PARTNERSHIP HEALTHPLAN OF CALIFORNIA
QUALITY/UTILIZATION ADVISORY COMMITTEE MEETING NOTICE

FROM: Leslie Erickson, Program Coordinator II, Quality Improvement
DATE: March 13, 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 also listed on the agenda.
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, March 19, 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
Chapa-de Indian Health: 11670 Atwood Road, Auburn 95603
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, Regional Medical Director, Southwest
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)
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
O'Leary, Hannah, MPH, Manager of Population Health
Power, Kathryn, Regional Director, Southeast
Quichocho, Sue, Manager of Quality Improvement, QI
Robinson, Gary, Program Manager II, Regulatory Affairs & Compliance
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: March 19, 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
Chapa-de Indian Health: 11670 Atwood Road, Auburn 95603
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* • Feb. 19 Quality/Utilization Advisory Committee (Q/UAC) Minutes	Robert Moore, MD	7: 30	5 - 18
2	*Acknowledgment and acceptance of draft minutes of the* • Feb. 11 Internal Quality Improvement (IQI) Committee Meeting Minutes • Jan. 29 Over/Under Utilization Workgroup • Feb. 6 Population Needs Assessment (PNA) Committee			19 - 43
II.	**Standing Updates**			
1	Quality and Performance Improvement Program Update	Nancy Steffen	7:35	45 - 56
2	HealthPlan Update	Robert Moore, MD	7:55	--
III.	**Old Business**			
	None			
IV.	**New Business – Consent Calendar Policies**			
	Consent Calendar	All	8:05	57
	Quality Improvement			
	MPQP1002 – Quality/Utilization Advisory Committee			59 - 63
	MPQP1004 – Internal Quality Improvement Committee			65 - 68
	Utilization Management			
	MCUP3124 – Referral to Specialists (RAF) Policy			69 - 73
	MCUP3126 – Behavioral Health Treatment (BHT) for Members Under the Age of 21			75 - 82
	MPUP3059 – Negative Pressure Wound Therapy (NPWT) Device/Pump			83 - 87
	Policy Transfer from Care Coordination to Transportation			

	Item	Lead	Time	Page #
	ARCHIVE MCCP2030 – Transportation-Related Travel Expenses: Lodging, Meals, Attendants, Parking and Tolls			88 - 94
	ACTIVATE MPTP2503 – Transportation-Related Travel Expenses: Lodging, Meals, Attendants, Parking and Tolls			95 - 101
V.	**New Business – Discussion Policies**			
	Synopsis of Changes			103 - 108
	Care Coordination			
	MCCP2024 – Whole Child Model for California Children's Services (CCS) – *note that the Family Advisory Committee (FAC) Charter is being added here with some changes as a **new Attachment B** and is no longer Attachment F to Population Health's MCND9002 – Cultural & Linguistic Program Description*	Shannon Boyle, RN	8:10	109 - 130
	Utilization Management			
	MPUG3002 – Acupuncture Services Guidelines	Lisa Ward, MD	8:17	131 - 134
	MPUP3018 – Health Services Review of Observation Code Billing	Tony Hightower, CPhT	8:24	135 - 138
VI.	**Presentations**			
1	Cultural & Linguistic Grand Analysis	Hannah O'Leary, MPH, CHES	8:30	
	• MCND9002 – C&L Program Description – *synopsis of change begins on p. 139*			141 - 191
	• Presentation			193 - 212
	• 2024 C&L Program Evaluation			213 - 255
	• Final Update of the 2024 C&L/QIHEPT Work Plan			257
	• 2025 C&L/QIHEPT Work Plan			259 - 260
VII. FYI	Mid-Year 2024-2025 QI Work Plan Update – *refer any questions to Nancy Steffen*			261 - 268
	Dental Code Flyer *as promised at Q/UAC Feb. 19 – refer questions to dentalsupport@partnershiphp.org*			269
	Adjournment scheduled for 8:55 a.m. Q/UAC next meets 7:30 a.m. Wednesday, April 16, 2025			

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
MEETING MINUTES

Quality and Utilization Advisory Committee (Q/UAC) Meeting
Wednesday, Feb. 19, 2025 / 7:30 a.m. – 9:04 a.m. Napa/Solano Room, 1st Floor

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

Voting Members Absent: Meagan Mulligan, FNP-BC

Partnership *Ex-Officio* Members Present:
Bides, Robert, RN, BSN, Mgr, Member Safety – Quality Investigations, QI
Cox, Bradley, DO, Regional Medical Director (Northeast)
DeVido, Jeff, MD, Behavioral Health Clinical Director
Esget, Heather, RN, BSN, ACM, Director of Utilization Management
Frankovich, Terry, MD, Associate Medical Director
Glickstein, Mark, MD, Associate Medical Director
Hightower, Tony, CPhT, Associate Director, UM Regulations
Jalloh, Mohamed "Moe", Pharm.D, Dir. of Health Equity (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, Pharm.D, Director of Pharmacy Services
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 – Quality Inspections
O'Connell, Lisa, Director, Enhanced Health Services
Randhawa, Manleen, Senior Health Educator, Population Health
Ribordy, Jeff, MD, Regional Medical Director (Northwest)
Ruffin, DeLorean, DrPH, Director of Population Health
Spiller, Bettina, MD, Associate Medical Director
Thornton, Aaron, MD, Associate Medical Director
Townsend, Colleen, MD, Regional Medical Director (Southeast)

Partnership *Ex-Officio* Members Absent:
Barresi, Katherine, RN, BSN, PHN, NE-BC, CCM, Chief Health Services Officer
Cotter, James, MD, Associate Medical Director
Gast, Brigid, MSN, BS, RN, NEA-BC, Senior Director, Care Management
Guillory, Ledra, Senior Manager of Provider Relations Representatives
Guevarra, Angela, RN, Associate Director, Care Coordination (SR)
Hartigan, Nicole, RN, Associate Director, Care Coordination (NR)
Kerlin, Mary, Senior Director of Provider Relations
Steffen, Nancy, Senior Director of Quality and Performance Improvement
Watkins, Kory, MBA-HM, Director, Grievance & Appeals

Guests:
Boyle, Shannon, RN, Manager of Care Coordination Regulatory Performance
Brown, Isaac, MBA/MHA, Director of Quality Management, QI
Brunkal, Monika, RPh, Associate Director, Population Health
Campbell, Anna, Health Policy Analyst, Utilization Management
Chishty, Shahrukh, Sr. Mgr of Foster Care Programs, Behavioral Health
Cunningham, Aryana, Policy Analyst, Care Coordination
Devan, James, Manager of Performance Improvement (Redding)
Durst, Jennifer, Sr. Mgr. of Performance Improvement, QI (Santa Rosa)
Erickson, Leslie, Program Coordinator II, QI (scribe)
Garcia-Hernandez, Margarita, PhD, Director, Health Analytics, Finance
Gual, Kristine, PMP, CPHQ, Director of Quality Measurement, QI
Innes, Latrice, Manager of G&A Compliance, Grievance & Appeals
Jensen, Annika, RN, Assoc Dir. of Clinical Integration, Care Coordination
Lopez, David, PR Representative, Provider Relations
Matthews, Richard "Doug," MD, Regional Medical Director (Chico)
O'Leary, Hannah, MPH, Manager of Population Health, Pop Health
Robertello, Kimberly, PhD, Senior Medicare QI Program Manager, QI
Sivasankar, Shivani, Senior Data Scientist I, Health Analytics, Finance
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 7:30 a.m. The Jan. 15, 2025 Q/UAC Minutes were approved as presented without comment. *Acknowledgment and acceptance of draft meeting minutes of the* • Jan. 7 Internal Quality Improvement (IQI) Committee • Jan. 23 Substance Use Internal Quality Improvement (SUIQI) Committee • Jan. 21 Quality Improvement Health Equity Committee (QIHEC) • Nov. 19, 2024 QIHEC (Approved Minutes)	Motion to **approve the Q/UAC minutes:** Steven Gwiazdowski, MD Second: Robert Quon, MD *Approved unanimously* Motion to **accept the other minutes:** Steven Gwiazdowski, MD Second: Robert Quon, MD *Approved unanimously*
II. Standing Updates		
1. Quality Improvement (QI) Department Update *Isaac Brown, MBA/MHA, Director of Quality Management, QI*	• The PCP QIP Measurement Year 2024 closed on Jan. 31. Providers are still able to look at their figures and reach out with any concerns. One of the major tools we have for providers is our eReports and our PQD dashboards. Refreshing some of these tools for MY2025, however, will be delayed until our Health Rules Payor (HRP) launches later this year to replace AMISYS. Partnership will keep providers posted on these changes and will also provide trainings as needed. • The Quality Measure Score Improvement (QMSI) workgroup has been busy. Pediatrician and Associate Medical Director Terry Frankovich, MD, will conduct a noontime webinar April 3 on developmental screening tools and CPT codes. Register at https://partnershiphp.webex.com/weblink/register/rd35df7db5fe1ef3b888bd39bf2a5d02c • Two webinars focused on best practices in pediatric preventive care for ages 0-30 months and ages 3-17 years old are being offered in February. • Partnership has not been seeing the data on application of topical fluoride, and so we went to our providers and to the Department of Health Care Services (DHCS) to find out why. Director of Quality Measurement Kristine Gual will explain: ○ DHCS identified a systems issue and has given us a work-around coding fix that we are asking dental administrators to implement within their systems. Dental Centers must use ICD Z29.3 (encounter for prophylactic fluoride administration). Such treatments completed in Federally Qualified Health Centers, Rural Health Centers and Tribal Health Dental Centers count toward DHCS measure rates. The measure, for children ages 1-20 years old, requires a minimum of two fluoride varnish applications per year. For questions: contact dentalsupport@partnershiphp.org. • We have launched our annual Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey. This will be the first year the 10 "expansion" counties will be included. • Many organizations within Partnership are engaged in the statewide Equity Practice Transformation (EPT) program. Self-assessments are now happening around how each organization is doing on leadership, data, empanelment, and team-based care.	For information only: no formal action required. There were no questions for Isaac.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION

2. HealthPlan Update
 	
Robert Moore, MD
Chief Medical Officer
	• Anyone who has a dental clinic is encouraged to immediately text or email your dental director to let them know the importance of using the Z29.3 code on every child who gets a dental fluoride varnish,
	• We have two new Regional Medical Directors who recently started with Partnership: Lisa Ward, MD, in Santa Rosa covering Marin and Sonoma counties, and Matthew Morris, MD, in Auburn, serving Placer, Nevada, Sierra, and Plumas counties. Welcome!
	• The Auburn office has just one conference room, which is booked out in conflict with Q/UAC, so Dr. Morris is here in Fairfield today. We hope soon to have a second conference room in Auburn.
	• Many persons have top of mind what is now happening in Washington, D.C. Partnership CEO Sonja Bjork, JD, Medical Director for Medicare Services Kermit Jones, MD, JD, and Director of Population Health DeLorean Ruffin, DrPH, recently took meetings with the Association for Community Plans, a national trade association representing 83 nonprofit health plans, including Partnership. Sonja reported that many proposals for cutting Medicaid are circulating in the Republican-controlled Congress, including an initiative proposed by a California Republican to prohibit coverage of undocumented individuals even if no federal dollars are involved. Also at risk are federal funds matching California's Prop. 35 Managed Care Organization (MCO) tax that is funding increases in Medi-Cal rates. Washington Democrats indicated to Sonja that they have little power to try and forestall cuts. Individuals and medical societies are encouraged to reach out to two Republican congressmen whose districts cover many of Partnership's counties: Doug LaMalfa (CA First) and Kevin Kiley (CA Third).
	• The State meanwhile is still putting forth many regulatory requirements. One will change the name of our Consumer Advisory Committee to the Community Advisory Committee, with a host of requirements that Partnership mostly already meets. This probably won't be finalized until the next Board of Commissioners' meeting.
	• Last week, the State released the details of a Community Reinvestment program wherein any health plan that earns a surplus on its Medi-Cal line of business must devote a portion of that to investing back in the community. This sounds good but is very detailed in who must review and sign off, including Partnership's Consumer Advisory Committee (CAC) and Quality Improvement Health Equity Committee (QIHEC), and every county's public health officer and behavioral health director. Moreover, plans must align with the CHIP (Children's Health Insurance Program) in each county as well as the State's quality strategy. There is much work to be done to operationalize all this.
	• The next round of CalAIM grant funding that was supposed to aid transitional rent and the justice-involved population is being delayed for some months.
	• Partnership favors three pieces of California legislation relating to obstetrical access:
	  ○ Senate Bill 228 – Comprehensive Perinatal Services Program (Sabrina Cervantes, D-Riverside) moves the CPSP program from the California department of Public Health to the Department of Health Care Services (DHCS). There is now an opportunity to offer amendments.
	  ○ Assembly Bill 55 – Alternative Birth Centers: Licensing and Medi-Cal Reimbursement (Mia Bonta D-Oakland) would ease some licensing requirements, now so difficult that only three such centers exist in California. Licensing is now required to accommodate Medicaid patients but not private patients, giving rise to access inequities.
		There were no questions for Dr. Moore.
		
		Meeting Postscripts:
		• An "Updated Billing Instructions" flyer on dental codes is appended to these minutes with the consent of the Q/UAC chair and vice-chair. It will also be shared FYI in March committee packets.
		• Partnership's Board of Commissioners on Feb. 26 approved changing the name of the Consumer Advisory Committee to the Community Advisory Committee.
		• AB 55 was re-referred Feb. 26 to the Assembly's Committee on Health.
		• SB 669 was introduced Feb. 20 and may be acted upon on or after March 23.
		• Dr. Moore's February 2025 Medical Directors Newsletter was forwarded March 3 to Q/UAC clinicians.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	○ SB 669 – Rural Hospitals: Standby Perinatal Medical Services (Mike McGuire, D-Healdsburg) would allow standby perinatal units such as that proposed by Plumas District Hospital.	
III. Old Business – None		
IV. New Business – Consent Calendar (Committee Members as Applicable)		
Consent Calendar	***Health Services Policies*** Care Coordination MCCP2020 – Lactation Policy and Guidelines MCCP2021 – Women, Infant and Children (WIC) Supplemental Food Program Utilization Management MCUP3064 – Communication Services MPUG3011 – Criteria for Home Health Services MPUG3019 – Hearing Aid Guidelines MPUP3048 – Dental Services (including Dental Anesthesia)	Motion to **approve as presented:** Robert Quon, MD Second: Steven Gwiazdowski, MD *Approved unanimously* Next Steps: March 12 Physician Advisory Committee (PAC)
V. New Business – Discussion Policies		
Policy Owner: Quality Improvement – *Presenter: Rachel Newman, RN, Manager, Clinical Compliance – Quality Investigations*		
MCQP1022 – Site Review Requirements and Guidelines	**Formerly MPQP1022, the alphanumeric is changing to "MC" as this policy only applies to Medi-Cal. Other agencies are responsible for Medicare site review.** Likewise, the alphanumeric also changes for Attachments A-L. A Supplemental Facility/Mobile Unit/Street Medicine Facility Site Review Tool is added as a NEW Attachment I. (Former attachments I, J, and K now become J, K, and L, respectively.) The Department of Health Care Services (DHCS) delegated the making of this new tool to all the Managed Care Plans (MCPs). This is what the MCPs submitted to DHCS, and we await their response. Some of the provisions herein may not apply to the street medicine component. "PHC" changed to "Partnership" throughout the document. Rachel went through the synopsis: note that although her team has been utilizing Attachment I for some time, DHCS still has not formally approved it. Dr. Gwiazdowski wondered at the State's need for such a long policy to cope with all its regulations. Dr. Moore said our contract necessitates it. He anticipates that DHCS will be similarly slow to provide oversight guidance to the MCPs re their contractual and regulatory responsibilities to CPSP, so we meanwhile are planning additional internal reviews of what we are referring to as the Partnership HealthPlan Perinatal Services (PHPS): CPSP-like services equivalent to or substantially similar to the services once defined and overseen by the California Department of Public Health (CDHP).	Motion to **approve as presented:** Steven Gwiazdowski, MD Second: Robert Quon, MD *Approved unanimously* Next Steps: March 12 PAC
Policy Owner: Quality Improvement – *Presenter: Mark Netherda, MD, Medical Director for Quality*		

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
MPQP1005 – Adult Preventive Health Guidelines	**Formerly MCQG1005, the alphanumeric is changing to "MP" as this policy will apply in part to Partnership Advantage, effective Jan. 1, 2026 in eight Partnership counties. Accordingly, both the footnote disclaimer and the Medicare link https://www.medicare.gov/coverage/preventive-screening-services are added to this policy.** This policy has a few minor changes pursuant to All Plan Letter (APL) 24-008, Immunization Requirements, which DHCS adopted last fall, subsequently causing updates to the Pediatric Preventive Guidelines and Initial Health Assessment policies that this committee saw in November 2024. **Related Policies additions:** MCUP3052 – Medical Nutrition Services and MCCP2026 – Diabetes Prevention Services **Purpose Statement:** Reference to Preventive Care for Medicare recipients is added. **VI.C. Medicare Preventive Care is added**: **1.** All recommendations described in Attachment A apply to Medicare recipients, provided age and other individual specific criteria are met. **2.** All adult vaccinations recommended by the current CDC's Advisory Committee on Immunization Practices apply. **3.** The following services are available to both Medicare and Medi-Cal recipients: a. Medical Nutrition Services (MNT) as outlined in Partnership policy MCUP3052 – Medical Nutrition Services. b. Diabetes Prevention Services (DPP) as outlined in Partnership policy MCCP2026 – Diabetes Prevention Services. 4. Medicare-specific preventive care visits as outlined on the Medicare website at http://www.medicare.gov/coverage/preventive-screening-services including, but not limited to **a.** A "Welcome to Medicare" visit **b.** An annual "adult wellness visit" (AWV) **c.** A cardiovascular behavioral therapy visit (performed by the PCP) **d.** An obesity behavioral therapy visit (performed by the PCP). **References are added:** K. Medicare Preventive & Screening Services – https://www.medicare.gov/coverage/preventive-screening-services L. California Assembly Bill 2132 Health Care Services: Tuberculosis (Sept. 29, 2024) https://leginfo.legislature.ca.gov/ **Attachment A is updated** in some sections, including: • Assessment for Hearing Impairment • *Screening for* Depression and Suicide *Risks in Adults and Perinatal Depression* • Tobacco Use and Tobacco Caused Disease Counseling, *including for Pregnant Persons* • Breast Cancer Screening by Mammography - The USPSTF (April 2024) recommends biennial mammography for persons with breasts and assigned female at birth ages 40 to 74 years (Grade B). For Transgender and Gender Diverse persons, consider "… the length of time of hormone use, dosing,	There were no questions. Motion to **approve as presented:** Robert Quon, MD Second: Brian Montenegro, MD *Approved unanimously* Next Steps: March 12 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	current age, and the age at which hormones were initiated." Shared decision making is recommended. • *Vitamin D, Calcium or Combined Supplementation for the Primary Prevention of Fractures in* Postmenopausal Persons Assigned as Female at Birth (this is a title change in what is a Grade D recommendation) Dr. Netherda went through the synopsis, adding that USPSTF on Jan. 14, 2025 confirmed that screening for osteoporosis in post-menopausal persons assigned female at birth is a Grade B recommendation. Dr. Netherda added "(currently under review)" after policy or grade recommendations that USPSTF is pondering, saying this will help guide him in his research for the next annual review of MPQG1005. Also, he may alphabetize the list within categories so users may more easily find topics of interest. Dr. Moote thanked Dr. Netherda for his hard work and said the changes will be presented in March meetings of the regional medical directors.	
MPQP1016 – Potential Quality Issue Investigation and Resolution	**This policy is being brought early to coincide with the annual PQI report and to make some language changes. References to "severity level" have been changed to "severity rating." Some timeframes have been clarified. The Partnership Advantage footnote disclaimer has been added.** Timeframes amended throughout document to clarify "days" as "calendar days." **III.D. Corrective Action Plan is now redefined:** A directive from the Peer Review Committee specifying required actions/ activities to be undertaken by a provider of concern. CAPs are given to educate the provider/facility on the identified issue/concern, with the goals of helping to prevent identified issues from recurring and improving member safety. CAPs contain clearly stated goals and timeframes for completion. **VI.C.1.a. addition:** The Investigator will begin an investigation within 30 days of receiving the PQI case referral. **VI.C.3.d.ii:** The timeframe for clinicians to acknowledge receipt and initiation of a CAP is 30 calendar days. If the CAP is not acknowledged and initiated by day 31, the Investigator will contact the POC. A 15-day extension may be granted for reasonable concerns. If the POC has not acknowledged and initiated the CAP by day 46, the Investigator will forward the case to the CMO/physician designee for further determination, including possible review by the Credentials Committee. **VI.C.3.d.iv.f):** "Coaching/counseling from the POC's Medical Director" is added to the list of what a CAP may stipulate. **VI.E.1. Track and Trend Report is modified to note:** In addition, providers and/or facilities who were given a severity rating of P2 or S2 and above at PRC will be monitored for at least the following year via the track and trend reports to determine if the identified concern is ongoing. If through this process, any additional concerns are identified, further investigation or actions may be implemented. **VI.E.4. is added:** A monthly report of the number of PQI referrals, open cases, and cases pending PRC presentation will be sent to the CMO and to the Medical Director of Quality. Dr. Netherda went through the synopsis, noting that it was Marshall Kubota, MD, who recommended that references to "days" be rewritten as "calendar days" where applicable. Some of the changes in the policy are	Motion to **approve as presented:** Steven Gwiazdowski, MD Second: John Murphy, MD *Approved unanimously* Next Steps: March 12 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	in anticipation of what the Member Safety - Quality Investigations team thinks might be recommended by the DHCS auditor based on remarks heard in December. We added that coaching and counseling from a provider of concern's medical director might be enough to meet the requirements of An imposed CAP (e.g., if it's a physician assistant who has done something we think needs a better review, having that just being overseen by the medical director might be an adequate response). We will now track and tend more closely those providers who have had severity ratings that are higher than we would like. We score on a scale of zero to three. We will now better track those who are scored a two or higher to make sure that we are not seeing a repeat of whatever it was that initially triggered the investigation. That is the minimum of what we will do. John Murphy, MD, asked if the team can issue a CAP or if only the Peer Review Committee can. Dr. Netherda responded that the team can strongly recommend but the decision to impose a CAP is the responsibility of Peer Review because an actual CAP is considered a more serious trackable event. There were no other questions.	
Policy Owner: Utilization Management – *Presenter: Shahrukh Chishty, Sr. Mgr, Foster Care Programs, Behavioral Health*		
MCUP3103 – Coordination of Café for *Child-Welfare* Involved Members – **NEW TITLE**	**This policy was updated and approved by DHCS for APL 24-013 "Managed Care Plan Child Welfare Liaison." The name of the policy was updated to reflect the new "Child Welfare-Involved" language. Policy template changes were also made to specify Behavioral Health as the Business Unit responsible for this policy.** **Section I:** Two Related Policies were added as follows: • MCCP2032 - CalAIM Enhanced Care Management (ECM) • MPQD1001- Quality and Performance Improvement Program Description **Section III.** New Definitions were added for • Assembly Bill 2083 • Child Welfare-Involved Youth • Enhanced Care Management (ECM) Provider:' • ECM Lead Care Manager • Resource Family **Section VI.** Language updates were made throughout the main policy section to use the phrase "child welfare-involved youth" in lieu of previous language, "children in foster care." **Section VI.C.** A new policy section was added to define the roles and responsibilities of Child Welfare Liaisons at Partnership. **Section VII. References:** Two new References were added for F. DHCS APL 24-013 G. California Foster Youth Bill of Rights Shahrukh noted that this policy was revised to reflect the broadening definition from foster care to child welfare. There are several categories within that larger scope, including members in foster care, in addition	There were no questions. Motion to **approve as presented:** Robert Quon, MD Second: Brian Montenegro, MD *Approved unanimously* Next Steps: March 12 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	to former foster youth, youth involved in the adoption process, youth placed with approved relatives and those engaged in family maintenance. Correspondingly, this policy title is updated. We indicated related policies and described in detail the role of the child welfare liaison who will support this work. Other than that, no other significant edits were introduced	
VI. Presentations		
Care Coordination Grand Analysis: • MPCD2013 – Care Coordination Program Description • Complex Case Management (CCM) Program Evaluation for CY 2023 (Report and Presentation) *Shannon Boyle, RN, Manager of Care Coordination Regulatory Performance* and *Shivani Sivasankar, Senior Data Scientist, Health Analytics*	**Policy is due for Annual Review** **Department Objectives & Goals (Page 3):** **Updated** foster care to Members involved in child welfare and foster care per APL 24-013 **Updated** referral source to include internal departments such as PHM, EHS, and Behavioral Health **Updated footnote (Page 6):** MCUP3143 updated to reflect new policy number MCAP7001 CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS) MCUP3142 updated to reflect new policy number MCAP7003 CalAIM Community Supports (CS) **Enhanced Care Management (ECM) Benefit (Page 12):** MCUP3143 updated to reflect new policy number MCAP7001 CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS) **Team Roles and Responsibilities (Page 12) Added:** Senior Director of Care Management- RN Associate Director of Clinical Integration Manager of Clinical Integration Supervisor of Case Management-LVN Care Coordination Business Analyst Clinical Advisor- RN Policy Analyst Senior Program Manager Program Manager I Program Manager II Customer Service Representative, CC **Updated JD Title:** Case Management Supervisor-RN to Supervisor of Case Management-RN **Updated JD for Behavioral Health Clinical Specialist-LCSW or LMFT to include:** Collaborates and coordinates care as part of the multidisciplinary team to evaluate and advocate for the medical, behavioral and psychosocial needs of the member while promoting quality and cost-effective outcomes	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Protected Health Information (Page 17) Updated: The Partnership Director of Regulatory Affairs and Program Development also serves as the Partnership Privacy Officer Shannon noted that Partnership's Care Coordination department is part of Health Services, is led by the Senior Director of Care Management and includes the care coordination director, regional associate directors, managers, case managers, social workers, and health care guides. Teams coordinate care and case management for members with care needs who are willing to participate, ensuring Partnership is the primary source of coverage or responsible for the benefit. Their responsibilities include assessing needs, coordinating services, and conducting outreach to target specific populations. The teams work in multidisciplinary care groups to meet members' needs, reduce duplication, and address challenges such as chronic illness, fragmented care, and complex health issues. The teams use evidence=based practices to create individualized care plans and interventions aimed at education, timely care access, and connecting members with resources to minimize care gaps during transitions and to achieve desired health outcomes. Shannon then went through the synopsis of changes to the Program Description. She noted that Care Coordination is growing fast: 11 new staff have recently been added. Robert Quon, MD, asked whether those job titles with "RN" after them must specifically be an RN or can they have higher licensure? Shannon said that those with the RN in their role title do need that licensure. Other roles do not require such licensure, and this is spelled out in the job descriptions within the Program Description. Shivani Sivasankar then presented the CCM Evaluation. The main objective was to assess the impact and see if there had been any increases in the appropriate usage of health and medical resources as well as any reduction in inappropriate utilization of healthcare resources. There were four steps to this data analysis. The first was focused on segregating the 255 members enrolled for CY 2023 into different case length analysis groups based on the number of days they were enrolled in the CCM program, and we tested the significant difference in average utilization metrics before enrollment, after enrollment and after program closure. The second step was focused mainly on the CCM group, and in the third step we identified significant factors that impact utilization metrics. In the fourth step, we compared the CCM group with the control group and tested significant difference in the utilization metrics. We only looked at three months after enrollment and three months after closure so that the utilization period was consistent across the three measurement periods. And then we determined eight different utilization metrics, and, for the case length analysis, we segregated the members into different case groups based on the number of months they were enrolled. The main purpose of this analysis was to see if the 40 members who were enrolled for less than one month had any significantly different results and if it made sense to exclude them from the next step of the analysis. Members that were enrolled for less than one month had a decrease in the number of unique drugs after enrollment compared to members who enrolled for just one to two months, whereas the number of unique drugs increased when compared to members who were enrolled for two to five months and from five to eight months. Specialty visits increased for members who were enrolled for less than one month, whereas it decreased after closure for members who were enrolled for more than eight months. Based on these results, their cases were not managed sufficiently and they were excluded from the next step of the analysis. Thus, 189 members were evaluated in the second step. Some of the key findings were they had lower visits after the end of the CCM program, lower inpatient visits, lower average inpatient days, lower PCP visits after the end of the program, higher specialty visits after the start of the program, and lower total allowed amount after the start and end of the program. However, we did not control for bias (third step) and we did not compare this to a control group (fourth step). In the third step, we identified significant parameters like gender, region, age group and risk level. And then we performed regression analysis to see if the significant parameters affected utilization metrics before enrollment and after closure.	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	In the fourth step, we compared these 189 members against a control group of 517 members who were eligible for at least one month but did not enroll during this utilization period. There were no significant results without adjusting for covariates, but after adjusting, the ED visits in the CCM group significantly decreased after enrollment and after closure compared to the control group; the average inpatient day visits dropped more significantly in the CCM group after closure. Some of the key findings were that members enrolled in the CCM program had significantly lowered ED visits, which decreased by 11% after the start of the program and decreased 37% after the end of the program. Inpatient visits decreased by 60% after the end of the program. Average inpatient days decreased by 70% after the end of the program. Total allowed amount decreased by 57% after the start of the program and 71% after the end of the program. PCP and specialty visits both decreased significantly after closure. In conclusion, when compared to the control group, the CCM program was effective in reducing ED visits, average inpatient days, total allowed amount after the start and end of the CCM program; increasing PCP visits, specialty visits and unique medications after the start of the CCM program; reducing inpatient visits, specialty visits and number of unique drugs after the end of CCM program. It was not effective in reducing inpatient visits after the start of CCM; reducing readmissions after start and end of CCM; increasing PCP visits after the end of the CCM program. Before taking questions, Dr. Moore noted that this analysis is done annually in part to satisfy NCQA requirements. Jennifer Wilson, MD, asked what the difference was between "unique medications" and "unique drugs"? Shivani said she used the terms interchangeably. Dr. Kubota asked for more specifics on those 40 members who were excluded, and Dr. Moore answered. Dr. Gwiazdowski asked about the statistical methodologies used and a conversation ensued between him, Shivani and Dr. Moore, who said they could continue the discussion after the meeting. Dr. Montenegro was curious about specialty visits increases and decreases and what specialties were included. Shivani responded that although specific specialties were not tabulated in this analysis, they could be in future. Dr. Montenegro said he asked because certain specialties may have access issues, so an intervention might have an unintended consequence of overwhelming an already scarce specialty. Dr. Moore said it would be a good call-out to know, for example, if it were a gastroenterologist doing a colonoscopy or was it an endocrinologist to manage their diabetes. Dave Katz, MD, wondered if any data was collected o~~n~~n the patient and family experience and, if so, whether it was correlated with utilization data. Shannon replied that we do have a CCM survey after closure, but sometimes it will not be completed, especially in those CCM cases closed for lack of engagement. Dr. Moore commented that it would be interesting to learn why some become disengaged but that would be a different survey. **Jennfer Wilson, MD / Robert Quon, MD to approve both the Program Description and the Evaluation.**	
PQI/PPC Annual Report *Robert Bides, RN, Manager, Member Safety – Quality Investigations*	Robert said Potential Quality Issues (PQIs) are defined as possible adverse variations from expected clinical performance, care, and outcomes. His team investigates all PQIs to determine if there is an actual quality issue or if there is an opportunity for improvement. PQIs come from internal and external sources. Provider Preventable Conditions (PPCs) are a medical condition of complication that a patient develops during a hospital stay or ambulatory surgical encounter that was not present at admission. PPCs are reportable to DHCS. The Member Safety - Quality Investigations team initially reviews and scores PQIs for both providers and system issues on a zero (care is appropriate), one (minor opportunity for improvement), two (moderate opportunity for improvement), or three (significant opportunity for improvement) level. Those scoring Provider 2 or System 2 or above are referred to the confidential Peer Review Committee. The PRC in 2024 reviewed 16 PQI cases, nine in the last two quarters. Nine of the 16 resulted in CAPs to providers, including six focal	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	reviews. Altogether, with the Investigations team that on a weekly basis both reviews and scores referred cases, 207 PQI cases were completed and closed in CY 2024. There were multiple providers with multiple PQIs; however, no significant treads emerged. As Dr. Netherda said in presenting the PQI policy today, providers or facilities given a rating of P2 or S2 or above will be monitored for at least a year. The top three referral sources in Q3/Q4 continued to be Grievance & Appeals (119), "other" (15), and Medical Directors (8). As expected, the number of PQI referrals increased 8% in 2024 above 2023 in part because of the 10-county expansion. This new "Eastern" region accounted for 40 (20%) of the 247 PQI cases referred in 2024. Q1/Q2 results were reported to this committee in August 2024. Today, we report Q3/Q4: 117 providers were involved in the 104 processed and closed PQIs. Of these 117, 64 were PCPs; 18 were specialists, and 31 were hospital or ER related. Once again, Shasta and Solano county-based practitioners/providers accounted for the most reviewed with 22 and 17, respectively. (This is both down from and a reverse of their Q3/Q4 2023 positions with 25 and 32, respectively.) There is no significant trend to report regarding the severity of cases reviewed. In 2024, just 9% (19 of 221 involved providers) were scored above a P1 or S1 compared with 11% (34 out of 302) in 2023 and 11% (16 of 149) in 2022. In Q3/Q4, only two PPC cases were reported to Partnership. (Dr. Moore commented at IQI Feb. 11 that he suspects more have occurred but that, although they may have been self-reported to DHCS as required, they were not reported to Partnership, as is also required.) Robert said we are doing outreach to hospitals to provide PPC education on reporting requirement. In conclusion, the number of Q3/Q4 2024 PQI referrals received (150) was significantly higher than the same period in 2023 (111). The Member Safety - Quality Investigations team has implemented more communication with providers of concern and continues to provide education to providers and facilities regarding the PQI process and PPC reporting. The team is also educating other Partnership departments. Dr. Wilson asked when looking at the PQI rates if cross referencing is done for access by county or region. Robert replied that this has not been done but he could ask the Health Analytics team to look at this for future reports. Dr. Wilson noted that Solano County has one of the highest numbers of PQIs (39 in 2024) but their access is likely poorer than Sonoma County, which accounted for 23 PQIs. She asked if access itself could be a reason behind many PQIs, and she also wondered if some PQIs occur because PCPs can hold on to a patient longer than they perhaps should because a higher level of care is not readily accessible. Dr. Netherda acknowledged that some PQIs do happen for this very reason but that access itself is not a PQI issue. Dr. Gwiazdowski, noting that some counties did not have a recorded PQI in 2024, wondered whether this indicates "best in breed" or that reporting is not being done as it should be. Robert replied that most of the PQIs do come through Grievance & Appeals, so if a member doesn't complain, we are not necessarily apprised that any issue exists. Dr. Moore added that if a county's denominator is low (e.g., Sierra only has a few hundred members and Modoc a few thousand), it is not surprising that no PQI data exists for them. "The biggest counties are Solano, Sonoma, Shasta, Humboldt, and they are all represented," he said. Colleen Townsend, MD, added that when a member complains about one thing that isn't a PQI and something else is involved that actually presents a PQI, we do look at that as well. Dr. Netherda reminded Q/UAC that this report is based on where the provider is, not where the member resides: a Modoc member might present a PQI but it involves a provider in a different county. Dr. Moore clarified, however, that the denominator is based on the member when the rates are compiled. Robert Quon, MD, asked Robert to talk about the "unable to determine" (UTD) rating and what cases those are likely to be. Robert replied that most recently, some involved behavioral health wherein records were more difficult to obtain. Closed UTD cases are referred back to the	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	provider's site or system with a request that that oversight body looks into the issue(s). Dr. Quon cautioned that, from a regulatory standpoint, having such a bucket creates a high risk. Dr. Moore clarified that a closed case labeled UTD may be because Partnership has no contractual oversight that requires a response. Dr. Quon suggested "closed by the facility" or "referred to the facility for investigation" might be better labels. Dr. Netherda clarified that DHCS has accepted "UTD," and we are careful to make sure that when we say that, it's because we passed it off to somebody else: it went to the CDPH if it's a facility, for example, or it went to the Nursing Board. It didn't end with us. Dr. Quon suggested that in future we then say "referred to the Nursing Board" or other appropriate agency; then it is clear the HealthPlan is taking an action and maintaining oversight.	
CY 2024 Site Review Report *Rachel Newman, RN*	A Site Review (SR) has two components: the Facility Site Review (FSR) and the Medical Record Review (MRR), according to DHCS-approved tools and standards. The FSR is an assessment of a facility's physical site across Access/Safety, Personnel, Office Management, Clinical Services, Preventive Services, and Infection Control concerns according to DHCS-approved guidelines and tools. A FSR is conducted by a registered nurse/DHCS-certified site reviewer on Partnership's Clinical Compliance team at the point of initial contracting and up to three years thereafter. The reviewer will issue a Corrective Action Plan (CAP) if any of the domains fall below 80%. MMRs are generally done virtually. Overall, 2024 average FSR scores by county looked good, Rachel said. (She noted that some elements are evaluated on an "all or nothing" basis. If just one staff member isn't trained or otherwise compliant, the site fails on that element and a CAP must be issued. Those are the State's rules.) What sites missed the most were accurate Emergency Medication Dosage charts, which must list all stocked medications. Overall, all regions have opportunities to switch to height adjustable eye charts and to improve staff training both in cultural and linguistic requirements and in disability rights and provider obligations. The MMR of randomly selected records is conducted three to six months after an initial FSR has been completed. It is repeated up to every three years thereafter on format, documentation, coordination of care, pediatric preventive care, adult preventive care, and OB/CPSP preventive care (if applicable). If any of these domains score below 80%, a CAP is required for the entire review. Rachel noted that we are seeing an uptick in MMR CAPs since the release of the 2022 Site Review Tools and because reviewers have more measures to look at. All regions have opportunities for improvement in adult and pediatric preventive health. Partnership continues to offer extensive training provided by a Certified Site Review nurse for all new site review criteria. The Clinical Compliance team continues to educate sites during the SR exit interview on the Individual Health Assessment (IHA), blood lead screening and testing, developmental screening tools and other criteria as needed. Web-ex trainings on preventive criteria and the IHA are available on request, as is training on the former Child Health and Disability Prevention Program (CHDP) protocols that have now transitioned from the Department of Public Health to the Managed Care Plans. Virtual MMRs continue to be a more efficient use of time with providers. There were no questions for Rachel.	
CY Physical Accessibility Review Survey (PARS) Report *Rachel Newman, RN*	A PARS is an assessment of how well members who are seniors or persons with disabilities (SPD) can navigate a practice site. Areas evaluated during this review include the parking lot, exterior building, interior building, restrooms, and exam rooms. Sites are assigned a designation of basic or limited accessibility based on the review findings. Partnership's Provider Directory is updated regularly for members to see which facilities meet their accessibility needs. Primary Care, OB, and High-Volume Specialty offices receive this review. Provider sites are categorized into three types:	

<table>
<tr><th>AGENDA ITEM</th><th>DISCUSSION</th><th>RECOMMENDATIONS / ACTION</th></tr>
<tr><td></td><td>
<table>
<tr><th>Level of Access / Domains:</th><th>Definition</th></tr>
<tr><td>Basic
Parking
Exterior Building
Interior Building
Restroom
Exam room</td><td>Facility met all 29 critical elements used to identify a sites capability of accommodating SPD members.
*All domains besides Medical Equipment are of a passing score.</td></tr>
<tr><td>Limited
Missing one or more domains above</td><td>Demonstrates that the facility is deficient in one or more areas.</td></tr>
<tr><td>Medical Equipment
This is noted in addition to access level of Basic or Limited as appropriate.</td><td>PCP site has a height adjustable exam table and patient accessible weight scales per guidelines (for wheelchair/scooter plus a patient).
**This is noted in addition to level of Basic or Limited access as appropriate.</td></tr>
</table>
A total of 174 sites were assessed across Partnership in 2024: 80 enjoy “basic” designation; 94 are deemed “limited.” An additional five PARS were done in Sacramento and Alameda counties for continuity of care. Partnership does not issue CAPs that would insist any practice site should mitigate a perceived PARS deficit because many practices do not own their physical plant.
There were no questions for Rachel.
</td><td></td></tr>
<tr><td>Dual Special Needs Plan (D-SNP) Model of Care

Kermit Jones, MD, JD, Medical Director for Medicare Services

and

Kimberly Robertello, PhD, Senior Medicare QI Program Manager</td><td>
The MOC is the framework we have to use both internally and externally by the Centers for Medicare and Medicaid Services (CMS) and NCQA to let them know the processes we are changing to get ready for the SNP, which goes live Jan. 1, 2026 in eight of our 24 counties. The MOC provides the foundation for promoting SNP quality, care management, and care coordination processes. NCQA reviews for approval each SNP’s MOC based on standards and scoring criteria established by CMS. Trainings on MOC Elements 1 & 2 can be found at https://snpmoc.ncqa.org/static/media/SNPApprvl_MOC12_CY2026.f6ab25f8cbd947497fa8.pdf (Reference is to Contract Year and not Calendar Year.)
There are four MOC sections: divided by a description of the SNP population, the care coordination components we are looking to design internally and externally, the SNP provider network to guarantee access, and then the quality measurement and performance score improvement. Each section is divided into elements, and those elements contain numerous factors wherein we narrate all the points NCQA wants us to articulate how we are executing care coordination and quality performance improvement procedures. Based on those elements and factors, the SNP can score as many as 64 points. Based on percentages, we can receive a one-, two-, or three-year approval. We are on track for a three-year approval, based on our performance in the December 2024 mock survey with our consultant. Additional DHCS expectations above NCQA mandates can be found at https://www.dhcs.ca.gov/provgovpart/Documents/CY2026-D-SNP-Policy-Guide.pdf
Dr. Jones noted that SNPs are required in MOC 1 to describe potential members and our “Most Vulnerable Population” (MVP) subset too by a
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AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	deep dive into the demographics; understand who is housed and who isn't; understand the degree of their chronic diseases; understand age and language barriers. Health Analytics has identified a number of member risk factors: number of members age 65 and older, those with 5+ co-morbid conditions, those who do not speak English at home, those age 25 and older without a high school diploma, those living in poverty, and those more than 65 of age who are homeless. The MOC 2 is the Care Coordination section focusing on specific CMS and DHCS care requirements, including a Health Risk Assessment (HRA), and Individualized Care Plan (ICP), and an Interdisciplinary Care Team (ICT) of providers, a case manager for each member, and in some cases, a care giver for the member as well. The MOC 3 describes both our proposed PCP and broad specialty care network in the eight counties and the accessibility of said care. The MOC 4 defines how the D-SNP will track performance, guide improvement efforts, document, share information with stakeholders, and creative an incentive structure in those areas that need to improve. Partnership has identified five areas of focus for the D-SNP population: improving care coordination and delivery of services through direct alignment of the HRAT, ICP, and ICT ensuring access; enhancing care transitions; ensuring appropriate utilization and improving member engagement. Within these five focal areas are nine performance metrics: HRA, ICP, and ICT completion; member access to preventive/ambulatory health services at least once each year; diabetes care through controlling blood sugar; controlling high blood pressure; providing statin therapies for members with cardiovascular disease; medication adherence around cholesterol, and transitions of care through member engagement post-discharge. Kimberly spoke more about reporting and oversight that will start with an internal Quality D-SNP subcommittee to be created to address performance and any CAPs, up through IQI, Q/UAC. PAC and the Board of Commissioners. A Medicare Steering Committee will be focused on operations. Dr. Jones concluded the presentation by noting important dates and milestones. The MOC has been submitted to both NCQA and DHCS. In June, we will launch the QI D-SNP subcommittee. We are currently reviewing all Health Services policies, some of which were talked about today. Next steps include committee and work group meetings, building organization-wide infrastructure, and integrating D-SNP work into Medi-Cal functions where able. Chris Swales, MD, noted that medication adherence is something providers cannot control, and he finds it frustrating to be monitored about that. Dr. Moore clarified that medication adherence is not one of the quality metrics we will be placing in our pay-for-performance program. It is, however, a measure that as a health plan, we are responsible for as part of our NCQA Stars rating. There were no other questions.	
VIII. **Adjournment** – Q/UAC adjourned at 9:04 a.m. Q/UAC next meets at 7:30 a.m. Wednesday, March 20.		

