Quality Improvement Program
All Lines of Business
2023

Quality Oversight Committee approval on	2/28/2023
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MISSION

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

VISION

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

VALUES

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

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

PURPOSE

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

STRATEGIC PRIORITIES (2022-2024)

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

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

Objectives:
- Improve customer service through the Voice of the Customer (VOICE) initiative, our customer service information technology system.
- Improve efficiency and effectiveness of financial management functions with the implementation of the additional phases of the SAP Enterprise Resource Planning (ERP).

- Complete the implementation of SyntraNet to support new and updated regulatory requirements, in addition to operational improvements across the enterprise.
- Modernize provider data management by defining and creating a roadmap for achieving our target state for our provider data ecosystem.
- Refine and implement our three-year technology roadmap and ensure that the reference architecture serves as a blueprint that evolves with L.A. Care's needs.
- Develop real-time interoperability capabilities to share data with providers and members.

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

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

Goal 1.3: Ensure long-term financial sustainability.

Objectives:
- Implement recommendations from the administrative expense benchmarking study and update the administrative expense target in the revised forecasts.

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

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

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

Goal 2.1: Mature and grow our Direct Network.

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

Goal 2.2: Improve our quality across products and providers.

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

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

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

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

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

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

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

Objectives:
- Maximize use of care managers and community health workers within our care management model.
- Expand upon our progress with palliative care and add other end-of-life services.

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

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

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

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

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

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

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

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

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

PROGRAM STRUCTURE

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

The following product lines are covered by the QI program description: Medi-Cal, L.A. Care Covered™ (On-Exchange), L.A. Care Covered Direct™ (Off-Exchange), PASC-SEIU Plan, and L.A. Care Medicare Plus (Dual-Special Needs Plan [D-SNP]). The program also supports the integration of Behavioral Health, Substance Use, and Managed Long-Term Services and Supports (MLTSS), Enhanced Care Management, and the Homeless Programs.

L.A. Care Direct Network

In 2016, L.A Care Health Plan addressed the access to care challenges in the Antelope Valley, with the establishment of the "L.A. Care Direct Network" (formerly referred to as the "Community Access Network," or "CAN"). This alternative to the delegated model is a network of directly contracted primary and specialty care physicians to provide healthcare services for Medi-Cal members in the Antelope Valley.

The L.A. Care Direct Network has successfully closed network gaps in the Antelope Valley and expanded to cover Medi-Cal members across Los Angeles County.

Members in the L.A. Care Direct Network can also benefit from enhanced access to care, while the directly contracted providers get the opportunity to serve Medi-Cal members beyond those

deemed in-network in accordance with their affiliated provider group contract(s). Additionally, Primary Care Physicians (PCPs) have the opportunity to participate in care delivery and quality initiatives, such as engaging in the L.A. Care Transform L.A. program. A technical assistance program that uses a practice coaching model to support patient centered care design, data driven quality improvement, and sustainable business operations (see section Transform L.A. for more details on the program).

Medi-Cal

Medi-Cal is California's Medicaid health care program, a public program that provides health care coverage to adults, families, older adults, and people with disabilities who meet certain income requirements. L.A. Care Health Plan has provided Medi-Cal coverage to residents of Los Angeles County since 1997. Currently, L.A. Care provides coverage to over 2.5 million members in collaboration with our Plan Partners: Anthem Blue Cross, Blue Shield Promise, and Kaiser Permanente.

Current significant Medi-Cal initiatives include the following:
- California Advancing and Innovating Medi-Cal (CalAIM) – a multi-year waiver that encompasses broad-based delivery system, program, and payment reform across the Medi-Cal. Some initiatives include an overhaul of the Population Health Management program, Mandatory Managed Care Enrollment of certain populations, and implementation of Community Supports, medically appropriate and cost-effective services.
- Redetermination – every year, the state is required to reassess the eligibility of Medi-Cal beneficiaries, with respect to circumstances that may change. Negative actions and redeterminations were placed on hold during the COVID-19 Public Health Emergency (PHE). When the PHE ends, millions of current Medi-Cal members may lose coverage if they do not submit their renewal forms to the state. L.A. Care is working to ensure members are aware of the process and complete forms on a timely basis.
- Coverage expansion to undocumented adults – as of January 1, 2024, the state is expanding full scope Medi-Cal coverage to an estimated 700,000 undocumented adults ages 26 through 49. Young adults and older adults coverage expansion occurred over the last couple of years, and California is moving to provide coverage for all undocumented residents by 2024.

L.A. Care Covered™ (On-Exchange-LACC)

Under the health care reform, L.A. Care Health Plan has proudly participated with Covered California to offer affordable health care coverage for residents of Los Angeles County, known as L.A. Care Covered™. This product line was launched on October 1, 2013 with a focus on serving diverse and low-income communities in Los Angeles County. The health care reform law also assists individuals/families pay their monthly premiums through the Covered California application process. Individuals/families may be eligible/qualify to receive federal premium assistance through the Advanced Premium Tax Credit (APTC) if their premium amount for the second lowest priced Silver plan is their region is more that 8.5% of their annual income. Moreover, individuals whose income is less than 250% of the FPL also qualify for special Cost Share Reduction (CSR) plans that reduce the out of pocket cost for receiving services.

As of mid-December 2022, L.A. Care Covered™ membership was 112,200. The Open Enrollment period for Covered California opens in the fall each year for coverage the following year. Individuals/families who experience an unexpected life event, such as losing a job, getting married/a domestic partnership, having/adopting a child, a change in household size, etc. may apply for coverage throughout the year during the Special Enrollment period.

L.A. Care's 2023 contract with Covered California includes the continuation of the multi-year Quality Improvement Strategy (QIS), which includes the following components:
- Provider networks based on quality
- Promoting provider quality performance and ongoing quality improvement
- Access to Centers of Excellence
- Hospital quality and safety
- Appropriate use of C-sections
- Reducing health disparities
- Promoting the development and use of care models in primary care
- Promoting the development and use of care models: Integrated Healthcare Models
- Patient-centered information and communication
- Patient-centered information: cost transparency

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

On March 1, 2015, a product line operated entirely by L.A. Care Health Plan was launched, known as L.A. Care Covered Direct™. L.A. Care Covered Direct™ offers affordable health coverage to residents of Los Angeles County with a focus on serving diverse and low-income communities. Those who do not qualify for financial assistance or prefer to purchase health coverage directly with L.A. Care Health Plan can choose coverage under L.A. Care Covered Direct™. As of mid-December 2022, L.A. Care Covered Direct™ membership was 56.

PASC-SEIU Plan

The PASC-SEIU Homecare Workers Health Care Plan (PASC-SEIU Plan) transitioned from Community Health Plan (CHP) to L.A. Care in February 2012. The Personal Assistance Services Council (PASC) and the Service Employees International Union (SEIU) developed the plan for In-Home Supportive Services (IHSS) Workers. PASC is the employer of record and contracts with L.A. Care Health Plan to provide member services, claims processing, COBRA/Cal-COBRA billing, and other health plan services. L.A. Care contracts with the L.A. County Department of Health Services and Citrus Valley Physicians Group, which comprise the PASC-SEIU Plan network. Effective January 1, 2014, L.A. Care updated its internal systems and processes to identify the product as the PASC-SEIU Plan, instead of the IHSS Plan, to avoid confusion with the IHSS benefit under Medi-Cal/Long-Term Services and Supports. As of mid-December 2022, PASC-SEIU membership was 49,584.

L.A. Care Medicare Plus (Dual-Special Needs Plan [D-SNP])

The Cal MediConnect (CMC) program ended on December 31, 2022. Starting on January 1, 2023, L.A. Care Cal MediConnect members transitioned to a new Exclusively Aligned Enrollment L.A. Care Medicare Plus (Dual-Special Needs Plan [D-SNP]). Under exclusively aligned enrollment,

members will be enroll in our L.A. Care D-SNP for Medicare benefits and L.A. Care Medi-Cal Managed Care Plan (MCP) for Medi-Cal benefits for better care coordination and integration. Many of the CMC operating, quality improvement programs and reporting structures will remain intact during the transition. Quality Improvement goals will be updated to reflect specific D-SNP Model of Care requirements and will include Medicare Key Performance Indicators (KPIs) such as Medicare Stars and Display measures.

L.A. Care Medicare Plus (Dual-Special Needs Plan [D-SNP]) *and Reporting Requirements*

The Centers for Medicare and Medicaid Services (CMS) uses Medicare Advantage Part C and Part D measurement sets for monitoring quality of care, member experience, and plan administration of contractual standards. L.A. Care monitors and reports all required Part C and Part D measure reports such as HEDIS, CAHPS, and Health Outcomes Survey (HOS) to NCQA and CMS. In addition, Medicare Plus (Dual-Special Needs Plan [D-SNP]) Plans must monitor and submit program specific measure reports to CMS "Core Measures", and to the Department of Health Care Services (DHCS) "California-Specific Measures" as required in the contract between DHCS and CMS. These measures evaluate the effectiveness of the Care Coordination and Quality Improvement Program Effectiveness (CCQIPE) and encompass Part C and D program areas.

Conceptual Framework

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

Better Outcomes - Population Health Management (PHM) is a model of care that addresses individuals' health needs at all points along the continuum of care, including in the community setting, through participation, engagement and targeted interventions for a defined population. The

goal of PHM is to maintain or improve the physical and psychosocial well-being of individuals and address health disparities through cost effective and tailored health solutions.

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

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

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

The Quality Improvement (QI) and Population Health Management (PHM) Programs are related in terms of operation and oversight, as both programs fall under the QI department. Additionally, the PHM program is a part of the QI Program Structure. L.A. Care's QI department maintains and executes a QI annual work plan that reflects ongoing activities throughout the year. The work plan is reviewed and updated by the appropriate business units quarterly. The work plan tracks active interventions and programs using metrics, such as Health Effectiveness Data Information Set (HEDIS) and program goals to create a Population Health Management Index, these are also used for the Population Health Management program to address members' needs most appropriately through workgroups and the PHM Cross Functional team. The QI Annual Evaluation is used as the foundation of the PHM Annual Impact report. The PHM program facilitates all deliverables to meet all state and regulatory requirements including but not limited to: the Department of Healthcare Services (DHCS) California Advancing and Innovating Medi-Cal (CalAIM) and the National Committee for Quality Assurance (NCQA) Population Health Management standards.

VISION FOR L.A. CARE HEALTH SERVICES
Optimize the health and wellness of our members.

GOALS AND OBJECTIVES

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

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

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

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

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

Objectives:
- Increase the awareness of health equity and implement strengthened, expanded and/or new health equity activities to support providers and members ultimately reducing health inequities within L.A. Care's membership.
- Ensure that the services we provide to members promote equity and are free of implicit bias or racism.
- Implement programs that address the causes of inequity that our members and their communities experience, including racism and poverty.
- Analyze existence of significant health care disparities in clinical areas.
- Reduce health disparities among our members by implementing targeted quality improvement programs.
- Promote physician involvement in health equity/ disparities and activities.

- Conduct focus groups or key informant interview with cultural or linguistic minority members to determine how to meet their needs.
- Address social determinants of health.

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

Objectives:
- Monitor, track and report critical incidents impacting patient safety from downstream entities and vendors.
- Identify and report patient safety risks and events.
- Identify, monitor, and address known or potential quality of care issues (PQIs), trends, and implement corrective actions as needed.
- Ensure that mechanisms are in place to support and facilitate continuity of care and transition of care, and to review the effectiveness of such mechanisms.
- Establish, maintain, and enforce policies regarding peer review activities and conflict of interest.
- Through credentialing, recredentialing and ongoing monitoring, promptly identify and address any issues with network providers that may impact patient safety.
- Establish standards of medical and behavioral health care (as required by product line) which reflect current medical literature and national benchmarks; design and implement strategies to improve compliance; and develop objective criteria and processes to evaluate and continually monitor performance and adherence to the clinical and preventive health guidelines.
- Conduct facility site and medical record reviews to ensure and support safe and effective provision of equitable clinical service.
- Support and assist practitioners and providers to improve safety within their practices.
- Identify and monitor patient safety measures for in-network hospitals and collaborate with other payers and stakeholders to help them achieve minimal performance targets.
- Monitor Provider Preventable Reportable Conditions to promptly identify potential issue with risk for or evidence of adverse health outcome and implement corrective action plans as needed.
- Review hospital quality and safety indicators and identify network hospitals that have a record of poor performance across domains of overall patient experience, maternity care, and hospital acquired infections. L.A. Care participates in a multi-plan hospital collaborative to engage poor performing hospitals and through dialogue and review of data, initiate an action plan to improve performance.

Goal – Improve Member Satisfaction:
Improve member satisfaction with the care and services provided by L.A. Care's network of providers. Identify potential areas for improvement through review of multiple sources of data, including, but not limited to, evaluation of member grievances and appeals, data collected from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys and data

collected from the Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS).

Objectives:
- Improve overall Rating of the Health Plan on the CAHPS surveys and prioritize areas impacting Rating of the Health Plan.
- Identify key drivers affecting CAHPS scores of the health plan.
- Collaborate with other departments and implement company-wide initiatives to provide exemplary service to our members and providers.
- Share CG-CAHPS data with provider groups, instruct them how to interpret the results and promote member experience interventions and best practices among Participating Physician Groups (PPGs), Management Services Organizations (MSOs) and physician practices/clinics.
- Periodic review of key service-related reports from both the health plan and delegated entities to identify opportunities to improve service and customer satisfaction.
- Leverage Appeals and Grievances data to gain insight into the drivers of member dissatisfaction and develop interventions to address these concerns in collaboration with vendors and delegated entities.
- Identify key areas for improvement, develop and monitor interventions based on the findings in the key service-related reports. Monitor results of the interventions.
- Ensure that the provision of healthcare services is accessible and available in order to meet the needs of our members.
- Work with provider groups to improve overall members access to care during and after hours.
- Offer regular webinars and patient experience trainings for clinicians and staff at clinics, PPGs, MSOs, and plan partners.

Goal – Provide Health Education Programs, Services and Resources:
Improve member health status through the delivery of targeted wellness and disease prevention services, programs, and resources. Educating and empowering members to effectively use primary and preventive health care services, modify personal health behaviors, achieve and maintain healthier lifestyles, and follow self-care regimens and treatment therapies for existing medical conditions, results in improved member health status and quality of care.

Objectives:
- Provide culturally appropriate health education services via multiple modalities including group and individual appointments at community locations, telephonic individual counseling, and online programming.
- Provide easily accessible, culturally appropriate, low reading level health education materials in Los Angeles County threshold languages and required health topics.
- Implement health education programs and services addressing prenatal/postpartum care, flu, asthma, diabetes, medical nutrition therapy, and tobacco cessation to complement QI programs and improve HEDIS, CAHPS, and CMS Five-Star Quality Ratings.
- Promote education programs on preventive health, patient safety, and reduction of health care disparities to complement quality improvement and health equity interventions.

- Support L.A. Care's network of primary care providers to reinforce positive health behavior change in patients during member doctor visits and refer to/document the delivery of health education services in the patient's medical chart.

Goal – Provide Culturally and Linguistically Appropriate Services:
Ensure medically necessary covered services are available and accessible to members regardless of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, language, marital status, gender, gender identity, or sexual orientation, <u>or identification with any other persons or groups defined in Penal Code 422.56,</u> and that all Covered Services are provided in a culturally and linguistically appropriate manner by qualified, competent practitioners and providers committed to L.A. Care's mission.

Objectives:
- Assess the cultural, ethnic and linguistic needs of members to reduce disparities.
- Assign members to providers based on their cultural, ethnic and linguistic needs.
- Provide education on language assistance requirements and cultural competency to assist providers in delivering culturally and linguistically appropriate healthcare to members.
- Ensure the availability and accessibility of cultural and linguistic services such as 24/7 interpreting services including American Sign Language (ASL) as well as provision of translated materials and alternative formats.
- Conduct member focused interventions with culturally competent outreach materials that focus on race, ethnicity, and language based disparities.

Goal – Improve the Delivery of Care for Persons with Complex Health Care Needs:
Ensure the coordinated delivery of care for members with complex health needs through effective care management interventions, including coordination with and referrals to linked or carved out services with Regional Centers, Medi-Cal Fee-For-Service, and state agencies including but not limited to; Department of Healthcare Services (DHCS), Department of Mental Health (DMH), Department of Public Health (DPH), Department of Public Social Services (DPSS), and California Children's Services (CCS).

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

Goal – Provide a Network of High Quality Providers and Practitioners:
Maintain a well-credentialed network of providers and practitioners based on recognized and mandated credentialing standards and cultural/linguistic needs of members. Provide continuous quality improvement oversight to the provision of health care within the L.A. Care system network

by monitoring and documenting the performance of L.A. Care's contracted network through facility site reviews, medical record reviews, and HEDIS scores.

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

Goal – Monitor and Improve Behavioral Healthcare:
Monitor and improve behavioral healthcare and coordination between medical and behavioral health care.

Objectives:
- Monitor and evaluate the utilization of behavioral health services managed by Managed Behavioral Health Organization (MBHO)
- Review and evaluate the results of Quality Improvement performance measures managed by MBHO
- Review and evaluate behavioral health workgroup initiatives/intervention implemented for behavioral health related measures
- Track and trend appeals and grievances rates, volume of cases and barriers and trends
- Review and approve member satisfaction survey analysis report
- Review and approve annual NCQA Health Plan standards as it relates to behavioral health
- Review and approve any changes in process of data collection that will impact performance measures
- Identify key quality issues and facilitate discussion with County partners on process improvement for access to care
- Review and track key pharmacy programs that support with medication management
- Support members have access to behavioral health services.

- Monitors and takes action to improve continuity of care and coordination.

Goal – Meet Regulatory and Other Health Plan Requirements:
Consistently meet quality standards as required by contract, regulatory agencies, recognized care guidelines, industry and community standards, and this Quality Improvement Program.

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

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

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

Goal – Provide Continuous Improvement of Quality of Care Model of Care (MOC):
L.A. Care must execute the care coordination/care management process and demonstrate measurable quality of care continuous improvement as described within the CMS approved MOC.

Objectives:
- Understanding our D-SNP target population
  - Identifying specific populations along with barriers that may factor into the members' health outcomes including demographics, social factors, culture and language, and community resources
  - Member and provider feedback (direct interactions, call center notes and surveys)
  - Stratifying members' risk levels using health care utilization and/or Health Risk Assessments to determine appropriate level of care team engagement

- Care Coordination and Care Management
  - Coordinate of covered Medicare benefits, Medi-Cal services between Medi-Cal Manage Care plan and state agencies
  - Coordinating services between providers and health settings during transitions
  - Facilitating communication across the ICT
  - Educating and supporting members and caregivers to manage complex health, pharmacy and behavioral health issues

- Specialized Provider Network
  - Adequate access, availability and adequacy of provider network reflective of the current population
  - Pay-for-Performance arrangements to improve member experience and health outcomes

- Quality Improvement
  - Quality Oversight Committee to oversee the success of the quality program with participation from cross functional leadership and medical directors in: Quality, Pharmacy, Provider Network, Compliance, Delegation Oversight, Customer Solution Center and Medicare Products
  - Established goals and benchmarks based on federal/state requirements and consistent with L.A. Care's mission and vision
  - Proactively identify performance trends and establish interventions and corrective action plans when performance is trending unfavorably

AUTHORITY AND ACCOUNTABILITY

The Board of Governors (Board) has ultimate accountability for L.A. Care's Quality Improvement Program. The Board approves the QI Program Description. L.A. Care Health Plan's Board consists of thirteen stakeholder members. As a public entity, all meetings of the Board and its subcommittees are subject to Brown Act (California's Open Meeting Law). Officers are elected annually. The Board members represent the following Los Angeles County stakeholder groups including but not limited to Free and Community Clinics, Private Disproportionate Share Hospitals (DSH), Federally Qualified Health Centers (FQHC), Los Angeles County (Department of Health

Services, Board of Supervisors), Children's Health Care Providers, Private Non-Disproportionate Share Hospitals, L.A. Care Member Advocates, L.A. Care Members and Physicians (L.A. County Medical Association). The Board nominates one additional member with health care expertise. All Board members are appointed by the Los Angeles County Board of Supervisors.

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

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

Meeting Schedule
The Board has scheduled ten meetings per year. All draft meeting agendas and meeting materials are publicly posted 72 hours prior to the meeting. An agenda is approved at the time of the meeting.

ORGANIZATIONAL STRUCTURE

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

Chief Operating Officer

The Chief Operating Officer (COO) is a senior member of the executive management team and reports directly to the Chief Executive Officer (CEO). The COO is responsible for the overall operational and administrative performance of enterprise functions. This position has organizational-wide responsibility to ensure a well-run and administratively capable organization.

Chief Financial Officer

The Chief Financial Officer (CFO) reports directly to the Chief Executive Officer (CEO). The CFO is responsible for all areas of accounting, finance, treasury, budgeting, revenue management & provider reimbursement, financial risk management, financial compliance/audit, materials procurement and fixed asset management. This role provides financial leadership and advice, both strategic and tactical financial perspectives, to the Board of Governors & L.A. Care senior management.

Chief Product Officer

The Chief Product Officer (CPO) owns the product strategy: to ensure product integrity, drive financial sustainability and deliver service excellence. The CPO leads the product teams and works across the matrix organization to continuously evaluate product performance and a portfolio

of products, service and program offerings to identify current and/or future opportunities that further evolve and improve product line performance and achieve growth and retention.

General Counsel

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

Executive Director, Medi-Cal

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

Executive Director Medicare Product

The Executive Director, Medicare Product role collaborates across the enterprise to ensure outstanding compliance and quality score results for the Medicare Plus (Dual-Special Needs Plan [D-SNP]) line of business while identifying and pursuing administrative efficiencies and process improvements that ultimately improve the customer experience. The position is responsible for strategically evaluating, planning and leading complex business initiatives that achieve the strategic product objectives that ensures product integrity, drives for financial sustainability and delivers service excellence.

Lead Executive Owner Innovation and Implementation

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

QI Program Physician Leadership

Chief Medical Officer

L.A. Care's Chief Medical Officer (CMO) is a physician, Board Certified in his or her primary care specialty, holding a current valid, unrestricted California Physician and Surgeon License. The CMO is an ex-officio member of the Board 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 Quality Medical Director.

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

Deputy Chief Medical Officer

The Deputy Chief Medical Director Officer is responsible for management and implementation of delegated Health Services functions in L.A. Care and provides oversight/monitoring of Plan Partners and PPGs. The Deputy CMO provides executive medical leadership over delegated departments and functions at the discretion of the CMO which include Utilization Management, Care Management, and Behavioral Health. In collaboration with the CMO, this individual will direct the overall clinical strategy and provide oversight to Health Services clinical initiatives, reporting, and outcomes measurement. This position will ensure implementation of the strategies, goals, and work plans designed by both him/herself and the CMO to enhance access and quality of healthcare for our members.

Chief Health Equity Officer

Chief Health Equity Officer is an enterprise leadership role, reporting to the Chief Executive Officer and matrixed to the Chief Human Resource Officer. The position partners with other executives to lead the organization's commitment and strategy to be a diverse, equitable, and inclusive (DEI) organization. The position is responsible for setting and implementing an overarching vision of DEI for the organization—both at the programmatic and administrative levels —that works to eliminate systemic organizational marginalization and promotes inclusion and anti-racist practices. There is a particular emphasis on addressing health disparities of our member population. The position is responsible for the promotion of internal and external DEI for L.A. Care's members, providers, employees and the Los Angeles community.

Chief Quality and Information Executive

The Chief Quality and Information Executive (CQIE) works collaboratively with the CMO and is a key position on the Health Services team who oversees the Quality Improvement department. This role is responsible to improve and maintain excellent equitable quality services for all members, including vulnerable populations. Implements strategy for the quality improvement

function within the health plan, in collaboration with the administrative and clinical leaders of the organization. Oversees regulatory readiness, quality measurement, and pay for performance programs and initiatives. The role will lead and be responsible for the planning, implementation and optimization of clinical information systems (CIS) used in the organization. Will assist in developing the vision and plan for the adoption of the new digital solutions and analysis for clinical process improvement. Reports directly to L.A. Care's Chief Medical Officer (CMO).

Chief Compliance Officer

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

Chief of Staff

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

Chief Pharmacy Officer

The Chief Pharmacy Officer is directly responsible for all business aspects related to Pharmacy Operations and significantly contribute to the strategic direction of the organization by integrating pharmaceutical care delivery with medical care and operational delivery strategy. The Chief Pharmacy Officer is responsible to provide pharmacy business and clinical forecast assessments to contribute to good decision making on the strategic direction of the organization to achieve its positive outcomes.

Chief of Enterprise Performance Optimization

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

Senior Medical Director, Utilization and Care Management Services

The Senior Medical Director will lead and work with a multi-disciplinary team, he/she is expected to execute L.A. Care Health Services' programs and strategic vision. The Senior Medical Director also is expected to ensure that the administrative functions related to utilization management (UM) are performed in a clinically appropriate and compliant manner. The administrative functions include performance of prospective, concurrent and retrospective utilization review, provider appeals and disputes and member grievances. On the care management (CM) side, the Senior Medical Director is expected to work with and support UM and CM staff on transition of care and community based care management needs.

Senior Medical Director, Behavioral Health & Social Services

The Senior Medical Director Behavioral Health and Social Services (BH/SS) is responsible for the development of the Behavioral Health and Social Services divisions of Health Services. The Senior Medical Director participates in all areas of quality assessment and improvement, including quality improvement programs, grievance and appeals, credentialing, and quality incentive programs for Behavioral Health and Social Services. The Senior Medical Director is responsible for overseeing behavioral health and social services participation in medical management and service coordination across the care continuum. The Senior Medical Director will be the key liaison with L.A. County Departments of Mental Health and of Public Health.

Medical Director, Quality

The Medical Director, Quality works collaboratively with the Chief Quality and Information Executive and is a key position on the Health Services team. This position will implement strategy for the quality improvement functions within the health plan, in collaboration with the administrative and clinical leaders of the organization. The position oversees the tracking and presentation of results of improvement efforts and ongoing measures of clinical processes; oversees regulatory readiness, quality measurement, and pay for performance programs and initiatives. The position is responsible for directing current network performance improvement programs and establishing new improvement activities, including methods to track peer review, credentialing and provider performance improvement plans, site surveys and potential clinical quality and critical events reviews.

QI PROGRAM RESOURCES

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

The QI Department works closely with other departments to achieve targeted outcomes and to facilitate and accomplish quality initiatives within the quality program. The QI Department works closely with the Enterprise Data Strategy and Analytics Department and collaborates with areas such as, but not limited to: Utilization Management, Provider Network Management, Customer Solutions Center, Credentialing, Pharmacy and Formulary, Facility Site Review, and Health Education, Cultural and Linguistic Services, Behavioral Health, and Care Management to achieve

outcome goals. A full organizational chart is attached to this program description (see attachment 1).

Senior Director, Quality and Accreditation

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

The Senior Director is further responsible for assuring all department functions are operating in accordance with the organization's mission, values and strategic goals and are provided in a manner that is responsive and sensitive to the needs of L.A. Care's culturally diverse membership. Directs all aspects of running an efficient team, including hiring, supervising, coaching, training, disciplining, and motivating direct-reports.

Senior Director, Stars Excellence

The Senior Director, Stars Excellence is responsible for strategy, planning, oversight and success of the Stars ratings for L.A. Care's Medicare Product and L.A. Care Covered (LACC) in accordance with the Medicare Advantage Product requirements and our Accountable Care Act Health Marketplace Exchange, Covered California Product, L.A. Care Covered requirements.

The Senior Director will be responsible for promoting the strategic Medicare Quality Rating System (QRS) Stars initiatives from development to successful execution, updating Senior Leadership on progress, challenges, barriers and suggested remediations.

Scope of oversight includes development of analytic and decision support systems to monitor progress and drive HEDIS/CAHPS/Stars initiatives to improve quality of care and system operations. The Senior Director also serves as senior subject matter expert, quality consultant and resource to Senior Leadership, PPGs, and practitioners and works with both internal and external quality stakeholders to identify opportunities for operational synergies to improve data capture and quality outcomes.

Senior Director, Safety Net Initiatives

The Senior Director, Safety Net Initiatives position has overall responsibility for planning and execution of strategies to improve the publicly-operated delivery system, community clinics, and private DSH hospitals through 1) joint planning, 2) operational improvement programs and activities, and 3) cross-sector collaboration. Significant focus is expected on delivery system transformation in the L.A. County Department of Health Services and nonprofit Community Clinics. This position develops and maintains critical strategic partnerships with local safety net health care and social service care providers, to improve L.A. County's delivery system to better serve vulnerable members.

Senior Director, Provider Network Development

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

Senior Director, Care Management

The Senior Director, Care Management (CM) is responsible for the delivery of Care Management to L.A. Care members with the main primary focus of setting and executing Care Management services. The Senior Director, CM will work with the CM Medical Directors and Director, Care Management in designing, enhancing and implementing programs, supporting system implementation and or enhancements. One of the key initiatives is to increase L.A. Care's community CM presence. This role is also responsible for outreaching and working with key stakeholders and provide subject matter expertise in support of the oversight, outreach and training of our Plan Partner Health Plans and Delegated Provider Groups.

Senior Director, Utilization Management

The Senior Director, Utilization Management (UM) has direct purview of all Utilization Management services, including prior authorization, clinical and concurrent review functions, post-service determinations, coordination for continuity of care, and all collateral UM programs. This role will oversee the Inpatient Director of UM and the Outpatient Director of UM, and the performance of their respective teams furnishing these services for all lines of business. The Senior Director is responsible for overseeing the planning, organization, direction, staffing and development of activities for Inpatient UM, Outpatient UM, Transitions of Care Program, the UM Admitting and ED Diversion Program, the UM Quality Assurance Team, the UM Education & Training Program, and the Delegate Support Team.

Senior Director, Regulatory Compliance

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

Director, Care Management Services

The Director, Care Management (CM) Services is responsible for the delivery of Care Management Services to L.A. Care members with the main primary focus of setting and executing Care Management services. This role is responsible for providing evidence of ongoing compliance with all regulatory and accreditation requirements. This role is also responsible for outreaching and working with key stakeholders and provide subject matter expertise in support of the oversight, outreach and training of our Plan Partner Health Plans and Delegated Provider Groups.

