PARTNERSHIP HEALTHPLAN OF CALIFORNIA
QUALITY/UTILIZATION ADVISORY COMMITTEE MEETING NOTICE

FROM: Leslie Erickson, Program Coordinator II, Quality Improvement
DATE: April 10, 2025
SUBJECT: Quality/Utilization Advisory Committee (Q/UAC) Meeting

The California Public Health Emergency has ended and Q/UAC has now returned to in-person meetings per Brown Act guidelines.
Meeting locations (and call-in information for Partnership staff only) are below and listed on the agenda too.
Please use your personal electronic device for reviewing the packet during the meeting. Hard copies will not be provided.

Meeting Time/Date: 7:30 – 8:55 a.m., Wednesday, April 16, 2025
Meeting Locations:

Partnership HealthPlan of California
4665 Business Center Drive, Fairfield, CA 94534 | Napa/Solano
2525 Airpark Drive, Redding, CA 96002 | Trinity Alps
495 Tesconi Circle, Santa Rosa, CA 95401 | Santa Rosa Huddle
2760 Esplanade Ave., Ste 130, Chico 95973 | Temp Conf Room

Other Locations:
Open Door Community Health Center, 3770 Janes Road, Arcata
HHS, 5730 Packard Ave., Suite 100, Marysville, CA 95901

Staff and members only may join by Telephone: 1-844-621-3956 Access Code 809 114 256
Partnership Offices: Please use the QUAC Partnership HealthPlan's Personal Room in WebEx
https://partnershiphp.webex.com/meet/quac | 809114256 (Need assistance? Contact IT at least one (1) day prior to the meeting.)

Voting Members:
Choudhry, Sara, MD
Gwiazdowski, Steven, MD, FAAP
Hackett, Emma, MD, FACOG
Lane, Brandy, PHC Consumer Member
Luu, Phuong, MD
Montenegro, Brian, MD
Mulligan, Meagan, FNP-BC
Murphy, John, MD
Quon, Robert, MD, FACP
Strain, Michael, PHC Consumer Member
Swales, Chris, MD
Thomas, Randolph, MD
Wilson, Jennifer, MD, MPH

PHC Staff (Ex-Officio) Members:
Barresi, Katherine, RN, BSN, PHN, NE-BC, Chief Health Equity Officer
Bides, Robert, RN, BSN, Mgr, Member Safety-Quality Investigations, QI
Bontrager, Mark, Sr. Director of Behavioral Health, Health Services
Cotter, James, MD, Associate Medical Director
Cox, Bradley, DO, Regional Medical Director, Northeast
Devido, Jeffrey, MD, Behavioral Health Clinical Director
Esget, Heather, BSN, ACM-RN, Director of Utilization Management
Frankovich, Terry, MD, Associate Medical Director
Gast, Brigid, MSN, BS, RN, NEA-BC, Sr. Director of Care Management
Glickstein, Mark, MD, Associate Medical Director
Guevarra, Angela, RN, Associate Director, Care Coordination (SR)
Guillory, Ledra, Senior Manager of Provider Relations Representatives
Hartigan, Nicole, RN, Associate Director, Care Coordination (NR)
Hightower, Tony, CPhT, Associate Director, UM Regulations
Jalloh, Mohamed "Moe," Pharm.D, Health Equity Officer
Jones, Kermit, MD, JD, Medical Director for Medicare Services
Katz, Dave, MD, Associate Medical Director
Kubota, Marshall, MD, Associate Medical Director
Leung, Stan, PharmD., Director of Pharmacy Services
Matthews, R. Douglas, MD, Regional Medical Director, Chico
Moore, Robert, MD, MPH, MBA, Chief Medical Officer (Chair)
Netherda, Mark, MD, Medical Director for Quality (Vice Chair)
Newman, Rachel, RN, BSN, Manager, Clinical Compliance - Inspections
O'Connell, Lisa, MHA, Director, Enhanced Health Services
Randhawa, Manleen, Senior Health Educator, Population Health
Ribordy, Jeff, MD, MPH, FAAP, Regional Medical Director, Northwest
Ruffin, DeLorean, DrPH, MPH, Director of Population Health
Spiller, Bettina, MD, Associate Medical Director
Steffen, Nancy, Senior Dir. of Quality and Performance Improvement
Thornton, Aaron, MD, Associate Medical Director
Townsend, Colleen, MD, Regional Medical Director, Southeast
Watkins, Kory, MBA-HM, Director, Grievance & Appeals

cc:
Andrews, Leigha, Regional Director, Southwest
Bjork, Sonja, JD, Chief Executive Officer
Blake, Jill, Regional Director, Auburn
Boyle, Shannon, RN, Manager of Care Coordination Regulatory Performance
Brown, Isaac, MHA/MBA, Director of Quality Management, QI
Brunkal, Monika, RPh, Associate Director of Population Health
Campbell, Anna, Policy Analyst, Utilization Management
Davis, Wendi, Chief Operations Officer
Devan, James, Manager of Performance Improvement, QI (NR)
Durst, Jennifer, Sr Mgr of Performance Improvement, QI (SE/SW)
Foster, Troy, Project Manager II, Quality Improvement
Garcia-Hernandez, Margarita, PhD, Director of Health Analytics
Gual, Kristine, Director of Quality Measurement, QI
Harrell, Bria, Project Manager I, Configuration
Innes, Latrice, Manager of Grievance & Appeals Compliance
Isola, Brandy, Mgt of Performance Improvement, QI (Chico/Auburn)
Jarrett-Lee, Kevin, RN, Associate Director, UM
Kerlin, Mary, Senior Director of Provider Relations
Klakken, Vicki, Regional Director, Northwest
McCune, Amy, MPH, MS, Manager of Quality Incentive Programs, QI
Morris, Matthew, MD, Regional Medical Director, Auburn
Nakatani, Stephanie, Manager of Provider Relations Representatives
Ocampo, Andrea, Pharm.D, Clinical Pharmacist, Pharmacy
O'Leary, Hannah, MPH, Manager of Population Health
Power, Kathryn, Regional Director, Southeast
Quichocho, Sue, Manager of Quality Improvement, QI
Sharp, Tim, Regional Director, Northeast
Stark, Rebecca, Regional Director, Chico
Ward, Lisa, MD, Regional Medical Director, Southwest

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA
QUALITY/UTILIZATION ADVISORY COMMITTEE (Q/UAC)
MEETING AGENDA

Date: April 16, 2025 **Time: 7:30 – 8:55 a.m.**

Locations: Partnership HealthPlan of California
4665 Business Center Drive, Fairfield, CA 94534 | Napa/Solano Room
2525 Airpark Drive, Redding, CA 96002 | Trinity Alps Conference Room
495 Tesconi Circle, Santa Rosa, CA 95401 | Santa Rosa Huddle Room
2760 Esplanade Ave., Ste 130, Chico 95973 | Temp Conf Room

Other Locations:
Open Door Community Health Center, 3770 Janes Road, Arcata
Health & Human Services Dept., 5730 Packard Ave., Suite 100, Marysville, CA 95901

Partnership Staff only may join by Web-ex:
https://partnershiphp.webex.com/meet/quac Meeting # 809 114 256

Partnership Staff only may join by Telephone:
1-844-621-3956 Access Code: 809 114 256

This Brown Act meeting may be recorded. Any audio or video tape recording of this meeting, made by or at the direction of Partnership, is subject to inspection under the Public Records Act and will be provided without charge, if requested.

Welcome / Introductions / Public welcome at cited locations

	Item	Lead	Time	Page #
I.	**Call to Order – Welcome/Introductions/Announcements/Approval/Acceptance of Minutes**			
1	*Approval of* • March 19 Quality/Utilization Advisory Committee (Q/UAC) Minutes	Robert Moore, MD	7: 30	5 - 17
2	*Acknowledgment and acceptance of draft minutes of the* • March 11 Internal Quality Improvement (IQI) Committee • March 18 Quality Improvement Health Equity Committee (QIHEC) • Feb. 27 Member Grievance Review Committee (MGRC)			19 - 30 31 - 46 47 - 52
II.	**Standing Updates**			
1	Quality and Performance Improvement Program Update	Nancy Steffen	7:35	53 - 64
2	HealthPlan Update	Robert Moore, MD	7:45	--
III.	**Old Business**			
	Early Policy Reviews to Accommodate D-SNP Implementation Schedule – *refer to updated 2025 calendar under FYI, p. 293; early renewals are highlighted in green*	Robert Moore, MD	7:55	--
IV.	**New Business – Consent Calendar**			
	Consent Calendar	All	8:00	65
	Proposed 2025-2026 Quality Incentive Program Measure Summaries – *direct questions to Troy Foster* • Hospital QIP and Perinatal QIP *Note that these were approved at the Physician Advisory Committee (PAC) April 9*			67 - 73
	Quality Improvement Policies			
	MPQP1006 – Clinical Practice Guidelines			75 - 79
	MPXG5001 – Clinical Practice Guidelines for the Diagnosis & Management of Asthma			81 - 83
	MPXG5002 – Clinical Practice Guidelines for Diabetes Mellitus			85 - 87

	Item	Lead	Time	Page #
	Utilization Management Policies			
	MCUP3121 – Neonatal Circumcision			89 - 90
	MPUP3014 – Emergency Services			91 - 98
	MPUP3026 – Inter-Rater Reliability Policy			99 - 101
	MPUP3051 – Long Term Care SSI Regulation			103 - 104
V.	**New Business – Discussion Policies**			
	None		--	--
VI.	**Presentations**			
1	UM/Pharmacy Grand Analysis • MPUD3001 – Utilization Management Program Description – *synopsis of changes begins on p. 105* • Annual (2024) Utilization Management Program Evaluation – NCQA UM Standard 1 Element B • Supplemental TAR Report to the 2024 UM Program Evaluation	Tony Hightower, CPhT Andrea Ocampo, Pharm.D	8:05	109 - 149 151 – 172 173 - 180
2	Population Needs Assessment – *presentation begins on p. 285*	Hannah O'Leary, MPH, CHES	8:25	181 - 292
VII. FYI	**Pharmacy Operations Update –** *refer any questions to Stan Leung, Pharm.D*			293
	Updated 2025 Policy Review Calendar – *refer questions to Leslie Erickson*			295 - 299
	Adjournment scheduled for 8:55 a.m. Q/UAC next meets 7:30 a.m. Wednesday, May 21, 2025			

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
MEETING MINUTES

Quality and Utilization Advisory Committee (Q/UAC) Meeting
Wednesday, March 19, 2025 / 7:33 a.m. – 8:38 a.m. Napa/Solano Room, 1st Floor

Voting Members Present:		
Sara Choudhry, MD	Brian Montenegro, MD	Michael Strain, PHC Consumer Member
Emma Hackett, MD, FACOG	Meagan Mulligan, FNP-BC	Chris Swales, MD
Phuong Luu, MD	John Murphy, MD	Randolph Thomas, MD
	Robert Quon, MD, FACP	Jennifer Wilson, MD
Voting Members Absent: Steven Gwiazdowski, MD, FAAP; Brandy Lane, PHC Consumer Member		
Partnership *Ex-Officio* Members Present:		
Bides, Robert, RN, BSN, Mgr, Member Safety – Quality Investigations, QI		Kubota, Marshall, MD, Associate Medical Director
Cox, Bradley, DO, Regional Medical Director (Northeast)		Leung, Stan, Pharm.D, Director of Pharmacy Services
DeVido, Jeff, MD, Behavioral Health Clinical Director		Moore, Robert, MD, MPH, MBA, Chief Medical Officer – Chair
Esget, Heather, RN, BSN, ACM, Director of Utilization Management		Netherda, Mark, MD, Medical Director for Quality – Vice Chair
Frankovich, Terry, MD, Associate Medical Director		Newman, Rachel, RN, BSN, Manager, Clinical Compliance – Quality Inspections
Gast, Brigid, MSN, BS, RN, NEA-BC, Senior Director, Care Management		O'Connell, Lisa, Director, Enhanced Health Services
Glickstein, Mark, MD, Associate Medical Director		Ribordy, Jeff, MD, Regional Medical Director (Northwest)
Hightower, Tony, CPhT, Associate Director, UM Regulations		Ruffin, DeLorean, DrPH, Director of Population Health
Jalloh, Mohamed "Moe", Pharm.D, Dir. of Health Equity (Health Equity Officer)		Spiller, Bettina, MD, Associate Medical Director
Jones, Kermit, MD, JD, Medical Director for Medicare Services		Steffen, Nancy, Senior Director of Quality and Performance Improvement
Katz, Dave, MD, Associate Medical Director		Thornton, Aaron, MD, Associate Medical Director
		Watkins, Kory, MBA-HM, Director, Grievance & Appeals
Partnership *Ex-Officio* Members Absent:		
Barresi, Katherine, RN, BSN, PHN, NE-BC, CCM, Chief Health Services Officer		Guevarra, Angela, RN, Associate Director, Care Coordination (SR)
Cotter, James, MD, Associate Medical Director		Hartigan, Nicole, RN, Associate Director, Care Coordination (NR)
Guillory, Ledra, Senior Manager of Provider Relations Representatives		Kerlin, Mary, Senior Director of Provider Relations
		Randhawa, Manleen, Senior Health Educator, Population Health
		Townsend, Colleen, MD, Regional Medical Director (Southeast)
Guests:		
Boyle, Shannon, RN, Manager of Care Coordination Regulatory Performance		Hoang, Hanh, PR Representative II, Provider Relations
Brown, Isaac, MBA/MHA, Director of Quality Management, QI		Isola, Brandy, Manager of Performance Improvement (Chico)
Brunkal, Monika, RPh, Associate Director, Population Health		Jarrett-Lee, Kevin, RN, Associate Director of UM
Campbell, Anna, Health Policy Analyst, Utilization Management		Jensen, Annika, RN, Assoc Dir. of Clinical Integration, Care Coordination
Devan, James, Manager of Performance Improvement (Redding)		O'Leary, Hannah, MPH, Manager of Population Health, Pop Health
Durst, Jennifer, Sr. Mgr. of Performance Improvement, QI (Santa Rosa)		Quichocho, Sue, Manager of Quality Measurement, QI
Erickson, Leslie, Program Coordinator II, QI (scribe)		Smith, Christine, Community Health Needs Liaison, Population Health
		Ward, Lisa, MD, Regional Medical Director (Southwest)

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
I. Call to Order Public Comment – *None made* Introductions Approval of Minutes	Chair Robert Moore, MD, MPH, MBA, called the meeting to order at 7:33 a.m. Meeting began with Nancy Steffen presenting the QI Update as quorum was not established until 7:36 a.m. The Feb. 19, 2025 Q/UAC Minutes were approved as presented without comment. *Acknowledgment and acceptance of draft meeting minutes of the* • Feb. 11 Internal Quality Improvement (IQI) Committee • Jan. 29 Over/Under Utilization Workgroup • Feb. 6 Populations Needs Assessment (PNA) Committee	Motion to **approve the Q/UAC minutes:** Brian Montenegro, MD Second: Randy Thomas, MD *Approved unanimously* Motion to **accept the other minutes:** Chris Swales, MD Second: Jennifer Wilson, MD *Approved unanimously*
II. Standing Updates		
1. Quality Improvement (QI) Department Update *Nancy Steffen, Senior Director of Quality and Performance Improvement, QI*	• eReports launched earlier this month. Primary Care Provider Quality Incentive program (PCP QIP) clinicians can access their gap lists, see their progress relative to our current core clinical measures, and take action on a member level. Requests went out March 14, asking providers to review their preliminary unit-of-service (UOS) measure and non-clinical measure 2024 performance. • Our Quality Measure Score Improvement series continues with a noon webinar Thursday, April 3, with Terry Frankovich, MD, covering both billing information and developmental screening tools appropriate under American Academy of Pediatrics (AAP) and Centers for Medicare and Medicaid Services (CMS) criteria. • The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) "drill-down" survey is providing us opportunities to help our members better understand their benefits, particularly their dental benefits. Although Partnership does not administer these benefits, we are participating in the statewide collaborative, Smile California, the entity that is helping direct the newest contract in the State's administration of the dental benefit. We can work down to a county level across our service region to improve our members' experience, eliminate access barriers, and enhance oral care through preventive measures. Last month, Isaac Brown highlighted our work to improve our topical fluoride measure. We have a custom code mapping about which we are informing our dental clinic colleagues, particularly in the Federally Qualified Health Centers (FQHC) and Tribal Health dental centers of an ICT code we need them to utilize when administering topical fluoride: Z29.3. • We have periodically reported on our Locum Pilot Initiative over the last several months. This is a short term solution to help provide better access with the goal of improving our priority Healthcare Effectiveness Data Information Set (HEDIS®) performance measures, particularly in well-child visits, as well as in our women's health measures cervical cancer screening. Recently, the project team facilitating this put together a nice summary of the outcomes: we saw a definite increase in well-care visits as we intended, and we will see that translate into the final scoring on the QIP 2024 measurement year for these provider organizations. This alleviated some scheduling backlog and helped our members get in to see their preferred clinicians. So that has a member experience component that is quite striking. We need to	For information only: no formal action required.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	look at offering a longer contract and then helping the participating provider organizations to prepare and test support staff for good onboarding of the locum, so they can hit the ground running. So, we are continuing this pilot in a second phase. Chris Swales, MD, commented that his organization has utilized locums with much the same results. He expressed concern that perhaps Partnership is hiring locums to achieve metrics rather than to better patient care. "You are getting people through but is the quality equal and is it worth it?" he asked. Dr. Moore acknowledged the question, saying he too has had "that variable experience" with some "amazing" locums and others he has had to let go early. He recounted a recent conversation with a third-year resident, who said two-thirds of her class is seeking locum opportunities to test out different environments before deciding on where and with whom to practice. Associate Medical Director Marshall Kubota, MD, added that utilizing locums on simple acute cases allows supervising providers to address the preventive and chronic needs of their regular patients.	
2. HealthPlan Update *Robert Moore, MD Chief Medical Officer*	• The State is projecting a big budget shortfall this year. The university systems are already experiencing cuts to their National Institutes of Health (NIH) grants. The big four things in the California budget are Cal State and University of California, K-12 education, prisons, and Medi-Cal. Severely affecting one of these four impacts the overall budget and all discretionary spending gets put at risk. Realizing this, the only ask of the California Academy of Family Physicians at its recent "lobby day" was 'just don't cut our GME (graduate medical education) funding.' • When the federal government passed its continuing resolution to fund the government through September, they did include extending the telemedicine flexibilities that were scheduled to stop April 1. Core FQHC funding was also extended to September. • Both House and Senate committees are looking at giant cuts to Medicaid. Hospitals, clinics and individual patients are blowing up the Washington switchboards. That is what needs to happen. Partnership's Chief Executive Officer Sonja Bjork's advice is to call local representatives, particularly if you have a Republican representing you. (We have two in the Partnership region.) Sonja specifically says it is better that individual constituents who will be harmed make those calls. Individual hospitals at risk of closing should also speak up. • Even though federal cuts have yet to happen, the State is already having a Medicaid shortfall and has hit its maximum borrowing ability for sustaining the Medicaid program. There are some hypotheses: the pharmacy carve-out is not going as planned or maybe covering the undocumented is a higher expense than they thought it was going to be. • Our Quality department recently hosted a multi-site presentation with the physician residency program performance improvement forum. We had six presentations. The three best presenters were each awarded a prize to attend a high-quality quality conference. • On activities related to promoting rural OB access and equity: Regional Medical Director Colleen Townsend, MD, led the effort to put together a nice conference addressing the challenges in prenatal care. It was well attended in multiple offices. The Surgeon General's office presented on maternal	There were no questions for Dr. Moore. *Meeting Postscript:* • SB 669 introduced Feb. 20 was set March 26 for an April 9 hearing. The Legislative Counsel's Digest and the bill text itself can be found at https://legiscan.com/CA/text/SB669/id/3135063

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	mortality. We had two talks on diabetes and pregnancy, and one excellent talk summarizing substance use disorder screening options. • California Senate Bill 669 introduced by Senate Pro Tempore Mike McGuire would allow hospitals to apply to become standby perinatal centers, allowing them to flex up when someone presents in labor or postpartum and to flex down when the immediate need is not there. Plumas District Hospital had that designation before it was granted by the California Department of Public Health. The CDPH later reversed all their statewide waivers, made everyone reapply, and then they wouldn't give that waiver to Plumas, which ended up closing its OB unit three years ago. The Senate Pro Tempore's office had Plumas present to those thought likely to be in opposition, like the American College of Obstetricians and Gynecologists (ACOG) and nursing unions. The presentation went well and the bill appears to be on its way to approval. Partnership is excited to support Plumas and potentially other rural hospitals in this endeavor. • Partnership continues to provide trainings for emergency obstetrics and airway in advanced neonatal airway into our rural regions. Partnership will be planning additional basic life support or BLSOs in future. A detailed article on all the other activities Partnership is doing in supporting maternal access and quality will be in an upcoming issue of Healthy World California. When we get that reference, we will send it to committee members to read in more detail. • The first of six Regional Medical Directors meetings this year will occur in Eureka March 21. You are all welcome to attend. Detailed notes are in development.	
III. Old Business – None		
IV. New Business – Consent Calendar (Committee Members as Applicable)		
Consent Calendar	***Health Services Policies*** <u>Quality Improvement</u> MPQP1002 – Quality/Utilization Advisory Committee MPQP1004 – Internal Quality Improvement Committee <u>Utilization Management</u> MCUP3124 – Referral to Specialist (RAF) Policy – ***pulled for clarification*** MPUG3126 – Behavioral Health Treatment (BHT) for Members Under the Age of 21 MPUP3059 – Negative Pressure Wound Therapy (NPWT) Device/Pump **John Murphy, MD, pulled MCUP3124** to question the intent of VI.J.2: "Referrals to contracted specialists are auto adjudicated and written approval is generated to the requesting PCP and specialist within one working day of the receipt of the request." Dr. Murphy asked if this means the Plan "rubber stamps" these requests and that a member could then directly schedule with the specialist? Dr. Moore clarified that if the PCP makes a referral, Partnership considers that "auto" from a regulatory standpoint. We do not add an additional step; however, if the referral is to a non-contracted specialist, a Partnership medical director will take a second look. Dr. Murphy then asked if this extends to all contracted providers in all specialties in	Motion to **approve slate as presented without MCUP3124:** Brian Montenegro, MD Second: Meagan Mulligan, FNP-BC *Approved unanimously* Motion to **approve MCUP3124 as presented:** John Murphy, MD Second: Randy Thomas, MD *Approved unanimously* <u>Next Steps</u>: April 9 Physician Advisory Committee (PAC)

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	network, and Dr. Moore said it does. He cautioned, however, that if the PCP-to-referral coordinator process breaks at the PCP office, delays can occur.	
V. New Business – Discussion Policies		
Policy Owner: Care Coordination – *Presenter: Shannon Boyle, RN, Manager of Care Coordination Regulatory Compliance*		
MCCP2024 – Whole Child Model for California Children's Services (CCS) – *the Family Advisory Committee (FAC) Charter is being added here as a* ***new Attachment B*** *and is no longer Attachment F to Population Health's MCND9002 – Cultural & Linguistic Program Description*	**Policy edits due to APL 24-015 supersedes APL 23-034** **Related Policies Added:** MCCP2035- Local Health Department (LHD) Coordination MCUP3104- Transplant Authorization Process MCCP2025- Pediatric Quality Committee Policy MCUP3037- Appeals of Utilization Management/ Pharmacy Decisions CGA024- Medi-Cal Member Grievance System MCUG3058- Utilization Review Guidelines ICF/DD, ICF/DD-H, ICF/DD-N Facilities **Updated:** MCUP3143 updated to reflect new policy number MCAP7001- CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS) **Removed:** MPCP2002- California Children Services (policy archived) **Definitions Added:** ICF/DD: Intermediate Care Facilities for the Developmentally Disabled ICF/DD-H: Intermediate Care Facilities for the Developmentally Disabled/Habilitative ICF/DD-N: Intermediate Care Facilities for the Developmentally Disabled/Nursing Newly Eligible WCM members Newly Transferred WCM members Receiving County Sending County **Attachments Added:** B. FAC Charter **Purpose updated and removed:** The counties included due to WCM now covering all counties **VI. Policy/Procedure Updated:** **A. CCS Program Eligibility Added:** A.1.b. Partnership provides services to WCM members with other health coverage, with full scope Medi-Cal as the payor of last resort A.2.e. added referral source: Medical Therapy Conference (MTC) referral A.3. Partnership will refer all members who demonstrate a potential CCS-Eligible Condition(s) or if a WCM member develops a new potential CCS-Eligible Condition as soon as possible to the county CCS Program A.4. Partnership will refer NICU, HRIF, and MTP members with potential CCS eligible conditions to the County CCS Program for review and determination of eligibility services	There were no questions. Motion to **approve as presented:** Jennifer Wilson, MD Second: Brian Montenegro, MD *Approved unanimously* Next Steps: April 9 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	A.5. Partnership will provide available necessary documentation received or retrieved by Partnership's case management or utilization management staff, or assist Network Providers in referring with necessary documentation A.6. Annual Medical Redetermination, Partnership will receive a list from the counties a minimum of 120 days in advance of the eligibility date. Partnership will make outreach attempts to obtain medical records, as well as take appropriate action if medical records recovery is unsuccessful. **B. Utilization Management** B.6. Partnership is required to cover all medically necessary blood, tissue, and solid organ transplants for WCM members. Refer to policy MCUP3104 Transplant Authorization Process for more details B.7. Partnership will conduct, at least quarterly reviews of their inpatient utilization data to assess whether all potential WCM members have been appropriately referred to the County CCS program. **C. Case Management and Care Coordination** C.1. Added: Members may decline Case Management services without impact to their enrollment and/or participation in the WCM Program C.3. Amended: new pediatric members, newly CCS-eligible members, or WCM transition members within 45 days of the County CCS program eligibility determination for newly eligible WCM members and newly transferred WCM members C.3.c.1). High Risk: C.3.c.1.b) amended: Members without available medical utilization data, claims data, or other assessments and/or survey information available C.3.c.1.e) Newly CCS-eligible members C.3.c.1.f) New CCS Members enrolled in Partnership C.4.a. updated licensed staff to Care Coordination staff and added to assist in the development of member's ICP C.4.b. added: to be Low Risk to identify the member's health care needs C.5.c. added: ICP for members determined to be high risk based on the results of the risk assessment process will be established within 90 calendar days of a completed risk assessment survey or other assessment by telephonic and/or in-person communication. However, if a member's family declines having an ICP developed, Partnership will notate the denial in the member's medical record as evidence of compliance. C.5.c.2) added: services including but not limited to palliative care C.5.d added: For members transitioning into the WCM Program from Classes CCS Programs, Partnership will complete the PRSP within 45 calendar days of transition to determine each member's risk level C.5.f. added: Partnership will provide information on what community resources exist for members to utilize via member's preferred method of communication or by telephone. The Partnership External Website which includes the Partnership's Community Resources pages has information readily available for the members. C.5.g. Updated to MCAP7001 C.10. added: Care Coordination plan will be developed at least 12 calendar months before the member ages out. Partnership will monitor the WCM member for at least 36 calendar months following age out of the WCM Program, to the extent feasible	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	C.11. added: A pediatric phase-out occurs when a treating CCS-paneled Provider determines that their services are no longer beneficial or appropriate to the treatment of the WCM member. Partnership will provide Care Coordination to WCM Members in need of an adult Provider when the WCM member no longer requires the services of a pediatric Provider. **D. Inter-County Transfer (ICT) Added:** Partnership and the County CCS program will collaborate to facilitate the exchange of ICT data to ensure that the CCS WCM member who relocate to another county can effectively transfer their CCS benefits without interruption, including the provision of continuation of services and the transfer of the current service authorization request. **F. Continuity of Care for WCM Implementation Added:** Partnership will be able to initiate, accept, and process COC requests from transitioning members, providers, and authorized representatives beginning 60 calendar days prior to the transition date. For further details regarding COC, refer to policy MCCP2014 Continuity of Care. **G. Partnership and CCS County Coordination Updated:** 2. Partnership and County CCS programs will coordinate the delivery of CCS services to CCS-eligible members to prevent duplication of services. Partnership and each WCM CCS county shall execute a Memorandum of Understanding (MOU) outlining respective responsibilities and obligations under the WCM, refer to APL 23-029 Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans and Third-Party Entities and Template for Memorandum of Understanding between [MCP] Medi-Cal Managed Care Plans and [County] California Childrens Services (CCS) Whole Child Model Program for more details. 5. Partnership coordinates with Regional Centers and ICF/DD, ICF/DD-H, and ICF/DD-N to ensure members who are individuals with developmental disabilities receive all medically necessary covered services per APL 23-023 Revised. 6. Partnership ensures that members living in ICF/DD Homes have access to a comprehensive set of services based on their needs and preferences across the continuum of care **H. Advisory Committees Added:** Partnership meets quarterly with a Clinical Advisory Committee for more details refer to policy MCCP2025 Pediatric Quality Committee. Family Advisory Committee (FAC) for CCS families composed of a diverse group of families that represent a range of conditions, disabilities, and demographics. Partnership representatives meet quarterly with the WCM Program stakeholder advisory group composed of representatives of CCS providers, County CCS Program administrators, health plans, family resource centers, regional centers, recognized exclusive representatives of County CCS providers, CCS case managers, CCS MTUs, and representatives from Family Advisory Committees. **I. CCS Liaison Added:** Partnership designates one individual as the point of contact for the MOU and the coordination of services between Partnership and Couty CCS Programs who has the knowledge and adequate training on the CCS Program and clinical experience with either the CCS Population or pediatric patients with complex medical conditions. **J. Dispute Resolution and Provider Grievances Added:**	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Medical eligibility determination disputes between Partnership and the County CCS Program will be resolved by the County CCS Program. If other disputes arise between Partnership and the County CCS Program, all parties will fulfill their responsibilities in alignment with DHCS policies, including APL, NL, MCP Contract and WCM MOU, without delay. Partnership will have a formal process to accept, acknowledge, and resolve Provider disputes and grievances. **K. Grievance, Appeal, and State Hearing Added:** Partnership will ensure that all members are provided information on Grievances, Appeals, and State Hearing rights and processes. All WCM members will be provided the same Grievance, Appeal, and State Hearing rights as other Partnership members. **References: Updated** - DHCS All Plan Letter (APL) 24-015 California Children's Services Whole Child Model Program (12/02/2024) **References: Added** - DHCS APL 23-029 - Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans and Third-Party Entities (10/11/2023) - Template for Memorandum of Understanding between [MCP] Medi-Cal Managed Care Plans and [County] California Childrens Services (CCS) Whole Child Model Program (07/2024) - DHCS APL 23-023 Intermediate Care Facilities for Individuals with Developmental Disabilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care (*Revised* 11/28/2023) - DHCS APL 25-005 Standards for Determining Threshold Languages, Nondiscrimination Requirements and Language Assistance Services (02/12/2025) - DHCS APL 21-011 Grievance and Appeal Requirements, Notice and "Your Rights" Template (08/31/2022) - DHCS All Plan Letter 23-022: Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-For-Service, on or After January 1, 2023 (08/15/2023) - CCS NL 05-0502 Medical Eligibility for Care in a CCS Approved Neonatal Intensive Care Unit (NICU) (05/01/2002) - CCS NL 10-1123 CCS Intercounty Transfer Policy (11/1/2023) Attachments 1-4: Process Flowchart, FAQs, and Checklists - CCS Medical Eligibility Guide - CCS NL 10-1224 California Children's Services Whole Child Model Program (*revised 12/02/24)* **Attachment A**: CCS Case Management Core Activities **New Attachment B**: The FAC Charter is no longer an attachment to Pop Health's C&L Program Description and is instead migrating to Care Coordination as a new attachment to this WCM policy. In this, the 10 "expansion" counties are named, and provider membership is now open but not limited to parent centers, such as family resource centers, etc. The roles and responsibilities of Family members, Partnership staff, and Local Consumer Advocate or Local Provider members are defined. Shannon began by saying the Whole Child Model is basically a consolidated one-stop shop to assist our pediatric members with CCS-eligible conditions. She went through an abbreviated synopsis of changes and	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	then cautioned that this policy may come back through committee again this year as just this week the Department of Health Care Service (DHCS) released an AIR (Additional Information Request). Shannon thanked everyone who assisted with this update. Dr. Moore noted that oftentimes a geographic expansion will trigger DHCS to look more closely at policies and impose regulations or extra requirements they heretofore did not. Such was the case with this WCM policy, he said.	
Policy Owner: Utilization Management – *Lisa Ward, MD, Regional Medical Director (Southwest)*		
~~MCUG~~ MPUG3002 – Acupuncture Services Guidelines	**This policy was updated to include regulations for the Partnership Advantage D-SNP line of business that will be effective Jan. 1, 2026.** **Section III.A**. **and D**. Definitions of Direct Member and Partnership Advantage Member were added. **Section VI.A** Updated introduction to specify that acupuncture services are a Partnership benefit for Members who meet Medi-Cal and/or Medicare medical necessity guidelines as applicable. **Section VI.B.** This section was reorganized but not changed. **Section VI.C.** In this section we bifurcated authorization guidelines for differences between Medi-Cal and Partnership Advantage (D-SNP) lines of business. **Section VI.D.** Updated to specify that Providers who render acupuncture services should be enrolled in the applicable Medi-Cal or Medicare program. **Section VII.D.** Added Reference for Medicare Guidelines for acupuncture. This is the recently-appointed Regional Medical Director's first Partnership policy review.	There were no questions. Motion to **approve as presented:** John Murphy, MD Second: Chris Swales, MD *Approved unanimously* Next Steps: April 9 PAC
Policy Owner: Utilization Management – *Tony Hightower, CPhT, Associate Director, Utilization Management Regulations*		
MPUP3018 – Health Services Review of Observation Code Billing	**This policy was updated to correct outdated code references and to include regulations for the Partnership Advantage D-SNP line of business that will be effective Jan. 1, 2026.** **Section III. C**. Definition of Partnership Advantage Member was added. **Section VI.E.1.b.** Clarification added that observation code Z7514 can be billed "by the facility." **Section VI.E.2**. Code specified for labor checks was changed from S4005 to 99221. Language referencing "contracted hospitals" as removed. Clarification was added that code 99221 is payable to clinicians. **Section VI.E.3**. Removed language referring to hospitals "contracted with PHC." **Section VI.E.3.d.** Removed paragraph describing codes to be used by non-contracted hospitals for labor checks. Instead, viewers will refer to VI.E.2. where we specified code 99221 for labor checks and removed language about whether or not the hospital is contracted. **Section VII.C.** Added Reference for Medicare Guidelines	Motion to **approve as presented:** Jennifer Wilson, MD Second: Meagan Mulligan, FNP-BC *Approved unanimously* Next Steps: April 9 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Tony noted outdated codes were removed as was language that specified codes were payable to contracted or "only contracted" providers. He then went through the synopsis. There were no questions.	
VI. Presentations		

Cultural & Linguistic Grand Analysis:
• MCND9002 – C & L Program Description
• Presentation:
  ○ 2024 Program Evaluation
  ○ Final Update of the 2024 C&L/QIHEPT Work Plan
  ○ 2025 C&L/ QIHEPT Work Plan
Hannah O'Leary, MPH, CHES, Manager of Population Health
QIHEPT*:*
Quality Improvement Health Equity Program Transformation
	Hannah prefaced her remarks by noting that QUAC saw MCND9002 in November 2024, and that it is coming back today on a new annual approval schedule (April PAC) as part of the new "C&L Trilogy" both to align with DHCS' APL 25-005 and with NCQA Health Equity Accreditation requirements. Some policy changes follow.
	• Added language as suggested by Partnership's NCQA consultant.
	• Updated references from APL 21-004 to the new APL 25-005, and added choice language from the new APL into the policy, Including updated language defining a qualified interpreter.
	• Added Punjabi as a new threshold language.
	• Added details around our notices to LEP members, including the updated Notice of Availability of Language Assistance and processes around translations.
	• Updated details on DEI trainings and program for Partnership staff, network providers, subcontractors, and downstream contractors.
	• Added a short section describing the new Cultural and Linguistic Program Evaluation, an annual evaluation being reviewed by IQI for the first time this month.
	• Updated description and responsibilities of the Quality Improvement and Health Equity Committee (QIHEC), per recent draft APL.
	• Updated description and responsibilities of the newly-renamed Community Advisory Committee (CAC) and Family Advisory Committee (FAC).
	• Updated with current 2025 goals, as seen on the C&L/QIHETP Work Plan.
	• Updated all diagrams
	• Added or updated hyperlinked footnotes (APL 25-005 hyperlink to be updated once it's live on DHCS's website).
	Updating Attachment C: Threshold and Concentration Languages for All Counties
	• Updating to the most current version from DHCS.
	Archiving Attachment F: FAC Charter
	The FAC Charter is removed from this policy, and now becomes Care Coordination's MCCP2024 new Attachment B.
	There were no questions on the policy at this time, so Hannah moved into her presentation.
	The C&L Evaluation Report is written to fulfill NCQA Health Equity Accreditation (HEA) requirements. It is a first of its kind, and the goal of it is really to tell us how we are doing on our cultural and linguistic services. It is based on our 2024 C&L Program Description and the 2024 C&L/QIHEPT Work Plan. The program description has been around for some time: historically, it was meant to align with just the DHCS requirements. It now satisfies both DHCS and NCQA regulatory bodies.
		Motion to **approve the Grand Analysis together with MCND9002 as presented:**
		Brian Montenegro, MD
		Second: Randy Thomas, MD
		Approved unanimously
		Next Steps:
		April 9 PAC
		At the end of the presentation, Randy Thomas, MD, asked what is meant by the term "member-facing." Hannah noted this is our "umbrella" term to mean both "member informing" materials that might help explain benefits and health education materials too.
		Meeting Postscript:
		Dr. Moore had asked if "member facing" is in our glossary of terms. Partnership presently does not utilize a glossary but UM and QI staff have conferred whether it is now advisable to create and maintain one, initially on our internal website, PHC4Me. In a new nascent form, a glossary may include approved definitions that span one or more policies, e.g., "closed loop referral."

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	The C&L/QIHEPT Work Plan was also created as part of the new HEA requirements, and it's a visual of activities that were planned for 2024. Again, we have seen this work plan before but now we are packaging it together into this "trilogy" packet and also reviewing the final results. The main goal of this Evaluation is to analyze cultural and linguistic service, resources and committee structure as described in the Program Description, and then to look at how we did on the goals we had set for ourselves. The findings are meant to feed into the 2025 Trilogy documents, driving next year's program description and work plan and, subsequently, next year's evaluation. The first part of this Evaluation really looks at the results of eight core C&L services from 2024, starting off with specifically fulfilled translation requests. In December 2024, more than 1,100 requests were fulfilled, nearly double the 720 requests fulfilled in 2023. Of these 2024 requests, 800 were on time and one was late. (Multiple individual requests are often bundled as one request.) Interpreter calls totaled nearly 321,000 as of December 2024, more than double the 133,191 requests in 2023. The year saw 689 requests for alternative formats (e.g., audio, large font, Braille), a decrease from 2023's total of 1,820 requests; however, 2024 data was drawn from just one department, so the true number of alternative format requests may be quite a bit higher. Partnership conducts a frequent language data collection: in 2024, our members spoke more than 32 different languages. The top languages were English, Spanish, Russian, Tagalog, and Punjabi. The Evaluation also includes data from our QIHEC (Quality Improvement Health Equity Committee) that reviews and provides insights on the results in quality improvement and health equity activities here at Partnership. (QIHEC had 35 or more attendees at each of its five meetings in 2024.) We'll also look at some data from our Community Advisory Committee that meets quarterly: CAC is a committee primarily of Partnership members and its purpose is to act as the voice or liaison between Partnership and the members that we serve. To date, we have 30 CAC members, and we are still recruiting to fill seven additional seats. We found that, while there is enough staff to really support the C&L program, there is room for additional help to support program activities. An example: our Health Education team, which lives within our Population Health department, has historically reviewed discriminations cases and given third-party input, but due to a recent influx of cases, this activity has been taken over by our Health Equity team. In response, an additional staff position in Health Equity has been created. Further, at the time this presentation was drafted, there were positions open to support some of the Diversity, Equity, and Inclusion (DEI) regulatory requirements. The second part of the C&L Evaluation looks at the results of the five goals Partnership set for 2024: improving our C&L services and reducing healthcare inequities as laid out in the Work Plan and described in the report: 1. By Aug. 31, 2024, we would define the framework and process by which the QIHETP Program Description, Work Plan, and Evaluation would be initiated in 2024 and maintained through approval to corresponding 2025 versions needed for Health Equity initial survey in June 2025. *The goal was delayed but will be met.* 2. By Sept. 30, 2024, submit the DEI training to DHCS for review to fulfill Phase One of APL 23-025 deliverables. *Some of these deliverables were delayed but the goal was met.* 3. By Dec. 31, 2024, 90% of members who have requested materials in an alternative format will receive one or more mailings in their preferred format. *The goal was met.* 4. By Dec. 31, 2024, increase the number of bilingual member services representative staff hired by 1% so that we could move closer to the organizational goal of 75% bilingual Member Services staff. *We were able to increase bilingual staff from 28 to 31, bringing total Member Services staff to 47.* 5. By Dec. 31, 2024, improve controlled blood pressure rates among American Indian/Alaskan Native members by 5% in at least one region. *It is unknown at this time if the goal was met due to some issues with the timing of our HEDIS® data. However, we should be able to analyze this goal later in the year once the data becomes available.*	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	The goals of the 2025 Work Plan were initially approved in 2024 but we have to bring them back around to complete this trilogy package. They have been updated or slightly modified since last we looked at them. These goals were chosen in tandem with Health Equity to align with both DHCS and NCQA requirements: some are tied to Health Equity initiatives, some are carried over from last year's work plan to account for trending requirements, and some of them were developed as a direct response to findings in the 2024 Evaluation. So, <u>for the 2025 Work Plan, there are a total of eight goals, the first to be achieved by June 30, 2025, and the rest by Dec. 31, 2025.</u> 1. Develop and propose a multi-year health equity strategic and tactical plan. 2. Distribute the DEI training to the provider network and Partnership staff and then submit the final version to DHCS. 3. See that 91% of members who have requested materials in an alternative format will be mailed those in their preferred format. 4. Increase the number of bilingual Member Services staff hired by 2% to move closer to the 75% organizational goal. 5. Improve controlled blood pressure rates among American Indian/Alaskan Native members by 5% in at least two regions. 6. Improve the rate of timely translations in the Utilization Management and/or Care Coordination departments to achieve the threshold of at least 90%. 7. Improve timely prenatal visit rates by at least 5% in the Eureka or Redding region and among the American Indian/Alaskan Native member population within 12 months with the global goal of improvement by 22% in the next five years. 8. Improve well-care visit rates among Black, White, and/or American Indian/Alaskan Native members by 5% overall or at least 1.25% in at least one region. Hannah closed by saying the 2025 C&L Program Description will continue to delineate C&L services, including language data collection, translation, interpreters, alternate formats, auxiliary aids, staff trainings, compliance monitoring, goals, and team structure. This Program Description and 2025 C&L/QIHEPT Work Plan will drive the 2025 Evaluation, which will be reviewed in early 2026. Jennifer Wilson, MD, asked how members get nominated to the Community Advisory Committee. Hannah said she was not sure about who made up the nominating committee. (Dr. Moore noted that the persons who do know are in our Finance Committee meeting that is happening now.) Prospective members can self-nominate, he said. His recollection is that the local reps look for community nominations and they submit them with summary documents to the CAC. The CAC itself will review them and vote. It used to be that it was hard to find people willing to serve; however, it is now becoming a competitive process, Dr. Moore said. Q/UAC Consumer Member Michael Strain asked how much lead time is required to arrange for interpreter services. Hannah believes the preference is 24-48 hours. Dr. Moore noted that some providers subscribe to an interpreter service that members can access instantly in the provider office. For those providers who don't have that service or if some unusual languages are requested, backup methods take some advance work, Dr. Moore said. Hannah added that here at Partnership, if a member was to call in, they can usually get an interpreter right away through the same subscription service.	
VII. FYI Attachments and Adjournment		
Mid-Year 2024-2025 QI Work Plan Update – *refer questions to Nancy Steffen*		
Dental Code Flyer *as promised at Feb. 19 Q/UAC – refer questions to dentalsupport@partnershiphp.org*		
Q/UAC adjourned at 8:38 a.m. Q/UAC next meets at 7:30 a.m. Wednesday, April 16.		

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
Respectfully submitted by: Leslie Erickson, Program Coordinator II, QI Signature of Approval: _____ Date: _____ Robert Moore, MD, MPH, MBA Chief Medical Officer and Committee Chair		

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA
INTERNAL QUALITY IMPROVEMENT (IQI) COMMITTEE MEETING MINUTES
Tuesday, March 11, 2025 / 1:30 – 2:51 PM

Members Present:
Andrews, Leigha, MBA, Regional Director (Southwest)
Bides, Robert, RN, BSN, Manager of Member Safety – Quality Investigations, QI
Boyle, Shannon, RN, Manager of Care Coordination Regulatory Performance
Brown, Isaac, MHA, MBA, Director of Quality Management, Quality Improvement
Brundage O'Connell, Lisa, MHA, Director of Enhanced Health Services
Brunkal, Monika, RPh, Assoc. Dir., Population Health
Campbell, Anna, Policy Analyst, Utilization Management
Davis, Wendi, Chief Operating Officer
Esget, Heather, RN, BSN, ACM, Director of Utilization Management
Garcia-Hernandez, Margarita, PhD, Director of Health Analytics
Gast, Brigid, MSN, BS, RN, NEA-BC, Sr. Director, Care Management
Innes, Latrice, Manager of Grievance & Appeals Compliance
Jalloh, Mohamed "Moe," Pharm.D, Health Equity Officer
Jones, Kermit, MD, JD, Medical Director for Medicare Services
Kubota, Marshall, MD, Associate Medical Director
Leung, Stan, Pharm.D, Director of Pharmacy Services
Moore, Robert, MD, MPH, MBA, Chief Medical Officer, Committee Chair
Newman, Rachel, RN, BSN, Manager, Clinical Compliance – Quality Inspections
Randhawa, Manleen, Senior Health Educator, Population Health
Ruffin, DeLorean, DrPH, MPH, Director of Population Health
Steffen, Nancy, Senior Director of Quality and Performance Improvement
Townsend, Colleen, MD, Regional Medical Director (Southeast)
Villasenor, Edna, Senior Director, Member Services and G&A

Members Absent:
Ayala, Priscila, Director, Network Services
Barresi, Katherine, RN, BSN, PHN, NE-BC, CCM, Chief Health Services Officer
Bjork, Sonja, JD, Chief Executive Officer
Hightower, Tony, CPhT, Associate Director, UM Regulations
Kerlin, Mary, Senior Director, Provider Relations
Klakken, Vicki, Regional Director (Northwest)
Matthews, Richard "Doug," MD, Regional Medical Director (Chico)
Netherda, Mark, MD, Medical Director for Quality, Committee Vice-Chair
Sharp, Tim, Regional Director (Northeast)
Turnipseed, Amy, Senior Director of External and Regulatory Affairs

Guests:
Arrazola, Kelcie, Education Specialist, Provider Relations
Beltran-Nampraseut, Athena, CPhT, Program Manager, QI
Booth, Garnet, Senior Program Manager, Provider Relations
Clark, Kristen, Manager of Quality & Training, Member Services
Cook, Dawn R., Program Manager II, QI (NCQA)
Cunningham, Aryana, Policy Analyst, Care Coordination
Devan, James, Manager of Performance Improvement, QI (Northeast)
DeVido, Jeff, MD, Behavioral Health Clinical Director
Durst, Jennifer, Senior Manager of Performance Improvement, QI
Erickson, Leslie, Program Coordinator II, QI (scribe)
Guillory, Ledra, Sr. Mgr of PR Representatives, Provider Relations
Gual, Kristine, Director of Quality Measurement, QI
Harris, Matthew, Education Specialist, Provider Relations
Harris, Vander, Senior Health Data Analyst I, Finance
Jensen, Annika, RN, Assoc. Dir., Clinical Integration, Care Coordination
Kung, Jen, Senior Health Data Analyst II, Finance
Moore, Jordan, Provider Education Specialist, Provider Relations
Morris, Matthew, MD, Regional Medical Director (Auburn)
Muncy, Kellie, Manager of Change Management and Configuration, Configuration
Nguyen, Tom, Manager of Health Analytics, Finance
O'Leary, Hannah, MPH, Manager of Population Health, Pop Health
Power, Kathryn, Regional Director (Southeast)
Quichocho, Sue, Manager of Quality Measurement, QI
Rathnayake, Russ, Senior Health Data Analyst I, Finance
Robertello, Kimberly, Senior Medicare QI Program Manager, QI
Roberts, Dorian, Sr. Mgr of PR Representatives, Provider Relations
Rhorer, Jeanelle, Supervisor of Configuration, Configuration
Shrivastava, Poorva, Sr Health Data Analyst, Health Analytics, Finance
Sivasankar, Shivani, Sr Data Scientist, Health Analytics, Finance
Spiller, Bettina, MD, Associate Medical Director
Stokes, Sarah, Project Coordinator II, QI (HEDIS®)
Vance, Brooke, Program Manager I, Network Services
Ward, Lisa, MD, Regional Medical Director (Southwest)

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
I. Call to Order Introductions Approval of Minutes	Chief Medical Officer and Committee Chair Robert Moore, MD, MPH, MBA, called the meeting to order at 1:31 p.m. Annika Jensen, RN, Care Coordination's new Associate Director of Clinical Integration, attended remotely and introduced herself. Approval of the Feb. 11, 2025 IQI Minutes *Acknowledgement and Acceptance of draft meeting minutes of the* • Jan. 29 Over/Under Utilization Workgroup • Feb. 6 Populations Needs Assessment (PNA) Committee	Motion to approve IQI Minutes: Isaac Brown Second: Stan Leung, Pharm.D Motion to accept other minutes: Lisa O'Connell Second: Brigid Gast, RN
II. Old Business – None		
III. New Business Consent Calendar (Committee Members as applicable)		
Health Services Policies Quality Improvement MPQP1002 – Quality/Utilization Advisory Committee MPQP1003 – Physician Advisory Committee (PAC) Policy MPQP1004 – Internal Quality Improvement Committee Utilization Management MCUP3124 – Referral to Specialists (RAF) Policy MCUP3126 – Behavioral Health Treatment (BHT) for Members Under the Age of 21 MPUP3059 – Negative Pressure Wound Therapy (NPWT) Device/Pump ***Non-Health Services Policies*** Member Services MC 305 – Distribution of Member Rights and responsibilities Credentialing MPCR16 – Lactation Consultant Credentialing Policy MPCR302 – Behavioral and Mental Health Practitioner Credentialing and Re-credentialing Requirements – ***pulled for discussion*** MPCR303 – Applied Behavioral Health and Substance Use Disorder Practitioner Credentialing and Re-credentialing Requirements – ***pulled for discussion*** MPCR400 – Provider Credentialing and Re-credentialing Verification Process and Record Security – ***pulled for discussion*** MPCR601 – Fair Hearing and Appeal Process for Adverse Decisions MPCR701 – Ancillary Care Services Provider Credentialing and Re-credentialing Requirements Anna Campbell **pulled MPCR302**, saying she sees nothing in this policy regarding Carelon as a delegated entity. Brooke Vance replied that we are in talks with Carelon and perhaps they have yet to resolve. Dr. Moore wondered if existing delegation language is sufficient. Brooke will check these issues with Renee Trosky, Network Services' manager of Provider Relations Network Compliance. Anna noted that perhaps some of the strict language in our Behavioral Health policies should be incorporated herein: there is no indication in this policy that "delegation" refers to Carelon and not to Partnership. In response to a question, Brooke noted that Licensed Vocational Nurses (LVN) and Registered Nurse (RN) are added to the practitioners affected by this policy only for Wellness and Recovery services. **Dr. Moore returned the policy to Network Services for more work. It is not approved to advance to March 12 Credentials Committee.**	Motion to **approve as presented but for the three pulled policies:** Nancy Steffen Second: Isaac Brown Next Steps: Health Services policies will go to the March 19 Quality/Utilization Advisory Committee (Q/UAC) and the April 9 Physician Advisory Committee (PAC) MC305 ends with Edna Villasenor. MPCR302 is returned to Network Services for more work. MPCR303 is approved as amended: Anna Campbell Second: Kermit Jones, MD, JD MPCR400 is approved as amended: Leigha Andrews Second: Marshall Kubota, MD *Meeting Postscript:* All Credentialing policies passed the Credentials Committee on March 12.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Anna **pulled MPCR303**, asking if this policy is not Network Services, rather than Provider Relations. Brooke said all credentialing policies are transferring from Provider Relations to Network Services as part of the department's (2024) reorganization. Anna noted that policy Reference B having to do with the National Committee for Quality Assurance (NCQA) should also contain mention of "Factor 7." This and the policy header will be fixed. Anna **pulled MPCR400** with security questions: are we now using Docu-sign? Brooke said we are not. Anna also corrected the References: "Element C" no longer exists; the proper citation is NCQA 2025 CR1, Elements A&B.	
IV. New Business – Discussion Policies		
Policy Owner: Care Coordination – *Presenter: Shannon Boyle, RN, Manager, Care Coordination Regulatory Performance*		
MCCP2024 – Whole Child Model for California Children's Services (CCS)	**Policy edits due to Department of Health Care Services (DHCS) All Plan Letter (APL) 24-015, which supersedes APL 23-034** **Related Policies Added:** MCCP2035- Local Health Department (LHD) Coordination MCUP3104- Transplant Authorization Process MCCP2025- Pediatric Quality Committee Policy MCUP3037- Appeals of Utilization Management/ Pharmacy Decisions CGA024- Medi-Cal Member Grievance System MCUG3058- Utilization Review Guidelines ICF/DD, ICF/DD-H, ICF/DD-N Facilities **Updated:** MCUP3143 updated to reflect new policy number MCAP7001- CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS) **Removed:** MPCP2002- California Children Services (policy archived) **Definitions Added:** ICF/DD: Intermediate Care Facilities for the Developmentally Disabled ICF/DD-H: Intermediate Care Facilities for the Developmentally Disabled/Habilitative ICF/DD-N: Intermediate Care Facilities for the Developmentally Disabled/Nursing Newly Eligible WCM members Newly Transferred WCM members Receiving County Sending County **Attachments Added:** B. FAC Charter **Purpose updated and removed:** The counties included due to WCM now covering all counties **VI. Policy/Procedure Updated:** **A. CCS Program Eligibility Added:** A.1.b. Partnership provides services to WCM members with other health coverage, with full scope Medi-Cal as the payor of last resort A.2.e. added referral source: Medical Therapy Conference (MTC) referral	Motion to **approve as presented**: Lisa O'Connell Second: Anna Campbell Next Steps: March 19 Q/UAC Discussion April 9 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	A.3. Partnership will refer all members who demonstrate a potential CCS-Eligible Condition(s) or if a WCM member develops a new potential CCS-Eligible Condition as soon as possible to the county CCS Program A.4. Partnership will refer NICU, HRIF, and MTP members with potential CCS eligible conditions to the County CCS Program for review and determination of eligibility services A.5. Partnership will provide available necessary documentation received or retrieved by Partnership's case management or utilization management staff, or assist Network Providers in referring with necessary documentation A.6. Annual Medical Redetermination, Partnership will receive a list from the counties a minimum of 120 days in advance of the eligibility date. Partnership will make outreach attempts to obtain medical records, as well as take appropriate action if medical records recovery is unsuccessful. **B. Utilization Management** B.6. Partnership is required to cover all medically necessary blood, tissue, and solid organ transplants for WCM members. Refer to policy MCUP3104 Transplant Authorization Process for more details B.7. Partnership will conduct, at least quarterly reviews of their inpatient utilization data to assess whether all potential WCM members have been appropriately referred to the County CCS program. **C. Case Management and Care Coordination** C.1. Added: Members may decline Case Management services without impact to their enrollment and/or participation in the WCM Program C.3. Amended: new pediatric members, newly CCS-eligible members, or WCM transition members within 45 days of the County CCS program eligibility determination for newly eligible WCM members and newly transferred WCM members C.3.c.1). High Risk: C.3.c.1.b) amended: Members without available medical utilization data, claims data, or other assessments and/or survey information available C.3.c.1.e) Newly CCS-eligible members C.3.c.1.f) New CCS Members enrolled in Partnership C.4.a. updated licensed staff to Care Coordination staff and added to assist in the development of member's ICP C.4.b. added: to be Low Risk to identify the member's health care needs C.5.c. added: ICP for members determined to be high risk based on the results of the risk assessment process will be established within 90 calendar days of a completed risk assessment survey or other assessment by telephonic and/or in-person communication. However, if a member's family declines having an ICP developed, Partnership will notate the denial in the member's medical record as evidence of compliance. C.5.c.2) added: services including but not limited to palliative care C.5.d added: For members transitioning into the WCM Program from Classes CCS Programs, Partnership will complete the PRSP within 45 calendar days of transition to determine each member's risk level C.5.f. added: Partnership will provide information on what community resources exist for members to utilize via member's preferred method of communication or by telephone. The Partnership External Website which includes the Partnership's Community Resources pages has information readily available for the members. C.5.g. Updated to MCAP7001 C.10. added: Care Coordination plan will be developed at least 12 calendar months before the member ages out. Partnership will monitor the WCM member for at least 36 calendar months following age out of the WCM Program, to the extent feasible	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	C.11. added: A pediatric phase-out occurs when a treating CCS-paneled Provider determines that their services are no longer beneficial or appropriate to the treatment of the WCM member. Partnership will provide Care Coordination to WCM Members in need of an adult Provider when the WCM member no longer requires the services of a pediatric Provider. **D. Inter-County Transfer (ICT) Added:** Partnership and the County CCS program will collaborate to facilitate the exchange of ICT data to ensure that the CCS WCM member who relocates to another county can effectively transfer their CCS benefits without interruption, including the provision of continuation of services and the transfer of the current service authorization request. **F. Continuity of Care for WCM Implementation Added:** Partnership will be able to initiate, accept, and process COC requests from transitioning members, providers, and authorized representatives beginning 60 calendar days prior to the transition date. For further details regarding COC, refer to policy MCCP2014 Continuity of Care. **G. Partnership and CCS County Coordination Updated:** 2. Partnership and County CCS programs will coordinate the delivery of CCS services to CCS-eligible members to prevent duplication of services. Partnership and each WCM CCS county shall execute a Memorandum of Understanding (MOU) outlining respective responsibilities and obligations under the WCM, refer to APL 23-029 Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans and Third-Party Entities and Template for Memorandum of Understanding between [MCP] Medi-Cal Managed Care Plans and [County] California Children's Services (CCS) Whole Child Model Program for more details. 5. Partnership coordinates with Regional Centers and ICF/DD, ICF/DD-H, and ICF/DD-N to ensure members who are individuals with developmental disabilities receive all medically necessary covered services per APL 23-023 Revised. 6. Partnership ensures that members living in ICF/DD Homes have access to a comprehensive set of services based on their needs and preferences across the continuum of care **H. Advisory Committees Added:** Partnership meets quarterly with a Clinical Advisory Committee for more details refer to policy MCCP2025 Pediatric Quality Committee. Family Advisory Committee (FAC) for CCS families composed of a diverse group of families that represent a range of conditions, disabilities, and demographics. Partnership representatives meet quarterly with the WCM Program stakeholder advisory group composed of representatives of CCS providers, County CCS Program administrators, health plans, family resource centers, regional centers, recognized exclusive representatives of County CCS providers, CCS case managers, CCS MTUs, and representatives from Family Advisory Committees. **I. CCS Liaison Added:** Partnership designates one individual as the point of contact for the MOU and the coordination of services between Partnership and County CCS Programs who has the knowledge and adequate training on the CCS Program and clinical experience with either the CCS Population or pediatric patients with complex medical conditions. **J. Dispute Resolution and Provider Grievances Added:** Medical eligibility determination disputes between Partnership and the County CCS Program will be resolved by the County CCS Program. If other disputes arise between Partnership and the County CCS Program, all parties will fulfill their responsibilities in alignment with DHCS policies, including APL, NL, MCP Contract and WCM MOU, without delay. Partnership will have a formal process to accept, acknowledge, and resolve Provider disputes and grievances. **K. Grievance, Appeal, and State Hearing Added:**	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Partnership will ensure that all members are provided information on Grievances, Appeals, and State Hearing rights and processes. All WCM members will be provided the same Grievance, Appeal, and State Hearing rights as other Partnership members. **References: Updated** - DHCS All Plan Letter (APL) 24-015 California Children's Services Whole Child Model Program (12/02/2024) **References: Added** - DHCS APL 23-029 - Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans and Third-Party Entities (10/11/2023) - Template for Memorandum of Understanding between [MCP] Medi-Cal Managed Care Plans and [County] California Children's Services (CCS) Whole Child Model Program (07/2024) - DHCS APL 23-023 Intermediate Care Facilities for Individuals with Developmental Disabilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care (*Revised* 11/28/2023) - DHCS APL 25-005 Standards for Determining Threshold Languages, Nondiscrimination Requirements and Language Assistance Services (02/12/2025) - DHCS APL 21-011 Grievance and Appeal Requirements, Notice and "Your Rights" Template (08/31/2022) - DHCS All Plan Letter 23-022: Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-For-Service, on or After January 1, 2023 (08/15/2023) - CCS NL 05-0502 Medical Eligibility for Care in a CCS Approved Neonatal Intensive Care Unit (NICU) (05/01/2002) - CCS NL 10-1123 CCS Intercounty Transfer Policy (11/1/2023) Attachment 1: Intercounty Transfer Process Flowchart Attachment 2: Intercounty Transfer Frequently Asked Questions Attachment 3: CCS Intercounty Transfer Check List Attachment 4: CCS Whole Child Model Intercounty Transfer Check List - CCS Medical Eligibility Guide - CCS NL 10-1224 California Children's Services Whole Child Model Program (*Revised* 12/02/2024) Attachment A: CCS Case Management Core Activities Before presenting the above synopsis of changes, Shannon mentioned that we are still waiting on DHCS to approve or send an Additional Information Request (AIR) for the APL and WCM.0029. There were no questions. Dr. Moore said the State really scrutinizes this policy, and he thanked everyone involved for their diligent hard work on this update.	
Policy Owner: Pharmacy – *Presenter: Stan Leung, Pharm.D, Director of Pharmacy Services*		
MPRP4034 – Pharmaceutical Patient Safety	**This policy now includes regulations for the Partnership Advantage D-SNP (Dual Special Needs Plan) Medicare line of business that will be effective Jan. 1, 2026 in eight Partnership counties.** **Definitions added** for Class I, II Recall and Partnership Advantage **Section VI.A.1.** Identify and notify practitioners and members of product withdrawals, which include voluntary withdrawals by the manufacturer or those under FDA requirement, for patient safety reasons or other reasons on a case-by-case basis **Section VI.B.2.** Removed Class III recalls as these do not require notification by NCQA. Added Medicare Part D Medications: When a drug is withdrawn from the market due to patient safety reasons, Partnership identifies those	Motion to **approve as presented**: Stan Leung, Pharm.D Second: Lisa O'Connell Next Steps: April 10 P&T (Pharmacy & Therapeutics Committee) May 14 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	members who have recently received a drug and those practitioners who have prescribed the drug. The members and practitioners are then both notified by mail for the drug withdrawal within thirty calendar days of FDA notification. **Section VI.C.1**. Physician-Administered Drug (PAD): When a drug in its entirety is withdrawn from the market due to patient safety reasons, Partnership provides notification to members and practitioners within 5 working days of FDA notification. **Section VI.C.2** Medicare Part D Medications: When a drug is withdrawn from the market due to patient safety reasons, Partnership identifies those members who have recently received the drug and those practitioners who prescribed the drug. The members and practitioners are then both notified by mail of the drug withdrawal within 5 working days of the FDA notification. **References:** Added Food and Drug Administration (FDA) Enforcement Reports at www.fda.gov Stan said this policy update principally addresses coming Medicare requirements under Partnership Advantage. Presently, under Medi-Cal, we only notify practitioners of drug recalls; however, under Partnership Advantage, we will do more notifications when a drug recall is imminent and before it is completely withdrawn from the market for patient safety reasons. There were no questions.	
MPRP4065 – Drug Utilization Review (DUR) Program	**Formerly MCRP4065, the alphanumeric is changing to "MP" as this policy now includes regulations for the Partnership Advantage D-SNP line of business that will be effective Jan. 1, 2026.** **Definitions added** for Partnership Advantage as CMS approved Dual-Eligible Special Needs Plan (D-SNP) and for PBM-A third party entity that manages prescription drug benefits for health plans. **Section IV.A.** Partnership DUR program meets both Medi-Cal and Medicare requirements **Section IV B.** Partnership Advantage Part D Quality Assurance Program in conjunction with delegate's system and policies and procedures require network providers to comply with minimum standards for pharmacy practice as established by the State, comply with Concurrent DUR and Retrospective DUR systems, policies and procedures requirements, identify and reduce internal medication errors, and provision of information to CMS regarding quality assurance measures and systems according to CMS guidelines **Section IV C.** Partnership delegates Medicare pharmacy functions to PBM and shall report results of oversight audits to Partnership's Delegation Oversight Review Sub-Committee. **References added** for Title 42 Chapter IV Subchapter B Part 423 Subpart D Stan noted that policy sections VI.B & C were somehow missing from the published IQI packet. The complete policy was emailed this morning (March 11) to IQI voters and invitees. There were no questions. *Those missing sections follow:* **B.** Partnership Advantage Part D Quality Assurance Program, in conjunction with delegated PBM's systems, policies and procedures, includes the following: 1. Representation that network providers are required to comply with minimum standards for pharmacy practice as established by the States. 2. Concurrent drug utilization review systems, policies, and procedures designed to ensure that a review of the prescribed drug therapy is performed before each prescription is dispensed to an enrollee in a sponsor's Part D plan, typically at the point-of-sale or point of distribution. The review must include, but not be limited to, a. Screening for potential drug therapy problems due to therapeutic duplication	Motion to **approve as presented**: Stan Leung, Pharm.D Second: Kermit Jones, MD, JD Next Steps: April 10 P&T May 14 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	b. Age/gender-related contraindications c. Over-utilization and under-utilization d. Drug-drug interactions e. Incorrect drug dosage or duration of drug therapy f. Drug-allergy contraindications g. Clinical abuse/misuse 3. Retrospective drug utilization review systems, policies, and procedures designed to ensure ongoing periodic examination of claims data and other records, through computerized drug claims processing and information retrieval systems, in order to identify patterns of inappropriate or medically unnecessary care among enrollees in a sponsor's Part D plan, or associated with specific drugs or groups of drugs. 4. Internal medication error identification and reduction systems. 5. Provision of information to CMS regarding its quality assurance measures and systems according to guidelines specified by CMS. C. Delegation Oversight and Monitoring 1. Partnership delegates Medicare pharmacy functions to a pharmacy benefits manager. 2. A formal agreement is maintained and inclusive of all delegated functions. 3. Oversight/Regular monitoring activities include, but are not limited to, an audit conducted no less than annually. 4. Results from the annual delegation oversight audit shall be presented to Partnership's Delegation Oversight Review Sub-Committee (DORS) for review and approval and reviewed by the Chief Medical Officer (CMO) or physician designee.	
Policy Owner: Utilization Management – *Presenter: Lisa Ward, MD, Regional Medical Director (Southwest)*		
MPUG3002 – Acupuncture Services Guidelines	**Formerly MCUG3002, the alphanumeric is updated as this policy now includes regulations for the Partnership Advantage D-SNP line of business that will be effective Jan. 1, 2026.** **Section III.A**. **and D**. Definitions of Direct Member and Partnership Advantage Member were added. **Section VI.A** Updated introduction to specify that acupuncture services are a Partnership benefit for Members who meet Medi-Cal and/or Medicare medical necessity guidelines as applicable. **Section VI.B.** This section was reorganized but not changed. **Section VI.C.** In this section we bifurcated authorization guidelines for differences between Medi-Cal and Partnership Advantage (D-SNP) lines of business. **Section VI.D.** Updated to specify that Providers who render acupuncture services should be enrolled in the applicable Medi-Cal or Medicare program. **Section VII.D.** Added Reference for Medicare Guidelines for acupuncture Dr. Ward noted that this is her first policy review in her new capacity as the Southwest's (Marin and Sonoma counties) Regional Medical Director. She thanked Anna Campbell for her help. Dr. Moore commented that this policy now notes some Treatment Authorization Requests (TARs) requirements under Medicare that are not required under Medi-Cal. There were no questions.	Motion to **approve as presented**: Anna Campbell Second: Brigid Gast, RN Next Steps: March 19 Q/UAC Discussion April 9 PAC
Policy Owner: Utilization Management – *Presenter: Anna Campbell, UM Policy Analyst*		

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
MPUP3018 – Health Services Review of Observation Code Billing	**This policy was updated to correct outdated code references and to include regulations for the Partnership Advantage D-SNP line of business that will be effective Jan. 1, 2026.** **Section III. C**. Definition of Partnership Advantage Member was added. **Section VI.E.1.b.** Clarification added that observation code Z7514 can be billed "by the facility." **Section VI.E.2**. Code specified for labor checks was changed from S4005 to 99221. Language referencing "contracted hospitals" as removed. Clarification was added that code 99221 is payable to clinicians. **Section VI.E.3**. Removed language referring to hospitals "contracted with PHC." **Section VI.E.3.d.** Removed paragraph describing codes to be used by non-contracted hospitals for labor checks. Instead, viewers will refer to VI.E.2. where we specified code 99221 for labor checks and removed language about whether or not the hospital is contracted. **Section VII.C.** Added Reference for Medicare Guidelines Anna said primary changes had to do with updating some codes and deleting others altogether. Configuration needs to be involved. It is possible that a Medicare member might be pregnant,so this policy will apply to both Medi-Cal and Partnership Advantage. There were no questions.	Motion to **approve as presented**: Stan Leung, Pharm.D Second: Brigid Gast, RN Next Steps: March 19 Q/UAC Discussion April 9 PAC
Policy Owner: Transportation		
MPTP2503 – Transportation - Related Travel Expenses: Lodging, Meals, Attendants, Parking and Tolls	**Formerly MCCP2030 under the auspices of Care Coordination, this policy is now transferring to Transportation. It retains the same title as it becomes MPTP2503. The old Care Coordination policy is now archived, effective April 9, 2025.** **This policy, once approved April 9 at PAC, may be found externally in the Providers' Manual new Section 7: Transportation.** **III.D added:** Partnership Advantage: Effective Jan. 1, 2026, Partnership HealthPlan of California will operate a Centers for Medicare & Medicaid Services (CMS)-approved Dual-Eligible Special Needs Plan (D-SNP) in specific counties as described in the Department of Health Care Services (DHCS) CalAIM Dual Eligible Special Needs Plan Policy Guide. This line of business will be known as Partnership Advantage and will be a Medicare Advantage plan offered to all full-benefit, dual-eligible beneficiaries 21 years of age or older who reside in the applicable counties. Partnership Advantage Members will be qualified to receive both Medi-Cal and Medicare services as described in the Partnership Advantage Member Handbook. **References Updated:** DHCS APL 24-015 supersedes former Whole Child Model citations. **Position Responsible for Implementing Procedure updated:** This policy is now the responsibility of the Director of Transportation Services. *MCCP2016 and MCCP2029 approved at PAC Jan. 8, 2025 will make the same transition from Care Coordination to Transportation later this year as MCTP2501 (or MPTP2501) and MCTP2502 (or MPTP2502), respectively, once reviewed for Medicare applicability.* This policy was not presented as scheduled. Since the changes are minor, Dr. Moore directed that the policy be on for consent, rather than discussion, at Q/UAC March 19.	Motion to **approve as updated**: Anna Campbell Second: Brigid Gast, RN Next Steps: March 19 Q/UAC Consent Calendar April 9 PAC
V. Presentations		

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
1. QI Update *Nancy Steffen, Senior Director, Quality Improvement and Performance*	• We are now at the end of the preliminary reporting period for the Primary Care Provider Quality Incentive Program (PCP QIP) and are accounting for lagging clinical claims data. The 2025 eReports has been launched, and providers may therein find their gap lists on clinical measures. • Eureka-based pediatrician and Partnership Associate Medical Director Teresa Frankovich, MD, at noon Thursday, April 3, will host a webinar aimed at educating providers on developmental screening tools and CPT codes. • We are now in work planning for our annual Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys, including our "drill-down" survey. Although we do not administer our members' dental benefits, we do recognize their frustration here. Partnership is collaborating with other stakeholders in "Smile California," an effort to educate and inform Medi-Cal members about the difference between their managed care plan services and State (carve-out) covered benefits. There are opportunities here to enhance rural health and to engage on a county level with dental fluoride treatments. • The QI Locum Pilot developed as a short-term solution to improve preventive care access for members specifically in well-child visits and cervical cancer screenings has been a success. Discussions are underway to extend some minimum contracts as we are just beginning to see results with some providers.	*For information only. No action is required.* There were no questions.
2. Cultural & Linguistic (C&L) Grand Analysis • MCND9002 – C&L Program Description • 2024 Program Evaluation • Final Update of the 2024 C&L/QIHEPT Work Plan • 2025 C&L/QIHEPT Work Plan *Hannah O'Leary, MPH, CHES, Manager of Population Health*	Hannah began by saying the C&L Program Description was looked at in November 2024 and is coming back today for an update to APL 25-005. (The presentation today marks the first time Partnership has conducted a C&L Grand Analysis, or "trilogy" review such as what Care Coordination does each February and Quality Improvement does each August.) **This update moves MCND9002 to a new annual approval schedule targeting the April Physician Advisory Committee (PAC), and includes revisions to continue alignment with NCQA Health Equity requirements. Some highlights follow:** • Added language as suggested by Partnership's NCQA consultant. • Updated references from APL 21-004 to the new APL 25-005, and added choice language from the new APL into the policy, including updated language defining a qualified interpreter. • Added Punjabi as a new threshold language. • Added details around our notices to LEP members, including the updated Notice of Availability of Language Assistance and processes around translations. • Updated details on Diversity, Equity, and Inclusion (DEI) trainings and program for Partnership staff, network providers, subcontractors, and downstream contractors. • Added a short section describing the new Cultural and Linguistic Program Evaluation, an annual evaluation being reviewed by IQI for the first time this month. • Updated description and responsibilities of the Quality Improvement and Health Equity Committee (QIHEC), per recent draft APL. • Updated description and responsibilities of the Consumer[1] Advisory Committee (CAC) and Family Advisory Committee (FAC).	Motion to **approve both the Program Description and the Grand Analysis as a whole as amended today for March 19 Q/UAC**: Nancy Steffen Second: Anna Campbell Next Steps: March 19 Q/UAC April 9 PAC

[1] Per DHCS directive, Partnership's Board of Commissioners on Feb. 26 agreed to substitute "Community" for "Consumer" in the CAC Charter. The present and future-facing C&L Trilogy components will be updated accordingly before March 19 Q/UAC, while any 2024 Evaluation reference will retain the former title.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	• Updated with current 2025 goals, as seen on the C&L/QIHETP (Quality Improvement and Health Equity Transformation Program) Work Plan. • Updated all diagrams • Added or updated hyperlinked footnotes (APL 25-005 hyperlink to be updated once it is live on DHCS's website). **Updating Attachment C:** Threshold and Concentration Languages for All Counties • Updating to the most current version from DHCS. **Archiving Attachment F:** The FAC (Family Advisory Committee) Charter is removed from this policy, and now becomes Care Coordination's MCCP2024 new Attachment B. Anna Campbell questioned some references to non discrimination and to Telehealth. Dr. Moore said he didn't believe Telehealth is a protected class and he recommended that Compliance be consulted. Anna also asked what is a "Patient Decision Support Tool"? Dr. Moore directed Hannah to remove these areas of concern from the policy document and resubmit it for March 19 Q/UAC. There were no other questions on MCND9002 itself. Hannah then presented the 2024 C&L Program Evaluation, which considers services and resources as outlined by the 2024 program description and the achievement of attendant 2024 work plan goals. The intent of this report is to show how Partnership is meeting member needs. This Evaluation will undergo some minor changes re staffing before it is presented to Q/UAC March 19. At Dr. Moore's request, the program findings page also will be updated to include 2023 figures, which will show how translation requests and interpreter calls each approximately doubled in 2024. QIHEC met five times in 2024 and CAC four times. CAC has 30 members, and we are recruiting more. Population Health's Health Education team reviews discrimination cases: we are hiring health equity staff to support this and DEI regulatory requirements. There were five 2024 work plan goals; the 2025 Work Plan contains eight similar goals. Year 2024 Goal 1 of initiating and maintaining this C&L/QIHEPT trilogy will be met as needed for NCQA Health Equity Accreditation Initial Survey (June 2025). Bi-lingual persons continue to be hired in Member Services and other departments. Year 2024 Goal 5 – improving blood pressure rates among American Indian/Alaskan Native members by 5% in at least one region – is yet undetermined in part because of HEDIS® (Healthcare Effectiveness Data Information Set) issues. This goal is amended as it continues in 2025. The first two goals for 2025 are new: by June 30, 2025, develop and propose a multi-year health equity strategic and tactical plan, and, by Dec. 31, 2025, distribute the DEI training to the provider network and Partnership staff and submit the final version to DHCS. These goals align with our NCQA HEQ Initial Survey. Nancy Steffen asked if HEDIS® performance will be used to ascertain whether we meet the 2025 goals which seek to redress health disparities among ethnic and racial groups. Hannah said yes. Nancy said that this then will feed up into the Health Equity Grand Analysis. (IQI and Q/UAC will hear this Analysis in October.) The HEDIS® team is now making changes as to how our data rolls up. Anna wondered if MCND9002's list of "member-facing departments" should be amended to include Behavioral Health as that department will be taking phone calls and talking to members after Partnership "de-delegates" Carelon this summer. Dr. Moore and Hannah agreed to include this addition in the 2026 policy update.	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
FYI Disseminations		
Mid-Year 2024-2025 QI Work Plan Update – *refer questions to Nancy Steffen*		
Dental Code Flyer as promised at Feb. 19 Q/UAC – *refer questions to dentalsupport@partnershiphp.org*		
VI. Adjournment		
Dr. Moore adjourned the meeting at 2:51 p.m. IQI will meet next on Tuesday, April 8, 2025.		
Respectfully Submitted by Leslie Erickson, Program Coordinator II, Quality Improvement *Approval Signature:* *Date:* *Robert Moore, MD, MPH, MBA* *Chief Medical Officer and Committee Chair*		

4665 Business Center Drive
Fairfield, California 94534

MEETING Minutes

Meeting & Project Name: Quality Improvement & Health Equity Committee (QIHEC)

Date: 3/18/2025 **Time**: 7:30 a.m.- 9:30 a.m.

