BOARD OF GOVERNORS

Compliance & Quality Committee Meeting

Meeting Minutes – November 21, 2024

L.A. Care Health Plan CR 100, 1055 W. Seventh Street, Los Angeles, CA 90017

Members
Stephanie Booth, *MD, Chairperson*
Al Ballesteros, *MBA**
G. Michael Roybal, *MD*
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*
Noah Paley, *Chief of Staff*
Acacia Reed, *Chief Operations Officer*
Edward Sheen, *MD, Chief Quality and Population Health Executive*
Maggie Marchese, *Senior Director, Audit Services*
Miguel Varela Miranda, *Senior Director II, Regulatory Operations, Compliance*
Michael Sobetzko, *Senior Director, Risk Management and Operations Support, Compliance*

** 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 2:05 P.M. She announced that members of the public may address the Committee on each matter listed on the agenda before the Committee's consideration of the item by submitting their comments via text, voicemail, or email.	
APPROVAL OF MEETING AGENDA	**The meeting Agenda was approved as submitted.**	**Approved unanimously 3 AYES (Booth, Roybal, and Vazquez)**
PUBLIC COMMENT	*There was no public comment.*	

APPROVED

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
APPROVAL OF MEETING MINUTES	**The October 17, 2024 meeting minutes were approved as submitted.**	**Approved unanimously. 3 AYES**
CHAIRPERSON REPORT	Chairperson Booth noted improvements in the organization's reporting and departmental operations related to the Compliance & Quality (C&Q) Committee oversight. She noted better organization and communication, leading to resolution of previously concerning issues. Chairperson Booth expressed gratitude to all departments, commending them for their support and excellent work.	
COMPLIANCE & INTERNAL AUDIT		
CHIEF COMPLIANCE OFFICER REPORT	Todd Gower, *Chief Compliance Officer*, presented the Chief Compliance Officer Report *(a copy of the written report can be obtained from Board Services).* Mr. Gower reported on four areas of focus for the Compliance Department. He noted the importance of preparing and presenting topics comprehensively at the Compliance and Quality Committee (C&Q) meetings. The draft calendar plan under review with Dr. Amin aims to ensure inclusion of required components for reporting compliance and quality across various areas. Mr. Gower reviewed the compliance department maturity over the past year, noting significant progress particularly in delegation oversight and technology enhancements in Governance, Risk, and Compliance (GRC). He commended the strengthening of audit and compliance practices, which have led to improved risk management and transparency. Mr. Gower expressed satisfaction with the success in communication, with regular updates to the Board and leadership. The department will continue to work to reach higher maturity levels, especially in technology. At the National Healthcare Anti-Fraud Association conference, he saw new technologies adopted by other organizations to enhance provider monitoring and auditing, which could be beneficial for anti-fraud initiatives. He mentioned tools like Healthcare Fraud Shield and continuous auditing technologies to support internal audits. He stressed the importance of the GRC system in centralizing policies, audit plans, and compliance work, ensuring that past audit findings and enforcement actions are properly addressed and monitored. He underscored the critical role of technology in maintaining control over information, reducing risks, and supporting hybrid working environments. He spoke about the collaborative efforts across various departments, including finance, operations, healthcare services, and network management, to enhance monitoring, controls, and communication, ensuring compliance and reducing the risk of regulatory enforcement actions.	

