BOARD OF GOVERNORS

Compliance & Quality Committee Meeting

Meeting Minutes – March 21, 2019

L.A. Care Health Plan CR 1025, 1055 W. Seventh Street, Los Angeles, CA 90017

Members

Christina R. Ghaly, MD, *Chairperson*
Al Ballesteros, MBA
Stephanie Booth, MD
Hilda Perez
Courtney Powers, JD
Ilan Shapiro, MD

Management

Thomas Mapp, *Chief Compliance Officer*
Richard Seidman, MD, MPH *Chief Medical Officer*
Augustavia J. Haydel, *General Counsel*

** Absent ** Teleconference*

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
CALL TO ORDER	Christina R. Ghaly, *Chairperson*, called the meeting to order at 2:10 pm. She announced that members of the public may address the Committee on each matter listed on the agenda before or during the Committee's consideration of the item, or on any other topic at the Public Comment section.	
APPROVAL OF MEETING AGENDA	The Agenda was approved as submitted.	**Approved unanimously. 6 AYES (Ballesteros, Booth, Ghaly, Perez, Powers and Shapiro)**
PUBLIC COMMENT	There was no public comment.	
APPROVAL OF MEETING MINUTES	The January 17, 2019 meeting minutes were approved as submitted. Member Stephanie Booth asked Thomas Mapp*, Chief Compliance Officer,* if L.A. Care shares with providers' members advance directives. Mr. Mapp responded that he will follow up at a future meeting.	**Approved unanimously. 6 AYES**
CHIEF MEDICAL OFFICER'S REPORT Richard Seidman, MD, MPH	Richard Seidman, MD, MPH, *Chief Medical Officer,* referred to his written report *(a copy of the report can be requested from Board Services)*:	

APPROVED

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	• California Department of Healthcare Services (DHCS) hosted a call with all of the California Medi-Cal Managed Care Plans earlier this month to announce an increased focus on pediatric screening and prevention services. • Anticipated changes include an expansion of the External Accountability Set, the set of measures plans are required to report to DHCS, further alignment with the Centers for Medicare and Medicaid Services (CMS) Core Measure Set, and an increase in the minimum performance level up to the 50th percentile of the national Medicaid average. Member Booth asked if the metric is set or can they be adjusted. Dr. Seidman responded that John Baackes, *Chief Executive Officer,* requested that this be handled as an expectation. Mr. Mapp stated that the DHCS representative said that comments and questions can be sent to their office. Dr. Seidman stated that California compares poorly to other states in quality measures and outcomes in Medicaid and California also pays poorly. California's Governor has asked for L.A. Care's input on the issue. Member Booth asked if DHCS developed these new ways to evaluate care. Dr. Seidman responded that the measures are new to California as the state is adopting measures used by the CMS. <u>Drug Pricing Executive Order</u> • On January 7, 2019, Governor Newsom issued an executive order directing California's Medicaid system (Medi-Cal) to negotiate prescription drug prices for all of its 13 million recipients. • The purpose of this change is to decrease the cost of drugs and the price for beneficiaries. • Jennifer Kent, Director of DHCS, explained that a preferred drug list would be used, and if the medication is on the list, doctors would not need to obtain prior authorization to prescribe it. • L.A. Care has been invited to participate in a conversation with DHCS and a small group of plans to share thoughts on the proposal. • Cherie Compartore, *Senior Director, Government Affairs* and Yana Paulson, *Chief Pharmacy Officer,* are scheduled to participate in a meeting in Sacramento on March 14.	

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	340 B Program • L.A. Care is currently developing a process to ensure accurate flagging of prescription claims for drugs purchased at the 340B discount. • Negotiations are underway with a vendor who would filter the pharmacy claims file against the 340B Covered Entities' claim files and correct the claim file data. • There would be no cost to L.A. Care, an administration fee would be charged only to the CE which did not correctly flag all the prescriptions filled with 340B discounted drugs. Member Booth asked how the state will get the necessary data to L.A. Care to be aware that a patient has not refilled a prescription. Dr. Seidman stated it has not been determined. Member Ballesteros noted that the cost savings realized through this process supports and enhances care coordination and clinical care, and the delivery system for services will be weakened if the funding is removed. He questioned what mechanism the state will use to fill the resulting funding gap. Dr. Seidman responded that it seems DHCS does not have confidence that the cost savings are always used appropriately. Utilization Management • L.A. Care has recently transitioned care for over 300 of its members to a group of directly contracted skilled nursing providers, known as SNFists. • This new care model means that there is no medical group (IPA or PPG) in the middle of the relationship between members and their provider, or SNFist. • The goals of this new approach are to ensure that our members receive the appropriate clinical resources needed to manage their health care needs; expedite discharge to the community and improve care coordination within SNFs and between hospital and the SNFs. • We have a better understanding of member health and social service needs and can direct resources to mitigate risk factors for hospital admissions or readmissions.	
CHIEF COMPLIANCE OFFICER REPORT Thomas Mapp	Mr. Mapp referred to his written report included in the meeting materials. *(A copy of his written report can be requested from Board Services).* Elysse Palomo, *Director of Regulatory Affairs,* reported on the 2018 CMS Program Audit	

