BOARD OF GOVERNORS

Compliance & Quality Committee Meeting

Meeting Minutes – February 15, 2024

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

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

Senior Management
Augustavia J. Haydel, *General Counsel*
Sameer Amin, *MD, Chief Medical Officer*
Terry Brown, *Chief of Human Resources*
Todd Gower, *Chief Compliance Officer*
Linda Greenfield, *Chief Product Officer*
Alex Li, *Chief Health Equity Officer*
Michael Sobetzko, *Senior Director, Risk Management and Operations Support*
Edward Sheen, MD, *Senior Quality, Population Health & Informatics Executive, Quality Improvement*

** 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.**	**Approved unanimously 3 AYES (Ballesteros, Booth, and Roybal)**
PUBLIC COMMENT	*There was no public comment.*	

APPROVED

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
APPROVAL OF MEETING MINUTES	Chairperson Booth stated that she will send Board Services staff her corrections to the meeting minutes. **The Janaury 18, 2024 meeting minutes were approved as submitted.**	**Approved unanimously.**
CHAIRPERSON REPORT • **Education Topics**	Chairperson Booth gave a Chairperson's Report. Chaiperson Booth spoke about the challenges of frequently diverting attention from planned tasks to address new regulations. She emphasizes the need to efficiently implement and adapt computer systems to comply with these regulations. She suggests that the organization should assess the time spent on planned tasks versus new directives and advocates for a proactive approach in preparing for future requirements. She recommends decisive action in acquiring necessary resources, including personnel and funding, to support the organization's goals. She proposes a strategic allocation of budgetary resources to address administrative needs and streamline processes. She noted the importance of developing a comprehensive plan for equipment and infrastructure to enhance the organization's operational efficiency and ability to adapt to new regulations seamlessly.	
COMPLIANCE & QUALITY COMMITTEE CHARTER UDPATE	Mr. Gower stated that revisions are still ongoing. He mentioned the need for further discussion and collaboration before finalizing the charter. Mr. Gower notes that some discrepancies between internal and external charters need resolution for clarity and understanding. He expresses confidence in resolving these differences and aims to align the charter with the functions of the compliance committee.	
CHIEF COMPLIANCE OFFICER REPORT	Todd Gower, *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).* Overview • 2023 Year End Review • 2024 Compliance Work Plan (COM 100) • Training Update • Issues Inventory • Delegation Oversight Auditing • Utilization Management Compliance • Quality Initiative Compliance 2023 Year End Review	

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	Mr. Gower reflected on the significant changes in compliance over the past year. These changes include the introduction of the Enterprise Performance Optimization (EPO) team, the retirement of the former chief compliance officer, and his own appointment to the role. Notably, the separation of internal audit from compliance aimed to enhance the organization's focus on its third-line defense. Mr. Gower emphasized the importance of ensuring that controls and processes are effectively in place while hiring full-time staff to stabilize and mature compliance functions. Regarding regulatory audits and monitoring, Mr. Gower discussed the division of responsibilities into regulatory operations and risk management. The focus on developing dashboards and Key Performance Indicators (KPIs) demonstrates a commitment to improving regulatory oversight. The organization has also seen progress in risk management, with increased documentation and follow-up on monitoring and mitigation activities. Additionally, initiatives such as new provider onboarding and training have been established, with plans to refine delegation oversight in the coming year. Looking ahead to 2024, Gower anticipates operationalizing plans developed in 2023 and further refining compliance processes. He highlights the ongoing commitment to enhancing audit services and mentions the approval of a work plan by the committee. 2024 Compliance Work Plan & Motion An effective compliance program promotes an organizational culture that supports integrity, accountability, and ethical behavior. Compliance is not just a set of policies and procedures in a binder but is dependent on the behavioral norms of the organization in much the same manner as quality. Compliance is not entirely subjective; it is bound by clearly defined regulatory and corporate integrity standards. The framework can be broken down into 7 key elements. The seven elements of an effective compliance program are: • Implementing written policies, procedures, and standards of conduct • Designating a compliance officer and compliance committee • Conducting effective training and education • Developing effective lines of communication • Conducting internal monitoring and auditing • Enforcing standards through well-publicized disciplinary guidelines • Responding promptly to detected offenses and undertaking corrective action Work Plan Status 2023 Overview: Twenty Projects. Many of the projects touched significant portions of the OIG 7 elements, but left gaps in the work plan to make sure there is an effective Compliance Program.	

