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

BOARD OF GOVERNORS

COMPLIANCE & QUALITY (C&Q)

COMMITTEE MEETING

April 17, 2025, at 2:00 PM

L.A. Care Health Plan

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

Lobby, Board Suite 100

ELEVATING HEALTHCARE IN LOS ANGELES COUNTY SINCE 1997

DRAFT

AGENDA

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

Thursday, April 17, 2025, 2:00 PM
1055 West 7th Street, Conference Room 100, 1st Floor
Los Angeles, CA 90017

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

To listen to the meeting via videoconference please register by using the link below:
https://lacare.webex.com/weblink/register/rb8444d0828cc5127ac14efee0b45d403

To listen to the meeting via teleconference please dial: +1-213-306-3065
Meeting Number: 2481 526 3579 Password: lacare

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.
The process for public comment is evolving and may change at future meetings.
All votes in a teleconferenced meeting shall be conducted by roll call.

If you are an individual with a disability and need a reasonable modification or accommodation pursuant to the Americans with Disabilities Act (ADA) please contact L.A. Care Board Services staff prior to the meeting for assistance by calling 213-428-5500 or by email to BoardServices@lacare.org.

Teleconference Site

Al Ballesteros
5650 Jillson Street
Commerce, CA 90040

WELCOME		Stephanie Booth, *MD, Chair*
1.	Approve today's meeting Agenda	*Chair*
2.	Public Comment (*please see instructions above)*	*Chair*
3.	Approve March 20, 2025, Meeting Minutes *p.3*	*Chair*
4.	Chairperson's Report • Education Topics	*Chair*
5.	Chief Compliance Officer Report *P.17*	Todd Gower *Chief Compliance Officer*
6.	Chief Medical Officer Report	Sameer Amin, *MD* *Chief Medical Officer*
7.	Provider Quality Review (PQR) Annual Report *P.20*	Rhonda Reyes *Manager, Quality Improvement Data Management*

8. Approve Utilization Management (UM) Documents *P.30* — Tara Nelson, *BSN, RN*, *Senior Director, Utilization Management*
   (COM A.0425)
   - 2024 UM Program Evaluation
   - 2025 UM Program Description
9. Quality Oversight Committee (QOC) Report — Edward Sheen, *MD*, *Chief Quality and Population Health Executive*
10. Public Comment on Closed Session Items

ADJOURN TO CLOSED SESSION (Est. time 30 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:
    Three potential cases
13. THREAT TO PUBLIC SERVICES OR FACILITIES
    CA Government Code Section 54957
    Consultation with: Todd Gower, Chief Compliance Officer, Tom MacDougall, Chief Information and Technology Officer, IT Executive Administration, Michael Sobetzko, Senior Director, Risk Management, and Vlad Popescu, Senior Director II, Information Technology Project Management, IT Executive Administration
14. CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION
    Gov. Code § 54956.9(d)(1)
    L.A. Care Health Plan's Notice of Contract Dispute under Contract No. 04-36069
    Department of Health Care Services (Case No. Unavailable)

RECONVENE IN OPEN SESSION

ADJOURNMENT

The next Compliance & Quality Committee meeting is scheduled on
Thursday, May 15, 2025, at 2:00 PM
and may be conducted as a teleconference meeting.

The order of items appearing on the agenda may change during the meeting.

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 – March 20, 2025

L.A. Care Health Plan CR 100, 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*
Linda Greenfeld, *Chief Product Officer, Executive Services*
Augustavia J. Haydel, *General Counsel*
Alex Li, *Chief Health Equity Officer*
Acacia Reed, *Chief Operations Officer*

** 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 2:02 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.**	**Unanimously Approved 4 AYES (Ballesteros, Booth, Roybal, and Vazquez)**
PUBLIC COMMENT	*There was no public comment.*	
APPROVAL OF MEETING MINUTES	Chairperson Booth stated that she made edits to the minutes and the final version was forwarded to Board Services. **The February 20, 2024 meeting minutes were approved as submitted.**	**Approved unanimously. 4 AYES**

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
CHAIRPERSON REPORT	Chairperson Booth stated that she had a few important but varied updates to share. She noted that the organization had received health equity accreditation for 2024 and recognized the Compliance team for successfully completing a disaster recovery test, which coincided with a real-life emergency. She pointed out that even though the test involved primarily technical systems, the experience highlighted the organization's ability to address people-related challenges during disasters, such as recent wildfires. She also shared observations on strategic planning, specifically suggesting changes to how L.A. Care presents its goals. Referring to the strategy around supporting a strong provider and partner network, Chairperson Booth noted that the current wording lacks clarity about how social needs are directly connected to health outcomes. She proposed modifying the language to better reflect the importance of addressing social drivers of health, such as food and shelter, to support member well-being. Chairperson Booth also discussed the strategy to improve member experience and the quality of care. She pointed out that while L.A. Care can support providers, the actual delivery of quality care depends largely on them. She expressed skepticism about how much the organization itself can directly influence clinical outcomes, but she noted that L.A. Care can help providers improve the patient experience during visits. She proposed rewording the strategy to say "improve the member experience with L.A. Care and with the process of receiving healthcare," to better reflect the organization's role. She noted the importance of setting realistic patient expectations. She shared her own experience with delayed medical appointments, she pointed out that many delays are part of the current healthcare system. She suggested L.A. Care explore ways to support patients when they are denied a service or treatment by offering a second opinion process. This would involve having trained individuals who can speak directly with members, explain medical decisions, and help patients understand when a service may not be medically necessary. She acknowledged that some individuals may not accept the explanation, but still believed this step would improve communication and trust.	

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
CHIEF COMPLIANCE OFFICER REPORT	Tower Gower, *Chief Compliance Officer*, gave a Chief Compliance Officer Report *(a copy of the written report can be obtained from Board Services).* Mr. Gower stated that his report would include updates from several departments within the organization, including Appeals and Grievances, Privacy and Security, the Special Investigations Unit (SIU), the Trainers' Training Report, Business Continuity, and Issues Management. He noted that a summary packet would be shared covering what was discussed during the most recent Internal Compliance Committee (ICC) meeting held on March 12. He pointed out that while the ICC has been operating for some time, efforts have recently been made to create a more structured approach so that meaningful updates can be shared with the Compliance and Quality (C&Q) Committee. During the March meeting, they reviewed subcommittee charters to ensure they are current and received reports from various oversight areas, including privacy, SIU, Pharmacy, Sales, and Delegation Oversight. Mr. Gower noted that the Delegation Oversight Committee has been enhanced through the use of new metrics and deeper reviews of delegate organizations, which has resulted in continuous improvements. One key takeaway from the meetingwas the need to streamline how information is presented. As part of this effort, all compliance presentations now include a summary slide that highlights key discussion points, related risks from the risk register, any connections to corrective action plans, and the main objectives of the topic. He explained that this change aims to help board members understand the relevance and context of the information more clearly. Mr. Gower referenced to a discussion on the organization's crisis management program and mentioned that further details on thewildfire emergency response would be shared by Michael Sobetzko, *Senior Director, Risk Management and Operations Support, Compliance* . The updates from various departments are now being presented in a more cohesive and concise manner to improve communication within the organization and with the C&Q Committee. He confirmed that the ICC report would be submitted to Board Services following the meeting.	

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
PROVIDER TRAINING PROGRAM UPDATE	Theresa Moore, *Senior Manager, Engagement and Strategy*, gave a Provider Training Program Update *(a copy of the written report can be obtained from Board Services).* The External Learning Provider Training Unit is responsible for facilitating regulatory and informational training for all contracted providers serving L.A. Care members. Providers are required to complete regulatory training within designated timeframes, and compliance is audited regularly. The training program includes onboarding for new providers through the Direct Network New Provider Onboarding Training (NPOT) program, which ensures that all providers meet training requirements before delivering services. Delegated networks must follow a Monthly Training Reporting (MTR) process to ensure their providers complete training. Compliance monitoring includes reviewing attestation forms, verifying sign-in sheets, and ensuring training completion records are properly documented. Non-compliance results in corrective action measures, including formal Corrective Action Plans (CAPs) that may escalate to Delegation Oversight Work Group (DOWG) recommendations for sanctions. The training program collaborates with multiple internal departments and specialty provider networks to ensure comprehensive education that enhances service quality and regulatory adherence. Chairperson Booth asked whose material is the Diversity Equity and Inclusion (DEI) in the gender diversects. Ms. Moore responded that L.A. Care works with a vendor that is considered a subject matter expert and they create the training that is approved by the Department of Health Care Services (DHCS). A vendor is developing the DEI training, which recently received content approval from DHCS. The first pilot session is scheduled for April 23 and will include three groups: one physician provider group (PPG), one hospital group, and one Enhanced Care Management team. Based on feedback from the pilot, the full DEI training is expected to launch in May 2025, with a goal of training all providers by the end the year. With regards to the \Transgender, Gender Diverse, and Intersex (TGI) training, L.A. Care is working with its Learning Experience team and a third-party expert. The TGI training will be incorporated into the organization's learning management system and will be used to train both internal staff and providers.	

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
COMPLIANCE TRAINING PROGRAM UPDATE	Mr. Sobetzko, *Senior Director, Risk Management and Operations Support*, gave a Compliance Training Program Update *(a copy of the written report can be obtained from Board Services).* The Compliance Training Program ensures that all new employees and contingent workers complete mandatory training on compliance, privacy, and fraud, waste, and abuse (FWA) policies. The training program is designed to prevent regulatory violations and mitigate risks associated with employee misconduct. The report provides a quarterly update on training completion rates and highlights any gaps in compliance. Failure to complete the training in a timely manner can expose L.A. Care to regulatory scrutiny and financial penalties. The residual risk associated with training non-compliance remains low, as the organization maintains a structured approach to tracking and enforcing training completion. The update\ outlined future enhancements to the training process, such as improved tracking mechanisms and potential policy updates to align with evolving regulatory requirements. ~~Ms. Sobetzko stated that it was a brief update, but he wanted to keep the Committee informed.~~ Chairperson Booth pointed out that due to the constantly changing nature of employment, it will be challenging to ever reach 100% completion on the employee side of training. Factors such as leaves of absence and staffing changes will always result in one or two employees being behind. Even when the gap is closed, new circumstances often arise, like onboarding or temporary coverage. She compared this to a 13-member board missing two or three participants, suggesting it's a natural part of organizational operations.	
SPECIAL INVESTIGATIONS UNIT UPDATE	Michael Devine, *Director, Special Investigations Unit*, gave a Special Investigations Unit (SIU) Update and *(a copy of the written report can be obtained from Board Services).* The] SIU provided a quarterly update on its efforts to detect and combat healthcare fraud. Healthcare fraud schemes, including false claims, kickbacks, and unnecessary services, pose significant risks to the integrity of the healthcare system. The report detailed ongoing investigations and financial recoveries from fraudulent activities. Key cases include a home health fraud settlement that resulted in a $1.5 million recovery, of which $848,000 has been successfully recouped. Additional recoveries from hospice, hospital, and dialysis center fraud cases have also contributed to L.A. Care's anti-fraud efforts. The current open case inventory stands at 551 cases, with a regulatory reporting compliance rate of 99.7%. Notably, the SIU has been actively collaborating with law enforcement and received recognition for its work in combating hospice fraud. The unit's success in fraud prevention and financial recovery reinforces its commitment to protecting healthcare resources and ensuring compliance with regulatory standards.	

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
Healthcare Fraud Shield: The State of Payment Integrity and Fraud, Waste, Abuse, and Error (FWAE)	*Karen Weintraub, AHFI, CPC-P, CPMA, CDC, Executive Vice President, Healthcare Fraud Shield*, gave a report on the State of Payment Integrity and Fraud, Waste, Abuse, and Error (FWAE). Ms. Weintraub spoke about the importance of fraud detection, payment integrity, and strategies to mitigate financial losses due to improper claims. Healthcare Fraud Shield, a leader in fraud detection and analytics, serves seven of the top ten U.S. commercial payers, working with over 65 health plans and analyzing data from more than 150 million lives. Their approach provides a return on investment (ROI) between 3:1 and 10:1, with the potential for 20:1 ROI when combined with specialized services. The organization leverages 80+ sources of public records data and shared analytics across 88 million members, making it one of the most advanced fraud detection entities in the healthcare industry. Healthcare Fraud Shield boasts a Net Promoter Score (NPS) of 94 in 2024, reflecting high customer satisfaction and the effectiveness of their fraud prevention solutions. To combat fraud, Healthcare Fraud Shield offers a comprehensive suite of fraud detection and payment integrity solutions that span the entire payment lifecycle. Their approach includes pre-payment and post-payment analytics, artificial intelligence (AI) and machine learning models, pharmacy fraud detection, specialized verification and record retrieval systems (SVRS), and case management tools for investigations. The pre-payment analytics system analyzes claims before payments are made, preventing fraudulent or erroneous transactions. It identifies suspicious billing patterns, provider behavior anomalies, and emerging fraud schemes in real-time. Post-payment analytics detect fraud in claims that have already been processed, allowing for financial recoveries from improper billing. This system identifies unlicensed providers, kickback schemes, and fraudulent billing activities through medical record reviews and patient interviews. Fraudulent claims cost healthcare payers billions of dollars annually, making pre-payment and post-payment detection critical in preserving financial integrity. She highlighted current fraud schemes affecting the healthcare industry, with a strong focus on Durable Medical Equipment (DME), wound care, home health, and prescription fraud. Fraudulent billing for unnecessary or non-existent medical devices is a growing issue, as is the excessive billing for wound care services that were either not performed or not medically necessary. In-home health fraud cases, providers submit claims for home visits that never took place or were billed at inflated rates. One of the most concerning areas of fraud involves medical and pharmacy claims, where providers manipulate the system to falsely prescribe expensive medications. A key example from the presentation detailed a case in which a patient with no medical history of infections was prescribed $158,000 worth of medications that were not needed. Across multiple cases, investigators identified $1.8 million in fraudulent prescription claims, with	

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	behavioral analytics showing that $1.3 million in improper payments had already been prevented due to fraud detection efforts. These findings underscore the importance of tracking emerging fraud patterns and acting swiftly to prevent financial losses. To enhance fraud detection and improve payment integrity, several technology-driven strategies are proposed. One major recommendation was the adoption of AI-based fraud analytics, which can rapidly identify suspicious claims and reduce manual investigations. The report noted L.A. Care does not currently use AI for fraud detection, but implementing AI-driven analytics could significantly improve efficiency and accuracy in identifying fraudulent activity. Another key area of improvement involves combining medical and pharmacy data to create a full view of patient claims, which can help uncover cross-sector fraud schemes that might otherwise go undetected. Her presentation emphasized the value of shared analytics, where multiple health plans share data to identify fraud trends across different organizations. L.A. Care does not currently participate in shared analytics, but doing so could enhance fraud detection capabilities by comparing data against known fraudulent billing patterns. The report also highlighted the need for process automation, stating that technology-driven fraud detection could reduce human error, save time, and increase cost savings. The report also noted the breaking down departmental silos within L.A. Care, ensuring that compliance, claims, Special Investigations Unit (SIU), and analytics teams collaborate effectively to combat fraud. Ms. Weintraub noted the critical need for advanced fraud detection techniques to protect healthcare funds and enhance payment integrity. Key takeaways included the necessity for AI-driven analytics, the benefits of shared data approaches, and the importance of cross-functional collaboration in fraud investigations. Preventing fraudulent claims before payments are made saves millions of dollars, and identifying emerging fraud trends, such as home health and pharmacy fraud, can further reduce financial losses. By implementing these strategies, L.A. Care can strengthen its compliance measures, improve fraud prevention efforts, and safeguard healthcare resources. The presentation concluded with a Q&A session, allowing L.A. Care board members and stakeholders to discuss potential enhancements to fraud detection efforts within the organization. She underscored the increasing sophistication of healthcare fraud schemes and the necessity for continuous improvements in fraud detection and prevention. By leveraging AI technology, data sharing, and streamlined processes, L.A. Care can enhance its fraud detection capabilities and protect itself from financial and regulatory risks. This presentation served as a crucial discussion point in helping L.A. Care refine its fraud prevention strategies and ensure the integrity of its healthcare payment systems.	

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
BUSINESS CONTINUITY **Emergency Incident Response, L.A. Fires**	Mr. Sobetzkogave a Business Continuity Report *(a copy of the written report can be obtained from Board Services).* Mr. Sobetzko provided an overview of L.A. Care's crisis management response to the January 2025 Los Angeles fires. Wildfires broke out on January 7, prompting the Governor to declare a State of Emergency for Los Angeles and Ventura counties. In response, L.A. Care activated its internal Incident Command structure, initiating emergency notifications and procedural adjustments to minimize disruption to healthcare services. The organization temporarily lifted pre-authorization and discharge requirements and removed certain restrictions on prescription refills to ensure continued access to care. Regular reports were submitted to regulatory agencies, including the Department of Managed Health Care (DMHC) and DHCS, to document the impact on operations and the effectiveness of response measures. Future steps include ongoing monitoring of provider and member impacts, finalizing an After-Action Report, and updating emergency preparedness protocols based on lessons learned from the incident. Board Member Vazquez stated that during the February ECAC meeting, there were concerns about the type of help being provided to families. The members would like to have a detailed report about the services that were directly provided to the families. Mr. Sobetzko responded he will review what went well and what did not, and provide a more informed report in the future. He does not have that much detail at this moment. Augustavia J. Haydel, *General Counsel*, stated that L.A. Care made some changes to accommodate some members. She noted there were some extensions made for pharmacy services so that members can obtain their medications more easily. Some patients were moved due to faclitites that were impacted. Sameer Amin, *Chief Medical Officer*, explained that L.A. Care took several actions in response to the wildfire emergency. L.A. Care conducted proactive outreach through case management, prioritizing members in affected zip codes, starting with those at highest risk, including homebound individuals. They coordinated with Enhanced Care Management (ECM) providers to do the same for their patients. The organization temporarily eased pharmacy restrictions, allowing early medication refills, and ensured Medi-Cal was doing likewise. They also arranged extra transportation to help move patients from compromised skilled nursing facilities to safer locations. They worked with hospitals to relax prior authorization requirements, making it easier to transfer patients and free up hospital capacity. Dr. Amin offered to provide a detailed list of these efforts for distribution to the RCACs and ECAC.	