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	Chairperson Booth asked what has changed. Mr. Gower responded by outlining several key initiatives and ongoing efforts to enhance the organization's governance structure and compliance practices. He discussed restructuring to support governance and the bifurcation of compliance and audit functions. He emphasized the importance of the risk committee's role in ensuring continuous communication and support for audits, addressing prior issues to avoid repetition and acknowledging significant improvements in IT security under the Chief Information and Technology Officer's leadership. Mr. Gower highlighted the critical focus on protecting member, provider, and employee data from fraud, particularly through enhanced IT security measures. He praised the support from various teams, including the Chief Information and Technology Officer and Advanced Analytics, in improving data protection and compliance. He mentioned the ongoing stakeholder mapping exercise aimed at identifying key areas of concern and strengthening communication between different lines of defense. He expressed openness to feedback and the importance of continuous improvement in compliance practices. He reviewed the 2024 work plan, noting progress in certain areas while emphasizing the need to enhance efforts in fraud prevention and detection. He recognized the complexity of L.A. County operations and the organization's achievements, particularly in comparison to other counties. Looking ahead to 2025, Mr. Gower outlined priorities such as stabilizing compliance, improving reporting and regulatory intake, and enhancing the GRC tools. He stressed the importance of maintaining good controls and effective communication in adapting to regulatory changes. Mr. Gower discussed efforts to continue maturing and scaling operations, acknowledging the challenges and progress made thus far. Chaiperson Booth stated that there is lots of information there, it tells what L.A. Care had before and what it did to get to higher levels. Mr. Gower responded that reviewing ways to enhance Compliance validates current operation status and continued focus will help with the work plan overall, making sure L.A. Care achieves higher maturity levels.	
INTERNAL AUDIT SERVICES	Magdelena Marchese, *Senior Director, Audit Services*, and Gennadiy Daych, *Director, Internal Audit*, reported on Internal Audit Services (*a copy of the presentation can be obtained from Board Services*). Ms. Marchese presented the status of the 2024 audits and noted four specific audits for discussion: • Provider Operations and Provider Network Audits: Internal Audit (IA) recommended moving these two audits to the 2025 work plan due to a new system implementation affecting the ability to provide relevant findings from the current manual processes. Testing these areas is suggested post-implementation. • New Audit Additions for 2024: Ms. Marchese introduced two new audits: o HR Audit focusing on the recruitment process and background checks.	

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	○ Transportation Audit evaluating the monitoring of transportation services through LA Care's "Call the Car" program. Ms. Marchese then discussed the closed audits since the last meeting in August: • Call Center Audit: This audit assessed the effectiveness of monitoring processes and controls in the call center. Four findings were identified in call handling, complaints and grievance handling, training, and quality assurance. • Risk Mitigation Plan Effectiveness Review: This review focused on the timeliness of the health risk assessment process for Medicare and MediCal lines of business. The Medicare line passed with no findings, but the MediCal line had three findings due to delays in deploying necessary reporting tools. Board Member Roybal asked about the high risk ratings, is that a regulatory high risk or is it operationally high risk. Ms. Marches responded that they were operational where some procedural areas were identified as high risk and required management action plans. Chaiperson Booth asked how the risk is determined to be fully completed. Internal Audit considers it complete once the audit is done and the corrective action plan is in place, and then it gets rechecked. Ms. Marchese explained that after an audit is considered complete, it continues to be monitored until all findings are fully remediated. Internal Audit does not close the issue until the management action plan (MAP), which the business unit commits to for addressing the findings, is fully implemented. Internal Audit follows the MAP to completion. Ms. Marchese mentioned that in future C&Q meetings, the status and progress of each MAP will be presented. Mr. Gower mentioned the disciplined approach in the current audit process, and noted the importance of consistency and regular reminders to avoid overlooking ongoing issues. He noted the positive examples of collaboration with marketing and member services departments to address past problems. Unlike regulators who simply report findings, Mr. Gower stressed that the IA team works closely with operations units to ensure proper follow-up and continued compliance. This approach enhances ongoing monitoring efforts within the organization. Member Roybal wondered if using "closed validation" would be helpful for documentation purposes. Ms. Marchese explained that they will report the closure of findings and observations, such as call handling processes, indicating the status of management action plans. Although they didn't have time to include it in the current report, the completion of these plans will be noted in future meetings. Mr. Gower noted the importance of ongoing validation to support the audit process and ensure continuous compliance with requirements. He acknowledged the supportive efforts of the Operations Department, the challenges in tracking activities which involve both manual reviews and technological support. He thanked the operations and IT teams for their contributions in facilitating these processes.	