Respectfully submitted by: Leslie Erickson, Program Coordinator II, QI

Signature of Approval: _____ Date: _____

Robert Moore, MD, MPH, MBA
Chief Medical Officer and Committee Chair

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
INTERNAL QUALITY IMPROVEMENT (IQI) COMMITTEE MEETING MINUTES
Tuesday, Feb. 11, 2025 / 1:30 – 3:33 PM

Members Present:
Andrews, Leigha, MBA, Regional Director, Southeast
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
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
Hightower, Tony, CPhT, Associate Director, UM Regulations
Innes, Latrice, Manager of Grievance & Appeals Compliance
Jalloh, Mohamed "Moe," Pharm.D, Health Equity Officer
Jones, Kermit, MD, JD, Medical Director for Medicare Services
Kerlin, Mary, Senior Director, Provider Relations
Klakken, Vicki, Regional Director (Northwest)
Kubota, Marshall, MD, Associate Medical Director
Leung, Stan, Pharm.D, Director of Pharmacy Services
Moore, Robert, MD, MPH, MBA, Chief Medical Officer, Committee Chair
Netherda, Mark, MD, Medical Director for Quality, Committee Vice-Chair
Newman, Rachel, RN, BSN, Manager, Clinical Compliance – Quality Inspections
Randhawa, Manleen, Senior Health Educator, 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
Davis, Wendi, Chief Operating Officer
Matthews, Richard "Doug," MD, Regional Medical Director (Chico)
Ruffin, DeLorean, DrPH, MPH, Director of Population Health
Sharp, Tim, Regional Director, Northeast
Turnipseed, Amy, Senior Director of External and Regulatory Affairs

Guests:
Biasotti, Danielle, RPhT, Assoc. Dir. ECM Ops, Enhanced Health Services
Bikila, Dejene, Manager of Data Science, Finance
Blake, Jill, Regional Director (Auburn)
Broadhead, Candi, Project Manager II, QI
Bushey, Lindsey, Project Manager I, QI
Chishty, Shahrukh, Sr. Mgr, Foster Care Programs, Behavioral Health
Cox, Bradley, DU, Regional Medical Director (Northwest)
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)
Gual, Kristine, Director of Quality Measurement, QI
Hannah, Bethany, Administrative Assistant I, Health Equity
Harris, Matthew, Education Specialist, Provider Relations
Harris, Vander, Senior Health Data Analyst I, Finance
Isola, Brandy, Manager of Performance Improvement, QI (Chico)
Jamali, Shahrzad, Improvement Advisor, QI (Chico)
Jensen, Annika, RN, Assoc. Dir., Clinical Integration, Care Coordination
Kim, Amanda, Improvement Advisor, QI (Redding)
Kung, Jen, Senior Health Data Analyst II, Finance
Lee, Donna, Manager of Claims, Claims
Moore, Jordan, Provider Education Specialist, Provider Relations
Moraghebi, Roudabeh, Manager of Health Analytics, Finance
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
Quichocho, Sue, Manager of Quality Measurement, QI
Rathnayake, Russ, Senior Health Data Analyst I, Finance
Robertello, Kimberly, Senior Medicare QI Program Manager, QI
Romero, Liz, Improvement Advisor, QI (Fairfield)
Shrivastava, Poorva, Sr Health Data Analyst, Health Analytics, Finance
Sivasankar, Shivani, Sr Data Scientist, Health Analytics, Finance
Stark, Rebecca, Regional Director (Chico)
Stokes, Sarah, Project Coordinator II, QI
Tryan, Tiffany, Improvement Advisor, QI (Redding)
Vaisenberg, Liat, Associate Director of Health Analytics, Finance
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. Dr. Colleen Townsend introduced Partnership's two new Regional Medical Directors, Lisa Ward, MD, in Santa Rosa, and Matthew Morris, MD, in Auburn. Both physicians were present in Fairfield for the meeting. Approval of the Jan. 7, 2025 IQI Minutes *Acknowledgement and Acceptance of draft meeting minutes of the* • Jan. 23 Substance Use Internal Quality Improvement (SUIQI) Committee	Motion to approve IQI Minutes: Mark Netherda, MD Second: Isaac Brown Motion to accept other minutes: Mark Netherda, MD Second: Stan Leung, Pharm.D
II. Old Business – None		
III. New Business Consent Calendar (Committee Members as applicable)		
Health Services Policies <u>Care Coordination</u> MCCP2020 – Lactation Policy and Guidelines MCCP2021 – Women, Infant and Children (WIC) Supplemental Food Program <u>Utilization Management</u> MCUP3064 – Communication Services MPUG3011 – Criteria for Home Health Services MPUG3019 – Hearing Aid Guidelines MPUP3018 – Health Services Review of Observation Code Billing MPUP3048 – Dental Services (including Dental Anesthesia) – ***pulled to audible a change*** <u>Transportation</u> - ***pulled*** MCCP2030 – Transportation-Related Travel Expenses: Lodging, Meals, Attendants, Parking and Tolls ***Non-Health Services Policies*** **Credentialing** – ***all but 500 and 700 pulled*** MPCR16 – Lactation Consultant Credentialing Policy MPCR17 – Standards for Contracted Primary Care *and Urgent Care* Physicians – **NEW TITLE** MPCR101 – Ensuring Non-discriminatory Credentialing and Re-credentialing Processes MPCR302 – Behavioral and Mental Health Practitioner Credentialing and Re-credentialing Requirements MPCR303 – Applied Behavioral Health and Substance Use Disorder Practitioner Credentialing and Re-credentialing Requirements MPCR500 – Ongoing Monitoring and Interventions MPCR700 – Assessment of Organizational Providers Anna Campbell and Leslie Erickson pulled Transportation and all Credentialing policies for formatting, content and other issues. Anna also pulled UM's MPUP3048 to audible a change at Section VI.A.: "Magellan" will be removed, and reference made instead to the DHCS-contracted pharmacy administrator. • MCCP2030 will be formally archived under Care Coordination and renamed as MPTP2503 under Transportation at March IQI. (Communications is now adding a Transportation page to the Provider Manual's Health Services section.) • Anna will review suggested urgent care language in MPCR17 for agreement with Utilization Management's MCUP3044 Urgent Care Services.	The CC and UM (but for MPUP3048) policies, were approved: Anna Campbell Second: Mark Netherda, MD Motion to **approve MPCR500 and MPCR700 as they would later be amended**: Isaac Brown Second: Mark Netherda, MD Motion to **approve an amended MPUP3048**: Anna Campbell Second: Marshall Kubota, MD <u>Next Steps:</u> Approved Health Services policies will go to the Feb. 19 Quality/ Utilization Advisory Committee (Q/UAC) and the March 12 Physician Advisory Committee (PAC) *Meeting Postscript:* MPCR500 and MPCR700 were approved at the Credentials Committee Feb. 12.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Network Services leadership noted that approval of MPCR500 and MPCR700 was essential to other items before the Credentials Committee on Feb. 12 and asked that IQI approve these two policies understanding that Leslie would fix the outstanding formatting and minor content issues. IQI agreed. (Brown/Netherda) Leslie fixed the issues and forwarded the corrected policies to Credentials Committee staff. Identified issues with the other Credentialing policies have been forwarded to appropriate staff to resolve, and these policies should come back to IQI in March.	
IV. New Business – Discussion Policies		
Policy Owner: Quality Improvement – *Presenter: Rachel Newman, RN, Manager, Clinical Compliance Inspection Team*		
MCQP1022 – Site Review Requirements and Guidelines	**Formerly MPQP1022, the alphanumeric is changing to "MC" as this policy only applies to Medi-Cal. Other agencies are responsible for Medicare site review.** Likewise, the alphanumeric also changes for Attachments A-L. A Supplemental Facility/Mobile Unit/Street Medicine Facility Site Review Tool is added as a NEW Attachment I. (Former attachments I, J, and K now become J, K, and L, respectively.) The Department of Health Care Services (DHCS) delegated the making of this new tool to all the Managed Care Plans (MCPs). This is what the MCPs submitted to DHCS, and we await their response. Some of the provisions herein may not apply to the street medicine component. "PHC" changed to "Partnership" throughout the document. There were no questions; however, Anna Campbell noted a discrepancy that was resolved with Rachel after the meeting: "CNM" and "LM" licensure was added to the list of who could become a Certified Master Trainer (CMT) and Certified Site Reviewer (CSR) and conduct both initial certifications and re-certifications. **The policy will proceed as amended to Q/UAC on Feb. 19.**	Motion to **approve as presented**: Mark Netherda, MD Second: Colleen Townsend, MD Next Steps: Feb. 19 Q/UAC March 12 PAC
Policy Owner: Quality Improvement – *Presenter: Mark Netherda, MD, Medical Director for Quality*		
MPQG1005 – Adult Preventive Health Guidelines	**Formerly MCQG1005, the alphanumeric is changing to "MP" as this policy will apply in part to Partnership Advantage, effective Jan. 1, 2026 in eight Partnership counties. Accordingly, both the footnote disclaimer and the Medicare link https://www.medicare.gov/coverage/preventive-screening-services are added to this policy.** This policy has a few minor changes pursuant to All Plan Letter (APL) 24-008, Immunization Requirements, which DHCS adopted last fall, subsequently causing updates to the Pediatric Preventive Guidelines and Initial Health Assessment policies that this committee saw in November 2024. **Related Policies additions:** MCUP3052 – Medical Nutrition Services and MCCP2026 – Diabetes Prevention Services **Purpose Statement:** Reference to Preventive Care for Medicare recipients is added. **VI.C. Medicare Preventive Care is added**: **1.** All recommendations described in Attachment A apply to Medicare recipients, provided age and other individual specific criteria are met. **2.** All adult vaccinations recommended by the current CDC's Advisory Committee on Immunization Practices apply. **3.** The following services are available to both Medicare and Medi-Cal recipients: a. Medical Nutrition Services (MNT) as outlined in Partnership policy MCUP3052 – Medical Nutrition Services. b. Diabetes Prevention Services (DPP) as outlined in Partnership policy MCCP2026 – Diabetes Prevention Services. 4. Medicare-specific preventive care visits as outlined on the Medicare website at	Motion to **approve as presented**: Colleen Townsend, MD Second: Isaac Brown Next Steps: Feb. 19 Q/UAC March 12 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	http://www.medicare.gov/coverage/preventive-screening-services including, but not limited to **a.** A "Welcome to Medicare" visit **b.** An annual "adult wellness visit" (AWV) **c.** A cardiovascular behavioral therapy visit (performed by the PCP) **d.** An obesity behavioral therapy visit (performed by the PCP). **References are updated.** **Attachment A is updated** in some sections, including: • Assessment for Hearing Impairment • *Screening for* Depression and Suicide *Risks in Adults and Perinatal Depression* • Tobacco Use and Tobacco Caused Disease Counseling, *including for Pregnant Persons* • Breast Cancer Screening by Mammography The USPSTF (April 2024) recommends biennial mammography for persons with breasts and assigned female at birth ages 40 to 74 years (Grade B). For Transgender and Gender Diverse persons, consider "… the length of time of hormone use, dosing, current age, and the age at which hormones were initiated." Shared decision making is recommended. • *Vitamin D, Calcium or Combined Supplementation for the Primary Prevention of Fractures in* Postmenopausal Persons Assigned as Female at Birth Dr. Netherda went through the synopsis and noted that the policy is also in accordance with California Assembly Bill 2132 on tuberculosis screening that went into effect Jan. 1. The Reference section is updated to reflect this. Dr. Moore thanked Dr. Netherda for his review of the United States Preventive Services Task Force (USPSTF) recommendations, which comprise this policy's Attachment A. Anna noted that, for Medi-Cal, policy section VI.A. states "An Initial Health Appointment (IHA) must be completed for all Members within 120 days of assignment to Partnership…" yet, the timeline for a first Medicare "adult well-care visit" is 12 months. Rachel added that "Medi-Medi" patients' records are not pulled for site review. **Dr. Moore said this apparent discrepancy would be investigated,** and he urged IQI to approve as-is; if necessary, the policy will be brought back. Isaac questioned how Partnership would know that "shared decision making" in breast cancer screening for gender diverse persons actually occurs. Dr. Moore said we wouldn't necessarily know or be able to capture this. Jennifer Durst suggested that all health centers might post "persons with breast tissue should be screened." **Dr. Moore said the QIP team could look into this.**	
MPQP1016 – Potential Quality Issue Investigation and Resolution	**This policy is being brought early to coincide with the annual PQI report and to make some language changes. References to "severity level" have been changed to "severity rating." Some timeframes have been clarified. The Partnership Advantage footnote disclaimer has been added.** **III.D. Corrective Action Plan is now redefined:** A directive from the Peer Review Committee specifying required actions/ activities to be undertaken by a provider of concern. CAPs are given to educate the provider/facility on the identified issue/concern, with the goals of helping to prevent identified issues from recurring and improving member safety. CAPs contain clearly stated goals and timeframes for completion. **VI.C.1.a. addition:** The Investigator will begin an investigation within 30 days of receiving the PQI case referral.	Motion to **approve as amended**: Marshall Kubota, MD Second: Anna Campbell Next Steps: Feb. 19 Q/UAC March 12 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	VI.C.3.d.ii: The timeframe for clinicians to acknowledge receipt and initiation of a CAP is 30 calendar days. If the CAP is not acknowledged and initiated by day 31, the Investigator will contact the POC. A 15-day extension may be granted for reasonable concerns. If the POC has not acknowledged and initiated the CAP by day 46, the Investigator will forward the case to the CMO/physician designee for further determination, including possible review by the Credentials Committee. **VI.C.3.d.iv.f):** "Coaching/counseling from the POC's Medical Director" is added to the list of what a CAP may stipulate. **VI.E.1. Track and Trend Report is modified to note:** In addition, providers and/or facilities who were given a severity rating of P2 or S2 and above at PRC will be monitored for at least the following year via the track and trend reports to determine if the identified concern is ongoing. If through this process, any additional concerns are identified, further investigation or actions may be implemented. **VI.E.4. is added:** A monthly report of the number of PQI referrals, open cases, and cases pending PRC presentation will be sent to the CMO and to the Medical Director of Quality. Dr. Netherda went through the synopsis, noting that the track and trend VI.E.1. was proactively modified based on comments heard during the December 2024 DHCS audit. (There was no Corrective Action Plan (CAP) issued that mandated this change.) Dr. Kubota suggested that all time framed in "days" be clarified to read "calendar days," if that is in fact what is meant. **The friendly amendment was accepted.**	
Policy Owner: Utilization Management – *Presenter: Shahrukh Chishty, Senior Manager of Foster Care Programs*		
MCUP3103 – Coordination of Care for Child Welfare-Involved Members – **NEW TITLE**	This policy was updated and approved by DHCS for APL 24-013 "Managed Care Plan Child Welfare Liaison." • The name of the policy was updated to reflect the new "Child Welfare-Involved" language. • Policy template changes were also made to specify Behavioral Health as the Business Unit responsible for this policy. **Section I:** Two Related Policies were added as follows: • MCCP2032 - CalAIM Enhanced Care Management (ECM) • MPQD1001- Quality and Performance Improvement Program Description **Section III.** New Definitions were added for • Assembly Bill 2083 • Child Welfare-Involved Youth • Enhanced Care Management (ECM) Provider:' • ECM Lead Care Manager • Resource Family **Section VI.** Language updates were made throughout the main policy section to use the phrase "child welfare-involved youth" in lieu of previous language, "children in foster care." **Section VI.C.** A new policy section was added to define the roles and responsibilities of Child Welfare Liaisons at Partnership. **Section VII. References:** Two new References were added for F. DHCS APL 24-013 G. California Foster Youth Bill of Rights	Motion to **approve as presented**: Anna Campbell Second: Brigid Gast, RN <u>Next Steps</u>: Feb. 19 Q/UAC March 12 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Shahrukh went through the synopsis, noting that "child welfare-involved" has several categories, including those in foster care and those in the process of being adopted. DHCS has approved these policy changes, she said. There were no questions.	
V. Presentations		
1. Care Coordination Grand Analysis • MPCD2013 - Care Coordination Program Description • Complex Case Management (CCM) CY 2023 Program Evaluation Report and Presentation *Brigid Gast, RN, Senior Director of Care Management* *Shannon Boyle, RN, Manager, Care Coordination Regulatory Performance* *Shivani Sivasankar, Senior Data Scientist, Health Analytics*	Dr. Moore remarked that the National Committee on Quality Assurance (NCQA) requires us to present Grand Analyses on certain aspects of the Partnership program, and that these analyses append to the annual renewals of the Health Services departments' program descriptions. Brigid Gast, RN, made opening remarks as to Care Coordination's mission and scope before turning over the presentation to Shannon Boyle, RN, who presented the synopsis of changes to the Program Description. **Policy is due for Annual Review** **Department Objectives & Goals (Page 3):** **Updated** foster care to Members involved in child welfare and foster care per APL 24-013 **Updated** referral source to include internal departments such as PHM, EHS, and Behavioral Health **Updated footnote (Page 6):** MCUP3143 updated to reflect new policy number MCAP7001 CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS) MCUP3142 updated to reflect new policy number MCAP7003 CalAIM Community Supports (CS) **Enhanced Care Management (ECM) Benefit (Page 12):** MCUP3143 updated to reflect new policy number MCAP7001 CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS) **Team Roles and Responsibilities (Page 12) Added:** Senior Director of Care Management- RN Associate Director of Clinical Integration Manager of Clinical Integration Supervisor of Case Management-LVN Care Coordination Business Analyst Clinical Advisor- RN Policy Analyst Senior Program Manager Program Manager I Program Manager II Customer Service Representative, CC **Updated Job Description Title:** Case Management Supervisor-RN to Supervisor of Case Management-RN **Updated Job Description for Behavioral Health Clinical Specialist-LCSW or LMFT to include:** Collaborates and coordinates care as part of the multidisciplinary team to evaluate and advocate for the medical, behavioral and psychosocial needs of the member while promoting quality and cost-effective outcomes	Motion to **approve the Program Description as presented**: Isaac Brown Second: Mark Netherda, MD Next Steps: Feb. 19 Q/UAC March 12 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Protected Health Information (Page 17) Updated: The Partnership Director of Regulatory Affairs and Program Development also serves as the Partnership Privacy Officer. Shivani Sivasankar prepared and presented the Complex Case Management (CCM) analysis for CY2023. The objective of this analysis was to determine the efficacy of the CCM program. This report reviewed and analyzed utilization metrics that evaluate member utilization such as ED visits, hospital stays, number of hospital days, PCP visits, specialty visits, number of medications and readmissions. The analysis is separated into four parts: 1. Case length analysis We included all eligible members enrolled in the CCM program during 2023 and evaluated the utilization metrics by the number of days the members were enrolled in the CCM program using ANOVA. Based on the analysis, it was determined that members who were enrolled for less than one month indicated their case was not managed as they had: lower unique medications after the start of CCM program compared to members who were enrolled for 1-8 months, higher specialty visits after the end of CCM program compared to members who were enrolled for more than eight months, and lower unique medications after the end of CCM program compared to members who were enrolled for 1-2 months. Thus, members who were enrolled for less than one month were excluded from the next analyses; 189 distinct members moved on to be included in the second analysis. 2. CCM group analysis We included eligible members enrolled in the CCM program for more than 30 days and evaluated the utilization metrics across three measurement periods: six months prior to CCM program enrollment, six months from the start of CCM services and, six months after the case has been closed to CCM using Paired T-Test. Based on the analysis, it was determined that the CCM program had made a significant impact on reducing ED visits, reducing inpatient visits, reducing average inpatient days, PCP visits and reducing Total Allowed Amount after the start and end of the program as well as increasing specialty visits after the start of the program. The disadvantage of this one group design is that there was no way to control bias (affects external validity) and there was no way to compare the individual differences between the control and CCM group (affects internal validity). 3. Identification of Significant Factors We also identified significant parameters (utilization metrics before enrollment, gender, age, region and risk level of the member) that impact utilization metrics after starting the CCM program and following CCM closure using regression analysis. 4. CCM group Vs Control Group Analysis We identified a control group which included eligible members who were not enrolled in any case management program and were matched to the distribution of risk factors (identified in the regression analysis) and eligibility months of the CCM group. The utilization metrics were compared between the members in the CCM group and members in the control group across the previously mentioned three measurement periods. We did not identify any significant results when we performed ANOVA without adjusting for any covariates. However, when we adjusted for all the significant covariates using ANCOVA, we determined that, when compared to the members in the control group, members enrolled in the CCM program had statistically significantly lower: ED visits, inpatient days and total amount for members after starting the CCM program as well as after the program closure; had higher: PCP visits, specialty visits	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	and unique number of medications after the start of the program; and had lower PCP visits, specialty visits, inpatient visits and unique number of medications after the end of the program. In conclusion, the CCM program, when compared to the control group was effective in many ways already identified. The CCM program, however, was not effective in reducing inpatient visits after the start of CCM, reducing readmissions after the start or end of CCM, and increasing PCP visits after the end of the CCM program. Anna asked questions about the total allowed amount, and Shivani answered. Dr. Moore commented that it was "good to hit triple digits" with 189 distinct members involved. There were no other questions or comments.	
2. Quality and Performance Improvement Update *Nancy Steffen, Senior Director for Quality and Performance Improvement*	• The grace period for the MY2024 PCP QIP has ended. The 2025 Preventive Care Dashboard launched Jan. 1 and is refreshed daily and accessible to those endeavoring to close any gaps. • With the pending launch of Health Rules Payor (HRP) in the second quarter this year, some other dashboards will be delayed. • Associate Medical Director and pediatrician Teresa Frankovich, MD, will host a developmental screening webinar at noon Thursday, Apil 3. This is to educate providers regarding both screening tools and CPT codes. • An "Improving Measure Outcomes: Pediatric Preventive Care" webinar occurred Feb. 10. A DHCS-approved flyer on Partnership's Health Babies Growing Together Program was distributed to providers and cited as a best practice. The flyer has been translated into Spanish, Russian, Tagalog, Hmong, and Punjabi. • Other best practices will be captured in future webinars. DHCS is expected to provide more guidance on dental fluoride, and Partnership will be sharing this with our providers. • The MY2024 Consumer Assessment of Healthcare Providers and Systems (CAHPS®) regulated survey has launched and will remain open through mid-May. This is the first such survey to include the 10 expansion counties. Related articles will appear in upcoming provider and member newsletters this spring. • We have had good retention of providers participating in the statewide Equity and Practice Transformation (EPT) Program. The Statewide Learning Collaboration (SLC) is meant to support participating practices awarded Provider Direct Payment Program (PDPP) funding. The EPT Practice Level Reporting was submitted to the Population Health Learning Center (PHLC) on Jan. 31. The next such upcoming "HEDIS®-like" data submission report is due July 31, covering CY2024.	*For information only.* Nancy thanked the Health Effectiveness Data Information Set (HEDIS®) team for their support to the EPT program.
3. D-SNP (Dual Special Needs Plan) Model of Care (MOC) *Kermit Jones, MD, JD, Medical Director for Medicare Services* and *Kimberly Robertello, PhD, Senior Medicare*	The MOC, which has been in development for about eight months, provides the basic framework under which the SNP will meet the needs of each of its enrollees after Jan. 1, 2026, go-live, Dr. Jones said. The MOC provides the foundation for promoting SNP quality, care management, and care coordination processes. NCQA reviews for approval each SNP's MOC based on standards and scoring criteria established by the Centers for Medicare and Medicaid Services (CMS). Trainings on MOC Elements 1 & 2 can be found at https://snpmoc.ncqa.org/static/media/SNPApprvl_MOC12_CY2026.f6ab25f8cbd947497fa8.pdf (Reference is to Contract Year and not Calendar Year.) There are four MOCs. In MOC 1, Partnership lets both DHCS and CMS know that we understand the SNP populations to be served, including the homeless and other Most Vulnerable Populations (MVP). NCQA scores 16 elements, each including numerous factors to address clinical and non-clinical requirements, across MOC 1-4. Were Partnership to score 85-100% of possible points, we would receive a three-year approval, Kimberly said, adding that our performance on the December 2024 mock survey bodes well. Additional DHCS expectations above NCQA mandates can be found at https://www.dhcs.ca.gov/provgovpart/Documents/CY2026-D-SNP-Policy-Guide.pdf	There were no questions. Dr. Moore congratulated everyone on their hard work to date. Oversight will be reported up through our existing committee structure, including IQI, Q/UAC, PAC, and the Board of Commissioners.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
QI Program Manager	Dr. Jones noted that SNPs are required in MOC 1 to describe potential members and the MVP too by age, gender, race, ethnicity, and language spoken. Moreover, "granular" attention is paid to low, medium, and high-risk populations. A number of member risk factors have been identified in each of the eight counties (Del Norte, Humboldt, Mendocino, Lake, Sonoma, Napa, Solano, and Marin) that will initially participate: number of members age 65 and older, those with 5+ co-morbid conditions, those who do not speak English at home, those age 25 and older without a high school diploma, those living in poverty, and those more than 65 of age who are homeless. The MOC 2 is the Care Coordination section focusing on specific CMS and DHCS care requirements, including a Health Risk Assessment (HRA), and Individualized Care Plan (ICP), and an Interdisciplinary Care Team (ICT) of providers and a case manager for each member. All D-SNP members are required to receive case management services: they will be risk-stratified to identify how much engagement is likely to occur. The MOC 3 describes both our proposed PCP and broad specialty care network in the eight-county region and the accessibility of said care. The MOC 4 defines how the D-SNP will track performance, guide improvement efforts, document, share information with stakeholders, and course correct as needed along the way. Partnership has identified five areas of focus for the D-SNP population: improving care coordination and delivery of services through direct alignment of the HRAT, ICP, and ICT ensuring access; enhancing care transitions; ensuring appropriate utilization and improving member engagement. Within these five focus areas are nine performance metrics: HRA, ICP, and ICT completion; member access to preventive/ambulatory health services at least once each year; diabetes care through controlling blood sugar; controlling high blood pressure; providing statin therapies for members with cardiovascular disease; medication adherence around cholesterol, and transitions of care through member engagement post-discharge. These metrics don't necessarily relate to our NCQA STAR rating as a health plan, Kimberly noted; however, any failure to meet goals year-over-year could result in Correct Action Plan(s) (CAP). Kimberly spoke more about reporting and oversight and Dr. Jones of important 2025 dates. Partnership needs to be ready to manage prior authorizations in October 2025. Next steps include committee and work group meetings, building organization-wide infrastructure, and integrating D-SNP work into Medi-Cal functions where able.	
4. PQI/PPC Annual Report *Robert Bides, RN, Manager, Member Safety – Quality Investigations*	Robert defined both Potential Quality Issues and Provider Preventable Conditions before saying that the confidential Peer Review Committee as the investigating body that meets monthly, reviewed 16 PQI cases in 2024, nine of these in the last two quarters. Altogether, with the Member Safety Quality Investigations team that (on a weekly basis) first reviews and scores referred cases, 207 PQI cases were completed and closed in CY 2024. Outcomes are confidential so it is difficult to exemplify specifics. The top three referral sources in Q3/Q4 continued to be Grievance & Appeals (119), "other" (15), and Medical Directors (8). As expected, the number of PQI referrals increased in 2024 above 2023 in part because of the 10-county expansion. This new "Eastern" region accounted for 40 (20%) of the 247 PQI cases referred in 2024. In Q3/Q4, 117 providers were involved in the 104 processed and closed PQIs. Of these 117, 64 were PCPs; 18 were specialists, and 31 were hospital or ER related. Robert and Dr. Netherda each remarked that primary care clinicians are the most commonly reviewed. Once again, Shasta and Solano county-based practitioners/providers accounted for the most reviewed with 22 and 17, respectively. (This is a down from and a reverse of their Q3/Q4 2023 positions with 25 and 32, respectively.)	SugarCRM (the PQI documenting and processing system) will be updated from version 8 to 14.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	There is no significant trend to report regarding the severity of cases reviewed. In 2024, just 9% (19 of 221 involved providers) were scored above a P1 or S1 (minor opportunity for improvement either in practitioner performance or systems issue, respectively) compared with 11% (34 out of 302) in 2023 and 11% (16 of 149) in 2022. In Q3/Q4, only two PPC cases were reported to Partnership. Dr. Moore commented that he suspects more have occurred but that, although they may have been self-reported to DHCS as required, they were not reported to Partnership, as is also required. Robert said we are doing outreach to hospitals to provide PPC education on reporting requirement. In conclusion, the number of Q3/Q4 2024 PQI referrals received (150) was significantly higher than the same period in 2023 (111). The Member Safety Investigation team has implemented more communication with providers of concern and continues to provide education to facilities regarding the PQI process and PPC reporting.	
5. CY2024 Site Review Report *Rachel Newman, RN*	A Site Review (SR) has two components: the Facility Site Review (FSR) and the Medical Record Review (MRR). The FSR is an assessment of a facility's physical site across Access/Safety, Personnel, Office Management, Clinical Services, Preventive Services, and Infection Control concerns according to DHCS-approved guidelines and tools. A FSR is conducted by a registered nurse/DHCS-certified site reviewer on Partnership's Clinical Compliance team at the point of initial contracting and up to three years thereafter. The reviewer will issue a Corrective Action Plan (CAP) if any of the domains fall below 80%. Overall, 2024 average FSR scores by county looked good, Rachel said. (She noted that what sites missed the most is accurate Emergency Medication Dosage charts, which must list all stocked medications.) Dr. Moore commented that when viewed by region, however, some do not score as well as others. He asked why this is so. Rachel noted that the Chico region sites were short on Infection Control. She said she does not know how these practices were scrutinized by previous health plans; however, Partnership is strict: *all* office staff must be trained. If even one individual staff is not trained, the site fails. Overall, all regions have opportunities to improve in staff training in cultural and linguistic, staff training in disability rights and provider obligations, and having height adjustable eye charts. The MMR of randomly selected records is conducted three to six months after an initial FSR has been completed. It is repeated up to every three years thereafter on format, documentation, coordination of care, pediatric preventive care, adult preventive care, and OB/CPSP preventive care (if applicable). If any of these domains score below 80%, a CAP is required for the entire review. Rachel noted that we are seeing an uptick in MMR CAPs since the release of the 2022 Site Review Tools and because reviewers have more measures to look at. All regions have opportunities for improvement in adult and pediatric preventive health. Partnership continues to offer extensive training provided by a Certified Site Review nurse for all new site review criteria. The Clinical Compliance team continues to educate sites during the SR exit interview on the Individual Health Assessment (IHA), blood lead screening and testing, developmental screening tools and other criteria as needed. Web-ex trainings on preventive criteria and the IHA are available on request, as is training on the former Child Health and Disability Prevention Program (CHDP) protocols that have now transitioned from the Department of Public Health to the Managed Care Plans. Virtual MMRs continue to be a more efficient use of time with providers.	Rachel asked for thoughts on dropping reporting of annual average FSR scores by region because reviews are generally conducted only every three years. Dr. Moore suggested she instead include a three-year rolling report.

<table>
<tr><th>AGENDA ITEM</th><th>DISCUSSION</th><th>RECOMMENDATIONS / ACTION</th></tr>
<tr><td>6. CY2024 Physical Accessibility Review Survey (PARS) Report

Rachel Newman, RN</td><td>A PARS is an assessment of how well members who are seniors or persons with disabilities (SPD) can navigate a practice site. Areas evaluated during this review include the parking lot, exterior building, interior building, restrooms, and exam rooms. Sites are assigned a designation of basic or limited accessibility based on the review findings. Partnership's Provider Directory is updated regularly for members to see which facilities meet their accessibility needs. Primary Care, OB, and High-Volume Specialty offices receive this review. Provider sites are categorized into three types:

<table>
<tr><th>Level of Access / Domains:</th><th>Definition</th></tr>
<tr><td>Basic
Parking
Exterior Building
Interior Building
Restroom
Exam room</td><td>Facility met all 29 critical elements used to identify a sites capability of accommodating SPD members.
*All domains besides Medical Equipment are of a passing score.</td></tr>
<tr><td>Limited
Missing one or more domains above</td><td>Demonstrates that the facility is deficient in one or more areas.</td></tr>
<tr><td>Medical Equipment
This is noted in addition to access level of Basic or Limited as appropriate.</td><td>PCP site has a height adjustable exam table and patient accessible weight scales per guidelines (for wheelchair/scooter plus a patient).
**This is noted in addition to level of Basic or Limited access as appropriate.</td></tr>
</table>

A total of 174 sites were assessed across Partnership in 2024: 80 enjoy "basic" designation; 94 are deemed "limited." An additional five PARS were done in Sacramento and Alameda counties for continuity of care. Partnership does not issue CAPs that would insist any practice site should mitigate a perceived PARS deficit because many practices do not own their physical plant.</td><td>Just 57 practice sites region-wide enjoy the noted additional medical equipment. Rachel suggested that providing such equipment to more sites might be appropriate via future grant programs.</td></tr>
<tr><td colspan="3">VI. Adjournment</td></tr>
<tr><td colspan="3">Dr. Moore adjourned the meeting at 3:33 p.m. IQI will next meet Tuesday, March 11, 2025.</td></tr>
<tr><td colspan="3">Respectfully Submitted by Leslie Erickson, Program Coordinator II, Quality Improvement
Approval Signature: Date:

Robert Moore, MD, MPH, MBA
Chief Medical Officer and Committee Chair</td></tr>
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Over/Under Utilization Workgroup

Meeting Name: Over/Under Utilization Workgroup

Objective of Meeting: Identify potential concerns for over/under utilization within the PHC network

Date: January 29th, 2025 **Time**: 3:00pm – 4:00pm

Location: Board Room **Owner:** Dr. Ribordy

Coordinator: Radha Chebolu (Health Analytics)

Attendees:

Partnership Health Plan	Partnership Health Plan	Partnership Health Plan
☒ Robert Moore	☒ Ledra Guillory	☒ Doreen Crume
☒ Jeff Ribordy	☐ Melissa Perez	☐ Sharon Hoffman-Spector
☒ James Cotter	☐ Wendi West	☒ Lisa Malvo
☐ Mary Kerlin	☐ Stan Leung	☐ Melanie Lam
☒ Margarita Garcia-Hernandez	☐ Nancy Steffen	☒ Cody West
☒ Dejene Bikila	☒ Brian Spiker	☐ Angela Guevarra
☒ Liat Vaisenberg	☒ Shivani Sivasankar	☐ Renee Trosky
☒ Kristine Gual	☐ Radha Chebolu	☐ Lisa O'Connell
☒ Amber Newell	☐ Tiphanie Salehi	☒ Jen Kung
☒ Athena Beltran-Nampraseut	☐ Kim Palfini	☒ James Devan
☐ Garnet Booth	☐ Mark Aguirre	☒ Isaac Brown
☐ Kim Fillette	☐ Shell Swift	☐ Amy McCune
☒ Lindsey Bushey	☐ Stephanie Nakatani Phipps	☒ Katherine Barresi
☐ Sarah Browning	☐ David Lopez	☒ Deanna Watson
☐ Emily Stoller	☒ Candis Broadhead	☐ Kristina Coester
☒ Monika Brunkal	☒ Alex Brito	☐ Rebecca Garcia
☐ Penny Thomas	☐ Ruth Hood	☐ David Lavine
☐ Christopher Triolo	☐ Derick Stacy	☐ Elijah Allen
☒ Jeffrey DeVido	☐ Mark Bontrager	☐ Erin Hall
☒ Anthony Sackett	☐ Greg Allen Friedman	☐ Dominic Salido
☐ Tim Sharp	☒ Akshay Sharma	☐ Mohamed Jalloh
☒ Rasitha Rathnayake	☐ Dave Hosford	☐ Tim Sharp
☐ DeLorean Ruffin	☐ Danielle Ogren	☐ Florentina Torres
☒ Vander Harris	☐ Hanh Hoang	☐ Qi Yao
☐ Michelle Rodriguez	☐ Amber Acosta	☐ Amanda Federico
☐ Cheng Saechao	☒ Tasha Krongard	☒ Brandy Isola
☒ Garvin Lum	☒ Jennifer Durst	☒ Eva Lopez
☒ Kimberly Robertello	☒ Poorva Shrivastava	☒ Reza Far
☒ Roudabeh Moraghebi	☒ Tom Nguyen	☒ Teresa Lugo
☒ Tony Sengdara		☒ Tony Sengdara

Action Items	Presenter	Due	Revise / Approve Date
Approve Minutes from 10/30/2024		01/29/2025	

Topic	Notes
1) Introductions & Objective of Meeting *Speaker:* Dr. Jeff Ribordy	Identify potential concerns for over/under utilization within the PHC network
2) Review & approve minutes from last meeting *Speaker:* Dr. Jeff Ribordy	
Underutilization Analysis Discussion Topics	
1) PCP Visit Report Owner: HA	Discuss Findings Overall PCP visit rate among Medi-Cal Prime members was higher in the Northern Region in 2024 Q3, compared to Eastern and Southern Regions. However, all the three regions saw a drop in rates from 2024 Q2 to 2024 Q3. At the county level, Del Norte County had the highest visit rate, followed by Colusa and Sonoma Counties. Nevada, Solano, and Placer had the lowest visit rates. 42% of the counties exceeded the target visit rate. Most counties experienced a drop in visit rates from 2024 Q2 to 2024 Q3, except for Tehama and Glenn Counties. Yolo County had a marked drop in visit rates from 2024 Q1 to Q2, followed by a sharp hike in visit rates from Q2 to Q3, largely due to Dignity/Woodland Contract's termination in Q2 and reinstation in Q3 respectively. The following clinics exceeded the target visit rate Chapa-De Indian Health, Ampla Health Yuba City Medical Center, and Ampla Health Richland Medical Center. The clinics in the view are listed in descending order by membership. Placer County placed last in the visit rate among all PHC counties. This was driven by a very low rate in Wellspace Roseville clinic, which attends to a high number of PHC members. The regional director informed that that location had EDI issues and that many claims were backlogged and waiting to be submitted. HA will work with PR to analyze the data again once the issues are resolved
2) Flu Vaccine/Smoking cessation counseling Owner: CMO	Discuss Findings MY 2024 Patient Experience – a. Have you had either a flu shot or flu spray in the nose since July 1, 2023? In 2022 and 2023, the percentage of members responding 'Yes' and 'No' was nearly identical, with 'Yes' responders slightly higher than 'No' responders. In contrast, 2024 witnesses a drop in 'Yes' responders, while 'No' responders increase by 8 percentage points. b. Do you smoke cigarettes or use tobacco every day, some days, or not at all? From 2022 and 2023, the percentage of members who answered "Everyday/Somedays" and "Not at

	all/Don't know" remained consistent, with majority of the members falling into the 'Not at all/Don't know' category. However, there was a notable decline in 'Everyday/Somedays' responders in 2024, dropping by 10 percentage points, while the "Not at all/Don't know" group remained steady, maintaining the same rate as 2023. c. In the last 12 months, how often were you advised to quit smoking or using tobacco by a doctor or other health provider in your plan? In 2022 and 2023, the proportion of members who responded 'Usually/Always' and 'Never/Sometimes' was nearly identical, with 'Usually/Always' responders outnumbering the 'Never/Sometimes' responders. In 2024, both 'Usually/Always' and 'Never/Sometimes' responders decreased, but 'Usually/Always' responders remained higher. The 'Usually/Always' responders exceeded the 'Never/Sometimes' responders by 13 percentage points. d. In the last 12 months. How often was medication recommended or discussed by a doctor or health provider to assist you with quitting smoking or using tobacco? From 2022 to 2024, a higher percentage of members reported 'Never/Sometimes' receiving assistance from their doctors compared to those 'Usually/Always' receiving assistance. However, the gap between these two groups decreased in 2023 and furthermore in 2024 the 2 groups, compared to 2022 and 2023. e. In the last 12 months, how often did you doctor or health provider discuss or provide methods and strategies other than medication to assist you with quitting smoking or using tobacco? Similar patterns were observed as in survey d.
3) Tobacco Screening Owner*:* HA	Discuss Findings The Tobacco Screening Rates have demonstrated an upward trend for both pediatric and adult populations from 2022 through 2024, with a marked acceleration from 2023 to 2024. Moreover, adult screening rates exceeded pediatric rates in all three years, and female screening rates exceeded the male screening rates, for both pediatric and adult populations. There are marked differences across the different demographic groups. Amongst the adults, Cambodian speakers had higher rates, while Punjabi speakers had higher rates among the pediatric populations. Adult Hispanic members exhibited higher rates. Within pediatric populations, Asian members had higher rates, whereas

	Native Americans had the lowest rates across the pediatric and adult groups. The Northern and Southern regions have shown an upward trend. In the Northern region, adults had higher screening rates than pediatric members in 2022 and 2023, though the rates for both age groups converged in 2024. The Southern region saw a small difference in rates between the adult and pediatric members in 2022, followed by an upward trend, with adults experiencing higher rates throughout. At the county level, majority of the Northern counties experienced an increase in rates from 2023 to 2024. Sonoma County was the only Southern County to exhibit an increase in rates during the same period. Among the Eastern counties, Yuba County had the highest rate and Colusa had the lowest rate in 2024.
4) Cervical cancer screening *Speaker:* QI	Discuss Findings For measurement year 2024 (MY2024), Partnership HealthPlan of California's (PHC's) performance on the HEDIS Cervical Cancer Screening measure relative to NCQA national Medicaid benchmarks varied across the five sub-regions. While the Southeast and Southwest Regions met the 50th percentile in MY2022, both the Northeast or Northwest sub-regions performed at the 25th percentile benchmark, which is below the DHCS minimum performance level (MPL) of NCQA's 50th national percentile. Early cancer detection is an essential component of women's health, and there are 7.4 new cases per 100,000 women per year.1 Measure Definition: The percentage of women 21- 64 years of age who were screened for cervical cancer using either of the following criteria: • Women ages 21- 64 years of age who had cervical cytology (Pap testing) performed within the last three years. • Women ages 30 - 64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last five years. • Women ages 30 - 64 years of age who had cervical cytology/high-risk human papillomavirus (hrHPV) co-testing within the last five years. Partnership promotes the HPV vaccination series

[1] https://www.cancer.org/cancer/cervical-cancer/about/key-statistics.html

	through the Immunizations for Adolescents (IMA-2) HEDIS measure and supports this initiative through the following projects - Women's Health and Perinatal Workgroup - Self-Collected HPV Specimens - Provider Trainings and Educational Materials - Enhanced Provider Engagement and Modified Primary Care Provider Quality Incentive Program (PCP QIP)
5) Foster youth *Speaker:* HA	As of January 2025, the top three counties with highest number of members were Butte from the Eastern counties, Shasta from the Northern counties, and Solano from the Southern counties had the highest number of child welfare-involved youth. White members had higher number of members, while Asian the lowest number of members. Among all the age groups, 10–17-year-olds had the largest membership. There are a total of 14,815 child welfare-involved members in 2024. About 55% received services in the service categories listed. The top 2 service categories for these members are Well Child Visits (34%) and ED Services (28%). Less than 5% of members received any services in all other service categories. 4,175 (28%) of members received ED services in 2024. Members in Modoc county and members who are Native or Pacific Islander have the highest share of members that received ED services. 89 members received 116 distinct Community Support Services. The highest number of services were for the Housing Transition/Navigation Services category. There were 21 members in Shasta who received such services. The category with the least number of services is Personal Care/Homemaker services.
Overutilization Analysis Discussion Topics	
1)	
Future Agenda Items	PCP visit rates will continue to be monitored
Next Meeting Date: TBD	

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MEETING MINUTES

Meeting Name: Population Needs Assessment Committee

Date: February 6, 2025 **Time**: 4 - 5 p.m.

Location: Marin Conference Room; Virtual

Attendees: DeLorean Ruffin, DrPH; Hannah O'Leary; Katherine Barresi, RN; Monika Brunkal, RPh; Tim Sharp

Virtual Attendees: Amanda Smith; Bethany Hannah; Colleen Townsend, MD; Gene Reyes; Jeff Ribordy, MD; Jill Blake; Leigha Andrews; Lilian Merino; Rebecca Stark; Richard Matthews, MD; Vicky Klakken; Wendy Starr; William Kinder; Yolanda Latham

Absent: Aaron Maxwell; Christine Smith; Denise Rivera; Greg Allen Friedman; Isaac Brown; Kathryn Power; Liat Vaisenberg; Lisa O'Connell; Margarita Hernandez; Mark Bontrager; Marshall Kubota, MD; Matt Hintereder; Mohamed Jalloh, PharmD; Nancy Steffen; Priscila Ayala; Robert Moore, MD; Wendi Davis

Agenda Topic	Minutes	Action Items
1. Intros *Time: 5 minutes* *Speaker: Hannah*	• CHNL expected to start in Auburn in February. ○ Fully staffed in all regions in March.	

2. CHA/CHIP updates
Time: 30 minutes
Speaker: Hannah
	Two PowerPoint presentations were used during this discussion, attached with these minutes.
	
