BOARD OF GOVERNORS

Provider Relations Advisory Committee

Meeting Minutes – December 6, 2023

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

Members

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

Management/Staff

John Baackes, *Chief Executive Officer*
Augustavia Haydel, Esq., *General Counsel*
Sameer Amin, MD, *Chief Medical Officer*
Noah Paley, *Chief of Staff*
Acacia Reed, *Chief Operating Officer*

**Absent ** Via Teleconference*

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
CALL TO ORDER	George Greene, Esq., *Committee Chairperson*, welcomed everyone and called the L.A. Care and JPA Provider Relations Advisory Committee (PRAC) meetings to order at 9:38 A.M. The meetings were held simultaneously. Mr. Greene thanked John Baackes, *Chief Executive Officer,* and his team for creating this committee that allows providers to raise issues and work together collaboratively to align in creating solutions for the issues identified. Mr. Greene described the process for public comment.	
APPROVE MEETING AGENDA	The Agenda for today's meeting was approved.	**Approved unanimously by roll call. 11 AYES (Ayoub, Booth, Flores, Greene, Matovsky, Moazzez, Movaghar, Raffoul, Silver, Topper, and Youredjian)**
PUBLIC COMMENTS	There was no public comment.	

APPROVED

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APPROVE MEETING MINUTES	An amendment was made to the August 1, 2023 meeting minutes to change the word "bariatric" to "psychiatric". The minutes of the August 1, 2023 meeting were approved as amended.	**Approved unanimously by roll call. 11 AYES**
CHAIRPERSON'S REPORT	Chairperson Greene is encouraged that Mr. Baackes and the L.A. Care leadership team are working to address the concerns of hospitals and a quality pool is being considered. Feedback from hospitals is positive. He continues to work with the L.A. Care leadership team on a draft dashboard for this committee that will include metrics important to hospitals and providers. He would like to hear from providers across the continuum of care about the information to be included in the dashboard. It would be very positive for providers to see the progress and public commitments made by L.A. Care to improve interaction with and among the provider community. The dashboard is a great way to continue dialogue, identify issues, and collaboratively work toward solutions, and for L.A. Care to demonstrate improvements underway. He expressed his appreciation to those participating on this committee.	
2024 MEETINGS SCHEDULE	Chairperson Greene asked committee members to please add to their schedules the 2024 meetings: February 21 May 15 August 21 November 20	
CHIEF EXECUTIVE OFFICER'S REPORT	Mr. Baackes thanked Chairperson Greene for his generous comments at the opening of the meeting. A number of issues will be coming up in 2024. California Department of Health Care Services (DHCS) contract with Medi-Cal managed care plans will affect L.A. Care's relationships with providers because there are new regulations that health plans will have a responsibility to cascade down to contracted providers. For example, new level of administrative reporting will be required with IPAs, hospitals. There will be a transition of care mandate. L.A. Care has already been working with some hospitals on that. Of most concern is how rates are determined here in Los Angeles County, because of countywide averaging (CWA). DHCS began using CWA in 2011, starting with 20% of the rate determined by averaging it with Health Net. In 2024, it will expand to 100%. The consequence is that up to and including this year, $1.2 billion has been diverted from L.A. Care to Health Net, a for-profit company owned by Centene	

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	Corporation, based in Pennsylvania. The CWA methodology drives to the lowest common denominator for medical cost. To maintain its share of revenue, L.A. Care would have to pay providers at the same (lower) rate as Health Net. L.A. Care currently pays providers more than Health Net. L.A. Care is trying to engage DHCS leadership, including the Secretary of Health and Human Services, in policy discussion on the purpose of CWA and what goal is achieved. As the public plan, L.A. Care has an obligation to support safety net providers and to give providers as many resources as necessary. Even with the managed care organization (MCO) tax reinstated, provider rates are lower than Medicare, and are lower than commercial health plan reimbursement. DHCS is also applying more quality measures on health care and review of disparities in health care. L.A. Care has pointed out that more measures and financial sanctions can be applied, but it will not incentivize health plans to do anything that that has not already been tried. What is needed is more resources. Mr. Baackes would like to discuss this issue with the committee because, at some point, a coalition will be needed to pressure DHCS into looking carefully at this policy; it is not good for providers. Sameer Amin, MD, *Chief Medical Officer,* commented on the increased administrative burden for the providers and for the care facilities. The number of quality metrics applied are ever expanding. No one challenges quality improvement, but how many different things can one focus on at one time? There is rapid change occurring in quality mandates; there is now a litany of items that health plans must track, not only for quality improvement and corrective action plans (CAPs). Health plan quality scores affect the auto assignment of members. A quality withhold as a percentage of premium is taken out of revenue at the beginning of the year. Medi-Cal applies the Managed Care Accountability Sets (MCAS) performance measures, which are quality metrics for health plans to track for equity and for a number of other important quality items. This is a whole new set of requirements, and financial sanctions are applied if minimum levels are not achieved by a health plan. There are also requirements for the Star rating for the Duals Special Needs Plan (D-SNP) and a quality transformation initiative (QTI) in California Covered as well as the 2023-25 Qualified Health Plan metrics. Some requirements are the same across the product lines but there are a lot that are not. L.A. Care has a joint responsibility with providers, delegated entities and facilities to come together on these very important quality metrics. If we can come together, it would be important to advocate for a focus on a few things that can be done well rather than 75 things that can be done marginally well. Each and every quality measure has associated sanctions	

