



Quality Improvement Program

All Lines of Business

2018

Quality Oversight Committee approval on

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3/15/18

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

STRATEGIC PRIORITIES (2015-2018)

Goal 1:

A highly-functioning health plan with clear lines of accountability, authority and communication, and with processes and people that drive efficiency and excellence.

Objectives:

- Ensure timely success of the core system conversion to improve efficiency and core operational functionality.
- Build a high performance workforce through the attraction, training and retention of high quality talent, capable of meeting the evolving needs of a large and complex health plan.
- Drive product line performance by establishing clear lines of accountability to support high-quality service and financial sustainability across all product lines.
- Enable product line performance through operational improvements and increased functionality.
- Effective collaboration with vendors and delegated entities, including Plan Partners, PPGs, and contracted providers of behavioral health services, pharmacy services, and transportation providing oversight, feedback and dialog to address deficiencies and identify opportunities to improve care delivery and outcomes.
- Increase use of data to drive decision-making across product lines and functional areas by centralizing data governance, management, and analytics and establishing tools that facilitate access to data.
- Optimize the financially responsible growth potential of Cal MediConnect and L.A. Care Covered.

Goal 2:

A network that aligns reimbursement with member risk and provider performance in support of high-quality, cost-efficient, and member-centric care.

Objectives:

- Optimize shared risk, dual risk and full risk contracting arrangements by product segment to align reimbursement with the specific needs and risk type of the population segment.
- Develop and implement a scorecard for Medi-Cal provider groups that reflects performance with respect to the Triple Aim, laying the groundwork for value-based reimbursement.
- Develop and implement strategies to promote quality performance in the provider network.

Goal 3:

Tailored models of care for the specific needs of our member populations.

Objectives:

- Develop and implement direct networks for subpopulations within our membership to improve access and quality.
- Develop tailored population health management programs for the unique needs of our vulnerable, high-risk, and other subpopulations.
- Reduce health disparities through targeted care management and quality improvement interventions.

Goal 4:

Recognized leader in improving health outcomes for low income and vulnerable populations in Los Angeles County.

Objectives:

- Develop an L.A. Care brand that articulates our value proposition.
- Actively support safety net providers' ability to perform their delegated functions and to leverage the investments made in healthcare information technology to succeed in a managed care environment.
- Mobilize our community resources to ensure that we are responsive and accountable to the needs of our members and constituents.
- Foster innovative approaches to improving the quality of care provided by the safety net.
- Collaborate with external organizations such as the Industry Collaboration Effort (ICE), the Integrated Healthcare Association (IHA), California Maternity Quality Care Collaborative (CMQCC) and the California Quality Collaborative (CQC) to learn and share best practices.

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 to achieve its goals and includes how the QI program is organized to meet program objectives, functional areas that support the program and their responsibilities and reporting relationships for the QI Department staff and QI Committees. These are described in detail in the program.

In addition to Medi-Cal, the following product lines have been added and will be covered by the QI program description: Medi-Cal Expansion, 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).

L.A. Care Health Plan Community Access Network (CAN)

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

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

Angeles County. L.A. Care intends to implement the CAN throughout the County geographically by region using L.A. Care's Regional Community Advisory Committee's ("RCAC") regions in L.A. County. The addition of these providers increased the total number of available primary care physicians, specialists, and mid-levels in the entire LA County from 144 to 273. These providers, along with previously contracted PPG providers, serve the needs of L.A. Care's members they benefit from having a direct relationship with L.A. Care, and have the opportunity to serve members beyond just those assigned to them by the provider group(s) with which they are contracted.

In order to maximize the benefits members and providers receive from this new network, L.A. Care took on more responsibility for directly managing the functions which touch our members and providers directly – care management, utilization management, and claims. The Community Access Network launched in February 2016. A communication plan informing external partners of this new network was developed in 2016. In March 2017, we expanded the L.A. Care CAN to, South Los Angeles and Long Beach and in June of 2017 – East Los Angeles and Central Los Angeles. We plan to expand throughout Los Angeles County in 2018.

SB 75 – Full Scope Medi-Cal for All Children

Under a new 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.

At L.A. Care, as of Nov 1, 2017 a total of 21,628 children under the age of 19 have been determined newly eligible for full scope Medi-Cal under SB75. As of Nov 1, 2017, there are 20,308 children under the age of 19 who are currently active L.A. Care members receiving full-scope Medi-Cal under SB75.

L.A. Care Covered™ (On-Exchange-LACC)

Under the health care reform, L.A. Care Health Plan has proudly participated with Covered California to offer affordable health care coverage for residents of Los Angeles County, known as L.A. Care Covered™. This product line was launched on October 1, 2013 with a focus on serving diverse and low-income communities in Los Angeles County. The health care reform law also assists individuals/family pay the monthly premiums through the Covered California application process. Individuals/families may be eligible/qualify for the federally subsidized rates and/or receive Advance Payment of Premium Tax Credits (APTC) if their income is at or below 400% of the Federal Poverty Line (FPL). The Open Enrollment period for Covered California opens in the fall each year for coverage the following year. Individuals/families who experience an unexpected life event, such as losing a job, may apply for coverage throughout the year during the Special Enrollment period.

L.A. Care Covered™ has the most affordable premiums in Los Angeles County for the Silver, Gold and Platinum metal levels.

- Our plans offer preventive care at no additional cost.
- Members have access to an extensive network of doctors, specialists, hospitals, pharmacies, and preventive care services - close to where they live, work, and play.
- A free Nurse Advice Line is available to all members 24 hours a day, 7 days a week.
- Health education, exercise classes, and disease management programs are available at no cost through our Family Resource Centers.

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

- Provider networks based on quality
- 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™.

L.A. Care Covered Direct™ offers the same health benefits and services through our four plans (Platinum, Gold, Bronze, and Minimum Coverage) which include:

- Preventive care at no additional cost.
- Access to an extensive network of doctors, specialists, hospitals, pharmacies, and preventive care services - close to where they live, work, and play.
- A free Nurse Advice Line available to all members, 24 hours a day, 7 days a week.
- Health education, exercise classes, and disease management programs available at no cost through our Family Resource Centers.

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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.

L.A. Care Cal MediConnect Medicare-Medicaid Plan (MMP)

The Coordinated Care Initiative (CCI) in California, passed into law in 2012, was created to respond to the needs of dual eligible beneficiaries and to deliver higher quality and more integrated care. Overall, the CCI strives to improve the integrated delivery of medical, behavioral, and long-term care services for beneficiaries.

Cal MediConnect (CMC) is one of the key components of the CCI and was launched in Los Angeles County in April 2014. CMC is a voluntary demonstration for dual eligible beneficiaries to receive coordinated medical, behavioral health, long-term institutional, and home-and community-based services through a single organized delivery system. The Cal MediConnect program aims to improve care coordination for dual eligible beneficiaries through the provision of high quality care that helps people stay healthy and in their homes for as long as possible. Additionally, shifting services out of institutional settings and into the home and community will help create a person-centered health care system that is also sustainable.

Currently, the demonstration is authorized through December 31, 2017. CMS has announced its intention to extend the MMP demonstration for an additional two years through the end of 2019. The Governor of California and the California Department of Health Care Services have also agreed to extend the demonstration as reflected in the Governor's Budget Assembly Bill 113.

L.A. Care's Cal MediConnect program aims to provide a seamless service delivery experience with the ultimate goals of improving care quality, better health and a more efficient delivery system. L.A. Care currently serves about 16,000 members in Cal MediConnect. A specific focus of CMC is delivering patient centered care through a Care Management approach that creates an interdisciplinary team working collaboratively to

meet the needs of the CMC member from a medical, psychological, social needs and community support perspective.

Managed Long Term Services and Supports (MLTSS)

L.A. Care's Managed Long Term Services and Supports (MLTSS) Department provides services that help individuals remain living independently in the community and oversees extended long-term care provided in a skilled nursing or intermediate care facility. MLTSS serves L.A. Care's members enrolled in the California Coordinated Care Initiative (CCI)/Cal MediConnect (CMC) and Medi-Cal. In 2014 the California Department of Health Care Services (DHCS) began the transition of the MLTSS benefit to L.A. Care. MLTSS oversees five programs: Long Term Care (LTC) Nursing Facilities; Community Based Adult Services (CBAS); Multipurpose Senior Services Program (MSSP); In-Home Supportive Services (IHSS); and Care Plan Options. MLTSS also supports member and staff inquiries and makes referrals to L.A. Care and community resources.

Conceptual Framework

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

Population Health: Improve the overall quality of care, by making health care more patient-centered, reliable, accessible, and safe. Improve the health of the U.S. population by supporting proven interventions to address behavioral, social, and environmental determinants of health in addition to delivering higher-quality care.

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

Per Capita Cost: Reduce the cost of quality health care for individuals, families, employers, and government. ^[1]

Furthermore, in order to achieve these aims, the strategy established five priorities, to help focus efforts by public and private partners including L.A. Care Health Plan. Those priorities are:

- 1) Improve medical care by increasing quality and the responsiveness of care networks.
- 2) Improve member and provider satisfaction with L.A. Care.
- 3) Implement an operational excellence strategy to excel at the full range of product lines offered by L.A. Care.
- 4) Improve financial sustainability of direct product lines.

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

- 5) Ensure access to care for low income and vulnerable populations through supporting the safety net and demonstrating value of the Local Initiative under the Medi-Cal Two-Plan model.

As the QI program aligns with the Triple Aim, there is increased integration of Medical Management and Quality Improvement in the QI program structure.

GOALS AND OBJECTIVES

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

Goal – Improve Quality of Care:

Improve and maintain the health and wellness of its members through the provision of coordinated, comprehensive, quality care for each member including those with complex health needs, such as, the Seniors and Persons with Disabilities (SPD) population.

Objectives:

- Improve access to high quality care for all covered lives
- Improve NCQA accreditation rating
- HEDIS scores per work plan targets.
- Improve Medicare Star ratings. (although not publically reported L.A. Care will track performance)
- Improve provider encounter data reporting.
- Improve our provider network data and adequacy.
- Utilizing a multi-disciplinary approach to assess, monitor and improve our policies and procedures.
- Promoting physician involvement in our Quality Improvement Program and activities.
- Meeting the changing standards of practice of the healthcare industry and adhere to all state and federal laws and regulations.
- Ensuring there is a separation between medical and financial decision making.
- Seeking out and identifying opportunities to improve the quality of care and services provided to our members and practitioners.
- Confirm that the quality improvement structure and processes maintained by L.A. Care comply with provisions of the L.A. Care Quality Improvement Program and meet state, federal, NCQA and other applicable professionally recognized standards.
- Coordinate relevant sources of information available to L.A. Care including quality of care performance review (e.g. QI activities reports, utilization management, member services, pharmacy, and other data).
- Collect and analyze data related to the goals and objectives and establish performance goals to monitor improvement including Managed Long-Term Services and Supports (MLTSS) [Community Based Adult Services (CBAS), Multipurpose Senior Services Program (MSSP), and In-Home Support Services

(IHSS) and Long-Term Care (LTC)/Skilled Nursing Facility (SNF) and other facilities through an organized committee structure.

- Identify opportunities for process improvement within L.A. Care, its delegates and contracted entities to drive patient-centric quality care and service by utilizing performance data to drive the QI process. Implement, monitor, and evaluate interventions to ensure members receive the highest quality healthcare available.
- Communicate the quality improvement process to practitioners/providers and members through appropriate persons and venues (e.g. meetings, print media, electronic media, and L.A. Care's website).
- Evaluate the Quality Improvement Program annually and modify the program as necessary to improve program effectiveness.
- Develop, monitor and operationalize a QI work plan that addresses quality and safety of clinical care and service, program scope, yearly objectives, planned activities, timeframe for each activity, responsible staff, monitoring previously identified issues, and conducting an annual evaluation of the program.

Goal – Monitor and Improve Patient Safety:

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

Objectives:

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

- Identify and monitor patient safety measures for in-network hospitals and collaborate with other payers and stakeholders to help them achieve minimal performance targets.
- Track Low-Risk NTSV C-Section rates for in-network maternity hospitals and collaborate with other payers and stakeholders such as the CMQCC and CHCF to help them meet or exceed the national goal of 23.9%

Goal – Improve Member Satisfaction:

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

Objectives:

- Improve overall rating of the health plan on the CAHPS Survey.
- Identify key drivers that affect CAHPS scores of the health plan.
- Collaborate with the Customer Solution Center to implement company-wide initiatives to improve our ability to provide exemplary service to our members and providers.
- Share C-G CAHPS data with provider groups, instruct them how to interpret the results and promote member experience interventions and best practices among PPGs, MSOs and physician practices/clinics.
- Prioritize areas that impact rating of the health plan.
- Periodic review of key service-related reports from both the health plan and delegated entities (e.g., Customer Solutions Center, PBM, Behavioral Health and Nurse Advice Line service reports) to identify opportunities to improve service and customer satisfaction.
- Leverage Appeals and Grievances data to gain insight into the drivers of member dissatisfaction and develop interventions to address these concerns in collaboration with vendors and delegated entities.
- Identify key areas for improvement, develop and monitor interventions based on the findings in the key service-related reports. Monitor results of the interventions.
- Consolidate multiple data sources in developing the analysis.
- Ensure that the provision of healthcare services is accessible and available in order to meet the needs of our members.
- Incorporate electronic media and venues to enhance member and provider engagement and address NCQA Member Connections Standards.

