



Quality Improvement Program

All Lines of Business

2020

Quality Oversight Committee approval on

2/12/2020

Compliance and Quality Committee approval on

3/19/2020

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MISSION

L.A. Care Health Plan's mission is to provide access to quality health care for Los Angeles County's vulnerable and low income communities and residents and to support the safety net required to achieve this purpose.

VISION

A healthy community in which all have access to the health care they need.

VALUES

We are committed to the promotion of accessible, high quality health care that:

- Is accountable and responsive to the communities we serve and focuses on making a difference;
- Fosters and honors strong relationships with our health care providers and the safety net;
- Is driven by continuous improvement and innovation and aims for excellence and integrity;
- Reflects a commitment to cultural diversity and the knowledge necessary to serve our members with respect and competence;
- Empowers our members, by providing health care choices and education and by encouraging their input as partners in improving their health;
- Demonstrates L.A. Care's leadership by active engagement in community, statewide and national collaborations and initiatives aimed at improving the lives of vulnerable low income individuals and families; and
- Puts people first, recognizing the centrality of our members and the staff who serve them.

PURPOSE

The Quality Improvement (QI) Program is designed to objectively and systematically monitor and evaluate the quality, safety, appropriateness and outcome of care and services delivered to our members. The QI Program provides mechanisms that continuously pursue opportunities for improvement and problem resolution. In addition, the QI program utilizes a population management approach to members and providers and collaborates with local, state and federal public health agencies and programs, as well as with providers and other health plans.

STRATEGIC PRIORITIES (2018-2021)

Strategic Direction 1: A high functioning health plan with clear lines of accountability, processes, and people that drive efficiency and excellence.

Goal 1.1:

Achieve operational excellence through improved health plan functionality.

Objectives:

- Enhance systems, tools, and processes to improve customer service through the Voice of the Customer (VOICE) initiative.

- Improve business functions related to financial management with the Enterprise Resource Platform (ERP).
- Modernize provider data management through continued operations of the Total Provider Management (TPM) initiative.
- Replace the Care Management platform and change business practices to improve coordination of care for members with the Care Catalyst initiative, specifically the new Population Health Management System (Syntra Net).
- Implement strategies to improve encounters and risk adjustment processes.

Goal 1.2:

Maximize the growth potential of our product lines.

Objectives:

- Implement a product governance process to ensure enterprise-wide alignment for products, programs, and service offerings across all lines of business.
- Create a tailored approach to member retention, based on unique needs of the product.
- Leverage our ability to offer member choice and provide value-added programs for all product lines.
- Analyze the feasibility of D-SNP options and begin designing a product to serve our dually eligible Medi-Cal and Medicare population.

Goal 1.3

Providers receive the individualized information and resources they need to provide high-quality care with low administrative burden.

Objectives:

- Provide practices with actionable data, including VIIP scores and Gaps in Care and Provider Opportunity reports, to support maintaining our NCQA Commendable status.
- Celebrate top providers and improved performance.
- Offer access to loan repayment and recruitment assistance for new physicians (Elevating the Safety Net).
- Support practice transformation and use of electronic resources such as Electronic Health Records (EHRs), Health Information Exchange (HIE), and virtual care.

Strategic Direction 2: A network that aligns reimbursement with member risk and provider performance in support high quality, cost-efficient care.

Goal 2.1:

Maintain a robust provider network that supports access to high-quality, cost efficient care.

Objectives:

- Engage in a provider network strategy that meets distinct business and competitive needs of all products and ensures that members receive high-value care.
- Optimize oversight of delegated functions.

Goal 2.2:

Build foundational capabilities to support expansion of the L.A. Care Direct Network.

Objectives:

- Strategically develop, expand, and address gaps in the Direct Network to meet all member needs.
- Improve the operations of all L.A. Care functions necessary to support and scale up the Direct Network.

Strategic Direction 3: Member-centric services and care, tailored to the needs of our varied populations.**Goal 3.1:**

Understand our member needs so we can better manage their care and plan for the future.

Objectives:

- Use all available data sources, including the Optum Impact Symmetry Suite (Member360), to assess and improve the population health of our membership.
- Incorporate assessment of social needs into the day-to-day work of staff who interact directly with members.
- Replace the Care Management platform and change business practices to improve coordination of care for members with the Care Catalyst initiative, specifically the new Population Health Management system (Syntra Net).

Goal 3.2:

Address members' unmet health and social needs by making care accessible in the right way, at the right place, at the right time.

Objectives:

- Utilize alternative approaches to expand access to care, including full implementation of Minute Clinic and telehealth opportunities.
- Expand care management at Community Resource Centers/Family Resource Centers.
- Implement initiatives that promote health equity in order to improve health disparities based on findings from the population health assessment and other data analytics.

Strategic Direction 4: Recognized leader in improving health for low income and vulnerable communities.**Goal 4.1:**

Be a local, state, and national leader to advance health and social services for low income and vulnerable communities.

Objectives:

- Advocate for policies that improve access to care and quality of life for low income communities.
- Demonstrate the value of public option.

- Contribute to and participate in the State’s Medi-Cal Waiver design efforts to ensure waiver programs support and meet member needs.

Goal 4.2:

Implement initiatives that improve the health and wellbeing of those served by safety net providers.

Objectives:

- Continue and expand the Elevating the Safety Net initiative.
- Expand the number, size, and scope of our Community Resource Centers to a total of 14 sites across 11 Regional Community Advisory Committee regions in partnership with Blue Shield of California Promise Health Plan.
- Fully implement L.A. Care as a Health Homes program CB-CME through care management based at Community Resource Centers/Family Resource Centers and continue to expand the Community Based Care Management Entity (CB-CME) network.

PROGRAM STRUCTURE

L.A. Care’s Quality Improvement Program describes the QI program structure, a formal decision-making arrangement where L.A. Care’s goals and objectives are put into an operational framework. Tasks to meet the goals and objectives are identified, grouped and coordinated in the activities described in the accompanying QI work plan. The QI program description defines how the organization uses its resources and analytical support to achieve its goals and includes how the QI program is organized to meet program objectives, functional areas that support the program and their responsibilities and reporting relationships for the QI Department staff and QI Committees. These are described in detail in the program.

The following product lines are covered by the QI program description: Medi-Cal, L.A. Care Covered™ (On-Exchange), L.A. Care Covered Direct™ (Off-Exchange), PASC-SEIU Plan, and L.A. Care Cal MediConnect Medicare-Medicaid Plan (MMP). The program also supports the integration of Behavioral Health, Substance Use, and Managed Long-Term Services and Supports (MLTSS), Health Homes, Whole Person Care, and the Homeless Programs.

L.A. Care Health Plan Direct Network

In 2016, L.A. Care filed an Amendment to its license for direct contracting in the Antelope Valley area of Los Angeles County. The Antelope Valley covers a large part of Los Angeles County and contains many sparsely populated areas. Residents have historically experienced challenges accessing care, including physician services.

To respond to those challenges, L.A. Care contracted directly with primary care physicians and specialists in that area who are accessible to Medi-Cal members who elect to join the “L.A. Care Direct Network” (LADN, formerly referred to as the “Community Access Network”). Due to the relative success of using the direct contracting approach in Antelope Valley, L.A. Care decided to expand the model throughout Los Angeles County.

These providers benefit from having a direct relationship with L.A. Care, and have the opportunity to serve members beyond just those assigned to them by the provider group(s) with which they are

contracted. Additionally, directly contracted Primary Care Practitioners have the ability to receive assistance from L.A. Care in transforming their practices through a program called, “Transform LA.”

SB 75 – Full Scope Medi-Cal for All Children

Under a law that was implemented May 1, 2016, children under 19 years of age are eligible for full-scope Medi-Cal benefits regardless of immigration status, as long as they meet all other eligibility requirements (Welfare and Institutions Code section 14007.8.) The Department of Health Care Services (DHCS) worked collaboratively with County Welfare Directors Association of California (CWDA), county human services agencies, Covered California, advocates, and other interested parties to identify impacted children and provide them with full Medi-Cal coverage benefits.

Senate Bill (SB) 104 – Medi-Cal Expansion to Undocumented Young Adults

Beginning January 1, 2020, Medi-Cal will expand full scope coverage to the low-income young adult population, between the ages of 19 through 25, regardless of their immigration status, if they meet all other eligibility requirements for the Medi-Cal program.

Full-scope Medi-Cal means they can access health services for free or at low cost, including preventive services – like annual check-ups, dental care, and medication.

There are two populations impacted by SB104:

- New Enrollee Population which consists of individuals ages 19-25 who are eligible for Medi-Cal, do not have satisfactory immigration status for full scope Medi-Cal and are not yet enrolled in Medi-Cal.
- Transition Population consists of individuals 19-25 currently enrolled in restricted scope Medi-Cal. The Transition population also includes beneficiaries receiving full scope Medi-Cal under SB75.

As of December 1, 2019, there are 17,153 L.A. Care Medi-Cal members under the age of 19 who are currently active that have been determined eligible for full scope Medi-Cal under SB75. This includes both MCLA and the Plan Partners. MCLA comprises 8,050 (47%) of the SB75 membership, while the Plan Partners comprising a combined 53% of total Medi-Cal SB75 membership. The breakdown of SB75 membership is as follows:

Plan Partner	Number of Active SB75 Members	Percent of Total
Blue Shield of California Health Plan	3,793	22%
Anthem Blue Cross	3,607	21%
Kaiser Permanente	1,703	10%
MCLA	8,050	47%
Total	17,153	100%

L.A. Care Covered™ (On-Exchange-LACC)

Under the health care reform, L.A. Care Health Plan has proudly participated with Covered California to offer affordable health care coverage for residents of Los Angeles County, known as L.A. Care Covered™. This product line was launched on October 1, 2013 with a focus on serving diverse and low-income communities in Los Angeles County. The health care reform law also assists individuals/family pay the monthly premiums through the Covered California application process. Individuals/families may be eligible/qualify to receive federal premium assistance through the Advanced Premium Tax Credit (APTC) if their income is at or below 400% of the Federal Poverty Line (FPL). Starting in 2020, individuals whose income is at or below 600% and above 200% of the FPL, may qualify for the California Premium Subsidy (CAPS) in addition to any federal APTC for which they qualify. Moreover, individuals whose income is less than 250% of the FPL also qualify for special Cost Share Reduction (CSR) plans that reduce the out of pocket cost for receiving services.

As of the end of December 2019, L.A. Care Covered™ membership was 76,222. The Open Enrollment period for Covered California opens in the fall each year for coverage the following year. Individuals/families who experience an unexpected life event, such as losing a job, may apply for coverage throughout the year during the Special Enrollment period.

L.A. Care's contract with Covered California includes a multi-year Quality Improvement Strategy (QIS), which includes the following components:

- Provider networks based on quality
- Promoting provider quality performance and ongoing quality improvement
- Access to Centers of Excellence
- Hospital quality and safety
- Appropriate use of C-sections
- Reducing health disparities
- Promoting the development and use of care models in primary care
- Promoting the development and use of care models: Integrated Healthcare Models
- Patient-centered information and communication
- Patient-centered information: cost transparency

L.A. Care Covered Direct™ (Off-Exchange-LACCD)

On March 1, 2015, a product line operated entirely by L.A. Care Health Plan was launched, known as L.A. Care Covered Direct™. L.A. Care Covered Direct™ offers affordable health coverage to residents of Los Angeles County with a focus on serving diverse and low-income communities. Those who do not qualify for financial assistance or prefer to purchase health coverage directly with L.A. Care Health Plan can choose coverage under L.A. Care Covered Direct™. As of the end of December 2019, L.A. Care Covered Direct™ membership was 95.

PASC-SEIU Plan

The PASC-SEIU Homecare Workers Health Care Plan (PASC-SEIU Plan) transitioned from Community Health Plan (CHP) to L.A. Care in February 2012. The Personal Assistance Services Council (PASC) and the Service Employees International Union (SEIU) developed the plan for

In-Home Supportive Services (IHSS) Workers. PASC is the employer of record and contracts with L.A. Care Health Plan to provide member services, claims processing, COBRA/Cal-COBRA billing, and other health plan services. L.A. Care contracts with the L.A. County Department of Health Services and Citrus Valley Physicians Group, which comprise the PASC-SEIU Plan network. Effective January 1, 2014, L.A. Care updated its internal systems and processes to identify the product as the PASC-SEIU Plan, instead of the IHSS Plan, to avoid confusion with the IHSS benefit under Medi-Cal/Long-Term Services and Supports. As of the end of December 2019, PASC-SEIU membership was 51,091.

Cal MediConnect

L.A. Care Cal MediConnect (CMC) was launched in April 2014 and currently has approximately 16,000 dual eligible members enrolled into the plan. L.A. Care is the largest Medicare-Medicaid Plan (MMP) in Los Angeles County. Dual Eligibles are not required to join Cal MediConnect Plans in California. L.A. Care currently provides Medi-Cal services to over 100,000 dual eligibles outside of Cal MediConnect who have chosen to obtain their Medicare services elsewhere. The objective of Medicare-Medicaid Plans is to deliver a fully integrated and coordinated system of care to those with complex care needs and to coordinated more home and community based services outside of the institutional care model. Cal MediConnect was initially set up as a three-year demonstration, which was renewed through December 2022. Dual Eligibles are diverse demographically and have a wide variety of health care needs.

Medicare-Medicaid plans are contractually required to follow a specific Model of Care framework.

All of the core model of care elements follow specific timeframe requirement and documentation which need to be reported and are subject to Medicare and Medicaid audit.

Please note as of September 11th, 2017, Medicare-Medicaid Plans (MMPs) are no longer required to submit a MOC to CMS or the State.

Medicare Operations conducts a review annually and updates the document to reflect new guidance to ensure the document is an accurate portrayal of the current CMC population and program. The most impactful change is the revised Health Risk Assessment, which now contains four quadrants: 1) Social, 2) Medical Chronic and Acute Conditions, 3) Functional Capacity, and 4) Behavioral Health.

The key components of the Cal MediConnect program, including Interdisciplinary Care Team (ICT), Health Risk Assessment (HRA), and Individualized Care Plan (ICP). Medicare Product, Clinical Assurance, and Care Management, working collaboratively, identify and monitor the most vulnerable members of the population by implementing the model of care program which includes the quality improvement activities designed for these individuals. The program includes a description of how L.A. Care evaluates the effectiveness of its model of care program including methodology and specific performance outcomes that demonstrate improvements. L.A. Care maintains documentation on the evaluation and makes it available to CMS as requested and during onsite audits. The Care Management department determines what actions to take based on the results of the model of care evaluation.

Conceptual Framework

The conceptual framework for the QI Program aligns with the National Quality Strategy. The National Quality Strategy presents three aims originally by the Institute for Healthcare Improvement (IHI) for the health care system, known as the Triple Aim. As a partner with CMS and the state of California on numerous programs, L.A. Care aligns its quality program and initiatives with the Triple Aim. The Triple Aim is used as a guiding principle to align local, state and national quality improvement efforts. The Triple Aim is defined as:



Better Care - Population Health Management (PHM) is a model of care that addresses individuals' health needs at all points along the continuum of care, including in the community setting, through participation, engagement and targeted interventions for a defined population. The goal of PHM is to maintain or improve the physical and psychosocial well-being of individuals and address health disparities through cost effective and tailored health solutions.

Improve Health - Improve overall satisfaction with care and services through safe, effective and accessible patient-centered delivery.

Lower Cost - Reduce the cost of quality health care for individuals, families, employers, and government. ^[1] Furthermore, in order to achieve these aims, L.A. Care established four priority strategic directions, to help focus efforts. Those are:

- 1) High Performing Enterprise
- 2) High Quality Network
- 3) Member-Centric
- 4) Health Leader

^[1] (<http://www.healthcare.gov/news/factsheets/2012/04/national-quality-strategy04302012a.html>)

The Quality Improvement (QI) and Population Health Management (PHM) Programs are related in terms of operation and oversight, as both programs fall under the QI department. Additionally, the PHM program is a part of the QI Program Structure. L.A. Care's QI department maintains and executes a QI annual work plan that reflects ongoing activities throughout the year. The work plan is reviewed and updated by the appropriate business units quarterly. The work plan tracks active interventions and programs using metrics, such as HEDIS and program goals, these are also used for the Population Health Management program to address members' needs most appropriately. The QI Annual Evaluation is used as part of the PHM Annual Impact report.

GOALS AND OBJECTIVES

The L.A. Care Quality Improvement Program, consistent with the L.A. Care mission, strives to improve quality of clinical care, safety of clinical care, quality of service, and member experience through the following goals and objectives:

Goal – Improve Quality of Care:

Improve and maintain the quality of care and service in the aim of the health and wellness of all L.A. Care members including those with complex health needs, such as, the Seniors and Persons with Disabilities (SPD) population.

Objectives:

- Improve health outcomes
- Improve health equity
- Address social determinants of health
- Improve access to high quality care for all covered lives
- Improve NCQA accreditation rating
- Improve or maintain HEDIS scores per work plan targets.
- Improve Medicare Star ratings. (although not publically reported L.A. Care will track performance).
- Improve provider encounter data reporting.
- Improve our provider network data quality and adequacy.
- Utilize a multi-disciplinary approach to assess, monitor and improve our policies and procedures.
- Promoting physician involvement in our Quality Improvement Program and activities.
- Meet the changing standards of practice of the healthcare industry and adhere to all state and federal laws and regulations.
- Ensure there is a separation between medical and financial decision making.
- Seek out and identify opportunities to improve the quality of care and services provided to our members and practitioners.
- Confirm that the quality improvement structure and processes are maintained by L.A. Care to comply with provisions of the L.A. Care Quality Improvement Program and meet state, federal, NCQA and other applicable professionally recognized standards.
- Coordinate relevant sources of information available to L.A. Care including quality of care performance review (e.g. QI activities reports, utilization management, member services, pharmacy, and other data).

- Collect and analyze data related to the goals and objectives and establish performance goals to monitor improvement including but not limited to Managed Long-Term Services and Supports (MLTSS).
- Identify opportunities for process improvement within L.A. Care, its delegates and contracted entities to drive patient-centric quality care and service by utilizing performance data to drive the QI process. Implement, monitor and evaluate interventions to ensure members receive the highest quality healthcare available.
- Communicate the quality improvement process to practitioners/providers and members through appropriate persons and venues (e.g. meetings, print media, electronic media, and L.A. Care's website).
- Evaluate the Quality Improvement Program annually and modify the program as necessary to improve program effectiveness.
- Develop, monitor and operationalize a QI work plan that addresses quality and safety of clinical care and service, program scope, yearly objectives, planned activities, timeframe for each activity, responsible staff, monitoring previously identified issues, and conducting an annual evaluation of the program.

Goal – Monitor and Improve Patient Safety:

Promote, monitor, evaluate and improve quality healthcare services through a system of collaboration between L.A. Care and its providers and practitioners by promoting processes that ensure timely, safe, effective, medically necessary, and appropriate care is available. In addition, L.A. Care monitors whether the provision and utilization of services meets professionally recognized standards of practice.

Objectives:

- Identify, monitor, and address known or potential quality of care issues (PQIs) and trends that affect the health care and safety of members and implement corrective action plans as needed.
- Ensure that mechanisms are in place to support and facilitate continuity of care and transition of care within the health care network and to review the effectiveness of such mechanisms.
- Establish, maintain, and enforce a policy regarding peer review activities including conflict of interest policy.
- Through credentialing, recredentialing and ongoing monitoring, promptly identify and address any issues with network providers that may impact patient safety for our covered population.
- Establish standards of medical and behavioral health care (as required by product line) which reflect current medical literature and national benchmarks; design and implement strategies to improve compliance; and develop objective criteria and processes to evaluate and continually monitor performance and adherence to the clinical and preventive health guidelines.
- Conduct facility review and medical record review to focus on the capacity of each provider site to ensure and support the safe and effective provision of clinical service.
- Foster a supportive environment to assist practitioners and providers to improve safety within their practices (e.g., member education information specific to clinical safety related to overuse of antibiotics or provider notifications of polypharmacy, etc.)

- Monitor tracking and reporting of critical incidents impacting patient safety from downstream entities and vendors.
- Identify and monitor patient safety measures for in-network hospitals and collaborate with other payers and stakeholders to help them achieve minimal performance targets.
- Monitor Provider Preventable Reportable Conditions to promptly identify potential issue with risk for or evidence of adverse health outcome and implement corrective action plans as needed.
- Track low-risk NTSV C-Section rates for in-network maternity hospitals and collaborate with other payers and stakeholders such as the California Maternal Quality Care Collaborative (CMQCC) and California Health Care Foundation (CHCF) to help them meet or exceed the national goal of 23.9%

Goal – Improve Member Satisfaction:

Improve member satisfaction with the care and services provided by L.A. Care’s network of providers and identify potential areas for improvement through review of multiple sources of data including evaluation of member grievances, and appeals as well as data collected from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys and CG-CAHPS.

Objectives:

- Improve overall rating of the health plan on the CAHPS surveys and prioritize areas that impact rating of the health plan.
- Identify key drivers that affect CAHPS scores of the health plan.
- Collaborate with other departments, such as the Customer Solution Center to implement company-wide initiatives to provide exemplary service to our members and providers.
- Share the Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG CAHPS) data with provider groups, instruct them how to interpret the results and promote member experience interventions and best practices among Participating Physician Groups (PPGs), Management Services Organizations (MSOs) and physician practices/clinics.
- Periodic review of key service-related reports from both the health plan and delegated entities (e.g., Customer Solutions Center, Pharmacy Benefit Manager (PBM), Behavioral Health and Nurse Advice Line service reports) to identify opportunities to improve service and customer satisfaction.
- Leverage Appeals and Grievances data to gain insight into the drivers of member dissatisfaction and develop interventions to address these concerns in collaboration with vendors and delegated entities.
- Identify key areas for improvement, develop and monitor interventions based on the findings in the key service-related reports. Monitor results of the interventions.
- Ensure that the provision of healthcare services is accessible and available in order to meet the needs of our members.
- Work with provider groups to improve overall members access to care during and after hours.

Goal – Provide Culturally and Linguistically Appropriate Services:

Ensure medically necessary covered services are available and accessible to members regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status,

sexual orientation, gender identity, health status, physical or mental disability, or identification with any other persons or groups defined in Penal Code 422.56, and that all Covered Services are provided in a culturally and linguistically appropriate manner by qualified, competent practitioners and providers committed to L.A. Care's mission. Promote health education and disease management that is age-defined, culturally and linguistically appropriate, condition-specific, and designed to promote life-long wellness by encouraging and empowering the member to adopt and maintain optimal health behaviors.

Objectives:

- Analyze existence of significant health care disparities in clinical areas.
- Assess the cultural, ethnic and linguistic needs of member.
- Identify and reduce specific health care disparities.
- Promote preventive health, health awareness programs, education programs, patient safety, health care disparities, and cultural and linguistic programs that complement quality improvement interventions.
- Provide culturally appropriate health education services in order to enhance members' health status.
- Ensure the availability and accessibility of cultural and linguistic services such as 24/7 interpreting services including American Sign Language (ASL) as well as materials translated and in alternative formats.
- Conduct member focused interventions with culturally competent outreach materials that focus on race/ethnicity/language specific risk.
- Maintain Multicultural Healthcare Distinction Certification.

Goal – Improve the Delivery of Care for Persons with Complex Health Care Needs:

Ensure the delivery and coordination of care of members with complex health needs through case management, complex case management, and effective coordination with services that are linked or carved out, such as, the Regional Centers (Disabilities) and the Department of Mental Health (DMH) and Department of Public Health (DPH).

Objectives:

- Incorporate Population Health Management Model into policies and procedures and workflows.
- Provide case management to those with complex health care needs, such as Seniors and Persons with Disabilities.
- Improve access to primary and specialty care ensuring that members with complex health conditions receive appropriate service. This will be ensured through audits, medical record reviews, and other oversight activities.
- Identify and reduce barriers to services for members with complex conditions.
- Sponsor the delivery of educational information to practitioners to enhance the diagnosis and treatment of medical/health conditions, those with Complex Health Care Needs.
- Address and resolve patient-specific issues including those with complex health needs.

Goal – Provide a Network of High Quality Providers and Practitioners:

Maintain a well-credentialed network of providers and practitioners based on recognized and mandated credentialing standards and cultural/linguistic needs of members. Provide continuous

quality improvement oversight to the provision of health care within the L.A. Care system network by monitoring and documenting the performance of L.A. Care's contracted network through facility site reviews, medical record reviews, HEDIS scores, and other focused studies.

Objectives:

- Establish and maintain policies, procedures, criteria, and standards for the credentialing and recredentialing and ongoing monitoring of plan practitioners and organizational providers.
- Educate practitioners regarding L.A. Care's performance expectations and provide feedback about compliance with those expectations.
- Monitor and document the performance of network practitioners in providing access and availability to quality care through the use of health-related indicators, member satisfaction surveys, provider satisfaction surveys, access and availability surveys, focused studies, facility inspections, medical record audits, and analysis of administrative data (e.g., grievance and appeals data).
- Incorporate NCQA Network Management Standards into policies and procedures and workflows regarding Access and Availability of providers and services.
- Collaborate with other key external stakeholders to assess hospital quality and performance measures and establish expectations for continued network participation.
- Systematically collecting, screening, identifying, evaluating and measuring information about the quality and appropriateness of clinical care and provide feedback to IPA/PMG's and Practitioners about their performance and also the network-wide performance.
- Objectively and regularly evaluating professional practices and performance on a proactive, concurrent and retrospective basis through Credentialing and peer review.

Goal – Monitor and Improve Behavioral Healthcare:

Monitor and improve behavioral healthcare and coordination between medical and behavioral health care.

Objectives:

- Collaborate with behavioral health practitioners and entities to ensure appropriate utilization of behavioral health services and continuity and coordination of medical and behavioral healthcare.
- Improve communication (exchange of information) between primary care practitioners and behavioral health practitioners.
- Monitor appropriate use and monitoring of psychopharmacological medications.
- Manage treatment access and follow-up for members with coexisting medical and behavioral conditions.
- Promote routine depression screenings are completed and appropriate follow-up is made for adolescent and adult members with chronic health conditions and for women during pregnancy and the postpartum period. and
- Link members to treatment when Substance Use Disorders are identified.

Goal – Meet Regulatory and Other Health Plan Requirements:

Consistently meet quality standards as required by contract, regulatory agencies, recognized care guidelines, industry and community standards, and this Quality Improvement Program.

Objectives:

- Monitor L.A. Care and network compliance with the contractual and regulatory requirements of appropriate state and federal agencies and other professional recognized standards, such as, NCQA.
- Maintain grievance and appeal procedures and mechanisms and assure that members can achieve resolution to problems or perceived problems relating to access or other quality issues.
- Establish, maintain, and enforce confidentiality policies and procedures for protection of confidential member, practitioner, and provider information in accordance with applicable state and federal regulations.
- Protect member identifiable health information by ensuring members' protected health information (PHI) is only released in accordance with federal, state, and all other regulatory agencies.
- L.A. Care does not exert economic pressure to cause institutions to grant privileges to providers that would not otherwise be granted, nor to pressure providers or institutions to render care beyond the scope of their training or experience.
- Assure compliance with the requirements of accrediting and regulatory agencies, including but not limited to, DHCS, DMHC, CMS, NCQA and Covered California.

Goal – Monitor Quality of Care in Long Term Care Nursing Facilities and Community-Based Adult Services (CBAS) Facilities

L.A. Care monitors its contracted Long Term Care (LTC) Nursing Facilities and Community-Based Adult Services (CBAS) Facilities to ensure quality and coordination of long term care services for members.

Objectives:

- Review state regulatory oversight of LTC and CBAS facilities and develop and maintain a process to identify and address quality issues through the credentialing, recredentialing and ongoing monitoring process.
- Review existing LTC Nursing Facility quality indicators and standards and establish how these can be leveraged in the credentialing, recredentialing and ongoing monitoring process.
- Maximize member referrals for appropriate MLTSS programs from provider groups and internal care management processes. In addition to new referrals, this includes expansion of existing MLTSS members to help maintain functional status and social skills such as non-severely impaired members receiving IHSS who may also benefit from CBAS or more impaired members age 65 years or older who may benefit from MSSP.
- Through LTC placement referrals and review of higher functioning existing LTC members, identify those who can remain or return to a community-based residence with appropriate support services.

Goal – Provide an Evidence Based Model of Care:

L.A. Care must implement an evidence-based Model of Care and evaluate the effectiveness of the care management process, which includes the quality improvement activities designed for these individuals that have measurable outcomes

Objectives:

- Improve access to essential services such as medical, mental health and social services
- Improve access to affordable care
- Assuring appropriate utilization of services
- Improve coordination of care through an identified point of contact
- Improve seamless transition of care across healthcare setting, providers, and health services
- Improve access to preventive health services
- Improve beneficiary health outcomes.

AUTHORITY AND ACCOUNTABILITY

The Board of Governors (BoG) has ultimate accountability for L.A. Care's Quality Improvement Program. The Board of Governors approves the QI Program Description. L.A. Care Health Plan's BOG consists of thirteen stakeholder members. As a public entity, all meetings of the BoG and its subcommittees are subject to Brown Act (California's Open Meeting Law). Officers are elected annually. The BOG members represent the following Los Angeles County stakeholder groups including but not limited to Free and Community Clinics, Private Disproportionate Share Hospitals (DSH), Federally Qualified Health Centers (FQHC), Los Angeles County (Department of Health Services, Board of Supervisors), Children's Health Care Providers, Private Non-Disproportionate Share Hospitals, L.A. Care Member Advocates, L.A. Care Members and Physicians (L.A. County Medical Association). The Board nominates one additional member with health care expertise. All BOG members are appointed by the Los Angeles County Board of Supervisors. The Board has delegated oversight of the QI Program to the Compliance and Quality Committee (C&QC), a subcommittee of the Board.

The Compliance and Quality Committee (C&Q) has final approval of the QI Program Description, Work Plan, and the Quality Improvement Annual Evaluation annually. The C&Q monitors all quality activities and reports its findings to the BOG. The Chief Compliance Officer, Chief Medical Officer and designated Quality leaders provide regular reports to the C&Q from the Quality Oversight Committee. Discussions, conclusions, recommendations, and approval of these reports are maintained in the minutes of the C&Q and BoG meetings.

Meeting Schedule

The BoG has scheduled ten meetings per year. All draft meeting agendas are publicly posted 72 hours prior to the meeting. A final agenda is approved at the time of the meeting.

ORGANIZATIONAL STRUCTURE

L.A. Care continues to operate under a matrix-management model, which designates Executive Directors by product line/population segments and Chief Officers over specific business units. The leadership team works together to align business processes to foster accountability internally and externally; eliminate duplication of functions; clarify communication with internal and external stakeholders; and add new functions in internal auditing, enterprise risk assessment, and single source for data management and analytics.



Chief Operating Officer

The Chief Operating Officer (COO) is a senior member of the executive management team and reports directly to the Chief Executive Officer (CEO). The COO is responsible for the overall operational and administrative performance of enterprise functions. This position has organizational-wide responsibility to ensure a well-run and administratively capable organization. Reporting to the position are the departments and functions that are focused on core health plan operations, such as membership services, human resources, information technology, claims, and provider network. The COO works closely with Product Line Executives and provides services and advice to ensure proper functioning of the product lines and achievement of strategic goals.

Chief Financial Officer

The Chief Financial Officer (CFO) is a senior member of the executive management team and reports directly to the Chief Executive Officer (CEO). The CFO is responsible for all areas of accounting, finance, treasury, budgeting, revenue management & provider reimbursement, financial risk management, financial compliance/audit, materials procurement and fixed asset management. Provide financial leadership and advice, both strategic and tactical financial perspectives, to the Board of Governors & L.A. Care senior management as it relates to financial performance and the interpretation of key financial information to enhance the overall effectiveness of the management decision making process. Develop, enhance, and enforce policies and procedures that will improve the overall operation and effectiveness of L.A. Care's internal controls. The CFO will work closely with Product Line Executives and provide services and advice to ensure proper functioning of the product lines and achievement of strategic goals.

Chief Product Officer

The Chief Product Officer (CPO) owns the product strategy: to ensure product integrity, drive financial sustainability and deliver service excellence. The CPO leads the product teams and works across the matrix organization to continuously evaluate product performance and our portfolio of products, service and program offerings to identify current and/or future opportunities that further evolve and improve product line performance and achieve growth and retention. The CPO is expected to drive top and bottom-line growth through understanding market needs, the

competitive landscape and the needs of varying consumer segments. This position drives efforts to meet and exceed consumer expectations for the end to end member experience across all lines of business at L.A. Care Health Plan. Lines of business include Medi-Cal (MCLA), Plan Partners, Cal MediConnect (CMC), L.A. Care Covered (LACC), L.A. Care Covered Direct (LACCD), and Personal Assistance Services Council (PASC-SEIU) Home Care Workers Health Care Plan and where applicable, all segments within each product line. The CPO oversees the development of the sales/marketing strategy and product positioning to ensure L.A. Care product lines represent the face of our brand which is a key component of the customer experience and organizational innovation.

Chief of Enterprise Integration

The Chief of Enterprise Integration is an advisory role to the CEO, focusing on data management and analytics, process improvement, risk management, and network strategy. The Chief of Enterprise Integration reports directly to the Chief Executive Officer. In addition, the Chief of Enterprise Integration collaborates with business stakeholders and IT. The Chief of Enterprise Integration contributes to the overall process improvement program, which supports L.A. Care's strategic goals and coordinates and evaluates continuous business process improvement initiatives. Coordinates organization-wide efforts to ensure that performance management and quality programs are developed and managed using a data-driven focus that sets priorities for improvements aligned to ongoing strategic imperatives. Develops standardized procedures for identifying, assessing, and addressing operational needs that enhance core functions and facilitate growth objectives. Designs processes to standardize provider recruiting, contracting, and communications by documenting operational issues and gaps and developing remediation/risk mitigation proposals for review and approval by leadership.

General Counsel

The General Counsel provides or arranges for the provision of legal services for the organization.

Executive Director Medi-Cal Plan Partners

The Executive Director of Medi-Cal Plan Partners will take specific responsibility for delivering top line revenues, net operating results and outstanding compliance and quality score results for a population segment product of the L.A. Care portfolio. The Executive Director is responsible for strategically evaluating, planning and leading complex business initiatives that support the strategic goals of a population segment product. The Executive Director is responsible for the quality, compliance and operational performance of L.A. Care's Medi-Cal subcontracted health plans: Anthem Blue Cross, Care 1st, and Kaiser. In addition, L.A. Care operates a Medi-Cal direct line of business, L.A. Care Medi-Cal. The program serves multiple member demographics and cultures throughout Los Angeles County.

Executive Director Medi-Cal

The Executive Director Medi-Cal will take specific responsibility for delivering top line revenues, net operating results and outstanding compliance and quality score results for a population segment product of the L.A. Care portfolio. The Executive Director is responsible for strategically

evaluating, planning and leading complex business initiatives that support the strategic goals of a population segment product.

The Executive Director is responsible for the quality, compliance and operational performance of L.A. Care's Medi-Cal direct line of business, L.A. Care Medi-Cal. Members are provided health care and coordinated services through L.A. Care's contracted network of providers, hospitals, pharmacies and ancillary service providers throughout Los Angeles County. Membership includes children, families, seniors and people with disabilities.

Executive Director Cal MediConnect (CMC/CCI)

The Executive Director of Cal MediConnect/CCI will take specific responsibility for delivering top line revenues, net operating results and outstanding compliance and quality score results for a population segment product of the L.A. Care portfolio. The Executive Director is responsible for strategically evaluating, planning and leading complex business initiatives that support the strategic goals of a population segment product. The Executive Director is responsible for the quality, compliance and operational performance of L.A. Care's Cal MediConnect/CCI direct line of business, L.A. Care Cal MediConnect/CCI. The goal of Cal MediConnect/CCI is to establish a coordinated and seamless system that will improve health care and help members stay longer in the comfort and security of their own homes and communities. Program features voluntary enrollment by beneficiaries who are dually eligible for Medi-Cal and Medicare benefits. Members are provided health care and coordinated services through L.A. Care's contracted network of providers, hospitals, pharmacies, long term services and support and ancillary service providers throughout Los Angeles County.

Executive Director L.A. Care Covered (LACC) & PASC-SEIU

The Executive Director for L.A. Care Covered & PASC-SEIU will take specific responsibility for delivering top line revenues, net operating results and outstanding compliance and quality score results for a population segment product of the L.A. Care portfolio. The Executive Director is responsible for strategically evaluating, planning and leading complex business initiatives that support the strategic goals of a population segment product. The Executive Director will oversee the following products:

- 1) L.A. Care Covered: A Covered California health benefits exchange product. Membership is approximately 15K.
- 2) PASC-SEIU Homecare Workers Health Care Plan: Health coverage to Los Angeles County's In-Home Supportive Services (IHSS) workers, who provide in-home services such as meal preparation and personal care services to Medi-Cal beneficiaries. Membership is approximately 45K.

Senior Director, HITEC-LA (Executive)

The essential function of the Senior Director, HIT, is to fulfill L.A. Care's vision and mission to support the L.A. County practices and achieve innovation related to clinical and cost improvement. This senior management position has overall responsibility for planning and execution of strategies to improve L.A. Care clinician operations and L.A. County practices through 1) HIT innovations, 2) operational improvement programs and activities, and 3) grant funded programs. Significant focus is expected on practice and operational transformation. This position shall ensure that L.A.

Care develops and maintains critical strategic partnerships with federal and state government funders, local delivery organizations, and practices. The Senior Director will play a critical role in advising the L.A. Care leadership team on policy, programmatic, and operational issues affecting practices in L.A. County and government programs. The position will report to the Chief Medical Officer. The role will be responsible for directing the work of the HIT strategic program portfolio, including government funded grants/programs and L.A. Care initiatives.

QI PROGRAM PHYSICIAN LEADERSHIP

Chief Medical Officer

L.A. Care's Chief Medical Officer (CMO) is a physician, Board Certified in his or her primary care specialty, holding a current valid, unrestricted California Physician and Surgeon License. The CMO is an ex-officio member of the BoG and reports to the Chief Executive Officer (CEO). The CMO is the senior healthcare clinician and has the ultimate responsibility for the QI Program and assigns authority for aspects of the program to the Medical Director Quality Improvement.

