



**AGENDA
COMPLIANCE & QUALITY COMMITTEE MEETING
BOARD OF GOVERNORS**

Thursday, January 18, 2024, 2:00 P.M.

L.A. Care Health Plan, 1st Floor, CR 100, 1055 W. 7th Street, Los Angeles, CA 90017

Members of the committee, staff and the public can attend the meeting in person at the address listed above. Public comment can be made live and in person at the meeting. A form will be available at the meeting to submit public comment. Members of the Committee or staff may also participate in this meeting via teleconference or videoconference.

To listen to the meeting via videoconference please register by using the link below:

<https://lacare.webex.com/lacare/j.php?MTID=m6593ad26088aa76c605fced2ae939f52>

To listen to the meeting via teleconference please dial: +1-213-306-3065

Meeting number: 2482 719 7291 Password: lacare

Teleconference Site

All Ballesteros, MBA

5650 Jillson St., Commerce, CA 90040

G. Michael Roybal, MD, MPH

245 South Fetterly Avenue
Los Angeles, CA 90022

For those not attending the meeting in person, public comments on Agenda items can be submitted in writing by e-mail to BoardServices@lacare.org, or by sending a text or voicemail to (213) 628-6420.

If we receive your comments by 2:00 P.M. on January 18, 2024, it will be provided to the Committee members in writing at the beginning of the meeting. The chat message, text, voicemail, or email must indicate if you wish to be identified or remain anonymous, and must include the name of the item to which your comment relates. If your public comment is not related to any of the agenda item topics, it will be read in the general public comment agenda item.

The purpose of public comment is an opportunity for members of the public to inform the governing body about their views. The Committee appreciates hearing the input as it considers the business on the Agenda. All public comments submitted will be read for up to 3 minutes during the meeting. The process for public comment is evolving and may change at future meetings. We thank you for your patience.

All votes in a teleconferenced meeting shall be conducted by roll call.

If you are an individual with a disability and need a reasonable modification or accommodation pursuant to the Americans with Disabilities Act (ADA) please contact L.A. Care Board Services staff prior to the meeting for assistance by text to 213 628-6420 or by email to BoardServices@lacare.org.

WELCOME

Stephanie Booth, MD, Chair

- 1. Approve today’s meeting Agenda Chair
- 2. Public Comment *(please see instructions above)* Chair
- 3. Approve November 16, 2023 Meeting Minutes P.4 Chair
- 4. Chairperson’s Report Chair
 - Education Topics
 - 2024 Committee Meeting Schedule
- 5. Chief Compliance Officer Report P.21 Todd Gower
 - Industry Update P.26 Chief Compliance Officer

- Compliance Program Plan P.27
- Delegation Oversight Monitoring P.29
- Issues Inventory Update P.33
- 2024 Internal Audit Plan **(COM 100)** P.37
- 2024 Risk Assessment **(COM 101)** P.50
- 2024 Compliance Program **(COM 102)** P.81

6. Chief Medical Officer Report P.114 Sameer Amin, MD
Chief Medical Officer
7. Chief Health Equity Officer Report P.133 Alex Li, MD
Chief Health Equity Officer
8. Quality Oversight Committee (QOC) Update Edward Sheen, MD
*Senior Quality, Population Health and
Informatics Executive*
9. Public Comment on Closed Session

ADJOURN TO CLOSED SESSION (Est. time 20 minutes)

10. PEER REVIEW
Welfare & Institutions Code Section 14087.38(o)
11. CONFERENCE WITH LEGAL COUNSEL—ANTICIPATED LITIGATION
Significant exposure to litigation pursuant to Section 54956.9(d)(2) of Ralph M. Brown Act:
Two potential cases
12. THREAT TO PUBLIC SERVICES OR FACILITIES
Government Code Section 54957
Consultation with: Todd Gower, Interim Chief Compliance Officer, Serge Herrera, Privacy Director,
and Gene Magerr , Chief Information Security Officer
13. CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION
Pursuant to Section 54956.9(d)(1) of the Ralph M. Brown Act
- Department of Managed Health Care Enforcement Matter Numbers: 18-799, 20-063, 21-428, 21-509, 21-680
 - Department of Health Care Services, Office of Administrative Hearings and Appeals, In the matter of: L.A. Care Health Care Plan Appeal No. MCP22-0322-559-MF

RECONVENE IN OPEN SESSION

ADJOURNMENT

The next meeting is scheduled on February 16, 2024 at 2:00 p.m.

Public comments will be read for up to three minutes.

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

THE PUBLIC MAY SUBMIT COMMENTS TO THE COMPLIANCE AND QUALITY COMMITTEE BEFORE DISCUSSION OF EACH ITEM LISTED ON THE AGENDA BY SUBMITTING THE COMMENT IN WRITING BY TEXT MESSAGE TO 213 628 6420, OR IN WRITING BY EMAIL TO BoardServices@lacare.org. Please follow additional instructions on the first page of this Agenda.

ACTION MAY NOT BE TAKEN ON ANY MATTER RAISED DURING THE PUBLIC COMMENT PERIODS UNTIL THE MATTER IS SPECIFICALLY LISTED ON A FUTURE AGENDA, according to California Govt Code Section 54954.2 (a)(3) and Section 54954.3.

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

Any documents distributed to a majority of the Board Members regarding any agenda item for an open session after the agenda has been posted will be available for public inspection at <http://www.lacare.org/about-us/public-meetings/board-meetings> and can be requested by email to BoardServices@lacare.org.

DRAFT

AGENDA and PRINTED MEETING MATERIALS ARE AVAILABLE FOR INSPECTION AT the Reception area off the main lobby at 1055 W 7th Street, Los Angeles, CA.

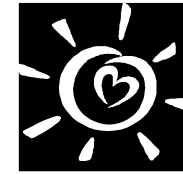
An audio recording of the meeting is made to assist in writing the minutes and is retained for 30 days.

Meetings are accessible to people with disabilities. Individuals who may require any accommodations (alternative formats - i.e., large print, audio, translation of meeting materials, interpretation, etc.) to participate in this meeting and wish to request an alternative format for the agenda, meeting notice, and meeting packet may contact L.A. Care's Board Services Department at (213) 628 6420. Notification at least one week before the meeting will enable us to make reasonable arrangements to ensure accessibility to the meetings and to the related materials.

BOARD OF GOVERNORS

Compliance & Quality Committee Meeting

Meeting Minutes – November 16, 2023



L.A. Care
HEALTH PLAN

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

John Baackes, *Chief Executive Officer*
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*
Michael Sobetzko, *Senior Director, Risk Management and Operations Support*

* Absent ** Via Teleconference

AGENDA ITEM / PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
CALL TO ORDER	<p>Chairperson Stephanie Booth, MD, called the L.A. Care Compliance & Quality Committee and the L.A. Care Health Plan Joint Powers Authority Compliance & Quality Committee meetings to order at 2:00 p.m.</p> <p>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.</p>	
APPROVAL OF MEETING AGENDA	<p>The meeting Agenda was approved as submitted.</p>	<p>Approved unanimously 3 AYES (Ballesteros, Booth, and Roybal)</p>
PUBLIC COMMENT	<p>There was no public comment.</p>	

DRAFT

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
APPROVAL OF MEETING MINUTES	The October 19, 2023 meeting minutes were approved as submitted.	Approved unanimously.
CHAIRPERSON REPORT	<p>Chairperson Booth gave the following report:</p> <p>She stated that she would like to ask the group what they would recommend to try to improve the system. Chairperson Booth said that if L.A. Care members are having difficulty getting their blood pressure they should be given blood pressure machines. They are cheaper than scales. She also thinks that better alignment with the medical profession complex can improve efficiency. If L.A. Care aligns better with doctors offices they can share best practices and it would save money. L.A. Care is constantly having to adjust to regulatory requirements. It is possible that this will allow everyone to address having to compete for employees.</p>	
COMMITTEE CHARTER REVIEW	Chairperson Booth stated that that the committee charter is still being reviewed. If necessary they can hold a special meeting on the matter.	
CHIEF COMPLIANCE OFFICER REPORT	<p>Todd Gower, <i>Interim Chief Compliance Officer</i>, and Compliance Department staff presented the Chief Compliance Officer Report (<i>a copy of the full written report can be obtained from Board Services</i>).</p> <p>He began by stating that the open session covers items related to annual training and provider training. Compliance has recently made changes regarding information gathering and presentation, with a focus on Internal Compliance Committee (ICC) procedures. Mr. Sobetzko will present the risk assessment process in January, and the internal audit program is being defined. The complete compliance program plan will be reviewed and approved in January. The report emphasizes a risk-based approach to compliance program review and auditing activities, particularly in delegation oversight. Mr. Gower highlights the stabilization of internal audit and the hiring of a new Director, aiming to bring in new personnel for internal audits.</p> <p>Mr. Sobetzko gave the following update:</p> <p>He discussed the provider training results during onboarding. There is a 10-day requirement for providers, applicable to both direct network and other providers. He reports a 100% compliance rate for direct network providers in September and October, attributing this success to a substantive change made in July, which made training compulsory before assigning providers to care members.</p>	

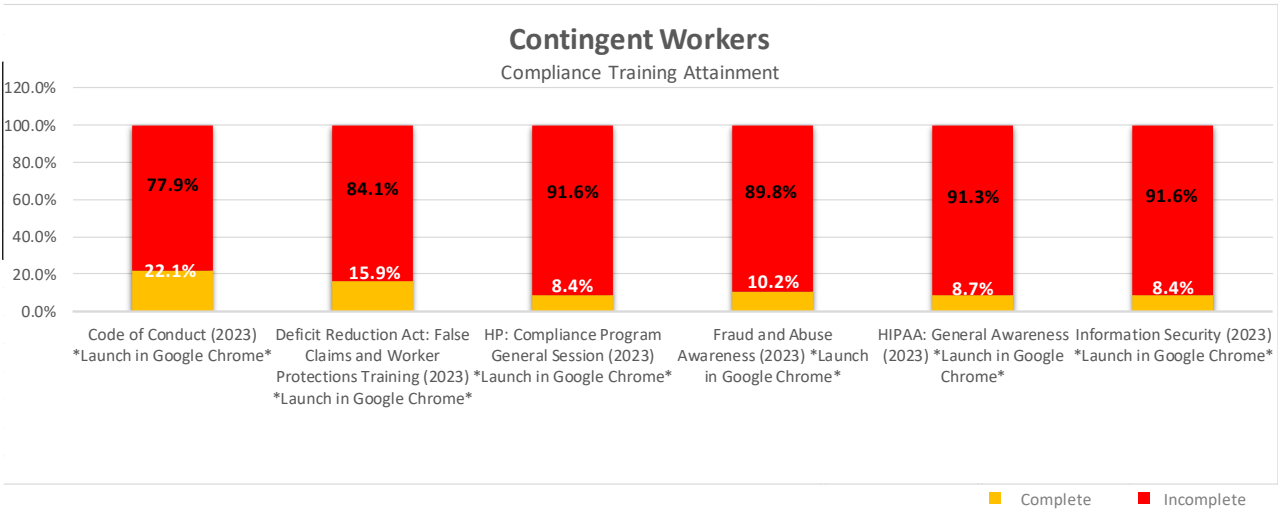
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	<p>Mr. Sobetzko noted the absence of a built-in requirement for participating physician group (PPG) training. Despite the diligent administration of training by the team, Theresa Moore, <i>Senior Manager, Engagement and Strategy, Compliance</i>, who was supposed to present, could not attend due to ongoing provider training. However, the report shows completion rates for primary care physicians (PCPs), specialists, and new industry providers, all at 100% in September, totaling 121 PCPs and specialists, along with 87 new industry providers. Mr. Sobetzko also mentions the need for corrective actions, illustrated by a non-compliance case with mental health in July and August. This triggered the initiation of a corrective action plan in September. While the mental health providers achieved a 100% completion rate for new providers, they will undergo a 90-day monitoring period to ensure the successful implementation of their corrective action plan.</p> <p>Chairperson Booth asked Mr. Sobetzko what exactly does L.A. Care train them to do. Mr Sobetzko responded that L.A. Care trains them to operate under our requirements and structure.</p> <p>Mr. Sobetzko gave a Compliance Training update.</p>	

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	<p style="text-align: center;">L.A. Care Staff (LAC)</p> <table border="1"> <thead> <tr> <th>2023 Annual Compliance Training:</th> <th>Completed</th> <th>Incomplete</th> <th>Attainment</th> </tr> </thead> <tbody> <tr> <td>Code of Conduct (2023) *Launch in Google Chrome*</td> <td>678</td> <td>1,205</td> <td>36.0%</td> </tr> <tr> <td>Deficit Reduction Act: False Claims and Worker Protections Training (2023) *Launch in Google Chrome*</td> <td>406</td> <td>1,480</td> <td>21.5%</td> </tr> <tr> <td>HP: Compliance Program General Session (2023) *Launch in Google Chrome*</td> <td>244</td> <td>1,642</td> <td>12.9%</td> </tr> <tr> <td>Fraud and Abuse Awareness (2023) *Launch in Google Chrome*</td> <td>328</td> <td>1,554</td> <td>17.4%</td> </tr> <tr> <td>HIPAA: General Awareness (2023) *Launch in Google Chrome*</td> <td>275</td> <td>1,608</td> <td>14.6%</td> </tr> <tr> <td>Information Security (2023) *Launch in Google Chrome*</td> <td>258</td> <td>1,623</td> <td>13.7%</td> </tr> <tr> <td></td> <td></td> <td></td> <td>19.4%</td> </tr> </tbody> </table>	2023 Annual Compliance Training:	Completed	Incomplete	Attainment	Code of Conduct (2023) *Launch in Google Chrome*	678	1,205	36.0%	Deficit Reduction Act: False Claims and Worker Protections Training (2023) *Launch in Google Chrome*	406	1,480	21.5%	HP: Compliance Program General Session (2023) *Launch in Google Chrome*	244	1,642	12.9%	Fraud and Abuse Awareness (2023) *Launch in Google Chrome*	328	1,554	17.4%	HIPAA: General Awareness (2023) *Launch in Google Chrome*	275	1,608	14.6%	Information Security (2023) *Launch in Google Chrome*	258	1,623	13.7%				19.4%	
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Contingent Workers (CW)			
2023 Annual Compliance Training:	Completed	Incomplete	Attainment
Code of Conduct (2023) *Launch in Google Chrome*	89	314	22.1%
Deficit Reduction Act: False Claims and Worker Protections Training (2023) *Launch in Google C	64	339	15.9%
HP: Compliance Program General Session (2023) *Launch in Google Chrome*	34	369	8.4%
Fraud and Abuse Awareness (2023) *Launch in Google Chrome*	41	362	10.2%
HIPAA: General Awareness (2023) *Launch in Google Chrome*	35	368	8.7%
Information Security (2023) *Launch in Google Chrome*	34	369	8.4%
			12.3%

Training Attainment	12.3%
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2023 Annual Compliance Training for the Board of Governors
 2023 – 2024 Annual Training for Board of Governors was rolled out on September 25, 2023. Due to an issue within DocuSign, the roll out was delayed until October 20, 2023. The integrated compliance training materials consist of;

- 1) General Compliance Information
- 2) Fraud, Waste and Abuse
- 3) L.A. Care’s Code of Conduct.

They currently have four out of 13 signed attestations from the Board. They will continue to educate employees, governing body members, delegates and vendors to satisfy the annual general compliance training requirements.

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	<p>Serge Herrera, <i>Director, Privacy, Compliance</i>, gave a Privacy Update. Incidents and Breaches</p> <table border="1" data-bbox="407 289 1671 574"> <thead> <tr> <th colspan="12">2023 PRIVACY VIOLATIONS</th> </tr> <tr> <th colspan="12">L.A. CARE</th> </tr> <tr> <th>L.A. CARE</th> <th>JAN</th> <th>FEB</th> <th>MAR</th> <th>APR</th> <th>MAY</th> <th>JUN</th> <th>JUL</th> <th>AUG</th> <th>SEP</th> <th>OCT</th> <th>TOTALS</th> </tr> </thead> <tbody> <tr> <td>Events</td> <td>2</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>1</td> <td>1</td> <td>3</td> <td>1</td> <td>1</td> <td>9</td> </tr> <tr> <td>Incidents</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>4</td> <td>0</td> <td>0</td> <td>1</td> <td>3</td> <td>0</td> <td>8</td> </tr> <tr> <td>Breaches</td> <td>1</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>1</td> </tr> <tr> <th colspan="12">BUSINESS ASSOCIATES</th> </tr> <tr> <th>Business Associates</th> <th>JAN</th> <th>FEB</th> <th>MAR</th> <th>APR</th> <th>MAY</th> <th>JUN</th> <th>JUL</th> <th>AUG</th> <th>SEP</th> <th>OCT</th> <th>TOTALS</th> </tr> <tr> <td>Events</td> <td>0</td> <td>0</td> <td>1</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>4</td> <td>0</td> <td>0</td> <td>5</td> </tr> <tr> <td>Incidents</td> <td>3</td> <td>1</td> <td>1</td> <td>2</td> <td>4</td> <td>1</td> <td>5</td> <td>5</td> <td>1</td> <td>6</td> <td>29</td> </tr> <tr> <td>Breaches</td> <td>1</td> <td>0</td> <td>1</td> <td>1</td> <td>0</td> <td>0</td> <td>1</td> <td>2</td> <td>1</td> <td>3</td> <td>10</td> </tr> </tbody> </table> <ul style="list-style-type: none"> - L.A. Care: Violations decreased during October with 1 event reported. The event involved 2 unencrypted emails to the correct recipient. Regulatory reporting was not required and the case has been closed. - Business Associates: Violations increased during October with 6 incidents and 3 breaches reported. The incidents involved unauthorized disclosures (2) and misdirected information (4). The 3 breaches all involved security attacks, 2 of which were part of Progress Software’s MOVEit breach. The attacks were reported by Blue Shield (2) and Independ Living Systems (ILS)(1). All 3 cases are still open and under investigation as they were reported during the end of October. <p>Mr. Sobetzko gave an Issues Inventory update. He addressed noncompliance issues related to interpreter availability and interpretive services. As of the end of October, work has commenced on a root cause analysis for issues such as dropped calls and incomplete connections during the transfer of interpretive services. The connectivity problems have been affecting calls, leading to a loss of interpretive services for members in need. While the root cause analysis is underway, the issue has not been resolved, and a finalized corrective action plan is pending. Mr. Sobetzko plans to provide an update on this matter in the next reporting period. Another issue he highlights is related to independent medical review forms for appeals and grievance cases. An internal review confirmed that some templates for these forms, provided by the Department of Managed Health Care, did not align or carry over to the independent medical review form. The compliance material review team is currently collaborating with Appeals & Grievance and the enterprise configuration team to address this issue. The focus is on coding and configuring the impacted templates to ensure proper connectivity with the independent medical review form. The specific templates affected have been identified, and the teams are actively working on resolving the discrepancies. Mr. Sobetsko stated that he discusses the ongoing process of revising templates, currently under review. The revised letters will be subjected to approval through the Podio platform, which serves as the internal workflow for communication material. Once approved internally, the</p>	2023 PRIVACY VIOLATIONS												L.A. CARE												L.A. CARE	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	TOTALS	Events	2	0	0	0	0	1	1	3	1	1	9	Incidents	0	0	0	0	4	0	0	1	3	0	8	Breaches	1	0	0	0	0	0	0	0	0	0	1	BUSINESS ASSOCIATES												Business Associates	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	TOTALS	Events	0	0	1	0	0	0	0	4	0	0	5	Incidents	3	1	1	2	4	1	5	5	1	6	29	Breaches	1	0	1	1	0	0	1	2	1	3	10	
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	<p>revised templates must be submitted to regulatory agencies for their approval, given the changes to preapproved templates. Mr. Sobetzko expresses hope that this process will be concluded by the next meeting. Addressing a query about the impact on different languages, Mr. Sobetzko acknowledges that he cannot confirm if all languages will be affected. However, he speculates that, from a process perspective, faulty templates in the initial English language are likely to be translated similarly. He emphasizes the importance of having templates come from a central source rather than being created by individual groups, expressing agreement with the sentiment that such a centralized approach would be more efficient.</p> <p>Mr. Sobetsko spoke about a past issue concerning a flu notice postcard that had an inappropriate prefix on the area code of the telephone number. While the mailing of those specific postcards has been resolved and corrected, internal discussions are ongoing to prevent a recurrence of such issues. The collaborative efforts involve marketing, compliance, regulatory affairs, and the material review team. They aim to implement a process ensuring that phone numbers are tested before inclusion in materials, preventing the distribution of any postcards or materials with untested phone numbers. Compliance has been working closely with the marketing team, and the process is currently in its second iteration of a corrective action plan. The final internal corrective action plan is scheduled for submission tomorrow.</p>	
CHIEF MEDICAL OFFICER REPORT	<p>Dr. Amin gave a Chief Medical Officer Report (<i>a copy of the meeting materials can be obtained from Board Services</i>).</p> <p>In Dr. Amin's Chief Medical Officer Report, he emphasizes the focus on quality measures. He discusses the achievement of regaining National Committee for Quality Assurance (NCQA) accreditation, highlighting the organization's transition to an accredited status across Medicaid, Medicare health maintenance organization (HMO), and the exchange line of business. The Medicaid line of business has earned a 3.5-star rating, while the Medicare HMO plan is now accredited as a 3-star plan. Dr. Amin also addresses the exchange line of business, which is also fully accredited with a pending CAP in April. He assures that the identified issue with a letter and notations has been or is in the process of being fixed. The report further covers the upcoming discretionary review of the oversight of Department of Health Services (DHS) in the April-May time frame, expressing confidence in retaining accreditation status during the conversation with regulatory agencies. In terms of quality measures, Dr. Amin discusses the growth of measures to 18 and the subsequent realignment into domains. He notes the organization's shift to a green tier, indicating improved performance and a positive outcome in terms of potential financial sanctions. Additionally, a quality project has been submitted to DHCS to address any underperformance within each domain, aligning with the Medicaid program's quality metrics. The overall message is one of accomplishment and progress in enhancing</p>	

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	<p>the quality of health services provided. He reported that New Benchmarks were released and several are higher. Department of Health Care Services (DHCS) updated their Auto Assignment (AA) Methodology which will likely lead to losses in membership. AA went from using 4 measure to 14 measures including and this includes Consumer Assessment of Healthcare Providers and Systems (CAHPS).</p> <p>Member Roybal asked Dr. Amin if he is also referencing L.A. Care Plan Partners when speaking about loss of membership. Dr. Amin confirmed. Member Roybal noted that in the past, Health Net has not done very well compared to L.A. Care and he expects them to also have these issues. Dr. Amin responds that the organization received the methodology for auto assignment about a month ago, and both the finance and quality teams are currently reviewing it to assess its implications. He expresses concerns about the numerous aspects that need attention and concentration in the upcoming changes. Dr. Amin highlights specific worries about the challenges faced by health plans, particularly in Medicaid, and the potential negative impact on CAHPS, not only in terms of patient response but also in making significant improvements. He emphasizes the difficulty in effecting changes, especially in areas focused on the provider group. He expresses a desire to avoid any negative consequences for the plan, given the inherent challenges that are primarily tied to how providers treat their members, making it crucial for the organization's overall performance. stated that L.A. Care just recently received the methodology.</p> <p>He notes significant improvements in clinical quality, enrollment experience, and plan efficiency and affordability management. Although the ratings are not final, there is optimism about achieving a 3-star rating in clinical quality, a 4-star in enrollment experience, and a 3-star in plan efficiency and affordability management. Dr. Amin attributes these positive trends to the hard work and performance of the team. Moving on to the Medicare line of business, Dr. Amin acknowledges challenges related to quality measures such as colonoscopies, mammograms, and cervical cancer screenings. Provider groups have shown a decrease in performance in 2023. The clinical quality team is actively working to address this issue, implementing pursuit lists and collaborating with vendors to improve member engagement and care.</p> <p>Despite the ongoing efforts, Dr. Amin emphasizes that there is still work to be done in the next two months over the holidays. He points out both highlights, particularly in pharmacy-related measures, and areas of underperformance among provider groups in certain quality measures, indicating a commitment to addressing these challenges for improvement.</p>	
QUALITY OVERSIGHT	Edward Sheen, MD, <i>Senior Quality, Population Health, and Informatics Executive</i> , gave a Quality Oversight Committee (QOC) meeting update.	

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
<p>COMMITTEE (QOC) UPDATE</p>	<ol style="list-style-type: none"> 1. Delegation Oversight Report: <ul style="list-style-type: none"> • Betsy Santana, Senior Manager of Clinical Initiatives, presented the partner and vendor oversight report, emphasizing continuous delegation oversight and quality improvement activities. • Anthem, one of the health plan partners, had 8 measures falling below the minimum performance level, including cervical cancer screening and adolescent immunizations. • Anthem identified root causes such as the residual impact of the COVID-19 pandemic, staff turnover, vaccine hesitancy, incomplete services during telehealth visits, and poor documentation. • Improvement plans are in progress, and Anthem aims to improve these measures by 5% in the next measurement year. 2. Audit Updates: <ul style="list-style-type: none"> • Blue Shield Promise had 7 measures that fell below the expected performance levels, resulting in the issuance of caps for 5 measures. • Kaiser performed better but did not meet expectations for 2 measures, leading to the issuance of caps for both. • Kaiser identified root causes, including a lack of parental understanding and systematic workflows for providers, and initiated projects for automated parental outreach and lab test ordering. 3. Follow-up Actions: <ul style="list-style-type: none"> • Anthem and Kaiser are working on quality improvement activities, with Anthem addressing residual impacts from the pandemic and staff turnover, while Kaiser is focusing on systematic workflows and parental engagement including building understanding. • Kaiser has launched a formal performance improvement project to increase follow-up after visits for mental health. <p>Dr. Sheen provided comprehensive updates on performance and improvement initiatives of health plan partners, showcasing a commitment to addressing identified challenges and implementing measures to enhance overall quality.</p> <p>Chairperson Booth requested clarification about incomplete visits. Dr. Sheen responded that there was a large volume of telehealth visits due to the pandemic and in most cases the visits were completed, but there are common challenges with telehealth visits and closing gaps in care. Many of them are not as comprehensive as in personal visits. Often there needs to be better documentation or patient self reporting to be able to close those gaps in care. And in many cases, because of that information is not being thoroughly documented or not being completely recorded as supplemental data. Those visits can be very positive for patients in other ways such as by expanding access to care and being more</p>	

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	<p>convenient. but they may not provide all the documentation and data needed to close those gaps in care to perform on these quality measures. To address this, the approach involves ongoing education and training for providers and patients to optimize telehealth interactions. Dr. Sheen anticipates improvement in reporting capabilities and stresses the need for increased productivity in telehealth visits. He notes the existence of data from various sources, such as patient records and provider charting, but highlights the importance of integrating this information into systems for comprehensive quality reporting. Even even in the realm of impersonal visits, there's a lot of supplemental data that needs to be more consistently and comprehensively recorded. And so it is a substantial area of opportunity.</p> <p>Chairperson Booth raises the issue of ownership and accessibility of the data layer, emphasizing the importance of having a comprehensive repository filled with relevant information. The suggestion is to enable individuals to address missing data or unanswered questions promptly, highlighting the significance of a robust and accessible data infrastructure.</p> <p>Dr. Sheen acknowledges the need for improvement in data collection and reporting and expresses a commitment to explore technology tools and platforms. He then introduced Thomas Mendez, <i>Director of Quality Performance</i>, who summarized the significant improvements in key metrics for measurement year 2022. Dr. Sheen highlighted positive trends but emphasized challenges, especially in telehealth-related gaps and specific measures like childhood visits, cancer screenings, and immunizations. Dr. Sheen outlined the identified root causes for metrics not meeting targets, including data challenges and underutilization of provider opportunity reports. He discussed ongoing interventions, such as social media campaigns, community events, and educational initiatives, to address gaps in care. Despite the challenges, he highlighted notable successes in meeting quality goals, emphasizing improvements in blood pressure control, childhood immunizations, and other key measures.</p> <p>Chairperson Booth inquired about the 20-point deficit in mental health follow-up visits and expressed curiosity about individuals or groups performing better. The member seeks insights into what strategies or practices might be contributing to their success, wanting to understand how they can learn and potentially implement similar approaches. Dr. Sheen responded to Chairperson Booth, acknowledging the struggles many healthcare systems face in mental health follow-up visits. He highlighted common challenges in data feeds after hospitalizations, emphasizing issues with patients' access to primary care providers and navigating the healthcare system. Dr. Sheen highlighted efforts to address these challenges, such as working on data flows, automating notifications, and incentivizing hospital partners to share data. Additionally, he mentioned ongoing initiatives in patient and provider education, expressing optimism about making progress despite the complexity of the issue.</p>	

