pharmacists, physician's assistants, registered nurses, advanced practice registered nurses, and doctors of osteopathy. Members of the committee have knowledge and expertise in one or more of the following: clinically appropriate prescribing of covered outpatient drugs, clinically appropriate dispensing and monitoring of covered outpatient drugs, drug use review, medical quality assurance, disease state management, evidence-based medicine, and care of elderly or disabled persons.

The P&T Committee uses clinical evidence from appropriate sources, such as government agencies, medical associations, national commissions, peer-reviewed journals, and authoritative compendia when making decisions about pharmaceutical procedures and formulary.

The PQOC also meets quarterly and has the following functions:
Oversight/Advisory of PBM Vendor:

- Review newly marketed drugs for potential placement on the formulary.
- Provides input on new drug products to Navitus P&T
  - L.A. Care has the ability to overrule a Navitus P&T formulary and/or utilization control decision when required by regulation or unique member characteristics in the health plan
- Develop protocols and procedures for the use, of and access to, non-formulary drug products.

L.A. Care Strategic and Administrative Operations:

- Specialty pharmaceutical patient management and distribution strategies.
- Pharmaceutical care program selection and evaluation.
- Develop, implement and review policies and procedures that will advance the goals of improving pharmaceutical care and care outcomes.
- Serve the health plan in an advisory capacity in matters of medication therapy.
- Recommend disease state management or treatment guidelines for specific diseases or conditions. These guidelines are a recommended series of actions, including drug therapies, concerning specific clinical conditions.

Utilization Management Committee (UMC)

The Utilization Management Committee (UMC) is responsible for oversight of all utilization management activities and promotes the optimum utilization of health care services, while protecting and acknowledging member rights and responsibilities. Only physician members, L.A. Care Directors, and Director-level members of the UM Committee may vote. A quorum is established when fifty one percent (51%) of voting members are present. Membership is reviewed at all meetings and new members most be approved by the committee before joining. Voting members of UMC include:

- CMO and DCMO
- L.A. Care Medical Directors (UM/CM, Behavioral Health and Quality)
- PPG Medical Directors
- Practicing Physicians
- L.A. Care Director, Utilization Management
- L.A, Care Director, Clinical Assurance
- L.A. Care Director, Quality Improvement
- L.A. Care Director, Pharmacy & Formulary
- L.A. Care Director, Managed Long Term Services and Supports
- L.A. Care Director, Care Management
- L.A. Care Director, Grievances and Appeals
- L.A. Care Lead UM Delegation Oversight Specialist

The CMO or designated Health Services Director serves as the Chairperson. The composition of UMC includes a participating Medical Director Behavioral Health to specifically address integration of behavioral and physical health, appropriate utilization of recognized criteria, development of policies and procedures, and case review, as needed. UMC facilitates clinical oversight and direction and responsibilities include:

- Maintaining the annual review and approval of the UM Program Description, work plans and evaluation; UM Policies/Procedures; UM Criteria; and other pertinent UM documents such as the UM Delegation Oversight Program

- Reviewing and approving all Policies/ Procedures for care management, behavioral health, long-term support services and appeals and grievances
- Reviewing medical policy, protocol, criteria and clinical practice guidelines, including but not limited to prior authorization guidelines and implementation of new technologies or new applications of existing technologies for potential addition as a new medical benefit for members
- Reviewing and analyzing utilization data from all departments for the identification of trends and monitoring for potential areas of over- and under-utilization
- Providing oversight of delegated activities
- Identifying practice variances or deviations among plan delegates and recommending what, if any, next steps are appropriate

The committee meets quarterly and all activities and recommendations are reported to the QOC and ultimately the Board of Governors. Meeting attendance is not exclusive to voting members. Others in attendance are typically present as a result of direct invitation, or serve as Ad-hoc members on the basis of meeting content. These attendees are required to sign a Confidentiality Statement prior to the start of the meeting or immediately upon arrival. All meetings of the UMC are formally documented in transcribed minutes that include discussion of each agenda topic, follow-up requirements, and recommendations to the QOC. All minutes are considered confidential. Draft minutes of prior meetings are reviewed and approved by the UMC with noted corrections. These minutes are then submitted to the QOC for review and approval.

Utilization Management Program Scope

L.A. Care offers coverage for comprehensive healthcare delivery, including ambulatory care, inpatient care, emergency services, behavioral health, therapy services, home health care, palliative care and hospice, rehabilitation services, skilled nursing services and preventive services depending on product line. Benefits packages and delegation of decision-making, however, differs across product lines and entity. The UM Program is therefore designed to work collaboratively with both different delegated entities and directly with providers in the community, where indicated, in an effort to assure the delivery of appropriate, cost-effective, quality-based healthcare. Successful implementation of the UM program necessitates the cooperative participation of L.A. Care, delegated entities, health care delivery organizations, providers, physicians and hospitals, as well as members, to ensure timely and effective delivery of health care. The UM staff performs specific functions including but not limited to:

- Use of the most current edition of approved UM evidence-based criteria, including the use of California Department of Health and Welfare Code of Regulations Title 22, Center for Medicare & Medicaid Services (CMS) Code of Federal Regulations (CFR) Title 42 and CMS National and Local Coverage Determinations
- Prospective, concurrent and retrospective utilization review for medical necessity, appropriateness of hospital admission, level of care and continued inpatient confinement on a frequency consistent with evidence-based criteria and L.A Care guidelines, L.A Care criteria/ medical policy and the member's condition. This review is performed cooperatively with the facility care team that may consist of the attending physician(s) and any associated health care personnel who can provide information that will substantiate medical necessity and level of care.
- Discharge planning in collaboration with the facility care team

- Review of requests for outpatient care, skilled nursing care, home health care, durable medical equipment, ambulatory surgery, ambulatory diagnostic and treatment procedures such as physical, occupational and speech therapies
- Ensuring members with chronic conditions including AIDS/HIV requiring continuing specialty care over a prolonged period of time are provided with standing referrals to specialists
- Providing second opinion consultations from qualified providers at no cost to the member
- Following requirements to ensure effective pain management for the terminally ill through medical and pharmacy authorization processes
- Reviewing and authorizing all medically necessary out-of-network requests when no in network options are either available or available timely
- Redirecting all referrals to providers capable and willing to perform the required services, including instances where providers object based on religious or ethical objections
- Evaluating all request for services that are deemed experimental, investigational or of unknown benefit
- Tracking and monitoring referrals and authorizations requests that require prior authorization including authorized, denied, deferred, or modified referrals
- Reviewing inpatient and outpatient UM data to determine appropriateness of member and provider utilization patterns

The UM program incorporates the monitoring and evaluation for the subsequent services and reviews and updates policies and procedures as appropriate at least annually related to:

- Acute hospital services
- Subacute care
- Ambulatory care
- Emergency and urgent care services
- Out of Network referrals when procedures not available in-network
- Durable Medical Equipment and supplies
- Ancillary care services including but not limited to home health care, skilled nursing care, subacute care, and pharmacy, laboratory and radiology services
- Long-term care including Skilled Nursing Facility (SNF) Care and Rehabilitation Facility Care
- Pharmacy drug formulary

Behavioral Health

Behavioral health services include treatment for mental health conditions and for substance misuse conditions. Members may self-refer for behavioral health services by using the toll-free referral number of the Plan's behavioral health vendor, Carelon Behavioral Health. Members do not need a referral from their Primary Care Provider (PCP) to receive behavioral health services.

In an effort to coordinate medical and behavioral health care, behavioral health providers are instructed to ask members to sign a release of information so that the behavioral health provider can contact the member's primary care provider. Behavioral health treatment however, is considered a confidential service, and the release of information is not a condition for the approval or provision of services.

Behavioral health services for Members with Medi-Cal as their primary insurance, including Dual Eligible members, are provided as follows:

- Members determined to have mental health needs that require mild to moderate mental health treatment are served by L.A. Care's delegated contractor, Carelon Behavioral Health
- Members determined to have serious mental health conditions are referred to the County Mental Health Plan. In Los Angeles County, the criteria for serious mental illness are enumerated on Form MH-703 of the L.A. County Department of Mental Health
- Dual-eligible members enrolled in Dual Special Needs Plans (D-SNPs) who require higher levels of mental health care are managed by Carelon Behavioral Health. Medi-Cal members who require higher levels of mental health care are managed by the County Department of Mental Health, as described in California's 1915(b) waiver
- Members determined to have a need for substance abuse treatment are referred to the Substance Abuse Prevention and Control (SAPC) division of the L.A. County Department of Public Health.
- An initial assessment may be performed by any of these entities listed above to determine the most appropriate level of service for the Member, including appropriate referral to a different provider organization. The MH-703 is the primary criteria utilized by Carelon Behavioral Health to triage mental health conditions. The American Society of Addiction Medicine (ASAM) Criteria are the primary criteria utilized by the Department of Public Health to triage substance abuse conditions

L.A. Care's mental health contractor, Carelon Behavioral Health, provides behavioral health services for Members with Covered California or PASC-SEIU as their insurance.

County Mental Health Plans provide crisis assessments and authorizations for acute in-patient care. Immediate access to the crisis service remains an option throughout all phases of treatment by any provider. Members may call the County crisis line directly without a referral. Members eligible for mental health services from L.A Care's delegated contractors will be re-directed to appropriate County services when needed.

A certain level of behavioral health services is appropriately delivered in the primary care setting. These services, including screening for conditions including depression and alcohol abuse; providing brief interventions; and providing referrals to appropriate services from specialists. Primary Care Providers may contact the county's Mental Health Plan, the county's Substance Abuse Service Helpline, or L.A. Care's delegated contractor, Carelon Behavioral Health, for telephone consultation.

L.A Care continues to be responsible for the arrangement and payment of all medically necessary, Medi-Cal-covered physical health care services, not otherwise excluded by contract, for L.A. Care beneficiaries who require substance abuse and/or specialty mental health services.

In compliance with Mental Health Parity requirements as required by Title 42, CFR Section 438.930, L.A. Care ensures direct access to an initial mental health assessment by a licensed mental health provider within the L.A. Care provider network. No referral from a PCP or prior authorization is required for an initial mental health assessment to be performed by a network mental health provider. L.A Care meets the general parity requirement (Title 42, CFR, §438.910(b)) that stipulates that treatment limitations for mental health benefits may not be more restrictive than the predominant treatment limitations applied to medical or surgical

benefits. Neither a referral from PCP nor prior authorization is required for a beneficiary to seek an initial mental health assessment from a network mental health provider.

Triage and Referral for Mental Health

L.A. Care monitors the triage and referral protocols for the delegated behavioral health services providers to assure they are appropriately implemented, monitored and professionally managed. Protocols employed by delegates are evidence based and compliant with regulatory standards. Protocols shall outline the level of urgency and appropriateness of the level of care. Triage processes may be conducted by L.A. Care behavioral health staff; by Carelon Behavioral Health staff; by Department of Mental Health staff; and by Department of Public Health staff.

Behavioral Health Treatment (BHT) for Members Under 21 Years of Age

L.A. Care has provided benefits for Behavioral Health Therapy for children diagnosed with Autism Spectrum Disorder (ASD) since September 2014. While most utilization management decisions are rendered by Carelon Behavioral Health or by the County's delegated behavioral health providers, L.A. Care conducts its own utilization management processes for the Medi-Cal BHT benefit.

Effective July 1, 2018, L.A Care expanded its benefit coverage to include Behavioral Health Treatment (BHT) for eligible Medi-Cal members under the age of 21 as required by the Early and Periodic Screening and Diagnostic Treatment (EPSDT) mandate.

Treatment services may include Applied Behavioral Analysis (ABA) and related treatment modalities, collectively termed Behavioral Health Treatment (BHT).

BHT is the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the direct observation, measurement and functional analysis of the relations between environment and behavior. BHT services teach skills through the use of behavioral observation and reinforcement, or through prompting to teach each step of targeted behavior. BHT services include a variety of behavioral interventions that are designed to be delivered primarily in the home and in other community settings.

L.A Care will provide BHT services for all members who meet the eligibility criteria for services as stated in Section 1905 of the Social Security Act (SSA) and outlined in Medi-Cal All Plan Letter (APL) 18-006 (Behavioral Health Treatment).

Transgender Health

Medi-Cal and other health plan regulations mandate coverage of healthcare services that correct or repair abnormal structures of the body for all members, including transgender beneficiaries. The spectrum of transgender health benefits includes hormonal interventions, durable medical equipment (e.g. chest binders), and surgical interventions. Medi-Cal APL 16-013 mandates that managed care plans cover all medically necessary reconstructive surgeries. Cosmetic surgeries are not a Medi-Cal defined benefit. The Medi-Cal All-Plan Letter mandates that treatment plans for transgender services must be jointly developed by the member's primary care provider, mental

health provider, and (if applicable) surgeon. To facilitate this process, the Behavioral Health Department assists with care coordination aspects of L.A. Care's transgender services. UM L.A. Care renders all decisions related to Transgender Health.

Pharmacy

L.A. Care delegates specific pharmacy prior authorization reviews, such as outpatient retail pharmacy, home infusions and self-injectables, along with other certain UM needs, such as the clinical criteria development process and pharmacy network contracting, to our contracted pharmacy benefit manager (PBM) Navitus Health Solution. UM decision-making for pharmaceuticals including but not limited to chemotherapy and physician administered drugs in the ambulatory setting is not delegated to the PBM and is performed either by LA Care staff or is delegated to the provider groups.

The formularies are made available for members, practitioners, and the public on the L.A. Care website and is updated at least monthly. The formulary is provided to members upon enrollment and to practitioners upon joining the network with the following information:

- Covered pharmaceuticals
- Copayment information, including tiers if applicable
- Pharmaceuticals that require prior authorization
- Limits on refills, doses or prescriptions
- Use of generic substitution, therapeutic interchange or step-therapy protocols
- How formulary updates are communicated, and how often, if the organization has scheduled formulary updates (e.g., quarterly)
- How prescribing practitioners must provide information to support an exception request

Navitus conducts drug utilization review for all submitted claims to promote patient safety through identification of drug utilization that is outside of standards of practice, suboptimal or unsafe based on clinical evidence or guidelines. This includes a prospective, concurrent and retrospective drug utilization review based on clinical information at the time of the coverage request submission. Treatment guidelines and principles used for drug utilization review are reviewed, validated, and approved by Navitus P&T Committee. Drug review programs and criteria are reviewed at least annually.

Concurrent drug review occurs at the dispensing pharmacy's point-of-sale (POS). The concurrent review at the POS compares the prescribed medication against previous drug history for drug-to-drug interactions, ingredient duplication, therapeutic duplication, age contradictions, drug-allergy contradictions, overutilization or underutilization, incorrect dosage, and high dose situation.

Retrospective drug review monitors prescriber and contracted pharmacies activities that deviate from established standards, benchmarks, and/or goals. It is used to detect patterns in prescribing, dispensing, or administering drugs.

L.A. Care offers an exception-to-coverage request process for circumstances where the formulary does not adequately accommodate members' clinical needs. Exceptions are considered based on medical necessity and the availability of needed pharmaceuticals on the formulary. Evaluation of medical necessity requires L.A. Care or its PBM to obtain all clinically relevant information from the treating practitioner, including but not limited to medical records documenting current health status, clinical history, experience if any with formulary medications, allergies, drug side effect experience, and/or other complicating factors. A clinical

pharmacist or physician must review exception requests within a defined time period. L.A. Care requires handling of exceptions using the same time frames used for pre-service determinations, including a provision for urgent requests based on clinical urgency. In the case of a denial of an exception request, the member and practitioner are notified and informed of all applicable internal and external appeal rights that would apply to any other medical necessity denial.

Navitus monitors for situations that pose an immediate threat to the health and safety of members and will notify members and clinicians of qualified drug recalls, withdrawals of products from the market due to reasons of safety, or situations that pose an imminent or distinct threat to the health and safety of members. Navitus sends communication to direct members and providers for Class I and Class II recall or voluntary drug withdrawal from the market for safety reasons within 30 calendar days of the FDA notification. Navitus uses an expedited process for those affected by Class I Recall.

Evaluation of New Medical Technology

L.A. Care evaluates the inclusion of new medical technologies and the new application of existing technologies in its benefit packages. While the basic benefits for each line of business are set based on our contractual obligations, L.A Care has the option of adding to this basic package of benefits for its members.

L.A. Care maintains a formal mechanism to evaluate and address new developments in technology and new applications of existing technology for inclusion in its benefits plan to keep pace with changes and to ensure that members have equitable access to safe and effective care. Evaluation of new technology is applied for medical and behavioral health procedures, pharmaceuticals, and devices. The Clinical Policy Committee is responsible for evaluating and recommending coverage status for a new technology to the UM Committee and to the Quality Oversight Committee. Requests for evaluation of a new technology or a new application of an existing technology may come from a member, practitioner, organization, L.A. Care's physician reviewers, or other staff. The committee will gather pertinent resource materials and data, provide initial discussion and assessment, and present its findings to the full UMC for discussion. UMC will make recommendations to the Product teams about formal benefit changes. Once a new benefit is added, the information is disseminated to all Primary Care Providers and appropriate

specialists in the form of a mail notification of benefit addition, and to all members in the next member newsletter.

New technologies are handled on a case-by-case basis that includes obtaining information regarding the safety, efficacy and indications that support the use of the intervention. There must be evidence that the proposed intervention will add to improved outcomes as compared to what is currently available. The service provider must have a record of safety and success with the intervention and cannot be part of a funded research protocol.

Quality Improvement Collaboration

The UM team works collaboratively with the Quality Improvement Department to enhance the care provided to our members through venues such as QOC, PQI process and daily UM activities.

In the committee environment the UM team takes an analytical, evaluative and strategic look at predetermined metrics to evaluate and offer recommendations which further enhance the UM program. Data is reviewed and discussed at least quarterly during UMC meetings. UMC provides guidance and direction to the UM program by coordinating activities and by functioning as the expert panel when needed. Collaboration includes but is not limited to:

- Reviewing, making recommendations to, and approving the UM Program Description annually
- Assuring individual member needs are taken into consideration when determinations for care are rendered
- Analyzing summary data and making recommendations for action
- Reviewing the recommendations of Process Implementation Teams (PIT) to develop UM improvement action plans, ongoing monitoring, and evaluation
- Recommending medical policy, protocol, and clinical practice guidelines based on provider and member experience information.

During daily activities the UM team support QI efforts in the identification of potential quality of care issues, reporting adverse occurrences identified while conducting UM case review, improvement of Healthcare Effectiveness Data and Information Set (HEDIS) scoring by referrals to care coordination and care coordination efforts to ensure members are seen by the appropriate provider for their condition.

Utilization Management Review Process

Review Criteria

L.A. Care applies written, objective, evidence-based criteria and considers the individual member's circumstance, and community resources when making medical appropriateness determinations for behavioral health care, physical health care and pharmaceutical services. The criteria are objective and consistent with sound principles and medical evidence. They are reviewed, developed and approved annually with involvement from actively practicing health care practitioners and the involvement of practitioners in the review and development shall be documented in the UMC minutes. The UM review criteria is available for disclosure to providers, members and the public upon request either in writing or by contacting the L.A. Care UM Department.

