Quality Improvement Program
All Lines of Business
2019

Quality Oversight Committee approval on	***2/25/19***
Compliance and Quality Committee approval on	***3/21/19***

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MISSION

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

VISION

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

VALUES

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

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

PURPOSE

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

STRATEGIC PRIORITIES (2018-2021)

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

Goal 1.1:
Members and providers get what they need from L.A. Care, accurately and consistently.

Objectives:

- Document and integrate health services processes.

- Maintain focus on VOICE, Total Provider Management, enrollment reengineering, claims/authorization stabilization, and IT architecture.

Goal 1.2:
Member across all products receive all the benefits they are entitled to, accurately and consistently.

Objectives:
- Refine and maintain benefit grids.
- Use product segment data to analyze trends and design interventions to optimize health and utilization.

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

Goal 2.1:
Develop a contracting strategy with rates that support access to high-quality, cost-efficient care.

Objectives:
- Conduct pricing analysis for hospital recontracting efforts.
- Develop actuarially sound PCP and SCP value-based pricing methodologies.
- Define provider network requirements by product.
- Analyze and report monthly hospital utilization changes.

Goal 2.2:
Administer benefits at the level that ensures the best outcome, whether through high quality delegated providers or directly.

Objectives:
- Optimize oversight of delegated functions.
- Factor VIIP scores into member assignment and network composition.

Goal 2.3:
Build foundational capabilities to support expansion of L.A. Care Direct Network.

Objectives:
- Add primary and specialty providers to the direct network.
- Improve administrative and health services support to enable the direct network to scale up.
- Convert contracts to capitation when membership reaches 500.

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

Goal 3.1:
Understand our member needs so we can respond more meaningfully and plan for the future.

Objectives:

- Implement Member360 analytics.
- Develop a view of the member by product segment to assess needs, utilization, and costs.

Goal 3.2:
Address memebers' unmet social needs and make care accessible in the right way, at the right place, at the right time.

Objectives:

- Implement care management platform, and integrate with other health services functions over time.
- Implement alternative approaches for urgent care, offsetting ED utilization.
- Expand care management at Family Resource Centers.
- Assess members' social needs that affect health and establish pathways to programs and resources that meet those needs.

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

Goal 4.1:
Be a local, state, and national leader to advance health and social services for low income and vulnerable communities.

Objectives:

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

Goal 4.2:
Implement initiatives that improve the health and wellbeing of those served by safety net providers.

Objectives:

- Implement the Elevating of the Safety Net initiative.
- Launch Family Resource Centers in every RCAC region.
- Implement Health Homes.

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.

The following product lines are 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 Direct Network

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

To respond to those challenges, L.A. Care contracted directly with primary care physicians and specialists in that area who are accessible to Medi-Cal members who elect to join the "L.A. Care Direct Network" (LADN, formerly referred to as the "Community Access Network"). Due to the relative success of using the direct contracting approach in Antelope Valley, L.A. Care decided to expand the model throughout Los Angeles County. L.A. Care is implementing the Direct Network throughout the County. These providers benefit from having a direct relationship with L.A. Care, and have the opportunity to serve members beyond just those assigned to them by the provider group(s) with which they are contracted.

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. As well, they have a specific focus for Practice Transformation through a program called, "TransformLA".

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.

As of December 1, 2018, there are 7,793 L.A. Care members under the age of 19 who are currently active that have been determined eligible for 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 some of 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
- Promoting provider quality performance and ongoing quality improvement
- Access to Centers of Excellence
- Hospital quality and safety
- Appropriate use of C-sections
- Reducing health disparities
- Promoting the development and use of care models in primary care
- Promoting the development and use of care models: Integrated Healthcare Models
- Patient-centered information and communication
- Patient-centered information: cost transparency

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

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

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.

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, 2019. 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, provider and staff inquiries and makes referrals to other L.A. Care programs and community resources. The MLTSS clinical teams (LTC and CBAS) are part of Case

Management's interdisciplinary care team (ICT) and also engage with providers and members during routine facility visits.

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

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] (http://www.healthcare.gov/news/factsheets/2012/04/national-quality-strategy04302012a.html)

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

Objectives:

- Improve access to high quality care for all covered lives
- Improve NCQA accreditation scoring and 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 California Maternal Quality Care Collaborative (CMQCC) and California Health Care Foundation (CHCF) to help them meet or exceed the national goal of 23.9%

Goal – Improve Member Satisfaction:
Improve member satisfaction with the care and services provided by L.A. Care's network of providers and identify potential areas for improvement through review of multiple sources of data including evaluation of member 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 the Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG CAHPS) data with provider groups, instruct them how to interpret the results and promote member experience interventions and best practices among Participating Physician Groups (PPGs), Management Services Organizations (MSOs) and physician practices/clinics.
- 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, Pharmacy Benefit Manager (PBM), Behavioral Health and Nurse Advice Line service reports) to identify opportunities to improve service and customer satisfaction.
- Leverage Appeals and Grievances data to gain insight into the drivers of member dissatisfaction and develop interventions to address these concerns in collaboration with vendors and delegated entities.
- Identify key areas for improvement, develop and monitor interventions based on the findings in the key service-related reports. Monitor results of the interventions.
- 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.

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.
- Incorporate NCQA Population Health Standards into policies and procedures and workflows.

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 IHHS 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).

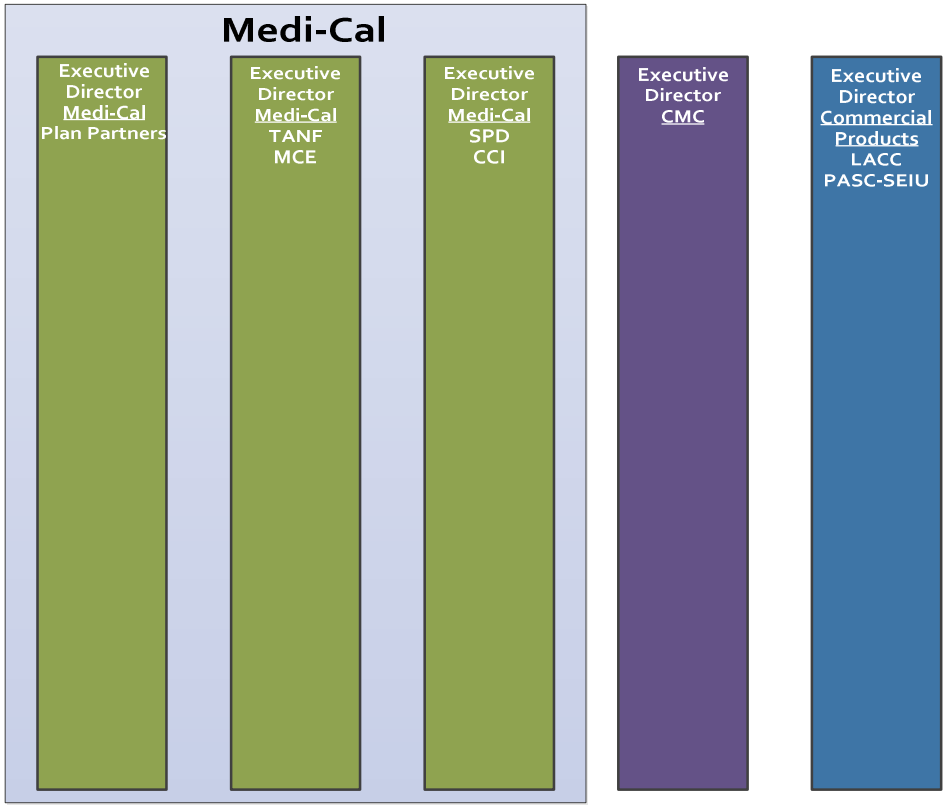
The Board has assigned oversight of the QI Program to the Compliance and Quality Committee (C&QC), a subcommittee of the Board.

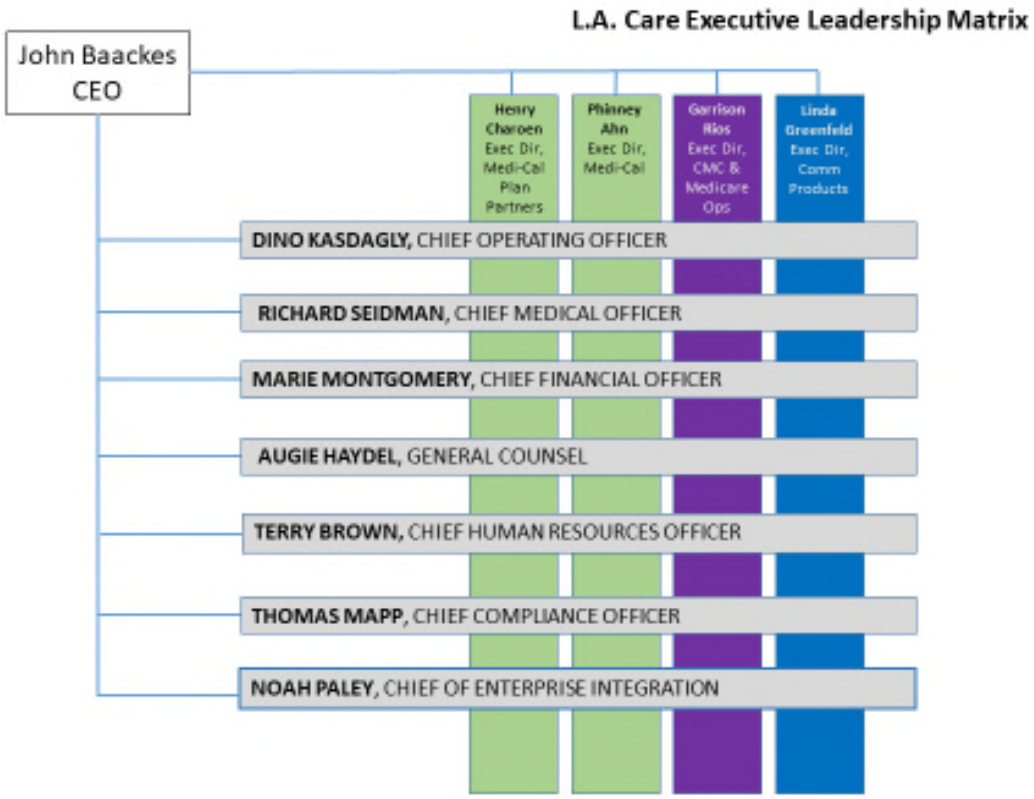
The Compliance and Quality Committee (C&QC) has final approval of the QI Program Description and the Quality Improvement Annual Evaluation annually. The C&QC monitors all quality activities and reports its findings to the Board of Governors. The Chief Medical Officer and designated Quality leaders provide 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 Executive Directors by product line/population segments and Chief Officers 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 an advisory role to the CEO, focusing on data management and analytics, process improvement, risk management, and network strategy. The Chief of Enterprise Integration reports directly to the Chief Executive Officer. In addition, the Chief of Enterprise Integration collaborates with business stakeholders and I.T. The Chief of Enterprise Integration contributes to the overall process improvement program, which supports L.A. Care's strategic goals and coordinates and evaluates continuous business process improvement initiatives. Coordinates organization-wide efforts to ensure that performance management and quality programs are developed and managed using a data-driven focus that sets priorities for improvements aligned to ongoing strategic imperatives. Develops standardized procedures for identifying, assessing, and addressing operational needs that enhance core functions and facilitate growth objectives. Designs processes to standardize provider recruiting, contracting, and communications by documenting operational issues and gaps and developing remediation/risk mitigation proposals for review and approval by leadership.

Chief Quality and Information Executive

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

General Counsel

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

Executive Director Medi-Cal Plan Partners

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

line of business, L.A. Care Medi-Cal. The program serves multiple member demographics and cultures throughout Los Angeles County.

Executive Director Medi-Cal

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

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

Executive Director Cal MediConnect (CMC/CCI)

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

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

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

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

QI PROGRAM PHYSICIAN LEADERSHIP

Chief Medical Officer

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

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

Deputy Chief Medical Officer

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

Chief Pharmacy Officer

The Chief Pharmacy Officer is directly responsible on all business aspects related to Pharmacy Operations and significantly contribute to the strategic direction of the organization by integrating pharmaceutical care delivery with medical care and operational delivery strategy. The Chief Pharmacy Officer is responsible in providing pharmacy business and clinical forecast assessments to contribute to good decision making on the strategic direction of the organization to achieve its positive outcomes. This position is responsible for developing and enforcing all policies & procedures in regards to the pharmacy operations. The responsibility will include oversight of regulatory/compliance, plan partners' related operations, related Operations of Subcontracted Plans in the Duals Pilot Project, Pharmacy Benefit Management (PBM) functions and

performance, clinical pharmacy service operations for direct lines of business, and vendor service agreements/RFPs. The Chief Pharmacy Officer will interface with external agencies including other Local Initiatives, Plan Partners, Subcontracted Plans, Medical Groups, regulators and other external organizations. The Chief Pharmacy Officer must ensure all pharmacy functions are operating in accordance with the organization's mission, values and strategic goals and are provided in a manner that is responsive and sensitive to the needs of L.A. Care's culturally diverse membership.

Utilization Management (UM) Medical Director

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

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

Medical Director Care Management Services

The Medical Director of Care Management Services will develop, manage and implement L.A. Care’s newly formed care management and coordination services program for our members. The Medical Director will be responsible for the operational component of the care management division which includes program design, strategic planning, regulatory reporting, staffing and staff training. The Medical Director will work in concert with other divisions within Health Services as well as across L.A. Care, its contracted medical provider groups and delivery systems (i.e., Hospitals, providers etc.). The position will also represent LA Care and interact with the County Health Agency’s Departments of Health Services, Mental Health (DMH), Public Health/Substance Abuse Prevention & Control (SAPC), contracted organizations and providers, medical groups, and other stakeholders in a manner that promotes collaborative working relationships in improving the care management and coordination for our members. The Medical Director will report to the Senior Medical Director. The Medical Director will work collaboratively with all the Health Services departments including Medical Management, Quality Improvement, Behavioral Health, Pharmacy, and Long Term Services and Supports and Clinical Member Services as well as other key organizational stakeholders like analytics and external stakeholders.

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 Enterprise Data Strategy and Analytics 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. A full organizational chart is attached to this program description (see attachment 1).

Senior Director Health Services

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

Senior Director, Safety Net Initiatives

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

Chief Financial Officer (CFO), and Product Executives. The role will be responsible for directing the work of the Safety Net Initiatives strategic project portfolio, including Department of Health Services (DHS) Support Services, Community Clinic Initiatives, and Program Development.

Senior Director, Medicare and Cal MediConnect Operations

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

Senior Director, Medicare Performance Management

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

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

Senior Director, Medi-Cal

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

competencies, professional development and performance management according to Human Resources guidelines and requirements.

Senior Director Enterprise Shared Services

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

Senior Director Compliance (Internal Audit)

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

Director, Quality Improvement/Accreditation

The Director of Quality Improvement/Accreditation is responsible for the direction, implementation and oversight of L.A. Care Health Plan's Quality Improvement, Accreditation, and Chronic Care Improvement Programs. The position reports directly to the Quality Improvement Medical Director and/or the Chief Quality and Information Executive. The Director leads staff in the performance of health plan quality improvement activities, establishes and monitors quality improvement goals, organizes outcomes research, Directs Accreditation activities, and assures that L.A. Care meets CMS, DMHC, NCQA, and other regulatory agencies' standards for quality. The

Director must be able to effectively present complex reports and findings to the appropriate committees and to the Compliance and Quality Committee of the Board and work well with others including community advocates and provider organizations.

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

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

Director, 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 Chief Quality and Information Executive.

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, Population Health Informatics

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

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

Director, 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, Medi-Cal

The Director of Medi-Cal supports the development and leads the execution of the Medi-Cal product strategic and tactical plan, which focuses on delivering an excellent overall member experience, facilitating product-specific initiatives, and understanding the membership to monitor trends, identify needs, and close gaps. The Director regularly collaborates with key internal leaders, external stakeholders, community partners. The Director understands the competitive landscape, overall needs of Medi-Cal members, the managed health care delivery system, and regulatory requirements impacting the Medi-Cal program. The Director ensures the organization infrastructure can support the product strategy while working with the product and internal stakeholder teams to retain and engage membership, maintain product integrity, ensure financial sustainability, maintain service level agreements, and deliver service excellence. The Director reports to the Executive Director of Medi-Cal to align the goals of product team members with department and enterprise goals while assessing competencies and monitoring performance according to Human Resources guidelines and requirements.

Director, Medicare Operations

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

Program Director for Health Equity

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

Director, 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, 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, and 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.

Director, Regulatory Affairs

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

mission and responsibilities of the Compliance Department and to support the mission and business operations of L.A. Care Health Plan.

Manager, Quality Improvement Initiatives

The Manager of Quality Improvement Initiatives is an experienced healthcare professional responsible for overseeing activities of LA Care's Quality Improvement Programs. The position reports directly to the 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, Health Informatics

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

Manager, 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 activates, 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

Manager, Facility Site Review (FSR)

The Manager of Facility Site Review (FSR) will work under the guidance of the Director of Provider Support Services. The Manager of Facility Site Review is responsible for the organization, compliance, direction and staffing of L.A. Care's Facility Site Review (FSR) function(s). Responsibilities includes supervisory visits of staff conducting site reviews and/or physical accessibility review survey (PARS) assessments, maintain regulatory compliance, oversight of plan partner related operations, operations for direct lines of business and/or

management of services agreement functions, and interfacing with external agencies including other Managed Care Plans (MCPs). The Manager of Facility Site Review will conduct site reviews when appropriate and necessary. The Manager of Facility Site Review is further responsible to assure all functions are operating in accordance with the organization's mission, values and strategic goals and are provided in a manner that is responsive and sensitive to the needs of L.A. Care's culturally diverse membership.

Manager, CSC A&G (Appeals and Grievances)

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

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

Manager, 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, Health Education

The Manager of Health Education is responsible for overseeing day-to-day operations for the assigned business unit, including supervising staff, providing coaching/guidance, and ensuring departmental and organizational priorities are met in a timely fashion. This position prepares and updates departmental administrative documents, including program descriptions, policies, work plans, and reports. The Manager monitors and ensures compliance with regulatory requirements, works with internal and external stakeholders to provide technical assistance, proposes and drives process improvement opportunities, and manages the budget for the assigned business unit.

Manager, Cultural and Linguistics Services

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

COLLABORATION THROUGH WORK GROUPS

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

Facility Site Review (FSR) Task Force

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

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

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

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

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

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

- Provider Support Services Director
- Facility Site Review Manager
- Facility Site Review Department Staff
- Strategic Partner Representatives
- Site Reviewers

The committee may invite other attendees as necessary.

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

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

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

PPG/Plan Partner Collaboration

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

Beginning in fall of 2016, L.A. Care began hosting webinars on QI topics for PPGs and Plan Partners. In 2018, we increased the frequency of the webinars to monthly, focusing on important areas including HEDIS performance, member satisfaction, and data submission. Additional webinars aimed at providers will offer an introduction to HEDIS and correct coding, as well as earning potential through the Incentive programs. These webinars aim to disseminate detailed

information on topics aligned with the organization's strategic goals. In addition to the expanded webinars, L.A. Care QI Department 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 treatment) are inclusive of inpatient treatment and outpatient treatment. Services are available across all L.A. Care lines of business and are managed based on the severity of the illness, the medically necessity services and the member's line of business. Specialty Mental Health and substance use disorder treatment services are carved out to the Los Angeles County Department of Mental Health (DMH) and the Los Angeles County

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

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

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

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

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), Chief Compliance Officer, or designee reports to the C&Q as often as needed. Draft agendas are publicly posted at least 72 hours prior to the meeting with the final agenda being approved at the time of the meeting in accordance with the Brown Act.

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

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

Board of Governors Community Advisory Committees

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

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

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

Frequency: ECAC meets monthly.

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

Regional Community Advisory Committees and CCI Councils

There are 11 Regional Community Advisory Committees (RCAC) 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 well-being of L.A. Care members in the region. The information is used by the advisory committees and L.A. Care to plan, implement, and evaluate programs which address the concerns identified.

See RCAC Member Handbook & Guidelines for further detail.

Internal Compliance Committee

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

Structure: The ICC's membership is comprised of L.A. Care staff involved in Compliance oversight and accountability activities for the organization. The committee is chaired by the Chief Compliance Officer and consists of nine (9) voting members. A quorum is established when a minimum of 50% of the voting membership are in attendance.

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

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

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

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

Quality Committees

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

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

- Utilization and Complex Case Management: Utilization Management Committee
- Credentialing and Peer Review: Credentialing Committee and Peer Review Committee for Potential Quality of Care Issues (PQIs) and Facility Site Review (FSR)
- Member Rights (grievance and appeals): Member Quality Service Committee
- Quality: Member Quality Service Committee and Quality Oversight Committee
- Pharmacy: Pharmacy Quality Oversight Committee (PQOC)
- HEDIS 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 meeting minutes are submitted to the Department of Health Care Services (DHCS) on no less than on a quarterly basis. The QOC is charged with aligning organization-wide quality improvement goals and efforts prior to program implementation and monitoring the overall performance of L.A. Care quality improvement infrastructure.