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
ISSUES MANAGEMENT UPDATE	Mr. Sobetzkogave an Issues Management Update *(a copy of the written report can be obtained from Board Services).* He provided an update on identified risks and compliance concerns affecting L.A. Care. Issues are classified into different categories based on their status, including open issues requiring oversight, deferred issues awaiting regulatory guidance, remediated issues with corrective action plans, and monitoring-only issues that require continued compliance tracking. The report included a summary of issues from previous years (2019-2024) as well as new concerns identified in the first quarter of the 2025 fiscal year. These issues have the potential to impact member access to care, L.A. Care's industry reputation, and its market position. While none of the reported issues resulted from regulatory corrective actions or internal audits, ongoing mitigation efforts remain a priority to ensure compliance with industry standards and best practices.	
PAYMENT INTEGRITY REPORT	Erik Chase, *Senior Director, Claims Integrity*, gave a Payment Integrity Report *(a copy of the written report can be obtained from Board Services).* The report focused on ensuring that claims processing and payments comply with regulatory requirements and internal policies. He outlined ongoing efforts to detect improper payments, prevent fraud, and recover overpayments. L.A. Care employs a combination of analytics, audits, and investigative measures to identify billing errors and fraudulent claims. The report may have included specific data points on financial recoveries, provider billing trends, and corrective actions implemented to address identified payment discrepancies. Maintaining payment integrity is crucial to protecting healthcare funds and ensuring that reimbursements are accurate and justified.	
APPEALS & GRIEVANCES (A&G) REPORT	Demetra Crandall, *Director, Customer Solution Center Appeals and Grievances*, gave a Appeals & Grievances (A&G) Report *(a copy of the written report can be obtained from Board Services).*The report provided an analysis of appeals and grievances submitted by L.A. Care members throughout 2024. The data included trends in member complaints, highlighting the highest-volume appeal and grievance categories for the reporting period. The report identified key areas where members expressed dissatisfaction, such as service denials, access to care, and provider-related concerns. Green-highlighted sections in the report indicated the top three grievance categories with the highest volume for the month. The findings will inform ongoing efforts to improve member experience, address systemic issues, and enhance service delivery. Regular monitoring of appeals and grievances helps L.A. Care identify patterns, assess provider performance, and implement necessary corrective measures to ensure member satisfaction. Board Member Roybal asked if attitude and service has steadily been increasing the whole calendar year. He asked if there are trends driving that. Ms. Crandall responded that it has been pretty	

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	consistent. There is not really one area. It is related to basic customer service by the provider, by the physician, or by the receptionist. It's just been pretty steady. There is not one specific driver. Board Member Roybal asked if they provide the details behind the grievance listed on the grievance form. Ms. Crandall explained that there has not been one specific issue driving grievances, it has been fairly steady. She clarified the process: when a grievance is received, the concerned provider or entity is contacted directly and given the details of the complaint. A collective report is shared with the provider network team, noting the trends such as repeated complaints about access or customer service. That team then works with the provider to address these issues. This feedback loop is tracked through the grievance forum, with the goal of seeing a decrease in complaints after intervention. Overall, providers are regularly informed about grievances related to them. Mr. Gower stated that as part of their delegation oversight efforts, each provider group now receives an individual scorecard that includes various performance measures, including audit results from the Special Investigations Unit. Grievances are one of the important areas being tracked. They are working to improve these dashboards to provide a clearer and more complete view of how all delegates and providers are performing, with growing attention on grievances in their oversight reviews. Board Member Vazquez stated her concern is that there are different categories in one. She asked if it is possible to work on these categories one by one, in the community some of the members are not satisfied. Board Member Vazquez explained some parents take their children to the clinic or doctor when they are sick, or when the parents themselves are not feeling well. However, they become frustrated when they are told they cannot be seen without an appointment. She shared that members often call customer service upset, asking how they are supposed to know five days in advance that they or their children will be sick. She expressed a desire to sort this issue into different categories so that, in the future, this information can help improve the services provided to members. Ms. Crandall explained that the data they have is broken down into more specific categories. For example, they can identify issues related to access to the pharmacy, access to doctors, transportation challenges, whether appointments are scheduled too far out, or if members are unable to reach providers by phone. The detailed information is shared with different departments within L.A. Care. While they already have a large number of categories, possibly too many and she offered to bring a more detailed breakdown to the next committee meeting so members can see how the data is categorized and how it all adds up.	

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
CHIEF MEDICAL OFFICER REPORT	Dr. Amin, gave a Chief Medical Officer Report *(a copy of the written report can be obtained from CO&E).* Dr. Amin reported that LA Care successfully implemented a new utilization management (UM) platform, transitioning from the outdated Syntranet system to a new platform called QNXT, which went live on March 7. This system is central to making timely authorization and denial decisions and ensuring that communication with providers and facilities is efficient and compliant. He explained that the implementation was a long-term, well-planned effort involving over 300 users. The team conducted three mock go-lives and three months of system testing, identifying and resolving more than 1,700 issues in advance. Business users engaged in workflow testing, which allowed the technical team to preemptively address problems related to letters, decision placements, and system functionality. A command center was established in January, months before the official launch, to ensure clear and timely communication across teams. Leadership played a key role, with designated leads overseeing operations and other senior leaders providing consistent guidance. Support needs from IT were minimal due to thorough user acceptance testing and multiple training cycles. Staff underwent nearly six months of training, including the use of detailed playbooks, and additional contractors were trained to offset anticipated productivity drops during the transition. Vendor management was another critical area, with close collaboration between internal teams and external vendors to maintain readiness and system support. The project team made several strategic recommendations for future platform transitions, emphasizing the importance of business-led training, iterative project management, strong vendor oversight, clear leadership accountability, and readiness to delay implementation when necessary. Despite a slight delay in launch by nearly two months to ensure quality, the system has now been live for two weeks. A dedicated team is addressing issues. Overall, Dr. Amin expressed confidence that L.A. Care will meet its turnaround time goals, noting that current performance is compliant.	
Approval of Quality Improvement (QI) & Health Equity (HE) Documents (COM 100) **2024 QIHE Annual Evaluation**	Bettsy Santana, *MPH, Senior Manager, Clinical Initiatives*, presented the 2024 Quality Improvement and Health Equity (QHIE) Program Annual Evaluation and the 2025 QIHE Program Description & Work Plan for approval *(a copy of the report can be obtained from Board Services).* <u>2024 Annual Evaluation of the Quality Improvement and Health Equity Program</u> Ms. Santana reported that the 2024 Annual Evaluation of the Quality Improvement and Health Equity (QIHE) Program provided a comprehensive overview of key activities and achievements from the previous year. The evaluation focused on clinical care quality, service delivery, member experience, and access to care, all of which contribute to L.A. Care's broader goals. She noted that teams across the organization participated in these initiatives, with oversight provided by QI committees.	

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Ms. Santana highlighted that L.A. Care received a 3.5-star rating for Medi-Cal and an "Accredited" status for Medicare, though the latter had only partial data reported. L.A. Care Covered (LACC) also maintained its accreditation, although it was not given a star rating due to Exchange plan scoring differences. A significant achievement in 2024 was receiving Health Equity Accreditation across all product lines. In terms of Healthcare Effectiveness Data and Information Set (HEDIS) performance, L.A. Care met the minimum performance level for 11 of 18 MCAS measures. She pointed out that three measures: Childhood Immunization Status, Well-Child Visits, and Cervical Cancer Screening,fell below target. However, improvements were seen in several other metrics, including high rankings for Chlamydia Screening, Breast Cancer Screening, Prenatal Care, Controlling Blood Pressure, Adolescent Immunizations, and Postpartum Care. Developmental screening also saw a notable improvement of over 11%. For care management and disease management, the Duals Special Needs Plan (DSNP) Model of Care goals were not met, but the Cardiovascular Disease Management Program showed positive results, with nearly 79% of graduates achieving blood pressure control. Patient safety concerns were identified in five hospitals for infection rates and in 32 hospitals with higher-than-desired C-section rates. Ms. Santana reported that member experience scores remained a challenge. While some scores improved slightly in Medi-Cal Adult and LACC categories, others,particularly Medi-Cal Child and Medicare, showed mixed results. Access to timely care appointments did meet DMHC standards, but internal goals remain more ambitious. Top issues in grievances and appeals included attitude and service concerns, billing issues, and access barriers across all product lines. Key accomplishments included the launch of 83 clinical quality campaigns, and achievement of most goals across Medi-Cal, DSNP, and LACC product lines. The network adequacy standards for primary care practitioners were consistently met, and L.A. Care achieved 12 out of 16 Member Equity Council goals. The pharmacy program completed over 5,900 member interventions and successfully met pharmaceutical safety communication targets. Additionally, the Potential Quality of Care Issues team processed over 8,200 referrals with a 99 percent compliance rate, exceeding their goal. Opportunities for improvement were noted in areas such as access and availability, member experience, children's wellness visits, and cancer screenings. Ms. Santana identified several root causes, including lingering effects of the COVID-19 pandemic, limited appointment access, provider burnout, staffing shortages, low reimbursement rates, and vaccine hesitancy. Issues also	

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
2025 QIHE Program Description & Work Plan	stemmed from member health literacy, inconsistent provider engagement in quality improvement, and data reporting challenges. She concluded that the QI Program will continue addressing these gaps through the 2025 Work Plan, focusing on data systems, appeals, immunizations, and screenings, while ongoing efforts are being made to improve member satisfaction. 2025 Quality Improvement and Health Equity Program Description and Work Plan The 2025 Quality Improvement and Health Equity Program outlines the organizational structure and decision-making framework for implementing L.A. Care's quality and equity goals. The updated strategic priorities, which include improving operational efficiency, supporting provider and partner networks to meet members' health and social needs, enhancing the member experience and quality of care, and positioning L.A. Care as a national leader in equitable healthcare. These priorities will continue through fiscal year 2026-2027. Ms. Santana presented several new goals for 2025, including monitoring Behavioral Health Treatment utilization, reviewing behavioral health network adequacy, and improving care transitions to reduce hospital readmissions. She also noted that the Stars Steering Committee was dissolved and merged into the Quality Improvement Steering Committee in 2024. The QIHE Work Plan remains a dynamic document that tracks progress and is updated throughout the year. For any unmet goals, the department performs barrier analyses, develops and prioritizes interventions, implements corrective actions, and evaluates their effectiveness. Ms. Santana reported that several performance measures were removed from the 2025 plan due to changes in regulatory requirements. For Medi-Cal, these included measures like pharyngitis testing and contraceptive care. The DSNP work plan added new measures related to kidney health, opioid use, and medication reviews, while also removing others like osteoporosis screening and inappropriate PSA testing. The eight core improvement pillars for the year: enhancing provider engagement, improving data quality and management, expanding outreach and access, improving member experience, increasing provider and member incentives, addressing staffing needs, and strengthening internal collaboration. Ms. Santana stated that these efforts reflect L.A. Care's holistic and aggressive approach to addressing organizational challenges and advancing its mission of equitable, high-quality care. **Motion COM 101.A0325**	

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Approve the 2024 Quality Improvement & Health Equity Annual Report and Evaluation (All lines of business) and the 2025 Program Description and 2025 Quality Improvement & Health Equity Program and Work Plan (All Lines of Business)	**Approved unanimously. 4 AYES**
PUBLIC COMMENT ON CLOSED SESSION ITEMS	*There was no public comment.*	
CLOSED SESSION	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: Three potential cases THREAT TO PUBLIC SERVICES OR FACILITIES CA Government Code Section 54957 Consultation with: Todd Gower, Chief Compliance Officer, Michael Sobetzko, Senior Director, Risk Management and Operations Support, Miguel Varela Miranda, Senior Director II, Regulatory Operations, Serge Herrera, Director, Privacy, Compliance, and Richard Zawaski, Senior Director II, Information Technology Operations Infrastructure and Security CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION Gov. Code § 54956.9(d)(1) L.A. Care Health Plan's Notice of Contract Dispute under Contract No. 04-36069 Department of Health Care Services (Case No. Unavailable)	
ADJOURNMENT	The meeting adjourned at 4:10 PM.	

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: _____

Compliance & Quality Committee Meeting

L.A. Care HEALTH PLAN®

For All of L.A.

Compliance

The Heartbeat of Accountability

Internal Compliance Committee (ICC) Executive Summary

April 2025 Meeting

Compliance
The Heartbeat of Accountability

OVERVIEW

The April 2025 Internal Compliance Committee (ICC) meeting was held April 9, 2025, and covered the following topics:

- Announcements and Updates
- 2026 Medicare Annual Implementation Cycle Overview
- Overview of Utilization Management and the Call Center Compliance and Oversight
- Report Out on Mazars Settlement Agreement
- Update on Internal Audit activities and Compliance Monitoring Key Performance Indicators

KEY TAKEAWAYS

1. Both Utilization Management and the Call Center have transitioned to new systems to better support their operations. These changes have had a temporary impact on their performance.
2. L.A. Care has completed Phase I of Mazars Settlement Agreement efforts, including the collection of over 900 documents and onboarding of ATTAC Consulting Group for support.
3. There are updates regarding audit and monitoring activities within Compliance, including updates on validation audits related to enforcement matters, recent results of Corporate Compliance Monitoring compliance roll-up scores, and the introduction of direct network monitoring key performance indicators.

MEETING SUMMARY

ANNOUNCEMENT AND UPDATES

There were several Compliance staffing announcements, including:

- New staff: Dominic Simonton (Director, Enterprise Risk Management), Paris Boyd (Manager, Compliance Monitoring), and Jim Hwang (Advisor, Vendor Risk Oversight).
- Promotions & Transfers: Janet Victorio (Sr. Manager, Compliance Delegation Oversight), Janita Umeh (Compliance Advisor III, Internal Audit), and Shelly Davis-Menendez (Compliance Advisor III, Regulatory Analysis and Communications).

IT Security has deployed a new software called Prevalent for vendor risk management. This tool will be able to generate a vendor risk score and general analysis of vendor's security posture and activity management as well as support procurement and oversight monitoring.

MEDICARE REGULATORY UPDATE

The 2026 CMS Final Rule was released on April 4th. Initial comparison of the final and proposed versions shows several requirements were not codified in the final rule, including marketing practices, health equity analysis, artificial intelligence guardrails, provider director changes, and improved access to behavioral health care and expanded formulary.

INTERNAL COMPLIANCE COMMITTEE EXECUTIVE SUMMARY

April 2025 Meeting

UTILIZATION MANAGEMENT COMPLIANCE

Monitoring on internal utilization management (UM) monitoring efforts include monitoring of authorization decisions, timeliness, and compliance with notification requirements.

- Over the past 12 months, UM has exceeded internal regulatory compliance performance goals (Goal = 95%+; actual = over 99%).
- In March, the bulk of L.A. Care's internal authorization processes transitioned to new systems: OnBase and QNXT. There is currently no backlog; however, there has been some decreased productivity across all business units. Temporary staff and increased training and education resources have been implemented to mitigate this risk.

CALL CENTER COMPLIANCE

Call center performance is monitored daily and is highly reliant on adequate staffing and technology to meet regulatory and internal Key Performance Indicators (KPIs).

- L.A. Care currently has passed CMS Secret Shopper calls; however, DHCS Timely Access Call metrics were only met in Q4 2024. Call Center internal KPIs average 80% of calls answered within 30 seconds and call abandonment rate of 3% or less. There is a new system that may impact KPIs.

MAZARS REPORT OUT

An update on L.A. Care's Work Plan compliance during the two-year Settlement Agreement, including milestones and key performance indicators was shared. This included an overview of Phase I completed milestones, such as the collection of over 900 documents across 60 findings and onboarding of ATTAC Consulting Group for support. Phase II efforts include Work Plan updates and approval, dual-audit tracking to test outcomes, and further mitigation efforts.

INTERNAL AUDIT UPDATES

2025 internal audits are focused on Enforcement Action validation testing in key areas and are set to launch this month. Upcoming audits include grievances and appeals, utilization management, prescription drug coverage, quality assurance, and access and availability. Documentation and data requests will be coordinated with ATTAC Consulting Group to minimize impact. Additionally, two 2024 audits were recently completed regarding HR recruitment processes and Prop 56 encounters and payments.

DELEGATION OVERSIGHT AUDIT UPDATES

An overview of current compliance scores of the Key Performance Indicators (KPIs) that Corporate Compliance Monitoring (CCM) tracks on a monthly basis was shared. Key focus areas include Claims Financial Accuracy, Appeals & Grievances (A&G), Call Center Performance, Network Adequacy, Provider Directory, and Utilization Management (UM). Results for the current fiscal year to date were displayed by line of business. Direct Network KPIs were also reported for the first time.

NEXT MEETING

The next ICC meeting is scheduled for May 14, 2025.

SUMMARY: Provider Quality Review Annual Report

Presenter Name: Rhonda Reyes, Manager, QI Data Management
Compliance and Quality Committee Meeting, April 17, 2025

Key Takeaway: The Quality Improvement (QI) Provider Quality Review (PQR) team manages the Potential Quality of Care Issue (PQI) process, a regulatory requirement to identify clinical issues/concerns and ensure high-quality patient care for L.A. Care members.

Key Objective: Provide annual report and inform Board of Program updates and any potential risks.

Risk Statement: Failure of the Quality Improvement (QI) Provider Quality Review (PQR) team to effectively manage the Potential Quality of Care Issue (PQI) process may lead to unaddressed clinical issues or concerns, resulting in compromised patient care quality and noncompliance with regulatory requirements, ultimately impacting the health and safety of L.A. Care members.

Risk Rating:

- **Inherent**: **High**
- **Likelihood of failure**: **Low**

Is this related to a regulatory corrective action: **Y**

Is this related to a compliance or internal audit corrective action plan: **N**

Supporting Details: Include 2–3 bullet points summarizing what the presentation will cover

- Identify PQIs from all sources
- Review quality concerns in a timely manner
- Take actions to address quality findings and partner with providers to improve care

Report Content & Background

- The Quality Improvement (QI) Provider Quality Review (PQR) team manages the Potential Quality of Care Issue (PQI) process, a regulatory requirement to identify clinical issues/concerns and ensure high-quality patient care for L.A. Care members.

- The QI PQR process evaluates occurrences with potential or suspected deviations from accepted standards of clinical care.

- QI PQR team conducts PQI reviews for L.A. Care's direct lines of business. Plan Partners (PP) are delegated to conduct QOC (Quality of Care) reviews for their assigned members and network providers.

- Annual oversight audits and quarterly monitoring of Plan Partners ensure PP QOC reviews align with L.A. Care P&P QI-001.

- All PQI reviews must be completed within six calendar months per (L.A. Care P&P QI-001).

PQR Strategic Priorities

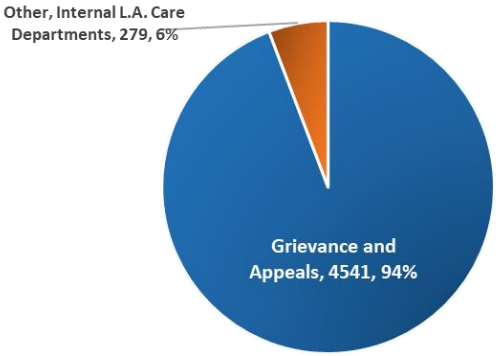
Patient Safety

1. Identify PQIs from all sources
2. Review quality concerns in a timely manner
3. Take actions to address quality findings
4. Partner with providers to improve care

Provider Quality Issue (PQI) Identification

Key Findings

- Most PQIs come directly from the Grievance department, with a small percentage originating from other L.A. Care departments.
- No PQIs were received from external providers, highlighting an opportunity to partner with network providers.
- All L.A. Care member-facing employees complete PQI identification training through our online learning platform.