L.A. Care draws from and follows the recommendations of a number of nationally recognized sources in the development of medical policy. Because nationally developed procedures for applying criteria are often designed for "uncomplicated" patients and for a complete delivery system, they may not be appropriate for patients with complications or for a delivery system with insufficient alternatives to patient care. Therefore, L.A. Care ensures the needs of individual patients and the characteristics of the local delivery system are taken into account when determining the medical necessity.

In the absence of applicable criteria, the L.A. Care UM medical staff refers the case for review to a licensed, board-certified practitioner in the same or similar specialty as the requested service. The reviewing practitioners base their determinations on their training, experience, the current standards of practice in the community, published peer-reviewed literature, the needs of the individual patients (age, comorbidities, complications, progress of treatment, psychosocial situation, and home environment when applicable), and characteristics of the local delivery system. L.A. Care contracts with a third-party

independent medical review organization that provides objective, unbiased medical determinations to support effective decision making based only on medical evidence.

On an annual basis, L.A Care distributes a statement to all its practitioners, providers, members and employees alerting them to the need for special concern about the risks of under-utilization. It requires employees who make utilization-related decisions and those who supervise them to sign a statement, which affirms that UM decision-making is based only on appropriateness of care and service.

Furthermore, L.A Care does not reward practitioners or other individuals conducting utilization review for issuing denials of coverage or service. Financial incentives for UM decision makers do not encourage decisions that result in under-utilization. There is a separation of medical decisions from fiscal and administrative management, to assure that fiscal and administrative management will not unduly influence medical decisions.

Working with practitioners and providers of care, the following factors are taken into consideration when applying guidelines to a particular case in review:

- Input from the treating practitioner
- Age of member
- Comorbidities in existence
- Complications
- Progress of treatment
- Psychosocial situation
- Home environment
- Consideration of the delivery system and availability of service to include but not limited to:
    - Availability of inpatient, outpatient and transitional facilities
    - Availability of outpatient services, include contracted and non-contracted specialists and specialty centers
    - Availability of highly specialized services, such as transplant facilities or cancer centers
    - Availability of skilled nursing facilities, subacute care facilities or home care in the organization’s service area to support the patient after hospital discharge
    - Local hospitals’ ability to provide all recommended services
- Benefit coverage

Review Documentation

Requests for prior authorization of services are to be submitted by the provider of service to the UM department by mail, fax or phone call. Pertinent data and information is required to enable a thorough assessment of medical necessity. If information is missing or incomplete, the request may be returned to the requester or denied for lack of established medical necessity. The following information must be provided on all requests:

- Member demographic information
- Provider demographic information
- Requested service/procedure to include specific CPT/HCPCS code(s)
- Member diagnosis (Using current ICD Code sets)
- Clinical indications necessitating service or referral
- Pertinent medical history, treatment or clinical data including but not limited to:
    - Office and hospital medical records
    - Diagnostic, laboratory and radiologic testing results

  - Treatment plans and progress notes
  - Recent physical exam results
  - Operative and pathological reports
  - Rehabilitation evaluations
  - Consultation notes from treating physicians
  - Unique patient characteristics and information including psychosocial history
  - Information from family/social support network
  - Case management notes
  - Network adequacy information for out of network requests
- Location of service to be provided
- Requested length of stay for all inpatient requests
- Proposed date of procedure for all outpatient surgical requests

Authorization Validity

Authorizations are generally approved for 90 days with a disclaimer stating that authorizations are valid only if the member is eligible on the actual date of service. Eligibility can be verified for most members 24 hours a day, 7 days a week by calling the L.A. Care UM Department or by logging into the Provider section at www.lacare.org.

Authorization Exemptions

L.A. Care maintains a list of services that currently do not require authorization for services despite financial responsibility and delegation. These include, for example, but are not limited to:

- Emergency medical services, screening and stabilization services as allowable under applicable rules and regulations and evidence of coverage for both in-network and out-of-network providers
- Sensitive Services, including pregnancy screening and diagnosis and abortion/pregnancy termination, sexual assault, outpatient mental health counseling and treatment, family planning services, diagnosis and treatment of sexually transmitted diseases and HIV counseling and testing for both in-network and out-of-network providers
- Preventive health services
- Nonmedical Transportation (NMT)

Delegated entities reserve the right to create their own prior authorization exemptions for services where they hold financial responsibility. An updated list of authorization requirements for services where L.A Care holds financial responsibility can be found on the Provider Section of www.la.care.org or by calling the L.A. UM Department.

Authorization Types

L.A. Care performs three types of authorization requests: pre-service/prior authorization, concurrent review and retrospective review.

Prior Authorization/Pre-service Request

Prior Authorization/Pre-Service is the formal process requiring a health care provider to obtain advance approval for coverage of specific services or procedures It allows for benefit determination, determination of Medical Necessity and clinical appropriateness, level of care assessment, assignment of the length of stay for inpatient admissions, appropriate facility placement prior to the delivery of service, and identification of the intensity of case management that may be needed for optimal patient

outcomes. This includes, for example, but not limited to specialty referrals, ancillary referrals, ambulatory or outpatient procedures (hospital-based, ambulatory surgery center), physician

administered drugs and infusions, office-based procedures and elective admissions. UM staff evaluates every proposed treatment plan and request, determines benefit eligibility and medical necessity using approved UM criteria, suitability of location and level of care prior to the approval of service delivery for select diagnoses and procedures.

Pre-service review requests are generated by the member's provider, either primary care provider or specialist, and submitted to L.A Care or its delegated provider either by mail, fax or secure Provider Portal.

L.A. Care monitors and analyzes request to identify trends and assist in follow-up care. Request for out-of–network referrals are reviewed to determine if the service is available and can be provided within the service area. Out-of-network request are also used to evaluate provider access and to determine if the local network requires enhancements to meet member needs.

UM staff evaluates every proposed treatment plan and request, determines benefit eligibility and medical necessity using approved UM criteria, suitability of location and level of care prior to the approval of service delivery for select diagnoses and procedures. Only a licensed health care professional may modify or deny a service request based on lack of medical necessity.

Continued Stay/Concurrent Review Request

Concurrent review requests occur while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care. They typically are associated with inpatient care, such as acute hospitalizations, skilled nursing and sub-acute facilities, residential treatment programs and ongoing ambulatory care such as home health.

Emergency room visits, however, where a prudent layperson, acting reasonably, would believe an emergency condition exists DO NOT require prior authorization (Medi-Cal and Medicare). For commercial health plan members, the standard is whether the enrollee him/herself reasonably believed he/she had an emergency medical condition, and DOES NOT require prior authorization to visit the emergency room. (The Knox-Keene Act's standard is subjective and takes into consideration whether the enrollee's belief was reasonable given the enrollee's age, personality, education, background, and other similar factors). Emergency health care services are available and accessible within the service area 24 hours a day, seven days a week.

L.A. Care provides 24-hour access for providers to coordinate a transfer in circumstances where the member has received emergency services and is stabilized but requires services the current provider does not offer.

Post-stabilization care for inpatient level of care and pre-approved elective admissions, with the exception of routine labor and delivery, do require authorization and notification of admission must be received within 24 hours of admission via fax, phone call or through a secure provider portal. Emergency room admissions to observation level of care do not require authorization for all lines of business. Emergency room admission (face) sheets and clinical notes are not considered a request for admission but notification of services rendered by an emergency room department. Upon receipt of the hospital admission (face) sheet, the UM Department will open a case and assign a tracking number.

Acute care hospitalization, skilled nursing facility, acute rehabilitation and long term acute care hospitalization reviews are performed by UM nurse specialists to ensure the medical necessity of admission and continued stay, the appropriateness of the level of care and the appropriateness of the care duration.

Requests for initial and continued authorization are reviewed concurrently throughout the stay as frequently as requested by the provider. Providers are responsible to provide sufficient documentation with each request. Denied admissions for inpatient level of care will automatically default to observation level of care for claims purposes. Additional objectives of continued stay review are:

- To ensure that services are provided in a timely and efficient manner
- To ensure that established standards of quality care are met
- To implement timely and efficient transfer to lower levels of care when clinically indicated and appropriate
- To implement effective and safe discharge planning
- To identify cases appropriate for Case Management

L.A. Care will determine the discharge date of an inpatient stay to be the earlier of the date specified for discharge in a Member's chart or the date specified by L.A. Care in a written denial notice to the hospital. At the time that a member no longer meets inpatient level of care, but meets medical necessity criteria for lower level of care such as a Nursing Facility Level A (NF-A) or Nursing Facility Level

B (NF-B), L.A. Care will issue a denial for continued acute inpatient level of care. If the Hospital has a contract for Acute Administrative Days, then a separate authorization will be issued for Acute Administrative Days while the patient awaits placement to a NF-A or NF-B.

In the event that there are delays in obtaining medically necessary procedures, L.A. Care will deny each day added to a Member's length of stay resulting from the unavailability of operating room space, rescheduling of surgery for space-related reasons, inadequate nursing procedures, or the failure to obtain timely necessary ancillary or diagnostic services.

If during this review the UM staff identify a potential Hospital Acquired Condition the UM staff will proceed with submitting a potential quality issue and document the finding in the claims section of the database.

UM nurse specialists shall begin discharge planning on the first business day after L.A. Care has been notified of the patient's admission by utilizing available resources to monitor the member's status and plan for discharge. Discharge planning is a critical component of the utilization management process

and shall include processes to ensure that necessary care, services, DME and supports are in place in the community for the Member once they are discharged from a hospital or institution.

Post-Service/Retrospective Review Request

Post-service/retrospective review requests occur after the medical care or services that have been received. Retrospective reviews will only be reviewed for emergency services where a delay in requesting the prior authorization would cause undo patient harm, the rendering provider is unaware L.A. Care is the primary payer for the services rendered or the rendering provider is unaware of the patient's insurance status at the time the services are rendered. All retrospective reviews are completed within regulatory turnaround times.

Determination Types

UM determinations are responses to requests for authorization based on the approved, evidence-based UM clinical criteria. These include approvals and adverse determinations. Adverse determinations include denials, modifications, extensions and termination of services. L.A Care issues three types of denials - medical necessity, benefit and administrative – and they may occur at any time in the course of the review process. Administrative denials include requests that, for example, fail to follow

administrative procedure, meet regulatory limitations or eligibility requirements. The following may be reasons that an administrative denial is issued: authorization request not required, duplicate request, authorization request or service line not accepted due to coding issue, request not submitted within a timely basis, member is not currently eligible/or was not eligible with L.A. Care at the time service was rendered, member has other health insurance and that carrier is responsible for the service requested or another provider must authorize service requested.

The adverse notifications must state the reason for the decision in terms specific to the member's condition or service request and in language that is easy to understand and references the criterion used in making the determination so the member and provider have a clear understanding of the Health Plan's rationale and enough information to file an appeal. L.A Care offers the practitioner the opportunity to discuss any adverse determination or potential adverse determination with the peer reviewer that initiated the adverse determination. Reconsiderations are entertained within 7 days of the denial being rendered.

Only a qualified health care professional acting through the designated authority of the Chief Medical Officer has the authority to render an adverse determination based on medical necessity.

Denial determinations may occur at different times and for various reasons including but not limited to:

- At the time of prior authorization; when the requested services are not medically indicated or not a covered benefit.
- When timely notification was not received from a facility for an inpatient stay to foster transfer of a medically stable patient
- When an inpatient facility fails to notify the Health Plan of admission within one business day of the admission or appropriate clinical information is not received

- Or after services are rendered at claims review when the services were not authorized, or are medically unnecessary.

A denial may also occur for inappropriate levels of care or inappropriate care. Notwithstanding previous authorization, payment for services may be denied if it is found that information previously given in support of the authorization was inaccurate.

The adverse notifications must state the reason for the decision in terms specific to the member's condition or service request and in language that is easy to understand and references the criterion used in making the determination so the member and provider have a clear understanding of the Health Plan's rationale and enough information to file an appeal. L.A Care offers the practitioner the opportunity to discuss any adverse determination or potential adverse determination with the peer reviewer that initiated the adverse determination. Reconsiderations are entertained within 7 days of the denial being rendered.

A member may request an Independent Medical Review (IMR) to obtain an impartial review of a denial decision concerning:

- The medical necessity of a proposed treatment
- Experimental or investigational therapies for a life-threatening or seriously debilitating disease or condition
- Claims for out-of-plan emergency or urgent medical services

L.A Care is aware of the need to be concerned about under-utilization of care and services for our members and monitors over and under-utilization through the year. Findings are reported to UMC. Decisions made by Utilization Reviewers are solely based on the appropriateness of the care or service. The Health Plan does not compensate any individual involved in the utilization process to deny care or services for our members nor do we encourage or offer incentives for denials.

Timeliness of UM Decisions

L.A. Care makes UM decisions in a timely manner to accommodate the clinical urgency of the situation and to minimize any disruption in the provision of care. L.A. Care measures the timeliness of decisions from the date when the organization receives the request, even if not all the information necessary to make a decision is available. L.A Care documents the date when the request is received and this counts as day 0, even if a non-urgent request is received after business hours. Requests can be considered non-urgent/routine or urgent.

Non-Urgent/Routine Request

A request for medical care or services for which application of the time periods for making a decision does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.

Urgent Requests

A request for medical care or services where application of the time frame for making routine or non-life threatening care determinations:

- Could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment, or
- Could seriously jeopardize the life, health or safety of the member or others, due to the member's psychological state, or
- In the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.

When a pre-service request is marked as urgent (expedited) on the request form, and the UM Nurse Specialist questions an urgent request, the request may be handled as a new request and decided within the timeframe appropriate for the type of decision notification.

L.A Care UM abides by established timeliness guidelines when processing any health service request and authorization request determination are made in compliance with Regulatory Standards for each Product Line as described in corresponding Policies/Procedures.

Inter-Rater Reliability

L.A Care assesses the consistency with which clinical staff, including physicians and nurse reviewers, applies UM criteria in decision-making and validates that L.A. Care's end users are accurately and appropriately applying the MCG tool for rendering medical determination decisions. Random cases are assigned through MCG Learning Modules. Each staff member must obtain a 90% passing score. Should the employee not meet 90 percent in the first two testing opportunities, they will work with their appropriate supervisor for remediation.. If the team falls below target, a corrective action plan is initiated by the Health Services Department under the direction of the UM Nurse Educator. The corrective action plan may include but not be limited to educational activities, increased scrutiny of decisions and/or institution of staff probationary period combined with supervision of decisions.

In addition, random audits of both UM nurse and medical director cases, including inpatient and outpatient, are performed throughout the year. This includes approvals and notice of actions. Clinical staff not involved in the original determination audits the cases. The audit assesses compliance with the following:

- Timeliness of the review
- Evaluation of the appropriate application of criteria
- Accuracy of the determination
- Readability/clarity of the determination letter

Availability of Criteria

All criteria used to review authorization request are available upon request. In the case of an adverse determination, the criteria used are made part of the determination file. Access to and copies of specific criteria utilized in the determination are also available to any requesting practitioner by mail, fax, email, or phone call. To obtain a copy of the UM criteria, practitioners may call the UM Department.

Members may request criteria used in making an authorization determination by calling the member services department to request a copy of the criteria. The UM team will work with member services to provide the criteria used in the review decision.

Communication Services

L.A. Care members, providers and the public may contact the UM department to discuss any aspect of the UM program. Members contact the Member Services Department at 1-800-839-9909 and may be warm transferred to either the appropriate delegate, or arrangements can be made to speak with a UM staff member depending on the delegation agreement. Providers contact the UM Department directly at 1-877-431-2273. UM staff is available at least 8 hours per normal business day (excludes weekends and holidays). During scheduled business hours, L.A. Care provides access to staff for members and practitioners seeking information about the UM process and the authorization of care. After hours' calls are answered by a contracted vendor and non-emergency calls are returned the following business day. Incoming calls outside of scheduled business hours requiring clinical decision-making are transferred to a L.A. Care on-call nurse for assistance. Staff identifies themselves by name, title and as representatives of L.A. Care when initiating or returning calls. HIPAA protocols are followed to ensure protection of privacy. Language assistance and TDD/TTY services are available as needed for members to communicate with L.A. Care regarding the UM program.

Appeals Process

Members and providers are provided fair and solution-oriented means to address concerns related to member rights as a beneficiary or provider. L.A. Care has a full and fair process for resolving member complaints and responding to member requests to reconsider a decision they find unacceptable regarding their care and service. The process for filing a complaint or an appeal is made available to the member in writing through the member handbook (Evidence of Coverage) and the L.A. Care Website and to the provider through the provider manual, the L.A. Care Website and policies and procedures.

Appeals for members enrolled in any of the four (4) product lines are submitted to L.A. Care's Appeals and Grievance department. The Appeals and Grievances processes are designed to handle individual disagreements in a timely fashion according to the requirements of the member's product line, and to ensure an appropriate resolution. However, a member with one of L.A. Care's Plan Partners, PPGs or Vendors delegated for appeals may also submit their appeals to L.A. Care directly as well as the delegate. The Appeals and Grievance appeals processes are described in detail in corresponding L.A. Care Appeals and Grievances P&Ps including, but not limited to, the specific product line requirements for timeframes when members can request an appeal.

Providers or members are provided up to 60 calendar days to submit an appeal in response to a Notice of Action (NOA) letter. A physician reviewer, other than the reviewer who made the initial denial determination, reviews each appeal case. The physician reviewer may request further information from the provider such as:

- Diagnostic information
- Previous treatment
- Clinical justification
- Opinions from specialists or other providers
- Evidence from the scientific literature prior to processing the request.

The member or provider may initiate expedited appeals. The physician reviewer is expected to make a decision as expeditiously as the medical condition requires, but no later than seventy-two (72) hours after the receipt of the appeal request.

Providers have 12 months to submit a Provider Dispute Resolution (PDR) requests in response to a Claims Department decision. Disputes over the medical necessity of services, such as a denied inpatient admission's lack of medical necessity or incorrect level of care decisions (Medical-Surgical unit vs. Intensive Care Unit, trauma vs non-trauma) are reviewed by the UM nurses or physician reviewers depending on the nature of the dispute.

L.A. Care Medi-Cal members have the right to request a State Fair Hearing from the California Department of Social Services at any time during the appeals process, or within 90 days of an adverse decision. L.A. Care and its Plan Partners comply with State Aid Paid Pending requirements, as applicable. Information on filing a State Fair Hearing is included annually in the member newsletter, in the member's evidence of coverage, and with each resolution letter sent to the member or the member's representative.

Data Collection, Analysis and Reporting

Data collection activities for analysis and reporting are coordinated by the UM department. In an effort to review appropriateness of care provided to members, aggregate data is tracked and trended from various data elements to determine over- and/or under-utilization patterns.