Goal – Provide Culturally and Linguistically Appropriate Services:

Ensure medically necessary covered services are available and accessible to members regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, gender identity, health status, physical or mental disability, or identification with any other persons or groups defined in Penal Code 422.56, and that all Covered Services are provided in a culturally and linguistically appropriate

manner by qualified, competent practitioners and providers committed to L.A. Care's mission. Promote health education and disease management that is age-defined, culturally and linguistically appropriate, condition-specific, and designed to promote life-long wellness by encouraging and empowering the member to adopt and maintain optimal health behaviors.

Objectives:

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

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

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

Objectives:

- Provide case management to those with complex health care needs, such as Seniors and Persons with Disabilities.
- Improve access to primary and specialty care ensuring that members with complex health conditions receive appropriate service through audits, medical record reviews, and other oversight activities.
- Use care coordinators and case managers for members who receive multiple services.
- Identify and reduce barriers to services for members with complex conditions.
- Sponsor the delivery of educational information to practitioners to enhance the diagnosis and treatment of medical/health conditions, those with Complex Health Care Needs.
- Address and resolve patient-specific issues including those with complex health needs, such as, SPDs.

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

Maintain a well-credentialed network of providers and practitioners based on recognized and mandated credentialing standards and cultural/linguistic needs of members. Provide continuous quality improvement oversight to the provision of health care within the L.A. Care system network by monitoring and documenting the performance of L.A. Care’s contracted network through facility site reviews, medical record reviews, HEDIS scores, and other focused studies.

Objectives:

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

Goal – Monitor and Improve Behavioral Healthcare:

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

Objectives:

- Collaborate with behavioral health practitioners and entities to ensure appropriate utilization of behavioral health services and continuity and coordination of medical and behavioral healthcare.
- Improve communication (exchange of information) between primary care practitioners and behavioral health practitioners.
- Monitor the appropriate diagnosis, treatment and referral of behavioral health care disorders commonly seen in primary care.
- Monitor appropriate use and monitoring of psychopharmacological medications.
- Manage treatment access and follow-up for members with coexisting medical and behavioral disorders.

- Screening for depression members with chronic diseases, promote routine screening for depression in the adolescent and adult population, including those with chronic disease and women during pregnancy and the postpartum period and ensuring appropriate follow-up.
- Identification and management of Substance Use Disorders.

Goal – Meet Regulatory and Other Health Plan Requirements:

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

Objectives:

- Monitor L.A. Care and network compliance with the contractual and regulatory requirements of appropriate state and federal agencies and other professional recognized standards, such as, NCQA and Joint Commission.
- Maintain grievance and appeal procedures and mechanisms and assure that members can achieve resolution to problems or perceived problems relating to access or other quality issues.
- Establish, maintain, and enforce confidentiality policies and procedures for protection of confidential member, practitioner, and provider information in accordance with applicable state and federal regulations.
- Protect member identifiable health information by ensuring members’ protected health information (PHI) is only released in accordance with federal, state, and all other regulatory agencies.
- L.A. Care does not exert economic pressure to cause institutions to grant privileges to providers that would not otherwise be granted, nor to pressure providers or institutions to render care beyond the scope of their training or experience.
- Assuring 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 services from provider groups and internal care management processes. In addition to new referrals, this includes expansion of existing MLTSS services to help maintain functional status and social skills such as non-

severely impaired members receiving IHSS who may benefit from CBAS or more impaired IHSS members who may benefit from MSSP.

- Through LTC placement referrals and review of higher functioning existing LTC members, identify those who can remain or return to a community-based residence with appropriate support services.

Goal – Provide an Evidence Based Model of Care:

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

Objectives:

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

AUTHORITY AND ACCOUNTABILITY

The Board of Governors (BoG) has ultimate accountability for L.A. Care’s Quality Improvement Program. The Board of Governors approves the QI Program Description. L.A. Care Health Plan’s Governing Body is the thirteen (13) member stakeholder Board of Governors (BoG). As a public entity, all meetings of the BoG and its subcommittees are conducted within the rules and regulations of the Brown Act (California Open Meeting Law). Officers are elected annually. The 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), Knox Keene Licensed Pre-Paid Health Plans (California Association of Health Plans), 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 has assigned oversight of the QI Program to the Compliance and Quality Committee (C&QC), a subcommittee of the Board.

The Compliance and Quality Committee (C&QC) has final approval of the QI Program Description and the Quality Improvement Annual Evaluation annually. The C&QC monitors all quality activities and reports its findings to the Board of Governors. The Chief Medical Officer and the Medical Director, Quality Improvement & Health Assessment provide regular reports to the C&QC from the Quality Oversight Committee. Discussions,

conclusions, recommendations, and approval of these reports are maintained in the minutes of the C&QC and BoG meetings.

Meeting Schedule

The BoG has scheduled ten (10) meetings per year. All draft meeting agendas are publicly posted 72 hours prior to the meeting. The final agenda is approved at the time of the meeting in accordance with the Brown Act.

ORGANIZATIONAL STRUCTURE

Following an organizational restructure in 2015-2016, L.A. Care continues to operate under a matrix-management model, which designates leaders by product line/population segments and also, Chief Executives over specific business units. This 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. The following figures were used to display accountability by product line/population segment and the matrix organization proposed and the organization under CEO. The realignment of functions and accountability is reflected in the narrative description and roles and responsibilities outlined in this document.

Chief Operating Officer

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

Chief Financial Officer

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

Chief of Enterprise Integration

The Chief of Enterprise Integration is responsible for managing the data analytics, process improvement, risk management, and the Project Management Office department. The Chief of Enterprise Integration reports directly to the Chief Executive Officer and will coordinate implementation of a matrix management model that integrates operations to support discrete lines of business in an optimally efficient and effective manner. The Chief of Enterprise Integration manages all data analytic activities that will improve access to and accuracy of data, utilize a single source of data (e.g., enterprise data warehouse), define options for improving workflow management and data integration that optimize core functions and enable planned growth, and improve the organization's overall ability to make data-driven decisions. In addition, the Chief of Enterprise Integration collaborates with business stakeholders and I.T. to ensure that all necessary data is stored in the Enterprise Data Warehouse in a timely manner to ensure that reports and analysis are available in a timely manner.

The Chief of Enterprise Integration is responsible for management of the overall process improvement program, which supports L.A. Care's strategic goals and coordinates and evaluates continuous business process improvement initiatives. Manages and coordinates organization-wide efforts to ensure that performance management and quality programs are developed and managed using a data-driven focus that sets priorities for improvements aligned to ongoing strategic imperatives. Develops standardized procedures for identifying, assessing, and addressing operational needs that enhance core functions and facilitate growth objectives. Designs a process to standardize provider recruiting, contracting, and communications. Builds a performance management team of process engineers and project managers to document operational issues and gaps, develop remediation/risk mitigation proposals for review and approval by leadership.

The Chief of Enterprise Integration is responsible for risk management activities, including but not limited to identification, benchmarking/metrics, and mitigation. Provides assistance by planning, coordinating and directing programs, studies and special projects in support of risk management activities. Utilizes innovation, knowledge and expertise to recommend mitigation plans. Directs and coordinates staff and activities to ensure that risk management practices, governance standards, processes, and metrics. The Chief of Enterprise Integration is responsible for the management of the Project Management Office (PMO) functions at L.A. Care. This includes, but is not limited to, all PMO methodology, processes and procedures, and large scale corporate projects. Through cross-functional teams, this position is responsible for the success of the PMO function through planning, developing and implementing a comprehensive plan to meet desired outcomes. Defines and implements asset optimization and return of investment models, infrastructure support, and proactive enterprise wide project portfolio reviews on an ongoing basis. Reviews enterprise wide projects and assists in identifying and establishing priorities, metrics, and processes. Manages the development and maintenance of a project scorecard, promotes project management within the organization, and participates in strategic planning. Oversees staff responsible for performance management activities (i.e., Project Managers and Project Analysts), process improvement evaluation and redesign, risk management, and data analytics.

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. Under the Quality Improvement umbrella are four areas: HEDIS, Disease Management, Quality Improvement, and Accreditation & Oversight. Responsibility to improve quality for vulnerable populations. Needs to implement strategy for the quality improvement function within the health plan, in collaboration with the administrative and clinical leaders of the organization. Must track and present results of improvement efforts and ongoing measures of clinical processes. Oversee regulatory readiness, quality measurement, and pay for performance programs and initiatives. Establish improvement activities, including methods to track implementation of action plans following site surveys and critical events reviews. The individual must maintain current competency in quality regulations and standards. The role will lead and be responsible for the planning and implementation of clinical information systems (CIS) used in the organization. Will assist in developing the vision and plan for the adoption of the new digital solutions and analysis for clinical process improvement. Reports directly to L.A. Care's Chief Medical Officer (CMO). May lead Data Governance Committees, Clinical Advisory Groups, and serve as liaison to various departments in bridging best practices with CIS solutions.

General Counsel

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

Executive Director Medi-Cal Plan Partners

The Executive Director of Medi-Cal Plan Partners will take specific responsibility for delivering top line revenues, net operating results and outstanding compliance and quality score results for a population segment product of the L.A. Care portfolio. The Executive Director is responsible for strategically evaluating, planning and leading complex business initiatives that support the strategic goals of a population segment product.

The Executive Director is responsible for the quality, compliance and operational performance of L.A. Care's Medi-Cal subcontracted health plans: Anthem Blue Cross, Care 1st, and Kaiser. In addition, L.A. Care operates a Medi-Cal direct line of business, L.A. Care Medi-Cal. The program serves multiple member demographics and cultures throughout Los Angeles County.

Executive Director Medi-Cal, TANF, and MCE

The Executive Director of Medi-Cal TANF, MCE will take specific responsibility for delivering top line revenues, net operating results and outstanding compliance and quality score results for a population segment product of the L.A. Care portfolio. The Executive Director is responsible for strategically evaluating, planning and leading complex business initiatives that support the strategic goals of a population segment product.

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

Executive Director Medi-Cal SPD, CCI

The Executive Director of Medi-Cal SPD/CCI will take specific responsibility for delivering top line revenues, net operating results and outstanding compliance and quality score results for a population product segment of the L.A. Care portfolio. The Executive Director is responsible for strategically evaluating, planning and leading complex business initiatives that support the strategic goals of a population product segment.

The Executive Director is responsible for the quality, compliance and operational performance of L.A. Care's Medi-Cal SPD/CCI population segments that are assigned to a directly contracted network and consists of Seniors and Persons with Disabilities and beneficiaries enrolled in the Coordinated Care Initiative.

Executive Director Cal MediConnect (CMC)

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

The Executive Director will oversee L.A. Care's product for Seniors and Persons with Disabilities who are eligible for both Medicare and Medi-Cal and enrolled in the duals demonstration pilot.

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

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

The Executive Director will oversee the following products:

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

QI PROGRAM PHYSICIAN LEADERSHIP

Chief Medical Officer

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

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

Deputy Chief Medical Officer

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

Utilization Management (UM) Medical Director

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

review; oversight, support and relationship management with our delegated medical groups and planned partners (Anthem Blue Cross, Care 1st and Kaiser).

In this role, the Medical Director will provide clinical direction and oversight of both direct and delegated UM functions for high value care and consistent with regulatory requirements. This position will also provide leadership as L.A. Care begins to further develop and implement critical UM strategies around transitions of care and out-of-network/out-of area coordination.

As part of the future vision of this role, we expect the Medical Director to also oversee or provide leadership for programs such as the hospitalist program, SNFist program, and other service and resource utilization based programs. The Medical Director will report to the Senior Medical Director. This position will work collaboratively with all the Health Services departments including Quality Improvement, Behavioral Health, Pharmacy, Health Outcomes and Analysis and Long Term Services and Supports and Clinical Member Services as well as other key organizational stakeholders.

Medicare Medical Director

The L.A. Care Medicare Medical Director is a physician, Board Certified in his or her primary care specialty, holding a valid, current, unrestricted California Physician and Surgeon License to practice medicine. The Medical Director is responsible for leading medical performance in quality and utilization management for the Medicare programs, including the Special Needs Plan, as well as the Duals Demonstration. The Medical Director works with all stakeholders touching L.A. Care Medicare members. The Medical Director works most closely with the Preferred Provider Groups. The Medical Director role is to improve quality and enhance member satisfaction and insure L.A. Care is efficient as it meets CMS requirements. This position also includes oversight responsibility for the delivery of medical services for Duals members. Ensures service delivery to members managed directly by L.A. Care. The Medical Director is responsible for the clinical operations and performance measurements to support 5 Star clinical performance. The Medicare Medical Director reports to the Chief Medical Officer (CMO).