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	<p>Dr. Amin added to the discussion by highlighting challenges related to quality metrics for follow-up after patients with mental health issues are discharged from the hospital. He explained that the difficulty often arises from including anyone with a mental health diagnosis in the denominator, even if it's not the primary reason for their hospitalization. This makes it challenging to ensure timely follow-up for mental health care. Dr. Amin mentioned a significant improvement initiative where contractual language with the behavioral health provider now includes quality markers, requiring them to proactively reach out to patients after discharge, particularly those falling within the denominator. This approach aims to enhance follow-up care for mental health issues and improve related quality metrics.</p> <p>Dr. Sheen continued his report, emphasizing a third highlight related to timely access to care. He highlighted Priscilla Lopez's, <i>Manager, Quality Improvement Accreditation, Quality Improvement</i>, efforts in creating a new report to monitor providers' refusals to participate in the Provider Appointment Availability Survey (PAAS). The report indicated a concerning trend, with a 2.1% increase in refusals overall, including a 3.4% increase among specialists and a 3% increase among behavioral health providers in 2022. Recognizing the potential impact on oversight and monitoring capabilities for access to care, Dr. Sheen identified a lack of provider education and training on the PAAS process as a potential root cause. Actions were already underway to address this challenge, including enhanced processes, additional education, and training. Refusals were now incorporated as an access to care measure in the corrective action plan system. Dr. Sheen concluded by providing updates on various committees, including credentials and peer review committee, pharmacy oversight committee, behavioral health quality committee, joint performance improvement collaborative committee, physician quality committee, steering committee, population health management team, quality performance management steering committee, and the star committee.</p>	
MEMBER EXPERIENCE SURVEY RESULTS	<p>Linda Carberry, <i>Manager, Quality Performance Management</i>, gave a report on L.A. Care's Member Experience Survey Results (<i>a copy of the full presentation can be obtained from Board Services.</i>).</p> <p>Medi-Cal CAHPS (Consumer Assessment of Healthcare Providers & Systems)</p> <ul style="list-style-type: none"> ▪ Adult & Child (Health Plan CAHPS) HPR (Health Plan Rating) ▪ Administered between February 18, 2023 and May 10, 2023 ▪ Final sample included 4,056 members (Adult) and 6,796 members (Child) <p>Adults completing survey: 652 Children completing survey: 740 NCQA response rates: 16.42% (Adult) & 15.14% (Child) Results Better than last year</p> <p>QHP EES (Quality Health Plan Enrollee Experience Survey) QRS (Quality Rating System)</p>	

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	<ul style="list-style-type: none"> ▪ Administered between February 17, 2023 and May 5, 2023 ▪ Final sample included 1,690 members <ul style="list-style-type: none"> - 213 completed survey - Response Rate: 18.23% <p>Similar rate as last year</p> <p>Preliminary Results: 4 Stars for Member Experience Covered CA line of business</p> <p>MAPD CAHPS (Medicare Advantage & Prescription Drug)</p> <ul style="list-style-type: none"> ▪ Not fielded in 2023 ▪ Contract changed from CMC (Cal Medi-Connect) to D-SNP (Dual Special Needs Plan) effective January 1, 2023 ▪ Members in the contract join on July 1, 2022 <ul style="list-style-type: none"> - Zero D-SNP members in the contract (still CMC members) ▪ We were therefore not permitted to field survey for DSNP in 2023 ▪ Next fielding of survey: 2024 <p>Medicare Advantage – D-SNP line of business</p> <p>Highlights Met: Adult & Child HP-CAHPS HPR (Health Plan Rating)</p> <ul style="list-style-type: none"> ▪ Satisfaction with Plan Physicians <ul style="list-style-type: none"> - Rating of Personal Doctor (Adult & Child) ▪ Effectiveness of Care <ul style="list-style-type: none"> - Flu Vaccinations for Adults ▪ How Well Doctors Communicate Composite for Adult <ul style="list-style-type: none"> - Doctor Explained Things - Doctor Listened Carefully - Doctor Showed Respect - Doctor Spent Enough Time ▪ Customer Service Composite for Adult <ul style="list-style-type: none"> - Customer Service Provided Information/Help - Customer Service Was Courteous/Respectful <p>Highlights Met: QHP QRS (Quality Rating System)</p>	

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	<p>Rating of Personal Doctor Rating of Specialist Rating of Health Plan Care Coordination</p> <ul style="list-style-type: none"> - Doctor Had Information - Doctor Discussed Medications <p>Brigitte Bailey, <i>Supervisor, Quality Improvement</i>, gave a report about L.A. Care’s Member Experience Improvement Efforts (<i>a copy of the full presentation can be obtained from Board Services</i>).</p> <p>Overview: Elevating Customer Experience Cross-Functional Team SullivanLuallin Group Patient Experience Trainings Meetings with PPGs and Clinics</p> <p>Elevating Customer Experience Cross-Functional Team (ECE CFT) Launched February 2022</p> <ul style="list-style-type: none"> - Convened by Dr. Katrina Miller Parrish. - Chaired by Linda Carberry, <i>Manager, Quality Performance Management</i>. <p>Goal: Bring together stakeholders across the organization to discuss all possible enterprise interventions, activities, and efforts focused on customer experience. Customers = <i>Members, Providers, Community</i>.</p> <p>Efforts:</p> <ul style="list-style-type: none"> - Fiscal Year 2022-2023 work plan. Drafting FY2023-2024 work plan in September. - Various presentations from departments on their customer experience efforts. - Vendor presentations on available products to support improvement of member experience. - Patient experience trainings <p>Teams attending include but are not limited to: Quality Improvement, Customer Solution Center, Communications, Marketing, Commercial Group Product Management, Medi-Cal Product, Medicare Product, Population Health Management, Care Management, Compliance, Health Equity and Provider Contracts.</p> <p>ECE CFT 2022-2023 Work Plan Five Main Priorities</p> <ol style="list-style-type: none"> 1. Improve the office visit experience 2. Expand access to care 	

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	<p>3. Ensure accountability for all network entities inclusive of Plan Partners, IPAs/PPGs, clinics, and provider network to prioritize customer experience</p> <p>4. Improve the member, provider, and community experience when engaging with L.A. Care</p> <p>5. Develop product-line specific strategies</p> <p>20 Strategies taking place across the organization identified to accomplish the 5 priorities.</p> <p>6. 16 departments with ongoing efforts</p> <p>Examples of strategies</p> <p>7. Patient experience trainings</p> <p>8. Improve measures around L.A. Care customer service</p> <p>9. Survey assessing public perception of L.A. Care</p> <p>10. Launch a Direct Network advisory board</p> <p>L.A. Care Quality Improvement team contracted with SullivanLuallin Group (SLG) in 2019 to deliver patient experience trainings:</p> <ul style="list-style-type: none"> • Trainings developed for • Managers/staff • Delivered by Thomas Jeffrey – President of SLG • Providers/clinicians • Delivered by Dr. Andrew Golden – Consultant with SLG <p><i>(a copy of the full report can be obtained from Board Services)</i></p>	
<p>POPULATION HEALTH MANAGEMENT (PHM)</p>	<p>Matthew Pirritano, <i>Director, Population Health Informatics</i>, and Steven Chang, <i>Senior Director, Care Management</i>, gave a report about Population Health Management (PHM) <i>(a copy of the full presentation can be obtained from Board Services)</i>.</p> <p>Mr. Pirritano discussed the key aspects of population health, emphasizing its comprehensive nature and evidence-based approach. He outlined the organization's goals for the past year and shared the performance results. The report included an overview of new surveys and requirements, such as the annual cognitive health assessment and all the Kelly and requirements. Mr. Pirritano highlighted the main areas covered under population health, including the creation of a member profile and a provider needs assessment, in compliance with DHCS requirements. He mentioned the monthly cross-functional team meetings to discuss related efforts across the organization. The report also touched on ongoing efforts, such as program evaluation as part of NCQA requirements. Looking ahead, Mr. Pirritano discussed the development of a new population health management index, a set of metrics tracked throughout the year. Closing the fiscal year, he shared that the organization achieved 13 out of</p>	

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	<p>16 goals, reaching the mid-tier target. This success contributes to staff bonus calculations, reflecting the team's dedication and hard work. Mr. Pirritano expressed excitement about the positive outcomes and acknowledged the collaborative efforts of the staff in achieving their targets.</p> <p>Mr. Chang discussed the significance of transitional care services within the vision for population health management. He highlighted recent revisions to include new populations, such as individuals receiving special mental health services, those undergoing substance use disorder treatment, members transitioning to and from nursing facilities, and extending pregnancy-related care to 12 months postpartum. For 2024, there is a shift in approach, aiming to provide transitional care services to all members. The proposed workflow involves offering these services to each member, with a simplified model to ensure effective coverage considering the vast membership. Notably, the assignment and availability of a care manager become the primary distinction between high-risk and low-risk members. For high-risk individuals, the plan is to assign a dedicated care manager for outreach. In contrast, the low-risk model for 2024 involves sending information sheets to members, potentially also to the facility. Mr. Chang mentioned that there is pending clarification on whether outreach to the facility where the member is admitted is required.</p> <p>Mr. Pirritano discussed the key performance indicators (KPIs) required by the state, providing an overview of how various health plans in the state are performing on these indicators. The KPIs include measures like the percentage of members with more visits than primary care and care management for high-risk members after discharge. The state provides thresholds, serving as either floors or ceilings for performance. Mr. Pirritano highlighted that their team is above the floor or below the ceiling for the specified metrics, indicating favorable performance.</p>	
<p>TRANSFORM LA AND PROVIDER ENGAGEMENT EFFORTS</p>	<p>Cathy Mechsner, <i>Manager, Practice Transformation Programs, Quality Improvement</i>, gave a report about Transform LA and Provider Engagement Efforts (<i>a copy of the presentation can be obtained from Board Services</i>).</p> <p>Transform L.A. is a value added technical assistance program focusing on:</p> <ul style="list-style-type: none"> ▪ Practice-Centered Transformation ▪ Data-Driven Quality Improvement ▪ Workflow Redesign ▪ Practice coach/facilitator model ▪ Modeled after the successful Transforming Clinical Practice Initiative (TCPI): ▪ CMS grant funded innovative quality improvement program, concluded in 2019 <p>Direct Network (DN) Practice Enrollment:</p> <ul style="list-style-type: none"> ▪ 19 primary care practices 	

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	<ul style="list-style-type: none"> ▪ 102 physicians ▪ 12,095 DN members (29% of total DN members) <p>Need to strengthen practice engagement</p> <ul style="list-style-type: none"> ▪ Created Recognition Program to increase practice engagement. <ul style="list-style-type: none"> - Up to \$30,000 incentive ▪ Restructured practice groupings <ul style="list-style-type: none"> - Transitioned from cohorts per enrollment year to levels of program progress: Low, Intermediate and Advanced ▪ Established time limit to complete program: 2-3 years <p>Practices continue to have challenges understanding QI</p> <ul style="list-style-type: none"> ▪ Reporting quality of care data from practice EMR ▪ Use of QI tools: <ul style="list-style-type: none"> - Plan, Do, Study, Act (PDSAs) cycles - Monthly QI review team meetings <p>High staff turnover contributes to poor performance</p> <ul style="list-style-type: none"> ▪ Care team members, office managers, physicians, etc. ▪ Sustaining practice QI knowledge and ongoing improvement is dependent on staff capacity <p>CQM/HEDIS Measure</p> <ul style="list-style-type: none"> ▪ HbA1C >9% (Poor Control) ▪ Working with Office Ally to correct erroneous data mapping. ▪ Impacts 8 practices <p>Next Steps:</p> <p>Education of new TLA Recognition Program</p> <ul style="list-style-type: none"> ▪ Ensure practices are fully apprised of Incentive program and are focused on achievement of program goals. <p>Leadership of Provider Engagement & Outreach workgroup</p> <ul style="list-style-type: none"> ▪ Continue cross QI team engagement to improve support of DN practices ▪ Solicit and incorporate Provider Advisory Collaborative feedback across QI programs <p>Continue to work closely with the Direct Network Administration team</p> <ul style="list-style-type: none"> ▪ Weekly meetings with the DNA 2.0 workgroup and CRM leadership to identify areas of partnership and resolve any challenges outside of the TLA program. ▪ Complete VIIP + DN Action Plan for improvements in: <ul style="list-style-type: none"> ▪ Domain 1: Adult Member satisfaction 	

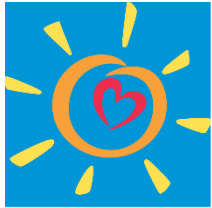
AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	<ul style="list-style-type: none"> ▪ Domain 2: Childhood Immunization Series 10 (CIS-10) Continue DN practice recruitment to grow the program 	
ADJOURN TO CLOSED SESSION	<p>Augustavia J. Haydel, Esq., <i>General Counsel</i>, announced the 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.</p> <p>PEER REVIEW Welfare & Institutions Code Section 14087.38(o)</p> <p>CONFERENCE WITH LEGAL COUNSEL—ANTICIPATED LITIGATION Significant exposure to litigation pursuant to Section 54956.9(d)(2) of Ralph M. Brown Act: Four potential cases</p> <p>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</p> <p>CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION Pursuant to Section 54956.9(d)(1) of the Ralph M. Brown Act</p> <ul style="list-style-type: none"> • 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	<p>The Committee reconvened in open session at 4:20 p.m.</p> <p>There was no report from closed session.</p>	
ADJOURNMENT	The meeting adjourned at 4:20 p.m.	

Respectfully submitted by:

APPROVED BY:

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

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



L.A. Care
HEALTH PLAN®

Compliance & Quality Committee (C&Q) Chief Compliance Officer Report

January 18, 2024

- In Person Only -

COMPLIANCE OFFICER OVERVIEW		
ITEM #:	DESCRIPTION:	OWNER / PRESENTER:
1	Chief Compliance Officer Comments	Todd Gower
2	Industry Update	Joni Noel, RGP
3	Compliance Program Plan Presentation for Approval	Todd Gower
4	Delegation Oversight Monitoring	Richard Rice, Jr.
5	Issues Inventory	Michael Sobetzko
6	Internal Audit Review <ul style="list-style-type: none">• 2023 Plan Close Out• 2024 Plan for Approval	Maggie Marchese
7	Risk Assessment Close Out 2023	Michael Sobetzko
8	Risk Assessment 2024 Plan	Michael Sobetzko
Complete Compliance Section to pass to CMO for the Quality Section		

Compliance & Quality Committee (C&Q)

Compliance Section – Open Session



L.A. Care
HEALTH PLAN®

For All of L.A.

January 18, 2024

Chief Compliance Officer Report

Summary of 2024 updates

- Compliance Organization Changes
- 2024 Risk Assessment
- Updated Compliance Program Plan
- Updated Internal Audit Plan from Audit Services

Compliance Program Mission and Vision

The Compliance Program is owned by the LA Care organization as a whole and includes compliance activities and efforts performed by all LA Care employees, board members and associated third parties. Below are the missions for both the Compliance Program and Department:

Compliance Program Mission

L.A. Care views compliance as a responsibility of all employees throughout the organization and will implement the appropriate systems and structures to provide all employees and business units support, advice and guidance to assure ethical and regulatory requirements are identified and met. L.A. Care shall operate as an ethical, compliant and transparent organization by fostering a culture of honesty and accountability, while adhering to the regulatory requirements governing our organization. Additionally, L.A. Care views compliance as the responsibility of all employees in order to help us achieve our mission to ensure all of L.A. Care's vulnerable population have the security of health insurance.

Compliance Department Mission

The L.A. Care Compliance Department shall be a strategic and collaborative business partner to the Board of Governors, employees and business units by providing advice, support and guidance on ethical and regulatory requirements as these groups make decisions and implement operations at L.A. Care. The L.A. Care Compliance Department will foster trust, honesty, ethics and integrity with all L.A. Care employees and third parties by providing guidance and counsel on compliance risks and their potential impact to L.A. Care, advice and support on implementing compliance best practices into operations, and the ability to report any potential compliance concerns confidentially and without fear of retaliation

Lines of Defense for L.A. Care

First Line: Risk and Lines of Business owners (i.e. Quality, UM, Finance, Claims)

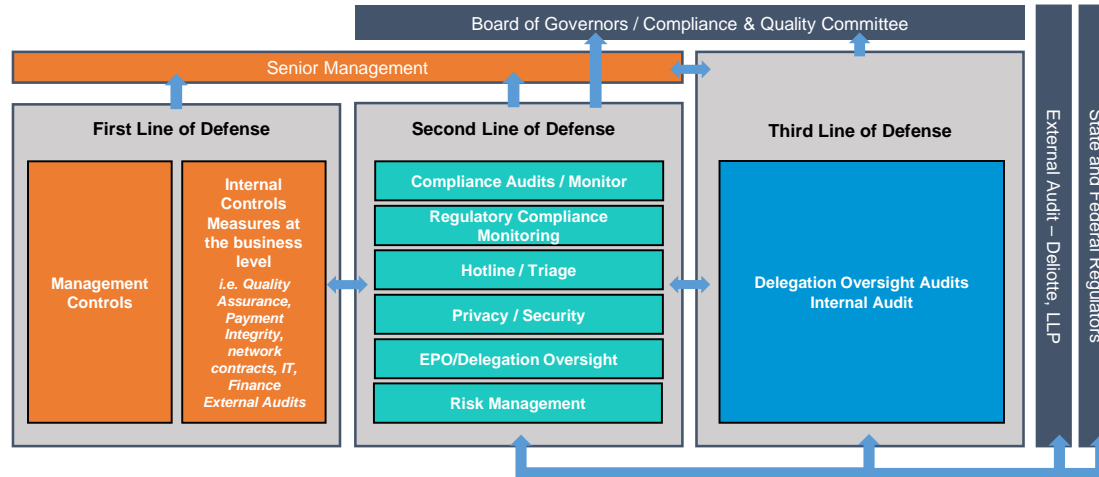
- The first line of defense (1LOD) is provided by front line staff and operational management. The systems, internal controls, control environment and culture developed and implemented by these business units is crucial in anticipating and managing operational and non-financial risks.

Second Line: Risk and Compliance Oversight

- The second line of defense (2LOD) is provided by the risk management and compliance functions. These functions provide the oversight and the tools, systems and advice necessary to support the first line in identifying, managing and monitoring risks.

Third Line: Risk assurance (Internal and External Audit/Regulators)

- The third line of defense (3LOD) is provided by Audit Services function. This function provides a level of independent assurance that the risk management and internal control framework is working as designed.



Industry Update



L.A. Care
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For All of L.A.

Presenter(s): Joni Noel, SVP – Healthcare,
RGP

Compliance Program Plan



L.A. Care
HEALTH PLAN®

For All of L.A.

Presenter(s): Todd Gower, CCO

Updated Compliance Program Plan

Key changes made to the plan for Approval by the Committee (see attached document)

- **Definition of Terms and References section**
- **Three Committees added:**
 - Delegation Oversight Committee
 - Risk Committee
 - Regulatory Implementation Oversight Committee
- **Responsibilities of the Compliance Department**
- **Risk Management Team further defined to include Issues Management and Provider Training**
- **Units that were assigned outside of Compliance are now updated in the plan reporting to Compliance:**
 - Delegation Oversight Monitoring reports to Regulatory Operations. This was previously named EPO
 - Delegation Oversight Auditing reports to Audit Services
 - Special Investigation Unit reports to Risk Management
- **Units assigned to Compliance now reporting to the CEO and C&Q**
 - Internal Audit
 - New Unit Audit Services is created to manage Internal Audit and Delegation Oversight Audit
- **Privacy is further defined with California confidentiality law, Privacy Officer defined Incident response & reporting**
- **Auditing and Monitoring further defined**

Delegation Oversight Monitoring



L.A. Care
HEALTH PLAN®

For All of L.A.

Presenter(s): Richard Rice, Jr.

Monitoring Summary

Through the joint Compliance Monitoring Program, Delegation Oversight Monitoring conducts delegate oversight of UM quantitative and qualitative measures based on regulatory requirements. Monthly, delegate Service Authorization Requests (SAR) logs are analyzed and scored for timeliness of decision-making and notifications to members. Qualitative monitoring is conducted through quarterly case file reviews of delegate SAR denials for appropriateness of decision-making and extensions taken, and contents of the Notices of Actions.

Quantitative Measures

The PPGs below were issued CAPS for being deficient for QTR 1/QTR 2 2023 for Quantitative measures. The description of issue table out lines the measures that were commonly noted as deficient during the CAP.

Order	PPGs Quantitative UM Caps in 2023Q1&Q2
1	AIPA - Angeles IPA
2	AHPN - Adventist Health Physician Network
3	AMHS – Alta Med Health Services
4	APIA - Allied Physicians
5	AXMG – Axminster Medical Group
6	BVMG - Bella Vista IPA
7	CFC - Community Family Care
8	CVPG - Citrus Valley Physicians Group
9	DHS – LA County DHS
10	EPDB - El Proyecto Del Barrio Inc.
11	GCMG - Global Care IPA
12	HCLA - Healthcare LA
13	LAKE - Lakeside Medical Group
14	OMNI - Omnicare Medical Group
15	PIPA - Preferred IPA of California
16	PROH - Prospect Medical Group (PMS)
17	PROS - Prospect Medical Group (MM)
18	REMG - Regal Medical Group

Description of Issue
<p><i>Not notifying Members of Expedited/Urgent Preservice Service Authorization Request Decisions within:</i></p> <ul style="list-style-type: none"> • Two Business Days of the Decision • Within 72 hours from Receipt of the Request
<p><i>Not notifying Providers of Standard/Routine Preservice Service Authorization Request Decisions within 24 Hours of the Decision*</i></p>
<p><i>Not notifying Providers of Expedited/Urgent Preservice Service Authorization Request Decisions within 24 Hours of the Decision*</i></p>

Qualitative Measures

The PPGs below were issued CAPS for being deficient for QTR1 /QTR2 2023 Qualitative Measures. The description of issue table outlines the measures that were commonly noted as deficient during the CAP.

Order	PPGs Qualitative UM Caps in 2023Q1&Q2
1	CVPG - Citrus Valley Physicians Group
2	PIPA - Preferred IPA of California
3	SC - Superior Choice Medical Group
4	APPL - AppleCare Medical Group, Inc.
5	PVMG - Pomona Valley Medical Group
6	AMHS – Alta Med Health Services
7	CFC - Community Family Care
8	DHS – LA County DHS
9	ECMG - Exceptional Care Medical Group
10	SEA – Memorial Care Select Health Plan

Description of Issue
Letter Content for Service Authorization Request Denials
Letter Content for Deferral Notices
Clinical Decision Making for Service Authorization Request Denials

Interventions (Qualitative and Quantitative CAPS):

- Delegation Oversight Monitoring continues to provide guidance to PPGs through feedback on CAPs, detailed feedback on case files reviews, and meetings with delegates as needed.
- Delegate rebuttals are addressed through PPG education, or revisions in results as needed.
- Delegation Oversight Monitoring will be working on the annual refresher training after Q4 reviews are completed

Issues Inventory Update



L.A. Care
HEALTH PLAN®

For All of L.A.

Presenter(s): Michael Sobetzko

Issues Inventory Update | Summary

Issues Reported in 2022 & 2023

176 items are listed in the Issues Inventory as of November 30, 2023⁽¹⁾

- **3** - New/In Review status:
- **49** - Open status:
- **0** - Issues Remediate
- **2** - Issues Closed to Inventory
- **0** - Issue Deferred

Issue Status	As of 10/31/2023	As of 11/30/2023
New	7	3
Open	44	46
Total New & Open Issues	51	49
	+	
Deferred	17	17
Remediated	99	99
Closed to Inventory	7	11
Total Inventory Count	174	176

(1) Includes issues reported in 2022 and 2023

Issues Inventory Update | Open Issues

Issue Name and Description	Date Reported	Business Unit	Status
<p>Alternate Format Selection Member Visual Impairment</p> <p>CMS Final Rule MA Requirements stipulate that D-SNP contractors must have a process for ensuring that Members can make a standing request to receive materials in alternative formats and in all non-English languages, at the time of request and on an ongoing basis thereafter. The regulation goes into effect 1/1/2024 and L.A. Care will not be compliant by this date.:(1529)</p>	11/29/2023	Cultural & Linguistic Humaira Theba, Naoko Yamashita	Open
<p>P2 Major Incident - Internal extensions 1472 and 1473 not working</p> <p>Internal transfers to Payment IVR extensions 1472 and 1473 are not working while doing direct transfers.(1525)</p>	11/1/2023	IT	Open

(1) Includes issues reported in 2022 and 2023

Issues Inventory Update | Closed Issues

Issue Name and Description	Date Reported	Accountable Exec./Business Unit	Closed Description	Date Closed
<p>Reconciliation Requirements for Physician Administered Drugs (PADs)</p> <p>On July 19, 2023, the Department of Health Care Services (DHCS) provided a notice of a Corrective Action Plan (CAP) to L.A Care Health Plan. for failure to meet Reconciliation Requirements for Physician Administered Drugs (PADs) Billed as Medical Claims (1527)</p>	11/15/2023	Acacia Reed, Erik Chase/Claims	DHCS confirmed L.A. Care demonstrated that it paid all clean claims and has met the minimum 90 percent of payment of all new claims. Therefore, DHCS closed the Corrective Action Plan (CAP) for the Failure to Meet Reconciliation Requirements for Physician Administered Drugs (PADs) Billed as Medical Claims as of November 15, 2023..	11/22/2023
<p>Provider Signature Requirement</p> <p>UM requested Provider signature requirement language for Medi-Cal and CMS Prior Authorization forms. (1526)</p>	11/6/2023	Tara Nelson, Stacey Reuter/UM	This issue was a guidance inquiry responded to by Regulatory Analysis and Communication unit.	11/21/2023

Internal Audit 2023 Close Out and 2024 Annual Work Plan



L.A. Care
HEALTH PLAN®

For All of L.A.

Presenter(s): Maggie Marchese

2024 Internal Audit Workplan

Role, Mission, Authority & Objectives

The Role of Internal Audit:

Internal Audit provides independent, objective assurance and consulting services designed to add value and improve the organization's operations. Internal Audit helps the organization accomplish its objectives by bringing a systematic and disciplined approach to evaluate and improve the effectiveness of risk management, control, and governance processes.

Mission & Authority:

The core mission of Internal Audit is to enhance and protect organizational value by providing risk-based and objective assurance, advice, and insight. In furtherance of this mission, the Internal Audit's Charter authorizes Internal Audit to have unrestricted access to all L.A. Care functions, activities, systems, records, property and personnel relevant to the performance of an audit, investigation or other special project.

2024 Internal Audit Workplan

Role, Mission, Authority & Objectives

Audit Plan Objectives:

The L.A. Care's Internal Audit developed a risk-based Annual Audit Work Plan with the following objectives in mind:

1. Improve the effectiveness of L.A. Care's governance, risk management, and control processes.
2. Assist L.A. Care's leadership in the discharge of their oversight, management, and operational responsibilities.
3. Assist management in addressing L.A. Care's financial, operational, and compliance risks and making informed risk acceptance decisions.
4. Support efforts to identify, evaluate, and mitigate risks.
5. Evaluate the existence, efficiency, and effectiveness of mitigating controls.
6. Provide assurance to management that internal controls are in place and operating as intended.
7. Add value and improve L.A. Care's operations.

2024 Internal Audit Workplan

Development Process

Development of the Audit Work Plan:

- Information considered in the development of the audit work plan includes previously identified or known risks and results from the 2024 risk assessment. Internal Audit also applied professional judgment to arrive at the projects ultimately prioritized in the 2024 Audit Work Plan.
- The audit work plan may be modified during the year as circumstances change. Also, new requests from management, changes in audit resources, and changes in L.A. Care's operations could result in updates to the audit work plan. Any significant updates to the audit work plan would require proper review and approval.
- Although the audit work plan contemplates a wide-ranging scope of review effort, it does **not** provide coverage for all components or systems. We attempted to maximize limited Internal Audit resources to provide reasonable coverage of the business activities and areas we believe require the most attention.

2024 Internal Audit Workplan

Development Process

Key inputs to the development of the 2024 Audit Work Plan:

- a. Industry knowledge and experience.
- b. Knowledge of control environment.
- c. Feedback from Compliance, including the Chief Compliance Officer, Risk Management and the Top 10 Risks analysis.
- d. Input/specific requests from L.A. Care's Senior Executive Leadership.
- e. Some rolled over audit projects from the RGP's 2023 Audit Work Plan.

NOTE: Internal Audit conforms to the mandatory elements of The Institute of Internal Auditors' (IIA) International Professional Practices Framework, including the Core Principles for the Professional Practice of Internal Auditing, the Code of Ethics, the International Standards for the Professional Practice of Internal Auditing (IIA Standards), and the Definition of Internal Auditing.

2023 Internal Audit Workplan - Status

A total of **17 IA projects** – This excludes projects to support Compliance such as Risk Mitigation follow-up activities and other Investigations.

