Board of Commissioners Meeting Agenda

Via Webex

April 27, 2022: 10:00 a.m. – 1:00 p.m.

In-person Locations:

PHC's Southeast Region Office located at 4605 Business Center Drive, Fairfield, CA

PHC's Northeast Region Office located at 2525 Airpark Dr., Redding, CA

****** As signed by the Governor on September 16, 2021, AB 361, allows for Brown Act teleconferencing flexibilities during a state of emergency ******

AB 361 authorizes public meetings with Brown Act requirements to be held via teleconference or telephone during a proclaimed state of emergency. It waives the Brown Act requirement for physical presence at the meeting for members, the clerk, and/ or other personnel of the body as a condition of participation for a quorum, due to the state of emergency caused by the spread of COVID-19 and the risk to the health or safety of attendees meeting in person would present.

Public Participation

The PHC Board of Commissioners meeting may be accessed through Webex:
https://partnershiphp.webex.com/meet/boardmeeting

Participant Pin: 803 736 976

Toll Free Number: 1-844-621-3956

Public comment is welcome during designated "Public Comments" time frames or by emailing comments to the Board Clerk at Board_FinanceClerk@partnershiphp.org by 5:00p.m on April 26, 2022. Comments received will be read during the meeting.

10:00A.M – Opening			
1.1 **Call to Order**			*Alicia Hardy, Chair*
1.2 **Roll Call**			*Clerk*
1.3	***ACTION***: Resolution to Approve the New Appointment of Gena Bravo to the PHC Board	4-5	*Liz Gibboney*
1.4	***ACTION***: Resolution to Approve the New Appointment of Keri Thomas to the PHC Board	6-7	*Liz Gibboney*
1.5	***ACTION***: Resolution to Approve the New Appointment of Erik McLaughlin to the PHC Board	8-9	*Liz Gibboney*

1.6	***ACTION:*** Approval of Agenda and Board Meeting Minutes for February 23, 2022	10-18	*Chair*
1.7 **Public Comment**			*Liz Gibboney*
1.8	***INFORMATION:*** CEO Report	19-20	*Liz Gibboney*
10:30A.M. – Consent Calendar			
3	***ACTION:*** Consent Calendar ▪ **3.1** Resolution to Accept all PHC Committee Minutes, Department Operating Report, and PHC Policies, Program Descriptions, and PCP QIP Changes Approved by PAC. ▪ **3.2** Resolution to Retire the 340B Advisory Committee ▪ **3.3** Resolution to Approve Care Coordination Program Description, MPCD2013 ▪ **3.4** Resolution to Approve HR Policies and Personnel Committee Minutes for April 20, 2022 ▪ **3.5** Resolution to Approve Findings That, as a Result of the Continuing COVID-19 Pandemic State of Emergency, Meeting in Person Would Present Imminent Risks to the Health or Safety of Attendees	21-22 23-24 25-64 65-71 72-73	*Liz Gibboney*
10:45A.M. – Regular Agenda Items			
4.1	***ACTION:*** Resolution to Approve Budget Assumptions for FY2022-2023	74-79	*Patti McFarland / Jeff Ingram*
10:55A.M. – Reports			
5.1	***INFORMATION:*** Metrics and Financial Update	80-95	*Patti McFarland / Jeff Ingram*
5.2	***INFORMATION:*** Operations Update	96-98	*Sonja Bjork*
5.3	***INFORMATION:*** Media Update	99-114	*Dustin Lyda*
5.4	***INFORMATION:*** CMO Report on Quality	115-121	*Dr. Moore*
11:35 – Education Sessions			
6.1	***INFORMATION:*** Claims Department Update		*Lisa Malvo / Nikki Rotherham*
6.2	***INFORMATION:*** Care Coordination Department Update		*Katherine Barresi / Melissa McCartney*
12:00-12:10 P.M. – BREAK			

Closed Session		
7.1	CONFERENCE WITH LEGAL COUNSEL—ANTICIPATED LITIGATION Significant exposure to litigation pursuant to Section 54956.9(d)(2) of Ralph M. Brown Act: Multiple Potential Cases	*Full Board, Outside Counsel, Liz Gibboney, Patti McFarland, Sonja Bjork, Amy Turnipseed Jeff Ingram, Kirt Kemp and Ashlyn Scott, Board Clerk*
1:00 P.M. – Adjournment		

Upcoming Meetings:

06/22/2022 – UC Davis, Putah Creek Lodge
08/24/2022 – PHC's Fairfield Office
10/26/2022 – TBD, Redding
12/07/2022 – PHC's Santa Rosa Office

BOARD MEMBER APPOINTMENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
April 27, 2022

Agenda Item Number:
1.3

Resolution Sponsor:
Liz Gibboney, CEO, Partnership HealthPlan of CA

Recommendation by:
Yolo County Board of Supervisors

Topic Description:
On January 11, 2022, Gena Bravo, President and CEO at Woodland Memorial Hospital, was appointed by the Yolo County Board of Supervisors to the Partnership Health Plan of California (PHC) Commission (known as the Board) to replace Dr. Ron Clement.

Gena Bravo's appointment commences on April 27, 2022 and concludes April 26, 2026.

Reason for Resolution:
To obtain Board approval to appoint Gena Bravo to the PHC Board as the Yolo County Representative.

Financial Impact:
There is no financial impact to the HealthPlan.

Requested Action of the Board:
Based on the recommendation of the Yolo County Board of Supervisors, the Board is asked to approve the new appointment of Gena Bravo to the PHC Board.

BOARD MEMBER APPOINTMENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
April 27, 2022

Agenda Item Number:
1.3

Resolution Number:
22-

IN THE MATTER OF: APPROVING THE NEW YOLO COUNTY APPOINTMENT FOR GENA BRAVO TO THE PHC BOARD

Recital: Whereas,

A. Certain agencies have responsibility for appointing Board members.

B. Yolo County has a vacant seat.

C. The Board has authority to approve and appoint committee members.

Now, Therefore, It Is Hereby Resolved As Follows:

1. To approve the new Yolo County appointment of Gena Bravo to the PHC Board.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 27th day of April 2022 by motion of Commissioner, seconded by Commissioner, and by the following votes:

AYES: Commissioners:

NOES: Commissioners:

ABSTAINED: Commissioners:

ABSENT: Commissioners:

EXCUSED: Commissioners:

_____
Alicia Hardy, Chair

_____
Date

ATTEST:

BY: _____
Ashlyn Scott, Board Clerk

BOARD MEMBER APPOINTMENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
April 27, 2022

Agenda Item Number:
1.4

Resolution Sponsor:
Liz Gibboney, CEO, Partnership HealthPlan of CA

Recommendation by:
Solano County Board of Supervisors

Topic Description:
On December 14, 2021, Keri Thomas, Vice President of External Affairs at Sutter Health, Valley Area, was appointed by the Solano County Board of Supervisors to the Partnership HealthPlan of California (PHC) Commission (known as the Board) to replace Abhishek Dosi.

Keri Thomas' appointment commences on April 27, 2022 and concludes December 31, 2024.

Reason for Resolution:
To obtain Board approval to appoint Keri Thomas to the PHC Board as the Solano County Hospital Representative.

Financial Impact:
There is no financial impact to the HealthPlan.

Requested Action of the Board:
Based on the recommendation of the Solano County Board of Supervisors, the Board is asked to approve the new appointment of Keri Thomas to the PHC Board.

BOARD MEMBER APPOINTMENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
April 27, 2022

Agenda Item Number:
1.4

Resolution Number:
22-

IN THE MATTER OF: APPROVING THE NEW SOLANO COUNTY APPOINTMENT FOR KERI THOMAS TO THE PHC BOARD

Recital: Whereas,

A. Certain agencies have responsibility for appointing Board members.

B. Solano County has a vacant seat.

C. The Board has authority to approve and appoint committee members.

Now, Therefore, It Is Hereby Resolved As Follows:

1. To approve the new Solano County appointment of Keri Thomas to the PHC Board.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 27th day of April 2022 by motion of Commissioner, seconded by Commissioner, and by the following votes:

AYES: Commissioners:

NOES: Commissioners:

ABSTAINED: Commissioners:

ABSENT: Commissioners:

EXCUSED: Commissioners:

_____
Alicia Hardy, Chair

_____
Date

ATTEST:

BY: _____
Ashlyn Scott, Board Clerk

BOARD MEMBER APPOINTMENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
April 27, 2022

Agenda Item Number:
1.5

Resolution Sponsor:
Liz Gibboney, CEO, Partnership HealthPlan of CA

Recommendation by:
Lake County Board of Supervisors

Topic Description:
On April 5, 2022, Erik McLaughlin, M.D., Public Health Officer at Lake County, was appointed by the Lake County Board of Supervisors to the Partnership HealthPlan of California (PHC) Commission (known as the Board) to replace Gary Pace, M.D.

Erik McLaughlin, M.D.'s appointment commences on April 5, 2022 and concludes April 4, 2026.

Reason for Resolution:
To obtain Board approval to appoint Erik McLaughlin, M.D. to the PHC Board as the Lake County Representative.

Financial Impact:
There is no financial impact to the HealthPlan.

Requested Action of the Board:
Based on the recommendation of the Lake County Board of Supervisors, the Board is asked to approve the new appointment of Erik McLaughlin, M.D. to the PHC Board.

BOARD MEMBER APPOINTMENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
April 27, 2022

Agenda Item Number:
1.5

Resolution Number:
22-

IN THE MATTER OF: APPROVING THE NEW LAKE COUNTY APPOINTMENT FOR ERIK MCLAUGHLIN, M.D. TO THE PHC BOARD

Recital: Whereas,

A. Certain agencies have responsibility for appointing Board members.

B. Lake County has a vacant seat.

C. The Board has authority to approve and appoint committee members.

Now, Therefore, It Is Hereby Resolved As Follows:

1. To approve the new Lake County appointment of Erik McLaughlin to the PHC Board.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 27th day of April 2022 by motion of Commissioner, seconded by Commissioner, and by the following votes:

AYES: Commissioners:

NOES: Commissioners:

ABSTAINED: Commissioners:

ABSENT: Commissioners:

EXCUSED: Commissioners:

_____
Alicia Hardy, Chair

_____
Date

ATTEST:

BY: _____
Ashlyn Scott, Board Clerk

MINUTES OF THE MEETING OF
PARTNERSHIP HEALTHPLAN OF CALIFORNIA (PHC) BOARD OF COMMISSIONERS
Meeting held via Webex
In person locations:
PHC's Southeast Office located at 4665 Business Center Drive, Fairfield
PHC's Northeast Office located at 2525 Airpark, Redding
On
February 23, 2022

Members Present: Jonathan Andrus, Mary Kay Brooks, Lewis Broschard, M.D., Paula Cohen, Cathryn Couch, Greta Elliott, Donnell Ewert, Dean Germano, Liz Hamilton, Alicia Hardy, Randall Hempling, Dave Jones, Karen Larsen, Wendy Longwell (11:42 arrival), Viola Lujan, Melissa Marshall, M.D., Benita McLarin, Mitesh Popat, M.D., Kathryn Powell, Tory Starr, Kim Tangermann, Jennifer Yasumoto, Nancy Starck (Chair).
Members Absent: None
Members Excused: Darcie Antle, Gerald Huber, Jed Rudd, Heather Snow
Staff: Amy Agle, Sonja Bjork, Rebecca Boyd-Anderson, Katherine Barresi, Dell Coats, Marissa Dominguez, Kim Fillette, Patty Hayes, Matt Hintereder, Peggy Hoover, Jeff Ingram, Margaret Kisliuk, Kirt Kemp, Mary Kerlin, Marshall Kubota M.D., John Lemoine, Stan Leung, Regina Littlefield, Dustin Lyda, Lisa Malvo, Melissa McCartney, Patti McFarland, Robert Moore M.D., Lisa O'Connell, Jose Puga, Erika Robinson, Nikki Rotherham, Jing Sancho, Chloe Schafer, Lynn Scuri, Tahareh Daliri Sherafat, Kevin Spencer, Amy Turnipseed, Colleen Valenti, Wendi West, Liz Gibboney, CEO and Ashlyn Scott, Board Clerk
Guests: Matt Gal, Gena Bravo

AGENDA ITEM	DISCUSSION	MOTION / ACTION
1.0 Opening	Commissioner Nancy Starck, Board Chair, called the bi-monthly meeting to order via Webex video conference and welcomed everyone to the meeting. Board members and attendees were informed that California bill AB 361, which relates to social distancing measures being taken for COVID-19, waives the Brown Act requirement for physical presence at the meeting for members, the clerk and/ or other personnel of the body as a condition of participation for a quorum. Board members were reminded to abstain from voting on any agenda item where they might have a conflict of interest, and to state their name before asking questions or making motions. As a reminder, Commissioner Starck read the PHC Mission Statement: "to help our members, and the communities we serve, be healthy." She also mentioned that guests would have an opportunity to speak at designated times throughout the agenda.	None

1.2 Roll Call	Ashlyn Scott, Clerk of the Commission, called the roll indicating there was a quorum.	None
1.3 Approval of Agenda and the Board Meeting Minutes for December 8, 2021	Chairwoman Starck asked if anyone had changes for the agenda or corrections for the December 8, 2021 minutes. Hearing no requests for modification, she asked for a motion to approve the agenda and minutes.	*Commissioner Starr moved to approve the agenda and minutes as presented, seconded by Commissioner Couch.* ***ACTION SUMMARY:*** Yes: 22 No: 0 Abstention: 0 Excused: 4 (Antle, Huber, Longwell, Rudd, Snow) Absent: 0 **MOTION CARRIED**
1.4 Commissioner Comment	Chairwoman Starck asked if there were any commissioner comments. Hearing none, she moved to Public Comment.	None
1.5 Public Comment and Correspondence	Chairwoman Starck asked if there were any public comments. Hearing no requests, she moved on to correspondence. Ashlyn Scott, Clerk, stated that there had been no correspondence since the last Board Meeting.	None
1.7 CEO Report	Ms. Gibboney began her report by highlighting PHC's nominee for the Annual Leadership in Advocacy Award, Board Member, Randall Hempling. The award is presented by the Association For Community Affiliated Plans (ACAP), with the goal of showing appreciation for local Medicaid advocates. Randall volunteered to be a part of a COVID test group in early vaccine testing and advocated publicly for the population to be vaccinated. Randall received Honorable Mention for this award. Thank you for all of your hard work and advocacy, Randall. Ms. Gibboney continued her report by covering the following topics: **Project Phoenix –** PHC is performing extensive testing, and we are in the midst of the first mock "go-live" exercise. Results of this exercise will inform additional changes, if needed. The second Mock Go Live is scheduled for April and the final Go-Live is scheduled for the July 4th holiday weekend. **CalAIM Waiver** – Phase 1 of the CalAIM Waiver began January 1. PHC currently has 19 Enhanced Care Management (ECM) contracts, including counties such as Marin, Mendocino, Sonoma and 13 Community Support contracts. There are approximately 877 members enrolled in ECM services (as of 2/10).	None

	MediCal Rx – The program went live on January 1, 2022. There are reports of long call center wait times and inconsistent guidance from Magellan. **Student Behavioral Health Incentive Program (SBHIP) –** PHC is working directly with Offices of Education in all of our 14 counties. We expect to hear back from the counties by March 8 regarding their interest in the grants. PHC expects to administer roughly $20M in funds throughout our 14 counties. **DHCS Proposed Telehealth Guidance –** DHCS has proposed continued coverage and payment parity for video and audio appointments. There will be additional coding to the capture different telehealth categories being used. **Data Exchange Framework Stakeholder Advisory Group** – the group continues to meet monthly. We expect to hear about the Administration's budget request at the March meeting. **New DHCS Base Contract** – PHC received a proposed expanded base contract from DHCS, which is over 400 pages. It includes new DHCS Quality metrics that Dr. Moore will cover during his report in today's meeting. **California State FY 22-23 Budget** – The State budget enrollment projections decrease MediCal membership by 3%. Redeterminations will resume at the end of the public health emergency, currently scheduled to expire at the end of March. The Governor has proposed Undocumented Adult Coverage, which would add approximately 31,000 members in PHC's service area. Health equity payments and a housing and homelessness incentive program are also included in the budget. **Housing and Homelessness Incentive Program** – This program is funded by the American Rescue Plan, and included $1.288B of one-time funds that Health Plans will administer. **Upcoming Board Meetings** The Strategic Planning Retreat has been rescheduled for June 22 at UC Davis and we are hopeful the same speakers will be able to attend.	
2 & 3 Consent Calendar	Chairwoman Starck stated that all items on the consent calendar would be approved with one motion unless someone requests to pull an item for further discussion. Hearing no requests, she asked for a motion to approve resolutions 3.1, 3.2, 3.3, 3.4. ▪ 3.1 Resolution to Accept all PHC Committee Minutes, Department Operating Report, and PHC Policies, Program Descriptions, and PCP QIP Changes Approved by PAC. ▪ 3.2 Resolution to Reappoint Jonathan Andrus to the PHC Board ▪ 3.3 Resolution to Approve Utilization Management Program Description, MPUD3001 ▪ 3.4 Resolution to Approve Findings That, as a Result of the Continuing COVID-19 Pandemic State of Emergency, Meeting in Person Would Present Imminent Risks to the	*Commissioner Jones moved to approve Resolutions 3.1, 3.2, 3.3, 3.4 as presented, seconded by Commissioner Hempling.* ***ACTION SUMMARY:*** Yes: 22

	Health or Safety of Attendees	No: 0 Abstention: 0 Excused: 4 (Antle, Huber, Longwell, Rudd, Snow) Absent: 0 **MOTION CARRIED**
4.1 Resolution to Approve the Semi-annual Board Dashboard	Sonja Bjork, Chief Operating Officer, presented the Board with the Semi-annual Board Dashboard. She covered the following areas in her presentation: ▪ Membership Dashboard – PHC's membership continues to increase, however we are anticipating a downward trend when redeterminations begin again. *Commissioner Starck commented that some counties are struggling to recruit and retain staff to assist with redeterminations, so the process may be slower than expected.* *Commissioner Ewert said at a conference in the fall, many county health officials were under the impression they would not have to tackle redeterminations from the look back period but instead as they come in.* ▪ Call Center Dashboard – all metrics are in the green for PHC and our delegates. There were some slight drops in service areas due to staffing challenges during the height of the pandemic. ▪ Medical Utilization Dashboard – COVID-related impacts were represented in this dashboard. The average length of hospital stay was significantly impacted by the pandemic, due to the hospitals inability to discharge or transfer patients to SNFs and / or nursing homes. ▪ Delegate Utilization Dashboard – PHC is required to closely monitor delegates and the utilization rates, to ensure our members are adequately accessing these services. ▪ TAR Dashboards – PHC continues to keep up with timely processing of TARs. The Pharmacy TAR response rate unsurprisingly decreased due to Pharmacy staff transferring to different departments ahead of Medi-Cal Rx. ▪ Grievance Dashboard – PHC did not meet grievance timeliness standards for 2 quarters, due to staffing challenges related to COVID, however there has been a big emphasis on hiring and training and we are confident the next report will reflect better scores. *Commissioner Starck questioned if there are any penalties for not meeting timeliness standards.*	*Commissioner Powell moved to approve Resolution 4.1 as presented, seconded by Commissioner Tangermann.* ***ACTION SUMMARY:*** Yes: 22 No: 0 Abstention: 0 Excused: 4 (Antle, Huber, Longwell, Rudd, Snow) Absent: 0 **MOTION CARRIED**

	Ms. Bjork responded that there are many tools that DHCS can use, including corrective action plans and letters, however they have not implemented any yet, but these results will be included in the next audit. ▪ Claims Dashboard – The Claims departments consistently exceeds timeliness standards, despite Phoenix going live in a few short months. ▪ HR Dashboard – PHC saw a dip in employee retention due to the vaccine mandate and return to office, but we continue to steadily hire and decrease the turnover rate. ▪ Specialty Access and Provider Satisfaction Dashboard – PHC maintained high levels of specialty access utilization, mainly due to many providers offering telehealth during the pandemic. ▪ IT Dashboard – There was a large dip in IT service, due to an AT&T outage last May. *Commissioner Popat asked about PHC's cyber security measures in light of the escalating tensions in Russia and Ukraine. PHC is a medium-to-large organization with lots of sensitive data, what is PHC doing to prevent a potential cyber-attack.* *CIO, Kirt Kemp responded that PHC has secure hardware and software in place and robust cyber insurance, that has increased 100% in cost. PHC blocks any emails originating from Russia and uses training software to test staff by imitating phishing emails and identify areas of improvement.* *Commissioner McLarin inquired if more PHC employees are requesting to work remotely full time.* *Ms. Bjork responded that PHC now offers a variety of flexible work schedules, but absolutely seeing a lot of desire to work remotely.* *Commissioner Germano asked if PHC has mandated the COVID booster vaccine.* *Ms. Bjork replied that though PHC has not mandated the booster, but we are highly encouraging it and holding raffles for staff who do receive it. Approximately 75% of PHC staff have received the booster.*	
4.2 Resolution to Approve the Compliance Dashboard for Q42021	Amy Turnipseed, Chief Strategy and Government Affairs Officer requested approval of the Q42021 Compliance Dashboard. PHC had one delegate request an extension of an audit and nine delegates that did not meet timeliness standards. 100% of PHC employees	*Commissioner Andrus moved to approve Resolution 4.2 as presented, seconded by Commissioner Larsen.*

	completed the Annual Compliance Training by the end of 2021. DHCS confirmed PHC had no findings in the last audit.	***ACTION SUMMARY:*** Yes: 22 No: 0 Abstention: 0 Excused: 4 (Antle, Huber, Longwell, Rudd, Snow) Absent: 0 **MOTION CARRIED**
4.3 Resolution to Approve Commendations and Appreciation for Karen Larsen's Service to PHC	Ms. Gibboney announced Board Member Karen Larsen has resigned from Yolo County and the PHC Board and has accepted a new position as CEO at the Steinberg Institute. Ms. Gibboney thanked Commissioner Larsen for her dedication and service to the PHC Board.	*Commissioner Ewert moved to approve Resolution 4.3 as presented, seconded by Commissioner McLarin.* ***ACTION SUMMARY:*** Yes: 22 No: 0 Abstention: 0 Excused: 4 (Antle, Huber, Longwell, Rudd, Snow) Absent: 0 **MOTION CARRIED**
4.4 Resolution to Approve Commendations and Appreciation for Donnell Ewert's Service to	Ms. Gibboney announced Board Member Donnell Ewert will retire from Shasta County and the PHC Board in April. Commissioner Ewert is one of the original Shasta board members and PHC will miss his passion and energy. *Commissioner Germano added that he has known Commissioner Ewert for 22 years and appreciated his kindred spirit and determination to be progressive in a county that is not.*	*Commissioner Jones moved to approve Resolution 4.4 as presented, seconded by Commissioner Germano.* ***ACTION SUMMARY:*** Yes: 22 No: 0 Abstention: 0 Excused: 4 (Antle, Huber, Longwell, Rudd, Snow) Absent: 0 **MOTION CARRIED**

4.5 Resolution to Approve Commendations and Appreciation for Heather Snow's Service to PHC	Ms. Gibboney announced Board Member Heather Snow has left her position in Del Norte. County for a position at Open Door Community Health Centers. Liz thanked Commissioner Snow for her dedication to the PHC Board and expressed gratitude that she will remain in PHC's services area.	*Commissioner Starr moved to approve Resolution 4.5 as presented, seconded by Commissioner Couch.* ***ACTION SUMMARY:*** Yes: 22 No: 0 Abstention: 0 Excused: 4 (Antle, Huber, Longwell, Rudd, Snow) Absent: 0 **MOTION CARRIED**
5.1 Metrics and Financial Update	Jeff Ingram, Senior Director of Financial Analysis, began his report by covering the financials ending December 31, 2021, mid-way through the fiscal year. PHC finished December with a favorable revenue of $1.3M and $54.0M year-to-date. 2021 rates were higher than expected, in part due to the inclusion of an LTC 10% add-on, pharmacy adjustments for the carve-out delay, and the Maternity Kick supplemental payments. Ahead of next fiscal year's budget preparations, PHC attempts to forecast resumption of redeterminations. Mercer has shared their projection of a 2% membership decrease trend quarter-over-quarter. Redetermination forecasts will be included in the budget assumptions presented to the Board in April. *Ms. McFarland and Mr. Ingram's full report is included in the Board packet.*	None
5.2 Operations Update	Sonja Bjork, Chief Operating Officer, began her report by expressing appreciation to the Board for being so engaged on important initiatives. She stated that Commissioner Starck reached out to inquire about the closure of one skilled nursing facility (SNF) in Healdsburg, which was included in the Operations Report. PHC found out about the closure incidentally instead of receiving proper notice and successfully placed 15 PHC members in new facilities. Ms. Bjork also thanked Commissioner Popat for sharing information on workforce development in Marin County and their partnership with UC Berkley to recruit new graduates. *Commissioner Hardy questioned what members are eligible for ECM services.* *Ms. Bjork said there are several different ways cases come into Complex Case Management, including trough Member Services, Grievance, referrals and claims-based analysis.* *Commissioner Couch said she saw that 800 PHC members had transitioned into the ECM program and questioned what the target number is.*	None

	Ms. Turnipseed responded that DHCS estimates less than 1% of members will be eligible and willing to participate. The member has to want to be a part of the program. PHC has sent our projections to DHCS and are awaiting approval. *Ms. Bjork's full report is included in the Board packet.*	
5.3 Media Update	Dustin Lyda, Associate Director of Communications & Public Affairs, presented the Board with a media and legislative update. Friday, February 18 was the deadline for bills to be introduced in the Legislature and PHC has created a list of bills we are watching. *Mr. Lyda's full report is included in the Board Packet.*	None
5.4 CMO Report on Quality	Dr. Moore, Chief Medical Officer began his report by highlighting DHCS' newly-released Comprehensive Quality Strategy, which included a roadmap of clinical quality measures that Managed Care Plans will be responsible for reporting or improving. Each plan will be required to have a Health Equity Officer and all plans will need to be NCQA accredited. Dr. Moore covered the measures health plans will be accountable for in 2022, which remains unchanged, however health plans will be reporting on many new measures in 2022, many of which we will be held accountable to in measurement year 2023. Using data from the Primary Care Quality Improvement Program (PCP QIP), PHC has some preliminary estimates of health disparities in 2021. A full analysis will be available later this year. *Commissioner Lujan asked what PHC is doing to address the disparities.* *Dr. Moore responded that screening for social determinants and interventions is a priority for DHCS and PHC, however data alone won't address the issues and simply giving someone a list of resources does not mean they will access them.* *Commissioner Lujan emphasized the importance of education and advocacy.* *Commissioner Germano asked what dictates high emergency department levels in a county?* *Dr. Moore county responded that after-hours care helps a lot, but cultural factors are an integral aspect as well.* *Dr. Moore's full report is included in the Board Packet.*	None

5.5 Local Innovations Grants on Housing Report	Written report	None
6.1 Closed Session	Chairwoman Starck adjourned the Board of Commissioner to Closed Session at 12:11PM. Ms. Gibboney announced the following items to be discussed in closed session. Action Pursuant to Government Code § 54956.87 – Contract Negotiations Action Pursuant to Government Code §54956.87(b) – Trade Secrets There was no action taken in Closed Session.	None
Adjournment	The Board adjourned at 1:02P.M.	None

Respectfully submitted by:
Ashlyn Scott, Board Clerk

Board Approval Date: 04/27/22

Signed: _____ _____
Ashlyn Scott, Clerk Alicia Hardy, Chair

Report from the Chief Executive Officer

April, 2022

System Disruption. As you all know, we experienced a significant disruption on March 19th affecting all of our systems. We have made excellent progress in restoration, making our member and provider service levels a top priority. We are providing a full update to the Finance Committee and Board at our meetings this month.

Kaiser Direct Contract Proposal. The Newsom Administration continues to push for its quietly-negotiated five-year direct contract with Kaiser, covering 900,000 MediCal enrollees. This arrangement would carve these members out of contracts with California's local health plans, such as PHC. Due to the advocacy efforts of our association, plans and concerned stakeholders, this issue is now part of a policy bill, AB 2724 (Arambula), and will be heard by the Assembly Health Committee on April 19th.

Working with our association, LHPC, we have offered the administration and Legislature amendments which calls for exempting COHS plans and offering clarification on enrollment provisions for the remaining plans that would be subject to this arrangement. Our thanks to the many partners who submitted letters of opposition and oppose unless amended positions!

CalAIM Waiver. With the Enhanced Care Management and Community Supports aspects of the newly-approved five year CalAIM waiver launched in "phase one" counties, we continue to grow our provider network as we prepare for "phase two" counties, which go-live with these programs in July, 2022. We now have 563 members enrolled and have ECM contracts with 21 providers.

Project Phoenix. We completed our first "mock" go-live in February/early March and postponed our second, scheduled for this month, due to the system disruption. We are discussing the disruption's impact to the project as part of the restoration process.

MediCal Rx (the Governor's Executive Order on Pharmacy). DHCS launched the pharmacy "carveout," also known as MediCal Rx, on January 1, 2022. The rollout has quieted down due to the State's relaxing of prior authorization requirements, although these will end in the next couple of months.

California State Budget. There are several proposals in the Governor's January Budget proposal affecting MediCal managed care including enrollment projections, coverage for undocumented adults, and health equity payments. Budget hearings are underway.

Housing and Homeless Incentive Program ("HHIP"). DHCS is rolling out another very significant incentive program for health plans to administer that would be focused on housing and homeless projects in our counties, based on homeless member counts. Funding would be available through March, 2024.

Behavioral Health. We are engaged with local school districts and Offices of Education, in anticipation of rolling out Student Behavioral Health Incentive Program ("SBHIP") funds, beginning with local service assessments. To date, ten of our 14 county Offices of Education have completed their letters of intent to participate, which will trigger funds flowing to those entities to complete assessments and report back to us.

NCQA Accreditation & HEDIS Performance. Our current focus area will be improving our performance in the area of member engagement and Consumer Assessment of Healthcare Providers and Systems ("CAHPS") survey scores. We have an internal multi-departmental team that is heading up this effort. Additionally, we are now scheduling our next "mock" audit for this coming September. We have also been working with NCQA on our system disruption to mitigate any impacts to our reporting.