Behavioral Health & Social Services Medical Director

The Medical Director of Behavioral Health & Social Services is a physician, completed residency training in his or her specialty, holding a valid, unrestricted California Physician and Surgeon License. The Medical Director is responsible for the development of the Behavioral Health and Social Services division of Health Services. The position is also responsible for clinical oversight, case management, and management of the Behavioral Health and Social Service activities for all lines of business including substance use. The Medical Director participates in all the quality areas, including quality improvement programs, grievance and appeals, credentialing, and quality incentive programs for Behavioral Health and Social Services. The Medical Director is responsible for overseeing behavioral health and social services participation in medical management and service coordination across the care continuum. The Medical Director will be the key liaison with

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

Chief Compliance Officer

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

QI PROGRAM RESOURCES

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

The QI Department works closely with other departments to achieve targeted outcomes and to facilitate and accomplish quality initiatives within the quality program. The QI Department works closely with the Healthcare Outcomes and Analysis Department and collaborates with areas such as, but not limited to: Medical Management, Provider Network Management, Customer Solutions Center, Credentialing, Pharmacy and Formulary, Facility Site Review, and Health Education, Cultural and Linguistic Services to achieve outcome goals. In addition, Quality Improvement and Research Consultants are available to the program.

Senior Director, Quality Improvement & Health Assessment (QIHA)

The L.A. Care Senior Director of Quality Improvement & Health Assessment reports to the Chief Quality and Information Executive and is directly responsible for the planning, organization, direction, staffing and development of L.A. Care's Quality function(s) including but not limited to, HEDIS, CAHPS, NCQA, Incentive Programs, Disease Management, and Quality Improvement Programs. Responsibility includes regulatory compliance, accreditation compliance, oversight of quality management vendor's related functions, QI for direct lines of business and/or management services agreement functions, and interfacing with external agencies including other Local Initiatives, Plan Partners and external organizations. The Senior Director is further responsible to assure all functions

are operating in accordance with the organization's mission, values and strategic goals and are provided in a manner that is responsive and sensitive to the needs of L.A. Care's culturally diverse membership. This Senior Director reports to the Chief Medical Officer.

- Directing and/or revising annually the Performance Improvement functions of the Annual Evaluation and Work Plan and presenting for review and approval.
- Directing quarterly Performance Improvement activity progress reports.
- Developing and/or revising annually Performance Improvement policies and procedures.
- Ensuring that quality trends and patterns are monitored, quality issues are identified and corrective action plans are developed.
- Monitoring and reporting to the Quality Oversight Committee (QOC), Joint Performance and Improvement Collaborative Committee (PICC) and Physician Quality Committee (PQC), and Member Quality Services Committee (MQSC), and Provider Improvement Medical Services Committee the status of Performance Improvement interventions and in accordance with the Quality Improvement Program.
- Interfacing with all internal departments to ensure compliance to the Performance Improvement activities and policies and procedures.
- Assuring compliance with the requirements of accrediting and regulatory agencies, including but not limited to, DHCS, DMHC, CMS, NCQA and Covered California.
- Serving as liaison with Regulatory Agencies for Performance Improvement activities.
- Ensuring that staff collects and monitors data and report identified trends to the QI Medical Director and Medical Services Committee.
- Ensuring that HEDIS, QIP, PIP, PDSA, and IP studies are conducted appropriately.
- Ensuring Member and Practitioner Satisfaction Surveys are conducted annually.
- Identifying compliance problems and formulating recommendations for corrective action.
- Monitoring delegated Quality Improvement activities to ensure proper performance of Quality Improvement functions in compliance with regulatory and delegation requirements.
- Reviewing Quality Improvement corrective action plans and other Quality Improvement reports for compliance to standards. Reporting IPA/PMG findings of non-compliance to the QI Medical Director, CMO and Delegated Oversight Committee.

Senior Director Health Services

The Senior Director of Health Services reports to the Chief Medical Officer for administrative and operational issues. The Senior Director is responsible for planning and implementing strategies to improve culturally appropriate health care services for L.A. Care members. These strategies includes but not limited to: 1) use of multiple prong approach to educate PPGs and providers, 2) maintain systematic method to conduct oversight and ensure compliance with network providers, and 3) incorporate culturally appropriate resources to address health care needs of L.A. Care's diverse membership. The Senior Director of Health Services develops and maintains critical strategic partnerships

with external stakeholders while advising leadership on policy, programmatic and operational issues effecting provider and member initiatives. The position reports directly to the Chief Medical Officer. The Senior Director of Health Services supervises Health Education Services, Cultural and Linguistic Services, Facility Site Review Department, Providing Continuing Education, and Health Services Training and Education Department.

Senior Director, Safety Net Initiatives

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

Senior Director, Medicare and Cal MediConnect Operations

The Senior Director of Medicare and Cal MediConnect Operations serves as a subject matter expert on federal rules and statues specific to Medicare. The Senior Director is responsible for developing and overseeing the implementation of a comprehensive business and operational plan that ensures a smooth transition of dual membership into managed care. The Senior Director will preserve and enhance high quality care while improving health outcomes and satisfaction with care, coordination of care, and timely access to care. The Senior Director develops ensures seamless coordination of services for In-Home Support Services (IHSS), Community based Adult Services (CBAS), Long Term custodial care in nursing facilitates, and the Multipurpose Senior Services (MPSS) Program. The Senior Director develops and monitors tools and matrix to measure program success through select measures. The Senior Director reports to the Chief Operations Officer.

Senior Director, Medicare Performance Management

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

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

Senior Director, Enterprise Pharmacy

The Senior Director of Enterprise Pharmacy is directly responsible for the planning, organizing, directing, staffing and developing L.A. Care's Pharmacy and Formulary by having oversight of the contracted Pharmacy Benefit Management (PBM) for its direct line of business. Furthermore, this Senior Director works collaboratively with the Plan Partners to ensure access to the pharmacy benefit for L.A. Care members. This Senior Director is also responsible for all pharmacy operations in accordance with the organization's mission, values and strategic goals that is responsive and sensitive to the needs of L.A. Care's culturally diverse membership. This Senior Director reports to the Executive Director of Health Services.

Position Requirements include: a graduate of accredited pharmacy school with Bachelors Degree or Doctorate of Pharmacy degree, a CA pharmacist license, a minimum of 10 years relevant Health Care experience, a minimum of 5 years relevant managed care experience, and a minimum of 5 years management/supervisory experience in a related capacity.

The Senior Director dedicates 25% of the time to quality improvement. The Senior Director is responsible for reporting Pharmacy Quality Oversight Committee (PQOC) results to the Quality Oversight Committee (QOC). In this role, the Senior Director is instrumental in the organizational QI process for pharmacy and continually contributes innovative QI projects to meet organizational goals.

Senior Director, Member and Medi-Cal Operations

The Senior Director of Member and Medi-Cal Operations is responsible for the management and development of all aspects of the Customer Solutions Center Department including membership information processing, and call center operations. The Senior Director develops a customer-oriented culture within Member Services with emphasis on dedication to the customer, service goals, respect for individuals, highest standards of quality, innovation, and implementing policies and procedures that reflect the vision of L.A. Care. The Senior Director manages the operation of the member service center, which provides one-stop service for members needing information regarding service/benefits, assistance with problems/complaints, and access to other business-related services, and is responsible to develop and manage a team that is customer-focused and empowered to resolve problems.

The Member and Medi-Cal Operations Senior Director is the primary liaison with the Department of Health Care Services, other local initiatives, the commercial plan, and the Department of Public Social Services regarding membership and eligibility issues.

Senior Director, Healthcare Outcomes and Analysis

The Senior Director of the Healthcare Outcomes and Analysis (HO&A) department must possess a graduate degree in public health, epidemiology, biostatistics, nursing or other relevant health field. The HO&A Senior Director dedicates 100% time to the HO&A department and reports directly to the Chief Medical Officer.

The HO&A department is the analytic unit for the Health Services service area. Duties and responsibilities include departmental decision-making, data analysis, ad hoc reporting, encounter data quality, project management, project coordination for HEDIS and CAHPS. The Senior Director works closely with the Quality Improvement department and other clinical areas such as Medical Management and Pharmacy.

The Senior Director also ensures that L.A. Care contracts with an appropriate Medicare CAHPS® vendor to conduct the Medicare CAHPS® satisfaction survey of Medicare enrollees. The Senior Director also ensures that all CMS required HEDIS data is submitted on time usually in June. The Senior Director reports to the Chief Medical Officer.

Senior Director Enterprise Shared Services

The Senior Director of Enterprise Shared Services provides leadership, planning and implementation, resource and budget management, vendor business process integration, and coordination of such activities across L.A. Care's entities, delegated provider entities and partner plans, and government agencies to align and develop business process and systems/technology capabilities (analysis, design, testing and problem/issue/risk resolution, and project management). These efforts seek to ensure enterprise-wide business functions/processes, policies and products can be effectively and efficiently administered and adapted via the Information Systems infrastructure to meet the company's Operations/Service, Medical, and Provider goals, competitive position, and underlying strategic and tactical objectives affecting operating costs, member maintenance and retention, revenue, member and provider satisfaction and compliance with internal and governmental policies. The Senior Director works extensively with business areas and internal and external IT personnel to represent and define business needs. The Senior Director leads and directs technical activities impacting key operational performance metrics in California Medi-Cal, federal CMS, and county programs such as: quality, encounters, provider disputes, cycle time and efficiency rates of customer self-service rates, claims and enrollment processing, electronic submission rates, claim and enrollment first pass rates, claim cost program controls.

Senior Director Internal Audit

The Senior Director of Internal Audit will exercise professional judgement in the design and execution of strategies to provide objective assurance on the adequacy of L.A. Care Health Plan's internal controls to the Board of Governors, senior and operations

management, independent accounts, regulators and other relevant parties. The Senior Director will lead the organization's internal audit department and functions, including the assessment of operating units and risk in collaboration with senior management and the independent accountants, and in the development of a risk-based audit plan to test financial, operational, IT and regulatory controls.

Director, Quality Improvement/Accreditation

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

The Quality Improvement/Accreditation Director interfaces with colleagues at other local initiative health plans statewide, with our sub-contracted health plan partners, provider groups, regulatory agencies and network providers to represent L.A. Care and lead statewide/local quality improvement projects. This position supervises the Quality Improvement Department, Quality Improvement Work Groups, Accreditation, Quality involvement in Access to Care, and any special projects as assigned by the Medical Director or Senior Director.

Develops and Implements Interventions to improve performance on key Medi-Cal Measures. Works closely with Medicare Operations on Quality Improvement efforts for CMC, QIP, CCIP, Annual QI Program and Evaluation. Oversees Incentive team which runs portfolio of Provider Pay for Performance programs and Member Incentives.

Director, Disease Management

The Disease Management Director directs the oversight of all assigned disease management programs and all related activities, including but not limited to, monitoring all stratification levels and associated interventions, leading the disease management teams, the condition specific managers, and other QI and Health Education staff. The Director is responsible for assigning member quarterly monitoring calls to the teams and providing documentation of ongoing compliance with NCQA, CMS, and DMHC requirements. This position is responsible for the overall strategic development and implementation of the programs including but not limited to budget management, CBO/vendor contracts and relationships, and daily activities such as monitoring inpatient census for disease management members, integration with utilization management and case management activities, and monitoring stratification levels and level changes. The

Director must also be able to help other team members communicate with difficult disease management members and problem solve findings in the quarterly monitoring. This position reports directly to the Senior Director Quality Improvement & Health Assessment. The Director of the Behavioral Health serves on the Behavioral Health Management Team and reports to the Medical Director, Behavioral Health. This position is responsible for the oversight of clinical and operations functions within the department. The director serves as a behavioral health subject matter expert in internal meetings throughout L.A. Care and external meetings with varied partners and stakeholders. This position pursues positive outcomes in the areas of quality of care, service utilization, member and consumer affairs, network enhancement, and data management. The Director conducts strategic planning to utilize resources in order to meet current and future departmental, Health Services, and Enterprise-wide goals.

Director, Utilization Management

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

Director, Medicare Operations

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

Director, Health Education, Cultural and Linguistic Services

The Director of the Health Education, Cultural and Linguistic Services Department oversees all health education and cultural and linguistic program planning, implementation and evaluation. This includes, but is not limited to strategies to develop, implement and evaluate health promotion and education interventions, cultural competency training and education, translation and interpretation services, and interventions to reduce health disparities for L.A. Care members. The Director ensures that L.A. Care is compliant with health education and cultural and linguistic regulatory requirements, and serves as the primary liaison with the Department of Health Care Services, Centers for Medicare and Medicaid Services (CMS) and Covered California on health education and cultural and linguistic issues.

Specific position duties and responsibilities include but are not limited to: maintaining policies, procedures, developing, implementing, and evaluating health education programs and services; reviewing and distributing health education materials and resources to members; participating in quality improvement planning, implementation, and evaluation; developing and/or acquiring health education services and resources for members; ensuring availability and accessibility of language assistance programs such as 24/7 interpreting including ASL and materials translated and in alternative formats; developing, implementing, and evaluating cultural sensitivity training for health plan staff and network providers; and conducting oversight of all subcontracted providers to ensure they are in compliance with the state and federal requirements. Position requirements include a master's degree in public health, with emphasis in health education, community and/or public health. Research and evaluation skills and experience working with underserved populations in managed healthcare systems are also required.