- 4 completed
- 2 with draft or final audit reports being completed
- 11 moved to the 2024 audit work plan due to timing of availability, priority and preparedness to test

2023 Internal Audit Workplan - Status

Audit Activity	Risk Focus	Status	2024 Next Steps
Staffing / Talent Acquisition Process Assessment	Staffing	Completed	Follow-up Review 2024
Data Management Governance Audit – Phase 1	IT	Completed	Audit was split into 2 phases
Data Management Governance Audit – Phase 2	IT	Draft Report to be submitted	Open audit - Final audit report to be issued 2024
FWA and Cost Containment Program Assessment	FWA Payment Integrity	Completed	Final Report issued – Monitor CAP implementation
Delegation Oversight Auditing and EPO Delegation Oversight Monitoring Program Assessment	Delegation Oversight	On Hold	Open audit - Final audit report to be issued 2024
IT - Appropriate Access Controls Risk Mitigation Plan Effectiveness Review	IT	On Hold	Moved to 2024 audit work plan
Disaster Recovery / Business Continuity Risk Mitigation Plan Effectiveness Review	IT	3 rd Party Assessment being conducted	Moved to 2024 audit work plan
DSNP Program Assessment	Key Programs	3 rd Party Assessment being conducted	Moved to 2024 audit work plan

2023 Internal Audit Workplan - Status

Audit Activity	Risk Focus	Status	2024 Next Steps
Provider Network – Access	Network	Considered	Moved to 2024 audit work plan
Marketing and Member Services	Member Services	Considered	Moved to 2024 audit work plan
Provider Dispute Resolution Audit	Provider Network	Considered	Moved to 2024 audit work plan
Follow-up Assessment- Transportation Benefit Audit (NMT& NEMT)	Member Services	Considered	Moved to 2024 audit work plan
Follow-up Assessment – IT Security	IT	Draft report completed by 3 rd Party	Follow-up Review 2024
HICE Shared IT Integrity and Security Audits – 2023	IT	Ongoing Scoping with HICE and BSC	Ongoing audits - Moving to Delegation Oversight Audit work plan.
Added - Provider Quality PQI - Untimely Processing	PQI - Untimely Processing	Completed	Follow-up Review 2024
Added - Plan Partner Contracts Audit	Provider Network	Considered	Moved to 2024 audit work plan
Added - Prop 56 Assessment	Finance and PNM	Considered	Moved to 2024 audit work plan

2024 Internal Audit Workplan - Proposed

Summary: We propose a total of **19 projects** comprised of **7 audits**, **8 follow-up assessments**, and **4 Risk Mitigation Plan Implementation Effectiveness Review**.

Audit Activity	Risk Focus	Type	Focus Area - High Level Description	Target Quarter
Provider Network: Access to Care	Network	Audit	Moved from 2023 to 2024 AWP. Assess the adequacy and effectiveness of LAC's provider network in delivering timely and accessible healthcare services.	Q1
Provider Quality: PQI	PQI - Untimely Processing	Follow-Up Assessment	Follow-up of 2023 audit. Conduct a follow-up review based on the RGP's 2023 review to ensure observations have been addressed/remediated.	Q1
Marketing and Member Services	Member Services	Audit	Moved from 2023 to 2024 AWP. Assess the internal Sales & Marketing representatives' enrollment practices and needed enhancements/improvements.	Q1
Provider Dispute Resolution	Provider Network	Audit	Moved from 2023 to 2024. Regulatory Compliance (verifying that PDR process complies with regulations).	Q1
Call Center	Member Services	Audit	New. Review workplace management processes to assess effectiveness of staff monitoring of Member Services and Provider Services.	Q2

2024 Internal Audit Workplan - Proposed

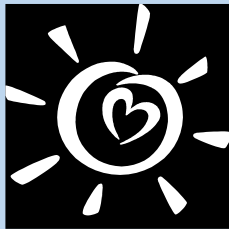
Audit Activity	Risk Focus	Type	Focus Area - High Level Description	Target Quarter
Provider Operations	Provider Operations	Audit	New. Review Provider Representatives' relationships/collaboration between Provider Network and QI teams.	Q2
HRA Reassessment Efforts	Provider Network	Risk Mitigation Plan Implementation Effectiveness Review	Moved from 2023 to 2024 AWP. Review process around HRA re-assessments efforts to ensure timeliness and compliance with applicable regulations.	Q2
Claims: Out-of-Area Emergency Services Claims	Claims	Follow-Up Assessment	Follow-up of 2023 audit. Conduct a follow-up review based on the RGP's 2023 review to ensure observations have been addressed/remediated.	Q2
IT: Appropriate Access Controls / IT System Security	IT	Risk Mitigation Plan Implementation Effectiveness Review	Moved from 2023 to 2024. Conduct an effectiveness review of risk mitigation plan implementation for risk # O19.	Q2
DSNP Implementation and Oversight	Key Programs	Follow-Up Assessment	Moved from 2023 to 2024. Under 3rd party review. Once it is completed, IA will follow-up on any findings/results.	Q2

2024 Internal Audit Workplan - Proposed

Audit Activity	Risk Focus	Type	Focus Area - High Level Description	Target Quarter
Appeals & Grievances: Process, Oversight and Support Systems	A&G	Follow-Up Assessment	Moved from 2023 to 2024. Under 3rd party review. Once it is completed, IA will follow-up on any findings/results.	Q3
Appeals & Grievances: Knox-Keene Violations	A&G	Follow-Up Assessment	Moved from 2023 to 2024. Under 3rd party review. Once it is completed, IA will follow-up on any findings/results.	Q3
Disaster Recovery / Business Continuity	IT	Follow-Up Assessment	Moved from 2023 to 2024. Under 3rd party review. Once it is completed, IA will follow-up on any findings/results.	Q3
Compliance Monitoring / Enforcement / Audits	Compliance	Follow-Up Assessment	Follow-up of 2023 audit. Assess corrective action plan implementation and remediation of 4Q23 mock CPE Program Audit.	Q3

2024 Internal Audit Workplan - Proposed

Audit Activity	Risk Focus	Type	Focus Area - High Level Description	Target Quarter
Vendor Management / Contracting Process	Vendor Mgt	Risk Mitigation Plan Implementation Effectiveness Review	New. Conduct an effectiveness review of risk mitigation plan implementation for risk # E5.	Q3
Plan Partner Contracts Audit	Provider Network	Audit	Moved from 2023 to 2024. Plan Partner contracting process	Q3
Staffing: Staffing / Skilled Hires / Time to Hire	Staffing	Follow-Up Assessment	Follow-up of 2023 audit. IA will conduct a follow-up review based on the RGP's 2023 assessment to ensure observations have been addressed/remediated.	Q4
Encounters/ Prop 56	Finance & PNM	Audit	Moved from 2023 to 2024. Assess current Finance Compliance oversight of the Prop 56.	Q4
LA Care Business Strategy - Strategic Alignment - Ability to Implement	IT	Risk Mitigation Plan Implementation Effectiveness Review	Moved from 2023 to 2024. Conduct an effectiveness review of risk mitigation plan implementation for risk #E1.	Q4



L.A. Care
HEALTH PLAN

Board of Governors
MOTION SUMMARY

Date: January 18, 2024

Motion No. COM 100.0224

Committee: Compliance and Quality

Chairperson: Stephanie Booth, MD

Issue: Approve 2024 Internal Audit Plan

New Contract **Amendment** **Sole Source** **RFP/RFQ was conducted in**

Background: The Internal Audit Plan summarizes the planned projects and activities as well as the audit schedule for 2024.

Member Impact: None

Budget Impact: None

Motion: To approve the 2024 Internal Audit Plan, as submitted.

Compliance & Quality Committee (C&Q)
2023 Risk Assessment
Top Risks Mitigation Review Close Out



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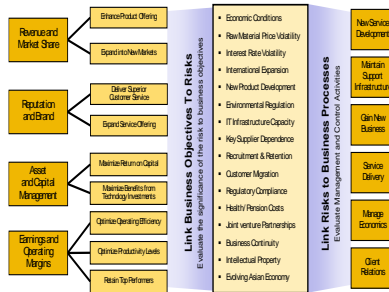
Presenter(s): Michael Sobetzko

Risk Assessment Process – Looking at 2023

Obtained Inputs- Market conditions, regulatory audits , prior assessments, SIU, Hotline, CAPs

- ▶ Market Factors and Implications
- ▶ Business Strategy Plans and L.A. Care Objectives
- ▶ Key Business Initiatives
- ▶ Key Business Processes

Mapped L.A. Care Strategic Objectives and Initiatives to Inherent Risks- Risk Universe and FY 22 Risks (where appropriate)

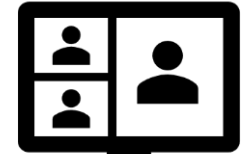


Created inherent risk profile to help inform questionnaire and criteria

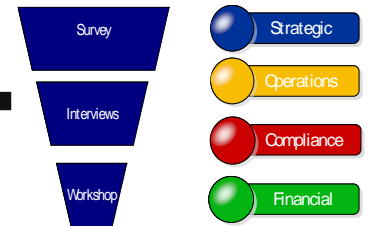
Refined Risk Assessment Criteria and develop a common vocabulary

Score	Rating	DEF	Source	Operational & Operational Scope	Relevant Report on Materiality to L.A. Care or to our stakeholders	Impact on Risk	Recovery
5	Critical	>100M	External/In-house report	Enterprise-wide, highly complex, non-routine business operations across the enterprise	Significant loss of customer confidence or loss of marketable goods	Complete market disruption	Partial resolution of liability
4	Significant	>100M	Recoverable, In-house, Semi-LA, 24/7/365	2 or more divisions, significant ongoing operations in business operations across the enterprise	Substantial loss of 2 or more marketable goods	25-50% reduction in market capitalization, needs to raise liquidity reserves	2 or more divisions or 50% reduction in market capitalization, needs to raise liquidity reserves, significant changes to strategy and operations
3	High	>50M	Recoverable, In-house, 24/7/365	1 or more divisions, Moderate impact with 1 or more divisions	Substantial loss of 1 or more marketable goods	10-25% reduction in market capitalization, minor liquidity call, the operations liquidity reserves	1 or more changes in operations, significant changes to strategy and operations
2	Medium	>20M	Temporary, In-house, 24/7/365	1 division, Limited impact with 1 division	United to incorporation loss of 1 marketable good	< 10% reduction in market capitalization, moderate liquidity reserves	Reformulation or adjustment to existing plans and operations
1	Low	<20M			United report		

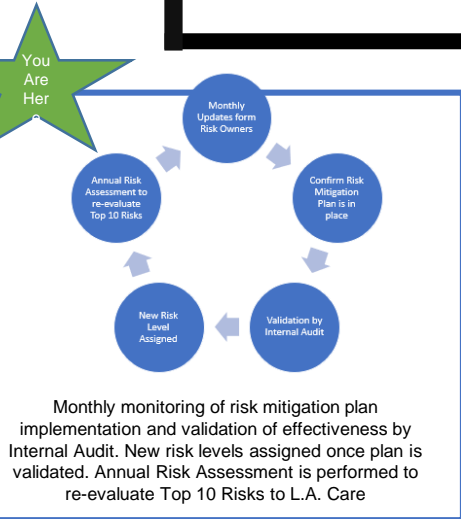
Conducted Focused Risk Assessment Interviews on top of the directed surveys



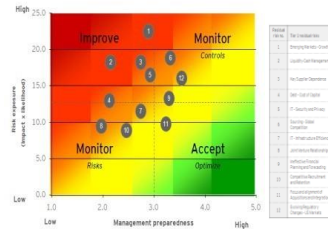
During Interviews shared results and feedback to Risk Owners



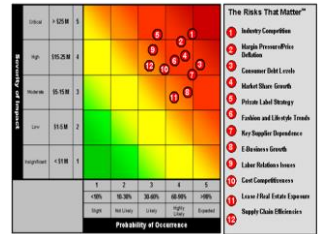
Assessed Key Business Risks with Responsible and Accountable Leaders Approved Risks



Monthly monitoring of risk mitigation plan implementation and validation of effectiveness by Internal Audit. New risk levels assigned once plan is validated. Annual Risk Assessment is performed to re-evaluate Top 10 Risks to L.A. Care



Developed Annual Monitoring Plan with the Top 10 Risks



Compiled updated Risk Assessment, Risk Profile and Risk Dashboard

Risk Management Update – Top Risks

Risk Mitigation Plan Status Key

Off Track Delayed On Track Validating Mitigation In Place

Risk #	Risk Title	Risk Mitigation Plan Status	Initial Risk Level	Current Risk Level	Comments
C2	HRA Assessment / Reassessment Timeliness	Delayed	Very High	Very High (based on 2024 Risk Assessment)	MCLA monitoring report development is delayed due to prioritization of D-SNP reports. This risk area is #9 on the list of 2024 Top 10 Risks and is included in the Internal Audit workplan for 2024.
C13	Compliance Program Effectiveness	Mitigation in Place	Very High	Medium: Needs Improvement	Internal assessment of 2021 CPE audit completed. Preliminary findings no longer reflect residual risk for original findings, but new lower-level risks were identified in the 2023 mock audit. A component of this will carry forward to 2024 monitoring activities.
O4	Provider Quality: PQI - Untimely Processing	Mitigation in Place	Very High	Medium: Needs Improvement	Internal Audit identified additional observations that impact PQI timeliness. Follow-up with risk owners began in late December 2023.
O20	Staffing: Staffing / Skilled Hires / Time to Hire	Mitigation in Place	Very High	Medium: Needs Improvement	Internal Audit completed the assessment and is working with HR Leadership on next steps for the follow-up review and opportunities for improvement. This risk area is #6 on the list of 2024 Top 10 Risks and is included in the Internal Audit workplan for 2024.

Risk Management Update – Top Risks

Risk Mitigation Plan Status Key				
Off Track	Delayed	On Track	Validating	Mitigation In Place

Risk # / Title	C2: HRA Assessment / Reassessment Timeliness
Risk Statement	Where HRA assessments are not completed timely, potential enrollees who need extensive care management interventions will not receive care or interventions. Also, the untimely completion will expose LA to regulatory violations.
Risk Owner(s)	Care Management: Steven Chang Customer Solutions Center: Rebecca Cristerna, Oscar Linares
Completed Risk Mitigation Activities	<ol style="list-style-type: none"> Workflows: Implemented new workflows for D-SNP and MCLA HRA completion <ul style="list-style-type: none"> Completion Date: 8/2023 D-SNP HRA Monitoring Reports: Implemented D-SNP HRA monitoring report <ul style="list-style-type: none"> Completion Date: 8/11/223
Open Remediation	<ol style="list-style-type: none"> MCLA HRA Monitoring Reports: Risk owners are working with IT production team to develop initial HRA and reassessment monitoring reports. <ul style="list-style-type: none"> Completion Date: TBD Audit: Internal Audit will conduct an effectiveness review of the risk mitigation plan implementation. <ul style="list-style-type: none"> Completion Date: TBD
Summary	MCLA Monitoring Report: Has been submitted to IT, but development is currently on hold due to the production team giving higher priority to finalizing D-SNP reports. The development of the MCLA monitoring report currently has a low priority level. Business owners are attempting to include the Medi-Cal monitoring report into the D-SNP reporting project. Even though IT’s review of the completion timeline for this report is still pending, it is anticipated that development will begin 1/1/2024. This could change depending on priorities. This risk area is #9 on the list of 2024 Top 10 Risks and is included in the Internal Audit workplan for 2024.

Risk Management Update – Top Risks

Risk Mitigation Plan Status Key				
Off Track	Delayed	On Track	Validating	Mitigation In Place

Risk # / Title	C13: Compliance Program Effectiveness
Risk Statement	With the Plan winning new contracts and past CAP, the need to have strong monitoring and auditing is key. Not having a robust Compliance Program could put the new and current products at Risk.
Risk Owner(s)	Compliance: Todd Gower
Completed Risk Mitigation Activities	<ol style="list-style-type: none"> Reorganization: Reorganize Compliance department <ul style="list-style-type: none"> Completion Date: June 2023 Conduct CPE Assessment: Engage third-party to conduct Annual Compliance Program Effectiveness (CPE) assessment <ul style="list-style-type: none"> Completion Date: 11/27/2023
Open Remediation	<ol style="list-style-type: none"> Audit: A component of this will carry forward to 2024 monitoring activities. <ul style="list-style-type: none"> Completion Date: TBD
Summary	Internal assessment of the 2021 CPE audit was completed. Preliminary findings no longer reflect residual risk for original findings, but new lower-level risks were identified in the 2023 mock audit. A draft report of the 2023 mock audit was received by Compliance on 11/27/2023. L.A. Care did not have any disputes, comments or feedback, and is accepting the findings and recommendations. Compliance is in the process of collecting draft CAPs from impacted business units by 1/15/24 on all five findings identified during the audit. This will be subject to follow-up to validate implementation based on the specified supporting documents and any additional information that may be needed. A component of this risk area will carry forward to 2024 monitoring activities.

Risk Management Update – Top Risks

Risk Mitigation Plan Status Key

Off Track

Delayed

On Track

Validating

Mitigation In Place

Risk # / Title	O4: Provider Quality: PQI - Untimely Processing
Risk Statement	Where PQI processing is not timely completed, L.A. Care could experience regulatory non-compliance with its attendant penalties, fines, and potential member and provider harm
Risk Owner(s)	Quality Improvement: Christine Chueh, Maria Casias, Rhonda Reyes
Completed Risk Mitigation Activities	<ol style="list-style-type: none"> Staffing: Implemented staffing changes to assist with the closure of backlog cases <ul style="list-style-type: none"> Completion Date: As of May 2023 Monitoring: Implemented monitoring with PQI and Grievances using monthly reports <ul style="list-style-type: none"> Completion Date: As of May 2023 Prioritization: Implemented prioritizing aging case assignments using PQI internal tracking log and weekly reports <ul style="list-style-type: none"> Completion Date: As of May 2023 Audit: Internal Audit conducted an effectiveness review of the risk mitigation plan implementation. <ul style="list-style-type: none"> Completion Date: 11/27/2023
Open Remediation	No remediation items remain open for this risk area.
Summary	Internal Audit Outcome: The mitigation plan is in place to address an influx of cases delivered to the PQR team due to PQI being routed incorrectly from A&G's PCT system as well as overall improving the monitoring and handling of PQI inventory volume. During the validation of this risk area, Internal Audit identified additional observations that impact PQI timeliness and will begin follow-up on these observations at the end of December.

Risk Management Update – Top Risks

Risk Mitigation Plan Status Key				
Off Track	Delayed	On Track	Validating	Mitigation In Place

Risk # / Title	O4: Provider Quality: PQI - Untimely Processing
Risk Statement	Where PQI processing is not timely completed, L.A. Care could experience regulatory non-compliance with its attendant penalties, fines, and potential member and provider harm
Risk Owner(s)	Quality Improvement: Christine Chueh, Maria Casias, Rhonda Reyes
Completed Risk Mitigation Activities	<ol style="list-style-type: none"> 1. Staffing: Implemented staffing changes to assist with the closure of backlog cases <ul style="list-style-type: none"> • Completion Date: As of May 2023 2. Monitoring: Implemented monitoring with PQI and Grievances using monthly reports <ul style="list-style-type: none"> • Completion Date: As of May 2023 3. Prioritization: Implemented prioritizing aging case assignments using PQI internal tracking log and weekly reports <ul style="list-style-type: none"> • Completion Date: As of May 2023 4. Audit: Internal Audit conducted an effectiveness review of the risk mitigation plan implementation. <ul style="list-style-type: none"> • Completion Date: 11/27/2023
Open Remediation	No remediation items remain open for this risk area.
Summary	Internal Audit Outcome: The mitigation plan is in place to address an influx of cases delivered to the PQR team due to PQI being routed incorrectly from A&G's PCT system as well as overall improving the monitoring and handling of PQI inventory volume. During the validation of this risk area, Internal Audit identified additional observations that impact PQI timeliness and will begin follow-up on these observations at the end of December.

Compliance & Quality Committee
2024 Annual Enterprise
Risk Assessment
Process Overview and Top Risks proposed



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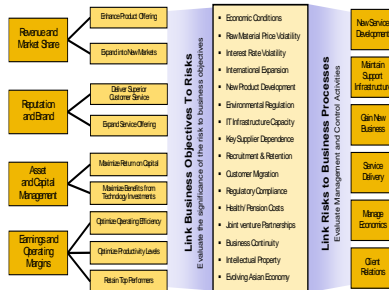
Presenter(s): Michael Sobetzko

Risk Assessment Process – 2024

Obtained Inputs- Market conditions, regulatory audits , prior assessments, SIU, Hotline, CAPs

- ▶ Market Factors and Implications
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Mapped L.A. Care Strategic Objectives and Initiatives to Inherent Risks- Risk Universe and FY 22 Risks (where appropriate)

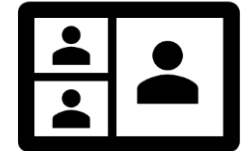


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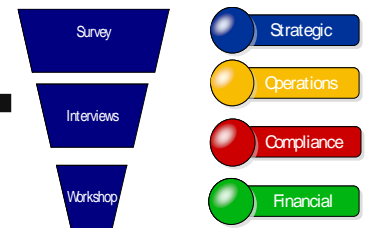
Refined Risk Assessment Criteria and develop a common vocabulary

Score	Rating	EFF	Source	Operational & Control Suite	Description of Impact	Recovery	Recovery
5	Critical	>100M	External/Inherent/Target	Enterprise-wide, highly complex, non-routine business operations across the enterprise	Significant loss of customer confidence & loss of marketable goods	Complete market withdrawal	Partial resolution of volatility
4	Significant	>100M	Recoverable/High/Target/Target/Target	2 or more divisions, significant ongoing operations in business operations across the enterprise	Substantial loss of 2 or more divisions	25-50% reduction in market capabilities, needs to assess liability reserves	2 or more divisions in total withdrawal, financial restructuring, significant changes to strategic plan
3	High	>50M	Recoverable/High/Target/Target/Target	1 or more divisions, Moderate impact with 1 or more divisions	Modest loss in 1 or more divisions	10-25% reduction in market capabilities, minor capacity cut, the maintenance quality issues	1 or more changes in operations, significant changes to strategic plan and culture
2	Medium	>20M	Targeted/High/Target/Target/Target	1 division, Limited impact with 1 division	Loss of 1 division	< 10% reduction in market capabilities, moderate impact on revenue	Reformulation or adjustment to existing plans and execution
1	Low	<20M	Targeted/Low/Target/Target/Target	1 division, Limited impact with 1 division	Loss of 1 division	Minimal impact	

Conducted Focused Risk Assessment Interviews on top of the directed surveys



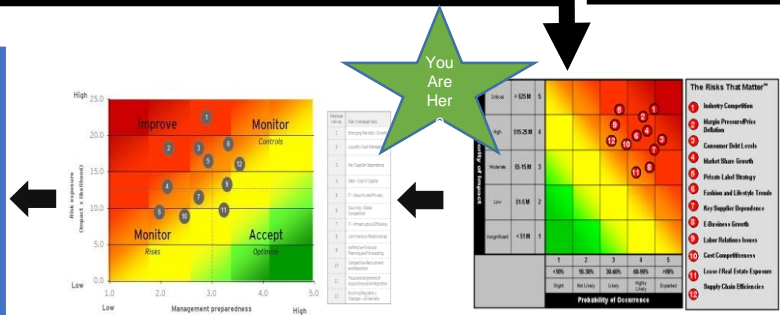
During Interviews shared results and feedback to Risk Owners



Assessed Key Business Risks with Responsible and Accountable Leaders Approved Risks



Monthly monitoring of risk mitigation plan implementation and validation of effectiveness by Internal Audit. New risk levels assigned once plan is validated. Annual Risk Assessment is performed to re-evaluate Top 10 Risks to L.A. Care



Developed Annual Monitoring Plan with the Top 10 Risks

Compiled updated Risk Assessment, Risk Profile and Risk Dashboard

Risk Assessment Update – 2024 Process

August 2023

- **37 leaders** and key individuals surveyed
- **17 interviews** with LA Care Leadership
- Responses from surveys and interviews resulted in **155 data points**

September 2023

- Matched **155 data points** to **38 risks** from 2023 +Issues Inventory + regulator findings
- **24 risks** from last year de-prioritized based on risk data
- **13 risks from 2023** were moved forward to be included in 2024 risks
- **6 new 2024 risks** were revealed as they did not match with 2023 risks (38+6-24= 20)

October - November 2023

- **20 risk themes** distributed to Leadership for feedback
- **Leadership voted** on probability and impact of 20 risk themes to rank risks

December 2023 – January 2024

- Compliance team scored top 12 ranked risks to estimate Management Preparedness and Controls
- **Top 10 Risks** revealed based on rank and compliance scores
- **LA Care Board reviews top 10 risks**

Risk Assessment Update – Next Steps

Overview:

- **Validation of six 2023 Top 10 risks** post remediation activities by Internal Audit
- Incorporated the 38 risks from 2023 considered for 2024
- **24 risks were de-prioritized** based on data collected and blended into the new risks
- **6 new risks were added in 2024.**
- Assessment efforts tied the risks to L.A. Care's 13 Business Tactics for 2023 – 2024.

Risk Mitigation Status

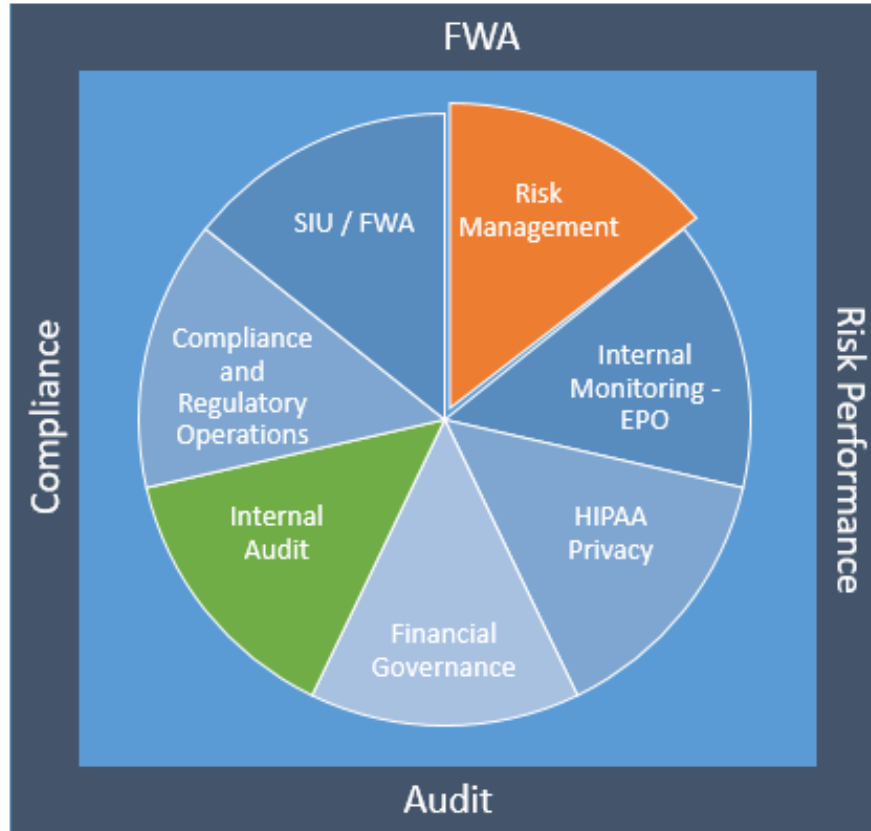
- 4 risks from 2023 Top 10 were mitigated (lower residual risk); 6 risks from 2023 Top 10 are rolled into 2024 risks.
- Tracking: Risk Mitigation activities are tracked vs Issues related to Risks, reducing confusion of what is be mitigated.