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	that include financial penalties. The financial penalties take money away from safety net providers and take away money from the health plans. It affects how much health plans can invest in the system to improve quality. This is a significant change in how the health plans are tracked and sanctioned. This will affect providers in pay for performance plans, and health plans will have to address operations and health plans will need a very heavy focus on quality. As a community, we do need to come together and focus on a few things that must be done well and avoid tracking and jumping after 500 things.	
COMMITTEE ISSUES		
DISCUSSION OF SUGGESTED ADDITIONAL MEMBER CATEGORIES	At the last L.A. Care Board meeting, Supervisor Hilda Solis suggested that this committee consider including a community member, a consumer or promotora, and Board Member Vaccaro suggested including a seat for a clinician from a federally qualified health center (FQHC). At the creation of this committee, Chairperson Greene viewed it as a committee for providers to have conversations about clinical and operational issues. There are forums for patient advocates to bring issues to L.A. Care. This Committee will discuss detailed topics focused on clinical and operational issues and there might be more appropriate forums for a promotora or consumer to represent the patient base. The Committee might be able to create an opportunity at those forums. With regard to a seat for a clinician from FQHC, the work and the dialogue at this committee might be appropriate for a clinician. Mr. Baackes noted that L.A. Care has an Executive Community Advisory Committee, which is comprised of the chairs of L.A. Care's 11 regional community advisory committees. L.A. Care members receive a stipend to represent consumers in their region. It is a forum to receive feedback from members of the health plan. L.A. Care has a Children's Health Consultant Advisory Committee, another forum that focuses on children's health issues. There is a Technical Advisory Committee, under the guidance of Dr. Alex Li, *Chief Health Equity Officer*, and focused on health disparity issues. All of these are open to the public. A consumer could attend these meetings and make public comments. There may not be a need to designate a seat at this committee. Mr. Baackes noted with regard to a seat for an FQHC clinician, it was noted that Los Angeles County Department of Health Services (DHS) sites and the FQHCs provide care for almost 40% of L.A. Care's membership. There was discussion about the feedback provided to L.A. Care from providers, particularly about the quality metrics, and it is insightful. There was a meeting yesterday with clinicians to discuss increasing cervical cancer screening rates. They noted that patients receive multiple invitations for screening and incentives. However, the patients do not come in, they do not	