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	• Completed (seven): We would need to validate these projects for effectiveness. These projects tie to investigatory processes, Delegation Oversight communication enhancements, Risk Management processes and Privacy BAA reviews. • Started (11): These projects have either started in 2024 or were part of projects from 2023. Key projects tie to expanding usage of the current compliance workflow engine (SAI GlobalC360), Business Continuity/Disaster Recovery, Delegation Oversight, Internal Audit maturity, and Regulatory Operations maturity • Planning (Two): The remaining projects, which are tied to privacy and regulatory operations maturity. We should start these projects in 2024. 2024 Draft Compliance Work Plan 2024 Overview: 28 Projects • Testing effectiveness (seven): Work with Audit Services to validate these completed projects for effectiveness. These projects tie to investigatory processes, Delegation Oversight communication enhancements, Risk Management processes and Privacy BAA reviews. • 2023 Rollover (13): These projects have either started in 2024 or were part of projects from 2023. • New Projects (eight): These projects focus on the OIG 7 elements, Medicare Compliance and overall Corporate Compliance Mr. Gower presented motion COM 100 *To approve the 2024 Compliance Work Plan, as submitted.* Mr. Sobetsko gave a Compliance Training Update.	**Approved unanimously 3 AYES (Ballesteros, Booth, and Roybal)**

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN

January 2024	2023 Annual Compliance Training			2024 New Hire Compliance Training		
	# Complete	# Incomplete	Percentage Completed	# Complete	# Incomplete	Percentage Completed
L.A. Care Employees	1832	3	99.80%	1116	40	96.50%
L.A. Care Contingent Workers	231	11	95.50%	526	41	92.80%
Board of Governors	13	0	100%	N/A	N/A	N/A
Note: 3 incomplete are EE's on LOA						

Mr. Sobetsko gave an Issues Inventory update.

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

- Open – Issues confirmed by Compliance Risk Operations that require oversight and monitoring with business units.
- Closed to Inventory – Issues in which business units' are seeking guidance about a regulation or best practice process.
- Deferred – Issues in which regulatory guidance (DHCS, DMHC, or CMS) is pending to resolve or issue resolution is dependent on another business units' implementation of a system or process.
- Remediated – Issues that require formal or informal corrective action plans for resolution.

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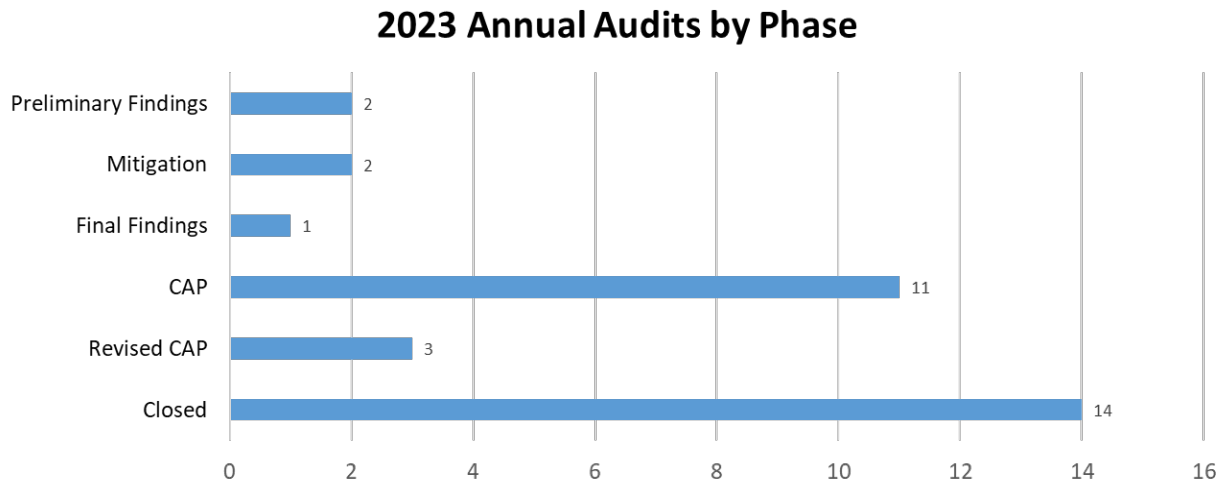
	• Tracking Only – Issues managed by other Compliance areas (such as Regulatory Affairs, Audits, Analysis, Communication and Internal Audit In which the risk management staff is following up for current status updates to closure. • Monitoring Only – Issues in which corrective action plans are completed and monitoring is to be done by Compliance Marita Nazarian, *Director, Delegation Oversight Audit,* gave a Delegation Oversight Audit update. 2023  2023 Delegating Oversight – Correction Action Plans (CAP) Validations CAP Validation occurs 60 days after CAPs are accepted.	