Keeping appropriate monitoring of risk without risk oversight fatigue:

Following the risk assessment and defining risk mitigation plans, ongoing oversight and updates will be critical for the success of proactive risk management:

- **Risk Prioritization-** Considering macro, micro economic/political factors and other priorities to L.A. Care
- **Educate enterprise on risk process**
- **Implementation of GRC**
- **Risk Governance-**
 1. Quarterly Risk Management Updates
 2. Creating an Internal Risk Governance Committee (outside of ICC and C&Q)
 3. Documented risk mitigation plans with Risk Owner based on risk profile and management preparedness
 4. Quarterly Risk Assessment Updates
 5. Risk mitigation remediation follow-up and testing plans based on risk profile

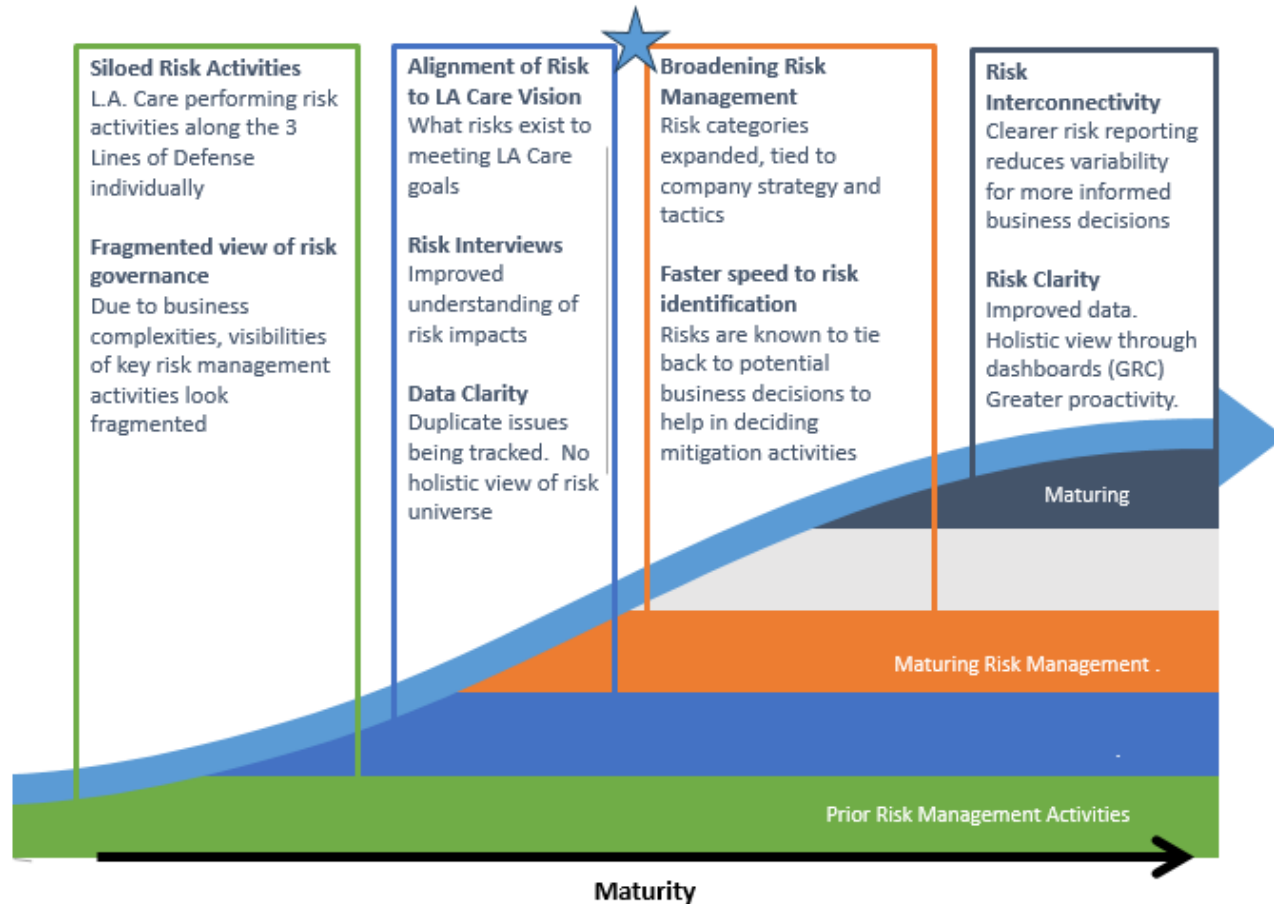
Integrated Risk and Compliance View 2.0



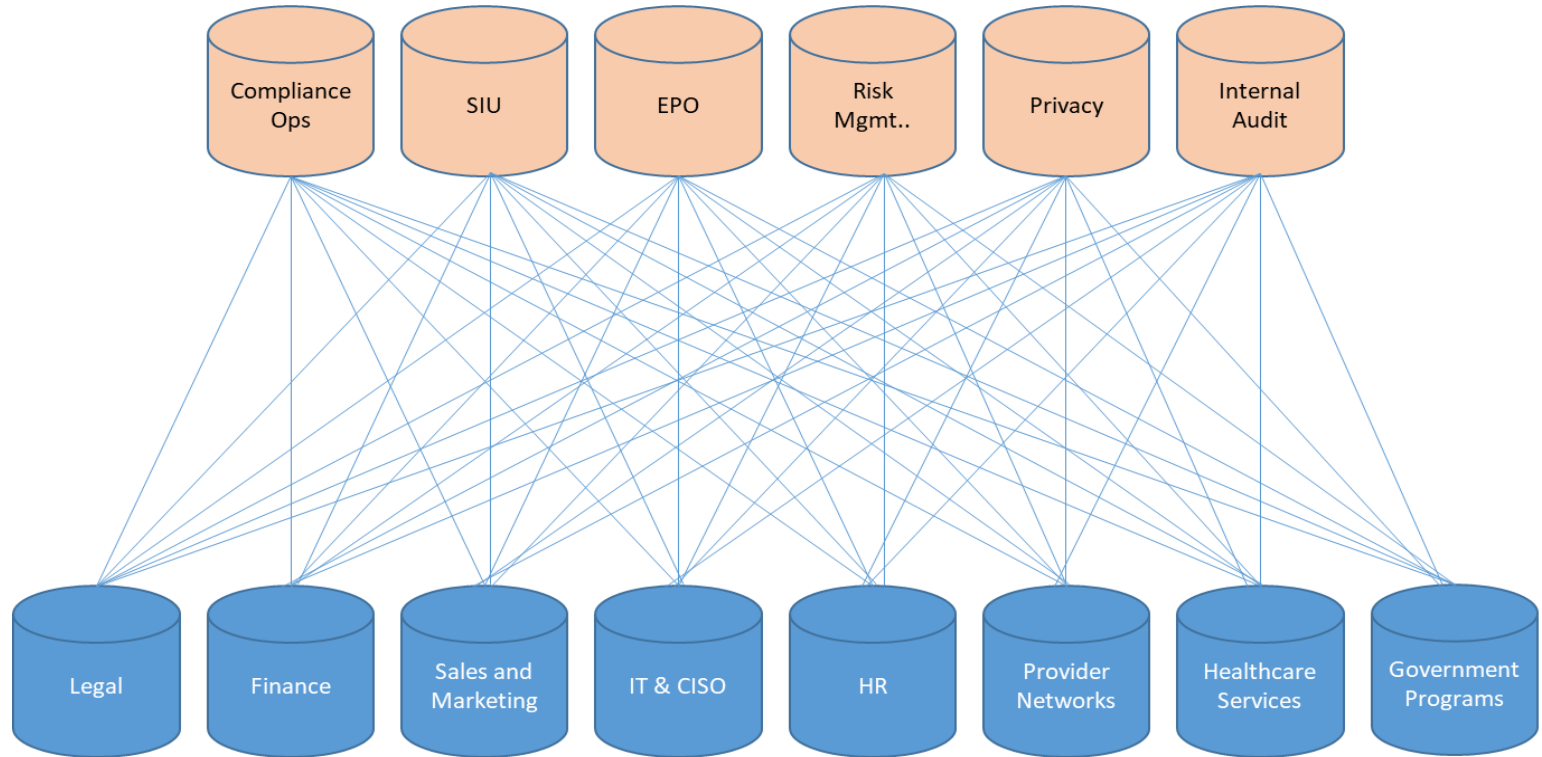
Benefits:

- Standardized Process
- Increased Visibility
- Enhanced Reporting
- Enhanced Monitoring
- Aligned Mitigation Strategies
- Streamlined Assessments
- Improved Scalability
- Common language

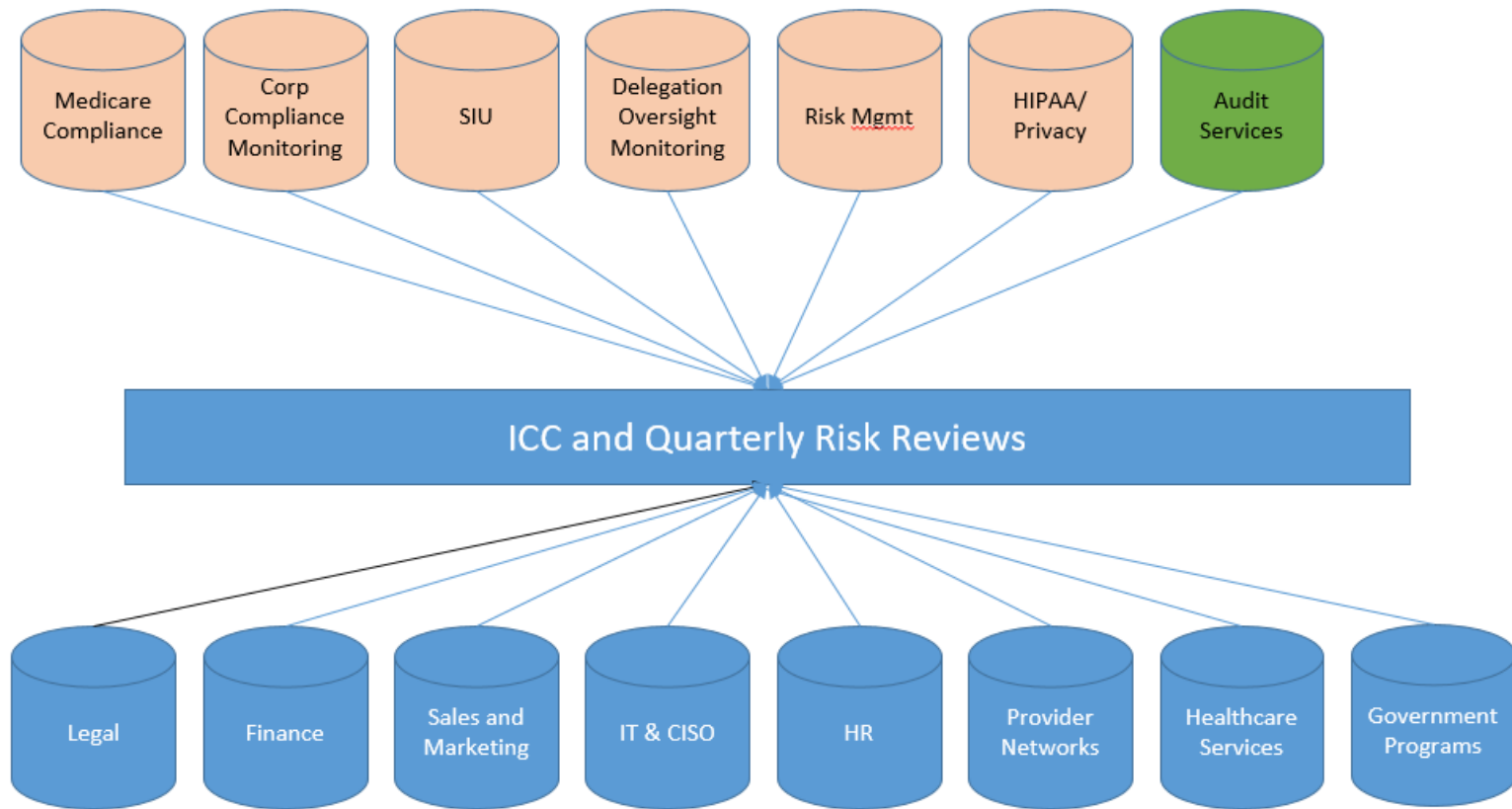
Current State - Risk Assessment Maturity



Current State – Risk Management



Draft Risk View – 2.0



Reiterating Lines of Defense

First Line: Risk and Lines of Business owners (i.e. Quality, UM, Finance, Claims)

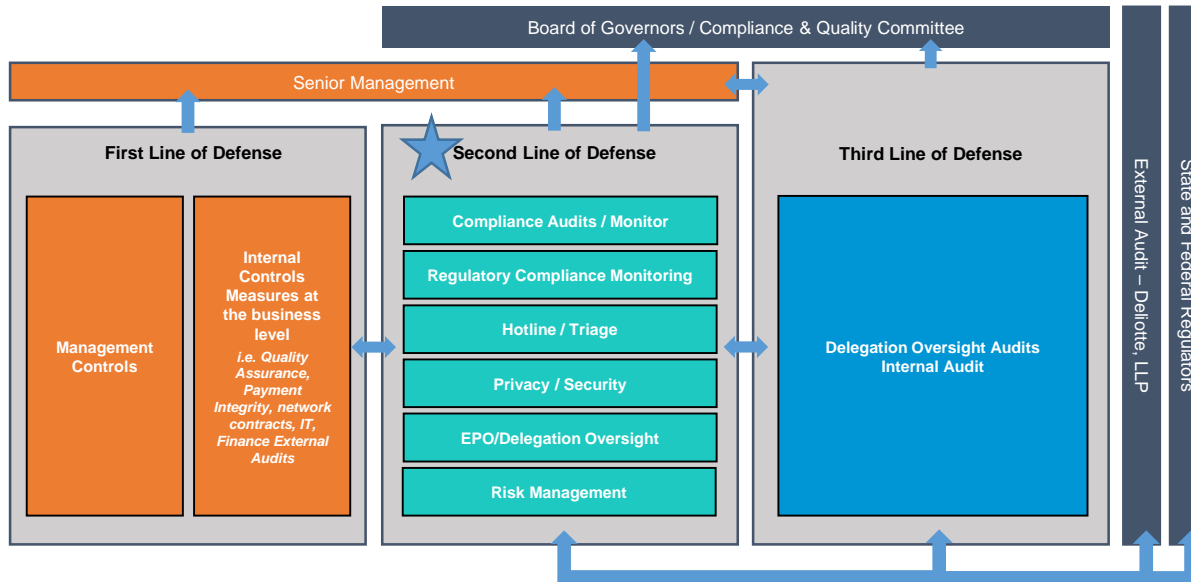
- The first line of defense (1LOD) is provided by front line staff and operational management. The systems, internal controls, control environment and culture developed and implemented by these business units is crucial in anticipating and managing operational and non-financial risks.

Second Line: Risk and Compliance Oversight

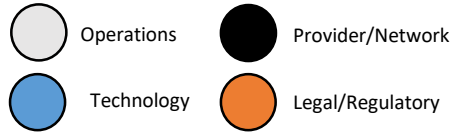
- The second line of defense (2LOD) is provided by the risk management and compliance functions. These functions provide the oversight and the tools, systems and advice necessary to support the first line in identifying, managing and monitoring risks.

Third Line: Risk assurance (Internal and External Audit/Regulators)

- The third line of defense (3LOD) is provided by Audit Services function. This function provides a level of independent assurance that the risk management and internal control framework is working as designed.

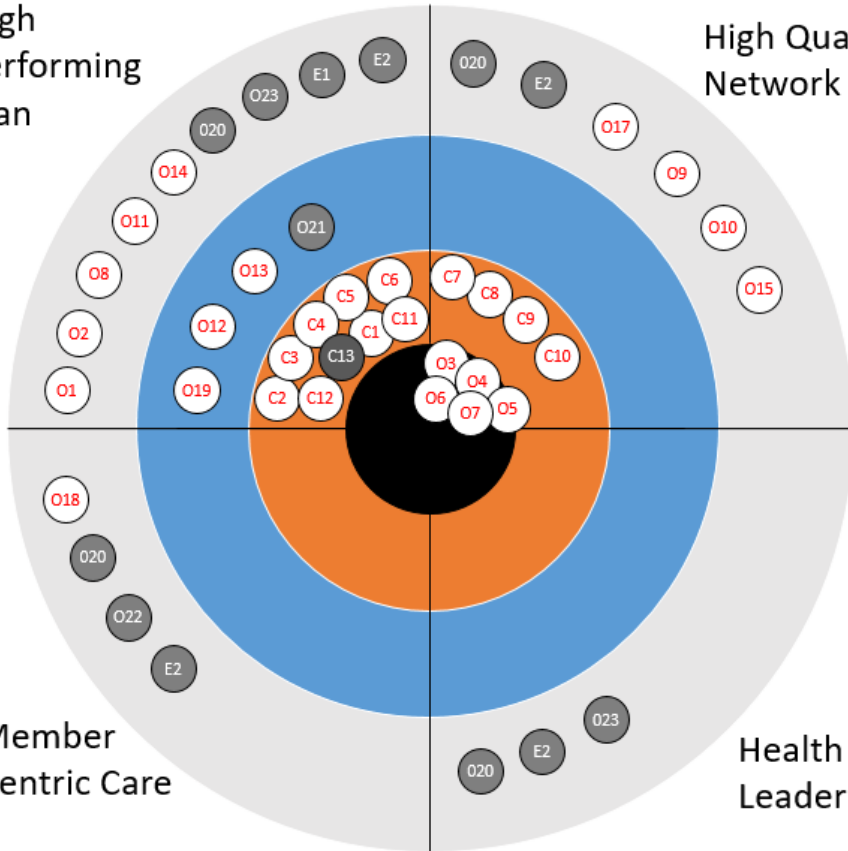


FY2023 Risk Assessment Impacts Mapped to Strategy



High Performing Plan

High Quality Network



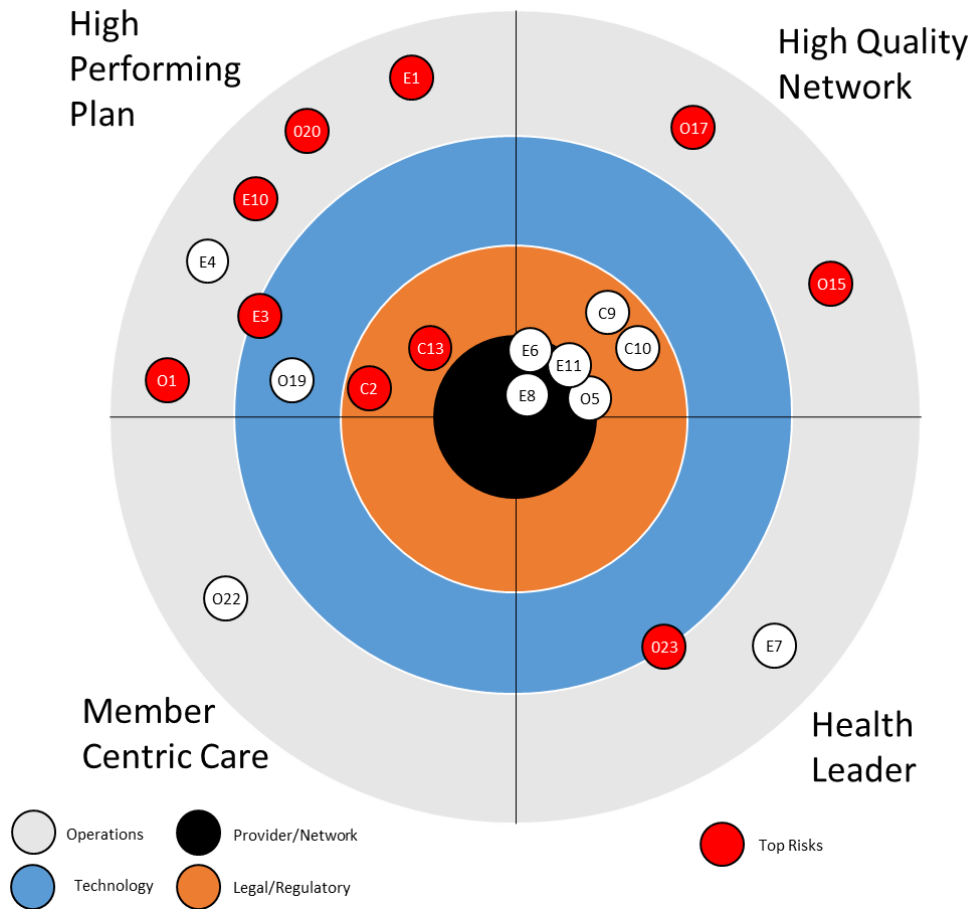
Member Centric Care

Health Leader

Ref #	Risks Assessed as Themes
C1/C3	Appeals and Grievances
E1, O8	Business Collaboration/Accountability/Culture to support
O14	Claims Operations/Cost Containment/FWA
C13	Compliance Matters – Enforcement / External Audits
O10	Community Outreach and Engagement
C2	CSC, CM, Medi-Cal Compliance
C4/C5	Data Management and Governance
O15	Delegation Oversight and monitoring
O23	New Products and Support– (DSNP & Cal Aim)
O18	Enrollment – Member Services
C11	HR Support and Talent Management/On-Off Boarding
O12, 13, 16	IT – Oversight, Outages and Collaboration, Shadow IT
O19	IT Security/Management/Oversight
O22	Member Satisfaction and Performance Measurement
E2	Pandemic
O2	Pharmacy and Formulary
C6, 12 & O11	Privacy – Policy, BAA, Timeliness
O1	Third-Party Risk Management/ Contracting Support/ Vendor Management
O17	Provider Network-Collaboration
O3, 4, 5, 6, 7 & C9, 10	Quality and Clinical
C8	Sales and Marketing Compliance
O20	Staffing concerns – Retention/Hire/Skills
O21	Syntranet system
O9 & C7	Utilization Management

Highlighted Cells – New Risks

FY2024 Risk Assessment Impacts Mapped to Strategy



Ref #	Risks Assessed as Themes
O5	QI Support
O23	DSNP
O22	Enterprise Approach
O20	Staffing
O19	System Security
O17	Data Governance
O15	Delegation Oversight
O1	Vendor Management
E8	New- Network solvency
E7	New- Market share
E6	New- Provider credentialing
E5	Budgeting Process & Prioritization
E3	Disaster Recovery / Business Continuity
E11	New- Provider contracting
E10	New- Encounter data Governance
E1	Business Strategy
C9	Provider Network Access to Care
C2	HRA Reassessment Efforts
C13	Compliance Monitoring/Enforcements/Audits
C10	NCQA

Highlighted Cells – Top rated Risks

Proposed Top Risks for 2024

Risk Id #	Impacted Business Unit(s)	Accountable Executive(s)	Risk Domain	Risk Name	Risk Description	2023 Risk Level	2024 Residual Risk Level	Items found in Issues Inv
C13	Compliance	Todd Gower	Regulatory	Compliance Monitoring / Enforcements / Audits	<ol style="list-style-type: none"> 1. Compliance departments ability to oversee the organization's performance including operational performance monitoring; operational readiness of all LOBs 2. Timely issuance of internal CAPs 3. Data driven view of LA Care's compliance - Identification of deficiencies 4. Repeat findings from external audits. CAPs and monitoring required 	Very High	Very High	Yes
O15	Compliance	Todd Gower	Operational	Delegation Oversight	<ol style="list-style-type: none"> 1. There is a risk of L.A. Care's Delegation Oversight to effectively monitor relationships and their agreements with L.A. Care which could lead to a potential increase in appeals and grievances, member harm and regulatory findings. 	High	Very High	Yes
O23	Product Compliance	Linda Greenfeld Todd Gower	Operational	DSNP Implementation and Oversight	<ol style="list-style-type: none"> 1. Monitoring program for DSNP is not fully rolled out for internal operations and delegates. 2. Risk that LA Care's implementation of DSNP to meet all requirements. LA Care is highly likely to be selected for audit by CMS. 	High	Very High	Yes
E10	Provider Network Finance	Noah Paley Afzal	Operational	Encounter Data	<ol style="list-style-type: none"> 1. Encounter data collection remains a challenge. Including timeliness and quality of encounters. 2. Challenge in paying Prop 56 payments related to LA Care's ability to pay individual providers directly 3. New requirement for implementation of Medi-Cal TRI. 	n/a	E10	Yes

Proposed Top Risks for 2024

Risk Id #	Impacted Business Unit(s)	Accountable Executive(s)	Risk Domain	Risk Name	Risk Description	2023 Risk Level	2024 Residual Risk Level	Items found in Issues Inventory
O20	Human Resources	Terry Brown	Operational	Staffing	<ol style="list-style-type: none"> 1. LA Care has difficulty in recruiting skilled talent and retaining needed talent. 2. Cumbersome and long process to recruit, promote, and receive approvals for hires. 3. Lack of competitive pay structure, bonus plans and benefits. 4. Difficulty in timely workforce management of staff when appropriate. 5. Geographic restrictions increase obstacles to hire skillsets in high demand. 	Very High	Very High	Yes
O1	IT / Finance / Legal	Tom MacDougall Afzal Shah Augie Haydel	Operational	Vendor Management / Contracting Process	<ol style="list-style-type: none"> 1. Lack of cross functional third-party vendor management and oversight. How to ensure vendors adhere to contractual requirements. 2. Complex contracting process, multiple touches across organization, contracting may delay in certain parts of process. 3. Shadow process for contracting that works outside the official procurement process. 4. Centralized owner that works cross functionally with business partners. 	n/a	Very High	Yes
C2	Care Management / Customer Solution Center	Sameer Amin Acacia Reed	Regulatory Operational	HRA Reassessment Efforts	<ol style="list-style-type: none"> 1. Where HRA assessments are not completed timely, potential enrollees who need extensive care management interventions will not receive care or interventions. Untimely completion will expose LA Care to regulatory violations. 	Very High	Very High	Yes

APPENDIX A



L.A. Care
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Remaining Risks

APPENDIX A – Top 10 Helpful Risk Management Terms

1. **Operational Risks** – Risks that are associated with the ongoing operation and service
2. **Probability** – The likelihood that a risk or opportunity occurs.
3. **Residual risks** – Identified risks for which no actions have been defined.
4. **Risk** – Is an uncertain future event or condition that, if it occurs, has a negative or positive effect on the organization
5. **Risk Acceptance** – Do nothing. Especially for small risks, no actions are defined according to the motto “If it happens, it happens.”
6. **Risk Domains** – Categories impacting the organization (Operational, Reputational, Financial, Regulatory)
7. **Risk Impact** – The damage if the risk occurs (delay, cost increase, loss of quality).
8. **Risk Owner** – The individual monitors their risks continuously and initiates the planned risk reduction actions or the emergency plan at the specified time.
9. **Stakeholder** – a person, group of people or an organization that is actively involved in the management of risk or is affected by the course of the management of risk. The Stakeholder can affect the execution of risk mitigation, positive or negative.
10. **Status** –
 - *Open*: Considered risk/issue being substantiated for next steps or if to be considered a risk/issue
 - *Under review*: Identified risk/issue has been substantiated for further review for mitigation activities
 - *Closed*: Identified risk/issue mitigation has been evidenced for Compliance or Internal Audit to test/assess/audit
 - Put in appendix

APPENDIX A – Remaining 2024 Risk Register – 1

Risk Id #	Impacted Business Unit(s)	Accountable Executive(s)	Risk Domain	Risk Name	Risk Description	2023 Risk Level	2024 Risk Level	Items found in Issues Inventory
C10	QI	Marina Acosta	Regulatory	NCQA Health Equity Distinction	1. In line with NCQA Health Equity Distinction, the Plan will need to collect sexual orientation, gender identity, (SOGI) and pronoun information. Gap in clinical data integration specific to race, ethnicity, language, sexual orientation and gender. Need plan partner / delegate oversight of NCQA Health Equity Accreditations standards.	High	High	Yes
E4	Enterprise	Cabinet	Financial	Budgeting Process and Prioritization	1. While budgetary constraints are understood, how can we better prioritize business unit needs and investments into IT systems to support LA Care's goals. Accountability to approved budget.	n/a	High	Yes
E6	Credentialing	Penny Tunney	Operations	Provider Credentialing	1. Cumbersome provider credentialing and onboarding process. Challenges in working with social services agencies.	n/a	High	Yes

APPENDIX A – Remaining 2024 Risk Register – 2

Risk Id #	Impacted Business Unit(s)	Accountable Executive(s)	Risk Domain	Risk Name	Risk Description	2023 Risk Level	2024 Risk Level	Items found in Issues Inventory
E7	Product	Linda Greenfield	Strategic	Market Share - Maintain and Gain	<ol style="list-style-type: none"> 1. Potential loss of market share due to CA State algorithm - membership assignment based on performance metrics 2. Inability to lift DMHC cap of 40k members on Direct Network 3. Become a 4 Star Plan 4. Member engagement - What are members' concerns and challenges 	n/a	High	Yes
E8	Finance / Provider Network	Afzal Shah/ Noah Paley	Financial	Network Solvency	<ol style="list-style-type: none"> 1. Providers, including hospitals, require financial monitoring and support to maintain long term solvency. Need better provider financial analytics. 	n/a	High	Yes
E11	Provider Network	Noah Paley	Financial	Provider Contracting	<ol style="list-style-type: none"> 1. Ensuring we are paying providers market or competitive rates. Leverage multiple contracting strategies (value-based contracting, etc.). 	n/a	High	Yes

APPENDIX A – Remaining 2024 Risk Register – 3

Risk Id #	Impacted Business Unit(s)	Accountable Executive(s)	Risk Domain	Risk Name	Risk Description	2023 Risk Level	2024 Risk Level	Items found in Issues Inventory
O22	Product	Robert Griffith	Strategic	Enterprise Approach to Multiple Product Lines	<ol style="list-style-type: none"> 1. Holistic thinking across product teams and the enterprise identifying areas where an all-product approach makes sense. 2. Challenges in creating a delivery model that is scalable to accommodate multiple product lines. 3. Processes, tools and capabilities need to be designed with the bigger picture in mind. All LOB stakeholders should be included to ensure that scalability is a focus from initial design. 	n/a	High	No

APPENDIX A – Remaining 2024 Risk Register – 4

Risk Id #	Impacted Business Unit(s)	Accountable Executive(s)	Risk Domain	Risk Name	Risk Description	2023 Risk Level	2024 Risk Level	Items found in Issues Inventory
O5	Quality Improvement	Maria Casias Christine Chueh Betsy Santana	Operational Regulatory	Quality Improvement Support	1. Business units providing incomplete reports or lack of information necessary for QI to address/escalate issues as appropriate. This information is needed to conduct QI activities and/or ensure compliance with regulatory requirements such as patient safety, member satisfaction, general network performance and all other categories as outlined in the Quality Improvement Program	Medium High	Medium	No
C9	QI/ATC Team	Maria Casias	Provider Network Regulatory	Provider Network Access To Care	1. DHCS and DMHC require health plans to ensure their network providers are adhering to the timely access standards. Low response rate for Provider Appointment Availability Survey (PAAS) and After-Hours survey.	High	Medium	Yes

APPENDIX B



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Prioritization

Appendix B

Leadership votes to rank on probability and impact

Probability of Risk
Low
Medium
High

Impact of Risk to Strategic Plans / Department Goals
Low
Medium
High

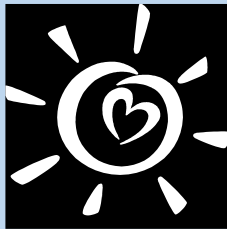
Compliance team scores for preparedness and controls

Score	Rank	Description of Controls
1	Poor Controls	Mostly reactive to risk occurrence (may be noticed by external party before internal awareness), limit planning in place.
2		Somewhere between 1 and 3
3	Some Controls	Reactive to risk but will be aware of occurrence and can address before external party awareness. Some planning in place to handle risk.
4		Somewhere between 3 and 5
5	Controls and Monitoring in place	Likely to see/predict risk in advance. Plans in place to handle risk, potentially proactively.

