Quality Improvement and Health Equity Program

All Lines of Business

2024

Quality Oversight Committee approval on	***2/27/2024***
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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

In 2024, the Quality Improvement Program was renamed the Quality Improvement and Health Equity Program (QIHEP) to better align and advance performance measures and health equity across all domains of care and service. Unless otherwise noted, QIHE will denote the program as a whole QI (Quality Improvement) and HE (Health Equity) activities will be used for their specific programs.

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

STRATEGIC PRIORITIES (2021-2024)

Strategic Direction 1: Achieve operational excellence by improving 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).
- 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 Eligible 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 Accreditation.
- 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 70,000 by Q2 2024.
- 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 and Health Equity Program (QIHEP) describes the QI and Health Equity program structure as 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 and grouped within the activities described in the accompanying QI work plan. The QIHEP description defines how the organization uses its resources and analytical support to achieve goals and includes how the QIHEP is organized to meet program objectives. These functional areas support the program and its responsibilities and reporting relationships for the QI Department staff, QI Committees, and subcommittees. They are coordinated in the activities described in the accompanying QI and Health Equity work plan.

The following product lines are covered by the QIHEP 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 Eligible Special Needs Plan (D-SNP). The program also supports the integration of Behavioral Health, Substance Use, Managed Long-Term Services and Supports (MLTSS), and CalAIM 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 clinical 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 (broader number of providers), while the directly contracted providers get the opportunity to serve Medi-Cal members in partnership with L.A. Care. Additionally, Primary Care Physicians (PCPs) have the opportunity to participate in practice transformation and quality initiatives, such as engaging in the L.A. Care Transform L.A. program. This is a technical assistance program using 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 low-income individuals and families in California who meet defined eligibility 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 approximately 2.3 million members in collaboration with our Plan Partners: Anthem Blue Cross and Blue Shield Promise.

Current significant Medi-Cal initiatives include the following:

- California Advancing and Innovating Medi-Cal (CalAIM) is a multi-year waiver encompassing broad-based delivery system, program, and payment reform across Medi-Cal. Some initiatives include overhauling the Population Health Management program, Mandatory Managed Care Enrollment of certain populations, and implementation of enhanced care management services, Community Supports (e.g., housing navigation, medically tailored meals etc.), and other medically appropriate and cost-effective services.
- Medi-Cal redetermination – every year, the state must reassess the eligibility of Medi-Cal beneficiaries. Negative actions and redeterminations were placed on hold during the COVID-19 Public Health Emergency (PHE). As the continuous coverage-unwinding period has begun, 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 in collaboration with our community and governmental partners to ensure that members are aware of the process and complete forms on time.
- 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. Over the past couple years, coverage expansions for young and older adults have occurred, and California is moving to provide coverage for all undocumented residents by 2024.
- Effective January 1, 2024, the Department of Health Care Services (DHCS) entered into a direct contract with Kaiser Permanente (Kaiser) as a Medi-Cal managed care plan within certain geographic regions of the State for a five-year contract term, with potential contract extensions. Therefore, L.A. Care's Plan Partner contract with Kaiser ended on December 31, 2023.

L.A. Care Covered™ (On-Exchange-LACC)

Under the Affordable Care Act, L.A. Care Health Plan has proudly participated with Covered California to offer affordable healthcare coverage for residents of Los Angeles County, known as L.A. Care Covered™. This product line was launched on October 1, 2013, focusing on serving diverse and low-income communities in Los Angeles County and enable individuals to stay with

their provider if they transition from Medi-Cal to Covered California or vice versa. L.A. Care was also the first public health plan in California to participate in Covered California. The Affordable Care Act also assists individuals and families in paying 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 in their region is more than 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 of receiving services.

As of mid-November 2023, L.A. Care Covered™ membership was 133,040. The Open Enrollment period for Covered California opens in the fall of each year for coverage the following year. Individuals/families who experience an unexpected life event, such as losing a job, getting married/entering a domestic partnership, having or adopting a child, change household size, etc., may apply for coverage throughout the year during a Special Enrollment period.

L.A. Care's 2024 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 deployment of accountable and integrated primary care models
Patient-centered information, cost transparency, and communication

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

On March 1, 2015, a product line that L.A. Care Health Plan operates entirely 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-November 2023, L.A. Care Covered Direct™ membership was 72.

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-November 2023, PASC-SEIU membership was 48,368.

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

The L.A. Care Medicare Plus (HMO D-SNP) plan is a Medicare Advantage Dual Eligible Special Needs Plan (D-SNP) that provides specialized care to beneficiaries dually eligible for Medicare and Medi-Cal and offers care coordination and wrap-around services. L.A. Care's Medicare Plus plan is an Exclusively Aligned Enrollment (EAE) plan. Under this type of plan, members are enrolled in the L.A. Care D-SNP for Medicare benefits and the L.A. Care Medi-Cal Managed Care Plan (MCP) for Medi-Cal benefits, allowing for better coordination of care and benefit integration using the SNP Model of Care framework as prescribed by the Bipartisan Budget Act (BBA) of 2018. Quality Improvement goals are tailored for our D-SNP population and designed to improve the quality of life and health outcomes of dually eligible beneficiaries.

L.A. Care Medicare Plus Dual Eligible 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 Eligible Special Needs Plan (D-SNP) Plans must monitor and submit program-specific "Part C" reports to CMS and "Core Measures" to the Department of Health Care Services (DHCS) "California-Specific Measures" as required in the contract between CMS and DHCS. Both program specific Part C and Core measures monitor the quality and effectiveness of L.A. Care's Model of Care.

Conceptual Framework

The conceptual framework for the QIHEP aligns with the National Quality Strategy. The National Quality Strategy presents four aims originally specified by the Institute for Healthcare Improvement (IHI) for the health care system, known as the Quadruple Aim. As a partner with the Centers for Medicare & Medicaid Services (CMS) and the state of California for 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 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 individuals' physical and psychosocial well-being 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 Costs - 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 QIHEP is co-led by the QI and Health Equity Departments. Additionally, the Population Health Management (PHM) program is part of the QIHEP Structure. Moving forward, L.A. Care's QI and Health Equity Department maintains and executes a QI and Health Equity annual work plan that reflects ongoing activities throughout the year. The work plan is reviewed and updated quarterly by the appropriate business units. The work plan tracks active interventions and programs using metrics, such as the Health Effectiveness Data Information Set (HEDIS) and program goals to create a Population Health Management Index. These are also used by the Population Health Management program to address members needs through workgroups and the PHM Cross Functional team. The QI and Health Equity Annual Evaluation are used as the foundation of the PHM Annual Impact report. The PHM program facilitates all deliverables to meet 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.

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

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

GOALS AND OBJECTIVES

The L.A. Care Quality Improvement and Health Equity Program, aligned with L.A. Care's mission, strives to **advance the equitable delivery of high-quality care and elevate member and provider experience.** Furthermore, in partnership with our members, community partners, and providers, we strive to make Los Angeles County **a leader in ensuring that everyone has a fair and just opportunity to be as healthy as possible** – i.e., attaining health equity for all. Below are the goals and objectives to improve L.A. Care's quality of health care services and its efforts towards achieving health equity.

Goals – Improve Quality of Care:
Improve health outcomes and ensure that all members receive access to equitable and the high quality of care.

Objectives:

- Develop, monitor, and operationalize a Quality Improvement and Health Equity 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 and Health Equity program and its progress toward influencing network-wide safe clinical practices.
- Maintain L.A. Care quality improvement structure and processes and ensure compliance with provisions of the L.A. Care Quality Improvement and Health Equity 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 and Health Equity Program annually and modify the program as necessary to improve program effectiveness. Identify opportunities for process improvement within L.A. Care and 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 and Health Equity Program.
- Meet healthcare industry standards of practice and adhere to all state and federal laws and regulations.
- Improve the National Committee for Quality Assurance (NCQA) accreditation rating and maintain accreditation status.
- Achieve the NCQA Health Equity Accreditation.
- Improve provider encounter data reporting.
- Improve Star 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 policies and procedures.

Goal – Improve Health Equity:
Improve health equity and reduce health disparities for L.A. Care members and L.A. County residents. Our health equity mission is to support, guide, and inspire staff and providers to provide equitable and accessible health care for all.

Objectives:
- Implement L.A. Care's Health Equity and Disparities Mitigation Plan 2023-2025, including its four (4) Health Equity Zone goals and 16 objectives.
- Implement strengthened, expanded, and/or new health equity activities, including targeted quality improvement and health equity programs, 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.
- Stratify data by race/ethnicity, language, gender identity, sexual orientation and geography for the existence of disparities in clinical areas, member/consumer surveys as well as appeals and grievances, and other functional areas.
- Promote physician involvement in health equity/disparities and activities.
- Conduct focus groups or key informant interviews with cultural or linguistic minority members to determine how to meet their needs.
- Address the social determinants/drivers of health.

Goal – Monitor and Improve Patient Safety:
Promote, monitor, evaluate, and improve equitable quality healthcare services through a collaboration system 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 affecting patient safety from contracted long-term care facilities.
- Identify and report patient safety risks and events.
- Identify, monitor, and address known or potential quality of care issues (PQIs) and 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 affect patient safety.
- Establish standards of medical and behavioral health care (as required by product line) that 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 the safe and effective provision of equitable clinical services.
- 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 issues with risk for or evidence of adverse health outcomes 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 collaboration to engage poor-performing hospitals 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 the overall Rating of the Health Plan on CAHPS surveys and prioritize areas affecting the 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 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, and develop and monitor interventions based on the findings in the key service-related reports. Monitor the results of the interventions.
- Ensure that the provision of healthcare services is accessible and available to meet members' needs.
- Work with provider groups to improve overall member 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. Educate and empower 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, ultimately resulting in improved member health status.

Objectives:
- Provide culturally appropriate health education services via multiple modalities, including group and individual appointments at community locations, telephonic individual counseling, and online programing.
- Provide easily accessible, culturally appropriate, low health literacy education materials in Los Angeles County threshold languages.
- Implement health education programs and services addressing prenatal/postpartum care, flu, asthma, diabetes, medical nutrition therapy, and tobacco cessation to complement QI and health equity 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 during member visits and refer to/document the delivery of health education services in the 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, creed, ancestry, national origin, ethnic group identification, age, health status, mental disability, physical disability**,** medical condition, genetic information, language, marital status, gender, gender identity, or sexual orientation, or identification with any other persons or groups defined in Penal Code 422.56, and that all covered services are provided in a culturally and linguistically appropriate manner by qualified, competent practitioners and providers committed to L.A. Care's mission.

Objectives:
- Assess the cultural, ethnic, and linguistic needs of members to reduce disparities. Provide education on language assistance requirements and cultural competency to assist providers in delivering culturally and linguistically appropriate care.
- Ensure the availability and accessibility of cultural and linguistic services such as 24/7 interpreting services, including American Sign Language (ASL), as well as the 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 the Population Health Management Model into policies, procedures, and workflows.
- Provide care management for members with complex healthcare 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.
- Coordinate services between providers and health settings during care transitions.
- Support members in resolving their individual barriers to physical and mental wellness and psychosocial well-being.
- Educate members on the management of chronic disease to support self-management and improve health literacy.

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 member cultural/linguistic needs. 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 the contracted network through facility site reviews, medical record reviews, and HEDIS scores.

Objectives:

- Establish and maintain policies, procedures, criteria, and standards for the credentialing, recredentialing, and ongoing monitoring of plan practitioners and organizational providers.
- Improve and maintain network adequacy to meet the needs of underserved member populations.
- Educate practitioners on 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 using health-related indicators, member satisfaction surveys, provider satisfaction surveys, access and availability surveys, facility site reviews, medical record audits, and analysis of administrative data (e.g., grievance and appeals data).
- Incorporate NCQA Network Management and Health Equity Standards into policies and procedures, and workflows involving Access and Availability of providers and services.
- Collaborate with other key external stakeholders to assess hospital quality and performance 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/PPGs and practitioners about their performance and network-wide performance.
- Objectively evaluate professional practices and performance on a proactive, scheduled, 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 healthcare providers.

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 (QI) 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 they related to behavioral health.
- Review and approve any changes in the 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 medication management.
- Review behavioral health provider survey results for access and availability.
- Monitor and take action to improve continuity of care and coordination.
- Identify opportunities for care coordination between contracted behavioral health providers and physical health providers.
- Monitor written policies and procedures to ensure appropriate QI functions, access and availability of practitioners, and reflect current standards of medical practice.

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 and Health Equity Program.

Objectives:
- Monitor L.A. Care and network compliance with the contractual and regulatory requirements of appropriate state and federal agencies and other professionally recognized standards.
- Maintain grievance and appeal procedures and mechanisms and ensure that members can resolve problems or perceived problems relating to service, access, or other quality of care issues.

- Establish, maintain, and enforce confidentiality policies and procedures for protecting confidential member, practitioner, and provider information per applicable state and federal regulations.
- Protect member' identifiable health information by ensuring members' protected health information (PHI) is released only 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, 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 and 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 comorbidities, demographics, social factors, culture and language, and community resources.
    - Identifying a subset of the total population designated as L.A. Care's most vulnerable.

- Correlating critical demographic characteristics with optimal clinical practices and requirements.
- Member and provider feedback (direct interactions, call center notes and surveys).
- Stratifying member risk levels using health care utilization and/or Health Risk Assessments to determine the appropriate level of care team engagement.
- Establishing key relationships with community-based partners that provide a broad range of needed resources and services to vulnerable D-SNP enrollees.

- Care Coordination and Care Management
  - Coordination of covered Medicare and Medi-Cal benefits and services creating a seamless member care experience.
  - Establishing accurate member risk, stratification, and assessment of needs through Health Risk Assessments.
  - Developing a comprehensive and goal-oriented, member-specific plan of care
  - Facilitating meetings and communication across the Interdisciplinary Care Team (ICT).
  - Educating and supporting members and caregivers to manage complex health, pharmacy, and behavioral health issues.
  - Specifically identifying caregiver adequacy, strain, and needed support.
  - Coordinating services between providers and healthcare settings during transitions of care.
  - Establishing Face-to-Face encounters through the care delivery continuum.
  - Addressing any enhanced care management needs.
  - Detecting and continued evaluation and treatment of dementia-related illnesses.
  - Identifying the need for end-of-life care through palliative care.

- Specialized Provider Network
  - Evidencing network use of accepted clinical practice guidelines.
  - Evidencing network expertise and compliance with all required plan, federal and state requirements.
  - Adequate access, availability, and adequacy of provider network reflective of the current population.
  - Rolling out Pay-for-performance arrangements to improve member experience and health outcomes.