Referral Source	FY 2023/2024	
	PQI	Rate
Grievance	4,519	93.76%
Appeals	22	0.46%
Customer Solution Center	95	1.97%
Care Management	110	2.28%
Special Investigation Unit	14	0.29%
Utilization Management	11	0.23%
Enterprise Performance Optimization	3	0.06%
Social Services	4	0.08%
Behavioral Health	11	0.23%
Referred from PQI	8	0.17%
Managed Long Term Services	4	0.08%
Department of Managed Health	0	0.00%
Pharmacy and Formulary	2	0.04%
Credentialing/Peer Review	4	0.08%
Member Relations Unit	1	0.02%
Critical Incident Report	4	0.08%
Health Education	3	0.06%
Mortality Report	5	0.10%
Total	4,820	

PQI Identification

Opportunities

1. Maintain collaboration with the Appeals & Grievances team and the Medical Directors to identify appropriate Quality of Care Grievances for PQI review.
   - Monthly PQR oversight review noted that **14%** of cases reviewed should have been sent to PQR but were not

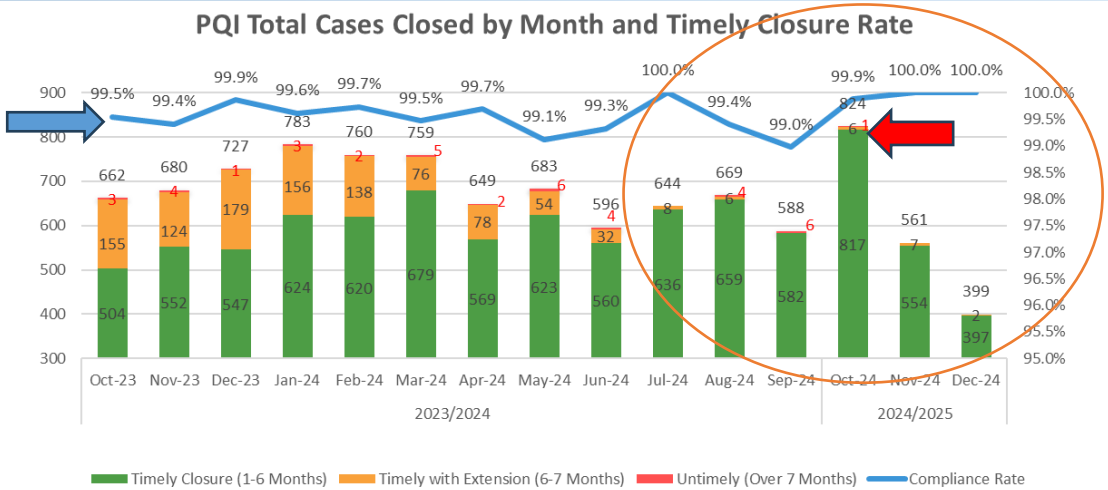
2. Ensure all other Departments report quality concerns to the PQR team through PQI training.

3. Collaborate with PPGs through PQR and PPG engagement meetings to strengthen the PQI referral process with external network providers.
   - PPG Training on how to submit a PQI

Timely Review of PQI

Key Findings

- PQR monitors the timeliness of closed cases as a Key Performance Indicator (KPI).
  - **Timely Closure**: Timely closure of cases has remained above **99%**.
  - **Extension Request:** The number of cases requiring extensions (marked in orange) is decreasing, due to reduced intake volume and the ability to close more cases each month.
  - **Untimely Cases:** We continue to see a decrease in untimely (red) cases. One case was closed untimely from October 2024 to December 2024 due to the need for additional medical records.



Timely Review of PQIs

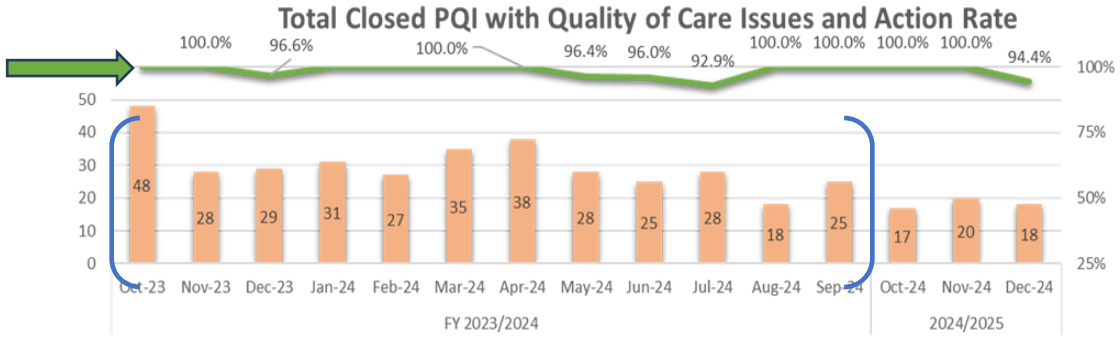
Opportunities

1. Ensure that sufficient administrative resources are allocated for the PQI review process.
2. Collaborate with the Appeals and Grievances (A&G) team to proactively assess downstream volume.
3. Work with the Contract Relationship Management, the Provider Network Management, and the Delegation Oversight teams to quickly get medical records for the PQI review.

Taking Action to Address Quality Findings

Key Findings

- Provider Quality Review monitors actions to address quality review findings.
  - **Actions Initiated:** A total of 355 actions were initiated, addressing **98.6%** of the identified quality findings.
  - **Quality of Care Issues:** 360 PQIs had quality of care issues identified from October 2023 to September 2024.
  - **No Action Taken:** Five quality of care issues did not have action taken because the provider was no longer contracted with L.A. Care or had already been coached during the case review process.
  - **CAP Validation**: The new corrective action plan validation process ensures compliance with CAP by setting a specific time for follow-up.



Partner with Providers to Improve Care

- Provider Quality Review has engaged in further collaborative discussions with PPGs to assess PQI findings and improve the efficiency of data requests and record collection.
- RNs are subject matter experts and assigned to groups. They offer valuable insights into challenges and solutions
- The summary of PQI findings is shared with the PPG and the Provider Network Management (PNM) team.

PPG Engagement				
MedPoint (annual) -Adventist Health -Bella Vista IPS -El Proyecto Del Barrio -Emanate Health IPA -Global Care -Health Care LA -Prospect (MCLA)	Optum Care Network (annual) -Apple Care Select -LA Family Community -Optum of California	Call the Car (quarterly)	*Astrana Health Mgmt. (annual) -Allied Pacific -Community Family Care	*Angeles IPA (annual)
		DHS (semi-annual)		*UCLA Medical Group
AltaMed/ OmniCare (annual)	Preferred IPA (annual)	L.A. Care Direct Network (DN) (quarterly)	*Prospect Medical (annual) -Pomona Valley Medical Grp. -Prospect (non MCLA)	*Physicians Data Trust (annual) -Citrus Valley Physicians -St Vincent IPA

* New PPG engagement opportunity in 2025

Taking Action to Address Quality Findings

Opportunities

1. Engage with appropriate stakeholders to safeguard patient safety.

   Escalating quality of care concerns to Compliance Delegation Oversight (DO) as needed.

2. Expand PQR engagement meetings to include additional PPGs, including L.A. Care Direct Network for reviewing PQI trend reports and collaborating on additional quality improvement opportunities.

3. Continue the CAP validation process to ensure compliance with submitted CAPs and to confirm they are functioning as intended.

SUMMARY: UM Program Description/ Evaluation

Presenter Name: Tara Nelson, Senior Director, Utilization Management

Key Takeaway: The final Utilization Management Program Description as well as the Program Evaluation are presented for review

Key Objective: Informational presentation to inform committee on the UM Program Description (PD) and UM Program Evaluation (PE) and allow for any questions or comment

Risk Statement: Failure for UM to maintain a compliant Program Evaluation and Program Description puts L.A. Care at risk of regulatory noncompliance, most specifically NCQA

Risk Rating ***(inherent or residual impact and likelihood)***:

- **Inherent | Residual impact**: **High**
- **Likelihood of occurrence: Low**

Is this in response to regulatory corrective action: **N**

Is this in response to compliance or internal audit corrective action plan: **N**

Supporting Details:

- Updates to 2025 UM Program Description
- Key takeaways from the 2023-2024 UM Program Evaluation

2025 UM Program Description

Calendar Year 2025

- Our UM team works closely with credentialling to ensure our program description meets all regulatory requirements
- The description is updated annually, ensuring to capture any changes to our UM program, scope, process, team members, or oversight
- Changes for 2025
  - Added Quality Team member descriptions
    - UM Policy Initiatives Nurse
    - UM Clinical Quality Nurse Supervisor
    - UM Policy Program Manager
    - UM Authorization Technician Training Specialist
    - UM Clinical Quality Nurse Reviewer
  - Updated legacy department names
  - Added Health Equity Expert staff description

UM Program Evaluation

- 2024 Fiscal Year Evaluation: October 2023 - September 2024
- The evaluation documents activities undertaken to achieve work plan goals and established the groundwork for future activities
- Outlines our achievements/wins, while also identifying opportunities for continued growth
- Evaluation, more specifically, consists of:
  - Review of the efficacy of the program structures
  - Assessment of department operations
  - Overview of innovative programs
  - Conclusion
  - Recommendations for 2025

Key Takeaways

- While UM is maintaining regulatory compliance with turnaround times, it is imperative that we continue to evaluate operational efficiency while also simplifying/optimizing our utilization requirements
- Continued enhancement of internal dashboards is required to track utilization patterns across our network, identifying gaps in care or under/over utilization trends
- All areas under the UM umbrella must continue to work together ensuring our members are supported post hospital admission, decreasing readmission rates across all lines of business

Board of Governors
MOTION SUMMARY

Date: April 17, 2025 **Motion No. COM 100.A0425**

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

Requesting Department: Utilization Management

Issue: Approval of 2024 UM Program Evaluation and 2025 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 2024 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 2025 UM Program Description describes 2025 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 April 17, 2025.

Member Impact: The 2024 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 2025 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.

- **2024 UM Program Evaluation**
- **2025 UM Program Description**

Utilization Management FY 2023 – FY 2024 Program Evaluation
March 20, 2025

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

CONTENTS

EXECUTIVE SUMMARY

L.A. Care implemented the FY 2023 - 2024 Utilization Management (UM) program in compliance with regulatory requirements, contractual obligation and accreditation standards. Most of the data reported covers activities conducted from October 1, 2023 through September 30, 2024. 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 2025 as highlighted in our 2025 UM Program Description.

INTRODUCTION

The Utilization Management Program is designed to meet the specific needs of L.A. Care members and providers. The 2024 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 2024 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 throughout the course of the fiscal year.

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 Plan 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 2024 UM Program highlights and accomplishments:

- The leadership team hired several key positions with experienced personnel: Clinical Operations Executive, Outpatient Director, Program Manager, UM Letters Manager, UM Policy Initiatives Nurse, Authorization Technician Trainers, and a Quality Supervisor.
- The UM Quality Assurance department created new tools to audit the clinical and intake teams ensuring to concentrate on sound clinical decision making and regulatory compliance.
- The UM Quality Assurance department also implemented an Authorization Technician onboarding program in addition to the existing clinical onboarding program.
- 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 MLTSS to collaborate and develop processes to ensure alignment with utilization review.

- Continued to participate 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), Care Management (CM), 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 the prior year 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 L.A. 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)
- 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

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

- Utilization Management
- Care Management
- Social Services
- Behavioral Health
- Managed Long Term Services and Supports (MLTSS)
- Pharmacy & Formulary
- Quality Improvement
- Safety Net Initiatives

Additional departments that contribute to the UM Program initiatives:

- Appeals & Grievances
- Corporate Compliance Monitoring
- Delegation Oversight

Each department 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 the course of the year, 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. Clinical Operations Executive, Senior Director and Directors 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).

Throughout the year, the committee reviewed multiple policies, analyzed over- and under-utilization 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 2024 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

REVIEW DOCUMENTATION

Requests for prior authorization of services are to be submitted by the provider of service to the UM department by mail, fax, phone call, email or provider portal. 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%
- Theses scores are inclusive of MCG cases and WPATH cases that were custom-built within the MCG Learning Management System (LMS)

Role	#Participants	Average Score
UM Physicians	10	98.14%
UM Outpatient Nurses	30	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%

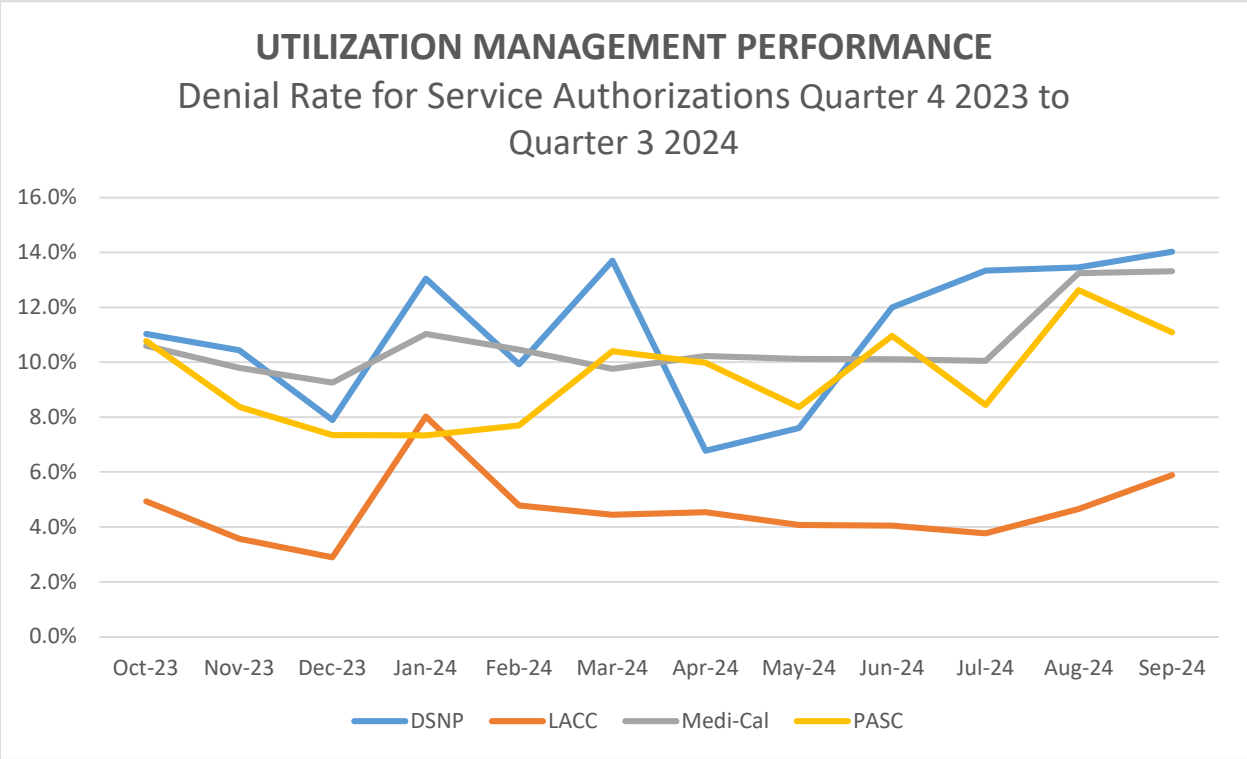
Role (October 2023)	#Participants	Average Score
UM Physicians	8	93.75%
UM Inpatient Nurses	45	94.28%

Role (November 2024)	#Participants	Average Score
UM Physicians	13	99.27%
UM IP Nurses	42	96.4%
Temporary Toney Nurses	7	99.92%

UTILIZATION MANAGEMENT PERFORMANCE

Authorizations Adverse Determination Rates

L.A Care continues to review the requests as appropriate to prevent subsequent potential delays in care.

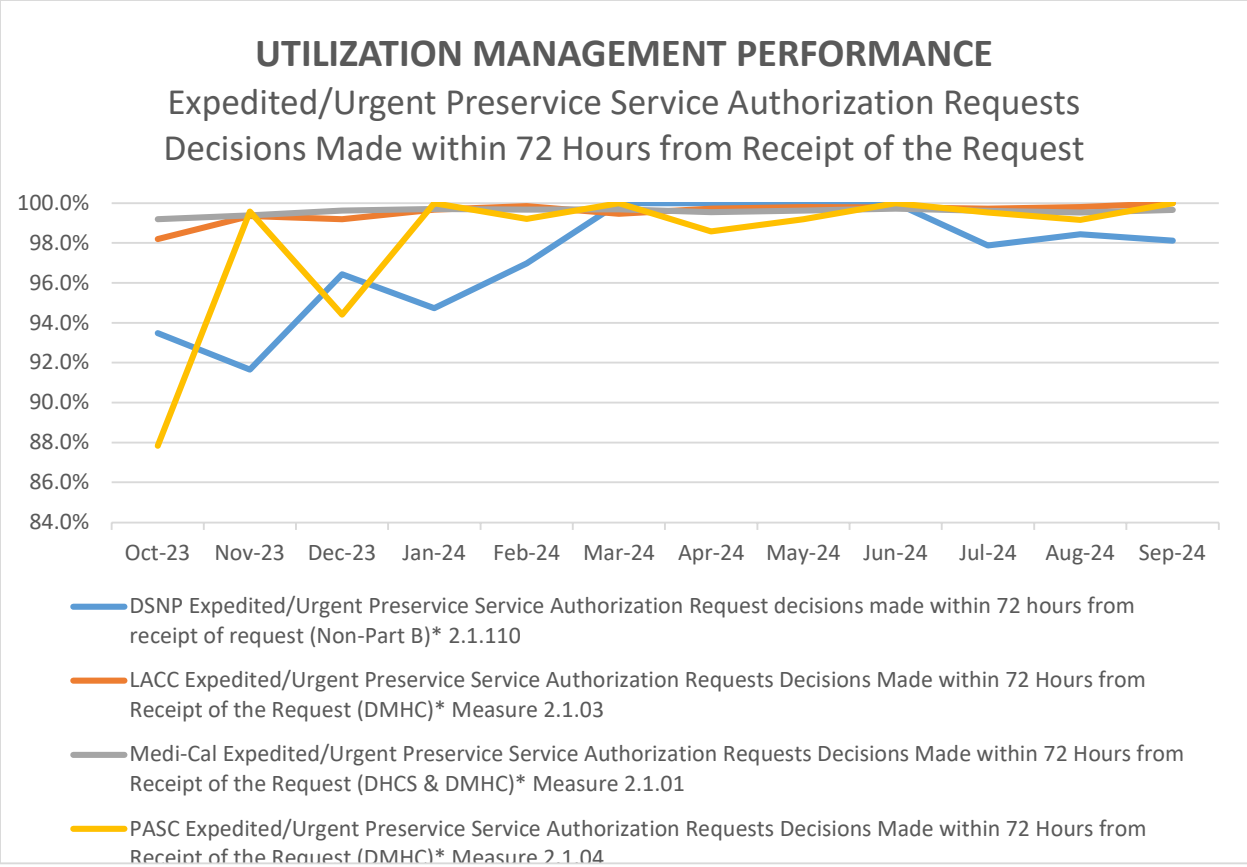


Quantitative Analysis:

- LACC had the lowest rate of Denied Authorizations with an average of less than 9%
- DSNP had the highest rate of Denied Authorizations with an average of 11.2%
- These results are inclusive of both administrative denials and medical necessity denials