Director, Population Health Informatics

The Director of Population Health Informatics provides strategic guidance and decision support to the organization in the areas of clinical health outcomes, health care utilization and cost effectiveness, quality of care, as well as provider and network performance. This includes leading the Health Services Analytics team on strategic analytics that include rigorous evaluation design, clinical and economic analysis, predictive modeling, and other innovative approaches to utilizing health plan data to identify strategic opportunities and optimize programming. The Director has administrative and decision-making responsibilities for the Health Information Management, and is responsible for managing the analysis of all core healthcare related data, providing expertise in the development of clinical technical specifications for prototype reporting.

Director, Population Health Management

The Director of Population Health Management (PHM) this role will establish the PHM strategy that focuses on the "whole person" and the member's entire care journey, provide wellness services and intervene on the highest-risk members and is responsible for leading the strategic and operational efforts for the organization in streamlining the population health management strategy to improve clinical health outcomes, health care utilization, cost effectiveness, and quality care. Responsibilities include leading strategic analytics, evaluation design, clinical and economic evaluation, and optimize programing, ensuring that PHM emphasizes the Quadruple Aim and addresses health at all points on the continuum of care with targeted interventions for a defined population, and address disparities through a cost-effective and tailored health solutions.

Director, Quality Performance Informatics

The Director of Quality Performance Informatics is responsible for directing data and operations for HEDIS, CAHPS and related staff. The Director is responsible for creating and optimizing procedures and policies relevant to the HEDIS and CAHPS process by managing a process management plan, setting time lines and overseeing the activities required to complete the HEDIS cycle, including activities related to the external NCQA HEDIS audit, quality control, project completion, and data submission.

Director, Clinical Pharmacy

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

compliance of all lines of business, management of all Clinical Pharmacy related services and costs.

Director, Pharmacy Compliance

The Director of Pharmacy Compliance ensures compliance with applicable federal, state and local laws and regulations, accreditation, licensure and contractual requirements and L.A. Care's policies and procedures. The position is responsible for conducting risk assessments, internal audits, reviews, and maintains the privacy and confidentiality of information is safeguarded and the assets of the organization are protected. The position is responsible in ensuring that all regulatory non-compliant findings are reported and resolved and corrective actions implemented in a timely manner.

Director, Behavioral Health

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

Director, Health Education Cultural and Linguistic Services

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

Director, Provider Contracts & Relationship Management

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

Director, Safety Net Programs and Partnerships

The Director, Safety Net Programs and Partnerships, is responsible to lead and direct the department including oversight of the Program Development and Community Clinic Initiatives units. This position provides direction and guidance to staff for the development, planning, and execution of strategic initiatives to support community clinic performance improvement, safety net health care delivery system transformation, and improved health outcomes for vulnerable

populations. This position is responsible for building relationships and fostering collaborative partnerships with external public and nonprofit stakeholders.

Director, Credentialing

The Credentialing Director oversees initial credentialing, recredentialing and ongoing monitoring of quality activities and validation of provider data for direct network contracted practitioners, providers and facilities. Including the ongoing monitoring of network providers to ensure operational and quality compliance issues. The Director is also responsible for ongoing monitoring to ensure delegates' compliance with state and federal regulatory standards and L.A. Care standards and ensures accuracy of practitioner data in internal databases and directories.

Director, Managed Long Term Services and Supports

The Director, Managed Long Term Services and Supports (MLTSS) program includes 1) In Home Supportive Services, 2) Community Based Adult Services, 3) Long Term Care, 4) Multipurpose Senior Services Program and 5) Care Plan Options as well as 6) managing the services with the skilled nursing care facility physician and team (SNFist) for our institutionalized long term care members and 7) assisting with the transition of palliative care members from the hospital to community-based programs. The Director is directly responsible for the planning, organization, direction, staffing and development of L.A. Care's MLTSS unit functions.

Director, Medi-Cal Plan Partner Administration

The Director of Medi-Cal Plan Partner Administration provides leadership support and drives to strengthen the high performing relationship with subcontracted health plans (Plan Partners) for the Medi-Cal product line. The Director supports the development and leads the execution of the Medi-Cal Plan Partner strategic and tactical plan, ensuring deliverables are on time and in alignment with L.A. Care's strategic vision while utilizing a clear understanding of the factors that impact membership growth, cost containment, operational excellence, and compliance/risk.

Director, Medi-Cal Product Management

The Director of Medi-Cal Product Management provides leadership support and drives toward exceling program performance of the Medi-Cal product line. Responsible for leading strategic initiatives and projects, and ensuring deliverables are on time and in alignment with L.A. Care's strategic initiatives. As an industry expert in Medi-Cal managed care, the Director will be responsible for identifying and driving solutions for program issues impacting member and revenue growth, cost containment, operational performance, and mitigating program risk. The Director will engage key internal and external stakeholders to ensure product integrity, service excellence, and financial sustainability for L.A. Care's Medi-Cal product for the communities served and in support of L.A. Care Strategic Initiatives.

Director, Medicare Strategy and Product Development

The Director, Medicare Strategy and Product Development provides leadership and drives for the end to end lifecycle for the Medicare (CMC, D-SNP, etc.) product lines. Responsible for leading strategic initiatives and projects, ensures deliverables are on time and in alignment with L.A. Care's strategic initiatives. As an industry expert in Medicare managed care and duals products, leads

the development of new product lines and enhancements to existing products. Engages key stakeholders to ensure continuity of product lines and impact of a new product line to the communities served and L.A. Care Strategic Initiatives. This individual will lead a team responsible for the day-to-day activities to ensure the delivery of products and services to the market are competitive, sustainable, and consistent.

Director, Customer Solution Center Appeals and Grievances

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

Director, Social Services

The Director, Social Services will be a key component in designing and developing a new Social Work Department for L.A. Care as part of the Clinical Member Services segment of Health Services to meet the demand of our new organization restructured matrix. Will provide oversight of Social Workers and Social Work services provided to L.A. Care members, including member assessment, case management, counseling and referral. The Director, Social Services provides day-to-day oversight of Social Workers and Social Work activities, and assures all department functions are operating in accordance with the organization's mission, values, and strategic goals, as well as individual department goals.

Director, Department of Health Services Managed Care Support Services

The Director, Department of Health Services Managed Care Support Services is responsible to lead and provide oversight of the DHS Managed Care Support Services (DHS MCSS) Unit and the administration of the DHS Quality Improvement Program. As the Director, this individual is responsible for (1) directing and managing a staff required to work collaboratively with L.A. County DHS staff to analyze and address a broad range of managed care operational issues and (2) oversee the timely execution of managed care operational solutions designed to streamline operational interfaces between L.A. Care Health Plan, L.A. County DHS Providers and the L.A. County DHS Managed Care Services Office.

Director, Delegation Oversight

The Director of Delegation Oversight serves as a senior leader within the Compliance Department. The Director will manage the Delegation Oversight Unit and ensure that all audits of plan partners, providers, Independent Physicians Association (IPAs), specialty health plans and other external first tier, downstream and related entities are audited 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. The Director

will also advise and support the Chief Compliance Officer on other duties as assigned to support the mission and responsibilities of the Regulatory Affairs and Compliance Department and to support the mission and business operations of L.A. Care Health Plan.

Director, Enterprise and Network Oversight Clinical Operations

The Director of Enterprise and Network Oversight Clinical Operations will lead a team that is responsible for both internal and external oversight and monitoring of delegated and non-delegated medical management and clinical operations' functions. The Director works closely with leadership to help design, execute, and monitor projects to support business goals and to accelerate the realization of L.A. Care's clinical compliance and quality standards, Enterprise and financial goals, and strategic objectives. The Director leads efforts to implement and maintain the clinical components of Enterprise Performance Optimizations (EPO's) integrated, proactive performance measurement and management activities, including metric-based programs, gap and risk analyses, focused audits, case file reviews, and spot investigations to ensure Plan and Network performance excellence.

Senior Manager, Quality Improvement Initiatives

The Senior Manager of Quality Improvement Initiatives is an integral part of the success of the Quality Improvement (QI) program, and will work closely with QI Leadership to help execute, and monitor strategic plans and programs to support business goals and objectives that are within the functional area or responsibility.

The Senior Manager works with direct reports to ensure that metrics are developed to measure operational requirements-based performance to proactively identify and timely remediate noncompliance with requirements by performing gap and risk analyses and taking corrective action to ensure all functional areas within scope are optimally compliant. The Senior Manager is responsible for the direction and staffing of L.A. Care's Quality Improvement Steering Committee and functions. Critical to the position is ensuring that the information is protected and processes are developed and implemented in accordance with regulatory and legal statutes.

Senior Manager, Provider Quality

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

Senior Manager, Incentives

The Senior Manager of Incentives is responsible for strategic oversight of the company's portfolio of pay-for-performance (P4P) and incentive programs, and value based reimbursement programs. The Senior Manager will lead the development of reward-based incentive programs for consumers to promote evidence-based, optimal care for enrollees, a wide variety of initiatives to reward

physicians, community clinics, provider groups and health plan partners for improved performance in health care delivery; and value based reimbursement programs for providers that promote adherence to clinical guidelines and link payment for performance. The Senior manager works towards creative and innovative ways to solve problems, provides guidance on how to best structure and operationalize incentives used to encourage healthy behavior.

Manager, Accreditation

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

Manager, Health Information Technology Program

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

Manager, Health Informatics

The Manager of Health Informatics plays a key role in optimizing end-user experience of and data procurement from external stakeholders such as PPGs, MSOs and Plan Partners and streamlining operational processes for data flow and ultimately, outcome measure improvement. This manager is responsible for teams performing research, analysis, development and maintenance of performance reports and digital solution optimization programs in coordination with the CMIE, EDSA, IT, and HIT. This manager will create and maintain policies and procedures relevant to research and performance data programs involving rate calculations, reports and validation checkpoints, which may involve other L.A. Care teams.

Manager, Behavioral Health Clinical Services

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

Manager, Quality Performance Metrics

The Quality Performance Metrics (QPM) Manager is responsible for providing management and oversight to ensure the annual HEDIS, CAHPS and Health Outcomes Survey (HOS) submissions are delivered according to technical specifications and deadlines. The Manager is responsible for managing the HEDIS/QPM staff, creating policies and procedures relevant to HEDIS and CAHPS submission requirements, and developing and implementing the work plan to successfully complete the annual submission cycle and compliance audit. The Manager oversees all internal and outsourced operations and activities involving standardized quality measurement and reporting. The Manager collaborates with internal and external stakeholders to ensure that HEDIS and CAHPS initiatives are fully integrated throughout the organization.

Manager, Stars Analytics

The Manager of Stars Analytics (MSA) is responsible for the operations, projects and planning for all reporting and analytics focused on Medicare Stars, QRS, and other data-sharing and/or quality improvement programs focused on enhancing member experience, quality of life, and thereby improving star ratings. The MSA is responsible for analyzing, monitoring, reporting, and providing technical collaboration and data driven decision making on clinical and operational quality improvement activities related to these programs. The MSA recommends policies, and leads process improvement efforts.

Manager, Quality Performance Management

The Quality Performance Management (QPM) Manager is responsible for providing management and oversight to ensure the annual HEDIS, CAHPS and HOS submissions are delivered according to technical specifications and deadlines. This individual is responsible for managing the HEDIS/QPM staff, creating policies and procedures relevant to HEDIS and CAHPS submission requirements, and developing and implementing the work plan to successfully complete the annual submission cycle and compliance audit.

Manager, Quality Data

The Manager of Quality Data ensures accurate and timely delivery of HEDIS and Survey data to regulatory entities, partners and other stakeholders. This position plays a key role in optimizing data procurement and streamlining operational processes for Extract, Transform, and Load (ETL). This position is responsible for data process regarding HEDIS and Surveys, including Member and Provider experience, Health Outcomes and others. This position will create and maintain policies and procedures relevant to HEDIS and Survey data process, coordinate with vendors, provider groups and plan partners to maximize data completeness, analyzing quality data results to identify improvement opportunities.

Manager, Clinical Programs

The Manager, Clinical Programs provides direct supervision of the clinical pharmacists and pharmacy technicians in order to assure operational effectiveness. The Manager of Clinical Programs leads the Pharmacy Department initiative to create a standard framework for establishing and updating Pharmacy Department Policies & Procedures delegating content development to other Pharmacy Department subject matter experts.

Manager, Ambulatory Care Advanced Practice Pharmacy

The Manager of Ambulatory Care Advanced Practice Pharmacy is responsible for developing and running effective and efficient pharmacy related programs, which includes developing and maintaining appropriate metrics to monitor and continually improve processes, performance and quality. The Manager provides direct supervision of clinical pharmacists and pharmacy technicians in order to assure operational effectiveness.

Manager, Formulary and Benefit Design

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

Manager, Pharmacy Appeals and Grievances

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

Manager, Facility Site Review (FSR)

The Manager of Facility Site Review is responsible for the organization, compliance, direction, and staffing of L.A. Care's FSR function(s). Responsibilities includes supervisory visits of staff conducting site reviews and/or physical accessibility review survey assessments, maintain regulatory compliance, oversight of plan partner related operations, operations for direct lines of business and/or management of services agreement functions, and interfacing with external agencies including other Managed Care Plans.

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

The Manager, Customer Solutions Center (CSC) A&G (Appeals & Grievances) is responsible for the centralized intake, logging and triage process for all member appeals and grievances. The Manager oversees the resolution of member appeals and grievances for all product lines in a manner consistent with regulatory requirements and L.A. Care policies and procedures. This position ensures the proper handling of member complaints whether presented by members, their authorized representative, the Ombudsman office, state contractors, member advocates, L.A. Care Board Members, providers, etc. The Manager is responsible ensures timely appeal and grievance reporting.

Manager, Health Education

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

Manager, Cultural and Linguistics Services

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

Manager, Health Equity

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

Manager, Social Services

The Manager, Social Services is responsible for managing social workers within our Headquarters' Social Services Department and social workers deployed to offsite locations. The Manager, Social Services performs a wide variety of managerial and administrative functions to assess department's needs and ensures program objectives are met. This position also helps in planning, developing, and evaluating the social services program. The Manager, Social Services assures individual department goals are responsive and sensitive to the needs of L.A. Care's culturally diverse membership.

Manager, Autism Program

The Manager, Autism Program will assist L.A. Care in initiatives to integrate behavioral health services in L.A. Care's programs. The primary focus of the position will be integrating the current ASD benefit and future benefits related to Behavioral Health Treatment. The Manager shall develop the behavioral health delivery system operations for all upcoming programs, as well as maintain responsibilities for implementing, operating and continually improving the service delivery system. The Manager will manage a team of Autism Program Specialists.

COLLABORATION THROUGH COMMUNITY PARTNERS

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

Facility Site Review (FSR) Task Force

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

Goals: The FSR Task Force goals are as follows but not limited to:
- Serve as a forum for the discussion of related facility site review activities.
- Identify issues and institute interventions as appropriate.
- Review results of interventions and follow-up as appropriate.
- Review facility site review reports and problem provider sites.
- Promote coordination and collaboration on facility site review processes.
- Work collaboratively to identify opportunities for improvement as related to the facility site review process and to decrease any duplicative assignments and surveys.
  Support and discuss identified issues and concerns as it relates to the L.A. County collaborative process as mandated by the California Department of Health Care Services (DHCS).

Functions: The functions of the FSR Task Force include, but are not limited to the following:
- Reviewing facility site review reports and determine opportunities for improvement.
- Updating committee members of California Department of Health Care Services (DHCS) Site Review Workgroup (SRWG) meetings.
- Provide a forum for discussion of facility site review activities.
- Formulate opportunities of improvement from facility site review data collected.
- Identify and communicate difficult provider sites.

Structure: The FSR Task Force membership is comprised of L.A. Care staff who are involved in FSR activities.
- Chief of Equity & Quality Medical Director(when available)
- Facility Site Review, Director
- Facility Site Review Manager
- Facility Site Review Department Staff
- Strategic Partner Representatives
- Site Reviewers

The committee may invite other attendees as necessary.

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

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

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

PPG/Plan Partner Collaboration

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

Beginning in 2016, L.A. Care hosts webinars on QI topics for PPGs, providers, and Plan Partners. In 2018, the frequency of the webinars was increased to monthly, focusing on important areas including HEDIS performance, member satisfaction, and data submission. Expanding the audience to include providers offers an introduction to HEDIS and correct coding, as well as earning potential through the incentive programs. These webinars aim to disseminate detailed information on topics aligned with the organization's strategic goals. In this year, L.A. Care included webinars to address pediatric care on best practices including vaccine hesistancy, Equity Oriented Primary Care in Action, QI in LBGTQ+ Health as well as Gender Affirming Care. In addition to the expanded webinars, L.A. Care QI Department actively engages with the PPGs using the provider portal to communicate care and service gaps that are actionable.

BEHAVIORAL HEALTH COLLABORATION

Behavioral Health Services are inclusive of both mental health and substance use disorder services. Behavioral Health Services are available for L.A. Care members across all lines of business. The system of care where member accesses treatment is based on the severity of member's symptoms and member's line of business. For Medi-Cal recipients, including both MCLA and L.A. Care Medicare Plus (Dual-Special Needs Plan D-SNP) lines of business, specialty mental health services are carved out to the Los Angeles County Department of Mental Health (DMH). Substance Use Disorder treatment is a benefit covered through the Department of Public Health, Substance Abuse Prevention and Control (DPH SAPC) for Medi-Cal recipients, including both MCLA and D-SNPlines of business. Substance Use Disorder treatment for members covered under PASC and Covered California is covered through L.A. Care's Managed Behavioral Health Organization (MBHO). Mild to moderate mental health services are the responsibility of the L.A.

Care and are managed by L.A. Care's contracted MBHO for all lines of business. L.A. Care collaborates with these entities to conduct activities to improve the coordination of behavioral healthcare and general medical care including collaborating with their provider networks.

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

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

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

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

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

Current quality measures and benchmarks are not in place for this benefit as it first became available to members in early 2014. The BHT team is working to disseminate provider and member satisfaction surveys as the first quality improvement initiative.

COMMITTEE STRUCTURE

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

Structure: The Committee is comprised of no more than six members of the Board, including at least one physician, none of whom is an employee of L.A. Care. The number shall be determined by the Chairperson of the Board. A Committee Chairperson is elected annually by Committee 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 OfficerChief Compliance Officer, or designee reports to the Committee as often as needed. Draft agendas are publicly posted at least 72 hours prior to the meeting with the final agenda and meeting materials 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: The committee is responsible for reviewing, evaluating, and reporting to the Board on quality improvement (QI) and utilization management (UM) activities. The Committee 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 Chief Medical Officer and the Compliance Officer, on the findings and matters within the scope of its responsibility. The committee receives regular reports from the Chief Medical Officer, the Chief Compliance Officer, and the Quality Oversight Committee.

Board of Governors Community Advisory Committees

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

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

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

Frequency: ECAC meets monthly.

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

Regional Community Advisory Committees

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

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

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

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

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

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

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

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

1. Improve member satisfaction in L.A. Care's provision of services;
2. Improve access to care;
3. Ensure culturally and linguistically appropriate services and programs;
4. Identify emerging needs in the community and developing programmatic responses;
5. Determine and prioritizing health education and outreach programs: and
6. Collaboratively addressing community health concerns.
7. Help in gathering information about issues and concerns pertinent to the health and well-being of L.A. Care members in the region. The information is used by the advisory committees and L.A. Care to plan, implement, and evaluate programs which address the concerns identified.

See Community Advisory Committees (CACs) Rules and Code of Conduct for further detail.

Internal Compliance Committee

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

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

Quorum and Voting: A quorum is established when a majority of the voting membership are in attendance.

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

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

Functions: The functions of the ICC include, but are not limited to the following:
- Maintain communication between the Board, the internal or external compliance auditors and management.
- Review matters concerning or relating to the compliance program.
- Ensure proper communication of significant regulatory compliance issues to management and the Board.
- Review significant healthcare regulatory compliance risk areas and the steps management has taken to monitor, control and report such compliance risk exposures.
- Annually review and reassess the adequacy of the Compliance Plan and the Internal Compliance Committee Charter
- The ICC may form/designate subcommittees to investigate and remediate issues and report back to ICC.

Quality Committees

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

Oversight of delegated activities occurs in the following committees with a summary of committee activities reported to Quality Oversight Committee (QOC) (See Committee Section of this program for full description of committee):
- Utilization and Complex Case Management: Utilization Management Committee (UMC)
- Credentialing and Peer Review: Credentialing and Peer Review Committee (CPRC) for Potential Quality of Care Issues (PQIs) and Facility Site Review (FSR)
- Member Rights (grievance and appeals): Quality Oversight Committee (QOC)
- Quality: Member Quality Service Committee (MQSC), QI Steering Committee (QISC), Joint Performance Improvement Collaborative Committee (PICC)/Physician Quality Committee (PQC).
- Pharmacy: Pharmacy Quality Oversight Committee (PQOC)
- Behavioral Health: Behavioral Health Quality Committee (BHQC)
- HEDIS/CAHPS: Quality Performance Management Steering Committee (QPMSC)
- Population Health Management Metrics: Population Health Management Cross Functional Team (PHMCFT)
- Medicare: Stars Steering Committee (SSC)
- Health Equity: Equity Council Steering Committee (ECSC)

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

The dissemination of information and findings to physicians may take various forms. These methods may include but are not limited to:
- Informal one-on-one meetings
- Formal medical educational meetings
- L.A. Care Newsletters
- Provider Relations and Physician Reports
- Quarterly Reports to the Board of Governors

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

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

Structure: The QOC membership is comprised of L.A. Care staff who are involved in improvement activities. The Committee is chaired by the Chief Medical Officer or physician designee.

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

Membership includes, but is not limited to Chief Quality and Information Executive, Chief Medical Officer, Deputy CMO, Quality Medical Director Senior Director Quality & Accreditation, Senior Director Enterprise Pharmacy, Senior Director Care Management, Senior Director Enterprise Performance Optimization, Director Delegation Oversight, Director Customer Solution Center Appeals & Grievances, Medical Directors, Director Quality Performance Informatics, Executive Directors of Products, Manager Facility Site Review, Director Utilization Management,

Director Provider Network Management, Compliance Officer, Director Marketing and Communications, Director Credentialing, and ad hoc members – (members from other departments are invited to attend when input on topics require their participation).

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

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

- Assure compliance with the requirements of accrediting and regulatory agencies, including but not limited to, DHCS, DMHC, CMS, NCQA and Covered California.
- Escalate concerning issues as per protocols, policies and procedures.
- Ensure follow-up, as appropriate.
- Improve quality, safety, and equity of care and service to members.
- Identify appropriate performance measures, standards, and opportunities for performance improvement.
- Identify actions to improve quality and prioritize based on analysis and significance; and indicate how the Committee determines these actions and ensure satisfactory closure.
- Formulate organization-wide improvement activities and gain support from appropriate departments.
- Ensure that QI Program activities and related outcomes undergo quantitative and qualitative analyses that incorporate aggregated results over time and compare results against goals and benchmarks.
- Ensure all departments have the opportunity to align project goals and map out responsibilities and deadlines prior to project implementation.
- Ensure that root cause analyses and barrier analyses are conducted for identified underperformance with appropriate targeted interventions.
- Ensure that the information available to the Plan regarding accessibility, availability and continuity of care is reviewed and evaluated, including but not limited to information obtained through enrollee and provider surveys, enrollee grievances and appeals, and triage or screening services.
- Ensure that opportunities for improvement are prioritized, and closed based on the analysis of performance data.
- Reviews the analysis and evaluation of QI activities of other committees or staff, identifies needed actions, and ensures follow up as appropriate.
- Review current quality improvement projects and performance improvement activities to ensure appropriate collaboration and minimize duplication of efforts.
- Review performance requirements of strategic projects and performance improvement activities to enhance effectiveness and make modifications as appropriate.
- Review, evaluate, and make recommendations regarding oversight of delegated activities, such as, audit findings, trending, and reports.
- Review and provide thoughtful consideration of changes in its QI and other policies and procedures and work plan and make changes to policies/work plan as needed.
- Review and modify the QI program description, annual QI Work Plan, quarterly work plan reports and annual evaluation of the QI program.

- Review and evaluate actions taken to determine if actions are effective in improving quality and what revisions, if any, need to be made to the actions.
- Provide and/or review and approve recommended changes to the QI Program and QI Work Plan activities based on updates and information sources available.

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

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

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

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

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

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

Frequency: The Joint PICC/PQC meets at least quarterly but as frequently as necessary to demonstrate follow-up on all findings and required actions.

Functions: The responsibilities of the Joint PICC/PQC include but is not limited to:
- Review of regulatory required improvement plans with the state.
- Make recommendations to L.A Care about issues relating to quality improvement activities and administrative initiatives.
- Promote initiatives and innovations offered to the provider community.
- Provide input and make recommendations to L.A. Care's Quality Oversight Committee (QOC) on policy decisions, as well as quality and service improvements.
- Ensuring practitioner participation in the QI program through planning, design, implementation and review.
- Provide a forum for dialogue to enhance the efficiency of practitioner business services including incentive programs and clinical information technology adoption.
- Review and discuss barriers to improvement of HEDIS and CAHPS and other QI measures.
- Review quality improvement project development and opportunities presented by L.A. Care and offer advisory feedback and recommendations as appropriate.
- Provide input and feedback on services provided to our members.
- Review and analyze member and provider satisfaction survey results and access to care results and make recommendations for improvement as appropriate.
- Ensure practitioner participation in the QI and Value Initiative for IPA Performance (VIIP) or Value Based Pay for Performance programs through planning, design, implementation and review.
- Assure compliance with the requirements of accrediting and regulatory agencies, including but not limited to, DHCS, DMHC, CMS, NCQA and Covered California.
- Select, evaluate, develop and approve/adopt preventive and clinical practice guidelines that are based on nationally developed and evidence based criteria.
- Other activities/issues as they arise.

Quality Improvement and Health Equity Committee (QIHEC)

L.A. Care will implement a Quality Improvement and Health Equity Committee (QIHEC). This committee will analyze, evaluate and respond to quality improvement (QI) and health equity activities. The implementation of this committee is under the umbrella of L.A. Care's Quality Improvement and Health Equity Transformation Program (QIHETP). L.A. Care will combine the PICC and PQC committee into a new QIHEC. The stakeholders required across all these committee has similar overlap and subject content for discussion and thus, this committee will consolidate for efficiency in the feedback received from the appropriate stakeholders.

The CHEO along with the Quality Improvement Medical Director, the CMO's designee, must implement and maintain the QIHEC.

As the PICC and PQC meeting already includes most of the same stakeholders, L.A. Care will identify those stakeholders not currently part of these meetings and invite them, most notably, ensuring there is active participation by members. Stakeholders will include network providers including, hospitals, clinics, county partners, physicians, Subcontractors, Downstream Subcontractors, Network Providers, and Members. The network providers will represent

clinicians that provider services to member that are affected by Health Disparities, Limited English Proficiency (LEP) Members, Children with Special Health Care Needs (CSHCN), Seniors and Persons with Disabilities (SPDs) and persons with chronic conditions.

L.A. Care will ensure there is a written summary of QIHEC activities and the QIHEC activities of its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors, findings, recommendations, and actions are prepared after each meeting and submitted to L.A. Care's Governing Board for QIHETP. The Governing Board is L.A. Care's QOC, which reports to the C&Q and then reports to the BoG. L.A. Care will ensure a written summary of the QIHEC activities is publicly available on the website at least on a quarterly basis. L.A. Care will ensure that its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors maintain a QIHEC that meets the requirements set forth in this Section. Contractor must also ensure that they report to Contractor's QIHEC quarterly, at a minimum

This meeting will continue with the quarterly meeting cadence, and more if needed, as specified by DHCS.

Utilization Management Committee

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

Structure: The UM Committee supports the Quality Oversight Committee in the area of appropriate provision of medical services and provides recommendations for UM activities. The CMO or designated Utilization Management Medical Director serves as the Chairperson. Findings and recommendations are presented to the Quality Oversight Committee.

Quorum and Voting: A quorum is established when 5 of the voting members are present. Only physician members, Senior Director, and Director level members of the UM committees may vote.

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

Frequency: The Committee meets at least quarterly.

Functions: The UM Committee is responsible for overall of all utilization management activities and promotes the optimum utilization of health care services, while protecting and acknowledging member rights and responsibilities. The responsibilities of the UM Committee include but are not limited to:

- Maintaining the annual review and approval of the UM Program Description, work plans and evaluation; UM Policies/Procedures; UM Criteria; and other pertinent UM documents such as the UM Delegation Oversight Program
- Reviewing and approving all Policies/ Procedures for care management, behavioral health, long-term support services and appeals and grievances
- Reviewing medical policy, protocol, criteria and clinical practice guidelines, including but not limited to prior authorization guidelines and implementation of new technologies or new applications of existing technologies for potential addition as a new medical benefit for members
- Reviewing and analyzing utilization data from all departments for the identification of trends and monitoring for potential areas of over- and under-utilization
- Providing oversight of delegated activities
- Identifying practice variances or deviations among plan delegates and recommending what, if any, next steps are appropriate

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

Credentialing/Peer Review Committee

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

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

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

Voting Members Membership includes, but is not limited to: L.A. Care Chief Medical Officer, Quality Medical Director, L.A. Care Utilization Management Medical Director, network physicians or designees, and other board certified medical specialists invited on an ad hoc basis. Nurse practitioners (NP) may vote on NP cases only and Doctoral level behavior health professionals may vote on behavioral health issues only.