At the data gathering/performance measurement phase, participants in the process may include programmers and analysts, staff nurses, and any other personnel required for the collection and validation of data. All data collection activities are documented and reported to UMC throughout the year. L.A. Care has developed benchmarks that are used as guidelines for comparison. UM data elements are reviewed to assess over/under utilization of services for either medical and/or behavioral health, which include but are not limited to the following:

Data collection activities may include, but are not limited to:

- Member satisfaction surveys
- Provider satisfaction surveys
- Hospital admit rates, bed days and length of stay
- Readmission statistics
- ER visits rates
- Referral Data
- Potential quality incident data
- Member appeal data
- Provider appeal data
- Internally developed databases
- Pharmacy utilization data
- Other administrative or clinical data

Delegation Oversight

The oversight of a delegated entity's ability to meet utilization management standards has been bifurcated between the Delegation Oversight and Clinical Assurance departments. Specifically, Delegation Oversight holds the responsibility for performing an annual audit of delegated entities, the aggregation of monitoring results and the production of a quarterly delegate scorecard.

Clinical Assurance monitors delegate performance data on a cadence more frequent than annual (weekly, monthly, quarterly, semi-annually) depending on prior performance, corrective action plans in place or urgent concerns that may arise for example. The results of this data will be reported to Delegation Oversight on a monthly basis, where applicable, and included in the quarterly scorecard.

The Utilization Management Department will review the most recent UM quantitative data related to health disparities and discuss with the relevant work group/committee:

- Measures are stratified by line of business (inclusive of Plan Partners and Department of Health Services (DHS) clinics), and demographic factors such as age, sex race, ethnicity, language, sexual orientation, gender identity and region.
- Utilization Management identifies groups experiencing low rates and a high volume of gaps in care and reports will include volume, types of services, denials, deferrals, modifications, as well as integrate Appeals and Grievances data.
- This is in line with the efforts in the Quality Improvement Health Equity Transformation Program (QIHETP).

Protected Health Information (PHI)

The Privacy Rule, described in 45 CFR Parts 160 and 165, applies to covered entities. The Privacy Rule allows covered providers, entities, and health plans to disclose PHI in order to carry out their health care functions.

L.A Care is fully compliant with the general rules, regulations and implementation specified in The Privacy Rule. L.A Care also provides reasonable administrative, technical, and physical safeguards to ensure PHI confidentiality, integrity and availability and to prevent unauthorized or inappropriate access, use or disclosure of PHI.

Statement of Confidentiality

Due to the nature of routine UM operations, L.A. Care has implemented policies and procedures to protect and ensure proper handling of confidential and privileged medical record information. Upon employment, all L.A. Care employees, including contracted professionals who have access to confidential or member information, sign a written statement delineating responsibility for maintaining confidentiality. In addition, all UM Committee members of each entity are required to sign a Confidentiality Agreement on an annual basis. Invited guests must sign a Confidentiality Agreement at the time of UMC attendance. This Agreement requires the member to maintain confidentiality of any and all information discussed during the meetings.

All records and proceedings of UMC related to member- or practitioner-specific information are confidential, and are subject to applicable laws regarding confidentiality of medical and peer review information, including Welfare and Institutions Code section 14087.58, which exempts the records

of UM proceedings from the California Public Records Act. All information is maintained in confidential files. L.A. Care and its delegates hold all information in strictest confidence.

Non-Discrimination Statement

L.A Care complies with applicable Federal civil rights laws and does not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, age, disability, or sex.

L.A Care will not deny or limit coverage, deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions on coverage, for any health services that are ordinarily or exclusively available to individuals of one sex, to a transgender individual based on the fact that an individual's sex assigned at birth, gender identity, or gender otherwise recorded is different from the one to which such health services are ordinarily are exclusively available. Also, L.A Care will not otherwise deny or limit coverage, deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions on coverage, for specific health services related to gender transition if such denial, limitation, or restriction results in discrimination against a transgender individual.

L.A Care provides free aids and services to people with disabilities to communicate with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

L.A Care provides free language services to people whose primary language is not English or those with limited English proficiency (LEP), such as:

- Qualified sign language interpreters
- Information written in other languages

Statement of Conflict of Interest

L.A. Care maintains a Conflict of Interest policy to ensure that staff and members of Committees avoid conflicts of interest. This policy precludes using proprietary or confidential L.A. Care information for personal gain or the gain of others, as well as direct or indirect financial interests in, or relationships with, current or potential providers, suppliers, or members, except when it is determined that the financial interest does not create a conflict.

Any individual who has been personally involved in the care and/or service provided to a patient, an event or finding undergoing quality evaluation may not vote or render a decision regarding the appropriateness of such care. All members of UMC are required to review and sign a conflict of interest statement, agreeing to abide by its terms.

Provider and Member Satisfaction

L.A Care conducts satisfaction surveys on both members and providers. Included in the evaluation are questions that deal with both member and provider satisfaction with the UM program. The responses to the survey are reviewed by staff from Health Services, Member Services, and Provider Services. Thresholds are set and responses that fall below are considered for corrective action by

the Health Plan. Corrective actions that were in place are evaluated at the time the follow-up annual survey is done unless committee feels an expedited time frame needs to be implemented.

Annual Program Evaluation

The Utilization Management program undergoes a written evaluation of its overall effectiveness annually by the UMC, which is reviewed and approved by QOC. Elements of the program evaluation include an objective assessment of meeting targeted goals to ensure appropriate, efficient utilization of resources/services for L.A Care members across the continuum of care in compliance with requirements of state/federal and regulatory entities. To ensure the provision of healthcare services are provided at the appropriate level of care, the evaluation considers:

- Inpatient bed day rate
- Inpatient average length of stay
- SNF admit rate
- SNF average length of stay
- Readmission rate
- Denial rate
- Timely completion of notifications of denial of care
- Timely completion of notifications of authorization of care
- Inter-Rater Reliability scoring
- Call Performance, including:
  - Daily Work Flow Monitoring
  - Call Abandonment rates
  - Call Volume
  - Average caller wait time
- The integration of Member/Provider satisfaction results concerning the UM program

To determine if the UM program remains current and appropriate, the organization annually evaluates:

- The program structure
- The program scope, processes, information sources used in the determination of benefit coverage and medical necessity
- The program polices and procedures
- The level of involvement of the senior-level physician and designated behavioral healthcare practitioner in the UM program
- And considers member's and practitioner's experience data when evaluating the UM program
- The organization updates the UM program and its description annually based on the evaluation

An assessment of Department resources are determined by looking at the impact of staffing changes, learning curves and system limitations which impede work effectiveness. There is a review of Inter-Rater reliability scoring in relation to staff training/re-education, acclimation to new technology such as documentation software/ hardware based on evaluating user acceptance, and the assessment of appropriate staffing ratio to ensure adherence to regulatory and internal performance standards.

A summary of the program evaluation, including a description of the program, is provided to members or practitioners upon request. When the evaluation is complete, an announcement indicating the availability of UM information is published in the member and provider newsletter.

The process for completing the evaluation is overseen by the Senior Medical Director as follows:

1. Data collection is assigned to the Program Manager and Quality Team (Data analyst).
2. The First draft is written by the Program Manager.
3. This is reviewed by the Senior Medical Director
4. Final approval comes from the Senior Medical Director.

Utilization Management FY 2022 – FY 2023 Program Evaluation
March 21, 2024

Medi-Cal, PASC-SEIU, L.A. Care Covered and Dual Special Needs Plans (D-SNP)

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EXECUTIVE SUMMARY

L.A. Care implemented the FY 2022 - 2023 Utilization Management (UM) program to be the best of our ability and especially in the light of the challenges that we all experienced with this pandemic. Most of the data reported covers activities conducted from October 1, 2022 through September 30, 2023. This report provides a detailed description and discussion of utilization management activities, delegation oversight, clinical performance, compliance metrics and strategic initiatives accomplished during the past year. The evaluation documents activities undertaken to achieve work plan goals and establishes the groundwork for future utilization management and delegation oversight activities. It outlines areas where we remain strong and identifies opportunities for continued growth and development.

We plan to continue our efforts to transform and evolve our UM department throughout 2024 as highlighted in our 2024 UM Program Description.

INTRODUCTION

The Utilization Management Program is designed to meet the specific needs of L.A. Care members and providers. The 2023 UM Program Description describes L.A. Care Health Plan's (L.A. Care) Utilization Management (UM) program along with the medical, pharmacy and behavioral health aspects of the Program. The UM Program Evaluation describes the effectiveness of the 2023 UM Program and identifies both accomplishments and performance improvement opportunities. The UM Program Evaluation covers services provided to membership enrolled in Medi-Cal, PASC-SEIU, Health Benefits Exchange (LACC), and Dual Special Needs Plans (D-SNP).

The report consists of:

- Achievements related to UM goals and objectives which serve as a foundation for L.A. Care's strategic healthcare goals,
- A review of the efficacy of the program structures,
- Assessments of department operations, i.e. under and over utilization; inter-rater reliability monitoring and analysis; beds days and length of stay; admissions and readmissions
- An overview of innovative programs aimed at interventions to delay the progression of disease while improving the quality of life in a community based setting.

The UM annual evaluation report concludes with an overall summary and recommendations for activities which will guide the department's management decisions through 2024.

PROGRAM GOALS AND OBJECTIVES

The L.A Care UM program serves to ensure that appropriate, high quality cost-effective utilization of health care resources, including medical and behavioral, are available to all members in a timely manner. This is accomplished in a fair, impartial, and consistent manner void of discrimination through the systematic and consistent application of utilization management processes based on current, relevant medical review criteria and expert clinical opinion when needed. The UM process provides a system whose main goal is to ensure equitable access to high quality health care across the network of providers for all eligible members by:

- Ensuring that requested services delivered are medically needed and consistent with diagnosis and level of care required for each individual taking into account any co-morbid condition that exists and the ability of the local delivery system to meet the need
- Defining the methods by which utilization criteria and clinical practice guidelines are selected, developed, reviewed, and modified based upon appropriate and current standards of practice and professional review
- Ensuring authorized services are covered under contract with the State of California Department of Health Services (DHCS) California Code of Regulations (CCR) Title 22 or CMS for Medi-Cal and Dual Special Needs Plans (D-SNP) members respectively.
- Coordinating thorough and timely responses to member and provider reconsiderations, and disputes associated with utilization issues

- Monitoring utilization practice patterns of practitioners, Participating Physician Groups (PPGs), Specialty Vendors, and Planned Partners to identify trends and opportunities for improvement.
- Monitoring both inpatient and outpatient care for possible quality of care deficiencies, and utilize indicator screening criteria, documenting and submitting all potential deficiencies to the Quality Improvement (QI) Department
- Identifying and addressing known or potential quality of care issues (PQIs) and trends that affect the health care and safety of members and implement corrective action plans as needed.
- Optimizing the member's health benefits by linking and coordinating services with the appropriate county/state sponsored programs
- Educating practitioners, providers and internal staff about L.A. Care's goals for providing quality, cost-effective managed health care on the utilization management policies and procedures to ensure alignment with the UM Program and Practices established by L.A. Care, as well as compliance with contractual, regulatory and accreditation requirements as well as assisting in achieving the goals and objectives of the Program
- Promoting and ensuring the integration of utilization management with quality monitoring and improvement, risk management, behavioral health and case management activities
- Improving physician and member satisfaction by analyzing member and practitioner experience data and complaints, regarding the UM program, to identify opportunities and implement appropriate interventions for continuous improvement of services.
- Ensuring a process for critical review and assessment of the UM program and plan on, at minimum, an annual basis, with updates occurring more frequently if needed. The process incorporates practitioner and member input along with any regulatory changes, changes to current standards of care, and technological advances
- Evaluating the ability of delegates to perform UM activities and to monitor performance.

PROGRAM HIGHLIGHTS AND ACCOMPLISHMENTS

The following is a brief summary of the 2023 UM Program highlights and accomplishments:

- The leadership team hired several key positions with experienced personnel: Senior Director, Program Manager, Quality Manager, Clinical Director, and a Clinical Supervisor
- The Quality department created new tools to audit the clinical and intake teams ensuring to concentrate on sound clinical decision making and regulatory compliance
- Routine staff training series established and maintained, emphasizing the need for consistency, accuracy, and quality across all areas of UM
- Invited other areas of LA Care to scheduled trainings, such as case management and the Special Investigations Unit, to provide education on what happens elsewhere at the plan
- Developed a weekly meeting between UM and CM to collaborate and develop processes to ensure UM is appropriately assess and refer members to case management when indicated
- Initiated a bi-weekly standing meeting with the contracting team to discuss concerns, barriers, silos, and provider issues in order to address promptly and eliminate possible delays to member care

- Participated in Joint Operating Meetings with hospitals and Participating Physician Group (PPG)s, and manage provider escalations for improved collaboration and accountability
- Standardized workflows and documentation of all the UM operational processes, yielding increase performance and productivity across the board
- Maintained 7 days/week, 24 hour coverage to comply with post stabilization requirements
- Collaborated with Customer Service Center (CSC), Provider Network Management (PNM) on customer (member) and provider-related services, Recruiting, Compensation, Marketing, and multiple leaders throughout Health Services on multiple projects throughout the year.
- Collaborated with the recruitment team to improve the candidate selection process

PROGRAM SCOPE

L.A. Care offers coverage for comprehensive healthcare delivery, including but not limited to ambulatory care services, inpatient care, emergency services, behavioral health, therapy services, home health care, palliative care and hospice, rehabilitation services, skilled nursing services and preventive services depending on product line. Benefits packages and delegation of decision-making, however, differs across product lines and entity. The UM Program is therefore designed to work collaboratively with both different delegated entities and directly with providers in the community, where indicated, in an effort to assure the delivery of appropriate, cost-effective, quality-based healthcare. Successful implementation of the UM program necessitates the cooperative participation of L.A. Care, delegated entities, health care delivery organizations, providers, physicians and hospitals, as well as members, to ensure timely and effective delivery of health care. The UM staff performs a specific scope of services including but not limited to:

- Using the most current edition of approved UM evidence-based criteria, including the use of California Department of Health and Welfare Code of Regulations Title 22, Center for Medicare & Medicaid Services (CMS) Code of Federal Regulations (CFR) Title 42 and CMS National and Local Coverage Determinations
- Performing prospective, concurrent, and retrospective utilization review for medical necessity, appropriateness of hospital admission, level of care and
- continued inpatient confinement on a frequency consistent with evidence-based criteria and L.A. Care guidelines, L.A. Care criteria/ medical policy and the member's condition. Because utilization targets continued to be largely met in 2022 despite the ongoing disruptions of the pandemic, no significant changes were made to the underlying team structure. Based on feedback from many of our facilities, this review continued to be performed with the facility care team with enhanced involvement of attending physician(s)
- Discharge planning in collaboration with the facility care team
- Reviewing requests for outpatient care, skilled nursing care, home health care, durable medical equipment, ambulatory surgery, ambulatory diagnostic and treatment procedures such as physical, occupational and speech therapies
- Ensuring members with chronic conditions requiring continuing specialty care over a prolonged period of time are provided with ongoing referrals to specialists
- Providing second opinion consultations from qualified providers at no cost to the member

- Following requirements to ensure effective pain management for the terminally ill through medical and pharmacy authorization processes
- Reviewing and authorizing all medically necessary out-of-network requests when no in network options are either available or available timely
- Evaluating all request for services that are deemed experimental, investigational or of unknown benefit and determining if coverage will be provided
- Tracking and monitoring referrals and authorizations requests that require prior authorization including authorized, denied, deferred, or modified referrals
- Reviewing inpatient and outpatient UM data to determine appropriateness of member and provider utilization patterns

The UM program incorporates the monitoring and evaluation for the subsequent services and reviews and updates policies and procedures as appropriate at least annually related to:

- Acute hospital services
- Subacute care
- Ambulatory care
- Emergency and urgent care services
- Out of Network referrals when procedures not available in-network
- Durable Medical Equipment and supplies
- Ancillary care services including but not limited to home health care, skilled nursing care, subacute care, and pharmacy, laboratory and radiology services
- Long-term care including Skilled Nursing Facility (SNF) Care and Rehabilitation Facility Care
- Pharmacy drug formulary

Based on the information above LA Care does not need to make any changes in the scope of the UM Program.

PROGRAM STRUCTURE

Various UM activities are delegated to different contracted providers through contractual arrangements, including but not limited to:

- Plan Partners
- Participating Provider Groups (PPGs)/Independent Practice Associations (IPAs)
- Beacon Health Services
- Navitus

The scope of delegated functions varies based on each entity and L.A. Care maintains responsibility for providing authorization and coordination of services for all non-delegated functions. A delegation agreement, including a detailed list of activities delegated and reporting requirements, is signed by both the delegate and L.A Care.

- Providers to whom UM activities have been delegated are responsible for reporting results and analyses to L.A Care on a quarterly or annual basis. Reports are summarized for review and evaluation by the UM Committee (UMC).
- Evaluation includes a review of both the processes applied in carrying out delegated UM activities, and the outcome achieved in accordance with the respective policy(s) and agreement governing the delegated responsibility.
- The UMC reviews delegate performance and make recommendations regarding opportunities for improvement and continuation of delegated functions.

A pre-delegation evaluation is conducted when delegation of functions to providers is being considered.

INTERNAL STRUCTURE

Internally, the UM program is housed within the Health Services Department that consists of the following teams:

- Utilization Management
- Care Management
- Social Work
- Behavioral Health
- Long Term Support Services (LTSS)
- Pharmacy
- Quality Improvement
- Safety Net Initiatives
- EPO
- Appeals and Grievances

Each department within Health Services plays a critical role in ensuring these are fulfilled. Within the UM Department, there are multiple levels of decision-making authority. Senior UM Leadership provides overnight and direction for the department. The Chief Medical Officer and Chief Operations Officer collaboratively are overall responsible for providing leadership, policy direction, clinical support and implementation, and oversight of the UM Program. Much of this authority is delegated. The Senior Medical Directors (both medical and behavioral health) provide direct oversight of the daily UM clinical decision making, training, and establishing criteria. During 2023, the Senior Medical Director remains extensively involved in the implementation and execution of the UM program, serving as chair for weekly meetings with nurse managers and continuing to provide oversight and direction for member care throughout the pandemic. Chief Operations Executive, Senior Director and Director of UM provide oversight of both non-clinical and clinical staff in terms of productivity and performance. The frontline staff includes authorization technicians, nurses, peer reviewers, pharmacists and behavioral health specialists that are responsible for performing all initial review of authorizations.

The UM committee (UMC) is charged with responsibility for oversight of the UM Program activities and processes. The committee chair and members provide objective and independent input on UM Program issues of concern and advice on program activities. The UMC is charged with authority and

accountability for all utilization management activities and processes. The UMC reports to the Quality Oversight Committee (QOC).

Over the course of 2023, the committee reviewed multiple policies, analyzed over and under reports, outlined challenges facing our UM Department and discussed mechanisms to collaborate in order to improve and streamline care. The UMC made reports to each subsequent QOC meeting. The Committee charter, composition of voting members, meeting schedule, and scope of topics addressed continues to meet the needs of L.A. Care and our members.

UTILIZATION MANAGEMENT PROCESS

UM decisions are based on benefit coverage and medical necessity. Benefits are defined by the members Evidence of Coverage and updated and reviewed annually. There were no changes made to the determination of benefit coverage in 2023 and sources remain adequate and appropriate. Medical necessity is determined by annually established UM criteria outlined below.

