BOARD OF GOVERNORS

Compliance & Quality Committee Meeting

Meeting Summary – September 21, 2023

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***

Senior Management
John Baackes, *Chief Executive Officer*
Augustavia J. Haydel, *General Counsel*
Sameer Amin, *MD, Chief Medical Officer*
Thomas Mapp, *Chief Compliance Officer*
Terry Brown, *Chief of Human Resources*
Noah Paley, *Chief of Staff*
Todd Gower, *Interim Chief Compliance Officer*
Linda Greenfield, *Chief Product 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 2:12 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. Member Roybal asked for approval for remote participation due to an unforeseen hospitalization and subsequent immobility issues. He would like the committee to know that he is in a room by himself.	**The Committee approved by consensus Dr. Roybal's remote participation.**
APPROVAL OF MEETING AGENDA	**The meeting Agenda was approved as submitted.**	**Approved unanimously by roll call. 3 AYES (Ballesteros, Booth, and Roybal)**
PUBLIC COMMENT	There was no public comment.	

APPROVED

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APPROVAL OF MEETING MINUTES	**The August 17, 2023 meeting minutes were approved as submitted.**	**Approved unanimously by roll call.** **3 AYES**
CHAIRPERSON REPORT • **Education Topics**	Chairperson Booth gave the following report: Chairperson Booth reported on the issues discussed during the meeting. She began by acknowledging Member Ballesteros, who had made an excellent point during the previous executive meeting regarding provider shortages and the overwhelming volume of provider opportunities in the healthcare industry. Dr. Amin had responded to this concern by emphasizing the need for practical solutions to address turnover-related issues and suggesting the prioritization and consolidation of these opportunities. He proposed organizing these reports in a manner that aligns with a physician's thought process and integrating them into the provider's workflow to streamline the process. Chairperson Booth emphasized the importance of organizing opportunity reports by listing each patient and their applicable opportunities, rather than listing each opportunity and the patients whom the opportunity applies. She suggested that this could be achieved with the help of technology, particularly computers, which can efficiently organize data as needed. The goal was to create an infrastructure that would centralize and make this healthcare-related data easily accessible to all healthcare providers. She acknowledged that implementing such a system would be a significant investment but believed that it would improve patient care, alleviate shortages, and simplify compliance processes. Chairperson Booth highlighted the challenge for providers of managing an increasing workload and the importance of working collaboratively with the health plan to make this investment a reality. She expressed the belief that such an initiative, based on technology and improved data management, would lead to better health outcomes, address social determinants of health, reduce duplication of services, and ultimately enhance health equity. Chairperson Booth underlined the potential for technology to transform healthcare and the need for collaboration to make it a reality. *Committee members did not submit any Education Topics for this meeting.*	
CHIEF COMPLIANCE OFFICER REPORT	Thomas Mapp, *Chief Compliance Officer*, and Compliance Department staff presented the Chief Compliance Officer Report: *(a copy of the full written report can be obtained from Board Services).* Mr. Mapp stated that the Chief Compliance Officer's report would consist of three components. The first component will address an education-related topic. He mentioned that in a previous meeting, a question had been raised regarding how the Compliance Department closes the loop on compliance issues from start to finish. To address this Michael Sobetzko, *Senior Director, Risk Management and*	

