DRAFT

AGENDA
COMPLIANCE & QUALITY COMMITTEE MEETING
BOARD OF GOVERNORS

Thursday, August 15, 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.

To listen to the meeting via videoconference please register by using the link below:
https://lacare.webex.com/lacare/j.php?MTID=m34b666817a2a7605216a5724b1bc38ec

To listen to the meeting via teleconference please dial: +1-213-306-3065
Meeting number: 2495 351 5748 Password: lacare

For those not attending the meeting in person, public comments on Agenda items can be submitted prior to the start of the meeting in writing by e-mail to BoardServices@lacare.org, or by sending a text or voicemail to (213) 628-6420. Due to time constraints, we are not able to transcribe and read public comment received by voice mail during the meeting. Public comment submitted by voice messages after the start of the meeting will be included in writing at the end of the meeting minutes.

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 June 20, 2024 Meeting Minutes P.3	*Chair*
4.	Chairperson's Report • Education Topics	*Chair*
5.	Committee Charter Status Update	Todd Gower *Chief Compliance Officer*
6.	Chief Compliance Officer Report P.17	Todd Gower
7.	Chief Medical Officer Report	Sameer Amin, *MD* *Chief Medical Officer*
8.	Transitional Care Services (CalAIM) P.92	Joycelyn Smart-Sanchez, *Director, Care Management, Care Management*
9.	Quality Improvement Reports • Quality Improvement Projects (QIPs/PIPS, PDSA) P.107	Rachel Martinez, *RN, BSN* *Supervisor, Quality Improvement, Quality Improvement*

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- Stars Update D-SNP P.117 — Donna Sutton, *Senior Director, Stars Excellence, Quality Improvement*

10. Public Comment on Closed Session

ADJOURN TO CLOSED SESSION (Est. time 20 minutes)

11. PEER REVIEW
Welfare & Institutions Code Section 14087.38(o)

12. 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

13. THREAT TO PUBLIC SERVICES OR FACILITIES
Government Code Section 54957
Consultation with: Tom MacDougall, Chief Information and Technology Officer

14. 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 September 19, 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.
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 – June 20, 2024

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

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

Senior Management
Sameer Amin, *MD, Chief Medical Officer*
Terry Brown, *Chief of Human Resources*
Todd Gower, *Chief Compliance Officer*
Augustavia J. Haydel, *General Counsel*
Alex Li, *Chief Health Equity Officer*
Tom MacDougall, *Chief Information and Technology Officer, IT Executive Administration*
Noah Paley, *Chief of Staff*
Acacia Reed, *Chief Operations Officer*
Edward Sheen, MD, *Senior Quality, Population Health, and Informatics Executive*

** Absent ** Via Teleconference*

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
CALL TO ORDER	Chairperson Stephanie Booth, *MD*, called the L.A. Care Compliance & Quality Committee and the L.A. Care Health Plan Joint Powers Authority Compliance & Quality Committee meetings to order at 2:02 P.M. She announced that members of the public may address the Committee on each matter listed on the agenda before the Committee's consideration of the item by submitting their comments via text, voicemail, or email.	
APPROVAL OF MEETING AGENDA	**The meeting Agenda was approved as submitted.**	**Approved unanimously 4 AYES (Ballesteros, Booth, Roybal, and Vazquez)**
PUBLIC COMMENT	*There was no public comment.*	

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
APPROVAL OF MEETING MINUTES	**The April 18, 2024 meeting minutes were approved as submitted.**	**Approved unanimously.**
CHAIRPERSON REPORT	Chairperson Booth spoke about two main issues: the use of acronyms and the confusion between fiscal and calendar years. She stressed the need for a standardized approach to acronyms, suggesting either always spelling them out, adding an appendix to each presentation, or creating an acronym list, although she noted the difficulty of maintaining such a list, because acronyms she hasn't noticed in over three years show up rather regularly. She said has gathered two lists of acronyms, none of which was defined in the Board Welcome packet from LA Care. For the first list, she collected and, often with help from Board Services or the writer of the document, determined what the acronym meant to convey. She then alphabetized the list. She began collecting and defining a second list of new acronyms almost immediately. She noted each list is quite long. Chairperson Booth referred to an idea she has mentioned previously. She has been hoping LA Care could create a virtual library to serve as a source of reference for Board Members. This library could be where the three lists of acronyms, after being merged and alphabetized, could reside. Chairperson Booth next considered the confusion sometimes created by the way different departments at LA Care refer to a year's-worth of time. Most items coming to the Board are based on the calendar year — January through December. However, Finance and Budget items are always based on the fiscal year — October through the next September. She wonders if this is confusing to Board members, as it still occasionally is for her. She suggested labeling the year "CY" or "FY," as appropriate. Third, she addressed the drop in the readability of appeals and grievance letters. She stated the timeliness of responses to patients was prioritized. The A&G team put a great deal of work into fixing timeliness issues and she congratulated the team for the very nearly perfect scores they had been reporting. However, the readability of the letters declined in that same timeframe. She knows it is highly ambitious, but she challenged the team with finding a better balance of work to be put toward each issue requiring improvement at any given time. The perfection to strive for, she suggested, should be the best balance of progress in each underperforming process and maintenance of each adequately performing process. She stated the unfairness of external entities re-auditing as issue and expecting improvement without allowing sufficient time for corrective action implementation, does not go unnoticed by the Board. Finally, Chairperson Booth suggested that these should be interesting topics for discussion for incoming C&Q committee members. Mr. Gower responded that as Compliance is creating a 2025 Compliance Work Plan it will be a good idea to provide an educational piece on what is being done in 2025 regarding what is changing in Compliance.	

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COMPLIANCE & QUALITY COMMITTEE CHARTER STATUS UPDATE	Todd Gower, *Chief Compliance Officer*, discussed the Compliance & Quality Committee Charter Process. He stated that he sent the committee Charter to Chairperson Booth for review and to get her comments and input. Once she provides her comments it will be sent to the rest of the committee for input. Chairperson Booth stressed the importance of the information being discussed. She proposed creating a document that includes relevant facts, opinions, and tasks. This document would serve as informal guidance for committee members, outlining important information and listing expected reports. Chairperson Booth suggested that this document be kept up-to-date and treated as unofficial guidance rather than a formal policy.	
CHIEF COMPLIANCE OFFICER REPORT	Todd Gower, *Chief Compliance Officer*, and the Compliance Department staff presented the Chief Compliance Officer Report *(a copy of the full written report can be obtained from Board Services).* Tara Nelson, *Senior Director, Utilization Management, Utilization Management,* presented information on Utilization Management (UM). Ms. Nelson reported on the overall compliance measures from January through April, noting that of over 180 measures, 179 were met with a rating between 95% and 100%. Four measures were between 90% and 95%, and one was below 90%. Direct network measures were above 95%. She explained that the few measures below 95% were due to past urgent decisions and notifications, which are being addressed. She highlighted that while extensions are being applied, the current reporting system does not account for the extensions, affecting the reported metrics. Ms. Nelson expressed confidence that these issues would be corrected in the next report. Chairperson Booth asked if the Direct Network metric" included measurements for UM services related only to Medi-Cal patients, and Ms. Nelson responded affirmatively. Ms. Nelson continued the report by focusing on specific compliance measures in April. She noted that 15 measures for the direct network were above 95%, and 45 measures for the rest of the population were similarly high, with one measure falling in the 90-95% range due to past urgent decisions. Nelson assured that this measure would improve by the next report. She then highlighted the current audits conducted by the quality team, focusing on internal review processes, regulatory compliance, and procedural consistency. These monthly audits cover various areas, including timeliness, decision-making, and template usage for doctors and outpatient clinical staff, ensuring proper prior authorization and intake processes. The audits also examine continuity of care for non-contracted requests, the accuracy and timeliness of letters, and the reasons behind overturned appeals to prevent future occurrences. Additionally, she mentioned that non-emergency medical transportation (NEMT) is audited to ensure proper processing of required Physician Certified Statement forms. Ms. Nelson offered to address any specific questions about	

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	the audits. Chairperson Booth asked what "AT Staff" refers to. Ms. Nelson responded that AT staff are Authorization Technicians, non-clinical intake staffs. She explained that when a provider faxes information, AT is the team that ingests that fax and creates the authorization. Ms. Nelson reviewed the detail involved in template audits. She explained that they examine whether the correct letter templates are used, including the presence of the Independent Medical Review form, appeal rates, peer-to-peer contact information, and the member's ability to request the criteria used. For denial reasons, the audits check if the doctor criteria and verbiage make sense and are correctly applied, ensuring clarity at a fifth-grade reading level. They also verify that the appropriate decision letters, such as those for extensions, are used. The audits assess peer-to-peer turnaround times and ensure that denials are made by the correct personnel, distinguishing between clinical and administrative denials. Nelson emphasized the importance of maintaining readability and health literacy throughout the process. Member Ballesteros asked Ms. Nelson for clarification on the continuity of care audit. He wanted to understand whether the audit examines the practical implementation of continuity of care processes for individual patients or if it focuses on the regulatory requirements as stated in the law. He questioned whether the audit reviews the actual procedures on the ground or the legal guidelines governing those procedures. Ms. Nelson responded by clarifying that the continuity of care (COC) audit focuses on eligibility rather than specific patient interactions with providers. It examines whether new members with established provider relationships within the past twelve months are appropriately managed according to regulatory requirements. This includes the issuance of various mandated letters, such as COC acknowledgment letters and notifications about the end of the COC period. She emphasized that these COC letters are different from standard process letters and are crucial for regulatory compliance. The audit ensures the correct letters are sent and the entire COC process is followed from start to finish. Member Ballesteros expressed his desire to understand the audit from the patient's perspective. He wanted to know if the audit assesses the patient experience, specifically whether patients received the necessary communications and how they perceived the process. He mentioned the potential disconnect between the procedural focus of the audit and the patient's understanding of the steps involved. Member Ballesteros highlighted that patients might simply perceive delays in moving from one step to another without grasping the detailed regulatory requirements, and he sought to understand how the audit addresses these immediate patient concerns. Member Vazquez would like to know when the results are expected for each of the categories. Ms. Nelson clarified that the audits shown are internal and process-related, remaining within the organization. They report the audits through UM and in monthly meetings with Sameer Amin, *MD, Chief Medical Officer*. The quality and education team conducts these assessments monthly, and	

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any identified gaps or failures prompt staff education to correct issues. The audits are internal and managed in-house.

Demetra Crandall, *Director, Customer Solution Center Appeals and Grievances, CSC Appeals & Grievances,* provided information about Appeals & Grievance (A&G).

A&G Audit Score Results FY 2023-2024

Months	Number of Evaluations	Department Threshold	Department Scores	Met/Not Met
October	747	95.00%	91.44%	Not Met
November	600	95.00%	93.64%	Not Met
December	242	95.00%	87.60%	Not Met
January	715	95.00%	87.59%	Not Met
February	408	95.00%	88.50%	Not Met
March	256	95.00%	91.47%	Not Met

- A&G staff conducts quality audits on appeal and grievance cases prior to resolution, post closure and focused audits to ensure that cases meet regulatory requirements.
- The number of evaluations decreased over time due to the team being utilized to assist with other regulatory functions.
- The A&G Leadership team is re-focusing efforts on audit results with associates to improve the department score.
- Increased staffing will assist with improving this measure. It will allow for the associates to have adequate time to process cases thoroughly and for training/retraining to occur.

A&G Audit Results
A&G utilized existing quality audit questions to track improvement on identified areas in the DMHC/DHCS audits.

Audit Questions

- Does the system reflect that the case was resolved and the resolution letter mailed timely based on regulations?

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN

Months 2023/2024	Number of Evaluations	Evaluations Passed	Evaluations Failed	Department Threshold	Department Scores	Met/Not Met
October	602	599	3	95.00%	99.50%	Met
November	376	373	3	95.00%	99.20%	Met
December	No Audits	No Audits	No Audits	No Audits	No Audits	No Audits
January	166	165	1	95.00%	99.40%	Met
February	105	104	1	95.00%	99.05%	Met
March	83	81	2	95.00%	97.59%	Met

- Is the resolution letter written in clear and concise language?

Months 2023/2024	Number of Evaluations	Evaluations Passed	Evaluations Failed	Department Threshold	Department Scores	Met/Not Met
October	602	551	51	95%	91.53%	Not met
November	376	324	52	95%	86.17%	Not met
December	No Audits	No Audits	No Audits	No Audits	No Audits	No Audits
January	166	141	25	95.00%	84.94%	Not met
February	105	75	30	95.00%	71.43%	Not met
March	86	66	17	95	79.52%	Not met

A&G New Quality Audit Questions
In an effort to remediate specific identified areas of non-compliance, the A&G team created new quality audit questions. Based on Regulatory Audit Findings, the new questions were added to the audit scorecards effective March 1, 2024.

Was the AOR/ARD process followed correctly?

Month 2024	Number of Evaluations	Evaluations Passed	Evaluations Failed	Department Threshold	Department Scores	Met/Not Met
March	113	113	0	95%	100.00%	Met

Was the case classified correctly?

Month 2024	Number of Evaluations	Evaluations Passed	Evaluations Failed	Department Threshold	Department Scores	Met/Not Met
March	78	72	6	95%	92.00%	Not Met

Erik Chase, *Senior Director, Claims Integrity, Claims Integrity,* reported on Claims Integrity. Mr. Chase noted that the data presented had been previously shared with the Board of Governors on June 6, and would be updated before the next board meeting. His presentation focused on illustrating the trends and challenges in claims processing and the steps taken to address them. Mr. Chase discussed the total paid claims, including interest, highlighting that there had been a notable increase in paid claims due to issues with Change Healthcare and adjustments to retro rates for skilled nursing facilities (SNFs). Despite the increase in volume, the interest paid on claims decreased, indicating improved timeliness in claims payments. This was a positive outcome of the efficiency measures implemented. He discussed the percentage of first-pass auto adjudications, emphasizing the role of automation in reducing errors and increasing consistency compared to manual processing. The rise in auto adjudication rates reflected the improvements. Mr. Chase

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	addressed claims timeliness compliance. He noted that the processes put in place during late 2023 led to an increase in compliance rates, surpassing the standards set for 30 calendar days and 45 business days. Additionally, he pointed out a significant reduction in the time taken to process claims, further underscoring the effectiveness of the new efficiency measures. He reported a decrease in the denial rate, attributing the improvement to a proactive review of denials. A significant factor identified was the coordination of benefits, where claims were previously denied due to discrepancies between primary and secondary payments. Changes in policy now allowed for claims processed at zero to not be classified as denied, which reduced the denial rate and improved encounter crediting. Further efforts were being made to educate providers on proper claim submission to avoid future issues. Regarding adjustments, Mr. Chase highlighted increased volumes due to retro rate adjustments for SNFs and transportation vendors, which had impacted adjustment volumes. He noted that the large volume of retro rate adjustments in 2023 had contributed to this increase. The report also covered the rise in Provider Dispute Resolution (PDR) volumes, particularly in December, which was linked to an increase in the Coordination of Benefits volume. Efforts were made to address these delays, and a focus was placed on educating providers about reimbursement terms to align expectations and reduce disputes. Mr. Chase mentioned ongoing improvements in average data processing times and the development of a new platform to enhance workflow capabilities. This platform was expected to provide better technology support for the PDR process. He acknowledged the collaborative efforts of the Payment Integrity and Special Investigations Unit teams, expressing gratitude for their contributions to improving claims processing and ensuring the integrity of payments. Michael Sobetzko, *Senior Director, Risk Management and Operations Support, Compliance,* gave an update on L.A. Care's Risk Committee (RC) and Issues Inventory update. Internal Compliance Committee approved the Risk Committee charter on April 10, 2024. RC Purpose: To ensure that L.A. Care can fulfill its requirement with respect to management of the Company's risks and assist management in setting the tone from the top and in developing a strong risk and compliance culture at all levels in the Company that results in appropriate consideration of risk and compliance in key strategic and business decisions. RC Goals: The primary goals of the Risk Committee are to: • Identify the key risks that could affect the ability of the Company to achieve its strategies and meet its regulatory obligations. • Establish an Enterprise Risk Management program to identify, measure, monitor and report on the risks the Company faces • Oversee Management Action Plans to ensure risks are properly mitigated. • Periodically review enterprise level activities that tie into risk profiles (e.g. vendors)	

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	RC Report-Out: The Risk Committee meets semi-monthly (or more often if necessary) and will report out to ICC and the Compliance & Quality committee of the board. • These reports highlight critical risks, trends, and areas requiring attention. • Status of Management Action Plans (MAPs) • RC Composition: The Risk Committee is made up of Director+ level representatives from across the enterprise RC Decision Making: • They consider risk appetite, regulatory compliance, and strategic alignment. • Recommendations from the risk committee may influence resource allocation, risk tolerance, and policy adjustments. Issues Inventory Update	

Status	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
Reported	5	6	7	10	4
Open	2	4	1	2	1
Closed to inventory	1		2	3	2
Deferred					
Remediated		1	3	1	
Tracking Only	2	1	1	4	1
Monitoring Only					

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

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN

- Tracking Only – Issues managed by other Compliance areas (such as Regulatory Affairs, Audits, Analysis, Communication and Internal Audit In which the risk management staff is following up for current status updates to closure.
- Monitoring Only – Issues in which corrective action plans are completed and monitoring is to be done by Compliance.