- Quality Improvement
  - Establishment of a program specific Model of Care Steering Committee to assess the performance and quality of D-SNP member care delivery.
  - Utilization of the 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.
  - Establishment of 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.

- Proactive assessment of all state-required clinical programs, access to those programs, and the overall impact on member health outcomes

AUTHORITY AND ACCOUNTABILITY

The Board of Governors (Board) has ultimate accountability for L.A. Care's Quality Improvement and Health Equity Program. The Board approves the QI and Health Equity Program Description. L.A. Care Health Plan's Board consists of thirteen stakeholders. As a public entity, all meetings of the Board and its subcommittees are subject to the 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 Physicians (L.A. County Medical Association). The Board nominates one additional member with healthcare expertise. The Los Angeles County Board of Supervisors appoints all Board members.

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

The Committee has final approval of the annual QI and Health Equity Program Description, QI and Health Equity Work Plan, and the Quality Improvement and Health Equity Annual Evaluation. The Committee monitors all quality activities and reports its findings to the Board. The Chief Compliance Officer, Chief Medical Officer, Chief Health Equity Officer, and designated Quality leaders provide regular reports to the Committee from the Quality Oversight Committee or QIHEC. 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 materials are posted publicly 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

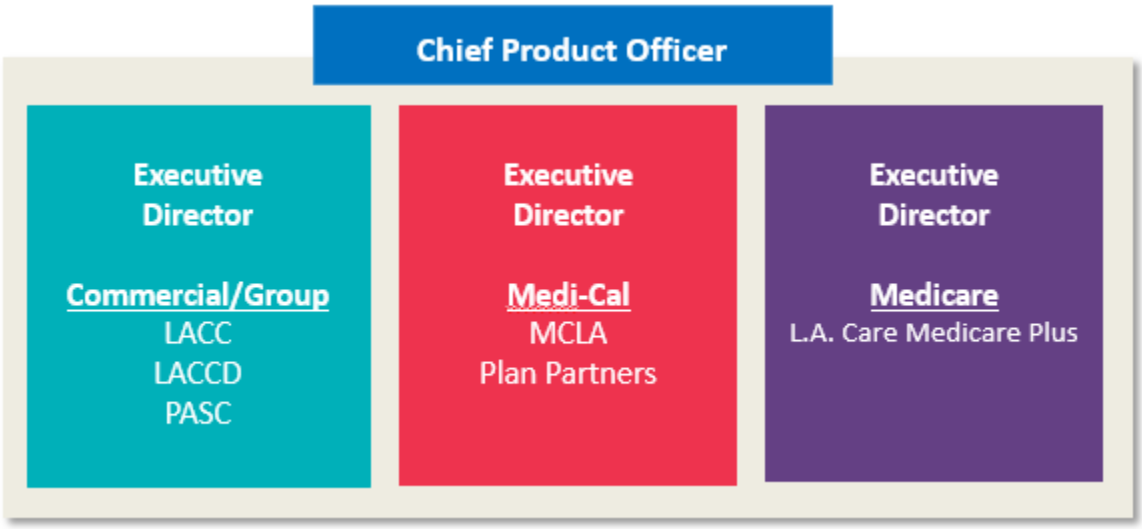
The Chief Operating Officer (COO) is a senior executive management team member and reports directly to the Chief Executive Officer (CEO). The COO is responsible for the overall operational and administrative performance of enterprise functions. This position has an organizational-wide responsibility 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 and 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, services, 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 Eligible 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 ensure product integrity, drive for financial sustainability, and deliver service excellence.

Executive Director, Commercial Products

The Executive Director, Commercial Products (L.A. Care Covered, PASC-SEIU) will take specific responsibility for delivering top and bottom line growth and outstanding compliance and quality score results for a population segment product of the L.A. Care Commercial portfolio. The position is responsible for strategically evaluating, planning and leading complex business initiatives that support the strategic goals of the product strategy and align with enterprise strategy.

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. The 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 AND HEALTH EQUITY PROGRAM 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 currently 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, has the ultimate responsibility for the QI and Health Equity Program, and assigns authority for aspects of the program to the Quality Medical Director.

- Ensures that qualified medical personnel, unhindered by fiscal or administrative management, render medical decisions.
- 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.

Chief Health Equity Officer

The 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 collaborates 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 the 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 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. The 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 (C&Q) Committee 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 ensures 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 Executive

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

Senior Quality, Population Health, and Informatics Executive

The Senior Quality, Population Health, and Informatics Executive works collaboratively with the Chief Medical Officer (CMO) and is a key position on the Health Services team as chief executive of the Quality Improvement Department. Under the Quality Improvement umbrella are quality performance management, Healthcare Effectiveness Data and Information Set (HEDIS), clinical initiatives, disease management, Quality Improvement, health education/culture/and linguistic services, population health, pay for performance initiatives/value-based payment programs, facility site review, accreditation and oversight, quality regulations and standards, and regulatory readiness. The position works across departments and functions to implement strategy for quality improvement and population health management within the health plan, in collaboration with the administrative and clinical leaders of the organization. The position establishes improvement activities, including methods to track implementation of action plans following site surveys and critical event reviews. Leads and is responsible for the planning and implementation of clinical

information systems (CIS) used in the organization. Assists in developing the vision and plan for the adoption of new digital solutions and analytics for clinical process improvement. Reports directly to L.A. Care's Chief Medical Officer. May lead Oversight Committees, Data Governance Committees, Clinical Advisory Groups, and serve as liaison to various departments in bridging best practices with CIS solutions.

Senior Medical Director, Medical Management

The Senior Medical Director, Medical Management is a key medical leadership role responsible for providing and overseeing the delivery and quality assurance of traditional medical management services and functions. Leading and working with a multi-disciplinary team executes L.A. Care Health Services' Medical Management programs and strategic vision and ensures that both the administrative and clinical functions related to medical management are performed in a clinically appropriate, evidence-based, and compliant manner. These functions consist of but are not limited to utilization management, appeals and grievances, provider disputes, care management, long-term care services, program design, and regulatory reporting, along with oversight, support, and relationship management within both our direct network, delegated medical groups and provider network. The Senior Medical Director will develop a common clinical framework on how the clinical staff conceptualizes and defines care and disease state management to drive consistency and accuracy in making all medical management decisions.

Senior Medical Director, Community Health

The Senior Medical Director, Community Health, essential function is to fulfill L.A. Care's vision and mission to support the L.A. County safety net. This Senior Medical Director has overall responsibility for the planning and execution of strategies to improve health in the community for the most vulnerable populations in LA County. The role will be responsible for directing the work of the Safety Net Initiatives strategic project portfolio, including Behavioral Health, Social Services, and Community Supports. Community Supports is part of a broader set of programs that includes housing transition navigation services, housing tenancy and sustaining services, medically tailored meals, recuperative meals, housing deposits, sobering centers, personal care services, and respite services amongst others. This position provides operational and business leadership in partnership with a senior medical director. The Senior Medical Director shall ensure that L.A. Care develops and maintains critical strategic partnerships with local safety net health care and social service care providers, to improve L.A. County's delivery system to better serve vulnerable members. The individual will play a critical role in advising the L.A. Care leadership team on policy, programmatic, and operational issues affecting Los Angeles safety net providers. The position will report to the Chief Medical Officer (CMO) with matrix responsibilities to the Chief Operating Officer (COO), Chief Financial Officer (CFO), and Product Executives.

Medical Director, Quality

The Medical Director, Quality reports to the Senior Quality, Population Health and Informatics Executive and is a key position on the Health Services team. This position will implement a strategy for the quality improvement functions within the health plan in collaboration with the organization's administrative and clinical leaders. 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.

Medical Director, CalAIM

The California Advancing and Innovating Medi-Cal (CalAIM) is a new statewide Centers for Medicare and Medicaid Services (CMS) waiver that seeks to expand care management support and community-based social services for vulnerable and qualified Medi-Cal beneficiaries in the community setting. The CalAIM waiver program specifically seeks to support those who are high utilizers of the health system, are homeless, have behavioral health, substance use service and/or complex medical needs. In the future, we are expected to support those who are discharged from the correctional systems. The CalAIM Medical Director will assume a key medical leadership role in the organization to help with the programmatic development as well as ensuring that the programs align with operational systems and tools while also performing utilization reviews of cases.

This position reports to the Senior Medical Director, Community Health. This position works closely with our CalAIM team as well as with the Behavioral Health, Care Management, Compliance, Provider Network, Social Services, Utilization Management, and many other internal L.A. Care Departments. This Medical Director is responsible for supporting the development and implementation of clinical protocols and policies and procedures and ensures that they are aligned with the regulatory and contractual requirements as well as ensuring that it aligns with our internal core systems, workflows, and processes. This job also entails a fair bit of network development and relationship building with the community-based social services, as well as supporting our oversight team when needed. Additionally, the Medical Director will also be critical to the collaborative work and education of delegated medical groups and Plan Partners (Anthem Blue Cross and Blue Shield Promise). It will ultimately help to cascade the CalAIM referral process and eligibility criteria information down to our various provider networks.

Clinical Operations Executive

The Clinical Operations Executive (COE) of L.A. Care Health Plan will be a senior leader focused on streamlining operations to improve clinical outcomes for its members. This individual will report directly to the Chief Operating Officer (COO) and be responsible for operational, clinical and administrative management and implementation of these functions in L.A. Care. This position will oversee the planning, organization, direction, staffing and development of L.A. Care's Utilization Management, Care Management, Managed Long Term Supportive Services and Clinical Assurance functions. Additionally, the COE will work closely with the Chief Medical Officer (CMO), receiving non-clinical operational functional guidance to ensure end-to-end operational integration as well as the Deputy CMO and Deputy COO. The COE will ensure regulatory compliance, oversight of Plan Partners' related operations, oversight of Participating Physician Group's (PPG) related delegated functions, operations for direct lines of business and/or managed service agreement functions, and interfacing with external agencies including local governing bodies, Plan Partners and other external organizations.

QI AND HEALTH EQUITY PROGRAM RESOURCES

The Senior Director Quality Improvement/Accreditation and the Senior Manager Clinical Initiatives have responsibility for implementation of the Quality Improvement and Health Equity Program and its day-to-day activities. The Quality Improvement (QI) Department has multidisciplinary staff to address all 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 other departments, such as, but not limited to, Health Equity, Utilization Management, Provider Network Management, Customer Solutions Center, Credentialing, Pharmacy and Formulary, 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, 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 that are responsible for planning, organization, direction, staffing, and development, 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.

Senior Director, Stars Excellence

The Senior Director, Stars Excellence is responsible for the 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 Affordable 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 remediation.

The scope of oversight includes developing analytic and decision support systems to monitor progress and drive HEDIS/CAHPS/Stars initiatives to improve the quality of care and system operations. The Senior Director also serves as a 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, 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 primary focus on setting and executing Care Management services. The Senior Director, CM, will work with the CM Medical Directors and Director, Care Management and Director of Enhanced 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 providing subject matter expertise in support of the oversight, outreach, and training of 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, the 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, such as 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. The Senior Director develops and recommends strategic compliance initiatives for L.A. Care, accountable to continuously streamline and improve the overall effectiveness of the department.

Senior Director, Managed Long- Term Services and Supports

The Senior Director, Managed Long Term Services and Supports (MLTSS) is responsible for the delivery of MLTSS and related services to L.A. Care members with the main primary focus of setting and executing numerous programs, in close collaboration with the Deputy CMO, Medical Directors, the Clinical Operations Executive and other senior leaders. The Senior Director, MLTSS program includes: 1) In Home Supportive Services; 2) Community Based Adult Services (CBAS); 3) Long Term Care; 4) Multipurpose Senior Services Program; 5) supplemental services including but not limited to Care Plan Options and CalAim Community Supports; 6) Palliative Care Program; 7) extended skilled stays at skilled nursing facilities, as well as 8) managing the services with the skilled nursing care facility physician and team (SNFist) for our institutionalized long term care members; and 9) assisting with the transition of palliative care members from the hospital to community-based programs. The Senior Director is directly responsible for the strategic vision, operational assessment, planning, organization, direction, staffing and development of L.A. Care's MLTSS unit functions including but not limited to all aspects of the interdisciplinary care team functions including Utilization Review, Care Management, Care Coordination, Care Transition, Social Work and member outreach and engagement in the plan of care. The Senior Director collaborates with providers to ensure member access and quality of care. The Senior Director's responsibilities includes both state and federal regulatory compliance, accreditation compliance, oversight of Plan Partners and Delegated Provider Groups operations related to MLTSS, oversight of MLTSS vendor's related delegated functions, operations for direct lines of business and/or management services agreement functions and interfacing with external agencies including Local Initiatives, Plan Partners and external organizations.

Director, Provider Quality

The Director, Provider Quality is responsible for the direction, implementation,, and oversight of the Peer Review and Provider Quality Review (PQR) program for Potential Quality of Care Issues (PQI). The Director is primarily responsible for leading the strategic and operational efforts for conducting oversight of Plan Partner andspecialty health plan PQR-related operations, PQI operations for direct lines of business (LOB) and/interfacing with external agencies, including other Local Initiatives, Plan Partners, Specialty Health Plan, and Community-Based Organizations to improve provider quality and ensure that the PQR programs align with industry standards. The Director is responsible for reporting to QI and L.A. Care Leadership and to the Compliance and Quality Committee of the Board by evidencingregulatory compliance of L.A. Care’s PQR program. The Director is further responsible for ensuring all functions are operating in accordance with the organization's mission, values, and strategic goals and are provided in a manner that is responsive and sensitive to the needs of L.A. Care's culturally diverse membership.

Director, 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 primary focus on setting and executing complex 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 providing 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, Population Health Informatics provides strategic guidance and decision support to the organization in the areas of clinical health outcomes, healthcare utilization, 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 programing. The Director has administrative and decision-making responsibilities for Health Information Management and is responsible for managing the analysis of all core healthcare-related data as well as providing expertise in the development of clinical technical specifications for prototype reporting.

Director, Population Health Management

The Director, Population Health Management (PHM) sets the PHM strategy that focuses on the "whole person" and the member's entire care journey, and intervene with the highest-risk members. The role is responsible for leading the operational efforts for the organization in streamlining initiatives aimed at improving clinical health outcomes, health care utilization, cost effectiveness, and quality care. The role's responsibilities include leading strategic analytics, evaluation design, clinical and economic evaluation, optimizing programing, ensuring that PHM emphasizes the Quadruple Aim, addressing health at all points on the continuum of care with targeted interventions for a defined population, and addressing disparities through cost-effective and tailored health solutions.