Non-Voting Members are subject matter experts from the following departments: Credentialing, Utilization Management, Appeals and Grievances Contract and Relationship Management, Quality Improvement (QI), Managed Long Term Support Services (MLTSS) Compliance, Legal, Facility Site Review (FSR), Special Investigations Unit (SIU), and additional non-voting members may attend on an adhoc 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, and any provider service types, contracted to provide services to an L.A. Care member, outlined in Policy PNMCRD-004.
- Determine if practitioners/providers meet credentialing/recredentialing and contracting eligibility requirements to participate in the network.
- Determine conditions for altering a practitioner's relationship with L.A. Care including closing the practitioner's assigned membership panel, suspension or termination of practitioners from the network.
- Determine and approve pre-contractual and annual delegated oversight activities for credentialing and recredentialing.
- Provide feedback on specific practitioner credentials that do not meet established credentialing criteria and issue recommendation(s) for handling such cases.
- Review and approve ancillary facilities including but not limited to: 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
- Community Supports and Enhanced Care Management

- Ensure compliance with state and federal regulatory agencies and accrediting bodies concerning credentialing and recredentialing activities.
- Collaborate with Compliance's Enterprise Performance Optimization (EPO) Department, to review and approve all credentialing delegation oversight activities and make recommendations concerning Corrective Action Plans (CAPs) and de-delegation, when applicable. Review, evaluate, and make recommendations regarding Potential Quality of Care Issues (PQIs) in collaboration with QI.
- Recommend additional investigation and/or reporting to CRM, Compliance, SIU, FSR, Pharmacy and MLTSS as indicated or as appropriate.
- Determine clinical appropriateness, quality of care and assigns the severity level to the case. PRC members may be requested to review the PQI case prior to the PRC meeting.
- Provide oversight of delegated peer review and delegated ongoing monitoring as needed.
- Review, recommend, take action, and monitor the clinical practice activity of the Practitioner network and mid-level practitioners.
- Provide Peer Review and take appropriate action against practitioners/providers when instances of quality and safety related to sanctions, complaints and adverse events are identified. Review fraud, waste and abuse cases identified by Special Investigation Unit (SIU) to determine if network providers' actions impact the safety, quality and/or care of members.
- Assure compliance with the requirements of accrediting and regulatory agencies, including but not limited to, DHCS, DMHC, CMS and NCQA.
- Ensure appropriate reporting to authorities, including 805, NPDB, etc., are made, as outlined in policy and procedure PNMCRD-011.
- Ensure Fair Hearing Procedures are offered and carried out in accordance with approved policy and procedure, LS-005.
- Facility Site Review provides the following reports to the committee for review and approval:
  - FSR Issues Report – Listing of providers/sites that are being followed by FSR
  - Scheduling Summary Report
  - Minimum Site Hours Report
  - Continued Noncompliance Report
  - Focus Review Reports
  - Planned Partner Audit Summary

Pharmacy Quality Oversight Committee

Role and Reporting Relationship: The Pharmacy Quality Oversight Committee (PQOC) is responsible for oversight of the Pharmacy and Therapeutics process administered by the existing Pharmacy Benefit Manager (PBM). The PQOC also reviews and evaluates newly marketed drugs for potential placement on the formulary and also reviews new medical technologies or new applications of existing technologies and recommend for benefit coverage, based on medical necessity. The PQOC develops utilization management criteria for all direct product lines of L.A. Care. The committee reports to the Quality Oversight Committee.

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

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

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

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

Frequency: The PQOC meets at least quarterly.

Functions: The PQOC has the following functions:

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

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

Behavioral Health Quality Committee

Role and Reporting Relationship: The Behavioral Health Quality Committee (BHQC) is responsible for collecting and reviewing data, developing, implementing, and monitoring

interventions based on the analysis of data to improve continuity and coordination of physical and behavioral health care needs. BHQC is attended by L.A. Care's Managed Behavioral Health Organization (MBHO, who is delegated for the mild-to-moderate impairment of mental, emotional, or behavioral functioning resulting from a mental health disorder for Medi-Cal, LACC and PASC-SEIU beneficiaries, in addition to specified behavioral health services in accordance with the plan benefit package for L.A. Care Medicare Plus beneficiaries, which is L.A. Care's Medicare Plus (Dual-Special Needs Plan [D-SNP]). BHQC is also attended by stakeholders from Department of Mental Health (DMH) and Department of Public Health Substance Abuse Prevention and Control (DPH SAPC) due to carve out specialty mental health services and substance use disorder services to County Mental Health Plans, respectively. L.A. Care works closely with the MBHO and County Mental Health Plans in order to collaborate with behavioral health practitioners (BHPs) and use information collected to coordinate medical and behavioral health care needs. This committee reports to the Quality Oversight Committee.

Quorum and Voting: A quorum is established when there is one medical director, three licensed behavioral health clinicians and one quality improvement representative is in attendance. Voting members include: L.A. Care Medical Director, L.A. Care Licensed Behavioral Health Clinician (i.e. LMFT, LCSW, LPCC, etc.), External Medical Director – from: PPG, MBHO, DMH, DPH SAPC, etc., External Licensed Behavioral Health Clinician (i.e. LMFT, LCSW, LPCC, etc.) – from PPG, MBHO, DMH, DPH SAPC, etc., Clinical Pharmacist, Registered Nurse, Nurse Practitioner or Physician Assistant and Quality Improvement Manager, or designee.

Membership: All Leads pertinent to Health Services Behavioral Health Department include but not limited to Chiefs, Medical Directors, Senior Directors, Directors, and Managers. Committee also includes external stakeholder Leads pertinent to Behavioral Health Department included but not limited to MBHO, County Partners (DPH SAPC and DMH) and PPGs. The committee will invite other contributing stakeholders across the organization on an as needed basis. Stakeholders include but not limited to pharmacy, product team, provider network management, appeals and grievances and compliance.

Frequency: The Behavioral Health Quality Committee meets quarterly.

Functions: The functions of the Behavioral Health Quality Committee include:
- BH Quality Improvement staff review MBHO's program documents, policies and work processes in order to ensure appropriate Quality Improvement (QI) functions:
  - Follows written policies and procedures for health services contracting to ensure contracted providers cooperate with the QI program.
  - Follows written policies and procedures to ensure availability of practitioners.
  - Follows written policies and procedures to ensure accessibility of practitioners for behavioral health and member services.
  - Follows written policies and procedures that reflect quality practices, practice guidelines and current standards of medical practice.
  - Implements mechanisms to ensure consistent application of clinical practice guidelines and compatible decisions.
  - Individual contracted behavioral health providers have activities to improve care coordination with physical health providers.

- o Monitors and takes action to improve continuity of care and coordination.

Member Quality Service Committee

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

Structure: Committee members include leadership from key internal departments required to participate in this committee including but not limited to: Provider Networks Management, Customer Solutions Center, Member Outreach, Appeals and Grievances, Behavioral Health, Social Work, Utilization Management/Case Management, Managed Long-Term Services and Support, Medicare Operations, Pharmacy, Quality Performance Informatics , Health Education, Cultural & Linguistic Services Department, Quality Improvement, Medi-Cal Product, Commercial and Group Product Management, Community Outreach & Education, Provider Quality Review, Facility Site Review, Population Health Informatics, and other departments.

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

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

Functions: The functions of the Member Quality Service Committee include:
- Create and maintain a member-centered culture for the organization.
- Review aggregate performance data on L.A. Care's network, including adherence to access and availability standards.
- Provide input, raise concerns and make recommendations to L.A. Care's Quality Oversight Committee (QOC) on the state of member experience.
- The committee may choose to invite representatives of subcontracted health plans or provider groups, as needed.
- Review and discuss quarterly delegated activity reports.
- Review and monitor effectiveness of Cultural & Linguistic services including the Language Assistance Program.

Quality Improvement Steering Committee

Role and Reporting Relationship: The Quality Improvement Steering Committee (QISC) is established by the authority of the L.A. Care QOC and through this Committee to the Compliance and Quality Committee (C&QC) then to the Board of Governors (BoG). This Committee is a

collaborative workgroup that engages business units from multiple departments across the organization that are involved in improvement of care, services, and provider and member satisfaction.

Structure: The Manger of Clinical Initiatives or designee serves as the Chairperson for the Quality Improvement Steering Committee.

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

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

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

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

Quality Performance Management (QPM) Steering Committee

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

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

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

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

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

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

Effectiveness of Committee will be measured by:
- Participant Engagement – attendance and contribution
- Timeliness of decision making and follow up as recorded in Committee minutes
- Timely resolution of barriers and challenges
- Adoption and implementation of innovative solutions to improve HEDIS rates
- Relevance of analyses of HEDIS and CAHPS results to the design of Quality Improvement interventions in the QI/Interventions team
- Enhanced operations and workflow for HEDIS/CAHPS

Population Health Management Cross Functional Team Committee

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

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

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

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

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

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

- Direct the PHM activities across L.A. Care in order to improve collaboration between departments to develop a holistic Population Health strategy.
- Recommend committee policy decisions.
- Review, analyze, and evaluate the PHM activities of the Committee.
- Ensure adequate participation in the Committee from appropriate departments.
- Ensure appropriate resources are given to Committee activities.
- Review current and prospective initiatives/interventions.
- Provide reports analysis, initiative/intervention approval (when necessary) and/or recommendations to PHM CFT.
- Report to the QOC on all activities.

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

Structure: The Equity Council Steering Committee will be chaired by the Quality Medical Director. The Steering Committee will include the chairs of three equity councils focused on three

constituencies; members, providers and vendors and, L.A. Care employees. The Steering Committee will be completed with a minimum of five at-large members.

The three councils include:

- **Member Equity Council** – This Council continues the work of the Health Equity Task Force that was formed during the 2019-2020 fiscal year. The Member Equity Council will recommend and implement strengthened or expanded activities to promote equity and reduce health disparities among members. This Council will align equity efforts enterprise-wide and increase the awareness of health equity throughout L.A. Care. Health equity is inclusive of eliminating the social determinants of health, social and racial injustice and the systems that create and perpetuate these circumstances. This Council will be chaired by the Health Equity Program Director.
- **Provider and Vendor Equity Council** – This Council will focus on diversity among L.A. Care participating providers to align with member diversity inclusive of race, ethnicity, language and other important demographics in order to offer member options based on their preferences. This includes recruiting additional primary care doctors in safety net practices and building a pipeline for future doctors with L.A. Care's Elevating the Safety Net Program. This Council will also provide recommendations to enhance diversity among vendors of purchased services at L.A. Care and promote equal opportunity. This Council will be chaired by the Executive Director of Commercial and Group Product.
- **L.A. Care Team Equity Council** – This Council is a forum for L.A. Care colleagues of different races, ethnicities, departments, and levels to raise and discuss issues and concerns and ensure L.A. Care stays on an upward course of inclusion. This Council will be chaired by the Director of the Center for Organizational Excellence.

Quorum and Voting: All committee members have voting privileges.

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

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

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

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

The goals of the Steering Committee are to:

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

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

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

National Committee for Quality Assurance (NCQA) Steering Committee

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

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

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

- Appeals and Grievances
- Behavioral Health
- Care Management
- Center for Organization Excellence
- Commercial & Group Product Management
- Communications
- Credentialing
- Customer Solution Center
- Enterprise Performance Optimization
- Health Education & Cultural Linguistics

- Human Resources
- Information Technology
- Medi-Cal Administration
- Medicare Product
- Pharmacy
- Population Health Management
- Provider Network Management
- Sales and Marketing
- Quality Improvement
- Quality Performance Management
- Utilization Management

Frequency: The NCQA Steering Committee may meet quarterly.

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

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

Stars Steering Committee

Role and Reporting Relationship: This committee provides vision, support and guidance for those who are directly responsible for executing Stars improvement projects and activities for L.A. Care Covered and Medicare and Medi-Cal eligible duals membership. The Committee oversees direction and strategies to implement programs and initiatives to optimize Star ratings and drive continuous improvements in the areas of member health, care experience, appropriate utilization of services and care coordination. The Committee monitors overall and individual performance across the Quality Rating System (QRS) and Centers for Medicare & Medicaid Services (CMS) Star ratings measures. The Committee reports up to the Quality Oversight Committee (QOC) and to the Chief Executive Officer (CEO) Cabinet.

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

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

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

- Chief Quality and Information Executive
- Executive Director, Medicare Products

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

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

Functions: The functions of the Stars Steering Committee include but are not limited to:
- Be committed to and advocate for L.A. Care's Stars goals and objectives.
- Understand the strategic implications and outcomes of Stars improvement projects and activities
- Monitor and review Stars improvement projects and activities at Committee meetings.
- Provide resources to support Stars improvement projects and ensure accountability.
- Control project scope based on resources and alignment with adopted goals and objectives
- Formally accept Stars improvement goals, objectives and project deliverables.
- Stars Steering Committee will report to the Quality Oversight Committee and the CEO.

Continuing Medical Education Committee

Role and Reporting Relationship: The Continuing Medical Education (CME) Committee is an internal committee of L.A. Care's Provider Continuing Education (PCE) Program. It is the mission of the CME Committee to continuously improve knowledge, competence, clinical skills and performance of our physician network and other healthcare professionals through effective continuing medical education activities to facilitate the optimal delivery of health care services to Los Angeles County's vulnerable populations and improve the overall health of the communities that L.A. Care serves.

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

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

Membership includes, but is not limited to Chief Medical Officer, L.A. Care Medical Directors, L.A. Care network physicians, Provider Continuing Education Program Manager, QI Director, and up to five (5) external 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 and CME activities.
- Completion and analysis of an annual professional medical education needs assessment based upon professional practice knowledge gaps and based upon desirable physician attributes.
- Plan the annual calendar of directly provided and jointly provided CME activities.
- Review and approve all components of each educational offering including learning, objectives, content, budget, faculty, and CME activities' 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 QI PROGRAM

The scope of the QI Program is reflective of the health care delivery system and provides a systematic approach to monitor care to identify opportunities for continuous improvement; encompassing the equity, quality and safety of both clinical care and service. The processes and procedures are designed to ensure that all medically necessary covered services are available and accessible to all members regardless of sex, race, color, religion, ancestry, national origin, ethnic group identification, language, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation, or identification with any other persons or groups defined in Penal Code 422.56, and that all covered services are provided in a culturally and linguistically appropriate manner.

The Quality Improvement Program is implemented through the multidisciplinary collaboration of departments across the entire organization. The program includes establishment of performance indicators and measurement methodologies, measurement of performance, quantitative and qualitative analysis of performance data and results, identification of improvement opportunities, prioritization of opportunities, timely implementation of strong interventions/corrective actions to continuously improve performance and evaluation to assess the effectiveness of interventions/corrective actions to measure the quality of equitable clinical and administrative services. There is an annual formal evaluation of the Quality Improvement Program to assess the overall effectiveness of the QI program and its progress toward influencing network-wide safe clinical practices.

L.A. Care's QI Program maintains compliance with DHCS, DMHC, CMS, NCQA, Covered California, and other regulatory entities to serve Medi-Cal, Medicare Plus (Dual-Special Needs Plans [D-SNP]), L.A. Care Covered, and PASC-SEIU members.

As provided under 42 CFR §422.152(c) and §422.152(d), QI programs must include Chronic Care Improvement Programs (CCIP) and Quality Improvement Projects (QIPs) that measure and demonstrate improvement in health outcomes and beneficiary satisfaction. L.A. Care also

conducts Plan, Do, Study, Act (PDSA) projects and Performance Improvement Projects (PIP), as required by DHCS, Covered California, CMS and other regulatory agencies.

CMS has reframed the QI program as a continuous performance improvement program that includes collection, reporting, and analysis of data that:
1. Assists beneficiaries in selecting plans that meet acceptable performance levels
2. Assists CMS in monitoring plan performance; and
3. Sets minimum requirements for Medicare-Medicaid plans (MMP) to assess their own performance through a robust internal performance improvement program.

Population Health Management Program (PHMP)
The Population Health Management Program (PHMP) strategy is documented in one central PHM program description that is reviewed and updated annually to meet regulatory requirements for NCQA and DHCS. Membership demographics are assessed and segmented through the annual Population Assessment and the programs are evaluated annually through a PHM Impact Evaluation using an annually updated Population Health Management Index of goals. Coordinating services through a PHMP helps meet the goals outlined by the Quadruple Aim healthcare model including improving patient and provider experience using evidence based quality care, improving the health of member populations, and providing cost effective member care.

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

L.A. Care's population health management services are provided by a team including: Health Education (HE) Program, Care Management including Complex Case Management (CCM) Program, Behavioral Health and Social Work, Utilization Management (UM), the Quality Improvement (QI) Program and other internal and external programs. PHMP's goal is to coordinate and ensure the right service at the right level. Rather than providing specific service categories into which individuals must fit, L.A. Care's population health management revolves around the individual's needs and adapts to his/her health status—providing support, access and education all along the continuum. Through a high tech, high touch, highly efficient workflow we can use the widest breadth of data sources with optimal process flow to achieve a holistic view of members and providers for ideal customer relationship management.

The major components of the PHMP are: (1) population identification; (2) stratifying and risk-based segmentation; (3) member enrollment health appraisal and engagement (4) intervening through monitoring; (5) evaluating program outcomes. The PHMP addresses the following areas along the continuum of care with interactive interventions:
- Keeping Members Healthy
- Early Detection/Emerging Risk
- Chronic Condition Management

- Complex Case Management
- Care Transitions
- Patient Safety

Risk Stratification and Segmentation and Tiering

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

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

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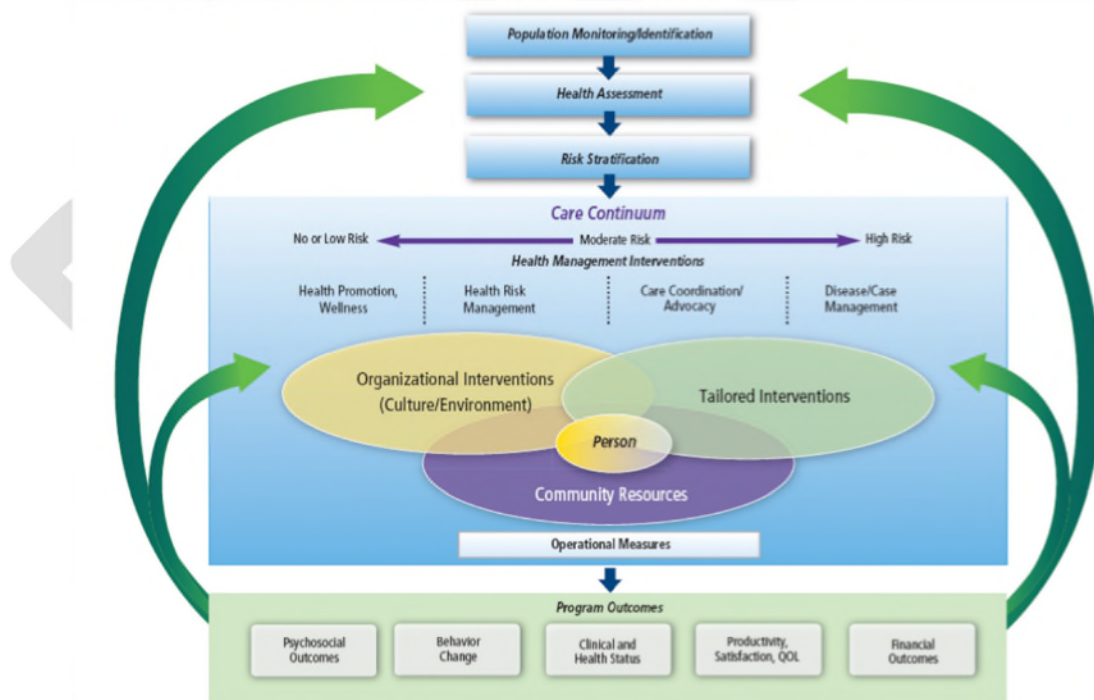
Source: Care Continuum Alliance, *Outcomes Guidelines Report*, Vol. 5, 2010.

QI Health Equity Program

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

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

The mission of L.A. Care Health Plan's Health Equity Unit is to, promote health equity by reducing or eliminating barriers that hinder opportunities for individuals and communities to attain the highest level of health. The overall goals of the Health Equity Unit are to:
1. Increase the awareness of health equity and implement strengthened, expanded and/or new health equity activities to support providers, staff and members ultimately reducing health inequities within L.A. Care's membership
2. Ensure that the services we provide to members promote equity and are free of implicit racism.
3. Implement programs that address the causes of inequity that our members and their communities experience, including racism and poverty.
4. Reduce health disparities among our members by implementing targeted quality improvement programs.

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

Quality of Equitable Care

HEDIS

L.A. Care measures clinical performance related to the Healthcare Effectiveness Data and Information Set (HEDIS), California Department of Health Care Services (DHCS) Managed Care Accountability Set (MCAS), the Integrated Healthcare Association (IHA), and Align Measure Perform (AMP) indicators. HEDIS results are annually audited by a National Committee for Quality Assurance (NCQA) and DHCS approved external auditors.

L.A. Care completes an on-site or remote HEDIS Audit to assess information and reporting systems, as well as methodologies for calculating performance measure rates with the following:

- Health Services Advisory Group (HSAG) the DHCS selected HEDIS Auditor and External Quality Review Organization (EQRO)
- Advent Advisory Group the NCQA Certified HEDIS Auditor

L.A. Care uses HSAG to audit MCAS performance measures, and Advent Advisory Group to audit HEDIS NCQA, Exchange, Medicare, MMP, and AMP performance measures. L.A. Care calculates and reports all NCQA, AMP, and DHCS MCAS reporting measure set and selected Use of Service performance measures using an NCQA HEDIS Certified Engine. L.A. Care reports audited results on the MCAS performance measures to DHCS and NCQA no later than June 15 of each year or such date as established by DHCS and NCQA. DHCS and HEDIS performance measures to NCQA will notify L.A. Care of the HEDIS measures selected for inclusion in the following years' utilization monitoring measure set.

DHCS Auto Assignment Percentage Allotment for 2023 (year 18):
- L.A. Care – 59.4%
- Health Net – 40.6%

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

Guidelines for Care – Clinical Practice and Preventive Health Guidelines

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

New and revised Clinical Practice and Preventive Health Guidelines are presented annually, and/or as necessary, to L.A. Care's Joint Performance Improvement Collaborative Committee and Physician Quality Committee for review and adoption. Adopted Clinical Practice and Preventive Health Guidelines are disseminated to new practitioners within the L.A. Care provider manual.

Existing practitioners shall be notified of newly adopted or updated guidelines via the provider newsletter, website, or targeted mailings. The provider newsletter advises providers to review the full list of adopted and updated guidelines made available on L.A. Care's provider website. L.A. Care's provider website is accessible to the public and can be viewed by network and out of network providers.

Clinical Practice and Preventive Health Guidelines may be monitored through Healthcare Effectiveness Data Information Set (HEDIS®) measures, medical record review process, or other measures as appropriate. Guidelines are also adopted that are salient to our membership and may be used for quality-of-care reviews, member and provider education, incentive programs, and to assure appropriate benefit coverage.

Preventive Health Guidelines

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

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

Behavioral Health Guidelines

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

Maternal Mental Health Program

Maternal mental health care is an established benefit for L.A. Care members designed to promote quality and cost effective outcomes while maintaining consistency with rigorous clinical principles and processes.

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

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

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

To supplement network and referral enhancements implemented by the Beacon Health Options, L.A. Care implements training and education programs focused on maternal mental health. To deliver and disseminate these trainings, L.A. Care will partner with community advocacy organizations, such as Maternal Mental Health Now; Diversity Uplifts and with subject matter experts such as reproductive psychiatrists in the provider network; and with existing perinatal health programs operated by the County Department of Public Health and Department of Health Services (Mama's Neighborhood). Guidelines and criteria shall be made available upon request to medical providers, including contracted obstetrics providers. L.A. Care will ensure compliance through oversight and monitoring through internal compliance programs and through provider network relations.

Health Assessments

For Medi-Cal members, the Initial Health Assessment (IHA) must be completed for newly enrolled members with their provider within 120 days of enrollment. The purpose of the IHA is to ensure the provision of complete history and physical examination and an Individualized Health Education Behavioral Assessment (IHEBA) either in person or virtually. PPGs/PCPs are responsible to cover and ensure the provision of an IHA. For new Plan members who choose their current PCP as their new plan PCP, an IHA still needs to be completed within 120 days of enrollment. Members are also encouraged to complete an IHA even if it has not been completed past the initial 120 calendar days of enrollment. The Staying Healthy Assessment covers the provision of the IHEBA for all existing members at their next non-acute care visit and that the IHEBA is reviewed at least annually by the Primary Care Provider (PCP) with the members who present for scheduled visits and is re-administered by the PCP at the appropriate age-intervals. Starting in January, 2023 DHCS will be removing the IHEBA requirement and the Initial Health Assessment name will be changed to the Initial Health Appointment. The 120-day timeframe will remain; however, a primary care visit within the timeframe can be used as a proxy for compliance with the new IHA requirements.

For Medicare members, there are two types of assessments the Health Risk Assessment (HRA) and the Annual Wellness Exam (AWE). The HRA is completed within 90 days of enrollment and at least annually thereafter. The purpose of the HRA is to directly assess the medical health, mental health, functional, cognitive, and psychosocial needs of Medicare members in order to develop an Individualized Care Plan (ICP) that effectively addresses each member's unique circumstances and preferences.

The purpose of the Annual Wellness Exam (AWE) is to obtain a comprehensive annual health assessment of the member to determine changes, if any, to member health status, both mental and physical, to ensure provision of timely and appropriate care according to member's identified

health conditions. Unlike the HRA which is usually a shorter telephonic assessment conducted by non-clinical staff, the AWE is an in-person examination conducted by the member's practitioner (MD, DO, NP, PA) to fulfill CMS requirements related to risk adjustment payment methodology AND to determine each member's health risk status to develop an appropriate care plan and promote member's involvement in their care. In addition, AWEs assure compliance with the CMS Model of Care and supports quality improvement efforts in diagnosing member health conditions for documentation of new conditions and substantiating existing conditions. L.A. Care is responsible for ensuring that participating providers properly document information in the patient's health record to support all diagnoses. The assessment is comprehensive and includes the completion of the Patient Health Questionnaire (PHQ-9) along with services related to preventive and chronic care management. Providers are awarded additional incentive dollars for satisfactorily completing the AWE. L.A. Care also offers an in-home assessment option by licensed practitioners for members and providers as needed.

Health Education and Cultural and Linguistic Services

Health Education

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

The Health Education Unit's goals are to provide and coordinate educational interventions that assist members to:
- Effectively use primary and preventive health care services, including health education services.
- Modify personal health behaviors, achieve and maintain healthier lifestyles, and promote positive health outcomes.
- Learn and follow self-care regimens and treatment therapies for existing medical conditions, chronic diseases, or other health conditions.
- Navigate the health system to ensure access to preventive health services.

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

Cultural and Linguistic Services

L.A. Care Health Plan is committed to serving a culturally and linguistically diverse population in Los Angeles County. The mission of L.A. Care Health Plan's Cultural and Linguistic Services

(C&L) unit is to ensure access to culturally and linguistically appropriate resources to promote health equity for all members.

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

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

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

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

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

Care Management/Disease Management Programs

The Care Management (CM) and Disease Management (DM) Programs are components of L.A. Care's Population Health Management Program (PHMP). The shared objective of the program is to improve both the health and functioning of eligible members with chronic medical conditions that may also be exacerbated by significant psychosocial needs. The programs achieve this

objective by supporting members and their caregivers through education, advocacy, and coordination of services. Members participating in the programs are equipped with the skills to effectively self-manage their health conditions and access the healthcare services they need. The programs are developed from evidenced-based clinical practice guidelines and support the growth of the care manager-member relationship, progression of individualized care plans, and member empowerment.

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

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

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

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

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

The CCIP addresses the following components:
- Multiple data sources are used to identify members eligible for the CCIP. Members meeting criteria for participation in the program are identified on a monthly basis and invited to enroll in the program.

- Member participation rates in the program are measured annually.
- Primary program interventions focus on home blood pressure monitoring, education on lifestyle modifications to reduce cardiovascular risk, medication access and adherence, and connection to services, supports, and resources.
- Condition monitoring, member adherence to care plans, consideration of other health conditions, and lifestyle barriers are accounted for in work with participating members, as indicated by clinical practice guidelines.
- Use of nationally recognized clinical guidelines that are reviewed at a minimum of every two years unless the guidelines change sooner.
- Member interventions are based on individualized member needs and clinical guideposts.
- Systematic program monitoring is integrated into the program, Program progress is reviewed at least annually and opportunities for improvement are addressed.

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

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

L.A. Care's Utilization Management activities are outlined in the Utilization Management Program Description, which includes persons with complex health conditions with CM as a separate program. The UM Program Description defines how UM decisions are made in a fair and consistent manner. The UM Program Description is approved by the UMC. For additional information, refer to the UM Program Description.

Transitional Care Program (TCP)

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

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

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

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

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

Managed Long Term Services and Supports (MLTSS)

L.A. Care has a Managed Long Term Services and Support Program Descriptions that includes CBAS, MSSP, IHSS and LTC. These programs address serving members with complex health needs, such as, seniors and people with physical or developmental disabilities and/or multiple chronic conditions.

L.A. Care's Managed Long Term Services and Supports (MLTSS) Department provides services that help individuals remain living independently in the community and also oversees extended long-term care provided in a skilled nursing facility. MLTSS serves L.A. Care's members enrolled in Medi-Cal and Medicare Plus (Dual-Special Needs Plans D-SNP). In 2014, the California Department of Health Care Services (DHCS) began the transition of the MLTSS benefit to L.A. Care. MLTSS oversees four programs: Long Term Care (LTC) Community Based Adult Services (CBAS); In-Home Supportive Services (IHSS); and Multipurpose Senior Services Program (MSSP). In addition, the MLTSS department oversees L.A. Care's Palliative Care benefit for Medi-Cal (MCLA only) members, as well as Skilled level of care benefits for members.

MLTSS also supports member, provider and staff inquiries and makes referrals to other L.A. Care programs and community resources. The MLTSS clinical teams (LTC and CBAS) are part of Case Management's interdisciplinary care team (ICT) and engage with providers and members during routine facility visits and telephonic outreach.

Through CalAIM's Community Supports program, MLTSS also manages Personal Care and Homemaker Services (PCHS), Respite for caregivers and Environmental Accessibility Adaptations (EAA, also known as Home Modifications). These supplemental services address social determinants of health, providing cost effective alternatives to support members at home.

Pharmacy Management

Pharmacy and formulary utilization is monitored regularly and updates are made to the formulary, utilization edits, guidelines, and policies and procedures based on clinical evidence available at the time of consideration. Since the management of the Medicare Part D Formulary is delegated to a contracted Pharmacy Benefit Manager (PBM), Navitus, the Pharmacy staff performs oversight to ensure compliance with CMS requirements. With the PBM, L.A. Care collects prescription drug quality measures, consistent with Medicare Part D requirements and has established quality

assurance measures and systems to reduce medication errors, adverse drug interactions and improve medication use. (See also Patient Safety section of this program).