Issues Inventory Years 2019-2024

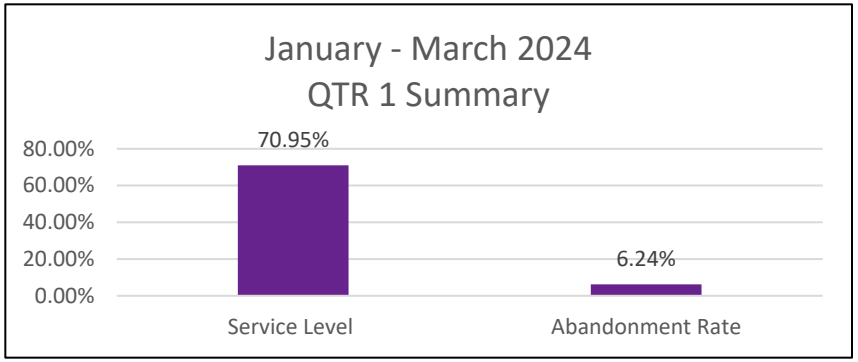
Year	2019	2020	2021	2022	2023	2024
Total	**6**	**134**	**32**	**105**	**212**	**27**
Open	**1**			**3**	**20**	**8**
Closed to Inventory					**126**	**7**
Deferred			**3**	**21**	**2**	
Remediated	**5**	**134**	**29**	**81**	**45**	**5**
Tracking Only					19	7
Monitoring Only						

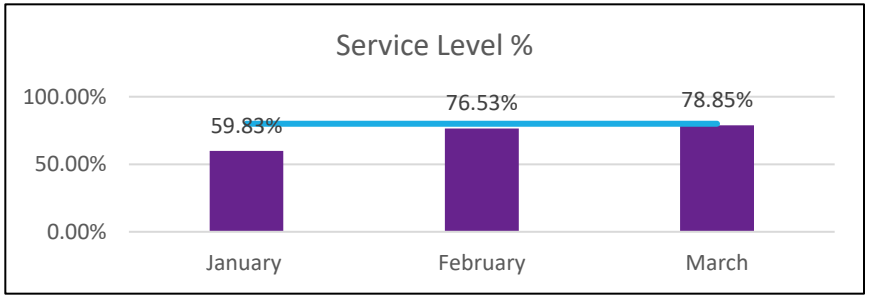
Open

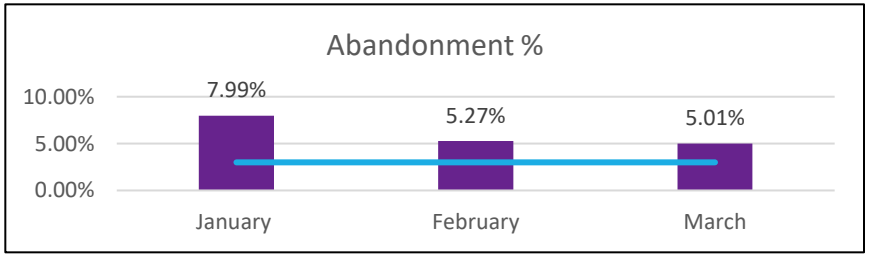
Issue Name and Description	Date Reported	Business Unit	Status
Call Center D-SNP Performance Metric Not Met Q12024 The plan did not meet the D-SNP internal enterprise performance target goals for call center service level >80% (January 59.83%, February 76.53% and March 78.85%) and abandonment <3% (January 7.99%, February 5.27% and March 5.01%) for the Q12024. (1569)	4/18/2024	Customer Solution Center	Open

Julie Valdivia, *Lead Customer Solution Center Workforce Management Analyst, Office of CSC Excellence*, gave a Customer Solution Center Call Center Corrective Action Plan Update.

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	D-SNP Call Center Performance	







Root Cause and Corrective Action Plans
Root Cause:

- The call center was challenged with meeting Key Performance Indicators (KPI) in January, February and March due to the following factors:
  - Increase in AHT during Open Enrollment

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN

- High attrition and shrinkage within Internal and Vendor staff impacting resource availability

Remediation Efforts:

- The WFM team implemented a Customer Solution Representatives shift bid change on March 11, 2024 to accommodate coverage for call arrival patterns
- The WFM team will continue to conduct a daily analysis of call volume trends and call arrival patterns in order to adjust staffing optimization
- A 6th work day for the Vendor staff has been and will continue to be scheduled during high call volume days. Overtime has also been and will continue to be implemented for internal phone staff, as an all-hands-on-deck (AHOD) approach with supplemental units to increase resource capability
- Three D-SNP classes were scheduled from January- March with a total of 21 CSRs, with added classes in April, May, June amounting in 20 CSRs.
- The Vendor was approved to increase their headcount as of May 2024, and have classes scheduled to onboard new staff
    - New hire training lasts approximately 6-10 weeks. After the training is completed, their average handle time will naturally be higher as they become familiarized with call handling and transition from a training environment to production

Michael Devine, *Director, Special Investigations Unit, Special Investigations Unit*, gave a Compliance SIU Update.

FY 2023-2024 Year to Date Recoveries & Savings Dashboard

	Mar – May 2024	FY Year-to-Date
Recoveries	$744K	$3.5M
Savings	$2.5M	$6.4M
Totals	$3.2M	$9.9M

Law Enforcement

Active Criminal Investigations (FBI, CA DOJ, LASD HALT)	48
Undercover Operations	0
Arrests	2
Pending Prosecution	11

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	Convictions 3 Mr. Devine announced that he was a speaker at the Healthcare Payment & Revenue Integrity Congress in Boston, Massachusetts, speaking on the topic of Pharmacy Fraud Investigations. Marita Nazarian, *Director, Delegation Oversight*, gave a Delegation Oversight Audit update. 2023 Delegation Oversight Audits 24 Participating Physician Group (PPG)/Independent Physician Association (IPA) Audited Initial Health Assessment (IHA): 91% of PPGs audited had untimely IHAs Medi-Cal Specialty Referrals • 79% of PPGs audited could not demonstrate that the member was scheduled for requested services; and • 94% of PPGs audited could not evidence that there was a follow-up conducted on the referral if it remained open or unused. 2024 Delegation Oversight Audits Five PPGs Audits Completed (Trends as of June 2024); PPGs are not clear on IHA obligations for D-SNP members Priscilla Lopez, *Manager, Quality Improvement Accreditation, Quality Improvement,* provided information on Quality Improvement. She reported that LA Care's accreditation status has been updated on the NCQA website, acknowledging the successful efforts of the delegation oversight and compliance teams. While celebrating this achievement, Ms. Lopez emphasized the need for ongoing improvement and the development of a plan to prevent future issues. The QI team continues it's collaboration with delegation and compliance material review teams to address missing language in notice of action denial letters. The team is preparing for the next Los Angeles County Department of Health Services discretionary survey, scheduled for June 2026, and between now and then is monitoring changes to the e-consult process and denial file volume. Ms. Lopez also introduced a new process improvement initiative aimed at enhancing data accessibility for delegates. The shift from provider-level report cards to an interactive dashboard will allow delegates to view compliance areas, filter data by specialty and line of business, and track usage frequency. This tool will be rolled out in the coming months, incorporating feedback from the latest access to care survey conducted between October and December 2023.	

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
CHIEF MEDICAL OFFICER REPORT	Edward Sheen, MD, *Senior Quality, Population Health, and Informatics Executive,* presented the June 2024 Chief Medical Officer report on behalf of Sameer Amin, *MD, Chief Medical Officer* (*a copy of the written report can be obtained from Board Services).* The Chief Medical Officer report focused on two main topics: provider engagement efforts and quality performance trends. In 2024, Dr. Sheen introduced a new system of Quality and Population Health Joint Operating Meetings (JOMs), designed to expand and deepen provider engagement. These monthly forums involve the ten largest practice groups accounting for up to 70% of the provider network and Plan Partners , aiming to improve collaboration, review performance data, design solutions, and address specific challenges. A JOM system for the Direct Network is also being developed. These systems represents a shift from infrequent engagements to a more consistent, structured, and interactive approach with deeper focus on provider voices. Dr. Sheen also provided an update on quality performance. The report indicated improvements in several metrics, with a notable decrease in MCAS sanctions from $890,000 to $300,000. For the measurement year 2023, 15 out of 18 measures showed performance improvements. Lack of reliable state data feeds for FUA and FUM measures remains a challenge. The 2024 performance trends are positive with many measures showing YTD improvement compared 2023. One headwind to keep in mind is impact of Kaiser plan partner exit which will have across the board impact on quality measure performance based on Kaiser's historical performance. t. Overall, the organization is seeing better performance compared to the previous year in quality, pharmacy, and operations domains.. Dr. Sheen highlighted ongoing efforts to maintain and enhance these improvements, emphasizing the collaborative efforts across teams to achieve better results.	
TRANSITIONAL CARE SERVICES (CalAIM)	*This agenda item was not discussed due to a lack of time.*	
PUBLIC COMMENT ON CLOSED SESSION ITEMS	*There was no public comment.*	
ADJOURN TO CLOSED SESSION	Augustavia J. Haydel, Esq., *General Counsel*, announced the following items to be discussed in closed session. The JPA Compliance and Quality Committee meeting adjourned and the Compliance and Quality Committee adjourned to closed session at 4:51 P.M. PEER REVIEW Welfare & Institutions Code Section 14087.38(o)	

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	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 THREAT TO PUBLIC SERVICES OR FACILITIES Government Code Section 54957 Consultation with: Magdalena Marchese, Senior Director, Audit Services, Executive Services CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION Pursuant to Section 54956.9(d)(1) of the Ralph M. Brown Act • Department of Managed Health Care Enforcement Matter Numbers: 18-799, 20-063, 21-428, 21-509, 21-680 • Department of Health Care Services, Office of Administrative Hearings and Appeals, In the matter of: L.A. Care Health Care Plan Appeal No. MCP22-0322-559-MF	
RECONVENE IN OPEN SESSION	The Committee reconvened in open session at 5:10 p.m. There was no report from closed session.	
ADJOURNMENT	The meeting adjourned at 5:15 p.m.	

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

APPROVED BY:

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

Compliance & Quality (C&Q) Committee Meeting

L.A. Care HEALTH PLAN®

For All of L.A.

Compliance Department

August 15, 2024

Chief Compliance Officer Report Out

Todd Gower

Chief Compliance Report & Agenda

1. Compliance Report Out from Internal Compliance Committee "ICC" (Todd Gower)
2. Risk Committee Report Out (Michael Sobetzko)
   - 2024 – 2025 Enterprise Risk Planning
3. Enterprise Risk Assessment - Management Action Plan Updates
   - Health Risk Assessment – Reassessment Efforts (Amanda Asmus)
   - Encounters Data (Hiroshi Fujii, Greg White, Loren Maddy)
   - Compliance Monitoring / Enforcement / Audits (Miguel Varela)
   - Delegation Oversight (Miguel Varela)
   - DSNP Implementation and Oversight (Miguel Varela)
4. Information Technology Risk Report Out (Penny Winkfield)
5. Delegation Oversight Monitoring Update (Albert Aguilar)
6. Issues Inventory (Michael Sobetzko)
7. Internal Audit and Delegation Oversight Auditing (Maggie Marchese)
8. Regulatory Audit Follow Ups (Lisa Pasillas-Le)

Risk Committee Report Out

Michael Sobetzko

2024-25 Enterprise Risk Assessment

Presenter(s): Mike Sobetzko

- Allysa Johnson from Gartner presented at the Risk Committee meeting on July 2nd.
- Goals for the Risk Management Team
  - Build survey
  - Top Risks by Risk Score
  - Top Risks by Demographic / Functional Area
  - Communication and Best Practices
  - Risk Appetite

ERM Process Overview

The ERM process includes actions that an organization takes to sense, evaluate, monitor and respond to internal and external risks.

Risk Identification

The process by which ERM identifies risks affecting the organization.

Risk Assessment

The application of quantitative and qualitative methods to assess the magnitude of risk exposure.

Risk Reporting

The communication of risk information to stakeholders that enables them to perform their oversight responsibilities and make risk-informed decisions.

Risk Response

The process and documentation of identifying and executing risk responses to minimize the probability of a risk occurring or the impact of a risk should it occur.

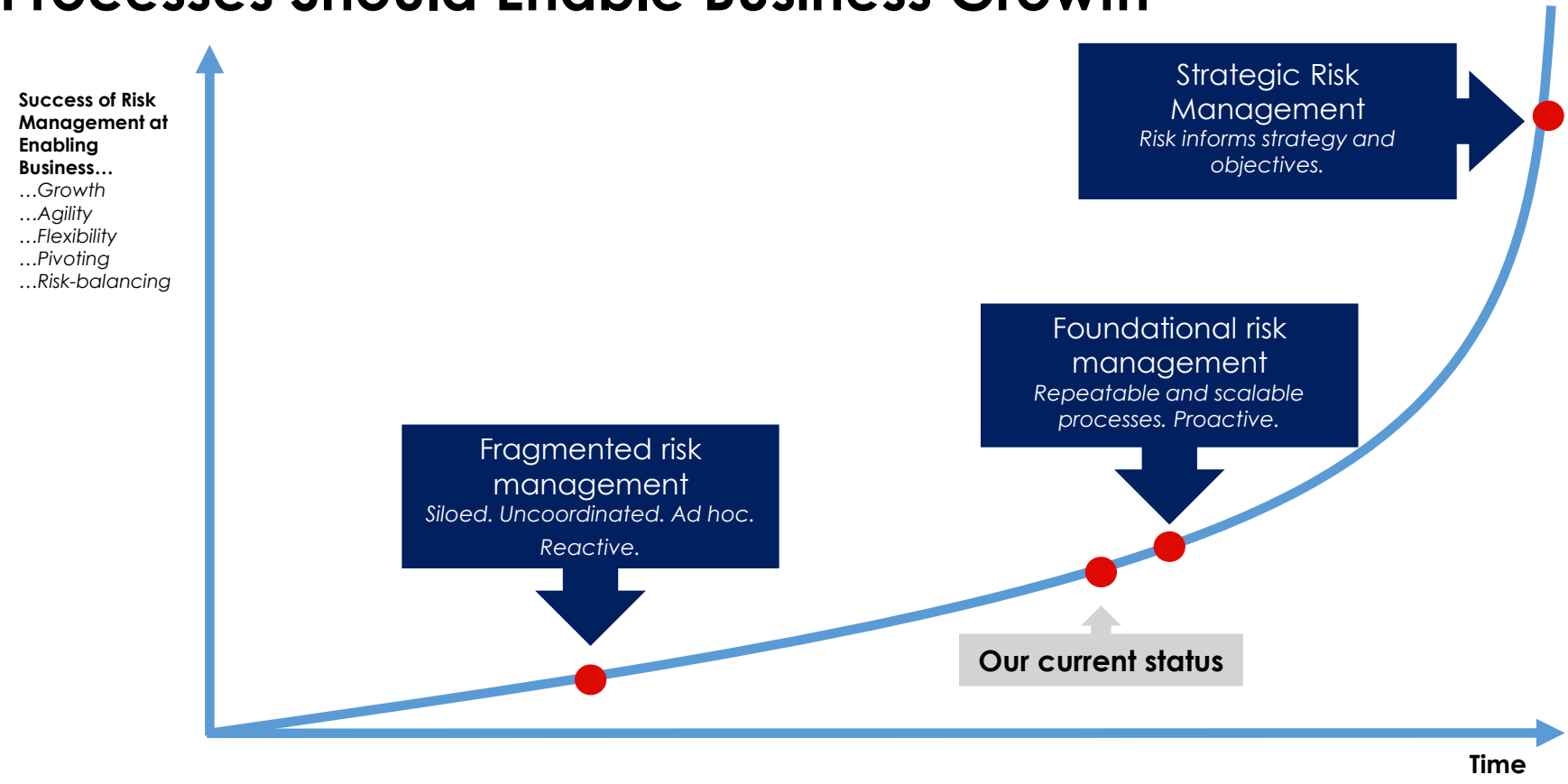
Risk Appetite

The amount of risk an organization is willing to assume in the pursuit of its strategic objectives. (The threshold of acceptable risk-taking is risk tolerance).

Risk Monitoring

The real-time or periodic system for monitoring changes in the probability of a risk occurring or the impact of a risk should it occur.

Processes Should Enable Business Growth



Source: Gartner

A Better Way Forward

1 Fragmented Risk Management

Risks are managed in silos by uncoordinated functions.

ERM Imperatives:

Create transparency around the enterprise risk profile

- Build consensus around a single risk 'language'
- Facilitate regular risk reporting and discussion at executive/board level
- Articulate risk appetite and begin developing risk metrics (KRIs)

Our Organization

2 Foundational ERM

Enterprise risk profile is managed at the enterprise level.