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	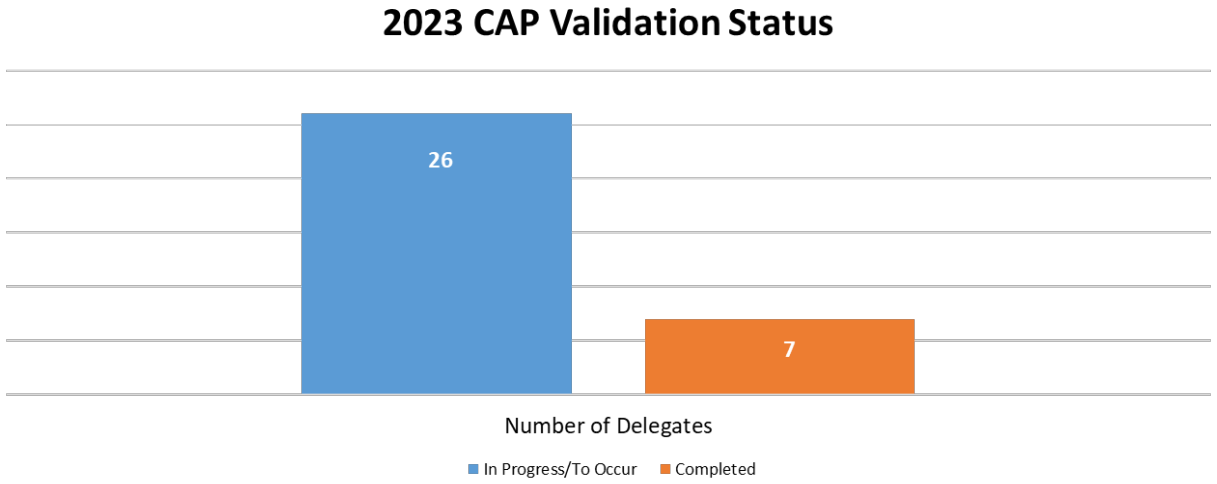 2023 Delegation Oversight Audits – Results Overview & Future Plans Delegates Areas of Success: • Cultural and Linguistics requirements • Privacy Policy and Procedures • Utilization Management Policy and Procedures and UM Programs Next Steps: Areas identified with repeat findings will undergo: • Deep dive into details of delegates findings. • Presentation to the Delegation Oversight Committee. • Collaboration with Delegation Oversight Monitoring team to develop metrics and monitor repeated findings. 2024 Delegating Oversight Audits: Outlook • 43 Audits scheduled from January – December • three D-SNP Risk Based Audits: 3 PPGs with highest D-SNP membership • Two Plan Partners • 30 PPGs • Eight SHPs/Vendors 2024 Risk Based Delegation Oversight Audit Scope:	

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- Past audit findings
- DSNP requirements
- NCQA requirements

Jennifer Rasmussen, *Clinical Operations Executive*, gave a Utilization Management Compliance update.