Geographic Expansion. As expected, DHCS made the long-awaited re-procurement announcements made on February 9th, granting conditional approval for PHC and several local health plans to expand their service area or change the model of managed care that they operate. We meet periodically with the counties, have updated them on the Kaiser issue, and will engage on CalAIM and other incentive programs that are being developed prior to the go-live date.

DHCS Contract. As part of the re-procurement process, DHCS released a new 400-page template contract for managed care plans, effective January 2024. In conjunction with other LHPC plans, our staff is reviewing each provision to identify new areas, areas needing clarification, and other provisions significantly different from current policy/operations.

Diversity, Equity and Inclusion. As we have discussed at previous Board meetings, DHCS is embedding health equity metrics in its new quality strategic plan and will roll out additional plan and provider requirements as part of its new draft contract for 2024.

Annual Board Strategic Planning Retreat. We have rescheduled our annual planning retreat for this June, to take place during our regularly-scheduled Board meeting.

Staff Count. We currently have 867 employees.

Upcoming 2021 Board Meetings and Events.

- Tuesday, June 21st – Board Retreat Dinner, Season's Restaurant, Davis
- Wednesday, June 22nd – Board Meeting and Retreat, UCDavis Conference Center
- August 24th – Board Meeting
- October 26th – Board Meeting
- December 7th – Board Meeting

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
April 27, 2022

Agenda Item Number:
3.1

Resolution Sponsor:
Liz Gibboney, CEO, Partnership HealthPlan of CA

Recommendation by:
PHC Advisory Groups and Committees

Topic Description:
Partnership HealthPlan of California (PHC) has a number of advisory groups and committees established by the Commission (known as the Board) with direct reporting responsibilities. These are the 340B, Compliance, Consumer Advisory, Finance, Personnel, Policies and Benefits, Physicians Advisory, Substance Use Services, Provider Advisory and Strategic Planning.

The Physician's Advisory Committee (PAC) has responsibility for oversight and monitoring for the quality and cost-effectiveness of medical care provided to PHC's members. A number of other PHC advisory groups and committees have direct reporting responsibilities to PAC. These are the Credentialing, Cultural & Linguistics & Health Education, Internal Quality Improvement, Member Grievance Review, Over/Under Utilization Workgroup, Peer Review, Pharmacy & Therapeutics, Provider Grievance Review, Quality/Utilization Advisory, Substance Use Services Internal Quality Improvement and Substance Use Services.

The Board is responsible for reviewing and accepting all minutes and packets approved by the various PHC advisory groups and committees, and approving the policies, program descriptions, and QIP policy changes that were approved by the PAC, from March 2022 through April 2022. In addition, the Board reviews and accepts PHC's Claims, Health Services, Human Resources, Member Services and Provider Relations department operating reports.

Reason for Resolution:
To provide commissioners with all PHC committee minutes, committee packets and departmental operational reports. In addition, to provide commissioners with all PHC policies and program descriptions approved by PAC and recommended for approval.

Financial Impact:
Any financial impact to the HealthPlan is included in the budget assumptions.

Requested Action of the Board:
Based on the recommendation of PHC's advisory groups & committees, the Board is asked to accept receipt of all PHC committee minutes, committee packets and the departmental operational reports. In addition, to approve all PHC policies and program descriptions approved by PAC linked to the packet.

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting
Date: April 27, 2022

Agenda Item Number:
3.1

Resolution Number:
22-

IN THE MATTER OF: ACCEPTING ALL PARTNERSHIP HEALTHPLAN OF CALIFORNIA (PHC) COMMITTEE MINUTES, COMMITTEE PACKETS, AND DEPARTMENTAL OPERATING REPORTS. IN ADDITION, TO APPROVE ALL PHC POLICIES AND PROGRAM DESCRIPTIONS APPROVED BY THE PHYSICIANS ADVISORY COMMITTEE (PAC)

Recital: Whereas,

A. The Board has fiduciary responsibility for the operation of the organization.

B. The Board has responsibility to review and accept all PHC committee minutes, packets and departmental operational reports. In addition to review and approve all PHC policies and program descriptions approved by PAC.

Now, Therefore, It Is Hereby Resolved As Follows:

1. To accept receipt of all PHC committee minutes, committee packets and departmental operational reports.
2. To obtain approval for all PHC policies and program descriptions approved by PAC and recommended for Board approval.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 27th day of April 2022 by motion of Commissioner, seconded by Commissioner, and by the following votes:

AYES: Commissioners:

NOES: Commissioners:

ABSTAINED: Commissioners:

ABSENT: Commissioners:

EXCUSED: Commissioners:

_____
Alicia Hardy, Chair

_____
Date

ATTEST:

BY: _____
Ashlyn Scott, Clerk

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
April 27, 2022

Agenda Item Number:
3.2

Resolution Sponsor:
Liz Gibboney, CEO, Partnership HealthPlan of CA

Recommendation by:
PHC Staff

Topic Description:
With the implementation of Medi-Cal Rx, on January 1, 2022, there is no longer a need for a 340B Committee at Partnership Healthplan.

Reason for Resolution:
To provide the Board with the recommendation of retiring the 340B Committee.

Financial Impact:
There is no financial impact to the HealthPlan.

Requested Action of the Board:
Based on the recommendation of the PHC staff, the Board is asked to approve the retirement of the 340B Committee.

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
April 27, 2022

Agenda Item Number:
3.2

Resolution Number:
22-

IN THE MATTER OF: APPROVING THE RETIREMENT OF THE 340B COMMITEE

Recital: Whereas,

A. PHC no longer oversees the pharmacy benefit for members.

B. There is no need for the 340B Committee at PHC.

C. The Board has responsibility to approve the elimination of a committee.

Now, Therefore, It Is Hereby Resolved As Follows:

1. To obtain approval for the retirement of the 340B Committee.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 27th day of April 2022 by motion of Commissioner, seconded by Commissioner, and by the following votes:

AYES: Commissioners:

NOES: Commissioners:

ABSTAINED: Commissioners:

ABSENT: Commissioners:

EXCUSED: Commissioners:

_____
Alicia Hardy, Chair

_____
Date

ATTEST:
BY: _____
Ashlyn Scott, Clerk

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
April 27, 2022

Agenda Item Number:
3.3

Resolution Sponsor:
Liz Gibboney, CEO, Partnership HealthPlan of CA

Recommendation by:
Quality / Utilization Advisory Committee & Physician Advisory Committee

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Topic Description:
The Care Coordination Program offers basic through complex services to all eligible PHC members. PHC staff work collaboratively with the member's primary care and other providers to coordinate clinical and supportive services to decrease the potential for fragmentation of care. The services help us fulfill our mission to help the members and the communities we serve be healthy.

Reason for Resolution:
To allow the full Board the opportunity to review and approve the Care Coordination Program Description when edits are made.

Financial Impact:
There is no measurable financial impact to the HealthPlan.

Requested Action of the Board:
Based on the recommendation of the Quality / Utilization Advisory Committee and the Physician Advisory Committee, the full Board is asked to approve the Care Coordination Program Description, MPCD2013.

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
April 27, 2022

Agenda Item Number:
3.3

Resolution Number:
22-

IN THE MATTER OF: APPROVING THE CARE COORDINATION PROGRAM DESCRIPTION, MPCD2013

Recital: Whereas,

A. The Board has the authority and responsibility for ensuring PHC has a comprehensive Care Coordination Program.

B. The Board has ultimate responsibility for approving the Care Coordination Program.

Now, Therefore, It Is Hereby Resolved As Follows:

1. To approve the Care Coordination Program Description, MPCD2013.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 27th day of April 2022 by motion of Commissioner, seconded by Commissioner, and by the following votes:

AYES: Commissioners:

NOES: Commissioners:

ABSTAINED: Commissioners:

ABSENT: Commissioners:

EXCUSED: Commissioners:

_____
Alicia Hardy, Chair

_____
Date

ATTEST:

BY: _____
Ashlyn Scott, Clerk

Partnership HealthPlan of California

CARE COORDINATION PROGRAM DESCRIPTION

MPCD2013

March ~~2021~~2022

Original Date: 01/20/2016
Revision Date(s): 06/21/17; *06/13/18; 11/14/18; 11/13/19; 04/08/20; 03/10/21; 03/09/22

*Through 2017, Approval Date reflective of the Quality/Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

Table of Contents

Program Purpose

To define the scope of services provided by Partnership HealthPlan of California's (PHC's) Care Coordination Department.

Introduction

Partnership HealthPlan of California's Care Coordination Department offers case management services to any plan member with care management needs who is willing to participate, and for whom PHC is either the primary source of coverage or for whom PHC may be responsible for the benefit, such as members eligible for California Children's Services (CCS). Case Management is a collaborative process that assesses, plans, implements, coordinates, monitors and evaluates the options and services required to meet the member's health and wellness needs. It is characterized by advocacy, communication, and resource management, while promoting quality and cost-effective interventions and outcomes. These services assist PHC in ensuring that we are fulfilling our mission to help the members and the communities we serve be healthy.

Department Objectives & Goals

The objectives and goals of PHC's Care Coordination Department are to:

- Educate members about the resources available to them through their plan benefits and how to use these resources to optimize his/her wellness.
- Assist members in understanding their health conditions and support members in becoming proficient in gaining/maintaining their optimum health and functionality
- Provide support for members with ~~emerging risk for, or existing,~~ chronic illness
- Facilitate timely access to care and efficient delivery of health care services, supplies, and equipment
- Promote communication between the member, member's supports (i.e., caregiver, guardian, or other concerned parties), providers, community resources, and long-term support systems
- Connect members to resources within their communities to support and to assist them in self-management of their health and well-being
- Collaborate with multidisciplinary health agencies and non-profit partners to link members to available community resources, where accessible
- Minimize gaps between healthcare settings by coordinating transitions across the healthcare continuum of age, coverage, service type, and location
- Improve member and provider satisfaction
- Provide education to members, providers, and community-based organizations about case management services offered by PHC and encourage referrals when needs or barriers are identified

Care Coordination is not intended to replace or be a substitute for the physician's management of a member's medical conditions. PHC staff works collaboratively with the practitioner to coordinate clinical and support services for members to decrease the potential for fragmentation of care.

Services offered through PHC's Care Coordination Department are available to eligible members, and outreach efforts may target a particular population depending on regulatory requirements and identified population needs. The following are examples of populations who may benefit from Care Coordination:

- Members new to the health plan who require expedited care.
- Children diagnosed with a California Children's Services (CCS) eligible condition.
- Medi-Cal PHC eligible enrollees who are designated by aid code as Seniors or Persons with Disabilities (SPD) and who may be at risk for an adverse outcome without an Individualized Care Plan (ICP).
- Children with Special Health Care Needs (CSHCN).
- Children and adults with developmental disabilities in collaboration with the California Regional Centers.
- Members identified as connected to the Genetically Handicapped Persons Program (GHPP) who require assistance and support.
- Members who are chronically ill or who have multiple complex medical conditions.
- Members preparing for an organ transplant.
- Members who require assistance accessing community-based programs and/or services.
- Members who are in a pivotal place with their healthcare needs due to transition across settings (i.e., acute hospital stay to home), across age groups (i.e., transition from pediatric to adult care), or across benefit structures (i.e., exhausting home health benefits or transitioning from curative care to hospice care).
- Members who have difficulties navigating the healthcare community.
- Members who have cognitive or communication deficits that require an advocate to help them communicate their health care needs.
- Members challenged with efficiently managing their health within PHC's managed care network.
- Children in Foster Care.

Scope of Services

The Care Coordination Department offers a variety of evidence-based services and interventions to coordinate care for members. Our team of Nurse Case Managers, Medical Social Workers, and Health Care Guides help to ensure services are coordinated for the member across the healthcare continuum. Taking the member's, or his/her caregiver's needs and preferences into account when communicating, the staff in the Care Coordination Department ~~and using~~uses evidence based practices such as ~~Through evidenced based practices such as,~~ Motivational Interviewing and principles from Dialectical Behavioral Therapy (DBT) to~~,~~ ~~the staff in the Care Coordination Department~~ ensure that the member's goals are at the center of an Individualized Care Plan (ICP). With the use of these member engagement techniques the team is able to assist the member in enhancing his or her autonomy and reaching their desired goals and outcomes.~~.~~

Identification and Referrals

The Care Coordination Department utilizes a variety of approaches to screen and identify members who may benefit from Case Management Services. These activities include:

- Internal reports, such as the Monthly Utilization Report, Monthly Pediatric Case Finding Report, Weekly Hospital Discharge Report, HEDIS Outreach Campaign List, etc.
- Review of referrals sent to the Care Coordination Department Help Desk email by both internal and external parties
- Heath Information Form (HIF)/Member Evaluation Tool (MET)
- Health Risk Assessment (HRA) Form
- Pediatric Health Risk Assessment (PHRA) Form
- Reports based on FFS Claims Data provided by the State, etc.

- Risk stratification reports

Referrals for Case Management Services originate from a variety of both internal and external sources. Members are commonly referred for Case Management from PHC's internal departments' such as Member Services, Pharmacy, Utilization Management, and/or Grievance. Externally, members may self-refer, or they may be referred by their caregivers, Primary Care Providers (PCPs), Specialists, Hospital Case Managers/Discharge Planners, and/or County or Community Partners such as Public Health Nurses, Medical Therapy Programs, Grant Programs, or Home Visiting Program Providers, etc.

Referrals for Case Management can be sent to the department directly via email, phone, PHC's member portal, or the Provider website referral form. Each referral sent to the department is reviewed by Care Coordination staff who, based on the information received upon intake, will identify the initial needs of the member and route the member to the appropriate team for case assignment.

Program Structure

Care Coordination services are based upon the acuity of the member's needs. Using a scale of one to ~~g~~five, themember's acuity determines the level of care coordination intervention. A member's acuity may be adjusted during the course of case management services as goals or met or additional barriers are encountered.

Acuity Level One:

Members with Acuity Level One are the lowest risk members in Care Coordination. Their needs are generally resolved within 30 days of identification and, the primary focus is to ensure these members are well-connected to their primary care providers or specialists who may be acting as primary care providers. Members who may be considered Acuity One include:

- New Member Health Information Forms (HIFs)
- Access to Care:
    - Primary or Specialty Care,
    - Behavioral Heath Therapy (BHT),
    - Early Periodic Screening Diagnostic and Treatment (EPSDT) services,
    - Transportation to/from Medi-Cal covered services.
- Those needing assistance with:
    - IHSS, Medi-Cal Dental,~~,~~ Meals on Wheels, etc.
    - Ancillary Services or DME covered by Medi-Cal
    - Prescriptions
    - Transitioning to a new primary care or specialty provider, including pediatric members preparing to transition from pediatric to adult care
    - Arranging routine screening appointments, such as those monitored through Healthcare Effectiveness Data and Information Set (HEDIS) measures.
    - Education for resources available in their area/community (housing, transportation, support groups, etc.)
- CCS member's annual re-assessment, risk review, and documentation to support redetermination of medical eligibility
- Members requesting to see out-of-network providers where an established relationship exists (Continuity of Care)

Interventions:

Members identified as an Acuity Level One will be assessed to identify his/her primary care coordination needs. Based on the member's stated goals, Care Coordination staff will assist the member in gaining access to necessary resources and supports. Typical interventions provided under Acuity Level One include, but are not limited to:

- Coordination of Services (appointments, referrals, DME, etc.)
- Collaboration with County/Community Agencies

Care Coordination staff work to help members overcome barriers to health and wellness care. When a member's barriers cannot be resolved promptly, Care Coordination staff create an Individualized Care Plan (ICP) to assist the member in achieving health and wellness goals. Throughout the course of the case, Care Coordination staff will reassess the assigned acuity level for the case and make adjustments as needed to provide the right level of care at the right time, including escalation to Complex Case Management (CCM) when warranted. Goals and interventions are routinely identified and evaluated by Care Coordination staff to track the member's progress. Goals and interventions may be added during the member's case management experience and closed as care needs resolve.

Acuity Level Two:

Members with Acuity Level Two have emerging risk of disease/disease exacerbation, a newly diagnosed chronic illness. They benefit from education and resources tailored to their condition along with a contact within the care coordination department should questions arise. Members assigned Acuity Level Two include those referred through or requiring assistance with:

- Maintenance of chronic conditions like diabetes, asthma, or mild to moderate mental illness
- High Risk Infant Follow Up (HRIF)
- Referrals from Population Health interventions

Interventions:

Members managed at an Acuity Level Two will be provided with Health Education resources supporting lifestyle management to maximize health and wellness, and to mitigate effects of chronic disease. Interventions provided for members with Acuity Level Two may include, but are not limited to:

- Emotional Support/ Active Listening
- Reinforcement of health maintenance screening and care
- Referrals to disease prevention/management programs, Population Health interventions, or Healthy Living classes
- Referrals to community support groups,
- Coordination of Services (appointments, referrals, DME, medical supplies,, etc.)
- Review of health education materials

Members in this acuity may require more intensive interventions should their condition warrant it or if the member requests additional support.

Transitions of Care

Acuity Level Three:

Transitions of Care services focus on members who are transitioning across settings (i.e., acute hospital stay to home) or across benefit structures (i.e., exhausting ~~home health benefits~~ residential treatment service benefits for substance use disorder or transitioning from curative care to hospice care). These members are vulnerable to lost information across the care continuum, fragmented care, may have difficulty navigating the health care system, or may need support ensuring a transition plan is executed as intended. Members considered Acuity Level Three may come from any source; however, the most common sources of referral are:

- Hospital Case Managers/Discharge Planners or Social Workers
- Weekly Hospital Discharge reports
- Other Care Coordination programs
- Referrals from PHC's Utilization Management team

Interventions

Case Management activities for members tiered at an Acuity Level Three ensure the member reconnects with primary care, specialty care (when needed) and community resources that will support health and wellness following a transition of care. Care Coordination staff will review the provider's plan of care, provide education/reinforcement for the transition plan, and develop an ICP supporting the member's successful transition along the care continuum. Typical interventions utilized during Case Management include, but are not limited to:

- Review of Discharge Summary/Plan
- Identification of ongoing care team roles and members
- Coordination of services (appointments, referrals, DME, food banks, homeless shelters, etc.)
- Referral to and collaboration with county/community agencies to provide support and reduce duplication of efforts
- Assistance with accessing programs such as Long Term Support Services (LTSS), Women, Infants, and Children (WIC) Program, or other social supports
- Motivational Interviewing to build on resiliencies
- Emotional Support/ Active Listening

Interventions are tailored in response to the member's assessed needs or stated goals. Care Coordination team members routinely evaluate the ICP and corresponding goals to evaluate the member's progress, update when necessary, and support the member in optimizing independence. Members with care needs that exceed the scope of Transitions of Care may move to Complex Case Management (CCM) for intensive care coordination support.

Complex Case Management (CCM)

Complex Case Management focuses on meeting the needs of the most fragile members through clinical intervention(s) and case management services~~.~~. These may be members with multiple chronic medical conditions, or they may have fragmented care, have difficulty navigating the health care system, or have other challenges that threaten to compromise their well-being if not supported through an ICP.

Acuity Level Four:

These members require the most intensive support available through clinical services and supports. Examples

of members commonly enrolled in CCM have at least one CCS-eligible condition along with social support

needs (in pediatric cases), members who have two or more chronic conditions (in adult cases). Alternatively, these members may have mental illness or substance use disorders~~, fragile housing,~~ or other challenges that threaten to compromise the member's well-being if not supported through an ICP. Cases in this tier may reflect more than one recent hospitalization within the past 2 months or had multiple emergency department visits relating to the eligible conditions. These cases have high risk of declining function, hospitalization, or readmission if appropriate interventions are not in place. Members assigned Acuity Level Four are often identified by:

- New Member Health Risk Assessments (HRAs) for new SPDs or CCS members
- Medical Therapy Programs/Units
- Hospital Discharge Planners or Social Workers
- Primary Care or Specialty Providers
- Internal case-finding reports (Monthly Utilization Report, Monthly Pediatric Case Finding Report, etc.)
- Care Coordination Help Desk email review
- Other internal Care Coordination services and activities
- Other internal departments (Utilization Management Rounds, Quarterly Grievance Review, Provider Relations etc.)
- Meetings with external organizations (Hospital Case Management Rounds, CCS county meetings, County Mental Health departments, Community-Based Organization collaborations, etc.)
- Risk stratification reports

Interventions

The primary focus of case management for members tiered at Acuity Level Four is the coordination of clinical services for medically complex cases. In addition, care coordination efforts will also address providing community connections, social supports, and integration with long-term support services. Care Coordination staff will perform a comprehensive assessment evaluating the member's medical, psycho-social, mental, emotional, and behavioral needs. The member and Care Coordination staff member will develop an ICP addressing both clinical and non-clinical concerns. Care Coordination staff will collaborate with the member to identify prioritized goals and select interventions/behaviors intended to meet these goals. Together, the member and Care Coordination staff will work through the duration of the case to overcome identified barriers to meeting these goals and achieving the health/wellness outcome(s) desired by the member. Typical interventions utilized during Complex Case Management include, but are not limited to:

- Personalized assessments
- Individualized Plan of Care (ICP)
- Motivational Interviewing to build on resiliencies
- Emotional Support/ Active Listening
- Review of disease signs/ symptoms
- Teach-back techniques to promote health and support lifestyle choices based on healthy behavior
- Coordination of Services (appointments, referrals, DME, medical supplies, etc.)
- Identification or barriers to established goals or treatment plan adherence
- Review for medical necessity of complex services such as Pediatric Shift Nursing or Residential Treatment Services
- Collaboration with the multi-disciplinary care team to ensure the member's care needs are expedited as well as reducing duplication of efforts amongst care team members

- Referral to and collaboration with county/community agencies
- Assistance with accessing programs such as LTSS, WIC, or other social supports.

Interventions are tailored in response to the member's assessed needs or stated goals. A copy of the ICP is provided to the member's provider(s) and to the member to facilitate collaboration and joint agreement on goals of care. The individualized care plan and corresponding goals are routinely evaluated by members of the Care Coordination clinical team to evaluate progress, update when necessary, and adjust the member's assigned acuity when appropriate. Care team conferences may be scheduled internally to provide clinical support, or with external parties (including the member/member's representative(s)) to ensure all members of the team are in agreement with the ICP and working toward common goals.

Acuity Level Five:

Members with Acuity Level Five are the highest risk members in Complex Case Management and they require more involvement than can be provided through telephonic forms of case management. These members experience extraordinary barriers to care, such as communication challenges, cognitive barriers, capacity issues, a severely fragmented provider/health care delivery system, and often require an onsite assessment(s) or multi-disciplinary conferences to meet their needs. Members considered for Acuity Level Five will be reviewed by a clinical supervisor for approval, with specific goals described for the face-to-face meeting.

Interventions

Acuity Level Five is distinguished from other acuities in that it includes all the interventions for other acuity levels as well as a face to face interaction between the case manager and the member/member's representative for one or more visits. This interaction may take place in the member's home, but more optimally occurs in a provider's office. These meetings are pre-scheduled and may include the member/member's representative, clinical member(s) of the care team with non-clinical support as appropriate to the case, the provider and/or specialist, ancillary provider(s) such as members of the Medical Therapy Unit or therapists, and other individuals who are a part of the member's multidisciplinary care team. Note: not all multidisciplinary care team meetings require a face to face visit; however, this intervention may be leveraged when the case complexity or communication challenges require extraordinary efforts for collaboration.

Care Coordination Process

When referred for Care Coordination, members are advised that these services are voluntary and the member is not required to participate. All case documentation of assessments, interventions, activity, and the member's ICP will be stored in the Care Coordination Department's Case Management software system. The Care Coordination team also documents when members decline to participate in case management or when they cannot be reached after multiple attempts through multiple means of contact.

The guiding principles for care coordination are identifying a member's goals of care and the barriers to meeting those goals, and then choosing interventions designed to overcome the barriers. When the identified goals are met, the case will be closed unless new goals, barriers, or needs are identified. At any time during the course of services, if the member's status or needs change, the case will be evaluated by the assigned Care Coordination staff member to determine acuity level appropriateness. Members who experience a change in condition where their needs cannot be met by Care Coordination will be screened and directed to other available services within, or external to PHC, when appropriate. In certain instances, staff may close a case

before completing the ICP or achieving the goals of Care Coordination. Examples of reasons where Care Coordination may be discontinued include:

- Member is no longer responsive to outreach efforts after 45 calendar days and multiple attempts
- Care Coordination staff and clinical leadership agree that member is uncooperative as evidenced by not demonstrating consistent adherence to the care plan.
- Member is obtaining case management services through another agency that duplicate the services offered through PHC, or is referred for case management to another service who is better suited to meeting the needs of the member (e.g., grant programs, county services, etc.)
- Member loses eligibility for PHC coverage.
- Continued inappropriate (derogatory, profane, abusive) behaviors towards the Care Coordination team with no improvement after documented discussions regarding the need for behavioral change.
- Cases closed to Care Coordination may be re-evaluated if the member's condition, or desire to participate, changes

Program Support

Care Coordination operations are supported by a leadership team and administrative support. To further the mission of Care Coordination and community connection, Health Services staff allocated to ensuring members have transportation to/from medical appointments in accordance with California Department of Health Care Services (DHCS) guidelines. In addition, staff are allocated to engage with the community to educate community partners on PHC care coordination services, to learn about resources available within the community, and to promote collaboration of effort/reduce duplication of services.

Enhanced Care Management (ECM)

Pursuant to APL 21-012, beginning January 1, 2022, PHC shall ~~provide~~offer ~~the~~ the CalAIM Enhanced Care Management (ECM) benefit for eligible members. The ECM benefit is unique and distinct from the care management services or programs offered by PHC. The ECM benefit primarily builds upon the design and learning from California's Whole Person Care Pilots (WPC) and Health Homes Program (HHP). The ECM benefit is part of the larger CalAIM proposal by DHCS as a way to advance and innovate Medi-Cal's approaches and services to those most vulnerable throughout the state.

PHC members may not be enrolled in any of Partnership's Care Coordination programs simultaneously with ECM. However, upon assessment of the member's needs and after obtaining the member's agreement to participate, PHC's Care Coordination department may refer the member to an ECM provider for services. Conversely, ECM providers may refer a member to one of Partnership's Care Coordination programs for support if indicated, or at the expressed desire by the member. For more information on the ECM benefit see PHC policy MCCP2032 CalAIM Enhanced Care Management (ECM).

Team Roles and Responsibilities

Senior Director of Health Services: At the senior level, provides overall direction to the Heath Services (HS) Care Coordination/Utilization Management/Population Health Leadership Team. This position has the ultimate responsibility to ensure that all workflow processes and Department Programs and services are consistent and meet all regulatory requirements in every office location.

Director of Care Coordination: Provides oversight of Care Coordination programs and services to improve the health of PHC members and to provide excellent customer service to members and providers. Works with the Chief Medical Officer, Senior Director of Health Services, and Associate/Regional Directors to meet

organization and department goals and objectives while developing and tracking measurable outcomes of department services. Works collaboratively with identified Health Services (HS) staff to ensure appropriate integration of PHC, DHCS, and NCQA guidelines, policies, and procedures.

Director of Care Coordination Operations: Responsible for the operational aspects of the Care Coordination Department, including Case Management and Transportation. He/she will be responsible for operationalizing department initiatives and projects. A key component of this position is the enhancement and refinement of existing programs, and enthusiastic innovation in the development, management, integration, and refinement of new and existing programs. This position is responsible for providing staff and organizational support, program development, monitoring, and implementation of all Care Coordination and Transportation functions in order to meet stated objectives and goals.

Associate Director of Care Coordination: Under direction from the Director of Care Coordination, manages and provides direction to the Care Coordination (CC) Department Managers and Supervisors for all services. Responsible for establishing and maintaining reports that will support the efficacy of department activity and to produce a summary at least annually or upon request, that includes documentation of department services, member outcomes, return on investment, and quality improvement activities.

Team Manager UM/CC: Assists the Associate Director of Care Coordination and Director of Care Coordination in the development, implementation and evaluation of PHC's clinical case management services. The Manager has day-to-day direction and management responsibility for the implementation of the care coordination department and reviews and submits clinical issues, updates, recommendations, and information to the HS Leadership when appropriate.

Non-Clinical Manager: Assists the Care Coordination Leadership in the development, implementation and evaluation of PHC's case management services. The non-clinical manager has day-to-day direction and management responsibility for the implementation of the care coordination department and reviews and submits issues, updates, recommendations, and information to the HS Leadership when appropriate.

Manager, Transportation Programs: Manages day-to-day operations of transportation services and benefits offered by PHC. Provides leadership, support, and education to assigned staff, and maintains relationships with providers, PHC contracted vendor(s), community partners, and county agencies, to promote collaboration and ensure smooth and consistent application of PHC transportation benefits. Participates in various internal venues to enhance cooperation and understanding of how the transportation program interacts with other initiatives to meet PHC's mission

Case Management Supervisor: Licensed clinician who provides supervisory oversight during daily department operations for assigned team members through sustained leadership and support. Using best clinical expertise and sound judgment (and in consultation with providers and staff), designs and implements high quality, cost effective care plans to enable members to achieve maximum medical improvement. Assists in determining appropriateness, quality and medical necessity of treatment plans.

Non-Clinical Supervisor: Provides supervisory oversight during daily department operations for assigned team members through sustained leadership and support. Using best expertise and sound judgment (and in consultation with clinical leaders, providers and staff), provides daily oversight, leadership, support, training and direction of nonclinical staff. Supports and assists the Team Manager and other Case Management Supervisors in developing and maintaining a cohesive team with a high level of productivity and accuracy to achieve the department's overall performance metrics.

Care Coordination Case Manager I: Licensed registered nurse who initiates and coordinates a multidisciplinary team approach to case management with members, health care providers, PHC's Chief Medical Officer or physician designee, and with any patient-identified health care designee. The Case Manager will collaborate, assess, plan, facilitate, evaluate, and advocate in order to meet the comprehensive medical, behavioral, and psychosocial needs of the member while promoting quality and cost-effective outcomes. The Case Manager will assist members to become empowered to accept and self-manage their condition(s). This position may be assigned cases requiring case management, review of complex treatment authorization requests, disease management, or special initiative programs.