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DELEGATION OVERSIGHT AUDIT SCHEDULE AND STATUS	Marita Nazarian, *Director, Delegation Oversight, Audit Services,* reported on the Delegation Oversight Audit Schedule and Status (*a copy of the written report can be obtained from Board Services*). In 2023, all 33 scheduled oversight audits were completed, with 29 having undergone corrective action plan validation. For 2024, 45 audits were planned, including 31 for Participating Phyiscian Groups (PPG), 12 for Plan Partners, and eight for specialty health plans and vendors. In addition to these, four pre-delegation assessments were conducted. So far, 12 of the 45 audits have been completed, with the majority progressing through CAP implementation. Ms. Nazarian noted success in the areas of cultural and linguistic audits and compliance program effectiveness, where delegates performed well. Audits ensured delegates translated member materials into preferred languages, used qualified translators, and provided cultural and linguistic training. Compliance audits checked for the presence of compliance officers, committees, and programs, as well as effective communication channels and routine monitoring processes. The team successfully hired a clinical audit manager, updated audit tools for 2024 and 2025 and utilized delegate reports for annual audits, demonstrating strong collaboration among business units within L.A. Care. Chairperson Booth wondered if, when working with these outside entities, are there usually simple things to fix or do they need to complete a root cause analysis. Ms. Nazarian responded that they complete a root cause analysis for any finding and provide the results. Corrective action plans are created with status of remediation. Mr. Gower applauded Ms. Nazarian and her team's efforts. Ms. Nazarian discussed challenges in completing case files for utilization management audits, particularly when delegates had difficulty gathering information from provider offices. To address this in 2025 audits, she proposed using internal reports for sample file selection rather than requesting universes from delegates. This approach would give delegates nearly two months more time to collect the necessary information. She mentioned that regulators typically request fewer samples than is done with L.A. Care, focusing on one line of business at a time. In contrast, L.A. Care audits delegates across all the lines of business, sometimes requesting 200 to 400 case files for a comprehensive audit covering various areas within each line of business. Chairperson Booth asked Ms. Nazarian if the volume of cases requested is too high. Ms. Nazarian responded that the number will not decrease, but will provide longer time to put them together. She noted that regulators are not gonna ask for that many when they're auditing delegates, and she has never seen any issues with delegates providing the case files to regulators during a regulatory audit, but it does happen ? during the annual audits due to regulators asking for large numbers of cases.	

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	Ms. Nazarian discussed several challenges related to utilization management audits. Delegates struggle to meet the 90% threshold for passing scores in case file reviews, particularly for denials. To address this in 2025, L.A. Care plans to conduct audit entrance calls with delegates to clearly highlight the clinical information needed in case files, aiming to improve their scores. Another challenge involved delegates being inconsistent in notifying L.A. Care about their subcontracting arrangements. To resolve this, L.A. Care will conduct a survey of delegates to gather details about all subdelegation arrangements. Additionally, a memo will be sent to re-educate delegates on the requirement to notify L.A. Care of subcontracting, ensuring that even minor subcontracting arrangements are communicated timely. Chairperson Booth asked how the second issue was related to repeat findings. Ms. Nazarian responded that some delegates fail to meet the 90% threshold in case file reviews, which can happen year after year. To help delegates, L.A. Care provides guidance on information that should be included in case files to meet the threshold and avoid repeat findings. Chairperson Booth stated she may not have been clear with her question, as the issue described seemed more related to incomplete case files and not how meeting the 90% threshold would prevent repeat findings. Ms. Nazarian responded that a repeat finding occurs when a delegate fails in an area and the following year the case files still do not meet the required 90%. By helping delegates understand what is needed in the case files, L.A. Care aims to prevent repeat failures and ensure delegates meet the threshold.	
COMPLIANCE TRAINING UPDATE	Michael Sobetzko, *Senior Director, Risk Management and Operations Support, Compliance*, reported on the 2024 Annual Compliance Training Program Results (*a copy of the written report can be obtained from Board Services*). The annual compliance training began in October and is due to be completed by December 15, with some cleanup tasks following that date. The training consists of six required modules for all employees and contingent workers, and includes HIPAA, code of conduct, overall compliance, privacy rules, fraud, waste, abuse and security awareness. As of November 7, the completion rate stood at 24%. Efforts to increase awareness have ramped up through heightened communication to associates and leadership, and supervisors receive automatic updates about outstanding training. The completion rate is expected to rise as the deadline approaches. Regarding training for the Board of Governors, Mr. Sobetzko noted that 10 out of 13 board members had completed their training, achieving a 77% completion rate with a goal to finish by the end of December.	