Authorization Request Timeliness Monitoring

Timeliness of Auth Decisions & Notifications	2023	Q1 2023	Q2 2023	Q3 2023	Q4 2023
All LOB (95%)	98%	97%	98%	99%	99%
Direct Network (MCLA subset: 95%)	97%	95%	96%	98%	99%
DSNP (95%)	97%	N/A	N/A	98%	96%

Description of Data: Overall timeliness for each LOB per quarter, all above goal of 95%
Relevance: Tight monitoring due to past enforcement action and CAPs in place for timeliness
Maintenance Activities:

- Leadership responsibility to monitor workflows and inventory daily, including holidays and weekends.
- Ongoing system improvements/streamlining opportunities within our current UM platform.
- Assessing UM inventory and staffing, ensuring UM has the team required to process incoming requests.

Quality Assurance – Letters (Letter Template and Content)

- Letters are a regulatory hot spot with history of findings and current CAPs. Heavy emphasis on inclusion of all required aspects for DMHC, DHCS, NCQA, and CMS for their LOB inclusions, respectively
- UM Actions:
  - Policy team established to monitor templates and audit samples for letter requirements to ensure regulatory compliance
  - Medical Director education with associated monthly audits assessing notice of action (NOA) verbiage appropriate
  - Letter library created and maintained by UM leadership in collaboration with MD team with NOA verbiage templates for MD use, ensuring consistency across MDs
  - Routine meetings with the MD team and quality to review audit fallouts or issues found

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Current Issues: QNXT Conversion (UM Platform Transition)

- SyntraNet to QNXT Transition Plan, planned for second half of 2024
  - Utilizing lessons learned from SyntraNet implementation in 2021, a team of leaders from each unit is participating in the planning and implementation
  - Multi-disciplinary UM team developing configuration requirements consisting of Sr. Director, Program Manager, Quality, Education, and various subject matter experts
  - Workgroup establishing a defined training plan for all staff, as well as focused education for specific areas/departments
  - Supplemental staffing requested to provide support for team education and transition, as productivity will be decreased due to virtual classroom time and learning a new system

Dr. Sheen gave a Quality Initiatives Compliance update.
Compliance Risk Summary – Open CAPs from Audits

Accreditation

- **NCQA Open CAP for 2023 Health Plan Accreditation survey: UM7B denial letters missing language**. The issue has already been corrected; half of files selected in the survey were actually prior to our updates and improvements taking effect.
- Accreditation is conducting mock file review prior to CAP survey to ensure all delegates are complying with letter language change

DHS

- **NCQA Discretionary Survey UM13C**: Not enough denial files to review per 8/30 methodology due to DHS eConsult specialty referral process

2021 DMHC Routine Survey

- **PASC-SEIU**: Implementation of procedures for overseeing delegated quality assurance functions. Inconsistency in QI policies and procedures being applied to PASC-SEIU product line when PASC-SEIU is accountable/applicable line of business.
- MCLA:
  1) PQR to implement reasonable procedures to investigate PQI in timely manner
  2) PQR to improve process to address confirmed quality issues identified in PQI referrals

Dr. Amin noted the complexities surrounding the referral process for specialty care within the healthcare system. He described how the absence of a prior authorization requirement led to delays in accessing specialists and raised concerns regarding members' appeals rights. To address these issues, a team implemented changes to separate clinical discussions from the process of getting patients referred to specialists. This involved creating two pathways: one for curbside discussions between doctors and another for obtaining prior authorizations. Dr. Amin explained the ongoing efforts to

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	refine these processes, ensuring clarity and adherence to established pathways. He said that the expected improvements following the implementation of new workflows and policies, aimed at resolving the identified issues and facilitating smoother referrals to specialty care. Chairperson Booth asked Dr. Amin if by "UM volume" he means "referral volume." Dr. Amin clarified that he was referring to referral volume through a different pathway. He acknowledged that due to the recent implementation of changes, there might not be enough volume passing through the system yet for auditing purposes. Dr. Amin anticipates that now that the process is fully separated, there should be sufficient volume soon. He concludes by expressing hope that this explanation clarifies the situation. Compliance Risk Summary – Provider Quality Review: Case Timeliness PQR team monitors timely case closure and risk by grouping cases into risk categories based on number of months cases have aged from dates PQIs are received • Annual FY 2022/2023 timely closure rate was 85%; during this reporting period, team was working on closure of backlog of untimely cases • Staffing has since increased to ensure timely closure and implementation of additional monitoring activities • FY Q1 2023/2024 timely closure rate: 99.6% Compliance Risk Summary – Provider Quality Review – Effective Actions • Upon completion of PQI review, the clinical reviewer, medical director, or peer review committee shall determine actions to address quality findings. - FY 2022/2023: 346 quality findings with 339 (98%) actions taken - Q1 2023/2024: 105 quality findings with 104 (99%) actions taken	