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

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

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

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

- 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 program description, annual QI Work Plan, quarterly work plan reports and annual evaluation of the QI program.
- Provide and/or review and approve recommended changes to the QI Program and QI Work Plan activities based on updates and information sources available.
- 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, CMS, 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 and are strictly confidential.
- A written agenda will be used for each meeting.
- Meeting minutes shall be comprehensive, timely, show indicators, recommendations, follow-up and evaluation of activities.
- The minutes are recorded in a nationally recommended format.
- All unresolved issue/action items are tracked in the minutes until resolved.
- The minutes and all case related correspondence are maintained 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 and website
- Provider Relations and Physician Reports
- Quarterly Reports to the Board of Governors

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 Chief Quality and Information Executive, Medical Director for Quality or designee, to the Quality Oversight Committee.

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

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

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

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

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

- 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 and VIIP or Value Based Pay for Performance programs through planning, design, implementation and review.
- Assuring compliance with the requirements of accrediting and regulatory agencies, including but not limited to, DHCS, DMHC, CMS, 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 and are strictly confidential.
- A written agenda will be used for each meeting.
- Meeting minutes shall be comprehensive, timely, show indicators, recommendations, follow-up and evaluation of activities.
- The minutes are recorded in a nationally recommended format.
- All unresolved issue/action items are tracked in the minutes until resolved.
- The minutes and all case related correspondence are maintained 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 and website
- Provider Relations and Physician Reports
- Quarterly Reports to the Board of Governors

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 Quality Improvement, Medical Director Medicare, Medical Directors or permanent MD Designees of Participating Physician Groups, Senior Director Clinical Assurance, Senior Director Enterprise Pharmacy, Director Managed Long Term Services & Supports (MLTSS), Senior Director Provider Network Management (PNM), UM Director, Care Management (CM) Director, Appeals and Grievances (A&G) Director, MLTSS Director, Behavioral Health Clinical Services Director, Provider Group Directors, Lead Delegation Oversight Specialist, UM Oversight and Compliance Specialist, and Medical Management Project Manager. Ad hoc members include Director Credentialing and Senior Director Health Services, Director Quality Performance Management/HEDIS.

Frequency: The Committee meets at least quarterly.

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

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

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

Delegation Oversight Plan, UM Notice of Action Templates, CM Management Program Evaluations and Descriptions, CM Policies/Procedures, and Care Coordination and Quality Improvement Program Effectiveness, MLTSS Management Program Evaluations and Descriptions, MLTSS Policies/Procedures and MLTSS Model of Care.

- Review pharmacy utilization data, including utilization reports received from Plan Partners to track and trend changes over time.
- Recommend actions to the Quality Oversight Committee when opportunities for improvement are identified from review of utilization data including, but not limited to, Ambulatory Visits, Emergency Visits, Hospital Utilization rates, Hospital Admission rates, Average Length of Stay rates, and Discharge rates.
- Review New Medical Technologies including new applications of existing technologies at least annually for potential addition as a new medical benefit for members.
- Review and make recommendations regarding oversight of delegated activities, such as, audit finding and reports.

Recording of Meeting and Dissemination of Action

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

The dissemination of UM 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
- L.A. Care Newsletters
- Provider Relations and Physician Reports
- Quarterly Reports to the Board of Governors

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

Credentialing/Peer Review Committee

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

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

Membership includes, but is not limited to:
Voting Members are the L.A. Care Chief Medical Officer, L.A. Care Medical Director Quality Improvement, *L.A. Care* Medical Management Medical Directors, network physicians or designees, and one (1) nurse practitioner (NP) (may vote on NP cases only). Doctoral level behavior health professionals may vote on behavioral health issues only.

Non-Voting Members are L.A. Care Credentialing Director, Credentialing Manager, Credentialing Auditors, 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, AC, attending physicians within a teaching facility, and Mid-Level disciplines, such as, Nurse Practitioner (NP), Certified Nurse Midwife (CNM), Clinical Nurse Specialist (CNS), Certified Registered Nurse Anesthetist CRNA, Licensed Midwives (LM), and Physician Assistants (PA), behavioral health practitioners, such as, Psychiatrists and other physicians, addiction medicine specialists, Doctoral or Master's level psychologists, Master's level clinical social workers, Master's level clinical nurse specialists or psychiatric nurse practitioners, physicians or Doctoral level professionals with expertise in Long Term Services and Supports (LTSS), autism service providers, qualified autism service professionals, or qualified autism service paraprofessionals, other behavioral health care specialists, or provider service types, as appropriate as outlined in Policy CR-004.

- Conditions for altering a practitioner's relationship with L.A. Care including freezing the practitioner's assigned membership panel, suspension or termination of practitioners from the network.
- Pre-contractual and annual delegated oversight activities for credentialing and recredentialing.
- Provide feedback on specific practitioner credentials that do not meet required standards and recommendation(s) for handling such cases.
- Review and approve facilities including Hospitals, Free Standing Surgical-Centers, Home Health agencies, Skilled Nursing facilities and mental health and substance abuse facilities providing care in inpatient, residential and ambulatory settings. For Center for Medicaid and Medicare Services (CMS), facilities include the following:
    - Hospice
    - Clinical Laboratory
    - Comprehensive Outpatient Rehabilitation Facility
    - Outpatient Physical Therapy and Speech Pathology Provider
    - Ambulatory Surgery Centers
    - End-Stage Renal Disease Provider (Dialysis Unit)
    - Outpatient Diabetes Self-Management Training Provider
    - Portable X-Ray Supplier
    - Rural Health Clinic (RHC)
    - Federally Qualified Health Center (FQHC)
    - Community-Based Adult Services (CBAS) Centers
- Ensure compliance with state and federal regulatory agencies and accrediting bodies concerning credentialing and recredentialing activities.
- Approve all delegation oversight activities, all Corrective Action Plans (CAPs) and de-delegation and recommendations.
- Review, evaluate, and make recommendations regarding Potential Quality of Care Issues (PQIs)
- Recommend additional investigation and/or reporting as indicated or as appropriate
- Determine clinical appropriateness, quality of care and assigns the severity level to the case. PRC members may be requested to review the PQI case prior to the PRC meeting.
- Provide oversight of level 0, 1 and 2 cases that have been closed with no need for committee review.
- Provide oversight of delegated peer review and ongoing monitoring as needed.
- 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 and are strictly confidential.
- A written agenda will be used for each meeting.
- Meeting minutes shall be comprehensive, timely, show indicators, recommendations, follow-up and evaluation of activities.
- The minutes are recorded in a nationally recommended format.
- All unresolved issue/action items are tracked in the minutes until resolved.
- The minutes and all case related correspondence are maintained in the Credentialing 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 Governors

Pharmacy Quality Oversight Committee

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

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

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

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

Frequency: The PQOC meets at least quarterly.

Functions: The PQOC has the following functions:

Oversight/Advisory of PBM Vendor:

- Review newly marketed drugs for potential placement on the formulary.
- 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.

Recording of Meeting and Dissemination of Action

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

Behavioral Health Quality Improvement Committee

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

Structure: Committee members from L.A. Care include: Medical Director of Behavioral Health and Social Services (chair), Director of Behavioral Health Services, Chief Medical Information Executive/Medical Director of Quality Improvement, Director of Case Management, Utilization Management Medical Director, Senior Director of Enterprise Pharmacy, Director Quality Improvement, Case Management, Behavioral Health and Social Services staff. Other attendees

include members from the MBHO such as the Clinical Director, the Assistance Vice President of Care Management and the Regional Quality Improvement Director. Additional committee members include leadership from L.A. County Department of Mental Health and L.A. County Department of Public Health/Substance Abuse Prevention & Control as well as Medical Directors of the contracted Preferred Physician Groups and community behavioral health providers and members of the behavioral health professionals in L.A. Care's contracted network.

Frequency: The Behavioral Health Quality 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.

Recording of Meeting and Dissemination of Action

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

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

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

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 , Quality Performance Management/HEDIS, Health Education, Cultural and Linguistic Services Department (HECLS), Quality Improvement (QI), Information Technology (IT), Compliance, Managed Long Term Services & Support, Product staff, and other departments.

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

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

- Create and maintain a member-centered culture for the organization.
- Review aggregate performance data on L.A. Care's network, including adherence to access and availability standards.
- Measure, report, set goals, and improve member satisfaction using CAHPS and CG-CAHPS as instruments to measure performance.
- Implement focused, measureable interventions regarding member experience. Provide input and make recommendations to L.A. Care's Quality Oversight Committee (QOC) on the state of member satisfaction on a quarterly basis.
- Review and provide thoughtful consideration of changes in its policies and procedures and make changes to policies and procedures as needed.
- The committee may choose to invite representatives of subcontracted health plans or provider groups, as needed.
- Review and discuss quarterly delegated activity reports including audit trends.
- Review of quarterly appeals and grievances reports

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 and are strictly confidential.
- A written agenda will be used for each meeting.
- Meeting minutes shall be comprehensive, timely, show indicators, recommendations, follow-up and evaluation of activities.
- The minutes are recorded in a nationally recommended format.
- All unresolved issue/action items are tracked in the minutes until resolved.
- The minutes and all case related correspondence are maintained 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 Governors

Quality Improvement Steering Committee

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

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

Membership includes, but is not limited to Medical Director Quality Improvement, Director Quality Improvement & Accreditation (Chair), Senior Director Medicare Operations, Director Quality Performance Management/HEDIS, Senior Director Health 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 every other month, but as frequently as necessary, to demonstrate follow-up on all findings and required actions.

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

- 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 Quality Improvement Steering Committee (QISC) minutes are contemporaneous, dated and signed and reflect all committee decisions made.
- Meeting minutes and all documentation used by the L.A. Care Committee structure and are the sole property of L.A. Care Health Plan and are strictly confidential.
- A written agenda will be used for each meeting.
- Meeting minutes shall be comprehensive, timely, show indicators, recommendations, follow-up and evaluation of activities.
- The minutes are recorded in a nationally recommended format.
- All unresolved issue/action items are tracked in the minutes until resolved.
- The minutes and all case related correspondence are maintained 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 QISC information and findings to physicians may take various forms. These methods may include but not limited to:

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

Continuing Medical Education Committee

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

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

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

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

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

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

SCOPE OF PROGRAM

The scope of the QI Program is reflective of the health care delivery system and provides for a systematic approach to continuous improvement, encompassing the quality 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(c) and §422.152(d), QI programs must include a Chronic Care Improvement Programs (CCIP) and Quality Improvement Project (QIP) that measures and demonstrates improvement in health outcomes and beneficiary satisfaction.

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

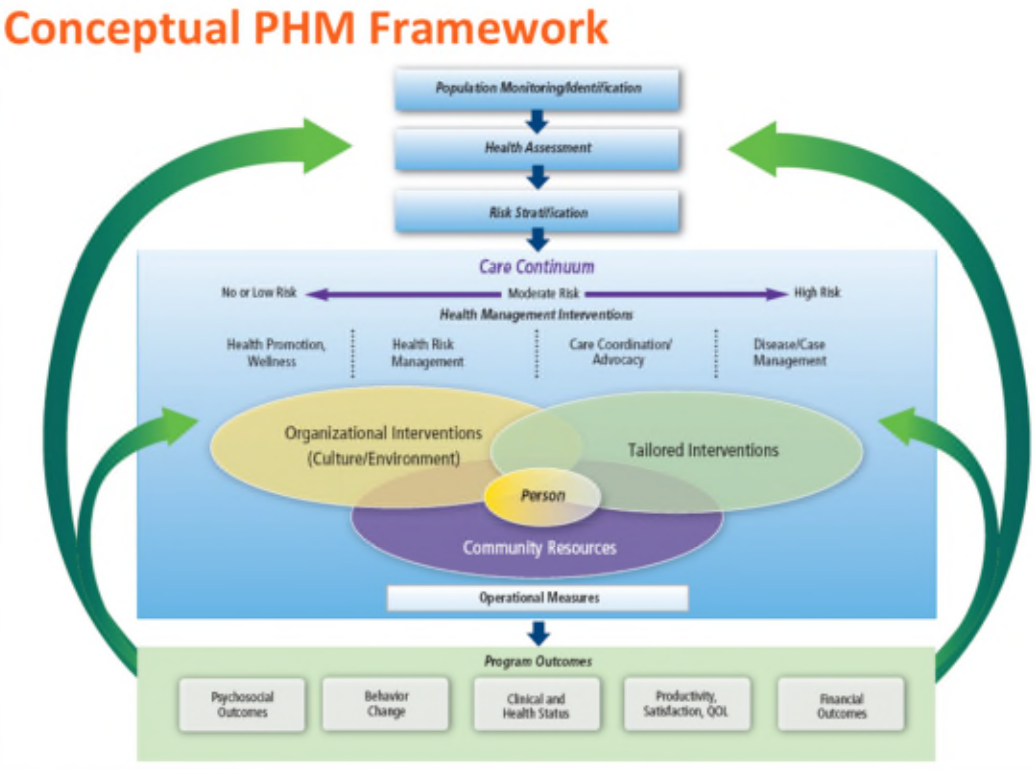
CMS has reframed the QI program as a continuous performance improvement program that includes collection, reporting, and analysis of data that:

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

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

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

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



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

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Population Health Management Program (PHMP)
2018 is the first year Population Health Management Program (PHMP) information was collected in one central PHM strategy document and the membership demographics assessed, segmented through population assessment and the programs evaluated through a PHM Impact Evaluation. Coordinating services through a PHMP) helps meet the goals outlined by the Triple Aim healthcare model including evidence based quality care, meeting regulatory requirements, and cost effective member care.

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

L.A. Care's population health management services are provided by a team that includes wellness and prevention, care management, social services, behavioral health and community resources together whose goal is to coordinate and ensure the right service at the right level. Rather than providing specific service categories into which individuals must fit, L.A. Care's population health management revolves around the individual's needs and adapts to his/her health status—providing support, access and education all along the continuum. Through a high tech, high touch, highly efficient workflow we can use the widest breadth of data sources with optimal process flow to achieve a holistic view of members and providers for ideal customer relationship management.

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

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

Quality of Care

Members with Complex Health Conditions, Seniors and Persons with Disabilities 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 but not limited to those related to race and ethnicity, language, disabilities and chronic conditions. L.A. Care objectives to address the cultural and linguistic needs of its membership includes, but is not limited to, the following:

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

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

HEDIS

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

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.

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

Acronym	HEDIS Measure Name	Administrative or Hybrid (A/H) or Electronic Clinical Data System (ECDS)	L.A. Care Covered Measure (QRS)	DHCS Auto Assignment Measure	DHCS Required Measure (EAS)	NCQA Accreditation Measures - Medicare	NCQA Accreditation Measure - Medi-Cal
AAB	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	A	X		X		X
ABA	Adult BMI Assessment	H	X				X
ADD	Follow-Up for Children Prescribed ADHD Medication-initiation	A	X				
ADD	Follow-Up for Children Prescribed ADHD Medication - Continuation and Maintenance	A	X				X
ADV	Annual Dental Visit (Total Rate)	A	X				X
AMB-ED	Ambulatory Care ED Visits	A			X		
AMB-OP	Ambulatory Care Outpatient Visits	A			X		
AMM	Antidepressant Medication Management - Acute Phase	A	X				
AMM	Antidepressant Medication Management-continuation phase	A	X			X	X
AMR	Asthma Medication Ratio (Total Rate)	A			X		X
ART	Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis	A					
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics	A					X
APP	Use of First –Line Psychosocial Care for Children and Adolescents on Antipsychotics	A					X
BCS	Breast Cancer Screening - Total	A	X		X	X	X

Acronym	HEDIS Measure Name	Administrative or Hybrid (A/H) or Electronic Clinical Data System (ECDS)	L.A. Care Covered Measure (QRS)	DHCS Auto Assignment Measure	DHCS Required Measure (EAS)	NCQA Accreditation Measures - Medicare	NCQA Accreditation Measure - Medi-Cal
CAP-12-19	Children & Adolescents' Access to Primary Care - 12-19 years	A			X		
CAP-12-24	Children & Adolescents' Access to Primary Care - 12-24 months	A			X		
CAP-25-6	Children & Adolescents' Access to Primary Care - 25 months-6yrs	A			X		
CAP-7-11	Children & Adolescents' Access to Primary Care - 7-11 years	A			X		
CBP	Controlling High Blood Pressure - Total	H	X	X	X	X	X
CCS	Cervical Cancer Screening	H	X	X	X		X
CDC-N	Comprehensive Diabetes Care - Medical Attention for Nephropathy	H	X		X		
CDC-BP	Comprehensive Diabetes Care - Blood Pressure Control (<140/90)	H			X	X	X
CDC-E	Comprehensive Diabetes Care - Eye Exams	H	X		X	X	X
CDC-H8	Comprehensive Diabetes Care - HbA1c Control <8%	H	X		X	X	X
CDC-H9	Comprehensive Diabetes Care - Poor HbA1c Control >9%	H			X		
CDC-HT	Comprehensive Diabetes Care – HbA1c Testing	H	X	X	X		
CHL	Chlamydia Screening in Women- (Total Rate)	A	X				X
CIS-3	Childhood Immunization Status - Combo 3	H	X	X	X		
CIS-10	Childhood Immunization Status - Combo 10	H					X
COL	Colorectal Cancer Screening	H	X			X	
CWP	Appropriate Testing for Children with Pharyngitis	A	X				X

Acronym	HEDIS Measure Name	Administrative or Hybrid (A/H) or Electronic Clinical Data System (ECDS)	L.A. Care Covered Measure (QRS)	DHCS Auto Assignment Measure	DHCS Required Measure (EAS)	NCQA Accreditation Measures - Medicare	NCQA Accreditation Measure - Medi-Cal
DDE	Potentially Harmful Drug-Disease Interactions in the Elderly (Total Rate)	A				X	
DAE	Use of High-Risk Medications in the Elderly (Rate 1 only)	A				X	
DSF	Depression Screening and Follow-Up for Adolescents and Adults	ECDS			X		
FUH	Follow-Up After Hospitalization for Mental Illness - 7 day	A	X			X	X
IET	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment - Engagement	A	X			X	X
EDU	Emergency Department Utilization					X	
IMA-2	Immunizations for Adolescents – Combination 2	H	X		X		X
LBP	Use of Imaging Studies for Low Back Pain	A	X		X		X
MMA-75	Medication Management for People with Asthma-75% Compliance Total (Ages 5-85)	A	X				X
MPM-ACE	Annual Monitoring for Patients on Persistent Medications - ACE/ARB	A	X		X		
MPM-DIG	Annual Monitoring for Patients on Persistent Medications - Digoxin	A	X				
MPM-DIU	Annual Monitoring for Patients on Persistent Medications - Diuretics	A	X		X		
MPM-DIU	Annual Monitoring for Patients on Persistent Medications – Combined Rate	A	X				
MRP	Medication Reconciliation Post-Discharge	H					

Acronym	HEDIS Measure Name	Administrative or Hybrid (A/H) or Electronic Clinical Data System (ECDS)	L.A. Care Covered Measure (QRS)	DHCS Auto Assignment Measure	DHCS Required Measure (EAS)	NCQA Accreditation Measures - Medicare	NCQA Accreditation Measure - Medi-Cal
OMW	Osteoporosis Management in Women Who Had a Fracture	A				X	
PCE	Pharmacotherapy Management of COPD Exacerbation Systemic Corticosteroid and Bronchodilator	A				X	X
PCR	Plan All Cause Readmissions	A	X		X	X	
PNU	Pneumococcal Vaccination Status for Older Adults	A				X	
PPC-PST	Prenatal and Postpartum Care - Postpartum Care	H	X		X		X
PPC-Pre	Prenatal and Postpartum Care - Timeliness of Prenatal Care	H	X	X	X		X
PSA	Non-Recommended PSA-Based Screening in Older Men	A				X	
SPC	Statin Therapy for Patients With Cardiovascular Disease (Both Rates)	A				X	X
SPD	Statin Therapy for Patients with Diabetes (Both Rates)	A				X	X
SSA	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	A					X
SSD	Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic Medications	A					X
URI	Appropriate Treatment for Children with Upper Respiratory Infections	A	X				X
W-15	Well-Child Visits in the First 15 Months of Life	H	X				

Acronym	HEDIS Measure Name	Administrative or Hybrid (A/H) or Electronic Clinical Data System (ECDS)	L.A. Care Covered Measure (QRS)	DHCS Auto Assignment Measure	DHCS Required Measure (EAS)	NCQA Accreditation Measures - Medicare	NCQA Accreditation Measure - Medi-Cal
W-34	Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	H	X	X	X		
WCC-BMI	Weight Assessment & Counseling for Nutrition& Physical for Children and Adolescents	H	X				X
WCC--N	Weight Assessment & Counseling for Nutrition& Physical for Children and Adolescents	H	X		X		
WCC-PA	Weight Assessment & Counseling for Nutrition& Physical for Children and Adolescents	H	X		X		

Safetynet Programs and Partnerships

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

Whole Person Care: L.A. County's Whole Person Care Program (WPC) comprises 15 different high-touch programs for 6 different vulnerable Medi-Cal populations, including high-risk homeless members, high-risk criminal justice reentry members, high risk members with MH or SUD needs, high-risk transition of care members, and high risk perinatal members. Programs use housing navigators and community health workers as well as licensed clinical staff to provide care management and wraparound services for varied program lengths (1 month to multi-year programs). The core focus is on addressing the social determinants of health as well as the member's health needs and engaging difficult-to-reach members. Over 10,800 MCLA member enrollments across all programs have occurred as of 6/2018 (includes duplicate members who enrolled in multiple programs).