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ISSUES INVENTORY	Micheal Sobetzko, *Senior Director, Risk Management and Operations Support, Compliance*, reported on the Issues Inventory (*a copy of the written report can be obtained from Board Services*). Mr. Sobetzko provided updates on items reported in September. The first item, which has been closed, concerned L.A. Care's method of processing corrected claims. Historically, corrected claims were reprocessed as new claims, with the original payment recovered, a practice that regulators suggested might confuse providers. In response, L.A. Care changed its approach to reprocess the initial claim as a correction. These adjustments were made to both automated systems and manual processes by late October.	
REGULATORY AUDIT (FOLLOW UP)	Miguel Varela Miranda, *Senior Director II, Regulatory Operations, Compliance,* (*a copy of the written report can be obtained from Board Services*). Mr. Miranda provided an update on two audits, beginning with a 2021 routine survey conducted by the Department of Managed Health Care (DMHC), with findings released in 2022. The audit reviewed L.A. Care performance from 2019 to 2021, covering appeals and grievances, quality management, utilization management, access and availability, and pharmacy. Mr. Miranda said that L.A. Care has significantly evolved since 2021, and the audit reflects a past snapshot. The audit process includes three phases: the preliminary report received in 2022, to which L.A. Care responded within 45 days; the final report, now publicly available on the DMHC website, requiring a supplemental response by November 30, 2023; and a follow-up report by DMHC addressing all findings. The organization is currently in the second phase of this process. Member Roybal asked Mr. Miranda about the timing of the preliminary report from the audit in 2022. Mr. Miranda responded that it was received in December 2023. Member Roybal expressed concern about the lengthy timeline of the audit process, noting that L.A. Care submitted a response within the required 45 days, but the DMHC took nearly two years to provide the findings. He questioned whether there are any statutory or regulatory requirements for the DMHC to respond in a timely manner, suggesting that this process might need to be re-evaluated. Mr. Gower acknowledged that timely responses from regulatory bodies, especially in enforcement matters, have always been a challenge, and the audit protocols, even at the federal level, are not very timely. Mr. Miranda explained that part of the delay in the audit process was due to the COVID emergency, which allowed regulatory bodies more flexibility. He mentioned that although the delay was an outlier, the organization is working to ensure timely responses through legal support. He provided a comparison of audit findings, showing a decrease in final findings from the preliminary reports for both the Local Initiative and Joint Powers Authority, attributing the improvement to	

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	internal efforts and documentation pushback. The DMHC requested supplemental responses for several findings, including quality assurance, utilization management, emergency services, and prescription drug coverage. The team is preparing to submit responses that are due by November 30. A follow-up audit is expected near the end of 2025. Mr. Miranda briefly discussed the 2024 Center for Medicare and Medicaid Services (CMS) third financial audit currently underway. The audit is conducted by CMS through a CPA firm to review the organization's risk-bearing liability losses and ability to effectively adjudicate claims. The audit is ongoing from September to December, with an extension to March 2025 for on-site work. The process will take time to complete and includes remediation, corrective action plans, and document submission. This audit helps CMS evaluate health plan's financial performance, and L.A. Care is ensuring all necessary documentation is provided.	
PAYMENT INTEGRITY REPORT	Erik Chase, *Senior Director, Claims Integrity, Claims Integrity*, gave a Payment Integrity Report (*a copy of the written report can be obtained from Board Services*). Mr. Chase reported on key metrics and goals aimed at improving payment processes and reducing associated costs. He presented the amount paid including interest over the last six months, noting a decrease in June due to fewer working days caused by a weekend start and a holiday. He highlighted a downward trend in interest payments, reflecting more timely claims paid as interest is added to late claims. The goal is to reduce the payments to zero by mitigating controllable adjustments. Mr. Chase discussed the first pass adjudication claims volume, indicating that most claims are auto-adjudicated with a high eighty to low nineties percentage, while the remaining approximately 10% are manually processed. He noted the importance of timeliness in processing claims to maintain compliance. The compliance requirement involves processing a high percentage of claims within 30 calendar days. Although there was a slight dip due to a specific issue and efforts to identify and remediate it brought the process back into compliance. He detailed the average days taken to process claims from receipt to adjudication, aiming to keep this duration short through high auto-adjudication rates. Mr. Chase also provided insights into the first pass claims denial rate, stressing the need to keep it low, and discussed common reasons for denials, such as duplicate claims, incorrect billing, and timely filing issues, while identifying educational opportunities with providers to reduce denials. He explained the top denial reasons, including duplicate claims, incorrect billing practices, denials related to providers not set up in the system or claims submitted outside the timely filing limit. His report concluded with a focus on total claims processed including originals and adjustments, and noted the importance of reducing controllable	