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	• L.A. Care received the final report with a score of 1.93 (0 is the best score possible). L.A. Care has submitted corrective action plans for the non-ICAR findings on February 8, and were accepted on March 5. CMS requires L.A. Care to hire a vendor to conduct a validation audit within 180 calendar days of CAP acceptance. The validation audit is to measure whether the CAPs achieved its intended result by remediating the non-compliance, *not* to evaluate whether a CAP was fully implemented. L.A. Care is conducting ongoing monitoring and remediation of the findings. • CMS Division of Compliance Enforcement requested additional information for the following audit findings in order to calculate the civil monetary penalties: o Misclassification of coverage determinations/appeals/grievances and failure to initiate o Inappropriate denials o Denial letter language o Grievance resolution letters – rights to file with QIO o Misclassification of SARs/appeals/grievances and failure to initiate • 218 members were affected and were fined $200 for each resulting in a $43,600 fine. Mr. Mapp stated that they were expecting a significantly higher number of members affected, and CMS was assured that LA Care took action to ensure that those members got the services they needed. Chair Ghaly asked if they identified the issues prior to the audit. Mr. Mapp responded that some of the issues were addressed before the audit took place. Ms. Palomo added that in the process the members that needed services were identified and L.A. Care conducted outreach to ensure that members were helped. Dr. Seidman stated that when a member calls L.A. Care to request a service that they may or may not need, CMS requires the health plan to open a Service Authorization Request (SAR). It is then determined by the health plan whether or not it is a medical necessity. Mr. Mapp pointed out that the process starts at the member services level. L.A. Care must then determine if it will be addressed by the call center or through Utilization Management. Member Booth asked if the SARs typically get approved. Dr. Seidman responded that many of the SARs do get approved. The medical groups first get the opportunity to approve the authorization.	

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	Audit Timeline
	• L.A. Care was notified of the Cal MediConnect (CMC) CMS Program Audit on August 20, 2018
	• Webinar reviews were held October 1-5, 2018
	• On-site review for Compliance Program effectiveness was October 15-18, 2018
	• Clean Period will be April 1 – June 30, 2019; must be 100% compliant.
	Validation Audit overview
	• Limited-scope audit that tests the audit findings
	• Conducted by outside vendor ATTAC
	• Audit review period: April 1 – June 30, 2019
	• Does not measure or evaluate whether a Corrective Action Plan (CAP) was fully implemented
	• Measures whether the CAP achieved its intended result by remediating the noncompliance.
	Risks:
	• Failure to pass will require additional validation audits and consulting fees
	• During the course of the validation audit, the auditors could find additional conditions that were not previously identified during the initial audit.
	Overall Remediation Status
	Corrective Action Plans:
	• Training (internal and delegates) completed
	• Documentation of new processes through work flows, revised policies and procedures completed
	• Monitoring implemented/enhanced oversight
	  o Increased frequency
	  o Increased sample size
	  o Live reviews versus reviewing case files
	Risks:
	• Delay in care coordination remediation	

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	○ IT dependencies; health information sharing between plan and provider groups • Review of denials is not current – reviewing December 2018 • Retroactive delegate reviews – non-compliance is identified after the fact ○ Oversight of Delegates' quality assurance programs <u>Lessons Learned</u> Mr. Baackes convened senior leadership remediation teams to lead strategic initiatives targeting the overall themes in the CMS Audit: • Improve delegation oversight program and performance monitoring • Improve regulatory knowledge and develop regulatory library • Clear lines of accountability A new monitoring program (that mirrors the CMS Audit Protocol) will prepare L.A. Care and its delegates for the validation audit. The program will ensure readiness in the following areas: • Pull a complete universe • Validate universe accuracy • Test compliance: sample selection, auditing • Communicate, report, and remediate non-compliance <u>Next Steps</u> 1. Build Validation Audit Work Plan with ATTAC (selected vendor). 2. Prepare for Validation Audit and conduct validation audit July/August 2019 3. Complete CAP Implementation by clean period • Continue to engage consultants for assistance with work plans, processes, and quality assurance activities. 4. Implement audit area-specific monitoring plans (internally and with delegates) to prepare and test for clean period. 5. Use monitoring results to remediate/improve/meet compliance. Member Perez pointed out there were four Immediate Corrective Action Required (ICARs) findings and 19 Corrective Action Required (CARs) that needed immediate attention. She asked when the Board will receive the final report. Ms. Palomo stated a final report is ready and will be provided to the Board. There were no significant changes when the final was compared to the draft report. The overall score was not affected.	

