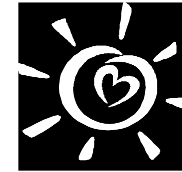
BOARD OF GOVERNORS
Compliance & Quality Committee Meeting
Meeting Minutes – August 20, 2024



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 2:00 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.** Chairperson Booth stated that Dr. Li will give a Chief Health Equity Officer update at the September meeting.	**Approved unanimously 3 AYES (Booth, Roybal, and Vazquez)**

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PUBLIC COMMENT	*There was no public comment.*	
APPROVAL OF MEETING MINUTES	**The June 20, 2024 meeting minutes were approved as submitted.**	**Approved unanimously.**
CHAIRPERSON REPORT	Chairperson Booth reported that although she had initially planned not to say much, an external evaluation prompted further discussion. The evaluation suggested that processes should enable business growth, but she disagreed with the assessment that their organization lacked a foundational risk management system. She emphasized that they have been refining their approach for some time, and significant improvements have been made. The risk identification process has become repeatable, evidenced by the fact that it is being implemented again this year. They have addressed prior issues and believe the organization is proactive, particularly in identifying personnel and IT-related challenges. Chairperson Booth expressed confidence that the evaluation underestimated their progress in risk management. Mr. Sobetzko stated that the Gartner consultant's role was to help the organization grow and mature its risk management processes. While the organization has been making improvements year over year, including changes in tools and methodology, Mr. Sobetzko emphasized that true scalability and repeatability would eventually make risk management an ingrained part of operations. He spoke about the formation of a risk committee as a significant step forward, noting that this committee moves the process from being managed by a small team within compliance to engaging the entire organization. This broader involvement is crucial for making risk management a foundational process. He explained that while the organization is still reactive in many ways, the goal is to reach a point where risk management is fully integrated into the business, informing strategic decisions rather than reacting to surfaced risks. Mr. Gower stated that their discussions around risk have evolved from being ad hoc to more structured and mature. Weekly meetings with the cabinet and the risk committee have helped identify key risk issues. Additionally, terms like "inherent risks" and "residual risks" are now part of their regular discussions, reflecting progress. He mentioned that during the most recent internal compliance committee meeting, they discussed the upcoming 2025 risk assessment process, further embedding risk identification and prioritization into their routine. This structured approach allows them to better prioritize efforts and financial resources. Mr. Gower acknowledged that while the organization is still working toward foundational risk management, the right tools, processes, and communication are in place to reach this level, with the ultimate goal of progressing to strategic risk management. Chairperson Booth asked if they should be on strategic risk management. Chairperson Booth's question about whether they should be focused on strategic risk management, Mr. Gower responded that while they aim to reach that level, their immediate goal is to establish a	

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	solid foundation for 2025. He noted that the process involved collecting and organizing a significant amount of unstructured data from prior years, including interviews and survey information. Now, with a more structured approach and a better-defined risk register, the organization is in a stronger position to approve and utilize this data. Mr. Gower said that this structured foundation is a crucial improvement for the executive team and the organization as a whole. Mr. Sobetzko added that a key missing component for reaching foundational risk management is defining the organization's risk tolerance. He explained that the organization needs to clearly establish its appetite for risk, so when risks arise, they can be assessed based on whether they exceed or fall below acceptable thresholds. This would make risk management more formulaic, allowing for a clearer prioritization of efforts based on the level of residual risk and the organization's tolerance. Much of the process relies on intuition and discussion, which, while important, lacks clear thresholds. He hoped that they would reach this point within the calendar year, and if the necessary tools and frameworks are implemented, the organization would achieve foundational risk management. Though the goal is to eventually move beyond this level, he stated that even a small step beyond the foundational stage would be a positive outcome.	
COMPLIANCE & QUALITY COMMITTEE CHARTER STATUS UPDATE	Todd Gower, *Chief Compliance Officer*, discussed the Compliance & Quality Committee Charter Process. Mr. Gower provided an update on the committee charter, stating that they have reached a good agreement on its contents. Although he had hoped to finalize it earlier, that was not completed. He will send it out for review soon, as the charter is now in its final stages. The next steps involve checking for spelling, grammar, and other minor details before sending it to the board and leadership team for review and approval at the next Compliance & Quality committee meeting. He noted that the suggested changes are minor, with no major format changes needed.	
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)*. Mr. Gower's report provided an overview of the compliance efforts within the organization. He emphasized the consistency of their internal compliance committee's process, which has helped address compliance issues transparently across the organization. He spoke about the ongoing refinement of how these issues are presented to the board and executives in a clearer manner. Mr. Gower, alongside Mr. Paley and Dr. Amin, is focusing on improving delegation oversight. While there is already a good process in place, further refinements are needed. They are addressing concerns related to FDR oversight to ensure compliance with guidelines from the Department of	