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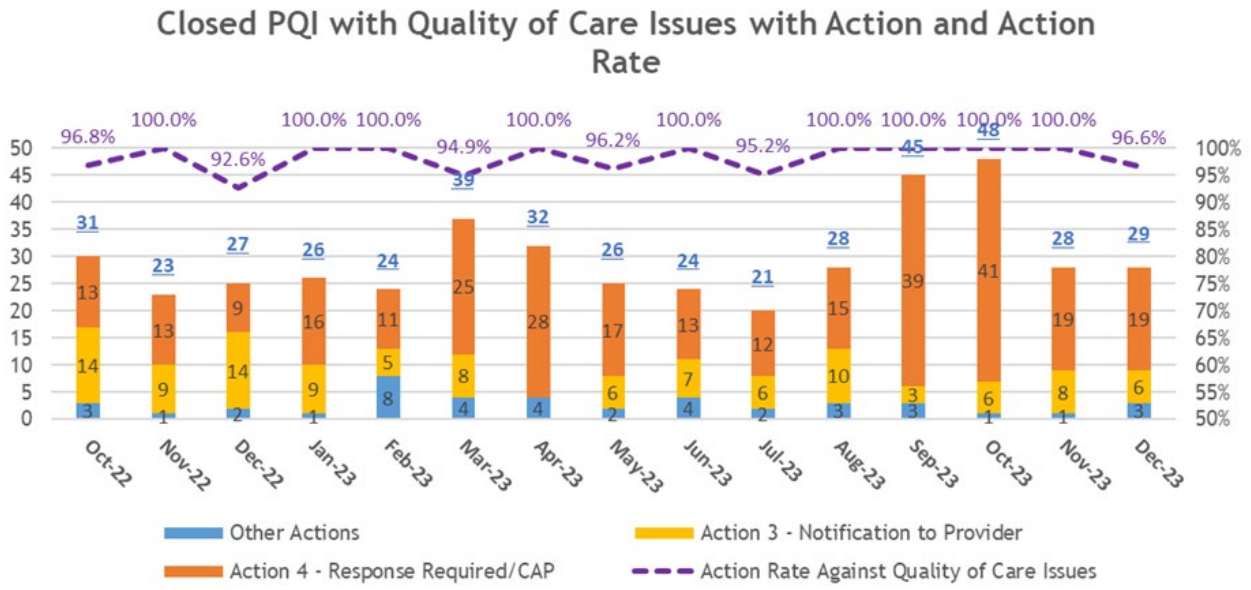

Compliance Risk Summary – Participating Physicians Groups, Delegate, and Vendor Issues

Team	Issue Summary
Accreditation	**NCQA**: Ongoing oversight of DHS eConsult process and generating enough files to review per NCQA survey methodologies
Accreditation	**Access to Care:** • PPGs with low survey response rates: Direct Network, Citrus Valley, and DHS • PPGs with delayed/no response to quarterly oversight and monitoring: Adventist Health Physicians and South Atlantic Medical Group
Initiatives	**Blood Lead Screening - Initial Health Assessments**: Rates have improved but still under 50th percentile; not all providers are meeting this level or responding to attestation requirement. Three delegated IPAs have not returned signed attestation.