TURN AROUND TIME COMPLIANCE - INTERNAL

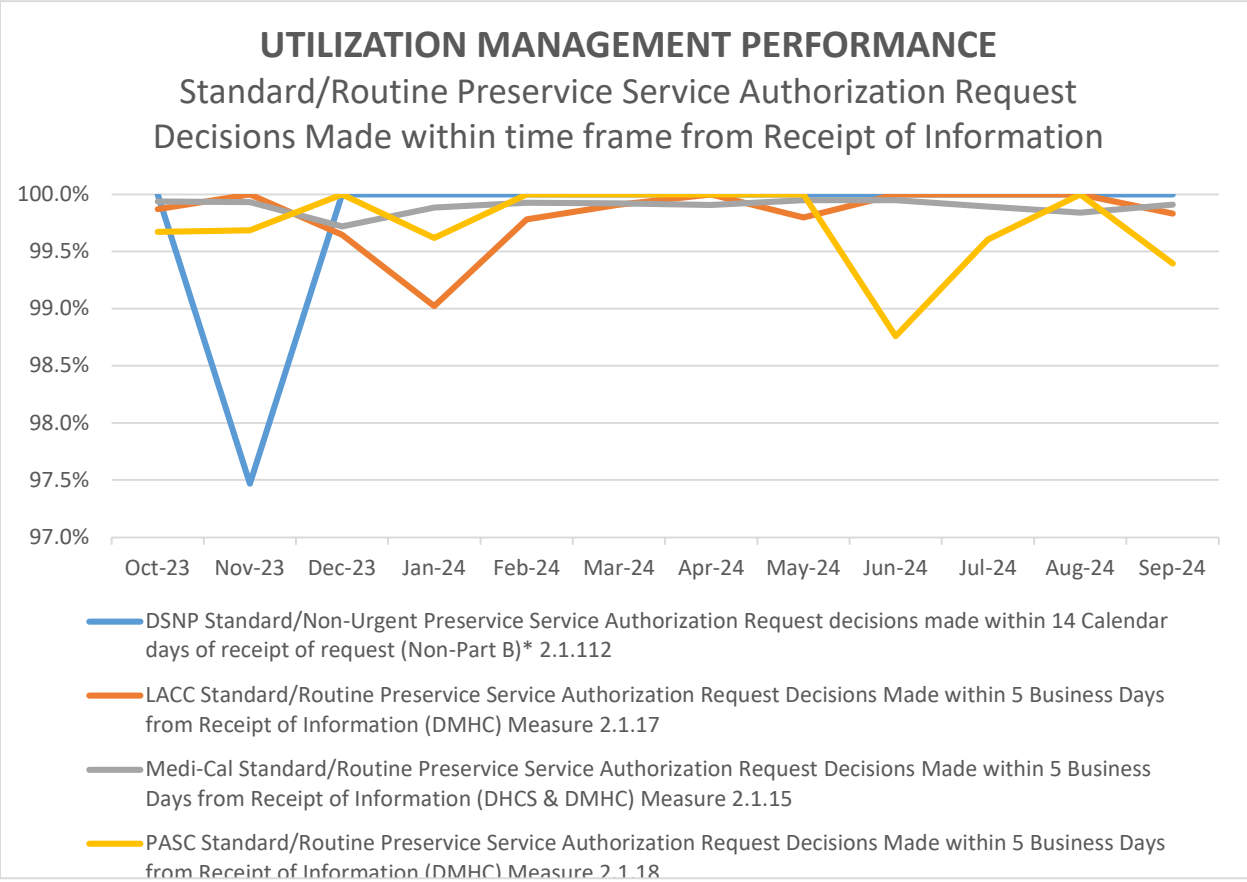
Urgent Request Compliance



Quantitative Analysis:

- Medi-Cal and LACC were above 96% compliance for urgent requests during all months
- The metric for PASC was updated after an analysis by Compliance Department
- All measures have an average of above 91% compliance for urgent requests during all months

Routine Request Compliance

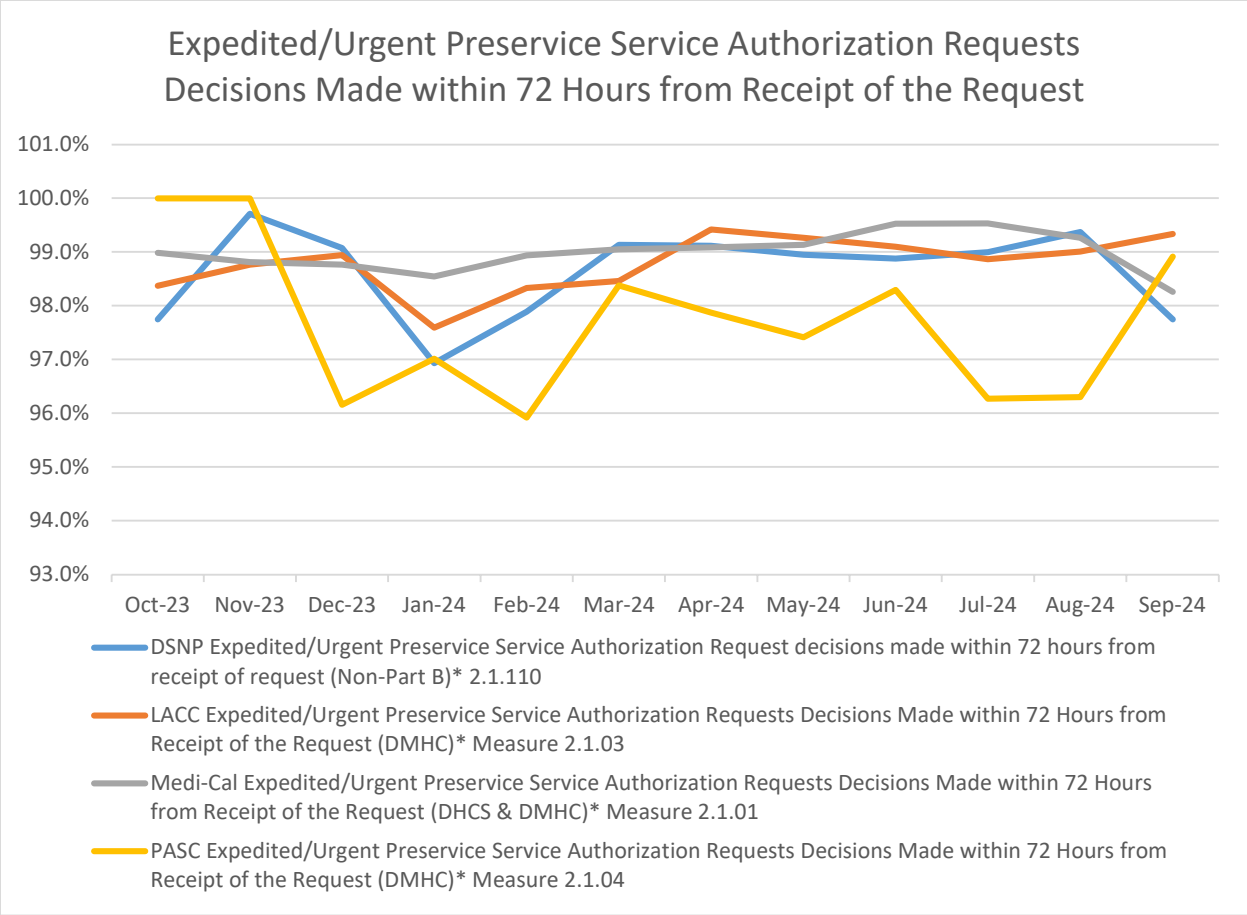


Quantitative Analysis:

- DSNP, LACC and PASC were above 98.5% compliance for routine requests during all months.
- All measures have an average of above 97% compliance for routine requests during all months.

TURN AROUND TIME COMPLIANCE - DELEGATE

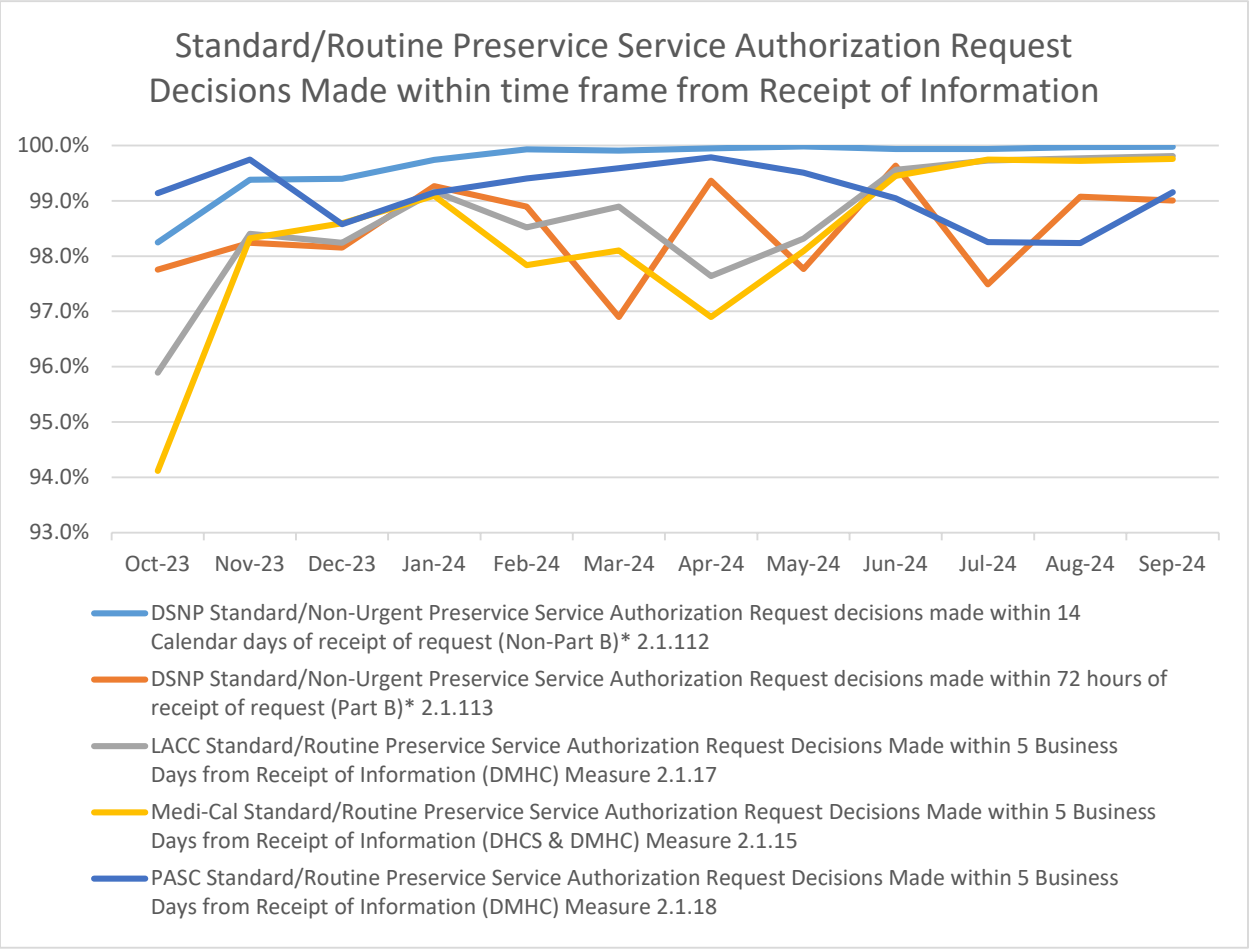
Urgent Request Compliance



Quantitative Analysis:

- All lines of business averaged above 96% compliance for urgent requests during all months.
- PASC had the lowest compliance rate for urgent requests at 96%.

Routine Request Compliance

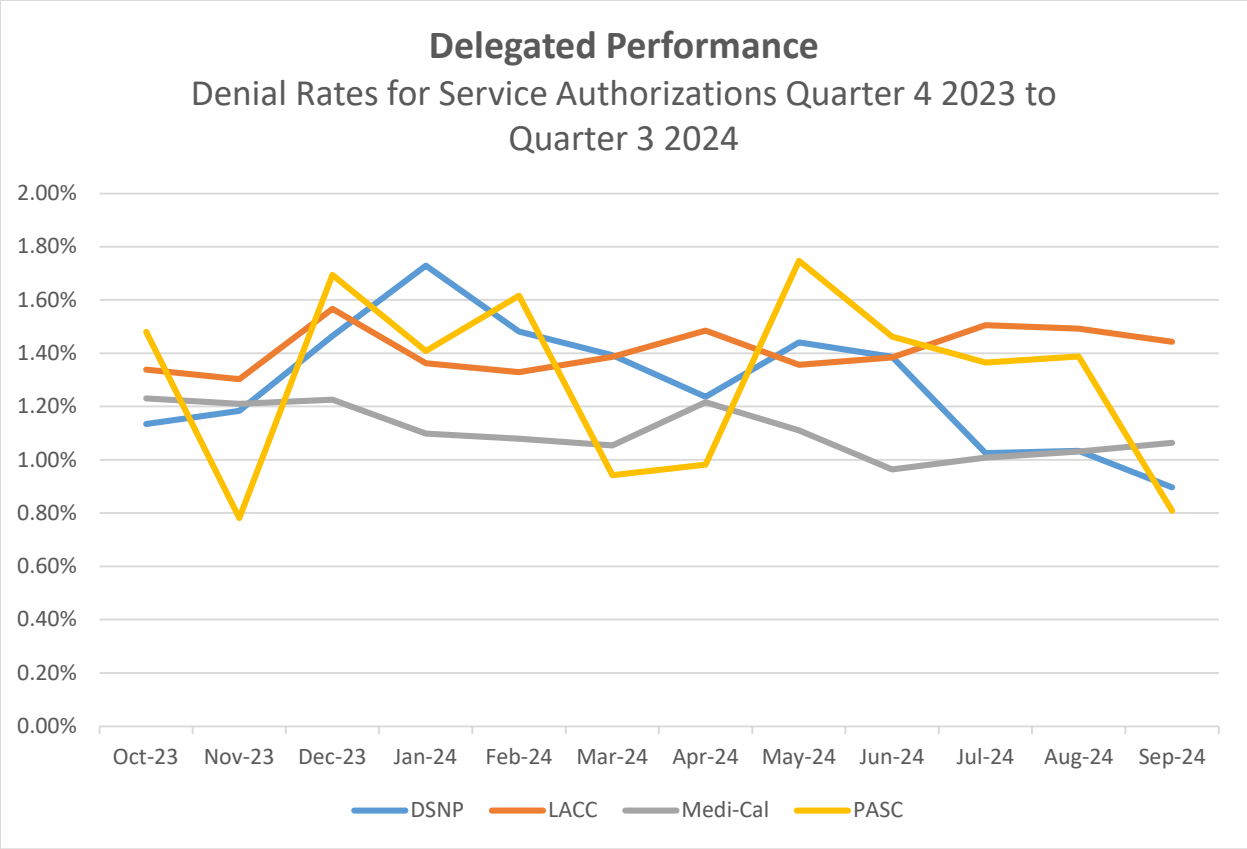


Quantitative Analysis:

- DSNP and PASC were above 98% compliance for routine requests during all months.
- All measures averaged above 97% compliance for routine requests.

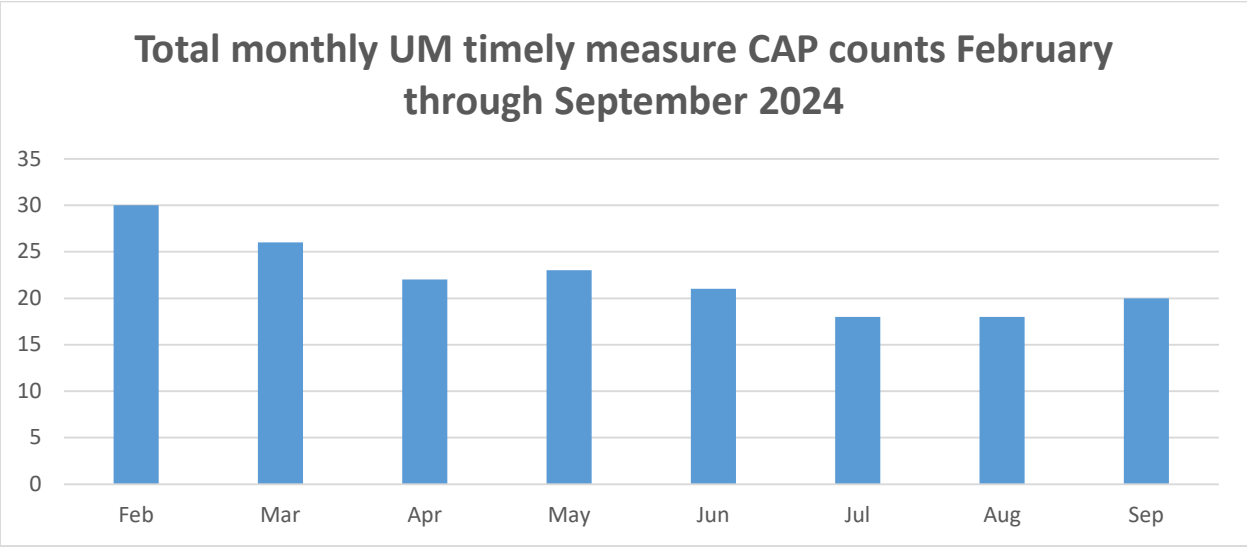
Delegated Performance

The graphs below indicate the volume of CAPs evaluated to date, based on deficiencies incurred as of the time from Quarter 4 2023 through Quarter 3 2024. 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 Corporate Compliance Monitoring (CCM) department continues to track non-compliant behavior and make recommendations on ways to improve. CCM started monthly Corrective Action Plans in January 2024. CAP counts for this period show a decreasing trend.

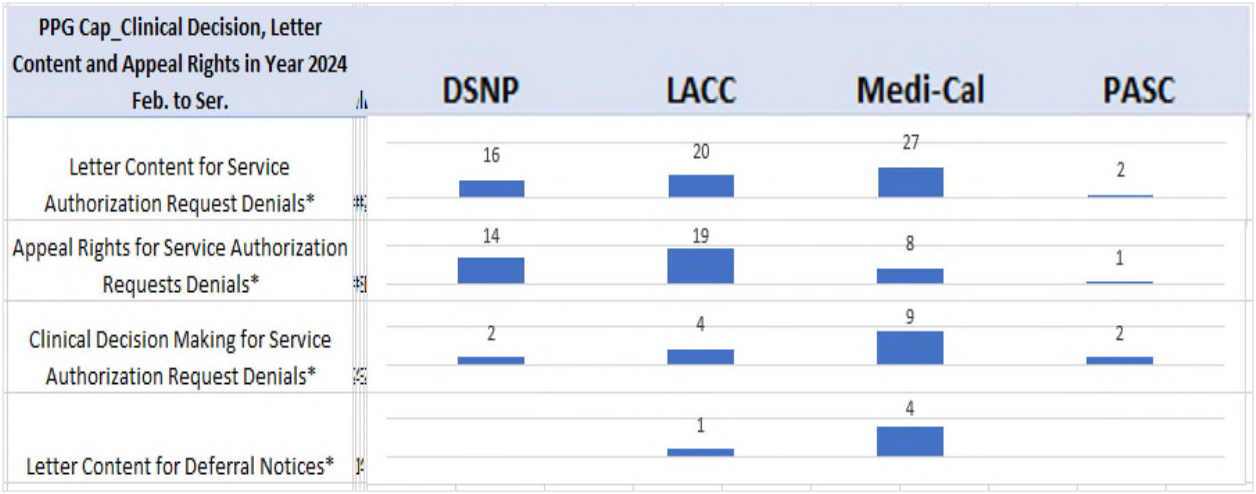


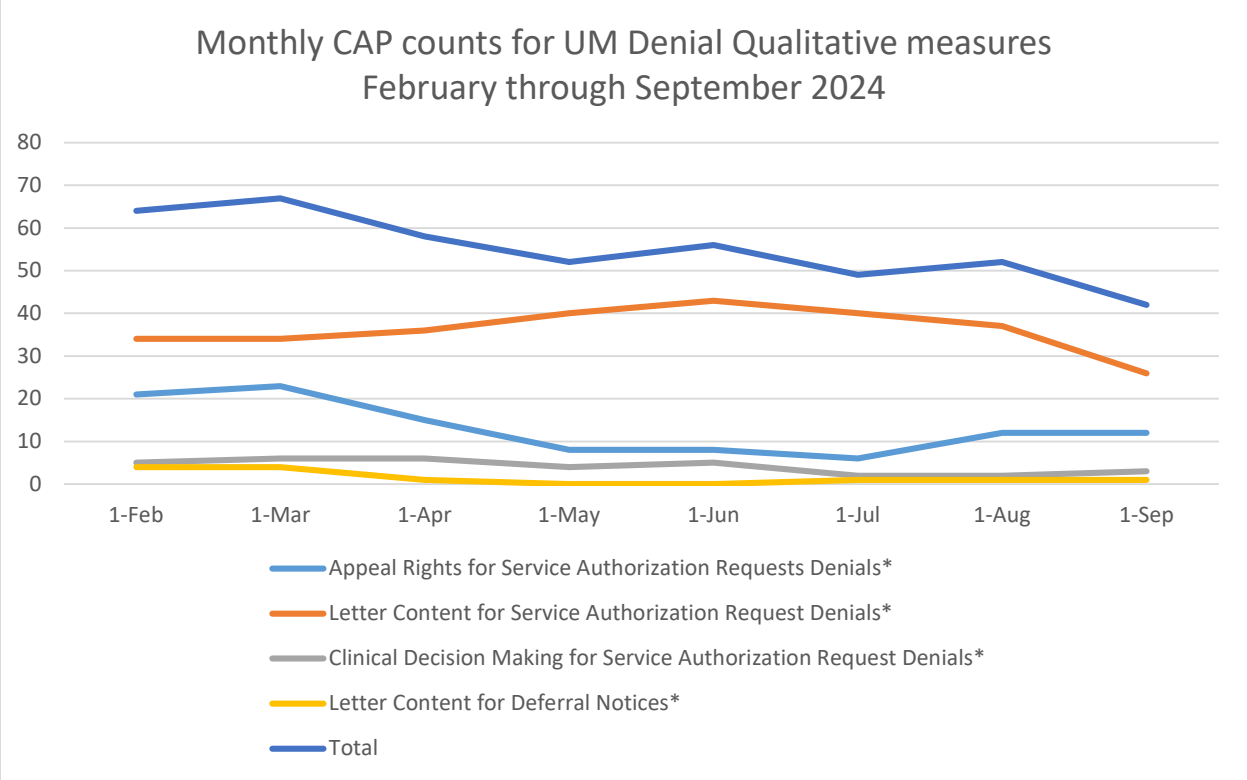
Average denial rates from Q3 2023 through Q3 2024:

- DSNP 1.28%
- LACC 1.42%
- Medi-Cal 1.11%
- PASC 1.31%



PPG Cap_UM Decisions and Nitification turnaround times in Year 2024 Feb. to Ser.	DSNP	LACC	Medi-Cal	PASC
Notify Members of Expedited/Urgent Preservice Service Authorization Request Decisions within 72 hours from Receipt of the Request	4			87
Expedited/Urgent Preservice Service Authorization Requests Decisions Made within 72 Hours from Receipt of the Request	3	5		7
Notify Providers of Expedited/Urgent Preservice Service Authorization Request Decisions within 72 Hours of Receipt of the Request (DHCS)"				13
Notify Providers of Expedited/Urgent Preservice Service Authorization Request Decisions within 24 Hours of the Decision (DMHC)"		8		4
Notify Providers of Standard/Routine Preservice Service Authorization Request Decisions within 24 Hours of the Decision		6		3
Notify Member of Standard/Non-Urgent Preservice Service Authorization Request Decision within 72 hours of receipt of request (Part B)"	12			
Notify Member of Expedited/Urgent Preservice Service Authorization Request Decision within 24 hours of receipt of request (Part B)"	10			
Standard/Non-Urgent Preservice Service Authorization Request decisions made within 72 hours of receipt of request (Part B)"	6			
Expedited/Urgent Preservice Service Authorization Request decisions made within 24 hours from receipt of request (Part B)"	2			
Notify Members of Expedited/Urgent Preservice Service Authorization Request Decisions within Two Business Days of the Decision (DMHC)"				2
Notify Providers of Expedited/Urgent Concurrent Service Authorization Request Decisions within 24 Hours of the Decision (DMHC)"				1
Expedited/Urgent Concurrent Service Authorization Request Decisions Made within 72 Hours from Receipt of the Request (DMHC)"				1


PPG Cap_Clinical Decision, Letter Content and Appeal Rights in Year 2024 Feb. to Ser.
DSNP
LACC
Medi-Cal
PASC
Letter Content for Service Authorization Request Denials*
16
20
27
2
Appeal Rights for Service Authorization Requests Denials*
14
19
8
1
Clinical Decision Making for Service Authorization Request Denials*
2
4
9
2
Letter Content for Deferral Notices*
1
4


Monthly CAP counts for UM Denial Qualitative measures
February through September 2024
80
70
60
50
40
30
20
10
0
1-Feb
1-Mar
1-Apr
1-May
1-Jun
1-Jul
1-Aug
1-Sep
Appeal Rights for Service Authorization Requests Denials*
Letter Content for Service Authorization Request Denials*
Clinical Decision Making for Service Authorization Request Denials*
Letter Content for Deferral Notices*
Total

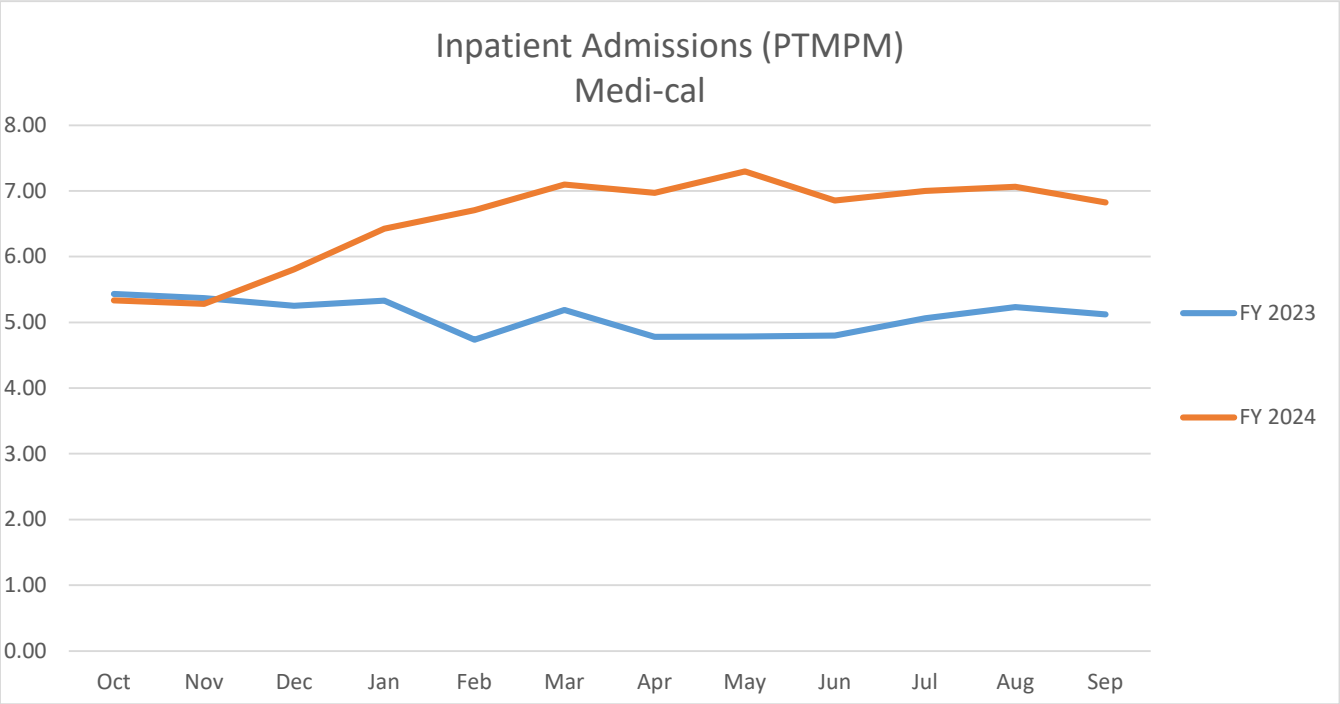
APPEALS AND GRIEVANCES PERFORMANCE

Appeal Review Decision	Count of Review Resolution	Percentage
Upheld	299	41.18%
Non-Clinical Review	208	28.65%
Overturned	91	12.53%
Adverse	52	7.16%
Fully Favorable	14	2.20%
Partially Favorable	3	0.41%
Withdrawn	14	3.86%
Completed	16	1.93%
Forwarded to IRE	1	0.14%
Modified	28	1.93%
Grand Total	**726**	**100%**

As outlined, over 41% 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.

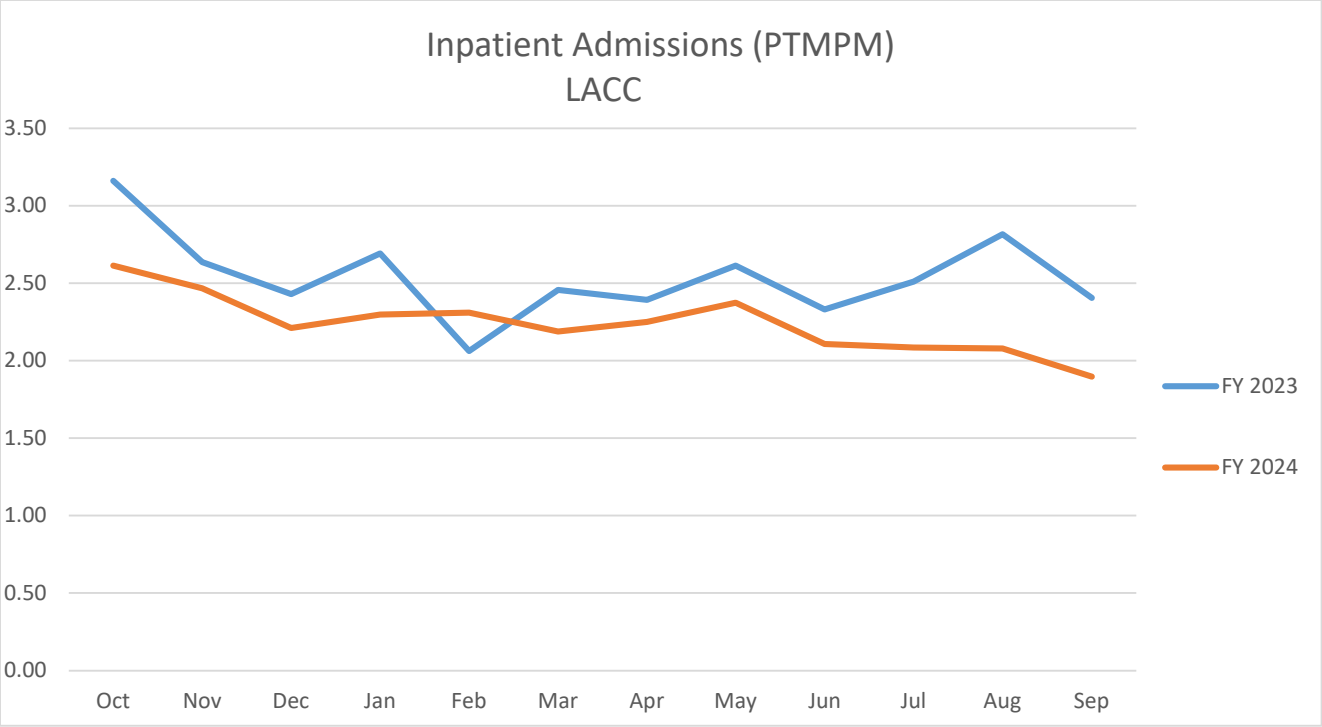
CLINICAL PERFORMANCE METRICS

Admissions Rates



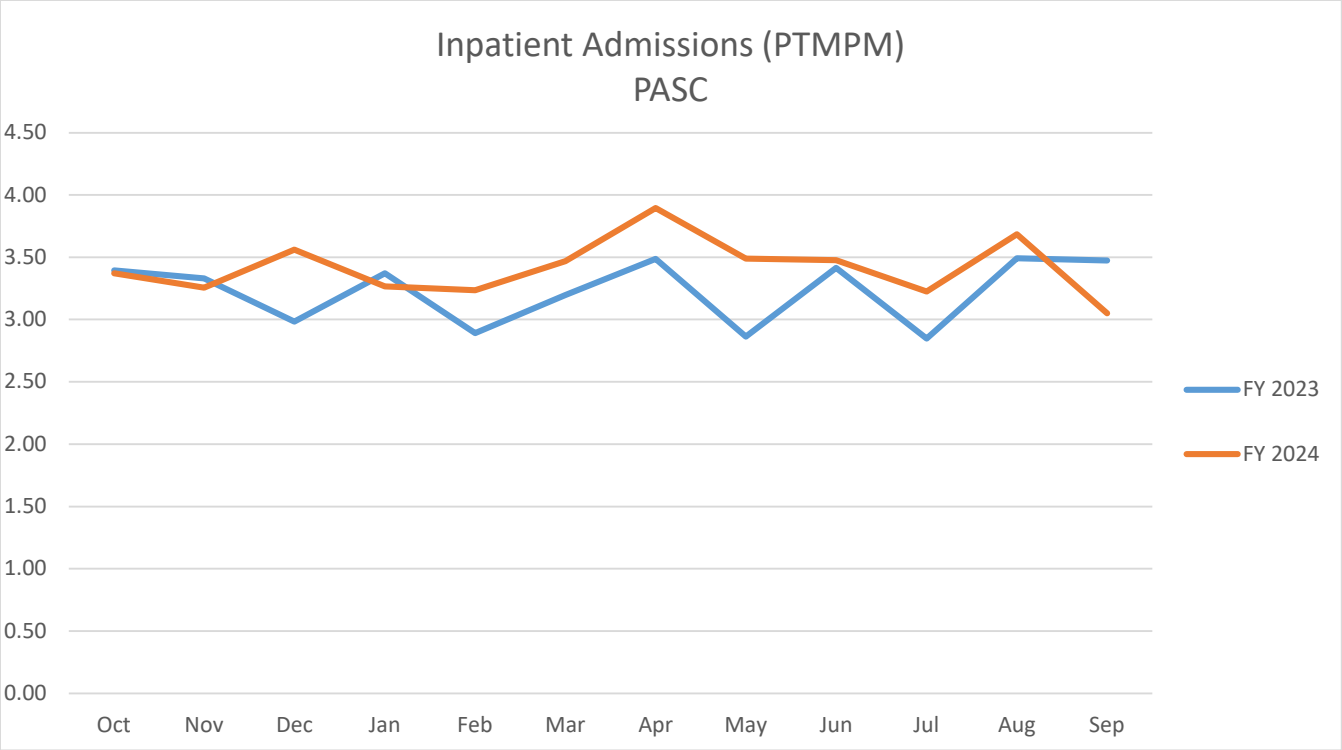
Quantitative Analysis:

- The highest rate in FY 2023 was in October 2023 and for FY 2024 it was in May 2024
- The lowest rate for FY 2023 was in February and FY 2024 in November



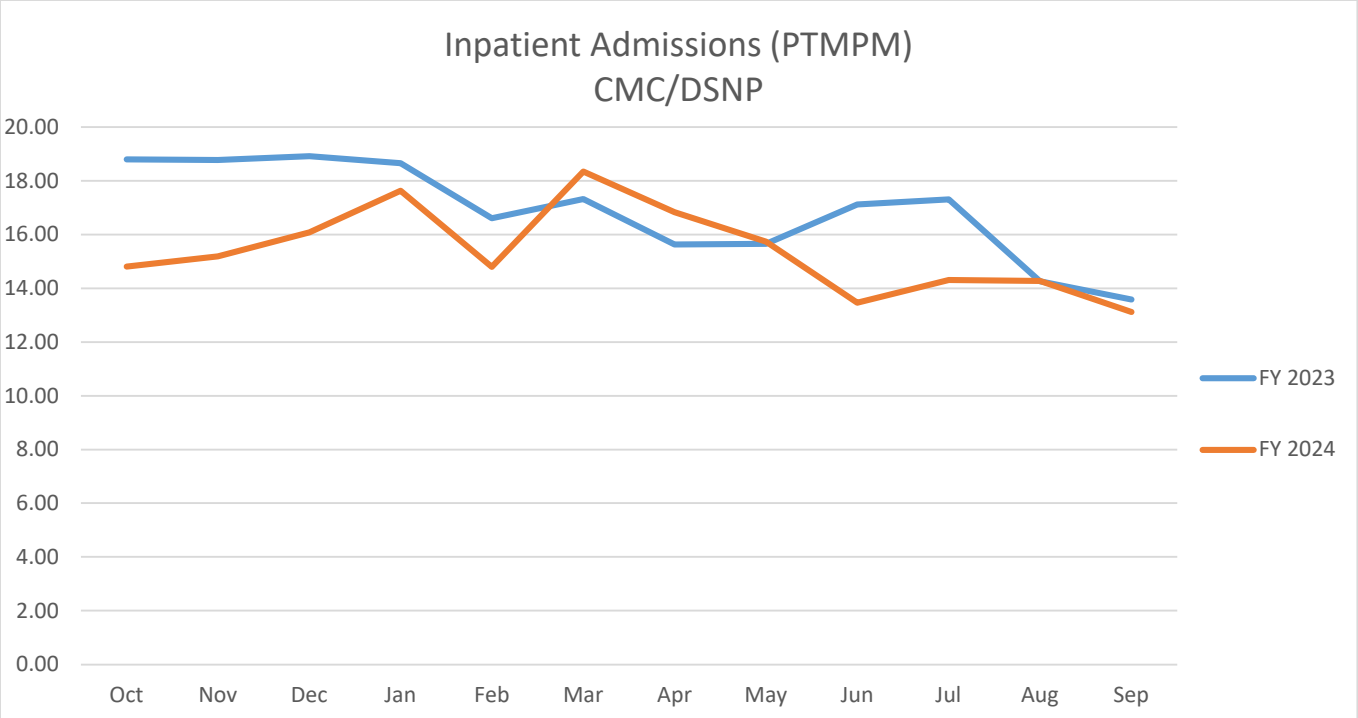
Quantitative Analysis:

- The highest rate in FY 2023 was in October and in FY 2024 it was also in October
- The lowest rate in FY 2023 was in February and in FY 2024 it was in September



Quantitative Analysis:

- The highest rate in FY 2023 was in April and August and in FY 2024 it was in April
- The lowest rate in FY 2023 was July and in FY 2024 it was in September