Care Coordination Case Manager II: Licensed registered nurse who initiates and coordinates a multidisciplinary team approach to case management with members, providers, PHC's Chief Medical Officer or physician designee, and any patient-identified health care designee. The Case Manager will collaborate, assess, plan, facilitate, evaluate, and advocate in order to meet the comprehensive medical, behavioral, and psychosocial needs of the member while promoting quality and cost-effective outcomes. The Case Manager will assist members to become empowered to accept and self-manage their condition(s). This position may be

assigned cases requiring case management, review of complex treatment authorization requests, diseasemanagement, or special initiative programs.

Behavioral Health Clinical Specialist: Licensed Practitioner of the Healing Arts (LPHA)~~1~~[1] who develops, implements, and coordinates medically necessary treatment services within PHC's Health Services for adults and children with behavioral health and/or substance use disorder needs. ~~Reviews residential placement authorization requests for residential treatment services according to the specific terms of the contract with the provider and in accordance with the medical necessity requirements for Medi-Cal eligible beneficiaries~~.

Medical Social Worker: Master's prepared social worker who initiates and coordinates a multidisciplinary team approach to case management with members, providers, PHC's Chief Medical Officer or physician designee, and any patient-identified health care designee. Identifies member's non-medical needs and provides psychosocial case management for assigned demographic (i.e., adults or pediatric population). The Medical Social Worker provides members and/or their families with the supports needed to cope with chronic, acute and/or terminal illnesses, often complicated by other social/environmental or historical factors.

Health Care Guide I/ CC: In collaboration with Care Coordination team members, this position provides support and guidance to HealthPlan members referred to the Care Coordination Department for Case Management services and programs. The Health Care Guide (HCG) I works closely with members, families, providers, community agencies and the interdisciplinary care team to assist in coordination of benefits in a timely and cost-effective manner while connecting members to available internal and external resources.

Health Care Guide II/ CC: In collaboration with Care Coordination team members, this position provides support and guidance to HealthPlan members referred to the Care Coordination Department for Case Management services and programs. The Health Care Guide II exercises a high degree of judgment, discretion, initiative and independence when working with members, families, providers, community agencies and/or the interdisciplinary team.

Health Care Guide III/ CC: In collaboration with Care Coordination team members, this position provides support and guidance to HealthPlan members referred to the Care Coordination Department for Case Management services and programs. The Health Care Guide III serves as a subject matter expert on PHC and departmental policies, procedures and programs, and provides ongoing mentorship to HCG I's and HCG II's. This position exercises a high degree of judgment, discretion, initiative and independence when working with members, families, providers, community agencies and/or the interdisciplinary team.

Quality and Training Supervisor: Under the direction of the Care Coordination Management team, this position is responsible for the design and structure of the Care Coordination Department's quality and training program. Organizes and implements identified training opportunities to department staff, maintains accurate records of standard training materials, and conducts presentations on PHC Care Coordination activities and programs to internal and external stakeholders alike.

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[1] ~~1~~ Licensed Practitioner of the Healing Arts (LPHA): Physicians, Nurse Practitioners, Physician Assistants, Registered Nurses, Registered Pharmacists, Licensed Clinical Psychologist, Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor, Licensed Marriage and Family Therapist (LMFT), and licensed-eligible practitioners working under the supervision of licensed clinicians.

[‡] ~~Licensed Practitioner of the Healing Arts (LPHA): Physicians, Nurse Practitioners, Physician Assistants, Registered Nurses, Registered Pharmacists, Licensed Clinical Psychologist, Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor, Licensed Marriage and Family Therapist (LMFT), and licensed-eligible practitioners working under the supervision of licensed clinicians.~~

Project Coordinator I: Provides routine and ad hoc reporting for key Health Services activities and initiatives. Works closely with designated department staff and leadership to gather, compile, and distribute reports and facilitates structured file and record management.

Coordinator I: Provides coordination and administrative support to department managers. Performs a variety of general clerical duties, including data entry, report generation, and develops forms and presentations.

Coordinator II: Coordinates assigned departmental projects and provide complex administrative support to senior management. Develops, implements and monitors processes, tools, and systems for collecting, tracking and managing information required for monitoring performance and deadlines. Develops and produces reports. In addition to the Coordinator I duties, the Coordinator II gives presentations, training, and guidance to internal PHC audiences. The Coordinator II also monitors inventory control processes, reporting schedules, and regulatory deadlines.

Clerk: Provides administrative support to the Care Coordination Team by answering phones, relaying messages, maintaining department files and calendars, preparing documentations/reports for distribution. Interfaces with the Health Services Department Administrative Assistants to assist with updating documents, ordering and managing department inventory and supplies.

Administrative Assistant: Provides direct administrative assistance and support to the department leadership. Manages calendar, organizes meetings, and prepares documentation and written correspondences. Interfaces with other PHC Department Administrative Assistants to organize meetings and activities, responds to requests, and maintains department policies and files.

Transportation Specialist: Works directly with members, providers and facilities to coordinate and authorize appropriate level of transports within the Member Services and Health Services guidelines. This position includes care coordination as identified during the transportation process.

Transportation Specialist Lead: Works directly with members, providers and facilities to coordinate and authorize appropriate level of transports within the Member Services and Health Services guidelines. This position includes care coordination as identified during the transportation process. Provides on-going training and support to less experienced and newly hired Transportation Specialists.

****Note: Staffing subject to change based upon program need and organizational growth.***

Care Coordination Program Quality Monitoring and Oversight

PHC's programs have been developed using evidence from a number of resources, including but not limited to, evidence-based clinical practice guidelines and resources that have scientifically supported evidence of the effectiveness of services that improve health outcomes. Examples include:

Patient-Centered Management of Complex Patients Can Reduce Costs Without Shortening Life, Sweeney L., Halpert A., Waranoff J; The American Journal of Managed Care. 2007:13:84:92

The Playbook (2017). Institute for Healthcare Improvement. Retrieved from https://www.bettercareplaybook.org/.

Supporting the Health Care Transition From Adolescence to Adulthood in the Medical Home, American Acaedemy of Pediatrics; Pediatrics. 2011; DOI: https://doi.org/10.1542/peds.2011-0969.

CMSA's IntegratedCase Management - A Manual for Case Managers by Case Managers, Frasier, K., Perez, R., Latour, C. (2017). Retrieved from https://www.cmsa.org/education/icm/.

Searching for a business case for quality in Medicaid managed care, Healthcare Management Review. 2008. vol. 33, issue 4, pg. 350-360. DOI: doi: 10.1097/01.HCM.0000318772.59771.b2.

Not less than annually, PHC Care Coordination Department reviews population assessment data to ensure the department programs reflect current member needs. Member identification sources and referral practices are updated to ensure the member subpopulations with greatest need are offered care coordination services. Vulnerable populations such as children, adolescents, members with disabilities, and mentally ill members are assessed along with the available community resources. Care Coordination programs are developed and refined to ensure that these services are coordinated to reduce duplication of effort while providing Care Coordination for those members who do not have access to appropriate alternatives. Revisions to the programs are made as necessary to continue to address the members' changing needs, or as required by PHC's contract with California's Department of Healthcare Services (DHCS)

Program quality is monitored through clinical audits performed monthly on randomly selected cases to ensure adherence to program guidelines and to support and guide care coordination staff toward best practice. Monthly and annual utilization reports are used to evaluate program efficacy. Members participating in select programs are surveyed for satisfaction with case management services after their case is closed or annually, if the member remains open to that program for greater than 18 months. No less than annually, Care Coordination leadership reviews grievances filed by members enrolled in care coordination. The information garnered from the audits, reports, surveys, grievances, and anecdotal data is taken into consideration in revising the program offerings to better meet the needs of PHC's population.

Provider and Member Satisfaction

PHC conducts satisfaction surveys on both members and providers. Included in the evaluation are questions that deal with both member and provider satisfaction with the CC program. The responses to the survey are reviewed by staff from Health Services, Member Services, and Provider Services. Thresholds are set and responses that fall below are considered for corrective action by the HealthPlan. The results as well as plans for corrective action are developed in conjunction with the Quality/Utilization Advisory Committee (Q/UAC). Corrective actions that were in place are evaluated at the time the follow-up annual survey is done unless the committee feels an expedited time frame needs to be implemented.

Annual Program Evaluation

The overall effectiveness of the Care Coordination program is evaluated annually and reviewed by Q/UAC and the Physician Advisory Committee (PAC). The Care Coordination program evaluation is shared annually with the Population Health Management and Quality Management departments as part of PHC's overall Population Health and Quality Strategies. Please see provided to members or practitioners upon request. The availability of CC services is published to PHC's website, member portal, and in the member and provider newsletters.

Protected Health Information

Partnership HealthPlan of California is fully compliant with the general rules, regulations and implementation specification as described in 45 Code of Federal Regulations Parts 160 and 164-HIPAA Privacy Rule-as of April 14, 2003. The Privacy Officer, Government Relations Specialist also serves as the Privacy Officer for the Health Plan. and has implemented a comprehensive program that includes "Notice of Privacy Practices " sent to ALL members, implementation of a confidential toll-free complaint line available to members, providers and PHC staff, and Business Associate Agreements with all PHC vendors, extensive training of internal staff and external providers, and policy and procedures around documentation of complaints of violations.

Statement of Confidentiality

Confidentiality of provider and member information is ensured at all times in the performance of CC activities through enforcement of the following:

- Members of the Q/UAC and PAC are required to sign a confidentiality statement that will be maintained in the QI files.
- CC documents are restricted solely to authorized Health Services Department staff, members of the PAC, Q/UAC, and Credentialing Committee, and reporting bodies as specifically authorized by the Q/UAC.
- Confidential documents may include, but are not limited to, Q/UAC and Credentialing meeting minutes and agendas, QI and Peer Review reports and findings, CC reports, or any correspondence or memos relating to confidential issues where the name of a provider or member are included.
- Confidential documents are stored in locked file cabinets with access limited to authorized persons only or they are electronically archived and stored on protected drives.
- Confidential paper documents are destroyed by shredding.

Non-Discrimination Statement

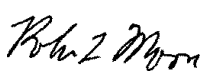
Partnership HealthPlan of California (PHC) does not discriminate on the basis of race, color, national origin, sex, age, or disability in its health programs and activities. PHC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. PHC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

PHC will not deny or limit coverage, deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions on coverage, for any health services that are ordinarily or exclusively available to individuals of one sex, to a transgender individual based on the fact that an individual's sex assigned at birth, gender identity, or gender otherwise recorded is different from the one to which such health services are ordinarily are exclusively available. Also, PHC will not otherwise deny or limit coverage, deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions on coverage, for specific health services related to gender transition if such denial, limitation, or restriction results in discrimination against a transgender individual.

PHC provides free aids and services to people with disabilities to communicate with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- PHC provides free language services to people whose primary language is not English, such as:
- Qualified sign language interpreters
- Information written in other languages

Care Coordination Program Approval

Robert Moore, MD, MPH, MBA 	~~*02/17/2021*~~*02/16/2022*
Quality/Utilization Advisory Committee Chairperson	*Date Approved*

Jeffrey Gaborko, MD 	~~*03/10/2021*~~*03/09/2022*
Physician Advisory Committee Chairperson	*Date Approved*

~~*Nancy Starek*~~	~~*04/28/2021*~~*04/27/2022*
Board of Commissioners Chairperson	*Date Approved*

Partnership HealthPlan of California

CARE COORDINATION PROGRAM DESCRIPTION

MPCD2013

March 2022

Original Date: 01/20/2016
Revision Date(s): 06/21/17; *06/13/18; 11/14/18; 11/13/19; 04/08/20; 03/10/21; 03/09/22

*Through 2017, Approval Date reflective of the Quality/Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

Table of Contents

Program Purpose

To define the scope of services provided by Partnership HealthPlan of California's (PHC's) Care Coordination Department.

Introduction

Partnership HealthPlan of California's Care Coordination Department offers case management services to any plan member with care management needs who is willing to participate, and for whom PHC is either the primary source of coverage or for whom PHC may be responsible for the benefit, such as members eligible for California Children's Services (CCS). Case Management is a collaborative process that assesses, plans, implements, coordinates, monitors and evaluates the options and services required to meet the member's health and wellness needs. It is characterized by advocacy, communication, and resource management, while promoting quality and cost-effective interventions and outcomes. These services assist PHC in ensuring that we are fulfilling our mission to help the members and the communities we serve be healthy.

Department Objectives & Goals

The objectives and goals of PHC's Care Coordination Department are to:

- Educate members about the resources available to them through their plan benefits and how to use these resources to optimize his/her wellness
- Assist members in understanding their health conditions and support members in becoming proficient in gaining/maintaining their optimum health and functionality
- Provide support for members with chronic illness
- Facilitate timely access to care and efficient delivery of health care services, supplies, and equipment
- Promote communication between the member, member's supports (i.e., caregiver, guardian, or other concerned parties), providers, community resources, and long-term support systems
- Connect members to resources within their communities to support and to assist them in self-management of their health and well-being
- Collaborate with multidisciplinary health agencies and non-profit partners to link members to available community resources, where accessible
- Minimize gaps between healthcare settings by coordinating transitions across the healthcare continuum of age, coverage, service type, and location
- Improve member and provider satisfaction
- Provide education to members, providers, and community-based organizations about case management services offered by PHC and encourage referrals when needs or barriers are identified

Care Coordination is not intended to replace or be a substitute for the physician's management of a member's medical conditions. PHC staff works collaboratively with the practitioner to coordinate clinical and support services for members to decrease the potential for fragmentation of care.

Services offered through PHC's Care Coordination Department are available to eligible members, and outreach efforts may target a particular population depending on regulatory requirements and identified population needs. The following are examples of populations who may benefit from Care Coordination:

- Members new to the health plan who require expedited care.
- Children diagnosed with a California Children's Services (CCS) eligible condition.
- Medi-Cal PHC eligible enrollees who are designated by aid code as Seniors or Persons with Disabilities (SPD) and who may be at risk for an adverse outcome without an Individualized Care Plan (ICP).
- Children with Special Health Care Needs (CSHCN).
- Children and adults with developmental disabilities in collaboration with the California Regional Centers.
- Members identified as connected to the Genetically Handicapped Persons Program (GHPP) who require assistance and support.
- Members who are chronically ill or who have multiple complex medical conditions.
- Members preparing for an organ transplant.
- Members who require assistance accessing community-based programs and/or services.
- Members who are in a pivotal place with their healthcare needs due to transition across settings (i.e., acute hospital stay to home), across age groups (i.e., transition from pediatric to adult care), or across benefit structures (i.e., exhausting home health benefits or transitioning from curative care to hospice care).
- Members who have difficulties navigating the healthcare community.
- Members who have cognitive or communication deficits that require an advocate to help them communicate their health care needs.
- Members challenged with efficiently managing their health within PHC's managed care network.
- Children in Foster Care.

Scope of Services

The Care Coordination Department offers a variety of evidence-based services and interventions to coordinate care for members. Our team of Nurse Case Managers, Medical Social Workers, and Health Care Guides help to ensure services are coordinated for the member across the healthcare continuum. Taking the member's, or his/her caregiver's needs and preferences into account when communicating, the staff in the Care Coordination Department uses evidence based practices such as Motivational Interviewing and principles from Dialectical Behavioral Therapy (DBT) to ensure that the member's goals are at the center of an Individualized Care Plan (ICP). With the use of these member engagement techniques the team is able to assist the member in enhancing his or her autonomy and reaching their desired goals and outcomes.

Identification and Referrals

The Care Coordination Department utilizes a variety of approaches to screen and identify members who may benefit from Case Management Services. These activities include:

- Internal reports, such as the Monthly Utilization Report, Monthly Pediatric Case Finding Report, Weekly Hospital Discharge Report, HEDIS Outreach Campaign List, etc.
- Review of referrals sent to the Care Coordination Department Help Desk email by both internal and external parties
- Heath Information Form (HIF)/Member Evaluation Tool (MET)
- Health Risk Assessment (HRA) Form
- Pediatric Health Risk Assessment (PHRA) Form
- Reports based on FFS Claims Data provided by the State, etc.
- Risk stratification reports

Referrals for Case Management Services originate from a variety of both internal and external sources. Members are commonly referred for Case Management from PHC's internal departments' such as Member Services, Pharmacy, Utilization Management, and/or Grievance. Externally, members may self-refer, or they may be referred by their caregivers, Primary Care Providers (PCPs), Specialists, Hospital Case Managers/Discharge Planners, and/or County or Community Partners such as Public Health Nurses, Medical Therapy Programs, Grant Programs, or Home Visiting Program Providers, etc.

Referrals for Case Management can be sent to the department directly via email, phone, PHC's member portal, or the Provider website referral form. Each referral sent to the department is reviewed by Care Coordination staff who, based on the information received upon intake, will identify the initial needs of the member and route the member to the appropriate team for case assignment.

Program Structure

Care Coordination services are based upon the acuity of the member's needs. Using a scale of one to five, the member's acuity determines the level of care coordination intervention. A member's acuity may be adjusted during the course of case management services as goals or met or additional barriers are encountered.

Acuity Level One:

Members with Acuity Level One are the lowest risk members in Care Coordination. Their needs are generally resolved within 30 days of identification and, the primary focus is to ensure these members are well-connected to their primary care providers or specialists who may be acting as primary care providers. Members who may be considered Acuity One include:

- New Member Health Information Forms (HIFs)
- Access to Care:
    - Primary or Specialty Care,
    - Behavioral Heath Therapy (BHT),
    - Early Periodic Screening Diagnostic and Treatment (EPSDT) services,
    - Transportation to/from Medi-Cal covered services.
- Those needing assistance with:
    - IHSS, Medi-Cal Dental, Meals on Wheels, etc.
    - Ancillary Services or DME covered by Medi-Cal
    - Prescriptions
    - Transitioning to a new primary care or specialty provider, including pediatric members preparing to transition from pediatric to adult care
    - Arranging routine screening appointments, such as those monitored through Healthcare Effectiveness Data and Information Set (HEDIS) measures.
    - Education for resources available in their area/community (housing, transportation, support groups, etc.)
- CCS member's annual re-assessment, risk review, and documentation to support redetermination of medical eligibility
- Members requesting to see out-of-network providers where an established relationship exists (Continuity of Care)

Interventions:

Members identified as an Acuity Level One will be assessed to identify his/her primary care coordination needs. Based on the member's stated goals, Care Coordination staff will assist the member in gaining access to necessary resources and supports. Typical interventions provided under Acuity Level One include, but are not limited to:

- Coordination of Services (appointments, referrals, DME, etc.)
- Collaboration with County/Community Agencies

Care Coordination staff work to help members overcome barriers to health and wellness care. When a member's barriers cannot be resolved promptly, Care Coordination staff create an Individualized Care Plan (ICP) to assist the member in achieving health and wellness goals. Throughout the course of the case, Care Coordination staff will reassess the assigned acuity level for the case and make adjustments as needed to provide the right level of care at the right time, including escalation to Complex Case Management (CCM) when warranted. Goals and interventions are routinely identified and evaluated by Care Coordination staff to track the member's progress. Goals and interventions may be added during the member's case management experience and closed as care needs resolve.

Acuity Level Two:

Members with Acuity Level Two have emerging risk of disease/disease exacerbation, a newly diagnosed chronic illness. They benefit from education and resources tailored to their condition along with a contact within the care coordination department should questions arise. Members assigned Acuity Level Two include those referred through or requiring assistance with:

- Maintenance of chronic conditions like diabetes, asthma, or mild to moderate mental illness
- High Risk Infant Follow Up (HRIF)
- Referrals from Population Health interventions

Interventions:

Members managed at an Acuity Level Two will be provided with Health Education resources supporting lifestyle management to maximize health and wellness, and to mitigate effects of chronic disease. Interventions provided for members with Acuity Level Two may include, but are not limited to:

- Emotional Support/ Active Listening
- Reinforcement of health maintenance screening and care
- Referrals to disease prevention/management programs, Population Health interventions, or Healthy Living classes
- Referrals to community support groups,
- Coordination of Services (appointments, referrals, DME, medical supplies,, etc.)
- Review of health education materials

Members in this acuity may require more intensive interventions should their condition warrant it or if the member requests additional support.

Transitions of Care

Acuity Level Three:

Transitions of Care services focus on members who are transitioning across settings (i.e., acute hospital stay to home) or across benefit structures (i.e., exhausting residential treatment service benefits for substance use disorder or transitioning from curative care to hospice care). These members are vulnerable to lost information across the care continuum, fragmented care, may have difficulty navigating the health care system, or may need support ensuring a transition plan is executed as intended. Members considered Acuity Level Three may come from any source; however, the most common sources of referral are:

- Hospital Case Managers/Discharge Planners or Social Workers
- Weekly Hospital Discharge reports
- Other Care Coordination programs
- Referrals from PHC's Utilization Management team

Interventions

Case Management activities for members tiered at an Acuity Level Three ensure the member reconnects with primary care, specialty care (when needed) and community resources that will support health and wellness following a transition of care. Care Coordination staff will review the provider's plan of care, provide education/reinforcement for the transition plan, and develop an ICP supporting the member's successful transition along the care continuum. Typical interventions utilized during Case Management include, but are not limited to:

- Review of Discharge Summary/Plan
- Identification of ongoing care team roles and members
- Coordination of services (appointments, referrals, DME, food banks, homeless shelters, etc.)
- Referral to and collaboration with county/community agencies to provide support and reduce duplication of efforts
- Assistance with accessing programs such as Long Term Support Services (LTSS), Women, Infants, and Children (WIC) Program, or other social supports
- Motivational Interviewing to build on resiliencies
- Emotional Support/ Active Listening

Interventions are tailored in response to the member's assessed needs or stated goals. Care Coordination team members routinely evaluate the ICP and corresponding goals to evaluate the member's progress, update when necessary, and support the member in optimizing independence. Members with care needs that exceed the scope of Transitions of Care may move to Complex Case Management (CCM) for intensive care coordination support.

Complex Case Management (CCM)

Complex Case Management focuses on meeting the needs of the most fragile members through clinical intervention(s) and case management services. These may be members with multiple chronic medical conditions, or they may have fragmented care, have difficulty navigating the health care system, or have other challenges that threaten to compromise their well-being if not supported through an ICP.

Acuity Level Four:

These members require the most intensive support available through clinical services and supports. Examples of members commonly enrolled in CCM have at least one CCS-eligible condition along with social support

needs (in pediatric cases), members who have two or more chronic conditions (in adult cases). Alternatively, these members may have mental illness or substance use disorders or other challenges that threaten to compromise the member's well-being if not supported through an ICP. Cases in this tier may reflect more than one recent hospitalization within the past 2 months or had multiple emergency departmentvisits relating to the eligible conditions. These cases have high risk of declining function, hospitalization, or readmission if appropriate interventions are not in place. Members assigned Acuity Level Four are often identified by:

- New Member Health Risk Assessments (HRAs) for new SPDs or CCS members
- Medical Therapy Programs/Units
- Hospital Discharge Planners or Social Workers
- Primary Care or Specialty Providers
- Internal case-finding reports (Monthly Utilization Report, Monthly Pediatric Case Finding Report, etc.)
- Care Coordination Help Desk email review
- Other internal Care Coordination services and activities
- Other internal departments (Utilization Management Rounds, Quarterly Grievance Review, Provider Relations etc.)
- Meetings with external organizations (Hospital Case Management Rounds, CCS county meetings, County Mental Health departments, Community-Based Organization collaborations, etc.)
- Risk stratification reports

Interventions

The primary focus of case management for members tiered at Acuity Level Four is the coordination of clinical services for medically complex cases. In addition, care coordination efforts will also address providing community connections, social supports, and integration with long-term support services. Care Coordination staff will perform a comprehensive assessment evaluating the member's medical, psycho-social, mental, emotional, and behavioral needs. The member and Care Coordination staff member will develop an ICP addressing both clinical and non-clinical concerns. Care Coordination staff will collaborate with the member to identify prioritized goals and select interventions/behaviors intended to meet these goals. Together, the member and Care Coordination staff will work through the duration of the case to overcome identified barriers to meeting these goals and achieving the health/wellness outcome(s) desired by the member. Typical interventions utilized during Complex Case Management include, but are not limited to:

- Personalized assessments
- Individualized Plan of Care (ICP)
- Motivational Interviewing to build on resiliencies
- Emotional Support/ Active Listening
- Review of disease signs/ symptoms
- Teach-back techniques to promote health and support lifestyle choices based on healthy behavior
- Coordination of Services (appointments, referrals, DME, medical supplies, etc.)
- Identification or barriers to established goals or treatment plan adherence
- Review for medical necessity of complex services such as Pediatric Shift Nursing or Residential Treatment Services
- Collaboration with the multi-disciplinary care team to ensure the member' s care needs are expedited as well as reducing duplication of efforts amongst care team members

- Referral to and collaboration with county/community agencies
- Assistance with accessing programs such as LTSS, WIC, or other social supports.

Interventions are tailored in response to the member's assessed needs or stated goals. A copy of the ICP is provided to the member's provider(s) and to the member to facilitate collaboration and joint agreement on goals of care. The individualized care plan and corresponding goals are routinely evaluated by members of the Care Coordination clinical team to evaluate progress, update when necessary, and adjust the member's assigned acuity when appropriate. Care team conferences may be scheduled internally to provide clinical support, or with external parties (including the member/member's representative(s)) to ensure all members of the team are in agreement with the ICP and working toward common goals.

Acuity Level Five:

Members with Acuity Level Five are the highest risk members in Complex Case Management and they require more involvement than can be provided through telephonic forms of case management. These members experience extraordinary barriers to care, such as communication challenges, cognitive barriers, capacity issues, a severely fragmented provider/health care delivery system, and often require an onsite assessment(s) or multi-disciplinary conferences to meet their needs. Members considered for Acuity Level Five will be reviewed by a clinical supervisor for approval, with specific goals described for the face-to-face meeting.

Interventions

Acuity Level Five is distinguished from other acuities in that it includes all the interventions for other acuity levels as well as a face to face interaction between the case manager and the member/member's representative for one or more visits. This interaction may take place in the member's home, but more optimally occurs in a provider's office. These meetings are pre-scheduled and may include the member/member's representative, clinical member(s) of the care team with non-clinical support as appropriate to the case, the provider and/or specialist, ancillary provider(s) such as members of the Medical Therapy Unit or therapists, and other individuals who are a part of the member's multidisciplinary care team. Note: not all multidisciplinary care team meetings require a face to face visit; however, this intervention may be leveraged when the case complexity or communication challenges require extraordinary efforts for collaboration.

Care Coordination Process

When referred for Care Coordination, members are advised that these services are voluntary and the member is not required to participate. All case documentation of assessments, interventions, activity, and the member's ICP will be stored in the Care Coordination Department's Case Management software system. The Care Coordination team also documents when members decline to participate in case management or when they cannot be reached after multiple attempts through multiple means of contact.

The guiding principles for care coordination are identifying a member's goals of care and the barriers to meeting those goals, and then choosing interventions designed to overcome the barriers. When the identified goals are met, the case will be closed unless new goals, barriers, or needs are identified. At any time during the course of services, if the member's status or needs change, the case will be evaluated by the assigned Care Coordination staff member to determine acuity level appropriateness. Members who experience a change in condition where their needs cannot be met by Care Coordination will be screened and directed to other available services within, or external to PHC, when appropriate. In certain instances, staff may close a case before completing the ICP or achieving the goals of Care Coordination. Examples of reasons where Care

Coordination may be discontinued include:

- Member is no longer responsive to outreach efforts after 45 calendar days and multiple attempts
- Care Coordination staff and clinical leadership agree that member is uncooperative as evidenced by not demonstrating consistent adherence to the care plan.
- Member is obtaining case management services through another agency that duplicate the services offered through PHC, or is referred for case management to another service who is better suited to meeting the needs of the member (e.g., grant programs, county services, etc.)
- Member loses eligibility for PHC coverage.
- Continued inappropriate (derogatory, profane, abusive) behaviors towards the Care Coordination team with no improvement after documented discussions regarding the need for behavioral change.
- Cases closed to Care Coordination may be re-evaluated if the member's condition, or desire to participate, changes

Program Support

Care Coordination operations are supported by a leadership team and administrative support. To further the mission of Care Coordination and community connection, Health Services staff allocated to ensuring members have transportation to/from medical appointments in accordance with California Department of Health Care Services (DHCS) guidelines. In addition, staff are allocated to engage with the community to educate community partners on PHC care coordination services, to learn about resources available within the community, and to promote collaboration of effort/reduce duplication of services.

Enhanced Care Management (ECM)

Pursuant to APL 21-012, beginning January 1, 2022, PHC shall offer the CalAIM Enhanced Care Management (ECM) benefit for eligible members. The ECM benefit is unique and distinct from the care management services or programs offered by PHC. The ECM benefit primarily builds upon the design and learning from California's Whole Person Care Pilots (WPC) and Health Homes Program (HHP). The ECM benefit is part of the larger CalAIM proposal by DHCS as a way to advance and innovate Medi-Cal's approaches and services to those most vulnerable throughout the state.

PHC members may not be enrolled in any of Partnership's Care Coordination programs simultaneously with ECM. However, upon assessment of the member's needs and after obtaining the member's agreement to participate, PHC's Care Coordination department may refer the member to an ECM provider for services. Conversely, ECM providers may refer a member to one of Partnership's Care Coordination programs for support if indicated, or at the expressed desire by the member. For more information on the ECM benefit see PHC policy MCCP2032 CalAIM Enhanced Care Management (ECM).

Team Roles and Responsibilities

Senior Director of Health Services: At the senior level, provides overall direction to the Heath Services (HS) Care Coordination/Utilization Management/Population Health Leadership Team. This position has the ultimate responsibility to ensure that all workflow processes and Department Programs and services are consistent and meet all regulatory requirements in every office location.

Director of Care Coordination: Provides oversight of Care Coordination programs and services to improve the health of PHC members and to provide excellent customer service to members and providers. Works with

the Chief Medical Officer, Senior Director of Health Services, and Associate/Regional Directors to meet organization and department goals and objectives while developing and tracking measurable outcomes of department services. Works collaboratively with identified Health Services (HS) staff to ensure appropriate integration of PHC, DHCS, and NCQA guidelines, policies, and procedures.

Director of Care Coordination Operations: Responsible for the operational aspects of the Care Coordination Department, including Case Management and Transportation. He/she will be responsible for operationalizing department initiatives and projects. A key component of this position is the enhancement and refinement of existing programs, and enthusiastic innovation in the development, management, integration, and refinement of new and existing programs. This position is responsible for providing staff and organizational support, program development, monitoring, and implementation of all Care Coordination and Transportation functions in order to meet stated objectives and goals.

