



# **Quality Improvement Program**

## **All Lines of Business**

### **2022**

<i>Quality Oversight Committee approval on</i>	<u>2/22/2022</u>
<i>Compliance and Quality Committee approval on</i>	<u>3/17/2022</u>

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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 equity, 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, providers, the community, and collaborates with local, state and federal public health agencies and programs, as well as with members, providers, the community, and other health plans.

## **STRATEGIC PRIORITIES (2022-2024)**

**Strategic Direction 1: Achieve operational excellence through improved health plan functionality.**

**Goal 1.1:** Build out information technology systems that support improved health plan functionality.

**Objectives:**

- Improve customer service through the Voice of the Customer (VOICE) initiative, our customer service information technology system.
- Improve efficiency and effectiveness of financial management functions with the implementation of the additional phases of the Systems, Applications, and Products in Data Processing (SAP) system, our Enterprise Resource Platform (ERP).
- Complete the implementation of SyntraNet to support operational improvements across the enterprise, with a particular emphasis on appeals and grievances.
- Modernize provider data management by defining and creating a roadmap for achieving our target state for our provider data ecosystem.
- Refine and implement our three-year technology roadmap and ensure that the reference architecture serves as a blueprint that evolves with L.A. Care's needs.
- Develop real-time interoperability capabilities to share data with providers and members.

**Goal 1.2:** Support and sustain a diverse and skilled workforce and plan for future needs.

**Objectives:**

- Conduct succession planning, particularly at the leadership level.
- Maintain a diverse and inclusive workforce, validated by data analysis, to model L.A. Care's commitment to Diversity, Equity, and Inclusion.
- Support a culture of accountability that encourages transparency.
- Improve managed care and Management Services Organization (MSO) acumen among staff.
- Promote retention of staff in an evolving work environment.

**Goal 1.3:** Ensure long-term financial sustainability.

**Objectives:**

- Implement recommendations from the administrative expense benchmarking study and update the administrative expense target in the revised forecasts.
- Develop risk arrangements for Enhanced Care Management (ECM) and the Dual Eligible Special Needs Plan (D-SNP).

**Goal 1.4:** Mature L.A. Care's family of product lines, taking an "all products" approach whenever possible.

**Objectives:**

- Launch a D-SNP to serve the dually-eligible Medicare and Medi-Cal population and transition members from Cal MediConnect (CMC) to the DSNP.
- Increase membership across all products by implementing member recruitment and retention strategies.
- Engage in a provider network strategy that meets distinct business and competitive needs of all products and ensures that members receive high-value care.

**Strategic Direction 2: Support a robust provider network that offers access to high-quality, cost-efficient care.**

**Goal 2.1:** Mature and grow our Direct Network.

**Objective:**

- Insource delegation functions that are currently outsourced, as appropriate and cost effective.
- Improve the operations of all L.A. Care functions necessary to support and scale up the Direct Network.
- Strategically address gaps in the Direct Network to meet all member needs countywide.
- Increase access to virtual care by implementing L.A. Care's Virtual Specialty Care Program (VSCP).

**Goal 2.2:** Improve our quality across products and providers.

**Objectives:**

- Achieve quality scores for the Direct Network that are commensurate with the median IPA network scores.
- Exceed the DHCS Minimum Performance Level for all measures for Medi-Cal, achieve a four-star quality rating for L.A. Care Covered, and build the infrastructure to achieve a four-star quality rating for our D-SNP.
- Improve clinical data integration and data governance, starting with race, ethnicity, language, sexual orientation, and gender identity data, in order to achieve the NCQA Health Equity Distinction.
- Improve clinical performance for children's care.

**Goal 2.3:** Invest in providers and practices serving our members and the L.A. County safety net.

**Objectives:**

- Assist our providers in adopting and using Health Information Technology (HIT) resources.
- Provide practice coaching to support patient centered care.
- Implement innovative programs to train, recruit, and retain highly qualified providers through the Elevating the Safety Net initiative.
- Utilize the Community Health Investment Fund (CHIF) to leverage opportunities for providers to increase quality and access to care.

**Strategic Direction 3: Provide services and care that meet the broad health and social needs of our members.**

**Goal 3.1:** Operate all components of California Advancing and Innovating Medi-Cal (CalAIM) as they are launched.

**Objectives:**

- Maximize care for L.A. Care members, within funding constraints, through successful implementation of Enhanced Care Management (ECM) and Community Supports for specified populations of focus.
- Ensure CalAIM Population Health Management (PHM) requirements are met.
- Monitor and establish infrastructure for longerterm CalAIM initiatives.

**Goal 3.2:** Establish and implement a strategy for a high-touch care management approach.

**Objectives:**

- Maximize use of care managers and community health workers within our care management model.
- Increase use of field-based care management in the community.
- Expand upon our progress with palliative care and add other end-of-life services.

**Goal 3.3:** Ensure that the services we provide to members promote equity and are free of implicit and explicit bias.

**Objectives:**

- Leverage external partnerships, grantmaking, and sponsorships to implement programs that address the root causes of inequity, including racism and poverty.
- Identify and reduce health disparities among our members by implementing targeted quality improvement programs.
- Implement initiatives to promote diversity among providers, vendors, and purchased services.
- Offer providers Diversity, Equity, and Inclusion resources to promote bias-free care.

**Strategic Direction 4: Serve as a national leader in promoting equitable healthcare to our members and the community and act as a catalyst for community change.**

**Goal 4.1:** Drive improvements to the Affordable Care Act by serving as a model of a successful public option.

**Objectives:**

- Play a leading role in advocating for a public option at the state and national levels.
- Provide expertise and assistance to other public plans interested in participating in state exchanges

**Goal 4.2:** Optimize members' use of Community Resource Centers and expand our member and community offerings.

**Objectives:**

- Increase the number of Community Resource Centers to 14, in partnership with Blue Shield of California Promise Health Plan, and increase number of annual visits to 50,000 across all centers by Q4 2022 and 60,000 by Q4 2023.
- Partner with community-based organizations to offer a range of services onsite.

**Goal 4.3:** Drive change to advance health and social services for our members and the community.

**Objectives:**

- Identify and prioritize actions, interventions, and programs to promote equity and social justice.
- Support regional Health Information Exchanges (HIE).
- Create a deliberate and tailored strategy to address homelessness among our members.

## **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, QI Committees and subcommittees. 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**

To address access to care challenges in the Antelope Valley, L.A. Care established the "L.A. Care Direct Network" (LADN, formerly referred to as the "Community Access Network," or "CAN"), a network of physicians with whom L.A. Care contracted directly to provide Medi-Cal members in the Antelope Valley with primary and specialty care.

Since its inception in 2016, the LADN has successfully closed network gaps in the Antelope Valley and expanded to cover Medi-Cal members across Los Angeles County. In addition to the Antelope Valley LADN membership, the Department of Managed Health Care (DMHC) has authorized L.A. Care to establish contracts directly with primary and specialty care providers to serve up to 50,000 Medi-Cal members who choose to participate in the LADN throughout Los Angeles

County. (The size and composition limits of the LADN are subject to DMHC oversight and may change over time.)

The LADN benefits both participating members as well as the providers contracted directly with L.A. Care to provide those members with primary and specialty care. While both benefit by having a direct relationship with L.A. Care, the LADN members may also benefit from enhanced access to care and the directly contracted providers get the opportunity to serve Medi-Cal members beyond those deemed in-network in accordance with their affiliated provider group contract(s). Additionally, directly contracted Primary Care Physicians have the opportunity to participate in care delivery quality initiatives, such as engaging in L.A. Care's Transform L.A. program, a technical assistance program that uses a practice coaching model to support patient centered care design, data driven quality improvement, and sustainable business operations (see section Transform L.A. for more details on the program).

### **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.

As of November 1, 2021, there are 21,910 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 11,111 (50.7%) of the SB75 membership, while the Plan Partners comprising a combined 49.3% of total Medi-Cal SB75 membership. The breakdown of SB75 membership is as follows:

<b>Plan Partner</b>	<b>Number of Active SB75 Members</b>	<b>Percent of Total</b>
Blue Shield of California Health Plan	4,361	19.9%
Anthem Blue Cross	4,620	21.1%
Kaiser Permanente	1,818	8.3%
MCLA	11,111	50.7%
<b>Total</b>	<b>21,910</b>	<b>100%</b>

Source: L.A. Care Health Plan Information Technology - November 1, 2021

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

Beginning January 1, 2020, Medi-Cal expanded 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 includes beneficiaries aging into the young adult expansion age group and continue to receive full scope Medi-Cal under SB 104.

Plan Partner	Number of Active SB 104 Members	Percent of Total
Blue Shield of California Health Plan	589	14.0%
Anthem Blue Cross	714	17.0%
Kaiser Permanente	117	2.7%
MCLA	2,790	66.3%
<b>Total</b>	<b>4,210</b>	<b>100%</b>

Source: L.A. Care Health Plan Information Technology – January 13, 2022

### **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/families pay their 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 March 19, 2021 through the end of 2022, the American Rescue Plan (ARP) expanded the APTC beyond 400% of the Federal Poverty Level if the amount of premium the individual has to pay for the second lowest priced Silver plan exceeds 8.5% of their annual income. In addition, the ARP increased the amount of APTC available.

As of mid- September 2021, L.A. Care Covered™ membership was 101,998. 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, getting married/a domestic partnership, having/adopting a child, a change in household size, etc. may apply for coverage throughout the year during the Special Enrollment period.

L.A. Care's 2022 contract with Covered California includes the continuation of the 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 mid-September 2021, L.A. Care Covered Direct™ membership was 78.

### **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 mid-September 2021, PASC-SEIU membership was 50,808.

### ***Cal MediConnect***

L.A. Care Cal MediConnect (CMC) was launched in April 2014 and currently has approximately 18,000 dual eligible members enrolled into the plan. L.A. Care is the largest Medicare-Medicaid Plan (MMP) in Los Angeles County. 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 coordinate 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.

The key components of the Cal MediConnect program include the stratification, assessment and care coordination of our CMC members; developing individualized care plans to meet their needs and leveraging the expertise of the Interdisciplinary Care Team to ensure the members' needs are coordinated and addressed. L.A. Care identifies and monitors the most vulnerable members of the population in our High Risk and Complex Care Management programs. Annually, L.A. Care Management develops a Program Description and Program Evaluation that describes our care management programs as well as outcomes for the different programs and lines of business, including CMC. Dual eligibles are diverse demographically and have a wide variety of health care needs, are not required to join Cal MediConnect Plans, but must remain enrolled in a Medi-Cal Managed Care Plan (MCP). L.A. Care currently provides Medi-Cal services to over 130,000 dual eligibles outside of Cal MediConnect who have chosen to obtain their Medicare services elsewhere.

### **CMC Transition to Duals Eligible Special Needs Plans (D-SNP)**

The Cal MediConnect (CMC) program ends on December 31, 2022. Starting on January 1, 2023, L.A. Care Cal MediConnect members will transitioned to a new Exclusively Aligned Enrollment Dual Eligible Special Needs Plan (D-SNP). Under exclusively aligned enrollment, members will be enroll in our L.A. Care D-SNP for Medicare benefits and L.A. Care Medi-Cal Managed Care Plan (MCP) for Medi-Cal benefits for better care coordination and integration.

Many of the CMC operating, quality improvement programs and reporting structures will remain intact during the transition. Quality Improvement goals will be updated to reflect specific D-SNP Model of Care requirements and will include Medicare Key Performance Indicators (KPIs) such as Medicare Stars and Display measures. Additional program details will be provided in the 2023 D-SNP Quality Improvement Program Description.

### **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 Center for Medicare & Medicaid Services (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.<sup>1</sup> 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

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 Health Effectiveness Data Information Set (HEDIS) and program goals to create a Population Health Management Index, these are also used for the Population Health Management program to address members' needs most appropriately through workgroups and the PHM Cross Functional team. The QI Annual Evaluation is used as the foundation of the PHM Annual Impact report.

#### **VISION FOR L.A. CARE HEALTH SERVICES**

Optimize the health and wellness of our members.

#### **GOALS AND OBJECTIVES**

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

##### **Goals – Improve Quality of Care:**

Improve health outcomes and ensure all members receive access to equitable and the highest quality of care and service in the aim of the health and wellness, for all covered lives.

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

**Objectives:**

- Develop, monitor and operationalize a QI work plan that addresses equity, quality and safety of clinical care and service, program scope, yearly objectives, planned activities, timeframe for each activity, responsible staff, monitoring previously identified issues from prior years, and conduct an annual evaluation of the overall effectiveness of the QI program and its progress toward influencing networkwide safe clinical practices.
- 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.
- Collect and analyze data related to the goals and objectives and establish performance goals to monitor improvement, including but not limited to HEDIS, CAHPS, and Star ratings.
- Communicate the quality improvement process to practitioners/providers and members through appropriate persons and venues.
- Evaluate the Quality Improvement Program annually and modify the program as necessary to improve program effectiveness. Identify opportunities for process improvement within L.A. Care as well as its delegates and contracted entities to drive member-centric equitable quality care and service by utilizing performance data to drive the QI process.
- Ensure there is a separation between medical and financial decision making.
- Promote physician involvement in our Quality Improvement Program and activities.
- Meet healthcare industry standards of practice and adhere to all state and federal laws and regulations.
- Improve National Committee for Quality Assurance (NCQA) accreditation rating and maintain accreditation status. Improve provider encounter data reporting.
- Improve our provider network data quality and adequacy.
- Maintain Multicultural Healthcare Distinction Certification (Health Equity Accreditation).
- Assess, monitor, and improve our policies and procedures.

**Goal – Improve Health Equity:**

Improve and ensure all members receive high quality and equitable care. Addressing health disparities is one way to improve health equity.

**Objectives:**

- Increase the awareness of health equity and implement strengthened, expanded and/or new health equity activities to support providers and members ultimately reducing health inequities within L.A. Care's membership.
- Ensure that the services we provide to members promote equity and are free of implicit bias or racism.
- Implement programs that address the causes of inequity that our members and their communities experience, including racism and poverty.
- Analyze existence of significant health care disparities in clinical areas.
- Reduce health disparities among our members by implementing targeted quality improvement programs.
- Promote physician involvement in health equity/ disparities and activities.
- Conduct focus groups or key informant interview with cultural or linguistic minority members to determine how to meet their needs.
- Address social determinants of health.

**Goal – Monitor and Improve Patient Safety:**

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

**Objectives:**

- Monitor, track and report critical incidents impacting patient safety from downstream entities and vendors.
- Identify and report patient safety risks and events.
- Identify, monitor, and address known or potential quality of care issues (PQIs), trends, and implement corrective actions as needed.
- Ensure that mechanisms are in place to support and facilitate continuity of care and transition of care, and to review the effectiveness of such mechanisms.
- Establish, maintain, and enforce policies regarding peer review activities and conflict of interest.
- Through credentialing, recredentialing and ongoing monitoring, promptly identify and address any issues with network providers that may impact patient safety.
- 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 site and medical record reviews to ensure and support safe and effective provision of equitable clinical service.
- Support and assist practitioners and providers to improve safety within their practices.
- 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.
- Review hospital quality and safety indicators and identify network hospitals that have a record of poor performance across domains of overall patient experience, maternity care, and hospital acquired infections. L.A. Care participates in a multi-plan hospital collaborative to engage poor performing hospitals and through dialogue and review of data, initiate an action plan to improve performance.

