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.*	

APPROVED

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.

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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.

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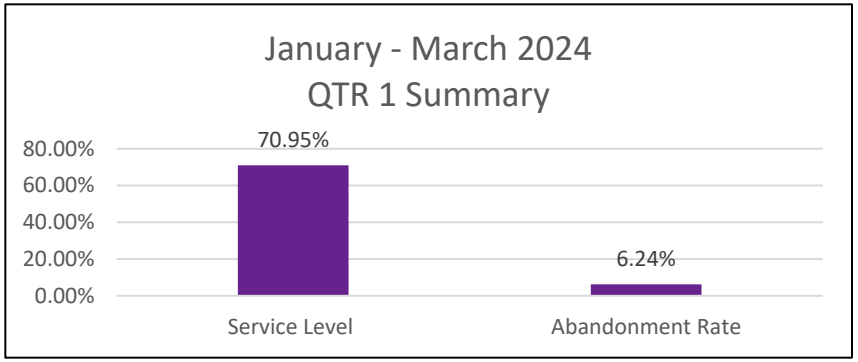
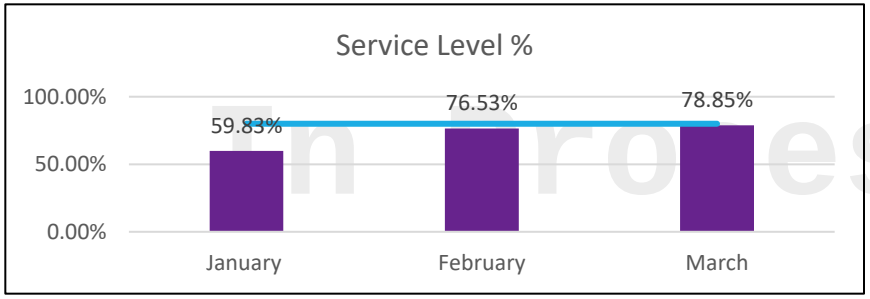
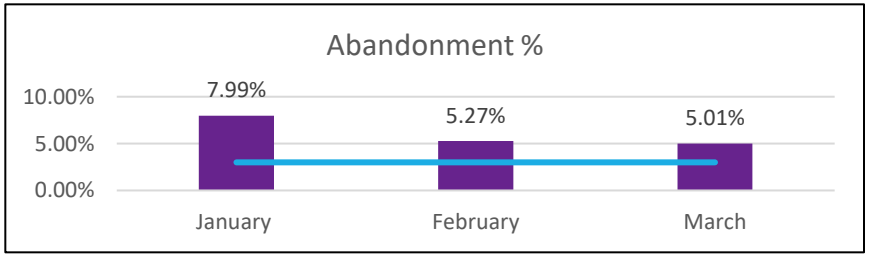
AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	D-SNP Call Center Performance	







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

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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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AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	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:

Signed by:
Stephanie R. Booth, MD
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Stephanie Booth, MD, *Chairperson*
Date Signed: 8/30/2024 | 9:34 AM PI

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