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	Operations Support, is scheduled to give a presentation and provide a case study illustrating how the compliance function typically operates. Mr. Sobetzko gave a report on Prevention, Detection, and Correction. Mr. Sobetzko highlighted the seven core compliance program requirements established by the Center for Medicare and Medicaid Services (CMS), which serve as the foundation of the compliance program. These requirements included having written policies and procedures, the presence of a compliance officer and compliance committee, effective training and education programs, clear lines of communication, well-publicized disciplinary standards, routine monitoring and auditing, and procedures for prompt responses to compliance issues. Mr. Sobetzko discussed the importance of aligning these core principles with the concepts of prevention, detection, and correction. He stated that while it is impossible to eliminate all risks and issues in their dynamic business environment, the compliance program's ability to prevent, detect, and correct these issues is essential. He described their approach to prevention, which involved annual policy reviews, updating policies to align with changing business requirements, and providing training and education to employees and providers. Effective lines of communication were maintained, and compliance and ethics hotlines were available for reporting issues. In terms of detection, Mr. Sobetzko discussed the importance of effective systems for routine monitoring, auditing, and identifying compliance risks. He explained the processes for internal investigations, conflict of interest management, and monitoring delegates to ensure compliance. Mr. Sobetzko spoke about operational controls, which serve as the foundation for detecting compliance issues and monitoring performance. He emphasized that operational controls are the initial line of defense in detecting potential compliance problems. These controls are vital for ensuring that the organization's activities are conducted in accordance with regulations and policies. He stressed the significance of capturing and tracking compliance issues as they arise. These issues can originate from various sources, including fraud, waste, abuse, or other types of noncompliance. He noted the role of the Special Investigation Unit in investigating allegations of fraud, waste, and abuse. This unit plays a crucial part in addressing compliance issues and ensuring they are properly handled. He said that the role of data analytics in identifying potential compliance risks and data-driven insights can help in proactively identifying areas that require attention and further investigation. Mr. Sobetzko discussed the importance of overseeing the compliance of delegates or third-party entities. Ensuring that delegates meet compliance standards is a key component of overall compliance management. He mentioned that internal audit plays a critical role in the compliance framework. Internal auditors conduct annual audits and validate identified risks. They are an essential part of the third line of defense within the organization. Mr. Sobetzko then emphasized the significance of the multiple lines of defense in maintaining compliance within the organization. He stressed that compliance does not start with the compliance department but begins in the operational and business areas where controls	

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	and processes are established. He presented a case study to illustrate the comprehensive process of addressing compliance issues. This case study showcased the steps taken from detecting an issue to correction and prevention. The case involved a backlog of cases in the Provider Quality Team. The corrective actions included staff training, improved case management, and enhanced case screening. Mr. Sobetzko discussed various preventative measures. These measures included better initial screening and triage processes, reducing manual processing, and potentially automating certain tasks. These steps were aimed at preventing future compliance issues and enhancing the overall effectiveness of the compliance program. He emphasized the need for a multifaceted approach to compliance management, involving various levels of oversight and proactive measures to ensure the organization's ongoing compliance with regulations and policies. Mr. Mapp stated that the presentation's goal is to illustrate how compliance issues progress through the organization. Member Ballesteros asked about the three lines of defense. He asked if those include L.A. Care employees or delegated entities. Mr. Sobetzko responded that they are L.A. Care employees, but some functions are delegated. Member Ballesteros asked if L.A. Care is being compliant. He noted that at some levels L.A. Care is responsible. If they are L.A. Care's delegated entity L.A. Care is responsible. Does L.A. Care have resources to provide training and oversight? Ms. Sobetzko responded that L.A. Care is able to provide oversight, but as far as training, he explained that training is provided to delegates when policies and procedures change or new implementations require their involvement. There are teams responsible for delegate oversight and delegation audits to monitor and audit delegate performance. Mr. Mapp stated that larger delegates tend to handle this better, especially those with prior experience working with the organization. However, smaller delegates, especially in community support areas, often lack experience in dealing with compliance and reporting issues. In such cases, the organization steps in to help them meet their obligations. He mentioned that some delegates lack the background in developing policies and systems controls, and in these cases, the health plan provides guidance to improve their readiness for audits. In high-risk scenarios, they may even engage in more hands-on assistance to ensure compliance and risk management goals are met. Miguel Varela Miranda, *Senior Director, Regulatory Compliance*, and Marie Mercado Grijalva, *Manager, Regulatory Analysis and Communications*, gave a report regarding operational readiness and the 2024 contract. They discussed the progress made and plans for the upcoming operational readiness activities for the medical line of business. Ms. Grijalva highlighted that they received approval to go live on January 1, 2024, based on their current submissions during the operational readiness process. However, this approval was contingent on completing the process, and there were still pending submissions and artifacts. They were reviewing the 2024 contract updates received in July to ensure	