	PNA Initial Findings Presentation
	• PNA is 105 pages this year.
	• 2025 PNA looking at the needs for 2024.
	• Intention to fill NCQA requirements.
	
	Slides 3-5 Key Findings
	• Economic instability
	• Lack of access to quality healthcare
	• Neighborhood and built environment challenges
	• Limited access to quality education
	• Social and community context challenges
	• Other data sources
	  ○ 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*
	  ○ Increased member diagnosis of substance use disorder
	  ○ High number of mental health visits among the White population compared to other groups
	  ○ Underperforming breast cancer screening rates and cervical cancer rates in the northern counties
	  ○ Health disparities found in specific measures:
	  ▪ Controlling high blood pressure
		• Share both sets of slides.
		
		• Connect with Mark B. to discuss language for this section of PNA

Agenda Topic	Minutes	Action Items
	▪ Child and adolescent well care visits ▪ Hemoglobin A1c Control for Diabetes – Poor Control ▪ Pre and post-natal care visits **Slides 6-8 Actions Taken** • Opportunities to address: o Organizational structure o Social and environmental needs o Member health and wellness o Access to care o Health disparities o 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 • 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 • Will conduct health education sessions in 2025 around tobacco prevention • Reimbursing for wellness coach staff at schools that function as lay mental health workers • Contracting with Alinea Medical Imaging for mobile mammography imaging • 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	

Agenda Topic	Minutes	Action Items

	Note: We do not have the wellness coach reimbursement officially approved.
	
	CHA/CHIP Updates Presentation
	• Worksheet updates:
	  ○ 5 worksheets are still in progress (Humboldt, Mendocino, Shasta, Sutter, and Yuba)
	  ▪ Shasta has agreed to sign (previously they had declined to sign) just needs to be route to the appropriate people on their end
	  ▪ Humboldt is still willing to sign but waiting to do so until they receive an answer about their funding proposal. We are working on an appropriate response to their request.
	  ▪ Mendocino said they would sign but have yet to do so. We have followed up with them several times.
	  ▪ We have gone back and forth several times with Yuba and Sutter – still waiting for final signature.
	• Goal Status:
	  ○ To date, the PNA Committee has approved goals for:
	  ▪ Modoc, Shasta, and Trinity
	
	  ○ 2 county goals are pending Committee approval which we will look at in the next few slides:
	  ▪ Glenn and Nevada – up for approval today
	
	  ○ 14 Goals have been drafted, but need final county approval
	  ▪ Butte – wants to focus on lead screening
	  ▪ Colusa – increase access to perinatal care (Postpartum Care & Timeliness of Prenatal Care)
	  ▪ Del Norte – would like to focus on increasing the rate of adolescent vaccinations
	  ▪ Lake – wants to focus on tobacco cessation in the adult population
	  ▪ Napa – a draft goal pending; waiting on transportation data validation
	  ▪ Plumas – wants to decrease the number of opioid overdose related emergency department visits
	  ▪ Sierra – wants to decrease the percentage of 9th graders who experience chronic sadness/hopelessness
	  ▪ Siskiyou – wants to focus on increasing Perinatal Depression Screening	

Agenda Topic	Minutes	Action Items
	▪ Solano – rethinking one of the strategies ▪ Sutter – wants to focus on 3 goals tied to their CHIP which includes topics such as • Behavioral Health • Sexually Transmitted Infections • ECM/CS ▪ Tehama – wants to focus on healthcare access ▪ Yolo - had to go back to the drawing board ▪ Yuba – wants to focus on 3 goals tied to their CHIP which include • Increasing colon cancer screenings • increasing adult and youth mental health awareness • centralizing information regarding parks and recreation sites ○ 3 counties have identified priority areas for their goal or have partially written their goal ▪ Humboldt – wants to focus on increasing childhood wellbeing by increasing referrals to home visiting program ▪ Marin – would like to focus on improving health of children 0-5 by way of CHWs ▪ Placer – wants to work on improving Immunization rates ○ 3 counties have not identified any sort of goal yet but we are maintaining consistent communication with them. ▪ Mendocino ▪ Sonoma ▪ Lassen • Glenn County Goal ○ Would like to tie their goal to transportation, due to data limitations this is the identified alternative. The goal includes objectives to delineate between in person and telehealth. ○ Goal: Increase access to specialty care for cardiovascular disease/Internal Medicine and Nephrology specialties. ▪ SMART Objective 1: By December 31, 2025, Glenn County aims to increase the percentage of RAF's used in which at least 68% of cardiovascular disease/Internal Medicine specialty referrals will result in	• Add baseline RAFs (if available)

Agenda Topic	Minutes	Action Items
	used RAFs and at least 77% of Nephrology specialty referrals will result in used RAFs. ▪ SMART Objective 2: Glenn County aims to increase the telehealth utilization for cardiovascular disease/Internal Medicine and Nephrology specialty visits from 0 to 5 completed visits for each specialty by December 31, 2025. • Strategy 1: Outreach • 1.1- Partnership & GCPH will collaborate and co-facilitate at least two informative sessions: one Member Informative Session and one Partner Informative Session. These sessions will include presentations on member benefits (i.e. Transportation and telehealth) by Partnership and on health topics related to cardiovascular disease and nephrology by GCPH. • 1.2- GCPH will engage in community events and partner with organizations focused on cardiovascular and nephrology health to distribute educational materials. Partnership may provide support by attending events to share information about member benefits, such as access to transportation and telehealth services for appointments. • Strategy 2: Transportation Data • 2.1- In collaboration with GCPH and Partnership, the Transportation CHIP Subcommittee will complete a comprehensive transportation landscape analysis in Glenn County including, but not limited to transportation providers, utilization trends and potential population stratifications by end of Quarter 2 of 2025. • Nevada County Goal ○ Goal: Improve IZ rates for children aged 0-2 years old ○ SMART Objective: By June 2026, increase the percentage of children who receive their third DTaP (Diphtheria, Tetanus, Pertussis) shot between 6-12 months from 52% to 67%. ○ Strategy 1: Implement Countywide Vaccination Awareness Campaign ○ 1.1 - Identify a local provider and patient to participate in a 30-second educational campaign video.	• Include provider education sessions on transportation. Make sure Providers and PH are on same page. • Approved with edits • Dr. Ribordy asks that this includes the language

Agenda Topic	Minutes	Action Items
	○ 1.2 - Create and promote the Nevada County Vax Facts website offering comprehensive information on childhood vaccinations, schedules, and resources for parents and caregivers, including messaging for community healthcare providers by August 2025.	"vaccinate at any visit" • Approved with edits
3. Open Discussion *Time: 10 minutes* *Speaker: All*	• Dr. Moore shared that there will soon be a CHA/CHIP standardization workgroup. ○ This group will be working towards standardization of resource requests and other processes. Invites for the workgroup are on the way. • Updates to the SharePoint for the CHA/CHIP area of work to include approved county goals and other relevant information. • County data reports will begin again in March. Ruth, Greg, and Garvin will be working on this.	
Next Meeting	• Reminder for dept. leaders: the CHNL team will be reaching cross-departmentally to engage SMEs as needed to support CHA/CHIP work. ○ Staff joining CHA/CHIP meetings or activities will need to log their hours – the CHNL team will give them details. • If attending a CHA/CHIP-relevant meeting, don't forget to send the CHA/CHIP team your notes at chachip@partnershiphp.org. The Committee will meet again next on 3/5/2025.	

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QI DEPARTMENT UPDATE
MARCH 2025
PREPARED BY NANCY STEFFEN
SENIOR DIRECTOR, QUALITY AND PERFORMANCE IMPROVEMENT

QUALITY IMPROVEMENT PROGRAMS (QIPS)

PROGRAM	UPDATE
PRIMARY CARE PROVIDER QUALITY IMPROVEMENT PROGRAM (PCP QIP)	• 2025 eReports launched within the provider network on 03/03/2025. This is the last time eReports will launch using Amysis data. • 2025 eReports Kick Off webinar was held Monday, 02/25/2025. A link will post to the PCP QIP webpage within the first week of March. Detailed specifications for the 2025 Measurement Year can be found in eReports, with an abridged version posted on the Partnership website under Providers within the Quality menu options. • 2024 payment season has begun. In March, the PCP QIP team will hold two preliminary periods – one for providers' preliminary review of Unit of Service measure performance and one for the Non-Clinical measure performance validation. Notifications to all participating providers are planned in the coming weeks.
PALLIATIVE CARE QUALITY IMPROVEMENT PROGRAM (PALLIATIVE CARE QIP)	• Payment preparation for July – December 2024 will begin this month. Payment is to be distributed in April/May 2025. • The Palliative QIP team was notified by the Palliative Care Quality Collaborative (PCQC) that due to a lack of funding, the organization will dissolve immediately and no longer exist. The Palliative QIP team and Partnership Medical Directors are discussing how to adjust given this development and necessary programmatic changes.
ENHANCED CARE MANAGEMENT QUALITY IMPROVEMENT PROGRAM (ECM QIP)	• Q4 2024 payment preparation has begun. The preliminary reporting period and subsequent payments are set to take place over March/April 2025.

QUALITY DATA TOOLS

TOOL	UPDATE
PARTNERSHIP QUALITY DASHBOARD (PQD)	• The 2025 Business Requirement Document for PCP QIP dashboard updates has been completed and reviewed with the EDW team. Development will begin in April 2026. • 2025 PQD will launch with HRP data in Quarter 3.
EREPORTS	• 2025 eReports HRP UAT is in progress.

PERFORMANCE IMPROVEMENT (PI)

ACTIVITY	UPDATE
STATE MANDATED WORK: *PERFORMANCE IMPROVEMENT*	*DHCS Comprehensive Quality Improvement (QI) & Health Equity (HE) Process* • Partnership submitted updated root cause analysis to DHCS for the pediatric, chronic disease, and reproductive health & cancer prevention measure domains on 02/14/2025.

PROJECT (PIP) & PLAN-TO-DO-STUDY-ACT (PDSA) CYCLE	• Partnership will be submitting new strategies and actions within each of the three measure domains noted above by 03/14/2025. Progress updates will be provided to DHCS in June and October this year. • In the prior year, Partnership was required to develop strategies and actions for Behavioral Health measures due to underperformance in Follow-up for ED Visits for Mental Illness measure. However, MY2023 performance exceeded both state and regional averages which means Partnership is not obligated to conduct improvement projects, however the rates are below the Medicaid 50th percentile and still warrant on-going focus and activities to drive improvement.
QUALITY MEASURE SCORE IMPROVEMENT	• DHCS has approved scripting for well child visit text messages from Partnership. QI is exploring pilot populations to test messaging effectiveness. • Partnership launched a small scale pilot funding 10 retinal imaging cameras in optometry deserts across the Partnership service region. The pilot will seek to understand best practices and processes to share with the network to assist practices in achieving the corresponding PCP QIP measure target. • The American Cancer Society will be attending Partnership's March Chronic Disease Quality Measure Score Improvement workgroup. They will be sharing information around colorectal cancer given March is colorectal cancer awareness month. Partnership will incorporate lessons learned in provider education. • Partnership is expanding efforts and pilot projects to expedite the newborn enrollment process to increase well visit data capture through claims. Partnership has had initial discussions with Fairchild Medical Center and Siskiyou County HHS to increase timeliness of notifications from the hospital to the enrollment unit. • ***Final Reminder:*** A Developmental Screening Webinar aimed at educating providers regarding developmental screening tools and CPT codes will be hosted by Dr. Frankovich on Thursday, April 3rd at 12pm. The corresponding quality measure assessed by DHCS in the Managed Care Accountability Set (MCAS) has been a low performing measure for Partnership, largely due to prescriptive coding requirements not consistently followed by providers. Dr. Frankovich is a pediatrician and one of the Partnership Medical Directors, based in the Eureka Region. Interested clinicians, practice managers and quality staff are encouraged to register via scanning this QR code:

IMPROVEMENT ACADEMY	• *ABCs of Quality Improvement* in-person training offerings:
	  ○ The final session of the 2024/2025 series will be held on Tuesday 03/25/2025 at the McConnell Foundation in Redding.
	• 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 – Breast and Cervical Cancer Screening** ○ **03/26/2025 – Diabetes Control** ○ **04/09/2025 – Chronic Disease and Colorectal Cancer Screening** ○ **04/23/2025 – Perinatal Care and Chlamydia Screening**
JOINT LEADERSHIP INITIATIVE (JLI)	• 2025 sessions are currently being scheduled: ○ Ampla Health ○ Adventist Health ○ Fairchild Medical Center – 07/01/2025 ○ La Clinica ○ Mendocino Community Health Center ○ OLE Health ○ Open Door Community Health Centers – 06/26/2026 ○ Santa Rosa Community Health ○ Shasta Community Health Centers – 04/14/2025 ○ Solano County Family Health Services After a full year in the PCP QIP, a baseline performance for the providers in the expansion counties has been established. Using this data and other qualitative factors, we have identified additional providers from the expansion region who we will soon be inviting to participate in the Joint Leadership Initiative.
REGIONAL IMPROVEMENT MEETINGS	• Redding hosted meetings for the Eureka and Redding regions on 03/03/2025 03/04/2025 respectively. • The Southeast regional meeting is on 03/13/2025. • Regional Quality Improvement Meetings are being planned for the Chico/Auburn regions.

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 ACCESS | *ORG GOALS*	• The Consumer Assessment of Healthcare Providers and Systems® (CAHPS) regulated survey (REG) kicked off in March and will continue through mid-May. Randomly selected Partnership members receive this survey, which informs the Patient Experience score tied to Partnership's Medicaid Health Plan Rating. Partnership oversees the CAHPS® regulated annual survey with distribution conducted by our contracted vendor, PressGaney (PG). • The QI CAHPS® Team began weekly monitoring through the PG online portal survey results by all modalities (mail, phone, online). This data informs stakeholders while the survey is active and in the field.

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<td>– FY 25/26
MEMBER EXPERIENCE</td>
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To further promote our members' awareness and understanding of the CAHPS® survey, the following strategies were implemented:

Social media posts
Rotating banner message on the home page of Partnership's website
Newsletter articles in both the Member and Provider Newsletters

Pre-planning and contracting are underway for the 2026 Non-Regulated Drill Down (DD) survey. By contracting with NCQA-certified vendor PG, we aim to:

Identify key DD core questions for adult and child populations. Core DD survey questions will be the same as those in the regulatory survey (e.g., Getting Need Care, Getting Care Quickly, etc.).

Why? Aligning DD and regulatory survey questions enhances qualitative and quantitative analysis, maximizing insights for targeted improvement efforts

Develop child DD survey questions that identify root causes.
Standardize reporting and re-design final presentation materials

The 24/25 Organizational Goal #4 (Access to Care and Member Experience Improvement) activities continue. The QI CAHPS team leads milestones 3 & 8 while overseeing progress in all (8) goal deliverables. Progress through the third-quarter goal period will be updated on the OpEx-PMO Organizational Goal dashboard in April.
Notable Milestone #3 Update—Enhancement & Member Education: Interventions and activities are underway to address barriers that hinder members' understanding and navigation of their Medi-Cal-covered benefits. Focus areas are highlighted below.
<table>
<tr><th>Transportation Services</th><th>Dental (Carve-out)</th><th>Behavioral Health</th><th>Vision</th></tr>
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The initial kick-off meeting with Medi-Cal Dental, Smile California, and key stakeholders was held in early March. The objective is to reduce member dissatisfaction by strengthening our collaborative efforts to educate and inform Medi-Cal members within our 24 counties about the difference between Partnership managed care plan services and State (carve-out) covered benefits.

Early planning for 25/26 Organizational Goals is underway. Stakeholders supporting the new organizational goals and metrics will begin developing the organizational goal charter drafts.

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<td>EQUITY AND PRACTICE TRANSFORMATION (EPT) PROGRAM</td>
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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.

$10,000 was awarded to twenty-three (23) qualifying provider organizations through the IPIP program. The IPIP is geared toward small and medium-sized

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	independent practices to support their planning and application process for the Provider Directed Payment Program (PDPP). o The EPT PM team is drafted a proposal for Executive review to use the remaining $1.2 Million for two areas of unmet need for low-performing Primary Care Physicians (PCPs); Leadership training and Support for replacing outdated Electronic Health Records (EHRs). o The IPIP funding may also be used to fund the second track of the Locum Pilot Initiative. • 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. The accepted provider organizations are spread across each of Partnership's sub-regions, including five (5) provider organizations contracted with Partnership 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. o 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. o 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. o 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 o Most Templates and rubrics for the May 2025 deliverables are available on PHLC's milestone page in the link below. ▪ The template and rubric for the second milestone, Implementation Plan, in the Data to Enable PHM, is not yet published. PHLC, the entity

	facilitating this program on DHCS' behalf, has yet to confirm when it will be available. ○ DHCS will funnel EPT payment(s) through MCPs by this month and EPT POs will receive their funding no later than 04/30/2025. • 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. ○ The Technical Assistance (TA) Requirement has changed. ▪ To remain in the EPT program, practices previously need to demonstrate 80% attendance in the Practice Track and Learning Community sessions of the EPT Technical Assistance. ▪ PHLC has assigned point values on all EPT TA events. Practices now have to accumulate a total of twenty-two (22) points in a calendar year. ▪ A quarterly report will be provided by PHLC to keep practices informed about their progress and the Practices who earn the most points will receive an award. ▪ The point values are as follows: • Learning Community: Four (4) points • Practice Track: Three (3) points • PopHealth+ eModules: Five (5) points • Office Hours: One (1) bonus point per month, regardless of the number office hour sessions attended.
LOCUM PILOT INITIATIVE	• 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. • A total budget of $250,000 was approved 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 is being 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. • Provider Specific Status Updates ○ Hill Country Community Clinic: Completed the grant requirements, as planned, in January 2025. A total of 204 visits were conducted, increasing general access and supporting patients without assigned PCPs. ○ Round Valley Indian Health: A team including the Regional Medical Director and Improvement Advisors met with the RVIH Executive Director to explore options directed at completing the grant activities. A follow-up meeting is pending and an amendment to extend the grant offering through May 2025 has been prepared. ○ Community Medical Center: Completed the initial grant activities and was awarded an extension to fund their locum through December 2024 to continue focusing on well-child visits, including disparity groups. Initial efforts resulted in the completion of 272 visits. During the extension, an additional 345 patient visits have been completed, primarily well-child visits and acute care. ○ Pit River Health Service: The grant activities and final evaluation have been completed; successfully completed 218 patient visits, primarily well-child visits. • Through data collected and participant feedback, a comprehensive Program Evaluation was completed, identifying key learnings: Benefits and successful strategies: ○ Locums enabled a higher volume of well-care visits and provided additional coverage ○ Alleviated schedule backlog allowing patients to see their preferred clinician ○ Program alignment with back-to-school season successfully increased WCVs ○ Support from Improvement Advisors and Pop Health specialists enhanced outreach ○ Anticipating support staff requirements improved efficiency Challenges and barriers: ○ Minimum three-month contract is preferred by agencies/locums ○ Dedicated support staff is necessary but difficult to maintain long term ○ Patient contact information outdated; members not established patients ○ Locum onboarding and time required to become fully proficient can be substantial ○ Some provider organization lack resources to implement and support the intervention • Preliminary 2024 QIP results indicate improved Well Child Visit (WCV) measure rates.

<table>
<tr><td></td><td>

Both Community Medical Center and Pit River reached 50th percentile and 90th percentile WCV targets at the sites supported by Locums. Both providers credit the pilot program for directly contributing to their success.

Discussions for expansion and exploring opportunities for Track 2 are in progress, integrating key insights and improvements to drive better outcomes.

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

Scheduling for Mobile Mammography events for FY Q3 (January – March 2025) is complete. Upcoming confirmed events in February and March include:

<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>Expansion</td><td>1</td><td>1</td><td>1</td></tr>
<tr><td>NE</td><td>4</td><td>4</td><td>5</td></tr>
<tr><td>NW</td><td>1</td><td>5</td><td>5</td></tr>
<tr><td>SE</td><td>2</td><td>2</td><td>2</td></tr>
<tr><td>SW</td><td>5</td><td>5</td><td>5</td></tr>
<tr><td>Plan Wide</td><td>13</td><td>17</td><td>18</td></tr>
</table>

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

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

Applications to receive a LeadCare ll Point of Care device continue to be open year-round and are readily available on our Lead Poisoning and Prevention provider facing page, along with resources.
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.
The program has developed a promotional strategy to communicate the importance of lead testing, highlight available resources, and emphasize year-round enrollment. Promotional materials, including links and QR codes to the provider-facing page, have been distributed to provider facing teams.
Outreach efforts continue, targeting providers with a denominator of 100+ who did not meet the 2024 QIP 50th percentile. Meetings are being scheduled to review the workflows, provide feedback based on 2024 best practices and address challenges.
PPLP also continues to collaborate with:

<u>Population Health Team & Butte County Public Health</u>: Supporting CALAIM Bold Goal efforts to exceed the 50th percentile for children's preventative care measures, Butte County Public Health submitted their application for a LeadCare ll device in December 2024, and an MOU is in progress.
<u>Communications Team</u>: Updating the Lead Poisoning and Prevention member-facing page with current resources.

</td></tr>
</table>

	○ Office of the CMO: An article is included in the March edition of the CMO newsletter. ○ Member Services: An article is included in the upcoming summer edition of the member newsletter.
EXACT SCIENCES: PROMOTING COLORECTAL CANCER SCREENINGS	• Partnership facilitated a multi-patient order on behalf of providers for Cologuard, that aligned with Colorectal Cancer Awareness Month (March). This initiative eliminated the 200-patient minimum barrier, which often prevents providers from placing bulk orders directly with our vendor, Exact Sciences. ○ An open office hours 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. ○ Five (5) provider organizations are participating in this initiative. ○ Pre-shipment notifications letters have been mailed, and live pre-shipment notification calls begin on 03/17/2025, with kits beginning to ship on 03/24/2025. • A second multi-patient order is planned for July – September to align with QIP's timeline for addressing 2025 and 2026 PCP QIP Measures.
QI TRILOGY PROGRAM	• The FY 2025/26 QI Program Description is in the process of being updated and will be finalized in April 2025. • The upcoming deliverables for the remaining QI Trilogy documents are: ○ 2024/25 QI Work Plan (Final Updates) - submissions due: 05/12/2025 ○ 2024/25 QI Evaluation – submissions due: 05/30/25 ○ 2025/26 QI Work Plan (New Goals) - submissions due: 06/18/2025

D-SNP

ACTIVITY	UPDATE
D-SNP Education	• A webinar titled "Capturing Patient Acuity through Coding" led by Dr. Kermit Jones, Medical Director of Medicare Services, was presented on 02/19/2025. Attendees included thirty-seven (37) individuals from thirteen (13) unique organizations along with seven (7) Partnership internal attendees. The webinar was attended by physicians and coding support personnel in the Partnership Advantage counties. CME/CE was offered and this offering will continue as an opportunity for Enduring Learning Credit. A follow-up webinar on the same topic is expected in the Fall of 2025. • To comply with regulatory requirements in 2026, a Model of Care (MOC) training course for external providers and Partnership personnel is being developed with collaboration from Quality, the Office of the CMO and Training & Development teams. The training will be required for employees of any contracted organization to complete within 90 days of employment or at the launch of the Partnership Advantage plan. Partnership personnel will complete the training as part of their onboarding training or as assigned in early 2026.
Part D/PBM	• The Pharmacy team and Optum began PBM implementation sessions which will occur regularly for 1.5 hours on Tuesdays and Thursdays through the end of 2025. Members

	from the Quality Department will participate in Operational Readiness and Clinical/Prior Authorization workgroups in preparation for Part D reporting requirements in 2026.
CAHPS Survey Project – Medicare Product Line	• The Medicare CAHPS program is in development. Interviews with sister plans have been conducted and relationships established for ongoing exchanges to help inform the buildout. • CMS approved survey vendors were evaluated through RFIs and follow-up conversations. The CAHPS team is exploring options for non-regulated survey(s) to be conducted in early-mid 2026. Given the long lead times for survey placement, Partnership will be prepared to contract with a vendor mid-2025.
Star Strategy Workgroups	• The HEDIS workgroup is meeting bi-monthly to prepare for HEDIS data management and reporting requirements for Medicare Part C and DHCS in 2026.
Elder Care QMSI	• The Elder Care QMSI Group will have its first meeting on 03/27/2025. The interdepartmental workgroup will focus on Medicare Part C, Part D and DHCS measures which will primarily affect the D-SNP population.

QUALITY ASSURANCE AND PATIENT SAFETY

ACTIVITY	UPDATE
POTENTIAL QUALITY ISSUES (PQI) FOR THE PERIOD: **02/01/2025 TO 02/25/2025**	• 96 PQI cases are currently open. • 27 referrals were received with 19 coming from Grievance and Appeals, 3 from Utilization Management, 3 from Medical Directors, and 2 from other sources. • 17 cases were processed and closed. • 2 cases were discussed at Peer Review Committee (PRC) on 02/19/2025 and there are 4 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: **01/29/2025 TO 02/21/2025**	• As of 02/27/2025, we have a total of 462 PCP and OB sites with an additional 34 reviews due to multiple check-ins (totaling 496 reviews). **Primary Care and OB Reviews:**

Region	# of FSR conducted	# of MRR conducted	# of FSR CAP issued	# of MRR CAP issued
Auburn	1	1	0	0
Chico	4	3	0	3
Eureka	1	1	0	1
Fairfield	5	5	2	3
Redding	4	3	1	3
Santa Rosa	4	4	0	3
Out of Area	1	0	0	0

New sites opened this period: None

HEALTHCARE EFFECTIVENESS DATA INFORMATION SET (HEDIS)

ACTIVITY	UPDATE

Annual HEDIS® Projects	• The HEDIS Measurement Year 2024 (MY2024) virtual audits both occurred in the month of February resulting in no audit findings for each:
	  ○ HSAG/DHCS Audit: 02/13/2025
	  ○ Advent Advisory/HealthPlan Accreditation Audit: 02/26/2025
	• Primary Source Verification (PSV) process for all non-standard supplemental and new data sources is in process currently for each project. PSV will include the review and validation of approximately 350 proof of service evidence, randomly selected by each auditor. The HEDIS team's goal is to obtain both auditors' approval and integrate all the data for MY2024.
	• The MCAS Supplemental Medical Record & Review (MRR) Project for administrative measure, Well Child Visits for Ages 15-30 Months (W30), has been completed. This project is intended to supplement the administrative data collected from claims & encounters, thus requiring pending PSV and auditor approval. Initial review and analysis have identified opportunities to drill down into the claims data to ensure the well child visits are being billed and captured accurately. A more detailed study will be conducted, which will result in a more proactive approach with IT, our Claims team, and providers to ensure more complete data is coded and captured for these visits.
	• Data collection is underway at the county level to ensure we are able to fulfill the new DHCS requirements for reporting all MCAS measures by county across the Partnership service region. This involves expanded over-sampling of hybrid (i.e. medical record based) measures versus prior years.
	• Overall, the HEDIS team continues to prepare for preliminary rate submissions due in April 2025 with final rates due at the end of May. The MY2024 Annual Summary of Performance Reports for both DHCS and HPA will be finalized and published in August 2025.

HEDIS® Program Overall	• The QI team has begun an education campaign with FQHC, Rural Health Center (RHC), and Tribal Health Dental Centers around coding best practices for fluoride varnish application services. Dental Centers must use an ICD code, Z29.3 (encounter for prophylactic fluoride administration) along with CDT/CPT codes for fluoride varnish services, for Partnership to receive data from DHCS that would indicate service completion for the Department of Health Care Service's (DHCS) measure for Topical Fluoride Varnish for Children. Fluoride varnish services completed in FQHC, RHC, and Tribal Health Dental Centers will count towards the Topical Fluoride for Children monitoring measure added to the PCP QIP in MY2025. • DHCS continues to share aspects of their plan to sanction MCPs at the county level for MY2024 MCAS performance below the MPL. DHCS has shared plans to allow MCPs to substitute all plan rates for MCAS hybrid measures within counties having an eligible member population below DHCS's threshold of 100 members; Partnership is awaiting guidance on whether this instruction also applies to administrative measures.

NATIONAL COMMITTEE FOR QUALITY ASSURANCE (NCQA) ACCREDITATION

ACTIVITY	UPDATE
NCQA Health Plan Accreditation (HPA) and Health Equity Accreditation (HEA)	• As part of a standard practice of our new NCQA consultant, Management Healthcare Resources (MHR), the NCQA Program Management Team hosts a monthly meeting with MHR. These meetings provide protected time and an opportunity for Partnership to discuss and/or seek clarification on NCQA policy changes and FAQs, MHR's processes, or any other topic of interest that may arise. The NCQA Program Management Team assesses relevant topics to discuss with MHR each month and provides an agenda to ensure the appropriate representation by MHR. • Each year, NCQA releases proposed updates to the current Standards and Guidelines. NCQA asks Health Plans to provide their feedback and/or comments on the proposed changes. NCQA released the proposed updates to the 2026 HPA Standards and Guidelines on 02/25/2025. Business Owners are asked to review the proposed changes and are encouraged to indicate if they Support, Do Not Support, or Support the Changes with Modifications by 03/21/2025. The NCQA Program team will share Partnership's feedback with our consultant for any additional comments or feedback, then provide a plan-wide response to NCQA by 03/25/2025. Proposed updates to the HEA Standards and Guidelines are scheduled for release in April or May 2025.
NCQA HPA	• The HPA Mock Renewal Survey is scheduled for 10/27/2025-10/30/2025. 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. • This will be a full scope review of evidence by our consultant, MHR. • MHR will review questions and address findings on the submitted evidence. • A final report and scoring will be distributed after the HPA Mock Renewal Survey. • Business Owners will submit a Corrective Action Plan (CAP) within three (3) weeks after receiving the scoring results.
NCQA HEA	• As of February 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.

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

Consent Calendar

March 19, 2025

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

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MPQP1002 (previously QP100102)</td><td colspan="3">Lead Department: Health Services
Business Unit: Quality Improvement</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Quality/Utilization Advisory Committee</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 12/1998</td><td colspan="4">Next Review Date: ~~09/11/2025~~04/09/2026
Last Review Date: ~~09/11/2024~~04/09/2025</td></tr>
<tr><td>Applies to:</td><td colspan="2">☐ Employees</td><td>☒ Medi-Cal</td><td colspan="2">☒ Partnership Advantage[1]</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>☐ 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: ~~09/11/2024~~04/09/2025</td></tr>
</table>

I. RELATED POLICIES:

A. MPQP1003 – Physician Advisory Committee (PAC)
B. MPQP1004 – Internal Quality Improvement Committee
C. MPQP1016 – Potential Quality Issue Investigation and Resolution
D. MPQP1053 – Peer Review Committee
E. CMP10 – Confidentiality
F. CMP36 – Delegation Oversight and Monitoring

II. IMPACTED DEPTS:

A. Health Services
B. Grievance & Appeals
C. Member Services
D. Provider Relations

III. DEFINITIONS:

N/A

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

The Quality/Utilization Advisory Committee (Q/UAC) is responsible for monitoring the quality of comprehensive medical care and services provided to Partnership HealthPlan of California's members. The committee's goals are to ensure quality improvement efforts are prioritized, resources are appropriate, and processes are in place for providing quality, appropriate and safe healthcare to members. The Q/UAC reviews Partnership's Health Services departments' activities, makes recommendations, and serves as an appeal body on certain medical care issues. On occasion, the Q/UAC may review Grievance & Appeals, Member Services, and Provider Relations policies. The Q/UAC may establish inpatient and ambulatory

[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.

review subcommittees as needed to accomplish its responsibilities. A subcommittee of the Q/UAC serves as the Peer Review Committee (PRC).

The Q/UAC provides policy and other recommendations to the Physician Advisory Committee. 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.

VI. POLICY / PROCEDURE:

A. Committee Structure

1. Composition

a. The Q/UAC is chaired by the CMO and comprised of formal voting representatives from community primary and specialty care practices and consumer representative(s). Licensed physicians and non-physician advanced practice clinicians (e.g., psychologists, nurse practitioners, physician assistants and certified nurse midwives) may serve on the committee. These clinician members of the committee represent licensed providers of 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.

1) Committee members serve open terms and may submit resignation to the CMO or his designee.

2) Voting members with annual attendance of <50% are evaluated for termination from the Q/UAC.

b. The following Partnership staff or their delegates serve as non-voting members:

Quality/Utilization Advisory Committee Standing Members	
Department Represented	**Position Title**
Administration	Director, Grievance and Appeals
Health Services	Chief Medical Officer – Committee Chair
	Medical Director for Quality – Committee Vice Chair
	Medical Director for Medicare Services
	~~Clinical Director of~~ Behavioral Health Clinical Director
	Regional and Associate Medical Director(s)
	Chief Health Services Officer
	Senior Director of Quality and Performance Improvement
	Director of Health Equity (Health Equity Officer)
	Director, Population Health Management
	Director, Enhanced Health Services
	Director(s) and Associate Director(s), Utilization Management
	Director(s) and Associate Director(s), Care Coordination
	Director, Pharmacy Services
	Manager, Member Safety - Quality Investigations
	Manager, Clinical Compliance – Quality Inspections
	Senior Health Educator
Provider Relations	Senior Provider Relations Rep Manager

2. Minutes: Minutes are recorded at all meetings. Minutes are maintained according to the confidentiality policy. Approved minutes are submitted monthly to the Delegation Oversight Reporting Subcommittee (DORS) and Regulatory Affairs and Compliance inboxes. RAC submits

these minutes monthly to the Department of Health Care Services (DHCS) and forwards that tracking number to designated QI staff.

3. Chair: The CMO chairs the Q/UAC. The Medical Director for Quality serves as vice chair. When neither is available, a Regional or Associate Medical Director or a non-Partnership clinician member of the Q/UAC acts as temporary chair.
4. Meetings: The Q/UAC meets at least ten (10) times a year with the option to add additional meetings if needed.
5. Compensation: Non-Partnership clinician and consumer committee members are eligible to receive a financial stipend for each meeting attended (unless otherwise compensated by Partnership for management responsibilities). This stipend may be in addition to other compensation when the member serves as a clinical consultant/physician adviser.
6. Voting: Only consumer and non-Partnership clinician members constitute the voting membership, with the CMO or acting chair serving in a tie breaking capacity as necessary. A quorum is 50% or more of the total voting members.
7. Confidentiality: To preserve an atmosphere promoting free and open discussion between and among committee members, each committee member signs an annual Confidentiality Agreement prepared and retained by Partnership. This agreement signifies the intent to protect individuals against misuse of information and to ensure all information, medical or otherwise, regarding patients, practitioners and providers is handled in a confidential manner.
8. Conflict of Interest: Each committee member signs an annual Conflict of Interest statement prepared and retained by Partnership.

B. Committee Responsibilities

1. Annually reviews, recommends, and approves the Utilization Management Program Description submitted by Health Services' Utilization Management department.
2. Annually reviews, recommends, and approves the Quality Improvement Program Description, Program Evaluation, and Work Plan submitted by Health Services' Quality Improvement department.
3. Annually reviews, recommends and approves the Population Health Management Strategy and Program Description and other Population Health documents as required.
4. Annually reviews, recommends and approves the Cultural & Linguistic Program Description, Program Evaluation, and Work Plan.
5. Annually reviews, recommends and approves the Care Coordination Program Description, status reports, and case management activities.
6. Annually reviews, recommends and approves the Quality Improvement and Health Equity Transformation Program (QIHETP) Program Description and other Health Equity documents as required.
7. Annually reviews and make recommendations for medical policy, new technology, and protocol changes based on guidelines and standards of practice; makes recommendations on Clinical Practice Guidelines (CPGs) and preventive health guidelines to the PAC.
8. Makes recommendations and approves Partnership policies addressing, but not limited to, quality improvement, utilization management, care coordination and health equity activities.
9. Identifies, reviews, and recommends improvements in all areas pertaining to the quality and appropriateness of medical care. Advises staff on selection and prioritization of quality improvement activities.
10. Develops and/or approves clinical criteria used by UM staff to perform prospective and concurrent inpatient, ambulatory review or other utilization activities.
11. Reviews utilization, financial, and other staff reports that display the utilization of services and outcomes of quality within the delivery system.

~~9.~~12. Serves as a review body to assist in the interpretation of medical benefit coverage based on medical necessity and appropriateness issues.

~~10.~~13. Provides oversight of delegated utilization management and quality improvement activities.

~~11.~~14. Reviews performance dashboards and make recommendations for corrective action on indicators that fall below established thresholds; ensures follow-up on corrective actions where identified.

~~12.~~15. Reviews and provides recommendations for member-related activities including Consumer Assessment of Healthcare Providers and Systems (CAHPS®), grievances, telephone access, appointment access, availability and other member satisfaction surveys.

~~13.~~16. Oversees the activities of its subcommittee, the Peer Review Committee (PRC), which serves as a peer review body for medical care issues. PRC members include ~~physician~~ clinician members of the Q/UAC and Partnership staff. PRC's charter is described in both MPQP1053 – Peer Review Committee and MPQP1016 - Potential Quality Issue Investigation and Resolution.

C. Committee Accountability
   1. The Q/UAC has oversight responsibility for the development, implementation, and effectiveness of the quality improvement and utilization management programs. The Q/UAC is accountable to the PAC, and through this body, to the Partnership ~~-~~ Board of Commissioners on Medical Care.

D. Delegation Oversight and Monitoring
   1. Partnership delegates quality improvement activities, responsibilities and committee structure.
   2. A formal agreement is maintained and inclusive of all delegated functions.
   3. Partnership conducts an audit not less than annually to ensure the appropriate policy and procedures are in place.
   4. Results from Oversight and Monitoring activities shall be presented to DORS for review and approval.

VII. REFERENCES:
N/A

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

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Medical Officer/Committee Chair

X. REVISION DATES:
Medi-Cal
06/21/00; 03/21/01; 05/15/02; 10/16/02; 09/15/04; 03/15/06; 03/21/07; 02/20/08; 03/18/09; 04/21/10; 09/19/12; 09/18/13; 04/16/14; 04/15/15; 04/20/16; 04/19/17; *06/13/18; 05/08/19; 09/11/19; 03/11/20; 09/09/20; 09/08/21; 09/14/22; 09/13/23; 09/11/24; 04/09/25

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

Policy/Procedure Number: MPQP1002 (previously QP100102 & MPQP1002)			**Lead Department: Health Services** Business Unit: Quality Improvement
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Original Date: 12/1998		**Next Review Date:** ~~09/11/2025~~04/09/2026 **Last Review Date:** ~~09/11/2024~~04/09/2025	
Applies to:	☐ **Employees**	☒**Medi-Cal**	☒**Partnership Advantage**

MPQP1002 - 03/21/2007 to 01/01/2015

Healthy Families
MPQP1002 - 10/01/2010 to 03/01/2013

Healthy Kids
MPQP1002- 03/21/2017 to 12/01/2016 (Healthy Kids program ended 12/01/2016)

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

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<tr><td colspan="2">Original Date: 05/17/2000</td><td colspan="4">Next Review Date: ~~09/11/2025~~04/09/2026
Last Review Date: ~~09/11/2024~~04/09/2025</td></tr>
<tr><td>Applies to:</td><td colspan="2">☐ Employees</td><td>☒ Medi-Cal</td><td colspan="2">☒ Partnership Advantage[1]</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>☐ 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: ~~09/11/2024~~04/09/2025</td></tr>
</table>

I. RELATED POLICIES:

A. CMP10 – Confidentiality
B. CMP36 – Delegation Oversight and Monitoring
C. MPQP1002 – Quality/Utilization Advisory Committee
D. MPQP1003 – Physician Advisory Committee (PAC)

II. IMPACTED DEPTS:

A. All

III. DEFINITIONS:

A. IQI – Internal Quality Improvement Committee
B. PAC – Physician Advisory Committee
C. UM – Utilization Management
D. P&T – Pharmacy and Therapeutics Committee
E. Q/UAC – Quality/Utilization Advisory Committee
F. QI – Quality Improvement
G. NCQA – National Committee for Quality Assurance

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

The Internal Quality Improvement (IQI) Committee is responsible for advising Partnership HealthPlan of California (Partnership) on quality activities at the health plan, with a goal of improving overall quality of care and service for members, providers and internal operations. Since quality activities are implemented through multiple departments, IQI- is a cross-departmental team that reviews new or revised policies, delegation reports, initiatives, activities, and other reports under the purview of Health Services departments (i.e~~e.g~~., Quality Improvement, Care Coordination, Utilization Management, Enhanced Health Services, Population Health Management, Health Equity, Behavioral Health, and Pharmacy). IQI also reviews external-facing Grievance & Appeals, Provider Relations, Credentials, Transportation, and Member Services policies. IQI reports to the Quality/Utilization Advisory Committee (Q/UAC), which ensures that plan

[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.

Policy/Procedure Number: **MPQP1004** (previously QP100104)		Lead Department: Health Services	
Policy/Procedure Title: Internal Quality Improvement Committee		☒External Policy ☐Internal Policy	
Original Date: 05/17/2000		**Next Review Date:** ~~09/11/2025~~04/09/2026 **Last Review Date:** ~~09/11/2024~~04/09/2025	
Applies to:	☐ Employees	☒ Medi-Cal	☒ Partnership Advantage

activities comply with all state and regulatory requirements and meets current National Committee for Quality Assurance (NCQA) standards and guidelines.

VI. POLICY / PROCEDURE:

A. Committee Structure

1. Membership:
   a. The IQI Committee is comprised of the following Partnership staff: (Standing committee members are required to appoint and send a designee if unable to attend)

Internal Quality Improvement Committee Standing Members	
Department Represented	**Position Title**
Administration	Chief Executive Officer
	Chief Operating Officer
	Chief Strategy & Government Affairs Officer
	Regional Manager(s)
	Compliance Manager, Grievance and Appeals
Configuration	Configuration Department Leadership
Finance	Director of Health Analytics
Health Services	Chief Medical Officer – Committee Chair
	Medical Director for Quality – Committee Vice Chair
	Medical Director for Medicare Services
	Chief Health Services Officer
	Senior Director of Quality and Performance Improvement
	Senior Director of Care Management
	Director of Health Equity (Health Equity Officer)
	Director of Population Health
	Director of Quality Management
	Director of Pharmacy Services
	Director, Care Coordination
	Director, Utilization Management
	Director, Enhanced Health Services
	Associate Director(s), Utilization Management
	Associate Director, Population Health
	Manager of Care Coordination Regulatory Performance
	Manager of Member Safety - Quality Investigations
	Manager, Clinical Compliance – Quality Inspections
	Senior Health Educator
	Associate Medical Director(s)
	Regional Medical Director(s)
Member Services	Senior Director of Member Services & Grievance
Provider Relations/Credentials	Senior Director, Provider Relations
	Associate Director of Provider Relations

   b. Standing members are responsible for maintaining an annual attendance rate of 75% or greater. Committee members may appoint a designee to attend.
2. Minutes: Minutes of all meetings are maintained according to the Confidentiality policy/procedure.

Approved Minutes are submitted monthly to the Delegation Oversight Reporting Subcommittee (DORS) and Regulatory Affairs and Compliance (RAC) inboxes. RAC submits these Minutes to the Department of Health Care Services (DHCS).

3. Chair: The Chief Medical Officer (CMO) chairs the committee. The Medical Director for Quality serves as Vice Chair. In the event that neither is able to chair, the CMO will appoint a designee.
4. Meetings: The Committee meets at least 10 times a year with the option to add additional meetings if needed.
5. Voting: Standing Member(s)/Designee(s) will vote and the Chair will acknowledge consensus.

B. Committee Responsibilities
1. Reviews policies and makes recommendations or revisions for effective monitoring and achievement of Quality Improvement (QI) objectives.
2. Monitors quality improvement projects across the organization that impact patient care, focusing on areas such as clinical outcomes, patient experience, including access and service, and cost efficiency.
3. Monitors utilization management activities for both medical and pharmacy management: denials, authorizations, appeals, etc.
4. Reviews policies and clinical guidelines that relate to physical health or behavioral services for our members, including credentialing, performance improvement initiatives, etc.
5. Reviews delegation reports for quality, utilization management, credentialing where concerns exist.
6. Reviews findings from regulatory audits and monitor progress on corrective action plans.
7. Reviews performance metrics (i.e., dashboards and indicator reports) and make recommendations for corrective action for indicators that are below established thresholds; assures appropriate follow-up on corrective actions that relate to quality of care and service concerns.
8. Makes recommendations in implementation of the "QI Trilogy" (i.e., the QI Program Description, Work Plan, and Evaluation), and the like "Grand Analyses" of Partnership's Care Coordination, Population Health, Health Equity, Pharmacy and Utilization Management departments, among others.
9. Oversees the activities of its subcommittees: the Population Needs Assessment (PNA) Committee, the Member Grievance Review Committee (MGRC), the Over/Under Utilization Workgroup, and the Substance Use Internal Quality Improvement Subcommittee (SUIQI).