Facilitator: Mohamed Jalloh, HEO

Coordinator: Bethany Hannah

Meeting Locations:

- WebEx

Attendees:

Shannon Boyle, Isaac Brown, Monika Brunkal, Anna Campbell, Kristina Coester, Dawn Cook, Nicole Curreri, James Devan, Jeffery DeVido, Heather Esget, Margarita Garcia-Hernandez, Kristine Gual, Bethany Hannah, Tony Hightower, Mohamed Jalloh, Amanda Kim, Mary Kerlin, Marshall Kubota, Yolanda Latham, Sue Lee, Stan Leung, Amanda McNair, Robert Moore, Mark Netherda, Rachel Newman, Hannah O'Leary, Sue Quichocho, Manleen Randhawa, Denise Rivera, Liz Romero, Delorian Ruffin, Anthony Sacket, Rebecca Stark, Wendy Starr, Nancy Steffen, Amanda Smith, Christine Smith, Ben Spencer, Chloe Ungaro, Vicquita Velazquez, Edna Villasenor, Emily Wellander, Kory Watkins

Absent: Priscilla Ayala, Katherine Barresi, Robert Bides, Sonja Bjork, Mark Bontrager, Cathryn Couch, Wendi Davis, Noemi Doohan, Greg Allen Friedman, Shandi Fuller, Brigid Gast, Ledra Guillory, Nisha Gupta, Latrice Innes, Vicky Klakken, Rachel Newman, Katheryn Power, Dorian Roberts, Lynn Scuri, Tim Sharp, Stephen Stake, Amy Turnipseed, Liat Vaisenberg

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External Advisory Members

Name	Affiliation	Org Type	1/21/25	3/18/25	5/20/25	7/15/25	9/16/25	11/18/25
Jason Cunningham, MD Chief Executive Officer	West County Health Centers	FQHC		X				
Eugene Durrah Equity Services Manager	Solano County	County						
Suzanne Edison-Ton, MD Chief Medical Officer	Communicare+ Ole	FQHC						
Hendry Ton, MD Associate Vice Chancellor	UC Davis	Health System		X				
Shandi Fuller, MD Maternal Child and Adolescent Health	Solano County	Public Health Department						
Lisa Wada Senior Manager, Quality Improvement	Providence	Health System	X					
Valerie Padilla Director of Quality and Patient Safety	Open Door Community Health	Health System		X				
Arlene Pena Senior Program of Quality Improvement	Aliados Health	Community Based Org	X	X				
Jeremy Plumb Systems Director, Quality Division	Northbay Medical Center	Hospital	X	X				
Lelia Romero Health Program Specialist - Health Equity	Lake County	Public Health Department		X				
Robin Schurig, MPH, CPH Executive Director	Health Alliance of Northern California	Community Based Org	X	X				

Candi Stockton, MD Health Officer of Humboldt County	Humboldt County	Public Health Department	X					
Tiffani Thomas Case Manager	Solano County Superior Court	Local Government	X	X				
Brandon Thornock Chief Executive Officer	Shasta Community Health Center	Health System	X					
Denise Whitsett Quality Improvement Coordinator	Community Medical Centers	Health System	X	X				

***FQHC= Federally Qualified Health Center

*****Members who do not attend at least half of meetings will be considered for removal per vote of committee.

Agenda Topic	Notes	Action Item
Agenda Item 1 **Introductions**	A. Dr. Jalloh conducted a roll call for external advisory members to mark their attendance. B. Quorum was met by having 9 members present.	
Agenda Item 2 **HE Updates** Speaker: Dr. Jalloh	A. Dr. Jalloh assures the committee that we will be proceeding as usual based on the contract deliverables mandated by the state for Health Equity since we will be held accountable if we do not per the current CA state policies B. Partnership has a new incentive program for Quality Improvement where we are giving health systems bonuses for closing gaps for specific disparities such as well care visits, breast cancer screenings, colorectal cancer screenings, or controlling blood pressure. We are not targeting one specific race group, we are letting health systems determine which group to focus on, based on the data that we will be providing to them C. Dr. Jalloh asked the committee to please let us know if their health system or if they hear of a health system that may be interested so that we can reach out to QIP@partnershiphp.org and see if they are eligible. D. There is an alternative health equity measure where if a unit of service measure and the payout is $2000.	

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Agenda Topic	Notes	Action Item
Agenda Item 3 **Meeting Minutes** Speaker: Dr. Jalloh	A. Motion to approve meeting minutes from November and January. 1st Arlene Pena 2nd Valerie Padia	Motion to approve meeting minutes from November and January. 1st Arlene Pena 2nd Valerie Padia
Agenda Item 4 **CMO Health Plan Updates** Speaker: Dr. Moore	State Level Policy Updates: A. Dr. Moore attended the American Academy of Family Physicians in Sacramento recently and there was a lot of concern about the state budget this year. B. Shortfalls noted in the Cal State university system and the University of California system which have been exacerbated by the NIH policy about covering indirect expenses for the NIH research dollars. C. In addition, there was some press about the state borrowing up to its maximum to cover its current Medicaid expenses. D. This is a year where the state will be looking at budget cuts, California by law is required to pass a balanced budget Federal Level Policy Updates: A. Extended telemedicine flexibility and FQHC funding up until Septembers 1st. B. Plans for massive spending cuts which include Medicaid cuts. Community Activities: A. 2nd annual Physician residency program performance improvement program where 6 residents did a presentation on their quality projects and 3 were selected as the best and were given an award. B. Activities related to promoting rural obstetric access and quality, a conference was conducted addressing challenges in prenatal care that was led by Dr. Townsend, and it went well. There were representatives from the Surgeon General's office talking about maternal mortality, there were a couple of talks on diabetes and pregnancy as well as an excellent talk on substance abuse screening options in pregnancy.	

Agenda Topic	Notes	Action Item
	C. A bill we are interested in moving forward on which is to help support hospitals to have a standby perinatal unit which is getting good support, we anticipate this bill will move forward. D. Partnership has been expanding life support and obstetric trainings coming up in May which are mostly full. E. Six regional director meetings starting on Friday in Eureka, and if there is any interest in attending, please contact Dr. Moore.	
Agenda Item 6 **CA Association Updates** Speaker: Arlene Pena and Robin Schurig	A. Arlene Pena mentioned that they are continuing to operate as usual with contracted initiatives, receiving guidance from funders, and making adjustments as needed. B. She highlighted the ongoing work with Salano County, particularly through a monthly improvement workgroup meeting with health centers in the county. In February, they began developing a Venn diagram to identify priorities and align the efforts of different organizations, focusing on well-child visits for children aged 0-15 months and 15-30 months. A shared aim statement was created for the group to guide their work. Several health initiatives are underway in Salano County: • The Community Health Worker (CHW) Initiative aims to provide outreach and education to hard-to-reach populations in Salano County, led by their population health team. • The Salano-Sonoma County HEALS initiative is ongoing and will continue through 2025. • The Doula Doula Initiative trains and certifies community members as doulas to support African American and Black women with informed birthing. It also includes an eight-month program to support pregnant individuals in a group setting focused on their childbirth experience. • The Health Informatics Team is working on setting up data systems to support the new 2025 Quality Improvement Program (QIP) measures and targets, including the new well-child check-ups for ages 0-30 months. Dashboards to track well-child visits are also being developed.	

Agenda Topic	Notes	Action Item
	• In February, the medical directors and chief medical officers met, as part of their bi-monthly schedule, to review and approve evidence-based clinical guidelines. During the meeting, they reviewed and approved the new breast cancer screening guidelines from the U.S. Preventive Services Task Force and updated pediatric immunization guidelines. These updated guidelines are now posted on their website. • The Social Drivers of Health (SDOH) Workgroup continues to meet to improve demographic data collection at health centers, adjusting to different funding guidance as needed. A new SDOH dashboard is being developed to help health centers stratify and analyze data to meet their specific needs. Progress is being made, with improvement in SDOH screening rates across health centers. • Robin Schurig announced that starting in May, the Director of Data and Technology from Health Alliances, Gabe Decker, will attend QIHEC meetings to provide data analysis updates. • Gabe handles data analysis for the Health Alliance of Northern California, the North Coast Clinics Network, and 15-member health centers across both consortia. • His ongoing work includes creating annual organizational profiles, developing quarterly regional dashboards, and preparing health equity supplemental dashboards, which are shared annually. • Gabe will report on the health equity dashboard and discuss disparities identified in the data. • Every other month, Quality Improvement (QI) peer networks meet to share best practices and challenges, with a focus on addressing disparities. • Gabe's contact information will be sent to Bethany to add him to the email list.	

Agenda Topic	Notes	Action Item
Agenda Item 7 **Grand Analysis:** Speaker: Hannah O'Leary	Hannah O'Leary gave a presentation on the Population Needs Assessment (PNA), which is written to meet regulatory requirements and provides a detailed report on the needs of partnerships' members. A. The PNA uses data from a variety of sources to assess the needs, and findings are grouped into categories based on the Healthy People 2030 domains of social determinants of health. B. Key findings include: • Economic stability: High poverty rates, food insecurity, economic instability, and disparities in access to social services. • Health care access and quality: Provider shortages, insufficient healthcare access, high rates of substance use disorder, mental health issues, chronic diseases, and unintentional injuries. • Neighborhood and built environment: Geographic isolation, lack of affordable housing, fire threats, and transportation challenges. • Education access and quality: Low education attainment and limited internet access. • Social and community context: High rates of adverse childhood experiences (ACEs), need for fostering community connections, and support for healthcare system navigation. C. Additional findings from other data sources include concerns about access to care, provider shortages, behavioral health issues, food insecurity, and income inequality. D. Disparities in health outcomes are pronounced among marginalized groups, particularly related to transportation, which complicates access to care in remote areas. E. Top chronic conditions in the adult population include hypertension, depression, and tobacco use, while among the pediatric population, anxiety, trauma stress, and depression are the leading conditions.	

Agenda Topic	Notes	Action Item
	F. In 2023, there was an increase in substance use disorder diagnoses, and mental health visits were highest among the white population. G. Breast cancer and cervical cancer screening rates in northern counties continue to underperform. H. The report also highlighted health disparities related to specific clinical measures, including high blood pressure, diabetes control, and prenatal care visits. I. The actions taken by the partnership to address identified needs are categorized into organizational structure, social and environmental needs, member health and wellness, access to care, health disparities, health education and cultural linguistics. J. Key actions include: • Hiring two regional directors for the eastern and southwestern regions. • Building relationships with community partners and local health jurisdictions to support community health assessments and improvement plans. • CalAIM Incentive Payment Program – was able to offer grant funding to address housing concerns • Awarding over $52 million in grants to for programs such as Enhanced Care Management and Community support services • Expanding workforce opportunities, including scholarships focused on healthcare and social work. • Supporting health education programs like asthma outreach, tobacco prevention, and mobile mammography services. • Recruiting and retaining healthcare professionals through a provider recruitment program. • Strengthening efforts to reduce disparities, especially for American Indian populations and postnatal care access. • Developing interactive health education videos on preventive care, vaccine safety, and mental health. • Member services offering community informational sessions in both English and Spanish to support members transitioning to the partnership.	

Agenda Topic	Notes	Action Item
	• Report will be posted online toward the end of June and is currently in draft form. Hannah O'Leary gave an overview of the Cultural and Linguistics Trilogy documents and their background. She shares Key Findings from the 2024 CNL Program Evaluation: 1. Translation Services: o Over 1,100 translation requests were fulfilled in 2024, nearly double the number from 2023. o Of these requests, 800 were completed on time, and one was late. 2. Interpreter Services: o Over 320,000 interpreter calls were made in 2024, a significant increase from the 133,000 calls in 2023. 3. Alternative Formats: o 689 requests for alternative formats (audio CDs, large font, braille) were fulfilled by December 2024, with 2023 seeing higher numbers. However, data was only available from one department, so the actual number might be higher. 4. Language Diversity: o Partnership Health Plan (PHC) members spoke over 32 different languages, with the most common being English, Spanish, Russian, Tagalog, and Pinjabi. 5. Quality Improvement and Health Equity Committee (QIHEC): o Over 35 attendees participated in each of the five QIHEC meetings in 2024. 6. Community Advisory Committee (CAC): o The CAC, made up of 30 members, met quorum in all its quarterly meetings, with seven additional being sought recruitment. 7. Cultural and Linguistics Policy Review:	

Agenda Topic	Notes	Action Item
	○ All CNL policies and reports were reviewed and approved as of December 2024. A new round of approvals is underway for upcoming documents, including the evaluation report. 8. Staffing Support: ○ While there is sufficient CNL staff to support the program, additional staff are needed to support the expanding workload, including the transfer of health equity responsibilities from the health education team to the health equity team. Goals for 2024: 1. Goal 1: Define the framework and process for the 2024 CNL program evaluation and work plan. This goal was delayed but will be met. 2. Goal 2: Submit DEI training to DHCS for review by September 2024. This goal was delayed but ultimately met. 3. Goal 3: Ensure that 90% of members who requested materials in an alternative format receive them. This goal was met by reviewing unfulfilled requests. 4. Goal 4: Increase the number of bilingual member services staff by 1%. This goal was met, with bilingual staff rising from 28 to 31. 5. Goal 5: Improve controlled blood pressure rates among American Indian/Alaska Native members by 5%. The goal's status is still unknown due to delays in data collection. Updated Goals for 2025: 1. Goal 1: Develop a multi-year health equity strategic plan by June 2025. 2. Goal 2: Distribute DEI training to provider networks and MCP staff by December 2025. 3. Goal 3: Ensure 91% of members receive materials in their requested alternative formats by December 2025. 4. Goal 4: Increase bilingual member services staff by 2% to meet a 75% bilingual staff target by December 2025.	

Agenda Topic	Notes	Action Item
	5. Goal 5: Improve controlled blood pressure rates among American Indian/Alaska Native members by 5% in at least two regions by December 2025. 6. Goal 6: Improve timely translations in the utilization management or care coordination departments to 90% by December 2025. 7. Goal 7: Improve prenatal visit rates by 5% in the Eureka/Reading region for American Indian/Alaska Native members by December 2025, with a five-year goal of a 22% improvement. 8. Goal 8: Improve welcome visit rates by 5% for Black, White, and American Indian/Alaska Native members by December 2025. Cultural and Linguistics Program Description: • This document outlines the cultural and linguistic services provided by the organization and is designed to meet both DHCS and NCQA health equity requirements. It includes various services aimed at improving access and addressing health equity concerns among diverse populations. Conclusion: • The 2025 CNL Work Plan and Program Description will drive the 2025 CNL Program Evaluation, which will be reviewed in early 2026.	
Agenda Item 8 **Community Information** Speaker: Dr. Ton	Health Equity Initiatives at UC Davis Health: • Guided by the Office for Health Equity, Diversity, and Inclusion (HeADI). • Focused on creating a welcoming, inclusive community with lifelong learning and health equity. • Serve a large proportion of Medi-Cal patients (around 40% of their patient mix). A. Key Programs: • Gender-affirming care provided across the care continuum.	

Agenda Topic	Notes	Action Item

	• Largest psychiatric provider for inpatient and outpatient services in Sacramento County.
	• Provide primary and specialty care to local Federally Qualified Health Centers (FQHCs).
	• Operate 13 culturally focused student-run clinics, with active faculty volunteer involvement.
	B. Addressing Health Disparities:
	• Identify and focus on four health disparities annually.
	• Current focus areas include:
	  ○ Blood pressure control for African American and Black patients.
	  ○ Hemoglobin and A1C control for Hispanic/Latinx patients.
	  ○ Advanced care planning for limited English-speaking patients.
	  ○ Exclusive milk feeding for newborns, particularly for African American and Black patients.
	• Efforts to reduce disparities showed positive progress, although not all goals have been reached yet.
	C. Community Engagement & Interventions:
	• Collaborated with community-based organizations for outreach, particularly in culturally sensitive education and telephonic outreach.
	• Used health equity advisors and disparity workgroups to guide and implement these initiatives.
	D. Collaboration with Solano County:
	• Conducted a five-year project assessing the needs of underserved communities (Latinx, Filipino, and LGBTQ+ groups) in the mental health system.
	• The project led to a 300% increase in access to care for LGBTQ+ members and a decrease in crisis utilization across all communities involved.
	• The model was successful enough to win a national award and has been used in other counties.	

Agenda Topic	Notes	Action Item
	E. Provider Education and Training: • Held annual symposia on LGBTQ+ health, refugee health, and cultural competency. • Monthly webinars on topics like trauma-informed education, racial equity, and the refugee experience. • Developed micro-modules and more advanced training for clinical staff on inclusion, diversity, and addressing microaggressions. F. Health Equity Leadership & Capacity Building: • Created a health equity leadership development program to educate leaders on health equity-focused decisions. • Developed tools to ensure health equity is considered at every phase of health system projects. G. Social Determinants of Health: • Focused on addressing root causes of health inequities such as poverty, food insecurity, and unemployment through the AIM initiative. • Increased local hiring and procurement to promote economic well-being in underserved communities. H. Healing and Social Rifts: • Established healing circles and a Truth and Racial Healing and Transformation Center to support community healing and collaborative dialogue. • The center helps both community and academic leaders learn restorative practices. I. Feedback & Impact: • Healing circles have helped community members process trauma and feel more connected. • Positive feedback from participants, indicating a sense of belonging and strengthening community connections. J. Challenges and Future Goals:	

Agenda Topic	Notes	Action Item
	• Despite some setbacks, ongoing efforts are focused on reducing disparities and fostering healing within the community, especially in response to national and local crises.	
Agenda Item 9 **Key Policy Discussion** **Health Equity Playbook** Speaker: All	Dr. Jalloh reviews the Health Equity Playbook with the Committee, giving credit to Brandy Isola for taking the lead on creating the Playbook. A. Health Equity Playbook Overview: • A "playbook" or checklist is provided to guide health equity activities. • It helps identify key health disparities and provides steps to understand and address them. B. Key Plays in the Playbook: 1. Identify Health Disparities: 2. Prioritize Disparities: 3. Identify Root Causes: 4. Co-Design Improvement Efforts: 5. Set Specific Goals: 6. Implement and Evaluate: 7. Integrate into Long-Term Vision: C. Playbook Distribution: • The playbook will be distributed for free to health systems as a reference for addressing health equity to ensure they have the tools to close the equity gaps Motion to approve playbook: 1st Motion: Valarie Padilla 2nd Motion: Arlene Pena	Motion to approve playbook: 1st Motion: Valarie Padilla 2nd Motion: Arlene Pena
Agenda Item 10:	Yolanda Latham reviewed the following policy recommendations with the committee: 1. Policy # MCUG3118 Prenatal and Perinatal Care	Motion to Approve Changes: 1st Motion: Valarie Padilla 2nd Motion: Tiffani Thomas

4665 Business Center Drive
Fairfield, California 94534

Agenda Topic	Notes	Action Item
Disparity Discussions: Policy Changes Speaker: Yolanda	• Recommended Changes: The committee suggested including a reference to additional race and ethnic groups that incur higher risks during pregnancy, as well as considering incorporating cardiovascular disease risks for populations with higher risks (such as AA, NA, PI). 2. Policy # MPXG5009 Lactation Clinical Practice Guidelines • Recommended Changes: The committee recommended adding the following text to the policy: "Health plan supports providers in offering culturally congruent care and traditional health services that respects and integrates a patient's cultural beliefs, values, and traditions into their treatment. The care aims to be sensitive to and compatible with the patient's cultural context" 3. Policy #MCNP9006 Doula Service Benefit • Recommended Changes: The committee recommends text encouraging Doulas attend continuing education that emphasizes culturally competent practices for those who serve tribal communities and offers resources that support this. Motion to Approve Changes: 1st Motion: Valarie Padilla 2nd Motion: Tiffani Thomas	
Disparity Discussions: QI/PHM	James Devan provided the following update: • In September of the previous year, the Department of Health Care Services (DHCS) offered a way for Partnership to mitigate financial losses through quality measure outcomes. • The team created a proposal to work with large providers that served significant populations, including African American, Native American, Pacific Islander, and Asian groups. • The proposal focused on about 2,500 members in the age range of 3 to 21 years who showed disparities in care. • Additional funding was provided to practices to engage members and complete visits before the end of the year.	

Agenda Topic	Notes	Action Item
	• The initiative is currently being evaluated, and results will be shared once available.	
Agenda Item 10 **Next Meeting** Speaker: Dr. Jalloh	Next Meeting: May 27, 2025, 7:30 a.m. – 9:00 a.m.	

MEMBER GRIEVANCE REVIEW COMMITTEE

Meeting Minutes for February 27, 2025

The Member Grievance Review Committee (MGRC) represents a multi-disciplinary oversight forum with representatives across multiple Partnership HealthPlan departments to track and trend Grievances, Appeals, Exempt Grievances, and State Hearing cases. It serves as a collaborative work group to discuss complex cases or improvement opportunities with the following key focus areas: quality improvements, clinical oversight, operational excellence, member experience, and regulatory compliance. Findings may be presented in the Internal Quality Improvement (IQI) Meeting and/or Quality Utilization Advisory Committees (QUAC).

DATE:	*Thursday, February 27, 2025*
TIME:	*2:00 p.m. to 3:00 p.m.*
LOCATION:	***WebEx link in meeting invite**
	Fairfield West | *Board Room*
	Airpark | *Burney Falls Conference Room*
	Avtech | *Whiskeytown Conference Room*
	Mark Netherda, MD, Medical Director, Quality
FACILITATOR:	*Kory Watkins, Director, Grievance & Appeals*
	Latrice Innes, Compliance Manager, Grievance & Appeals

ATTENDEES			
☐	Aaron Maxwell, Transportation	☐	Maria Cabrera, Member Services
☐	Anthony Sackett, Quality	☒	Michela Englehart, Administration
☐	Amanda Bernal, Population Health	☒	Mark Netherda, MD, Health Services
☐	Bettina Spiller, MD, Health Services	☐	Mary Kerlin, Provider Relations
☐	Danielle Biasotti, CPhT, Care Coordination	☒	Melissa Perez, Provider Relations
☒	Chloe Ungaro, Provider Relations	☒	Michelle Mootz, Transportation
☒	Dorian Roberts, Provider Relations	☒	Mori McLennan, Grievance & Appeals
☒	Edna Villasenor, Member Services	☐	Mohamed Jalloh, Pharm D, Health Equity
☐	Gary Robinson, Compliance	☐	Nicole Talley, Behavioral Health
☐	Garnet Booth, Provider Relations	☐	Nicole Curreri, Population Heath
☐	Hanh Hoang, Provider Relations	☐	Nikki Rotherham, Claims
☒	Hannah O'Leary, Population Health	☐	Nisha Gupta, Population Health
☐	Heather Esget, Utilization Management	☐	Ramneek Kaur, Population Heath
☐	James Cotter, MD, Health Services	☐	RayLyn McBroome, Grievance & Appeals
☒	Jayne Cappello, Grievance & Appeals	☒	Rebecca Stark, Administration
☒	Jill Blake, Administration	☐	Renee Trosky, Provider Relations
☐	Katherine Barresi, RN, Care Coordination	☒	Robert Bides, RN, Quality
☒	Kathryn Power, Administration	☐	Robert Moore, MD, Health Services
☒	Kenzie Hanusiak, Compliance	☐	Rosemenia Santos, RN, Quality
☐	Kermit Jones, MD, Medicare Services	☒	Stan Leung, Pharm.D., Pharmacy
☒	Kory Watkins, Grievance & Appeals	☒	Stephanie Nakatani-Phipps, Provider Relations
☒	Latrice Innes, Grievance & Appeals	☐	Tim Sharp, Administration
☐	Ledra Guillory, Provider Relations	☐	Tony Hightower, Utilization Management
☒	Leigha Andrews, Administration	☐	Vicquita Velazquez, Health Equity
☒	Lisa Ooten, Pharm. D., Pharmacy	☒	Vivian Gill, RN, Grievance & Appeals
☐	Lonni Hemphill, CPhT, Compliance	☒	Wendi Davis, Administration
☐	Manleen Randhawa, Population Health		

HANDOUTS			
1	Meeting Agenda	2	Meeting Minutes from November 21, 2024
3	Meeting PowerPoint Presentation		

I. WELCOME & INTRODUCTIONS

A. Meeting Minutes

Minutes from the MGRC meeting on November 21, 2024 were reviewed and approved without changes
Motion to Approve: Rebecca Stark
Second: Mark Netherda, MD

II. STANDING AGENDA

A. Old Business

1. Quality Assurance

- This case could have been sent to a Medical Director, as the case involves timed dialysis care. The late transportation provider is directly affecting the care of the member by infringing on the time the member can be dialyzed. Records from the Dialysis center could confirm if this has occurred more than once for this member. The staff was provided additional training during the Bi-Weekly GNS Meeting on January 16, 2025. This issue is now closed.

B. Department Updates

1. Department Updates

DHCS

- G&A completed the audit in December.
- During the exit interview, concerns regarding our PQI process were expressed. However, DHCS has not issued final findings.
- G&A has preemptively been making improvements given the previous audit findings. The removal of Second Level Grievance terminology has been removed from most of G&A's system. However, during the UAT of the new C2 system it was discovered that Second Level Grievance needed to be removed, which is currently in process.
- The implementation of Appeal Rights on grievances that result in adverse decisions is the updated process in place of Second Level Grievances.

NCQA

- There is an upcoming mock audit in April or May.
- Working on UM12 Information Integrity Report formerly known as System Controls. This report includes system changes. For example, if there are date changes to the notification date or the close date of a case.

D-SNP

- G&A is currently working on the Partnership Advantage Policy. There will be separate policies for Medi-Cal and the Partnership Advantage.
- G&A continues to meet with other Partnership Medicare Leaders to ensure the department is on track

for Partnership Advantage Implementation.

JIVA

- ZeOmega created workflows which have been approved.

Process Improvements

- We are working on G&A's internal auditing process. While reviewing DHCS and NCQA audits, we have found some areas that need improvement in our auditing process. We are providing more feedback to our staff to ensure they understand their required areas for improvement.

2. Staffing

We have two (2) vacant Grievance Case Analysts (GCA) positions open and one (1) Grievance Resolution Specialist open; we promoted one of our Grievance Associates to a GCA. She will start training once we have hired the other two GCA positions.

B. Case Statistics

1. Case Statistics

There were 1,916 cases closed in 4Q24. Fifteen (15) cases were closed past 30-days, resulting in a 99.1% timeliness performance rate for the 4Q24. Members were notified their case was received within five (5) calendar days of receipt for all but 11 cases resulting in a 99.3% timeliness rate. G&A's timeliness goal is 98.6%.

There was an increase of three (3) lost State Hearings during 4Q24 regarding transgender services, transportation related expenses and approval for a medically necessary wheelchair due to the member's condition.

Q: Why was there such an increase in State Hearings for 4Q24? (44 State Hearings in 3Q24 compared to 88 State Hearings in 4Q24)
A: There has been an increase in State Hearings, primarily aimed at ensuring that cases are resolved with all necessary information. Additionally, many individuals are opting to bypass the Appeals process and directly file State Hearings. A significant number of these cases pertain to transportation and gender-affirming services.

Here is a quick update regarding the State Hearing we appealed related to transgender surgery; we have received confirmation the appeal was received. It is called a Re-Hearing. We will provide status updates at these meetings until the appeal is resolved.

October continues to be the month with the most cases closed. The trends each year prove to be consistent with the highs and lows. In the 3Q25, they are likely to show an upward trend due to the de-delegation from Carelon.

Tracking the cases by the receipt date will help us spot changes as they happen. For instance, Transportation Services shared Budget Friendly's complaints with them. They took action based on that feedback, and it led to fewer complaints coming in afterwards.

C. Compliance & Strategy

1. Delegation Oversight

Carelon
The planned de-delegation from Carelon from grievance and appeals will take place in 3Q25.
For the calendar year 2024, Carelon submitted 313 Grievances and 0 Appeals. We are anticipating an increase in Grievances and Appeals going forward as our staff will be answering the calls who know how to identify a grievance and know how to file one.

Kaiser Permanente
Kaiser has not submitted quarterly reports since April, which was reporting 1Q24.

VSP
VSP submitted the 4Q24 quarterly report timely. Currently, we are conducting an audit on VSP's policies where we found a discrepancy regarding the amount of time to respond to Partnership for a Grievance. Our Grievances need to be closed within 30 days. VSP's policy states they have 25 days to respond.
Recently, we received a State Hearing regarding VSP services which we requested VSP to have representation at the hearing as well. Upon more research, VSP discovered the provider submitted the claim incorrectly. They worked with the provider to correct the claim. The member withdrew the hearing after the claim was reprocessed appropriately with a paid claim.

Q: There has been an increase in grievances regarding access to care in Modoc and Yolo counties. Is there any additional information at this time you can report on?
A: At this time, we do not have any additional information. However, we will run a report for you.

2. Inter-Rater Reliability (IRR) Findings
IRR assesses the accuracy of clinical decisions made by GNS. The Chief Medical Officer completes the assessment. Officer (CMO), or his designee, and provides clinical oversight on cases that are at higher risk for errors. The cases are also assessed by G&A leadership to identify learning opportunities. The following issues were identified during the assessment of cases closed in 3Q24:

- The Grievance Nurse Specialist should have sent a case to be reviewed by a physician. A child was seen with a broken arm in the emergency room. The follow-up appointment was over 2 weeks after this visit. They were able to get a walk-in appointment after a few days. We might have sent it for a PQI investigation if she had to wait until the scheduled appointment. She may have had complications in the healing process. This was discussed during the Bi-Weekly GNS meeting on January 16, 2025.
- The Grievance Nurse Specialist should have sent a case to be reviewed by a physician. The Dignity contract interruption led to the delay in getting a PET scan. There were steps to ensure this did not happen in critical cases. This case was submitted for a PQI investigation. This was discussed during the Bi-Weekly GNS meeting on January 16, 2025.

3. The PULSE Report
The 1Q25 PULSE Report will be released March 10, 2025. If you would like to be added to the email distribution list, please email Latrice. The report can also be found on the Grievance and Appeals page on PHC4ME.

A highlight to look for:

- Increase in Overturned State Hearings

C. *Investigations*

Case Spotlight

Issue:
Member requested authorization for facial feminization surgery to treat gender dysphoria. The TAR contained 13 CPT codes, in which Partnership approved 11. Partnership denied CPT codes 15839 and 15876 (bilateral buccal fat excision and submental liposuction), citing a lack of medical necessity.

Background:
A factor in Partnership's decision was that these procedures were not medically necessary for the treatment of the member's gender dysphoria and were not covered under Medi-Cal benefits. However, the Administrative Law Judge (ALJ) focused on the necessity of these procedures as integral components of the overall facial feminization surgery plan. The ALJ found that the procedures were essential for achieving a more feminine appearance by removing excess fat and tissue after reducing facial bone size.

Learning Opportunity:
Moving forward, it may be more efficient to approve these procedures upfront based on the procedures recommended by the plastic surgeon, as many of these cases ultimately end with the ALJ siding with the member's plastic surgeon and affirming the necessity of these treatments. In addition, it's a good reminder to evaluate the overall surgical plan and how each procedure supports the larger goal of treating gender dysphoria, ensuring all parts of the surgery are considered as integral components of the approved plan.

Discussion:
Mori: There has been an increase in these cases, so we wanted to open the topic up for discussion on this platform. The ALJs approve of these services more frequently; would a blanket approval be more appropriate for these types of services?

Dr. Netherda noted this is a considerable discussion that has been discussed at several CMO meetings. Regarding a blanket approval, that discussion would need to include Dr. Moore, Dr. Kubota (who specializes in transgender services), and the Quality Improvement department. This topic has become not only a medical issue but a political issue as well.

Kenzie Hanusiak mentioned that per the APL for Gender Dysphoria-related services, the plans are obligated to assess not only for medical necessity but also from the criteria for reconstructive surgery. If in the denial letter, it was not made clear that the case was reviewed under both criteria, which could be contributing to the ALJ's decision to agree with the member.

Dr. Netherda stated it would be useful for the information Kenzie just provided to be shared at the CMO meeting.

Kory Watkins added that this case was reviewed for both medical necessity and the criteria for reconstructive surgery. The denial indicated it was not medically necessary and deemed to be a cosmetic procedure.

Dr. Netherda suggested that instead of using the word cosmetic, use reconstructive or the actual language that is in the APL.

Kory mentioned that G&A frequently uses that language, and the doctor who attends the hearings is good at reviewing from both of those perspectives.

FOLLOW-UP

Next Meeting: *Thursday, May 22, 2025 | 2 p.m. – 3 p.m.*

PARTNERSHIP HEALTHPLAN of CALIFORNIA

QI Department Update
April 2025
Prepared by Nancy Steffen
Senior Director, Quality and Performance Improvement

Quality Incentive Programs (QIPs)

PROGRAM	UPDATE
Primary Care Provider (PCP) QIP	• All preliminary reporting and provider review periods for Measurement Year (MY) 2024 have been completed. The QIP team is processing final scores and payments, which includes validation and Executive review for approval to distribute payments. • Final payments are estimated for distribution by the end of May 2025.
Palliative Care QIP	• Payment for the July – December 2024 period is in progress. Payment is targeted for distribution by the end of May 2025. • The data registry, Palliative Care Quality Collaborative (PCQC), has dissolved as of 04/01/2025. The Palliative Care QIP team is discussing with participants how to proceed in MY2025.

Perinatal QIP (PQIP)	• The proposed measure set for MY2025-2026 will be presented at April quality committee meetings.
	• The proposed changes for MY2025-2026 are as follows:
	  ○ Sharing EMR data via Partnership's certified HEDIS Data Aggregator (DAV), Datalink, will be added as a Gateway measure for the ECDS measure.
	  ○ A new monitoring measure is proposed to capture Timely Comprehensive Assessments. This measure will be developed in collaboration with our Member Safety Inspections team.

Enhanced Care Management (ECM) QIP	• Payment for Q4 2024 is underway with distribution planned for April.

Hospital QIP (HQIP)	• The proposed measure set for MY2025-2026 will be presented at April quality committee meetings.
	• The proposed changes for MY2025-2026 are as follows:
	  ○ Remove the PCQC requirement from the Palliative Care Capacity measure for Extra Large Hospitals
	  ○ Move the Expanding Delivery Privileges measure to Phase II
	  ○ Add a new Doula Support measure and a new Vaccines for Children Enrollment measure.

Quality Data Tools

TOOL	UPDATE
Partnership Quality Dashboard (PQD)	• The 2025 Business Requirements Document (BRD) for PCP QIP dashboard updates has been approved and turned over to the EDW team for development. 2025 PQD will launch with HRP (i.e. new core claims system) data in Quarter 3.
eReports	• 2025 eReports HRP UAT remains in progress.

PERFORMANCE IMPROVEMENT (PI)

ACTIVITY	UPDATE

STATE MANDATED WORK: *PERFORMANCE IMPROVEMENT PROJECT (PIP) & PLAN-TO-DO-STUDY-ACT (PDSA) CYCLE*	*DHCS Comprehensive Quality Improvement (QI) & Health Equity (HE) Process*
	• Partnership submitted new strategies and actions within the pediatric, chronic disease, and reproductive health and cancer prevention domains on 03/14/2025. Progress updates will be provided to DHCS in June and October this year. Several strategies and actions include:
	  ○ Academic detailing sessions from Partnership's Pharmacy team encompassing medication-based best practices for conditions including asthma, statin therapy, controlling high blood pressure, diabetes, and opioid disorder.
	  ○ Expediting newborn enrollment and primary care provider selection through Labor & Delivery engagement or through perinatal care.
	  ○ Education and training on use of Z29.3 diagnosis code for fluoride application in dental practices to increase administrative capture of fluoride application for children.
	  ○ Increasing use of in-office lead screening
	• Partnership continues to work with provider partners on the two required Performance Improvement Projects (PIPs) under behavioral health and pediatric disparities.
	  ○ The BH PIP is in collaboration with Open Door Community Health Centers tracking transitions of care for patients who present in the Emergency Department for mental health events and require follow-up.
	  ○ Pediatric Disparity PIP piloted a project with NorthBay (Solano) that involved Partnership Health Pop Health staff contacting birth parents shortly after the birth to assure connection with primary care provider of choice. NorthBay providing information to birthing parents was a huge help and boosted call connection/reach rates significantly. The W15 PIP Workgroup is now exploring additional delivery hospitals to expand this pilot and continue to test the efficacy of this strategy to improve W15 measure performance.

QUALITY MEASURE SCORE IMPROVEMENT	• The Women's Health and Perinatal workgroup with Dr. Townsend and Provider Relations hosted a webinar on 4/1 to inform providers about cervical cancer self-swab options through their laboratory vendors. • The Chronic Disease workgroup hosted a representative from the American Cancer Society. The representative shared national statistics on Colorectal Cancer disparities and educational resources for the team. • The Chronic Disease workgroup also sponsored a Colorectal Cancer educational flyer with our provider network through Provider Relations. This flyer was co-branded between Partnership and the American Cancer Society. See subsequent section titled, EXACT SCIENCES: PROMOTING COLORECTAL CANCER SCREENINGS for additional program level activities. • Partnership has received approval from DHCS to send reminders to members who had a 1st dose of HPV vaccine but have not received a second dose and are eligible per the adolescent immunizations measure.

Improvement Academy	• The final ABCs of Quality Improvement session was held in Redding on 03/25/2025. There were 43 attendees from 15 unique parent organizations. Feedback through the post-training survey was largely positive (72% extremely satisfied and 28% satisfied). 72% of respondents indicated this was their first time attending this event. • Status update on the *Improving Measure Outcomes* webinar series: ○ **02/12/2025 Preventative Care for Children Ages 0-30 Months** – 79 attendees from 36 unique organizations ○ **02/26/2025 Preventative Care for 3-17 Year Olds** – 55 attendees from 33 unique organizations ○ **03/12/2025 – Chronic Disease and Colorectal Cancer Screening** – 67 attendees from 45 unique organizations ○ **03/26/2025 – Perinatal Care and Chlamydia Screening** ○ **04/09/2025 – Breast and Cervical Cancer Screening** ○ **04/23/2025 – Diabetes Control**
Joint Leadership Initiative (JLI)	• 2025 sessions are currently being scheduled: • Ampla Health • Adventist Health – in process • Fairchild Medical Center – 07/01/2025 • Mendocino Community Health Center – targeting Summer 2025 • Open Door Community Health Centers – 06/26/2026 • Shasta Community Health Centers – 04/14/2025 • Solano County Family Health Services – 5/06/2025
Regional Improvement Meetings	• Redding and Eureka meetings will be held in June 2025 and invites will go out in May. • Chico and Auburn meetings are being planned for the summer. • Fairfield region will meet May 20, 2025

Note: Detailed information and recordings of Performance Improvement related webinars are posted to the PHC Website: http://www.partnershiphp.org/Providers/Quality/Pages/PIATopicWebinarsToolkits.aspx

QI Program & Project Management

ACTIVITY	UPDATE
Consumer Assessment of Healthcare Providers and Systems® (CAHPS) Program - Medi-Cal product line & Org Goals – FY 24/25 Member Experience and	**CAHPS Survey Fielding Timeline – Measurement Year 2024** The Consumer Assessment of Healthcare Providers and Systems® (CAHPS) regulated survey for Measurement Year 2024 remains active in the field.

Survey Methodology	Launch Date	Status
• First survey questionnaire	• 02/14/2025	• Complete
• First reminder letter	• 02/21/2025	• Complete
• Second survey questionnaire	• 03/21/2025	• Complete
• Second reminder letter	• 03/28/2025	• Complete
• Begin telephone interviewing	• 04/11/2025	• Complete
• End telephone interviewing/data collection	• 04/25/2025	•

Access | *Org Goals – FY 25/26 Member Experience*

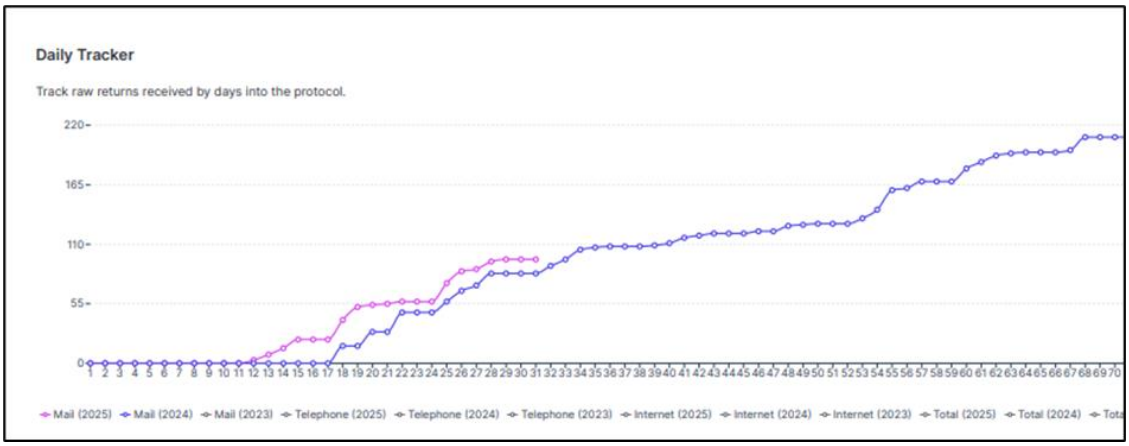
Preliminary Mail Response Rate Trends and Outreach Strategy

Mail response rates remain steady for both Adult and Child populations, with a slight increase compared to 2024. As part of a strategy to improve response rate, the CAHPS® team increased the Child sample size this reporting year – from 4,125 to 5,000. This larger sample size may be a contributing factor to the increased rate shown in the table below. The combined results indicate strong participation across both populations.

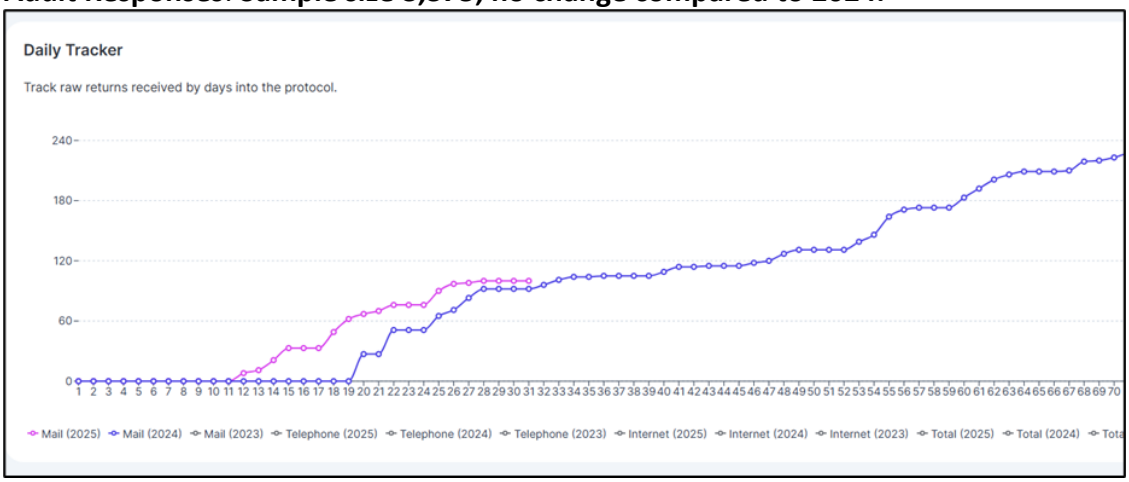
We anticipate a further increase in response rates as the survey vendor begins implementing phone follow-up protocols. These will include a combination of one reminder call and three automated calls, with live agents available to survey members in both English and Spanish formats.

Modality: Mail

Child Responses – Sample size 5,000; an increase from 4,125 in 2024.



Adult Responses: Sample size 3,375; no change compared to 2024.



	FY 2024/25 Organizational Goal #4 Progress Update: Access to Care & Member Experience Improvement The 2024-25 Org Goal #4 focuses on Access to Care and Member Experience Improvement. All goal contributors are focused on completing the remaining milestone activities during the last fiscal quarter of this period. As of this month, we have achieved a 61% completion rate for 8 milestones.
EQUITY AND PRACTICE TRANSFORMATION (EPT) PROGRAM	**Program Overview and IPIP Funding Allocation** The DHCS Equity and Practice Transformation (EPT) Program is a statewide initiative with the goal of advancing health equity while reducing COVID-19 driven care disparities. The funding is divided between three (3) programs; the Initial Planning Incentives Payments (IPIP), the Provider Directed Payment Program (PDPP), and the Statewide Learning Collaborative (SLC). Partnership received $1,526,085 in Initial Planning Incentives Payments (IPIP) funding. Of this amount: • $10,000 was awarded to twenty-three (23) qualifying provider organizations through the IPIP program. The IPIP is geared toward small and medium-sized independent practices to support their planning and application process for the Provider Directed Payment Program (PDPP). • In the past month, the Executive team approved the use of the remaining $1.2 Million in IPIP funding for two areas of unmet needs for low-performing Primary Care Physicians (PCPs): 1) Leadership training and 2) Support for replacing outdated Electronic Health Records (EHRs). • $900K will be allocated to the development and implementation of the PCP Leadership training which will be led by the PMO/OpEx team. • $300K will be allocated to support replacing outdated EHRs, a grant program which will be led by the QI Program and Project Management team. **PDPP Participation and Deliverable Requirements** All twenty-seven (27) provider organizations, who were invited by DHCS to participate in the PDPP, sent acceptance responses to DHCS by the 01/26/2024 deadline. Partnership had the third most accepted applications of all managed care plans with a 49% acceptance rate vs 29% state-wide. Accepted provider organizations span Partnership's sub-regions, including five (5) from the 2024 - 10 county expansion, eight (8) tribal health centers, and seven (7) provider organizations already engaged under Partnership's Enhance Provider Engagement (EPE) program. DHCS has recalculated the final award amounts, due to budget revisions. • Following the budget revisions, the dropout rate for the EPT cohort across the state is 5%. All twenty-seven (27) provider organizations sponsored by Partnership remain enrolled and engaged in the program. • EPT practices that did not complete the 2024 deliverables, by the 11/01/2024 due date, have until 11/2025 to submit as a requirement to remain enrolled in the program: ▪ Empanelment and Access Milestone 1: Empanelment Assessment

	▪ Empanelment and Access Milestone 2: Empanelment Policy and Procedure ▪ Data to Enable Population Health Management (PHM) Milestone 1: Data Governance and HEDIS Reporting Assessment and Data Governance Policy and Procedure. • The next EPT submission period will open on 05/01/2025 and the following deliverables will be due: ▪ Year 2 PhmCAT ▪ Data to Enable PHM Milestone 2: Implementation Plan ▪ Stratified HEDIS-like measures ▪ Key Performance Indicators (KPI) reports ▪ All Rejected or unsubmitted 2024 EPT deliverables • All templates and rubrics for the May 2025 deliverables are available on PHLC's milestone page in the link below. https://pophealthlearningcenter.org/milestones-and-deliverables/#may-25 • As of 03/25/2025, DHCS has not funneled EPT payments to Partnership. EPT POs are still expected to receive their funding no later than 04/30/2025. **Statewide Learning Collaborative** The Statewide Learning Collaborative (SLC) is meant to support practices awarded the PDPP funding in the implementation of practice transformation activities, sharing and spread of best practices, practice coaching activities, and achievement of quality and equity goals stated in their PDPP applications. Participation in the SLC is a requirement for all participants in the PDPP. EPT practices are diligently working on their May 2025 deliverables due on 05/01/2025. PHLC is hosting office hour sessions to help EPT practices learn more about population health best practices, work through implementation challenges, and prepare for deliverables submission. • Office hour topics include: EPT deliverables portal review, PhmCAT support sessions, Data implementation, Data Exchange Framework (DxF) bootcamp, and Access. • EPT practices and MCPs are welcome to register for any office hour sessions on PHLC's event calendar page linked below https://pophealthlearningcenter.org/eventcalendar/
LOCUM PILOT INITIATIVE	**Overview of the QI Locum Pilot** The QI Locum Pilot Initiative was developed as a short-term solution to provide access to clinicians with the goal of improving HEDIS performance in preventative care, specifically well-child visits and cervical cancer screenings. This offering was designed as a limited grant program, whereby select provider organizations are granted funds to hire a Locum Tenens Provider for a 4-week period in Track 1.

Track 1 Summary and Funding Model

A total budget of $250,000 was approved for Track 1 with some funding remaining, given progress since kick-off; participants have received up to:

- $45,000 when hiring a Physician.
- $31,600 when hiring an Advanced Practicing Clinician.

The Grant was paid in two installments:

- 50% upon signing the agreement.
- 50% upon completion of the four-week assignment and submission of a post-program survey.

Program Implementation and Participation

The initial cohort of providers was selected from those participating in the PCP Modified QIP. Out of six extended invitations, four applications were received and approved. The Locum assignment periods were carried out asynchronously through January of 2025. Weekly Provider check-ins and data collection were conducted by a Partnership Improvement Advisor throughout the Locum Provider's employment. Locum Providers alleviated a backlog of Well-Child and Adolescent Visits (WCV) while enabling urgent care coverage and allowing patients to schedule visits with their preferred physician.

Track 1 Provider Specific Status Updates

Hill Country Community Clinic, Community Medical Center, and Pit River Health Services completed their grant requirements.

Round Valley Indian Health received an amendment to their agreement to extend their grant offering through May 2025 and are working towards completing their grant requirements.

Track 2 Planning and Executive Review

Track 2 is currently under Executive review and proposed for implementation in FY 25/26. This offers strategic opportunities to address provider shortages, enhance health care quality, and improve patient outcomes. By allocating targeted funding to support temporary staffing, this initiatives aims to;

- Strengthen provider networks
- Increase access to care
- Drive measurable improvements in member health experiences.

If approved, it would expand the scope of the Locum Pilot as follows.

- Grant funding would be provided to eligible PCPs to support six (6) locum providers for 16-week assignments to increase provider capacity, reduce appointment backlogs, and improve HEDIS and preventive care measures.
- Total proposed funding: $576K, equating to $32K per month for each participating provider (up to six total).

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- Edits to the application and agreement are currently in progress, pending executive approval.
- QI Performance Improvement (PI) managers are identifying provider organizations that may be potential candidates for Track 2 participation.

</td></tr>
<tr><td>Mobile Mammography Program</td><td>

Upcoming Event Days (FY Q3)

<table>
<tr><th colspan="4">Upcoming Event Days
01/01/2025 – 03/31/2025</th></tr>
<tr><th>Region</th><th># of Provider Organizations</th><th># of Provider Sites</th><th># of Event Days</th></tr>
<tr><td>Auburn</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>Chico</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>Eureka</td><td>2</td><td>6</td><td>6</td></tr>
<tr><td>Fairfield</td><td>2</td><td>2</td><td>2</td></tr>
<tr><td>Redding</td><td>5</td><td>5</td><td>6</td></tr>
<tr><td>Santa Rosa</td><td>4</td><td>4</td><td>4</td></tr>
<tr><td>Plan Wide</td><td>14</td><td>17</td><td>18</td></tr>
</table>

- Scheduling for Mobile Mammography event days for FY Q4 (April – June 2025) is currently in progress.

</td></tr>
<tr><td>Partnering For Pediatric Lead Prevention Program (PPLP)</td><td>

LeadCare II Device Access and Evaluation

Partnership has continued its Partnering for Pediatric Lead Prevention program (PPLP) that funds point-of-care lead testing devices for practices. Applications are now available year-round. Details can be found on the PLPP page on Partnership's website. https://www.partnershiphp.org/Providers/HealthServices/Pages/Health%20Education/Lead-Poisoning-and-Prevention.aspx

Providers approved in Fall 2023, who received their devices in January – February 2024, are currently being evaluated to determine if they met the 2024 QIP 50th benchmark.

Promotion and Outreach Efforts

To raise awareness and encourage ongoing participation, the program launched a promotional campaign emphasizing the importance of lead testing, promoting year-round enrollment and highlighting available resources. Promotional materials, including direct links and QR codes, have been shared with provider-facing teams.

Target outreach efforts are also underway for providers with a denominator of 100 or more who did not meet the 2024 QIP 50th percentile. Meetings are being scheduled to review the workflows, provide recommendations based on 2025 best practices and address any challenges.

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</table>

Exact Sciences: Promoting Colorectal Cancer Screenings	**March Cologuard Initiatives Removes Order Barriers** Partnership facilitated a multi-patient Cologuard order on behalf of providers aligned with Colorectal Cancer Awareness Month (March), removing the 200 patient-minimum requirement. Five provider organizations participated. Preshipment letters and calls are underway, kits shipped on 03/24/2025. An open office hour webinar was held on 02/11/2025 with Exact Sciences to address provider questions. Custom marketing materials with the provider logos, along with additional outreach support were provided by Exact Sciences. A second multi-patient order is planned for July – September to align with QIP's timeline for addressing 2025 and 2026 PCP QIP measures. Providers may submit orders from 07/21/2025 – 08/18/2025. An open office hour webinar will be held on 07/23/2025 with Exact Sciences to address provider questions. Pre-shipment patient notification letters will be mailed and live pre-shipment notification calls will begin on 09/22/2025. Orders are expected to ship on 09/29/2025.

QI Trilogy Program	• The FY 2025/26 QI Program Description is on track to be finalized by 04/28/2025
	• Upcoming deliverables for the remaining QI Trilogy documents are as follows:
	  • 2024/25 QI Work Plan (Final Updates) - submissions due: 05/12/2025
	  • 2024/25 QI Program Evaluation – submissions due: 05/30/2025
	  • 2025/26 QI Work Plan – submissions due: 06/18/2025

D-SNP

ACTIVITY	UPDATE
Project Tracker	• Quality is participating in tracking all D-SNP related projects in the shared Partnership Advantage Ops Project Tracker. Updates are submitted monthly by all Quality department leaders for any D-SNP related work.
HEDIS	• Baseline state Medicare data was evaluated for prospective D-SNP members in the eight county Partnership Advantage region to estimate future HEDIS performance. This data addresses HEDIS measure performance in preventative care/screenings and chronic condition management.
CAHPS Survey Project – Medicare Product Line	• No major updates to report at this time.
MOC Training (Internal and External)	• To comply with regulatory requirements in 2026, two Model of Care (MOC) training courses are being developed with collaboration from Quality, the Office of the Chief Medical Officer (CMO) and Training & Development (T&D) teams. One training is for external providers and the second is for Partnership personnel. The external MOC training will be required for member-facing employees of any contracted organization to complete annually beginning in 2026. The external MOC training will be hosted on Rival, a recently contracted platform used for Partnership's upcoming Health Equity training.

	Provider Relations will manage communications to providers and tracking of training completion. • Partnership personnel will complete the internal MOC training as part of their onboarding or as assigned in early 2026. T&D plans to host the Partnership employee training as part of its Learning Management System (LMS).

QUALITY ASSURANCE AND PATIENT SAFETY

ACTIVITY	UPDATE
POTENTIAL QUALITY ISSUES (PQI) FOR THE PERIOD: **02/26/2025 TO 03/26/2025**	• 25 PQI referrals were received with 16 coming from Grievance and Appeals, 4 from Utilization Management, 3 from Medical Directors, and 2 from other sources. • 24 cases were processed and closed. • 97 PQI cases are currently open. • 2 cases were discussed at Peer Review Committee (PRC) on 03/19/2025 and there are 5 cases awaiting PRC review. • Upgrading of the SugarCRM PQI application (processing, documentation, and tracking system) has started with an anticipated completion date in May 2025.
FACILITY SITE REVIEWS (FSR) & MEDICAL RECORD REVIEWS (MRR) FOR THE PERIOD: **02/24/2025 TO 03/28/2025**	• As of 04/01/2025, we have a total of 461 PCP and OB sites with an additional 31 reviews due to multiple patient check-in locations (totaling 492 reviews). **Primary Care and OB Reviews:** **Region** / **# of FSR conducted** / **# of MRR conducted** / **# of FSR CAP issued** / **# of MRR CAP issued** Auburn: 1 / 1 / 1 / 1 Chico: 5 / 3 / 1 / 3 Eureka: 4 / 3 / 0 / 2 Fairfield: 3 / 2 / 3 / 2 Redding: 1 / 1 / 1 / 1 Santa Rosa: 9 / 9 / 1 / 4 Out of Area: 0 / 1 / 0 / 0 New sites opened this period → • Ampla Health North Chico Medical • Orchard Hospital Medical Specialty Center • West Sacramento Primary Care • UC Davis • Sutter Health

HEALTHCARE EFFECTIVENESS DATA INFORMATION SET (HEDIS)

ACTIVITY	UPDATE
HEDIS® Program Overall	• Partnership completed an inventory of Short/Doyle Mental Health and Substance Use Disorder service claims sent by DHCS to Partnership that represent County Department of Behavioral Health services billed to Medi-Cal in 2023-2024. Partnership still experiences significant data completeness issues with County DBH service data, particularly for services from Q4 2024. The lack of complete 2024 Behavioral Health service data will impact MY2024 HEDIS performance on the Follow Up after ED Visit for Mental Health (FUM) and Follow Up After ED Visit for Substance Use (FUA) measure sets. The inventory was sent to DHCS's Chief Data Officer and Chief Quality and Medical Officer on 03/13/2025. • Partnership also continues its engagement with the DHCS Data Team to address data completeness issues within the DHCS Monthly Claims Data Feed files around the Topical Fluoride for Children (TFL-CH) measure; and around coordination of education campaign efforts around coding best practices for fluoride varnish application services using the ICD code Z29.3 3 (encounter for prophylactic fluoride administration) with CDT and CPT service codes. • Partnership has begun engagement with an external consultant with expertise in data validation and data exchange between DHCS, managed care payers, and provider networks. The engagement will continue through 2025 and will focus on identifying and addressing data completeness issues within Partnership's array of supplemental data sources; and on strengthening the validation tools and methodologies used by the HEDIS, PCP QIP, and internal stakeholder teams.

NATIONAL COMMITTEE FOR QUALITY ASSURANCE (NCQA) ACCREDITATION

ACTIVITY	UPDATE
NCQA Health Plan Accreditation (HPA) and Health Equity Accreditation (HEA)	• NCQA releases updates to the current HPA and HEA Standards and Guidelines three (3) times a year in November, March, and July. These changes include corrections, clarifications, policy changes and regulatory changes. The March updates were released on 03/31/2025 and have been shared with the applicable Business Owners. • Each year, NCQA releases proposed updates to the Standards and Guidelines. NCQA asks Health Plans to provide their feedback and/or comments on the proposed changes. This comment period is known as Public Comments. NCQA released the proposed updates to the 2026 HPA Standards and Guidelines on 02/25/2025. Applicable Business Owners were asked to review the proposed changes and indicate if they Support, Do Not Support, or Support the Changes with Modifications by 03/21/2025. The NCQA Program Management Team provided a plan-wide response to NCQA by the 03/25/2025 due date. • Proposed updates to the 2026 HPA Standards and Guidelines include:

Standard Category	Type of Change	Standard/Element
QI	New Element	QI 2C, 4A
PHM	Revised	PHM 1A, 1B, 2A, 3B, 3C, 4B, 6B

<table>
<tr><td></td><td>
<table>
<tr><td></td><td>New Element</td><td>PHM 3A, 3D</td></tr>
<tr><td rowspan="4">NET</td><td>Revised</td><td>NET 1A, 1D, 3C, 5A, 5C, 5E, 5F, 5H, 5I</td></tr>
<tr><td>New Factor</td><td>NET 2B</td></tr>
<tr><td>New Element</td><td>NET 2D</td></tr>
<tr><td rowspan="3">UM</td><td>Revised</td><td>UM 1A, 1B, 5A, 5B, 5C, 5D, 11B</td></tr>
<tr><td>New Factor</td><td>UM 1A, 3A,</td></tr>
<tr><td>New Element</td><td>UM 1B, 1C, 1D, 1E, 1F, 13E</td></tr>
<tr><td>ME</td><td>Retire</td><td>ME 5C</td></tr>
</table>
Proposed updates to the 2026 HEA Standards and Guidelines are scheduled for release in April or May 2025.
</td></tr>
<tr><td>NCQA HPA</td><td>The HPA Mock Renewal Survey is scheduled for 10/27-30/2025. The purpose of the HPA Mock Renewal Survey is to assess Partnership’s readiness, address identified gaps and develop action plans for meeting compliance when preparing for Partnership’s HPA Renewal Survey scheduled for 09/22/2026.
An evidence preparation training session will be held the week of 06/23/2025. Other details, including a tentative timeline for submission of the Year 1 evidence, timing for the distribution of the final report and results, and submission of an Action Plan, were reviewed and discussed during the February/March Business Owner Check-in meetings.</td></tr>
<tr><td>NCQA HEA</td><td>Partnership’s HEA Initial Survey is scheduled for submission on 06/17/2025.
As of March 2025, Partnership’s HEA compliance rate is 86.21%, receiving 25 points out of the 29 total applicable points available. The NCQA Program Management Team is working closely with the Business Owners to ensure all applicable evidence is revised to sustain compliance in accordance with NCQA’s look-back periods, timelines, and expectations.
An Introductory Call with our Accreditation Survey Coordinator (ASC) from NCQA was held on 03/20/2025. The purpose of the call was for NCQA to learn more about Partnership and review the survey process.
Business Owners submitted their annotated and bookmarked evidence by the 03/28/2025 due date, with a few exceptions. These exceptions include documents identified on the Evidence Submission Tracker with later dates due to committee review, publication and distribution of newsletters, and select delegation activities.</td></tr>
</table>

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
QUALITY/UTILIZATION ADVISORY COMMITTEE (QUAC)

Consent Calendar

April 16, 2025

Items on the Consent Calendar have minor or no changes and are recommended by staff for approval.

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Summary of Approved Measure Set for Measurement Year 2025-26

HQIP Measurement Set

Providers have the potential to earn a total of 100 points in six domains 1) Readmissions; 2) Advanced Care Planning; 3) Clinical Quality; 4) Patient Safety; 5) Operations/Efficiency; 6) Patient Experience. Individual measure values will be assigned for the final and approved measurement set.

Key: New Measure || Change to Measure Design

2024-25 Measures	2025-26 Recommendations
Risk Adjusted Domain 1. Risk Adjusted Readmissions (RAR) 2. 7-Day Follow-up Clinical Visit (RAR) **Palliative Care Domain** 3. Palliative Care Capacity **Clinical Domain** 4. Elective Delivery Before 39 Weeks 5. Exclusive Breast Milk Feeding Rate 6. Nulliparous, Term, Singleton Vertex (NTSV) Cesarean Rate 7. Vaginal Birth After Cesarean (VBAC) 8. Expanding Delivery Privileges 9. Increasing Mammography Capacity **Patient Safety Domain** 10. CHPSO Patient Safety Organization Participation 11. Substance Use Disorder Referral, Medication Assisted Treatment (MAT) **Operations / Efficiency Domain** 12. QI Capacity 13. Hospital Quality Improvement Platform **Patient Experience Domain** 14. Cal Hospital Compare-Patient Experience 15. Health Equity	**Risk Adjusted Domain** 1. Risk Adjusted Readmissions (RAR) 2. 7-Day Follow-up Clinical Visit (RAR) **Palliative Care Domain** **3. Palliative Care Capacity** **Clinical Domain** 4. Elective Delivery Before 39 Weeks 5. Exclusive Breast Milk Feeding Rate 6. Nulliparous, Term, Singleton Vertex (NTSV) Cesarean Rate 7. Vaginal Birth After Cesarean (VBAC) **8. Expanding Delivery Privileges** **9. Doula Support** **10. Increasing Mammography Capacity** **11. Vaccines For Children Enrollment** **Patient Safety Domain** 12. CHPSO Patient Safety Organization Participation 13. Substance Use Disorder Referral, Medication Assisted Treatment (MAT) **Operations / Efficiency Domain** 14. QI Capacity 15. Hospital Quality Improvement Platform **Patient Experience Domain** 16. Cal Hospital Compare-Patient Experience 17. **Health Equity**

Programmatic Changes:

I. Descriptions of Potential 2025-26 Measure Changes for Core Measurement Set

A. Change(s) to Existing Measures for 2025-26

1. **Palliative Care Measure 3:** Remove references to the Palliative Care Quality Collaborative (PCQC)

   Rationale: PCQC dissolved in March 2025. A note was added mid-year to the 2024-25 specifications to reflect change, but change is needed for this year. Hospitals will use data from their inpatient EMRs to report to Partnership.

   Measure Requirements for X-Large hospitals with ≥ 100 beds

   Required to provide the following to Partnership:

   Part 1. Hospitals must submit a report summarizing the number of palliative care consults per month for the measurement year July 1, 2025 – June 30, 2026

   Part 2. Rate of consults who have completed an Advance Care Directive or have a signed POLST to be included in the report described in Part 1:

   - **Numerator**: Anyone with an Advance Directive or POLST status in the hospital's inpatient EMR and on the palliative care service at either the time of consult ***or*** the time of discharge.
   - **Denominator:** Patients with a palliative care consult recorded in the hospital's inpatient EMR and on the palliative care service, discharged alive from July 1, 2025 – June 30, 2026.

   Part 3. Submit Attestation form Appendix II showing inpatient palliative care capacity: at least two trained***** Licensed Clinician (RN, NP, or PA), and an arrangement for availability of either video or in-person consultation with a Palliative Care Physician

2. **Measure 8: Expanding Delivery Privileges:** Since we have moved into the second year of this measure and it is a multi-phase measure, it is suggested to replace "phase one" language with "phase two' language:

   Measure Specification:

   In this second phase of measure implementation, hospitals are now required to work toward actively recruiting, granting privileges, and demonstrating evidence of family physicians' and nurse midwives' clinical activity.

Measure Requirements

This multi-phase measure began with ***Phase One*** in the 2024-25 measurement year, which asked hospitals to develop by-laws and/or policy and procedure to expand delivery privileges to midwives and family physicians. With ***Phase One*** completed in 2024-25, this measure moved into ***Phase Two*** for the 2025-26 HQIP Measurement Year starting July 1, 2025.

Phase Two Requirement: Hospital's that have developed by-laws and/or policy and procedure allowing midwives and family physicians to hold delivery privileges, must now show evidence that they are actively recruiting and/or share their provider privileges list of midwives and family physicians who have been granted delivery privileges.

Note: If a hospital did not develop by-laws and/or policy and procedures expanding delivery privileges to midwives and family physicians, they must complete develop those and meet phase two requirements to meet the measure requirements for the 2025-26 measurement year.

3. **Revise Health Equity Measure:** Switch from an annual report on Health Equity to submission of CMS Health Equity Attestation as written below:

Measure Specifications

Partnership recognizes that health equity work can be very diverse and take many forms and Hospitals are being asked by multiple agencies to be committed to health equity. Since all hospitals need to report to CMS on health equity, rather than ask organizations to produce additional proof of their health equity work, Partnership has decided to reduce the administrative burden on hospitals by aligning our measure with CMS requirements. Hospitals may now report their health equity work to Partnership by submitting the same documentation submitted to the Centers for Medicare & Medicaid Services (CMS) for the Hospital Commitment to Health Equity Measures.

Measure Requirements

Hospitals shall submit a copy of their most recent CMS program attestation for the Hospital Commitment to Health Equity Measure to earn points for this measure. The attestation should cover part of the HQIP measurement year.

Target

Full Points: 5 Points earned for submitting current CMS Health Equity Attestation that meets all five domains.

Exclusions

Very Small sized hospitals with less than 25 Licensed General Acute beds are excluded from participation in this measure.

B. Potential New Measures for 2025-26 Measurement Year

Measure 9: Doula Support

It is suggested to add a Doula Support measure like the Expanding Delivery Privileges measure to encourage hospitals to allow Doula's to support birthing parents during delivery.

Measure Specifications

This measure will be implemented over multiple years, with **Phase One** starting with the 2025-26 measurement year. In future years, hospitals will be required to work toward actively recruiting and allowing doulas to provide support during labor and delivery.

Measure Requirements

Hospitals will develop medical staff bylaws and/or policies and procedures that allow doulas to support birthing parents in the hospital during labor and delivery.

In future years, we anticipate a second phase of this measure to include evidence that doulas are being utilized in labor and delivery

Hospitals with existing bylaws and/or written policies that allow doulas to provide support during labor and delivery will get full points for the measure.

2. Measure 11: Vaccines For Children (VFC) Enrollment

It is suggested to add a measure incentivizing hospitals for enrolling in the cost saving Vaccines For Children program offered by the California Department of Public Health (CDPH).

Measure Specification:

HQIP birthing hospitals can save cost and positive impact their newborn population by enrolling in the 'no cost" Vaccination For Children program through CDPH. Partnership's HQIP birthing hospitals will be eligible to receive points by successfully enrolling in the CDPH's VFC program by the end of the measurement year.

Target

Target: Enrollment in VFC program by June 30, 2026

Proposed FY 2025-2026
Perinatal Quality Improvement Program (PQIP)
Measurement Set

I. Summary of Current and Proposed Measures and/or Measure Changes

(A) Core Measurement Set Measures

Participating Comprehensive Perinatal Services Program (CPSP) and select non-CPSP providers who provide quality and timely prenatal and postpartum care to PARTNERSHIP members have the option to earn additional financial incentives. The PQIP framework offers a simple and meaningful measurement set developed with PCPs and OB/GYNs in mind and includes the following measures: 1) Timely Immunization Status - Tdap and Influenza Vaccine; 2) Timely Prenatal Care; and 3) Timely Postpartum Care.

(B) Electronic Data Measure

DataLink allows for data exchange from Provider Electronic Health Records to PARTNERSHIP in order to capture depression screening and follow-up care. DataLink implementation is a vital component of furthering PQIP technical advancement through the capture of claims and electronic data directly exported from participating providers Electronic Health Records (EHR) systems.

Key:

New Proposed Measures || Change to Measure Design

Current FY2024-25 Measures	Proposed FY2025-26 Measures
ECDS & Clinical Domains	
Perinatal Medicine: 1. Electronic Clinical Data Systems (ECDS) 2. Prenatal Immunization 3. Timely Prenatal Care 4. Depression Screening 5. Timely Postpartum Care	**Perinatal Medicine:** 1. Electronic Clinical Data Systems (ECDS) 2. Prenatal Immunization 3. Timely Prenatal Care 4. Depression Screening 5. Timely Postpartum Care 6. Timely Comprehensive Assessments Monitoring

PQIP FY 2024-25 DESCRIPTIONS OF MEASURES AND 2025-26 PROPOSED CHANGES

A. CLINICAL MEASURES NO CHANGES BEING MADE IN 2025-26

Prenatal Immunization Status
The number of women who had one dose of the tetanus, diphtheria, acellular pertussis vaccine (Tdap) within 30 weeks before delivery date and an influenza vaccine during their pregnancy.

Timely Prenatal Care
Timely prenatal care services rendered to pregnant PARTNERSHIP members in the first trimester, as defined as less than 14 weeks of gestation, or within 42 days of enrollment in the organization.

Alternatively, timely prenatal care services rendered to pregnant PARTNERSHIP members at 14 or more weeks of gestation.

Timely Postpartum Care
Timely postpartum care is a measure of quality care and can contribute to healthier outcomes for women after delivery. The postpartum visit is an important opportunity to educate new mothers on expectations about motherhood, address concerns, and reinforces the importance of routine preventive health care.