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	want a screening. It was asked of L.A. Care, how many times do they need to ask the patient and how much do we need to pay them to get them in for these services so sanctions are not imposed. It is a real issue, and L.A. Care has asked for data from providers. Mr. Baackes suggested joint messaging to the regulators, because the regulators have decided that health plans could receive a financial sanction if any measure is below the national 50th percentile. Dr. Amin commented that adding a physician representative would be great because there are a lot of things physicians do not know about, such as how health plans are sanctioned and the basis for imposing sanctions. The measures are based on national performance, not state or regional performance. There are great differences nationally in Medicaid. Another important point is that the measures and sanctions are based not on the number of patients treated for the minimum performance level (MPL) but is compared to 100% of the health plan member population. This is stunning, because it does not allow for even one person to decline care. Clinicians know that does not make sense, because some people will decline the vaccination, a mammogram or cervical cancer screening. Those who decline are still counted for the denominator, and a health plan would be sanctioned based on those members. There is agreement on adding a seat for a clinician from a federally qualified health center.	**The Committee approved a motion to add a clinician from a federally qualified health center.** **Approved unanimously by roll call. 11 AYES**
OPEN FORUM	Mr. Baackes noted there were two items that people wanted to discuss in the open forum, and if there are other items, the Committee will hopefully be able to discuss those as well. The first is a request from Sabra Matovsky, representing Healthcare L.A., about changes in contracts for community-based organizations including FQHCs that participate in the Enhanced Care Management (ECM) benefit under the California Advancing and Improving Medi-Cal (CalAIM) initiative. L.A. Care contracts with community based organizations to provide ECM additional care and it is the first time funding has been specifically earmarked for this. The second year of this program will close at the end of the month, and L.A. Care was proposing changes for next year based on new requirements from DHCS. Mr. Baackes invited Dr. Amin, Steven Chang, LCSW, CCM *Senior Director, Care Management*, and Noah Ng, LCSW, *Director, Enhanced Care Management*, to comment on proposed changes. Dr. Amin commented that there was not much information about ECM initially. L.A. Care began building the infrastructure and creating some distinction between ECM and complex case management, which occurs in secure accredited process here at the health plan, and general case management conducted by providers. In so doing, there was a real push for funding up front to build the resources to do work. Providing funding monthly to establish the program seemed like a good idea. A provider reporting a new ECM patient to L.A. Care would begin receiving a monthly payment. It became very difficult to track the quality of	

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	care, the number of visits, how those visits are going, which is important data for the health plan. There was no general push to send encounter data to L.A. Care when paying the providers monthly. L.A. Care operated like this for a while, it helped build the provider network for ECM benefits and L.A. Care is happy with how that went. Now, as the program matures there is a general sense that the program needs to move toward making sure that patients who need more care management are seen more often and in person and that the care is of a high quality. Providers need to spend a lot of time with those members, and not just a few minutes over the telephone. Not to imply that is happening, but it is hard to document. The method proposed is to pay the same amount in a different way; more closely tied to the actual visits that are occurring. This could be characterized more as capitation versus fee for service. In discussions with DHCS, it was not actually pure capitation. Pure capitation relates to a geographic area, and funding on a per-member-per-month basis for all the members in that area, whether or not care is provided in that month. L.A. Care is conducting this differently. A provider sends information about a patient that meets the ECM criteria and the provider will receive monthly funding. The prior process incurred a lot of effort to gather data afterwards on whether the patients were being seen or still in the program created acrimony. It was not true capitation. When the program started, Dr. Amin visited community clinics and all of them said they knew reconciliation was coming. There is a concern about it because the funding is in question without appropriate data. L.A. Care will not know if there has been an issue. L.A. Care must track data carefully to properly reconcile funding. L.A. Care determined that there must be a more organized way to do this that allows the providers and health plan to better support the community. The methodology that is proposed will serve the ECM population. L.A. Care will have a good sense of the clinical quality, of the number of touches that are happening and L.A. Care will pay similar to current funding, particularly if the provider is putting in a lot of effort. L.A. Care will make sure to align with the ECM provider community in implementing the change. The change is not to save money and is not to upend the process. This is a collaborative effort to make sure the patients are getting the right quality of care with support of the ECM community. L.A. Care has received feedback that there has not been enough time to have a discussion about the change and it will be delayed for as long as needed to get on the same page. There will be more discussion about it to gather input and then move forward in March or April. This should not be taken as a unilateral change to save money, this is about getting to a mature state, so it can grow moving forward and to understand who is in the program.	