REVIEW CRITERIA

L.A. Care applies written, objective, evidence-based criteria and considers the individual member's circumstance, and community resources when making medical appropriateness determinations for behavioral health care, physical health care and pharmaceutical services. The criteria are objective and consistent with sound principles and medical evidence. They are reviewed, developed and approved annually with involvement from actively practicing health care practitioners and the involvement of practitioners in the review and development shall be documented in the UMC minutes. The UM review criteria is available for disclosure to providers, members and the public upon request either in writing or by contacting the L.A. Care UM Department.

L.A. Care draws from and follows the recommendations of a number of nationally recognized sources in the development of medical policy. Because nationally developed procedures for applying criteria are often designed for "uncomplicated" patients and for a complete delivery system, they may not be appropriate for patients with complications or for a delivery system with insufficient alternatives to patient care. Therefore, L.A. Care ensures the needs of individual patients and the characteristics of the local delivery system are taken into account when determining the medical necessity.

In the absence of applicable criteria, the L.A. Care UM medical staff refers the case for review to a licensed, board-certified practitioner in the same or similar specialty as the requested service. The reviewing practitioners base their determinations on their training, experience, the current standards of practice in the community, published peer-reviewed literature, the needs of the individual patients (age, comorbidities, complications, progress of treatment, psychosocial situation, and home environment when applicable), and characteristics of the local delivery system. L.A. Care contracts with a third-party independent medical review organization that provides objective, unbiased medical determinations to support effective decision making based only on medical evidence.

On an annual basis, L.A Care distributes a statement to all its practitioners, providers, members and employees alerting them to the need for special concern about the risks of under-utilization.

It requires employees who make utilization-related decisions and those who supervise them to sign a statement, which affirms that UM decision-making is based only on appropriateness of care and service.

Furthermore, L.A Care does not reward practitioners or other individuals conducting utilization review for issuing denials of coverage or service. Financial incentives for UM decision makers do not encourage decisions that result in under-utilization. There is a separation of medical decisions from fiscal and administrative management, to assure that fiscal and administrative management will not unduly influence medical decisions.

Working with practitioners and providers of care, the following factors are taken into consideration when applying guidelines to a particular case in review:

- Input from the treating practitioner
- Age of member
- Comorbidities in existence
- Complications
- Progress of treatment
- Psychosocial situation
- Home environment
- Consideration of the delivery system and availability of service to include but not limited to:
    - Availability of inpatient, outpatient and transitional facilities
    - Availability of outpatient services, include contracted and non-contracted specialists and specialty centers
    - Availability of highly specialized services, such as transplant facilities or cancer centers
    - Availability of skilled nursing facilities, subacute care facilities or home care in the organization's service area to support the patient after hospital discharge
    - Local hospitals' ability to provide all recommended services
- Benefit coverage

<u>REVIEW DOCUMENTATION</u>

Requests for prior authorization of services are to be submitted by the provider of service to the UM department by mail, fax or phone call. Pertinent data and information is required to enable a thorough assessment of medical necessity. If information is missing or incomplete, the request may be returned to the requester or denied for lack of established medical necessity. The following information must be provided on all requests:

- Member demographic information
- Provider demographic information
- Requested service/procedure to include specific CPT/HCPCS code(s)
- Member diagnosis (Using current ICD Code sets)

- Clinical indications necessitating service or referral
- Pertinent medical history, treatment or clinical data including but not limited to:
    - Office and hospital medical records
    - Diagnostic, laboratory and radiologic testing results
    - Treatment plans and progress notes
    - Recent physical exam results
    - Operative and pathological reports
    - Rehabilitation evaluations
    - Consultation notes from treating physicians
    - Unique patient characteristics and information including psychosocial history
    - Information from family/social support network
    - Case management notes
    - Network adequacy information for out of network requests
- Location of service to be provided
- Requested length of stay for all inpatient requests
- Proposed date of procedure for all outpatient surgical requests

INTERRATER RELIABILITY (IRR)

Consistency of the application of UM Criteria shall be checked at all levels of the L.A. Care Utilization Review decision-making process following the established UM Interrater Reliability (IRR) testing. L.A. Care Health Plan shall maintain an established process for interrater reliability testing, evaluation and monitoring to improve the consistency and accuracy of the application of UM review criteria. Where applicable, L.A. Care acts upon opportunities to improve consistency. All clinical staff that makes UM decisions must take an IRR assessment. The passing grade is 90%. Failed scenarios were reviewed with appropriate supervisors/educators for direct remediation as needed.

Outpatient Scoring Summary

MCG IRR

- Participants were provided three attempts over the testing period to achieve an average passing score of 90%.
- Ninety Five percent of participants scored at or above 90%. The highest score was 100% and the lowest score was 90.00%
- Five percent scored below 90%. The highest score was 80% and the lowest score was 65%

Role	#Participants	Average Score
UM Physicians	9	88.75%

UM Outpatient Nurses	24	98.54%
UM Dual Role Nurses	5	100%
UM A&G Nurses	3	100%

WPATH IRR

- Participants were provided three attempts over the testing period to achieve an average passing score of 90%.
- Ninety four percent of participants scored at or above 90%. The highest score was 100% and the lowest score was 100.00%
- Six percent scored below 90%. The highest score was 75% and the lowest score was 50%

Role	#Participants	Average Score
UM Physicians	13	95.19%
UM OP Nurses	25	100%

Inpatient Scoring Summary

MCG IRR

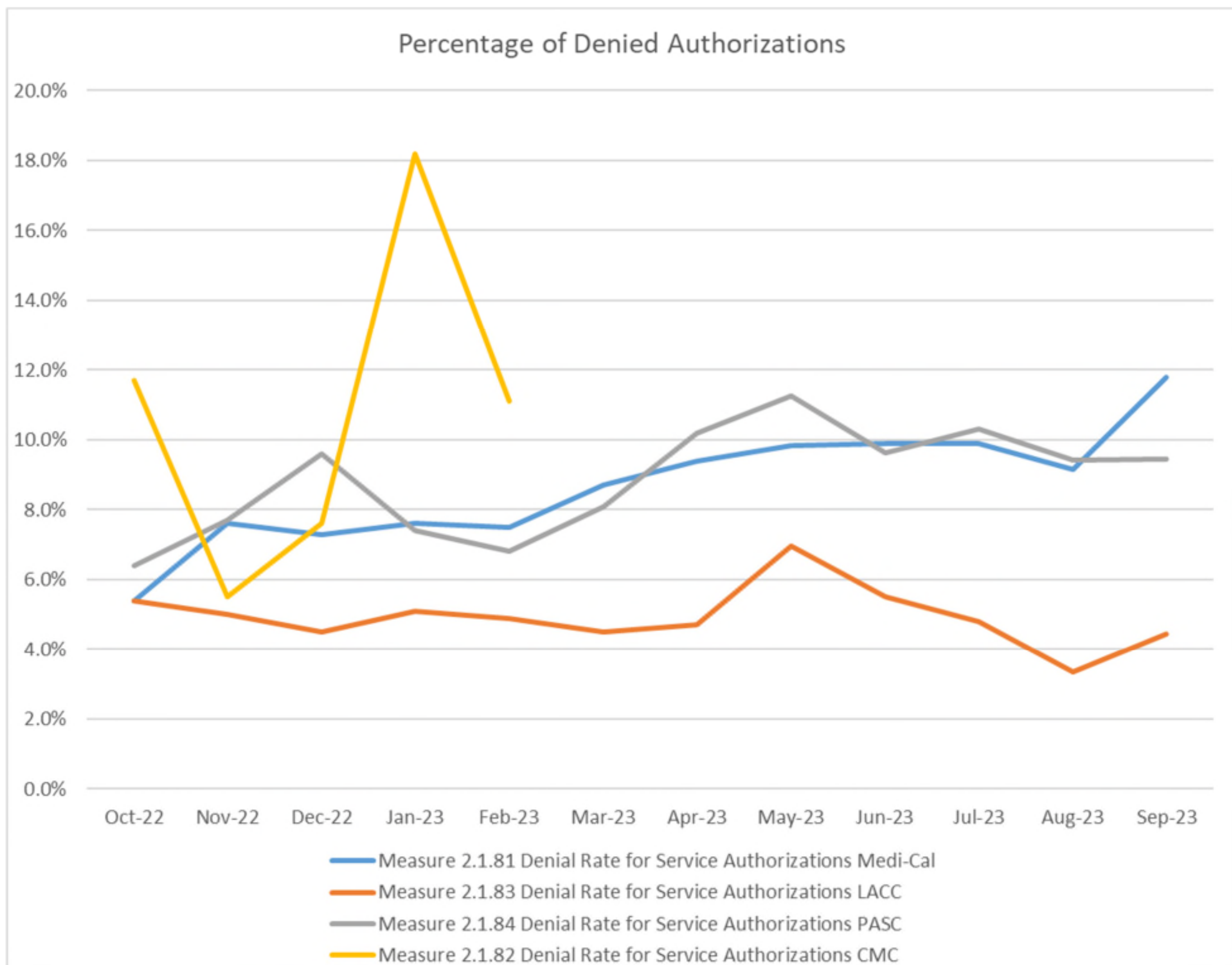
- Participants were provided three attempts over the testing period to achieve an average passing score of 90%.
- All participants scored at or above 90%. The highest score was 100% and the lowest score was 90.00%

Role	#Participants	Average Score
UM Physicians	8	93.75%
UM Inpatient Nurses	45	94.28%

UTILIZATION MANAGEMENT PERFORMANCE

Authorizations Adverse Determination Rates

L.A Care strives to keep adverse determination as low as possible. The rate for Medi-cal has remained around 5 - 12% throughout 2023. The denial rates for the other lines of business has a more erratic pattern, largely due to a much lower volume of requests. We work with our providers whole heartedly to obtain as much of the clinical record we can to approve.

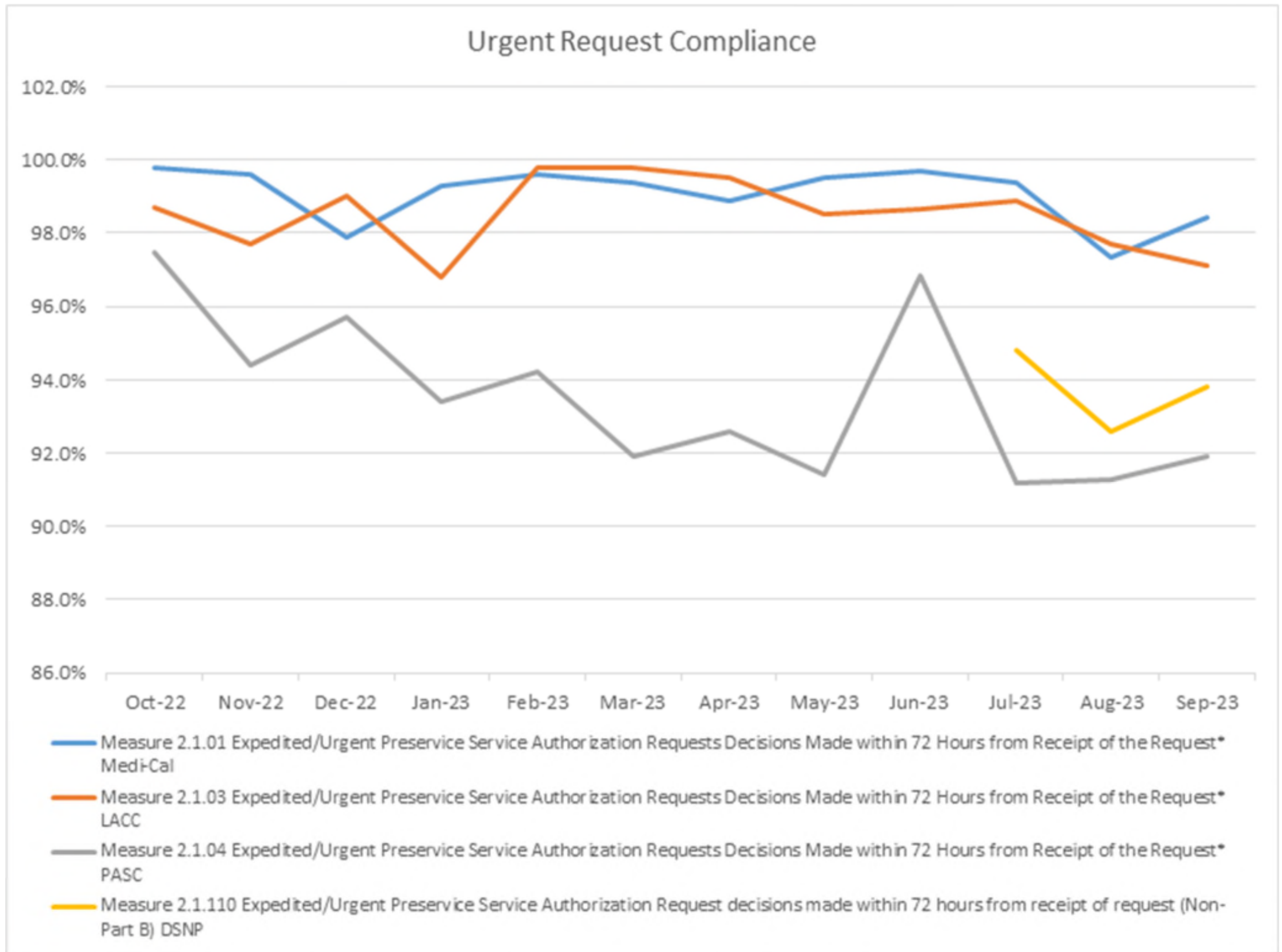


Quantitative Analysis:

- LACC had the lowest rate of Denied Authorizations with around 5%
- PASC had the highest rate of Denied Authorizations with around 8.9%
- Medi-Cal Denied Authorizations increased by about 3.5%, PASC increased by about 1.8%, and LACC decreased by about 0.8%
- DSNP Denied Authorizations are not included because monitoring did not start until Dec 2023
- CMC Denied Authorization monitoring was discontinued after Feb 2023

TURN AROUND TIME COMPLIANCE - INTERNAL

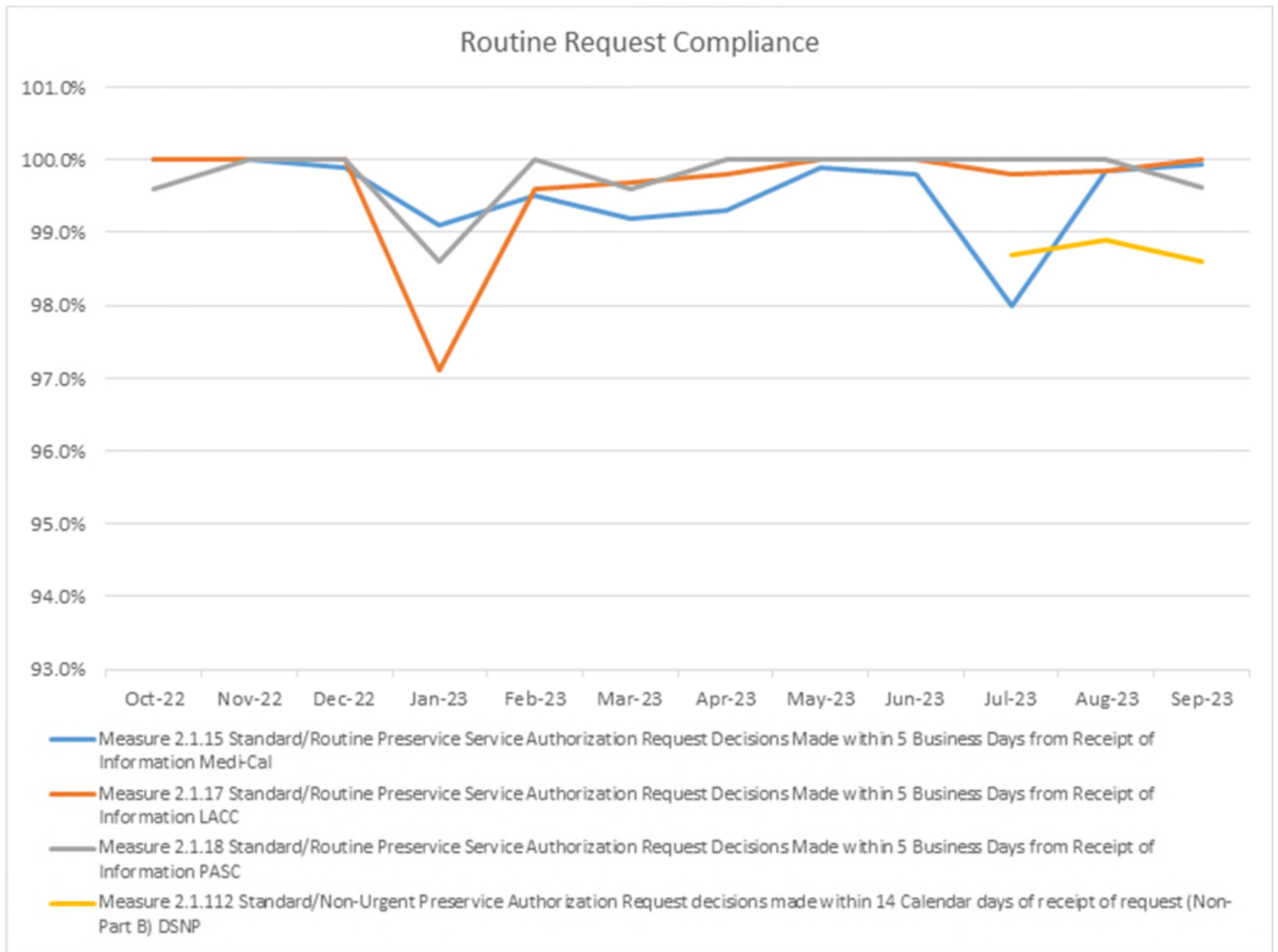
Urgent Request Compliance



Quantitative Analysis:

- Medi-Cal and LACC were above 96% compliance for urgent requests during all months
- PASC had the lowest compliance for urgent requests at about 93.5%
- All measures were above 91% compliance for urgent requests during all months
- DSNP compliance monitoring for urgent requests began in July 2023
- CMC monitoring was discontinued after Feb 2023