Appendix B – 13 Tactics to Help Drive Priority

37 survey participants were asked to choose 3 of L.A. Care's 13 Business Tactics for 2023 – 2024 which align with their functions and describe issues that would impact their ability to achieve those tactics.

1	Build out information technology systems that support improved health plan functionality
2	Support and sustain a diverse and skilled workforce and plan for future needs;
3	Ensure long-term financial sustainability
4	Mature L.A. Care's family of product lines, taking an "all products" approach whenever possible
5	Mature and grow our Direct Network
6	Improve our quality across products and providers
7	Invest in providers and practices serving our members and the L.A. County safety net
8	Operate all components of California Advancing and Innovating Medi-Cal (CalAIM) as they are launched
9	Establish and implement a strategy for a high-touch care management approach
10	Ensure that the services we provide to members promote equity and are free of implicit and explicit bias
11	Drive improvements to the Affordable Care Act by serving as a model of a successful public option
12	Optimize members' use of Community Resource Centers and expand our member and community offerings;
13	Drive change to advance health and social services for our members and the community.



L.A. Care
HEALTH PLAN

Board of Governors
MOTION SUMMARY

Date: January 18, 2024

Motion No. COM 101.0224

Committee: Compliance and Quality

Chairperson: Stephanie Booth, MD

Issue: Approve 2024 Risk Assessment

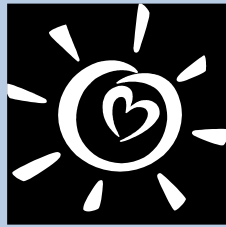
New Contract **Amendment** **Sole Source** **RFP/RFQ was conducted in**

Background: The 2024 Risk Assessment summarizes the process and results of the annual risk assessment program. The 2024 Risk Assessment highlights the top ten risks, identified during the annual process, for which management action plans will be requested and monitored.

Member Impact: None

Budget Impact: None

Motion: To approve the 2024 Risk Assessment



L.A. Care
HEALTH PLAN

Board of Governors
MOTION SUMMARY

Date: January 18, 2024

Motion No. COM 102.0224

Committee: Compliance and Quality

Chairperson: Stephanie Booth, MD

Issue: Approve CY 2024 Compliance Work Plan

New Contract **Amendment** **Sole Source** **RFP/RFQ was conducted**

Background:

L.A. Care is required to develop a compliance program that strives to prevent, detect and correct compliance issues; and ensures appropriate communication with regulatory agencies

- Three key elements and seven functional processes
 - Three key elements
 - Prevention of compliance issues
 - Detection - Identification of potential compliance issues
 - Correction - Resolution of those issues through corrective action.
 - Seven functional processes to support the key elements: (1) policies, procedures, standards of conduct; (2) Compliance officer, committees, governing body focused on Compliance; (3) training and education for staff; (4) lines of communication; ((5) well-publicized disciplinary guidelines; (6) systems for monitoring and auditing to prevent and correct problems; (7) existing systems to appropriately elevate and respond to compliance issues

•
Member Impact: None

Budget Impact: None.

Motion: To approve the 2024 Compliance Program.



L.A. Care
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Compliance Program



**ELEVATING
HEALTHCARE**
IN LOS ANGELES COUNTY
SINCE 1997



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I. Compliance Program Overview

Local Initiative Health Authority for Los Angeles County (hereafter, "L.A. Care Health Plan" or "L.A. Care") is committed to establishing and maintaining its business operations in compliance with ethical standards, contractual obligations, and all applicable Federal and State standards, statutes, regulations and rules, including those about the State of California requirements and the Medicare Advantage and Prescription Drug programs. L.A. Care's compliance commitment extends to its internal business operations and oversight and monitoring responsibilities relating to its business partners and first-tier, downstream, and related entities.

L.A. Care's Compliance Program incorporates the seven core elements of an effective compliance program to satisfy Medicare requirements and regulations.

1. Written Policies, Procedures, and Standards of Conduct
2. Chief Compliance Officer, Compliance Committee, Governing Body
3. Effective Training and Education
4. Effective Lines of Communication
5. Enforcement of Standards through Well-Publicized Disciplinary Guidelines
6. Effective Systems for Routine Monitoring and Auditing
7. Procedures and Systems for Promptly Responding to Compliance Issues

As the Compliance Organization continues to mature and evolve, L.A. Care has tailored its Compliance Program to fit recent enforcement matters and internal compliance effectiveness assessment, as well as our evolving business environment. Moreover, the Compliance Program is dynamic and must include a robust monitoring and auditing plan. Compliance is working closely with their I.T. and Business units to evaluate their internal monitoring, compliance monitoring, and effective auditing efforts. The Compliance Program applies to Board members, L.A. Care employees, first tier, downstream, and related entities (FDRs), including contracted Knox-Keene licensed health plans and participating providers.

As part of our commitment, Compliance and L.A. Care continue to formalize its compliance activities by developing this Compliance Plan ("Plan") that guides the prevention, detection, and correction of compliance issues. This Plan includes actions to prevent and detect violations of ethical standards, contractual obligations, applicable law, and the involvement of L.A. Care's governing body and executive staff. The Compliance Program incorporates existing compliance elements and functions and expands upon them to improve the quality of L.A. Care's compliance efforts. The Compliance Program applies to all lines of business of L.A. Care, including Medicare Parts C and D.

II. Goals and Objectives

L.A. Care's Compliance Program is designed to facilitate the provision of quality healthcare services to all its members. L.A. Care's Compliance Program aims to ensure that all L.A. Care members receive appropriate and quality healthcare services through a provider network in compliance with all applicable state and federal rules and regulations and L.A. Care contractual requirements.

L. A. Care's Compliance Program incorporates the following objectives:

- Provides oversight of delegated responsibilities to the PPGs/IPAs, Plan Partners, and other sub-contracted entities.
- Implements and monitors corrective action plans with PPGs/IPAs and sub-contracted entities to address deficiencies in the provision of health care services.
- Conducts auditing and internal monitoring activities of L.A. Care business units and first-tier, downstream, and related entities to assess compliance with L.A. Care's performance standards.
- Identifies and investigates potential fraud, waste, and abuse activities. Takes appropriate action(s) to report or resolve suspicious activities.
- Provides education and other resources to assist internal business units and first-tier, downstream, and related entities in compliance with Privacy requirements.
- Educates staff and enforces adherence to L.A. Care's Code of Conduct standards and mission.
- Provides new legislative updates to PPGs/IPAs and sub-contracted entities that specify required actions to ensure contractual compliance. Makes additional information about compliance activities and requirements available to PPGs/IPAs continuously.
- Annual Compliance Program Effectiveness review to determine opportunities to improve the compliance program.

The Compliance program ensures compliance with all federal and state rules and regulations, L.A. Care's payer contracts, and other standards as applicable regulatory agencies require. The Compliance Program also extends to (as appropriate) first tier, downstream and related entities, PPGs/IPAs, Plan Partners, and Contractors affiliated with L.A. Care.

The Compliance Program addresses L.A. Care's performance concerning the following requirements:

- Rules and Regulations promulgated by and for the Department of Managed Health Care.
- Rules and Regulations promulgated by and for the Centers for Medicare & Medicaid Services.
- All applicable federal rules and regulations that apply to the provision of health services.
- Terms and conditions as outlined in L.A. Care's contracts with California and federal agencies, private foundations, and other payer organizations to provide health care services.
- The State and Federal Governments' right to access premises to assure compliance with the Contract(s) and for any other reasonable purpose, with or without notice to L.A. Care.

III. Definition of Terms

Abuse

Actions that may, directly or indirectly, result in unnecessary costs to L.A. Care, Medi-Cal or the Medicare program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors. (Medicare Managed Care Manual (MMCM) Ch. 21, Section 20)

Delegated Activity

A specific plan function pertaining to the performance of healthcare and/or administrative services that is performed by an entity under the terms of a plan contract.

Delegation

A legal assignment to another party of the authority for particular functions, tasks, and decisions on behalf of the original party. The original party remains liable for compliance and fulfillment of all rules, requirements, and obligations pertaining to the delegated functions.

Downstream Entity

Any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the MA benefit, below the level of the arrangement between an

MAO or applicant or a Part D plan sponsor or applicant and a first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services. (MMCM Ch. 21, Section 20 and 42 C.F.R. § 423.501)

False Claims Act (“FCA”)

The False Claims Act, pursuant to 31 United States Code (U.S.C.) Sections 3729-3733, protects the government from being overcharged or sold shoddy goods or services. The FCA imposes civil liability on any person who knowingly submits, or causes to be submitted, a false or fraudulent claim to the federal government. The “knowing” standard includes acting in deliberate ignorance or reckless disregard of the truth or falsity of the information. There are civil monetary penalties and criminal penalties for submitting false claims, which may include criminal fines, imprisonment, or both. (31 U.S.C. Sections 3729-3733)

First Tier Entity

Any party that enters into a written agreement, acceptable to CMS, with an MAO or Part D plan sponsor or applicant to provide administrative services or health care services to a Medicare eligible individual under the MA program or Part D program. L.A. CARE is a first tier entity. (MMCM Ch. 21, Section 20 and 42 C.F.R. § 423.501)

Fraud

Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. (MMCM Ch. 21, Section 20 and 18 U.S.C. § 1347)

Related Entity

Any entity that is related to an MAO or Part D sponsor by common ownership or control and (1) performs some of the MAO or Part D plan sponsor’s management functions under contract or delegation; (2) furnishes services to Medicare enrollees under an oral or written agreement; or (3) leases real property or sells materials to the MAO or Part D plan sponsor at a cost of more than \$2,500 during a contract period. (MMCM Ch. 21, Section 20 and 42 C.F.R. § 423.501)

Sub-Delegation

Process that occurs when the delegate gives a third entity the authority to carry out a delegated function. (NCQA)

Waste

Overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to L.A. Care or the Medicare program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources. (MMCM Ch. 21, Section 20)

IV. Written Policies, Procedures, and Standards of Conduct

L.A. Care's policies, procedures, and standards of conduct include the following:

- L.A. Care's commitment to comply with all applicable Federal and State standards;
- Describes compliance expectations as embodied in the Code of Conduct, including the requirement for all parties to identify and report noncompliant or unethical behavior;
- Describes the implementation and operation of the compliance program;
- Guides employees and others in dealing with potential compliance issues
- Identifies how to communicate compliance issues to appropriate compliance personnel;
- Tells how potential compliance issues will be investigated and resolved;
- Provides actions for non-intimidation and non-retaliation for good faith participation in the compliance program, including, but not limited to, reporting potential issues, analyzing issues, conducting self-evaluations, audits, and remedial actions, and reporting to appropriate officials.

V. Chief Compliance Officer, Compliance Committee, Governing Body, and Compliance Department Structure

CHIEF COMPLIANCE OFFICER

The Chief Compliance Officer serves as the focal point for all compliance activities and is vested with the day-to-day operations of the compliance program. The Chief Compliance Officer is responsible for developing, operating, and monitoring the Compliance Program. The Chief Compliance Officer reports to the Chief Executive Officer ("CEO") but has the authority to report directly to the Board of Governors, as necessary.

The Chief Compliance Officer is an L.A. Care employee and not an employee of any first-tier, downstream, or related entity. The Chief Compliance Officer reports directly and periodically to the Compliance & Quality Committee, which is a subcommittee of the Board of Governors and the Board of Governors of L.A. Care on the activities and status of the compliance program, including issues identified, investigated, and resolved by the compliance program.

The role of the Chief Compliance Officer shall include, but not be limited to, the following activities:

- Ensure the seven elements of compliance are incorporated into the compliance program;
- Providing regulatory interpretation and guidance regarding Federal and state regulations and CMS manuals;
- Establishing the overall framework and overseeing the implementation of the Medicare Compliance Program to promote compliance with applicable Medicare Advantage and Part D regulatory and legal requirements;
- Ensuring that Medicare compliance reports are provided regularly to the L.A. Care's governing body, CEO, and compliance committee;
- Creating and coordinating training programs to ensure the L.A. Care Health Directors, employees, contractors, delegated entities, and other third parties are knowledgeable about the Code of Conduct, Compliance Program, policies and procedures, and statutory requirements;
- Ensuring that the DHHS OIG and GSA exclusion lists have been checked for all members of the workforce, governing body members, and FDRs before hire/contract and monthly ongoing and coordinating any resulting personnel issues with L.A. Care's Human Resources, Security, Legal, or other departments as appropriate;
- Identification and prevention of payment of Part C and D claims submitted by providers whom the DHHS OIG or GSA has excluded;
- Ensuring that all L.A. Care employees are aware of how to detect and prevent any compliance violations, including potential or actual fraud, waste, or abuse, as well as report noncompliance or FWA without fear of retaliation;
- Establish various mechanisms for L.A. Care employees, Board members, senior management, delegated entities, and members to report known or suspected noncompliance or fraud, waste, and abuse;
- Enforcing appropriate and consistent disciplinary action, including termination, in conjunction with the corporate human resources department, against employees who have engaged in acts or omissions constituting noncompliance or acts of fraud, waste, and/or abuse;
- Responding to reports of potential FWA, including the coordination of internal investigations with the SIU or internal audit department and the development of appropriate corrective or disciplinary actions, if necessary;
- Maintaining documentation for each report of potential noncompliance or potential FWA received from any source through any reporting method;
- Conducting an annual assessment of risk areas based on information gathered from a variety of sources, including CMS guidance, internal assessments, enrollee complaints, CMS inquiries, or other avenues; and recommending new

or revised metrics, policies and procedures, enhanced training courses, or other activities that may be tracked and measured to demonstrate compliance;

- Conducting internal monitoring and auditing activities of operational areas identified at risk of noncompliance through the annual risk assessment process, as well as ad hoc internal audits for areas in which issues are identified outside the annual risk assessment process;
- Overseeing monitoring and auditing activities related to compliance and fraud, waste, and abuse that L.A. Care staff and contractors/vendors perform;
- Reporting any potential fraud or misconduct related to the Medicare programs to CMS, its designee;
- Maintaining documentation for each report of noncompliance, potential fraud, waste, or abuse received through any of the reporting methods (i.e., hotline, mail, in-person) which describe the initial report of noncompliance, the investigation, the results of the investigation, and all corrective and/or disciplinary action(s) taken as a result of the investigation, as well as the respective dates when each of these events and/or actions occurred and the names and contact information for the person(s) who took and documented these actions;
- Developing, implementing, and evaluating corrective action plans resulting from noncompliance and/or fraud, waste, and abuse; or
- Coordinate potential fraud investigations/referrals between L.A. Care and the NBI MEDIC, as well as any documentation or procedural requests that the NBI MEDIC makes of L.A. Care.

BOARD OF GOVERNORS

L.A. Care's Compliance Program is subject to oversight by the Board of Governors. The Board of Governors has established a Compliance and Quality Committee to provide review and oversight regarding the Compliance Program. The Board of Governors and the Compliance and Quality Committee know the content and operations of the Compliance program.

COMPLIANCE COMMITTEES

L.A. Care's Compliance Program operates with the oversight and/or support of the following committees, as described below.

1. **Compliance and Quality Committee (C&Q).** The Compliance and Quality Committee (C&Q) is a subcommittee of the Board of Governors. The C&Q committee monitors L.A. Care's compliance efforts and reports findings to the Board. The C&Q committee is charged with reviewing the overall performance of L.A. Care and providing direction for action based on findings.

2. **Internal Compliance Committee (ICC).** The Internal Compliance Committee (ICC) provides oversight, advice, and general guidance to L.A. Care Health Plan senior management on all matters relating to L.A. Care and its first-tier, downstream, and related entities compliance with mandated and non-mandated performance standards. The ICC, through the Chief Compliance Officer, periodically reports to the Compliance and Quality Committee of the Board of Governors on the activities and status of the Compliance program. The ICC ensures that L.A. Care adopts and monitors the implementation of policies and procedures that require L.A. Care and its employees, the Plan Partners, and the providers to act in full compliance with all applicable laws, regulations, contractual requirements, and policies.

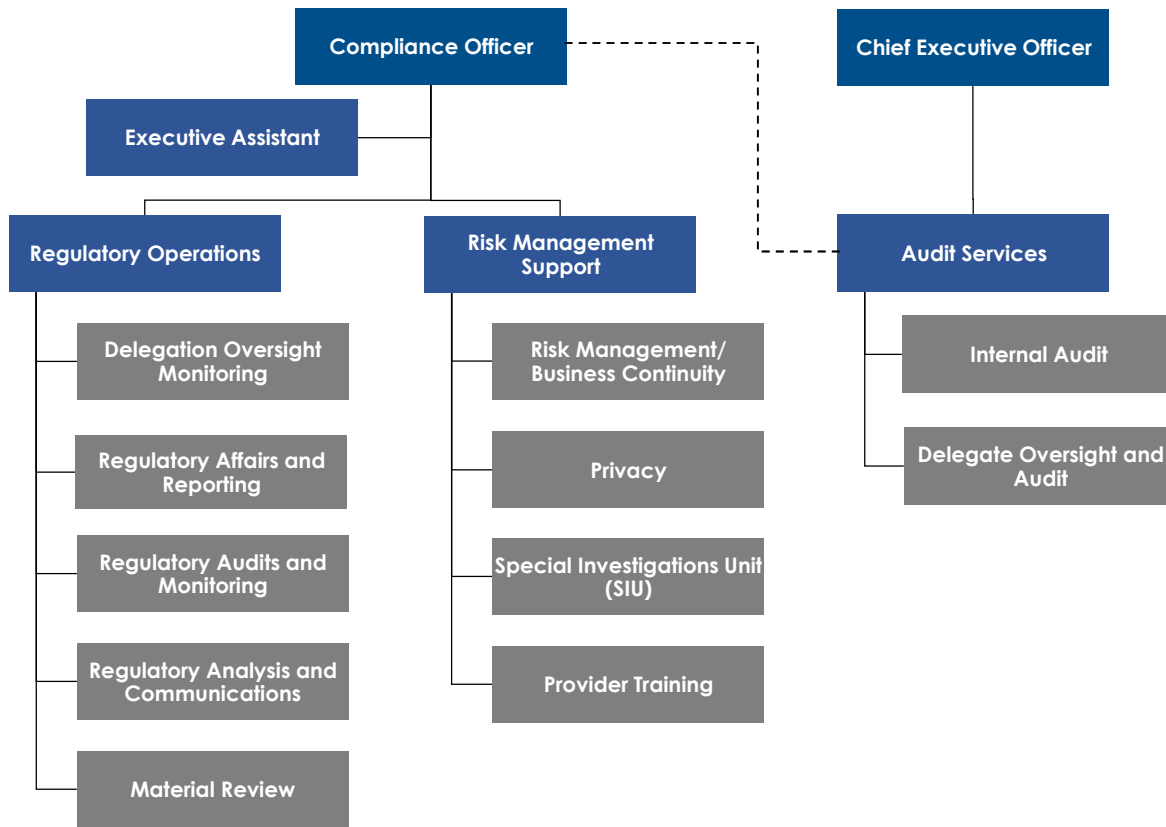
The duties and responsibilities of the ICC include but are not limited to the following:

- Reviewing and approving Compliance Department policies and procedures that describe the scope and authority for compliance activities;
- Ensuring that the Compliance and Quality Committee receives at least quarterly reports on the status of the Compliance Program, including issues identified and investigated;
- Ensuring that training and education are appropriately completed for employees and contractors/vendors to maintain compliance;
- Ensuring L.A. Care has mechanisms for employees, Board members, senior management, delegated entities, and members to ask compliance questions and report known or suspected noncompliance or fraud, waste, and abuse;
- Reviewing reports and recommendations of the Chief Compliance Officer regarding compliance activities. Based on these reports, the Committee makes recommendations regarding future compliance priorities and resources;
- Providing input into the monitoring and auditing work plan, which addresses areas of focus for the year;
- Set goals and monitor the progress of compliance with those goals; review major compliance issues identified by committee members;
- Overseeing a system of controls to carry out the Compliance Program;
- Engage in oversight activities related to the correction of compliance risks and identification of areas for training and education of associates; and
- Oversee corrective action plans and ensure that they are implemented and monitored and are effective in correcting the deficiency.

3. **Special Investigations Unit Committee (SIU)**. The Special Investigations Unit (SIU) committee is responsible for the communication of L.A. Care's Fraud, Waste, and Abuse detection efforts and activities. Information about L.A. Care's SIU is communicated to its Members and providers via provider bulletins, provider mailings, provider trainings, member newsletters, Evidence of Coverage, and L.A. Care's Regional Community Advisory Committee (RCAC) meetings.
4. **Security and Privacy Oversight Committee (SPOC)**. The Security and Privacy Oversight Committee (SPOC) provides oversight and general guidance and advises L.A. Care Health Plan leadership on matters relating to the information security, privacy, and integrity of the organization's facility, network, and information assets of members and employees.
5. **Sanctions Committee**. The Sanctions Committee reviews issues on delegated entity noncompliance, evaluates noncompliance, and imposes penalties on such delegates for noncompliance. Issues of noncompliance are presented by the delegation oversight function and any other L.A. Care business units that have obtained delegate/vendor noncompliance information.
6. **Delegation Oversight Committee (DOC)**. The Delegation Oversight Committee (DOC) provides oversight and general guidance and advises L.A. Care Health Plan leadership on matters relating to compliance effectiveness of the Plan's delegated network. The oversight includes monitoring and auditing their financial solvency, compliance program effectiveness, credentialing processes, U.M. and Q.I. activities, and I.T. controls for data and systems management.
7. **Risk Committee (R.C.)**. The Risk Committee (R.C.) provides oversight and general guidance and advises L.A. Care Health Plan leadership on matters relating to proactive risk management, including the status of mitigation activities of the top identified risks by the Plan. The Annual/Yearly Risk Assessment calls out the likelihood, impact, and management preparedness of the identified and inherent risks for the Plan. The purpose of the R.C. is to make sure Risk Mitigation Ownership has appropriate accountability and responsibilities assigned, monitored, and audited for the effectiveness of their processes and controls.
8. **Regulatory Implementation Oversight (RIO) Committee**. The Regulatory Implementation Oversight (RIO) Committee serves as a forum for the Compliance Department to announce and oversee implementation efforts for all applicable new or revised laws, requirements, and guidance impacting any of L.A. Care's lines of business. It shall report issues of noncompliance and escalated items to the ICC, as appropriate, on those findings and matters within the scope of their responsibility.

COMPLIANCE DEPARTMENT STRUCTURE

The chart below shows the current Compliance Department structure.



RESPONSIBILITIES OF THE COMPLIANCE DEPARTMENT

The Compliance Department provides support to the Chief Compliance Officer in promoting ethical conduct, instilling a commitment to compliance, and exercising diligence in ensuring the overall Compliance Plan requirements are met. Specifically, the Compliance Department's responsibilities include:

- Ensuring consistent and timely reporting of relevant compliance, privacy, or other concerns to the Chief Compliance Officer. Working with the applicable business units to implement appropriate and timely corrective actions that will result in measurable compliance.
- Assisting the Chief Compliance Officer in reporting compliance matters to state regulators and escalating issues to senior management and the Board when necessary.
- Assisting, advising, and overseeing the individual business units in the design, administration, and implementation of their individual work plans and policies.
- Conducting assessments of risk areas based on information gathered from a variety of sources, including new regulatory guidance, internal assessments, member complaints, DMHC inquiries, or other avenues, and recommending new or revised metrics, policies and procedures, enhanced training courses, or other activities that may be tracked and measured to improve compliance.

- Conducting independent monitoring and auditing of identified risk areas to ensure compliance with health plan regulations and working with business units to ensure effective corrective actions are implemented in a timely manner.
- Monitoring and reporting on key compliance and performance metrics for the purpose of resolving identified patterns and trends and working with business units on internal corrective actions.
- Developing relevant and effective compliance training programs that support the Compliance Plan and providing education and awareness for managed care staff.
- Designing, implementing, maintaining, and managing member privacy assurance functions, including investigations to evaluate potential inappropriate access to or release of PHI and performing privacy risk assessments in accordance with federal law and guidelines and L.A. CARE established protocols.
- Maintaining up-to-date knowledge of all state and federal regulations affecting regulatory compliance for the operations of the Plan required under the law and this Compliance Plan, attending conference calls, DMHC roundtables, and outside compliance trainings or conferences by regulatory agencies or professional associations.

RISK MANAGEMENT SUPPORT

The Risk Management unit investigates and evaluates product line and enterprise-wide risk, including the development of an annual assessment of enterprise risks, as well as disaster recovery and business continuity planning.

SPECIAL INVESTIGATIONS UNIT

The Special Investigations Unit (SIU), which reports to Risk Management, conducts all fraud, waste, and abuse investigations, as well as some Internal Investigations. In addition, Leadership has created an internal investigation review process with Legal, Human Resources, and Compliance to assess SIU cases that may need outside legal or investigatory support due to required expertise and/or potential conflicts depending on the assigned cases.

PRIVACY

The Privacy unit, reporting to Risk Management, directs and supports L.A. Care's business units in its HIPAA compliance efforts, which include monitoring Federal and State privacy rules, developing privacy policies, providing guidelines procedures, conducting ongoing HIPAA training on the workforce, and conducting ongoing auditing and monitoring initiatives. Privacy also partners with Information Security on security rules and policies.

RISK MANAGEMENT AND BUSINESS CONTINUITY

The Risk Management and Business Continuity unit directs and supports L.A. Care's business units in following-up on reported L.A. Care Issues, CAPs and Disaster Recovery issues to closure. Upon closure, Issue Management reports their efforts up to ICC and C&Q. In addition, this unit monitors L.A. Care's current Business Continuity and Disaster Recovery process improvement and management preparedness efforts. Audit Services will be asked test effectiveness depending on the severity and risk to the organization.

PROVIDER TRAINING

The Provider Training unit, reporting to Risk Management, directs and supports L.A. Care's Provider Training efforts, which include awareness of provider responsibilities to Federal and State compliance rules.

REGULATORY OPERATIONS

The Regulatory Operations unit is responsible for material review and regulatory analysis with oversight of any associate implementation. In addition, Regulatory Operations include Regulatory Affairs, Delegation Oversight Monitoring, and Corporate Compliance Monitoring.

MATERIAL REVIEW

The Material Review Unit assists with communications to other stakeholders, such as (health care providers and vendors) to review communications intended for members enrolled in any of the lines of business at L.A. Care and ensure materials comply with federal and state regulations, as well as contract requirements.

REGULATORY ANALYSIS AND COMMUNICATIONS

The Regulatory Analysis and Communications ensures the appropriate dissemination of new and revised regulatory guidance to stakeholders. This unit also assists with organization-wide interpretation of regulatory guidance and oversight of the policy management program.

REGULATORY AFFAIRS AND REPORTING

The Regulatory Affairs and Reporting unit has the primary responsibility of managing relationships with regulatory agencies, regulatory agency relationships, and reporting. This unit also assists with regulatory disclosures and inquiries.

REGULATORY AUDITS AND MONITORING

The Regulatory Affairs unit has the primary responsibility of managing regulatory audits. The Regulatory Affairs unit works with responsible business units, delegates, and vendors to review respective findings, conduct root-cause analysis, develop corrective action plans, and monitor these corrective action plans for implementation and effectiveness.

DELEGATION OVERSIGHT MONITORING

The Delegation Oversight Monitoring function, reporting to Regulatory Operations, performs monitoring of prospective and participating subcontractors, delegates, and vendors. The Compliance Department develops monitoring and oversight activities to ensure the effective operation of the delegation oversight function by federal and state regulatory requirements and NCQA accreditation standards. The unit also manages critical performance indicators and the development of a monitoring program for L.A. Care.

INTERNAL AUDIT AND AUDIT SERVICES

The mission of the Internal Audit unit and Audit Services, which reports separately to the CEO with a dotted line into the C&Q Committee, is to provide independent and objective assurance and support related to L.A. Care's operations, delegates, direct network, and I.T. systems.

The Audit Services team uses a risk-based approach to decide what audit projects will be conducted. Each year, an Internal Audit Plan is created that outlines the audits, assessments, and consults to be conducted during the year. In addition, The Delegation Oversight Auditing function performs annual auditing of prospective and participating subcontractors, delegates, and vendors. Audit Services develops auditing activities to ensure the effective operation of the delegation oversight function by federal and state regulatory requirements and NCQA accreditation standards.

Not included in the Annual Internal Audit Plan is the annual Financial Audit. An independent external auditor conducts the external audit.