Associate Director of Care Coordination: Under direction from the Director of Care Coordination, manages and provides direction to the Care Coordination (CC) Department Managers and Supervisors for all services. Responsible for establishing and maintaining reports that will support the efficacy of department activity and to produce a summary at least annually or upon request, that includes documentation of department services, member outcomes, return on investment, and quality improvement activities.

Team Manager UM/CC: Assists the Associate Director of Care Coordination and Director of Care Coordination in the development, implementation and evaluation of PHC's clinical case management services. The Manager has day-to-day direction and management responsibility for the implementation of the care coordination department and reviews and submits clinical issues, updates, recommendations, and information to the HS Leadership when appropriate.

Non-Clinical Manager: Assists the Care Coordination Leadership in the development, implementation and evaluation of PHC's case management services. The non-clinical manager has day-to-day direction and management responsibility for the implementation of the care coordination department and reviews and submits issues, updates, recommendations, and information to the HS Leadership when appropriate.

Manager, Transportation Programs: Manages day-to-day operations of transportation services and benefits offered by PHC. Provides leadership, support, and education to assigned staff, and maintains relationships with providers, PHC contracted vendor(s), community partners, and county agencies, to promote collaboration and ensure smooth and consistent application of PHC transportation benefits. Participates in various internal venues to enhance cooperation and understanding of how the transportation program interacts with other initiatives to meet PHC's mission

Case Management Supervisor: Licensed clinician who provides supervisory oversight during daily department operations for assigned team members through sustained leadership and support. Using best clinical expertise and sound judgment (and in consultation with providers and staff), designs and implements high quality, cost effective care plans to enable members to achieve maximum medical improvement. Assists in determining appropriateness, quality and medical necessity of treatment plans.

Non-Clinical Supervisor: Provides supervisory oversight during daily department operations for assigned team members through sustained leadership and support. Using best expertise and sound judgment (and in consultation with clinical leaders, providers and staff), provides daily oversight, leadership, support, training and direction of nonclinical staff. Supports and assists the Team Manager and other Case Management Supervisors in developing and maintaining a cohesive team with a high level of productivity and accuracy to achieve the department's overall performance metrics.

Care Coordination Case Manager I: Licensed registered nurse who initiates and coordinates a multidisciplinary team approach to case management with members, health care providers, PHC's Chief Medical Officer or physician designee, and with any patient-identified health care designee. The Case Manager will collaborate, assess, plan, facilitate, evaluate, and advocate in order to meet the comprehensive medical, behavioral, and psychosocial needs of the member while promoting quality and cost-effective outcomes. The Case Manager will assist members to become empowered to accept and self-manage their condition(s). This position may be assigned cases requiring case management, review of complex treatment authorization requests, disease management, or special initiative programs.

Care Coordination Case Manager II: Licensed registered nurse who initiates and coordinates a multidisciplinary team approach to case management with members, providers, PHC's Chief Medical Officeror physician designee, and any patient-identified health care designee. The Case Manager will collaborate, assess, plan, facilitate, evaluate, and advocate in order to meet the comprehensive medical, behavioral, and psychosocial needs of the member while promoting quality and cost-effective outcomes. The Case Manager will assist members to become empowered to accept and self-manage their condition(s). This position may be assigned cases requiring case management, review of complex treatment authorization requests, diseasemanagement, or special initiative programs.

Behavioral Health Clinical Specialist: Licensed Practitioner of the Healing Arts (LPHA)[1] who develops, implements, and coordinates medically necessary treatment services within PHC's Health Services for adults and children with behavioral health and/or substance use disorder needs..

Medical Social Worker: Master's prepared social worker who initiates and coordinates a multidisciplinary team approach to case management with members, providers, PHC's Chief Medical Officer or physician designee, and any patient-identified health care designee. Identifies member's non-medical needs and provides psychosocial case management for assigned demographic (i.e., adults or pediatric population). The Medical Social Worker provides members and/or their families with the supports needed to cope with chronic, acute and/or terminal illnesses, often complicated by other social/environmental or historical factors.

Health Care Guide I/ CC: In collaboration with Care Coordination team members, this position provides support and guidance to HealthPlan members referred to the Care Coordination Department for Case Management services and programs. The Health Care Guide (HCG) I works closely with members, families, providers, community agencies and the interdisciplinary care team to assist in coordination of benefits in a timely and cost-effective manner while connecting members to available internal and external resources.

Health Care Guide II/ CC: In collaboration with Care Coordination team members, this position provides support and guidance to HealthPlan members referred to the Care Coordination Department for Case Management services and programs. The Health Care Guide II exercises a high degree of judgment, discretion, initiative and independence when working with members, families, providers, community agencies and/or the interdisciplinary team.

Health Care Guide III/ CC: In collaboration with Care Coordination team members, this position provides support and guidance to HealthPlan members referred to the Care Coordination Department for Case Management services and programs. The Health Care Guide III serves as a subject matter expert on PHC and

[1] Licensed Practitioner of the Healing Arts (LPHA): Physicians, Nurse Practitioners, Physician Assistants, Registered Nurses, Registered Pharmacists, Licensed Clinical Psychologist, Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor, Licensed Marriage and Family Therapist (LMFT), and licensed-eligible practitioners working under the supervision of licensed clinicians.

departmental policies, procedures and programs, and provides ongoing mentorship to HCG I's and HCG II's. This position exercises a high degree of judgment, discretion, initiative and independence when working with members, families, providers, community agencies and/or the interdisciplinary team.

Quality and Training Supervisor: Under the direction of the Care Coordination Management team, this position is responsible for the design and structure of the Care Coordination Department's quality and training program. Organizes and implements identified training opportunities to department staff, maintains accurate records of standard training materials, and conducts presentations on PHC Care Coordination activities and programs to internal and external stakeholders alike.

Project Coordinator I: Provides routine and ad hoc reporting for key Health Services activities and initiatives. Works closely with designated department staff and leadership to gather, compile, and distribute reports and facilitates structured file and record management.

Coordinator I: Provides coordination and administrative support to department managers. Performs a variety of general clerical duties, including data entry, report generation, and develops forms and presentations.

Coordinator II: Coordinates assigned departmental projects and provide complex administrative support to senior management. Develops, implements and monitors processes, tools, and systems for collecting, tracking and managing information required for monitoring performance and deadlines. Develops and produces reports. In addition to the Coordinator I duties, the Coordinator II gives presentations, training, and guidance to internal PHC audiences. The Coordinator II also monitors inventory control processes, reporting schedules, and regulatory deadlines.

Clerk: Provides administrative support to the Care Coordination Team by answering phones, relaying messages, maintaining department files and calendars, preparing documentations/reports for distribution. Interfaces with the Health Services Department Administrative Assistants to assist with updating documents, ordering and managing department inventory and supplies.

Administrative Assistant: Provides direct administrative assistance and support to the department leadership. Manages calendar, organizes meetings, and prepares documentation and written correspondences. Interfaces with other PHC Department Administrative Assistants to organize meetings and activities, responds to requests, and maintains department policies and files.

Transportation Specialist: Works directly with members, providers and facilities to coordinate and authorize appropriate level of transports within the Member Services and Health Services guidelines. This position includes care coordination as identified during the transportation process.

Transportation Specialist Lead: Works directly with members, providers and facilities to coordinate and authorize appropriate level of transports within the Member Services and Health Services guidelines. This position includes care coordination as identified during the transportation process. Provides on-going training and support to less experienced and newly hired Transportation Specialists.

****Note: Staffing subject to change based upon program need and organizational growth.***

Care Coordination Program Quality Monitoring and Oversight

PHC's programs have been developed using evidence from a number of resources, including but not limited to, evidence-based clinical practice guidelines and resources that have scientifically supported evidence of the effectiveness of services that improve health outcomes. Examples include:

Patient-Centered Management of Complex Patients Can Reduce Costs Without Shortening Life, Sweeney L., Halpert A., Waranoff J; The American Journal of Managed Care. 2007:13:84:92

The Playbook (2017). Institute for Healthcare Improvement. Retrieved from https://www.bettercareplaybook.org/.

Supporting the Health Care Transition From Adolescence to Adulthood in the Medical Home, American Academy of Pediatrics; Pediatrics. 2011; DOI: https://doi.org/10.1542/peds.2011-0969.

CMSA's IntegratedCase Management - A Manual for Case Managers by Case Managers, Frasier, K., Perez, R., Latour, C. (2017). Retrieved from https://www.cmsa.org/education/icm/.

Searching for a business case for quality in Medicaid managed care, Healthcare Management Review. 2008. vol. 33, issue 4, pg. 350-360. DOI: doi: 10.1097/01.HCM.0000318772.59771.b2.

Not less than annually, PHC Care Coordination Department reviews population assessment data to ensure the department programs reflect current member needs. Member identification sources and referral practices are updated to ensure the member subpopulations with greatest need are offered care coordination services. Vulnerable populations such as children, adolescents, members with disabilities, and mentally ill members are assessed along with the available community resources. Care Coordination programs are developed and refined to ensure that these services are coordinated to reduce duplication of effort while providing Care Coordination for those members who do not have access to appropriate alternatives. Revisions to the programs are made as necessary to continue to address the members' changing needs, or as required by PHC's contract with California's Department of Healthcare Services (DHCS)

Program quality is monitored through clinical audits performed monthly on randomly selected cases to ensure adherence to program guidelines and to support and guide care coordination staff toward best practice. Monthly and annual utilization reports are used to evaluate program efficacy. Members participating in select programs are surveyed for satisfaction with case management services after their case is closed or annually, if the member remains open to that program for greater than 18 months. No less than annually, Care Coordination leadership reviews grievances filed by members enrolled in care coordination. The information garnered from the audits, reports, surveys, grievances, and anecdotal data is taken into consideration in revising the program offerings to better meet the needs of PHC's population.

Provider and Member Satisfaction

PHC conducts satisfaction surveys on both members and providers. Included in the evaluation are questions that deal with both member and provider satisfaction with the CC program. The responses to the survey are reviewed by staff from Health Services, Member Services, and Provider Services. Thresholds are set and responses that fall below are considered for corrective action by the HealthPlan. The results as well as plans for corrective action are developed in conjunction with the Quality/Utilization Advisory Committee (Q/UAC). Corrective actions that were in place are evaluated at the time the follow-up annual survey is done unless the committee feels an expedited time frame needs to be implemented.

Annual Program Evaluation

The overall effectiveness of the Care Coordination program is evaluated annually and reviewed by Q/UAC and the Physician Advisory Committee (PAC). The Care Coordination program evaluation is shared annually with the Population Health Management and Quality Management departments as part of PHC's overall Population Health and Quality Strategies. Please see provided to members or practitioners upon request. The availability of CC services is published to PHC's website, member portal, and in the member and provider newsletters.

Protected Health Information

Partnership HealthPlan of California is fully compliant with the general rules, regulations and implementation specification as described in 45 Code of Federal Regulations Parts 160 and 164-HIPAA Privacy Rule-as of April 14, 2003. The Privacy Officer, Government Relations Specialist also serves as the Privacy Officer for the Health Plan. and has implemented a comprehensive program that includes "Notice of Privacy Practices " sent to ALL members, implementation of a confidential toll-free complaint line available to members, providers and PHC staff, and Business Associate Agreements with all PHC vendors, extensive training of internal staff and external providers, and policy and procedures around documentation of complaints of violations.

Statement of Confidentiality

Confidentiality of provider and member information is ensured at all times in the performance of CC activities through enforcement of the following:

- Members of the Q/UAC and PAC are required to sign a confidentiality statement that will be maintained in the QI files.
- CC documents are restricted solely to authorized Health Services Department staff, members of the PAC, Q/UAC, and Credentialing Committee, and reporting bodies as specifically authorized by the Q/UAC.
- Confidential documents may include, but are not limited to, Q/UAC and Credentialing meeting minutes and agendas, QI and Peer Review reports and findings, CC reports, or any correspondence or memos relating to confidential issues where the name of a provider or member are included.
- Confidential documents are stored in locked file cabinets with access limited to authorized persons only or they are electronically archived and stored on protected drives.
- Confidential paper documents are destroyed by shredding.

Non-Discrimination Statement

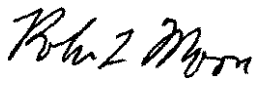
Partnership HealthPlan of California (PHC) does not discriminate on the basis of race, color, national origin, sex, age, or disability in its health programs and activities. PHC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. PHC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

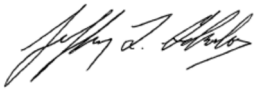
PHC will not deny or limit coverage, deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions on coverage, for any health services that are ordinarily or exclusively available to individuals of one sex, to a transgender individual based on the fact that an individual's sex assigned at birth, gender identity, or gender otherwise recorded is different from the one to which such health services are ordinarily are exclusively available. Also, PHC will not otherwise deny or limit coverage, deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions on coverage, for specific health services related to gender transition if such denial, limitation, or restriction results in discrimination against a transgender individual.

PHC provides free aids and services to people with disabilities to communicate with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- PHC provides free language services to people whose primary language is not English, such as:
- Qualified sign language interpreters
- Information written in other languages

Care Coordination Program Approval

Robert Moore, MD, MPH, MBA 	***02/16/2022***
Quality/Utilization Advisory Committee Chairperson	*Date Approved*

Jeffrey Gaborko, MD 	***03/09/2022***
Physician Advisory Committee Chairperson	*Date Approved*

	04/27/2022
Board of Commissioners Chairperson	*Date Approved*

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
April 27, 2022

Agenda Item Number:
3.4

Resolution Sponsor:
Liz Gibboney, CEO, Partnership HealthPlan of CA

Recommendation by:
The Personnel Committee

Topic Description:
On April 20, 2022, the Personnel Committee met and performed their annual review of PHC's Human Resource (HR) policies for staff.

Reason for Resolution:
To provide the Board with the Personnel Committee meeting minutes for April 20, 2022 for review and approval. In addition, to ensuring that Board members are aware of current HR policies for staff.

Financial Impact:
There is no financial impact to the HealthPlan.

Requested Action of the Board:
Based on the recommendation of the Personnel Committee, the Board is asked to approve all current HR policies for staff reviewed by the Personnel Committee and on April 20, 2022 and the meeting minutes.

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
April 27, 2022

Agenda Item Number:
3.4

Resolution Number:
22-

IN THE MATTER OF: APPROVING ALL CURRENT HR POLICIES FOR STAFF REVIEWED BY THE PERSONNEL COMMITTEE ON APRIL 20, 2022 AND THE MEETING MINUTES

Recital: Whereas,

A. The Personnel Committee has the responsibility to review all current HR policies for staff on an annual basis, and then recommend approval to the full Board.

B. The Personnel Committee reviewed all current HR policies for staff on April 20, 2022.

C. The Board has responsibility to review and approve all current HR policies for staff.

Now, Therefore, It Is Hereby Resolved As Follows:

1. To obtain approval for the current HR policies for staff reviewed by the Personnel Committee on April 20, 2022 and the meeting minutes.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 27th day of April 2022 by motion of Commissioner, seconded by Commissioner, and by the following votes:

AYES: Commissioners:

NOES: Commissioners:

ABSTAINED: Commissioners:

ABSENT: Commissioners:

EXCUSED: Commissioners:

_____
Alicia Hardy, Chair

_____
Date

ATTEST:
BY: _____
Ashlyn Scott, Clerk

PERSONNEL COMMITTEE MEETING MINUTES
April 20, 2022

In-Person Locations:
PHC's Southern Region Office located at 4665 Business Center Drive, Fairfield, CA 94534
PHC's Northern Region Office located at 2525 Airpark Drive, Redding, CA 96001

Teleconference with the following Webex information:
Meeting Number 2455 974 0209

Committee Members Present:
Greta Elliott, Randall Hempling, and Nancy Starck

Committee Members Not Present:
Viola Lujan and Gerald Huber

Public Attendees:
None

Staff Present
Liz Gibboney, CEO, Patti McFarland, CFO, Regina Littlefield, Sr. Director of Human Resources, Wendi West, Sr. Director of Northern Region, Jamie Hayes, Administrative Assistant II, and Kalei Spangler, Program Coordinator I

AGENDA ITEM 1.1 – 1.2 OPENING
The annual meeting was called to order at 1:04 pm and everyone on the phone was identified and present online.

AGENDA ITEM 1.3 PUBLIC COMMENTS
There were no public members in attendance. No public comments.

OPENING COMMENTS
Mrs. Littlefield welcomed everyone to the meeting.

AGENDA ITEM 1.4 PHC's 2022 BENEFIT HIGHLIGHTS
Mrs. Littlefield stated that there were no new benefit changes and that all benefits have been carried over from last year. She inquired whether anyone had questions.

Commissioner Starck commented that it was a great benefits package and asked about employee feedback and if they are generally happy with the options. Mrs. Littlefield said employee feedback is that the benefits package is excellent. There has been very positive feedback from the employees.

Commissioner Hempling asked how often the employees receive this information. Mrs. Littlefield advised that employees receive this information once a year. Additionally, they have access throughout the year on our PHC4Me intranet.

AGENDA ITEM 1.5 PHC'S 2022 Human Resources Benefits Portfolio

Mrs. Littlefield stated that the portfolio is an example of the total value of compensation employees receive from PHC (e.g. paid leave benefits, future financial well-being, health and wellness benefits, other benefits, employer-provided benefits, and annual salary). Mrs. Littlefield also added that this started as a manual process and is now being processed and distributed electronically. She inquired whether anyone had questions.

Commissioner Starck asked if this is helpful in recruitment and retention efforts and Mrs. Littlefield said yes and it is well received as a recruitment and retention tool.

AGENDA ITEM 1.6 PHC's HUMAN RESOURCE POLICIES

Mrs. Littlefield reviewed one new policy and four existing policies with minor changes.

Group 1: New Policies

- **Other Leaves, HR 712 –** Reason for addition: *This policy was created for those types of leaves that are not medically related (e.g. jury duty, military, bereavement and time off for voting). In creating this policy, we were able to archive Policy HR708 (Bereavement Leave) and Policy HR707 (Jury Duty). This policy includes time off for victims of crimes noting that this is a sensitive issue. She inquired whether anyone had questions.*

  Commissioner Starck asked if this is a separate policy as opposed to additions to an existing policy. Mrs. Littlefield confirmed.

Group 2: Policies Containing Changes

- **Performance Reviews, HR404** - Reason for the change: *This was an updated policy to reflect the current practice that if a performance evaluation has been completed within the last 90 days, a new launch will not be necessary. Mrs. Gibboney added that sometimes clarification is needed when situations arise and this policy reflects that clarification. She inquired whether anyone had question.*

  There were no questions or comments.

- **Compensation, HR 508 -** Reason for the change: *If an employee previously eligible for LSMP receives a promotion in the middle of their review period, they will receive a prorated LSMP. Payout for the LSMP will occur with the annual review process. She inquired whether anyone had questions.*

  There were no questions or comments.

- **Bilingual Standards & Compensation, HR 509 -** Reason for the change: *HR509 & HR510 were combined, incorporating HR509 into HR510. Archiving Policy HR510 (Bilingual Compensation Program). She inquired whether anyone had questions.*

  Commissioner Starck asked if this was a PHC created test or a standardized test used nationally. Mrs. Littlefield advised that PHC did not create a standard bilingual test but standard testing is outsourced by a third party.

- **Employee Recognition, HR 608 -** Reason for the change: *This policy was updated to reflect the current practice that includes the WOW (What Outstanding Work) Award and nomination guidelines. She inquired whether anyone had questions.*

  Commissioner Elliott asked if employees like and work towards this award. Mrs. Littlefield said yes they work towards it, and look forward to the recognition they receive from leadership and their peers at our PHC All Staff Quarterly Town Halls.

  Commissioner Hempling made a suggestion regarding wording on the Working Together Value Statement to "…employees feel…" stating that the word 'feel' is emotional and tactile. A better word might be "know" or "believe". Example would be: "To know they are valued". Mrs. Littlefield, Mrs. Gibboney, and Ms. McFarland thought this was a great suggestion.

Group 3: Policies Containing No-Changes

Mrs. Littlefield inquired whether anyone had questions.

Commissioner Starck asked how often policies and procedures were reviewed by staff. Mrs. Littlefield said that staff receives all changes to policies throughout the year and are reviewed annually with the attorneys.

Mrs. Gibboney added that the HR Steering Committee Meeting was started over 3 years ago and is scheduled monthly to discuss current issues and any policy and procedure changes or suggestions.

List of Policies Containing No Changes:

- HR115 – Discrimination, Harassment, and Retaliation Prevention
- HR210 – Working Out of Job Class
- HR213 – Job Descriptions
- HR407 – Suspected Abuse or Neglect of Members
- HR504 – Overtime
- HR506 – Employee Reimbursement for Employee Growth & Career Development
- HR511 – Attendance & Punctuality
- HR512 – Mileage Reimbursement
- HR514 – Employee Growth & Career Development
- HR515 – Relocation & Moving Expenses
- HR516 – Pay Related to Community Events
- HR604 – Spot Bonus
- HR605 – Management Incentive Program
- HR606 – Employee Award Program
- HR610 – Holiday Pay
- HR701 – Paid Time Off (PTO)
- HR702 – Paid Time Off Cash-Out Program
- HR703 – Family and Medical Leave; Pregnancy Disability Leave, Reasonable Accommodation, and Transfer; Personal Medical Leave; and Service Member Leave
- HR706a – 9/80 Workweek (Exempt)
- HR706b – 9/80 Workweek (Non-Exempt)
- HR709 – Sick Leave for On-Call Employees
- HR710 – Paid Sick Leave (PSL)
- HR803 – Workers Compensation
- HR901 – Severance Pay

AGENDA ITEM 1.7 PHC's 2022 Event Calendar

Mrs. Littlefield said this item is included to let the Committee know what events PHC provides monthly and those that have been impacted by current events. She inquired whether anyone had questions.

Commissioner Starck commented that she likes HEDIS Week.

Mrs. Gibboney informed that the event calendar is reviewed at the biweekly Executive Meeting.

AGENDA ITEM 1.8 PROPOSAL: Additional Holidays

Mrs. Littlefield proposed adding 3 additional holidays (Cesar Chavez, Juneteenth and Veterans' Day). If approved, would allow staff to designate their selection of one of the three holidays to observe during the year and the choice to make a different selection each year. PHC's goal is to remain inclusive and conscientious of our employee's culture and their personal holiday observances. She inquired whether anyone had questions.

Commissioner Starck questioned if we're offering the employees one additional holiday instead of choosing one of the 3 federal holidays? Such as a floating holiday?

Mrs. Gibboney responded that employees used to have a floating holiday to use at their discretion. However, the implementation as proposed would restrict them to choose one of the 3 federal holidays, rather than go back to a floating holiday.

Commissioner Starck inquired as to why we are proposing additional holidays for employees.

Mrs. Gibboney responded that she observed the recently sanctioned federal holiday, Juneteenth, and wanted to provide awareness to our employees. With PHC embracing health equity and diversity as our organization grows, thought this was a good time to implement such holiday observance.

Mrs. West was concerned with potential employee feedback asking why we are celebrating Juneteenth as opposed to Veterans Day. Wendi's understanding is that the idea is to acknowledge all 3 holidays without closing for business operations.

Mrs. Gibboney asked Commissioner Starck how Humboldt County handles this, and Commissioner Starck advised that Humboldt County employees get all the holidays.

Ms. McFarland suggested to keep the office open through these observed holidays due to staffing needs and member services, however, she thinks we could select more celebrated holidays for our staff to choose from.

Mrs. Gibboney clarified that PHC is not asking employees to come up with one holiday to celebrate every year, rather each employee would have their preference of the holiday they choose to observe that year.

Commissioner Hempling was concerned about paying time and a half for those staff working on these holidays.

Ms. McFarland explained that PHC would only pay time and a half to those that have chosen to observe that holiday and get asked to work. She suggested to run this by counsel.

Commissioner Starck asked is the intent to provide an additional benefit or lean into equity, or both? She said there are other holidays to consider offering that may be important to others opposed to the ones we have chosen for them. She asked how hard it would be to re-visit the floating holiday. Commissioner Elliott added she personally would like the floating holidays.

Mrs. Littlefield mentioned that PHC used to have a cultural day in the organization, "International Celebration Day". We could bring that back and give employees a floating holiday, which would also demonstrate diversity.

Commissioners closing comments: Commissioner Starck likes the floating holiday with variety. Commissioner Elliott said she is not opposed to either one, and Commissioner Hempling said he likes the 3 to choose from as long as we word it correctly.

Mrs. Gibboney said she is leaning towards a floating holiday with more parameters. Variety but personal choice. Offering communication for upcoming celebrated holidays on a monthly basis throughout the year. Commissioner Hempling agreed that we should communicate on upcoming holidays and why we should celebrate them.

After discussion, a Motion was made by Commissioner Hempling, seconded by Commissioner Starck to:

> *"Approve one additional eight (8) hour floating holiday, including messaging in an effort to raise awareness, and evaluate after one year."*

Vote carried unanimously.

AGENDA ITEM 2.1 ADJOURNMENT

Mrs. Littlefield thanked everyone and adjourned the meeting at 1:57 pm.

ALL IN FAVOR OF POLICY CHANGES:

Greta Elliott, Board Commissioner
Nancy Starck, Board Commissioner
Randall Hempling, Board Commissioner
Liz Gibboney, CEO
Patti McFarland, CFO
Regina Littlefield, Sr. Director of Human Resources
Wendi West, SR. Director of Northern Region

Minutes respectfully submitted by:
Kalei Spangler, Program Coordinator I
Jamie Hayes, Administrative Assistant II

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
April 27, 2022

Agenda Item Number:
3.5

Resolution Sponsor:
Liz Gibboney, CEO, Partnership HealthPlan of CA

Recommendation by:
PHC Staff

Topic Description:
AB361 authorizes public meetings with Brown Act requirements to be held via teleconference or telephone during a state of emergency. Virtual public meetings still require standard meeting agendas and notices and the ability for the public to provide public comment. To continue virtual meetings, the Commission must make findings every 30 days that 1) it has reconsidered the circumstances of the ongoing COVID-19 pandemic state of emergency and 2) either the state of emergency continues to directly impact the ability of the public to meet safely in person, or state or local officials continue to impose or recommend measures to promote social distancing.

Due to the ongoing risk of community transmission of COVID-19, it is recommended that the Partnership HealthPlan of California Commission continues to offer virtual attendance as an option and encourages in-person attendance following current PHC guidelines with regard to vaccinations, masking, social distancing and other protective measures.

Reason for Resolution:
To allow the Board the opportunity to review and approve ongoing virtual Board Meetings, due to the ongoing risk of community transmission of COVID-19.

Financial Impact:
There is no additional financial impact to the HealthPlan.

Requested Action of the Board:
Based on the recommendation of PHC staff and public health officials, the Board is asked to approve the recommended to continue to offer virtual attendance, due to the ongoing risk of community transmission of COVID-19.

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
April 27, 2022

Agenda Item Number:
3.5

Resolution Number:
22-

IN THE MATTER OF: APPROVING THE RECOMMENDED CONTINUATION OF MEETING VIRTUALLY

Recital: Whereas,

A. AB361, signed by Governor Newsom on September 16, 2021, requires the Commission must make findings every 30 days to continue to offer virtual attendance.

Now, Therefore, It Is Hereby Resolved As Follows:

1. To approve the recommended continuation of offering virtual attendance for meetings, due to the ongoing risk of COVID-19 transmission, for the next 30 days, per AB 361.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 27th day of April 2022 by motion of Commissioner, seconded by Commissioner, and by the following votes:

AYES: Commissioners:

NOES: Commissioners:

ABSTAINED: Commissioners:

ABSENT: Commissioners:

EXCUSED: Commissioners:

_____
Alicia Hardy, Chair

_____
Date

ATTEST:

BY: _____
Ashlyn Scott, Clerk

REGULAR AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board / Finance Committee (when applicable)
Meeting Date: April 20, 2022
Board Meeting Date: April 27, 2022

Agenda Item Number:
4.1

Resolution Sponsor:
Liz Gibboney, CEO, Partnership HealthPlan of CA

Recommendation by:
PHC Staff

Topic Description:
The PHC budget process is usually a three-step process: budget assumptions are presented to Finance Committee and Board in April, a preliminary Health Care budget at Finance Committee in May, with the final budget (health care, administrative, and operations) presented to the Finance Committee and Board in June.

Reason for Resolution:
The purpose of this resolution is to provide the attached budget assumptions to the Board for FY 2022-2023 and to direct staff to prepare a full operational budget.

Financial Impact:
The financial impact is significant.

Requested Action of the Board:
Based on the recommendation of PHC staff, the Board is asked to approve budget assumptions for FY 2022-2023.

REGULAR AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board / Finance Committee (when applicable)
Meeting Date: April 20, 2022
Board Meeting Date: April 27, 2022

Agenda Item Number:
4.1

Resolution Number:
22-

IN THE MATTER OF: APPROVING BUDGET ASSUMPTIONS FOR FY 2022-2023

Recital: Whereas,

A. The Board has responsibility for establishing budget policy and specific budget approval.

B. In prior meetings, PHC staff, the Finance Committee and Board provided direction and input.

Now, Therefore, It Is Hereby Resolved As Follows:

1. To approve budget assumptions for FY 2022-2023.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 27th day of April 2022 by motion of Commissioner, seconded by Commissioner, and by the following votes:

AYES: Commissioners:

NOES: Commissioners:

ABSTAINED: Commissioners:

ABSENT: Commissioners:

EXCUSED: Commissioners:

_____
Alicia Hardy, Chair

_____
Date

ATTEST:

BY: _____
Ashlyn Scott, Clerk

Partnership HealthPlan of California

2022-23 Budget Assumptions

April 2022

Introduction

Each year, starting in January, Partnership HealthPlan of California (PHC) begins building the annual budget for Board review and approval in June. As part of this process, PHC presents to the Finance Committee and the Board key components of the budget development for review and approval. Specifically, in April, draft budget assumptions are presented to the Finance Committee and Board, followed by the draft health care expense budget in May. In June, the final budget—including previously reviewed component parts and a fully developed administrative budget—are presented to the Board for final review and approval. This document outlines the Plan's draft budget assumptions that inform PHC's revenue and cost projections as impacted by estimated changes in enrollment, health care costs, administrative costs, as well as disposition of incentive arrangements and reserves.