B. ELECTRONIC DATA MEASURE

PROPOSED CHANGE: **ECDS DataLink Gateway Measure 1**
DataLink contracting was incentivized in the 2024-25 measurement year. This year, the ECDS measure would become a ***Gateway Measure*** requirement for perinatal providers to receive incentive dollars. Some providers may have completed this during the 2024-25 measurement year. However, if a perinatal provider did not complete a contract and implementation with DataLink during the 2024-25 measurement period, they must complete all ***Implementation Phases*** and ***Participation Requirement Steps*** below by June 30, 2026 in order to be eligible for incentive payment in the 2025-26 measurement year.

C. *PROPOSED* MONITORING MEASURE 6: Timely Comprehensive Assessments

During the 2025-26 Measurement Year, Partnership will be monitoring claims data looking for members receiving full psychosocial, nutrition, and behavioral health assessments each trimester of pregnancy and once postpartum (up to 1 year after delivery). This measure is a monitoring only measure, without any incentive dollars attached to the measure. This measure may be developed into an incentive measure in future years.

D. MEASURE INCENTIVE BREAKDOWN

Measure	Incentive Per Submission	Measure Requirement
Gateway Measure: ECDS: DataLink Implementation	**None.** Requirements must be met to be eligible to receive PQIP incentive dollars.	DataLink contracting and implementation completed by June 30, 2026.
Prenatal Immunization Status	$37.50 (Tdap) $12.50 (Influenza)	The number of women who had one dose of the tetanus, diphtheria, acellular pertussis vaccine (Tdap) within 30 weeks before delivery date and an influenza vaccine during their pregnancy (i.e. within 40 weeks of delivery date).
Timely Prenatal Care	$100 (<14 weeks gestation) $25 (≥14 weeks gestation)	Timely prenatal care services rendered to pregnant Partnership members in the first trimester, as defined as less than 14 weeks of gestation, or within 42 days of enrollment in the organization. Alternatively, timely prenatal care services rendered to pregnant Partnership members at 14 or more weeks of gestation.
Timely Postpartum Care	$25 (1st visit) $50 (2nd visit)	Two Timely postpartum care services rendered to Partnership members with one occurring within 21 days after delivery and the other occurring between 22 and 84 days after delivery.
Monitoring Measure: Timely Comprehensive Assessments	**None.** This measure is a monitoring only measure with no incentive amounts attached.	Partnership will monitor the use of timely comprehensive assessments through claims data and potentially site audits.

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MPQP1006 (previously QP100106)</td><td colspan="3">Lead Department: Health Services
Business Unit: Quality Improvement</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Clinical Practice Guidelines</td><td colspan="3">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 05/19/1999</td><td colspan="4">Next Review Date: ~~05/08/2025~~05/14/2026
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<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALS</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: ~~05/08/2024~~05/14/2025</td></tr>
</table>

I. RELATED POLICIES:

A. MPXG5001 - Clinical Practice Guidelines Diagnosis and Management of Asthma
B. MPXG5002 - Clinical Practice Guidelines for Diabetes Mellitus
C. MPXG5003 - Major Depression in Adults Clinical Practice Guidelines
D. MPXG5008 - Clinical Practice Guidelines: Pain Management, Chronic Pain Management, and Safe Opioid Prescribing
E. MPXG5009 - Lactation Clinical Practice Guidelines
~~E.~~F. MCCP2020 – Lactation Policy and Guidelines

II. IMPACTED DEPTS:

A. Health Services
B. Member Services
C. ~~Provider Relations~~Network Services
~~C.~~D. Provider Relations

III. DEFINITIONS:

A. Clinical Practice Guidelines (CPGs) are evidence-based strategies for clinical management of Partnership HealthPlan of California (Partnership) members who are at risk for, or who have, certain clinical conditions. The objectives of implementing CPGs are:
   1. To educate providers regarding comprehensive current evidence-based management practices for a given condition with the intent of improving quality of care.
   2. To minimize inter-practitioner variation in an attempt to reduce the use of out-of-date or sub optimal approaches to care.
   3. To define the objective clinical criteria against which provider and health plan performance will be measured in the areas covered by CPGs.
   4. To define best practices to be used in care coordination programs and to specify the clinical content to be used in Partnership health education programs.
   5. To help practitioners and members make decisions about appropriate health care for specific clinical circumstances and behavioral health services.

IV. ATTACHMENTS:

[1] This policy may also apply in part to Partnership Advantage, the HealthPlan's Medicare product effective Jan. 1, ~~2026~~2026, in eight counties: Del Norte, Humboldt, Mendocino, Lake, Marin, Sonoma, Napa, and Solano, and may be subject to change based on Centers for Medicare and Medicaid Services (CMS) rules.

Policy/Procedure Number: MPQP1006 (previously QP100106)			**Lead Department: Health Services** Business Unit: Quality Improvement
Policy/Procedure Title: Clinical Practice Guidelines			☒ **External Policy** ☐ **Internal Policy**
Original Date: 05/19/1999		**Next Review Date: 05/08/202505/14/2026** **Last Review Date: 05/08/202405/14/2025**	
Applies to:	☐**Employees**	☒**Medi-Cal**	☒**Partnership Advantage**

A. N/A

V. PURPOSE:

~~To define, describe, and guide the process for Partnership HealthPlan of California's Clinical Practice Guideline (CPG) development, adoption, implementation, and performance evaluation.~~To define, describe, and guide the process for Partnership's Clinical Practice Guideline (CPG) development, adoption, implementation, and performance evaluation.

Policy/Procedure Number: MPQP1006 (previously QP100106)			**Lead Department: Health Services** Business Unit: Quality Improvement
Policy/Procedure Title: Clinical Practice Guidelines			☒ **External Policy** ☐ **Internal Policy**
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Applies to:	☐**Employees**	☒**Medi-Cal**	☒**Partnership Advantage**

VI. POLICY / PROCEDURE:

A. CPG Development and Implementation

1. Determination of need:
   a. Suggested topics for clinical practice guidelines will be elicited from the following areas:
      1) Clinical committees: Physician Advisory Committee (PAC), Quality/Utilization Advisory Committee (Q/UAC), and Pharmacy & Therapeutics Committee (P&T)
      2) Partnership providers and practitioners
      3) Partnership staff
   b. CPG topics may be chosen because of the high frequency of the condition among health plan members, excessive morbidity or mortality as determined by retrospective review of health plan data, wide variations in practice patterns among health plan practitioners, potential risk for over- or under-utilization of services, or high cost of care for the condition.
   c. Partnership will develop at least two non-preventive acute or chronic care clinical guidelines and at least two guidelines related to behavioral conditions. There may be a clinical guideline that includes both the medical and behavioral components and where this occurs; the second behavioral guideline will address a separate condition or an aspect of a behavioral condition distinctly different from the behavioral guideline adopted by Partnership.
2. Recommendations for new topics are forwarded to the Q/UAC, along with background information regarding the frequency of the condition among health plan members, the rates of morbidity and mortality arising from the condition, the availability of nationally recognized guidelines, and other pertinent materials. The Q/UAC determines which topics are scheduled for CPG development.
3. Partnership Health Services staff conducts a literature search to determine whether any professionally recognized organization has developed an applicable guideline or expert consensus statement that is available to the public. If so, this "source guideline," per the recommendation of the Physician Advisory Committee, will be referenced in the CPG and appropriate internet sites will be listed. If a source guideline has not been developed or is not publicly available, Partnership staff develops a draft CPG based upon available objective peer-reviewed medical literature. When Partnership contracted provider groups have a CPG on the topic, an effort is made to make Partnership's CPG consistent with that of the provider group.
4. The draft CPG will include:
   a. Brief introduction to the specific CPG, defining why it is an important clinical condition to manage (e.g., incidence, morbidity, social impact).
   b. Key points in diagnosis and management:
      1) Key issues in accurate diagnosis/differential diagnosis.
      2) Key issues in treatment and follow-up.
   c. Indicators monitored by Partnership to measure compliance with the CPG.
   d. References, which will either include the specific CPG adopted by Partnership or, in the case where nationally recognized guidelines are not available, the sources used to develop the CPG.
5. A CPG may be drafted by any medically licensed Partnership provider or staff member or subject matter expert. The draft is reviewed and initially approved by the Medical Director for Quality, the Chief Medical Officer, or medically licensed designee.
6. The draft CPG is then reviewed by Partnership's Associate Director of Utilization Management, ~~the Senior Director, Quality and Performance Improvement~~Medical Director for Quality, ~~the Director,~~ Pharmacy Services Director, ~~the Senior Director, Provider Relations~~Associate Director of Network Services, and a member of Population Health's Cultural and Linguistics team to ensure that the CPG is consistent with UM criteria, member education, benefit interpretation, QI program goals, and practitioner communications. When indicated, the ~~Member Services~~ Director of Grievance & Appeals and Member Services and/or Behavioral Health Clinical Director may also be asked to

review a CPG.

7. If the draft CPG was created due to a lack of "nationally recognized guidelines," then an "expert workgroup" is convened to review the draft and make further recommendations regarding its content.
   a. The workgroup will include at least one, but two if available, board-certified practicing physicians of the specialty area to which the guideline applies, as well as at least one primary care provider if the condition is one typically managed by primary care providers.
   b. Depending upon the complexity of the subject or length of the draft CPG, the workgroup may be asked to meet in person or may communicate by telephone or email.
8. The draft CPG is then forwarded to the Q/UAC for consideration. The draft can be:
   a. Approved as presented, or,
   b. Modified by the Q/UAC and approved, or,
   c. Referred back to the "expert workgroup" for further modification in the case of a CPG created due to no "source guidelines." Once acted upon by the "expert workgroup," the draft can be resubmitted to the Q/UAC.
   d. After approval by the Q/UAC, the CPG is then submitted to the PAC, which may approve, modify or refer back to the "expert workgroup" for further consideration.
9. Once approved by the PAC, the CPG will be disseminated in the following manner:
   a. The CPG is used in making utilization management determinations, quality of care, benefit interpretations, care coordination decisions, and designing health educational materials.
   b. The CPG is incorporated into the Provider Manual, viewable on the Partnership Website.
10. Review and updating CPGs
    a. CPGs will be reviewed annually from the approval date and updated as appropriate.
    b. If a significant new intervention (e.g., diagnostic test, drug, or surgical intervention) becomes available before the next scheduled revision of the CPG, staff consults with Chief Medical Officer (CMO) and, if the CMO recommends modifications of the CPG, the updated CPG will be referred to the Q/UAC and PAC for approval. Experts in the focus area will be consulted as appropriate.

B. Monitoring Use of CPGs
1. Once a CPG is approved by the PAC, a copy of the CPG is forwarded to a designated physician at the provider site. The site may adopt the Partnership CPG, or submit its CPG to Partnership for approval.
2. Partnership audits practice site adherence to CPGs through the annual collection of data using standardized measures such as Healthcare Effectiveness Data and Information Set (HEDIS®) measures. Data collection occurs through HEDIS® and Partnership's Primary Care Provider Quality ~~Improvement~~ Incentive Program (PCP QIP).

VII. REFERENCES:
N/A

VIII. DISTRIBUTION:
A. Partnership Department Directors
B. Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Medical Officer

X. REVISION DATES:
Medi-Cal
06/21/00; 08/15/01; 08/20/03; 09/15/04; 03/15/06; 03/21/07; 02/20/08; 03/18/09; 05/18/11; 02/15/12;

Policy/Procedure Number: MPQP1006 (previously QP100106)			**Lead Department: Health Services** Business Unit: Quality Improvement
Policy/Procedure Title: Clinical Practice Guidelines			☒ **External Policy** ☐ **Internal Policy**
Original Date: 05/19/1999		**Next Review Date: 05/08/202505/14/2026** **Last Review Date: 05/08/202405/14/2025**	
Applies to:	☐**Employees**	☒**Medi-Cal**	☒**Partnership Advantage**

02/20/13; 02/19/14; 02/18/15; 02/17/16; 04/19/17; *03/14/18; 03/13/19; 03/11/20; 04/14/21; 05/11/21; 05/10/23; 05/08/24; 05/14/25

Partnership Advantage
N/A

*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.

PREVIOUSLY APPLIED TO:
Healthy Kids - MPQP1006 (Healthy Kids program ended 12/01/2016)
03/21/07; 02/20/08; 03/18/09; 05/18/11; 02/15/12; 02/20/13; 02/19/14; 02/18/15; 02/17/16 to 12/01/2016
PartnershipAdvantage:
MPQP1006 - 03/21/2007 to 01/01/2015
Healthy Families:
MPQP1006 - 05/18/11 to 03/01/2013

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

GUIDELINE/ PROCEDURE

<table>
<tr><td colspan="3">Guideline/Procedure Number: MPXG5001 (previously XG100501)</td><td colspan="3">Lead Department: Health Services
Business Unit: Quality Improvement</td></tr>
<tr><td colspan="3">Guideline/Procedure Title: Clinical Practice Guidelines for the Diagnosis & Management of Asthma</td><td colspan="3">☒External Policy
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<tr><td colspan="2">Original Date: 04/19/2000</td><td colspan="4">Next Review Date: ~~05/08/2025~~05/14/2026
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</table>

I. RELATED POLICIES:
MPUG3031 - Nebulizer Guidelines

II. IMPACTED DEPTS:
Health Services

III. DEFINITIONS:
N/A

IV. ATTACHMENTS:
A. N/A

V. PURPOSE:
Asthma is a chronic condition of airway inflammation that manifests in wheezing, coughing, and dyspnea. The prevalence of asthma has remained relatively unchanged in the U.S. for many years, and it currently affects 6.5% of the population, age under 18 years and 8.0% of the population, ages 18 years and older (2021 National Health Interview Survey [NHIS] Data).

VI. GUIDELINE / PROCEDURE:
A. Key Points in Diagnosis and Management
1. Diagnosis – The symptoms of asthma can be caused by other conditions, including, allergies, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), gastroesophageal reflux disease (GERD), bronchiectasis, sarcoidosis, pulmonary embolism, panic disorder, respiratory infection (bacterial or viral), and vocal cord dysfunction, among others. An accurate diagnosis rests on an accurate history, physical findings, pulmonary function tests (PFTs), and chest x-ray (CXR).
2. Treatment – The long-term goals of asthma management are symptom control and risk reduction. Routine preventive measures should follow Advisory Committee on Immunization Practices (ACIP) guidelines. Main principles of management consist of medications, non-pharmacologic therapies and strategies, as well as training and educating patients on essential asthma self-management skills. Pharmacotherapy should be individualized to the particular patient. This guideline cannot cover

[1] This policy may also apply in part to Partnership Advantage, the HealthPlan's Medicare product effective Jan. 1, 2026 in eight counties: Del Norte, Humboldt, Mendocino, Lake, Marin, Sonoma, Napa, and Solano, and may be subject to change based on Centers for Medicare and Medicaid Services (CMS) rules.

every situation.

a. Starting in 2019 the Global Initiative for Asthma (GINA) report has recommended that adults and adolescents should no longer use short acting beta agonist (SABA)-only treatment for any degree of asthma severity. All adults and adolescents should receive inhaled corticosteroid (ICS)-containing controller treatment to reduce their risk of serious exacerbations and to control symptoms.

b. The GINA report divides treatment into ~~2~~ two tracks based on the rescue therapy chosen
   i. Rescue therapy is low dose ICS-formoterol (GINA's preferred track)
   ii. Rescue therapy is a SABA
      a) SABA used as needed *with* as needed low-dose ICS at the same time, *or*
      b) SABA used as needed while on daily ICS controller therapy

c. Each track follows a stepwise escalation in ICS-dosing and the use of add-on therapies (see add-on options below) based on patients initial presentation and symptom control while on therapy.

B. Asthma Medication List ~~(Refer to Medi-Cal Rx Contract Drugs List for prescription coverage)~~
   1. Controller therapy
      a. Primary controller therapy options
         i. Inhaled corticosteroids.
         ii. Inhaled corticosteroid / long acting beta agonist (LABA) combination inhalers.
      b. Add-on controller therapy options
         i. Leukotriene receptor antagonists,
         ii. Inhaled long-acting muscarinic antagonist (LAMA)
         iii. Inhaled long-acting beta agonists not recommended as monotherapy for asthma.
         iv. Mast cell stabilizer,
         v. Non-Formulary biologics.
   2. Rescue therapy
      a. Low dose ICS-formoterol combination for ages ≥ 12 (off-label)
         i. GINA preferred as needed combo-therapy reliever for Step 1 through Step 5
         ~~ii.~~
      b. Short-acting beta agonist inhalers:
         i. Inhaled albuterol
         ii. Inhaled levalbuterol

C. Indicator Monitored by Partnership HealthPlan of California (Partnership): The following indicator will be monitored for measurement of adherence to this guideline (as reference from Healthcare Effectiveness Data and Information Set (HEDIS®) measure: Asthma Medication Ratio)
   1. The percentage of members 5–64 years of age during the measurement year who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.
   2. Consider targeted intervention on those patients with suboptimal AMR score (<0.5) Interventions may include evaluating patient's asthma pharmacotherapy for underuse of ICS and overuse of rescue inhalers, confirming pharmacy records for prescriptions filled in the pharmacy, and engaging patients on the importance of medication adherence.

VII. REFERENCES:

A. Partnership has adopted the asthma guidelines entitled 2024 GINA Main Report: ~~Global Initiative for Asthma.~~ Global Strategy for Asthma Management and Prevention. ~~(July 10, 2023)~~. Available from www.ginasthma.org.

~~A.~~B. GINA 2024 Summary Guide for Asthma Management and Prevention (Dec. 26, 2024)

Guideline/Procedure Number: MPXG5001 (previously XG100501)			**Lead Department: Health Services** Business Unit: Quality Improvement
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Original Date: 04/19/2000		**Next Review Date:** ~~05/08/2025~~05/14/2026 **Last Review Date:** ~~05/08/2024~~05/14/2025	
Applies to:	☐**Employees**	☒**Medi-Cal**	☒**Partnership Advantage**

~~B.~~C. Centers for Disease Control and Prevention (CDC) National Center for Health Statistics: https://www.cdc.gov/nchs/fastats/asthma.htm

~~C.~~D. Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP) https://www.cdc.gov/vaccines/acip/index.html

~~D.~~E. Medi-Cal Rx Contract Drugs List https://medi-calrx.dhcs.ca.gov/home/cdl/

VIII. DISTRIBUTION:

A. Partnership Pharmacy Department
B. Partnership Utilization Management Staff
C. Partnership Provider Manual
D. Partnership Department Directors

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Medical Officer

X. REVISION DATES:

Medi-Cal
10/17/01; 09/18/02, 12/17/03; 04/20/05; 06/20/07; 02/19/14; 01/20/16; 01/18/17; *02/14/18; 02/13/19, 02/12/20; 02/10/21; 04/14/21; 05/11/22; 05/10/23; 05/8/24; 05/14/25
Partnership Advantage
N/A

*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.

PREVIOUSLY APPLIED TO:

PartnershipAdvantage
MPXG5001 - 06/20/2007 to 01/01/2015

Healthy Families
MPXG5001 - 08/18/2010 to 03/01/2013

Healthy Kids (Healthy Kids program ended 12/01/2016)
MPXG5001 - 06/20/07; 08/18/10; 02/15/12; 02/19/14; 01/20/16 to 12/01/16

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

GUIDELINE/ PROCEDURE

<table>
<tr><td colspan="3">Guideline/Procedure Number: MPXG5002 (previously XG100502)</td><td colspan="3">Lead Department: Health Services
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<tr><td colspan="3">Guideline/Procedure Title: Clinical Practice Guidelines for Diabetes Mellitus</td><td colspan="3">☒External Policy
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I. RELATED POLICIES:

A. MPUG3025 - Insulin Infusion Pump and Continuous Glucose Monitor Guidelines
B. MCUP3052 - Medical Nutrition Services
C. MCCP2026 - Diabetes Prevention Program

II. IMPACTED DEPTS:

Health Services

III. DEFINITIONS:

N/A

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

Diabetes is a group of metabolic diseases characterized by hyperglycemia resulting from defects in insulin secretion, insulin action, or both. The chronic hyperglycemia of diabetes is associated with long-term damage, dysfunction, and failure of different organs, especially the eyes, kidneys, nerves, heart, and blood vessels.

VI. GUIDELINE / PROCEDURE:

A. KEY POINTS IN DIAGNOSIS AND MANAGEMENT
   1. Diagnosis Criteria for the diagnosis of diabetes
      a. A1C ≥ 6.5%; or
      b. Fasting plasma glucose ≥ 126 mg/ dL; or
      c. 2-h plasma glucose ≥ 200 mg/dL during an oral glucose tolerance test
      d. In a patient with classic symptoms of hyperglycemia or hyperglycemic crisis, a random plasma glucose ≥ 200 mg/dL;
      e. In the absence of unequivocal hyperglycemia, the result should be confirmed by repeat testing.

[1] This policy may also apply in part to Partnership Advantage, the HealthPlan's Medicare product effective Jan. 1, 2026 in eight counties: Del Norte, Humboldt, Mendocino, Lake, Marin, Sonoma, Napa, and Solano, and may be subject to change based on Centers for Medicare and Medicaid Services (CMS) rules.

2. On-going Care Management and Treatment: The glycemic goal in adults is the lowering of Hemoglobin A1C to below 8%, unless contraindicated based on age, comorbid conditions, risk of hypoglycemia, and/or no access to resources or support systems. The principles of treatment consist of lifestyle modifications (e.g., physical activity and exercise, nutrition, smoking cessation, immunization); pharmacotherapy, appropriate weight management, diabetes self-management education, depression screening, management of co-morbidities (e.g., hypertension, dyslipidemia), screening for and treatment of complications of diabetes (e.g., coronary heart disease, nephropathy, retinopathy, neuropathy, foot care).

B. MEDICATIONS

The pharmacy benefit is carved-out to Medi-Cal Fee-for-Service (Medi-Cal Rx) as described in the Department of Health Care Services' All Plan Letter (APL) 22-012 and the Governor's Executive Order N-01-19 effective Jan~~uary~~ 1, 2022. The pharmacy benefit for Partnership Advantage members will be administered by Partnership and our delegated Pharmacy Benefits Manager (PBM)>

C. INDICATORS MONITORED BY Partnership: These indicators will be monitored for measurement of adherence to this guideline.

1. Healthcare Effectiveness Data and Information Set (HEDIS®)
   a. Retinal eye exam
   b. Glycemic Status Assessment for Patients with Diabetes
   c. Blood pressure control (<140/90 mm Hg)
2. Primary Care Provider Quality Improvement Program
   a. Retinal eye exam
   b. A1C good control (< 9%)

VII. REFERENCES:

A. American Diabetes Association: Standards of Medical Care in Diabetes 2025~~4~~. https://diabetesjournals.org and https://diabetesjournals.org/care/issue/48/Supplement_1 (January 2025) ~~https://diabetesjournals.org/care/article/47/Supplement_1/S5/153943/Summary-of-Revisions-Standards-of-Care-in-Diabetes~~

B. ~~Partnership~~Department of Health Care Services (DHCS) All Plan Letter (APL) 22-012 Governor's Executive Order N-01-19, Regarding Transitioning Medi-Cal Pharmacy Benefits from Managed Care to Medi-Cal Rx (revised Dec. 30, 2022 supersedes APL 20-020)

VIII. DISTRIBUTION:

A. HS Department UM Staff
B. Partnership Provider Manual
C. Partnership Department Directors

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Medical Officer

X. REVISION DATES:

Medi-Cal
12/19/01; 09/18/02; 09/15/04; 11/17/04; 03/21/07; 04/21/10; 06/20/12; 06/18/14; 10/19/16; *02/14/18; 04/10/19; 05/13/20; 05/12/21; 05/11/22; 05/10/23; 05/08/24

*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.

PREVIOUSLY APPLIED TO:

Guideline/Procedure Number: MPXG5002 (previously XG100502)			**Lead Department: Health Services** Business Unit: Quality Improvement
Guideline/Procedure Title: Clinical Practice Guidelines for Diabetes Mellitus			☒ **External Policy** ☐ **Internal Policy**
Original Date: 04/19/2000		**Next Review Date: 05/08/2025** **Last Review Date: 05/08/2024**	
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**

PartnershipAdvantage
MPXG5002 - 03/21/2007 to 01/01/2015

Healthy Families
MPXG5002 - 05/18/2007 to 03/01/2013

Healthy Kids (Healthy Kids program ended 12/01/2016)
04/21/10; 06/20/12; 06/18/14; 10/19/16 to 12/01/16

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MCUP3121</td><td colspan="3">Lead Department: Health Services
Business Unit: Utilization Management</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Neonatal Circumcision</td><td colspan="3">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 11/28/2012
Effective Date: 01/01/2013</td><td colspan="4">Next Review Date: ~~05/08/2025~~05/14/2026
Last Review Date: ~~05/08/2024~~05/14/2025</td></tr>
<tr><td>Applies to:</td><td colspan="2">☐ Employees</td><td>☒ Medi-Cal</td><td colspan="2">☐ Partnership Advantage</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td>☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td>☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIAL~~S~~ING</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: ~~05/08/2024~~05/14/2025</td></tr>
</table>

I. RELATED POLICIES:
MCUP3041 – Treatment Authorization Request (TAR) Review Process

II. IMPACTED DEPTS:
A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:
N/A

IV. ATTACHMENTS:
A. N/A

V. PURPOSE:
To describe the approval process for circumcision.

VI. POLICY / PROCEDURE:
A. Background: In August, 2012, the American Academy of Pediatrics revised its recommendation on penile circumcision (detailed in Pediatrics: Based on a review of the current medical evidence, the health benefits of newborn penile circumcision justify access to this procedure for those families who choose it.) In October, 2012 the Board of Commissioners voted to ratify the recommendation of the Physician Advisory Committee, to add newborn penile circumcision as a supplemental benefit for our M~~m~~embers.
B. Services covered: Newborn penile circumcision is performed at the request of the child's parent(s)/ or legal guardian(s), after full informed consent is obtained from the parent(s)/ legal guardian(s) by the surgeon, describing the risks, benefits and alternatives of the procedure. It should be performed under local anesthesia, in either the hospital setting (for newborns) or in the office setting. In general, it is performed within 3 weeks of birth, unless the child is born premature, in which case it may be done at an older age. No Treatment Authorization Request (TAR) is required for newborn penile circumcision if the newborn is under 4 months of age. Same day surgery or hospital admission solely for the purpose of performing newborn penile circumcision (without medical indications) is not covered.
C. Penile circumcisions for other indications: Circumcisions performed for medical indications (including, but not limited to, paraphimosis, phimosis, chronic balanitis) require a TAR and are subject to InterQual® criteria.

Policy/Procedure Number: MCUP3121			**Lead Department: Health Services** **Business Unit: Utilization Management**
Policy/Procedure Title: Neonatal Circumcision			☒ **External Policy** ☐ **Internal Policy**
Original Date: 11/28/2012 Effective 01/01/2013		**Next Review Date: 05/08/202505/14/2026** **Last Review Date: 05/08/202405/14/2025**	
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☐ **Partnership Advantage**

VII. REFERENCES:

A. American Academy of Pediatrics. Male Circumcision: Task force on Circumcision. Pediatrics 2012; 130/3756; available online at: http://pediatrics.aappublications.org/content/130/3/e756.full.pdf+html

B. InterQual® criteria

VIII. DISTRIBUTION:

A. Partnership Department Directors

B. Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Health Services Officer

X. REVISION DATES: 01/20/16; 11/16/16; 11/15/17; *02/13/19; 03/11/20; 03/10/21; 05/11/22; 05/10/23; 05/08/24; 05/14/25

*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.

PREVIOUSLY APPLIED TO: N/A

****

In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:

- Consistent with sound clinical principles and processes
- Evaluated and updated at least annually
- If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request

The materials provided are guidelines used by Partnership to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under Partnership.

Partnership's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MPC~~C~~UP3014 (previously MCUP3014; UP100314)</td><td colspan="3">Lead Department: Health Services
Business Unit: Utilization Management</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Emergency Services</td><td colspan="3">☒External Policy
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<tr><td colspan="2">Original Date: 06/20/2001</td><td colspan="4">Next Review Date: ~~05/08/2025~~05/14/2026
Last Review Date: ~~05/08/2024~~05/14/2025</td></tr>
<tr><td>Applies to:</td><td colspan="2">☐ Employees</td><td colspan="3">☒ Medi-Cal</td><td>☒ Partnership Advantage</td></tr>
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<tr><td colspan="4">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: ~~05/08/2024~~05/14/2025</td></tr>
</table>

I. RELATED POLICIES:

A. MCUP3124 – Referral to Specialists (RAF) Policy
B. MCUP3041 – Treatment Authorization Request (TAR) Review Process
C. MCCP2018 – Advice Nurse Program

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

A. Emergency Medical Condition is defined as a condition which is manifested by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention could result in:
   1. Placing the health of the member (or, in the case of a pregnant woman, the health of the member and/or her unborn child) in serious jeopardy
   2. Serious impairment of bodily functions; ~~or~~
   3. Serious dysfunction of any bodily organ or part; or
   ~~3.~~4. Death

B. Partnership Advantage: Effective January 1, 2026, Partnership HealthPlan of California will operate a Centers for Medicare & Medicaid Services (CMS)-approved Dual-Eligible Special Needs Plan (D-SNP) in specific counties as described in the Department of Health Care Services (DHCS) CalAIM Dual Eligible Special Needs Plan Policy Guide. This line of business will be known as Partnership Advantage and will be a Medicare Advantage plan offered to all full-benefit, dual-eligible beneficiaries 21 years of age or older who reside in the applicable counties. Partnership Advantage Members will be qualified to receive both Medi-Cal and Medicare services as described in the Partnership Advantage Member Handbook.

C. Physician: Medical Doctor (MD) or Doctor of Osteopathy (DO)

~~C.~~D. Provider: For the purposes of this policy, the provider is a physician, nurse practitioner or physician assistant.

~~D.~~E. Triage evaluation is defined as a screening examination performed on a member where emergency or urgent services are not required in order to determine the appropriate location and time for the definitive evaluation of that member's problem.

~~E.~~F. Urgent conditions are defined as a sudden onset of a medical condition or the worsening of an existing medical condition such that the patient is in mild distress, but without severe pain, significant loss of

function or threatened by loss of life and where urgent therapeutic intervention within 48 hours is needed to minimize the possibility of patient morbidity.

IV. ATTACHMENTS:

ADDENDA (*See pages 65 -87*)

A. Non-Urgent Medical Conditions
B. Urgent Medical Conditions
C. Emergency Medical Conditions

V. PURPOSE:

To define the circumstances under which emergency services are covered.

VI. POLICY / PROCEDURE:

A. Payment for Services and Prior Authorization
   1. Partnership HealthPlan of California may review claims submitted by facilities and practitioners to determine the appropriate payment level. Partnership reserves the right to monitor claims submitted to determine that the billing accurately reflects the level of services provided.
   2. Partnership covers emergency services without prior authorization for evaluation and treatment of an emergency medical condition.

B. Referral of Triaged Members and Follow-up
   1. Under Federal and State laws, a screening examination (triage services) is required to be performed on every patient presenting to the emergency department (24 hours a day). This will be reimbursed by Partnership. If a plan member is determined to not require emergency or urgent services, the facility will communicate with the Primary Care Provider (PCP) to determine the need for further medical attention.
   2. Partnership members may generally be referred by the treating Emergency Department (ED) provider for care to their PCP's office or an urgent care facility under the following circumstances:
      a. The member is willing to be seen in the PCP's office or urgent care facility.
      b. The member has transportation to the alternative site.
      c. The Emergency Department staff arranges an appointment for the member at a time suitable and medically appropriate for the member.
      d. The PCP or urgent care facility agrees to see the member at the appointed time.
   3. The emergency department or urgent care facility is expected to notify the PCP if follow-up care is required. The emergency department should send a copy of the ED record to the PCP or responsible provider within 48 hours of the ED visit. The emergency department provider should notify the PCP or the responsible provider at the time of the ED visit if urgent follow-up care by the PCP or responsible physician is required. Follow-up care by a specialist after an ED visit must have a Referral Authorization Form (RAF) from the PCP to be considered for payment (exception to this is for initial orthopedic or neurosurgery consult after ED referral and for certain capitated specialist services).
   4. Emergency department staff will determine if the patient also must be evaluated by an emergency department physician prior to referral to the PCP for treatment. For more information on post stabilization services, please refer to policy MCUP3041 Treatment Authorization Request (TAR) Review Process.
   5. Partnership has a dedicated after-hours local phone number (707) 430-4808 or toll free number (855) 798-8759 to receive calls from physicians and hospital staff for addressing post-stabilization care and inter-facility transfer needs 24 hours per day, 7 days per week. Calls are returned within 30 minutes of the time the call was received. Partnership's Chief Medical Director or physician designee is on call 24 hours per day 7 days per week to authorize medically necessary post-stabilization care services and to respond to hospital inquiries within 30 minutes. Partnership clinical

staff are available 24 hours per day 7 days per week to coordinate the transfer of a member whose emergency medical condition is stabilized.

C. Section 1882(c)(3) of the federal Social Security Act (as enacted by Section 4081(b)(2)(C) of the federal Omnibus Budget Reconciliation Act of 1987 (OBRA):
   1. Pursuant to APL 21-015, OBRA services shall be billed and reimbursed through Medi-Cal FFS.
      a. Every person who presents to an emergency department must receive a medical screening evaluation by a physician or provider under the supervision of a physician without prior authorization.
      b. Medical screening must be performed prior to asking about the individual's ability to pay or before verifying Medicaid (Medi-Cal) eligibility.
      c. Each person who presents to the ED must be stabilized by medical treatment, as needed.
      d. The ED provider has the obligation to treat a patient in the emergency department if, in the provider's judgment, adequate care will not be obtained at another facility.
      e. Transfers between emergency departments are appropriate only if the emergency physician at the second hospital accepts the transfer.

D. Advice Nurse Program
   1. Partnership maintains 24-hour emergency telephone availability with physician backup for Members through the Partnership Advice Nurse Line at (866) 778-8873. (See policy MCCP2018 Advice Nurse Program). If the Partnership Advice Nurse directs a member to the ED, Partnership will pay for the visit. The advice nurse faxes a copy of the Triage Call Documentation Report to the ED. This report is to be attached to the claim when it is submitted for payment.

E. Coverage for Services Rendered Outside of the State of California, but within the U.S.
   1. Medically necessary medical care outside of the State of California, within the limits of benefits as outlined in Title 22, is covered only when one of the following conditions is met:
      a. An emergency arises from accident, injury or illness; or
      b. The health of the individual would be endangered if care and services are postponed until it is feasible that the member return to California; or
      c. The health of the individual would be endangered if travel were undertaken to return to California; or
      d. It is customary practice in border communities for residents to use medical resources in adjacent areas outside California; or
      e. The out-of-state treatment plan has been proposed by the member's attending provider, and the plan has been received, reviewed and authorized by Partnership before the services are provided AND the proposed treatment is not available from resources and facilities within the State of California.
      f. Prior authorization is required for ALL out-of-state services, except:
         1) Emergency services as defined in Section 51056 – California Code of Regulations
         2) Services provided in border areas adjacent to California where it is customary practice for California residents to avail themselves of such services. Under these circumstances, program controls and limitations are the same as for services from providers within the state.
         3) No services are covered outside the United States, except for emergency services requiring hospitalization in Canada or Mexico.

F. Emergency Department Contracts
   1. Certain in-plan Emergency Departments have voluntarily entered into contractual relationships with Partnership. Addenda A, B and C are samples of non-urgent, urgent & emergency medical conditions applicable to these contracted Emergency Departments.

G. Decisions Made on Medical Appropriateness
   1. On an annual basis, Partnership distributes a statement to all its practitioners, providers, members and employees alerting them to the need for special concern about the risks of under-utilization. It

requires employees who make utilization-related decisions and those who supervise them to sign a statement, which affirms that Utilization Management (UM) decision making is based only on the appropriateness of care and service. Furthermore, Partnership does not reward practitioners, or other individuals conducting utilization reviews, for issuing denials of coverage for services. Financial incentives for UM decision-makers do not encourage decisions that result in under-utilization, and Partnership does not use incentives to encourage barriers to care and service. This does not preclude the use of appropriate incentives for fostering efficient, appropriate care.

H. Prescribed Medications Under Emergency Circumstances
   1. When the course of treatment provided to a member under emergency circumstances requires the use of medication, a sufficient quantity shall be provided to the member to last until the member can reasonably be expected to have a prescription filled.

VII. REFERENCES:

A. Omnibus Reconciliation Act (OBRA) regulations: Section 1882(c)(3) of the federal Social Security Act (SSA) as enacted by Section 4081(b)(2)(C) of OBRA, Public Law 100-203
B. Title 22 California Code of Regulations (CCR)
C. Title 22 CCR Sections 51056, 53855
D. Department of Health Care Services (DHCS) Contract Exhibit AE, Attachment 1, Definitions and Exhibit A, Attachment III Section 3.3.16 Emergency Services and Post-Stabilization Care Services
E. DHCS All Plan Letter (APL) 21-015 Benefit Standardization and Mandatory Managed Care Enrollment Provisions of the California Advancing and Innovating Medi-Cal Initiative (CalAIM) (10/18/2021) Attachment 1: Mandatory Managed Care Enrollment (MMCE) Requirements (*Revised* 10/14/2022)
E.F. Medicare Managed Care Manual 100-16: Chapter 4 Benefits and Beneficiary Protections, Section 20 Ambulance, Emergency, Urgently Needed and Post-Stabilization Services. Implementation date 01/01/2015 or any subsequent updates published by CMS.

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Health Services Officer

X. REVISION DATES:

Partnership Advantage (Program effective January 1, 2026)
05/14/25

Medi-Cal
05/09/95; 10/10/97 (name change only); 06/21/00; 10/18/00; 08/15/01; 09/18/02; 10/20/04; 02/16/05, 10/18/06; 10/17/07, 08/20/08; 11/18/09; 05/18/11; 05/15/13; 01/20/16; 08/17/16; 08/16/17; *09/12/18; 09/11/19; 08/12/20; 08/11/21; 05/11/22; 04/12/23; 05/08/24; 05/14/25

*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.

PREVIOUSLY APPLIED TO: N/A

****

Policy/Procedure Number: MPCUP3014 (previously MCUP3014; UP100314)			**Lead Department: Health Services** **Business Unit: Utilization Management**
Policy/Procedure Title: Emergency Services			☒ **External Policy** ☐ **Internal Policy**
Original Date: 06/20/2001		**Next Review Date: 05/08/202505/14/2026** **Last Review Date: 05/08/202405/14/2025**	
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**

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- If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request

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Original Date: 06/20/2001		**Next Review Date: 05/08/202505/14/2026** **Last Review Date: 05/08/202405/14/2025**	
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**

ADDENDUM A

NON-URGENT MEDICAL CONDITIONS

Treatment for the following conditions requires non-urgent services with regard to payment to contracted facilities, unless extenuating circumstances necessitate urgent or emergency services and these needs are documented in the medical record. In these circumstances, Partnership reserves the right to review the record. (Note that this list is not exhaustive or definitive.)

* Rash - minimally symptomatic
* External parasites
* First degree burns (small)
* Insect bites (no systemic symptoms)
* Minor puncture wounds (no evidence of infection or foreign object)
* Uncomplicated diarrhea (no blood in stool, no vomiting or symptoms of dehydration)
* Non-active but prior history of nausea/vomiting/diarrhea
* Hemorrhoids – minimally symptomatic
* Uncomplicated constipation
* URI symptoms with no shortness of breath
* Simple UTI – minimally symptomatic
* Urethral or vaginal discharge without bleeding
* Routine tetanus immunization
* Suture removal
* Routine dressing changes
* Missed physician appointments
* Prescription refills
* Follow-up visits
* Pre-employment physical examinations
* Exposures to communicable diseases (e.g. hepatitis, TB, STD, except accidental exposure to blood)
* Any other condition which appears uncomplicated and stable per judgment of ED staff.

Policy/Procedure Number: MPCUP3014 (previously MCUP3014; UP100314)			**Lead Department: Health Services** **Business Unit: Utilization Management**
Policy/Procedure Title: Emergency Services			☒ **External Policy** ☐ **Internal Policy**
Original Date: 06/20/2001		**Next Review Date: 05/08/202505/14/2026** **Last Review Date: 05/08/202405/14/2025**	
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**

ADDENDUM B

URGENT MEDICAL CONDITIONS

Treatment for the following conditions requires urgent services with regard to payment to contracted facilities, unless extenuating circumstances necessitate emergency services and these needs are documented in the medical record. In these circumstances, Partnership reserves the right to review the record. (Note that this list is not exhaustive or definitive.)

* Chickenpox
* Localized cellulitis
* Abscess requiring I & D
* Insect bites with systemic symptoms
* Small second degree burns
* Otitis media/Ear ache
* Otitis externa
* URI, complicated by abnormal vital signs
* Bronchitis
* Conjunctivitis
* Pharyngitis
* Sinusitis
* Back pain not requiring parenteral analgesics
* Stable Angina – not requiring diagnostic evaluation or parenteral therapy
* Asthma without SOB and/not requiring nebulizer treatment and 80% or greater of predicted peak flow measurement
* UTI-symptomatic
* Vaginitis
* Urethritis
* Menstrual cramps
* Dysfunctional Uterine Bleeding (DUB) without hemorrhage
* Acute gastroenteritis
* Hemorrhoids with bleeding
* Mild abdominal pain
* Minor contusion
* Minor laceration - no suturing
* Mild sprain/strain
* Headache not requiring diagnostic evaluation or parenteral analgesic
* Accidental Exposure to Blood with HIV risk
* Chronic arthritis
* Minor joint pain
* Localized tooth pain (mild)

Policy/Procedure Number: MPCUP3014 (previously MCUP3014; UP100314)			**Lead Department: Health Services** **Business Unit: Utilization Management**
Policy/Procedure Title: Emergency Services			☒ **External Policy** ☐ **Internal Policy**
Original Date: 06/20/2001		**Next Review Date: 05/08/202505/14/2026** **Last Review Date: 05/08/202405/14/2025**	
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**

EMERGENCY MEDICAL CONDITIONS **ADDENDUM C**

Treatment for the following conditions requires emergency services with regard to contracted facilities. This list is not intended to be all inclusive or definitive, and the ED physician may determine that emergency services were indicated for conditions other than those listed below. In these cases, Partnership reserves the right to review the record.

*Chest pain - R/O cardiac problem
*Angina - unstable
*Myocardial Infarction
*Congestive heart failure
*Stroke
*Significant abdominal pain with diagnostic work-up
*Pyelonephritis
*Acute GI bleed
*Asthma requiring nebulizer treatment or peak flow less than 80% of expected measurement.
*Pneumonia
*Acute back pain requiring parenteral analgesics
*Fractures or joint injury requiring splinting or reduction
*Lacerations requiring suturing
*Traumatic amputation
*Pyrexia - R/O sepsis in children with diagnostic work-up
*Hypovolemia/dehydration with IV treatment
*Acute psychiatric conditions
*Intoxication
*Delirium
*Hemorrhage in early pregnancy
*PID
*Genital tract hemorrhage
*Rape/sexual assault
*Labor/pre-term labor (to L & D)
*Acute allergic reaction with therapeutic injection of medication
*Acute seizure
*Severe headache requiring therapeutic injection for pain or diagnostic evaluation (CT)
*Uncontrolled epistaxis
*Meningitis
*Sepsis
*Significant acute change in vision
*Foreign body in eye
*Corneal abrasion
*Large first or second degree burn
*Third degree burns
*MVA
*Gunshot/stabbing
*Loss of consciousness
*Poisoning
*Overdose

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MPUP3026 (previously UP100326)</td><td colspan="3">Lead Department: Health Services
Business Unit: Utilization Management</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Inter-Rater Reliability Policy</td><td colspan="3">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 02/16/2000</td><td colspan="4">Next Review Date: ~~05/08/2025~~05/14/2026
Last Review Date: ~~05/08/2024~~05/14/2025</td></tr>
<tr><td>Applies to:</td><td colspan="2">☐ Employees</td><td colspan="2">☒ Medi-Cal</td><td>☒ Partnership Advantage</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td colspan="2">☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td colspan="2">☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td colspan="2">☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td colspan="2">☐ CREDENTIAL~~SING~~</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date ~~05/08/2024~~05/14/2025</td></tr>
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I. RELATED POLICIES:

A. MCUP3041 – Treatment Authorization Request (TAR) Review Process
B. MCRP4068 – Medical Benefit Medication TAR Policy
C. MCUP3144 – Residential Substance Use Disorder Treatment Authorization

II. IMPACTED DEPTS:

Health Services

III. DEFINITIONS:

A. IRR: Inter-Rater Reliability
B. TAR: Treatment Authorization Request

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

To assess the consistency with which Partnership HealthPlan of California's physician and non-physician reviewers apply utilization management (UM) criteria and to evaluate Inter-Rater Reliability (IRR).

VI. POLICY / PROCEDURE:

A. Goal
   1. To ensure that medical management criteria are being utilized appropriately and consistently in UM decision making.
B. Methodology
   1. The Inter-Rater Reliability mechanism uses live cases.
   2. Partnership retrospectively reviews/ audits a sample of UM determination files.
   3. Sample Description
      a. Over the course of a year period, 50 cases or 5% of reviewer case load (whichever is less) will be audited for each physician and non-physician reviewer. (For the purposes of this policy, a reviewer is the physician or non-physician who made the initial determination for a treatment authorization request.)
      b. If less than 50 cases are available for a particular reviewer, all cases will be reviewed for IRR.

4. Implementation
   a. The audit review of TARs reviewed by physician and non-physician reviewers is coordinated and scheduled by Health Services ~~Project Coordinators~~ Analysts and Administrative Assistants at least biannually as follows:
      1) For Nurse Coordinator staff, each selected TAR is audited by a clinical staff member who is a licensed employee in a non-supervisory role, has passed their 90 day probation period, and was not involved in the initial determination.
         a) Nurse Coordinators who operate in the capacity of behavioral health authorizations to review Substance Use Disorder (SUD) treatment TARs are required to complete specialized ASAM[1] training annually.
      2) For Physician Reviewer staff (including the Behavioral Health Clinical Director), sample TARs selected are audited by a Physician Reviewer who has passed their 90 day probationary period and was not involved in the initial review. If there is no alternate Physician Reviewer on staff available to perform an inter-rater reliability audit, a physician experienced in UM employed by a Medi-Cal Managed Care Plan performs the review. The Chief Medical Officer reviews the audit findings.
      3) For Pharmacy staff, a pharmacist reviewer or lead pharmacy technician reviews determinations rendered by another pharmacist or pharmacy technician, respectively, who was not involved in the initial determination.

C. Reporting
   1. An audit summary is reported at least annually or more often as needed to the Internal Quality Improvement (IQI) Committee.

D. Results
   1. An accuracy rate of 90% is targeted. After presentation to the IQI Committee, the audit summary is also presented to the Quality/Utilization Advisory Committee (Q/UAC). If a reviewer falls below the targeted threshold, a corrective action plan is initiated by the Health Services Department under the direction of the appropriate department Director. The corrective action plan may include, but not be limited to, educational activities, increased oversight of decisions or prohibiting the reviewer from making UM decisions, and/or institution of staff probationary period combined with supervision of decisions.

VII. REFERENCES:

A. Department of Health Care Services (DHCS) Contract Exhibit A, Attachment III~~5~~, 2.3.1. Utilization Management Program, Prior Authorizations and Review Procedures~~Provision 2(D)~~
B. National Committee for Quality Assurance (NCQA) Guidelines (Effective July 1, 2025~~4~~) UM 2 Clinical Criteria for UM Decisions, Element C, Factors 1 and 2
C. Department of Health Care Services (DHCS) Intergovernmental Agreement for Drug Medi-Cal Organized Delivery System (DMC-ODS) Services

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Health Services Officer, Chief Medical Officer, Behavioral Health Clinical Director

[1] American Society of Addiction Medicine (ASAM) Criteria - As defined in the Department of Health Care Services (DHCS) Drug Medi-Cal Organized Delivery System Intergovernmental Agreement, pertains to necessary care for biopsychosocial severity and is defined by the extent and severity of problems in all six multidimensional assessment areas of the patient.

Policy/Procedure Number: MPUP3026 (previously UP100326)			**Lead Department: Health Services** **Business Unit: Utilization Management**
Policy/Procedure Title: Inter-Rater Reliability Policy			☒ **External Policy** ☐ **Internal Policy**
Original Date: 02/16/2000		**Next Review Date: 05/08/202505/14/2026** **Last Review Date: 05/08/202405/14/2025**	
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**

X. REVISION DATES:

Partnership Advantage (Program effective January 1, 2026)
05/14/25

Medi-Cal
11/28/01; 01/15/03; 10/20/04; 10/19/05; 10/18/06, 08/20/08; 08/18/10; 10/01/10; 05/16/12; 01/20/16; 08/17/16; 02/15/17; *03/14/18; 08/08/18; 05/08/19; 11/13/19; 04/08/20; 08/12/20; 08/11/21; 05/11/22; 04/12/23; 05/08/24; 05/14/25

*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.

PREVIOUSLY APPLIED TO:
Healthy Kids MPUP3026 (Healthy Kids program ended 12/01/2016)
10/18/06; 08/20/08; 08/18/10; 10/01/10; 05/16/12; 01/20/16; 08/17/16 to 12/01/2016

****

In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:

- Consistent with sound clinical principles and processes
- Evaluated and updated at least annually
- If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request

The materials provided are guidelines used by Partnership to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under Partnership.

Partnership's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

Policy/Procedure Number: MPC~~C~~UP3051 (previously MCUP3051, UP100351)			**Lead Department: Health Services** **Business Unit:** Utilization Management	
Policy/Procedure Title: Long Term Care SSI Regulation (previously Long Term Care Admissions)			☒**External Policy** ☐ **Internal Policy**	
Original Date: 01/17/2001		**Next Review Date:** ~~05/08/2025~~05/14/2026 **Last Review Date:** ~~05/08/2024~~05/14/2025		
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**	
Reviewing Entities:	☒ **IQI**	☐ **P & T**	☒ **QUAC**	
	☐ **OPERATIONS**	☐ **EXECUTIVE**	☐ **COMPLIANCE**	☐ **DEPARTMENT**
Approving Entities:	☐ **BOARD**	☐ **COMPLIANCE**	☐ **FINANCE**	☒ **PAC**
	☐ **CEO** ☐ **COO**	☐ **CREDENTIAL~~SING~~**	☐ **DEPT. DIRECTOR/OFFICER**	
Approval Signature: *Robert Moore, MD, MPH, MBA*		**Approval Date:** ~~05/08/2024~~05/14/2025		

I. RELATED POLICIES:
MCUG3038 – Review Guidelines for Member Placement in Long Term Care (LTC) Facilities

II. IMPACTED DEPTS:
A. Health Services
B. Claims

III. DEFINITIONS:
A. LTSS: Long-Term Services and Supports
~~A.~~B. SSI: Supplemental Security Income
~~B.~~C. SSA: Social Security Administration
~~C.~~D. MC171 Form: Medi-Cal Long Term Care Facility Admission and Discharge Notification form

IV. ATTACHMENTS:
A. N/A

V. PURPOSE:
To ensure that Long Term Care (LTC) facilities notify the Social Security Administration (SSA) and Partnership Health Plan of California of an admission to the LTC facility of a Partnership member with Supplemental Security Income (SSI).

VI. POLICY / PROCEDURE:
A. Notification to Social Security Administration
1. For Partnership members with SSI, the LTC facility is required to submit the MC171 form to the SSA within two weeks of admission to the facility. A copy of the form must be sent to Partnership. The form must be filled out completely and accurately.
2. Partnership's Long~~-~~-Term Services and Supports~~Care~~ (~~LTC~~LTSS) Nurse Coordinators confirm the receipt of the MC171 form ~~for~~ with all LTC Treatment Authorization Requests (TARs) as required per policy MCUG3038 Review Guidelines for Member Placement in Long Term Care (LTC) Facilities~~Partnership members with SSI~~.
   a. If a facility does not submit the MC171 form, the TAR is denied for "information requested not received" and the facility is notified.

VII. REFERENCES:
Medi-Cal Provider Manual/ Guidelines: Admissions and Discharges (*admis*)

Policy/Procedure Number: MPC~~C~~UP3051 (previously MCUP3051, UP100351)			**Lead Department: Health Services** **Business Unit: Utilization Management**
Policy/Procedure Title: Long Term Care SSI Regulation (previously Long Term Care Admissions)			☒ **External Policy** ☐ **Internal Policy**
Original Date: 01/17/2001		**Next Review Date: 05/08/202505/14/2026** **Last Review Date: 05/08/202405/14/2025**	
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**

VIII. DISTRIBUTION:

A. Partnership Provider Manual
B. Partnership Department Directors

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Health Services Officer

X. REVISION DATES:

Partnership Advantage (Program effective January 1, 2026)
05/14/25

Medi-Cal
02/20/02; 08/20/03; 02/08/05; 10/15/08; 11/18/09; 01/18/12; 01/20/16; 10/19/16; 10/18/17; *02/13/19; 03/11/20; 03/10/21; 05/11/22; 05/10/23; 05/08/24; 05/14/25

*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.

PREVIOUSLY APPLIED TO: N/A

****

In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:

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The materials provided are guidelines used by Partnership to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under Partnership.

Partnership's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.

Synopsis of Changes to Discussion Policies

Policy Number & Name	Page Number	Summary of Revisions (Please include why the change was made, i.e. NCQA, APL, Medi-Cal guidelines, clarification etc.)	External Documentation (Notice required outside of originating department)
Policy Owner: Utilization Management – *Presenter: Tony Hightower, CPhT, Associate Director, UM Regulations*			
MPUD3001 Utilization Management Program Description	109 -147	Annual updates to our UM Program Description for both UM and Pharmacy activities were made in conjunction with our annual UM Program Evaluation. **Page 2:** Under Program Objectives, added the definition of "medically necessary" and provided examples of service types that would require medical necessity review. **Page 2:** In the Program Staff description for the CMO, added the Senior Director of Care Management position as a collaborator. **Pages 3 and 4:** In the assigned responsibilities for the Medical Director of Medicare Services, added that this physician assists with coverage in UM and has the authority to make decisions based on medical necessity which result in the approval or denial of coverage for UM activities. **Page 6:** Added Program Staff description for the new position of Senior Director of Care Management. **Page 6:** Updated the direct report for the Director of Utilization Management to be the Senior Director of Care Management. Also added that the Director of UM coordinates with the new EHS department. **Page 7:** Updated title to Director of Enhanced Health Services (formerly Director of Utilization Management Strategies). Updated for CalAIM language in assigned responsibilities, including Street Medicine. Removed responsibility for regularly attending meetings with facilities, and added responsibilities related to expertise in housing services. **Page 8:** Updated title to Associate Director of Enhanced Health Services (formerly Director of Enhanced Care Management Operations). Updated for CalAIM language in assigned responsibilities. **Page 8:** Removed Program Staff description for Associate Director of Housing and Incentive Programs. **Page 9:** Updated Program Staff description for Associate Director of Utilization Management Regulation to better describe delegation oversight process. **Page 9:** Added new Program Staff description for Senior Manager of Justice Involved Programs – RN	NCQA team Compliance Provider Relations

Synopsis of Changes to Discussion Policies

Policy Number & Name	Page Number	Summary of Revisions (Please include why the change was made, i.e. NCQA, APL, Medi-Cal guidelines, clarification etc.)	External Documentation (Notice required outside of originating department)
		Page 10: Updated Program Staff description for Manager of Long Term Support Services (LTSS) – RN to specify that this position has the authority to make decisions on coverage not relating to medical necessity. **Page 10:** Updated title to Clinical Manager, Enhanced Health Services- RN for position previously described as Clinical Manager, CalAIM Justice Liaison, ECM Program. Responsibilities were reorganized. Justice responsibilities went to new Staff description for Senior Manager of Justice Involved Programs – RN. This position will work with EHS leadership to manage and evaluate the CalAIM program. **Page 11:** Updated title to Clinical Supervisor of Enhanced Health Services- RN for position previously described as Supervisor of UM Strategies. No change in responsibilities. **Pages 14-15:** Added new Program Staff description for Program Manager I – (LTSS) **Pages 14 – 16**: Updated terminology to describe CalAIM or EHS as appropriate to our new Enhanced Health Services department. **Page 17:** In the Committee description for PAC, added non-physician clinicians as part of the voting membership. **Page 18:** In the Committee description for QUAC, added committee function for Approving and ensuring implementation of evidence-based guidelines and policies of medical practice including preventive, chronic care, and behavioral health initiatives **Page 18:** In the Committee description for QIHEC, added "grievance and appeal data" to the list of items the committee will analyze, Updated name of CAC committed to "Community" Advisory Committee instead of previous "Consumer." **Page 19:** In the Committee description for SUIQI, added Senior Director of Behavioral Health and Senior Manager of Behavioral Health as committee members. **Page 19:** Updated name of CAC committed to "Community" Advisory Committee instead of previous "Consumer."	

Synopsis of Changes to Discussion Policies

Policy Number & Name	Page Number	Summary of Revisions (Please include why the change was made, i.e. NCQA, APL, Medi-Cal guidelines, clarification etc.)	External Documentation (Notice required outside of originating department)
		Pages 22-23: Updated County Mental Health Plan (MHP) term to be County Behavioral Health Plan (BHP) per state guidance. **Page 28:** Updated name of CAC committed to "Community" Advisory Committee instead of previous "Consumer." **Pages 30-31:** Updated language regarding alternative formats and auxiliary aids in the No Cost Linguistic Services section. Added reference to MCND9002 Cultural and Linguistic Program Description for more information. **Page 31:** Added definition of medical necessity to Denial Determinations section. **Page 31:** Added that denial determinations may occur "When out-of-network services are not clinically appropriate." **Page 33:** Added "Member utilization data" and "Provider prescribing data" to the list of data collection activities for UM analysis and reporting. **Page 34:** In the Statement of Confidentiality section, added that confidentiality statements signed by QUAC and PAC members are "securely stored" in QI files. Also added description of Partnerships Privacy Office responsibilities and a statement on how Partnership maintains administrative structure, reporting procedures, due diligence procedures to protect PHI. **Page 34:** In the Non-Discrimination Statement section, added expanded language per DHCS to describe national origin as including "limited English proficiency (LEP) and primary language" and sex as including "sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity; and sex stereotypes."	

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Partnership HealthPlan of California

UTILIZATION MANAGEMENT PROGRAM DESCRIPTION

MPUD3001

May ~~2024~~2025

Table of Contents

PROGRAM PURPOSE

Partnership HealthPlan of California is a County Organized Health System (COHS) contracted by the State of California to provide Medi-Cal Beneficiaries with a health care delivery system to meet their medical needs.

The mission of Partnership HealthPlan of California is "To help our Members, and the Communities we serve, be healthy." Our vision is to be "the most highly regarded health plan in California."

Partnership has program descriptions and policies to describe the structures needed to provide high quality health care while being stewards of taxpayer resources. In the Utilization Management Program Description, Partnership outlines the structure of our measurement and management of utilization of health care services within our system.

The Partnership Utilization Management (UM) program serves to implement a comprehensive integrated process that actively evaluates and manages utilization of health care resources delivered to all members, and to actively pursue identified opportunities for improvement.

The utilization program resides within the Health Services Department, which consists of six (6) teams including:

- Utilization Management
- Care Coordination
- Population Health
- Pharmacy
- Quality Improvement
- Health Equity

The Partnership UM program serves to accomplish the following:

- Ensure that members receive the appropriate quality and quantity of healthcare services
- Ensure that healthcare service is delivered at the appropriate time
- Ensure that the setting in which the service is delivered is consistent with the medical care needs of the individual

The UM program provides a reliable mechanism to review, monitor, evaluate, recommend and implement actions on identification and correction of potential and actual utilization and resource allocation issues.

Partnership recognizes the potential for under-utilization and takes appropriate steps and actions to monitor for this. The processes for UM decision making are based solely on the appropriateness of care and services and existence of coverage. Partnership does not reward practitioners or other individuals for issuing denials of coverage. Financial incentives for UM decision makers do not encourage decisions that result in under-utilization and Partnership does not use incentives to encourage barriers to care and service. This does not preclude the use of appropriate incentives for fostering efficient, appropriate care.

PROGRAM OBJECTIVES

UM Program Objectives

The Partnership UM program serves to ensure that appropriate, high quality cost-effective utilization of health care resources is available to all members. This is accomplished through the systematic and consistent application of utilization management processes based on current, relevant medical review criteria and expert clinical opinion when needed. The utilization management process provides a system that ensures equitable access to high quality health care across the network of providers for all

eligible members as follows:

- Ensures authorized medically necessary services are covered under contract with the State of California Department of Health Services (DHCS) California Code of Regulations (CCR) Title 22 - For Medi-Cal Members (Title 22)

- Coordinates thorough and timely investigations and responses to member and provider reconsideration and appeals associated with utilization issues

- Initiates needed operational revisions to prevent problematic issues from reoccurring

- Ensures that services which are delivered are medically necessary, which is defined as "reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury," and that those services are consistent with diagnosis and level of care required for each individual, taking into account any co-morbid condition that exists and the ability of the local delivery system to meet the need. Other examples of service-types requiring medical necessity review include (but are not limited to):
  - Services where continuing previously established care is necessary
  - Pharmaceuticals covered under Partnership's medical benefit
  - Out-of-network services that are only covered in clinically appropriate circumstances

- Educates members, practitioners, providers and internal staff about Partnership's goals for providing quality, cost-effective, managed health care

- Defines the methods by which utilization criteria and clinical practice guidelines are selected, developed, reviewed, and modified based upon appropriate and current standards of practice and professional review

- Promotes and ensures the integration of utilization management with quality monitoring and improvement, risk management, and case management activities

- Ensures a process for critical review and assessment of the UM program and plan on, at minimum, an annual basis, with updates occurring more frequently if needed. The process incorporates provider, practitioner and member input along with any regulatory changes, changes to current standards of care, and technological advances

- Evaluates the ability of delegates to perform UM activities and to monitor performance

Program Structure

This section outlines the individual program staff and their assigned activities and responsibilities, including approval authority and the involvement of the designated physician.

Program Staff

Chief Medical Officer (CMO) – MD/DO
The Chief Medical Officer is responsible for the implementation, supervision, oversight and evaluation of the UM Program.

This position provides guidance and overall direction of UM activities and has the authority to make decisions based on medical necessity
which result in the approval or denial of coverage. The assigned activities for this position include but are not limited to:

- Assuring that the UM program fulfills its purpose, works towards measurable goals, and remains in regulatory compliance
- In collaboration with the Chief Health Services Officer, the Senior Director of Care Management, and the Director(s) and Associate Directors of Utilization Management; oversees UM program operations and assists in the development and coordination of UM policies and procedures.
- Reviews for the consistent application of UM decision criteria at least annually and implements corrective actions when needed
- In collaboration with the Health Equity Officer (HEO), oversees Quality Improvement and Health Equity Transformation Program (QIHETP) operations and serves as Co-Chair of the Quality Improvement and Health Equity Committee (QIHEC)
- Serves as the Committee Chair for the Quality/Utilization Advisory Committee (Q/UAC) and regularly attends the Physician Advisory Committee (PAC). CMO (or designee) also serves as the Pharmacy and Therapeutics (P&T) Committee Chair.
- Ensures timely medical necessity review and decisions are made by daily staffing physicians for medical review consultation
- Guides and assists in the development and revision of Partnership medical policy, criteria, clinical practice guidelines, new technology assessments, and performance standards for Q/UAC review, adaptation and PAC approval
- As the chairman of the Q/UAC, presents UM activities on a regular basis to the Q/UAC and provides periodic updates on utilization management activities to the PAC and the Board of Commissioners
- Evaluates the overall effectiveness of the UM program
- Evaluates and uses provider and member experience data when evaluating the UM program in collaboration with the Chief Health Services Officer and appropriate committees

Medical Director – MD/DO

The Medical Director is a physician who oversees the appropriateness and quality of care delivered through Partnership and the cost-effective utilization of services.

- Coordinates with the Directors, Associate Directors, and Managers of UM to provide daily support and appropriate direction to staff on issues pertaining to UM
- Serves on the Quality/Utilization Advisory Committee, Pharmacy & Therapeutics Committee, Credentials Committee and Internal Quality Improvement Committee as requested by the CMO/ may work with community provider committees and advisory boards on medical issues and policies
- Supervises and evaluates other Medical Directors as assigned (direct reports)

Medical Director for Quality - MD/DO

The Medical Director for Quality is a physician who provides clinical and operational guidance for Quality and Performance Improvement activities and is responsible for supervision and oversight of the Quality Assurance & Patient Safety, Clinical Quality & Patient Safety and Quality Measurement–HEDIS teams. This physician also has the authority to make decisions based on medical necessity which result in the approval or denial of coverage for UM activities.

The assigned activities for this position include but are not limited to:

- Serves as the Committee Vice Chair for the Quality/Utilization Advisory Committee (Q/UAC)
- Serves as the Chair for the Peer Review Committee
- Regularly attends the Credentials Committee
- Regularly attends the Physician Advisory Committee (PAC)
- Regularly attends the Internal Quality Improvement (IQI) Committee
- Regularly attends the Quality Improvement and Health Equity Committee (QIHEC)

- Evaluates the appropriateness and quality of medical care delivered through Partnership in all regions
- Participates in enterprise-wide projects that require physician involvement, especially as related to Quality and Performance Improvement activities
- Assists with coverage in the UM Department for medical necessity reviews, applying evidence-based UM decision criteria to the review process in determining medical appropriateness and necessity of services for Partnership members
- Other duties as assigned by the Senior Director of Quality or by the Chief Medical Officer

Medical Director of Medicare Services – MD/DO

The Medical Director of Medicare Services is a physician that oversees the appropriateness and quality of care delivered through Partnership and the cost-effective utilization of services. This physician also has the authority to make decisions based on medical necessity which result in the approval or denial of coverage for UM activities.

- Participates in Medicare Dual Special Needs Plan (D-SNP) policy, strategy and tactical activities, with the Medicare leads in other departments
- Providing medical leadership for Partnership's Medicare activities, including utilization management, quality, care coordination, pharmacy grievances, and compliance activities
- Assists with coverage in the UM Department for medical necessity reviews, applying evidence-based UM decision criteria to the review process in determining medical appropriateness and necessity of services for Partnership members
- Other duties, as assigned

Regional Medical Director - MD/DO

The Regional Medical Director is a physician with the authority to make decisions based on medical necessity which result in the approval or denial of coverage.

The assigned activities for this position include but are not limited to:

- Evaluates the appropriateness and quality of medical care delivered through Partnership in the designated regional area
- Participates in enterprise-wide projects that require Physician involvement
- Other duties as assigned by the Chief Medical Officer.

Associate Medical Director - MD/DO

This Physician has the authority to make decisions based on medical necessity that result in the approval or denial of coverage. The assigned activities for this position include:

- Coverage in the UM Department for medical necessity reviews applying evidence-based UM decision criteria to the review process in determining medical appropriateness and necessity of services for Partnership members
- Provides review of quality of care issues and serves on Q/UAC
- Other duties as assigned by the Chief Medical Officer

Behavioral Health Clinical Director - MD/DO/PhD/ PsyD

The Partnership Behavioral Health Clinical Director is an MD, DO, clinical PhD, or PsyD who is actively involved in the behavioral health aspects of the UM program. This Director provides clinical oversight of Partnership's behavioral health activities including substance use services and the activities of Partnership's delegated managed behavioral health organization(s). The Behavioral Health Clinical Director has the authority to make decisions based on medical necessity which result in the approval or denial of coverage for behavioral health or substance use services. The assigned activities for this position include:

- Establishes UM policies and procedures in collaboration with Partnership's delegated managed behavioral health organization(s)
- Oversees and monitors quality improvement activities
- Facilitates network adequacy
- Participates in the peer review process
- Evaluates behavioral health care and substance use disorder (SUD) treatment services requests in collaboration with Partnership's delegated managed behavioral health organization(s)
- Oversees and monitors functions of Partnership's delegated managed behavioral health organization(s)
- Serves on Quality/Utilization Advisory Committee; Quality Improvement and Health Equity Committee (QIHEC); Pharmacy and Therapeutics Committee; Credentials Committee and Internal Quality Improvement Committee including the Substance Use Internal Quality Improvement Subcommittee.

Pharmacy Services Director – Pharm.D.

This position is responsible for overseeing all HealthPlan activities related to medication benefit and pharmacy services and supervising the Partnership Pharmacy management team, Partnership Clinical Pharmacists, and support staff. The assigned activities for this position include but are not limited to:

- Medication coverage management
- Development of applicable policies and guidelines
- Serves on the Pharmacy and Therapeutics (P&T) Committee (serving as Chair when designated by the CMO), the Global Medi-Cal Drug Utilization Review (DUR) Board and the Pediatric Quality Committee (PQC)
- Drug utilization review
- Regularly attends the Quality Improvement and Health Equity Committee (QIHEC)
- Drug prior authorization for medications covered under the medical benefit
- Implementation of cost effective utilization management measures for medications covered under the medical benefit
- Participation in provider education initiatives such as academic detailing with plan physicians
- Medical education meetings
- Assisting with development of Clinical Practice Guidelines
- Other duties as assigned by the Chief Medical Officer

Chief Health Services Officer - RN

Provides executive leadership on current and new Health Services programs, operations, projects, policies and procedures to ensure high quality results across the continuum. This position has the authority to make decisions on coverage not relating to medical necessity. The assigned activities include:

- Provides oversight and guidance for the UM program across all regions including daily support and appropriate direction to staff on issues pertaining to UM.
- Provides after-hours clinical coverage for providers requesting authorization for services pursuant to health plan policies and procedures.
- Reports to the Q/UAC on Health Services activities
- Coordinates departmental UM and Quality Improvement efforts
- Oversees the design and implementation of Quality Improvement and UM programs in order to meet Medicare Model of Care standards as well as National Commission on Quality Assurance (NCQA) and Utilization Review Accreditation Commission (URAC) accreditation for both Medi-Cal and future Medicare lines of business (D-SNP).
- Has a lead role in regulatory audits (DHCS, DMHC, CMS, NCQA)
- Collaborates with providers and facilities
- Monitors and analyzes UM data to inform decision making
- Develops recommendations based on data analysis and strategic planning
- Collaborates with the Chief Medical Officer and the Q/UAC on UM activities

- Evaluates and uses provider and member experience data when evaluating the UM program in collaboration with the Chief Medical Officer
- Serves as Chairperson of the Benefit Review Evaluation Workgroup (BREW)

Director of Health Equity – MD/DO/PharmD/RN

The Director of Health Equity serves as the Health Equity Officer (HEO) and is responsible for the co-implementation, co-supervision, co-oversight and evaluation of the Quality Improvement and Health Equity Transformation Program (QIHETP). This position provides guidance and overall direction of QIHETP activities and has the authority to make decisions based on the health equity annual plan. The assigned activities for this position include but are not limited to:

- Assuring that the QIHETP program fulfills its purpose, works towards measurable goals, and remains in compliance with regulatory requirements.
- In collaboration with the Chief Medical Officer (CMO); oversees QIHETP program operations and assists in the development and coordination of QIHETP policies and procedures.
- Serves as a Co-Chair for the Quality Improvement, Health Equity Committee (QIHEC) and the Population Needs Assessment (PNA) committee and regularly attends the Quality/Utilization Advisory Committee (Q/UAC) as a standing member
- Guides and assists in the development and revision of QIHETP medical policy, criteria, clinical practice guidelines, new technology assessments, and performance standards for QIHEC review
- Other duties as assigned the Chief Executive Officer (CEO)
- Provides guidance to in staff trainings and on-site continuing education regarding diversity, equity, and inclusion and health equity
- Provides support for obtaining recommended accreditations that support diversity, equity, inclusion, and health equity (e.g. NCQA Health Equity Accreditation)

Senior Director of Care Management- RN

Under the direction of the Chief Health Services Officer, this position is responsible for setting and carrying out the overarching strategic direction and goals of the Utilization Management and Care Coordination Departments. This position maintains and oversees proper delivery, coordination and execution of all related services and activities to improve the health outcomes of members and has the authority to make decisions on coverage not relating to medical necessity. Assigned activities include:

- Oversees and manages a large team of clinical and non-clinical staff while working in cross collaboration with both Medical Directors and other senior departmental leaders
- Responsible for overseeing the operations, programming and alignment of Utilization Management and Care Coordination department programs and activities
- Proactively works with key internal and external stakeholders to implement policies, procedures and/or initiatives that fulfill the organization's goals, strategic priorities and mission
- Provides clinical leadership in the design and implementation of programs and procedures for all lines of business; demonstrates decisiveness and communicates decisions and rationale clearly
- Stays abreast of health care policies, regulations and changes as they relate to those issued by CMS, DHCS, NCQA and/or other associated agencies
- Utilizes data to analyze and support quality patient outcomes and ongoing evaluation of the organization's Care Coordination and Utilization Management programs; ensuring effective and efficient health and quality outcomes, improving care coordination and meeting requirements of contracts

Director of Utilization Management - RN

Under the direction of the Senior Director of Care Management, this position is responsible for the day-to-day implementation of Partnership's UM Program and ensuring consistent development, implementation, and maintenance of health services programs. This position has the authority to make decisions on coverage not relating to medical necessity. Assigned activities include:

- Implements the UM program
- Provides day to day direction to UM Associate Directors, Managers and Supervisors ~~within~~ to meet department goals and objectives and is available to staff on-site or by telephone
- Conducts annual performance evaluations for assigned UM staff
- Conducts monitoring activities
- Participates in staff trainings and on-site continuing education
- Participates in clinical audits of health services programs and services; oversees the nursing component of the audits and assists with development of corrective action plans when necessary
- Reports to the Q/UAC on UM activity
- Collaborates with providers and facilities
- Develops recommendations for program improvements
- Coordinates activities with Quality Improvement, Care Coordination, Population Health, Health Equity, Enhanced Health Services, Member Services, Claims, and Provider Relations departments to identify, track, and monitor quality of care outcomes and trends
- Participates in establishing and maintaining reports which relay the efficacy of UM activities and summarizes, at least annually, the UM activity, quality improvement activities and utilization outcomes, with supporting statistical data at IQI and Q/UAC

Director of ~~Utilization Management Strategies- RN~~Enhanced Health Services

Under the direction of the Chief Health Services Officer, plans, monitors and evaluates utilization management activities to identify strategic initiatives to enhance the efficacy of the UM program, while improving health outcomes, in a cost effective manner. This position has the authority to make decisions on coverage not relating to medical necessity. Assigned activities include:

- Serves as Director ~~for the Community Supports Initiative~~of CalAIM program
- Responsible for oversight of h~~H~~ousing and i~~I~~ncentive payment p~~P~~rograms
- Responsible for connecting with Street Medicine programs
- Collaborates with the provider relations contracting team to identify strategic opportunities and develops recommendations
- Participates in contract review and negotiations
- ~~Attends regular meetings with hospitals, long-term care facilities and community agencies to facilitate cost effective and appropriate alternative placements~~
- In collaboration with the Chief Health Services Officer and Senior Director of Provider Relations, reviews and processes provider grievances in accordance with appropriate regulatory requirements and participates in provider grievance meetings
- Works with county agencies and community-~~-~~based organizations to facilitate the DHCS CalAIM initiative related to Enhanced Care Management (ECM) and Community Support (CS) Services with focus on improving medical health outcomes and healthcare costs
- Works collaboratively with claims and configuration department leaders and team members to identify systematic issues or opportunities for staff and/or provider education
- Attends claims configuration meetings and Benefit Review Evaluation Workgroup (BREW) as well as IQI, Q/UAC and PAC
- Works with providers and/or vendors to facilitate issue resolution and ensure a consistent UM process
- Develops, reviews, and/or revises Partnership UM policies and procedures in collaboration with the Chief Health Services Officer as appropriate.
- Develops expertise in housing services funded through the Medi-Cal program including 1915(c) Home and Community Based Services Waivers and other Medicaid housing related opportunities such as Assisted Living Waivers.