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	Mr. Mapp noted that one of the ICARs was in regards to SARs and three others were in the process of being remediated. Member Booth asked if L.A. Care is sure that everything that was found in the audit was cleared. Mr. Mapp noted that slide 8 of the presentation outlines what L.A. Care needs to do operationally to address the issues.	
APPROVE QUALITY IMPROVEMENT PROGRAMS DOCUMENTS Richard Seidman, MD, MPH. • **2018 Quality Improvement Program Evaluation**	Dr. Seidman introduced Maria Casias, RN, BSN, MPH, *Director, Quality Improvement Accreditation.* Ms. Casias summarized the 2018 Quality Improvement Program Evaluation and 2019 Quality Improvement Program Description and Work Plan *(a copy of the presentation can be requested from Board Services)*: <u>Regulatory Compliance/Audits/Accreditation</u> • Department of Health Care Services (DHCS) o For Medi-Cal Seniors and People with Disabilities (SPD) & Non-SPD, total of three findings compared to six findings in 2017 o For Cal MediConnect (CMC), total of three findings compared to 11 findings in 2015 • Center for Medicare Services (CMS) final score: 1.93; improvement from 2014 score of 2.39 • Department of Managed Healthcare (DMHC): Fourteen new findings • National Committee for Quality Assurance (NCQA) ratings o Medi-Cal – "Commendable status" o CMC – "Accredited status" o L.A. Care Covered – "Accredited status" <u>Consumer Assessment of Healthcare Providers and Systems (CAHPS) Performance</u> • Adult scores remained low in 2018 o NCQA points: 3.29 o Dissatisfaction is traceable to the Medicaid expansion population • Pediatric scores continued moderately rising in 2018 o NCQA points: 6.54 o Enrollee Experience: 1 star, down from 2 stars in 2017 o CMC: NCQA Points 3.25 (below 25th percentile) o Opportunity: To improve access measures for all lines of business	

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	Member Shapiro asked how the measurements are conducted. Ms. Casias responded it is a health plan survey for members who have seen their provider in the last six months. Surveys will be conducted at the medical group level to gather necessary data. Consultants will be contracted to look into low performing providers to retrain them and their staff to improve member experience.
	
	Member Shapiro asked if there are any CAHPS incentives being provided to medical groups. Dr. Seidman responded that for the NCQA accreditation, L.A. Care is required to conduct a plan survey and submit the results. He pointed out that one of the VIIP program domains is member experience and surveys are conducted at the medical group level.
	
	<u>Healthcare Effectiveness Data and Information Set (HEDIS) Performance</u>
	• Medicaid
	  o HEDIS: 24.95
	  o Significant improvement in 10 measures
	  o Significant decline in 4 measures
	• Medicare
	  o HEDIS: 17.38
	• LACC/Marketplace Quality Rating System (QRS)
	• Four stars, up from 3 stars in 2017
	• DHCS Auto Assignment
	• 54% is a drop from 64% previous year
	
	<u>Population Health Management</u>
	• L.A. Care developed a coordinated Population Health Management Program.
	• Population Health Management Strategy
	• Population Assessment
	• A Cross-Functional Team
	
	<u>Clinical Practice Guidelines</u>
	• Joint Performance Improvement Collaborative Committee and Physician Quality Committee (PICC/PQC) approved new and revised clinical practice and preventive health guidelines.
	• Links posted on website to support providers in their practice.	

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	Provider Continuing Education (PCE) Program • L.A. Care continues to be accredited as a CME/CE provider • In 2018, L.A. Care implemented • 32 directly provided CME/CE activities • 47 jointly provided CME/CE activities with other healthcare organizations • L.A. Care received 88% to 95% on level of satisfaction with each CME/CE activity Cultural and Linguistics Services • Top requested languages: Spanish, Khmer, Chinese • Processed 6,377 face-to-face interpreting requests • 6,116 were for medical appointments • Telephonic interpreting services provided 170,369 requests Health Education • *Healthy Moms program*: outreach to 6,108 post-partum members • *Healthy Pregnancy program*: 5,902 pregnant members identified • *Healthy Baby program*: 28,711 immunization packets mailed • The Youth Empowerment Campaign sent 15,080 letters to increase awareness about and improve chlamydia screening rates. Member Perez asked if the TEXT4BABY program is still in effect. Dr. Seidman the program is still active. Member Shapiro asked what percentage of L.A. Care members received interpreting services. He noted that the number seems low. Ms. Casias responded that the number only reflects the L.A. Care's direct line of business. Member Perez requested data showing how many times interpreters were used for each language. Patient Safety • For Pharmaceutical Safety Program: • Concurrent Drug Utilization Review/Retrospective Drug Use Evaluation. • Over 12,000 letters were mailed to prescribers for Drug-Drug Interactions. • Medication Adherence Program:	