VI. Effective Training and Education

The continuing training and education of L.A. Care's employees on their legal and ethical obligations under applicable laws, regulations, and policies (including, but not limited to, federal health program requirements) is a critical element of the Compliance Program. L.A. Care is committed to taking all necessary steps to communicate effectively its standards, policies, and procedures to all affected personnel. Additionally, L.A. Care regularly reviews and updates its training programs and identifies additional areas of training as needed based on new developments.

The Compliance Program reinforces the ongoing commitment of each business unit to the overall purposes of the organization's Code of Conduct standards. Through the Compliance Program, L.A. Care staff, vendors, key stakeholders, and others who do business with and on behalf of L.A. Care are identified as a component of the Code of Conduct standards that are held responsible for the objectives of the Code of Conduct.

Education and training include, but are not limited to:

- Annual Compliance Training;
- Code of Conduct;
- Privacy;
- Fraud, Waste and Abuse.

In addition, L.A. Care has developed a program to provide Fraud, Waste, and Abuse training as well as general Compliance training to its first-tier, downstream, and related entities (FDRs) on an annual basis.

First-tier, downstream, and related entities who have met the fraud, waste, and abuse certification requirements through enrollment into the Medicare program or accreditation as a Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) are deemed to have met the training and educational requirements for fraud, waste, and abuse.

These training programs are conducted for new employees and Board members after hire or appointment and annually after that. These training programs are updated before annual training to incorporate any changes to Federal or state laws or regulations regarding compliance and/or fraud, waste, and abuse requirements.

VII. Effective Lines of Communication and Pathways for Reporting Compliance Concerns

L.A. Care is committed to fostering dialogue between management and employees and among all stakeholders and L.A. Care management, including first-tier, downstream, and related entities. It is essential for all individuals who perform services for L.A. Care members to know where to turn when they are seeking answers to questions or reporting potential instances of fraud, waste, abuse, or other potential violations of law, regulations, or company policies. Employees also should feel free to make these inquiries or reports without fear of retaliation or retribution. To facilitate these goals, L.A. Care expects its managers to maintain an open-door policy that facilitates effective communication with employees. We also establish various communication mechanisms with our first tier, downstream, and related entities regarding compliance and performance issues and regulatory information, including routine meetings with compliance and management staff of first tier, downstream, and related entities.

L.A. Care encourages and expects its staff, vendors, members, first tier, downstream, and related entities to promptly and appropriately report actual or potential wrongdoing, errors, actual or potential violations of law, regulation, policy, procedure, contractual obligation, ethics, or the Code of Conduct. As noted below, L.A. Care has established several pathways for reporting any performance or compliance issue and enforces policies for non-retaliation for such reporting. Any such reports may be communicated anonymously or with the reporter's contact information.

REPORTING TO L.A. CARE MANAGEMENT

Reports of performance or compliance concerns may be made to any of the following individuals: Chief Compliance Officer, Chief of Human Resources, Human Resources Business Partner, or any member of the L.A. Care management team.

REPORT COMPLIANCE ISSUES – COMPLIANCE HOTLINE/HELPLINE

L.A. Care Compliance Hotline and Helpline are available to Board members, employees, contractors, providers, members, first tier, downstream, and related entities, and other interested persons for confidential/anonymous reporting of violations or suspected violations of the law and/or compliance program and/or questionable or unethical conduct or practices including, but not limited to the following:

- Incidents of fraud, waste, and abuse;
- Criminal activity (fraud, kickback, embezzlement, theft, etc.);
- Conflict of interest issues; and
- Code of Conduct violations.

Verbal communications to the Compliance Helpline, written reports to the Compliance Department, and reports to Management staff shall be treated confidentially to the extent permitted by applicable law and circumstances. The caller and/or reporter need not provide his or her name. Communications via the Compliance Helpline or in writing shall be treated as privileged to the extent permitted by applicable law.

Reporting Compliance Issues:

- **On the Phone:** *L.A. Care Compliance Hotline: 1-800-400-4889 or 213-694-1250 x4292*
- **Website:** <http://www.lacare.ethicspoint.com>; or
- **Via Email:** reportingfraud@lacare.org

REPORT PRIVACY AND INFORMATION SECURITY INCIDENTS

Staff is encouraged to report privacy and information security incidents to the Privacy Officer and/or Information Security Officer.

Report HIPAA and privacy incidents to PrivacyOfficer@lacare.org

Report security incidents infosec@lacare.org
(CC: PrivacyOfficer@lacare.org)

A. HIPAA

The Health Insurance Portability & Accountable Act of 1996 (HIPAA) is enforced by the OCR and requires healthcare entities to ensure certain risk safeguards are in place to prevent the inadvertent or intentional release of PHI.

The HIPAA Final Privacy Rule (as amended) sets forth the specific program elements L.A. Care must have in place to ensure that information is maintained in a confidential manner. Program elements of an effective privacy program include many of the same elements addressed in this overall Compliance Plan, including:

- Risk analysis and monitoring.
- Effective employee privacy education.
- Use of a Business Associates Agreement (BAA) or similar agreement for any entity who will be viewing or handling any elements of PHI.
- Policies regarding disciplinary or corrective actions following a confirmed privacy event.

B. California Confidentiality Laws

The State of California has enacted legislation that complements, and in some cases extends, the obligations of health providers under the Privacy Rule. L.A. Care adheres to the requirements of these statutes and promulgating regulations:

- **Confidentiality of Medical Information Act (CMIA) [CA. Gov. Code § 56 et seq.]**
Places limits on the disclosure of patients' medical information by medical providers, health plans, and businesses organized for the purpose of maintaining medical information. It specifically prohibits many types of marketing uses and disclosures.
- **Use of PHI for Direct Marketing [CA Civ. Code § 1798.91]**
Prohibits a business from seeking to obtain medical information from an individual for direct marketing purposes without, (1) clearly disclosing how the information will be used and shared, and (2) getting the individual member's consent.
- **Patient Access to Health Records [CA H&SC § 123110]**
With minor limitations, gives patients the right to see and copy information maintained by health care providers relating to the patients' health conditions. The law also gives patients the right to submit amendments to their records, if the patients believe that the records are inaccurate or incomplete.
- **Insurance Information & Privacy Protection Act [CA Ins. Code § 791]**
Sets standards for the collection, use, and disclosure of personal information gathered in connection with insurance transactions by insurance companies, agents, or insurance- support organizations. It generally prohibits disclosure of personal or privileged information collected or received in connection with an insurance transaction unless the disclosure is: (1) authorized in writing by the individual, or (2) necessary for conducting business. The individual must be given an opportunity to opt-out of disclosure for marketing purposes.

C. L.A. Care Privacy Plan

As required by HIPAA and relevant matters of law, L.A. Care has implemented various policies used by the Plan to maintain member confidentiality.

- **Privacy Officer**

L.A. Care has designated a Privacy Officer. The Privacy Officer is responsible for maintaining an effective privacy protection program that supports compliance with the Privacy Rule and all related matters of law.

- **Notice of Privacy Practices**

L.A. Care has developed a Notice of Privacy Practices that is publicly available

- **Incident Response & Reporting**

All employees and network providers are responsible for notifying the Compliance Department regarding any potential or confirmed breach of a member's privacy and/or a privacy complaint from a member. Upon notification, the Compliance Department conducts an investigation of all relevant facts. If necessary, a review of computer access logs to patient records will be performed. Once all pertinent details are collected through the investigation, the Compliance Department determines if the breach is federally reportable. All privacy incidents are documented and on the Privacy Incident Log.

- A privacy breach that meets the prescribed risk threshold (as provided by the OCR) is reported to the OCR electronically through the agency's online reporting portal. Privacy incidents affecting members shall be reported to the Privacy Officer, pursuant to the stipulations in the plan-to-plan agreement. If necessary, the Chief Compliance Officer notifies Corporate Communications for significant or extensive breach incidents requiring notification of the media.

POTENTIAL MISCONDUCT OR FRAUD, WASTE AND ABUSE REPORTING

Staff is encouraged to report privacy and information security incidents to the Privacy Officer and/or Information Security Officer.

Report potential FWA to reportingfraud@lacare.org

CONFIDENTIALITY AND NON-RETALIATION

Verbal communications to the Compliance Hotlines, written reports to the Compliance department, and reports to management staff shall be treated confidentially to the extent permitted by applicable law and circumstances. The caller and/or reporter need not provide his or her name. Communications to the Compliance Hotline or in writing shall be treated as privileged to the extent permitted by applicable law.

L.A. Care's policy prohibits any retaliatory action against a Board member, employee, or employee of a first-tier, downstream, or related entity for making any verbal or written communication in good faith. Discipline shall not be increased because a Board member, employee, or first tier, downstream, and related entities reported his or her violation or misconduct. Prompt and complete disclosure may be considered a mitigating factor in determining a Board member's, employee's, or first tier, downstream and related entities discipline or other sanction.

Although Board members, Employees, and first-tier, downstream, and related entities are encouraged to report their wrongdoing, Board members, Employees, and Contractors may not use any verbal or written report to insulate themselves from the consequences of their violations or misconduct. Board members, Employees, and Contractors shall not prevent, or attempt to prevent, a Board member, employee, or Contractor from communicating via the Compliance Helpline or any other mechanism. If a Board member, employee, or Contractor attempts such action, he or she is subject to disciplinary action up to and including dismissal or termination.

L.A. Care also takes violations of its reporting policy (e.g., retaliation) seriously, and the Chief Compliance Officer will review disciplinary and/or other corrective action for violations, as appropriate, with the Compliance and Quality Committee.

VIII. Enforcement of Standards through Well-publicized Disciplinary Guidelines

L.A. Care takes all reports of violations, suspected violations, questionable conduct, or practices seriously. L.A. Care's Compliance program and enterprise policies and procedures include clear disciplinary policies that establish the consequences of violating the law, regulations, or company policies. The disciplinary policies are enforced through the following means:

- There are well-publicized disciplinary standards available to all parties;
- There is consistent application of disciplinary standards and
- There is a well-documented standardized process that is followed when taking disciplinary action.

Although each situation is considered on a case-by-case basis, L.A. Care consistently undertakes appropriate disciplinary action to address inappropriate conduct and to deter future violations. L.A. Care policies and procedures and the Code of Conduct state that employees in violation of policies and procedures may be disciplined up to and including termination of employment.

When appropriate, the progressive discipline procedure consists of:

- Verbal counseling and education;
- First written warning with enhanced education and oversight;
- Final written warning, which may include suspension; and
- Discharge/termination.

Disciplinary action may also be taken for:

- Authorizing or participating in a violation;
- Failing to report a violation or suspected violation;
- Refusing to cooperate with the investigation of a suspected violation;
- Retaliating against an individual who reported, in good faith, a suspected violation; and
- Failing to complete required training.

IX. Effective Systems for Routine Monitoring and Auditing

L.A. Care has established the following procedures for its various monitoring and auditing activities:

MONITORING AND AUDITING

To ensure that all L.A. Care Health Plan members receive high-quality and medically appropriate healthcare services, L.A. Care shall staff perform an annual audit of contracted risk-bearing or delegated organizations, which evaluate the contracted/delegated entity's performance and compliance with all contractual and regulatory requirements. L.A. Care shall also regularly conduct internal audits and monitor its operations to identify and correct any potential occurrences of noncompliance or barriers to compliance. Compliance audit priorities will be determined annually or as new risks are identified. L.A. Care will assess current enforcement trends, operational and clinical risks identified during the annual risk assessment, guidance from regulatory authorities, potential compliance issues of which it is aware, and the annual OIG Work Plan when assigning audit priorities.

Audit reports and/or findings will be prepared, and results of an audit will be provided to the appropriate members of senior management and to the Compliance and Quality Committee to ensure that management is aware of the results and can take necessary steps to correct any concerns to prevent reoccurrence of the activity. Audit reports shall specifically identify the reason for the audit, any suspected noncompliance, areas where corrective action is needed, or self-disclosure is appropriate, and in which cases, if any, subsequent audits or studies would be advisable to ensure that the recommended corrective actions have been implemented and are effective.

RISK ASSESSMENT AND MITIGATION MANAGEMENT

L.A. Care Compliance Department has established and implemented an effective system for the identification of risk. On an annual basis, the Compliance Department will conduct risk analysis, including the CMS and CMC annual risk assessment of the organization.

OVERSIGHT OF DELEGATED ACTIVITIES

L.A. Care delegates certain functions and/or processes to contractors who are required to meet all contractual, legal, and regulatory requirements and comply with L.A. Care Policies and Procedures and other guidelines applicable to the delegated functions.

L.A. Care maintains oversight over all contractors, including but not limited to the following delegated activities:

- Utilization Management;
- Review of Provider Dispute resolution cases;
- Practitioner and provider credentialing and re-credentialing;
- Provider network contracting;
- Claims payment;
- Cultural & Linguistic services;
- Pharmaceutical services/benefits;
- Care management/coordinator of care and
- Compliance Program Effectiveness.

OVERSIGHT OF NON-DELEGATED ACTIVITIES

L.A. Care also maintains oversight of the following internal activities that are not delegated to contractors and remain the responsibility of L.A. Care:

- Quality Improvement Program;
- Member Grievances;
- Development of credentialing standards in specified circumstances;
- Development of utilization standards;
- Development of quality improvement standards;
- Pharmacy and drug utilization review
- Compliance and Program Integrity Plans

OVERSIGHT AUDITS AND REPORTS

L.A. Care conducts various oversight audits, including pre-delegation, annual, and ad-hoc or unannounced audit and monitoring activities. The annual audit of delegated PPGs/IPAs, Plan Partners, and sub-contracted entities is conducted to ensure that delegated responsibilities and services comply with program requirements. Any deficiencies identified during the annual audit process will result in corrective action plans. The corrective action plan developed by a PPG/IPA, Plan Partner, or sub-contracted entity will identify the deficiency, outline how the deficiency will be corrected, and set a time frame for implementing the corrective actions.

Regularly (monthly or quarterly), PPGs/IPAs, Plan Partners, and Specialty Health Plans are required to submit tracking/activity reports to L.A. Care. The reports are analyzed to identify opportunities for improvement and to establish trends and/or patterns. Any variances and/or identified deficiencies will be communicated to the PPG/IPA or Specialty Health Plan as applicable. Additional information will be requested to explain the identified variances or deficiencies. The reports submitted by PPGs/IPAs and Specialty Health Plans address activities in utilization management, member services, pharmacy, information systems, provider network services, financial solvency, and claims reimbursement. Below are examples of the new Auditing Reports for 2024

A. Anti-Fraud Plan & Report

In accordance with California Health and Safety Code, Section 1348, L.A. Care will prepare an annual Anti-Fraud Plan that is integrated into the routine managed care compliance activities through investigation of potential or actual FWA. The purpose of the Anti-Fraud Plan is to organize and implement an effective strategy to identify and reduce costs to health plans, providers, members, and others impacted by fraudulent activities and to protect consumers in the delivery of healthcare services through timely detection, investigation, and reporting or prosecution of suspected FWA.

The elements of the Anti-Fraud Plan include:

- a. Designation of an individual with specific investigative expertise in leading fraud investigations;
- b. Training of Plan and FDR employees concerning detection of healthcare fraud in managed care;
- c. The Plan's procedure for managing incidents of suspected fraud; and
- d. The internal procedure for referring suspected fraud to the appropriate government agency.

The anti-fraud activities, investigations, reports, and corrective actions are summarized and submitted to the DMHC in an annual report. This annual report includes specific actions taken by the Plan to prevent or detect misconduct, the number of reports made to a government agency regarding suspected fraudulent activity, the number of cases prosecuted by the Plan, and any other recommendations the Plan may have to combat healthcare fraud in the industry.

The Chief Compliance Officer, or his/her designee(s), is responsible for overseeing the performance of the following activities:

- a. Developing and implementing an effective program to detect, investigate, report, and resolve potential and actual instances of FWA.
- b. Maintaining member continuity of care and quality of care during FWA investigations.
- c. Improving provider understanding of fraudulent practices and reporting methods through effective and ongoing provider education.
- d. Improving member understanding of fraudulent practices and reporting methods.
- e. Responding to member needs, such as escalated complaints and FWA concerns.
- f. Creating a mechanism for the detection of FWA. Ongoing monitoring responsibilities include reviewing coding trends for all provider types to identify outliers that may require additional assistance, education, or corrective action, if necessary. Analysis includes medical record documentation reviews with additional related information.
- g. Coordinating investigations with internal L.A. Care departments (i.e., Corporate Compliance, Legal) and, as applicable, with law enforcement or government agencies. L.A. CARE is responsible for conducting special investigations to determine provider compliance and assisting legal counsel with responding to requests from enforcement agencies.
- h. Improving overall FWA awareness and education.

B. Annual Planned Projects and Activities

Each year the Chief Compliance Officer reviews and adopts a set of planned projects and activities for the Compliance Department to work toward during that year. These projects and activities are a part of the overall process for assessing and evaluating relative risk to the Plan. The Compliance Department completes ongoing risk assessments as part of its annual plan of projects and activities. Potential risks identified from external resources are reviewed and evaluated for relevance to L.A. Care managed care lines of business, and if applicable, the effectiveness of current internal controls already in place are evaluated. The planned projects and activities are reviewed annually by the C&Q Committee.

The Compliance Department monitors activities on a regular basis to ensure regulatory and compliance activities are completed timely.

- a. The Compliance Plan is reviewed and approved annually by the C&Q Committee.
- b. Activity reports reflecting trends are presented regularly to the C&Q Committee.
- c. Regulatory and compliance activities are completed timely, accurately documented, and maintained in a secure drive or database.

The planned projects and activities assist in building an effective work plan that the organization uses to maintain and enhance L.A. Care's compliance risk posture. In addition, the compliance risk assessment process considers the reasonableness of the levels of effort and effectiveness of various functions performed within L.A. Care.

C. Consideration of Plan Risks

1. On-going Mechanisms for Identifying and Assessing L.A. Care Compliance Risks:

- Compliance monitoring and auditing, investigations, and risk assessments conducted by the Plan's Compliance Department, and government surveyors to monitor compliance and assist in the reduction of identified problem areas.
- Compliance staff participation on key committees within L.A. Care and external industry-wide work groups and open lines of communication with L.A. Care Compliance Organization.
- Ongoing review of the OIG Work Plan and DMHC identified objectives.
- Ongoing review of guidance and other materials published by the DMHC, OIG, CMS, and the Office of Civil Rights (OCR) websites.
- The investigation and remediation of identified systemic problems.

The Chief Compliance Officer, or his/her designee(s), will work with the L.A. Care management team to ensure ongoing compliance with state and federal regulations and to correct any deficiencies that have been identified. The Chief Compliance Officer, or his/her designee(s), will issue CAPs as necessary to ensure that all deficiencies are resolved appropriately.

Ongoing efforts to monitor compliance will include an annual mock audit of medical management and claims and finance activities using the same audit methodology as the DMHC. The Compliance Department also performs routine internal monitoring and auditing of other managed care activities including, but not limited to, appeals and grievances, denied referrals, and certain denied claims. Claims payment practices are audited on an ongoing basis by the finance claims auditors.

2. Annual Compliance Program Risk Assessment Process:

The Compliance Department and Internal Audit gathers and analyzes input from the ongoing monitoring mechanisms and develops risk assessments and priorities. These assessments include review of current regulatory trends, trade organizations, and professional journals and may include discussions with Plan leaders, external vendor partners, and benchmarking with select peer institutions. The Compliance Department compiles a composite of high risk areas to guide planned projects and activities along with a review of compliance program efficacy.

D. Monitoring by External Agencies

The Chief Compliance Officer and the Compliance Department monitor the results of audits conducted by external agencies and the completion of the Plan's CAPs. The Chief Compliance Officer, or his/her designee(s), works closely with Plan leaders to ensure all CAPs are implemented efficiently and communicated to external agencies. Plan leaders overseeing reimbursement, medical management, financial operations, and other audited areas are responsible for ensuring implementation of CAPs with their teams and areas of responsibility. All CAPs are sent to the Compliance Department for review and approval before releasing to the external agency.

The Chief Compliance Officer, or his/her designee(s), will be the key contact person(s) for any DMHC audits, working with the appropriate management team within L.A. Care to provide the DMHC with the necessary documents, filings, and materials. The Chief Compliance Officer, or his/her designee(s), will monitor the DMHC website for updated Technical Assistance Guides (audit tools).

1. Oversight of Plan, Provider, and Administrative Contracts

The Chief Compliance Officer, or his/her designee(s), works closely with the Provider Network Management Department in order to track and maintain copies of all L.A. Care Provider contracts and subsequent amendments. Many Plan agreements require acceptance by the DMHC and shall not be considered effective until the DMHC has accepted the agreement or notified the Plan that no objections are forthcoming. The Compliance Department reviews contracts and agreements prior to execution to ensure legally mandated contract elements are included in the document. Any changes to the L.A. CARE contract templates will be filed with the DMHC within thirty (30) days of the effective date of the change.

2. Payment Integrity & Proper Billing

Claims payment practices are audited by L.A. CARE monthly, and the DMHC every three (3) years. Though each audit focuses on different areas, ongoing monitoring efforts serve as an internal control to the reimbursement and payment areas, where claims and billing operations are often the source of FWA in the industry and, therefore, historically have been the focus of government regulation, scrutiny, and sanctions. DMHC's main focuses are claims payment accuracy, timeliness, and provider dispute resolution.

3. Provider Credentialing & Peer Review

The Credentialing Department is responsible for responding to audits. The audits focus on NCQA standards, timeliness, primary source verification, ongoing monitoring, sanctions and exclusions monitoring, and file review.

4. Medical Management

The UM and QM Departments are audited annually by DMHC every three (3) years. The audits focus on UM file review, UM timeliness, UM documentation, case management, access, and continuity of care.

5. Corrective Action Plans (CAPs)

The Chief Compliance Officer, or his/her designee(s), will review audit results and ensure CAPs are submitted timely, maintain a grid showing final scores, date CAP is due, and date CAP was submitted.

E. Delegation Oversight Monitoring

Prior to executing a contract or delegation agreement with a potential delegate, a pre-delegation audit is completed to determine the ability of the potential delegate to assume responsibility for delegated activities and to maintain L.A. Care standards, applicable state and federal regulatory requirements, and accreditation requirements. The initial evaluation includes, but is not limited to, a review of the entity's operational capacity and resources to perform the delegated functions, the entity's ability to meet contractual and regulatory requirements, and verification that the entity is not excluded in the OIG List of Excluded Individuals/Entities (LEIE), the General Services Administration (GSA) System of Award Management (SAM), or the California Department of Health Care Services Medi-Cal Suspended and Ineligible Provider List from participating in health programs. Results of the initial evaluation and ongoing delegation audits are presented to the Delegation Oversight Committee for review and approval. Pre-delegation and ongoing delegation audits of medical management activities are also reported to QI and UM.

1. Contracting with Delegates

Once an entity has been approved, the delegation agreement specifies the activities that L.A. CARE delegates to the delegate, each party's respective roles and responsibilities, reporting requirements and frequency, and the process for performance evaluations and audits. Delegation agreements also include provisions for disciplinary actions and remedies for any instances of non-compliance with the contract and applicable state and federal regulations. Prior to any sub-delegation, the delegate must obtain approval from L.A. CARE, who will directly monitor the sub-delegate's compliance with requirements.

2. Annual Delegation Oversight Audits

The Audit Service as Department will conduct an annual comprehensive delegation oversight audit to determine the delegate's performance of the delegated activities. High risk delegates are those that are continually non-compliant or at risk of non-compliance based on identified gaps with

contractual standards, applicable state, CMS, and accreditation requirements, or L.A. Care policies and procedures. Any previously identified issues, which include any CAPs, service level performance, or complaints and appeals from the previous year will be factors that are included in the delegation oversight audit. Any delegate deemed high risk or vulnerable is presented to the DOC for suggested follow-up audit. Delegates determined to be high risk may be subjected to a more frequent monitoring and auditing schedule, as well as additional reporting requirements.

If L.A. Care has reason to believe the delegate's ability to perform a delegated function is compromised, an additional focused audit may be performed. The Chief Compliance Officer, or his/her designee(s), may also recommend focused audits upon evaluation of non-compliant trends or reported incidents. The results of these audits will be reported to the DOC. The risk assessment process and reports from delegates will be managed by the Chief Compliance Officer, or his/her designee(s), and presented to the DOC for review and discussion. L.A. Care is ultimately responsible for identifying and correcting all instances of non-compliance with all delegated entities.

A focused audit may be initiated for any of the following reasons, or any other reason at the discretion of the Chief Compliance Officer, or his/her designee(s):

- Failure to comply with regulatory requirements or L.A. Care policies and procedures or service standards;
- Failure to comply with a CAP;
- Reported or alleged FWA;
- Significant policy variations that deviate from L.A. Care or state, federal, or accreditation requirements;
- Bankruptcy, impending bankruptcy, or insolvency that may impact services to members (either suspected or reported);
- Sale, merger, or acquisition involving the delegate;
- Significant changes in the management of the delegate; or
- Changes in resources that impact L.A. Care and/or the delegate's operations.

3. Corrective Actions and Additional Monitoring and Auditing

The Chief Compliance Officer, or his/her designee(s), shall submit summary reports of all monitoring, auditing, and corrective action activities to the ICC and C&Q. In instances where non-compliance is identified, a CAP shall be developed by the delegate and reviewed and approved by the Chief Compliance Officer, or his/her designee(s). Every CAP is presented to the DOC for approval. Supplemental and focused audits of delegates, as well as additional reporting, may be required until compliance is achieved.

At any time, L.A. Care may implement sanctions or require remediation by a delegate for failure to fulfill contractual obligations, including development and implementation of a CAP. Failure to cooperate with L.A. Care in any manner may result in termination of the delegation agreement, in a manner authorized under the terms of the agreement.

COMPLIANCE WORK PLAN

The Compliance Work Plan is developed annually and is based, in part, upon the performance of the prior year's Compliance program and the results of audits, monitoring, and other oversight and investigation activities.

The Compliance Work Plan includes:

- Risk Assessment;
- Current GRC technology support for success;
- Vendor Risk Management and FDR assessment;
- Regulatory intake and implementation follow-up;
- Annual roadmap and strategy;
- Planned activities and measurable goals and/or benchmarks to be undertaken in the ensuing year;
- Staff member(s) responsible for each activity;
- Time frames within which each activity is to be achieved;
- Key findings, interventions, analysis of findings/progress, and monitoring activities of previously identified issues.

X. Procedures and Systems for Promptly Responding to Compliance Issues and Suspected Fraud, Waste and Abuse

INVESTIGATING COMPLIANCE ISSUES AND FRAUD, WASTE AND ABUSE ALLEGATIONS

L.A. Care conducts timely and reasonable investigation of all compliance issues and fraud, waste, and abuse allegations. Suppose the investigation leads to credible information regarding the validity of the allegation. In that case, the Compliance Department will make the appropriate referrals to the NBI MEDIC for its D-SNP or Cal Medi-Connect programs or to the Program Integrity Unit at DHCS for its Medi-Cal program, including voluntary self-reporting of potential fraud or misconduct related to the Medicare program to CMS or its designee. In addition, law enforcement agencies are notified as necessary and as required by law.

The Code of Conduct communicates the requirement that all L.A. Care employees are responsible for reporting suspected fraud, waste, or abuse. The Special Investigations Unit is responsible for performing internal and external investigations into all fraud, waste,

and abuse allegations of or suspected activities associated with L.A. Care programs, members, providers, and first-tier, downstream, and related entities. The SIU, in consultation with relevant internal management, refers suspected fraud matters to appropriate state and federal regulators and assists law enforcement by providing information needed to conduct investigations.

CORRECTIVE ACTIONS AND ROOT CAUSE ANALYSES

Corrective action initiatives, as identified through routine monitoring and internal audit activities or the investigation of noncompliance or fraud, waste, and abuse, are monitored and managed by the Chief Compliance Officer. Corrective actions are designed to correct conduct or issues and to address the causes of compliance issues as may be identified in a root cause analysis. Corrective action plans are implemented for both internal and first-tier, downstream, and related entity noncompliance or performance issues. Corrective action plans are documented in a format determined by the Chief Compliance Officer and include specific implementation tasks, individuals accountable for implementation, and required time frames for remediation activities.

Corrective action initiatives may include actions such as the repayment of identified overpayments and making reports to government authorities, including CMS or its designees (e.g., NBI MEDIC) and law enforcement, as necessary or required. The Chief Compliance Officer will report any routine corrective actions to the Internal Compliance Committee, the senior leadership team, and the Board every quarter.

Compliance and Fraud, Waste, and Abuse corrective actions may include but not be limited to:

- Termination of employment;
- Creation of or revision to policies and procedures;
- Self-reporting of the issue to CMS or other regulatory agencies;
- Referral to NBI MEDIC or other law enforcement or regulatory agencies;
- Repayment of overpayments – L.A. Care can demand a refund of overpayments from fraud or abuse claims submitted by providers or members;
- Identifying and recommending providers for termination, including physicians and pharmacists who have defrauded or abused the system;
- Identifying and recommending members for dis-enrollment due to fraud abuse or
- Provider education - The business and operations units shall have the ability to notify and educate providers and pharmacies regarding activities that may involve claims data or referral information that indicates a potential problem.

Corrective actions may include various auditing and monitoring activities to confirm that the corrective action initiatives have remediated noncompliance or performance issues.