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	proper preparedness. By the end of August, they had submitted 213 artifacts, with 194 approved, and one remaining submission scheduled for December 29. There are additional artifacts pending due dates, which might be requested in the upcoming months or next year, especially for elements like emergency preparedness. The report also covered their recent call with CMS (Centers for Medicare & Medicaid Services), where they provided updates on changes and readiness for the open enrollment period. The call was successful, and CMS expressed confidence in their readiness, with no significant concerns raised. Regular monthly meetings were held with CMS to address any issues or observations. Richard Rice Jr., *Director, Delegation Oversight Performance Monitoring and Account Management*, reported on the enhancements being made to the notice of non-compliance and corrective action processes. Currently, the department has a communication team responsible for sending out notices of non-compliance and tracking them with business units. They are also working on tracking corrective action plans (CAPs) issued by internal business units to delegates, ensuring proper remediation. The proposed changes involve centralizing the tracking of notices and CAPs. They plan to re-establish the Delegation Oversight Committee to provide a more formalized structure for tracking corrective action plans and audit performance for each delegate. The new committee, expected to be re-established by November 1, will comprise members from different business units, including finance, compliance, and monitoring teams. The committee will have access to a dashboard spreadsheet to monitor the status of corrective actions and assess delegate performance. These enhancements aim to improve oversight and accountability in compliance processes.	

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CHIEF MEDICAL OFFICER REPORT	Dr. Amin gave a Chief Medical Officer Report. Dr. Amin highlighted two major areas of concern. The first issue he addressed was related to the vendor for utilization management platform. Dr. Amin stated that the purpose was to have a unified utilization management platform and provider portal but expressed concerns about the vendor's inability to meet L.A. Care's requirements. He also mentioned that the vendor was acquired by Up Health and later went public. Dr. Amin shared that the organization had been closely collaborating with the vendor, particularly since the beginning of 2023. They worked on streamlining their demands to expedite the platform's completion, focusing on regulatory and compliance requirements for community support. Weekly meetings at an executive level and frequent workgroup meetings were part of the strategy, with an aggressive timeline set for completion by December. Dr. Amin explained the critical role of their platform in authorizations, referrals, and provider interactions and the potential compliance and cost issues if the system malfunctioned. He also mentioned the challenge of the delays in rolling out the provider portal. Dr. Amin shared their optimism about meeting their goals and addressed the recent bankruptcy filing by Up Health, reassuring the committee that they had contingency plans in place and the situation was under control. Regarding the second area of focus, Dr. Amin discussed the ongoing refinement of activities related to appeals and grievances. The health services team was collaborating closely with Acacia Reed's team to improve information retrieval from the appeals and grievances function. They had appointed a medical director to review and triage grievances, enhance analytics, and extract data from appeals and grievances. Dr. Amin spoke about the institution of more meetings and better categorization for quality service and quality of care issues to reduce the number of grievances effectively. He highlighted the positive outcomes of these efforts, including a significant reduction in cases from 800 to a more manageable range of 50-600. Dr. Amin expressed enthusiasm for the collaboration between health services and Appeals and Grievances, considering it the beginning of fruitful refinement activities.	
ACCESS AND AVAILIBILITY	Priscilla Lopez, *Manager, Quality Improvement Accreditation, Quality Improvement,* gave a presentation on Access and Availability *(a copy of the full written report can be obtained from Board Services).* Dr. Amin introduced Ms. Lopez, who serves as the Manager of Quality Improvement Accreditation in the Quality Assurance department. Dr. Amin emphasized the significance of the access and availability survey, especially in terms of primary care providers (PCP) and specialty access. He described their new aggressive approach to addressing these issues and highlighted the detailed nature of the survey report. Dr. Amin noted that providing line-level details about who is failing and where improvements are required was a novel aspect for the committee, as compared to vendor surveys conducted in the past. Following his comments, Dr. Amin introduced Ms. Lopez to lead the discussion.	

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	Ms. Lopez reported on the following items *(a copy of the full report can be obtained from Board Services.):*
	Access to Care
	• Regulatory Guidelines
	  – Standards
	  – Performance Goals
	• Deep Dive
	  – Performance by PPG/PP/DN and Line of Business
	  o PCP
	  o SCP
	  o After Hours
	• Remediation Plans
	  – Prior and Current Enforcement
	  – Communication
	• Improvement Plan
	