- Leads Partnership discussions regarding state and federal housing/homeless policy, legislative, and regulatory strategy and implementation, and oversee and support regional and local policy initiatives, with a strong economic equity lens.
- Works with local agencies, state networks, and community organizations to identify issues and develop consensus positions on policy issues.
- Carries out research and policy analyses on issues and opportunities related to state housing policy and low-income housing programs, gathers member input, and establishes policy priorities and a legislative and regulatory agenda on an annual and ongoing basis.
- Interacts with housing advocacy groups and other organizations to identify emerging issues and opportunities.

Associate Director of Utilization Management - RN

Under the direction of the Director of Utilization Management, manages and provides direction to the Utilization Management department Managers, Supervisors and staff for all product lines ensuring consistent development, implementation, and maintenance of health services programs. This position has the authority to make decisions on coverage not relating to medical necessity. Assigned activities include:

- Implements the UM program
- Provides day to day direction to UM Managers and Supervisors to meet department goals and objectives and is available to staff on-site or by telephone
- Conducts annual performance evaluations for assigned UM staff
- Conducts monitoring activities
- Participates in staff trainings and on-site continuing education
- Audits medical records as appropriate and monitors for consistent application of UM criteria by UM staff, for each level and type of UM decision
- Collaborates with providers and facilities
- Develops recommendations for program improvements
- Coordinates activities with Care Coordination, Population Health, Quality Improvement, Member Services, Claims, and Provider Relations departments to identify, track, and monitor quality of care outcomes and trends
- Participates in establishing and maintaining reports which relay the efficacy of UM.

Associate Director of Enhanced ~~Care Management Operations~~Health Services

Under the direction of the Director of ~~Utilization Management Strategies~~Enhanced Health Services, is responsible for managing the ~~Medi-Cal Enhanced Care Management (ECM) benefit~~CalAIM program. Provides strategic support and management/supervisory support for the CS and ECM staff, including but not limited to, strategic goal setting, program planning, budget/account management, and supervision of team members.

- Participates in internal and external meetings, providing input and guidance to community stakeholders and partners regarding the ~~ECM benefit~~CalAIM program
- Fosters cross-departmental collaboration in shared operational activities related to the ECM benefit and CS services (ex: Provider Relations, Care Coordination, Claims, etc.)
- In collaboration with Provider Relations, prepares and reviews provider and member education materials related to ~~the ECM benefit~~CalAIM
- Ensures timely monitoring and oversight of Partnership-contracted ECM and CS providers, pursuant to DHCS regulations and Partnership policies and procedures
- Identifies trends, patterns and/or opportunities for enhancements to workflows, tools and/or systems to promote efficiency, cost, and quality of ECM and CS services
- As directed, prepares or provides updates on DHCS deliverables and reports associated with ~~the ECM benefit~~CalAIM, including but not limited to the DHCS Model of Care template, DHCS ECM Exception Request(s), and/or DHCS ECM and CS reporting guidelines
- Maintains knowledge of ~~ECM benefit~~CalAIM requirements and shares updates with appropriate internal/external stakeholders, as necessary

~~*Associate Director of Housing and Incentive Programs*~~

~~Under the direction of the Director of Utilization Management Strategies, administers housing programs for Partnership HealthPlan of California; represents the Plan with existing and emerging housing providers including counties and Continuums of Care for the Plan's member counties; advocate for, promotes and makes recommendations regarding housing and related services for Partnership members experiencing homelessness, or at risk of homelessness. This position tracks and oversees state DHCS grant programs and initiatives that are to be administered by Partnership, in coordination with other departments such as Behavioral Health, at the direction of the CEO. Assigned activities include:~~

- ~~Develops expertise in the existing resources and safety net housing needs in each county served by Partnership.~~
- ~~Develops expertise in housing services funded through the Medi-Cal program including 1915(c) Home and Community Based Services Waivers and other Medicaid housing related opportunities such as Assisted Living Waivers.~~
- ~~Leads Partnership discussions regarding state and federal housing/homeless policy, legislative, and regulatory strategy and implementation, and oversee and support regional and local policy initiatives, with a strong economic equity lens.~~
- ~~Works with local agencies, state networks, and community organizations to identify issues and develop consensus positions on policy issues.~~
- ~~Carries out research and policy analyses on issues and opportunities related to state housing policy and low-income housing programs, gathers member input, and establishes policy priorities and a legislative and regulatory agenda on an annual and ongoing basis.~~
- ~~Interacts with housing advocacy groups and other organizations to identify emerging issues and opportunities.~~
- ~~Represents Partnership in various community planning and collaboration efforts.~~

Associate Director of Utilization Management Regulations

Under the direction of the Director of Utilization Management, provides oversight of the UM Program to ensure compliance with regulatory requirements including, but not limited to, requirements of DHCS, CMS, and the National Committee for Quality Assurance (NCQA) . Assigned activities include:

- Coordinates activities with External and Regulatory Affairs Compliance, Member Services, Claims, and Provider Relations departments to identify, track, and monitor quality of care issues and trends related to UM Department processes
- Prepares reports on departmental activities according to established schedules and format. Identifies patterns and trends, conducts retrospective review as needed and works with UM Leadership to develop corrective action plans.
- Prepares and presents the annual evaluation, program description to IQI and Q/UAC
- Participates in the grievance process
- Acts as primary contact and support to each UM Delegate, providing training and support as necessary
- Conducts delegation oversight through regular auditing of each UM Delegate, prepares audit reports for review by the Director of Utilization Management, ~~Chief Health Services Officer, and the Chief Medical Officer or physician designee,~~ and prepares information for the Delegation Oversight Review Sub-Committee (DORS) and NCQA Steering Committee.
- Collaborates with Department leaders to ensure that all policies and procedures related to regulatory requirements are updated at least annually, or as needed, and presented to appropriate committees for review. Assists Partnership staff and providers with the interpretation of Partnership policies, procedures, and regulatory requirements.
- Works with UM Leadership and UM Trainer to develop standardized training content and materials for new staff and ongoing education for existing staff
- Participates in the planning and development of new/ enhanced Health Services plan benefits or product lines as needed. Attends Benefits Review and Evaluation Workgroup meetings
- Participates in audits by various regulatory agencies as necessary

Senior Manager of Justice Involved Programs – RN
Under the direction of the Director of Enhanced Health Services, is responsible for working directly with justice-involved agencies and providers who serve justice-involved members in Partnership HealthPlan of California's county network. The assigned activities include:

- Serves as the Justice Liaison for the HealthPlan
- Facilitates communication with external stakeholders including: network providers, county staff, state prison system, probation offices, police/sheriff departments and other stakeholders as appropriate
- Oversees and develops a system for care coordination for this designated population on behalf of the HealthPlan, ensuring providers and staff are capable of serving this member population.
- Serves as the HealthPlan lead for oversight of any applicable MOUs between the HealthPlan and other entities as directed by DHCS and supports MOU activities and requirements to ensure HealthPlan compliance.
- Establishes systems to ensure connections with county mental health plans for the delivery of specialty mental health services on behalf of this specific population.
- Serves as a point of escalation for care managers if they face operational obstacles when working with County and/or community partners.

Manager of Utilization Management - RN
Responsible for the implementation, management and evaluation of an effective and systematic UM Program. Provides day-to-day guidance to UM staff and manages all aspects of utilization review activities and is available to staff on-site or by telephone. Working with the Chief Medical Officer, Chief Health Services Officer, Directors of UM, Associate Directors of UM, utilization committees, and Health Plan Directors, promotes efficient resource utilization throughout the organization, providing leadership, teambuilding and direction needed to ensure attainment of UM goals. This position has the authority to make decisions on coverage not relating to medical necessity. The assigned activities include:

- Coordinates completion of activities
- Monitors for consistent application of UM criteria by UM staff for each level and type of UM decision
- Participates in staff trainings and on-site continuing education
- Provides recommendations for interventions designed to improve utilization management issues
- Coordinates implementation of interventions
- Develops UM policy and procedures for Q/UAC approval
- Develops, or coordinates development of, documentation of UM activities
- Conducts annual performance evaluations for assigned UM staff

Manager of Long Term Support Services (LTSS) – RN

Provides leadership and clinical oversight for operational aspects of Utilization Management for Long Term Support Services (LTSS); including the responsibility for providing daily oversight, leadership, support and management of assigned staff. Collaborates with departmental and Health Services leadership to oversee and monitor the provision of LTSS benefits and services; coordinating with Partnership providers and/or community stakeholders as necessary. This position has the authority to make decisions on coverage not relating to medical necessity.

- Provides day-to day direction to licensed clinical staff regarding utilization review, care coordination, discharge planning, and other services across the continuum of care for members in need of LTSS
- Ensures compliance with regulatory/accreditation requirements related to UM by collaborating with other departments and maintaining survey and audit readiness
- Leads, develops and operationalizes evidence-based best practices and activities to address LTSS benefits and/or services (ex: Transitional Care Services, facility placements, care coordination, etc.)

- Identifies and incorporates quality-monitoring activities to improve the quality of care, outcomes, and/or costs for members receiving one or more LTSS (ex: Skilled Nursing, Community Based Adult Services, In-Home Support Services, etc.)

Clinical ~~Team~~ Manager, Enhanced Health Services - RN~~CalAIM Justice Liaison, ECM Program~~
Assists the Director and Associate Director of ~~Utilization Management Strategies and Associate Director of~~ Enhanced Health Services (EHS)~~Care Management (ECM) Operations~~ in the development, implementation, ~~and/or expansion of the Medi-Cal ECM benefit and collaborating strategic initiatives.~~ management and evaluation of an effective and systematic CalAIM Program. Provides day-to-day guidance to nursing staff and manages all aspects of utilization review activities and is available to staff on-site or by telephone. This position has the authority to make decisions on coverage not relating to medical necessity. The assigned activities include:

- Monitors for consistent application of UM criteria by EHS staff for each level and type of EHS decision
- Participates in staff trainings and on-site continuing education
- Provides recommendations for interventions designed to improve utilization management issues
- Coordinates implementation of interventions
- Oversees auditing and oversight of CalAIM providers
- ~~This position is responsible for serving as Partnership's Justice Liaison~~
- ~~Communicates with network providers and other stakeholders in the Partnership service area to coordinate this work~~
- ~~Provides clinical oversight activities and program support to ECM providers~~
- Collaborates with departmental leadership to oversee and maintain a cohesive team with a high level of productivity, accuracy and quality to achieve goals and objective
- Maintains updated policies and procedures, workflows, documentation, desktops, reports, etc.
- Fosters cross-departmental leadership in shared operational activities related to the CalAIM initiatives. (ex: Provider Relations, Utilization Management, Claims, etc.)
- Maintains knowledge of the CalAIM initiatives and shares updates with appropriate internal /external stakeholders when necessary

Manager of Utilization Management Operations
Responsible for the operational aspects of Utilization Management, including responsibility for providing daily oversight, leadership, support, and management of assigned staff. Ensures compliance with established criteria, regulations, standards, best practices and Health Plan benefits. The assigned activities include:

- Provides daily operations oversight and direction to the team Supervisor(s) and Data Coordinators
- Manages day to day functions including coordination of assignments, monitoring of call volume and adherence to Partnership workplace policy and is available to staff on-site or by telephone
- Assists in the refinement/improvement of the HS programs
- Provides performance feedback to the Data Coordinator staff and conducts staff trainings as needed.
- Monitors UM Data Coordinator activity for consistent application of desktop processes and procedures by UM Data Coordinator staff
- Provides leadership, direction, training, and support to the assigned staff
- Participates in staff trainings and on-site continuing education
- Conducts annual performance evaluations for assigned UM staff

Senior Programmer Analyst
This position supports the design, development, and documentation of Partnership's core claims processing, TAR processing, and claims processing platforms. Provides technical support and problem resolution to UM Department end users.

- Maintains in-depth knowledge of various Partnership systems
- Tests, schedules, and implements new releases and upgrades of software
- Tests, schedules, and implements interface changes to systems, when needed
- Supports development of business requirements for various system implementations
- Uses sound technical judgment and makes appropriate systems decisions
- Assists in development and maintenance of policies and procedures to document new and changed elements of UM Operations

Inpatient/Outpatient/LTSS Nurse Supervisor UM - RN

This position is responsible for the daily mentorship and oversight of the staff assigned to inpatient, ~~or~~ outpatient or LTSS services. This position has the authority to make decisions on coverage not relating to medical necessity. The assigned activities include:

- Works collaboratively with all levels of leadership within the department to efficiently coordinate workflow and individual staff assignments
- Provides day to day supervision to the assigned team, overseeing daily operations of the inpatient, ~~or~~ outpatient or LTSS review process
- Participates in staff trainings and on-site continuing education. With UM Leadership, conducts annual performance evaluations for assigned UM staff
- Audits medical records as appropriate and monitors for consistent application of UM Criteria by UM staff, for each level and type of UM decision.
- This position, in addition to his/her own case load, may be assigned cases in the area of oversight as deemed necessary to provide coverage

Clinical Supervisor of ~~Utilization Management Strategies~~Enhanced Health Services - RN

Provides daily supervision and program support to designated staff. Assists departmental leadership in developing and maintaining a cohesive team with a high level of productivity, accuracy and quality to achieve goals and objectives

- Provides daily leadership, direction, resources, training, evaluation, coverage, and program support to assigned staff
- Performs supervisory functions such as timecard management, directing work activities, conducting annual reviews and training to staff
- Maintains active participation with inbound and outbound provider reporting and other related duties, adjusting assignments as necessary to meet business needs and/or regulations
- Facilitates meetings with Partnership providers and/or external community partners as necessary
- Supports organizational collaboration and communication regarding CalAIM initiatives through active collaboration

Inpatient/Outpatient Nurse Lead UM - RN/ LVN

This position is responsible for assisting with oversight of daily operations of the inpatient or outpatient review process (as assigned). This position has the authority to make decisions on coverage not relating to medical necessity. The assigned activities include:

- Provides direction and support, to staff concerning daily assignments.
- Participates in interview process and provides training in inpatient or outpatient review for new hires.
- Evaluates appropriateness of care through interpretation of benefits as outlined in Title 22, Medi-Cal Provider Manual using Partnership policies and procedures, and InterQual criteria.
- Documents and maintains patient-specific records in the data collection software system.
- Assists in the refinement/improvement of the Health Services programs. Participates in continuous process improvement endeavors.
- Works with other Partnership departments to resolve issues relating to authorization of medical services.
- Participates in Inter-rater Reliability studies, reviewing medical records as assigned.

- Communicates regularly with the UM Team Manager and works collaboratively to resolve issues.

Nurse Coordinator/ UM II - RN/ LVN

Work collaboratively with all levels of UM leadership and other Partnership staff to develop, implement, and evaluate health outcomes, provider performance and other performance indicators pertinent to quality of care. This position has the authority to make decisions on coverage not relating to medical necessity. Assigned activities include:

- Assist in training and orientation of new staff to the department upon request
- Review and authorization of DME, Ancillary and Medical TARs based on established guidelines
- Review and authorization of Long Term Care TARs based on established guidelines
- Review and authorization of inpatient Hospital TARs based on established guidelines
- Review and authorization of Enhanced Care Management (ECM) and Community Supports TARs based on established guidelines
- Reviews residential placement authorization requests for substance use disorder (SUD) 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. Licensed staff who operate in the capacity of behavioral health authorizations are required to complete specialized ASAM[1] training annually.
- Retrospective review of services to determine medical necessity
- Refer cases to the Chief Medical Officer for requests that may not appear to meet evidence-based medical necessity criteria
- Determines if requested services are part of the member's benefit package
- Work collaboratively with the Care Coordination, Population Health, Pharmacy and Quality Improvement staff on UM issues

Nurse Coordinator/ UM I - RN/ LVN

Work collaboratively with all levels of UM leadership and other Partnership staff to develop, implement, and evaluate health outcomes, provider performance and other performance indicators pertinent to quality of care. This position has the authority to make decisions on coverage not relating to medical necessity. Activities assigned include:

- Review and authorization of DME, Ancillary and Medical TARs based on established guidelines.
- Review and authorization of Long Term Care TARs based on established guidelines.
- Review and authorization of inpatient Hospital TARs based on established guidelines.
- Review and authorization of Enhanced Care Management (ECM) and Community Supports TARs based on established guidelines
- Reviews residential placement authorization requests for SUD 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. Licensed staff who operate in the capacity of behavioral health authorizations are required to complete specialized ASAM[1] training annually.
- Retrospective review of services to determine medical necessity
- Refer cases to the Chief Medical Officer for requests that may not meet medical necessity criteria
- Determine if requested services are part of the member's benefit plan
- Work collaboratively with the Care Coordination, Population Health, Pharmacy, and Quality Improvement staff on UM issues

Clinical Pharmacist – Pharm.D., RPh

[1] American Society of Addiction Medicine (ASAM) Criteria - As defined in the Department of Health Care Services (DHCS) Drug Medi-Cal Organized Delivery System Intergovernmental Agreement, pertains to necessary care for biopsychosocial severity and is defined by the extent and severity of problems in all six multidimensional assessment areas of the patient.

Work collaboratively with all levels of Pharmacy leadership to review medication Treatment Authorization Requests (TARs) to promote safe, appropriate, and cost effective drug therapy.

- Communicates and educates prescribers on TAR processes, TAR determination, and Partnership medication coverage policies
- Provides oversight to the pharmacy technician staff in the daily TAR review process
- Participates in P&T meetings and conduct drug utilization reviews to identify treatment gaps and optimize medication therapy outcomes based on national treatment guidelines and evidence-based medicine
- Participates in the development of technician drug review guidelines and creation of authorization criteria for medical benefit medications
- Participates and works with other departments on cross-departmental initiatives that require Clinical Pharmacy input/participation
- Support HEDIS and other clinical quality improvement work through provider academic detailing and member engagement activities
- Ensures compliance with regulatory and quality standards/requirements including, but not limited to, the standards of the National Committee for Quality Assurance (NCQA) and the requirements for the California Department of Health Care Services (DHCS) and the Centers for Medicare and Medicaid Services (CMS)
- Other duties as assigned by the Pharmacy Services Director

Pharmacy Technician – CPhT, RPhT

Work collaboratively with all levels of Pharmacy leadership to review medication Treatment Authorization Requests to promote safe, appropriate, and cost effective drug therapy.

- Reviews and approves TARs based on established internal pharmacy technician review guidelines &/or Partnership drug TAR requirements (prior authorization criteria for use). If a TAR cannot be approved based on guidelines/criteria, the pharmacy technician will refer the TAR to the Clinical Pharmacist for an escalated review.
- Educates prescribers on TAR processes, TAR determination, and Partnership medication coverage policies.
- Supports HEDIS and other clinical quality improvement work through provider academic detailing and member engagement activities.

Data Coordinator/ Supervisor UM – Administrative

Works closely with UM Leadership to establish consistent evaluation of Data Coordinators' work performance. Responsible for oversight of Data Coordinators.

- Monitors day to day functions including coordination of assignments, monitoring of call volume and adherence to Partnership workplace policy and is available to staff on-site or by telephone
- Assists in the refinement/improvement of the HS programs
- Provides performance feedback to the Data Coordinator staff and conducts staff trainings as needed.
- Monitors UM Data Coordinator activity for consistent application of desktop processes and procedures by UM Data Coordinator staff
- Provides leadership, direction, training, and support to the assigned staff
- Participates in staff trainings and on-site continuing education
- Conducts annual performance evaluations for assigned UM staff

Policy Analyst

This position is responsible for drafting, editing, reviewing, auditing, tracking, monitoring and maintaining utilization management policies and procedures for Partnership. Under the supervision of the Associate Director of Utilization Management Regulations, ensures compliance with governing rules, regulations, and/or accreditation standards.

- Prepares UM policies and/or related materials for appropriate committees' review and attends meetings of the Internal Quality Improvement Committee and Quality/Utilization Advisory Committee.
- Performs policy research to analyze current and/or new regulations by applicable Partnership regulators and/or accrediting agencies (ex: DHCS, DMHC, CMS, NCQA, etc.)
- Reviews both draft and final All Plan Letters (APLs) and/or regulatory changes and supports leaders with the research, planning, implementation and/or operational readiness submissions across the organization.
- Participates in audits with Partnership's regulatory and/or accreditation bodies by preparing policies, documents and/or reports as needed.
- Conducts analysis, collects information, and evaluates impact of regulatory and compliance issues to inform auditing and monitoring activities.
- Analyzes the impact of new programs/benefits and efficacy of existing processes, policies, procedures and trainings.

Program Manager I – (Regulatory/Delegation)

Under the direction of the Associate Director of UM Regulations, assigned activities include:

- Responsible for day to day duties associated with oversight of UM delegated entities
- Responsible for successful implementation of new activities and processes with delegated entities
- Identifies and resolves issues and concerns with UM delegation to ensure risk is mitigated in a timely manner and recommends solutions to Leadership for final decision, as necessary
- Responsible for collecting and tracking required document submissions from delegated entities
- Coordinates and participates in both desktop and onsite audits of delegated entities
- Ensures efficient and appropriate collaboration between the Utilization Management staff and UM delegated entities

Program Manager I – (EHS~~CalAIM CS/ECM~~)

Under the direction of an Associate Director of ~~CalAIM (CS/ECM),~~Enhanced Health Services, develops, implements, improves, and manages assigned programs related to CalAIM. Participates in the design, implementation, and/or expansion of strategic programs and departmental initiatives. Supports the development and execution of program goals, outcome measures, and program reporting.

- Creates and delivers CalAIM program information and reports to both internal and external stakeholders
- Supports the development and execution of strategies to engage stakeholders.
- Responsible for program evaluation and continuous improvement activities
- Responsible for successful implementation of CalAIM activities.
- Reviews program data accuracy, completeness, and required submissions.

Program Manager I – (LTSS)

Under the direction of the Manager of Long Term Support Services (LTSS), supports operational aspects of Utilization Management related to LTSS including monitoring and reporting of the provision of LTSS benefits and services. Assigned activities include:

- Serves as the In-Home Supportive Services (IHSS) Specialist
- Serves as the Community Provider Advisory Council (CPAC) Coordinator
- Facilitates Point Click Care discharge reporting
- Monitors and tracks Letters of Agreement (LOAs)
- Coordinates with Health Analytics for Dashboard reporting
- Coordinates Critical Incident Review
- Creates specialized documents (Desktops, Info sharing with facilities and other departments, etc)
- Acts as a point of contact for the team for additional reporting needs

Project Coordinator II - (EHS~~CalAIM CS/ECM~~)
Under the direction of an Associate Director of Enhance Health Services~~CalAIM (CS/ECM)~~, provides coordination and implementation support of defined tasks for CalAIM programs. Conducts business analysis to evaluate programs, exercises independent judgement in leading assigned projects, tracks and reports data to a higher complexity level, coordinates daily activities, communicates program status to stakeholders.

- Coordinates, facilitates, and leads both internal and external meetings for CalAIM Providers.
- Supports the successful implementation of CalAIM projects.
- Customarily and regularly compiles, reviews and analyzes project data and results.
- Develops expertise in program focus areas and stays informed of key developments and training/development opportunities within our network and across the healthcare industry, maintains accurate provider listing for CalAIM Providers.

Project Coordinator I - (EHS~~CalAIM CS/ECM~~)
Under the direction of an Associate Director of ~~CalAIM (CS/ECM),~~Enhanced Health Services, provide coordination and implementation support of defined tasks for CalAIM program.

- Coordinates and facilitates both internal and external meetings for CalAIM Providers.
- Develops and publishes agendas, meeting minutes, and necessary documentation
- Attends project meetings, follows up on assigned tasks, and communicates the status of projects to the supervisor
- Manages, tracks, and processes CS or ECM referrals

Health Services Analyst I
Performs routine and ad-hoc reporting and data management for internal and external users; assists in maintaining reporting systems within the department. Prepares, analyzes, reports, and manages data used for both plan-wide and regional decision making for evaluating performance in key quality measures and the effective use of health plan resources on a routine and ad hoc basis. Works collaboratively with departments company-wide to identify data needs, develop and maintain data queries and tools, and complete accurate reporting to support performance and process improvements.

Continuing Education Program Coordinator - Administrative
Provides administrative support to the Chief Medical Officer. Responsible for coordinating the Continuing Education program, including planning meetings and trainings. Audits each CME/CE activity to ensure all elements required by organizations overseeing Partnership's educational programs are documented. Maintains organized electronic versions of all continuing education records.

Executive Assistant to CMO - Administrative
Provides administrative support to the Chief Medical Officer. Responsible for maintaining and updating online policy and procedure manuals and managing appointment calendars. Coordinates setup and executes minutes for designated meetings.

Executive Assistant to the Chief Health Services Officer - Administrative
Provides administrative support to the Chief Health Services Officer. Manages appointment calendar, develops agendas, organizes meetings and executes minutes for designated meetings.

Health Services Administrative Assistant II – UM, EHS - Administrative
Provides administrative support to the Utilization Management Director and/or other UM Leadership. Manages appointment calendars, coordinates setup and executes minutes for designated meetings.

Health Services Administrative Assistant I – UM - Administrative

Provides administrative support to UM Leadership. Manages appointment calendars and works closely with the Information Technology Department to ensure appropriate electronic functioning for the Utilization Management Department.

Health Services Administrative Assistant I – CMO - Administrative
Responsible for administrative support to the Associate and Regional Medical Directors. Responsible for managing appointment calendars, scheduling daily UM and pharmacy workload coverage for the MDs, developing weekly and monthly schedules for distribution to other departments, and coordinating Peer-to-Peer requests from providers. Coordinates setup and executes minutes for designated meetings.

Authorization Specialist/ UM Trainer – Administrative
Responsible for providing training on all appropriate software platforms for new hires. Creates and maintains current training materials for the UM department. In conjunction with UM leadership team, prepares and delivers retraining of identified topics as deemed necessary.

- Facilitates independent DME consultant evaluation visits to members for specialty equipment needs as needed or directed by UM Leadership.
- Acts as a resource regarding UM department software programs and special projects upon request and is available to staff on-site or by telephone
- Coordinates with Member Services Call Center system to place members into appropriate Direct Member status related to their care.

Data Coordinator/ UM Lead - Administrative
Under the direction of the Data Coordinator Supervisor and UM Leadership:

- Monitors Data Coordinator documentation for accuracy
- Ensures Data Coordinator staff have the resources required for completing TAR entry and using good judgment and is available to staff on-site or by telephone
- Enters both manual and electronic submitted data into Partnership systems for RAF and TAR authorizations
- Monitors UM Data Coordinator staff for consistent application of desktop processes and procedures
- Responsible for assisting with ongoing staff education in proper use of systems and Partnership UM Departmental policies and procedures
- Participates in staff trainings and on-site continuing education

Coordinator II - Administrative
Under the direction of applicable UM/ ~~CalAIM~~ EHS leadership:

- Serves as a resource to other departments who have inquiries into the UM/ CalAIM process
- Responsible for the input of data and information concerning UM/ CalAIM Referrals and Authorizations
- Receives and responds to telephonic inquiries from providers regarding status of authorization requests and other questions or concerns
- Performs triage and transfers calls to appropriate professional staff when indicated
- Responsible for clerical processing of appeals (as applicable) in accordance with policy, procedures, timeframes and requirements of various regulatory bodies for all lines of business
- Acts as liaison to Claims Department in coordinating timely response to all claims inquiries
- Participates in special projects, tasks and assignments as directed

Coordinator I - Administrative

Under the direction of applicable UM/ ~~CalAIM~~ EHS leadership - responsible for the input of data and information concerning UM/CalAIM Referrals and Authorizations.

- Maintains departmental documents
- Receives and responds to telephonic inquiries from providers regarding status of authorization requests and other questions or concerns
- Performs triage and transfers calls to appropriate professional staff when indicated
- Responsible for clerical processing of appeals (as applicable) in accordance with policy, procedures, timeframes and requirements of various regulatory bodies for all lines of business
- Acts as liaison to Claims Department in coordinating timely response to all claims inquiries
- Participates in special projects, tasks and assignments as directed

Committees

Board of Commissioners

The Board of Commissioners on Medical Care (the Commission) promotes, supports, and has ultimate accountability, authority and responsibility for a comprehensive and integrated UM program. The Commission is ultimately accountable for the efficient management of healthcare resources and services provided to members. The Commission has delegated direct supervision, coordination, and oversight of the UM program to the Q/UAC which reports to the PAC, the committee with overall responsibility for the program. Members of the Commission are appointed by the county Boards of Supervisors for each geographic service area and include representation from the community as follows: consumers, businesses, physicians, providers, hospitals, community clinics, HMOs, local government, and County Health Departments. The Commission meets six times a year.

The purpose of the Commission is to negotiate exclusive contracts with DHCS and to arrange for the provision of health care services to qualifying individuals, as well as other purposes set forth in the enabling ordinances established by the respective counties.

Physician Advisory Committee (PAC)

The PAC monitors and evaluates all Health Services activities and is directly accountable to the Board of Commissioners for the oversight of the UM program. The PAC meets at least ten (10) times a year and may not convene in the months of July and December, with the option to add additional meetings if needed. Voting membership includes external Primary Care Providers (PCPs), board certified high-volume specialists, ~~and~~ behavioral health practitioners and non-physician clinicians. A voting provider member of the committee chairs the PAC. The Partnership Chief Executive Officer, Chief Operating Officer, Chief Financial Officer, Chief Medical Officer, Medical Director for Quality, Regional Medical Director(s), Clinical Director of Behavioral Health, Chief Health Services Officer and leadership from the Quality and Performance Improvement, Provider Relations, Utilization Management, and Pharmacy departments attend the PAC meetings regularly. Other Partnership staff attend on an ad hoc basis to provide expertise on specific agenda items. The PAC oversees the activities of the Q/UAC and other quality-related committees and reports activities to the Board of Commissioners.

Quality/Utilization Advisory Committee (Q/UAC)

The Q/UAC is responsible to assure that quality, comprehensive health care, and services are provided to Partnership members through an ongoing, systematic evaluation and monitoring process that facilitates continuous quality improvement. Q/UAC voting membership includes consumer representative(s) and external providers who are contracted primary care providers (PCPs) and board certified specialists in the areas of internal medicine, family medicine, pediatrics, OB/GYN, neonatology, behavioral health, and representatives from other high volume specialties. The Partnership Chief Medical Officer (CMO) (chair of the committee), Clinical Director of Behavioral Health, Health Equity Officer, Medical Director for Quality, Manager, Patient Safety-Quality Investigations, Associate and Regional Medical Directors and leadership from the Quality and Performance Improvement, Provider Relations, Utilization Management, Care Coordination, Population Health, Pharmacy, and Grievance Departments attend the Q/UAC meetings regularly. Other Partnership staff attend on an ad hoc basis to

provide expertise on specific agenda items. The committee meets on a monthly at least ten (10) times per year, with the option to add additional meetings if needed. Q/UAC activities and recommendations are reported to the PAC and at least quarterly to the Commission. The Q/UAC provides guidance and direction to the UM program by coordinating activities and by functioning as the expert panel when needed. Coordination includes but is not limited to:

- Reviewing, making recommendations to, and approving the *UM Program Description* annually
- Assuring individual member needs are taken into consideration when determinations for care are rendered and in the development of medical policy and procedures.
- Analyzing summary data and making recommendations for action
- Reviewing action plans for quality improvements of UM activities and providing ongoing monitoring and evaluation
- Reviewing medical policy, protocol, criteria and clinical practice guidelines
- Approving and ensuring implementation of evidence-based guidelines and policies of medical practice including preventive, chronic care, and behavioral health initiatives
- Providing oversight of delegated activities

Pharmacy and Therapeutics Committee (P&T)

The P&T Committee is chaired by Partnership's Chief Medical Officer (CMO), or designee such as the Director of Pharmacy, and is comprised of Partnership's Pharmacy Director, Associate and Regional Medical Directors, Partnership staff and network practitioners including pharmacists, primary care physicians, behavioral health and other specialists. P&T makes decisions and recommendations on development and review of the physician administered drugs (PADs) provided under the medical drug benefit, medication policy and procedures, and drug approval criteria. P&T Committee also serves as Partnership's Drug Utilization Review (DUR) Board to review Partnership's DUR program and activities and make recommendations where necessary to improve Partnership's drug utilization. The P&T meets quarterly, providing regular activity reports and recommendations to the PAC, the approval authority for P&T related activities.

Quality Improvement and Health Equity Committee (QIHEC)

The Quality Improvement and Health Equity Committee (QIHEC) is responsible for analyzing and evaluating the results of Quality Improvement (QI) and Health Equity activities including annual review of the results of performance measures, utilization data, grievance and appeal data, consumer satisfaction surveys, and findings and activities of other Partnership specific committees. (e.g. ~~Consumer~~ Community Advisory Committee, Population Needs Assessment (PNA) Committee, etc). This committee shall also be responsible for instituting actions to address health equity performance deficiencies, including policy recommendations, and ensuring appropriate follow-up of identified performance deficiencies.

The QIHEC provides recommendations to the Internal Quality Improvement Committee (IQI) and to the Quality/Utilization Advisory Committee (Q/UAC) Committee. The Q/UAC provides recommendations to the Physician Advisory Committee (PAC). PAC is responsible for oversight and monitoring of the quality and cost-effectiveness of medical care provided to Partnership members and is comprised of the Chief Medical Officer (CMO) and participating clinician representatives from primary and specialty care disciplines.

Substance Use Services Internal Quality Improvement Subcommittee (SUIQI)

A committee comprised of appropriate Partnership and County staff tracks progress towards successful completion of quality initiatives, surveys, audits, and accreditation for the Partnership's Substance Use Services oversight. The SUIQI meets at least quarterly. Activities and progress are reported to the IQI. This also includes

- Review of Utilization Management retroactive and appeals review
- Review of inter-rater reliability for peer review and utilization management
- Review of quality of service, quality of facility, and access complaints and grievances

- Investigation of potential overuse, underuse, and misuse of services.
- Review of policies related to provision of SU services

Members of the committee include the Behavioral Health Clinical Director, the CMO, Senior Director of Behavioral Health, Senior Manager of Behavioral Health and representatives from the Provider Relations, Member Services, Claims, Compliance, Behavioral Health and Quality Improvement Departments.

~~*Consumer*~~ *Community Advisory Committee (CAC)*

The CAC is composed of Partnership members who represent the diversity and geographic areas of Partnership's membership, including hard-to-reach populations. The CAC is a liaison group between members and Partnership, advocating for members by ensuring that the health plan is responsive to the health care and information needs of all members. The CAC meets quarterly, reviews and makes recommendations regarding Member Services' quality improvement activities, provides feedback on quality and health equity initiatives and serves in the capacity of a focus group. A CAC member(s) is selected to serve on the Board of Commissioners to provide member input and report back to the CAC.

UTILIZATION MANAGEMENT PROGRAM SCOPE

UM activities are developed, implemented and conducted by the Partnership Health Services Department under the direction of the Chief Medical Officer and the Chief Health Services Officer. The UM staff performs specific activities.

Specific functions include:

- Prospective, concurrent and retrospective utilization review for medical necessity, appropriateness of hospital admission, level of care and continued inpatient confinement on a frequency consistent with evidence-based criteria and Partnership guidelines, Partnership criteria/ medical policy and the member's condition. This review is performed cooperatively with the facility care team which may consist of the attending physician(s) and any associated health care personnel who can provide information that will substantiate medical necessity and level of care.
- Discharge planning in collaboration with the facility care team
- Review inpatient and outpatient UM data to determine appropriateness of member and provider utilization patterns
- Use of most current edition of InterQual® Criteria for medical authorization, and other Partnership UM guidelines and medical policy as developed and approved by the Quality / Utilization Advisory Committee (Q/UAC)
- Use of California Department of Health and Welfare Code of Regulations Title 22, Center for Medicare & Medicaid Services (CMS) Code of Federal Regulations (CFR) Title 42 and National and Local Coverage Determinations
- Review certification requests for skilled nursing care, home health care, durable medical equipment, ambulatory surgery, ambulatory diagnostic and treatment procedures such as physical, occupational and speech therapies.

The UM program incorporates the monitoring and evaluation for the subsequent services and reviews and updates policies and procedures as appropriate but at least annually.

- Acute hospital services
- Subacute care
- Ambulatory care
- Emergency and urgent care services
- Durable Medical Equipment and supplies

- Ancillary care services, including but not limited to home health care, skilled nursing care, subacute care, pharmacy, laboratory and radiology services
- Long-term care including Skilled Nursing Facility (SNF) Care and Rehabilitation Facility Care
- Residential Substance Use Disorder (SUD) treatment
- Behavioral Health Therapy (BHT)
- Community Supports
- Enhanced Care Management
- Physician administered drugs (medical drug benefit)

PHARMACY PROGRAM SCOPE

The Pharmacy Department within Health Services is responsible for the utilization management of the medical drug benefit – those medications administered to a member directly during a medical stay/visit at a clinic, office, or hospital, and billed to Partnership as part of a medical service claim; this includes drugs administered at time of service by physicians, dentists, podiatrists, nurse practitioners and physician assistants. Drugs and other prescription services provided to a member by a pharmacy are not within the scope of Partnership's Pharmacy Program because the pharmacy benefit is carved-out to State Medi-Cal through the Medi-Cal Rx Program.

Out of Scope for Partnership Pharmacy Program:

- Pharmacy benefits and services pursuant to Executive Order N-01-19 and the Medi-Cal Rx program. The Medi-Cal pharmacy benefits and services administered by DHCS in the FFS delivery system is identified collectively as Medi-Cal Rx. This includes:
  - Covered Outpatient Drugs, as defined by SSA 1927(k)(2): prescription drugs which are not provided as part of *medical* service and thus are under the scope of the Pharmacy Benefit.
  - Self-administered medications provided to a member to take/inject/inhale/apply/insert (or otherwise administer) at home.
  - Medication and supply services provided to members at long-term care and skilled nursing facilities.
  - Medications administered by an infusion pharmacy or home health agency in a pharmacy infusion suite or in the member's home
- Medications and services statutorily defined as a non-Medi-Cal benefit
- Medications provided in a medical setting which are carved out of the Managed Care Plan (MCP) capitation agreement: antivirals for HIV/AIDs, drugs and blood factor products for Hemophilia, drug and alcohol substance use disorder treatment (prescribed outside a narcotic treatment program), antipsychotics, and certain antidepressants (MAOI).

In Scope for Partnership Pharmacy Program:

- Utilization management of drugs administered in a medical setting and billed by the medical provider under the medical benefit, which includes:
  - Drugs other than Covered Outpatient Drugs. The SSA 1927(k)(2) definition of a Covered Outpatient Drug does not include any drug, biological product, or insulin provided as part of, or as incident to, the provision of and billing for medical or institutional services [SSA 1927(k)(3)]
  - Development of coverage criteria for injectable drugs requiring prior authorization based on current nationally accepted treatment guidelines, current medical literature, and input from specialists. These criteria may be drug-specific or class-specific.
  - Application of billing limits, restrictions, or requirements based on FDA approved indications and dosing &/or State Medi-Cal billing requirements. Such utilization management examples include maximum daily dose, allowed dosing frequency, age limits, place of service (e.g. dialysis centers) and current ICD (diagnosis) requirements.
  - The medical provider submits prior authorization requests directly to the pharmacy department. See policy MCRP4068 *Medical Benefit Medication TAR Policy* for further details.

- Pre-service, Concurrent, and Post-Service (Retrospective) pharmaceutical utilization reviews of medical necessity using established prior authorization criteria requirements set forth by Partnership Pharmacy & Therapeutics (P&T) Committee, or as required by State Policy (All Plan Letters), or in accordance with Partnership case-by-case review guideline (below) when Partnership criteria are not yet established. Timeliness standards mirror those for UM Program Timeliness (see page 26).
- Case-by-case review shall consider:
  - The member's individual medical needs (allergies, disease history, treatment history, concurrent medications, concurrent disease states, contraindications) and assessment of access and local delivery system
  - Prescriber's scope of practice/areas of specialization
  - The FDA approved package labeling for indication(s), maximum safe & effective dosing, appropriate age group, recommended screenings and monitoring,
  - Prescribed drug's recommended place in therapy according to indication &/or nationally recognized treatment guidelines
  - Availability & effectiveness of preferred treatments for the same indication
  - Industry-standard clinical resources including (but not limited to): Lexi-Drug, Elsevier/Gold Standard Clinical Pharmacology, National Comprehensive Cancer Network (NCCN), UpToDate, IPD Analytics, and Facts & Comparisons
  - Trials of preferred alternatives: There is no set number of preferred medications that must be tried before a non-preferred medication can be approved. Trials of preferred alternatives is unique to each drug and may depend on factors including but not limited to available treatment alternatives, pharmacologic and therapeutic similarities between different treatments, indication, and member's reason for failure with previous treatments. The number of trials required will be based on the clinical judgement of the physician or clinical pharmacist reviewer.

- Retrospective Drug Utilization Review (DUR) (post-claim analysis, educational programs)
  - Improve medication therapy outcome and reduce and prevent inappropriate use, fraud, or abuse.
- AB 1114 Pharmacist Services pursuant to APL 22-012 *Revised* "Governor's Executive Order N-01-19, Regarding Transitioning Medi-Cal Pharmacy Benefits from Managed Care to Medi-Cal RX" (12/30/2022)
- Disease/Medication Management Programs
  - Improve medication adherence, address therapeutic gaps, and optimize medication therapy outcome.
- Support of Care Coordination and Case Management
  - Support members with complex medication regimen, multiple health conditions, behavioral and substance use disorder.
- Support of Quality Improvement (e.g. HEDIS, outcomes measures)
  - Performance improvement in medication related quality measures.

Mental Health

Members may self-refer for mental health services to mental health providers using the delegated Behavioral Health Organization's toll-free referral numbers or by contacting the preferred behavioral health provider directly. Members do not need a referral or prior authorization to receive mental health services.

In an effort to coordinate the member's overall health care, mental health providers are instructed to ask members to sign a release of information so that the mental health provider can contact the member's PCP or other providers. However, the release of information is not a condition for the approval or provision of services.

Mental health services for Members with Medi-Cal as their primary insurance are provided as follows:

- Members determined to have Non-Specialty Mental Health Services (NSMHS) needs that require mild to moderate mental health treatment are served by Partnership's delegated managed behavioral healthcare organization (MBHO), Carelon Behavioral Health, at (855) 765-9703.
- Members determined to require Specialty Mental Health Services (SMHS) for moderate to severe mental health conditions are referred to the County ~~Mental~~ Behavioral Health Plan (B~~M~~HP) in the Member's county of eligibility. The administration of such referrals is addressed in the respective Memorandum of Understanding (MOU) with each respective County Mental Health Plan, consistent with California statutes and regulations.
- DHCS requires Managed Care Plans (MCPs) and B~~M~~HPs to use specific Screening and Transition of Care Tools for members under age 21 (youth) and for members age 21 and over (adults) to determine the appropriate mental health delivery system referral for members who are not currently receiving mental health services when they contact the MCP or B~~M~~HP seeking mental health services. These tools can be found on the DHCS website on this page: https://www.dhcs.ca.gov/Pages/Screening-and-Transition-of-Care-Tools-for-Medi-Cal-Mental-Health-Services.aspx

County ~~Mental~~ Behavioral Health Plans provide crisis assessments and authorizations for care. Immediate access to the crisis service remains an option throughout all phases of treatment by any provider. Each County operates crisis services which to address clients in crisis; crisis services also act as a backup after hours and on weekends as well as at other times of provider unavailability. Members may call the County crisis line directly, without a referral. Members eligible for mental health services from Partnership delegated contractor(s) will be re-directed to appropriate County crisis services as needed.

A certain level of mental health services is appropriately dealt with in a primary care practice, including screening and referrals to services. Primary Care Providers may contact each county's ~~Mental~~ Behavioral Health Plan or Partnership's delegated contractor, Carelon Behavioral Health, for telephone consultation. For detailed referral and consultation procedures, PCPs can refer to Partnership Policy MPCP2017 Scope of Primary Care—Behavioral Health and Indications for Referral Guidelines.

Partnership is responsible for the delivery of non-specialty mental health services for children under age 21 and outpatient mental health services for adult beneficiaries with mild to moderate impairment of mental, emotional, or behavioral functioning resulting from a mental health disorder, as defined by the current Diagnostic and Statistical Manual of Mental Disorders (DSM). Outpatient mental health services are delivered as specified in policy MCUP3028 *Mental Health Services* whether they are provided by PCPs within their scope of practice or through Partnership's provider network. Partnership continues to be responsible for the arrangement and payment of all medically necessary, Medi-Cal-covered physical health care services, not otherwise excluded by contract, for Partnership beneficiaries who require specialty mental health services.

In compliance with Mental Health Parity requirements on October 1, 2017, as required by Title 42, CFR Section 438.930, Partnership ensures direct access to an initial mental health assessment by a licensed mental health provider within the Partnership provider network. No referral from a PCP or prior authorization is required for an initial mental health assessment to be performed by a network mental health provider.

Partnership meets the general parity requirement (Title 42, CFR, §438.910(b)) which stipulates that treatment limitations for mental health benefits may not be more restrictive than the predominant treatment limitations applied to medical or surgical benefits. Neither a referral from the PCP nor prior authorization is required for a beneficiary to seek any mental health service, including the initial mental health assessment from a network mental health provider.

If a dispute occurs between the local County ~~Mental~~ Behavioral Health plan and Partnership HealthPlan of California (Partnership) or its delegated contractor, Carelon Behavioral Health, both parties will participate in a dispute resolution process as defined in Partnership Policy ADM52 Dispute Resolution Between Partnership and MHPs in Delivery of Behavioral Health Services. This is consistent with the dispute resolution process outlined by State regulations and the individual County/Partnership Memoranda of Understanding.

Triage and Referral for Mental Health

Partnership monitors the triage and referral protocols for the delegated MBHO services provider(s) to assure they are appropriately implemented, monitored and professionally managed. Protocols employed by delegates must be clinically based and accepted industry practices. Protocols shall outline the level of urgency and appropriateness of the care setting.

Triage and referral decisions are performed by the Care Coordination team of the delegated MBHO services provider with oversight by Partnership's Behavioral Health Clinical Director. Partnership and its delegate work collaboratively with the respective County ~~Mental~~ Behavioral Health Plans to coordinate and ensure members receive care at the appropriate level in a timely manner.

Substance Use Disorder Treatment Services/ Wellness & Recovery Program

Partnership works to ensure that members receive effective and appropriate behavioral health care services for both mental health and substance use disorders. Partnership provides Substance Use Disorder (SUD) treatment services as outlined in the Regional Drug Medi-Cal Model (Regional Model). SUD services are administered either by Partnership or through individual counties not participating in the Regional Model. Partnership

The range of services in the Wellness & Recovery Program include:

- Outpatient treatment (licensed professional or certified counselor, up to nine hours per week for adults)
- Intensive outpatient treatment for individuals with greater treatment needs (licensed professional or certified counselor, structured programming, 9-19 hours per week for adults)
- Detoxification services (withdrawal management)
- Residential treatment (Prior authorization is required as per policy MCUP3144 *Residential Substance Use Disorder Treatment Authorization*)
- Medication assisted treatment (MAT) (methadone, buprenorphine, disulfiram, and naloxone). *Partnership is financially responsible for the dispensing of these medications when services occur in a contracted Narcotic Treatment Program (NTP)/ Opioid Treatment Program (OTP) facility. When MAT is prescribed outside of a NTP/OTP (e.g. dispensed through a pharmacy) the medications will be authorized through the state Medi-Cal Rx program.*
- Care Coordination
- Recovery services (aftercare)

Behavioral Health Treatment (BHT) for Members Under 21 Years of Age

Partnership has provided benefits for Behavioral Health Therapy for children diagnosed with Autism Spectrum Disorder (ASD) since September 2014. Effective July 1, 2018, Partnership expanded its benefit coverage to include Behavioral Health Treatment (BHT) for eligible Medi-Cal members under the age of 21 as required by the Early and Periodic Screening and Diagnostic Treatment (EPSDT) mandate.

Treatment services may include Applied Behavioral Analysis (ABA) and other services known as Behavioral Health Treatment (BHT).

BHT is the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the direct observation, measurement and functional analysis of the relations between environment and behavior.

BHT services teach skills through the use of behavioral observation and reinforcement, or through prompting to teach each step of targeted behavior. BHT services include a variety of behavioral interventions that have been identified as evidence-based by nationally recognized research reviews and/or other nationally recognized scientific and clinical evidence that are designed to be delivered primarily in the home and in other community settings.

Partnership will provide medically necessary BHT services covered under Medicaid for all members who meet the eligibility criteria for services as stated in 1905® of the Social Security Administration (SSA) and outlined in DHCS All Plan Letter (APL) 23-010 *Revised*.

- Additional detailed information regarding the BHT benefit can be found in the following Partnership Policies and Procedures:
  - MPUP3126 *Behavioral Health Treatment (BHT) for Members Under the Age of 21*
  - MCCP2014 *Continuity of Care*

Quality Improvement Collaboration

The UM team works collaboratively with the Quality Improvement (QI) Department to enhance the care provided to our members through venues such as the Internal Quality Improvement Committee (IQI), the Quality/ Utilization Advisory Committee (Q/UAC) and daily UM activities.

In the committee environment, the UM team takes an analytical, evaluative and strategic look at predetermined metrics to evaluate and offer recommendations which further enhance the UM program. Data is reviewed and discussed at least bi-annually during the IQI and Q/UAC meetings. The Q/UAC provides guidance and direction to the UM program by coordinating activities and by functioning as the expert panel when needed. Collaboration includes but is not limited to:

- Reviewing, making recommendations to, and approving the *UM Program Description* annually
- Assuring individual member needs are taken into consideration when determinations for care are rendered
- Analyzing summary data and making recommendations for action
- Reviewing the recommendations of Process Implementation Teams to develop UM improvement action plans, ongoing monitoring, and evaluation
- Recommending medical policy, protocol, and clinical practice guidelines based on provider and member experience information.

During daily activities, the UM team supports QI efforts in the identification of potential quality of care issues, reporting adverse occurrences identified while conducting UM case review, improvement of Healthcare Effectiveness Data and Information Set (HEDIS®) scoring by referrals to care coordination, and care coordination efforts to ensure members are seen by the appropriate provider for their condition.

UTILIZATION MANAGEMENT PROCESS

Partnership applies written, objective, evidence-based criteria (InterQual® and pharmaceutical criteria) and considers the individual member's circumstance and community resources when making medical appropriateness determinations for behavioral health and physical health care services.

On an annual basis, Partnership distributes a statement to all its practitioners, providers, members and employees alerting them to the need for special concern about the risks of under-utilization. It requires employees who make utilization-related decisions and those who supervise them to sign a statement which affirms that UM decision making is based only on appropriateness of care and service.

Furthermore, Partnership does not reward practitioners or other individuals conducting utilization review for issuing denials of coverage or service. Financial incentives for UM decision makers do not encourage decisions that result in under-utilization and Partnership does not use incentives to encourage barriers to care and service. This does not preclude the use of appropriate incentives for fostering efficient, appropriate care.

Working with practitioners and providers of care, the following factors are taken into consideration when applying guidelines to a particular case in review:

- Input from the treating practitioner
- Age of member
- Comorbidities in existence
- Complications
- Progress of treatment
- Psychosocial situation
- Home environment
- Consideration of the delivery system and availability of services to include but not be limited to:
  - Availability of inpatient, outpatient, transitional and residential treatment (SUD) facilities
  - Availability of outpatient services
  - Availability of highly specialized services, such as transplant facilities or cancer centers
  - Availability of skilled nursing facilities, subacute care facilities or home care in the organization's service area to support the patient after hospital discharge
  - Local hospitals' ability to provide all recommended services
- Benefit coverage

Referrals and requests for prior authorization of services are to be submitted by the provider of service to the Partnership UM department by fax or through Partnership's Online Services portal, which is a Secure Electronic Internet system. The following information must be provided on all requests.

- Member demographic information
- Provider demographic information
- Requested service/procedure to include specific CPT/HCPCS code(s)
- Member diagnosis (Using current ICD Code sets)
- Clinical indications necessitating service or referral
- Pertinent medical history, treatment or clinical data
- Location of service to be provided
- Requested length of stay for all inpatient requests
- Proposed date of procedure for all outpatient surgical requests

Pertinent data and information is required to enable a thorough assessment of medical necessity. If information is missing or incomplete, the requestor will be notified and given an opportunity to submit additional information.

Elective Admission Precertification
The UM department evaluates every proposed treatment plan, and determines benefit eligibility, suitability of location and level of care prior to the approval of service delivery for select diagnoses and procedures.

Utilizing written criteria such as InterQual®, Medi-Cal Criteria and Partnership medical policy approved by the Q/UAC, licensed and professional UM staff review and approve completed Treatment Authorization Requests (TARs).

Only the Chief Medical Officer or physician designee may make a medical necessity determination and have the authority to deny a service request based on lack of medical necessity. Partnership offers the practitioner the opportunity to discuss any medical necessity denial determination with the physician reviewer rendering the decision.

Referral Management
Referrals are generated by the primary care provider and submitted to Partnership's Online Services (OLS) portal (or by fax or mail). Partnership monitors and analyzes requests to identify trends and assist in follow-up care. Requests for out-of-network referrals are reviewed to determine if the service is available and can be provided within Partnership's network. Out-of-Network requests are also used to evaluate provider access and to determine if the local network requires enhancements to meet member needs.

Continued Stay/Concurrent Review
Acute care hospitalization reviews are performed by licensed professionals to ensure medical necessity of continued stay, the appropriateness of level of care, and care duration. This review is conducted either on site, by accessing the facility electronic medical record through a secure portal, or telephonically using written Partnership medical policy, InterQual®, and/or Medi-Cal guidelines.

Requests for authorization are reviewed within 24 hours of notification of admission and concurrently throughout the stay. The UM team facilitates discharge planning in collaboration with the facility care team and makes referrals to Partnership case management and social services as appropriate.

Consideration of available services in the local service area or delivery system and the ability to meet the member's specific health care needs are evaluated as part of application of criteria and the development of an ongoing plan of care and discharge plan.

Only the Chief Medical Officer or physician designee has the authority to deny a request for service based on lack of medical necessity. Partnership offers the practitioner with clinical expertise in the area being reviewed the opportunity to discuss the application of criteria in determining medical necessity or any determination based on lack of clinical justification with the physician reviewer.

In addition to individual conversations with practitioners on specific case reviews, Partnership conducts several committees for the purpose of hearing and incorporating practitioner input in the development of medical policy. Partnership, through the Physician Advisory Committee (PAC), the Quality/ Utilization Advisory Committee, and the Pharmacy and Therapeutics Committee (P&T) , provides practitioners with clinical expertise in several areas the opportunity to advise or comment on the development and/or adaptation of UM criteria and provide feedback or instruction on the application of that criteria. Within the previously stated committees, Partnership evaluates UM criteria and procedures against current clinical and medical evidence and updates them accordingly.

Skilled Nursing/Sub acute/ Long-Term Acute/Rehabilitation Facility Review
Review of all Skilled Nursing and Rehabilitation Facility confinements are performed by licensed professionals to ensure medical necessity of continued stay and the appropriateness of level and

duration of care. This review is conducted telephonically using written Partnership medical policy, Title 22 criteria, and/or InterQual® criteria. Requests for authorization are reviewed within 24 hours of notification of admission. The UM team facilitates discharge planning in collaboration with the facility care team and makes referrals to Partnership case management and social services as appropriate.

Consideration of available services in the local service area or delivery system, and the ability to meet the member's specific health care needs are evaluated as part of applying criteria and the development of an ongoing plan of care and discharge plan.

Discharge Planning
Discharge planning is a critical component of the utilization management process and begins upon admission with an assessment of the patient's potential discharge needs. It includes preparation of the family and the patient for continuing care needs and initiation of arrangements for services or placement needed after acute care discharge.

Partnership Nurse Coordinators work with hospital discharge planners, case managers, admitting/attending physicians and ancillary service providers to assist in making necessary arrangements for post-discharge needs.

Post-Service Retrospective Review
Post-service retrospective reviews may occur when a member is retroactively granted Medi-Cal benefits by the State of California, when a provider does not realize an authorization is required prior to rendering a service, when the rendered service code billed does not match the code authorized, or the service may have been rendered after the expiration of the authorization. TARs must be received by Partnership within 15 business days of the date of service or within 60 calendar days of either a denial from the primary insurance carrier or retrospective eligibility. (TARs submitted beyond these timeframes are considered late but will still be reviewed for medical necessity.)

All retrospective reviews are completed within 30 calendar days of receipt of request. Electronic or written notification of the decision and how to initiate a routine or expedited appeal if applicable, is communicated to the provider within 24 hours of decision, but no longer than 30 calendar days from the date of the receipt of the request. Written notification is mailed to the member within two (2) business days of the decision.

Services requiring an authorization can be retrospectively reviewed for medical necessity, appropriateness of setting, and length of stay up to one year after services are rendered and may result in an adverse determination.

Emergency Room Visits
Emergency room visits where a prudent layperson, acting reasonably, would believe an emergency condition exists, DO NOT require prior authorization.

Timeliness of UM Decisions

Partnership makes UM decisions in a timely manner to accommodate the clinical urgency of the situation and to minimize any disruption in the provision of care. Partnership measures the timeliness of decisions from the date when the organization receives the request from the member or PCP, even if the Partnership does not have all the information necessary to make a decision. Partnership documents the date when the request is received and the date a decision is rendered in the UM documentation system.

Partnership has communicated to both providers and members the practice of processing non-urgent requests during the next business day if the request is received after business hours.

Partnership Utilization Management abides by the following timeliness guidelines when processing health services requests.

Urgent Requests
A request for medical care or services where application of the time frame for making routine or non-life threatening care determinations could jeopardize the live, health or safety of the member or others due to the member's psychological state or, in the opinion of the practitioner with knowledge of the members medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment requested.

Concurrent Review Request:
A request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care.

Pre-Service Request
A request for medical care or services that Partnership must approve in advance, in whole or in part.

Non-Urgent Request
A request for medical care or services for which application of the time periods for making a decision does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.

Post-Service Request / Retrospective Review
A request for medical care or services that have been received.

Non-Behavioral Healthcare Decisions, Pharmacy Decisions, and Behavioral Healthcare Decisions

Type of Request	Decision Time Frame	Notification[1] Time Frame	Extended Time Frame
Urgent concurrent review	72 hours of receipt of request	72 hours of receipt of request	May be extended one time up to 14 calendar days from receipt of request
Urgent pre-service	72 hours of receipt of request	72 hours of receipt of request	May be extended one time up to 14 calendar days from receipt of request
Non-urgent pre-service	5 business days of receipt of request	24 hours of determination date[1]	May be extended *two (2)* times for up to 14 calendar days each period (28 days total from receipt of request) [2]
Post-service	30 calendar days of receipt of request	30 calendar days of receipt of request	N/A

[1] Notification: Give electronic or written notification of decision to practitioner (and member when required).
Per DHCS requirement, written notification must be mailed to a member within two (2) business days of the decision.
[2] Per DHCS regulations

Review Criteria
Current InterQual® criteria sets are used as the main review guidelines. Additional criteria are selected or developed using other resources as necessary to help in determining review decisions which include, but are not limited to, Medi-Cal (State of California) guidelines and State policy letters (see policy MCUP3139 *Criteria and Guidelines for Utilization Management*). InterQual® criteria are produced using a rigorous development process based on evidence-based medicine and reviewed at least annually, but as frequently as quarterly, by a panel of board-certified specialists. All UM policies

are based on InterQual® criteria and are reviewed annually by the Quality/Utilization Committee (Q/UAC) and the Physician Advisory Committee (PAC) which also include board-certified specialists who are practicing network physicians. All Pharmacy policies are reviewed annually by the Pharmacy and Therapeutics (P&T) Committee and PAC. Refer to pharmacy policies MCRP4068 *Medical Benefit Medication TAR Policy* and MPRP4001 *P&T Committee* for further details regarding pharmaceutical criteria.

In the absence of applicable criteria, the Partnership UM medical staff refers the case for review to a licensed, board-certified practitioner in the same or similar specialty as the requested service. The reviewing practitioners base their determinations on their training, experience, the current standards of practice in the community, published peer-reviewed literature, the needs of the individual patients (age, comorbidities, complications, progress of treatment, psychosocial situation, and home environment when applicable), and characteristics of the local delivery system. Board-certified consultants are available through our providers on our Quality/Utilization Advisory Committee (Q/UAC). Partnership also contracts with a third-party independent medical review organization which provides objective, unbiased medical determinations to support effective decision making based only on medical evidence. (See policy MCUP3138 *External Independent Medical Review*.)

Criteria are selected, reviewed, updated or modified using feedback from the Q/UAC and PAC as well as member feedback identified in member survey results and the ~~Consumer~~ Community Advisory Committee (CAC), State policy letters, State Memorandums of Understanding and/or medical literature, among other sources. In collaboration with actively practicing practitioners, criteria are evaluated on at least an annual basis. Relevant clinical information is obtained when making a determination based on medical appropriateness and the treating practitioner is consulted as appropriate. All information obtained to support decision-making is documented in the utilization management documentation system.

Decisions are based on information derived from the following sources:

- Clinical records
- Medical care personnel
- Facility utilization management staff
- Attending physician (attending physician can be the primary care physician, hospitalist or the specialist physician (or all three as necessary)
- Board-certified specialists are consulted when medically necessary

When applying criteria to a treatment request, reviewers consider the needs of the individual patient (age, comorbidities, complications, progress of treatment, psychosocial situation, and home environment when applicable) as well as the availability of services in the local delivery system and their ability to meet the member's specific health care needs.

Inter-Rater Reliability (IRR)

Partnership assesses the consistency with which physician and non-physician reviewers apply UM criteria in decision making and evaluates Inter-Rater Reliability. The Inter-Rater Reliability mechanism uses live cases to ensure medical management criteria are appropriately and consistently applied in making UM determinations. The methodology employed is designed to annually assess 50 cases or 5% of reviewer case load, whichever is less, over the course of a year period.

The following types of reviews/reviewers are audited:

- Nurse Coordinator Review of Inpatient Services
- Nurse Coordinator Review of Outpatient Services
- Nurse Coordinator Review of Long Term Care Services
- Behavioral Health (BH) Nurse Coordinator Review of Residential Substance Use Disorder Treatment Authorizations

- Physician Review of Medical Necessity Authorizations
- Pharmacist and Pharmacy Technician Review of Pharmacy TARs

A performance target of 90% accuracy is set for inter-rater reliability. An audit summary is reported at least annually or more often as needed to the Internal Quality Improvement (IQI) Committee. If a reviewer falls below the targeted threshold, a corrective action plan is initiated and monitored and results are presented to the Quality/Utilization Advisory Committee (Q/UAC) for review and discussion. Please refer to policy MPUP3026 *Inter-Rater Reliability Policy* for a full description of the IRR process.

Availability of Criteria

All criteria used to review authorization request are available upon request. In the case of an adverse determination, the criteria used are made part of the determination file. Access to and copies of specific criteria utilized in the determination are also available to any requesting practitioner by mail, fax, email, or on our website: http://www.partnershiphp.org. To obtain a copy of the UM criteria, practitioners may call the Partnership UM Department at (800) 863-4155.

Members may request criteria used in making an authorization determination by calling the member services department to request a copy of the criteria. The UM team will work with member services to provide the criteria used in the review decision.

Partnership's Provider Relations Department notifies providers in writing through the New Provider Credentialing Packet and the provider's contract that UM criteria is available online at http://www.partnershiphp.org in the Provider Manual section. Providers are also notified quarterly in writing via the Quarterly Provider Newsletter about the on-line availability of UM criteria and policies at http://www.partnershiphp.org in the Medi-Cal Provider Manual section.

COMMUNICATION SERVICES

Partnership provides access to staff for members and practitioners seeking information about the UM process and the authorization of care in the following ways:

- Calls from members are triaged through Member Services staff who are accessible to practitioners and members to discuss UM issues during normal working hours when the health plan is in operation (Monday - Friday 8 a.m. - 5 p.m.).
- After normal business hours, Members and Providers may contact the Partnership voice mail service to leave a message which is communicated to the appropriate person on the next business day. Calls received after normal business hours are returned on the next business day and calls received after midnight on Monday - Friday are returned on the same business day.
- After normal business hours, members may contact the advice nurse line at (866) 778-8873 for assistance with clinical concerns.
- Practitioners, both in-network and out-of-network, may contact UM staff directly either through secure email or voicemail. Each voice mailbox is confidential and will accept messages after normal business hours. Calls received after normal business hours are returned on the next business day and calls received after midnight on Monday - Friday are returned on the same business day.
    - Partnership has a dedicated after-hours phone number local (707) 430-4808 or toll free (855) 798-8759 to receive calls from physicians and hospital staff for addressing post-stabilization care and inter-facility transfer needs 24 hours per day, 7 days per week. Calls are returned within 30 minutes of the time the call was received. Partnership's Chief Medical Director or physician designee is on call 24 hours per day 7 days per week to authorize medically necessary post-stabilization care services and to respond to hospital inquiries within 30 minutes. Partnership

clinical staff are available 24 hours per day 7 days per week to coordinate the transfer of a member whose emergency medical condition is stabilized.

- Partnership UM staff identify themselves by name, title and organization name when initiating or returning calls regarding UM issues.
- Partnership maintains a toll free number (800) 863-4155 that is available to both members and practitioners.
- Members can view information about Partnership's language assistance services and disability services in the Member Handbook which is made available to members upon enrollment and is always viewable online at http://www.partnershiphp.org/Members/Medi-Cal/Documents/MCMemberHandbook.pdf
  Additionally, Partnership provides annual written notice to Members about our language assistance services and disability services (e.g. TTY for hearing impaired) in our Member Newsletter.

Linguistic services are provided by Partnership to monolingual, non-English speaking or limited English proficiency (LEP) Medi-Cal beneficiaries as well as eligible members with sensory impairment for population groups as determined by contract. These services include the following:

No Cost Linguistic Services:

- Qualified oral interpreters, Video Remote Interpreters (VRI), sign language interpreters or bilingual providers and provider staff at key points of contact available in all languages spoken by Medi-Cal beneficiaries
- Written information and materials (to include notice of action, grievance acknowledgement and resolution letters) are fully translated by qualified translators into threshold languages for Partnership Members according to regulatory timeframes, and into other languages or alternative formats upon request. Alternative m~~M~~aterial formats ~~are also available~~ include audio, large print and electronically for members with hearing and/or visual disabilities. Braille versions are available for members with visual disabilities. Auxiliary aids are also available upon request. Please refer to MCND9002 Cultural and Linguistic Program Description for more information. The organization may continue to provide translated materials in other languages represented by the population at the discretion of Partnership, such as when the materials were previously translated or when translation may address Health Equity concerns.
- Use of California Relay Services for hearing impaired [TTY/TDD: (800) 735-2929 or 711]

Partnership regularly assesses and documents member cultural and linguistic needs to determine and evaluate the cultural and linguistic appropriateness of its services. Assessments cover language preferences, reported ethnicity, use of interpreters, traditional health beliefs and beliefs about health and health care utilization. (See policy MCND9002 *Cultural and Linguistic Program Description*)

Denial Determinations

Denial determinations may occur at any time in the course of the review process. Only the Chief Medical Officer, or a physician designee acting through the designated authority of the Chief Medical Officer, has the authority to render a denial determination based on medical necessity which is defined as "reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury." ~~(see Program Structure section for details).~~

A denial determination may occur during continued stay/concurrent review in which case notification and/or discussion with the treating practitioner and the Health Plan physician adviser/Chief Medical Officer or physician designee is offered.

Denial determinations may occur at different times and for various reasons including but not limited to:

- At the time of prior authorization; when the requested service is not medically indicated or not a covered benefit.
- When timely notification was not received from a facility for an inpatient stay to foster transfer of a medically stable patient
- When an inpatient facility fails to notify the Health Plan of admission within one business day of the admission or appropriate clinical information is not received
- When out-of-network services are not clinically appropriate
- Or after services are rendered at claims review when the services were not authorized, or are medically unnecessary

A denial may also occur for inappropriate levels of care or inappropriate care. Notwithstanding previous authorization, payment for services may be denied if it is found that information previously given in support of the authorization was inaccurate.

Partnership offers the practitioner the opportunity to discuss any denial or potential denial determination based on lack of medical necessity with the Health Plan Chief Medical Officer, or a physician designee.

The denial notification states the reason for the denial in terms specific to the member's condition or service request and in language that is easy to understand and references the criterion used in making the determination so the member and provider have a clear understanding of the Health Plan's rationale and enough information to file an appeal.

Partnership HealthPlan of California is aware of the need to be concerned about under-utilization of care and services for our members. Partnership monitors over and under-utilization through the Over/Under Utilization Workgroup which reviews annual utilization patterns. Decisions made by Partnership's Utilization Reviewers are solely based on the appropriateness of the care or service.

The Health Plan does not compensate any individual involved in the utilization process to deny care or services for our members nor do we encourage or offer incentives for denials.

Process for a Provider to Appeal an Adverse Benefit Determination on Behalf of a Member

Members and providers are provided fair and solution-oriented means to address perceived problems in exercising rights as a Medi-Cal beneficiary or provider, in accordance with requirements of Partnership's contract with the Department of Health Care Services (DHCS). This process is entirely separate from that of State Fair Hearings, to which members retain their access. Please refer to Partnership policy MCUP3037 *Appeals of Utilization Management/ Pharmacy Decisions* for a full description of the process.

Data Sources

Utilization Management supports the effective, efficient, and appropriate utilization of member benefits through ongoing review, evaluation and monitoring of the member's personal health information in making medical necessity determinations.

Data sources may include, but are not limited to:

- Medical records, from outpatient provider offices and hospital records (including accessing hospital Electronic Medical Records (EMR); for current and historical data
- Member handbook/Evidence of Coverage
- Consultations with treating physicians
- Network adequacy information
- Local delivery system capacity information
- Specialist referrals
- Recent Physical exam results
- Diagnostic testing results
- Treatment plans and progress notes
- Operative and pathological reports
- Rehabilitation evaluations
- Patient characteristics and information
- Patient psychosocial history
- Information from family / social support network
- Prospective/concurrent/retrospective utilization management activities
- Claim/encounter (administrative) data

Data Collection, Analysis, and Reporting

Data collection activities for analysis and reporting are coordinated by the UM department. At the data gathering/performance measurement phase, participants in the process include programmers and analysts in the Finance and Health Services departments, staff nurses, and any other personnel required for the collection and validation of data. All data collection activities are documented and reported to the Q/UAC twice a year and more often if requested. Data collection activities may include, but are not limited to:

- Member satisfaction surveys
- Provider satisfaction surveys
- Readmission statistics
- Potential quality incident data
- Member appeal data
- Provider appeal data
- Internally developed databases
- Pharmacy utilization data
- Other administrative or clinical data
- Member utilization data
- Provider prescribing data

EVALUATION OF NEW MEDICAL TECHNOLOGY

Partnership evaluates the inclusion of new medical technologies and the new application of existing technologies in its benefit packages. While the basic benefits are set by the State of California Department of Health Care Services (DHCS) and outlined in Title 22 of the Health and Welfare Code, Partnership has the option of adding to this basic package of benefits for its members.

Partnership's Policy MCUP3042 *Technology Assessment* outlines the steps taken during the determination process. The Partnership Physician Advisory Committee will review all cases and make a final recommendation to the Board of Commissioners as to new benefits. The Commission is the only entity that can add benefits.

Once a new benefit is added, the information is disseminated to all Primary Care Providers and appropriate specialists in the form of a mail notification of benefit addition, and to all members in the next member newsletter.

New technologies are handled on a case-by-case basis which includes obtaining information regarding the safety, efficacy and indications that support the use of the intervention. There must be evidence that the proposed intervention will add to improved outcomes as compared to what is currently available. The service provider must have a record of safety and success with the intervention and cannot be part of a funded research protocol. The Chief Medical Officer works closely with the requesting physician and specialists as needed in researching these cases.

DELEGATION

UM activities that are delegated to contract providers are reviewed and approved on an annual basis by the Q/UAC. A delegation agreement, including a detailed list of activities delegated and reporting requirements is signed by both the delegate and Partnership.

- Providers to whom UM activities have been delegated are responsible for reporting results and analyses to Partnership on a quarterly or annual basis. Reports are summarized for review and evaluation by Partnership's Delegation Oversight Review Sub-Committee (DORS) and Q/UAC.
- Audits are conducted no less than annually and evaluation includes a review of both the processes applied in carrying out delegated UM activities, and the outcome achieved in accordance with the respective policy(s) and agreement governing the delegated responsibility.
- The Q/UAC reviews evaluations and make recommendations regarding opportunities for improvement and continuation of delegated functions.

A pre-delegation evaluation is conducted when delegation of functions to providers is being considered.

Protected Health Information (PHI)

The Privacy Rule, described in 45 CFR Parts 160 and 165, applies to covered entities. The Privacy Rule allows covered providers, entities, and health plans to disclose PHI in order to carry out their health care functions.

Partnership HealthPlan of California is fully compliant with the general rules, regulations and implementation specified in The Privacy Rule. Partnership also provides reasonable administrative, technical, and physical safeguards to ensure PHI confidentiality, integrity and availability and to prevent unauthorized or inappropriate access, use or disclosure of PHI.

The Partnership Director of Regulatory Affairs and Program Development also serves as the Partnership Privacy Officer. Partnership has implemented a comprehensive program that includes "Notice of Privacy Practices" (NPP) sent to all members, as well as implementation of a confidential toll-free complaint line available to members, providers and Partnership staff. For non-covered entities, Partnership requires Business Associate Agreements (BAA). Additionally, there is training on an annual basis for the Partnership workforce and Partnership providers/networks, and Partnership maintains policies and procedures around documentation of complaints of violations or suspected privacy incidents.

STATEMENT OF CONFIDENTIALITY

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

- Members of the Q/UAC and PAC are required to sign a confidentiality statement that will be maintained and securely stored in the QI files.
- UM documents are restricted solely to authorized Health Services Department staff, members of the PAC, Q/UAC, and Credentials Committee, and reporting bodies as specifically authorized by the Q/UAC.
- Confidential documents may include, but are not limited to Q/UAC and Credentials Committee meeting minutes and agendas, QI and Peer Review reports and findings, UM 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.
- Partnership has designated a Privacy Officer responsible to oversee compliance with the Health Insurance Portability and Accountability Act (HIPAA) and other state and federal privacy laws.
- Partnership maintains administrative structure, reporting procedures, due diligence procedures, training programs and other methods to ensure effective compliance in use and disclosure of members' Protected Health Information (PHI).