**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 Clinician and Group Consumer Assessment of Healthcare Providers and Systems (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, to implement company-wide initiatives to provide exemplary service to our members and providers.
- Share 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 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 Health Education Programs, Services and Resources:**

Improve member health status through the delivery of wellness and disease prevention services, programs, and resources by educating and empowering members to effectively use primary and preventive health care services, modify personal health behaviors, achieve and maintain healthier lifestyles, and follow self-care regimens and treatment therapies for existing medical conditions.

**Objectives:**

- Provide or coordinate health education services via multiple channels including group appointments at community locations, telephonic individual counseling, and online programming.
- Provide easily accessible, culturally appropriate, low literate health education materials in Los Angeles County threshold languages and required health topics.
- Implement health education programs addressing prenatal/postpartum care, flu, asthma, diabetes and tobacco cessation to complement QI programs and improve HEDIS, CAHPS, and CMS Five-Star Quality Ratings.
- Support L.A. Care's network of primary care providers who in turn reinforce positive health behavior change in patients during member doctor visits, refer to and document the delivery of health education services in the patient's medical chart, and administer the Staying Healthy Assessment Tool (SHA).

**Goal – Provide Culturally and Linguistically Appropriate Services and Promote Health Education Programs for members optimal health:**

Ensure medically necessary covered services are available and accessible to members regardless of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental

disability, physical disability, medical condition, genetic information, language, marital status, gender, gender identity, or sexual orientation, 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.

**Objectives:**

- Assess the cultural, ethnic and linguistic needs of members to reduce disparities.
- Assign members to providers based on their cultural, ethnic and linguistic needs.
- Promote preventive health, health awareness programs, education programs, patient safety, reduction of health care disparities, and cultural and linguistic programs that complement quality improvement and health equity interventions.
- Provide culturally appropriate health education services in order to enhance members' health status.
- Provide education on language assistance requirements and cultural competency to assist providers in delivering culturally and linguistically appropriate healthcare to members.
- Ensure the availability and accessibility of cultural and linguistic services such as 24/7 interpreting services including American Sign Language (ASL) as well as provision of translated materials and alternate formats.
- Conduct member focused interventions with culturally competent outreach materials that focus on race, ethnicity, and language based disparities.

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

Ensure the coordinated delivery of care for members with complex health needs through effective care management interventions, including referrals to linked or carved out services with Regional Centers, Department of Mental Health (DMH), Department of Public Health (DPH) and Department of Public Social Services (DPSS).

**Objectives:**

- Incorporate Population Health Management Model into policies, procedures, and workflows.
- Provide care management for members with complex health care needs.
- Improve member access to primary and specialty care, ensuring members with complex health conditions receive appropriate service.
- Identify and reduce barriers to needed healthcare and social services for members with complex health conditions.
- Support members in resolving their individual barriers to physical and mental wellness.

**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, and HEDIS scores.



**Objectives:**

- Establish and maintain policies, procedures, criteria, and standards for the credentialing and recredentialing and ongoing monitoring of plan practitioners and organizational providers.
- Improve and maintain network adequacy to meet the needs of underserved member population.
- 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, facility site review, 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 collect, screen, identify, evaluate and measure information about the quality and appropriateness of clinical care and provide feedback to IPA/PPG's and Practitioners about their performance and also the network-wide performance.
- Objectively and regularly evaluate 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 co-occurring medical and behavioral health conditions.
- Promote routine depression, anxiety and substance use disorder screenings are completed and appropriate follow-up referrals are made for adolescent and adult members with chronic health conditions and for women during pregnancy and the postpartum period.
- 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.
- 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.
- Ensure 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.
- Ensure 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. The approach includes quality improvement activities with measureable outcomes

**Objectives:**

- Improve access to essential medical, mental health, and social services.
- Improve access to affordable care.
- Ensure appropriate utilization of services.
- Improve coordination of care through an identified point of contact.
- Improve continuity of services for members across transitions in 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&Q), 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.

### 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. This role provides financial leadership and advice, both strategic and tactical financial perspectives, to the Board of Governors & L.A. Care senior management.

### 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 a 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.



## **General Counsel**

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

## **Executive Director, Medi-Cal**

The Executive Director, Medi-Cal will take specific responsibility for delivering product integrity, service excellence, and financial sustainability for the Medi-Cal product line. The Executive Director is responsible for strategically developing initiatives that support growth and retention for the Medi-Cal product.

## **Executive Director Cal MediConnect (CMC)**

The Executive Director, Cal MediConnect (CMC) is responsible for strategically evaluating, planning and leading complex business initiatives that achieve the strategic product objectives that ensures product integrity, drives for financial sustainability and delivers service excellence. This role collaborates across the enterprise to ensure outstanding compliance and quality score results for the CMC line of business while identifying and pursuing administrative efficiencies and process improvements that ultimately improve the customer experience.

## **Lead Executive Owner Innovation and Implementation**

The Lead Executive Owner Innovation and Implementation ("Lead Executive Owner") is responsible for driving the strategic and operational efforts to enhance existing processes; working with functional business leaders to develop new processes; and implementing business strategies that are responsive to internal and external customer needs in support of assigned strategic programs. Lead Executive Owner will also be responsible for working within and beyond the established infrastructure to develop metrics, to be reported to the executive leadership and all of L.A. Care, that articulate performance; utilization comparisons; and cost of care.

## **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 Chief of Equity and Quality Medical Director.

- Ensures that medical decisions are rendered by qualified medical personnel, unhindered by fiscal or administrative management.
- Ensures that the medical care provided meets the community standards for acceptable medical care.
- Ensures that medical protocols and rules of conduct for plan medical personnel are followed.
- Develops and implements medical policy.
- Ensures 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 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, and Behavioral Health. 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.

### **Chief Equity and Quality Medical Director**

Chief of Equity and Quality Medical Director is an enterprise leadership role that partners with other senior leaders to develop and drive forward the key strategies of the organization as they relate to Diversity, Equity, and Inclusion (DEI). The position is responsible for setting and implementing an overarching vision of DEI for the organization—both at the programmatic and administrative levels that works to eliminate systemic organizational marginalization and promotes inclusion and anti-racist practices. The position is responsible for the promotion of internal and external DEI for L.A. Care's members, providers and employees.

As Quality Medical Director, this position 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. The position is responsible for directing network performance improvement programs and establishing 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.

### **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. This role is responsible to improve and maintain excellent equitable 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. Oversees regulatory readiness, quality measurement, and pay for performance programs and initiatives. 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).

### **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. The Chief Compliance Officer chairs the Internal Compliance Committee (ICC) and presents recommended actions to the Compliance & Quality Committee (C&QC) of the Board.

### **Chief of Staff**

The Chief of Staff (COS) serves as a strategic leader and advisor to the Chief Executive Officer (CEO) and executive leadership team. In this role, the COS cultivates cohesion within the leadership team to improve strategic decision-making and foster inclusion and collaboration, resulting in a high-performing management team. This position facilitates the development and execution of strategic goals and initiatives and ensure all activities are appropriately integrated with the strategic plan. In addition to these functions, the COS is responsible for overseeing the organization's network operations, performance management, communications, and government affairs teams.

### **Chief Pharmacy Officer**

The Chief Pharmacy Officer is directly responsible for 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 to provide pharmacy business and clinical forecast assessments to contribute to good decision making on the strategic direction of the organization to achieve its positive outcomes.

### **Chief of Enterprise Performance Optimization**

The Chief of Enterprise Performance Optimization (CEPO) is responsible for creating an integrated, efficient Enterprise Performance Optimization (EPO) organization. The CEPO will develop a centralized, integrated, Enterprise and Network-wide Oversight and Performance Optimization Program (Program) to ensure Plan and Network excellence. The CEPO will also implement a Network Performance Measurement and Management Program (Network M&M) to enable the Plan to make evidence-based decisions to optimize network composition, support value-based contracting, and to ensure all providers meet healthcare quality and administrative compliance standards to deliver safe, effective, equitable, efficient, timely, and patient-centered care. The CEPO will ensure that these programs are responsive to regulatory, market, structural, and policy changes, and is tailored to accelerate the realization of L.A. Care's quality standards,

### **Senior Medical Director, Utilization and Care Management Services**

The Senior Medical Director will be assigned planning, organizing, directing and developing L.A. Care's regional network medical management (utilization and care management) model. Leading and working with a multi-disciplinary team, he/she is expected to execute L.A. Care Health Services' programs and strategic vision. The Senior Medical Director also is expected to ensure that the administrative functions related to utilization management (UM) are performed in a clinically appropriate and compliant manner. The administrative functions include performance of prospective, concurrent and retrospective utilization review, provider appeals and disputes and member grievances. On the care management (CM) side, the Senior Medical Director is expected

to work with and support UM and CM staff on transition of care and community based care management needs.

### **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. 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.

### **Medical Director Behavioral Health & Social Services**

The Medical Director of Behavioral Health & Social Services 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. This position is responsible for the overall clinical oversight and program development for Behavioral Health and Social Services Departments.

## **QI PROGRAM RESOURCES**

The Quality Improvement/Accreditation Senior 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, Quality and Accreditation**

The Senior Director of Quality and Accreditation is responsible for managing many efforts and teams for the Quality Improvement department including administrative/operational issues and works with executive leaders. The Senior Director oversees teams and efforts who are responsible for overseeing the planning, organization, direction, staffing and development of including but not limited to clinical quality and service excellence improvement efforts for the Plan and for our network.



The Senior Director is further responsible for assuring all department 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. Directs all aspects of running an efficient team, including hiring, supervising, coaching, training, disciplining, and motivating direct-reports.

Responsibilities include ensuring regulatory and accreditation compliance and continuous quality improvement to develop plans and programs.

### **Senior Director, Safety Net Initiatives**

The Senior Director, Safety Net Initiatives 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 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.

### **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. 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.

### **Senior Director Provider Network Development**

The Senior Director, Provider Network Development is charged with direct oversight of provider contracting, relationship management, provider engagement, and the development of the provider network strategy. Working closely with the Chief of Staff, this position will also work closely with the Chief Medical Officer, Chief Financial Officer, and other members of L.A. Care's leadership team to ensure alignment of L.A. Care's contracting strategies, provider development and outcomes management in a way that results in better quality and value, and is responsible for evolving the organization's analysis and use of data to ensure a compliant and accessible network and align the network with strategies for both the enterprise and distinct product offerings.

### **Senior Director, Care Management**

The Senior Director, Care Management (CM) is responsible for the delivery of Care Management to L.A. Care members with the main primary focus of setting and executing Care Management services. The Senior Director, CM will work with the CM Medical Directors and Director, Care Management in designing, enhancing and implementing programs, supporting system implementation and or enhancements. One of the key initiatives is to increase L.A. Care's community CM presence. 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.

### **Senior Manager, Provider Quality**

The Senior Manager of Provider Quality will work closely with QI Leadership to help execute, and monitor strategic plans and programs to support business goals and objectives that are within the functional area or responsibility. The Senior Manager will ensure that metrics are developed to measure operational requirements-based performance to proactively identify and timely remediate noncompliance with requirements by performing gap and risk analyses and taking corrective action to ensure all functional areas within his/her scope are optimally compliant. The Senior Manager is responsible for the direction and staffing of L.A. Care's Committee, Peer Review and Potential Quality Incidents (PQI) reviews, committees and functions

### **Senior Manager, Incentives**

The Senior Manager of Incentives is responsible for strategic oversight of the company's portfolio of pay-for-performance (P4P) and incentive programs, and value based reimbursement programs. The Senior Manager will lead 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, community clinics, provider groups and health plan partners for improved performance in health care delivery; and value based reimbursement programs for providers that promote adherence to clinical guidelines and link payment for performance. The Senior manager works towards creative and innovative ways to solve problems, provides guidance on how to best structure and operationalize incentives used to encourage healthy behavior.

### **Senior Director, Regulatory Compliance**

The Senior Director Regulatory Compliance serves as a senior leader within the Compliance Department, leading compliance efforts across all functions across L.A. Care. The Senior Director manages the following compliance and regulatory functions: management of external regulatory audits; including audit readiness and corrective action plans; enterprise-wide compliance monitoring strategies; including administrative and clinical; regulatory agency management; including relationship and complaint management with State and Federal regulatory agencies; regulatory reporting; including design and implementation of quality assurance strategies to ensure reports submitted to regulators are timely, complete, and accurate, and Compliance Committee and Board of Governors compliance reports, meetings and issue escalation.

### **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. This role is responsible for providing evidence of ongoing compliance with all regulatory and accreditation requirements. 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, and is responsible for managing the analysis of all core healthcare related data, providing expertise in the development of clinical technical specifications for prototype reporting.

### **Director, Population Health Management**

The Director of Population Health Management (PHM) 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 and is responsible for leading the strategic and operational efforts for the organization in streamlining the population health management strategy to improve clinical health outcomes, health care utilization, cost effectiveness, and quality care. Responsibilities include leading strategic analytics, evaluation design, clinical and economic evaluation, and optimize programing, ensuring that PHM emphasizes the Triple Aim and addresses health at all points on the continuum of care with targeted interventions for a defined population, and address disparities through a cost-effective and tailored health solutions.

### **Director, Quality Performance Informatics**

The Director of Quality Performance Informatics is responsible for directing data and operations for HEDIS, CAHPS and related 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, including activities related to the external NCQA HEDIS audit, quality control, project completion, and data submission.

### **Director, Clinical Pharmacy**

The Director of Clinical Pharmacy Services is directly responsible for all aspects related to Clinical Pharmacy Operations. Responsibilities include the development and implementation of all policies & procedures related to Clinical Pharmacy operations, assisting in the management of the pharmacy health care spend, and accountability for: strategic planning and leadership, regulatory compliance of all lines of business, management of all Clinical Pharmacy related services and costs.

### **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. The position is responsible for conducting risk assessments, internal audits, reviews, and maintains the privacy and confidentiality of information is safeguarded and the assets of the organization are protected. The position is responsible in ensuring that all

regulatory non-compliant findings are reported and resolved and corrective actions implemented in a timely manner.

### **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 Contracts & Relationship Management**

The Director of Provider Contracts and Relationship Management is responsible for leading an organization that develops, negotiates, evaluates, implements, and manages contractual relationships with a provider network consisting of physicians, physician groups (PPGs), hospitals, ancillary providers, and other healthcare providers. The Director maintains a comprehensive and compliant network, addressing complex and problematic provider-related issues, grievances, and concerns timely, effectively, and appropriately thereby ensuring provision of covered services to L.A. Care's diverse membership throughout all product offerings.

### **Director, Safety Net Programs and Partnerships**

The Director, Safety Net Programs and Partnerships, is responsible to lead and direct the department including 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 is responsible for building relationships and fostering collaborative partnerships with external public and nonprofit stakeholders.

### **Director, Credentialing**

The Credentialing Director oversees initial credentialing, recredentialing and ongoing monitoring of quality activities and validation of provider data for direct network contracted practitioners, providers and facilities. Including the ongoing monitoring of network providers to ensure operational and quality compliance issues. The Director is also responsible for ongoing monitoring to ensure delegates' 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.

### **Director, Medicare Strategy and Product Development**

The Director, Medicare Strategy and Product Development provides leadership and drives for the end to end lifecycle for the Medicare (CMC, D-SNP, etc.) product lines. Responsible for leading strategic initiatives and projects, ensures deliverables are on time and in alignment with L.A. Care's strategic initiatives. As an industry expert in Medicare managed care and duals products, leads the development of new product lines and enhancements to existing products. Engages key stakeholders to ensure continuity of product lines and impact of a new product line to the communities served and L.A. Care Strategic Initiatives. This individual will lead a team responsible for the day-to-day activities to ensure the delivery of products and services to the market are competitive, sustainable, and consistent.