Routine Request Compliance

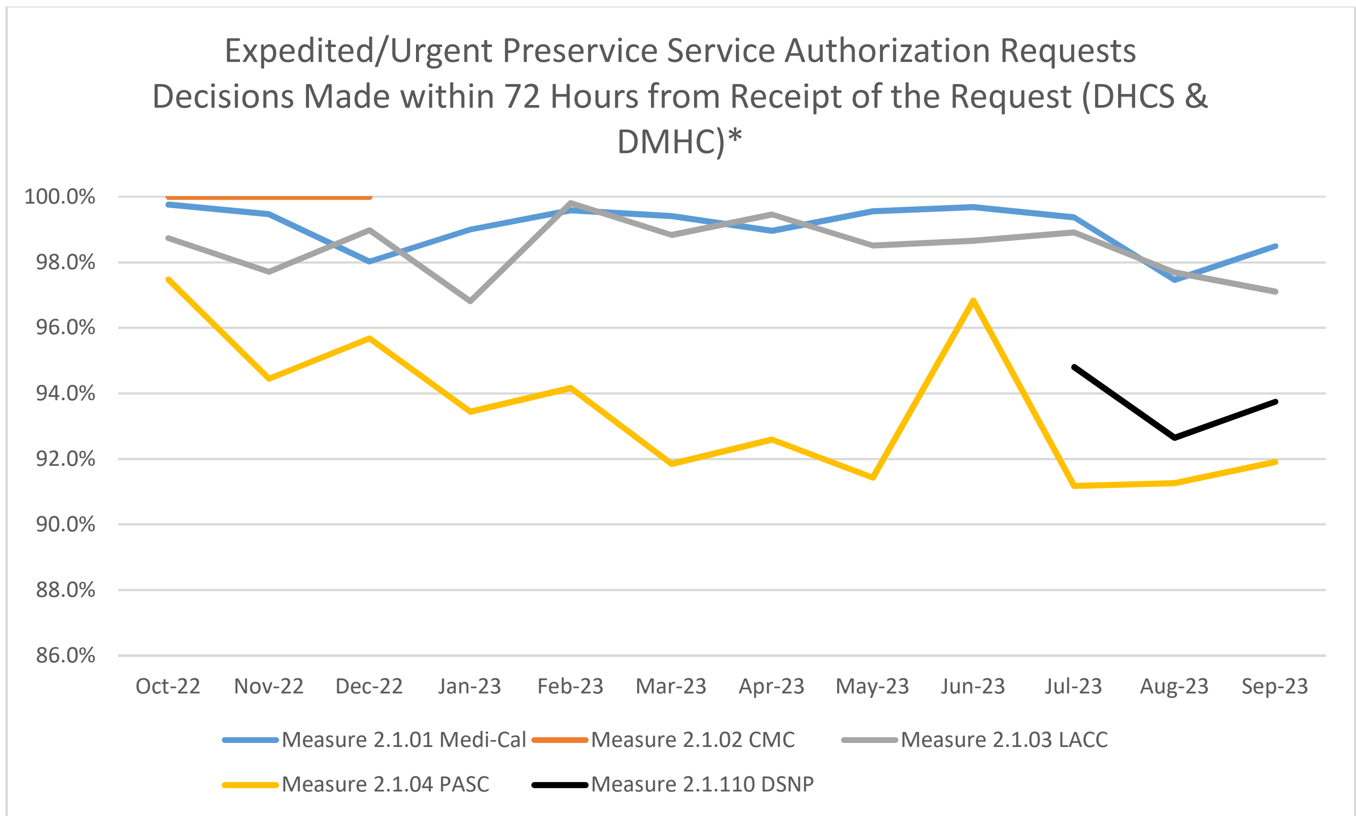


Quantitative Analysis:

- LACC and PASC were above 98% compliance for routine requests during all months
- All measures were above 97% compliance for routine requests during all months
- DSNP compliance monitoring for routine requests began in July 2023
- CMC Monitoring was discontinued after Feb 2023

TURN AROUND TIME COMPLIANCE - DELEGATE

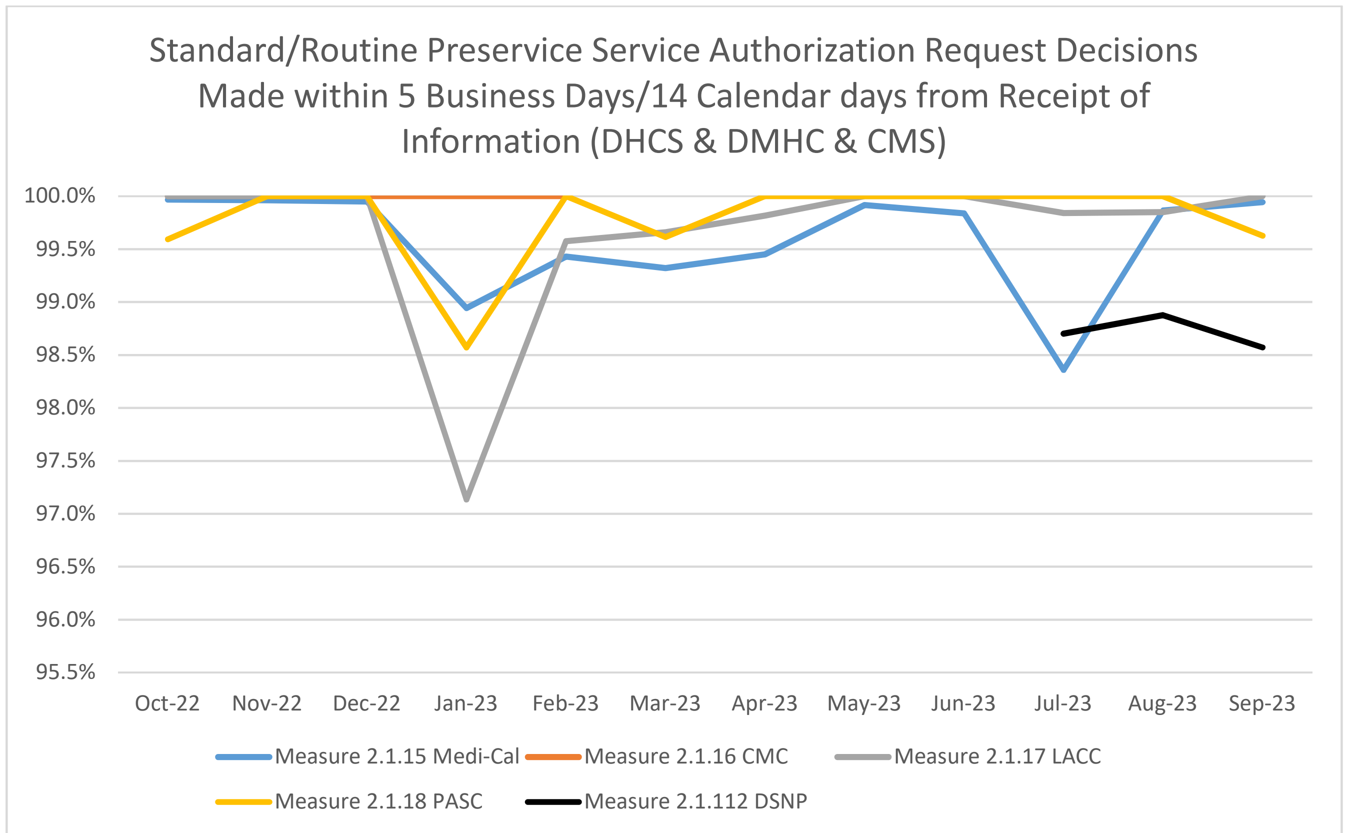
Urgent Request Compliance



Quantitative Analysis:

- Medi-Cal and LACC were above 95% compliance for urgent requests during all months
- PASC had the lowest compliance for urgent requests at about 91%
- All measures were above 91% compliance for urgent requests during all months
- DSNP compliance monitoring for urgent requests began in July 2023

Routine Request Compliance



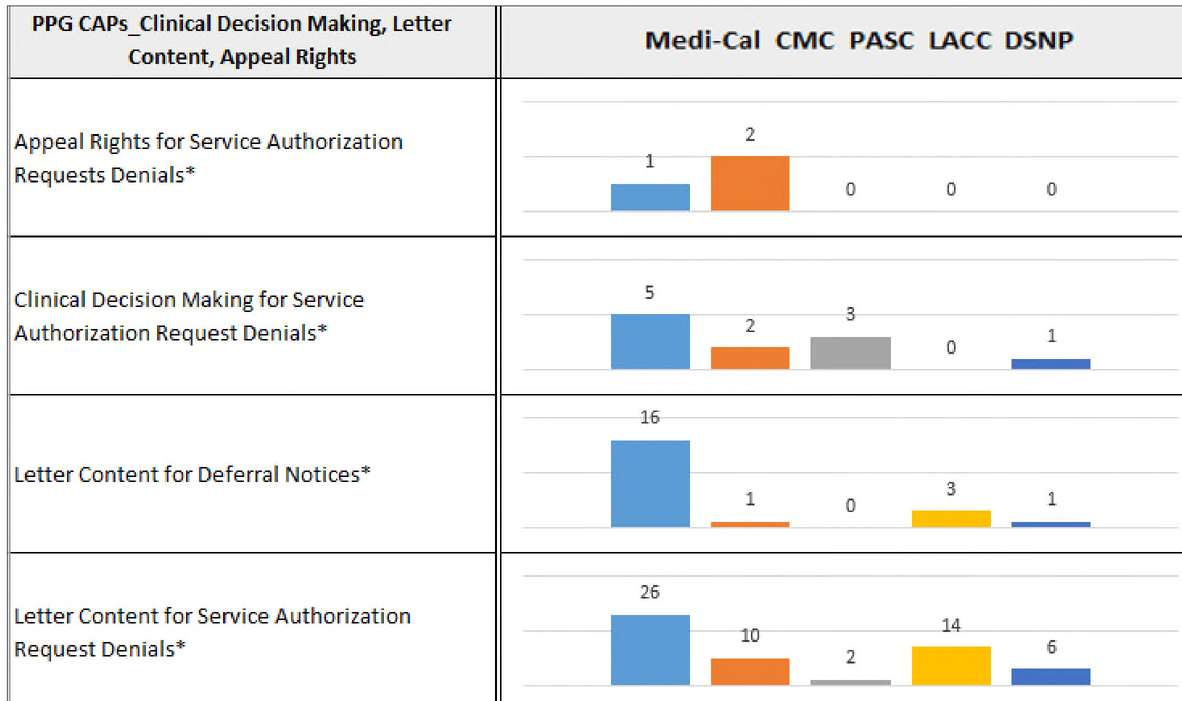
Quantitative Analysis:

- Medi-Cal, CMC, PASC and DSNP were above 98% compliance for routine requests during all months
- All measures were above 97% compliance for routine requests during all months
- DSNP compliance monitoring for routine requests began in July 2023

Delegated Performance

The graphs below indicate the volume of CAPs evaluated to date, based on deficiencies incurred as of the time from Quarter 4, 2022 to Quarter 3, 2023. There is active efforts being made to ensure all functions of utilization management delegated to another entity are clinically appropriate and compliant, both in terms of clinical decision making and timeliness. Our EPO department continues to track non-compliant behavior and make recommendations on ways to improve.

PPG CAPs_UM Decision and Notification Turnaround Times	Medi-Cal	CMC	PASC	LACC	DSNP
Expedited/Urgent Concurrent Service Authorization Request Decisions Made within 72 Hours from Receipt of the Request*	4		2	3	1
Expedited/Urgent Preservice Service Authorization Request decisions made within 24 hours from receipt of request (Part B)*					1
Expedited/Urgent Preservice Service Authorization Requests Decisions Made within 72 Hours from Receipt of the Request*	1	3	1		
Notify Member of Expedited/Urgent Preservice Service Authorization Request Decision within 24 hours of receipt of request (Part B)*					4
Notify Member of Standard/Non-Urgent Preservice Service Authorization Request Decision within 72 hours of receipt of request (Part B)*					11
Notify Members of Expedited/Urgent Concurrent Service Authorization Request Decisions within 72 hours from Receipt of the Request*	1				
Notify Members of Expedited/Urgent Preservice Service Authorization Request Decisions within 72 hours from Receipt of the Request*	68	4			1
Notify Members of Expedited/Urgent Preservice Service Authorization Request Decisions within Two Business Days of the Decision*	3			1	
Notify Providers of Expedited/Urgent Concurrent Service Authorization Request Decisions within 24 Hours of the Decision*	2			1	
Notify Providers of Expedited/Urgent Preservice Service Authorization Request Decisions within 24 Hours of the Decision*				7	
Notify Providers of Expedited/Urgent Preservice Service Authorization Request Decisions within 72 Hours of Receipt of the Request*	2	5			
Notify Providers of Standard/Routine Preservice Service Authorization Request Decisions within 24 Hours of the Decision*	3			1	
Standard/Non-Urgent Preservice Service Authorization Request decisions made within 72 hours of receipt of request (Part B)*					1



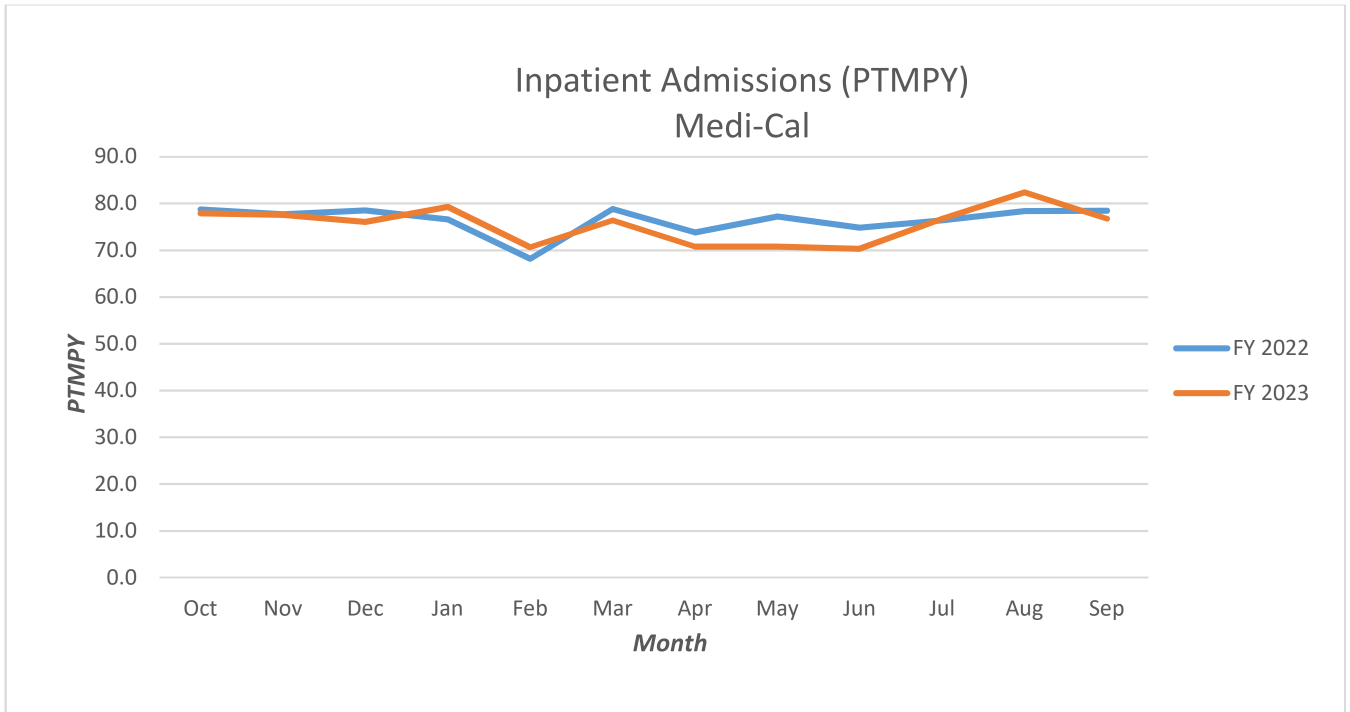
APPEALS AND GRIEVANCES PERFORMANCE

Appeal Review Decision	Count of Review Resolution	Percentage
Upheld	386	55.62%
Overturned	170	24.50%
Non-Clinical Review	121	17.44%
Withdrawn	14	2.02%
Completed	2	0.29%
Modified	1	0.14%
Grand Total	**694**	**100%**

As outlined, over 55% of notice of actions were upheld in appeals. Initial decisions rendered by medical director staff is both accurate and consistent. Decision overturned were done so because of additional information provided, most commonly the missing information outlined in the NOA letter. LA Care continues to make strides to ensure all appropriate documentation is provide from the onset of the request to reduce administrative burden and erroneous adverse decisions.