NON-DISCRIMINATION STATEMENT

Partnership complies with applicable Federal civil rights laws and does not discriminate, exclude people, or treat them differently on the basis of race, color, national origin (including limited English proficiency (LEP) and primary language), age, disability, or sex (including sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity; and sex stereotypes).

Partnership 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, Partnership 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.

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

- Qualified sign language interpreters or Video Remote Interpreters (VRI)
- Written information in other formats (large print, audio, Braille, accessible electronic formats, other formats)

Partnership provides free language services to people whose primary language is not English or those with limited English proficiency (LEP). These services include the following:

- Qualified oral interpreters, Video Remote Interpreters (VRI), sign language interpreters or bilingual providers and provider staff at key points of contact
- Information written in other languages
- Use of California Relay Services for hearing impaired

STATEMENT OF CONFLICT OF INTEREST

Any individual who has been personally involved in the care and/or service provided to a patient, an event or finding undergoing quality evaluation may not vote or render a decision regarding the appropriateness of such care. All members of the Q/UAC are required to review and sign a conflict of interest statement, agreeing to abide by its terms.

PROVIDER AND MEMBER SATISFACTION

Partnership conducts satisfaction surveys on both members and providers. Included in the evaluation are questions that deal with both member and provider satisfaction with the UM 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 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 Utilization Management program undergoes a written evaluation of its overall effectiveness annually by the Q/UAC, which is reviewed and approved by the PAC.

At a minimum the evaluation considers UM department activities and outcomes, the review of Key Performance Indicator metrics such as Productivity, Timeliness, Bed-days, readmission rates and denial rates along with resource effectiveness and barriers to performance.

Preparation for the Annual Program Evaluation involves participation by all Utilization Management and Pharmacy leadership including but not limited to:

- Chief Health Services Officer
- Director, Pharmacy Services
- Directors of UM
- Associate Directors of UM
- UM Managers

Elements of the program evaluation include an objective assessment of meeting targeted goals to ensure appropriate, efficient utilization of resources/services for Partnership members across the continuum of care in compliance with requirements of state/federal and regulatory entities.

- Annual UM Program Description update
- Annual review and evaluation of UM processes (meeting goals and identifying opportunities for process improvements)
- Timely review and update of UM policies and procedures
- Obtain approval of UM policies and procedures at Q/UAC

Inter-Rater Reliability scoring and TAR timeliness are compared with regulatory compliance standards and internal benchmarks.

To determine if the UM program remains current and appropriate, the organization annually evaluates:

- The program structure
- The program scope, processes, information sources used in the determination of benefit coverage and medical necessity
- The level of involvement of the senior-level physician and designated behavioral healthcare practitioner in the UM program
- Consideration of member and practitioner experience data when evaluating the UM program

The organization updates the UM program and its description annually based on the evaluation.

To ensure the provision of healthcare services at the appropriate level of care the evaluation considers:

- Inpatient bed day rate
- Inpatient average length of stay

- SNF admit rate
- SNF average length of stay
- Readmission rate
- Denial rate
- Timely completion of notifications of denial of care
- Timely completion of notifications of authorization of care
- Rate of referrals to Care Coordination
- Effectively integrating feedback - the program reflects on Member/Provider satisfaction results concerning the UM program looking at:
    - Daily Work Flow Monitoring
    - Call Abandonment rates
    - Call Volume
    - Average caller wait time

An assessment of Department resources is determined by looking at the impact of staffing changes, learning curves and system limitations which impede work effectiveness. There is a review of Inter-Rater Reliability scoring in relation to staff training/re-education, acclimation to new technology such as documentation software/ hardware based on evaluating user acceptance, and the assessment of appropriate staffing ratio to ensure adherence to regulatory and internal performance standards.

A summary of the program evaluation, including a description of the program, is provided to members or practitioners upon request.

REFERENCES:

- Department of Health Care Services (DHCS) standards
- National Committee for Quality Assurance (NCQA) Guidelines (Effective July 1, 20254) UM Standards
- Covered Outpatient Drugs, SSA 1927(k)(2), SSA 1927(k)(3)
- California State Department of Health Care Services (DHCS) Medi-Cal Rx Resources and Reference Materials:
- https://www.dhcs.ca.gov/provgovpart/pharmacy/Pages/Medi-CalRX.aspx
- State Medi-Cal Managed Care Plans: https://www.dhcs.ca.gov/services/Pages/Medi-CalManagedCare.aspx

Original Date: QI/UM Program 04/22/1994 effective 05/01/1994**Revision Date(s): 08/16/95**
Revision Date(s): UM Program Description - 04/17/97; Board Approval January 28, 1998; 06/10/98; 01/20/99; 05/2000; 05/01/01; (UD100301) 03/20/02; 08/20/03; 10/20/04; 10/13/05; 06/21/06; (MPUD3001) 04/16/08; 08/03/10; 11/19/14; 02/17/16; 04/19/17; *06/13/18; 04/10/19, 06/12/19 *(Amended)*, 11/13/19 *(Amended);* 04/08/20; 06/10/20 (*Amended*); 04/14/21; 01/12/22; 05/11/22; 05/10/23; 05/08/24; 05/14/25

*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.

UM PROGRAM DESCRIPTION APPROVAL

	04/16/2025

Robert Moore, MD, MPH, MBA — *Date Approved*
Quality/Utilization Advisory Committee Chairperson

	05/14/2025

Steven Gwiazdowski, MD — *Date Approved*
Physician Advisory Committee Chairperson

	06/25/2025

Kim Tangermann ——— *Date Approved*
Board of Commissioners Chairperson

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Annual Utilization Management (UM) Program Evaluation

NCQA UM Standard 1 Element B

Evaluation Period
January 1, 2024 – December 31, 2024

Production Date: March 21, 2025

Prepared by: Tony Hightower, CPhT, Associate Director of UM Regulations
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Table of Contents

Related Reports:

1. Consistency in Applying Criteria Report – NCQA UM Standard 2 Element C
2. UM Timeliness Report – NCQA UM Standard 5 Element D
3. Provider Satisfaction Survey
4. Member Grievance and Appeals (G&A) PULSE Report

Executive Summary:

The Annual Utilization Management (UM) Program Evaluation analyzes all aspects of data related to the UM program, identifies gaps and opportunities for improvement, and updates the program as necessary to ensure the program remains current and appropriate. Key elements in this annual evaluation include program structure, program scope, processes, and information sources, as well as level of involvement of senior-level physicians and designated behavioral healthcare practitioners in the UM program. In addition, data for member and practitioner experience with the UM process is evaluated to identify improvement and actionable opportunities. This report does not contain Carelon Behavioral Health data for evaluation of the UM program. Carelon Behavioral Health is NCQA accredited, and as such, reports from Carelon Behavioral Health will be reviewed through delegation oversight.

Methodology / Data:

As outlined below, Partnership HealthPlan of California (Partnership) collects all aspects of data related to the UM program and evaluates key elements and performance indicators of the UM program against its established goals and thresholds. From this evaluation, Partnership determines if any gaps exist in particular program activities or structure, identifies opportunities for improvement, prioritizes those opportunities, and takes actions that will improve the UM program in order to better serve our members. The evaluation was conducted as a collaboration between UM, Pharmacy, Quality Improvement, Provider Relations, Member Services, and Grievances and Appeals.

Program Structure

- Physician to Nurse ratio
- Physician to Behavioral Health Nurse ratio
- Physician to Pharmacist ratio
- Staff to Treatment Authorization Request (TAR) ratio

Program scope, processes, and information sources used to determine benefit coverage and medical necessity

- Monitoring and evaluation of services and updates to policies and procedures (P&P), as appropriate, but at least annually
- Utilization Management activities to ensure appropriate care
- TAR timeliness
- Inter-Rater Reliability (IRR)
- Level of care

Level of involvement of senior level physician in the UM determination

- Advisory committee structure and participation

Member and Practitioner experience with the UM program

- Member Grievance and Appeals Pulse Report
- Provider Satisfaction Survey

I. PROGRAM EVALUATION

A. PROGRAM STRUCTURE

1. STAFFING OVERSIGHT

Physician to Nurse, Physician to Pharmacist, and Physician to Behavioral Health (BH) Nurse ratios are measured annually to evaluate the level of involvement of senior level physicians in the UM program. Partnership establishes a minimum threshold of Medical Directors to Nurses at 1:5 (0.20) and Medical Directors to Pharmacists at 1:5 (0.20). Partnership establishes a minimum threshold of Behavioral Health Clinical Directors to BH Nurse staff at 1:5 (0.20). A ratio falling below Partnership's established threshold will require an evaluation of the current staffing structure and UM processes to determine if changes will be implemented. Staff count is an average of the total number of FTEs in each staff category at the end of each month.

Staffing Oversight												
2024	**JAN**	**FEB**	**MAR**	**APR**	**MAY**	**JUN**	**JUL**	**AUG**	**SEPT**	**OCT**	**NOV**	**DEC**
Nurses	40	41	45	46	49	57	56	57	57	63	67	70
Pharmacists[1]	5	5	5	5	5	5	5	5	5	5	5	5
MDs	**11**	**11**	**11**	**12**	**12**	**12**	**12**	**12**	**12**	**12**	**12**	**12**
MD: Nurse Ratio	0.28	0.27	0.24	0.25	0.26	0.21	0.21	0.21	0.21	0.19	0.18	0.17
MD: Pharmacist Ratio	2.20	2.20	2.20	2.40	2.40	2.40	2.40	2.40	2.40	2.40	2.40	2.40
BH Nurse	2	2	2	2	2	2	1	1	1	2	2	2
BH Clinical Director	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**
BH MD: BH Nurse Ratio	0.50	0.50	0.50	0.50	0.50	0.50	1.0	1.0	1.0	0.50	0.50	0.50

[1]Includes only Pharmacists who perform TAR reviews.

Partnership's Physician to Nurse, Physician to Pharmacist, and Physician to BH Nurse ratios all met the threshold goal of 1:5 (0.20) in 2024, except for Oct-Dec Physician to Nurse ratios. This was the result of UM onboarding 13 nurses during this time period. For 2025, Partnership has hired two (2) additional Physicians, bringing the Physician to Nurse ratio back within the 1:5 (0.20) threshold.

2. STAFFING WORKLOAD

Staff-to-TAR ratios are measured and monitored monthly to evaluate the level of staffing to ensure PHC has adequate and appropriate staffing to meet the daily workload demands and comply with standards and requirements set forth by Partnership policy and procedure.

The UM and Pharmacy departments monitor and evaluate TAR to FTE ratios to assess staffing adequacy. A 20% change in the month-over-month ratio is established as the UM and Pharmacy Departments' threshold for further assessment of staffing model and to determine if an intervention is necessary. Calculation used is the month to month difference between TARs/staff/day divided by the TARs/staff/day from the preceding month. Example below is the inpatient number for TARs/Nurse/day in January = 25.9 and February = 20.4. The difference between the two months is 5.5 and the January Staff-to-TAR ratio is 25.9. The change in the month-over-month ratio is calculated as 5.5/25.9 = 0.212 or 21.2%.

NOTE: Due to the relatively low volume of Wellness & Recovery (Behavioral Health) TARs and small number of reviewers, that category of reviews is excepted from the 20% threshold standard.

Utilization Management:

Inpatient TARs – All Regions												
2024	**JAN**	**FEB**	**MAR**	**APR**	**MAY**	**JUN**	**JUL**	**AUG**	**SEPT**	**OCT**	**NOV**	**DEC**
Nurse FTE (Inpatient)	11	13	15	15	14	16	17	17	18	20	20	20
Total TARs	5994	5302	5255	5387	5429	5225	5912	5490	5521	5674	4994	5459
Working days	21	20	21	22	22	20	22	22	20	23	19	20
TARs per nurse per day	**25.9**	**20.4**	**16.7**	**16.3**	**17.6**	**16.3**	**15.8**	**14.7**	**15.3**	**12.3**	**13.1**	**13.6**

Outpatient TARs – All Regions												
2024	**JAN**	**FEB**	**MAR**	**APR**	**MAY**	**JUN**	**JUL**	**AUG**	**SEPT**	**OCT**	**NOV**	**DEC**
Nurse FTE (Outpatient)	23	23	24	24	27	30	28	29	29	32	36	38
Total TARs	27117	23062	23240	23776	22744	21679	22652	21665	17416	19925	16222	15805
Working days	21	20	21	22	22	20	22	22	20	23	19	20
TARs per nurse per day	**56.1**	**50.1**	**46.1**	**45.03**	**38.29**	**36.13**	**36.77**	**33.96**	**30.03**	**27.07**	**23.72**	**20.80**

SNF/LTC TARs – All Regions												
2024	**JAN**	**FEB**	**MAR**	**APR**	**MAY**	**JUN**	**JUL**	**AUG**	**SEPT**	**OCT**	**NOV**	**DEC**
Nurse FTE (SNF/LTC)	4	3	4	5	6	9	10	10	9	9	9	10
Total TARs	2779	1766	1739	1568	1521	2202	2050	1661	1660	1684	1512	1747
Working days	21	20	21	22	22	20	22	22	20	23	19	20
TARs per nurse per day	**33.1**	**29.4**	**20.7**	**14.3**	**11.5**	**12.2**	**9.3**	**7.6**	**9.2**	**8.1**	**8.8**	**8.7**

Wellness & Recovery (Behavioral Health) TARs – All Regions												
2024	**JAN**	**FEB**	**MAR**	**APR**	**MAY**	**JUN**	**JUL**	**AUG**	**SEPT**	**OCT**	**NOV**	**DEC**
BH RN FTE (SUD)	2	2	2	2	2	2	1	1	1	2	2	2
Total TARs	154	130	180	171	161	145	153	147	149	151	161	159
Working days	21	20	21	22	22	20	22	22	20	23	19	20
TARs per RN per day	**3.7**	**3.3**	**4.3**	**3.9**	**3.7**	**3.6**	**7**	**7**	**7**	**3**	**4**	**4**

For calendar year (CY) 2024, the UM department processed a total of 344,695 Treatment Authorization Requests (TARs) that included requests for outpatient settings, inpatient acute hospital settings, durable medical equipment, skilled nursing/long term care facilities, and residential treatment for substance use disorders (SUD). This is a 40% increase in total TAR volume compared to CY 2023. On a business daily average, Partnership's UM department processed 1368 TARs, compared to 985 TARs per day for CY 2023. Nurse and BH Nurse full-time employees (FTEs) are defined by the total number of FTEs at the end of the month. Partial FTEs are the result of leave of absence and/or cross-coverage of staffing over different review types. TARs per staff ratios are expressed as the daily average of TARs per nurse FTE.

For UM staffing adequacy, month-to-month TAR to FTE ratios outside of the 20% variance threshold were identified across each category beginning in January due to the immediate spike in TAR volume resulting from Partnership's 10-county expansion. Variance for SNF/LTC TARs persisted intermittently throughout the year, driven by a combination of fluctuations in TAR volume and the hiring of new staff to adjust for new TAR volume norms. Interventions by the UM team in addressing these variances have included continuing a multi-year effort of cross-training UM nursing staff for timely coverage across review categories, the hiring of temporary staff, as well as requisitioning permanent positions to address staffing gaps.

Pharmacy:

Pharmacy TARs – All Regions												
2024	**JAN**	**FEB**	**MAR**	**APR**	**MAY**	**JUN**	**JUL**	**AUG**	**SEPT**	**OCT**	**NOV**	**DEC**
Total TARs	1065	994	877	879	865	848	881	883	797	1001	858	810
Working days	21	20	21	22	22	20	22	22	20	23	19	20
Tech FTE[1]	4	5	7	7	7	7	7	7	7	7	7	7
TARs per Tech per day	**13**	**10**	**6**	**6**	**6**	**6**	**6**	**6**	**6**	**6**	**6**	**6**
RPh FTE[1]	5	5	5	5	5	5	5	5	5	5	5	5
TARs per RPh per day	**10**	**10**	**8**	**8**	**8**	**8**	**8**	**8**	**8**	**9**	**9**	**8**

[1]Includes only staff who perform TAR reviews.

Pharmacy Technician and Clinical Pharmacist full-time employees (FTEs) are defined by the total number of respective FTEs at the end of the month. TARs per staff ratios are expressed as the daily average of TARs per Technician and Pharmacist FTE.

For CY 2024, Partnership's Pharmacy department processed a total of 10,758 TARs, which includes requests for Physician Administered Drugs (PADs). This is a 43.4% increase in total TAR volume compared to CY 2023. On a business daily average, Partnership's Pharmacy department processed 43 TARs. The increase in TAR volume was attributed to the 10-county expansion in January 2024.

In CY 2024, month-to-month TAR to FTE ratios outside of the 20% variance threshold were identified across for both Pharmacists and Technicians beginning in January due to the immediate spike in TAR volume resulting from Partnership's 10-county expansion. To address these variances, the Pharmacy team hired permanent positions for technicians to address staffing gaps and adjusted workflows to improve efficiency. Department leadership continued to monitor timeliness and inter-rater reliability (IRR) on a quarterly basis to ensure the Pharmacy department had adequate staffing levels to meet daily workload demands.

3. EVALUATION OF THE PHC ADVISORY COMMITTEE STRUCTURE

Physician Advisory Committee (PAC)

The PAC is responsible for oversight and monitoring of the quality and cost-effectiveness of medical care provided to Partnership members. The PAC reviews the activities of the Quality/Utilization Advisory Committee (Q/UAC), Pharmacy and Therapeutics (P&T) Committee, the Quality Improvement Program (QIP) Advisory Group, the Pediatric Quality Committee (PQC), and the Credentials Committee. The PAC then makes recommendations and assists Partnership in other ways as defined in Partnership's policies and procedures. The PAC meets at least ten (10) times a year, and may not convene in the months of July or December, with the option to add additional meetings if needed. Only committee members who are not Partnership staff may vote.

The Chief Medical Officer (CMO) serves in a tie breaking capacity as necessary. A quorum is the majority of members of the committee or subcommittee, as described in the Partnership by-laws. Committee attendees include external primary care physicians (PCPs), board certified high-volume specialists and non-physician clinicians from medical centers serving Partnership Members. A voting provider member of the committee chairs PAC. Partnership monitors and evaluates meeting the quorum to ensure the UM program and policies are reviewed and approved by this Partnership advisory committee in compliance with Partnership policies and procedures.

2024	JAN	FEB	MAR	APR	MAY	JUN	AUG	SEPT	OCT	NOV
Total voting members in attendance	12	13	17	16	12	15	13	17	13	16
Total voting members	14	15	19	19	21	21	20	22	23	22
Quorum	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

A total of 10 PAC meetings were held in 2024. Quorum requirements were met for all 10 meetings. Review of the committee's activities confirm it executed the responsibilities of its functions. No further action or change to this aspect of the program was deemed necessary.

Quality/Utilization Advisory Committee (Q/UAC)

The Q/UAC is responsible for monitoring the quality of medical care and services provided to Partnership members. The Q/UAC annually reviews, recommends, and approves the UM Program Description submitted by the UM unit of the Health Services (HS) Department and provides recommendations to the PAC. The Q/UAC meets at least 10 times a year and may convene in the months of July or December if needed. The Q/UAC is chaired by the Partnership Chief Medical Officer (CMO) and is comprised of formal voting representatives from community primary and specialty care practices, as well as consumer representative(s). The physician members represent licensed providers from hospitals, medical groups, and practice sites in geographic sections of Partnership's service area. The consumer representative(s) must be a consumer from one of the counties served by Partnership. A quorum is the majority of members of the committee or subcommittee as described in the Partnership by-laws. Voting members with annual attendance of less than 50 percent are evaluated for termination from the Q/UAC. Partnership monitors and evaluates meeting quorum to ensure the UM program and policies are reviewed and approved by this Partnership advisory committee in compliance with Partnership policies and procedures.

2024	JAN	FEB	MAR	APR	MAY	JUN	AUG	SEP	OCT	NOV
Total voting members in attendance	11	8	10	11	9	8	10	9	10	9
Total voting members	11	8	10	11	9	9	10	9	10	9
Quorum	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

A total of 10 Q/UAC meetings were held in 2024. Quorum requirements were met for all 10

meetings. Review of the committee's activities confirms it executed the responsibilities of its functions. No further action or change to this aspect of the program was deemed necessary.

Pharmacy & Therapeutics Committee (P&T)

The P&T Committee is chaired by Partnership's Chief Medical Officer (CMO), or designee such as the Director of Pharmacy, and is comprised of Partnership's Pharmacy Director, Associate and Regional Medical Directors, Partnership staff, and practicing members from the community including pharmacists, primary care physicians, behavioral health and other specialists. P&T makes decisions and recommendations on development and review of Physician Administered Drugs (PADs) provided under the medical drug benefit, medication policy and procedures, and drug approval criteria. P&T Committee also serves as Partnership's Drug Utilization Review (DUR) Board to review Partnership's DUR program and activities and make recommendations where necessary to improve Partnership's drug utilization. The P&T meets quarterly, providing regular activity reports and recommendations to the PAC, the approval authority for P&T related activities. A quorum, defined by one-third of the practicing members from the community, must be present in order to conduct the P&T Committee meeting. A consensus recommendation is made on drug coverage changes and drug/benefit policies. If no consensus is established, the issue is voted on with the decision determined by majority vote of the voting membership. Voting membership includes the practicing members from the community, Partnership CMO, Partnership Medical Directors, Partnership Director of Pharmacy, Partnership Manager of Clinical Pharmacy and Partnership Clinical Pharmacists.

2024	January	April	July	October
Total # of Practicing Members in Attendance	4	3	5	3
Total # of Practicing Members	7	9	9	8
Quorum	Yes	Yes	Yes	Yes

A total of four P&T meetings were held in 2024. Quorum requirements were met for all four meetings. Review of the committee's activities confirms it executed the responsibilities of its functions. No further action or change to this aspect of the program was deemed necessary.

B. PROGRAM SCOPE

1. POLICY REVIEW

The UM and Pharmacy Departments review each policy at least annually in order to remain compliant with Partnership policy and regulatory requirements. Although one (1) policy fell outside of this review schedule (as a result of the unforeseen circumstances resulting from Partnership's 10-county expansion), no additional actions are needed at this time.

For 2024, the UM Department had 77 policies which encompass both behavioral and non-behavioral healthcare. Of those 77 policies, 52 policies did not have substantive revisions and were approved as consent. 24 policies had substantive revisions that were reviewed and approved by the respective external advisory committee. One (1) policy was not reviewed at committee in 2024

because it was under internal review by a cross departmental workgroup for updates according to new contracts in 10 new expansion counties.

For 2024, the Pharmacy Department had seven policies, all of which did not have substantive revisions and were approved as consent.

Department	Policies	Policies reviewed for consent	Policy revisions approved
UM	77	52	24
Rx	7	7	0

C. PROGRAM PROCESS

1. UM TIMELINESS FOR NON-BEHAVIORAL AND BEHAVIORAL DECISIONS AND PHARMACY TIMELINESS

(Reference*: NCQA Utilization Management Standard 5 Element D report*)**

UM and Pharmacy monitored timeliness compliance on a quarterly basis to evaluate performance and identify opportunities for operation and reporting improvements. Below are the 2024 results, interventions and ongoing activities by UM and Pharmacy to address identified gaps and opportunities.

Summary of Results:

- UM non-behavioral health achieved 55.88% annual compliance toward NCQA notification timeliness standards.
- UM behavioral health had one (1) denial decision for 2024 and scored 100% toward NCQA notification timeliness standards.
- Pharmacy achieved 97.68% annual compliance toward NCQA notification timeliness standards.

UM: UM did not meet the 95% timeliness goal for non-urgent pre-service, urgent pre-service, urgent concurrent, or post-service requests in 2024.

In 2024, TAR volume for the UM department increased by 40% year-over-year from 2023 as a result of the 10-county expansion. This increase in TAR volume vastly exceeded Partnership's budgetary and staffing projections, and impacted UM's ability to comply with the timeliness goals across all review categories in 2024. UM has pursued, and continues to pursue, the following remedies in order to mitigate risk to overall timeliness:

- Hiring of permanent nursing staff in order to address work volume in excess of budgetary projections.
- Working with Human Resources to engage with additional hiring agencies to produce temporary-to-hire opportunities for external candidates.
- Adjustments to UM workflows to decrease training timeframes and allow for new hires to enter into production more quickly
- Adjustments to the entire UM review workflow continuum to address inefficiencies
- Evaluating TAR denial rates to create opportunities for auto-approval for requests with low denial rates

Pharmacy:

Pharmacy did not meet the 95% timeliness goal for urgent pre-service requests in 2024. Timeliness goals were met for non-urgent pre-service and post-service requests. No urgent concurrent requests were reviewed in 2024.

In 2024, there was a 43% increase in TAR volume year-over-year from 2023 due to the 10-county expansion. This increase in TAR volume exceeded TAR volume projections and impacted Pharmacy's ability to meet timeliness goals for urgent pre-service requests. To mitigate risk to timeliness, the Pharmacy department implemented the following:

- Prioritizing requests that require translation
- Deprioritizing post-service requests given the longer turn-around-time to allow more timely reviews of urgent pre-service and non-urgent pre-service requests
- Identifying and flagging gene therapy requests at data entry and treating as urgent
- Streamlined processes for TARs that require external reviews
- Directly assigning TARs to technicians as needed
- Hiring of permanent technician staff which began during Q4 2023 and continued in Q1 2024 to address staffing gaps as a result of the increase in TAR volume

Both the UM and Pharmacy departments plan to continue to closely monitor and evaluate timeliness performance and data integrity, and will provide quarterly reports to leadership for update and review.

2. CONSISTENCY OF APPLYING UM CRITERIA

(Reference*: NCQA Utilization Management Standard 2 Element C Report*)**

The organization uses a methodology of 5% or 50 TARS, whichever is less, for each staff member to test inter-rater reliability (IRR). For 2024, 50 TARs per reviewer pursuant to Partnership Policy MPUP3026 (including appeal cases where indicated on Partnership's P&P) were reviewed by each nurse coordinator, pharmacy technician, pharmacist, and physician for IRR.
The IRR concurrence rate by reviewer type is as follows:

- Nurse Reviewers: 3190 TAR cases were reviewed with a total concurrence rate of 95%.
- BH Nurse Reviewers: 105 TAR cases were reviewed with a total concurrence rate of 100%.
- Physician Reviewers: 759 TAR cases were reviewed with a total concurrence rate of 97%.
- Pharmacist Reviewers: 252 TAR cases were reviewed with a total concurrence rate of 98%.
- Pharmacy Technician Reviewers: 409 TAR cases were reviewed with a total concurrence rate of 96%.

2024 Results:
Partnership met the 90% concurrence score goal for all reviewer types. No additional action is required.

3. APPROPRIATE CARE: MONITORING FOR OVER/UNDERUTILIZATION

Summary of Over/Underutilization Workgroup Activities from 2024
Prepared March 21, 2025
Summarized by Robert Moore, CMO

Overview:

Partnership has systematic processes for monitoring for over-utilization and under-utilization of services (see Appropriate Service and Coverage Policy MPUP3006 and UM Program Description MPUD3001 for details). Evaluation and analysis of the availability of primary care and specialty care providers and accessibility of primary care and specialty care services are evaluated as part of the network adequacy and availability section of the QI evaluation, following DHCS and NCQA standards. The Over-/Under-utilization Workgroup evaluates available data on PCP utilization to determine if any apparent under-utilization is associated with capitation of providers (versus due to data incompleteness). Specialty utilization patterns are addressed in the Access and Availability Grand Analysis (part of the annual QI evaluation), and as a separate report on follow ups for specialty referral, presented to IQI and Q/UAC each January.

The under-utilization of preventive care is initially identified in two ways: results of annual quality data reporting (HEDIS® measures and some others); and medical record reviews conducted periodically at each PCP and prenatal care site. HEDIS results are reviewed by the quality committees (IQI and Q/UAC) and governance committees (PAC and Board). The HEDIS Measure Improvement Workgroup prioritizes interventions to improve HEDIS measures and monitors these interventions, and the NCQA Steering Committee oversees these efforts. Preventive healthcare deficiencies identified through the site review process are addressed with corrective action plans, or other actions as detailed in the Site Review Requirements and Guidelines Policy MPQP1022. Additional analysis of selected preventive care measures that are under-utilized is also presented at each Over-/Under-utilization Workgroup meeting.

Over-utilization of clinical activities/procedures may be prevented through the overall prior authorization process for pharmacy, inpatient hospital, long-term care, skilled nursing, durable medical equipment etc. The potential and propensity of health care providers to over-utilize a service is a factor for deciding which services/medications etc. are subject to prior authorization; cost is the other major factor that is considered. The policies and standards which define prior authorization criteria are designed to assure medically necessary use without overuse. Surveillance for over-utilization of medications/services/equipment that do not require prior authorization is conducted by the medical directors, nurses and pharmacists when reviewing clinical records for other purposes (in the UM/pharmacy prior authorization, peer review, HEDIS data abstraction, medical record review, fraud/waste/abuse reporting and grievance processes).

Individual instances of potential over-utilization are noted and potentially addressed with the individual clinician (depending on the certainty of over-utilization by the reviewer and the implications of the over-utilization). If a systematic or more global overutilization is suspected,

the CMO or designee is consulted. Based on the review of the CMO or designee, data analysis related to the potential over-utilization will be conducted and the results presented at the Over/Under Utilization Workgroup. In addition, systematic review of hospital-based care metrics are reviewed for patterns of potential overuse. Actions based on the over-utilization depend on the circumstances but may include referral to the Fraud, Waste & Abuse (FWA) Subcommittee, Peer Review Committee, Credentials Committee, and/or quality committees.

Summary of Over-Under Utilization Workgroup Analyses
for January 2024 through December 2024.

Meeting dates in 2024: January 24, April 29, August 6 and October 30.

Analysis of PCP visits for under-utilization is conducted at each meeting. The average number of billed visits per capitated member per year is calculated for each PCP site and is evaluated from different perspectives at different meetings.

The January meeting found that the Northern and Southern Regions' rates are quite close to each other but are below the target rate. Marin had the highest PCP visit rate in 2023 and Lake had the lowest visit rate. The Southern Region's visit rates in 2023 are lower than that of 2022 and also the pre-Covid rates. The Northern Region's rates in 2023 trended close to 2022 and most of the monthly rates are lower than those of 2019.

The April meeting had an additional focus on Telemedicine utilization. We found that the percentage of Telehealth visits are higher in the Southern Region than in the Northern Region. The age group of adults aged 21-64 had a higher percentage of visits among the 3 age groups evaluated. Marin, Sonoma, and Solano Counties had a higher percentage of Telehealth visits. Del Norte observed a dramatic increase from 2023 Q1 through Q3 and had a slight decrease from Q3 through Q4. Napa and Lake Counties observed a higher increase in visit percentages. The Southern Region's well care visit rates in 2023 were lower than those of 2019, while the Northern Region's rates were closer to the 2019 rates. Overall, the Northern Region performed better than the Southern Region. Marin, Mendocino, Trinity, Napa, and Del Norte had higher well care visit rates.

The October meeting reviewed data through the end of the second quarter of the calendar year. The Overview dashboard displays the PCP visit rate across Partnership's 24 counties. The Eastern Region, that includes 9 out of the 10 expansion counties, is shown in green. The Eastern Region Rates, based on the first 6 months of 2024, trend slightly lower than the Southern and Northern Regions but right above the target of 2.2 visits per member per year. Colusa County has the highest visit rates, followed by Sutter and Butte. Placer has the lowest rate, followed by Nevada and Sierra. Colusa County has the highest visit rates, followed by Sutter and Butte. Placer has the lowest rate, followed by Nevada and Sierra. The sharp drop in Yolo County in Q2 of 2024 is related to the Woodland contract termination. The low rates in Solano County are driven by low rates in Solano County Health Services.

The January meeting reviewed the Specialty Office visit speed of referral for 2023 CAHPS. Higher proportion of specialist visits had visits "as soon as needed" were found in Modoc, Yolo, Siskiyou and Solano Counties. Low proportion of "as soon as needed" were found in Del Norte, Humboldt, Marin and Mendocino. Marin and Modoc identified the health plan review of specialist referrals as the cause of delay, two counties where out-of-network referrals are more common.

Overall specialty visit rates were reviewed in the October meeting, with overall use of specialists rising to highest levels in 2024. Compared to a well-managed benchmark, rates of specialist underutilization were lowest in otolaryngology (34%), Dermatology (41%), and Endocrinology (34%). Of note, the rate of use of rheumatology and endocrinology were up to 55% overall, likely related to an increased use of specialty telemedicine. The largest single driver of specialist underutilization is the stagnant rates of reimbursement for private practice Medicare (mostly) and Medi-Cal (to a lesser degree). Partnership conducts focused interviews of specialists in the Northern Region, where the shortages are more acute, to look at additional drivers and potential interventions. Proposition 35 might help with reimbursement rates, if it survives Federal scrutiny.

Preventive care metrics reviewed for under-utilization in this time period are:

- **Well Child Visits**: Six well-child visits in the first 15 months of life. HEDIS results show a low rate across all regions and most counties, in spite of being part of the PCP QIP, and the PCP QIP rate is substantially higher than the HEDIS rate. A deep dive shows that the true rate is actually higher than the national 50th percentile, but data for early visits is missed due to this measure being an administrative measure, and early visits done under the mother's CIN number are not matchable to count towards the measure numerator. A PIP in Solano County focusing on the Black population is underway.
- **Childhood Immunization Status**, as reflected by CIS-10. Vaccination rates declined in 2023 (really plummeted), relative to 2020 and 2021 and 2022. The major driver for this is an increased vaccine hesitancy post-COVID, especially for the Influenza vaccination. Rates were especially low in the Northern Region. Interventions for childhood vaccination include: Media messages in some markets, provider education, and partnering with sites on QI projects, eReports tools and dashboards, and participation in DHCS Affinity Group. This measure is part of the PCP QIP.
- **Lead Screening in Children**: Results in the 2023 HEDIS measurement year show low rates (25th percentile or lower) of infant lead screening across the network, with the highest rates being in Humboldt County. Lead testing is part of the PCP QIP, and grants to support point of care lead testing continue to be rolled out. Vigorous provider education about lead toxicity is ongoing.
- **Follow up after ED visits for Mental Health Diagnoses**: The HEDIS rate in 2023 was below the 25th percentile in all regions. Although some data from County Mental Health are sent to Partnership, this data is incomplete, contributing to the low rate. An intensive program to use HIE to augment state data is ongoing, but county legal interpretation that patients must

opt-in to share data with the HIE will likely lead to low rates of new mental health visit data. Other projects related to putting case managers into Emergency rooms are also hoped to improve this rate.

Other evaluations for potential under-utilization included:

- Advance Directives. The use of advanced directives is assessed at a community level by supplemental questions on the annual CAHPS survey. Lake and Napa have the highest levels of Advanced Directives being completed (over 30%), while Mendocino and Modoc Counties have the lowest rates. Trinity and Napa Counties have higher rates of conversation with clinicians about the Advance Directive; Marin has the lowest rate of putting the AD into the medical record. This remains a Unit of Service measure in the PCP QIP.
- Tobacco Screening and referral to treatment rates as assessed in CAHPS (January meeting) survey found high rates in Modoc, Lassen and Trinity and low rates in Lake and Mendocino Counties. Lake has the highest rate of nicotine use in Partnership. Screening rates based on claims data jumped from 1.4% in 2022 to 3.3% in 2023, reflective of a new unit of service measure in the PCP QIP.
- Rate of Fluoride Varnish Treatment rates increased from 2022 to 2023, but the overall rate is low due to lack of data on fluoride varnish applications in Dental visits conducted at FQHCs, RHCs, and Tribal Health Centers. This is a Unit of Service QIP measure. Partnership has a dental hygienist who educates primary care practices on the use of fluoride varnish in the office.
- Vaccination in Pregnancy (Flu and TDaP) were reviewed in the April meeting: rates were rising slightly for Influenza vaccination in 2023 (34.4%) compared to 2022 (33.6%). For the TDaP vaccine, the overall rate also rose slightly from 66.1% in 2022 to 66.9% in 2023. Both have much room for improvement. This is part of the perinatal QIP, and the results are shared with PCP medical directors, perinatal providers, and public health officers each year. Additionally, data on two other vaccines that are recommended in pregnancy, COVID and RSV was reviewed. COVID vaccination rates in Pregnancy dropped from 31.3% in 2022 to 8.2% in 2023. The RSV vaccine was new in 2023, but the rate of use was low: just 1.56% in 2023.
- ACES screening peaked in 2022 and dropped in 2023. This screening is paid with a supplemental payment per year for children of $29. The reason for the decrease may be that providers do not find benefit from annual screening of children without changes in their social situation, or that providers are reprioritizing their time to focus on measures in the PCP QIP.
- Vasectomies: The number of men who had vasectomies remained steady from 2022-2023, the rate is very uneven, with high rates in Lassen, Modoc, and Humboldt Counties and low rates in Del Norte, Yolo and Solano Counties. Rates in Shasta and Siskiyou are increasing with a new provider of these services in Shasta County.
- Developmental screening rates (October meeting) rose very slightly, but remain low, in spite of rather robust extra payment being paid for each developmental screen that occurs, including

at FQHCs. Educational programming on developmental screening continues to be offered annually, including at regional medical director meetings.

Analyses for potential over-utilization that were presented at the Over-/Under-utilization Workgroup include the following:

An annual review of hospital utilization was conducted in August. Major findings were a small decrease in Average Length of Stay (ALOS), a small decrease in hospital readmission, and emergency room visits in 2023. The PCP QIP, the palliative care QIP, and the Hospital QIP all incentivize more appropriate use of hospitalization.
Specific comparison of capitated hospitals, who are responsible for their own Utilization Management, and non-capitated hospitals (where PHC does UM), showed that hospitalization rates appeared to be lower at Queen of the Valley Hospital and Woodland, and medium at Adventist Hospitals, Marin and NorthBay.

Evaluations of potential areas of over-utilization

- ER visits with CT scans was reviewed in the October meeting. The trend has changed over the years; currently the highest rates are UC Davis Medical Center, Sutter Santa Rosa, and several Dignity hospital emergency rooms. The lowest rates were in Adventist system Emergency Rooms, Queen of the Valley Hospital, and several small rural hospitals. Overall rates fell from 2022 to 2023, and this will continue to be monitored with feedback given to the ED groups where the rates are highest.

Areas of over-utilization with ongoing activities

- In the January meeting, C-Section rates and other maternity measures by hospital were reviewed for 2022 data, and some hospitals were found to have relatively higher levels of NTSV (nulliparous, term, singleton, vertex) C-section rates. Interventions: This measure is part of the hospital QIP. Educational interventions of major OB providers by the perinatal provider education workgroup at PHC highlighted differences.

D. INFORMATION SOURCE USED TO DETERMINE BENEFIT COVERAGE AND MEDICAL NECESSITY

Partnership uses the most currently available InterQual® Criteria sets as the primary review guidelines for UM medical necessity decisions. For the calendar year 2024, UM used the 2023 InterQual decision criteria until the 2024 version became electronically available.

InterQual® criteria and other approved UM criteria outside of InterQual®, are reviewed, discussed, and evaluated at Partnership's Q/UAC and PAC as described in policy MCUP3139 Criteria and Guidelines for Utilization Management. Criteria utilized include, but are not limited to, Medi-Cal (State of California) guidelines, Medicare criteria, State policy letters, national treatment guidelines, and clinical practice recommendations from UpToDate®. UM criteria are also reviewed at the

monthly internal CMO/MD meeting attended by the CMO and Medical Directors, leadership from UM, Population Health, Care Coordination, Quality, Pharmacy, and Grievances & Appeals, as well as ad hoc specialists in the appropriate field of the policies being developed.

In addition, Partnership's medication decision criteria and pharmacological drug classes are reviewed in collaboration with external and internal providers on an on-going and annual basis. Criteria are selected, reviewed, updated or modified using feedback from the Partnership staff, the P&T Committee, the PAC, the Consumer Advisory Committee (CAC), external providers, State policy letters, or medical literature among other sources.

Summary: UM and Pharmacy criteria are timely and comprehensively reviewed. No change to this aspect of the program was deemed necessary.

E. INVOLVEMENT OF SENIOR LEVEL PHYSICIANS IN THE UM PROCESS

Partnership's CMO and Medical Directors actively participate in the monthly review, discussion, and approval of policies and procedures in Partnership's IQI, P&T, and Q/UAC Committees. Policies approved in IQI, P&T, and Q/UAC are presented at PAC where attending network practitioners and Partnership's CMO and Medical Directors discuss and approve the presented policies. The CMO and Medical Directors also actively participate in clinical rounds and perform UM review and decisions to fulfill their assigned responsibilities for their scope of work. Partnership delegates the behavioral health UM process to NCQA Accredited organizations. However, Partnership has a designated Behavioral Health Clinical Director who actively participates in Partnership's UM Program. Partnership's committees also include network behavioral health practitioners who actively participate and contribute to Partnership's UM Program. Throughout the year, Partnership's UM Program demonstrated practitioners were actively involved in key aspects of the UM program, and therefore no further action is needed.

F. ASSESSING EXPERIENCE WITH THE UM PROCESS

1. IMPROVING PRACTITIONER EXPERIENCE WITH THE UM PROCESS

Partnership contracts with an external entity, Press Ganey (PG), to administer the Physician Satisfaction Survey annually. All contracted Primary Care Provider (PCP) sites and Specialists were surveyed across Partnership's Northern and Southern Region network. A total of 303 physician/specialist surveys were completed from April 19 – June 14, 2024. The response rates for the two types of providers are as follows: PCPs 47%, Specialists 53%.

Partnership establishes a minimum threshold of 90% satisfaction and tracks and trends variations greater than 5% from the preceding year.

Please refer to Appendix I for Physician Satisfaction Survey Data.

Summary of PCP Outcomes:

- All UM and Pharmacy questions among PCPs met their respective goal of 90% for strongly

agree or agree. No further interventions needed.

Summary of Specialist Outcomes:

- All UM and Pharmacy questions among Specialists met their respective goal of 90% for strongly agree or agree. No further interventions needed.

2. MEMBER EXPERIENCE WITH THE UM AND PHARMACY PROCESS

This portion of the program evaluation was provided by the Grievance and Appeals (G&A) department through the G&A PULSE Report. The report contains an analysis of member-reported Grievance concerns about any dissatisfactory experience related to Utilization Management (UM). If the number of grievances per 1,000 members in the current period (2024) increases by more than 10% from the previous period (2023), then the Threshold is triggered. An unmet NCQA Threshold identifies growing areas of member dissatisfaction and intervention(s) may be required.

Partnership's membership and the total number of cases received increased in 2024. In 2024, a total of 270 concerns were reported regarding the UM process, compared to 205 concerns in the previous year. In spite of this increase in cases received, Partnership did not exceed the threshold in any category in 2024.

The primary issue reported concerning the UM process was access-related issues. Notably, 66.3% of these access-related issues were associated with Partnership's Referral Authorization Form (RAF) process, while the remaining 33.7% were linked to the Treatment Authorization Request (TAR) process.

Among the reported issues within the referral process, delays by providers (119) was the most reported concern. Members alleged that their primary care providers were delaying submission of RAFs, consequently causing delays in obtaining appointments with specialists.

The most prominent driver behind member dissatisfaction with the TAR process was related to providers delaying submission of TARs to Partnership (44 reported concerns).

Please refer to Appendix II for further details of member satisfaction data for 2024.

II. Conclusion:

The UM Program Evaluation report assesses the program's effectiveness, capacity, and integrity in managing the utilization of healthcare resources delivered to our members and ensures our members receive the appropriate quality and quantity of care at the appropriate time and setting. In addition, the evaluation report identifies gaps and improvement opportunities for which interventions are developed.

In this evaluation, the results demonstrated strengths in the areas of consistency in applying criteria, comprehensive review of information sources, program structure and others. Opportunities were identified in improving TAR timeliness.

Based on the results from the 2024 UM program evaluation, Partnership concludes there are no significant changes required for the UM program. Partnership's UM program functions effectively and efficiently through a solid program structure, comprehensive set of policies, and robust support, guidance, and engagement from senior level physicians and advisory committee members. Activities addressing the improvement opportunities will continue to be monitored, measured, and reported in future evaluations.

APPENDIX I: Improving Practitioner Experience with the UM process

Key:

- ≥5% Improvement relative to prior year
- ≥5% Decline relative to prior year
- n= total respondents

Trended PCP Regional and Plan-wide Performance on the Physician Satisfaction Survey

PCP (% Strongly Agree or Agree)	2023			2024			% Difference			
	North (n=23)	South (n=86)	2023 Total	North (n=46)	South (n=97)	2024 Total	North	South	2024 Goal	2024 Performance Goal Met
I am satisfied with my interactions with UM Staff.	95%	99%	98%	92%	92%	92%	-3%	-7%	90%	Yes
I am satisfied with the PHC e-RAF system.	86%	97%	94%	95%	99%	97%	9%	2%	90%	Yes
I am satisfied with my interactions with PHC Pharmacy Staff	100%	91%	93%	94%	94%	94%	-6%	3%	90%	Yes

Trended Specialist Regional and Plan-wide Performance on the Provider Satisfaction Survey

Specialist (% Strongly Agree or Agree)	2023			2024			% Difference			
	North (n=49)	South (n=98)	2023 Total	North (n=53)	South (n=107)	2024 Total	North	South	2024 Goal	2024 Performance Goal Met
I know how to determine whether or not a service requires that TAR (Auth) be submitted to PHC.	93%	88%	89%	86%	96%	92%	-7%	8%	90%	Yes
My TARs are approved in a timely manner.	97%	80%	85%	94%	97%	96%	-3%	17%	90%	Yes
When a TAR for medical service is	97%	79%	84%	87%	91%	90%	-10%	12%	90%	Yes

Specialist (% Strongly Agree or Agree)	2023			2024			% Difference			
	North (n=49)	South (n=98)	2023 Total	North (n=53)	South (n=107)	2024 Total	North	South	2024 Goal	2024 Performance Goal Met
denied by the plan, the basis for denial is clearly specified.										
When one of my TARs is returned/deferred for more information, I know what additional documentation I need to submit.	97%	95%	96%	98%	92%	94%	1%	-3%	90%	Yes
I am satisfied with my interactions with UM Staff.	97%	100%	99%	100%	98%	99%	3%	-2%	90%	Yes
I am satisfied with the PHC e-RAF system.	77%	100%	92%	90%	96%	94%	**13%**	-4%	90%	Yes
I am satisfied with the PHC e-TAR system.	94%	99%	97%	96%	97%	96%	2%	-2%	90%	Yes
I am satisfied with my interactions with PHC Pharmacy Staff	100%	99%	99%	100%	98%	98%	0	-1%	90%	Yes

APPENDIX II: Member Experience with the UM process

THE UM EXPERIENCE

REPORTING PERIOD

As required by NCQA, this section reports G&A findings about members who encountered problems with the authorization or referral process in 2024 compared to 2023. For more details, please reference the attached NCQA UM 1B: Member Experience-UM Threshold Report.

OVERVIEW

There were 270 reported concerns regarding the UM process in 2024 compared to 205 in 2023. We have met the threshold in all categories of the UM1B report. There continues to be communication issues between members and their providers regarding referrals. This resulted in providers delaying or refusing to submit TARs or Referral Authorization Forms (RAFs).

DISSATISFACTION WITH RAF PROCESS

Of the 270 UM concerns, 179 of them were related to the RAF process. Of those, 119 of the concerns were related to a member's primary care provider allegedly delaying their RAF request, causing delays in getting appointments with specialists.

RAF Process	
# of Reported Concerns	
Delayed by Provider	119
Refused by Provider	16
Member dislikes overall	14
Delayed by Partnership	14
Other	16
Total	179

DISSATISFACTION WITH TAR PROCESS

Member's concerns related to the prior authorization process account for 91 of the 270 cases reported. The largest driver was members alleging their provider delayed submission of their TAR to Partnership.

TAR Process	
# of Reported Concerns	
Delayed by Provider	44
Delayed by Partnership	20
Member dislikes overall	12
Refused by Provider	6
Other	9
Total	91

4Q24 Grievance and Appeals PULSE Report: Supplemental Data
NCQA UM 1B: Member Experience-UM Threshold Report
REPORTING PERIOD: 2023 and 2024
Year-to-Year Report

Grievances Only Reporting Period: Annual 2023 vs. Annual 2024								
	Previous Period: 2023			Current Period: 2024				
NCQA Category	Grievances	Avg PHC Mship	Grievances p/1,000	Grievances	Avg PHC Mship	Grievances p/1,000	Threshold	Threshold Met?
Access	139	678,546	0.20	185	1,078,335	0.17	0.23	Yes
Attitude/Service	46		0.07	59		0.05	0.07	Yes
Billing/Financial	0		0.00	0		0.00	0.00	Yes
Quality of Care	20		0.029	26		0.024	0.03	Yes
Quality of Provider Office	0		0.000	0		0.000	0.00	Yes
TOTAL	205		0.30	270		0.25	0.33	Yes

Purpose of report: It reflects a subset of data from the ME.7 Member Experience Report. Data reflects member-reported dissatisfaction related to experiences with the TAR and RAF process. If the number of cases per 1,000 members in the current period increases by more than 10% from the previous period, then the Threshold is triggered. An unmet NCQA Threshold(s) identifies growing areas of member dissatisfaction and an intervention(s) maybe required. This report is published bi-annually. The March report provides an annual depiction of the two years under evaluation. The September report provides a mid-year update. All data is reported with a 95% confidence level.

Published March 2025

Prepared March 21, 2025

Utilization Management and Pharmacy Reports

The tables below present data for all UM and Pharmacy TARs according to the following categories and statuses:

I. **UM TARs:**

A. A total of **344,695** UM TARs completed in 2024 are presented in comparison to the 2023 UM TARs completed in four tables below according to these categories:

1. Inpatient
2. Outpatient (includes TAR types a.- d.)
   a. Durable Medical Equipment (DME)
   b. Medical
   c. Ancillary
   d. Transportation
3. Long term care (LTC)
4. Wellness and Recovery (TARS for Residential SUD Treatment)

B. For each category of UM TAR, the following TAR status types are summarized:

1. Approved TARs
   a. Approved
   b. EB Approved
   c. IB Approved
   d. CTC (capped to capped)
   e. Correction Received
   f. Modified per Correction Request

2. Approved as Modified TARs

3. Admin Modification TARs

4. Denied TARs
   a. <u>Medical Necessity Denials*</u>
      1) Med Nec Not Justified
      2) Denied by Cap Hosp
      3) Member Not Eligible
      4) Other Insurance
      5) Not timely (new category in 2023 for TARs received more than 1 year from date of service)
   b. <u>Administrative Denials</u>
      1) Admin Denial Duplicate AR
      2) Admin Denial No Auth Required
      3) Admin Denial Void

5. Appeals and Grievance TARs
   a. Grievance Overturned
   b. Overturned by Appeal
   c. Appeal Partially Overturned
   d. Appeal Upheld

SUPPLEMENTAL TAR REPORT to the 2024 UM PROGRAM EVALUATION

Data Summary for UM TARs (2023 and 2024)

Year	Total TARs	Total Approved	% Approved	Total App. as Mod.	% App. as Mod.	Total Admin Mod.	% Admin Mod.	Total Med. Nec. Denials	% Med. Nec. Denials	Total Admin Denials	% Admin Denials
2023	246,245	204,689	83.1%	1,424	0.58%	3,040	1.2%	10,957	4.4%	25,942	10.5%
2024	344,695	274,099	79.5%	2,093	0.61%	2,733	0.8%	14,118	4.1%	51,385	14.9%

Data Summary for UM Grievances and Appeals (2023 and 2024)

Year	Total Grievances Overturned	Total Appeals	Total Appeals Overturned	% Appeals Overturned	Total Appeals Partially Overturned	% Appeals Partially Overturned	Total Appeals Upheld	% Appeals Upheld
2023	36	157	41	26.1%	3	1.9%	113	71.97%
2024	38	226	53	23.5%	2	0.9%	171	75.66%

INPATIENT TARs

TAR STATUS	JAN		FEB		MAR		APR		MAY		JUN		JUL		AUG		SEPT		OCT		NOV		DEC		TOTAL	
	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024
Approved	3,072	4,912	2,779	4,649	2,974	4,481	2,821	4,814	3,074	4,841	2,704	4,591	2,955	5,177	3,079	4,661	2,857	4,631	2,985	4,997	2,936	4,300	2,732	4,208	34,968	56,262
EB Approved	3	20	2	6	6	17	7	14	1	8	5	6	6	9	6	14	4	2	3	2	2	1	2	1	47	100
IB Approved	6	12	11	35	49	61	9	10	30	19	135	70	4	15	6	29	35	91	6	18	25	46	119	524	435	930
CTC / Capped Review	1	3	6	9	44	31	2	0	5	0	87	15	0	5	3	5	14	20	0	7	6	6	14	69	182	170
Correction Received	0	0	0	1	0	3	0	1	1	2	0	1	0	2	0	1	0	4	0	1	0	4	1	9	2	29
Modified per Correction Request	1	3	2	0	2	3	0	3	2	4	1	4	1	1	4	0	4	0	4	0	4	1	4	1	29	20
TOTAL (APPROVED)	3,083	**4,950**	2,800	**4,700**	3,075	**4,596**	2,839	**4,842**	3,113	**4,874**	2,932	**4,687**	2,966	**5,209**	3,098	**4,710**	2,914	**4,748**	2,998	**5,025**	2,973	**4,358**	2,872	**4,812**	**35,663**	**57,511**
Approve as Modified	**23**	**34**	**18**	**39**	**24**	**45**	**25**	**40**	**17**	**49**	**25**	**52**	**17**	**69**	**20**	**71**	**31**	**63**	**18**	**67**	**30**	**81**	**29**	**48**	**277**	**658**
Admin Modification	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**		**0**		**0**		**0**	**0**
Med Nec Not Justified	34	64	39	66	44	73	30	75	44	80	29	94	18	82	37	90	37	106	43	103	38	127	46	128	**439**	**1,088**
Denied by Cap Hospital	5	3	3	3	3	5	7	6	8	5	5	8	9	7	3	9	0	11	3	9	2	3	4	6	**52**	**75**
Member not Eligible	10	17	7	10	9	12	7	8	9	10	6	8	5	18	7	19	7	10	8	8	7	15	7	11	**89**	**146**
Not Timely	0	0	1	0	0	0	0	0	0	0	0	1	0	0	0	1	0	0	0	0	2	0	0	0	**3**	**2**
Other Insurance	46	190	42	110	41	129	49	126	44	119	55	118	38	171	39	191	48	191	97	137	74	148	96	172	**669**	**1,802**
TOTAL (MED NEC DENIALS)	95	**274**	92	**189**	97	**219**	93	**215**	105	**214**	95	**229**	70	**278**	86	**310**	92	**318**	151	**257**	123	**293**	153	**317**	**1,252**	**3,113**
Admin Denial (Duplicate TAR)	74	110	38	63	48	63	32	69	36	72	37	63	33	84	34	104	47	124	44	109	45	83	43	92	**511**	**1,036**
Admin Denial (No Auth Required)	53	96	52	144	67	108	40	86	82	88	58	79	54	88	53	103	60	109	64	90	81	77	56	84	**720**	**1,152**
Admin Denial (Void)	116	512	85	161	99	222	77	114	111	114	81	109	105	166	94	181	119	157	120	118	136	96	122	106	**1,265**	**2,056**
TOTAL (ADMIN DENIALS)	243	718	175	368	214	393	149	269	229	274	176	251	192	338	181	388	226	390	228	317	262	256	221	282	**2,496**	4,244
TOTAL (DENIALS)	338	992	267	557	311	612	242	484	334	488	271	480	262	616	267	698	318	708	379	574	385	549	374	599	**3,748**	**7,357**
Grievance Overturned	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0
Overturned by Appeal	1	1	0	1	0	0	1	2	0	1	0	0	0	4	0	1	0	1	0	2	1	1	0	0	3	14
Appeal Partially Overturned	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0
Appeal Upheld	16	17	5	5	3	2	7	19	5	17	1	6	13	14	2	10	0	1	4	6	3	5	0	0	59	102
TOTAL TARs	3,463	5,994	3,090	5,302	3,413	5,255	3,114	5,387	3,469	5,429	3,229	5,225	3,258	5,912	3,387	5,490	3,263	5,521	3,399	5,674	3,393	4,994	3,275	5,459	**39,753**	**65,642**
IP Nurse FTE	**13**	**11**	**13**	**13**	**14**	**15**	**14**	**15**	**14**	**14**	**14**	**16**	**13**	**17**	**11**	**17**	**10**	**18**	**12.00**	**20.00**	**14.00**	**20.00**	**15.00**	**20.00**		
Working Days	**20**	**21**	**19**	**20**	**23**	**21**	**20**	**22**	**22**	**22**	**22**	**20**	**20**	**22**	**23**	**22**	**20**	**20**	**22**	**23**	**20**	**19**	**19**	**20**		
TARs per Nurse per Day	13.32	25.95	12.51	20.39	10.60	16.68	11.12	16.32	11.26	17.63	10.48	16.33	12.53	15.81	13.39	14.68	16.32	15.34	12.88	12.33	12.12	13.14	11.49	13.65		

OUTPATIENT TARs

TAR STATUS	JAN		FEB		MAR		APR		MAY		JUN		JUL		AUG		SEPT		OCT		NOV		DEC		PY	CURRENT
	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024
Approved	10,338	20,105	10,097	17,394	12,139	17,474	10,395	17,182	12,479	17,000	11,872	15,412	10,834	15,055	12,694	14,964	11,014	10,380	11,859	11,222	11,211	9,497	10,471	9,558	135,403	175,243
EB Approved	1,107	921	1,208	788	1,543	756	753	651	804	651	811	845	746	1,023	1,148	1,145	896	998	1,142	942	929	738	875	849	11,962	10,307
CTC / Capped Review	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Correction Received	12	70	19	74	27	103	20	62	25	96	73	78	23	45	31	49	43	54	77	26	78	38	105	62	533	757
Modified per Correction Request	795	1,427	605	898	478	579	644	1,252	613	920	280	556	707	1,056	656	799	369	358	764	773	512	457	324	229	6,747	9,304
TOTAL (APPROVED)	12,252	22,523	11,929	19,155	14,187	18,912	11,812	19,147	13,921	18,667	13,036	16,891	12,310	17,179	14,529	16,957	12,322	11,790	13,842	12,963	12,730	10,730	11,775	10,698	154,645	195,612
Approve as Modified	84	71	104	70	101	74	106	94	97	74	64	70	58	177	114	101	103	110	94	181	94	167	90	167	1,109	1,356
Admin Modification	237	149	276	158	278	179	278	177	329	133	270	156	219	275	231	289	258	245	235	324	210	308	211	334	3,032	2,727
Med Nec Not Justified	493	258	428	226	548	313	594	426	694	255	458	239	696	715	770	358	596	470	685	902	537	982	438	633	6,937	5,777
Denied by Cap Hospital	0	1	3	0	1	2	2	0	0	2	2	2	3	0	2	0	1	1	1	0	0	0	2	1	17	9
Member not Eligible	12	27	11	13	22	23	11	29	14	23	18	26	18	30	17	40	25	20	8	20	12	15	16	24	184	290
Not Timely	0	1	0	3	0	2	0	1	0	0	1	1	0	1	0	2	5	0	1	17	3	1	1	1	11	30
Other Insurance	223	418	148	369	197	371	161	351	171	379	200	366	193	422	219	415	190	346	241	423	197	325	217	293	2,357	4,478
TOTAL (MED NEC DENIALS)	728	705	590	611	768	711	768	807	879	659	679	634	910	1,168	1,008	815	817	837	936	1,362	749	1,323	674	952	9,506	10,584
Admin Denial (Duplicate TAR)	511	801	488	627	651	739	542	792	691	863	616	848	579	983	605	920	508	706	613	776	556	745	538	849	6,898	9,649
Admin Denial (No Auth Required)	909	2,255	883	1,994	990	2,230	863	2,251	995	1,988	900	2,666	844	2,257	956	2,102	883	3,301	974	3,696	845	2,545	848	2,433	10,890	29,718
Admin Denial (Void)	328	605	304	435	354	388	350	478	366	351	319	412	388	589	392	466	338	423	433	598	377	399	331	369	4,280	5,513
TOTAL (ADMIN DENIALS)	1,748	3,661	1,675	3,056	1,995	3,357	1,755	3,521	2,052	3,202	1,835	3,926	1,811	3,829	1,953	3,488	1,729	4,430	2,020	5,070	1,778	3,689	1,717	3,651	22,068	44,880
TOTAL (DENIALS)	2,476	4,366	2,265	3,667	2,763	4,068	2,523	4,328	2,931	3,861	2,514	4,560	2,721	4,997	2,961	4,303	2,546	5,267	2,956	6,432	2,527	5,012	2,391	4,603	31,574	55,464
Grievance Overturned	4	4	3	3	2	1	5	2	3	1	1	0	9	6	2	7	0	3	4	4	2	3	0	3	35	37
Overturned by Appeal	8	0	2	2	1	4	3	8	3	3	0	1	5	8	3	2	3	1	5	8	1	2	1	0	35	39
Appeal Partially Overturned	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	1	2
Appeal Upheld	7	4	5	6	4	2	2	20	3	5	0	1	4	10	12	6	3	0	8	12	4	0	0	0	52	66
TOTAL TARs	15,069	27,117	14,584	23,062	17,336	23,240	14,729	23,776	17,287	22,744	15,885	21,679	15,326	22,652	17,852	21,665	15,235	17,416	17,144	19,925	15,568	16,222	14,468	15,805	190,483	255,303
OP Nurse FTE	24	23	24	23	23	24	23	24	23	27	23	30	22	28	23	29	23	29	24.00	32.00	27.00	36.00	27.00	38.00		
Working Days	20	21	19	20	23	21	20	22	22	22	22	20	20	22	23	22	20	20	22	23	20	19	19	20		
TARs per Nurse per Day	31.39	56.14	31.98	50.13	32.77	46.11	32.02	45.03	34.16	38.29	31.39	36.13	34.83	36.77	33.75	33.96	33.12	30.03	32.47	27.07	28.83	23.72	28.20	20.80		

SNF/LTC TARs

TAR STATUS	JAN		FEB		MAR		APR		MAY		JUN		JUL		AUG		SEPT		OCT		NOV		DEC		PY	CURRENT
	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024
Approved	1,192	2,098	907	1,321	1,043	1,210	803	1,133	1,018	1,083	914	1,765	816	1,545	986	1,217	831	1,192	879	1,239	806	1,221	781	1,376	10,976	16,400
EB / IB Approved	128	239	146	187	133	209	126	190	133	219	118	195	146	243	134	205	151	192	169	192	133	85	104	122	1,621	2,278
Correction Received	11	25	9	18	20	66	10	3	28	16	72	28	12	12	18	13	22	38	17	22	28	22	47	51	294	314
Modified per Correction Request	0	13	0	9	0	12	0	22	0	19	0	7	0	27	0	17	0	9	14	19	19	13	21	4	54	171
TOTAL (APPROVED)	1,331	2,375	1,062	1,535	1,196	1,497	939	1,348	1,179	1,337	1,104	1,995	974	1,827	1,138	1,452	1,004	1,431	1,079	1,472	986	1,341	953	1,553	12,945	19,163
Approve as Modified	5	4	3	2	5	9	1	5	3	7	2	7	4	6	2	2	0	3	7	12	5	16	1	6	38	79
Admin Modification	0	0	1	0	0	0	1	1	0	0	1	1	0	0	0	0	0	0	1	3	0	1	4	0	8	6
Med Nec Not Justified	5	10	4	6	5	24	11	20	7	31	8	29	8	29	7	33	9	18	9	25	9	15	6	21	88	261
Member not Eligible	2	7	2	3	4	4	2	3	1	3	1	4	4	7	0	0	4	2	2	3	1	4	4	6	27	46
Not Timely	0	0	0	1	0	0	0	3	0	1	0	1	0	1	0	0	0	4	0	1	0	0	2	2	2	14
Other Insurance	3	7	5	9	5	17	6	25	12	5	18	6	3	8	8	6	6	7	4	4	8	3	2	3	80	100
TOTAL (MED NEC DENIALS)	10	24	11	19	14	45	21	51	20	40	27	40	15	45	15	39	19	31	15	33	18	22	14	32	197	421
Admin Denial (Duplicate TAR)	42	79	34	95	51	105	39	94	60	81	54	75	52	82	53	80	35	111	43	67	30	63	41	63	534	995
Admin Denial (No Auth Required)	0	1	0	0	1	1	0	0	0	1	0	0	0	0	0	0	2	0	0	0	0	0	0	0	3	3
Admin Denial (Void)	62	294	74	112	79	82	58	67	61	55	57	84	63	90	83	88	59	84	85	97	52	69	63	93	796	1,215
TOTAL (ADMIN DENIALS)	104	374	108	207	131	188	97	161	121	137	111	159	115	172	136	168	96	195	128	164	82	132	104	156	1,333	2,213
TOTAL (DENIALS)	114	398	119	226	145	233	118	212	141	177	138	199	130	217	151	207	115	226	143	197	100	154	118	188	1,530	2,634
Grievance Overturned	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Overturned by Appeal	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	0	0	3	0
Appeal Partially Overturned	0	0	0	2	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3
Appeal Upheld	0	1	0	1	0	0	0	1	1	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	2	3
TOTAL TARs	1,450	2,779	1,185	1,766	1,346	1,739	1,060	1,568	1,324	1,521	1,245	2,202	1,109	2,050	1,291	1,661	1,119	1,660	1,231	1,684	1,092	1,512	1,076	1,747	14,526	21,886
LTSS Nurse FTE	7	4	7	3	7	4	7	5	7	6	6	9	5	10	6	10	4	9	5.00	9.00	5.00	9.00	6.00	10.00		
Working Days	20	21	19	20	23	21	20	22	22	22	22	20	20	22	23	22	20	20	22	23	20	19	19	20		
TARs per Nurse per Day	10.36	33.08	8.91	29.43	8.36	20.70	7.57	14.25	8.60	11.52	9.43	12.23	11.09	9.32	9.36	7.55	13.99	9.22	11.19	8.14	10.92	8.84	9.44	8.74		

Wellness & Recovery (BH) TARs

TAR STATUS	JAN		FEB		MAR		APR		MAY		JUN		JUL		AUG		SEPT		OCT		NOV		DEC		PY	CURRENT
	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024
Approved	94	125	72	91	30	73	73	137	58	90	30	44	103	107	66	73	50	44	113	94	64	61	26	27	779	966
EB Approved	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	0
IB Approved	16	20	35	22	82	84	27	20	55	60	89	78	32	32	72	61	64	89	35	47	61	80	88	103	656	696
Correction Received	0	5	0	11	0	17	0	8	0	8	0	19	0	7	0	11	0	13	0	6	0	19	0	27	0	151
Modified per Correction Request	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL (APPROVED)	110	**150**	107	**124**	112	**174**	100	**165**	113	**158**	119	**141**	135	**146**	138	**145**	115	**146**	148	**147**	125	**160**	114	**157**	1,436	**1,813**
Approve as Modified	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Admin Modification	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
TOTAL (MED NEC DENIALS)	1	**0**	1	**0**	0	**0**	0	**0**	0	**0**	0	**0**	0	**0**	0	**0**	0	**0**	0	**0**	0	**0**	0	**0**	**2**	**0**
Admin Denial (Duplicate TAR)	1	3	1	5	3	4	0	4	0	1	1	4	4	1	3	1	3	2	2	4	4	0	4	0	**26**	**29**
Admin Denial (No Auth Required)	0	0	1	0	0	0	0	0	0	0	1	0	1	2	0	0	0	0	0	0	0	0	0	0	**3**	**2**
Admin Denial (Void)	2	1	0	1	0	2	0	2	2	2	2	0	6	4	0	1	0	1	0	0	1	1	3	2	**16**	**17**
TOTAL (ADMIN DENIALS)	3	4	2	6	3	6	0	6	2	3	4	4	11	7	3	2	3	3	2	4	5	1	7	2	**45**	48
TOTAL (DENIALS)	4	4	3	6	3	6	0	6	2	3	4	4	11	7	3	2	3	3	2	4	5	1	7	2	**47**	**48**
Grievance Overturned	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Overturned by Appeal	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Appeal Partially Overturned	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Appeal Upheld	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL TARs	114	154	110	130	115	180	100	171	115	161	123	145	146	153	141	147	118	149	150	151	130	161	121	159	1,483	1,861
SUD Nurse FTE	**2**	**2**	**2**	**2**	**1**	**2**	**1**	**2**	**2**	**2**	**2**	**2**	**2**	**1**	**2**	**1**	**2**	**1**	**2.00**	**2.00**	**2.00**	**2.00**	**2.00**	**2.00**		
Working Days	**20**	**21**	**19**	**20**	**23**	**21**	**20**	**22**	**22**	**22**	**22**	**20**	**20**	**22**	**23**	**22**	**20**	**20**	**22**	**23**	**20**	**19**	**19**	**20**		
TARs per Nurse per Day	2.85	3.67	2.89	3.25	5.00	4.29	5.00	3.89	2.61	3.66	3.73	3.63	3.65	6.95	3.07	6.68	3.93	7.45	3.41	3.28	3.25	4.24	3.18	3.98		

II. **Pharmacy TARs:**

A. A total of **10,758** Pharmacy TARs were completed in 2024 and are presented in the table below. Table includes all requests for Physician Administered Drugs (PADs).

B. The final determination statuses are Approved, Approved as Modified, Denied, and Void.

1. **Approved -** Full quantity requested is approved
2. **Approved as Modified** - TAR approved with quantity less than requested amount
3. **Denied**
    a. Medical Necessity Denials*
        1) Medical Necessity Not Justified
        2) Member Not Eligible
        3) Other Health Insurance
        4) Carve-out to Fee-For-Service (FFS)
    b. Administrative Denials
        1) Duplicate TAR
        2) No Auth Required
4. **VOID**

C. 2024 Provider Appeals

1. Total Appeals = 11
2. Appeals Overturned = 6 (55%)
3. Appeals Upheld = 5 (45%)

*For NCQA purposes, only TARs with an Adverse Benefit Determination for medical necessity in which clinical criteria are applied for review are considered for timeliness reporting and file review.

Pharmacy TARs

TAR STATUS	JAN		FEB		MAR		APR		MAY		JUN		JUL		AUG		SEP		OCT		NOV		DEC		TOTAL	
	2023	**2024**	2023	**2024**	2023	**2024**	2023	**2024**	2023	**2024**	2023	**2024**	2023	**2024**	2023	**2024**	2023	**2024**	2023	**2024**	2023	**2024**	2023	**2024**	2023	**2024**
Approved	426	625	342	600	502	544	432	562	456	516	476	512	409	514	472	553	380	490	491	632	404	545	340	538	5,130	6,631
Approved as Modified	26	68	29	51	19	47	16	24	28	37	15	32	11	32	21	33	18	29	27	34	24	28	20	28	254	443
Medical Necessity Not Justified	74	118	79	110	77	86	64	95	62	96	63	82	55	108	60	102	59	84	81	139	59	118	62	102	795	1240
Member Not Eligible	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	2	0
Other Health Insurance	13	23	10	29	19	39	11	18	22	30	14	29	13	17	10	19	14	26	9	22	11	20	6	16	152	288
Carve-out to FFS	0	1	0	2	0	0	0	0	0	1	0	1	0	0	0	0	0	0	0	1	0	0	0	0	0	6
TOTAL (MED NEC DENIALS)	87	142	89	141	96	125	76	113	84	127	77	112	68	125	71	121	73	110	90	162	70	138	68	118	949	1,534
Admin Denial	93	206	99	165	84	123	70	147	61	157	60	162	57	190	70	144	53	141	61	144	101	121	109	100	918	1,800
Void	21	24	23	37	39	38	19	33	20	28	21	30	32	20	13	32	12	27	10	29	24	26	17	26	251	350
Total TARs	**653**	**1065**	**582**	**994**	**740**	**877**	**613**	**879**	**649**	**865**	**649**	**848**	**577**	**881**	**647**	**883**	**536**	**797**	**679**	**1,001**	**623**	**858**	**554**	**810**	7,502	**10,758**
Working Days	20	21	19	20	23	21	20	22	22	22	22	20	20	22	23	22	20	20	22	23	20	19	19	20		
Tech FTE	5	4	5	5	5	7	5	7	5	7	5	7	5	7	5	7	4	7	4	7	4	7	5	7		
TARs/tech per day	6.5	12.7	6.1	9.9	6.4	6.0	6.1	5.7	5.9	5.6	5.9	6.1	5.8	5.7	5.6	5.7	6.7	5.7	7.7	6.2	7.8	6.5	5.8	5.8		
RPh FTE	7	5	7	5	7	5	7	5	7	5	7	5	5	5	5	5	5	5	5	5	5	5	5	5		
TARs/RPh per day	4.7	10.1	4.4	9.9	4.6	8.4	4.4	8.0	4.2	7.9	4.2	8.5	5.8	8.0	5.6	8.0	5.4	8.0	6.2	8.7	6.2	9.0	5.8	8.1		

Year	Total	% Approved and Modified	% Med Nec Denials	% Admin Denials	% Void
2024	10,758	66%	14%	17%	3%
2023	7,502	72%	13%	12%	3%

Population Needs Assessment

May 2025

Contents

I. Population Needs Assessment Overview

Partnership HealthPlan of California is a not-for-profit Medi-Cal managed care plan (MCP) serving 24 counties in Northern California. As of December 2024, the plan has approximately 895,129 members.[1] On January 1, 2024, Partnership expanded its service area by adding 10 new counties. Partnership is 1 of 6 County Organized Health System (COHS) managed care plans in California, endorsed by its counties' Board of Supervisors.

Most Medi-Cal beneficiaries, including Seniors and Persons with Disabilities (SPDs), California Children's Services (CCS) beneficiaries, and those in skilled nursing facilities are automatically assigned to Partnership. In addition, dual-eligible Medicare-Medicaid members are assigned to Partnership as a secondary line of coverage. In 2024, Partnership provided primary and specialty health services through a contracted network of community providers, medical groups, Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs), Indian Health Centers, local hospitals (acute and other), skilled nursing facilities, pharmacies, and ancillary providers.[2] As of January 2024, Partnership is no longer contracted with Kaiser Permanente due to the statewide Kaiser Transition to an individual Medi-Cal managed care plan.

Each year, Partnership conducts an overall assessment of the health environment, community needs, and the factors that influence the well-being of the member population. This assessment is required by both the California Department of Health Care Services (DHCS) as part of a larger annual deliverable, and the National Committee for Quality Assurance (NCQA) Health Plan Accreditation Standards for an annual Population Needs Assessment (PNA). The results of this assessment are used to develop the PNA, which informs Partnership's Population Health Management Strategy, as well as the Cultural & Linguistics Program description and their related work plans. To develop the 2025 PNA, Partnership integrates and analyzes various data sources, including:

- Partnership Member Enrollment data
- Local Community Needs Assessments
- County Health Rankings and Roadmaps
- Small Area Income and Poverty Estimates (SAIPE)
- U.S. Census Bureau data
- Published articles and reports from the CDC and other reputable sources

[1] Partnership Membership Dashboard, 2024
[2] Partnership Quality and Performance Improvement Program Description, 2024

- Partnership Integrated Claims and Encounter data
- Healthcare Effectiveness Data and Information Set (HEDIS®) results
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey data
- Health Disparities data from Partnership's "Reducing Health Care Disparities" report
- Timely Access data
- Partnership Grievance and Appeals data
- Internal Human Resources reports
- Other sources as relevant

Member enrollment data is further segmented by age, gender, race/ethnicity, primary language, geographic distribution, and other factors, to identify gaps in services and health disparities.