Director, Provider Contracting

The Director of Provider Contracting is responsible for developing, negotiating, and managing financially sound contracts with participating physician groups (PPGs), Management Service Organizations (MSOs), hospitals, ancillary providers, and other healthcare providers and maintain a comprehensive and compliant network of healthcare providers ensuring provision of covered services to L.A. Care's members. The Director leads the Provider Contracting Team and manages

the daily functions of the provider contracting team including, but not limited to, hiring and training staff, and successfully implements contracting documents to include network-wide strategic, legislative, and operational changes, including but not limited to, contract administration, and identifies opportunities to support safety net providers. The Director also manages the use of various analytical resources and financial data to conduct and manage complex analyses, prepare and interpret impact reports and recommend contracting strategies and alternatives. The Director ensures alignment of L.A. Care's contracting strategies, provider development and outcomes management in a way that results in better quality and value.

Director, Credentialing

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

Director, Quality Performance Management/HEDIS

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

Director, Medicare Performance Management

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

activities related to Medicare quality. These activities include provider or other training programs, development of member and/or provider educational and information materials. The Director reports to the Senior Director, Medicare Programs, but works closely with the Chief Medical Officer and Medical Management staff.

Director, Appeals and Grievances

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

Director, Provider Support Services

The Director of Provider Support Services will be directly responsible for the planning, organization, direction, staffing, oversight, development, and/or continuous process improvements for the following departments:

- Facility Site Review (FSR)
- Provider Continuing Education (CME) Program
- Health Services Training Program (NEW)

Responsibilities include regulatory compliance, accreditation compliance, oversight of Plan Partners and related operations, oversight of related delegated functions as appropriate, operations for direct lines of business and/or management of services agreement functions, and interfacing with internal customers and external agencies to include but not limited to collaborative health plans statewide, regulatory agencies, and/or advocacy organizations as necessary. The Director of Provider Support Services is further responsible to lead and direct the department to ensure all functions are operating in accordance with the organization's mission, values and strategic goals and are provided in a manner that is responsive and sensitive to the needs of L.A. Care's culturally diverse providers and membership.

Director, Clinical Assurance and Delegation Support

The Director of Clinical Assurance and Delegation Support is directly responsible for the planning, organizing, directing, staffing and developing L.A. Care's Clinical Assurance Department. Responsibility includes, but is not limited to, regulatory compliance, accreditation compliance, oversight of L.A. Care' delegated network of Plan Partners, Participating Physician Groups and Specialty Health Plans related to Health Services and managing challenging clinical situations. The Director is also responsible to manage and oversee the preparation of the required health services responses, reports, policy and procedures to regulatory agencies. The Director is

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

Manager, Quality Improvement Initiatives

The Manager of Quality Improvement Initiatives is an experienced healthcare professional responsible for overseeing activities of LA Care's Quality Improvement Programs. The position reports directly to the Clinical Director of Quality Improvement. The Manager manages the performance of health plan quality improvement activities, provider quality reviews, establishes and monitors quality improvement goals, organizes outcomes research, and assures that L.A. Care meets CMS, DMHC, NCQA and other regulatory agencies' standards for quality. The Manager interfaces with colleagues at other local initiative health plans statewide, with our sub-contracted

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

Manager, Accreditation

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

resource components associated with annual HEDIS studies, and ongoing development of policies and procedures. Serves as the departmental point of contact in the absence of the Director. Possesses a strong quality improvement background that includes clinical experience in the acute and ambulatory settings as well as managed care and NCQA, specifically within the Medicaid and government sponsored programs environments.

Manager, Provider Quality

The Provider Quality Manager is directly responsible for the organization, direction and staffing of L.A. Care's Credentialing Committee, Peer Review and Potential Quality Issue (PQI) reviews, committees and functions. Responsibility includes regulatory compliance, oversight of plan partner related operations, operations for direct lines of business and/or management services agreement functions, and interfacing with external agencies including other Local Initiatives, Plan Partners and Community Based Organizations. Critical to the position is ensuring that the

information is protected and processes are developed and implemented in accordance with regulatory and legal statutes. The Manager is further responsible to assure all functions are operating in accordance with the organization's mission, values and strategic goals and are provided in a manner that is responsive and sensitive to the needs of L.A. Care's culturally diverse membership.

Manager, Disease Management Asthma Program

The Asthma Disease Management Manager is responsible for oversight of the Asthma Disease Management Program and all related activities, including but not limited to, monitoring all stratifications levels and associated interventions, managing the asthma disease management team including other QI and Health Education staff, oversight of assigning member monitoring calls to the team. The Manager is responsible for providing documentation of ongoing compliance with NCQA, CMS, Covered California, and DMHC requirements. The Manager is responsible for the overall implementation of the program, including but not limited to, clinical workflow and clinical issues with CBO/vendor contracts and relationships, and daily activities such as oversight of monitoring inpatient census for disease management members, integration with utilization management and case management activities, and monitoring stratification levels and level changes. The Manager helps other team members communicate with difficult disease management members and problem solve findings in the phone condition monitoring. The Manager conducts staff development coaching and has discretion of personnel issues and escalates staffing concerns to upper-management appropriately. The Manager oversees program metrics and staff metrics. The Asthma Disease Management Manager reports directly to the Disease Management Director.

Manager, Disease Management Diabetes/CVD Program

The Diabetes/CVD Disease Management Manager is responsible for oversight of the Diabetes/CVD Disease Management Program and all related activities, including but not limited to, monitoring all stratification levels and associated interventions, managing the diabetes/CVD disease management team including other QI and Health Education staff, oversight of assigning member monitoring calls to the team. The Manager is responsible for providing documentation of ongoing compliance with NCQA, CMS, Covered California, and DMHC requirements. Additionally, the Manager is responsible for the overall implementation of the program, including but not limited to, clinical workflow and clinical issues with CBO/vendor contracts and relationships, and daily activities such as oversight of monitoring inpatient census for disease management members, integration with utilization management and case management activities, and monitoring stratification levels and level changes. The Manager helps other team members communicate with difficult disease management members and problem solve findings in the phone condition monitoring. The Manager conducts staff development coaching and has discretion of personnel issues and escalates staffing concerns to upper-management appropriately. The Manager oversees program metrics and staff metrics. The Diabetes/CVD Disease Management Manager reports directly to the Disease Management Director.

Manager, Incentives Programs

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

Manager, Quality Performance Metrics

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

Senior Manager, Facility Site Review

The Senior Manager of Facility Site Review is responsible for the management of daily operations of the Facility Site Review (FSR) Department, including development, implementation, administration and evaluation of goals and strategies. The Senior Manager serves as the organizations Master Trainer and heads the FSR Collaborative, which is responsible for the assignment and tracking of FSR activities for all Health Plans in L.A. County. The Senior Manager recruits and manages staff, including performance management, talent development, cross-training and coaching and counseling as appropriate. The Senior Manager proposes process improvement activities to ensure cost effective and efficient operations. The Senior Manager prepares, reviews, and updates policies and procedures for the FSR Department. The Senior Manager develops, monitors, and reports metrics designed to evaluate effectiveness of assigned programs. He or she creates operational and capital budgets. The Senior Manager ensures operational goals and objectives are met through expense management and within approved budget.

Manager, Appeals and Grievances

The Appeals and Grievances Department Manager is responsible for the centralized intake, logging and triage process for all member appeal and grievances. The Manager oversees the resolution of member appeals and grievances for all product lines including State Fair Hearings (SFH) in a manner consistent with regulatory requirements from the Department of Managed Health Care (DMHC), Department of Health Care Services (DHCS), and Centers for Medicare and Medicaid Services (CMS), as well as requirements from the National Committee on Quality Assurance (NCQA) and L.A. Care policies and procedures, ensuring the proper handling of member complaints whether presented by members, their authorized representative, the Ombudsman office, state contractors, member advocates, L.A. Care Board Members, providers, etc. The Manager is responsible for establishing and monitoring processes to oversee and coordinate the identification, documentation, reporting, investigation, and resolution of all member appeal and grievances and SFH in a timely and culturally-appropriate manner. The Manager works with internal committees (i.e., Quality Oversight Committee (QOC), Member Quality Service Committee (MQSC), etc.) to review and analyze appeal and grievance trends and recommends corrective action as necessary. The Manager coordinates, tracks, and trends internal and external appeal and grievance reports and oversees the complaint systems for L.A. Care Plan Partners, including identifying opportunities for improvement. The Manager ensures timely appeal and grievance reporting to regulatory agencies, Internal Compliance Department, internal Quality Oversight Committee, etc. The Manager collaborates with internal Departments to ensure the use of appropriate appeal and grievance issue codes, timely resolution, and refers to community partners as appropriate. Additionally, the Manager is responsible for leading internal and external audits, coordinating the collection of deliverables and responding to corrective action plans as necessary.

Manager, Clinical Appeals and Grievances

The Manager of Clinical Appeals and Grievances is responsible for managing the clinical work activities of the Appeals and Grievances Department, ensure that service standards are met and ensure adherence to established policies and procedures regarding the appeals and grievance process. The Manager supervises the Appeals and Grievances Nurse staff. The Manager meets regularly with the medical management staff with close interface with program Medical Directors in clarifying and resolving Clinical Appeals and Grievances cases, and works closely with the Director of Appeals and Grievances in communicating with executive staff, as well as other internal department contacts. The Manger maintains external contact with regulatory agencies, health networks, community based organizations, and medical groups.

Manager, Cultural and Linguistics Services

The Manger of Cultural and Linguistic Services is responsible for the management of the Cultural &Linguistic Services Unit and its programs and services. Responsibilities includes but are not limited to: 1) ensure L.A. Care and its subcontractors are compliant with state and federal regulatory agencies and NCQA standards;2) provide technical assistance to internal departments and L.A. Care subcontractors;3) improve and/or standardize departmental processes to be efficient and effective;4) oversee interpretation

and translation services and cultural competency training programs;5) develop and implement departmental policies and procedures;7) manage

departmental budget and staff;8) represent L.A. Care Health Plan at stakeholder meetings; and 9) complete other related activities as requested.

COLLABORATION THROUGH WORK GROUPS

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

Facility Site Review (FSR) Task Force

The FSR Task Force reviews issues related to facility site review and medical record review processes. The 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 scores.

PPG/Plan Partner Collaboration

In the fall of 2014, L.A. Care began regularly scheduled meetings with high-volume PPGs, Plan Partners and the Department of Health Services (DHS). The goal of these meetings is to show a united force in engaging our members, as well as improvement outcomes measured by HEDIS scores. We are focusing on HEDIS, Quality Rating Systems, and DHCS auto assignment measures. Meetings will occur, at a minimum, quarterly. Example agenda items will include prioritization of measures, barrier analysis, interventions to improve performance, and data capture/transmission.

Beginning in fall of 2016, L.A. Care began hosting webinars on QI topics for PPGs and Plan Partners. In 2018, we will increase the frequency of the webinars to monthly, focusing on important areas including HEDIS data, member satisfaction, and disparities. Additional webinars aimed at providers will offer an introduction to HEDIS and correct coding, as well as earning potential through the Physician P4P program. 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 will actively increase the engagement with the PPGs using web portal to communicate care and service gaps that are actionable.

BEHAVIORAL HEALTH COLLABORATION

Behavioral Health Services (mental health and substance use disorder) are inclusive of inpatient treatment and outpatient treatment. Services are available across all L.A. Care lines of business and are managed depending on severity of the illness, the medically necessary services and the line of business. Specialty Mental Health and substance use disorder treatment services are carved out to the Los Angeles County Department of Mental Health (DMH) and the Los Angeles County Substance Abuse Prevention & Control Program respectively. Mild to moderate behavioral health

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

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

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

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

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 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) 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 and the Quality Oversight Committee.

Board of Governors Community Advisory Committees

Executive Community Advisory Committee

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

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

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

Frequency: ECAC meets monthly.

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

Regional Community Advisory Committees and CCI Councils

There are 11 Regional Community Advisory Committees (RCAC) and four CCI Councils to help ensure that communities are involved in the design and delivery of services by L.A. Care throughout Los Angeles County. RCACs and CCI Councils 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 or CCI Council is based on the criteria approved by the Board of Governors. All RCAC and CCI Council members are appointed by the BoG.

Quorum and Voting: A majority of the RCAC or CCI Council 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 and CCI Councils are volunteers. RCAC and CCI Council 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 and CCI Council 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 or CCI Council 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 and CCI Councils 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 and CCI Council members shall set the date and time of each meeting.

Function and Role: RCACs and CCI Councils 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. Improving member satisfaction in L.A. Care’s provision of services;
2. Improving access to care;
3. Ensuring culturally and linguistically appropriate services and programs;
4. Identifying emerging needs in the community and developing programmatic responses;
5. Determining 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 wellbeing 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 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 policies

Structure: The ICC’s membership is comprised of L.A. Care staff involved in Compliance oversight and accountability activities for the organization. A quorum is established when a minimum of 50% of the membership is in attendance. The committee is chaired by the Compliance Officer or designee. All members can vote on all other committee actions/activities.