### **Director, Customer Solution Center Appeals and Grievances**

The Customer Solution Center 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 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.

### **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, and assures all department functions are operating in accordance with the organization's mission, values, and strategic goals, as well as individual department goals.

### **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. 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.

## **Director, Clinical Assurance and Delegation Support**

The Director of Clinical Assurance and Delegation Support is directly responsible for the planning, organizing, directing, staffing. Responsibility includes, but are not limited to, regulatory compliance, accreditation compliance, oversight of L.A. Care's 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.

## **Manager, Quality Improvement Initiatives**

The Manager of Quality Improvement Initiatives is responsible for overseeing activities of LA Care's Quality Improvement Programs. 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. 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 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, Health Information Technology Program**

The Manager, Health Information Technology Program plays a key delivery role in helping to achieve various programs and projects in the HIT department. The position requires exceptional leadership, management, HIT and healthcare skills to accomplish technology enabled performance improvement. This position reports to the Senior Executive Director, HIT Department, manages direct reports consultants and software vendors. This position is responsible for implementing operational strategy at a program/project level.

## **Manager, Health Informatics**

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 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.

### **Manager, Behavioral Health Clinical Services**

The Manager for Behavioral Health Clinical Services supervises the behavioral health clinical team, contributes to 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, Quality Performance Metrics**

The Quality Performance Metrics (QPM) Manager is responsible for providing management and oversight to ensure the annual HEDIS, CAHPS and Health Outcomes Survey (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. The Manager collaborates with internal and external stakeholders to ensure that HEDIS and CAHPS initiatives are fully integrated throughout the organization.

### **Manager, Quality Performance Management**

The Quality Performance Management (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. This individual 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.

### **Manager, Quality Data**

The Manager of Quality Data ensures 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 Extract, Transform, and Load (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 maintain policies and procedures relevant to HEDIS and Survey data process, coordinate with vendors, provider groups and plan partners to maximize data completeness, analyzing quality data results to identify improvement opportunities.

### **Manager, Clinical Programs**

The Manager, Clinical Programs provides direct supervision of the clinical pharmacists and pharmacy technicians in order to assure operational effectiveness. The Manager of Clinical Programs leads 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 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.

### **Manager, Formulary and Benefit Design**

The Manager of Formulary and Benefit Design will act as the lead for 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 is responsible for the organization, compliance, direction, and staffing of L.A. Care's FSR function(s). Responsibilities includes supervisory visits of staff conducting site reviews and/or physical accessibility review survey 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.

### **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 in a manner consistent with regulatory requirements 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 ensures timely appeal and grievance reporting.



### **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, proposes and drives process improvement opportunities, and manages the budget for the assigned business unit.

### **Manager, Cultural and Linguistics Services**

The Manager of Cultural and Linguistic Services is responsible for the management of the Cultural & Linguistic Services Unit and its programs and services. Responsibilities include 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, Health Equity**

The Manager of Health Equity is responsible for management of equity efforts throughout the organization including being responsible for the planning, organization, direction, management, staffing and development of L.A. Care's Health Equity Department. This position will develop and implement operational processes to support L.A. Care equity efforts. The manager will analytically identify resources needed for each project and will work to define roles and responsibilities for these resources and to develop reports that include status updates on project deliverables and project issues. The manager is responsible for review and update of relevant policies and procedures. Supports management/leadership in development of equity strategy and solicits feedback from equity councils.

### **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 position also helps in planning, developing, and evaluating the social services program. The Manager, Social Services 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 Manager will manage a team of Autism Program Specialists.

### **Advisor, Quality Performance Informatics**

The Advisor Quality Performance Informatics is responsible for contributing to planning, strategy and oversight of county, state and national activities and efforts related to improving quality ratings and scores under the direction of QI Leadership. The Advisor serves as consultant and subject matter expert to coordinate and optimize strategies and activities by various departments for improving quality ratings and scores. Scope of oversight includes development of analytic and decision support systems to monitor progress and drive forward HEDIS/CAHPS/Stars initiatives to improve quality of care. The Advisor also serves as quality consultant to L.A. Care plan partners, Participating Physician Groups (PPGs), and practitioners and works with both internal and external quality stakeholders to identify opportunities for operational synergies to improve data capture and quality outcomes.

## **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 and to decrease any duplicative assignments and surveys.
- 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.

- Chief of Equity & Quality Medical Director(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. Other medical groups are met with on an as needed basis.

Beginning in 2016, L.A. Care hosts webinars on QI topics for PPGs, providers, and Plan Partners. In 2018, the frequency of the webinars was increased 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 are inclusive of both mental health and substance use disorder services. Behavioral Health Services are available for L.A. Care members across all lines of business. The system of care where member accesses treatment is based on the severity of member's symptoms and member's line of business. For Medi-Cal recipients, including both MCLA and CMC lines of business, specialty mental health services are carved out to the Los Angeles County Department of Mental Health (DMH). Substance Use Disorder treatment is a benefit covered through the Department of Public Health, Substance Abuse Prevention and Control (DPH SAPC) for Medi-Cal recipients, including both MCLA and CMC lines of business. Substance Use Disorder treatment for members covered under PASC and Covered California is covered through L.A. Care's Managed Behavioral Health Organization (MBHO). Mild to moderate mental health services are the responsibility of the L.A. Care and are managed by L.A. Care's contracted MBHO for all lines of business. 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 and DMH, 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.

Due to the 42 CFR. Part 2, there is no current data exchange process between L.A. Care and DPH SAPC.

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 L.A. 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 2014. 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), 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**

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.

*Quorum and Voting:* 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) QI committees and any subcommittees. 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 by 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): Quality Oversight Committee (QOC)
- Quality: Member Quality Service Committee, QI Steering Committee, Joint Performance Improvement Collaborative Committee (PICC)/Physician Quality Committee (PQC).
- Pharmacy: Pharmacy Quality Oversight Committee (PQOC)
- Behavioral Health: Behavioral Health Quality Committee (BHQC)
- HEDIS/CAHPS: Quality Performance Management Steering Committee (QPMSC)
- Population Health Management Metrics: Population Health Management Cross Functional Team (PHMCFT)
- Medicare: Stars Steering Committee (SSC)

### **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 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 are 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 and external 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. The Committee is chaired by the Chief Medical Officer or physician designee.

*Quorum and Voting:* A quorum is established when a minimum of 50% of the membership is in attendance. Voting members are managers and above.

*Membership* includes, but is not limited to Chief Quality and Information Executive, Chief of Equity and Quality Medical Director, Chief Medical Officer, Deputy CMO, Director Clinical Assurance, Senior Director Quality & Accreditation, Senior Director Enterprise Pharmacy, Senior Director Care Management, Senior Director Enterprise Performance Optimization, Director Customer Solution Center Appeals & Grievances, Medical Directors, Director Quality Performance Informatics, 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:

- Assure compliance with the requirements of accrediting and regulatory agencies, including but not limited to, DHCS, DMHC, CMS, NCQA and Covered California.
- Escalate concerning issues as per protocols, policies and procedures.
- Ensure follow-up, as appropriate.
- Improve quality, safety, and equity of care and service to members.
- Identify appropriate performance measures, standards, and opportunities for performance improvement.
- Identify actions to improve quality and prioritize based on analysis and significance; and indicate how the Committee determines these actions and ensure satisfactory closure.
- Formulate organization-wide improvement activities and gain support from appropriate departments.
- Ensure that QI Program activities and related outcomes undergo quantitative and qualitative analyses that incorporate aggregated results over time and compare results against goals and benchmarks.
- Ensure all departments have the opportunity to align project goals and map out responsibilities and deadlines prior to project implementation.
- Ensure that root cause analyses and barrier analyses are conducted for identified underperformance with appropriate targeted interventions.
- Ensure that 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.
- Ensure that opportunities for improvement, prioritized and potentially, closed based on the analysis of performance data.

- 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.
- Review performance requirements of strategic projects and performance improvement activities to enhance effectiveness and make modifications as appropriate.
- 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.
- 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.
- Provide and/or review and approve recommended changes to the QI Program and QI Work Plan activities based on updates and information sources available.

### **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 network practitioners 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 Chief of Equity and Quality Medical Director or designee, to the Quality Oversight Committee.

*Structure:* The Joint PICC/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 Chief of Equity and Quality Medical Director or the CMO. 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.

*Quorum and Voting:* A quorum is established with at least 3 physicians in attendance.

*Membership* includes, but is not limited to, Chief Medical Officer (chair) or physician designee, Chief of Equity and Quality Medical Director, Medical Directors of Care Management, Utilization Management, Medicare, and Behavioral Health, Senior Director Quality & Accreditation, Chief Pharmacy Officer, Directors Utilization Management and Care Management, 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 PICC/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 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 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 Value Initiative for IPA Performance (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 and clinical practice guidelines that are based on nationally developed and evidence based criteria.
- Other activities/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. Findings and recommendations are presented to the Quality Oversight Committee.

*Quorum and Voting:* 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.

*Membership* includes, but is not limited to, CMO, Utilization Management Medical Director, Behavioral Health Medical Director, Chief of Equity and Quality Medical Director, 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, 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 Director Quality Performance Informatics.

*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 statistics and reporting.
- Participate in the Utilization Management/continuing care programs aligned with the Program's quality agenda including areas noted as needing improvement.
- 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.
- Recommend actions to the Quality Oversight Committee when opportunities for improvement are identified from review of utilization data.
- Review Inter Rater Reliability results and make recommendations as needed.
- Discuss and review audit results both internal and external.
- Discuss and support implementation of new regulatory processes as needed.
- Review New Medical Technologies including new applications of existing technologies upon request.
- Review and make recommendations regarding oversight of delegated activities.

The L.A. Care Utilization Management program document contains more detailed information pertaining to UMC responsibilities.

## **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 uses a peer review process to make recommendations regarding credentialing decisions, 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.

*Quorum and Voting:* A quorum is established when a minimum of three (3) physicians are present. Voting members are physicians and one (1) nurse practitioner (NP) (may vote on NP cases only). Doctoral level behavior health professionals may vote on behavioral health issues only.

Membership includes, but is not limited to:

*Voting Members* are the L.A. Care Chief Medical Officer, Chief of Equity and Quality Medical Director, 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 Senior Director, and QI Nurse Specialists, Compliance, Legal, Facility Site Review, SIU, 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.

- Determine 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.
- Determine and approve pre-contractual and annual delegated oversight activities for credentialing and recredentialing.
- Provide feedback on specific practitioner credentials that do not meet established credentialing criteria and issue 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.
- Collaborate with Enterprise Performance Optimization (EPO) Department, to review and approve all credentialing delegation oversight activities and make recommendations concerning Corrective Action Plans (CAPs) and de-delegation, when applicable. Review, evaluate, and make recommendations regarding Potential Quality of Care Issues (PQIs)
- Recommend additional investigation and/or reporting to CRM, Compliance, SIU, FSR, Pharmacy and MLTSS 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.
- Review fraud, waste and abuse cases identified by Special Investigation Unit (SIU) to determine if network providers' actions impact the safety, quality and/or care of members.
- Assure compliance with the requirements of accrediting and regulatory agencies, including but not limited to, DHCS, DMHC, CMS and NCQA.

- Ensure appropriate reporting to authorities, including 805, NPDB, etc., are made, as required.
- Ensure Fair Hearing Procedures are offered and carried out in accordance with approved policy and procedure, LS-005.
- Facility Site Review provides the following reports to the committee for review and approval:
  - FSR Issues Report – Listing of providers/sites that are being followed by FS
  - Scheduling Summary Report
  - Minimum Site Hours Report
  - Continued Noncompliance Report
  - Focus Review Reports
  - Planned Partner Audit Summary

### **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 also reviews new medical technologies or new applications of existing technologies and recommend for benefit coverage, based on medical necessity. The PQOC develops utilization management criteria for all direct product lines of L.A. Care. The committee reports to the Quality Oversight Committee.

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.

*Quorum and Voting:* A quorum for the transaction of all business of this committee shall consist of one L.A. Care Medical Director, one L.A. Care Pharmacy Director, and two external Medical Directors/Physicians/Pharmacists [e.g., from contracted Plan Partner Groups (“PPGs”)]. Voting membership includes designated physicians and pharmacists exclusively, including external physicians from Participating Physician Groups (“PPGs”) and external pharmacists from network pharmacies.

*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 and new medical technologies or new applications of existing technologies for potential placement on the formulary.
- Provide input on new drug or new/existing medical technology 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 or medical technology 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.

*Quorum and Voting:* A quorum is established when a minimum of 50% of the membership is in attendance. Voting members are managers and above.

*Membership:* 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, Chief of Equity and Quality Medical Director, Director of Case Management, Utilization Management Medical Director, Senior Director of Enterprise Pharmacy, Senior Director Quality and Accreditation, 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, Cultural and Linguistic services/Language Assistance Program, 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 including but not limited to: Provider Networks Management, Customer Solutions Center, Member Outreach, Appeals and Grievances, Behavioral Health, Social Work, Utilization Management/Case Management, Managed Long-Term Services and Support, Medicare Operations, Pharmacy, Quality Performance Informatics , Health Education, Cultural and Linguistic Services Department, Quality Improvement, Medi-Cal Product, Commercial and Group Product Management, Community Outreach & Education, Provider Quality Review, Facility Site Review, Population Health Informatics, Delegation Oversight, and other departments.

*Quorum and Voting:* A quorum is established when a minimum of 51% of the membership is in attendance. All committee members have voting privileges.

*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.
- Implement focused, measureable interventions. Provide input and make recommendations to L.A. Care's Quality Oversight Committee (QOC) on the state of member experience on a quarterly basis.
- 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/annual 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 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 Manager of Clinical Initiatives or designee serves as the Chairperson for the Quality Improvement Steering Committee.

*Quorum and Voting:* A quorum is established when a minimum of 51% of the membership is in attendance. All committee members have voting privileges.

*Membership* includes, but is not limited to Chief of Equity and Quality Medical Director, Chief Quality and Information Executive, Senior Director Quality & Accreditation, Director Care Management, Program Director Health Equities, Senior Director Medicare Operations, Director Quality Performance Informatics, Director Population Health Management, Pharmacy Clinical Programs Manager, Manager Accreditation, Manager Clinical Initiatives (Chair), Director Health Education & Cultural Linguistics Services, Manager Behavioral Health Clinical 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 QOC and through this Committee to the 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 QPM Steering Committee.

*Quorum and Voting:* A quorum is established when a minimum of 50% of the membership is in attendance. Voting members are managers and above.

*Membership* includes, but is not limited to Director of Quality Performance Informatics, Chief Medical Officer, Deputy Chief Medical Officer, Chief Quality and Information Executive, Chief of Equity and Quality Medical Director, Director of Population Health Management, Senior Director of Quality and Accreditation, Manager of Quality Improvement Initiatives, Director of Health Population Informatics, Manager of Incentives, QPM Manager(s), Supervisor, QPM Program Manager(s), and Product Solutions Manager.

*Frequency:* The 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 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
- Relevance of analyses of HEDIS and CAHPS results to the design of Quality Improvement interventions in the QI/Interventions team
- 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 QOC and through this Committee to the 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.

*Quorum and Voting:* A quorum is established when a minimum of 50% of the membership is in attendance. Voting members are managers and above.