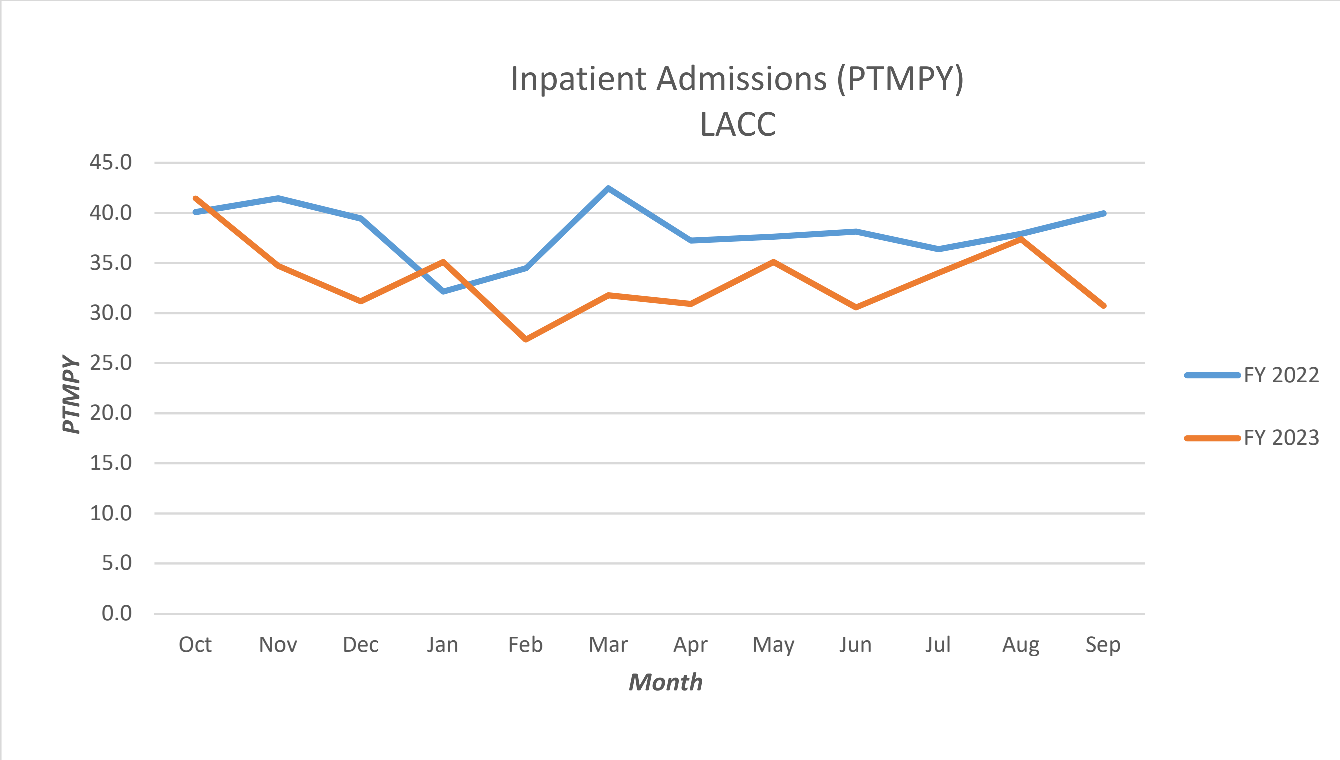
CLINICAL PERFORMANCE METRICS

Admissions Rates



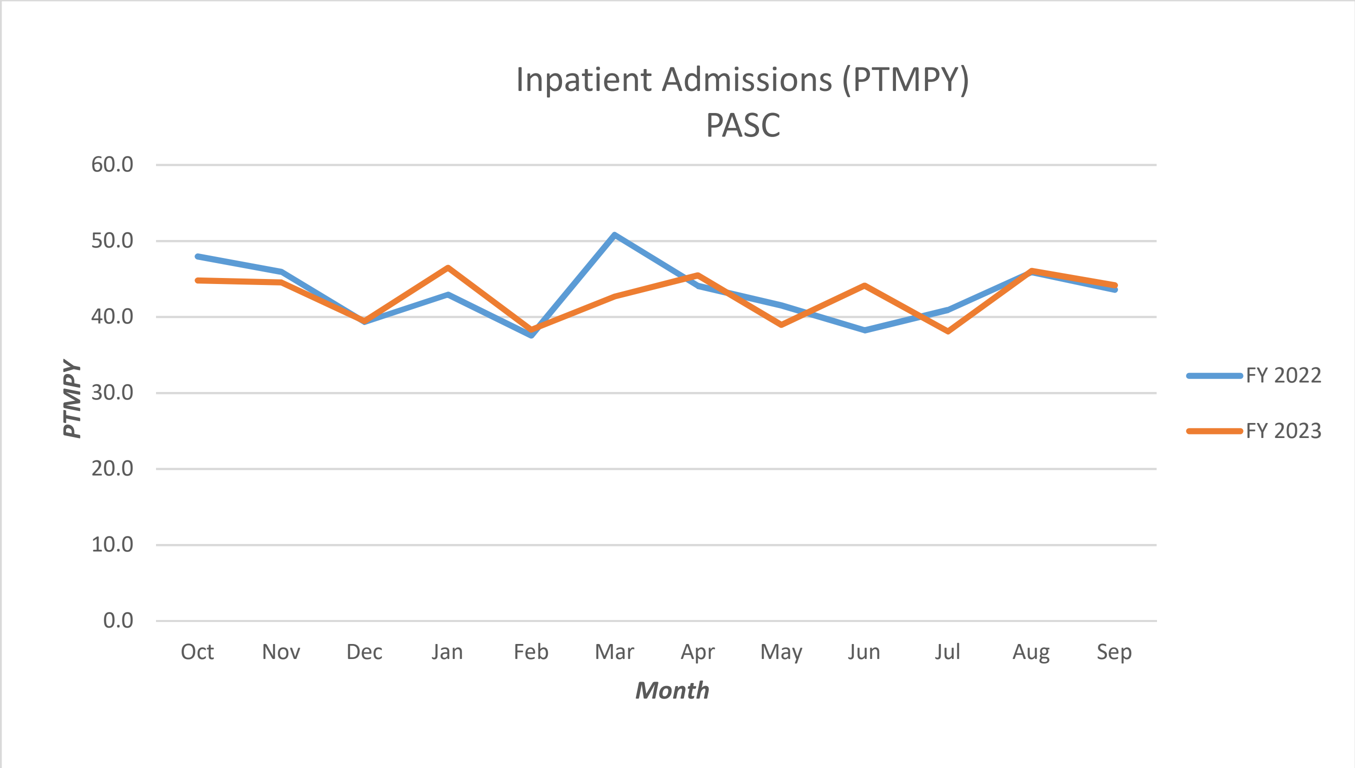
Quantitative Analysis:

- There was an overall downward trend for FY2023
- The highest rate in FY 2022 was in March 2022 and for FY 2023 it was in August 2023
- The lowest rate for FY 2022 was in February and FY 2023 in June



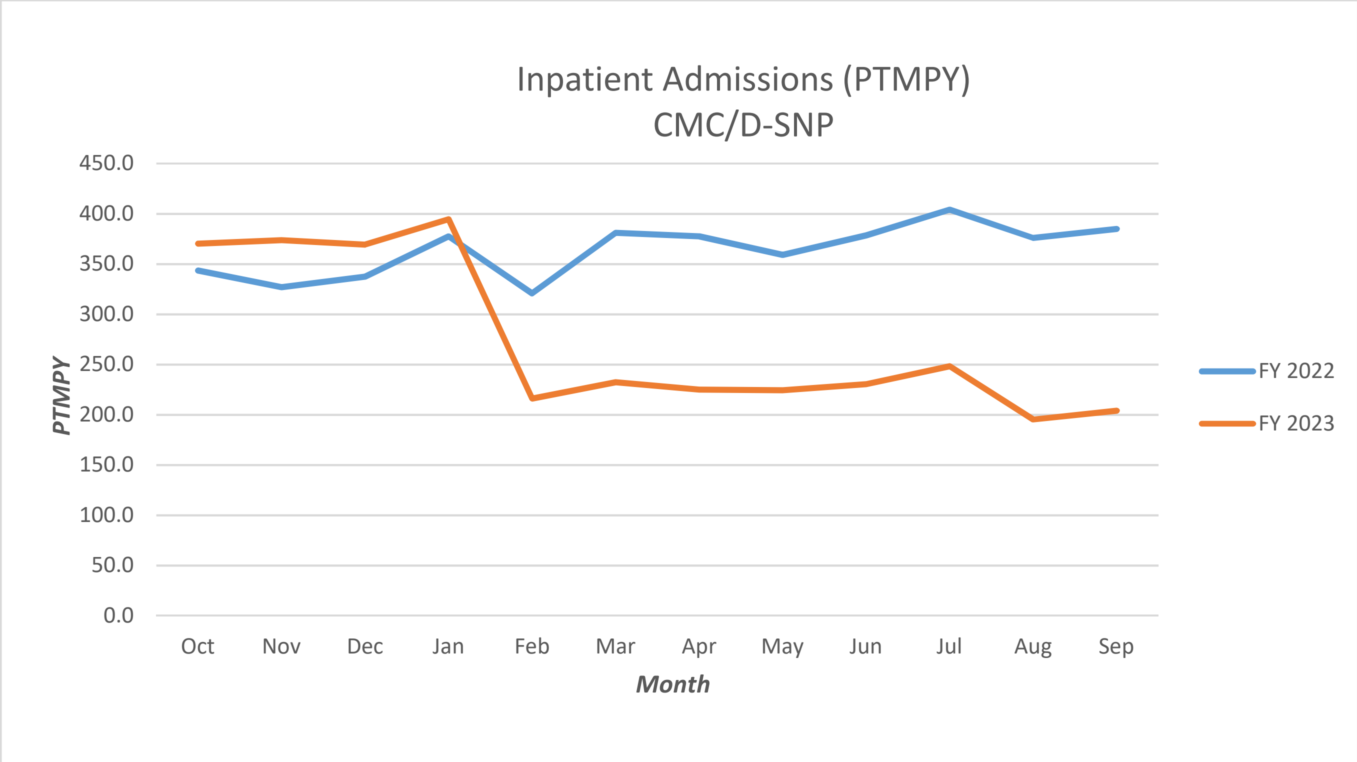
Quantitative Analysis:

- The highest rate in FY 2022 was in March and in FY 2023 it was in October
- The lowest rate in FY 2022 was in January and in FY 2023 it was in February
- There was a decline in the rate in October through December 2023 that began to increase in February



Quantitative Analysis:

- The highest rate in FY 2022 was in March and in FY 2023 it was in January
- The lowest rate in FY 2022 was February and in FY 2023 it was in July
- There was a sharp increase in the rate in March in FY2022 while FY2023 remained largely the same throughout the year



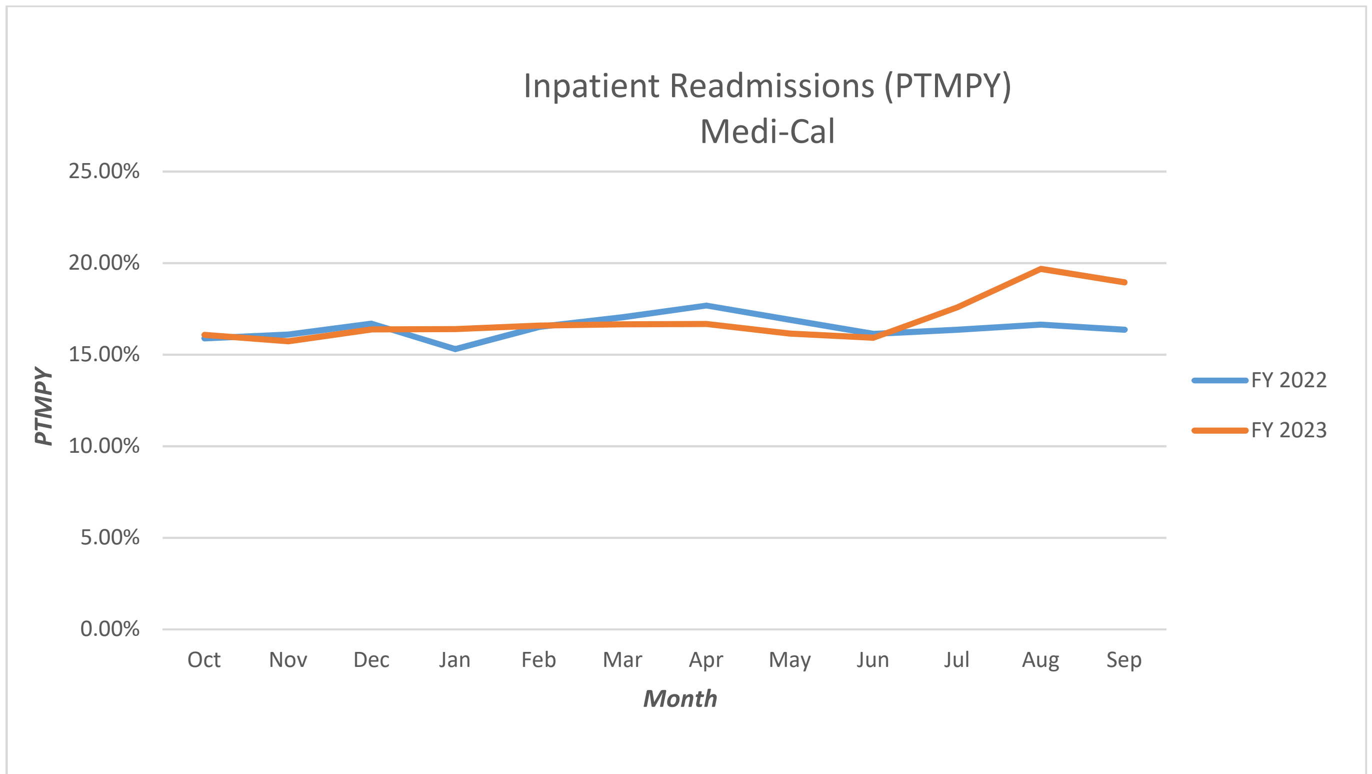
Quantitative Analysis:

- The highest rate in FY 2022 was in in July and in FY 2023 it was in January
- The lowest rate in FY 2022 was February and in FY 2023 it was also in February
- After the decrease in January 2023, the rate remained relatively the same in FY 2023. The rate did not fluctuate much throughout FY 2022

Conclusion:

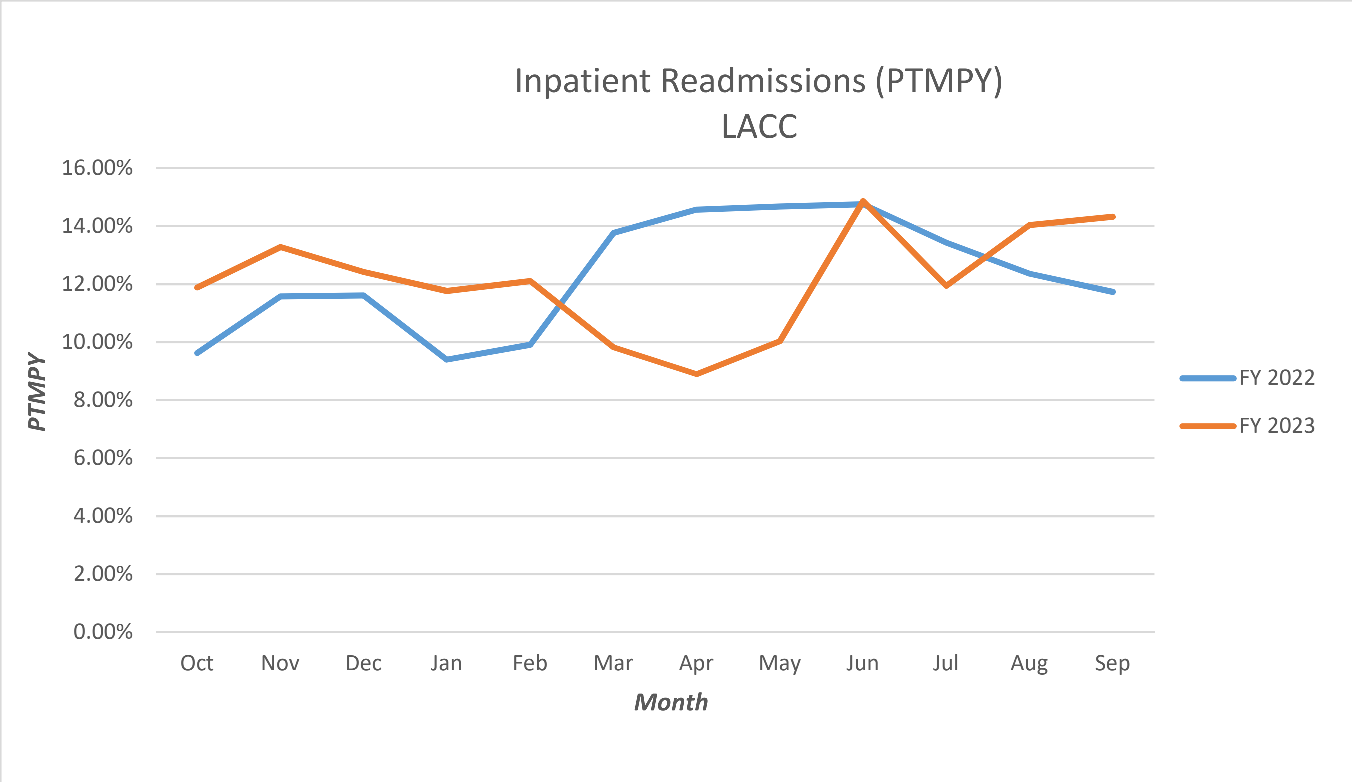
Inpatient admissions improved over the course of 2023 for all lines of business. This is likely due to resolution of the pandemic and individuals able to get care otherwise. LA Care continues to make active efforts reducing the unnecessary utilization of hospital care for services that can and should be provided in the ambulatory environment.

Readmission Rates



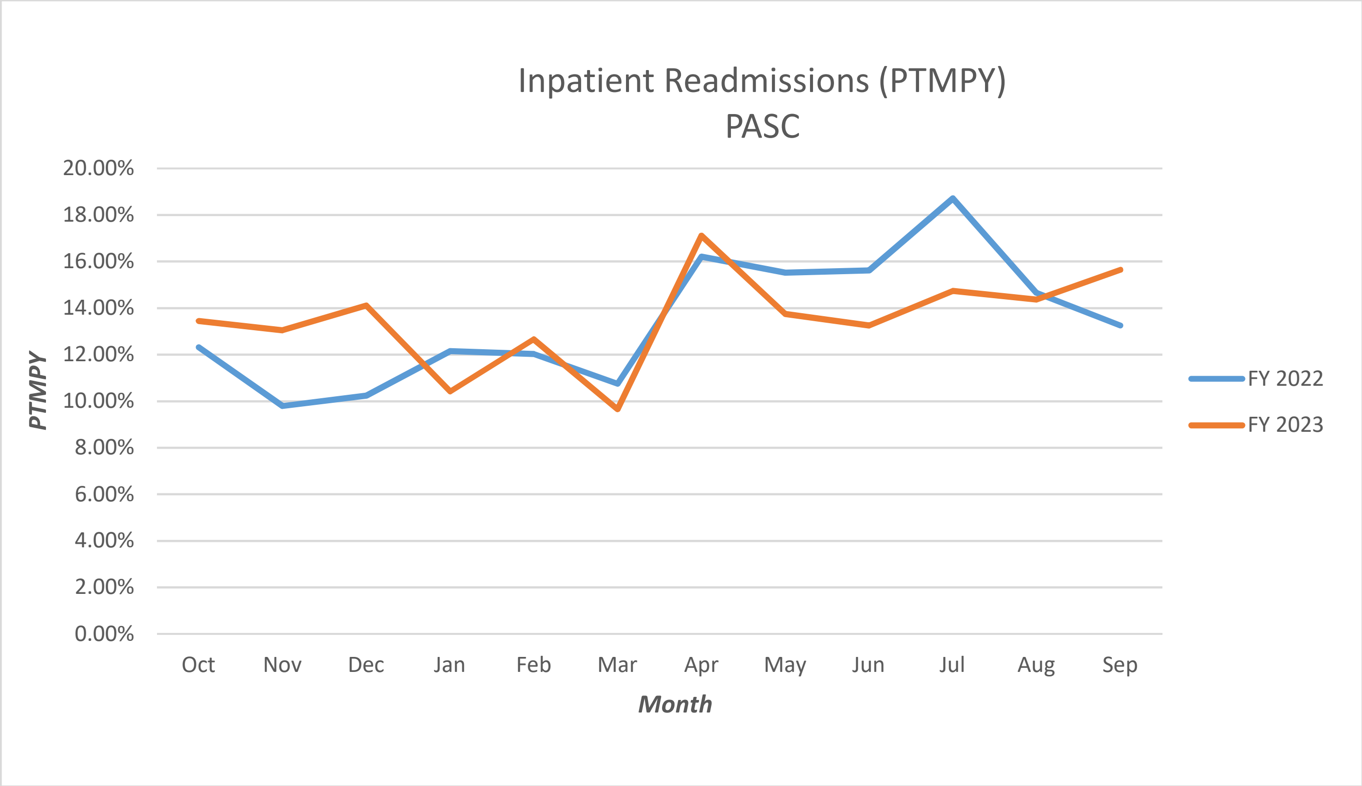
Quantitative Analysis:

- Overall FY 2022 remained relatively the same in its rate while FY 2023 had increased
- The highest rate is in August 2023
- The lowest rate is in January 2022
- The rate in August Year 2023 is higher than the rate August in Year 2022 by about 3%.