Homeless Programs: In 2016, L.A. Care made a $20M, 5-year grant commitment to the Housing for Health Program via fiscal intermediary Brilliant Corners. Under the grant, L.A. Care will fund rental subsidies for 300 new homeless individuals/families to move into permanent supportive housing, with supportive services provided in-kind by L.A. County as part of the Whole Person

Care program. L.A. Care is partnering with hospitals, PPGs, and clinics to identify homeless individuals with high health needs for the program. L.A. Care also recently launched a 16-bed recuperative care pilot with the National Health Foundation. In addition, L.A. Care refers members to the local Coordinated Entry System and recuperative care / interim housing process through the Los Angeles Homeless Services Authority (LAHSA) and collaborates closely with health plan and county partners through the Corporation for Supportive Housing's managed care roundtable

QI Health Disparities Program Description

L.A. Care Health Plan is committed to serving a demographically diverse population. L.A. Care Health Plan's health equity program supports and works collaboratively with other L.A. Care Health Plan Departments, including, but not limited to Health Education and Cultural and Linguistics Services, Quality Improvement, Community Outreach & Engagement, Care Management, Disease Management, Customer Solutions Center (Member Services), and the various product departments (Medi-Cal Administration, Medicare Operations, Commercial & Group Plan Operations) to achieve improved health outcomes for members.

Health equity is when individuals have access to the conditions needed for optimal health and well-being. The mission of L.A. Care Health Plan's Health Equity Unit is to achieve health equity by eliminating or reducing barriers that hinder opportunities for individuals and communities to attain the highest level of health. The overall goals of the Health Equity Unit are to:

1. Systematically address and reduce health disparities in order to improve health outcomes.
2. Increase alliance building and partnerships with common and un-common external organizations.
3. Explore and introduce novel services outside the narrow scope of direct health care services to positively impact health.
4. Focus on specific demographic populations that require additional resources for equitable care, not equal care, recognizing long-standing policies have impacted certain populations more.
5. Increase integration of health and outside social systems.
6. Advocate for changes in observed policies and systems inequities.

Cal MediConnect

L.A. Care Cal MediConnect (CMC) was launched in April 2014 and currently has approximately 16,000 dual eligible members enrolled into the plan. L.A. Care is the largest Medicare-Medicaid Plan (MMP) in Los Angeles County. Dual Eligibles are not required to join Cal MediConnect Plans in California. L.A. Care currently provides Medi-Cal services to over 100,000 dual eligibles outside of Cal MediConnect who have chosen to obtain their Medicare services elsewhere. The objective of Medicare-Medicaid Plans is to deliver a fully integrated and coordinated system of care to those with complex care needs and to coordinated more home and community based services outside of the institutional care model. Cal MediConnect was initially set up as a three-year demonstration, which was renewed through December 2019. Dual Eligibles are diverse demographically and have a wide variety of health care needs.

Medicare-Medicaid plans are contractually required to follow a specific Model of Care framework that includes:

- Initial and Annual Health Risk Assessments and Stratification
- Development of Individual Care Plans
- Engagement of an Interdisciplinary Care Team based on the members needs identified in the Health Risk Assessment

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

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

Medicare Operations conducts a review annually and updates the document to reflect new guidance to ensure the document is an accurate portrayal of the current CMC population and program. The most impactful change is the revised Health Risk Assessment, which now contains four quadrants:

1. Social
2. Medical Chronic and Acute Conditions
3. Functional Capacity
4. Behavioral Health

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

Medicare Measurement and Reporting Requirements

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

Chronic Care Improvement Programs (CCIP) - Medicare

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

At a minimum, the CCIP addresses the following components:

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

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

Quality Improvement Projects (QIPs)

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

Performance Improvement Project (PIPs)

L.A. Care conducts quality and performance improvement projects with the aim of achieving meaningful and sustainable improvements, which are statistically significant, in aspects of clinical and non-clinical care. L.A. Care conducts at least three state-mandated Rapid-cycle Performance Improvement Projects (PIPs); two PIPs for Medi-Cal and one PIP for Cal MediConnect. PIPs are initiatives focused on one or more clinical and/or non-clinical areas with the aim of improving health outcomes and beneficiary satisfaction. PIPs are generally conducted over an 18-month period but may change at the discretion of DHCS. Additional 'ad hoc' PIPs can be required based on priorities identified by DHCS. L.A. Care is responsible for ensuring delegates comply with all applicable state and federal laws and regulations and other contract requirements as well as DHCS's guidance, including 'All Plan Letters' for quality and performance improvement requirements.

For Medi-Cal, L.A. Care chooses the first PIP topic from one of four state-selected topics related to the Medi-Cal Managed Care Program Quality Strategy priority areas. 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. The second Medi-Cal PIP topic is selected from a specific area in need of improvement and requires DHCS approval. PIPs are conducted over a 12 to 18-month period and require the submission of 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

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

Plan-Do-Study-Act (PDSA)

For the Medi-Cal plan, L.A. Care identifies HEDIS indicators with rates below the MPL using the final audited HEDIS measurement year rates submitted to DHCS that are part of the External Accountability Set (EAS). L.A. Care completes and submits a PDSA cycle worksheet for each measure with a rate below the MPL and conducts quarterly evaluations of the ongoing rapid-cycle quality improvement interventions. PDSA's are used by L.A. Care to perform small tests of

change in real work settings to determine if the change is an improvement. PDSAs have the flexibility of being able to make adjustments throughout the improvement process with real-time tracking and evaluation of the interventions. L.A. Care develops PDSA cycles using Specific, Measurable, Achievable, Relevant, and Time-Bound (SMART) objectives with interventions selected and tested. The progress of a PDSA is monitored by DHCS and interventions are either adopted, modified or abandoned by L.A. Care based on the change experienced.

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

Quality Improvement Projects 2018-2019

Topic	*Type*	*Product line*
Improving CIS- 3 Rates	PIP	Medi-Cal
Improving Medication Adherence Among African American Diabetics 35-45yrs of age	PIP	Medi-Cal
Improving Individual Care Plan completion Rates	PIP	CMC
Improving Postpartum Rates	PDSA	Medi-Cal
Reducing Avoidable Inpatient and ER Visits From Long –Term Care Settings	PDSA	CMC

Patient Safety

L.A. Care is committed to improving patient safety and promoting a supportive environment for network practitioners and other providers to improve patient safety. Information about safety issues is received from multiple sources including but not limited to member and practitioner grievances, adverse issues, pharmacy data such as polypharmacy, facility site reviews, continuity of care activities, and member satisfaction survey results. Many of the ongoing QI Program measurement activities, including measures for accessibility, availability, adherence to clinical practice guidelines and medical record documentation include safety components. When performance is analyzed for these measures, patient safety is considered, opportunities are identified and prioritized and actions taken to improve safety.

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

A “critical incident” is an incident in which the enrollee is exposed to abuse, neglect or exploitation, a serious, life threatening, medical event for the enrollee that requires immediate

emergency evaluation by medical professional(s), the disappearance of the enrollee, a suicide attempt by the enrollee, unexpected death of the enrollee, and restraint or seclusion of the enrollee.

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

Potential Quality of Care Issue (PQI) Reviews

Potential Quality of Care Issue (PQI) cases are referred to the Quality Improvement (QI) Department for clinical evaluation, investigation, resolution, and tracking. The PQI referral criteria are developed specifically for each of the care delivery support teams (i.e. Customer Solution Center Team, Appeals and Grievance Team, Case Management Team, Utilization Management and Behavior Health Team) to appropriately identify the potential quality of care concern. Ongoing clinical trainings by PQI Nurses are conducted semi-annually to ensure both new and seasoned staff understand the PQI referral criteria and how to submit a PQI.

The PQI 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.

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

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 adheres to established DHCS medical record standards and guidelines to facilitate communication, coordination and continuity of care, and to promote safe, efficient and effective treatment. L.A. Care monitors primary care provider (PCP) medical record documentation and compliance with DHCS medical record guidelines. A medical record review is completed, at minimum, every three years for all PCP practice site to evaluate compliance with medical record

standards. A follow up audit can be conducted for those PCP sites that do not meet acceptable standards as determined by the certified site reviewer.

Guidelines for Care – Clinical Practice and 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 two Clinical Practice Guidelines one medical and one behavioral health conditions.

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 one behavioral health guidelines. Behavioral health clinical practice guidelines are available for all practitioners through L.A. Care's and the MBHO's website with paper copies available upon request.

Disease Management Programs

The Disease Management Programs are a component of L.A. Care's Population Health Management Program (PHMP) with the objective to improve the health status of its eligible members with chronic conditions. The programs achieve this objective by educating the member and by enhancing the member's ability to self-manage his or her condition or illness. 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 2019 to meet the needs of these members as well as the providers in this network.

Pharmacy Management

Pharmacy and formulary utilization is monitored regularly with reports and updates to the Quality Oversight Committee (QOC). The Pharmacy Quality Oversight Committee (PQOC) performs regular reviews and updates to the formulary, utilization edits, guidelines, and policies and procedures based on clinical evidence available at the time of consideration. Since the management of the Medicare Part D Formulary is delegated to a contracted Pharmacy Benefit Manager (PBM), Navitus, the Pharmacy staff performs oversight to ensure compliance with CMS requirements. With the PBM, L.A. Care collects prescription drug quality measures, consistent with Medicare Part D requirements and has established quality assurance measures and systems to reduce medication errors, adverse drug interactions and improve medication use. (See also Patient Safety section of this program). Additionally, L.A. Care participates in the Part D Medication Therapy Management (MTM) program, which examines multi-drug therapy for specific chronic conditions. The MTM program can be used to satisfy the requirements under the Centers for Medicare and Medicaid Services (CMS) that pertain to assessing the quality and appropriateness of care and services, as outlined in 42 CFR §438.204, §438.208, §438.240, and §422.152.

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

L.A. Care reviews for quality assurance of SinfoniaRx, to ensure our vendor is up to the standard according to CMS guidance.

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 Experience

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

Provider Satisfaction

L.A. Care monitors provider satisfaction with L.A. Care on relevant health programs, services, and processes. In order to obtain more actionable feedback, the annual provider satisfaction survey also includes open-ended questions that allow providers to give feedback on service quality issues otherwise not captured on the survey. To assess provider satisfaction, we also monitor provider grievances. The survey questions focus on L.A. Care's practitioner service areas: access to specialists, utilization management, disease management, quality management, care management, complex care management, behavioral health, and coordination of care between PCPs and hospitals, coordination of transition of care, home health, pharmacy services, and free standing surgical facilities, and overall satisfaction. The survey is fielded annually for all lines of business and separately samples primary care physicians, specialty care physicians, community clinics, and

provider groups. Results are presented to the Joint Performance Improvement Collaborative Committee (PICC) & Physician Quality Committee (PQC).

Complaints and Appeals

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

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

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

Availability of Practitioners

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

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

- Ensuring that standards are in-place to define practitioners who serve as Primary Care Practitioners (Pediatrics, Family Practice, General Practice, Internal Medicine, etc.).
- Assigning members to a Primary Care Physician within five miles of their home unless otherwise requested by the member or family. In locations where there is a dearth of primary care physicians and none are available within the 5-mile standard, L.A. Care uses Alternative Access Standards as approved by regulatory bodies to determine availability.

- Referring each member to a specialist within travel distance requirements applicable to the member's affiliated line of business. Where these standards cannot be met due to a scarcity of physicians within the member's geographic location, L.A. Care measures availability against Alternative Access Standards as approved by the appropriate regulatory body.
- Ensuring a database is in-place which analyzes practitioner availability and network ability to meet the special cultural need of our members.
- Ensuring members are within (15) fifteen miles or (30) thirty minutes from a contracted hospital and ancillary service. Where hospitals travel distance standards cannot be met because of a member's geographical location, L.A. Care will adhere to Alternative Access Standards as approved by the appropriate regulatory body.
- Providing members with covered transportation services as needed.
- 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
- 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 offered the availability of telephonic and/or digital access to the following services for all product lines.

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

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

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

Measure	
Plan Administration (Customer Service)	

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. They are also designed to improve L.A. Care's administrative data capture via encounters, labs, and other admin data sources. Incentive programs provide a highly visible platform to engage providers in quality improvement activities; provide peer-group benchmarking and actionable performance reporting; and deliver value-based revenue tied to quality. Incentives for physicians, community clinics, PPGs, and health plan partners are aligned where possible so that all providers pursue common performance improvement priorities.

2019 marks the ninth year of L.A. Care's Physician P4P Program, which targets high-volume solo and small group physicians and community clinics. The Physician P4P Program provides performance reporting, and financial rewards for practices serving Medi-Cal members, and represents an opportunity to receive significant revenue above capitation. Eligible physicians and clinics receive annual incentive payments for outstanding performance and improvement on multiple HEDIS measures. Starting with the measurement year (MY) 2017, program performance on the state access and availability surveys determine the amount of incentive payment providers will retain. Future program years may include a domain and measures related to utilization management, which are currently being tested for program fit.

Starting in 2017, the Value Initiative for IPA Performance (VIIP) was merged with LA P4P to provide a stronger platform and alignment for quality improvement. 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. 'VIIP+P4P' continues in 2019 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 measures and domain weighting will be reevaluated for the MY 2019 program, with some focused changes to align with shifting priorities. Encounter data submission remains a vital component of the program as demonstrated by the encounter data volume payment gates. The encounter data gate methodology was updated in 2018 to set more accurate encounter benchmarks and better reflect PPG membership composition. The VIIP+P4P program also actively engages with PPGs

to develop 'Action Plans' focused on setting SMART Goals and improving performance. The VIIP program is also being developed for the Cal MediConnect and L.A. Care Covered lines of business (LOB), with a set of domains and measures relevant to providers and members in those LOBs.

L.A. Care's Plan Partner Incentive Program aligns the efforts of L.A. Care with those of its strategic partners as a critical point for improving the outcomes and satisfaction of members. This program was redesigned in 2018 to more closely mirror the VIIP+P4P program, to create a stronger platform for shared quality improvement strategies between plans and provider groups. The program now measures and rewards plan partners for performance on a broader set of metrics, including clinical quality, access and availability, utilization, encounters and patient satisfaction. The program will continue to utilize these metrics in 2019 with targeted areas of modification.

SALES AND MARKETING

L.A. Care provides support to multiple initiatives throughout the organization utilizing the services of the in-house Sales and Marketing Business Unit, Health Plan Field Representatives, Community Outreach and Enrollment Support Services, Health Educators, and the Family Resource Centers (FRCs) 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, which L.A. Care offers.

Marketing staff are aligned by product lines; health plan initiatives and the recently expanded FRCs, which are now open and operating in Lynwood, Inglewood, Boyle Heights, Pacoima and Palmdale, with our East L.A. center set to open in January 2019. The FRCs provide free health education and healthy living classes in underserved communities.

Community and member awareness messaging and campaigns are developed and implemented throughout L.A. County. This is accomplished through marketing outreach at educational events, and advertising health and insurance programs specifically target communities where access to quality health care is limited.

The Health Plan Field Representatives, Community Outreach and Enrollment Support Services, Family Resource Center Representatives, and Health Educators conduct product presentations, at educational and marketing events. This provides an opportunity for consumers and members to learn more about Medi-Cal, Cal MediConnect, and the Covered California Marketplace. Community-based events, health fairs, and open houses are prescheduled and are posted on L.A. Care's website and promoted through social media to provide members and non-members with information on the conveniently located events held throughout L.A. County. Additional outreach is provided to Enrollment Entities and their down-line Certified Insurance Agents (CIAs) and Certified Enrollment Counselors (CECs) to educate and update them on the programs that L.A. Care members receive, as well as potential eligibility for L.A. Care's product lines including Medi-Cal, Cal MediConnect, 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 and incentive programs, provider marketing in-services and campaigns and health

educational events. It is a concerted effort to build and maintain effective relationships. The primary focus of the provider outreach, is to target L.A. Care contracted providers who serve low-income seniors and people with disabilities.

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

QUALITY IMPROVEMENT PROCESS AND HEALTH INFORMATION SYSTEMS

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

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

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

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

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

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

- Other information CMS, NCQA or other regulatory agencies may require.

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

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

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

Incentives and collaborative performance improvement programs such as the VIIP Action Plan are used to entice network provider and members 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 as possible.

Performance Target

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

Significant Improvement

L.A. Care defines Significant Improvement as a 95% probability that the improvement is real and is determined by a statistical "p-value" of less than or equal to 0.05. L.A. Care measures baseline and follow-up rates at defined intervals to measure improvement or decline. It is not expected that a *QI* project initiated in a given year will achieve improvement in that same year. The CMS assumes a 3-year cycle for most organizations to reach demonstrable improvement. A significant change can be measured over several years of interventions and measurement.

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

Meaningful Improvement

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

Sustained Improvement

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

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

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

MEMBER CONFIDENTIALITY

L.A. Care keeps confidential information secure and makes it available only to L.A. Care employees, contractors, and affiliates who have a need to know in order to do their job functions and signed a confidentiality 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 Plans, and External Entities to provide specific health care services and perform other delegated functions. L.A. Care requires and ensures that each delegate maintain adequate processes, is

appropriately and adequately staffed and complies with applicable standards and regulatory requirements. Specific elements of the QI program may be delegated. However, L.A. Care 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 delegates 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.

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 (SEE Attachment 4)

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.

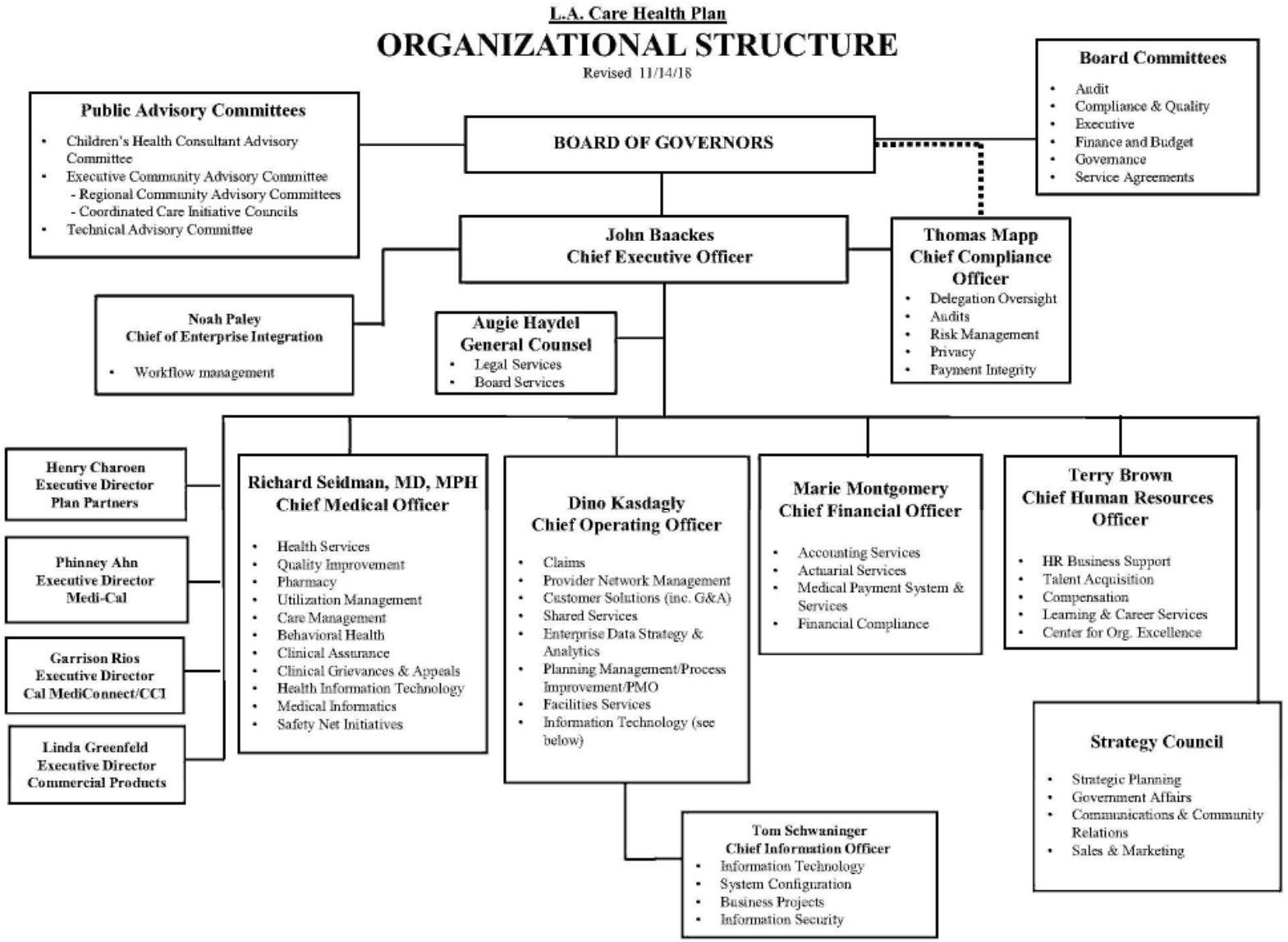
The QI Work Plan includes a description of:

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

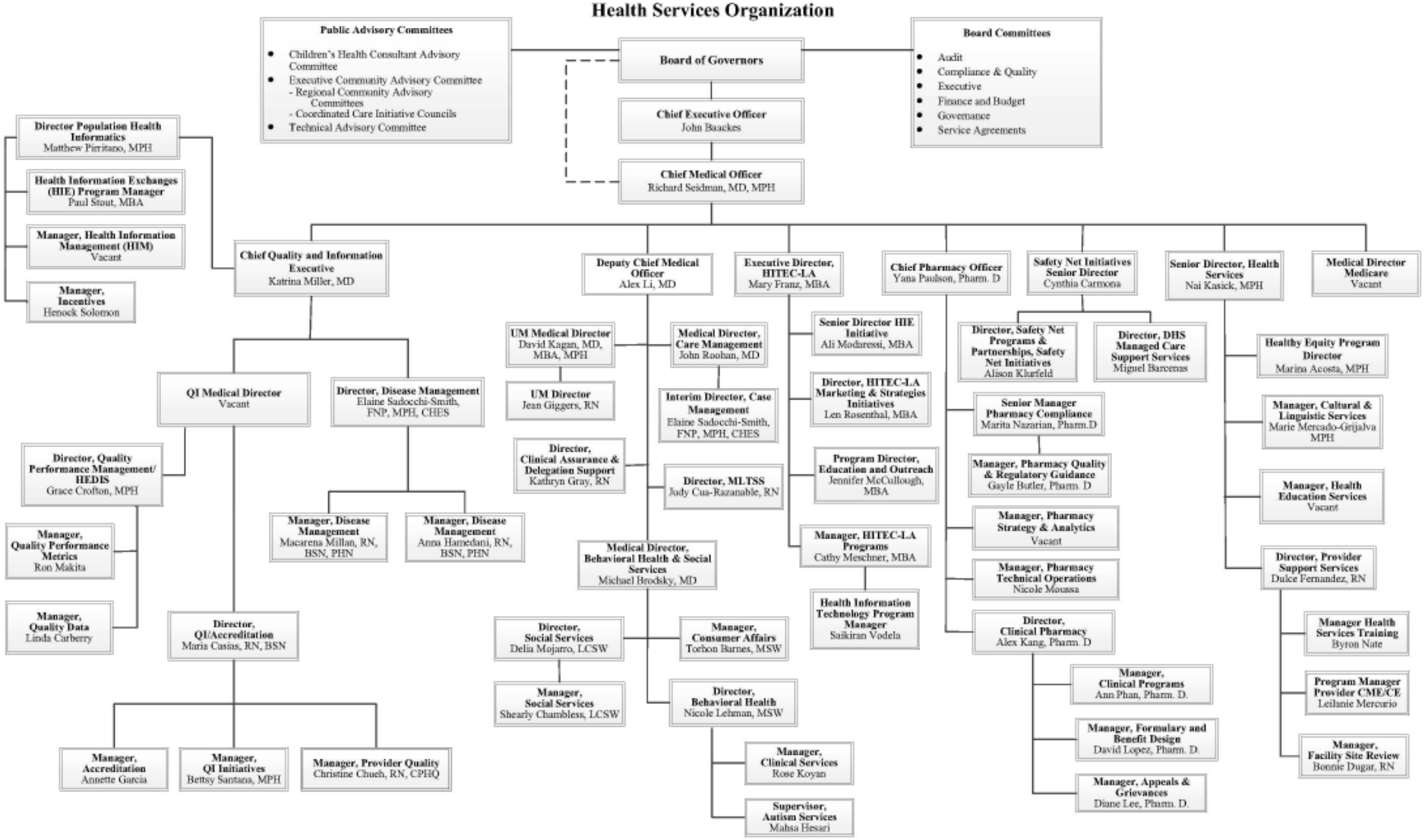
Each of the elements identified on the Work Plan has activities defined, responsibility assigned, and the date by which completion is expected. The QI Work Plan and Quality Improvement Program description are presented to the Quality Oversight Committee for review and approval. Quarterly updates to the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

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

Attachment 1	Organizational Structure
Attachment 2	Health Services Organization
Attachment 3	Quality Program Committee Structure
Attachment 4	2019 QI Work Plan including Medicare

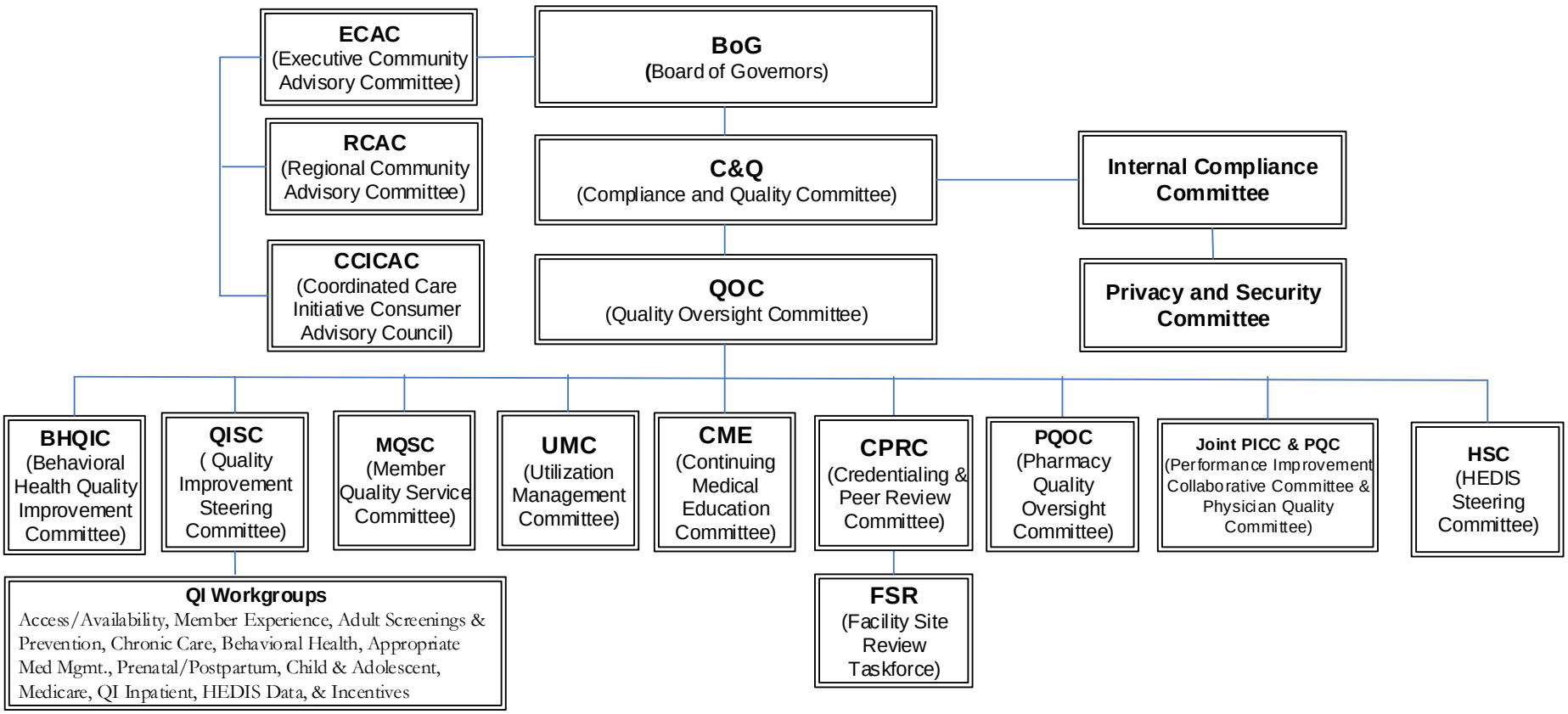

L.A. Care Health Plan
ORGANIZATIONAL STRUCTURE
Revised 11/14/18
Public Advisory Committees
Children's Health Consultant Advisory Committee
Executive Community Advisory Committee
- Regional Community Advisory Committees
- Coordinated Care Initiative Councils
Technical Advisory Committee
BOARD OF GOVERNORS
Board Committees
Audit
Compliance & Quality
Executive
Finance and Budget
Governance
Service Agreements
John Baackes
Chief Executive Officer
Thomas Mapp
Chief Compliance Officer
Delegation Oversight
Audits
Risk Management
Privacy
Payment Integrity
Noah Paley
Chief of Enterprise Integration
Workflow management
Augie Haydel
General Counsel
Legal Services
Board Services
Henry Charoen
Executive Director
Plan Partners
Phinney Ahn
Executive Director
Medi-Cal
Garrison Rios
Executive Director
Cal MediConnect/CCI
Linda Greenfeld
Executive Director
Commercial Products
Richard Seidman, MD, MPH
Chief Medical Officer
Health Services
Quality Improvement
Pharmacy
Utilization Management
Care Management
Behavioral Health
Clinical Assurance
Clinical Grievances & Appeals
Health Information Technology
Medical Informatics
Safety Net Initiatives
Dino Kasdagly
Chief Operating Officer
Claims
Provider Network Management
Customer Solutions (inc. G&A)
Shared Services
Enterprise Data Strategy & Analytics
Planning Management/Process Improvement/PMO
Facilities Services
Information Technology (see below)
Marie Montgomery
Chief Financial Officer
Accounting Services
Actuarial Services
Medical Payment System & Services
Financial Compliance
Terry Brown
Chief Human Resources Officer
HR Business Support
Talent Acquisition
Compensation
Learning & Career Services
Center for Org. Excellence
Strategy Council
Strategic Planning
Government Affairs
Communications & Community Relations
Sales & Marketing
Tom Schwaninger
Chief Information Officer
Information Technology
System Configuration
Business Projects
Information Security

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



ATTACHMENT 3

L.A. Care Health Plan
Quality Improvement Committees



Attachment 4

L.A. Care Health Plan
2019 QI Work Plan

Performance Measures for Planned Activities for Objectives	HEDIS Acronym	Regulatory Agencies	2018 Rates	2019 Rates	2019 Goal	Goal Met/Not Met	Responsible Staff/Department	Timeframe for completion	Reports to: (Dates are 2019 unless otherwise noted)	Interventions/Updates	Comments/Barriers	Recommend for '19 Work Plan
Service - Access												
Member Services Department Telephone Abandonment Rate			**Medi-Cal:** **Q1: 3.49%** **Q2: 1.47%** **Q3: 0.92%** **Q4: 1.81%** **CMC:** **Q1: 1.21%** **Q2: 1.87%** **Q3: 0.78%** **Q4: 1.46%** **LACC:** **Q1: 5.55%** **Q2: 2.69%** **Q3: 1.42%** **Q4: 3.26%**		**Medi-Cal & CMC:** Total incoming calls abandoned ≤ 5% **LACC:** Total incoming calls abandoned ≤ 3%		Robert Martinez (CSC)	Quarterly	**Member Quality Service Committee (MQSC):** **Feb 1 2, May 7,** **July 16, Oct 14**			
Member Services Department Telephone Wait Time- Service Level			**Medi-Cal:** **Q1: 76.20%** **Q2: 89.72%** **Q3: 95.56%** **Q4: 91.10%** **CMC:** **Q1: 87.67%** **Q2: 88.35%** **Q3: 96.72%** **Q4: 94.17%** **LACC:** **Q1: 73.33%** **Q2: 88.26%** **Q3: 94.35%** **Q4: 93.63%**		**ALOB:** 80% of total incoming calls answered ≤ 30 seconds		Robert Martinez (CSC)	Quarterly	**MQSC:** **Feb 1 2, May 7,** **July 16, Oct 14**			
Member Services Department Initial Call Resolution		**LACC ONLY**	**LACC ONLY:** **100%**		80% of Covered California enrollee issues will be resolved within one (1) business day of receipt of the issue. Does not include appeals or grievances.		Robert Martinez (CSC)	Quarterly	**MQSC:** **Feb 1 2, May 7,** **July 16, Oct 14**			
ID Card Processing Time		**LACC ONLY**	**LACC ONLY:** **Q1: 100 %** **Q2: 97%** **Q3: 97%** **Q4: 100%**		99% of LACC ID cards issued within 10 business days of receiving complete and accurate enrollment information and binder payment for a specific consumer(s)		Aurora Cabrera Cabellon (CSC)	Quarterly	**MQSC:** **Feb 1 2, May 7,** **July 16, Oct 14**			
Non-Emergent Ancillary Services -within 15 business days of request, for appointment		**DMHC** **DHCS** **CMS** **NCQA**	**2018 MY2017 ATC Survey Results:** **Medi-Cal:** **MRI 100%** **Mammogram 100%** **Physical Therapy 100%** **CMC:** **MRI 100%** **Mammogram 100%** **Physical Therapy 100%** **LACC/LACCD:** **MRI 100%** **Mammogram 100%** **Physical Therapy 100%** **PASC: No ancillary rates reported for PASC due to data challenges.**		**Medi-Cal**: 100% **CMC**: 100% **LACC**: 100% **PASC**: 100%		Christine Salary (QI)/ Annette Garcia (QI)	Annually: Sept '19	**MQSC: Oct 14**			
After Hour Care - Practitioners surveyed have after-hour care process such as exchange service, automated answering/paging system, or directly accessible, in order to respond to member call with five person within 30 minutes. **(VIIP+P4P, Physician P4P, Plan Partner Incentive)**		**DMHC** **DHCS** **CMS** **NCQA**	**2018 MY2017 ATC Survey Results:** **Medi-Cal:** **PCP Access 73% Timeliness 55% Combined Access & Timeliness 50%** **CMC:** **PCP Access 73% Timeliness 57% Combined Access & Timeliness 50%** **LACC/LACCD:** **PCP Access 73% Timeliness 57% Combined Access &Timeliness 50%** **PASC:** **PCP Access 69% Timeliness 52% Combined &Timeliness 58%**		**Medi-Cal:** PCP Access 77% Timeliness 58% Combined Access & Timeliness 51% **CMC:** PCP Access 77% Timeliness 60% Combined Access & Timeliness 53% **LACC:** PCP Access 77% Timeliness 60% Combined Access &Timeliness 53% **PASC:** PCP Access 72% Timeliness 66% Combined &Timeliness 61%		Christine Salary (QI)/ Annette Garcia (QI)	Annually: Sept '19	**MQSC: Oct 14**			

Performance Measures for Planned Activities for Objectives	HEDIS Acronym	Regulatory Agencies	2018 Rates	2019 Rates	2019 Goal	Goal Met/Not Met	Responsible Staff/Department	Timeframe for completion	Reports to: (Dates are 2019 unless otherwise noted)	Interventions/Updates	Comments/Barriers	Recommend for '19 Work Plan
Routine Primary Care (Non-Urgent) - Practitioners surveyed have routine primary visits available within 10 business days.		**DMHC** **DHCS** **CMS** **NCQA**	**2018 MY2017 ATC Survey Results:** **Medi-Cal: 97.0%** **LACC/LACCD: 97.0%** **CMC: 97.0%** **PASC: 96.0%**		**Medi-Cal:** 100% **LACC:** 99% **CMC:** 99% **PASC:** 100%		Christine Salary (QI)/ Annette Garcia (QI)	Annually: Sept '19	**MQSC: Oct 14**			
Routine Specialty Care (Non-Urgent) - Specialist practitioners surveyed have routine specialty care visits available within 15 business days of request.		**DMHC** **DHCS** **CMS** **NCQA**	**2018 MY2017 ATC Survey Results:** **Medi-Cal: 86%** **CMC: 87%** **LACC/LACCD: 85%** **LACCD: 85%** **PASC: 91%**		**Medi-Cal:** 92% **LACC:** 90% **CMC:** 93% **PASC:** 96%		Christine Salary (QI)/ Annette Garcia (QI)	Annually: Sept '19	**MQSC: Oct 14**			
Urgent Care (PCP) - Urgent care appointments available within 48 hours. **(VIIP+P4P, Physician P4P, Plan Partner Incentive)**		**DMHC** **DHCS** **CMS** **NCQA**	**2018 MY2017 ATC Survey Results:** **Medi-Cal: 92%** **CMC: 92%** **LACC/LACCD: 92.0%** **PASC: 96.0%**		**Medi-Cal:** 96% **LACC:** 96% **CMC:** 95% **PASC:** 99%		Christine Salary (QI)/ Annette Garcia (QI)	Annually: Sept '19	**MQSC: Oct 14**			
Urgent Care (SCP) - Urgent care appointments available within 96 hours.		**DMHC** **DHCS** **CMS** **NCQA**	**2018 MY2017 ATC Survey Results:** **Medi-Cal: 82%** **CMC: 84%** **LACC/LACCD: 82%** **PASC: 90%**		**Medi-Cal:** 86% **LACC:** 87% **CMC:** 89% **PASC:** 95%		Christine Salary (QI)/ Annette Garcia (QI)	Annually: Sept '19	**MQSC: Oct 14**			
Service - *Availability*												
Drive Distance to PCP (Geomapping, Optum Reports)			**Q1 2018:** **Medi-Cal: 99.3%** **LACC: 99. 7%** **CMC: 99.0%** **Q2 - 2018** **Medi-Cal: 100%** **LACC: 99.7%** **CMC: 99.6%** **Q3-2018** **Medi-Cal : 99.6%** **LACC: 99.7%** **CMC: 99.0%** **Q4: Available Q1 2019.**		95% of members have access to a PCP within 10 miles radius of their primary residence		Gwen Cathey (PNM)/ Acacia Reed (PNM)	Quarterly	**MQSC: Oct 14**			
Drive Distance to all SCP, including identified high volume SCP (Geomapping, Optum Reports)			**Q1 2018:** **Medi-Cal: 99.8%** **LACC: 99.6%** **CMC: 98.9%** **Q2 - 2018** **Medi-Cal: 99.7%** **LACC: 99.6%** **CMC: 99.1%** **Q3-2018** **Medi-Cal: 99.7%** **LACC: 99.6%** **CMC: 99.2%** **Q4: Available Q1 2019.**		90% of members have access to specialty care practitioners within 15 miles radius of their primary residence		Gwen Cathey (PNM)/ Acacia Reed (PNM)	Quarterly	**MQSC: Oct 14**			

Performance Measures for Planned Activities for Objectives	HEDIS Acronym	Regulatory Agencies	2018 Rates	2019 Rates	2019 Goal	Goal Met/Not Met	Responsible Staff/Department	Timeframe for completion	Reports to: (Dates are 2019 unless otherwise noted)	Interventions/Updates	Comments/Barriers	Recommend for '19 Work Plan
Ratio - PCP (excludes mid-level providers) (Geomapping, Optum Reports)			**Q1 2018:** **Medi-Cal: 1:316** **LACC: 1:19** **CMC: 1:7** **Q2 - 2018** **Medi-Cal: 1: 463** **LACC: 1: 19** **CMC: 1:7** **Q3-2018** **Medi-Cal: 1:346** **LACC: 1:19** **CMC: 1:7** **Q4: Available Q1 2019.**		1: 2000 members		Gwen Cathey (PNM)/ Acacia Reed (PNM)	Quarterly	**MQSC: Oct 14**			
Ratio - High Volume Specialist (Note the top 5 specialists can vary year to year)			**Q3 2018:** **Medi-Cal:** Cardiovascular Disease: 1:3911 Podiatry: 1:7198 OB/GYN: 1:1384 Oncology: 1:5539 Ophthalmology: 1:4195 **LACC:** Urology: 1:130 Cardiovascular Disease: 1:68 Podiatry: 1:303 Dermatology: 1:435 OB/GYN: 1:1 **CMC:** Cardiovascular Disease: 1:27 Nephrology: 1:46 OB/GYN: 1:17 Oncology: 1:40 Ophthalmology: 1:27		The top 5 specialists (can vary year to year) by LOB		Gwen Cathey (PNM)/ Acacia Reed (PNM)	Annual	**MQSC: Oct 14**			
Service Improvements					**Goal Methodology:** **2018 rates used to determine an attainable % increase** **If a National benchmark was met in the Work Plan then the next benchmark was set as the goal. If the next percentile is not attainable per prior year trending, the goal was set accordingly.**							
Service - *Member Satisfaction (Experience) ADULT*												
ADULT - Rating of Health Plan (Enterprise Goal) **(Medi-Cal: Rating of 8, 9, or 10 of 10)** **(LACC: Mean-scored 0-100 -- not comparable to NCQA %s)** **(CMC: Rating of 9 or 10 of 10 Usually/Always) (Tier 1)**	**CAHPS (Medi-Cal & CMC)/ EES (LACC)**	**Star (C27)** **NCQA: Medi-Cal & CMC QRS**	**2018 Rate:** **Medi-Cal: 73.99%** **LACC: 72.55%** **CMC: 86%**		**Medi-Cal: 78%** **LACC: 76%** **CMC: 90%**		Bettsy Santana (QI)/ Rodney Truong (QPM)	Annually: Sept '19	**MQSC: Oct 14**			
ADULT - Rating of Health Care (Enterprise Goal) **(Medi-Cal: Rating of 8, 9, or 10 of 10)** **(LACC: Mean-scored 0-100 -- not comparable to NCQA %s)** **(CMC: Rating of 9 or 10 of 10 Usually/Always) (Tier 1)**	**CAHPS (Medi-Cal & CMC)/ EES (LACC)**	**Star (C26)** **NCQA: Medi-Cal & CMC QRS**	**2018 Rate:** **Medi-Cal: 66.25%** **LACC: 75.78%** **CMC: 86%**		**Medi-Cal: 70%** **LACC: 79%** **CMC: 90%**		Bettsy Santana (QI)/ Rodney Truong (QPM)	Annually: Sept '19	**MQSC: Oct 14**		**Member Experience (CG-CAHPS) measures in Plan Partner Incentive, Medi-Cal VIIP>P4P.**	
ADULT - Rating of Personal Doctor (Enterprise Goal) **(Medi-Cal: Rating of 8, 9, or 10 of 10)** **(LACC: Mean-scored 0-100 -- not comparable to NCQA %s)** **(CMC: Rating of 9 or 10 of 10 Usually/Always)**	**CAHPS (Medi-Cal & CMC)/ EES (LACC)**	**NCQA: Medi-Cal & CMC QRS**	**2018 Rate:** **Medi-Cal: 80.16%** **LACC: 86.91%** **CMC: NA**		**Medi-Cal: 84%** **LACC: 90%** **CMC: 92%**		Bettsy Santana (QI)/ Rodney Truong (QPM)	Annually: Sept '19	**MQSC: Oct 14**		**Member Experience (CG-CAHPS) measures in Plan Partner Incentive, Medi-Cal VIIP>P4P. Name of measure is "Rating of PCP".**	