Director, Quality Performance Informatics

The Director, 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 HEDIS and CAHPS processes by managing a process management plan, setting timelines, and overseeing the activities required for completing the HEDIS cycle, including activities related to external NCQA HEDIS audit, quality control, project completion, and data submission.

Director, Clinical Pharmacy

The Director, 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 spending, and accountability for: strategic planning and leadership, regulatory compliance for all lines of business, and management of all Clinical Pharmacy related services and costs.

Director, Pharmacy Compliance

The Director, 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, and reviews and ensuring that the privacy and confidentiality of information, ensuring that it is appropriately safeguarded. The position is responsible for ensuring that all regulatory non-

compliant findings are reported and resolved and that corrective actions are implemented in a timely manner.

Director, Behavioral Health

The Director, Behavioral Health serves on the Behavioral Health Management Team and reports to the Senior Medical Director, Community 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, Cultural and Linguistic Services is responsible for the overall direction and management of the Health Education, Cultural and Linguistic Services department. The HECLS Director ensures L.A. Care's compliance with cultural and linguistic and health education regulatory requirements, and serves as the primary liaison with regulatory agencies on HECLS issues. The position ensures the operationalization of the wellness and disease prevention programs, health education services and resources for members. This includes oversight and management of Health in Motion programming, nurse advice line, diabetes and nutrition programs, maternal programs, materials and wellness platform. The HECLS Director is also responsible for building relationships and fostering collaborative partnerships with external stakeholders as well as internal L.A. Care business units including Care Management, Quality Improvement, Provider Network Management, Facility Site Review, Pharmacy, Sales & Marketing, Community Outreach & Engagement, Customer Solution Center, and the Community Resource Centers.

Director, Provider Contracts & Relationship Management

The Director, 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 effectively and appropriately in a timely manner, thereby ensuring the provision of covered services to L.A. Care's diverse membership throughout all product offerings.

Director, Housing Initiatives

The Director, Housing Initiatives, is responsible to lead and direct the department, which includes oversight of the Plan's programs to address housing and homelessness. This position provides direction and guidance to staff for the development, planning, and execution of strategic initiatives to support safety net health care delivery system transformation, and improved health outcomes for vulnerable populations. This position will be responsible for building relationships and fostering collaborative partnerships with external public and nonprofit stakeholders including: L.A. County Department of Health Care Services (DHS), Department of Mental Health (DMH), Department of Public Health (DPH), community clinics, homeless service providers, and criminal

justice reentry providers. The Director will interface with state and regulatory agencies to develop mutually-beneficial approaches to develop and implement health system reform efforts. This position will work closely with L.A. Care Chief Operating Officer (COO), Chief Medical Officer (CMO), and leadership to align new programs and initiatives with L.A. Care strategic priorities and achieve the triple aim.

Director, Community Health

The Director, Community Health is a key leader on the Community Health Team, reporting to the Senior Director of Community Health. The objective of Community Health at L.A. Care is to deploy a best-in-class, value-based, economically sustainable program that effectively delivers a comprehensive, coordinated suite of services to address social determinants of health and behavioral health needs for all L.A. Care's 2.7 million members. The Director of Community Health will lead the development and operations of L.A. Care's Community Health platform--the processes, teams, and technology infrastructure upon which all L.A. Care's Community Health initiatives run. The Director of Community Health will also play a key role in developing L.A. Care's value-based strategy for the deployment and sustainment of Community Health services within the context of the broader managed Medi-Cal program.

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. This includes 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 the accuracy of practitioner data in internal databases and directories.

Director, Medi-Cal Plan Partner Administration

The Director, 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 affect membership growth, cost containment, operational excellence, and compliance/risk.

Director, Medi-Cal Product Management

The Director, Medi-Cal Product Management provides leadership support and drives toward excelling in the 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 affecting 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's Strategic Initiatives.

Director, Medicare Strategy and Product Development

The Director, Medicare Strategy and Product Development provides leadership and drives the end-to-end lifecycle for the Medicare (CMC, D-SNP, etc.) product lines. 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 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.

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. This individual ensures 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 is a key leader in designing, and developing and ongoing oversight of The Social Work Department for L.A. Care as part of the Clinical Member Services segment of Health Services. The Director of Social Services is responsible for several initiatives and capacity building efforts to address the Social Determinants of Health needs of our members. This position collaborates closely with team leadership and other internal departments to support business strategies through an integrated portfolio of internal and external client facing projects/initiatives and contributes to the development of larger enterprise client facing programs/products.

Director, Department of Health Services Managed Care Support Services

The Director, Department of Health Services Managed Care Support Services is responsible for leading and providing oversight of the Los Angeles County Department of Health Service Managed Care Support Services (DHS MCSS) Unit and the administration of the DHS Quality Improvement Program. DHS is the Los Angeles County owned and operated safety health system that includes 4 hospitals and over 20+ community clinics along with academic affiliation with UCLA and USC. 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) overseeing 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, 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.

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 the identification of non-compliant provider sites and the 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 the following:

- 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 they relate 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 determining 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 for 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 may be 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, the action taken, and the follow-up required (if any). Draft minutes of prior meetings are reviewed and approved at the next scheduled meeting.

PPG/Plan Partner Collaboration

L.A. Care's Quality Improvement department regularly meets with high-volume PPGs, Plan Partners and the Department of Health Services (DHS). The newly formed STARS team began meeting with some of the high-volume Medicare PPGs in 2022. 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), quality of care findings, and the DHCS Managed Care Accountability Set (MCAS). Agenda items include prioritization of measures, barrier analysis, interventions to improve performance, data capture/transmission, incentive program performance, and L.A. Care's Provider Opportunity Reports. The QI team aims to hold quarterly meetings, but for highly engaged PPGs, a bi-monthly cadence of meetings occurs. It meets with other medical groups 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. The QI team also collaborates with external organizations and subject matter experts, such as WIC, to broaden the scope of webinar topics. Webinars aim to disseminate detailed information on topics aligned with the organization's strategic goals. In 2023, over 20 webinars were held on topics ranging from cervical cancer screenings to behavioral health measures, and reducing firearm injuries. In addition to the expanded webinars, the L.A. Care QI Department actively engages with the PPGs using the provider portal to communicate actionable care and service gaps.

BEHAVIORAL HEALTH COLLABORATION

Behavioral Health Services are inclusive of both mental health and substance use disorder programs. Behavioral Health Services are available for L.A. Care members across all lines of

business. The system of care where a member accesses treatment is based on the severity of the member symptoms and the member line of business. For Medi-Cal recipients, including both MCLA and L.A. Care Medicare Plus (Dual Eligible 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-SNP lines of business. Substance Use Disorder treatment for members covered under PASC and Covered California is covered through L.A. Care's Managed Behavioral Health Organization (MBHO). Mild to moderate mental health services are the responsibility of L.A. Care and managed by L.A. Care's contracted MBHO for all lines of business. The Behavioral Health Department works closely with various departments across the organization and facilitates coordination of care with DMH and DPH-SAPC, supports members and providers when accessing services through MBHO's provider network, and co-manages members requiring complex case management services within L.A. Care. The Behavioral Health Department has a dedicated phone line that is answered during business hours to provide support and address consultation needs to not only internal departments within L.A. Care but also external stakeholders such as PPGs/IPAs, hospitals, and other health care providers who have questions about how members can access Behavioral Health services.

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

L.A. Care has a directly contracted network to provide members with Behavioral Health Treatment services. The Behavioral Health Treatment (BHT) team oversees the Care Coordination/Management and Utilization Management components 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.

COMMITTEE STRUCTURE

Board of Governors Compliance and Quality Committee
Role and Reporting Relationships: The Chairperson of the Board appoints Members of the Compliance & Quality (C&Q) Committee. The C&Q Committee is a Committee of L.A. Care Board of Governors. The committee oversees quality activities, maintains written minutes of all its meetings, and regularly reports 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 Chairperson of the Board shall determine the number. Committee members elect a Committee Chairperson annually. Committee members should be independent of management and free of any relationship that in the opinion of the Board, would interfere with the exercise of independent judgment as a Committee member. A quorum is established in accordance with L.A. Care's bylaws. L.A. Care's Chief Medical Officer, Chief Compliance Officer, or designee reports to the Committee as often as needed. Draft agendas are posted publicly 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), health equity and utilization management (UM) activities. The Committee approves the QIHE 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, Chief Health Equity 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, who 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 policies 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 and Health Equity Program is a quarterly ECAC agenda item to provide the opportunity for members to hear about quality improvement and health equity 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. The BoG appoints all RCAC members.

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 RCAC members are recommended by ECAC and approved by the BoG in accordance with applicable law, regulations, and the organization's 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 ethnicity, culture, linguistics, 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 an 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 are attained.

Advisory committees elect two volunteer leaders: a Chairperson and 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 members of L.A. Care's BoG: a consumer member and 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 and Health Equity 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 develop programmatic responses;
5. Determine and prioritize health education and outreach programs and

6. Collaboratively address community health concerns.
7. Gather information about issues and concerns pertinent to the health and wellbeing of L.A. Care members in the region.

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 attends.

Membership includes, but is not limited to the Chief Compliance Officer (chair), and up to eight voting members. A quorum is established when the majority of its members attend. In addition to the Chief Compliance Officer, the following positions are also ICC members: 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 to the ICC.

Quality Committees

L.A. Care's quality committees oversee various functions of the QI and Health Equity program (see attachment 3) in QI committees and subcommittees. The activities of the quality committees are formally documented in transcribed minutes, which summarize each agenda item, the discussion, the action taken, and the 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 the Quality Oversight Committee (QOC) (See Committee Section of this program for a full description of the 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
- 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) and Quality Improvement and Health Equity Committee (QIHEC)

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 the L.A. Care Health Plan and are strictly confidential.
- A written agenda will be used for each meeting.
- Meeting minutes shall be comprehensive, and timely, and show indicators, recommendations, follow-up and evaluation of activities.
- The minutes are recorded in a nationally recommended format.
- All unresolved issues/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 the following:

- Informal one-on-one meetings
- Formal medical education 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 that 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 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's quality improvement infrastructure.

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

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

Membership includes, but is not limited to, Chief Medical Officer, Chief Health Equity Officer, 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, subcommittee chairs and/or their designee, 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 ensures satisfactory closure.
- Formulate organization-wide improvement activities and gain support from appropriate departments.
- Ensure that QI and Health Equity 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 of quarterly/annual appeals and grievances reports.
- Review and provide thoughtful consideration of changes in its QI and other policies and procedures and work plan and make changes to policies/work plan as needed.
- Review and modify the QI and Health Equity program description, annual QI and Health Equity Work Plan, quarterly work plan reports, and annual evaluation of the QI and Health Equity program.
- Review and monitor effectiveness of Cultural & Linguistic services including the Language Assistance 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 and Health Equity Program and QI and Health Equity Work Plan activities based on updates and information sources available.

Quality Improvement and Health Equity Committee (QIHEC)

Role and Reporting Relationship: The Quality Improvement and Health Equity Committee (QIHEC) committee ensures practitioner participation in the Quality Improvement and Health Equity programs through planning, designing, and reviewing quality improvement and health

equity activities and interventions, as well as ensuring that clinical and preventive health guidelines designed to improve equitable member care and network performance are reviewed and approved. The QIHEC provides an opportunity to dialogue with the provider community and members, including hospitals, clinics, county partners, physicians, community health workers, and other non-clinical providers, to gather recommendations and feedback on clinical and administrative initiatives. The QIHEC committee plays a crucial role in ensuring the active participation of L.A. Care members. Member representatives will be included in this committee to ensure input on health equity activities and to be involved in decision-making process. L.A. Care is able to make more informed decisions based on the needs and preferences of its members voiced in this committee

Structure: The committee reports to the C&Q and QOC on findings and matters within its scope of responsibility, which are presented in a meeting summary to the QOC by the Chief Health Equity Officer and CMO physician designee or the CMO. In addition, such recommendations are brought to the QOC Committee as part of the regular report to the QOC by the QIHEC co-chairs.

Quorum and Voting: A quorum is established with at least 50% or more voting members in attendance. Voting members are: Non-L.A. Care Physicians, PPGs, Plan Partners representatives, L.A. Care consumer members, and L.A. Care staff that are managers and above.

Membership: All Leads pertinent to Health Services Quality, including but not limited to Chiefs, Medical Directors, Senior Directors, Directors, and Managers in Health Services and Clinical Operations. In addition, Health Equity leads are integral members of the committee. Delegated Plan Partner Utilization Management, Appeals & Grievances, and QI Directors, designees, and Delegated Provider Group representatives are also members of this committee. Other staff may attend on an ad hoc basis.

Network Physicians represent a broad spectrum of appropriate network primary care physicians and specialists, including behavioral health physicians serving L.A. Care members. These physicians include but are not limited to practitioners who provide health care services to Seniors and People with Disabilities (SPD) and chronic conditions (such as asthma, diabetes, congestive heart failure, etc.) and/or members receiving Long-Term Support Services (LTSS). Current committee members may recommend committee members for inclusion. L.A. Care's Plan Partners as well as L.A. Care members, will represent these stakeholder groups on QIHEC.

Voting committee members must attend at least 75% of meetings within the calendar year. If a voting committee member does not have 75% attendance, the Committee Co-Chairs or designee will ascertain if the provider still wants to be a committee member; if not, a replacement will be found.

Frequency: The committees meet quarterly but as frequently as necessary to demonstrate follow-up on all findings and required actions.

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

- Maintain an adequate oversight procedure to ensure Subcontractor, including Plan Partners, and Downstream Subcontractor compliance with all QI or Health Equity delegated activities.

- Assure compliance with the requirements of accrediting and regulatory agencies, including but not limited to the Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC), Centers for Medicare & Medicaid Services (CMS), National Committee for Quality Assurance (NCQA), and Covered California.
- Review the regulatory required improvement plans with the state.
- Select, evaluate, develop, approve, and adopt preventive and clinical practice guidelines for reducing disparities and evidence-based criteria.
- Promote initiatives and innovations discovered by and offered to the provider community and members.
- Review and discuss quality improvement and health equity projects and opportunities presented by committee members, including barriers to improvement of HEDIS and other QI/QIHEP measures.
- Review and analyze member and provider satisfaction survey results, for example CAHPS and access to care results, and make recommendations for improvement as appropriate.
- Make recommendations, including addressing performance deficiencies, to the L.A. Care Quality Oversight Committee (QOC) and Compliance and Quality about issues relating to equity, quality improvement policy decisions, activities, and service improvements, ensuring appropriate follow-up.
- Provide input and feedback on services provided to members.
- Ensure practitioner participation in the QI/QIHEP and Value Initiative for IPA Performance (VIIP) or Value Based Pay for Performance (P4P) programs through planning, design, implementation, and review.
- Review reports referenced in the appendix.
- Other activities/issues as they arise.