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	Justice and Office of the Inspector General. Though progress has been made, there are still areas to improve to achieve a more robust and effective compliance organization. Mr. Sobetzko gave a Risk Committee report. 2024-2025 Enterprise Risk Assessment He stated that Allysa Johnson from Gartner presented at the Risk Committee meeting on July 2. 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 Mr. Sobetzko's outlined several key initiatives currently underway. In collaboration with the Gartner group, the committee is building a new enterprise risk assessment for 2025. The process involves the entire organization, with each department contributing to a risk catalog that identifies potential risks across the enterprise. This catalog will form the basis for a risk survey, which will guide the assessment process. The committee members are responsible for sharing this information with their teams and providing their department's perspective on potential risks. The enterprise risk assessment will focus on risk identification, monitoring, and aligning with the organization's risk appetite, or tolerance for risk. Once the risk catalog is finalized, surveys will be deployed, and Gartner will help analyze the data to provide insights into the areas of greatest risk. This process will integrate data from various sources, such as issues inventories and corrective action plans, to evaluate the true residual risks. Mr. Sobetzko said that the risk committee will review past management action plans from previous assessments. The committee aims to shift from solely relying on compliance reports to leveraging the expertise of those managing the action plans, fostering a broader and more collaborative approach to risk management. This will enable the committee to gain deeper insights and ensure timely, data-driven risk mitigation strategies. Amanda Asmus, *Director, Care Management, Care Management*, gave a report on the timely completion of Health Risk Assessments (HRAs) for Medi-Cal and dual members, emphasizing the regulatory and clinical risks of delays. If HRAs are not completed promptly, the organization risks regulatory violations and impacts members needing high-intensity care coordination. To mitigate this risk, operational reports were developed to oversee and ensure timely completion of HRAs. The Medi-Cal HRA reports were expanded to include new populations as of January 2023, and these reports were fully operational by July 2024. Similarly, the DSNP HRA reports were also fully operational by July 2024. As a result, the older CMC HRA reports used for ad hoc outreach are being phased	

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	out. Ms. Asmus noted the development of an Optum Impact Pro report that identifies high-risk members per Department of Health Care Services (DHCS) guidelines. This report is still being iterated to comply with changing DHCS regulations, with an estimated completion date yet to be determined. Greg White, *Director, Healthcare Analytics, Risk Adjustment Strategies & Initiatives*, reported on the challenges surrounding the timeliness and quality of encounter data intake. The primary risk involves the impact on Prop 56 and other programs, where accurate and timely data submission to DHCS or CMS is necessary for reimbursement and correct risk score calculations. To address this, an Encounter Data Governance Committee was established based on consultant recommendations, with its charter completed on July 1. He said that participating physician group (PPG) outreach has been initiated to monitor and assist with data submissions. Analysts are assigned to the largest PPGs to help correct submission errors, although staffing limitations prevent covering all PPGs. This outreach began in November and remains ongoing. Mr. White also spoke about the development of Key Performance Indicators (KPIs) for encounters, aimed at creating a unified data source for the entire enterprise. This effort started in July, with full implementation expected by the end of the year. He noted that a staffing analysis and enhancement request for the 2025 budget to monitor PPG submissions more effectively and investigate errors. This request was initiated in July, with an expected decision by the end of September. Member Roybal asked if L.A. Care gets a its data from clearignhouses or does it get data from each individual PPG. Mr. White responded that all capitated providers submit data through a clearinghouse vendor, FinThrive, as monitoring each PPG's file individually would require significantly more staff. FinThrive is commonly used by PPGs to submit to multiple healthcare entities. Fee-for-service providers and hospitals, on the other hand, submit data through the claims system, QNXT. He clarified that FinThrive performs initial checks for syntactical errors before data reaches LA Care. If L.A. Care rejects the data, it is sent back to the PPG for corrections. LA Care prefers to receive all data, whether accepted or rejected, in order to work with PPGs to correct errors and gain insights into the issues. Miguel Varela Miranda, *Senior Director II, Regulatory Operations, Compliance,* gave Compliance Monitoring Summary, Compliance Delegation Oversight Summary, and Dual Special Needs Plan (DSNP) Oversight Summary *(a copy of the slides can be obtained from Board Services).* Penny Winkfield, *Director, Information Security Risk and Compliance, IT Executive Administration,* gave a Information Technology Risk Report Out. Vulnerability Management Program Summary:	