Performance Measures for Planned Activities for Objectives	HEDIS Acronym	Regulatory Agencies	2018 Rates	2019 Rates	2019 Goal	Goal Met/Not Met	Responsible Staff/Department	Timeframe for completion	Reports to: (Dates are 2019 unless otherwise noted)	Interventions/Updates	Comments/Barriers	Recommend for '19 Work Plan
ADULT - Rating of Specialist Seen Most Often (Enterprise Goal) **(Medi-Cal: Rating of 8, 9, or 10 of 10 & LACC: Mean-scored 0-100 -- not comparable to NCQA %s)** **(CMC: Rating of 9 or 10 of 10 Usually/Always)**	**CAHPS (Medi-Cal & CMC)/ EES (LACC)**	**NCQA: Medi-Cal & CMC QRS**	**2018 Rate:** **Medi-Cal: 77.04%** **LACC: 84.88%** **CMC: NA**		**Medi-Cal: 80%** **LACC: 88%** **CMC: NA (No rate prior year)**		Bettsy Santana (QI)/ Rodney Truong (QPM)	Annually: Sept '19	**MQSC: Oct 14**			
ADULT - Getting Care Quickly (Enterprise Goal) **(Medi-Cal: Always+Usually)** **(LACC: Mean-scored 0-100 -- not comparable to NCQA %s.)** **(CMC: Rating of 9 or 10 of 10 Usually/Always)** **(Tier 1)**	**CAHPS (Medi-Cal & CMC)/ EES (LACC)**	**Star (C24)** **NCQA: Medi-Cal & CMC QRS**	**2018 Rate:** **Medi-Cal: 72.05%** **LACC: 67.12%** **CMC: 75%**		**Medi-Cal: 76%** **LACC: 71%** **CMC: 79%**		Bettsy Santana (QI)/ Rodney Truong (QPM)	Annually: Sept '19	**MQSC: Oct 14**		**Member Experience (CG-CAHPS) measures in Plan Partner Incentive, Medi-Cal VIIP+P4P. Name of measure is "Getting Timely Care".**	
ADULT - Getting Needed Care (Enterprise Goal) **(Medi-Cal: Always+Usually)** **(LACC: Mean-scored 0-100 -- not comparable to NCQA %s.)** **(CMC: Rating of 9 or 10 of 10 Usually/Always)** **(Tier 1)**	**CAHPS (Medi-Cal & CMC)/ EES (LACC)**	**Star (C23)** **NCQA: Medi-Cal & CMC QRS**	**2018 Rate:** **Medi-Cal: 76.79%** **LACC: 66.30%** **CMC: 83%**		**Medi-Cal: 80%** **LACC: 70%** **CMC: 87%**		Bettsy Santana (QI)/ Rodney Truong (QPM)	Annually: Sept '19	**MQSC: Oct 14**		**Member Experience (CG-CAHPS) measures in Plan Partner Incentive, Medi-Cal VIIP+P4P**	
ADULT - Customer Service (Enterprise Goal) **(Medi-Cal: Always+Usually)** **(LACC: Mean-scored 0-100 -- not comparable to NCQA %s.)** **(CMC: Rating of 9 or 10 of 10 Usually/Always)** **(Tier 2)**	**CAHPS (Medi-Cal & CMC)/ EES (LACC)**	**Star (C25)** **NCQA: Medi-Cal**	**2018 Rate:** **Medi-Cal: 87.53%** **CMC: 90%**		**Medi-Cal: 91%** **CMC: 94%**		Bettsy Santana (QI)/ Rodney Truong (QPM)	Annually: Sept '19	**MQSC: Oct 14**			
ADULT - Coordination of Care (Enterprise Goal) **(Medi-Cal: Always+Usually)** **(LACC: Mean-scored 0-100 -- not comparable to NCQA %s.)** **(CMC: Rating of 9 or 10 of 10 Usually/Always)** **(Tier 1)**	**CAHPS (Medi-Cal & CMC)/ EES (LACC)**	**Star (C28)** **NCQA: Medi-Cal & CMC QRS**	**2018 Rate:** **Medi-Cal: 78.38%** **LACC: 82.79%** **CMC: 83%**		**Medi-Cal: 82%** **LACC: 80%** **CMC: 86%**		Bettsy Santana (QI)/ Rodney Truong (QPM)	Annually: Sept '19	**MQSC: Oct 14**			
ADULT - Flu Vaccination Ages 18-64 (Enterprise Goal) **(Medi-Cal & LACC % vaccinated)** **(CMC - Annual Flu Vaccine 65 and Older - Rating of 9 or 10 of 10 Usually/Always)** **(Tier 1)** **CW7 Quality Withhold – Annual Flu Vaccine (Tier 1)**	**CAHPS (Medi-Cal & CMC)/ EES (LACC)**	**Star (C03)** **NCQA: Medi-Cal & CMC QRS** **QW**	**2018 Rate:** **Medi-Cal: 39.81%** **LACC: 36.25%** **CMC: 65%** **MCLA: 37%**		**Medi-Cal: 43%** **LACC: 40%** **CMC QW: 69%** **MCLA: 40%**		Bettsy Santana (QI)/ Rodney Truong (QPM)	Annually: Sept '19	**MQSC: Oct 14**			
ADULT - Medical Assistance with Tobacco Cessation - Advising Smokers and Tobacco Users to Quit (Enterprise Goal) **(Medi-Cal: % Yes)** **(LACC: Always+Usually)** **(CMC: Always, Usually, and Sometimes - CAHPS - Medicare)**	**CAHPS (Medi-Cal & CMC)/ EES (LACC)**	**NCQA: Medi-Cal & CMC QRS**	**2018 Rate:** **Medi-Cal: NA** **LACC: NA** **CMC: 39%**		**Medi-Cal: NA (No rate prior year)** **LACC: NA (No rate prior year)** **CMC 42%**		Bettsy Santana (QI)/ Rodney Truong (QPM)	Annually: Sept '19	**MQSC: Oct 14**			
ADULT - Access to Care (Enterprise Goal)	**CAHPS EES (LACC)**		**NA**		**LACC: 70%**		Bettsy Santana (QI)/ Rodney Truong (QPM)	Annually: Sept '19	**MQSC: Oct 14**			
ADULT - Access to Information (Enterprise Goal)	**CAHPS EES (LACC)**		**NA**		**LACC: 63%**		Bettsy Santana (QI)/ Rodney Truong (QPM)	Annually: Sept '19	**MQSC: Oct 14**			
ADULT - Plan Administration (Enterprise Goal)	**CAHPS EES (LACC)**		**NA**		**LACC: 74%**		Bettsy Santana (QI)/ Rodney Truong (QPM)	Annually: Sept '19	**MQSC: Oct 14**			

Performance Measures for Planned Activities for Objectives	HEDIS Acronym	Regulatory Agencies	2018 Rates	2019 Rates	2019 Goal	Goal Met/Not Met	Responsible Staff/Department	Timeframe for completion	Reports to: (Dates are 2019 unless otherwise noted)	Interventions/Updates	Comments/Barriers	Recommend for '19 Work Plan
Service - ***Member Satisfaction (Experience) CHILD***												
CHILD - Rating of Health Plan (Enterprise Goal) (Medi-Cal: Rating of 8, 9, or 10 of 10)	**CAHPS**	**NCQA: Medi-Cal**	**<u>2018 Rate</u>: Medi-Cal:82.97%**		**Medi-Cal: 85%**		Bettsy Santana (QI)/ Rodney Truong (QPM)	Annually: Sept '19	**MQSC: Oct 14**			
CHILD - Rating of Health Care (Enterprise Goal) (Medi-Cal: Rating of 8, 9, or 10 of 10)	**CAHPS**	**NCQA: Medi-Cal**	**<u>2018 Rate:</u> Medi-Cal: 84.13%**		**Medi-Cal: 87%**		Bettsy Santana (QI)/ Rodney Truong (QPM)	Annually: Sept '19	**MQSC: Oct 14**		**Member Experience (CG-CAHPS) measures in Plan Partner Incentive, Medi-Cal VIIP+P4P.**	
CHILD - Rating of Personal Doctor (Enterprise Goal) (Medi-Cal: Rating of 8, 9, or 10 of 10)	**CAHPS**	**NCQA: Medi-Cal**	**<u>2018 Rate:</u> Medi-Cal: 86.73%**		**Medi-Cal: 89%**		Bettsy Santana (QI)/ Rodney Truong (QPM)	Annually: Sept '19	**MQSC: Oct 14**		**Member Experience (CG-CAHPS) measures in Plan Partner Incentive, Medi-Cal VIIP+P4P. Name of measure is "Rating of PCP".**	
CHILD - Rating of Specialist Seen Most Often (Enterprise Goal) (Medi-Cal: Rating of 8, 9, or 10 of 10)	**CAHPS**	**NCQA: Medi-Cal**	**<u>2018 Rate:</u> Medi-Cal: NA**		**Medi-Cal: NA (No rate prior year)**		Bettsy Santana (QI)/ Rodney Truong (QPM)	Annually: Sept '19	**MQSC: Oct 14**			
CHILD - Getting Care Quickly (Enterprise Goal) (Medi-Cal: Always+Usually)	**CAHPS**	**NCQA: Medi-Cal**	**<u>2018 Rate:</u> Medi-Cal: 84.04%**		**Medi-Cal: 87%**		Bettsy Santana (QI)/ Rodney Truong (QPM)	Annually: Sept '19	**MQSC: Oct 14**		**Member Experience (CG-CAHPS) measures in Plan Partner Incentive, Medi-Cal VIIP+P4P. Name of measure is "Getting Timely Care".**	
CHILD - Getting Needed Care (Enterprise Goal) (Medi-Cal: Always+Usually)	**CAHPS**	**NCQA: Medi-Cal**	**<u>2018 Rate:</u> Medi-Cal: 79.04%**		**Medi-Cal: 82%**		Bettsy Santana (QI)/ Rodney Truong (QPM)	Annually: Sept '19	**MQSC: Oct 14**		**Member Experience (CG-CAHPS) measures in Plan Partner Incentive, Medi-Cal VIIP+P4P. .**	
CHILD - Customer Service (Enterprise Goal) (Medi-Cal: Always+Usually)	**CAHPS**	**NCQA: Medi-Cal**	**<u>2018 Rate:</u> Medi-Cal: 85.22%**		**Medi-Cal: 87%**		Bettsy Santana (QI)/ Rodney Truong (QPM)	Annually: Sept '19	**MQSC: Oct 14**			
CHILD - Coordination of Care (Enterprise Goal) (Medi-Cal: Always+Usually)	**CAHPS**	**NCQA: Medi-Cal**	**<u>2018 Rate:</u> Medi-Cal: NA**		**Medi-Cal: NA (No rate prior year)**		Bettsy Santana (QI)/ Rodney Truong (QPM)	Annually: Sept '19	**MQSC: Oct 14**			
Service - *Complaints and Appeals*												
Appeals Resolution (all Lines of Business)			**Q1: 88% Q2: 75% Q3: 78% Q4: 99%**		95% appeal resolution within 30 days. **<u>LACC ONLY:</u>** 90% appeal resolution within 5 days		Lisa Marie Golden (G&A)	Quarterly Reports	**MQSC: Feb 1 2, May 7, July 16, Oct 14**			
Complaint Resolution (all Lines of Business)			**Q1:93% Q2: 54% Q3: 76% Q4: 99%**		95% complaint resolution within 30 days		Lisa Marie Golden (G&A)	Quarterly Reports	**MQSC: Feb 1 2, May 7, July 16, Oct 14**			
Grievance Resolution (LACC Only)			**Q1:92% Q2: 55% Q3: 64% Q4: 74%**		95% of Covered California enrollee grievances resolved within 30 calendar days of initial receipt		Lisa Marie Golden (G&A)	Quarterly Reports	**MQSC: Feb 1 2, May 7, July 16, Oct 14**			
Complaint & Appeals Analysis - Complaint categories based on the following categories: Quality of Care, Access, Attitude/Service, Billing/Financial, and Quality of Practitioner Office Site (all Lines of Business)			**Quarterly reports reviewed at MQSC**		100% of complaints & appeals will be analyzed quarterly to identify top 5 complaint categories.		Lisa Marie Golden (G&A)	Quarterly Reports	**MQSC: Feb 1 2, May 7, July 16, Oct 14**			
Access-Related Grievances at PPG Level			**Quarterly reports reviewed at MQSC**		Baseline for 2017 with Tentative Goal ≤2 Access-Related Grievances per 1000 members per month for Medi-Cal		Lisa Marie Golden (G&A)/ Katrina Miller (QI)	Quarterly Reports	**MQSC: Feb 1 2, May 7, July 16, Oct 14**			

Performance Measures for Planned Activities for Objectives **Service -** ***Provider Satisfaction***	HEDIS Acronym	Regulatory Agencies	2018 Rates	2019 Rates	2019 Goal	Goal Met/Not Met	Responsible Staff/Department	Timeframe for completion	Reports to: (Dates are 2019 unless otherwise noted)	Interventions/Updates	Comments/Barriers	Recommend for '19 Work Plan
PCP satisfaction with UM process (timely decisions for pre-auth)			**2017 Rate: 79.4%**		80% of PCPs will be overall satisfied with timely decisions for pre-auths.		Jean Giggers (UM)/ David Kagan (UM)/ Albert Lee	Annually: Sept '19	**UMC: Dec 13**			
PCP satisfaction with UM process (clinically reasonable decisions for pre-auths)			**2017 Rate: 78.5%**		80% of PCPs will be overall satisfied with clinically reasonable decisions for pre-auths.		Jean Giggers (UM)/ David Kagan (UM)/ Albert Lee	Annually: Sept '19	**UMC: Dec 13**			
SCP satisfaction with UM process (timely decisions for pre-auths)			**2017 Rate: 71.6%**		80% of SCPs will be overall satisfied with timely decisions for pre-auths.		Jean Giggers (UM)/ David Kagan (UM)/ Albert Lee	Annually: Sept '19	**UMC: Dec 13**			
SCP satisfaction with UM process (clinically reasonable decisions for pre-auths)			**2017 Rate: 71.4%**		80% of SCPs will be overall satisfied with clinically reasonable decisions for pre-auths.		Jean Giggers (UM)/ David Kagan (UM)/ Albert Lee	Annually: Sept '19	**UMC: Dec 13**			
Clinical Improvements and Initiatives												
Clinical - ***Continuity and Coordination of Medical Care***												
Coordination of Care: PCP/SCP Communication		**NCQA**	**Rate: 42.80%**		80% of PCPs will rate the frequency of adequate clinical feedback from specialists to whom they have referred a patient		Bettsy Santana (QI)/ Maria Casias (QI)/ PNM	Annually: Sept '19	**4th Qtr. Attached to QI Eval; included in Coordination of Care Report Quality Oversight Committee (QOC) July 22, 2019**			
Coordination of Care: SCP/PCP Communication		**NCQA**	**Rate: 38.90%**		80% of SCPs will rate their communication with PCPs as receiving adequate clinical information for patient that were referred		Bettsy Santana (QI)/ Maria Casias (QI)/ PNM	Annually: Sept '19	**4th Qtr. Attached to QI Eval; included in Coordination of Care Report Quality Oversight Committee (QOC) July 22, 2019**			
Coordination of Care: Transitions in Management, ED/Inpatient to PCP **Follow-up After Hospitalization for Mental Illness (FUH)/ Quality Withhold CW8**		**NCQA** **CMS** **QW**	**Follow-up After Hospitalization for Mental Illness (FUH):** 30-Day (CMC): 46.88% 7-Day (LACC): NA (Denominator less than 30) **Postpartum Care (PPC):** MCLA: 56.05% **Prenatal Care (PPC):** MCLA: 79.62%		**2018 Goal** **Follow-up After Hospitalization for Mental Illness (FUH):** 30-Day (CMC): 56% **(QW)** **7-Day (LACC): 47%** **Postpartum Care (PPC):** MCLA: 60% **Prenatal Care (PPC):** MCLA: 75%		Andrew Guy (QI)/ Michael Brodsky (BH) Med Ops Reporting: Veronica Mones Anna Kazaryan Marie Martin	Annually: Sept '19	**4th Qtr. Attached to QI Eval; included in Coordination of Care Report Quality Oversight Committee (QOC) July 22, 2019**			
Clinical - *Continuity and Coordination of Medical and Behavioral Care*												
Exchange of Information between PCPs and Behavioral Health Providers (BHPs)		**NCQA**	**DMH- 76.4%** **Beacon-70.7%**		80% of providers will be always/usually satisfied with the exchange of information between PCPs and BHPs (ALOB)		Nicole Lehman (BH)/ Michael Brodsky (BH)/ Beacon	Annual: Due Oct '19	**Behavioral Health Quality Improvement Committee (BHQIC):** **Dec 3**			
Appropriate diagnosis, treatment and referral of behavioral health disorders commonly seen in primary care: Appropriate Treatment of Depression		**NCQA: Medi-Cal (Continuation Phase ONLY)** **QRS**	**U** **AMM (Acute Phase):** Medi-Cal: 64.72% LACC: 60.77% CMC: 65.71% **AMM (Continuation Phase):** Medi-Cal: 46.10% LACC: 47.69% CMC: 53.89%		**LACC:** 50% of providers will meet clinical practice guidelines for members with depression: Percent of members(18+) newly diagnosed with depressive disorder who received two or more outpatient Behavioral Health (BH) visits within 84 days (12 weeks) of initial diagnostic visit and who received one or more medication visits within 84 days (12 weeks) of initial diagnostic visit **AMM (Acute Phase):** Medi-Cal: 66% LACC: 65% CMC: 68% **AMM (Continuation Phase):** Medi-Cal: 50% LACC: 53% CMC: 56%		Grace Crofton (QPM)/ Ron Makita (QPM) / Michael Brodsky (BH)/ Andrew Guy (QI)/ Beacon	Annual: Due Oct '19	**BHQIC: Dec 3**			
Management of treatment access and follow-up for members with coexisting medical and behavioral disorders		**NCQA**	**2018 Rate: 100%**		100% of providers will be notified of members on diabetes and antipsychotic medication		Nicole Lehman (BH)/ Michael Brodsky (BH)/ Andre Guy (QI)	Annual	**BHQIC: Dec 3**			
Primary or secondary preventive behavioral health program		**NCQA**	**10.9% (AMSC)**		Substance Abuse Screening (AMSC)		Nicole Lehman (BH)/ Michael Brodsky (BH)	Annual	**BHQIC: Dec 3**			