Outlook for 2022-23

Although the COVID-19 pandemic impacts have softened on the delivery system, the emergency response continues to have a significant impact on our financial planning efforts. The continuation, and unknown end, of the public health emergency (PHE) remains to be the largest variable to the Plan's finances. More specifically, the pause in redeterminations steadily increased the plans membership since the start of the pandemic impacting revenue, rate development, non-operating income and health care trends. The resumption of the redeterminations will likely have an unknown gradual impact as the Counties work through their respective eligibility back-logs. The unknowns in membership have material impacts to our revenue rates as Mercer bases overall reimbursement on underlying membership assumptions. PHC will receive updated rates with an expected delivery of mid-year unless the end to the PHE is announced sooner. Unlike the prior year, Staff will hold out as long as possible on factoring the end of the PHE in our financial modeling in hopes of receiving an update prior to finalizing the budget.

Due to the materiality of the impacts relating to the PHE, Staff may need to complete an off-cycle budget if developments arise during the upcoming fiscal year.

Enrollment

PHC's membership has experienced consistent month-over-month growth since March 2020, which is almost completely a result of the public health emergency (PHE) declaration. The freeze of member redeterminations has steadily increased the membership by means of limiting the terms managed care organizations would have experienced under normal circumstances. The chart below illustrates, by county, the growth trends along with the overall point in time increases for PHC's membership.

PHC Membership as of 2/28/2022

County	T3M	T6M	T10M	Feb '22 vs Mar '20	# of MM
Solano	0.7%	0.7%	0.7%	23.0%	23,865
Sonoma	0.5%	0.5%	0.6%	20.4%	20,624
Shasta	0.3%	0.3%	0.4%	17.4%	9,986
Yolo	0.2%	0.7%	0.6%	19.2%	9,466
Marin	0.5%	0.5%	0.6%	22.5%	8,322
Humboldt	0.4%	0.4%	0.4%	14.2%	7,299
Napa	0.4%	0.4%	0.4%	18.6%	5,110
Mendocino	0.2%	0.3%	0.4%	14.5%	5,009
Lake	0.3%	0.3%	0.3%	14.5%	4,244
Siskiyou	0.1%	0.1%	0.3%	13.1%	2,194
Del Norte	0.2%	0.1%	0.3%	10.3%	1,145
Trinity	0.4%	0.4%	0.5%	25.6%	1,081
Lassen	0.5%	0.5%	0.6%	17.5%	1,252
Modoc	0.6%	0.6%	0.6%	19.2%	624
Total	**0.4%**	**0.5%**	**0.5%**	**18.8%**	**100,221**
	Trailing # Month average month-to-month increase			**Point-in-time comparison, % △ and # of members**	

Overall, PHC has increased membership by roughly 100,000 members. It is also evident that the growth trends have leveled off as most of the counties trailing averages are relatively flat. The trailing 10-month average (T10M) of 0.5% is down from 0.9% this time last year. The net member increases have been primarily in the Family (Child & Adult) and Medi-Cal expansion (MCE) aid categories; which is fitting as these are the members that are most likely to move in and out of Medi-Cal as life circumstances change. PHC's overall long term care (LTC) counts have decreased, which is a result of COVID related impacts.

Membership will continue to slowly grow until the PHE has officially ended and redeterminations are resumed. Each of PHC's fourteen counties will need to systematically work through all enrolled members to determine Medi-Cal eligibility. There will be a substantial amount of ineligible members, reversing the month-over-month gains at an unknown rate. Like prior years, PHC will likely pick an aggressive attrition rate to ensure the overall budget does not include an unrealistic revenue target. This provides inherent upside if the membership counts remain higher than estimated, relieving margin pressures.

PHC Staff will monitor the membership development in the coming months and will update the budget assumptions accordingly. The flex budget will help account for material changes that develop after the final presentation of the 2022-23 budget, variances will be noted and presented to the respective Committees.

Revenue

Major anticipated revenue impacts are noted below:

- **Medi-Cal Rates:** DHCS delivered final rates for calendar year (CY) 2022, spanning the first six months of the upcoming FY, but will be revised pending any PHE developments or lack thereof. CY 2023 rates, spanning the second 6 months of the FY, will be estimated based on

prior year trends as they will not be released until later this year. Staff will account for membership changes, program updates, and any additional efficiency factors that have been applied to prior cycles.

- **Supplemental Revenue:** The MCO Tax is designed to be an "at-risk" program, meaning there is a fixed liability and the revenue is subject to membership experience. This becomes a challenge in times of volatile membership trends, causing plans to move between gain and loss positions over time, though, the program tends to be zero-sum. The MCO program will sunset, again, at the end of CY 2022. There are 10 Proposition 56 programs (Tobacco Tax dollars) flowing through the Plan, representing roughly $80.0 - $100.0 million in revenue in a given 12 month period. Programs vary in offsetting expenses and risk mitigation structures. PHC tracks each program and routinely reports to DHCS on the progress of payments. The Value Based Payment (VBP P56 program) is slated to sunset on 6/30/2022. The last supplemental revenue to mention is the various programs that were a result of the reformed Hospital Quality Assurance Fee (HQAF): Private Hospital Directed Payment Program (PHDP), Designated Public Hospital Enhanced Payment Program (DPH-EPP), and Designated Public Hospital Quality Improvement Program (DPH-QIP). These programs have historically been risk-free to the Plan and have been appropriately recorded as a balance sheet only item, no revenue and expense impacts. As these programs move to a risk-based model, PHC may begin recognizing the revenue and expenses.
- **Interest Income:** In March of 2020, the Federal Open Market Committee (FOMC) dropped the federal funds rate to a target range of 0 to 0.25% in the wake of the COVID 19 outbreak. The committee maintained this target range through the beginning of 2022 in an effort to achieve maximum employment and a long term inflation rate of 2%. During the March 16, 2022 FOMC meeting, the second of eight regularly scheduled meetings for the year, the Committee decided to increase the target federal funds rate by 25 basis points to a range of 0.25% to 0.50%. This was the first increase to the federal funds rate in three years. The Committee anticipates additional increases throughout the year to curb elevated inflation and bring the inflation rate closer to the long term goal of 2%.While there is not a direct correlation between the federal funds rate and the interest rate earned on deposits or investments held, PHC's overall yield tends to follow a similar direction. The Plan will assume an annual rate of return of .50%. PHC will revise the rate accordingly based on any future actions taken by the Federal Reserve.
- **Rental Income:** Currently, PHC leases space to 13 tenants in Fairfield and one tenant in Redding. Tenants are currently being sought for previously leased, vacant space and for the newly available space on the third floor of 4605 in Fairfield. Rental income will be estimated based on existing and anticipated lease agreements. For anticipated leases, rental income will be projected using lease rates that are approximately 90% of current market rates. Building maintenance costs associated with the leased space will be included in administrative costs.

Health Care Costs

Health care cost projections for fiscal year 2022-23 will be based on the Plan's historical claims experience for all counties. PHC cost experience from January 2019 through January 2022 will serve as the base data for budget development. Completion factors will be incorporated where appropriate to account for incurred but not yet reported claims. PHC is closely monitoring health care costs in the context of membership fluctuations and the impacts of the pandemic, adjusting our budget methodology accordingly to better estimate future trends.

The base period costs will be adjusted for:

- COVID-19 historical trend impacts
- Changes in provider contracting, either through new payment amendments or ongoing and/or anticipated negotiations.
- Reasonable assumptions regarding underlying utilization trends based on internal analysis and a review of DHCS trends used in developing Plan capitation rates.
- Effects of changes in current case management, utilization management, and specific disease management programs from year-to-year, or newly developed programs. Specific

programs such as Complex Case Management are monitored on an annual basis to ensure a continuous positive return on investment.
- Expense impacts related to operational improvements or efficiency gains, inclusive of configuration changes impacting historical trends.
- Other material anticipated benefit, price, and enrollment related changes.

Incentive Arrangements

PHC anticipates an increase in overall funding for all five major incentive programs subject to final revenue projections when rates from DHCS are received. The continued pause in redeterminations has increased the volume of assigned members eligible for incentive payments. PHC Staff are actively reviewing changes to guidelines and requirements directed by CMS and DHCS. The draft and final budget proposals presented in May and June 2022 will have more details on the impacts to incentives.

Administrative Costs

- **Staff:** With the launch of CalAIM on January 1, 2022 PHC began providing services as required and outlined by DHCS. As the program requirements continue to expand over the State's five year plan, PHC will propose staffing changes as needed in addition to tending to other infrastructure needs. In fiscal year 2022-23 PHC will evaluate the cost benefit of bringing in-house certain administrative services currently being performed by third parties. Should this happen, the number of staff would increase but overall costs are expected to be budget neutral due to the elimination of the third party administration costs. As with prior years, a vacancy rate will be determined based on historical trends. Staffing changes are currently being reviewed and final numbers are to be determined.
- **Benefits:** PHC is currently researching employer benefit trends and will present the estimated percentage change for employee medical, dental and vision benefits during the May review. Benefit changes approved by Board will be incorporated.
- **Salaries:** Current unemployment trends continue to remain low while the number of job openings continues to be high in comparison to job seekers. A shortage of qualified workers coupled with high inflation will likely continue to put pressure on salary, wages and benefits to remain competitive. PHC is in the process of completing a company-wide salary survey and the final results of survey will be incorporated into the fiscal year 2022-23 budget. According to the January 2022 Economic News Release from the U.S. Bureau of Labor Statistics, the Western Region of the U.S. employment cost index (ECI) for the 12 months ending December 2021 ranged from 3.2 percent to 5.5 percent. Given the index was computed when several employers were starting to resume normal business activity and when inflation began to take off, PHC will wait for the March release to obtain a better gauge on the proposed annual merit increase.
- **Capital:** New capital purchase recommendations, primarily related to IT needs, general building repairs as well as tenant improvements for new leases, will be included on the final detailed capital expenditures budget list. Depreciation will be calculated based on anticipated purchase dates, completion dates for those items that are considered construction in progress, and existing capital assets.

Reserves

Board designated reserves are calculated according to policy: 60 days of operating expenses, $15 million for infrastructure, and an additional amount set aside for the Strategic use of Reserves (SUR)-already approved but not yet incurred. The total fund balance, including the projected Board designated amount for the year ending June 30, 2022 will be presented with the final budget.

FINANCIAL HIGHLIGHTS
Of The Partnership HealthPlan Of California
For the Period Ending February 28, 2022

Financial Analysis for the Current Period

Total (Deficit) Surplus

For the month ending February 28, 2022, PHC reported a net surplus of $27.2 million, bringing the year-to-date surplus to $106.6 million. Significant variances are explained below.

Revenue

Total Revenue is greater than budget by $20.6 million for the month and $72.9 million for the year-to-date. The year-to-date favorable variance is due to higher than budgeted rates for both calendar year (CY) 2021 and 2022. CY 2021 favorability was related to COVID-19 impacts along with considerations for the delay in the pharmacy carve-out. CY 2022 is also favorable to budget expectations primarily due to the prolonging of the public health emergency (PHE). PHC anticipates updated CY 2022 rate schedules later in the fiscal year once the PHE concludes. Also contributing to the favorable variance are prior period adjustments for maternity kick and Indian Health Service programs, both of which have offsets in healthcare costs. Additionally, Other Revenue includes year-to-date revenue of $9.0 million for the Behavioral Health Integration (BHI) Incentive Program and $2.5 million for the COVID-19 vaccine incentive; corresponding expenses are being recorded in Healthcare Investment Funds.

Healthcare Costs

Total Healthcare Costs are lower than budget by $2.1 million for the month and $26.2 million for the year-to-date. Long Term Care and Inpatient Hospital FFS are collectively $35.9 million favorable for the year-to-date due to prior period IBNR adjustments and lower than budgeted expenses. Hospital Capitation and Hospital Stop- Loss are $20.1 million favorable for the year-to-date due primarily to FY 2019-20 stop-loss expense true-up and lower than budgeted stop-loss expenses for FY 2021-22. Physician and Ancillary expenses are $8.4 million favorable for the year-to-date due to prior period IBNR adjustments. Transportation expense is $13.9 million unfavorable year-to-date due to higher than anticipated utilization specific to drug rehabilitation trips and specialty visits. Pharmacy expenses are $4.7 million unfavorable year-to-date due to higher than budgeted cost and unbudgeted true-up of prior year pharmacy expense for Kaiser's whole child model population. Healthcare Investment Funds expenses are $5.7 million unfavorable year-to-date due to unbudgeted BHI Incentive Program and COVID-19 vaccine incentive expenses, offsets mentioned in revenue above. Global Subcapitation is $18.0 million unfavorable year-to-date due to unbudgeted prior period expense true-ups for maternity kick, higher than budgeted global subcap rates for January 2022, adult age band catch-up accrual, CY 2021 rate updates, and unbudgeted mental health capitation expense.

Administrative Costs

Total administrative costs are under budget by $1.0 million for the month and $11.3 million for the year-to- date. This positive variance continues to primarily be in Employee expenses due to the greater number of open positions than originally anticipated. Lower depreciation costs and building repairs and maintenance, which contribute to the positive variance in Occupancy, can be attributed to a few capital and IT projects that were budgeted for the earlier part of the year but are only now slowly beginning to take place. These positive variances are offset by the variance in Computer and Data due to the timing of purchases.

FINANCIAL HIGHLIGHTS
Of The Partnership HealthPlan Of California
For the Period Ending February 28, 2022

Balance Sheet

Total Cash & Cash Equivalents decreased by $102.4 million for the month. $273.8 million in State Capitation payments and $2.7 million in Drug Medi-Cal payments were received, and $880,935 in transfers between cash and Board Designated Reserves were recorded during the month; these payments were offset by $196.0 million in healthcare cost payments, $164.8 million in HQAF disbursements, and $17.2 million in administrative and capital costs. The remaining difference can be attributed to interest and other revenues.

General Statistics

Membership

Membership had a total net increase of 1,677 members for the month.

Utilization Metrics and High Dollar Case

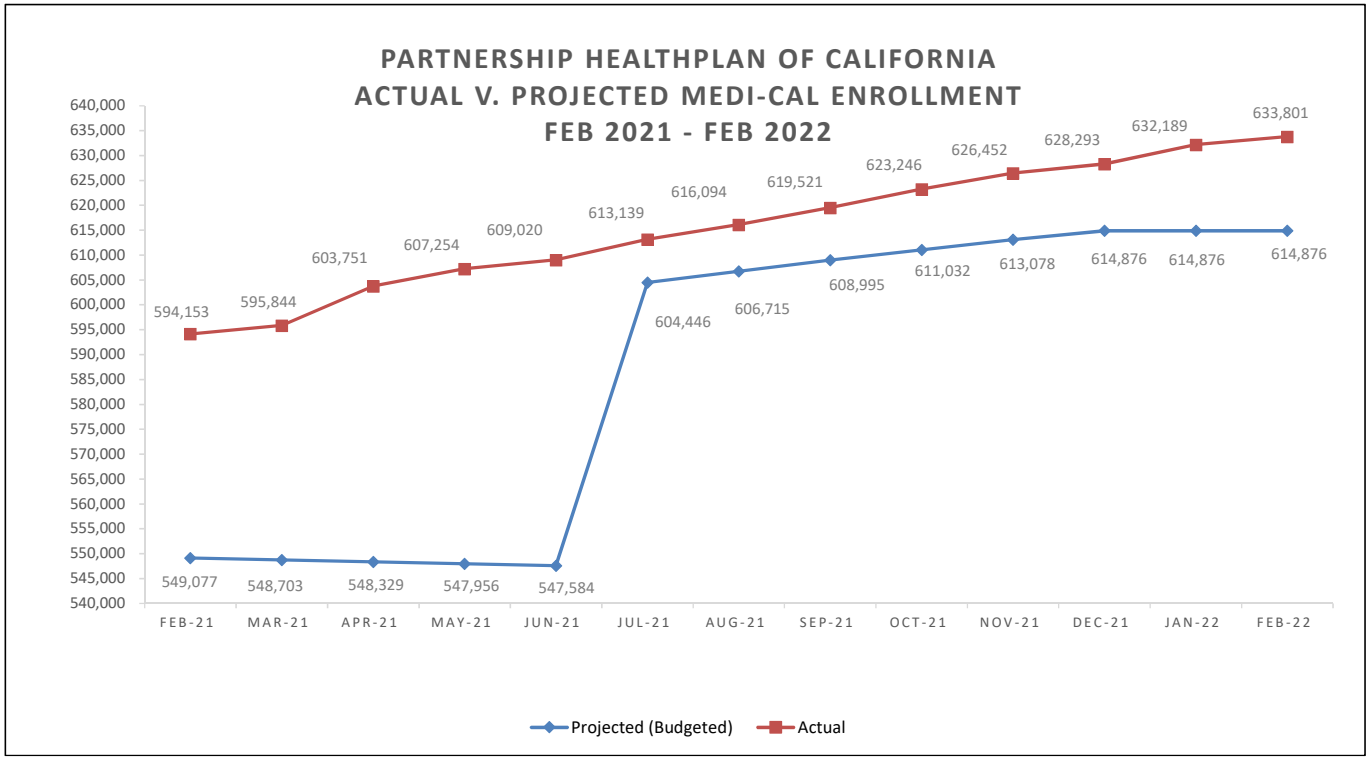
For the fiscal year 2021/22 through February 28, 2022, 270 members reached the $250,000 threshold with an average cost of $441,913. For fiscal year 2020/21, 511 members reached the $250,000 threshold with an average cost per case was $491,687. For fiscal year 2019/20, 443 members reached the $250,000 threshold with an average claims cost of $484,888.

Current Ratio/Required Reserves

Current Ratio Including Required Reserves	**1.83**
Current Ratio Excluding Required Reserves:	**1.26**
Required Reserves:	**$550,765,673**
Total Fund Balance:	**$757,239,100**

Days of Cash on Hand

Including Required Reserves:	**108.21**
Excluding Required Reserves:	**65.37**



Member Months by County:

County	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
Solano	117,647	117,747	119,971	120,604	120,997	121,963	122,560	123,349	124,247	125,202	125,748	126,876	127,721
Napa	30,546	30,923	31,144	31,392	31,532	31,637	31,786	31,879	31,874	32,186	32,223	32,566	32,447
Yolo	54,572	54,835	55,239	55,646	55,623	56,116	56,290	56,687	57,644	58,371	58,386	58,531	58,770
Sonoma	113,043	113,765	114,542	115,779	116,329	117,149	118,045	118,578	119,138	119,850	120,345	121,061	121,635
Marin	42,072	42,338	42,763	43,137	43,322	43,642	43,883	44,239	44,637	44,731	44,833	45,288	45,344
Mendocino	37,601	37,604	38,196	38,305	38,504	38,627	38,773	38,942	39,128	39,272	39,266	39,507	39,422
Lake	31,933	32,135	32,390	32,520	32,605	32,826	32,933	33,083	33,137	33,281	33,340	33,552	33,537
Del Norte	11,861	11,889	11,947	12,040	12,069	12,089	12,147	12,138	12,175	12,166	12,271	12,233	12,245
Humboldt	56,063	55,975	56,835	57,014	57,052	57,391	57,547	57,895	58,203	58,217	58,347	58,779	58,818
Lassen	7,776	7,777	7,952	7,986	8,002	8,045	8,129	8,186	8,189	8,264	8,343	8,413	8,383
Modoc	3,693	3,606	3,729	3,722	3,708	3,760	3,761	3,785	3,809	3,803	3,820	3,871	3,883
Shasta	64,168	64,121	65,446	65,488	65,653	66,074	66,323	66,734	66,922	67,042	67,225	67,304	67,413
Siskiyou	18,208	18,139	18,552	18,540	18,506	18,691	18,733	18,826	18,926	18,830	18,859	18,921	18,911
Trinity	4,970	4,990	5,045	5,081	5,118	5,129	5,184	5,200	5,217	5,237	5,287	5,287	5,272
All Counties Tota	**594,153**	**595,844**	**603,751**	**607,254**	**609,020**	**613,139**	**616,094**	**619,521**	**623,246**	**626,452**	**628,293**	**632,189**	**633,801**

Medi-Cal Region 1: Solano, Napa, Yolo & Marin; Medi-Cal Region 2: Sonoma, Mendocino & Rural 8 Counties

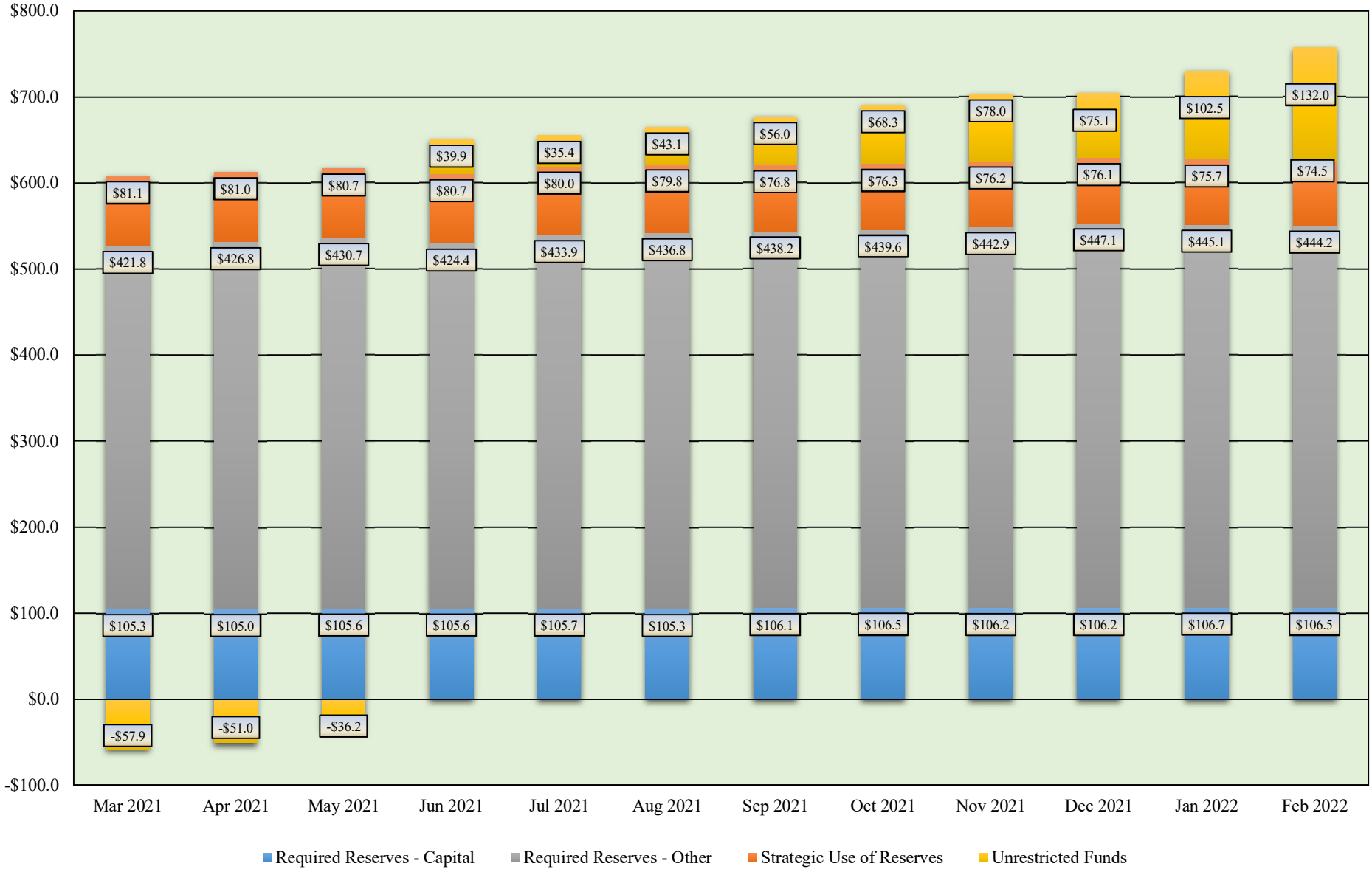
Partnership HealthPlan of Californi
Comparative Financial Indicators Monthly Report
Fiscal Year 2021 - 2022 & Fiscal Year 2020 - 2021

FINANCIAL INDICATORS	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22					YTD	Avg / Month As of Feb-22
Total Enrollment	612,565	615,504	619,135	622,749	625,752	627,918	632,226	633,903					4,989,752	623,719
Total Revenue	285,770,409	290,492,773	289,217,239	289,434,715	295,168,702	291,059,764	280,860,131	279,174,488					2,301,178,220	287,647,278
Total Healthcare Costs	258,057,572	256,910,666	252,438,582	251,402,013	258,737,530	263,716,815	230,109,224	227,347,264					1,998,719,666	249,839,958
Total Administrative Costs	9,527,532	9,674,878	10,915,842	10,456,654	10,013,386	12,195,146	11,432,906	10,800,640					85,016,984	10,627,123
Medi-Cal Hospital & Managed Care Taxes	13,854,167	13,854,167	13,854,167	13,854,167	13,854,167	13,854,167	13,854,167	13,854,167					110,833,336	13,854,167
Total Current Year Surplus (Deficit)	4,331,138	10,053,062	12,008,648	13,721,881	12,563,619	1,293,636	25,463,834	27,172,417					106,608,234	13,326,030
Total Claims Payable	479,612,906	469,987,817	490,436,456	489,196,877	474,284,933	488,534,512	474,970,355	492,259,098					492,259,098	482,410,369
Total Fund Balance	654,962,002	665,015,064	677,023,711	690,745,593	703,309,212	704,602,848	730,066,681	757,239,100					757,239,100	697,870,526
Reserve Fund - Required Reserves	433,909,347	436,773,283	438,173,175	439,588,278	442,927,577	447,118,437	445,125,440	444,244,504					444,244,504	440,982,505
Reserve Fund - Capital Assets	105,684,355	105,331,238	106,055,796	106,519,267	106,191,511	106,189,354	106,721,219	106,521,169					106,521,169	106,151,739
Reserve Fund - Strategic Use of Reserves	80,012,212	79,785,705	76,769,579	76,300,252	76,231,209	76,149,155	75,717,707	74,488,498					74,488,498	76,931,789
Unrestricted Fund Balance	35,356,088	43,124,838	56,025,161	68,337,796	77,958,915	75,145,902	102,502,315	131,984,929					131,984,929	73,804,493
Fund Balance as % of Reserved Funds	105.71%	106.93%	109.02%	110.98%	112.47%	111.94%	116.33%	121.11%					121.11%	111.83%
Current Ratio	1.15:1	1.16:1	1.16:1	1.19:1	1.20:1	1.17:1	1.19:1	1.26:1					1.26:1	1.19:1
Medical Loss Ratio w/o Tax	94.94%	92.93%	91.76%	91.34%	92.11%	95.29%	86.64%	86.16%					91.44%	91.44%
Admin Ratio w/o Tax	3.51%	3.50%	3.97%	3.80%	3.56%	4.41%	4.30%	4.09%					3.89%	3.89%
Profit Margin Ratio	1.52%	3.46%	4.15%	4.74%	4.26%	0.44%	9.07%	9.73%					4.63%	4.63%

FINANCIAL INDICATORS	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	YTD	Avg / Month As of Jun-21
Total Enrollment	556,087	563,455	569,392	574,604	579,254	583,912	588,652	593,177	596,201	601,587	606,935	608,597	7,021,853	585,154
Total Revenue	244,622,822	258,045,152	257,210,637	268,252,952	261,036,547	260,390,466	266,550,404	280,192,651	270,995,801	280,012,525	287,059,375	271,418,148	3,205,787,480	267,148,957
Total Healthcare Costs	228,533,285	240,676,950	241,362,720	247,291,936	246,025,716	239,273,022	247,842,498	255,154,457	241,380,692	245,272,242	245,019,491	179,666,787	2,857,499,796	238,124,983
Total Administrative Costs	10,312,618	9,352,080	10,205,235	10,149,122	9,951,801	11,135,881	10,084,463	10,394,568	11,620,169	10,791,482	10,521,875	9,504,028	124,023,322	10,335,277
Medi-Cal Hospital & Managed Care Taxes	12,073,441	12,468,750	12,468,750	12,468,750	12,468,750	12,468,750	12,468,750	12,468,750	12,468,750	12,468,750	12,468,750	12,468,750	149,229,691	12,435,808
Total Current Year Surplus (Deficit)	(6,296,521)	(4,452,629)	(6,826,068)	(1,656,856)	(7,409,720)	(2,487,187)	(3,845,308)	2,174,876	5,526,190	11,480,051	19,049,259	69,778,582	75,034,671	6,252,889
Total Claims Payable	401,791,137	412,650,255	443,747,870	454,556,100	443,896,724	465,413,310	498,051,908	533,566,353	511,412,385	524,307,516	540,428,719	459,028,387	459,028,387	474,070,889
Total Fund Balance	569,299,672	564,847,043	558,020,975	556,364,119	548,954,399	546,467,212	542,621,904	544,796,781	550,322,971	561,803,022	580,852,281	650,630,864	650,630,864	564,581,770
Reserve Fund - Required Reserves	385,127,705	388,857,534	392,130,843	397,251,115	402,055,814	404,937,855	409,782,082	416,395,226	421,825,722	426,777,482	430,741,070	424,393,928	424,393,928	408,356,365
Reserve Fund - Capital Assets	106,003,559	105,914,664	106,538,718	106,279,522	106,095,318	106,918,382	107,015,106	106,595,855	105,296,542	104,979,446	105,564,656	105,550,369	105,550,369	106,062,678
Reserve Fund - Strategic Use of Reserves	85,732,498	84,460,474	84,275,330	83,096,409	82,803,306	82,590,776	82,439,453	81,423,816	81,052,937	81,038,133	80,724,657	80,743,188	80,743,188	82,531,748
Unrestricted Fund Balance	(7,564,090)	(14,385,629)	(24,923,916)	(30,262,927)	(42,000,039)	(47,979,801)	(56,614,736)	(59,618,116)	(57,852,230)	(50,992,038)	(36,178,101)	39,943,378	39,943,378	(32,369,020)
Fund Balance as % of Reserved Funds	98.69%	97.52%	95.72%	94.84%	92.89%	91.93%	90.55%	90.14%	90.49%	91.68%	94.14%	106.54%	106.54%	94.58%
Current Ratio	1.09:1	1.08:1	1.07:1	1.07:1	1.05:1	1.04:1	1.02:1	1.02:1	1.02:1	1.03:1	1.04:1	1.16:1	1.16:1	1.06:1
Medical Loss Ratio w/o Tax	98.06%	97.76%	98.36%	96.49%	98.80%	96.37%	97.90%	95.68%	93.76%	92.11%	89.67%	69.76%	93.61%	93.61%
Admin Ratio w/o Tax	4.42%	3.80%	4.16%	3.96%	4.00%	4.48%	3.98%	3.90%	4.51%	4.05%	3.85%	3.69%	4.06%	4.06%
Profit Margin Ratio	-2.57%	-1.73%	-2.65%	-0.62%	-2.84%	-0.96%	-1.44%	0.78%	2.04%	4.10%	6.64%	25.71%	2.34%	2.34%