Population Health staff completed the analysis and made the decisions included in the report, with cross-departmental input and approval as needed. The writing staff consist of these positions:

Position Title	Department
Manager	Population Health
Community Health Needs Liaisons	Population Health

A. Summary of Key Findings

Since the January 2024 10-county expansion, Partnership's membership remained relatively stable for the remainder of 2024. At the close of 2024, Partnership served approximately 895,129 members throughout 24 counties. The 2025 Population Needs Assessment draws from a broad range of data sources to identify member needs along with the overall community conditions where members live.

a. Summary of Findings

Local community needs assessments identified a variety of priority areas of need that can be grouped by Healthy People 2030 domains of Social Determinants of Health (SDoH), including:

- Economic stability: high poverty rates, economic instability, food insecurity and disparities in access to social services

- Healthcare access and quality: provider shortages, insufficient access to healthcare, mental health, substance use disorder and prenatal care services
- Neighborhood and built environment: geographic isolation, lack of affordable housing, safe neighborhoods, higher rates of violence, unintentional injury, fire threat, and challenges with transportation
- Education access and quality: Low education attainment and limited internet access
- Social and community context: higher rates of adverse childhood experiences (ACEs), need for fostering community connections, trusted leaders and institutions, and healthcare system navigation

A review of the data sources highlights significant concerns related to access to care, behavioral health, and other social determinants of health. Across multiple counties, challenges such as a shortage of healthcare providers, transportation barriers, and economic instability are prevalent. Behavioral health, including mental health and substance use disorders, is consistently identified as a primary concern. Additionally, social determinants like income inequality, housing insecurity, and food deserts disproportionately affect marginalized communities, exacerbating health disparities. These factors contribute to a landscape where members face compounding obstacles to achieving optimal health.

Disparities in health outcomes are particularly pronounced among racial minorities, LGBTQ+ individuals, and Indigenous populations. Maternal and child health disparities, coupled with high rates of adverse childhood experiences (ACEs), further emphasize the need for targeted interventions. The availability of healthcare providers remains a significant concern across all counties, particularly in rural and frontier regions, where the number of available providers in areas like primary care, dental care, and mental/behavioral health is insufficient to meet demand.

Transportation challenges further complicate access to care, especially in remote areas where long distances must be traveled to access healthcare services. Many individuals lack reliable transportation options and geographical isolation exacerbates the difficulty in attending provider visits. Housing issues also remain a constant challenge, with a lack of affordable and quality housing preventing many individuals from securing stable living situations. This issue has remained persistent during 2024, contributing to a continued homelessness crisis across many counties.

In 2024, there were 118 wildfires in Partnership's regions, contributing to loss of available housing, and possible adverse pulmonary and cardiovascular effects. Compounding these environmental factors are lifestyle choices like smoking. Adult smoking rates were equal to or higher than the state average in all of Partnership's counties, and some smokers start as early as elementary school.

Partnership utilizes claims and encounter data to approximate disease prevalence among its members. In 2024, hypertension, tobacco use, depression, anxiety, substance use, and obesity were the 6 most prevalent conditions diagnosed among adults. The most common diagnoses for pediatric members were anxiety, trauma/stress, depression, asthma, obesity, and substance use. Telehealth utilization in general has increased for 2024. Partnership's southern region had the highest number of members accessing specialty mental health services. Breast cancer screening rates and cervical cancer rates in the northern counties also continue to underperform.

To determine if there are health disparities within the overall population served, Partnership reviewed the HE6: Reducing Healthcare Disparities report, which analyzed samples by race/ethnicity, gender, and language. The analysis found that both the "Some Other Race" and Asian groups had the lowest controlled blood pressure measures when compared to all other racial/ethnic groups. For HbA1c control in diabetes, the Native Hawaiian/Other Pacific Islander, American Indian and Alaska Native, and Black/African American populations all performed below the 50th percentile for poor control, indicating disparities in managing diabetes. In terms of Child and Adolescent Well Care Visits, Native Hawaiian/Other Pacific Islander, Black/African American, White, and American Indian and Alaska Native groups had lower rates of completion, performing below the 50th percentile. For prenatal care visits, Native Hawaiian and Other Pacific Islander, American Indian and Alaska Native, and Black/African American populations also performed below the 50th percentile. These findings highlight significant disparities in healthcare access and outcomes for these populations.

b. 2024 Summary of Planned Actions

Partnership works closely with provider and community resources to ensure members have access to a wide range of services. This PNA revealed opportunities for action by addressing needs in the following areas: organizational structure, social and environmental needs, member health and wellness, access to care, health disparities, and health education/culture and linguistics.

In the realm of organizational structure, in 2024, Partnership hired two new regional directors. One director was hired to fill the role for the new Auburn (Eastern) region,

overseeing Plumas, Nevada, Placer and Sierra Counties. The other director was hired to replace the director in the Santa Rosa (Southwest) region, overseeing Sonoma and Marin counties. Partnership will also be implementing new technological advances to better support its efforts, including a new claims system and the DHCS PHM Service platform. Furthermore, Partnership also added teams who work to build relationships with community partners and other stakeholders, including the recent mandate for Partnership to work collaboratively with the Local Health Jurisdictions in its service area on their Community Health Assessments (CHA) and Community Health Improvement Plans (CHIP). These teams, alongside other population health staff, connect members to local resources and follow up to ensure their needs are met. They also represent Partnership at various community collaborative meetings and events to learn about the ongoing needs of communities.

The position of Director of Health Equity was filled in January 2023, overseeing internal staff equity, provider and non-provider contractor equity, member equity, and interventions designed to mitigate health disparities. In 2024, Health Equity branched off into its own department. To support this important work, the Health Equity department has hired several staff in 2024 with plans to continue growing the team in 2025.

To address social and environmental concerns, Partnership has dedicated staff and resources to manage these concerns and to collaborate with other community agencies in addressing these challenges. One example is the state funds and initiatives like the CalAIM Incentive Payment Program which provides the means for managed care plans to offer grant funding to address housing concerns. Lastly, as part of DHCS's Incentive Payment Program (IPP), Partnership has awarded over $52 million to more than 100 CalAIM providers via grants to build capacity for programs such as Enhanced Care Management (ECM) and Community Supports (CS) services; both of these programs work to ensure the needs of the most vulnerable members are met.

Many of Partnership's counties have household incomes below the state average, and local Community Health Assessments revealed challenges around sufficient employment and income. In collaboration with community partners, Partnership is working to increase workforce opportunities including providing member scholarships to aid in education with a focus on health care, social work, and other related fields.

One of the ways Partnership provides support for members living in fire-prone areas was by creating a Fire and Disaster Reporting email inbox for member- and provider-facing departments within Partnership in 2023. Partnership continued to use the Fire and Disaster Reporting email inbox for internal reporting, monitoring, and notifications around disasters in Partnership's service area that happened in 2024. The inbox is used

as a tool to share information within Partnership HealthPlan in the event an environmental disaster threatens to affect members, providers, or the community. Partnership also posted member materials to Partnership's website comprised of a Disaster Preparedness booklet and Emergency Kit Pocket Card.

In the realm of member health and wellness, pediatric members with asthma who live in Partnership's Northern Region may have more difficulties controlling their asthma than those living in the Southern Region. Wildfires are more prevalent in Partnership's Northern Region than in the Southern Region, and this may contribute to the poorer asthma control. In alignment with CalAIM BPHM, requirements Partnership rolled out the new Asthma Emergency Department (ED) Visit Outreach Program Campaign at the end of 2024 to better support members with asthma. The Asthma Management campaign will offer additional support to members who were recently seen in the ED for their asthma and will be reviewed for effectiveness in 2025. To help manage other member chronic diseases, and in alignment with DHCS' Population Health Management requirements, Partnership continues to support and refine its Basic Population Health Management programs centered on hypertension, diabetes, and depression.

In 2024, Partnership explored conducting health education sessions around tobacco prevention in counties with high tobacco usage. Plans are in place to conduct these sessions in 2025. Partnership also implemented an ADHD program to help address mental health conditions in children which will continue into 2025. Furthermore, as part of Partnerships' efforts to improve poor behavioral health outcomes and increase access among K-12 students, Partnership is actively participating in and supporting our school partners through implementation of the new Multi-Payer Fee Schedule which includes new and expanded behavioral health provider types. Partnership also continues to contract with Alinea Medical Imaging to bring mobile mammography imaging to rural communities and to health centers that do not have ready access to mammography services. With 72 mobile mammography days in 19 different Partnership counties and modest improvements in screening outcomes, Partnership intends to continue this collaboration in 2025. Other organizational efforts in the realm of member health and wellness include efforts to increase cervical cancer screenings and colon cancer screenings.

Finally, Partnership continues to make significant investments into expanding services for maternal and child health. Partnership performs outreach to all members with babies from ages 0-30 months and children ages 3 to 6 years, offering incentives to attend well-care visits and encouraging vaccinations. Additional outreach campaigns target pre-teen visits for vaccinations and wellness visits. Furthermore, Partnership has allocated staff, and time to collaborate with public health officers, and other necessary

stakeholders which has resulted in plans to conduct school-based clinics, and other strategies to promote childhood wellness care. Partnership will continue to evaluate the impact of these activities through appropriate reports, monitoring efforts, and multi-disciplinary committees.

Efforts to improve access include Partnership's development of a multi-pronged approach to recruit and retain providers. For example, Partnership started a Provider Recruitment Program in January 2024, which focused on helping the contracted network recruit and retain high-quality health professions in Partnership counties; this program provided incentives, including sign-on bonuses. Partnership also has a Provider Retention Initiative (PRI) to recognize primary care clinicians who have devoted their careers to the safety net, while helping to incentivize additional years of service in effort to preserve institutional knowledge and clinical leadership in Partnership networks. These Partnership efforts focus on strengthening recruitment of PCPs, behavioral health providers, mid-levels, and specialists in the areas where access is impacted most, as indicated by high HPSA scores or the "frontier" geographic designation.

American Indian/Alaska Native populations face many health disparities. To help remedy known health disparities, Partnership will continue its strategy to strengthen relationships and collaborative efforts with tribal health providers within its service area, to decrease known health disparities between American Indian and non-American Indian members. Partnership has been an active participant in several such efforts. Partnership is also heavily involved in other activities geared towards addressing health disparities among other populations and are later described in this report.

To help support health education/culture and linguistics, Partnership created member-facing videos on several topics to help educate members in a more interactive way in 2024. Topics included preventive care, vaccines safety and efficacy, and mental health. Each of Partnership's counties has a dedicated county resource page and the support of Partnership's Population Health Department in accessing those resources. These resources are continuously updated and improved upon, and Population Health staff monitor and follow up on resource needs of members. Partnership will also continue to collaborate with community groups and plans to offer educational sessions to members, particularly non-English-speaking ones, about available benefits like vision, mental health services, and preventative care services. Furthermore, Partnership Member Services staff are conducting in-person presentations called Member (or Community) Informative Sessions". Member Services staff provide an overview of Partnership's services and the resources that are available to members. While onsite, Member Services staff also provide in-the-moment support, helping members navigate their

transition into Partnership. Partnership conducts these sessions primarily in English and Spanish. Finally, Partnership will continue to offer members an opportunity to submit grievances and appeals and will further its own organizational culture of diversity, equity and inclusion by offering regular staff and provider trainings.

II. Data Sources

A. Overview of Procedures, Resources, and Methodologies

Partnership collects, integrates, and assesses data from its member population to develop the PNA and various related activities. Partnership uses this data to determine the profile and needs of its member population, which may include, but is not limited to:

- Member demographics such as age, language (including limited English proficiency), race/ethnicity, and geographic location
- Local community needs assessments
- Social Determinants of Health (SDoH), drawn from County Health Rankings
- Service utilization, based on integrated claims and encounter data
- Health conditions and health-related behaviors, based on Partnership's HEDIS data
- Timely Access Data
- Key populations such as child and adolescent members, members with multiple chronic conditions, vulnerable populations, members with disabilities, and members with serious mental illness or serious emotional disturbance (SMI/SED), based on member demographics, and integrated claims and encounter data
- Member satisfaction or lack thereof, based on CAHPS data and member grievance data
- Partnership's Reducing Health Care Disparities Report (i.e. 2024 Health Disparities data)

1. 2024 Partnership Member Enrollment Data

Partnership demographic data is based on the Medi-Cal enrollment data received as of December 2024. This data includes the total number of individuals enrolled in Medi-Cal and assigned to Partnership by eligibility group. Through daily and monthly releases, DHCS submits eligibility and enrollment data to Medi-Cal Managed Care Plans based on their service areas. This data includes member-level characteristics such as

race/ethnicity, age, gender, language, and eligibility indicators for seniors and persons with disabilities, and members enrolled in the California Children's Services Program.

2. Local Community Needs Assessments

The Community Needs Assessment section was compiled using the most recent versions of publicly available Community Health Assessment (CHA), Community Health Improvement Plans (CHIPs), or Local Community Health Needs Assessment (CHNA) reports from each of Partnership's 24-county service area. The reports were published in different years ranging from 2022-2025. Some of Partnership's counties have CHA reports in progress, set to be released in the near future. The reports used to summarize needs in each county are based on the most recent reports available.

3. 2024 County Health Rankings and Roadmaps

The County Health Ranking and Roadmaps program is a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute.[3] The 2024 Annual County Health Rankings uses the most currently available data to measure a range of vital health factors, such as air pollution, adult smoking, severe housing problems, physical inactivity, and food environment index (access to healthy foods). County Health Rankings also typically includes measures such as high school graduation rates, obesity, unemployment, income inequality, teen births, and more. The rankings are modeled after a view of population health that highlights the many factors that influence one's health. If these factors improve, communities thrive and reduce health disparities for subpopulations. The rankings are determined by:

- Health Outcomes: The overall ranking in health outcomes measures the general health of county residents. They reflect the physical and mental well-being of residents within a community through measures representing length of life and quality of life.
- Health Factors: The overall ranking in health factors represents many things that influence quality of life and how long we live. Health factors represent circumstances or behaviors that can be modified to improve the length and quality of life for residents. They are predictors of how healthy our communities can be in the future.

4. 2024 Partnership Integrated Claims and Encounter Data

Partnership's Health Analytics team manages an integrated data set, including medical, behavioral, laboratory results, and services directly reimbursed by the state (e.g.,

[3] Robert Wood Johnson Foundation, About Us, 2024

pharmacy claims). The 2024 data set is gathered from information submitted by health care providers such as doctors, hospitals, and ancillary services. The data set documents both the diagnosed clinical conditions, and the services and items received by beneficiaries to treat these diagnosed conditions. Data is presented in a series of Tableau dashboards showing prevalence of disease, benefit utilization, referral practices, and other utilization benchmarks. Partnership's paid claims, laboratory results, and encounter data are integrated with state-provided data, such as California Immunization Registry (CAIR) data, state pharmacy claims, and claims from our delegated managed behavioral healthcare organization (Carelon Behavioral Health).

5. 2024 Healthcare Effectiveness Data and Information Set (HEDIS®)

HEDIS is a measurement tool maintained by the National Committee for Quality Assurance (NCQA). HEDIS is used to evaluate clinical quality in a standardized way. The California Department of Healthcare Services (DHCS) and NCQA selects a subset of measures for Medi-Cal plans to report on annually as required for State and NCQA Accreditation reporting. NCQA and DHCS use annual HEDIS performance reporting to evaluate the delivery of quality care and services to its members. For Measurement Year 2024 (MY2024) Partnership will be required to report the HEDIS measures at the plan-wide level to include all (24) counties. The DHCS required reporting measures is referred to as the Managed Care Accountability Set (MCAS); the methodology for each HEDIS measure is described in the annual NCQA HEDIS Technical Specifications corresponding to the measurement year.

Using the NCQA Quality Compass benchmarks and thresholds, DHCS sets targets for minimum and high performance. The DHCS-specified minimum performance level (MPL) is set at the 50th percentile based on the National Medicaid benchmarks and varies by each measure.

In addition to the DHCS required reporting, Partnership is also required to report the HEDIS performance for HealthPlan Accreditation. Rate performance and scoring is based on the NCQA HealthPlan Rating Methodology. The MY2024 Annual Summary of Performance Report for both the DHCS and HPA will be posted on the Partnership HealthPlan Website in August 2025. Partnership uses annual HEDIS results to evaluate clinical quality outcomes in a standardized way, and to evaluate health inequities for our members by race, ethnicity, language, and geographic region.

6. 2024 Timely Access Data

Partnership's Provider Relations department gathers Timely Access data through an annual survey. This survey identifies the time before providers' third next available

appointments for adult and pediatric primary care, newborn visits, and urgent care visits. This survey is used to evaluate appointment care access for Partnership members.

7. 2024 Consumer Assessment of Healthcare Providers and Systems (CAHPS)

Partnership has chosen Press Ganey (PG) to conduct member surveys in alignment with the National Committee for Quality Assurance (NCQA). These surveys aim to gather information about members' experiences with their health plan and healthcare providers. The feedback collected helps our plan understand the experiences of covered members/patients and their families across the provider network and health plan delivery.

The CAHPS (Consumer Assessment of Healthcare Providers and Systems) surveys ask adult members and parents or guardians of child members to provide feedback on a range of categories, such as:

- Getting Needed Care
- Getting Care Quickly
- How Well Doctors Communicate
- Customer Service
- Coordination of Care
- Ease of Filling Out Forms
- Rating of Health Care
- Rating of Personal Doctor
- Rating of Specialist
- Rating of Health Plan
- Effectiveness of Care Measures

This needs assessment report will focus on the composite scores for the following performance measures concerning adults and children: Rating of Health Care, Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Coordination of Care, Rating of Personal Doctor, and Rating of Specialist.

The CAHPS survey for Measurement Year (MY) 2023 and Reporting Year (RY) 2024 will cover the period from July 1, 2023, to December 31, 2023.

8. 2024 Health Disparities Data Report

In 2024, Partnership convened a multidisciplinary team to assess health disparities in our member population as part of a grand analysis to complete the HE 6: Reducing Healthcare Disparities report which was completed in September 2024. This analysis looked at race and ethnicity, language, and gender data, as well as Partnership’s effort

to implement impactful interventions to reduce inequities and improve any culturally and linguistically appropriate services (CLAS) identified through the analysis. Partnership utilized measurement year 2023 (MY 2023) Health Plan Accreditation final measure samples (n=186 to 167,450 members) to evaluate each of the clinical measures of focus later described in the health disparities section. The rates for each measure are comprised of the members included in each measure's audit for Partnership's Health Plan Accreditation plan-wide summary of performance report. Partnership's HEDIS vendor, Inovalon, provided the random member sample generated for each measure, along with member race/ethnicity demographic information. Inovalon is classified as a direct data source. This report provides data on health disparities specific to Partnership members.

B. Other Data Sources

In addition to the specific sources listed above, Partnership integrates data from member-reported health appraisals, data collected through health services programs and case management activities, as well as member feedback following participation in a Partnership intervention. Internal staff development, including mandated training courses, is monitored through Partnership's Learning Management System (LMS).

Partnership regularly reviews published research in areas impacting our population. Partnership leaders and clinicians subscribe to journals that describe evidence-based care, and promising practices to implement among members with complex needs and those with behavioral health or substance use disorders. These journals include research that addresses SDoH, health equity, and population health management strategies. Partnership also reviews national data sources, such as the CDC and the US Preventive Services Task Force to track national trends and align ourselves with emerging care protocols. For specific demographic information in our various regions, we reference United States Census Bureau reports, which includes the SAIPE State and County Estimates for 2023.

C. Population Segmentation

After reviewing Partnership's overall population needs, the member population is segmented into subpopulations with similar needs and characteristics. Each of these subpopulations are further assessed to identify any additional needs and disparities. This process pulls information from a variety of reports that may include but are not limited to member demographics, health/risk assessments, laboratory results, disease morbidity reports, HEDIS scorecards, member and provider satisfaction surveys, as well as reports and analyses of over and under-utilization of care. Partnership reviews population segmentation on an annual basis to evaluate for disparities, potential

inequities, and to ensure that all populations are served. However, a number of factors may influence Partnership to conduct additional reviews of population segmentation, such as state findings, natural disasters, and standard business practices.

In addition to evaluating member needs, Partnership also analyzes programs and activities no less than annually. Partnership uses the results to inform and refine its interventions, including those activities and resources to address health care disparities, and evaluate whether Partnership and community resources are sufficient to address member needs.

III. Key Findings

A. Member Demographics

1. Membership/Group Profile

While member demographic information can fluctuate month to month, at the close of 2024, Partnership served approximately 895,129 Medi-Cal beneficiaries in 24 counties in Northern California. Partnership primarily serves children and adults under the age of 65. In 2024, Partnership served approximately 582,593 adults and 312,216 children. In 2024, Partnership worked to ensure that previously uninsured individuals, or individuals transitioning to full-scope Medi-Cal maintain their existing Primary Care Provider (PCP) assignments to the maximum extent possible.[4] This recent Department of Health Care Services requirement expanded eligibility for full-scope Medi-Cal to individuals who are 26 through 49 years of age, and who do not have satisfactory immigration status (SIS). The needs of this population vary and are further described under the Local Community Needs Assessment and throughout this document.

2. Geographic Distribution

In 2023, Partnership's service area included Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Shasta, Siskiyou, Solano, Sonoma, Trinity and Yolo Counties. In January 2024, Partnership added 10 new counties to our service area: Tehama, Glenn, Colusa, Butte, Sutter, Yuba, Plumas, Sierra, Nevada and Placer. Partnership's 4 regional offices are centrally located in Fairfield, Redding, Santa Rosa, and Eureka. In 2024, Partnership opened two new regional locations in Auburn and Chico as part of this 10-county expansion.

[4] All Plan Letter - 23-031 Medi-Cal Managed Care Plan Implementation Of Primary Care Provider Assignment For The Age 26-49 Adult Expansion Transition

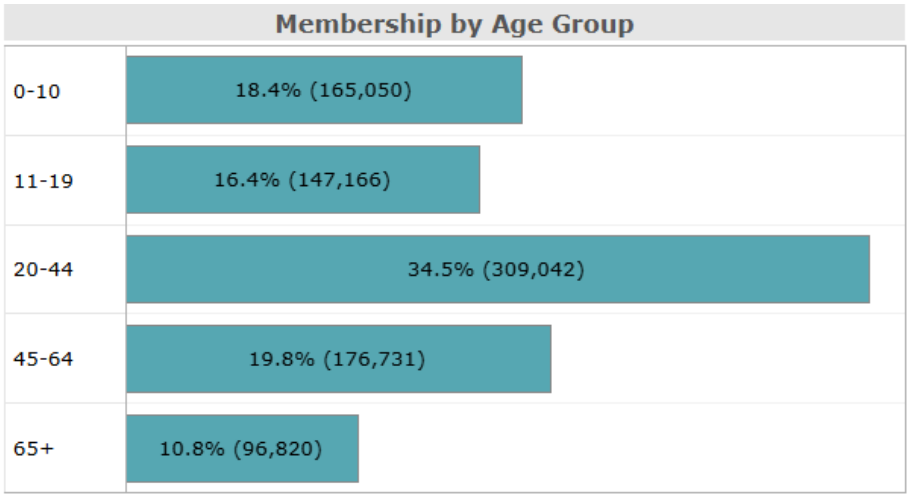
Figure 1: Map of Partnership Counties as of January 2024

Partnership, 2024

3. Age and Gender

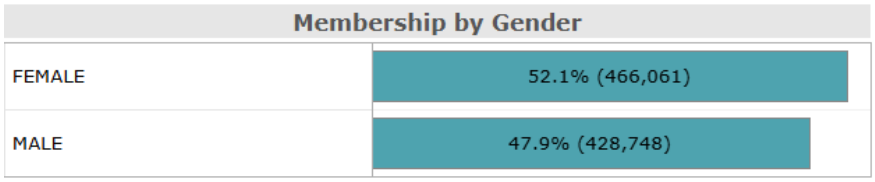
According to December 2024 Partnership enrollment data, 18.4% of members are ages 0-10, 16.4% of members are ages 11-19, 34.5% of members are ages 20-44, 19.8% of members are ages 45-64, and 10.8% of members are ages 65 and older. Additionally, 52.1% of members are female while 47.9% are male (see Figures 2 and 3). There were 11,295 babies born to Partnership members during 2024.

Figure 2: 2024 Partnership Membership by Age Group



December 2024 Member Enrollment Data, Partnership

Figure 3: 2024 Partnership Membership Gender

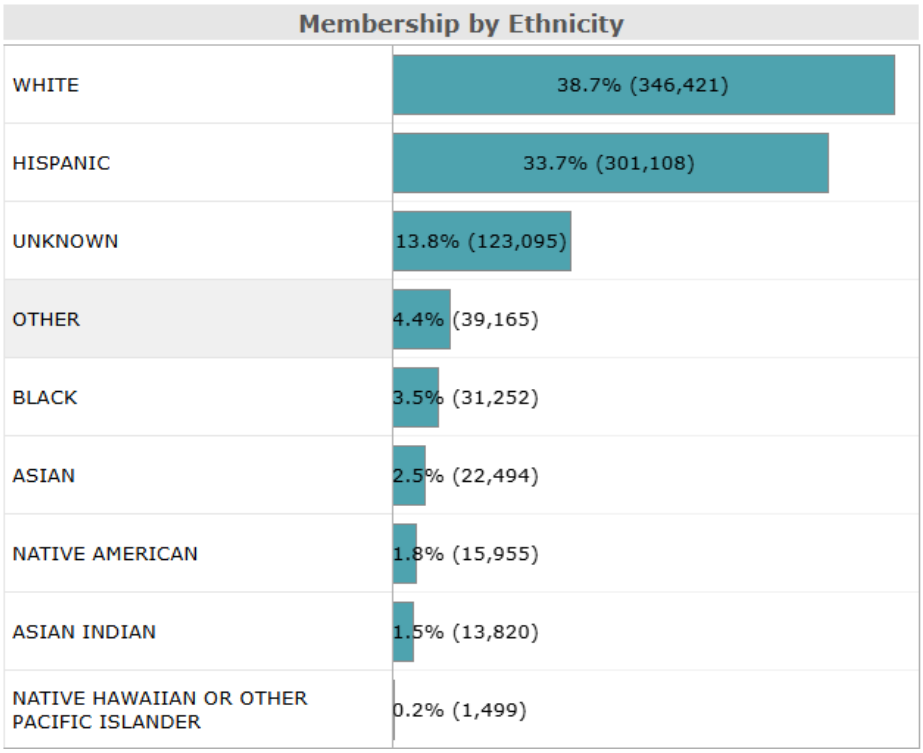


Source: December 2024 Member Enrollment Data, Partnership

4. Race/Ethnicity

The largest ethnic groups across all 24 counties are White (38.7%) and Hispanic (33.7%). Figure 4 illustrates the racial and ethnic composition of Partnership's members as of December 2024. One limitation with the race/ethnicity category is Hispanic as a category tends to outweigh other races, and multi-racial categories tend not to be reported at all. Furthermore, there are different rates of multiethnic reporting by members when signing up for Medical when compared to the census. This limits the accuracy of interpretation or racial disparities, such that small differences may not need to be intervened upon.

Figure 4: 2024 Partnership Membership by Race/Ethnicity

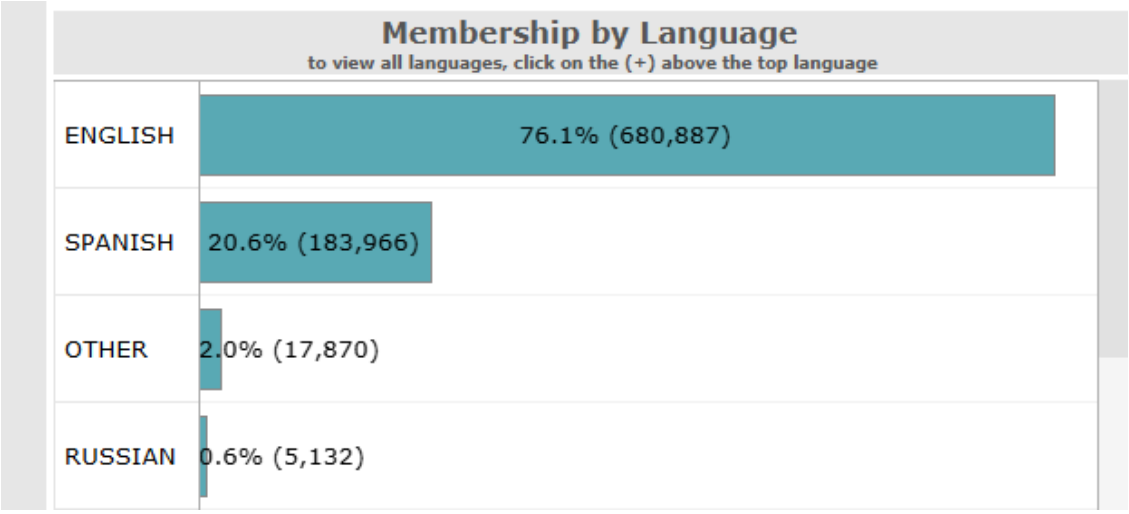


Source: December 2024 Member Enrollment Data, Partnership

5. Primary Language

English continues to be the primary language spoken by Partnership's members. Based on Partnership's December 2024 enrollment data, 76.1% of members identify as English speaking and 24% identify as limited English proficiency (LEP). Partnership has 3 threshold languages – Spanish, Russian, and Tagalog. New threshold languages are added as needed. Members identifying as Spanish speaking total 20.6%. Russian and Tagalog speakers account for 0.9% of LEP members, while 2.5% of the population speaks a language other than the 3 threshold languages. This data demonstrates a need to ensure LEP members can access care in their own language to stay healthy.

Figure 5: 2024 Partnership Membership by Primary Language

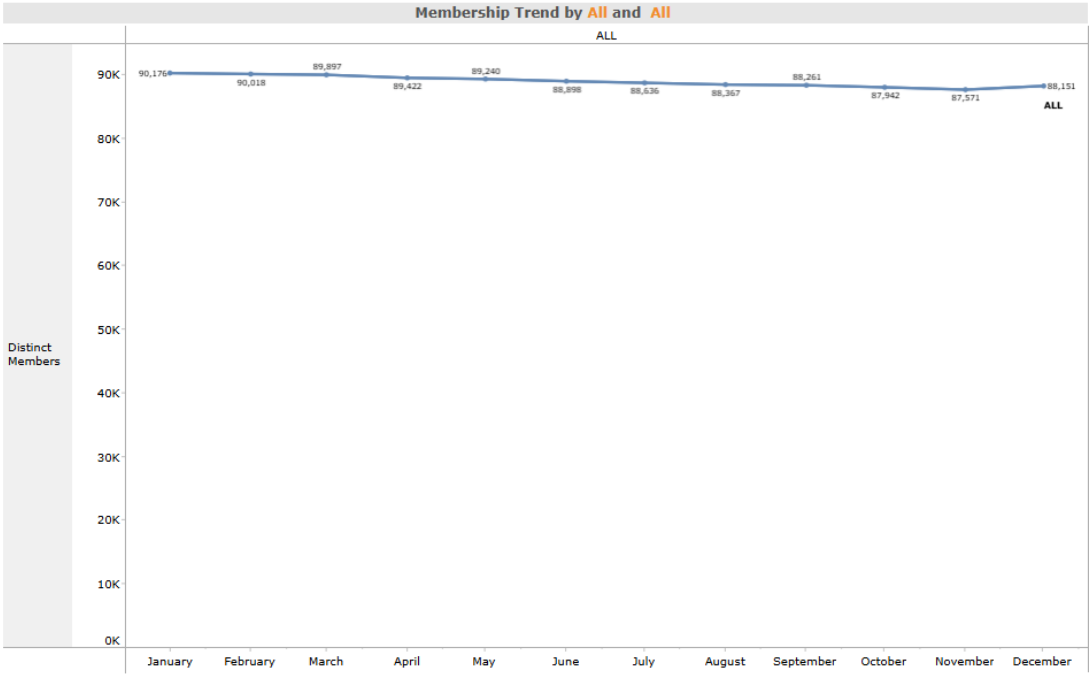


Source: Partnership's December 2024 Member Enrollment Data

6. Disability

Based on December 2024 Partnership enrollment data, approximately 88,151 members are disabled as shown in Figure 6. Furthermore, 9,605 of all disabled members are ages 0-20; 71,396 are ages 21-64; and 23,399 are ages 65 and older. Finally, 51,043 of all disabled members are males while 48,822 are females. Furthermore, California Children's Services (CCS) supports children with complex physical health needs; this program had 11,041 member enrollees as of December 2024. Together this data demonstrates there is a significant number of members with disabilities that may require additional care and resources to remain healthy.

Figure 6: 2024 Partnership Membership Disability Category Trend



Source: Partnership's December 2024 Member Enrollment Data

IV. Local Community Needs Assessment

A. Summary of Local Community Needs Assessments

In January 2024, Partnership expanded its service area to include an additional 10 counties: Butte, Colusa, Glenn, Nevada, Placer, Plumas, Tehama Sierra, Sutter and Yuba. Since then, Partnership's service area has covered 24 counties, each with a diverse demographic makeup. This 2025 PNA includes assessments of Partnership's existing and newly added counties.

Since late 2023, Partnership has actively collaborated with Local Health Jurisdictions (LHJs) to engage in the assessment and health improvement planning processes led by each LHJ. This collaboration involved participating in and supporting each county's Community Health Assessment (CHA), Community Health Needs Assessment (CHNA), and Community Health Improvement Plan (CHIP). Through this collaboration and a review of the available CHA reports (or similar documents) from the 24 counties, a range of priority need areas and gaps in services or care were revealed. Partnership aims to align its activities with the identified priority needs across its service area.

The Local Community Health Assessment section of this report was compiled using the most recent publicly available Community Health Assessment (CHA), Community

Health Improvement Plan (CHIP), and/or Community Health Needs Assessment (CHNA) reports from the 24 counties, published primarily between 2022 and 2025 by LHJs and non-profit hospitals. Although the 24-county service area is geographically expansive and ethnically diverse, there were common priority needs mentioned across each county, many of which could be categorized as SDoH.

The most prevalent SDoH issues across all 24 counties can be grouped into the Healthy People 2030 categories: economic stability; healthcare access and quality; neighborhood and built environment; education access and quality; and social and community context.[5] Recognizing the prominent themes of the assessments collectively and their alignment within these categories help to provide clarity on the SDoH impacts to the health of our members.

Economic Stability

- Theme: Economic Instability and Poverty
    - High poverty rates, unemployment, economic instability, and disparities in access to social services.
- Theme: Food Insecurity
    - Rising rates of food insecurity, limited access to supermarkets, and challenges in promoting healthy eating habits.

Healthcare Access and Quality

- Theme: Limited Access to Healthcare
    - Barriers to accessing primary, specialty, and dental care are prevalent, including transportation challenges, and healthcare provider shortages.
- Theme: Behavioral and Mental Health Needs
    - High rates of suicide, substance use disorders, and the need for comprehensive mental/behavioral health services.
- Theme: Chronic Disease and Injury Prevention
    - High rates of chronic illnesses like heart disease, diabetes, and obesity, as well as unintentional injuries including overdose and motor vehicle collisions.

Neighborhood and Built Environment

- Theme: Homelessness and Housing Affordability

[5] Healthy People 2030 Social Determinants of Health

    - Lack of affordable housing, homelessness, and associated stressors impacting health and stability.
- Theme: Transportation and Geographic Isolation
    - Transportation limitations and geographic isolation, especially in rural areas, hinder access to healthcare, resources, and economic opportunities.
- Theme: Environmental and Physical Risks
    - Vulnerability to wildfires, extreme heat, and drought, as well as disparities in access to green spaces and safe neighborhoods.

Education Access and Quality

- Theme: Educational and Technological Disparities
    - Low educational attainment and limited internet access hinder opportunities for economic mobility and access to telehealth services.

Social and Community Context

- Theme: Community and Social Support Needs
    - A strong need for fostering community connections, safe neighborhoods, and guidance through healthcare systems, along with leveraging trusted leaders and institutions.

A scan of the county's health assessments reveals widespread concerns about access to care, behavioral health, and other social determinants of health. Many counties struggle with a lack of healthcare providers, transportation barriers, and economic instability. Behavioral health issues, including mental health challenges and substance use, are consistently identified as major priorities. Social determinants such as income inequality, housing insecurity, and food deserts disproportionately impact marginalized communities, amplifying health disparities.

Disparities in health outcomes are commonly noted, with racial minorities, LGBTQ+ individuals, and Indigenous populations facing unique challenges. For instance, African American residents in Marin County experience lower life expectancy and higher premature death rates, while Indigenous communities in Mendocino and Shasta Counties report historical trauma and exclusion. Maternal and child health disparities, coupled with high rates of adverse childhood experiences (ACEs), further underline the need for targeted interventions to support vulnerable populations.

Despite these challenges, counties have identified opportunities to improve health outcomes through collaboration and leveraging community strengths. Resilience, close-

knit communities, successful partnerships, resourcefulness, and existing support programs offer a foundation for positive change which can be leveraged to improve health outcomes through targeted interventions and collective action.

1. Butte County

In 2024, Butte County published its Community Health Improvement Plan,[6] focusing on three priority areas: Access to Care, Behavioral Health, and Food Security. These priorities were identified based on the six health needs outlined in the 2023 Community Health Assessment.[7] While ongoing efforts are required to address these critical areas, the county has valuable assets at its disposal, including public, nonprofit, and tribal healthcare providers, as well as Community Health Workers. Existing programs, such as the Boys and Girls Club, the Butte County Department of Behavioral Health, culturally tailored support groups, and numerous organizations and collaboratives dedicated to combating food insecurity, will play an integral role. The CHIP aims to harness these resources, focusing on strengthening and improving the county's overall health outcomes in these areas.

2. Colusa County

Colusa County Public Health completed its Community Health Assessment in 2024, identifying seven strategic issues: Access to Medical Healthcare Services, Access to Behavioral Healthcare Services, Access to Existing Services and Resources, Affordable Housing, Lack of Economic Opportunity and Sustainability, ACEs Prevention and Response, and Environmental Health Risks.[8] The assessment also highlighted the county assets, which are strong community engagement and collaboration, abundant resources, and supportive programs like the Mobile Health Clinic, Safe Haven, and the Emergency Domestic Well Program, all of which will support efforts to improve community health.

3. Del Norte County

Del Norte County recently completed their 2024 Community Health Assessment,[9] which identified multiple health needs. These health needs include high rates of substance abuse and mental health challenges, chronic diseases, insufficient oral and healthcare access, poor maternal and child health outcomes, and environmental health risks. Del Norte CHA revealed multiple strengths which include a resilient community, abundant outdoor resources like trails and beaches, and supportive programs such as CalFresh

[6] Butte County Community Health Improvement Plan 2024-2027
[7] Butte County Community Health Assessment Report 2023
[8] Colusa County Community Health Assessment Report 2024
[9] Del Norte County 2024 Community Health Assessment

and WIC that foster collaboration and well-being. These efforts aim to address disparities while leveraging the community's strengths.

4. Glenn County

Glenn County's 2024 Community Health Assessment identified seven health priorities during the assessment process.[10] These priorities were Access to Resources, Medical Provider Shortage, Behavioral Health Systems, Transportation, ACEs (Adverse Childhood Experiences), Income, and Safety. The assessment also highlighted community strengths that supported efforts to address the top four health needs. Despite its small size, the county featured numerous community strengths, including resources such as a senior center and substance use disorder programs. It offered a variety of services, including urgent care, transportation, and specialized healthcare. The community strengths highlight how the community comes together to help one another, ensuring that people have access to the support they need.

5. Humboldt County

Humboldt's last Community Health Assessment (CHA) was completed in 2018.[11] The CHA showed a range of community health concerns such as access to primary, specialty care and mental health services. During the Community Health Improvement Planning cycle, new data was revealed, and Humboldt released an Enhanced Community Health Assessment in 2022 which focused on the Oral Health Assessment and the Youth Report on Substance use in Humboldt County.[12] The Oral Health Assessment discussed individuals who had complex health or behavioral health conditions, and housing and transportation concerns which impact accessing needed care. This report also identified a lack of access to routine dental care among the population surveyed, with over 90% of respondents stating they had challenges with accessing dental services. The oral health report shared that many of the barriers are due to financial constraints, travel challenges, and lack of providers which has led to a higher number of visits to the emergency room among adults. The Youth Report on Substance Use in Humboldt County is based on a survey called "Your Thoughts on Substance Use in Humboldt." The survey showed responders in Humboldt were largely concerned with the uptake of alcohol and drug use as a means to cope with ACEs. Respondents also expressed the need for community to better support against substance use, and the need for additional substance use prevention.

The 2024 Community Health Needs Assessment (CHNA) by the Southern Humboldt Community Healthcare District focuses on its 775-square-mile service area in

[10] Glenn County Community Health Assessment Report 2024
[11] 2018 Humboldt County Community Health Assessment
[12] 2022 Enhanced Humboldt County Community Health Assessment

northwestern California.[13] The findings align with public health concerns identified in the 2018 Humboldt CHA and the 2022 enhanced assessment, but they also highlight emerging challenges within the service area. These include the growing risks posed by wildfires and drought to community health and safety, as well as the limited availability of affordable housing and unreliable high-speed internet, which are obstacles to economic growth and the recruitment of skilled workers.

6. Lake County

Lake County's most recent CHA was completed in 2022.[14] Their priority areas are insufficient access to care, health risk behaviors, and mental health. Concerns with access to care included timely treatment, travel distances, transportation challenges, availability of treatments, provider retention, and high usage of the Emergency Department due to a lack of urgent care providers. Health risk behaviors include unhealthy eating, lack of physical activity, excessive screen time, tobacco and substance use, maternal and child health concerns, and concerns around preventive healthcare. Mental health concerns include the possible increase of domestic violence, self-medication to address poor mental health, stigma around seeking mental health care, lack of mental health providers, no health insurance, substance use, crime, unemployment, higher rates of suicide, intentional self-harm, and substance use overdoses.

7. Lassen County

As of December 2024, Lassen County has not yet finalized their CHA. However, work is underway, with a contractor engaged to manage the coordination among partners including Partnership. This process began in December 2023 and is ongoing throughout 2024 and into early 2025.

Other local health assessments have been completed. According to Banner Health's 2022 CHNA by Banner Lassen Medical Center, Lassen County's priority needs include: access to care, chronic disease management, and behavioral health.[15] The same assessment also identifies areas of strength for Lassen County, such as health behaviors (lower rates of physical inactivity and sexually transmitted diseases), clinical care (uninsured and dentists), and social and economic factors (unemployment and income inequality). In these areas, when compared to the state, Lassen has health data that is stronger.

[13] Southern Humboldt Community Healthcare District 2024
[14] 2022 Lake County Community Health Assessment
[15] 2022 Banner Health Community Health Needs Assessment

8. Marin County

Marin County completed their last CHA in 2022.[16] This assessment showed that, compared to any other racial and ethnic group, the African American population had the lowest life expectancy, highest premature deaths, and highest percent of babies with low birth weight. The report also showed that Hispanic residents had a higher percentage of the population living in poverty, the highest number of uninsured people, and lower educational attainment and third grade reading and math levels compared to all other racial and ethnic groups. Median income data showed that the lowest median income was among the Black population, despite higher levels of educational attainment than Hispanic residents. Other top health concerns were around meeting basic/functional needs such as housing, jobs/income, and education; access to quality primary health care such as insurance coverage, differences in health insurance rates by race and ethnicity, and preventable hospitalizations; access to mental/behavioral health and substance use services to prevent overdose deaths, and death by self-harm; access to community connections; structural racism; and increased community connectedness to prevent suicide rates, excessive drinking, and school suspensions.

9. Mendocino County

According to the 2023 Mendocino County Community Health Improvement Plan (CHIP), the overall priority areas identified were: maternal health, adolescent health, disparities in the Indigenous communities; and serious health and safety concerns that were a result of SDoH.[17] Maternal health outcomes were poorer due in part to the county's remote geographical area, which makes it difficult to attend appointments. Maternal health outcomes were also poorer due in part to the historical trauma and mistrust felt by the local Indigenous population. Adolescent health outcomes were worse due to motor vehicle accidents, gun violence and assault, drug overdose, and higher rates of ACEs (due in part to high rates of poverty).

10. Modoc County

Modoc County released their last Community Health Needs Assessment (CHNA) in January 2024.[18] Modoc's CHNA identifies significant health and socio-economic challenges, particularly in its classification as a rural frontier county. Modoc County faces high poverty, unemployment, low educational attainment, and limited access to healthcare. It has higher rates of chronic disease, risk behaviors, and poor physical and mental health when compared to California. These factors are contributing to increased disability and earlier mortality. However, Modoc County benefits from less pollution,

[16] 2022 Marin County Community Health Assessment
[17] 2023 Mendocino County Community Health Improvement Plan
[18] 2024 Modoc County Community Health Needs Assessment

including cleaner air and water, than most other counties in the state. The community has identified that mental health, substance use, chronic disease, and domestic violence are notable concerns. Barriers to health include poverty, inadequate job opportunities, limited healthcare access, and insufficient public transportation. Prenatal care rates are also a concern with less births receiving early care at significantly lower rates than California's average. While Modoc County has significantly higher rates of homeownership, the median household income is low with nearly 30% of all children living in poverty. Key recommendations include economic and workforce development, improving transportation, offering more community activities and recruiting additional healthcare providers to address healthcare service gaps and improve health outcomes.

11. Napa County

Napa County completed its recent Community Health Improvement Plan (CHIP) in November 2024, identifying five key health priorities: housing, behavioral health, access to health services, racial equity and LGBTQIA+ inclusion, and economic stability.[19]

Key challenges were identified in the housing sector, including the rising cost of living, low wages, and limited availability of affordable housing options. In the area of mental health, systemic and cultural challenges persist, such as a shortage of mental health professionals, clinician burnout, increased patient caseloads, and the stigma surrounding access to care. County residents reported significant difficulty accessing healthcare services due to several factors: long wait times, reliance on emergency departments (ED) as a first point of care, a complex healthcare system, and barriers to accessing transgender healthcare services. Racism was also cited as a major barrier for residents of color, with limited representation in leadership positions, and challenges in interactions with law enforcement. Many families highlighted the need for higher wages and greater employment opportunities to meet the high cost of living.

Despite these persistent challenges, Napa County has notable strengths, including strong system cohesion, efficient emergency response capabilities, access to green spaces, and a high-quality public service sector. These assets, alongside community stakeholder engagement, will be instrumental in supporting ongoing action planning and improving the health priority areas identified in the CHIP.

12. Nevada County

The 2025 Nevada County Community Health Improvement Plan identified the following health areas of focus: comprehensive healthcare and social services, affordable early learning and care (ELC) programs, and vaccination rates for children.[20] Healthcare

[19] 2024 Napa County Community Health Improvement Plan
[20] 2025 Nevada County Community Health Improvement Plan

access included lack of providers, siloed healthcare delivery system, and gaps in care coordination. Issues were identified within the county's ELC provider network, such as limited geographic access to affordable care programs and transportation barriers for families with low socioeconomic status. Local data indicated that 82% of kindergarten students were fully up to date with required vaccines, which is lower than the state's average. The county's assets include a strong network of community-based organizations, dedicated healthcare providers, and active partnerships among local agencies. These resources contribute to ongoing efforts to improve health outcomes and address gaps in service delivery.

13. Placer County

The 2024 Placer County Community Health Improvement Plan highlighted the following health priorities: lifestyle and preventative health concerns, aging and older adults, and the built environment.[21] Lifestyle and preventive health concerns highlighted the need for improved access to nutrition, physical activity, and chronic disease management, with a focus on reducing health disparities. Aging populations face challenges related to healthcare access, service availability, and aging in place, especially in rural areas. The built environment priority aims to improve infrastructure to support healthy living, such as safer housing, better transportation, and more accessible public spaces. Placer County's assets include a robust network of healthcare providers, community organizations, and strong partnerships that support these initiatives and work to reduce health inequities and enhance the well-being of all residents.

14. Plumas County

Plumas County published its Community Health Improvement Plan in 2023, identifying the top three priorities selected by the community.[22] The three priority health issues were: Drug and Alcohol Abuse and Overdose, Limited Access to Preventive Services, and Suicide. Other areas of focus included priority gaps, such as resource knowledge, coordination, and navigation, family support, harm reduction, and sustainability. These gaps were to be addressed through interventions targeting priority health issues.

15. Shasta County

The 2023 Shasta County Community Health Assessment (CHA) identified nine key health needs: access to basic needs such as housing, jobs, and food; a safe, violence-free environment; access to mental and behavioral health and substance-use services; increased community connections; access to quality primary care; access to specialty and extended care; system navigation; injury and disease prevention and management;

[21] 2024 Placer County Community Health Improvement Plan
[22] Plumas County Community Health Improvement Plan 2023-2028

and access to functional needs.[23] When compared to the previous CHA, it is clear that several health concerns persist, including issues related to housing, medical providers, mental health resources, substance abuse, employment, and rural transportation. Unintentional injuries, including drug-related deaths, are a leading cause of death in the county, with rates surpassing state averages. Shasta County also ranks high in cancer-related deaths. These ongoing challenges highlight the need for sustained investment in community infrastructure to address complex problems effectively. Shasta County also faces significant economic disparities. These economic challenges are compounded by rising housing costs and a lack of affordable childcare, which affects many low-income families. Additionally, the county has a notably high rate of children entering foster care, particularly infants, and struggles with high levels of emotional abuse and maltreatment.

The Indigenous community in Shasta County also faces unique challenges, including a lack of inclusion, barriers to maintaining cultural practices, and inadequate mental health resources. There is an emphasized need for more programs supporting Indigenous welfare, cultural preservation, and services for youth. Despite these challenges, the community's strengths lie in its cultural traditions, elders, and practices, which could play a central role in fostering community well-being.

16. Sierra County

The 2023 Sierra County Community Health Assessment findings, based on both data analysis and community feedback, highlighted the following priority health needs: teen electronic cigarette use, teen mental health, adult mental health, adult cigarette smoking, adult drinking, access to healthy foods, recreational activity, services, communication, and community.[24] The county's assets within the community, including the area's natural beauty, outdoor recreational activities, strong community support, local health initiatives, and outreach efforts.

17. Siskiyou County

Siskiyou County is currently developing an updated CHNA for 2025. Although this CHNA is in progress, the previously released CHNA in 2022identified multiple high priority health needs including: access to mental/behavioral health and substance use; injury and disease prevention management; access to basic needs such as housing, jobs, and food; access to primary, and dental care; concerns around healthy eating and exercise; concerns around access to functional needs such as transportation and maintaining conditions that allow individuals with disabilities to remain mobile; and the need for safe/violence free environments.[25] Geographic distance and barriers contribute

[23] 2023 Shasta County Community Health Assessment
[24] Sierra County Health Assessment 2023
[25] 2022 Siskiyou County Community Health Needs Assessment

significantly to food deserts, limited access to healthcare, public transportation, limited broadband access and fewer economic opportunities. Communities that are 1.5hr+ from the I5 corridor are ranked in the bottom 99% of healthy communities. Other themes that arose were strengthening community relationships and improved workforce infrastructure. Siskiyou was able to identify 139 resources with potential to help meet the needs of the county service area.

18. Solano County

Solano County is planning for an updated Community Health Assessment (CHA) in 2025. The current CHA, covering the period from 2020 to 2025, identified eight priority health areas, which include: socioeconomic challenges, lack of access to safe and secure housing, barriers to accessing healthcare, poorer educational outcomes compared to the state average, higher rates of domestic violence hospitalizations, injury deaths (both intentional and unintentional), and violent crimes, as well as elevated rates of opioid use and suicide ideation.[26] The CHA also identified barriers to healthy eating and active living, and poor maternal and infant health outcomes. Following the CHA, Solano County released its CHIP in January 2023.[27] The CHIP outlines several strategic priorities to address the top health needs identified in the CHA: workforce development, community and youth engagement, equity-driven investments, harm reduction, alongside enhanced access to healthcare services.

19. Sonoma County

Sonoma County released their joint Community Health Assessment and Improvement Plan in 2023. Sonoma County assessed 12 priority health needs on the subjects of climate change, healthy food access, economic security and housing, education, structural racism, access to clinically and culturally responsive care, coordinated systems of care, chronic disease prevention, communicable disease prevention, youth mental health, adult mental health, and substance use. The Improvement Plan outlines 4 priority areas for action: to address structural and institutional racism, improve community members' connection to resources, improve system of care coordination, and strengthen capacity of mental health and substance use services.[28]

20. Sutter County

Sutter County published its Community Health Improvement Plan in 2023, outlining three health priorities for the next 3-5 years: combating homelessness, building resilient communities (with a focus on adverse childhood experiences, behavioral health, and

[26] 2020 Solano County Community Health Assessment
[27] 2023 Solano County Community Health Improvement Plan
[28] 2023 Sonoma County Community Health Assessment and Improvement Plan

nutrition/food access), and reducing STIs.[29] In its 2022 Community Health Assessment, Sutter County highlighted numerous community resources that promote health and well-being, including parks, bike paths, and senior activities.[30] The Sutter-Yuba Homeless Consortium addresses homelessness, while programs such as Family S.O.U.P. and the Yuba/Sutter Resiliency Connection support families and foster resilience. Cultural groups celebrate diversity, and agriculture is showcased through farmers' markets. The Sutter County Public Health Branch works to ensure equitable access to these resources and will leverage them to address the three health priorities.

21. Tehama County

Tehama County's 2023 Community Health Assessment reveals many challenges that its residents confront, including high poverty and unemployment rates, low educational attainment, and restricted access to healthcare.[31] Tehama has the sixth lowest per capita income in the state and inequities exist geographically within the county, with rates of poverty varying greatly among communities. Tehama also ranks in the zero percentile for park access. While Tehama has better air and water quality, the area experiences significant risks for wildfire due to extreme heat and drought.

These interconnected issues significantly impact health, leading to premature death and reduced life expectancy among the population. The insights gained from this assessment are crucial for the development of Tehama's CHIP, currently in progress as of December 2024. By pinpointing critical areas for strategic, collective action, efforts can be mobilized to enhance health outcomes and foster a healthier future for all Tehama residents.

22. Trinity County

Trinity County released a Community Health Equity Assessment in 2023, that highlights many needs of the county.[32] Main drivers of health inequity identified were poverty, isolation, limited economic opportunity, and lack of affordable housing. Other significant health disparities include inadequate access to a supermarket; high risk of living in a wildfire-prone area; highest rates of childcare cost burden compared to the rest of California; twice the rate of premature death when compared to the state, including the highest rates of suicide in the state, and higher rates of deaths related to unintentional injuries. Educational disparities; lower rates of internet access compared to California; higher rates of violent crime higher rates of suicide, higher rates of death from unintentional injuries, motor vehicle collisions and overdose. Approximately 1 in 5 Trinity

[29] Sutter County Community Health Improvement Plan 2023
[30] Sutter County Community Health Assessment 2022
[31] 2023 Tehama County Community Health Assessment
[32] 2023 Trinity County Health Equity Assessment

County residents had one or more disabilities with higher rates among American Indian/Alaska Native residents. Challenges also include higher rates of risk-adjusted hospitalizations due to chronic conditions; transportation limitations; technology limitations, and inadequate and unequal insurance coverage. Over half of Trinity County community members also identified economic instability and the physical environment as a root cause of inequity, with many families experiencing hardship but not qualifying for social service assistance.

Despite these challenges Trinity County has several assets, including successful interventions that foster partnerships across sectors, mobile services, trust-building programs. Potential interventions to improve health equity include “meeting people where they are”, accessible services, robust communication with micro-communities, health education on disease prevention, incentives for providers, and securing funding for community efforts. Trinity also boasts strengths such as pride, personal responsibility, resourcefulness, and a close-knit community.

23. Yolo County

Yolo County’s most recent CHA was completed in 2023.[33] It revealed 11 significant health needs. These needs include: access to resources to meet basic needs such as housing, jobs and food; the need for mental/behavioral health and substance use care; prevention for injury and disease; opportunities for healthy behaviors like healthy eating and exercise; access to primary, specialty, extended care, and dental care; guidance through the healthcare system; a need for community; safe places to live, and access to functional needs such as transportation.[34] Other areas of concern are around homelessness, poverty, housing costs, disparities in education, and life expectancy.

Yolo County has a variety of assets. They have some of the highest vaccination rates in their area due to strong community connection; 367 resources to support mental and physical health needs such as farmer’s markets, neighborhoods, and trails; a variety of trusted leaders and institutions; great schools; and good jobs.

24. Yuba County

Yuba County’s Community Health Improvement Plan for 2023-2028 outlined key priorities aimed at enhancing the well-being of the community.[35] These priorities included healthcare access, mental health services, and the creation of safe neighborhoods and built environments. The community’s strengths, identified in the 2022 Community Health Assessment, such as a lower cost of living compared to urban

[33] 2023-2025 Yolo County Community Health Assessment
[34] 2023-2025 Yolo County Community Health Assessment
[35] 2023 Yuba County Community Health Improvement Plan

centers, access to natural areas like mountains and the ocean, and strong local resources such as public transportation and available services in areas like nutrition and legal support provide a solid foundation for the county's efforts to foster a healthier and more vibrant community.[36]

B. Social Determinants of Health (SDoH)

Social Determinants of Health, also known as, "social influencers of health," as defined by the World Health Organization (WHO), are "the conditions in which people are born, grow up, live, work and age, and the systems put in place to deal with illness. These conditions are in turn shaped by a wider set of forces: economics, social policies and politics."[37] Healthy People 2030 offers several examples of SDoH including income, polluted air, access to healthy foods and physical activity, and safe housing.[38]

Standardized collection of individual member SDoH is not available. There is no validated means of using diagnosis codes or claims data reliably to indicate 1 or more social determinant of health, and the data is quite incomplete; therefore, it is not useful for meaningful analysis. Instead, Partnership uses the Small Area Income and Poverty Estimates (SAIPE) State and County Estimates for 2023, County Health Rankings & Roadmaps data, and local, publicly available Community Health Assessment reports to understand the drivers that influence the health of our population. We use this data, along with data provided by our county public health agencies, provider partners, and community-based organizations, to gain insight into the needs of our members and the communities where they live. This helps foster collaborative efforts with local agencies in order to improve the social supports that help meet the needs of our members.

1. Income

Income plays a major role in SDoH, specifically as it relates to health outcomes. More income often leads to better health outcomes, and vice versa. Below is a table detailing the income among Partnership's different counties.[39]

[36] 2022 Yuba County Community Health Assessment
[37] World Health Organization. "Social Determinants of Health." *Health Topics*.2025
[38] Healthy People 2030, Social Determinants of Health
[39] SAIPE Data, U.S. Census Bureau, 2024

Table 1: SAIPE State and County Estimates 2023

Partnership Northern Region	Median Household Income
California	**$95,473**
Del Norte	$70,231
Humboldt	$61,307
Lassen	$77,743
Modoc	$51,996
Shasta	$71,935
Siskiyou	$58,975
Tehama	$77,719
Trinity	$52,079

Partnership Southern Region	Median Household Income
California	**$95,473**
Lake	$51,848
Marin	$135,960
Mendocino	$63,621
Napa	$98,580
Solano	$92,711
Sonoma	$96,312
Yolo	$82,359

Partnership Eastern Region	Median Household Income
California	**$95,473**
Butte	$65,000
Colusa	$60,000
Glenn	$58,000
Nevada	$87,142
Sutter	$70,000
Yuba	$62,000
Placer	$110,020
Plumas	$64,121
Sierra	$67,675

Source: United States Census Bureau 2024

2. Air Pollution and Wildfires

In 2024, 118 wildfires in Partnership's regions burned more than acres 853,412. With the increasing rate of wildfires in California, there is an increased possibility of impacts on Partnership's covered counties health. Fires increase the possibility of adverse pulmonary effects such as chronic bronchitis, asthma and decreased lung function.[40] Long-term exposure to poor air quality can increase premature death risk among people 65 and older.

County Health Rankings and Roadmaps measures air pollution as the average daily density of fine particulate matter in micrograms per cubic meter. Across the state of California, this measure was 7.1 in Reporting Year 2024 (Measurement Year 2019).[41] The Partnership County with the highest rates of air pollution is Plumas at 12.2.

Table 2: Air Pollution – Particulate Matter by Partnership County in 2024

Partnership Northern Region	Air Pollution- Particulate Matter
California	***7.1***
Del Norte	6.1
Humboldt	6.8
Lassen	6.0
Modoc	5.8

Partnership Southern Region	Air Pollution - Particulate Matter
California	***7.1***
Lake	3.1
Marin	6.4
Mendocino	6.0
Napa	5.9

Partnership Eastern Region	Air Pollution - Particulate Matter
California	***7.1***
Butte	7.1
Colusa	7.0
Glenn	7.8
Nevada	6.3

[40] Environmental Protection Agency (EPA), 2024
[41] County Health Rankings, Air Pollution: Particulate Matter, 2024

Partnership Northern Region	Air Pollution-Particulate Matter
California	***7.1***
Shasta	6.6
Siskiyou	5.8
Tehama	5.4
Trinity	6.8

Partnership Southern Region	Air Pollution - Particulate Matter
California	***7.1***
Solano	9.0
Sonoma	5.7
Yolo	7.7

Partnership Eastern Region	Air Pollution - Particulate Matter
California	***7.1***
Sutter	8.5
Yuba	8.7
Placer	7.2
Plumas	12.2
Sierra	5.1

Source: 2024 County Health Rankings & Roadmaps

Table 3 below shows how many fires occurred and the amount of acreage burned in each county in 2024. Butte and Tehama County were the counties with the most acreage burned in 2024 at 382,642 and 376,537 acres, respectively.

Table 3: Number of Wildfires and Acreage Burned by Partnership County in 2024

Partnership County	Number of Fires in 2024	Acres Burned in 2024
Butte	16	382,642
Colusa	3	21,961
Del Norte	0	0
Glenn	2	79
Humboldt	8	20,376
Lake	5	3,473
Lassen	8	1,025
Marin	1	18
Mendocino	5	144
Modoc	7	6,892
Napa	0	0
Nevada	1	28
Placer	10	1839
Plumas	1	3,007
Shasta	9	5,561
Sierra	2	3,723
Siskiyou	9	16,240
Solano	7	1,093
Sonoma	8	1,381
Sutter	0	0
Tehama	8	376,537
Trinity	3	7,290
Yolo	0	0
Yuba	5	103

Partnership County	Number of Fires in 2024	Acres Burned in 2024
Total	**118**	**853,412**

Source: [2024 Fire Season Incident Archive | CAL FIRE]

3. Adult Smoking

According to the CDC, cigarette smoking continues to be a main cause of preventable conditions such as disease, disability, and death among the U.S. population. The California Department of Public Health stated in their "2024 Results of the 2023 California Youth Tobacco Survey" that 7.3% of California high school respondents used tobacco in the last 30 days since completing the survey.[42] Vaping also continues to be a concern. Reponses showed that 29% of California high school respondents report being exposed to secondhand vapor in a car or room in the last 2 weeks, and about a third (42.1%) shared that they were exposed to secondhand vapor outdoors.

Smoking affects almost every organ of the human body; it can also cause cancer in various parts of the body. Smoking can be a contributing factor to a variety of diseases including cancer, heart disease, stroke, lung diseases, diabetes, and chronic obstructive pulmonary disease (COPD). Secondhand smoke can also increase the risk for health concerns.[43] With the growing prevalence of e-cigarettes and vaping products marketed to adolescents, it is important to continue to educate young people and parents on the harmful effects of tobacco use.

County Health Rankings and Roadmaps say that on average, 9% of adults in Reporting Year 2024 (Measurement Year 2021) were current smokers in California. Adult smoking rates were equal to or higher than the state average in all of Partnership's counties; rates of smoking in Partnership counties ranged from as low as 9% to as high as 19%.

Table 4: 2024 Rate of Adult Smoking by Partnership County

Partnership Northern Region	Adult Smoking Rate
California	***9%***
Del Norte	17%
Humboldt	17%
Lassen	19%
Modoc	17%
Shasta	15%

Partnership Southern Region	Adult Smoking Rate
California	*9%*
Lake	16%
Marin	9%
Mendocino	15%
Napa	11%
Solano	12%

Partnership Eastern Region	Adult Smoking Rate
California	***9%***
Butte	15%
Colusa	14%
Glenn	16%
Nevada	12%
Sutter	14%

[42] 2024 California Department of Public Health Results of the 2023 California Youth Tobacco Survey
[43] Center for Disease Control and Prevention. Secondhand Smoke.

Partnership Northern Region	Adult Smoking Rate
California	***9%***
Siskiyou	16%
Tehama	16%
Modoc	17%
Shasta	15%

Partnership Southern Region	Adult Smoking Rate
California	*9%*
Sonoma	11%
Yolo	11%

Partnership Eastern Region	Adult Smoking Rate
California	***9%***
Yuba	15%
Placer	14%
Plumas	10%
Sierra	13%

Source: 2024 County Health Rankings & Roadmaps. Red indicates higher than California average adult smoking rate.

4. Physical Inactivity

Low physical activity relates to several diseases such as diabetes, cancer, hypertension, cardiovascular disease, and premature mortality. Physical activity can improve sleep, cognitive ability, and bone and musculoskeletal health. Physical activity not only affects individuals, but also communities.[44]

The 2024 County Roadmaps and Rankings measure physical inactivity as the percentage of adults aged 18 and over reporting no leisure-time physical activity, with higher values indicating less physical activity. In Reporting Year 2024 (Measurement Year 2021), the California state average was 20%. Among counties covered by Partnership HealthPlan, the Northern Region had physical inactivity rates equal to or higher than the state average. In contrast, the Southern Region and Eastern Region matched the state average but also displayed variations with some counties showing higher rates than state levels. Napa (18%), Sonoma (18%), Marin (13%), Nevada (15%), Placer (15%), Plumas (18%), and Sierra (18%) had rates of physical inactivity that were better than the state average.

Table 5: 2024 Rate of Physical Inactivity by Partnership County

Partnership Northern Region	Physical Inactivity
California	***20%***
Del Norte	23%
Humboldt	20%
Lassen	22%
Modoc	22%
Shasta	20%
Siskiyou	21%
Trinity	22%

Partnership Southern Region	Physical Inactivity
California	***20%***
Lake	24%
Marin	13%
Mendocino	21%
Napa	18%
Solano	21%
Sonoma	17%
Yolo	20%

Partnership Eastern Region	Physical Inactivity
California	***20%***
Butte	20%
Colusa	26%
Glenn	25%
Nevada	15%
Sutter	24%
Yuba	23%
Placer	15%

[44] Center for Disease Control and Prevention. Physical Inactivity

Partnership Northern Region	Physical Inactivity
California	***20%***
Tehama	23%

Partnership Southern Region	Physical Inactivity
California	***20%***

Partnership Eastern Region	Physical Inactivity
California	***20%***
Plumas	18%
Sierra	18%

Source: 2024 County Health Rankings & Roadmaps. Red indicates higher than California average.

5. Severe Housing Problems

As of November 2024, there are approximately 187,084 unhoused people in California.[45] Additionally, 27% of California's households experienced at least one of the following housing problems: overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities. Severe housing problems remain a significant issue in California. In Reporting Year 2024 (Measurement Year 2020), many of Partnership's service area members continued to experience severe housing problems, especially in counties such as Humboldt (25%), Mendocino (24%), Yolo (23%), Shasta (21%), Marin (22%), Napa (22%), Sonoma (22%), Glenn (22%), and Nevada (20%). See Table 6.[46] Partnership's Southern Region experiences higher levels of severe housing problems, likely due to its proximity to the San Francisco Bay Area and Sacramento, while the Eastern Region shows notable challenges in counties such as Glenn and Nevada.

Table 6: 2024 Rate of Severe Housing Problems by Partnership County

Partnership Northern Region	Severe Housing Problem
California	**26%**
Del Norte	19%
Humboldt	25%
Lassen	15%
Modoc	12%
Shasta	21%
Siskiyou	17%
Trinity	21%
Tehama	22%

Partnership Southern Region	Severe Housing problem
California	**26%**
Lake	20%
Marin	22%
Mendocino	24%
Napa	22%
Solano	20%
Sonoma	22%
Yolo	23%
Napa	22%

Partnership Eastern Region	Severe Housing Problem
California	***26%***
Butte	21%
Colusa	17%
Glenn	22%
Nevada	20%
Sutter	19%
Yuba	19%
Placer	16%
Plumas	15%
Sierra	20%

Source: 2024 County Health Rankings & Roadmaps

[45] HUD 2024 Continuum of Care Homeless Assistance Programs Homeless Populations and Subpopulations

[46] County Health Rankings, Severe Housing Shortage, 2024

6. Food Environment Index

The Food Environment Index (FEI) accounts for access to healthy foods and food insecurity. Food insecurity is defined "as a household-level economic and social condition of limited or uncertain access to adequate foods." Many areas across Partnership's 24 counties are designated as food deserts—areas where healthy and fresh foods are not readily available for people to access. In these regions, processed foods high in sugar, sodium, fat, and additives often dominate what is available. Additionally, some communities lack food pantries or other supplemental food resources, further restricting access to healthy foods.

The FEI considers three factors: the distance someone lives from a grocery store or supermarket, the availability of locations to purchase healthy foods within communities, and financial barriers to accessing healthy foods. According to the County Health Rankings and Roadmaps Reporting Year 2024 (Measurement Year 2020), California scored a high 8.6 on a scale from 0 (worst) to 10 (best).[47]

Partnership's regions show a range of scores reflecting regional disparities:

- Northern Region: FEI ranges from 6.2 in Modoc County to 7.7 in Lassen County.
- Southern Region: FEI is highest in Marin County (9.3) and lowest in Lake County (7.8).
- Eastern Region: FEI is highest in Placer County (8.9) and lowest in Colusa County (6.9).

Counties with the highest scores include Marin (9.3), Placer (8.9), and Sonoma (8.8), indicating better access to healthy foods. In contrast, rural counties such as Modoc (6.2), Sierra (6.4), and Del Norte (6.5) face significant challenges. This data suggests that rural counties generally encounter more difficulties accessing healthy foods, underscoring the need for targeted interventions to address food insecurity in these areas.

Table 7: 2024 Food Environment Index (FEI) in Partnership Counties

Partnership Northern Region	FEI
California	***8.6***
Del Norte	6.5
Humboldt	7.4
Lassen	7.7

Partnership Southern Region	FEI
California	***8.6***
Lake	7.8
Marin	9.3
Mendocino	7.5

Partnership Eastern Region	FEI
California	***8.6***
Butte	7.5
Colusa	6.9
Glenn	7.6

[47] County Health Rankings, Food Environment Index, 2024

Partnership Northern Region	FEI
California	***8.6***
Modoc	6.2
Shasta	7.5
Siskiyou	6.8
Trinity	6.9
Tehama	7.0

Partnership Southern Region	FEI
California	***8.6***
Napa	8.9
Solano	8.7
Sonoma	8.8
Yolo	8.5

Partnership Eastern Region	FEI
California	***8.6***
Sutter	7.5
Nevada	8.0
Yuba	7.1
Placer	8.9
Plumas	8.2
Sierra	6.4

Source: 2024 County Health Rankings & Roadmaps

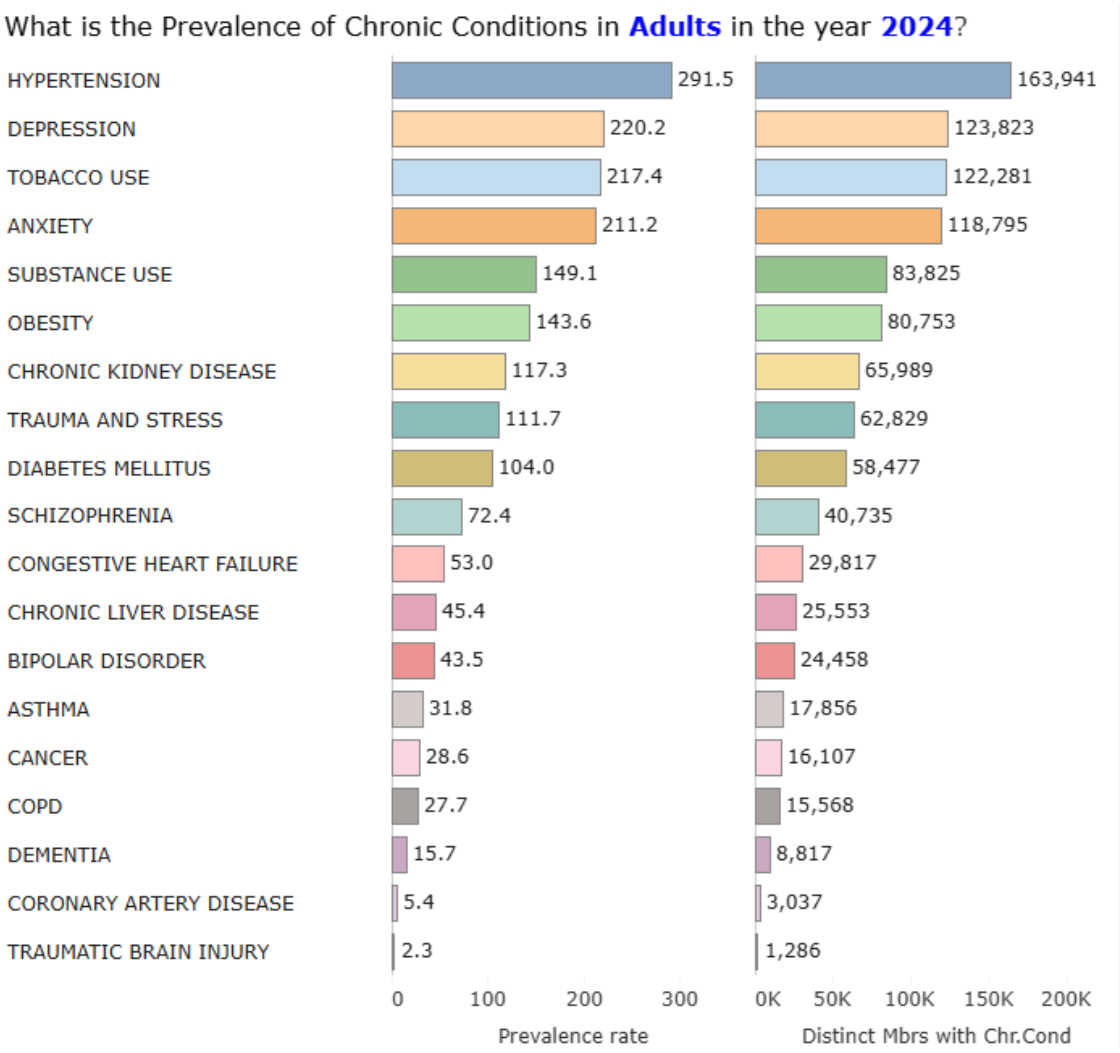
C. Disease Prevalence

1. Chronic Disease

The 2024 Partnership Integrated Claims and Encounter data highlighted many chronic diseases that are prevalent in adults and children. Chronic diseases can be defined as conditions that last 1 year or more and either require continuing medical attention, limit day-to-day living, or both. Partnership bases estimates of chronic disease prevalence on claims and encounter data, while recognizing the limitations of this data to represent the true prevalence of disease. Due to delays in claim processing, full 2024 data will not be available until March 2025. Furthermore, the true prevalence of chronic disease is likely higher than what claims data reflects.