Membership includes, but is not limited to the Compliance Officer (chair), Senior Director Provider Network Management, Senior Director Member and Medi-Cal Operations, Chief Medical Officer, Senior Director Quality Improvement & Health Assessment, Director of Financial Compliance, Assistant Managing Counsel, Associate Counsel, and Privacy Officer.

Frequency: The ICC meets every other month 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:

- Monitors and oversees the compliance of L.A. Care member and provider grievance process for opportunities for improvement.
- Ensure that appropriate clinical issues are forwarded to the Quality Improvement Department when required.
- Monitor the claims payment timeliness and encounter data process of L.A. Care.

- Make recommendations to senior management to include, but not limited to, imposing appropriate sanctions, extending or renewing provider contracts, the establishing of policies, procedures, and standards, imposing additional conditions of participation, and reviewing corrective action plans for any organization that is either directly or indirectly contracted with L.A. Care.

Quality Committees

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

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

- Utilization and Complex Case Management: Utilization Management Committee
- Credentialing and Peer Review: Credentialing Committee and Peer Review Committee for Potential Quality of Care Issues (PQIs) and Facility Site Review (FSR)
- Member Rights (grievance and appeals): Member Quality Service Committee
- Quality: Quality Improvement Steering Committee
- Disease Management: Joint Performance Improvement Collaborative Committee and Physician Quality Committee
- Pharmacy Quality Oversight Committee (PQOC)
- HEDIS Steering

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

Quality Oversight Committee

Role and Reporting Relationships: The Quality Oversight Committee (QOC) is an internal committee of L.A. Care which reports to the Board of Governors through the Compliance and Quality Committee. The QOC is charged with aligning organization-wide quality improvement goals and efforts prior to program implementation and monitoring the overall performance of L.A. Care quality improvement infrastructure.

Structure: The QOC membership is comprised of L.A. Care staff who are involved in improvement activities. A quorum is established when a minimum of 50% of the

membership is in attendance. The Committee is chaired by the Chief Medical Officer or physician designee. Voting members are managers and above.

Membership includes, but is not limited to Medical Director of Quality Improvement & Health Assessment, Chief Medical Officer, Senior Director Quality Improvement & Health Assessment, Senior Director Medical Management, Senior Director Clinical Assurance, Quality Improvement Director, Senior Director Enterprise Pharmacy, Senior Director Medical Management, Medical Directors, Senior Director Healthcare Outcomes and Analysis, Senior Director Member and Medi-Cal Operations, Manager Facility Site Review, Director Utilization Management, Director Health Education, 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:

- Analyzes and evaluates the results of QI activities, identifies needed actions, and ensures follow up as appropriate.
- Review current quality improvement projects and performance improvement activities to ensure appropriate collaboration and minimize duplication of efforts.
- Formulate organization-wide improvement activities and gain support from appropriate departments.
- Review performance requirements of strategic projects and performance improvement activities to enhance effectiveness and make corrections as appropriate.
- Ensure all departments have the opportunity to align project goals and map out responsibilities and deadlines prior to project implementation.
- Ensure that QI Program activities and related outcomes undergo quantitative data analyses that incorporate aggregated results over time and compare results against goals and benchmarks.
- Ensure that root cause analysis/barrier analyses are conducted for identified underperformance with appropriate targeted interventions. Analysis will include organization staff who understand the processes that may present barriers to improve.
- Ensure that opportunities for improvement are identified and prioritized based on the analysis of performance data.
- Ensure that, on not less than a quarterly basis, the information available to the plan regarding accessibility, availability and continuity of care is reviewed and evaluated, including but not limited to information obtained through enrollee and provider surveys, enrollee grievances and appeals, and triage or screening services.
- Identify actions to improve quality and prioritize based on analysis and significance; and indicate how actions are chosen.

- Review and evaluate actions taken to determine if actions are effective in improving quality and what revisions, if any, need to be made to the actions.
- Review, evaluate, and make recommendations regarding oversight of delegated activities, such as, audit findings 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 and UM program descriptions, annual QI and UM Work Plans, quarterly work plan reports and annual evaluation of the QI and UM programs.
- Provide and/or review and approve recommended changes to the QI and UM Programs and QI and UM Work Plans' activities based on updates and information sources available.
- Review and monitor effectiveness of Cultural and Linguistic services including the Language Assistance Program.
- Ensuring practitioner participation in the QI program through planning, design, implementation and review.
- Assuring compliance with the requirements of accrediting and regulatory agencies, including but not limited to, DHCS, DMHC, CMSCMS, NCQA and Covered California.
- Developing and approving preventive health and clinical practice guidelines that are based on nationally developed and accepted criteria.
- Ensuring follow-up, as appropriate.

Recording of Meeting and Dissemination of Action

- All Quality Oversight Committee (QOC) minutes are contemporaneous, dated and signed and reflect all committee decisions made.
- Meeting minutes and all documentation used by the QOC Committee are the sole property of L.A. Care Health Plan 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 in the Quality Improvement Department.
- The minutes are available for review by appropriate regulatory and accrediting agencies but may not be removed from the premises.

The dissemination of Quality Oversight Committee (QOC) information and findings to physicians may take various forms. These methods may include but not limited to:

- Informal one-on-one meetings
- Formal medical educational meetings
- L.A. Care Newsletters
- Provider Relations and Physician Reports
- Quarterly Reports to the Board of Directors

In addition, QOC meeting minutes are submitted to DHCS quarterly.

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

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

Structure: The Joint Performance and Improvement Collaborative Committee (PICC) and Physician Quality Committee (PQC) serves as an advisory group to L.A. Care's Quality Improvement infrastructure for the delivery of health services to all lines of business in Los Angeles County. The committee reports to the QOC on findings and matters within its scope of responsibility which are presented to the QOC by the Medical Director (QIHA) or the CMO. A quorum is established with a simple majority of voting members. The Committee is chaired by the Chief Medical Officer or physician designee. Voting members are Physicians, L.A. Care staff that are managers and above, Network Physicians, Plan Partners three (3) votes each and Provider Groups 2 votes each.

Membership includes, but is not limited to, Chief Medical Officer (chair), Medical Director (QIHA), Medical Director Medicare, Behavioral Health and Care Management Medical Director, Senior Director Quality Improvement & Health Assessment, Quality Improvement Director, Senior Director Enterprise Pharmacy, Director Utilization Management, Senior Director Healthcare Outcomes and Analysis, Director Health Education, Cultural and Linguistic Services, Senior Director Provider Network Management, Senior Director Member and Medi-Cal Operations. 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. Committee members may be recommended for inclusion by current committee members. Appointments will be made by the Chief Medical Officer or Medical Director, Quality Improvement and Health Assessment.

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

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

- Review of quarterly Over/Underutilization UM stats such as inpatient bed days, ER, IHAs, etc.
- Review of quarterly Appeals and Grievances Report.
- Review and discuss quarterly delegated activity reports including audit trends.
- Review and discuss linked and carved out services for persons with complex health needs.
- Review of mandated 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.
- 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.
- Review and provide input and feedback regarding L.A. Care disease management programs.
- Provide input and feedback on services provided to our members.
- Select, evaluate, and adopt evidence based clinical practice and preventive guidelines.
- Review and analyze member and provider satisfaction survey results and access to care results and make recommendations for improvement as appropriate.
- Ensuring practitioner participation in the QI program through planning, design, implementation and review.
- Assuring compliance with the requirements of accrediting and regulatory agencies, including but not limited to, DHCS, DMHC, CMSCMS, NCQA and Covered California.
- Developing and approving preventive health and clinical practice guidelines that are based on nationally developed and accepted criteria.
- Other issues as they arise.

Recording of Meeting and Dissemination of Action

- All Joint Performance and Improvement Collaborative Committee (PICC) and Physician Quality Committee (PQC) minutes are contemporaneous, dated and signed and reflect all committee decisions made.

- Meeting minutes and all documentation used by the L.A. Care Committee structure and are the sole property of L.A. Care Health Plan 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 in the Quality Improvement Department.
- The minutes are available for review by appropriate regulatory and accrediting agencies but may not be removed from the premises.

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

- Informal one-on-one meetings
- Formal medical educational meetings
- L.A. Care Newsletters
 - Provider Relations and Physician Reports
 - Quarterly Reports to the Board of Directors

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 Medical Management Medical Director serves as the Chairperson. A quorum is established when fifty one percent (51%) of voting members are present. Only physician members and Senior Director, and Director level members of the UM committees may vote. Findings and recommendations are presented to the Quality Oversight Committee.

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

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:

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

The L.A. Care Utilization Management program document contains more detailed information pertaining to UMC responsibilities. There is also a separate Model of Care description.

Credentialing/Peer Review Committee

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

Structure: The Credentialing/Peer Review Committee addresses the credentialing and recredentialing and peer review activities for all lines of business. The Credentialing/Peer Review Committee serves as a peer review body and retains the right to approve or deny providers at all times and is the final approval of credentialing activities. The Credentialing/Peer Review Committee addresses peer review activities for all lines of business in order to assess and improve the quality of care rendered. It is responsible for overseeing quality of the medical care rendered in order to determine whether accepted

standards of care have been met by investigating and resolving potential problems brought to the PRC as potential quality of care issues or PQIs. The Chief Medical Officer (CMO) or physician designee serves as the Committee Chairperson and is responsible for all credentialing and peer review activities. A quorum is established when a minimum of three (3) physicians are present.

Membership includes, but is not limited to:

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

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

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

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

- Credentialing and recredentialing of practitioners [MD, DO, DPM, DC, DDS/DMD, and Mid-Level disciplines, such as, Nurse Practitioner (NP), Certified Nurse Midwife (CNM), Clinical Nurse Specialist (CNS) and Physician Assistants (PA), and behavioral health practitioners] as outlined in Policy CR-004.
- Conditions for altering a practitioner's relationship with L.A. Care including freezing the practitioner's assigned membership panel, suspension or termination of practitioners from the network.
- Pre-contractual and annual delegated oversight activities for credentialing and recredentialing.
- Provide feedback on specific practitioner credentials that do not meet required standards and recommendation(s) for handling such cases.
- Review and approve facilities including Hospitals, Free Standing Surgical-Centers, Home Health agencies, Skilled Nursing facilities and mental health and substance abuse facilities providing care in inpatient, residential and ambulatory settings. For Center for Medicaid and Medicare Services (CMS), facilities include the following:
 - Hospice
 - Clinical Laboratory
 - Comprehensive Outpatient Rehabilitation Facility
 - Outpatient Physical Therapy and Speech Pathology Provider
 - Ambulatory Surgery Centers
 - End-Stage Renal Disease Provider (Dialysis Unit)
 - Outpatient Diabetes Self-Management Training Provider
 - Portable X-Ray Supplier
 - Rural Health Clinic (RHC)

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

Recording of Meeting and Dissemination of Action

- All Credentialing/Peer Review Committee minutes are contemporaneous, dated and signed and reflect all committee decisions made.
- Meeting minutes and all documentation used by the L.A. Care Committee structure and are the sole property of L.A. Care Health Plan 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 in the Quality Improvement Department.
- The minutes are available for review by appropriate regulatory and accrediting agencies but may not be removed from the premises.

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

- Informal one-on-one meetings
- Formal medical educational meetings
- Quarterly Reports to the Board of Directors

Pharmacy Quality Oversight Committee

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

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

Structure: Medical Director of Medical Management serves as the Chairperson for the PQOC. Only physicians and pharmacist members have voting privileges.

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

Frequency: The PQOC meets at least quarterly.

Functions: The PQOC has the following functions:

Oversight/Advisory of PBM Vendor:

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

L.A. Care Strategic and Administrative Operations

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

Behavioral Health Quality Improvement Committee

Role and Reporting Relationship: The Behavioral Health Quality Improvement Committee is responsible for collecting and reviewing data, as well as prioritizing, developing,

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

Structure: Committee members from L.A. Care include: Medical Director of Behavioral Health and Social Services (chair), Director of Behavioral Health Services, Chief Medical Information Executive/Medical Director of Quality Improvement, Director of Case Management, Utilization Management Medical Director, Senior Director of Enterprise Pharmacy, Senior Director Quality Improvement & Health Assessment, Quality Improvement Director, and Quality Improvement, Case Management, Behavioral Health and Social Services staff.. Members from the MBHO including the: Program Director, State Director of Southern California, Quality Improvement, and Utilization Management staff from LA County Department of Mental Health and LA County Department of Public Health/Substance Abuse Prevention & Control. 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 Improvement Committee meets quarterly.

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

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

Member Quality Service Committee

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

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

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, and improve member satisfaction using CAHPS and CG-CAHPS as instruments to measure performance.
 - Define measurement.
 - Define reporting.
 - Set goals.
- Implement focused, measurable interventions. Provide input and make recommendations to L.A. Care's Quality Oversight Committee (QOC) on the state of member satisfaction on a quarterly basis.
- Review and provide thoughtful consideration of changes in its policies and procedures and make changes to policies and procedures as needed.
- The committee may choose to invite representatives of subcontracted health plans or provider groups, as needed.