Partnership HealthPlan of California
Fund Balance Comparison
(in Millions of Dollars)

For the Past 12 Months Ending February 28, 2022



PARTNERSHIP HEALTHPLAN OF CALIFORNIA
Membership and Financial Summary
For The Period Ending February 28, 2022

CURRENT MONTH	PRIOR MONTH	INC / DEC	MEMBERSHIP SUMMARY	CURRENT YTD AVG	PRIOR YTD AVG	VARIANCE
633,903	632,226	1,677	**Total Membership**	623,719	576,067	47,652

ACTUAL MONTH	BUDGET MONTH	$ VARIANCE MONTH	FINANCIAL SUMMARY	ACTUAL YTD	BUDGET YTD	$ VARIANCE YTD
279,174,488	258,605,474	20,569,014	**Total Revenue**	2,301,178,220	2,228,233,300	72,944,920
227,347,264	229,415,023	2,067,759	**Total Healthcare Costs**	1,998,719,666	2,024,881,323	26,161,657
10,800,640	11,817,062	1,016,422	**Total Administrative Costs**	85,016,984	96,366,317	11,349,333
13,854,167	14,382,637	528,470	**Medi-Cal Managed Care Tax**	110,833,336	113,235,700	2,402,364
27,172,417	**2,990,752**	**24,181,665**	**Total Current Year Surplus (Deficit)**	**106,608,234**	**(6,250,040)**	**112,858,274**
86.16%	93.94%		**Medical Loss Ratio (HC Costs as a % of Rev, excluding Managed Care Tax)**	91.44%	95.74%	
4.09%	4.84%		**Admin Ratio (Admin Costs as a % of Rev, excluding Managed Care Tax)**	3.89%	4.56%	

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
Balance Sheet
As Of February 28, 2022

	February 2022	January 2022
A S S E T S		
Current Assets		
Cash &Cash Equivalents	**677,905,415**	**780,352,876**
Receivables		
Accrued Interest	86,100	43,100
State DHS - Cap Rec	280,000,469	277,568,180
Other Healthcare Receivable	2,035,430	3,566,196
Miscellaneous Receivable	5,953,319	2,885,227
Total Receivables	**288,075,318**	**284,062,703**
Other Current Assets		
Payroll Clearing	18,876	7,855
Prepaid Expenses	4,702,561	5,303,845
Total Other Current Assets	**4,721,437**	**5,311,700**
Total Current Assets	**970,702,170**	**1,069,727,279**
Non-Current Assets		
Fixed Assets		
Motor Vehicles	154,341	154,341
Furniture & Fixtures	7,518,859	7,518,859
Computer Equipment - HP	541,886	541,886
Computer Equipment	20,453,491	20,425,116
Computer Software	20,462,331	20,462,331
Leasehold Improvements	962,374	962,374
Land	6,767,292	6,767,292
Building	55,932,088	55,932,088
Building Improvements	30,250,112	30,163,770
Accum Depr - Motor Vehicles	(142,641)	(141,628)
Accum Depr - Furniture	(7,000,129)	(6,971,417)
Accum Depr - Comp Equip - HP	(541,886)	(541,886)
Accum Depr - Comp Equipment	(18,857,059)	(18,588,952)
Accum Depr - Comp Software	(18,732,320)	(18,552,831)
Accum Depr - Leasehold Improvements	(962,374)	(962,374)
Accum Depr - Building	(8,701,536)	(8,576,547)
Accum Depr - Bldg Improvements	(8,676,580)	(8,513,966)
Construction Work-In-Progress	27,092,919	26,642,764
Total Fixed Assets	**106,521,168**	**106,721,220**
Other Non-Current Assets		
Deposits	38,899	37,399
Board-Designated Reserves	443,944,504	444,825,440
Knox-Keene Reserves	300,000	300,000
Prepaid - Other Non-Current	2,209,037	2,209,037
Net Pension Asset	7,231,258	7,231,258
Deferred Outflows Of Resources	930,354	930,354
Total Other Non-Current Assets	**454,654,052**	**455,533,488**
Total Non-Current Assets	**561,175,220**	**562,254,708**
Total Assets	**1,531,877,390**	**1,631,981,987**

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
Balance Sheet
As Of February 28, 2022

	February 2022	January 2022
L I A B I L I T I E S & F U N D B A L A N C E		
Liabilities		
Current Liabilities		
Accounts Payable	111,912,887	92,761,907
Unearned Income	3,570,627	3,070,137
Suspense Account	4,702,737	3,834,894
Capitation Payable	25,792,924	23,859,924
State DHS - Cap Payable	32,633,113	32,633,113
Accrued Healthcare Costs	7,995,885	180,801,475
Claims Payable	63,246,070	63,246,070
Incurred But Not Reported-IBNR	429,013,028	411,724,285
Quality Improvement Programs	93,986,078	88,198,560
Total Current Liabilities	**772,853,349**	**900,130,365**
Non-Current Liabilities		
Deferred Inflows Of Resources	1,784,941	1,784,941
Total Non-Current Liabilities	**1,784,941**	**1,784,941**
Total Liabilities	**774,638,290**	**901,915,306**
Fund Balance		
Unrestricted Fund Balance	**131,984,929**	**102,502,315**
Reserved Funds		
Reserve Fund-Board Designated	428,944,504	429,825,440
Reserve Fund-Board Designated-Infrastructure	15,000,000	15,000,000
Reserve Fund-Board Designated-Capital Assets	106,521,169	106,721,219
Reserve Fund-Strategic Use Of Reserve	74,488,498	75,717,707
Reserve For Restricted Fund-Knox-Keene	300,000	300,000
Total Reserved Funds	**625,254,171**	**627,564,366**
Total Fund Balance	**757,239,100**	**730,066,681**
Total Liabilities And Fund Balance	**1,531,877,390**	**1,631,981,987**

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
Statement of Cash Flow
For The Period Ending February 28, 2022

	Current Month Activity	Year-To-Date Activity
CASH FLOWS FROM OPERATING ACTIVITIES:		
Cash Received From:		
Capitation from California Department of Health Care Service	273,828,008	2,676,353,463
Other Revenues	97,930	720,381
Cash Payments to Providers for Medi-Cal Members		
Capitation Payments	(40,851,431)	(338,593,366)
Medical Claims Payments	(155,183,096)	(1,630,538,281)
Drug Medi-Cal		
DMC Receipts from Counties	2,654,769	16,849,447
DMC Payments to Providers	(1,843,967)	(15,318,815)
Cash Payments to Vendors	(172,002,927)	(434,127,463)
Cash Payments to Employees	(9,748,682)	(70,485,140)
Net Cash (Used) Provided by Operating Activities	**(103,049,396)**	**204,860,226**
CASH FLOWS FROM CAPITAL FINANCING & RELATED ACTIVITIES:		
Purchases of Capital Assets	(279,000)	(8,106,793)
Net Cash Used by Capital Financial & Related Activities	**(279,000)**	**(8,106,793)**
CASH FLOWS FROM INVESTING ACTIVITIES:		
Board-Designated Reserve Transfers	880,935	(19,850,576)
Interest and Dividends on Investments	-	342,858
Net Cash (Used) Provided by Investing Activities	**880,935**	**(19,507,718)**
NET (DECREASE) INCREASE IN CASH & CASH EQUIVALENTS	**(102,447,461)**	**177,245,715**
CASH & CASH EQUIVALENTS, BEGINNING	**780,352,876**	**500,659,700**
CASH & CASH EQUIVALENTS, ENDING	**677,905,415**	**677,905,415**
RECONCILIATION OF OPERATING (LOSS) INCOME TO NET CASH PROVIDED (USED) BY OPERATING ACTIVITIES:		
TOTAL OPERATING (LOSS) INCOME	**27,129,417**	**106,267,377**
DEPRECIATION	**764,924**	**6,164,816**
CHANGES IN ASSETS AND LIABILITIES:		
Other Receivables	(1,537,325)	7,810,015
California Department of Health Services Receivable	(2,432,289)	12,482,677
Other Assets	302,891	580,975
Accounts Payable and Accrued Expenses	(150,353,275)	4,534,847
Accrued Claims Payable	17,288,743	33,230,712
Quality Improvement Programs	5,787,518	33,788,807
Net Cash Provided (Used) by Operating Activities	**(103,049,396)**	**204,860,226**

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Statement of Revenues and Expenses

For The Period Ending February 28, 2022

****The Notes to the Financial Statement are an Integral Part of this Statement****

ACTUAL MONTH	BUDGET MONTH	$ VARIANCE MONTH	ACTUAL MONTH PMPM	BUDGET MONTH PMPM		ACTUAL YTD	BUDGET YTD	$ VARIANCE YTD	ACTUAL YTD PMPM	BUDGET YTD PMPM
633,903	**633,903**	**-**			**TOTAL MEMBERSHIP**	**4,989,752**	**4,989,752**	**-**		
					REVENUE					
275,418,989	258,389,224	17,029,765	434.48	407.62	State Capitation Revenue	2,287,850,541	2,226,503,300	61,347,241	458.51	446.22
43,000	101,583	(58,583)	0.07	0.16	Interest Income	340,858	812,664	(471,806)	0.07	0.16
3,712,499	114,667	3,597,832	5.86	0.18	Other Revenue	12,986,821	917,336	12,069,485	2.60	0.18
279,174,488	**258,605,474**	**20,569,014**	**440.41**	**407.96**	**TOTAL REVENUE**	**2,301,178,220**	**2,228,233,300**	**72,944,920**	**461.18**	**446.56**
					HEALTHCARE COSTS					
22,219,859	18,233,983	(3,985,876)	35.05	28.76	Global Subcapitation	172,326,314	154,291,628	(18,034,686)	34.54	30.92
2,381,210	2,598,706	217,496	3.76	4.10	Capitated Medical Groups	18,585,950	19,485,044	899,094	3.72	3.91
					Physician Services					
6,053,448	6,368,807	315,359	9.55	10.05	PCP Capitation	48,206,946	48,963,177	756,231	9.66	9.81
209,314	205,546	(3,768)	0.33	0.32	Specialty Capitation	1,632,449	1,607,062	(25,387)	0.33	0.32
32,902,426	35,181,498	2,279,072	51.90	55.50	Non-Capitated Physician Services	274,747,389	282,093,728	7,346,339	55.06	56.53
39,165,188	**41,755,851**	**2,590,663**	**61.78**	**65.87**	**Total Physician Services**	**324,586,784**	**332,663,967**	**8,077,183**	**65.05**	**66.66**
					Inpatient Hospital					
17,333,869	18,376,803	1,042,934	27.34	28.99	Hospital Capitation	136,536,706	140,304,262	3,767,556	27.36	28.12
55,542,197	64,953,420	9,411,223	87.62	102.47	Inpatient Hospital - FFS	448,199,393	477,041,281	28,841,888	89.82	95.60
850,000	1,903,461	1,053,461	1.34	3.00	Hospital Stoploss	(1,399,061)	14,987,004	16,386,065	(0.28)	3.00
73,726,066	**85,233,684**	**11,507,618**	**116.30**	**134.46**	**Total Inpatient Hospital**	**583,337,038**	**632,332,547**	**48,995,509**	**116.90**	**126.72**
32,312,715	28,853,169	(3,459,546)	50.97	45.52	Long Term Care	263,037,721	270,161,608	7,123,887	52.72	54.14
39	-	(39)	-	-	Pharmacy	183,588,912	178,908,641	(4,680,271)	36.79	35.86
					Ancillary Services					
968,133	1,004,818	36,685	1.53	1.59	Ancillary Services - Capitated	7,691,784	7,720,613	28,829	1.54	1.55
37,344,819	36,829,250	(515,569)	58.91	58.10	Ancillary Services - Non-Capitated	308,371,128	309,426,230	1,055,102	61.80	62.01
38,312,952	**37,834,068**	**(478,884)**	**60.44**	**59.69**	**Total Ancillary Services**	**316,062,912**	**317,146,843**	**1,083,931**	**63.34**	**63.56**
					Other Medical					
1,963,350	2,419,300	455,950	3.10	3.82	Quality Assurance	17,124,871	19,253,068	2,128,197	3.43	3.86
3,902,862	1,195,318	(2,707,544)	6.16	1.89	Healthcare Investment Funds	16,881,758	11,162,540	(5,719,218)	3.38	2.24
80,900	111,417	30,517	0.13	0.18	Advice Nurse	671,300	891,336	220,036	0.13	0.18
2,504	9,533	7,029	-	0.02	HIPP Payments	30,745	76,264	45,519	0.01	0.02
6,356,399	4,246,774	(2,109,625)	10.03	6.70	Transportation	47,751,564	33,824,140	(13,927,424)	9.57	6.78
12,306,015	**7,982,342**	**(4,323,673)**	**19.42**	**12.61**	**Total Other Medical**	**82,460,238**	**65,207,348**	**(17,252,890)**	**16.52**	**13.08**
6,923,220	6,923,220	-	10.92	10.92	Quality Improvement Programs	54,733,797	54,683,697	(50,100)	10.97	10.96
227,347,264	**229,415,023**	**2,067,759**	**358.64**	**361.93**	**TOTAL HEALTHCARE COSTS**	**1,998,719,666**	**2,024,881,323**	**26,161,657**	**400.55**	**405.81**
					ADMINISTRATIVE COSTS					
7,066,597	7,165,834	99,237	11.15	11.30	Employee	55,736,305	60,071,656	4,335,351	11.17	12.04
7,496	73,303	65,807	0.01	0.12	Travel And Meals	145,072	369,590	224,518	0.03	0.07
1,109,370	1,771,204	661,834	1.75	2.79	Occupancy	8,591,691	12,776,264	4,184,573	1.72	2.56
267,025	402,046	135,021	0.42	0.63	Operational	1,965,400	3,411,412	1,446,012	0.39	0.68
1,346,470	1,510,586	164,116	2.12	2.38	Professional Services	11,240,978	12,987,784	1,746,806	2.25	2.60
1,003,682	894,089	(109,593)	1.58	1.41	Computer And Data	7,337,538	6,749,611	(587,927)	1.47	1.35
10,800,640	**11,817,062**	**1,016,422**	**17.03**	**18.63**	**TOTAL ADMINISTRATIVE COSTS**	**85,016,984**	**96,366,317**	**11,349,333**	**17.03**	**19.30**
13,854,167	14,382,637	528,470	21.86	22.69	Medi-Cal Managed Care Tax	110,833,336	113,235,700	2,402,364	22.21	22.69
27,172,417	**2,990,752**	**24,181,665**	**42.88**	**4.71**	**TOTAL CURRENT YEAR SURPLUS (DEFICIT)**	**106,608,234**	**(6,250,040)**	**112,858,274**	**21.39**	**(1.24)**

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
NOTES TO FINANCIAL STATEMENTS
February 28, 2022

1. ORGANIZATION

The Partnership HealthPlan of California (PHC) was formed as a health insurance organization, and is legally a subdivision of the State of California, but is not part of any city, county or state government system. PHC has quasi-independent political jurisdiction to contract with the State for managing Medi-Cal beneficiaries who reside in various Northern California Counties. PHC is a combined public and private effort engaged principally in providing a more cost-effective method of healthcare. PHC began serving Medi-Cal eligible persons in Solano in May 1994. That was followed by Napa in March of 1998, Yolo in March of 2001, Sonoma in October 2009, Marin and Mendocino in July 2011, and eight Northern Counties in September 2013. Beginning July 2018 and in accordance with direction from the Department of Health Care Services (DHCS), PHC has consolidated its reporting from these fourteen counties into two regions; these are in alignment with the two DHCS rating regions.

As a public agency, the HealthPlan is exempt from state and federal income tax.

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

ACCOUNTING POLICIES:
The accounting and reporting policies of PHC conform to generally-accepted accounting principles and general practices within the healthcare industry.

PROPERTY AND EQUIPMENT:
Effective July 2015, property and equipment totaling $10,000 or more are recorded at cost; this includes assets acquired through capital leases and improvements that significantly add to the productive capacity or extend the useful life of the asset. Costs of maintenance and repairs are expensed as incurred. Depreciation for financial reporting purposes is provided on a straight-line method over the estimated useful life of the asset. The costs of major remodeling and improvements are capitalized as building or leasehold improvements. Leasehold improvements are amortized using the straight-line method over the shorter of the remaining term of the applicable lease or their estimated useful life. Building improvements are depreciated over their estimated useful life.

INVESTMENTS:
PHC investments can consist of U.S. Treasury Securities, Certificates of Deposits, Money Market and Mutual Funds, Government Pooled Funds, Agency Notes, Repurchase Agreements, Shares of Beneficial Interest and Commercial Paper and are carried at fair value.

BOARD-DESIGNATED & KNOX KEENE RESERVES:

In April 2004, PHC's Board established a policy to set aside in a reserve account a designated amount that represents the Knox-Keene Tangible Net Equity (TNE) requirement. This policy was subsequently revised and reflected on the balance sheet since July 2012. Based on this policy and as of February 2022, PHC has Board-Designated and Knox-Keene Reserves of $550.5 million and $0.3 million respectively. To account for the Board approved Strategic Use of Reserves (SUR) initiatives, which includes funding for the Wellness & Recovery program, $74.5 million has been set aside as a "Reserve Fund-Strategic Use of Reserve." The amount represents the net amount remaining of all of the SUR projects that have been approved to date; this balance is periodically adjusted as projects are completed.

3. STATE CAPITATION REVENUE

Medi-Cal capitation revenue is based on the monthly capitation rates, as provided for in the State contract, and the actual number of Medi-Cal eligible members. Capitation revenues are paid by the State on a monthly basis in arrears based on estimated membership. As such, capitation revenue includes an estimate for amounts receivable from or refundable to the State for projected changes in membership and trued up monthly through a State reconciliation process. These estimates are continually monitored and adjusted, as necessary, as experience develops or new information becomes known.

4. HEALTHCARE COST

PHC continues to develop completion factors to calculate estimated liability for claims incurred but not reported. These factors are reviewed and adjusted as more historical data become available. Budgeted capitation revenues and healthcare costs are adjusted each month to reflect changes in enrollee counts.

5. QUALITY IMPROVEMENT PROGRAM

PHC maintains quality incentive contracts with acute care hospitals and primary care physicians. As of February 2022, PHC has accrued a Quality Incentive Program payout of $94.0 million.

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
NOTES TO FINANCIAL STATEMENTS
February 28, 2022

6. **ESTIMATES**

Due to the nature of the operations of the Partnership HealthPlan, it is necessary to estimate amounts for financial statement presentation. Substantial overstatement or understatement of these estimates would have a significant impact on the statements. The items estimated through various methodologies are:

- Value of Claims Incurred But Not Received
- Quality Incentive Payouts
- Earned Capitation Revenues
- Total Number of Members
- Retro Capitation Expense for Certain Providers

7. **COMMITMENTS AND CONTINGENCIES**

In the ordinary course of business, the HealthPlan is party to claims and legal actions by enrollees, providers, and others. After consulting with legal counsel, HealthPlan management is of the opinion any liability that may ultimately be incurred as a result of claims or legal actions will not have a material effect on the financial position or results of the operations of the HealthPlan.

8. **UNUSUAL OR INFREQUENT ITEMS REPORTED IN CURRENT MONTH'S FINANCIAL STATEMENTS**

None noted.

Partnership HealthPlan of California
Investment Schedule
February 28, 2022

Name of Investment	Investment Type	Yield to Maturity	Trade Date	Maturity Date	Call Date	Face Value	Market Value	Credit Rating Agency	Credit Rating
FUNDS HELD FOR INVESTMENT:									
Highmark Money Market	Cash & Cash Equiv	NA	Various	NA	NA	NA	$ 1,533,293	NA	NR
Certificate of Deposit for Knox Keene	Cash & Cash Equiv	0.00015	NA	1/4/2022	NA	NA	$ 300,000	NA	NR
FUNDS HELD FOR OPERATIONS:									
Merrill Lynch Institutional	Cash for Operations	NA	NA	NA	NA	NA	$ 66,742,598		
Merrill Lynch MMA - Checking	Cash for Operations	NA	NA	NA	NA	NA	$ 163,292		
UB - General, MMA, and Sweeps	Cash for Operations	NA	NA	NA	NA	NA	$ 936,135,591		
Government Investment Pools (LAIF)	Cash for Operations	NA	NA	NA	NA	NA	$ 75,000,000		
Government Investment Pools (County)	Cash for Operations	NA	NA	NA	NA	NA	$ 40,542,674		
West America Payroll	Cash for Operations	NA	NA	NA	NA	NA	$ 1,918,585		
Petty Cash	Cash for Operations	NA	NA	NA	NA	NA	$ 3,300		
GRAND TOTAL:							$ 1,122,339,333		

Required Reserves (Liquid)		
Board Designated Assets	$	443,944,504
Knox Keene Reserves	$	300,000
Total Required Reserves (Liquid)	**$**	**444,244,504**
Cash on Hand / Cash Days Available:		
Including Required Reserves	$	1,122,149,918
Excluding Required Reserves	$	677,905,414
Cash Days Available incl. Required Reserves		**108.21**
Cash Days Available excl. Required Reserves		**65.37**

Partnership HealthPlan of California
Investment Yield Trends

FISCAL YEAR 21/22		JUL	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	YTD
Interest Income		69,194	34,507	35,073	48,030	35,292	32,599	43,164	43,000					340,859
Cash & Investments at Historical Cost	(1)	492,803,755	513,054,483	588,066,155	570,252,227	294,587,864	673,772,755	780,352,876	677,905,415					573,849,441
Computed Yield	(2)	0.17%	0.08%	0.08%	0.10%	0.10%	0.08%	0.07%	0.07%					
Total Rate of Return	(3)	0.17%	0.12%	0.10%	0.10%	0.11%	0.10%	0.09%	0.09%					
CA Pooled Money Investment Account (PMIA)	(4)	0.22%	0.22%	0.21%	0.20%	0.20%	0.21%	0.23%	0.28%					

FISCAL YEAR 20/21		JUL	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	YTD
Interest Income		101,518	79,393	129,142	85,682	69,555	60,493	95,805	55,872	54,937	85,764	51,531	41,924	911,616
Cash & Investments at Historical Cost	(1)	447,722,427	457,223,207	608,616,971	474,773,196	430,208,837	457,366,473	747,219,094	482,418,564	609,864,227	566,842,230	657,099,091	500,659,700	536,667,835
Computed Yield	(2)	0.27%	0.21%	0.29%	0.19%	0.18%	0.16%	0.19%	0.11%	0.12%	0.17%	0.10%	0.09%	
Total Rate of Return	(3)	0.27%	0.24%	0.25%	0.24%	0.23%	0.22%	0.21%	0.20%	0.19%	0.19%	0.18%	0.17%	
CA Pooled Money Investment Account (PMIA)	(4)	0.92%	0.78%	0.69%	0.62%	0.58%	0.54%	0.46%	0.41%	0.36%	0.34%	0.32%	0.26%	

NOTES:

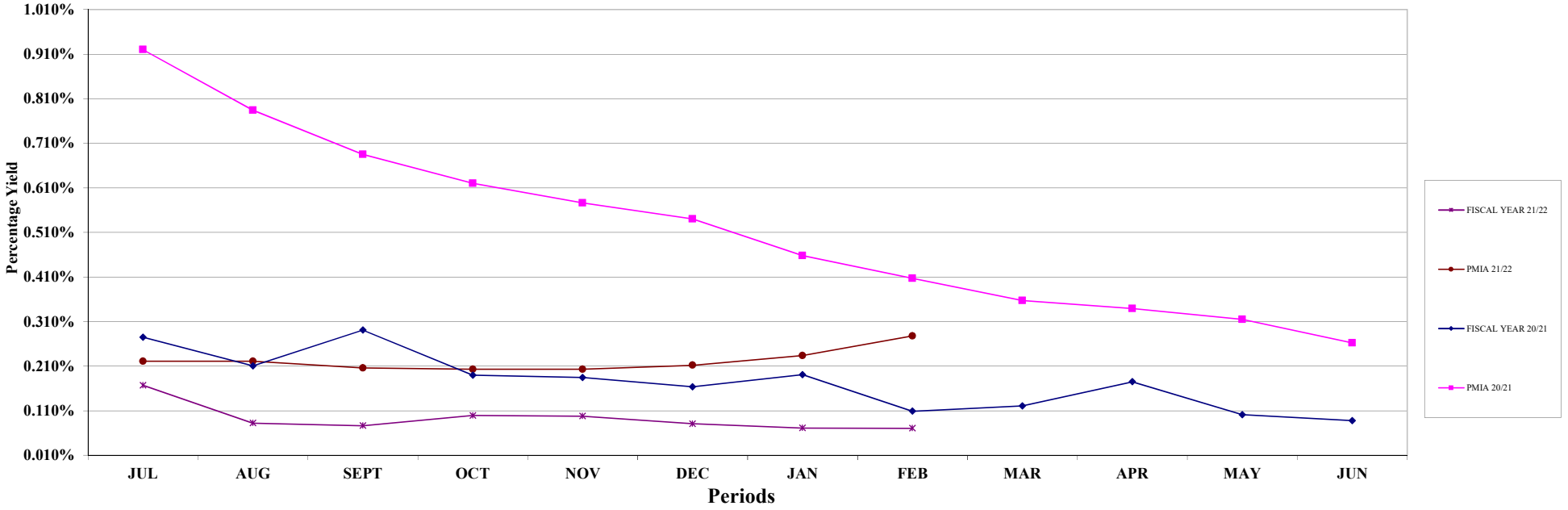
(1) Investment balances include Restricted Cash and Board Designated Reserves
YTD for Cash & Investments is average year-to-date

(2) Computed yield is calculated by annualizing the current month's interest divided by the current month's average balance.

(3) Total Rate of Return is computed based on year-to-date interest income annualized divided by an average of the fiscal year's portfolio's market value at month-end.

(4) LAIF limits the amount a single government entity can deposit into LAIF; currently that amount is set at $75 million.

Partnership HealthPlan of California
Investment Yield Trends



Operations Report

Sonja Bjork, Chief Operating Officer
April 27, 2022

System Disruption

In the initial period after the March 19 system disruption, PHC operations were at a standstill. Our very diligent and creative department leaders quickly regrouped and developed work around solutions in order to re-establish communications with staff, members and providers. This included outreach calls to many of our stakeholders to explain the situation and provide them with ways to contact us. In the ensuing days our teams adjusted these approaches as various systems were restored by our IT experts. We are very pleased that everything from our Call Center to our on-line services are now operational. The staff are busy addressing the backlog of claims and treatment authorization requests, as well as following up with members and provider inquiries. Our team has been through many emergency situations over the past several years, and we relied upon the tools that we have in place in order to communicate. This included communication thru a back-up system via text and personal email as well as daily calls with our community emergency response team. At this point, each department has their own recovery plan that will guide them as we get back on track with normal production and service, as well as our bigger picture plans. We thank our stakeholders for their patience and their support through these very difficult weeks.

Health Services

Care Coordination

The Care Coordination team has been working closely with our phase one ECM providers. As part of the benefit requirement, Care Coordination has been tracking ECM provider capacity. When a provider indicates they have the ability to serve more members, PHC sends over a list of potentially eligible members to them. ECM providers in five (5) of PHC's phase one counties have been conducting outreach & engagement activities for the ECM benefit, as well as submitting TARs and claims for ECM services. We continue to meet with potential providers to expand our network and we are planning for phase two of ECM which starts on July 1 in nine (9) other PHC counties: Del Norte, Humboldt, Trinity, Siskiyou, Lassen, Modoc, Lake, Solano and Yolo.

Population Health

Our team has continued to attend events in the community to meet with and engage our members. During the month of April, we have many health fairs and blood pressure screening events on our calendar.

In addition, Population Health leadership have been developing campaigns that will allow our Healthy Living Coaches to assist members with asthma and diabetes in better managing their condition using our Healthy Living Tools

Finally, we are utilizing the findings from our Population Needs Assessment to address health equity concern. Two examples include supporting Black/African American members in managing blood pressure and helping non-White, non-English speaking members report their grievances to PHC.

Utilization Management

The Utilization Management team continues to participate in joint operations meetings with many of our providers. These meetings provide our staff an opportunity to discuss length of stay/discharge planning issues with our hospital partners and pre-authorization and referrals with our outpatient providers. These meetings also allow our providers a better understand of PHC's processes and gives them a forum to discuss any barriers they are encountering.

Member Services

The 2021 CAHPS survey was launched on February 18, 2022, and is currently underway to measure the member's experience as it relates to their interactions with the health plan, providers and overall delivery system. From extensive cross functional department analysis, we've opted for a larger sample size to improve confidence in scoring along with helping ensure there are no measures that do not meet the minimum response requirement to be considered statistically valid (minimum 100 responses per question). We've over sampled by 150% for the adult survey and 100% for the child survey respectively. Our target response rate is 18%+ based on past several years of data ranging from 16-18% and hope to achieve this with phone follow up and offering a new method of completing their survey online via QR code provided in the paper survey.

Configuration

The configuration department has a unit devoted to Essette. This is the platform PHC uses for care coordination, population health, pharmacy and utilization management. Over the years, we have supported these depts. in customizing the program to meet our needs. We have established an Essette Oversight Committee that helps us discuss issues and determine priorities for configuring the system regarding our approach to adding modules. We are also preparing for a major upgrade to this software that will give

us an Appeal and Grievance Module including a separate Pharmacy Module (currently it is included in UM module). The upgrade will enhance the quality and improve the system to handle all of the different department needs.

We recently added aid code 76 to our coverage. Under the American Rescue Plan Act (ARPA), California's Department of Health Care Services opted to broaden the scope of coverage for currently eligible and newly eligible pregnant individual so they can receive the full breadth of medically necessary services during both the pregnancy and postpartum periods and has extended the postpartum period to provide and additional ten months of coverage following the current 60 day postpartum period, for a total of 12 months.