*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, Senior Director Quality and 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 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.

### **Equity Council Steering Committee**

*Role and Reporting Relationship:* The Equity Council Steering Committee is an internal committee that reports to the CEO cabinet. The Steering Committee will oversee the efforts of the three councils – The Member Equity Council focused on members, the Provider & Vendor Equity Council focused on the provider network and contracted vendors, and the L.A. Care Team Council focused on L.A. Care employees. The Steering Committee will provide strategic guidance and thought-partnership to the councils and ensure their accountability.

*Structure:* The Equity Council Steering Committee will be chaired by the Medical Director for Diversity, Equity, Inclusion and Quality. The Steering Committee will include the chairs of three equity councils focused on three constituencies; members, providers and vendors and, L.A. Care employees. The Steering Committee will be completed with a minimum of five at-large members.

The three councils include:

- **Member Equity Council** – This Council continues the work of the Health Equity Task Force that was formed during the 2019-2020 fiscal year. The Member Equity Council will recommend and implement strengthened or expanded activities to promote equity and reduce health disparities among members. This Council will align equity efforts enterprise-wide and increase the awareness of health equity throughout L.A. Care. Health equity is inclusive of eliminating the social determinants of health, social and racial injustice and the systems that create and perpetuate these circumstances. This Council will be chaired by the Health Equity Program Director.
- **Provider and Vendor Equity Council** – This Council will focus on diversity among L.A. Care participating providers to align with member diversity inclusive of race, ethnicity, language and other important demographics in order to offer member options based on their preferences. This includes recruiting additional primary care doctors in safety net practices and building a pipeline for future doctors with L.A. Care's Elevating the Safety Net Program. This Council will also provide recommendations to enhance diversity among

vendors of purchased services at L.A. Care and promote equal opportunity. This Council will be chaired by the Executive Director of Commercial and Group Product.

- **L.A. Care Team Equity Council** – This Council is a forum for L.A. Care colleagues of different races, ethnicities, departments, and levels to raise and discuss issues and concerns and ensure L.A. Care stays on an upward course of inclusion. This Council will be chaired by the Director of the Center for Organizational Excellence.

*Quorum and Voting:* All committee members have voting privileges.

*Membership:* The Steering Committee will be comprised of at least 9 subject matter experts from across the organization. The Steering Committee will aim to reflect the various internal departments including representation from Health Equity, Health Services, Operations, Human Resources and Products. Additionally, the Steering Committee will aim to represent the racial/ethnic, linguistic, gender, age, and individuals with disabilities diversity of L.A. Care employees.

Steering Committee participants will attend and engage in meetings. Participants will strive to effectively communicate and collaborate on new and existing strategies, ideas and interventions that impact equity. Above all, participants will be respectful, patient, and culturally sensitive to other participants.

*Frequency:* The committee will meet weekly. Meeting frequency and schedule subject to change.

*Functions:* L.A. Care's Equity Council Steering Committee establishes a cross-functional, interdepartmental committee of subject matter experts tasked with building a coordinated strategy to assess and address equity and social justice at L.A. Care.

The goals of the Steering Committee are to:

1. Address and improve diversity, equity, and inclusion at L.A. Care for Employees, Members, Providers, Vendors, Stakeholders, and with our business practices.
2. Ensure L.A. Care is a safe space, physically, emotionally and intellectually, for employees, where inclusion is a core value.
3. Advocate for diversity, equity, inclusion in a climate of social justice for our Providers, Vendors and Stakeholders.

In order to reach the defined Steering Committee goals, the objectives are:

1. Identify and prioritize key metrics to evaluate diversity, equity and inclusion efforts.
2. Identify short (i.e. low-resourced internal, departmental projects) and long-term (i.e. resource intensive, internal cross-functional, external partner, community collaboration projects) strategies to support organizational efforts.
4. Recommend strategic L.A. Care investments.
5. Serve as a conduit to ensure communication and coordination of equity activities across the organization and with the community-at-large.
6. Assess Steering Committee's impact at the member, health plan, provider, vendor, stakeholder, and community level.

## **National Committee for Quality Assurance (NCQA) Steering Committee**

*Role and Reporting Relationship:* L.A. Care is a National Committee for Quality Assurance (NCQA) Accredited Health Plan. The Accreditation Team supports L.A. Care Accreditation efforts by conducting the NCQA Steering Committee to provide all internal departments with NCQA standards and updates, survey readiness management and NCQA survey process management for L.A. Care. This committee serves as a platform for stakeholders to assess their NCQA survey readiness and an opportunity for all to ask questions.

*Structure:* The Quality Improvement Accreditation Manager serves as the person presiding over the NCQA Steering Committee.

*Membership includes* all accountable departments that are responsible for providing adequate support, coverage, and evidence for NCQA standards. Each of the accountable departments have an accountable lead, responsible owner, supporting staff and back up staff. The accountable departments include but are not limited to:

- Enterprise Optimization Organization
- Customer Solution Center
- Appeals and Grievances
- Utilization Management
- Care Management
- Behavioral Health
- Credentialing
- Health Education & Cultural Linguistics
- Population Health Management
- Provider Network Management
- Quality Improvement

*Frequency:* The NCQA Steering Committee may meet quarterly or as frequently as necessary.

*Functions:* The functions of the NCQA Steering Committee include but are not limited to:

- Discuss the Health Plan Accreditation and Health Equity Accreditation new standards and guidelines.
- Accreditation Survey Process/Results.
- NCQA Timeline/Annual Reports/File review and non-file review elements.
- NCQA Public Comments, FAQs, Clarifications, Corrections, and Policy Changes.
- Management of Accountability Matrices.

## **Stars Steering Committee**

*Role and Reporting Relationship:* This committee provides vision, support and guidance for those who are directly responsible for executing Stars improvement projects and activities for L.A. Care Covered and Medicare and Medi-Cal eligible duals membership. The Committee oversees direction and strategies to implement programs and initiatives to optimize Star ratings and drive continuous improvements in the areas of member health, care experience, appropriate utilization of services and care coordination. The Committee monitors overall and individual performance



across the QRS and CMS Star ratings measures. The Committee reports up to the QOC and to the CEO Cabinet.

*Structure:* The Committee will be chaired by the Chief Quality and Information Executive or designee. All executive leadership committee members have voting privileges and Stars Core Team will have one vote.

*Quorum and Voting:* A quorum is established when a minimum of 50% of the membership is in attendance.

*Membership includes* executive leadership of departments that are responsible for directly or indirectly executing Stars improvement programs and activities.

- Chief Quality and Information Executive
- Executive Director, Medicare Products
- Executive Director, Commercial and Group Product Management
- Chief Medical Officer
- Chief Product Officer
- Chief Operations Officer
- Chief of Equity and Quality Medical Director
- Chief of Staff Executive Services
- Chief of Communications and Community Relations
- Chief Enterprise Performance Optimization
- Stars Core Team
  - Stars Program Manager
  - Stars Manager Analytics
  - Stars Performance Improvement, Lead

*Frequency:* Committee meets every quarter and at least two times a year.

*Functions:* The functions of the Stars Steering Committee include but are not limited to:

- Be committed to and advocate for L.A. Care's Stars goals and objectives.
- Understand the strategic implications and outcomes of Stars improvement projects and activities
- Monitor and review Stars improvement projects and activities at Committee meetings.
- Provide resources to support Stars improvement projects and ensure accountability.
- Control project scope based on resources and alignment with adopted goals and objectives
- Formally accept Stars improvement goals, objectives and project deliverables.
- Stars Steering Committee will report to the Quality Oversight Committee and the CEO.

### **Continuing Medical Education Committee**

*Role and Reporting Relationship:* The Continuing Medical Education (CME) Committee is an internal committee of L.A. Care's Provider Continuing Education (PCE) Program. It is the mission of the CME Committee to continuously improve the clinical and related knowledge of our provider communities through effective medical education programs in order to facilitate the optimal

delivery of health care services to vulnerable populations and to improve the overall health care status of the communities that L.A. Care serves.

*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.

*Quorum and Voting:* A quorum is established when a minimum of 50% of the membership is in attendance. All committee members have voting privileges.

*Membership* includes, but is not limited to Chief Medical Officer, L.A. Care Medical Directors, L.A. Care network physicians, 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 monitor care to identify opportunities for continuous improvement; encompassing the equity, 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 sex, race, color, religion, ancestry, national origin, ethnic group identification, language, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation, 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 collaboration 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/corrective actions to continuously improve performance and evaluation to assess the effectiveness of

interventions/corrective actions to measure the quality of equitable clinical and administrative services. A formal evaluation of the Quality Improvement Program is performed annually to assess the overall effectiveness of the QI program and its progress toward influencing networkwide safe clinical practices.

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, L.A. Care Covered, and PASC-SEIU members.

As provided under 42 CFR §422.152(c) and §422.152(d), QI programs must include Chronic Care Improvement Programs (CCIP) and Quality Improvement Projects (QIPs) that measure and demonstrate 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, regulatory agencies 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.

### **Population Health Management Program (PHMP)**

The Population Health Management Program (PHMP) strategy is documented in one central PHM program description that is reviewed and updated annually to meet regulatory requirements. Membership demographics are assessed and segmented through the annual Population Assessment and the programs are evaluated annually through a PHM Impact Evaluation using an annually updated Population Health Management Index of goals. Coordinating services through a PHMP helps meet the goals outlined by the Triple Aim healthcare model including improving patient experience using evidence based quality care, improving the health of member populations, , and providing 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 including: Health Education (HE) Program, Care Management including Complex Case Management (CCM) Program, Behavioral Health and Social Work, Utilization Management (UM), the Quality Improvement (QI) Program and other internal and external programs. PHMP's 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 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:

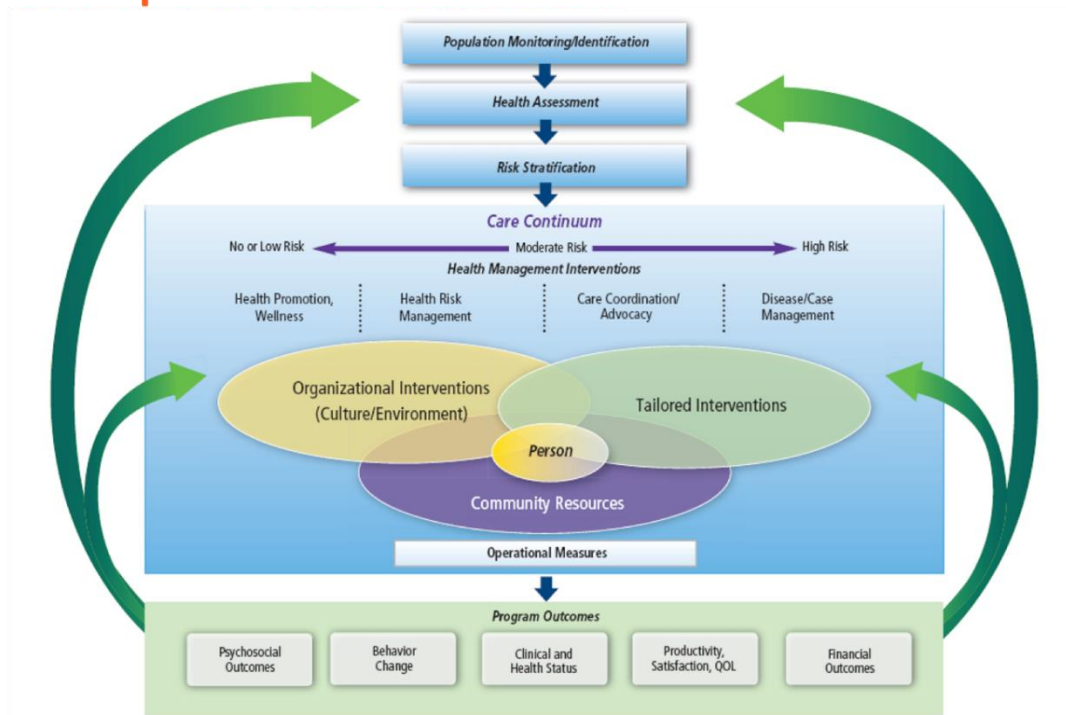
- Keeping Members Healthy
- Early Detection/Emerging Risk
- Chronic Condition Management
- Complex Case Management
- Care Transitions
- Patient Safety

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

L.A Care uses 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

## QI Health Equity Program

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, Safety Net Initiatives, Strategic Planning, Behavioral Health, Care Management, Social Services, Communications, Community Benefits, Customer Solutions Center (Member Services), Delegation Oversight, and the various product departments, Office of Chief of Staff and Compliance to improve health outcomes for members.

L.A. Care employs an Equity Council Structure inclusive of a Steering Committee, Member Equity Council, Provider & Vendor Council, L.A. Care Team Council (for employees) and a Consumer Health Equity Council (made up of health plan members). The Equity Council Steering Committee will lead L.A. Care's efforts on equity and social justice with high visibility throughout the organization. The Equity Council Steering Committee will institutionalize accountability for equity at the member, network & vendor, and L.A. Care level. This structure is driving change and holding the organization accountable internally.

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. Ensure that the services we provide to members promote equity and are free of implicit racism.
3. Implement programs that address the causes of inequity that our members and their communities experience, including racism and poverty.
4. Reduce health disparities among our members by implementing targeted quality improvement programs.

The action plan to address health equity is robust and ambitious; it is structured as such to capture initiatives required for L.A. Care to move towards greater achievement of health equity in its member populations and the community as a whole. Additionally, L.A. Care has introduced an Equity Provider Recognition Award. The award will measure and reward providers' performance on health equity efforts, which includes reducing health disparities and addressing the social determinants of health, specifically food security screenings and ensuring those needs are met. All clinics, Independent Physician Associations (IPAs) and solo and small group providers may participate among any lines of business.

## **Quality of Equitable Care**

### ***HEDIS***

L.A. Care measures clinical performance related to the Healthcare Effectiveness Data and Information Set (HEDIS), DHCS Managed Care Accountability Set (MCAS), the Integrated Healthcare Association (IHA), and Align Measure Perform (AMP) indicators. HEDIS results are audited by NCQA and DHCS approved external auditors.

On an annual basis, L.A. Care completes an on-site or remote HEDIS Compliance Audit with both Health Services Advisory Group (HSAG) — the DHCS selected HEDIS Auditor and External Quality Review Organization (EQRO) — and Advent Advisory Group (the NCQA Certified 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 HSAG for performance measures that constitute the MCAS set and Advent Advisory Group for NCQA, Exchange, Medicare, MMP, and AMP. Compliance Audits are performed by an HSAG and Advent Advisory Group for their respective submissions. L.A. Care calculates and reports all NCQA, AMP, and DHCS MCAS reporting measure sets and selected Use of Service performance measures. HEDIS rates for L.A. Care are calculated by an NCQA Certified HEDIS Engine, which are verified by HSAG and Advent Advisory Group. Rates for DHCS-developed performance measures are calculated by HSAG. L.A. Care reports audited results on the MCAS performance measures to DHCS and NCQA no later than June 15 of each year or such date as established by DHCS and NCQA. DHCS and NCQA will notify L.A. Care of the HEDIS measures selected for inclusion in the following years' utilization monitoring measure set.

See Attachment 4 that outlines specific Quality of Care measures and activities that are the subject of ongoing monitoring and evaluation specific to line of business.

### ***Guidelines for Care – Clinical Practice and Preventive Health Guidelines***

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 are 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 advises 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. Guidelines are also adopted that are salient to our membership and may be used for quality-of-care reviews, member and provider education, 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.