ERM Imperatives:

Integrate ERM with the strategy-setting process

- Focus the risk assessment on interdependencies and on fast-moving, complex risks
- Help the business identify optimal risk response strategies
- Share risk management principles broadly within the organization and ensure they are understood and used
- Coordinate efficient information flow among siloes, leveraging a network of risk liaisons

3 Strategic ERM

Risk discipline is built into strategic decision making.

ERM Imperatives:

- Monitor wide range of Key Risk Indicators (KRIs) from across organization, with established mitigation processes in place if metrics are tripped
- Track emerging risks before they become threats to the business
- Curate risk information before it reaches executives or owners
- Foster an evolving culture of risk-awareness aligned with organizational risk tolerance and appetite

Risk Assessment Survey Timeline approx. 2.5 months

Build

- ❑ **Client visits the Gartner risk platform, scrolling down the page to click on the "digital intake platform" and completes the following 6 steps**
  1. Risk catalog (~2hrs)
  2. Rating scales (~1hr)
  3. Demographic groups (optional)
  4. Confidential / Non-confidential
  5. Other (survey instructions, etc.)
  6. Click "Submit"

Gartner builds the survey
Roughly 3-5 business days.
Client receives link by email and through the portal

- ❑ **Client reviews the test link**
  Input edits through the portal
  Approve and request live link through the portal

Deploy

- ❑ **Client drafts the survey email**
  Use Gartner's provided template
  Create an excel list of all recipients' email addresses

- ❑ **Client sends out the live link**
  Run a mail-merge using the excel

Gartner delivers participation updates
Bi-weekly (Tuesday and Friday)

- ❑ **Client sends any needed email reminders to participants**
  Keep survey open roughly 2 weeks

- ❑ **Client requests Gartner close the survey**

Gartner builds and delivers the report
Roughly 2-3 weeks

Interpret

Gartner and Client schedule a call to review the report
Usually about 1 hour
Best practices on interpreting and manipulating the data

Gartner helps client identify and clarify visible data trends in the report.

- ❑ **Client uses identified data trends to draft risk profile hypotheses**
  Used for reporting risk themes
  Used for follow-up discussions with stakeholders
  Used for mitigation planning

2024 Enterprise Risk Assessment Management Action Plans ("MAPs")

Mike Sobetzko & Business Unit Management Owners

Health Risk Reassessment (HRA) Summary

Presenter(s): Amanda Asmus

RISK DESCRIPTION AND ACTIVITY	STATUS	START DATE	END DATE
Risk Description: Health Risk Assessments are not completed timely. Potentially, enrollees who need extensive care management interventions will not receive care or interventions. Untimely completion will expose L.A. Care to regulatory violations.			
Operational Reports Expansion Remediation Plan and Timeline			
MCLA HRA Operational reports expanded to capture new MCLA Populations.	Completed	2023	7/2024
DSNP HRA Operational reports expanded to capture new DSNP line of business.	Completed	2023	7/2024
CMC-era Operational Reports and ad-hoc reports. Care Management and EvenMORE teams have been relying on ad-hoc reports and workarounds based on old reports to manually track DSNP HRA outreach and completion. Legacy reports will be phased out once all DSNP reports are operational	In Progress	2023	8/2024
DHCS High Risk populations configured into iPro reports in accordance with DHCS revisions.	In Progress	8/2023	TBD

Encounter Data Collection Summary

Presenter(s): Greg White, Loren Maddy

RISK DESCRIPTION AND ACTIVITY	STATUS	START DATE	END DATE
Risk Description: Data Intake, timeliness, and quality of encounters received, and Implementation of Medi-Cal Targeted Rate Increase (TRI).			
Data Governance, Collection and Timeliness Remediation Plan and Timeline			
Establish an Encounter Data Governance Committee	Completed	7/1/24	7/30/24
PPG Outreach – Analysts have been assigned to reach out to our largest PPGs to assist with their submissions and error correction. This is a newly established function as previous monitoring was done at the submitter level.	In Progress	11/30/23	TBD
Development of Encounter KPIs – Based on recommendations from Arete consulting, new KPI's have been defined and are under development. These KPIs should be available by the end of Q4 2024	In Progress	7/1/24	12/31/24
Staffing Analysis and Enhancements – In order to expand efforts to monitor encounter submissions at the PPG level, as well as investigate issues that arise with their submissions, a request for additional FTEs has been included in the 2025 Budget year.	In Progress	7/1/24	9/30/25

Compliance Monitoring Summary

Presenter(s): Miguel Varela

RISK DESCRIPTION AND ACTIVITY	STATUS	START DATE	END DATE
Risk Description: Compliance departments ability to oversee the organizations performance including operational performance monitoring and operational readiness of all lines of business (LOBs). Timely issuance of internal CAPs. Data driven view of LA Care's compliance and identification of deficiencies. Repeat findings from external audits. CAPs and monitoring required.			
Compliance Restructuring and Operational Improvements Remediation Plan and Timeline			
Restructure of Regulatory Compliance vertical – To ensure L.A. Care has the appropriate oversight and monitoring, the department formerly known as EPO, will need to be integrated into the Regulatory Operations vertical.	Completed	10/1/23	5/1/24
Quantification and Analysis – Once the structural changes have been made, each department leader will analyze their areas and assess the maturity level of the division. This analysis will need to encompass current state, GAP analysis, and future proposals.	Completed	12/1/23	5/1/24
Enhance Corporate Compliance Monitoring – Update processes to ensure appropriate oversight and monitoring; Based on the analysis and recommendations to develop the function, the Corporate Compliance Monitoring division will need to hire the necessary staff. Additionally, the team will need to develop workflows and procedures that capture the oversight and monitoring process of our enterprise,	In Progress	12/1/23	10/1/24

Compliance Delegation Oversight Summary

Presenter(s): Miguel Varela

RISK DESCRIPTION AND ACTIVITY	STATUS	START DATE	END DATE
Risk Description: There is a risk of L.A. Care's Delegation Oversight not effectively monitoring relationships and their agreements to L.A. Care. As a result this could lead to a potential increase in appeals and grievances, member harm and regulatory findings.			
Compliance Delegation Oversight Monitoring Improvements Remediation Plan and Timeline			
Establish a Compliance Delegation Oversight Committee – The Compliance Delegation Oversight team is standing up a three-tiered Committee structure that will allow for the ingestion of information from different L.A. Care Business areas completing Oversight activities. The purpose is to collectively assess our Delegates performance, which is inclusive of contractual and regulatory obligations. Through the committee meetings we can collectively remediate delegate performance issues.	Completed	4/2024	7/2024
Delegate Scorecards – The Delegation Oversight Monitoring team is establishing a process to ingest information from functional areas who are completing oversight activities, digesting the information, and manually populating Delegate scorecards ("baseball cards"). The scorecards will allow for assessment of Delegate's performance.	Completed	6/2024	7/2024
Appeals and Grievances by Delegate – Begin exploring the options of receiving A&G reports by Delegates. This will require working sessions with A&G and IT analytics teams to figure out how to obtain this information related to each Delegate, starting with PPGs and vendors.	In Progress	1/1/25	4/30/25
Monitoring of Plan Partner Appeals and Grievances – Obtain recurring reports from Plan partners in order to begin monitoring delegated A&G.	In Progress	1/1/25	4/30/25

Dual Special Needs Plan (DSNP) Oversight Summary

Presenter(s): Miguel Varela

RISK DESCRIPTION AND ACTIVITY	STATUS	START DATE	END DATE
Risk Description: A monitoring program for DSNP has not been fully rolled out for internal operations and delegates. It is uncertain if LA Care's implementation of DSNP met all requirements. LA Care is highly likely to be selected for audit by CMS.			
DSNP Oversight & Audit Readiness Remediation Plan and Timeline			
Establish a Compliance Delegation Oversight Committee – The Compliance Delegation Oversight team is standing up a three-tiered Committee structure that will allow for the ingestion of information from different L.A. Care Business areas completing Oversight activities. This centralization process will provide the oversight needed on the multiple activities happening within L.A. Care.	Completed	Q1 2024	Q2 2024
Delegate Scorecards – the Delegation Oversight Monitoring team established a framework to gather and visualize compliance-related information for each of our delegates. These "baseball cards" will allow for a holistic analysis on the performance from each delegate.	Completed	Q1 2024	Q2 2024
Development of DSNP KPI – Identify, create, and implement Key Performance Indicators (KPIs) related to DSNP metrics.	In Progress	1/1/24	10/1/24
Staffing Analysis and Enhancements – Compliance teams are conducting staffing analysis and requesting enhancements that will allow for this additional work.	In Progress	1/1/24	10/1/24

Information Technology Risk Report Out

Penny Winkfield

Vulnerability Management Program

Overview/Summary:

- Over the last year, the Information Security (InfoSec) Department has grown and matured. Initially focusing on redesigning the department to align with and support the various business verticals, staffing the newly designed InfoSec department with subject matter experts, and modernizing legacy technologies for better visibility into malicious activities and deviations from known behaviors has reduced the probability of exploitation and increased the organizations overall security posture.
- One of the next areas of focus is to implement a formalized Vulnerability Management Program. Vulnerability Management is a vast topic which consist of people, processes, and technologies, all of which are significant components within the program.
- Managing all of the complexities associated with a Vulnerability Management Program requires dedicated resources focused on identification, remediation, and tracking of vulnerabilities, in conjunction with correlating the likelihood of exploitation with the impact to the organization if exploitation were to occur.

Vulnerability Management Program

High-level timeline Vulnerability Management Program

ACTIVITY	STATUS	Start Date	End Date
Hire a dedicated Vulnerability Program Manager	Complete	4/18/24	6/14/24
Formalize a Vulnerability Management Program	**In Progress**	**6/5/24**	**2/14/25**
Consolidate vulnerability efforts across InfoSec teams	In Progress	7/15/24	10/31/24
Configuration of VM Tooling	In Progress	7/15/24	2/5/25
Develop VM Tooling Capabilities and Requirements	Not Started	8/5/24	9/5/24
Procurement of Tools	Not Started	9/5/24	12/5/24
Develop a process to identify and prioritize vulnerabilities	Not Started	8/5/24	9/5/24
Develop a process track and validate remediation efforts	Not Started	8/5/24	9/5/24
Define and report on performance measures	Not Started	8/5/24	9/5/24
Develop data retention process mapped to HIPAA	Not Started	9/5/24	2/5/25
Develop metrics to track improvements	Not Started	8/5/24	2/14/25

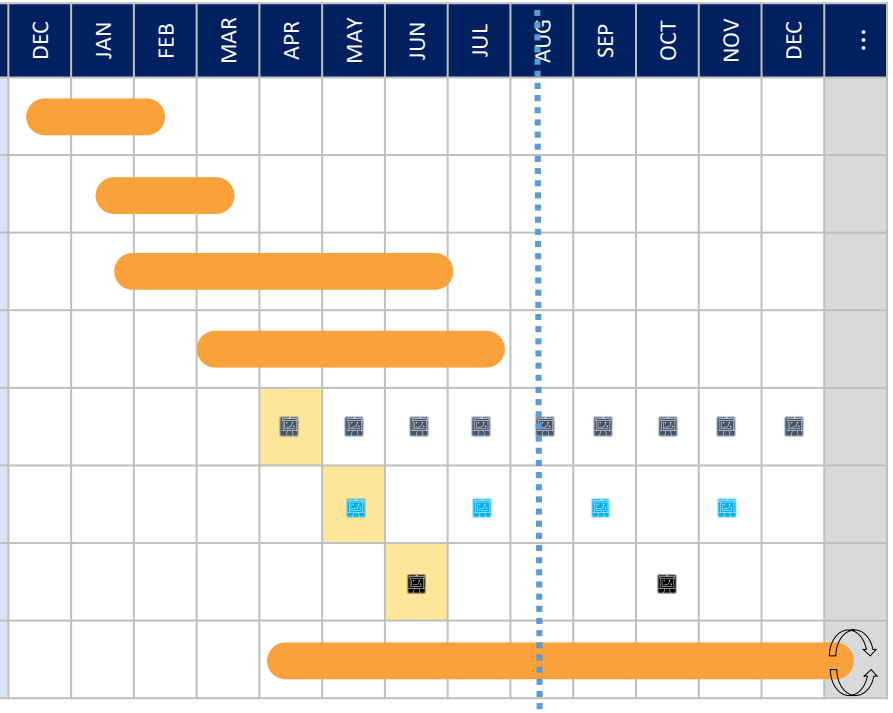
Delegation Oversight Monitoring Report Out

Miguel Varela

Compliance Delegation Oversight (DO) Committee Build Timeline

All of the following DO Committee build activities have been completed.

ACTIVITIES	STATUS
1. Align on the strategy and vision for Delegation Oversight Program	Complete
2. Assess existing capabilities across the organization to identify programmatic gaps and opportunities	Complete
3. Develop, review, and approve Delegation Oversight charter(s)	Complete
4. Design and build Delegation Oversight Program and related processes	Complete
5. Facilitate DO Workgroup Meetings (Monthly)	Complete
6. Facilitate Delegate Sanction Committee Meetings (every other month)	Complete
7. Facilitate Executive DO Committee Meetings (Quarterly)	Complete
8. Ongoing education, review, and process improvement	In Progress



Initial Committee Meeting(s) will be utilized to review and approve the charter, align on expectations, structure and cadence for the meetings.

Compliance Delegation Oversight – Recent Accomplishment

Oversight activities, including monitoring and auditing, is shared across L.A. Care business units. DO Compliance is continually improving internal processes to drive coordinated oversight of our Delegates.

Held **a total of 7 DO Committee meetings**: 4 Delegate Oversight Workgroup Meeting (DOWG), 2 Delegate Sanction Committee (DSC), and 1 Executive Delegation Oversight Committee (EDOC)

Developed **an internal Delegate "baseball card" process for a select # of delegates to foster Delegate-specific review of oversight results and discussions/escalations**. Currently DO Monitoring has generated and discussed 15 internal "delegate baseball cards" during the DOWG meetings

Established a **Delegate Sanctioning framework and process**. Actively assessing two PPGs for potential sanctioning

Streamline the **issuance and tracking of Delegate Notices of Non-Compliance (NONC)**

Supported **multiple business units establish an escalation paths (and "hand offs")** between the business and Compliance for Delegate compliance escalations

Provided **Compliance advisory support to business units** in establishing internal CAP issuance and management processes

Compliance Delegation Oversight – Upcoming Priorities

Compliance Delegation Oversight is prioritizing the following initiatives to help close Compliance risks, issues, and gaps associated to our Delegates.

Continue **facilitating collaborative conversations about Delegate Compliance performance**

Potentially sanction Delegates if/when deemed necessary – following the Sanctioning rubric and framework

With the expected CMS Program Audit early 2025 and expected expansion to MAPD, **focus on increasing maturity of FDR Compliance Program**

Continue to **bridge lines of communication, reporting, and collaboration between Operations and Compliance**

Issues Inventory

Michael Sobetzko

Issues Inventory Update – Summary

Status	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Reported	5	6	7	10	4	6	27						
Open	2	2	1	2	1	1							
Closed to inventory	1	3	2	3	2	3							
Deferred													
Remediated		1	3	1									
Tracking Only	2		1	4	1	2	27						
Monitoring Only													

- **June 2024 – (21) Tracking Only Issues represent the preliminary findings for the 2024 DHCS Medical Audit**
- **Open** – Issues confirmed by Compliance Risk Operations that require oversight and monitoring with business units.
- **Closed to Inventory** – Issues in which business units' are seeking guidance about a regulation or best practice process.
- **Deferred** – Issues in which regulatory guidance (DHCS, DMHC, or CMS) is pending to resolve or issue resolution is dependent on another business units' implementation of a system or process.
- **Remediated** – Issues that require formal or informal corrective action plans for resolution.
- **Tracking Only** – Issues managed by other Compliance areas (such as Regulatory Affairs, Audits, Analysis, Communication and Internal Audit In which the risk management staff is following up for current status updates to closure.
- **Monitoring Only** – Issues in which corrective action plans are completed and monitoring is to be done by Compliance.