C. Committee Accountability
1. IQI is accountable to the Q/UAC, and through this body, to the PAC and Partnership's Board of Commissioners.

D. Delegation Oversight and Monitoring
1. Partnership delegates quality improvement activities, responsibilities and committee structure.
2. A formal agreement is maintained and inclusive of all delegated functions.
3. Partnership conducts an audit not less than annually to ensure the appropriate policy and procedures are in place.
4. Results from Oversight and Monitoring activities shall be presented to DORS and RAC for review and approval.

VII. REFERENCES:
N/A

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

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Medical Officer/Committee Chair

Policy/Procedure Number: MPQP1004 (previously QP100104)			**Lead Department: Health Services**
Policy/Procedure Title: Internal Quality Improvement Committee			☒**External Policy** ☐**Internal Policy**
Original Date: 05/17/2000		**Next Review Date: ~~09/11/2025~~04/09/2026** **Last Review Date: ~~09/11/2024~~04/09/2025**	
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**

X. REVISION DATES:

Medi-Cal

06/20/01; 09/18/02; 09/15/04; 03/15/06; 03/21/07; 02/20/08; 03/18/09; 04/21/10; 09/19/12; 10/16/13; 04/16/14; 04/15/15; 04/20/16; 04/19/17; *06/13/18; 05/08/19; 09/11/19; 04/08/20; 09/09/20; 09/08/21; 09/14/22; 09/13/23; 09/11/24; 04/09/25

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

MPQP1004 – 03/21/2007 to 01/01/2015

Healthy Kids- 3/21/20017 to 12/01/2016 (Healthy Kids program ended 12/01/2016)

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="4">Policy/Procedure Number: MCUP3124</td><td colspan="3">Lead Department: Health Services
Business Unit: Utilization Management</td></tr>
<tr><td colspan="4">Policy/Procedure Title: Referral to Specialists (RAF) Policy</td><td colspan="3">☒ External Policy
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I. RELATED POLICIES:

A. MCUP3041 – Treatment Authorization Request (TAR) Review Process
B. MCUP3039 – Direct Members
C. MCCP2016 – Transportation Policy for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT)
D. MCUP3037 – Appeals of Utilization Management/ Pharmacy Decisions
E. CGA024 – Medi-Cal Member Grievance System
F. MPNET100 – Access Standards and Monitoring

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

A. Medical Necessity: Medical Necessity means 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.
B. ~~PHC~~Partnership Provider Network: Providers that are contracted with Partnership HealthPlan.
C. Referral Authorization Form (RAF) process: is defined as the process by which the primary care provider (PCP) submits a request to Partnership HealthPlan of California ~~(PHC)~~ to refer a ~~PHC~~Partnership enrollee to a specialist for evaluation and/or treatment.
D. Tertiary Medical Care: is specialized consultative care, usually on referral from primary or secondary medical care personnel, by specialists working in a center that has personnel and facilities for special investigation and treatment.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

To describe the procedure used by the ~~PHC~~Partnership Utilization Management (UM) Department to process Referral Authorization Forms (RAFs) based upon the medical necessity of the request.

VI. POLICY / PROCEDURE:

A. Members assigned to a primary care provider (PCP) must have an approved RAF on file for the

~~PHC~~Partnership Claims Department to reimburse the specialist for elective/scheduled services rendered. RAFs are not required for members who have another insurance plan as the primary carrier or are assigned a ~~PHC~~Partnership Direct Member status (see policy MCUP3039 Direct Members.)

B. Specialist to Specialist Referral
   1. A specialist may request a referral to another specialist from the primary care provider ONLY under the following circumstances:
      a. Referral must be within the same specialty field as the specialist
      b. Referrals must be for emergent or urgent conditions only
      c. Referral must be sent to the member's PCP to submit to ~~PHC~~Partnership

C. Obstetric/Gynecological (OB/GYN) Services
   1. OB/GYN services do not require a RAF.
      a. During obstetrical care, the M~~m~~ember may be referred to obstetrical subspecialty service providers without a RAF for medically necessary obstetrical services (e.g. amniocentesis, perinatology services, etc.)
      b. A RAF must be submitted by the PCP when a pregnant M~~m~~ember requires specialty services outside of perinatal subspecialties.

D. Certified Nurse Midwife (CNM) and Certified Nurse Practitioner (CNP) Services
   ~~2.~~1. Members have the right to obtain out-of-network CNM and/or CNP services if the services are not available in-network.

~~D.~~E. Complex Cancer Treatment
   1. The California Cancer Care Equity Act allows members diagnosed with a complex cancer to request a referral to access medically necessary services from a National Cancer Institute (NCI)-designated comprehensive cancer center, an NCI Community Oncology Research Program (NCORP)-affiliated site, or a qualifying academic cancer center.

F. Indian Health Services (IHS)
   1. Partnership allows for access to both in-network and out-of-network IHS providers without requiring a referral from a network PCP or prior authorization.
      a. IHS providers, whether in-network or out-of-network, can refer members directly to network providers without requiring a referral from a network PCP or prior authorization.

~~E.~~G. Referral to a Specialist Outside of ~~PHC~~Partnership's Network
   1. PCPs are expected to make every effort to direct the ~~member~~ Member to an in-network specialist within ~~PHC~~Partnership's service area. ~~PHC~~Partnership also may have contracting specialists outside its service area. The PCP and/or their referral coordinator can find contracting provider information on ~~PHC~~Partnership's Provider Online Services Portal.
   2. A referral request to an out~~-~~of~~-~~network specialist requires additional documentation and clinical review. The following must be submitted:
      a. Evidence of exhaustion of ~~PHC~~Partnership's contracted specialists in the provider network (e.g. denial letters, referral denials) within the member's county of residence or 60 miles driving distance (whichever is greatest). ~~PHC~~Partnership may provide transportation if the referral is approved and ~~member~~ Member meets criteria for transportation benefit. See policy MCCP2016 Transportation Policy for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT).
      b. Clinical documentation supporting the medical necessity for a referral to a non-contracting provider such as History and Physical, PCP progress notes, letter from PCP.
      ~~b.~~c. Referrals to out-of-network specialists will only be approved when the out-of-network specialist has a demonstrated specialized skill or training that contracted, in-network specialists do not have.
   3. When a PCP requests a referral to an out of network specialist, ~~PHC~~Partnership's clinical staff will

review the request to determine if an in-network specialist is available. If ~~so~~an in-network specialist is identified, the case is reviewed by ~~PHC~~Partnership's Chief Medical Officer (CMO) or Physician Designee to determine if redirection to the in-network specialist is medically appropriate ~~necessary appropriate; in this context, this means that the out of network specialist has demonstrated a specialized skill or training that contracted, in-network specialists do not have~~. If the determination is made that the ~~member~~ Member should be redirected to an in-network specialist, the PCP is notified and provided with possible alternative in-network specialist(s). The ~~member~~ Member is also notified of the determination and both the ~~member~~ Member and PCP are provided the right to file a grievance or appeal (refer to ~~PHC~~Partnership policies CGA024 Medi-Cal Member Grievance System and MCUP3037 Appeals of Utilization Management/ Pharmacy Decisions).

4. ~~PHC~~Partnership will coordinate services when an out-of-network provider is medically necessary. Coordination may include, but is not limited to, entering into a single case agreement with the provider and coordinating transportation if the ~~member~~ Member meets criteria as per Welfare and Institutions Code (WIC) 14197.04 and/or ~~PHC~~Partnership policy MCCP2016 Transportation Policy for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT).
    a. In the event that timely access to an appointment is not available as per access standards (see policy MPNET100 Access Standards and Monitoring), ~~PHC~~Partnership will authorize and arrange for out-of-network access to appointments.

~~F.~~H. Referral to a Tertiary Care Center Outside of ~~PHC~~Partnership's Network

1. If a PCP submits a request to refer a ~~member~~ Member to an out of network tertiary care center, the medical records are reviewed by ~~PHC~~Partnership's Chief Medical Officer (CMO) or Physician Designee to evaluate the medical necessity for the tertiary level of care.
2. If the CMO or Physician Designee determines that the services could be provided at an alternative level of care, the PCP is notified of the determination and the right to request a peer to peer discussion with the reviewing physician. The ~~member~~ Member is notified of the determination and provided with information on how to file a grievance or appeal (refer to ~~PHC~~Partnership policies CGA024 Medi-Cal Member Grievance System and MCUP3037 Appeals of Utilization Management/ Pharmacy Decisions).

~~G.~~I. Standing Referrals

1. A ~~member~~ Member with a condition or disease that requires an extended access referral for specialized medical care may receive an extended referral to a specialist or specialty care center that has expertise in treating the condition or disease.

~~H.~~J. Referral Authorization Process

1. A PCP should submit the RAF electronically using ~~PHC~~Partnership's Online Services (OLS) portal. Electronic submission allows for the most expedient processing. If online submission is not possible, the RAF may be submitted via fax or mail to ~~PHC~~Partnership's Health services department for review.
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.
3. All referrals to non-contracted providers will be reviewed for medical necessity as described in section VI. E above.
4. An electronic copy of the RAF determination is sent via electronic fax to the referring PCP.
5. If a RAF is determined to be pended, modified, or denied, a notification letter is mailed to the Member and also faxed to the PCP.
6. In general, there are no limits to the number of visits, but in certain circumstances, such as transitioning care back to local specialist or if a pattern of over-utilization is noted on retrospective review, then ~~PHC~~Partnership may impose limits on the number of visits or time period covered by the RAF. At the end of approved time period, a new RAF from the PCP will be required.

Policy/Procedure Number: MCUP3124			**Lead Department: Health Services** **Business Unit:** Utilization Management
Policy/Procedure Title: Referral to Specialists (RAF) Policy			☒**External Policy** ☐**Internal Policy**
Original Date: (UM-1) 12/27/1995 (Effective 08/21/2013 - RAF Review Policy split from TAR/RAF Review)		**Next Review Date:** ~~04/10/2025~~04/09/2026 **Last Review Date:** ~~04/10/2024~~04/09/2025	
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☐ **Partnership Advantage**

~~J.~~K. Treatment Authorization Requirements

1. If the services to be rendered require a Treatment Authorization Request (TAR) from ~~PHC~~Partnership, it is the responsibility of the rendering provider (specialist and/or facility) to submit a TAR to ~~PHC~~Partnership for review. See policy MCUP3041 TAR Review Process.

~~J.~~L. Monitoring Referrals

1. ~~PHC~~Partnership monitors referrals to specialists, including open or unused referrals, using data from ~~PHC~~Partnership's electronic referral system and claims. This information is submitted to the Internal Quality Improvement (IQI) Committee at least annually or more often as needed.
2. ~~PHC~~Partnership audits the referral completion rate for a subset of high volume. This becomes part of the annual report of their referral completion rate which is reviewed by the Quality/ Utilization Advisory Committee (QUAC) and by the IQI Committee.

VII. REFERENCES:

A. InterQual® Criteria
B. Medi-Cal Guidelines
C. Welfare and Institutions Code (WIC) 14197.04

VIII. DISTRIBUTION:

A. ~~PHC~~Partnership Department Directors
B. ~~PHC~~Partnership Provider Manual

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

X. REVISION DATES: RAF Procedure [UM-1]: 12/27/95; 05/27/99; (TAR/RAF [UP100341] - 06/21/00; 04/18/01; 03/20/02, 05/21/03 attachments revised 10/01/03; 04/21/04; 01/19/05; 04/20/05; 09/21/05, 10/18/06, 08/20/08, 07/15/09; 5/19/10; 07/20/11, 08/21/13; 03/19/14; 04/15/15; 09/16/15; 06/15/16; 04/19/17; 09/20/17; *11/14/18; 02/12/20; 09/09/20; 02/10/21; 03/09/22; 03/08/23; 04/10/24; 04/09/25

*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 ~~PHC~~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

Policy/Procedure Number: MCUP3124			**Lead Department: Health Services** **Business Unit:** Utilization Management
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Applies to:	☐ **Employees**	☒ **Medi-Cal**	☐ **Partnership Advantage**

benefits covered under ~~PHC~~Partnership.

~~PHC~~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

<table>
<tr><td colspan="3">Policy/Procedure Number: MC~~P~~UP3126 (previously MPUP3126)</td><td colspan="3">Lead Department: Health Services
Business Unit: Utilization Management</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Behavioral Health Treatment (BHT) for Members Under the Age of 21</td><td colspan="3">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 08/19/2015
Effective Date: 09/15/2014 vs. DHCS</td><td colspan="4">Next Review Date: ~~04/10/2025~~04/09/2026
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I. RELATED POLICIES:

A. MCCP2022 - Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services
B. MPCP2006 - Coordination of Services for Members with Special Health Care Needs (MSHCNS) and Persons with Developmental Disabilities
C. MCUP3041 - Treatment Authorization Request (TAR) Review Process
D. MCCP2014 - Continuity of Care
E. MCUP3113 - Telehealth Services

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services
D. Provider Relations

III. DEFINITIONS:

A. **Autism Spectrum Disorder (ASD)** is characterized by varying degrees of difficulty in social interaction, verbal and non-verbal communication, and manifestation of repetitive behavior and restricted interests. According to Diagnostic and Statistical Manual (DSM) V, a diagnosis of ASD includes several conditions including Autistic Disorder, Pervasive Developmental Disorder Not Otherwise Specified (PDD-NOS) and Asperger Syndrome.
B. **Applied Behavioral Analysis (ABA)** is the design, implementation, and evaluation of environmental modifications to produce socially significant improvement in human behavior. ABA includes the use of direct observation, measurement, and functional analysis of the relations between environment and behavior. (BACB Certification Board Guidelines 2012)
C. **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 are based on reliable evidence and are not experimental. BHT services include a variety of behavioral interventions that have been identified as evidenced-based by nationally recognized research reviews and/or other nationally recognized scientific and clinical evidence and are designed to be delivered primarily in the home and in other community settings.
D. **Behavior Analyst Certification Board (BACB)** is a corporation established to meet professional credentialing needs identified by behavior analysts and government agencies. They have defined

requirements for behavior provider certification. They are accredited by the National Commission for Certifying Agencies.

E. **California Association for Behavioral Analysis (CalABA)** is the state association for professional behavior analysts in California. The association publishes guidelines and offers support and resources for behavior analysts. It has provided guidelines and recommendations to the Department of Developmental Services (DDS) and other entities toward ensuring appropriate, cost-effective behavior services, and utilization of qualified experts in the delivery of services.

F. **Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Supplemental Services** is a federally mandated Medicaid/ Medi-Cal benefit for Medi-Cal ~~member~~Members under age 21 for medically necessary treatment services needed to correct or ameliorate a defect, physical illness, mental illness or a condition, even if the service or item is not otherwise included in the State's Medicaid Plan. (Source: Title 22, California Code of Regulations (CCR), Sections 51184; 51242; 51340; 51532)

G. **IEP**: Individualized Education Program

H. **IFSP**: Individualized Family Service Plan

I. **IHSP**: Individualized Health & Support Plan

J. **LEA**: Local Educational Agency

K. **Medicaid**: A joint federal and state program that helps cover medical costs for some people with limited income and resources. Medi-Cal is California's Medicaid health care program, supported by federal and state taxes.

L. **Parent Training - Service Type** refers to instruction, observation and/or modeling behavior techniques under the direct guidance/ supervision of the behavior therapy agency staff who developed the behavior treatment plan.

M. **Release of Information (ROI) Consent Form** is a form valid one calendar year from the date of signature of the ~~member~~Member to allow the Regional Center and/or Regional Center Behavioral Health Treatment (BHT) provider to share the treatment information with the managed care plan.

N. **Skills Training - Service Type** refers to treatment toward development of improvement of adaptive functioning. Domains of adaptive function may include communication (receptive/ expressive and pragmatic language); socialization; fine and gross motor development; self-help/ daily living skills-eating, toileting, dressing, hygiene; and social emotional functioning. (Source: Autism Spectrum Disorders- Best Practice Guidelines Screening, Diagnosis and Assessment, California Department of Developmental Services, pg 51-52.)

O. **Therapeutic Behavior Service - Service Type** refers to treatment that seeks to identify the stimulus of challenging behaviors and then developing a plan that promotes the development of new skills while reducing the adverse behavior. Challenging behaviors may include tantrums, aggression, self-injury. (Source: Autism Spectrum Disorders- Best Practice Guidelines Screening, Diagnosis and Assessment, California Department of Developmental Services, pg 64-65.)

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

To define Partnership HealthPlan of California's ~~(PHC's)~~ responsibilities to provide ~~for~~ Behavioral Health Treatment (BHT) services to ~~PHC~~Partnership Medi-Cal eligible ~~member~~Members under age 21 covered by the Early and Periodic Screening Diagnostic and Treatment (EPSDT) Supplemental Services benefit.

VI. POLICY / PROCEDURE:

A. ~~PHC~~Partnership is responsible for providing Early and Periodic Screening, Diagnostic and Treatment services for ~~member~~Members under the age of 21. Services include medically necessary Behavioral Health Treatment (BHT) services covered under Medicaid that are determined to be medically necessary

to correct or ameliorate any physical or behavioral conditions, regardless of whether California's Medi-Cal plan covers such services for adults.

B. General Criteria for BHT Services Covered Under Medicaid
In order to be eligible for BHT services, a ~~PHC~~Partnership Medi-Cal ~~member~~Member must meet all of the following coverage criteria. The recipient must:
1. Be under 21 years of age
2. Have a recommendation from a licensed physician, surgeon or psychologist that states evidence-based BHT services are medically necessary and covered under Medicaid, regardless of diagnosis.
3. Be medically stable and without a need for 24-hour medical/nursing monitoring or procedures provided in a hospital or intermediate care facility for persons with intellectual disabilities (ICF/ID)
4. Appear to have persistent developmentally inappropriate behavior.

C. Medical Necessity Criteria for BHT Services Covered Under Medicaid
1. Member exhibits the presence of excesses and/or deficits of behaviors that significantly interfere with home or community activities (including, but not limited to, aggression, self-injury, elopement, and/or social interaction, independent living, play and/or communication skills) requiring behavioral assessment and treatment.
   a. ~~PHC~~Partnership utilizes current clinical criteria and guidelines when determining what BHT services covered under Medicaid are medically necessary and ensures appropriate independent review of ~~member~~Members' medical needs for BHT services in accordance with EPSDT requirements and medically accepted standards of care.
2. Some common diagnoses with evidence-based results reflecting this form of therapy to be highly beneficial include, but are not limited to, Autism Spectrum Disorder (ASD), Attention Deficit Hyperactivity Disorder (ADHD), bipolar and schizophrenia.

D. Covered Services for Behavior Assessment and Behavioral Health Treatment (BHT)
1. A Treatment Authorization Request (TAR) will be required for all BHT services and should be faxed or electronically submitted from the provider to the Health Services Department for review based upon medical necessity criteria and procedures otherwise in compliance with ~~PHC~~Partnership policy MCUP3041 TAR Review Process.
   a. The TAR must include the following documentation:
      1) Medical or mental health diagnosis
      2) Length and severity of the condition
      3) History and Physical exam including mental status, development status and/or any form of comprehensive diagnostic testing
      4) The Functional Behavioral assessment conducted by a Board Certified Behavior Analyst, which documents the severity of behavioral and speech issues, and the details of the BHT therapy services that are recommended to address these issues
   b. If the above documentation is not available OR the information is beyond twelve months, ~~PHC~~Partnership may make a one-time allowance to approve a single visit in order to fulfill TAR requirements.
2. A signed and dated Release of Information (ROI) consent form must be submitted with any BHT related clinical documentation or TAR. The ROI is valid for one calendar year from the date of signature and may be cancelled by the ~~member~~Member or legal guardian at any time. Failure to do so may result in a delay of service.

E. Providers of Services
1. Medically necessary BHT services covered under Medicaid must be provided and supervised under a ~~PHC~~Partnership-approved treatment plan developed by a BHT service provider who meets the requirements contained in California's Medicaid State Plan.[1]

[1] Refer to California's Medicaid State Plan, Limitations on Attachment 3.1-A,13c - Preventive Services, BHT, and Attachment 3.1-A, Supplement 6.

2. BHT services must be provided by a Qualified Autism Service Provider, Qualified Autism Service Professional, or Qualified Autism Service Paraprofessional who meets the requirements contained in California's Medicaid State Plan.[1]

F. Treatment Plan Criteria
   1. BHT services covered under Medicaid must be provided, observed, and directed under a ~~PHC~~Partnership-approved behavioral treatment plan developed by a BHT Service Provider for the specific ~~member~~Member being treated.
   2. The behavioral treatment plan must identify the medically necessary services to be provided in each community setting in which treatment is medically indicated, including on-site at school or during remote school sessions, during school hours and effective coordination with the Local Educational Agency (LEA).
   3. ~~PHC~~Partnership permits and encourages (but does not require) the ~~member~~Member's parent(s)/guardian(s) to be involved in the development, revision, and modification of the behavioral health treatment plan, in order to promote their participation in treatment.
   4. The behavioral treatment plan must include a description of patient information, reason for referral, brief background information including:
      a. Demographics
      b. Living situation
      c. Home/school/work information
      d. Clinical review including recent assessment/reports, any assessment procedures and the results as well as the evidenced-based BHT services.
   5. BHT interventions must utilize evidenced-based or science-based promising practice that minimize behavioral conditions and promote positive behavioral outcomes across a wide range of aberrant behaviors and/or ameliorate functional status concerns. The intervention(s) must include a treatment plan that meets Best Practice Treatment Plan guidelines. The intervention should be time-limited based on termination/discontinuation criteria that are clarified at the outset of treatment.
   6. An intervention must be effective (evidenced-based or science-based promising practice), appropriate, and necessary as it relates to the diagnosis and/or identified behavioral concerns (determined need) and be provided with the goal to improve function.
   7. The behavioral treatment plan must include outcome measurement assessment criteria that will be used to measure achievement of behavior objectives.
   8. Includes the ~~member~~Member's current level of need (baseline, expected behaviors the parent/guardian will demonstrate, including condition under which it must be demonstrated and mastery criteria [the objective goal], date of introduction, estimated date of mastery, specific plan for generalization and report goal as met, not met, modified [include explanation]).
   9. Identifies measurable long-, intermediate-, and short term goals and objectives that are specific, behaviorally defined, developmentally appropriate, socially significant, and based upon clinical observation.
   10. Clearly identifies the service type, number of hours of direct service(s), observation and direction, parent/guardian training, support and participation needed to achieve the goals and objectives, the frequency at which the ~~member~~Member's progress is measure and reported, transition plan, crisis plan and each individual BHT service provider responsible for delivering the services.
   11. Includes care coordination involving the parent(s), legal guardian, or legally responsible person, and the school, state disability programs, and others as applicable
   12. Considers the ~~member~~Member's age, school attendance requirements, and other daily activities when determining the number of hours of medically necessary direct service and supervision.
      a. ~~PHC~~Partnership must not limit BHT services on the basis of school attendance or other categorical exclusions. Blanket limitations or restrictions on benefits and services, such as caps

on number of hours, are prohibited.

13. Delivers BHT services in a home or community-based setting, including clinics.
    a. BHT services that are provided in school, in the home, or other community setting must be clinically indicated, medically necessary and delivered in the most appropriate setting for the direct benefit of the ~~member~~Member. BHT hours delivered across settings, including during school, must be proportionate to the ~~member~~Member's medical need for BHT services in each setting.
14. Providers of BHT services must review, revise, and/or modify the behavioral treatment plan no less than once every six months.
15. The behavioral treatment plan must include an exit plan/criteria to modify or discontinue services. Only a determination that services are no longer medically necessary under EPSDT standard can be used to reduce or eliminate services.

G. Transition of Care When Member Turns 21
   1. Treatment plan criteria requires that the BHT provider indicates a transition plan for the ~~member~~Member. Members turning 21 will be referred to the providers, community agencies and/or Regional Center noted in the transition plan for continued therapy or services if indicated.

H. BHT Service Limitations
   1. Before initiating BHT interventions for a specific behavior, the possibility that the behavior is related to a particular mental health, medical, or skill deficit or sensory problem, should be evaluated. The deficit or sensory problem should be addressed via treatment (outside of BHT) that is best suited to that condition.
   2. The following services do not meet medical necessity criteria or qualify as Medi-Cal covered BHT services for reimbursement:
      a. Services rendered when continued clinical benefit is not expected.
      b. Provision or coordination of respite, day care, or educational services, or reimbursement of a parent, legal guardian, or legally responsible person for costs associated with participation under the behavioral treatment plan.
      c. Treatment whose sole purpose is vocationally or recreationally based.
      d. Custodial care. (As defined for purposes of BHT services, custodial care is provided primarily for maintaining the ~~member~~Member's or anyone else's safety. It could be provided by persons without professional skills or training.)
      e. Services, supplies, or procedures, performed in a non-conventional setting, including, but not limited to, resorts, spas, and camps.
      f. Services rendered by a parent, legal guardian, or legally responsible person.
      g. Services that are not evidence-based or science-based promising practice behavioral interventions.
   3. ~~PHC~~Partnership is not contractually responsible for educationally necessary BHT services covered by a LEA and provided pursuant to a ~~member~~Member's IFSP, IEP, or IHSP. However, if medically necessary and covered under Medicaid, ~~PHC~~Partnership must provide supplementary BHT services, and must provide BHT services to address gaps in service caused when the LEA discontinues the provision of BHT services (e.g. during a Public Health Emergency [PHE]).
      a. If medically necessary BHT services are otherwise still needed, but the need is not documented in an IEP or IFSP/IHSP, then ~~PHC~~Partnership may coordinate any needed BHT services in a school-linked setting.
      b. When school is not in session, ~~PHC~~Partnership must cover medically necessary BHT services that were being provided by the LEA when school was in session.

I. Coordination of Care
   1. ~~PHC~~Partnership has primary responsibility for ensuring that EPSDT ~~member~~Members receive all medically necessary BHT services covered under Medicaid. ~~PHC~~Partnership must establish data and information sharing agreements as necessary to coordinate the provision of services with other

entities that may have overlapping responsibility for the provision of BHT services, including but not limited to Regional Centers (RCs), LEAs, and County Mental Health Plans (MHPs). Refer to policy MCCP2022 Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services.

a. When another entity has overlapping responsibility to provide BHT services to a ~~member~~Member, ~~PHC~~Partnership must assess the medical needs of the ~~member~~Member for BHT services across community settings, according to the EPSDT standard and determine what BHT services (if any) are actively being provided by other entities.
b. ~~PHC~~Partnership will coordinate the provision of all services including durable medical equipment (DME) and medication with the other entities to ensure that ~~PHC~~Partnership and the other entities are not providing duplicative services.
c. ~~PHC~~Partnership will ensure that all of the ~~member~~Member's needs for BHT services covered under Medicaid are being met in a timely manner, regardless of payer, and based on the individual needs of the ~~member~~Member.

2. Medically necessary BHT must not be considered duplicative when ~~PHC~~Partnership has overlapping responsibility with another entity for the provision of BHT services unless the service provided by the other entity is currently being provided is the same type of service (e.g. ABA), addresses the same deficits, and is directed to equivalent goals.
3. ~~PHC~~Partnership has the primary responsibility to provide all medically necessary BHT services. When services provided by a LEA or RC do not fulfill all of the Member's medical need for BHT services, ~~PHC~~Partnership must authorize any remaining medically necessary services. ~~PHC~~Partnership must not rely on LEA programs to be the primary Provider of medically necessary BHT services on-site at school or during remote school sessions. Furthermore, ~~PHC~~Partnership must not assume that BHT services included in a ~~member~~Member's IEP/IHSP/IFSP are actively being provided by the LEA. ~~PHC~~Partnership is responsible for determining whether such services continue to be provided by the LEA, and must provide any medically necessary BHT services that have been discontinued by the LEA, for example during a PHE. Refer to policy MPCP2006 Coordination of Services for Members with Special Health Care Needs (MSHCNs) and Persons with Developmental Disabilities.
4. If a ~~member~~Member's IEP team concludes that ~~PHC~~Partnership-approved BHT services are necessary to the ~~member~~Member's education, the IEP team must determine that ~~PHC~~Partnership-approved BHT services must be included in the ~~member~~Member's IEP. Services in a ~~member~~Member's IEP must not be reduced or discontinued without formal amendment of the IEP. If the ~~PHC~~Partnership-contracted Provider determines that BHT services included in a ~~member~~Member's IEP are no longer medically necessary, ~~PHC~~Partnership is not authorized to use Medi-Cal funding to provide such services.
   a. ~~PHC~~Partnership is solely financially responsible for providing, or coordinating with the LEA to provide any BHT services included in a ~~member~~Member's IEP until such time that the IEP is amended.
   b. ~~PHC~~Partnership must coordinate with the LEA to ensure that BHT services that are determined to be no longer medically necessary are removed from the IEP as ~~PHC~~Partnership-provided services upon amendment of the IEP.
5. In the event that BHT services are no longer medically necessary, ~~PHC~~Partnership will attempt to obtain written agreement from the LEA to oversee the provision of services included in the IEP.
   a. ~~PHC~~Partnership may coordinate with the LEA to contract directly with a school-based BHT services practitioner, if the practitioner is enrolled in Medi-Cal and otherwise qualified as required by APL 23-010 *Revised*, to provide any medically necessary BHT services included in a Member's IEP.
   b. ~~PHC~~Partnership may reimburse the LEA for the school-based Provider's services only to the extent the services continue to meet the EPSDT standard of medical necessity.
6. While BHT does not specifically include prescription drug therapy, children with ABA are likely to

have prescription drug therapy as part of their treatment regimen. ~~PHC~~Partnership is required to ensure Members have access to and support medication adherence for the prescription drug benefits carved-out to Medi-Cal Rx.

7. ~~PHC~~Partnership is the primary Provider of medically necessary BHT services for Members eligible for EPSDT. Whenever Members are unable to receive BHT services from school-based Providers or other entities with overlapping responsibility for the provision of BHT services, ~~PHC~~Partnership is responsible for covering any gap in medically necessary services for the Member. ~~PHC~~Partnership is required to provide case management and coordination of care to ensure that Members can access medically necessary BHT services.

J. Continuity of Care
   1. For ~~member~~Members under the age of 21 years of age transitioning BHT services from a Regional Center, ~~PHC~~Partnership will automatically generate a Continuity of Care Request.
   2. Continuity of Care with an out-of-network BHT provider can be granted for up to 12 months when all of the following Department of Health Care Services (DHCS) criteria are met:
      a. The ~~member~~Member has an existing relationship with a qualified provider of BHT services. An existing relationship means the ~~member~~Member has seen the out-of-network BHT provider at least one time during the six months prior to either the transition of services from the Regional Center (RC) to ~~PHC~~Partnership or the date of the ~~member~~Member's initial enrollment with ~~PHC~~Partnership if enrollment occurred on or after July 1, 2018.
      b. The provider and ~~PHC~~Partnership can agree to a rate, with the minimum rate offered by ~~PHC~~Partnership being the established Medi-Cal Fee for Service (FFS) rate for the applicable BHT service.
      c. The provider does not have any documented quality of care concerns that would cause him/her to be excluded from the ~~PHC~~Partnership's network.
      d. The provider is a California State Plan approved provider
      e. The BHT provider supplies ~~PHC~~Partnership with relevant treatment information for the purpose of determining medical necessity, as well as current treatment plan, as long as it is allowable under federal and state privacy laws and regulations.
   3. For more information on ~~PHC~~Partnership's Continuity of Care policy and BHT, please refer to policy MCCP2014 Continuity of Care.
   4. ~~PHC~~Partnership will not provide continuity of care for services not covered by Medi-Cal.

K. Timely Access Standards
   1. ~~PHC~~Partnership must provide BHT services in accordance with timely access standards, pursuant to WIC Section 14197 and the contract between DHCS and ~~PHC~~Partnership.

VI. REFERENCES:

A. Behavior Analyst Certification Board, Inc (BCBA): *Guidelines—Health Plan Coverage of Applied Behavior Analysis Treatment for Autism Spectrum Disorder* (2012)
B. California Association for Behavior Analysis (CalABA): *Report of the Task Force of California Association for Behavior Analysis—Guidelines for Applied Behavior Analysis (ABA) Services and Recommendations for Best Practices for Regional Center Consumers* (March 2011)
C. California Department of Developmental Services, *Autism Spectrum Disorders- Best Practice Guidelines Screening, Diagnosis and Assessment*, (2002)
D. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-010 *Revised*: Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21 (11/22/2023)
E. Diagnostic and Statistical Manual (DSM) V
F. Title 22, California Code of Regulations (CCR), Sections 51184; 51242; 51340; 51532
G. DHCS All Plan Letter (APL) 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)
H. DHCS State Plan Amendment (SPA) 14-026 01/21/2016

I. DHCS All Plan Letter (APL) 23-005: Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21 (03/16/2023)
J. DHCS All Plan Letter (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)

VII. DISTRIBUTION:
A. ~~PHC~~Partnership Department Directors
B. ~~PHC~~Partnership Provider Manual

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

IX. REVISION DATES: 08/19/15 effective 09/15/14 per DHCS; 11/18/15; 09/21/16; 06/21/17; *06/13/18; 02/13/19; 02/12/20; 05/13/20; 05/12/21; 05/11/22; 06/14/23; 10/11/23; 04/10/24; 04/09/25

*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 ~~PHC~~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 ~~PHC~~Partnership.

~~PHC~~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="4">Policy/Procedure Number: MPUP3059 (previously UP100359)</td><td colspan="3">Lead Department: Health Services
Business Unit: Utilization Management</td></tr>
<tr><td colspan="4">Policy/Procedure Title: Negative Pressure Wound Therapy (NPWT) Device/Pump</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 10/15/2003</td><td colspan="4">Next Review Date: ~~05/08/2025~~04/09/2026
Last Review Date: ~~05/08/2024~~04/09/2025</td></tr>
<tr><td>Applies to:</td><td colspan="2">☐ Employees</td><td colspan="2">☒ Medi-Cal</td><td colspan="2">☒ 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">☐ CREDENTIALS</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="4">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: ~~05/08/2024~~04/09/2025</td></tr>
</table>

I. RELATED POLICIES:

A. MCUP3013 - Durable Medical Equipment (DME) Authorization
B. MCUG3134 - Hospital Bed/ Specialty Mattress Guidelines
C. MCUG3007 - Authorization of Ambulatory Procedures and Services
D. MCUP3041 - Treatment Authorization Request (TAR) Review Process

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

A. Negative Pressure Wound Therapy (NPWT) - Involves applying continuous or intermittent topical negative pressure to a special dressing positioned in the wound cavity or over a flap or graft. The pressure distributing wound dressing helps remove fluids from the wound and stimulates the growth of healthy granulation tissue.

~~A.~~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.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

To define the clinical indications for NPWT [also known as Negative Pressure Wound Therapy or Vacuum-Assisted Closure (VAC)] system to improve wound healing in an outpatient setting for Partnership HealthPlan of California ~~(PHC)~~ M~~m~~embers.

Policy/Procedure Number: MPUP3059 (previously UP100359)			**Lead Department: Health Services** **Business Unit:** Utilization Management
Policy/Procedure Title: Negative Pressure Wound Therapy (NPWT) Device/Pump			☒**External Policy** ☐**Internal Policy**
Original Date: 10/15/2003		**Next Review Date:** ~~05/08/2025~~04/09/2026 **Last Review Date:** ~~05/08/2024~~04/09/2025	
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**

VI. POLICY / PROCEDURE:

A. Initial Coverage:

~~PHC~~Partnership will approve the use of NPWT when either criterion A.1., A.2. or A.3. AND InterQual® Durable Medical Equipment (DME) criteria ~~is~~ are met. NPWT Treatment Authorization Requests (TARs) are reviewed in one month increments.

1. Ulcers and Wounds in the Home Setting:
   a. The patient has one of the following chronic ulcers or wounds, present for at least two weeks despite appropriate wound care: Stage III or IV pressure ulcer, a neuropathic (diabetic) ulcer, venous or arterial insufficiency ulcer or mixed etiology ulcer.
   b. A complete wound therapy program described below by criterion 1) and criteria 2), 3), or 4) as applicable depending on the type of wound, should have been tried or considered and ruled out prior to application of NPWT.
      1) For all chronic ulcers or wounds, the following components of a wound therapy program must include a minimum of all of the following general measures, which should either be addressed, applied, or considered and ruled out prior to application of NPWT.
         a) Documentation in the patient's medical record of evaluation, care, and wound measurements by a licensed medical professional, and
         b) Application of dressings to maintain a moist wound environment, and
         c) Debridement of necrotic tissue if present, and
         d) Evaluation of and provision for adequate nutritional status
      2) For Stage III or IV pressure ulcers:
         a) The patient has been appropriately turned and positioned, and
         b) The patient has used a group 2 or 3 (e.g. low air loss mattress) support surface for pressure ulcers on the posterior trunk or pelvis
         c) The patient's moisture and incontinence have been appropriately managed
      3) For neuropathic (for example, diabetic) ulcers:
         a) The patient has been on a comprehensive diabetic management program, and
         b) Reduction in pressure on a foot ulcer has been accomplished with appropriate modalities.
      4) For venous insufficiency ulcers:
         a) Compression bandages and/or garments have been consistently applied, and
         b) Leg elevation and ambulation have been encouraged.

~~2. Acute surgical or traumatic wounds:~~
~~a. The patient has an acute open surgical or open traumatic wound.~~

2. Ulcers and Wounds Encountered in an Inpatient Setting:
   a. When NPWT is initiated in an inpatient setting by the treating physician, it will be covered upon discharge for the first month if no Exclusions from Coverage apply. (see section VI.B. below)
   b. NPWT applied in an inpatient setting will be reviewed as a Continued Coverage request rather than an initial request. (see section VI.C. below)

B. Exclusions from Coverage:

A NPWT will be denied as not medically necessary if one or more of the following are present:

1. The presence in the wound of necrotic tissue with eschar, if debridement is not attempted;
2. Untreated osteomyelitis within the vicinity of the wound
3. Cancer present in the wound
4. The presence of a fistula to an organ or body cavity within the vicinity of the wound
5. Exposed vasculature, nerves, anastomosis or organs

C. Continued Coverage:

1. For wounds and ulcers described under VI.A. above, once placed on an NPWT, in order for coverage to continue, a licensed medical professional must do the following:

a. On a regular basis,
   1) Directly assess the wound(s) being treated

   2) Supervise or directly perform the dressing changes
b. On at least a weekly basis, document changes in the ulcer's dimensions and characteristics.

2. If criteria C.1.a.1) and 2) are not met, continued coverage of this therapy will be denied as not medically necessary.

D. When Coverage Ends:
1. For wounds and ulcers described under VI.A. or VI.B. above, NPWT will be denied as not medically necessary with any of the following, whichever occurs earliest:
   a. Criteria C.1.a.1) and 2) cease to occur, or
   b. In the judgment of the treating physician, adequate wound healing has occurred to the degree that NPWT may be discontinued, or
   c. Any measurable degree of wound healing has failed to occur over a one month period of treatment. There must be documented in the patient's medical records quantitative measurements of wound characteristics including wound length and width (surface area), and depth, serially observed and documented, over a specified time interval. The recorded wound measurements must be consistently and regularly updated and must have demonstrated progressive wound healing from month to month, or
   d. Four (4) months (including the time NPWT was applied in an inpatient setting prior to discharge to the home) have elapsed using a NPWT in the treatment of any wound.
2. Coverage beyond four (4) months will be given individual consideration on a case-by-case basis. If the wound has not shown progress over the prior month, a patient assessment must be completed by the clinician managing the wound. Documentation should include an evaluation for factors and medical conditions impeding wound healing, such as diabetes, poor nutritional status or infection, with submission of recent, relevant labs (complete blood count [CBC], comprehensive metabolic panel [CMP], albumin, wound cultures, hemoglobin A1C [HgA1C]).

E. Supplies Covered:
1. Coverage is provided up to a maximum of 15 dressing kits per wound per month unless there is documentation that the wound size requires more than one dressing kit for each dressing change.
2. Coverage is provided up to a maximum of 10 canister sets per month unless there is documentation evidencing a large volume of drainage (greater than 90 ml of exudate per day.) For high volume exudative wounds, a stationary pump with the largest capacity canister must be used. Excess utilization of canisters related to equipment failure (as opposed to excessive volume drainage) will be denied as not medically necessary.
3. Amounts greater than 15 dressing kits per wound per month or 10 canister sets per month in the absence of documentation clearly explaining the medical necessity of the excess quantities will be denied as not medically necessary.

F. Documentation:
1. A written order for the negative pressure wound therapy pump and supplies must be signed and dated by the treating physician and obtained by the supplier prior to delivery of the item. Documentation of the history, previous treatment regimens (if applicable), and current wound management orders must be documented. Additionally, concurrent measurements must also be submitted to support the need for NPWT.
2. Documentation of wound evaluation and treatment, documentation of quantitative measurements of wound presence of granulation and necrotic tissue characteristics including wound length and width (surface area), and depth, and amount of wound exudate (drainage), indicating progress of healing must be entered at least weekly. The supplier of the equipment and supplies must obtain from the treating clinician an assessment of wound healing progress, based upon the wound measurement as

documented in the patient's medical record.

VII. REFERENCES:

A. Medi-Cal Provider Manual/ Guidelines: Durable Medical Equipment (DME): Other DME Equipment (*dura other*) section Negative Pressure Wound Therapy (NPWT) Devices

B. InterQual® DME Equipment Criteria – Negative Pressure Wound Therapy (NPWT) Pump

~~B.~~C. Centers for Medicare & Medicaid Services (CMS) Standards: Local Coverage Determination (LCD) L33821 Negative Pressure Wound Therapy Pumps 01/01/2024 or any subsequent updates published by CMS.

VIII. DISTRIBUTION:

A. ~~PHC~~Partnership Department Directors

B. ~~PHC~~Partnership Provider Manual

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

X. REVISION DATES:

Partnership Advantage (Program effective January 1, 2026)
04/09/25

Medi-Cal
10/20/04; 10/18/06; 08/20/08; 10/01/10; 04/18/12; 04/15/15; 04/20/16; 04/19/17; *06/13/18; 04/10/19; 05/13/20; 04/14/21; 05/11/22; 05/10/23; 05/08/24; 04/09/2025

*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 MPUP3059 (Healthy Kids program ended 12/01/2016)
10/18/06; 8/20/08; 10/01/10; 04/18/12; 04/15/15; 04/20/16 to 12/01/2016

PartnershipAdvantage:
MPUP3059 - 10/18/06 to 01/01/2015

Healthy Families:
MPUP3059 - 10/01/2010 to 03/01/2013

****

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 ~~PHC~~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 ~~PHC~~Partnership.

Policy/Procedure Number: MPUP3059 (previously UP100359)			**Lead Department: Health Services** **Business Unit:** Utilization Management
Policy/Procedure Title: Negative Pressure Wound Therapy (NPWT) Device/Pump			☒**External Policy** ☐**Internal Policy**
Original Date: 10/15/2003		**Next Review Date:** ~~05/08/2025~~04/09/2026 **Last Review Date:** ~~05/08/2024~~04/09/2025	
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**

~~PHC~~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="4">Policy/Procedure Number: MCCP2030</td><td colspan="4">Lead Department: Health Services</td></tr>
<tr><td colspan="4">Policy/Procedure Title: Transportation-Related Travel Expenses: Lodging, Meals, Attendants, Parking and Tolls</td><td colspan="4">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: (MCCP2016) 10/21/2015 (Effective 01/08/2020 – Transportation Policy for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT) Policy split)</td><td colspan="5">Next Review Date: N/A~~02/14/2025~~
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<tr><td colspan="4">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="4">Archived Date: 04/12/2025~~Approval Date: 02/14/2024~~</td></tr>
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I. RELATED POLICIES:

A. MCCP2024 - Whole Child Model for California Children's Services (CCS)
B. MCCP2022 - Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services
C. MCCP2016 - Transportation Guidelines for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT)
D. CMP09 - Investigating & Reporting Fraud, Waste and Abuse
E. CGA024 - Medi-Cal Member Grievance System

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services
D. Grievance
E. Finance
F. Provider Relations

III. DEFINITIONS:

A. California Children's Services (CCS): A state program for children up to 21 years of age, who have been determined eligible for the CCS program due to the presence of certain diseases or health problems.
B. Medical Necessity (Age 21 and over): As defined per Partnership HealthPlan of California's (PHC's) contract with the Department of Health Care Services (DHCS), medically necessary means 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.
C. Medical Necessity (Under Age 21): In addition to the definition noted in III.B. above, medical necessity for members under age 21 is also defined as services necessary to correct or ameliorate defects and physical and mental illnesses that are discovered by the screening services (per Section 1396d(r)(5) of Title 42 of the United States Code)
D. Whole Child Model (WCM): A comprehensive program for the whole child encompassing care coordination in the areas of primary, specialty, and behavioral health for any pediatric member insured by PHC.