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

Starting January 2022, L.A. Care's MTM program is contracted out to Navitus Clinical Engagement Center (CEC) to perform medication reviews for our Cal MediConnect members, including Comprehensive Medication Reviews (CMR) and Targeted Medication Reviews (TMR). CMRs occur at least annually to identify any potential medication duplications or conflicts, prescriber or over-the-counter consult opportunities, and decisive clinical information. Following the CMR, members are provided with a Medication Action Plan (MAP) and a Personal Medication List (PML). TMRs occur at least quarterly to review the members' prescriptions and make contact to members' and/or prescribers for any identified potential pharmacotherapy concerns. Data from Navitus' CEC is analyzed and reported to CMS. In addition, L.A. Care reviews for quality assurance of Navitus' CEC, to ensure our vendor is up to the standard according to CMS guidance.

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

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

Safety Net Programs and Partnerships

Health Homes: The Health Homes Program (HHP) is a high-touch care management and wraparound services program, authorized by the Department of Health Care Services (DHCS), for Medi-Cal members that launched in July 2019. Medi-Cal members with multiple chronic physical health and/or behavioral health conditions and high acuity (such as recent Inpatient (IP) &/or Emergency Room (ER) history) are eligible for the program. Members who opt-in to the program receive varied services, including comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual & family support services, and referral to community & social supports (which includes individual housing transition & tenancy support services). L.A. Care delivers the program through a network of 34 contracted high volume providers, and has enrolled more than 18,000 MCLA members since the program launched in July 2019.

HHP will sunset at the end of 2021, with enrolled members grandfathering into a new Medi-Cal benefit, Enhanced Care Management (ECM), effective January 1, 2022. ECM builds off the

successes of HHP, using a similar community-based provider model to provide eligible members with high-touch care management and care coordination services.

Whole Person Care: L.A. County's Whole Person Care Program (WPC) ended on 12/31/2021 and all eligible members transitioned to L.A. Care's new Enhanced Care Management and Community Supports programs. There were over 8,200 members who transitioned to Enhanced Care Management and 7,400 members who transitioned to Community Supports programs.

Homeless Programs: L.A. Care has various programs to address the health and social needs of homeless members. In 2016, L.A. Care made a $20M, 5-year grant commitment to the Housing for Health Program (HFH) via fiscal intermediary Brilliant Corners. Under the grant, L.A. Care funded rental subsidies for 300 new homeless individuals/families to move into permanent supportive housing, with supportive services provided in-kind by L.A. County as part of the Whole Person Care program; 331 households have been housed to date. L.A. Care and HFH were also awarded nearly $20 million in additional funds from the state to launch Housing for Healthy CA to house 250 new homeless members starting in 2021, 88 households have been housed to date. In addition, L.A. Care refers members to the local Coordinated Entry System (CES) and county recuperative care/interim housing process through the Los Angeles Homeless Services Authority (LAHSA) and collaborates closely with health plan and county partners through various forums and roundtables.

L.A. Care launched expanded programs for members experiencing homelessness through the CalAIM Community Supports initiative in 2022. On January 1, 2022, L.A. Care launched Homeless and Housing Support Services (HHSS, a combined program offering both Housing Navigation and Tenancy Services) and Recuperative Care, and added Housing Deposits on July 1, 2022. Collectively Housing Navigation, Housing Deposits, and Tenancy Services form a continuum that spans the search for housing, the resource support necessary to move into housing, and support to sustain successful long-term residency. Recuperative Care is short-term residential care for medically vulnerable individuals who no longer require hospitalization, but still need to heal from an injury or illness and whose condition would be exacerbated by an unstable living environment.

L.A. Care is also participating actively in the Housing and Homelessness Incentive Program (HHIP), a voluntary DHCS program where Medi-Cal Managed Care Plans can earn funds by completing various metrics related to improving care, infrastructure, and outcomes for members experiencing homelessness. The HHIP program's goals are (1) to help MCPs develop the capacity and partnerships to connect members to needed housing services, and (2) to reduce and prevent homelessness. L.A. Care is eligible to earn up to $290M in one-time funds via HHIP over 2022 and 2023. Early program achievements include creating a data matching process with the local Continuums of Care for their Homeless Management Information Systems (HMIS), investing in countywide infrastructure to improve unit acquisition as well as adding and expanding services for people experiencing homelessness who need assistance with their activities of daily living.

Postpartum Care Extension Program

The Postpartum Care Extension Program provides extended coverage for Medi-Cal members during both the pregnancy and after pregnancy. The 12-month postpartum coverage period for

Medi-Cal eligible pregnant individuals will begin on the last day of the pregnancy and will end on the last day of the month in which the 365th day occurs.

The Postpartum Care Extension Program extends coverage by L.A. Care for up to 12 months after the end of the pregnancy regardless of income, citizenship, or immigration status and no additional action is needed.

Elevating the Safety Net initiative

In 2018, L.A. Care launched the Elevating the Safety Net (ESN) initiative with an approved five-year investment of up to $155 million to address the physician shortage looming in Los Angeles County. L.A. Care's ESN initiative prioritizes investments that enable community-based organizations, teaching institutions, and safety net employers to recruit, train, and deploy a new wave of health care professionals — especially those coming from and committed to working in underserved communities. L.A. Care's ESN initiative goals include increasing the number of primary care physicians (PCPs), including psychiatrists; supporting students by cultivating their pursuit of careers in the health professions; improving diversity in the workforce by increasing the supply of health professionals who come from underserved communities; and expanding the health outreach and prevention roles of community health workers and home health workers who have some of the most trusted relationships in our communities.

To date, L.A. Care's ESN initiative has invested nearly $93.6 million, of the approved $155 million, to support ten diverse programs by offering full medical school scholarships for low-income, first generation, and underrepresented students; offering loan repayment awards for PCPs committed to practicing in safety-net settings and underserved communities; offering salary subsidy grants for safety net employers who hire PCPs; expanding primary care residency slots across sponsoring institutions, including universities, hospitals, and clinics; offering grants to teaching institutions to establish new medical education programs with a community focus; offering internships for college students and recent graduates from underrepresented communities who are interested in pursuing careers in Los Angeles County's safety net; and expanding training opportunities for community health workers and home health workers who can serve our most vulnerable member populations.

In 2022, L.A. Care Board of Governors approved continued investments for an additional five years, through 2027, in four of the ten programs under the ESN initiative – Medical School Scholarship Program, Provider Loan Repayment Program, Provider Recruitment Program and In-Home Support Services Training Program.

CalAIM Incentive Payment Program

In 2022, the Department of Health Care Services (DHCS) made CalAIM Incentive Payment Program (IPP) funding available to implement and expand Enhanced Care Management (ECM) and Community Supports (CS) by incentivizing managed care plans (MCPs), including L.A. Care, to drive MCP delivery system investments in provider capacity and delivery system infrastructure; bridge current silos across physical and behavioral health care service delivery; reduce health disparities and promote health equity; achieve improvements in quality performance; and encourage take-up of CS.

Over the next few years, as DHCS makes IPP funding available to MCPs, L.A. Care will continue collaborating with Los Angeles County MCPs to invest in local ECM and CS infrastructure and capacity building.

Quality Improvement Projects (QIPs)

L.A. Care conducts Quality Improvement Projects (QIPs) in compliance with the Department of Health Care Services' (DHCS), Covered California's, and the Centers for Medicare and Medicaid Services' (CMS) requirements. DHCS requires that Medi-Cal plans have two long-term quality improvement projects known as Performance Improvement Projects (PIPs) and assigns rapid cycle quality improvement projects know as Plan Do Study Act cycles (PDSAs) and/or Strengths Weaknesses Opportunities and Threats (SWOT) worksheets for low performing measures. CMS requires dual plans to participate in one QIP that is a DHCS-facilitated statewide collaborative during the course of Cal MediConnect (CMC). The Quality Improvement (QI) program includes the Chronic Care Improvement Program (CCIP) that meets the requirement of 42 CFR §422.152 for each contract. CMS may require PDSAs at their discretion. Per guidance of these entities, both Medi-Cal and Medicare PIPs and QIPs are overseen by DHCS. Covered California requires a multi-year QIP that addresses disparities in care for chronic conditions by racial and ethnic identity.

Performance Improvement Project (PIPs)

L.A. Care conducts quality and performance improvement projects with the aim of achieving meaningful and sustainable improvements, which are statistically significant, in aspects of clinical and non-clinical care. L.A. Care conducts at least four state-mandated rapid-cycle PIPs/QIPs; two PIPs for Medi-Cal, one QIP for Covered California, and one QIP for Medicare Plus (Dual-Special Needs Plan [D-SNP]). PIPs/QIPs are initiatives focused on one or more clinical and/or non-clinical areas with the aim of improving health outcomes and beneficiary satisfaction. Additional ad hoc PIPs can be required based on priorities identified by DHCS. L.A. Care is responsible for ensuring delegates comply with all applicable state and federal laws and regulations and other contract requirements as well as DHCS' guidance, including All Plan Letters for quality and performance improvement requirements.

For Medi-Cal, L.A. Care chooses the first PIP topic from state-selected topics related to the Medi-Cal Managed Care Program Quality Strategy priority areas. The second Medi-Cal PIP topic is selected from a specific area in need of improvement and requires DHCS approval. PIPs are conducted over a 12 to 18-month period and require the submission of four modules to DHCS' External Quality Review Organization (EQRO) L.A. Care participates in quarterly collaborative meetings to learn of evidence-based strategies and quality improvement science and to collaborate on improvement strategies.

For Medicare Plus (Dual-Special Needs Plan [D-SNP])**,** the PIP is an assigned statewide collaborative PIP. The PIP must utilize the outcome-focused improvement strategies and must be documented and submitted on forms supplied by the EQRO, which differ from the Medi-Cal forms. CCIPs promote effective management of chronic disease, improve care and health outcomes for enrollees with chronic conditions, and be conducted over a three-year period. L.A. Care's CCIP improves care coordination, processed, and health outcomes, utilize outcome-focused improvement strategies, address one or more CMS Quality Strategy Goals. L.A. Care conducts

activities as described in the Plan Sections and Annual Update sections but there is no requirement to submit them to CMS; however, L.A. Care must make the information on the status and results available upon CMS request.

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

Plan-Do-Study-Act (PDSA) and Strengths Weaknesses Opportunities and Threats (SWOT)

In addition to the PIPs, improvement projects are undertaken with Managed Care Accountability Set (MCAS) measures below the Minimum Performance Level (MPL) in any given reporting year; these are referred to as PDSA cycles and/or SWOTs that are evaluated quarterly and documented and submitted on PDSA cycle and SWOT worksheets. For Medi-Cal, L.A. Care identifies HEDIS indicators with rates below the MPL using the final audited HEDIS measurement year rates submitted to DHCS that are part of the MCAS. L.A. Care completes and submits a PDSA cycle and/or SWOT worksheet for each measure with a rate below the MPL and conducts quarterly evaluations of the ongoing rapid-cycle quality improvement interventions. PDSAs are used by L.A. Care to perform small tests of change in real work settings to determine if the change is an improvement. PDSAs have the flexibility of being able to make adjustments throughout the improvement process with real-time tracking and evaluation of the interventions. L.A. Care develops PDSA cycles using Specific, Measurable, Achievable, Relevant, and Time-Bound (SMART) objectives with interventions selected and tested. The progress of a PDSA is monitored by DHCS and interventions are either adopted, modified or abandoned by L.A. Care based on the change experienced. SWOTs can replace the PDSA should there be multiple measures within a single domain that fall below the MPL. SWOTs allow a more broad approach to improving HEDIS measures and allow L.A. Care to focus on multiple areas to improve overall performance.

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

Patient Safety

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

L.A. Care collects and tracks critical incidents (CI) for L.A. Care Medicare Plus (Dual-Special Needs Plan D-SNP) enrollee and ensures referrals to appropriate agencies are made for follow up. As noted in policy and procedure (P&P) QI-027 Critical Incident Reporting and Tracking, a "critical incident" is an incident in which the enrollee is exposed to abuse, neglect or exploitation, a serious, life threatening, medical event for the enrollee that requires immediate emergency evaluation by medical professional(s), the disappearance of the enrollee, a suicide attempt by the enrollee, unexpected death of the enrollee, and restraint or seclusion of the enrollee. An annual Getting to Know Critical Incident training is mandatory to member-facing staff to ensure both new and seasoned staff understand the Critical Incident criteria and how to submit a CI.

L.A. Care follows state laws to report and monitor referrals to local Adult Protective Services (APS) agencies or, when appropriate, law enforcement, and tracks the number of cases referred for enrollees, including those receiving Managed Long-Term Services and Supports (MLTSS). As deemed necessary, critical incidents maybe investigated further through potential quality of care review process.

Potential Quality of Care Issue (PQI) Reviews

The Potential Quality of Care Issue (PQI) review activity, set forth in Policy & Procedure (P&P) QI-001 PQI, is an established process for thorough, appropriate, and timely resolution of potential quality of care issues related to potential quality of care or potential quality of service issues that may affect the patient's health outcome and safety. PQI cases are referred to the Quality Improvement (QI) Department Provider Quality Review (PQR) team. The QI PQR team maintain and enforce the policy working with physicians through peer review processes. The PQI referral criteria are developed specifically for each of the care delivery support teams (i.e. Customer Solution Center (CSC) Team, Appeals and Grievance (A&G) Team, Case Management Team, Utilization Management, and Behavior Health Team) to appropriately identify the potential care concern. An annual Getting to Know Potential Quality of Care Issues training is mandatory to member-facing and provider-facing to ensure both new and seasoned staff understand the PQI referral criteria and how to submit a PQI. The PQR team meets with CSC, A&G and other areas as needed to discuss sample cases, staff education and process improvement.

Another assessment of Patient Safety is done through a stringent proactive review of quarterly encounter data from deceased members to proactively assess pattern of encounters and identify potential unexpected deaths, as well as oversight review of CSC and A&G cases to identify any missed opportunity to refer a PQI and to remediate gaps knowledge or process with CSC and A&G.

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

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

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

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

FSRs are conducted to ensure that all contracted PCP sites have sufficient capacity to provide appropriate primary health care services and can maintain patient safety standards and practices. The FSR confirms the PCP site operates in compliance with all applicable local, state, and federal laws and regulations.

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

Hospital Quality and Safety

To continually improve patient safety and healthcare outcomes in an inpatient setting, L.A. Care tracks and trends hospital performance to reduce variation and assure consistent and standardized metrics across all contracted hospitals and for all lines of business. To that end, L.A. Care subscribes to annual reports with a number of hospital patient safety and quality indicators from Cal Hospital Compare (CHC) supplemented with data and reports from Centers for Medicare and Medicaid Services (CMS), California Department of Public Health (CDPH), and the California Maternity Quality Care Collaborative (CMQCC). Each of these entities provides performance comparisons across hospitals along with regional and national benchmarks of quality and safety. Some examples of hospital quality and safety metrics monitored are hospital acquired infections such as Methicillin-resistant staphylococcus aureus (MRSA), Catheter-associated Urinary Tract Infection (CAUTI), Central Line-associated Blood Stream Infection (CLABSI), Clostridium difficile (C.Diff), and Surgical Site Infection – Colorectal Surgery (SSI-Colon), along with Hospital Safety Grade (from the Leapfrog Group), overall patient experience scores from Hospital-CAHPS, Nulliparous, Term, Singleton, Vertex (NTSV) C-Section Rate to minimize medically unnecessary c-section deliveries when vaginal deliveries are indicated. During 2022, L.A. Care re-assessed the report subscription tier for CHC and moved in subscribing to a more

comprehensive option—from Tier 4 to Tier 3. This change in tier provided L.A. Care access to data for a wider range of hospitals and measures. Tier 4, the prior subscription, limited the dataset to a select number of hospitals. By moving to Tier 3, L.A. Care now has access to data for all hospitals available to CHC. Additionally, the upgrade further expanded the measure set included in CHC's reports. The new measures include data on Vaginal Births After Cesarean Deliveries (VBAC), breastfeeding, and episiotomy rates and deliveries by certified nurse midwives.

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

Pharmacy

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

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

Quality of Equitable Services

Member Experience

L.A. Care monitors member satisfaction with care and service to identify potential areas for improvement. To assess member satisfaction, L.A. Care reviews multiple sources of data. These include, but are not limited to, evaluation of member grievances/appeals, data collected from the annual Health Plan and Clinician and Group Consumer Assessment of Healthcare Providers and Systems (HP- and CG-CAHPS) surveys, the Qualified Health Plan (QHP) Enrollee Survey, the Medicare Advantage and Prescription Drug Plan (MAPD) CAHPS, and any other ad-hoc member surveys. QI identifies opportunities for improvement, sets priorities, and selects/implements/monitors/evaluates interventions through various internal committees. Results are presented to the Member Quality Service Committee (MQSC), the Joint Performance

Improvement Collaborative Committee (PICC) & Physician Quality Committee (PQC), the Quality Oversight Committee (QOC), and Compliance and Quality Committee (C&Q).

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

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

Appeals and Grievances

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

Availability of Practitioners

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

To continuously review, evaluate, and improve access and to ensure Members are able to obtain appointments within established standards for time and distance. L.A. Care creates and develops

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

- Ensuring that standards are in-place to define practitioners who serve as Primary Care Practitioners (Pediatrics, Family Practice, General Practice, Internal Medicine, etc.).
- Assigning members to a Primary Care Physician within ten miles of their home unless otherwise requested by the member or family. In locations where there is a dearth of primary care physicians and none are available within the 10-mile standard, L.A. Care uses Alternative Access Standards as approved by regulatory bodies to determine availability.
- Referring each member to a specialist within travel distance requirements applicable to the member's affiliated line of business. Where these standards cannot be met due to a scarcity of physicians within the member's geographic location, L.A. Care measures availability against Alternative Access Standards as approved by the appropriate regulatory body.
- Ensuring a database is in-place which analyzes practitioner availability and network ability to meet the special cultural need of our members.
- Ensuring members are within (15) fifteen miles or (30) thirty minutes from a contracted hospital and ancillary service. Where hospital travel distance standards cannot be met because of a member's geographical location, L.A. Care will adhere to Alternative Access Standards as approved by the appropriate regulatory body.
- Providing members with covered transportation services as needed.
- Reassessing the appropriateness of existing standards as required as well as annually evaluating providers' compliance with existing standards.
- Annually reviewing and measuring the effectiveness of these standards through network adequacy assessment results, network surveys, and analyses of network access and availability.

Accessibility of Services

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

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

- Inclusion of member complaint data.

Effective 07/01/2022, non-urgent follow-up appointments with a non-physician mental health care (NPMH) or substance use disorder provider must be offered within 10 business days of the prior appointment for those undergoing a course of treatment for an ongoing mental health or substance use disorder condition, except as provided in Section 1367.03(a)(5)(H).

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

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

Customer Solutions Center L.A. Care has established standards for access to customer solutions center by telephone. These standards include call abandonment rate, wait time, and service level.

Teladoc Health, Inc. Services

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

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

MinuteClinic

L.A. Care offers our direct line of business members: Medi-Cal (MCLA), L.A. Care Covered (LACC), L.A. Care Covered Direct (LACCD) and PASC-SEIU Members have additional access to care at all 17 MinuteClinic locations in L.A. County when members cannot reach their PCP or need afterhours care. MinuteClinic is a walk-in health care retail clinic, located in select CVS Pharmacy stores and are open 7 days a week, but the hours vary by location and during seasons of higher demand. Members can view wait times on the MinuteClinic website prior to visiting and hold a place in line up to 3 days in advance, they can also walk-in without an appointment. Members can receive timely care without an authorization.

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

Nurse Advice Line

L.A. Care provides direct line of business members (MCLA, D-SNP, LACC, LACCD, and PASC) 24-hours per day, 7 days per week (24/7) as required by Department of Managed Health Care. Members can access a live Registered Nurse Health Coaches for symptom and condition management support, general health information, resource navigation guidance and more. The NAL Registered Nurse Health Coaches assess the members' situation and direct them to the appropriate level of care. The Registered Nurse Health Coaches strive to maintain a consistent, evidence-based approach when supporting members through the continuum of health and healthcare. They can also guide members to resources like telehealth and/or refer them to internal departments such as Care Management, Behavioral Health, and Social Services. The NAL provides assessment, evaluation, and/or advice to members and serves as L.A. Care's mechanism for the provision of triage and screening services.

Contracting

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

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

Provider Satisfaction Survey

L.A. Care monitors provider satisfaction with L.A. Care on relevant health programs, services, and processes. In order to obtain more actionable feedback, the annual provider satisfaction survey also includes open-ended questions that allow providers to give feedback on service quality issues otherwise not captured on the survey. The survey questions focus on L.A. Care's practitioner service areas: information exchange between providers, utilization management, member/provider solutions support, quality improvement, care management, behavioral health, the Direct Network, pharmacy services, and overall satisfaction. The survey is fielded annually for all lines of business and samples primary care physicians, specialty care physicians, and the Direct Provider Network. Results will be rolled up into any affiliations stated with community clinics, and provider groups. Results are presented to the Joint Performance Improvement Collaborative Committee (PICC) & Physician Quality Committee (PQC).

Transform L.A.

Transform L.A. is a practice-level technical assistance program delivered through tailored practice coaching. Engaging with a practice coach is on opt-in amenity for L.A. Care Direct Network

primary care providers who use an electronic health record (EHR). The program supports practices in building quality improvement capacity and delivering high quality, evidence-based care that will provide measurable value to the practice and their patients.

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

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

The Integrated In-Person and Virtual Specialty Care Program is a pilot program that incorporates use of eConsults between PCPs and SCPs to address non-urgent questions where a primary care provider may need assistance on. If patients need additional follow-up, there is support with scheduling for the patient via telehealth or in-person visit if needed. This pilot program is an opt-in alternative specialty care access pathway for L.A. Care Direct Network (DN) PCPs and members only.
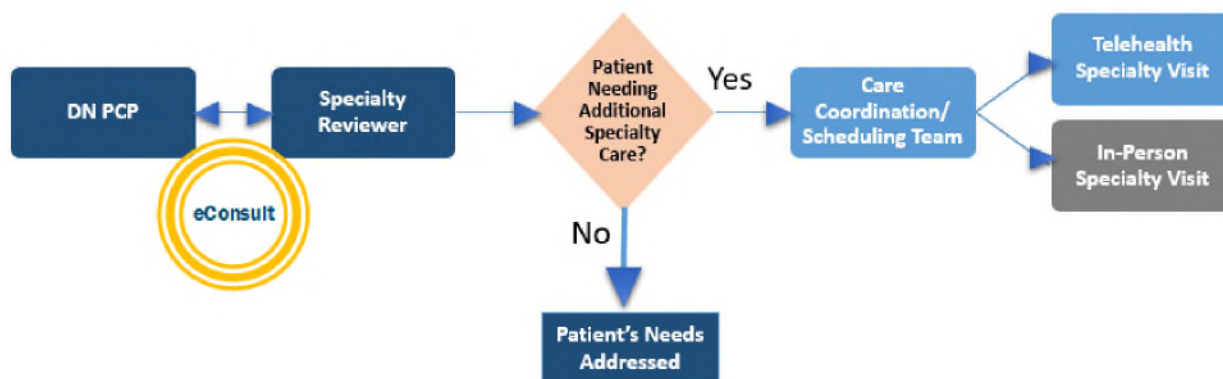
This pilot program was set to launch Winter 2021/22 with a subset of targeted DN Primary Care Practices and key specialty care partners, including Children's Hospital L.A. (pediatric specialists), HubMD (adult telehealth specialists), and Beacon (behavioral health specialists). However, due to the pandemic, we delayed the launch of this pilot to April of 2022.

First 5 LA/Help Me Grow LA

L.A. Care received a grant agreement from First 5 LA to provide a 3-year program/pilot to improve awareness of and increase developmental milestone screenings for children ages 0-5 years. This program is part of the Help Me Grow LA system to provide early identification and interventions

for children who may not be on track with developmental milestones. The program will follow the recommendations of the American Academy of Pediatrics (AAP) for infants and toddlers for screenings to be conducted at ages: 9 months, 18 months, and 24-30 months to identify any possible delays that children may be experiencing. Approximately 15% of children are estimated to have a development delay, and by conducting screenings at these ages, early identification of the delay can be treated with interventions that will help the child progress to be ready for kindergarten and onward in school.

The program consists of two parts: (1) community and provider education and (2) a 10-practice pilot. The goal for the education campaign is to increase awareness of the importance of developmental milestones and early interventions, as well as availability of local resources to provide assistance. The education campaign includes print, social media and information/links on L.A. Care's website for the member and provider portals. Community education materials are available in eight languages at the L.A. Care/Blue Shield Promise Community Resource Centers. Early childhood development classes are also available for the community and members and 3 CME events (1 completed, 2 remaining) on childhood development topics are offered for providers and care teams.

The clinical pilot provides an on-site practice coach, best practices education for providers and care teams for conducting screenings as well as providing referrals. The coaches help the practices to optimize workflows to achieve the program goals of 15% improvement in number of screenings and referrals. The coaches collect the program progress data, which is reported to First 5 LA to evaluate and share learnings with the health care community in LA County.

Credentialing/Recredentialing

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

Member, Provider, and Practitioner Communication

Member Communication

Member communication occurs through many channels. The member evidence of coverage booklet provides members with a written description of health plan benefits and other subscriber issues. Member newsletters disseminate information regarding changes to benefit coverage and services, preventive healthcare guidelines, special events and services, legislative changes, health management programs, enrollment information, health education, access to interpreter services, and issues related to patient safety. Targeted mailings are used to promote L.A. Care's care

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

L.A. Care offers the availability of telephonic and/or digital access to the following services for all product lines.
- Electronic Health Appraisal
- Self-Management Tools
- Functionality of Claims Processing
- Pharmacy Benefit Information
- Personalized Information on Health Plan Services
- Member Support through Innovative Technologies (prescribing, scheduling, etc.)
- 24 Hour Health Information Line including Interpreter Services
- Encouraging Wellness and Prevention

Provider and Practitioner Communication

The L.A. Care Health Plan provider/practitioner e-newsletter, *thePULSE*, and *Progress Notes* communicates updates on all aspects of the health plan including pharmacy procedures, health management programs, provider and patient education opportunities, cultural and linguistic training opportunities, Language Assistance Program services, Utilization Management program changes, and patient safety issues. Progress Notes is published quarterly, four times a year. L.A. Care also publishes a provider e-newsletter thePULSE, six times a year. Additionally, providers are emailed and faxed about the aforementioned topics along with other regulatory requirements. Providers are regularly kept abreast of health plan initiatives and updates via the L.A. Care website and on the provider portal. They may use these resources to stay informed and/or call to request paper copies.

Member Incentive Programs

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

Provider Incentive Programs

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

2023 marks the thirteenth year of L.A. Care's Physician P4P Program, which targets high-volume solo and small group physicians and community clinics. The Physician P4P Program provides performance reporting, and financial rewards for practices serving Medi-Cal members, and represents an opportunity to receive significant revenue above capitation. Eligible physicians and clinics receive annual incentive payments for outstanding performance and improvement on multiple HEDIS measures. L.A. Care is exploring adding new domains and measures related to Utilization Management and Member Experience for future Physician P4P program years, which are currently being tested for program fit.

The Value Initiative for IPA Performance (VIIP) aims to improve the quality of care for L.A. Care members by supporting the development of a robust network of high performing PPGs. VIIP continues in 2023 and measures, reports, and provides financial rewards for provider group performance across multiple domains, including HEDIS Clinical Quality, Utilization, Encounters and Member Experience. The VIIP program also actively engages with PPGs to develop 'Action Plans' focused on setting SMART Goals and improving in lower performing areas, which has shown to improve PPG performance year-over-year. With its success in Medi-Cal, the VIIP program expanded to the Cal MediConnect (CMC) and L.A. Care Covered (LACC) lines of business (LOBs) in 2018, with a set of domains and measures relevant to providers and members for those LOBs and offers additional opportunities to earn value-based revenue. Starting in 2023, L.A. Care will launch a L.A. Care Medicare Plus (Dual-Special Needs Plan [D-SNP]) VIIP Program for its Medicare providers and members. While the Medi-Cal and Medicare programs are fully run in-house, the LACC VIIP program is unique as L.A. Care collaborates with the Integrated Health Care Association (IHA) on their Align, Measure, Perform (AMP) Program, sharing data, performance targets and program design with IHA for LACC groups.

L.A. Care's Plan Partner Incentive Program aligns the efforts of L.A. Care with those of its strategic partners as a critical point for improving the outcomes and satisfaction of members. This program closely mirrors the VIIP program, to create a stronger platform for shared quality improvement strategies between plans and provider groups. The program measures and rewards plan partners for performance on a broad set of metrics, including HEDIS Clinical Quality, Utilization, Encounters and Member Experience. A proportion of Plan Partner incentive payments are tied to the performance of its contracted PPGs, with the aim to promote collaboration between plans and their PPGs on quality improvement efforts. The program will continue to utilize these metrics in 2023 with targeted areas of modification.

SALES, MARKETING AND COMMUNITY OUTREACH

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

Marketing staff are aligned by product lines, health plan initiatives and the Community Resource Centers. Marketing staff participate in workgroups to collaborate and develop collateral materials in various formats, languages and reading levels to support member and consumer understanding of the benefits, programs and services, which L.A. Care offers. Community and member awareness messaging and campaigns are developed and implemented throughout L.A. County. This is accomplished through marketing outreach at educational events, and advertising in communities where access to quality health care is limited.

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

The Health Plan Field Representatives and Contracted Agents conduct product presentations at educational and marketing events. This provides an opportunity for consumers and members to learn more about Medi-Cal, Medicare Plus (Dual-Special Needs Plan [D-SNP]), the Covered California Marketplace and PASC-SEIU. Community-based events, health fairs, and open houses are posted on L.A. Care's website and promoted through social media. This provides members and non-members with information on conveniently located events held throughout L.A. County. Enrollment Entities and their down-line Certified Insurance Agents (CIAs) and Certified Enrollment Counselors (CECs) receive additional outreach. They are educated and updated on the programs that L.A. Care members have access to, as well as potential eligibility for L.A. Care's Medi-Cal, Medicare Plus (Dual-Special Needs Plan [D-SNP]), and L.A. Care Covered product lines.

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

tasks such as changing a doctor, reprinting ID cards, paying a premium or checking a claim through L.A. Care Connect, our secure online member portal.

L.A. Care is in frequent communication with its provider network via email and fax. L.A. Care continually seeks opportunities to improve provider awareness and secure their commitment to L.A. Care. This is accomplished through provider participation in joint operational meetings, PPG Summits, 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.