- Ensuring that medical decisions are rendered by qualified medical personnel, unhindered by fiscal or administrative management.
- Ensuring that the medical care provided meets the community standards for acceptable medical care.
- Ensuring that medical protocols and rules of conduct for plan medical personnel are followed.
- Developing and implementing medical policy.
- Ensuring that the Quality Improvement and Utilization Management Departments interface appropriately to maximize opportunities for quality improvement activities.

Deputy Chief Medical Officer

The Deputy Chief Medical Director Officer reports to the Chief Medical Officer (CMO) for administrative and clinical issues and is responsible for management and implementation of delegated Health Services functions in L.A. Care and provides oversight/monitoring of Plan Partners and PPGs. The Deputy CMO provides executive medical leadership over delegated departments and functions at the discretion of the CMO which include Utilization Management, Care Management, Clinical Assurance, and Behavioral Health. This position may also lead special projects and chairs committees and task forces, as assigned by the CMO. In collaboration with the CMO, this individual will direct the overall clinical strategy and provide oversight to Health Services clinical initiatives, reporting, and outcomes measurement. This position will ensure implementation of the strategies, goals, and work plans designed by both him/herself and the CMO to enhance access and quality of healthcare for our members. This position will design and implement innovative projects to improve access and quality of care for L.A. Care members and safety-net providers. The Deputy CMO will represent the CMO internally and externally in his/her absence and to external constituents. The Deputy CMO will serve as lead spokesperson for L.A. Care on medical issues in the absence of the CMO.

Chief Quality and Information Executive

The Chief Quality and Information Executive (CQIE) works collaboratively with the CMO and is a key position on the Health Services team who oversees the Quality Improvement department

which includes four areas: Quality Performance Management, Facility Site Review, Quality Improvement, with Incentives, Initiatives, Accreditation, and Health Information Management. This role is responsible to improve and maintain excellent quality services for all members, including vulnerable populations. Implements strategy for the quality improvement function within the health plan, in collaboration with the administrative and clinical leaders of the organization. Must track and present results of improvement efforts and ongoing measures of clinical processes. Oversees regulatory readiness, quality measurement, and pay for performance programs and initiatives. Establishes improvement activities, including methods to track implementation of action plans following site surveys and critical events reviews. The individual must maintain current competency in quality regulations and standards. The role will lead and be responsible for the planning, implementation and optimization of clinical information systems (CIS) used in the organization. Will assist in developing the vision and plan for the adoption of the new digital solutions and analysis for clinical process improvement. Reports directly to L.A. Care's Chief Medical Officer (CMO). May lead Data Governance Committees, Clinical Advisory Groups, and serve as liaison to various departments in bridging best practices with CIS solutions.

Quality Improvement Medical Director

The L.A. Care Medical Director for Quality Improvement works collaboratively with the Chief Quality and Information Executive and is a key position on the Health Services team. Under the Quality Improvement umbrella are 6 main areas: Quality Performance Management (clinical quality rates and surveys), Disease Management, Quality Improvement (clinical and other interventions) Health Information Management, Performance and Incentives, and Accreditation & Oversight. The Medical Director will implement strategy for the quality improvement functions within the health plan, in collaboration with the administrative and clinical leaders of the organization. The Medical Director oversees the tracking and presentation of results of improvement efforts and ongoing measures of clinical processes; oversees regulatory readiness, quality measurement, and pay for performance programs and initiatives. The Medical Director is responsible for directing current network performance improvement programs and establish new improvement activities, including methods to track peer review, credentialing and provider performance improvement plans, site surveys and potential clinical quality and critical events reviews. The Medical Director must maintain current competency in provider quality regulations and standards. The Medical Director reports directly to L.A. Care's Chief Quality and Information Executive and next to the Chief Medical Officer. The Medical Director may lead and act as an advisor to Credentialing and Peer Review Committees, Clinical Advisory Groups, and serve as liaison to various provider focused departments such as Credentialing and Provider Network Management in establishing and maintaining best practice operations for provider quality.

Utilization Management (UM) Medical Director

The L.A. Care Medical Director for Utilization Management will assume a key medical leadership role in the organization. He/she is a physician, Board Certified in his or her primary care specialty, holding a valid, current, unrestricted California Physician and Surgeon License to practice medicine. The Medical Director is responsible for providing, overseeing the delivery and quality assurance of traditional utilization management (UM) services and resources, consisting of prior authorization, retro review, and concurrent review; oversight, support and relationship management with our delegated medical groups and planned partners (Anthem Blue Cross, Care 1st and Kaiser).

In this role, the Medical Director will provide clinical direction and oversight of both direct and delegated UM functions for high value care and consistent with regulatory requirements. This position will also provide leadership as L.A. Care begins to further develop and implement critical UM strategies around transitions of care and out-of-network/out-of area coordination. The Medical Director to oversee or provide leadership for programs such as the hospitalist program, SNFist program, and other service and resource utilization based programs. The Medical Director will report to the Senior Medical Director. This position will work collaboratively with all the Health Services departments including Quality Improvement, Behavioral Health, Pharmacy, Health Outcomes and Analysis and Long Term Services and Supports and Clinical Member Services as well as other key organizational stakeholders.

Medical Director Care Management Services

The Medical Director, Care Management Services will develop, manage, and implement L.A. Care's newly formed care management and coordination services program for our members.

The Medical Director will be responsible for the operational component of the care management division which includes program design, strategic planning, regulatory reporting, staffing and staff training. This position will work in concert with other divisions within Health Services as well as across L.A. Care, its contracted medical provider groups and delivery systems (i.e., Hospitals, providers etc.).

The position will also represent L.A. Care and interact with the County Health Agency's Departments of Health Services, Mental Health (DMH), Public Health/Substance Abuse Prevention & Control (SAPC), contracted organizations and providers, medical groups, and other stakeholders in a manner that promotes collaborative working relationships in improving the care management and coordination for our members. As part of the future vision of this role, we expect the Medical Director to provide leadership and develop models that will further integrate L.A. Care with the delivery system by supporting targeted populations through appropriate engagements to achieve better health and outcomes and be certified in NCQA Care Management and Disease Management Programs.

The Medical Director will report to the Senior Medical Director. This position will work collaboratively with all the Health Services departments including Utilization Management, Quality Improvement, Behavioral Health, Pharmacy, and Long Term Services and Supports and Clinical Member Services as well as other key organizational stakeholders like analytics and external stakeholders.

Behavioral Health & Social Services Medical Director

The Medical Director of Behavioral Health & Social Services is a physician, completed residency training in his or her specialty, holding a valid, unrestricted California Physician and Surgeon License. The Medical Director is responsible for the development of the Behavioral Health and Social Services division of Health Services. The position is also responsible for clinical oversight, case management, and management of the Behavioral Health and Social Service activities for all lines of business including substance use. The Medical Director participates in all the quality areas, including quality improvement programs, grievance and appeals, credentialing, and quality incentive programs for Behavioral Health and Social Services. The Medical Director is

responsible for overseeing behavioral health and social services participation in medical management and service coordination across the care continuum. The Medical Director will be the key liaison with L.A. County Departments of Mental Health and Public Health. This position will be responsible oversight and coordination of vendor services. This position is responsible for the overall clinical oversight and program development for Behavioral Health and Social Services Departments. As needed, this position will participate in federal, state, and as well as foundation-funded projects focused on the improvement of population-wide behavioral health and social determinants of health. The Medical Director reports to the Deputy Chief Medical Officer.

Chief Pharmacy Officer

The Chief Pharmacy Officer is directly responsible on all business aspects related to Pharmacy Operations and significantly contribute to the strategic direction of the organization by integrating pharmaceutical care delivery with medical care and operational delivery strategy. The Chief Pharmacy Officer is responsible in providing pharmacy business and clinical forecast assessments to contribute to good decision making on the strategic direction of the organization to achieve its positive outcomes. This position is responsible for developing and enforcing all policies & procedures in regards to the pharmacy operations. The responsibility will include oversight of regulatory/compliance, plan partners' related operations, related Operations of Subcontracted Plans in the Duals Pilot Project, Pharmacy Benefit Management (PBM) functions and performance, clinical pharmacy service operations for direct lines of business, and vendor service agreements/RFPs. The Chief Pharmacy Officer will interface with external agencies including other Local Initiatives, Plan Partners, Subcontracted Plans, Medical Groups, regulators and other external organizations. The Chief Pharmacy Officer must ensure all pharmacy functions are operating in accordance with the organization's mission, values and strategic goals and are provided in a manner that is responsive and sensitive to the needs of L.A. Care's culturally diverse membership.

Chief Compliance Officer

The Chief Compliance Officer ensures that L.A. Care meets all state contract requirements, while providing oversight for the delivery of health care services via subcontracts with the extensive provider network. Chief Compliance Officer serves as a reference and coordinates the organization's activities to conform to federal and state statutes, regulations, policies and other contractual requirements as well as overall corporate compliance. Chief Compliance Officer also assists departments of L.A. Care in proactively addressing issues of compliance and maximizing effectiveness. The Chief Compliance Officer chairs the Internal Compliance Committee (ICC) and presents recommended actions to the Compliance & Quality Committee (C&QC) of the Board.

QI PROGRAM RESOURCES

The Quality Improvement/Accreditation Director and the Quality Improvement Manager have responsibility for implementation of the Quality Improvement Program and its day-to-day activities. The Quality Improvement (QI) Department has multidisciplinary staff to address all aspects of the department functions.

The QI Department works closely with other departments to achieve targeted outcomes and to facilitate and accomplish quality initiatives within the quality program. The QI Department works

closely with the Enterprise Data Strategy and Analytics Department and collaborates with areas such as, but not limited to: Utilization Management, Provider Network Management, Customer Solutions Center, Credentialing, Pharmacy and Formulary, Facility Site Review, and Health Education, Cultural and Linguistic Services, Behavioral Health, and Care Management to achieve outcome goals. In addition, Quality Improvement and Research Consultants are available to the program. A full organizational chart is attached to this program description (see attachment 1).

Senior Director Health Services

The Senior Director of Health Services reports to the Chief Medical Officer for administrative and operational issues. The Senior Director is responsible for planning and implementing strategies to improve culturally appropriate health care services for L.A. Care members. These strategies includes but not limited to: 1) use of multiple prong approach to educate PPGs and providers, 2) maintain systematic method to conduct oversight and ensure compliance with network providers, and 3) incorporate culturally appropriate resources to address health care needs of L.A. Care's diverse membership. The Senior Director of Health Services develops and maintains critical strategic partnerships with external stakeholders while advising leadership on policy, programmatic and operational issues effecting provider and member initiatives. The position reports directly to the Chief Medical Officer. The Senior Director of Health Services supervises Health Education Services, Cultural and Linguistic Services, Facility Site Review Department, Providing Continuing Education, and Health Services Training and Education Department.

Senior Director, Safety Net Initiatives

The essential function of the Senior Director, Safety Net Initiatives, is to fulfill L.A. Care's vision and mission to support the L.A. County safety net. This senior management position has overall responsibility for planning and execution of strategies to improve the publicly-operated delivery system, community clinics, and private DSH hospitals through 1) joint planning, 2) operational improvement programs and activities, and 3) cross-sector collaboration. Significant focus is expected on delivery system transformation in the L.A. County Department of Health Services and nonprofit Community Clinics. This position shall ensure that L.A. Care develops and maintains critical strategic partnerships with local safety net health care and social service care providers, to improve L.A. County's delivery system to better serve vulnerable members. The Senior Director will play a critical role in advising the L.A. Care leadership team on policy, programmatic, and operational issues affecting Los Angeles' safety net providers. The position will report to the Chief Medical Officer (CMO) with matrix responsibilities to the Chief Operating Officer (COO), Chief Financial Officer (CFO), and Product Executives. The role will be responsible for directing the work of the Safety Net Initiatives strategic project portfolio, including Department of Health Services (DHS) Support Services, Community Clinic Initiatives, and Program Development.

Senior Director, Medicare and Cal MediConnect Operations

The Senior Director of Medicare and Cal MediConnect Operations serves as a subject matter expert on federal rules and statues specific to Medicare. The Senior Director is responsible for developing and overseeing the implementation of a comprehensive business and operational plan that ensures a smooth transition of dual membership into managed care. The Senior Director will preserve and enhance high quality care while improving health outcomes and satisfaction with

care, coordination of care, and timely access to care. The Senior Director develops ensures seamless coordination of services for In-Home Support Services (IHSS), Community based Adult Services (CBAS), Long Term custodial care in nursing facilitates, and the Multipurpose Senior Services (MPSS) Program. The Senior Director develops and monitors tools and matrix to measure program success through select measures. The Senior Director reports to the Chief Operations Officer.

Senior Director, Medicare Performance Management

The Senior Director, Medicare Performance Management will be responsible in providing strategic direction, leadership and operational direction for quality improvement activities across the organization for L.A. Care's Medicare programs. This includes the Medicare Special Needs Plan for Dual Eligible (D-SNP) and the Medicare-Medicaid Financial Alignment Demonstration (FAD), Cal MediConnect.

The position is responsible for developing and overseeing implementation and execution of clinical and nonclinical HEIDS and Stars-related activities, including integration of Stars activities with HCC risk adjustment activities. Design, implement and execute strategies and work with cross-functional HEDIS and Stars improvement teams to ensure overall goals of the organization are met and to optimize outcomes. Lead cross-functional teams to develop, implement and manage reporting dashboard and ensure full compliance with NCQA and CMS requirements and guidelines. Lead efforts to respond effectively in this area to Duals Demonstration (Cal MediConnect) program and requirements as well. Opportunity to be innovative, strategic.

Senior Director, Medi-Cal

The Senior Director of Medi-Cal develops and leads the execution of the Medi-Cal Product Line segment strategic and tactical plan, regularly interfacing with key enterprise leaders and external stakeholders, advocates and community partners. The Senior Director understands the competitive landscape and overall member needs, delivery system, and regulatory/legislative environment impacting Medi-Cal. The Senior Director ensures the company infrastructure can support the product, continually working with the product team and internal stakeholder partners to retain and grow membership, maintain product integrity and provide service excellence. The Senior Director collaborates with the Executive Director to ensure intake and prioritization process is developed and implemented for multi-year team initiatives and business strategy. The Senior Director works to align individual team member goals with department and enterprise goals and assesses competencies, professional development and performance management according to Human Resources guidelines and requirements.

Senior Director Enterprise Shared Services

The Senior Director of Enterprise Shared Services provides leadership, planning and implementation, resource and budget management, vendor business process integration, and coordination of such activities across L.A. Care's entities, delegated provider entities and partner plans, and government agencies to align and develop business process and systems/technology capabilities (analysis, design, testing and problem/issue/risk resolution, and project management). These efforts seek to ensure enterprise-wide business functions/processes, policies and products can be effectively and efficiently administered and adapted via the Information Systems

infrastructure to meet the company's Operations/Service, Medical, and Provider goals, competitive position, and underlying strategic and tactical objectives affecting operating costs, member maintenance and retention, revenue, member and provider satisfaction and compliance with internal and governmental policies. The Senior Director works extensively with business areas and internal and external IT personnel to represent and define business needs. The Senior Director leads and directs technical activities impacting key operational performance metrics in California Medi-Cal, federal CMS, and county programs such as: quality, encounters, provider disputes, cycle time and efficiency rates of customer self-service rates, claims and enrollment processing, electronic submission rates, claim and enrollment first pass rates, claim cost program controls.

Senior Director Compliance (Internal Audit)

The Senior Director of Compliance (Internal Audit) serves as a senior leader within the Compliance Department. The Senior Compliance Director will manage the Internal Audit unit of the Compliance Department. The Senior Compliance Director will lead a department whose responsibilities include the planning, coordination and performance of an internal audit plan and related audits, including documentation of internal controls of L.A. Care's business operations. The Senior Compliance Director will develop and implement a program of internal controls and staff training regarding the internal control process. The Senior Compliance Director will prepare executive summaries and reports, develop and conduct training activities for subordinates, peers and L.A. Care business units and lead or participate in interdisciplinary teams. Although the Senior Compliance Director's primary responsibility is management of the Internal Audit unit, the Senior Compliance Director will also advise and support the Chief Compliance Officer on other duties as assigned to support the mission and responsibilities of the Compliance Department and to support the business operations of L.A. Care Health Plan.

Senior Director, Delegation Oversight

Reporting to the Chief Executive Officer (CEO), the Senior Director, Delegation Oversight is responsible for the development of centralized Delegation Oversight infrastructure to increase efficiency in the oversight of L.A. Care's contracted entities. This position will work closely with cross-functional executive leadership and is responsible for building and maintaining a new business unit with three verticals: Delegation Oversight Audit, Performance Monitoring and Oversight, and Account Management and Communications, housing a staff of 70+ employees. The new business unit is aimed at establishing clear visibility into the entire delegate landscape. This includes, but is not limited to, supporting L.A. Care's 2021 strategic initiative of building a high quality network by optimizing oversight of delegated functions, consolidate monitoring of services performed on its behalf, and standardize processes.

As a key part of leadership, this position must be a resourceful proactive individual who can anticipate problems and lend solutions leading to operational standardization and automation. The role calls for cross-collaboration across business units and stakeholders to assure that their expertise is leveraged and their perspectives are given due consideration to build an integrated, centralized operational unit.

This position will provide leadership, direction, and management on all aspects of the creation of the Delegation Oversight business unit by implementing a systematic and disciplined approach to

audit, oversight, monitoring, account management, and communications with delegated entities. This position will create a delegation oversight model that centralizes audit activities, streamlines account management and communication, and maintains a repository of complete and accurate performance data and manages risk to ensure delegated entities are performing in accordance with state, federal, National Committee for Quality Assurance (NCQA) and contractual requirements.

Director, Quality Improvement/Accreditation

The Director of Quality Improvement/Accreditation is responsible for the direction, implementation and oversight of L.A. Care Health Plan's Quality Improvement, Accreditation, and Chronic Care Improvement Programs. The position reports directly to the Quality Improvement Medical Director and/or the Chief Quality and Information Executive. The Director leads staff in the performance of health plan quality improvement activities, establishes and monitors quality improvement goals, organizes outcomes research, Directs Accreditation activities, and assures that L.A. Care meets CMS, DMHC, NCQA, and other regulatory agencies' standards for quality. The Director must be able to effectively present complex reports and findings to the appropriate committees and to the Compliance and Quality Committee of the Board and work well with others including community advocates and provider organizations.

The Quality Improvement/Accreditation Director interfaces with colleagues at other local initiative health plans statewide, with our sub-contracted health plan partners, provider groups, regulatory agencies and network providers to represent L.A. Care and lead statewide/local quality improvement projects. This position supervises the Quality Improvement Department, Quality Improvement Work Groups, Accreditation, Quality involvement in Access to Care, and any special projects as assigned by the Medical Director or the Chief Quality and Information Executive. Develops and Implements Interventions to improve performance on key Medi-Cal Measures. Works closely with Medicare Operations on Quality Improvement efforts for CMC, QIP, CCIP, Annual QI Program and Evaluation. Oversees Incentive team which runs portfolio of Provider Pay for Performance programs and Member Incentives.

Director, Care Management Services

The Director, Care Management (CM) Services is responsible for the delivery of Care Management Services to L.A. Care members with the main primary focus of setting and executing Care Management services, in close collaboration with the Deputy CMO, Medical Directors, the Clinical Operations Executive and other senior leaders. This role will have Director, Care Management positions reporting to it, who are responsible for their assigned programs and carrying out the overarching strategic goals of the Care Management department. The Director, CM Services will also work with the CM Medical Directors and Director, Care Management in designing, enhancing and implementing programs, and report on regulatory requirements.

One of the key initiatives is to increase L.A. Care's community CM presence. The Director, CM Services is also responsible for providing evidence of ongoing compliance with all regulatory and accreditation requirements (i.e. health risk assessments and interdisciplinary care plan and care team programs, population health management). This role is also responsible for outreaching and working with key stakeholders and provide subject matter expertise in support of the oversight, outreach and training of our Plan Partner Health Plans and Delegated Provider Groups.

Director, Population Health Informatics

The Director of Population Health Informatics provides strategic guidance and decision support to the organization in the areas of clinical health outcomes, health care utilization and cost effectiveness, quality of care, as well as provider and network performance. This includes leading the Health Services Analytics team on strategic analytics that include rigorous evaluation design, clinical and economic analysis, predictive modeling, and other innovative approaches to utilizing health plan data to identify strategic opportunities and optimize programming. The Director has administrative and decision-making responsibilities for the Health Information Management. The Director oversees a skilled staff, who are currently focused on efforts in clinical data reporting and analytics, data visualization and insights. The Director is responsible for managing the analysis of all core healthcare related data including encounters/claims, HL7 and other utilization data supporting key strategic programs including Population Health, Pay for Performance, Health Information Technology programs, Care Management, Utilization Management and special studies and projects. The Director leads and provides expertise in the development of clinical technical specifications for prototype reporting through reporting applications such as SAS, Oracle or SQL or programming in R or Python.

The Director reports to the Chief Quality and Information Officer, and advises the L.A. Care Health Services Leadership, including Quality Improvement, Utilization Management, Health Education and Cultural Linguistics, Pharmacy, and Safety Net Initiatives. The Director also serves as Health Services Informatics Subject Matter Expert to IT, Customer Solutions Center, and Provider Network Management on key findings from Population Health data, and other studies and data sets. Administrative responsibilities of the Director include budget planning, direct oversight of day to day operations, performance evaluation for the HIM staff, participation on committees, and management of vendors.

Director, Population Health Management

The Director of Population Health Management (PHM) reports to the Quality Improvement Medical Director for administrative and operational issues and works collaboratively with the Directors of Quality Improvement and Health Services to oversee Population Health Management. The Director is primarily responsible for leading the strategic and operational efforts for the organization in streamlining the population health management strategy by consolidating PHM-related elements into one category to improve clinical health outcomes, health care utilization, cost effectiveness, and quality care. Responsibilities include leading strategic analytics that include rigorous evaluation design, clinical and economic evaluation, and optimize programming, ensuring that PHM emphasizes the Triple Aim and addresses health at all points on the continuum of care, including the community setting through participation, engagement and targeted interventions for a defined population, and address disparities through a cost-effective and tailored health solutions. This role will establish the PHM strategy that focuses on the “whole person” and the member’s entire care journey, provide wellness services and intervene on the highest-risk members. The Director role is further responsible for assuring the PHM strategy is in accordance with the organization's mission, values and strategic goals and are provided in a manner that is responsive and sensitive to the needs of L.A. Care's culturally diverse membership.

Director, Quality Performance Management/HEDIS

The Director of Quality Performance Management is responsible for directing data and operations for HEDIS, CAHPS and related staff, including overseeing the Manager, Quality Performance Metrics, Program Manager, nurse abstractors, schedulers, and clerical staff. The Director is responsible for creating and optimizing procedures and policies relevant to the HEDIS and CAHPS process by managing a process management plan, setting time lines and overseeing the activities required to complete the HEDIS cycle. The Director takes a leadership role in activities related to the external NCQA HEDIS audit, quality control, project completion, and data submission. The Director oversees staff responsible for work flow functions, directs the HEDIS abstractors, creates strategies for medical record and electronic data procurement and scheduling, and develops training curricula. In addition to these responsibilities, the Director works with product evaluation, develops and manages the budget and accounts for variations, works with the legal advisor on contract review, interviews vendors who provide technical services, compliance auditors, and provider groups. The Director initiates and champions quality improvement projects and committee meetings related to overall HEDIS performance and presents these results to the provider network, plan partners and L.A. Care leadership.

Director, Utilization Management

The Director of Utilization Management is directly responsible for the planning, organization, direction, staffing and development of L.A. Care's Utilization Management function(s) including but not limited to Utilization Review, Care Transitions and Member Outreach. Responsibility includes regulatory compliance, accreditation compliance, oversight of Plan Partners' and Delegated Provider Groups related operations, oversight of utilization management/care management vendor's related delegated functions, operations for direct lines of business and/or management services agreement functions, and interfacing with external agencies including other Local Initiatives, Plan Partners and external organizations. The Director is further responsible to lead and direct the department to ensure all functions are operating in accordance with the organization's mission, values and strategic goals and are provided in a manner that is responsive and sensitive to the needs of L.A. Care's culturally diverse membership.

Director, Behavioral Health

The Director of the Behavioral Health serves on the Behavioral Health Management Team and reports to the Medical Director, Behavioral Health. This position is responsible for the oversight of clinical and operations functions within the department. The director serves as a behavioral health subject matter expert in internal meetings throughout L.A. Care and external meetings with varied partners and stakeholders. This position pursues positive outcomes in the areas of quality of care, service utilization, member and consumer affairs, network enhancement, and data management. The Director conducts strategic planning to utilize resources in order to meet current and future departmental, Health Services, and Enterprise-wide goals.

Director, Medi-Cal

The Director of Medi-Cal supports the development and leads the execution of the Medi-Cal product strategic and tactical plan, which focuses on delivering an excellent overall member experience, facilitating product-specific initiatives, and understanding the membership to monitor trends, identify needs, and close gaps. The Director regularly collaborates with key internal

leaders, external stakeholders, community partners. The Director understands the competitive landscape, overall needs of Medi-Cal members, the managed health care delivery system, and regulatory requirements impacting the Medi-Cal program. The Director ensures the organization infrastructure can support the product strategy while working with the product and internal stakeholder teams to retain and engage membership, maintain product integrity, ensure financial sustainability, maintain service level agreements, and deliver service excellence. The Director reports to the Executive Director of Medi-Cal to align the goals of product team members with department and enterprise goals while assessing competencies and monitoring performance according to Human Resources guidelines and requirements.

Director, Medicare Operations

The Director, Medicare Operations is responsible for supporting and leading the development and implementation of operational activities and planning for L.A. Care's Medicare products. The position is responsible for promoting the success of L.A. Care's Medicare/Integrated products and driving compliance. Importantly, the position oversees the development of a range of required activities and functions related to the daily operations of the Medicare products, including but not limited to bid and application development, benefit design and implementation, market analyses, and management of outside vendors and delegated entities. This position is responsible for managing annual Medicare product planning, developing and executing the process, overseeing the design and benefit implementation, regulating reporting, audit preparation of member/provider materials, review and communication of HPMS and other regulatory requirements. The position supervises staff of different levels, including pharmacy management, project management and with staff across business units to implement and operationalize the Medicare products

Program Director for Health Equity

The Program Director for Health Equity is responsible for the leadership, enterprise direction, planning, management, and evaluation of organizational health equity and social determinants of health initiatives/programs. Under the leadership and supervision of the QI Medical Director and in consultation with the CMO and other key stakeholders, the Program Director develops multi-year plan and executes priority initiatives to identify and address disparities in health and health care for L.A. Care members and communities. The Program Director also leads the implementation and evaluation of L.A. Care's Social Determinants of Health (SDoH) Initiative in collaboration with the Senior Director of Health Services and the Steering Committee. This position facilitates the Steering Committee meetings, creates and maintains an annual work plan, develops a centralized SDoH activity tracking system, facilitates coordination and integration of existing and future activities and processes, and is the thought leader for the strategic implementation of these efforts.

Director, Clinical Pharmacy

The Director of Clinical Pharmacy Services is directly responsible for all aspects related to Clinical Pharmacy Operations, which includes Formulary Management and Benefit Design, Pharmacy Appeals and Grievances and Clinical Pharmacy Programs. Responsibilities include the development and implementation of all policies & procedures related to Clinical Pharmacy operations and assisting in the management of the pharmacy health care spend. Other responsibilities include accountability for: strategic planning and leadership, regulatory

compliance of all lines of business, management of all Clinical Pharmacy related services and costs, oversight of operations of Subcontracted Plans in the Duals Pilot Project, management of the Pharmacy Benefit Management (PBM) functions and performance, pharmacy service operations for direct lines of business including MTM, specialty pharmacy, STAR performance and pharmacy related quality programs. The Director will interface with external agencies including regulators, other Local Initiatives, Plan Partners, Medical Groups and other external organizations. Must ensure all Clinical Pharmacy functions are operating in accordance with the organization's mission, values and strategic goals and are provided in a manner that is responsive and sensitive to the needs of L.A. Care's culturally diverse membership. The director also provides strategic support and leadership in the area of pharmaceutical management for the populations being served. Innovations in Clinical Pharmacy services is one of the expectations of the job and includes managing Specialty Pharmaceuticals. The director is also expected to provide support and leadership to the Utilization Management department, Quality Improvement department and other areas of the organization. This position is expected to foster collaboration with all departments of L.A. Care including but not limited to Finance, Medicare Operations, Utilization Management, Quality Improvement, Appeals and Grievances, Credentialing and Claims. Of note is the importance of improving the Medicare Pharmacy STAR ratings and collaboration with Health Outcomes and Analysis to achieve the improvements in STAR ratings.

Director, Pharmacy Compliance

The Director of Pharmacy Compliance ensures compliance with applicable federal, state and local laws and regulations, accreditation, licensure and contractual requirements and L.A. Care's policies and procedures. Expertise in Centers for Medicare and Medicaid Services (CMS), California Department of Managed Health Care (DMHC), California Department of Health Care Services (DHCS) and National Committee for Quality Assurance (NCQA) regulations is required. The position is responsible for conducting risk assessments, internal audits and reviews to ensure that L.A. Care's mission and values are maintained, the privacy and confidentiality of information is safeguarded and the assets of the organization are protected. Additional responsibilities include managing all external and internal audits to conclusion, which includes; oversee the gathering and preparing all requested documents, ensuring that all questionnaires are fully answered, samples are prepared for the auditor's review and leading the subject matter experts during the auditor interviews. The position is responsible in ensuring that all regulatory non-compliant findings are reported and resolved and corrective actions implemented in a timely manner. Additional responsibilities include the design of vendor oversight program, plan partner oversight program as well as the design of business processes, which have appropriate controls in place to ensure the accuracy of results that can be validated.

Director, Health Education Cultural and Linguistic Services

The Director, Health Education, Culture and Linguistic Services is directly responsible for the leadership, planning, organization, direction, management, staffing and development of L.A. Care's health education and culture and linguistic services program, including L.A. Care's for Kids, targeted health promotion interventions, and CME functions.

Director, Provider Contracting

The Director of Provider Contracting is responsible for developing, negotiating, and managing financially sound contracts with participating physician groups (PPGs), Management Service Organizations (MSOs), hospitals, ancillary providers, and other healthcare providers and maintain a comprehensive and compliant network of healthcare providers ensuring provision of covered services to L.A. Care's members. The Director leads the Provider Contracting Team and manages the daily functions of the provider contracting team including, but not limited to, hiring and training staff, and successfully implements contracting documents to include network-wide strategic, legislative, and operational changes, including but not limited to, contract administration, and identifies opportunities to support safety net providers. The Director also manages the use of various analytical resources and financial data to conduct and manage complex analyses, prepare and interpret impact reports and recommend contracting strategies and alternatives. The Director ensures alignment of L.A. Care's contracting strategies, provider development and outcomes management in a way that results in better quality and value.

Director, Safety Net Programs and Partnerships

The Director, Safety Net Programs and Partnerships, is responsible to lead and direct the department, which includes oversight of the Program Development and Community Clinic Initiatives units. This position provides direction and guidance to staff for the development, planning, and execution of strategic initiatives to support community clinic performance improvement, safety net health care delivery system transformation, and improved health outcomes for vulnerable populations. This position will be responsible for building relationships and fostering collaborative partnerships with external public and nonprofit stakeholders including: L.A. County Department of Health Care Services (DHS), Department of Mental Health (DMH), Department of Public Health (DPH), community clinics, homeless service providers, and criminal justice reentry providers. The Director will interface with state and regulatory agencies to develop mutually-beneficial approaches to develop and implement health system reform efforts. This position will work closely with L.A. Care Chief Operating Officer (COO), Chief Medical Officer (CMO), and leadership to align new programs and initiatives with L.A. Care strategic priorities and achieve the triple aim.

Director, Credentialing

The Credentialing Director oversees the operations and personnel in the Credentialing Department, Facility Site Review Department, and quality issues, including the planning and development of activities/procedures to ensure compliance with National Committee for Quality Assurance (NCQA), Department of Health Services (DHCS), Center for Medicare and Medicaid Services (CMS). The Director oversees delegated credentialing and facility site review to ensure compliance with state and federal regulatory standards and L.A. Care standards and ensures accuracy of practitioner data in internal databases and directories.

Director, Managed Long Term Services and Supports

The Director, Managed Long Term Services and Supports (MLTSS) program includes 1) In Home Supportive Services, 2) Community Based Adult Services, 3) Long Term Care, 4) Multipurpose Senior Services Program and 5) Care Plan Options as well as 6) managing the services with the skilled nursing care facility physician and team (SNFist) for our institutionalized long term care

members and 7) assisting with the transition of palliative care members from the hospital to community-based programs. The Director is directly responsible for the planning, organization, direction, staffing and development of L.A. Care's MLTSS unit functions including but not limited to all aspects of the interdisciplinary care team functions including Utilization Review, Care Management, Care Coordination, Care Transition, Social Work and member outreach and engagement in the plan of care. The Director oversees the transition of Medi-Cal Fee for Service programs into Medi-Cal Managed Care. The Director collaborates with providers to ensure member access and quality of care. The Director's responsibilities includes both state and federal regulatory compliance, accreditation compliance, oversight of Plan Partners and Delegated Provider Groups operations related to MLTSS, oversight of MLTSS vendor's related delegated functions, operations for direct lines of business and/or management services agreement functions and interfacing with external agencies including Local Initiatives, Plan Partners and external organizations. The Director of MLTSS is further responsible to assure all functions are operating in accordance with the organization's mission, values and strategic goals, as well as individual departmental goals, and are provided in a manner that is responsive and sensitive to the needs of L.A. Care's culturally diverse membership.

Director, Medicare Performance Management

This position is responsible for providing strategic direction and leadership for quality improvement activities across the organization for L.A. Care's Medicare program Cal MediConnect. The Director's projects include, but are not limited to implementing and providing oversight over quality management functions specific to the Medicare lines of business to ensure that activities are aligned with overall strategic direction and appropriately coordinated with Medi-Cal quality management functions, assure ongoing operational compliance with state and federal quality improvement/assurance requirements (i.e., CMS QIP, CCIP requirements, Chapter 5, etc.) and provide direction and support to other L.A. Care staff in the development and execution of activities related to Medicare quality. These activities include provider or other training programs, development of member and/or provider educational and information materials. The Director reports to the Senior Director, Medicare Programs, but works closely with the Chief Medical Officer and Utilization Management staff.

Director, Appeals and Grievances

The Appeals and Grievances Director is responsible for the strategic Management and Oversight of the Appeals and Grievances Department. The Director oversees the resolution of member appeals and grievances for all product lines, including State Fair Hearings in a manner consistent with regulatory requirements from the Department of Managed Health Care, Department of Health Care Services, Centers for Medicare and Medicaid Services, as well as requirements from the National Committee on Quality Assurance (NCQA) and L.A. Care policies and procedures, ensuring the proper handling of member and provider complaints whether presented by members, their authorized representative, the Ombudsman office, state contractors, member advocates, L.A. Care Board Members, providers, etc. The Director reports to the Executive Director of Health Services.

Director, Social Services

The Director, Social Services will be a key component in designing and developing a new Social Work Department for L.A. Care as part of the Clinical Member Services segment of Health Services to meet the demand of our new organization restructured matrix. Will provide oversight of Social Workers and Social Work services provided to L.A. Care members, including member assessment, case management, counseling and referral. The Director, Social Services provides day-to-day oversight of Social Workers and Social Work activities, including review and care planning process, coordination of services, and provision of appropriate member referrals to providers and community resources. The Director, Social Services serves as a liaison between L.A. Care Social Work Department and other community service providers. The Director, Social Services assures all department functions are operating in accordance with the organization's mission, values, and strategic goals, as well as individual department goals are provided in a manner that is responsive and sensitive to the needs of L.A. Care's culturally diverse membership.

Director, Department of Health Services Managed Care Support Services

The Director, Department of Health Services Managed Care Support Services is responsible to lead and provide oversight of the DHS Managed Care Support Services (DHS MCSS) Unit and the administration of the DHS Quality Improvement Program (QIP). This position provides direction and guidance to staff assigned to support DHS managed care transformation and performance improvement initiatives aimed at strengthening DHS' ability to comply with L.A. Care delegated functions. As the Director, this individual is responsible for (1) directing and managing a staff required to work collaboratively with L.A. County DHS staff to analyze and address a broad range of managed care operational issues and (2) oversee the timely execution of managed care operational solutions designed to streamline operational interfaces between L.A. Care Health Plan, L.A. County DHS Providers and the L.A. County DHS Managed Care Services Office. Additionally, the Director is responsible for building, nurturing and maintaining strong relationships and working partnerships with L.A. County DHS management staff. The Director serves as the primary L.A. Care management liaison to the DHS Managed Care Services management staff and work closely with the COO and CMO to align DHS initiatives with L.A. Care strategic priorities.

Director, Clinical Assurance and Delegation Support

The Director of Clinical Assurance and Delegation Support is directly responsible for the planning, organizing, directing, staffing and developing L.A. Care's Clinical Assurance Department. Responsibility includes, but is not limited to, regulatory compliance, accreditation compliance, oversight of L.A. Care' delegated network of Plan Partners, Participating Physician Groups and Specialty Health Plans related to Health Services and managing challenging clinical situations. The Director is also responsible to manage and oversee the preparation of the required health services responses, reports, policy and procedures to regulatory agencies. The Director is responsible to ensure all functions are operating in accordance with the organizations, mission, values and strategic goals and are provided in a manner that is responsive and sensitive to the needs of L.A. Care's culturally diverse membership.