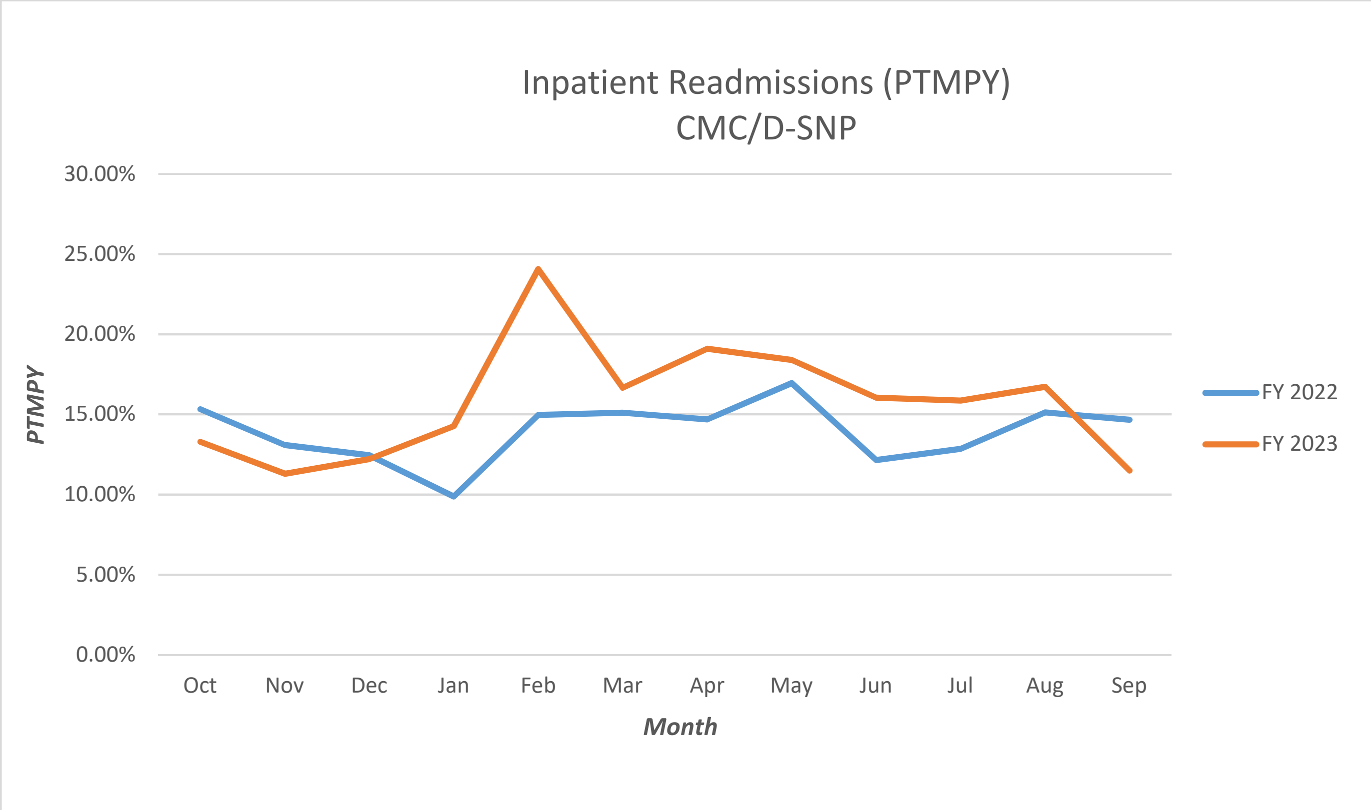
Quantitative Analysis:

- The highest rate is in May 2023
- The lowest rate is in April 2023
- There was an increase from April through June 2023



Quantitative Analysis:

- The highest rate is in Year 2022 in July
- The lowest rate is in March 2023
- The rate in July Year 2022 is higher than the rate in July Year 2023 by about 4%.
- FY 2023 experienced a sharp increase between March and April



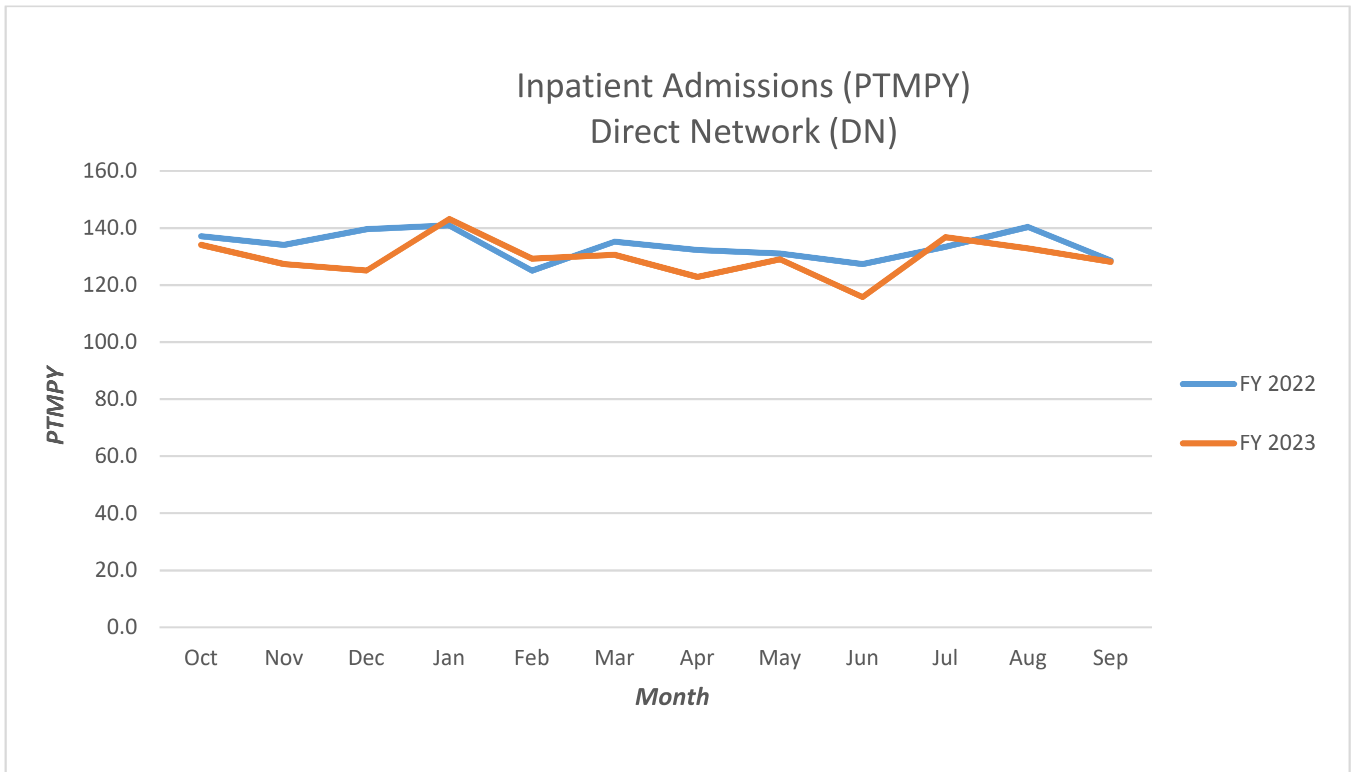
Quantitative Analysis:

- The highest rate is in Year 2023 in February
- The lowest rate is in January 2022
- The rate in February Year 2023 is higher than the rate in February Year 2022 by about 9%.

Conclusion:

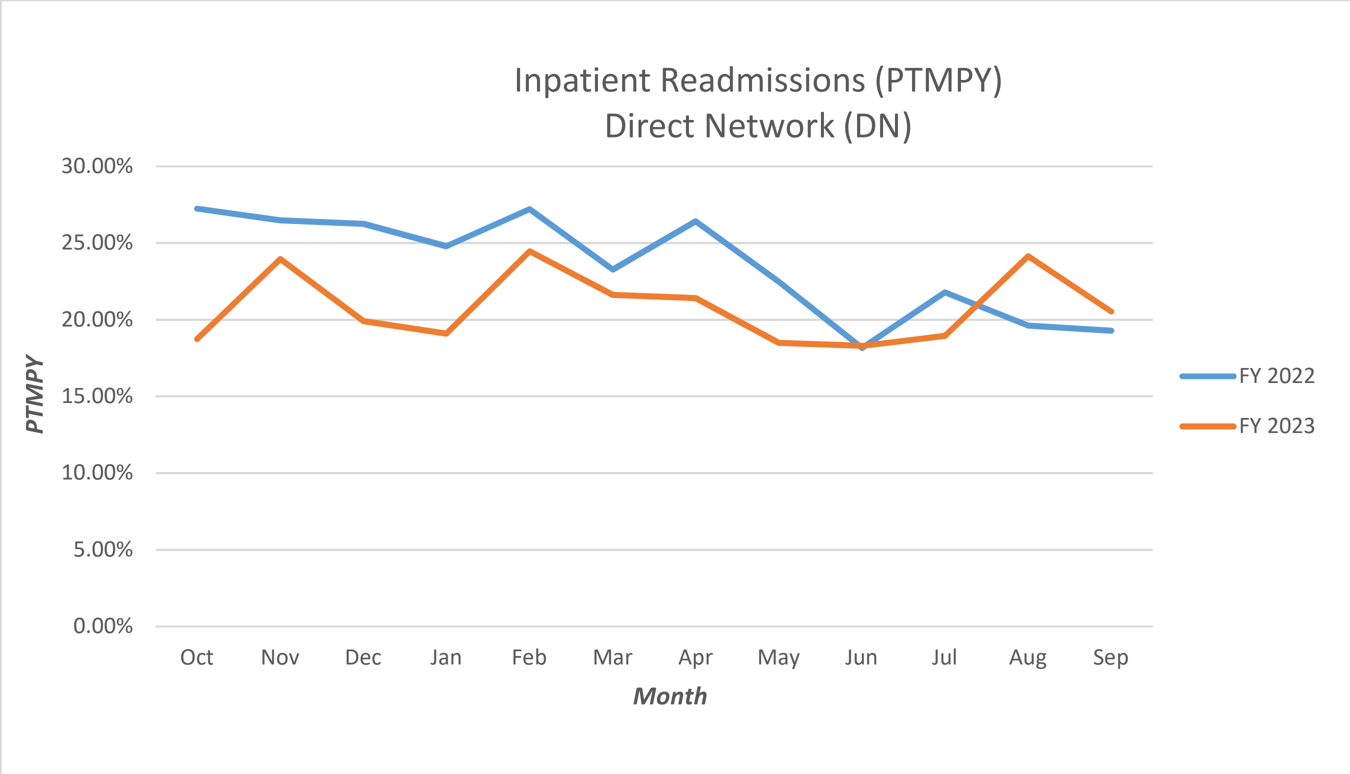
Readmission rates overall remains above our goal of 15%. As result, there will be focused efforts in 2024 to address unnecessary readmissions.

Direct Network



Quantitative Analysis:

- The highest rate in FY 2022 was in in August and in FY 2023 it was in January
- The lowest rate in FY 2022 was February and in FY 2023 it was in June
- After the decrease in January 2023, the rate remained relatively the same in FY 2023. The rate did not fluctuate much throughout FY 2022



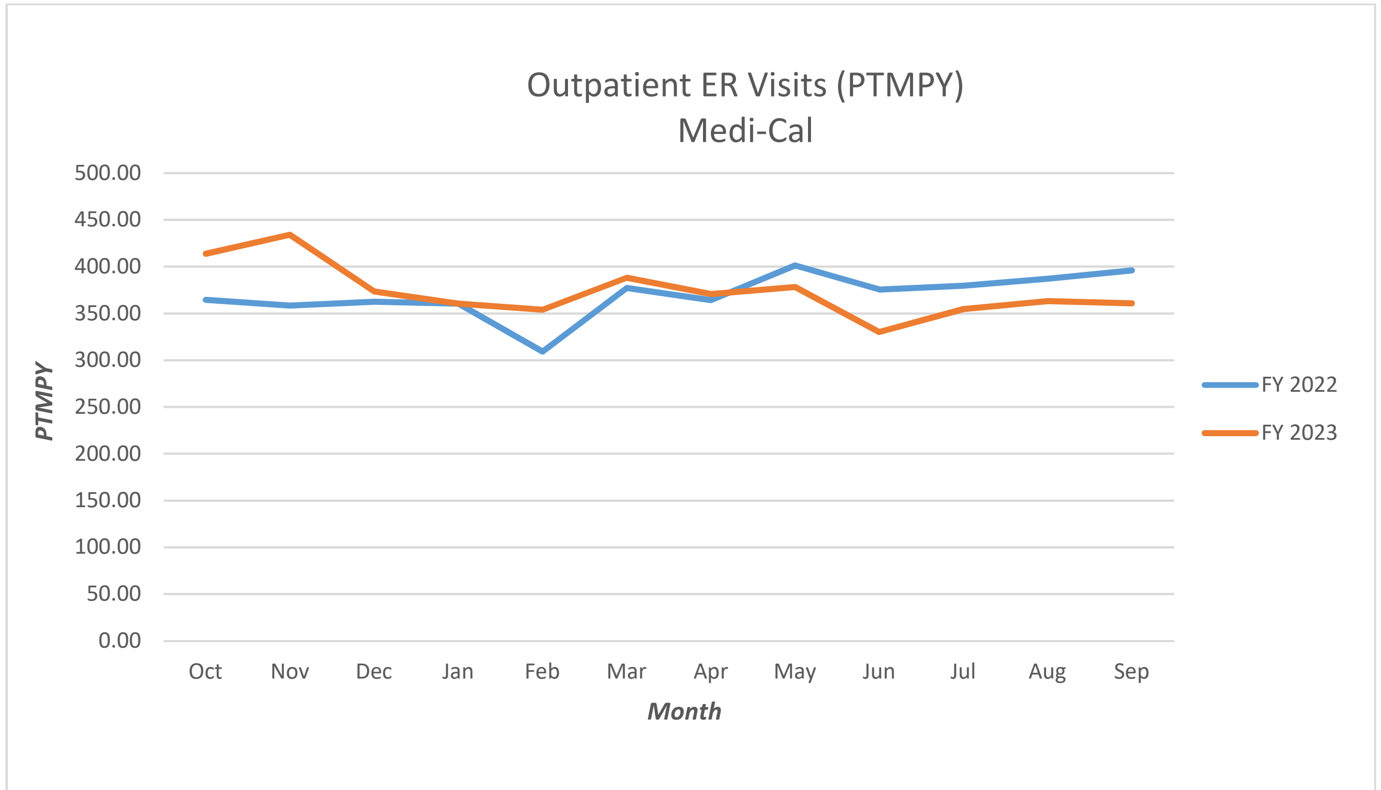
Quantitative Analysis:

- The highest rate is in Year 2022 in February
- The lowest rate is in May 2023
- The rate in January Year 2022 is higher than the rate in January Year 2023 by about 5%.
- FY 2023 readmissions remained stable from May through July

Conclusion:

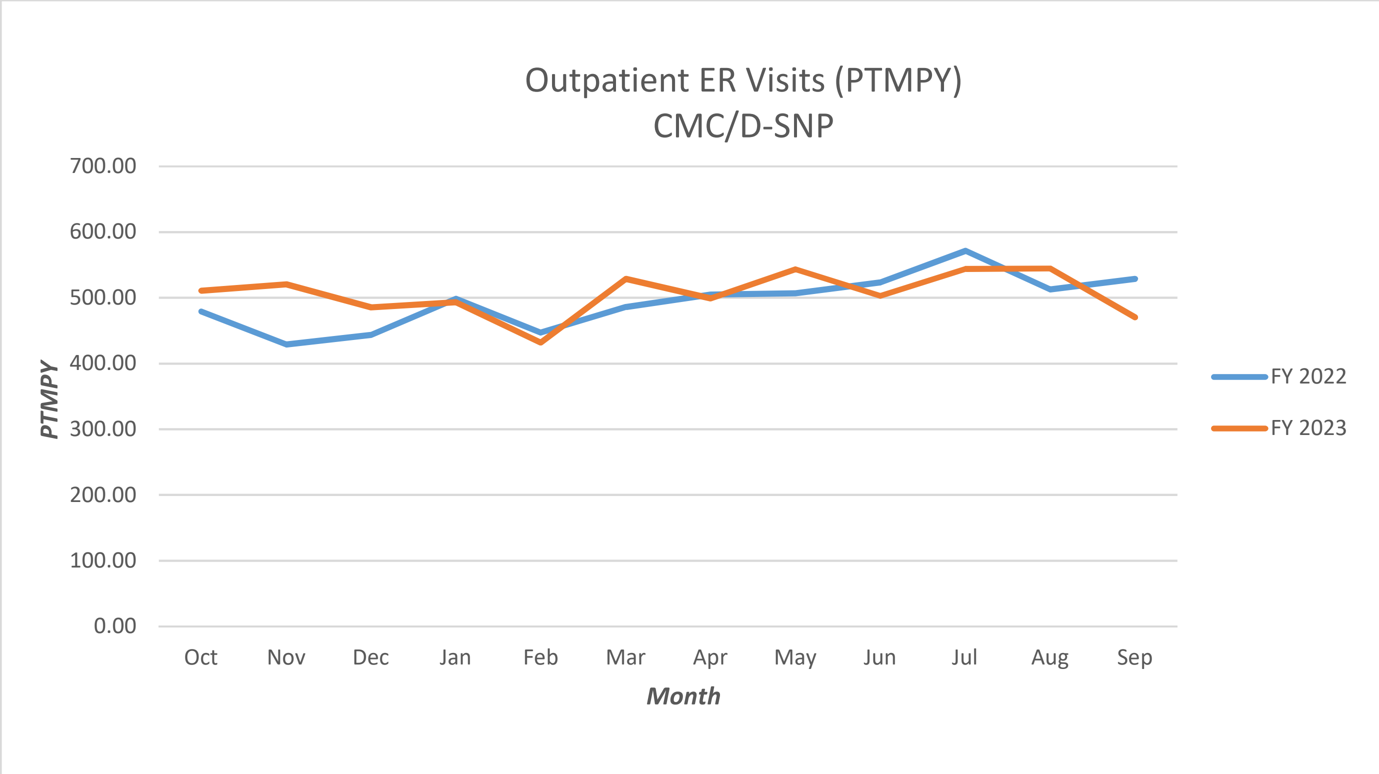
L.A. Care Direct Network admissions has increased over 2023 and remains above the Medi-Cal average . The medical management of inpatient care transitioned from Optum to LA Care at the end of 2022 and we will continue to track and bring the Direct Network performance in line with the remaining aspects of the network. The Direct Network does encompass a more challenging population both clinically and geographically (i.e. antelope valley) that makes ease and usefulness of primary care challenging.