Utilization Management Committee

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

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

Quorum and Voting: A quorum is established when five (5) of the voting members are present. Only physician members, Senior Directors, 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, Senior 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 all utilization management activities and promotes the optimum utilization of healthcare services while protecting and acknowledging member rights and responsibilities. The responsibilities of the UM Committee include but are not limited to the following:

- 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, 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 the 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, and Doctoral-level behavioral 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 ad hoc basis.

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

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

- Credentialing and recredentialing of practitioners MD, DO, DPM, DC, DDS/DMD, AC, attending physicians within a teaching facility, and Mid-Level disciplines, such as Nurse Practitioner (NP), Certified Nurse Midwife (CNM), Clinical Nurse Specialist (CNS), Certified Registered Nurse Anesthetist CRNA, Licensed Midwives (LM), and Physician Assistants (PA), behavioral health practitioners, such as, Psychiatrists and other physicians, addiction medicine specialists, Doctoral or Master's level psychologists, Master's level clinical social workers, Master's level clinical nurse specialists or psychiatric nurse practitioners, physicians or Doctoral level professionals with expertise in Long-Term Services and Supports (LTSS), autism service providers, qualified autism service professionals, or qualified autism service paraprofessionals, other behavioral health care specialists, 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 the Centers 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 and quality of care and assign 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 the Special Investigation Unit (SIU) to determine if network providers' actions affect 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 FSR is following
    - 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) oversees 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 recommends new medical technologies, or new applications of existing technologies, and recommendations for benefit coverage based on medical necessity. The PQOC develops utilization management criteria for all pharmacy-managed direct product lines of L.A. Care (i.e., D-SNP, LACC/D, and PASC-SEIU). 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: The Chief Pharmacy Executive and an L.A. Care Medical Director serve as the Chairpersons 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 healthcare professionals may be invited on an ad hoc basis to provide information when additional medical or pharmacotherapy expertise is required for medical, drug or policy evaluations.

Frequency: The PQOC meets at least quarterly.

Functions: The PQOC has the following functions:

Oversight/Advisory of PBM Vendor:

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

L.A. Care Strategic and Administrative Operations

- Specialty pharmaceutical patient management and distribution strategies.
- Pharmaceutical care program selection and evaluation.

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

Behavioral Health Quality Committee

Role and Reporting Relationship: The Behavioral Health Quality Committee (BHQC) holds several critical functions, including the collection and thorough review of behavioral health related data, as well as 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 several key stakeholders, including L.A. Care's Managed Behavioral Health Organization (MBHO), which is fully delegated for the management of the behavioral health benefit for MCLA, LACC, PASC-SEIU, and Medicare Plus beneficiaries, which is L.A. Care's Dual Eligible Special Needs Plan (D-SNP) in accordance with the plan benefit package. Stakeholders including the Los Angeles County Department of Mental Health (DMH) and the Los Angeles County Department of Public Health Substance Abuse Prevention and Control (DPH-SAPC), physicians from Participating Physician Groups (PPGs), also attend BHQC and various cross-functional departments throughout the organization. L.A. Care works closely with the MBHO and County Behavioral 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 (1) medical director, three (3) licensed behavioral health clinicians (LMFT, LCSW, or LPCC), and one (1) Quality Improvement manager/director, or designee, attends. 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/Director, or designee.

Membership: Committee members include leadership from key internal departments including but not limited to Quality Improvement, Provider Networks Management, Appeals and Grievances, Medicare Operations, Pharmacy, Medi-Cal Product, Commercial and Group Product, Medicare Product, and other departments. Committee members also include external stakeholders, including but not limited to L.A. Care's MBHO, County Partners (DPH-SAPC and DMH) and PPGs.

Frequency: The Behavioral Health Quality Committee meets quarterly.

Functions: The goal of the Behavioral Health Quality Committee is to work collaboratively with internal and external stakeholders to improve overall quality, safety, and equity of care and services for members accessing behavioral health services. The committee has the following functions listed below:

- Monitor and evaluate the utilization of behavioral health services managed by Managed Behavioral Health Organization (MBHO).
- Review and evaluate the results of Quality Improvement (QI) performance measures managed by MBHO.
- Review and evaluate behavioral health workgroup initiatives/interventions 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 the 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.
- Review behavioral health provider survey results for access and availability.
- Monitor and take action to improve continuity of care and coordination.
- Identify opportunities for care coordination between contracted behavioral health providers and physical health providers.
- Monitor written policies and procedures to ensure appropriate QI functions, access, and availability of practitioners and reflect current standards of medical practice.

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: Access & Availability Surveys, Call Center Metrics, and Interface of Provider Satisfaction with Member Satisfaction, Network Adequacy Report, Member Retention Reports, and Member Satisfaction Surveys. 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: Quality Medical Director 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 attends. 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.

Quality Improvement Steering Committee

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

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

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

Membership includes, but is not limited to, Quality Medical Director, Senior Quality Population Health and Informatics 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, Senior Manager Clinical Initiatives (Chair), Director Health Education & Cultural Linguistics Services, Director STARS Excellence, 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.
- Analyze disparities and developing goals and programs to improve and promote health equity.
- Provide initiative/intervention approval (when necessary) and/or recommendations to QI workgroups.
- Address challenges and barriers that arise in launching/managing initiatives/interventions.
- 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 and 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 attends. Voting members are managers and above.

Membership includes, but is not limited to, the Director of Quality Performance Informatics, Chief Medical Officer, Quality Medical Director, Director of Population Health Management, Senior Director of Quality and Accreditation, Senior 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 the QPM Steering Committee.
- Report to the QOC on all activities.

The 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 and 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, 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 PHM Director, 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 attends. 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, 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, provide oversight and strategic guidance and input to PHM programs across L.A. Care, and 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 of appropriate departments in the Committee.
- 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 Equity Council focused on the provider network, 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 Chief Health Equity Officer will chair the Equity Council Steering Committee. The Steering Committee will include the chairs of three equity councils focused on three constituencies, members, providers, 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. The Chief Health Equity Officer or designee will chair this Council.
- **Provider 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. The Executive Director of Commercial and Group Product will chair this Council.
- **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. The Team Equity Council Chair will be selected by the Equity Steering Committee.

Quorum and Voting: All committee members have voting privileges.

Membership: The Steering Committee will be comprised of at least nine 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 communicate and collaborate effectively 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 monthly. 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, and stakeholders with our business practices.
2. Ensure L.A. Care is a safe space, for employees, physically, emotionally, and intellectually, where inclusion is a core value.
3. Advocate for diversity, equity, inclusion in a climate of social justice for our members, providers, vendors, and other key 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 community benefit 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 for both Health Plan and Health Equity, 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 has an accountable lead, responsible owner, supporting staff, and backup staff. The accountable departments include but are not limited to the following:

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

- 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 and MCAS 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, measure performance, 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 measure performance across the Quality Rating System (QRS) and Centers for Medicare & Medicaid Services (CMS) Star ratings and California's Department of Health Care Services (DHCS) Managed Care Accountability Sets (MCAS). The Committee reports to the Quality Oversight Committee (QOC) and to the Chief Executive Officer (CEO) Cabinet.

Structure: The Senior Quality Population Health and Informatics Executive, Executive Director Medicare Products and Executive Director, Commercial and Group Product Management or designee will chair the Committee. All executive leadership committee members have voting privileges, and the Stars Core Team will have one vote.

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

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

- Senior Quality, Population Health, and Informatics Executive
- Executive Director, Medicare Products
- Executive Director, Commercial and Group Product Management
- Chief Health Equity Officer
- 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
- Senior Manager, Quality Improvement Initiatives,
- Stars Core Team
    - Stars Program Manager
    - Stars Manager Analytics
    - Stars Performance Improvement, Lead

Frequency: Committee meets at least every quarter and but targets to meet monthly.

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

- Be committed to and advocate for L.A. Care's Stars and MCAS goals and objectives.
- Understand the strategic implications and outcomes of Stars and MCAS improvement projects and activities
- Monitor and review Stars and MCAS improvement projects and activities at Committee meetings.
- Provide resources to support Stars and MCAS improvement projects and ensure accountability.
- Control project scope based on resources and alignment with adopted goals and objectives
- Formally accept Stars' and MCAS's improvement goals, objectives, and project deliverables.
- Stars and MCAS 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 improve continuously 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 healthcare 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 membership attends. All committee members have voting privileges.

Membership includes, but is not limited to, the 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 or other health care providers representing different specialties.

Frequency: The Continuing Medical Education Committee meets on a quarterly basis, a 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 on 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 AND HEALTH EQUITY PROGRAM

The scope of the QI and Health Equity Program is reflective of the healthcare 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 medically necessary covered services are available and accessible to all members regardless of sex, race, color, religion, creed, ancestry, national origin, ethnic group identification, language, age, health status, 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 and Health Equity Program is implemented through the multidisciplinary collaboration of departments across the entire organization. The program includes the 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 and Health Equity Program to assess its overall effectiveness and progress toward influencing network-wide safe clinical practices and improving health disparities.

L.A. Care's QI and Health Equity Program maintains compliance with DHCS, DMHC, CMS, NCQA, Covered California, and other regulatory entities to serve Medi-Cal, Medicare Plus (Dual Eligible 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 (PIPs), 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. Every three years, starting in 2025, L.A. Care collaborates with local health departments and Plan Partners to develop a Population Needs Assessment. This collaboration also identifies and provides community-based services to address social determinants of health. Coordinating services through a PHMP helps to meet the goals outlined by the Quadruple Aim including improving patient and provider experience using evidence-based care, improving the health of populations, and delivering cost-effective member care.

The PHMP strives to address health needs at all points along the continuum of health and wellbeing 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 healthcare 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 and Health Equity 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 the 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) member stratification and risk-based segmentation; (3) member enrollment health appraisal and engagement; (4) intervening through monitoring; and (5) program outcomes evaluation. The PHMP addresses the following areas along the continuum of care with interactive interventions:

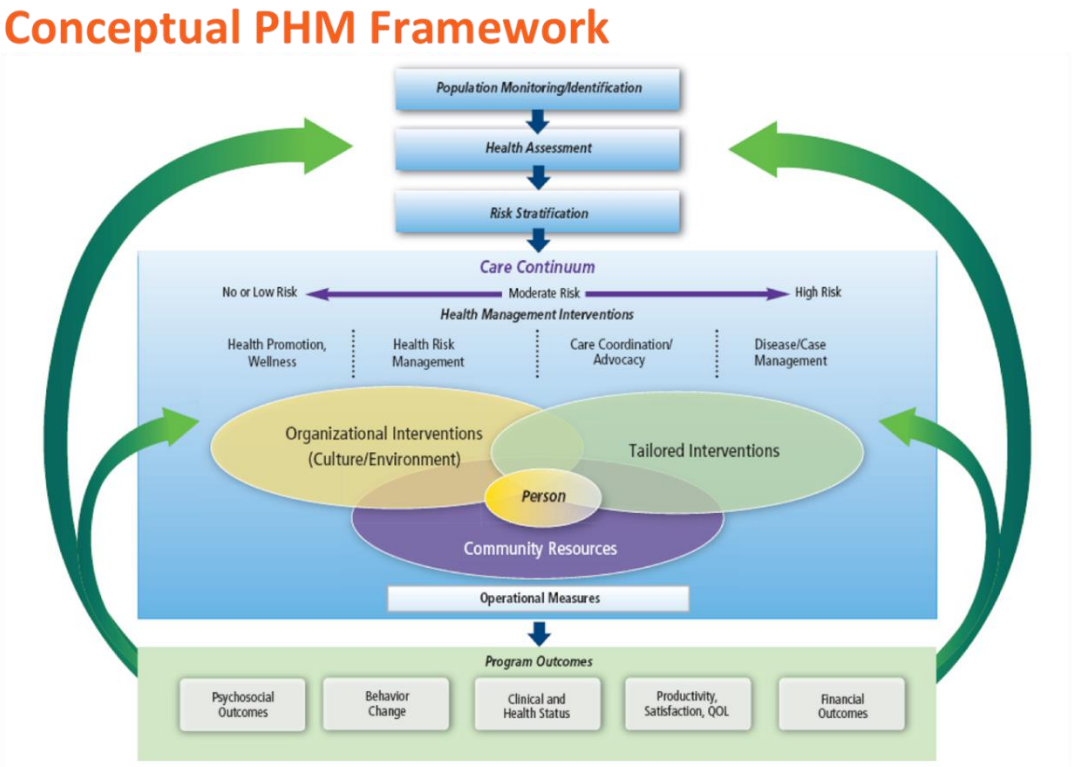
- Keeping Members Healthy
- Early Detection/Emerging Risk
- Chronic Condition Management
- Complex Case Management
- Care Transitions
- Patient Safety

Risk Stratification, 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 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 the quality of life among our members by preventing exacerbations and reducing the effects of complications of those who participate in L.A. Care's Population Health Management programs.

The model includes care teams enabled by f health information technology to meet diverse care needs, improve quality of care, and lower costs. All Health Services programs must follow a standard structure to include Identification, Stratification, Enrollment/Engagement, Interventions, and Outcomes (ISEIO). Below are details of the PHM ISEIO Framework.



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

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QI Health Equity Program

Supporting vulnerable populations and addressing health disparities is part of L.A. Care's mission. L.A. Care recruited and hired a new Chief Health Equity Officer (CHEO), Alexander Li, MD, in February 2023. Dr. Li leads the Health Equity Department and the health equity team recently published the 2023-25 L.A. Care Health Equity and Disparities Mitigation Plan (HEDMP) to guide the QI Health Equity program over the next two years.

Below is a brief overview of L.A. Care's four health equity zones.

The four Health Equity Zones that will serve as areas of focus are:

1. **Address key health disparities:** close racial and ethnic gaps in health outcomes among members;

2. **Lead change**: provide leadership and be an ally for community partners to promote health equity and social justice;
3. **Move towards equitable care:** ensure that our members have access to care and services that are free of bias and that our providers are supported in delivering equitable, culturally tailored care;
4. **Embrace diversity, equity, and inclusion (DEI):** serve as a model in supporting an equitable and inclusive work environment, as reflected in our workforce and business practices.