### ***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. L.A. Care adopts one

set of behavioral health guidelines to be used across all lines of business. 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.

### **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 1, 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. L.A. Care will ensure compliance through oversight and monitoring through internal compliance programs and through provider network relations.

### **Health Assessments**

For Medi-Cal members, we conduct an annual health assessment within 90-days of becoming a plan member and annual thereafter. The Initial Health Assessment (IHA) must be completed for newly enrolled members. The purpose of the IHA is to ensure the provision of complete history and physical examination and an Individualized Health Education Behavioral Assessment (IHEBA) to each new Medi-Cal member within 120 calendar days of enrollment (60 days for members 18 months or younger) either in person or virtually. PPGs/PCPs are responsible to cover and ensure the provision of an IHA. For new Plan members who choose their current PCP as their new plan PCP, an IHA still needs to be completed within 120 days of enrollment. Members are also encouraged to complete an IHA even if it hasn't been completed past the initial 120 calendar days.



of enrollment. The Staying Healthy Assessment covers the provision of the IHEBA for all existing members at their next non-acute care visit and that the IHEBA is reviewed at least annually by the Primary Care Provider (PCP) with the members who present for scheduled visits and is re-administered by the PCP at the appropriate age-intervals.

For Medicare members, there are two types of assessments the Health Risk Assessment (HRA) when the member joins the plan and the Annual Wellness Exam (AWE). The purpose of the HRA is to directly assess the medical health, mental health, functional, cognitive, and psychosocial needs of Medicare members in order to develop an Individualized Care Plan (ICP) that effectively addresses each member's unique circumstances and preferences.

The purpose of the Annual Wellness Exam (AWE), is to obtain a comprehensive annual health assessment of the member to determine changes, if any, to member health status, both mental and physical, to ensure provision of timely and appropriate care according to member's identified health conditions. Unlike the HRA which is usually a shorter telephonic assessment conducted by non-clinical staff, the AWE is an in-person examination conducted by the member's practitioner (M.D., D.O., N.P., P.A.) to fulfill CMS requirements related to risk adjustment payment methodology AND to determine each member's health risk status to develop an appropriate care plan and promote member's involvement in their care. In addition, AWEs assure compliance with the CMS Model of Care and supports quality improvement efforts in diagnosing member health conditions for documentation of new conditions and substantiating existing conditions. L.A. Care is responsible for ensuring that participating providers properly document information in the patient's health record to support all diagnoses. Since the assessment is comprehensive, with completion of the Patient Health Questionnaire (PHQ-9) along with services related to preventive and chronic care management, providers are awarded additional incentive dollars for satisfactorily completing the AWE. L.A. Care also offers an in-home assessment option by licensed practitioners for members and providers as needed.

### ***Health Education and Cultural and Linguistic Services***

#### **Health Education**

The mission of L.A. Care's Health Education Unit is to improve member health status through the delivery of wellness and disease prevention services, programs, and resources.

The Health Education Unit's goals are to provide and coordinate educational interventions that assist members to:

- Effectively use primary and preventive health care services, including health education services.
- Modify personal health behaviors, achieve and maintain healthier lifestyles, and promote positive health outcomes.
- Learn and follow self-care regimens and treatment therapies for existing medical conditions, chronic diseases, or other health conditions.
- Navigate the health system to ensure access to preventive health services.

L.A. Care delivers health education services, programs and resources through:

- ***Health In Motion***<sup>™</sup> which provides culturally appropriate health education programming via multiple channels, including group appointments at community locations and telephonic individual counseling.
- ***My Health in Motion***<sup>™</sup>, L.A. Care's online health and wellness platform, through which members can access a personal health assessment, self-paced workshops and a health coach through the chat feature.
- Low literacy **health education materials** in Los Angeles County threshold languages and required health topics.
- **Health education programs** addressing prenatal/postpartum care, flu, asthma, diabetes and tobacco cessation to improve HEDIS, CAHPS, and CMS Five-Star Quality Ratings.

### **Cultural and Linguistic Services**

L.A. Care Health Plan is committed to serving a culturally and linguistically diverse population in Los Angeles County. The mission of L.A. Care Health Plan's Cultural and Linguistic Services (C&L) unit is to ensure access to culturally and linguistically appropriate resources to promote health equity for all members.

The C&L Services Unit aims to provide quality language services, maintain compliance and create cultural awareness through education for provider network and staff, through the following overarching goals:

1. Ensure members with limited English proficiency (LEP) and disabilities receive the same scope and quality of health care services that others receive through provision of quality language assistance and auxiliary services.
2. Continuous support to provider network and staff in providing culturally and linguistically appropriate care to all members through education.
3. Improve health outcomes and decrease disparities through culturally and linguistically responsive programs and services.
4. Continually evaluate and improve C&L program for more equitable and inclusive care.

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

L.A. Care seeks to reduce disparities and improve the health and overall well-being of all its members, including Seniors and Persons with Disabilities (SPD). 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's objective is to address the cultural and linguistic needs of its membership includes, but is not limited to, the following:

- Reduce health care disparities in clinical areas.
- Improve cultural competency in member materials and communications.
- Improve network adequacy to meet the needs of underserved groups.
- Improve other areas of needs the organization deems appropriate.

L.A. Care has undertaken significant efforts to improve services for Seniors and Persons with Disabilities, to address their complex health needs. This effort has involved a review of L.A. Care's departments for the ability to appropriately serve and effectively communicate with members with disabilities. This includes the provision of L.A. Care member materials in alternate formats: Braille, audio, large print (no less than 20-point font), accessible electronic format (such as a data CD), as well as ensuring the availability of sign-language interpretation services, when requested. L.A. Care's care management process includes comprehensive assessment to identify the need for more intensive interventions or expanded coordination, including specialty referrals for linked and carved out services.

### ***Care Management/Disease Management Programs***

The Care Management (CM) and Disease Management (DM) Programs are components of L.A. Care's Population Health Management Program (PHMP). The shared objective of the program is to improve both the health and functioning of eligible members with chronic medical conditions that may also be exacerbated by significant psychosocial needs. The programs achieve this objective by supporting members and their caregivers through education, advocacy, and coordination of services. Members participating in the programs are provided with the skills to effectively self-manage their health conditions and access the healthcare services they need. The programs are developed from evidenced-based clinical practice guidelines and support the growth of the care manager-member relationship, progression of individualized care plans, and member empowerment.

The programs are offered to eligible members for voluntary participation and they are able to opt into or out of the programs at any time. Members identified to be eligible for participation in the programs receive telephonic outreach or written program information that explain the program services. Member assessments, individualized care plans, progress notes, and related member information are documented in Clinical Care Advance (CCA), L.A. Care's clinical documentation system. Documenting in CCA allows ongoing review and sharing of information between members and staff as well as monitoring and reporting on the care management activities.

During intake of a case with the member, a comprehensive assessment is completed to understand the member's main health concerns as well as potential gaps in their resources. Interventions can then be developed that are member-centric, focusing on the individual's preferences and needs. Progress towards member goals and outcomes of interventions are tracked and monitored in CCA. Interventions may include providing educational or informational materials that are culturally and linguistically appropriate for the member. With the member's consent, the care management team communicates information about the member's condition and care plan, with providers and caregivers in order to ensure the member's care is integrated and coordinated. Regular communication and coordination allow the providers and participating members of the interdisciplinary team to work in a concerted manner and avoid duplication or disruption in the care needed by the member. Care Managers collaborate with both internal and external programs or resources to address a member's identified needs.

On an annual basis, the program is evaluated on both quantitative and qualitative measures that analyze program outcomes. The evaluation includes analysis of elements such as program participation rates, utilization impact, as well as member satisfaction with the programs.

### ***Chronic Care Improvement Programs (CCIP)/Disease Management - Medicare***

The objective of L.A. Care's Chronic Care Improvement Program (CCIP) is to improve the health status of eligible members at risk for chronic heart conditions. Developed from evidence-based clinical practice guidelines, the program achieves this objective by educating participating members and enhancing their ability to self-manage their conditions and implement lifestyle changes to reduce risks of disease progression. The CCIP was selected based on an analysis of internal data examining disease prevalence within the L.A. Care population, in support of CMS requirements to align with the Centers for Disease Control and Prevention and Centers for Medicare and Medicaid Services' Million Hearts® Initiative.

The CCIP addresses the following components:

- Multiple data sources are used to identify members eligible for the CCIP. Members meeting criteria for participation in the program are identified on a monthly basis.
- Member participation rates in the program are measured annually.
- Condition monitoring, member adherence to care plans, consideration of other health conditions, and lifestyle barriers are accounted for in work with participating members, as indicated by clinical practice guidelines.
- Use of nationally recognized clinical guidelines that are reviewed at a minimum of every two years unless the guidelines change sooner.
- Member interventions are based on individualized member needs and clinical guideposts.
- Systematic program monitoring is integrated into the program, Program progress is reviewed at least annually and opportunities for improvement are addressed.

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

### ***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 with CM as a separate program. The UM Program Description defines how UM decisions are made in a fair and consistent manner. The UM Program Description is approved by the UMC. For additional information, refer to the UM Program Description.

### **Transitional Care Program (TCP)**

L.A. Care's Transitional Care Program (TCP) is for L.A. Care's Medi-Cal direct line of business. The purpose of the Transitional Care Program (L.A. Care TCP) at L.A. Care Health Plan is to improve care transitions by providing support to patients and their caregivers during the transition from hospital or other institutional setting (e.g., skilled nursing facility, custodial care) to home. The L.A. Care TCP incorporates best practices from health services research.

Prior to discharge to a lower level of care, L.A. Care identifies members who are at high risk of experiencing a readmission. L.A. Care utilizes an internally developed predictive model. The results of the predictive model are applied to current L.A. Care inpatients and are displayed in the Readmission Risk tool. All patients are identified by L.A. Care Health Plan.

This program is a post discharge intervention. The hospital will continue to be responsible for all discharge arrangements. The hospitals will be responsible for providing the TCP team with member's discharge plan/discharge summary as soon as it is available.

The Community Health Worker (CHW) will request discharge information from the hospital in order for L.A. Care pharmacy team to conduct a reconciliation of medication and provide members primary care physician with recommendation.

The CHW provides information and support to members and caregivers during the transition period. The CHW assists the member and caregiver in formulating key questions and concerns to raise with outpatient providers. The CHW empowers the patient and caregiver to contact health care providers whenever needed. Additionally, the CHW collects information about the member's priorities and needs in the home environment. To fulfill these disparate roles, the CHW's responsibilities include collaborating with the hospital discharge team on the post discharge plan.

### **Managed Long Term Services and Supports (MLTSS)**

L.A. Care has a 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 and/or multiple chronic conditions.

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 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 four programs: Long Term Care (LTC) Community Based Adult Services (CBAS); In-Home Supportive Services (IHSS); and Care Plan Options (CPO). While CPO is not a benefit, these discretionary services can be accessed by CMC members when appropriate. In addition, the MLTSS department oversees L.A. Care's Palliative Care benefit for Medi-Cal (MCLA only) members, as well as Skilled level of care benefits for members.

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 and telephonic outreach.

### ***Pharmacy Management***

Pharmacy and formulary utilization is monitored regularly and updates are made 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 CMS requirements 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.

Starting January 2022, L.A. Care's MTM program is contracted out to Navitus Clinical Engagement Center (CEC) 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 Navitus' CEC is analyzed and reported to CMS. In addition, L.A. Care reviews for quality assurance of Navitus' CEC, to ensure our vendor is up to the standard according to CMS guidance.

Furthermore, L.A. Care's Pharmacy Department has partnered with the California Right Meds Collaborative (CRMC), an initiative of the University of Southern California (USC) School of Pharmacy, to develop a network of pharmacies that will deliver Comprehensive Medication Management (CMM) services to address the high burden of chronic disease states in our local communities.

Lastly, L.A. Care has also launched a pharmacy ambulatory care program. Our ambulatory care pharmacist is currently contracted with three clinics and has established Collaborative Practice Agreements. The ambulatory care pharmacist can independently assess the member, order labs, and provide medication management services to our high-risk members.

### ***Cal MediConnect Measurement and Reporting Requirements***

The Centers for Medicare and Medicaid Services (CMS) uses Medicare Advantage Part C and Part D measurement sets for monitoring quality of care, member experience, and plan administration of contractual standards. L.A. Care monitors and reports all required Part C and Part D measure reports such as HEDIS, CAHPS, and Health Outcomes Survey (HOS) to NCQA and CMS. In addition, Cal MediConnect Plans must monitor and submit program specific measure reports to CMS "Core Measures", and to the Department of Health Care Services (DHCS) "California-Specific Measures" as required in the contract between DHCS, CMS and the Cal MediConnect

Plan “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.

### ***Safety Net Programs and Partnerships***

Health Homes: The Health Homes Program (HHP) is a high-touch care management and wraparound services program, authorized by the Department of Health Care Services (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 Inpatient (IP) &/or Emergency Room (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 34 contracted high volume providers, and has enrolled more than 18,000 MCLA members since the program launched in July 2019.

HHP will sunset at the end of 2021, with enrolled members grandfathering into a new Medi-Cal benefit, Enhanced Care Management (ECM), effective January 1, 2022. ECM builds off the successes of HHP, using a similar community-based provider model to provide eligible members with high-touch care management and care coordination services.

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 Mental Health (MH) or Substance Use Disorder (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. Approximately 16,200 MCLA members were enrolled across all WPC programs in March 2021, including some duplicate program enrollments.

Whole Person Care was extended through December 2021, and will transition into the new Enhanced Care Management and Community Supports (CS) programs as of January 1, 2022. L.A. Care is collaborating closely with L.A. County to transition member and provider relationships from WPC to ECM and CS in order to preserve infrastructure and promote continuity of care.

Homeless Programs: L.A. Care has various programs to address the health and social needs of homeless members. In 2016, L.A. Care made a \$20M, 5-year grant commitment to the Housing for Health Program (HFH) 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; 331 households have been housed to date. L.A. Care and HFH were also awarded nearly \$20 million in additional funds from the state to launch Housing for Healthy CA to house 250 new homeless members starting in 2021, 83 households have been housed to date.

L.A. Care has contracts with six (6) recuperative care providers to help provide a safe place for homeless members discharging from the hospital. L.A. Care also provides housing navigation and tenancy support services to homeless members enrolled in the Health Homes program, and has provided two consecutive years of grant funding for legal assistance to Angelenos facing eviction. In addition, L.A. Care refers members to the local Coordinated Entry System (CES) and county 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.

L.A. Care will launch expanded programs for members experiencing homelessness through the CalAIM Community Supports initiative in 2022. On January 1, 2022, L.A. Care will launch Homeless and Housing Support Services (HHSS, a combined program offering both Housing Navigation and Tenancy Services) and Recuperative Care, and will add Housing Deposits on July 1, 2022. L.A. Care will grandfather members receiving Housing Navigation or Tenancy Services through Whole Person Care or Health Homes into the HHSS program in 2022, with approximately 9,000 to 10,000 MCLA members expected to transition. L.A. Care will also grandfather in approximately 500 MCLA members in the WPC recuperative care program to Community Supports on January 1. L.A. Care is working closely with the L.A. County Departments of Health Services and Mental Health to build contractual relationships and referral pathways that will link Community Supports to other housing services for members available through the local CES.