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	Dr. Amin invited Mr. Chang and Mr. Ng to correct any misstatement and provide more information. It was commented that there was very little guidance. There has been massive confusion and rewrites of rules, with programs in flight nonstop. Different health plans operate on different strategies about how providers should care for members, what kinds of reports must be submitted and how the programs are supposed to function with changing rules at different time periods. Not everyone is changing at the same time that regulators change the requirements. It is confusing and difficult to build the steep infrastructure requirements for this program. The health centers have now been able, post COVID, to hire some of the staff necessary for these programs. Valley Community Healthcare just hired a director and at this point they need to know if they need to let that person go, because they were at a capitation of closer to $400 dollars a month and that is now down to $12. It is not sustainable for this work. There is a reporting problem for health centers that have been providing services, as they have not been asked to send reports since the first visit. That is a direct feedback from a provider. It was asked if there is an expectation that the case manager is going to be on their end or for an LCSW to do the social service arrangements for these patients. Providers have difficulty finding available LCSWs. These are issues for brainstorming a program that will actually support the community better. Dr. Amin responded that the problems will not be solved today. It is important to address issues that were brought up. Getting health plans to align with requirements is important. L.A. Care has been speaking with regulators about how it is practiced in other counties, and none is comparable to Los Angeles County with 2.9 million Medi-Cal members. It is L.A. Care's responsibility to try to collaborate and align with other health plans. He has instructed the L.A. Care ECM team to go out and talk to other health plans about how they are doing it. L.A. Care has learned that financial models have changed several times in this one year period. They are not one hundred percent solid in what they are doing either. L.A. Care will try to get one process established. L.A. Care has historically set precedent and organized the community. In terms of asking for information, it is a significant issue, internally and externally, L.A. Care will get this right when it can get current data. IT infrastructure will need to be established in the community and in L.A. Care's systems to facilitate reporting. Regarding the significant decrease in reimbursement, it is likely L.A. Care has not explained that well. The intent was not to decrease funding, but to implement funding for individual care. L.A. Care will review cases where there is a significant drop in compensation.	

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	Regarding the delivery of care, it needs to be very clear that ECM services are over and above what the health plan or providers would do for general case management. There is a concern bubbling, particularly as clinical audits get underway – and this is not to say it is pervasive – that to start getting capitation, a provider only has to have one touch for one minute. Eventually the health plan would reconcile and take back that money. That is not ECM. Health plans must be very careful about how it is paying to prevent abuse in the system. Dr. Amin does not personally feel that ECM providers are abusing the system. They are trying their best to take care of ECM members. Providers and health plans need to work together so that the services are over and above and are special care management. Care should be mostly in person, and in the community. Outside of the clinic walls and then it should mostly be clinical. There is space for some non-clinical work and the health plan will pay for it. There is also space for some telephonic work, and the health plan will pay for that. Predominantly the care needs to be highly intense case management that happens in the community. Mr. Ng commented that Dr. Amin captured the significant issues as L.A. Care moves to change its payment model. This is a unique program trying to do something different here in California to show the federal government and other states how intensive case management can look. This program is not just complex care management or basic case management at the primary care provider. Unfortunately, the small amount of data that L.A. Care has received shows that was happening. Providers were going back to telephonic, non-clinical interventions. L.A. Care needs providers to be with us in this move, and L.A. Care wants to support providers. The delay in implementation will allow time to meet with providers individually to understand their needs and how L.A. Care can help them through the transition so that the goals of the providers and health plan align. L.A. Care has listened to feedback about clinical support and challenges in hiring staff. There are opportunities for LVNs and others that can be also be incorporated into the clinical model. Recognizing that service delivery is not limited to para professionals, many providers were using capitated payments to support para professional telephonic interventions. L.A. Care is trying to move into what the spirit of ECM is supposed to be about. The language DHCS uses in describing ECM is that it breaks down to the walls of the clinic, takes it out of the clinic setting. That is what L.A. Care hopes to achieve, and support the clinics and providers in being able to get there. L.A. Care will take the time needed to inform and support providers. There is currently a contract amendment for providers, that is very specific about supporting providers in outreach to members to bring more members into the program. That was not part of the current model. L.A. Care is looking to enhance payment to providers to allow	

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	reimbursement for outreach to any L.A. Care member who may be eligible for ECM. We want providers to feel comfortable in reaching out to members to try to engage and enroll them in ECM. L.A. Care wants to compensate providers for that and it is in the contract amendment sent out for signature by providers. Mr. Chang commented about clinical and the non-clinical services. L.A. Care has providers that want to go out into the field more often. Right now, the capitation puts a ceiling on sending clinical teams out, and they actually probably do need to receive more than the current capitation rate. L.A. Care is trying to address this. With a sense of fairness, a provider making phone calls each month should not receive the same capitation as a provider sending clinical staff out to the member three to five times per month or even more often because of the acuity of the member. It was commented that clinics may be shy about doing more outreach to enroll more members without a good sense that there is a functional program for the member. Dr. Amin responded that L.A. Care is working to be much clearer about finances, and is scheduling time with FQHCs, community clinics, and with ECM providers for a brain storming session. As mentioned previously, meetings will be held with other health plans about how they are doing their financial model. A meeting will be held with DHCS to talk about best practices and their experience with the different health plans in terms of what worked and what did not work. Dr. Amin thanked providers for their feedback. He hopes it is recognized that the change is well-intentioned and L.A. Care will take the time to make sure there is opportunity for a full discussion. Hector Flores appreciates this discussion and he supported adding a clinician seat because these types of conversations need that perspective among others. He suggested recasting L.A. Care's approach to CalAIM, to the extent that DHCS oversight allows it, because there is a lot of variability among providers. Many are disproportionately serving the unhoused, and they need resources immediately to do the work that their mission calls them to do. While at the other end of the spectrum, in his observation, there is a lot of FQHCs and private offices seeing most women and children. In reference to earlier discussion about how an equitable distribution of these funds can be made in a way that makes sense and achieves the goals of CalAIM. He suggested that the committee set up a work group that recasts how we approach CalAIM. The challenges for FQHCs are significant. For L.A. Care, almost two thirds of primary care visits and the L.A. Care network are with private solo and small practices. Many of them are not familiar with CalAIM or how to use it on behalf of their patients.	