For the purpose of the QI Health Equity Program as related to performance measures and goals, please access the HEDMP and review Zone 1: Addressing Key Health Disparities. The full HEDMP can be found here.

Since this is the inaugural year where L.A Care has a HEDMP the L.A. Care Health Equity team developed an organized infrastructure to promote health equity and DEI initiatives and culture. L.A. Care Health Equity team created an Equity Council structure that includes the Equity Council Steering Committee, Member Equity Council, Consumer Health Equity Council, Provider Equity Council, and L.A. Care Team Council. Below are further details of the councils:

- The **Equity Council Steering Committee (ECSC)** is the governing committee that leads L.A. Care's efforts on equity and social justice with high visibility throughout the organization. It is composed of staff and senior leaders. ECSC will institutionalize accountability for equity at the member, network, and staff level. The ECSC is chaired by the CHEO and reports up to the CEO.
- The **Member Equity Council** recommends, expands and implements activities that promote health equity and equity of services among members. The Council will also align health equity efforts enterprise-wide and increase the awareness of health equity throughout L.A. Care. Health equity efforts are inclusive of modifiable and actionable social determinants of health.
    - The **Consumer Health Equity Council** provides a forum for consumers to advocate and discuss their perspectives on important issues related to L.A. Care's activities. This council reports up to the Member Equity Council.
- The **Provider Equity Council** focuses on diversity among L.A. Care's participating providers and seeks to align our network and be responsive to the diversity of the members we serve.
- **L.A. Care Team Council** includes representation from different departments across L.A. Care. This Council provides a forum where DEI initiatives are discussed. Thereafter, the Team Council makes recommendations and supports the implementation of recommendations.

Additionally, L.A. Care's Health Equity and Quality Improvement Department created a new Quality Improvement and Health Equity Committee (QIHEC). The QIHEC is composed of L.A. Care staff, members, and providers who jointly review and provide recommendations for quality improvement and health equity initiatives. The new committee is co-chaired by the Quality Medical Director and Chief Health Equity Officer.

DHCS issued an All Plan Letter (APL 23-025) Diversity, Equity, and Inclusion Training (DEI) program requirements on September 14, 2023. This APL states that Medi-Cal managed care plans (MCPs) are required to develop a DEI program that encompasses sensitivity, diversity, cultural competency, cultural humility, and health equity trainings for all L.A. Care staff, Subcontractors, Downstream Subcontractors, and Network Providers. L.A. Care is currently working collaboratively with internal and external stakeholders to implement this training for all stakeholders by December 31, 2025. L.A. Care will work with other health plans throughout the region, including L.A. Care's Plan Partners and competitors, to implement a model ensuring that all Medi-Cal providers receive DEI training. The DEI program progress and updates will be presented at the QIHEC.

Implementation for Equity Practice Transformation (a $700 Million dollar 5 year program) will commence on January 1, 2024. This new program can potentially enable L.A. Care QI and Health Equity teams to work in closer partnership with providers to address health disparities as well as impact HEDIS and other performance measures.

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), and the Integrated Healthcare Association's (IHA) Align. Measure. Perform. (AMP) program. HEDIS and AMP results are annually audited by National Committee for Quality Assurance (NCQA), and HEDIS results are by 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, Medicaid, Exchange, Medicare, Special Needs Plan (SNP), and AMP performance measures. L.A. Care calculates and reports all NCQA, AMP, and DHCS MCAS reporting measure sets 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 NCQA will notify L.A. Care of the HEDIS measures selected for inclusion in the following years' measure sets.

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 from peer reviewed sources for health conditions that are most salient to members for the provision of preventive as well as 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.

New and revised Clinical Practice and Preventive Health Guidelines are presented annually or more frequently as necessary, to L.A. Care's Quality Improvement and Health Equity Committee (QIHEC). 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 processes, or other measures as appropriate. In addition, guidelines that are salient to members 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. The California Department of Health Care Services provides periodicity schedules for health assessment and dental referrals by age 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 provide prenatal or postpartum care to ensure that 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, Carelon Behavioral Health, 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 Carelon Behavioral Health, L.A. Care implements training and education programs focused on maternal mental health. To deliver and disseminate these trainings, L.A. Care partners with community organizations, perinatal health programs operated by the County Department of Public Health and Department of Health Services. 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 via internal compliance programs and provider network relations.

Health Assessments

For Medi-Cal members, the Initial Health Appointment (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 medical and mental health history, identification of risks, assessment of need for preventive screens or services, health education and diagnosis and disease treatment plans either in person or virtually. PPGs/PCPs are responsible to cover and ensure IHA provision and to document outreach, scheduled visits, and all components of an IHA within the member medical records. 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 still encouraged to complete an IHA even if it has not yet been completed within the initial 120 calendar days of enrollment.

Per federal requirements, all Medi-Cal members are screened for health needs within 90 days of enrollment using the Health Information Form (HIF/MET). Additional Medi-Cal populations will receive a comprehensive assessment through the Health Risk Assessment (HRA). Medi-Cal populations required to receive an assessment include:

- Those with long-term services and support (LTSS) needs
- Those entering Complex Case Management (CCM)
- Those entering Enhanced Care Management (ECM)

- Children with Special Health Care Needs (CSHCN)
- Pregnant individuals.
- Seniors and persons with disabilities who meet the definition of "high risk" as established in existing APL requirements.

For Medicare members, there are two types of assessments the 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 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 physical and mental health status, and to ensure the provision of timely and appropriate care according to member 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). The purpose is to fulfill CMS requirements related to risk adjustment payment methodology and to determine member health risk status to develop an appropriate care plan and promote member engagement in their care. In addition, AWEs assure compliance with the CMS Model of Care and support quality improvement efforts in substantiating and diagnosing new member health conditions. L.A. Care is responsible for ensuring that participating providers properly document information in the member health records 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 AWEs. L.A. Care also offers an in-home assessment option by licensed practitioners for members and providers as needed.

Health Education, 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 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 health education programing via multiple channels, including group appointments at community locations and individual telephonic counseling.
- **My *Health in Motion™*** is L.A. Care's online health and wellness platform, through which members can access personal health assessments, self-paced workshops, and health coaching.
- **Health education materials** in Los Angeles County threshold languages and required health topics in plain language.
- **Health education programs** addressing prenatal/postpartum care, flu, asthma, COPD, diabetes and kidney disease, 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 staff and the provider network, 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 the provision of quality language assistance and auxiliary services.
2. Continuous support to staff and the provider network 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 the 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 well-being of all 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, ethnicity, language, disabilities and chronic conditions, as well as Members who use MLTSS. L.A. Care aims to address the cultural and linguistic needs of members 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.

L.A. Care has undertaken significant efforts to improve services for Seniors and Persons with Disabilities and to address their complex health needs. This effort has involved a review of L.A. Care departments for the ability to appropriately serve and effectively communicate with members with disabilities. This includes the provision of L.A. Care member vital documents in alternative 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 American Sign-Language interpretation services. L.A. Care's care management process includes a 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 services coordination. Members participating in the programs are equipped with the skills to effectively self-manage health conditions and access required healthcare services. The programs are developed from evidenced-based clinical practice guidelines and support 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 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 of care management activities.

During the intake of a case with the member, a comprehensive assessment is completed to understand the member health concerns as well as potential resource gaps. Interventions that are member-centric, focusing on the individual preferences and needs, and can then be developed. Progress towards member goals and intervention outcomes are tracked and monitored in CCA. Interventions may include providing educational or informational materials that are culturally and linguistically appropriate. With member consent, the care management team communicates to providers and caregivers information about member health conditions and care plans to ensure that the care is integrated and coordinated. Regular communication and coordination allows providers and interdisciplinary teams to coordinate care together. Care Managers collaborate with both internal and external programs and resources to address identified a member needs.

On an annual basis, program outcomes are evaluated through quantitative and qualitative measures. The evaluation includes an analysis of elements such as program participation rates, utilization impact, as well as member satisfaction.

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 disease progression risks. 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 includes 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 Services (TCS)

L.A. Care's Transitional Care Services (TCS) Program is available to all L.A. Care Medi-Cal L.A. Care's Transitional Care Services (TCS) Program is available to all L.A. Care Medi-Cal members.

The purpose of the TCS Program is to provide additional support to members experiencing a care transition. These transitions between health care settings can include, but are not limited to, discharges from hospitals, acute care facilities, skilled nursing facilities (SNFs), home- or community-based settings, community supports, post-acute care facilities, or long-term care (LTC) settings. When members experience a care transition, they are at higher risk of experiencing care gaps and adverse health events. L.A. Care provides support to members during and after a care transition to ensure they have the adequate supports and services to complete a successful and safe transition.

Based on a member's risk level, members are either auto-assigned to a TCS Care Manager or can opt into receiving TCS support, which will trigger the assignment of a TCS Care Manager. TCS Care Managers collaborate with members and facility staff to address member discharge planning needs, including access to services to facilitate a safe discharge. Furthermore, the TCS Care Manager collaborates with facility staff to complete a discharge risk assessment and ensure the member and their PCP receive a discharge summary.

Following discharge, the TCS Care Manager will follow up with the member and provide support with accessing follow up medical appointments, assist with medication reconciliation, review the discharge summary with the member, and as needed, connect the member to longer-term care management services should there be ongoing needs.

Managed Long Term Services and Supports (MLTSS)

L.A. Care has Managed Long Term Services and Supports Program Descriptions that includes CBAS, MSSP, IHSS and LTC. These programs address serving members with complex health needs, such as seniors and members 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 to continue live independently in the community. The MLTSS team oversees extended long-term care services provided in a skilled nursing facility. MLTSS serves L.A. Care's members enrolled in Medi-Cal and Medicare Plus (Dual Eligible Special Needs Plans D-SNP). MLTSS oversees four core programs: Long-Term Care (LTC), Community-Based Adult Services (CBAS), In-Home Supportive Services (IHSS), and Multipurpose Senior Services Program (MSSP).

In 2023, MLTSS has expanded the oversight of LTC members through CalAIM's benefit standardization of the LTC benefit. While LTC custodial and adult subacute care services have been carved into L.A. County Managed Care Plans (MCP) since 2014, the full LTC benefit transitioned to MCPs beginning January 1, 2024. This includes pediatric subacute care and members who reside in Intermediate Care Facilities for the Developmentally Disabled (ICF/DD).

For a more robust nursing facility program, MLTSS nurses review ongoing Skilled Nursing Facility (SNF) level of care benefits for members. Likewise, the MLTSS team supports SNF and ICF/DD facilities with care transitions for members transferring from one setting or level of care to another under CalAIM's Population Health Management (PHM) Transitional Care Services

(TCS) program. This includes, but is not limited to, discharges to home or community based settings.

In addition, the MLTSS department oversees L.A. Care's Palliative Care benefit for Medi-Cal (MCLA only) and D-SNP members to offer an extra layer of support to members with serious illnesses.

MLTSS also supports members, providers, and staff by making referrals to other L.A. Care programs and community resources. The MLTSS clinical team is part of Care Management's interdisciplinary care team (ICT) and engages with providers and members during ad hoc facility visits and telephonic outreach.

Through CalAIM's Community Supports program, MLTSS and manages Personal Care and Homemaker Services (PCHS), Respite for caregivers, Environmental Accessibility Adaptations (EAA, also known as Home Modifications), Nursing Facility Transition and Diversion (NFTD) to Assisted Living Facilities (ALF), and Community Transition Services (CTS) from LTC to a home setting. These supplemental services address social determinants of health, providing cost-effective alternatives to support members at home and those transitioning from nursing homes back to the community.

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 our Commercial and 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 and adverse drug interactions and improve medication use. (See also Patient Safety section of this program). Starting January 2022, Medi-Cal pharmacy benefit was transitioned to Department of Health Care Services (DHCS) and managed by Magellan Health.

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.

As of January 2023, L.A. Care's MTM program is contracted out to Navitus Clinical Engagement Center (CEC) to perform medication reviews for our Medicare Plus (D-SNP) 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 Recommended To-Do-List (TDL) and a Personal Medication List (PML). TMRs occur at least quarterly to review member prescriptions and make contact with 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 collaborated 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 a pharmacy ambulatory care program. Our ambulatory care pharmacist is currently contracted with two clinics and has established Collaborative Practice Agreements. The ambulatory care pharmacist can independently assess the member, order labs, and provide medication management services to high-risk members.

Community Health

Community Health Department

The Community Health team leads L.A Care's value-based programs focused on: Social Determinants of Health, Behavioral Health, support for vulnerable communities, and providing services in non-traditional settings of care. Community Health at L.A. Care is comprised of Behavioral Health, Community Supports, Housing Initiatives, Field/Street Medicine, Social Services and additional pilot programs and innovative solutions to best serve L.A. Care's most vulnerable members.

Behavioral Health

Behavioral Health is integrated within Community Health to ensure the social needs of members with mental health and substance use conditions are addressed and to support coordination of care. Please refer to the Behavioral Health program description for additional information about L.A. Care's Behavioral Health services.

Community Supports

The Community Health Platform unit is responsible for coordinating Community Supports and other initiatives within Community Health to ensure a comprehensive system of services to address the complex health and health-related social needs of L.A Care members. L.A. Care's Community Health Platform unit currently consists of five (5) full-time positions, which includes the Community Health Director, two (2) Program Managers, one (1) Program Analyst, and one (1) Clinical Data Analyst. The Community Health Platform unit is under the Senior Director of Community Health.

The 14 Community Supports that are part of the California Advancing and Innovating Medi-Cal (CalAIM) Initiative of the Department of Health Care Services (DHCS) are listed below. CalAIM Community Supports are cost-effective and medically appropriate services to avoid higher levels of care. While eligibility criteria varies for each service, Community Supports address social determinants of health and serve L.A. Care's most vulnerable members including but not limited to those who are experiencing homelessness or at risk of experiencing homelessness, have food insecurity, need assistance with activities of daily living, and/or live with a chronic condition such as asthma.

Housing Transition Navigation Services	Nursing Facility Transition/Diversion to Assisted Living Facilities
Housing Deposits	Community Transition Services/Nursing Facility Transition to a Home
Housing Tenancy and Sustaining Services	Personal Care and Homemaker Services
Short-Term Post-Hospitalization Housing	Environmental Accessibility Adaptations (Home Modifications)
Recuperative Care (Medical Respite)	Medically Tailored Meals
Respite Services	Sobering Centers
Day Habilitation Programs	Asthma Remediation

Since 2022, L.A. Care has made available twelve (12) Community Supports under CalAIM. The Community Health Platform unit is also working to expand the existing Community Supports provider network to facilitate access to services for L.A. Care members.