#### *Provisional Postpartum Care Extension*

As of April 1, 2022, the Department of Health Care Services (DHCS) will implement a Provisional Postpartum Care Extension (PPCE) extending the coverage period for individuals receiving pregnancy related-and postpartum care to include an additional ten months of coverage following the current 60-day postpartum period for a total of 12 months, without requiring a mental health diagnosis. The 12 month postpartum coverage period for Medi-Cal eligible pregnant individuals will begin on the last day of the pregnancy and will end on the last day of the month in which the 365<sup>th</sup> day occurs. This will supersede the current state-only PPCE program implemented under Senate Bill (SB) 104 on August 1, 2020, which extended the coverage of individuals covered in a pregnancy Medi-Cal aid category for up to 12 months after the end of the pregnancy if diagnosed with a maternal mental health condition during their pregnancy, 60-day postpartum period, or within 90-days from the end of the postpartum period.

L.A. Care covers maternal mental health care for women during pregnancy and for up to two months after the end of pregnancy. The PPCE program extends that coverage for up to 12 months from the end of pregnancy, regardless of maternal mental health diagnosis.

#### ***Quality Improvement Projects (QIPs)***

L.A. Care conducts Quality Improvement Projects (QIPs) in compliance with the Department of Health Care Services' (DHCS), Covered California's, 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 QIP 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 and QIPs are overseen by DHCS. Covered California requires a multi-year QIP that addresses disparities in care for chronic conditions by racial and ethnic identity.

### ***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 four state-mandated rapid-cycle PIPs/QIPs; two PIPs for Medi-Cal, one QIP for Covered California, and one QIP for Cal MediConnect. PIPs/QIPs 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' 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 DHCS' External Quality Review Organization (EQRO). L.A. Care participates in quarterly collaborative meetings 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 EQRO, which 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.

L.A. Care and Covered California together select measures related to chronic condition management to be monitored and improved over the course of several years. L.A. Care is required to follow the reporting templates for both the data submission and the QIP report.

### ***Plan-Do-Study-Act (PDSA)***

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. 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. PDSAs 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 (MCOD) Contract Manager.

### ***Patient Safety***

L.A. Care is committed to ensuring patient safety and promoting a supportive environment for network practitioners and other providers to improve patient health outcome and safety. Information about safety issues is received from multiple sources including but not limited to member and practitioner grievances, care management and utilization management activities, 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 (CI) for Cal MediConnect (CMC) enrollee and ensures referrals to appropriate agencies are made for follow up. As noted in policy and procedure (P&P) QI-027 Critical Incident Reporting and Tracking, 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. An annual Getting to Know Critical Incident training is mandatory to member-facing staff to ensure both new and seasoned staff understand the Critical Incident criteria and how to submit a CI.

L.A. Care follows state laws to report and monitor 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). As deemed necessary, critical incidents maybe investigated further through potential quality of care review process.

### **Potential Quality of Care Issue (PQI) Reviews**

The Potential Quality of Care Issue (PQI) review activity, set forth in Policy & Procedure (P&P) QI-001 PQI, is an established process for thorough, appropriate, and timely resolution of potential quality of care issues related to potential quality of care or potential quality of service issues that may affect the patient’s health outcome and safety. PQI cases are referred to the Quality Improvement (QI) Department Provider Quality Review (PQR) team. The QI PQR team maintain and enforce the policy working with physicians through peer review processes. The PQI referral criteria are developed specifically for each of the care delivery support teams (i.e., Customer

Solution Center (CSC) Team, Appeals and Grievance (A&G) Team, Case Management Team, Utilization Management and Behavior Health Team) to appropriately identify the potential care concern. An annual Getting to Know Potential Quality of Care Issues training is mandatory to member-facing and provider-facing to ensure both new and seasoned staff understand the PQI referral criteria and how to submit a PQI. The PQR team meets with CSC, A&G and other areas as needed to discuss sample cases, staff education and process improvement.

The oversight process of CSC and A&G cases started in 2020 and will continue throughout fiscal year 2021-2022. A random sample of CSC calls and A&G cases that were not referred to PQI are reviewed at least quarterly to identify any missed opportunity to refer a PQI and to remediate gaps knowledge or process with CSC and A&G. Another assessment of Patient Safety is done through a stringent review of quarterly encounter data from deceased members to proactively assess pattern of encounters and identify potential unexpected deaths.

The L.A. Care PQI Interrater Reliability (IRR) evaluation, set forth in P&P QI-32 PQI IRR, is an established process for case reviewer testing, evaluation, and monitoring to improve the consistency and accuracy of the application of review criteria in the leveling and final reporting of PQI. The IRR review criteria are further enhanced for fiscal year 2021-2022 adding two (2) new reviews to assess appropriate and relevant medical records and/or provider responses are collected and reviewed and PQI reviews are appropriately and comprehensively addressing member concerns. All PQI cases closed/leveled by PQI nurse reviewers are subject to IRR review at least quarterly by clinical staff (i.e., Senior Manager Provider Quality, Chief of Equity and Quality 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.

A corrective action plan and/or further action may be required to address quality issue with adverse effect and/or adverse health outcome based on PQI investigation. The provider in question will be asked to perform a formal root cause analysis prior to completing a corrective action plan for the identified finding/deficiency. Root Cause Analysis (RCA) is an in-depth process or technique for identifying the most basic factor(s) underlying a variation in quality issue. A corrective action plan will outline the problem, a statement of the desired situation going forward, and specific steps to be taken to remediate the identified issue.

### **Facility Site Review (FSR) and Medical Record Review (MRR)**

State law requires all Health Plans to have adequate facilities and service site locations available to meet contractual requirements for the delivery of primary care within their service areas. All Primary Care Provider (PCP) sites must have the capacity to support the safe and effective provision of primary care services. To ensure compliance, L.A. Care Facility Site Review Department is required to perform initial and subsequent site reviews, consisting of an FSR and an MRR, using the Department of Health Care Services (DHCS) FSR and MRR tools and standards. The site review process is part of the L.A. Care's quality improvement programs that focus on the capacity of each PCP site to ensure and support the safe and effective provision of appropriate clinical services.

FSRs are conducted to ensure that all contracted PCP sites have sufficient capacity to provide appropriate primary health care services and can maintain patient safety standards and practices.

The FSR confirms the PCP site operates in compliance with all applicable local, state, and federal laws and regulations.

MRRs are conducted to review medical records for format, legal protocols, and documented evidence of the provision of preventive care and coordination and continuity of care services. The medical record provides legal proof that the patient received care. Incomplete records or lack of documentation implies the PCP did not provide quality, timely, or appropriate medical care.

### **Hospital Quality and Safety**

To continually improve patient safety and healthcare outcomes in an inpatient setting, L.A. Care tracks and trends hospital performance to reduce variation and assure consistent and standardized metrics across all contracted hospitals and for all lines of business. To that end, L.A. Care subscribes to annual reports with a number of hospital patient safety and quality indicators from Cal Hospital Compare supplemented with data and reports from Centers for Medicare and Medicaid Services (CMS), California Department of Public Health (CDPH), and the California Maternity Quality Care Collaborative (CMQCC). Each of these entities provides performance comparisons across hospitals along with regional and national benchmarks of quality and safety. Some examples of hospital quality and safety metrics monitored are hospital acquired infections such as Methicillin-resistant staphylococcus aureus (MRSA), Catheter-associated Urinary Tract Infection (CAUTI), Central Line-associated Blood Stream Infection (CLABSI), Clostridium difficile (C.Diff), and Surgical Site Infection – Colorectal Surgery (SSI-Colon), along with Hospital Safety Grade (from the Leapfrog Group), overall patient experience scores from Hospital-CAHPS, Nulliparous, Term, Singleton, Vertex (NTSV) C-Section Rate to minimize medically unnecessary c-section deliveries when vaginal deliveries are indicated.

In addition, L.A. Care participates in an L.A. County multi-plan collaborative, launched in 2021, along with Health Net, and Molina to drive improvements in key hospital quality and safety indicators referencing hospital scorecards based on the indicators listed above. Hospital quality and safety indicators are reviewed and monitored at the monthly Inpatient (IP) Workgroup, attended by representatives from Utilization Management, Care Management, Quality Improvement, and Pharmacy. Concurrently, to improve on appropriate utilization of services and minimize avoidable readmissions and Emergency Department (ED) visits, the IP Workgroup reviews metrics and indicators for Transition of Care to improve IP/OP communication and handoffs, and Risk Adjusted 30 day Readmissions, Emergency Department Utilization, and Acute IP Admissions. Benchmarks and goals are set and corrective action plans developed when rates are trending unfavorably or goals are not met.

### **Pharmacy**

Pharmacy safety measures include edits at the point of service. Each prescription filled is subject to a prospective drug utilization review or concurrent drug utilization review (CDUR). This review includes a search for possible drug interactions and previous known allergies to reduce the risk of dispensing medications with potential adverse consequences. Starting January 2022, Medi-Cal Rx transition will occur. After transition, CDUR edits will be handled by the Department of Health Care Services (DHCS) and Magellan Health.

L.A. Care Pharmacy will continue to perform retrospective drug utilization reviews (RDUR) after Medi-Cal Rx transition. RDUR is administered by our Pharmacy Benefit Manager (PBM), Navitus, for all Lines of Business (LOBs). Navitus reviews post-adjudication pharmacy claims to identify members and providers with potentially inappropriate/excessive utilization of medication therapy and sends a mailer to the identified providers three times annually in March, July, and November.

## Quality of Equitable 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 grievances/appeals, data collected from the annual Health Plan and Clinician and Group Consumer Assessment of Healthcare Providers and Systems (HP- and CG-CAHPS) surveys, the Qualified Health Plan (QHP) Enrollee Survey, the Medicare Advantage and Prescription Drug Plan (MAPD) CAHPS, 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.

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

Measure	
Data Source: CAHPS and QHP Surveys	
Access to Care (Getting Needed Care, Getting Care Quickly)	Rating of All Health Care
Doctor-Patient Communication	Rating of Health Plan
Care Coordination (coordination of members' health care services)	Rating of Personal Doctor
Customer Service	Rating of Specialist (specialist seen most often)

### *Appeals and Grievances*

Appeals and Grievances (A&G) are tracked and trended on a quarterly basis for timeliness of acknowledgement and resolution, issue types, and by provider type. In general, the appeal and grievance process includes a thorough investigation and evaluation to ensure timely access to care and the delivery of quality care and/or services. Potential quality issues are identified and referred to an appropriately-licensed professional for evaluation and further management of clinical issues, such as timeliness of care, access to care, and appropriateness of care, including review of the clinical judgments involved in the case. The quarterly report is presented and reviewed by the Member Quality Service Committee (MQSC), the Credentialing/Peer Review Committee, the Quality Oversight Committee (QOC), Utilization Management Committee (UMC), and Internal

Compliance Committee (ICC).). Committees will identify potential interventions and measure(s) to address opportunities for improvement.

### ***Availability of Practitioners***

Availability of practitioners is assessed by the Provider Network Management (PNM) Department using L.A. Care established quantifiable standards for both geographic distribution and numbers (ratio of providers to members) of PCPs, 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. Primary care practitioners include those who practice in the areas of Family Practice/General Medicine, Internal Medicine, Obstetrics/Gynecology, and Pediatrics. High volume areas of specialty care are determined by the number of encounters within a specific timeframe. L.A. Care has identified Oncology and Cardiovascular Disease as high impact specialties across all lines of business. Additionally, L.A. Care assesses the cultural, ethnic, racial, and linguistic needs of its members and adjusts the availability of providers if necessary.

To continuously review, evaluate, and improve access and to ensure Members are able to obtain appointments within established standards for time and distance. L.A. Care creates and develops 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 established 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 ten 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 10-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 hospital 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 as well as annually evaluating providers' compliance with existing standards.
- Annually reviewing and measuring the effectiveness of these standards through network adequacy assessment results, network surveys, and analyses of network access and availability.

### ***Accessibility of Services***

L.A. Care has established standards for the accessibility of primary care, specialty care, behavioral health care, and ancillary care as prescribed by the Department of Managed Healthcare (DMHC), Centers for Medicare and Medicaid Services (CMS), the Department of Healthcare Services (DHCS), and the National Committee for Quality Assurance (NCQA). These include standards to address the following, but is not limited to:

- Routine primary and specialty care appointments
- 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 may include but are not limited to: CAHPS survey, Access to Care studies, and L.A. Care's Behavioral Health Partner.

To continuously review, evaluate, and improve access to availability of services and ensure members are able to obtain appointments within established standards for timely access, an access to care study is conducted annually to measure the compliance of contracted physicians in rendering medical care within timeframes established by the regulatory agencies aforementioned above. The study measures in "wait-days" the length of time it takes for a patient to receive various types of primary care and specialty care for routine and urgent appointments. The targeted specialties are based on DMHC regulation and L.A. Care's high volume and high impact specialty types. There are also surveys for ancillary and behavioral health care providers.

*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.

### ***Teladoc Health, Inc. Services***

Effective January 1, 2020, L.A. Care offers general medical telehealth services to our direct lines of business: Medi-Cal (MCLA), Cal MediConnect (CMC), L.A. Care Covered (LACC), and L.A. Care Covered Direct (LACCD) and PASC-SEIU members through our contracted partner, Teladoc Health, Inc. (Teladoc). The addition of Teladoc in L.A. Care's network improves access to care when the primary care doctor is not available and helps to reduce avoidable urgent care and emergency room utilization for non-emergent services.

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

### ***MinuteClinic***

L.A. Care offers our direct line of business members (MCLA, CMC, LACC, PASC-SEIU, and LACCD) additional access to care at all 17 MinuteClinic locations in L.A. County when members cannot reach their PCP or need afterhours care. 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. Members can receive timely care without an authorization.

This expansion of our contracted provider network, launched June 2019 offers access for minor, non-emergency services and helps 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, minor injuries or skin conditions, gynecology (women's health), and administer vaccinations for adults.

### ***Nurse Advice Line***

L.A. Care provides direct line of business members (MCLA, CMC, LACC, LACCD, and PASC) access to a 24/7/365 nurse advice line (NAL). Members can access a live Registered Nurse for symptom and condition management support, general health information, resource navigation guidance and more. The NAL health coaches assess the members' situation and direct them to the appropriate level of care. The health coaches strive to maintain a consistent, evidence-based approach when supporting members through the continuum of health and healthcare. They can also guide members to resources like telehealth and/or refer them to internal departments such as care management and social services. The NAL provides assessment, evaluation, and/or advice to members and serves as L.A. Care's mechanism for the provision of triage and screening services.

### ***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.



### ***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: information exchange between providers, utilization management, member/provider solutions support, quality improvement, care management, behavioral health, the Direct Network, 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).