IV. ATTACHMENTS:

Policy/Procedure Number: MCCP2030		Lead Department: Health Services
Policy/Procedure Title: Transportation-Related Travel Expenses: Lodging, Meals, Attendants, Parking and Tolls		☒ **External Policy** ☐ **Internal Policy**
Original Date: (MCCP2016) 10/21/2015 (Effective 01/08/2020 – Transportation Policy for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT) Policy split)	**Next Review Date:** N/A~~02/14/2025~~ **Last Review Date:** 02/14/2024	
Applies to:	☒ **Medi-Cal**	☐ **Employees**

A. N/A

V. PURPOSE:

To outline the circumstances by which Partnership HealthPlan of California (PHC) will approve parking, toll(s), meal(s), lodging, attendant salary reimbursement and/or any other qualifying necessary expenses related to travel in accordance with state and federal regulations.

VI. POLICY / PROCEDURE:

A. **TRANSPORTATION-RELATED TRAVEL EXPENSES BENEFITS**

1. Upon approval of Non-Emergency Medical Transportation (NEMT) or Non-Medical Transportation (NMT) services, members and their attendant may be eligible for the following services:
   a. Advance booking or reimbursement of reasonable and necessary expenses for lodging.
   b. Advance payment or reimbursement of reasonable and necessary expenses for meals.
   c. Reimbursement of reasonable and necessary expenses for an accompanying attendant's salary.
   d. Reimbursement of reasonable and necessary expenses for parking and tolls.
   e. Other necessary expenses, for which reimbursement is requested, will be reviewed on a case by case basis.
2. Requests made for these services without an approved accompanying NEMT or NMT service will be reviewed on a case by case basis. If approved, the provided service will not exceed what is described in this policy.
3. Parking, toll(s), meal(s) and/or lodging costs shall not be authorized if volunteer, community, or other transportation-related travel services are available to the member at no charge.
4. If approved, parking, toll(s), meal(s) and/or lodging shall be arranged for the least expensive and most appropriate services.
5. Requests for transportation-related travel expenses within 50 miles of the member's residence may be subject to additional review, up to and including Medical Director review for necessity.
6. Reimbursements for transportation-related travel expenses require attendance verification before reimbursements will be issued.
   a. Attendance verification may include discharge instructions, signed note from medical staff office on letterhead or a screenshot of printout from an online patient portal. Attendance verification must have date of service, member information and facility name clearly visible

B. **LODGING**

1. Lodging must be requested prior to the approved check-in date.
   a. If requested a minimum of five (5) calendar days prior to the approved check-in date, lodging can be booked in advance by PHC.
   b. Members can choose to be reimbursed for lodging in lieu of advanced booking; however, if lodging is requested with fewer than five (5) calendar days' notice, advanced booking will not be available.
   c. In order for reimbursement to be issued or subsequent advanced bookings to be made, the following documentation must be provided to PHC within ninety (90) calendar days of the check-out date.
      1) Attendance verification as outlined in section VI.A.6. above.
      2) If the request is for reimbursement, a receipt showing proof of payment must be provided.
   d. Members will be reimbursed for lodging based on the cost documented on the receipt, not to exceed $131 per night.
      1) The form of reimbursement offered by PHC is decided by PHC and may be in the form of cash, check, or other forms of prepaid cards.

2) Reimbursement will be issued within sixty (60) calendar days of receiving the required receipts and/or proof of payment.

2. If multiple members in the same family and/or household request lodging, both the size of room and/or number of rooms booked will be in accordance with the number of members and attendants approved for lodging.
3. Reimbursement for the cost of lodging provided by facilities sponsored by charitable organizations should not be greater than the customary charges to families.
4. Members seeking outpatient care are eligible to receive lodging if the member's trip to the outpatient provider cannot be completed in one twelve (12) hour day, including roundtrip travel and foreseen appointment duration.
   a. Round trip travel time will be calculated using publicly available online mapping services. These estimated travel times are used as a guide to calculate eligibility and may not be representative of the actual time it took to complete the drive on any given date of service.
   b. The appointment duration must be verified with the outpatient provider's office prior to the scheduled appointment; if the duration is not verifiable it cannot be included in the travel time calculation. If the actual appointment duration was longer than projected at the time of verification and results in the travel time exceeding one twelve (12) hour day, PHC will review the request for reimbursement.
   c. For members who have diagnoses that prevent them from traveling in a vehicle for the above length of time, PHC may authorize lodging services upon confirmation from the treating provider that the condition(s) limit their ability to travel for that duration in one day.
   d. For members whose appointment time requires a departure prior to 6:00 am, or the return to residence is anticipated to be after 10:00 pm, PHC may cover lodging on a case-by-case basis.
      1) Estimated departure and return times are calculated using the projected travel times provided by publicly available online mapping software. These estimated travel times are used as a guide to calculate eligibility and may not be representative of the actual time it took to complete the drive on any given date of service.
5. Members under the age of 21, seeking inpatient care may be eligible for lodging for their parent/legal guardian in the following situations:
   a. For intensive care settings when the parent/legal guardian is not permitted to stay at the member's bedside, PHC may initially authorize up to seven (7) nights of lodging per hospitalization for one parent/legal guardian. The need for additional nights of lodging shall be evaluated on a case-by-case basis per the member's circumstances.
   b. For non-intensive care settings when the parent/legal guardian is able to stay at the member's bedside, PHC may authorize one (1) night of lodging for one (1) parent/legal guardian after every six (6) nights of member hospitalization.
   c. The total maximum authorization when the member is in an inpatient setting shall be fifteen (15) nights of lodging for each thirty (30) days of member hospitalization, beginning with the day of the member's admission. Each new hospitalization shall begin a new thirty (30) day benefit period.
6. Authorization for lodging needed to obtain medically necessary services for major organ transplants is covered for living donors.

C. **MEALS**

1. Meals must be requested prior to the date of service for which they are needed.
   a. If the request for meals is made a minimum of two (2) business days prior to the date of service, meals payments can be issued in advance by PHC upon request.

2. Reimbursement for meals is based on the US General Services Administration's (GSA) standard per diem rate.
    a. If the request was for advance payment, the reimbursement will be $66 per day.
    b. If the request was for reimbursement, the payment will be made based on the cost documented on the receipt, not to exceed $66 per day.
    c. The form of reimbursement offered by PHC is decided by PHC and may be in the form of cash, check, or other forms of prepaid cards.
    d. Reimbursement will be issued within sixty (60) days of receiving the required receipts and/or proof of payment.
3. In order for reimbursement to be issued or subsequent advanced payments to be made, the following documentation must be provided to PHC within ninety (90) days of the approved date of service.
    a. Attendance verification as outlined in section VI.A.6. above.
4. Meals payments will be issued for each approved member and their one (1) accompanying attendant.
    a. For members age 21 and up, the attendant must be deemed medically necessary as explained in section VI.D. of this policy.
    b. Members under the age of 21 can receive meals payments for one (1) accompanying parent/legal guardian.
5. Hospital meal vouchers provided to the member can be reimbursed to the hospital when billed via invoice. The value of the provided meal vouchers will be deducted from the member's meal reimbursement.
6. Members seeking outpatient care are eligible to receive meals if the member's trip to the outpatient provider cannot be completed in one twelve (12) hour day, including roundtrip travel and foreseen appointment duration.
    a. Round trip travel time will be calculated using publicly available online mapping services. These estimated travel times are used as a guide to calculate eligibility and may not be representative of the actual time it took to complete the drive on any given date of service.
    b. The appointment duration must be verified with the outpatient provider's office prior to the scheduled appointment, if the duration is not verifiable it cannot be included in the travel time calculation. If the actual appointment duration was longer than projected at the time of verification and results in the travel time exceeding one twelve (12) hour day PHC will review the request for reimbursement.
    c. For members who have diagnoses that prevent them from traveling in a vehicle for the above length of time, PHC may authorize meal services upon confirmation from the treating provider that the condition(s) limit their ability to travel for that duration in one day.
    d. For members whose appointment time requires a departure prior to 6:00 am, or the return to residence is anticipated to be after 10:00 pm, PHC may cover meals on a case-by-case basis.
        1) Estimated departure and return times are calculated using the projected travel times provided by publicly available online mapping software. These estimated travel times are used as a guide to calculate eligibility and may not be representative of the actual time it took to complete the drive on any given date of service.
7. Members under the age of 21, seeking inpatient care may be eligible for meals for their parent/legal guardian in the following situations:
    a. For intensive care settings when the parent/legal guardian is not permitted to stay at the member's bedside, PHC may initially authorize up to seven (7) days of meals per hospitalization for one (1) parent/legal guardian. The need for additional days of meals shall be evaluated on a case-by-case basis per the member's circumstances.

b. For non-intensive care settings when the parent/legal guardian is able to stay at the member's bedside, PHC may authorize one (1) day of meals for one (1) parent/legal guardian after every six (6) nights of member hospitalization.
c. The total maximum authorization when the member is in an inpatient setting shall be fifteen (15) days of meals for each thirty (30) days of member hospitalization, beginning with the day of the member's admission. Each new hospitalization shall begin a new thirty (30) day benefit period.
d. Member's age two (2) and younger may qualify for meals for their mother for the entire hospitalization if the mother is breastfeeding, regardless of intensive care status.

8. Authorization for meals needed to obtain medically necessary services for major organ transplants is covered for living donors.

D. **ATTENDANTS**

1. Qualified Attendants
   a. In order for member to be approved for meals, lodging and/or salary reimbursement for their attendant, the attendant must be determined to be medically necessary to facilitate the approved NEMT or NMT.
   b. Attendants must be able to safely accompany the member and not require additional assistance.
   c. The services provided by the attendant must exceed the capabilities of the NEMT or NMT staff facilitating the transport.
   d. Requests for meals, lodging & salary for attendants are subject to PHC Medical Director review. Members may be asked to provide medical records justifying the necessity of the attendant; if not provided, the request may be denied.
2. Attendant Salary
   a. Members who require the services of a paid attendant may be eligible to receive reimbursement for the attendant's salary for the duration of their approved NEMT or NMT request.
   b. Requests for attendant salary reimbursement must be made to PHC, in advance, regardless of the mode of transport provided.
   c. Attendant salary will not be reimbursed if the attendant is related to the member.
   d. In order for reimbursement to be issued, a receipt including proof of payment must be supplied to PHC within ninety (90) days of the date of service.
   e. The form of reimbursement offered by PHC is decided by PHC and may be in the form of cash, check, or other forms of prepaid cards.
   f. Reimbursement will be issued within sixty (60) days of receiving the required receipts and/or proof of payment.

E. **PARKING & TOLLS**

1. Members will be reimbursed for parking up to $50 per day and tolls at the full cost, as long as the cost is reasonable and supported by receipts.
   a. In order for reimbursement to be issued, the following documentation must be provided to PHC within ninety (90) days of the approved date of service:
      1) Attendance verification as outlined in section VI.A.6. above.
      2) A receipt showing proof of payment must be provided.
   b. The form of reimbursement offered is decided by PHC and may be in the form of cash, check, or other forms of prepaid cards.
   c. Reimbursement will be issued within sixty (60) days of receiving the required receipts and/or proof of payment.
   d. Parking and tolls reimbursement needed to obtain medically necessary services for major organ transplants is covered for living donors.

Policy/Procedure Number: MCCP2030		Lead Department: Health Services
Policy/Procedure Title: Transportation-Related Travel Expenses: Lodging, Meals, Attendants, Parking and Tolls		☒ **External Policy** ☐ **Internal Policy**
Original Date: (MCCP2016) 10/21/2015 (Effective 01/08/2020 – Transportation Policy for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT) Policy split)	**Next Review Date:** N/A~~02/14/2025~~ **Last Review Date:** 02/14/2024	
Applies to:	☒ **Medi-Cal**	☐ **Employees**

F. **RETROACTIVE REQUESTS**
1. PHC will review retroactive reimbursement requests for the services listed in this policy if the member paid out of pocket for the services during a month in which retroactive eligibility to Medi-Cal and PHC has been assigned. PHC's review for eligibility to the requested services will follow all applicable criteria listed in this policy except for the requirement to have requested the service in advance.

G. **OTHER TRAVEL EXPENSES**
1. Requests for other reasonable necessary expenses will be reviewed on a case by case basis. If approved, reimbursement is the only option for payment and will require receipts to be provided.

H. **WHOLE CHILD MODEL (WCM) / CALIFORNIA CHILDREN'S SERVICES (CCS) – MAINTENANCE AND TRANSPORTATION**
1. For PHC Whole Child Model (WCM) members, maintenance & transportation costs are covered pursuant to CCS program guidelines and in accordance with the Department of Health Care Services (DHCS) All Plan Letter (APL) 22-008. For more information on transportation, please see PHC policies MCCP2024 Whole Child Model for California Children's Services (CCS) and MCCP2016 Transportation Policy for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT).
2. For a CCS/WCM-eligible member whose post-hospitalization discharge plan documents the need for daily medical visits for treatment of the CCS-eligible condition and the distance precludes making the trip to the hospital in one twelve (12) hour day, lodging and meals may be authorized for the member and parent(s)/legal guardian(s).
3. A CCS/WCM eligible member and/or the member's parents(s)/legal guardian(s) will be responsible for payment of parking/toll(s), meal(s), and/or lodging when choosing to go to a facility or provider that is not the closest CCS-approved facility/paneled provider. Parking, toll(s), meal(s) and/or lodging that occurs beyond the closest provider capable of delivering the level/type of service required by the member's CCS-eligible condition are the responsibility of the CCS/WCM eligible member and/or the member's parent(s)/legal guardian(s).
4. Parking, toll(s), meal(s) and/or lodging may be a benefit for CCS/WCM members for whom PHC or the CCS State Regional Office authorized medical care outside of California.

VII. REFERENCES:

A. DHCS APL 22-008 Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses (05/18/2022)
B. DHCS Transportation Workgroup Frequently Asked Questions (FAQs) re: APL22-008 (05/18/2022)
C. DHCS CCS Numbered Letter (N.L.): 03-0810 Maintenance and Transportation for CCS Clients to Support Access to CCS Authorized Medical Services (8/19/2010)
D. DHCS APL 21-005: California Children's Services Whole Child Model Program (*Revised* 12/10/2021)
E. DHCS APL 23-005: Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21 (03/16/2023)
F. Title 42 United States Code (USC), Sections 1396, 1396d(a) and (r), 1396s(c)(2)(B)(i)
G. DHCS APL 22-013 Provider Credentialing / Recredentialing and Screening / Enrollment (07/19/2022 and *Revised for FAQs 08/24/2022*)
H. DHCS APL 21-011 Grievance and Appeal Requirements, Notice and "Your Rights" Templates (*Revised* 08/31/2022)

VIII. DISTRIBUTION:

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IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Senior Director, Health Services

X. REVISION DATES: 02/10/21; 02/09/22; 10/12/22; 02/08/23; 04/12/23; 02/14/24; ARCHIVED 04/12/2025

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

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~~C.~~D. 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

Policy/Procedure Number: MPTP2503 (previously MCCP2030)			Lead Department: Transportation
Policy/Procedure Title: Transportation-Related Travel Expenses: Lodging, Meals, Attendants, Parking and Tolls			☒ **External Policy** ☐ **Internal Policy**
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Handbook.

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   e. Other necessary expenses, for which reimbursement is requested, will be reviewed on a case by case basis.
2. Requests made for these services without an approved accompanying NEMT or NMT service will be reviewed on a case by case basis. If approved, the provided service will not exceed what is described in this policy.
3. Parking, toll(s), meal(s) and/or lodging costs shall not be authorized if volunteer, community, or other transportation-related travel services are available to the member at no charge.
4. If approved, parking, toll(s), meal(s) and/or lodging shall be arranged for the least expensive and most appropriate services.
5. Requests for transportation-related travel expenses within 50 miles of the member's residence may be subject to additional review, up to and including Medical Director review for necessity.
6. Reimbursements for transportation-related travel expenses require attendance verification before reimbursements will be issued.
   a. Attendance verification may include discharge instructions, signed note from medical staff office on letterhead or a screenshot of printout from an online patient portal. Attendance verification must have date of service, member information and facility name clearly visible

B. LODGING

1. Lodging must be requested prior to the approved check-in date.
   a. If requested a minimum of five (5) calendar days prior to the approved check-in date, lodging can be booked in advance by Partnership~~HC~~.
   b. Members can choose to be reimbursed for lodging in lieu of advanced booking; however, if lodging is requested with fewer than five (5) calendar days' notice, advanced booking will not be available.
   c. In order for reimbursement to be issued or subsequent advanced bookings to be made, the following documentation must be provided to Partnership~~HC~~ within ninety (90) calendar days of the check-out date.

1) Attendance verification as outlined in section VI.A.6. above.
2) If the request is for reimbursement, a receipt showing proof of payment must be provided.

d. Members will be reimbursed for lodging based on the cost documented on the receipt, not to exceed $131 per night.
   1) The form of reimbursement offered by Partnership~~HC~~ is decided by Partnership~~HC~~ and may be in the form of cash, check, or other forms of prepaid cards.
   2) Reimbursement will be issued within sixty (60) calendar days of receiving the required receipts and/or proof of payment.

2. If multiple members in the same family and/or household request lodging, both the size of room and/or number of rooms booked will be in accordance with the number of members and attendants approved for lodging.
3. Reimbursement for the cost of lodging provided by facilities sponsored by charitable organizations should not be greater than the customary charges to families.
4. Members seeking outpatient care are eligible to receive lodging if the member's trip to the outpatient provider cannot be completed in one twelve (12) hour day, including roundtrip travel and foreseen appointment duration.
   a. Round trip travel time will be calculated using publicly available online mapping services. These estimated travel times are used as a guide to calculate eligibility and may not be representative of the actual time it took to complete the drive on any given date of service.
   b. The appointment duration must be verified with the outpatient provider's office prior to the scheduled appointment; if the duration is not verifiable it cannot be included in the travel time calculation. If the actual appointment duration was longer than projected at the time of verification and results in the travel time exceeding one twelve (12) hour day, Partnership~~HC~~ will review the request for reimbursement.
   c. For members who have diagnoses that prevent them from traveling in a vehicle for the above length of time, Partnership~~HC~~ may authorize lodging services upon confirmation from the treating provider that the condition(s) limit their ability to travel for that duration in one day.
   d. For members whose appointment time requires a departure prior to 6:00 am, or the return to residence is anticipated to be after 10:00 pm, Partnership~~HC~~ may cover lodging on a case-by-case basis.
      1) Estimated departure and return times are calculated using the projected travel times provided by publicly available online mapping software. These estimated travel times are used as a guide to calculate eligibility and may not be representative of the actual time it took to complete the drive on any given date of service.
5. Members under the age of 21, seeking inpatient care may be eligible for lodging for their parent/legal guardian in the following situations:
   a. For intensive care settings when the parent/legal guardian is not permitted to stay at the member's bedside, Partnership~~HC~~ may initially authorize up to seven (7) nights of lodging per hospitalization for one parent/legal guardian. The need for additional nights of lodging shall be evaluated on a case-by-case basis per the member's circumstances.
   b. For non-intensive care settings when the parent/legal guardian is able to stay at the member's bedside, Partnership~~HC~~ may authorize one (1) night of lodging for one (1) parent/legal guardian after every six (6) nights of member hospitalization.
   c. The total maximum authorization when the member is in an inpatient setting shall be fifteen (15) nights of lodging for each thirty (30) days of member hospitalization, beginning with the day of the member's admission. Each new hospitalization shall begin a new thirty (30) day benefit period.

6. Authorization for lodging needed to obtain medically necessary services for major organ transplants is covered for living donors.

C. **MEALS**

1. Meals must be requested prior to the date of service for which they are needed.
   a. If the request for meals is made a minimum of two (2) business days prior to the date of service, meals payments can be issued in advance by Partnership~~HC~~ upon request.
2. Reimbursement for meals is based on the US General Services Administration's (GSA) standard per diem rate.
   a. If the request was for advance payment, the reimbursement will be $66 per day.
   b. If the request was for reimbursement, the payment will be made based on the cost documented on the receipt, not to exceed $66 per day.
   c. The form of reimbursement offered by Partnership~~HC~~ is decided by Partnership~~HC~~ and may be in the form of cash, check, or other forms of prepaid cards.
   d. Reimbursement will be issued within sixty (60) days of receiving the required receipts and/or proof of payment.
3. In order for reimbursement to be issued or subsequent advanced payments to be made, the following documentation must be provided to Partnership~~HC~~ within ninety (90) days of the approved date of service.
   a. Attendance verification as outlined in section VI.A.6. above.
4. Meals payments will be issued for each approved member and their one (1) accompanying attendant.
   a. For members age 21 and up, the attendant must be deemed medically necessary as explained in section VI.D. of this policy.
   b. Members under the age of 21 can receive meals payments for one (1) accompanying parent/legal guardian.
5. Hospital meal vouchers provided to the member can be reimbursed to the hospital when billed via invoice. The value of the provided meal vouchers will be deducted from the member's meal reimbursement.
6. Members seeking outpatient care are eligible to receive meals if the member's trip to the outpatient provider cannot be completed in one twelve (12) hour day, including roundtrip travel and foreseen appointment duration.
   a. Round trip travel time will be calculated using publicly available online mapping services. These estimated travel times are used as a guide to calculate eligibility and may not be representative of the actual time it took to complete the drive on any given date of service.
   b. The appointment duration must be verified with the outpatient provider's office prior to the scheduled appointment, if the duration is not verifiable it cannot be included in the travel time calculation. If the actual appointment duration was longer than projected at the time of verification and results in the travel time exceeding one twelve (12) hour day Partnership~~HC~~ will review the request for reimbursement.
   c. For members who have diagnoses that prevent them from traveling in a vehicle for the above length of time, Partnership~~HC~~ may authorize meal services upon confirmation from the treating provider that the condition(s) limit their ability to travel for that duration in one day.
   d. For members whose appointment time requires a departure prior to 6:00 am, or the return to residence is anticipated to be after 10:00 pm, Partnership~~HC~~ may cover meals on a case-by-case basis.
      1) Estimated departure and return times are calculated using the projected travel times provided by publicly available online mapping software. These estimated travel times are used as a guide to calculate eligibility and may not be representative of the actual time it

took to complete the drive on any given date of service.

7. Members under the age of 21, seeking inpatient care may be eligible for meals for their parent/legal guardian in the following situations:
   a. For intensive care settings when the parent/legal guardian is not permitted to stay at the member's bedside, Partnership~~HC~~ may initially authorize up to seven (7) days of meals per hospitalization for one (1) parent/legal guardian. The need for additional days of meals shall be evaluated on a case-by-case basis per the member's circumstances.
   b. For non-intensive care settings when the parent/legal guardian is able to stay at the member's bedside, Partnership~~HC~~ may authorize one (1) day of meals for one (1) parent/legal guardian after every six (6) nights of member hospitalization.
   c. The total maximum authorization when the member is in an inpatient setting shall be fifteen (15) days of meals for each thirty (30) days of member hospitalization, beginning with the day of the member's admission. Each new hospitalization shall begin a new thirty (30) day benefit period.
   d. Member's age two (2) and younger may qualify for meals for their mother for the entire hospitalization if the mother is breastfeeding, regardless of intensive care status.
8. Authorization for meals needed to obtain medically necessary services for major organ transplants is covered for living donors.

D. **ATTENDANTS**

1. Qualified Attendants
   a. In order for member to be approved for meals, lodging and/or salary reimbursement for their attendant, the attendant must be determined to be medically necessary to facilitate the approved NEMT or NMT.
   b. Attendants must be able to safely accompany the member and not require additional assistance.
   c. The services provided by the attendant must exceed the capabilities of the NEMT or NMT staff facilitating the transport.
   d. Requests for meals, lodging & salary for attendants are subject to Partnership~~HC~~ Medical Director review. Members may be asked to provide medical records justifying the necessity of the attendant; if not provided, the request may be denied.
2. Attendant Salary
   a. Members who require the services of a paid attendant may be eligible to receive reimbursement for the attendant's salary for the duration of their approved NEMT or NMT request.
   b. Requests for attendant salary reimbursement must be made to Partnership~~HC~~, in advance, regardless of the mode of transport provided.
   c. Attendant salary will not be reimbursed if the attendant is related to the member.
   d. In order for reimbursement to be issued, a receipt including proof of payment must be supplied to Partnership~~HC~~ within ninety (90) days of the date of service.
   e. The form of reimbursement offered by Partnership~~HC~~ is decided by Partnership~~HC~~ and may be in the form of cash, check, or other forms of prepaid cards.
   f. Reimbursement will be issued within sixty (60) days of receiving the required receipts and/or proof of payment.

E. **PARKING & TOLLS**

1. Members will be reimbursed for parking up to $50 per day and tolls at the full cost, as long as the cost is reasonable and supported by receipts.
   a. In order for reimbursement to be issued, the following documentation must be provided to Partnership~~HC~~ within ninety (90) days of the approved date of service:
      1) Attendance verification as outlined in section VI.A.6. above.
      2) A receipt showing proof of payment must be provided.

b. The form of reimbursement offered is decided by Partnership~~HC~~ and may be in the form of cash, check, or other forms of prepaid cards.
c. Reimbursement will be issued within sixty (60) days of receiving the required receipts and/or proof of payment.
d. Parking and tolls reimbursement needed to obtain medically necessary services for major organ transplants is covered for living donors.

F. **RETROACTIVE REQUESTS**
1. Partnership~~HC~~ will review retroactive reimbursement requests for the services listed in this policy if the member paid out of pocket for the services during a month in which retroactive eligibility to Medi-Cal and Partnership~~HC~~ has been assigned. Partnership~~HC~~'s review for eligibility to the requested services will follow all applicable criteria listed in this policy except for the requirement to have requested the service in advance.

G. **OTHER TRAVEL EXPENSES**
1. Requests for other reasonable necessary expenses will be reviewed on a case by case basis. If approved, reimbursement is the only option for payment and will require receipts to be provided.

H. **WHOLE CHILD MODEL (WCM) / CALIFORNIA CHILDREN'S SERVICES (CCS) – MAINTENANCE AND TRANSPORTATION**
1. For Partnership~~HC~~ Whole Child Model (WCM) members, maintenance & transportation costs are covered pursuant to CCS program guidelines and in accordance with the Department of Health Care Services (DHCS) All Plan Letter (APL) 22-008. For more information on transportation, please see Partnership~~HC~~ policies MCCP2024 Whole Child Model for California Children's Services (CCS) and MCCP2016 Transportation Policy for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT).
2. For a CCS/WCM-eligible member whose post-hospitalization discharge plan documents the need for daily medical visits for treatment of the CCS-eligible condition and the distance precludes making the trip to the hospital in one twelve (12) hour day, lodging and meals may be authorized for the member and parent(s)/legal guardian(s).
3. A CCS/WCM eligible member and/or the member's parents(s)/legal guardian(s) will be responsible for payment of parking/toll(s), meal(s), and/or lodging when choosing to go to a facility or provider that is not the closest CCS-approved facility/paneled provider. Parking, toll(s), meal(s) and/or lodging that occurs beyond the closest provider capable of delivering the level/type of service required by the member's CCS-eligible condition are the responsibility of the CCS/WCM eligible member and/or the member's parent(s)/legal guardian(s).
4. Parking, toll(s), meal(s) and/or lodging may be a benefit for CCS/WCM members for whom Partnership~~HC~~ or the CCS State Regional Office authorized medical care outside of California.

VII. REFERENCES:

A. DHCS APL 22-008 Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses (05/18/2022)
B. DHCS Transportation Workgroup Frequently Asked Questions (FAQs) re: APL22-008 (05/18/2022)
C. DHCS CCS Numbered Letter (N.L.): 03-0810 Maintenance and Transportation for CCS Clients to Support Access to CCS Authorized Medical Services (8/19/2010)
D. DHCS ~~APL 21-005~~APL 24-015: California Children's Services Whole Child Model Program (~~*Revised* 12/10/2021~~Dec. 2, 2024 *supersedes* APL 23-034 and 21-005)
E. DHCS APL 23-005: Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21 (03/16/2023)
F. Title 42 United States Code (USC), Sections 1396, 1396d(a) and (r), 1396s(c)(2)(B)(i)

Policy/Procedure Number: MPTP2503 (previously MCCP2030)			Lead Department: Transportation
Policy/Procedure Title: Transportation-Related Travel Expenses: Lodging, Meals, Attendants, Parking and Tolls			☒ **External Policy** ☐ **Internal Policy**
Original Date: (MCCP2016) 10/21/2015 (Effective 01/08/2020 – Transportation Policy for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT) Policy split)			**Next Review Date: 04/09/2026** **Last Review Date: 04/09/2025**
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒~~☐~~ **Partnership Advantage**

G. DHCS APL 22-013 Provider Credentialing / Recredentialing and Screening / Enrollment (07/19/2022 and *Revised for FAQs ~~08/24/2022~~01/02/2025*)
H. DHCS APL 21-011 Grievance and Appeal Requirements, Notice and "Your Rights" Templates (*Revised* 08/31/2022)

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

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: ~~Senior Director, Health Services~~~~Chief Health Services Officer~~ Director of Transportation Services

X. REVISION DATES: ~~02/10/21; 02/09/22; 10/12/22; 02/08/23; 04/12/23; 02/14/24~~
~~MPTP2503 (04/0912/2025)~~
Medi-Cal
N/A

Partnership Advantage
N/A

PREVIOUSLY APPLIED TO:
MCCP2030 (Archived 04/0912/2025)
02/10/21; 02/09/22; 10/12/22; 02/08/23; 04/12/23; 02/14/24

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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~~HC~~ 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~~HC~~.

Partnership~~HC~~'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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Synopsis of Changes to Discussion Policies

Health Below is an overview of the policies that will be discussed at the March 19, 2025 Quality/Utilization Advisory Committee (Q/UAC) meeting. Please look over the changes to each and note any questions or comments you may have to help keep a progressive meeting agenda.

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: Care Coordination – *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*	109 - 130	**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	Health Services Claims Member Services 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)
		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	

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)
		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 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.	

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)
		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:** 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)	

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)
		- 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 **New Attachment B**: The Family Advisory Committee (FAC) Charter is no longer an attachment to Population Health's Cultural & Linguistic Program Description and is instead migrating to Care Coordination as a new attachment to this WCM policy. In this new attachment, 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.	
Policy Owner: Utilization Management – *Lisa Ward, MD, Regional Medical Director (Southwest)*			
~~MCUG~~ MPUG3002 – Acupuncture Services Guidelines	131 - 134	**This policy was updated to include regulations for the Partnership Advantage D-SNP line of business that will be effective January 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.	Configuration Provider Relations Network Services

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)
		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	
Policy Owner: Utilization Management – *Tony Hightower, CPhT, Associate Direction, Utilization Management Regulations*			
MPUP3018 – Health Services Review of Observation Code Billing	135 - 138	**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 January 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	Configuration Provider Relations Provider Contracting Network Services

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

Policy/Procedure Number: MCCP2024				**Lead Department: Health Services** Business Unit: Care Coordination	
Policy/Procedure Title: Whole Child Model For California Children's Services (CCS)				☒**External Policy** ☐ **Internal Policy**	
Original Date: 11/14/2018 **Effective Date:** 01/01/2019 per DHCS			**Next Review Date:** ~~02/14/2025~~04/12/2026 **Last Review Date:** ~~02/14/2024~~04/12/2025		
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**	☐ **CREDENTIALING**	☐ **DEPT. DIRECTOR/OFFICER**	
Approval Signature: *Robert Moore, MD, MPH, MBA*				**Approval Date:** ~~02/14/2024~~04/12/2025	

I. RELATED POLICIES:

A. MPCD2013 – Care Coordination Program Description
B. MCCP2007 – Complex Case Management
C. MCCP2023 – New Member Needs Assessment
D. MCCP2019 – Identification and Care Coordination for Seniors and Persons with Disabilities and/or California Children's Services
E. MPCP2006 – Coordination of Services for Members with Special Health Care Needs (MSHCNs) and Persons with Developmental Disabilities
F. MCCP2014 – Continuity of Care
G. MCCP2030 – Ancillary Transportation Services: Lodging, Meals, Attendants, Parking and Tolls
H. MCRP4064 – Continuation of Prescription Drugs[1]
I. MCUP3039 – Direct Members
J. MCUP3013 – Durable Medical Equipment (DME) Authorization
K. MCUP3041 – Treatment Authorization Request (TAR) Review Process
~~K.~~L. MCCP2032 - CalAIM Enhanced Care Management (ECM)
~~L.~~M. MCAP7001~~MCUP3143~~ - CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS)
~~M. MPCP2002 California Children's Services~~
N. MCCP2035 - Local Health Department (LHD) Coordination
O. MCUP3104 - Transplant Authorization Process
P. MCCP2025 - Pediatric Quality Committee Policy
Q. MCUP3037 Appeals of Utilization Management/ Pharmacy Decisions
R. CGA024 Medi-Cal Member Grievance System
~~N.~~S. MCUG3058 – Utilization Review Guidelines ICF/DD, ICF/DD-H, ICF/DD-N Facilities

[1]Effective January 1, 2022, with the implementation of Medi-Cal Rx, the pharmacy benefit is carved-out to Medi-Cal fee-for-service (FFS) as described in All Plan Letter (APL) 22-012 *Revised*, and all medications (Rx and OTC) which are provided by a pharmacy must be billed to the State Medi-Cal/~~Magellan~~DHCS-contracted pharmacy administrator instead of P~~artnership~~~~HC~~. Refer to the P~~artnership~~~~HC~~ website page for pharmacy authorization criteria and a link to the State Medi-Cal Contract Drug List (CDL):
http://www.partnershiphp.org/Providers/Pharmacy/Pages/Formularies.aspx
~~The State Medi- Cal Contract Drug List (CDL) can be found in both the Medical and Pharmacy provider manual sections of the website at https://files.medi-cal.ca.gov/pubsdoco/Publications.aspx?t=4~~

Policy/Procedure Number: MCCP2024			**Lead Department: Health Services** Business Unit: Care Coordination
Policy/Procedure Title: Whole Child Model For California Children's Services (CCS)			☒ **External Policy** ☐ **Internal Policy**
Original Date: 11/14/2018 **Effective Date:** 01/01/2019 per DHCS			**Next Review Date:** **04/12/2026~~02/14/2025~~** **Last Review Date: 04/12/2025~~02/14/2024~~**
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☐ **Partnership Advantage**

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services
D. Provider Relations

III. DEFINITIONS:

~~A.~~ California Children's Services (CCS): A state program for children up to 21 years of age, who have been determined eligible for the CCS program due to the presence of certain diseases or health problems.

~~C.~~B. Direct Member: Direct Members are those whose service needs are such that Primary Care Provider (PCP) assignment would be inappropriate. Assignment to Direct Member status may be based on the member's medical condition, prime insurance, demographics or administrative eligibility status. Direct Members do not require a Referral Authorization Form (RAF) to see a specialist.

C. ICF/DD: Intermediate Care Facilities for the Developmentally Disabled

D. ICF/DD-H: Intermediate Care Facilities for the Developmentally Disabled/Habilitative

E. ICF/DD-N: Intermediate Care Facilities for the Developmentally Disabled/Nursing

~~D.~~F. Individualized Care Plan (ICP): A care plan developed through Care Coordination tailored to the needs of the member and supporting him/her to attain the health/wellness goals that he/she has identified. This care plan may be developed through discussion with the member and/or with the member's caregiver, and will reflect collaboration with the member's providers.

~~E.~~G. Memorandum of Understanding (MOU): Where no reimbursement is to be made, Partnership~~HC~~ shall negotiate in good faith ~~an~~ a MOU for services provided by said agency. MOU shall describe the scope and responsibilities of both parties in the provision of services to Members; billing and reimbursements; reporting responsibilities; and how services are to be coordinated.

H. Newly Eligible WCM members: Members recently determined to be eligible for the WCM Program with no history of participation in the WCM or CCS Programs.

I. Newly Transferred WCM members: Any Member who is new to the MCP but already a part of the CCS/WCM Program, as in the case of ~~ICT~~Intercounty Transfer (ICT).

~~F.~~J. Pediatric Health Risk Assessment (PHRA): An assessment form mailed to newly enrolled pediatric members (under age 21) with corresponding Seniors and Persons with Disabilities (SPD) aid codes and/or California Children's Services (CCS) identifiers who may be at risk for adverse health outcomes without support from an Individualized Care Plan (ICP).

K. Pediatric Risk Stratification Process (PRSP): A process in which a child's medical needs are triaged into high-risk and low-risk. This process will help identify those children that are at a higher risk for needing medical case management.

L. Receiving County: i.e. County to which a member is moving to and in which they will claim residence.

~~G.~~M. Sending County: i.e. CCS counties from which members are moving.

~~H.~~N. Whole Child Model (WCM): A comprehensive program for the whole child encompassing providing comprehensive diagnostic and treatment services and care coordination in the areas of primary, specialty, and behavioral health for any pediatric member insured by Partnership~~HC~~.

IV. ATTACHMENTS:

A. Pediatric Risk Stratification Process

~~A.~~B. FAC Charter

V. PURPOSE:

To describe how California Children's Services (CCS) and the coordination of care for the CCS-eligible population assigned to Partnership HealthPlan of California (Partnership~~HC~~) will be integrated into the operations of Partnership~~HC~~ as part of the Whole Child Model (WCM); and to outline the collaboration between Partnership~~HC~~, providers, county CCS agencies, community resources, and the CCS member and ~~his/her~~their caregiver. ~~The counties included are Lake, Marin, Mendocino, Napa, Solano, Sonoma, Yolo, Del Norte, Humboldt, Lassen, Modoc, Shasta, Siskiyou, and Trinity[2].~~ The goals of the WCM are as follows:

~~[2] Collaboration between the California Children's Services (CCS) program and Partnership as an adjunct to the county specific Memorandum of Understanding (MOUs). The counties included are Tehama, Plumas, Glenn, Butte, Colusa, Sutter, Yuba, Sierra, Nevada, and Placer and would not apply to this policy. Refer to policy MPCP2002 - California~~

A. Ensure ongoing, timely eligibility determination for CCS conditions.
B. Coordinate appropriate care and services for Partnership~~HC~~'s pediatric population through integration of care for both CCS-eligible and non-CCS-eligible conditions.
C. Work collaboratively with the member/caregiver to establish a medical home while ensuring access to necessary specialty services.
D. Ensure collaboration between Partnership~~HC~~ and county CCS agencies to promote consistent care delivery standards.
E. Authorize medically necessary and appropriate services for care related to both CCS and non-CCS conditions.
F. Develop and implement an Individualized Care Plan (ICP) or care coordination strategy to support member/caregiver in accessing services and managing his/her health and wellbeing.

VI. POLICY / PROCEDURE

A. CCS Program Eligibility
1. Partnership~~HC~~ actively screens for members who may meet the CCS program eligibility.
   a. Partnership~~HC~~ will instruct providers to refer members with suspected CCS eligible conditions to the CCS program in the county of residence or to DHCS where applicable for CCS program eligibility determination. As part of the referral process, Partnership~~HC~~ will instruct providers to submit supporting medical documentation sufficient to allow for CCS eligibility determination by the local CCS Program and/or DHCS.
   b. Partnership provides services to WCM members with other health coverage, with full scope Medi-Cal as the payor of last resort.
~~1.~~2. Partnership~~HC~~ proactively identifies eligible members for the CCS program and services through use of risk stratification, monthly reports, as well as through multiple referral sources. Data sources include, but are not limited to:
   a. New Member Assessments such as the Health Information Form (HIF) or the Pediatric Health Risk Assessment (PHRA)
   b. Internal reports such as the monthly Pediatric Case Finding Report, the monthly Utilization Report, ~~the weekly Hospital Daily~~ Admission, Discharge, and Transfer~~ischarge~~ Reports, etc.
   c. Provider or Specialist referral
   d. Member / Caregiver self-referral
   ~~d.~~e. Medical Therapy Conference (MTC) referral
   ~~e.~~f. External reports such as county CCS enrollment report(s), Regional Center report(s), Medical Therapy Unit/Medical Therapy Program (MTU/MTP) report(s), etc.
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 for an eligibility determination and supply the necessary clinical documentation to the County CCS Program for a CCS eligibility determination if the member:
   a. Demonstrates a potential CCS-Eligible Condition(s) as outlined in the CCS Eligibility Manual, including results from diagnostic services or who is undergoing diagnostics for CCS;
   b. Presents at the Emergency Department, Provider, or facility for other primary conditions, and demonstrates a potential CCS-Eligible Condition(s); or
   c. Demonstrates a potential MTP eligible condition.
4. Partnership~~HC~~ will refer NICU, HRIF, and MTP members with potential CCS eligible conditions to

~~Children's Services for more details.~~

the County CCS Program for review and determination of eligibility for services.

a. CCS NICU eligibility may involve identification of a potential CCS-Eligible Condition which may confer CCS Program eligibility beyond the NICU stay. Partnership will~~must~~ inform the County CCS Program if a Member is at any point subsequently identified as having a potential CCS-Eligible Condition so that the County CCS Program can conduct the CCS eligibility determination process for the Member. MCPs will~~must~~ review authorizations and determine if services meet CCS NICU referral requirements in accordance with CCS Program guidelines found in CCS NICU Standards and CCS N.L. 02-0413.

b. Partnership will~~must~~ conduct NICU eligibility assessments in accordance with CCS Program guidelines for medical eligibility for care in a CCS-approved NICU, as found in CCS NL 05-0502. All members identified as meeting the criteria for the NICU eligibility assessment will~~must~~ be referred to the County CCS program as described above.

c. Partnership will~~must~~ refer all Members with a potential MTP eligible condition to the County CCS Program and will~~must~~ include all supporting documentation with the referral. As a part of the CCS eligibility review, the County CCS Program will review and determine MTP eligibility. County MTPs will~~must~~ submit referrals to Partnership for Medically Necessary specialty services and follow-up treatment, as prescribed by the MTC physician or CCS-paneled physician who is providing the MTP medical direction for occupational and physical therapy services. Partnership will collaborate with county MTU/MTP programs to facilitate referrals to the program, when MTU/MTP service needs are identified, including the members under age three who are at risk for needing MTU/MTP services.

d. Partnership~~HC~~ will~~must~~ conduct a HRIF program acuity assessment and authorize any HRIF services for the member in accordance with the HRIF Eligibility Criteria. Partnership~~HC~~ will~~must~~ ensure access or arrange for the provision of HRIF case management services. Partnership~~HC~~ will~~must~~ notify the county of any CCS-eligible neonates, infants, and children up to three years of age who have been identified as having a potential CCS-eligible condition through the HRIF program.

e. ~~-~~Partnership will include supporting documentation of the member's potential CCS-Eligible condition when submitting referrals to the CCS Program for eligibility determinations for HRIF, MTP, and NICU. Documentation may include NICU discharge summaries, HRIF reports and final reports, or necessary documentation as listed below.

5. Partnership~~HC~~ will ~~provide instruct providers to provide~~provide available necessary ~~or~~documentation received or retrieved by Partnership's case management or utilization management staff, or assist Network Providers in referring with necessary documentation, including but not limited to current medical records, case notes, discharge summaries (if applicable), physical examination results, laboratory test results, radiologic findings, and other tests/examinations or reports that pertain or support to the CCS-Eligible Condition, including any MTP diagnosis to the CCS county. ~~-~~Independent counties will review for the initial medical determination for the CCS program and dependent counties will send it to DHCS, who is responsible for dependent county medical determinations. ~~California Department of Health Care Services (DHCS) staff to review for the initial medical determination and annual medical redetermination for the CCS program.~~ All documentation will~~must~~ be, to the extent possible, produced within the last 6~~six~~ months but no later than 12 months. Partnership~~HC~~ ~~must~~will make outreach attempts to the Network Provider and the CCS member to obtain medical records, as well as take appropriate action if medical records recovery is unsuccessful. ~~In the event of a provider's failure to refer in a reasonable timeframe, PHC will intervene to provide referral information and educate the provider on the importance of referrals to the CCS program~~County CCS will~~must~~ notify Partnership ~~HC~~ within 5 days of receipt if referral is incomplete where Partnership~~HC~~ will then notify Network Provider for record request. The case

manager will send the received or retrieved medical record documentation to the County CCS.~~.~~

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~~b.~~a. A complete referral shall include:

1) First and last name of the referred member
2) First and last name of parent or legal guardian (except for members aged 18 years or older)
3) Date of birth
4) Address and telephone number
5) Statement of services requested
6) A ~~medical report~~comprehensive medical documentation identifying the suspected CCS-eligible medical condition

~~c.~~b. The referral shall be transmitted by a method mutually agreed upon by both P~~artnership~~artnership~~HC~~ and the county CCS program/DHCS. Referrals will be made upon identification and will not be postponed until the annual CCS medical eligibility redetermination period.