Director, Regulatory Affairs

The Director of Regulatory Affairs serves as a leader within the Compliance Department. The Director will manage the following regulatory affairs functional responsibilities: (1) Regulatory reporting, key performance indicator analytics and monitoring; (2) relationship and complaint management with state and federal regulatory agencies; (3) management of all external regulatory audits; and (4) Compliance Committee and Board of Governors compliance reports, meetings and issue escalation. The Director will ensure that all external regulatory audits, regulatory reporting, monitoring and governance activities are conducted in accordance with Compliance Department policies and procedures and guidance from all applicable regulatory agencies. The Director will prepare executive summaries and reports, develop and conduct training activities for subordinates, peers and L.A. Care business units and lead or participate in interdisciplinary teams. Although the Director's primary responsibility is management of the Regulatory Audit Unit, the Director will also advise and support the Chief Compliance Officer on other duties as assigned to support the mission and responsibilities of the Compliance Department and to support the mission and business operations of L.A. Care Health Plan.

Manager, Quality Improvement Initiatives

The Manager of Quality Improvement Initiatives is an experienced healthcare professional responsible for overseeing activities of LA Care's Quality Improvement Programs. The position reports directly to the Director of Quality Improvement and Accreditation. The Manager manages the performance of health plan quality improvement activities, establishes and monitors quality improvement goals, organizes outcomes research, and assures that L.A. Care meets CMS, DMHC, NCQA and other regulatory agencies' standards for quality. The Manager interfaces with colleagues at other local initiative health plans statewide, with our sub-contracted health plan partners, provider groups, regulatory agencies and network providers to represent L.A. Care and lead statewide/local quality improvement projects. This position supervises the Quality Improvement Initiatives Team, Quality Improvement Work Groups, and any special projects as assigned by the Medical Director or QI Director. Develops and Implements Interventions to improve performance on key Measures. Works closely with Product Operations on Quality Improvement efforts for CMC. QIP, CCIP, Annual QI Program and Evaluation.

Manager, Accreditation

The Manager, Quality Improvement Accreditation is an experienced healthcare professional responsible for managing activities associated with Accreditation, the use of ongoing monitoring and analysis of plan performance, to facilitate the design and implementation of clinical and service related quality improvement studies and activities in support of the Quality Improvement Plan and strategic objectives of the organization. Position activities involve frequent day to day interface with Plan Partners, regulatory agencies and internal L.A. Care departments in support of established accreditation standards, quality improvement activities including budgetary and other resource components associated with annual HEDIS studies, and ongoing development of policies and procedures.

Manager, Provider Quality

The Provider Quality Manager is directly responsible for the organization, direction and staffing of L.A. Care's Potential Quality Issue (PQI) reviews. Responsibility includes regulatory

compliance, oversight of plan partner related operations, operations for direct lines of business and/or management services agreement functions, and interfacing with external agencies including other Local Initiatives, Plan Partners and Community Based Organizations. Critical to the position is ensuring that the information is protected and processes are developed and implemented in accordance with regulatory and legal statutes. The Manager is further responsible to assure all functions are operating in accordance with the organization's mission, values and strategic goals and are provided in a manner that is responsive and sensitive to the needs of L.A. Care's culturally diverse membership.

Manager, Health Informatics

The Manager of Health Informatics is an important role on the Health Services team who will work closely with Health Service staff as a manager of cross-functional operations and improvement efforts including Operations teams and staff, in particular Shared Services, IT, EDSA and PNM. The Manager of Health Informatics plays a key role in optimizing end-user experience of and data procurement from external stakeholders such as PPGs, MSOs and Plan Partners and streamlining operational processes for data flow and ultimately, outcome measure improvement. This manager is responsible for teams performing research, analysis, development and maintenance of performance reports and digital solution optimization programs in coordination with the CMIE, EDSA, IT, and HIT. This role will be an SME for VIIP and P4P/Incentives programs which are high profile projects for L.A. Care and its CEO. This manager will create and maintain policies and procedures relevant to research and performance data programs involving rate calculations, reports and validation checkpoints which may involve other L.A. Care teams. This role maintains an environment that promotes collaboration, responsibility, accountability, and professional growth within the team environment for Informatics programs.

Manager, Behavioral Health Clinical Services

The Manager for Behavioral Health Clinical Services supervises the behavioral health clinical team. Reports to the Director of Behavioral Health and consults with the Medical Director, Behavioral Health as needed. The manager contributes the clinician perspective at management team discussions, Health Services meetings, Enterprise-wide planning sessions and stakeholder meetings. The manager engages with County agencies, community based organizations, contracted provider groups, participating physician groups (PPGs), and other stakeholders to promote collaboration. The Manager directs clinician participation in interdisciplinary care teams and executes special initiatives as assigned.

Manager, Incentives Programs

The Manager of Incentives Programs is responsible for strategic oversight of the company's portfolio of pay for performance and incentive programs, and value based reimbursement programs. The Manager provides leadership direction to a project and analytic staff tasked with designing, building, operating and evaluating programs for all product lines, including Medi-Cal, Cal MediConnect and L.A. Care Covered. The Manager leads the development of reward-based incentive programs for consumers to promote evidence based, optimal care for enrollees, a wide variety of initiatives to reward physicians, provider groups and hospitals for improved performance in health care delivery; and value based reimbursement programs for providers that promote adherence to clinical guidelines and link payment to performance. The Manager is further

responsible to assure all functions are operating in accordance with the organization's mission, values and strategic goals and are provided in a manner that is responsive and sensitive to the needs of L.A. Care's culturally diverse membership.

Manager, Quality Performance Metrics

The Quality Performance Metrics (QPM) Manager is responsible for providing management and oversight to ensure the annual HEDIS, CAHPS and HOS submissions are delivered according to technical specifications and deadlines. The Manager is responsible for managing the HEDIS/QPM staff, creating policies and procedures relevant to HEDIS and CAHPS submission requirements, and developing and implementing the work plan to successfully complete the annual submission cycle and compliance audit. The Manager oversees all internal and outsourced operations and activities involving standardized quality measurement and reporting that encompasses rate generation, chart retrieval and abstraction and the MR validation audit. In addition to these responsibilities, the Manager monitors and manages the QPM budget accounting for monthly variations, works with Vendor Procurement and Legal to vet services to be rendered by external entities. The Manager collaborates with internal and external stakeholders to ensure that HEDIS and CAHPS initiatives are fully integrated throughout the organization. The QPM Manager reports to the Director, Quality Performance Management/HEDIS

Manager, Quality Performance Management

The Quality Performance Management (QPM) Manager is responsible for providing management and oversight to ensure the annual Healthcare Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Systems (CAHPS) and Health Outcomes Survey (HOS) submissions are delivered according to technical specifications and deadlines. This individual will be responsible for managing the HEDIS/QPM staff, creating policies and procedures relevant to HEDIS and CAHPS submission requirements, and developing and implementing the work plan to successfully complete the annual submission cycle and compliance audit. The Manager oversees all internal and outsourced operations and activities involving standardized quality measurement and reporting that encompasses rate generation, chart retrieval and abstraction and the Medical Record validation audit. The Manager collaborates with internal and external stakeholders to ensure that HEDIS and CAHPS initiatives are fully integrated throughout the organization.

Manager, Quality Data

The Manager of Quality Data is an important role on the quality data team. This position will work closely with technical, clinical, and compliance personnel to ensure accurate and timely delivery of HEDIS and Survey data to regulatory entities, partners and other stakeholders. This position plays a key role in optimizing data procurement and streamlining operational processes for ETL. This position is responsible for data process regarding HEDIS and Surveys, including Member and Provider experience, Health Outcomes and others. This position will create and maintains policies and procedures relevant to HEDIS and Survey data process. This position will also coordinate with vendors, provider groups and plan partners to maximize data completeness, analyzing quality data results to identify improvement opportunities. The Manager participates in Quality Improvement initiatives and committee meetings. The Manager in this role will have a

pivotal role in the success of L.A. Care as public reporting and data process efficiency are of utmost importance.

Manager, Clinical Programs

The Manager, Clinical Programs assists the Director of Clinical Pharmacy in supporting the strategic direction and oversight of clinical pharmacy programs and services to support L.A. Care members and prescribers across all lines of business. Provides direct supervision of the clinical pharmacists and pharmacy technicians in order to assure operational effectiveness which includes the implementation and adherence to L.A. Care's Policies & Procedures that meet CMS, the California Department of Health Care Services (DHCS), the California Department of Managed Health Care (DMHC), the Managed Risk Medical Insurance Board (MRMIB), NCQA and other rules/ regulations/ standards. The Manager of Clinical Programs will also lead the Pharmacy Department initiative to create a standard framework for establishing and updating Pharmacy Department Policies & Procedures delegating content development to other Pharmacy Department subject matter experts.

Manager, Ambulatory Care Advanced Practice Pharmacy

The Manager of Ambulatory Care Advanced Practice Pharmacy will have an expert understanding of all ambulatory care disease states including diabetes care, heart failure, hypertension, hyperlipidemia, anticoagulation and other common disease states seen at the ambulatory care setting and will assist the Director of Clinical Pharmacy in supporting the strategic direction and oversight of ambulatory care programs and services to support L.A. Care members and prescribers across all lines of business. The Manager is responsible for developing and running effective and efficient pharmacy related programs, which includes developing and maintaining appropriate metrics to monitor and continually improve processes, performance and quality. The Manager provides direct supervision of clinical pharmacists and pharmacy technicians in order to assure operational effectiveness which includes the implementation and adherence to L.A. Care's Policies & Procedures that meet Centers for Medicare and Medicaid Services(CMS), the California Department of Health Care Services (DHCS), the California Department of Managed Health Care (DMHC), the Managed Risk Medical Insurance Board (MRMIB), NCQA and other rules/regulations/standards.

Manager, Formulary and Benefit Design

The Manager of Formulary and Benefit Design will act as the lead of managing all the lines of business formularies by ensuring all regulatory and business needs are met. In addition, he/she will manage the Pharmacy Quality Oversight Committee (PQOC) recommendations, discussions and decisions.

Manager, Pharmacy Appeals and Grievances

The Pharmacy Manager of Appeals and Grievances will manage all grievances and appeals cases provided to the pharmacy department by the Grievances and Appeals department.

Manager, Facility Site Review (FSR)

The Manager of Facility Site Review (FSR) will work under the guidance of the Director of Provider Support Services. The Manager of Facility Site Review is responsible for the organization, compliance, direction and staffing of L.A. Care's Facility Site Review (FSR) function(s). Responsibilities includes supervisory visits of staff conducting site reviews and/or physical accessibility review survey (PARS) assessments, maintain regulatory compliance, oversight of plan partner related operations, operations for direct lines of business and/or management of services agreement functions, and interfacing with external agencies including other Managed Care Plans (MCPs). The Manager of Facility Site Review will conduct site reviews when appropriate and necessary. The Manager of Facility Site Review is further responsible to assure all functions are operating in accordance with the organization's mission, values and strategic goals and are provided in a manner that is responsive and sensitive to the needs of L.A. Care's culturally diverse membership.

Manager, Customer Solutions Center (CSC) A&G (Appeals and Grievances)

The Manager, Customer Solutions Center (CSC) A&G (Appeals & Grievances) is responsible for the centralized intake, logging and triage process for all member appeals and grievances. The Manager oversees the resolution of member appeals and grievances for all product lines (Medi-Cal, Medi-Cal Direct, Medicare, PASC-SEIU and L.A. Care Covered) in a manner consistent with regulatory requirements from the Department of Managed Health Care, Department of Health Care Services, Centers for Medicare & Medicaid Services, as well as requirements from the National Committee on Quality Assurance (NCQA) and L.A. Care policies and procedures. This position ensures the proper handling of member complaints whether presented by members, their authorized representative, the Ombudsman office, state contractors, member advocates, L.A. Care Board Members, providers, etc.

The Manager is responsible for establishing and monitoring processes to oversee and coordinate the identification, documentation, reporting, investigation and resolution of all member appeals and grievances in a timely and culturally-appropriate manner. Coordinates, tracks, and resolves internal and external appeal and grievance complaints for L.A. Care Plan Partners, including identifying opportunities for improvement. Ensures timely appeal and grievance reporting to regulatory agencies, internal Regulatory Affairs and Compliance Department, internal Quality Oversight Committee, etc. Collaborates with internal departments (Member Services, Provider Network Operations, Claims, Utilization Management, Pharmacy, and Quality Management) to ensure the use of appropriate appeal and grievance issue codes, timely resolution, and refers to community partners as appropriate. Responsible for maintaining and updating on an annual basis, or as necessary, appeal and grievance policies and procedures, member correspondence, etc., consistent with regulatory changes.

Manager, Health Education

The Manager of Health Education is responsible for overseeing day-to-day operations for the assigned business unit, including supervising staff, providing coaching/guidance, and ensuring departmental and organizational priorities are met in a timely fashion. This position prepares and updates departmental administrative documents, including program descriptions, policies, work plans, and reports. The Manager monitors and ensures compliance with regulatory requirements,

works with internal and external stakeholders to provide technical assistance, proposes and drives process improvement opportunities, and manages the budget for the assigned business unit.

Manager, Cultural and Linguistics Services

The Manger of Cultural and Linguistic Services is responsible for the management of the Cultural &Linguistic Services Unit and its programs and services. Responsibilities includes but are not limited to: (1) ensure L.A. Care and its subcontractors are compliant with state and federal regulatory agencies and NCQA standards; (2) provide technical assistance to internal departments and L.A. Care subcontractors; (3) improve and/or standardize departmental processes to be efficient and effective; (4) oversee interpretation and translation services and cultural competency training programs; (5) develop and implement departmental policies and procedures; (7) manage departmental budget and staff; 8) represent L.A. Care Health Plan at stakeholder meetings; and 9) complete other related activities as requested.

Manager, Social Services

The Manager, Social Services is responsible for managing social workers within our Headquarters' Social Services Department and social workers deployed to offsite locations. The Manager, Social Services performs a wide variety of managerial and administrative functions to assess department's needs and ensures program objectives are met. This includes day-to-day oversight of social services activities, which includes, but is not limited to, intake process, assessment of member, care coordination and coordination of services, provision of appropriate member referrals to providers and community resources, reviewing outcome measures and productivity, supporting staff with complex tasks. This position also helps in planning, developing, and evaluating the social services program, which includes, but is not limited to, establishing strategic partnerships with community resources, evaluating and improving processes, program and policy development, and performing staff development activities.

In addition, the Manager participates in Care Management ICT Team meetings as needed, and serves as a liaison between management, the community and staff. The Manager, Social Services assures all department functions are operating in accordance with the organization's mission, values, and strategic goals; the Social Services Manager also assures individual department goals are responsive and sensitive to the needs of L.A. Care's culturally diverse membership.

Manager, Autism Program

The Manager, Autism Program will assist L.A. Care in initiatives to integrate behavioral health services in L.A. Care's programs. The primary focus of the position will be integrating the current ASD benefit and future benefits related to Behavioral Health Treatment.

The Manager shall develop the behavioral health delivery system operations for all upcoming programs, as well as maintain responsibilities for implementing, operating and continually improving the service delivery system. The position will require an interface with numerous departments at L.A. Care and require network management, program implementation, claims and oversight skills. The Manager will manage a team of Autism Program Specialists.

COLLABORATION THROUGH COMMUNITY PARTNERS

L.A. Care collaborates with its delegated business partners to coordinate QI activities for all lines of business.

Facility Site Review (FSR) Task Force

L.A. Care is an active member of The FSR Task Force, which reviews issues related to facility site review, medical record review, and corrective action plan processes. The FSR Task Force is the forum to discuss facility site review activities including identification of non-compliant provider sites and formulation of interventions to improve processes and compliance scores. The FSR Task Force is comprised of internal and external representatives of L.A. Care and its delegated Strategic Partners.

Goals: The FSR Task Force goals are as follows but not limited to:

- Serve as a forum for the discussion of related facility site review activities.
 - Identify issues and institute interventions as appropriate.
 - Review results of interventions and follow-up as appropriate.
 - Review facility site review reports and problem provider sites.
 - Promote coordination and collaboration on facility site review processes.
 - Work collaboratively to identify opportunities for improvement as related to the facility site review process.
- Support and discuss identified issues and concerns as it relates to the L.A. County collaborative process as mandated by the California Department of Health Care Services (DHCS).

Functions: The functions of the FSR Task Force include, but are not limited to the following:

- Reviewing facility site review reports and determine opportunities for improvement.
- Updating committee members of California Department of Health Care Services (DHCS) Site Review Workgroup (SRWG) meetings.
- Provide a forum for discussion of facility site review activities.
- Formulate opportunities of improvement from facility site review data collected.
- Identify and communicate difficult provider sites.

Structure: The FSR Task Force membership is comprised of L.A. Care staff who are involved in FSR activities.

- Medical Director, Quality Improvement (when available)
- Facility Site Review, Director
- Facility Site Review Manager
- Facility Site Review Department Staff
- Strategic Partner Representatives
- Site Reviewers

The committee may invite other attendees as necessary.

Chairperson: The Facility Site Review Director or Facility Site Review Manager is the chairperson for the FSR Task Force. A designee maybe assigned temporarily in their absence, as necessary.

Frequency: The FSR Task Force meets once a month on the last Friday of every month with the exception of Thanksgiving and Christmas Holidays.

Minutes: The activities of the Facility Site Review (FSR) Task Force are formally documented in transcribed minutes, which summarize each agenda item, the discussion, action taken, and follow-up required (if any). Draft minutes of prior meetings are reviewed and approved at the next scheduled meeting.

PPG/Plan Partner Collaboration

In the fall of 2014, L.A. Care’s Quality Improvement department began regularly scheduled meetings with high-volume PPGs, Plan Partners and the Department of Health Services (DHS). The goal of these meetings is to form a united approach in engaging our members, as well as improve health outcomes using industry standard metrics such as HEDIS and CAHPS. We focus on NCQA Accreditation, Quality Rating System, DHCS auto-assignment measures, and the DHCS Managed Care Accountability Set (MCAS). Example agenda items include prioritization of measures, barrier analysis, interventions to improve performance, and data capture/transmission. Meetings occur, at a minimum, quarterly for DHS, the Plan Partners, and priority groups like Health Care LA, and as needed.

Beginning in 2016, L.A. Care hosts webinars on QI topics for PPGs, providers, and Plan Partners. In 2018, we increased the frequency of the webinars to monthly, focusing on important areas including HEDIS performance, member satisfaction, and data submission. Expanding the audience to include providers offers an introduction to HEDIS and correct coding, as well as earning potential through the incentive programs. These webinars aim to disseminate detailed information on topics aligned with the organization’s strategic goals. In addition to the expanded webinars, L.A. Care QI Department actively engages with the PPGs using the provider portal to communicate care and service gaps that are actionable.

BEHAVIORAL HEALTH COLLABORATION

Behavioral Health Services (mental health and substance use disorder treatment) are inclusive of inpatient treatment and outpatient treatment. Services are available across all L.A. Care lines of business and are managed based on the severity of the illness, the medically necessary services and the member’s line of business. Specialty Mental Health and substance use disorder treatment services are carved out to the Los Angeles County Department of Mental Health (DMH) and the Los Angeles County

Substance Abuse Prevention & Control Program respectively. Mild to moderate behavioral health services are the responsibility of the L.A. Care and are managed by our contracted Managed Behavioral Health Organization (MBHO). L.A. Care collaborates with these entities to conduct activities to improve the coordination of behavioral healthcare and general medical care including collaborating with their provider networks.

The behavioral health aspects of the QI program are described in a separate QI program description developed by the delegated MBHO and approved by L.A. Care.

In addition, L.A. Care works closely with the MBHO, DMH, and DPH to annually collect data about the following areas that could identify potential opportunities for collaboration between medical and behavioral health:

- Exchange of information between PCPs and Behavioral Health Specialists,
- Appropriate diagnosis, treatment and referral of behavioral health disorders to all appropriate levels of care,
- Appropriate uses of psychopharmacological medications,
- Management of treatment access and follow-up for members with coexisting medical and behavioral disorders,
- Alcohol Misuse Screening and Counseling (AMSC) in the primary care setting.
- Primary and/or secondary preventive health program implementation, and
- Special needs of members with severe and persistent mental illness.

L.A. Care has a directly contracted network to provide members with Behavioral Health Treatment services. The Behavioral Health Treatment (BHT) team oversees Care Coordination/Management and Utilization Management aspects of the BHT benefit. Progress reports, and treatment plans submitted by LA Care's directly contracted BHT provider network are reviewed by Board Certified Behavior Analysts. This team renders utilization review decisions based on state mandated guidance.

Current quality measures and benchmarks are not in place for this benefit as it first became available to members in early 2015. Currently, the BHT team is working to disseminate provider and member satisfaction surveys as the first quality improvement initiative.

COMMITTEE STRUCTURE

Board of Governors Compliance and Quality Committee

Role and Reporting Relationships: Members of the Compliance & Quality Committee (C&Q) of the L.A. Care Board of Governors (BoG) are appointed by the Chairperson of the BoG. C&Q oversees quality activities, maintains written minutes of all its meetings, and regularly reports its activities to the BoG.

Structure: C&Q is comprised of no more than six members of the BoG, including at least one physician, none of whom is an employee of L.A. Care. The number shall be determined by the Chairperson of the Board. A Committee Chairperson is elected annually by the C&Q members. Committee members should be independent of management and free of any relationship that, in the opinion of the Board, would interfere with the exercise of independent judgment as a Committee member. A quorum is established in accordance with L.A. Care's bylaws. L.A. Care's Chief Medical Officer (CMO), Chief Compliance Officer, or designee reports to the C&Q as often as needed. Draft agendas are publicly posted at least 72 hours prior to the meeting with the final agenda being approved at the time of the meeting in accordance with the Brown Act.

Frequency: The Committee is required to meet at least four times annually and is scheduled to meet monthly. Meetings are subject to laws governing public agencies.

Functions: C&Q is responsible for reviewing, evaluating, and reporting to the BoG on quality improvement (QI) and utilization management (UM) activities. The C&Q approves the QI and UM Program Documents, Work Plans and annual evaluations. It makes recommendations to the Board periodically, in consultation with the Chief Executive Officer or designee, the CMO and the Compliance Officer, on the findings and matters within the scope of its responsibility. C&Q receives regular reports from the CMO, the Chief Compliance Officer, and the Quality Oversight Committee.

Board of Governors Community Advisory Committees

Executive Community Advisory Committee

The Executive Community Advisory Committee (ECAC) serves as an advisory committee to the Board of Governors and can place items on the Board of Governors (BoG) Meeting Agendas. ECAC Meetings are subject to laws governing public agencies.

Quorum and Voting: A majority of ECAC members must be present to have an official ECAC meeting. All official acts of ECAC require a majority vote of the members present. No vote or election shall be by secret ballot.

Membership: ECAC members are the Chairpersons of the 11 Regional Community Advisory Committees (RCAC), Chairpersons of the four CCI Councils, and two At-Large Members which are elected annually by ECAC members. ECAC also annually elects a volunteer Chairperson and Vice-Chairperson.

Frequency: ECAC meets monthly.

Function: At ECAC meetings, matters related to advisory committee governance, L.A. Care programs, and recommendations on healthcare services and policy are considered and may be forwarded in the form of motions which may be placed on the BoG meeting agenda for consideration and action. The Quality Improvement Program is a quarterly ECAC agenda item to provide the opportunity for members to hear about Quality Improvement activities and provide feedback for program development.

Regional Community Advisory Committees and CCI Councils

There are 11 Regional Community Advisory Committees (RCAC) to help ensure that communities are involved in the design and delivery of services by L.A. Care throughout Los Angeles County. RCACs comply with state laws and regulations governing L.A. Care, and meetings are subject to laws governing public agencies. The organizational structure and procedures for the RCACs are recommended by ECAC to the BoG. Membership in a RCAC is based on the criteria approved by the Board of Governors. All RCAC members are appointed by the BoG.

Quorum and Voting: A majority of the RCAC members must be present to have an official advisory committee meeting. All official acts require a majority vote of the members present. No vote or election shall be by secret ballot.

Membership: The criteria for membership is recommended by ECAC and approved by the BoG, in accordance with applicable law, regulations, and the organization bylaws. All participants in the RCACs are volunteers. RCAC membership is not a form of employment with L.A. Care, nor is any permanent relationship or right to serve implied or established by membership in the advisory committees.

There are three categories of members that were recommended by ECAC and approved by the Board of Governors: consumer members who receive healthcare coverage from L.A. Care or care for someone who does; provider members who work at clinics, hospitals, medical offices and other sites where L.A. Care members receive healthcare services; and consumer advocates who represent community based organizations interested in healthcare services in Los Angeles County. The composition of members in each advisory committee shall seek to be representative of ethnic, cultural, linguistic, age, sexual orientation, disability, special medical needs or other characteristics of the member population in the region served by the advisory committee.

Each RCAC meets every other month and shall have at least eight members and no more than 35 members, with a target membership of 20 members, one-third of whom shall be members of L.A. Care as defined above. If a RCAC membership falls below the minimum of eight members, the advisory committee will be encouraged to make new member recruitment its top priority. Advisory committees with less than eight members should delay implementing any large projects until a sufficient number of new members is attained.

Advisory committees elect two volunteer leaders: a Chairperson and a Vice-Chairperson. In partnership with the staff of the Community Outreach and Engagement (CO&E) department of L.A. Care, the Chairpersons or Vice Chairpersons lead discussions, preside over business meetings and represent the advisory committee at meetings of the ECAC. An important responsibility of advisory committee members is the election of two of the members of L.A. Care's BoG: a consumer member and a consumer advocate.

Frequency: RCACs meet every other month on a schedule and location to be determined jointly by L.A. Care staff and the advisory committee members. With guidance from CO&E staff, RCAC members shall set the date and time of each meeting.

Function and Role: RCACs serve in an advisory capacity and may be given opportunities by the BoG and/or the management of L.A. Care to provide input and evaluate the operation of managed care services in Los Angeles County. Community and L.A. Care member input may be requested on the Quality Improvement Program, including the following:

1. Improve member satisfaction in L.A. Care's provision of services;
2. Improve access to care;
3. Ensure culturally and linguistically appropriate services and programs;
4. Identify emerging needs in the community and developing programmatic responses;
5. Determine and prioritizing health education and outreach programs: and

6. Collaboratively addressing community health concerns.
7. Help in gathering information about issues and concerns pertinent to the health and well-being of L.A. Care members in the region. The information is used by the advisory committees and L.A. Care to plan, implement, and evaluate programs which address the concerns identified.

See RCAC Member Handbook & Guidelines for further detail.

Internal Compliance Committee

Role and Reporting Relationships: The Internal Compliance Committee (ICC) provides oversight, advice, and general guidance to L.A. Care Health Plan's Chief Compliance Officer and senior management on all matters relating to L.A. Care and its subcontractors' compliance with mandated and non-mandated performance standards. The Committee shall ensure that L.A. Care adopts and monitors the implementation of policies and procedures that require L.A. Care and its employees, the Plan Partners, and the providers to act in full compliance with all applicable laws, regulations, contractual requirements and business goals. The Committee shall also ensure that L.A. Care Health Plan has established an appropriate compliance program, Code of Ethics and Conduct and compliance policies and procedures. Additionally, ICC ensures that monitoring, auditing and corrective action plans are sufficient to address compliance and fraud, waste and abuse concerns, and approves the Compliance Plan.

Structure: The ICC's membership is comprised of L.A. Care staff involved in Compliance oversight and accountability activities for the organization. The committee is chaired by the Chief Compliance Officer and consists of up to eight (8) voting members. A quorum is established when a minimum of 5 of the voting membership are in attendance.

Membership includes, but is not limited to the Chief Compliance Officer (chair), and up to eight voting members. A quorum is established when five members are in attendance. In addition to the Chief Compliance Officer, the following positions are also member of ICC: a representative of the Health Services Department, a representative of the Finance Department, a representative of the Chief Operating Officer, and a representative from the Office of Chief Product Officer.

Frequency: The ICC meets at least quarterly but as frequently as necessary to act upon any important matters, findings or required actions.

Functions: The functions of the ICC include, but are not limited to the following:

- Maintain communication between the Board, the internal or external compliance auditors and management.
- Review matters concerning or relating to the compliance program.
- Ensure proper communication of significant regulatory compliance issues to management and the Board.
- Review significant healthcare regulatory compliance risk areas and the steps management has taken to monitor, control and report such compliance risk exposures.
- Annually review and reassess the adequacy of the Compliance Plan and the Internal Compliance Committee Charter

- The ICC may form/designate subcommittees to investigate and remediate issues and report back to ICC.

Quality Committees

L.A. Care’s quality committees oversee various functions of the QI program (see attachment 3). The activities of the quality committees are formally documented in transcribed minutes, which summarize each agenda item, the discussion, action taken, and follow-up required. Draft minutes of the prior meeting are reviewed and approved at the next meeting. Minutes are then signed and dated. Minutes are also reported to their respective Committee as required under “Role and Reporting Relationships”. All activities and associated discussion and documentation by the committee participants are considered confidential and shall abide with L.A. Care policies and procedures for written, verbal, and electronic communications.

Oversight of delegated activities occurs in the following committees with a summary of committee activities reported to Quality Oversight Committee (QOC) (See Committee Section of this program for full description of committee):

- Utilization and Complex Case Management: Utilization Management Committee
- Credentialing and Peer Review: Credentialing Committee and Peer Review Committee for Potential Quality of Care Issues (PQIs) and Facility Site Review (FSR)
- Member Rights (grievance and appeals): Member Quality Service Committee
- Quality: Member Quality Service Committee and Quality Oversight Committee
- Pharmacy: Pharmacy Quality Oversight Committee (PQOC)
- HEDIS/CAHPS: Quality Performance Management Steering Committee (QPMSC)
- Population Health Management Metrics: Population Health Management Cross Functional Team (PHMCFT)

Recording of Meeting and Dissemination of Action

- All Quality Committee minutes are contemporaneous, dated and signed and reflect all committee decisions made.
- Meeting minutes and all documentation used by the L.A. Care Committee structure and are the sole property of L.A. Care Health Plan and are strictly confidential.
- A written agenda will be used for each meeting.
- Meeting minutes shall be comprehensive, timely, show indicators, recommendations, follow-up and evaluation of activities.
- The minutes are recorded in a nationally recommended format.
- All unresolved issue/action items are tracked in the minutes until resolved.
- The minutes and all case related correspondence are maintained at L.A. Care.
- The minutes are available for review by appropriate regulatory and accrediting agencies but may not be removed from the premises.

The dissemination of information and findings to physicians may take various forms. These methods may include but not limited to:

- Informal one-on-one meetings
- Formal medical educational meetings
- L.A. Care Newsletters

- Provider Relations and Physician Reports
- Quarterly Reports to the Board of Governors

The following section describes the role, reporting relationships, meeting frequency and functions of L.A. Care’s quality committees. The committees serve as the major mechanism for intradepartmental collaboration for the Quality Program.

Quality Oversight Committee

Role and Reporting Relationships: The Quality Oversight Committee (QOC) is an internal committee of L.A. Care which reports to the Board of Governors through the Compliance and Quality Committee. The QOC meeting minutes are submitted to the Department of Health Care Services (DHCS) on no less than on a quarterly basis. The QOC is charged with aligning organization-wide quality improvement goals and efforts prior to program implementation and monitoring the overall performance of L.A. Care quality improvement infrastructure.

Structure: The QOC membership is comprised of L.A. Care staff who are involved in improvement activities. A quorum is established when a minimum of 50% of the membership is in attendance. The Committee is chaired by the Chief Medical Officer or physician designee. Voting members are managers and above.

Membership includes, but is not limited to Chief Quality and Information Executive, Medical Director for Quality, Chief Medical Officer, Deputy CMO, Director Clinical Assurance, Director Quality Improvement & Accreditation, Senior Director Enterprise Pharmacy, Medical Directors, Senior Director Health Services, Director Quality Performance Management/HEDIS, Executive Directors of Products, Manager Facility Site Review, Director Utilization Management, Director Provider Network Management, Compliance Officer, Director Marketing and Communications, Director Credentialing, and ad hoc members – (members from other departments are invited to attend when input on topics require their participation).

Frequency: The QOC meets at least quarterly but as frequently as necessary to demonstrate follow-up on all findings and required actions. The meeting dates are established annually.

Functions: The functions of the Quality Oversight Committee include, but are not limited to the following:

- Reviews the analysis and evaluation of QI activities of other committees or staff, identifies needed actions, and ensures follow up as appropriate.
- Review current quality improvement projects and performance improvement activities to ensure appropriate collaboration and minimize duplication of efforts.
- Formulate organization-wide improvement activities and gain support from appropriate departments.
- Review performance requirements of strategic projects and performance improvement activities to enhance effectiveness and make corrections as appropriate.
- Ensure all departments have the opportunity to align project goals and map out responsibilities and deadlines prior to project implementation.

- Ensure that QI Program activities and related outcomes undergo quantitative data analyses that incorporate aggregated results over time and compare results against goals and benchmarks.
- Ensure that root cause analysis/barrier analyses are conducted for identified underperformance with appropriate targeted interventions. Analysis will include organization staff who understand the processes that may present barriers to improve.
- Ensure that opportunities for improvement are identified and prioritized based on the analysis of performance data.
- Ensure that, on not less than a quarterly basis, the information available to the plan regarding accessibility, availability and continuity of care is reviewed and evaluated, including but not limited to information obtained through enrollee and provider surveys, enrollee grievances and appeals, and triage or screening services.
- Identify actions to improve quality and prioritize based on analysis and significance; and indicate how actions are chosen.
- Review and evaluate actions taken to determine if actions are effective in improving quality and what revisions, if any, need to be made to the actions.
- Review, evaluate, and make recommendations regarding oversight of delegated activities, such as, audit findings, trending, and reports.
- Review and provide thoughtful consideration of changes in its QI and other policies and procedures and work plan and make changes to policies/work plan as needed.
- Review and modify the QI program description, annual QI Work Plan, quarterly work plan reports and annual evaluation of the QI program.
- Provide and/or review and approve recommended changes to the QI Program and QI Work Plan activities based on updates and information sources available.
- Assure compliance with the requirements of accrediting and regulatory agencies, including but not limited to, DHCS, DMHC, CMS, NCQA and Covered California.
- Ensure follow-up, as appropriate.

Joint Performance and Improvement Collaborative Committee (PICC) and Physician Quality Committee (PQC)

Role and Reporting Relationship: The Joint Performance and Improvement Collaborative Committee (PICC) and Physician Quality Committee (PQC) primary objective is to ensure practitioner participation in the QI program through planning, design, and review of programs, quality improvement activities, interventions, and evidence based clinical practice guidelines designed to improve performance. The committee will provide an opportunity to dialogue with the provider community and gather feedback on clinical and administrative initiatives. The committee reports through the Medical Director Quality Improvement or designee, to the Quality Oversight Committee.

Structure: The Joint Performance and Improvement Collaborative Committee (PICC) and Physician Quality Committee (PQC) serves as an advisory group to L.A. Care's Quality Improvement infrastructure for the delivery of health services to all lines of business in Los Angeles County. The committee reports to the QOC on findings and matters within its scope of responsibility which are presented to the QOC by the Medical Director Quality Improvement or the CMO. A quorum is established with a simple majority of voting members. The Committee is

chaired by the Chief Medical Officer or physician designee. Voting members are Physicians, L.A. Care staff that are managers and above, Network Physicians, Plan Partners three (3) votes each and Provider Groups 2 votes each.

Membership includes, but is not limited to, Chief Medical Officer (chair), Medical Director for Quality, Medical Directors of Care Management, Utilization Management, Medicare, and Behavioral Health, Director Quality Improvement & Accreditation, Chief Pharmacy Officer, Directors Utilization Management and Care Management, Senior Director Health Services, Senior Director Provider Network Management, Executive Directors of Products. Members from other departments are invited to attend when input on topics require their participation. Delegated Plan Partner UM, A&G, and QI Directors or designees, Delegated Provider Group representatives are also members of this committee. Other staff may attend on an ad hoc basis.

Network Physicians represents a broad spectrum of appropriate network primary care physicians and specialists, including behavioral health physicians serving L.A. Care members. These physicians include but not limited to practitioners who provide health care services to Seniors and Persons with Disabilities and chronic conditions (such as asthma, diabetes, congestive heart failure, etc.) and/or members receiving Managed Long-Term Services and Supports (MLTSS). Physician members of the community are appointed for three year terms with an option to serve for another 3 years or a total of 6 years. Participating practitioners are external to the organization and part of the organizations network. Committee members may be recommended for inclusion by current committee members. Appointments will be made by the Chief Medical Officer or designee.

Frequency: The Joint Performance and Improvement Collaborative Committee (PICC) and Physician Quality Committee (PQC) meets at least quarterly but as frequently as necessary to demonstrate follow-up on all findings and required actions.

Functions: The responsibilities of the Joint PICC & PQC include but is not limited to:

- Review and discuss linked and carved out services for persons with complex health needs.
- Review of regulatory required improvement plans with the state.
- Make recommendations to L.A. Care about issues relating to quality improvement activities and administrative initiatives.
- Promote initiatives and innovations offered to the provider community.
- Provide input and make recommendations to L.A. Care's Quality Oversight Committee (QOC) on policy decisions, as well as quality and service improvements.
- Ensuring practitioner participation in the QI program through planning, design, implementation and review.
- Provide a forum for dialogue to enhance the efficiency of practitioner business services including incentive programs and clinical information technology adoption.
- Review and discuss barriers to improvement of HEDIS and CAHPS and other QI measures.
- Review Appeals & Grievances Annual Report.
- Review quality improvement project development and opportunities presented by L.A. Care and offer advisory feedback and recommendations as appropriate.
- Provide input and feedback on services provided to our members.

- Review and analyze member and provider satisfaction survey results and access to care results and make recommendations for improvement as appropriate.
- Ensure practitioner participation in the QI and VIIP or Value Based Pay for Performance programs through planning, design, implementation and review.
- Assure compliance with the requirements of accrediting and regulatory agencies, including but not limited to, DHCS, DMHC, CMS, NCQA and Covered California.
- Select, evaluate, develop and approve/adopt preventive health and clinical practice guidelines that are based on nationally developed and evidence based criteria.
- Other issues as they arise.