Issues Inventory Years 2019 – 2024

OPEN
DEFERRED
TRACKING ONLY

Year	2019	2020	2021	2022	2023	2024
Total	**6**	**134**	**32**	**105**	**212**	**60**
Open				**2**	**15**	**5**
Closed to Inventory					**126**	**16**
Deferred			**3**	**21**	**2**	
Remediated	**6**	**134**	**29**	**82**	**50**	**5**
Tracking Only					19	**34**
Monitoring Only						

Issues Inventory Update – Open

Issue Name and Description	Date Reported	Business Unit	Status
CMS Interoperability and Patient Access Final Rule L.A.Care is investigating delegates' full compliance with implementing CMS Patient Access & Interoperability Final Rule published on May 1, 2020 which is putting patient first giving them access to their health information when they need it most and in a way, they can use it. (1576)	5/31/2024	UM; Delegation Oversight	**CMS Interoperability and Patient Access Final Rule** L.A.Care is investigating delegates' full compliance with implementing CMS Patient Access & Interoperability Final Rule published on May 1, 2020 which is putting patient first giving them access to their health information when they need it most and in a way, they can use it. (1576)

Issue Inventory Update – Remediated Issues

Issue Name and Description	Date Reported	Accountable Exec./Business Unit	Remediation Description	Date Remediated
Overpayment by enrollee for deductible and out-of-pocket maximum (OOPM). Enrollee was charged over the enrollee's deductible and out-of-pocket maximum (OOPM) (1187)	12/5/2019	Soledad Castillo	The members out-of-pocket-maximum (OOPM) reimbursements were completed for calendar years member 2018, 2019, 2020 & 2021.	5/28/2024

Overpayment Deductible and Out-of-Pocket Maximum

Soledad Castillo

Overpayment Deductible and Out-of-Pocket Maximum
Corrective Action Plan (CAP) – Overview

- **What was/were the root cause/s for the overpayment and out-of-pocket maximum issues?**
  - Lack of Monitoring: We did not have a clear line of sight into members who were meeting and exceeding their Maximum Out-of-Pocket.
  - Lack of Communication to our PPGs: We did not clearly and consistently communicate with our PPGs the members who had met their Maximum Out-of-Pocket.

- **What actions/steps were implemented to ensure no future issues?**
  - Creation and generation of a daily report that identifies members who have met and/or exceeded their Maximum Out-of-Pocket (MOOP).
  - Based on the daily reporting of members who have met and/or exceeded their Maximum Out-of-Pocket (MOOP), the team has created a new communication process which informs the PPG of all members who have met or exceeded their MOOP in addition to the corresponding transactions. This allows the PPGs to have insight into any members who have met the MOOP as well as any encounters that need to be adjusted.

- **What oversight/monitoring process were implemented?**
  - Daily monitoring of report
  - Monthly lookbacks for the next 90 days to determine effectiveness of corrective actions

Overpayment Deductible and Out-of-Pocket Maximum
Corrective Action Plan (CAP) – Remediation

- **Cross functional team has been working to reimburse members who have exceeded their annual OOPM**

- **Completed all reimbursements activities for all identified members for the following Service Years:**
  - 2019
  - 2020

- **The team has also created all reimbursement claims for:**
  - 2018
  - 2021
  - All reimbursement claims were created by April 30, 2024
  - MPSS has been processing these payments on a weekly basis
  - The bulk of what is remaining are due to HIGH DOLLAR amounts
  - Review with respective PPGs to ensure accuracy of HIGH DOLLAR reimbursement amounts
  - MPSS continues to monitor for returned mail or checks that have not been cashed for over 90 days
  - Return mail details are sent to CSC for telephone outreach to validate address
  - Targeting to complete all payments by July 26, 2024

- **Requested OOP reports for 2022 and 2023**
  - Want to ensure that the PPGs did not continue to collect OOP despite being notified
  - IT expects to have both reports to team by week of July 29th

Issue Inventory Update – Remediated Issues

Issue Name and Description	Date Reported	Accountable Exec./Business Unit	Remediation Description	Date Remediated
Non-Compliance Timely Termination of Enhance Care Management Providers The Credentialing Committee issued an Administrative Termination decisions for three Enhance Care Management (ECM) providers with effective dates September 22nd 2022 and October 27th 2022. During a quality check process of the Provider Data Management (PDM) Department, we identified these providers remain active and potentially servicing members.(1545)	1/25/2024	Provider Data Management/ Christine Salary	The Providers (Watts, All for Health and Queenscare) were terminated due to outstanding credential documents. The credential documents were received, the system was configured with the updated information and the providers are now active.	6/12/2024

Corrective Action Plan (CAP) for Enhanced Care Management (ECM)

Miguel Barcenas

Enhanced Care Management (ECM) CRM Corrective Action Plan (CAP) Timeline – Summary

Status	Jan-24	Feb-24	Mar-24	Apr-24	May-24
Open	3	2	2	1	0
Remediated	1	0	1	1	0

- **Open** – number of reported issues to ECM CRM.
- **Remediated** – number of issues that were corrected and closed.

***ECM CRM team self imposed CAP for the 3 providers whose NPIs termed by credentialing.*

Enhanced Care Management (ECM) Contract Relationship Management (CRM) CAP – Overview

Findings/Observations	Date Received	Corrective Action	Status
1. ECM Contracted Provider NPI # 1639241888 terminated on 10/27/22 by credentialing. The ECM provider group account remained active and did not follow the required re-credentialing process. Non credentialed provider remained actively contracted.	12/29/2023	Queens Care was re-credentialed and this issue was remediated 12/22/22.	Closed

Enhanced Care Management (ECM) Contract Relationship Management (CRM) CAP – Overview

Findings/Observations	Date Received	Corrective Action	Status
1. ECM Contracted Provider NPI # 1306128822 terminated on 10/27/2022. All for Health, Health for All was terminated on 10/27/22 and is not in good standing due non-compliance of the re-credentialing of the NPI 1306128822. The facility is not eligible to add any new services or have new member referrals until they become credentialed.	12/29/2023	Account Manager communicated concerns with All for Health. Provider group was explained that they would not be able to add ECM membership to NPI# 1306128822 due to non-compliance issue. Provider group confirmed their interest in completing the re-credentialing process. On 1/26/24, CRM/PNM received the updated HDO application from provider for review to ensure all documentation is complete for re-credentialing process. CRM/PNM completed the Provider Information Form (PIF).	Closed

Enhanced Care Management (ECM) Contract Relationship Management (CRM) CAP – Overview

Findings/Observations	Date Received	Corrective Action	Status
1. ECM Contracted Provider NPI 1477649119 terminated on 9/22/2022. The ECM provider account remained active and did not follow the required re-credentialing process. Non credentialed provider remained actively contracted.	12/29/2023	In January 2023, Account Manager communicated concerns with Watts regarding the importance of maintaining compliance with re-credentialing process and any other contractual requirements. Provider was re-credentialed for Community Supports services effective 1/3/2024. CRM/PNM Account Manage added ECM to the PIF so that is shows active for ECM and CS. Account Manager communicated the need to stay compliant with all contractual requirements	Closed

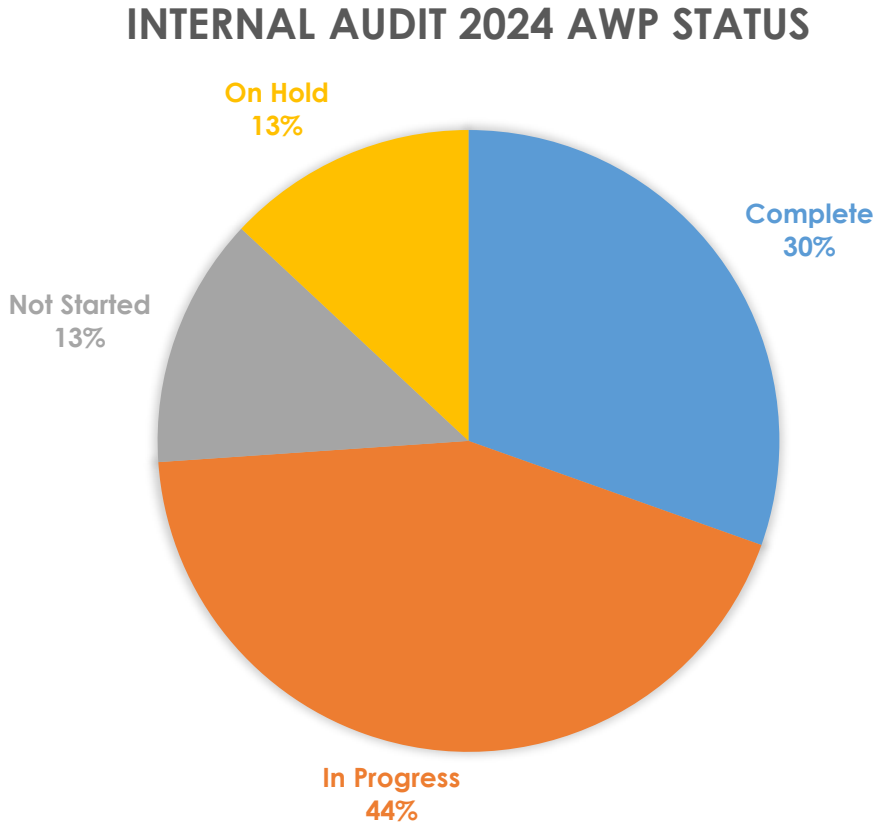
Enhanced Care Management (ECM) Contract Relationship Management (CRM) CAP – Monitoring Process

Monitoring Process	Business Unit	Workflow Summary	Implemented
Account Coordinator process will be documented available for review in a Barstow folder. This process will allow ECM/CRM Account Coordinator to review, access, and monitor credentialing updates found on the credentialing files will be completed on a monthly basis.	ECM CRM Cal AIM Team	Account Coordinator is to review the Credentialing SharePoint folder to identify providers that need re-credentialing. The Account Coordinator will notify the assigned Account Manager of the re-credentialing dates so that they can communicate with the provider and support the re-credentialing process.	3/28/2024

Internal Audit and Delegation Oversight Auditing

Magdalena Marchese

Audit Services – 2024 Internal Audit Work Plan (AWP)



STATUS	#
Complete	7
In Progress	10
Not Started	3
On Hold	3
Grand Total	**23**

Audit Services – 2024 Internal Audit Plan (IA)

Audit Activity	Type	Status	Notes
Marketing and Member Services	Audit	Complete	Moved from 2023 to 2024 AWP
Plan Partner Contracts Audit	Audit	Complete	Moved from 2023 to 2024 AWP
Provider Network: Access to Care	Audit	On Hold	Moved from 2023 to 2024 AWP
Call Center	Audit	In Progress	New
Provider Operations	Audit	On Hold	New
Provider Dispute Resolution Swapped with Plan Partners Audit	Audit	Complete	Moved from 2023 to 2024 AWP
Encounters/ Prop 56	Audit	Not Started	Moved from 2023 to 2024 AWP
Provider Quality: Potential Quality Issue (PQI)	Follow-Up Assessment	Complete	Follow-up of 2023 audit
IT System Security: SIEM and Vulnerability Management Audit (swap for IT Appropriate Access Controls/IT System Security - split into 3 Audits)	Implementation	In Progress	Moved from 2023 to 2024 AWP

Audit Services – 2024 Internal Audit Plan (IA) (cont.)

Audit Activity	Type	Status	Notes
DSNP Implementation and Oversight	Progress Report	Complete	Moved from 2023 to 2024 AWP
HRA Reassessment Efforts	Risk Mitigation Plan Implementation Effectiveness Review	In Progress	Moved from 2023 to 2024 AWP
Claims: Out-of-Area Emergency Services Claims	Follow-Up Assessment	Complete	Follow-up of 2023 audit
Appeals & Grievances: Process, Oversight and Support Systems	Risk Mitigation Plan Implementation Effectiveness Review	In Progress	Moved from 2023 to 2024 AWP
Appeals & Grievances: Knox-Keene Violations	Risk Mitigation Plan Implementation Effectiveness Review	In Progress	Moved from 2023 to 2024 AWP
Compliance Monitoring / Enforcement / Audits	Follow-Up Assessment	In Progress	Follow-up of 2023 audit
Vendor Management / Contracting Process	Risk Mitigation Plan Implementation Effectiveness Review	On Hold	New

Audit Services – 2024 Internal Audit Plan (IA) (cont.)

Audit Activity	Type	Status	Notes
Disaster Recovery / Business Continuity	Implementation	Not Started	Moved from 2023 to 2024 AWP
Staffing: Staffing / Skilled Hires / Time to Hire (Benchmarking is a separate Audit)	Follow-Up Assessment	Not Started	Follow-up of 2023 audit
LA Care Business Strategy - Strategic Alignment - AKA Regulatory Change Management	Risk Mitigation Plan Implementation Effectiveness Review	In Progress	New
Data Management and Governance Phase I - Initial Audit carry over from 2023	Follow-Up Assessment	In Progress	New
Data Management and Governance Phase II - Initial Audit carry over from 2023	Follow-Up Assessment	In Progress	New
FDR First Tier, Downstream, and Related (FDR) Entities - Initial Audit carry over from 2023	Follow-Up Assessment	Complete	Moved from 2023 to 2024 AWP
IA developing a SharePoint designed to incorporate a formal workflow process to track all internal audit-related CAPs.	Project	In Progress	New

Progress Report Summary: D-SNP Implementation

Scope & Focus: IA performed a follow-up progress report on the implementation of the D-SNP program in collaboration with Change Healthcare (CHC). IA evaluated the risks identified in the CHC program summary dated January 31, 2023 and included the following procedures:

- Extracted risks and CHC recommended mitigations for completion
- Each risk was reviewed with a point of contact (POC) for the area of concern to determine if completed/mitigated, in process or still open
- Advisory/Consultative progress report prepared based on information received from operations
- Reviewed required D-SNP reporting and identified POC's and last submission dates for each report

Follow-up Assessment Objectives: This review was limited to nine (9) risks identified by CHC in the program summary presented to L.A. Care (LAC) and the status of those risks from the testament of the business owners for completeness/mitigation. Also reviewed required regulatory reporting for last submission dates and POC's.

Conclusion: Risks Identified by CHC and testament of business owners - Of the nine (9) risks identified, five (5) are green (based on attestation from business area completed/no longer a risk), two (2) are yellow (based on attestation from business area in process or other reviews pending), two (2) are red (business is aware there are issues in these areas). Required D-SNP reports (not tested for completeness & accuracy, only validated last submission dates and main contact person that submits the report. Of the nineteen (19) reports, sixteen (16) are green meaning they were submitted timely, three (3) reports were yellow as they were not required in 2023 and LAC was in the process of submitting for the first time in 2024 at the time of this review.

Recommendations:

- Develop an organizational process for monitoring and closing identified issues.
- Develop a matrix of required Regulatory Affairs & Reporting reports, POC's for submissions, Agency name and deadlines.
- Ensure policies & procedures are relevant, reviewed and updated.
- Organization implementations should utilize a RACI (Responsible, Accountable, Consulted, and Informed) matrix and a full project/program closure process and procedure to ensure successful implementations.

Progress Report Summary: Dual Special Needs Plan (D-SNP) Implementation

Summary of Progress Report and Current State

Risk Item #	Risk (R)	Mitigation (M) & CHC Recommendations	Status	Disposition
1. MOOP (Member Out of Pocket Tracking)	1R1. Incomplete claims data to track the MOOP including: copays, deductibles, and cost share from the PPGs (Preferred Provider Group) 1R2. Review and implement the rules for handoffs for deductible or MOOP accumulators.	1M1. Create a database with all claim data, PPG and LAC (L.A. Care) paid claims that includes the deductibles and all cost-sharing amounts. 1M2. Test and verify the process for the MOOP and the inpatient deductible are accurately accumulating in the LAC system, and the data is successfully communicated to PPGs.	Yellow	Disposition: LAC opened this finding on 12/15/19. As per the notes in the issues log (4/11/24) Claims is on track to create a database with all claim data and test the data, to close this issue.
2. Reporting	2R1. There is an audit risk if the right processes and reporting are not in place. This impacts the universes and can result in audit findings.	2M1. Implement, test and validate the data for the reporting requirements to ensure that LAC is capable of generating required reports. Create D-SNP specific dashboard(s) for each area to monitor the requirements.	Red	Disposition: Compliance is aware of the lack of Dashboards/Reporting for D-SNP and are working through the creation and implementation process.
3. Reporting	3R1. Care Coordination lacks the reports needed to monitor the process. Specific issue- Care Coordinators need the enrollment queue and completed membership status to monitor incoming member needs.	3M1. Provide the reporting specs and flow to IT for report design and implementation working with Care Coordination to ensure reports are developed based on specifications.	Green	Disposition: Complete
4. HRA (Health Risk Assessments)	4R1. The methodology for calculating the HRA completion rate is inaccurate as it does not account for the total membership. It is critical that HRA pass audit validation and that Medicare Rating (STARs) measure is achieved.	4M1. CHC provided reporting requirements and functional specs for IT.	Green	Disposition: Complete

Progress Report Summary: D-SNP Implementation (continued)

Summary of Progress Report and Current State

Risk Item#	Risk (R)	Mitigation (M) & CHC Recommendations	Status	Disposition
5. Claims	5R1. Policies & Procedures (P&P's) and the system configuration needed are not compliant for D-SNP. 5R2. For Appeals and Disputes, ensure that the processes and rules meet regulatory requirements: and the member is not put at risk due to non-compliant processes.	5M1. Policy & Procedure development, system reconfiguration and re-training are needed ASAP.	Yellow	Disposition: Claims department in collaboration with Mazar's Audit should address any risks identified by CHC. If not risk items will be included in the Internal Audit planned for Q4 2024 PDR audit.
6. Care Management	6R1. Handling of low risk and unable to reach members with risk levels not visible to the PPGs.	6M1. Enable the PPGs to see the risk level of all members the plan is sending to them. It allows them to better manage high risk-based patient and then in turn refer to LAC.	Green	Disposition: Complete
7. Care Management	7R1. Lack of care coordination and information exchange amongst LAC, delegated entities and facilities for transition of care case handling.	7M1. Create a process for tracking and reporting on members who are admitted or discharges/transferred from the acute facilities. The delay in reporting back to LAC has a direct impact on the transition of care process.	Green	Disposition: Complete
8. Returned Mail	8R1. Returned mail processes need further development within CSC (Customer Service Center) laterals and other areas of LAC coming forth; Policy created by CHC had not been implemented. 8R2. A corporate mail room Policy & Procedures (P&Ps) is also needed.	8M1. Establish a firm process that encompasses hand-offs from all areas and communication to Enrollment of returned mail and member forwarding addresses to assist with capturing out-of-area members.	Red	Disposition: LAC needs to review process compared to policy for discrepancies.
9. Training	9R1. More detailed training on D-SNP benefit detail is needed across all departments.	9M1. Prepare additional D-SNP specific benefit training materials for in depth training for new and existing staff.	Green	Disposition: Complete

Follow-up Assessment Summary: Risk Mitigation Plan Effectiveness Review

Untimely Processing of Potential Quality Issues (PQI)

Scope & Focus:
IA performed a follow-up assessment of the Risk Mitigation Plan Effectiveness Review for the untimely processing of PQI. The scope of this follow-up assessment includes the Observations, Recommendations, and Management Responses from the Risk Mitigation Plan Effectiveness Review for the Untimely Processing of PQI.