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	adjustments by improving the accuracy of the adjudication process, while acknowledging that some adjustments are uncontrollable due to retroactive rate changes by DHCS. Member Roybal asked if L.A. Care gets the payment back as mentioned earlier. Mr. Chase explained that a rate increase requires going back to the effective date and reprocessing claims, paying out the incremental difference based on the new rate. For example, if the rate increases from $100 to $105, they would pay the additional $5 per claim from the effective date. Conversely, when rates decrease, such as from $100 to $95, they identify overpayments, move them to payment integrity, and issue recovery letters to providers, notifying them of the overpayment and the amount due based on the claims submitted during the period between the rate change and system reconfiguration. Mr. Chase reported on provider disputes, explaining that providers have the right to dispute claims often due to denials or perceived underpayments. He described tracking the volume of disputes, the percentage of upheld decisions, and using these instances as educational opportunities to work with providers on contract interpretation to reduce disputes. He emphasized maintaining compliance in processing disputes within 45 days, noting a temporary dip in May 2024 due to a surge in COVID-related cases. Mr. Chase noted efforts to reduce the average days to process disputes and improve efficiency in the dispute process. He mentioned the success in exceeding the payment integrity goal, achieving $206 million against a target of $170.8 million in 2024. The focus moving forward is on prepayment strategies to avoid costs rather than recovering funds after payment, aiming for more effective collaboration with providers to ensure accurate claim submissions. Mr. Gower pointed that that 2025 will focus on prevention in payment integrity, aligning with Mr. Chase's points. He noted the need to enhance premium reviews and prevention efforts rather than just increasing the number of investigators. Mr. Gower noted advancements in technology for faster detection and prevention, acknowledging the time required to implement these technologies. He and Mr. Chase are considering involving experienced individuals and companies for a proof of concept to improve detection and alert systems, ensuring quicker identification of provider activities.	
HEALTH SERVICES		
MEDI-CAL ACCOUNTABILITY SET (MCAS) UPDATES	Sameer Amin, *MD, Chief Medical Officer*, *Chief Quality and Population Health Executive,* stated that Edward Sheen, *Chief Quality and Population Health Executive,* will be presenting the Managed Care Accountability Set (MCAS) Update (*a copy of the written report can be obtained from Board Services*). Dr. Amin gave the following updates before the MCAS update:	