Figure 7 shows a collection of chronic diseases among the adult population. The 6 most prevalent chronic condition claims for adults were: Hypertension (291.5 per 1000 adult members), Depression (220.2 per 1000 adult members), Tobacco use (217.4 per 1000 adult members), Anxiety (211.2 per 1000 adult members), Substance Use (149.1 per 1000 adult members), and Obesity (143.6 per 1000 adult members).

Figure 7: 2024 Adults Chronic Conditions Prevalence Data Per 1000 Members

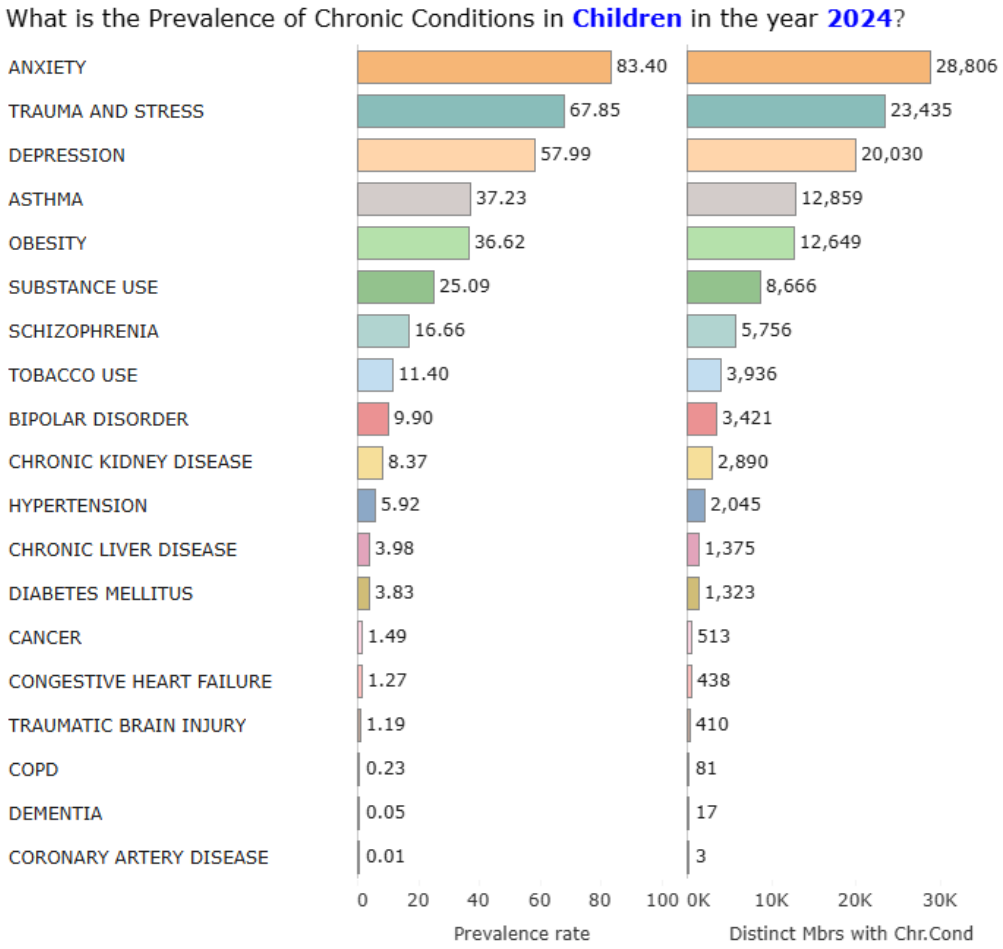


Source: 2024 Partnership Integrated Claims and Encounter Data, Partnership

Figure 8 shows a collection of chronic diseases among the pediatric population. The 6 most prevalent chronic conditions found in pediatric claims were: Anxiety (83.4 per 1000 members), Trauma and Stress (67.85 per 1000 members), Depression (57.99 per 1000 members), Asthma (37.23 per 1000 members) Obesity (36.62 per 1000 members), and Substance Use (25.09 per 1000 members). The top three chronic diseases identified in the pediatric population are related to mental health. Poor mental health can impact daily functions.[48] As such, this data demonstrates a significant need to address anxiety, trauma/stress, and depression among the pediatric population.

[48] OASH, HHS.gov

Figure 8: 2024 Children Chronic Conditions Prevalence Data Per 1000 Members



Source: 2024 Partnership Integrated Claims and Encounter Data, Partnership

2. HEDIS® Scores

Partnership uses HEDIS measure performance to assess how well the health plan is providing preventive care and serving members with chronic diseases. The DHCS Minimum Performance Level (MPL) is set at the 50th percentile and the High-Performance Level (HPL) is set at the 90th percentile amongst health plans nationwide. Appendix A shows the HEDIS scores for all DHCS tracked performance measures for Reporting Year 2024 (Measurement Year 2023). In MY 2023, Partnership was responsible for reporting its HEDIS measure performance in 4 regional reporting units: Northeast (Shasta, Siskiyou, Lassen, Trinity, Modoc), Northwest (Humboldt, Del Norte), Southeast (Solano, Yolo, Napa), and Southwest (Sonoma, Mendocino, Marin, Lake). In 2024, Partnership added 10 new counties (Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Yuba). Starting in MY2024, Partnership will report plan-wide performance for its entire service region, including its new expansion

counties. This reporting will also include drilldowns of plan-wide performance down to the county-level.

a. Controlling High Blood Pressure

Hypertension affects almost one-half the U.S. adult population and is an important risk factor for cardiovascular disease.[49] The HEDIS MPL for Controlling High Blood Pressure was set at the 50th percentile of 61.31% for the 2024 Reporting Year (2023 Measurement Year).[50] In the 2024 reporting year, all reporting regions were at or above the MPL for controlling high blood pressure.

b. Comprehensive Diabetes Care

The HEDIS MPL around the Comprehensive Diabetes Care measure indicator for poor diabetes control (HbA1c level >9%) was set at the 50th percentile of 37.96% for the 2024 Reporting Year (2023 Measurement Year). This measure is HEDIS's only measure where lower scores are considered better; this is because performance is inversely related to the percentage reported. Partnership's Northeast Region Performance for this indicator went below the MPL with a performance of 38.81%. In contrast, the Northwest regional performance was 33.15%. Partnership's Southern Region Performance for Comprehensive Diabetes Care also went below the MPL with a performance of 31.32% and 33.06% in the Southeast and Southwest regions, respectively. These scores indicate that majority of Partnership's reporting regions performed better than the HEDIS MPL for this indicator, demonstrating strong performance across most areas.[51]

c. Preventive Care

One goal of Healthy People 2030 is to increase preventive care for people of all ages;[52] yet, it is estimated that only 8% of adults 35 years and older in the United States get all recommended preventive care services.[53] Getting preventive care helps prevent disease and premature death by using preventive screening tests such as colorectal and breast cancer screening for adults, tracking of child development milestones, and various vaccinations for all ages. It is of utmost importance to help people comprehend the importance of getting preventative care in a timely manner to stay healthy and

[49] Center for Disease Control and Prevention (CDC), 2024
[50] Partnership Health Plan of California HEDIS Measures, 2024
[51] Partnership Health Plan of California HEDIS Measures, 2024
[52] Health.gov Healthy People 2030 Literature Summary, n.d.
[53] Borsky A., et. al., 2018

reduce health inequities. Partnership believes this work is foundational to help our members and our communities stay healthy.

(1) Adult Cancer Screening

Timely cancer screenings are a major component of preventive care for adult members. Partnership annually monitors and assesses 3 cancer metrics. Breast cancer and cervical cancer screenings are metrics that are a part of both the DHCS MCAS and NCQA health plan accreditation measure sets in MY2023. Colorectal cancer screening is a HEDIS measure that will be included in the NCQA health plan accreditation measure set starting in MY2024. In preparation, Partnership has included a colorectal cancer screening measure as part of the Primary Care Provider Quality Improvement Program (PCP QIP), Partnership's largest pay-for-performance program; it is also part of initiatives to encourage appropriate testing for early detection of colon cancer.

There was some improvement in breast cancer screenings in comparison to the previous measurement year. The DHCS-specified MPL was set at the 50th percentile of 52.60% for the 2024 Reporting Year (2023 Measurement Year). The Northeast and Northwest were still below the MPL standing at 50% and 45.64%, respectively. However, the Southeast and Southwest were above the MPL standing at 59.95% and 57.06%, respectively.[54]

Cervical Cancer Screening showed similar changes. The MPL for this measure set at the 50th percentile of 57.11% for the 2024 Reporting Year (2023 Measurement Year). The Northeast Region's performance for this indicator fell below the MPL, with a result of 45.97%. In contrast, the Northwest Region's performance went above the MPL, reaching 58.72%, compared to last year's performance. In the Southern regions, the Southeast and Southwest were above the MPL at 59.84% and 61.75%, respectively.[55]

(2) Pediatric Well-Care and Immunizations

Well-child visits and vaccines play a vital role in ensuring children stay healthy. They are also metrics DHCS was heavily focused on for 2024. Well-child visits track growth and milestones, opening the door for parents to address any questions or concerns they may have around their child's health. Children who are not protected by vaccines are more likely to contract and pass on certain diseases.[56] A recent study identified common barriers to getting to well-child visits, including difficulty in requesting time off

[54] Partnership Health Plan of California HEDIS Measures, 2024
[55] Partnership Health Plan of California HEDIS Measures, 2024
[56] Center for Disease Control and prevention (CDC), 2024

from work, childcare, and other stressors.[57] Addressing social determinants of health plays an important role for improving attendance of well-child visits.

The MPL for Childhood Immunizations Status (CIS-Combo 10) was set at the 50th percentile of 30.90% for the 2024 Reporting Year (2023 Measurement Year). For children ages 0-2 who received all the recommended immunizations by the time they turned 2 years old, the Northeast (8.03%) and Northwest (18.98%) continued to perform below the MPL while the Southeast (44.53%) and the Southwest (37.47%) regions performed above the MPL (see appendix A).

The DHCS MPL for Immunizations for Adolescents (IMA Combo 2) was set at the 50th percentile of 34.31%. The proportion of adolescents receiving the recommended Tdap and meningococcal vaccines by age 13 was below the MPL in the Northeast and Northwest regions, 20.19% and 31.87% respectively. The Southeast exceeded the HPL at 51.82% and Southwest region went above the MPL at 47.93%. This data demonstrates a need to address vaccination rates among the pediatric population in certain regions.

3. Serious and Persistent Mental Illness (SPMI)

Partnership provides mild to moderate mental and behavioral health services for its members through Carelon Behavioral Health. Partnership does not provide services to members who have severe mental and behavioral health needs, otherwise known as serious and persistent mental illness (SPMI) members. NCQA defines SPMI as “a diagnosable mental, behavioral, or emotional disorder resulting in functional impairment that substantially interferes with or limits one or more major activities.” Partnership does support coordination of care for members with SPMI and helps connect them to the appropriate level of care.

When a Partnership member has a higher level of impairment beyond mild to moderate, and needs specialty mental health services (SMHS), the member’s PCP or mental health provider can refer the member to the county mental health plan. Partnership will help coordinate a member’s first appointment with a county mental health plan provider to help them choose the right care for them. These include SMHS for Medi-Cal members who meet services rules for SMHS. These services may include outpatient, residential, and inpatient services.[58]

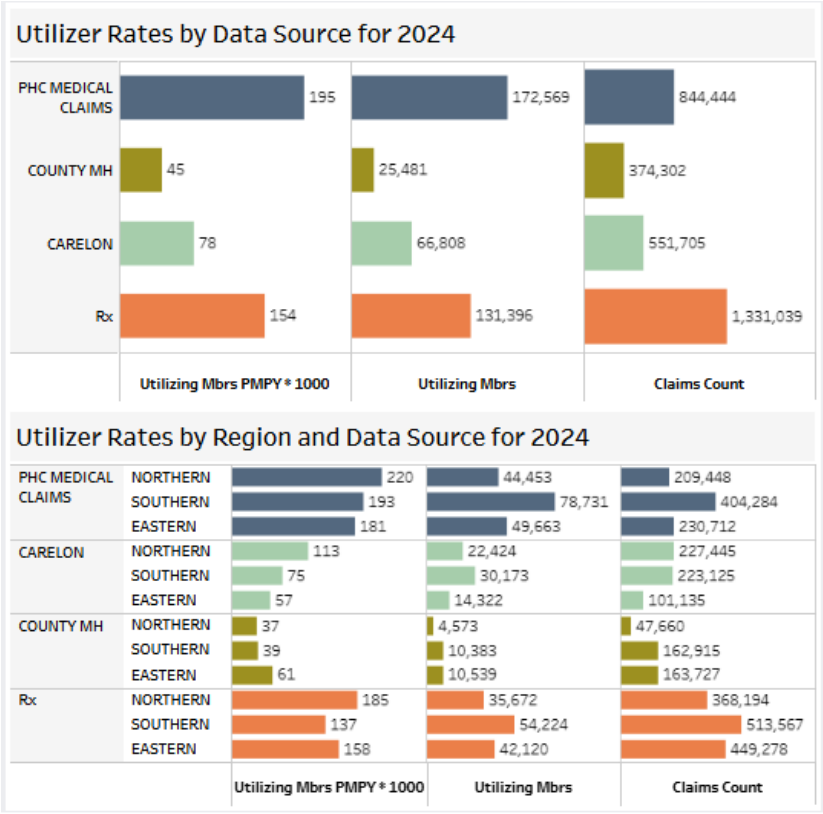
[57] Wolf et. al., 2020
[58] Partnership HealthPlan of California Medi-Cal Member Handbook, 2025

Partnership's regulatory body, the Department of Health Care Services, has two definitions of members who qualify for SMHS,[59] otherwise known as members with SPMI. These definitions are differentiated by age. Recipients 21 years and over must have a significant impairment that is due to a suspected or diagnosed mental health disorder. Recipients under 21 years of age must meet at least 1 of 2 criteria. Criteria 1 is: the member has a significant impairment, a probable reason to believe there is deterioration or lack of developmental progress in key life functions, or there is a need for SMHS. Criteria 2 is: the member's condition listed in criteria 1 is due to a suspected or diagnosed mental health disorder, or a significant trauma that could result in future mental health concerns.

Due to limited data availability, the number of members accessing SMHS through county mental health serves as a proxy for the number of Partnership members with SPMI. Figure 9 shows that in 2024, there were 25,481 unique members that accessed specialty mental health services through county mental health and received at least one service. The same figure shows this number further broken down by region. The number of members who access SMHS through county mental health, and therefore the estimated number of members with SPMI, are as follows: 4,573 in the Northern region, 10,383 members in the Southern Region, and 10,539 members in the Eastern region. Due to difficulty in data collection, Partnership is unable to provide data on how many members have been referred to SMHS. Nonetheless, this data shows there is a significant number of members with SPMI who need coordination of care and resources from the county to get the care they need.

[59] Department of Health Care Services, Non-Specialty Mental Health Services, 2022

Figure 9: Partnership Mental Health Utilization Overview - Utilizer Rates by Data Source, 2024



Source: Partnership Data 2024

D. Access to Care

There are many barriers to accessing health care within the general population, but populations in rural communities and in low-income areas are more significantly affected. Such barriers include, but are not limited to, access to fewer health care providers, cultural and linguistic challenges, broadband access for telehealth, and transportation challenges. Health literacy challenges can also contribute to a person's ability to access and use health care services.

1. Provider Availability

Lack of PCP availability is the most common barrier for Partnership members wanting to attend annual checkups and get routine screenings and vaccinations. These appointments are important both for preventive health care and for identifying the need for specialty care and other services. County Health Rankings provides a ratio of the

population to primary care providers in Reporting Year 2024 (Measurement Year 2021).[60]

For California as a whole, the ratio of individuals to providers reported in Reporting Year 2024 (Measurement Year 2021) is 1,230:1. As of December 2024, in Partnership's Northern Region comprised of the Eureka Region (indicated with "NW" in Table 8) and the Redding Region (indicated with "NE" in Table 8), all the counties underperformed when compared to the California ratio. Lake, Del Norte, Lassen and Trinity counties have the least availability of providers to the population with Lake at a ratio of 2,370:1, Del Norte at a ratio of 1,650:1, Lassen at a ratio of 3,680:1 and Trinity at a ratio of 5,350:1. In Partnership's Eastern Region comprised of both the Chico Region and Auburn Region (indicated with "E" in Table 8 below), all the counties within the Chico Region underperformed when compared to the California ratio. Yuba and Glenn counties have the least availability of providers to the population with Yuba at a ratio of 4,910:1 and Glenn at a ratio 5,760:1. In Partnership's Sothern Region comprised of the Santa Rosa Region (indicated with "SW" in Table 8) and the Fairfield Region (indicated with "SE" in Table 8) multiple counties performed better compared to the California ratio, including Marin (670:1), Sonoma (980:1), Solano (1,190:1), Napa (1,020:1), and Yolo (810:1). Despite these countywide numbers, Partnership contracts with a robust primary care network, and is able to meet the DHCS access and availability standards for primary care.

Table 8: Ratio of Population to Primary Care Providers by County

Ratio of Providers to County Population	
California Average: 1,230:1	
County	**Ratio**
Sierra (E)	-
Marin (SW)	670:1
Yolo (SE)	810:1
Placer (E)	820:1
Sonoma (SW)	980:1
Napa (SE)	1,020:1
Solano (SE)	1,190:1
Shasta (NE)	1,280:1
Mendocino (NW)	1,290:1
Sutter (E)	1,320:1
Plumas (E)	1330:1
Siskiyou (NE)	1,340:1

[60] County Health Rankings, Primary Care Physicians, 2024

Nevada (E)	1,380:1
Humboldt (NW)	1,640:1
Del Norte (NW)	1,650:1
Butte (E)	1,710:1
Tehama (NE)	1,870:1
Modoc (NE)	2,170:1
Lake (NW)	2,370:1
Colusa (E)	3,650:1
Lassen (NE)	3,680:1
Yuba (E)	4,910:1
Trinity (NE)	5,350:1
Glenn (E)	5,760:1

Source: County Health Rankings & Roadmaps, 2024. Primary Care Physicians. Green indicates that compared to the previous year's data, provider availability improved (i.e. there were less patients per provider). Red indicates that compared to the previous year's data, provider availability worsened (i.e. there were more patients per provider).

Partnership's recent Grand Analysis Report on Network Adequacy also revealed that between January 1, 2023, and December 31, 2023, 43% of standard member grievances and 50.1% of appeals and second level grievances were related to provider access. This same report also revealed that between January 2023 to December 2023, Partnership met its goal of less than 20 referrals per 1,000 members for out-of-network requests.[61]

Physical access at provider facilities can be a challenge for Partnership's seniors and members with disabilities. One of the ways of assessing a facility's physical accessibility is through a Physical Accessibility Review Survey (PARS), which tracks any changes in a facility's physical accessibility. Physical access is categorized as either "Basic" or "Limited." A facility categorized as "Basic" has met all 29 critical elements used to identify a site's capability of accommodating members who are seniors and/or persons with disabilities. Elements, or domains, include parking, the exterior and interiors of the building, the restroom(s), and the exam room(s). If a facility is categorized as "Limited," it is missing 1 or more of the domains. As of December 2024, 96 out of 179 inspected facilities were categorized as Limited; and 83 inspected facilities were categorized as Basic.[62]

[61] Partnership HealthPlan of California Grand Analysis: Network Adequacy Report: Assessment of Network Adequacy, 2024
[62] Partnership HealthPlan of California PARS report, 2024

2. 2024 Consumer Assessment of Healthcare Providers and Systems (CAHPS)

The CAHPS survey gives members an opportunity to give feedback about their ability to access care and their satisfaction with the care received. The CAHPS survey measure year or period is 2023 (July 1, 2023 – December 31, 2023) and the reporting year is 2024. The CAHPS adult composite scores for reporting year 2024 showed that the ratings decreased in most areas, including rating of all health care, getting needed care, getting care quickly, how well doctors communicate, and coordination of care (see Table 9). The exception to these decreasing rates is the scores for rating of personal doctor and rating of specialist seen most often, which increased from 66.9% in 2023 to 70% in 2024 and 64.4% in 2023 to 69.5% in 2024, respectively (see Table 9).

The collective decreases in measures in Table 9 suggest that compared to 2023, adult members are overall less happy with their care. Since trust between a patient and provider can be a key element to certain positive health outcomes,[63] a negative patient experience likely indicates a lower level of trust. Thus, negative member experience scores could indicate members may be less likely to trust their doctor and are at risk of worse health outcomes. Partnership's Provider Relations department does work closely with local providers to improve access to care for our members.

Table 9: Measure Year (MY) 2023 and Reporting Year (RY) 2024 Adults CAHPS Health Care Performance Results

ADULT CAHPS Health Care Performance	***2023*** (Previous Reporting YR)	***2024*** (Current Reporting YR)
Rating of Health Care (% 9 or 10)	55.7%	46.3%
Getting Needed Care (% Always or Usually)	76.4%	73.9%
Getting Care Quickly (% Always or Usually)	69.5%	68.0%
How Well Doctors Communicate (% Always or Usually)	92.9%	92.6%
Coordination of Care (% Always or Usually)	86.6%	78.8%
Rating of Personal Doctor (% 9 or 10)	66.9%	70.0%
Rating of Specialist (% 9 or 10)	64.4%	69.5%

Source: 2023 CAHPS Medicaid Adult 5.1H Survey, 2024, Press Ganey (p. 9-10). Green indicates an increase in score from the previous reporting year. Red indicates a decrease in score from the previous reporting year.

Compared to 2023, the CAHPS child composite scores for reporting year 2024 increased in most areas such as getting needed care, getting care quickly, how well

[63] BMC Primary Care, 2024

doctors communicate, and rating of personal doctor (see Table 10). The exceptions to these increasing rates are the scores for areas of rating of health care, rating of specialist, and Coordination of care which decreased from 64.3% in 2023 to 58.9% in 2024, from 69.5% in 2023 to 63.9% in 2024, and from 81.1% in 2023 to 80.4% in 2024, respectively.

The increases in certain measures in Table 10 suggest that compared to 2023, pediatric members are happier overall with their health care. Since trust between a patient and provider can be a key element to certain positive health outcomes,[64] a positive patient experience likely indicates a higher level of trust. Positive member experience scores indicate members may be more likely to trust their doctor, which can lead to better health outcomes. This data seems to demonstrate that the pediatric population is overall happier with their health care.

Table 10: Measure Year (MY) 2023 and Reporting Year (RY) 2024 Child CAHPS Health Care Performance Results

CHILD CAHPS Health Care Performance	***2023*** (Previous Reporting YR)	***2024*** (Current Reporting YR)
Rating of Health Care (% 9, or 10)	64.3%	58.9%
Getting Needed Care (% Always or Usually)	76.7%	77.1%
Getting Care Quickly (% Always or Usually)	76.3%	78.9%
How Well Doctors Communicate (% Always or Usually)	92.7%	93.0%
Coordination of Care (% Always or Usually)	81.1%	80.4%
Rating of Personal Doctor (% 9, or 10)	74.4%	75.5%
Rating of Specialist (% 9, or 10)	69.5%	63.9%

Source: 2023 CAHPS Medicaid Child 5.1H Survey, 2024, Press Ganey (p. 9-10). Green indicates an increase in score from the previous reporting year. Red indicates a decrease in score from the previous reporting year.

3. Third Next Available Appointment

Partnership's Provider Relations department conducts the annual Third Next Available (3NA) survey. This point-in-time survey assesses the availability of members' access to non-urgent primary care appointments for adult, pediatric, and newborn appointments, as well as urgent care appointments. The 3NA survey also assesses overall telephone

[64] BMC Primary Care, 2024

accessibility during business hours using the number of rings before the phone is answered, minutes on hold, average wait time before seeing a provider, and if a return-call is received within 30 minutes.

PCPs are held to performance expectations with 2 specific standards of interest. Standard 1 is defined as “the percentage of providers who have a 3rd next available primary care adult and/or pediatric primary care appointment in less than or equal to 10 business days.” Standard 2 is defined as “the percentage of providers who have a 3rd next available newborn and/or urgent primary care appointment in less than or equal to 48 hours.”

The results of the 3NA survey show that 91.4% of providers in the Northern region, 91.3% of providers in the Eastern region and 78.7% of providers in the Southern region met Standard 1 for adult primary care appointments. For all pediatric primary care appointments, the survey results showed that 93.6% of providers in the Northern region, 96.4% of providers in the Eastern region and 85.1% of providers in the Southern region met Standard 1. Furthermore, the survey results showed that 100% of the providers in the Northern region, 99.0% of providers in the Southern region and 93.2% of providers in the Eastern region met Standard 2 for newborn primary care appointments. Finally, 97.9% of providers in the Northern region, 97.4% of providers in the Southern region, and 95.4% of providers in the Eastern region met Standard 2 for urgent primary care appointments. The results of this survey are displayed in Table 11. This data seems to demonstrate that for all appointment types in each region, most clinics are meeting the standard and are able to provide members, including pediatric members, with the care they need.

Table 11: 2024 Partnership Third Next Appointment Availability

Third Next Available (3NA) Survey Findings 2024									
Provider Type	Standard	Median Days (number of days) for Established PCP Appointment				Percentage of Clinics Meeting PCP Standards			
		North	South	East	Plan	North	South	East	Plan
Primary Care Adult	3rd Next Available Non-urgent Care primary care appointments within 10 business days of request	3	5	2.5	3	91.4%	78.7%	91.3%	86.2%
Primary Care Pediatrics	3rd Next Available Non-urgent Care primary care appointments within 10 business days of request	3	4	2	3	93.6%	85.1%	96.4%	91.3%
Primary Care Newborn Appointments	3rd Next Available Newborn appointments within 48 hours of discharge	1	1	1	1	100%	99.0%	93.2%	97.4%
Primary Care Urgent Care	3rd Next Available Urgent Care appointments within 48 hours of request	1	1	0	0	97.9%	97.4%	95.4%	96.9%

Source: 2024 Partnership Third Next Available Survey, 2024 Summary

When looking at 3NA primary care appointment access by county, some provider sites in Butte, Humboldt, Lassen, Marin, Mendocino, Napa, Siskiyou, Solano, Sutter, Trinity, Yolo, and Yuba counties did not meet all of the standards for appointment accessibility. Sites that do not meet the standards are surveyed again and are provided with a corrective action plan, as needed.

4. Telemedicine

a. Telehealth Utilization Report

Telemedicine and telephone visit opportunities can help ensure access to needed health care. Partnership uses 2 sources of telehealth data for specialty care: The Telehealth Utilization Report and the eConsult Utilization Report. The Telehealth Utilization Report details video data and shows all video visits completed between a patient, provider, and specialist.

In 2024, telemedicine utilization shows 25,089 visits scheduled and 16,748 (66.8%) completed visits through Partnership-contracted specialty telemedicine providers (see Table 12). This data represents an increase in both scheduled and completed telemedicine visits in 2024 when compared to 2023.

Table 12: Adult Telemedicine Appointment Details as of December 2024

Adult Telemedicine Appointment Details as of December 2024					
Scheduled Appointments	Completed Visits	Completed Visits Rate	No Show Rate	Cancelled Visits Rate	Avg. Business Days to Appt.
25,089	16,748	66.8%	9.3%	8.7%	25.3

Source: Adult Telemedicine Appointment Details Report, 2024, Partnership

As of December 2024, the number of scheduled pediatric telemedicine appointments was 6,268 and the number of completed pediatric telemedicine appointments was 3,964. From December 2023 to December 2024, the number of completed pediatric telemedicine appointments ranged from approximately 164-406 visits per month, with a high of approximately 406 per month in May 2024. Since access to care is an important part of staying healthy, this data demonstrates that there is opportunity to increase the rates of access to care for the pediatric population through telemedicine.

Table 13: Pediatric Telemedicine Appointment Details as of December 2024

Pediatric Telemedicine Appointment Details as of December 2024					
Scheduled Appointments	Completed Visits	Completed Visits Rate	No Show Rate	Cancelled Visits Rate	Avg. Business Days to Appt.
6,268	3,964	63.2%	17.2%	19.6%	37.9

Source: Pediatric Telemedicine Appointment Details Report for 2024, Partnership

b. eConsult Utilization Report

The second source of telehealth data for specialty care is Partnership's eConsult Utilization Report. This report shows the utilization data of the online eConsult platform. This platform is where providers can directly message specialists regarding patient care; by using this method, the needs of the patients can be met without requiring a face-to-face visit.

As of December 2024, there were 1,281 adult eConsults completed. Of those, 69.0% were closed because the patient's needs were addressed eConsult, while 27.9% were referred to face-to-face services.

Table 14: Adult eConsult Utilization Report, 2024 Partnership

Adult eConsult Utilization Report as of December 2024				
Submitted eConsults	Completed eConsults	Closed – Patient Needs Addressed	Average Time from Referral to Consult, in Days	Closed – Refer Face-to-Face
1,295	1,281	69.0%	2.6	27.9%

Source: Adult eConsult Utilization Report, 2024 Partnership

As of December 2024, there were 103 completed pediatric eConsults. Of those, 75.7%. were closed because the patient's needs were addressed through eConsult, while 17.5% of consults were referred for face-to-face services.

Table 15: Pediatric eConsult Utilization Report, As of December 2023 Partnership

Pediatric eConsult Utilization Report as of December 2024				
Submitted eConsults	Completed eConsults	Closed – Patient Needs Addressed	Average Time from Referral to Consult, in Days	Closed – Refer Face-to-Face
103	103	75.7%	2.5	17.5%

Source: Pediatric eConsult Utilization Report, 2024 Partnership

Although telehealth has the ability to improve access to care, Partnership members living in rural and remote areas with limited broadband access may still struggle to receive the care they need. Rural members often require in-person visits to meet their medical needs. In addition, many Partnership members lack the equipment or knowledge needed to connect to a telemedicine appointment.

E. Member Experience of Care

1. Satisfaction with Health Plan

Partnership contracted with Press Ganey (PG) to perform the 2024 CAHPS survey. The report is based on data as of July 2024. PG reached out to 3,375 adult members and the guardians of 4,125 pediatric members to participate in the survey. There were 510 adult responses (15.3% of those surveyed) and 659 pediatric responses (16.1% of those surveyed).

The CAHPS results discovered that 87.0% of adult respondents answered "Always" or "Usually" when asked if they received helpful information or were treated with courtesy and respect. This measure is collectively referred to as Customer Service which changed from 56.8% in 2023 to 54.5% in 2024. This represents a slight decrease from

the 2023 survey results. Table 16 denotes changes in various measures between 2023 and 2024.

Other categories also showed mixed responses. Adult members were less satisfied with the Rating of Health Plan (decrease from 56.8% to 54.5%), Getting Needed Care (decrease from 76.5% to 74.0%), but were more satisfied with the Ease of Filling Out Forms (decrease from 96.0% to 97.7%). The decrease in certain measures in Table 16 suggests that compared to 2023, adult members are less happy with Partnership. Thus, members may be less likely to trust their health plan and may experience worse health outcomes.

Table 16: Measure Year (MY) 2023 and Reporting Year (RY) 2024 Adult CAHPS Summary Rates for Health Plan Performance

ADULT CAHPS Health Plan Performance	***2023*** (Previous Reporting YR)	***2024*** (Current Reporting YR)
Rating of Health Plan (% 9 or 10)	56.8%	54.5%
Getting Needed Care (% Always or Usually)	76.4%	74.0%
Customer Service (% Always or Usually)	88.6%	87.00%
Ease of Filling Out Forms (% Always or Usually)	96.0%	97.7%

Source: Measure Year (MY) 2023 and Reporting Year (RY) 2024 CAHPS Medicaid Adult 5.1 H, 2024, Press Ganey (p. 10). Red indicates a decrease in score from the previous reporting year. *Green indicates an increase in score from the previous reporting year.*

The Measure Year (MY) 2023 and Reporting Year (RY) 2024 Child CAHPS survey results revealed that 68.1% of respondents completing forms on behalf of pediatric members rated their child's Health Plan as good or excellent (scores of 9 or 10), compared to 68.0% in 2023. This marks a slight increase. Another notable improvement was observed in Customer Service, which increased from 89.9% in 2023 to 91.2% in 2024. However, the percentage of respondents reporting the ease of filling out forms as "Always or Usually" decreased slightly from 95.4% in 2023 to 94.2% in 2024. Despite these mixed trends, the percentage of respondents reporting success in "Getting Needed Care" rose modestly from 76.7% to 77.0%. These results, as outlined in Table 17, suggest that while pediatric members' interactions with Partnership improved, challenges remain in filling out forms. These factors may influence members' trust in their health plan and their likelihood of seeking care for health concerns as needed. This

data seems to demonstrate that the pediatric population is overall happier with their health plan.

Table 17: Measure Year (MY) 2023 and Reporting Year (RY) 2024 Child CAHPS Summary Composite Rates for Health Plan Performance

Pediatric CAHPS Health Plan Performance	***2023*** (Previous Reporting YR)	***2024*** (Current Reporting YR)
Rating of Health Plan (% 9 or 10)	68%	68.1%
Getting Needed Care (% Always or Usually)	76.7%	77.0%
Customer Service (% Always or Usually)	89.9%	91.2%
Ease of Filling Out Forms (% Always or Usually)	95.4%	94.2%

Source: MY 2023 CAHPS® MEDICAID CHILD 5.1H SURVEY 2023, Press Ganey (p. 12). Green indicates an increase in score from the previous reporting year. Red indicates a decrease in score from the previous reporting year.

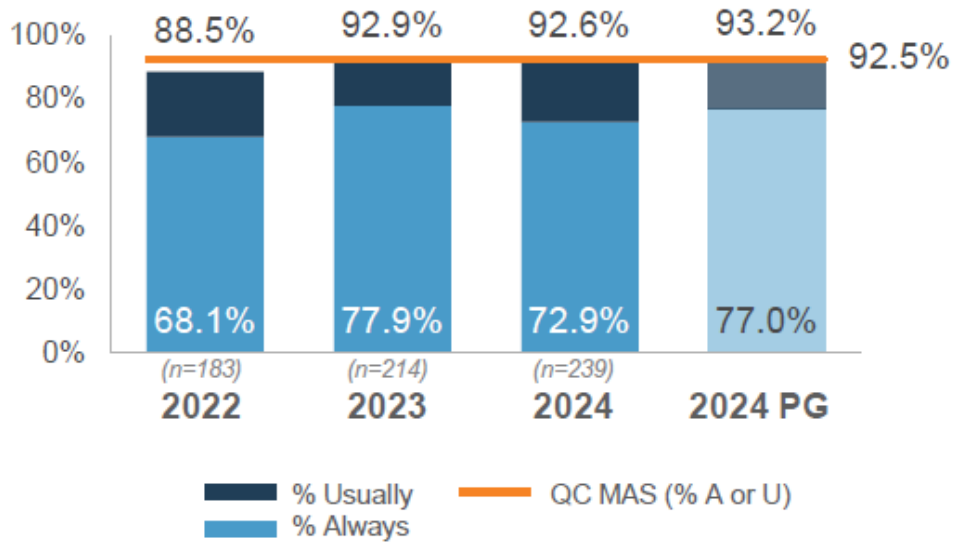
2. Doctor Communication

Partnership uses the Measure Year (MY) 2023 and Reporting Year (RY) 2024 CAHPS survey data to evaluate how satisfied members are with the interactions they have with their doctors. The score is a composite, comprised of indicators measuring how well a member's doctor explained things, if they listened carefully, showed respect, and if the doctor spent enough time with them.

The percentage of adult members who felt their doctor communicated well with them always or usually decreased on aggregate from 92.9% in 2023 to 92.6% in 2024 as compared to the Quality Compass (QC) score shown in the following figures. Partnership scored slightly above Press Ganey's 2024 Benchmark in all aspects of how well doctors communicate with Partnership adult members. Having good communication with one's doctor can help build a relationship and fosters trust between the member and the provider,[65] which can be a proxy measure for health outcomes. Therefore, having good communication with one's doctor is important to ensure Partnership members have the best possible health outcomes.

[65] BMC Primary Care, 2024

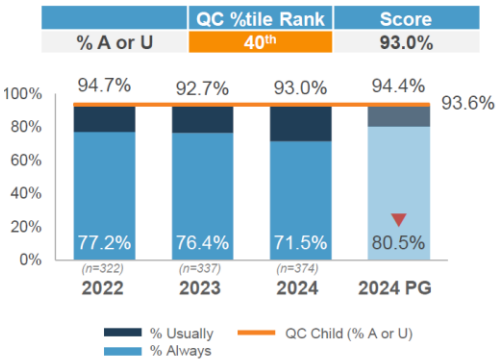
Figure 10: 2024 Adult Composite CAHPS Survey Result



Source: Measure Year (MY) 2023 and Reporting Year (RY) 2024 CAHPS Medicaid Adult 5.1H Survey, Partnership, 2024

The results of the Child CAHPS Survey show that members rated their care experience with children's providers slightly higher than providers for adults. The percentage of child members who felt their doctor communicated well with them always or usually decreased on aggregate from 92.7% in 2023 to 93.0% in 2024. This minor decrease means Partnership is slightly below PG's Benchmark score, which stays higher at 94.4%. Having good communication with one's doctor is important to ensure Partnership pediatric members trust their doctors and will have the best possible health outcomes. This data demonstrates that the population is generally happy with their providers.

Figure 11: Measure Year (MY) 2023 and Reporting Year (RY) 2024 Child Composite CAHPS Survey Result



Source: Measure Year (MY) 2023 and Reporting Year (RY) 2024 CAHPS Medicaid Child 5.1 Survey, Partnership, 2024

F. Health Disparities

The 2024 health disparities data is taken from a grand analysis called the HE 6: Reducing Healthcare Disparities report.[66]

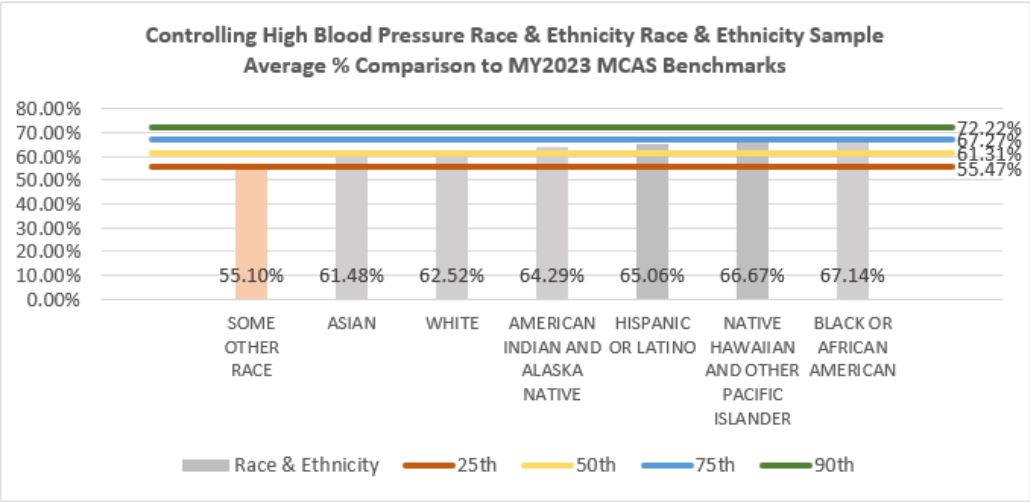
The key measures for the 2024 Health Equity Report are: controlling high blood pressure (CPB), Hemoglobin A1c Control for Patients with Diabetes (HBD), Prenatal and Postpartum Care (PPC), and Child and Adolescent Well Care Visits (WCV). Due to low sample sizes (n=186 to 368) for the hybrid measures in the Health Plan Accreditation data (MY23), and the absence of statistically significant inequities identified for all measures, no substantial disparities were found. In response, Partnership evaluated the MY 2023 Managed Care Accountability Set (MCAS) final rate samples (n=812 to 167,450 members) to provide a meaningful analysis of the key measures. Please refer to Appendix H for the NCQA Health Plan Accreditation generated sample results. The following results are from the MY 2023 Managed Care Accountability Set (MCAS) final rate samples:

1. Controlling High Blood Pressure (CPB)

HE 6: Reducing Healthcare Disparities report found that the 'Some Other Race' group performed below the MPL at 55.10%, compared to higher-performing populations. In contrast, the Asian population performed at 61.48%, the White population at 62.52%, the American Indian and Alaska Native group at 64.29%, the Hispanic or Latino group at 65.06%, and the Native Hawaiian and other Pacific Islander group at 66.67%, with the Black/African-American population performing at 67.14%. While all groups except the 'Some Other Race' group hit at least the 50th percentile, no group exceeded the 90th percentile threshold. Controlling high blood pressure is an important part of staying healthy. As such, this data demonstrates there is a need to better address controlling high blood pressure among the 'Some Other Race' group.

[66] Partnership HealthPlan of California, 2024 HE 6: Reducing Healthcare Disparities report

Figure 12: 2024 Controlling High Blood Pressure

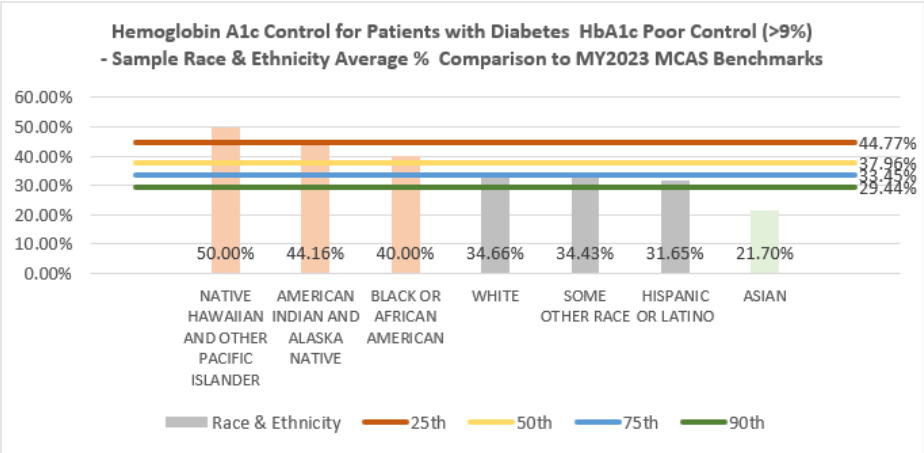


Source: 2024 Partnership Health Equity Standards HE6 – Reducing Healthcare Disparities

2. Hemoglobin A1c Control for Patients with Diabetes (HBD) HbA1c 3. Poor Control (>9.0%):

The HE 6: Reducing Healthcare Disparities report found that when comparing the sample's average rate for each race/ethnicity group to the MCAS benchmarks, the Native Hawaiian and Other Pacific Islander (50%), American Indian and Alaska Native (44.16%), and Black or African American (40%) groups all performed below the MPL – 50th. In contrast, the Asian population had the lowest rate of poor control at 21.70%, performing above the 90th percentile. Controlling Hemoglobin A1c Control for Patients with Diabetes (HBD) HbA1c is an important part of staying healthy. Therefore, the data in Figure 13 demonstrates there is a need to better address hemoglobin A1c control among the Native Hawaiian and Other Pacific Islander group, American Indian and Alaska Native, and Black or African American groups.

Figure 13: Hemoglobin A1c Control for Diabetes – Poor Control

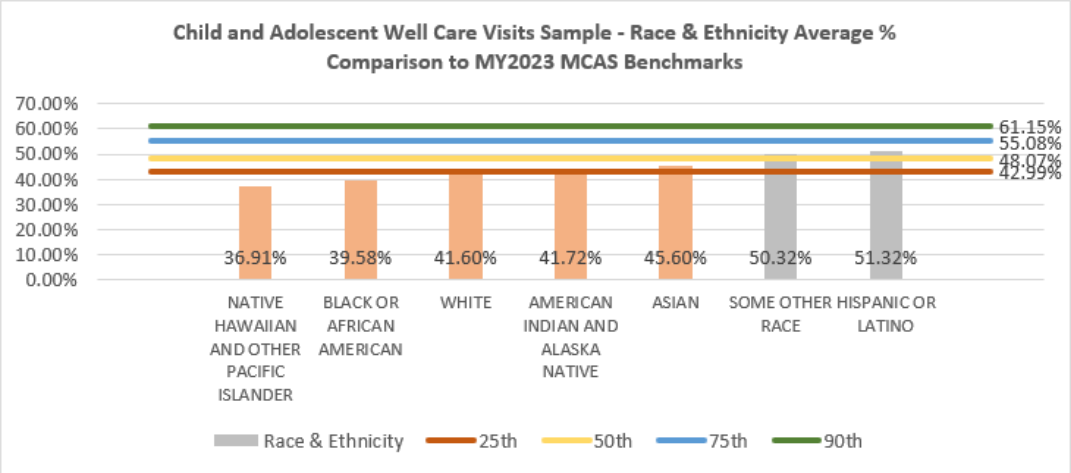


Source: 2024 Partnership Health Equity Standards HE6 – Reducing Healthcare Disparities

4. Child and Adolescent Well Care Visits (WVC):

The HE 6: Reducing Healthcare Disparities report on Child and Adolescent Well Care Visits (WCV) found that the majority of racial/ethnic groups did not meet the MPL – 50th percentile, and no group performed above the 90th percentile. Specifically, the Native Hawaiian and Other Pacific Islander (36.91%), and Black or African American (39.58%), White (41.60%) populations, and American Indian and Alaska Native (41.72%) populations performed the lowest, falling below the MPL – 50th percentile. In contrast, the Asian population (45.60%) performed slightly better, though still below the 50th percentile, indicating overall limited access to or utilization of well-care visits compared to the benchmark. The Hispanic population performed the best (51.32) and performed above the MPL 50th percentile. Well child visits are an important part of staying healthy. As such, while the data in Figure 14 demonstrates a need to address the low rates of well child visits among all groups (except for the “Some Other Race” category and the Hispanic/Latino Population), the Native Hawaiian and other Pacific Islander pediatric sub-population are of particular interest. While this population only makes up 0.2% of the total Partnership member population (as noted in previously in Figure 4), the data demonstrates the Native Hawaiian and other Pacific Islander pediatric population performed the lowest on this clinical measure and shows a clear need for this population to have better access to child and adolescent well care visits.

Figure 14: Child and Adolescent Well Care Visits

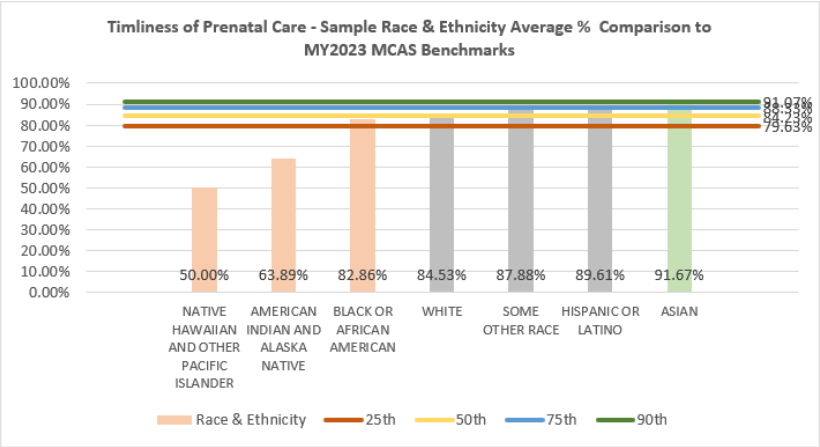


Source: 2024 Partnership Health Equity Standards HE6 – Reducing Healthcare Disparities

5. Prenatal and Postpartum Care (PPC):

The HE 6: Reducing Healthcare Disparities report on Prenatal Care Visits (PPC) found that the Native Hawaiian and Other Pacific Islander (50%), American Indian and Alaska Native (63.89%), and Black or African American (82.86%) groups all had lower rates of completion, performing below the MPL – 50th percentile. In contrast, the Asian group had a higher rate of completion at 91.67%, performing above the 90th percentile, as shown in Figure 15. Prenatal care is an important part of staying healthy. As such, the data in the figure demonstrates there is need to address prenatal care access among the Native Hawaiian and Other Pacific Islander group, American Indian and Alaska Native, and Black or African American groups.

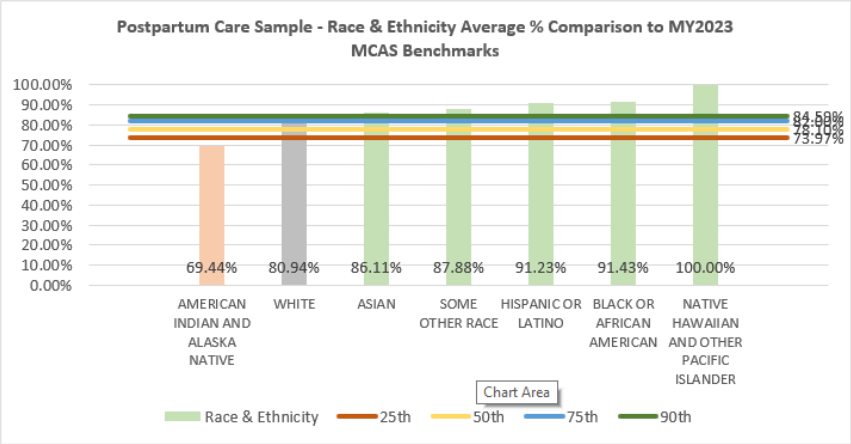
Figure 15: Prenatal and Postpartum Care (PPC - Pre)



Source: 2024 Partnership Health Equity Standards HE6 – Reducing Healthcare Disparities

For Postpartum Care, the American Indian and Alaska Native group (69.44%) was the only group with a completion rate below the MPL – 50th percentile. In comparison, the Asian (86.11%), 'Some Other Race' (87.88%), Hispanic or Latino (91.23%), Black or African American (91.43%), and Native Hawaiian and Other Pacific Islander (100%) groups all had higher rates of completion, performing above the 90th percentile, as shown in Figure 16. The White population (80.94%) performed just below the 75th percentile. Postpartum care is an important part of staying healthy. As such, while the American Indian and Alaska Native population only makes up 1.8% of the total Partnership member population (as noted in previously in Figure 4), the data in Figure 16 demonstrates this sub-population performed the lowest on this clinical measure. As such, there is clear need to address access to postpartum care among the American Indian and Alaska Native group who are of childbearing age.

Figure 16: Prenatal and Postpartum Care (PPC - Post)



Source: 2024 Partnership Health Equity Standards HE6 – Reducing Healthcare Disparities

G. Health Education, Cultural & Linguistic Gap Analysis

Partnership maintains a Health Education unit responsible for creating and providing health education materials at an appropriate reading and comprehension level for members. The Health Education unit creates some materials to meet the needs of various member-outreach activities carried out by the organization. Other health education materials are more readily available on the Member Portal through the Healthy Living Tool. There are additional external health education materials available for both member and provider access on PCH's external website:

- Members: www.partnershiphp.org/Members/Medi-Cal/Pages/Health%20Education/Health-Education---Members.aspx
- Providers: www.partnershiphp.org/Providers/HealthServices/Pages/Health%20Education/HealthEducationProviders.aspx

Printed copies of materials are available to both members and providers. Educational and informing materials created by the Health Education Team are reviewed and updated no less than every 5 years and are translated into all Partnership threshold languages (Spanish, Russian, Tagalog; Punjabi will likely become part of this list in 2025); other languages are available upon member request. The Health Education unit reviews educational materials on the external website on an annual basis. This established process has been effective in providing materials to members, both directly and through providers.

The Health Education team is also responsible for the Cultural & Linguistic program, including evaluation of member grievances for issues arising from discrimination (which includes discrimination based on language), and performance of audits for delegates mandated to carry out various Cultural and Linguistic responsibilities. They also review and recommend staff and provider training to promote awareness of diversity, equity, and inclusion to serve our members better as requested. The evaluation of member grievances for issues arising from discrimination will transition to the Health Equity department in 2025.

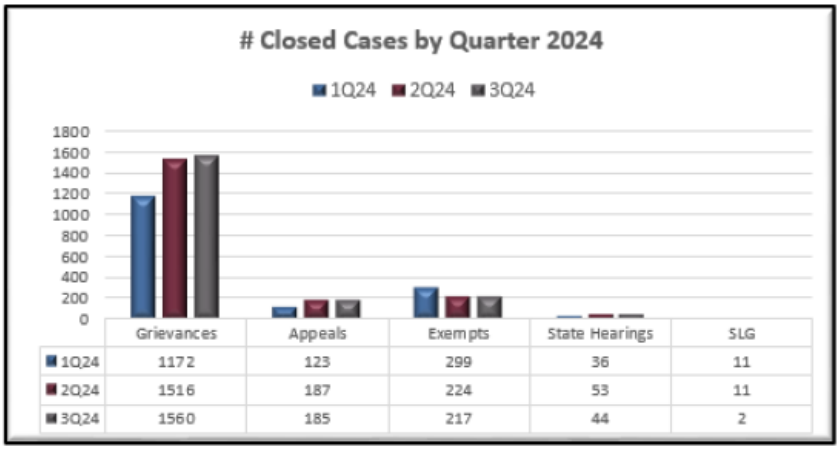
1. Grievance and Appeals

Grievance and Appeals (G&A) data is used to analyze member experience with the health plan and health care services, providing insight into member engagement with

the health plan, and capturing reports of discrimination. Each year, Partnership compares the year-to-date results reported in the Fourth Quarter G&A Pulse report. This Pulse report captures data for the first 3 quarters of each calendar year. Time limitations prevent capture and use of fourth quarter data in this PNA.

By the end of the third quarter in 2024, the G&A team closed 4,248 cases, representing an increase from the 2,766 cases closed for member reported grievances in 2023. English speakers and the White population continue to be the groups that file the majority of grievances and appeals.

Figure 17: Number of Closed Cases by Quarter 2024



	Grievances	Appeals	Exempts	State Hearings	SLG
1Q24	1172	123	299	36	11
2Q24	1516	187	224	53	11
3Q24	1560	185	217	44	2

Source: 4Q 2024 Partnership Grievance & Appeals Pulse Report, Partnership

The top 5 ethnicities of people filing grievances in third quarter 2024 were White (56.0%), Hispanic (19.6%), Native American (19.6%), Asian (15.8%), and Other/Unknown (5.2%). See Figure 18 below.

Figure 18: G&A Pulse Report by Members Ethnicities vs. Partnership Overall Membership by Ethnicity

3Q24 % CASES BY ETHNICITY		
Member Ethnicity	% Cases	% Membership
White	56.0%	38.9%
Hispanic	19.6%	33.6%
Other/Unknown	5.2%	17.9%
Black (African Amer	0.4%	3.5%
Asian	15.8%	2.5%
Native American	19.6%	1.8%
Asian Indian	0.7%	1.6%
Native Hawaiian or	0.1%	0.2%
Grand Total	100.0%	100.0%

Source: 4Q 2024 Partnership Grievance & Appeals Pulse Report, Partnership

In 2024, Partnership identified a disparity in grievances reported by member race/ethnicity and by language. The grievances reported continue to not be proportionate to the percentage of different races/ethnicities and languages within Partnership's membership. Between 2023 and 2024, the proportion of grievances shifted further away from alignment with the demographics of Partnership members. This may indicate a lack of member trust in Partnership to take their concerns seriously, which can lead to less health seeking behaviors (e.g. attending primary care visits) and thus poorer health outcomes for the member population.

Grievances reported by White members increased from 53.2% in 2023 to 56.0% in 2024, which coincides with the percentage of White members increasing from 37.0% to 38.9% in the same period. Grievances reported by Hispanic members increased from 11.8% in 2023 to 19.6% in 2024, which coincides with the percentage of Hispanic members increasing from 32.2% to 33.6% in the same period.

Grievance reporting increased most significantly between 2023 and 2024 by Native American members, where grievance reporting increased from 1.8% in 2023 to 19.6% in 2024, although there was an overall decrease in the percentage of Native American members from 2.1% to 1.8%. See Table 18 below.

Table 18: Grievances by Race/Ethnicity over Time

Member Race/Ethnicity	2023 % of Cases	2023 % of Membership	2024 % of Cases	2024 % of Membership
White	53.2%	37.0%	56.0%	38.9%
Hispanic	11.8%	32.2%	19.6%	33.6%
Other/Unknown	11.0%	9.1%	5.2%	17.9%
Black (African American)	7.8%	5.2%	0.4%	3.5%
Asian	-	-	15.8%	2.5%
Native American	1.8%	2.1%	19.6%	1.8%
Asian Indian	0.5%	0.8%	0.7%	1.6%
Native Hawaiian or Pacific Islander	-	-	0.1%	0.2%

Source: 4Q2023 & 4Q2024 Partnership Grievance & Appeals Pulse Report, Partnership HealthPlan of California

Members who speak English continue to report grievances much more frequently than those who speak other languages or use sign language. See Figure 19 below.

Figure 19: G&A Pulse Report by Members Language vs. Partnership Overall Language Profile

3Q24 % CASES BY LANGUAGE		
Member Language	% Cases	% Membership
English	90.6%	76.2%
Spanish	8.0%	20.5%
Other	1.1%	2.0%
Russian	0.0%	0.6%
Punjabi	0.1%	0.5%
Tagalog	0.1%	0.3%
Grand Total	100.0%	100.0%

Source: 4Q 2024 Partnership Grievance & Appeals Pulse Report, Partnership

The percentage of English-speaking members who reported grievances decreased from 93.0% in 2023 to 90.6% in 2024. Grievances in Partnership's other languages were low in 2024, however, compared to 2023, grievances in Spanish and Other increased from

2023 to 2024. A lack of grievances can be a sign of lack of trust in an organization. Since trust is important for certain health outcomes,[67] this data suggests there is a disproportionate number of English members reporting their grievances compared to LEP members and therefore a need to be addressed.

Table 19: Grievances by Language over Time

Language	2023 % of Cases	2023 % of Membership	2024 % of Cases	2024 % of Membership
English	93.0%	78.0%	90.6%	76.2%
Spanish	5.6%	19.4%	8.0%	20.5%
Other	0.9%	1.9%	1.1%	2.0%
Tagalog	0.1%	0.4%	0.1%	0.3%
Russian	0.3%	0.3%	0.0%	0.6%
Punjabi	-	-	0.1%	0.5%

Source: 4Q2023 & 4Q2024 Partnership Grievance & Appeals Pulse Report, Partnership HealthPlan of California

2. Diversity, Equity, and Inclusion Training

a. Partnership Staff Training

Partnership is committed to ensuring both staff and members feel included and have equal opportunities for their mental, social, and physical wellbeing. One of the ways Partnership addresses inclusion is through an annual Health Equity Week for staff. A project team designs emails, videos, and interactive activities to raise staff awareness of the diversity of Partnership's employees and members, and how to respectfully interact with others. Health Equity Week 2025 will continue to take place in April. Below are the results of Health Equity Week 2024.

Table 20: LMS Completion Report for Health Equity Week 2023 Activities

LMS Activity	Total Completions
Health Equity Week 2024: A Conversation with Partnership's Dr. Mohamed Jalloh & Hannah O'Leary	236
Health Equity Week 2024: Gena, a Member's Story	266

[67] BMC Primary Care, 2024

Health Equity Week 2024: Madeline, a Member's Story	280

Source: LMS Training Report; Partnership Human Resource Department, 2024

Partnership also offers virtual and recorded training sessions for all staff to remind them of the legal rights of our diverse team and to educate them on how best to include others in office activities. There are at least 2 mandatory educational sessions per year. As additional training opportunities arise, they are made available to staff based on interest or assignment. Human Resources tracks staff participation through the Learning Management System (LMS). As of December 31, 2024, there were 1,307 Partnership employees.[68] In 2024, Partnership employees completed the following trainings:

Table 21: Training Sessions for Partnership Staff

Total Completion	Partnership Training Sessions	Staff Assignment
1421	Diversity Basics: Foundations	Assigned to all staff in April 2024 and all new hires, temps, & contractors
445	Cultural & Linguistics Program Overview and Staff Training	Assigned to new hires and temps only
443	Affordable Care Act – Section 155	Assigned to new hires and temps only
280	Health Equity Week 2024: Madeline, a Member's Story	Optional training for all Partnership staff
266	Health Equity Week 2024: Gena, a Member's Story	Optional training for all Partnership staff
236	Health Equity Week 2024: A Conversation with Partnership's Dr. Mohamed Jalloh & Hannah O'Leary	Optional training for all Partnership staff
20	Improving Health Outcomes for People Living in The Crisis of Poverty	Optional training for all Partnership staff
24	Tale of Two Zip Codes	Optional training for all Partnership staff
1	Partnership's Health Equity Journey: The Present	Optional training for all Partnership staff

[68] Partnership Human Resources, 2024

Source: Partnership Human Resources, 2024

To promote awareness and understanding of diversity, equity, and inclusion, Partnership will continue to identify and mandate high-quality staff training(s) on an annual basis. Some staff may seek further training opportunities to gain better insight into their peers and Partnership's population. In 2025 and beyond, DEI trainings for Partnership will evolve to align with new DHCS regulatory requirements.

b. Provider Training

Partnership is committed to enhancing the member experience by actively reviewing and offering training to contracted providers, with a focus on reducing unintended bias, discrimination, and health disparities. In 2024, Partnership's Cultural and Linguistic/Health Education Team reviewed and updated the comprehensive toolkit designed to help providers document patient language needs in medical records, utilize interpreter services, and refer patients to culturally and linguistically appropriate community programs. Additionally, Partnership offers an on-demand Cultural and Linguistic training webinar for providers and their staff, ensuring they receive the necessary tools to improve cultural competency and communication with patients. Furthermore, Partnership provides cultural awareness and sensitivity training for all contracted providers and their employees who interact with members of the Seniors and People with Disabilities population, supporting a more inclusive and effective healthcare experience.

Partnership's Director of Health Equity developed a training program in 2024 to align with DHCS's APL 24-016 Diversity, Equity, and Inclusion Training Program Requirements.[69] In 2025 and beyond, Partnership will begin offering providers regular DEI training to align with NCQA and DHCS quality standards.

V. Review of Activities, Resources, and Opportunities

Over the past 25 years, Partnership has cultivated strong relationships with the provider community, public health, and community-based organizations on behalf of its members. As of January 2024, Partnership has established 6 regional offices to maintain a community presence and ensure members have local access to someone who can address their concerns.

[69] APL 24-016 Diversity, Equity, And Inclusion Training Program Requirements

Each year Partnership leadership takes the opportunity to review existing programs, resources, and structures to ensure they meet member needs. Department directors collaborate with the executive team to review Partnership's strategic plan and ensure Partnership resources are aligned with its mission and the evolving environment. Departments prepare their budgets to ensure staffing, talent, and knowledge are available to meet Partnership's various initiatives. The 2025 PNA demonstrates how Partnership addresses member needs through various activities. To best support both health and overall wellbeing, Partnership works closely with provider and community resources to ensure members have access to a wide range of services. However, this PNA also revealed opportunities to address needs in the areas of organizational structure; social and environmental needs; member health and wellness; access to care; health disparities; and health education and culture and linguistics.

A. Organizational Structure

In 2024, Partnership hired two new regional directors. One director was hired to fill the role for the new Auburn (Eastern) region, overseeing Plumas, Nevada, Placer and Sierra Counties. The other director was hired to replace the director in the Santa Rosa (Southwest) region, overseeing Sonoma and Marin counties.

Partnership's new claims system was scheduled to go live in mid-2024 but has since been postponed to a later date. Once the new claims system is implemented, there are several other projects planned to help Partnership meet the needs of its population, including a move to a new Grievance platform (scheduled to go live in 2025), and integration of the planned DHCS PHM Service platform called Medi-Cal Connect. Medi-Cal Connect provides key stakeholders with the full story of an individual's benefits as well as health and population-level insights.[70] Medi-Cal Connect also grants Medi-Cal health plans, providers, and other key partners with access to data, tools, and assessments to improve health outcomes and drive equity throughout California. The new claims system will be sufficient for Partnership's future needs and provide a framework on which Partnership may build additional IT structures to meet the needs of the organization and our members.

The position of Director of Health Equity was filled in January 2023, overseeing internal staff equity, provider and non-provider contractor equity, member equity, and interventions designed to mitigate health disparities. In 2024, Health Equity branched off into its own department. To support this important work, the Health Equity department has hired several staff in 2024 with plans to continue growing the team in 2025.

[70] Medi-Cal Frequently Asked Questions, 2024

In 2024, Partnership hired a new Director of Population Health to oversee and implement a variety of initiatives. Within Partnership's Population Health department, there are teams who work to build relationships with community partners and other stakeholders; this work includes the recent mandate for Partnership to work collaboratively with the Local Health Jurisdictions in its service area on their Community Health Assessments (CHA) and Community Health Improvement Plans (CHIP). These teams represent Partnership at various county and community collaborative meetings and learn about the ongoing needs of communities. This is one way that Partnership remains informed about the needs of the counties and communities it serves. Through relationships established in these meetings, organizations work together to identify, conceptualize, and implement interventions for health concerns or disparities in the local communities. In addition to these community partner-facing teams within Population Health, Partnership's medical directors regularly meet with clinic medical directors to discuss the clinical needs of patients, and they work together to make connections and find solutions for the providers and the members. Finally, other Partnership teams attend community events, often hearing firsthand of various needs of Partnership's member.

There are also staff assigned to collect information about available community resources and make these resources available on Partnership's external website (see Appendix D for a full list of Community Resources resources). Additionally, internal staff may use these community resources to augment Partnership's program offerings through closed-loop referrals. Partnership members have the option to contact Partnership's Population Health Department to learn how to access local community resources. Population Health staff also routinely provide community resources to members during their various outbound call campaigns. Population Health staff track the resources provided to members, and conduct follow-up calls to ensure the resource(s) met the needs of the member. Partnership has identified many community resources that are integrated into member care and offers them as member needs arise. These community resources are sufficient for Partnership member needs, though they are continuously updated and improved as new resources emerge.

DHCS's California Advancing and Innovating Medi-Cal (CalAIM) project aims to expand community resources to meet member needs and encourages multi-sector collaboration to overcome social and environmental barriers to health. Partnership continues to look to community agencies and other organizations to implement community health workers, doulas, enhanced care management and community supports services to provide services to members in their communities and to support basic needs. The infrastructure to provide these services to members remains in progress, but many agencies are developing training programs to meet the need for these positions.

Partnership is working closely with provider groups and training organizations to develop this pool of workers and incorporate them into program offerings.

B. Social and Environmental Needs

1. Housing Shortage

Partnership's service area has a significant homeless member population and an even larger percentage of members who struggle to maintain housing. California has a shortage of affordable housing. In 2024, California's homeless population grew by 3% to over 187,000 people experiencing homelessness.[71] The local Community Health Assessments and the County Health Rankings data also highlight a lack of stable housing as a pressing issue. Housing and homelessness are chronic concerns for managed care plans; however, Partnership has dedicated staff and resources to manage these concerns and to collaborate with other community agencies in addressing these challenges. State funds and initiatives like the CalAIM Incentive Payment Program provide the means for managed care plans to offer grant funding to address housing concerns. Lastly, as part of DHCS's Incentive Payment Program (IPP), Partnership has awarded over $52 million to more than 100 CalAIM providers via grants to build capacity for programs such as Enhanced Care Management (ECM) and Community Supports (CS) services; both of these programs work to ensure the needs of the most vulnerable members are met.

2. Economic Instability (Low Income and Unemployment)

Partnership members experience more social and structural barriers to health and well-being than many in the state of California. Twenty of Partnership's counties have household incomes below California's state average.[72] The Community Health Assessments revealed that many of Partnership's counties face challenges around having sufficient employment and income. Unemployment can make it difficult for Partnership members to access basic needs like housing and food for themselves and their families. There are often insufficient resources in communities to provide living-wage jobs for residents. In collaboration with community partners, Partnership is working to increase workforce opportunities within its regions to address the widespread concerns of poverty, unemployment, and low household incomes.

In 2024, Partnership offered scholarships to Sacramento City College's Community Health Worker (CHW) Certificate Program to help create employment opportunities for

[71] The 2024 Annual Homelessness Assessment Report to Congress
[72] US Census Bureau, 2023

members. In 2024 there were two awardees. Partnership also contracts with organizations that serve as Supervising CHW providers. These organizations provide CHW services to Partnership members. Some of these efforts included working to build out a CHW training program using pharmacy technicians who are certified as CHWs and exploring how to expand the CHW network in collaboration with interested local public health departments as part of the newly mandated CHA/CHIP work. Finally, Partnership is offering a Member Scholarship Program aimed at helping our members secure funding towards education with a focus on health care, social work, or public service (see Appendix C). These local efforts have potential to create new jobs in Partnership's service area, which can ultimately help improve economic stability of the communities we serve.

3. Air Quality and Wildfires

Many Partnership members live under the persistent threat of wildfires. Wildfires can lead to poor air quality, loss of housing, stress and anxiety, and long-term effects from these factors. Created in 2023, Partnership continued to use the Fire and Disaster Reporting email inbox for internal reporting, monitoring, and notifications around disasters in Partnership's service area that happened in 2024. The inbox is used as a tool to share information with other member- and provider-facing departments within Partnership HealthPlan in the event an environmental disaster threatens to affect members, providers, or the community. In 2024, during instances of a sizable fire or natural disaster, Partnership staff sent out informational emails from the Fire and Disaster Reporting inbox to keep leaders within the organization apprised of the situation(s). This allowed for seamless and centralized internal communication and enabled member- and provider-facing departments to be prepared to support members in their time of need.

Another way Partnership supported member engagement with this topic was through posting materials to Partnership's website. These materials are comprised of a Disaster Preparedness booklet and Emergency Kit Pocket Card. The booklet included information on creating an action plan, preparing an emergency kit, and listed common emergency resources available throughout the state. It also included a QR code that links members to Partnership's community resource pages if they want more information. The pocket card is a small checklist of items to pack in an emergency kit and go-bag in the event of an emergency. The pocket card can be printed out and easily stored in an emergency bag or in an easy-to-access space within the home for use. The resources allocated to these efforts are sufficient for Partnership member needs.

C. Member Health and Wellness

1. Chronic Disease

HEDIS performance measure reporting provides some insight into the overall health and wellbeing of health plan members. DHCS continues to rollout various programs under CalAIM, including the ever-evolving Population Health Management (PHM) Policy Guide.[73] The PHM Policy Guide includes a variety of ongoing mandates, including a mandate for Managed Care Plans to include chronic disease basic population health management (BPHM) programs that address hypertension, diabetes, asthma, and depression. In 2024, Partnership worked to refine these programs, including setting eligibility criteria focused on specific populations. These programs continue to align with PNA findings showing that hypertension, depression, and tobacco use are the most common chronic diseases in our adult population in 2024.

To combat hypertension, Partnership collaborated with providers and other community agencies to provide member education and referrals for recently diagnosed individuals. Partnership developed an outreach campaign to encourage members to attend regular doctor appointments, take anti-hypertensive medications as prescribed, and make healthy lifestyle changes. In 2024, as a result of identified disparities, Partnership modified its hypertension intervention to focus primarily on African American, Native American/Alaska Native, and Native Hawaiian/Other Pacific Islander members as part of Partnerships Populations of Focus. The core components of the modified intervention will generally remain the same. There are sufficient resources to perform this new program, and Partnership will review its efficacy in 2025.

Many Partnership counties have adult smoking rates that are higher than the state average. As a result of this finding, Partnership's Population Health Department continues to ask questions about smoking behavior to our members during outbound call campaign scripts for all campaigns. In 2024, Partnership also explored conducting health education sessions around tobacco prevention in certain counties with high tobacco usage. Partnership plans to conduct these sessions in 2025; efficacy of these sessions will be reviewed.

Partnership members in all regions face health challenges, though there are regional variations in health. For example, pediatric members with asthma who live in Partnership's Northern Region may have more difficulties controlling their asthma than those living in the Southern Region. Wildfires are more prevalent in Partnership's Northern Region than in the Southern Region, and this may contribute to the poorer

[73] Department of Health Care Services DHCS, 2024

asthma control. There may be other contributing factors as well. In order to better support members with asthma, Partnership's Pharmacy department created an asthma management program for adults with asthma emergency department visits. This program was piloted from August 2022 to February 2023. The results of the pilot showed improvement in several of the outcomes that were tracked, including the number of members who reached the AMR target of 0.5 compared to a control group. However, a major limitation to continuing the project in its original form was pharmacist time.

Due to programmatic challenges, and to align with CalAIM BPHM, the project was modified and is now run by Population Health. The new Asthma Emergency Department (ED) Visit Outreach Program Campaign was rolled out at the end of 2024. The Asthma Management campaign will offer additional support to members who were recently seen in the ED for their asthma. Members will receive an asthma education handbook and those who may want additional help can speak with a pharmacist who can provide education on effective self-management of their asthma and use of medications. Effectiveness of this program will be assessed in the future. There are sufficient resources to perform this new program.

The top 3 chronic diseases found among Partnership children in 2024 were mental health concerns (anxiety, trauma/stress, and depression). The CDC states that children with ADHD often have other coexisting conditions (including anxiety disorder).[74] As such, one way Partnership addressed mental health conditions in children was through weekly ADHD new start reports. These helped identify Partnership primary members aged 6-12 years old that had filled a new ADHD medication. The Pharmacy team sent fax notifications to prescribers alerting them that their patient had filled a new ADHD medication, and encouraged the scheduling of a follow-up appointment within 30 days of the medication fill date. Follow-up calls were made after fax was sent to confirm receipt. The results from the intervention conducted March through December 2023 showed an improvement in follow-up care rate when compared to the baseline rate from MY2022. Data results from the intervention were collected through February 2024. The project is slated to continue in 2025 with some modifications. There are sufficient resources to perform this new program.

Partnership's local community needs assessment showed that substance use is a pressing concern in Partnerships communities. Furthermore, in alignment with DHCS mandates,[75] Partnership recently conducted outreach to members with low utilization of

[74] CDC, 2024
[75] APL 24-012 Non-Specialty Mental Health Services: Member Outreach, Education, And Experience Requirements

non-specialty mental health services, demonstrating that some populations are not effectively utilizing these services. As part of efforts to improve poor behavioral health outcomes, which can go hand in hand with substance abuse,[76] Partnership is actively participating in and supporting our school partners through implementation of the new Multi-Payer Fee Schedule which includes new and expanded behavioral health provider types. There are sufficient resources to perform this new program.