QUALITY IMPROVEMENT PROCESS AND HEALTH INFORMATION SYSTEMS

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

L.A. Care's Quality Improvement infrastructure includes a comprehensive array of clinical and service performance measurement that provide information about the processes and outcomes of population health, equity, clinical care and member experience. The results of performance measurement are coordinated with other network initiatives, teams and oversight committees. Staff throughout the enterprise participate in these activities and are educated as to their roles and responsibilities in improving performance.

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

L.A. Care uses many different sources to obtain performance data. The data sources include but are not limited to encounters/claims, pharmacy and lab data through direct, supplemental or Health Information Exchange (HIE) pathways; medical record review or facility site review results, and other monitoring and audit results as well as grievances, appeals, and denial overturns. Reports used to reflect this data include but are not limited to: HEDIS results, quality and performance

reports, member and provider satisfaction survey results, network access and availability reports. Advanced Analytics and Data Science techniques are also used such as Risk Scores, the Readmission Risk Tool and a multifactorial Member Experience analysis.

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

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

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

- Other information from regulators: CMS, DHCS, DMHC or accrediting bodies, such as NCQA may require.

L.A. Care ensures that information and data received from providers are accurate, timely, and complete. All HEDIS measures are audited by an external auditor to ensure accuracy. Performance data for the key indicators are collected, aggregated, integrated, and analyzed on a recurring schedule and business activity monitoring is used to verify volume and timeliness. Multiple data points are displayed together on graphs to show historical performance and facilitate analysis and trending. Each review includes quantitative and qualitative, and when possible causal analysis. Evaluating the effectiveness of previous interventions is included and influences the next step in planning.

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

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

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

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

delivered via a paper-based, manual release process, L.A. care aims to provide all pertinent data and analyzed opportunities in web-accessible format and as frequently refreshed as possible.

Performance Target

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

Significant Improvement

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

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

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

Meaningful Improvement

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

Sustained Improvement

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

Whenever possible L.A. Care selects indicators for which data are available on the performance of other comparable organizations (or other components of the same organization), or for which there exist local or national data for a similar population in the fee-for-service sector.

It is important that the measures of performance before and after interventions be comparable in order to measure improvement accurately. The same methods must be used for identifying the target population and for selecting individual cases for review.

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

MEMBER CONFIDENTIALITY

L.A. Care is obligated, both legally and ethically, to protect the interest of its members by maintaining the confidentiality of all members in accordance with applicable laws and regulations. L.A. Care has Privacy and Security Programs that include relevant policies and procedures aimed at protection the confidentiality of our members. Confidential member information is made available only to L.A. Care employees, contractors, and affiliates who have a need-to-know in order to do their job functions and have signed confidentiality agreements. L.A. Care ensures that all individuals or agencies who participate in the use, creation, maintenance, or disclosure of protected health information limit the use and disclosure only to the minimum necessary to complete the task. Without a signed authorization, disclosure of protected health information is limited to the purposes of treatment, payment, or health care operations and as described in our Notice of Privacy Practices. These purposes include the use of protected health information for quality of care activities, care management service referrals, statistical evaluation, claims payment processes, medical payment determinations, practitioner credentialing, peer review activities, and the grievance and appeals process.

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

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

CONFIDENTIALITY

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

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

DISEASE REPORTING STATEMENT

L.A. Care's provider network complies with disease reporting standards as cited by the California Code of Regulations (CCR), Title 17 (Section 2500), which states that public health professionals, medical providers and others are mandated to report approximately 85 diseases or conditions to their local health department. The primary objectives 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. For a list of reportable diseases and reporting forms, please visit the Los Angeles County Department of Health Services Acute Communicable Disease Control department website at: http://lapublichealth.org/acd/cdrs.htm and via a link on the L.A. Care website at www.lacare.org/providers/provider-central/faqs.

OVERALL L.A. CARE DELEGATION

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

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

QI Delegation

L.A. Care has written service agreements with delegated Plan Partners, Specialty Health Plans, and External Entities to provide specific health care services and perform other delegated functions. L.A. Care requires and ensures that each delegate is capable of managing the delegated activities and are in compliance with L.A. Care, current NCQA standards, state and federal regulatory requirements, and other applicable regulatory requirements and guidelines. Specific elements of the QI program may be delegated; however, L.A. Care remains responsible for and has appropriate structures and mechanisms to oversee all delegated QI activities including health equity. All components of the QI process, maintained by delegates, will be made available to L.A. Care at the time of scheduled oversight audits as well as ongoing monitoring. On an annual basis, L.A. Care evaluates the delegates' performance against NCQA, DMHC/DHCS, and CMS standards for the delegated activities. L.A. Care also conducts ongoing monitoring through oversight reports, meetings, and collaboration to continually assess compliance with standards and requirements. Oversight audit and monitoring results are reviewed, opportunities for performance improvement are identified and reported to the delegate. The delegate must have an established QI program, which includes health equity, work plan, and policies and procedures consistent and current with L.A. Care QI Program and NCQA standards. A Corrective Action Plan (CAP) is issued if deemed necessary, to address deficiencies. After the delegate receives final Annual Audit Findings, the delegate has 15 business days to provide L.A. Care a completed CAP form. After all CAPs for all audit areas are accepted and audit is closed, L.A. Care may conduct a CAP

validation 60 calendar days after audit close date to ensure that substantial correction of deficiencies occurred and the CAP implemented was satisfactory.

L.A. Care is accountable for all quality improvement functions and responsibilities that are delegated and contracts with Delegates should at a minimum include:
- Quality improvement responsibilities, and specific delegated functions and activities
- L.A. Care's oversight, monitoring, and evaluation processes and Delegate's agreement to such processes.
- L.A. Care's reporting requirements and approval processes. The contract agreement shall include Delegate's responsibility to report quality improvement activities at least quarterly.
- L.A. Care's actions/remedies if Delegate's obligations are not met.

ANNUAL QI PROGRAM EVALUATION

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

ANNUAL QI WORK PLAN (SEE Attachment 5)

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

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

Each of the elements identified on the Work Plan has activities defined, responsibility assigned, and the date by which completion is expected. The QI Work Plan and Quality Improvement Program description are presented to the Quality Oversight Committee for review and approval.

Quarterly updates to the Work Plan are documented and reported to the Quality Oversight Committee. Quarterly work plan updates are available to regulatory agencies if requested.

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

Attachment 1   Organizational Structure

Attachment 2   Health Services Organization

Attachment 3   Quality Program Committee Structure

Attachment 4   HEDIS Measures

Attachment 5   2023 QI Work Plan including Medicare

ATTACHMENT 1

BOARD OF GOVERNORS

Public Advisory Committees
- Children's Health Consultant Advisory Committee
- Executive Community Advisory Committee
- Regional Community Advisory Committees
- Technical Advisory Committee

Board Committees
- Audit
- Compliance & Quality
- Executive
- Finance and Budget
- Governance
- Service Agreements

Thomas Mapp
Chief Compliance Officer
- Compliance (145)
- Enterprise Portfolio Mgmt. Office (120)
- Internal Audit
- Governance
- Material Review
- Privacy
- Regulatory Analysis &Communications
- Regulatory Compliance, Reporting & Monitoring
- Risk Management & Operations Oversight
- Special Investigation Unit (309)

John Baackes
Chief Executive Officer

Mitra Madjdi
Manager, Office of the CEO

Acacia Reed
Chief Operating Officer
- Advanced Analytics Lab (307)
- Care Management (641)
- Claims Data and Support Services (310)
- Claims Integrity (330)
- CSC Appeals & Grievance (348)
- CSC Training & Performance (319)
- Customer Solution Call Center (321)
- Enrollment Services (322)
- Enterprise Configuration (450)
- Enterprise Performance Optimization (140)
- Even MORE Outreach & Service (327)
- Even MORE Quality (323)
- Managed Care Services (305)
- MLT Services and Supports (612)
- Office of CSC Excellence (320)
- Utilization Management (640)

Augie Haydel
General Counsel
- Board Services (170)
- General Legal Services (116)
- Health Care Legal Services (117)
- Legal Services (115)

Linda Greenfeld
Chief Product Officer
- Medi-Cal Product Management (111)
- Commercial & Group Product Mgmt. (155)
- Community Benefit Program (135)
- Product Sales (672)
- Marketing (372)
- Medicare Product (328)
- Strategy, Regulatory/External Affairs (165)

Thomas MacDougall
Chief Information Officer
- IT Executive Administration (410)
- IT Enterprise Architecture (435)
- IT Enterprise Data Management (440)
- IT Operations & Infrastructure (420)
- IT Solutions Delivery (470)

Terry Brown
Chief Human Resources Officer
- Facilities Services (260)
- HR Business Support Services (250)
- Organizational Effectiveness (250)
- Talent Strategy & HR Technology (251)
- Total Rewards/Compensation (250)

Vacant
Chief of Equity and Quality
Medical Director

Noah Paley
Chief of Staff
- Community Resource Center HQ Admin (160)
- CRC Boyle Heights (163)
- CRC ELA (168)
- CRC El Monte (162)
- CRC Inglewood (167)
- CRC Lynwood (166)
- CRC Metro LA (159)
- CRC Norwalk (158)
- CRC Pacoima (169)
- CRC Palmdale| 161)
- CRC Pomona (156)
- CRC Wilmington (153)
- Communications (335)
- Community Outreach and Engagement (340)
- CMC Consumer Advisory Comm. (180)
- Government Affairs (130)
- Provider Data Management (360)
- Provider Network Management (345)

Richard Seidman, MD, MPH
Chief Medical Officer
- CalAim–Non Medical (148)
- CalAim- Medical (648)
- Behavioral Health (613)
- Cultural & Linguistic (350)
- Facility Site Review (645)
- Health Education (650)
- Health Services (610)
- Pharmacy & Formulary (630)
- Population Health Mgmt. (355)
- Provider Support Services (380)
- Quality Improvement (620)
- Quality Performance Mgmt. (655)
- Safety Net Initiatives (164)
- Social Services (614)

Marie Montgomery
Chief Financial Officer
- Accounting Services (225)
- Actuarial Services (220)
- Finance Services (210)
- Financial Compliance (235)
- Medical Payment System & Services (240)
- Risk Adjustment Strategies & Initiatives (315)

2023
L.A. Care Health Plan
Health Services Organization

Board of Governors

Public Advisory Committees
- Children's Health Consultant Advisory Committee
- Executive Community Advisory Committee
  - Regional Community Advisory Committees
  - Coordinated Care Initiative Councils
- Technical Advisory Committees

Board Committees
- Audit
- Compliance & Quality
- Executive
- Finance and Budget
- Governance
- Service Agreements

Chief Executive Officer — John Baackes

Chief Compliance Officer — Thomas Mapp
- **Chief of Enterprise Performance Optimization** — Cagla Ozden
  - **Director, Delegation Oversight** — Martha Nazarian, Pharm.D
    - **Director, Delegation Oversight Performance Monitoring and Account Management** — Richard Rice
  - **Director, Enterprise and Network Oversight Clinical Operations** — Ann Marie Miller

Chief of Staff — Noah Paley

Chief Health Equity Officer — Alex Li, MD
- **Manager, Health Equity** — Marina Acosta, MPH

Chief Medical Officer — Sameer Amin, MD

Chief Pharmacy Officer — Yuna Paulson, PharmD
- **Director, Pharmacy Compliance** — Diane Lee, PharmD
- **Manager, Pharmacy Strategy & Analytics** — Janet Tsui, PharmD, MBA
- **Manager, Pharmacy Technical Operations** — Nicole Moussa
- **Director, Clinical Pharmacy** — Alex Kang, PharmD
  - **Manager, Pharmacy Appeals and Grievances** — Su Kang, PharmD
  - **Manager, Clinical Programs** — Ann Phan, PharmD
  - **Manager, Formulary and Benefit Design** — David Lopez, PharmD, APh, BCACP
  - **Manager, Ambulatory Care Advanced Practice** — Hanna Sung, PharmD

Director, Safety Net Programs & Partnerships — Karl Calhoun
- **Director, DHS Managed Care Support Services** — Miguel Barcenas
- **Manager Safety Net Programs** — Melissa Wanyo
- **Manager Safety Net Programs** — William Afuno
- **Safety Net Initiatives and QI Programs** — Paola Valdivia
- **Safety Net Initiatives Senior Director** — Cynthia Carmona

Deputy Chief Medical Officer — Vacant
- **Senior Medical Director, Utilization Management and Care Management Services** — Susan Stone, MD
- **Medical Director, CalAIM** — Kevin Burns
- **Provider Support Services Continuing Education Program Manager II** — Leilanie Mercurio
- **Senior Medical Director, Behavioral Health & Social Services** — Michael Brodsky, MD
  - **Director, Behavioral Health** — Rose Koyan
    - **Manager, Behavioral Health Clinical Services** — Vacant
    - **Manager, Autism Program** — Mahsa Ilesari
  - **Director, Social Services** — Delia Mojarro, LCSW
    - **Manager, Social Services** — Lauren Villanueva, MSW, ACSW
    - **Manager, Social Services** — Jessica Tapia, MSW, LCSW
    - **Manager, Social Services** — Tiffany Hayes, MSW, ACSW

Chief Operating Officer — Acacia Reed
- **Clinical Operations Executive** — Jennifer Rasmussen, MPH, CHES
  - **Senior Director, Care Management** — Steven Chang, LCSW, CCM
    - **Director, Care Management** — Joycelyn Smart-Sanchez, MBA, LCSW
    - **Director, Care Management** — Amanda Asmus, RN
    - **Manager, Care Management** — Silovena Aleksander, LCSW
    - **Manager, Care Management** — Lakshmi Koranmpai, RN
    - **Manager Community Based Care** — Noah Ng, LCSW
  - **Senior Director, MLTSS** — Judy Cua-Razanabao, RN
    - **Manager, Community Based Adult Services** — James Kawakami, RN
    - **Clinical Manager** — Cynthia Dizon, RN
    - **Manager, MLTSS Clinical Services** — Patrice Antwine
    - **Manager, Skilled Nursing** — Dawn Knotts, RN
  - **Senior Director, Utilization Management** — Tara Nelson, RN, BSN
    - **Director, Utilization Management** — Kelly Frost, RN
    - **Manager, Clinical Outpatient** — Catherine Nguyen, RN
    - **Manager, Utilization Management Quality Assurance** — Esther Jando, RN
    - **Manager, Utilization Management Operations** — Khadine, Kelly-Hill
    - **Manager, Utilization Management Operations** — Karina Bemebenin

Senior Medical Director, Direct Network — David Kagan, MD

Chief Quality and Information Executive — Karina Parrish, MD, FAAP
- **Quality Medical Director** — Vacant
  - **Senior Director, Stars Excellence** — Donna Sutton
    - **Manager, Stars Analytics** — Rodney Troong
  - **Director, Health Education, Cultural and Linguistic Services** — Lumiara Theba, MPH
    - **Manager, Health Education Services** — Wendy Sasser, MHA
    - **Manager, Cultural & Linguistics Services** — Naoko Yamashita
  - **Senior Director, QI/Accreditation** — Maria Cassas, RN, BSN, PHN, MPH
    - **Manager, QI Accreditation** — Priscilla Lopez, MPH
    - **Senior Manager, Clinical Initiatives** — Bettsy Saatian, MPH
    - **Senior Manager, Provider Quality** — Christine Chueh, RN, CPHQ
    - **Manager Health Information Technology Program** — Cathy Mechiser, MBA
    - **Director, Population Health Management** — Elaine Sadocchi-Smith, FNP, MPH, CHES
    - **Manager, Facility Site Review** — Jacqueline Lechon, RN
  - **Director, Quality Performance Management** — Thomas Mendez
    - **Manager, Quality Performance Management** — Linda Carberry
    - **Manager, Quality Performance Metrics** — Ronald Makita
    - **Manager, Quality Data** — Vacant
- **Director Population Health Informatics** — Matthew Pirritano, Ph.D
- **Manager, Health Information Management (HIM)** — John Choe, MPH
- **Senior Manager, Incentives** — Ifeneck Solomon
- **Manager, Health Information Technology Data Programs** — Saikiran Vodela
- **Health Information Exchanges (HIE) Program Manager** — Paul Stout, MBA

L.A. Care Health Plan
Quality Improvement Committees

ECSC (Equity Council Steering Committee)

BoG (Board of Governors)

C&Q (Compliance and Quality Committee)

QOC (Quality Oversight Committee)

Internal Compliance Committee

Privacy and Security Committee

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

QIHEC* (Quality Improvement and Health Equity Committee)

SSC (Stars Steering Committee)

PHMCFT (Population Health Management Cross Functional Team)

QPMSC (Quality Performance Management Steering Committee)

PQOC (Pharmacy Quality Oversight Committee)

CPRC (Credentialing & Peer Review Committee)

FSR (Facility Site Review Taskforce)

UMC (Utilization Management Committee)

MQSC (Member Quality Service Committee)

QISC (Quality Improvement Steering Committee)

BHQC (Behavioral Health Quality Committee)

ECAC (Executive Community Advisory Committee)

RCAC (Regional Community Advisory Committee)

CCICAC (Coordinated Care Initiative Consumer Advisory Council)

QI Workgroups
Access/Availability, Member Experience, Preventive & Chronic Care, Behavioral Health, Appropriate Med Mgmt., Maternal & Child Health, QI Inpatient, Incentives, & Stars

*QIHEC is under development, the PICC/PQC will be restructured as a part of the QIHEC

Acronym	HEDIS Measure Name	Administrative or Hybrid (A/H) or Electronic Clinical Data System (ECDS)	L.A. Care Covered Measure (QRS)	*DHCS Auto Assignment Measure	DHCS Required Measure (MCAS)	NCQA Accreditation Measures - Medicare	NCQA Accreditation Measure - Medi-Cal
AAB	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	A	X			X	X
ADD	Follow-Up for Children Prescribed ADHD Medication - Continuation and Maintenance	A					X
ADV	Annual Dental Visit (Total Rate)	A	X				X
AHU	Acute Hospitalization Utilization – Total Acute -65+ years	A				X	
AMM	Antidepressant Medication Management - Acute Phase	A	X				
AMM	Antidepressant Medication Management- Continuation Phase	A	X			X	X
AMO	Annual Monitoring for Persons on Long-term Opioid Therapy	A	X				
AMR	Asthma Medication Ratio – Total	A	X		X		X
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics – Total	A					X
APP	Use of First –Line Psychosocial Care for Children and Adolescents on Antipsychotics	A					X
BPD	Blood Pressure Control for Patients with Diabetes	H				X	NCQA
BCS-E	Breast Cancer Screening - Total	ECDS & A	X		X	X	X
CBP	Controlling High Blood Pressure - Total	H	X		X	X	X
CCS	Cervical Cancer Screening	H	X		X		X
CDC-HT	Comprehensive Diabetes Care – HbA1c Testing	H		X			
CHL	Chlamydia Screening in Women- (Total Rate)	A	X		X		X
CIS-10	Childhood Immunization Status - Combo 10	H	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 (MCAS)	NCQA Accreditation Measures - Medicare	NCQA Accreditation Measure - Medi-Cal
COL	Colorectal Cancer Screening	H	X			X	
COU	Risk of Continued Opioid Use – 31 day rate	A				X	X
CWP	Appropriate Testing for Pharyngitis	A	X			X	X
DAE	Use of High-Risk Medications in Older Adults (Rate 3 only)	A				X	
DDE	Potentially Harmful Drug-Disease Interactions in Older Adults (Total Rate)	A				X	
DRR-E	Depression Remission or Response for Adolescents and Adults	ECDS			X		
DEV	Developmental Screening in the First Three Years of Life	A			X		
DSF-E	Depression Screening and Follow-Up for Adolescents and Adults	ECDS			X		
EDU	Emergency Department Utilization -65+ years	A				X	
EED	Eye Exam for Patients with Diabetes	H	X			X	X
FMC	Follow-up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions - 7-days (65+years)	A				X	
FUA	Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 7-days	A				X	X
FUA	Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 30-days	A			X		
FUH	Follow-Up After Hospitalization for Mental Illness - 7 day and 30 day (LACC only)	A	X			X	X
FUI	Follow-Up After High-Intensity Care for Substance Use Disorder - 7 days	A				X	X

Acronym	HEDIS Measure Name	Administrative or Hybrid (A/H) or Electronic Clinical Data System (ECDS)	L.A. Care Covered Measure (QRS)	*DHCS Auto Assignment Measure	DHCS Required Measure (MCAS)	NCQA Accreditation Measures - Medicare	NCQA Accreditation Measure - Medi-Cal
FUM	Follow-up After Emergency Department Visit for Mental Illness - 7 day	A				X	X
FUM	Follow-up After Emergency Department Visit for Mental Illness – 30- days	A			X		
HBD	Hemoglobin A1c Control for Patients with Diabetes – HbA1c Control <8%	H	X			X	X
HBD	Hemoglobin A1c Control for Patients with Diabetes – HbA1c Poor Control >9%	H			X		
HDO	Use Of Opioids At High Dosage	A				X	X
HFS	Hospitalization Following Discharge From a Skilled Nursing Facility - 30-Day	A				X	
HPC	Hospital for Potentially Preventable Conditions	A				X	
IET	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment – Initiation	A	X				
IET	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment - Engagement	A	X			X	X
INR	International Normalized Ratio Monitoring for Individuals on Warfarin	A	X				
IMA-2	Immunizations for Adolescents – Combination 2	H	X		X		X
KED	Kidney Health Evaluation for Patients with Diabetes	A	X			X	X
LBP	Use of Imaging Studies for Low Back Pain	A	X				X

Acronym	HEDIS Measure Name	Administrative or Hybrid (A/H) or Electronic Clinical Data System (ECDS)	L.A. Care Covered Measure (QRS)	*DHCS Auto Assignment Measure	DHCS Required Measure (MCAS)	NCQA Accreditation Measures - Medicare	NCQA Accreditation Measure - Medi-Cal
LSC	Lead Screening in Children	H			X		
OMW	Osteoporosis Management in Women Who Had a Fracture	A				X	
OSW	Osteoporosis Screening in Older Women	A				X	
PCE	Pharmacotherapy Management of COPD Exacerbation Systemic Corticosteroid and Bronchodilator	A				X	X
PCR	Plan All Cause Readmissions	A	X			X	X
PDC	Proportion of Days Covered	A	X				
PNU	Pneumococcal Vaccination Status for Older Adults	A				X	
POD	Pharmacotherapy for Opioid Use Disorder	A				X	X
PPC-Pst	Prenatal and Postpartum Care - Postpartum Care	H	X		X		X
PPC-Pre	Prenatal and Postpartum Care - Timeliness of Prenatal Care	H	X	X	X		X
PRS-E	Prenatal Immunization Status - Combination Rate	ECDS					X
PSA	Non-Recommended PSA-Based Screening in Older Men	A				X	
RDM	Race/Ethnicity Diversity of Membership	A				X	X
SPC	Statin Therapy for Patients With Cardiovascular Disease (Both Rates)	A				X	X
SPD	Statin Therapy for Patients with Diabetes (Both Rates)	A				X	X

Acronym	HEDIS Measure Name	Administrative or Hybrid (A/H) or Electronic Clinical Data System (ECDS)	L.A. Care Covered Measure (QRS)	*DHCS Auto Assignment Measure	DHCS Required Measure (MCAS)	NCQA Accreditation Measures - Medicare	NCQA Accreditation Measure - Medi-Cal
SAA	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	A				X	X
SSD	Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic Medications	A					X
TFL-CH	Topical Fluoride Varnish for Children	A			X		
TRC	Transition of Care - All Four Rates – 65+ years	H				X	
UOP	Use of Opioids from Multiple Providers	A				X	X
URI	Appropriate Treatment for Upper Respiratory Infections	A	X			X	X
W30	Well-Child Visits in the First 30 months of Life	A	X		X		
WCC-BMI	Weight Assessment & Counseling for Nutrition& Physical for Children and Adolescents	H	X				X
WCC--N	Weight Assessment & Counseling for Nutrition& Physical for Children and Adolescents	H	X				
WCC-PA	Weight Assessment & Counseling for Nutrition& Physical for Children and Adolescents	H	X				
WCV	Child and Adolescent Well-Care Visits	A	X	X	X		

*Auto-assignment measures subject to change awaiting DHCS update

Category	Performance Measures for Planned Activities for Objective	HEDIS Acronym	Regulatory Agencies	2022 Rates	2023 Rates	2023 Goal	Goal Met/Not Met	Department	Responsible Staff/Department	Timeframe for completion	Reports to: (Rates are 2023 unless otherwise noted)	Interventions/Updates/Comments	Barriers	Recommendation for 2024 Work Plan
Service - Access	Member Services Department Telephone Abandonment Rate			**Medi-Cal** Q1: 57.56% Q2: 57.67% Q3: 55.41% Q4: 68.55% **CMC:** Q1: 6.38% Q2: 5.84% Q3: 2.99% Q4: 2.48% **LACC:** Q1: 2.77% Q2: 2.54% Q3: 2.69% Q4: 2.06%		**Medi-Cal & D-SNP:** Total incoming calls abandoned ≤ 5% **LACC:** Total incoming calls abandoned ≤ 7%		EPG, CSC	Cagla Ozden (EPG)/ Robert Martinez (CSC)/ Michael Nguyen (CSC)/ Liliana Bravo (CCS)	Quarterly	**Member Quality Service Committee (MQSC):** Feb 14, May 25 Aug 29 Nov 7		Follow up from Q4 2022: Staffing barrier is ongoing.	
Service - Access	Member Services Department Telephone Wait Time- Service Level			**Medi-Cal** Q1: 18.75% Q2: 29.02% Q3: 15.45% Q4: 27.34% **CMC:** Q1: 88.69% Q2: 91.86% Q3: 86.22% Q4: 92.31% **LACC:** Q1: 88.28% Q2: 90.86% Q3: 87.68% Q4: 92.18%		**ALOS:** 80% of total incoming calls answered ≤ 30 seconds		EPG, CSC	Cagla Ozden (EPG)/ Robert Martinez (CSC)/ Michael Nguyen (CSC)/ Liliana Bravo (CCS)	Quarterly	**Member Quality Service Committee (MQSC):** Feb 14, May 25 Aug 29 Nov 7		Follow up from Q4 2022: Staffing barrier is ongoing.	
Service - Access	Non-Emergent Ancillary Services -within 15 business days of request, for appointment		DMHC DHCS CMS NCQA	**MY 2021 AA Survey Results:** **Medi-Cal** Mammogram: 81% Physical Therapy: 95% **CMC** Mammogram: 86% Physical Therapy: 100% **LACC** Mammogram: 84% Physical Therapy: 100% **LACCB** Mammogram: 84% Physical Therapy: 91% **PASC** Mammogram: 84% Physical Therapy: 92%		**MY 2022 performance:** All lines of business: Ancillary mammogram: 97% Ancillary Physical Therapy: 100%		QI	Emil Berkes (QI)/ Priscilla Lopez (QI)	Annually: Sept '23	MQSC: Nov 7 Joint PICC PQCt July 18 C&Qt Sept 28		Follow up from Q4 2022: As a result of the data issues, our survey vendor CSS will be surveying/fielding more than 50% of telehealth providers as part of wave 2, which goes against DMHC Survey methodology expected to received on February 2023.	
Service - Access	After Hour Care - Practitioners surveyed have after-hour care process such as an exchange service, automated answering/paging system, or directly accessible, in order to respond to a member call with live person in the 30 minutes.		DMHC DHCS CMS NCQA	**2022 MY 2021 ATC Survey Results:** **Medi-Cal** PCP Access: 80% PCP Timeliness: 69% Combined Access & Timeliness: 65% **CMC** PCP Access: 80% PCP Timeliness: 70% Combined Access & Timeliness: 66% **LACC** PCP Access: 80% PCP Timeliness: 70% Combined Access & Timeliness: 66% **LACCB** PCP Access: 80% PCP Timeliness: 70% Combined Access & Timeliness: 66% **PASC** PCP Access: 70% PCP Timeliness: 75% Combined Access & Timeliness: 71%		**MY 2022 performance:** All lines of business: PCP Access: 77% PCP Timeliness: 54% PCP: Combined Access & Timeliness: 49%		QI	Emil Berkes (QI)/ Priscilla Lopez (QI)	Annually: Sept '23	MQSC: Nov 7 Joint PICC PQCt July 18 C&Qt Sept 28		Follow up from Q4 2022: As a result of the data issues, our survey vendor CSS will be surveying/fielding more than 50% of telehealth providers as part of wave 2, which goes against DMHC Survey methodology expected to received on February 2023.	
Service - Access	Routine Primary Care (Non-Urgent) - Practitioners surveyed have routine primary visits available within 10 business days.		DMHC DHCS CMS NCQA	**2022 MY 2021 ATC Survey Results** **Medi-Cal** 92% **LACC** 92% **LACCB** 92% **CMC** 92% **PASC** 79%		**MY 2022 performance:** All lines of business: PCP: 94%		QI	Emil Berkes (QI)/ Priscilla Lopez (QI)	Annually: Sept '23	MQSC: Nov 7 Joint PICC PQCt July 18 C&Qt Sept 28		Follow up from Q4 2022: As a result of the data issues, our survey vendor CSS will be surveying/fielding more than 50% of telehealth providers as part of wave 2, which goes against DMHC Survey methodology expected to received on February 2023.	
Service - Access	Routine Specialty Care (Non-Urgent) - Specialist practitioners surveyed have routine specialty care visits available within 15 business days of request.		DMHC DHCS CMS NCQA	**2022 MY 2021 ATC Survey Results** **Medi-Cal** 77% **LACC** 76% **LACCB** 76% **CMC** 73% **PASC** 90%		**MY 2022 performance:** All lines of business: SCP: 69%		QI	Emil Berkes (QI)/ Priscilla Lopez (QI)	Annually: Sept '23	MQSC: Nov 7 Joint PICC PQCt July 18 C&Qt Sept 28		Follow up from Q4 2022: As a result of the data issues, our survey vendor CSS will be surveying/fielding more than 50% of telehealth providers as part of wave 2, which goes against DMHC Survey methodology expected to received on February 2023.	
Service - Access	Urgent Care (PCP) - Urgent care appointments available within 48 hours.		DMHC DHCS CMS NCQA	**2022 MY 2021 ATC Survey Results** **Medi-Cal** 81% **LACC** 79% **LACCB** 79% **CMC** 79% **PASC** 88%		**MY 2022 performance:** All lines of business: PCP: 65%		QI	Emil Berkes (QI)/ Priscilla Lopez (QI)	Annually: Sept '23	MQSC: Nov 7 Joint PICC PQCt July 18 C&Qt Sept 28		Follow up from Q4 2022: As a result of the data issues, our survey vendor CSS will be surveying/fielding more than 50% of telehealth providers as part of wave 2, which goes against DMHC Survey methodology expected to received on February 2023.	