Utilization Management Committee

Role and Reporting Relationship: The Utilization Management Committee (UMC) is a subcommittee of the QOC and focuses on the UM activities.

Structure: The UM Committee supports the Quality Oversight Committee in the area of appropriate provision of medical services and provides recommendations for UM activities. The CMO or designated Utilization Management Medical Director serves as the Chairperson. A quorum is established when fifty-one percent (51%) of voting members are present. Only physician members and Senior Director, and Director level members of the UM committees may vote. Findings and recommendations are presented to the Quality Oversight Committee.

Membership includes, but is not limited to, CMO, Utilization Management Medical Director, Behavioral Health Medical Director, Medical Director Quality Improvement, Medical Director Medicare, Medical Directors or permanent MD Designees of Participating Physician Groups, Senior Director Clinical Assurance, Senior Director Enterprise Pharmacy, Director Managed Long Term Services & Supports (MLTSS), Senior Director Provider Network Management (PNM), UM Director, Care Management (CM) Director, Appeals and Grievances (A&G) Director, MLTSS Director, Behavioral Health Clinical Services Director, Provider Group Directors, Lead Delegation Oversight Specialist, UM Oversight and Compliance Specialist, and Utilization Management Project Manager. Ad hoc members include Director Credentialing and Senior Director Health Services, Director Quality Performance Management/HEDIS.

Frequency: The Committee meets at least quarterly.

Functions: The UM Committee is responsible for overall direction and development of strategies to manage the UM Program.

The responsibilities of the UM Committee include but are not limited to:

- Review of quarterly Over/Underutilization UM stats such as inpatient bed days, ER, readmissions, etc.
- Participate in the Utilization Management/continuing care programs aligned with the Program's quality agenda.
- Monitor for potential areas of over and underutilization and recommend appropriate actions when indicated.
- Receive and review utilization data.

- Annual review and approval of the UM Program Evaluation and Description, UM Policies/Procedures, UM Criteria, and other pertinent UM documents, such as, the UM Delegation Oversight Plan, UM Notice of Action Templates, CM Management Program Evaluations and Descriptions, CM Policies/Procedures, and Care Coordination and Quality Improvement Program Effectiveness, MLTSS Management Program Evaluations and Descriptions, MLTSS Policies/Procedures and MLTSS Model of Care.
- Review pharmacy utilization data, including utilization reports received from Plan Partners to track and trend changes over time.
- Recommend actions to the Quality Oversight Committee when opportunities for improvement are identified from review of utilization data including, but not limited to, Ambulatory Visits, Emergency Visits, Hospital Utilization rates, Hospital Admission rates, Average Length of Stay rates, and Discharge rates.
- Review New Medical Technologies including new applications of existing technologies at least annually for potential addition as a new medical benefit for members.
- Review and make recommendations regarding oversight of delegated activities, such as, audit finding and reports.

The L.A. Care Utilization Management program document contains more detailed information pertaining to UMC responsibilities. There is also a separate Care Coordination and Quality Improvement Program Effectiveness description.

Credentialing/Peer Review Committee

Role and Reporting Relationship: The Credentialing/Peer Review Committee is a subcommittee of the Quality Oversight Committee.; however, in accordance with state law, minutes will not be submitted but rather a summary of the meeting. The minutes are confidential information protected under California Evidence Code 1157.

Structure: The Credentialing/Peer Review Committee addresses the credentialing and recredentialing and peer review activities for all lines of business. The Credentialing/Peer Review Committee serves as a peer review body and retains the right to approve or deny providers at all times and is the final approval of credentialing activities. The Credentialing/Peer Review Committee addresses peer review activities for all lines of business in order to assess and improve the quality of care rendered. It is responsible for overseeing quality of the medical care rendered in order to determine whether accepted standards of care have been met by investigating and resolving potential problems brought to the PRC as potential quality of care issues or PQIs. The Chief Medical Officer (CMO) or physician designee serves as the Committee Chairperson and is responsible for all credentialing and peer review activities. A quorum is established when a minimum of three (3) physicians are present.

Membership includes, but is not limited to:

Voting Members are the L.A. Care Chief Medical Officer, L.A. Care Medical Director Quality Improvement, L.A. Care Utilization Management Medical Director, network physicians or designees, and one (1) nurse practitioner (NP) (may vote on NP cases only). Doctoral level behavior health professionals may vote on behavioral health issues only.

Non-Voting Members are L.A. Care Credentialing Director, Credentialing Manager, Credentialing Auditors, Director Utilization Management, Clinical Grievance Specialist, Senior Director Provider Network Management, QI Director, and QI Nurse Specialists, and other board certified medical specialists invited on an ad hoc basis.

Frequency: The Committee meets at least quarterly but as frequently as necessary to demonstrate follow-up on all findings and required actions. The meeting dates are established and published each year.

Functions: The Credentialing/Peer Review Committee has the following functions:

- Credentialing and recredentialing of practitioners [MD, DO, DPM, DC, DDS/DMD, AC, attending physicians within a teaching facility, and Mid-Level disciplines, such as, Nurse Practitioner (NP), Certified Nurse Midwife (CNM), Clinical Nurse Specialist (CNS), Certified Registered Nurse Anesthetist CRNA, Licensed Midwives (LM), and Physician Assistants (PA), behavioral health practitioners, such as, Psychiatrists and other physicians, addiction medicine specialists, Doctoral or Master's level psychologists, Master's level clinical social workers, Master's level clinical nurse specialists or psychiatric nurse practitioners, physicians or Doctoral level professionals with expertise in Long Term Services and Supports (LTSS), autism service providers, qualified autism service professionals, or qualified autism service paraprofessionals, other behavioral health care specialists, or provider service types, as appropriate as outlined in Policy CR-004.
- Conditions for altering a practitioner's relationship with L.A. Care including freezing the practitioner's assigned membership panel, suspension or termination of practitioners from the network.
- Pre-contractual and annual delegated oversight activities for credentialing and recredentialing.
- Provide feedback on specific practitioner credentials that do not meet required standards and recommendation(s) for handling such cases.
- Review and approve facilities including Hospitals, Free Standing Surgical-Centers, Home Health agencies, Skilled Nursing facilities and mental health and substance abuse facilities providing care in inpatient, residential and ambulatory settings. For Center for Medicaid and Medicare Services (CMS), facilities include the following:
 - Hospice
 - Clinical Laboratory
 - Comprehensive Outpatient Rehabilitation Facility
 - Outpatient Physical Therapy and Speech Pathology Provider
 - Ambulatory Surgery Centers
 - End-Stage Renal Disease Provider (Dialysis Unit)
 - Outpatient Diabetes Self-Management Training Provider
 - Portable X-Ray Supplier
 - Rural Health Clinic (RHC)
 - Federally Qualified Health Center (FQHC)
 - Community-Based Adult Services (CBAS) Centers
- Ensure compliance with state and federal regulatory agencies and accrediting bodies concerning credentialing and recredentialing activities.

- Approve all delegation oversight activities, all Corrective Action Plans (CAPs) and de-delegation and recommendations.
- Review, evaluate, and make recommendations regarding Potential Quality of Care Issues (PQIs)
- Recommend additional investigation and/or reporting as indicated or as appropriate
- Determine clinical appropriateness, quality of care and assigns the severity level to the case. PRC members may be requested to review the PQI case prior to the PRC meeting.
- Provide oversight of level 0, 1 and 2 cases that have been closed with no need for committee review.
- Provide oversight of delegated peer review and ongoing monitoring as needed.
- Review, recommend, take action, and monitor the clinical practice activity of the Practitioner network and mid-level practitioners.
- Provide appropriate Peer Review that meets the level of practice of the Practitioners and specialists they are reviewing.
- Assure compliance with the requirements of accrediting and regulatory agencies, including but not limited to, DHCS, DMHC, CMS, NCQA and Covered California.
- Ensure appropriate reports, including 805, NPDB, etc., are made, as required.
- Ensure Fair Hearing Procedures are offered and carried out in accordance with approved policies and procedures.

Pharmacy Quality Oversight Committee

Role and Reporting Relationship: The Pharmacy Quality Oversight Committee (PQOC) is responsible for oversight of the Pharmacy and Therapeutics process administered by the existing Pharmacy Benefit Manager (PBM). The PQOC also reviews and evaluates newly marketed drugs for potential placement on the formulary and develops utilization management criteria for all direct product lines of L.A. Care.

Additionally, the PQOC provides a peer review forum for L.A. Care’s clinical policies/programs, provider communication strategies, pharmaceutical quality programs/outcomes, and specialty drug distribution options.

Structure: An L.A. Care Health Plan appointed Medical Director serves as the Chairperson for the PQOC. Only physicians and pharmacist members have voting privileges.

Membership: Voting membership includes physicians and pharmacists. Additional L.A. Care staff and/or health care professionals may be invited on an ad hoc basis to provide information when additional medical or pharmacotherapy expertise is required for medical, drug or policy evaluations.

Frequency: The PQOC meets at least quarterly.

Functions: The PQOC has the following functions:

Oversight/Advisory of PBM Vendor:

- Review newly marketed drugs for potential placement on the formulary.
- Provide input on new drug products to Navitus P&T

- L.A. Care has the ability to overrule a Navitus P&T formulary and/or utilization control decision when required by regulation or unique member characteristics in the health plan
- Develop protocols and procedures for the use, of and access to, non-formulary drug products.

L.A. Care Strategic and Administrative Operations

- Specialty pharmaceutical patient management and distribution strategies.
- Pharmaceutical care program selection and evaluation.
- Develop, implement and review policies and procedures that will advance the goals of improving pharmaceutical care and care outcomes.
- Serve the health plan in an advisory capacity in matters of medication therapy.
- Recommend disease state management or treatment guidelines for specific diseases or conditions. These guidelines are a recommended series of actions, including drug therapies, concerning specific clinical conditions.

Behavioral Health Quality Committee

Role and Reporting Relationship: The Behavioral Health Quality Committee (BHQC) is responsible for collecting and reviewing data, as well as prioritizing, developing, implementing, and monitoring interventions based on the analysis of data to improve continuity and coordination of medical and behavioral health care. L.A. Care delegates Behavioral Health services for Medi-Cal, Medicare, PASC-SEIU, and Covered California to a Managed Behavioral Health Organization (MBHO). L.A. Care works closely with the MBHO in order to collaborate with behavioral health practitioners (BHPs) and use information collected to coordinate medical and behavioral health care. This committee reports to the Quality Oversight Committee.

Structure: Committee members from L.A. Care include: Medical Director of Behavioral Health and Social Services (chair), Director of Behavioral Health Services, Chief Medical Information Executive/Medical Director of Quality Improvement, Director of Case Management, Utilization Management Medical Director, Senior Director of Enterprise Pharmacy, Director Quality Improvement, Case Management, Behavioral Health and Social Services staff. Other attendees include members from the MBHO such as the Clinical Director, the Assistance Vice President of Care Management and the Regional Quality Improvement Director. Additional committee members include leadership from L.A. County Department of Mental Health and L.A. County Department of Public Health/Substance Abuse Prevention & Control as well as Medical Directors of the contracted Preferred Physician Groups and community behavioral health providers and members of the behavioral health professionals in L.A. Care’s contracted network.

Frequency: The Behavioral Health Quality Committee meets quarterly.

Functions: The functions of the Behavioral Health Quality Committee include:

- Assess exchange of information between BHPs, medical/surgical specialists, organization providers or other relevant medical delivery systems.
- Assess appropriate diagnosis, treatment, and referral of behavioral health disorders commonly seen in primary care settings.

- Assess appropriate use of psychopharmacological medications and consistent guidelines for prescribing by behavioral and medical practitioners.
- Assess the screening and managing of patients with coexisting medical and behavioral health conditions.
- Discuss, develop, prioritize, and evaluate interventions to measure effectiveness and evaluate member experience data.
- Collaboratively develop and adopt primary or secondary prevention programs for behavioral health and evaluate effectiveness of program through process or outcomes data.
- Identify opportunities for improvement across all measures.
- Develop training seminars and conferences to educate primary care providers on screening, diagnosis and treatment of mental health and substance uses disorders in the primary care settings.
- Facilitate discussion between primary care physician network and behavioral health practitioner network including LA County DMH and DPH/SAPC as it relates to coordination of care and opportunities for improvement.

Member Quality Service Committee

Role and Reporting Relationship: The Member Quality Service Committee (MQSC) is responsible for improving and maintaining the L.A. Care member experience for all product lines. The scope of the committee includes, but is not limited to; analysis of the following sources to identify opportunities for improvement in member satisfaction as identified in the following: Member Satisfaction Surveys, Member Retention Reports, Access & Availability Surveys, Appeals & Grievances Data, and Interface of Provider Satisfaction with Member Satisfaction. The committee will also act as a Steering Committee for member quality service issues. The Member Quality Service Committee reports its findings and recommendations to the Quality Oversight Committee.

Structure: Committee members include leadership from key internal departments required to participate in this committee are as follows: Provider Networks Management (PNM), Customer Solutions Center, Appeals and Grievances, Utilization Management/Case Management, Medicare Operations, Member Outreach, Pharmacy, Sales/Marketing, Communications, Quality Performance Management/HEDIS, Health Education, Cultural and Linguistic Services Department (HECLS), Quality Improvement (QI), Information Technology (IT), Compliance, Managed Long Term Services & Support, Product staff, and other departments.

Frequency: The Member Quality Service Committee meets at least quarterly but as frequently as necessary to demonstrate follow-up on all findings and required actions. The meeting dates are established annually.

Functions: The functions of the Member Quality Service Committee include:

- Create and maintain a member-centered culture for the organization.
- Review aggregate performance data on L.A. Care’s network, including adherence to access and availability standards.
- Measure, report, set goals, and improve member satisfaction using CAHPS and CG-CAHPS as instruments to measure performance.

- Implement focused, measureable interventions regarding member experience. Provide input and make recommendations to L.A. Care’s Quality Oversight Committee (QOC) on the state of member satisfaction on a quarterly basis.
- Review and provide thoughtful consideration of changes in its policies and procedures and make changes to policies and procedures as needed.
- The committee may choose to invite representatives of subcontracted health plans or provider groups, as needed.
- Review and discuss quarterly delegated activity reports including audit trends.
- Review of quarterly appeals and grievances reports.
- Review and monitor effectiveness of Cultural and Linguistic services including the Language Assistance Program.

Quality Improvement Steering Committee

Role and Reporting Relationship: The Quality Improvement Steering Committee (QISC) is established by the authority of the L.A. Care Quality Oversight Committee (QOC) and through this Committee to the Compliance and Quality Committee (C&QC) then to the Board of Governors (BoG). This Committee is a collaborative workgroup that engages business units from multiple departments across the organization that are involved in improvement of care, services, and provider and member satisfaction.

Structure: The Director of Quality Improvement & Accreditation serves as the Chairperson for the Quality Improvement Steering Committee.

Membership includes, but is not limited to Medical Director Quality Improvement, Chief Quality and Information Executive, Director Quality Improvement & Accreditation (Chair), Director Care Management, Program Director Health Equities, Senior Director Medicare Operations, Director Quality Performance Management/HEDIS, Senior Director Health Services, Director Population Health Management, Pharmacy Clinical Programs Manager, Behavioral Health Project Manager, Manager Accreditation, Manager Quality Improvement, Director Health Education & Cultural Linguistics Services, Project Manager(s), Quality Improvement, Project Manager, Medicare Operations, and Manager Incentives.

Frequency: The Quality Improvement Steering Committee meets every other month, but as frequently as necessary, to demonstrate follow-up on all findings and required actions.

Functions: The functions of the Quality Improvement Steering Committee include:

- Direct the QI Workgroups and activities selected for improvement.
- Recommend workgroup policy decisions.
- Review, analyze, prioritize, and evaluate the Quality Improvement activities of the Workgroups.
- Ensure adequate participation in the workgroups.
- Ensure appropriate resources are given to workgroup activities.
- Review current and prospective initiatives/interventions.
- Provide initiative/intervention approval (when necessary) and/or recommendations to QI workgroups.

- Report to the QOC on all activities.

Quality Performance Management (QPM) Steering Committee

Role and Reporting Relationship: The QPM Steering Committee is established by the authority of the L.A. Care Quality Oversight Committee (QOC) and through this Committee to the Compliance and Quality Committee (C&Q) then to the Board of Governors (BoG). This Committee is a collaborative group that engages business units from multiple departments across the organization that are involved in the monitoring and improvement of HEDIS and CAHPS scores across all measures.

Structure: The Director of Quality Performance Informatics serves as the Chairperson for the Quality Performance Management (QPM) Steering Committee.

Membership includes, but is not limited to Director of Quality Performance Informatics, Informatics, Chief Medical Officer, Deputy Chief Medical Officer, Chief Quality and Information Executive, Quality Improvement Medical Director, Director of Population Health Management, Director of Quality Improvement and Accreditation, Manager of Quality Improvement Initiatives, Director of Health Population Informatics, Manager of Incentives, QPM Manager(s) and QPM Program Manager(s), Director of Plan Partner Operations, Director of Safety Net Initiatives, Director of Pharmacy, Director of Medicare Operations, Director of Commercial Group Product Management, and Director of Risk Adjustment

Frequency: The Quality Performance Management (QPM) Steering Committee meets every two months. but as frequently as necessary, to demonstrate follow-up on all findings and required actions.

Functions: The functions of the Quality Performance Management (QPM) Steering Committee include:

- Direct the QPM activities across L.A. Care in order to improve data collection and subsequent scores.
- Recommend Committee policy decisions.
- Review, analyze, and evaluate the QPM activities of the Committee.
- Ensure adequate participation in the Committee from related departments.
- Ensure appropriate resources are given to Committee activities.
- Review current and prospective initiatives/interventions.
- Provide reports analysis, initiative/intervention approval (when necessary) and/or recommendations to QPM Steering Committee.
- Report to the QOC on all activities.

Effectiveness of Committee will be measured by:

- Participant Engagement – attendance and contribution
- Timeliness of decision making and follow up as recorded in Committee minutes
- Timely resolution of barriers and challenges
- Adoption and implementation of innovative solutions to improve HEDIS rates
- Enhanced operations and workflow for HEDIS/CAHPS

Population Health Management Cross Functional Team Committee

Role and Reporting Relationships: The Population Health Management (PHM) Cross-Functional Team (CFT) is an internal committee of L.A. Care which reports to the L.A. Care Quality Oversight Committee (QOC) and through this Committee to the Compliance and Quality Committee (C&Q) then to the Board of Governors (BoG). This Committee is a collaborative group that engages business units from multiple departments across the organization that are involved in the development, execution and monitoring and evaluation of programs for members and providers across the continuum of health.

Structure: The PHM CFT membership is comprised of L.A. Care staff who are involved in improvement activities. The Committee is chaired by the Director, PHM who is primarily responsible for but not limited to: Directing the PHM CFT meetings, reporting PHM activities to QOC, acting on behalf of the committee, addressing issues that arise between meetings, ensuring all appropriate PHM activity and reports are presented to the committee and bring appropriate guest and special presentations to the PHM CFT.

Membership includes, but is not limited to the Director, PHM, Department Assistant PHM, Program Managers, PHM, Director, Population Health Informatics, Manager, Population Health Informatics, Chief Quality and Information Executive, Director, Quality Improvement Accreditation, Manager, Quality Improvement Accreditation, Quality Improvement Project Manager, representatives from Health Services, Product Team, Data and Informatics, Member Outreach, and ad hoc members – (members from other departments are invited to attend when input on topics require their participation).

Frequency: The PHM CFT meets on the third Tuesday of each month but as frequently as necessary to demonstrate follow-up on all findings and required actions. As needed, PHM items will be addressed through other appropriate committees, such as Quality Improvement Steering Committee (QISC) as appropriate.

Functions: The objective of the PHM CFT is to establish a formal process to address gaps identified in the annual Population Assessment and to provide oversight and strategic guidance and input to PHM programs across L.A. Care and to meet regulatory requirements. The committee serves as a platform for team and department leads to present current and prospective initiatives/interventions and programs for approval as well as provide updates regarding NCQA PHM results, present Population Assessment findings and develop actions and initiative/interventions and programs to address gaps and to present results and evaluations. In addition, the PHM CFT promotes inter-departmental coordination and alignment of PHM related initiatives, improvement efforts, data/reporting requests and participation. The scope includes but is not limited to the following:

- Direct the PHM activities across L.A. Care in order to improve collaboration between departments to develop a holistic Population Health strategy.
- Recommend committee policy decisions.
- Review, analyze, and evaluate the PHM activities of the Committee.
- Ensure adequate participation in the Committee from appropriate departments.
- Ensure appropriate resources are given to Committee activities.
- Review current and prospective initiatives/interventions.

- Provide reports analysis, initiative/intervention approval (when necessary) and/or recommendations to PHM CFT.
- Report to the QOC on all activities.

Continuing Medical Education Committee

Role and Reporting Relationship: The Continuing Medical Education (CME) Committee reports to the Quality Oversight Committee and Senior Director of Health Services.

Structure: The CMO or designee, shall serve as CME Committee Chair. The Chair shall have knowledge and experience in CME program planning. All members of the committee may vote.

Membership includes, but is not limited to Chief Medical Officer, L.A. Care Medical Directors, L.A. Care network physicians, Senior Director of Health Services, Provider Continuing Education Program Manager, QI Director, and up to five (5) outside physicians representing different specialties.

Frequency: The Continuing Medical Education Committee meets on a quarterly basis, minimum of three meetings per year or as necessary, to address the CME needs of all lines of business and to demonstrate follow-up on all findings and recommendations.

Functions: The Continuing Medical Education Committee has the following functions:

- Plan, develop, implement, and evaluate L.A. Care’s CME program.
- Complete and analyze results of an annual professional medical education needs assessment.
- Plan the annual calendar of directly provided and jointly provided CME activities.
- Review and approve all components of each educational offering including learning, objectives, content, budget, faculty, and evaluations.
- Provide an annual program and report including findings and recommendations to the QOC and the Board of Governors.
- Oversee the (re)application process for maintaining CME accreditation status.

SCOPE OF PROGRAM

The scope of the QI Program is reflective of the health care delivery system and provides for a systematic approach to continuous improvement, encompassing the quality and safety of both clinical care and service. The processes and procedures are designed to ensure that all Medically Necessary Covered services are available and accessible to all Members regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, gender identity, health status, physical or mental disability, or identification with any other persons or groups defined in Penal Code 422.56, and that all Covered Services are provided in a culturally and linguistically appropriate manner.

The Quality Improvement Program is implemented through the multidisciplinary cooperation of departments across the entire organization. The program includes establishment of performance indicators and measurement methodologies, measurement of performance, quantitative and qualitative analysis of performance data and results, identification of improvement opportunities,

prioritization of opportunities, timely implementation of strong interventions to improve performance and evaluation to assess the effectiveness of interventions.

L.A. Care's QI Program encompasses compliance with DHCS, DMHC, CMS, NCQA, Covered California, and other regulatory entities to serve Medi-Cal, Cal MediConnect, and L.A. Care Covered, and PASC-SEIU members.

As provided under 42 CFR §422.152(c) and §422.152(d), QI programs must include a Chronic Care Improvement Programs (CCIP) and Quality Improvement Project (QIP) that measures and demonstrates improvement in health outcomes and beneficiary satisfaction.

L.A. Care also conducts Plan, Do, Study, Act (PDSA) projects and Performance Improvement Projects (PIP), as required by DHCS and CMS.

CMS has reframed the QI program as a continuous performance improvement program that includes collection, reporting, and analysis of data that:

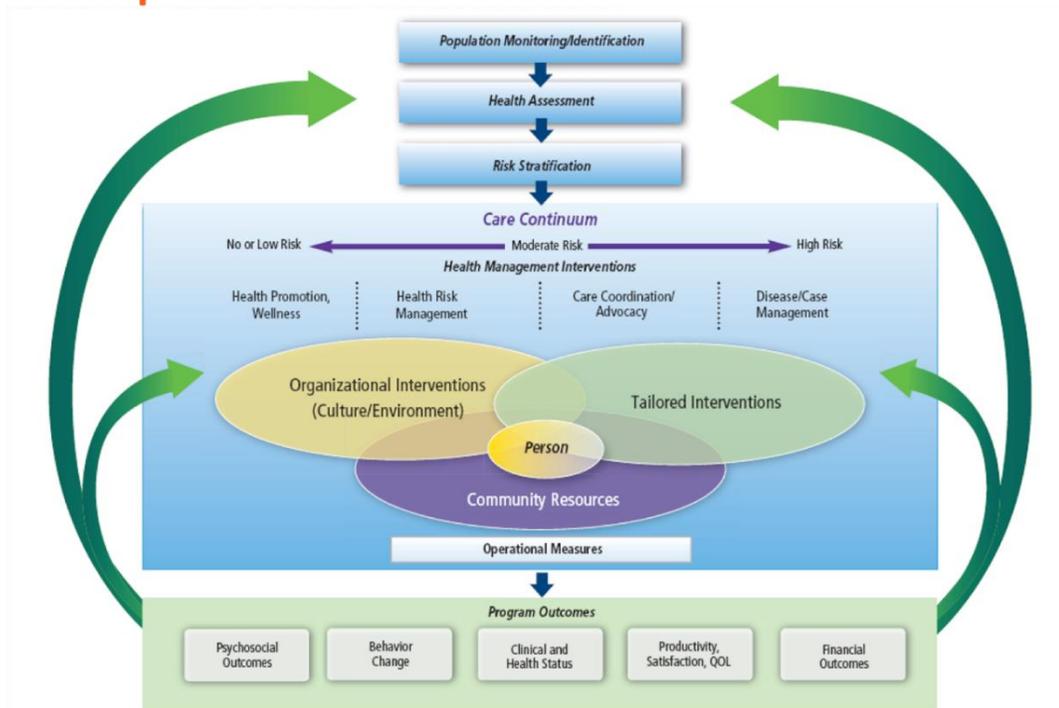
1. Assists beneficiaries in selecting plans that meet acceptable performance levels
2. Assists CMS in monitoring plan performance; and
3. Sets minimum requirements for Medicare-Medicaid plans (MMP) to assess their own performance through a robust internal performance improvement program.

Identification, Stratification, Enrollment/Engagement, Interventions and Outcomes (ISEIO)

In 2018, L.A. Care developed a Population Health Framework for all Health Services programs and interventions. The goal is to address L.A. Care members through a focus on a population-driven, patient-centered model of care by engaging the whole population to meet the needs of all members regardless of where the member lies on the continuum of health. The goal of the Population Health management (PHM) programs is to provide a continuum of coordinated, comprehensive care using evidence-based practice guidelines to thereby improve quality of life among our members by preventing exacerbations and reducing the effects of complications of those who participating in L.A. Care's Population Health Management programs.

The model includes a combination of health information technology, the care team and ancillary providers, so that diverse care needs can be met, quality of care can be improved and cost will be sustainably impacted. All Health Services programs must follow a standard structure to include: Identification, Stratification, Enrollment/Engagement, Interventions and Outcomes (ISEIO). Below details the PHM ISEIO Framework.

Conceptual PHM Framework



Source: Care Continuum Alliance, *Outcomes Guidelines Report*, Vol. 5, 2010.

1

Population Health Management Program (PHMP)

The Population Health Management Program (PHMP) information is documented in one central PHM strategy program description that is reviewed and updated annually and the membership demographics assessed, segmented through the annual Population Assessment and the programs are evaluated annually through a PHM Impact Evaluation. Coordinating services through a PHMP helps meet the goals outlined by the Triple Aim healthcare model including evidence based quality care, meeting regulatory requirements, and cost effective member care.

The PHMP strives to address health needs at all points along the continuum of health and wellbeing, through participation of, engagement with and targeted interventions for the member population across all lines of business. The integration of population health management consolidates and coordinates multiple program and service offerings into one seamless system, producing efficiencies that drive improved health outcomes and reduce overall health care spending.

L.A. Care's population health management services are provided by a team that includes wellness and prevention, care management, social services, behavioral health and community resources together whose goal is to coordinate and ensure the right service at the right level. Rather than providing specific service categories into which individuals must fit, L.A. Care's population health management revolves around the individual's needs and adapts to his/her health status—providing support, access and education all along the continuum. Through a high tech, high touch, highly

efficient workflow we can use the widest breadth of data sources with optimal process flow to achieve a holistic view of members and providers for ideal customer relationship management.

The Population Health Management Program is conducted through coordination and collaboration with the following programs: Health Education (HE) Program, Care Management including Complex Case Management (CCM) Program, Disease Management (DM) Program, Behavioral Health and Social Work, Utilization Management (UM), the Quality Improvement (QI) Program and other internal and external programs. The major components of the PHMP are: 1) population identification; 2) stratifying and risk-based segmentation; 3) member enrollment health appraisal and engagement 4) intervening through monitoring; 5) evaluating program outcomes. The PHMP addresses the following areas along the continuum of care with interactive interventions:

- Keeping Members Healthy
- Early Detection/Emerging Risk
- Chronic Condition Management
- Complex Case Management
- Care Transitions
- Patient Safety

Quality of Care

Members with Complex Health Conditions, Seniors and Persons with Disabilities (SPD) and Culturally and Linguistically Diverse Membership

L.A. Care seeks to improve the health and overall well-being of all its members, including Seniors and Persons with Disabilities (SPD) as well as focusing on health disparities. L.A. Care specifically develops programs that target and accommodate members who are at higher risk for health disparities including but not limited to those related to race and ethnicity, language, disabilities and chronic conditions. L.A. Care objectives to address the cultural and linguistic needs of its membership includes, but is not limited to, the following:

- To reduce health care disparities in clinical areas.
- To improve cultural competency in Materials and communications.
- To improve network adequacy to meet the needs of underserved groups.
- To improve other areas of needs the organization deems appropriate.

L.A. Care has undertaken a significant effort to improve services for Seniors and Persons with Disabilities. This population is one that often has complex health needs. This effort has involved review of L.A. Care's departments for the ability to appropriately serve and communicate with disabled members including the availability of L.A. Care member materials in alternative formats (large print, and audio) and to assure the availability of sign-language interpreting as requested. L.A. Care is also developing an enhanced care coordination process to include screening mechanisms to identify the need for more intensive case management and coordination of specialty referral including referrals for linked and carved out services.

HEDIS

L.A. Care measures clinical performance related to Healthcare Effectiveness Data and Information Set (HEDIS) and DHCS Managed Care Accountability Set (MCAS) indicators. HEDIS results are audited by NCQA and DHCS approved external auditors.

On an annual basis, L.A. Care completes an on-site HEDIS Compliance Audit with both HSAG (the DHCS HEDIS Auditor) and Advent Advisory Group (the NCQA HEDIS Auditor) to assess L.A. Care’s information and reporting systems, as well as L.A. Care’s methodologies for calculating performance measure rates. L.A. Care uses the DHCS-selected contractor for performance measures that constitute the MCAS. Compliance Audits are performed by an External Quality Review Organization (EQRO). L.A. Care calculates and reports all NCQA, IHA AMP, and DHCS MCAS and selected Use of Service performance measures. HEDIS rates for L.A. Care are calculated by an NCQA Certified HEDIS Engine and verified by the DHCS-selected EQRO. Rates for DHCS-developed performance measures are calculated by the EQRO. L.A. Care reports audited results on the MCAS performance measures to DHCS no later than June 15 of each year or such date as established by DHCS. DHCS will notify L.A. Care of the HEDIS measures selected for inclusion in the following years’ utilization monitoring measure set.

The following table outlines specific Quality of Care measures and activities that are the subject of ongoing monitoring and evaluation specific to line of business:

Acronym	HEDIS Measure Name	Administrative or Hybrid (A/H) or Electronic Clinical Data System (ECDS)	L.A. Care Covered Measure (QRS)	DHCS Auto Assignment Measure	DHCS Required Measure (MCAS)	NCQA Accreditation Measures - Medicare	NCQA Accreditation Measure - Medi-Cal
AAB	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	A	X				X
ABA	Adult BMI Assessment	H	X		X		X
ADD	Follow-Up for Children Prescribed ADHD Medication-initiation	A			X		
ADD	Follow-Up for Children Prescribed ADHD Medication - Continuation and Maintenance	A			X		X
ADV	Annual Dental Visit (Total Rate)	A	X				X
AMB-ED	Ambulatory Care ED Visits	A			X		
AMB-OP	Ambulatory Care Outpatient Visits	A					

Acronym	HEDIS Measure Name	Administrative or Hybrid (A/H) or Electronic Clinical Data System (ECDS)	L.A. Care Covered Measure (QRS)	DHCS Auto Assignment Measure	DHCS Required Measure (MCAS)	NCQA Accreditation Measures - Medicare	NCQA Accreditation Measure - Medi-Cal
AMM	Antidepressant Medication Management - Acute Phase	A	X		X		
AMM	Antidepressant Medication Management-continuation phase	A	X		X	X	X
AMR	Asthma Medication Ratio (Total Rate)	A			X		X
ART	Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis	A					
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics	A			X		X
APP	Use of First –Line Psychosocial Care for Children and Adolescents on Antipsychotics	A					X
AWC	Adolescent Well-Care Visits	H			X		
BCS	Breast Cancer Screening - Total	A	X		X	X	X
CBP	Controlling High Blood Pressure - Total	H	X	X	X	X	X
CCS	Cervical Cancer Screening	H	X	X	X		X
CDC-N	Comprehensive Diabetes Care - Medical Attention for Nephropathy	H	X				
CDC-BP	Comprehensive Diabetes Care - Blood Pressure Control (<140/90)	H				X	X
CDC-E	Comprehensive Diabetes Care - Eye Exams	H	X			X	X
CDC-H8	Comprehensive Diabetes Care - HbA1c Control <8%	H	X			X	X
CDC-H9	Comprehensive Diabetes Care - Poor HbA1c Control >9%	H			X		
CDC-HT	Comprehensive Diabetes Care – HbA1c Testing	H		X			

Acronym	HEDIS Measure Name	Administrative or Hybrid (A/H) or Electronic Clinical Data System (ECDS)	L.A. Care Covered Measure (QRS)	DHCS Auto Assignment Measure	DHCS Required Measure (MCAS)	NCQA Accreditation Measures - Medicare	NCQA Accreditation Measure - Medi-Cal
CHL	Chlamydia Screening in Women- (Total Rate)	A	X		X		
CIS-3	Childhood Immunization Status - Combo 3	H	X	X			
CIS-10	Childhood Immunization Status - Combo 10	H			X		X
COL	Colorectal Cancer Screening	H	X			X	
CWP	Appropriate Testing for Pharyngitis	A	X				X
DDE	Potentially Harmful Drug-Disease Interactions in Older Adults (Total Rate)	A				X	
DAE	Use of High-Risk Medications in Older Adults (Rate 2 only)	A				X	
DSF	Depression Screening and Follow-Up for Adolescents and Adults	ECDS					
EDU	Emergency Department Utilization	A				X	
FUA	Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	A					
FUH	Follow-Up After Hospitalization for Mental Illness - 7 day	A	X			X	X
FUM	Follow-up After Emergency Department Visit for Mental Illness	A					
HDO	Use Of Opioids At High Dosage	A					
IET	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment - Engagement	A	X			X	X
IMA-2	Immunizations for Adolescents – Combination 2	H	X		X		X

Acronym	HEDIS Measure Name	Administrative or Hybrid (A/H) or Electronic Clinical Data System (ECDS)	L.A. Care Covered Measure (QRS)	DHCS Auto Assignment Measure	DHCS Required Measure (MCAS)	NCQA Accreditation Measures - Medicare	NCQA Accreditation Measure - Medi-Cal
LBP	Use of Imaging Studies for Low Back Pain	A	X				X
MMA-75	Medication Management for People with Asthma-75% Compliance Total (Ages 5-85)	A	X				X
MRP	Medication Reconciliation Post-Discharge	H				X	
OMW	Osteoporosis Management in Women Who Had a Fracture	A				X	
PCE	Pharmacotherapy Management of COPD Exacerbation Systemic Corticosteroid and Bronchodilator	A				X	X
PCR	Plan All Cause Readmissions	A	X		X	X	
PNU	Pneumococcal Vaccination Status for Older Adults	A				X	
PPC-PST	Prenatal and Postpartum Care - Postpartum Care	H	X		X		X
PPC-Pre	Prenatal and Postpartum Care - Timeliness of Prenatal Care	H	X	X	X		X
PSA	Non-Recommended PSA-Based Screening in Older Men	A				X	
SPC	Statin Therapy for Patients With Cardiovascular Disease (Both Rates)	A				X	X
SPD	Statin Therapy for Patients with Diabetes (Both Rates)	A				X	X
SAA	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	A					X
SSD	Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic Medications	A			X		X

Acronym	HEDIS Measure Name	Administrative or Hybrid (A/H) or Electronic Clinical Data System (ECDS)	L.A. Care Covered Measure (QRS)	DHCS Auto Assignment Measure	DHCS Required Measure (MCAS)	NCQA Accreditation Measures - Medicare	NCQA Accreditation Measure - Medi-Cal
UOP	Use of Opioids from Multiple Providers	A					
URI	Appropriate Treatment for Upper Respiratory Infections	A	X				X
W-15	Well-Child Visits in the First 15 Months of Life	H	X		X		
W-34	Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	H	X	X	X		
WCC-BMI	Weight Assessment & Counseling for Nutrition & Physical for Children and Adolescents	H	X		X		X
WCC--N	Weight Assessment & Counseling for Nutrition & Physical for Children and Adolescents	H	X				
WCC-PA	Weight Assessment & Counseling for Nutrition & Physical for Children and Adolescents	H	X				

Safetynet Programs and Partnerships

Health Homes: The Health Homes Program (HHP) is a high-touch care management and wraparound services program, authorized by DHCS, for Medi-Cal members that launched in July 2019. Medi-Cal members with multiple chronic physical health and/or behavioral health conditions and high acuity (such as recent IP &/or ER history) are eligible for the program. Members who opt-in to the program receive varied services, including comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual & family support services, and referral to community & social supports (which includes individual housing transition & tenancy support services). L.A. Care delivers the program through a network of more than 25 contracted high volume providers, and CBOs and plans to serve approximately 4,000-5,000 MCLA members. L.A. Care enrolled more than 2,000 MCLA members in the first six months of the program.