Follow-up Assessment Objectives:
Determine if risk owners risk owners have implemented effective mitigation activities to address the observations found in the Risk Mitigation Plan Effectiveness Review for the Untimely Processing of PQI.

Conclusion:
Results of the Follow-Up Assessment
All samples passed the transaction review for determining Case Summary accuracy. No errors were found.

Areas Where Remediation Actions were not Fully Implemented / Ineffective:
There are two areas in which Internal Audit's recommendations for A&G were not implemented:

- A&G's inability to staff at the appropriate level to accommodate grievance intake volumes.
- A&G's inability to produce an analysis showing the root cause for grievance increases due to software system limitations. While the rationale for omitting implementation in these two instances was agreed upon by Internal Audit, we recognize that the data restrictions experienced by A&G due to system limitations is a barrier to A&G's ability to function optimally.

Follow-up Assessment Summary: Risk Mitigation Plan Effectiveness Review – Untimely Processing of PQI

Summary of Initial Observations and Recommendations

Initial Obs. #	Recommendations	Team	Status	Risk Level
1: PQI Case Influx	Continue to review PQI monitoring reports.	PQR/A&G	Implemented	Low
2: PQR Staffing	Fill open PQR positions.	PQR	Implemented	Low
3: A&G Staffing	Fill open A&G positions.	A&G	Not Implemented	High
4: Manual Processing of PQI	Move forward with obtaining software vendor to automate PQI case intake and processing.	PQR	In Progress	Moderate
	Data Entry controls for PQI Tracker: backup and recovery.	PQR	Implemented	Low
	Data Entry controls for PQI Tracker: version history.	PQR	Implemented	Low
	Data Entry controls for PQI Tracker: process document with sampling methodology.	PQR	Implemented	Low
5: Grievance and PQI Volume Increases	Conduct an independent review to determine the reasons for the increase in grievances.	A&G	N/A	Moderate
	Continue efforts to reduce Triage 0 cases by implementing: a PQI triage process and a process for the development of A&G's Grievance Forum.	A&G	Implemented	Low
6: Unsubstantiated PQI Referrals	Complete A&G staff training regarding appropriate PQI referrals.	PQR	Implemented	Low
	Develop new PQI referral triage process.	A&G	Implemented	Low
7: Errors in Case Summary Documentation	Monitor this issue to ensure Case Summaries all have a closure date documented, and the "Date Case Closed" matches the MD signature date.	PQR	Implemented	Low

Plan Partners Contract Compliance Audit Summary

Scope & Focus:

IA Reviewed the Plan Partner Contract Compliance. The focus of the audit included:

- Delegation Oversight (DO) and Compliance departments' audit findings from the Plan Partner's most recent audit.
- Compliance's Regulatory Analysis and Communications (RAC) department's requests from Plan Partners related to applicable new regulations, new All Plan Letters (APL) and revised APLs.
- Issues experienced by regulatory reports submitted by the Plan Partners and with Plan Partners' implementation of NCQA Accreditation requirements.
- DO Communication notifications to Plan Partners where action items were requested.
- PPA's Monthly Plan Partner Compliance meetings.

Audit Objectives:

- Plan Partners are compliant with contractual and regulatory requirements when reviewed during L.A. Care's (LAC) audits of the Plan Partners.
- LAC has an effective process in place to escalate Plan Partner issues to Compliance arising from Credentialing audits.
- Plan Partners respond timely and completely to LAC's requests related to; APL and other regulatory requirements, required regulatory report submissions, NCQA accreditation requirements, and action items submitted through the Delegation Oversight Communications' departmental intake form.
- LAC has effective relationship management and action item follow-up related to monthly Plan Partner Compliance Meetings.

# attributes tested	# attributes failed	Error rate	Passing rate
551	72	13%	87%

Plan Partners Contract Compliance Audit Summary

Conclusion:

Regulatory Analysis and Communications (RAC) - There are significant gaps in the process for how Plan Partners are notified of new regulatory requirements. Multiple process gaps exist, including:

- There is no process for:
  - Distributing revised All Plan Letter (APL) communications to Plan Partners.
  - Distributing APLs that do not include a review tool from the DHCS.
  - Designating internal responsibility for following up with Plan Partners regarding Compliance requests.
  - Following up with the Plan Partners regarding untimely or incomplete action items.
- There is no business unit designated to review inbound action item submissions from the Plan Partners to confirm compliance with LAC's requests resulting from the new or revised regulations.

Regulatory Reporting - The Plan Partners submitted their reports untimely in these two instances during the audit period; however, the Regulatory Reporting team worked with the Plan Partners effectively to receive the completed reports.

Quality Improvement Accreditation - There is a gap in the effectiveness of LAC's ability to enforce required action from the Plan Partners regarding regulatory requirements. In this case, the Plan Partner, Blue Shield Promise (BSP), refuses to comply with NCQA's mandated Health Equity Accreditation requirement. As such, LAC could be at risk for regulatory noncompliance as the delegation of this function is required.

Plan Partner Administration (PPA) - We determined the relationship management, meeting structure and action item follow-up related to monthly Plan Partner Compliance Meetings hosted by PPA for Plan Partner compliance communication is occurring as intended.

Plan Partners Contract Compliance Audit Summary

Conclusion (continued):

DO Communications – The Plan Partners respond completely to LAC's action item requests sent through the DO Communications process. Untimely submissions from the Plan Partners are infrequent. A process gap exists with compliance related requests, as currently no business unit is responsible for reviewing the completeness of responses from the Plan Partners. According to the RAC department, in the future, DO is requesting staff to be responsible for Delegate Implementation Oversight. As such, we passed samples for the completeness-related attribute if the Plan Partner completed the requested action item; however, the quality of the documents submitted were not reviewed by the auditor.

Delegation Oversight (DO) – The Plan Partners are compliant with DO's audit requests as their responses to LAC were timely and complete.

Credentialing – The Plan Partner reviewed (BSP) is compliant with Credentialing audit requests as their CAP mitigation responses to L.A. Care were timely and complete.

Area	Low	Moderate	High
Plan Partner Contract Compliance	0	2	4

Based on the number of the Moderate findings noted, the overall audit rating is determined to be "***Significant Improvement Needed***." Management has provided detailed responses to address the issues noted and is committed to implementing corrective actions for all findings by **December 31, 2024**.

Please do not hesitate to reach out to the Internal Audit Services team if you have any questions or would like additional information related to any areas of this audit or report.

Plan Partners Contract Compliance Audit Scope Summary

Key Stakeholders	Scope	Scope Rationale
Delegation Oversight Audits	A universe of 17 findings from the most recent Delegation Oversight Audits for the Plan Partners including the BSP audit conducted on September 12, 2023 and the Anthem audit conducted on June 20, 2023. The business units included in this audit universe were: Quality Improvement (QI), Member Rights (MR) and Utilization Management (UM).	The most recent audit results were reviewed to ensure audit results are current and relevant.
Credentialing Audits	A universe of 17 findings from the most recent Delegation Oversight Audits for the Plan Partners including the BSP audit conducted on September 12, 2023 and the Anthem audit conducted on June 20, 2023. The business units included in this audit universe were: Quality Improvement (QI), Member Rights (MR) and Utilization Management (UM).	
Compliance (Regulatory Analysis and Communications) Requests	A universe of all new regulations and new or revised All Plan Letters (APLs) issued between September 1, 2023 and February 29, 2024 that required action (such as a policy and procedure or a signed attestation form) from the Plan Partners.	The timeframe for this audit was selected and agreed upon by key stakeholders in order to ensure a six month look back period was captured in the audit results.
Regulatory Reporting Requests	A universe of all regulatory reporting requests when issues were experienced from the Plan Partners between September 1, 2023 and February 29, 2024.	
NCQA Accreditation Requirements	A universe of all NCQA accreditation requests where issues were experienced from the Plan Partners between September 1, 2023 and February 29, 2024.	
Delegation Oversight Communications	A universe of communications sent by the Delegation Oversight Communications department (formerly called Enterprise Network Communications and Engagement) from various business units within L.A. Care issued between September 1, 2023 - February 29, 2024 that required action from the Plan Partners.	
Plan Partner Administration (PPA): Compliance Related Relationship Management	A universe consisting of all the monthly Plan Partner Compliance Meetings hosted by PPA between September 1, 2023 and February 29, 2024.	

Plan Partners Contract Compliance Audit Summary

Summary Findings and Recommendations

#	Finding	Recommendations	Risk Rating
Regulatory Analysis and Communications			
1	There is no evidence that a notification was distributed to the Plan Partners regarding new or revised APL requirements.	• Develop and implement a process for distributing revised All Plan Letter (APL) communications to Plan Partners. • Currently, new or revised APLs that do not include a review tool from the DHCS are not automatically distributed to the Plan Partners. This is a process gap that has been identified by Compliance. Internal audit recommends developing and implementing a process for distributing APLs to Plan Partners that do not include a review tool from the DHCS. • Develop and implement a process for following up with the Plan Partners regarding untimely or incomplete action items related to new regulations and new/revised APL requirements	High
2	There is no evidence that follow up with Plan Partners for the Compliance requests were completed.		
3	There is no evidence that the Plan Partners submitted timely documentation requested from L.A. Care related to new or revised APLs or regulations.		
4	There is no evidence that the Plan Partners submitted complete documentation to L.A. Care for requests related to new or revised APLs or regulations		
Quality Improvement Accreditation			
5	There is no evidence that the Plan Partner, BSP, provided a complete response to the request, including providing a letter of intent to L.A. Care agreeing to the mandatory Health Equity Accreditation requirements.	We recommend that QI Accreditation work with PPA and Legal to ensure contract language is sufficient to hold Plan Partners accountable to regulatory oversight agency requirements. Additionally, we recommend developing and implementing a process to escalate Plan Partner issues internally for resolution and responsiveness to regulatory requirements.	Moderate
Delegation Oversight Communications			
6	There is no evidence that the requested action was received timely from the Plan Partner.	Develop and implement a process for escalating untimely responses from the Plan Partners, including a workflow, and criteria for enforcement actions.	Moderate

Risk Mitigation Plan Effectiveness Review Summary: Out-of-Area Emergency Room Claims

Scope & Focus: IA Reviewed the Heritage Medical Group (HMG) out-of-area (OOA) emergency room (ER) claims processed by the Claims Production department for the period May 2023 through October 2023. The review period is limited to six months as the risk mitigation activities were not fully implemented by key stakeholders until May 2023. Scope of this review is limited to QNXT, the claims processing software system used by L.A. Care (LAC). The scope excluded HMG OOA ER claims for the Cal MediConnect line of business as it is no longer offered as of January 1, 2023.

# claims tested	# claims with errors	Error rate	Passing rate
35	27	77%	23%
# attributes tested	**# attributes failed**	**Error rate**	**Passing rate**
210	69	32%	68%

Audit Objectives: Determine if risk owners have implemented effective plans to address risks from the 2023 risk assessment. Risk mitigation activities reported for this risk area to ensure improperly denied OOA ER claims were identified and paid correctly, included:

- Adding an ER flag to data reports
- Monitoring the risk area using an exception report
- Monthly review and reporting

Conclusion: The mitigation plan for the improper denial of HMG OOA ER Claims process is not effective. While monitoring reports were developed to identify HMG OOA ER claims for the purpose of processing them correctly, the Claims Examiner assigned to adjudicate the claims in scope of this review did not follow the established process to ensure the claims were adjudicated correctly prior to being improperly denied in the claims system. The table below summarizes the number of issues found and related Risk Ratings.

Area	Low	Moderate	High	Very High
Improperly Denied OOA ER Claims	**0**	1	0	4

Based on the number of the findings noted, the overall audit rating is determined to be "***Significant Improvement Needed***." Management has provided detailed responses to address the issues noted and is committed to implementing corrective actions for all findings by September 30, 2024. *Additional information or questions please reach out to Internal Audit Services.

Risk Mitigation Plan Effectiveness Review Summary: Improper Denial of OOA ER Claims

Summary Findings and Recommendations

Finding	Recommendation	Risk Rating
Transaction Review: OOA ER claims were not adjudicated correctly	1. To ensure Claims Compliance can effectively monitor risk, management should implement a robust monitoring process for any low priority/deprioritized risk mitigation activities (1st line of defense activities performed by Claims Integrity and/or Claims Data and Support Services). This should include the criteria used by management to determine if a risk area is high enough priority to require monitoring by Claims Compliance and who should monitor low priority/deprioritized risks. 2. A comprehensive report should be developed and implemented, listing all improperly denied OOA ER claims (including both LACC and CMC) for the purpose of reprocessing them correctly. This report should include a retroactive view of the improperly denied claims and should be re-generated 180 days from the last covered date of service for OOA ER services denied incorrectly. 3. Develop and implement a process document for correctly reprocessing improperly denied OOA ER claims and provide training to all staff that are required to follow this process.	Very high
Transaction Review: Missing Exception Reports		Medium
Transaction Review: Missing Fallout Reports and QA Validation Reports		Very high
Ineffective controls and oversight of adjudicating OOA ER claims correctly		Very high
Process for adjudicating HMG OOA ER claims correctly is not being followed.		Very high

First Tier, Downstream, and Related (FDR) Entities Assessment Summary

Scope & Focus: FDR compliance activities performed by L.A. Care (LAC) business units which had vendors billing over $1M during 07/01/2022 through 05/31/2023. Out of scope: Business units (BU) with contracted vendors that did not bill more than $1M during that period. Monitoring and oversight of the following entities:

1. Delegation Oversight Monitoring.
2. Delegation Oversight Auditing.
3. Sales.
4. Marketing.
5. Information Technology.
6. Health Education, Cultural and Linguistics.

Audit Objective: Determine the extent to which LAC has adequate and documented policies, procedures, reporting, and processes to support FDR compliance and meet industry and regulatory standards.

Conclusion: FDR compliance at LAC is siloed and fragmented. Delegation Oversight (DO) Auditing does a thorough review for FDR compliance with delegates and managing risk associated with FDR monitoring and oversight. The annual audits performed by DO Auditing are thorough and contain questions relevant to FDR compliance. Currently, DO is monitoring 56 PPG delegates but no non-medical FDR vendors.

Other BU owners of vendor contracts within LAC are responsible for monitoring vendors to ensure the vendor is meeting the requirements of the contract. The BU will monitor: required FWA training, cultural competency training, adherence to a Code of Conduct, and screening for individuals/entities excluded from participation in federal programs, only if the contract states that it is required.

Based on the number of "High" observations noted, the overall audit rating is "***Significant Improvement Needed***." Compliance management has provided detailed responses to address the issues noted and is committed to developing and directing the FDR program, and implementing corrective actions for all observations by November 1, 2024.