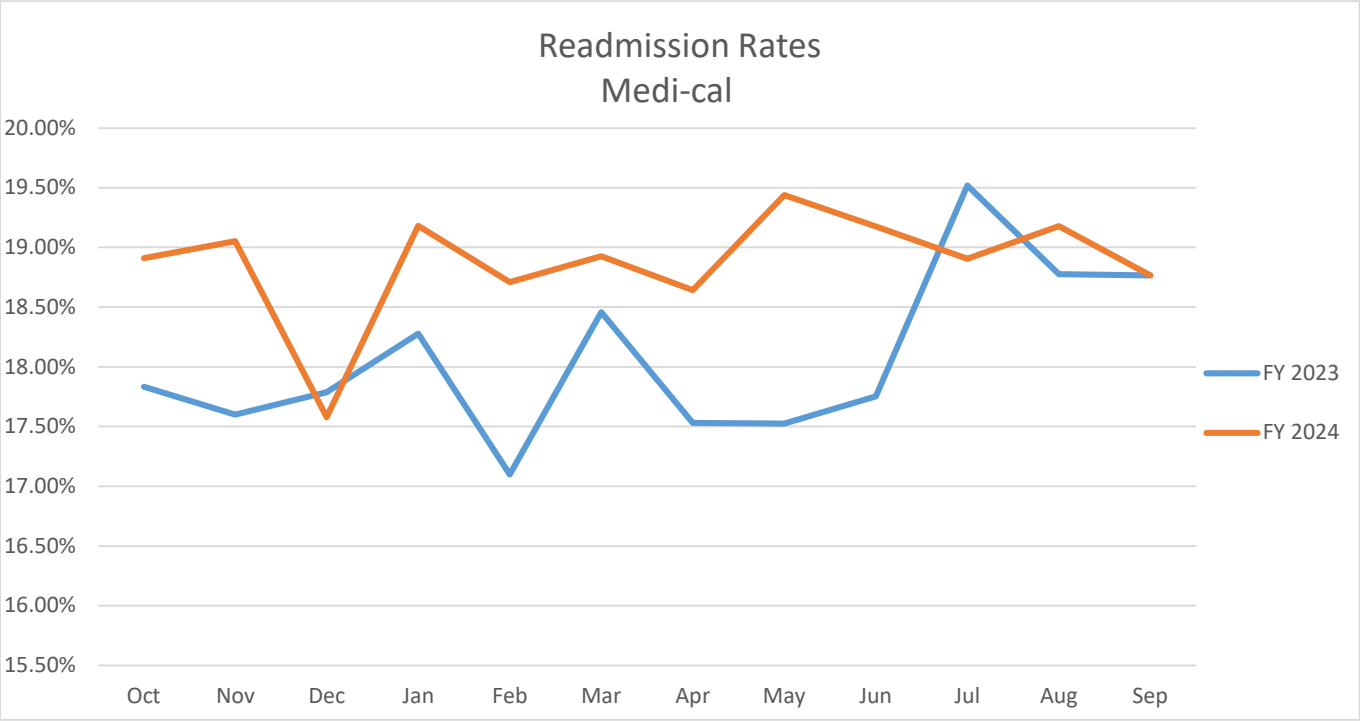
Quantitative Analysis:

- The highest rate in FY 2023 was in in December and in FY 2024 it was in March
- The lowest rate in FY 2023 was September and in FY 2024 it was also in September

Conclusion:

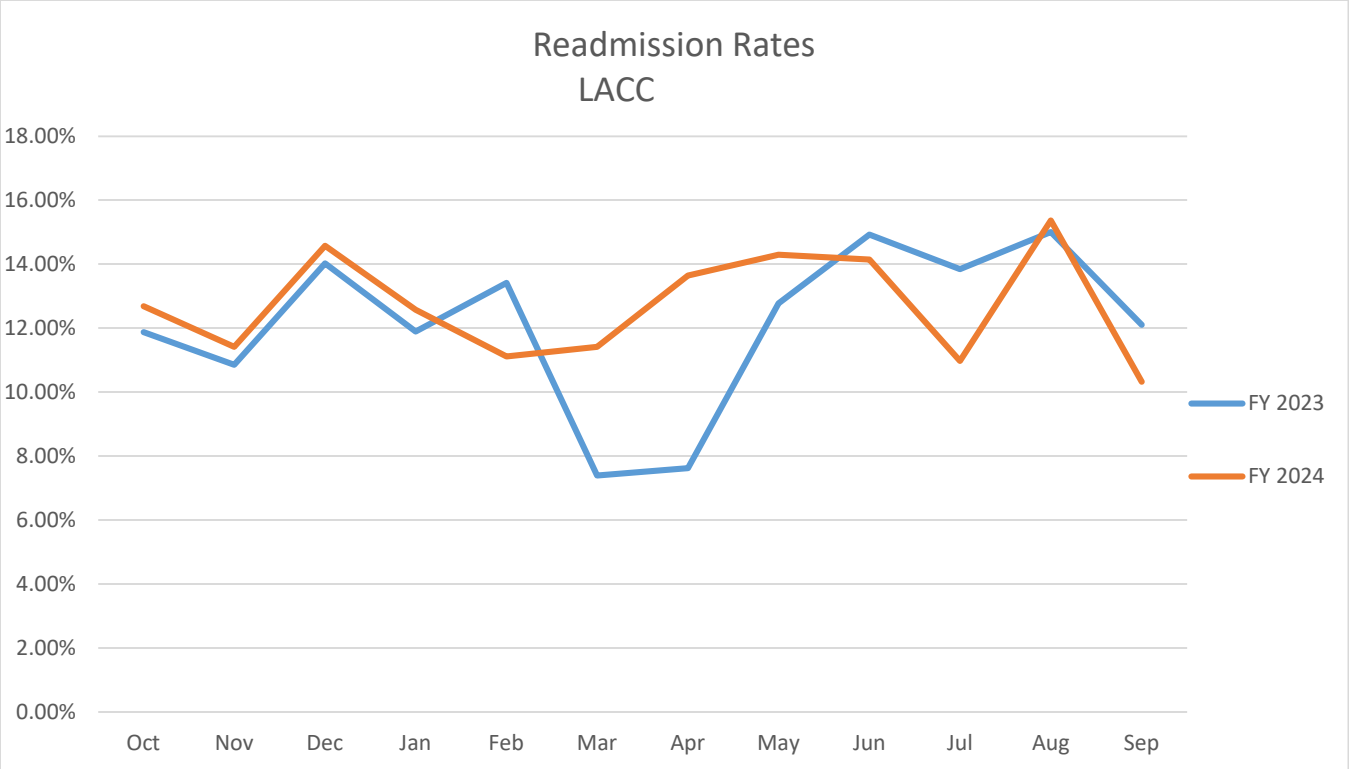
Inpatient admissions improved over the course of 2024 for all lines of business. LA Care continues to make active efforts reducing the unnecessary utilization of hospital care for services that can and should be provided in the ambulatory environment.

Readmission Rates



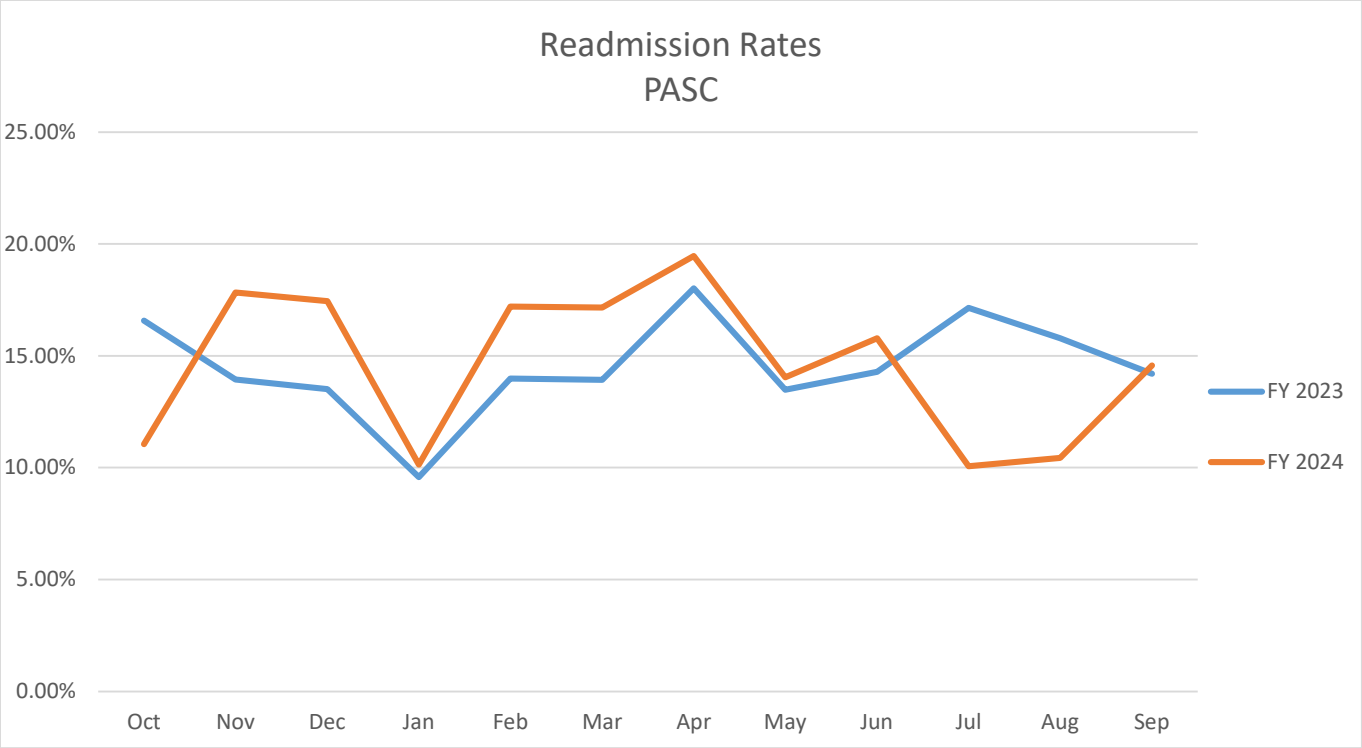
Quantitative Analysis:

- The highest rate is in July 2023
- The lowest rate is in February 2023
- The rate in May FY 2023 is higher than the rate May in FY 2024 by about 2%.



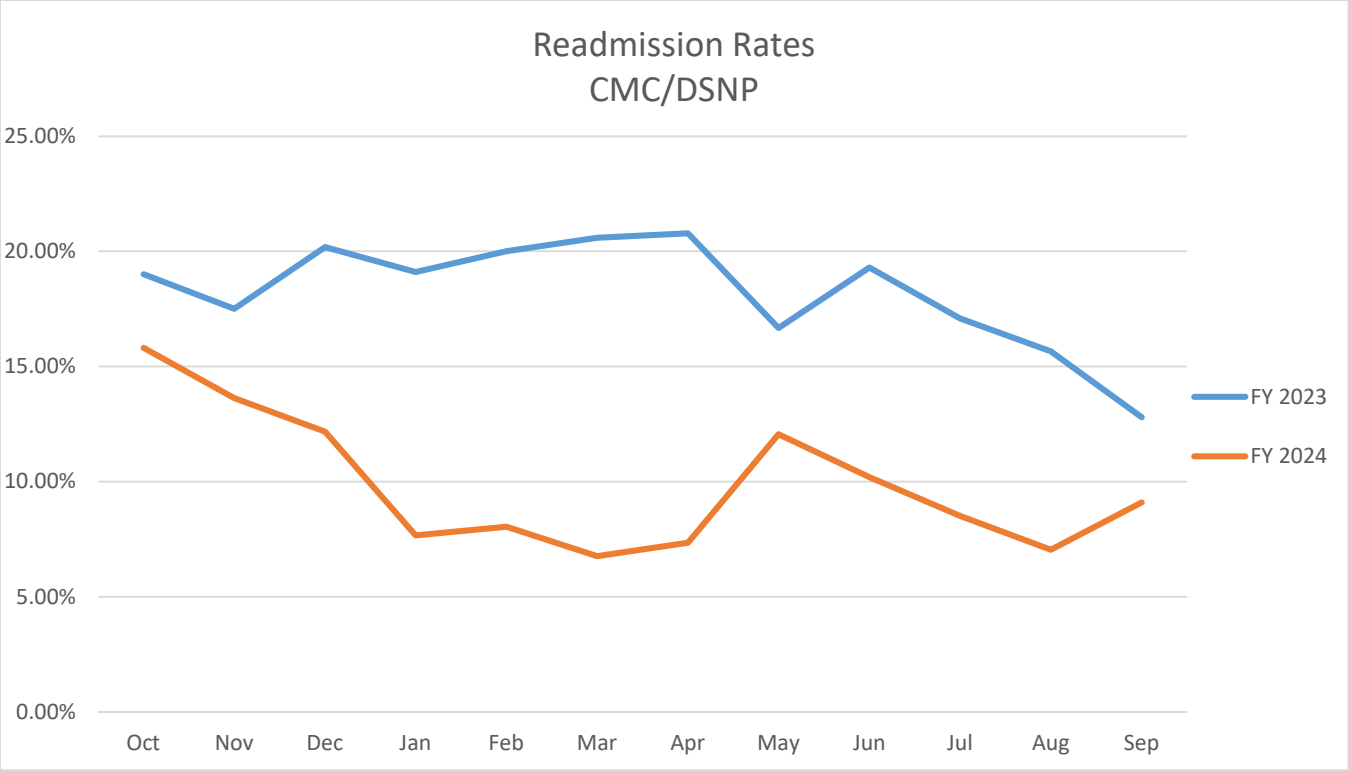
Quantitative Analysis:

- The highest rate is in August 2024
- The lowest rate is in March 2023
- There was an increase from April through June 2023



Quantitative Analysis:

- The highest rate is in Year 2024 in April
- The lowest rate is in January 2023
- The rate in July Year 2023 is higher than the rate in July Year 2024 by about 7%.
- FY 2023 experienced an increase between January and April



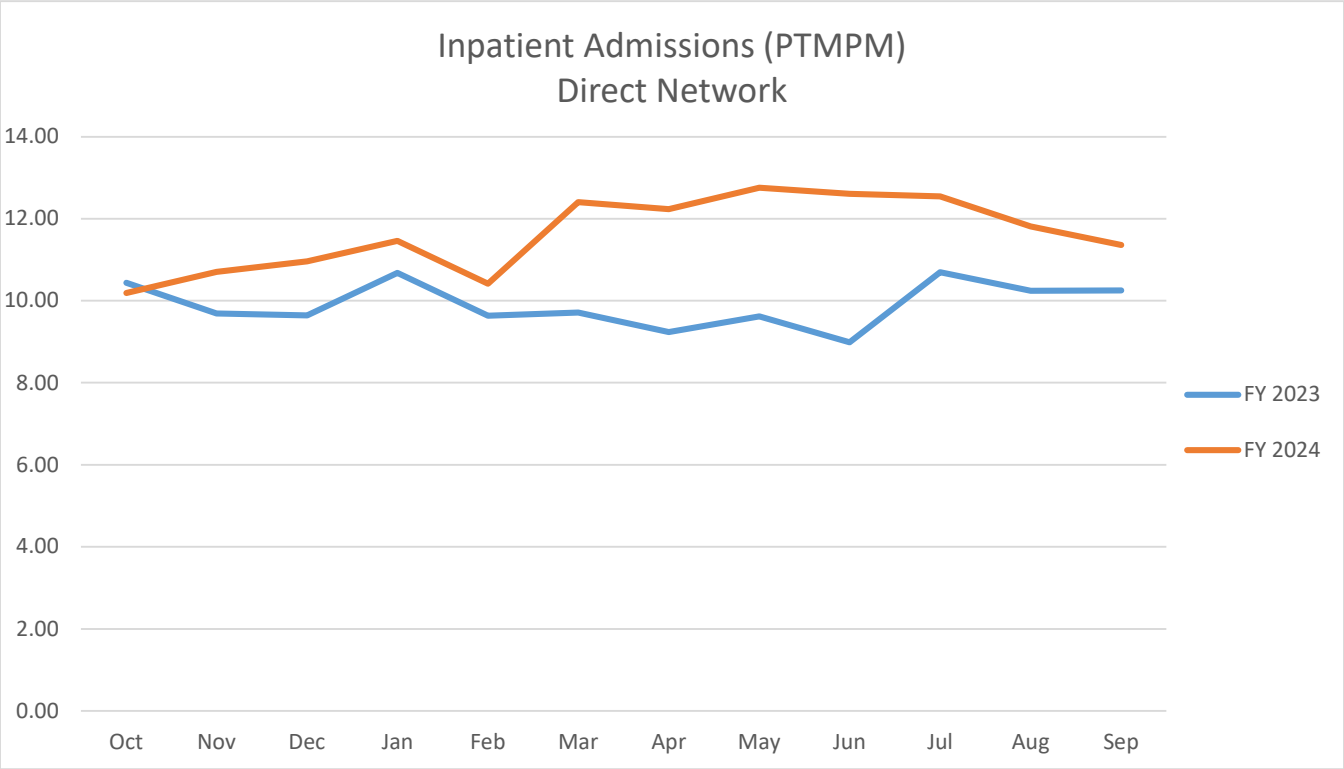
Quantitative Analysis:

- The highest rate is in Year 2023 in April
- The lowest rate is in March 2024
- The rate in April Year 2024 is lower than the rate in April Year 2024 by about 13%.

Conclusion:

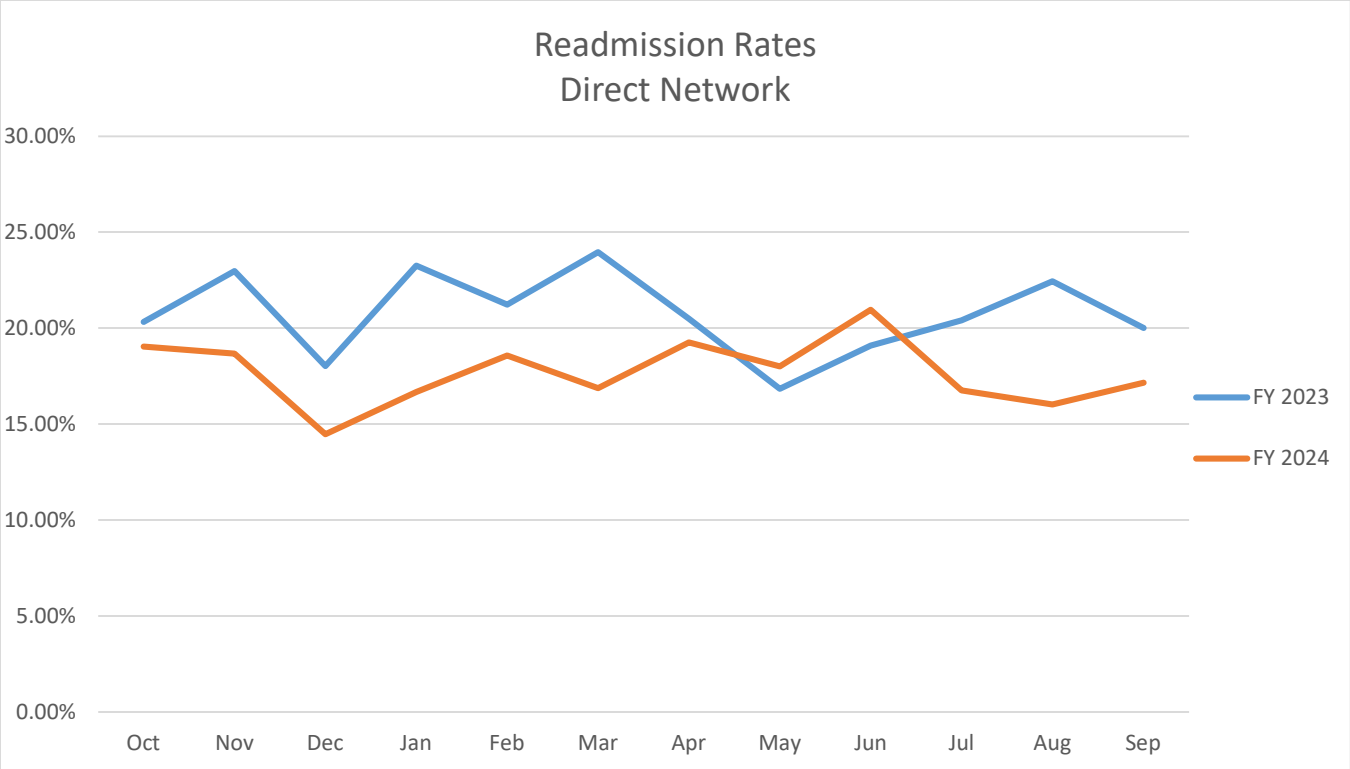
Readmission rates average overall remains above our goal of 15%. As result, there will be focused efforts in 2025 to address unnecessary readmissions.