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Access & Availability – Key Metrics: Access to Care: Annual Provider Appointment Availability Survey + After Hours

	MY 2022 L.A. Care Medi-Cal Compliance Rate	L.A. Care's Performance Goal	Variance
Primary Care			
Urgent	73%	84%	11%
Routine	88%	94%	6%
Preventive (Adult)	97%	98%	1%
Preventive (Child)	91%	94%	3%
Prenatal	96%	98%	2%
In-Office Waiting	99%	98%	-1%
Call Back	70%	80%	10%
Reschedule	96%	96%	0%
No Show Process	99%	99%	0%
Specialist			
Urgent	57%	80%	23%
Routine	72%	80%	8%
Prenatal	84%	96%	12%
In-Office Waiting	96%	97%	1%
Call Back	51%	80%	29%
Reschedule	92%	91%	-1%
No Show Process	98%	99%	1%
After Hours			
Access	76%	81%	5%
Timeliness	65%	80%	15%

Quality Measures – Financial Risk from new DHCS Policies

- L.A. Care received preliminary "intent to sanction" based on Medi-Cal Accountability Set (MCAS)
- Although L.A. Care was in highest tier for quality based on regional benchmarks, DHCS's sudden shift in methodology at end of the year was based on questionable methodology including unrealistic "100%" targets and benchmarks. This is basis for current appeal and widespread intense health plan concerns.
- For MY 2023 L.A. Care is at risk to miss MPL on 8 measures as two new measures with large gaps in state data required for management were added to MCAS Set
- Additionally for 2024, the Quality Withhold program will be in effect: early estimates of ~$15 million at risk.

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	Member Roybal suggested leveraging L.A. Care as a clearinghouse and developer of standardized procedures and guidelines to increase access to healthcare. He proposeed working with clinical pharmacists to provide care without the need for a provider visit, using established protocols compliant with nursing or pharmacy boards. Roybal suggests this strategy could alleviate the burden on primary care doctors and increase efficiency in patient care. He emphasizeed the importance of supporting practices by providing standardized procedures and compensation mechanisms for expanded care services. Member Roybal believes this approach could effectively enhance patient access to care, particularly through the utilization of nurse practitioners and clinical pharmacists. Dr. Amin acknowledged Member Roybal's suggestion as excellent and indicates that they are actively exploring its implementation. He confirms that the L.A. Care could serve as a platform for this initiative. Dr. Amin mentions a plan in progress to incorporate clinical pharmacists and nurse practitioners into the care process, aiming to reduce the number of visits required, especially for patients with complex health conditions. He also hints at potential funding mechanisms to support these efforts, indicating a commitment to facilitating expanded care services within primary care. Member Roybal noted that L.A. Care should also look at training in particular Registered Nurses on standardized procedures and standardized guidelines. Dr. Sheen thanked Member Roybal for his comments and confirmed that increasing access to healthcare is indeed a priority for L.A. Care. He mentioned ongoing discussions with the Pharmacy Deparment to optimize every interaction with members, focusing on health education and closing care gaps. Dr. Sheen emphasized their commitment to internal efforts to facilitate expanded care services, echoing Dr. Amin's previous remarks about their team's dedication. He highlighted the Community Resource Centers (CRC) as a valuable opportunity to involve various healthcare professionals, not just pharmacists and nurse practitioners, but also dietitians, care managers, dentists, and others. Dr. Sheen acknowledged the challenges of operationalizing team-based care models within the primary care environment due to reimbursement models and operational complexities. Quality Measures – Sanctions YTD as of January 5, 2024 Rates have improved recently which may lessen monetary impact for MY 2023	

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Measure Description	Measure Type	MY 2023 Admin Rate	YTD Admin Rate MY 2022	YTD MY 2022 vs MY 2023	50th%	MY2022
Cervical Cancer Screening (CCS)	H	50.10%	49.78%	0.32%	57.11%	51.26%
Follow-Up After Emergency Department Visit for Substance Use (FUA)	A	25.20%	21.89%	3.31%	36.34	26.15%
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	A	28.40%	28.74%	-0.34%	54.87	35.70%
Lead Screening in Children (LSC)	H	55.45%	53.72%	1.72%	62.79%	54.34%
Prevention - Topical Fluoride For Children	A	8.99%	0.24%	8.75%	19.3	0.28%
Well-Child Visits in the First 30 Months of Life (W30)	A	43.47%	43.03%	0.44%	58.8	45.63%
Well-Child Visits in the First 30 Months of Life (W30)	A	62.88%	61.61%	1.27%	66.76	62.64%
Child and Adolescent Well-Care Visits (WCV)	A	40.91%	37.83%	3.08%	48.07	46.64%