Whole Person Care: L.A. County’s Whole Person Care Program (WPC) comprises 15 different high-touch programs for 6 different vulnerable Medi-Cal populations, including high-risk homeless members, high-risk criminal justice reentry members, high risk members with MH or SUD needs, high-risk transition of care members, and high risk perinatal members. Programs use housing navigators and community health workers as well as licensed clinical staff to provide care management and wraparound services for varied program lengths (1 month to multi-year programs). The core focus is on addressing the social determinants of health as well as the

member's health needs and engaging difficult-to-reach members. Over 28,753 MCLA member enrollments across all programs have occurred as of 9/30/2019 (includes duplicate members who enrolled in multiple programs).

Homeless Programs: In 2016, L.A. Care made a \$20M, 5-year grant commitment to the Housing for Health Program via fiscal intermediary Brilliant Corners. Under the grant, L.A. Care funded rental subsidies for 300 new homeless individuals/families to move into permanent supportive housing, with supportive services provided in-kind by L.A. County as part of the Whole Person Care program; 253 households have been housed to date. L.A. Care has a 16-bed recuperative care pilot with the National Health Foundation. L.A. Care also provides housing navigation and tenancy support services to homeless members enrolled in the Health Homes program, and recently provided grant funding for legal assistance to Angelenos facing eviction. In addition, L.A. Care refers members to the local Coordinated Entry System and recuperative care/interim housing process through the Los Angeles Homeless Services Authority (LAHSA) and collaborates closely with health plan and county partners through various forums and roundtables.

Managed Long Term Services and Supports (MLTSS)

L.A. Care's Managed Long Term Services and Supports (MLTSS) Department provides services that help individuals remain living independently in the community and also oversees extended long-term care provided in a skilled nursing or intermediate care facility. MLTSS serves L.A. Care's members enrolled in the California Coordinated Care Initiative (CCI)/Cal MediConnect (CMC) and Medi-Cal. In 2014 the California Department of Health Care Services (DHCS) began the transition of the MLTSS benefit to L.A. Care. MLTSS oversees five programs: Long Term Care (LTC) Community Based Adult Services (CBAS); Multipurpose Senior Services Program (MSSP); In-Home Supportive Services (IHSS); and Care Plan Options (CPO). MLTSS also supports member, provider and staff inquiries and makes referrals to other L.A. Care programs and community resources. The MLTSS clinical teams (LTC and CBAS) are part of Case Management's interdisciplinary care team (ICT) and also engage with providers and members during routine facility visits. In addition, the MLTSS department oversees L.A. Care's Palliative Care benefit for Medi-Cal members.

QI Health Equity Program

L.A. Care Health Plan ("L.A. Care") is committed to serving a demographically diverse population. Health equity means that everyone has a fair and just opportunity to be as healthy as possible. Addressing health disparities is one way to improve health equity. In order to best address observed health disparities, L.A. Care will employ a holistic, health equity lens for these efforts. L.A. Care's health equity program supports and works collaboratively with other L.A. Care departments including, but not limited to Health Education and Cultural and Linguistics Services, Quality Improvement, Population Health Management, Quality Performance Management, Community Outreach & Engagement, Strategic Planning, Behavioral Health, Care Management, Social Services, Human Resources, Customer Solutions Center (Member Services), Delegation Oversight, and the various product departments (Medi-Cal Administration, Medicare Operations, and Commercial & Group Plan Management) to improve health outcomes for members.

The mission of L.A. Care Health Plan's Health Equity Unit is to, promote health equity by reducing or eliminating barriers that hinder opportunities for individuals and communities to attain the highest level of health. The overall goals of the Health Equity Unit are to:

1. Increase the awareness of health equity and implement strengthened, expanded and/or new health equity activities to support providers, staff and members ultimately reducing health inequities within L.A. Care's membership
2. Systematically address and reduce health disparities in order to improve health outcomes.
3. Increase alliance building and partnerships with community partners and local health systems to align and synergize collective health equity efforts.
4. Advocate for changes in policies and health system processes to improve health equity.

Maternal Mental Health Program

Maternal mental health care is an established benefit for L.A. Care members, however, recent legislation has been passed to help ensure support for perinatal women by linking them to behavioral health providers and other supportive community resources. This program is designed to promote quality and cost effective outcomes and is consistent sound clinical principles and processes.

As of July 1st, 2019, L.A. Care will require all licensed health care practitioners who provides prenatal or postpartum care for members to ensure mothers are offered screening or are appropriately screened for maternal mental health conditions. These screenings shall take place during at least one of the following periods during pregnancy and postpartum:

- Prenatal period (during pregnancy before birth)
- Postpartum period (up to 1 year after giving birth)
- Perinatal period (during pregnancy and postpartum)

L.A. Care's Managed Behavioral Health Organization, Beacon Health Options, has implemented a maternal mental health program centered around network identification and development, member linkage to appropriate providers, case management support and data tracking.

To supplement network and referral enhancements implemented by the Beacon Health Options, L.A. Care plans to implement training and education programs focused on maternal mental health. To deliver and disseminate these trainings, L.A. Care will partner with community advocacy organizations, such as Maternal Mental Health Now; with subject matter experts such as reproductive psychiatrists already in the provider network; and with existing perinatal health programs operated by the County Department of Public Health (such as Black Infant Health and the Nurse Family Partnership) and Department of Health Services (Mama's Neighborhood).

Guidelines and criteria shall be made available upon request to medical providers, including contracted obstetrics providers professionals. L.A. Care will ensure compliance through oversight and monitoring through internal compliance programs and through provider network relations.

Care Management/Disease Management Programs

The Care Management (CM) and Disease Management (DM) Programs are a component of L.A. Care's Population Health Management Program (PHMP) with the objective to improve the health

status of its eligible members with chronic conditions. The programs achieve this objective by educating the member and by enhancing the member's ability to self-manage his or her condition or illness. Programs are developed from evidenced-based clinical practice guidelines and support the practitioner–patient relationship, plan of care and foster patient empowerment. L.A. Care's Disease Management Programs include: Asthma, Diabetes, and Cardiovascular Risk Reduction. These conditions were selected based on common chronic conditions experienced by L.A. Care members and the success of disease management programs in helping patients with chronic illness improve their health status over the course of the disease. At a minimum each disease management program addresses the following components:

- Systematic identification and stratification of members who qualify for programs monthly through sources including claims or encounter data, pharmacy data, health appraisal results, laboratory results if applicable, data collected through the UM or case management processes, data from wellness or health coaching programs and information from EHRs if available and member and practitioner referrals.
- Integration of member information from disease management, case management, utilization management, wellness programs and the health information line to facilitate access to member health information for continuity of care.
- Improve patient self-management/activation of disease through education, empowerment, monitoring, and communication.
- L.A. Care's Disease Management and Care Management Programs document all member interactions for members in L.A. Care's Core System Clinical Care Advance (CCA). Nurses document members' assessments and problems, goals and interventions and reporting is pulled from CCA.
- As part of the CCA transition, all active DM members will have care plans that include personalized goals and interventions based on clinical practice guidelines. For example, care plans will include goals and interventions to improve medication compliance, the use of asthma action plans and the use of internal and community based asthma resources. CM activities have been documented in CCA since its implementation.
- Interventions are provided based on member's stratification and assessment.
- Condition monitoring, patient adherence to the program's treatment plans, consideration of other health conditions, co-morbidity, psychosocial, depression screening, and lifestyle issues as indicated by clinical practice guidelines.
- Provide culturally and linguistically appropriate health education materials.
- Communicate information about the member's condition to caregivers with member's consent.
- Improve practitioner performance of condition treatment through adoption of evidence-based clinical guidelines and practitioner and member feedback.
- Expand program services and resources through community collaboration.
- Provision for eligible members to receive written program information regarding how to use the services, how members become eligible to participate, and how to opt in or opt out.
- Annual measurement and analysis of member satisfaction and complaints and inquiries.
- Annual measurement of active program participation rates.
- Tracking of at least one performance measure for each disease management program. Each measurement addresses a relevant process or outcome, produces a quantitative result, is population based, uses data and methodology that are valid for the process or outcome

measured, and is analyzed in comparison to a benchmark or goal. These results are reported in the annual QI program evaluation.

Utilization Management (UM) (Serving members with complex health needs)

L.A. Care’s Utilization Management activities are outlined in the Utilization Management Program Description, which includes persons with complex health conditions. The UM Program Description defines how UM decisions are made in a fair and consistent manner. L.A. Care also has Care Management activities and there is a Care Management Program Description and a Complex Case Management Program Description. L.A. Care also has Managed Long Term Services and Support Program Descriptions that includes CBAS, MSSP, IHSS and LTC. These programs address serving members with complex health needs, such as, seniors and people with physical or developmental disabilities (SPDs) and/or multiple chronic conditions. There is one staff person dedicated to working with “linked and carved out services” such as the Regional Centers, California Children Services (for children with complex health care needs) and the Department of Mental Health. The UM Program Description is approved by the UMC. For additional information, refer to the UM Program Description.

Transition of Care Programs

As part of the UM process, PPGs must maintain a process to manage discharges through a Transition of Care (TOC) program. The TOC program should evaluate members at the time of the admission to identify members “at risk” for an adverse or complicated transition.

PPGs will be assessed to ensure the TOC program meets the minimum requirements. The policy of L.A. Care is that all PPGs have a TOC program, which supports appropriate coordination of care in a member-centric manner that is cost effective.

For L.A. Care Direct Line of Business Members, L.A. Care will continue to be responsible for providing TOC services directly. The L.A. Care-provided TOC Program will be reviewed and enhanced during 2020 to meet the needs of these members as well as the providers in this network.

Pharmacy Management

Pharmacy and formulary utilization is monitored regularly with reports and updates to the Quality Oversight Committee (QOC). The Pharmacy Quality Oversight Committee (PQOC) performs regular reviews and updates to the formulary, utilization edits, guidelines, and policies and procedures based on clinical evidence available at the time of consideration. Since the management of the Medicare Part D Formulary is delegated to a contracted Pharmacy Benefit Manager (PBM), Navitus, the Pharmacy staff performs oversight to ensure compliance with CMS requirements. With the PBM, L.A. Care collects prescription drug quality measures, consistent with Medicare Part D requirements and has established quality assurance measures and systems to reduce medication errors, adverse drug interactions and improve medication use. (See also Patient Safety section of this program).

Additionally, L.A. Care participates in the Part D Medication Therapy Management (MTM) program, which examines multi-drug therapy for specific chronic conditions. The MTM program can be used to satisfy the requirements under the Centers for Medicare and Medicaid Services

(CMS) that pertain to assessing the quality and appropriateness of care and services, as outlined in 42 CFR §438.204, §438.208, §438.240, and §422.152.

L.A. Care’s MTM program is contracted out to SinfoniaRx to perform medication reviews for our Cal MediConnect members, including Comprehensive Medication Reviews (CMR) and Targeted Medication Reviews (TMR). CMRs occur at least annually to identify any potential medication duplications or conflicts, prescriber or over-the-counter consult opportunities, and decisive clinical information. Following the CMR, members are provided with a Medication Action Plan (MAP) and a Personal Medication List (PML). TMRs occur at least quarterly to review the members’ prescriptions and make contact to members’ and/or prescribers for any identified potential pharmacotherapy concerns. Data from SinfoniaRx is analyzed and reported to CMS. In addition, L.A. Care reviews for quality assurance of SinfoniaRx, to ensure our vendor is up to the standard according to CMS guidance.

Medicare Measurement and Reporting Requirements

The Centers for Medicare and Medicaid Services (CMS) has implemented a comprehensive measurement set for monitoring quality of care, member experience, and plan administration of contractual standards. For Cal MediConnect, L.A. Care measures and reports all required HEDIS, CAHPS, and Health Outcomes Survey (HOS) measures to NCQA and CMS. In addition, Medicare-Medicaid Plans (MMP) are required to report Core, California-specific Part C and Part D measures per the three-way contract. These measures evaluate the effectiveness of the Care Coordination and Quality Improvement Program Effectiveness (CCQIPE) and encompass Part C and D program areas.

Chronic Care Improvement Programs (CCIP) - Medicare

The objective of L.A. Care’s Chronic Care Improvement Program (CCIP) is to improve the health status of its eligible members at risk for chronic heart conditions. The program achieves this objective by educating the member and by enhancing the member’s ability to self-manage his or her condition or illness or implement risk reduction lifestyle and clinical changes. CCIPs are developed from evidenced-based clinical practice guidelines and support the practitioner–patient relationship, the plan of care as well as foster patient empowerment. The CCIP was selected based on an analysis of internal data relating to disease prevalence within the L.A. Care population, in addition to CMS requirements to align with the Centers for Disease Control and Prevention and Centers for Medicare and Medicaid Services’ Million Hearts® Initiative.

At a minimum, the CCIP addresses the following components:

- Multiple data sources and QI processes are used to identify need for CCIP. Identifying enrollees who meet the criteria for participation in the program monthly.
- The CCIP demonstrates a rigorous enrollment method that reaches a significant segment of the targeted population while exhibiting robust participation in the program. Participation in the program is measured annually by member participation rates.
- Condition monitoring, patient adherence to the program’s treatment plans, consideration of other health conditions and lifestyle issues as indicated by clinical practice guidelines. Interventions reach a significant segment of the targeted population, impact multiple aspects of problem, and address health literacy/cultural needs of members.

- Use of nationally recognized clinical guidelines that are reviewed at a minimum of every two years unless the guidelines change earlier.
- Member interventions are based on stratification.
- Systematic program monitoring is integrated into the program; program progress of enrollee is reviewed at least annually and opportunities for improvement are addressed. At least one performance measure for each program is tracked. Specific, appropriate outcome/performance measures are provided.

Topic	Product Line
Chronic Care Improvement Plan (CCIP/Disease Management)	
Cardiovascular Disease	Cal MediConnect, Medi-Cal, and L.A. Care Covered

Quality Improvement Projects (QIPs)

L.A. Care conducts Quality Improvement Projects (QIPs) in compliance with the Department of Health Care Services’ (DHCS), and the Centers for Medicare and Medicaid Services (CMS) requirements. DHCS requires that Medi-Cal plans have two long-term quality improvement projects known as Performance Improvement Projects (PIPs) and assigns rapid cycle quality improvement projects known as Plan Do Study Act cycles (PDSAs) for low performing measures. CMS requires dual plans to participate in one PIP that is a DHCS-facilitated statewide collaborative during the course of Cal MediConnect (CMC). CMS may require PDSAs at their discretion. Per guidance of these entities, both Medi-Cal and CMC PIPs are overseen by DHCS.

Performance Improvement Project (PIPs)

L.A. Care conducts quality and performance improvement projects with the aim of achieving meaningful and sustainable improvements, which are statistically significant, in aspects of clinical and non-clinical care. L.A. Care conducts at least three state-mandated rapid-cycle PIPs; two PIPs for Medi-Cal and one PIP for Cal MediConnect. PIPs are initiatives focused on one or more clinical and/or non-clinical areas with the aim of improving health outcomes and beneficiary satisfaction. Additional ad hoc PIPs can be required based on priorities identified by DHCS. L.A. Care is responsible for ensuring delegates comply with all applicable state and federal laws and regulations and other contract requirements as well as DHCS’s guidance, including All Plan Letters for quality and performance improvement requirements.

For Medi-Cal, L.A. Care chooses the first PIP topic from state-selected topics related to the Medi-Cal Managed Care Program Quality Strategy priority areas. The second Medi-Cal PIP topic is selected from a specific area in need of improvement and requires DHCS approval. PIPs are conducted over a 12 to 18-month period and require the submission of four modules to the Health Services Advisory Group (HSAG). In addition to the PIPs, improvement projects are undertaken with Managed Care Accountability Set (MCAS) measures below the Minimum Performance Level (MPL) in any given reporting year; these are referred to as PDSA cycles that are evaluated quarterly and documented and submitted on PDSA cycle worksheets. L.A. Care participates in

quarterly collaborative meetings facilitated by HSAG to learn of evidence-based strategies and quality improvement science and to collaborate on improvement strategies.

For CMC, the PIP is an assigned statewide collaborative PIP. The PIP must utilize the outcome-focused improvement strategies and must be documented and submitted on forms supplied by the HSAG, differ from the Medi-Cal forms. L.A. Care is required to use the DHCS EQRO methodology for their PIP submissions. The methodology is outlined and determined at the start of each new PIP and follows the lifecycle through to completion.

Plan-Do-Study-Act (PDSA)

For Medi-Cal, L.A. Care identifies HEDIS indicators with rates below the MPL using the final audited HEDIS measurement year rates submitted to DHCS that are part of the MCAS. L.A. Care completes and submits a PDSA cycle worksheet for each measure with a rate below the MPL and conducts quarterly evaluations of the ongoing rapid-cycle quality improvement interventions. PDSA’s are used by L.A. Care to perform small tests of change in real work settings to determine if the change is an improvement. PDSAs have the flexibility of being able to make adjustments throughout the improvement process with real-time tracking and evaluation of the interventions. L.A. Care develops PDSA cycles using Specific, Measurable, Achievable, Relevant, and Time-Bound (SMART) objectives with interventions selected and tested. The progress of a PDSA is monitored by DHCS and interventions are either adopted, modified or abandoned by L.A. Care based on the change experienced.

For the CMC Plan, PDSAs are issued by CMS on an as needed basis. Similar to Medi-Cal, the CMC PDSAs use SMART objectives to measure improvement and intervention are either adopted, modified or abandoned by L.A. Care based on the change experience. The PDSAs are submitted quarterly on a PDSA cycle worksheet issued by CMS. The progress of the PDSA(s) is managed by Managed Care Operations Division (MCO) Contract Manager.

Quality Improvement Projects 2019-2021

<i>Topic</i>	<i>Type</i>	<i>Product line</i>
Improving CIS- 3 Rates	PIP	Medi-Cal
Improving Asthma Medication Ratio Rates	PIP	Medi-Cal
Improving Individual Care Plan Completion Rates	PIP	CMC
Reducing Avoidable Inpatient and ER Visits From Long –Term Care Settings	PDSA	CMC

Patient Safety

L.A. Care is committed to improving patient safety and promoting a supportive environment for network practitioners and other providers to improve patient safety. Information about safety issues is received from multiple sources including but not limited to member and practitioner

grievances, adverse issues, pharmacy data such as polypharmacy, facility site reviews, continuity of care activities, and member satisfaction survey results. Many of the ongoing QI Program measurement activities, including measures for accessibility, availability, adherence to clinical practice guidelines and medical record documentation include safety components. When performance is analyzed for these measures, patient safety is considered, opportunities are identified and prioritized and actions taken to improve safety.

L.A. Care collects and tracks critical incidents by Cal MediConnect (CMC) enrollee and ensures referrals to appropriate agencies are made for follow up. L.A. Care also makes referrals to local Adult Protective Services (APS) agencies or, when appropriate, law enforcement, and tracks the number of cases referred for enrollees, including those receiving Managed Long-Term Services and Supports (MLTSS).

A “critical incident” is an incident in which the enrollee is exposed to abuse, neglect or exploitation, a serious, life threatening, medical event for the enrollee that requires immediate emergency evaluation by medical professional(s), the disappearance of the enrollee, a suicide attempt by the enrollee, unexpected death of the enrollee, and restraint or seclusion of the enrollee.

L.A. Care follows state laws to report suspected child or adult abuse, neglect, or domestic violence and makes referrals to appropriate agencies as appropriate. L.A. Care has a policy on reporting suspected cases and tracks referred cases.

Potential Quality of Care Issue (PQI) Reviews

Potential Quality of Care Issue (PQI) cases are referred to the Quality Improvement (QI) Department Provider Quality Review (PQR) team for clinical evaluation, investigation, resolution, and tracking. The PQI referral criteria are developed specifically for each of the care delivery support teams (i.e. Customer Solution Center Team, Appeals and Grievance Team, Case Management Team, Utilization Management and Behavior Health Team) to appropriately identify the potential quality of care concern. The PQR nurses conduct the initial triage review for all PQI referrals to ensure all referrals are meeting PQI referral criteria. Triage 0 is assigned when the referral does not meet PQI referral criteria. Triage 1, 2, 3 or 4 will be assigned for cases requiring further review for quality of care concerns. Ongoing clinical trainings are done at least annually to ensure both new and seasoned staff understand the PQI referral criteria and how to submit a PQI. PQI updates are shared with L.A. Care network providers and provider groups through QI Webinar. Meeting with Customer Solution Center, A&G and other areas are scheduled as needed to discuss cases and process improvement. In 2020, monthly oversight of Customer Solution Center and A&G will be implemented by random review of cases that are not identified and referred as PQI to capture potential miss identification of PQIs. The PQR team will continue to explore other venues where PQI can be proactively identified, i.e. from encounter data review on mortality report and/or collaboration with UM to review provider preventable reportable condition.

The PQR nurses conduct the initial clinical review of all PQI referrals. PQI severity level 0/no quality of care, level 1/appropriate quality of care, and/or quality of service cases are closed and tracked by QI nurse/s. All other quality of care issues with severity level 2/borderline quality of care and above are reviewed by QI Medical Director. PQI cases with severity level 3/moderate quality of care or 4/serious and/or significant quality of care are subsequently presented to the Peer

Review Committee for review, assignment of final severity level, action, and resolution as needed. All PQI cases are tracked and trended on a quarterly basis for timeliness of acknowledgement and resolution, issue type, provider type, and severity level assignment. A provider scoring algorithm was designed to apply weighted point values to all severity levels. This allows trending for a high volume of lower scoring cases as well as high severity cases. Any provider/provider group/facility meeting the threshold of 5 points or more within the rolling 12-month measurement period, a focused review will be conducted to identify trends or patterns of issues. The finding of the focused review will be presented to the QI Medical Director or designee for further action and/or presentation to Credentialing/Peer Review Committee and/or Quality Oversight Committee. The committee will identify potential interventions and measure(s) to address opportunities for improvement.

L.A. Care PQI Interrater Reliability (IRR) evaluation, set forth in P&P QI-32 PQI IRR, is an established process for interrater reliability testing, evaluation, and monitoring to improve the consistency and accuracy of the application of review criteria in the leveling and final reporting of PQI. Every quarter, all PQI cases closed/leveled by PQI nurse reviewers are subject to IRR review by clinical staff (i.e. Provider Quality Manager, QI Medical Director or CMO designee(s)). IRR results are reviewed with all PQI reviewers to identify system/process improvement needs and/or identify the needs for individual/group education.

Hospital Safety

L.A. Care uses Cal Hospital Compare (CHC) data to compare patient safety performance across California Hospitals. CHC produces three Hospital Honor Rolls: Maternity Care, a Patient Safety Honor Roll and a Leapfrog Hospital Safety Grade. The CHC report also generated Patient Safety poor performers to identify hospitals who have fall below the median rate for the following for Calendar Year 2017: Central Line Associated Blood Stream Infections (CLABSI), Catheter-Associated Urinary Tract Infections (CAUTI), Surgery Site Infection- Colon (SSI –Colon), Methicillin-Resistant Staphylococcus Aureus (MRSA), and Clostridium difficile (CDIFF). NTSV C-Section Rates are reported from the California Maternity Quality Care Collaborative (CMQCC) for each network hospital providing maternity care. California Department of Public Health (CDPH) reports CLABSI, MRSA, SSI-Colon, and C.Diff rates to monitor hospital and patient safety. L.A. Care also uses Centers for Medicare and Medicaid Services (CMS) to measure CAUTI rates. QI collaborates with Utilization Management and Provider Network Management (PNM) hospital managers to develop intervention/plans. L.A. Care also reviews whether any of these metrics will be used as a quality based contract element for hospital contracts.

Pharmacy

Pharmacy safety measures include edits at the point of service. Each prescription filled is subject to a prospective drug utilization review. This review includes a search for possible drug interactions and previous known allergies to reduce the risk of dispensing medications with potential adverse consequences.

Facility Site/Medical Record Review

L.A. Care adheres to established DHCS medical record standards and guidelines to facilitate communication, coordination and continuity of care, and to promote safe, efficient and effective

treatment. L.A. Care monitors primary care provider (PCP) medical record documentation and compliance with DHCS medical record guidelines. A medical record review is completed, at minimum, every three years for all PCP practice site to evaluate compliance with medical record standards. A follow up audit can be conducted for those PCP sites that do not meet acceptable standards as determined by the certified site reviewer.

Guidelines for Care – Clinical Practice and Preventive Health Guidelines

L.A. Care Health Plan (L.A. Care) systematically reviews and adopts evidence-based Clinical Practice and Preventive Health Guidelines promulgated from peer reviewed sources for diseases and health conditions identified as most salient to its membership for the provision of preventive, acute or chronic medical and behavioral health services. L.A. Care maintains processes to ensure that healthcare is delivered according to professionally recognized standards of care. For selected treatment most relevant to the insured population, L.A. Care adopts and disseminates Clinical Practice and Preventive Health Guidelines sponsored by government and non-government organizations.

New and revised Clinical Practice and Preventive Health Guidelines are presented annually, and/or as necessary, to L.A. Care’s Joint Performance Improvement Collaborative Committee and Physician Quality Committee for review and adoption. Adopted Clinical Practice and Preventive Health Guidelines shall be disseminated to new practitioners within the L.A. Care provider manual. Existing practitioners impacted by newly adopted or updated guidelines shall be notified via the provider newsletter or targeted mailings. The provider newsletter shall advise providers to review the full list of adopted and updated guidelines made available on L.A. Care’s provider website.

Clinical Practice and Preventive Health Guidelines may be monitored through Healthcare Effectiveness Data Information Set (HEDIS®) measures, medical record review process, or other measures as appropriate. L.A. Care annually measures two Clinical Practice Guidelines one medical and one behavioral health conditions.

Clinical practice guidelines provide the clinical basis for L.A. Care’s Disease Management Programs for Diabetes, Asthma, and Cardiovascular Risk. Guidelines are also adopted that are salient to its membership and may be used for quality-of-care reviews, member and provider education, and/or incentive programs, and to assure appropriate benefit coverage.

Preventive Health Guidelines

Adult preventive health services are provided in accordance with the most recent U.S. Preventive Services Task Force (USPSTF) Guidelines. Pediatric preventive health services are provided to members up to age 21 years and in accordance with the most recent ‘Recommendations for Preventive Health Care’ by the American Academy of Pediatrics (AAP) Bright Futures. Periodicity schedules for health assessment and dental referrals by age are provided by the California Department of Health Care Services for members up to age 20 years.

Adult and child immunizations are provided in accordance with Immunization schedules approved by the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), the American Academy of Family Physicians (AAFP), and the American

College of Obstetricians and Gynecologists (ACOG). Perinatal Prenatal services are provided in accordance with the AAP and ACOG Guidelines for Perinatal Care.

The Centers for Medicare and Medicaid Services generally provides preventive health services to Medicare members in accordance with the USPSTF Guidelines. These services are published online at: <https://www.medicare.gov/coverage/preventive-and-screening-services.html>

Behavioral Health Guidelines

For selected lines of business, L.A. Care delegates behavioral health services to a National Committee for Quality Assurance (NCQA) Accredited Managed Behavioral Health Organization (MBHO). For enrollees in those plans, the MBHO collaborates with L.A. Care on the approval and monitoring of the selected Clinical Practice Guidelines for behavioral health with input and approval at the Behavioral Health Quality Committee quarterly meetings. For its overall population, L.A. Care shall adopt at one behavioral health guidelines. Behavioral health clinical practice guidelines are available for all practitioners through L.A. Care's and the MBHO's website with paper copies available upon request.

Quality of Services

Member Experience

L.A. Care monitors member satisfaction with care and service to identify potential areas for improvement. To assess member satisfaction, L.A. Care reviews multiple sources of data including, but not limited to, evaluation of member complaints, grievances, appeals, data collected from the annual Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, and other ad-hoc member surveys. Opportunities for improvement are identified; priorities are set; and interventions are selected, implemented, monitored and evaluated through various internal committees. Results are presented to the Member Quality Service Committee, the Joint PICC & PQC, the QOC, and Compliance and Quality Committee.

Provider Satisfaction Survey

L.A. Care monitors provider satisfaction with L.A. Care on relevant health programs, services, and processes. In order to obtain more actionable feedback, the annual provider satisfaction survey also includes open-ended questions that allow providers to give feedback on service quality issues otherwise not captured on the survey. The survey questions focus on L.A. Care's practitioner service areas: access to specialists, utilization management, disease management, quality management, care management, behavioral health, and coordination of care between PCPs and hospitals, coordination of transition of care, pharmacy services, and overall satisfaction. The survey is fielded annually for all lines of business and samples primary care physicians, specialty care physicians, community clinics, and provider groups. Results are presented to the Joint Performance Improvement Collaborative Committee (PICC) & Physician Quality Committee (PQC).

Complaints and Appeals

Complaints including those related to Cultural and Linguistic issues and appeals are tracked and trended on a quarterly basis for timeliness of acknowledgement and resolution, issue types, and by

provider type. The quarterly report is presented and reviewed by the Member Quality Service Committee, the Credentialing Committee, and the Quality Oversight Committee (QOC). Committees will identify potential interventions and measure(s) to address opportunities for improvement.

L.A. Care Health Plan collaborates with a Quality Improvement Organization (QIO) appointed by CMS in the state of California. QIOs are organizations comprised of practicing doctors and other health care experts under contract to the Federal government to monitor and improve the care given to Medicare enrollees. The following types of issues would be referred to QIOs for their review:

- Complaints raised by enrollees about the quality of care provided by physicians, inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Medicare health plans, and ambulatory surgical centers.
- Continued stay denials for enrollees receiving care in acute inpatient hospital facilities as well as coverage terminations in SNFs, HHAs and CORFs.
- Quality of Care Issue: A quality of care complaint may be filed through the L.A. Care's grievance process and/or a QIO. A QIO must determine whether the quality of services (including both inpatient and outpatient services) provided by a Medicare health plan meets professionally recognized standards of health care, including whether appropriate health care services have been provided and whether services have been provided in appropriate settings.

Availability of Practitioners

Availability of practitioners is assessed by the Provider Network Management (PNM) Department using quantifiable standards for both geographic distribution and numbers (ratio of providers to members) of PCPs, and high volume and high impact specialists, including high volume behavioral health practitioners and specific high volume ancillary providers. L.A. Care has defined standards for geographic availability of providers and physician to enrollee ratios. L.A. Care assesses the cultural, ethnic, racial, and linguistic needs of its members and adjusts the availability of providers if necessary.

In creating and developing our delivery system of practitioners, L.A. Care takes into consideration assessed special and cultural needs and preferences of our members. L.A. Care develops and adheres to establishes standards for availability of primary care, specialty care, hospital based and ancillary providers by:

- Ensuring that standards are in-place to define practitioners who serve as Primary Care Practitioners (Pediatrics, Family Practice, General Practice, Internal Medicine, etc.).
- Assigning members to a Primary Care Physician within five miles of their home unless otherwise requested by the member or family. In locations where there is a dearth of primary care physicians and none are available within the 5-mile standard, L.A. Care uses Alternative Access Standards as approved by regulatory bodies to determine availability.
- Referring each member to a specialist within travel distance requirements applicable to the member's affiliated line of business. Where these standards cannot be met due to a scarcity of physicians within the member's geographic location, L.A. Care measures availability against Alternative Access Standards as approved by the appropriate regulatory body.
- Ensuring a database is in-place which analyzes practitioner availability and network ability to meet the special cultural need of our members.

- Ensuring members are within (15) fifteen miles or (30) thirty minutes from a contracted hospital and ancillary service. Where hospitals travel distance standards cannot be met because of a member's geographical location, L.A. Care will adhere to Alternative Access Standards as approved by the appropriate regulatory body.
- Providing members with covered transportation services as needed.
- Reassessing the appropriateness of existing standards as required and annually evaluating providers' compliance with existing standards.
- Annually reviewing and measuring the effectiveness of these standards through specialized studies.

Accessibility of Services

L.A. Care has established standards for the accessibility of primary care, specialty care, behavioral health care, and ancillary care. These include standards to address the following, but is not limited to:

- Appointments for routine primary care and specialty care
- Urgent primary and specialty care appointments
- Emergency Care
- After hours access to primary care
- Wait times for appointments
- Preventive health appointments
- Telephone service
- Routine, urgent, and non-life-threatening emergent behavioral health care
- Behavioral health telephone access
- Language assistance services
- Inclusion of member survey information (CAHPS)
- Inclusion of member complaint data.

L.A. Care collects and performs an annual analysis of data to measure its performance against its access standards. The data sources include but are not limited to: CAHPS survey, Access to Care studies, and L.A. Care's Behavioral Health Partner.

An access to care study is conducted annually to measure the compliance of contracted physicians in rendering medical care within timeframes established by the Department of Managed Healthcare (DMHC), Centers for Medicare and Medicaid Services (CMS), and other regulatory agencies. The study measures in "wait-days" the length of time it takes for a patient to receive various types of primary care appointments and routine appointments in targeted areas of specialty care and behavioral healthcare.

Customer Solutions Center L.A. Care has established standards for access to customer solutions center by telephone. These standards include call abandonment rate, wait time, and service level. Performance data are provided to the MQSC on a regular basis.

Telehealth Services

Effective January 1, 2020, L.A. Care offers Telehealth services for our direct line of business members (MCLA, CMC, and LACC) to improve access to care when their primary care doctor is not available.

This expansion of our contracted provider network offers increased access for minor, non-emergency services by phone or video chat. L.A. Care's Telehealth is staffed by U.S. Board Certified licensed doctors who can diagnose, treat, and write prescriptions for low acuity illnesses, cold/flu, vomiting, diarrhea, minor rashes, minor burns and more.

L.A. Care's Telehealth services allow members to receive care when their primary care doctor isn't available. Our vendor, Teladoc, offers U.S. Board Certified licensed doctors available 24/7 in California by phone or video chat to treat non-emergency medical issues. Teladoc provides our members with an additional option for urgent care when they are unable to get to their doctor's office. This increased access may also help reduce unnecessary emergency room visits.

Minute Clinics

L.A. Care offers a new way for our direct line of business members (MCLA, CMC and LACC) to access care at all MinuteClinic locations in L.A. County. MinuteClinic is a walk-in health care retail clinic, located in select CVS Pharmacy stores and are open 7 days a week, but the hours vary by location and during seasons of higher demand. Members can view wait times on the MinuteClinic website prior to visiting and hold a place in line up to 3 days in advance, they can also walk-in without an appointment.

This expansion of our contracted provider network, launched Saturday June 1, 2019 offers access for minor, non-emergency services and will help increase access to health care for members when their primary care physician is not available. MinuteClinic locations are staffed by nurse practitioners, who can diagnose, treat, and write prescriptions for low acuity illnesses, injuries or skin conditions, and administer vaccinations for adults.

Contracting

L.A. Care requires that its contracted network cooperate with L.A. Care's quality improvement activities, as well as provide L.A. Care access to medical records and that member information be kept confidential according to applicable laws.

L.A. Care requires that all provider network contracts contain an affirmative statement indicating that practitioners may freely communicate with patients about their treatment, regardless of benefit coverage limitations.

L.A. Care does not exert economic pressure to cause institutions to grant privileges to providers that would not otherwise be granted, nor to pressure providers or institutions to render care beyond the scope of their training or experience.

Transform L.A.

Transform L.A. is a technical assistance program for L.A. Care Direct Network providers that provide primary care services and use an electronic health record (EHR) that supports practices in

building quality improvement capacity and delivering high quality, evidence-based care that will provide measurable value to your practice and your patients.

Areas of Focus Can Include:

- Using data to drive practice improvements
- Implementing population health management (PHM) strategies
- Running reports on clinical quality measures from your EHR and/or other PHM tools
- Optimizing Healthcare Effectiveness Data Information Set (HEDIS) results, and P4P, Prop 56, and VBP revenue
- Providing workflow redesign support
- Training staff on variety of topics, such as Quality Improvement 101 and medical assistant professional development modules

Credentialing/Recredentialing

L.A. Care develops and adheres to credentialing and recredentialing policies and procedures, including a process to document the mechanism for the credentialing/recredentialing and ongoing monitoring of licensed independent practitioners and health delivery organizations (HDOs) with whom it contracts, including the autism network. The Credentialing Department performs audits of our delegated partners each year and collaborates with, and receives reports of activity from the Facility Site Review (FSR) Department, Payment Integrity (Special Investigations Unit) Department, Appeals and Grievances (A&G) Department, and the Potential Quality of Issues (PQI) Team, through the monthly Credentialing/Peer Review Committee meeting. The Credentialing Department reports regularly to the Quality Oversight Committee with an update from the Credentialing Committee.

Member, Provider, and Practitioner Communication

Member Communication

Member communication occurs in a variety of ways. The member evidence of coverage booklet provides members with a written description of health plan benefits and other subscriber issues. Member newsletters disseminate information regarding changes to benefit coverage and services, preventive healthcare guidelines, special events and services, legislative changes, health management programs, enrollment information, health education, access to interpreter services, and issues related to patient safety. Targeted mailings are used to promote L.A. Care’s care management programs, chronic care improvement programs, health education opportunities, and Regional Community Advisory Committee events. Educational materials are available through the Health Education, Cultural and Linguistic Services Department. Materials are developed to address the cultural and linguistic needs of L.A. Care’s diverse population. QI program updates and improvements in care management resulting from its overall quality improvement program are also posted for all stakeholders on the website. Members are notified of the information that is available on the L.A. Care website and may use this site and/or call customer solutions center to request paper copies of information available on the website. The Regional Community Advisory Committees also provide a means to facilitate member participation in the Quality Improvement program.

L.A. Care offers the availability of telephonic and/or digital access to the following services for all product lines.