Direct Network



Quantitative Analysis:

- The highest rate in FY 2023 was in in July and in FY 2024 it was in May
- The lowest rate in FY 2023 was June and in FY 2024 it was in February
- After the decrease in January 2023, the rate remained relatively the same in FY 2023. The rate increased slightly in February of FY 2024



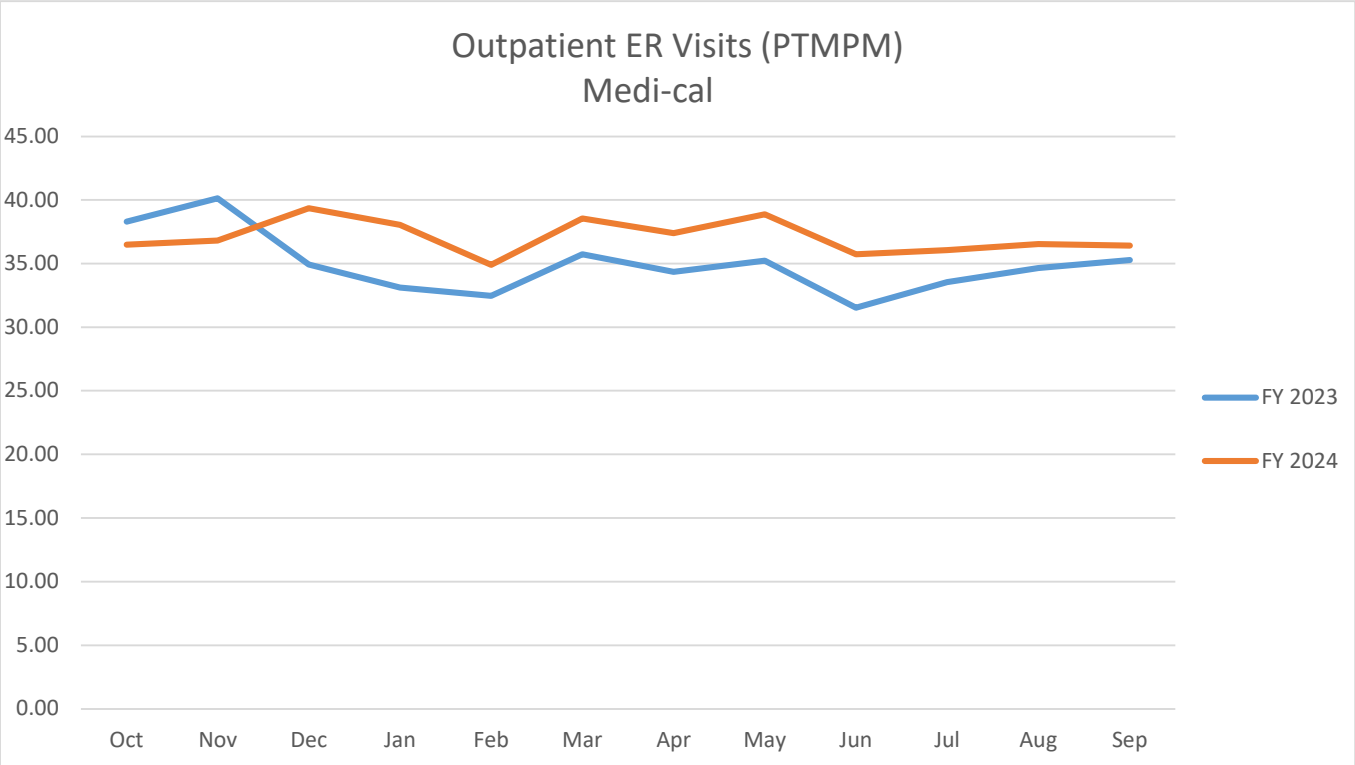
Quantitative Analysis:

- The highest rate is in Year 202 in March
- The lowest rate is in December 2024
- FY 2024 readmissions averaged around 17%

Conclusion:

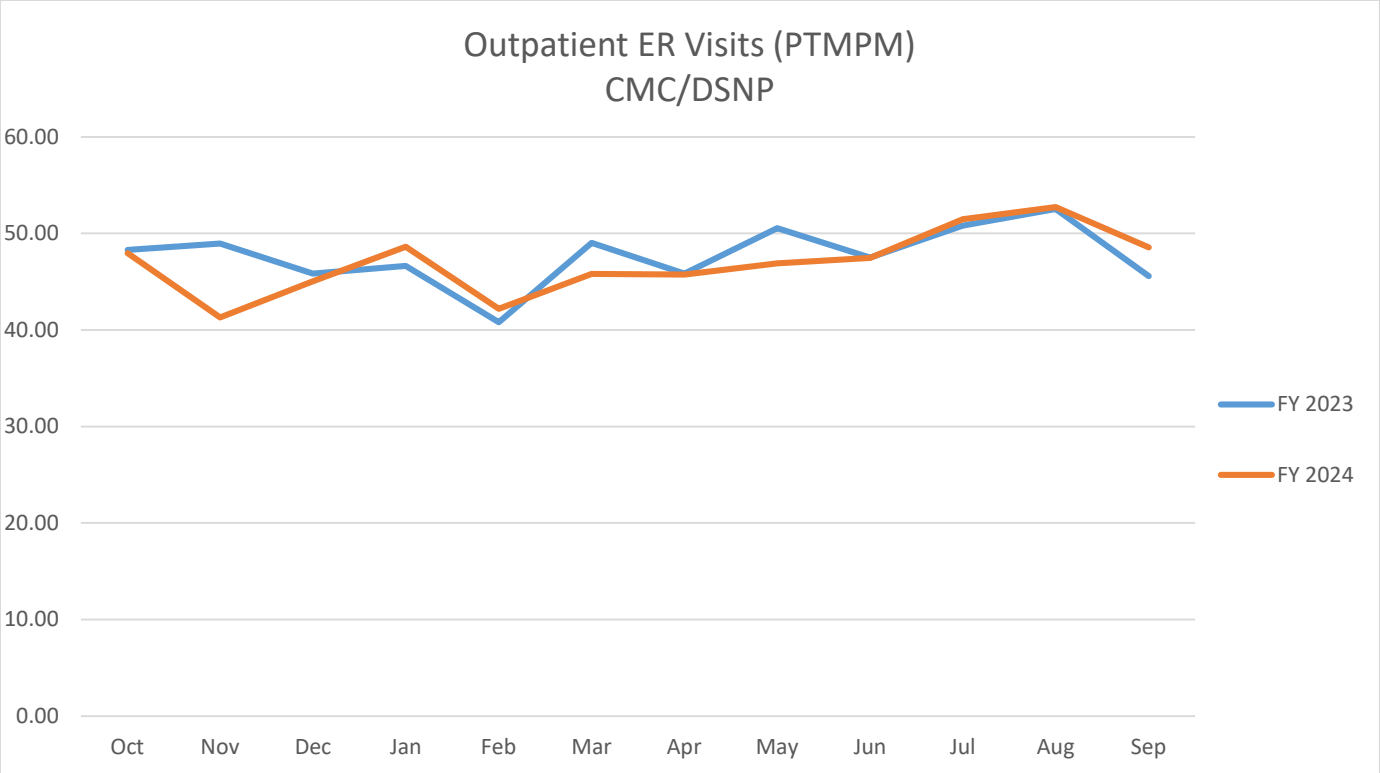
L.A. Care Direct Network admissions has increased over 2024 and remains above the Medi-Cal average . We will continue to track and bring the Direct Network performance in line with the remaining aspects of the network. The Direct Network does encompass a more challenging population both clinically and geographically that makes ease and usefulness of primary care challenging.

ER Utilization



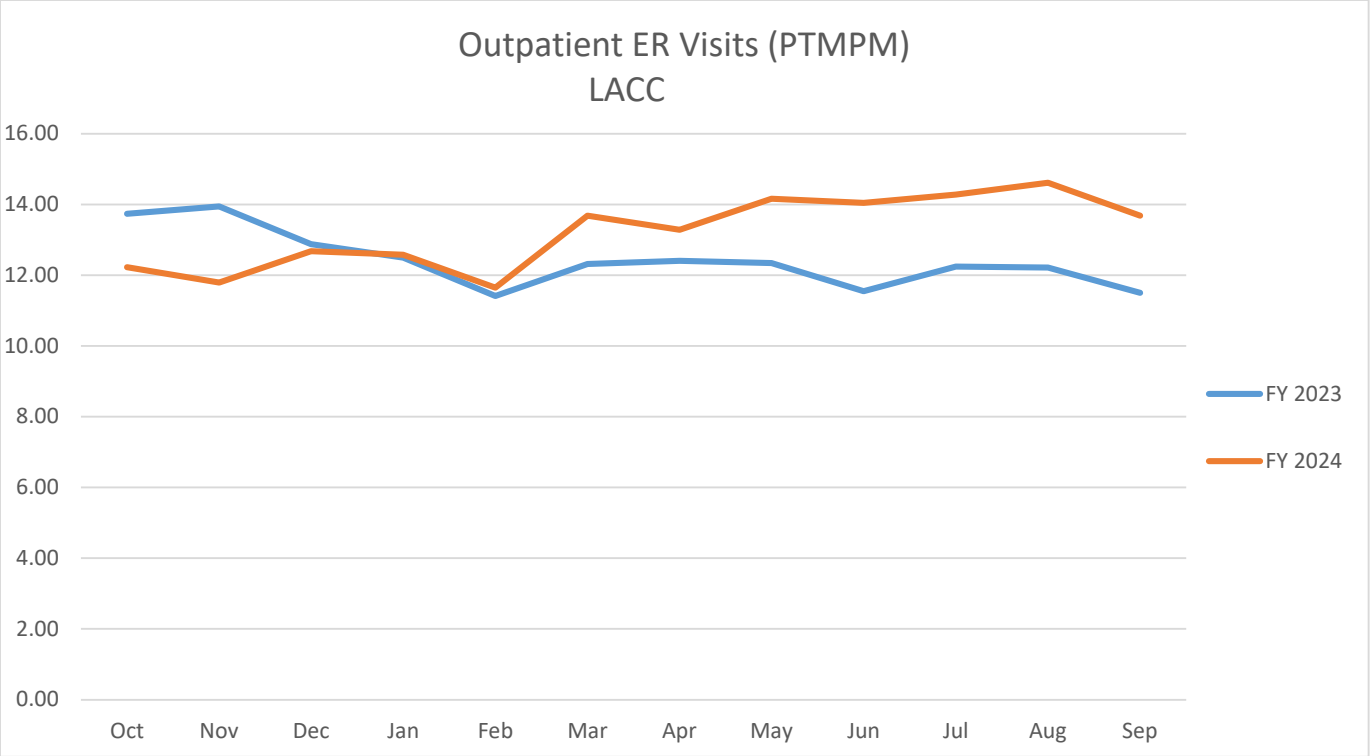
Quantitative Analysis:

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



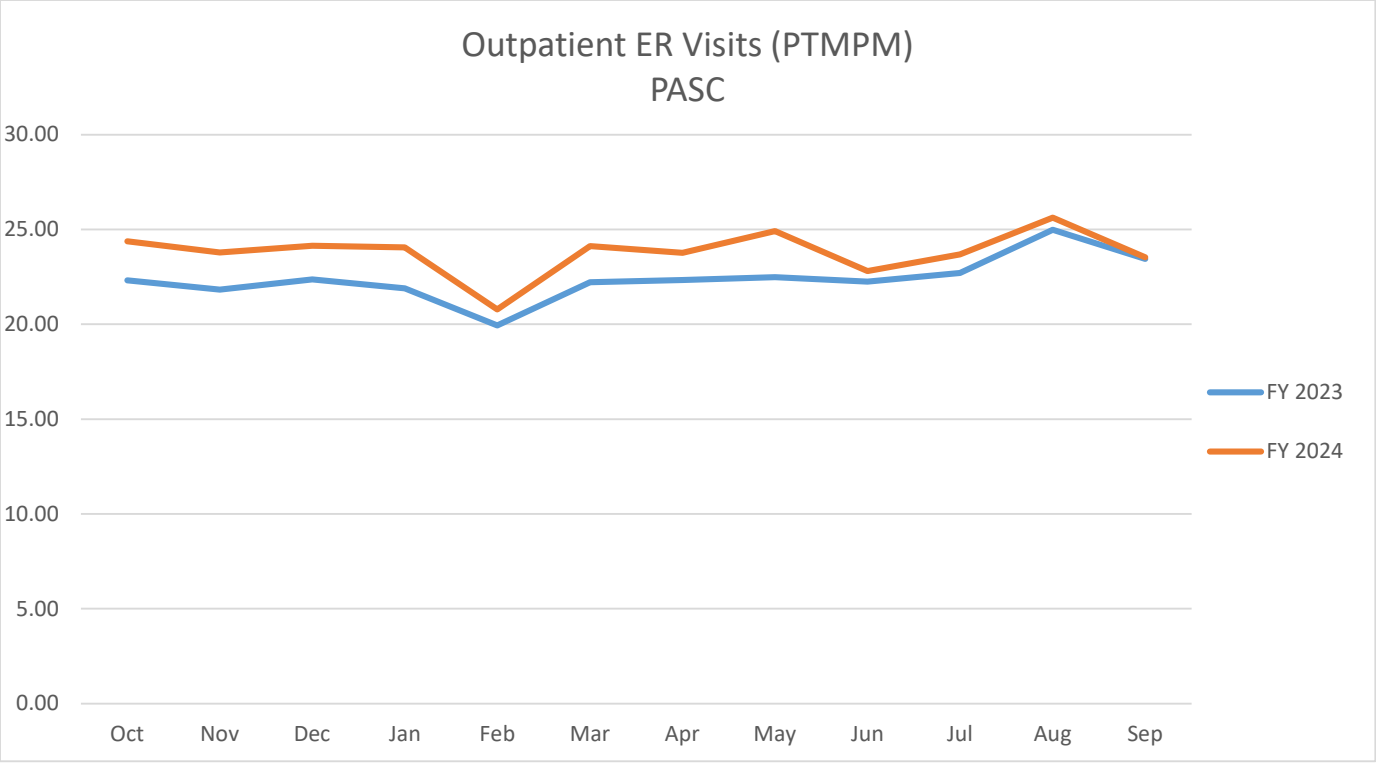
Quantitative Analysis:

- The highest rate is Year 2024 in August and Year 2023 also in August
- The lowest rate is Year 2023 in February



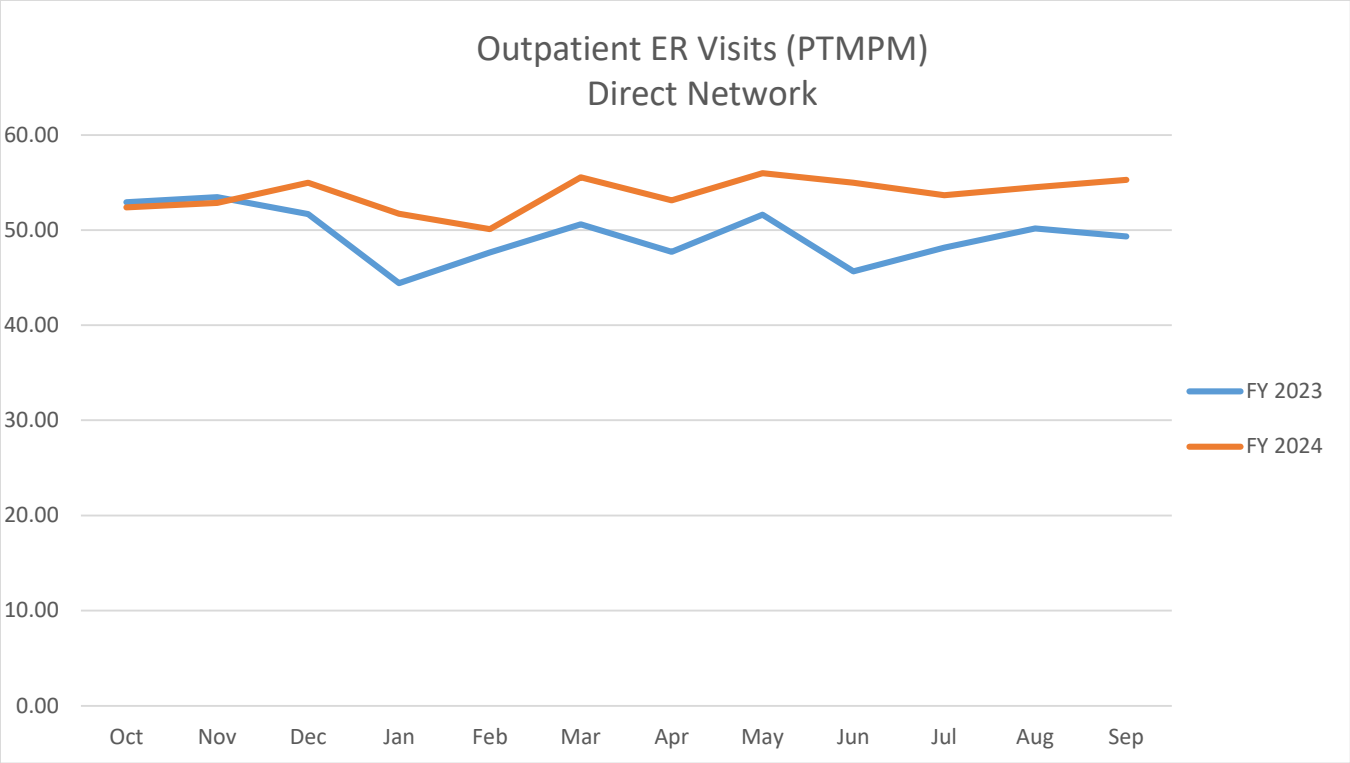
Quantitative Analysis:

- The rate for FY2023 has decreased over the year
- The highest rate is in 2024 in August
- The lowest rate is in September 2023



Quantitative Analysis:

- Rates had increased over the year for both FY2023 and FY2024
- The highest rate is in August 2024
- The lowest rate is in February 2023
- Both rates hovered around the same numbers throughout the year



Quantitative Analysis:

- The rates for FY 2023 and FY2024 remained steady over the fiscal year
- The highest rate is Year 2023 in May
- The lowest rate is Year 2023 in January
- There was a slow decline in FY 2023 until January

Conclusion:

ER utilization remains relatively flat over 2024. 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, 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 Memorandum of Understandings (MOUs) with the L.A. County Behavioral Health Departments including both 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 (MCLA) 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=245)	SCPs (n=179)	DN (n=246)
Very Satisfied	27%	24%	28%
Satisfied	39%	31%	35%
Neutral	18%	26%	22%
Dissatisfied	1%	2%	3%
Very Dissatisfied	3%	3%	3%
Does Not Apply	4%	9%	4%

Quantitative Analysis:

- The Overall Satisfaction with Utilization Management category with the highest number of respondents is DN.
- 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 39% from PCPs, 31% from SCPs and 35% from DN.
- The answers with the lowest rate percentage from each population is as follows:
    - PCPs: Dissatisfied with 1%
    - SCPs: Dissatisfied with 2%
    - DN: Dissatisfied/Very Dissatisfied both with 3%
- 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 26% of all responses
    - For SCPs: positive answers were 55% and negative answers were 40% of all responses
    - For DN: positive answers were 63% and negative answers were 32% of all responses

Overall Satisfaction with Contracted Provider Group's Referral Process

Overall Satisfaction with Contracted Provider Group's Referral Process	PCPs (n=245)	SCPs (n=179)	DN (n=246)
Very Satisfied	25%	20%	26%
Satisfied	42%	35%	31%
Neutral	14%	13%	13%
Dissatisfied	2%	5%	4%
Very Dissatisfied	1%	1%	2%

Quantitative Analysis:

- The highest percentage of answers were in the "Satisfied" field with 42% from PCPs, 35% from SCPs and 31% from DN.
- The answers with the lowest rate percentage from each population is as follows:
    - PCPs: Very Dissatisfied with 1%
    - 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 67% and negative answers were 17% of all responses
    - For SCPs: positive answers were 55% and negative answers were 19% of all responses
    - For DN: positive answers were 57% and negative answers were 19% 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. Because of internal performance monitoring and multiple regulatory and accreditation audits performed in 2024, opportunities for improvement were identified and new initiatives were put into place.