6. For the Annual Medical Redetermination~~view~~, Partnership will receive a list from the counties a minimum of 120 days in advance of the eligibility end date. Partnership sorts by soonest eligibility end date and will make outreach attempts to the Network Provider and the CCS member to obtain medical records, as well as take appropriate action if medical records recovery is unsuccessful.
   a. Partnership will provide the documentation received or retrieved by Partnership's case management staff (VI.A.5.a), including ~~documentations on~~ efforts made to receive required documentation when it is not available, to the County CCS program no later than 60 calendar days before the Member's program eligibility end date, unless the County CCS Program verified that all needed medical information is already available to them. DHCS is responsible for dependent county medical determinations and independent counties conduct medical determinations for their counties.

~~1. The County CCS Program and/or the State will review and complete annual eligibility no later than thirty (30) calendar days prior to the CCS client's program eligibility end date.~~

   b. The county CCS program/DHCS will notify the member and/or primary caregiver of the CCS program eligibility determination.
   c. The County CCS Program/State will complete CCS program eligibility on new Medi-Cal covered referrals within ~~ten (~~10 ~~)~~ working days of receipt of a referral or receipt of adequate medical reports to a medical eligibility determination. The disposition of eligibility determination will be documented in the state eligibility tracking system and will be made available to P~~artnership~~artnership~~HC~~ at the time the decision is made.

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~~3. PartnershipHC will inform the member/caregiver and primary care provider of the referral, within 90 days of making the referral.~~

~~4.~~7. When P~~artnership~~artnership~~HC~~ becomes aware that a member has lost P~~artnership~~artnership~~HC~~ ~~eligibility, or~~eligibility or has moved out of P~~artnership~~artnership~~HC~~'s service area, P~~artnership~~artnership~~HC~~ will notify the County CCS program~~.~~.

8. The County CCS Program will alert P~~artnership~~artnership~~HC~~ of any CCS case closure or loss of eligibility and ~~will send~~ a CCS Notice of Action (NOA) will be sent to family upon case closure.

~~5.~~9. Partnership will inform the member/caregiver and primary care provider of the referral.

~~1. If a member or caregiver(s) disputes the county CCS program eligibility determination, the member/caregiver(s) must appeal to the county and/or DHCS directly. The CCS county program shall communicate all resolved disputes in writing to PHC within a timely manner.~~

~~C.~~B. Utilization Management

1. Under WCM, CCS members are able to receive the same CCS benefits and services through P~~artnership~~artnership~~HC~~ as they did through County CCS programs. These services are based on medical

necessity and are reviewed by Partnership~~HC~~ Health Services staff. In addition, care for pediatric members will also consider the benefits outlined in APL 23-005 "Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members under the age of 21" and Partnership~~HC~~ policy MPCP2006 "Coordination of Services for Members with Special Health Care Needs (MSHCNs) and Persons with Developmental Disabilities."

2. Partnership~~HC~~ ensures coverage for medically necessary Medi-Cal covered services for the member's potential CCS eligible condition while CCS eligibility is determined.
3. Once CCS program eligibility is established, Partnership~~HC~~ is responsible for the provision of all medically necessary covered services under the WCM and assigns the member to "Direct Member" status as described in policy MCUP3039 Direct Members. –Direct Members do not require a Referral Authorization Form (RAF) to see a specialist, however, Partnership~~HC~~ assigns the member a medical home to ensure completion of preventative care.
4. Partnership~~HC~~ shall provide the CCS Maintenance and Transportation (M&T) benefits for CCS eligible members or the member's family seeking transportation to a medical service related to their CCS-eligible condition when the cost of M&T presents a barrier to accessing authorized CCS services and per criteria set forth in DHCS Numbered Letter (NL) 03-0810. M&T services include meals, lodging, and other necessary costs (i.e. parking, tolls, etc.). (See policy MCCP2030 – Meals, Lodging, Parking and Tolls for Members under 21 years of Age).
5. County MTU/MTP programs will perform the initial review of therapy services, durable medical equipment (DME), orthotics and prosthetics per state guidelines. ~~(~~See Attachment E of Partnership policy MCUP3013 Durable Medical Equipment (DME) Authorization for recommended review process).
    a. Once the MTU/MTP review is completed by MTU/MTP staff, a referral packet will be sent to vendor for their use in submitting a Treatment Authorization Request (TAR). [See policy MCUP3041 Treatment Authorization Request (TAR) Review Process.] A TAR packet will include the following:
        1) First and last name of the member
        2) Date of birth
        3) Client Identification Number (CIN)
        4) Statement of services requested/ prescription form
        5) Medical justification for the requested services, such as therapy notes, physician visit notes, etc.
    b. If the request is deemed unnecessary or inappropriate, the MTU/MTP program will forward a copy of their recommendation with supporting documentation to Partnership~~HC~~.
    ~~c. The County MTU/MTP liaison will assist PartnershipHC with interpretation of applicable CCS DME numbered letters.~~
    c. The county MTU/MTP ~~liaison~~ will provide technical assistance to the vendor, family and Partnership~~HC~~ in the approval process.
6. Partnership~~HC~~ is required to cover all medically necessary blood, tissue, and solid organ transplants for WCM members, please refer to Partnership~~HC~~ policy MCUP3104 Transplant Authorization Process for more details.
~~6.~~7. Partnership~~HC~~ will~~must~~ conduct, at least quarterly, a review of their inpatient utilization data to assess whether all potential WCM members have been appropriately referred to the County CCS program. If Partnership identifies any Members that have a potential CCS Eligible-Condition and a referral has not been made to the County CCS Program, Partnership will~~must~~ promptly refer the member, providing their most recent medical records as outlined above.

C. Case Management and Care Coordination
1. Partnership~~HC~~ members participating in the WCM and their families/caregivers are eligible to

receive comprehensive Care Coordination and Case Management services. Members may decline Case Management services without impact to their enrollment and/or participation in the WCM Program.

~~1.~~2. Pediatric members who are new to Partnership~~HC~~ will be mailed a survey to stratify their risk in accordance with policies MCCP2023 New Member Needs Assessment, and MCCP2019 Identification and Care Coordination for Seniors and Persons with Disabilities and/or California Children's Services.

a. Pediatric members assigned a Seniors and Persons with Disabilities (SPD) aid code and/or those with a CCS identifier will be sent a PHRA survey within 10 calendar days of enrollment into the plan.
    1) The Health Risk Assessment (HRA) will address:
        a) General health status as reported by the member and/or primary caregiver(s)
        b) Recent health care utilization (ex. outpatient, emergency room, inpatient visits, school days missed due to illness, etc.)
        c) Review of health history; both CCS and non-CCS diagnoses and past surgeries.
        d) Referral needs
        e) Prescription medication utilization
        f) Durable Medical Equipment (DME) needs
        g) Need for specialized therapies if applicable (ex. physical, occupational, speech, mental or behavioral health services, and educational or developmental services).
        h) Limitations of Activities of Daily Living (ADLs) or daily functioning if applicable.
        i) Demographics and Social History, including but not limited to member demographics, home/school environment(s), and cultural and linguistic needs and preferences.

b. New pediatric members who are not assigned an SPD aid code, or who are not identified as a CCS beneficiary, will be sent a Health Information Form (HIF) survey with their Partnership~~HC~~ Welcome Packet.

~~2.~~3. Partnership~~HC~~ will use a Pediatric Risk Stratification Process (PRSP) to assess the risk new pediatric members, newly CCS-eligible members, or WCM transition members within 45 days of the ~~enrollment or transition from a C~~county CCS program eligibility determination for newly eligible WCM members and newly transferred WCM members. Members will be assigned a risk score (High or Low) based on PRSP results. The methodology of the PRSP is as follows:

a. Members with available claims data:
    1) Application of a Pediatric Risk Stratification Algorithm (see Attachment A)
    2) Analysis of utilization and costs
b. Members previously managed by a County CCS Program:
    1) Case Review with County CCS staff, when possible
c. Risk Assignment:
    1) High Risk:
        a) Members who qualify as High Risk through any of the screening methods
        b) Members without available medical utilization data, claims data, or other assessments and/or survey information available
        c) Members in the NICU
        d) Members with a new CCS diagnosis
        e) Newly CCS-eligible members
        ~~e)~~f) New CCS Members enrolled in Partnership~~HC~~
    2) Low Risk:
        a) Members who do not meet the criteria for High Risk

~~3.~~4. Partnership~~HC~~ will use the results of the PRSP and the HRA or HIF responses to triage Care Coordination interventions.
   a. High Risk Members will be assessed telephonically, by video or in-person by Care Coordination~~licensed~~ staff within 90 calendar days of a completed HRA or when identified by PSRP to be High Risk to assist in the development of the member's ICP.
   b. Low Risk Members will be assessed telephonically, by video or in-person by a Health Care Guide within 120 days of completed HRA or when identified by PRSP to be Low Risk to identify the member's health care needs.

~~4.~~5. Partnership~~HC~~ will offer care coordination to all CCS members. Building upon the information gathered through the risk assessment process, and in collaboration with the member, his/her family, and/or his/her designated primary caregiver(s), Partnership~~HC~~'s Care Coordination department will review the member's needs and document the results in the case management system.
   a. All CCS members will be assigned an Acuity Level ranging from One to Five, and the acuity level may be adjusted throughout the course of the case as the member's needs change. See MPCD2013 Care Coordination Program Description for further information on Acuity Levels and associated activities.
   b. Low Risk CCS members (Acuity Levels One to Two) will be assessed through targeted questions that ensure WCM members have access to care and coordination of benefits to support their health and wellbeing. Low Risk members will be reassessed annually to ensure that the member's needs are addressed and that there have been no significant changes in the member's condition. Specific areas for review will include:
      1) Information and education regarding Partnership~~HC~~'s Care Coordination services and where to go for ongoing information, care, and support
      2) Medical (primary care and CCS specialty) services
      3) Other medically necessary services provided within Partnership~~HC~~'s network, or when necessary, services provided by an out-of-network provider
      4) Resources available in the community
      5) Age-specific questionnaires
   c. High Risk CCS members (Acuity Levels Three, Four, and Five) will be assessed through comprehensive, age-specific questions to support transitions of care across settings or from pediatric to adult care, complex care coordination, facilitate interactions between providers and community agencies, and bolster fragile support systems. The results will be documented in an Individualized Care Plan (ICP) tailored to the needs of the member, incorporating the member/caregiver's goals and preferences, and providing measurable objectives and timetables. ICP for members determined to be high risk based on the results of the risk assessment process will~~must~~ 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~~HC~~ will~~must~~ notate the denial in the member's medical record as evidence of compliance. –The ICP will gather information, as appropriate, such as:
      1) Information and education on the roles of the interdisciplinary care team, where to go for ongoing information, care, and support.
      2) Medical (primary care and CCS specialty) services, including care needs that may be met under Early and Periodic Screening Diagnostic, and Treatment (EPSDT) services including but not limited to palliative care.
      3) Developmental, behavioral, and mental health concerns. This includes mild-to moderate or county specialty mental health services, as well as county substance use disorder (SUD) or Drug Medi-Cal service needs.

4) Family/community supports.
5) Home health services.
6) Services provided in school and community.
7) Other medically necessary services provided within PartnershipHC's network, or when necessary services provided by an out-of-network provider.
8) Resources available in the community, including those outside the scope of responsibility of PartnershipHC.
9) Identification of other programs with which the member is affiliated, such as: Regional Centers, MTP/MTUs; High Risk Infant Follow-Up (HRIF): Genetically Handicapped Persons Program (GHPP), etc., in order to promote collaboration and reduce duplication of effort.
10) Planning for when the CCS member will age-out of the CCS program.
11) Pediatric provider phase-out planning, supporting the transition from pediatric to adult providers while taking into consideration the member's medical condition and the established need for care with adult providers.

d. For members transitioning into the WCM Program from Classic CCS Programs, Partnership mwillust complete the PRSP within 45 calendar days of transition to determine each member's risk level. Partnership willmust also complete all required telephonic and/or in-person communication and ICPs for high-risk Members, and all required telephonic and/or in-person communication for low risk Members, within one year of the transition. Additionally, Partnership willmust reassess a Member's risk level and needs at the annual medical eligibility redetermination, or upon a significant change to a Member's condition. Regardless of a member's risk level, all communications, whether by phone, mail, or other forms of communication, willmust inform the member and/or the member's designated caregivers that assessments will be provided in a linguistically and culturally appropriate manner, and willmust identify the method by which providers will arrange for in-person assessments.
~~4)~~
e. PartnershipHC's Care Coordination department facilitates referrals to specialty care when appropriate. If needed, PartnershipHC Care Coordination will make direct referrals as well.
1)WCM members are assigned to Direct Member status which allows for direct referral to specialty clinics by providers and member self-referral without a Referral Authorization Form (RAF). PartnershipHC provides guidance and facilitates sharing of information between clinical settings as needed and per DHCS guidelines.
f. 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.
g. For pediatric members stratified as high risk, PartnershipHC shall offer the CalAIM Enhanced Care Management (ECM) benefit for eligible members. The ECM benefit is unique and distinct from the care management services or programs offered by PartnershipHC. ECM can be provided in addition to the WCM Program and PartnershipHC will ensure non-duplication of services. Refer to policies MCCP2032 CalAIM Enhanced Care Management (ECM) and MCAP7001MCUP3143 CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS) for more details.

~~5.~~6. No less than annually, or upon significant change in the WCM member's condition, PartnershipHC will reassess the WCM member and his/her:
a. Risk level via the PRSP,
b. Age-specific needs and milestones,

c. Age-Out transition plan and Pediatric Provider Phase Out plan, where appropriate
d. Documentation needed to support eligibility re-determination

~~6.~~7. When a Partnership~~HC~~ member is receiving services through an MTP/MTU, Partnership~~HC~~ staff will act as a liaison with the county MTP/MTU, and collaborate in providing coordinated delivery of care.

~~7.~~8. All information and communications with members and/or designated caregiver(s) will be provided in a linguistically and culturally appropriate manner.

~~8.~~9. In collaboration with Partnership~~HC~~'s Utilization Management Department, Care Coordination staff will coordinate and authorize HRIF services for members needing case management services.
a. Partnership~~HC~~ will notify the CCS county of record of CCS-eligible neonates, infants and children up to 3 years of age that lose Medi-Cal coverage for HRIF services. Partnership~~HC~~ will provide continuity of care information to the member.

10. For members aging out of WCM, Partnership~~HC~~ will provide comprehensive, individualized case management support to assist the member, family, designated caregiver(s), and providers in transition care to the appropriate setting. The care coordination plan will~~must~~ be developed at least 12 calendar months before the member ages out. Per state guidelines, Partnership~~HC~~ will monitor the WCM member for at least 36 calendar~~three~~ months~~years~~ following age out of the WCM Program, to the extent feasible.

11. 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~~must~~ 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. The timing of the transition will~~must~~ be individualized to take into consideration the WCM Member's medical condition and the established need for care with adult Providers.~~, while the WCM member remains a PartnershipHC member.~~

D. Inter-County Transfer (ICT)

1. Partnership~~HC~~ and the County CCS program will~~must~~ collaborate to facilitate the exchange of ICT data to ensure that CCS WCM members who relocate to another county can effectively transfer their CCS benefits without interruption, including the provision of continuation of services and the transfer of current service authorization request.
2. CCS-eligible Members that move out of a WCM county:
   a. County CCS Programs will initiate the data transfer request to Partnership~~HC~~ using Attachment 4 "Whole Child Model Inter-County Transfer Form" of CCS NL 10-1123, "CCS Intercounty Transfer Policy."
   b. Partnership~~HC~~ will provide the County CCS Program office with relevant member transfer data including case management notes and utilization data for the previous 12 months within 10 business days using Attachment 4 or an agreed upon process between the sending county and Partnership~~HC~~.
   c. The sending county CCS program will coordinate the sharing of CCS-eligible member data to the receiving county.
3. CCS-eligible Members that move into a WCM county, the sending county CCS Program will provider transfer data to Partnership~~HC~~.
4. CCS-eligible Members that move from one WCM county to a different WCM county, Partnership~~HC~~ will provide transfer data to the receiving MCP and the County CCS Program.
5. When the previous county, receiving county, or Partnership~~HC~~ cannot agree on the transfer process, the county or Partnership~~HC~~ will contact CCSProgram@dhcs.ca.gov.
6. The sending county is responsible for obtaining the member's medical information even if the transfer is to the same MCP in the receiving county.
   a. If there are no physical copies of the medical reports within the last 12 months, the transfer case

notes should include a written statement indicating that there are no physical copies of medical reports for the last 12 month period.

7. When a member moves out of PartnershipHC service area:
   a. Member is assigned to a direct member status called HP 8 (Out of Area), refer to PartnershipHC Policy MCUP3039 Direct Members for more details.

D.E. Continuity of Care

1. PartnershipHC maintains a process to allow for members to continue receiving care with an existing in-network or out-of-network provider for up to 12 months in accordance with Health and Safety Code 1373.96. For further information, please see policy MCCP2014 Continuity of Care.
2. In addition to the specifications outlined in PartnershipHC Policy MCCP2014, members participating in WCM have the additional continuity of care provisions, when applicable, outlined below:
   a. Specialized or Customized DME: If the WCM member has an established relationship with a specialized or customized DME provider, PartnershipHC will provide access to that provider for up to 12 months. PartnershipHC may extend the continuity of care (COC) with a DME provider beyond the 12 months for specialized or customized DME still under warranty and deemed medical necessary by the treating provider.
   b. Case Management: Where available, WCM members may continue to receive case management and care coordination services from their existing Public Health Nurse (PHN) at their CCS county office of record. Members who wish to continue to receive case management services under COC must request to do so within 90 days of transitioning to PartnershipHC under the WCM. In the event that the county PHN is unavailable, PartnershipHC will provide the member with comparable case management services.
   Prescription Drugs [3]: CCS-eligible members transitioning into the PartnershipHC Whole Child Model
   c.b. program are allowed continued use of any currently prescribed prescription drug that is part of their prescribed therapy for the CCS-eligible condition. For further details, please see policy MCRP4064 Continuation of Prescription Drugs.
3. 60 days prior to the end of their authorized COC period, WCM members are notified in writing of information regarding the WCM appeal process for COC limitations. This notice explains the member's right to petition PartnershipHC for an extension of the COC period, criteria used to evaluate the petition and the appeals process if PartnershipHC denies the petition.
   a. WCM members willmust direct their first appeal of a COC decision to PartnershipHC.
   b. WCM member, member's family or designated caregiver of the WCM member may appeal the COC limitation to the DHCS Director (or designee) after exhausting PartnershipHC's appeal process.

[3] Effective January 1, 2022, with the implementation of Medi-Cal Rx, the pharmacy benefit is carved-out to Medi-Cal fee-for-service (FFS) as described in All Plan Letter (APL) 22-012 *Revised*, and all medications (Rx and OTC) which are provided by a pharmacy must be billed to the State Medi-Cal/MagellanDHCS-contracted pharmacy administrator instead of PartnershipHC. Refer to the PartnershipHC website page for pharmacy authorization criteria: http://www.partnershiphp.org/Providers/Pharmacy/Pages/Formularies.aspx and links to tThe State Medi-Cal Contract Drug List (CDL): can be found in both the Medical and Pharmacy provider manual sections of the website at https://files.medi-cal.ca.gov/pubsdoco/Publications.aspx?t=4http://www.partnershiphp.org/Providers/Pharmacy/Pages/Formularies.aspx

c. The DHCS Director (or designee) will have 5 business days from the date of appeal to inform the family or caregiver of receipt and will~~must~~ provide a decision on the appeal within 30 calendar days from the date of the request. If the member's health is at risk, the DHCS Director (or designee) will inform the member of the decision within 72 hours.

F. Continuity of Care for WCM Implementation

1. Partnership will~~must~~ 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.
   a. Continuity of Care for Providers: Upon receipt of detailed transition data from DHCS for each transitioning member, or at least 30 calendar days prior to the transition date, whichever occurs sooner, Partnership will~~must~~ conduct outreach to OON COC eligible providers with whom members have pre-existing relationships to initiate a Network Provider Agreement or a COC for Providers agreement.
      1) Partnership will review all available data to identify eligible providers that provided services to CCS beneficiaries during the 12 months preceding the transition.
   b. Continuity of Care for Covered Services – Prior Authorization and Active Course of Treatment: Partnership will~~must~~ honor active Prior Authorizations identified in any data available to Partnership and/or when requested by a transitioning member, provider, or authorized representative, and the MCP obtains documentation of the Prior Authorization before or within the six-month period following the transition date.
   c. Durable Medical Equipment Providers and Medical Supplies: Partnership will~~must~~ allow members to keep their existing DME rentals and medical supplies from their existing DME Providers without further authorization for the full 12-month period following the transition date and until a reassessment has been completed and the new equipment or supplies are in the possession of the Member and ready for use.
   d. Continuing Services with County CCS Program Public Health Nurse (PHN): WCM members or the member's parents, custodial parents, legal guardians, or other Authorized Representatives may request continuing case management and Care Coordination from their CCS County PHN within 90 calendar days of transitioning to the WCM program. If the requested County CCS Program PHN is no longer available to provide case management and Care Coordination, Partnership will~~must~~ transition those services to one of its CCS Case Managers who has received adequate training on the CCS Program, and has clinical experience with the CCS population or pediatric patients with complex medical conditions.
   e. Member and Provider Outreach and Education: Partnership will~~must~~ follow the member notification guidelines for COC requests in APL 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 and Partnership will~~must~~ inform members of their continuity of care protections and include information about these protections in member information packets, handbooks, and on the Partnership website.
2. For further details regarding COC, please see policy MCCP2014 Continuity of Care.

~~E.~~G. Partnership~~HC~~ and CCS County Coordination

1. Partnership~~HC~~ and County CCS programs will coordinate the delivery of CCS services to CCS-eligible members to prevent duplication of services.
2. Partnership~~HC~~ 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.

~~3.~~ Partnership~~HC~~ shall hold collaborative meetings with WCM CCS counties no less than quarterly to assist in overall coordination of services, to update policies, procedures and protocols as appropriate, and to discuss activities related to the MOUS and WCM matters.

3.

4. Partnership~~HC~~ shall work collaboratively with the CCS county office of record to assist in the inter-county transfer for CCS-eligible members who move from a WCM county to a non-WCM county. Similarly, the county CCS office will provide transfer data to Partnership~~HC~~ if a CCS-eligible member moves into a WCM county. The county CCS program retains the responsibility for providing transfer data, including clinical and other relevant data, from one county to another.
5. Partnership~~HC~~ coordinates with Regional Centers and Intermediate Care Facilities for the Developmentally Disabled (ICF/DD), Intermediate Care Facilities for the Developmentally Disabled-Habilitative (ICF/DD-H) homes, and Intermediate Care Facilities for the Developmentally Disabled-Nursing (ICF/DD-N) to ensure members who are individuals with developmental disabilities receive all medically necessary covered services in accordance with APL 23-023 *Revised* Intermediate Care Facilities for Individuals with Developmental Disabilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care, please refer to MCUG3058 Utilization Review Guidelines ICF/DD, ICF/DD-H, ICF/DD-N Facilities for more details.
6. Partnership~~HC~~ 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, including Basic Population Health Management (BPHM), Transitional Care Services (TCS), care management programs, and Community Supports as appropriate in coordination with the Regional Center. Please refer to MPCD2013 Care Coordination Program Description for more details.

H. Advisory Committees
1. Partnership meets quarterly with a Clinical Advisory Committee. For more details on Partnership~~HC~~ Clinical Advisory committees, refer to Partnership~~HC~~ policy MCCP2025 Pediatric Quality Committee.
2. Partnership meets quarterly with a Family Advisory Committee (FAC) for CCS families composed of a diverse group of families that represent a range of conditions, disabilities, and demographics. The FAC includes, but not be limited to, parent centers, such as family resource centers, family empowerment centers, and parent training and information centers. For more details, please refer to Partnership Policy MCCP2024- B FAC Charter. Family members serving on this advisory committee may receive a reasonable per diem payment to enable participation in the advisory committee. For more details on per diem payments, refer to Partnership policy ADM21 Stipends for Committee Members Serving on Partnership's CAC, FAC, PQC, Provider Grievance Review, QIHEC and Q/UAC Committees. A representative of this committee will be invited to serve as a Member of the statewide DHCS CCS stakeholder advisory group.
    a. Partnership meeting facilitation and representation ensures proper coordination of roles and responsibilities and support to participating members.
    b. FAC meetings are conducted with options for attendance in-person and via teleconference.
    c. Partnership recruits FAC families through opportunities for discussion during ongoing case management interaction, offering per diem payment, engagement and discussion with community based organizations, regional centers, and county CCS programs to collaborate on shared communication, opportunity for families to represent on FAC (including outreach to counties where membership representation is needed), and through other Partnership departments where customer service and engagement indicates an opportunity for members to participate. These members will be referred to

Care Coordination for member or family outreach to discuss the FAC.

d. Partnership recruits FAC members through engagement and discussion during meetings, and outreach to the following representatives from Partnership counties: local providers, CCS County staff, Parent Advocacy groups, or CCS paneled providers. This may include, but not limited to, parent centers, such as family resource centers, family empowerment centers, and parent training and information centers.

——Partnership retains FAC families and members through offering per diem payment, facilitating quarterly meeting series that includes diverse range of representation and meeting topics, including resource speakers, for engagement, offering flexibility and encouragement of family participation in advisory capacity, as well as contributions from representative members.

e.

3. 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

1. Partnership~~HC~~ 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. Partnership~~HC~~ designates a liaison with training on the full spectrum of rules and regulations pertaining to the CCS Program, including referral requirements and processes, annual medical eligibility redetermination processes with County CCS Programs, and care management and authorization processes for CCS children. The liaison will~~must~~ ensure the case management assignment is communicated to the county, as needed.

J. Dispute Resolution and Provider Grievances

——Medical eligibility determination disputes between Partnership~~HC~~ and the County CCS Program will~~must~~ be resolved by the County CCS Program. The County CCS Program, in consultation with DHCS in dependent counties, will~~must~~ make a medical eligibility determination. ~~If a member or caregiver(s) disputes the county CCS program eligibility determination, the member/caregiver(s) must appeal to the county and/or DHCS directly. The CCS county~~The CCS County program shall communicate all resolved disputes in writing to Partnership~~HC~~ within a timely manner.

1.

2. If other disputes arise between Partnership and the County CCS Program, all parties will~~must~~ fulfill their responsibilities in alignment with DHCS policies, including APL, NL, MCP Contract and WCM MOU, without delay. This includes ensuring that members have timely access to services as specified under the WCM MOU. Partnership and County CCS Programs will ~~to~~ attempt to resolve all disputes at the local level before submitting the dispute to DHCS for resolution.
3. If disputes between Partnership and the County CCS Program cannot be resolved, the ~~u~~dispute will~~must~~ be submitted to DHCS by either entity, via email with subject "Request for Resolution" to CCSProgram@dhcs.ca.gov, for review and final determination.
4. For more details, please refer to APL 23-029 Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans and Third-Party Entities and APL 24-015– California Children's Services Whole Child Model Program.
5. Partnership will~~must~~ have a formal process to accept, acknowledge, and resolve Provider disputes and grievances. A CCS Provider may submit directly to Partnership a dispute or grievance concerning the processing of a payment or non-payment of a claim by Partnership. The dispute resolution process will~~must~~ be communicated by Partnership to all of its CCS Providers.

K. Grievance, Appeal, and State Hearing
1. Partnership will~~must~~ ensure that all members are provided information on Grievances, Appeals, and State Hearing rights and processes. All WCM members will~~must~~ be provided the same Grievance, Appeal, and State Hearing rights as other Partnership members. Please refer to Partnership policies MCUP3037 Appeals of Utilization Management/ Pharmacy Decisions ~~will~~and CGA024 Medi-Cal Member Grievance System for more details.

~~VIII.~~IX. REFERENCES:

A. DHCS All Plan Letter (APL) 24~~31~~-015~~03405~~ ~~*Revised*~~ California Children's Services Whole Child Model Program (12/02~~710~~/2024~~31~~)
B. California Code, Health and Safety Code §1373.96
~~C.~~ CCS Numbered Letter (NL) 03-0810 Maintenance and Transportation for CCS Clients to Support Access to CCS Authorized Medical Services (08/19/2010)
~~D.~~C.
~~E.~~D. DHCS APL 23-005 - Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21 (03/16/2023)
~~F.~~E. DHCS APL 22-012 – Governor's Executive Order N-01-19 Regarding Transitional Medi-Cal Pharmacy Benefits from Managed Care to Medi-Cal Rx (*Revised* 12/30/2022)
F. DHCS APL 23-029 - Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans and Third-Party Entities (10/11/2023)
G. Template for Memorandum of Understanding between [MCP] Medi-Cal Managed Care Plans and [County] California Childrens Services (CCS) Whole Child Model Program (07/2024)
H. 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)
I. DHCS ~~APL 21-004 Standards for Determining Threshold Languages, Nondiscrimination Requirements and Language Assistance Services~~APL 25-005~~21-004~~ Standards for Determining Threshold Languages, Nondiscrimination Requirements and Language Assistance Services (02/12/2025)~~5/03/2022)~~
J. DHCS APL 21-011 Grievance and Appeal Requirements, Notice and "Your Rights" Template (08/31/2022)
K. 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)
L. CCS NL 05-0502 Medical Eligibility for Care in a CCS Approved Neonatal Intensive Care Unit (NICU) (09/06/2024~~05/01/2002~~)
M. 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
N. CCS Medical Eligibility Guide (03/15/2017)
O. CCS NL 10-1224 California Children's Services Whole Child Model Program (*Revised* 12/02/2024)
Attachment A: CCS Case Management Core Activities

~~IX.~~X. DISTRIBUTION:

A. P~~artnership~~~~HC~~ Department Directors

B. Partnership~~HC~~ Provider Manual

~~X.~~XI. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Health Services Officer~~Senior Director, Health Services~~

~~XI.~~XII. REVISION DATES: 11/13/19; 02/12/20; 04/14/21; 01/12/22; 01/11/23; 02/14/24; 04/12/25

PREVIOUSLY APPLIED TO:
MPCP2002 – California Children's Services was previously in effect 04/25/1995 – 12/31/2018 and reinstated 01/01/2024-12/21/2024

****

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~~HC~~ 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~~HC~~.

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

Pediatric Risk Stratification Algorithm

PHC will use a Pediatric Risk Stratification Process (PRSP) to assess the risk of all potential WCM participants within 45 days of enrollment or transition from a county CCS program. Any member who qualifies as high risk in any of the categories below will be stratified as High Risk. Members who do not qualify in any of the categories below will be stratified as Low Risk.

	Response	High Risk
Utilization Data Finding Claims costs in prior 12 months ≥ $50,000	Yes	X
Weighted Algorithm including the following data points applying the formula (Snyder, 2005)**:** -6.07 + (Frequent medications x 0.8) + (Office/Outpatient Clinic Visits x 0.69) + (Breathing Problems x 1.32)		**Weighted score > -0.50**
Frequent medications defined as **any one of the following** • >12 prescriptions in past 12 months *or* • >7 months with prescriptions in past 12 months *or* • >6 unique prescriptions in past 12 months *or* • Total days' supply >300 in past 365 days If any of the above is true, then Frequent Medications equals yes; else, no	[Yes=2 No=1] * 0.8	
Breathing Problems defined as **any one of the following** claims ICD10 diagnosis codes: • J98x, • J95821x, • J44x, • J80x, • J96x, • R06x • P22x, • R092x, • P28x, • P240x, • P27x	[Yes=2 No=1] * 1.32	
Number of Doctor's Office/Clinic Visits in past 12 months scored as: • None = 1 • One visit = 2 • Two to three visits = 3 • Four to six visits = 4 • Greater than 6 visits = 5	[score] * 0.69	
Identification as High Risk by CCS/MTP Staff		X
NICU Admission		X
New CCS Diagnosis		X

References

Snyder, A. W. (2005, September). Development of Risk Assessment Tool for Predicting Pediatric Health Services Utilization. *Journal of Clinical Outcomes Management, 12*(9), 451-458.

Partnership HealthPlan of California's Whole Child Model Family Advisory Committee (FAC) Charter

Purpose:

The Whole Child Model FAC is a Member Advisory Group to the Chief Executive Officer (CEO) and staff of Partnership HealthPlan of California (Partnership), providing input, review and recommendations on policies and issues that affect children and their families served through the Whole Child Model (WCM) program.

The WCM FAC is intended to promote open communication between families with children who have special health care needs, health plan leadership, California Children's Services (CCS) agencies, and local family support providers. It serves as a mutual learning forum for committee members and health plan staff to make a positive difference in the care the health plan provides to CCS beneficiaries.

Authority and Responsibility:

SB 586 (Hernandez, 2016) established a ~~Whole Child Model~~WCM program, under which managed care plans served by a county organized health system or Regional Health Authority in designated counties would provide CCS services to Medi-Cal eligible CCS children and youth. This legislation also required each Medi-Cal managed care plan participating in the ~~Whole Child Model~~WCM program to establish a family advisory group for CCS families (WIC 14094.17(b)(1)).

The WCM FAC may make recommendations to the CEO, based on member and community input and feedback.

As this is an Advisory Committee to the CEO, the Brown Act does not apply.

Membership:

Membership status is reviewed and approved by a committee of Partnership~~HC~~ leadership.

Membership includes:

- WCM CCS M~~m~~embers and/or family members composed of a diverse group that represents a range of conditions, disabilities, and demographics – Family representatives from each Partnership~~HC~~ county (Butte, Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Nevada, Placer, Plumas, Shasta, Sierra, Siskiyou, Solano, Sonoma, Sutter, Tehama, ~~and~~ Trinity, ~~and~~ Yolo, and Yuba). Equal representation (two representatives) from each county is sought but not required.[1] Partnership meeting facilitation and

[1] Please note, if there are not enough CCS family members to fill both positions on the WCM FAC, Partnership~~HC~~ will allow a county representative from that county to fill that position.

representation ensures proper coordination of roles and responsibilities and support to participating members.

- Local Consumer Advocates – maximum of one (1) local consumer advocate representing CCS families.
- Local Providers - maximum of one (1) representative from each PartnershipHC region, including CCS County staff, Parent Advocacy groups or CCS paneled providers. This provider must be serving PartnershipHC Members in Butte, Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Nevada, Placer, Plumas, Shasta, Sierra, Siskiyou, Solano, Sonoma, Sutter, Tehama, Trinity, or Yolo, or Yuba County. This may include, but not limited to, parent centers, such as family resource centers, family empowerment centers, and parent training and information centers.

Committee Staff

- PartnershipHC employees will serve as support staff to the WCM FAC.

Membership roles and responsibilities:

Family Members

- Family members play a crucial role in ensuring productive discussions. They are responsible for presenting family member input, setting a clear purpose, and establishing a positive tone. They provide relevant updates since the last meeting to keep everyone informed and offer valuable input on processes, challenges, and ideas. Additionally, they identify upcoming topics and suggest new ideas for future meetings. This role ensures that meetings are collaborative and effective.

Partnership Staff

- Partnership Staff play a crucial role in ensuring meeting effectiveness and smooth operation. The responsibilities include arranging all logistical aspects, such as scheduling, preparing the venue, and distributing materials. They assist in facilitating the meeting by managing the agenda and, importantly, encouraging and guiding productive discussions. Additionally, they monitor attendance to ensure all relevant parties are present and engaged. Following the meeting, they track and manage action items to ensure timely completion and progress. They also help prepare meeting topics to provide relevant and timely discussions. Furthermore, they collect and incorporate feedback from family members, local providers, and local consumer advocates to continually enhance service quality. This role is essential for maintaining organization, effective communication, and actionable outcomes within the partnership.

Local Consumer Advocate or Local Provider

- As a Local Consumer Advocate or Provider, the role is to support and enhance the effectiveness of meetings by contributing expertise and insights. They attend and actively listen to meetings to fully understand the discussions and decisions. They provide support and clarity based on their expertise when relevant questions arise. Additionally, they respond to inquiries about their specific community or organization, offering informed and accurate information to assist

with decision-making. The contributions are essential for ensuring that meetings are well-informed and that community-specific issues are effectively addressed.

Terms:
WCM CCS Mmember and/or family member will be appointed to a two-year term. At the end of the term the member may be reappointed to a subsequent two-year term.

Local Consumer Advocate will be appointed to a two -year term. At the end of the term this position will be open to other applicants in the region. If there is no other applicant the advocate may be reappointed to a subsequent term.

Local CCS County Representative will be appointed to a two -year term. At the end of the term, this position will be open to other applicants from other counties in the region. If there is no other applicant the county representative may be reappointed to a subsequent term.

FAC Chair and Vice Chair:

The FAC shall select a Chair and Vice Chair. -The Chair and Vice Chair shall be a CCS Member or family representative. selected by the voting members of the FAC.

The role of the Chair is to provide meeting facilitation and direct the meeting process through the agenda. The Chair will guide and lead discussion to ensure all participants are provided equal opportunity for participation.

The role of the Vice Chair is to preside at the meetings of the FAC in the absence of the Chair.
If both Chair and Vice Chair are absent, the WCM FAC members present will select one member to act as Chair for the meeting.

The FAC shall elect a Chair and Vice Chair for a two-year term.

Meetings:

The WCM FAC shall meet four (4) times per year (i.e., quarterly).

These meetings will be on the 3rd Tuesday of every third month. This time can be changed at any time by a vote of the Committee.

These meetings will be located at PartnershipHC offices, and remotely. PartnershipHC will provide technical support for remote meeting access. When feasible, meetings could be held at alternative locations with prior approval by the organizers.

Meeting Compensation:

Appointed Members are eligible to receive a stipend for meeting attendance.

Agendas, Minutes, Reports:

Partnership~~HC~~ staff will work in collaboration with the Committee, to develop the agenda for each meeting.

Partnership~~HC~~ staff are responsible for agenda and meeting material production and distribution.

Partnership~~HC~~ staff will record minutes of meetings which will be approved by the FAC members at each subsequent meeting.

Review of Charter:

The FAC shall review this charter as needed. Any proposed changes shall be submitted to the CEO for approval.

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

GUIDELINE / PROCEDURE

<table>
<tr><td colspan="3">Guideline/Procedure Number: ~~MCUG3002~~ MPUG3002
(previously MCUG3002, UG100302)</td><td colspan="3">Lead Department: Health Services
Business Unit: Utilization Management</td></tr>
<tr><td colspan="3">Guideline/Procedure Title: Acupuncture Services Guidelines</td><td colspan="3">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 02/16/1995</td><td colspan="4">Next Review Date: ~~04/10/2025~~04/09/2026
Last Review Date: ~~04/10/2024~~04/09/2025</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~~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: ~~04/10/2024~~04/09/2025</td></tr>
</table>

I. RELATED POLICIES:

A. MCUP3124 – Referral to Specialists (RAF) Policy
B. MCUP3041 – Treatment Authorization Request (TAR) Review Process
C. MCUP3042 – Technology Assessment
D. MCCP2022 – Early & Periodic Screening, Diagnostic and Treatment (EPSDT) Services

II. IMPACTED DEPTS:

A. Health Services
B. Member Services
C. Claims

III. DEFINITIONS:

A. **Direct Member:** Direct Members are those whose service needs are such that Primary Care Provider (PCP) assignment would be inappropriate. Assignment to Direct Member status may be based on the member's aid code, prime insurance, demographics or administrative approval based on qualified circumstances. A Referral Authorization Form (RAF) is not required for Direct Members to see Partnership network providers and/or certified Medi-Cal providers willing to bill Partnership for covered services. However, many specialists will still request a RAF from the PCP to communicate background patient information to the specialist and to maintain good communication with the PCP.

~~A.~~B. **EPSDT: Early** and **Periodic Screening, Diagnostic and Treatment Supplemental Services** is a federally mandated Medicaid/ Medi-Cal benefit for Medi-Cal ~~member~~Members under age 21 for medically necessary treatment services needed to correct or ameliorate a defect, physical illness, mental illness or a condition, even if the service or item is not otherwise included in the State's Medicaid Plan. [Source: Title 42 US Code Section 1396(a)(43) and 1396d(r)]

C. **Medical necessity** –Necessary health care services are those needed to protect life, to prevent significant illness or significant disability, or to alleviate pain.

~~B.~~D. **Partnership Advantage:** Effective January 1, 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.

Guideline/Procedure Number: MPCUG3002 (previously MCUG3002, UG100302)			**Lead Department: Health Services** **Business Unit: Utilization Management**
Guideline/Procedure Title: Acupuncture Services Guidelines			☒ **External Policy** ☐ **Internal Policy**
Original Date: 02/16/1995		**Next Review Date:** ~~04/10/2025~~03/12/2026 **Last Review Date:** ~~04/10/2024~~03/12/2025	
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

This guideline describes the conditions under which acupuncture services are authorized and the procedures which providers should follow to obtain such authorizations.

VI. GUIDELINE / PROCEDURE:

A. Acupuncture services are a Partnership HealthPlan of California ~~(PHC)~~ benefit for M~~m~~embers who meet ~~the~~ Medi-Cal and/or Medicare medical necessity guidelines as applicable.

B. Benefit Limitations:

1. Acupuncture services for Partnership Members are limited to treatment performed to prevent, modify or alleviate the perception of severe, persistent chronic pain resulting from a generally recognized medical condition.
2. The Primary Care Provider (PCP) must refer the member to the acupuncturist using a Referral Authorization Form (RAF).
   a. Direct members can be referred by their PCP through a physician order.
3. CPT code 99202 for initial visit, may only be used by Partnership-contracted acupuncture providers.

~~1.~~4. Acupuncture CPT codes 97810 through 97814 are covered under this policy.

~~2.~~5. The maximum length of acupuncture services covered in a 24-hour period is 45 minutes.

C. Authorizations

~~3.~~1. Medi-Cal Members: As per Medi-Cal guidelines and California Code of Regulations, Title 22, Section 51304, Medi-Cal M~~m~~embers are limited to 2 visits per month.

a. No Treatment Authorization Request (TAR) is required unless services exceed two visits per month.
   1) Additional monthly visits require prior treatment authorization (TAR) with justification of medical necessity.

~~a.~~b. ~~PHC~~ Partnership finds insufficient published evidence of any benefits of acupuncture treatment in children under age 12. PHC considers acupuncture in children under age 12 to be experimental. See ~~PHC~~ Partnership policy MCUP3042 Technology Assessment for policies concerning investigational services and interventions.

~~b.~~ For children ages 12 through 20, EPSDT criteria will be considered when evaluating requests for services.

~~c. Acupuncture services for members are limited to treatment performed to prevent, modify or alleviate the perception of severe, persistent chronic pain resulting from a generally recognized medical condition.~~

~~The Primary Care Provider (PCP) must refer the member to the acupuncturist using a Referral Authorization Form (RAF). Direct members can be referred by their PCP through a physician order.~~

c. ~~No Treatment Authorization Request (TAR) is required unless services exceed two visits per month.~~

~~4.~~2. Partnership Advantage Members:

a. Medicare only covers acupuncture services for chronic low back pain.
b. No TAR is required for up to 2 visits a month (same as Medi-Cal). A TAR is required for more than this limit.
   1) For Medicare only, medical necessity frequency limits are up to 12 visits within 90 days for the first TAR, and up to an additional 8 visits within the next 270 days if the condition is

improving but not resolved, for a second TAR.

2) No more than 20 visits per calendar year are covered.

~~1)~~3) Any TAR submitted beyond the 2 visits per month Medi-Cal limit will be limited to that diagnosis.

~~C.~~ Clinician Certification:

D.

1. A physician, podiatrist or certified acupuncturist must be qualified to render acupuncture services and enrolled in the applicable Medi-Cal or Medicare program and eligible to provide Medi-Cal or Medicare services as applicable.
2. Services are not reimbursed when billed as part of an emergency or inpatient service.
3. Services are not reimbursed if rendered by a physician assistant, nurse practitioner, certified nurse midwife, or licensed midwife unless the rendering provider is also a certified acupuncturist.

~~a.~~ Non-acupuncture services rendered by a certified acupuncturist will not be reimbursed.

4.
5. Acupuncture services provided by Indian Health Services providers to American Indian/Alaskan Native ~~member~~Members, irrespective of contracting or in-network status, are reimbursable consistent with the Department of Health Care Services (DHCS) fee-for-service provider manual.