### ***Transform L.A.***

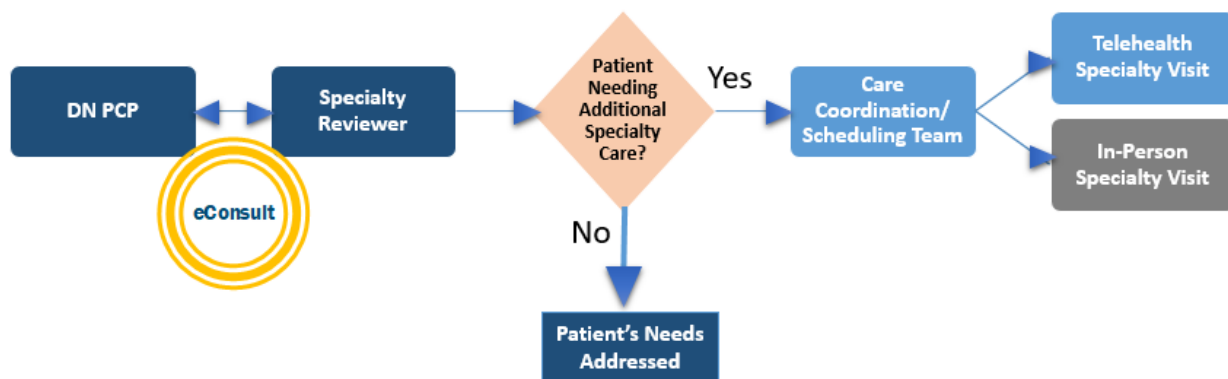
Transform L.A. is a practice-level technical assistance program delivered through tailored practice coaching. Engaging with a practice coach is an opt-in amenity for L.A. Care Direct Network primary care providers who use an electronic health record (EHR). The program supports practices in building quality improvement capacity and delivering high quality, evidence-based care that will provide measurable value to the practice and their patients.

#### **Areas of Focus Can Include:**

- Using data to drive practice improvements
- Supporting telehealth program development
- Implementing population health management (PHM) strategies
- Running reports on clinical quality measures from the practice's EHR and/or other PHM tools
- Optimizing Healthcare Effectiveness Data Information Set (HEDIS) results, Pay-for-Performance (P4P), Prop 56, and Value-Based Payment (VBP) revenue
- Conducting observations and providing workflow redesign guidance/best practices
- Training staff on variety of topics, such as Quality Improvement 101 and medical assistant professional development modules

### ***Integrated In-Person and Virtual Specialty Care Program (V-SCP)***

The Integrated In-Person and Virtual Specialty Care Program is a model of care that incorporates use of eConsults between PCPs and SCPs and if patients need additional follow-up, there is support in coordination of patient access to specialty care services via telehealth or in-person as needed. The program is an opt-in alternative specialty care access pathway for L.A. Care Direct Network PCPs and members only.



The program is set to launch Winter 2021/22 with a subset of targeted DN Primary Care Practices and key specialty care partners, including Children’s Hospital L.A. (pediatric specialists), HubMD (adult telehealth specialists), and Beacon (behavioral health specialists).

### ***First 5 LA***

L.A. Care has received a grant agreement from First 5 LA to provide a 3-year program/pilot to improve awareness of and increase developmental milestones screenings for children ages 0-5 years. This program is part of the Help Me Grow: LA system to provide early identification and interventions for children who may not be on track with developmental milestones. The program will follow the recommendations of the American Academy of Pediatrics (AAP) for infants and toddlers to be screened at ages: 9 months, 18 months, and 24-30 months to identify any possible delays that children may be experiencing. Approximately 15% of children are delayed with development and by conducting screenings at these ages, early identification of such delays can be treated with interventions that will help the child progress to be on track and ready for kindergarten and onward in school.

The program will consist of two main parts: (1) community and provider education and (2) 10 practice/clinic pilot. The goal for the education portion is to increase awareness of the importance of the developmental milestones and early interventions when need as well as availability of local community resources to provide assistance. There will be an education campaign rolled out through print, social media and information/links on L.A. Care’s website through the respective member and provider portals. Annual CME events focused on early childhood development will be held for providers and similarly focused classes for families and community members will be offered at L.A. Care’s CRCs and other CBOs.

The clinical pilot will provide an on-site practice coach, best practices education for providers and care teams for conducting screenings as well as providing referrals. Also, coaches will conduct a baseline assessment of the practice’s data for several measures including number of screenings and referrals conducted and help the practice to optimize workflows to achieve the program goals of 15% improvement in number of screenings and referrals. Data will be collected and reported to the L.A. Care project management for analysis to ultimately gain knowledge and share/spread the learnings throughout the health care community in LA County.

### ***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 supports the Enterprise Performance Optimization (EPO) Department, by providing subject matter expertise concerning the performance of delegation 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.

### ***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 populations. 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. 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 (prescribing, scheduling, etc.)
- 24 Hour Health Information Line including Interpreter Services
- Encouraging Wellness and Prevention

#### ***Provider and Practitioner Communication***

The L.A. Care Health Plan provider/practitioner newsletter, and *Progress Notes* communicates updates on all aspects of the health plan including pharmacy procedures, 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 quarterly, four times a year. L.A. Care also publishes a provider e-newsletter the PULSE, six times a year. Providers are also emailed and faxed about the aforementioned topics. Providers are regularly kept abreast of the health plan information via 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.

### ***Member Incentive Programs***

Member incentives are a key part of L.A. Care's strategy to focus on priorities related to member engagement and experience, health education and receipt of important medical services. These interventions are designed to educate and encourage members to proactively seek needed care, and offer eligible members an opportunity to be rewarded for health and wellness behaviors. Current and past programs include member incentives for high impact measures such as COVID vaccines, postpartum care, flu shots, follow-up visits for mental illness after hospitalization, breast cancer screenings, well-child visits and more. Member incentives undergo evaluations and adjustments based on organizational priorities and network performance on important measures. L.A. Care will continue to operate member incentives seeking to deliver programs that are innovative in design and effective in reach.

### ***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 to promote collaboration and common performance improvement priorities for all providers in L.A. Care's network.

2022 marks the twelfth 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 2022 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, which has shown to improve PPG performance year-over-year. With its success in Medi-Cal, the VIIP program has expanded to the Cal MediConnect (CMC) and L.A. Care Covered (LACC) lines of business (LOBs), with a set of domains and measures relevant to providers and members for those LOBs and offers additional opportunities to earn value-based revenue. While the Medi-Cal and CMC programs are fully run in-house, the LACC VIIP program is unique as L.A. Care collaborates with the Integrated Health Care Association (IHA) on their Align, Measure, Perform (AMP) Program, sharing data, performance targets and program design with IHA for LACC groups.

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 closely mirrors the VIIP program, to create a stronger platform for shared quality improvement strategies between plans and provider groups. The program measures and rewards plan partners for performance on a broad 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 2022 with targeted areas of modification.

## **SALES, MARKETING AND COMMUNITY OUTREACH**

L.A. Care provides support to multiple initiatives throughout the organization utilizing the services of the in-house Sales, Marketing, and Communications & Community Relations Business Units. Services are provided through Health Plan Field Representatives, Contracted Agents, Community Outreach and Engagement Services, Volunteer Health Promoters, and the Community Resource Centers.

Marketing staff are aligned by product lines, health plan initiatives and the Community Resource Centers. Marketing staff participate 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. 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 in communities where access to quality health care is limited.

The Community Resource Centers, which are operated in collaboration with plan partner Blue Shield of California Promise Health Plan, are located in Boyle Heights, East L.A., El Monte, Inglewood, Lynwood, Pacoima, Palmdale, Pomona, and Wilmington. When fully operational, the Community Resource Centers provide free health education, exercise and healthy living classes in underserved communities, as well as social needs support for members and resource center guests. During the pandemic, the resource centers have offered on-demand virtual exercise and healthy cooking classes, and they have hosted dozens of drive-thru food pantries and vaccine clinics to support our members and communities.

The Health Plan Field Representatives and Contracted Agents 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 posted on L.A. Care's website and promoted through social media. This provides members and non-members with information on conveniently located events held throughout L.A. County.

Enrollment Entities and their down-line Certified Insurance Agents (CIAs) and Certified Enrollment Counselors (CECs) receive additional outreach. They are educated and updated on the programs that L.A. Care members have access to, as well as potential eligibility for L.A. Care's Medi-Cal, Cal MediConnect, and L.A. Care Covered product lines.

Member-focused newsletters are distributed quarterly, to help our members (a) navigate the managed care system to; (b) understand the benefits and services available; (c) become educated about disease prevention and (d) receive care and support for their well-being. L.A. Care's *Be Well*, Medi-Cal newsletter, addresses the health concerns of children, young adults, and growing families (under 55 years old). *Live Well*, L.A. Care's *Cal-MediConnect* newsletter, addresses the concerns of senior members and persons with disabilities (55 years and over). *Stay Well*, the LACC/LACCD newsletters, targets members enrolled in the L.A. Care Covered product line. L.A. Care offers a variety of benefit and health education information on its primary website. 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.

L.A. Care continually seeks opportunities to improve provider awareness and secure their commitment to L.A. Care. This is accomplished through provider 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 provider outreach, is to target L.A. Care contracted providers who serve low-income seniors and people with disabilities.

## **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 to identify opportunities aimed at improving population health, equity, 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, measures, and other information to DHCS, DMHC, CMS, and other regulatory bodies, its enrollees, network providers, and the general public. In doing so, L.A. Care safeguards the confidentiality of member data and the doctor-patient relationship. Health Information data and documentation of the overall quality improvement program is maintained and made available for those aforementioned 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 that provide information about the processes and outcomes of population health, equity, clinical care and member experience. The results of performance measurement are coordinated with other network initiatives, teams and oversight committees. Staff throughout the enterprise participate in these activities and are educated as to their roles and responsibilities in improving performance.

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

L.A. Care uses many different sources to obtain performance data. The data sources include but are not limited to encounters/claims, pharmacy and lab data through direct, supplemental or Health Information Exchange (HIE) pathways; medical record review or facility site review results, and other monitoring and audit results as well as grievances, appeals, and denial overturns. Reports used to reflect this data include but are not limited to: HEDIS results, quality and performance reports, member and provider satisfaction survey results, network access and availability reports. Advanced Analytics and Data Science techniques are also used such as Risk Scores, the Readmission Risk Tool and multifactorial Member Experience analysis.

Performance goals are established for each indicator. Performance goals may be based on historical trends, normative data, standards, goals, or benchmarks. Benchmarks are regarded as the best level of performance set by industry organizations. The initial performance goal for a new indicator is often to analyze baseline data. Some indicators, while having acceptable and sustained performance with nominal variation, will be continually monitored 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 network regarding safety and clinical care 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 Demographics – 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 data on the performance of comparable organizations.
- Other Utilization, Diagnosis and Outcome Metrics – Data on the 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 – Resources outside the organization, including Medicare or Medicaid fee-for-service data, data from other managed care organizations and local/national public health reports on the 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 disenrollment 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.
- Data elements from CMS Part C & D, NCQA, and other regulatory reporting.
- Other information our regulators: CMS, DHCS, DMHC or accrediting bodies, such as NCQA may require.

L.A. Care ensures that information and data received from providers are accurate, timely, and complete. All HEDIS measures are audited by an external auditor to ensure accuracy. Performance data for the key indicators are collected, aggregated, integrated, and analyzed on a recurring schedule and business activity monitoring is used to verify volume and timeliness. 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 a regulatory or accrediting body.

Interventions are developed, prioritized, and implemented based on metric results and root cause analyses 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 a 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 with plan and 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 disparities, multiple members, providers, and services. Interventions to improve performance include health promotion and health education programs, informing members on strategies to improve their health or their use of health care delivery systems. 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.

Value Based Incentives and collaborative performance improvement programs such as the VIIP Action Plan are used to entice network providers and members to achieve evidenced-based health prevention and improvement. While opportunity or gap in care 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 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.

Setting goals for statistically-significant improvement over the prior year’s measure (baseline) provides a clear rationale. For a difficult measure, a rational target is often statistically significant improvement over a three-year period.

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 the practical importance of a change in terms of its benefit to the subjects of the intervention (members, providers, etc.). It can involve a large benefit to a small number of patients, or a small benefit to a large number of patients. It may be expressed as numbers of patients served, with comparisons as to why that number is meaningful. If well-measured, meaningfulness can be expressed as a ratio of numbers served within a denominator population. Statistically, it can be expressed as an effect size or phi coefficient.

### ***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 selects 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 must be used for identifying the target population and for selecting individual cases for review.

Follow-up measurements should use the same methodology and time frames as the baseline measurement, with the exception that the baseline data can cover an entire population at risk, while the follow-up measurement may use a representative sample as long as it is of sufficient size to test for the effect size determined *a priori* for the project.

## **MEMBER CONFIDENTIALITY**

L.A. Care is obligated, both legally and ethically, to protect the interest of its members by maintaining the confidentiality of all members in accordance with applicable laws and regulations. L.A. Care has Privacy and Security Programs that include relevant policies and procedures aimed at protection the confidentiality of our members. Confidential member information is made available only to L.A. Care employees, contractors, and affiliates who have a need-to-know in order to do their job functions and have signed confidentiality agreements. 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 and as described in our Notice of Privacy Practices. 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) or as restricted by contractual arrangements.

L.A. Care maintains member confidentiality in written, verbal, and electronic communications. L.A. Care has specific privacy and security 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's provider network 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 85 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](http://www.lacare.org/providers/provider-central/faqs).

## **OVERALL L.A. CARE DELEGATION**

### **Independent Practice Association/Participating Provider Groups (IPA/PPG)**

L.A. Care delegates responsibility for specific health care delivery functions and administrative services to its members to IPA/PPGs. L.A. Care maintains accountability and ultimate responsibility for the associated activities by overseeing performance in the following areas: Utilization Management, Care Management, Credentialing, 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, development and review of health education materials, 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 is capable of managing the delegated activities and are in compliance with L.A. Care, current NCQA standards and state and federal

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. On an annual basis, L.A. Care evaluates the delegates' performance against NCQA, DMHC/DHCS, and CMS standards for the delegated activities. L.A. Care also conducts ongoing monitoring through oversight reports, meetings, and collaboration to continually assess compliance with standards and requirements. Oversight audit and monitoring results are reviewed, opportunities for performance improvement are identified and reported to the delegate. A Corrective Action Plan (CAP) is issued if deemed necessary, to address deficiencies. After the delegate receives final Annual Audit Findings, the delegate has 15 business days to provide L.A. Care a completed CAP form. After all CAPs for all audit areas are accepted and audit is closed, L.A. Care may conduct a CAP validation 60 calendar days after audit close date to ensure that substantial correction of deficiencies occurred and the CAP implemented was satisfactory.

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 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 overall 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 equitable 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 is available to regulatory agencies if requested.

## **ANNUAL QI WORK PLAN (SEE Attachment 5)**

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 equitable 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, equity, 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 identified in prior years.
- Planned evaluation of the QI program.