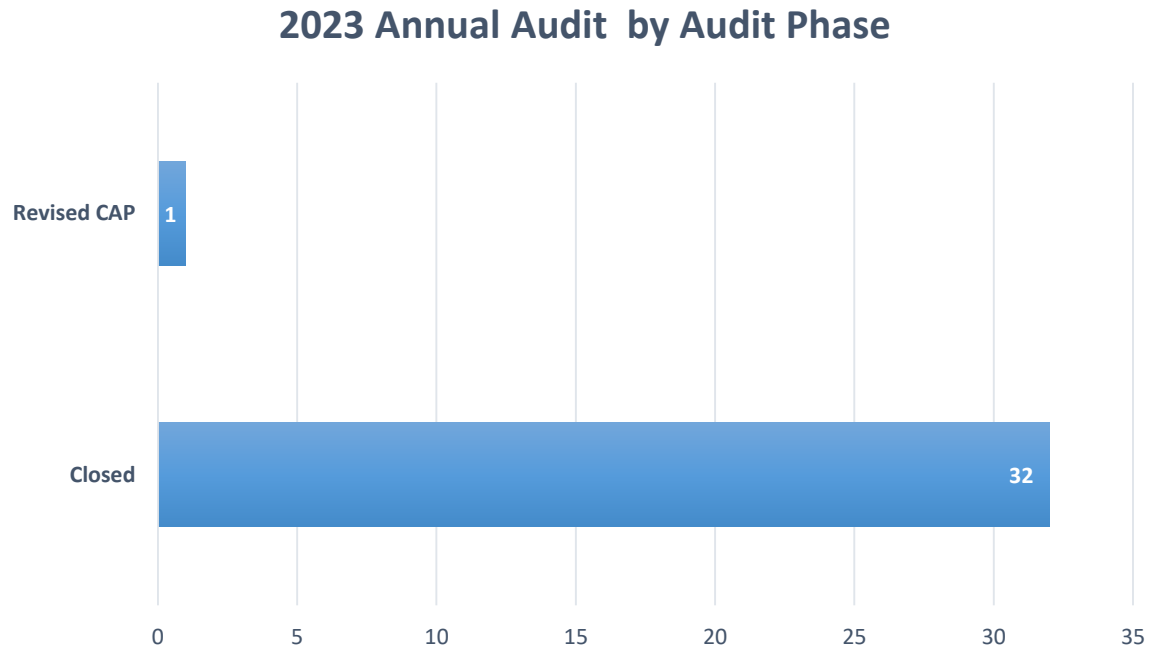
FDR Entities Assessment Report Summary

Summary Observations and Recommendations

Observation	Recommendation	Risk Rating
FDR compliance of vendors at L.A. Care is siloed and fragmented.	Compliance should direct and be responsible for organization-wide FDR compliance of FDR vendors by possibly implementing key activities/elements.	High
There is no process for identifying FDRs.	A multi-disciplinary team (Delegation Oversight Committee), which includes business owners from procurement, contracting, IT, finance, compliance, and legal to review the statement of work of a particular vendor in question and assess to evaluate and determine if a vendor is an FDR.	High
There is no process and policy for evaluating and onboarding FDRs.	• The Delegation Oversight Committee may ensure an initial evaluation as necessary to determine the ability of the potential FDR to assume responsibility for delegated activities and to maintain L.A. Care standards and regulatory requirements • Develop a due diligence questionnaire for potential FDR entities to submit to the Delegation Oversight Committee. • Results and recommendations of the initial evaluation should be documented in a report and presented to the Chief Compliance Officer (CCO). • Establish a central FDR depository for FDR Assessment documentation.	High
There is no evidence that a complete list of FDR entities is maintained.	Compliance department should maintain, review, and update the complete FDR entity inventory. Compliance department will be ready to provide the FDR inventory to regulators when required.	High

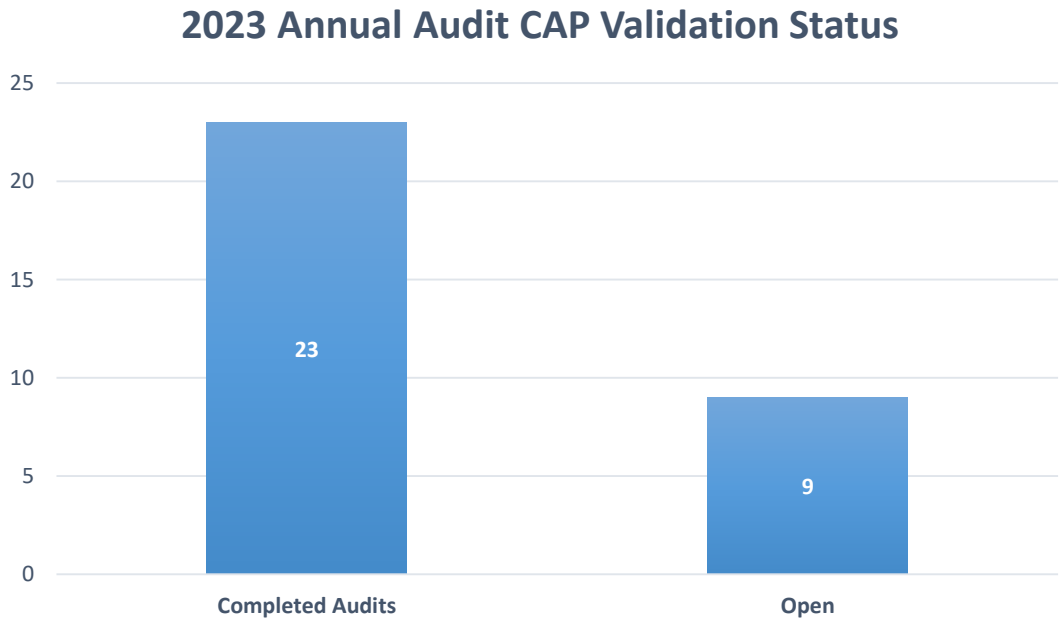
2023 Delegation Oversight Audits

Presenter: Magdalena Marchese

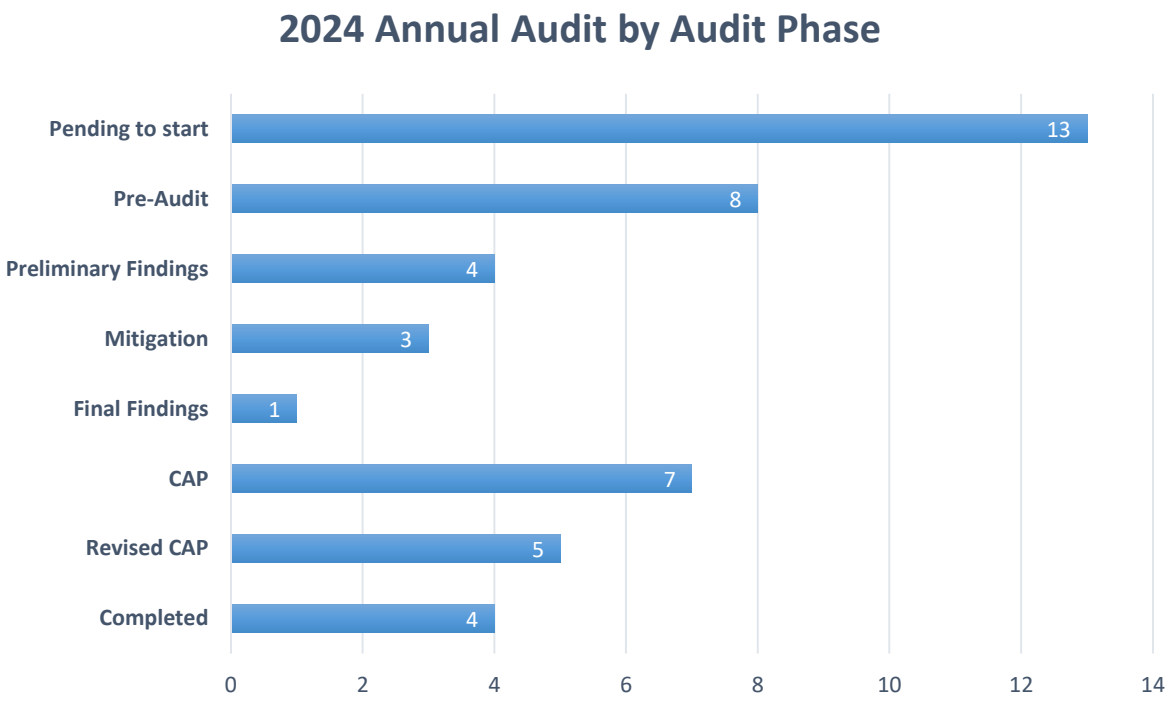


2023 Delegating Oversight: CAP Validations

CAP Validation occurs 60 days after CAPs are accepted.

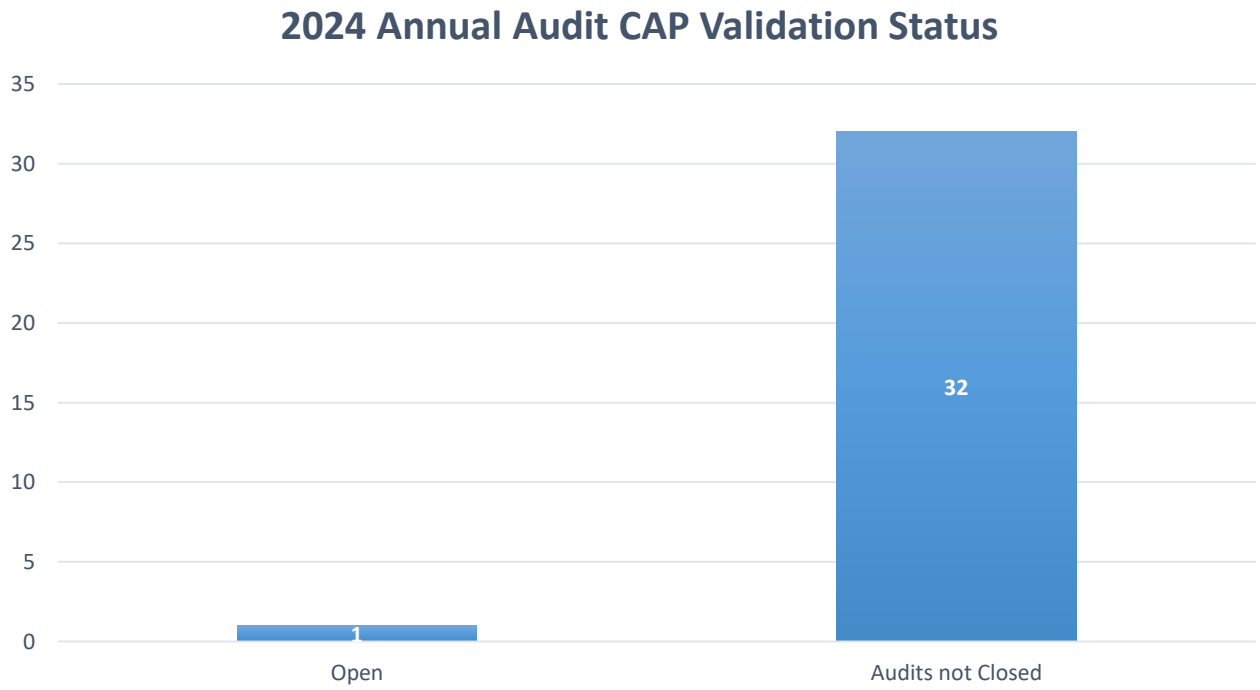


2024 Delegation Oversight Audits



2024 Delegating Oversight: CAP Validation

CAP Validation occurs 60 days after CAPs are accepted.



2024 Delegation Oversight Successes

- Areas of Success:
  - Management working with Delegation Oversight Monitoring team to monitor and discuss repeated findings.
  - Non-Clinical team working with Health Equity team on how to audit for Diversity Equity Inclusion (DEI) for the 2025 Annual Audits.
  - UM hired a full-time Registered Nurse, Clinical Auditor.
  - UM team is collaborating with the Care Management team to ensure our Dual Eligible Special Needs Plan (D-SNP) Audit tools are up-to-date.
  - Ensuring that all Utilization Management audit tools align with each line of business requirements.

2024 Delegating Oversight Audits: Outlook

- 45 Audits scheduled from January- December
  - 3 Dual Eligible Special Needs Plan (D-SNP) Risk Based Audits: 3 PPGs with highest D-SNP membership
  - 1 Compliance Program Effectiveness (CPE) Focus Audit
  - 2 Plan Partners
  - 31 Primary Physician Groups (PPGs)
  - 8 Specialty Health Providers/Vendors
  - 2 Pre-Delegation Assessments

- 2024 Risk Based Delegation Oversight Audit Scope:
  - Past audit findings
  - DSNP requirements
  - NCQA requirements

Regulatory Audits

Miguel Varela Miranda and Lisa Pasillas-Le

2021 DMHC Routine Survey Overview

- **Lines of Business:** MCLA, LACC, LACC-D, PASC-SEIU
- **Review Period:** September 1, 2019 – August 31, 2021
- **Virtual Onsite:** January 31, 2022 – February 4, 2022
- **Audit Areas:**
  - Appeals & Grievances
  - Quality Management
  - Utilization Management
  - Access & Availability
  - Pharmacy
  - Delegation Oversight
- **Participating Delegates:**
  - PPGs associated with the MSOs: MedPoint Medical Management, Electronic Health Plans (Thrifty), Network Medical Management, Physicians Data Trust
  - Optum (AppleCare Medical Management)
  - L.A. County Department of Health Services
  - Navitus
  - Beacon Health Options

Action Items & Next Steps

- **Action Items:** Regulatory Audits is collecting updated status and supporting documents to validate implementation of CAPs submitted to the Regulator.
- Regulatory Audits will continue to work with the BU's through completion of CAP.

Total of 242 CAPs:

- 225 have been completed
- **17 CAPs remain outstanding**. Team is actively working with the business units to remediate and complete the implementation.

2022 - 2023 DHCS Medical Audit: Overview

- **LOB and Audit Review Period:**
  - Medi-Cal including SPD
  - July 1, 2021 through January 31, 2023
- **Onsite Visit:**
  - February 27, 2023 – March 10, 2023
- **Participating Delegates:**
  - Beacon
  - L.A. County DHS (*Delegated UM Activities*)
  - Call the Car
- **Exit Conference:** Wednesday October 18, 2023
- **Summary of Final Findings:** 16 Medi-Cal

Summary of Findings			
Category		**2021-2022 Summary of Findings**	**2022-2023 Summary of Findings**
Category 1	**Utilization Management**	5 Final Findings	7 Draft Findings
Category 2	**Case Management and Coordination of Care**	3 Final Findings	3 Draft Findings
Category 3	**Access and Availability**	2 Final Findings	No Findings
Category 4	**Member's Rights**	4 Final Findings	5 Draft Findings
Category 5	**Quality Improvement**	No Findings	1 Draft Findings
Category 6	**Administrative and Organizational Capacity**	1 Final Findings	No Findings
Total		**15 Final Findings**	**16 Final Findings**

Action Items & Next Steps

- **Status:**
  - As of June 12, 2024, DHCS "Accepted" 12 of the 16 CAPs. The following 4 CAPs were in a "Partially Accepted' or a Additional Questions" status. Pending updated status from DHCS based on June 12, 2024 responses.
    - **1.5.1 Partially Accepted:** DHCS confirmed the Precision Scheduling Report has been fully implemented and L.A. Care is performing monthly monitoring/follow-up with DHS.
    - **4.1.1 Additional Questions:** DHCS focused on quality assurance audits of quality of care and quality of services including frequency and percentage of cases audited.
    - **4.1.3 Additional Questions:** DHCS focused on A&G presenting grievance audit results to the Compliance and Quality Committee
    - **4.1.4 Partially Accepted:** DHCS focused on steps the Plan is taken to ensure letters sent to members contain a clear and concise explanation including performing a quality review prior to mailing.
- **Next Steps:**
  - Regulatory Audits is in process of reviewing the CAPs and supporting documentation to validate implementation of CAPs submitted to the Regulator.

2022-2023 BH, NEMT & NMT Focused Audit Overview

- **LOB and Audit Review Period:**
  - Medi-Cal including SPD
  - July 1, 2021 through January 31, 2023
- **Onsite Visit:**
  - February 27, 2023 – March 10, 2023
- **Participating Delegates:**
  - Call the Car
- **Exit Conference:** Wednesday October 18, 2023

Summary of Findings			
Category		**Performance Area**	**2022-2023 Summary of Draft Findings**
Category 2	**Case Management and Coordination of Care**	Behavioral Health – SMHS, NSMHS, AND SUDS	1 Draft Finding
Category 3	**Access and Availability of Care**	Transportation – NEMT and NMT	2 Draft Findings
		Total	**3 Draft Findings**

Action Items

- **Status:**
  - On July 17, 2024, L.A. Care notified DHCS of our disagreement with the 3 draft audit findings. Pending DHCS response to L.A. Care's Draft Audit Report Response Form.

Finding 2.1 Referral Loop Closure:	Finding 3.1 Transportation Brokers:	Finding 3.2 Ambulatory Door-to-Door:
•The Plan did not ensure that the referral loop was closed, and that the new provider accepted the care of the member. •***Disagree with Finding:*** As a result of LAC's review, samples selected were not required to be reported to the County as these members had no indication of transition from SMHS to NSMHS, or vice versa.	•The Plan did not have the ability to supplement its transportation network if the transportation broker's network was not sufficient. •***Disagree with Finding:*** Call the Car (CTC) has a robust network of transportation brokers, procedures to supplement the network, and L.A. Care continues to actively enhance the existing transportation network to provide the appropriate level of service for our members.	•The Plan did not ensure its delegate, Call the Car, provided the appropriate level of service for members requiring ambulatory door-to-door service •***Disagree with Finding:*** L.A. Care does not agree that inappropriate level of service was provided to ambulatory members in accordance with DHCS requirements. DHCS does not require plans to add walkers or crutches as a level of service or mode of transport on the PCS forms.