Performance Measures for Planned Activities for Objectives	HEDIS Acronym	Regulatory Agencies	2018 Rates	2019 Rates	2019 Goal	Goal Met/Not Met	Responsible Staff/Department	Timeframe for completion	Reports to: (Dates are 2019 unless otherwise noted)	Interventions/Updates	Comments/Barriers	Recommend for '19 Work Plan
Special needs of members with severe and persistent mental illness		**NCQA: Medi-Cal**	**Medi-Cal: 85.6%** **LACC: 67.9%** **CMC: 75.7%**		HEDIS results for Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) **Cal MediConnect & LACC: MPL** **Medi-Cal: 88%**		Grace Crofton (QPM)/ Ron Makita (QPM)/ Nicole Lehman (BH)/ Michael Brodsky (BH)/ Andre Guy (QI)	Annual	**BHQIC: Dec 3**			
Clinical Improvements Note that HEDIS measure goals are set ensuring that MPLs are met.		**Hybrid (H)/Admin (A)/** **Electronic Clinical Data Systems (ECDS)/** **Auto-Assignment/** **Star/Accreditation (NCQA)/** **EAS (DHCS)/** **QRS (LACC)/Quality Withhold (QW)**	**2018 HEDIS Rates** **(MY 2017)**	**2019 HEDIS Rates** **(MY 2018)**	**Goal Methodology:** **2018 rates used to determine an attainable % increase** **If a National benchmark was met in the Work Plan then the next benchmark was set as the goal. If the next percentile is not attainable per prior year trending, the goal was set accordingly.**							
Clinical Improvement												
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis **(Plan Partner Incentive, Medi-Cal VIIP+P4P and Physician P4P)**	**AAB**	**A** **EAS** **QRS** **NCQA: Medi-Cal**	**2018 Rates:** Medi-Cal: 33.63% LACC: 35.37%		**Medi-Cal: 30%** **LACC: 32%**		Bettsy Santana (QI)/ Rodney Truong (QPM)	Annual: By June '19	**QOC: September 23** **PICC & PQC: Oct 29**			
Colorectal Cancer Screening **(Tier 1)**	**COL**	**H** **Star (C02)** **NCQA: Medicare** **QRS**	**2018 Rates:** CMC: 57.66% LACC: 49.15%		**CMC: 61%** **LACC; 54%**		Bettsy Santana (QI)/ Rodney Truong (QPM) Med Ops Reporting: Veronica Mones Anna Kazaryan Marie Martin	Annual: Due June '19	**QOC: September 23** **PICC & PQC: Oct 29**			
Adult BMI Assessment	**ABA**	**H** **Star (C07)** **NCQA: Med-Cal** **QRS**	**2018 Rates:** Medi-Cal: 95.83% LACC: 93.20% CMC: 95.83% MCLA: 96.49%		**Medi-Cal: 96%** **LACC: 95%** **CMC: 98%** **MCLA: 98%**		Bettsy Santana (QI)/ Rodney Truong (QPM)	Annual: By June '19	**QOC: September 23** **PICC & PQC: Oct 29**			
Children's Health/Well Visits												
Well Child Visits First 15 Months of Life	**W15**	**H** **QRS**	**2018 Rate:** **LACC: NA**		**LACC: NA (No rate prior year)**		Bettsy Santana (QI)/ Rodney Truong (QPM)	Annual: By June '19	**QOC: September 23** **PICC & PQC: Oct 29**			
Well Child Visits 3-6 yrs of age **(Plan Partner Incentive, Medi-Cal VIIP+P4P and Physician P4P)**	**W34**	**H** **Auto-Assignment** **EAS** **QRS**	**2018 Rate:** Medi-Cal: 74.65% LACC: 65.63%		**Medi-Cal: 79%** **LACC: 76%**		Bettsy Santana (QI)/ Rodney Truong (QPM)	Annual: By June '19	**QOC: September 23** **PICC & PQC: Oct 29**			
Weight Assessment & Counseling for Nutrition & Physical Activity for Children & Adolescents **(Plan Partner Incentive, Medi-Cal VIIP+P4P and Physician P4P - [BMI Total])**	**WCC**	**H** **BMI:** **NCQA: Medi-Cal** **QRS** **Nutrition & Physical Activity:** **NCQA: Medi-Cal** **(Retiring for H2019)** **EAS** **QRS**	**2018 Rates:** **Medi-Cal** BMI: 78.89% **LACC:** BMI: 76.17% Nutrition: 77.46% Physical Activity: 68.65%		**Medi-Cal** **BMI: 81%** **LACC:** **BMI: 81%** **Nutrition; 82%** **Physical Activity: 74%**		Bettsy Santana (QI)/ Rodney Truong (QPM)	Annual: By June '19	**QOC: September 23** **PICC & PQC: Oct 29**			
Childhood Immunizations- Combo 3	**CIS-3**	**H** **Auto-Assignment** **EAS** **QRS**	**2018 Rate:** Medi-Cal: 70.80% LACC: NA (Denominator less than 30)		**Medi-Cal: 74%** **LACC: 20%**		Bettsy Santana (QI)/ Rodney Truong (QPM)	Annual: By June '19	**QOC: September 23** **PICC & PQC: Oct 29**			

Performance Measures for Planned Activities for Objectives	HEDIS Acronym	Regulatory Agencies	2018 Rates	2019 Rates	2019 Goal	Goal Met/Not Met	Responsible Staff/Department	Timeframe for completion	Reports to: (Dates are 2019 unless otherwise noted)	Interventions/Updates	Comments/Barriers	Recommend for '19 Work Plan
Childhood Immunizations- Combo 10 **(Enterprise Goal)** **(Plan Partner Incentive, Medi-Cal VIIP+P4P and Physician P4P)**	**CIS-10**	**H** **NCQA: Medi-Cal**	**2018 Rate:** Medi-Cal: 31.63% LACC: NA MCLA: 30.80%		**Medi-Cal: 34%** **LACC: 20%** **MCLA: 33%**		Bettsy Santana (QI)/ Rodney Truong (QPM)	Annual: By June '19	**QOC: September 23** **PICC & PQC: Oct 29**			
Children and Adolescents Access to PCP for (ages 7-11)	**CAP (ages 7-11)**	**A** **EAS**	**2018 Rate:** Medi-Cal: 89.14%		**Medi-Cal: 94%**		Bettsy Santana (QI)/ Rodney Truong (QPM)	Annual: By June '19	**QOC: September 23** **PICC & PQC: Oct 29**			**N**
Children and Adolescents Access to PCP for (ages 12-19)	**CAP (ages 12-19)**	**A** **EAS**	**2018 Rate:** Medi-Cal: 86.49%		**Medi-Cal: 90%**		Bettsy Santana (QI)/ Rodney Truong (QPM)	Annual: By June '19	**QOC: September 23** **PICC & PQC: Oct 29**			**Y**
Immunization for Adolescents - Combination 2 **(Plan Partner Incentive, Medi-Cal VIIP+P4P and Physician P4P)**	**IMA-2**	**H** **NCQA: Medi-Cal** **EAS** **QRS**	**2018 Rate:** Medi-Cal: 39.66% LACC: NA (Denominator less than 30)		**Medi-Cal: 42%** **LACC: 35%**		Bettsy Santana (QI)/ Rodney Truong (QPM)	Annual: By June '19	**QOC: September 23** **PICC & PQC: Oct 29**			
Appropriate Testing for Children w/ Pharyngitis **(Plan Partner Incentive, Medi-Cal VIIP+P4P and Physician P4P)**	**CWP**	**A** **NCQA: Medi-Cal** **QRS**	**2018 Rate:** Medi-Cal: 28.98% LACC: NA (Denominator less than 30)		**Medi-Cal: 32%** **LACC: NA** **(Prior year denominator <30)**		Bettsy Santana (QI)/ Rodney Truong (QPM)	Annual: By June '19	**QOC: September 23** **PICC & PQC: Oct 29**			
Appropriate Rx for Children w/ URI	**URI**	**A** **NCQA: Medi-Cal** **QRS**	**2018 Rate:** Medi-Cal: 88.82% LACC: 87.10%		**Medi-Cal: 85%** **LACC: 84%**		Bettsy Santana (QI)/ Rodney Truong (QPM)	Annual: By June '19	**QOC: September 23** **PICC & PQC: Oct 29**			
Women's Health Initiatives												
Prenatal Visits **(Plan Partner Incentive, Medi-Cal VIIP+P4P and Physician P4P)**	**PPC (Prenatal)**	**H** **Auto Assignment** **NCQA: Medi-Cal** **EAS** **QRS**	**2018 Rate:** Medi-Cal: 82.22% LACC: 79.69%		**Medi-Cal: 84%** **LACC: 85%**		Nai Kasick (HECLS)/ Rodney Truong (QPM)	Annual: By June '19	**QOC: September 23** **PICC & PQC: Oct 29**			
Postpartum Care **(Plan Partner Incentive, Medi-Cal VIIP+P4P and Physician P4P)**	**PPC (Postpartum)**	**H** **NCQA: Medi-Cal** **EAS** **QRS**	**2018 Rate:** Medi-Cal: 56.54% LACC: 62.50%		**Medi-Cal: 60%** **LACC: 65%**		Nai Kasick (HECLS)/ Rodney Truong (QPM)	Annual: By June '19	**QOC: September 23** **PICC & PQC: Oct 29**			
Breast Cancer Screenings **(Plan Partner Incentive, Medi-Cal VIIP+P4P and Physician P4P)**	**BCS**	**A** **Star (C01)** **EAS** **QRS** **NCQA: Medi-Cal & Medicare**	**2018 Rate:** Medi-Cal: 59.53% LACC: 64.64% CMC: 60.08%		**Medi-Cal: 61%** **LACC: 71%** **CMC: 64%**		Bettsy Santana (QI)/ Rodney Truong (QPM)	Annual: By June '19	**QOC: September 23** **PICC & PQC: Oct 29**			

Performance Measures for Planned Activities for Objectives	HEDIS Acronym	Regulatory Agencies	2018 Rates	2019 Rates	2019 Goal	Goal Met/Not Met	Responsible Staff/Department	Timeframe for completion	Reports to: (Dates are 2019 unless otherwise noted)	Interventions/Updates	Comments/Barriers	Recommend for '19 Work Plan
Cervical Cancer Screenings **(Plan Partner Incentive, Medi-Cal VIIP+P4P and Physician P4P)**	**CCS**	**H** **Auto-Assignment** **EAS** **QRS** **NCQA: Medi-Cal**	**2018 Rate:** Medi-Cal: 60.55% LACC: 50.98%		**Medi-Cal: 64%** **LACC: 57%**		Bettsy Santana (QI)/ Rodney Truong (QPM)	Annual: By June '19	**QOC: September 23** **PICC & PQC: Oct 29**			
Chlamydia Screening In Women (Total) **(Plan Partner Incentive, Medi-Cal VIIP+P4P and Physician P4P)**	**CHL**	**A** **NCQA: Medi-Cal** **QRS**	**2018 Rate:** Medi-Cal: 64.71% LACC: 59.45%		**Medi-Cal: 67%** **LACC: 63%**		Bettsy Santana (QI)/ Rodney Truong (QPM)/ Nai Kasick (HECLS)	Annual: By June '19	**QOC: September 23** **PICC & PQC: Oct 29**			
Chronic Condition Measures (Plan Wide)												
Medication Management for People with Asthma (MMA) - 75% Compliance	**MMA - 75%**	**A** **75% Compliance Rate** **NCQA: Medi-Cal** **QRS**	**2018 Rate:** Medi-Cal: 54.27% LACC: 78.13%		**Medi-Cal:** **75% compliance: 56%** **LACC:** **75% compliance: 81%**		Bettsy Santana (QI)/ Rodney Truong (QPM)	Annual: By June '19	**QOC: September 23** **PICC & PQC: Oct 29**			
Diabetes: Eye Exam (retinal) performed **(Plan Partner Incentive, Medi-Cal VIIP+P4P and Physician P4P)**	**CDC-** **Eye Exam**	**H** **Star (C13)** **NCQA: Medi-Cal & Medicare** **EAS** **QRS**	**2018 Rate:** Medi-Cal: 63.26% LACC: 48.17% CMC: 70.37%		**Medi-Cal: 69%** **LACC: 53%** **CMC: 76%**		Bettsy Santana (QI)/ Rodney Truong (QPM)	Annual: By June '19	**QOC: September 23** **PICC & PQC: Oct 29**			
Diabetes: A1C Screening **(Plan Partner Incentive, Medi-Cal VIIP+P4P and Physician P4P)**	**CDC-** **A1C Screening**	**H** **Auto-Assignment** **EAS** **QRS**	**2018 Rate:** Medi-Cal: 86.37% LACC: 90.95% CMC: 90.37%		**Medi-Cal: 88%** **LACC: 93%** **CMC: 92%**		Bettsy Santana (QI)/ Rodney Truong (QPM)	Annual: By June '19	**QOC: September 23** **PICC & PQC: Oct 29**			
Diabetes: A1C Poor Control (>9.0%) (A lower rate indicates better performance)	**CDC-** **A1C Poor Control (>9.0%)**	**H** **Star (C15)** **EAS**	**2018 Rate:** Medi-Cal: 35.52% CMC: 24.44%		**Medi-Cal: 32%** **CMC: 22%**		Bettsy Santana (QI)/ Rodney Truong (QPM)	Annual: By June '19	**QOC: September 23** **PICC & PQC: Oct 29**			
Diabetes: A1C Good Control (<8.0%) **(Enterprise Goal)** **(Plan Partner Incentive, Medi-Cal VIIP+P4P and Physician P4P)**	**CDC-** **A1C Good Control (<8.0%)**	**H** **NCQA: Medi-Cal & Medicare** **EAS** **QRS**	**2018 Rate:** Medi-Cal: 51.09% LACC: 62.35% CMC: 62.47%		**Medi-Cal: 54%** **LACC: 64%** **CMC: 66%**		Bettsy Santana (QI)/ Rodney Truong (QPM)	Annual: By June '19	**QOC: September 23** **PICC & PQC: Oct 29**			
Diabetes: Medical attention for nephropathy	**CDC-** **Nephropathy**	**H** **Star (C14)** **EAS** **QRS**	**2018 Rate:** Medi-Cal: 92.70% LACC: 94.13% CMC: 96.79%		**Medi-Cal: 93%** **LACC: 96%** **CMC: 99%**		Bettsy Santana (QI)/ Rodney Truong (QPM)	Annual: By June '19	**QOC: September 23** **PICC & PQC: Oct 29**			
Diabetes: Blood Pressure Control (<140/90 mm Hg)	**CDC-** **Blood Pressure Control (<140/90 mm Hg)**	**H** **NCQA: Medi-Cal & Medicare** **EAS**	**2018 Rate:** Medi-Cal: 65.21% CMC: 69.63%		**Medi-Cal: 69%** **CMC: 75%**		Bettsy Santana (QI)/ Rodney Truong (QPM)	Annual: By June '19	**QOC: September 23** **PICC & PQC: Oct 29**			

Performance Measures for Planned Activities for Objectives	HEDIS Acronym	Regulatory Agencies	2018 Rates	2019 Rates	2019 Goal	Goal Met/Not Met	Responsible Staff/Department	Timeframe for completion	Reports to: (Dates are 2019 unless otherwise noted)	Interventions/Updates	Comments/Barriers	Recommend for '19 Work Plan
Statin Therapy for Patients with Cardiovascular Disease	**SPC**	**A** **Star (C22)** **(NCQA: Medi-Cal & Medicare**	**2018 Rate:** Medi-Cal Total Statin Therapy: 73.13% Medi-Cal Total Adherence: 76.98% CMC Total Statin Therapy: 74.84% CMC Total Adherence: 76.42%		**Medi-Cal Total Statin Therapy: 76%** **Medi-Cal Total Adherence: 79%** **CMC Total Statin Therapy: 77%** **CMC Total Adherence: 79%**		Joseph Mishreki (Pharm)/ Rodney Truong (QPM)	Annual: By June '19	**QOC: September 23** **PICC & PQC: Oct 29**			
Statin Therapy for Patients with Diabetes	**SPD**	**A** **NCQA: Medi-Cal & Medicare**	**2018 Rate:** Medi-Cal Received Statin Therapy: 64.20% Medi-Cal Statin Adherence: 72.03% CMC Received Statin Therapy: 72.43% CMC Statin Adherence: 75.30%		**Medi-Cal Received Statin Therapy: 67%** **Medi-Cal Statin Adherence: 74%** **CMC Received Statin Therapy: 75%** **CMC Statin Adherence: 77%**		Joseph Mishreki (Pharm)/ Rodney Truong (QPM)	Annual: By June '19	**QOC: September 23** **PICC & PQC: Oct 29**			
Controlling High Blood Pressure **(Enterprise Goal)** **(Plan Partner Incentive, Medi-Cal VIIP+P4P and Physician P4P)**	**CBP**	**H** **Auto-Assignment** **NCQA: Medi-Cal** **EAS** **QRS** **QW**	**2018 Rate:** Medi-Cal: 65.03% LACC: 56.36% CMC: 69.54% MCLA: 64.60%		**Medi-Cal: 73%** **LACC: 61%** **CMC: 56%** **MCLA: 67%**		Bettsy Santana (QI)/ Rodney Truong (QPM)	Annual: By June '19	**QOC: September 23** **PICC & PQC: Oct 29**			
Asthma Medication Ratio (Total) **(Enterprise Goal)** **(Plan Partner Incentive, Medi-Cal VIIP+P4P and Physician P4P)**	**AMR**	**A** **NCQA: Medi-Cal**	**2018 Rates:** Medi-Cal: 62.09% MCLA: 56.70%		**Medi-Cal: 65%** **MCLA: 62%**		Bettsy Santana (QI)/ Rodney Truong (QPM)	Annual: By June '19	**QOC: September 23** **PICC & PQC: Oct 29**			
Use of Imaging Studies for Low Back Pain	**LBP**	**A** **NCQA: Medi-Cal** **EAS** **QRS**	**2018 Rate:** Medi-Cal: 72.41% LACC: 76.27%		**Medi-Cal: 68%** **LACC: 72%**		Bettsy Santana (QI)/ Rodney Truong (QPM)	Annual: By June '19	**QOC: September 23** **PICC & PQC: Oct 29**			
Pharmacotherapy Management of COPD Exacerbation (dispensed a systemic corticosteroid within 14 days of the event) **(Enterprise Goal)**	**PCE-** **(dispensed a systemic corticosteroid within 14 days of the event)**	**A** **NCQA: Medi-Cal & Medicare**	**2018 Rate:** Medi-Cal: 59.20% CMC: 61.17% MCLA: 57.20%		**Medi-Cal: 62%** **CMC: 62%** **MCLA: 62%**		Bettsy Santana (QI)/ Rodney Truong (QPM)/ Elaine Sadocchi-Smith (QI)	Annual: By June '19	**QOC: September 23** **PICC & PQC: Oct 29**			
Pharmacotherapy Management of COPD Exacerbation (dispensed a bronchodilator within 30 days of the event)	**PCE-** **(dispensed a bronchodilator within 30 days of the event)**	**A** **NCQA: Medi-Cal & Medicare**	**2018 Rate:** Medi-Cal: 77.20% CMC: 85.11%		**Medi-Cal: 80%** **CMC: 88%**		Bettsy Santana (QI)/ Rodney Truong (QPM)/ Elaine Sadocchi-Smith (QI)	Annual: By June '19	**QOC: September 23** **PICC & PQC: Oct 29**			
Annual Monitoring for Patients on Persistent Medications-ACE inhibitors or ARBs	**MPM-** **ACE inhibitors or ARBs**	**A** **EAS** **QRS**	**2018 Rate:** Medi-Cal: 88.96% LACC: 86.38%		**Medi-Cal: 91%** **LACC: 88%**		Bettsy Santana (QI)/ Rodney Truong (QPM)	Annual: By June '19	**QOC: September 23** **PICC & PQC: Oct 29**			
Annual Monitoring for Patients on Persistent Medications-Diuretics	**MPM-** **Diuretics**	**A** **EAS** **QRS**	**2018 Rate:** Medi-Cal: 88.33% LACC: 85.19%		**Medi-Cal: 91%** **LACC: 87%**		Bettsy Santana (QI)/ Rodney Truong (QPM)	Annual: By June '19	**QOC: September 23** **PICC & PQC: Oct 29**			
Annual Monitoring for Patients on Persistent Medications **Total** (Monitoring Key Long-term Medications) (note state measure excludes anticonvulsant)	**MPM-** **Total**	**A** **QRS**	**2018 Rate:** LACC: 86.02%		**LACC: 87%**		Bettsy Santana (QI)/ Rodney Truong (QPM)	Annual: By June '19	**QOC: September 23** **PICC & PQC: Oct 29**			