Depression was the second most common chronic condition among Partnership members in 2024. As such, Partnership has also continued to refine its BPHM program which offers to help manage depression for members who recently suffered a stroke or a myocardial infarction. This program will meet DHCS requirements for a depression intervention program and test the benefits of having non-clinical staff provide lifestyle coaching for depression. It is possible that members who had a recent depression diagnosis have also recently suffered a recent stroke or a myocardial infarction. Therefore, this BPHM program has potential to decrease the number of Partnership members diagnosed with depression in the future. Currently, Partnership has staff dedicated to this program, although more staff resources are budgeted should current staffing prove insufficient.

2. Health Screening

To address the need for cancer screenings, Partnership continues to collaborate with Alinea Medical Imaging to bring mobile mammography imaging to rural communities and health centers lacking access to mammography sites. Mammography is a proactive screening that detects breast cancer, and providers have the opportunity to follow up with anyone who had findings on their imaging. Throughout 2024, there were 72 mobile mammography days conducted in 19 Partnership counties (Butte, Colusa, Del Norte, Glenn, Humboldt, Lake, Marin, Mendocino, Modoc, Nevada, Shasta, Siskiyou, Solano, Sonoma, Sutter, Tehama, Trinity, Yolo, Yuba). In 2024, there was some improvement in breast cancer screenings in comparison to the previous measurement year. This modest improvement helps demonstrate the success of this collaboration and will continue in 2025 to reach more members. There are sufficient resources for this endeavor.

Partnership's Women's Health and Perinatal Workgroup conducted a 6-month Cervical Cancer Screening Self-Swab pilot project in early 2024. There were 5 Primary Care Provider practices participating, with plans to pilot tests of 200 Partnership members. This workgroup closed out the Cervical Cancer Screening self-swab pilot project in September 2024. Eighty-nine of the 200 self-swab kits were used by the close of the

[76] NIH, 2023

project. Due in large part to technical and logistical issues with the self-swab kit vendor, only 3 of the 5 initial providers were able to participate in the program. In July of 2024, the FDA approved self-swab as a sample collection methodology in a health care setting. The pilot has given Partnership great insight into how we can best support providers to adopt this method into their workflow and improve our members' access to valuable cancer screening.

Partnership also started a colorectal cancer screening pilot project in 2022 along with Exact Sciences to increase the number of colorectal cancer testing. Partnership continues to support our providers using the bulk ordering option for colorectal cancer screening with Exact Sciences. The goal is to increase the number of colorectal cancer testing among the 45 years of age and older population.

3. Wellness Care

Partnership continues to make significant investments into expanding services for maternal and child health. Partnership performs outreach to all members with babies from ages 0-30 months and children ages 3 to 6 years, offering incentives to attend well-care visits and encouraging vaccinations. Additional outreach campaigns are targeting pre-teen visits for vaccinations and wellness visits. Furthermore, Partnership has allocated staff, and time to collaborate with public health officers, and other necessary stakeholders in the exploration and planning of school-based clinics, and other strategies to promote childhood wellness care. The resources allocated are sufficient for these efforts, and Partnership will evaluate the impact of these activities through appropriate reports, monitoring efforts, and multi-disciplinary committees as appropriate.

D. Access to Care

Partnership operates in a broad service area encompassing urban, suburban, rural, and frontier settings. Partnership's provider network is challenged by a national shortage of providers, and an aging provider community. Because of this, Partnership continues to sponsor a workforce development program called the Provider Recruitment Program (PRP). The PRP offers a sign-on bonus for providers when they contract with Medi-Cal for the first time, and/or if they come from a county outside of the ones that Partnership serves (see Appendix E). Partnership also continues to support a Provider Retention Initiative (PRI) program. The PRI is intended to recognize primary care clinicians who have devoted their careers to the safety net, while helping to incentivize additional years of service from them. The hope is to preserve institutional knowledge and clinical leadership in Partnership networks (Appendix F). Although this work is already in place,

a long-term strategy is essential to address the provider shortage in Partnership's service area.

With oversight from Partnership's Board of Commissioners, and in collaboration with state and national initiatives, Partnership continuously works to make the provider recruitment program effectively support expanded access to primary care. In particular, Partnership is expanding efforts to strengthen recruitment of PCPs, behavioral health providers, mid-levels, and targeted specialists in the areas where access is impacted most.

Finally, Partnership works to prevent loss of access to care. Efforts include a variety of activities, such as:

- Continuing to support a primary care program using a telehealth service called TeleMed2U (see Appendix G)
- Continuing to support the mobile mammography program centered around providers located in areas without imaging centers or in proximity to imaging centers with significant access barriers
- Supporting a modified Quality Improvement program (QIP) that focuses on providers that are the lowest performing in the Primary Care Provider (PCP) QIP
- Continued support of the QIP program for primary care
- Utilization of Partnership's Transportation Services to allow members to attend provider appointments

E. Health Disparities

The PNA revealed notable care gaps between racial/ethnic groups, particularly from the HE 6: Reducing Healthcare Disparities report. For Controlling High Blood Pressure (CPB), the 'Some Other Race' group had the lowest rates of control (55.10%), while the Black/African American population had the highest rates (67.14%); all racial categories hit the 25th percentile MCAS benchmark for this measure. In Hemoglobin A1c Control for Patients with Diabetes (HBD), the Native Hawaiian and Other Pacific Islander (50%), American Indian and Alaska Native (44.16%), and Black or African American (40%) populations had significantly higher rates of poor control, performing below the MPL – 50th percentile. In contrast, the Asian population had the lowest rate of poor control (21.7%), performing above the 90th percentile, indicating better control of diabetes. For Child and Adolescent Well Care Visit completions, the Hispanic/Latino (51.32%), and "Some Other Race" category (50.32%) had higher rates compared to other groups, both of which hit the 50th percentile MCAS benchmark for this measure. The Native Hawaiian and Other Pacific Islander population had the lowest rate of completion (36.91%), suggesting disparities in access to well-care visits. Regarding timely prenatal care, the

Asian population had the highest rates of completion (91.67%), while the Native Hawaiian and Other Pacific Islander population had the lowest (50%), and was 1 of 3 racial groups to not hit the 50th percentile MCAS benchmark for this measure. Finally, for postpartum care, Native Hawaiian and Other Pacific Islanders had the highest rates of postpartum care (100%), while the American Indian and Alaska Native population had the lowest (69.44%) and was the only racial category that did not hit the 50th percentile MCAS benchmark for this measure. These findings highlight significant health disparities across various racial/ethnic groups, with certain populations experiencing lower levels of care and worse health outcomes compared to others.

Partnership will continue to perform outbound call campaigns that encourage the perinatal population to attend their pre and postpartum appointments and encourages families to attend well-child visits with their children. In addition to these efforts, Partnership also recently hosted a photoshoot aimed at increasing prenatal and postpartum care and well child visit rates among African American/Black, Alaska Native/American, and Hispanic pregnant members. This short-term intervention aimed to increase supportive community interactions and social support, raise awareness and promote the use of available benefits, and connect members with doula services and Partnership's outbound call campaign programs. Partnership plans to expand this intervention in 2025 into three events with different focuses. Events are intended to focus on efforts to connect pregnant members to perinatal resources, offer a no-cost setting for professional development, and encourage vaccines typically received during pregnancy. These efforts will be evaluated in 2026. Partnership will also continue to participate in efforts that support members recently diagnosed with hypertension and diabetes, with special emphasis on the African American, Native American/Alaska Native, and Pacific Islanders populations.

Lastly, American Indian/Alaska Native populations face many health disparities, with recent health disparities data demonstrating lower completion rates of postnatal care visits among this population. Due to historic lack of trust in government and other challenges, traditional QI approaches have had limited success. As such Partnership will continue its strategy to strengthen relationships and collaborative efforts with tribal health providers within its service area to decrease known health disparities among American Indian/Alaska Native (AI/AN) members. Many of these strategies are described in Partnership's Tribal Health Engagement Strategic and Tactical Plan.

Partnership has also been an active participant in tribal perinatal efforts. One effort is creating homegrown collaboratives to identify needs and work towards interventions. For example, in Siskiyou County, these efforts aim to streamline collaboration among clinical and community initiatives to support perinatal care and education, expand

cultural awareness across the health system and build provider skillsets for addressing pregnancy related urgencies. There are also Native American driven efforts focused on providing community support to access and education for pregnant individuals and families in which Partnership plays a supporting role.

Lastly, Partnership continues to grow its Tribal Liaison position to provide a more formal point of contact and advocate for AIAN needs in alignment with new DHCS mandates. While there are sufficient resources currently allocated to strengthen existing relationships, Partnership will continue to explore modifying our programs as additional health needs are identified.

F. Health Education, Culture & Linguistics

Partnership has an ongoing concern that its members lack knowledge around their benefits and how to use them. While managed care plans have several departments dedicated to member support, Partnership recognized an opportunity to support efforts to increase member awareness of Partnership benefits, including development of videos, written materials, and the distribution of educational materials at community outreach efforts in various threshold languages as appropriate. One example is heavily promoting the Growing Together Program to Partnership's providers and community partners; this program promotes well-child visits and perinatal care with (see Appendix B for the update flyer).

Another example is Partnership's Member Services staff conducting in-person presentations. These presentations are referred to as "Member (or Community) Informative Sessions" and provide an educational and collaborative forum for new members and county partners while also building upon our organizational branding campaign centered around "Your Partner in Health". At these sessions, Member Services staff provide an overview of Partnership's services and the resources that are available to members. While onsite, Member Services staff provide in-the-moment support, helping members navigate their transition into Partnership. Partnership conducts these sessions primarily in English and Spanish. Sessions may also be conducted in other languages and are available on request. The overall goal with these sessions is to ensure Partnership members and community partners gain knowledge about Partnership's benefits and services, and to leave a positive and lasting impression that Partnership is responsive and here to support all the communities we serve. Partnership will also continue to collaborate with community groups and plans to offer educational sessions to members about available benefits like vision, mental health services, and preventative care services.

Partnership also offers robust Community Resource pages on our external website (see Appendix D). These pages are a collection of local resources that are meant to supplement member needs. Each of Partnership's counties has a dedicated county page. Partnership members also have the option to contact Partnership's Population Health Department to learn how to access local community resources. Population Health staff also routinely provide community resources to members during their various outbound call campaigns. Population Health staff track the resources provided to members, and conduct follow-up calls to ensure the resource(s) met the needs of the member. These community resources are sufficient for Partnership member needs, though they are continuously updated and improved as new resources emerge.

Member grievance data provides insight into member engagement with the health plan, their experience of culturally and linguistically appropriate care, and reported rates of discrimination. Members who want to report grievances with their care must know how to report grievances using the appropriate channels and feel some assurance that their concerns will be taken seriously. Therefore, Partnership uses reported grievances as a proxy for trust in the agencies against whom the grievance is filed. While a general lack of trust in government and institutions may be the root cause for some distrust, Partnership works to overcome this through demonstrating responsiveness to member needs, as reflected in interactions with our members. This effort is ongoing and, while there are sufficient resources allocated, there are likely more opportunities to educate members on their rights and how to exercise them.

Finally, in alignment with DHCS and NCQA objectives, Partnership will continue its own organizational culture of diversity, equity and inclusion by offering regular staff and provider trainings. The goal of these trainings are to engage staff and providers in topics relating to equity (e.g., race, ethnicity, gender, and more) and the barriers members experience that prevent them from being healthy. Partnership also hosts an annual Health Equity Week to educate on and promote health equity for its members and staff. Activities from Health Equity week 2024 included a staff town hall highlighting health equity efforts, staff interviews, member stories, and more. Finally, Partnership's Director of Health Equity has also been tasked with developing a mandatory Diversity, Equity, and Inclusion training for all Partnership network providers and other relevant stakeholders; a pilot rollout will go live mid-2025.

VI. Stakeholder Engagement

Partnership solicits stakeholder engagement on the PNA through multiple pathways. The Population Health department uses reports from pertinent departments to draft the report. The Quality Improvement and Health Equity Committee (QIHEC) and Population

Needs Assessment Committees review and provide feedback as needed on the final draft of the PNA, along with any proposed interventions. Population Health staff gather member feedback through Partnership's Community Advisory Committee (CAC) (formerly known as the Consumer Advisory Committee) and Family Advisory Committee (FAC). The CAC reviews findings from the annual PNA, along with any proposed recommendations, and their feedback is incorporated in the final report as appropriate.

The PNA then undergoes review by Partnership's Internal Quality Improvement (IQI) Committee, Partnership's Quality/Utilization Advisory Committee (Q/UAC), Partnership's Physician Advisory Committee (PAC), and by Partnership's Board of Commissioners before submission to the National Committee for Quality Assurance (NCQA) annually, and as part of DHCS regulatory requirements.

Once final, the PNA is made available in a variety of forums for use and strategic planning by contracted health care providers, practitioners, and allied health care personnel. These forums may include, but are not limited to, provider newsletters, Provider Online Services via Partnership's website, HEDIS training, and the Community Report. Furthermore, the PNA is posted on Partnership's internal and external websites. Lastly, Partnership identifies pertinent information related to member needs in the report and uses that information to update current activities and design new interventions to address the identified needs as necessary.

VII. Works Cited

1. Banner Lassen Medical Center. (2022). Banner Health 2022 CHNA: Retrieved from https://www.bannerhealth.com/-/media/files/project/bh/chna-reports/2022-new/california/banner-lassen-medical-center-susanville.ashx
2. Borsky, A., et. al. (2018). Few Americans Receive All High-Priority, Appropriate Clinical Preventive Services. *Health Affairs.* VOL. 37, NO. 6. https://doi.org/10.1377/hlthaff.2017.1248
3. Butte County Health and Human Services. (2024). *Butte County Community Health Assessment* (Revised April 20, 2024). Retrieved from https://www.buttecounty.net/DocumentCenter/View/12035/Butte-County-Community-Health-Assessment-Revised-on-April-20-2024-PDF
4. Butte County Health and Human Services. (2024). *Butte County Community Health Improvement Plan (CHIP) 2024-2027*. Retrieved from https://www.buttecounty.net/DocumentCenter/View/14331/Butte-County-CHIP-2024-2027
5. Cal Fire. (2024). Cal Fire 2024 Incidents. Retrieved from 2024 Fire Season Incident Archive | CAL FIRE
6. California Department of Public Health. (2024). Results of the 2023 California Youth Tobacco Survey. Retrieved from https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/CTCB/CDPH Document Library/ResearchandEvaluation/SurveyInstrumentsTrainingManualsAndProtocols/CYTS2023AnnualReport_FINAL.pdf
7. Center for Disease Control and Prevention (CDC). (2024). *Diseases that Vaccines Help Protect Against.* Retrieved from https://www.cdc.gov/vaccines-children/diseases/index.html
8. Centers for Disease Control and Prevention. (2023). *Physical activity and health: A report of the surgeon general*. Centers for Disease Control and Prevention. December, 2024, from https://www.cdc.gov/physical-activity/php/about/index.html
9. Center for Disease Control and Prevention (CDC). (2023). Smoking and Tobacco Use Second Hand Smoke. Retrieved from https://www.cdc.gov/tobacco/secondhand-smoke/index.html
10. CDC (2024). *Attention-Deficit / Hyperactivity Disorder (ADHD): Other Concerns and Conditions with ADHD.* Retrieved from https://www.cdc.gov/adhd/about/other-concerns-and-conditions.html#cdc_generic_section_3-anxiety-and-depression
11. Colusa County Health and Human Services, Public Health Division. (2023). Colusa County Community Health Assessment. Retrieved from https://acrobat.adobe.com/id/urn:aaid:sc:va6c2:786755c1-f220-46c6-ac69-bcbf0175a14a

12. Coren, A., and Miller, J. (April 2023). *2023 Mendocino County Community Health Improvement Plan".* Mendocino County Public Health Department. Retrieved from https://www.mendocinocounty.org/home/showpublisheddocument/61104/638338395370100000
13. County Health Rankings and Roadmaps. (2024). Air Pollution. Retrieved from https://www.countyhealthrankings.org/health-data/health-factors/physical-environment/air-and-water-quality/air-pollution-particulate-matter?state=06&year=2024
14. County Health Rankings and Roadmaps. (2024). California. Retrieved from https://www.countyhealthrankings.org/health-data/california?year=2024
15. County Health Rankings & Roadmaps. (2024). *Food Environment Index*. County Health Rankings & Roadmaps. Retrieved from https://www.countyhealthrankings.org/health-data/california?year=2024
16. County Health Rankings & Roadmaps. (2024). *Primary care physicians*. University of Wisconsin Population Health Institute. Retrieved from https://www.countyhealthrankings.org/health-data/health-factors/clinical-care/access-to-care/primary-care-physicians?year=2024&tab=1
17. County Health Rankings and Roadmaps. (2024). Severe Housing Problems. Retrieved from https://www.countyhealthrankings.org/health-data/health-factors/physical-environment/housing-and-transit/severe-housing-problems?year=2024&state=06
18. Department of Health Care Services, (2022). *Non-Specialty Mental Health Services*. Retrieved from https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/D84845A9-9DA6-434D-8B97-00CD24F101E7/nonspecmental.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO
19. Department of Health Care Services. (2023, December 20). APL 23-031 - Medi-Cal Managed Care Plan Implementation Of Primary Care Provider Assignment For The Age 26-49 Adult Expansion Transition. Retrieved from https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx
20. Department of Health Care Services. (2024). *All Plan Letter 24-016: Diversity, equity, and inclusion training program requirements (supersedes APL 23-025)*. California Department of Health Care Services. https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL%202024/APL24-016.pdf
21. Department of Health Care Services. (September 17, 2024). *All Plan Letter 24-012: Non-Specialty Mental Health Services: Member Outreach, Education, And Experience Requirements.* California Department of Health Care Services.

https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL%202024/APL24-012.pdf.
22. U.S. Department of Housing and Urban Development. (2023, November 20). *HUD 2024 Continuum of Care Homeless Assistance Programs Homeless Populations and Subpopulations.* HUD Exchange. Retrieved from https://files.hudexchange.info/reports/published/CoC_PopSub_State_CA_2024.pdf
23. U.S. Department of Housing and Urban Development. (December 2024). The 2024 Annual Homelessness Assessment Report (AHAR) to Congress. HUD User. Retrieved from https://www.huduser.gov/portal/sites/default/files/pdf/2024-AHAR-Part-1.pdf
24. Diaz, H., Schmedtlein, M., Ainsworth, D., & Van, T. (April 2022). *2022 Community Health Needs Assessment Key Findings Report Summary Siskiyou County.* Community Health Insights. Retrieved from https://drive.google.com/file/d/1fHL76rwlZw1jDDdao2_g6R_ck2sg3A4u/view
25. Environmental Protection Agency (EPA). (2024). Retrieved from https://www.epa.gov/wildfire-smoke-course/health-effects-attributed-wildfire-smoke
26. Glenn County Health and Human Services Agency, Public Health. (2024). *Glenn County Community Health Assessment Report*. Retrieved from https://www.canva.com/design/DAGJdHCipAA/k754x3-yUGFlDeQGt6qqIQ/view?utm_content=DAGJdHCipAA&utm_campaign=designshare&utm_medium=link&utm_source=editor
27. Healthy People 2030. (2020). *Social Determinants of Health*. Social Determinants of Health - Healthy People 2030. https://health.gov/healthypeople/priority-areas/social-determinants-health
28. Healthy Marin Partnership. (2022). *Marin County 2022 Community Needs Assessment: A Summary of Key Findings*. Retrieved from https://www.healthymarin.org/content/sites/marin/FINAL_2022_CHA-HMP_V.2.pdf
29. Healthy People 2030. (2024). Retrieved from https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/employment
30. Healthy People 2030. (2023). Retrieved from https://health.gov/healthypeople/objectives-and-data/browse-objectives/preventive-care.
31. Humboldt County Department of Health & Human Services, Public Health. (2018). Humboldt County Community Health Assessment. Retrieved from https://humboldtgov.org/DocumentCenter/View/71701/2018-Community-Health-Assessment-PDF

32. Humboldt County Department of Health & Human Services, Public Health. (2022). *Humboldt County Enhanced Community Health Assessment.* Retrieved from https://humboldtgov.org/DocumentCenter/View/110760/CHA-Enhancement-2022-PDF
33. Lake County California: 2022 Community Health Needs Assessment. (2022). County of Lake, Public Health. Retrieved from https://www.lakecountyca.gov/ArchiveCenter/ViewFile/Item/569
34. Lerch, Seraina, et. al. (2024). A model of contributors to a trusting patient-physician relationship: a critical review using systemic search strategy. *BMC Primary Care*. Retrieved from https://bmcprimcare.biomedcentral.com/articles/10.1186/s12875-024-02435-z.
35. Medi-Cal Connect: Frequently Asked Questions, (2024). https://www.dhcs.ca.gov/CalAIM/Documents/Medi-Cal-Connect-Overview-QA.pdf
36. Modoc County Public Health. (2024). *Modoc County Community Health Needs Assessment.* Retrieved from https://webgen1files.revize.com/modochealth/Modoc%20County%20Community%20Health%20Needs%20Assessment%20Final%2001-31-24.pdf
37. Napa 2024 Community Health Improvement Plan. (2024). Napa County Health and Human Services Agency, Providence Queen of the Valley Medical Center. Retrieved from https://www.livehealthynapacounty.org/uploads/5/1/4/4/51449431/2024_napa_county_chip_issued_november_2024.pdf
38. OASH, U.S. Department of Health and Human Services. (N.D). *Mental Health for Adolescents*. Retrieved from https://opa.hhs.gov/adolescent-health/mental-health-adolescents. Accessed March 2025.
39. Partnership HealthPlan of California Dashboard. (2024). 3rd Next Available Survey, 2024 Summary Dashboard.
40. National Institute of Mental Health (NIH). (March 2024). *Substance Use and Co-Occurring Mental Disorders*. Retrieved from https://www.nimh.nih.gov/health/topics/substance-use-and-mental-health.
41. Partnership HealthPlan of California. (2024). Partnership Integrated Claims and Encounter Data.
42. Partnership HealthPlan of California. (2024). Adult Telemedicine Appointment Details Report.
43. Partnership HealthPlan of California. (2024). Adult eConsult Utilization Report.
44. Partnership HealthPlan of California. (2024). Grievance & Appeals Pulse Report, Fourth Quarter 2024.
45. Partnership HealthPlan of California. (2023). Health Equity Standards – HE 6: Reducing Healthcare Disparities

46. Partnership HealthPlan of California (2024). Human Resources LMS Data for Health Equity.
47. Partnership Health Plan of California HEDIS Measures. (2024). HEDIS Annual Explorer.
48. Partnership HealthPlan of California. (2024). Mental Health Utilization Overview Data.
49. Partnership HealthPlan of California. (2024). PARS Report_1.1.2024-12.31.2024.
50. Partnership HealthPlan of California. (2024). 2023 Partnership Integrated Claims and Encounter Data.
51. Partnership HealthPlan of California. (2024). Partnership Membership Enrollment Data.
52. Partnership HealthPlan of California. (2024). Pediatric eConsult Utilization Report.
53. Partnership HealthPlan of California. (2024). Pediatric Telemedicine Appointment Details Report.
54. Partnership HealthPlan of California. (2024). Quality and Performance Improvement Program description.
55. Partnership HealthPlan of California Provider Relations. Trosky, R. (2024). Grand Analysis Report: Network Adequacy Report: Assessment of Network Adequacy
56. Partnership HealthPlan of California. (2025). *Medi-Cal Member Handbook*. P. 64, 85. Retrieved from https://www.partnershiphp.org/Members/Medi-Cal/Documents/MemberHandbook/MemberHandbook_ENG.pdf
57. Plumas County Health and Human Services. (2023). *Plumas County Community Health Improvement Plan 2023*. Retrieved from https://www.plumascounty.us/DocumentCenter/View/47101/Plumas-County-CHIP-2023-Final
58. Robert Wood Johnson Foundation. (2024). About Us. Retrieved from https://www.countyhealthrankings.org/about-us
59. SAIPE State and County Estimates for 2023 for California. (2024). Retrieved from https://www.census.gov/data/datasets/2023/demo/saipe/2023-state-and-county.html
60. Shasta County Health and Human Services, Public Health. (2023). *Shasta County Community Health Assessment*. Retrieved from https://www.shastacounty.gov/media/60661
61. Sierra County Public Health Department. (2023). Sierra County Community Health Assessment 2023. Retrieved from https://sierracounty.ca.gov/DocumentCenter/View/9346/Community-Health-Assessment-CHA-2023

62. Solano County Department of Public Health. (January 2023). Community Health Improvement Plan. Retrieved from https://www.solanocounty.com/civicax/filebank/blobdload.aspx?blobid=40374
63. Sonoma County Department of Health Services. (December 2023). Sonoma County Community Health Assessment and Improvement Plan. Retrieved from https://sonomacounty.ca.gov/Main%20County%20Site/Health%20and%20Human%20Services/Health%20Services/Documents/About%20Us/Public%20Reports/Phase1-Sonoma-CommunityHealthAssessmentImprovePlan-2023.pdf
64. Southern Humboldt Community Healthcare District. (2024). *Community health needs assessment 2024*. Retrieved from https://sohumhealth.org/app/uploads/2024/07/SHCHD_CHNA_2024.pdf
65. SPH Analytics. (MY) 2023 RY2024 CAHPS Medicaid Adult 5.1 Survey, Partnership HealthPlan of California
66. SPH Analytics. (MY) 2023 (RY) 2024CAHPS Medicaid Child 5.1 Survey, Partnership HealthPlan of California
67. SPH Analytics. (RY) 2024. At-A-Glance Report, (MY) 2023 Medicaid Adult CAHPS 5.1 H. 10.
68. SPH Analytics. (RY) 2024. At-A-Glance Report, 2023 Medicaid Child CAHPS 5.0 H. 10.
69. Sutter County Health and Human Services, Public Health. (2022). *Sutter County Community Health Assessment 2022*. Retrieved from https://www.suttercounty.org/home/showpublisheddocument/5794/637968489830900000
70. Sutter County Health and Human Services. (2023). *Sutter County Community Health Improvement Plan 2023-2028*. Retrieved from https://www.suttercounty.org/home/showpublisheddocument/6770/638339306743730000
71. Tehama County Health Services. (2023). *Tehama County Health Assessment.* Retrieved from https://www.tehamacohealthservices.net/wp-content/uploads/2023/10/2023-Tehama-CHA-FINAL.pdf
72. Trinity County Department of Public Health. (2023). Equity Assessment. Retrieved from https://www.trinitycounty.org/DocumentCenter/View/2530/Trinity-County-Equity-Assessment
73. World Health Organization. (2024). https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1
74. Yolo County. (2023). Community Health Assessment. Retrieved from https://www.yolocounty.org/home/showpublisheddocument/75735/638096518955230000

75. Yuba County Health and Human Services Department. (2022). 2022 Yuba County Community Health Assessment. Retrieved form https://cms7files.revize.com/yubaca/CHA%20Final%20(Print%20Version).pdf
76. Yuba County Health and Human Services. (2023). *Yuba County Community Health Improvement Plan*. Retrieved from https://cms7files.revize.com/yubaca/Yuba%20County%20CHIP%20-%20FINAL.pdf

VIII. Appendix A: HEDIS® MCAS Regional Performance Report Year 2024; Measurement Year 2023

Select Report Year
Report Year 2024; Measurement Year 2023

Select Provider Type
All Providers

HEDIS Regional Performance
Report Year 2024; Measurement Year 2023
Performance Relative to Quality Compass® Medicaid Benchmarks

PARTNERSHIP HEALTHPLAN of CALIFORNIA

- **Above HPL** (high performance level, based on NCQA's Quality Compass Medicaid 90th percentile)
- **Below MPL** (minimum performance level,based on NCQA's Quality Compass Medicaid 50th percentile)

	Regional Performance				National Medicaid Benchmarks			
Measures	NORTHEAST	NORTHWEST	SOUTHEAST	SOUTHWEST	25TH	50TH	75TH	90TH
Asthma Medication Ratio (AMR) - Asthma Medication Ratio*	49.92%	58.54%	69.61%	66.50%	58.94%	65.61%	70.82%	75.92%
***Breast Cancer Screening (BCS-E)*	50.00%	45.64%	59.95%	57.06%	47.09%	52.60%	57.48%	62.67%
Cervical Cancer Screening (CCS)	45.97%	58.72%	59.84%	61.75%	50.85%	57.11%	61.80%	66.48%
Childhood Immunization Status (CIS) - Combo 10	8.03%	18.98%	44.53%	37.47%	24.57%	30.90%	37.64%	45.26%
Chlamydia Screening in Women (CHL) - Total*	49.23%	51.78%	59.02%	57.40%	49.65%	56.04%	62.90%	67.39%
Controlling High Blood Pressure (CBP)	61.34%	63.14%	64.29%	64.75%	55.47%	61.31%	67.27%	72.22%
Follow-Up After Emergency Department Visit for Mental Illnes (FUM) - 30 Days Total*	30.34%	31.60%	27.35%	34.81%	47.01%	54.87%	64.29%	73.26%
Follow-Up After Emergency Department Visit for Substance Use (FUA) - 30 Days Total*	38.85%	32.46%	29.85%	30.00%	27.75%	36.34%	42.67%	53.44%
Hemoglobin A1c Control for Patients With Diabetes (HBD) - HbA1c Poor Control (>9%)	38.81%	33.15%	31.32%	33.06%	44.77%	37.96%	33.45%	29.44%
Immunizations for Adolescents (IMA) - Combo 2	20.19%	31.87%	51.82%	47.93%	29.44%	34.31%	40.88%	48.80%
Lead Screening in Children (LSC)	51.09%	64.96%	61.07%	59.37%	49.61%	62.79%	70.07%	79.26%
Prenatal and Postpartum Care (PPC) - Postpartum care	81.36%	82.19%	87.50%	93.71%	73.97%	78.10%	82.00%	84.59%
Prenatal and Postpartum Care (PPC) - Timeliness of prenatal care	85.30%	79.00%	88.75%	93.71%	79.63%	84.23%	88.33%	91.07%
Well Care Visits (WCV) - Total*	41.64%	48.03%	47.79%	49.45%	42.99%	48.07%	55.08%	61.15%
Well Child 30 (W30) - Well child visits for age15-30 months*	56.09%	65.44%	65.20%	67.47%	62.07%	66.76%	71.35%	77.78%
Well Child 30 (W30) - Well child visits in the first 15 months*	39.25%	45.26%	36.83%	46.28%	52.84%	58.38%	63.34%	68.09%

**- Administrative Measures. The entire eligible population is used in calculating performance (versus a systematic sample drawn from the eligible population for the hybrid measures). NOTE: Report excludes measures reported to DHCS where DHCS does not hold Managed Care plans accountable for meeting specific performance targets.*
****BCS-E In historical measurement years was named BCS. New data collections ECDS*
- HBD - HbA1c Poor Control is an inverted measure; a lower rate results in a better performance.
Note: AMR is a new measure held to MPL for MY2023

2

IX. Appendix B: Growing Together Program Flyer

PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

The Growing Together Program

Our Growing Together Program supports members during and after pregnancy, and children from birth up to age 3. This program is offered to Partnership members at no cost. Learn how the Growing Together Program can help you.

The Growing Together Program features:

The Prenatal Program – earn up to $50 in gift cards!

This program encourages early prenatal care. Members will receive a $25 gift card for getting their flu vaccine while pregnant, and another $25 gift card for getting their Tdap vaccine between 27 weeks and delivery. Call us to join as soon as you know you are pregnant.

You will also get:

- A welcome call upon referral
- Up to 3 check-in phone calls throughout the program
- Information about doula benefits
- Support for prenatal visits
- Referrals to care coordination
- Health education

The Postpartum Program – earn up to $100 in gift cards!

This program encourages postpartum and well-baby visits. Members will receive a $50 gift card for each of their 2 postpartum exams ($100 total) between 7 to 84 days after delivery.

You will also get:

- A welcome call upon having your new baby
- Up to 2 check-in calls throughout the program
- Help to enroll your baby into Medi-Cal
- Support for postpartum and well-baby visits
- Referrals to care coordination
- Health education

PartnershipHP.org (800) 863-4155 HealthEd175_102324

ACCREDITED NCQA HEALTH PLAN

The Healthy Baby Program – earn up to $200 dollars in gift cards!

This program encourages well-baby visits. Parents or caregivers will receive a $25 gift card each for taking their baby to the following visits:

- 2 well-child visits before 3 months
- 2 well-child visits before 9 months
- 2 well-child visits between 9-15 months
- 2 well-child visits between 15-30 months

Parents or caregivers can receive an extra $100 in gift cards if their baby receives all required vaccines, including 2 flu shots, by 24 months of age. A vaccine record must be submitted to Partnership's Population Health Department. Call us to enroll your baby as soon as they get Partnership.

You will also get:

- A welcome call
- Referrals to care coordination
- Check-in calls at 3, 7, 14, 22, 26, and 30 months
- Support for well-baby visits and the recommended screenings and vaccines

To learn more or sign up for the Growing Together Program, call us at **(855) 798-8764**, Monday – Friday, 8 a.m. to 5 p.m. TTY users can call the California Relay Service at **(800) 735-2929** or **711**. You can also email us at PopHealthOutreach@partnershiphp.org.

This notice does not change your Partnership benefits or keep you from getting the care you need.

X. Appendix C: Member Scholarship Program

PARTNERSHIP HEALTHPLAN of CALIFORNIA
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MEMBER SCHOLARSHIPS 2025

Apply for up to $10,000 Towards higher education!

Partnership HealthPlan of California is introducing our first-ever scholarship program for our members! **The Partnership Member Scholarship Program** provides one $10,000 scholarship and four $5,000 scholarships. Scholarships are awarded on the basis of: the quality of responses to essay questions; the strength of the applicant's expression of interest in a career in health care, social service, or public service; and a letter of recommendation.

Who can enter: Current Partnership members, those who were Partnership members within the past 12 months, or foster care youth who were Partnership members within the past three years. The entrant must show they intend to pursue a career in health care, social service, or public service and must be enrolled at or applying to a higher education institution and enrolled within one year of the application due date.

How to enter: Entrants must complete the application form including essay questions; obtain one letter of recommendation; and sign a waiver of confidentiality and release, as well as an accuracy statement. **Applications can be submitted from January 6 through February 28, 2025.**

Essay questions: (See application for details and word limits.)

1. How will your studies further your plans for a career in health care and/or human/public/social services fields? What are your career goals?
2. How has Partnership HealthPlan of California been a partner in your health/life? (This can be medical care, services, and/or supports that Partnership has helped provide.)
3. Optional: Is there anything else you want to share that makes you a good candidate to receive this award?

Scholarship winners: Partnership will review all entries and determine recipients. Scholarship winners will be announced in May 2025.

For more information, visit our Member Scholarship Program webpage.

If you have additional questions, email Communications@partnershiphp.org

XI. Appendix D: Community Resource Page

XII. Appendix E: Provider Recruitment Program

PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

Provider Recruitment Program

January 2024 Update

Partnership is pleased to announce the launch of a new 2024 Provider Recruitment Program (PRP) agreement for partners located in our 24-county region. The PRP's purpose is to help our contracted network recruit and retain high-quality health professionals in our region to improve access to care for Partnership members. This 2024 PRP adds new incentives and provider eligibility, among making other changes. Highlights include:

Program Incentives Available (payable over five years):

- **$100,000** for physicians (providing services in family medicine, internal medicine, pediatrics, obstetrics and psychiatry)
- **$120,000** for medical residents training in Partnership's 24-county region ($20K payable in program year three with a five-year commitment post-graduation)
- **$50,000** for nurse practitioners/physician assistants/certified nurse midwives (NPs/PAs/CNMs)

Newly Eligible Providers:
Obstetric providers (obstetricians, CNMs, family medicine physicians and NPs/PAs, women's health NPs) whose clinical care focuses on perinatal care, including labor and delivery

Behavioral Health Professionals Program Highlights / Incentives Available:

- **$20,000** signing bonus for licensed behavioral health professionals
  - Licensed clinical social workers
  - Licensed marriage and family therapists
  - Licensed professional clinical counselor
  - Licensed clinical psychologists
- **$4,000/$5,000** signing bonus for certified substance use disorder (SUD) and bilingual certified SUD counselors

New Application Process:
We've adopted a grant lifecycle management platform to help improve PRP application efficiency

Key Criteria

- Candidates must not have accepted an offer to practice at a partner site under the previous PRP.
- If the candidate is currently practicing, they must be from outside of Partnership's 24 counties.
- Providers in training or residency programs within Partnership's 24 counties qualify for support.
- A reasonable effort must be made to submit requests for program support before offers are made.
- Please see Partnership's PRP webpage for additional important program criteria.

Questions

Please contact the Workforce Development team with any questions or requests:
wfd@partnershiphp.org | (707) 430-4846

PartnershipHP.org (707) 863-4100 Eureka | Fairfield | Redding | Santa Rosa

ACCREDITED NCQA HEALTH PLAN

XIII. Appendix F: Provider Retention Initiative

PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

Provider Retention Initiative

January 2025

Partnership has updated the Provider Retention Initiative (PRI), which is now available and open for applications until June 30, 2025. The PRI is intended to recognize primary care clinicians, as well as those who offer perinatal services (including labor and delivery) and/or obstetrics/gynecology, who have devoted their careers to the safety net, while helping to incentivize additional years of service from them. Our hope is that the PRI will help preserve institutional knowledge and clinical leadership and mentorship within our network, while a younger generation of providers can learn from and train with these committed health professionals.

PRI eligibility is limited to practitioners who provide services to Partnership members with Partnership's contracted partners in our 24-county region.

Provider Program Highlights / Incentives Available:

- $45,000 award for doctor of medicine (MD) / doctor of osteopathic medicine (DO) – three-year commitment
- $30,000 award for nurse practitioner (NP) / physician assistant (PA) / certified nurse midwife (CNM) – three-year commitment

Award Payment Cycle:

Award	FY 24/25	FY 24/25	FY 25/26	FY 26/27
$45,000 MD/DO	$7,500	$7,500	$15,000	$15,000
$30,000 NP/PA/CNM	$5,000	$5,000	$10,000	$10,000

Key Criteria:

- Provider (MD/DO/NP/PA/CNM) has provided services with organization for 15 years or more and has confirmed commitment for practicing at least three more years.
- Provider eligibility is limited to family medicine, internal medicine, obstetrics, and pediatrics.
- Provider must serve in a leadership or mentorship capacity within organization.
- Given funding limitation, provider organization must complete a competitive grant application.
- Provider organization must have a signed Provider Recruitment Program agreement.

Questions:

Please contact the Workforce Development team with any questions or requests:
wfd@partnershiphp.org | (707) 430-4846

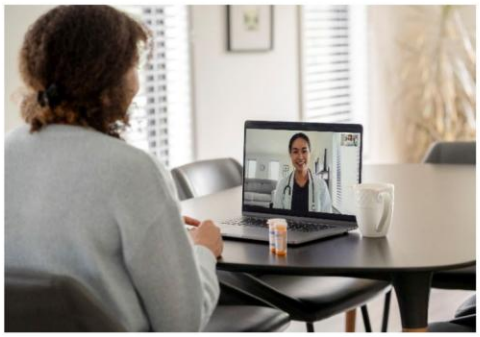
PartnershipHP.org (707) 863-4100

ACCREDITED NCQA HEALTH PLAN

XIV. Appendix G: At-Home Telehealth Specialty Visits

At-Home Telehealth Specialty Visits

Did you know you could have a telehealth specialty visit from your home?



You may be able to have this visit from your home if your main doctor refers you to see a specialist. This is a telehealth specialty visit. You can use any computer, laptop, tablet, or smart device to have a telehealth specialty visit. The specialty care doctor will help treat your health care needs and will work with you to take care of your issue. Ask your main doctor if a telehealth specialty visit from home is right for you.

Here is how it works:

1. Your main doctor refers you to a specialist
2. TeleMed2U and UC Davis are our telehealth specialty doctors. They will call you to set up your visit
3. The specialist's office will call you to confirm your visit. They will make sure you have what you need for your visit.
4. The specialist will give you a Zoom link. Use the Zoom link to log into the App when it is time to meet with the specialist.
5. If you need medicine, the specialist will send it to the pharmacy you choose.

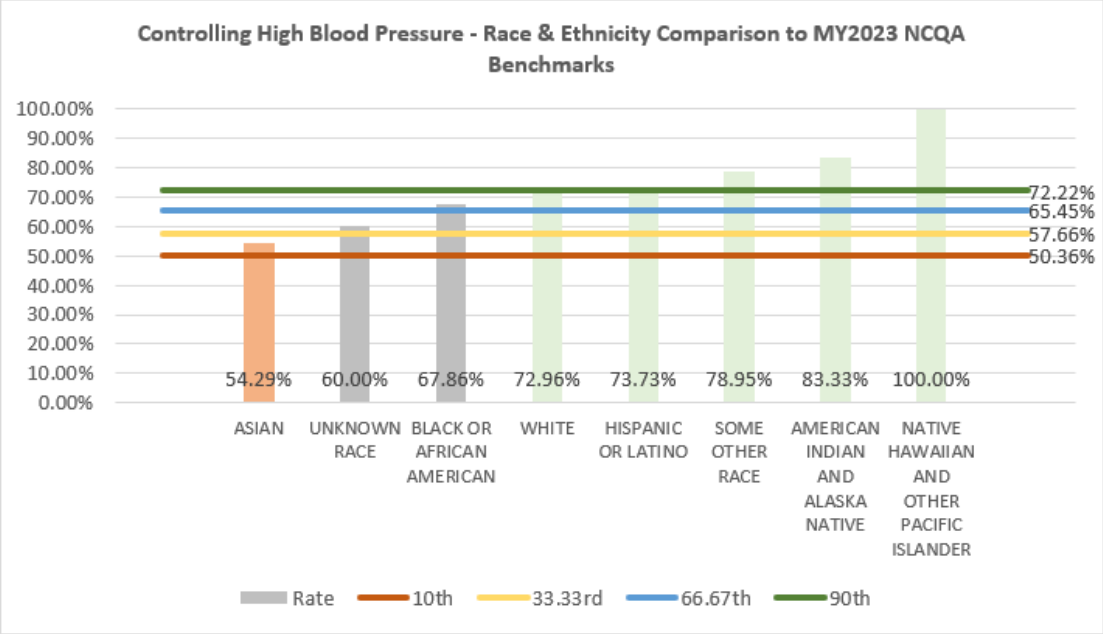
Call or email the telehealth specialist if you have any trouble or if you need to reschedule your visit:

- Please send an email to referrals@telemed2u.com , or call or text **(855) 446-8628** for adult specialty care.
- Call UC Davis at **(800) 482-3284** for specialty care for kids.

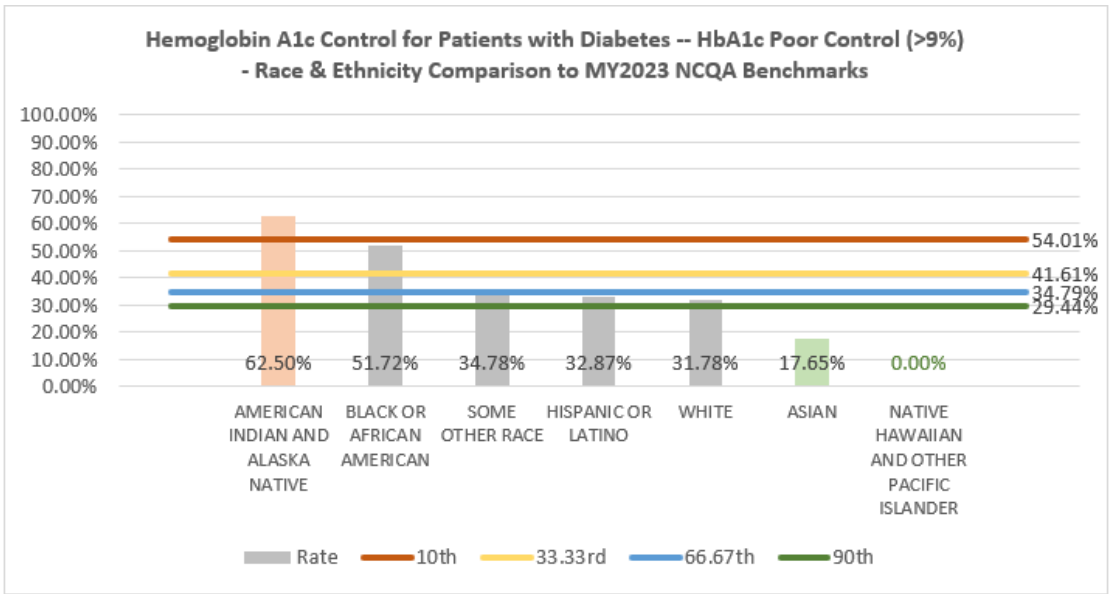
Read the questions and answers below to find out more.

XV. Appendix H – NCQA Benchmarks

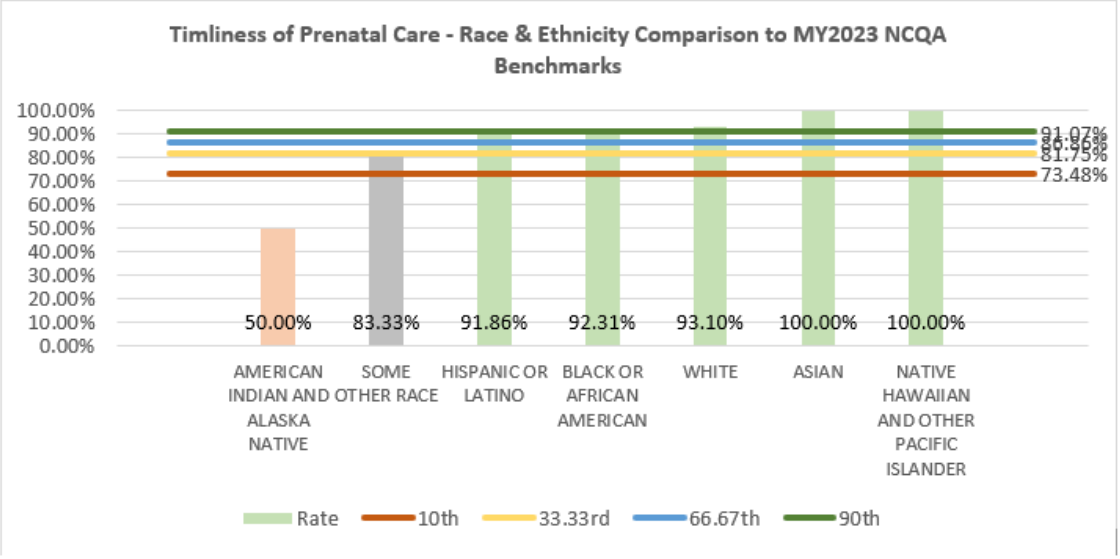
Graph I: Controlling High Blood Pressure - Race & Ethnicity Comparison to MY2023 NCQA Benchmarks



Graph 2: Hemoglobin A1c Control for Patients with Diabetes -- HbA1c Poor Control (>9%) - Race & Ethnicity Comparison to MY2023 NCQA Benchmarks

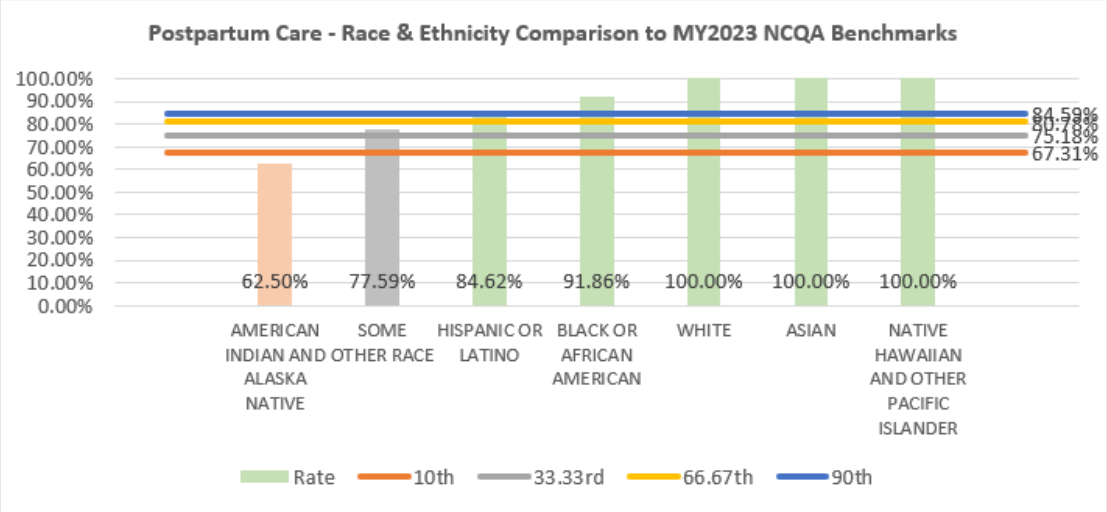


Graph 3: Timeliness of Prenatal Care - Race & Ethnicity Comparison to MY2023 NCQA Benchmarks

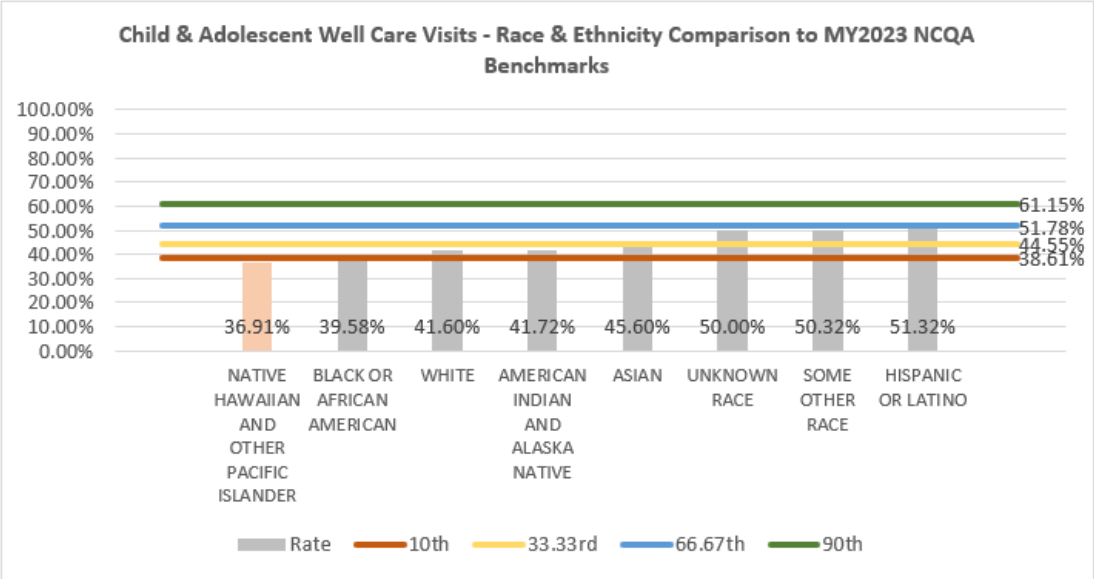


Note: Bars highlighted orange indicate a group had lowest percentile performance of all groups included in measure sample, and were only group to fall into the percentile. Bars highlighted green indicate groups performed above the 90th percentile.

Graph 4: Postpartum Care (PPC – Post) - Race & Ethnicity Comparison to MY2023 NCQA Benchmarks



Graph 5: Child & Adolescent Well Care Visits (WCV) - Race & Ethnicity Comparison to MY2023 NCQA Benchmarks



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2025 Population Health Needs Assessment

Preliminary Findings from 2024

Hannah O'Leary, MPH, CHES

Background

- An in-depth report of Partnership's member needs for 2024
- Pulls from a variety of data sources including:
  - Local community needs assessments
  - County health rankings and roadmaps
  - Partnership claims data
  - Healthcare Effectiveness Data and Information Set (HEDIS) scores
  - Timely access data
  - Our Consumer Assessment of Healthcare Providers and Systems (CAHPS) data™
  - Partnership's health disparities report

Key Findings

Local external community needs assessments across our 24 counties identified a variety of priority areas, including:

- Economic instability
- Lack of access to quality healthcare
- Neighborhood and built environment challenges
- Limited access to quality education
- Social and community context challenges

Key Findings

Additional data revealed:

- Concerns around access to care, behavioral health, and social determinants of health
- Disparities in health outcomes among marginalized groups
- Transportation concerns
- Environmental concerns, including 118 wildfires
- Chronic conditions among adult Partnership members: hypertension, depression, and tobacco use
- Chronic conditions among child Partnership members: anxiety, trauma/stress, depression

Key Findings (Cont'd)

- Highest rates of members accessing SMHS in southern region.
- Underperforming breast cancer screening rates and cervical cancer rates in the northern counties.
- Health disparities found in specific measures:
  - controlling high blood pressure
  - child and adolescent well care visits
  - Hemoglobin A1c Control for Diabetes – Poor Control
  - pre and post natal care visits

Actions Taken

- Opportunities to address:
  - Organizational structure
  - Social and environmental needs
  - Member health and wellness
  - Access to care
  - Health disparities
  - Health education/culture and linguistics
- Hired new regional directors for the Auburn and Santa Rosa offices.
- Created the community health needs liaisons team to work collaboratively with key stakeholders to learn about community needs

Actions Taken (Cont'd)

- CalAIM Incentive Payment Program – was able to offer grant funding to address housing concerns.
- Awarded over $52 million to more than 100 CalAIM providers via grants for programs such as Enhanced Care Management and Community Supports services
- Increasing workforce opportunities, including member scholarships to support careers in health care, social work, and other related fields.
- Utilized the fire and disaster reporting inbox for 2024 disasters in Partnership's service area.
- Roll out of new Asthma Emergency Department Visit Outreach Program Campaign

Actions Taken (Cont'd)

- Will conduct health education sessions in 2025 around tobacco prevention
- Helping schools to expand the use of behavioral health workers.
- Contracting with Alinea Medical Imaging for mobile mammography imaging
- Conducted a 6-month Cervical Cancer Screening Self-Swab pilot project in 2024.
- Continuing to support services for maternal and child health.
- Provider recruitment and retention programs
- Continuing to strengthen relationships and collaborative efforts with local tribal health providers
- Dedicated community resource page for all 24 counties
- Created member-facing videos on several topics to help educate members
- Member (Community) Informative sessions

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
PHARMACY OPERATIONS UPDATE

April 2025

The Pharmacy department within Health Services is responsible for the utilization management of the medical drug benefit – those medications administered to a member directly during a medical stay/visit at a clinic, office, or hospital, and billed to Partnership as part of a medical service claim; this includes drugs administered at time of service by physicians, dentists, podiatrists, nurse practitioners and physician assistants. Drugs (and some non-drug services) provided to a member by a pharmacy (including pharmacy infusion centers) are not within the scope of Partnership's Pharmacy Program because the pharmacy benefit is carved-out to State Medi-Cal through the Medi-Cal Rx Program.

Pharmacy promotes and supports Partnership's quality improvement initiatives and optimal clinical outcomes by analyzing drug utilization data and developing and implementing interventions to address therapeutic gaps and improve quality measure performance. Examples of drug utilization reviews include monitoring Latent Tuberculosis Infection drug treatments, concurrent opioid and benzodiazepine prescribing, and antipsychotic drug utilization in the pediatric population. When suboptimal or unsafe drug regimens are identified, Partnership's Pharmacy will provide fax notification to prescriber with recommendations on best practices.
Additionally, Partnership's clinical pharmacists provide academic detailing to clinicians and Quality Improvement teams, sharing strategies on addressing identified medication gaps that are impactful to quality measures such as the Asthma Medication Ratio, Controlling High Blood Pressure, and Diabetes A1C Control.

In preparation for the Medicare D-SNP (Dual Special Needs Program) Jan. 1, 2026 go-live, Partnership's Pharmacy department is working with OptumRx, our selected Program Benefits Manager (PBM), to implement the Medicare Part D benefit. Additionally, Pharmacy is working with internal and external partners to prepare and implement the Medicare Part B benefit.

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Health Services and Other External Policies before 2025 IQI/QUAC

As of April 9, 2025: subject to frequent change. Calendar shifts for Medicare review

NOTE: Policies in bold-face type have attachments.

Policies should be renewed once in a 12-month cycle but may come back early and more than once in a calendar year per APL, NCQA needs, etc.

Health Services Policy Point Persons
Care Coordination: Alondra Diaz/Shannon Boyle
Enhanced Health Services: Lisa O'Connell/Danielle Biasotti
Health Equity: Mohamed Jalloh
Pharmacy: Janet Ramos/Stan Leung
Population Health: Greg Allen Friedman/Hannah O'Leary
Quality Improvement: Leslie Erickson
Utilization Management: Anna Campbell/Tony Hightower

Non-Health Services Policy Point Persons
Credentialing: Renee Trosky/Brooke Vance/Heidi Lee
Grievance & Appeals: Kory Watkins/Latrice Innes
Member Services: Anna Hernandez/Edna Villasenor
Network Services: Renee Trosky/Priscila Ayala
Transportation: Aaron Maxwell

Note: *Pharmacy policies track IQI/P&T/PAC. Pharmacy policies should go to IQI the month before they are to be considered in QUARTERLY P&T. (New Pharmacy policies may develop in 2025 to reflect D-SNP needs effective Jan. 1, 2026.)*

	IQI Meets	P&T	PAC Approval Date
MCRP4065 – Drug Utilization Review (DUR) Program	March 11	April 10	May 14, 2025
MPRP4034 – Pharmaceutical Patient Safety	March 11	April 10	May 14, 2025
MCRP4064 – Continuation of Prescription Drugs	June 10	July 10	Aug. 13, 2025
MCRP4068 – Medical Benefit Medication TAR Policy	June 10	July 10	Aug. 13, 2025
MPRP4001 – Pharmacy & Therapeutics (P&T) Committee	June 10	July 10	Aug. 13, 2025
MCRP4066 – AB1114 Benefit Implementation	Sept. 9	Oct. 9	Nov. 12, 2025
MPRP4062 – Drug Wastage Payments	Sept. 9	Oct. 9	Nov. 12, 2025

Note: *Credentialing policies are reviewed and approved at the Credentials Committee the day following IQI review.*

January 2025 *meetings (Dec. 23, 2024 submission deadline);* ***PAC approved policies carry 02/12/2025 date***		
Care Coordination	MCCP2018	Advice Nurse Program
	MCCP2031	Private Duty Nursing under EPSDT
	MCCP2035	Local Health Department (LHD) Coordination
	MPCP2017	Scope of Primary Care – Behavioral Health and Indications for Referral Guidelines
Enhanced Health Services (EHS)[1]	**MCAP7001**	CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS) *formerly MCU3143*
	MCAP7003	CalAIM Community Supports (CS) *formerly MCUP3142*
Quality Improvement	MPQP1018	Preventive Health Guidelines
	MPQP1038	Physician Orders for Life-Sustaining Treatment (POLST)
	MPQP1053	Peer Review Committee
Utilization Management	**MCUG3022**	Incontinence Guidelines
	MCUP3034	PCP-to-PCP Transfers & Assignment of New Members to PCP
	MCUP3044	Urgent Care Services
	MCUP3104	Transplant Authorization Process
	MCUP3113	Telehealth Services
	MPUP3129	Podiatry Services
No Health Equity, Population Health, MS, PR, Transportation		
Network Services: Credentialing	**MPCR11**	Credentialing of Community Health Workers (CHW) Supervising Providers
	MPCR20	Medi-Cal Managed Care Plan Provider Screening and Enrollment
	MPCR300	Physician Credentialing and Re-credentialing Requirements
Grievance & Appeals	CGA024	Medi-Cal Member Grievance System

February *2025 meetings (Jan. 28, 2025 submission deadline);* ***PAC approved policies carry 03/12/2025 date***		
Care Coordination	MCCP2020	Lactation Policy and Guidelines
	MCCP2021	Women, Infants and Children (WIC) Supplemental Food Program
	MPCD2013	Care Coordination Program Description
Quality Improvement	**MCQP1022**	Site Review Requirements and Guidelines
	MPQG1005	Adult Preventive Health Guidelines
	MPQP1016	Potential Quality Issue Investigation and Resolution
Utilization Management	MCUP3064	Communication Services
	MPUG3011	Criteria for Home Health Services
	MCUP3103	Coordination of Care for Child-Welfare Involved Members
	MPUG3019	Hearing Aid Guidelines
	MPUP3018	Health Services Review of Observation Code Billing
	MPUP3048	Dental Services (including Dental Anesthesia)
No EHS, Health Equity, Population Health, G&A, MS, PR		

[1] *Both policies migrated from UM to EHS – and were assigned these new alphanumerics – following Jan. 15 Q/UAC direction. Accordingly, Communications has updated the Provider Manual by creating a new EHS section within the Health Services tab.*

Network Services: Credentialing	**MPCR17**	Standards for Contracted Primary Care and Urgent Care Physicians
	MPCR101	Ensuring Non-discriminatory Credentialing and Re-credentialing Processes
	MPCR302	Behavioral and Mental Health Practitioner Credentialing and Re-credentialing Processes
	MPCR500	Ongoing Monitoring and Interventions
	MPCR700	Assessment of Organizational Providers
March** 2025 meetings (Feb. 25, 2025 submission deadline); **PAC approved policies carry 04/12/2025 date		
Care Coordination	**MCCP2024**	Whole Child Model for California Children's Services (CCS)
Population Health	**MCND9002**	Cultural & Linguistic Program Description *(one leg of the new C&L Trilogy presentation)*
Quality Improvement	MPQP1002	Quality/Utilization Advisory Committee
	MPQP1003	Physician Advisory Committee (PAC)
	MPQP1004	Internal Quality Improvement Committee
Utilization Management	MPUG3002	Acupuncture Service Guidelines
	MPUG3025	Insulin Infusion Pump and Continuous Glucose Monitor Guidelines
	MCUP3039	Direct Members
	MCUP3124	Referral to Specialists (RAF) Policy
	MPUP3018	Health Services Review of Observation Code Billing
	MPUP3059	Negative Pressure Wound Therapy (NPWT) Device/Pump
	MPUP3126	Behavioral Health Treatment (BHT) for Members Under the Age of 21
No EHS, Health Equity, G&A, PR		
Network Services: Credentialing	MPCR16	Lactation Consultant Credentialing Policy
	MPCR303	Applied Behavioral Health and Substance Use Disorder Practitioner Credentialing and Re-credentialing Requirements
	MPCR400	Provider Credentialing and Re-credentialing Verification Process and Record Security
	MPCR601	Fair Hearing and Appeal Process for Adverse Decisions
	MPCR701	Ancillary Care Services Provider Credentialing and Re-credentialing Requirements
Member Services	**MC305**	Distribution of Member Rights and Responsibilities
Transportation	MPTP2503	Transportation-related Travel Expenses: Loding, Meals, Attendants, Parking, and Tolls *(formerly MCCP2030)*
April** 2025 meetings (March 25, 2025 submission deadline); **PAC approved policies carry 05/14/2025 date		
Care Coordination	MPCP2026	Diabetes Prevention Program
Quality Improvement	MPQP1006	Clinical Practice Guidelines
	MPXG5001	Clinical Practice Guidelines for the Diagnosis & Management of Asthma
	MPXG5002	Clinical Practice Guidelines for Diabetes Mellitus
Utilization Management	**MCUP3037**	Appeals of Utilization Management/Pharmacy Decisions
	MCUP3047	Tuberculosis Related Treatment
	MCUP3121	Neonatal Circumcision
	MPUD3001	Utilization Management Program Description
	MPUG3031	Nebulizer Guidelines
	MPUP3014	Emergency Services
	MPUP3026	Inter-Rater Reliability Policy
	MPUP3051	Long Term Care SSI Regulations
No EHS, Health Equity, Population Health, G&A, MS, Transportation		
Network Services: Credentialing	**MPCR4B**	Identification of HIV/AIDS Specialists
	MPCR13	Credentialing of Pain Management Specialist
	MPCR13A	Credentialing of Hospice and Palliative Care Medicine Specialist
	MPCR13B	Buprenorphine Prescriber Credentialing
	MPCR13C	Osteopathic Manipulation Treatment Credentialing
	MPCR19	Skilled Nursing Facility Providers (SNFists) Credentialing Policy
	MPCR304	Allied Health Practitioners Credentialing and Re-credentialing Requirements
	MPCR600	Range of Actions to Improve Practitioner Performance
	MPCR800	Delegation of Credentialing and Re-credentialing Activities
Provider Relations	MPPR203	Provider Enrollment Status Guidelines
	MPPR209	Provider Network/Subcontractor Contract Terminations and Facility De-certifications and Suspensions
May** 2025 meetings (April 29, 2025 submission deadline); **PAC approved policies carry 06/11/2025 date		
Care Coordination	MCCP2025	Pediatric Quality Committee Policy
	MCCP2034	Transitional Care Services (TCS)
	MPCP2006	Coordination of Services for Members with Special Health Care Needs (MSHCNs) and Persons with Developmental Disabilities
EHS	MPAP7005	Street Medicine *(formerly MCUP3146)*
	MCCP2033	Community Health Worker (CHW) Services Benefit

Health Services and Other External Policies before 2025 IQI/QUAC

As of April 9, 2025: subject to frequent change. Calendar shifts for Medicare review

NOTE: Policies in bold-face type have attachments.

Policies should be renewed once in a 12-month cycle but may come back early and more than once in a calendar year per APL, NCQA needs, etc.

Quality Improvement	**MCQP1025**	Substance Use Disorder (SUD) Facility Site Review and Medical Record Review
	MPQP1047	Advance Directives
	MCQP1052	Physical Accessibility Review Survey – SR Part C
	MPQP1055	Provider Preventable Conditions (PPC) Reporting
	MPXG5003	Major Depression in Adults Clinical Practice Guideline
Utilization Management	MCUP3003	Rehabilitation Guidelines for Acute Skilled Nursing Inpatient Services
	MCUG3110	Evaluation and Management of Obstructive Sleep Apnea in Adults
	MCUG3134	Hospital Bed / Specialty Mattress Guidelines
	MCUP3028	Mental Health Services
	MCUP3041	Treatment Authorization Request (TAR) Review Process
	MCUP3114	Physical, Occupational and Speech Therapies
	MCUP3115	Community Based Adult Services
	MCUP3136	Fecal Microbiota Transplant (FMT)
	MCUP3144	Residential Substance Use Disorder Treatment Authorization
No Health Equity, Population Health, G&A, MS, Transportation		
NS: Credentialing	MPCR13D	Registered Pharmacists for AB114 Credentialing
Provider Relations	**MPNET100**	Access Standards and Monitoring
	MPPR208	Provider Notification of Provider Termination, Site Closure or Change in Location Information
	MPPR200	Partnership Provider Contracts
	MPPR207	Annual Physician Satisfaction Survey
June** 2025 meetings (May 27, 2025 submission deadline); **PAC approved policies carry 08/13/2025 date – NO IQI/QUAC/PAC meetings in July 2025		
Care Coordination	**MCCP2014**	Continuity of Care (Medi-Cal)
Population Health	MCND9001	Population Health Management Strategy & Program Description
Quality Improvement	**MPXG5008**	Clinical Practice Guidelines: Pain Management, Chronic Pain Management, and Safe Opioid Prescribing
	MPXG5009	Lactation Clinical Practice Guideline
	MPQP1008	Conflict of Interest Policy for QI Activities
Utilization Management	MCUP3041-A	TAR Requirements *attachment to MCUP3041*
	MCUP3013	Durable Medical Equipment (DME) Authorization
	MCUP3042	Technology Assessment
	MCUP3053	Acute Inpatient Administrative Days
	MCUP3133	Wheelchair Mobility, Seating and Positional Components
	MCUP3138	External Independent Medical Review
	MCUP3139	Criteria and Guidelines for Utilization Management
	MCUP3141	Delegation of Inpatient Utilization Management
	MPUP3006	Appropriate Service & Coverage Policy
	MCUG3032	Orthotic and Prosthetic Appliances
	MCUG3038	Review Guidelines for Member Placement in Long Term Care (LTC) Facilities
	MCUG3058	Utilization Review Guidelines for ICF/DD, ICF/DD-H, ICF/DD-N Facilities
	MCUP3020	Hospice Service Guidelines
	MCUP3049	Pain Management Specialty Services
	MPUP3116	Positron Emission Tomography (PET Scans)
No EHS, Health Equity, G&A, Transportation		
Network Services: Credentialing	MPCR602	Reporting Actions to Authorities
	MPCR15	Doula Credentialing and Re-credentialing Criteria
	MPCR200	Credentials Committee and CMO Credentialing Program Responsibilities
Member Services	MC334	American Indian Rights and Protections
Provider Relations	MPNET101	Wellness and Recovery Access Standards and Monitoring
	MPPRGR210	Provider Grievance
August** 2025 meetings (July 29, 2025 submission deadline); **PAC approved policies carry 09/10/2025 date		
Care Coordination	MCCP2022	Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services
Health Equity	MCEP6002	Quality Improvement and Health Equity Committee (QIHEC)
Population Health	**MCNP9004**	Regulatory Required Notices and Taglines
	MCNP9006	Doula Services Benefit
Quality Improvement	MPQD1001	Quality and Performance Improvement Program Description [one leg of the QI Trilogy]
	MPQP1048	Reporting Communicable Diseases
	MPQG1011	Non-Physician Medical Practitioners & Medical Assistants Practice Guideline

Utilization Management	**MCUG3007**	Authorization of Ambulatory Procedures
	MCUG3010	Chiropractic Services
	MCUG3024	Inpatient Utilization Management
	MCUG3118	Prenatal and Perinatal Care
	MCUP3012	Discharge Planning (Non-capitated Members)
	MCUP3052	Medical Nutrition Services
	MCUP3111	Pulmonary Rehabilitation
	MCUP3119	Sterilization Consent Protocol
	MCUP3130	Osteopathic Manipulation Treatment
	MCUP3140	Palliative Care: Pediatric Program for Members Under the Age of 21
	MCUP3145	Eating Disorder Management Policy
	MPUP3078	Second Medical Opinions
	MCUP3028	Mental Health Services
	MCUP3101	Screening and Treatment for Substance Use Disorders
	MCUP3106	Waiver Programs
	MCUP3125	Gender Dysphoria/Surgical Treatment
	MCUP3131	Genetic Screening & Diagnostics
	MCUP3137	Palliative Care Intensive Program (Adult)
No EHS, Health Equity, G&A, PR		
Network Services: Credentialing	**MPCR12**	Credentialing of Individual and Private Duty Nurses Under EPSDT
	MPCR301	Non-Physician Clinician Credentialing and Re-credentialing Requirements
	MPCR100	Credential and Re-credential Decision Making Process
	MPCR102	Provider Directory Accuracy
Member Services	**MP301**	Assisting Providers with Missed Appointments
	MP316	Provider Request to Discharge Member & Assistance with Inappropriate Member Behavior
	MP300	Member Notification of Provider Termination or Change in Location
Transportation[2]	MCCP2016	Transportation Policy for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT)
	MCCP2029	Emergency Medical Transportation
September** 2025 meetings (Aug. 26, 2025 submission deadline); **PAC approved policies carry 10/08/2025 date		
Care Coordination	MCCP2007	Complex Case Management
	MCCP2019	Identification and Care Coordination for Seniors and Persons with Disabilities and/or California Children's Service
	MCCP2023	New Member Needs Assessment
~~EHS~~	~~MCCP2033~~	~~Community Health Worker (CHW) Services Benefit~~
~~Quality Improvement~~	~~**MPXG5003**~~	~~Major Depression in Adults Clinical Practice Guidelines~~
Utilization Management	~~MCUP3003~~	~~Rehabilitation Guidelines for Acute Skilled Nursing Inpatient Services~~
	MCUP3015	Family Planning By-Pass Services
	MCUP3050	Medication Abortion in the First Trimester
	~~**MCUP3115**~~	~~Community Based Adult Services~~
	MCUP3128	Cardiac Rehabilitation
	MPUP3035	Preoperative Day Review
No Health Equity, Population Health, G&A, MS, Transportation		
~~Credentialing~~	~~MPCR13D~~	~~Registered Pharmacists for AB1114 Credentialing~~
~~Network Services~~	~~MPPR200~~	~~Partnership Provider Contracts~~
	~~MPPR207~~	~~Annual Physician Satisfaction Survey~~
	~~MPPR209~~	~~Provider Network/Subcontractor Contract Terminations and Facility De-certifications and Suspensions~~
October** 2025 meetings (Sept. 23, 2025 submission deadline); **PAC approved policies carry 11/12/2025 date		
EHS	**MCCP2032**	CalAIM Enhanced Care Management (ECM)
Health Equity	MCED6001	Quality Improvement and Health Equity Transformation Program (QIHETP) Program Description
~~Quality Improvement~~	~~**MPQP1008**~~	~~Conflict of Interest Policy for QI Activities~~
~~Utilization Management~~	~~MCUG3032~~	~~Orthotic and Prosthetic Appliances~~
	~~**MCUG3038**~~	~~Review Guidelines for Member Placement in Long Term Care (LTC) Facilities~~
	~~**MCUG3058**~~	~~Utilization Review Guidelines for ICF/DD, ICF/DD-H, ICF/DD-N Facilities~~
	~~MCUP3020~~	~~Hospice Service Guidelines~~

[2] *New alphanumerics will be assigned as policies migrate from Care Coordination.*

	~~**MCUP3049**~~ ~~MPUP3116~~	~~Pain Management Specialty Services~~ ~~Positron Emission Tomography (PET Scans)~~
No Care Coordination, Population Health, MS, PR, Transportation		
~~Credentialing~~	~~**MPCR15**~~ ~~MPCR200~~	~~Doula Credentialing and Re-credentialing Criteria~~ ~~Credentials Committee and CMO Credentialing Program Responsibilities~~
Grievance & Appeals	CGA022	Member Discrimination Grievance Procedure
November** 2025 meetings (Oct. 28, 2025 submission deadline); **PAC approved policies carry 01/14/2026 date – NO IQI/QUAC/PAC meetings in December 2025		
~~Health Equity~~	~~MCEP6002~~	~~Quality Improvement and Health Equity Committee (QIHEC)~~
~~Population Health~~	~~**MCNP9006**~~	~~Doula Services Benefit~~
Quality Improvement	**MCQG1015** **MCQP1021** ~~**MPQG1011**~~	Pediatric Preventive Health Guidelines Initial Health Appointment ~~Non-Physician Medical Practitioners & Medical Assistants Practice Guideline~~
Utilization Management	~~MCUP3028~~ ~~**MCUP3101**~~ MCUP3102 ~~MCUP3106~~ ~~MCUP3125~~ ~~**MCUP3131**~~ ~~**MCUP3137**~~	~~Mental Health Services~~ ~~Screening and Treatment for Substance Use Disorders~~ Vision Care ~~Waiver Programs~~ ~~Gender Dysphoria/Surgical Treatment~~ ~~Genetic Screening & Diagnostics~~ ~~Palliative Care Intensive Program (Adult)~~
No Care Coordination, EHS, G&A, PR		
~~Credentialing~~	~~**MPCR100**~~ ~~MPCR102~~	~~Credential and Re-credential Decision Making Process~~ ~~Provider Directory Accuracy~~
~~Member Services~~	~~MP300~~	~~Member Notification of Provider Termination or Change in Location~~
~~Transportation~~	~~MCCP2016~~ ~~MCCP2029~~	~~Transportation Policy for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT)~~ ~~Emergency Medical Transportation~~