Within Community Health, Behavioral Health is responsible for the provision of Sobering Center services and Social Services is responsible for the provision of Recuperative Care and Asthma Remediation. Housing Initiatives provides Housing Transition Navigation Services, Housing Deposits, and Housing Tenancy and Sustaining Services in collaboration with Social Services.

The Community Health Platform unit within Community Health also collaborates with other service areas within L.A. Care to deliver Community Supports to members, including Health Education and Cultural and Linguistic Services for the provision of Medically Tailored Meals and Managed Long Term Services and Supports for the provision of Nursing Facility Transition to Assisted Living Facility, Community Transition Services, Environmental Accessibility Adaptations, Personal Care and Homemaker Services, and Respite Services.

Furthermore, the Community Health Platform unit ensures Community Supports are coordinated with other program and services within L.A. Care, such as Enhanced Care Management and in the community to best meet the needs of members. In order to do so, the Community Health Platform unit facilitates training to build knowledge and awareness of available services among internal and external (community-based) stakeholders and to increase referrals for Community Supports.

Housing Initiatives

The Housing Initiatives unit within Community Health oversees L.A. Care's various programs to address the health and social needs of homeless members. The Housing Initiatives unit consists of twelve 12 full-time positions, which includes the Housing Initiatives Director, two (2) Managers, four (4) Program Managers, two (2) Program Analysts, one (1) Clinical Data Analyst, one (1) Data Analyst, and one (1) Program Liaison. The Housing Initiatives unit is under the Senior Director of Community Health.

The Housing Initiatives unit includes L.A. Care's Homeless and Housing Support Services (HHSS), which makes available Housing Transition Navigation Services, Housing Deposits, and Housing Tenancy and Sustaining Services as part of CalAIM Community Supports. Collectively, these services form a continuum to help members who are experiencing homelessness identify, secure, and maintain safe and stable housing.

The Housing Initiatives unit also oversees L.A. Care's Field/Street Medicine program, which is planned for implementation in April 2024. This program is intended to provide medically necessary services and linkage to Community Supports to members who are experiencing homelessness in the field (lived environment) to reduce barriers to care.

Furthermore, L.A. Care participated in the voluntary DHCS Housing and Homelessness Incentive Program (HHIP), which was available in 2022 and 2023. The goals of the program are (1) to help Managed Care Plans develop the capacity and partnerships to connect members to needed housing services, and (2) to reduce and prevent homelessness. Through HHIP, L.A. Care earns incentive funds by achieving various performance metrics related to improving care, infrastructure, and outcomes for members experiencing homelessness. L.A. Care is eligible to earn up to $290M in one-time funds via HHIP. Program achievements include creating a data matching process with the local Continuums of Care with 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. In addition to these achievements, additional investments via grant awards have been made by L.A. Care to support providers and community partners in expanding Street Medicine Capacity and Housing Equity. Priority areas for future funding investments include; Infrastructure, including Health Information Exchange (HIE), Data Exchange and Workforce; Field Medicine, Housing Retention, Unit Acquisition and Eviction Prevention.

Social Services

Social Services is integrated within Community Health to address the various social needs of members and to support coordination of care within L.A. Care and in the community. Please refer to the Social Services program description for additional information about L.A. Care's Social Services.

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 March 2018, L.A. Care's Board of Governors approved the launch of the Elevating the Safety Net (ESN) initiative with a 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 healthcare professionals — especially those coming from and committed to working in underserved communities. L.A. Care's ESN initiative goals include (1) increasing the number of primary care physicians (PCPs), including psychiatrists; (2) supporting students by cultivating their pursuit of careers in the health professions; (3) improving diversity in

the workforce by increasing the supply of health professionals who come from underserved communities; and (4) 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 over $104.5 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 May 2022, the 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.

In October 2023, the L.A. Care Board of Governors approved an additional $50 million to invest in current active programs through 2027, including the Medical School Scholarship Program, Provider Loan Repayment Program, Provider Recruitment Program, and In-Home Support Services Training Program, in addition to new investments in emerging workforce needs.

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.

Since 2022, L.A. Care has collaborated with Los Angeles County MCPs to invest in local ECM and CS infrastructure and capacity building. With IPP earnings to date, L.A. Care has committed nearly $35 million in provider incentives to support systems enhancements, hiring of core staff, and improvements in reporting capabilities. Moreover, L.A. Care has also invested in service contracts to deliver training, certification, and technical assistance to ECM and CS providers in Los Angeles County.

Quality Improvement Projects (QIPs)

L.A. Care conducts Quality Improvement Projects (QIPs) in compliance with Department of Health Care Services (DHCS), Covered California, and the Centers for Medicare and Medicaid

Services' (CMS) requirements. DHCS requires that Medi-Cal plans have two long-term quality improvement projects known as Performance Improvement Projects (PIPs) and assigns rapid cycle quality improvement projects known as Plan Do Study Act cycles (PDSAs) and/or Strengths Weaknesses Opportunities and Threats (SWOT) worksheets for low performing measures. Medicare Advantage (MA) organizations (MAOs) must have an ongoing Quality Improvement Program, as required by section 1852(e) of the Social Security Act and 42 CFR §422.152 (a). The Quality Improvement and Health Equity 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 the 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 Projects (PIPs)

L.A. Care conducts quality and performance improvement projects with the aim of achieving meaningful and sustainable improvements, which are statistically significant, for both clinical and non-clinical care. L.A. Care conducts at least three state-mandated rapid-cycle PIPs/QIPs, two PIPs for Medi-Cal, and one QIP for Covered California. 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 that 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, DHCS has assigned L.A. Care Health Plan two mandated PIPs for 2023 through 2026. DHCS has outlined, with the assistance of DHCS' External Quality Review Organization (EQRO) specific topics for clinical and non-clinical PIPs. L.A. Care will follow the templates provided by EQRO and attend all trainings to ensure compliance with this regulation. PIPs will be conducted over three-year period with the first year identifying a baseline and the second and third years conducting intervention cycles to reach the PIP goal. L.A. Care will follow EQRO organization templates for all submissions. Technical calls are available to L.A. Care for support. L.A. Care participates in quarterly collaborative meetings to learn evidence-based strategies and quality improvement science and to collaborate on improvement strategies.

For Medicare Plus (Dual Eligible Special Needs Plan [D-SNP])**,** L.A. Care uses the current CCIP to fulfill this requirement. CCIP promotes effective management of chronic disease, improves care and health outcomes for enrollees with chronic conditions, and is conducted over a three-year period. L.A. Care's CCIP improves care coordination, and health outcomes. It utilizes outcome-focused improvement strategies, and addresses 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 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 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 based on the assigned tier from DHCS. 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 adopted, either 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 MPL. SWOTs allow a broader approach to improving HEDIS measures and allow L.A. Care to focus on multiple areas to improve overall performance.

For the Dual Eligible Special Needs Plans (D-SNPs), PDSAs are issued by CMS on an as-needed basis. Similar to Medi-Cal, the D-SNP PDSAs use SMART objectives to measure improvement, and interventions are adopted, either 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 Managed Care Operations Division (MCOD) Contract Manager manages the progress of the PDSA.

Patient Safety

L.A. Care is committed to ensuring patient safety and promoting a supportive environment for network practitioners and other providers to improve health outcomes 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, facility site reviews, continuity of care activities, and member satisfaction survey results. Many of the ongoing QI and Health Equity 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 are taken to improve safety.

L.A. Care conducts a review of reported critical incidents (CI) for L.A. Care Medicare Plus (Dual Eligible Special Needs Plan D-SNP) enrollees and ensures that 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; restraint or seclusion

of the enrollee; or other catastrophic event. An annual Getting to Know Critical Incident training is mandatory for member-facing staff to ensure both new and seasoned staff understands the Critical Incident criteria and how to submit a CI.

L.A. Care follows state laws to report to local Adult Protective Services (APS) agencies or, when appropriate, law enforcement and tracks the number of cases reported for enrollees who are receiving long-term care services. As deemed necessary, critical incidents may be investigated further through the 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 maintains and enforces the policy by 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 Team, and Behavior Health Team to appropriately identify the potential care concern. An annual Getting to Know Potential Quality of Care Issues training is mandatory for member facing and provider-facing staff 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 completed through a stringent proactive review of quarterly encounter data from deceased members to proactively assess encounter patterns and identify potential unexpected deaths, as well as an oversight review of CSC and A&G cases to identify any missed opportunity to refer a PQI and to remediate knowledge gaps 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 internal quality audit by the PQR audit team. The 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 issues with adverse effects and/or adverse health outcomes 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 issues. 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, the 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 L.A. Care's quality improvement programs that focus on the capacity of each PCP site to ensure 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 that PCP practice sites operate 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 that the PCP did not provide quality, timely, or appropriate care.

Hospital Quality and Safety

To continually improve patient safety and health outcomes in the 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. L.A. Care reviews hospital quality and safety indicators and identifies network hospitals that have a record of poor performance across domains of overall patient experience, maternity care, and hospital-acquired infections. 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 quality and safety benchmarks. 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) infection, and Surgical Site Infection; Hospital Safety Grades (from the Leapfrog Group); overall patient experience scores from Hospital-CAHPS; and Nulliparous, Term, Singleton, and Vertex (NTSV) C-Section Rates to minimize medically unnecessary - C-section deliveries when vaginal deliveries are indicated. L.A. Care has developed a Hospital Performance Dashboard. In this Dashboard, hospitals safety measures are included to display hospital performance. The following six measures are included on the dashboard:

- Hospital Acquired Infections
- Patient Experience Measures
- C-Section
- Overall Rating

- Patient Safety
- Readmission

Using internal and publicly reported data, L.A. Care annually identifies high and low performing hospitals for overall and metric specific criteria; and has started to meet with underperforming hospitals in 2023. The objective is to learn more about what hospitals are doing to improve underperforming metrics, barriers experienced, and to better understand the context for hospital performance and determine how to support hospitals in addressing these metrics.

During 2022, L.A. Care re-assessed the report subscription tier for CHC and moved towards 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 to contain 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, initially established along with Health Net, L.A. Care, and Molina. Since its launch, this collaboration has expanded to include Cal Hospital Compare, Covered California, Blue Shield, and Elevance. This work aims to establish clarity with poor-performing hospitals on the importance the collaborative partners place on hospital quality performance, specifically on priority metrics, and to improve communication across partners and hospitals in ways that will facilitate desired improvements. The ultimate goal is to drive improvements in key hospital quality and safety indicators 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 Executive Services, Health Services, Utilization Management, Care Management, Managed Long-Term Services and Support, Quality Improvement, Behavioral Health, and Pharmacy. Concurrently, to improve on appropriate utilization of services, minimize avoidable readmissions and Emergency Department (ED) visits, and improve Transitions of Care as well as provider communication, the IP Workgroup monitors the following standardized measures:

ACRONYM	MEASURE
AHU	Acute Hospitalization, risk-adjusted
EDU	Emergency Department Utilization, risk adjusted
PCR	Plan All-Cause Readmission, risk-adjusted
TRC	Transitions of Care - CMC, all four sub-measures
TRC	Transitions of Care, Patient Engagement, and Medication Reconciliation Post 30 Days Discharge
FMC	Follow-up service within seven days of ED visit for members with multiple high-risk chronic conditions.
HAI	Hospital Acquired Infection

ACRONYM	MEASURE
HFS	Hospitalization following discharge from a Skilled Nursing Facility (SNF)
HPC	Hospitalization for Potentially Preventable Complications
NTSVCB	Nulliparous, Term, Singleton, Vertex Cesarean Birth rate

Priority levels, 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. As of January 2022, CDUR edits for MCLA members are handled by the Department of Health Care Services (DHCS) and Magellan Health.

Our Pharmacy Benefit Manager (PBM), Navitus, administers retrospective drug utilization reviews (RDUR) for all lines of business. 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 within the health plan and provider network. 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 Quality Improvement and Health Equity Committee (QIHEC), the Quality Oversight Committee (QOC), and the 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

L.A. Care Health Plan demonstrates our commitment to service excellence by ensuring that members have access to both its clinical and behavioral health services. The Appeal and Grievance business unit documents, resolves and tracks member dissatisfaction and disputes. The Appeal and Grievance business unit monitors the appeal and grievance data for emerging trends and/or patterns and collaborates with other departments in L.A. Care to drive continuous improvement. The data is analyzed to identify gaps and to implement interventions to better serve our membership. Appeals and grievance trends, barriers, and interventions are presented directly to Product Operations Management teams and other Operational business units as needed. Quarterly reports demonstrating barriers, trends and interventions are presented to the following internal cross-departmental multidisciplinary committees and public advisory board committees: Member Quality Service Committee (MQSC), Quality Oversight Committee (QOC), Utilization Management Committee (UMC), Behavioral Health Quality Committee (BHQC), Internal Compliance Committee (ICC), Compliance & Quality Committee (C&Q), Executive Community Advisory Committee (ECAC), and Credentialing & Provider Network Management.

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. The number of encounters within a specific timeframe determines high volume areas of specialty care. 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 as necessary.

The Plan actively shapes our network of healthcare providers taking into account the unique cultural and specific needs of our members. By establishing and following guidelines for the accessibility of primary care, specialty care, hospital services, and supplementary healthcare providers, L.A. Care maintains a high standard of service delivery. Below are standards and guidelines followed by the Plan:

- 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 needs of members.
- Ensuring members are within 15miles or 30 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 reviews and measure 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 are not limited to the following:

- 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
- Prenatal appointments
- Ancillary appointments
- 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 ten 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 access standards. The data sources may include but are not limited to the CAHPS survey, Access to Care studies, and L.A. Care's Behavioral Health Partner.

To continuously review, evaluate, and improve access to the services and ensure that 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 "wait days" the length of time it takes 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 its customer solutions center by telephone. These standards include call abandonment rate, wait times, and service level.

Teladoc Health, Inc. Services

Effective January 1, 2020, L.A. Care offers general medical telehealth services to direct lines of business: Medi-Cal (MCLA), Dual Special Needs Program (D-SNP), 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 to 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 to minor, non-emergency services by phone or video chat. Teladoc providers are U.S. Board Certified physicians who can diagnose, treat, and write prescriptions for low acuity illnesses and health needs.

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) PASC-SEIU, and D-SNP have additional options for access to care at all 22 MinuteClinic locations in L.A. County when members are unable to reach their PCP or need after-hours care. MinuteClinics are walk-in health care retail clinics, located in select CVS Pharmacy stores that 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 the 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 in June 2019, offers access to minor, non-emergency services and helps to 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 vaccinations.