XI. Measures to Prevent, Detect, and Correct Fraud, Waste, and Abuse

Under the SIU of Risk Management, L.A. Care conducts investigations of all suspected fraud, waste, and abuse allegations, including evaluation of all suspected FWA activities in the healthcare industry and how such trends might affect the operations of L.A. Care and its members and stakeholders. The Code of Conduct communicates the requirement that all L.A. Care employees are responsible for reporting suspected fraud, waste, or abuse. The SIU is responsible for performing internal and external investigations into all fraud, waste, and abuse allegations of or suspected activities associated with L.A. Care programs, members, providers, and first-tier, downstream, and related entities. The SIU, in consultation with relevant internal management, refers suspected fraud matters to appropriate state and federal regulators and assists law enforcement by providing information needed to conduct investigations.

L.A. Care also conducts data mining of its claims, encounters, and other data to identify potential fraud schemes and communicates potential fraud schemes with its first-tier, downstream, and related entities.

XII. References

- California Confidentiality of Medical Information Act (CMIA) [CA. Gov. Code § 56 et seq.] California Insurance Information & Privacy Protection Act [CA Ins. Code § 791]
- Deficit Reduction Act of 2005 (DRA)
- False Claims Act (FCA) [31 USC § 3729 et seq.]
- Fraud Enforcement Recovery Act of 2009 [Public Law No. 111-21]
- Health Information Technology for Economic & Clinical Health (HITECH) – in part to ARRAY of 2009 [Pub. L. 111-5 § 13400-13424]
- Health Insurance Portability & Accountability Act of 1996 [42 USC § 1320(d-6)] HIPAA Administrative Simplification [45 CFR Parts 160, 162, 164]
- Knox-Keene Act Health Care Service Plan Act of 1975 [HSC 1340 et seq.] Medicare Managed Care Manual, Chapter 21
- Medicare, Medicaid & SCHIP Extension Act (MMSEA) of 2007 § 111 [42 U.S.C. § 1395y(b)(8)]
- Office of Inspector General's Compliance Program Guidance for Medicare+ Choice (MA+) Organizations Offering Coordinated Care Plan [FR Vol 64 No. 219 11.15.1999]

- Patient Protection and Affordable Care Act of 2010 [42 U.S.C. § 18001 et seq.] Title 28 of the California Code of Regulations – Managed Health Care
- Title 42 – Public Health and Title 45 – Public Welfare of the Code of Federal Regulations. United States Sentencing Commission Chapter Eight - Sentencing of Organizations

XIII. Conclusion

L A. Care's Compliance Program is constantly evolving to ensure that the organization adopts and monitors the implementation of policies and procedures and other performance standards that require L.A. Care Health Plan and its employees, participating providers, and other contracted entities to act in full compliance with all applicable laws, regulations and contractual requirements. The Compliance Program description is subject to future amendments to reflect the compliance department's scope of activities and L.A. Care Health Plan's legal and financial compliance with applicable laws, regulatory requirements, industry guidelines, and policies.

CMO Report December 2023

Summary of Major Interval Events

- L.A. Care received a preliminary “intent to sanction” based on the Medi-Cal Accountability Set (MCAS) performance for \$890k on 12/5/23. As previously noted, this was based on a new framework that placed L.A. Care in the highest tier for quality (based on State and/or Regional benchmarks), but in tier 2 for financial sanctions (based on national benchmarks). The sanction amount is heavily influenced by the size of the health plan while underrepresenting how close the plan is to the actual benchmark. We immediately began discussions with LHPC and DHCS to advocate for a different methodology and had our Meet and Confer with DHCS on 12/19/23. Though regulators understood and seemed aligned with our concerns, on 12/29/23 we received a formal Sanction Notice without any adjustments to the methodology or amount. We will vigorously defend our position and are planning to formally appeal.
- L.A. Care received information on the 2024 Q1 and Q2 default auto-assignment rates for new unassigned membership at the end of November. As we have discussed, there was a sudden and dramatic change in DHCS’s methodology that has shifted the balance away from Local Health Plans despite a continued differential in quality performance. Using the new calculation, L.A. Care’s default rate shifted from 59% to 53%. Information about the methodology was sparse leading into the end of December at which point, it became clear that there were calculation errors. After DHCS refreshed the numbers, Plans were given from 12/20-12/26 to check the calculation. Health Services discovered a number of significant concerns with the new methodology, collaborated with other Local Health Plans, and held a series of discussions with DHCS in an attempt to defer the policy change. By the evening of 12/22, we received notice from DHCS that they would reopen stakeholder discussions and would consider changing the auto-assignment methodology to better reflect Plan performance. They have stated that their IT platform will not allow them to alter the assignment methodology for Q1, but they will disproportionately correct Q2-Q4 assignment to adjust for any changes in the methodology that would have affected Q1. We have a weekly meeting schedule with DHCS to arrive on a new calculation by February.
- We are continuing to make progress with our Field Medicine Plan for the County. This represents a way of delivering care to the unhoused in an operationally sound and scalable way. We intend on deploying Street Medicine services to provide members with in-the-moment access to care while creating a glidepath to longitudinal care and full primary care assignment. The plan incorporates financial support for high provider-density regions with large unhoused populations that require greater coordination through “Care Collaboratives.” It also extends support for City and County Interim Housing Initiatives. Stakeholder meetings are ongoing this week and will conclude by mid-month. We are preparing a significant investment of HHIP and IPP funds to support implementation of the plan in March. The Community Health team will be making a full presentation to the Board of Governors in an upcoming session.
- The CM/UM/MLTSS department is moving forward with a reorganization of its efforts around over and underutilization of healthcare services in the network. We have a new medical director who has come on board to lead this effort alongside our Analytics and Quality Improvement departments. She is currently prepping our dashboarding and aligning on a list of high priority efforts. At the same time, we have completed hiring our new in-house Medical Directors who, while providing some UM physician review, will each have an additional focus on clinical collaboration across the organization including for claims, appeals and grievances, fraud/waste/abuse, network, California Children’s Services, and discharge planning.

Departmental Review

Care Management/Utilization Management/MLTSS Departments

Care Management

Enhanced Care Management (ECM)

ECM leaders continue to implement quality improvement activities related to staff roles, technology, and processes to align with the DHCS ECM Policy Guide.

- **Data Integrity**
 - Coordinators from the CM team completed corrections of thousands of enrollments
 - Continued creating code sets to assist with accuracy and completeness of enrollment data
 - Developed Referral and Enrollment KPIs for internal use and for DHCS reporting

- **Payment Model**
 - Conducted a full payment reconciliation on CY 2022 and Q1 2023. Complete and accurate numbers are now available for reporting and payment recovery amounts validated to claims/encounters.
 - Worked with Actuary to develop a fee-for-service (FFS) rate structure. We are anticipating moving forward with this change once we have obtained additional feedback from our network with likely implementation April 2024.
 - Updated the ECM provider contract to include compensation for outreach services to offer members ECM. This change in payment is retro to July 2023 and covers all outreach including unsuccessful attempts at reaching members.

- **Clinical Oversight**
 - Team is testing the new audit tool with a few providers. Concurrently, the ECM team is communicating standards and expectations to all providers in advance of launching full-scale audits during Q1 2024.
 - Developing reports to assess provider performance such as average time from referral to enrollment and rates of face-to-face interventions.

- **Network**
 - Working with IT to develop a dashboard to overlay the provider network expertise and capacity with our ECM eligible membership.
 - Numerous factors will likely prompt changes to network as providers respond to changes in the payment model, contract and oversight activities described above.
 - Developed the LA County ECM provider capacity report with partnership from the local MCPs. This will support capacity planning and DHCS reporting requirements.
 - In collaboration with local MCPs the team sent out the Justice Involved (JI) ECM provider survey to assess how many of our current providers can meet the DHCS JI Provider requirements. The survey results along with follow up meetings helped finalize the LA County JI ECM provider network, which will serve our members upon release from incarceration.

- **Staffing**
 - Continue to add and update job aids. Reference guides have been developed to standardize compliant processes.
 - Team building
 - Current: 6 FTEs +1 Consultant
 - In recruitment: 10 positions (4 backfills, 6 new positions)
 - Future: 4 new positions pending approval
- **Enrollment**
 - Plan to increase its ECM Enrollment from the current ~10k to 30k members for Q3 2024. This goal will require significant cross-functional efforts and the ECM provider network to achieve.

Transitional Care Services (TCS)

- CM team began implementing the TCS program in Q1 2023 using Care Managers (CM) and Community Health Workers (CHWs). With 16 new staff hired in August and September and finishing training, we have been able to increase monthly outreach to hospitalized members dramatically: 147 in July 2024 in August and 554 in September – a remarkable 377% increase in only two months. As of mid-October, year-to-date 1,929 members have been outreached for TCS. We anticipate that with the additional planned hiring and training that by end of Q2 2024 we will reach the goal of outreaching to 3K high-risk admissions per month.
- So far, we have had a high engagement rate, with about 44% of members we outreach to participating in part or all of the TCS process. While difficult to measure outcomes at this point in the program, there is intrinsic value in engaging with our members in the critical period post-transition to help with follow-up visits, medications and other services critical to members in their most vulnerable time after hospitalization.
- The CM team is working with other departments
 - CM is collaborating with the MLTSS team in the development of plans for new populations of focus that will also need TCS starting in 2024, primarily the long term care population residing in skilled nursing facilities (SNF) and in Intermediate Care Facilities for the Developmentally Disabled (ICF-DD). In partnership with CM, MLTSS is creating workflows, assessing staffing needs, testing tools, drafting letters, determining documentation standards and creating training schedule and materials.
 - In addition, Network is working to ensure PPGs are aware of, and are performing, TCS for the high-risk populations for which they are responsible.
- In response to LAC and other health plans’ feedback, DHCS issued updated guidance late-October for the TCS requirements for 2024 related to low-risk members.
 - Plans no longer have to assign all members with a transition to a care coordinator. However, hospitals, SNFs etc. will need to inform each member that TCS services are available through their health plan and inform members about how to reach out to the health plan to start the process.
 - We are adjusting our plans accordingly. LAC will have a centralized intake line to the TCS team that take the requests and then assign staff.
 - We will need to build system and process to establish responsibilities and hand-offs between LAC, PPGs, hospitals and potential vendors.

General CM

- CM had no audit findings in the reports from the recent DHCS and DMHC Preliminary reports. Despite that, the team continues to work on improvements in areas identified as potential findings during the on-site portion of the audits such as California Children's Services (CCS) (see below).
- CM continues to work on adopting and implementing new PHM requirements from DHCS (not covered in above sections).
 - These efforts include significant IT work such as:
 - Configuring IPRO (analytic stratification tool) to account for newly introduced DHCS high-risk populations, including those meeting definitions for SMHS/SUD, those transitioning into or out of SNFs, and individuals within 12 months post-partum.
 - Implementing an effective system of tracking members in CM and TCS across the PPGs so case transfers, assignments, and coordination are seamless.
 - Integration of DHCS's PHM Service risk stratification and segmentation logic into IPRO and CCA (Case Management documentation platform) upon its release in CY2024.
 - Transitioning to the new version of CCA.
 - Headwinds
 - DHCS expectations have shifted throughout the year. While some of the changes are welcome, the changes hold challenges in planning and implementation.
 - High-risk populations are more fluid than DHCS is accounting for. These populations have associated expectations for assessment, care coordination, TCS, and formal care management that do not divide cleanly between the PPGs and LAC's internal CM team because the stratifications do not necessarily account for clinical or utilization risk.
 - Team Building
 - Hiring remains a focus as we build capacity to meet the new requirements. Bringing on experienced and/or skilled staff at a pace that matches the pipeline of new work for DSNP and PHM has been difficult.
 - Attrition in recent months is higher than the department's multi-year trend due to both the demands of the work itself as well as the current volume of attractive job prospects outside of the organization.
 - As of 10/31/23: 53 new staff have started (including staff for ECM and TCS) during CY2023.
 - With the expanded requirements and populations of focus, recruitment continues for numerous positions. Examples include: Coordinators (9 + 2 Supervisors); Program Manager (1); Care Managers (12 + 5 Supervisors + 1 Manager); Data analyst (1).
- DSNP
 - CM continues to work on adopting and implementing new DSNP requirements. These efforts include significant IT work such as:
 - Configuring a new Health Risk Assessment (HRA) into CCA to account for new required DSNP elements. The HRA is the foundation for nearly all care coordination processes. Consequently, in addition to the HRA, all current operational and regulatory reports as well as related operational processes will need revisions to account for the new HRA.
 - Updating note templates and modules in CCA in order to track and report face-to-face activities in accordance with new DSNP program expectations.
 - LAC's CM team is performing well on DSNP metrics and is advising EPO on the audit and oversight of PPG performance.

- CM staff audit process was selected for review in the recent Medicare mock Compliance Program Effectiveness audit and received positive feedback on their monitoring processes.

Utilization Management

Timeliness Corrective Action Plans (relates to June 2021 regulatory disclosure, 2021 DHCS Audit and 2022 Enforcement Action. The DMHC Preliminary Report for the 2021 Routine Survey also listed two timeliness findings.) UM continues to make extraordinary progress in this area. We have made incremental improvements quarter over quarter for the past year.

Compliance Scorecard measures – Q3 2023 most recent available

- Overall performance for all Lines of Business
 - 50/52 measures > 95%
 - 50/50 measures > 90%
- Direct Network only (Medi-Cal subset)
 - 20/20 measures > 95%
 - LAC continues to submit Direct Network scores and narratives on process enhancements and staffing levels to DMHC via quarterly reports.

UM Team Development

Since 1/1/23, 42 new FTEs have been hired

- As of 10/31/23 multiple positions were open
- Note: UM expectations/standards have been made clear, and are being enforced with the team leading to an increased turnover rate. Anticipate this will level-off with the latest round of resignations
 - 2 new Supervisor positions to support the growth of the Quality Team (in recruitment)
 - 4 Medical Directors (two hired with start dates in November, one in December, one in January.)
 - Quality Manager (resignation, filled with internal candidate early November)
 - Director, Outpatient (resignation, in recruitment for external candidate)
 - Manager, Inpatient (resignation, filled, start date 11/20/23)
 - Supervisor, Inpatient (internal transfer, subsequently filled with start date 11/6/23)
 - Supervisor, Outpatient (internal transfer, in recruitment)
- The Quality team now has seven auditors (five clinical, two nonclinical), four trainers (two clinical, two nonclinical), and one policy nurse. These positions are critical to ensure staff are trained for compliance and quality and to conduct monitoring and oversight of the team that will help us sustain the demonstrated improvements as well as ensure implementation of corrective action plans from regulatory audits (described below).
- The ER/Admit team phone queue went live in mid-May, but has three openings that have been difficult to fill as they are evening and night shifts. This has also been a tough team to keep staffed as the calls can be challenging. Maintaining management coverage for nights and weekends has been difficult.
- The Discharge Planning team has been sluggish to staff but has 5/6 positions filled. Progress also slowed when the Supervisor for the team was on a leave during all of October. A P&P was developed to set standards for phone queue management and customer service.
- The data analyst has been assisting with tracking productivity and projecting staff capacity. As a result, in early November the Inpatient clinical teams restructured to a pod system to better distribute work based on hospital volume and contract type (DRG and per diem). The inpatient team was also able to significantly reduce the inventory of aging concurrent review cases.

Systems

- SyntraNet – enhancements have been on schedule for deployment since September and are scheduled to continue to the end of the year. The system is now displaying member ages and correct due dates for decisions and notifications, which will assist the team in prioritizing cases for completion, thus maintaining the high timeliness metrics. The post-stabilization log for tracking and monitoring was also added.
- QXNT UM – Plans are in full swing for a conversion from Syntranet to QNXT in 2024. UM team is working with LAC IT and Cognizant staff to develop and execute an extensive workplan. Currently the team is building specifications for work queues and planning for user acceptance testing to start in mid-December. While these planning stages heavily impact the leadership on multiple teams (UM, ECM, MLTSS, CS), we look forward to the future flexibility and improved speed of configuration as regulatory requirements and business-needs change. In addition, we welcome the integration with QNXT claims that is expected to reduce abrasion that impacts our day-to-day relationships with our providers.

UM Cross-Functional Collaborations

- Coordination between UM and Grievance & Appeals and Quality
 - The three teams have increased their meeting frequency to weekly.
 - A new processes and leveling for medical directors to review grievances that appear to have quality of care (QOC) concerns ASAP after receipt continues to be developed and refined. Findings from the recent audit reports as well as updated guidance from DHCS regarding timeliness and peer protection are being accounted for. The new clinical grievances workflow is expected to be completed by the first week in December, and receiving sign-off from Compliance by mid-December. Once regulatory compliance is validated, all relevant policies and procedural documentation will be updated to reflect the substantive changes and Health Services and Operations leadership will convene to plan and implement a clinical staff model designed to support this new process.
 - The Medical Directors received training in the PCT system in October and are now documenting directly in the A&G system rather than by email.
 - A framework for metrics and reporting was developed to track denials rates, appeal rates, uphold/overturn rates and break down by entity (e.g. LAC, PPG). The business case is under review with IT.
 - The Appeals nurses participated in the 2023 MCG IRR, all with passing scores. Discussion is occurring to establish MCG training course of action.
- California Children's Services (CCS)
 - SyntraNet now displays dates of birth in the work queues allowing easy identification of members under 21.
 - We created and filled a UM Supervisor position that will oversee inpatient and outpatient UM staff who will review all pediatric authorization requests to determine whether the member is already enrolled in CCS or needs to be referred to CCS. All complex kids with CCS or CCS eligible diagnoses will be referred to CM/ECM/PPG.
 - Our medical director Dr. Lina Shah has experience with CCS and is working with both UM and CM teams in building processes to ensure kids with complex medical needs are connected with the services they need through formal CCS program enrollment and/or collaboration with other specialty providers.
 - The UM CCS UM Supervisor, and CM leadership have established a CCS workgroup which meets routinely to ensure continued collaboration and process progression.

- In October, DHCS released the final new MOU template with an All Plan Letter. The team is reviewing the new requirements and working with their counterparts at LA County CCS Office to implement it.
- Hospital and SNF
 - UM, MLTSS, PNM, Finance and AAL continue to work on updating contracts with particular focus on ensuring rate allowances that will facilitate timely discharges from hospitals by offering greater access to SNF beds.
 - UM inpatient team continues to meet weekly with multiple hospitals to assist with complex discharge planning needs. While new contracts are pending, Finance has allowed PNM to work with UM on member specific Letters of Agreements to move complex members out of acute beds.
 - Developed a template for hospitals to use in seeking skilled nursing placements to meet the member's needs. The template pilot has been going well with one hospital system and one SNF system working with LAC to expedite discharges. We continue to streamline more targeted referral processes with other large SNF chains.

Managed Long Term Services & Supports (MLTSS)

Since January 2022, the MLTSS team has grown from administering six categories of benefits and services to 15 by 2024. In order to maintain current operations and implement new ones from CalAim, 19 additional staff were approved in June and all of the new positions have been filled as of November.

Community Based Adult Services (CBAS)

- New staff are in training and are expected to take on full time review of new requests for 5-day/week services early in 2024. The staff will focus on reviewing requests to determine the appropriate visit frequency for the member's condition and prevent avoidable over-utilization.
- Team is also working with AAL to quantify the impact of prior efforts to appropriately reduce CBAS frequency requests of 6 and 7 days per week and estimate the savings from UM activities.
- MLTSS leaders are working with AAL on a claims recovery project in which providers were paid inappropriately despite lack of authorization, incorrect codes and incorrect dates/frequency of services. The second part of this effort will use all findings to work with claims team to ensure controls are established to prevent erroneous payments going forward.

CalAIM & Community Supports (CS)

- The MLTSS team is currently administering the following CS services: Personal Care and Homemaker Services; Caregiver Respite; Environmental Accessibility Adaptations
 - Each of these CS have low referrals and approvals.
 - Personal Care and Homemaker Services: while referrals have steadily increased, the highest month so far was August 2023 with 112
 - Caregiver Respite: the average monthly referrals remains in the low double digits with the highest month at 21 in July 2023
 - Environmental Accessibility Adaptations: only two months so far this year have seen double digit referrals
 - LAC is not unique in low uptake of the CS services. DHCS believes that these CS services are underutilized statewide. The Department has provided updated guidance to plans about benefit and eligibility standardization along with expectations that plans increase member access and uptake of these services in 2024.

- In collaboration with the Community Health team, MLTSS is promoting the CS offerings in numerous forums including the JOMs (Joint Operating Meetings) occurring with PPGs (Provider Groups), hospitals and SNFs (Skilled Nursing Facilities). The MLTSS team offers separate more detailed training sessions on the services, eligibility criteria, and referral/approval processes. The team has been conducting an average of two trainings per month and also promotes the services during the quarterly webinars with CBAS centers and SNFs.
- MLTSS is preparing for additional CS services becoming effective 1/1/24.
 - Intermediate Care Facility For Developmentally Disabled (ICF-DD) Long-Term Care Carve-In from FFS Medi-Cal (benefits are administered by Regional Centers).
 - Nursing Facility Transitions/Diversions to Assisted Living Facilities (Transitioning members who meet program and medical criteria for transition out of LTC) and Community Transition Services/Nursing Facility Transition to a Home.

New Populations/Benefits Standardization

- MLTSS continues to prepare for the 1/1/24 effective date for members residing in Intermediate Care Facilities for the Developmentally Disabled (ICF-DD)
 - Webinar held in October with Regional Centers and ICF-DDs with 73 external participants
 - MLTSS continues to collaborate in regular workgroups with other health plans on operational process alignment for this new population.
 - LAC has provided feedback to DHCS on their proposed ICF-DD Carve-in Resource Policy Guide.
 - Syntranet updates are in progress and user acceptance testing is being set up
- Pediatric Sub-Acute Carve In 1/1/2024. Though the DHCS APL is still in draft form and pending publication, planning progresses
 - System readiness: Codes are in process of being loaded with the new heading
 - Provider readiness: working with PNM and CRM to contract all three pediatric sub-acute facilities in LA County. Drafting letter to providers.
 - Working with PNM on PCP/PPG assignment – likely to follow the methodology of other long-term care members
 - Provider training – planning in progress
 - Updating existing policies/procedures and referral forms to add Pediatric subacute as appropriate

Palliative Care

- Palliative Care SB 1004 (APLs 17-015 and 18-020) benefit is currently for full-benefit-only Medi-Cal members (excludes partial and full duals). Benefit expands to full duals in DSNP (under Medi-Cal) on 1/1/24.
- Despite steady increases, referrals and enrollment are low for this benefit, averaging around 50 per month with a current census of 224. MLTSS team is using the PPG, hospital and SNF JOMs to promote the service's benefits and availability. They will also be providing an in-service to ECM providers. Additionally, UM and CM are redirecting members ineligible for hospice for palliative care where appropriate. We are looking at ways we can use our IPRO risk stratification data to further increase referrals as the program has previously shown to positively affect utilization.

Community Health

Community Supports Operations & Reporting:

- CS staff worked alongside ECM team to resubmit revisions to DHCS for the Quarterly Implementation Monitoring Report (QIMR) for 2022 Q1, 2022 Q2, and 2022 Q3. Plan partner data changed and L.A. Care had more claims to support the reporting of Services Received.
- DHCS Member Information Sharing - CS staff are working with internal IT to build out the CS Authorization Status File (ASF) and prepare for processing CS Return Transmission Files (RTFs) in accordance to DHCS requirements
- Developed draft of DHCS Supplement Data Request for Q1 2023 to give them information needed to create provider payment rates

Community Supports - SyntraNet:

- CS staff outreached to Excell HCA/UpHealth to specify assistance required with ASF development, and plan for SyntraNet ingestion of RTF data.
- CS staff are continuing to work with IT and Excell HCA/UpHealth on several data discrepancies and issues on both Daily Scrum meetings and Technical CalAIM issue calls

Social Services

- Provided an in-person training at a CRC (Community Resource Center) to showcase our Community Link and engage Community Based Organizations to collaborate through our Community Link.
- Our Community Health Coordinators attended various community events and health fairs to provide information to the community about our Community Resource Centers and the Community Health Worker Benefit.
- Our Recuperative Care Staff continues to provide on-site visits to Recuperative Care Centers in our network. This last month our staff worked with our Communications Department on a success story of a homeless members that entered into permanent supportive housing out of a recuperative care center.

HHSS:

- Members Enrolled (as of 11/15/2023): 11,024 members enrolled in HHSS
- Provider Network:
 - Currently 28 contracted for HHSS: Includes 4 new providers, 15 also contracted for HD
 - January 2024 provider load: 9 new providers in process
- Provider Capacity Report:
 - Q3 2023 Quarterly Provider Staffing and Report (reported as of 9/3/2023)
 - Total: 29,063
 - DHS: 26,034
 - Non-DHS: 3,029
- Claims Needed Report: CS staff have prepared October Claims Needed Report for HHSS Providers. This report will help HHSS providers be more compliant and timely in submission of HHSS claims

HHIP:

- Metric 1.6 - Housing Equity: Awards for infrastructure/capacity and innovation
 - Max earnings: \$6.9M
 - Applications are under review
- Metric 2.1 - 10% Increase from MP1 (Measurement Period 1): Relationships with SM (Street Medicine) providers to meet MP2 increase
 - Max earnings: \$13.8M
 - Request for Applicant submissions received and being reviewed
- Metric 3.2 – Screening for high utilizers

- Max earnings: \$6.9M
- Engaging with MLK and DHS: DHCS has approved partial points and we are likely to achieve the 2% threshold. Pursuing max 5%.
- Metric 3.3 – ECM enrollment: Increase ECM enrollment for HHSS eligible members from MP1 to MP2
 - Max earnings: \$6.6M
 - Reporting of ECM enrollment sent to eligible HHSS providers
- Metric 3.6 – Eviction Prevention: Execute agreement for 2nd installment of funds
 - Max earnings: \$13.8M
 - Investment in Mayor’s Fund Eviction Prevention
 - Exploring coinciding investment in County’s eviction prevention services

Street Medicine (SM):

- Development of SM network contract in progress
- SM network service structure: Developing a regional structure for service delivery based on anchor providers
- SM rates are in development
 - We are currently analyzing potential SM provider rates and exploring supplemental HHIP-funded rates for anchor providers
- Development of geo mapping of SM providers
- Conducting individual meetings with SM providers to preview proposed operational model

Pharmacy

Star Rating Metrics

- **Medication Adherence:** Our medication adherence STAR measures continue to trend higher than the same time last year. We are on track to meet our goal for CY2023.
 - Comprehensive Adherence Solutions Program (CASP): After evaluating the adherence call programs offered by Navitus and L.A. Care Pharmacy department, we have determined that our program is superior in both call connection and member engagement rates. The quality of calls made by L.A. Care Pharmacy also surpasses those of Navitus. As a result, L.A. Care Pharmacy intends to transition all adherence call efforts in-house for 2024. Pharmacy continues to pursue the implementation of Salesforce Intelligent Desktop (IDT) to further strengthen our in-house adherence call program, ultimately improving our STAR performance across 3 triple-weighted adherence measures.
 - CVS Medication Adherence Program: Launched 11/1/23.
 - Participating Physician Group (PPG) Collaboration: Pharmacy is proactively pursuing collaboration opportunities with PPGs to improve medication adherence and statin measures. We will leverage PPG clinical pharmacists to facilitate timely initiation of refills and statin therapy. Successful initial meetings have been held with Optum and Altamed.
 - Formulary Team Expanded Rejected Claim & Transition Fill Outreach: Formulary team reviews daily rejected claims and transition fill reports and conducts outreach to providers and members. Outreach is conducted to ensure appropriateness of rejections, resolve rejections, encourage utilization of preferred alternatives, and submission of coverage determinations as needed. As of 11/6/23, 388 claims identified for outreach were successfully reached by the prescriber, member, or pharmacy.

- **Medication Therapy Management (MTM) Program:** CMS requires health plans to offer MTM services to Medicare members, including an annual comprehensive medication review (CMR). Pharmacy, in collaboration with Navitus Clinical Engagement Center (MTM vendor), OutcomesMTM, and CustomHealth pilot program, achieved 73% completion rate of eligible members in 2023 Q3, a notable improvement from 2022 Q2 at 60%. Pharmacy has implemented a hybrid model with MTM vendor starting on 11/1. L.A. Care pharmacists are conducting CMRs alongside MTM vendor for additional assistance to boost CMR completion rate.
- **Care for Older Adults (COA):** Medication reviews completed by summer interns have been reviewed by L.A. Care pharmacists and sent to STARS team for dissemination. PPGs will be educated at upcoming Joint Operations Meetings (JOMs) on how to close the gap for their members. Pharmacy is also submitting MTM comprehensive medication reviews for this measure. We are projected to achieve a 4 star rating based on the medication reviews that have already been completed by Pharmacy and Navitus (2,671 as of 10/25/2023), in addition to the number of reviews anticipated to be completed by the PPGs.
- **Statin Use in Persons with Diabetes (SUPD)/Statin Therapy for Patients with Cardiovascular Disease (SPC):** Pharmacy, in collaboration with Navitus Clinical Engagement Center, has launched a new provider-facing intervention in late-September 2023. Pharmacy is also collaborating with PPGs to facilitate appropriate initiation of statin therapy. Outcomes will be provided in future reports.