- Electronic Health Appraisal
- Self-Management Tools
- Functionality of Claims Processing
- Pharmacy Benefit Information
- Personalized Information on Health Plan Services
- Member Support through Innovative Technologies (eConsult, prescribing, scheduling, etc.)
- 24 Hour Health Information Line including Interpreter Services
- Encouraging Wellness and Prevention

The following table lists key measures captured for all lines of business as a component of annual CAHPS:

Measure	
Data Source: CAHPS	
Access to Care (getting needed care, getting care quickly)	Rating of All Health Care
Access to information (plan information on costs)	Rating of Health Plan
Care Coordination (coordination of members' health care services)	Rating of Personal Doctor
Medical Assistance with Smoking and Tobacco Use	Rating of Specialist (specialist seen most often)

Provider and Practitioner Communication

A provider/practitioner newsletter communicates updates on all aspects of the health plan including pharmacy procedure, health management programs, provider and patient education opportunities, cultural and linguistic training opportunities, Language Assistance Program services, Utilization Management program changes, and patient safety issues. The newsletter is published four times a year. L.A. Care also publishes a provider e-newsletter six times a year. Providers are kept abreast of the information that is available on the L.A. Care website and on the provider portal. They may use these resources to stay updated and/or call to request paper copies.

Provider Incentive Programs

L.A. Care’s Quality Improvement (QI) Department operates provider pay-for-performance (P4P) incentive programs to improve HEDIS, CAHPS, access to care, auto-assignment, NCQA accreditation, and member care. They are also designed to improve L.A. Care’s administrative data capture via encounters, labs, and other admin data sources. Incentive programs provide a highly visible platform to engage providers in quality improvement activities; provide peer-group benchmarking and actionable performance reporting; and deliver value-based revenue tied to quality. Incentives for physicians, community clinics, PPGs, and health plan partners are aligned where possible so that all providers in L.A. Care’s network pursue common performance improvement priorities.

2020 marks the tenth year of L.A. Care’s Physician P4P Program, which targets high-volume solo and small group physicians and community clinics. The Physician P4P Program provides performance reporting, and financial rewards for practices serving Medi-Cal members, and represents an opportunity to receive significant revenue above capitation. Eligible physicians and clinics receive annual incentive payments for outstanding performance and improvement on multiple HEDIS measures. L.A. Care is exploring adding new domains and measures related to utilization management and member experience for future Physician P4P program years, which are currently being tested for program fit. Additional metrics related to medical record request compliance and California Immunization Registry (CAIR) usage are also being tested.

The Value Initiative for IPA Performance (VIIP) aims to improve the quality of care for L.A. Care members by supporting the development of a robust network of high performing PPGs. VIIP continues in 2020 and measures, reports, and provides financial rewards for provider group performance across multiple domains, including HEDIS clinical quality, utilization, encounters and member experience. The VIIP program also actively engages with PPGs to develop ‘Action Plans’ focused on setting SMART Goals and improving in lower performing areas. With its success in Medi-Cal, the VIIP program has expanded to the Cal MediConnect and L.A. Care Covered lines of business (LOBs), with a set of domains and measures relevant to providers and members for those LOBs.

L.A. Care’s Plan Partner Incentive Program aligns the efforts of L.A. Care with those of its strategic partners as a critical point for improving the outcomes and satisfaction of members. This program was redesigned in 2018 to more closely mirror the VIIP program, to create a stronger platform for shared quality improvement strategies between plans and provider groups. The program now measures and rewards plan partners for performance on a broader set of metrics, including HEDIS clinical quality, utilization, encounters and member experience. A proportion of plan partner incentive payments are tied to the quality performance of its contracted PPGs, with the aim to promote collaboration between plans and their PPGs on quality improvement efforts. The program will continue to utilize these metrics in 2020 with targeted areas of modification.

SALES AND MARKETING

L.A. Care provides support to multiple initiatives throughout the organization utilizing the services of the in-house Sales and Marketing Business Unit, Health Plan Field Representatives, Community Outreach and Enrollment Support Services, Health Educators, and the Resource Centers. Marketing staff participates in workgroups to collaborate and develop collateral materials in various formats, languages and reading levels to support member and consumer understanding of the benefits, programs and services, which L.A. Care offers.

Marketing staff are aligned by product lines, health plan initiatives and the Resource Centers, which are open and operating in Lynwood, Inglewood, Boyle Heights, Pacoima, Palmdale, and East L.A., with our Pomona Community Resource Center, which opened in November 2019. The Resource Centers provide free health education and healthy living classes in underserved communities.

Community and member awareness messaging and campaigns are developed and implemented throughout L.A. County. This is accomplished through marketing outreach at educational events,

and advertising health insurance programs in communities where access to quality health care is limited.

The Health Plan Field Representatives, Community Outreach and Enrollment Support Services, Resource Center Representatives, and Health Educators conduct product presentations, at educational and marketing events. This provides an opportunity for consumers and members to learn more about Medi-Cal, Cal MediConnect, the Covered California Marketplace and PASC-SEIU. Community-based events, health fairs, and open houses are prescheduled and are posted on L.A. Care's website and promoted through social media to provide members and non-members with information on the conveniently located events held throughout L.A. County.

Additional outreach is provided to Enrollment Entities and their down-line Certified Insurance Agents (CIAs) and Certified Enrollment Counselors (CECs) to educate and update them on the programs that L.A. Care members receive, as well as potential eligibility for L.A. Care's product lines including Medi-Cal, Cal MediConnect, L.A. Care Covered, and PASC-SEIU.

L.A. Care continually seeks opportunities to improve provider awareness and secure their commitment to L.A. Care through participation in joint operational meetings, physician quality improvement and incentive programs, provider marketing in-services and campaigns and health educational events. It is a concerted effort to build and maintain effective relationships. The primary focus of the provider outreach, is to target L.A. Care contracted providers who serve low-income seniors and people with disabilities.

Member-focused newsletters are distributed to our members quarterly, (including our health Plan Partners' Medi-Cal enrollment) and help members (a) navigate the managed Medi-Cal system to obtain care; (b) understand the benefits and services available; (c) educate about disease prevention and (d) support well-being. L.A. Care's *Be Well* newsletter addresses the health concerns of children, young adults, and growing families (under 55 years old). The *Live Well newsletter* is designed to address the concerns of senior members and members with disabilities (55 years and over). L.A. Care offers a variety of benefit and health education information on its primary website, www.lacare.org. Additionally, members can access personal health information and perform tasks such as changing a doctor, reprinting ID cards, paying a premium or checking a claim through L.A. Care Connect, our secure online member portal.

QUALITY IMPROVEMENT PROCESS AND HEALTH INFORMATION SYSTEMS

L.A. Care maintains and operates a Quality Improvement Program that is designed to monitor performance in key areas and identify opportunities to improve population health, care coordination, cost of care and member safety and experience. L.A. Care formally adopts and maintains goals by which performance is measured, assessed, and evaluated. L.A. Care uses secure procedures to develop, compile, evaluate, and report data and measures and other information to DHCS, DMHC, CMS, and other regulatory bodies, its enrollees, and the general public. In doing so, L.A. Care safeguards the confidentiality of the doctor-patient relationship. Health Information data and documentation of the overall quality improvement program is maintained and made available for DHCS, DMHC, CMS, and other regulatory bodies as requested and during onsite audits.

L.A. Care’s Quality Improvement infrastructure includes a comprehensive array of clinical and service performance measurement activities that provide information about the processes and outcomes of population health, clinical care and member experience. The performance measurement activities are coordinated with other network activities, teams and efforts. Staff throughout the enterprise participate in these activities and are educated as to their role and responsibility to make every effort in improving performance.

When identifying critical performance measures, the demographic characteristics and health risks of the covered population are considered (see the Population Assessment for further detail). Key indicators are identified overall and per subpopulation. These indicators are related to culture, demographics and outcome of care or service delivery. A sound rigorous measurement methodology is developed and followed for all indicators. Performance is measured and tracked over time and compared with pertinent controls. Most indicators are rate-based indicators or scalar measures. Rate-based indicators describe the percentage or ratio at which a subgroup is performing. Scalar measures use a scale such as satisfaction rating scale. Some indicators are sentinel event indicators and require analysis of each and every occurrence. L.A. Care is proactive in identifying potential quality issues from multiple data sets and systems.

L.A. Care uses many different sources to obtain performance data. The data sources include but are not limited to HEDIS results, quality reports, grievances, appeals, denial overturns, member and provider satisfaction survey results, network access and availability reports, encounter data, utilization data, medical record review results and facility site review results.

Performance goals are established for each indicator. Performance goals may be based on historical performance, normative data, standards, goals, or benchmarks. Benchmarks are known as the best level of performance set by industry organizations. The initial performance goal for a new indicator is often to “obtain baseline data.” Some indicators, although they have acceptable sustained performance with acceptable variation, will always be measured because of the importance of knowing that performance is maintained or because of reporting requirements. Efforts to further improve performance may require systemic changes that are not considered feasible. The performance goal in these instances may be to sustain the same level in subsequent measurement cycles.

The Quality Improvement program ensures that information from all parts of the safety of clinical care organization are routinely collected and interpreted to identify issues in the areas of clinical services, quality of services, access to care, and member experience. Types of information to be reviewed include:

- Population Information – data on enrollee characteristics relevant to health risks or utilization of clinical and non-clinical services, including age, sex race, ethnicity, language and disability or functional status.
- Performance Measures – data on the organization’s performance as reflected in standardized measures, including when possible Local, State or National information on performance of comparable organizations.
- Other utilization, diagnosis and outcome information - Data on utilization of services, cost of operations, procedures, medications, and devices; admitting and encounter diagnoses,

adverse incidents (such as death, avoidable admission or readmission and patterns of referrals or authorizations requests).

- Information demonstrating L.A. Care has a fiscally sound operation.
- Analysis of opportunities from results of standard measures.
- External data sources – data from outside the organization, including Medicare or Medicaid fee-for-service data, data from other managed care organizations and local national public health reports on condition or risks for specified populations.
- Enrollee Information on their experiences with care to the extent possible. Data from surveys (such as, Health Outcomes Survey (HOS), the Consumer Assessment of Health Plans and Provider Systems or CAHPS), information from the grievance and appeals processes, and information on disenrollments and requests to change providers. (Note that general population surveys may under-represent populations who may have special needs, such as linguistic minorities or the disabled. Assessment of satisfaction for these groups may require over sampling or other methods, such as focus groups or enrollee interviews). In addition to information generated with the organization, the QI Program assesses information supplied by purchasers, such as data on complaints.
- Availability, accessibility, and acceptability of Medicare approved and covered services.
- Measures related to behavioral health, care coordination/transitions, and MLTSS, as required.
- Data elements from CMS Part C & D, NCQA, and other regulatory reporting.
- Other information CMS, NCQA or other regulatory agencies may require.

L.A. Care ensures that information and data received from providers are accurate, reliable, timely, and complete. All HEDIS measures are audited by external auditor to ensure accuracy.

Performance data for the key indicators are collected, aggregated, integrated, and analyzed on a recurring schedule. Multiple data points are displayed together on graphs to show historical performance and facilitate analysis and trending. Each review includes quantitative and qualitative, and when possible causal analysis. Evaluating the effectiveness of previous interventions is included and influences the next step in planning.

Action is triggered when undesirable sentinel events, patterns and/or trends are identified; comparison with established benchmarking reflects an undesirable level of performance and/or undesirable variance from recognized and accepted standards; improvement is desired, even in the absence of a performance variance; or compliance falls beneath the standard or goal set by L.A. Care and/or regulatory body.

Interventions are developed, prioritized, and implemented based on metric results and root cause analysis revealing highest opportunity actions. An in-depth review is conducted on the areas identified as having the greatest potential for improving care, safety, and health status outcomes of members as per resources available. Continuous quality improvement is realized when data are collected and analyzed, interventions are planned and implemented, measurement is repeated and performance continually improved. The cycle is continuous and maintained on a schedule that is not limited by the end of the calendar year. Quality Improvement is accomplished by using the improvement model described. This process embraces the Plan, Do, Study, and Act (PDSA) model of improvement and rapid-cycle tests of change.

The L.A. Care QI Department works cross-functionally and with network partners to address opportunities to improve community-wide delivery of care through the selection, design, and implementation of interventions. Wherever possible, these interventions are designed to achieve systemic or procedural improvements affecting multiple members, providers, and services. Interventions to improve performance include health promotion and health education programs, to inform members of ways to improve their health or their use of the health care delivery system. Process modifications to administrative processes are used to improve quality of care, accessibility and service. Great efforts are focused on modifications to the provider network, such as, additions of pertinent and high performing providers and facilities to improve accessibility and availability. Other processes may include adjustments to customer services, utilization and case management activities, models of care, preventive services and health education. Interventions to improve provider performance may include presentation of provider education programs, individual provider feedback on individual and aggregate performance and distribution of best practice material.

Incentives and collaborative performance improvement programs such as the VIIP Action Plan are used to entice network provider and members to achieve evidenced-based health prevention and improvement. While opportunity reports have historically been delivered via a paper-based, manual release process, L.A. care aims to provide all pertinent data and analyzed opportunities in web-accessible format and as frequently refreshed as possible.

Performance Target

The terms benchmark and performance targets are not necessarily one and the same. L.A. Care uses nationally recognized or industry benchmarks to measure for success and improvements (i.e. NCQA benchmarks and thresholds, DHCS set benchmarks, CMS or other regulatory). Recognized benchmarks may be used as a performance target or not if unattainable. In this case or when there is no established or available benchmark for a particular indicator L.A. Care may create an internal performance target based on a clear rationale. The target should be something that an organization strives for, but may not necessarily reach.

Significant Improvement

L.A. Care defines Significant Improvement as a 95% probability that the improvement is real and is determined by a statistical “p-value” of less than or equal to 0.05. L.A. Care measures baseline and follow-up rates at defined intervals to measure improvement or decline. It is not expected that a *QI* project initiated in a given year will achieve improvement in that same year. A significant change can be measured over several years of interventions and measurement.

L.A. Care hopes to demonstrate, through repeated measurement of the quality indicators selected for the project, significant change in performance relative to the performance observed during baseline measurement.

Meaningful Improvement

Meaningful Improvement is defined as a 90% probability that the change is real and is calculated using a statistical “p-value” of <0.10.

Sustained Improvement

Sustained improvement is defined as reaching a prospectively set benchmark and sustaining that improvement for three consecutive years.

Whenever possible L.A. Care should select indicators for which data are available on the performance of other comparable organizations (or other components of the same organization), or for which there exist local or national data for a similar population in the fee-for-service sector. It is important that the measures of performance before and after interventions be comparable in order to measure improvement accurately. The same methods of identifying the target population and of selecting individual cases for review must be used for both measurements.

Follow-up measurements should use the same methodology and time frames as the baseline measurement, except that, when baseline data was collected for the entire population at risk, in which case the follow-up measurement may use a reliable sample instead.

MEMBER CONFIDENTIALITY

L.A. Care keeps confidential information secure and makes it available only to L.A. Care employees, contractors, and affiliates who have a need to know in order to do their job functions and signed a confidentiality agreement. L.A. Care ensures that all individuals or agencies who participate in the use, creation, maintenance, or disclosure of protected health information limit the use and disclosure only to the minimum necessary to complete the task. Without a signed authorization, disclosure of protected health information is limited to the purposes of treatment, payment, or health care operations. These purposes include the use of protected health information for quality of care activities, care management service referrals, statistical evaluation, claims payment processes, medical payment determinations, practitioner credentialing, peer review activities, and the grievance and appeals process.

Network practitioners and providers are obligated to maintain the confidentiality of member information and information contained in a member's medical record and may only release such information as permitted by applicable laws and regulation, including Health Insurance Portability & Accountability Act (HIPAA).

L.A. Care maintains confidentiality in written, verbal, and electronic communications. L.A. Care has specific policies that outline appropriate storage and disposal of electronic and hard copy materials so that confidentiality is maintained within the plan and network.

CONFIDENTIALITY

To the extent permitted by law, QI Committee proceedings and records of proceedings are protected and kept confidential pursuant to applicable law, including but not limited to California Evidence Code Section 1157 (a) of the California Evidence Code and California Welfare and Institutions Code Section 14087.38 Subsections (n)-(q) and are thereby confidential and may not be discoverable.

All member/patient information available at any of the L.A. Care locations is confidential and protected from unauthorized dissemination by L.A. Care, its employees and agents.

DISEASE REPORTING STATEMENT

L.A. Care complies with disease reporting standards as cited by the California Code of Regulations (CCR), Title 17 (Section 2500), which states that public health professionals, medical providers and others are mandated to report approximately 96 diseases or conditions to their local health department. The primary objective of disease reporting and surveillance is to protect the health of the public, determine the extent of morbidity within the community, evaluate risk of transmission, and intervene rapidly when appropriate. Forms to report diseases can be found at <http://lapublichealth.org/acd/cdrs.htm> and via a link on the L.A. Care website at www.lacare.org/providers/provider-central/faqs.

OVERALL L.A. CARE DELEGATION

Independent Practice Association/Primary Provider Groups (IPA/PPG)

L.A. Care delegates responsibility for specific functional activities for the delivery of care and service to its members to IPA/PPGs. **L.A. Care does not delegate Quality Improvement activities to contracted IPA's and Medical Groups.** L.A. Care maintains accountability and ultimate responsibility for the associated activities by overseeing performance in the following areas: Utilization Management, Credentialing, Quality Improvement, Financial Solvency, Claims Timeliness, Culture and Linguistics and Health Education. Delegated functions include, but are not limited to: preventive health services, health education activities, clinical practice guidelines, and access standards. Non-delegated functions include clinical studies, clinical grievances, appeals, HEDIS/QIP studies, facility site/medical record reviews, access studies, Health Education materials development and review, member and practitioner satisfaction surveys. Delegated IPAs will be expected to have a functioning quality improvement program in place.

QI Delegation

L.A. Care has written service agreements with delegated Plan Partners, Specialty Health Plans, and External Entities to provide specific health care services and perform other delegated functions. L.A. Care requires and ensures that each delegate maintain adequate processes, is appropriately and adequately staffed and complies with applicable standards and regulatory requirements. Specific elements of the QI program may be delegated. However, L.A. Care remains responsible for and has appropriate structures and mechanisms to oversee all delegated QI activities. All components of the QI process, maintained by delegates, will be made available to L.A. Care at the time of scheduled oversight audits as well as ongoing monitoring. Oversight audit and monitoring results are reviewed, opportunities for performance improvement are identified and reported to the delegate and corrective action plans are required to address deficiencies. Currently, the delegate has 60 calendar days to implement the corrective action plan (CAP). After that period, L.A. Care may conduct CAP validation to ensure that substantial correction of deficiencies occurred and the CAP implemented was satisfactory. In addition, L.A. Care provides ongoing monitoring through substantive review and analysis of delegate reports and collaboration with delegates to continually assess compliance with standards and requirements.

L.A. Care is accountable for all quality improvement functions and responsibilities that are delegated and contracts with Delegates should at a minimum include:

- Quality improvement responsibilities, and specific delegated functions and activities

- L.A. Care’s oversight, monitoring, and evaluation processes and Delegate’s agreement to such processes.
- L.A. Care’s reporting requirements and approval processes. The contract agreement shall include Delegate’s responsibility to report findings and actions taken as a result of the quality improvement activities at least quarterly.
- L.A. Care’s actions/remedies if Delegate’s obligations are not met.

ANNUAL QI PROGRAM EVALUATION

Annually, L.A. Care reviews data, reports, and other performance measures regarding program activities to assess the effectiveness of its QI Program. This evaluation includes a review of completed and continuing program activities and audit results; trending of performance data; analysis of the results of QI initiatives including barriers, successes, and challenges; an assessment of the effectiveness of monitoring activities and identifying and acting upon quality and safety of clinical care and service issues; an evaluation of the overall effectiveness of the QI program including progress toward influencing network-wide safe clinical practices; and the goals and plans for the next year. The annual QI Program Evaluation is presented to the Joint Performance Improvement Collaborative Committee (PICC) & Physician Quality Committee (PQC), Quality Oversight Committee (QOC), and Compliance & Quality Committee (C&Q) for review and approval and available to regulatory agencies if requested.

ANNUAL QI WORK PLAN (SEE Attachment 4)

The annual QI Work Plan is developed in collaboration with cross-departmental staff and is based, in part, upon the results of the prior year’s QI Program evaluation.

The QI Work Plan includes a description of:

- The QI program scope including quality of clinical care, service, safety of clinical care, and member experience.
- Planned activities and measureable goals and/or benchmarks that encompass a comprehensive program scope, including the quality and safety of clinical care and quality of service, and member experience to be undertaken in the ensuing year.
- Staff member(s) responsible for each activity.
- The time frame within which each activity is to be achieved.
- Key findings, interventions, analysis of findings/progress and monitoring of previously identified issues.
- Planned evaluation of the QI program.

Each of the elements identified on the Work Plan has activities defined, responsibility assigned, and the date by which completion is expected. The QI Work Plan and Quality Improvement Program description are presented to the Quality Oversight Committee for review and approval. Quarterly updates to the Work Plan are documented and reported to the Quality Oversight Committee. Quarterly work plan updates are available to regulatory agencies if requested.

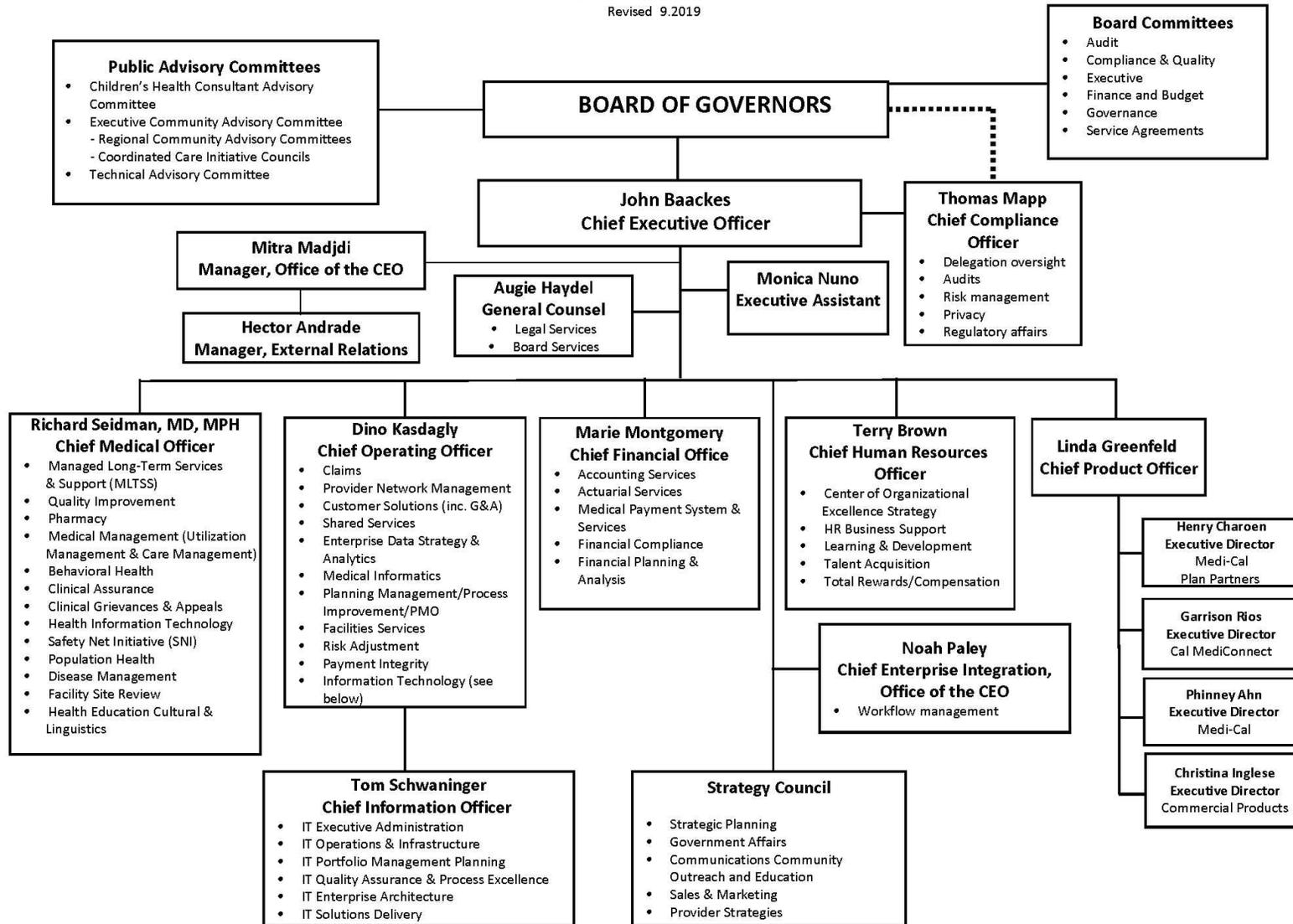
Endnotes:

Source: Medicare Managed Care Manual Chapter 5- Quality Assessment Rev. 100, 08-05-11

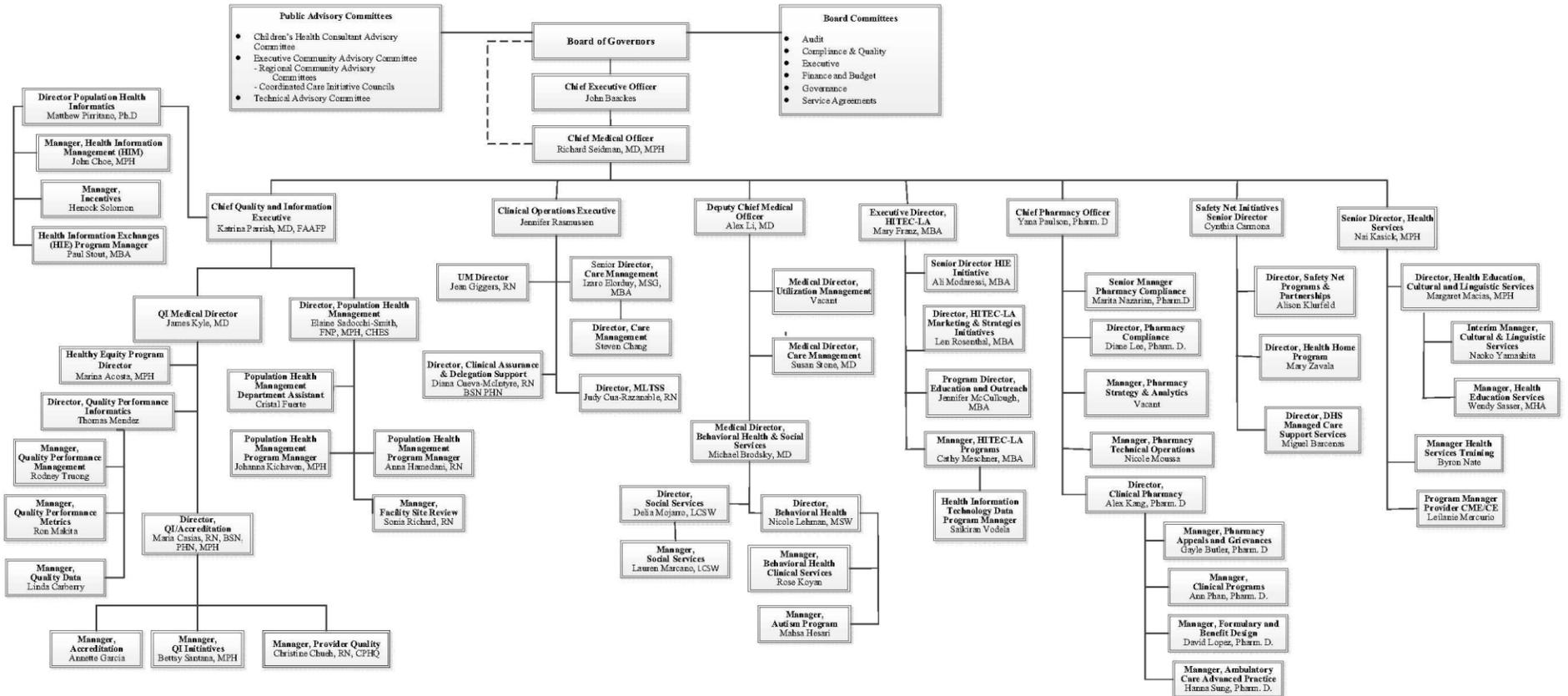
Attachment 1	Organizational Structure
Attachment 2	Health Services Organization
Attachment 3	Quality Program Committee Structure
Attachment 4	2020 QI Work Plan including Medicare

ATTACHMENT 1

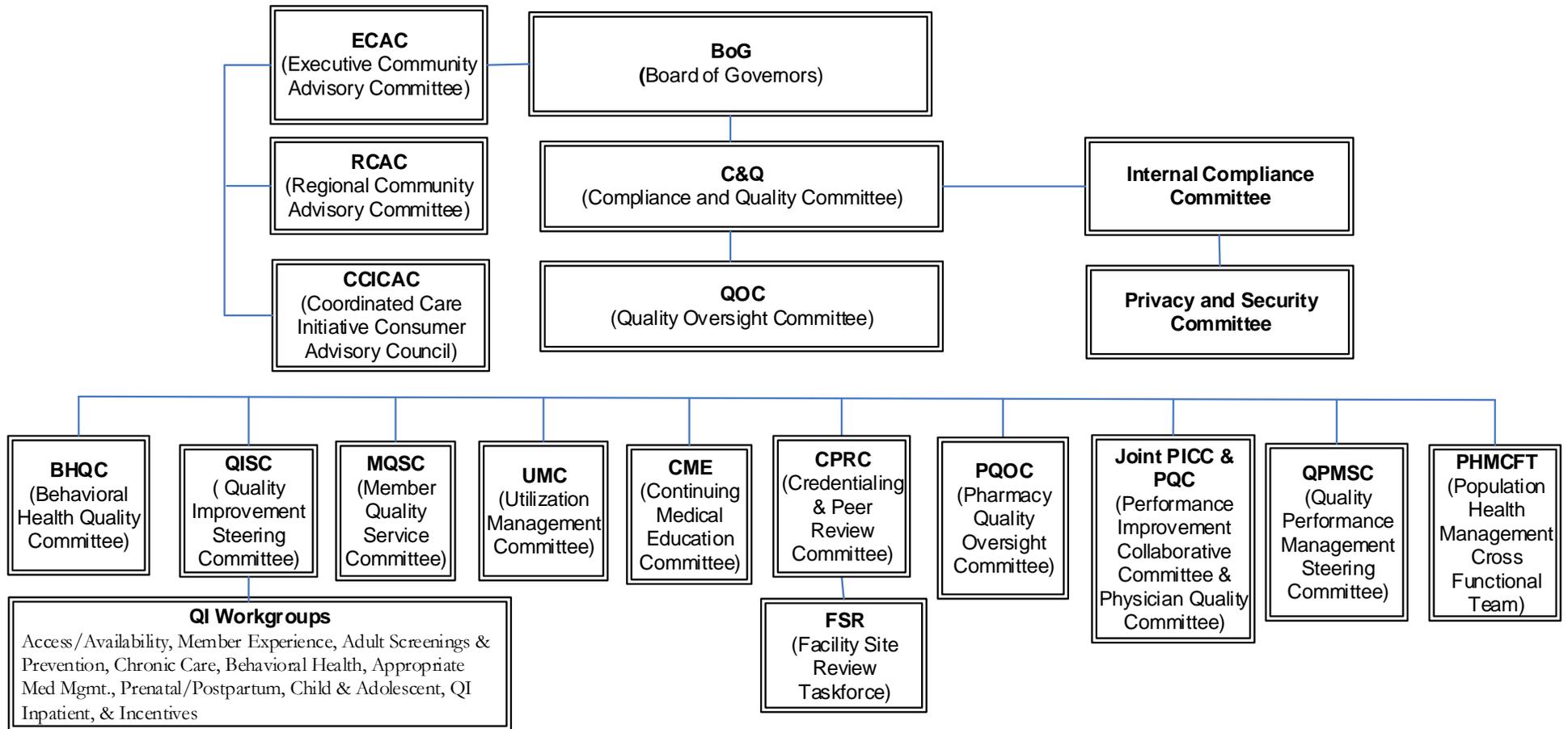
L.A. Care Health Plan
 ORGANIZATIONAL STRUCTURE
 Revised 9.2019



**ATTACHMENT 2
L.A. Care Health Plan
Health Services Organization**



ATTACHMENT 3
L.A. Care Health Plan
Quality Improvement Committees



ATTACHMENT 4

2020 QI Work Plan including Medicare

Attachment 4

Performance Measures for Planned Activities for Objectives	HEDIS Acronym	Regulatory Agencies	2019 Rates	2020 Rates	2020 Goal	Goal Met/Not Met	Responsible Staff/Department	Timeframe for completion	Reports to: (Dates are 2020 unless otherwise noted)	Interventions/Updates	Comments/Barriers	Recommend for 2020 Work Plan
Service - Access												
Member Services Department Telephone Abandonment Rate			<p><u>Medi-Cal:</u> Q1: 9.40% Q2: 11.30% Q3: 5.70% Q4: 2.50%</p> <p><u>CMC:</u> Q1: 3.08% Q2: 3.23% Q3: 3.98% Q4: 3.40%</p> <p><u>LACC:</u> Q1: 4.37% Q2: 2.56% Q3: 2.80% Q4: 2.33%</p>				Robert Martinez (CSC), Michael Nguyen (CSC)	Quarterly	Member Quality Service Committee (MQSC): Feb 11, April 14, Aug 11, Oct 20			
Member Services Department Telephone Wait Time- Service Level			<p><u>Medi-Cal:</u> Q1: 62.82% Q2: 64.93% Q3: 78.52% Q4: 85.36%</p> <p><u>CMC:</u> Q1: 84.34% Q2: 81.26% Q3: 81.25% Q4: 86.36%</p> <p><u>LACC:</u> Q1: 85.88% Q2: 89.93% Q3: 85.92% Q4: 88.40%</p>		<p><u>MOB:</u> 80% of total incoming calls answered ≤ 30 seconds</p>		Robert Martinez (CSC)/ Michael Nguyen (CSC)	Quarterly	MQSC: Feb 11, April 14, Aug 11, Oct 20			
Member Services Department Initial Call Resolution		LACC ONLY	<p><u>LACC:</u> Q1: 100% Q2: 100% Q3: 100% Q4: 100%</p>		80% of Covered California enrollee issues will be resolved within one (1) business day of receipt of the issue. Does not include appeals or grievances.		Robert Martinez (CSC)/ Michael Nguyen (CSC)	Quarterly	MQSC: Feb 11, April 14, Aug 11, Oct 20			
ID Card Processing Time		LACC ONLY	<p><u>LACC:</u> Q1: 100% Q2: 100% Q3: 100% Q4: 100%</p>		99% of LACC ID cards issued within 10 business days of receiving complete and accurate enrollment information and binder payment for a specific consumer(s)		Aurora Cabrera Cabelon (CSC)/ Maria Buarens (CSC)	Quarterly	MQSC: Feb 11, April 14, Aug 11, Oct 20			
Non-Emergent Ancillary Services -within 15 business days of request, for appointment		DMHC DHCS CMS NCQA	<p><u>2019MY2018 ATC Survey Results:</u></p> <p><u>Medi-Cal:</u> MRI 100% Mammogram 92% Physical Therapy 87%</p> <p><u>CMC:</u> MRI 100% Mammogram 100% Physical Therapy 90%</p> <p><u>LACC:</u> MRI 100% Mammogram 92% Physical Therapy 87%</p> <p><u>LACC:</u> MRI 100% Mammogram 92% Physical Therapy 87%</p> <p><u>PASC:</u> No ancillary rates reported for PASC due to data challenges.</p>				Isabella Urbano (QH)/ Annette Garcia (QH)	Annually: Sept 20	MQSC: Oct 20			
After Hour Care - Practitioners surveyed have after-hour care process such as exchange service, automated answering/routing system, or directly accessible, in order to respond to member call with live person within 30 minutes.		DMHC DHCS CMS NCQA	<p><u>2019 MY2018 ATC Survey Results:</u></p> <p><u>Medi-Cal:</u> PCP Access 85% Timeliness 34% Combined Access & Timeliness 32%</p> <p><u>CMC:</u> PCP Access 85% Timeliness 34% Combined Access & Timeliness 32%</p> <p><u>LACC:</u> PCP Access 86% Timeliness 33% Combined Access & Timeliness 33%</p> <p><u>LACC:</u> PCP Access 86% Timeliness 36% Combined Access & Timeliness 35%</p> <p><u>PASC:</u> PCP Access 83% Timeliness 18% Combined Access & Timeliness 18%</p>				Isabella Urbano (QH)/ Annette Garcia (QH)	Annually: Sept 20	MQSC: Oct 20			

Performance Measures for Planned Activities for Objectives	HEDIS Acronym	Regulatory Agencies	2019 Rates	2020 Rates	2020 Goal	Goal Met/Not Met	Responsible Staff/Department	Timeframe for completion	Reports to: (Dates are 2020 unless otherwise noted)	Interventions/Updates	Comments/Barriers	Recommend for 2020 Work Plan
Routine Primary Care (Non-Urgent) - Practitioners surveyed have routine primary visits available within 10 business days.		DMHC DHCS CMS NCQA	<u>2019 MY2018 ATC Survey Results:</u> Medi-Cal 95% LACC 94% LACCD 94% CMC 94% PASC 86%				Isabella Urbano (QU) Annette Garcia (QI)	Annually: Sept 20	MQSC: Oct 20			
Routine Specialty Care (Non-Urgent) - Specialist practitioners surveyed have routine specialty care visits available within 15 business days of request.		DMHC DHCS CMS NCQA	<u>2019 MY2018 ATC Survey Results:</u> Medi-Cal 92% LACC 89% LACCD 88% CMC 90% PASC 93%				Isabella Urbano (QU) Annette Garcia (QI)	Annually: Sept 20	MQSC: Oct 20			
Urgent Care (PCP) - Urgent care appointments available within 48 hours.		DMHC DHCS CMS NCQA	<u>2019 MY2018 ATC Survey Results:</u> Medi-Cal 88% LACC 88% LACCD 88% CMC 87% PASC 74%				Isabella Urbano (QU) Annette Garcia (QI)	Annually: Sept 20	MQSC: Oct 20			
Urgent Care (SCP) - Urgent care appointments available within 96 hours.		DMHC DHCS CMS NCQA	<u>2019 MY2018 ATC Survey Results:</u> Medi-Cal 87% LACC 84% LACCD 84% CMC 85% PASC 88%				Isabella Urbano (QU) Annette Garcia (QI)	Annually: Sept 20	MQSC: Oct 20			
Service - Availability												
Drive Distance to PCP (Geomapping, Optum Reports)			<u>Q1 2019</u> Medi-Cal: 99.3% LACC: 99.7% CMC: 99.0% <u>Q2 2019</u> Medi-Cal: 95.0% LACC: 99.7% CMC: 99.0% <u>Q3 2019</u> Medi-Cal: 99.3% LACC: 99.7% CMC: 99.0% <u>Q4 2019</u> Medi-Cal: 99.3% LACC: 99.8% CMC: 99.3%				Gwen Cathey (PNM) Acacia Reed (PNM)	Quarterly	MQSC: Oct 20	95% of members have access to a PCP within 10 miles radius of their primary residence		
Drive Distance to all SCP, including identified high volume SCP (Geomapping, Optum Reports)			<u>Q1 2019</u> Medi-Cal: 100 % LACC: 99.7% CMC: 99.1% <u>Q2 2019</u> Medi-Cal: 100% LACC: 99.7% CMC: 98.8% <u>Q3 2019</u> Medi-Cal: 99.8 LACC: 99.7% CMC: 99.25% <u>Q4 2019</u> Medi-Cal: 99.8% LACC: 99.8% CMC: 99.25%				Gwen Cathey (PNM) Acacia Reed (PNM)	Quarterly	MQSC: Oct 20	90% of members have access to specialty care practitioners within 15 miles radius of their primary residence		