Next Steps

Status

- After the final report is issued, MCQMD will send a "CAP Request Letter" to the Plan.
- The Plan will be required to provide a Corrective Action Plan (CAP) and respond to any deficiencies documented in the report within 30 calendar days of the date of the letter using the Attachment A CAP Response Form.
- DHCS expects all remediation efforts to be in place no later than month 6 of the CAP, unless prior approval for an extended implementation effort is granted by DHCS.

2024 DHCS Network Adequacy Annual Validation (NAV) Audit

- **Purpose:**
  - Starting in 2024, CMS requires DHCS to perform an annual network validation audit of all Medi-Cal managed plans.
  - Review data, systems and methods used to **calculate network adequacy indicator results.**
  - Provide a validation rating for each indicator that reflects HSAG's confidence that the methodology used ensures accuracy, completeness, and consistency.
- **Lines of Business:**
  - Medi-Cal
- **Audit Review Period:**
  - Network adequacy data reported to DHCS for contract year October 2023 data.
- **Virtual Visit:**
  - July 15th, 2024

Business Areas under review regarding network adequacy:	
1 - Provider Data Management	5 - Enrollment Services
2 - Quality Improvement	6 - Contract & Relationship Management
3 - Credentialing	7 - Enterprise Data Management
4 - I.T. Operations	8 - Provider Data Unit

Action Items & Next Steps

- During the July 15, 2024 virtual audit the **HSAG auditor indicated they did not identify any potential preliminary findings.**
- LA Care business unites have completed all of the follow items requested by HSAG and submitted on July 22, 2024.
- **Next Steps:**
  - HSAG will communicate preliminary network adequacy validation findings to health plans by 9/30/2024.
  - The final NAV audit aggregate report will be sent to DHCS by HSAG between 12/18/2024 and 01/08/2025.
  - Regulatory Audits is working on the lessons learned and recommendations for this new audit.

2024 DHCS Medical Audit Overview

- **Lines of Business:**
  - Medi-Cal including SPDs (Contract Numbers 04-36069 and 23-30232)
  - State Supported Services (Contract Numbers 22-20466 and 23-30264)
- **Audit Review Period:**
  - February 1, 2023 – January 31, 2024
- **Onsite Visit:**
  - June 10, 2024-June 21, 2024
- **Participating Delegates:**
  - Beacon
  - L.A. County DHS (*Delegated UM Activities*)
  - Call the Car

Audit Areas Under Review:	
1-Utilization Management	4-Member's Rights
2-Case Management & Coordination of Care	5-Quality Improvement
3-Access and Availability	6-Administrative & Organizational Capacity

Action Items & Next Steps

- Regulatory Audits is collecting a disagreement statement or Corrective Action Plan (CAP) including the corresponding supporting documents.
  - There are 21 potential preliminary findings and have been assigned to the respective business owners. Below is a breakdown:
    - 5 Findings - The business owners have and/or are in the process of providing a final disagreement statement w/supporting documents. **Received.**
    - 15 Findings - The business owners is in the process of providing a complete CAP w/supporting documents. **Received.**
    - 1 Finding - related to the Encounter Data-Prop 56 finding is pending business owner assignment.
- DHCS will issue a formalized draft report with the final preliminary findings within 60-90 days from the Friday 6/21/2024 concluding onsite meeting.
- DHCS will schedule an "Exit Conference" and LAC will have 15 calendar days from the date of the exit conference to provide any written feedback on each finings with "Agree with Finding, or Disagreement with Finding. Any disagreements with a finding must include fact and supporting documentation.

Questions??

Transitional Care Services (TCS): Overview and Updates

L.A. Care HEALTH PLAN
For All of L.A.

ELEVATING HEALTHCARE IN LOS ANGELES COUNTY
SINCE 1997

Joycelyn Smart-Sanchez
Director, Care Management
August 15th 2024

Transitional Care Services (TCS)

Program Goals

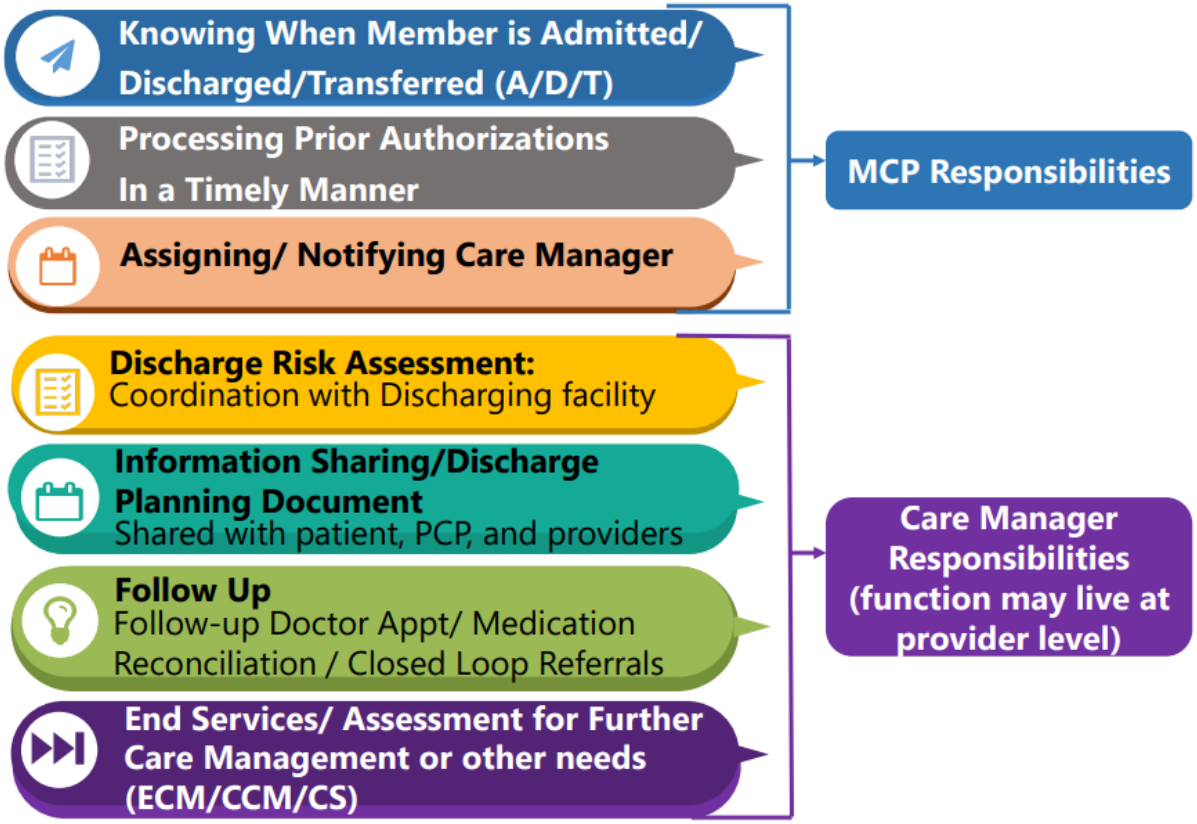
Care Transitions Definition:
When a member **transfers from one setting or level of care to another**, including but not limited to, discharges from hospitals, institutions, other acute care facilities, and skilled nursing facilities to home or community-based settings, Community Supports, post-acute care facilities, or long-term care settings.

Goals for Transitional Care

- ✓ Members can transition to the **least restrictive level of care that meets their needs and is aligned with their preferences** in a timely manner without interruptions in care.
- ✓ Members receive the **needed support and coordination to have a safe and secure transition** with the least burden on the Member as possible.
- ✓ Members continue to have the **needed support and connections to services that make them successful in their new environment**.

TCS Core Components: Required TCS Elements for All Managed Care Plan Members

Core Required TCS Elements



TCS High Risk Populations

TCS High Risk Populations, per DHCS, include:

- Members with LTSS needs;
- Those entering in or entering ECM or CCM;
- Children with Special Health Care Needs (CSHCN);
- All Pregnant individuals, including 12 months postpartum;
- Seniors and persons with disabilities who meet the definitions of “high risk”;
- Members with a mental health need or SUD;
- Any member transitioning to or from a SNF;
- Any member that is identified as high risk by the discharging facility
- Other members assessed as high-risk by RSST

Transitional Care Services (TCS) Overview

DHCS Population Health Management (PHM) Requirement

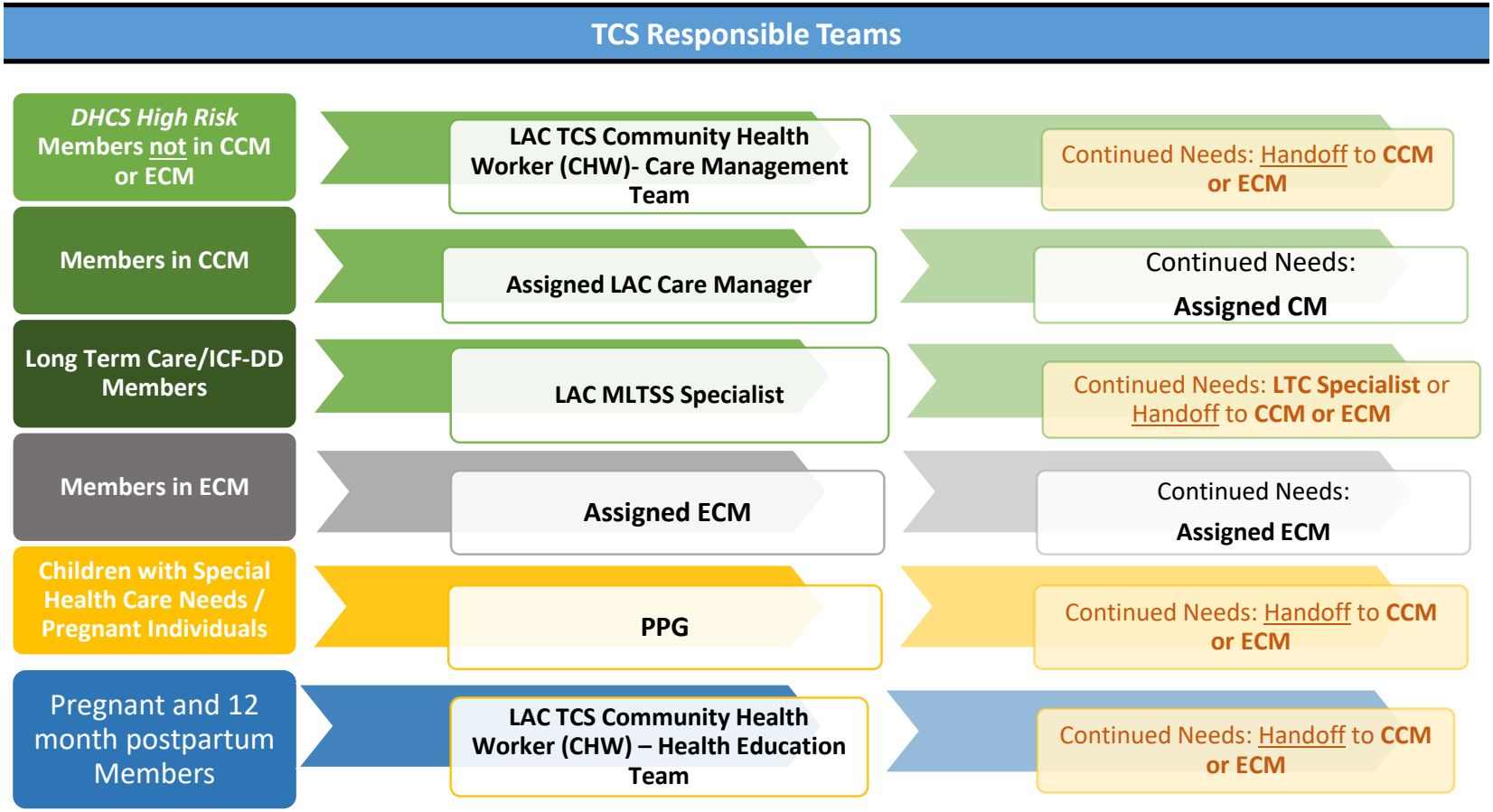
Formal Guidance on Phased Implementation of Transitional Care Services	
By 1/1/23	• MCPs must ensure **all transitional care services are complete (including having a care manager/single point of contact) for all high-risk members**[1] as defined in the PHM Policy Guide. • MCPs must implement **timely prior authorizations** and **know when members are admitted, discharged or transferred for all members.** • MCPs must develop and **execute a plan to ramp up** transitional care services. The plan must address how the MCPs will meet the timeline and requirements.
By 1/1/24	• MCPs are required to ensure **all transitional care services are complete for all members**. As noted in the PHM Policy Guide, MCPs are strongly encouraged to contract with hospitals, Accountable Care Organizations, PCP groups, or other entities to provide transitional care services, particularly for lower- and medium-rising- risk members.

L.A. Care's TCS Readmission Risk Tool (RRT)

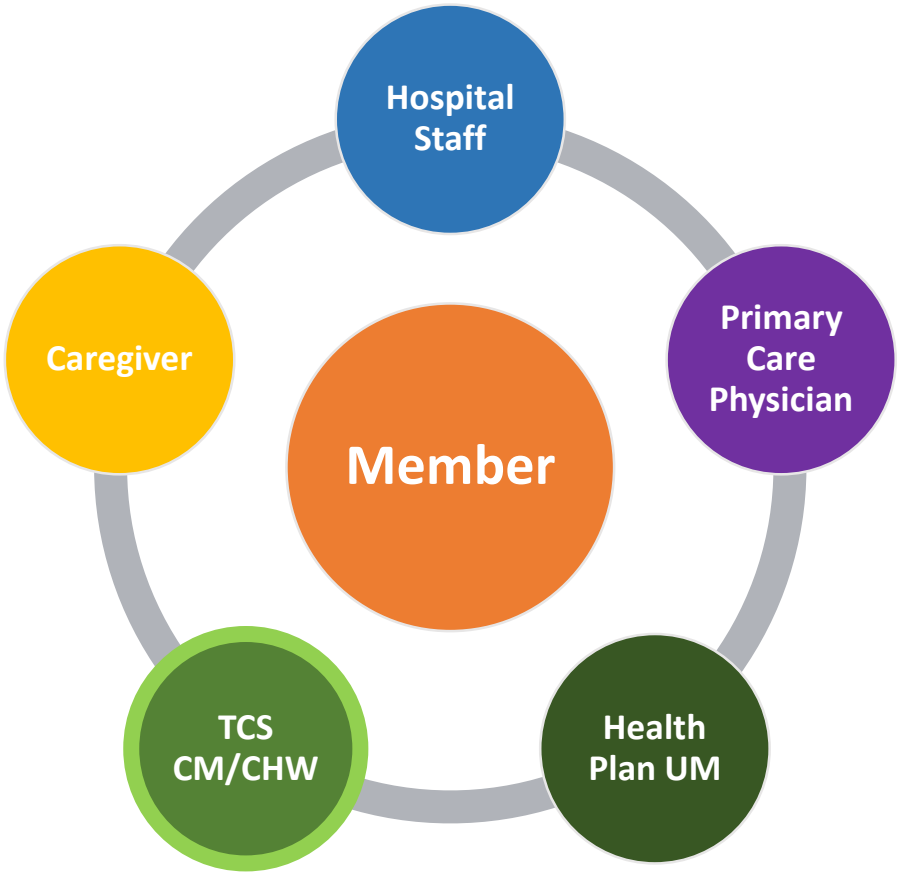
TCS Teams and Cohort Management

TCS Responsible Team	TCS Cohort
LAC Care Management Team	Members enrolled in CM: • CM CCS • CM Low Risk Case Management • CM Medium Risk Case Management • CM High Risk Case Management • CM CCM Program • CM Transplant
ECM Provider	• MCLA members enrolled in ECM
MLTSS Team	• MCLA members managed by MLTSS for LTC • ICF for Developmental Disabilities (ICF-DD)
LAC CM CHW Team	• High-Risk SPD MCLA members • MCLA members with an iPro Complex Risk Stratification • MCLA members receiving LTSS services, but not LTC • Non-DHCS High Risk • Home Health Services in last 30 days • Postpartum within the last 12 months • Long Term Care in last 30 days (excluding MLTSS LTC)
LAC Health Ed Team	• Pregnant MCLA members
PPG	• Children with Special Health Care Needs (CSHCN)