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	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.	

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

Mr. Magerr clarified that L.A. Care has been actively managing vulnerabilities through three departments. The Cyber Defense Department addresses vulnerabilities based on what cybercriminals are exploiting. The Engineering and Architecture team handles security patching for operating systems and ensures no vulnerabilities exist in new solutions. Ms. Winkfield's team

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	facilitates risk assessments and penetration tests, prioritizing and addressing vulnerabilities as they arise. He noted that this program is part of a broader strategy and aligns with the department's timeline. A dedicated vulnerability program manager was hired, who has expanded the definition of vulnerabilities to include factors like secure software builds and end-user training. The goal is to take a holistic approach to vulnerability management, maturing the department's processes. Chairperson Booth asked if the tools they are talking about are related to software. Ms. Winkfield responded that it can be related to software or hardware. That is part of all of these assessments. It can be a combination. Mr. Gower responded that they are being very proactive. Mr. Sobetzko gave an Issues Inventory update.	

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

Soledad Castillo, *Senior Director, Claims Data and Support Services, Claims Data and Support Services,* gave a report on Overpayment Deductible and Out-of-Pocket Maximum.
Ms. Soledad Castillo reported that L.A. Care had been collecting copayments from members who had already met their maximum out-of-pocket (MOOP) limits for the years 2018 through 2021. The root cause was a lack of clear oversight regarding when members met their MOOP and a lack of communication with PPGs. To address the issue, a daily monitoring dashboard was created to track members nearing or exceeding their MOOP. Communication channels with PPGs were also established to ensure that once members reached their MOOP, no further copayments were collected.

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	Ms. Castillo explained that the effectiveness of these measures is being monitored through daily reports and monthly lookbacks for the next 90 days to confirm that the processes are working. The team also conducts an annual review to check for any members who paid beyond their MOOP and promptly remediates such cases. Reimbursement for affected members has been completed, except for four cases where checks were returned. In these cases, further steps are being taken to update addresses and resend the checks. Ms. Castillo also mentioned that L.A. Care collaborates with PPGs to verify the data, create claims for reimbursement, and ensure accuracy through their Quality Assurance team and finance department. Any checks that remain uncashed after 90 days are sent to the state if a member cannot be reached. Miguel Barcenas, *Director, Provider Contracts and Relationship Management, Provider Network Management,* reported on an issue involving three providers who failed to submit their recredentialing documentation on time. These providers were identified, and LA Care took steps to remediate the situation by April. Each provider was successfully recredentialed, with their cases closed upon completing the necessary documentation reviews. To prevent similar issues in the future, L.A. Care has implemented a process where account coordinators review monthly credentialing reports to identify providers nearing recredentialing deadlines. The coordinators then notify both the manager and account manager, who in turn remind the providers to submit their recredentialing documentation to stay compliant with the program. *(A copy of the full Compliance Officer Report can be obtained from Board Services.)*	
CHIEF MEDICAL OFFICER REPORT	Sameer Amin, *MD, Chief Medical Officer*, gave a Chief Medical Officer report *(a copy of the materials can be obtaidne from Board Services).*	