Performance Measures for Planned Activities for Objectives	HEDIS Acronym	Regulatory Agencies	2019 Rates	2020 Rates	2020 Goal	Goal Met/Not Met	Responsible Staff/Department	Timeframe for completion	Reports to: (Dates are 2020 unless otherwise noted)	Interventions/Updates	Comments/Barriers	Recommend for 2020 Work Plan
Rates - PCP (excludes mid-level providers) (Geomapping, Spurn Reports)			<p>Q1 2019 Medi-Cal: 1:284 LACC: 1:15 CMC: 1:7</p> <p>Q2 2019 Medi-Cal: 1:288 LACC: 1: 29 CMC: 1: 9</p> <p>Q3 2019: Medi-Cal: 1:283 LACC: 1:27 CMC: 1:8</p> <p>Q4 2019: Medi-Cal: 1:267 LACC: 1:37 CMC: 1:6</p>		1: 2000 members		Gwen Cathey (PNM)/ Acacia Reed (PNM)	Quarterly	MQSC: Oct 20			
Rates - High Volume Specialist (Note the top 5 specialists can vary year to year)			Q1, Q2, Q3, and Q4 Pending		The top 5 specialists (can vary year to year) by LOB		Gwen Cathey (PNM)/ Acacia Reed (PNM)	Annual	MQSC: Oct 20			
Service Improvements					<p><u>Goal Methodology:</u> 2019 rates used to determine an attainable % increase If a National benchmark was met in the Work Plan then the next benchmark was set as the goal. If the next percentile is not attainable per prior year trending, the goal was set accordingly. Measures that are part of PHM, the goal was set to match PHM. <u>QTY:</u> Quality Withhold Measure</p>							
Service - Member Satisfaction (Experience) ADULT												
ADULT - Rating of Health Plan (Medi-Cal: Rating of 8, 9, or 10 of 10) (LACC: Mean scored 0-100 -- not comparable to NCQA %s) (CMC: Rating of 9 or 10 of 10 Usually/Always) (Tier 1)	CAHPS (Medi-Cal & CMC)/ EES (LACC)	NCQA: Medi-Cal & CMC QRS	Medi-Cal: 72.88% LACC: 72.55% CMC: 69%		Medi-Cal: 75% LACC: 76% CMC: 72%		Betty Santana (QI)/ Esther Bue (QPM)	Annually: Sept 20	MQSC: Oct 20			
ADULT - Rating of Health Care (Medi-Cal: Rating of 8, 9, or 10 of 10) (LACC: Mean scored 0-100 -- not comparable to NCQA %s) (CMC: Rating of 9 or 10 of 10 Usually/Always) (Tier 1)	CAHPS (Medi-Cal & CMC)/ EES (LACC)	NCQA: Medi-Cal & CMC QRS	Medi-Cal: 71.84% LACC: 77.89% CMC: 64%		Medi-Cal: 74% LACC: 80% CMC: 67%		Betty Santana (QI)/ Esther Bue (QPM)	Annually: Sept 20	MQSC: Oct 20		Member Experience (CG-CAHPS) measures in Plan Partner Incentive, Medi-Cal VIP+PAP, CMC VIP & LACC VIP.	
ADULT - Rating of Personal Doctor (Medi-Cal: Rating of 8, 9, or 10 of 10) (LACC: Mean scored 0-100 -- not comparable to NCQA %s) (CMC: Rating of 9 or 10 of 10 Usually/Always)	CAHPS (Medi-Cal & CMC)/ EES (LACC)	NCQA: Medi-Cal & CMC QRS	Medi-Cal: 78.43% LACC: 82.52% CMC: 78%		Medi-Cal: 80% LACC: 85% CMC: 81%		Betty Santana (QI)/ Esther Bue (QPM)	Annually: Sept 20	MQSC: Oct 20		Member Experience (CG-CAHPS) measures in Plan Partner Incentive, Medi-Cal VIP+PAP & CMC VIP. Name of measure is "Rating of PCP".	
ADULT - Rating of Specialist Seen Most Often (Medi-Cal: Rating of 8, 9, or 10 of 10) (LACC: Mean scored 0-100 -- not comparable to NCQA %s) (CMC: Rating of 9 or 10 of 10 Usually/Always)	CAHPS (Medi-Cal & CMC)/ EES (LACC)	NCQA: Medi-Cal & CMC QRS	Medi-Cal: 75.22% LACC: 82.65% CMC: NA		Medi-Cal: 78% LACC: 85% CMC: NA (No rate prior year)		Betty Santana (QI)/ Esther Bue (QPM)	Annually: Sept 20	MQSC: Oct 20			
ADULT - Getting Care Quickly (Medi-Cal: Always/Usually) (LACC: Mean scored 0-100 -- not comparable to NCQA %s) (CMC: Rating of 9 or 10 of 10 Usually/Always) (Tier 1)	CAHPS (Medi-Cal & CMC)/ EES (LACC)	NCQA: Medi-Cal & CMC QRS	Medi-Cal: 76.78% LACC: 66.37% CMC: 81%		Medi-Cal: 79% LACC: 69% CMC: 84%		Betty Santana (QI)/ Esther Bue (QPM)	Annually: Sept 20	MQSC: Oct 20		Member Experience (CG-CAHPS) measures in Plan Partner Incentive, Medi-Cal VIP+PAP, CMC VIP & LACC VIP. Name of measure is "Getting Timely Care".	

Performance Measures for Planned Activities for Objectives	HEDIS Acronym	Regulatory Agencies	2019 Rates	2020 Rates	2020 Goal	Goal Met/Not Met	Responsible Staff/Department	Timeframe for completion	Reports to: (Dates are 2020 unless otherwise noted)	Interventions/Updates	Comments/Barriers	Recommend for 2020 Work Plan
ADULT - Getting Needed Care (Medi-Cal: Always+Usually) (LACC: Mean-scored 0-100 -- not comparable to NCQA %s) (CMC: Rating of 9 or 10 of 10 Usually/Always) (Tier 1)	CAHPS (Medi-Cal & CMC)/ EES (LACC)	NCQA: Medi-Cal & CMC QRS	Medi-Cal: 76.62% LACC: 66.86% CMC: 88%		Medi-Cal: 79% LACC: 69% CMC: 94%		Betty Santana (QI)/ Esther Bue (QPM)	Annually: Sept 20	MQSC: Oct 20		Member Experience (CG-CAHPS) measures in Plan Partner Incentive, Medi-Cal VIP+PAP & CMC VIP.	
ADULT - Coordination of Care (Medi-Cal: Always+Usually) (LACC: Mean-scored 0-100 -- not comparable to NCQA %s) (CMC: Rating of 9 or 10 of 10 Usually/Always) (Tier 1)	CAHPS (Medi-Cal & CMC)/ EES (LACC)	NCQA: Medi-Cal & CMC QRS	Medi-Cal: NA LACC: 76.68% CMC: 94%		Medi-Cal: NA (No rate prior year) LACC: 79% CMC: 94%		Betty Santana (QI)/ Esther Bue (QPM)	Annually: Sept 20	MQSC: Oct 20		Member Experience (CG-CAHPS) measure in LACC VIP.	
ADULT - Flu Vaccination Ages 18-64 (Enterprise Goal) (Medi-Cal & LACC % vaccinated) (CMC - Annual Flu Vaccine 65 and Older - Rating of 9 or 10 of 10 Usually/Always) (Tier 1) CW? Quality Withhold - Annual Flu Vaccine (Tier 1)	CAHPS (Medi-Cal & CMC)/ EES (LACC)	NCQA: Medi-Cal & CMC QRS QW	Medi-Cal: 40.46% LACC: 39.66% CMC: 68% MCLA: 34%		Medi-Cal: 43% LACC: 42% CMC: 70% (QW 69%) MCLA: 34%		Sudhu Kumar QI/ Rodney Truong (QPM)/ Jackie Kaljian (HE)	Annually: Sept 20	MQSC: Oct 20			
ADULT - Medical Assistance with Tobacco Cessation - Advising Smokers and Tobacco Users to Quit (Medi-Cal: % Yes) (LACC: Always+Usually) (CMC: Always, Usually, and Sometimes - CAHPS - Medication)	CAHPS (Medi-Cal & CMC)/ EES (LACC)	NCQA: Medi-Cal & CMC QRS	Medi-Cal: NA LACC: NA CMC: 54%		Medi-Cal: NA (No rate prior year) LACC: NA (No rate prior year) CMC: 58%		Betty Santana (QI)/ Esther Bue (QPM)	Annually: Sept 20	MQSC: Oct 20			
ADULT - Plan Administration (Customer Service)	CAHPS EES (LACC)		LACC: 74.81%		LACC: 77%		Betty Santana (QI)/ Esther Bue (QPM)	Annually: Sept 19	MQSC: Oct 14			
Overall ADULT NCQA Score (Medi-Cal & LACC) (Enterprise Goal)	CAHPS	NCQA	Medi-Cal: 4.08% LACC: 3 Stars		Medi-Cal: 4.38% LACC: 3 Stars or greater		Betty Santana (QI)	Annually: Sept 19	MQSC: Oct 14			
Overall ADULT NCQA Score (CMC) (Enterprise Goal)	CAHPS	NCQA	CMC: 6.24%		CMC: 6.54%		Betty Santana (QI)	Annually: Sept 19	MQSC: Oct 14			
Service - Member Satisfaction (Experience) CHLD												
CHILD - Rating of Health Plan (Medi-Cal: Rating of 8, 9, or 10 of 10)	CAHPS	NCQA: Medi-Cal	Medi-Cal: 86.65%		Medi-Cal: 89%		Betty Santana (QI)/ Esther Bue (QPM)	Annually: Sept 20	MQSC: Oct 20			
CHILD - Rating of Health Care (Medi-Cal: Rating of 8, 9, or 10 of 10)	CAHPS	NCQA: Medi-Cal	Medi-Cal: 82.26%		Medi-Cal: 86%		Betty Santana (QI)/ Esther Bue (QPM)	Annually: Sept 20	MQSC: Oct 20		Member Experience (CG-CAHPS) measures in Plan Partner Incentive, Medi-Cal VIP+PAP.	
CHILD - Rating of Personal Doctor (Medi-Cal: Rating of 8, 9, or 10 of 10)	CAHPS	NCQA: Medi-Cal	Medi-Cal: 84.23%		Medi-Cal: 87%		Betty Santana (QI)/ Esther Bue (QPM)	Annually: Sept 20	MQSC: Oct 20		Member Experience (CG-CAHPS) measures in Plan Partner Incentive, Medi-Cal VIP+PAP. Name of measure is "Rating of PCP".	
CHILD - Rating of Specialist Seen Most Often (Medi-Cal: Rating of 8, 9, or 10 of 10)	CAHPS	NCQA: Medi-Cal	Medi-Cal: NA		Medi-Cal: NA (No rate prior year)		Betty Santana (QI)/ Esther Bue (QPM)	Annually: Sept 20	MQSC: Oct 20			
CHILD - Getting Care Quickly (Enterprise Goal) (Medi-Cal: Always+Usually)	CAHPS	NCQA: Medi-Cal	Medi-Cal: 80.37%		Medi-Cal: 83%		Betty Santana (QI)/ Esther Bue (QPM)	Annually: Sept 20	MQSC: Oct 20		Member Experience (CG-CAHPS) measures in Plan Partner Incentive, Medi-Cal VIP+PAP. Name of measure is "Getting Timely Care".	
CHILD - Getting Needed Care (Enterprise Goal) (Medi-Cal: Always+Usually)	CAHPS	NCQA: Medi-Cal	Medi-Cal: 83.91%		Medi-Cal: 86%		Betty Santana (QI)/ Esther Bue (QPM)	Annually: Sept 20	MQSC: Oct 20		Member Experience (CG-CAHPS) measures in Plan Partner Incentive, Medi-Cal VIP+PAP.	
CHILD - Coordination of Care (Medi-Cal: Always+Usually)	CAHPS	NCQA: Medi-Cal	Medi-Cal: NA		Medi-Cal: NA (No rate prior year)		Betty Santana (QI)/ Esther Bue (QPM)	Annually: Sept 20	MQSC: Oct 20			
Overall CHILD NCQA Score (Medi-Cal) (Enterprise Goal)	CAHPS	NCQA: Medi-Cal	Medi-Cal: 7.65%		Medi-Cal: 7.85%		Betty Santana (QI)	Annually: Sept 20	MQSC: Oct 20			
Service - Complaints and Appeals												
Appeals Resolution (all Lines of Business)			Q1: 88% Q2: 97% Q3: 90% Q4: 95%		95% appeal resolution within 30 days		Lisa Marie Golden (G&A)	Quarterly Reports	MQSC: Feb 11, April 14, Aug 11, Oct 20			

Performance Measures for Planned Activities for Objectives	HEDIS Acronym	Regulatory Agencies	2019 Rates	2020 Rates	2020 Goal	Goal Met/Not Met	Responsible Staff/Department	Timeframe for completion	Reports to: (Dates are 2020 unless otherwise noted)	Interventions/Updates	Comments/Barriers	Recommend for 2020 Work Plan
Complaint Resolution (all Lines of Business)			Q1: 99% Q2: 95% Q3: 92% Q4: 97%		95% complaint resolution within 30 days		Lisa Marie Golden (G&A)	Quarterly Reports	MQSC: Feb 11, April 14, Aug 11, Oct 20			
Grievance Resolution (LACC Only)			Q1: 99% Q2: 95% Q3: 96% Q4: 98%		95% of Covered California enrollee grievances resolved within 30 calendar days of initial receipt		Lisa Marie Golden (G&A)	Quarterly Reports	MQSC: Feb 11, April 14, Aug 11, Oct 20			
Complaint & Appeals Analysis - Complaint categories based on the following categories: Quality of Care, Access, Attitude/Service, Billing/Financial, and Quality of Practitioner Office Site (all Lines of Business)			Q1: Report reviewed during July 2019 MQSC Q2: Report will be reviewed November 2019 MQSC Q3: Report reviewed during January 2020 MQSC Q4: Report will be reviewed January 2020 MQSC		100% of complaints & appeals will be analyzed quarterly to identify top 5 complaint categories.		Lisa Marie Golden (G&A)	Quarterly Reports	MQSC: Feb 11, April 14, Aug 11, Oct 20			
Access-Related Grievances at PPG Level			Q1: Report reviewed during July 2019 MQSC Q2: Report will be reviewed November 2019 MQSC Q3: Report reviewed during January 2020 MQSC Q4: Report will be reviewed January 2020 MQSC		Baseline for 2017 with Tentative Goal <2 Access-Related Grievances per 1000 members per month for Medi-Cal		Lisa Marie Golden (G&A)/ Karin Miller (QI)	Quarterly Reports	MQSC: Feb 11, April 14, Aug 11, Oct 20			
Service - Provider Satisfaction												
PCP satisfaction with UM process (timely decisions for pre-auth)			2018 Rate: 84.3%		80% of PCPs will be overall satisfied with timely decisions for pre-auths.		Jean Giggers (UM)	Annually: Sept 20	UMC: Dec 8			
PCP satisfaction with UM process (clinically reasonable decisions for pre-auths)			2018 Rate: 84.0%		80% of PCPs will be overall satisfied with clinically reasonable decisions for pre-auths.		Jean Giggers (UM)	Annually: Sept 20	UMC: Dec 8			
SCP satisfaction with UM process (timely decisions for pre-auths)			2018 Rate: 75.5%		80% of SCPs will be overall satisfied with timely decisions for pre-auths.		Jean Giggers (UM)	Annually: Sept 20	UMC: Dec 8			
SCP satisfaction with UM process (clinically reasonable decisions for pre-auths)			2018 Rate: 76.7%		80% of SCPs will be overall satisfied with clinically reasonable decisions for pre-auths.		Jean Giggers (UM)	Annually: Sept 20	UMC: Dec 8			
Overall Satisfaction with UM			2018 Rate: PCP: 86.1% SCP: 74.0%		80% of PCPs & SCPs will be overall satisfied with UM		Jean Giggers (UM)	Annually: Sept 20	UMC: Dec 8			
Clinical Improvements and Initiatives												
Clinical - Continuity and Coordination of Medical Care												
Coordination of Care: PCP/SCP Communication		NCQA	2019 Rates: PCP: 25%		80% of PCPs will rate the frequency of adequate clinical feedback from specialists to whom they have referred a patient		Sindhu Kumar (QI) Benny Santana (QI) Maria Casias (QI) PNM	Annually: Sept 20	4th Qtr. Attached to QI Eval; included in Coordination of Care Report Quality Oversight Committee (QOC) July 28, 2020			
Coordination of Care: SCP/PCP Communication		NCQA	2019 Rates: SCP: 60%		80% of SCPs will rate their communication with PCPs as receiving adequate clinical information for patient that were referred		Sindhu Kumar (QI) Benny Santana (QI) Maria Casias (QI) PNM	Annually: Sept 20	4th Qtr. Attached to QI Eval; included in Coordination of Care Report Quality Oversight Committee (QOC) July 28, 2020			
Coordination of Care: Transitions in Management, ED/Inpatient to PCP		NCQA CMS	Postpartum Care (PPC): MCLA: 62.18% Prenatal Care (PPC): MCLA: 85.49%		Postpartum Care (PPC): MCLA: 65% Prenatal Care (PPC): MCLA: 88%		Sindhu Kumar (QI) Jacqueline Kallujan (Health Ed) Maricela Rojas (Health Ed) Med Ops Reporting: Veronica Mones Ajana Katarayan Marie Martin	Annually: Sept 20	4th Qtr. Attached to QI Eval; included in Coordination of Care Report Quality Oversight Committee (QOC) July 28, 2020			
Appropriate Use of Medications-Polypharmacy			Q1: 100% Q2: 100% Q3: 100% Q4: 100%		90% of providers will be notified of members who meet criteria (MultiRx: 11 or more prescriptions in 3 of 4 months, Multi-Prescriber: 7 or more unique prescribers in 2 of 4 months, Duplicate Therapy: 2 or more Rx's in same drug class consistently in 3 of 4 months during lookback period)		Nicole Quang (Pharm)/ Ann Phan (Pharm)	Quarterly	QOC: 4/28/20, 7/28/20, 11/24/20 4th Qtr. Attached to QI Eval			

Performance Measures for Planned Activities for Objectives	HEDIS Acronym	Regulatory Agencies	2019 Rates	2020 Rates	2020 Goal	Goal Met/Not Met	Responsible Staff/Department	Timeframe for completion	Reports to: (Dates are 2020 unless otherwise noted)	Interventions/Updates	Comments/Barriers	Recommend for 2020 Work Plan
Transitions of Care - All Four Rates (Tier 2) (New Accreditation Measure RY2020)	TRC	H NCQA: Medicare CMC	CMC Rate: 34.31%		CMC: 37%		Sindu Kumar (QI)/ Betty Santana (QI)/ Maria Casias (QI)/ PNM	Annually: Sept 20	4th Qtr. Attached to QI Eval; included in Coordination of Care Report Quality Oversight Committee (QOC) July 28, 2020			
Follow-up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (7-day total rate) (Tier 2) (New Accreditation Measure RY2020)	FMC	A NCQA: Medicare CMS	Rate: 44.09%		CMC: 47%		Sindu Kumar (QI)/ Betty Santana (QI)/ Maria Casias (QI)/ PNM	Annually: Sept 20	4th Qtr. Attached to QI Eval; included in Coordination of Care Report Quality Oversight Committee (QOC) July 28, 2020			
Clinical - Continuity and Coordination of Medical and Behavioral Care												
Exchange of Information between PCPs and Behavioral Health Providers (BHPs)		NCQA	DMH Sufficient - 87.5% Timely - 59.8% Accurate - 75.7% Clear - 82.5% Beacon Sufficient - 59.4% Timely - 79.8% Accurate - 75.9% Clear - 67.8%		80% of providers will be always/usually satisfied with the exchange of information between PCPs and BHPs (ALIB)		Nicole Lehman (BH)/ Michael Brodsky (BH)/ Andrew Guy (QI)/ Beacon	Annual Due Oct 20	Behavioral Health Quality Improvement Committee (BHQIC): Dec 1			
Appropriate diagnosis, treatment and referral of behavioral health disorders commonly seen in primary care: Appropriate Treatment of Depression		NCQA: Medi-Cal (Continuation Phase ONLY) QRS	AMM (Acute Phase): Medi-Cal: 64.79% LACC: 65.13% CMC: 64.79% AMM (Continuation Phase): Medi-Cal: 57.16% LACC: 47.69% CMC: 57.16% AMM (Continuation Phase): Medi-Cal: 46% LACC: 50% CMC: 41%		LACC: 50% of providers will meet clinical practice guidelines for members with depression. Percent of members (18+) newly diagnosed with depressive disorder who received two or more outpatient Behavioral Health (BH) visits within 84 days (12 weeks) of initial diagnostic visit and who received one or more medication visits within 84 days (12 weeks) of initial diagnostic visit AMM (Acute Phase): Medi-Cal: 57.16% LACC: 68% AMM (Continuation Phase): Medi-Cal: 46% LACC: 50% CMC: 41%		Ron Makin (QPM)/ Michael Brodsky (BH)/ Andrew Guy (QI)/ Beacon	Annual Due Oct 20	BHQIC: Dec 1			
Management of treatment access and follow-up for members with coexisting medical and behavioral disorders		NCQA	SMD: Medi-Cal: 99.8% CMC: 100% LACC: 100% SSD: Medi-Cal: 99.9% CMC: 100% LACC: 100%		100% of providers will be notified of members on diabetes and antipsychotic medication		Nicole Lehman (BH)/ Michael Brodsky (BH)/ Andrew Guy (QI)	Annual	BHQIC: Dec 1			
Primary or secondary preventive behavioral health program		NCQA	15.75%(AMSC)		Substance Abuse Screening (AMSC)		Nicole Lehman (BH)/ Michael Brodsky (BH)/ Andrew Guy (QI)	Annual	BHQIC: Dec 1			
Special needs of members with severe and persistent mental illness		NCQA: Medi-Cal	2019 Rates: Medi-Cal: 78.85%		HEDIS results for Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) Cal MediConnect & LACC: MPL Medi-Cal: 81%		Ron Makin (QPM)/ Nicole Lehman (BH)/ Michael Brodsky (BH)/ Andrew Guy (QI)	Annual	BHQIC: Dec 1			
Clinical Improvements <i>Note that HEDIS measure goals are set ensuring that MPL are met.</i>		Hybrid (H)/Admin (A)/ Electronic Clinical Data Systems (ECDS)/ Auto-Assignment/ Accreditation (NCQA)/ MCA (DHCS)/ QRS (LACC)/Quality Withhold (QW)	2019 HEDIS Rates (MY 2018)	2020 HEDIS Rates (MY 2019)	Goal Methodology: 2019 rates used to determine an attainable % increase If a National benchmark was met in the Work Plan then the next benchmark was set as the goal. If the next percentile is not attainable per prior year trending, the goal was set accordingly. Measures that are part of PHM, the goal was set to match PHM. QWL Quality Withhold Measure							
Clinical Improvement												
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	AAB	A QRS NCQA: Medi-Cal	2019 Rates: Medi-Cal: 35.54% LACC: 24.32%		Medi-Cal: 39% LACC: 27%		Betty Santana (QI)/ Sindu Kumar (QI)/ Rodney Truong (QPM)/ Nicole Quang (Pharm)	Annual: By June 20	QOC: September 22 PCC & PQ: Nov 3			

Performance Measures for Planned Activities for Objectives	HEDIS Acronym	Regulatory Agencies	2019 Rates	2020 Rates	2020 Goal	Goal Met/Not Met	Responsible Staff/Department	Timeframe for completion	Reports to: (Dates are 2020 unless otherwise noted)	Interventions/Updates	Comments/Barriers	Recommend for 2020 Work Plan
Colorectal Cancer Screening (Tier 1)	COL	H NCQA: Medicare QRS	2019 Rates: CMC: 61.04 % LACC: 53.77%		CMC: 65% LACC: 56%		Sidhu Kumar (QI) Rodney Truong (QPM) Med Ops Reporting: Veronica Mones Anita Kazaryan Marie Martin	Annual By June '20	QOC: September 22 PICC & PQC: Nov 3			
Adult BMI Assessment	ABA	H NCQA: Medi-Cal MCAS QRS	2019 Rates: Medi-Cal: 95.88% LACC: 95.29% CMC: 97.06% MCLA: 94.74%		Medi-Cal: 90% LACC: 98% CMC: 98% MCLA: 96%		Betty Santana (QI) Rodney Truong (QPM)	Annual By June '20	QOC: September 22 PICC & PQC: Nov 3			
Children's Health/Well Visits												
Adolescent Well-Care Visits New MCAS Measure (Medi-Cal) (Enterprise Goal)	AWC	H MCAS	N/A		MCLA: 45%		Betty Santana (QI) Rodney Truong (QPM) Keren Mahgrefteh (QI)	Annual By June '20	QOC: September 22 PICC & PQC: Nov 3			
Well Child Visits First 15 Months of Life (Plan Partner Incentive, Medi-Cal VHP+PAP and Physician P4P)	W15	H MCAS QRS	2019 Rate: LACC: 36.84% Medi-Cal: 29.93% MCLA: 31.20%		Medi-Cal: 66% LACC: 34%		Betty Santana (QI) Rodney Truong (QPM) Keren Mahgrefteh (QI)	Annual By June '20	QOC: September 22 PICC & PQC: Nov 3			
Well Child Visits 3-6 yrs of age (Plan Partner Incentive, Medi-Cal VHP+PAP and Physician P4P)	W34	H Auto-Assignment MCAS QRS	2019 Rate: Medi-Cal: 74.45% LACC: 74.71%		Medi-Cal: 79% LACC: 77%		Betty Santana (QI) Rodney Truong (QPM) Keren Mahgrefteh (QI)	Annual By June '20	QOC: September 22 PICC & PQC: Nov 3			
Weight Assessment & Counseling for Nutrition & Physical Activity for Children & Adolescents (Plan Partner Incentive, Medi-Cal VHP+PAP and Physician P4P - BMI Total)	WCC	H BMI NCQA: Medi-Cal MCAS (RY2021) QRS Nutrition & Physical Activity QRS	2019 Rates: Medi-Cal: BMI: 93% Nutrition: 85.28% Physical Activity: 83.61% LACC: BMI: 86% Nutrition: 83% Physical Activity: 75.28%		Medi-Cal: BMI: 93% Nutrition: 88% Physical Activity: 86% LACC: BMI: 86% Nutrition: 83% Physical Activity: 78%		Betty Santana (QI) Rodney Truong (QPM) Keren Mahgrefteh (QI)	Annual By June '20	QOC: September 22 PICC & PQC: Nov 3			
Childhood Immunizations - Combo 3 (Enterprise Goal)	CIS-3	H QRS	2019 Rate: Medi-Cal: 72.26% LACC: 82.00%		Medi-Cal: 75% LACC: 85%		Betty Santana (QI) Keren Mahgrefteh (QI) Rodney Truong (QPM)	Annual By June '20	QOC: September 22 PICC & PQC: Nov 3			
Childhood Immunizations - Combo 10 (Enterprise Goal) (Plan Partner Incentive, Medi-Cal VHP+PAP and Physician P4P)	CIS-10	H Auto Assignment NCQA: Medi-Cal MCAS	2019 Rate: Medi-Cal: 33.82% LACC: N/A MCLA: 39.20%		Medi-Cal: 35% LACC: 85% MCLA: 35%		Betty Santana (QI) Rodney Truong (QPM)	Annual By June '20	QOC: September 22 PICC & PQC: Nov 3			
Immunization for Adolescents - Combination 2 (Plan Partner Incentive, Medi-Cal VHP+PAP and Physician P4P)	IMA-2	H NCQA: Medi-Cal MCAS QRS	2019 Rate: Medi-Cal: 42.82% LACC: 39.29%		Medi-Cal: 48% LACC: 42%		Betty Santana (QI) Keren Mahgrefteh (QI) Rodney Truong (QPM)	Annual By June '20	QOC: September 22 PICC & PQC: Nov 3			

Performance Measures for Planned Activities for Objectives	HEDIS Acronym	Regulatory Agencies	2019 Rates	2020 Rates	2020 Goal	Goal Met/Not Met	Responsible Staff/Department	Timeframe for completion	Reports to: (Dates are 2020 unless otherwise noted)	Interventions/Updates	Comments/Barriers	Recommend for 2020 Work Plan
Appropriate Testing for Pharyngitis	CWP	A NCQA: Medi-Cal QRS	2019 Rate: Medi-Cal: 31.19% LACC: 64.29%		Medi-Cal: 34% LACC: 67%		Betty Santana (QI)/ Keren Mahgrefeh (QI)/ Rodney Truong (QPM)	Annual By June '20	QOC: September 22 PICC & PQG: Nov 3			
Appropriate Rx for Upper Respiratory Infections	URI	A NCQA: Medi-Cal QRS	2019 Rate: Medi-Cal: 88.74% LACC: 90.28%		Medi-Cal: 92% LACC: 93%		Betty Santana (QI)/ Keren Mahgrefeh (QI)/ Rodney Truong (QPM)	Annual By June '20	QOC: September 22 PICC & PQG: Nov 3			
Metabolic Monitoring for Children and Adolescents on Antipsychotics (Total) (NEW MCAS Measure RY 2021)	APM	A MCAS (RY2021)	2019 Rate: Medi-Cal: 49.08%		Medi-Cal: 52%		Betty Santana (QI)/ Keren Mahgrefeh (QI)/ Rodney Truong (QPM)	Annual By June '20	QOC: September 22 PICC & PQG: Nov 3			
Women's Health Initiatives												
Prenatal Visits (Plan Partner Incentive, Medi-Cal VHP+P4P and Physician P4P)	PPC (Prenatal)	H Auto Assignment NCQA: Medi-Cal MCAS QRS	2019 Rate: Medi-Cal: 87.80% LACC: 88.27%		Medi-Cal: 92% LACC: 92%		Margaret Marcia (HECLS)/ Rodney Truong (QPM)	Annual By June '20	QOC: September 22 PICC & PQG: Nov 3			
Postpartum Care (Plan Partner Incentive, Medi-Cal VHP+P4P and Physician P4P) (Enterprise Goal)	PPC (Postpartum)	H NCQA: Medi-Cal MCAS QRS	2019 Rate: Medi-Cal: 62.72% LACC: 69.39%		Medi-Cal: 69% LACC: 76% MCLA: 69%		Margaret Marcia (HECLS)/ Rodney Truong (QPM)	Annual By June '20	QOC: September 22 PICC & PQG: Nov 3			
Breast Cancer Screenings (Tier1) (Plan Partner Incentive, Medi-Cal VHP+P4P, CMC VHP, LACC VHP and Physician P4P)	BCS	A MCAS QRS NCQA: Medi-Cal & Medicare	2019 Rate: Medi-Cal: 60.98 % LACC: 72.99 % CMC: 63.66%		Medi-Cal: 65% LACC: 75% CMC: 66%		Sinhu Kumar (QI)/ Rodney Truong (QPM)	Annual By June '20	QOC: September 22 PICC & PQG: Nov 3			
Cervical Cancer Screenings (Plan Partner Incentive, Medi-Cal VHP+P4P and Physician P4P)	CCS	H Auto-Assignment EAS QRS NCQA: Medi-Cal	2019 Rate: Medi-Cal: 66.08% LACC: 53.53%		Medi-Cal: 69% LACC: 57%		Sinhu Kumar (QI) Rodney Truong (QPM)	Annual By June '20	QOC: September 22 PICC & PQG: Nov 3			
Chlamydia Screening In Women (Total) (Plan Partner Incentive, Medi-Cal VHP+P4P and Physician P4P)	CHL	A NCQA: Medi-Cal MCAS QRS	2019 Rate: Medi-Cal: 66.77 % LACC: 59.04%		Medi-Cal: 73% LACC: 62%		Betty Santana (QI)/ Rodney Truong (QPM)/ Margaret Marcia (HECLS)	Annual By June '20	QOC: September 22 PICC & PQG: Nov 3			
Chronic Condition Measures (Plan Wide)												
Diabetes: Eye Exam (retinal) performed (Tier 2) (Plan Partner Incentive, Medi-Cal VHP+P4P, CMC VHP, LACC VHP and Physician P4P)	CDC- Eye Exam	H NCQA: Medi-Cal & Medicare QRS	2019 Rate: Medi-Cal: 64.72% MCLA: 63.67% LACC: 60.54% CMC: 75.56%		Medi-Cal: 71% MCLA: 66% LACC: 63% CMC: 78%		Betty Santana (QI)/ Rachel Martinez (QI)/ Irene Elorduy (CM)/ Steven Chang (CM)/ Ana Dominguez (CM)/ Rodney Truong (QPM)	Annual By June '20	QOC: September 22 PICC & PQG: Nov 3			
Diabetes: A1C Screening (Tier 2)	CDC- A1C Screening	H Auto-Assignment MCAS (Remove RY2021)	2019 Rate: Medi-Cal: 86.13% MCLA: 83.90%		Medi-Cal: 90% MCLA: 86%		Betty Santana (QI)/ Rachel Martinez (QI)/ Irene Elorduy (CM)/ Steven Chang (CM)/ Ana Dominguez (CM)/ Rodney Truong (QPM)/ Mary Anne Choi (Pharm)	Annual By June '20	QOC: September 22 PICC & PQG: Nov 3			

Performance Measures for Planned Activities for Objectives	HEDIS Acronym	Regulatory Agencies	2019 Rates	2020 Rates	2020 Goal	Goal Met/Not Met	Responsible Staff/Department	Timeframe for completion	Reports to: (Dates are 2020 unless otherwise noted)	Interventions/Updates	Comments/Barriers	Recommend for 2020 Work Plan
Diabetes: A1C Poor Control (<9.0%) (Tier 2) (A lower rate indicates better performance)	CDC- A1C Poor Control (<9.0%)	H MCAS	2019 Rate: Medi-Cal: 35.28% MCLA: 35.58%		Medi-Cal: 32% MCLA: 31%		Betty Santana (QI)/ Rachel Martinez (QI)/ Izaro Ekerdy (CM)/ Steven Chang (CM)/ Ana Dominguez (CM)/ Rodney Truong (QPM)/ Mary Anne Choi (Pharm)	Annual By June '20	QOC: September 22 PICC & PQC: Nov 3			
Diabetes: A1C Good Control (<8.0%) (Tier 2) (Enterprise Goal) (Plan Partner Incentive, Medi-Cal VHP-PAP, CMC VHP, LACC VHP and Physician PAP)	CDC- A1C Good Control (<8.0%)	H NCQA: Medi-Cal & Medicare QRS	2019 Rate: Medi-Cal: 51.09% MCLA: 49.09% LACC: 61.56% CMC: 62.22%		Medi-Cal: 51% MCLA: 51% LACC: 63% CMC: 64%		Betty Santana (QI)/ Rachel Martinez (QI)/ Izaro Ekerdy (CM)/ Steven Chang (CM)/ Ana Dominguez (CM)/ Rodney Truong (QPM)/ Mary Anne Choi (Pharm)	Annual By June '20	QOC: September 22 PICC & PQC: Nov 3			
Diabetes: Medical Attention for Nephropathy (May be included for LACC VHP)	CDC- Nephropathy	H QRS	2019 Rate: Medi-Cal: 90.51% MCLA: 91.01% LACC: 94.89% CMC: 97.04%		Medi-Cal: 83% MCLA: 82% LACC: 95% CMC: 98%		Betty Santana (QI)/ Rachel Martinez (QI)/ Izaro Ekerdy (CM)/ Steven Chang (CM)/ Ana Dominguez (CM)/ Rodney Truong (QPM)	Annual By June '20	QOC: September 22 PICC & PQC: Nov 3			
Diabetes: Blood Pressure Control (<140/90 mm Hg) (Tier 2)	CDC- Blood Pressure Control (<140/90 mm Hg)	H NCQA: Medi-Cal & Medicare	2019 Rate: Medi-Cal: 70.80% CMC: 70.12 %		Medi-Cal: 73% CMC: 73%		Betty Santana (QI)/ Rachel Martinez (QI)/ Izaro Ekerdy (CM)/ Steven Chang (CM)/ Ana Dominguez (CM)/ Rodney Truong (QPM)	Annual By June '20	QOC: September 22 PICC & PQC: Nov 3			
Statin Therapy for Patients with Cardiovascular Disease (Tier 2)	SPC	A NCQA: Medi-Cal & Medicare	2019 Rate: Medi-Cal: Total Statin Therapy: 80.53% Total Adherence: 79.69% CMC: Total Statin Therapy: 77.03% Total Adherence: 72.67%		Medi-Cal: Total Statin Therapy: 83% Total Adherence: 79% CMC: Total Statin Therapy: 79% Total Adherence: 76%		Ann Phan (Pharm)/ Nicole Quang (Pharm)/ Rodney Truong (QPM)	Annual By June '20	QOC: September 22 PICC & PQC: Nov 3			
Statin Therapy for Patients with Diabetes (Tier 2) (Enterprise Goal - Adherence 80% - Goal)	SPD	A NCQA: Medi-Cal & Medicare	2019 Rate: Medi-Cal: Received Statin Therapy: 69.20% Statin Adherence: 65.76% CMC: Received Statin Therapy: 74.06% Statin Adherence: 72.13%		Medi-Cal: Received Statin Therapy: 73% Statin Adherence: 69% CMC: Received Statin Therapy: 77% Statin Adherence: 74%		Ann Phan (Pharm)/ Nicole Quang (Pharm)/ Rodney Truong (QPM)	Annual By June '20	QOC: September 22 PICC & PQC: Nov 3			
Controlling High Blood Pressure (Tier 1) (Plan Partner Incentive, Medi-Cal VHP-PAP, LACC VHP and Physician PAP)	CBP	H Auto-Assignment NCQA: Medi-Cal & Medicare MCAS QRS QW	2019 Rate: Medi-Cal: 71.05% LACC: 68.13% CMC: 73.24% MCLA: 70.49%		Medi-Cal: 73% LACC: 70% CMC: 76% (QW 71%) MCLA: 73%		Betty Santana (QI)/ Rachel Martinez (QI)/ Rodney Truong (QPM)	Annual By June '20	QOC: September 22 PICC & PQC: Nov 3			
Member Satisfaction with Disease Management Programs-CVD		None	Member Satisfaction Survey not fielded in 2019.		90% for all lines of business for all programs		Izaro Ekerdy (CM)/ Steven Chang (CM)/ Ana Dominguez (CM)	Annual By Oct. '20	QOC: Nov 24			
Asthma Medication Rate (Total) (Enterprise Goal) (Plan Partner Incentive, Medi-Cal VHP-PAP, LACC VHP and Physician PAP)	AMR	A NCQA: Medi-Cal MCAS	2019 Rates: Medi-Cal: 69.90% MCLA: 55.64%		Medi-Cal: 64% LACC: 79% MCLA: 58%		Betty Santana (QI)/ Rachel Martinez (QI)/ Rodney Truong (QPM)	Annual By June '20	QOC: September 22 PICC & PQC: Nov 3			
Medication Management for People with Asthma (MDMA) - 75% Compliance	MMA - 75%	A 75% Compliance Rate NCQA: Medi-Cal QRS	2019 Rates: Medi-Cal: 62.44% LACC: 52.55% MCLA: 43.60%		Medi-Cal: 44% LACC: 57% MCLA: 46% 75% compliance: 44% 75% compliance: 57% 75% compliance: 46%		Betty Santana (QI)/ Izaro Ekerdy (CM)/ Steven Chang (CM)/ Ana Dominguez (CM)/ Rodney Truong (QPM)	Annual By June '20	QOC: September 22 PICC & PQC: Nov 3			