Nurse Advice Line

L.A. Care provides a 24/7 Nurse Advice Line (NAL) to it's direct line of business members (MCLA, D-SNP, LACC, LACCD, and PASC). Members can access a live Registered Nurse Health Coach (RN/HC) for symptom and condition management support, general health information, resource navigation guidance, and more. The RN/HC assesses member needs, directs them to the appropriate level of care, and strives to maintain a consistent, evidence-based approach. They can also guide members to resources such as 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 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 Quality Improvement and Health Equity Committee (QIHEC).

Equity and Practice Transformation (EPT) Payment Program

The Equity and Practice Transformation (EPT) Payment Program is a one-time $700 million Department of Health Care Services (DHCS) initiative designed to improve primary care for Medi-Cal recipients by advancing equity, reduce COVID-19-driven care disparities, invest in up-stream care models/partnerships to address health/wellness, and fund practice transformation aligned with value-based payment models. The 5-year program aligns with the DHCS: Comprehensive Quality Strategy, Equity Roadmap and "50 by 2025 Bold Goals" programs. EPT will provide Directed Payments to practices to invest in technology, infrastructure, staffing, technical assistance, and improvements in access to care with a focus on health equity. The program also includes a state-wide learning collaborative.

Program enrollment was offered to primary care Pediatrics, Family Medicine, Internal Medicine, OB/GYN, or Behavioral Health providers providing integrated behavioral health services in a primary care setting. Also, included are FQHCs and FQHC look-alikes and Rural and Indian health Centers. Practices must have a minimum number of assigned Medi-Cal and D-SNP lives across all payers of 1,000. For Rural and Indian Health Centers, the minimum is 500 Medi-Cal/D-SNP lives. The maximum funding for Directed Payments paid to practices is rated by the total number of Medi-Cal/D-SNP lives. From July 2023 – December 2023, L.A. Care has been focused on enrolling practices into the PDPP program.

The PDPP framework is composed of three pathways: foundational infrastructure investments, scaling evidence-based models of team-based care, and preparations to assume risk-bearing contracts or alternative payment models. These pathways include two categories of activities or milestones for practices to complete. The PDPP will begin in January 2024.

Transform L.A.

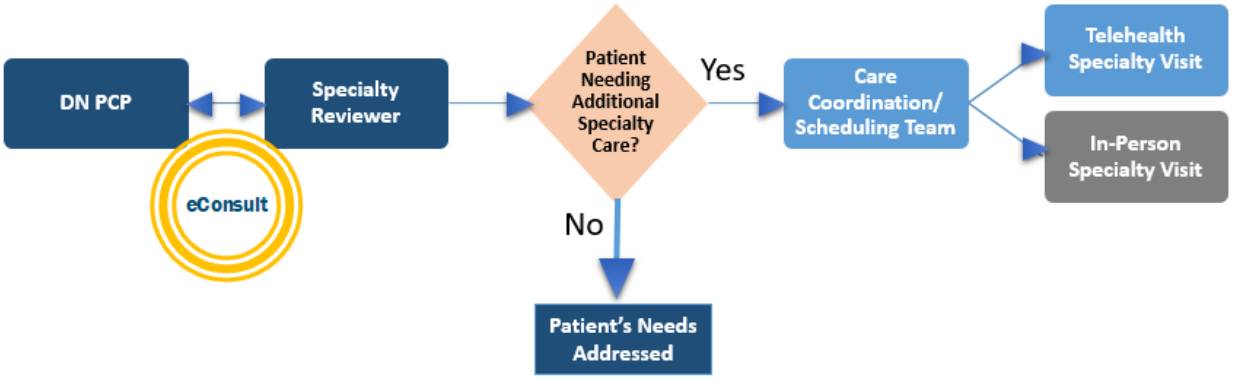
Transform L.A. is a practice-level technical assistance program delivered through tailored practice coaching. Engaging with a practice coach is an opt-in amenity for L.A. Care Direct Network primary care providers who depend on the use of an electronic health record (EHR) for patient records. The program 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
- 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), Proposition 56, and Value-Based Payment (VBP) revenue
- Providing workflow redesign/optimization guidance and implementation of best practices for primary care delivery
- Training staff on a variety of topics, such as Quality Improvement 101 and medical assistant professional development modules
- Leveraging L.A. Care's Health Services/Quality Improvement resources

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 the 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 launched in Winter of 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 Carelon (behavioral health specialists). However, due to the pandemic, we delayed the launch of this pilot to July 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 follows the recommendations of the American Academy of Pediatrics (AAP) 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 developmental delay, and by conducting screenings at these ages, delays can be treated with proactive interventions to improve outcomes.

The program consists of two parts: (1) community and provider education and (2) a 6-practice pilot. The goal of the education campaign is to increase awareness of the importance of developmental milestones and early interventions, as well as the 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 three CME events (2 completed, 1 remaining) on childhood development topics are offered for providers and care teams. To date, 50 classes of the planned 60 have been completed.

The clinical pilot provides two on-site practice coaches that teach best practices to provider and care teams for conducting screenings as well as providing referrals. The coaches help practices optimize workflows to achieve the program goals of a 15% improvement in the number of screenings and referrals. The coaches collect program data, which are reported to First 5 LA to evaluate and share learnings with the LA County healthcare community.

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, health delivery organizations (HDOs), autism professionals, and non-medical professionals with whom it contracts or refers members for services. The Credentialing Department manages all delegated credentialing activities including oversight and monitoring by providing subject matter expertise concerning the performance of delegated partners each year and collaborates with, the Compliance Department, Facility Site Review (FSR) Department, Payment Integrity (Special Investigations Unit) Department, Appeals and Grievances (A&G) Department, Managed Long-Term Services and Support (MLTSS) Department, Pharmacy Department, Claims Department, and the Potential Quality of Issues (PQI) Team, to report activities 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 Community Advisory Council 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. Quality Improvement program updates and changes 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.

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 e-newsletter, *the PULSE*, and *Progress Notes* communicates quarterly 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. L.A. Care also publishes a provider e-newsletter the PULSE, 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 component 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 adult and child vaccines, postpartum care, follow-up visits for mental illness after hospitalization, cancer screenings, well-child visits and more. Member incentives undergo evaluations on performance metrics, return on investment (ROI) analysis 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, organizations, participating physician groups (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.

L.A. Care's Physician P4P Program 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 started paying out on domains and measures related to Utilization Management and Member Experience with the 2023 Physician P4P program year after several years of testing and will continue in 2024.

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 in Medi-Cal, L.A. Care Covered (LACC), and Dual Eligible Special Needs Plan (D-SNP) for Medicare. VIIP continues in 2024 and measures, reports, and provides financial rewards for provider group performance across multiple domains, including HEDIS Clinical Quality, Utilization, Encounters,

Member Experience, Care Management, and Medication Management. 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. 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 monetarily 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. Plan Partner quality performance also affects the proportion of auto-assigned members they receive. The program will continue to utilize these metrics in 2024 with targeted areas of modification.

L.A. Care will be launching new P4P programs for its contracted hospitals and skilled nursing facilities (SNFs) in 2024. The programs will utilize metrics designed to increase quality by assessing whether the services provided are safe, effective, patient-centered, timely, efficient, and equitable. Example measures included in the Hospital P4P include readmission rates, hospital-acquired infections, NTSV C-section rates, etc. Example measures included in the SNF P4P include percent of residents experiencing one or more falls with a major injury, number of hospitalizations per 1,000 long-stay resident days, healthcare-associated infections requiring hospitalizations, and more.

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 Community Resource Centers.

Marketing staff are aligned by product lines, health plan initiatives, and the Community Resource Centers. Marketing staff lead 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 direct to consumer marketing, 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 West LA, East LA, El Monte, Inglewood, Lincoln Heights, Long Beach, Lynwood, Norwalk, Metro LA, Palmdale, Panorama City, Pomona,

South LA, 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-through food pantries and vaccine clinics to support 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 Eligible 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 Eligible Special Needs Plan (D-SNP), and L.A. Care Covered product lines.

Member-focused newsletters are distributed quarterly, to help 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 Eligible 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 benefits 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 frequently communicating 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. There 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 and Health Equity 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 and health equity program are 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 measurements systems 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 on 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 outcomes 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, and 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 improve further 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 and Health Equity 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 encountering diagnoses, adverse incidents (such as death, avoidable admission or readmission and patterns of referrals or authorization 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 the 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 and Health Equity 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.

L.A. Care ensures that information and data received from providers are accurate, timely, and complete. An external auditor to ensure accuracy audits all HEDIS measures. 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, data and, when possible, a 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 the 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 available resources. Continuous quality improvement is realized when data are collected and analyzed, interventions are planned and implemented, measurement is repeated, and performance is 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 the 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 support network providers and members to achieve evidence-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 a timely and easily accessible web-accessible format.

Performance Target

The terms benchmark and performance targets are not necessarily the same. L.A. Care uses nationally recognized or industry benchmarks to measure success and improvements (i.e., NCQA benchmarks and thresholds, DHCS set benchmarks, CMS, or other regulatory bodies). 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 difficult measures, a rational target is often statistically significant improvement over three-years.

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 the number 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 interests 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, including relevant policies and procedures to protect our members' confidentiality. 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 participating in the use, creation, maintenance, or disclosure of Protected Health Information (PHI) or Personal Information (PI) 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 treatment, payment, or health care operations, as described in our Notice of Privacy Practices. These purposes include using PHI/PI 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. They may only release such information as permitted by applicable laws and regulations, including the 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, 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 L.A. Care location is confidential and protected from unauthorized dissemination by L.A. Care, its employees, and its agents.

COMMUNICABLE DISEASE REPORTING STATEMENT

L.A. Care' notifies its network of the requirement by the county and requests network providers to comply 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 are to protect the health of the public, determine the extent of morbidity within the community, evaluate the 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 Public Health's 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 healthcare delivery functions and administrative services to IPAs/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, Cultural and Linguistics. Delegated functions include, but are not limited to, preventive health services,

clinical practice guidelines, and meeting 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, and member as well as practitioner satisfaction surveys. Delegated IPAs are required to have an effective quality improvement and health equity 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 healthcare services and perform other delegated functions. L.A. Care requires and ensures that each delegate is capable of managing the delegated activities and complying 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 assess continual compliance with standards and requirements. Oversight audit and monitoring results are reviewed, and opportunities for performance improvement are identified and reported to the delegate. The delegate must have an established QIHE program, which includes a work plan, and policies and procedures consistent and current with the 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 the Final Annual Audit Findings (FAAF), the delegate has 20 business days to provide L.A. Care with a completed CAP form. After all CAPs for all audit areas are accepted and the audit is closed, L.A. Care may conduct a CAP validation 60 calendar days after the 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, Contracts with Delegates should at a minimum, include:

- Quality improvement and health equity responsibilities, and specific delegated functions and activities
- L.A. Care's oversight, monitoring, and evaluation processes and the Delegate agreement to such processes.
- L.A. Care's reporting requirements and approval processes. The contract agreement shall include the Delegate' responsibilities to report quality improvement activities at least quarterly.
- L.A. Care shall take actions/remedies if the Delegate' obligations are not met.

ANNUAL QI AND HEALTH EQUITY PROGRAM EVALUATION

L.A. Care annually reviews data, reports, and other performance measures regarding program activities to assess the overall effectiveness of its QI and Health Equity 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 and Health Equity Program including progress toward influencing network-wide safe clinical practices; and the goals and plans for the next year. The annual QI and Health Equity Program Evaluation is presented to the Quality Improvement and Health Equity Committee (QIHEC)), Quality Oversight Committee (QOC), and Compliance & Quality Committee (C&Q) for review and approval. It is available to regulatory agencies if requested.

ANNUAL QI AND HEALTH EQUITY WORK PLAN (SEE Attachment 5)

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

The QIHE Work Plan includes a description of the following:

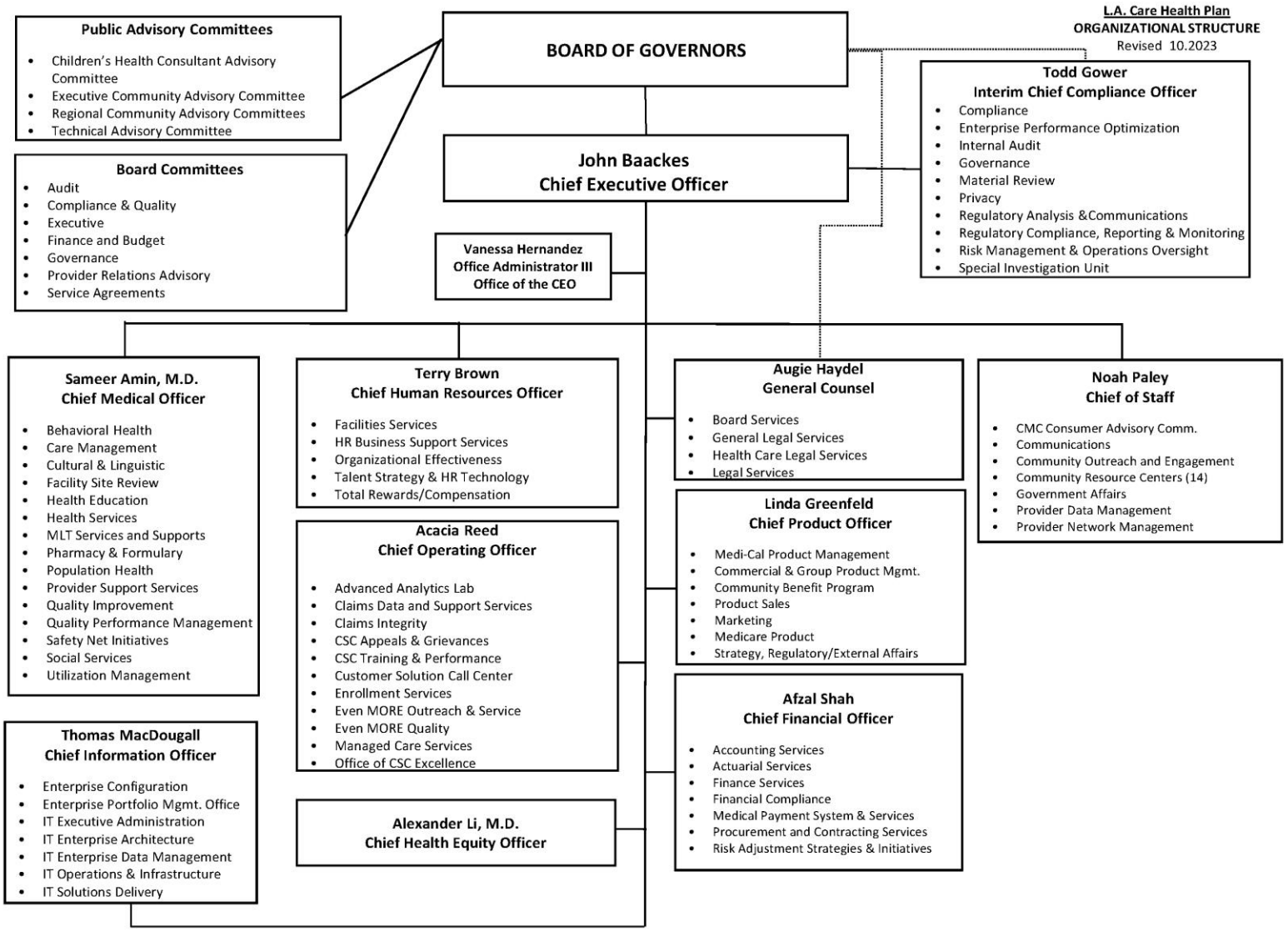
- The QI and Health Equity Program scope includes the quality of equitable clinical care, service, safety of clinical care, and member experience.
- Planned activities and measurable goals and/or benchmarks that encompass a comprehensive program scope, including, equity, quality and safety of clinical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