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	Dr. Amin responded that he wishes that regulators were aware of provider opinion and heard it more loudly and clearly. The regulators want health plans to grow the program, enroll members despite not having details worked out. L.A. Care has told regulators that time is needed to make sure the programs are set up properly, and that there is an infrastructure in the provider community to do this, the health plan needs to make sure it is funding the right things, is it unhoused, women and children? Are community supports programs going to improve quality for members? Their response is, grow the program. This is challenging. A report was released this week regarding issues with CalAIM in general being built on the fly, and a new auditors report out regarding how DHCS has conducted the implementation of CalAIm. The push to have a larger and larger program is not concordant with health plans operating a higher quality program. Dr. Flores added that regarding performance of the constituent provider networks, the last thing an unhoused person wants to do is get colorectal cancer screening. They have 100 other priorities to survive. Providers need to be able to account for that and understand patient priorities. On the other hand, there may be opportunities to provide screening for patients who come to a provider with a sore throat or a prescription refill. Providers can look at the equity pathway that would engage a patient's in care. It takes resources and a lot of counseling for some patients. Providers need to challenge themselves to move the needle from just quality measures to equity. Dr. Amin noted that the member who is unhoused and may have mental health issues might prioritize getting a roof over their head or having access to food before completing a health screening. That is a really good point and it speaks to how quality measures and the minimum performance level for a patient population at a state and a regional basis compared to a national basis with varied populations in other states. You will see that L.A. Care and every other health plan perform well when compared to California performance levels. At the national minimum performance level, the performance is significantly lower because there are very different challenges in Los Angeles County than in other states. Mr. Greene acknowledged that L.A. Care works with recuperative care providers for members being discharged from hospitals, to ensure that they are assisted in the transition to permanent housing or at least interim housing. L.A. Care has programs to address food insecurity. L.A. Care is working with an organization called Bento, which addresses food insecurity through a technology platform as simple as the most simple cell phone that there is. The efforts are there and CalAIM can create a pathway. He is confident that L.A. Care	

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	will continue to find creative ways to utilize the flexibility in CalAIM to address some of social determinants of health. Stephanie Booth, MD, member of the L.A. Care Board of Governors and is a pediatrician. She would like L.A. Care to report to this Committee about solo and small group providers to find out how much they do know about CalAIM and ECM. She suggested asking these providers to help communicate with regulators directly about their experience with the programs. Dr. Amin responded that for ECM and Community Supports programs, a main task is education. There is a significant effort starting up to train providers and hospitals on the available resources. Mr. Ng noted that training is currently underway. All six health plans joined together to provide education to providers and hospitals across the network. Providers contracted with any of the six health plans have been invited and multiple sessions are held in person. Plans are providing information and want to make sure that providers can ask questions. Dr. Booth noted the training is great, but could they write a letter to the Governor or to DHCS. Chairperson Greene suggested asking leadership to present an update at a future meeting. Zahra Movaghar, Preferred IPA, commented that for the last year, Preferred has made efforts to refer patients to ECM that qualify to enroll. The challenge is lack of information sharing, as they do not receive data on the member. In their community, there is about maybe 60 ECM providers, and each is working with 30 IPAs or medical groups. Mr. Baackes responded that he has badgered DHCS about using community-based organizations for ECM. L.A. Care has been doing complex care management internally. L.A. Care has 75-85 community-based organizations, half of which do not have the administrative capability to do the reporting needed. DHCS insisted that community based organizations be used for ECM. Mr. Baackes will continue to push back. Some ECMs perform well, particularly those embedded in the practices. L.A. Care should be able to do the enhanced care management. L.A. Care has a plan to use the community resource centers to base community health workers so they will be closer to where the patient is, and can go to their homes and see them. But right now L.A. Care is being stonewalled by DHCS insisting ECM has to be provided through community based organizations. Ms. Movaghar stated it is a challenge to even to get a report from L. A. Care too. A comment was made in agreement with Ms. Movaghar. There may not be information on patients being discharged from the hospital. It would be helpful to know which organization is a partner when conducting discharge planning.	