Northern Region

On Thursday, April 21, in collaboration with the T Abraham and Meghan Hardin, from the Hospital Council, the NE Region co-hosted the Independent Rural Hospitals Forum. CEOs and other Administrative leaders from independent rural hospitals met with PHC executive leaders to discuss current issues and challenges that are unique to these facilities. One of the primary concerns for these smaller hospitals, like most providers in California remains the lack of workforce.

In an effort to support improvement in this area our Workforce Development Team, is continuing to work on multiple approaches:

We have launched a scholarship for current and former members who have apply and are ultimately accepted in the upcoming Sacramento Community College, CHW (Community Health Worker) training program. Applicants may be eligible for up to a $1,000 scholarship to be applied to tuition and direct educational expenses (e.g. application fees and books).

SCC's program and CHW scholarship are accepting applications until April 30, 2022. Additional details on the opportunities can be found here: https://scc.losrios.edu/academics/community-health-care-worker-program-details/chw-training-program-scholarship

In addition, our Provider Recruitment Program was successful in supporting 103 accepted offers for 46 physicians (MD/DO), 51 Advanced Practice Providers (NP/PA), and six (6) behavioral health licensed professionals, during the last 15 months ending March 1, 2022.

PHC Press Releases: **None to Report**

PHC Mentioned:

Partnership HealthPlan of California systems down, rumors of hacking afloat
Napa Valley Register
April 8, 2022
Partnership HealthPlan of California — which serves 14 counties worth of Medi-Cal users — has shut down its network operations following concerns over hacking activity.

Hacking group claims responsibility for ransomware attack on Northern California health care network
The Press Democrat
March 30, 2022
A ransomware group called Hive is claiming to have stolen private data for 850,000 members of Partnership HealthPlan of California, a nonprofit that manages health care for Medi-Cal patients in 14 counties.

Medi-Cal healthplan website and computer systems down
The Press Democrat
March 24, 2022
Partnership HealthPlan of California, a nonprofit health care organization that serves more than 618,000 Medi-Cal members in 14 Northern California counties, is experiencing “technical difficulties, resulting in a disruption to certain computer systems,” according to its website, which is currently down.

Medical professionals urge county to contract
Record Bee
February 21, 2022
Counties in California are now required to adopt the 1115 waiver, which expands alcohol/drug treatment services to anyone on Medi-Cal.

Legislative Tracking - 2022

Fed / State	Tier	Origin	Bill No.	Author(s) / Sponsor(s)	Summary	Last Date	House Location / Last Action	PHC Position
State	**1**	**AB**	4	Arambula, Bonta, Chiu, Gipson, Lorena Gonzalez, Reyes, and Santiago	**Medi-Cal: elibility** Effective January 1, 2022, this bill would instead extend eligibility for full scope Medi-Cal benefits to anyone regardless of age, and who is otherwise eligible for those benefits but for their immigration status.	8/26/2021	Senate-In Committee Process-Appropriations	LHPC - Support
State	**1**	**AB**	14	Aguiar-Curry, Bloom, Bonta, Cristina Garcia, Eduardo Garcia, Low, Petrie-Norris, Quirk, Quirk-Silva, Reyes, Robert Rivas, Santiago, Stone, and Weber	**Communications: broadband services: California Advanced Services Fund.** Eliminates the sunset of the California Advanced Services Fund (CASF), authorizes the collection of an unspecified surcharge on intrastate telecommunications service costs to continue grants, and makes various modifications to the program including redefining unserved households and prioritizing grant disbursements	10/8/2021	Approved by the Governor	
State	**1**	**AB**	32	Aguiar-Curry	**Telehealth.** Expands coverage of telehealth to require health plans and health insurers to cover audio only (telephone), and to reimburse for services delivered using telephone at the same payment rate as in-person visits. Continues some telehealth payment and enrollment flexibilities put in place by the Department of Health Care Services (DHCS) for the Medi-Cal program during the COVID19 pandemic.	7/8/2021	Senate-In Committee Process-Health	LHPC - Watch
State	**1**	**AB**	34	Muratsuchi, Eduardo Garcia, and Santiago	**Communications: Broadband for All Act of 2022.** Broadband for All Act of 2022 (the Act), requires voters be asked to authorize the issuance of $10 billion in general obligation bonds to fund the 2022 Broadband for All Program (the Program).	5/20/2021	Died pursuant to Art. IV, Sec. 10(a) of the Constitution.	
State	**1**	**AB**	41	Wood	**Broadband infrastructure.** Directs the California Broadband Council to define and identify priority areas for broadband deployment within the state, based on specified criteria, and to develop a notification system to coordinate conduit deployment between the California Department of Transportation (Caltrans), the California Public Utilities Commission (CPUC) and internet service providers (ISPs).	10/8/2021	Approved by the Governor	
State	**2**	**AB**	77	Petrie-Norris	**Substance use disorder treatment services.** This bill would declare the intent of the Legislature to enact Jarrod's Law, a licensure program for inpatient and outpatient programs providing substance use disorder treatment services, under the administration of the department.	3/26/2021	Died pursuant to Art. IV, Sec. 10(a) of the Constitution.	

Legislative Tracking - 2022

Fed / State	Tier	Origin	Bill No.	Author(s) / Sponsor(s)	Summary	Last Date	House Location / Last Action	PHC Position
State	**2**	**AB**	93	Garcia and Rivas	**Pandemic response practices.** This bill would require the Legislative Analyst's Office to conduct a comprehensive review and analysis of issues related to the state's response to the COVID-19 pandemic, including, among others, whether local public health departments were sufficiently staffed and funded to handle specified pandemic-related responsibilities, and what specific measures of accountability the state applied to monitor and confirm that local public health departments were following state directives related to any dedicated COVID-19 funds allocated to counties. The bill would require the office to report to the Joint Legislative Audit Committee and the health committees of the Legislature by June 30, 2022.	3/26/2021	Died pursuant to Art. IV, Sec. 10(a) of the Constitution.	
State	**2**	**AB**	95	Low	**Employees: bereavement leave.** This bill requires an employer, including any public sector employer, to provide up to 10 business days of unpaid bereavement leave upon the death of a spouse, child, parent, parent-inlaw, sibling, grandparent, grandchild or domestic partner.	5/20/2021	Died pursuant to Art. IV, Sec. 10(a) of the Constitution.	
State	**2**	**AB**	97	Nazaran	**Health care coverage: insulin affordability.** This bill would prohibit a health care service plan contract or a health disability insurance policy, as specified, issued, amended, delivered, or renewed on or after January 1, 2022, from imposing a deductible on an insulin prescription drug.	8/26/2021	Senate-In Committee Process-Appropriations	
State	**2**	**AB**	98	Frazier	**Health care: medical goods: reuse and redistribution.** This bill would require the department, upon appropriation by the Legislature, to establish a comprehensive 3-year pilot program in the Counties of Contra Costa, Napa, and Solano to facilitate the reuse and redistribution of durable medical equipment and other home health supplies.	6/29/2021	Senate-In Committee Process-Human Services	
State	**1**	**AB**	112	Holden	**Medi-Cal eligibility.** This bill extends, from one year to three years, the duration during which Medi-Cal benefits are suspended when an adult becomes an inmate of a public institution.	5/20/2021	Died pursuant to Art. IV, Sec. 10(a) of the Constitution.	
State	**2**	**AB**	114	Maienschein	**Medi-Cal benefits: rapid Whole Genome Sequencing.** Requires Rapid Whole Genome Sequencing (RWGS), including individual sequencing, trio sequencing for a parent or parents and their baby, and ultra-rapid sequencing, to be a Medi-Cal covered benefit for any Medi-Cal beneficiary who is one year of age or younger and is receiving inpatient hospital services in an intensive care unit (ICU).	7/13/2021	Senate-In Committee Process-Appropriations	

Legislative Tracking - 2022

Fed / State	Tier	Origin	Bill No.	Author(s) / Sponsor(s)	Summary	Last Date	House Location / Last Action	PHC Position
State		**AB**	240	Rodriguez	**Local health department workforce assessment.** This bill would require the department to contract with an appropriate and qualified entity to conduct an evaluation of the adequacy of the local health department infrastructure and to make recommendations for future staffing, workforce needs, and resources, in order to accurately and adequately fund local public health. The bill would exempt the department from specific provisions relating to public contracting with regard to this requirement.	8/26/2021	Senate-In Committee Process-Appropriations	
State	**1**	**AB**	265	Petrie-Norris	**Medi-Cal: reimbursement rates.** This bill removes a restriction that caps laboratory rates in the fee-for-service Medi-Cal program at 80% of the rate the federal Medicare program pays	5/20/2021	Died pursuant to Art. IV, Sec. 10(a) of the Constitution.	
State	**2**	**AB**	278	Flora	**Medi-Cal: podiatric services.** This bill extends to doctors of podiatric medicine (DPM) a number of Medi-Cal provider enrollment provisions that current apply to physicians, including shortening the approval timeline for provider enrollment in Medi-Cal from 180 days to 90 days	5/20/2021	Died pursuant to Art. IV, Sec. 10(a) of the Constitution.	
State	**1**	**AB**	309	Gabriel and O'Donnell	**Pupil mental health: model referral protocols.** This bill requires, contingent on appropriation, the California Department of Education (CDE) to develop model mental health referral protocols, in consultation with various entities, and post the protocols on its website. The bill requires CDE to consult with various entities in developing the protocols. The protocols are for voluntary use by local educational agencies.	10/8/2021	Approved by the Governor	
State	**1**	**AB**	347	Arambula	**Health care coverage: step therapy.** This bill would clarify that a health care service plan that provides coverage for prescription drugs may require step therapy, as defined, if there is more than one drug that is appropriate for the treatment of a medical condition.	10/9/2021	Approved by the Governor	
State	**1**	**AB**	361	Rivas	**Open meetings: local agencies: teleconferences.** This bill would authorize a local agency to use teleconferencing without complying with the teleconferencing requirements imposed by the Ralph M. Brown Act when a legislative body of a local agency holds a meeting for the purpose of declaring or ratifying a local emergency, during a declared state of emergency or local emergency, as those terms are defined, when state or local health officials have imposed or recommended measures to promote social distancing, and during a declared local emergency provided the legislative body makes certain determinations by majority vote.	10/8/2021	Approved by the Governor	

Legislative Tracking - 2022

Fed / State	Tier	Origin	Bill No.	Author(s) / Sponsor(s)	Summary	Last Date	House Location / Last Action	PHC Position
State	**1**	**AB**	367	Cristina Garcia	**Menstrual products.** This bill would enact the Menstrual Equity for All Act of 2021, which would require a public school, as provided, maintaining any combination of classes from grades 6 to 12, inclusive, to stock the school's restrooms with an adequate supply of free menstrual products, as defined, available and accessible, free of cost, in all women's restrooms and all-gender restrooms, and in at least one men's restroom, at all times, and to post a designated notice, on or before the start of the 2022–23 school year, as prescribed.	10/8/2021	Approved by the Governor	
State	**1**	**AB**	368	Bonta	**Medically supportive food.** This bill would require the department to establish, no earlier than January 1, 2022, a pilot program for a 2-year period in 3 counties, including the County of Alameda, to provide food prescriptions for medically supportive food, such as healthy food vouchers or renewable food prescriptions, to eligible Medi-Cal beneficiaries, including individuals who have a specified chronic health condition, such as diabetes and hypertension, when utilizing	5/20/2021	Died pursuant to Art. IV, Sec. 10(a) of the Constitution.	
State	**1**	**AB**	369	Kamlager	**Medi-Cal: street medicine and utilization controls.** Requires the Department of Health Care Services (DHCS) to implement a Medi-Cal presumptive eligibility (PE) enrollment process for persons experiencing homelessness (PEH).	10/8/2021	Vetoed by Governor	
State	**2**	**AB**	382	Kamlager	Extends the sunset date of the statewide California Children's Services (CCS) Whole Child Model (WCM) program stakeholder advisory group by an additional two years, from December 31, 2021 to December 31, 2023, and removes "labor organizations" from the CCS WCM stakeholder advisory group, and would instead include "recognized exclusive representatives of CCS county providers" on the WCM advisory group.	7/9/2021	Secretary of State-Chaptered	
State	**2**	**AB**	383	Salas	**Mental health: older adults.** Creates an Older Adult Mental Health Services Administrator (Administrator) within the Department of Health Care Services (DHCS) who is required to oversee mental health services for older adults.	8/26/2021	Senate-In Committee Process-Appropriations	
State	**2**	**AB**	457	Santiago	**Protection of Patient Choice in Telehealth Provider Act.** Establishes the Protection of Patient Choice in Telehealth Provider Act, which requires a health care service plan (health plan) and a health insurer to arrange for the provision of a service via telehealth to an enrollee or an insured through a third-party corporate telehealth provider, only if specified notice conditions are met and the enrollee or insured, once notified as specified, elects to receive the service via telehealth through a third-party corporate telehealth provider.	10/1/2021	Secretary of State-Chaptered	
State	**1**	**AB**	470	Carillo	**Medi-Cal: eligibility.** Repeals the Medi-Cal "asset test" by prohibiting resources including property or other assets from being used to determine eligibility under the Medi-Cal program, to the extent permitted by federal law	8/26/2021	Assembly-In Committee Process-Appropriations	LHPC - Support

Legislative Tracking - 2022

Fed / State	Tier	Origin	Bill No.	Author(s) / Sponsor(s)	Summary	Last Date	House Location / Last Action	PHC Position
State	**2**	**AB**	521	Mathis	**Medi-Cal: unrecovered payments: interest rate.** This bill authorizes the director of the Department of Health Care Services (DHCS) to waive, for up to 12 months, any or all interest and penalties assessed resulting from an audit or examination for overpayments	5/20/2021	Died pursuant to Art. IV, Sec. 10(a) of the Constitution.	
State	**2**	**AB**	523	Nazaran	**Program of All-Inclusive Care for the Elderly.** This bill would require the department to make permanent the specified PACE program flexibilities instituted, on or before January 1, 2021, in response to the state of emergency caused by COVID-19 by means of all-facility letters or other similar instructions taken without regulatory action.	10/6/2021	Vetoed by Governor	
State	**1**	**AB**	540	Petrie-Norris	**Program of All-Inclusive Care for the Elderly.** This bill would exempt a beneficiary who is enrolled in a PACE organization with a contract with the department from mandatory or passive enrollment in a Medi-Cal managed care plan.	8/26/2021	Senate: Appropriations	LHPC - Concerns
State	**1**	**AB**	552	Quirk-Silva	**Integrated School-Based Behavioral Health Partnership Program.** This bill would establish the Integrated School-Based Behavioral Health Partnership Program to provide prevention and early intervention for, and access to, behavioral health services for pupils.	4/6/2021	Read third time. Passed. Ordered to the Senate.	
State	**1**	**AB**	563	Berman	**School-based health programs.** Requires the California Department of Education (CDE) to establish an Office of School-Based Health Programs for the purpose of improving the operation of, and participation in, schoolbased health programs, including the Medi-Cal Administrative Activities claiming process (SMAA) and the Local Education Agency Medi-Cal billing option program (LEA BOP). Requires that $500,000 in federal reimbursements be made available for transfer through an interagency agreement to CDE for the support of the Office.	6/9/2021	Senate: Education and Health	
State	**1**	**AB**	586	O'Donnell and Wood	**Pupil health: health and mental health services: School Health Demonstration Project.** TEstablishes, subject to an appropriation for this purpose, the School Health Demonstration Project to provide intensive technical assistance to selected local educational agencies (LEAs) to enable the long-term sustainable provision of health and mental health services to pupils.	6/23/2021	Senate: Education	
State	**2**	**AB**	601	Fong	**Medi-Cal: reimbursement.** This bill would make a technical, nonsubstantive change to these provisions.	2/12/2021	Assembly - Pending referral	

Legislative Tracking - 2022

Fed / State	Tier	Origin	Bill No.	Author(s) / Sponsor(s)	Summary	Last Date	House Location / Last Action	PHC Position
State	**2**	**AB**	644	Waldrom	**California MAT Re-Entry Incentive Program.** This bill requires a person to participate in a post-release substance abuse program, rather than an institutional substance abuse program, to be eligible for a 30-day reduction in the period of parole for every six months of treatment that is not ordered by the court	7/9/2021	Chaptered	
State	**1**	**AB**	650	Muratsuchi	**Employer-provided benefits: health care workers: COVID-19: hazard pay retention bonuses.** This bill, the Health Care Workers Recognition and Retention Act, would require a covered employer, as defined, to pay hazard pay retention bonuses in the prescribed amounts on January 1, 2022, April 1, 2022, July 1, 2022, and October 1, 2022, to each covered health care worker, as defined, that it employs.	6/3/2021	Assembly Floor: Inactive File	LHPC - Watch
State	**2**	**AB**	671	Wood	**Medi-Cal: pharmacy benefits.** Requires the Department of Health Care Services (DHCS) to provide a disease management or similar payment to a pharmacy for specified costs and activities that are associated with dispensing specialty drugs in an amount necessary to ensure beneficiary access, as determined by DHCS based on the results of a DHCS-contracted survey completed during the 2020 calendar year	5/27/2021	Assembly: Inactive	
State	**1**	**AB**	685	Maienschein	**Health care service plans: reimbursement.** This bill would require health service plans and insurers to obtain an independent board-certified emergency physician review of the medical decisionmaking related to a service before denying benefits, reimbursing for a lesser procedure, reducing reimbursement based on the absence of a medical emergency, or making a determination that medical necessity was not present for claims billed by a licensed physician and surgeon for emergency medical services, as specified.	3/15/2021	Died pursuant to Art. IV, Sec. 10(a) of the Constitution.	
State	**1**	**AB**	703	Rubio	**Open meetings: local agencies: teleconferences.** This bill would remove the requirements of the act particular to teleconferencing and allow for teleconferencing subject to existing provisions regarding the posting of notice of an agenda and the ability of the public to observe the meeting and provide public comment.	5/3/2021	Died pursuant to Art. IV, Sec. 10(a) of the Constitution.	
State	**2**	**AB**	797	Wicks and Low	**Health care coverage: treatment for infertility.** This bill would require every health care service plan contract or health insurance policy that is issued, amended, or renewed on or after January 1, 2022, to provide coverage for the treatment of infertility.	3/11/2021	Died pursuant to Art. IV, Sec. 10(a) of the Constitution.	
State	**1**	**AB**	822	Rodriguez	**Medi-Cal: psychiatric emergency medical conditions.** This bill requires Medi-Cal coverage for "observation services for a psychiatric emergency medical condition," in an emergency department or in an onsite or offsite observation unit, and describes billing, payment responsibility and dispute resolution for payment between county mental health plans and Medi-Cal managed care plans.	5/20/2021	Died pursuant to Art. IV, Sec. 10(a) of the Constitution.	LHPC - Oppose unless Amended

Legislative Tracking - 2022

Fed / State	Tier	Origin	Bill No.	Author(s) / Sponsor(s)	Summary	Last Date	House Location / Last Action	PHC Position
State	**2**	**AB**	848	Calderon	**Medi-Cal: monthly maintenance amount: personal and incidental needs.** This bill increases the personal needs allowance (PNA) amount from $35 to $80 per month for a Medi-Cal-eligible individuals who lives in a medical institution or nursing facility, or receives services from a Program of All-Inclusive Care for the Elderly	5/20/2021	Died pursuant to Art. IV, Sec. 10(a) of the Constitution.	
State	**2**	**AB**	852	Wood	**Nurse practitioners: scope of practice: practice without standardized procedures.** Adds the new category of nurse practitioners (NPs) who are authorized to practice independently starting January 1, 2023, to provisions of law that include physician and surgeons and other relevant health care licensees, corrects a drafting error related to the conditions when an independent NP must refer to a physician and surgeon, adds the new independent NPs to pharmacy definitions for prescribers, and makes other technical and clarifying changes.	4/18/2022	"From committee chair, with author's amendments: Amend, and re-refer to committee. Read second time, amended, and re-referred to Com. on B., P. and E.D."	
State	**1**	**AB**	862	Chen	**Medi-Cal: emergency medical transportation services.** The bill would provide that during the entirety of any Medi-Cal managed care rating period for which the program is implemented an eligible provider shall not be an emergency medical transport provider, as defined, who is subject to a quality assurance fee or eligible for the add-on increase, and would provide that the program's provisions do not affect the application of the specified add-on to any payment to a nonpublic emergency medical transport provider.	2/25/2021	Died pursuant to Art. IV, Sec. 10(a) of the Constitution.	
State	**2**	**AB**	875	Wood	**Medi-Cal: demonstration project.** This bill implements several components of the California Advancing and Innovating Medi-Cal (CalAIM) initiative proposed by Department of Health Care Services (DHCS).	5/20/2021	Died pursuant to Art. IV, Sec. 10(a) of the Constitution.	
State	**2**	**AB**	882	Gray and Salas	**Proposition 56 Medi-Cal Physicians and Dentists Loan Repayment Act Program.** This bill changes eligibility criteria for loan repayment assistance under the Proposition 56 MediCal Physicians and Dentists Loan Repayment Act Program (Loan Repayment Program), specifies the program is funded subject to an appropriation in the annual budget act and repeals the program's January 1, 2026, sunset date	5/20/2021	Died pursuant to Art. IV, Sec. 10(a) of the Constitution.	LHPC - Oppose unless Amended
State	**1**	**AB**	935	Maienschein	**Telehealth: mental health.** Establishes the Mothers and Children Mental Health Support Act of 2021 which requires health care service plans (health plans) and health insurers, by July 1, 2022, to provide access to a telehealth consultation program that meets specified criteria and gives providers who treat children and pregnant and certain postpartum persons with access to a mental health consultation program, as specified.	4/28/2021	Died pursuant to Art. IV, Sec. 10(a) of the Constitution.	LHPC - Oppose unless Amended
State	**1**	**AB**	1011	Waldron	**Health care coverage: substance use disorders.** This bill would require health care service plan contracts and health insurance policies issued, amended, or renewed on or after January 1, 2022, that provide outpatient prescription drug benefits to cover all medically necessary prescription drugs approved by the United States Food and Drug Administration (FDA) for treating substance use disorders that are appropriate for the specific needs of an enrollee or insured, and would require those drugs to be placed on the lowest cost-sharing tier of the plan or insurer's prescription drug formulary, unless specified criteria are met	4/13/2021	Died pursuant to Art. IV, Sec. 10(a) of the Constitution.	

Legislative Tracking - 2022

Fed / State	Tier	Origin	Bill No.	Author(s) / Sponsor(s)	Summary	Last Date	House Location / Last Action	PHC Position
State		**AB**	1015	Blanca Rubio	**Board of Registered Nursing: workforce planning: nursing programs: clinical placements.** This bill would require the board to incorporate regional forecasts into its biennial analyses of the nursing workforce. The bill would require the board to develop a plan to address regional areas of shortage identified by its nursing workforce forecast and identify in the plan additional facilities that could offer clinical placement slots.	10/6/2021	Chaptered by Secretary of State - Chapter 591, Statutes of 2021	
State	**2**	**AB**	1050	Gray	**Medi-Cal: application for enrollment: prescription drugs.** This bill prohibits the Department of Health Care Services from taking any action that materially increases the administrative burden or cost of dispensing 340B drugs by federally qualified health centers (FQHCs) and rural health clinics (RHCs), including, but not limited to, changes that adversely impact the use of contract pharmacy arrangements.	5/20/2021	Died pursuant to Art. IV, Sec. 10(a) of the Constitution.	LHPC - Watch
State	**1**	**AB**	1051	Bennett	**Medi-Cal: specialty mental health services: foster youth.** Excludes foster youth or probation-supervised youth who are placed in a community treatment facility, group home, or Short-Term Residential Therapeutic Program (STRTP) outside their county of original jurisdiction, from the requirements of presumptive transfer of specialty mental health services (SMHS)	9/1/2021	Senate: Appropriations	
State	**2**	**AB**	1130	Wood	**California Health Care Quality and Affordability Act.** Establishes the Office of Health Care Affordability (office) within the Office of Statewide Health Planning and Development (OSHPD) and requires the office to analyze the health care market for cost trends and drivers of spending, create a state strategy for controlling the cost of health care and ensuring affordability for consumers and purchasers, and enforce cost targets.	6/16/2021	From committee chair, with author's amendments: Amend, and re-refer to committee. Read second time, amended, and re-referred to Com. on HEALTH.	
State	**1**	**AB**	1131	Wood	**Health information exchange.** This bill would require, by January 1, 2023, health plans, hospitals, medical groups, testing laboratories, and nursing facilities, at a minimum, contribute to, access, exchange, and make available data through the network of health information exchanges for every person, as a condition of participation in a state health program, including Medi-Cal, Covered California,	5/20/2021	Died pursuant to Art. IV, Sec. 10(a) of the Constitution.	
State	**2**	**AB**	1132	Wood	**Health Care Consolidation and Contracting Fairness Act of 2021.** CalAIM: This bill implements several components of the California Advancing and Innovating Medi-Cal (CalAIM) initiative proposed by Department of Health Care Services (DHCS). S	6/16/2021	Senate: Health and Public Safety	
State	**1**	**AB**	1158	Petrie-Norris	**Alcoholism or drug abuse recovery or treatment facilities: recovery residence: insurance coverage.** This bill would require a licensee operating an alcoholism or drug abuse recovery or treatment facility to maintain specified insurance coverages, including, among others, commercial general liability insurance and employer's liability insurance.	10/1/2021	Senate: Appropriations	

Legislative Tracking - 2022

Fed / State	Tier	Origin	Bill No.	Author(s) / Sponsor(s)	Summary	Last Date	House Location / Last Action	PHC Position
State	**1**	**AB**	1160	Blanca Rubio	**Medically supportive food.** Effective for contract periods commencing on or after January 1, 2022, this bill would authorize Medi-Cal managed care plans to provide medically tailored meals to enrollees.	3/4/2021	Died pursuant to Art. IV, Sec. 10(a) of the Constitution.	
State	**1**	**AB**	1178	Irwin	**Medi-Cal: serious mental illness: drugs.** This bill would delete the prior authorization requirement for any drug prescribed for the treatment of a serious mental illness, as defined, for a period of 365 days after the initial prescription has been dispensed for a person over 18 years of age who is not under the transition jurisdiction of the juvenile court.	5/20/2021	Died pursuant to Art. IV, Sec. 10(a) of the Constitution.	
State	**1**	**AB**	1355	Levine	**Medi-Cal: Independent Medical Review System.** This bill would require the department to establish the Independent Medical Review System (IMRS) for the Medi-Cal program, commencing on January 1, 2022, which generally models the above-described requirements of the Knox-Keene Health Care Service Plan Act.	1/3/2022	Read third time. Passed. Ordered to the Senate.	
State	**1**	**AB**	1430	Arambula	**Pharmacy: dispensing: controlled substances.** This bill, with certain exceptions, on and after June 30, 2022, would require a pharmacist who dispenses in solid oral dosage form a controlled substance in Schedule II or Schedule IIN of the federal Controlled Substances Act to dispense it in a lockable vial, as defined, provide a specified opioid factsheet, and, if the lockable vial uses an alphanumeric passcode or other code, include the code in any patient notes in the database or other system used by the pharmacy in the dispensing of prescription drugs.	5/20/2021	Died pursuant to Art. IV, Sec. 10(a) of the Constitution.	
State	**1**	**AB**	1900	Arambula	**Medi-Cal: income level for maintenance**. Under current law, certain medically needy persons with higher incomes qualify for Medi-Cal with a share of cost, if they meet specified criteria. Under existing law, the share of cost for those persons is generally the total after deducting an amount for maintenance from the person's monthly income. Existing law requires the department to establish income levels for maintenance at the lowest levels that reasonably permit a medically needy person to meet their basic needs for food, clothing, and shelter, and for which federal financial participation will still be provided under applicable	4/2/20223	Set FOR Hearing ON 06-APR-22 9 a.m.	
State	**1**	**AB**	1929	Arambula	**Medi-Cal: violence preventive services**. Would require the tate Department of Health Care Services to establish, no later than January 1, 2024, a violence intervention pilot program at a minimum of 9 sites, including at least one site in 9 specified counties, and would require the department to consult with identified stakeholders, such as professionals in the community violence intervention field, for purposes of establishing the pilot program.	3/16/2022	Re-referred to Com. on HEALTH."	

Legislative Tracking - 2022

Fed / State	Tier	Origin	Bill No.	Author(s) / Sponsor(s)	Summary	Last Date	House Location / Last Action	PHC Position
State	**1**	**AB**	1930	Arambula	**Medi-Cal: comprehensive perinatal services.** Under current law, a pregnant individual or targeted low-income child who is eligible for, and is receiving, health care coverage under any of specified Medi-Cal programs is eligible for full-scope Medi-Cal benefits for the duration of the pregnancy and for a period of one year following the last day of the individual's pregnancy. This bill, during the one-year postpregnancy eligibility period, and as part of comprehensive perinatal services under Medi-Cal, would require the department to cover additional comprehensive perinatal assessments and individualized care plans and to	4/2/2022	Set FOR Hearing ON 26-APR-22 1:30 p.m.	
State	**1**	**AB**	1937	Patterson	**Medi-Cal: out-of-pocket pregnancy costs.** Would require the State Department of Health Care Services, on or before January 1, 2024, to establish a health expense account program for pregnant Medi-Cal beneficiaries and pregnant subscribers of the Medi-Cal Access Program. The bill would make a Medi-Cal beneficiary who is pregnant or a pregnant subscriber of the Medi-Cal Access Program eligible for reimbursement for "out-of-pocket pregnancy related costs," as defined, in an amount not to exceed $1,000. The bill would require the person to submit the request for reimbursement within 3 months of the end of the	3/17/2022	"Re-referred to Com. on HEALTH."	
State	**1**	**AB**	1944	Lee & Garcia	**Local government: open and public meetings.** Current law, the Ralph M. Brown Act, requires, with specified exceptions, that all meetings of a legislative body of a local agency, as those terms are defined, be open and public and that all persons be permitted to attend and participate. Current law, until January 1, 2024, authorizes a local agency to use teleconferencing without complying with those specified teleconferencing requirements in specified circumstances when a declared state of emergency is in effect, or in other situations related to public health. This bill would specify that if a member of a legislative body elects to	4/19/2022	"Re-referred to Com. on L. GOV."	
State	**1**	**AB**	1993	Wicks, Aguiar-Curry, Low, and Akilah Weber	**Employment: COVID-19 vaccination requirements.** Would require an employer to require each person who is an employee or independent contractor, and who is eligible to receive the COVID-19 vaccine, to show proof to the employer, or an authorized agent thereof, that the person has been vaccinated against COVID-19. This bill would establish an exception from this vaccination requirement for a person who is ineligible to receive a COVID-19 vaccine due to a medical condition or disability or because of a sincerely held religious belief, as specified, and would	3/17/2022	"Referred to Coms. on L. and E. and JUD."	
State	**1**	**AB**	2123	Villapudua	**Bringing Health Care into Communities Act of 2023.** Current law also establishes various programs to facilitate the expansion of the health care workforce in rural and underserved communities, including, but not limited to, the Health Professions Career Opportunity Program and the California Registered Nurse Education Program. This bill, the Bringing Health Care into Communities Act of 2023, would establish the Bringing Health Care into Communities Program to be administered by the agency to provide housing grants to specified health	4/21/2022	"Re-referred to Com. on H. and C.D."	
State	**1**	**AB**	2402	Rubio	**Medi-Cal: continuous eligibility.** Current law requires the State Department of Health Care Services, to the extent federal financial participation is available, to exercise a federal option to extend continuous eligibility for the Medi-Cal program to children 19 years of age and younger until the earlier of either the end of a 12-month period following the eligibility determination or the date the child exceeds 19 years of age. Under this bill, a child under 5 years of age would be continuously eligible for Medi-Cal, including without regard to income and	3/30/2022	"From committee: Do pass and re-refer to Com. on APPR. (Ayes 12. Noes 0.) (March 29). Re-referred to Com. on APPR."	