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	• Auto Assignment Methodology: He reported on fruitful discussions with DHCS regarding the auto assignment process for members who are not immediately assigned to a primary care provider. They have developed a new methodology based on national benchmarks, which includes a 5% cap on annual swings. The new system, derived from CMS's value-based plan for hospitals, includes an 18-point scale that better reflects quality improvements. This change is expected to result in L.A. Care securing 57% of the auto assignment, with the remaining 43% going to Health Net. • QNXT Transition: Dr. Amin mentioned the transition from Syntranet to QNXT for utilization management. The team is conducting user acceptance training and mock go-lives to ensure smooth system implementation. The release date is set for December 9, 2024, with real-life deployment to follow. Additional nursing staff will be available during the transition to handle inefficiencies. • Provider Portal: Dr. Amin discussed the development of a provider portal, which is part of a regulatory commitment to allow electronic authorization submission and tracking. The portal is expected to go live in December, with internal testing ongoing. There was positive feedback from a recent presentation on the portal. Dr. Sheen introduced Brigitte Bailey, *Supervisor, Quality Improvement*, to give the report. Ms. Bailey provided an update on the 2023 performance of the MCAS measures, where the organization is held accountable by DHCS. Of the 15 measures, six did not meet the minimum performance level (MPL), with three of those related to children's health, childhood immunization status, and well-child visits for children up to 30 months. Other measures that fell short included cervical cancer screening, and follow-ups after emergency department visits for mental illness and substance use. Asthma medication ratio was also cited as below MPL, but this was due to a data mapping issue being addressed with DHCS. As of October 25, 2023, the organization received a sanction notice of $122,000, a reduction of nearly $700,000 from the previous year, highlighting improvements across the organization. DHCS did not sanction any plans for emergency department visit performance due to state data gaps. Ms. Bailey emphasized ongoing efforts to improve measures like childhood immunizations and cervical cancer screenings, including outreach, educational campaigns, and provider partnerships. The organization also launched an incentive program for cervical cancer screenings and is exploring self-collection options. Additionally, they are working with high-performing PPGs to identify and replicate successful strategies to improve vaccination rates, especially for flu shots. For the upcoming 2025 measurement year, no new measures will be introduced, which was seen as a positive development.	

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	Dr. Sheen thanked Ms. Bailey for the summary and added a few thoughts for context. He addressed the legal review, mentioning that an administrative review was requested concerning the MCAS penalties for measurement year 2022. This appeal is still in progress, with discovery activities ongoing and a hearing tentatively scheduled for spring 2025. Dr. Sheen highlighted that the concerns raised about the MCAS methodology are still valid today, and they look forward to the hearing's outcome. He then acknowledged the reduction in sanctions for 2023, from $800,000 to $207,000, which is a significant decrease, though they are still dissatisfied with any penalties. Dr. Sheen explained that they had a "meet and confer" meeting with DHCS, where they reiterated that the concerns from 2022 remain, and they are applying the same perspective to the 2023 data. He emphasized that the upcoming hearing in spring 2025 will address both 2022 and 2023 measurement years. Dr. Sheen also discussed the AMR issue, which Ms. Bailey had previously mentioned. Although they exceeded the Minimum Performance Level (MPL), there were issues with drug codes and data mapping, which prevented them from meeting technical requirements on paper. However, they did meet the MPL, and this issue was also part of the "meet and confer" discussion. Turning to the 2024 performance, Dr. Sheen noted that they are in the middle of their 4th Quarter campaign push, making it too early to determine the results, but they are doing everything they can to close the gaps. Despite the exit of Kaiser, which boosted L.A. Care's measures, they are still achieving improvements across the board.	
MEMBER EXPERIENCE SURVEY RESULTS	*This presentation was postponed until the January 16, 2025 meeting.*	
PUBLIC COMMENT ON CLOSED SESSION ITEMS	*There was no public comment.*	
CLOSED SESSION	PEER REVIEW Welfare & Institutions Code Section 14087.38(o) CONFERENCE WITH LEGAL COUNSEL—ANTICIPATED LITIGATION Significant exposure to litigation pursuant to Section 54956.9(d)(2) of Ralph M. Brown Act: Three potential cases CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION L.A. Care Health Plan's Notice of Contract Dispute under Contract No. 04-36069	

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	Department of Health Care Services (Case No. Unavailable)	
APPROVE INTERNAL AUDIT (IA) SERVICES WORKPLAN (COM 100)	Chairperson Booth advised that the committee will revisit agenda item 6 to approve the Internal Audit (IA) Services Work Plan (a copy of the work plan can be obtained from Board Services). She advised that the public can obtain a copy of the work plan by contacting Board Services. **COM 100.0225** **Approve Internal Audit (IA) Services Work Plan.**	**Approved unanimously. 3 AYES**
ADJOURNMENT	The meeting adjourned at 4:40 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:

Signed by: Stephanie Booth, MD.
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Stephanie Booth, MD, *Chairperson*
Date Signed: 1/29/2025 | 2:02 PM PS

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