	Ms. Lopez's discussed the review of measurement year 2022 access to care survey results. She introduced the regulatory guidelines and standards set by DHCS and the methodology for administering the annual access to care survey. The report outlined accessibility standards for different provider groups, emphasizing the importance of compliance. Ms. Lopez presented performance goals and standards, highlighting that the minimum rate of compliance was set at 80% and the annual calculation aimed for statistically significant improvements. The report provided an overview of aggregate performance by measure, identifying areas that needed improvement. She explained the annual survey process, which involved conducting surveys from October to December and receiving results by Spring. Corrective action plans were developed based on these results and shared with provider groups. Quarterly oversight and monitoring were implemented to bring noncompliant providers into compliance. She spoke about the performance of provider groups by access to care standards, emphasizing the need for action in certain areas. Her report mentioned specific zip codes and the compliance status of different provider groups for various standards. It was noted that red indicators signified areas that required immediate attention. Ms. Lopez expressed her concern about the amount of red indicating noncompliance and the need for prompt action. They discussed issues related to delegates and the importance of getting specialists in the network to take action. She stressed the importance of working closely with the vendor to ensure accurate survey results. Ms. Lopez highlighted the need to loop back with the vendor for a clearer picture of the situation. Remediation plans were expected to address these challenges, and the report shared an example of a report card and communication sent to noncompliant provider groups.	

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	Member Roybal asked if L.A. Care tracks the number of patients empaneled with each provider. He pointed out that an over-impaneled situation might make it challenging for patients to secure available time slots. Dr. Roybal was curious if L.A. Care conducts such tracking and whether it considers whether providers are contracted with the plan. He asked for information on whether they inquire about the total number of patients per particular provider. Mr. Paley acknowledged that tracking the panel size of primary care providers is relatively straightforward. The organization systematically monitors the panel sizes of providers across all lines of business. L.A. Care also has mechanisms in place to close panels when they reach a certain limit, currently set at 2,000 members, with the possibility of extension when associated with a mid-level provider by 1,000. He explained that they track the overall number of patients assigned to a particular PCP, whether through their plan partners or their direct network. They have established procedures to address panel closure when size limits are reached. Dr. Amin stated that the situation is complex with the specialty network since they are often contracted through delegates who must demonstrate network adequacy. However, network adequacy does not necessarily guarantee sufficient appointment availability. Managing this aspect becomes part of their delegation oversight function, and acquiring such information can be difficult outside of comprehensive surveys. Member Roybal had a follow-up question regarding whether the organization has data or conducted an analysis on providers or groups that consistently fail to meet the availability standards. He inquired whether L.A. Care assesses its alignment with the standards and whether, even if they have a panel size of 2,000 members, they would consider reducing it to 1,800 or a different number if they cannot meet the timeliness access standards. Mr. Paley stated that that is precisely the rigor that L.A. Care is partaking in with access to care information. L.A. Care is developing a specific dashboard similar to the one created for the direct network for all delegated provider groups in various lines of business to connect results in access to care and utilization and look at panel size to coordinate a very focused discussion to improve a provider group's access that they are providing to members.	
ADJOURN TO CLOSED SESSION	Augustavia J. Haydel, Esq., *General Counsel*, announced the following items to be discussed in closed session. The JPA Compliance and Quality Committee meeting adjourned and the Compliance and Quality Committee adjourned to closed session at 3:35 P.M. PEER REVIEW Welfare & Institutions Code Section 14087.38(o) CONFERENCE WITH LEGAL COUNSEL—ANTICIPATED LITIGATION Significant exposure to litigation pursuant to Section 54956.9(d)(2) of Ralph M. Brown Act: Five potential cases THREAT TO PUBLIC SERVICES OR FACILITIES	

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	Government Code Section 54957 Consultation with: Thomas Mapp, Chief Compliance Officer, Serge Herrera, Privacy Director and Gene Magerr, Chief Information Security Officer CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION Pursuant to Section 54956.9(d)(1) of the Ralph M. Brown Act • Department of Managed Health Care Enforcement Matter Numbers: 18-799, 20-063, 21-428, 21-509, 21-680 • Department of Health Care Services, Office of Administrative Hearings and Appeals, In the matter of: L.A. Care Health Care Plan Appeal No. MCP22-0322-559-MF	
RECONVENE IN OPEN SESSION	The Committee reconvened in open session at 4:37 p.m. There was no report from closed session.	
ADJOURNMENT	The meeting adjourned at 4:37 p.m.	

Respectfully submitted by:

Victor Rodriguez, *Board Specialist II, Board Services*
Malou Balones, *Board Specialist III, Board Services*
Linda Merkens, *Senior Manager, Board Services*

APPROVED BY:

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Stephanie Booth, MD.
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Stephanie Booth, MD, *Chairperson* 11/17/2023 | 12:06 PM PST
Date Signed: _____

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