Legislative Tracking - 2022

Fed / State	Tier	Origin	Bill No.	Author(s) / Sponsor(s)	Summary	Last Date	House Location / Last Action	PHC Position
State	**1**	**AB**	2449	Rubio	**Open meetings: local agencies: teleconferences**. Current law, until January 1, 2024, authorizes a local agency to use teleconferencing without complying with specified teleconferencing requirements in specified circumstances when a declared state of emergency is in effect, or in other situations related to public health. This bill would authorize a local agency to use teleconferencing without complying with those specified teleconferencing requirements if at least a quorum of the members of the legislative body participates in person from a	4/19/2022	Set FOR Hearing ON 04-MAY-22 9:30 a.m.	
State	**1**	**AB**	2458	Weber	**California Children's Services: reimbursement rates.** Would make legislative findings relating to the need for an increase in the reimbursement rates for physician services provided under the California Children's Services (CCS) Program. Under the bill, subject to an appropriation, and commencing January 1, 2023, those reimbursement rates would be increased by adding at least 25% to the above-described augmentation percentage relative to the applicable Medi-Cal rates. The bill would make the rate increase applicable only if the services are	4/2/2022	Set FOR Hearing ON 06-APR-22 9 a.m.	
State	**1**	**AB**	2581	Salas	**Health care service plans: mental health and substance use disorders: provider credentials.** Current law requires a health care service plan contract issued, amended, or renewed on or after January 1, 2021, that provides hospital, medical, or surgical coverage to provide coverage for medically necessary treatment of mental health and substance use disorders, under the same terms and conditions applied to other medical conditions, as specified.	4/19/2022	"Re-referred to Com. on HEALTH."	
State	**1**	**AB**	2659	Patterson	**Medi-Cal managed care: midwifery services.**Would require a Medi-Cal managed care plan to have within its provider network at least one licensed midwife (LM) or certified-nurse midwife (CNM) within each county where the Medi-Cal managed care plan provides services to Medi-Cal beneficiaries. The bill would exempt a Medi-Cal managed care plan from that requirement for purposes of a given county if no LM or CNM is available in that county or if no LM or CNM in that county accepts Medi-Cal payments.	3/10/2022	Referred to Com. on HEALTH	
State	**1**	**AB**	2680	Arumbula	**Medi-Cal: Community Health Navigator Program.** Would require the department to create the Community Health Navigator Program to make direct grants to qualified community-based organizations, as defined, to conduct targeted outreach, enrollment, retention, and access activities for Medi-Cal-eligible individuals and families. The bill would specify the basis for issuing a grant, including specified factors in the applicant's service area.	4/18/2022	"Re-referred to Com. on HEALTH."	
State	**1**	**AB**	2724	Arumbula	**Medi-Cal: alternate health care service plan.** Would authorize the State Department of Health Care Services to enter into one or more comprehensive risk contracts with an alternate health care service plan (AHCSP), as defined, to serve as a primary Medi-Cal managed care plan for specified eligible beneficiaries in geographic regions designated by the department. The bill would require the Health Care Options Program, which is an entity overseen by the department for Medi-Cal managed care education and enrollment, to disenroll any member of an	4/20/2022	"From committee: Amend, and do pass as amended and re-refer to Com. on APPR. (Ayes 10. Noes 2.) (April 19)."	
State	**1**	**SB**	17	Pan	**Public health crisis: racism.** This bill establishes the Office of Racial Equity (ORE) as an independent public entity to coordinate, analyze, develop, evaluate, and recommend strategies for advancing racial equity across state agencies, departments, and the Governor's office, as specified; and requires each state agency to develop and implement a Racial Equity Plan, as specified.	8/23/2021	Assembly: Appropriations	

Legislative Tracking - 2022

Fed / State	Tier	Origin	Bill No.	Author(s) / Sponsor(s)	Summary	Last Date	House Location / Last Action	PHC Position
State	**2**	**SB**	28	Caballero	**Digital Infrastructure and Video Competition Act of 2006.** This bill expands the authority of the California Public Utilities Commission (CPUC) to regulate cable video franchises, modifies annual data reporting requirements for video service provider holding a state video franchise, requires the CPUC to consult with local governments regarding franchise violations, and requires the CPUC to evaluate a franchisee's service obligations.	10/8/2021	Chaptered by Secretary of State. Chapter 673, Statutes of 2021	
State	**1**	**SB**	40	Hurtado	**Health care workforce development: California Medicine Scholars Program.** This bill would create the California Medicine Scholars Program, a 5-year pilot program commencing January 1, 2023, and would require the Office of Statewide Health Planning and Development to establish and facilitate the pilot program.	8/16/2021	Assembly: Appropriations	
State	**1**	**SB**	56	Durazo	**Medi-Cal: eligibility.** This bill would, subject to an appropriation by the Legislature, and effective July 1, 2022, extend eligibility for full-scope Medi-Cal benefits to individuals who are 60 years of age or older, and who are otherwise eligible for those benefits but for their immigration status.	6/23/2021	Assembly: Appropriations	LHPC - Support
State	**2**	**SB**	65	Skinner	**Maternal care and services. T**his bill establishes a comprehensive program to improve maternal and infant outcomes: (1) requires state and local investigating, tracking reviewing and reporting of maternal and infant deaths throughout the state; (2) enacts the Midwifery Workforce Training Act to increase the number of students educated and trained as certified nurse midwives and midwives prepared for service in specified neighborhoods and communities; (3) increases postpartum Medi-Cal coverage from 60 days to one year; (4) requires Medi-Cal coverage for doulas; (5) enhances Cal WORKS benefits; and (6) creates a guaranteed income pilot.	10/4/2021	Assembly: Appropriations	LHPC - Watch
State	**1**	**SB**	221	Wiener	**Health care coverage: timely access to care.** This bill codifies existing timely access to care standards for health plans and health insurers, applies these requirements to Medi-Cal managed care plans, adds a standard for non-urgent follow-up appointments for nonphysician mental health care or substance use disorder providers that is within 10 business days of the prior appointment, and, prohibits contracting providers and employees from being disciplined for informing patients about timely access standards.	10/8/2021	Chaptered by Secretary of State. Chapter 724, Statutes of 2021	

Legislative Tracking - 2022

Fed / State	Tier	Origin	Bill No.	Author(s) / Sponsor(s)	Summary	Last Date	House Location / Last Action	PHC Position
State	**2**	**SB**	226	Pan	**Medi-Cal: County of Sacramento.** This bill would authorize the Board of Supervisors of the County of Sacramento to establish a health authority to perform specified duties, including negotiating and entering into contracts with health plans, as prescribed.	10/1/2021	Assembly - Appropriations	
state	**1**	**SB**	242	Newman	**Health care provider reimbursements.** This bill would require a health care service plan or health insurer to contract with its health care providers to reimburse, at a reasonable rate, their business expenses that are medically necessary to comply with a public health order to render treatment to patients, to protect health care workers, and to prevent the spread of diseases causing public health emergencies.	10/6/2021	Chaptered by Secretary of State. Chapter 538, Statutes of 2021	LHPC - Oppose
State	**1**	**SB**	256	Pan	**California Advancing and Innovating Medi-Cal.** Require the (DHCS) to seek federal approval for, and implement, waivers for the CalAIM initiative in accordance with the CalAIM Terms and Conditions and consistent with existing federal law; requires DHCS to implement the Population Health Management, Enhanced Care Management, In Lieu of Services, and Incentive Payments components of the CalAIM initiative; and authorizes DHCS to implement the mandatory managed care enrollment population and regional ratesetting	6/10/2021	Assembly - Health	
State	**2**	**SB**	281	Dodd	**Medi-Cal: California Community Transitions program.** This bill requires individuals who have resided less than 60 consecutive days in an inpatient facility to be eligible for services under the temporary, state-only California Community Transitions (CCT) program.	7/6/2021	Assembly - Health	
State	**1**	**SB**	293	Limon	**Medi-Cal specialty mental health services.** Requires the DHCS, on or after January 1, 2022, to develop standard forms relating to medical necessity criteria, mandatory screening and transition of care tools, and documentation requirements for specialty mental health services (SMHS) provided under Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program.	8/23/2021	Assembly - Appropriations	
State	**1**	**SB**	316	Eggman and McGuire	**Medi-Cal: federally qualified health centers and rural health clinics.** This bill would authorize reimbursement for a maximum of 2 visits taking place on the same day at a single location if after the first visit the patient suffers illness or injury requiring additional diagnosis or treatment, or if the patient has a medical visit and a mental health visit or a dental visit, as defined.	9/9/2021	Assembly - Appropriations	LHPC - Support
State	**1**	**SB**	365	Caballero	**E-consult service.** This bill would make electronic consultation services reimbursable under the Medi-Cal program for enrolled providers, including FQHCs or RHCs. The bill would require the department to seek federal waivers and approvals to implement this provision.	10/6/2021	Veto sustained.	LHPC - Support

Legislative Tracking - 2022

Fed / State	Tier	Origin	Bill No.	Author(s) / Sponsor(s)	Summary	Last Date	House Location / Last Action	PHC Position
State	**1**	**SB**	371	Caballero	**Health information technology.** This bill would require any federal funds CHHSA receives for health information technology and exchange to be deposited in the California Health Information Technology and Exchange Fund.	6/3/2021	Assembly - Health	
State	**1**	**SB**	409	Caballero	**Pharmacy practice: SARS-CoV-2 and influenza testing.** This bill would also authorize a pharmacist or a pharmacy to perform, under specified conditions, any aspect of any FDA-approved or authorized point-of-care test for the presence of SARS-CoV-2, the virus that causes COVID-19, or influenza that is classified as waived under CLIA.	10/6/2021	Chaptered by Secretary of State. Chapter 604, Statutes of 2021	
State	**2**	**SB**	428	Hurtado	**Health care coverage: adverse childhood experiences screenings.** This bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2022, to provide coverage for adverse childhood experiences screenings.	10/7/2021	Chaptered by Secretary of State. Chapter 641, Statutes of 2021	
State		**SB**	441	Hurtado	**Health care workforce training programs: geriatric medicine.** This bill would require the office to include students and professionals with training in geriatrics in administering the Health Professions Career Opportunity Program, National Health Service Corps State Loan Repayment Program, and the Steven M. Thompson Physician Corps Loan Repayment Program. The bill would also state the intent of the Legislature to provide geriatricians practicing in underserved areas access to existing loan repayment programs offered by the state, encouraging more geriatric care providers to practice in federally designated	8/26/2021	August 26 hearing: Held in committee and under submission.	
State	**1**	**SB**	508	Stern	**Mental health coverage: school-based services.** This bill would authorize an LEA to have an appropriate mental health professional provide brief initial interventions at a school campus when necessary for all referred pupils, including pupils with a health care service plan, health insurance, or coverage through a Medi-Cal managed care plan, but not those covered by a county mental health plan.	4/21/2021	Senate - Health	LHPC - Watch
State	**2**	**SB**	521	Bradford	**Drug manufacturers: value-based arrangement.** Authorizes DHCS to enter into a written value-based arrangements with drug manufacturers based on outcome data or other metrics, as determined by DHCS and drug manufacturers, pursuant to contracts between DHCS and manufacturers.	8/26/2021	Assembly - Appropriations	

Legislative Tracking - 2022

Fed / State	Tier	Origin	Bill No.	Author(s) / Sponsor(s)	Summary	Last Date	House Location / Last Action	PHC Position
State	**2**	**SB**	523	Leyva	**Health care coverage: contraceptives.** This bill establishes the Contraceptive Equity Act of 2021 (Act), which ensures coverage for federal Food and Drug Administration-approved contraceptive drugs, devices, and products without cost sharing and medical management applicable to all insureds and enrollees, as specified, and requires employee health benefit plan contracts provided by the California Public Employees Retirement System (CalPERS), the University of California (UC), the California State University (CSU), and plans directly operated by a bona fide public or private institution of higher learning to comply with the Act. Establishes specified limitations on employers with respect to an employee's reproductive decision making.	8/26/2021	Assembly - Appropriations	

CMO Report to Board

April 2022

Topics for this Month:

1. Impact of IT system issues on quality
2. DHCS Population Health Update

1. Impact of IT System Issues on Quality

Here is a brief summary of the impacts of the PHC IT system disruption on PHC Quality functions.

a. HEDIS: the outage occurred in the middle of the annual HEDIS data collection process. NCQA agreed to a 3 week delay in the final audit, which is giving us additional time to reactivate data feeds from Kaiser and DHCS and to gather and review medical records. There may still be a small effect on our final rates; we won't know for sure until June or July. Since 2021 is a pandemic year, overall attention by our network on quality measures has suffered, so rates are expected to be closer to 2020 than to 2019.

b. Quality Incentive Program: QIP payments for the PCP QIP and Perinatal QIP are anticipated to either go out on time, or with a very small delay. We will announce any delay during the week of 4/25. The Palliative Care QIP has an unrelated potential delay related to the conversion of the Palliative Care Quality Network to become the Palliative Care Quality Collaborative, with a delay in automatically transitioning data on existing patients to the new system. Our palliative care providers are aware of this potential delay. Access to Partnership Quality Dashboard and E-reports was disrupted for a few weeks.

c. NCQA accreditation: PHC notified NCQA of the disruption, as required by NCQA. We believe we will be able to stay on schedule for our three year re-accreditation visit, about a year out.

d. Site Reviews: No significant delays

e. Peer Review: System used to process potential quality issues being repaired. Minor delays with minimal effect on overall timeliness.

f. Performance Improvement Activities/Joint Leadership Initiatives: The performance improvement team lacked access to quality data, resulting in some cancelled meetings where such data is required.

g. DHCS standards: While PHC instituted a prior-authorization holiday, we expect some timeliness standards to be negatively impacted by the system outage. Fortunately, our baseline timeliness was excellent in most areas, which will mitigate the overall impact.

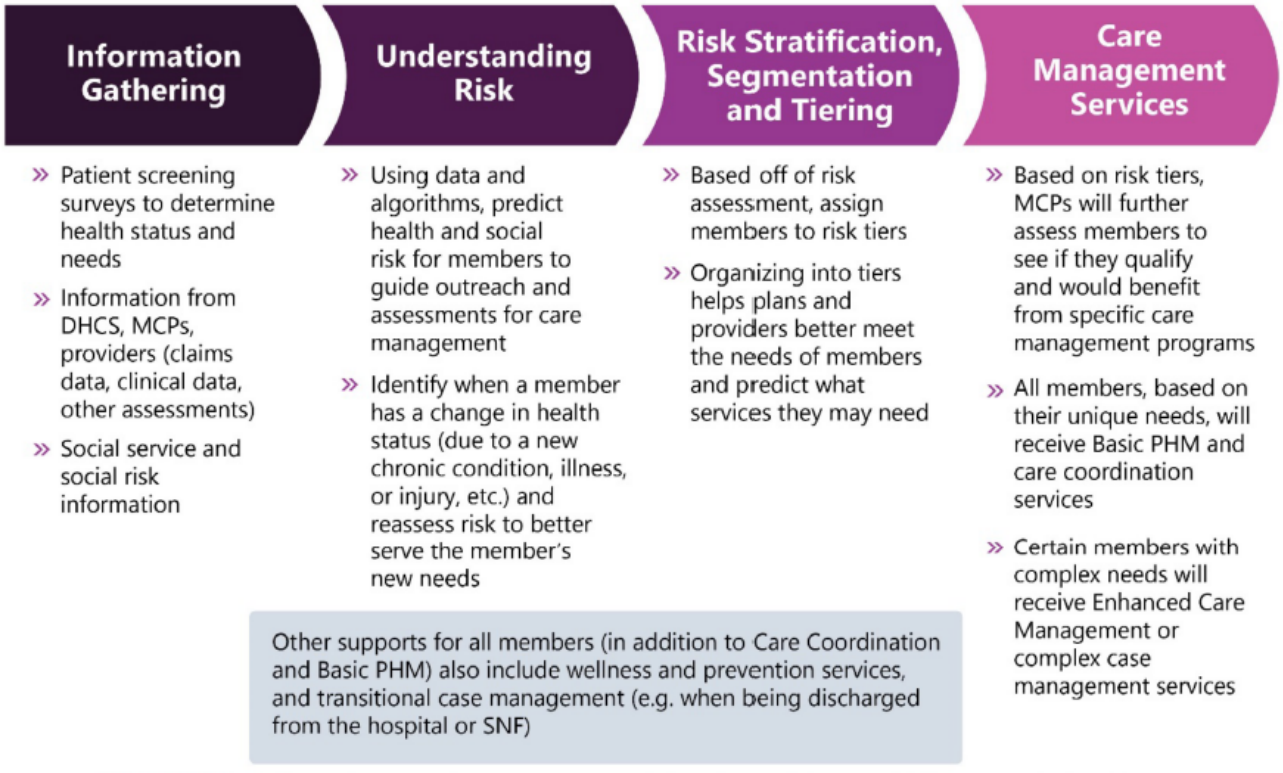
2. **CalAIM Population Health Initiative**

The term Population Health is used by different organizations to mean different things.

Organization Type	Definition of Population Health Management	Example
Public Health (county and state)	Public Health interventions and outcomes at the whole-population level.	County wide initiatives to increase COVID vaccination in children
Primary Care Providers	The use of a registry or other tools to design interventions for patients with particular diseases or demographic characteristics	Finding patients due for mammography; outreach activities to ensure those women receive their mammogram
Risk-bearing entities (usually capitated, like IPAs, medical groups)	Control of costs by identifying sub-populations of high risk for health care utilization; intervening to mitigate this future utilization	Identification of current high utilizers (and potentially those predicted to be high cost in the future) and assigning these individuals to a provider case manager to intervene in a way that reduces costs.
Health Plans	Define through NCQA Accreditation: population segmentation by risk category, with different levels of intervention to each category	Categorization of patients with multiple complex conditions and assigning them to a Health Plan case management program.
Organizations working on reducing health inequities	Categorizing health and social outcomes based on race, ethnicity and other variables reflective of historical vulnerability, and designing interventions to reduce disparities	Stratification of data by race/ethnicity/income etc. and focusing attention on disparities reflective of historical discrimination or racism.
DHCS	Close to the NCQA definition (above), with additional assessment tools.	

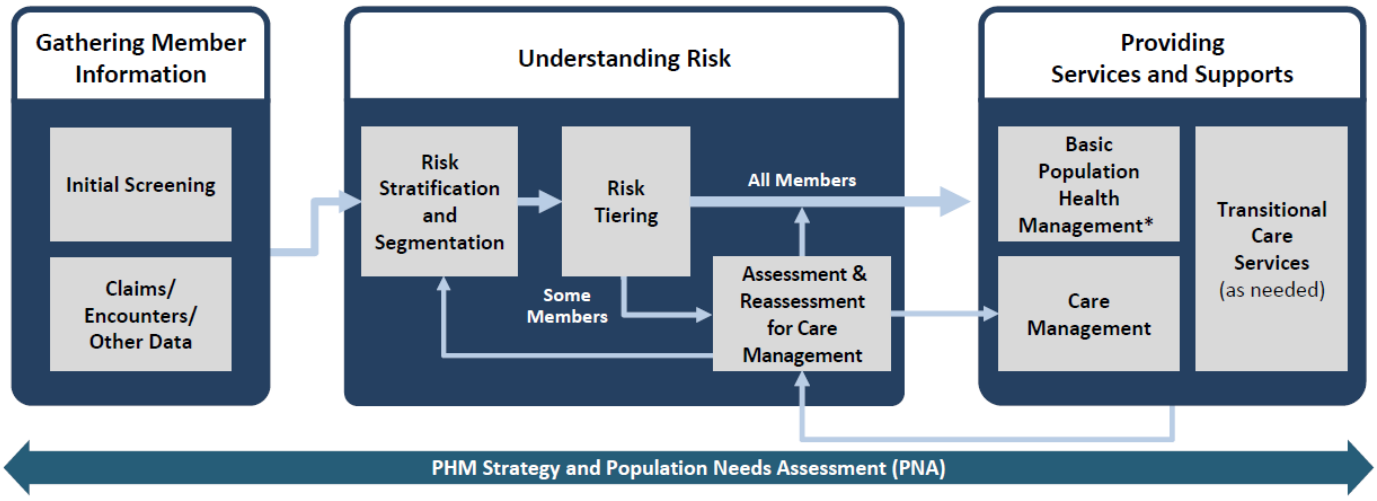
In the DHCS comprehensive quality strategy, the Population Health Management activities are summarized here:

Figure 23: Population Health Management Program Framework



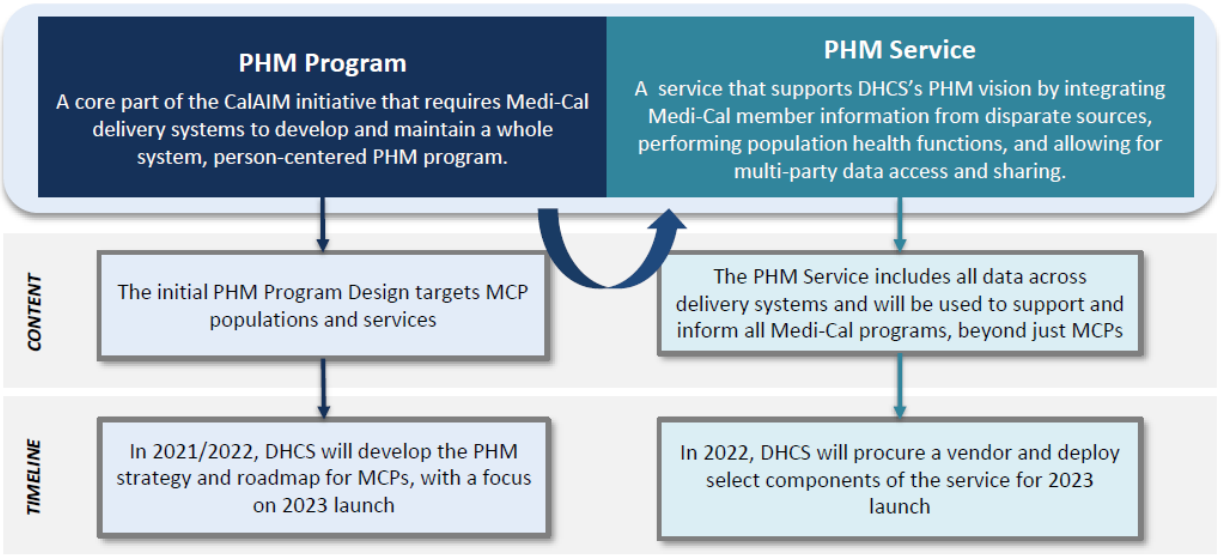
*Rising risk includes patients who have one or several chronic conditions or risk factors, and who either move in and out of stability with their conditions or who are at risk for significant, predictable health events. Common risk factors include: obesity, smoking, SDOH (e.g. housing or food instability), substance abuse, and, for young children, presence of a positive ACES screening.

Another diagram from DHCS to show the overall framework for PHM:



*Basic PHM includes: Access, utilization and engagement with primary care, Care coordination, Wellness and prevention programs, Programs addressing chronic disease, and Program to address maternal health outcomes

To help with the first two steps of this process (information gathering and understanding risk), DHCS is working with consultants to integrate data sources from a variety of sources into a Population Health Management Service, which they envision will allow better risk stratification and intervention. Here is how these fit together:



On April 14, DHCS announced a new aspect of their Population Health Management Initiative, called the PHM Provider Initiative, done in conjunction with CPCA and Kaiser:

DHCS
Single access point for DHCS, MCPs, and Beneficiaries

- CalAIM PHM implementation
- Managed care plans (MCPs) requirements, including NCQA accreditation
- Prevention, wellness and care coordination for all members
- Care management programs based on need
- PHM Service
  - Social and health data aggregation and access
  - Standardized risk stratification and risk tier
  - Optimize enrollment in eligible programs
  - Access to longitudinal patient records
  - Repository for standard assessments

Managed Care Plans

- PHM strategy
- Provide prevention and CM programs
- Coordination with Providers and community
- Quality and health equity efforts
- Development of Community Supports (aka "In Lieu of Services")
- Oversight of ECM
- NCQA Accreditation

PHM Provider Initiative

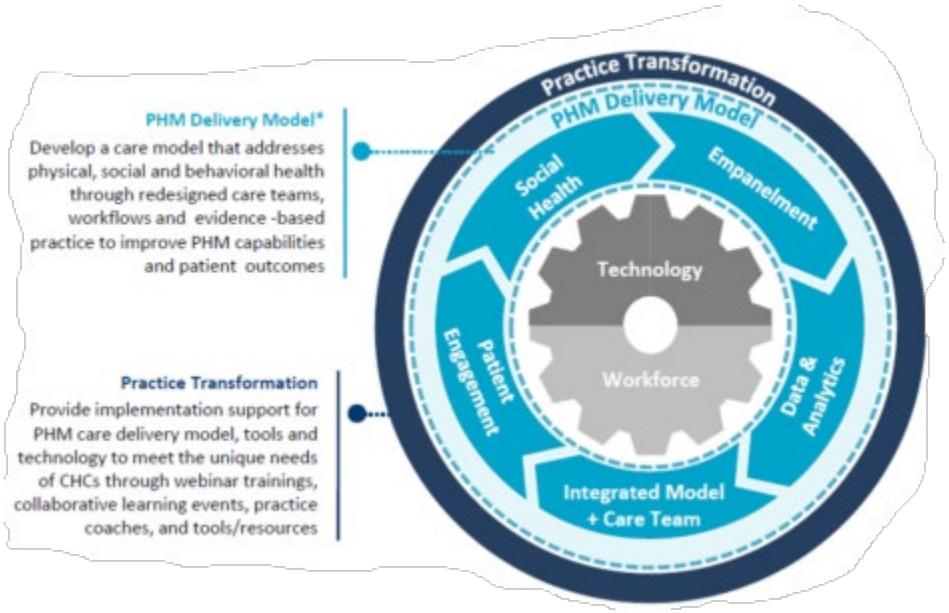
- APM readiness
- Whole person care approach
- Community and member engagement
- Utilize MCP risk stratification
- Empanelment
- Risk based care teams
- Clinical decision support including gaps in care
- Linkage and close loop for social health services
- Quality metric performance training and reporting

While not listed in this slide from DHCS, there is dialogue about the potential role of DHCS and Kaiser in standardizing the use of Community Health Information Exchange, (vendors include Blue Binder, Aunt Bertha, and Unite Us). No additional details were presented to the DHCS Medical Directors, but we have heard some activities are going on in this area.

The vision is of this PHM Provider Initiative is to advance population health management capabilities to improve population outcomes. They see this as in synergy with CalAIM, APM 2.0 and encounter data projects.

The timeline is to convene design teams in 2022 to co-design the solutions and tools, to launch the intervention in 8 pilot counties in 2023 (including Sonoma, Mendocino and Humboldt in the PHC region), and to evaluate for impact in 2024 and potentially move to a state-wide roll-out.

The scope of activities to be included in this initiative combines Practice Transformation and changing the delivery model:



DHCS has now invited PHC to become involved in the first phase of the process.

New PHM Provider Initiative and Patient Centered Medical Home

The scope of activities is similar to the Patient Centered Medical Home Initiative, which led to accreditation/certification standards for health care providers. Other variations of the Patient Centered Medical Home included the “Patient Centered Health Home,” the “Patient and Family Centered Health Home,” and the “Person Centered Health Home,” to include a larger health context, the family and caregivers, to de-emphasize the health care hierarchy, and to align with the structure of Community Health Centers. Here is one diagram to show the major components:

The February 2011 Joint Guidelines for Patient-Centered Medical Home recognition and accreditation program notes these core principles:

1. Assigning a personal physician (clinician) in a team-based medical practice
2. Whole-person orientation (broad spectrum of care done or coordinated by PCP; shared decision making respecting patient's preferences; self-management; inclusion of caregivers)
3. Coordinated and/or integrated care
4. Activities focused on clinical quality of the patient panel
5. Enhanced access (option for same day care and virtual visits)

Other organizations have other variations of these components; collectively all are included in the proposed PHM Provider Initiative.

Considerations:

1. How does the PHM Provider Initiative fit in with PCHM and related practice transformation initiatives of the past 25 years?
2. What was learned from prior work on the PCMH and related initiatives? How would that inform this new PHM Provider Initiative?
3. How can we leverage the newer concepts of implementation science to support scalability of this effort?
4. Other local/individual factors are prerequisites or predictors of success in practice transformation efforts: strength of leadership, management, IT, and financial/political stability. How do these fit into the PHM Provider Initiative?

5. We are looking for clarification of the vision of DHCS and Kaiser on the long-term plan for the relationship between health centers and Kaiser, as this will impact the rollout of the PHM Provider Initiative.