Recording of Meeting and Dissemination of Action

- All Member Quality Service Committee (MQSC) minutes are contemporaneous, dated and signed and reflect all committee decisions made.
- Meeting minutes and all documentation used by the L.A. Care Committee structure and are the sole property of L.A. Care Health Plan 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 in the Quality Improvement Department.
- The minutes are available for review by appropriate regulatory and accrediting agencies but may not be removed from the premises.

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

- Informal one-on-one meetings
- Formal medical educational meetings
- L.A. Care Newsletters
- Provider Relations and Physician Reports
- Quarterly Reports to the Board of Directors

Quality Improvement Steering Committee

Role and Reporting Relationship: The Quality Improvement Steering Committee (QISC) is established by the authority of the L.A. Care Quality Oversight Committee (QOC) and through this Committee to the Compliance and Quality Committee (C&Q) 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 Senior Director of Quality Improvement & Health Assessment serves as the Chairperson for the Quality Improvement Steering Committee.

Membership includes, but is not limited to Medical Director, Quality Improvement & Health Assessment Senior Director, Quality Improvement & Health Assessment (Chair), Senior Director, Medicare Operations, Director, Quality Improvement, Director, Quality Performance Management/HEDIS, Director, Health Education & Cultural Linguistics Services, Pharmacy Clinical Programs Manager, Behavioral Health Project Manager, Access and Availability Project Manager, Project Manager(s), Quality Improvement, and Project Manager, Medicare Operations, Manager Incentives.

Frequency: The Quality Improvement Steering Committee meets monthly, 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:

- Directing the QI Workgroups and activities selected for improvement.
- Recommending workgroup policy decisions.
- Reviewing, analyzing and evaluating the Quality Improvement activities of the Workgroups.
- Ensuring adequate participation in the workgroups.

- Ensuring appropriate resources are given to workgroup activities.
- Reviewing current and prospective initiatives/interventions.
- Providing initiative/intervention approval (when necessary) and/or recommendations to QI workgroups.
- Reporting to the QOC on all activities.

Recording of Meeting and Dissemination of Action

- All Member Quality Service Committee (MQSC) minutes are contemporaneous, dated and signed and reflect all committee decisions made.
- Meeting minutes and all documentation used by the L.A. Care Committee structure and are the sole property of L.A. Care Health Plan 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 in the Quality Improvement Department.
- The minutes are available for review by appropriate regulatory and accrediting agencies but may not be removed from the premises.

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

- Informal one-on-one meetings
- Formal medical educational meetings
- L.A. Care Newsletters
- Provider Relations and Physician Reports
- Quarterly Reports to the Board of Directors

Continuing Medical Education Committee

Role and Reporting Relationship: The Continuing Medical Education (CME) Committee reports to the Quality Oversight Committee.

Structure: The Behavioral Health Department Medical Director serves as the Chairperson for the committee. A quorum is established when a minimum of three (3) physicians are present. Only physician members of the committee may vote.

Membership includes, but is not limited to Chief Medical Officer, Behavioral Health Department Medical Director, MM Medical Director, network physicians, Director of Health Education, Cultural and Linguistic Services or designee, CME Coordinator, QI Director, and up to five (5) outside physicians representing different specialties.

Frequency: The Continuing Medical Education Committee meets on an as needed basis, but as frequently 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:

- 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 CME calendar.
- Review and approve all components of each educational offering including objectives, content, budget, faculty, and evaluation.
- Provide an annual program and report including findings and recommendations to the QOC and the Board of Governors.
- Oversee the (re)application process for maintaining CME accreditation status.

SCOPE OF PROGRAM

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

The Quality Improvement Program is implemented through the multidisciplinary cooperation of departments across the entire organization. The program includes establishment of performance indicators and measurement methodologies, measurement of performance, quantitative and qualitative analysis of performance data and results, identification of improvement opportunities, prioritization of opportunities, timely implementation of strong interventions to improve performance and re-measurement to assess effectiveness of interventions.

L.A. Care’s QI Program encompasses compliance with DHCS, DMHC, CMS, NCQA and other regulatory entities to serve our population of members from Medi-Cal, Medicare Duals, and Covered California Exchange.

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

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

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

1. Assists beneficiaries in selecting plans that meet acceptable performance levels
2. Assists CMS in monitoring plan performance; and

3. Sets minimum requirements for MA plans to assess their own performance through a robust internal performance improvement program.

Population Health Management

This year, 2018, will be the first year that all of the NCQA Population Health Management (PHM) focused standards will be collected in one central PHM strategy document. What follows is a high level summary of that strategy.

The concept of population health initially gained prominence in Canada and the UK (Evans & Barer, 1994). The original aim of population health as stated by the Health Promotion and Programs Branch of Health Canada was to improve the health of populations and to reduce health disparities (Health Canada, 1998). Population health made its way to the United States with the Institute of Medicine's 1998 Publication, *Summarizing Population Health Directions for the Development and Application of Population Metrics* (1998). It was viewed as the next logical step in the practice of public health. In 2003, Kindig and Stoddart attempted to clarify the definition of population health (David Kindig & Stoddart, 2003) as "the health outcomes of a group of individuals, including the distribution of such outcomes within the group (p. 380)." This was followed by the publication of the seminal article by Berwick, Nolan, and Whittington (Berwick, Nolan, & Whittington, 2008), in which they laid out the triple aim: that health care should focus on maintaining the health of individuals, maintaining the health of populations, and lowering per capita costs.

Population Health Management (PHM) is a must have for a health plan from multiple perspectives: evidenced based quality care, regulatory requirements, and financial responsibility. The goals outlined by the Triple Aim are the model for the healthcare industry and for L.A. Care. Within L.A. Care the following department all contribute to the overall Population Health Management Strategy: Quality Improvement (QI), Health Education and Cultural and Linguistics Services (HECLS), Disease Management (DM), Care Management (CM), and Utilization Management (UM).

Health Education and Cultural and Linguistics Services (HECLS)

To maintain the health of members, both those who are healthy, and those with chronic health conditions L.A. Care maintains a comprehensive health education program. The program is publicized through IPAs and medical groups. It provides the opportunity for group level appointments with certified health educators and registered dietitians as well as individual telephonic coach and specialized counseling for members with chronic illnesses. The program also emphasizes the teaching of self-management techniques.

Disease Management (DM)

L.A. Care also focuses on maintaining the health of members with emerging disease risks. To this end L.A. Care has disease management programs for Asthma, Diabetes, and Cardiovascular disease. To identify members in need of disease management services predictive models are used that incorporate claims and encounter history. Once members are identified their initial acuity level is loaded into a care management application where disease management nurses can refer to it and update it based on their interactions with the members. Members who meet criteria are also referred to the interdisciplinary care team

(ICT) who works with the member and their providers to develop an individualized care plan (ICP). In addition to members identified through the predictive model members are also referred to the program through the nurse advice line, disease manager referrals, UM prior authorization or concurrent nurses, hospital discharge planners, PCPs, and member or family.

Care Management (CM)

Members are assigned to risk groups by a predictive model. Once members are assigned to risk groups an individualized care plan (ICP) in coordination with the member is developed for high and complex risk members. An automated version of the care plan is created first based solely on Health Risk Assessment (HRA) responses, and then updated by members of the care team. Text notes are added to the care management application Clinical Care Advanced (CCA). Health Appraisal or clinical care gaps are included in the member profile if added by the care team. For moderate and low risk members delegated to PPGs, a care plan is encouraged for moderate risk, but only a consideration for low risk. Once members are identified as candidates for care management they are sent a welcome letter describing care management, introducing the case manager and the idea of the interdisciplinary care team management concept.

Utilization Management (UM)

For those who need authorizations for claims or higher-level products and services, utilization management (UM) is done for the directly contracted providers through the L.A. Care UM department and CCA. Currently a phone call or fax is the initiation step for a “case” and authorization techs generate the case for review within CCA. CCA has been set up to include clinical decision support for UM. The clinical decision support provided is through MCG. While MCG is currently only available internally, L.A. Care intends to make this a part of a future upgraded provider portal that will include electronic authorization capabilities.

Conclusion

In summary, Population Health Management is L.A. Care’s charge and responsibility. NCQA accreditation and our reputation hinge on the effective population and directed medical management that can only be achieved with the marriage of people, process and technology.

We must address this core area of our business. There are multiple options for better ways to achieve a high tech, high touch workflow process, and gain efficiency and staff, network and member satisfaction and engagement at the same time. Much work has already been to identify specific areas and methods for improvement.

Quality of Care

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

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

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

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

HEDIS

L.A. Care measures clinical performance related to Healthcare Effectiveness Data and Information Set (HEDIS) and External Accountability Set (EAS) indicators. HEDIS data is audited by an NCQA – approved external auditor.

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

Medicare Measurement and Reporting Requirements

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

Chronic Care Improvement Programs (CCIP) - Medicare

The objective of L.A. Care's Chronic Care Improvement Program (CCIP) is to improve the health status of its eligible members at risk for chronic heart conditions. The program achieves this objective by educating the member and by enhancing the member's ability to self-manage his or her condition or illness or implement risk reduction lifestyle and clinical changes. CCIPs are developed from evidenced-based clinical practice guidelines and support the practitioner-patient relationship, the plan of care as well as foster patient empowerment. The CCIP was selected based on an analysis of internal data relating to disease prevalence within the L.A. Care population, in addition to CMS requirements to align with the Centers for Disease Control and Prevention and Centers for Medicare and Medicaid Services' Million Hearts® Initiative. This is a national initiative that set an ambitious goal to prevent 1 million heart attacks and strokes by 2017.

At a minimum, the CCIP addresses the following components:

- Multiple data sources and QI processes are used to identify need for CCIP. Identifying enrollees who meet the criteria for participation in the program monthly.
- The CCIP demonstrates a rigorous enrollment method that reaches a significant segment of the targeted population while exhibiting robust participation in the program. Participation in the program is measured annually by member participation rates.
- Condition monitoring, patient adherence to the program's treatment plans, consideration of other health conditions and lifestyle issues as indicated by clinical practice guidelines. Interventions reach a significant segment of the targeted population, impact multiple aspects of problem, and address health literacy/cultural needs of members.
- Use of nationally recognized clinical guidelines that are reviewed at a minimum of every two years unless the guidelines change earlier.
- Member interventions are based on stratification.
- Systematic program monitoring is integrated into the program; program progress of enrollee is reviewed at least annually and opportunities for improvement are addressed. At least one performance measure for each program is tracked. Specific, appropriate outcome/performance measures are provided.

Chronic Care Improvement Plan (CCIP):

- Cardiovascular Disease (Cal MediConnect)

Quality Improvement Projects (QIPs)

L.A. Care conducts Quality Improvement Projects (QIPs) in compliance with the Department of Health Care Services' (DHCS), The National Committee for Quality Assurance (NCQA) and the Centers for Medicare and Medicaid Services (CMS) requirements. Per guidance of these entities, QIPs may include small group or state wide collaboratives with other contracted managed care plans as required. CMS requires that Medicare Advantage Organizations maintain one active QIP project. In 2015, DHCS transitioned from QIPs to rapid cycle Performance Improvement Projects (PIPs) to meet the QIP requirements.

QIPs and PIPs are initiatives focused on one or more clinical and/or non-clinical areas with the aim of improving health outcomes and beneficiary satisfaction. QIPs are generally conducted over a three-year period. PIPs are general conducted over an 18 month period but may change at the discretion of CMS or DHCS (for more details regarding PIPs, see below PIP section).

L.A. Care continuously reviews its performance on a variety of dimensions of care and services for enrollees and in doing so, identifies areas for potential improvement, carries out individual projects to undertake system interventions to improve care, and monitors the effectiveness of those interventions.

An individual QI project developed in support of CMS requirements involves the following:

1. An aspect of clinical care or non-clinical services is identified and the members who would benefit from participation in the QIP. Target population is appropriate to the topic and is clearly defined, with clear numerator, denominator, and exclusion criteria. Topic is relevant, important, and developed with a strong QI data-driven process.
2. The QIP outlines robust indicators that are objective, clearly and unambiguously defined, based on current clinical knowledge, and measurable. Data sources and collection methodology is valid and reliable. Specification of clearly defined objectives and quality indicators to measure performance are selected including, but not limited to, changes in health status, functional status, enrollees satisfaction, and valid processes for these and/or other outcomes.
3. Collection of baseline data.
4. Identification and implementation of appropriate system interventions to improve performance. Intervention reaches a significant segment of the targeted population and beneficiary participation is robust. Realistic interventions address multiple aspects of the problem, based on root cause analysis.
5. Repeated data collection occurs to evaluate the continuing effect of the interventions and determine the need for further action and/or modifications.
6. Goal of significant, sustainable improvement.

Because the key QI project components are interdependent, failure on any one of them affects the overall project. Documentation of a completed project will provide evidence of compliance with each component.