~~2.~~

~~3. The Primary Care Provider (PCP) must refer the member to the acupuncturist using a Referral Authorization Form (RAF). Direct members can be referred by their PCP through a physician order.~~

~~4. No Treatment Authorization Request (TAR) is required unless services exceed two visits per month.~~

~~5. The maximum length of acupuncture services covered in a 24 hour period is 45 minutes.~~

~~CPT code 99202 for initial visit, may only be used by PHC-contracted acupuncture providers~~

REFERENCES:

A. Medi-Cal Provider Manual/ Guidelines: Acupuncture *(acu)*

B. Title 42 US Code Section 1396(a)(43) and 1396d(r)

C. California Code of Regulations (CCR), Title 22, Section 51304

~~C.~~D. Medicare National Coverage Determinations (NCD) Manual 100-03: Chapter 1, Part 1, Section 30.3 Acupuncture. Implementation Date 06/24/2020 or any subsequent updates published by CMS.

VII. DISTRIBUTION:

A. ~~PHC~~Partnership Department Directors

B. ~~PHC~~Partnership Provider Manual

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

IX. REVISION DATES:

Partnership Advantage (Program effective January 1, 2026)
04/09/25

Medi-Cal
04/28/00; 09/19/01; 10/16/02; 09/15/04; 09/21/05; 10/17/07; 10/15/08; 01/21/09; 04/21/10; 01/18/12; 10/15/14; 02/18/15; 05/20/15; 08/19/15; 05/18/16; 11/16/16; 11/15/17; *08/08/18; 06/12/19; 06/10/20; 02/10/21; 05/11/22; 04/12/23; 04/10/24; 04/09/25

*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.

Guideline/Procedure Number: MPC~~C~~UG3002 (previously MCUG3002, UG100302)			**Lead Department: Health Services** **Business Unit: Utilization Management**
Guideline/Procedure Title: Acupuncture Services Guidelines			☒ **External Policy** ☐ **Internal Policy**
Original Date: 02/16/1995		**Next Review Date:** ~~04/10/2025~~03/12/2026 **Last Review Date:** ~~04/10/2024~~03/12/2025	
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**

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 ~~PHC~~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 ~~PHC~~Partnership.

~~PHC~~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

Policy/Procedure Number: MPUP3018 (previously UP100318)				**Lead Department:** Health Services Business Unit: Utilization Management	
Policy/Procedure Title: Health Services Review of Observation Code Billing				☒ **External Policy** ☐ **Internal Policy**	
Original Date: 10/25/1995			**Next Review Date:** ~~03/13/2025~~04/09/2026 **Last Review Date:** ~~03/13/2024~~04/09/2025		
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**	☐ **CREDENTIALS**	☐ **DEPT. DIRECTOR/OFFICER**	
Approval Signature: *Robert Moore, MD, MPH, MBA*				**Approval Date:** ~~03/13/2024~~04/09/2025	

I. RELATED POLICIES:

A. MCUP3014 - Emergency Services
B. MCUG3024 - Inpatient Utilization Management
C. MCUG3118 - Prenatal and Perinatal Care

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

A. Observation Stay: A period of up to a maximum of 48 hours when a ~~member~~Member's medical condition requires continuous monitoring on an out-patient basis to evaluate patient's medical condition or to determine need for in-patient admission. Such services are covered only when provided by the order of a physician. An observation day should be billed as 1 unit per each 24 hour period to a maximum of 2 units for a 48 hour period.

B. Labor Check: An in-hospital evaluation of a pregnant ~~member~~Member beyond 20 weeks from the last menstrual period (LMP) who presents with a complaint of uterine contractions or suspected rupture of membranes. Claims for labor checks are considered only if the woman is evaluated and discharged. If a woman is admitted to the hospital based upon the findings at the labor check, the labor check visit is considered to be a component of the inpatient stay and is not paid as a separate claim.

~~B.~~C. 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.

IV. ATTACHMENTS:

A. N/A

Policy/Procedure Number: MPUP3018 (previously UP100318)		Lead Department: Health Services Business Unit: Utilization Management	
Policy/Procedure Title: Health Services Review of Observation Code Billing		☒ **External Policy** ☐ **Internal Policy**	
Original Date: 10/25/1995		**Next Review Date: 03/13/202504/09/2026** **Last Review Date: 03/13/202404/09/2025**	
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**

V. PURPOSE:

This policy describes the conditions under which observation codes should be used for the care of Partnership HealthPlan of California ~~(PHC)~~ M~~m~~embers.

VI. POLICY / PROCEDURE:

A. Providers can bill the observation code when a ~~member~~Member's medical condition requires continuous monitoring for an additional period of time beyond what is usual and customary for the service provided up to a maximum of 48 hours.

B. Emergency Services: The observation code is to be used if the ~~member~~Member requires more than two hours of continuous monitoring starting from the time that the initial clinical assessment has been completed. Reassessments of the ~~member~~Member's condition must occur at least every 20-30 minutes.

C. Post-Operative Recovery Services: Member must require monitoring for more than two hours after leaving the surgical area in order to use observation codes. Monitoring must be performed in order to evaluate the ~~member~~Member for postoperative complications and nursing reassessment must be done every 20-30 minutes. The observation code can be billed at one unit for each 24-hour period up to a maximum of 48 hours or 2 units. The first two hours are covered by the recovery room fee.

D. Outpatient Services: Member must require monitoring for more than two hours following an outpatient procedure or treatment. Monitoring must be necessary in order to stabilize the ~~member~~Member before discharge and nursing reassessment must be done at least every 20-30 minutes. The observation code can be billed beyond the second hour.

E. Labor and Delivery (L&D): Obstetrical patients seen in the context of a labor check may require observation for a time period beyond one hour to determine whether labor is present or in order to evaluate a potential medical or obstetrical problem. In this case, the claim should be submitted with the observation code (with the number of observation units indicated), and not as a labor check. Individual interventions may be ordered and billed to ~~PHC~~Partnership as describe below:

1. Obstetrical Observation Claims using code Z7514:
   a. When a pregnant ~~woman~~ Member beyond 20 weeks from the LMP is evaluated in labor and delivery for an urgent obstetrical condition other than active contractions or suspected rupture of membranes, only the observation code should be used and not the labor check code.
   b. Monitoring must include nursing reassessment at least every 20-30 minutes with detailed notes regarding the ~~member~~Member's obstetrical status. The observation code Z7514 can be billed by the facility if the ~~member~~Member is monitored in the labor and delivery area and no other room charges are billed.
   c. During the observation period, individual interventions such as stress and non-stress tests, diagnostic ultrasound evaluations, and non-routine laboratory tests may be ordered and then billed to ~~PHC~~Partnership.
   d. ~~PHC~~Partnership reviews for medical necessity all claims submitted for "observation" of obstetrical patients. The medical record pertaining to the observation period must be submitted with the claim.
2. Labor checks ~~at contracted hospitals~~ are to be billed with code ~~S4005~~ 99221 and are an all-inclusive code, payable to the clinician.
   a. Labor checks include, but are not limited to:
      1) Check-in and interval history
      2) Fetal monitor strip [not full non-stress test (NST)]
      3) Cervix check; sterile speculum exam if necessary
      4) Urine dipstick for protein, if performed
      5) Sonogram for fetal position and fetal heart rate (FHR), as needed
      6) Blood pressure checks.
   b. ~~PHC~~Partnership pays for up to three labor checks per ~~member~~Member per 24-hour period. A

single labor check can be billed per confinement in ~~Labor & Delivery (~~L&D~~)~~; multiple claims for labor checks are not paid if provided during the same confinement.

c. Non-stress tests, contraction stress tests, and routine prenatal labs are not paid if provided during a labor check. Lab services are paid if medically necessary.

d. If a labor check requires observation for over one hour, or if evaluation of a potential medical or obstetrical problem is necessary, the claim must be submitted as an observation claim "Z7514" rather than a labor check.

3. In some ~~of the~~ hospitals ~~contracted with PHC~~, pregnant patients over a specified gestational age (usually 20 weeks LMP) are referred to L&D, rather than the emergency department, for evaluation of non-obstetrical problems, as well as those related to pregnancy.

a. Claims for urgent problems not requiring either a labor check or observation are paid at the emergency department or urgent care visit rate.

b. Claims for emergent problems are paid on a fee for service basis. If an observation period is necessary beyond the time needed for initial patient evaluation, the observation billing code Z7514 may be used.

c. The same diagnosis and procedure codes used to differentiate between emergent and urgent care visits in the emergency department are used for non-obstetrical evaluations.

~~d. Non-contracted hospitals which bill should use CPT 99218 for labor checks. This includes all services outlined above in VI.A.E.3. If the provider bills for more than one labor check, it should be coded as Z7514 (observation) with appropriate number of units, all related services provided, and a copy of the medical records attached. Claims will be subject to review by the Health Services Department prior to payment.~~

~~e.~~d. If a pregnant ~~member~~Member is evaluated and treated for a non-obstetrical problem in the ~~Labor and Delivery~~L&D area, the provider must bill according to ~~PHC~~Partnership policy MCUP3014 Emergency Services policy for payment of emergent or urgent problems. Claims for emergent problems are paid on a fee ~~-~~ for ~~-~~ service basis.

F. If a ~~member~~Member requires more than 48 hours of monitoring, the claim must be made for an inpatient day and the fees will be covered by the hospital capitation rate or per diem rate if there is a physician's order to admit the ~~member~~Member as an inpatient and the ~~member~~Member meets medical criteria (InterQual® and/or ~~PHC~~Partnership policy). The observation rate will not be reimbursed when the ~~member~~Member is allowed to sleep at the site at a time when the ~~member~~Member does not require continuous monitoring.

VII. REFERENCES:

A. InterQual® Criteria

B. Medi-Cal Guidelines

~~B.~~C. Medicare Guidelines (for Partnership Advantage Members)

VIII. DISTRIBUTION:

A. ~~PHC~~Partnership Department Directors

B. ~~PHC~~Partnership Provider Manual

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

X. REVISION DATES:

Partnership Advantage (Program effective January 1, 2026)
04/09/2025

Medi-Cal

10/10/97 (name change only); 06/01/00; 04/18/01; 02/20/02; 10/20/04; 10/19/05; 11/16/05; 06/21/06, 08/20/08, 06/17/09; 07/21/10; 10/01/10; 11/28/12; 02/18/15; 02/17/16; 02/15/17; *03/14/18; 03/13/19; 03/11/20; 03/10/21; 05/11/22; 04/12/23; 03/13/24; 04/09/25

*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:
MCUP3017 Health Services Review of Non-admission In-hospital Obstetrical Evaluations (Solano County Only) was Archived 04/12/2023

Healthy Kids KK UM113 11/16/2005; MPUP3018 (Healthy Kids program ended 12/01/2016)
06/21/06, 08/20/08, 06/17/09; 07/21/10; 10/01/10; 11/28/12; 02/18/15; 02/17/16 to 12/01/16

Healthy Families:
MPUP3018 - 10/01/2010 to 03/01/2013

Synopsis of Changes to MCND9002

Policy Number	Policy Name	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: Population Health *Presenter: Hannah O'Leary, Manager of Population Health*			
MCND9002	Cultural & Linguistic Program Description	**This update moves MCND9002 to a new annual approval schedule targeting April Physician Advisory Committee (PAC), and includes revisions to align with new DHCS APL 25-005, and 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 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.	Grievance & Appeals Health Equity Member Services Pharmacy Utilization Management Communications Quality Improvement

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Cultural & Linguistic Program Description

MCND9002

~~November~~ April 202~~4~~5

Original Date: 02/19/2014

Previously Applied to MPLD7001 02/19/14 to 09/09/20

Revision Dates: MCND9002 09/09/20; 09/08/21; 09/14/22; 11/8/23; 11/13/24; 04/9/2025

Table of Contents

Program Purpose

To demonstrate the commitment of Partnership HealthPlan of California (Partnership) to deliver culturally and linguistically appropriate health care services to a culturally and linguistically diverse population of members and potential members in a way that promotes Health Equity for all members.

Introduction

This Cultural and Linguistic (C&L) Program description defines how Partnership uses its resources to achieve the goals and commitments to delivering culturally and linguistically competent health care services to all Partnership members, including members with Limited English Proficiency (LEP) or sensory impairment. This program description also describes how Partnership offers care and services in a way that is effective, health equity-driven, understandable, and respectful and responds to diverse cultural health beliefs and practices and linguistic/communication needs.[1]

Partnership ~~also~~ works to ensure there is equal access to the provision of high quality interpreter and linguistic services for LEP members and potential members, and for members and potential members with disabilities, in compliance with federal and state law, and ~~APL 21-004~~APL 25-005.[2] Partnership makes this commitment to the availability and accessibility of these C&L services, along with a commitment to nondiscriminatory treatment of members ~~,~~ regardless of sex, race, color, national origin (including LEP and primary language), religion, ancestry, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, health status, marital status, gender, gender identity, sexual orientation, or identification with any other persons or group as defined in Title VI of the Civil Rights Act of 1964~~,~~[3] ~~or~~ Section 1557 of the Affordable Care Act of 2010~~,~~[4]~~,~~ the Americans with Disabilities Act of 1990,[5]~~,~~ or as specifiedc in APL 25-005.[6]~~=~~ Partnership maintains, continually monitors, improves, and evaluates cultural and linguistic services that

[1] National Culturally and Linguistically Appropriate Services Standards

[2] All Plan Letter 25-005 Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services ~~APL 21-004~~APL 25-005 ~~-~~and Threshold and Concentration Languages

[3] Penal Code 422.56

[4] ACA 1557

[5] Americans with Disabilities Act of 1990

[6] ~~Penal Code 422.56~~

support covered services for all members, including members less than 21 years of age.[7]

All covered services, member-facing programs, member facing (including health education) and/or outreach material are provided in a culturally and linguistically appropriate manner that promotes health equity for all members. Member facing materials are routinely distributed in all of Partnerships threshold languages, meet the requirements of APL 18-016 Readability and Suitability of Written Health Education Materials,[8] and are available in accessible formats upon member request. Partnership also ensures that members receive all Member Information in a language or alternative format of their choice.

Objectives

Partnership's C&L Program objectives are accomplished through interdepartmental collaboration and include:

- Collecting and updating data on the race/ethnicity, language, sexual orientation and gender identity of Partnership members and sharing this information with providers. This effort is part of Partnership's goal to monitor and evaluate how CLAS may impact health equity and outcomes, which can better inform service delivery. Members will be advised of the intent to share their data and will be given the right to opt out of data sharing in accordance with their privacy rights.
- Ensuring Partnership's staff, providers' and delegates' Cultural and Linguistic services comply with the Department of Health Care Services (DHCS) and Federal regulations without limitations, particularly relating to communication assistance requirements and access for members with disabilities.[9,10,11,12,13]
- Continually assessing, monitoring, improving, and evaluating Partnership's C&L services that support covered services for members, including members under the age of 21.
- Addressing deficiencies and gaps in Partnership's C&L services.

[7] Penal Code 422.56
[8] APL 18-016 Readability and Suitability of Written Health Education Materials
[9] 22 CCR 53876; 21202.5; 51202.5; 51309.5(a)
[10] 28 CCR 1300.67.04(c)(2)(A)-(B); 1300.67.04(c)(2)(G)(v)-(c)(4)
[11] 42 CFR 438.206(c)(2); 438.10; 438.404
[12] W&I Code 14029.91
[13] Medi-Cal Managed Care Plans, Exhibit A, Scope of Work 5.2.10

- Communicating Partnership's C&L Services and Standards to staff, providers, delegates, and community members.

Measurable objectives can be found later in this document and in the joint Quality Improvement Health Equity Transformation Program (QIHETP) and Cultural and Linguistics (C&L) annual work plan.

Programs and Services

Partnership's C&L programs and services outlined below encompass the services directly provided to members and potential members, as well as the support provided to Partnership staff, providers', and delegates' capacity in understanding the C&L needs of our member population. Partnership will take ~~immediate~~ action to improve its culturally and linguistically appropriate services when deficiencies are noted.

Language Data Collection

At least every three years, DHCS gathers language information for individuals enrolled in Medi-Cal and shares this information with Managed Care Plans (MCPs) to address potential changes to threshold and concentration standard languages (see MCND9002 attachment C for threshold languages) as well as any changes in state and/or federal law. Partnership reviews overall language prevalence per state-published data every three years in order to identify emerging language patterns that may impact Partnership members or potential members. This data is also used to assess languages in a way that aligns with DHCS requirements as outlined in ~~APL 21-004~~APL 25-005 as well as aligns with NCQA requirements for threshold languages of five (5) percent or 1,000 individuals~~)~~, as well as languages spoken by one (1) percent or 200 individuals (whichever is less). According to ~~APL 21-004~~APL 25-005 and its attachments, MCPs must provide translated written member information to specific groups in the MCP's service area as identified by DHCS in the Threshold and Concentration Language dataset.[14] Partnership also routinely collects and maintains records of member language preferences spoken by one (1) percent of the member population or less.

In addition to DHCS's language data collection and analysis process for Partnerships' member population, Partnership ~~will~~ conducts its own data analysis at the community and/or census level to determine and report out on the languages spoken by five (5) percent or 1,000 individuals, whichever is less, and by 1% of the population or 200

[14] ~~APL 21-004~~APL 25-005 and Threshold and Concentration Languages

individuals, whichever is less. For more details on this process, please refer to the Community Language Assessment report.

At the time of the writing of this document, Partnership's concentration standard and/or threshold languages are Russian, Tagalog, ~~and~~ Spanish, and Punjabi, as determined by DHCS. For information on threshold languages as determined by Partnership using NCQA methodology, please refer to the Community Language Assessment report.

These practices help to address potential changes to threshold and concentration standard languages, as well as any changes in state and/or federal law. This information is used as part of the assessment of language services for members to improve the Cultural and Linguistics program offerings, and when possible, to guide network development. Partnership will retain a list of the DHCS- provided, and Partnership-determined threshold and concentration standard languages. Adjustments to the list will be based on findings from the Community Language Assessment report and DHCS's triennial timeline.

Partnership distributes a written notice in English and ~~up to 18~~ other languages spoken by 1 percent of the members served by the organization or by 200 individuals (whichever is less), informing members that the organization provides language assistance services and how they can obtain it at no cost to the member. Non-speaking or Limited English Proficient (LEP) members can also request language and/or interpretation services, or even refuse interpreter services; this request is then documented in Partnership's member record.[15] Pa~~. Pa~~rtnership may use or disclose the member's preferred language with Partnership network practitioners/providers, subcontractors, or other covered entities for the purposes of ensuring communication and care delivery are in a culturally sensitive and linguistically appropriate manner. Members are informed ~~when language information is directly collected~~ that their language preferences may be shared when language information is directly collected.

Partnership also assesses and collects data on the cultural and linguistic needs of the member population through the written Population Needs Assessment (PNA). Each year, Partnership assesses the overall environment, specific community needs, and the factors that influence the health and well-being of the assigned member population. This information is collected from its member population data and integrated into the PNA, which- helps drive~~s~~ the goals of Partnership's Population Health Management Strategy, the Cultural & Linguistics Program, and their associated work plans. Both of these work plans are the driving force by which Partnership responds to the cultural and linguistic

[15] ~~APL 22-017~~APL 22-017 Primary Care Provider Site Reviews: Facility Site Review ~~And~~ and APL 22-017 MMR Standards

diversity and needs of Partnership's member population. The report is written in accordance with the requirements of the National Committee for Quality Assurance (NCQA) Health Plan Accreditation Standards for an annual Population Needs Assessment (PNA).

Finally, in alignment with DHCS's Population Health Management Policy Guide, Partnership collects information on language needs as part of its collaboration with each Local Health Jurisdiction in its service area.[16] This collaborative work is referred to as the Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) process. Based on this collaborative work, and input from various stakeholders, including Partnership's C~~onsumer~~ommunity Advisory Committee (CAC) (formerly known as the Consumer Advisory Committee), Partnership annually reviews, and updates as needed, its strategies and work streams related to the DHCS Bold G~~g~~oals, health equity, health education materials, wellness and prevention programs, and cultural and linguistic and quality improvement strategies to address identified health and social needs in accordance with the population-level needs and the DHCS Comprehensive Quality Strategy.[17] Findings from both the PNA and CHA/CHIP work are shared with our providers and other stakeholders as needed on a regular basis.

Language Assistance Services

Partnership members are entitled to timely language assistance services at no cost to them, such as oral interpretation services (including the provision of auxiliary aids and services) and written translation of critical and vital informing materials in their preferred threshold language, including oral interpretation and American Sign Language, as well as their preferred alternate format. Partnership members can request Interpreting and/or translation services by contacting the Member Services Department or any other member-facing department (Utilization Management, Population Health, Care Coordination, Grievance & Appeals, and Transportation). Members can also call a toll-free number with TTY/TDD.

~~Language Assistance Taglines~~Notice of Availability of Language Assistance Services and Auxiliary Aids and Services, Nondiscrimination Notices, and Member Information

In alignment with APL 2~~5~~1-00~~5~~4[18] and other DHCS requirements, Partnership ~~publishes~~ provides nondiscrimination notices and Language Assistance Notice of

[16] DHCS Basic Population Health Management Policy Guide
[17] DHCS Comprehensive Quality Strategy
[18] APL 25-005~~All Plan Letter 21-0045-005 Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services~~

Availabilitylanguage assistance taglines. They are sent with all member correspondences as well. Nondiscrimination notices are provided in English and the top 18 non-English languages spoken by Limited English Proficient (LEP) individuals in the state and inform Members, Potential Members, and the public about nondiscrimination, protected characteristics, accessibility requirements, and information on how to file a grievance. A Language Assistance Notice of Availability Language assistance taglines isare published also provided in a conspicuously visible font size in English and California's the top 18 non-English languages spoken by Limited English Proficient (LEP) individuals in the state; they inform members, potential members, and the public of all available language assistance services at no cost to them and as well as how to access them (including written translation and interpretation).

The Language Assistance Notice of Availability ese taglines and nondiscrimination notices are provided in a font size no smaller than 12-point and are available in all Threshold Languages/Concentration Standard Languages andand in an ADA-compliant, accessible format. Aalternative formats available to members (includesing Braille, large-size print font that is no smaller than 20-point, , accessible electronic format, or audio format), and Auxiliary Aids at no cost to the member, and upon request. Consideration is also given for the special needs of members with disabilities or LEP members.

Vital Nondiscrimination notices and the Language Assistance Notice of Availability are also sent with all member correspondences, which member correspondences include, but are not limited to:

- Partnership Member Handbook/Evidence of Coverage (EOC)
- Partnership Provider Directory
- Form letters and notices critical to obtaining services
- Notices of Action
- Notice of Appeal Resolution Letters
- Notices of Adverse Benefit Determination
- Grievance and Appeals letters
- Welcome Packets
- Marketing Information
- Preventive health reminders
- Member surveys
- Notices advising of the availability of free language assistance services
- Newsletters

- All member information, informational notices, and materials critical to obtaining services targeted to members, potential enrollees, applicants, and members of the public
- Other written communications and/or informational notices for members, Potential Members, and the public as applicable.

The nondiscrimination notice and the Language Assistance Notice of Availability ~~notice with taglines~~ includes Partnership's toll-free and Telephone Typewriters (TTY)/Telecommunication Devices for the Deaf (TDD) telephone number for obtaining these services and ~~, and~~ are posted in the following places in a clear and prominent manner:[19]

a) In the Member Handbook/EOC and other electronic and written communications,
~~a)~~b) ~~In a conspicuous place l~~in all physical locations in 20-point font sans serif where Partnership interacts with the public and where members seeking heath programs or activities would be able to read or hear the notice ~~interacts with the public~~;
c) In a location on Partnership's website that is accessible on the home page, and in a manner that allows Members, Potential Members, and members of the public to easily locate the information; and
~~a)~~d) In all Member information and other informational notices, in accordance with federal and state law and this APL.
~~b) In the Member Handbook/EOC, and in all Member Information, informational notices, and materials critical to obtaining services targeted to Members, Potential Members, applicants, and the public at large, in accordance with APL 21-004 and APL 22-002, 42 CFR section 438.10(d)(2)-(3), and W&I section 14029.91(a)(3) and (f).~~

In alignment with DHCS requirements, all member facing material and correspondences (member informing and health education) are created using simple language, are culturally and linguistically appropriate, are provided at a 6th grade reading level, are in a format that is easily understood, in a font size no smaller than 12-point, are translated and sent in the member's preferred language (including Partnership's threshold languages) and format; member informing materials ~~, and~~ are approved by DHCS before distribution, while~~.~~ h~~H~~ealth education materials are approved by a Qualified

[19] APL 25-005~~All Plan Letter 21-004 Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance ServicesAll Plan Letter 25-005 Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services~~

Health educator as defined by APL 18-016.[20] Translation of member facing materials are provided to members at no cost to them.

Partnership also provides members with requested information in their preferred format in a timely fashion. Preferred formats ~~includes~~include Braille, large-size print font no smaller than 20-point, accessible electronic format, audio compact disc (CD) format, or data CD format), and through Auxiliary Aids at no cost and upon member request. Partnership maintains a library of all ~~member facing~~member facing materials in all Partnership threshold languages, including the major correspondence, health education materials, and other benefit-relate member informing materials. Any mailed correspondence is sent according to the member's preferred threshold language or format. Other documents, such as letters or utilization review determinations are translated within 2 business days. Members may also request translation of other documents. Translated materials are completed within 2 business days of the request and members receive their fully translated materials in a timely manner.

Translation Service

Partnership utilizes United Language Group (ULG) as the certified translation service of all member-facing materials (including vital written materials) for LEP Members and Potential Members who speak Partnership's Threshold or Concentration Standard Languages. Partnership translates all member facing materials into its designed threshold and concentration standard languages or other languages as requested. Members can inform Partnership of their preferred language to receive written translations of member materials in the identified Threshold Language, or other languages as necessary, at no cost to the member from a qualified translator.

Member requests are fulfilled in a timely manner. ULG services are provided at no cost to the member. Partnership aims to have written member information translated within 2-5 business days depending on the complexity and rarity of the language requested; threshold and concentration languages are defined by DHCS ~~APL 21-004~~APL 25-005. All translations are verified by separate, additional ULG translators to ensure cultural and linguistic accuracy as well as appropriate grammar and context (see ~~attachment~~ MCND9002 attachment D Process for Culturally and Linguistically Appropriate Translations for further translation explanation).

[20] APL 18-016 Readability and Suitability of Written Health Education Materials

Partnership has adopted the definition of a qualified translator/vendor as delineated in ~~APL 21-004~~APL 25-005.[21]~~[12]~~ Per this APL, a translator interpreting for Partnership member must:

- Adhere to generally accepted translator ethics principles, including client confidentiality,
- Have demonstrated proficiency in writing and understanding both written English and the written non-English language(s) in need of translation; and,
- Be able to translate effectively, accurately, and impartially to and from such language(s) and English, using any necessary specialized vocabulary, or terms without changes, omissions, or additions and while preserving the tone, sentiment, and emotional level of the original written statement~~terminology, and phraseology~~.
-

Partnership has requirements for their translator certification process, as set forth by ULG Translations~~Services~~ in MCND9002 D Process for Culturally and Linguistically Appropriate Translations.

Interpreter Services

Partnership provides equal and timely access to high quality, oral and non-oral interpretation services to members who are monolingual, non-English-speaking, or LEP from a qualified interpreter on a 24-hour, 7 days a week basis at all key points of contact and at no cost to all members and potential ~~members. Oral interpreter services are available for any language spoken by the member (see MCND9002 attachment A for criteria and authorization requirements for interpreting services). Key~~members. ~~Key~~ P~~p~~oints of contact include the medical care setting, such as telephone, advice, Urgent Care, and other outpatient encounters with providers; and non-medical care settings, such as a member services, orientations, and appointment scheduling. ~~.~~ Oral interpreter services are available for any language spoken by the member (s~~s~~ee MCND9002 attachment A for criteria and authorization requirements for interpreting services). Interpreter services are available in all of Partnership's threshold languages, and over ~~200~~ 140 additional languages are available upon member request through Partnership's contracted language service provider. The m~~M~~ember's preferred language (if other than English) is also prominently noted in their medical record, as well as their request or refusal of language/interpretation services (including refusal of interpreter services from members with disabilities) in accordance with ~~Title VI of the Civil Rights Act of 1964~~APL

[21] APL 25-005

25-005.[22][27] [23]. As described in the translation services section above, Partnership offers written translation services of member facing materials in its threshold and concentration languages and upon member request; however, sight translation (oral interpretation) of written information can also be provided upon member request.

Any Partnership staff member who provides interpreter services to members in a non-English language is tested for proficiency through Human Resources before engaging members in that language.

Partnership has also contracted with AMN HealthCare as their language interpretation service provider. Sight translation (oral interpretation) of written information can also be provided upon member request. Partnership ensures that timely access to care will not be delayed due to lack of interpretation services. Language services through AMN Healthcare are available for any member in need of an interpreter, member facing staff, and providers working with Partnership members. Member-facing delegates are also required to provide interpreter services for members, however, workflows vary per delegate.

Partnership uses the definition provided by APL 21-004APL 25-005 in vendor selection and to define a qualified interpreter as an interpreter who:[9][2]

- Has demonstrated proficiency in speaking and understanding both spoken English and at least one other spoken language (qualified interpreters for relay interpretation must demonstrate proficiency in two non-English spoken languages);
- Be able to interpret effectively, accurately, and impartially to and from such language and English, (or between two non-English languages for relay interpretation), using any necessary specialized vocabulary, or terms without changes, omissions, or additions and while preserving the tone, sentiment, and emotional level of the original oral statement; and
- Adhere to generally accepted interpreter ethics principles, including client confidentiality.
-
  - Has demonstrated proficiency in speaking and understanding both spoken English and the non-English language in need of interpretation,

[22] APL 25-005
[23] Title VI of the Civil Rights Act of 1964

- ~~Is able to interpret effectively, accurately, and impartially, both receptively and expressively, to and from such language(s) and English, using any necessary specialized vocabulary and phraseology; and,~~
- ~~Adheres to generally accepted interpreter ethics principles, including client confidentiality.~~

When providing high quality interpretive services for an individual with disabilities, Partnership uses qualified non-oral interpretation services either through a remote interpreting service or an onsite appearance ~~per~~ in alignment with the requirements stated in ~~APL 21-004~~APL 25-005. This definition asserts that an interpreter who provides interpretive services for an individual with disabilities is an interpreter who:

- Adheres to generally accepted interpreter ethics principals, including client confidentiality; and
- Is able to interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary, terminology, and phraseology~~.~~ without changes, omissions, or additions while preserving the tone, sentiment, and emotional level of the original statement; and
- Has demonstrated proficiency in communicating in and understanding English and a non-English language (including American Sign Language) or another communication modality such as cued-language transliterators or oral transliterators.

For an individual with a disability, qualified interpreters can include sign language interpreters, oral transliterators (individuals who represent or spell in the characters of another alphabet), and cued language transliterators (individuals who represent or spell by using a small number of handshapes).

When providing Video Remote Interpreter (VRI) services, Partnership provides real-time, full-motion video and audio over a dedicated high-speed, wide-bandwidth video connection or wireless connection. The connection is delivered through high-quality video images that do not produce lags, choppy, blurry, or grainy images, or irregular pauses in communication; and provide a sharply delineated image that is large enough to display the interpreter's face, arms, hands, and fingers, and the participating individual's face, arms, hands, and fingers, regardless of body position. Partnership provides clear, audible transmission of voices, and adequate training to users of the technology and other involved individuals so that they may quickly and efficiently set up and operate the VRI.

Partnership does not allow for the use of unqualified interpreters, adult friends, family, or minor accompanying a member to provide interpreting services or facilitate communication except:

- As a temporary measure when there is an emergency involving an imminent threat to the safety or welfare of the Member or the public and a qualified interpreter is not immediately available; or,
- If the LEP Member or member with a disability specifically requests that an accompanying adult interpret or facilitate communication. This request must be done in private with a qualified interpreter present and without an accompanying adult present. Additionally, the accompanying adult must agree to provide that assistance, the request and agreement is documented, and reliance on that accompanying adult for that assistance is appropriate under the circumstances. ~~The exceptions to this rule are as follows:~~
- ~~In the middle of an emergency where a qualified interpreter is not available, or~~
- ~~If the member explicitly requests the accompanying person to interpret, the accompanying person agrees to help, and it is appropriate for the situation.~~

Auxiliary Aids and Services

In accordance with ~~APL 21-004~~APL 25-005 and APL 22-022, Partnership provides the following auxiliary aids and ~~services~~ services in an accessible format, in a timely manner, and at no cost to the member, ~~to members,~~including qualified interpreters and written materials in alternative ~~formats, to members~~ their authorized representative (AR) or someone with whom it is appropriate for Partnership to communicate with ("companion") by request or as needed, ~~and at no cost to the member~~and in a way to preserve member privacy. This is done in a way to protect the Member's privacy and to ensure that Members with disabilities have an equal opportunity to participate in, or enjoy the benefits of, the MCP's services, programs, and activities. Auxiliary aids and services include~~:~~

- Qualified oral and sign language interpreters on-site or through VRI services; note takers; real-time computer-aided transcription services; written materials; exchange of written notes; telephone handset amplifiers; assistive listening devices; telephone handset amplifiers; assistive listening devices; assistive listening systems; telephones compatible with hearing aids; closed caption decoders; open and closed captioning, including real-time captioning; voice, text, and video-based telecommunications products and systems, including text telephones~~/telephone typewriters~~ (TTYs)~~ or Telecommunication Devices for the Deaf (TDD)~~, videophones, captioned telephones, or equally effective telecommunications devices; videotext displays; accessible information and

communication technology; or other effective methods of making aurally delivered information available to individuals who are deaf or hard of hearing.

- Qualified readers; taped texts; audio recordings; Braille materials and displays; screen reader software; magnification software; optical readers; secondary auditory programs; large print materials (no less than 20-point font); accessible information and communication technology; or other effective methods of making visually delivered materials available to individuals who are blind or have low vision.

Please see MCND-9002 attachment B to learn more about how Partnership provides auxiliary aids and services for persons with disabilities.

Alternate Formats

In accordance with ~~APL 21-004~~APL 25-005 and APL 22-002, Partnership provides member information to members and potential members in alternate formats to meet the cultural and linguistic needs of members, including Braille, large print text (20 point ~~font~~ or larger), audio, and accessible electronic formats, at no cost to the member and with primary consideration of the individuals request for specific auxiliary aids or service. Partnership maintains record of member's linguistic capability upon member enrollment, and as reported thereafter, using data provided by DHCS or reported to Partnership by the member and/or their AR, or by Subcontractors. Partnership also collects and stores the alternative format selections of members. Partnership members, their ARs, or someone with whom it is appropriate for Partnership to communicate with ("companion"), are encouraged to call Partnership or report their format preference via the DHCS AFS application system; this information is then passed on to Partnership for incorporation into the member record and implemented as appropriate. This information is also shared with Partnership subcontractors and network providers as appropriate.

In alignment with APL 22-002, when a member contacts Partnership about electronic alternative formats, Partnership also informs the member that, unless they request a password-protected format, the requested member information will be provided in an electronic format that is not password protected~~, which may make the information more vulnerable to loss or misuse~~. Partnership then communicates to the member that they may request an encrypted electronic format with unencrypted instructions on how the Member can access the encrypted information.[24]

[24] APL 22-002 Alternative Format Selection for Members with Visual Impairments

Trainings

In alignment with APL 24-016, Partnership provides Diversity, Equity, and Inclusion (including sensitivity, communication skills, cultural competency/humility training, health equity, and related trainings) for practitioners of our network providers, Partnership staff, and subcontractors and downstream subcontractors. Contracted network providers, contractors, and subcontractors are eligible to submit their own diversity, equity, and inclusion training for review and approval by Partnership's Director of Health Equity in consideration of DHCS regulatory requirements. Separately, Partnership educates contracted network providers, contractors, subcontractors, and staff on Partnership-specific policies, practices, and guidelines for Partnership-specific cultural and language assistance services. ~~In alignment with APL 23-025 Diversity, Equity, And Inclusion Training Program Requirements, Partnership educates and trains all contracted network providers on diversity, equity and inclusion (including sensitivity, communication skills, cultural competency/humility training, health equity, and related trainings)[25], as well as Partnership-specific culturally and linguistically appropriate policies and practices. Providers also separately receive a review of Partnership's policies and procedures for language assistance services and how to access them. Partnership provides trainings for contracted Network Providers within 90 days of their start date, with retraining as needed during re-credentialing cycles.[26]~~

Partnership provides trainings for contracted practitioners of Network Providers within 90 days of their start date, with retraining as needed during re-credentialing cycles. The training program for providers will be region specific and include consideration of health-related social needs and disparities that are specific to Partnership's servicing counties and demographics. Practitioners from different regions will receive different course recommendations that are unique to their region. Practitioners are required to acknowledge review of their region's respective disparity report during the completion of the training. For more information on the provider training, please see the forthcoming policy on Diversity, Equity, and Inclusion Training Program Requirements for External Practitioners.

Partnership staff will receive the staff-specific DEI training on an annual basis. Partnership staff training records are managed by Human Resources while the Provider training records are managed by Provider Relations and Health Equity Department.

~~[25] APL 23-025 Diversity, Equity, and Inclusion Training Program Requirements~~
~~[26] APL 23-025 Diversity, Equity, and Inclusion Training Program Requirements~~

Also in alignment with APL 24-016, Partnership's Director of Health Equity reviews and oversees the evidence-based DEI trainings and program. The training content will be delivered as digital training modules via an electronic Learning Management System (LMS) to allow asynchronous training delivery throughout Partnership's 24 counties of service. It will review 3 three major themes to ensure coverage of Partnership member demographics including, but not limited to, members' sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, health status, marital status, gender, gender identity, sexual orientation, or identification with any other person or groups defined in Penal Code section 422.56 within specific regions. For details on the 3 three themes described in the training, see the forthcoming policy Diversity, Equity, and Inclusion Training Program Requirements for External Practitioners. ~~Also in alignment with APL 23-025, Partnership's Director of Health Equity reviews and oversees the evidence-based DEI trainings and program. The training content will be delivered as training modules via an electronic Learning Management System (LMS) to allow asynchronous training delivery throughout Partnership's 24 counties of service. It will review 3 major themes to ensure coverage of Partnership member demographics including, but not limited to, members' sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, health status, marital status, gender, gender identity, sexual orientation, or identification with any other person or groups defined in Penal Code section 422.56 within specific regions. For details on the 3 themes described in the training, see the forthcoming policy Diversity, Equity, and Inclusion Training Program Requirements for External Practitioners.~~

~~The training program will be region specific and include consideration of health-related social needs that are specific to Partnership's servicing counties. Practitioners from different regions will receive different course recommendations that are specific to their region. Practitioners will also acknowledge review of their region's respective disparity report during the completion of the training. For more information on this training, please see the forthcoming policy on Diversity, Equity, and Inclusion Training Program Requirements for External Practitioners.~~

~~Partnership has two mandatory trainings required for Partnership staff. Permanent and temporary staff receive the cultural and linguistic program trainings upon hire. Upon hire and then annually, permanent, temporary, and contracted employees receive a diversity basics training with topics such as diversity, equity, and inclusion.~~

The Cultural and Linguistic unit audits DHCS-identified delegates' annual trainings to ensure that they are in compliance with required elements.

Partnership's State Hearing Representative is working towards becoming ~~expected to become~~ a certified ADA Coordinator, who advises Partnership on how and when accommodation requests should be honored. ~~Partnership staff training records are maintained by Human Resources while the Provider training records are maintained by Provider Relations.~~

Beyond offering training to promote Cultural and Linguistic related topics, Partnership works to identify and act on at least one area of opportunity to improve the diversity, equity, inclusion (DEI) and cultural humility within the following groups per the findings of the annual Health Equity Accreditation workforce analyses~~Beyond offering training to promote Cultural and Linguistic related topics, Partnership works to identify and act on at least one area of opportunity to improve the diversity, equity, inclusion (DEI) and cultural humility within the following groups per the findings of the Health Equity Accreditation workforce analyses~~:

- Staff
- Leadership
- Governing bodies
- Committees
- Providers

Assessment and Evaluation

Cultural and Linguistic Program Evaluation

On an annual basis, Partnership writes an evaluation report detailing the Cultural and Linguistic (C&L) program structure and interventions performed in accordance with PHM and other Partnership efforts of the given year. Key elements in this annual evaluation include program structure/processes, goals for completed activities, review of the C~~onsumer~~ommunity Advisory Committee (CAC) feedback, overall program effectiveness, and opportunities for improvement.

Linguistic Capacity Assessments

Partnership identifies and tracks the language capabilities of clinicians and other provider office staff during the credentialing process. When available, Partnership contracts with qualified bilingual providers as a linguistic service to members and potential members at no cost and, when possible, to reflect the linguistic needs of Partnership's members. Using the results from an annual, self-reported survey of our primary care sites, as well as documentation of staff changes, Partnership publishes updates to the Provider Directory to best reflect the linguistic capabilities at provider offices.

Annually, Partnership performs an audit of its ~~contracted~~ delegated ~~translation~~ cultural and linguistic services providers ~~(including employees, contracted staff, and other individuals who provide linguistic service)~~ to ensure their services meet the needs of our members, including members under 21 years of age as well as their parents, guardians, and authorized representatives. Identified gaps are addressed as needed.

In accordance with Partnership's Policy HR509 Bilingual Standards, Partnership assesses the linguistic capabilities of its bilingual staff ~~members~~ from member-facing departments to ensure they meet the necessary linguistic requirements to serve as qualified interpreters. Partnership's Human Resources Department maintains a record of staff members deemed as qualified interpreters, and their evaluation results.

Member-facing Departments include:

- Care Coordination
- Grievance & Appeals
- Member Services
- Population Health Management
- Transportation
- Utilization Management

- ~~Member Services~~
- ~~Utilization Management~~
- ~~Population Health Management~~
- ~~Care Coordination~~
- ~~Grievance & Appeals~~
- ~~Transportation~~

Administrative Oversight & Compliance Monitoring

Internal Oversight

Within Partnership's Population Health department, the Senior Health Educator (a masters-prepared or MCHES-certified professional) monitors and oversees ~~all~~ regulatory requirements related to Cultural & Linguistics ~~services~~ programs and requirements for compliance purposes and to ensure the delivery of culturally and linguistically appropriate health care services. Partnership also ~~recently~~ created the Population Needs Assessment Committee to review findings and strategies, as needed, to address C&L needs identified in the collaborative work referred to as the CHA and CHIP (please refer to MCND9001 for more detail). To protect the privacy of members, Partnership treats race/ethnicity, language, sexual orientation and gender identity as

protected health information (PHI). Member PHI data cannot be used for denial of services, nor for coverage and benefits.

Partnership also houses the Quality Improvement Health Equity Transformation Program (QIHETP). ~~The~~ The QIHETP is designed to develop, implement, monitor, and maintain a health equity transformation system. The goal of this system is to address improvements in the quality of care delivered by all of its providers in any setting ~~,~~ and take appropriate action to improve upon the health equity and health care delivered to members. ~~The~~ Partnership's ~~-~~QIHETP serves to accomplish the following:

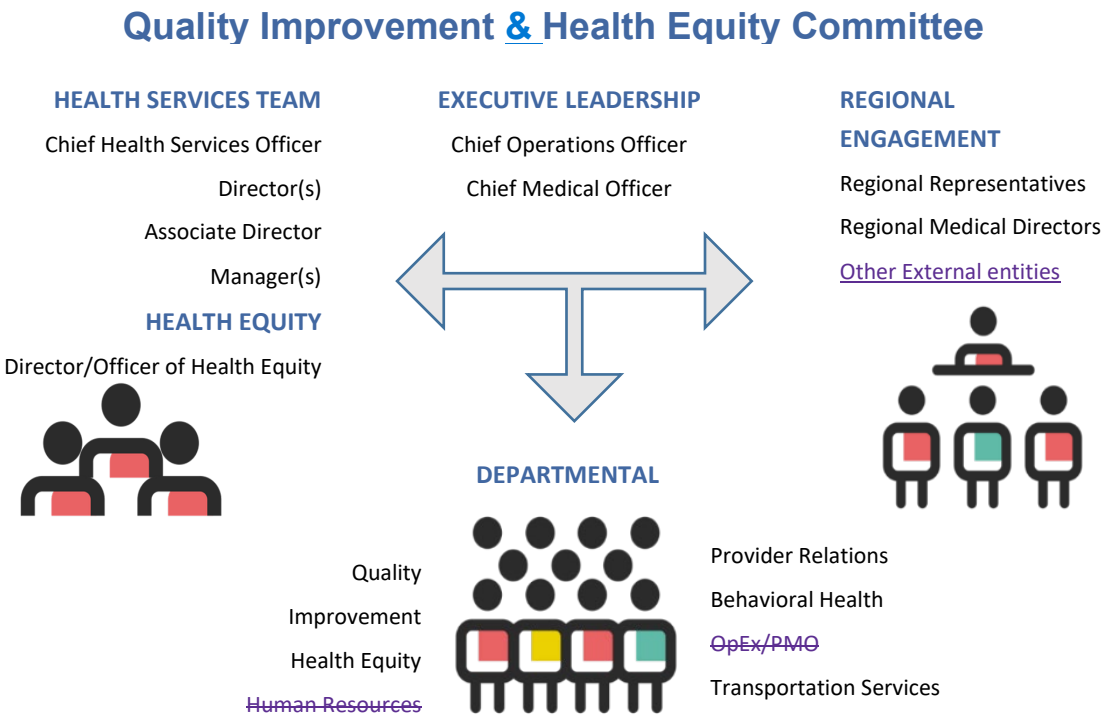
- Ensure that members receive the appropriate quality and quantity of healthcare services
- Ensure that healthcare service is delivered at the appropriate time and in an equitable manner

For more information on QIHETP, refer to MCED6001 QIHETP Program description.