RECOMMENDATIONS FOR 2025

Based on the 2024 L.A. Care Utilization Management Program Evaluation and the feedback surveys, the following recommendations for the 2025 Work Plan are as outlined below:

- Continue to drive process improvement to improve turnaround time compliance
- Ensure that the new UM core system is optimally designed to maximize operational efficiency and maintain compliance with regulatory requirements & accreditation standards. This includes the development of custom-designed reports and dashboards in parallel, allowing timely risk mitigation as appropriate.
- 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
- Enhance internal operational reports and quality review of regulatory reports to ensure efficiency and compliance
- 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 A&G 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
    - 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;
- Continue to identify mechanism to improve overall California Children Services (CCS) reporting to ensure the appropriate referrals are made to the CCS program.

L.A. Care Health Plan

Utilization Management

Program Description 2025

Table of Contents

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 (MLTSS)
- Pharmacy
- Quality Improvement
- Safety Net Initiatives

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 (Inpatient, Outpatient, Quality) 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 (Inpatient, Outpatient, Quality) 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 QOC 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 Senior 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
- Medical Directors represent a variety of practice specialties inclusive of, but not limited to:
    - Family Medicine
    - Cardiology
    - Pediatrics
    - Psychiatry
    - Internal Medicine
    - Surgery and Critical Care
    - Emergency Medicine
    - Pulmonology
    - Palliative Care

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 Policy Program Manager

The Utilization Management Policy Program Manager is responsible for leading and managing a portfolio of strategic and transformational UM programs and projects, and supporting the development and implementation of Utilization Management initiatives to comply with regulatory and accreditation requirements. The UM Policy Program Manager ensures executive summaries of new policies and regulatory requirements are submitted to leadership for review and approval in a timely manner.

UM Policy Initiatives Nurse

The Utilization Management Policy Initiatives Nurse is tasked with updating and maintaining policies and procedures related to Utilization Management for all lines of business, working with UM Senior Leadership and other business unit leaders in the development and review of policies and procedures to certify compliance with regulatory guidelines and mandates, and accreditation standards.

UM Clinical Quality Nurse Supervisor

The Utilization Management Clinical Quality Nurse Supervisor is responsible in understanding the operational procedures across multiple different teams within the department to ensure practices and supporting documentation are compliant with all regulatory requirements. The UM Clinical Quality Nurse Supervisor is also tasked with triaging identified issues/problems as they related to clinical audits and forming resolution in collaboration with UM leaders and subject matter experts within the department.

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 Clinical Quality Nurse Reviewer

The Utilization Management Clinical Quality Nurse Reviewer is responsible for conducting and tracking targeted and random internal department documentation audits. This role ensures that UM practices and supporting documentation are compliant with all regulatory requirements and accreditation standards. Additionally, this position focuses on UM cases for all lines of business to identify areas of opportunity for increasing positive audit outcomes and improved service to L.A. Care's membership

UM Authorization Technician Training Specialist

The Utilization Management Authorization Technician (AT) Training Specialist is responsible for conducting AT training across in alignment with current policies and procedures, and internally established workflows. This position coordinates and provides the onboarding of AT new hires and is responsible for ongoing training, education, and remediation for existing staff, in collaboration with the respective UM leaders.

Utilization Management Quality Reporting & Auditing Specialist

The Utilization Management Quality Reporting & Auditing Specialist I is responsible for dynamically working with the quality team and UM Leadership to support and ensure effective implementation of reporting and auditing work plans and projects, working collaboratively and independently on components of reporting and auditing projects.

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.

Health Equity Expert

The Health Equity Expert represents the Health Equity Department and provides insights on the impact of social risk factors on enrollees. The HE expert is also actively involved in the development of HE metrics and annual analysis. Results of this analysis will be used by the UM committee in driving organizational changes.

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
- 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, 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 Directory, Corporate Compliance Monitoring / Delegation Oversight

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
- Reviewing and approving all Policies/ Procedures for care management, behavioral health, managed 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 20-018 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 prior authorization 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.

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: prior authorization, concurrent review and retrospective review.

Prior Authorization Request

Prior Authorization 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.

Prior authorization 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: 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 prior authorization request is marked as urgent (expedited) on the request form, but the request does not meet the criteria for an urgent priority, the request may be downgraded and the decision is rendered within the timeframe appropriate for the case.

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 an opportunity to submit an appeal in response to a Notice of Action (NOA) letter. The timeframes vary depending on the line of business. 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:

- 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 Compliance Delegation Oversight, Corporate Compliance Monitoring and Internal Audit teams are responsible for overseeing the activities of delegated entities outside of the health plan. These teams are jointly responsible for performing an annual audit of delegated entities, the aggregation of monitoring results and the production of a delegate scorecard.

Delegate data is monitored on a cadence more frequent than annual (weekly, monthly, quarterly, semi-annually). Notices of non-compliance are issued as appropriate. The monitoring results are reported to Delegation Oversight Workgroup on a routine basis.

Analysis of Utilization of Services and Health Equity Analysis

The Utilization Management Committee will review the most recent UM quantitative data related to health disparities and discuss during the quarterly UMC meetings:

- 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.

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

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.

Exhibits

- Exhibit A - Acronyms
- Exhibits B - Key Performance Indicators
- Exhibit C - PPG Monitoring

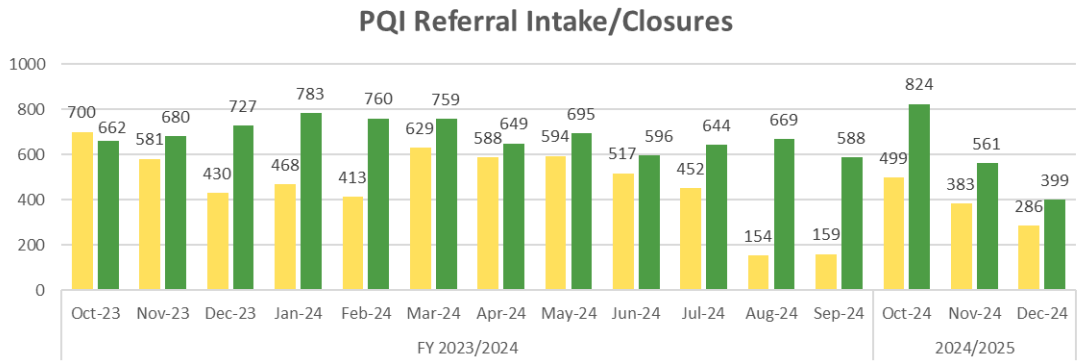
Acronyms

Abbreviation	Definition
A&G	Appeals and Grievances
CRM	Contract Relationship Management
DHS	Los Angeles County Department of Health Services
DN	Direct Network
DO	Delegation Oversight
EOM	End of Month
FY	Fiscal Year
KPI	Key Performance Indicator
P&P	Policies and Procedures
PNM	Provider Network Management
PP	Plan Partners
PPG	Participating Physicians Group
PQI	Potential Quality Issue
PQR	Provider Quality Review
PTMPY	Per Thousand Member Per Year
QI	Quality Improvement
QOC	Quality of Care
RN	Registered Nurse
SME	Subject Matter Expert

Key Performance Indicators

PQI Monthly Intake Vs. Closure Rates

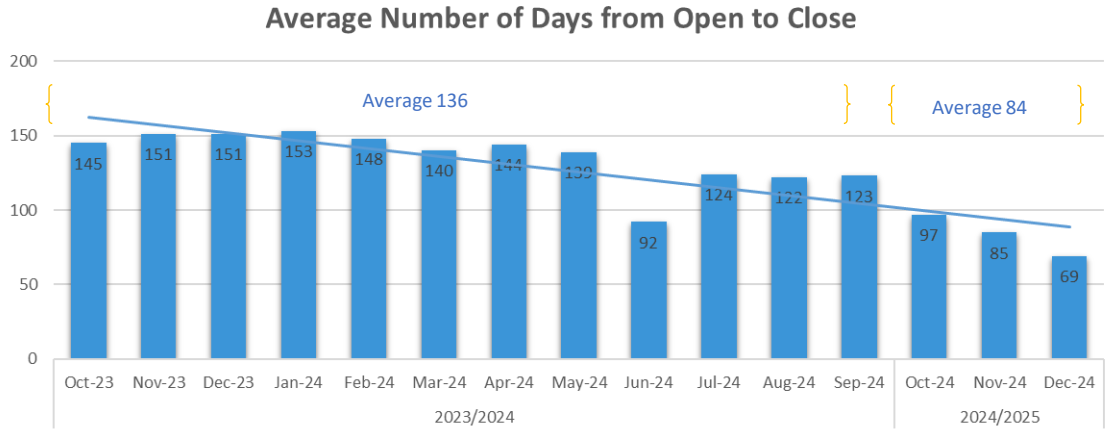
- **Intake Sources**: Quality issues may be referred to the Provider Quality Review (PQR) department from various internal and external sources. However, the majority (95%) of these referrals come from Appeals and Grievances.
- **Monthly Intake**
  - From October to December 2024, the average monthly intake of PQI referrals is 361, excluding 348 duplicates from October and November.
  - August and September 2024 have low intake due to 154 missed PQIs from grievances submitted in October.
- **Monthly Closure**
  - The average monthly case closures for the October – December 2024 period is 478 PQIs (excluding closed duplicates), which exceeds the average intake rate.
  - The high closure rate in October 2024 is attributed to reallocating staff from triage to resolve duplicate cases in Kaizen and complete triage cases in the legacy system.



Key Performance Indicators

PQI Average Number of Days from Open to Close

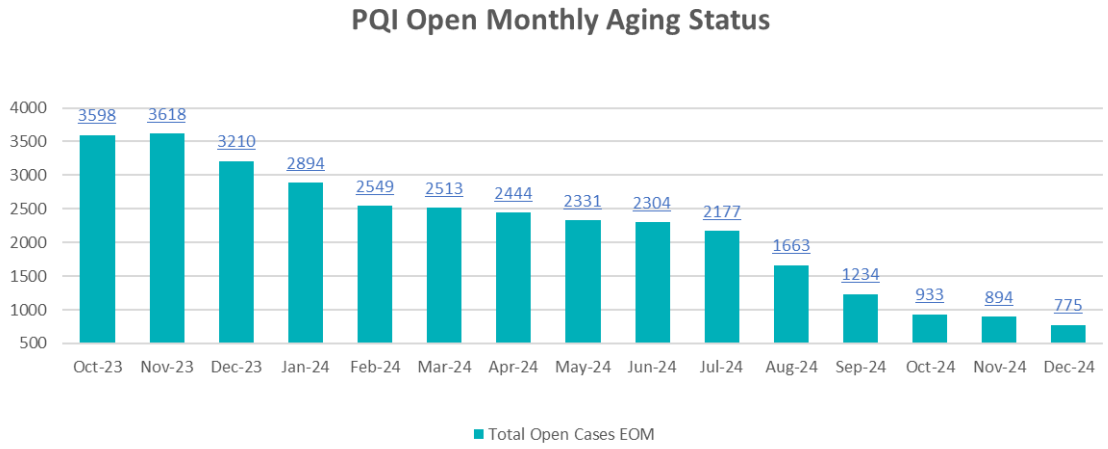
- **Days Open to Close**: The PQR team tracks the total number of days from PQI initiated to when PQI is closed.
  - The Average number of days taken to close a PQI displays a steady decline from 136 to 84 days, indicating cases are being closed around the three- to four-month time frame, exceeding our goal of case closure within six months.
  - The shorter review period for cases results from increased staffing and a lower volume of grievances referred.



Key Performance Indicators

PQI Open Monthly Aging Status

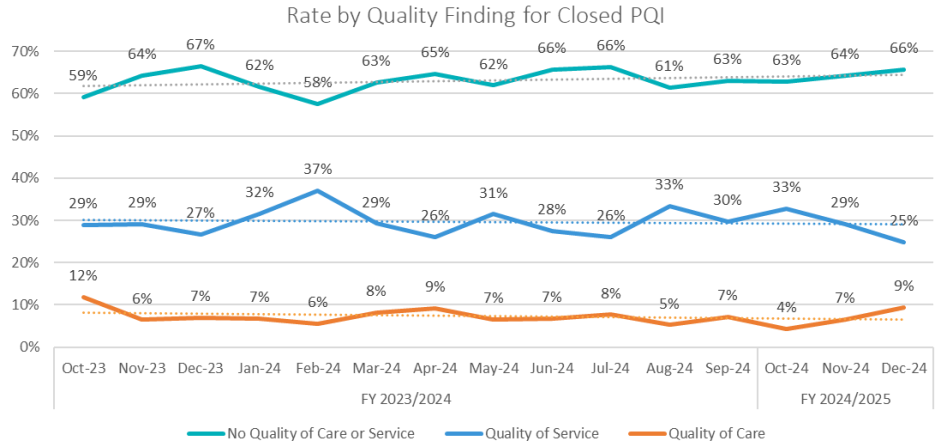
- **Open Aging Tracking:** The PQR team tracks the total open PQIs each month at the end of each month.
  - **Total Open Aging**: The total number of open aging PQIs is trending downward, decreasing from 3,598 in October 2023 to 775 in December 2024. This decline is attributed to a reduction in intake volume and an increase in case closures.



Key Performance Indicators

PQIs Closed by Quality Finding

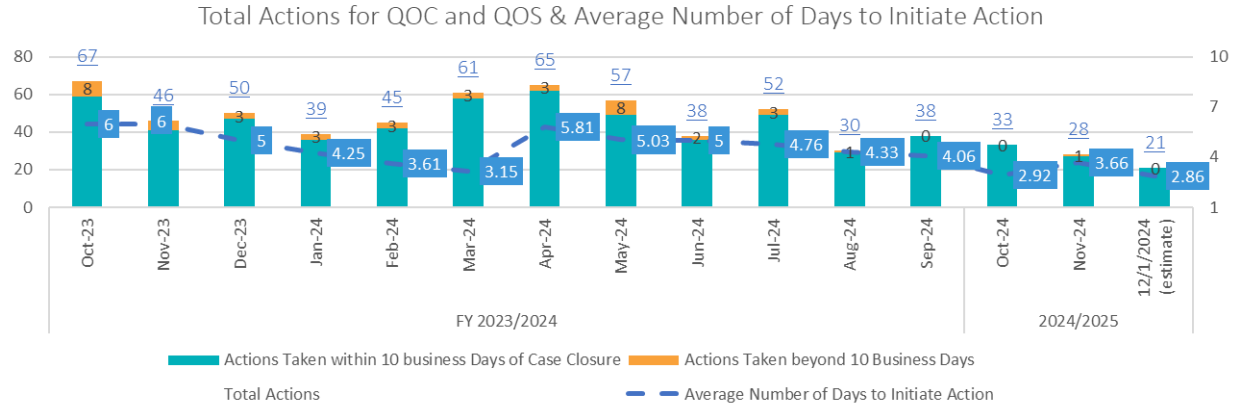
- The total closed PQIs for October 2023– September 2024 is 8,262 cases, of which 3,442 (41.6%) are unsubstantiated or duplicate referrals. The remaining 4,820 cases were forwarded for clinical review.
  - **Quality of Care**: 366 cases **(7.59%)** identified issues related to the quality of care.
  - **Quality of Service**: 1,426 cases **(29.59%)** had substantiated service-related issues.
  - **No Quality of Care or Service**: 3,028 **(62.82%)** showed no concerns regarding quality of care or service.



Key Performance Indicators

Total Actions for all Severity Levels and Average Days to Initiate Action

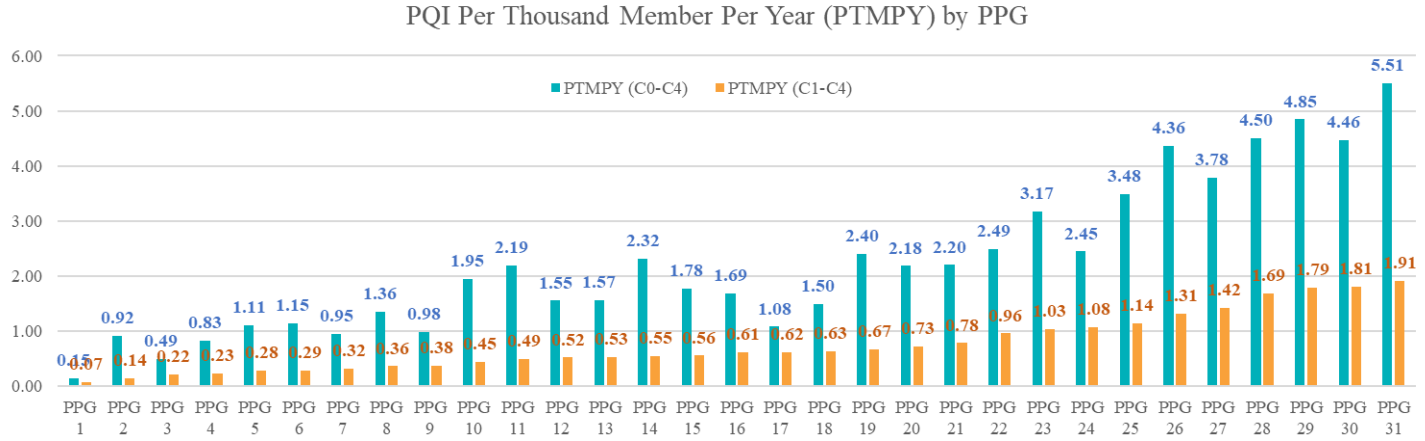
- **Action Initiation Procedure:** The PQR team follows an internal procedure that requires action to be initiated within 10 business days after a case is closed.
  - A total of 603 actions were initiated for all PQIs between October 2023 and September 2024.
  - The decline in actions taken corresponds with the total number of cases processed that included a clinical review during the same period.
  - The average number of days to initiate an action has decreased from 4.75 days (in FY2023/2024) to 3.14 days for the period from October 2024 to December 2024. This indicates that actions are now being taken more promptly after the case closure date.



PPG Monitoring

- An examination of each PPG is performed with consideration of membership size. The graph below displays the number of PQIs per thousand members per year (PTMPY) for each PPG. The average PTMPY rate, using severity rates of **C1-C4**, across all PPGs is **0.76** PQIs per thousand members per year. Low-performing PPGs may be contacted to review PQI findings and improvement opportunities.

- In addition to monitoring PPGs at a per-thousand-member-per-year rate, we also meet regularly with selected PPGs, including L.A. Care's Direct Network, or ad hoc as needed, to review PQI findings and share trends to promote better collaboration and identify improvement opportunities



C0 = No Quality of Care or Service
C1 = Quality of Service
C2 = Borderline Quality of Care
C3/C4 = Moderate or Serious Quality of Care