Performance Measures for Planned Activities for Objectives Other Measures	HEDIS Acronym	Regulatory Agencies	2018 Rates	2019 Rates	2019 Goal	Goal Met/Not Met	Responsible Staff/Department	Timeframe for completion	Reports to: (Dates are 2019 unless otherwise noted)	Interventions/Updates	Comments/Barriers	Recommend for '19 Work Plan
Board Certification	**BCR**	**A**	**Fam Med:** 63.93% **IM:** 73.19% **Pediatricians:** 75.77% **OB/GYN:** 79.60% **Geriatricians:** 65.73% **Other:** 80.88%		**NA**		Rodney Truong (QPM)	Annual: By June '19	**QOC: September 23** **PICC & PQC: Oct 29**			
Topical Fluoride Varnish Utilization			20.27 PTPY individuals received fluoride treatment in 2017 compared to 23.90 PTPY in 2016 (<6 yrs).		**NA**		Bettsy Santana (QI) / Marla Lubert (QI)	Annual: By June '19	**QOC: July 22**			
Behavioral Health					**QW: Quality Withhold Measure**							
Antidepressant Medication Management (Acute Phase)	**AMM-** **Acute Phase**	**A** **QRS**	**2018 Rates:** LACC: 60.77%		**LACC: 65%**		Bettsy Santana (QI)/ Rodney Truong (QPM)	Annual: By June '19	**BHQIC: Sept. 10**			
Antidepressant Medication Management (Continuation Phase)	**AMM-** **Continuation Phase**	**A** **NCQA: Medi-Cal & Medicare** **QRS**	**2018 Rates:** Medi-Cal: 46.10% LACC: 47.69% CMC: 53.89%		**Medi-Cal: 50%** **LACC: 53%** **CMC: 56%**		Bettsy Santana (QI)/ Rodney Truong (QPM)	Annual: By June '19	**BHQIC: Sept. 10**			
Follow-Up for Children Prescribed ADHD Medication-initiation Phase	**ADD-** **Initiation Phase**	**A** **QRS**	**2018 Rates:** LACC: NA (Denominator less than 30)		**LACC: NA** **(Prior year denominator <30)**		Bettsy Santana (QI)/ Rodney Truong (QPM)	Annual: By June '19	**QOC: September 23** **PICC & PQC: Oct 29**			
Follow-Up for Children Prescribed ADHD Medication - Continuation and Maintenance Phase	**ADD-** **Continuation and Maintenance Phase**	**A** **QRS** **NCQA: Medi-Cal**	**2018 Rates:** Medi-Cal: 41.88% LACC: NA (Denominator less than 30)		**Medi-Cal: 45%** **LACC: NA (Prior year rate <30)**		Bettsy Santana (QI)/ Rodney Truong (QPM)	Annual: By June '19	**QOC: September 23** **PICC & PQC: Oct 29**			
Follow-Up After Hospitalization for Mental Illness (in 7 days) **(Enterprise Goal)**	**FUH7**	**A** **QRS** **NCQA: Medi-Cal & Medicare**	**2018 Rates:** Medi-Cal: NB LACC: NA (Denominator less than 30) CMC: 28.13%		**Medi-Cal: NB (Not a benefit)** **LACC: 31%** **CMC: 30%**		Bettsy Santana (QI)/ Rodney Truong (QPM)	Annual: By June '19	**QOC: September 23** **PICC & PQC: Oct 29**			
Follow-Up After Hospitalization for Mental Illness (in 30 days) **(Enterprise Goal)**	**FUH30**	**A** **QW**	**2018 Rates:** CMC: 46.88%		**CMC QW: 56%**		Bettsy Santana (QI)/ Rodney Truong (QPM)	Annual: By June '19	**QOC: September 23** **PICC & PQC: Oct 29**			
Depression Screening and follow-up plan (DSF)	**DSF**	**EAS**	**2018 Rates:** Medi-Cal Screening: 2.11% Medi-Cal Follow-Up: 68.04%		**First year measure for H2018. ECDS was not reported and status of auditing ECDS for H2019 is still pending so goal is pending.**		Bettsy Santana (QI)/ Rodney Truong (QPM)	Annual: By June '19	**BHQIC: Sept. 10**			
Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications	**SSD**	**A** **NCQA: Medi-Cal** **CMC & LACC: NCQA Report**	**2018 Rates:** Medi-Cal: 85.25%		**Medi-Cal: 88%**		Bettsy Santana (QI)/ Rodney Truong (QPM)	Annual: By June '19	**QOC: September 23** **PICC & PQC: Oct 29**			
Diabetes Monitoring for People with Diabetes and Schizophrenia	**SMD**	**A** **NCQA Report**	**2018 Rates:** Medi-Cal: 70.40%		**Medi-Cal: 72%**		Bettsy Santana (QI)/ Rodney Truong (QPM)	Annual: By June '19	**QOC: September 23** **PICC & PQC: Oct 29**			

Performance Measures for Planned Activities for Objectives	HEDIS Acronym	Regulatory Agencies	2018 Rates	2019 Rates	2019 Goal	Goal Met/Not Met	Responsible Staff/Department	Timeframe for completion	Reports to: (Dates are 2019 unless otherwise noted)	Interventions/Updates	Comments/Barriers	Recommend for '19 Work Plan
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment - **Initiation Total**	**IET- Initiation Total**	**A** **QRS**	**2018 Rates:** LACC: 23.94%		**LACC: 29%**		Bettsy Santana (QI)/ Rodney Truong (QPM)	Annual: By June '19	**QOC: September 23 PICC & PQC: Oct 29**			
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment - **Engagement Total**	**IET- Engagement Total**	**A** **NCQA: Medicare QRS**	**2018 Rates:** Medi-Cal: Not available LACC: 0.70% CMC: 3.33%		**Medi-Cal: NB (Not a benefit) LACC: 2% CMC: 4%**		Bettsy Santana (QI)/ Rodney Truong (QPM)	Annual: By June '19	**QOC: September 23 PICC & PQC: Oct 29**			
Disease Management Programs- Asthma												
Medication Management for People with Asthma 75% compliance	**MMA- 75% Compliance**	**A** **NCQA: Medi-Cal QRS**	**2018 Rates:** MCLA: 43.59% LACC: 78.13%		**MCLA: 45% LACC: 81%**		Elaine Sadocchi-Smith (QI)/ Rodney Truong (QPM)	Annual: By June '19	**QOC: September 23 PICC & PQC: Oct 29**			
% of members who have Asthma Action Plan	**AAP**	**None**	**2018 Rates:** 34.0%		**65% for all lines of business (measured by Disease Management satisfaction survey; member self-report)**		Elaine Sadocchi-Smith (QI)	Annual: By Oct. '19	**QOC: September 23 PICC & PQC: Oct 29**			
Member Satisfaction with Disease Management Programs-Asthma		**None**	**2018 Rates:** 97.8%		95% of the members in Asthma program will be overall satisfied (all LOBs)		Elaine Sadocchi-Smith (QI)	Annual: By Oct. '19	**QOC: Nov 25**			
Disease Management Programs- Diabetes												
Diabetes: Eye Exam (retinal) performed	**CDC- Eye Exam**	**H** **Star (C13) NCQA: Medi-Cal & Medicare EAS QRS**	**2018 Rates:** MCLA: 64.84% LACC: 48.17 % CMC: 70.37%		**MCLA: 69% LACC: 53% CMC: 76%**		Elaine Sadocchi-Smith (QI)/ Rodney Truong (QPM)	Annual: By Oct. '19	**QOC: September 23 PICC & PQC: Oct 29**			
Diabetes: A1C	**CDC- A1C Screening**	**H** **Auto-Assignment EAS QRS**	**2018 Rates:** MCLA: 84.77% LACC: 90.95% CMC: 90.37%		**MCLA: 88% LACC: 93% CMC: 92%**		Elaine Sadocchi-Smith (QI)/ Rodney Truong (QPM)	Annual: By Oct. '19	**QOC: September 23 PICC & PQC: Oct 29**			
Diabetes: A1C Poor Control (>9.0%) (Note the lower (A lower rate indicates better performance)	**CDC- A1C Poor Control (>9.0%)**	**H** **Star (C15) EAS**	**2018 Rates:** MCLA: 34.77% CMC: 24.44%		**MCLA: 28% CMC: 22%**		Elaine Sadocchi-Smith (QI)/ Rodney Truong (QPM)	Annual: By Oct. '19	**QOC: September 23 PICC & PQC: Oct 29**			
Diabetes: A1C Good Control (<8.0%) **(Enterprise Goal)**	**CDC- A1C Good Control (<8.0%)**	**H** **Star (C15) NCQA: Medi-Cal & Medicare EAS QRS**	**2018 Rates:** MCLA: 49.22% LACC: 62.35% CMC: 62.47%		**MCLA: 54% LACC: 64% CMC: 66%**		Elaine Sadocchi-Smith (QI)/ Rodney Truong (QPM)	Annual: By Oct. '19	**QOC: September 23 PICC & PQC: Oct 29**			
Diabetes: Medical Attention for Nephropathy	**CDC- Nephropathy**	**H** **Star (C14) EAS QRS**	**2018 Rates:** MCLA: 92.97% LACC: 94.13% CMC: 96.79%		**MCLA: 94% LACC: 96% CMC: 99%**		Elaine Sadocchi-Smith (QI)/ Rodney Truong (QPM)	Annual: By Oct. '19	**QOC: September 23 PICC & PQC: Oct 29**			
Member Satisfaction with Disease Management Programs-Diabetes			**2018 Rate:** 94.5%		90% for all lines of business for all programs		Elaine Sadocchi-Smith (QI)	Annual: By Oct. '19	**QOC: Nov 25**			

Performance Measures for Planned Activities for Objectives **Disease Management Programs- Cardiovascular Disease (CVD)**	HEDIS Acronym	Regulatory Agencies	2018 Rates	2019 Rates	2019 Goal	Goal Met/Not Met	Responsible Staff/Department	Timeframe for completion	Reports to: (Dates are 2019 unless otherwise noted)	Interventions/Updates	Comments/Barriers	Recommend for '19 Work Plan
Member Satisfaction with Disease Management Programs- CVD		**None**	**2018 Rate:** 87.0%		90% for all lines of business for all programs		Elaine Sadocchi-Smith (QI)	Annual: By Oct. '19	**QOC: Nov 25**			
State Quality Improvement Projects												
Childhood Immunization Status-3 PIP			**Jan 2018: 50%** **Dec 2018: 43%**		By June 30, 2019, increase the rate of CIS-3 completion by age two in the San Gabriel Valley from 40.9% to 51%		Carolina Coleman (QI)/ Bettsy Santana (QI)	Due to State: July 2019	**QOC: September 23** **PICC & PQC: Oct 29**			
Improving medication adherence in African Americans on Diabetes medication PIP			**Jan 2018: 56%** **Dec 2018: 44%**		By June 30, 2019, decrease the rate of African American Medi-Cal Direct members 35-45 years old, who are not assigned to DHS and have a PDC for diabetes medication of 0.8 or less, from 54% to 38%.		Carolina Coleman (QI)/ Bettsy Santana (QI)	Due to State: July 2019	**QOC: September 23** **PICC & PQC: Oct 29**			
Medicare/Medicaid Quality Improvement Projects												
Reducing Avoidable Hospital Admissions Long Term Care Facilities (PDSA)		**CMS**	**NA**		By, January 31, 2019, a targeted intervention to potentially reduce inpatient hospitalizations, potentially avoidable ED visits, and readmission rates for L.A. Care MediConnect members residing in nursing facilities by 10%		Keren Mahgerefteh (QI)/ Bettsy Santana (QI)	Quarterly	**Jan. 31, 2019**			
CMS MMP- Individualized Care Plan (PIP)		**CMS**	**2018 Rates:** **Measure 1.5 High Risk:** **Baseline rate -2017 Q4 37.27%** **Q1 2018 59%** **Q2 2018 60%** **Q3 2018 58%** **Measure 1.5 Low Risk:** **Baseline rate- 2017 Q4 36.06%** **Q1 2018 57%** **Q2 2018 58%** **Q3 2018 66%** **Measure 1.6:** **Baseline rate for 2017 100%** **Q1 2018 100%** **Q2 2018 96%** **Q3 2018 100%** -		By, March 15, 2019: **Measure 1.5:** High Risk - 2018 Goal: 39% **Measure 1.5:** Low Risk - 2018 Goal: 40% **Measure 1.6:** CMC members who has an ICP and had at least one documented discussion of care goals in the initial ICP. To maintain the baseline rate of 100%.		Karen Mahgerefteh (QI)/ Bettsy Santana (QI)	Due to CMS/DHCS: March 16, 2018	**5/17/19 and 7/18/2019**			
Postpartum Care (PDSA)	**PPC- Post**	**DHCS**	**56.54%**		**60%**		Andrew Guy (QI)/ Bettsy Santana (QI)	7/1/2019	**30-Apr-19**			
Clinical - *Patient Safety*												
Potential Quality Issues			**Q1 & Q2: 99.7%** **Q3 & Q4: 99.5%**		100% of PQI investigation will be completed in 6 months		Christine Chueh (QI)	Biannually and end of year	**Credentialing/** **Peer Review Committee:** **May 24, Nov 15**			
Critical Incidents Reporting and Tracking			**Rate: 100%**		Measure 1.6: CMC members who has an ICP and had at least one documented discussion of care goals in the initial ICP. To maintain the baseline rate of 100%.		Christine Chueh (QI)	Biannually and end of year	**QOC: May 22 Nov 29**			
FSR- needlestick safety			**Q1: Compliance Rate = 75%** **Q2: Compliance Rate = 74%** **Q3: Compliance Rate = 72%** **Q4: Compliance Rate = 75%**		80%		Dulce Fernandez (FSR)	Quarterly	**QOC: May 22**			

Performance Measures for Planned Activities for Objectives	HEDIS Acronym	Regulatory Agencies	2018 Rates	2019 Rates	2019 Goal	Goal Met/Not Met	Responsible Staff/Department	Timeframe for completion	Reports to: (Dates are 2019 unless otherwise noted)	Interventions/Updates	Comments/Barriers	Recommend for '19 Work Plan
FSR- spore testing of autoclave/sterilizer			**Q1: Compliance Rate = 78%** **Q2: Compliance Rate = 85%** **Q3: Compliance Rate =76%** **Q4: Compliance Rate = 81%**		85%		Dulce Fernandez (FSR)	Quarterly	**QOC: May 22**			
Medical Record Documentation			**Q1: Compliance Rate = 89%** **(150 out of 168 sites)** **Q2: Compliance Rate = 85%** **(152 out of 179)** **Q3: Compliance Rate = 90%** **(157 out of 175)** **Q4: Compliance Rate = 86%** **(160 out of 186)**		95% of sites reviewed achieve ≥ 80% compliance		Dulce Fernandez (FSR)	Quarterly	**QOC: May 22**			
Appropriate Use of Medications-Polypharmacy			**Q1: 100%** **Q2: 100%** **Q3: 100%** **Q4: 100%**		90% of providers will be notified of members who meet criteria (Multi-Rx: 13 or more prescriptions in 3 of 4 months, Multi-Prescriber: 7 or more unique prescribers in 2 of 4 months, Duplicate Therapy: 2 or more Rx's in same drug class consistently in 3 of 4 months during lookback period)		Joseph Mishreki (Pharm)/ Ann Phan (Pharm)	Quarterly	**QOC: 4/22/19, 7/22/19, 11/25/19** **4th Qtr. Attached to QI Eval**			
Appropriate Use of Medications - Controlled Substances			**Q1: 100%** **Q2: 100%** **Q3: 100%** **Q4: 100%**		Retrospective Drug Utilization Review (RDUR): Controlled Substance Monitoring 90% of providers will be notified via mail of members who meet criteria (9 or more of the following: Rx's for controlled substances + unique prescribers + unique pharmacies for at least 2 of 4 months). Mailing occurs three times a year. Repeat Alert will also occur for patients identified in above mailing 4 or more times over-2-year period.		Joseph Mishreki (Pharm)/ Ann Phan (Pharm)	Quarterly	**QOC: 4/22/19, 7/22/19, 11/25/19** **4th Qtr. Attached to QI Eval**			
Appropriate Use of Medications - Triple Threat			**2018 Baseline Rate:** **Q1: 100%** **Q2: 100%** **Q3: 100%** **Q4: 100%**		Retrospective Drug Utilization Review (RDUR): Triple Threat Criteria 90% of providers will be notified via mail of members who had Rxs for each of the following drug classes: opioids, skeletal muscle relaxants, and benzodiazepines/hypnotics (sleep aids) in a month for at least 2 of 4 months. Mailing occurs three times a year.		Joseph Mishreki (Pharm)/ Ann Phan (Pharm)	Quarterly	**QOC: 4/22/19, 7/22/19, 11/25/19** **4th Qtr. Attached to QI Eval**			
Potentially Inappropriate Medication (PIM)			**Rate : 100%**		Concurrent DUR edits in place for members with Potential mediation overutilization		Joseph Mishreki (Pharm)	Quarterly	**QOC: 4/22/19, 7/22/19, 11/25/19** **4th Qtr. Attached to QI Eval**			
Medication Therapy Management (MTM) program			**<u>CMR completion rate:</u>** **<u>CMC (2017):</u>** **Q1.: 14%** **Q2.: 39%** **Q3.: 42%** **Q4.: 80%** **CMC (2018):** **Q1: 23%** **Q2: 29%** **Q3: 56%** **Q4: 80%**		CMC only: MTM program with SinfoniaRx for 2019: Comprehensive Medication Review (CMR)-- phone intervention by pharmacist or other qualified clinician. Goal of 85% by the end of the year.		Joseph Mishreki (Pharm)/ Ann Phan (Pharm)	Quarterly	**QOC: 4/22/19, 7/22/19, 11/25/19** **4th Qtr. Attached to QI Eval**			
Clinical- Clinical Practice & Preventive Guidelines												
Clinical Practice Guidelines			**N/A**		100% review and approval at least every 2 years/updates as required.		Bettsy Santana/ Katrina Miller (QI)	Annual and as needed for updates	**PICC & PQC: July 23**			
Clinical Practice Guidelines			**N/A**		Measure at least 2 guidelines (i.e., DSF & LBP)		Bettsy Santana (QI)/ Katrina Miller (QI)	Annual	**PICC & PQC: July 23**			
Preventive Health Guidelines (PHGs)			**N/A**		Review, update, approve, & distribute Preventive Health Guidelines		Bettsy Santana (QI)	Annual	**PICC & PQC: Oct 29**			
LACC Measures												
Quality Rating System Clinical Effectiveness Rating (QIS 3.1)			**4 stars**		Achieve four stars for HEDIS measures in QRS		Katrina Miller (QI)/ Grace Crofton (QPM)/ Ron Makita (QPM)/ Carolina Coleman (QI)	Annual	**QOC: Nov. 25**			
Quality Rating System QHP Enrollee Survey Summary Rating (QIS 3.2)			**1 star**		Achieve four stars for EES/CAHPS measures in QRS		Katrina Miller (QI)/ Grace Crofton (QPM)/ Ron Makita (QPM)/ Carolina Coleman (QI)	Annual	**QOC: Nov. 25**			

Performance Measures for Planned Activities for Objectives	HEDIS Acronym	Regulatory Agencies	2018 Rates	2019 Rates	2019 Goal	Goal Met/Not Met	Responsible Staff/Department	Timeframe for completion	Reports to: (Dates are 2019 unless otherwise noted)	Interventions/Updates	Comments/Barriers	Recommend for '19 Work Plan
Network Design Based on Quality (QIS 3.5)			**N/A**		Establish quality criteria in provider contracts		Katrina Miller (QI)/ Eddie Calles (PNM)	Annual	**QOC: Nov. 25**			
Appropriate Use of C-Sections (QIS 3.8)			**N/A**		Reamend hospital contracts to not incentivize C-sections		Katrina Miller (QI)/ Eddie Calles (PNM)	Annual	**QOC: Nov. 25**			
Hospital Safety (QIS 3.9)			**N/A**		Reamend 75% or more of hospital contracts to tie at least 2% of payment to quality performance		Katrina Miller (QI)/ Eddie Calles (PNM)	Annual	**QOC: Nov. 25**			
Reducing Health Disparities (QIS 3.4) (PIP)			**N/A**		Metric A: Increase self-reporting of race/ethnicity to 80% of LACC members Metric B: reduce disparities for members with asthma, diabetes, and/or hypertension		Marina Acosta/ Carolina Coleman (QI)	Annual	**QOC: Nov. 25**			
Primary Care Promotion (CIS 3.6)			**N/A**		Re-contract with IPAs to create a business case for team-based care		Katrina Miller (QI)/ Eddie Calles (PNM)	Annual	**QOC: Nov. 25**			
Integrated Healthcare Models (QIS 3.7)			**N/A**		Identify IPAs that meet IHM criteria and increase the LACC enrollment at IHM providers		Katrina Miller (QI)/ Eddie Calles (PNM)	Annual	**QOC: Nov. 25**			
Admissions for Hypertension among Members with Hypertension 18-85 yrs		**QIS**	**Medi-Cal & LACC combined rate: 0.16 Rate for African Americans: 0.32**		**Reduce disparity Among African Americans**		Carolina Coleman (QI)/ Rodney Truong (QPM)	Annual: By June '19	**QOC: September 23 PICC & PQC: Oct 29**			
Admissions for Diabetes Short-term Complications among Members with Diabetes 18-75 yrs		**QIS**	**Medi-Cal & LACC combined rate: 0.71 Rate for African Americans: 1.58**		**Reduce disparity Among African Americans**		Carolina Coleman (QI)/ Rodney Truong (QPM)	Annual: By June '19	**QOC: September 23 PICC & PQC: Oct 29**			
Admissions for Diabetes Long-Term Complications among Members with Diabetes 18-75 yrs		**QIS**	**Medi-Cal & LACC combined rate: 1.00 Rate for African Americans: 1.46**		**Reduce disparity Among African Americans**		Carolina Coleman (QI)/ Rodney Truong (QPM)	Annual: By June '19	**QOC: September 23 PICC & PQC: Oct 29**			
Admissions for Asthma among Older Adults with Asthma 40-85 yrs		**QIS**	**Medi-Cal & LACC combined rate: 0.43 Rate for Latinos: 0.72**		**Reduce disparity Among Latinos**		Carolina Coleman (QI)/ Rodney Truong (QPM)	Annual: By June '19	**QOC: September 23 PICC & PQC: Oct 29**			
Proportion of Days Covered - Medication Adherence for Diabetes Medications		**QRS**	**74.52%**		**76%**		Rodney Truong (QPM)	Annual: By June '19	**QOC: September 23 PICC & PQC: Oct 29**			
Proportion of Days Covered - Medication Adherence for Hypertension (RAS antagonists)		**QRS**	**76.22%**		**77%**		Rodney Truong (QPM)	Annual: By June '19	**QOC: September 23 PICC & PQC: Oct 29**			
Proportion of Days Covered - Medication Adherence for Cholesterol (Statins)		**QRS**	**67.16%**		**68%**		Rodney Truong (QPM)	Annual: By June '19	**QOC: September 23 PICC & PQC: Oct 29**			