California Right Meds Collaborative (CRMC)

- CRMC is an initiative with USC to establish a network of community pharmacies that provide comprehensive medication management (CMM) to members with chronic diseases, such as diabetes and cardiovascular disease. As of October 2023, an average A1c reduction of 2.7% from an A1c baseline of 11.5% is observed in patients who complete at least 5 visits with a pharmacist. In addition, an average reduction in systolic blood pressure (SBP) of 18.4 in patients with baseline blood pressure >140/90 mmHg with 3 or more visits with the pharmacist.
- Multiple CRMC pharmacies have submitted interest forms to contract with LA Care for the Community Health Worker (CHW) benefit to expand current services.

Clinical Pharmacy Pilot Program (Ambulatory Care)

- A clinical pharmacist participates as part of the healthcare team once weekly at various FQHCs to improve medication use and safety for L.A. Care members with uncontrolled diabetes and/or uncontrolled hypertension.
- Clinical pharmacist will also be assisting in closing out gaps for COA Medication Review and Transitions of Care (TRC) for DSNP members.
- Current clinics include Wilmington Community Clinic and Harbor Community Clinic.

Community Resource Center (CRC) Flu Clinics

- Pharmacy in collaboration with Health Education, CRC leadership, and North Star Alliances planned and hosted 10 successful flu clinics. USC Medical Plaza Pharmacy offered health screenings (blood pressure and blood glucose), in addition to flu and COVID vaccines. All Pharmacy Team members have volunteered to attend ≥ 2 events. The number of vaccines and health screenings administered are listed below:
 - Flu shots administered: 1,061

- COVID shots administered: 347
- Members with either blood pressure or blood glucose health screening: 56
- Members with both health screenings: 798

Quality Improvement

Executive Summary

- NCQA Health Plan Accreditation Survey results have been received. L.A. Care's status is **Accredited** for Medicaid and Medicare. Our Exchange line of business is Accredited, but under a Corrective Action Plan requiring a written response within 30 days and onsite survey in May 2024.
- A Direct Network Physician Advisory Collaborative meeting was held in September.
- The first Provider Engagement Event was held successfully at the Lynwood CRC on 10/26/23.
- DHCS Equity and Practice Transformation (EPT) Grant announced that 133 practices have selected LA Care as their managed care plan. This includes 83 small/medium-sized independent practices and 50 FQHCs. We are now reviewing these applicants to submit our concurrence for their participation in EPT to DHCS.

Health Education & Cultural Linguistic Services (HECLS)

- Maternal health texting campaigns, PPC1 (Prenatal), and PPC2 (Post-partum) received the Activate 2023 Award for Achieving Health Equity from mPulse at their annual conference. The two campaigns were recognized for content, strong member engagement, and successful results.
- Multimodal Fight the Flu campaign activities underway: texting campaign launched on 9/22 with 439,027 members enrolled in the flu texting campaign. Additionally, end-of-call flu script, flu postcards, social media campaign, automated flu message, newsletter articles, provider email, and fax blast are additional initiatives in flight.
- The Diabetes Prevention Program (DPP) under the new vendor (Diabetes Care Partners) reached highest enrollment to date with 197 members enrolled in FY 22-23. This was a 42% increase from FY 21-22 under the previous vendor Solera, and the highest number of members (n=46) who achieved a weight loss goal of at least 5% reduction in body weight.
- Meals As Medicine program has completed most activities related to the Medically Tailored Meals DHCS-required alignment within MCPs. This includes eligibility criteria expansion and documentation uniformity. New criteria going into effect on 1/1/2024 will add an extensive list of diet responsive conditions to the current eligible conditions and eliminate any age restrictions.
- First Pediatric Healthy Lifestyle program for ages 6 to 13 years were completed at Lynwood CRC with seven initial participants and five who completed the three-session pilot. The program is expanding to Inglewood, Metro and El Monte CRCs with the support of Registered Dietitians.
- Three trainings on "Writing in Plain Language and Readability using Health Literacy Advisor" were conducted during the months of October and November with approximately 180 participants. These trainings aim to train and educate staff from departments that develop member letters and materials.
- The Adult Weight Management program, a six week skills based series of workshops, will be piloted at the Inglewood CRC in January. Efforts are underway to expand to other CRCs and develop a virtual option.

Initiatives

- The Managed Care Accountability Set (MSCAS) Performance and Sanctions:-DHCS recently released their new methodology for determining sanctions. The new methodology takes into consideration state and regional benchmarks along with national benchmarks. Based on this new methodology, L.A. Care is

in the Green Tier and has no financial sanction for Measurement Year (MY) 2022. L.A. Care will need to complete one project due to low performance in the Child Health domain.

- The Department of Health Care Services also released new benchmarks for the MY 2023 MCAS. While some benchmarks were lowered, some increased substantially such as the Follow-Up After Emergency Department Visit for Mental Illness (FUA) 30-Day Follow-Up. This increases the total number of measures at risk to meet the minimum performance level (MPL) to eight measures.
- The at-home test kit contract with ixLayer was accelerated, signed, and executed on 10/13/2023. Plans are underway to mail out the test kits in December. Notification to providers is scheduled to go out mid-November through various channels to ensure that providers are aware of this new resource for members.
- Clinical initiatives team hosted “Q4 push” meetings to discuss specific interventions and measures that L.A. Care will be focused on through the remainder of year. The team is also supporting discussions with Participating Provider Groups (PPGs) on their efforts to close out the measurement year.
- A chase list of noncompliant members for specific measures (BCS, CIS, LSC, CBP, COA, EED, HBC >9%, W30) was curated for each PPG to support closing gaps and distributed on October 13, 2023 with requests for follow-up. Additionally, initiatives shared W30 and CIS incentive program information along with a list of eligible members for PPGs to outreach. Meetings were conducted with: AltaMed Health Services, Allied Pacific IPA, Optum Care Network/Apple Care Select, Community Family Care, Exceptional Care Medical Group, Global Care IPA, Health Care LA IPA, Prospect, and Preferred.
- Retinal-Eye Exam (EED) outreach conducted by Vision Service Plan continues. A Q4 priority is to focus on Dual Eligible Special Needs Plan (D-SNP) populations. Member outreach (04/03/23-08/10/23) statistics are as follows: 2,259 MCLA members, 400 members scheduled to date, 181 gaps closed. Provider outreach (04/08/2023-08/10/2013) statistics are as follows: 17,123 noncompliant members sent to assigned eye-care providers, 3,650 gaps closed.
- All seven text messaging campaigns to improve preventive care are now live:
 - **Comprehensive Diabetes Care (CDC)**
 - **Well-Child Visits in the First 30 Months of Life (W30A&B)**
 - **Adults Access to Preventive and Ambulatory Care (AAP)**
 - **Colorectal Cancer Screening (COL)**
 - **Controlling Blood Pressure (CBP)**
 - **Breast Cancer Screening (BCS)**

Quality Improvement- Practice Transformation Programs

First 5LA/HMG LA

- Cohort 1 practices (APHCV + Kids & Teens MCG) are screening 51.9% of our members aged 0-5 years old, realizing a 38% increase in screenings over baseline (14%) through September.
- Cohort 2 practices (T.H.E., Bartz-Altadonna, Palmdale Pediatrics, and White Memorial CMC) have generated a 12.6% increase over baseline for completed screenings through September.
- Completed 50 out of 60 early childhood development classes for members through November.

Transform L.A.-Direct Network

- Current program enrollment: 19 practices, 102 providers, 12,095 DN members (29% of total DN members).
- One new practice has enrolled in the program.
- A1C <9%: 7% improvement over baseline and Controlling Blood Pressure: 10% improvement over baseline

EQuIP LA – Direct Network

- Baseline data for four practices have been successfully submitted. Practices have completed their baseline assessments of quality improvement capabilities. Development of health equity based program goals under way.

Equity & Practice Transformation Payments Program

- Enrollment has concluded. Total number of practices that selected LA Care: 133: 83 small/medium sized independent practices and 50 FQHCs/look-alikes/large practices. Exceeded enrollment goal (60) by 122%.
- A review of applications is underway.

Provider Quality Review (PQR)/Potential Quality of Care Issues (PQI)

- **Total PQI Reviewed**
 - FY 2022/2023 (October 2022 - September 2023) the PQR team reviewed and closed 7,337 cases. 2,165 (30%) were classified as duplicates or triage zero, meaning that they did not meet the PQI referral criteria. The remaining 5,172 cases were reviewed for quality of care or service issues. 339 had actions taken to address the PQI findings. The PQI actions included communication to inform provider of quality review findings (no response required), provider response required for quality review findings, and corrective action plans required for quality review findings. As of April 2023, the monthly rate for timely closure has averaged above 99%.
- **Aging PQI Cases:** As of October 31st, 2023, there were 3,734 cases open. 3,358 cases in green (0-151 days), 300 cases in yellow (152-183 days), 75 cases in orange (184-213 days), and one case entered the untimely aging category of 214+ days.
- **PQR – Critical Incident (CI) Reporting**
 - The PQR department is currently undertaking the reinstatement of Critical Incident (CI) Reporting. Under the new guidelines from DHCS, Critical Incident reporting will now include DSNP and MCLA members. The team is consulting Compliance and Legal team to understand regulatory reporting to ensure we require the impacted facilities to report CI. We will finalize the requirement and P&P by 11/20/2023.
- **PQR – Staffing Updates**

PQI referrals remain high. A&G and PQR leadership continue to work together to enhance the end-to-end process. Meanwhile, the PQR team staff up to ensure timely processing of referrals. As of November 6, 2023, all approved positions are filled.

Accreditation

National Committee for Quality Assurance (NCQA): Health Plan Accreditation

L.A. Care's status is **Accredited** for Medicaid and Medicare. Our Exchange line of business is **Accredited** but under a Corrective Action Plan requiring a written response within 30 days and onsite survey in May 2024.

CATEGORY SCORING THRESHOLDS							
STANDARD CATEGORY	CATEGORY RESULT	POINTS RECEIVED AND PERCENTAGE	TOTAL APPLICABLE POINTS (TOTAL POSSIBLE)	≥80% THRESHOLD POINTS (ACCREDITED)	< 80% - ≥ 55% THRESHOLD POINTS (PROVISIONAL)	< 55% THRESHOLD POINTS (DENIED)	MUST-PASS REQUIREMENTS
QI - Quality Management and Improvement	ACCREDITED	14.00 (82.35 %)	17.00	13.60	9.35	9.18	
PHM - Population Health Management	ACCREDITED	18.00 (85.71 %)	21.00	16.80	11.55	11.34	
NET - Network Management	ACCREDITED	28.00 (100.00 %)	28.00	22.40	15.40	15.12	
UM - Utilization Management	ACCREDITED	43.50 (94.57 %)	46.00	36.80	25.30	24.84	1 Failed Must-Pass Elements
CR - Credentialing	ACCREDITED	17.00 (100.00 %)	17.00	13.60	9.35	9.18	0 Failed Must-Pass Elements
ME - Member Experience	ACCREDITED	26.00 (100.00 %)	26.00	20.80	14.30	14.04	

- The CAP is for **UM 7B: Written Notification of Nonbehavioral Healthcare Denials**. During the file review, 15 out of the 30 files did not include a statement that members and their treating physicians can obtain a copy of the actual benefit provision, guideline, protocol, or other similar criterion on which the denial decision was based.
 - Please note, this letter was corrected and implemented prior to the survey. However, half of the selected files were for dates prior to the issue being corrected.
 - Next Steps: QI will coordinate CAP completion with EPO and our consultants. The CAP response due date is December 3, 2023.
 - QI will also coordinate a mock file review by our consultants in February 2024 in preparation for the CAP survey.

- **Discretionary Review – UM 13 Elements C: Review of UM Program and D: Opportunities for Improvement**
 - Part of the evidence for the DHS discretionary survey did not meet all standards and will therefore also be included in the CAP survey.
 - Next Steps: QI will coordinate an **internal CAP** completion with EPO and our consultants.
 - QI will also coordinate a mock file review by our consultants in February 2024 as preparation for the CAP survey.

- **Near Misses:**
 - The requirements for the elements listed below were not fully met, although similar evidence was accepted in a prior survey. A one-time exception was granted and full points have been awarded for this survey only. Compliance will be evaluated during our next survey in 2026. Regardless, QI is actively working with the accountable business units on completing an **internal CAP** to ensure these gaps are addressed.

Health Equity Accreditation (HEA)

- NCQA survey submission will be 12/5/2023.

- Health Equity Evidence Updates
 - The minimum passing score to achieve accreditation is 80%
 - QI Accreditation estimates a **worst-case scenario score of 84%** once all evidence is reviewed
 - The survey holds 2 critical (must pass) factors.
 - We have no concerns about meeting requirements for either of these elements.

- HE 7 Standard: Delegation of Health Equity Activities
 - NCQA Selected Delegates:
 - Anthem: HEA Accredited, however, still pending agreement
 - Teladoc: Pending discussion
 - Carelon: Pending response
 - Liberty: Agreed to delegation

Access to Care

- MY2022: CAP responses- 32 of 33 received. Past-due follow-up notifications have been sent to the remaining provider groups. DHS Pending CAP submission
 - DHS reached out to L.A. Care on 9/8 concerning appointment availability survey and corrective action plan concerns. DHS has shared five areas of concern. Investigation of concerns have resulted in a minor edit to DHS's report card and CAP regarding PCP routine and urgent appointments.
 - All other issues were related to provider contact list issues which have been resolved for MY2023
 - QI Accreditation is finalizing follow-up communication with DHS.

STARS/HEDIS

- MY2023 performance continues to project to 3.0 (rounding down). Most HEDIS measure performance is still projected to perform lower year over year. The overall performance is projected to improve from a 2.44 to 2.94 despite substantial increases in cut-points. Both the Operations and Pharmacy measure performance are performing higher with overall domain performance improving from 2.28 to 2.96 (Operations) and from 2.31 to 2.85 (Pharmacy) despite huge increases in cut-points.
- HEDIS Q4 recovery effort continues which includes 1) reconciliation between PPG performance tracking vs. LAC received encounter information; 2) review of PPG Q4 improvement plans and areas LAC can assist and 3) review of supplemental data submission (and potential under-submissions).
- For the High Touch HEDIS Outreach RFP, AdhereHealth was selected as the vendor of choice. The contract is currently in redline review between L.A. Care legal and AdhereHealth Legal with the goal to have the contract approved prior to 12/31/23 and implementation kicking off early Q1 2024.

Surveys: (CAHPS (Consumer Assessment of Healthcare Providers and Systems)/HOS (Healthcare Outcomes Survey)/QHP (Quality Health Plan)/Off Season

- Surveys were deployed late September/October 2023
 - MAPD(Medicare Advantage Part D)/HOS Offseason
 - TAR (Timely Access Reporting) QHP Offseason (LACC(Covered CA) population)
 - LACC-D (Direct)
 - PASC (Personal Assistance Services Council) (Using Commercial CAHPS survey – in anticipation of potential accreditation decision in the future)
 - Provider Satisfaction Survey (PSS)
- Identify methods for improving member services and experience for this composite to count positively towards CAHPS performance
 - Identify consistently poor performing providers
 - Identify consistently poor performing office locations
 - Identify lower rated PCPs

Population Health Management (PHM)

- For Enterprise Goals, the PHM team is tracking the 2022-2023 PHM index and is currently on track to meet the mid-goal, with 13/16 of the goals met for at least one line of business.
- The 2023-2024 PHMI is in development and work is in progress across the enterprise to update goals for the next cycle.
- The PHM team will develop the 2023 PHM Program Description in Q4 2023 and will include the CalAIM requirements.
- CalAIM Strategy document was submitted to Compliance and will be passed forward to DHCS.
- L.A. Care submitted the CalAIM Key Performance Indicators (KPIs) report to DHCS.

Initial Health Assessment (IHA) transitioning to Initial Health Appointment

- The QI-047 IHA Policy and all related materials have been updated per APL 22-030.
- Further IHA provider training is in development.
- The IHA workgroup has drafted documentation on root causes of poor IHA completion rates and has created a corrective action plan (CAP). Next steps include enhancing reporting and monitoring tools, and strengthening the PPG accountability process.
- All Network Providers (PPG and Direct Network) have access to monthly IHA due reports on the provider portal to support IHA completion for members within 120 days of enrollment. Soon they will also receive monthly (currently quarterly) reporting on members who have not had their IHA.

Annual Cognitive Health Assessment (ACHA) APL 22-025

- The Policy for APL 22-025 developed by the PHM team and approved by DHCS will go to QOC for internal approval in November after the process is more established.
- DHCS is sending the reports on providers completing the Dementia Aware training and L.A. Care has notified all providers of the new APL requirements.

Facility Site Review (FSR)

- The total Public Health Emergency (PHE) related backlog spanning 3/15/2020-12/31/2021 is now down to **20**. To date **377** audits have been completed from the backlog.
- In Q3 2023, **6** FSR/MRR audits were conducted and completed from the backlog.
- L.A. Care FSR is working with the LA County Collaborative (According to APL 22-017, all health plans operating in the LA County area must collaborate to establish systems and implement procedures for the coordination, consolidation, and data sharing of site reviews for mutually contracted PCPs. All health plans within a county have equal responsibility and accountability for participation in the site review collaborative processes) on the FSR/MRR backlog audits to be completed by 12/31/2023.
- FSR is working with the LA County Collaborative on a combined mobile unit tool and condensed street medicine tool. All MCP's are currently piloting this tool. Feedback still pending.

Population Health Informatics

Health Information Management (HIM) Analytics

- The Population Health Assessment, which is a document submitted to NCQA annually showing the different health profiles of LA Care (Member Demographics, Utilization Rates, Top Diagnoses, etc.) has begun and is on track to be completed in early January 2024.
- Preliminary data research is being conducted for the upcoming SNF and Hospital Incentive Programs and the availability and usability of each measures' rates from publically available data sources (such as Nursing Home Compare) are being evaluated.
- Continued development of the Hospital Performance Dashboard is ongoing. This Dashboard is updated on an annual basis (may change to quarterly) which reports the performance of Hospitals

based on CMS quality metrics. This Dashboard is used by various teams when meeting with Hospitals.

- The first phase of a new STARS Dashboard has been published. HIM is working alongside the STARS Team for phase 2 which will include Operations and Member Experience metrics. Discussions are also in progress to develop a LACC Dashboard for MY 2024.
- A Social Determinants of Health/Initial Health Assessment/Health Information Exchange Report is currently being developed to distribute to PPGs that will inform provider groups of their performance in these three domains. This report will be distributed quarterly.
- Given the recent spike in COVID cases, HIM has been tasked with ingesting all available vaccination data streams to identify the uptake of vaccine boosters in the L.A. Care population. The ingestion code has been completed and will be run on a monthly basis.
- HIM continues analytic support for Annual Cognitive Health Screening and IHAs for elderly and new members.
- HIM continues its analytic work on the CalAIM project. Measures are currently being developed which monitor PCP visits and ambulatory care.
- HIM is working alongside Community Health to identify the homeless population with greater accuracy for the HHIP program.

Health Information Exchange Ecosystem (HIEc)

- L.A. Care is revising the Hospital Services Agreement (HSA) to mandate hospital participation in Health Information Exchanges (HIEs). This revision will enforce compliance with CMS 9115 standards for Hospital ADT notifications and require participation in the CalHHS Data Exchange Framework (DXF).
- A similar directive is underway for Skilled Nursing Facilities (SNFs), obligating them to engage in DXF and facilitate information exchange with HIEs.
- Effective January 1, 2024, involvement in Health Information Exchanges (HIEs) will become part of the Hospital Pay-for-Performance (P4P) program. Hospitals will be eligible for incentives upon achieving set milestones in HIE participation.
- Likewise, beginning January 1, 2024, Skilled Nursing Facilities' (SNFs) engagement in HIEs will be incorporated into SNF Pay-for-Performance (P4P) program, offering incentives for SNFs that reach specific HIE participation milestones.
- Edifecs has been selected as the Clinical Data Repository (CDR) vendor, tasked with managing real-time ADT data ingestion via FHIR from LANES and CMT.
- The One-Time HIE Adoption Incentive Program has been successfully launched, offering incentives from October 1, 2023, to September 30, 2026, for providers, particularly aimed at FQHCs and small or solo group providers, to enhance HIE adoption and DXF participation.
- The California Health and Human Services Agency (CalHHS) has designated LANES as a Qualified Health Information Organization (QHIO). In this capacity, LANES is set to serve as the QHIO for L.A. Care and is actively working on the implementation of the Data Exchange Framework (DXF) to enable the exchange of health and social services information in alignment with the established DXF policies and procedures.

Incentives

- Final 2022 HEDIS and other domain data are being processed for use in the P4P Programs. We are aiming to complete all six program reports and payments between Thanksgiving and Christmas.

- The 2023 Update Action Plans have been sent to L.A. Care from the PPGs. L.A. Care and Plan Partner subject matter experts have provided feedback on the PPG projects. Final action plan results are expected from the PPGs in January 2024.
- A new Hospital P4P Program is close to being finalized. The program will be previewed with hospital leadership in November/December. The goal is to launch the program in January 2024.
- A new SNF P4P Program is close to being finalized. The program will be previewed with SNF leadership in November/December. The goal is to launch the program in January 2024.
- 2023 Provider Opportunity Report (POR)/Gap in Care (GIC) reports are being produced monthly. Plans for report enhancements are under way alongside efforts towards more effective use of the Cozeva platform.



L.A. Care
HEALTH PLAN®

For All of L.A.

Health Equity and Disparities Mitigation Efforts:

Brief and First 6 Month Progress Report



C&Q Committee

Alex Li, MD

January 2024



**ELEVATING
HEALTHCARE**
IN LOS ANGELES COUNTY
SINCE 1997

Sample Key Accomplishments

Internal:

- Co-lead our Equity Practice Transformation Initiative (134 practices signed up with L.A. Care) that potentially impacts around 1.5 million Medi-Cal members
- Led L.A. Care's (NCQA) Health Equity Accreditation effort
- Examine quality performance reports (HEDIS) by race/ethnicity and geography.

External:

- Organized and co-chairing the California Local Health Plans' Chief Health Equity Officer meetings
- Invited by National Academy of Science, Engineering and Medicine to participate in the Health Equity Roundtable
- Working closely with a coalition on how we can reduce the burden of medical debt for Los Angeles County residents
- Working closely with LAUSD on vaccine catch up and improving health and wellness for school age children and youth

L.A. Care's Health Equity Zones



Health Equity Zone 1: Address Key Health Disparities.
Close racial and ethnic gaps in health outcomes among members
Percentage of People with Diabetes Control

	American Indian and Alaska Native Hispanic or Latino (n=150)	American Indian and Alaska Native (N=173)	Asian (N=8,142)	Black or African American (8,969)	Native Hawaiian and Other Pacific Islander (N=166)	Hispanic or Latino (N=43,483)	White (N=8,105)
MCLA	54%	34.7%	60.7%	40.6%	30.1%	42.8%	45.6%
LACC	N/A	N/A	63.6%	44.4%	65%	50.7%	49.5%
Medicare CMC/DSNP	50%	N/A	75.2%	57.1%	N/A	55.7%	57.5%

Timeliness of Prenatal Care

	Asian (N=611)	Black or African American (1,367)	Hispanic or Latino (N=8,257)	White (N=1,246)
MCLA	60.7%	40.6%	42.8%	45.6%
LACC	63.6%	44.4%	50.7%	49.5%

-No data were shown for American Indian and Native Alaskan and Native Hawaiian and Pacific Islander as the denominator was <30.

-No data were shown for CMC/DSNP line of business.

Postpartum Care

	Asian (N=611)	Black or African American (1,367)	Hispanic or Latino (N=8,257)	White (N=1,246)
MCLA	67.1%	53.8%	67.6%	60.1%
LACC	49%	44.4%	66%	68.3%

-No data were shown for American Indian and Native Alaskan and Native Hawaiian and Pacific Islander as the denominator was <30.

-No data were shown for CMC/DSNP line of business.

Healthy Equity Zone 2: Lead Change.

*Provide leadership and be an ally for community partners
(Focus on L.A. County and Its Children and Youth)*

- Addressing children/youth health and social service needs together.
- Bringing together key stakeholders together.
- Addressing children and youths with special needs.



- 60+ Attendees
 - Academics
 - Community Based Organizations
 - County department representatives
 - DCFS, DHS, DMH, DPH and Sheriff
 - Funders
 - Payers
 - People with Lived Experiences
 - Providers
 - Public Safety Representatives
 - School Representatives

Focus on L.A. County and Its Children

- * **Building Resilience in Schools:** Address safety concerns related to firearms, anxiety created by gun violence, pandemics etc.
- **Addressing Post-Pandemic Vaccine Misinformation and Vaccine Catch Up**
- **Child Welfare Gaps:** Explore greater clinical coordination between primary care providers, behavioral health specialist, Department of Children and Family Services and optimize CalAIM youth and foster care resources
- **Rethinking the Pediatric Medical Home and Transition to Adult Systems of Care**

Building Resilience in Schools

Where are we now:

- Period of grief, trauma and burnout: e.g. coming out of pandemic, lots of caregiver stress, not knowing what is going to happen in the future.
- Time of regression: rising behavioral health issues and students falling behind academically and decline of social skills
- Rising crisis: Pre (kids feeling hopeless, other social determinants like housing and food insecurity) and in crisis students e.g. ER's getting overwhelmed with suicide attempts; Learning how to work in a system and in a post-pandemic environment.
- Inadequate support: e.g for parent and children/ and youth with neurodevelopmental issues;
- Systems are under-resourced: Insufficient to meet the needs of what folks are seeing in communities and on the ground.

Next Steps After Roundtable

- Develop and draft issues summary briefs for each theme around Jan 2024
- Meet and further develop the recommendations
 - Create position papers for each theme by June 2024
- Share with key stakeholders and ask stakeholders to share with their respective organizations
- Meet with L.A County officials/board offices, departments school districts etc.
- Follow up with the same group in 1 year

Health Equity Zone 3: Move Towards Equitable Care.

Ensure that our members have access to care and services that are free of bias and that our providers are supported in delivering equitable, culturally tailored care.

Lynwood Social Needs Resources

Food

- **5 Breads 2 Fish:** Serves families free groceries at a different location in L.A. at 1 PM for every day of the week
- **Downey Food Help:** Does free food distributions every Saturday from 9 AM – 12 PM at 10909 New Street, Downey, CA 90241
- **Lynwood Food Pantries:** Offers free food at certain times and days of the week; list is in QR code



[5 Breads 2 Fish](#)



[Downey Food Help](#)



[Lynwood Food Pantry List](#)

Transportation

- **Metro GoPass:** All students in the Lynwood Unified School District can ride Metro buses and trains for free with [GoPass](#) after contacting their school
- **Low Income Fare is Easy (LIFE) Program:** Offers free rides and discounted Metro and transit agency fares for qualifying LA County residents
- **Lyft Up Initiative:** Provides free or discounted rides for grocery and job access in LA



[Metro GoPass Lookup](#)



[Lyft Grocery Access](#)




[Lyft Jobs Access](#)



[LIFE Program](#)

Maternal Health

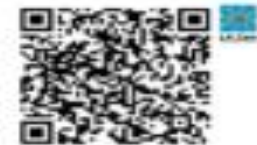
- **CinnaMoms:** Hosts virtual support circles to support women who breastfeed
- **Love of a Little One (LLO):** Offers pro-bono services to BIPOC & LGBTQ+ families that need them
- **L.A. Care Healthy Mom Program (HMP):** Provides support for new moms to get the postpartum care that they need 



[CinnaMoms](#)



[LLO](#)



[HMP](#)



Health *Equity*

Health Equity Zone 4: Embrace Diversity, Equity, and Inclusion.
Serve as a model in supporting an equitable and inclusive work environment, as reflected in our workforce and business practices.



Health *Equity*

Health Equity Impact Assessment Tool

Directions: One of the key aims of our health equity efforts is for us to think thoughtfully about how we structure our programs at L.A. Care with the goal to improve access to services in a more equitable way (Please see: Health Equity Zone 4 in the 2023-25 L.A. Care Health Equity and Disparities Mitigation Plan).

This Health Equity Impact Assessment Tool seeks to help us as an organization assess the effects of your project or program on our members and providers. Please answer the following questions to assess your project and impact on health equity.

Health Equity Zone 4



Health *Equity*

Involve Community Members Impacted or Solicit Input from Key Informants

-Have you sought feedback or input from community members or key informants during your planning?

[Please list those community (non-L.A. Care) members or key informants that you have consulted]

Identifying Disparities or Inequities

-Has your team found evidence of disparities or inequities while reviewing or planning for the project?

[Please provide disparities evidence]

(Many) Next Steps over the next 3-6 months

- Achieve NCQA Health Equity Accreditation
- Continue to collaborate with community partners that align with L.A. Care's mission and 2023-25 Health Equity and Disparities Mitigation Plan
- Apply a “health equity lens” with L.A Care data and reports (stratify race/ethnicity, gender, and geographic regions) to identify opportunities
- Work on health equity, diversity, equity and inclusion training modules for providers, staff and vendors
- Identify opportunities to invest in communities and aligns with our mission and health equity plan

Questions?