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	• Pharmacy Technicians calls to members, pharmacies and prescribers to investigate barriers to adherence and remedies. • In July 2018, providers started receiving a non-adherence scorecard letter. • Potential Quality Issues • Provider quality track and trend process enhanced • Critical Incident Reporting • Compliance with quarterly submission at 100% • Facility Site Review • Needle stick safety rate increased to 73% from 70% • Spore testing of autoclaves at 79% down from 81% Member Booth asked how many critical incidents were reported. Ms. Casias responded that she did not have that information. CMS requires that L.A. Care is reporting these incidents. <u>Addressing Disparities</u> • African Americans have lowest rates for A1c testing, Asthma Medication Ratio, and Antidepressant Medication Management • American Indians have the lowest rates for hospital admissions for long-term diabetes complications and hypertension <u>Access to Care, After Hours and Appointment Availability</u> • Did not meet performance goals for urgent and routine appointments • Met most of the goals for all other appointment types • Did not meet performance goals for after-hour access • There was an improvement in the performance for all after-hours access standards. <u>Member Participation, Community Outreach and Engagement</u> • Advisory Member Outreach • RCAC members reached 4,297 community members • Community Partnerships • Outreach focused on Women's health, diabetes and heart health <u>Provider Incentive Programs</u> • L.A. Care's Physician P4P Program (Measurement Year 2017)	

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2019 Quality Improvement Program Description and Work Plan	• L.A. Care's VIIP+P4P Program (MY 2017)
	• L.A. Care's Plan Partner Incentive Program (MY 2017)
	
	<u>Member Incentive Programs (2018)</u>
	As of November 2018:
	• Cervical Cancer Screening ($50 gift card)
	• Breast Cancer Screening - L.A. Care Covered ($50 gift card)
	• Follow-Up for Hospitalization after Mental Illness
	• Comprehensive Diabetes Care (CMC members)
	
	<u>2019 Program Description Revisions</u>
	• Strategic Priorities: Updated to 2018-2021.
	• Language and membership numbers were updated for SB75, which provides eligibility regardless of immigration status.
	• CMC demonstration authorized through December 31, 2019.
	• Incorporated language that the MLTSS clinical teams, Long Term Care Nursing Facilities and Community Based Adult Services are part of Case Management's Interdisciplinary Care Team.
	• The Quality Improvement Department went through a restructure in 2018 to align functions.
	• Several positions had revisions to the responsibilities to align with the changes in structure. Some positions were removed and others added.
	• Population Health Management (PHM) was updated to reflect that the PHM Program is up and running.
	• Language modifications to clearly state the goals, functions, structure, and reporting responsibilities for several committees.
	
	<u>Significant Program Changes</u>
	• Included the Safety Net Programs and Partnerships:
	  o Health Homes Program
	  o The Whole Person Care Program (WPC)
	  o Homeless Program Duals program updated to include program objectives, framework, and key components
	• Revised Pharmacy Management processes for Medication Therapy Management, Comprehensive Medication Review, and the Quality Assurance programs	

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	• Availability of Practitioners includes high impact specialists, and the use of alternative access standards. • Comprehensively detailed the Value Initiative for IPA Performance (VIIP+ P4P) Program. Member Perez thanked Ms. Casias for her hard work on presentation. Member Booth asked if the motion can be split into two. A motion to approve the 2018 Quality Improvement Annual Report & Evaluation and a motion to approve the 2019 Quality Improvement Program & Work Plan. **<u>Motion COM A.0319</u>** **To approve Quality Improvement documents:** • **2018 Quality Improvement Annual Report & Evaluation – All lines business** • **2019 Quality Improvement Program & Work Plan – All lines of business.**	**Approved unanimously. 6 AYES**
ANNUAL COMMITTEE CHAIR ELECTION Augustavia J. Haydel, Esq.	Augustavia J. Haydel, Esq., *General Counsel,* reminded the committee that there was an election held on September 8, 2018 due to the previous chair terming out. She reviewed the process for Committee Chair election and asked for nominations for Committee Chair. Member Booth nominated herself. Member Perez nominated Member Booth. Member Ballesteros nominated Member Ghaly. Member Ghaly nominated Member Booth. Member Ghaly declined her nomination. **Member Booth was elected Committee Chair by unanimous vote.**	**Approved unanimously. 6 AYES**
ADJOURNMENT	The meeting was adjourned at 3:10 p.m.	

Respectfully submitted by:
Victor Rodriguez, *Board Specialist, Board Services*
Malou Balones, *Senior Board Specialist, Board Services*
Linda Merkens, *Senior Manager, Board Services*

APPROVED BY:

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

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APPROVED BY:

Stephanie Booth

Stephanie Booth, MD, *Chairperson*
Date Signed: 5/16/2019

APPROVED