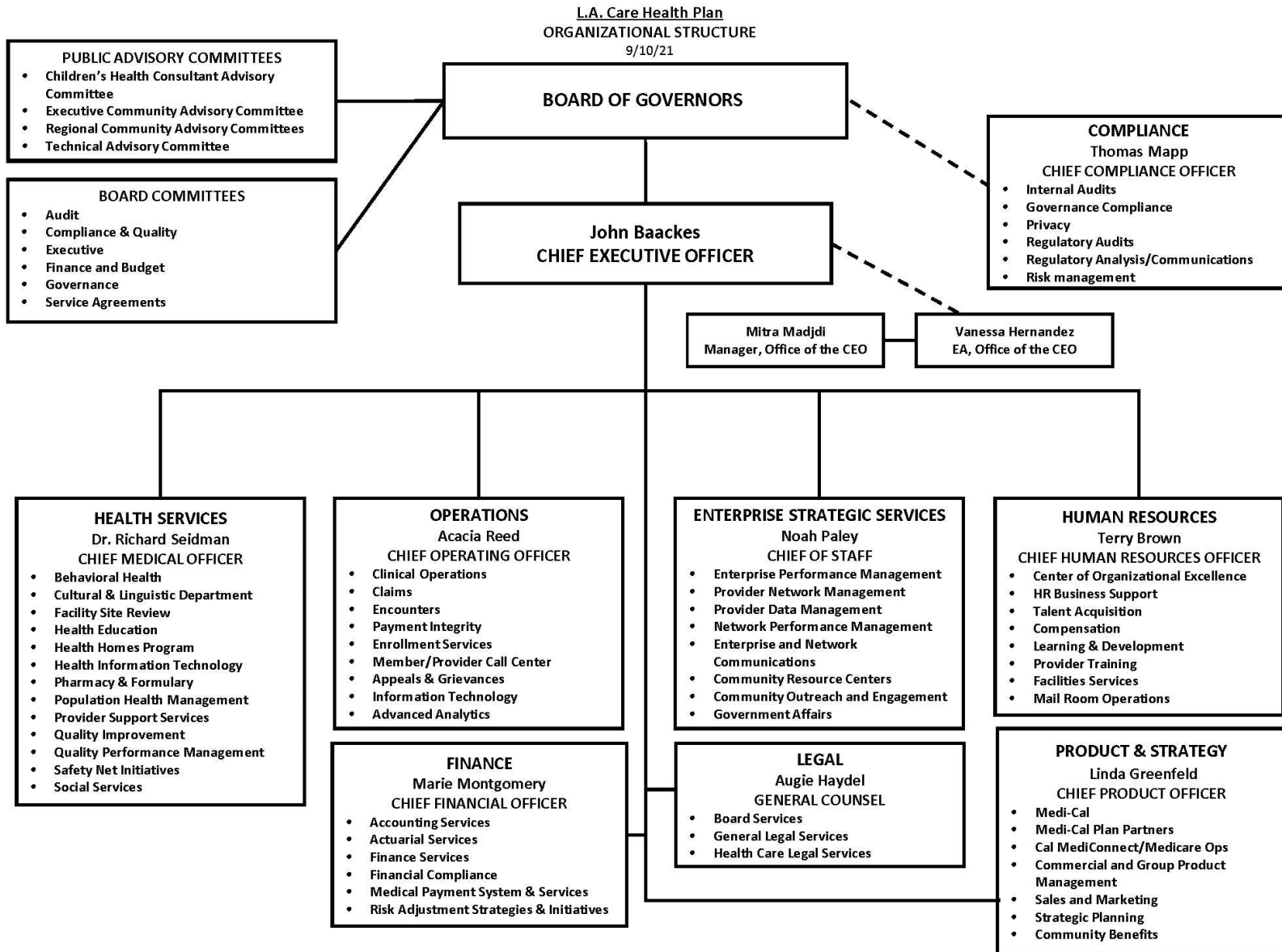
Each of the elements identified on the Work Plan has activities defined, responsibility assigned, and the date by which completion is expected. The QI Work Plan and Quality Improvement Program description are presented to the Quality Oversight Committee for review and approval. Quarterly updates to the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

Endnotes:

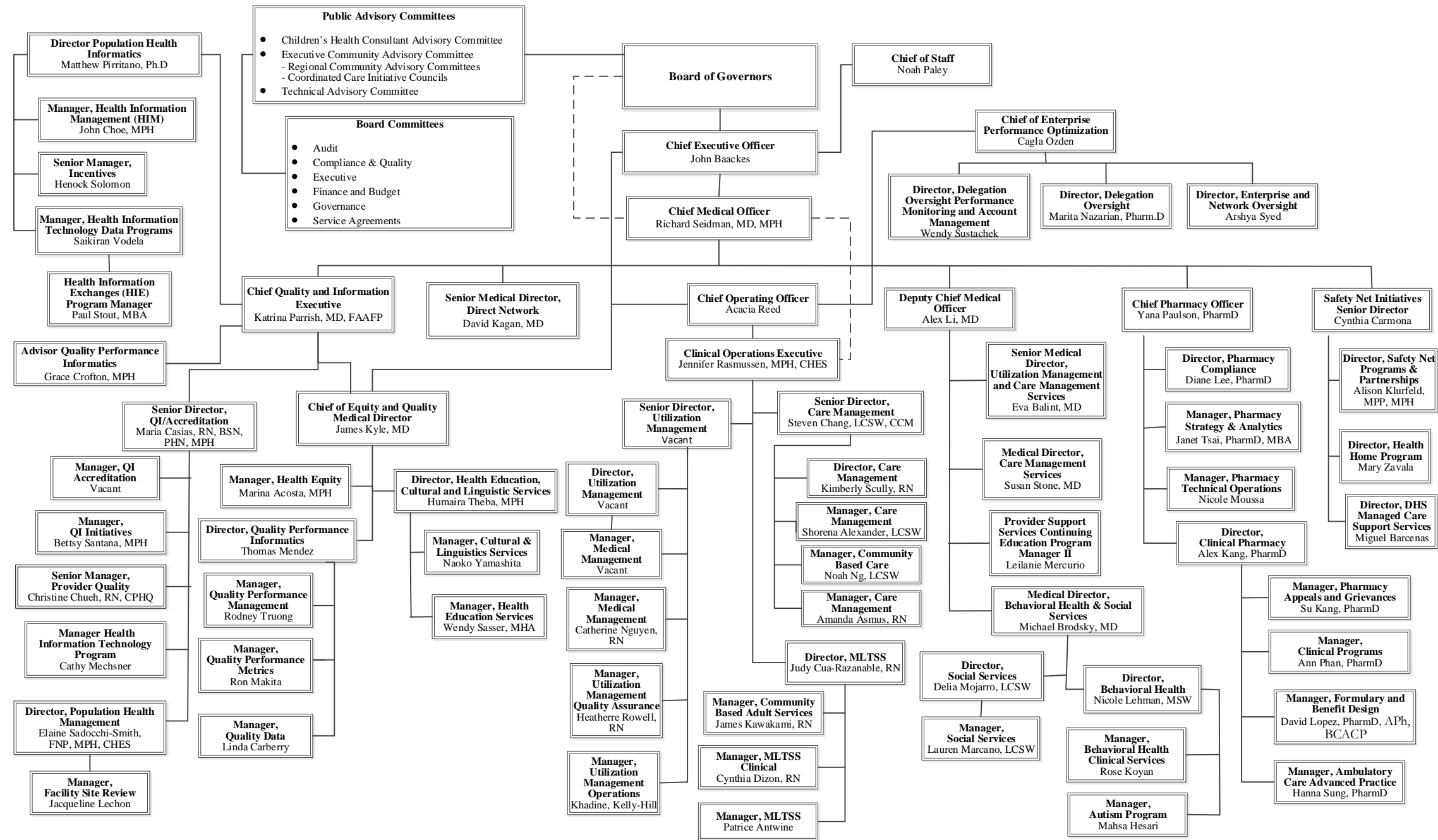
Source: Medicare Managed Care Manual Chapter 5- Quality Assessment Rev. 100, 08-05-11

Attachment 1	Organizational Structure
Attachment 2	Health Services Organization
Attachment 3	Quality Program Committee Structure
Attachment 4	HEDIS Measures
Attachment 5	2022 QI Work Plan including Medicare

# ATTACHMENT 1



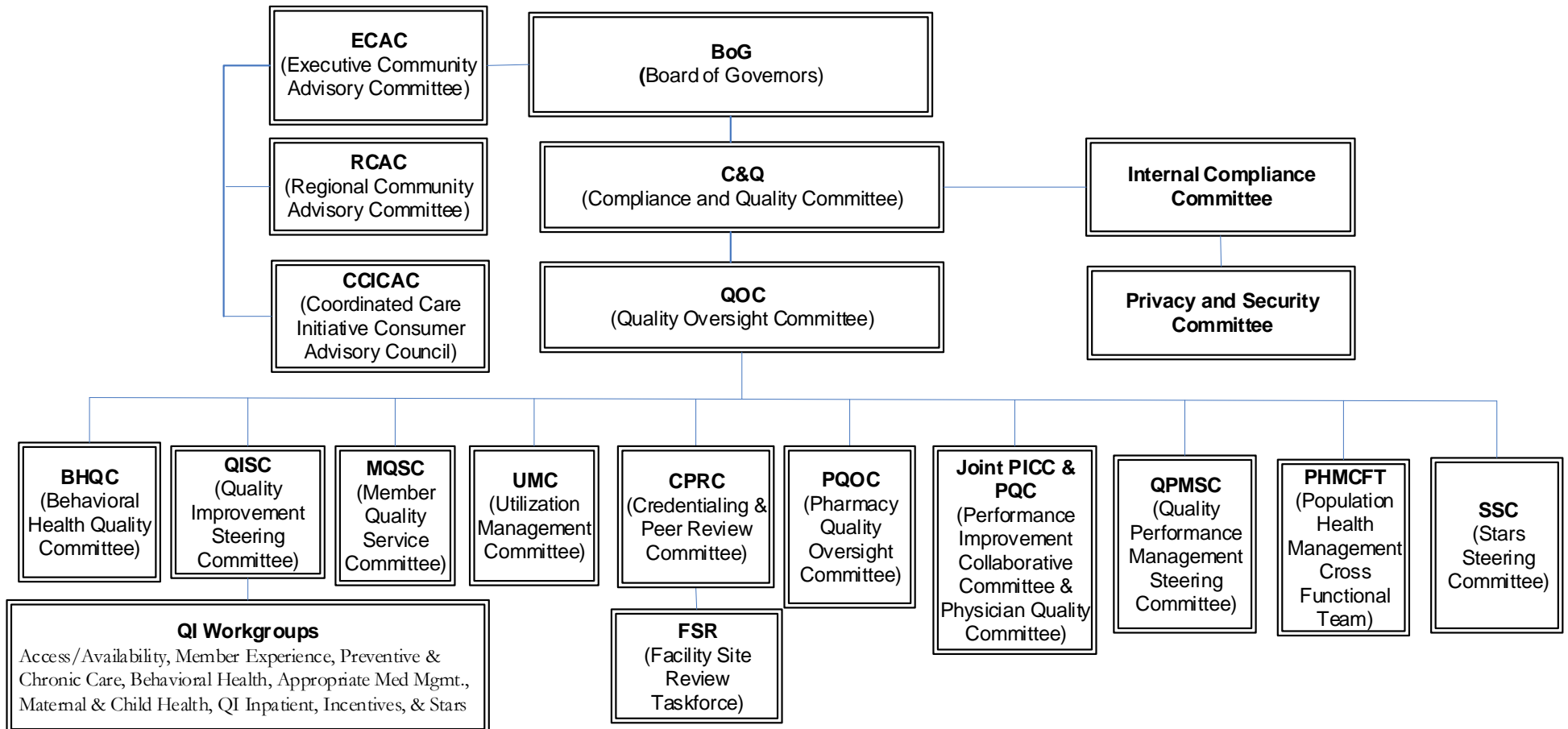
2022  
L.A. Care Health Plan  
Health Services Organization





# ATTACHMENT 3

## L.A. Care Health Plan Quality Improvement Committees



## ATTACHMENT 4

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	X
ADD	Follow-Up for Children Prescribed ADHD Medication - Continuation and Maintenance	A					X
ADV	Annual Dental Visit (Total Rate)	A	X				X
AHU	Acute Hospitalization Utilization – Total Acute -65+ years	A				X	
AMM	Antidepressant Medication Management - Acute Phase	A	X				
AMM	Antidepressant Medication Management- Continuation Phase	A	X			X	X
AMO	Annual Monitoring for Persons on Long-term Opioid Therapy	A	X				
AMR	Asthma Medication Ratio – Total	A	X				X
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics – Total	A					X
APP	Use of First –Line Psychosocial Care for Children and Adolescents on Antipsychotics	A					X
BPD	Blood Pressure Control for Patients with Diabetes	H				X	X
BCS	Breast Cancer Screening - Total	A	X		X	X	X
CBP	Controlling High Blood Pressure - Total	H	X		X	X	X
CCS	Cervical Cancer Screening	H	X		X		X
CDC-HT	Comprehensive Diabetes Care – HbA1c Testing	H		X			
CHL	Chlamydia Screening in Women- (Total Rate)	A	X		X		X
CIS-3	Childhood Immunization Status - Combo 3	H	X	X			

## ATTACHMENT 4

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
CIS-10	Childhood Immunization Status - Combo 10	H	X		X		X
COL	Colorectal Cancer Screening	H	X			X	
COU	Risk of Continued Opioid Use – 31 day rate	A				X	X
CWP	Appropriate Testing for Pharyngitis	A	X			X	X
DAE	Use of High-Risk Medications in Older Adults (Rate 3 only)	A				X	
DDE	Potentially Harmful Drug-Disease Interactions in Older Adults (Total Rate)	A				X	
EDU	Emergency Department Utilization -65+ years	A				X	
EED	Eye Exam for Patients with Diabetes	H	X			X	X
FMC	Follow-up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions - 7-days (65+years)	A				X	
FUA	Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 7-days	A				X	X
FUA	Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 30-days	A			X		
FUH	Follow-Up After Hospitalization for Mental Illness - 7 day and 30 day (LACC only)	A	X			X	X
FUI	Follow-Up After High-Intensity Care for Substance Use Disorder - 7 days	A				X	X
FUM	Follow-up After Emergency Department Visit for Mental Illness - 7 day	A				X	X
FUM	Follow-up After Emergency Department Visit for Mental Illness – 30- days	A			X		

## ATTACHMENT 4

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
HBD	Hemoglobin A1c Control for Patients with Diabetes – HbA1c Control <8%	H	X			X	X
HBD	Hemoglobin A1c Control for Patients with Diabetes – HbA1c Poor Control >9%	H	X		X		
HDO	Use Of Opioids At High Dosage	A				X	X
HFS	Hospitalization Following Discharge From a Skilled Nursing Facility - 30-Day	A				X	
HPC	Hospital for Potentially Preventable Conditions	A				X	
IET	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment – Initiation	A	X				
IET	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment - Engagement	A	X			X	X
INR	International Normalized Ratio Monitoring for Individuals on Warfarin	A	X				
IMA-2	Immunizations for Adolescents – Combination 2	H	X		X		X
KED	Kidney Health Evaluation for Patients with Diabetes	A	X			X	X
LBP	Use of Imaging Studies for Low Back Pain	A	X				X
LSC	Lead Screening in Children	A			X		
OMW	Osteoporosis Management in Women Who Had a Fracture	A				X	
OSW	Osteoporosis Screening in Older Women	A				X	

## ATTACHMENT 4

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
PCE	Pharmacotherapy Management of COPD Exacerbation Systemic Corticosteroid and Bronchodilator	A				X	X
PCR	Plan All Cause Readmissions	A	X			X	X
PDC	Proportion of Days Covered	A	X				
PNU	Pneumococcal Vaccination Status for Older Adults	A				X	
POD	Pharmacotherapy for Opioid Use Disorder	A				X	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
PRS	Prenatal Immunization Status - Combination Rate	ECDS					X
PSA	Non-Recommended PSA-Based Screening in Older Men	A				X	
RDM	Race/Ethnicity Diversity of Membership	A				X	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	X
SSD	Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic Medications	A					X
TRC	Transition of Care - All Four Rates	H				X	

## ATTACHMENT 4

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				X	X
URI	Appropriate Treatment for Upper Respiratory Infections	A	X			X	X
W30	Well-Child Visits in the First 30 months of Life	A	X		X		
WCC-BMI	Weight Assessment & Counseling for Nutrition& Physical for Children and Adolescents	H	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				
WCV	Child and Adolescent Well-Care Visits	A	X	X	X		

## **ATTACHMENT 5**

2022 QI Work Plan including Medicare