Transitional Care Services: Responsible Teams and Handoffs



TCS Care Coordination

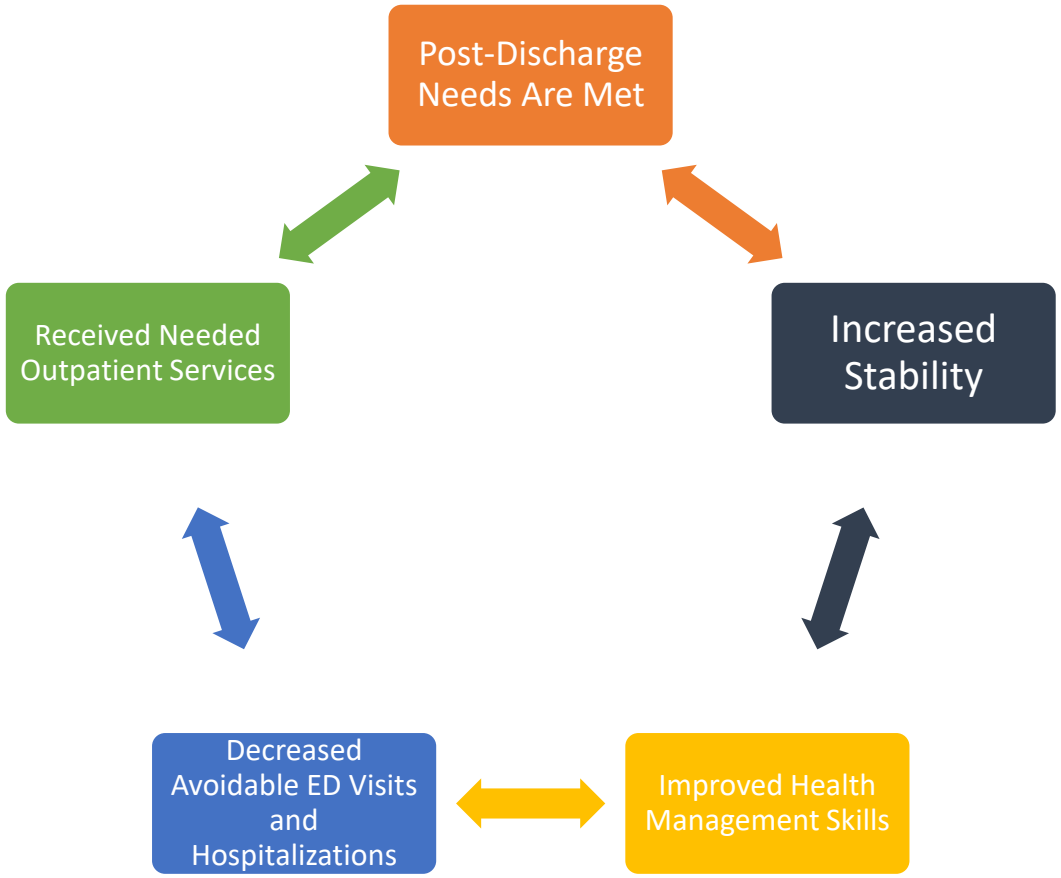


Admission and Pre-Discharge Requirements

TCS CHW ensures the following have been completed for each member:

- **Discharge Risk Assessment** to evaluate risk of:
  - Re-institutionalization
  - Re-hospitalization
  - Mental health and/or SUD relapse
- Engagement of member (or caregiver) to document **treatment/discharge preferences**
- **Medication reconciliation**
- Member receives the **discharge instructions**
- PCP and the TCS CM receives the **discharge summary**
- Arrangements for **appropriate post-discharge care**
- Evaluation of **all appropriate care settings** based on member's care needs

TCS Post Discharge Goal for Members



Post Discharge Member Follow Up

Post Discharge Follow-Up

- **Post-discharge TCS services include**, but are not limited to:
  - Scheduling follow-up provider appointments
  - Education and support
  - SUD and mental health treatment initiation
  - Medication reconciliation
  - Referrals to social service organizations
  - Referrals to necessary at-home services
  - Referrals to longer-term or intensive care coordination programs
  - Ensure all post-discharge needs are met

TCS Low Risk Model

- **TCS Low Risk Members are:**
  - Medi-Cal members not considered DHCS High Risk
  - Not auto-assigned to a TCS CHW

- **Dedicated TCS Central Intake Line**
  - Established to receive Member and Provider calls requesting TCS services

- **Post Discharge Support to Members**
  - Mirrors support provided for DHCS High-Risk members

- **Continued Care Management Needs:**
  - Handoff to Care Management or Enhanced Care Management (ECM)

CalAIM PHM Key Performance Indicators

MCPs expected to report out quarterly to DHCS on the following KPIs:

1. **Percentage of transitions for high-risk members with at least one interaction with assigned care manager within 7 days post discharge.**
   - **Target Rate:** TBD
   - **Range Across Plans as of 11/2023:** 0% to 74%
   - **L.A. Care Rate 1/1/23 to 1/1/24:** 5.4%

2. **Percentage of acute hospital stay discharges with follow-up ambulatory visit within 7 days post discharge.**
   - **Target Rate:** 25%
   - **Range Across Plans as of 11/2023:** 12% to 70%
   - **L.A. Care Rate 1/1/23 to 1/1/24:** 29.44%

Successes and Barriers

- **Key Successes:**
  - Members Served as of 7/31/24: 16,973
  - Monthly volume increase for Provider and Member calls seeking TCS support
  - Members transitioning to ECM, Care Management and/or Community Supports for continued support beyond TCS
  - L.A. Care Pharmacy and TCS CHW collaboration for medication reconciliations

- **Challenges and Barriers:**
  - ADT data not comprehensive
  - Receiving timely hospital discharge planning documents
  - Unengaged members post discharge

Transitional Care Services (TCS)

Quality Improvement Projects (QIPs/PIPS, PDSA) Update

Compliance & Quality (C&Q) Committee
Date: 8/15/2024
Presenter: Rachel Martinez, RN BSN
Supervisor for Clinical Initiatives, QI

ELEVATING HEALTHCARE IN LOS ANGELES COUNTY SINCE 1997

Report Content & Background

Review of current and upcoming Quality Improvement Projects.

There are four types of projects that can be required by regulators:

- **Quality Improvement Projects (QIPs):** These have unique product line specific requirements and last from 9 months to 3 years. All product lines may issue a QIP but typically Medi-Cal does not.

- **Performance Improvement Projects (PIPs):** PIPs are typically 18-month long projects with the first half identifying areas of need, performing causal analysis, and planning interventions followed by testing of interventions.

- **Plan-Do-Study Act (PDSA):** PDSA projects are in much shorter timeframes with interventions tested in 30-90 day cycles. Typically these have two intervention cycles and are required by regulators for low performance on a measure.

- **Strengths Weakness Opportunities and Threats (SWOT):** An analysis project of strengths, weakness, opportunities, and threats among existing resources for a particular area of focus.

* PDSAs or SWOTs are issued by Medi-Cal only when L.A. Care does not meet minimum performance level (MPL) for MCAS measures.

Overview of 2023-2024 DHCS Quality Improvement Projects

- SWOT issued 2022 for Well-Child Visits in the First Thirty Months of Life (W30) and Childhood Immunization Status Combination Ten (CIS-10): closed in 2023
- DHCS issued all health plans in California two PIPs to begin for September 2023-2026
- The first PIP is based on disparity, specifically Black/African American Children who will be turning 15 months each measurement year. The measure's focus is Well-Child Visits in First 30 Months of Life: 0-15 months (W30 6+).
- The second non-clinical PIP will be focused on behavioral health needs around Emergency Department Use for Substance Use and Mental Illness. L.A. Care is focusing on notification to providers
- Two new DHCS quality improvement projects (QIPs) were issued for low performance in the children's domain:
  - A3 Lean Process
  - Child Health Equity Sprint Collaborative

2022-2023 SWOT: W30 and CIS-10

Project	Product Line	Requirement	Interventions	Key Findings & Lessons Learned

SWOT: Children's Doman (Well-Child Visits in the First 30 Months of Life and Childhood Immunization Status: combination Ten)	Medi-Cal	Completed 2023	• The 4th and last SWOT submission was submitted 9/29/2023.
			• DHCS accepted final submission
			• A unique feature of SWOT was including Plan Partners (Anthem Blue Cross & Blue Shield Promise) and Transform L.A. in the process.
			• Recap of SWOT strategies:
			  • W30 Custom Report for Plan Partners
			  • Additional member touchpoints
			  • Leveraging additional nursing staff
			  • Focusing on flu immunization
				✓ Value from strengthening communication and collaborative efforts with Plan Partners and other L.A. Care teams
				✓ Low flu vaccine rates continue to impact CIS-10
				✓ New process implemented to increase member phone numbers
				✓ Clinics and providers continue to struggle with lack of financial and staffing resources

Active QIP: LACC Diabetes Disparity Reduction

Project	Product Line	Requirement Status	Interventions	Lessons Learned
Diabetes Disparity QIP: Improving A1c levels among Black/ African American (BAA) and American Indian/Alaskan Native (AIAN) populations.	LACC	Active	• QI department contracts with vendor GA Foods, to deliver Medically Tailored Meals (MTM) to target audience with A1c > 8 • Members who participate will receive 2 meals/day, 7 days/week x 8 weeks • Members can also work with L.A. Care's Health Education - Registered dietician • As of 6/14/2024, 47 members have been sent diabetes education materials • Diabetes Mailer magnet (white board refrigerator magnet to assist members in tracking their diabetes health information and next steps) • 22 (46.8%) members have enrolled and 17 referred to L.A. Care's Diabetes Education program.	✓ Collaborate with internal data teams to ensure we have valid member data for outreach and evaluation reporting ✓ Value of using more accurate race and ethnicity data to identify member population ✓ Ensure vendor compliance & member satisfaction with meal delivery terms ✓ Challenges of managing a small eligible member population ✓ Difficulty in evaluating whether a member has improved self-management ✓ Limited A1c lab data impacts evaluation

2023-2026 Medi-Cal PIPs

Project	Product Line	Requirement Status	Interventions	Lessons Learned/ Barriers
Well-Child Visits in First Thirty Months of Life: 0-15 months (W30 6+)	Medi-Cal	Active	PIP is based on disparity. Focus on Black/ African American members in SPA 6. Data analysis: majority of PIP population not reaching 6 visits is missing only 1 or 2 visits. Analysis will be rerun using the last retrospective MY2023 W30 Report. Interventions: • Community Health Workers (CHW) called 90 PIP members in February and March 2024. • Give Your Baby a Healthy Start Brochure and accompanying letter were mailed to 308 members late June 2024 • Planning Q4 intervention. Next submission due 9/11/2024	✓ How to generate custom PIP report to capture all PIP members ✓ Analysis reveals high number of missed early visits. ✓ Opportunities with CHW calls to provide additional support

2023-2026 Medi-Cal PIPs (cont.)

Project	Product Line	Requirement Status	Interventions	Lessons Learned/ Barriers
Improve the percentage of provider notifications for members with SUD/SMH diagnoses following or within 7 days of emergency department (ED) visit.	Medi-Cal	Active	Created customized dual report from Point Click Care (PCC) targeting the following HEDIS Measures: 1. Follow-up after ED Visit for Mental Illness (FUM) 2. Follow-up after ED Visit for Alcohol or Substance Abuse (FUA) Leveraging provider portal and SFTP to enable providers and IPAs to extract reports Initiating SMART alert system for LANES and PCC.	✓ Not all IPAs and providers using HIE platforms ✓ Some IPAs and clinics have access to LANES but have difficulties using ✓ No standard means for providers to receive notifications about SUD/SMH diagnoses-related ED visits.

New 2024 Medi-Cal QIP

Project	Product Line	Requirement Status	Interventions	Lessons Learned
DHCS Child Health Equity Sprint Collaborative – W30/Child and Adolescent Well-Care Visits)	Medi-Cal	Active	Collaborating with Northeast Valley Health Corporation. Sun Valley will be site for future interventions. • **Intervention 1:** Equity & Transparent, Stratified, and Actionable Data- complete • **Aim statement:** By March 2025, increase WCV rate for Hispanic/Latino Infants ages 0-30 months at Northeast Valley Health Corporation: Sun Valley Health Center by statistically significant margin (5.6%). • **Intervention 2:** Understand Provider and Patient/Caregiver Experiences • Currently planning site visit to experience member journey and interview providers and members.	✓ L.A. Care experiences data lags that are reflected in Provider Opportunity Reports ✓ More effective to utilize custom reports and compare with data collected

New 2024 Medi-Cal QI Project

Project	Product Line	Requirement Status	Interventions	Lessons Learned
DHCS A3 Lean Process (W30, WCV, and Lead Screening in Children)	Medi-Cal	Active	Provider Interventions: • CHWs will call parents to schedule W30 appointments • Purchase blood lead testing machines for areas with known disparities • Organize Provider Gap in Care lists for the provider portal at the clinic level. • Provider webinar on Children's Well Care visits. Provider Engagement: Meet monthly with delegates to regularly review performance rates, barriers, and best practices through QI Joint Operations Meetings (JOMs). Member Interventions: • Text messages, Robo calls, and letters	Still pending after recent first submission.

Questions?

DSNP / Stars Quality Update

L.A. Care HEALTH PLAN
For All of L.A.

ELEVATING HEALTHCARE IN LOS ANGELES COUNTY SINCE 1997

Donna Sutton
Senior Director – Stars Excellence
August 15th, 2024

Overview: Medicare Star Quality Program

Purpose

CMS
(Centers for Medicare and Medicaid)
Federal policy and oversight

Health Plans
Provides actionable data to improve quality of care

Consumers
Provides information to make informed healthcare decisions

Program Cycle

CY2024
Measurement Year
Health Plan's perform is measured via predefined metrics

CY2025
Performance Analysis Year
CMS reviews performance, establishes Star Rating cut-points

CY2026
Star Rating Year

CMS awards Star Rating to Health Plans

CY2027
Payment Year

CMS pays Health Plans

- ***Significant incentive payments for above average performance***
- ***Financial payments occur 3 years after performance***

Overview: Medicare Star Quality Program

Scoring the Medicare Stars Quality Program

39 — ***# of Metrics***

5 — ***Measure Domains***

Screenings & Tests
Pharmacy
Member Satisfaction
Health Outcomes
Regulatory / Access

Generates an overall Star Rating

Improvement Measures (Part C & D)

- *Evaluate significant net improvement or decline*
- *Incentive for consistent YOY performance improvement*

Categorical Adjustment Index (CAI)

- *Offset to adjust for % of contracts beneficiaries with LIS, DE, and disability status*

Reward Factor

- *Incentive for contracts that are higher performing with minimal performance variance*

Add-on to overall Star Rating

Stars Rating Scale

Star quality programs leverage a 5-Star scale:

Numeric	Graphic	Description
5		Excellent
4		Above Average
3		Average
2		Below Average
1		Poor

Cut-points for Star ratings based on:

- *National benchmarks*
- *Performance of other Health Plans*
- *Tend to increase each year*

D-SNP Star Ratings Goals for MY2024

Star Rating Legend

1	2	3	4	5

	MY2023 Projected	MY2024 Goal
HEDIS	2.50	2.79
Pharmacy	3.15	3.62
Operations	3.80	3.62
CAHPS	2.06	2.12
HOS	4.33	4.33
Overall Rating	2.94	3.02
CAI	.065	.065
w/ Improvement		3.21
Adjusted Rating	3.01	3.28

Key Points:

- *For MY2024, focus on either incremental, statistically significant improvements or targeted next Star Rating level achievement for HEDIS, Pharmacy and Operations measures in MY2024*
  - *HEDIS and Pharmacy continue to improve*
  - *Operations*
  - *CAHPS / HOS using prior MY2022 performance as proxy and adjusting for measure weight changes*
- *Areas of additional improvement will need to be identified and leveraged to provide additional buffer to exceed 3.26 (rounding to 3.5) overall rating*
- *Risk*
  - *Final cut-points for MY2023 will be received in September 2024*

MY2023 using 1st plan preview scores and projected Star Ratings cut-points based on MY2022 revised cut-points
MY2024 using projected cut-points based on revised / final MY2022 cut-points

As of 8/11/24

Improvement Pillars

(Selected Initiatives)

Increase Care Options

- FIT and A1c test Kits launched
- Adding fluoride kits
- Adding Mobile Mammography
- Health Education, Cultural, and Linguistic Services
- Exploring care via home visits and new settings

Expand Member Communication

- New text messages for CCS, LSC, WCV and flu (for kids)
- Fluoride Social Media
- VSP partnership for member outreach
- Expansion of direct mail campaigns
- Member Wellness Platform (My HIM)

Deepen Provider Engagement & Accountability

- Expanding PPG collaboration
- New required QI / Population Health JOMs and Action Plan Forums
- Expanding provider outreach
- Education: CMEs & Webinars

Provider and Member Incentives

- Updated provider incentives
- New L.A. Care Honor Roll
- Provider Recognition Awards
- New Provider Incentive Reports and Engagement
- New Member Incentives

Data Management & Integrity

- Data reconciliation
- Enhancing provider data submission
- Understanding and addressing rejected encounters
- Provider education and training
- Building data management capabilities and processes

Deepen Blue Shield Promise and Anthem Plan Partner Collaboration

- Aligning strategy and initiatives
- Data reconciliation
- Joint provider engagement
- Sharing best practices
- Incentives Alignment

Strengthen collaboration and coordination across teams including with Pharmacy, Care Management, Community Resource Centers, Appeals/Grievances, Customer Solution Center, Analytics/IT, Product, Enterprise Performance Optimization, and Provider Network Management: every member and provider interaction is opportunity