ER Utilization



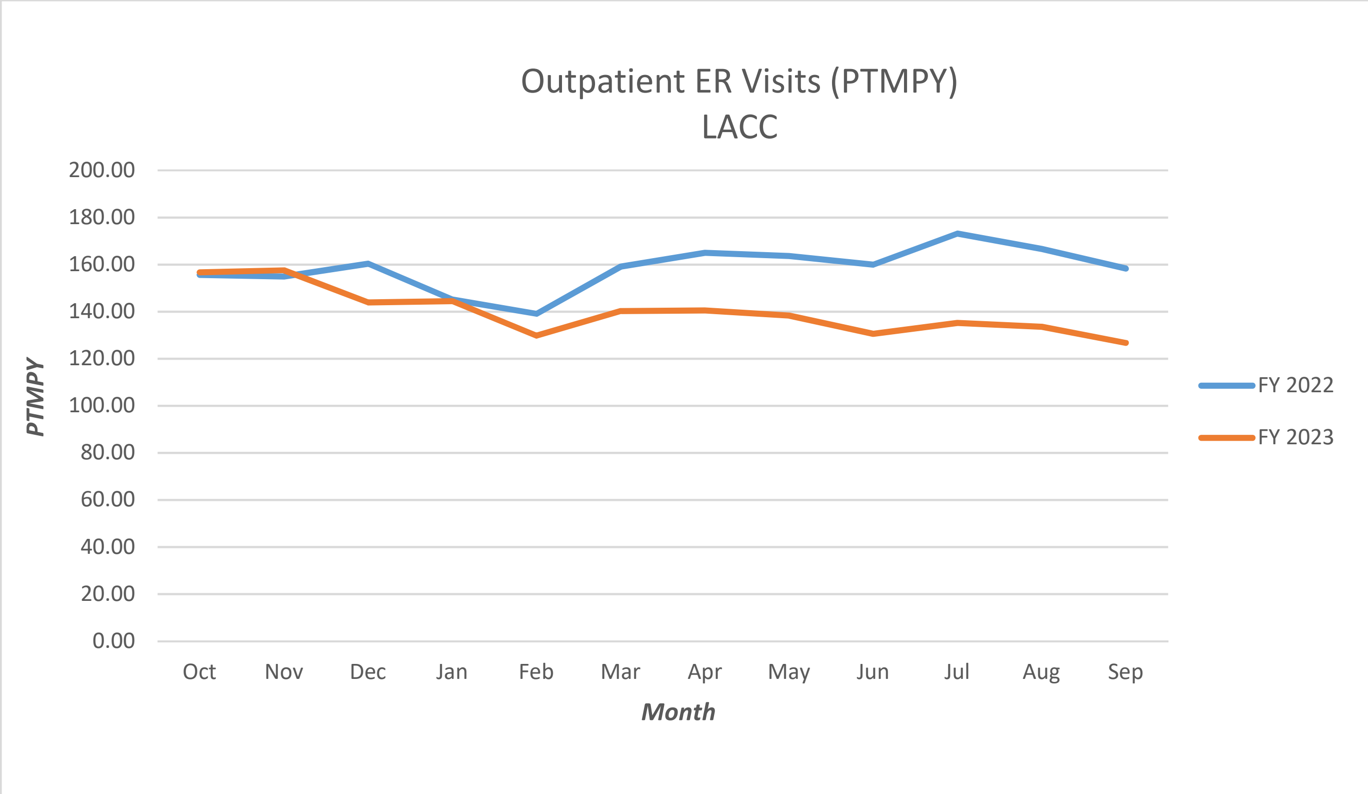
Quantitative Analysis:

- The rates for FY2023 decreased slightly over the fiscal year
- The highest rate is Year 2023 in November
- The lowest rate is Year 2022 in February
- There was a slow decline in FY 2023 until February



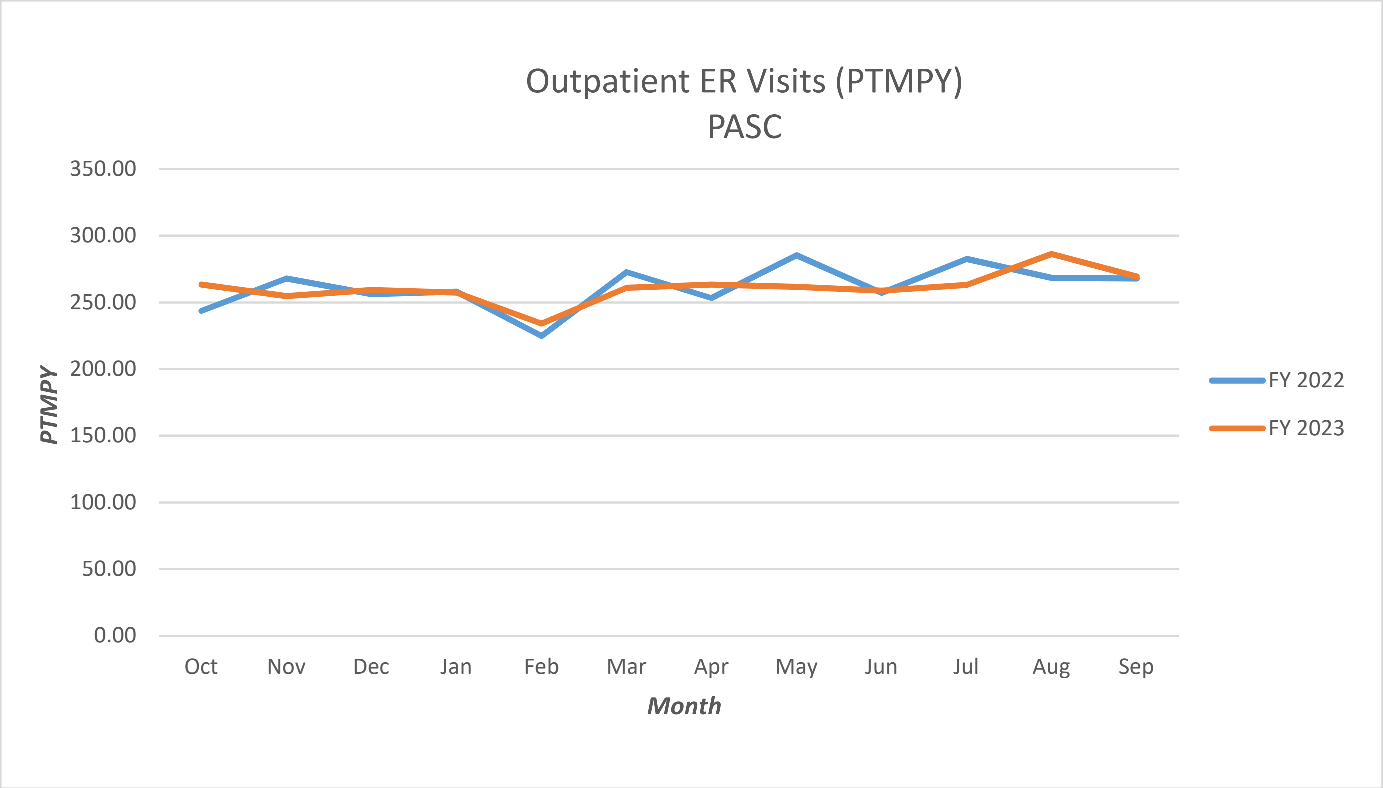
Quantitative Analysis:

- The highest rate is Year 2022 in July and Year 2023 in May and August
- The lowest rate is Year 2022 in November



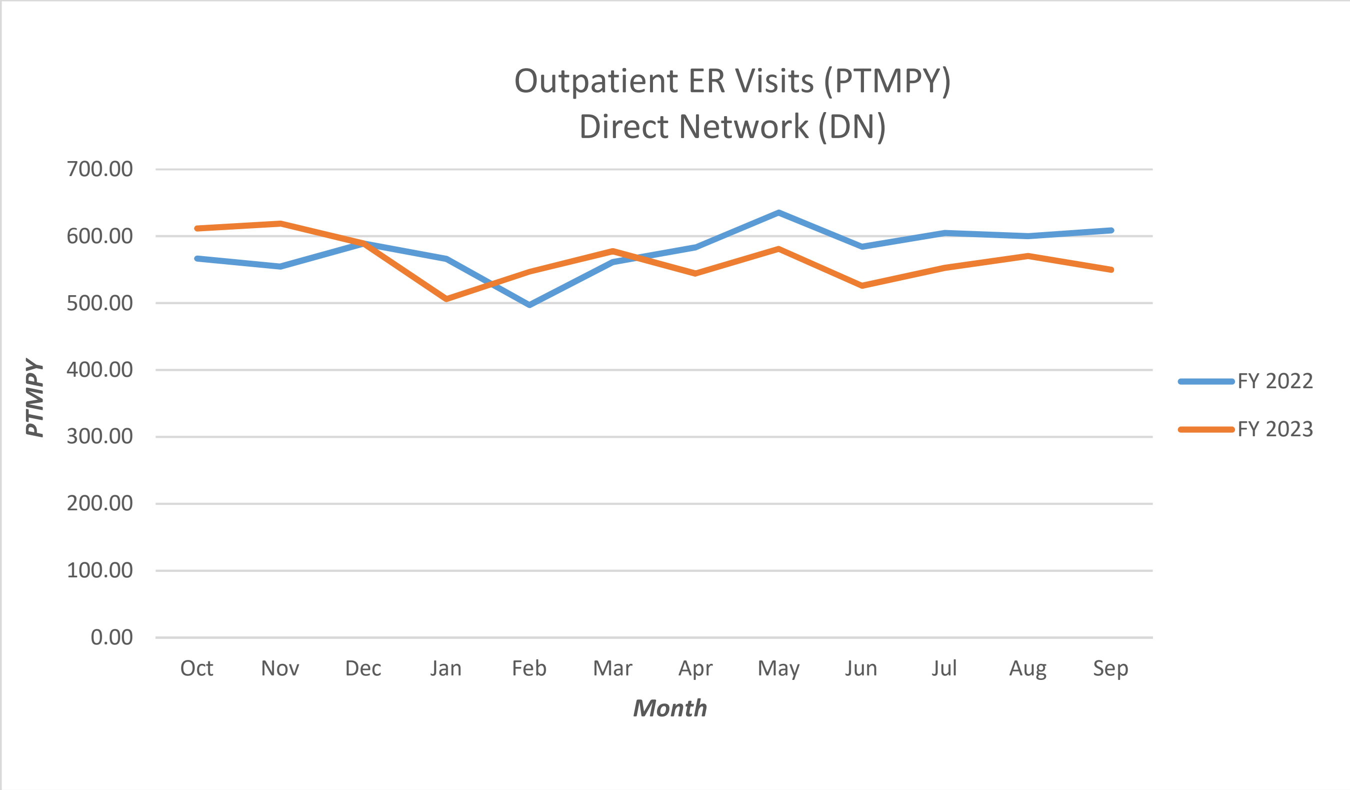
Quantitative Analysis:

- The rate for FY2023 has decreased over the year
- The highest rate is in 2022 in July
- The lowest rate is in September 2023



Quantitative Analysis:

- Rates had increased over the year for FY2023
- The highest rate is in August 2023
- The lowest rate is in February 2022
- Both rates hovered around the same numbers throughout the year



Quantitative Analysis:

- The rates for FY 2023 decreased slightly over the fiscal year
- The highest rate is Year 2022 in May
- The lowest rate is Year 2022 in February
- There was a slow decline in FY 2023 until January

Conclusion:

ER utilization remains relatively flat over 2023. About 50% of all ER visits are deemed non-emergent and would be best served in a less intensive environment. L.A. Care continues to make efforts improving access to ambulatory and urgent care when appropriate.

BEHAVIORAL HEALTH UTILIZATION

Background

L.A. Care Health Plan (L.A. Care) provides Mental Health and Substance Use Disorder Services through Primary Care Providers (PCP), Behavioral Health Specialty Providers through L.A. Care's behavioral health vendor, Carelon Behavioral Health (formerly known as Beacon Health Options), Los Angeles County Department of Mental Health (DMH), and Los Angeles County Department of Public Health (DPH). For members enrolled in Medi-Cal, including MCLA and D-SNP lines of business (LOB), the delivery system in which members can access care is based on the type and severity of symptoms and impairment. For commercial LOBs, all services besides primary care (PCP) screenings are provided by Carelon Behavioral Health. The delivery system in which member accesses their care is the organization that completes utilization management reviews based on established State regulatory criteria.

The Plan's MBHO is an NCQA-accredited and state-licensed entity which adheres to the same regulatory standards as the Plan for concurrent reviews, prior authorizations, and other UM activities. The MBHO develops and adopts its own regulatory criteria, which are based on Medicare NCD's and LCD's, Medicaid national and state-specific regulations, state regulations for commercial plans, and other regulatory requirements. In turn, the MBHO's Utilization Management requirements are reviewed by the Behavioral Health Medical Director, a board-certified psychiatrist, and other licensed and/or certified behavioral health subject matter experts. The Behavioral Health Medical Director makes recommendations to the Utilization Management Committee about adoption of the MBHO's policies.

L.A. Care has executed Memoranda of Understandings (MOUs) with the L.A. County Mental Health Plan (MHP and the L.A. County Drug Medi-Cal Organized Delivery System (DMC-ODS) which outline roles and responsibilities for covered services. The County MHP and DMC-ODS systems conduct their own Utilization Management reviews that are regulated separately by State Medi-Cal agency and comply with a separate set of regulatory standards. L.A. Care does not have an oversight authority over these County processes.

There are two domains or services that are excluded from the County Department of Mental Health, Public Health, and L.A. Care's MBHO. The utilization management of below services are conducted directly by L.A. Care staff.

1. **Behavioral Health Treatment (BHT)**
   L.A. Care conducts Utilization Management of BHT services for all Medi-Cal members under 21 years of age with a recommendation from a licensed physician, surgeon or psychologist that evidence-based BHT services are medically necessary. These services include Applied Behavior Analysis (ABA) and related evidence-based treatments. For this benefit, the Plan's first-level reviews are conducted by internationally certified Subject Matter Experts, termed Board-Certified Behavior Analysts (BCBA's). The Plan's second-level reviews are conducted by the Behavioral Health Medical Director, a board-certified psychiatrist.

For all other lines of business, utilization reviews of BHT are completed by L.A. Care's MBHO.

2. **Transgender Health Services (all lines of business)**

These services, which include mental health assessments, endocrine treatments, and surgical interventions, are reviewed by L.A. Care's UM nurses (first level) and medical directors.

The senior medical director for behavioral plays a critical and crucial in the effectuation of behavioral health utilization and remains actively engaged overseeing, educating and coaching all the clinical staff in decision making. The senior medical director actively participates in multiple committees including behavioral health and utilization management.

MEMBER AND PROVIDER SURVEYS

Overall Satisfaction with Utilization Management

Overall Satisfaction with Utilization Management	PCPs (n=573)	SCPs (n=298)	DN (n=342)
Very Satisfied	21%	20%	18%
Satisfied	43%	41%	45%
Neutral	22%	25%	19%
Dissatisfied	3%	3%	6%
Very Dissatisfied	1%	2%	5%
Does Not Apply	5%	5%	3%

Quantitative Analysis:

- The Overall Satisfaction with Utilization Management category with the highest number of respondents is PCPs.
- The Overall Satisfaction with Utilization Management category with the lowest number of respondents is SCPs.
- The highest percentage of answers were in the "Satisfied" field with 43% from PCPs, 41% from SCPs and 45% from DN.
- The answers with the lowest rate percentage from each population is as follows:
    - PCPs: Very Dissatisfied with 1%
    - SCPs: Very Dissatisfied with 2%
    - DN: Very Dissatisfied with 5%
- The answers associated with Positive answers and Negative answers are as follows for each population.
    - For PCPs: positive answers were 64% and negative answers were 31% of all responses
    - For SCPs: positive answers were 61% and negative answers were 35% of all responses
    - For DN: positive answers were 63% and negative answers were 33% of all responses

Overall Satisfaction with Contracted Provider Group's Referral Process

Overall Satisfaction with Contracted Provider Group's Referral Process	PCPs (n=457)	SCPs (n=270)	DN (n=258)
Very Satisfied	22%	14%	20%
Satisfied	44%	36%	40%
Neutral	16%	17%	15%
Dissatisfied	4%	2%	3%
Very Dissatisfied	2%	1%	2%
Does Not Apply	1%	1%	0%

Quantitative Analysis:

- The highest percentage of answers were in the "Satisfied" field with 44% from PCPs, 36% from SCPs and 40% from DN.
- The answers with the lowest rate percentage from each population is as follows:
    - PCPs: Very Dissatisfied with 2%
    - SCPs: Very Dissatisfied with 1%
    - DN: Very Dissatisfied with 2%
- The answers associated with Positive answers and Negative answers are as follows for each population.
    - For PCPs: positive answers were 66% and negative answers were 23% of all responses
    - For SCPs: positive answers were 50% and negative answers were 21% of all responses
    - For DN: positive answers were 60% and negative answers were 20% of all responses

L.A Care uses provider surveys to enhance and improve our processes. We make active efforts to ensure the authorizations we request are purposeful and provide value to our network. We limit the number of services that require authorization is they are approved at high rates. We continue to work with our providers to remove as much administrative burden in the authorization process and ensure that all authorizations are approved timely and within regulatory compliance. We make efforts to educate our providers when the cause of dissatisfaction, for example, is the result of poor provider behavior.

CONCLUSIONS

Overall, the team did our very best to maintain all aspects of compliance for our members and execute the UM program in a robust and meaningful manner. Doing so has required staff restructuring, process improvement, clinical training, operational redesign and improved quality oversight. We strive to maintain all aspects of our compliance needs within the regulatory and contractual requirements, monitoring of performance within the established benchmarks or goals, identifying opportunities for improvement and enhancing processes and outcomes.

To create this comprehensive approach to the UM program structure, practicing physicians provided input through the UM Committee and subcommittees. The program has continued to grow and develop, becoming more streamlined in its' work streams, having better consistency amongst the clinical staff in decision-making and monitoring the utilization of the network overall. The functions of utilization management have expanded well beyond the scope of the UM department alone and into other domains, especially with the roll out of CalAIM. Because of internal performance monitoring and multiple regulatory audits performed in 2022, opportunities for improvement were identified and will be incorporated into goals for 2024.

RECOMMENDATIONS FOR 2024

Based on the 2023 L.A. Care Utilization Management Program Evaluation and the feedback surveys, the following recommendations for the 2024 Work Plan are as outlined below:

- Continue to drive process improvement to improve turnaround time compliance;
- Enhance our new core UM system to improve performance and automation;
- Simplify and optimize our utilization requirements and rules based on historical patterns;
- Improve the clinical oversight of our work, both internally and at the delegate, to ensure all decisions and actions are sound and accurate
- Develop more robust strategies on ways to improve our overall utilization patterns by better aligning financial, clinical and operational goals
- Creation of standardized UM workflows to improve productivity, efficiency and compliance;
- Meet for timeliness goals and optimize the timeliness of both clinical and non-clinical staff:
- Continue to work on the advancement of our dashboards to help keep track of open cases, employee productivity and due dates;
- Continue to develop our dashboards on utilization patterns across our network to identify under and over patterns and access gaps;
- Continue to collaborate with our PPGs to reduce utilization variation;
- Tailor our networks of providers to improve communication and oversight of our providers;
- Collaborate with claims and G&A to Improve the retro review, appeals and PDR process;
- Ongoing clinical staff education to improve accuracy and consistency of UM decision making;
- Continued monitoring of ambulatory and hospital metrics to enhance optimal utilization;
- Expand our network of PCPs, hospitalists and specialists to support the direct network for member access;
- Continued work on special programs such as:
    - Transition of Care services for high risk individuals

    - Adding In lieu of services such as recuperative care and congregate living
    - Improving efforts around managing and referrals for those who need institutional placement and palliative care services
    - Reduce barriers to transgender health and autism spectrum disorder services
    - Support referrals to qualified centers for major organ transplant services
- IRR testing will continue at least annually for all physicians and nurses who are involved in UM decision making;
- To improve the area of consistency of decision-making across the network, develop a schedule for PPG Physician UM discussions hosted by L.A. Care physicians in which IRR activities will be addressed;
- Continue to identify mechanism to improve overall California Children Services (CCS) reporting to ensure the appropriate referrals are made to the CCS program.