In some instances, CMS may require a particular QIP that is specific to the organization. There may be instances in which CMS believes that some aspects of care require greater emphasis, either because of the organization's relationship to populations with special health care needs or because the organization's performance is in need of greater improvement in some areas than in others. This type of project may be required in response to a remedial or corrective action request or if a previous QIP did not meet CMS' expectations.

Quality Improvement Project (QIP):

- All Cause Readmissions (Cal MediConnect)

DHCS Mandated Improvement Projects

Performance Improvement Project (PIP)

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. The quality and performance improvement projects are focused and designed to improve the health of L.A. Care members. L.A. Care conducts at least three state-mandated Rapid-cycle Performance Improvement Projects (PIPs); two contract-required PIPs for Medi-Cal and one PIP for Cal-MediConnect. In addition to the PIPs, improvement projects are undertaken with External Accountability Set (EAS) measures below the Minimum Performance Level (MPL) in any given reporting year; these are referred to as Plan-Do-Study-Act (PDSA) cycles that are evaluated quarterly and documented and submitted on PDSA cycle worksheets. L.A. Care is responsible for ensuring delegates comply with all applicable state and federal laws and regulations and other contract requirements as well as DHCS's guidance, including 'All Plan Letters' for quality and performance improvement requirements.

Plan-Do-Study-Act (PDSA)

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

Performance Improvement Projects (PIPs)

For Medi-Cal, L.A. Care chooses the first PIP topic from one of four state-selected topics related to the Medical 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. The Cal MediConnect PIP chosen by L.A. Care addresses an area related to Long Term Support Services (LTSS)/Care Co-ordination. L.A. Care chooses PIP topics in areas that have a demonstrated need for improvement such as an area in which the corresponding HEDIS measure had a rate that was below expectations. Plan specific data is used to narrow the focus on the topic to address the area in need of improvement (i.e. high-volume, low performing providers; a focused population). Rapid-cycle PIPs are conducted over a 12-18 month period and require the submission of five modules to the Health Services Advisory Group (HSAG) with modules 1-3 requiring validation by HSAG before the PDSA in Module 4 can be conducted. L.A. Care participates in quarterly collaborative meetings facilitated by HSAG to obtain technical assistance on evidence-based strategies and quality improvement science and to collaborate on improvement strategies.

Modules 1-5

1. PIP Initiation
2. SMART Aim Data Collection
3. Intervention Determination
4. Plan-Do-Study-Act
5. PIP Conclusions

PIPs and PDSAs

Performance Improvement Projects (PIPs):

- Childhood Immunization Status (CIS-3) Improving Immunization Adherence of Two Year Old (Medi-Cal)
- Medication Management for People with Asthma (MMA) (Medi-Cal)
- Managed Long Term Support Services (Cal MediConnect)

Plan-Do-Study-Act (PDSA) Cycle Worksheets:

- Prenatal Care (Medi-Cal)
- Postpartum Care (Medi-Cal)

Patient Safety

L.A. Care is committed to improving patient safety and promoting a supportive environment for network practitioners and other providers to improve patient safety. Information about safety issues is received from multiple sources including member and practitioner grievances, adverse issues, pharmacy data such as polypharmacy, facility site reviews, continuity of care activities, and member satisfaction survey results. Many of the ongoing QI Program measurement activities, including measures for accessibility, availability, adherence to clinical practice guidelines and medical record documentation include safety components. When performance is analyzed for these measures, patient

safety is considered, opportunities are identified and prioritized and actions taken to improve safety.

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

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

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

Potential Quality Issue (PQI) reviews:

Potential Quality of Care Issue (PQI) cases are referred to the Quality Improvement (QI) Department for clinical evaluation, investigation, resolution, and tracking. The QI nurse conducts the initial clinical review of all PQI referrals. PQI severity level 0/no quality of care, level 1/appropriate quality of care, and/or quality of service cases are closed and tracked by QI nurse/s. All other quality of care issues with severity level 2/borderline quality of care and above are reviewed by QI Medical Director. PQI cases with severity level 3/moderate quality of care or 4/serious and/or significant quality of care are subsequently presented to the Peer Review Committee for review, assignment of final severity level, action, and resolution as needed. Closed PQI cases are tracked and trended on a quarterly basis for timeliness of acknowledgement and resolution, issue type, provider type, and severity level assignment. The committee will identify potential interventions and measure(s) to address opportunities for improvement.

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

L.A. Care has established medical record standards to facilitate communication, coordination and continuity of care, and to promote safe, efficient and effective treatment. L.A. Care monitors PCP medical record documentation. A medical record review is completed every three years for each practice site to evaluate compliance with medical record standards. A follow up audit can be conducted for those PCP sites that do not meet acceptable standards as determined by the certified site reviewer.

Guidelines for Care – Clinical Practice and Preventative Health Guidelines

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

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

Clinical Practice and Preventive Health Guidelines may be monitored through Healthcare Effectiveness Data Information Set (HEDIS®) measures, medical record review process, or other measures as appropriate. L.A. Care annually measures at least two important aspects of at least two Clinical Practice Guidelines for medical conditions; and at least two Clinical Practice Guidelines for behavioral conditions, with at least one behavioral condition addressing children and adolescents; and two Preventive Health Guidelines.

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). Periodicity schedules for health assessment and dental referrals by age are provided by the California Department of Health Care Services for members up to age 20 years.

Adult and child immunizations are provided in accordance with Immunization schedules approved by the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), the American Academy of Family Physicians (AAFP), and the American College of Obstetricians and Gynecologists (ACOG). Perinatal Prenatal services are provided in accordance with the AAP and ACOG Guidelines for Perinatal Care.

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

Clinical Practice Guidelines

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

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 Improvement Committee quarterly meetings. For Medi-Cal members, L.A. Care is responsible for the delivery of behavioral health services to members with mild to moderate levels of behavioral health conditions and L.A. Care collaborates with the primary care physician network to equip them to diagnose and treat behavioral health conditions with mild to moderate levels of functional impairment. The L.A. County Department of Mental Health (LACDMH) is responsible for providing services to Med-Cal members with severe and persistent mental illness and moderate to severe levels of functional impairment. For its overall insured population, L.A. Care shall adopt at least two behavioral health guidelines, one of which addresses children and adolescents.

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.

Disease Management Programs

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

- Systematic identification and stratification of members who qualify for programs monthly through sources including claims or encounter data, pharmacy data, health appraisal results, laboratory results if applicable, data collected through the UM or

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

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

L.A. Care's Utilization Management activities are outlined in the Utilization Management Program Description, which includes persons with complex health conditions. The UM Program Description defines how UM decisions are made in a fair and consistent manner.

There is a Case Management Program Description and a Complex Case Management Program Description. There is also 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 (SPDs) and/or multiple chronic conditions. There is one staff person dedicated to working with “linked and carved out services” such as the Regional Centers, California Children Services (for children with complex health care needs) and the Department of Mental Health. The UM Program Description is approved by the UMC and QOC. For additional information, refer to the UM Program Description.

Transition of Care Programs

As part of the UM process, PPGs must maintain a process to manage discharges through a Transition of Care (TOC) program. The TOC program should evaluate members at the time of the admission to identify members “at risk” for an adverse or complicated transition. L.A Care and its PPGs may utilize a screener to identify the most appropriate interventions for the program. Levels of the program should include at a minimum, activities to address high scores indicating possibility of post-acute problems, moderate/low scores and One Day admissions.

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

As contracting models have evolved to include more extended delegation, L.A. Care will be working to develop monitoring capabilities to make sure that transition of care activities at the PPG level occur seamlessly.

For L.A. Care Direct Line of Business Members, L.A. Care will continue to be responsible for providing TOC services directly. The L.A. Care-provided TOC Program will be reviewed and enhanced during 2018 to meet the needs of these members as well as the providers in this network.

Cal MediConnect Model of Care (MOC)

L.A. Care officially launched Cal MediConnect (CMC) in April 2014 and currently has approximately 16,000 dual eligible members enrolled in the demonstration. . Enrollment for prior years as follows (approximate): 2016 - 12,000, 2017 - 15,000. The initial Model of Care developed as part of the CMC readiness review process was approved for the length of the demonstration (through 12/31/17). This version was closely based on the D-SNP Model of Care and the associated population. The 2018 Model of Care for renewal was approved with a score of 100% and for a three-year period.

Medicare Operations conducts a review annually and updates the document to reflect new guidance to ensure the document is an accurate portrayal of the current CMC population

and program. The most impactful change to the Model of Care is the revised template which now contains four sections:

1. Description of the Population
2. Care Coordination
3. Provider Network
4. MOC Quality Measurement and Performance Management

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

Medicare Operations, Clinical Assurance, and Care Management, working collaboratively, identify and monitor the most vulnerable members of the population by implementing the model of care program which includes the quality improvement activities designed for these individuals. The program includes a description of how L.A. Care evaluates the effectiveness of its model of care program including methodology and specific performance outcomes that demonstrate improvements. L.A. Care maintains documentation on the evaluation and makes it available to CMS as requested and during onsite audits. The Care Management department determines what actions to take based on the results of the model of care evaluation. For additional information, see the MOC program description.

The MOC details the key components of the Cal MediConnect program, including Interdisciplinary Care Team (ICT), Health Risk Assessment (HRA), and Individualized Care Plan.

Pharmacy Management

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

Additionally, L.A. Care participates in the Part D Medication Therapy Management (MTM) program, which examines multi-drug therapy for specific chronic conditions. The MTM program can be used to satisfy the requirements under Medicare and Medicaid that pertain to assessing the quality and appropriateness of care and services, as outlined in 42 CFR §438.204, §438.208, §438.240, and §422.152.

L.A. Care Health Plan's MTM program is contracted out to SinfoniaRx to perform medication reviews for our members, which include the following services: Comprehensive Medication Reviews (CMR) and Targeted Medication Reviews (TMR). CMRs occur at least annually to identify any duplications or conflicts with their medications, prescriber consult to resolve any problems found with the medications, over-the-counter consult to resolve minor ailments, and drug information on any new medication. Members are also provided with a Medication Action Plan (MAP) and a Personal Medication List (PML) after completing their CMR. TMRs, which occur at least quarterly, will review the member's prescription medications and contact the member and/or prescriber by phone or mail if a potential pharmacotherapy concern is detected. L.A. Care collects data from SinfoniaRx, analyzes the data and reports MTM measures to CMS. In addition, L.A. Care ensures the accuracy of the MTM measures and determines what actions to take based on the results of the MTM measurements.

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.

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 reports regularly to the Quality Oversight Committee with an update from the Credentialing Committee.

Quality of Services

Member Satisfaction

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

Quality Service Committee, the Joint PICC & PQC, the QOC, and Compliance and Quality Committee.

Provider Satisfaction

L.A. Care monitors provider satisfaction with L.A. Care on relevant health programs, services, and processes. The annual provider satisfaction survey also includes open-ended questions related to service improvements. To assess provider satisfaction we monitor provider grievances and conduct provider satisfaction surveys. The survey questions focus on L.A. Care's practitioner service areas, such as, overall satisfaction, access to specialists, utilization management, credentialing, contracting processes, and coordination of care between PCPs and hospitals, home health, pharmacy services, and free standing surgical facilities. The survey is fielded annually for all lines of business and includes primary care physicians, specialty care physicians, community clinics, hospitals, and Provider Groups. Results are presented to the Member Quality Service Committee, the Joint PICC & PQC, the QOC, and Compliance and Quality Committee.

Complaints and Appeals

Complaints including those related to Cultural and Linguistic issues and appeals are tracked and trended on a quarterly basis for timeliness of acknowledgement and resolution, issue types, and by provider type. The quarterly report is presented and reviewed by the Member Quality Service Committee, the Credentialing Committee, and the QOC. Committees will identify potential interventions and measure(s) to address opportunities for improvement.

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

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

Availability of Practitioners

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

In creating and developing our delivery system of practitioners, L.A. Care takes into consideration assessed special and cultural needs and preferences of our members. L.A. Care establishes availability of primary care, specialty care, hospital based and ancillary Practitioners 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 each member to a Practitioner within five miles of their home unless specially requested by the member or family.
- Referring each member to a specialist within (15) fifteen miles of their home unless specially requested by the member or family.
- Ensuring a database is in-place which analyzes practitioner availability and 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.
- Providing members with transportation as needed.
- Providing member requests of special cultural and language needs.
- Annually reviewing and measuring the effectiveness of these standards through specialized studies.

Accessibility of Services

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

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

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

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

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

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 health care 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 disease management programs, chronic care improvement programs, health education opportunities, and Regional Community Advisory Committee events. Educational materials are available through the Health Education, Cultural and Linguistic Services Department. Materials are developed to address the cultural and linguistic needs of L.A. Care's diverse population. QI program updates and improvements in care management resulting from its overall quality improvement program are also posted for all stakeholders on the website. Members are notified of the information that is available on the L.A. Care website and may use this site and/or call customer solutions center to request paper copies of information available on the website. The Regional Community Advisory Committees also provide a means to facilitate member participation in the Quality Improvement program.

Effective July 1, 2015 L.A. Care will offer the availability of telephonic and/or digital access to the following services for all product lines.