SERVICE														
Category	Performance Measure or Planned Activities for Objective	HEDIS Acronym	Regulatory Agencies	2022 Rates	2023 Rates	2023 Goal	Goal Met/Not Met	Department	Responsible Staff/Department	Timeframe for completion	Reports to: (Rates are 2023 unless otherwise noted)	Interventions/Updates/Comments	Barriers	Recommend for 2024 Work Plan
Service – Access	Urgent Care (SCP) - Urgent care appointments available within 96 hours.		DMHC DHCS CMS NCQA	**2022 MY 2021 ATC Survey Results:** **Medi-Cal:** 67% **LA CC:** 69% **LA CCD:** 60% **CMC:** 67% **PASC:** 61%		**MY 2022 performance:** **All line of business:** SCP: 80%		QI	Eva Berrios (QI)/ Priscilla Lopez (QI)	Annually: Sept '23	MQSC: Nov 7 Joint PI CC PQCt July 18 C&Qt Sept 22		Follow up from Q4 2022: As a result of the data issues, our survey vendor CBS will be surveying/ fielding more than 60% of telehealth providers as part of wave 2, which goes against DMHC Survey methodology expected so received on February 2023.	
Service – Availability	Drive Distance to PCP (Geomapping, Optum Reports)			**Q1:** Medi-Cal: 99% LA CC: 100% CMC: 99% PASC: 98% **Q2:** Medi-Cal: 99% LA CC: 100% CMC: 99% PASC: 98% **Q3:** Medi-Cal: 99% LA CC: 100% CMC: 99% PASC: 98% **Q4:** Data available mid-Feb 2023.		95% of members have access to a PCP within 10 miles radius of their primary residence		PNM	Kerstin Mirmazian (PNM)/ Leah Lowe (PNM)/ Eddie Galles (PNM)	Quarterly	MQSC: Nov 7			
Service – Availability	Drive Distance to all SCP, including identified high volume SCP (Geomapping, Optum Reports)			**Q1:** Medi-Cal: 100% LA CC: 100% CMC: 99% PASC: 96% **Q2:** Medi-Cal: 100% LA CC: 100% CMC: 99% PASC: 95% **Q3:** Medi-Cal: 100% LA CC: 100% CMC: 99% PASC: 95% **Q4:** Data available mid-Feb 2023.		90% of members have access to specialty care practitioners within 15 miles radius of their primary residence		PNM	Kerstin Mirmazian (PNM)/ Leah Lowe (PNM)/ Eddie Galles (PNM)	Quarterly	MQSC: Nov 7			
Service – Availability	Ratio – PCP (excludes mid-level providers) (Geomapping, Optum Reports)			**Q1:** Medi-Cal: 1:522 LA CC: 1:34 CMC: 1:2 PASC: 1:156 **Q2:** Medi-Cal: 1:555 LA CC: 1:34 CMC: 1:2 PASC: 1:155 **Q3:** Medi-Cal: 1:569 LA CC: 1:37 CMC: 1:2 PASC: 1:155 **Q4:** Data available mid-Feb 2023.		1 : 2000 members		PNM	Kerstin Mirmazian (PNM)/ Leah Lowe (PNM)/ Eddie Galles (PNM)	Quarterly	MQSC: Nov 7			
Service – Availability	Ratio – High Volume Specialists (Note: the top 5 specialties can vary year to year)			Q1/Q2/Q3/Q4 detailed ratios by specialty (Medi-Cal, LA CC & LA CCD, CMC, PASC) — data for Ophthalmology, Dermatology, Podiatry, Urology, Cardiovascular Disease, Oncology, Infectious Disease. Q4: Data available mid-Feb 2023.		1:3000 members for high-volume specialties		PNM	Kerstin Mirmazian (PNM)/ Leah Lowe (PNM)/ Eddie Galles (PNM)	Annual	MQSC: Nov 7			
Service – Availability	Direct Network Drive Distance to PCP (Geomapping, Optum Reports)			**Q1:** Medi-Cal: 98% **Q2:** Medi-Cal: 98% **Q3:** Medi-Cal: 98% **Q4:** Medi-Cal: Data available mid-Feb 2023.		95% of members have access to a PCP within 10 miles radius of their primary residence		PNM	Kerstin Mirmazian (PNM)/ Leah Lowe (PNM)/ Eddie Galles (PNM)	Quarterly	MQSC: Nov 7		Follow up from Q4 2022: Lack of providers for recruitment opportunities in rural areas.	
Service – Availability	Direct Network Drive Distance to all SCP, including identified high volume SCP (Geomapping, Optum Reports)			**Q1:** Medi-Cal: 98% **Q2:** Medi-Cal: 98% **Q3:** Medi-Cal: 98% **Q4:** Data available mid-Feb 2023.		90% of members have access to specialty care practitioners within 15 miles radius of their primary residence		PNM	Kerstin Mirmazian (PNM)/ Leah Lowe (PNM)/ Eddie Galles (PNM)	Quarterly	MQSC: Nov 7		Follow up from Q4 2022: Lack of providers for recruitment opportunities in rural areas.	
Service – Availability	Direct Network Ratio – PCP (excludes mid-level providers) (Geomapping, Optum Reports)			**Q1:** Medi-Cal: 1:98 **Q2:** Medi-Cal: 1:106 **Q3:** Medi-Cal: 1:111 **Q4:** Data unavailable until mid-Feb 2023.		1 : 2000 members		PNM	Kerstin Mirmazian (PNM)/ Leah Lowe (PNM)/ Eddie Galles (PNM)	Quarterly	MQSC: Nov 7		Follow up from Q4 2022: Lack of providers for recruitment opportunities in rural areas.	

The work plan follows a Quarterly reporting cadence filed for the 2023 QI Work plan associated with QAPI structure.

SERVICE													
Category	Performance Measures for Planned Activities for Objective	HEDIS Acronym	Regulatory Agencies	2022 Rates	2023 Rates	2023 Goal	Goal Met/Not Met	Department	Responsible Staff/Department	Timeframe for completion	Report to: (Dates are 2023 unless otherwise noted)	Interventions/Updates/Comments	Barriers	Recommend for 2024 Work Plan
Service - Availability	Direct Network Ratio - High Volume Specialist (Note the top 3 specialties can vary year to year)			Q4: OBGYN 1:91; OPHTHALMOLOGY 1:171; DERMATOLOGY 1:524; PODIATRY 1:451; UROLOGY 1:379; CARDIOVASCULAR DISEASE 1:135; ONCOLOGY 1:110; Q3: OBGYN 1:105; OPHTHALMOLOGY 1:194; DERMATOLOGY 1:591; PODIATRY 1:509; UROLOGY 1:447; CARDIOVASCULAR DISEASE 1:160; ONCOLOGY 1:126 Q2: OBGYN 1:110; OPHTHALMOLOGY 1:195; DERMATOLOGY 1:627; PODIATRY 1:542; UROLOGY 1:464; CARDIOVASCULAR DISEASE 1:173; ONCOLOGY 1:136 Q1: Data available mid-Feb 2023.		OBGYN 1:1000 OPHTHALMOLOGY 1:2500 DERMATOLOGY 1:4100 PODIATRY 1:3000 UROLOGY 1:4100 CARDIOVASCULAR DISEASE 1:2900 ONCOLOGY 1:5000		PNM	Kevin Minassian (PNM)/ Leah Lowe (PNM)/ Eddie Callen (PNM)	Annual	NCQSC: Nov 7		Follow up from Q4 2022: Lack of providers for recruitment opportunities in rural areas.
Service - Complaints and Appeals	Appeals Resolution (all Lines of Business)			FY Q1: 76.79% FY Q2: 95.65% FY Q3: 100% FY Q4: 99.03		95% appeal resolution within 30 days		EPO, A&G	Cigla Ozden (EPO)/ Deneira Crandall (A&G)/ Rosemaria Paul (A&G)/ Edwin Corrales (A&G)	Quarterly Reports	NCQSC: Feb 14, May 23, Aug 29, Nov 7			
Service - Complaints and Appeals	Complaints Resolution (all Lines of Business)			FY Q1: 98.62% FY Q2: 98.85% FY Q3: 99.75% FY Q4: 99.85%		95% complaint resolution within 30 days		EPO, A&G	Cigla Ozden (EPO)/ Deneira Crandall (A&G)/ Rosemaria Paul (A&G)/ Edwin Corrales (A&G)	Quarterly Reports	NCQSC: Feb 14, May 23, Aug 29, Nov 7			
Service - Complaints and Appeals	Grievance Resolution (LACC Only)			FY Q1: 92.24% FY Q2: 98.56 FY Q3: 99.86% FY Q4: 99.85%		99% of Covered California enrollee grievances resolved within 30 calendar days of initial receipt		EPO, A&G	Cigla Ozden (EPO)/ Deneira Crandall (A&G)/ Rosemaria Paul (A&G)/ Edwin Corrales (A&G)	Quarterly Reports	NCQSC: Feb 14, May 23, Aug 29, Nov 7			
Service - Complaints and Appeals	Complaints & Appeals Analysis - Complaints categories based on the following categories: Quality of Care, Access, Attitude/Service, Billing/Financial, and Quality of Practitioner Office Site (all Lines of Business)			FY Q1: 100% FY Q2: 100% FY Q3: 100% FY Q4: 100%		100% of complaints & appeals will be analyzed quarterly to identify top 5 complaint categories.		EPO, A&G	Cigla Ozden (EPO)/ Deneira Crandall (A&G)/ Rosemaria Paul (A&G)/ Edwin Corrales (A&G)	Quarterly Reports	QSC: Feb 28, July 25, Sept 26, Nov 28			
Service - Complaints and Appeals	Letter templates are reviewed at least annually			NA		100% of letter templates are reviewed at least annually and upon receiving new guidance from regulators		EPO, A&G	Cigla Ozden (EPO)/ Deneira Crandall (A&G)/ Rosemaria Paul (A&G)/ Edwin Corrales (A&G)	Annual Report	QSC: Nov 28			
Service - Provider Satisfaction	PCP satisfaction with UM process (timely decisions for pre-auth)			2021 Rate: 89.5%		Maintain 80% PCP satisfaction rate with timely decisions for pre-auth.		EPO, UM, QPM	Cigla Ozden (EPO)/ Finia Nelson (UM)/ Esther Jando (UM)/ Linda Carberry (QPM)	Annually: Sept '23	UMC: Dec 14			
Service - Provider Satisfaction	PCP satisfaction with UM process (clinically reasonable decisions for pre-auth)			2021 Rate: 89.5%		Maintain 80% PCP satisfaction rate with clinically reasonable decisions for pre-auth.		EPO, UM, QPM	Cigla Ozden (EPO)/ Finia Nelson (UM)/ Esther Jando (UM)/ Linda Carberry (QPM)	Annually: Sept '23	UMC: Dec 14			
Service - Provider Satisfaction	SCP satisfaction with UM process (timely decisions for pre-auth)			2021 Rate: 75.4%		Achieve 80% SCP satisfaction rate with timely decisions for pre-auth.		EPO, UM, QPM	Cigla Ozden (EPO)/ Finia Nelson (UM)/ Esther Jando (UM)/ Linda Carberry (QPM)	Annually: Sept '23	UMC: Dec 14		Follow up from Q4 2022: System development was needed to overcome some system limitations and development needs. Staff attrition and LOAs have necessitated constant re-evaluation of cross-training, hiring and use of temporary staff.
Service - Provider Satisfaction	SCP satisfaction with UM process (clinically reasonable decisions for pre-auth)			2021 Rate: 73.8%		Achieve 80% SCP satisfaction rate with clinically reasonable decisions for pre-auth.		EPO, UM, QPM	Cigla Ozden (EPO)/ Finia Nelson (UM)/ Esther Jando (UM)/ Linda Carberry (QPM)	Annually: Sept '23	UMC: Dec 14			
Service - Provider Satisfaction	Overall Satisfaction with UM			2021 Rate: PCP: 76.8% SCP: 73.3%		Maintain 80% PCP overall satisfaction rate with UM Achieve 80% SCP overall satisfaction rate with UM		EPO, UM, QPM	Cigla Ozden (EPO)/ Finia Nelson (UM)/ Esther Jando (UM)/ Linda Carberry (QPM)	Annually: Sept '23	UMC: Dec 14			
Clinical - Continuity and Coordination of Medical Care	Coordination of Care PCP/SCP Communication		NCQA	2022 Rate: PCP: 74%		75% of PCPs will rate the frequency of adequate clinical feedback from specialists to whom they have referred, upstairs		QI	Betsy Sansana (QI)/ Rachel Martinez (QI)	Annually: Sept '23	4th Qtr. Attached to QI Eval; included in Coordination of Care Report Member Quality Service Committee (MQSC) Nov 3, 2022			
Clinical - Continuity and Coordination of Medical Care	Coordination of Care SCP/PCP Communication		NCQA	2022 Rate: SPC: 71%		66% of SCPs will rate their communication with PCPs as receiving adequate clinical information for patients that were referred.		QI	Betsy Sansana (QI)/ Rachel Martinez (QI)	Annually: Sept '23	4th Qtr. Attached to QI Eval; included in Coordination of Care Report Member Quality Service Committee (MQSC) Nov 3, 2022			

SERVICE													
Category	Performance Measures for Planned Activities for Objective	HEDIS Acronym	Regulatory Agencies	2022 Rates	2023 Rates	2023 Goal	Goal Met/Not Met	Department	Responsible Staff/Department	Timeframe for completion	Reports to: (Rates are 2023 unless otherwise noted)	Interventions/Updates/Comments	Barriers	Recommend for 2024 Work Plan
Clinical - Continuity and Coordination of Medical Care	Coordination of Care Movement Across Settings		NCQA CMS	Postpartum Care (PPC): Medi-Cal 80%		Achieve a rate of 81% of new mothers receiving postpartum care within 7-84 days of delivery		QI, HECLS	Rachel Martinez (QI)/ Maricela Rojas (HECLS)/ Humara Phuba (HECLS)	Annually: Sep '23	4th Qtr. Attached to QI Eval; Included in Coordination of Care Report Member Quality Service Committee (MQSC) Nov 3, 2022			
Clinical - Continuity and Coordination of Medical Care	Appropriate Use of Medications-Polypharmacy			Q1: 100% Q2: 100% Q3: 100% Q4: Data available 3/31/2023		90% of providers will be notified of members who meet criteria (Multi-Rx: 13 or more prescriptions to 1 of 4 months, Multi-Prescriber: 1 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)		QI, Pharm	Rachel Martinez (QI)/ Andy Han (Pharm)/ Ann Phan (Pharm)	Quarterly	QOC: 4/29/23, 7/29/23, 10/28/23 4th Qtr. Attached to QI Eval			
Clinical - Continuity and Coordination of Medical and Behavioral Care	Exchange of Information between PCPs and Behavioral Health Providers (BHPs)		NCQA	Pending		3% improvement from measurement year 2020 with providers being "always/usually satisfied" with the exchange of information between PCP and Behavioral Health Practitioners (BH PCP/CP and BHPs (with both DMH and Beacon)		BH	Rose Kooyan (BH)/ Sam Maeda (BH)	Annual: Due Oct '25	Behavioral Health Quality Committee (BHQC) in Dec 6		Follow up from Q4 2022: PCPs continue to lack knowledge on how to refer members and what information can be shared between providers. Lack of shared medical record platform for real-time data sharing.	
Clinical - Continuity and Coordination of Medical and Behavioral Care	Appropriate diagnosis, treatment and referral of behavioral health disorders commonly seen in primary care: Appropriate Treatment of Depression	AMM (Acute Phase & Continuation Phase)	NCQA Medi-Cal (Continuation Phase ONLY) QRS	2022 Rates: AMM (Acute Phase): Medi-Cal 65.29% LACC: 71.62% CMC: 77.08% AMM (Continuation Phase): Medi-Cal 44.89% LACC: 52.29% CMC: 50.10%		LACC: 90% 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 (Continuation Phase): Medi-Cal 47% LACC: 55% D-SNP: 57%		QI, BH	Rose Kooyan (BH)/ Sam Maeda (BH)/ Johanna Gonzalez (QI)	Annual: Due Oct '23	BH QC: Dec 6		Follow up from Q4 2022: Members generally may seek services to manage or treat symptoms during an acute phase of an episode and once symptoms improve or subside, members become more reluctant to continue taking medication which may impact both acute and continuation phase of this measure. With PCPs prescribing majority of antidepressant medication, they may not have the expertise to treat major depressive disorder and may impact follow-up care for this population.	
Clinical - Continuity and Coordination of Medical and Behavioral Care	Primary or secondary preventive behavioral health program		NCQA (Report)	% of PCPs utilizing SBIRT 2022: 18.63%		1% improvement from measurement year 2020		BH	Rose Kooyan (BH)/ Sam Maeda (BH)	Annual	BH QC: Dec 6		Follow up from Q4 2022: Member level barrier: Members may feel uncomfortable disclosing substance use because of fear of a negative reaction from provider, or because they are not ready to discuss substance use issues. Provider level barrier: Providers may have lack of clinical knowledge and training about SUD and maybe reluctant to screen for these areas. Additionally, providers may lack resources to complete the screening or may not know/unaware about how to access addiction treatment/think it's too difficult to access addiction treatment.	
Clinical - Continuity and Coordination of Medical and Behavioral Care	Management of treatment access and follow-up for members with coexisting medical and behavioral disorders	SMD (A)	NCQA (Report)	MY 2021 Rates SMD: Medi-Cal 70.61% CMC: N/A LACC: N/A		100% of providers will be notified of members on diabetes and antipsychotic medication		QI, BH	Rose Kooyan (BH)/ Sam Maeda (BH)/ Johanna Gonzalez (QI)	Annual	BH QC: Dec 6		Follow up from Q4 2022: Members prescribed antipsychotic medication receiving the prescription from psychiatrists, from County (carved out) does not have data about members lab work, making follow-up difficult to ensure screenings for A1C are scheduled.	
Clinical - Continuity and Coordination of Medical and Behavioral Care	Special needs of members with severe and persistent mental illness	SSD (A)	NCQA Medi-Cal	2022 Rates SSD: Medi-Cal 78.90% CMC: NA LACC: NA SSD: Medi-Cal 79% LACC: 74% D-SNP: 77%		100% of providers will be notified of members needing Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)		QI, BH	Rose Kooyan (BH)/ Sam Maeda (BH)/ Johanna Gonzalez (QI)	Annual	BH QC: Dec 6		Follow up from Q4 2022: Members prescribed antipsychotic medication receiving the prescription from psychiatrists, from County (carved out) does not have data about members lab work, making follow-up difficult to ensure screenings for A1C are scheduled.	
Clinical	Blood Lead Screening (APL 20-016) lead test between ages of 6 month to 6 years old		DHCS	Q1: 95% Q2: 95% Q3: 95% Q4: Data available after 2/28/23		Comply with the APL and provide quarterly notifications to the PPGs and Plan Partners of members up to 72 months who are in need of a blood lead screening.		QI, HIM	Laura Clark (QI)/ Betzy Sanchez (QI)/ John Chao (HIM)/ Nancy Pang (HIM)	Annual: By Dec '25	MEQC: May 23		Follow up from Q4 2022: IT issues continue to impact the data exchange.	

SERVICE Category	Performance Measures for Planned Activities for Objective	HEDIS Acronym	Regulatory Agencies	2022 Rates	2023 Rates	2023 Goal	Goal Met/Not Met	Department	Responsible Staff/Department	Timeframe for completion	Reports to (Dates are 2023 unless otherwise noted)	Interventions/Updates/Comments	Barriers	Recommend for 2024 Work Plan
Clinical	Aggregate IHA Potential Completion Rate		DHCS	**Medi-Cal (MCLA):** Q1: 56.4% Q2: 20.8% Q3: 61% Q4: 56.6% **CMC:** Q1: 61% Q2: 66.3% Q3: 55.8% Q4: 55.3%		MCLA: 27% D-SNP: 68%		PHM	Johanna Kishoyan (PHM)	Quarterly	QI Steering Committee 5/03/23, 7/19/23, 08/15/23		Follow up from Q4 2022: Low rates of compliance.	
Clinical - Quality Improvement Projects	Childhood Immunization Status-10 PIP	CIS-10	DHCS	NA		By December 31, 2022, use key driver diagram interventions to increase the percentage of CIS-10 rates among St. John's Prayer Clinic members, from 20.4% to 20.6%.		QI	Rachel Martinez (QI)/ Betsy Samuma (QI)	2021-2022	QOC: November 28 PICC & FQC: April 18 & Nov 21			
Clinical - Quality Improvement Projects	Health Equity PIP: Reducing rates of Hemoglobin A1c >9% for Black and African American Members	HBD	DHCS	Medi-Cal: 53.7%		Our aim is to reduce the number of members with an A1c >9% from 66.7% (66 members) to 63.2% (36 members), a statistically significant change using the Chi-squared Test without Yate's Correction. PIP evaluation will be completed by April 2023 to determine if goal was met.		QI	Alison Patsy (QI)/ Betsy Samuma (QI)	12/31/2023	QOC: November 28 PICC & FQC: April 18 & Nov 21		Follow up from Q4 2022: FCPA barriers (members have to opt-in).	
	SWOT - W30/CIS-10	W30/CIS-10	DHCS	**MY 2023/RY 2022 Medi-Cal Rates:** W30-6: 33.16% (A) W30-2: 59.47% (A) CIS-10: 33.58% (H)		**Reach MCAS MPL for MY 2023/RY 2024:** W30-6: 56.93% (A) W30-2: 70.67% (A) CIS-10: 58.2% (H)		QI	Laura Chase (QI)/ Betsy Samuma (QI)/ Rachel Martinez (QI)/ Brigina Bailey (QI)	Submission due to DHCS on: 11/01/2022, 1/20/2023 3/30/2023 9/30/2023	QOC: November 28 PICC & FQC: April 18 & Nov 21			
Clinical - Quality Improvement Projects	Diabetes Disparity for A1c Control (>8%) in African American/Native Americans (QIP)	HBD	LACC ONLY	BAAs: 57.6%		**End Goal for H2023 (MY 2022)** BAAs: 57%		QI	Betsy Samuma (QI)/ Brigina Bailey (QI)	12/31/2023	QOC: November 28 PICC & FQC: April 18 & Nov 21		Follow up from Q4 2022: Delays in internal contracting process remain a barrier - execution of contracts, RFP launch.	
Clinical - Patient Safety	Potential Quality Issue			Q1: 608 out of 628 (96.8%) were processed timely, 20 cases fell out of compliance while taking in account extensions granted and holidays. Q2: 712 out of 756 (94.2%) were processed timely, 44 cases fell out of compliance while taking in account extensions granted and holidays. Q3: 1503 out of 1566 (96.0%) were processed timely, 65 cases fell out of compliance while taking in account extensions granted and holidays. Q4: 1168 out of 1857 (63%) were processed timely, 694 cases fell out of the timely aging category taking into account extensions granted and holidays.		90% of PQI investigation will be completed in 6 months		QI	Christine Chuah (QI)	Annually end of IPY	QOC: April 25, Nov 28		Follow up from Q4 2022: The PQR team continues to work closely with the A&G team. Additional backlog from grievances discovered of 612 cases. PQR team and grievances have identified the issue and working on remediation efforts.	
Clinical - Patient Safety	Potential Quality Issue Reporting from Customer Solution Center and Appeal and Grievance (New goal starting 2023)			Q1: The PQR team reviewed 30 CSC calls (10 calls per month) and 53 appeals/grievances (1% of monthly appeals/grievances) that were not referred to PQI and assess for any potential care concern. Q2: The PQR team reviewed 50 CSC calls (10 calls per month) and 53 appeals/grievances (1% of monthly appeals/grievances) that were not referred to PQI and assess for any potential care concern. Q3: The PQR team reviewed 30 CSC calls (10 calls per month) and 90 appeals/grievances (10 cases per month) that were not referred to PQI and assess for any potential care concern. Q4: The PQR team reviewed 50 appeals/grievances every month that were not referred to PQI and assess for any potential care concern. The cases that were identified having quality of care concerns are referred back to A&G for additional processing.		1% or 20 cases of member concerns that are not referred to PQI will be randomly reviewed by PQR team quarterly.		QI	Christine Chuah (QI)	Monthly end of IPY	QOC: April 25, Nov 28			
Clinical - Patient Safety	Critical Incidents Reporting and Tracking			Q1: 23 (88%) of 26 groups submitted the Q4 2021 quarterly report. Q2: 24 (92.3%) of 26 groups submitted the Q1 2022 quarterly report. Q3: 26 (100%) of 26 groups submitted the Q2 2022 quarterly report. Q4: 26 (100%) of 26 groups submitted the Q3 2022 quarterly report.		100% of Critical Incidents Reported and Tracked.		QI	Christine Chuah (QI)	Annually end of IPY	QOC: April 25, Nov 28		Follow up from Q4 2022: Frequent staff turnover; no longer with the company and therefore the remaining staff were not familiar with the reporting requirements. PHM Account Managers had to be involved to assist with the collection of the reports.	

*The asterisk and Hemoglobin Gini approximate as defined by the 2023 QHP and is correlated with QHP objectives

	Category	Performance Measures for Planned Activities for Objective	HEDIS Acronym	Regulatory Agencies	2022 Rate	2023 Rate	2023 Goal	Goal Met/Not Met	Department	Responsible Staff/Department	Timeframe for completion	Reports to: (Rates are 2023 unless otherwise noted)	Interventions/Updates/Comments	Barriers	Recommend for 2024 Work Plan
SERVICE															
	Clinical - Patient Safety	FSR- needlestick safety			Q1: Compliance Rate - 75% (Based on 201 applicable Audits) Q2: Compliance Rate - 72% (Based on 245 applicable Audits) Q3: Compliance Rate - 77% (Based on 176 applicable Audits) Q4: Compliance Rate - 70 % (Based on 102 applicable Audits)		80%		FSR, PHM	Elaine Sadocchi-Smith (PH MD) Jacqueline Leehon (FSR)	Quarterly	QOC: 4/25/23, 7/25/23, 10/20/23 4th Qtr. Attached to QI Eval		**Follow up from Q4 2022:** Lack of knowledge and training regarding medical record review standards by site staff and physician. Increase use of telehealth for episodic visits. PCP sites does no maintain corrective action taken upon completion of their site review process. Electronic medical record (EMR) systems do no provide a field to document certain criteria and will incur additional cost to PCP sites if implemented.	
	Clinical - Patient Safety	FSR- spore testing of autoclave/sterilizer			Q1: Compliance Rate - 88% (Based on 52 applicable Audits) Q2: Compliance Rate - 74% (Based on 31 applicable Audits) Q3: Compliance Rate - 84% (Based on 25 applicable Audits) Q4: Compliance Rate - 88% (Based on 25 applicable Audits)		85%		FSR, PHM	Elaine Sadocchi-Smith (PH MD) Jacqueline Leehon (FSR)	Quarterly	QOC: 4/25/23, 7/25/23, 10/20/23 4th Qtr. Attached to QI Eval		**Follow up from Q4 2022:** Short staffed at sites, sites not using autoclave or hardly using autoclave, tasks have been deferred/forgotten, autoclave was just bought, new staff at sites, spore test results kept elsewhere (instruments are autoclaved offsite), procedures have stopped/slowed down because of the pandemic, so reusable instruments do not need to be autoclaved.	
	Clinical - Patient Safety	Facility Site Review (FSR) MR A Completion Rate per chart review (MRP complete in chart)			Q1: Medi-Cal Adult: 57% Q1: Medi-Cal Child: 65% Q1: CM-C Adult: 66% Q1: CM-C Child: 66% (Based on 195 MRR Audits) Q2: Medi-Cal Adult: 50% Q2: Medi-Cal Child: 71% Q2: CM-C Adult: 49% Q2: CM-C Child: 64% (Based on 224 MRR Audits) Q3: Medi-Cal Adult: 42% Q3: Medi-Cal Child: 68% Q3: CM-C Adult: 41% Q3: CM-C Child: 68% (Based on 165 MRR Audits) Q4: Medi-Cal Adult: 44% Q4: Medi-Cal Child: 72% Q4: CM-C Adult: 62% Q4: CM-C Child: 73% (Based on 175 MRR Site Audits)		Medi-Cal Adult: 50% Medi-Cal Child: 68% D-SNP Adult: 50% D-SNP Child: 70%		FSR, PHM	Irisa Mahon (FSR) / Johanna Kithcart (PHM)	Quarterly	QI Steering Committee 5/17/23, 7/19/23, 10/15/23		**Follow up from Q4 2022:** Lack of knowledge and training regarding medical record review standards by site staff and physician. Increase to use of telehealth for episodic visits. Electronic medical record (EMR) systems do not provide a field to document certain criteria and will incur additional cost to PCP sites if implemented. Provider offices still being impacted by COVID.	
	Clinical - Patient Safety	Appropriate Use of Medications - Controlled Substances			Q1: 100% Q2: 100% Q3: 100% Q4: Data available 3/31/2023		Retrospective Drug Utilization Review (RDUR): Controlled Substance Monitoring 90% of providers will be notified via mail of members who meet criteria (4 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 a 1-year period.		Pharm	Ann Khuu (Pharm)/ Andy Han (Pharm)	Quarterly	QOC: 4/25/23, 7/25/23, 10/20/23 4th Qtr. Attached to QI Eval			
	Clinical - Patient Safety	Appropriate Use of Medications - Triple Threat			Q1: 100% Q2: 100% Q3: 100% Q4: Data available 3/31/2023		Retrospective Drug Utilization Review (RDUR): Triple Threat Criteria 90% of providers will be notified via mail of members who had Rx for each of the following drug classes: opioids, skeletal muscle relaxants, and benzodiazepine/hypnotics (sleep aids) in a month for at least 2 of 4 months. Mailing occurs three times a year.		Pharm	Ann Khuu (Pharm)/ Andy Han (Pharm)	Quarterly	QOC: 4/25/23, 7/25/23, 10/20/23 4th Qtr. Attached to QI Eval			
	Clinical - Patient Safety	Potentially Inappropriate Medication (PIM)			Q1: 100% Q2: 100% Q3: 100% Q4: Data available 3/31/2023		Concurrent DUR edits in place for members with Potential medication overutilization		Pharm	Ann Khuu (Pharm)/ Andy Han (Pharm)	Quarterly	QOC: 4/25/23, 7/25/23, 10/20/23 4th Qtr. Attached to QI Eval			
	Clinical	Clinical Practice Guidelines (CPGs)			NA		100% review and approval at least every 2 years/updates as required.		QI	Betsy Samsena (QI)/ Rachel Martinez (QI)	Annual and as needed for updates	P4CC & PQC: April 18			
	Clinical	Preventive Health Guidelines (PHGs)			NA		100% Review and approval at least annually or as needed, distribute as requested and made available online for both providers and members to access.		QI	Betsy Samsena (QI)/ Rachel Martinez (QI)	Annual	P4CC & PQC: July 18			
	Clinical	Proportion of Days Covered (PDC) (Priority 3)	PDC (A)	Quality Rating System (QRS)	**MY 2021 Rates:** LACC: Renin Angiotensin System (RAS) Antagonism: 75.09% Diabetes All Class: 75.63% Statins: 70.56%		LACC: **Renin Angiotensin System (RAS) Antagonism: 76% Diabetes All Class: 76% Statins: 71%**		Pharm, QPM	Ann Khuu (Pharm)/ Andy Han (Pharm)	Annual: By June '22	QOC: September 26 P4CC & P QC: Nov 28			