Performance Measures for Planned Activities for Objectives	HEDIS Acronym	Regulatory Agencies	2019 Rates	2020 Rates	2020 Goal	Goal Met/Not Met	Responsible Staff/Department	Timeframe for completion	Reports to: (Dates are 2020 unless otherwise noted)	Interventions/Updates	Comments/Barriers	Recommend for 2020 Work Plan
Pharmacotherapy Management of COPD Exacerbation (dispensed a systemic corticosteroid within 14 days of the event)	PCE- (dispensed a systemic corticosteroid within 14 days of the event)	A NCQA: Medi-Cal & Medicare	2019 Rate: Medi-Cal: 68.47% CMC: 76.02%		Medi-Cal: 72% CMC: 77%		Betty Santana (QI)/ Rodney Truong (QPM)	Annual By June '20	QOC: September 22 PICC & PQC: Nov 3			
Pharmacotherapy Management of COPD Exacerbation (dispensed a bronchodilator within 30 days of the event)	PCE- (dispensed a bronchodilator within 30 days of the event)	A NCQA: Medi-Cal & Medicare	2019 Rate: Medi-Cal: 83.61% CMC: 83.26%		Medi-Cal: 86% CMC: 86%		Betty Santana (QI)/ Rodney Truong (QPM)	Annual By June '20	QOC: September 22 PICC & PQC: Nov 3			
Use of Imaging Studies for Low Back Pain	LBP	A NCQA: Medi-Cal QRS	2019 Rate: Medi-Cal: 71.74% LACC: 71.39%		Medi-Cal: 76% LACC: 74%		Betty Santana (QI)/ Rachel Martinez (QI)/ Rodney Truong (QPM)	Annual By June '20	QOC: September 22 PICC & PQC: Nov 3			
Other Measures												
Board Certification	BCR	A	Fam Med: 34.13% ME: 58.52% Pediatrics: 57.41% OB/GYN: 59.38% Geriatrics: 56.41% Other: 70.92%		NA		Rodney Truong (QPM)	Annual By June '20	QOC: September 22 PICC & PQC: Nov 3			
Topical Fluoride Varnish Utilization		DHCS	Medi-Cal: 20,91 PTPY individuals received fluoride treatment in FY 2018 compared to 19,88 PTPY in FY 2017 (<5 yrs). MCLA: 11,88 PTPY individuals received fluoride treatment in FY 2018 compared to 14,09 PTPY in FY 2017 (<5 yrs).		NA		Betty Santana (QI)/ Marie Lubert (QI)	Annual By June '20	QOC: July 28			
Health Information Management (HIM) department runs aggregate HIA report on the HIA completion rate						Medi-Cal: CMC:	Johanna Kichaven (PIM)/ Anni Hamedani (PIM)	Quarterly	QI Steering Committee 5/20/20, 7/15/20, 11/18/20			
Behavioral Health												
QW: Quality Withhold Measure												
Antidepressant Medication Management (Acute Phase)	AMM- Acute Phase	A MCAS QRS	2019 Rates: LACC: 65.13%		Medi-Cal: 63% LACC: 68%		Betty Santana (QI)/ Andrew Guy QI/ Rodney Truong (QPM)	Annual By June '20	BHQIC: Sept. 1			
Antidepressant Medication Management (Continuation Phase) (Plan Partner Incentive, Medi-Cal VIP, PIP, CMC VIII and Physician PIP)	AMM- Continuation Phase	A NCQA: Medi-Cal & Medicare MCAS QRS	2019 Rates: Medi-Cal: 43.14% LACC: 47.69% CMC: 57.16%		Medi-Cal: 46% LACC: 50% CMC: 61%		Betty Santana (QI)/ Andrew Guy QI/ Rodney Truong (QPM)	Annual By June '20	BHQIC: Sept. 1			
Follow-Up for Children Prescribed ADHD Medication- initiation Phase	ADD- Initiation Phase	A MCAS (Reportable Only)	2019 Rates: Medi-Cal: 40.88% LACC: NA (Denominator less than 30)		Medi-Cal: 44% LACC: NA (Prior year denominator <30)		Betty Santana (QI)/ Andrew Guy QI/ Rodney Truong (QPM)	Annual By June '20	QOC: September 22 PICC & PQC: Nov 3			
Follow-Up for Children Prescribed ADHD Medication - Continuation and Maintenance Phase (Tier 2) (Enterprise Goal)	ADD- Continuation and Maintenance Phase	A MCAS NCQA: Medi-Cal	2019 Rates: Medi-Cal: 43.20% LACC: NA		Medi-Cal: 47% MCLA: 30% LACC: NA (Prior year denominator <30)		Betty Santana (QI)/ Andrew Guy QI/ Rodney Truong (QPM)	Annual By June '20	QOC: September 22 PICC & PQC: Nov 3			
Follow-Up After Hospitalization for Mental Illness (in 7 days) (Tier 2)	FUH7	A QRS NCQA: Medi-Cal & Medicare	2019 Rates: Medi-Cal: 30.54% LACC: 26.23% CMC: 29.53%		Medi-Cal: 36% LACC: 30% CMC: 35%		Betty Santana (QI)/ Andrew Guy QI/ Rodney Truong (QPM)	Annual By June '20	QOC: September 22 PICC & PQC: Nov 3			
Follow-Up After Hospitalization for Mental Illness (in 30 days) (Tier 1)	FUH30	A QW	2019 Rates: CMC: 48.99%		CMC: 51% (QW 56%)		Betty Santana (QI)/ Andrew Guy QI/ Rodney Truong (QPM)	Annual By June '20	QOC: September 22 PICC & PQC: Nov 3			
Depression Screening and follow-up plan (DSF)	DSF	ECDS MMP	2019 Rates: Medi-Cal Screening: 0.03% Medi-Cal Follow-Up: 27.59%		Medi-Cal Screening: 3% Medi-Cal Follow-Up: 30%		Betty Santana (QI)/ Andrew Guy QI/ Rodney Truong (QPM)	Annual By June '20	BHQIC: Sept. 1			
Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications	SSD	A NCQA: Medi-Cal MCAS CMC & LACC: NCQA Report	2019 Rates: Medi-Cal: 78.85%		Medi-Cal: 82% Cal MediConnect & LACC: MPL		Betty Santana (QI)/ Andrew Guy QI/ Rodney Truong (QPM)	Annual By June '20	QOC: September 22 PICC & PQC: Nov 3			
Diabetes Monitoring for People with Diabetes and Schizophrenia	SMD	A NCQA Report	2019 Rates: Medi-Cal: 73.02%		Medi-Cal: 76%		Betty Santana (QI)/ Andrew Guy QI/ Rodney Truong (QPM)	Annual By June '20	QOC: September 22 PICC & PQC: Nov 3			
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment - Initiation Total	IEI- Initiation Total	A QRS	2019 Rates: LACC: 33.14%		LACC: 36%		Betty Santana (QI)/ Andrew Guy QI/ Rodney Truong (QPM)	Annual By June '20	QOC: September 22 PICC & PQC: Nov 3			

Use work plan address the QIP program scope as defined by the 2020 QIP table in attachment and QIP objectives.

Performance Measures for Planned Activities for Objectives	HEDIS Acronym	Regulatory Agencies	2019 Rates	2020 Rates	2020 Goal	Goal Met/Not Met	Responsible Staff/Department	Timeframe for completion	Reports to: (Dates are 2020 unless otherwise noted)	Interventions/Updates	Comments/Barriers	Recommend for 2020 Work Plan
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment - Engagement Total	IEE-Engagement Total	A NCQA: Medi-Cal & Medicare QRS	2019 Rates: Medi-Cal: 5.63% LACC: 4.51% CMC: 4.55%		Medi-Cal: 8% LACC: 7% CMC: 6%		Betty Santana (QI)/ Andrew Gay (QI)/ Rodney Truong (QPM)	Annual: By June 30	QOC: September 22 PICC & PQ: Nov 3			
State Quality Improvement Projects												
Childhood Immunization Status-10 PIP	CIS-10	DHCS	2019 Rate: Medi-Cal: 33.82%		Medi-Cal: 35%		Keren Mahgerefteh (QI)/ Betty Santana (QI)	2019-2021	QOC: September 22 PICC & PQ: Nov 3			
Asthma Medication Ratio (AMR) Disparity PIP	AMR	DHCS	2019 Rates: 30%		Smart Aim: By June 30, 2021, decrease the percentage of people between the ages of 19-59 in SFA 6 diagnosed with persistent asthma and who have not filled a prescription for a controller medication in the past 12-months from 30% to 26%.		Rachel Martinez (QI)/ Betty Santana (QI)	11/22/2019	QOC: September 22 PICC & PQ: Nov 3			
Diabetes Disparity for A1c Control (<8%) in African Americans/Naive Americans PIP	CDC	LACC ONLY	AIAN: 37.37% BAA: 43.88%		AIAN: 46.53% BAA: 44.05%		Marina Acosta (HE)	12/31/2020	QOC: September 22 PICC & PQ: Nov 3			
Medicare/Medicaid Quality Improvement Projects												
CMS MMP: Individualized Care Plan (PIP) (Enterprise Goal)		CMS	2019 Rates: <u>Measure 1.5 High Risk:</u> Q1: 58% Q2: 59% Q3: 59% Q4: Pending <u>Measure 1.5 Low Risk:</u> Q1: 73% Q2: 71% Q3: 69% Q4: Pending <u>Measure 1.6:</u> Q1: 100% Q2: 100% Q3 & Q4: Pending		By March 15, 2020: <u>Measure 1.5:</u> CMC members initially stratified as high risk, enrolled 90-days or longer at the end of the reporting period and had an Individualized Care Plan (ICP) completed. To achieve statistically significant improvement over the prior year. Baseline rate 2017 Q4: 37.27%. <u>Measure 1.5:</u> CMC members initially stratified as low risk, enrolled 90-days or longer at the end of the reporting period and had an ICP completed. To achieve statistically significant improvement over the prior year. Baseline rate 2017 Q4: 36.00%. <u>Measure 1.6:</u> CMC members who has an ICP and had at least one documented discussion of care goals in the initial ICP. To maintain the baseline rate of 100%.		Keren Mahgerefteh (QI)/ Betty Santana (QI)	Due to CMS/DHCS: March 16, 2018	5/17/19 and 7/18/2019			
Clinical - Patient Safety												
Potential Quality Issues			Q4 2018 - Q1 2019: 887 out of 890 (99.7%) were processed timely. 3 cases fell out of compliance with 6-month processing time. Q2 2019: 488 out of 489 (99.8%) were processed timely. 1 case fell out of compliance with 6-month processing time despite one month extension. Q3 2019: 466 out of 634 (73.5%) were processed timely. 168 cases fell out of compliance with 6-month processing time. Q4 2019: 606 out of 1040 (58.3%) were processed timely. 434 cases fell out of compliance with 6-month processing time.		65% of PQI investigation will be completed in 6 months		Christine Church (QI)	Annually and end of FY	QOC: April 22 Nov 24			
Critical Incidents Reporting and Tracking			Q4 2018: 100% Q1 2019: 96.4% (27 out of 28 groups except LogistiCare submitted the Q1 2019. Q2 2019: 100% Q3 2019: 100% Q4 2019: report due 2/15/2020		100% of Critical Incidents Reported and Tracked		Christine Church (QI)	Annually and end of FY	QOC: April 28 Nov 24			
FSR: needstick safety			Q1: Compliance Rate = 79 % Q2: Compliance Rate = 76% Q3: Compliance Rate = 84% Q4: Compliance Rate = 74%		80%		Sonia Richard (FSR) / Elaine Sadoschi-Smith (PHM)	Quarterly	QOC: 4/28/20, 7/28/20, 11/24/20 4th Qtr. Attached to QI Eval			
FSR: spore testing of autoclave/sterilizer			Q1: Compliance Rate = 83% Q2: Compliance Rate = 87% Q3: Compliance Rate = 82% Q4: Compliance Rate = 71%		85%		Sonia Richard (FSR) / Elaine Sadoschi-Smith (PHM)	Quarterly	QOC: 4/28/20, 7/28/20, 11/24/20 4th Qtr. Attached to QI Eval			

Performance Measures for Planned Activities for Objectives	HEDIS Acronym	Regulatory Agencies	2019 Rates	2020 Rates	2020 Goal	Goal Met/Not Met	Responsible Staff/Department	Timeframe for completion	Reports to: (Dates are 2020 unless otherwise noted)	Interventions/Updates	Comments/Barriers	Recommend for 2020 Work Plan
Facility Site Review (FSR) HIA Completion Rate per chart review (HEBA and H&P complete in chart)			Medi-Cal Adult: 51% (2018 46%) Medi-Cal Child: 71% (2018 61%) CMC Adult: 50% (2018 46%) CMC Child: 73% (2018 64%)		Medi-Cal Adult: 50% Medi-Cal Child: 68% CMC Adult: 50% CMC Child: 70%		Sonia Richards (FSR) Irina Melion (FSR) / Johanna Kichaven (PHM) Anni Hamedani (PHM)		QI Steering Committee: 5/20/20, 7/15/20, 11/18/20			
Appropriate Use of Medications - Controlled Substances			Q1: 100% Q2: 100% Q3: 100% Q4: 100%		Retrospective Drug Utilization Review (RDUR): Controlled Substance Monitoring 90% of providers will be notified via mail of members who meet criteria (9 or more of the following Rx) for controlled substances - unique prescribers - unique pharmacies for at least 2 of 4 months). Mailing occurs three times a year. Repeat Alert will also occur for patients identified in above mailing 4 or more times over 2-year period.		Nicole Quang (Pharm)/ Ann Phan (Pharm)	Quarterly	QOC: 4/28/20, 7/28/20, 11/24/20 4th Qtr. Attached to QI Eval			
Appropriate Use of Medications - Triple Threat			Q1: 100% Q2: 100% Q3: 100% Q4: 100%		Retrospective Drug Utilization Review (RDUR): Triple Threat Criteria 90% of providers will be notified via mail of members who had Rx for each of the following drug classes: opioids, skeletal muscle relaxants, and benzodiazepines/hypnotics (sleep aids) in a month for at least 2 of 4 months. Mailing occurs three times a year.		Nicole Quang (Pharm)/ Ann Phan (Pharm)	Quarterly	QOC: 4/28/20, 7/28/20, 11/24/20 4th Qtr. Attached to QI Eval			
Potentially Inappropriate Medication (PIM)			Q1: 100% Q2: 100% Q3: 100% Q4: 100%		Concurrent DUR edits in place for members with Potential medication overutilization		Nicole Quang (Pharm)/ Ann Phan (Pharm)	Quarterly	QOC: 4/28/20, 7/28/20, 11/24/20 4th Qtr. Attached to QI Eval			
Medication Therapy Management (MTM) program			CMR Completion rate: CMC: 100% Q1: 15% Q2: 42% Q3: 58% Q4: 85%		CMC only: MTM program with SintoniaRx for 2019: Comprehensive Medication Review (CMR) - phone intervention by pharmacist or other qualified clinician. Goal of 85% by the end of the year.		Nicole Quang (Pharm)/ Ann Phan (Pharm)	Quarterly	QOC: 4/28/20, 7/28/20, 11/24/20 4th Qtr. Attached to QI Eval			
Clinical - Clinical Practice & Preventive Guidelines												
Clinical Practice Guidelines			N/A		100% review and approval at least every 2 years/updates as required.		Betty Santana/ Dr. Kyla QO/ Rachel Martinez (QI)	Annual and as needed for updates	PICC & PQC: July 7			
Clinical Practice Guidelines			N/A		Measure at least 2 guidelines (i.e., Depression Screening and Follow-up for Adolescents and Adults (DSF) & Use of Imaging Studies for Low Back Pain (LBP))		Betty Santana/ Dr. Kyla QO/ Rachel Martinez (QI)	Annual	PICC & PQC: July 7			
Preventive Health Guidelines (PHGs)			N/A		Review, update, approve, & distribute Preventive Health Guidelines		Betty Santana (QI)/ Rachel Martinez (QI)	Annual	PICC & PQC: July 7			
LACC Measures												
Quality Rating System Clinical Effectiveness Rating (QIS 3.1)			3 stars		Achieve four stars for HEDIS measures in QRS		Katrina Miller (QI)/ Ron Makina (QPM)/ Sonia Kumar (QI)	Annual	QOC: Nov. 24			
Quality Rating System QHP Enrollee Survey Summary Rating (QIS 3.2)			1 star		Achieve four stars for EESCAHPS measures in QRS		Katrina Miller (QI)/ Ron Makina (QPM)/ Carolina Coleman (QI)	Annual	QOC: Nov. 24			
Proportion of Days Covered - Medication Adherence for Diabetes Medications (LACC VHP)		QRS	LACC: 70.64%		LACC: 74%		Rodney Truong (QPM)	Annual By June '20	QOC: September 22 PICC & PQC: Nov 3			
Proportion of Days Covered - Medication Adherence for Cholesterol (Statins) (LACC VHP)		QRS	LACC: 63.16%		LACC: 66%		Rodney Truong (QPM)	Annual By June '20	QOC: September 22 PICC & PQC: Nov 3			
Other Population Health Management (PHM) Enterprise Goals												
Percentage of members with care plan completed within 90 days of enrollment (excluding unable to contact and refusals) (Core Measure 3.2) (Tier 1)			CMC: 55%		CMC: 60%		Veronica Zapata (CM)/ Irene Elkertig (CM)/ Steven Chang (CM)	Annual By June '20	QOC: September 22 PICC & PQC: Nov 3			
Percent of gaps identified and addressed based on Health Risk Assessment (HRA) responses with MLTSS needs and "Successful Post HRA Outreach results in SPD and CMC (APL/DPL) - Does not include members unable to contact or declined services			MCLA: 100% CMC: 100%		MCLA: 70% CMC: 70%		Judy Cui-Razonable	Annual By June '20	QOC: September 22 PICC & PQC: Nov 3			

Performance Measures for Planned Activities for Objectives	HEDIS Acronym	Regulatory Agencies	2019 Rates	2020 Rates	2020 Goal	Goal Met/Not Met	Responsible Staff/Department	Timeframe for completion	Reports to: (Dates are 2020 unless otherwise noted)	Interventions/Updates	Comments/Barriers	Recommend for 2020 Work Plan
The Utilization Management Department will achieve 90% compliance with denial letters for all lines of business for nine or more months (New 2020)			N/A		MCLA: 90% LACC: 90% CMC: 90%		David Kagan, MD (UM)	Annual By June '20	QOC: September 22 PICC & PQC: Nov 3			
The Utilization Management Department will achieve 95% compliance turn around time with outpatient service requests for all lines of business for nine or more months (New 2020)			N/A		MCLA: 95% LACC: 90% CMC: 95%		David Kagan, MD (UM)	Annual By June '20	QOC: September 22 PICC & PQC: Nov 3			
Cal Medi Connect - Medicare-Medicaid Plans (MMP) Measures			Rate 2019 Rate (MY 2018)	Rate 2020 Rate (MY 2019)	<u>Goal Methodology:</u> 2019 rates used to determine an attainable % increase If a National benchmark was met in the Work Plan then the next benchmark was set as the goal. If the next percentile is not attainable per prior year trending, the goal was set accordingly. Measures that are part of PHM, the goal was set to match PHM. QW: Quality Withhold Measure							
Follow-up After Emergency Department Visit for Alcohol and other Drug Abuse or Dependence (7-day rate only) (Tier 2) (New Accreditation Measure RY2020)	FUA	A MMP	CMC: 6.41% MED-CAL: 2.59%		CMC: 7.25% MED-CAL: 3.5%		Rodney Truong (QPM)/ Esther Bue (QPM)	Annual By June '20	QOC: September 22 PICC & PQC: Nov 3			
Follow-up After Emergency Department Visit for Mental Illness (7-day rate only) (Tier 2) (New Accreditation Measure RY2020)	FUM	A MMP	CMC: 31.25% MED-CAL: 30.91%		CMC: 41.22% MED-CAL: 34%		Rodney Truong (QPM)/ Esther Bue (QPM)	Annual By June '20	QOC: September 22 PICC & PQC: Nov 3			
Osteoporosis Management in Older Women who had a Fracture (Tier 1)	OMW	A NCQA: Medicare	CMC: 29.41%		CMC: 32%		Rodney Truong (QPM)/ Esther Bue (QPM)/ Ann Phan (Pharm)/ Nicole Quang (Pharm)	Annual By June '20	QOC: September 22 PICC & PQC: Nov 3			
Plan All Cause Readmission Rate (Note: lower rate = better performance) (Enterprise Goal) (Tier 1)	PCR	A NCQA: Medicare MCAS QRS QW	<u>2019 Rates:</u> Observed Readmission Rate CMC: 16.32% MED-CAL: 21.88% LACC: 9.36% <u>Expected Readmission Rate:</u> CMC: 21.58% MED-CAL: 21.71% LACC: 11.74% <u>QW Ratio:</u> CMC: 0.7564 MED-CAL: 0.9904 LACC: 0.7976		Medi-Cal, MCLA, & LACC: <1% CMC: <1% (QW >0.85% (Q/I))		Rodney Truong (QPM)/ Esther Bue (QPM)	Annual: Due June '20	QOC: Nov 24			
Overall Rating of Drug Plan (Rating 9 or 10, out of 10) (Usually/Always) (Tier 1)		CMS	CMC: 70%		CMC: 73%		Ann Phan (Pharm)/ Esther Bue (QPM)	Annually: Sept '20	MQSC: Oct 20			
Getting Needed Drugs (RX) (Usually/Always) (Tier 1)		CMS	CMC: 59%		CMC: 62%		Med Ops Reporting: Veronica Mones Anna Kazaryan Marie Martin	Annually: Sept '20	MQSC: Oct 20			
Medication Adherence for Diabetes Medications (Tier 1) Quality Withhold Measure: CW12 - Medication Adherence for Diabetes Medications		CMS QW	Q1: 93.85% Q2: 90.23% Q3: 87.80% Q4: Data available 6/2020		CMC: 85% (QW 80%)		Ann Phan (Pharm)/ Nicole Quang (Pharm)/ Esther Bue (QPM)	Annually: Sept '20	MQSC: Oct 20			
Medication Adherence for Hypertension (RAS antagonists) (Tier 2)		CMS QRS	Q1: 92.72% Q2: 90.37% Q3: 88.30% Q4: Data available 6/2020		CMC: 80%		Ann Phan (Pharm)/ Nicole Quang (Pharm)/ Esther Bue (QPM)	Annually: Sept '20	MQSC: Oct 20			

Performance Measures for Planned Activities for Objectives	HEDIS Acronym	Regulatory Agencies	2019 Rates	2020 Rates	2020 Goal	Goal Met/Not Met	Responsible Staff/Department	Timeframe for completion	Reports to: (Dates are 2020 unless otherwise noted)	Interventions/Updates	Comments/Barriers	Recommend for 2020 Work Plan
Medication Adherence for Cholesterol (Statins) (Tier 2)		CMS QRS	Q1: 91.87% Q2: 89.45% Q3: 87.50% Q4: Data available 6/2020		CMC: 74%		Ann Phan (Pharm)/ Nicole Quang (Pharm)/ Esther Bae (QPM) Med Ops Reporting: Veronica Mones Anna Kazaryan Marie Martin	Annually: Sept '20	MQSC: Oct 20			
MTM Program Completion Rate for CMR (Tier 2)		CMS	CMR Completion rate: CMC (2019): Q1: 15% Q2: 42% Q3: 58% Q4: 85%		CMC: 90 % CMC only: MTM program with SinfoniaRx for 2019: Comprehensive Medication Review (CMR) - phone intervention by pharmacist.		Ann Phan (Pharm)/ Nicole Quang (Pharm) Med Ops Reporting: Veronica Mones Anna Kazaryan Marie Martin	Annually: Sept '20	MQSC: Oct 20			
Non-Recommended PSA-Based Screening in Older Men (Note: Lower rate indicates better performance)	PSA	A CMS Medicare	CMC: 28.64%		CMC: 28%		Betty Santana (QI)/ Santia Kumar (QI)/ Rodney Truong (QPM)	Annual: By June '20	QOC: September 22 PICC & PQC: Nov 3			
Pneumococcal Vaccination Status for Older Adults (Tier 2)	PNU	A CAHPS Medicare	CMC: 60%		CMC: 63%		Betty Santana (QI)/ Esther Bae (QPM) Med Ops Reporting: Veronica Mones Anna Kazaryan Marie Martin	Annually: Sept. '20	QOC: September 22 PICC & PQC: Nov 3			
Potentially Harmful Drug-Disease Interactions in Older Adults - Combination Rate (Note: lower rates signify better performance)	DDE0	A NCQA: Medicare	CMC: 40.47%		CMC: 40%		Nicole Quang (Pharm)/ Ann Phan (Pharm)	Annually: Sept '20	QOC: September 22 PICC & PQC: Nov 3			
Use of Opioids at High Dosage (Tier 2) (New Accreditation Measure RY2020) (Note: lower rates signify better performance)	HDO	A NCQA: Medi-Cal, LACC, & Medicare	2019 Rate: Medi-Cal: 3.13% LACC: NA CMC: 2.79		Medi-Cal: 0% LACC: 0% CMC: 0%		Nicole Quang (Pharm)/ Ann Phan (Pharm)	Annually: Sept '20	QOC: September 22 PICC & PQC: Nov 3			
Use of Opioids from Multiple Providers - Multiple Prescribers and Multiple Pharmacies Rate (Tier 2) (New Accreditation Measure RY2020) (Note: lower rates signify better performance)	UOP	A NCQA: Medi-Cal, LACC, & Medicare	2019 Rate: Medi-Cal: 0.10% LACC: NA CMC: NA		Medi-Cal: 0% LACC: 0% CMC: 0%		Nicole Quang (Pharm)/ Ann Phan (Pharm)	Annually: Sept '20	QOC: September 22 PICC & PQC: Nov 3			
Use of High Risk Medication in Older Adults - two drugs (Note: lower rates signify better performance)	DAE2	A NCQA: Medicare	CMC: 12.99%		CMC: 12%		Nicole Quang (Pharm)/ Ann Phan (Pharm)	Annually: Sept '20	QOC: September 22 PICC & PQC: Nov 3			
Medication Reconciliation Post-Discharge (Tier 1) (New Medicare Accreditation Measure RY2020)	MRP	II Medicare EAS (MLTSS)	CMC: 34.85% MLTSS: 34.09%		CMC: 37% MLTSS: 27%		Betty Santana (QI)/ Rodney Truong (QPM)	Annual: Due June '20	QOC: September 22 PICC & PQC: Nov 3			
Emergency Department Utilization (Tier 1) (VIP)	EDU	A NCQA: Medicare	2019 HEDIS: Total Observed Rate: 460.29 Total Expected Rate: 444.23 Ratio of Observed/Expected: 1.04 - needs to be 1 or under		CMC: < 1%		Rodney Truong (QPM)/ Betty Santana (QI) Med Ops Reporting: Veronica Mones Anna Kazaryan Marie Martin	Annual: Due June '20	QOC: September 22 PICC & PQC: Nov 3			

Performance Measures for Planned Activities for Objectives	HEDIS Acronym	Regulatory Agencies	2019 Rates	2020 Rates	2020 Goal	Goal Met/Not Met	Responsible Staff/Department	Timeframe for completion	Reports to: (Dates are 2020 unless otherwise noted)	Interventions/Updates	Comments/Barriers	Recommend for 2020 Work Plan
Acute Hospitalization Utilization (Tier 2) (New Accreditation Measure RY2020)	AHU	A NCQA: Medicare	CMC: 1.02 (Total O/E Ratio)		CMC: O/E Ratio <1		Rodney Truong (QPM)/ Betty Santana (QI) Med Ops Reporting: Veronica Mones Anna Kazaryan Marie Martin	Annual: Due June '20	QOC: September 22 PICC & PQ: Nov 3			
Hospital for Potentially Preventable Conditions (Tier 2) (New Accreditation Measure RY2020)	HPC	A NCQA: Medicare	CMC: 1.3702 (Total O/E Ratio)		CMC: O/E Ratio <1		Rodney Truong (QPM)/ Betty Santana (QI) Med Ops Reporting: Veronica Mones Anna Kazaryan Marie Martin	Annual: Due June '20	QOC: September 22 PICC & PQ: Nov 3			
CAW-7 California Quality Withhold & CA 4.1 : Reduction in emergency department use for seriously mentally ill and substance use disorder members (Tier 1)	CA 4.1 CA QW - CAW 7	CMS QW	Rate available end of April 2020		CMC: CAW 7: 10% (QW) decrease in the performance rate for the measurement year compared to the performance rate for the baseline year (2019)		Betty Santana (QI) Med Ops Reporting: Veronica Mones Anna Kazaryan Marie Martin	Annually	QOC Nov 24			
CA 1.6 (CAW8)-Percent of members with documented discussions of care goals (For DY2 through DY5) (Tier 1)		CMS QW	Rate available March 2020		CMC: CA 1.6 ≥ National Average QW 95%		Betty Santana (QI)/ Kathryn Gray (CA)/ Irwin Harris (CM) Med Ops Reporting: Veronica Mones Anna Kazaryan Marie Martin	Annually	QOC Nov 24			
CA 1.12 (CAW9)-Percent of members who have a care coordinator and have at least one care team contact during the reporting period (For DY2 through DY5) (Tier 1)		CMS QW	Rate available March 2020		CMC: CA 1.12 ≥ National Average QW 95%		Irwin Harris (CM) Med Ops Reporting: Veronica Mones Anna Kazaryan Marie Martin	Annually	QOC Nov 24			
CW 13 Encounter Data - Encounter data for all services covered under the demonstration, with the exception of Prescription Drug Event (PDE) data, submitted in compliance with demonstration requirements. (Tier 1)		CMS QW	Rate available March 2020		CMC QW: 80%		Encounters Team (QI) Med Ops Reporting: Veronica Mones Anna Kazaryan Marie Martin	Annually	QOC Nov 24			
CW 11 Controlling Blood Pressure- Percent of plan members 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) for members 18-59 years of age and 60-85 years of age with diagnosis of diabetes or (150/90) for members 60-85 without a diagnosis of diabetes during the measurement year. (Tier 1)		CMS NCQA: Medicare QW	Rate available March 2020		CMC QW: 71%		Betty Santana(QI) Med Ops Reporting: Veronica Mones Anna Kazaryan Marie Martin	Annually	QOC Nov 24			
Hospital Utilization												
Hospital Bed Days Per 1000 - Excluding OB delivery (VIP) (Tier 2)			Q1: 1,364.03 Q2: 1,265.75 Q3: 982.16 Q4: data not available Subject to change as claims adjudicate		CMC: 1134K		Med Ops Reporting: Veronica Mones Marie Martin	Quarterly	QOC: Feb 12, April 28, Sept 28, Nov 24			
Hospital Admissions - Excluding OB delivery (VIP) (Tier 1)			Q1: 277.77 Q2: 266.51 Q3: 227.78 Q4: data not available Subject to change as claims adjudicate		CMC: 220K		Med Ops Reporting: Veronica Mones (MO)/ Marie Martin (MO)	Quarterly	QOC: Feb 12, April 28, Sept 28, Nov 24			
Hospital Average Length of Stay - Excluding OB delivery (Tier 2)			Q1: 4.91 Q2: 4.75 Q3: 4.31 Q4: data not available Subject to change as claims adjudicate		CMC: 4.2/1000		Med Ops Reporting: Veronica Mones Marie Martin	Quarterly	QOC: Feb 12, April 28, Sept 28, Nov 24			
Ambulatory Services												
Emergency Room Visits (VIP)			Q1: 780.34 Q2: 784.98 Q3: 750.65 Q4: data not available Subject to change as claims adjudicate		CMC: 688.86		Med Ops Reporting: Veronica Mones Marie Martin	Quarterly	QOC: Feb 12, April 28, Sept 28, Nov 24			
HRA Compliance Rate (Core 2.1) Completed HRAs/ (CMC Population who reached 90th day until the last day of the reporting period - Unable to Contact members - Members who declined) (Tier 1)			Q1: 100% Q2: 99% Q3: 100% Q4: data not available		CMC: 90% of all Medicare enrollees within 90 days		Veronica Mones (MO)/ Marie Martin (MO)/ Veronica Zapata (MO)/ Customer Solutions Center/ Rebecca Cisterno (MORE)	Quarterly	QOC: Feb 12, April 28, Sept 28, Nov 24			
Administrative												
Annual Review of Policies & Procedures		DHCS CMC			100% Annual Review of P&Ps		Each Department Head	Each QOC as needed and by specific committee reported to QOC	QOC: Feb 12, April 28, Sept 28, Nov 24			

Performance Measures for Planned Activities for Objectives	HEDIS Acronym	Regulatory Agencies	2019 Rates	2020 Rates	2020 Goal	Goal Met/Not Met	Responsible Staff/Department	Timeframe for completion	Reports to: (Dates are 2020 unless otherwise noted)	Interventions/Updates	Comments/Barriers	Recommend for 2020 Work Plan
Departmental Oversight Reporting Requirements		DHCS CMC			100% submission of timely delegate oversight reporting for each department		QI: Andrew Gay (QI) MS: Geoffrey Virrano CSC AKG: Lisa Marie Gaskin (G&A) NAL: Brigitte Bailey (HE)	QOC & MSQC quarterly	QOC: Feb 12, April 28, Sept 28, Nov 24 MSQC: Feb 11, May 12, Aug 11, Oct 20			
QI Program Description & Work Plan		DHCS CMS NCQA Standard: QI Element A			2020 QI Program Description & Work Plan approval		Maria Casias (QI)	QOC: 2/12/20 C & Q: 3/19/20	QOC: 2/12/20 C & Q: 3/19/20			
QI Evaluation		DHCS CMS NCQA Standard: QI Element B			2019 QI Evaluation approval		Maria Casias (QI)	QOC: 2/12/20 C & Q: 3/19/20	QOC: 2/12/20 C & Q: 3/19/20			
QI Work Plan Updates		DHCS			Review and Update of QI Work Plan		Maria Lubert (QI)/ Marian Casias (QI)	Biannually/ Final attached to QI eval	QOC: 7/28/20, 11/24/20			
QI Reports to Board					Update Board (C&Q) on QI activities		Richard Seidman (CMO)/ Kathrin Miller (CMIE)/ Marian Casias (QI)	At least quarterly	C & Q: 1/16/20, 3/19/20, 5/21/20, 8/20/20, 9/17/20, 11/19/20			
UM Program Documents					2020 Annual UM Program Description & UM Work Plan, & 2019 UM Evaluation approval		Irwin Harris (UM)/ Alex Li (UM)	UMC: 3/24/20 C & Q: 5/21/20	UMC: 3/24/20 C & Q: 5/21/20			
CM Program Documents					2020 Annual CM Program Description & 2019 CM Evaluation approval		Itzaro Ekordey (CM)/ Steven Change (CM)	UMC: 3/24/20 C & Q: 5/21/20	UMC: 3/24/20 C & Q: 5/21/20			