- Electronic Health Appraisal
- Self-Management Tools
- Functionality of Claims Processing
- Pharmacy Benefit Information
- Personalized Information on Health Plan Services
- Member Support through Innovative Technologies (eConsult, prescribing, scheduling, etc.)

- 24 Hour Health Information Line including Interpreter Services
- Encouraging Wellness and Prevention

Provider and Practitioner Communication

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

Provider Incentive Programs

L.A. Care's Quality Improvement (QI) Department operates pay-for-performance incentive programs for providers to improve HEDIS, CAHPS, access and availability, auto-assignment, NCQA accreditation, and member care. Incentive programs provide a highly visible platform to engage providers in quality improvement; provide peer-group benchmarking and actionable performance reporting; and deliver performance-based revenue above capitation. Incentives for physicians, community clinics, PPGs, and health plan partners are aligned where possible so that all providers pursue common performance improvement priorities.

2018 marks the eighth 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 receive annual incentive payments for outstanding performance and improvement on multiple HEDIS measures. Starting in 2017, performance on access and availability surveys determined the amount of incentive payment providers will receive.

In 2016, L.A. Care launched the Value Initiative for IPA Performance (VIIP) to hold L.A. Care's Medi-Cal PPGs accountable for member care using a multitude of industry standard metrics. Starting in 2017, VIIP was merged with LA P4P to provide a stronger platform and alignment for quality improvement. 'VIIP+P4P' continues in 2018 and measures, reports, and provides financial rewards for provider group performance across multiple domains, including clinical quality, access and availability, utilization, encounters and patient satisfaction. The goal of the program is to improve the quality of care for L.A. Care members by supporting the development of a robust network of high performing PPGs. Encounter data submission remains a vital component of the VIIP+P4P program as demonstrated by the encounter data volume payment gates. The encounter data gating methodology will be used to adjust incentive payments based on each provider group's level of encounter data submission, which reinforces the organization's efforts to increase administrative data capture. The program also actively engages with IPAs to develop 'Action Plans' focused on setting SMART Goals and improving performance.

L.A. Care's incentive program for health plan partners will be redesigned in 2018 to more closely mirror the VIIP+P4P program. The program will continue to measure and reward plan partners for performance on essential HEDIS measures, with the potential addition of access and availability, member satisfaction, encounter timeliness and utilization domains.

SALES AND MARKETING

L.A. Care provides support to multiple initiatives throughout the organization utilizing the services of the in-house Sales and Marketing Department, Health Plan Field Representatives, Community Outreach and Education Representatives, Health Educators and the Family Resource Centers Representatives. Marketing staff participates in workgroups to collaborate and develop collateral materials in formats, languages and reading levels to support member and consumer understanding of the benefits, programs and services that they are eligible for. Marketing staff are aligned by product lines; health plan initiatives and the recently expanded Family Resource Centers. Centers are now open and operating in Lynwood, Inglewood, Boyle Heights, Pacoima and Palmdale. Family Resource Centers provide free health education and healthy living services in underserved communities. Community and member awareness messaging and campaigns are developed and implemented throughout L.A. County in the form of marketing, outreach educational events and advertising on health and insurance programs specifically targeted to communities where access to quality health care is limited.

The Health Plan Field Representatives, Community Outreach and Education Specialists, Family Resource Center Representatives and Health Educators conducts, product presentations, outreach educational and marketing events to extend the opportunity for consumers and members to learn more about Medi-Cal, Cal MediConnect, and the Covered California Marketplace. Community based educational events, health fairs and open house events are prescheduled and are posted on L.A. Care's web site and promoted through social media to provide members and non-members with information on the conveniently located events that are conducted throughout L.A. County.

Additional education outreach is provided to Enrollment Entities & their down-line Certified Insurance Agents (CIAs) and Certified Enrollment Counselors (CECs) to educate and update them on the programs that L.A. Care members receive as well as eligibility for L.A. Care's product lines including Medi-Cal, Cal MediConnect and L.A. Care Covered. L.A. Care continually seeks opportunities to improve provider awareness and secure their commitment to L.A. Care through participation in joint operational meetings, physician quality improvement programs, incentive programs, provider marketing in-services and campaigns, health educational events and building and maintaining effective relationships. The target focus of the provider outreach is for L.A. Care contracted providers who serve low-income seniors and people with disabilities.

Member-focused newsletters are distributed to our members four times a year (including our health plan partners' Medi-Cal enrollment) that focuses on (a) helping members navigate the managed Medi-Cal system to obtain care; (b) understanding the benefits and services available. Two newsletters are utilized to better focus the content based on the need to communicate to young and building families as well as the aging and disabled

members that we serve. *Be Well* addresses the interests of young and building families and *Live Well* is designed to address the interests of aging and disabled members.

L.A. Care offers a variety of benefit and health education information on its primary website, www.lacare.org. Additionally, members can access personal health information and perform tasks such as changing a doctor, reprinting ID cards, paying a premium or checking a claim through L.A. Care Connect, our secure online member account.

QUALITY IMPROVEMENT PROCESS AND HEALTH INFORMATION SYSTEMS

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

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

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

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

Performance goals are established for each indicator. Performance goals may be based on historical performance, normative data, standards, goals, or benchmarks. Benchmarks are known best level of performance set by industry organizations. The initial performance

goal for a new indicator is often to “obtain baseline data.” Some indicators, although they have acceptable sustained performance with acceptable variation, will always be measured because of the importance of knowing that performance is maintained or because of reporting requirements. Efforts to further improve performance may require systemic changes that are not considered feasible. The performance goal in these instances may be to sustain the same level in subsequent measurement cycles. Other indicators may be removed from the process because they provide data considered less valuable than alternative uses of the resources involved.

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

- Population Information – data on enrollee characteristic relevant to health risks or utilization of clinical and non-clinical services, including age, sex race, ethnicity, language and disability or functional status.
- Performance Measures – data on the organization’s performance as reflected in standardized measures, including when possible Local, State or National information on performance of comparable organizations.
- Other utilization, diagnosis and outcome information - Data on utilization of services, cost of operations, procedures, medications, and devices; admitting and encounter diagnoses, adverse incidents (such as death, avoidable admission or readmission and patterns of referrals or authorizations requests).
- Information demonstrating L.A. Care has a fiscally sound operation.
- Analysis of opportunities from results of standard measures.
- External data sources – data from outside organization, including Medicare or Medicaid fee-for-service data, data from other managed care organizations and local national public health reports on condition or risks for specified populations.
- Enrollee Information on their experiences with care to the extent possible, to developments in their health status. Data from surveys (such as, Health Outcomes Survey (HOS), the Consumer Assessment of Health Plans and Provider Systems or CAHPS), information from the grievance and appeals processes, and information on disenrollments and requests to change providers. (Note that general population surveys may under represent populations who may have special needs, such as linguistic minorities or the disabled. Assessment of satisfaction for these groups may require over sampling or other methods, such as focus groups or enrollee interviews). In addition to information generated with the organization, the QI Program assesses information supplied by purchasers, such as data on complaints.
- Availability, accessibility, and acceptability of Medicare approved and covered services.
- Measures related to behavioral health, care coordination/transitions, and MLTSS, as required.
- Data elements from CMS Part C & D reporting.
- Other information CMS may require.

L.A. Care (Provider Network Management Department) ensures that information and data received from providers are accurate, reliable, 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 an appropriately times and recurring schedule. Multiple data points are displayed together on graphs to show historical performance and facilitate analysis and trending. Each review includes quantitative and qualitative, and when possible causal analysis. Evaluating the effectiveness of previous interventions is included and influences the next step in planning.

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

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

The L.A. Care QI Department works with cross-functionally 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 multiple members, providers, and services.

Interventions to improve performance include health promotion and health education programs, to inform members of ways to improve their health or their use of the health care delivery system. Process modifications to administrative processes are used to improve quality of care, accessibility and service. Great efforts are focused on modifications to the provider network, such as, additions of pertinent and high performing providers and facilities to improve accessibility and availability. Other processes may include adjustments to customer services, utilization and case management activities, models of care, preventive services and health education. Interventions to improve provider performance may include presentation of provider education programs, individual provider feedback on individual and aggregate performance and distribution of best practice material.

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

Performance Target

The terms benchmark and performance targets are not necessarily one and the same. LA Care uses Nationally Recognized benchmarks to measure for improvements (i.e. NCQA benchmarks and thresholds, DHCS set benchmarks, CMS or other regulatory). Recognized benchmark may be a performance target, but sometimes there is not an established or available benchmark for a particular indicator. If this is the case, 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 calculated using a statistical “P” value of <0.05. L.A. Care measures a 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. The CMS assumes a 3-year cycle for most MA organizations to reach demonstrable improvement. A significant change can be measured over several years of interventions and measurement.

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

Meaningful Improvement

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

Sustained Improvement

Sustained improvement is defined as reaching a prospectively set benchmark and sustaining that improvement.

Whenever possible L.A. Care should select indicators for which data are available on the performance or 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 or identifying

the target population and or selecting individual cases for review must be used for both measurements.

The repeat measurement should use the same methodology and time frames as the baseline measurement, except that, when baseline data was collected for the entire population at risk, the repeat measurement may use a reliable sample instead.

MEMBER CONFIDENTIALITY

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

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

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

CONFIDENTIALITY

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

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

DISEASE REPORTING STATEMENT

L.A. Care complies with disease reporting standards as cited by the California Code of Regulations, 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 www.lapublichealth.org/acd/cdrs.htm and via a link on the L.A. Care website at www.lacare.org.

QI DELEGATION

L.A. Care has written service agreements with delegated Plan Partners, Specialty Health Plan, and External Entity to provide specific health care services and perform other delegated functions. L.A. Care requires and ensures that each delegate maintain adequate processes, is appropriately and adequately staffed and complies with applicable standards and regulatory requirements. Specific elements of the QI program may be delegated. However, L.A. Care retains accountability and ultimate responsibility for all components of the QI Program. All components of the QI process, maintained by delegates, will be made available to L.A. Care at the time of scheduled oversight audits. Oversight audit results are reviewed, opportunities for performance improvement are identified and reported to the delegate and corrective action plans are required to address deficiencies. As appropriate, follow up to assess compliance occurs approximately six (6) months following the evaluation. In addition, L.A. Care provides ongoing monitoring through substantive review and analysis of delegate reports and collaboration with delegate to continually assess compliance with standards and requirements.

Center for Medicare & Medicaid Innovation (CMMI) Funding Opportunity: Transforming Clinical Practice Initiatives (TCPI) Los Angeles Practice Transformation Network (LAPTN)

Los Angeles Practice Transformation Network (LAPTN) is one of 39 health care collaborative networks selected by CMS in 2015 to participate in the national Transforming Clinical Practice Initiative (TCPI). LAPTN receives up to \$15.8 million over four years to help L.A. County clinicians improve care for patients with diabetes and/or depression, transform their practices, and lower costs.

Through multiple Network Partners, LAPTN provides 3,200 L.A. County clinicians with onsite and remote support to help them more effectively treat patients at high risk for hospitalization, optimize transitions to community care settings after acute hospitalization, increase frequency of medication reconciliation, and improve patient medication education and management in all care settings.

By the end of 2019, LAPTN aims to achieve seven main goals:

1. Partner with 3,200 clinicians to transform to value-based care
2. Work with 90% clinicians focusing on medically underserved and disadvantaged
3. Generate cost savings of \$60M
4. Improve health outcomes for approximately 81,000 patients
5. Reduce unnecessary hospitalizations
6. Reduce unnecessary testing and procedures to improve efficiency
7. Build evidence base to scale effective solutions

TCPI is one of the largest federal investments uniquely designed to support clinician practices through nationwide, collaborative, and peer-based learning networks which facilitate large-scale practice transformation. TCPI provides \$685 million to national and regional health care networks and supporting organizations to help equip more than 140,000 clinicians with tools and support needed to provide better care, increase patients' access to information, and reduce costs. These awards are part of a comprehensive strategy to enable new levels of coordination, continuity, and integration of care, while transitioning volume-driven systems to value-based, patient-centered, health care services.

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

L.A. Care delegates responsibility for specific functional activities for the delivery of care and service to its members to IPA/PPGs. **L.A. Care does not delegate Quality Improvement activities to contracted IPA's and Medical Groups.** L.A. Care maintains accountability and ultimate responsibility for the associated activities by overseeing performance in the following areas: Utilization Management, Credentialing, Quality Improvement, Culture and Linguistics and Health Education. Delegated functions include, but are not limited to: preventive health services, health education activities, clinical practice guidelines, and access standards. Non-delegated functions include clinical studies, clinical grievances, appeals, HEDIS/QIP studies, facility site/medical record reviews, access studies, Health Education materials development and review, member and practitioner satisfaction surveys. Delegated IPAs will be expected to have a functioning quality improvement program in place. Care1st retains the right to revoke any delegated function if compliance with standards are not met.

ANNUAL QI PROGRAM EVALUATION

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

ANNUAL QI WORK PLAN

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

The QI Work Plan includes a description of:

- The QI program scope including quality of clinical care, service, and safety of clinical care.

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

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

Endnotes:

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