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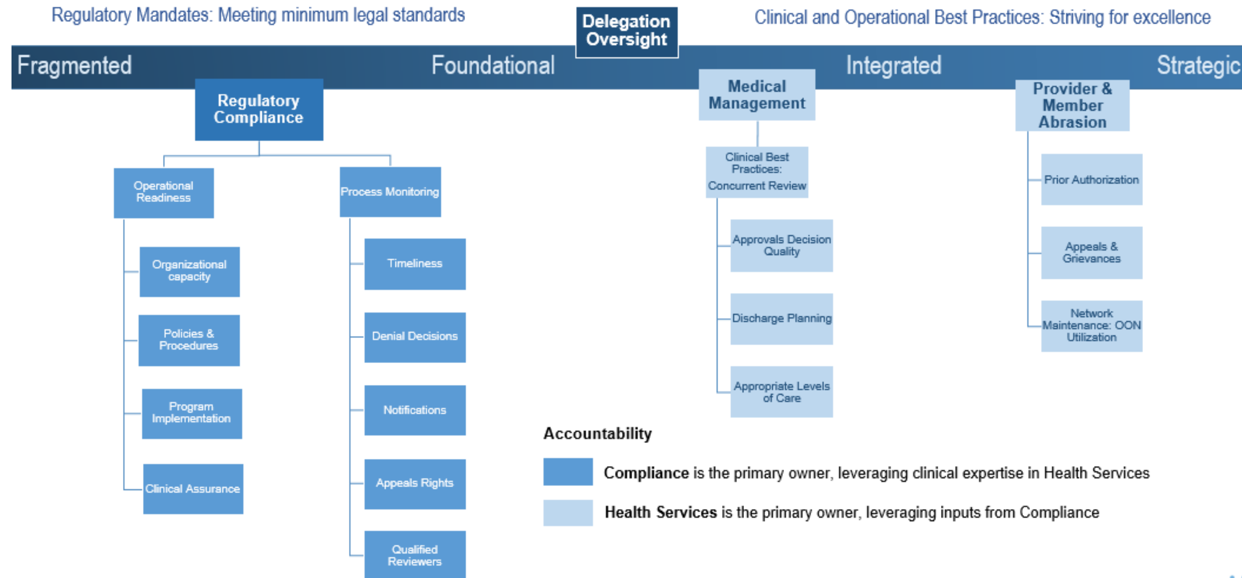

Our goal is to enhance our oversight of delegated utilization management function performed by our contracted provider network to ensure accountability, increase operational efficiency, and uphold the highest standards of governance and quality.

Objectives:

Close gaps in regulatory compliance

- Notification Letters
- Over- and Under-Utilization

Reduce administrative provider burden

- Optimizing the PA List to remove the "always approved"
- Maintaining appropriate networks (OON vs INN use)
- Reducing denials
- Minimizing appeals/grievances

Clinical Optimization

- Minimizing avoidable utilization, promoting value based care

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	Framework for Health Services Enhanced Delegation Oversight Activities 1. Gather comprehensive data on delegates 2. Analyze collected data to identify trends, root causes, and areas for improvement. 3. Provide feedback to PPGs based on the analysis and make actionable best practices recommendations 4. Support PPGs in implementing recommended changes and monitor their progress 5. Evaluate the effectiveness of the new soft function and identify areas for improvement	
TRANSITIONAL CARE SERVICES (CalAIM)	Joycelyn Smart-Sanchez, *Director, Care Management, Care Management,* gave a presentation on Transitional Care Services *(a copy of the presentation can be obtained from Board Services).* Ms. Joycelyn Smart-Sanchez, Director of Care Management for Medi-Cal at LA Care, provided an overview of the Transitional Care Services (TCS) program. TCS focuses on supporting members as they transition from one level of care to another, such as from hospitals to home care, ensuring they receive the necessary services and support to safely transition to a lower level of care. Ms. Smart-Sanchez said that while TCS builds on existing practices, it introduced new responsibilities for care managers, such as conducting discharge risk assessments, coordinating post-discharge follow-ups, and ensuring timely communication with primary care providers (PCPs). The program is particularly focused on high-risk populations, including those with specific medical conditions, pregnant and postpartum members, and individuals eligible for Enhanced Care Management (ECM) or Community Support (CS) services. The TCS program was rolled out in phases, starting in January 2023 for high-risk members, with all Medi-Cal members becoming eligible in January 2024. Ms. Smart-Sanchez detailed the different teams within LA Care that manage TCS for various populations, including ECM teams, Community Health Workers, and specialized teams for long-term care and pregnant members. She noted the importance of care coordination, where TCS caremanagers serve as the single point of contact for members, ensuring seamless communication between healthcare providers and facilitating access to necessary services. Ms. Smart-Sanchez also discussed the program's key performance indicators (KPIs), including the percentage of high-risk	