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	Mr. Ng noted that data is usually the first topic of conversations around ECM. He invited suggestions from the committee members. LANES is key to having strong HIE. There is a lot of work to integrate data from the CalAIM programs in Los Angeles County and provide access to IPAs and other primary care providers. He noted there are challenges in alignment, especially in a county that has six health plans. He recognizes what providers are feeling. ECM was designed without a lot of clear direction, which allowed for and encouraged variability. DHCS was telling plans to try it a little bit differently. In July, DHCS realized that may have been a bad idea, and started providing more clarity on alignment across the state. There is discussion at the state level to align payment, which can impact the today's conversations. The six health plans have begun standardizing forms and processes to simplify administrative tasks for providers, but Mr. Ng recognizes that it does not solve all the problems with standardization. Richard Ayoub, CEO of Project Angel Food noted that there were statements about reporting from community based organizations. Project Angel Food contracts with L.A. Care for medically tailored meals, and in that process the organization was carefully vetted and had to go through a lot of scrutiny. He asked if other community based organizations cannot fulfill the requirements of the contract. Mr. Baackes responded that he was speaking about the 75 community based organizations that specifically are doing enhanced care management. It was a different process. A comment was made in reference to Dr. Amin's statements about the national versus regional benchmarks. In talking to FQHCs across the country, there are different requirements for becoming a primary care provider. In New York, a patient must be seen three times at the clinic, and then that clinic is responsible for the quality metrics. In Oregon, it is two times. In California, that patient becomes your patient at enrollment, and may have never come to your clinic and may go elsewhere even after outreach attempts. The clinic may carry the member on the roll, but they have no intention of ever coming in and getting any of services from the clinic. Asian Pacific called every single new patient for a year, 27% of the contact information at enrollment was not valid. For a clinic to reach the national minimum performance level, it must be perfect with every member. Providers are starting with a 27% deficit and running as hard as possible. This contributes to provider burn out. It is hard to recruit physicians. It is a lack of understanding at the state level or a lack of acknowledgment of these issues at the state level is creating pressures that fray the system. Mr. Baackes agreed her point, and noted that information needs to DHCS. L.A. Care could convey it, but it would have more impact if many providers joined to convey. The 27%	

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	invalid information came from DHCS. Medi-Cal enrollment forms are completed by the beneficiary. DHCS needs to recognize that when providers are not able to contact 27% of enrollees, the metrics cannot be achieved. Dr. Amin noted that the initial visit requirement is called retroactive claims based assignment attribution. California is such a highly delegated system that members are assigned in advance. It works well for Medicare advantage, because there is a very tight connection between the primary care doctor and the member. It does not work so great for Medicaid when there are people who are unhoused or have many social determinants of health. ` It also does not work very well for the health benefit exchange population (California Covered). Many exchange providers have left California, and one of the reasons is the expectation for quality and the national metrics. Chairperson Greene reported that the hospital community engagement with L.A. Care over the past couple of years, to raise issues and challenges from the hospital perspective contributed to the creation of this committee. As part of that dialogue, Mr. Baackes and the L.A. Care team have made six commitments to support provider partners. • investment in utilization management • updating the provider dispute resolution procedure and process while looking at root cause analysis to reduce first pass claims denials • alternative reimbursements such as administrative day rates • single point of contact team for resolving claims, authorization and discharge issues • enhancements to the provider portal, and • non emergent medical transportation Of those issues, utilization management provider, dispute resolution procedures, claims denials and the non-emergent medical transportation issues continue to be brought to the attention of the leadership of the hospital association. A request has been made that L.A. Care consider a baseline dashboard that could be shared at these committee meetings. L.A. Care leadership could share the work being done to move towards collaborative improvement. He appreciates that Mr. Baackes and the leadership team continue working on the issues and hopeful that the committee can agree on what a dashboard might look like. Mr. Baackes noted that Mr. Greene sent a model for a dashboard. The committee should know that for the last six or seven months, a draft dashboard has been reviewed by the Board of Governors. Improvements continue in a number of the items. Following the vetting process with the Board, the goal is to have a public dashboard. L.A. Care is not there yet. Mr. Baackes suggested a report on some of the items mentioned, because L.A. Care has made great progress on most of them. A separate report can be made on the status of the	