SERVICE

Category	Performance Measures for Planned Activities for Objective	HEDIS Acronym	Regulatory Agency	2022 Rates	2023 Rates	2023 Goal	Goal Met/Not Met	Department	Responsible Staff/Department	Timeframe for completion	Report to: (Rates are 2023 unless otherwise noted)	Interventions/Updates/Comments	Barriers	Recommend for 2024 Work Plan
Clinical	Medication Adherence for Diabetes Medications	NA	CMS Medicare Stars (Medicare D-SN: Star Weight 3)	Q1: 95% Q2: 90% Q3: 96% Q4: Data available after 2/28/25		D-SNP: 85%		Pharm	Ann Phan (Pharm)/ Andy Han (Pharm)	Annually: Sep '23	MQSC: Nov 7			
Clinical	Medication Adherence for Hypertension (RAS antagonists)	NA	CMS Medicare Stars (Medicare D-SN: Star Weight 3)	Q1: 95% Q2: 95% Q3: 95% Q4: Data available after 2/28/25		D-SNP: 86%		Pharm	Ann Phan (Pharm)/ Andy Han (Pharm)	Annually: Sep '22	MQSC: Nov 7			
Clinical	Medication Adherence for Cholesterol (Statin)	NA	CMS Medicare Stars (Medicare D-SN: Star Weight 3)	Q1: 95% Q2: 95% Q3: 95% Q4: Data available after 2/28/25		D-SNP: 81%		Pharm	Ann Phan (Pharm)/ Andy Han (Pharm)	Annually: Sep '23	MQSC: Nov 7			
Clinical	MTM Program Completion Rate for CMR	NA	CMS Medicare Stars (Medicare D-SN: Star Weight 1)	CMR Completion rate: CMC (2022): Q1: 17% Q2: 45% Q3: 61% Q4: 79%		D-SNP: 89% D-SNP only: MTM program with Navitus CEC for 2022: Comprehensive Medication Review (CMR) - phone intervention by pharmacist.		Pharm	Ann Phan (Pharm)/ Andy Han (Pharm)	Annually: Sep '23	MQSC: Nov 7			
Clinical	CA 6.1 (CAW3) Reduction in emergency departments use for seriously mentally ill and substance use disorder members	NA	CMS	Pending		D-SNP: CAW3: 10% decrease in the performance rate for the measurement year compared to the performance rate for the baseline year (2018)		QI, BH	Betsy Samana (QI)/ Rose Konyan (BH)	Annually	QOC: Nov 28		Follow up from Q4 2022: Lag in data; not informed of member's admission until after following month. High member UTC rate, specifically for high utilizers.	
Clinical	CA 1.6 (CAW3) Percent of members with documented discussions of care goals (For DY2 through DY5)	NA	CMS	Q1 2022: 100% Q2 2022: 100% Q3 2022: 100% Q4 2022: due to Compliance 2/21/23		D-SNP: 100%		EPO, CM	Cagla Ozden (EPO)/ Evelyn Dickerson (EPO)/ Janet Victorio (EPO)/ Lourdes Sapangan (EPO)/ Sivvier Chang (CM)/ Ana Dominguez (CM)	Annually	QOC: Nov 28			
Clinical	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.	NA	CMS	Q1: 95.7% Q2: 97.56% Q3: 96.3% Q4: 91.27%		D-SNP: 90%		Encounters	Saisaa Nadig (Encounters)/ Greg White (Encounters)	Annually	QOC: Nov 28			
Clinical	Special Needs Plan (SNP) Care Management (The percent of eligible Special Needs Plan (SNP) enrollees who transacted a health risk assessment (HRA) during the measurement year.)	NA	CMS Medicare Stars (Medicare CIS: Star Weight 1)	NA		D-SNP: >75%		EPO, CM, Compliance	Cagla Ozden (EPO)/ Sivvier Chang (CM)/ Amanda Asmus (CM)/ Rebecca Okienwa (CBC)	Annually	QOC: Nov 28			
Clinical	Care Plan Completion (Care 3.2) Percent of members with a care plan completed within 90 days of enrollment.		CMS	ICP Completion Rate: Q1: 28% Q2: 28% Q3: 25% Q4: Due to Compliance 2/21/23 Compliance Rate (include completed ICP, Refusal, UTC's): Q1: 65% Q2: 66% Q3: 65% Q4: Due to Compliance 2/21/23 UTC Completion Rate: Q1: 38% Q2: 41% Q3: 40% Q4: Due to Compliance 2/21/23		Meet or Exceed Q1-Q3 2022 CA Average Rates: ICP Compliance Rate - 90% UTC Completion Rate - Reduction of UTC Rate by 5% of CA Average		EPO, CM, Compliance	Cagla Ozden (EPO)/ Evelyn Dickerson (EPO)/ Janet Victorio (EPO)/ Lourdes Sapangan (EPO)/ Sivvier Chang (CM)/ Amanda Asmus (CM)	Quarterly	QOC: Nov 28		Follow up from Q4 2022: Unable to contact rate continues to be high. Lack of members' contact information. Per PPG, the lack of member's engagement was due to redundancy with member outreach from multiple or single teams in a short span of time for the same reason. Members tend not to answer the PP Go calls anymore and if they do, they complain or decline to participate.	
Clinical	Members with ICP Completed (CA 1.5) Percentage of members enrolled for 90 days or longer who had an initial ICP completed as of the end of the reporting period.		CMS	High-Risk Members with Completed ICP Rate: Q1: 66% Q2: 66% Q3: 66% Q4: Due to Compliance 2/21/23 Low-Risk Members with Completed ICP Rate: Q1: 56% Q2: 56% Q3: 56% Q4: Due to Compliance 2/21/23		Meet or Exceed Q1-Q3 2022 CA Average Rates: High - 77% Low - 77%		EPO, CM, Compliance	Cagla Ozden (EPO)/ Evelyn Dickerson (EPO)/ Janet Victorio (EPO)/ Lourdes Sapangan (EPO)/ Sivvier Chang (CM)/ Amanda Asmus (CM)	Quarterly	QOC: Nov 28		Follow up from Q4 2022: Unable to contact rate continues to be high. Lack of members' contact information. Per PPG, the lack of member's engagement was due to redundancy with member outreach from multiple or single teams in a short span of time for the same reason. Members tend not to answer the PP Go calls anymore and if they do, they complain or decline to participate.	
Administrative	Annual Review of Policies & Procedures		DHCS CMC			100% Annual Review of P&Ps	NA	QI	Maria Ozaleas (QI)/ Maria Lubeti (QI)	Each QOC as needed and by specific committee reported to QOC	QOC: Feb 28, April 25, Sept 26, Nov 28			
Administrative	Departmental Oversight Reporting Requirements		DHCS CMC	NA	NA	100% submission of timely delegate oversight reporting for each department	NA	QI, EPO, CBC, A&G, HECLS	Betsy Samana (QI)/ Cagla Ozden (EPO)/ Geoffrey Vitorino (CBC)/ Demetra Chandall (A&G)/ Windy Santer (HECLS)	QOC & MSQC Quarterly	QOC: Feb 28, April 25, Sept 26, Nov 28 MSQC: Feb 14, May 25, Aug 29, Nov 7			
Administrative	QI Program Description & Work Plan		DHCS CMS NCQA	NA	NA	2023 QI Program Description & Work Plan approval	NA	QI	Maria Ozaleas (QI)/ Maria Lubeti (QI)	Annual	QOC: 2/28/23 C & QI 3/16/23			
Administrative	Annual Evaluation of the QI Program		DHCS CMS NCQA	NA	NA	Completion of the 2022 QI Annual Evaluation of the QI Program (e.g., evaluation of resources, committees, activities, and completing the write-up) & approval	NA	QI	Maria Ozaleas (QI)/ Maria Lubeti (QI)	Annual	QOC: 2/28/23 C & QI 3/16/23			

SERVICE													
Category	Performance Measure for Planned Activities for Objective	HEDIS Acronym	Regulatory Agencies	2022 Rates	2023 Rates	2023 Goal	Goal Met/Not Met	Department	Responsible Staff/Department	Timeframe for completion	Reports to: (Rates are 2023 unless otherwise noted)	Interventions/Updates/Comments	Barriers	Recommend for 2024 Work Plan
Administrative	QI Work Plan Updates		DHCS	NA	NA	Review and Update of QI Work Plan	NA	QI	Maria Qamar (QI)/ Maria Luberi (QI)	Biannually/ Final attached to QI eval	QrOC: 7/25/23, 10/26/23			
Administrative	QI Reports to Board		DHCS	NA	NA	Update Board (CB&C) on QI activities	NA	QI, CMO, CM&E	Maria Qamar (QI)/ Maria Luberi (QI)/ Samuar Amin (CMO)/ Karthra Parrish (CM&E)	At least quarterly	C & Qt: 1/19/23, 2/16/23, 3/16/23, 4/20/23, 5/18/23, 6/15/23, 8/17/23, 9/21/23, 10/19/23, 11/16/23			
Administrative	UM Program Documents		DHCS CMS NCQA	NA	NA	2025 Annual UM Program Description & UM Work Plan & 2022 UM Evaluation approval	NA	EPG, UM	Oglia Ozden (EPG)/ Pina Nelson (UM)/ Esther Jando (UM)	Annual	UMC: 12/15/23, 2/16/23			
Administrative	CM Program Documents		DHCS CMS NCQA	NA	NA	2023 Annual CM Program Description & 2022 CM Evaluation approval	NA	EPG, CM	Oglia Ozden (EPG)/ Amanda Asmus (CM)	Annual	UMC: 3/16/23, 12/14/23			

HEDIS

Category	Performance Measure for Planned Activities for Objectives	HEDIS Acronym/ Stratification Required	Regulatory/ Reporting Agencies	MY 2021 Rates	MY 2022 Rates	2023 Goal	Goal Met/Not Met	Department	Responsible Staff/Department	Timeframe for completion	Reports to (Dates are 2023 unless otherwise noted)	Interventions/Updates/Comments	Barriers	Recommend for 2024 Work Plan
Adult Preventive	Colorectal Cancer Screening (Total) (Priority 1) (CMC V11P4P4P and LACC V11P4P4P)	COL (H)	NCQA Accreditation Medicare; DHHC Health Equity and Quality Measure Set (HEQ&HS); LACC Quality Transformation Initiative (QTI); M-CAS (Reportable Only); Medicare Stars (Medicare COL Star Weight 1)	MY 2021 Rates CMC: 60.69% LACC: 46.33%	MY 2022 Rates D-SNP: LACC:	LACC: 61% D-SNP: 63%	D-SNP: LACC:	QI	Johanna Gonzalez (QI)/ Betsy Serrano (QI)	Annual By June'23	QOC September 26 F/OC & F/QC Nov 21		Follow up from Q4 2021: Marketing specialist not being assigned to the COL mailer due to staffing.	
Child & Adolescent Health	Well-Child Visits in the First 30 months of Life - Well-Child Visits in the First 15 Months (Priority 1) (Plan Partner Incentive, Medi-Cal V11P4P4P, Physician P4P, and Direct Network)	W30-A (A)/	DHHC Health Equity and Quality Measure Set (HEQ&HS); M-CAS (MPL); Quality Rating System (QRS)	MY 2021 Rates Medi-Cal: 35.56% LACC: 57.74%	MY 2022 Rates Medi-Cal LACC:	Medi-Cal: 38% LACC: 38%	Medi-Cal LACC:	QI	Laura Gann (QI)/ Betsy Serrano (QI)	Annual By June'23	QOC September 26 F/OC & F/QC Nov 21		Follow up from Q4 2021: Birthday card continues to be on hold.	
Child & Adolescent Health	Well-Child Visits in the First 30 months of Life - Well-Child Visits for Age 15 Months - 30 Months (Priority 1) (Plan Partner Incentive, Medi-Cal V11P4P4P, Physician P4P, and Direct Network)	W30-B (A)/	DHHC Health Equity and Quality Measure Set (HEQ&HS); M-CAS (MPL); Quality Rating System (QRS)	MY 2021 Rates Medi-Cal: 58.47% LACC: 91.11%	MY 2022 Rates Medi-Cal LACC:	Medi-Cal: 62% LACC: 83%	Medi-Cal LACC:	QI	Laura Gann (QI)/ Betsy Serrano (QI)	Annual By June'23	QOC September 26 F/OC & F/QC Nov 21			
Child & Adolescent Health	Child and Adolescent Well-Care Visits - Total (Priority 1) (Plan Partner Incentive, Medi-Cal V11P4P4P, Physician P4P, and Direct Network)	WCV (A)/	Auto Assignment; DHHC Health Equity and Quality Measure Set (HEQ&HS); M-CAS (MPL); Quality Rating System (QRS)	MY 2021 Rates Medi-Cal: 46.89% LACC: 40.59%	MY 2022 Rates Medi-Cal LACC:	Medi-Cal: 48% LACC: 41%	Medi-Cal LACC:	QI	Laura Gann (QI)/ Betsy Serrano (QI)	Annual By June'23	QOC September 26 F/OC & F/QC Nov 21		Follow up from Q4 2021: Birthday card continues to be on hold.	
Child & Adolescent Health	Childhood Immunization- Combo 10 (Priority 1) (Plan Partner Incentive, Medi-Cal V11P4P4P, LACC V11P4P4P, Physician P4P and Direct Network)	CIS-10 (H)/	NCQA Accreditation Medi-Cal; DHHC Health Equity and Quality Measure Set (HEQ&HS); LACC Quality Rating System (QRS) Quality Transformation Initiative (QTI)	MY 2021 Rates Medi-Cal: 35.38% LACC: 34.55%	MY 2022 Rates Medi-Cal LACC:	Medi-Cal: 33% LACC: 60%	Medi-Cal LACC:	QI	Laura Gann (QI)/ Betsy Serrano (QI)	Annual By June'23	QOC September 26 F/OC & F/QC Nov 21			
Child & Adolescent Health	Developmental Screening in the First Three Years of Life (Priority 1) (New M-CAS (MPL) MY 2023)	DEV (A)	M-CAS (MPL)	MY 2021 Rates Medi-Cal: 21.86%	MY 2022 Rates Medi-Cal	H 2021 is the baseline as it was the first year of reporting these measures	N/A	QI, BH	Laura Gann (QI)/ Betsy Serrano (QI)/ Rose Cooper (BH)/ Michael Brodey (BH)	Annual By June'22	QOC September 28 F/OC & F/QC Nov 19		Follow up from Q4 2021: Postcards at 6 delay mailer due to changes in vendor and source statements required mailings	
Child & Adolescent Health	Immunization for Adolescents - Combination 2 (Priority 2) (Plan Partner Incentive, Medi-Cal V11P4P4P, LACC V11P4P4P, Physician P4P and Direct Network)	IMA-2 (H)/	NCQA Accreditation Medi-Cal; DHHC Health Equity and Quality Measure Set (HEQ&HS); M-CAS (MPL); Quality Rating System (QRS)	MY 2021 Rates Medi-Cal: 48.90% LACC: 50.86%	MY 2022 Rates Medi-Cal LACC:	Medi-Cal: 41% LACC: 37%	Medi-Cal LACC:	QI	Laura Gann (QI)/ Betsy Serrano (QI)	Annual By June'23	QOC September 26 F/OC & F/QC Nov 21			
Child & Adolescent Health	Lead Screening in Children (Priority 1) (New M-CAS Measure MY 2021)	LSC (H)	M-CAS (MPL)	MY 2021 Rates Medi-Cal: 52.50%	MY 2022 Rates Medi-Cal	Medi-Cal: 56%	N/A	QI	Laura Gann (QI)/ Betsy Serrano (QI)	Annual By June'23	QOC September 26 F/OC & F/QC Nov 21			
Child & Adolescent Health	Topical Fluoride for Children (Priority 2) (New M-CAS Measure MY 2021)	TFL-CH	M-CAS (MPL)	N/A	MY 2022 Rates Medi-Cal	Baseline	N/A	QI	Laura Gann (QI)/ Betsy Serrano (QI)	Annual By June'23	QOC September 26 F/OC & F/QC Nov 21			
Women's Health	Prenatal Visits (Priority 1) (Plan Partner Incentive, Medi-Cal V11P4P4P, Physician P4P and Direct Network)	PPC (H)/ (Prenatal)	Auto Assignment; NCQA Accreditation Medi-Cal; DHHC Health Equity and Quality Measure Set (HEQ&HS); M-CAS (MPL); Quality Rating System (QRS)	MY 2021 Rates Medi-Cal: 93.16% LACC: 80.06%	MY 2022 Rates Medi-Cal LACC:	Medi-Cal: 91% LACC: 81%	Medi-Cal LACC:	HECLS	Kristin Schlaeri (HECLS)/ Marisela Lajas (HECLS)/ Wendy Sasser (HECLS)	Annual By June'23	QOC September 26 F/OC & F/QC Nov 21			
Women's Health	Postpartum Care (Priority 1) (Plan Partner Incentive, Medi-Cal V11P4P4P, Physician P4P and Direct Network)	PPC (H)/ (Postpartum)	NCQA Accreditation Medi-Cal; DHHC Health Equity and Quality Measure Set (HEQ&HS); M-CAS (MPL); Quality Rating System (QRS)	MY 2021 Rates Medi-Cal: 80.80% LACC: 71.70%	MY 2022 Rates Medi-Cal LACC:	Medi-Cal: 81% LACC: 75%	Medi-Cal LACC:	HECLS	Kristin Schlaeri (HECLS)/ Marisela Lajas (HECLS)/ Wendy Sasser (HECLS)	Annual By June'23	QOC September 26 F/OC & F/QC Nov 21		Follow up from Q4 2021: Reviewing CMT data to verify if there are focused non additional scenarios identify more deliveries for the Healthy Mom program.	
Women's Health	Breast Cancer Screening (Total) (Priority 1) (Plan Partner Incentive, Medi-Cal V11P4P4P, CMC V11P4P4P, LACC V11P4P4P, Physician P4P and Direct Network)	BCS (A)/	NCQA Accreditation Medi-Cal & Medicare; DHHC Health Equity and Quality Measure Set (HEQ&HS); M-CAS (MPL); Quality Rating System (QRS); Medicare Stars (Medicare COL Star Weight 1)	MY 2021 Rates Medi-Cal: 54.98% LACC: 60.61% CMC: 62.97%	MY 2022 Rates Medi-Cal LACC: D-SNP:	Medi-Cal: 58% LACC: 60% D-SNP: 64%	Medi-Cal LACC: D-SNP:	QI	Johanna Gonzalez (QI)/ Betsy Serrano (QI)	Annual By June'23	QOC September 26 F/OC & F/QC Nov 21		Follow up from Q4 2021: Marketing specialist not being assigned to the BCS mailer due to staffing.	
Women's Health	Cervical Cancer Screening (Priority 1) (Plan Partner Incentive, Medi-Cal V11P4P4P, LACC V11P4P4P, Physician P4P and Direct Network)	CCS (H)	NCQA Accreditation: Medi-Cal; DHHC Health Equity and Quality Measure Set (HEQ&HS); M-CAS (MPL); Quality Rating System (QRS)	MY 2021 Rates Medi-Cal: 64.97% LACC: 55.47%	MY 2022 Rates Medi-Cal LACC:	Medi-Cal: 62% LACC: 67%	Medi-Cal LACC:	QI	Johanna Gonzalez (QI)/ Betsy Serrano (QI)	Annual By June'23	QOC September 26 F/OC & F/QC Nov 21		Follow up from Q4 2021: Due to other competing priorities and holiday timing, letter will be launching in January 2023.	

HEDIS

Category	Performance Measure for Planned Activities for Objectives	HEDIS Acronym Tow Diversity Simulation Required	Regulatory/ Reporting Agency	MY 2021 Rates	MY 2022 Rates	2023 Goal	Goal Met/Not Met	Department	Responsible Staff/Department	Timeframe for completion	Reports to (Dates are 2023 unless otherwise noted)	Interventions/Updates/Comments	Barriers	Recommend for 2024 Work Plan
Chronic Conditions	Diabetes: Hemoglobin A1c Control for Patients With Diabetes — HbA1c Control >9% (Priority I) (Plan Partner Incentive, Medi-Cal VIIP+P+P, LACC VIIP+P+P and Direct Network)	HBD (H) A1C Good Control (<8%)	NCQA Accreditation Medi-Cal & Medicare Quality Rating System (QRS) Quality Transformation Initiative (QTI)	MY 2021 Rates Medi-Cal: 58.56% LACC: 57.42% CNC: 63.84%	MY 2022 Rates Medi-Cal: LACC: D-SNP:	Medi-Cal: 58% LACC: 60% D-SNP: 65%	Medi-Cal: LACC: D-SNP:	QI, Pharm	Allison Patel (QI)/ Betsy Serrano (QI)/ Ann Phan (Pharm)/ Andy Han (Pharm)	Annual By June'23	QOC September 26 PICC & FQC Nov 21			
Chronic Conditions	Statin Therapy for Patients with Cardiovascular Disease (CMC - Priority I)	SPC (A)	NCQA Accreditation Medi-Cal & Medicare Medicare Stars (Medicare C16 Star Weight 1)	MY 2021 Rates Medi-Cal: N/A Medicare Total Statin Therapy: 68.28% Total Adherence: 76.29%	MY 2022 Rates Medi-Cal: N/A D-SNP: Total Statin Therapy: Total Adherence:	Medi-Cal: N/A D-SNP: Total Statin Therapy: 82% Total Adherence: 88%	Medi-Cal: N/A D-SNP: Total Statin Therapy: Total Adherence: 88%	Pharm	Ann Phan (Pharm)/ Andy Han (Pharm)	Annual By June'23	QOC September 26 PICC & FQC Nov 21			
Chronic Conditions	Statin Therapy for Patients with Diabetes (CMC - Priority I)	SPD (A)	NCQA Accreditation Medi-Cal & Medicare	MY 2021 Rates Medi-Cal: N/A CNC: Total Statin Therapy: 62.10% Total Adherence: 80% 74.29%	MY 2022 Rates Medi-Cal: N/A D-SNP: Total Statin Therapy: Total Adherence:	Medi-Cal: N/A D-SNP: Received Statin Therapy: 85% Statin Adherence: 77%	Medi-Cal: N/A D-SNP: Received Statin Therapy: Statin Adherence: 88%	Pharm	Ann Phan (Pharm)/ Andy Han (Pharm)	Annual By June'23	QOC September 26 PICC & FQC Nov 21			
Chronic Conditions	Controlling High Blood Pressure (Priority I) (Plan Partner Incentive, Medi-Cal VIIP+P+P, CMC VIIP+P+P, LACC VIIP+P+P, Physician P+P and Direct Network)	CBP (H)	NCQA Accreditation Medi-Cal & Medicare DHCS Health Equity and Quality Measure Set (HEQMS) NCAS (NPL) LACC Quality Rating System (QRS) Quality Transformation Initiative (QTI) MMP Medicare Display Measure Medicare Stars (Medicare C12 Star Weight 1)	MY 2021 Rates Medi-Cal: 61.46% LACC: 39.56% CNC: 61.81%	MY 2022 Rates Medi-Cal: LACC: D-SNP:	Medi-Cal: 62% LACC: D-SNP: 65%	Medi-Cal: LACC: D-SNP:	QI, Pharm, CM	Allison Patel (QI)/ Betsy Serrano (QI)/ Ann Phan (Pharm)/ Andy Han (Pharm)/ Steven Cheng (CM)/ Amanda Arenas (CM)/ Sharona Alzadeh (CM)	Annual By June'23	QOC September 26 PICC & FQC Nov 21		Roll-up from Q4 2021: For BP call team vision, the members originally identified for distribution & close all-source BP call for numerous different reasons (could not be reached, refused care already had seen etc). The eligible/end amount of the intervention... Will have to rethink evaluation design based on this.	
Chronic Conditions	Asthma Medication Ratio (Total) (Priority 2) (New NCAS INFL MY 2023) (Plan Partner Incentive, Medi-Cal VIIP+P+P, Physician P+P and Direct Network)	AMR (A)	NCQA Accreditation Medi-Cal DHCS Health Equity and Quality Measure Set (HEQMS) NCAS (NPL) Quality Rating System (QRS)	MY 2021 Rates Medi-Cal: 66.76% LACC: 75.87%	MY 2022 Rates Medi-Cal: LACC:	Medi-Cal: 72% LACC: 78%	Medi-Cal: LACC:	QI, Pharm	Allison Patel (QI)/ Betsy Serrano (QI)/ Ann Phan (Pharm)/ Andy Han (Pharm)	Annual By June'23	QOC September 26 PICC & FQC Nov 21		Roll-up from Q4 2021: Administrative issue with finding pre-approved members reported back launch date.	
Chronic Conditions	Kidney Health Evaluation for Patients With Diabetes (New Accreditation Measure MY 2022) (D-SNP Priority 2)	KED (A)	NCQA Accreditation: Medi-Cal & Medicare Medicare Stars (Medicare C16 Star Weight 1) Quality Rating System (QRS)	MY 2021 Rates CNC: 95.51%		N/A	N/A	QI, Pharm	Allison Patel (QI)/ Betsy Serrano (QI)/ Ann Phan (Pharm)/ Andy Han (Pharm)	Annual By June'23	QOC September 26 PICC & FQC Nov 21			
Behavioral Health	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing - (Total) (Priority 2)	APM (A)	NCQA Accreditation: Medi-Cal NCAS (Reportable Only)	MY 2021 Rates Medi-Cal: 51.71%	MY 2022 Rates Medi-Cal:	Medi-Cal: 48%	Medi-Cal: Met	QI	Johanna Gonzalez (QI)	Annual By June'23	QOC September 26 PICC & FQC Nov 21		Roll-up from Q4 2021: Team encountered a few barriers such as the build was the data file that accurately depicts providers taking care of members under the measure.	
Behavioral Health	Antidepressant Medication Management (Continuation Phase) (Priority 2) (LACC VIIP)	AMM (A) (Continuation Phase)	NCQA Accreditation: Medi-Cal & Medicare NCAS (Reportable Only) Quality Rating System (QRS)	MY 2021 Rates Medi-Cal: 48.16% LACC: 51.16% CNC: 57.86%	MY 2022 Rates Medi-Cal: LACC: D-SNP:	Medi-Cal: 47% LACC: 55% D-SNP: 65%	Medi-Cal: LACC: D-SNP:	QI, QPH	Johanna Gonzalez (QI)/ Thomas Mendez (QPH)	Annual By June'23	QOC September 26 PICC & FQC Nov 21			
Behavioral Health	Follow-Up for Children Prescribed ADHD Medication - Continuation and Maintenance Phase (Priority 2)	ADD (A) (Continuation and Maintenance Phase)	NCQA Accreditation: Medi-Cal NCAS (Reportable Only)	MY 2021 Rates Medi-Cal: 61.31%	MY 2022 Rates Medi-Cal:	Medi-Cal: 68%	Medi-Cal:	QI, QPH	Johanna Gonzalez (QI)/ Thomas Mendez (QPH)	Annual By June'23	QOC September 26 PICC & FQC Nov 21		Roll-up from 2021: One barrier identified through our team was provider data mapping to capture our current standing of the ADD measure.	
Behavioral Health	Follow-up After Emergency Department Visits for Alcohol and other Drug Abuse or Dependence (30-day Rate only) (Priority 2)	FUA (A)	MMPs Medicare-Medicaid Plans NCAS (NPL)	MY 2021 Rates Medi-Cal: 6.17% CNC: 16.25%	MY 2022 Rates Medi-Cal: D-SNP:	Medi-Cal: 21% CNC: 18%	N/A	QI, BH	Johanna Gonzalez (QI)/ Rose Kopystei (BH)/ Sam Meeda (BH)		QOC September 26 PICC & FQC Nov 21		Roll-up from Q4 2021: Team is continuously working with QPH to identify a cadency where users can receive the FUH Incentive Tracking Log on a monthly basis for the team's sub-programs.	
Behavioral Health	Follow-up After Emergency Department Visits for Mental Illness (30-day Rate only) (Priority 2)	FUM (A)	MMPs Medicare-Medicaid Plans NCAS (NPL)	MY 2021 Rates Medi-Cal: 26.47% CNC: 32.30%	MY 2022 Rates Medi-Cal: D-SNP:	Medi-Cal: 54%	N/A	QI, BH	Johanna Gonzalez (QI)/ Rose Kopystei (BH)/ Sam Meeda (BH)		QOC September 26 PICC & FQC Nov 21		Roll-up from Q4 2021: Data issues. We address issue where all FUM admissions in time to develop team enters to ensure 7 day after care requirements met.	
Behavioral Health	Follow-Up After Hospitalization for Mental Illness (in 30 days) (Priority 3)	FUH 30 (A)	Medicare Display Measure Quality Rating System (QRS)	MY 2021 Rates CNC: 63.43%	MY 2022 Rates D-SNP:	D-SNP: 88%	D-SNP:	QI, QPH	Johanna Gonzalez (QI)/ Thomas Mendez (QPH)	Annual By June'23	QOC September 26 PICC & FQC Nov 21			
Behavioral Health	Diabetes Monitoring for People with Diabetes and Schizophrenia (Priority 3)	SMD		MY 2021 Rates SMD: Medi-Cal: 76.61% CNC: N/A LACC: N/A	MY 2022 Rates SMD: Medi-Cal: CNC: LACC:	Medi-Cal: 78% D-SNP: 78% LACC: 90%	Medi-Cal: LACC: D-SNP:	QI, QPH	Johanna Gonzalez (QI)/ Thomas Mendez (QPH)	Annual By June'23	QOC September 26 PICC & FQC Nov 21			
Behavioral Health	Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications (Priority 3)	SSD (A)	NCQA Accreditation: Medi-Cal NCAS (Reportable Only)	MY 2021 Rates Medi-Cal: 78.90%	MY 2022 Rates Medi-Cal:	Medi-Cal: 78% LACC: 74% CNC: 77%	Medi-Cal:	QI, QPH	Johanna Gonzalez (QI)/ Thomas Mendez (QPH)	Annual By June'23	QOC September 26 PICC & FQC Nov 21		Roll-up from Q4 2021: Members prescribed antipsychotic medication receiving the prescription from psychiatrist from County (carve out). Access these data about members lab work, making follow-up difficult to ensure screening for A1C are scheduled.	