Performance Measures for Planned Activities for Objectives ★Star Measures	HEDIS Acronym	Regulatory Agencies	2018 Rates 2018 Rate (MY 2017)	2019 Rates Rate 2019 Rate (MY 2018)	2019 Goal Goal Methodology: 2018 rates used to determine an attainable % increase If a National benchmark was met in the Work Plan then the next benchmark was set as the goal. If the next percentile is not attainable per prior year trending, the goal was set accordingly. QW: Quality Withhold Measure	Goal Met/Not Met	Responsible Staff/Department	Timeframe for completion	Reports to: (Dates are 2019 unless otherwise noted)	Interventions/Updates	Comments/Barriers	Recommend for '19 Work Plan
C04- Improving or Maintaining Physical Health ★**(HOS)** **Quality of Life Survey - SF12 Physical Component Score**	**PCS**	**Star** **Health Outcomes Survey (HOS)**	**Adjusted PCS score: 37.1% (adj)** **(MY 2016)**		**CMC: 69%**		Keren Mahgerefteh (QI)/ Grace Crofton (HEDIS)/ Rae Starr (QPM)	Annually: Sept '18				
C05 - Improving or Maintaining Mental Health★**(HOS)** **Quality of Life Survey - SF12 Mental Component Score**	**MCS**	**Star** **Health Outcomes Survey (HOS)**	**Adjusted MCS score:** **49.5% (adj)** **(MY 2016)**		**CMC: 84%**		Keren Mahgerefteh (QI)/ Grace Crofton (HEDIS)/ Rae Starr (QPM)	Annually: Sept '18				
C06 - Monitoring Physical Activity ★ **(HOS)** **(Tier 2)**	**PAO Advise Rate**	**CMS** **Health Outcomes Survey (HOS)**	**Rate: 53.88% (Medicare HOS 2017 Cohort 20 Baseline Report)**		**CMC: 53.88% (Medicare HOS 2017 Cohort 20 Baseline Report)**		Rodney Truong (QPM)/ Rae Starr (QPM) Med Ops Reporting: Veronica Mones Anna Kazaryan Marie Martin	Annually: Sept '19	**QOC: September 23** **PICC & PQC: Oct 29**			
C09- Care for Older Adults- Medication Review ★ **(Tier 2)**	**COA2**	**H**	**CMC: 61.31%**		**CMC:65%**		Rodney Truong (QPM)/ Rae Starr (QPM) Med Ops Reporting: Veronica Mones Anna Kazaryan Marie Martin	Annual: Due June '19	**QOC: September 23** **PICC & PQC: Oct 29**			
C10 - Care for Older Adults- Functional Status Assessment ★ **(Tier 2)**	**COA3**	**H**	**CMC: 52.80%**		**CMC: 56%**		Rodney Truong (QPM)/ Rae Starr (QPM) Med Ops Reporting: Veronica Mones Anna Kazaryan Marie Martin	Annual: Due June '19	**QOC: September 23** **PICC & PQC: Oct 29**			
C11 - Care for Older Adults- Pain Assessment ★ **(Tier 2)**	**COA4**	**H**	**CMC: 72.26%**		**CMC: 89%**		Rodney Truong (QPM)/ Rae Starr (QPM) Med Ops Reporting: Veronica Mones Anna Kazaryan Marie Martin	Annual: Due June '19	**QOC: September 23** **PICC & PQC: Oct 29**			
C12 - Osteoporosis Management in Older Women who had a Fracture ★ **(Tier 1)**	**OMW**	**A** **NCQA: Medicare**	**CMC: 27.27%**		**CMC: 32%**		Rodney Truong (QPM)/ Rae Starr (QPM) Med Ops Reporting: Veronica Mones Anna Kazaryan Marie Martin	Annual: Due June '19	**QOC: September 23** **PICC & PQC: Oct 29**			
C17 - Disease - Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis ★ **(Tier 2)**	**ART**	**A**	**CMC: 72.00%**		**CMC:74%**		Rodney Truong (QPM)/ Rae Starr (QPM) Med Ops Reporting: Veronica Mones Anna Kazaryan Marie Martin	Annual: Due June '19	**QOC: September 23** **PICC & PQC: Oct 29**			
C18 - Reducing the Risk of Falling★**(HOS)** **(Tier 2)**	**FRM Manage Rate**	**Health Outcomes Survey (HOS)**	**CMC: 64.04% (Medicare HOS 2017 Cohort 20 Baseline Report)**		**CMC: 64.04% (Medicare HOS 2017 Cohort 20 Baseline Report)**		Rodney Truong (QPM)/ Rae Starr (QPM) Med Ops Reporting: Veronica Mones Anna Kazaryan Marie Martin	Annual: Due June '19	**QOC: September 23** **PICC & PQC: Oct 29**			

L.A. Care Health Plan
2019 QI Work Plan

Performance Measures for Planned Activities for Objectives	HEDIS Acronym	Regulatory Agencies	2018 Rates	2019 Rates	2019 Goal	Goal Met/Not Met	Responsible Staff/Department	Timeframe for completion	Reports to: (Dates are 2019 unless otherwise noted)	Interventions/Updates	Comments/Barriers	Recommend for '19 Work Plan
C21 - Plan All Cause Readmission Rate **★(Note lower rate = better performance) (Enterprise Goal)** **(Tier 1)**	**PCR**	**A** **NCQA: Medicare** **QRS** **QW**	**MCLA: O=22.8%; E=21.9%; O/E = 1.04** **LACC: O=6.7%; E=9.3%;O/E = 0.72** **CMC: O=15.73%; E=19.87%; OE= 0.79**		**MCLA: ≤22% or O/E <1.0** **LACC: ≤9% or O/E <1.0** **CMC (QW): ≤19% or O/E <1.0**		Rodney Truong (QPM)/ Rae Starr (QPM) Med Ops Reporting: Veronica Mones Anna Kazaryan Marie Martin	Annual: Due June '19	**QOC: Nov 25**			
D07 - Overall Rating of Drug Plan (Rating 9 or 10, out of 10) ★ (Usually/Always) **(Tier 2)**		**CMS**	**CMC: 88%**		**CMC: 89%**		Ann Phan (Pharm)/ Rae Starr (QPM) Med Ops Reporting: Veronica Mones Anna Kazaryan Marie Martin	Annually: Sept '19	**MQSC: Oct 14**			
D08 - Getting Needed Drugs (RX) ★ (Usually/Always) **(Tier 2)**		**CMS**	**CMC: 92%**		**CMC: 92%**		Ann Phan (Pharm)/ Rae Starr (QPM) Med Ops Reporting: Veronica Mones Anna Kazaryan Marie Martin	Annually: Sept '19	**MQSC: Oct 14**			
D10- Medication Adherence for Diabetes Medications★ **(Tier 1)** **Quality Withhold Measure: CW12 – Medication Adherence for Diabetes Medications**		**CMS** **QW**	**CMC: 81%** **(as of 1/31/19 Patient Safety Report)**		**CMC: 81% (QW: 73%)**		Ann Phan (Pharm)/ Rae Starr (QPM) Med Ops Reporting: Veronica Mones Anna Kazaryan Marie Martin	Annually: Sept '19	**MQSC: Oct 14**			
D11 - Medication Adherence for Hypertension (RAS antagonists) ★ **(Tier 2)**		**CMS** **QRS**	**CMC: 80%** **(as of 1/31/19 Patient Safety Report)**		**CMC: 79%**		Ann Phan (Pharm)/ Rae Starr (QPM) Med Ops Reporting: Veronica Mones Anna Kazaryan Marie Martin	Annually: Sept '19	**MQSC: Oct 14**			
D12 - Medication Adherence for Cholesterol (Statins)★ **(Tier 2)**		**CMS** **QRS**	**CMC: 77%** **(as of 1/31/19 Patient Safety Report)**		**CMC: 73%**		Ann Phan (Pharm)/ Rae Starr (QPM) Med Ops Reporting: Veronica Mones Anna Kazaryan Marie Martin	Annually: Sept '19	**MQSC: Oct 14**			
D13- MTM Program Completion Rate for CMR★ **(Tier 2) (Enterprise Goal)**		**CMS**	**CMC: 79%**		**CMC: 85%** **CMC only: MTM program with SinfoniaRx for 2019: Comprehensive Medication Review (CMR)-- phone intervention by pharmacist.** **Enterprise Goal: 80%**		Ann Phan (Pharm) Med Ops Reporting: Veronica Mones Anna Kazaryan Marie Martin	Quarterly:	**MQSC: Oct 14**			
Non-Recommended PSA-Based Screening in Older Men (Note: Lower rate indicates better performance)	**PSA**	**A** **CMS**	**CMC: 30.31%**		**CMC: 28%**		Bettsy Santana (QI)/ Rodney Truong (QPM)	Annual: Due June '19	**QOC: September 23** **PICC & PQC: Oct 29**			
Pneumococcal Vaccination Status for Older Adults **(Tier 2)**	**PNU**	**A** **CAHPS**	**CMC: 55%**		**CMC: 59%**		Bettsy Santana (QI)/ Rae Starr (QPM) Med Ops Reporting: Veronica Mones Anna Kazaryan Marie Martin	Annually: Sept. '19	**QOC: September 23** **PICC & PQC: Oct 29**			
Potentially Harmful Drug-Disease Interactions- Falls + tricyclic antidepressants, antipsychotics or sleep agents (Note lower rates signify better performance)*	**DDE1**	**A** **NCQA: Medicare**	**CMC: 44.71%**		**CMC: 37%**		Joseph Mishreki (Pharm)/ Ann Phan (Pharm)	Annually: Sept '19	**QOC: September 23** **PICC & PQC: Oct 29**			
Potentially Harmful Drug-Disease Interactions-Dementia + tricyclic antidepressants, anticholinergic agents* (Note lower rates signify better performance)	**DDE2**	**A** **NCQA: Medicare**	**CMC: 52.50%**		**CMC: 45%**		Joseph Mishreki (Pharm)/ Ann Phan (Pharm)	Annually: Sept '19	**QOC: September 23** **PICC & PQC: Oct 29**			

Performance Measures for Planned Activities for Objectives	HEDIS Acronym	Regulatory Agencies	2018 Rates	2019 Rates	2019 Goal	Goal Met/Not Met	Responsible Staff/Department	Timeframe for completion	Reports to: (Dates are 2019 unless otherwise noted)	Interventions/Updates	Comments/Barriers	Recommend for '19 Work Plan
Potentially Harmful Drug-Disease Interactions- Chronic Renal Failure + NSAIDS* (Note lower rates signify better performance)	**DDE3**	**A** **NCQA: Medicare**	**CMC: 26.54%**		**CMC: 14%**		Joseph Mishreki (Pharm)/ Ann Phan (Pharm)	Annually: Sept '19	**QOC: September 23** **PICC & PQC: Oct 29**			
Potentially Harmful Drug-Disease Interactions- Combination Rate* (Note lower rates signify better performance)	**DDE0**	**A** **NCQA: Medicare**	**CMC: 45.14%**		**CMC: 39%**		Joseph Mishreki (Pharm)/ Ann Phan (Pharm)	Annually: Sept '19	**QOC: September 23** **PICC & PQC: Oct 29**			
Use of High Risk Medication in the Elderly - one drug* (Note lower rates signify better performance)	**DAE1**	**A** **NCQA: Medicare**	**CMC: 24.97%**		**CMC: 22%**		Joseph Mishreki (Pharm)/ Ann Phan (Pharm)	Annually: Sept '19	**QOC: September 23** **PICC & PQC: Oct 29**			
Use of High Risk Medication in the Elderly - two drugs* (Note lower rates signify better performance)	**DAE2**	**A** **NCQA: Medicare**	**CMC: 12.42%**		**CMC: 11%**		Joseph Mishreki (Pharm)/ Ann Phan (Pharm)	Annually: Sept '19	**QOC: September 23** **PICC & PQC: Oct 29**			
Medication Reconciliation Post-Discharge	**MRP**	**H** **EAS (MLTSS)**	**CMC: 26.03%** **MLTSS: 9.06%**		**CMC: 29%**		Judy Cua-Razonable (MLTSS)	Annual: Due June '19	**QOC: September 23** **PICC & PQC: Oct 29**			
Percentage of gaps identified and addressed, if feasible based on MSSP Care Plans in SPD and CMC (APL 17-012 requirement)			**N/A**		**Enterprise Goals:** **MCLA: 70%** **CMC: 70%**		Judy Cua-Razonable (MLTSS)	Annual: Due June '19	**QOC: September 23** **PICC & PQC: Oct 29**			
Emergency Department Utilization (New Measure for 2018) **(VIIP)** **(Tier 2)**	**EDU**	**A** **NCQA: Medicare**	**2018 HEDIS :** **Total Observed Rate: 472.74** **Total Expected Rate: 463.09** **Ratio of Observed/Expected: 1.02 - needs to be 1 or under**		**CMC: ≤ 1%**		Rodney Truong (QPM)/ Bettsy Santana (QI) Med Ops Reporting: Veronica Mones Anna Kazaryan Marie Martin	Annual: Due June '19	**QOC: September 23** **PICC & PQC: Oct 29**			
CA 3.2 (State Report): Completion of ICP for High/Complex risk members within 90 calendar days from date of enrollment **(Enterprise Goal)**			**CMC: 60%**		**CMC: CA 3.2 (State Report): 90%** **Completion of ICP for High/Complex risk members within 90 calendar days from date of enrollment**		Elaine Sadocchi-Smith (QI)	Annually	**QOC Nov 25**			
CAW-7 California Quality Withhold & CA 4.1 : Reduction in emergency department use for seriously mentally ill and substance use disorder members	**CA 4.1** **CA QW - CAW 7**	**CMS** **QW**	**Rate available April 2019**		**CMC: CAW 7: 10% (QW) decrease in the performance rate for the measurement year compared to the performance rate for the baseline year**		Bettsy Santana (QI) Med Ops Reporting: Veronica Mones Anna Kazaryan Marie Martin	Annually	**QOC Nov 25**			
CA 1.6 (CAW8)-Percent of members with documented discussions of care goals [For DY2 through DY5]		**CMS** **QW**	**Rate available March 2019**		**CMC: CA 1.6 ≥ National Average** **QW 65%**		Bettsy Santana (QI)/ Kathryn Gray (CA)/ John Roohan (CM) Med Ops Reporting: Veronica Mones Anna Kazaryan Marie Martin	Annually	**QOC Nov 25**			
CA 1.12 (CAW9)-Percent of members who have a care coordinator and have at least one care team contact during the reporting period [For DY2 through DY5]		**CMS** **QW**	**Rate available March 2019**		**CMC: CA 1.12 ≥ National Average** **QW 88%**		Kathryn Gray (CA)/ John Roohan (CM) Med Ops Reporting: Veronica Mones Anna Kazaryan Marie Martin	Annually	**QOC Nov 25**			
CW 13 Encounter Data - Encounter data for all services covered under the demonstration, with the exception of Prescription Drug Event (PDE) data, submitted in compliance with demonstration requirements. (Tier 1)		**CMS** **QW**	**currently 94% and on track final rate not yet available**		**CMC QW: 80%**		Encounters Team (QI) Med Ops Reporting: Veronica Mones Anna Kazaryan Marie Martin	Annually	**QOC Nov 25**			
CW 11 Controlling Blood Pressure- Percent of plan members 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) for members 18-59 years of age and 60-85 years of age with diagnosis of diabetes or (150/90) for members 60-85 without a diagnosis of diabetes during the measurement year. (Tier 1)		**CMS** **NCQA: Medicare** **QW**	**Final rate not available**		**CMC QW: 56%**		Bettsy Santana(QI) Med Ops Reporting: Veronica Mones Anna Kazaryan Marie Martin	Annually	**QOC Nov 25**			

Performance Measures for Planned Activities for Objectives **Hospital Utilization**	HEDIS Acronym	Regulatory Agencies	2018 Rates	2019 Rates	2019 Goal	Goal Met/Not Met	Responsible Staff/Department	Timeframe for completion	Reports to: (Dates are 2019 unless otherwise noted)	Interventions/Updates	Comments/Barriers	Recommend for '19 Work Plan
Hospital Bed Days Per 1000 - Excluding OB delivery **(VIIP)**			**Q1: 1,220.20** **Q2: 1,063.35** **Q3: 986.45** **Q4: 568.11**		**CMC: 1134/K**		Med Ops Reporting: Veronica Mones Marie Martin	Quarterly	**QOC: Feb 25, April 22, Sept 23 Nov 25**			
Hospital Admissions - Excluding OB delivery **(VIIP)**			**Q1: 246.93** **Q2: 226.59** **Q3: 230.51** **Q4: 146.1**		**CMC: 220/K**		Med Ops Reporting: Veronica Mones Marie Martin	Quarterly	**QOC: Feb 25, April 22, Sept 23 Nov 25**			
Hospital Average Length of Stay - Excluding OB delivery			**Q1: 4.9** **Q2: 4.69** **Q3: 4.28** **Q4: 3.89**		**CMC: 4.2/1000**		Med Ops Reporting: Veronica Mones Marie Martin	Quarterly	**QOC: Feb 25, April 22, Sept 23 Nov 25**			
Ambulatory Services												
Emergency Room Visits **(VIIP)**			**Q1: 762.13** **Q2: 690.83** **Q3: 759.44** **Q4: 521.68**		**CMC: 688.86** (10% reduction from 765.41 the 2018 goal)		Med Ops Reporting: Veronica Mones Marie Martin	Quarterly	**QOC: Feb 25, April 22, Sept 23 Nov 25**			
HRA Compliance Rate (Core 2.1) Completed HRAs/ (CMC Population who reached 90th day until the last day of the reporting period – Unable to Contact members – Members who declined)			**Q1: 99.66%** **Q2: 99.83%** **Q3: 99.87%** **Q4: Not Available**		**CMC: 90% of all Medicare enrollees within 90 days**		Veronica Mones (MO)/ Marie Martin (MO)/ Customer Solutions Center/ Rebeca Cristerna(MORE)	Quarterly	**QOC: Feb 25, April 22, Sept 23 Nov 25**			
Administrative												
Annual Review of Policies & Procedures		**DHCS** **CMC**	**NA**		100% Annual Review of P&Ps		Each Department Head	Each QOC as needed and by specific committee reported to QOC	**QOC: Feb 25, April 22, Sept 23 Nov 25**			
Departmental Oversight Reporting Requirements		**DHCS** **CMC**	**NA**		100% submission of timely delegate oversight reporting for each department		QI: Andrew Guy MS: Geoffrey Vitrano A&G: Lisa Marie Golden NAL: Jenny Li	**QOC& MSQC** quarterly	**QOC: Feb 25, April 22, Sept 23 Nov 25** **MSQC: Feb 12, May 7, July 16, Oct 14**			
QI Program Description & Work Plan		**DHCS** **CMS** **NCQA Standard: Q1 Element A**	**NA**		2019 QI Program Description & Work Plan approval		Maria Casias (QI)	**QOC**: 2/25/19 **C & Q**: 3/21/19	**QOC: 2/25/19** **C & Q: 3/21/19**			
QI Evaluation		**DHCS** **CMS** **NCQA Standard: Q1 Element B**	**NA**		2018 QI Evaluation approval		Maria Casias (QI)	**QOC**: 2/25/19 **C & Q**: 3/21/19	**QOC: 2/25/19** **C & Q: 3/21/19**			
QI Work Plan Updates		**DHCS**	**NA**		Review and Update of QI Work Plan		Marla Lubert (QI)/ Maria Casias (QI)	Biannually/ Final attached to QI eval	**QOC: 7/22/19, 11/25/19**			
QI Reports to Board			**NA**		Update Board (C&Q) on QI activities		Richard Seidman (CMO)/ Katrina Miller (CMIE)/ Maria Casias (QI)	At least quarterly	**C & Q: 1/17/19, 3/21/19, 5/16/19, 8/15/19, 9/19/19, 11/21/19**			
UM Program Documents			**NA**		2019 Annual UM Program Description & UM Work Plan, & 2018 UM Evaluation		David Kagan/ Alex Li	**UMC**:3/26/19 **C & Q**: 5/16/19	**UMC: 3/26/1 9** **C & Q: 5/16/19**			