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public dashboard. Mr. Baackes noted that a dashboard with internal operations data in public gives him pause when L.A. Care's competition does not provide the same information. Mr. Greene appreciates the commitment to exploring what that might look like and stated that they will be pushing the competition to do the same thing.

Abraham Rivera, *Provider Network Account Manager,* presented a Call the Car performance summary for August, September and October 2023 (*a copy of the data reviewed is available by contacting Board Services).*

Indicator	Aug-23	Sep-23	Oct-23
Calls Answered in 30 Seconds (Telecom)	83%	82%	92%
Abandonment Rate on Incoming Calls (Telecom)	3%	3%	1%
Scheduled On Time Performance: Scheduled routine trips	96%	97%	97%
Will Call On Time Performance: Scheduled return trips without a specific pick-up time	100%	100%	100%
Discharge On Time Performance: Facility discharge to home	97%	98%	97%
Transfer On Time Performance: Facility to facility transfer	91%	91%	90%
Provider Cancellations and/or Provider Missed Pick-Ups	0.06%	0.07%	0.09%
Member Complaints and Grievances (Substantiated)	0.05%	0.05%	0.05%
CTC Call and Trip Volume			
Calls Offered: Number of calls received by CTC call center	144,603	142,487	162,081
Total Trips: Number of reservations created	295,540	286,553	308,822

AJ Lopez, *Director, Provider Contracts and Relationship Management,* commented that there were more than 250,000 transports per month, or about 8,300+members per day. This is an A grade program in its fifth year. There may be complaints to the Board hears about occasionally but the overall performance is very high.

Chairperson Green asked the source of the data. Mr. Lopez responded that the numbers come from multiple streams. Call the Car, as broker and manager of the transportation service, works with a subcontractor network, with thousands of drivers and vehicles in their

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	fleet on a punch-type system. The punch detail has a range of plus or -15 minutes. In addition, the advanced analytics team is working on more of a dashboard type system. The numbers are based on as good as real time information as we know it right now. There was a question about member complaints and grievances and the meaning of substantiated allegations. Mr. Rivera noted that the data is only showing substantiated allegations to remove the complaints that can be proven not to be 100% factual. Acacia Reed, *Chief Operating Officer,* noted that when the appeals and grievances team conducts research, the complaint is validated. David Silver, of Rockport Healthcare skilled nursing, commented that the report does not reflect the experience Rockport has. There are many more challenges with transportation and Call the Car. Chairperson Greene noted that this is not what he has heard from the hospital community, and is aware that improvements are being sought. He asked if member complaints and grievances could be viewed as a measure of member satisfaction. The provider community needs to hear from patients about how satisfied they are with the care being provided. For hospitals there are metrics used that can impact revenue. He asked about the protocol used to measure client satisfaction. Mr. Baackes responded that for Medi-Cal it is the annual Consumer Assessment of Healthcare Providers & Systems (CAHPS). The survey is conducted by a third party, and results are compared among all the plans. There are similar surveys for D-SNP and other product lines. There is not a specific component of the surveys that relates to transportation. The survey is standardized and run by contractors hired by Centers for Medicare and Medicaid Services (CMS). Ms. Reed noted that grievances are member complaints. The experience on the provider side may be different. Grievance data reflects only the grievances filed by members, and would not include provider concerns discussed in a joint operations meeting or something like that. Mr. Baackes asked that a work group be formed to find out how the feedback from trusted providers can be reconciled. Mr. Baackes sees the numbers, but also hears people saying that this is not the experience they're having.	
ADJOURNMENT	The meeting adjourned at 11:05 a.m.	

Respectfully submitted by:
Linda Merkens, *Senior Manager, Board Services*

APPROVED BY:

Malou Balones, *Board Specialist III, Board Services*
Victor Rodriguez, *Board Specialist II, Board Services*

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George Greene, Esq., *Chairperson*
Date Signed 3/19/2024 | 3:38 PM PDT

APPROVED