HEDIS

Category	Performance Measure for Planned Activities for Objectives	HEDIS Acronym Race/Ethnicity Stratification Required	Regulatory/ Reporting Agencies	MY 2021 Rates	MY 2022 Rates	2023 Goal	Goal Met/Not Met	Department	Responsible Staff/Department	Timeframe for completion	Reports to (Dates are 2023 unless otherwise noted)	Interventions/Updates/Comments	Barriers	Recommend for 2024 Work Plan
Appropriate Medication Management	Depression Management in Older Women who had a Fracture **(Priority 1)**	DMM (A)	NCQA Accreditation: Medicare / Medicare Stars (Medicare-OSB Star Weight 1)	MY 2021 Rates CMC: 59.54%	MY 2022 Rates D-SNP:	D-SNP: 41%	D-SNP:	Pharm	Ana Phan (Pharm)/ Andy Han (Pharm) Alison Patel (QI)/ Betsy Senters (QI)/	Annual By June'23	QOC September 26 P/QC & P-QC Nov 21			
Inpatient	Plan All Cause Readmission Rates (Non-lower Rates indicate better performance) **(Priority 1)** (Plan Partner Incentive, Medi-Cal MLP-P4P, CMC MLP-P4P, LACC MLP-P4P, Direct Network)	PCR (A)'	NCQA Accreditation: Medi-Cal & Medicare / DHCH Health Equity and Quality Measure Set (HEQMS) / NCAS (Reportable Only) / Quality Rating System (QRS)	MY 2021 O/E Rates Medi-Cal: 0.9657 LACC: 0.9419 CMC: 1.1134	MY 2022 O/E Rates Medi-Cal: LACC: D-SNP:	Medi-Cal : <0.9% (O/E) LACC: <0.4% (O/E) D-SNP: <0.9% (O/E)	Medi-Cal: LACC: D-SNP:	QPM	Arjun Patel (QPM)	Annual By June'23	QOC September 26 P/QC & P-QC Nov 21			
Inpatient	Transitions of Care - All Four Rates **(Priority 1)** (Plan Partner Incentive, CMC MLP-P4P, LACC MLP, Medi-Cal MLP, Physician P4P, Direct Network)	TRC (H)	NCQA Accreditation: Medicare / Medicare Display Measure / Medicare Stars (Medicare DMH 0.0-2.0)	MY 2021 Rates **CMC:** Receipt of Discharge information: 3.89% Patient engagement after inpatient discharge: 81.37% Notification of Inpatient Admission: 3.11% Medication reconciliation post discharge: 39.41%	MY 2022 Rates **D-SNP:** Receipt of Discharge information: Patient engagement after inpatient discharge: Notification of Inpatient Admission: Medication reconciliation post discharge:	**D-SNP:** Receipt of Discharge information: 8% Patient engagement after inpatient discharge: 82% Notification of Inpatient Admission: 11% Medication reconciliation post discharge: 40%	**D-SNP:** Receipt of Discharge Information: Patient engagement after inpatient discharge Notification of Inpatient Admission Medical reconciliation post discharge	QPM	Arjun Patel (QPM)	Annual By June'23	QOC September 26 P/QC & P-QC Nov 21		Follow up from Q4 2022. Provider monitoring and oversight by LACC is a major barrier. Investigating AA1's Admission Risk Tool and H&I platforms to eliminate current TRC processes across the network.	

CAHPS

Category	Performance Measures for Planned Activities for Objectives	Member Experience Surveys by LOB	Regulatory Agencies	2022 Rates	2023 Rates	2023 Goal	Goal Met/Not Met	Department	Responsible Staff/Department	Timeframe for completion	Reports to: (Dates are 2023 unless otherwise noted)	Interventions/Updates/Comments	Barriers	Recommend for 2024 Work Plan
Member Experience ADULT	ADULT - Rating of Health Plan (Medi-Cal Rating of 8+ 9+10) (CMC Rating 9+10)	CAHPS (Medi-Cal & CMC)	NCQA Accreditation: Medi-Cal & Medicare (Medicare C21: Star Weight 4)	Medi-Cal: 72.4% CMC: 66%	Medi-Cal: D-SNP:	Medi-Cal: 73% D-SNP: 90%	Medi-Cal: D-SNP:	QI	Brigitte Bailey (QI)/ Bettsy Santana (QI)	Annually: Sept '23	MQSC: Nov 7		**Follow up from Q4 2022:** Primary barrier to provider education/training is limited up-to-date contact information for provider offices. Additionally, CMEs are not available for the trainings, making them less appealing. Providers may not be motivated to improve CAHPS scores due to a lack of provider-level incentives.	
Member Experience ADULT	ADULT - Rating of Health Care Quality (Medi-Cal Rating of 8+ 9+10) (CMC Rating 9+10) (Plan Partner Incentive, Medi-Cal VIIP+P4P, Direct Network, CMC VIIP+P4P)	CAHPS (Medi-Cal & CMC)	NCQA Accreditation: Medi-Cal & Medicare (Medicare C20: Star Weight 4)	Medi-Cal: 73.93% CMC: 64%	Medi-Cal: D-SNP:	Medi-Cal: 75% D-SNP: 80%	Medi-Cal: D-SNP:	QI	Brigitte Bailey (QI)/ Bettsy Santana (QI)	Annually: Sept '23	MQSC: Nov 7		**Follow up from Q4 2022:** Primary barrier to provider education/training is limited up-to-date contact information for provider offices. Additionally, CMEs are not available for the trainings, making them less appealing. Providers may not be motivated to improve CAHPS scores due to a lack of provider-level incentives.	
Member Experience ADULT	ADULT - Rating of Personal Doctor (Rating of 8+ 9+ 10) (Plan Partner Incentive, Medi-Cal VIIP+P4P, Direct Network)	CAHPS (Medi-Cal & CMC)	NCQA Accreditation: Medi-Cal & Medicare	Medi-Cal: 79.15% CMC: 75%		Medi-Cal: 80% D-SNP: 91%	Medi-Cal: D-SNP:	QI	Brigitte Bailey (QI)/ Bettsy Santana (QI)	Annually: Sept '23	MQSC: Nov 7		**Follow up from Q4 2022:** Primary barrier to provider education/training is limited up-to-date contact information for provider offices. Additionally, CMEs are not available for the trainings, making them less appealing. Providers may not be motivated to improve CAHPS scores due to a lack of provider-level incentives.	
Member Experience ADULT	ADULT - Rating of Specialist Seen Most (Medi-Cal Rating of 8+ 9+10) (CMC Rating 9+10)	CAHPS (Medi-Cal & CMC)	NCQA Accreditation: Medi-Cal & Medicare	Medi-Cal: 82.72% CMC: NA		Medi-Cal: 84% D-SNP: 88%	Medi-Cal: D-SNP:	QI	Brigitte Bailey (QI)/ Bettsy Santana (QI)	Annually: Sept '23	MQSC: Nov 7		**Follow up from Q4 2022:** Primary barrier to provider education/training is limited up-to-date contact information for provider offices. Additionally, CMEs are not available for the trainings, making them less appealing. Providers may not be motivated to improve CAHPS scores due to a lack of provider-level incentives.	
Member Experience ADULT	ADULT - Getting Care Quickly (Usualy + Always) (Plan Partner Incentive, Medi-Cal VIIP+P4P, Direct Network, CMC VIIP+P4P)	CAHPS (Medi-Cal & CMC)	NCQA Accreditation: Medi-Cal & Medicare (Medicare C18: Star Weight 4)	Medi-Cal: 73.49% CMC: 80%		Medi-Cal: 75% D-SNP: 73%	Medi-Cal: D-SNP:	QI	Brigitte Bailey (QI)/ Bettsy Santana (QI)	Annually: Sept '23	MQSC: Nov 22		**Follow up from Q4 2022:** Primary barrier to provider education/training is limited up-to-date contact information for provider offices. Additionally, CMEs are not available for the trainings, making them less appealing. Providers may not be motivated to improve CAHPS scores due to a lack of provider-level incentives.	
Member Experience ADULT	ADULT - Getting Needed Care (Usually/Always) (Plan Partner Incentive, Medi-Cal VIIP+P4P, Direct Network, CMC VIIP+P4P)	CAHPS (Medi-Cal & CMC)	NCQA Accreditation: Medi-Cal & Medicare (Medicare C17: Star Weight 4) DMHC Health Equity and Quality Measure Set (HEQMS)	Medi-Cal: 77.53% CMC: 82%		Medi-Cal: 79% D-SNP: 76%	Medi-Cal: D-SNP: Not Met	QI	Brigitte Bailey (QI)/ Bettsy Santana (QI)	Annually: Sept '23	MQSC: Nov 7		**Follow up from Q4 2022:** Primary barrier to provider education/training is limited up-to-date contact information for provider offices. Additionally, CMEs are not available for the trainings, making them less appealing. Providers may not be motivated to improve CAHPS scores due to a lack of provider-level incentives.	
Member Experience ADULT	ADULT - Coordination of Care (Usually/Always)	CAHPS (Medi-Cal & CMC)	NCQA Accreditation: Medi-Cal & Medicare (Medicare C22: Star Weight 4)	Medi-Cal: 78.44% CMC: 85%		Medi-Cal: 79% D-SNP: 81%	Medi-Cal: D-SNP:	QI	Brigitte Bailey (QI)/ Bettsy Santana (QI)	Annually: Sept '23	MQSC: Nov 7		**Follow up from Q4 2021:** Primary barrier to provider education/training is limited up-to-date contact information for provider offices. Additionally, CMEs are not available for the trainings, making them less appealing. Providers may not be motivated to improve CAHPS scores due to a lack of provider-level incentives.	
Member Experience ADULT	ADULT - Flu Vaccination Ages 18-64 (Medi-Cal vaccinated) (CMC - Annual Flu Vaccine 65 and Older) (CMC VIIP+P4P)	CAHPS (Medi-Cal & CMC)	NCQA Accreditation: Medi-Cal & Medicare (Medicare C03: Star Weight 1)	Medi-Cal: 40.87% CMC: 77%		Medi-Cal: 42% D-SNP: 78%	Medi-Cal: D-SNP:	HECLS	Alvarado (HECLS)/ Wendy Sasser (HECLS)	Annually: Sept '23	MQSC: Nov 7		**Follow up from Q4 2022:** HIM team still testing and addressing the issues with the CAIR registry for flu data. This has been a barrier in determining historical and accurate flu vaccination rates for all LOBs. In addition, timely launch of automated calls was a challenge due to competing timelines with other programs and their call campaigns during similar timeframes. Automated calls launched later than expected.	
Member Experience ADULT	ADULT - Medical Assistance with Tobacco Cessation - Advising Smokers and Tobacco Users to Quit (Medi-Cal: % Yes)	CAHPS (Medi-Cal)	NCQA Accreditation: Medi-Cal	Medi-Cal: 61.54%		Medi-Cal: 63%	Medi-Cal:	HECLS	Jesse Navarro (HECLS)	Annually: Sept '23	MQSC: Nov7		**Follow up from Q4 2021:** Due to delay in approval of tobacco materials, tobacco mailers has been pushed for Q1 of FY 2022-2023	
Enrollee Experience Survey	Rating of Health Plan	QHP EES	Quality Rating System (QRS)	LACC: 73.05%		LACC: 79%	LACC:	QI	Brigitte Bailey (QI)/ Bettsy Santana (QI)	Annually: Sept '23	MQSC: Nov 7		**Follow up from Q4 2022:** Primary barrier to provider education/training is limited up-to-date contact information for provider offices. Additionally, CMEs are not available for the trainings, making them less appealing. Providers may not be motivated to improve CAHPS scores due to a lack of provider-level incentives.	
Enrollee Experience Survey	Rating of Health Care (LACC VIIP+P4P)	QHP EES	Quality Rating System (QRS)	LACC: 77.12%		LACC: 82%	LACC:	QI	Brigitte Bailey (QI)/ Bettsy Santana (QI)	Annually: Sept '23	MQSC: Nov 7		**Follow up from Q4 2022:** Primary barrier to provider education/training is limited up-to-date contact information for provider offices. Additionally, CMEs are not available for the trainings, making them less appealing. Providers may not be motivated to improve CAHPS scores due to a lack of provider-level incentives.	

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CAHPS

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Enrollee Experience Survey	Rating of Personal Doctor	QHP EES	Quality Rating System (QRS)	LACC: 82.61%		LACC: 84%	LACC:	QI	Brigitte Bailey (QI)/ Bettsy Santana (QI)	Annually: Sept '23	MQSC: Nov 7		**Follow up from Q4 2022:** Primary barrier to provider education/training is limited up-to-date contact information for provider offices. Additionally, CMEs are not available for the trainings, making them less appealing. Providers may not be motivated to improve CAHPS scores due to a lack of provider-level incentives.	
Enrollee Experience Survey	Rating of Specialist Seen Most Often (LACC Rating 9+10)	QHP EES	Quality Rating System (QRS)	LACC: 79.00%		LACC: 82%	LACC:	QI	Brigitte Bailey (QI)/ Bettsy Santana (QI)	Annually: Sept '23	MQSC: Nov 7		**Follow up from Q4 2022:** Primary barrier to provider education/training is limited up-to-date contact information for provider offices. Additionally, CMEs are not available for the trainings, making them less appealing. Providers may not be motivated to improve CAHPS scores due to a lack of provider-level incentives.	
Enrollee Experience Survey	ADULT - Flu Vaccination Ages 18-64	QHP EES	Quality Rating System (QRS)	LACC: 47.19%		LACC: 50%	LACC:	QI, HECLS	Brigitte Bailey (QI)/ Susan Alvarado (HECLS)/ Wendy Sasser (HECLS)	Annually: Sept '23	MQSC: Nov 7		**Follow up from Q4 2022:** HIM team still testing and addressing the issues with the CAIR registry for flu data. This has been a barrier in determining historical and accurate flu vaccination rates for all LOBs. In addition, timely launch of automated calls was a challenge due to competing timelines with other programs and their call campaigns during similar timeframes. Automated calls launched later than expected.	
Enrollee Experience Survey	ADULT - Medical Assistance with Tobacco Cessation - Advising Smokers and Tobacco Users to Quit (LACC: Always+Usually)	QHP EES	Quality Rating System (QRS)	NA		LACC: 64%	LACC:	HECLS	Jesse Navarro (HECLS)	Annually: Sept '23	MQSC: Nov 7		**Follow up from Q4 2022:** Due to delay in approval of tobacco materials, tobacco mailers has been pushed for Q1 of FY 2022-2023 distribution.	
	ADULT -Getting Care Quickly (LACC VIIP+P4P)	QHP EES	Quality Rating System (QRS)	LACC: 65.02%		LACC: 63%	LACC:	QI	Brigitte Bailey (QI)/ Bettsy Santana (QI)	Annually: Sept '23	MQSC: Nov 7		**Follow up from Q4 2022:** Primary barrier to provider education/training is limited up-to-date contact information for provider offices. Additionally, CMEs are not available for the trainings, making them less appealing. Providers may not be motivated to improve CAHPS scores due to a lack of provider-level incentives.	
Enrollee Experience Survey	ADULT - Getting Needed Care (LACC VIIP+P4P)	QHP EES	Quality Rating System (QRS)	LACC: 64.26%		LACC: 63%	LACC:	QI	Brigitte Bailey (QI)/ Bettsy Santana (QI)	Annually: Sept '23	MQSC: Nov 7		**Follow up from Q4 2022:** Primary barrier to provider education/training is limited up-to-date contact information for provider offices. Additionally, CMEs are not available for the trainings, making them less appealing. Providers may not be motivated to improve CAHPS scores due to a lack of provider-level incentives.	
Enrollee Experience Survey	ADULT - Access to Information (Plan Information on Costs)	QHP EES	Quality Rating System (QRS)	LACC: 51.75%		LACC: 53%	LACC:	QI	Brigitte Bailey (QI)/ Bettsy Santana (QI)	Annually: Sept '23	MQSC: Nov 7		**Follow up from Q4 2021:** Primary barrier to provider education/training is limited up-to-date contact information for provider offices. Additionally, CMEs are not available for the trainings, making them less appealing. Providers may not be motivated to improve CAHPS scores due to a lack of provider-level incentives.	
Enrollee Experience Survey	ADULT - Care Coordination (Coordination of Members' Health Care Services) (LACC VIIP+P4P)	QHP EES	Quality Rating System (QRS)	LACC: 75.27%		LACC: 77%	LACC:	QI	Brigitte Bailey (QI)/ Bettsy Santana (QI)	Annually: Sept '23	MQSC: Nov 7		**Follow up from Q4 2022:** Primary barrier to provider education/training is limited up-to-date contact information for provider offices. Additionally, CMEs are not available for the trainings, making them less appealing. Providers may not be motivated to improve CAHPS scores due to a lack of provider-level incentives.	
Enrollee Experience Survey	ADULT - Plan Administration (Customer Service)	QHP EES	Quality Rating System (QRS)	72.12%		LACC: 73%	LACC:	QI	Brigitte Bailey (QI)/ Bettsy Santana (QI)	Annually: Sept '23	MQSC: Nov 7		**Follow up from Q4 2022:** Primary barrier to provider education/training is limited up-to-date contact information for provider offices. Additionally, CMEs are not available for the trainings, making them less appealing. Providers may not be motivated to improve CAHPS scores due to a lack of provider-level incentives.	
Member Experience CHILD	CHILD - Rating of Health Plan (Rating of 8+9+10)	CAHPS	NCQA Accreditation: Medi-Cal	Medi-Cal: 87.32%		Medi-Cal: 88%	Medi-Cal:	QI	Brigitte Bailey (QI)/ Bettsy Santana (QI)	Annually: Sept '23	MQSC: Nov 7		**Follow up from Q4 2022:** Primary barrier to provider education/training is limited up-to-date contact information for provider offices. Additionally, CMEs are not available for the trainings, making them less appealing. Providers may not be motivated to improve CAHPS scores due to a lack of provider-level incentives.	
Member Experience CHILD	CHILD - Rating of Health Care (Rating of 8+9+10) (Plan Partner Incentive, Medi-Cal VIIP+P4P, Direct Network)	CAHPS	NCQA Accreditation: Medi-Cal	Medi-Cal: 84.73%		Medi-Cal: 86%	Medi-Cal:	QI	Brigitte Bailey (QI)/ Bettsy Santana (QI)	Annually: Sept '23	MQSC: Nov 7		**Follow up from Q4 2022:** Primary barrier to provider education/training is limited up-to-date contact information for provider offices. Additionally, CMEs are not available for the trainings, making them less appealing. Providers may not be motivated to improve CAHPS scores due to a lack of provider-level incentives.	
Member Experience CHILD	CHILD - Rating of Personal Doctor (Rating of 8+9+10) (Plan Partner Incentive, Medi-Cal VIIP+P4P, Direct Network)	CAHPS	NCQA Accreditation: Medi-Cal	Medi-Cal: 87.55%		Medi-Cal: 89%	Medi-Cal:	QI	Brigitte Bailey (QI)/ Bettsy Santana (QI)	Annually: Sept '23	MQSC: Nov 7		**Follow up from Q4 2022:** Primary barrier to provider education/training is limited up-to-date contact information for provider offices. Additionally, CMEs are not available for the trainings, making them less appealing. Providers may not be motivated to improve CAHPS scores due to a lack of provider-level incentives.	

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CAHPS

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Member Experience CHILD	CHILD - Rating of Specialist Seen Most Often (Rating of 8+9+10)	CAHPS	NCQA Accreditation: Medi-Cal	Medi-Cal: NA		Medi-Cal: 90%	Medi-Cal:	QI	Brigitte Bailey (QI)/ Bettsy Santana (QI)	Annually: Sept '23	MQSC: Nov 7		**Follow up from Q4 2022:** Primary barrier to provider education/training is limited up-to-date contact information for provider offices. Additionally, CMEs are not available for the trainings, making them less appealing. Providers may not be motivated to improve CAHPS scores due to a lack of provider-level incentives.	
Member Experience CHILD	CHILD - Getting Care Quickly (Usually + Always) (Plan Partner Incentive, Medi-Cal VIIP+P4P, Direct Network)	CAHPS	NCQA Accreditation: Medi-Cal	Medi-Cal: 80.29%		Medi-Cal: 81%	Medi-Cal:	QI	Brigitte Bailey (QI)/ Bettsy Santana (QI)	Annually: Sept '23	MQSC: Nov 7		**Follow up from Q4 2022:** Primary barrier to provider education/training is limited up-to-date contact information for provider offices. Additionally, CMEs are not available for the trainings, making them less appealing. Providers may not be motivated to improve CAHPS scores due to a lack of provider-level incentives.	
Member Experience CHILD	CHILD - Getting Needed Care (Usually + Always) (Plan Partner Incentive, Medi-Cal VIIP+P4P, Direct Network)	CAHPS	NCQA Accreditation: Medi-Cal DMHC Health Equity and Quality Measure Set (HEQMS)	Medi-Cal: 82.36%		Medi-Cal: 83%	Medi-Cal:	QI	Brigitte Bailey (QI)/ Bettsy Santana (QI)	Annually: Sept '23	MQSC: Nov 7		**Follow up from Q4 2022:** Primary barrier to provider education/training is limited up-to-date contact information for provider offices. Additionally, CMEs are not available for the trainings, making them less appealing. Providers may not be motivated to improve CAHPS scores due to a lack of provider-level incentives.	
Member Experience CHILD	CHILD - Coordination of Care (Usually + Always)	CAHPS	NCQA Accreditation: Medi-Cal	Medi-Cal: 78.81%		Medi-Cal: 80%	Medi-Cal:	QI	Brigitte Bailey (QI)/ Bettsy Santana (QI)	Annually: Sept '23	MQSC: Nov 7		**Follow up from Q4 2022:** Primary barrier to provider education/training is limited up-to-date contact information for provider offices. Additionally, CMEs are not available for the trainings, making them less appealing. Providers may not be motivated to improve CAHPS scores due to a lack of provider-level incentives.	
D-SNP	Rating of Drug Plan (Rating 9 or 10, out of 10)		CMS (Medicare D@S Star Weight 4)	CMC: 66%		D-SNP: 91%	D-SNP:	Pharm	Andy Han (Pharm)/ Ann Phan (Pharm)	Annually: Sept '23	MQSC: Nov 7			
D-SNP	Getting Needed Drugs (RX) (Usually/Always) (CMC VIIP+P4P)		CMS (Medicare D@S Star Weight 4)	CMC: 93%		D-SNP: 88%	D-SNP:	Pharm	Andy Han (Pharm)/ Ann Phan (Pharm)	Annually: Sept '23	MQSC: Nov 7			
D-SNP	Pneumococcal Vaccination Status for Older Adults	PNU	CAHPS NCQA Accreditation: Medicare	CMC: 60%		D-SNP: 61%	D-SNP:	HECLS, Pharm	Susan Alvarado (HECLS) Andy Han (Pharm) Ann Phan (Pharm)	Annually: Sept '23	QOC: September 26 PICC & PQC: Nov 21			
Health Outcomes Survey	Management of Urinary Incontinence in Older Adults (collected in HOS) (CMC VIIP+P4P)	MUI	CMS	CMC 2021 Rates: 45.11%	D-SNP 2022 Rates:	N/A	N/A	N/A	Thomas Mendez (QPM)/ Linda Carberry (QPM)	Annual: Due June '23	QOC: September 26 PICC & PQC: Nov 21			
Health Outcomes Survey	Physical Activity in Older Adults (collected in HOS) (CMC VIIP+P4P)	PAO	CMS	CMC 2021 Rates: 69.22%	D-SNP 2022 Rates:	N/A	N/A	N/A	Thomas Mendez (QPM)/ Linda Carberry (QPM)	Annual: Due June '23	QOC: September 26 PICC & PQC: Nov 21			
Health Outcomes Survey	Falls Risk Management (collected in (HOS) (CMC VIIP+P4P)	FRM	NCQA Accreditation: Medicare CMS	CMC 2021 Rates: 68.28%	D-SNP 2022 Rates:	N/A	N/A	N/A	Thomas Mendez (QPM)/ Linda Carberry (QPM)	Annual: Due June '23	QOC: September 26 PICC & PQC: Nov 21			

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EQUITABLE HEALTH

Category	Performance Measures for Planned Activities for Objectives	HEDIS Acronym	Regulatory Agencies	2021 Rates	2022 Rates	2022 Goal	Goal Met/ Not Met	Department	Responsible Staff/Department	Timeframe for completion	Reports to: (Dates are 2022 unless otherwise noted)	Interventions/Updates/Comments	Barriers	Recommend for 2024 Work Plan
Equitable Health	Percentage of Black/ African American members receiving timely prenatal care (MCLA: 70%)					3-year goal: Reduce PPC disparities for BAA MCLA members by at least 4% over three years.		HECLS; HET; QI	Marina Acosta, MPH (HE)/ Nirshila Chand (HE)	Annual By FY2022-FY2023 end	QOC: Nov 28			
Equitable Health	Launch first Generating African American Infant and Nurturers' Survival Initiative I (GAAINSI) Initiative by FY2021-FY2022 end					3-year goal: Reduce PPC disparities for BAA MCLA members by at least 4% over three years.		Community Benefits (CB)	Marina Acosta, MPH (HE)/ Nirshila Chand (HE)/ Shavonda Webber Christmas (CB)	Annual By FY2022-FY2023 end	QOC: Nov 28			
Equitable Health	Connect and participate with at least one external collaborative in the Prenatal/Postpartum Care effort					3-year goal: Reduce PPC disparities for BAA MCLA members by at least 4% over three years.		HET; HECLS; PHM	Marina Acosta, MPH (HE)/ Nirshila Chand (HE)	Annual By FY2022-FY2023 end	QOC: Nov 28			
Equitable Health	Pending CC approval: Meet L.A. Care internal COVID vaccination rates					Overall vaccination rate goal for 12+ membership is 85% Black/African Americans member vaccination rate goal is 72% AIAN member vaccination rate goal is 72%		COVID Command Center	Marina Acosta, MPH (HE)/ Nirshila Chand (HE)	Annual By FY2022-FY2023 end	QOC: Nov 28		Follow up from Q4 2022: Vaccination hesitancy remains high in historically disenfranchised and under-invested communities.	

HEDIS	Performance Measures for Planned Activities for Objectives	HEDIS Acronym	Regulatory/ Reporting Agencies	MY 2021 Rates	MY 2022 Rates	2023 Goal	Goal Met/ Not Met	Department	Responsible Staff/Department	Timeframe for completion	Reports to: (Dates are 2023 unless otherwise noted)	Interventions/Updates/Comments	Barriers	Recommend for 2024 Work Plan
Adult Preventive	Colorectal Cancer Screening (Total) (Priority 1) (CMC VHP+P4P and LACC VHP+P4P)	COL (H)	NCQA Accreditation: Medicare LACC: Quality Rating System (QRS) Quality Transformation Initiative (QTI) MCAS (Reportable Only) Medicare Stars (Medicare C02: Star Weight 1)	MY2021 Rates: CMC: 60.69% LACC: 46.23%		D-SNP: 63% LACC: 61%	D-SNP: LACC:	QI	Johanna Gonzalez (QI)/ Bettsy Santana (QI)	Annual By June '23	QOC: September 26 PICC & PQC: Nov 21			
Child & Adolescent Health	Lead Screening in Children (Priority 1) (New MCAS Measure MY 2022)	LSC (H)	MCAS (MPL)	MY2021 Rates: Medi-Cal: 52.50%		Medi-Cal: 56%	Medi-Cal:	QI	Laura Gunn (QI)/ Bettsy Santana (QI)	Annual By June '23	QOC: September 26 PICC & PQC: Nov 21			
Chronic Conditions	Diabetes: Hemoglobin A1c Control for Patients With Diabetes — HbA1c Control <8% (Priority 1) (Plan Partner Incentive, Medi-Cal VHP+P4P, LACC VHP+P4P and Direct Network)	H8D~ (H) A1C Good Control (<8.0%)	NCQA Accreditation: Medi-Cal & Medicare LACC: Quality Rating System (QRS) Quality Transformation Initiative (QTI)	MY2021 Rates: Medi-Cal: 50.38% LACC: 57.42% CMC: 65.84%		Medi-Cal: 50% LACC: 60% D-SNP: 65%	Medi-Cal: LACC: D-SNP:	QI, Pharm	Alison Patey (QI)/ Bettsy Santana (QI)/ Ann Phan (Pharm)/ Andy Han (Pharm)	Annual By June '23	QOC: September 26 PICC & PQC: Nov 21			
Chronic Conditions	Controlling High Blood Pressure (CMC - Priority 1) (Plan Partner Incentive, Medi-Cal VHP+P4P, CMC VHP+P4P, LACC VHP+P4P, Physician P4P and Direct Network)	CBP (H)	NCQA Accreditation: Medi-Cal & Medicare MCAS (MPL) LACC: Quality Rating System (QRS) Quality Transformation Initiative (QTI) MMP QW Medicare Display Measure Medicare Stars (Medicare: DMC16)	MY2021 Rates: Medi-Cal: 61.48% LACC: 58.54% CMC: 61.81%		Medi-Cal: 62% LACC: 62% D-SNP: 67%	Medi-Cal: LACC: D-SNP:	CM	Susan Stone (CM)/ Steven Chang (CM)/ Amanda Asmus (CM)/ Shorena Alexander (CM)	Annual By June '23	QOC: September 26 PICC & PQC: Nov 21			

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