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	members contacted within seven days post-discharge and follow-up with PCPs. She acknowledged variability in data reporting across different health plans, which the state is currently addressing to standardize data collection methods. As of the end of the previous month, the TCS program had served nearly 17,000 members, reflecting its growing impact. Despite being a relatively young program, TCS continues to expand, with ongoing efforts to increase staffing and improve service delivery.	
QUALITY IMPROVEMENT PROJECTS (QIPs/PIPS, PDSA)	Rachel Martinez, *RN, BSN, Supervisor, Quality Improvement, Quality Improvement,* gave a presentation about Quality Improvement Projects *(a copy of the presentation can be obtained from Board Services).* Ms. Martinez reported on four types of regulatory projects: Quality Improvement Projects (QIPs), Performance Improvement Projects (PIPs), Plan-Do-Study-Act (PDSA) cycles, and Strengths Weaknesses Opportunities and Threats (SWOT) analyses. These projects vary in duration and scope, with PDSAs and SWOTs typically initiated by Medi-Cal when minimum performance levels are not met, such as the 2022 SWOT for Well-Child Visits and Childhood Immunization, which closed in 2023. She also highlighted upcoming PIPs for 2023-2026 focusing on disparities in well-child visits for Black/African American children and behavioral health needs related to emergency department use.	
STARS UPDATE D-SNP	Donna Sutton, *Senior Director, Stars Excellence, Quality Improvement,* gave a D-SNP/Stars Quality Update *(a copy of the presentation can be obtained from Board Services).* Donna Sutton provided an overview of the D-SNP (Dual Eligible Special Needs Plans) program, explaining the purpose of the Stars Quality Program, which serves as a tool for Center for Medicare and Medicaid Services (CMS) to implement federal policy, provide oversight on health plan performance, and offer consumers information to make informed decisions. She outlined the program's timeline, emphasizing that it takes up to three years to receive payment based on performance, and described the 39 metrics across five domains that determine the star rating. Additionally, she discussed new evaluation measures for improvement in Part C and Part D, the impact of the Categorical Adjustment Index (CAI) for plans serving higher-risk populations, and the significance of maintaining high star ratings for financial incentives and industry positioning.	
PUBLIC COMMENT ON CLOSED SESSION ITEMS	*There was no public comment.*	

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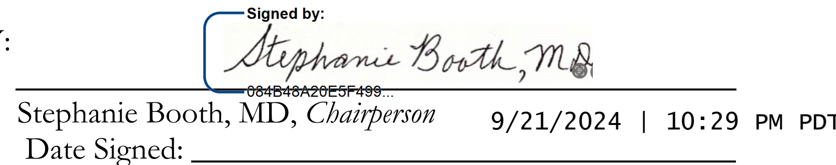
ADJOURN TO CLOSED SESSION	Augustavia J. Haydel, Esq., *General Counsel*, announced the following items to be discussed in closed session. The JPA Compliance and Quality Committee meeting adjourned and the Compliance and Quality Committee adjourned to closed session at 4:51 P.M. PEER REVIEW Welfare & Institutions Code Section 14087.38(o) 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: 9/21/2024 | 10:29 PM PDT

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