CHIEF MEDICAL OFFICER REPORT

Dr. Amin presented the February 2024 Chief Medical Officer Report *(a copy of the meeting materials can be obtained from Board Services).*

Dr. Amin, the Chief Medical Officer, provided a comprehensive update on the ongoing efforts to address appeals and grievances, which have been highlighted as significant areas of concern due to multiple audit findings. He emphasized that the entire team, including the grievances team, medical management team, and quality teams, has been actively engaged in meetings since 2023 to develop a completely new process and workflow to handle grievances effectively. The primary goal of this initiative is to address four major concerns identified in the audits comprehensively. Rather than just patching up small areas, the team aimed to completely rethink the process to build a better system for both members and internal teams. The four areas of focus included misclassifications of grievances, timely resolution of clinical grievances, immediate review of clinical grievances by a medical director, and timely resolution of confirmed quality of care issues. Over several months, the team collaborated extensively with the customer solution center (CSC) team to ensure the new process was comprehensive from the outset. This involved aligning on process changes to achieve regulatory compliance, enhance efficiency, and reduce the number of patient quality issues needing review. Additionally, a consultant previously involved in enforcement actions was engaged to review and validate the new process for compliance. The implementation of the new workflow includes modifications to policies and procedures, new desktop processes, and updated training materials for A&G teams and quality teams. New heads for appeals and grievances have been approved to hire clinical staff for the department, focusing on ensuring appropriate classification upfront and

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	reviewing/closing clinical grievances at the A&G level before escalation. Several key adjustments have been made to improve the process, including providing more robust technical definitions to the CSC, including an approved list of questions for better clinical information gathering, and adopting severity leveling criteria aligned with the team's standards. The development of a case summary based on clinical documentation, initial case leveling, and review by a medical director were also highlighted as critical improvements. The new process aims to ensure prompt and appropriate resolution of grievances, with emergent cases addressed immediately and others within a defined timeframe. Dr. Amin emphasized the importance of clearer communication with members regarding grievance outcomes, including providing formal member resolution letters for closure. Dr. Amin described the efforts as involving cross-functional collaboration and marked this as a watershed moment in improving how the organization deals with appeals and grievances. He noted that the newly approved heads are in the process of being hired and that staff have already been trained on the new process, which is set to be fully implemented in the next 30 days.	
CHIEF HEALTH EQUITY OFFICER REPORT • **Quality Improvement Health Equity Committee (QIHEC) Update**	Alex Li, *MD, Chief Health Equity Officer*, gave a Chief Health Equity Report *(a copy of the written report can be obtained from Board Services).* • In his report, Dr. Li provided an update on the newly formed Quality Improvement Health Equity Committee (QIHEC) which is a new 2024 DHCS managed care plan contract requirement.. He highlighted the key requirements which includes a greater participation among providers and also the inclusion of members. Given the new QI and health equity framework as well as the prescribed committee membership, L.A. Care combining two existing committees (Joint Performance Improvement Collaborative Committee (PICC) and Physician Quality Committee) and transitioned them to QIHEC. In addition to the structural changes, DHCS also required QIHEC to report to the Board of Governors and that our report and minutes be made available to public. The QIHEC's minutes are summarized for C&Q. In brief, the QIHEC policy was approved in November 2023, and this occurred at the first Quality Improvement Health Equity Committee meeting (November 2023). Dr. Li also briefly outlined the committee's composition which includes: L.A. Care staff, delegated plan partners, medical groups, DHS, FQHCs and members. At the QIHEC meeting, the committee reviewed L.A. Care's 2023-25 Health Equity and Disparities Mitigation Plan and Blue Shield Promise's health equity plan. QIHEC also reviewed reviewed the current set of QI corrective action plans, the CalAIM Enhanced Care Management Program, the Provider Incentive and the 2024 provider CME program.	
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	

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	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: Three potential cases THREAT TO PUBLIC SERVICES OR FACILITIES 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 4:22 p.m. There was no report from closed session.	
ADJOURNMENT	The meeting adjourned at 4:22 p.m.	

Respectfully submitted by:

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

APPROVED BY:

_____
Stephanie Booth, MD, *Chairperson*
Date Signed: _____

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