Each of the elements identified in the Work Plan has activities defined, responsibilities assigned, and the date by which completion is expected. The QI and Health Equity Work Plan and Quality Improvement and Health Equity 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. 117, 08-08-14

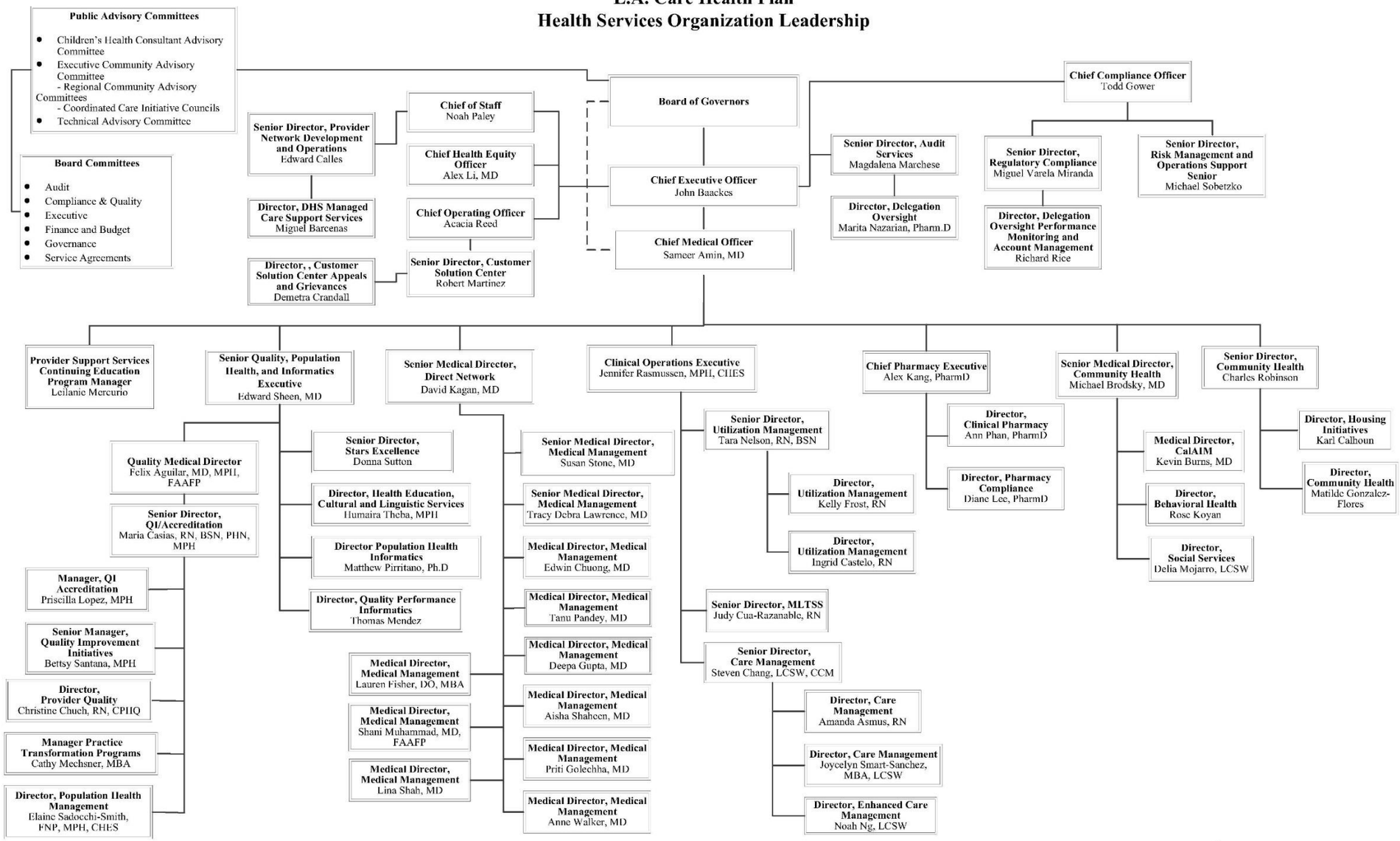
Attachment 1	Organizational Structure
Attachment 2	Health Services Organization Leadership
Attachment 3	Quality Program Committee Structure
Attachment 4	HEDIS Measures
Attachment 5	2024 QI and Health Equity Work Plan including Medicare

ATTACHMENT 1



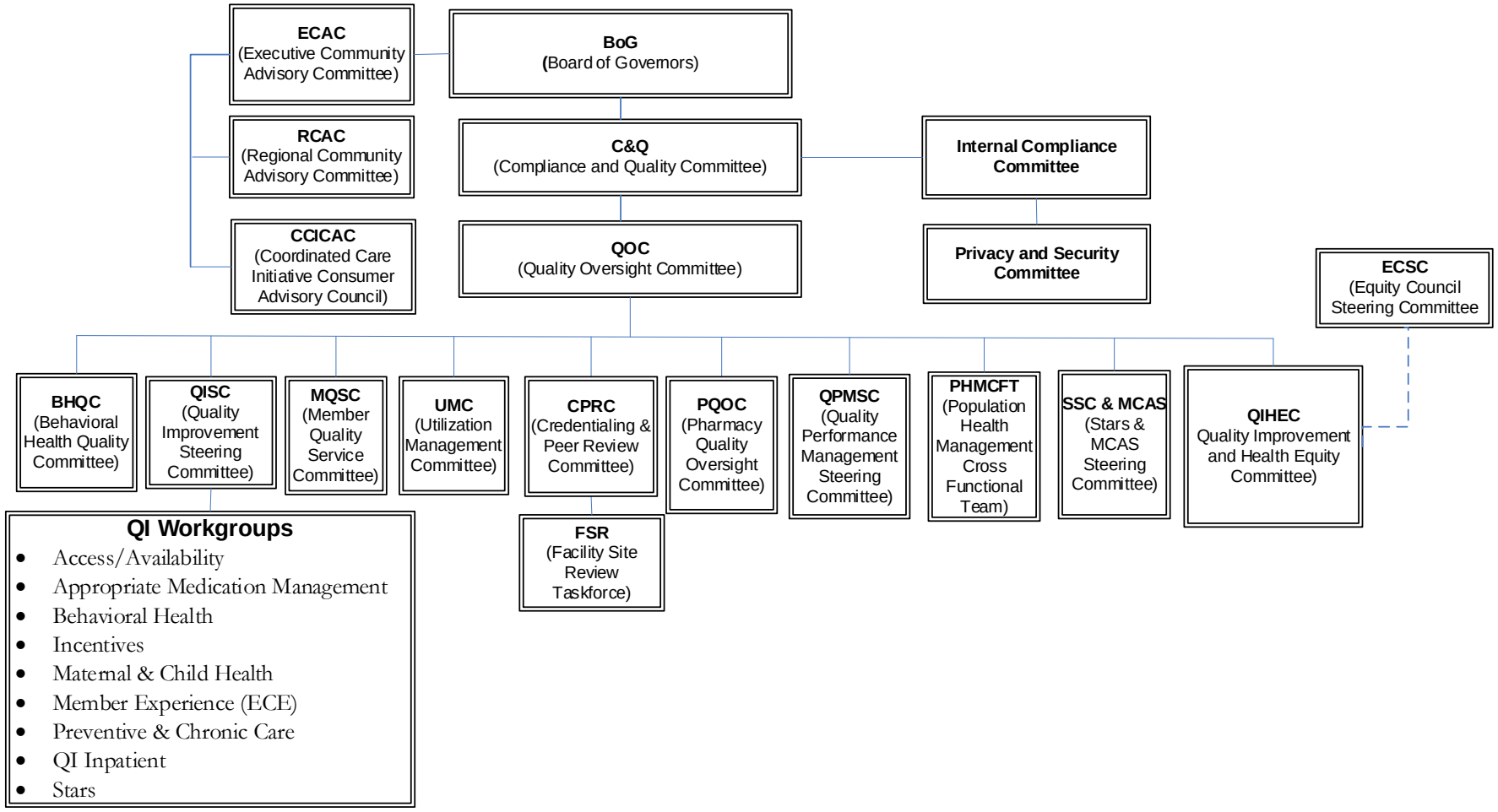
ATTACHMENT 2

2024
L.A. Care Health Plan
Health Services Organization Leadership



ATTACHMENT 3

L.A. Care Health Plan
Quality Improvement Committees



ATTACHMENT 4

Acronym	HEDIS Measure Name	Administrative or Hybrid (A/H) or Electronic Clinical Data System (ECDS)	L.A. Care Covered Measure (QRS)	*DHCS Auto Assignment Measure	DHCS MCAS Measures Held to Minimum Performance Levels	NCQA Accreditation Measures - Medicare	NCQA Accreditation Measure - Medi-Cal
AAB	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	A	X			X	X
ACP	Advance Care Planning	A				X	
ADD-E	Follow-Up for Children Prescribed ADHD Medication - Continuation and Maintenance	ECDS					X
AHU	Acute Hospitalization Utilization – Total Acute -65+ years	A				X	
AIS-E	Adult Immunization Status (All 4 Rates)	ECDS	X			X	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-E	Metabolic Monitoring for Children and Adolescents on Antipsychotics – Total	ECDS					X
BPD	Blood Pressure Control for Patients with Diabetes	H				X	X
BCS-E	Breast Cancer Screening - Total	ECDS	X		X	X	X
CBP	Controlling High Blood Pressure - Total	H	X	X	X	X	X
CCS	Cervical Cancer Screening	H	X		X		X
CHL	Chlamydia Screening in Women -Total	A	X		X		X
CIS-10	Childhood Immunization Status - Combo 10	H	X	X	X		X
COL	Colorectal Cancer Screening – Total	H	X				
COL-E	Colorectal Cancer Screening - Total	ECDS				X	X

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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 MCAS Measures Held to Minimum Performance Levels	NCQA Accreditation Measures - Medicare	NCQA Accreditation Measure - Medi-Cal
CWP	Appropriate Testing for Pharyngitis	A				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	
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		X	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		
FUH7	Follow-Up After Hospitalization for Mental Illness - 7 day	A	X			X	X
FUH30	Follow-Up After Hospitalization for Mental Illness - 7 day and 30 day (LACC only)	A	X				
FUI	Follow-Up After High-Intensity Care for Substance Use Disorder - 7 days	A				X	X
FUM7	Follow-up After Emergency Department Visit for Mental Illness - 7 day	A		X		X	X

ATTACHMENT 4

Acronym	HEDIS Measure Name	Administrative or Hybrid (A/H) or Electronic Clinical Data System (ECDS)	L.A. Care Covered Measure (QRS)	*DHCS Auto Assignment Measure	DHCS MCAS Measures Held to Minimum Performance Levels	NCQA Accreditation Measures - Medicare	NCQA Accreditation Measure - Medi-Cal
FUM30	Follow-up After Emergency Department Visit for Mental Illness – 30- days	A		X	X		
GSD	Glycemic Status Assessment for Patients with Diabetes – Glycemic Status Control (<8%)	H		X		X	X
GSD	Glycemic Status Assessment for Patients with Diabetes - Glycemic Status Poor Control (>9%)	H	X		X		
HFS	Hospitalization Following Discharge From a Skilled Nursing Facility - 30-Day	A				X	
HPC	Hospital for Potentially Preventable Complications	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		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	X
LDM	Language Diversity of Membership	A				X	X
LSC	Lead Screening in Children	H			X		

ATTACHMENT 4

Acronym	HEDIS Measure Name	Administrative or Hybrid (A/H) or Electronic Clinical Data System (ECDS)	L.A. Care Covered Measure (QRS)	*DHCS Auto Assignment Measure	DHCS MCAS Measures Held to Minimum Performance Levels	NCQA Accreditation Measures - Medicare	NCQA Accreditation Measure - Medi-Cal
OED	Oral Evaluation, Dental Services	A	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				
PDS-E	Postpartum Depression Screening and Follow-Up—Screening	ECDS					X
POD	Pharmacotherapy for Opioid Use Disorder	A				X	X
PPC-Pst	Prenatal and Postpartum Care - Postpartum Care	H	X	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
SAA	Adherence to Antipsychotic Medications for	A				X	X

ATTACHMENT 4

Acronym	HEDIS Measure Name	Administrative or Hybrid (A/H) or Electronic Clinical Data System (ECDS)	L.A. Care Covered Measure (QRS)	*DHCS Auto Assignment Measure	DHCS MCAS Measures Held to Minimum Performance Levels	NCQA Accreditation Measures - Medicare	NCQA Accreditation Measure - Medi-Cal
	Individuals with Schizophrenia						
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	
URI	Appropriate Treatment for Upper Respiratory Infections	A	X			X	
W30	Well-Child Visits in the First 30 months of Life	A	X	X	X		
WCC-BMI	Weight Assessment & Counseling for Nutrition& Physical for Children and Adolescents	H	X				X
WCC--N	Weight Assessment & Counseling for Nutrition& Physical for Children and Adolescents	H	X				
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

ATTACHMENT 5

2024 QI and Health Equity Work Plan including Medicare