- As part of the QIHETP, ~~and~~ in accordance with MCND9001 and MCEP6002, the Quality Improvement Health Equity Committee (QIHEC) is responsible for analyzing and evaluating the results of quality improvement and health equity activities including annual review of the results of performance measures, utilization data, consumer satisfaction surveys, and findings and activities of internal PHC specific committee. ~~is comprised of various stakeholders including community based organizations, academic institutions, clinical stafand Partnership members.~~

~~This committee meets quarterly to align interdepartmental efforts promoting health equity through both member-facing and systemic interventions outlined in the C&L/QIHETP Work plan (see figure below). As described in MCEP6002, the QIHEC is responsible for analyzing and evaluating the results of quality improvement and health equity activities including annual review of the results of performance measures, utilization data, consumer satisfaction surveys, and findings and activities of internal Partnership-specific committees.~~ This committee is also responsible for developing actions to address performance deficiencies and ensuring appropriate follow-up of identified performance deficiencies. ~~The QIHEC provides recommendations to the Quality/Utilization Advisory Committee (Q/UAC) (see policy MPQP1002). QIHEC also makes a good faith effort to recruit individuals representing the racial/ethnic, linguistic, gender identity that are represented in our 24 counties. Ideally, the committee is looking to include individuals representing such groups in our network – especially groups that constitute at least 5% of the population at a minimum. Annually, the Health Equity Officer reviews the composition of the committee and will work with committee members to make a good faith effort to meet such thresholds.~~ Furthermore, the QIHEC meets bi-

monthly to align interdepartmental efforts promoting health equity through both member-facing and systemic interventions outlined in the C&L/QIHETP Work plan (see figure below). Lastly, the QIHEC provides recommendations to the Quality/Utilization Advisory Committee (Q/UAC) (see policy MPQP1002). For more details on the QIHEC, refer to MCEP6002 Quality Improvement and Health Equity Committee (QIHEC).



- The QIHEC provides recommendations to the Quality/Utilization Advisory Committee (Q/UAC) (see policy MPQP1002). Review and develop equity-focused interventions intended to address disparities in the utilization and outcomes of physical and behavioral health care services. This is done by engaging with a member and using a family-centric approach

- Review activities and identify opportunities to improve health equity throughout Partnership, with oversight and participation of the governing Board of Commissioners and the QIHEC.

- Promote participation from a broad range of network providers, including but not limited to hospitals, clinics, county partners, physicians, community health workers, and other non-clinical providers for QIHETP development and performance reviews.

- ~~Review health equity-related training activities and validate that the trainings review the impact of structural and institutional racism, and health inequities on members, staff, subcontractors, and downstream subcontractors per DHCS's published DEI training All Provider Letters (APLs).~~

Community Engagement

Partnership's ~~Consumer~~ Community Advisory Committee (CAC) and Whole Child Model Family Advisory Committee (FAC) serves as a linkage between Partnership and the community (see attachment MCND9002-E CAC Guiding Principles and ~~attachment MCND9002-F FAC Charter for additional details~~Policy MCCP2024 for more details on these committees). The CAC and FAC consists of culturally and linguistically diverse Partnership members and community advocates. The advisory committee seeks to include individuals representing the racial/ethnic and linguistic groups that constitute at least 5% of the population at a minimum. When possible, Partnership works to include Seniors and Persons with Disabilities (SPD) (including representatives who receive LTSS and/or individuals representing LTSS recipients), persons with chronic conditions, Limited English Proficient (LEP) Members, adolescents and/or parents and/or caregivers of children, including current and/or former foster youth and Members from diverse cultural and ethnic backgrounds or their representatives, to participate in establishing public policy.

One role of the CAC and FAC is to advise Partnership on the development and implementation of its C&L services program. The CAC and FAC also work to identify and help prioritize opportunities for improvement. The CAC can also provide input and advice, including, but not limited to, the following:

- Culturally and linguistically appropriate service or program design, including culturally and linguistically appropriate health education;
- Priorities for health education and outreach program;
- Member satisfaction survey results;
- Plan marketing materials and campaigns.
- Communication of needs for Network development and assessment;
- Community resources and information;
- Population Health Management (including wellness and prevention strategies) and Quality Interventions;
- Health Delivery Systems Reforms to improve health outcomes;
- Carved Out Services;
- Coordination of Care;
- Health Equity;
- Accessibility of Services; ~~;~~
- Development of covered, Non-Specialty Mental Health Services (NSMHS) outreach and education plan;
- Input on Quality Improvement and Health Equity and the Population Needs Assessment;
- Health related initiatives;

- Reforms to improve health outcomes, accessibility, and coordination of care for Members; and
- Inform the development of the MCP's Provider Manual.
- Resource allocation; and
- Other community-based initiatives

To learn more about the CAC, please refer to MCND9002 attachment E CAC Guiding Principles.

Delegate/Vendor Audits

In alignment with DHCS requirements, Partnership delegates some C&L services to subcontractors, including interpreter services, translator services and the coordination of auxiliary aids and services in a culturally and linguistically ~~and linguistically~~ appropriate way. A formal agreement is maintained and inclusive of all delegate functions. Partnership's Health Education unit conducts an audit no less than annually on these delegated bodies. This audit helps to ensure that delegates have appropriate policies and procedures in place to meet compliance with state and federal language and communication assistance requirements as well as civil rights laws requiring access to members with disabilities and other C&L service requirements. The annual audits also help to ensure Subcontractors and Downstream Subcontractors deliver culturally and linguistically competent care, including offering interpreter services when a Limited English Proficient (LEP) Member accesses a Provider who does not speak the Member's language. Any unmet requirements result in the delegate receiving preliminary CAPs. Any preliminary CAPs that were not closed within the timeframe given by the Audit team are deemed final CAPs. Any final CAPs will go to Delegation Oversight Review Sub-committee (DORS) for additional review and direction, even if the delegate submits appropriate documentation before the DORS meeting.

Partnership acknowledges the type of relationship described above is known to the National Committee for Quality Assurance (NCQA) as a vendor relationship. Partnership has no known entities acting upon its behalf that would constitute a delegate as defined by the NCQA Health Equity Accreditation standards.

Goals and Work Plan

Partnership has measurable, culturally and linguistically appropriate goals for the improvement of CLAS standards and for the reduction of health care inequities that are presented annually in the C&L/QIHETPP~~T~~C ~~/C&L~~ Work Plan. ~~Partnership has an~~This annual work plan ~~that~~ describe~~d~~ the planned work for the coming year, along with the strategy and rubrics for monitoring against the measurable goals for the improvement of

CLAS and reduction of health care inequities; this annual plan is approved by various committees, including:

- The Quality Improvement and Health Equity Committee (QIHEC)~~, and~~
- The Internal Quality Improvement (IQI) Committee
- The Quality Utilization Advisory Committee (Q/UAC)
- The Physician's Advisory Committee (PAC) as final approval~~.~~

Partnership communicates its progress in implementing and sustaining CLAS standards by way of the C&L work plan to all stakeholders, and constituents as appropriate~~, and the general public~~.

~~2024-~~2025 Goals

Partnership identified multiple goals for ~~2024-~~2025. ~~Goals 1-5~~Several goals will carry over from 2024 to track trends from year to year; goals 1-2 and 6-~~8~~10 are new goals. Goals carried over from 2024 were modified based on findings of the Cultural and Linguistic Program Evaluation. These goals are listed below. Additional goal details can found in the C&L/QIHETP Work Plan:

- Goal 1: By June 30, 2025 develop and propose a multi-year health equity strategic and tactical plan ~~By August 31, 2024, define the framework and processes by which the QIHETP Program Description, C&L/QIHETP Work Plan, and QIHETP Evaluation will be initiated in 2024 and maintained through approval of corresponding 2025 versions needed for HEA Initial Survey in June 2025~~.
    - This goal was chosen to strategize and streamline ~~required~~the required initiatives to advance Health Equity.
- Goal 2: By December 31, 2025 Distribute the DEI training to the provider network and MCP staff and submit the final version to DHCS ~~By September 30, 2024, submit DEI training to DHCS for review to fulfill Phase I APL-23-025 deliverables~~.
    - This goal was chosen due in part to new regulatory requirements around DEI trainings and to ensure all member facing individuals are equipped to provide appropriate care.
- Goal 3: By December 31, 2025, 91% of members who have requested materials in an alternative~~e~~ format will be mailed in their preferred format. ~~By December 31, 2024, 90% of members requesting an alternate format will receive at least one mailing in their preferred format.~~
    - This goal was chosen to ensure members receive information in a way that they can understand.
- Goal 4: ~~By December 31, 2024, increase the number of bilingual Member Service Representative (MSR) staff hired by 1% to move closer to organizational~~

~~goal of 75% of bilingual MSR staff~~ By December 31, 2025, increase the number of bilingual Member Service Representative (MSR) staff hired by 2% to move closer to organizational goal of 75% of bilingual MSR staff.

- This goal was chosen to align with an existing organizational goal to have 75% of the Member Services staff possess bilingual skills.

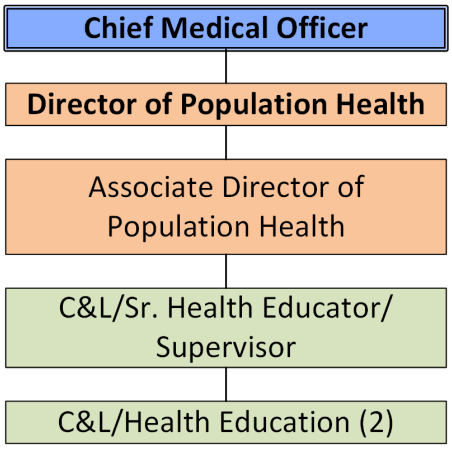
- Goal 5: ~~By December 31, 2024, improve controlled blood pressure rate among American Indian/Alaska Native members by 5%n at least one region~~ By December 31, 2025, improve controlled blood pressure rates among American Indian/Alaska Native members by 5% in at least two regions.
  - This goal was chosen due in part to the fact that American Indian/Alaska Native members are a current Population of Focus at Partnership.
- Goal 6: By December 2025, improve the rate of timely translations in the Utilization Management and/or Care Coordination department to achieve the threshold of at least 90%.
  - Goal 6 was chosen due to the recognized need for quality translation services and an overall positive member experience.
- Goal 7: By December 31, 2025, improve timely prenatal visit rates by at least 5% in the American Indian/Alaska Native Member Population within 12 months, in the Eureka region (Del Norte, Humboldt, Lake, and Mendocino), or Redding region (Lassen, Modoc, Shasta, Siskiyou, Tehama, and Trinity), with the global goal of improvement by 22% in the next 5 years.~~By December 31, 2025, improve prenatal visits by at least 5% in the NE or NW region in the American Indian/Alaska Native Member Population within 12 months with the global goal of improvement by 22% in the next 5 years.~~
- Goal 8: By December 31, 2025, improve Well Care Visits rate among Black, White, and/or American Indian/Alaska native members by 5% overall or ~~in~~ at least 1.25% in at least one region.
  - Goals 7 and 8 were chosen due to the recognized disparities in each goal's respective clinical measure and population of focus.

Partnership will continue to monitor these goals through the annual C&L Work Plan to ensure the goals are met. Progress toward these~~is~~ goals will be reviewed on a quarterly basis. Progress toward this goal will be also be reviewed no less than annually by the committees described above.

Population Health Department Structure

Population Health operations are supported by a leadership team and administrative staff that recruits, promotes, and supports a culturally and linguistically diverse structural and organizational environment that is responsive to Partnership members.

Partnership's Population Health department is responsible for developing, maintaining, and overseeing implementation of Partnership's overall PHM strategy (MCND9001), and identifying the health disparities, wellness needs, and health education needs of Partnership's members. These efforts are also supported by other Partnership departments, and include making referrals to culturally and linguistically appropriate community service ~~programs, and~~programs and aligning organizational and community efforts to meet these needs, in accordance with DHCS and NCQA requirements. ~~In order to~~To accomplish these objectives, Population Health departmental resources are leveraged to engage internal stakeholders, external stakeholders, and members aligning existing projects and efforts to promote health equity for Partnership's population, including the provision of cultural and linguistic services. Population Health department staff are allocated to develop and share member education materials, ensure all member subpopulations have resources specific to their needs, identify and refer to culturally and linguistically appropriate community service programs when available, engage with the community, educate community partners on Partnership programs and interventions, learn about resources available within communities, and promote collaboration of effort and reduce duplication of services.



Team Roles and Responsibilities

Chief Medical Officer:

As the principal manager of medical care, the Chief Medical Officer is responsible for the appropriateness and quality of medical care delivered through Partnership HealthPlan of California (Partnership) and for the cost-effectiveness of the utilization of services. This position provides overall direction to multiple departments, including the Population Health Management Team and has the ultimate responsibility of ensuring that departmental programs and services are consistent and meet all regulatory requirements in every office location. Required education includes an MD/DO degree from an accredited program preferably in a primary care specialty required; minimum

two (2) years' experience in a managed care plan preferred with duties comparable to those listed above, and experience administering medical programs. This role also requires board certification in a specialty and a minimum of seven (7) years clinical/medical practice experience.

Director of Population Health

The Director of Population Health Provides oversight of Population Health strategy, programs and services to improve the health of Partnership members. Reports to the Chief Medical Officer. Works with the Senior Director of Quality and Performance Improvement and other department leaders to meet organization and department goals and objectives while developing and tracking the measurable outcomes of department services. This professional must have training in Public Health and Population Health processes. This role also requires at least five (5) years of experience in a leadership/management role.

Associate Director of Population Health

Assists the Director of Population Health in the development, implementation and evaluation of Partnership's population health interventions and program oversight. The Associate Director oversees the Managers of Population Health and the operational workings of the Population Health department. The Associate Director reviews and submits issues, updates, recommendations, and information to the HS Leadership when appropriate. Ensures ongoing audit readiness for Population Health deliverables. This professional must have a Bachelor's degree, an RN license is preferred, with a minimum of five (5) years health care operations experience and three (3) years in a management role.

Supervisor

Provides supervisory oversight during daily department operations for assigned team members through sustained leadership and support. Using best expertise and sound judgment (and in consultation with clinical leaders, providers, and staff), provides daily oversight, leadership, support, training, and direction of Population Health staff.

Supports and assists ~~the Manager and other~~Population Health Management leadership and other Supervisors in developing and maintaining a cohesive team with a high level of productivity and accuracy to achieve the department's overall performance metrics. Required education includes a Bachelor's degree in Business, Communication, Healthcare Administration, a related field, or 3-5 years of managed care experience, or equivalent combination of education and experience.

Senior Health Educator

A public health masters-prepared (or MCHES-certified) professional who ensures the delivery of approved health education and member informing resources for both members and primary care providers. Develops ~~trainings~~ materials for ~~contracted providers, internal Partnership staff,~~ Partnership members, and community members as appropriate ~~and~~ to promote cultural competency, health equity, and member wellness. Monitors and oversees all regulatory requirements related to Health Education, Cultural & Linguistics programs. The Senior Health Educator may also perform supervisor responsibilities.

Health Educator(s)

Trained and competent to actively participate in the design and implementation of the Health Education Program. Assesses the health education needs of internal staff, leads on specific member education projects, and monitors health education materials, and evaluates member grievances. Serves as a resource to internal staff and providers to ensure compliance with state requirements for educational member materials. Required education includes a Bachelor's Degree in Health Education, Public Health, Community Health or related field; experience in Public Health Education. A minimum two (2) years of health education experience is preferred.

Cultural & Linguistic Program Description Approval

	03/19/2025

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

	04/09/2025

Steve Gwiazdowski, M.D. — *Date Approved*
Physician Advisory Committee Chairperson

	06/25/2025

Kim Tangermann — *Date Approved*
Board of Commissioners Chairperson

Criteria and Authorization Requirements for Interpreting Services

Telephonic or Video Remote Interpreter Services

a. Member or patient (non-member) is being seen at a PHC contracted provider site.
b. Member or patient does not have other health coverage (OHC) that covers the requested/required interpreting service.
c. Telephonic or Video Remote Interpreter Services do not require prior authorization through PHC's Member Services.

Sign Language Interpreters

a. Member is enrolled in PHC at the point the service is required.
b. Member does not have OHC that is primary to PHC, that covers the requested/required interpreting service.
c. Appointment is for a service that is covered by PHC.
d. Member has hearing and/or speech impairment.
e. Sign Language Interpretation services require prior authorization through PHC's Member Services department. Requests can be made by calling Member Services in advance at (800) 863-4155.

Face-to-Face Interpreter Services

a. Member is enrolled in PHC at the point the service is required.
b. Member does not have OHC that is primary to PHC, that covers the requested/required interpreting service.
c. The appointment is for a service that is covered by PHC.
f. Face-to-face interpretation services require prior authorization through PHC's Member Services department. Requests can be made by calling Member Services in advance at (800) 863-4155.
d. Behavioral Health Treatment (BHT) services for members under 21 years of age, such as evaluations and Applied Behavior Analysis, in a therapeutic and/or home setting are a PHC benefit and fall under PHC responsibility to arrange and schedule face-to-face interpreter services.
e. If face-to-face interpreter services are being requested at a hospital, PHC staff contacts the Patient Services department at the hospital for these services. If the hospital refuses to provide these services, PHC arranges the service. The Provider Relations department is notified of the hospital's refusal to provide service.
f. If face-to-face interpreter services are being requested for PHC Medi-Cal covered mental health services, the caller is referred to Carelon Behavioral Health (formerly Beacon Health Options) at (855) 765-9703. Carelon is responsible to provide face-to-face interpreting services. Members are advised to contact Carelon three (3) business days in advance of their appointment to arrange the service.

Providing Auxiliary Aids and Services for Persons with Disabilities

1. Identification and Assessment of Need:
    a. PHC provides notice of the availability of and procedure for requesting auxiliary aids and services through our language assistance taglines and non-discrimination notices.
    b. When a member, their authorized representative (AR), or someone with whom it is appropriate for PHC to communicate (hereafter called "companion") identifies as having a disability affecting the ability to communicate, access, or manipulate written materials, or requests an auxiliary aid or service:
        i. The member/AR/companion can fill out and submit PHC's Auxiliary Aid Request Form
            1. PHC staff will notate this request and reach out to the member/AR/companion to determine what aids or services are necessary to provide effective communication, based on their identified disability.
        ii. The member/AR/companion can tell PHC staff over the phone about their auxiliary aids or services request.
            1. PHC staff will notate this request at time of call.
            2. PHC staff will then work with the member/AR to determine what aids or services are necessary to provide effective communication based on their identified disability.

2. Provision of Auxiliary Aids and Services:
    a. PHC staff will determine and provide the appropriate aid and/or service necessary for members/ARs/companions with impaired sensory, manual, or speaking skills in a timely manner. MCND9002 lists the auxiliary aids and services PHC provides.

Threshold and Concentration Languages For All Counties as of March 2024

COUNTY/# of Languages that meet T/CS (Inc. English)	Arabic	Armenian	Cambodian	Chinese*	English	Farsi	Hindi**	Hmong	Japanese**	Korean	Laotian**	Mien**	Punjabi**	Russian	Spanish	Tagalog	Thai**	Vietnamese
Alameda (5)	N	N	N	Y	Y	Y	N	N	N	N	N	N	N	N	Y	N	N	Y
Alpine (1)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N
Amador (1)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N
Butte (2)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N
Calaveras (1)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N
Colusa (2)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N
Contra Costa (3)	N	N	N	Y	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N
Del Norte (1)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N
El Dorado (2)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N
Fresno (3)	N	N	N	N	Y	N	N	Y	N	N	N	N	N	N	Y	N	N	N
Glenn (2)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N
Humboldt (2)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N
Imperial (2)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N
Inyo (2)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N
Kern (2)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N
Kings (2)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N
Lake (2)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N
Lassen (1)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N
Los Angeles (11)	Y	Y	Y	Y	Y	Y	N	N	N	Y	N	N	N	Y	Y	Y	N	Y
Madera (2)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N
Marin (2)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N
Mariposa (1)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N
Mendocino (2)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N
Merced (3)	N	N	N	N	Y	N	N	Y2	N	N	N	N	N	N	Y	N	N	N
Modoc (2)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N
Mono (2)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N
Monterey (2)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N
Napa (2)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N
Nevada (2)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N
Orange (8)	Y	N	N	Y	Y	Y	N	N	N	Y	N	N	N	Y	Y	N	N	Y
Placer (3)	N	N	N	N	Y	N	N	N	N	N	N	N	N	Y	Y	N	N	N
Plumas (1)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N

Riverside (3)	N	N	N	Y	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N
Sacramento (8)	Y	N	N	Y	Y	Y	N	Y	N	N	N	N	N	Y	Y	N	N	Y
San Benito (2)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N
San Bernardino (4)	N	N	N	Y	Y	N	N	N	N	N	N	N	N	N	Y	N	N	Y
San Diego (8)	Y	N	N	Y	Y	Y	N	N	N	N	N	N	N	Y	Y	Y	N	Y
San Francisco (5)	N	N	N	Y	Y	N	N	N	N	N	N	N	N	Y	Y	N	N	Y
San Joaquin (4)	N	N	Y2	N	Y	N	N	N	N	N	N	N	N	N	Y	N	N	Y2
San Luis Obispo (2)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N
San Mateo (4)	N	N	N	Y	Y	N	N	N	N	N	N	N	N	N	Y	Y2	N	N
Santa Barbara (2)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N
Santa Clara (7)	N	N	N	Y	Y	Y	N	N	N	N	N	N	N	Y	Y	Y	N	Y
Santa Cruz (2)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N
Shasta (1)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N
Sierra (2)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N
Siskiyou (1)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N
Solano (3)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	Y2	N	N
Sonoma (2)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N
Stanislaus (3)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N
Sutter (3)	N	N	N	N	Y	N	N	N	N	N	N	N	Y	N	Y	N	N	N
Tehama (2)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N
Trinity (1)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N
Tulare (2)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N
Tuolumne (1)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N
Ventura (2)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N
Yolo (3)	N	N	N	N	Y	N	N	N	N	N	N	N	N	Y2	Y	N	N	N
Yuba (2)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N

Notes:

*Chinese is the combination of Cantonese, Mandarin, and Other Chinese Language. Where Chinese has been identified as a threshold or concentration language and the Member has requested to receive translated written information in either traditional or simplified Chinese characters, the MCP must provide written information in the Member's preferred characters. However, if the Member has not indicated a preference for simplified or traditional Chinese characters, and the MCP does not yet have a process in place to provide written translations in Chinese, the MCP must provide translations in Simplified Chinese characters. Only upon Member request will the MCP be required to provide translated written information in traditional Chinese characters.

**Hindi, Japanese, Laotian, Mien, Punjabi, Thai, and Ukranian are new languages added per APL-21-004. As of March 2024 data, there are no new languages added, nor data available for Ukranian language.

1) Threshold Standard Languages (**Y**) ≥ 3,000 per language or ≥ 5% of the Medi-Cal Population that speak the language per county.

2) Concentration Languages (**Y2**) ≥ 1,000 per zip code or ≥ 1,500 per two contiguous counties. Hmong in Merced county, Cambodian and Vietnamese in San Joaquin county, Tagalog in San Mateo county, Tagalog in Solano county, and Russian in Yolo county.

UNITED LANGUAGE GROUP®

United Language Group: Quality and Culturally and Linguistically Appropriate Translation Services

September 27, 2023

UNITED LANGUAGE GROUP

ULG: Written Translation Quality Processes and Overview

United Language Group has nearly four decades of experience providing qualified written translation and localization services for the U.S. healthcare, health insurance and medical industries in over 235 languages. We approach language access with evidence-based solutions, proactive measures and culturally-sensitive communication to ensure equitable, meaningful access for all diverse communities and populations

From health education and vital documents to member outreach and enrollment materials, ULG delivers high service standards with every translation project, delivering language translation with quality, service and speed. Our ISO-certified quality assurance processes, rigorous linguist assessment and qualification requirements, and metric-driven reporting ensure that all translated materials meet the high level of accuracy that is required while still resonating on a cultural level.

1. **Translator Qualifications and Language Proficiency Assessments**

   ULG has adopted a rigorous screening and training process to assess, evaluate, and qualify our healthcare translators. All translators must be native speakers of the language into which they translate, and most average ten or more years of experience in most languages, hold language certification and/or advanced degrees, and all must pass a variety of tests and questionnaires to measure each applicant's language skill and proficiency in source and target languages, as well as healthcare terminology and cultural appropriateness. The results, combined with the applicant's background and experience, indicate whether a linguist is skilled and proficient enough to work with ULG. We further continue this with training, rating, and assigning the most appropriate translators to work on any given project. Please see below for requirements for our translators in our linguist qualification policy:

   - Must pass a rigorous translation test for accuracy and regional nuance.
   - Most hold a verifiable language certification and at least one advanced degree from a recognized university. Additional degree(s) in industry subject matter are preferred and prioritized
   - Must be a native and primary speaker of their target language(s).
   - Must have >5 years of professional translations experience. >10 years is preferred and prioritized.
   - Must provide 3+ contactable references from clients and samples of previous work to be assessed.
   - Ongoing assessment: In addition to these entry criteria, ULG linguists are continuously assessed at the project level as part of the QA step.

   Additionally, ULG looks to ensure the following:

   - ATA Accreditation: Many of our translators are certified by the American Translators Association (ATA). However, ATA certification is not available in many of the language pairs of the U.S. LEP populations. Due to our high standards of linguist proficiency requirements, we rely on our multi-step qualification process and translator's background, assessment results, education and references to determine their skill level.
   - Technical capabilities: We require translators have appropriate electronic tools, working

knowledge of translation memory, automated term lists and other software programs.

- Onboarding: Once a translator is qualified and approved through the recruitment and qualification process mentioned above, an on-boarding process is in place that includes contract signing, confidentiality agreements, portal training and customer-specific training as well as process and policy review.
- Ongoing monitoring: Work completed by our active translators undergoes our internal quality assessment audits on a regular sample of translation projects. All linguists must maintain high quality scores on these audits to continue working with us.

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2. Metrics and KPI's For Consistent Service Delivery

ULG's Quality/Information Security Management System (QMS/ISMS) guides our policies, principles, processes and procedures which describe how ULG manages organizational goals, meets applicable customer and regulatory requirements and complies with our ISO certifications (see attached)

Our quality process enables us to optimize our services and deliver consistent quality, and timely language services. This approach also facilitates achieving consistent results by measuring KPI's such as turnaround time, accuracy and more, thereby helping to ensure timely, accurate and reliable translations that meet client requirements. Metrics and KPIs tracked include:

- On-time deliveries: ULG maintains a 99% on-time delivery (OTD) rating. On-time delivery is automatically tracked through our secure portal and Translation Management System. ULG translation services and timelines are aligned to meet customer-specific or product-specific timelines, such as rapid-turn Grievance and Appeals, annual enrollment materials, and more.
- Translation Quality: Measuring translation quality is vital to understanding and evaluating final deliverables. Regular quality-level audits help to identify any potential issues with processes/resources and allow us to identify trends that require immediate corrective action.
- Customer Satisfaction: Gathering feedback directly from our clients allows us to identify potential issues which are not visible/identifiable from other reports/KPIs. As well, it indicates where improvements and innovations may be needed.
- TM leveraging analysis: By analyzing TM (translation memory) we identify content trends and savings to maximize the TM leveraging.
- Utilization: Comparing translation volumes against utilization numbers is a great way to identify ULG's capacity for scalability planning for account growth and managing volume projects.

3. Language Quality Control and Quality Assessment Process

Language quality control is at the heart of ULG's ability to help ensure accurate, effective and culturally appropriate translations. Our documented quality-driven policies, procedures, evaluation

standards, and multi-step translation processes, help ensure consistently high quality for every translation in every language.

ULG knows the importance of ensuring linguistic accuracy, readability, and cultural appropriateness in written translations. Our teams take special care to ensure cultural nuance and appropriate literacy levels are applied to each delivery. We also follow industry-leading best practices from healthcare-focused institutes such as Centers for Medicare & Medicaid Services, Department of Health and Human Services, American Medical Association and more. Some examples include:

- Utilizing qualified, subject-matter professional translators who have the appropriate cultural knowledge, translation and writing skills needed to for high-quality, culturally appropriate translations.
- A requirement for using multiple, separate and qualified professionals listed above for every translation.
- Providing linguists with training, reference/ background information, target audience insight, and any specific requirements to better result in a translation that resonates with the intended recipient.
- Ensuring translations preserve the content and meaning of the original text, easy to understand, and translated with cultural and linguistic sensitivity as needed.
- Multiple QA steps to ensure translated text is reviewed for accuracy, cultural and linguistic appropriateness, and literacy level consistency.

Quality Control is measured across the process. Separate, experienced, native-speaking linguists translate, edit and proofread each translation as well as perform an auto check to ensure content matches any approved term lists/glossaries. Separate, qualified proofreaders are utilized with every language pair and service we offer. Proofreaders check for any errors in the grammar, syntax, punctuation, sentence structure and more. They also can check to ensure that the translated text is contextually correct and culturally appropriate. Translated and formatted documents can also go through an additional multi-step Third-Party Quality Assurance (QA) process that includes tasks such as checking sizing and placement of text or headers/footers, text and graphic formatting, function of hyperlinks, updating/ formatting of tables of contents and indices, formatting/placement of bullets and margins and column and page breaks. Quality e assurance representative sign off on the process once complete and is saved for tracking purposes.

Leslie Iburg

Leslie Iburg
Director of Healthcare Accounts
United Language Group,
September 27, 2023

Certificate of Registration

This certifies that the Information Security Management System of

United Language Group, Inc.

1550 Utica Avenue
Suite 420
Minneapolis, Minnesota, 55416, United States

has been assessed by NSF-ISR and found to be in conformance to the following standard(s):

ISO 27001:2013

Scope of Certification:

The ULG Information Security Management System will provide the framework of processes and best practices for the protection of client and employee information and the management of risk to information security in accordance with the Statement of Applicability version 7.0 27th Jan 2020

Statement of Applicability (SOA): January 27, 2020 V 7.0

Sameer Vachani
Senior Director, NSF-ISR

Certificate Number:	C0748976-IM3
Certificate Decision Date:	17-MAR-2023
Certificate Issue Date:	24-MAR-2023
Cycle Effective Date:	11-APR-2023
Certificate Expiration Date*:	10-APR-2026

Issued by:
NSF International Strategic Registrations (NSF-ISR)
789 N. Dixboro Road, Ann Arbor, MI 48105 USA

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ANAB ANSI National Accreditation Board ACCREDITED ISO/IEC 17021-1 MANAGEMENT SYSTEMS CERTIFICATION BODY

MEMBER OF MULTILATERAL RECOGNITION ARRANGEMENT IAF

Certificate of Registration

ANNEX PAGE FOR CERTIFICATE NUMBER: C0748976-IM3

This Annex is only Valid in connection with the above-mentioned certificate issued by NSF-ISR

CERTIFICATE ISSUE DATE:
24-MAR-2023
CERTIFICATE EXPIRATION DATE:
10-APR-2026

United Language Group, Inc.
1550 Utica Avenue
Suite 420
Minneapolis, Minnesota, 55416, United States

Location:	Scope:
United Language Group, Inc. - 67852 Unit 27 Glenrock Business Park Ballybane, Galway, H91 AE12, Ireland	The ULG Information Security Management System will provide the framework of processes and best practices for the protection of client and employee information and the management of risk to information security in accordance with the Statement of Applicability version 7.0 27th Jan 2020
Location:	**Scope:**
United Language Group, Inc.- C0359514 Office No. 713- 714, Neelkanth Corporate IT Park Neelkanth Corporate IT Park Kirol Road, Vidyavihar (West) Mumbai, 400086, India	The ULG Information Security Management System will provide the framework of processes and best practices for the protection of client and employee information and the management of risk to information security in accordance with the Statement of Applicability version 7.0 27th Jan 2020

Issued by:
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MEMBER OF MULTILATERAL RECOGNITION ARRANGEMENT IAF

Community Advisory Committee
Guiding Principles

I. Purpose & Overview

The purpose of the Community Advisory Committee (CAC) is to act as a liaison between Partnership HealthPlan of California (Partnership) and our members. The CAC provides Partnership members with a forum to discuss common issues of interest and importance, while creating a supportive and informative environment. Partnership's CAC is primarily composed of members, advocates, and stakeholders. The CAC may also include participation from select providers within the service area. Partnership values the input received through the CAC and considers the feedback during annual reviews and policy/procedural updates that affect quality and Health Equity. Additionally, Partnership provides relevant updates to the CAC on how their input is incorporated.

The CAC also advocates for Partnership members by ensuring that the health plan is responsive to the diversity of health care needs of all members. Partnership will make a good faith effort to ensure that CAC members feel supported in their role and may provide resources to help educate CAC members so they can effectively participate in CAC meetings.

The CAC is responsible for and shall carry out the duties listed below:

- Identifying and advocating for preventative care practices utilized by Partnership
- Participate in the development and updating of cultural and linguistic policy and procedure decisions related to quality improvement, member education, and operational and cultural competency issues that may affect groups who speak a primary language other than English
- Provide input on necessary member/provider targeted services, programs, and trainings
- Make recommendations regarding the cultural appropriateness of communications, partnerships, and/or services
- Review Population Needs Assessment findings and discuss improvement opportunities related to Health Equity and Social Drivers of Health
- Identify member concerns that may influence Partnership policies and practices
- Ensure that the concerns of members of all cultures are respected and addressed, including members that speak a primary language other than English
- Serve as advocates for members of Partnership, promote self-advocacy, and cultural competency, thereby improving health outcomes
- Review and provide input regarding Member Rights and Responsibilities and other member materials
- Annually review grievance and appeal data

Community Advisory Committee Guiding Principles

- Review and make recommendations regarding Member Services' Quality Improvement activities, including but not limited to the Member Satisfaction Survey results
- Provide feedback and input on Partnership's health education and community focused activities

To manage the operations of this committee, Partnership has a designated CAC Facilitator and Coordinator. The CAC Coordinator, in partnership with the Facilitator is responsible for managing the operations of the CAC. Together, they ensure compliance with all statutory, rule, and DHCS contractual requirements.

These Guiding Principles, may be updated or amended as needed to comply with regulatory or accreditation body requirements, or as proposed by CAC members and/or Partnership staff.

II. Membership

Member Selection

All Partnership members are eligible to become a CAC member if seats are available by completing a CAC application and meeting the requirements below:

- They are an eligible Partnership member, legal parent of a minor (under age 18), or a legal guardian or conservator of an eligible Partnership member
- Will regularly attend and actively participate in meetings

Partnership's CAC Selection Committee is tasked with selecting and appointing all CAC members. The purpose of the CAC Selection Committee is to ensure that the committee is composed of representatives that bring different perspectives, ideas, and views to the committee. These representatives may reflect Partnership's population and serve the following:

- Members of hard-to-reach populations
- Members of diverse racial and ethnic backgrounds, genders, gender identity, sexual orientation, physical disabilities, age backgrounds (including parents/caregivers of adolescents/foster youth), IHS Provider representatives)
- Limited English Proficient (LEP) Members

Community Advisory Committee
Guiding Principles

Partnership conducts an annual review to ensure that CAC membership is representative of its membership base. Partnership may modify the CAC membership base to reflect changes in member demographics.

Each county within Partnership's service area is allocated a set amount of CAC seats available to members. To determine this allocation, Partnership established a ratio based on the number of Partnership Board of Commissioner seats that each county holds. The ratio selected for each county is defined as 1.5 times the number of Partnership Board of Commissioner seats per county.

The CAC Selection Committee will ensure that all CAC members are selected by June 29, 2024.

Member Responsibilities

- Regularly attend scheduled meetings
- Arrive in a timely manner
- Participate in CAC meetings
- Provide opinions and feedback to improve Partnership services
- Provide updated contact information to the CAC Facilitator and/or Coordinator for the purpose of meeting notices
- Notify the CAC Facilitator and/or Coordinator in advance if you cannot attend a meeting

Membership Term

CAC members may serve for a term of up to four (4) years. At the end of the four (4) year term, CAC members may continue their role as long as there is not a replacement CAC member available.

A CAC member who is absent for three (3) consecutive CAC meetings shall lose voting privileges at the subsequent meeting and will forfeit their membership. The individual may reapply for a seat on the CAC.

CAC members may lose their membership seat and privileges by a quorum of the CAC. CAC members may terminate their position at any time by resigning. The member may resign by calling, emailing, or sending a letter to the CAC Facilitator and/or Coordinator. The CAC Selection Committee

Community Advisory Committee
Guiding Principles

will make a good faith effort to replace any vacant seats due to member resignation (voluntary or involuntary) within 60 calendar days.

Compensation

A CAC member may receive a stipend for travel and childcare expenses that allows them to attend CAC meetings during their membership term. No CAC member shall receive any profit from the operations of Partnership. This provision shall not prevent reasonable compensation to a CAC member for services performed for Partnership, if such compensation is not in conflict with Partnership policies or procedures, is permitted by these Guiding Principles, and is approved by the Chief Executive Officer of Partnership.

Member Demographic Report

Partnership prepares an annual Member Demographic Report that highlights the composition of the CAC. The Member Demographic Report is submitted to DHCS no later than April 1 of each calendar year. Partnership strives to ensure that the CAC is representative of Partnerships' member demographic. The CAC Member Demographic Report will also identify the following:

- Description of the CAC's ongoing role and impact in decision-making about Health Equity, health-related initiatives, cultural and linguistic services, resource allocation, and other community-based initiatives, including examples of how CAC input impacted and shaped Contractor initiatives and/or policies
- Barriers/challenges in meeting or increasing alignment between CAC's membership with the demographics of the members within Partnership's service area
- Ongoing, updated, and new efforts and strategies undertaken in CAC membership recruitment to address the barriers and challenges to achieving alignment between CAC membership with the demographics of the members within Partnership's service area

Board of Commissioners

The CAC reports directly to Partnership's Board of Commissioners. A community representative from Partnership's Northern and Southern Regions will be selected every two years to represent the CAC on the Board of Commissioners. Selection will then rotate from region to region within the larger region.

Community Advisory Committee Guiding Principles

Department of Healthcare Services (DHCS) Statewide Community Advisory Committee
The CAC shall select and appoint one member of the CAC, or another Partnership member, to serve as the Partnership representative to the DHCS' Statewide Community Advisory Committee. Partnership shall compensate the representative for time and participation within the Statewide CAC, including transportation expenses to appear in-person.

Non-Liability of Members
CAC members shall not be personally liable for the debts, liabilities, or other obligations of Partnership.

III. Committee Meetings

Meeting Schedule
CAC meetings are held four times a year (quarterly) and at times and in formats, that foster and facilitate CAC member participation. The CAC meeting schedule is published at the beginning of each year and posted on Partnership's website. Partnership may conduct additional CAC meetings to discuss and take action on matters of urgency.

The principal offices of Partnership's CAC for the transactions of its business for all regions are located at the following meeting locations:

Address	County
4665 Business Center Drive, Fairfield, CA 94534	Solano
495 Tesconi Circle, Santa Rosa, CA 95401	Sonoma
3688 Avtech Parkway, Redding, CA 96002	Shasta
1036 5th St., Suite E, Eureka, CA 95501	Humboldt

CAC meetings are open to the public and we welcome and encourage attendance. Meetings may also be held at additional sites, which will be listed on the meeting notice. Meeting notices are posted in a centralized location on Partnership's website up to 30 days, and no later than 72 hours prior to the meeting. Video conferencing equipment is used when members from multiple locations participate.

Community Advisory Committee
Guiding Principles

Facilitation of Meetings

CAC meetings are conducted in compliance with the Ralph M. Brown Act. The CAC Facilitator(s) is responsible for the facilitation of all CAC meetings. The CAC Coordinator acts as secretary or may appoint a member/designee to act as secretary of the meeting, for the purpose of taking meeting minutes. Meeting minutes are posted on Partnership's website and distributed to members before the next quarterly meeting. Partnership will also submit meeting minutes to DHCS within 45 calendar days.

Quorum

For the purpose of the CAC, a quorum is defined as the minimum number of members in attendance required to conduct the business of the committee. The CAC quorum shall consist of at least ½ (one half) of the CAC membership seats held. Every act or decision done or made by a quorum is an act of the CAC as a whole.

CAC Records

Partnership shall maintain CAC records, for no less than 10 years. CAC records shall include the following:

- Minutes of all meetings of the CAC, indicating the time and place of holding such meetings, whether regular or special, and the names of those present
- A copy of the Guiding Principles and any modifications to date, which shall be open to inspection

Partnership HealthPlan of California's Whole Child Model Family Advisory Committee (FAC) Charter

Purpose:

The Whole Child Model FAC is a Member Advisory Group to the Chief Executive Officer (CEO) and staff of Partnership HealthPlan of California (Partnership), providing input, review and recommendations on policies and issues that affect children and their families served through the Whole Child Model (WCM) program.

The WCM FAC is intended to promote open communication between families with children who have special health care needs, health plan leadership, California Children's Services (CCS) agencies, and local family support providers. It serves as a mutual learning forum for committee members and health plan staff to make a positive difference in the care the health plan provides to CCS beneficiaries.

Authority and Responsibility:

SB 586 (Hernandez, 2016) established a WCM program, under which managed care plans served by a county organized health system or Regional Health Authority in designated counties would provide CCS services to Medi-Cal eligible CCS children and youth. This legislation also required each Medi-Cal managed care plan participating in the WCM program to establish a family advisory group for CCS families (WIC 14094.17(b)(1)).

The WCM FAC may make recommendations to the CEO, based on member and community input and feedback.

As this is an Advisory Committee to the CEO, the Brown Act does not apply.

Membership:

Membership status is reviewed and approved by a committee of Partnership leadership.

Membership includes:

- WCM CCS Member and/or family member – Family representatives from each DHC county (Butte, Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Nevada, Placer, Plumas, Shasta, Sierra, Siskiyou, Solano, Sonoma, Sutter, Tehama, Trinity, Yolo, and Yuba). Equal representation (two representatives) from each county is sought but not required.[1]
- Local Consumer Advocate – maximum of one (1) local consumer advocate representing CCS families.
- Local Providers - maximum of one (1) representative from each Partnership region, including CCS County staff, Parent Advocacy groups or CCS paneled

[1] Please note, if there are not enough CCS family members to fill both positions on the WCM FAC, Partnership will allow a county representative from that county to fill that position.

providers. This provider must be serving Partnership Members in Butte, Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Nevada, Placer, Plumas, Shasta, Sierra, Siskiyou, Solano, Sonoma, Sutter, Tehama, Trinity, Yolo, or Yuba County.

Committee Staff

- Partnership employees will serve as support staff to the WCM FAC.

Terms:
WCM CCS Member and/or family member will be appointed to a two-year term. At the end of the term the member may be reappointed to a subsequent two-year term.

Local Consumer Advocate will be appointed to a two -year term. At the end of the term this position will be open to other applicants in the region. If there is no other applicant the advocate may be reappointed to a subsequent term.

Local CCS County Representative will be appointed to a two -year term. At the end of the term, this position will be open to other applicants from other counties in the region. If there is no other applicant the county representative may be reappointed to a subsequent term.

FAC Chair and Vice Chair:

The FAC shall select a Chair and Vice Chair. The Chair and Vice Chair shall be a CCS Member or family representative selected by the voting members of the FAC.

The role of the Chair is to provide meeting facilitation and direct the meeting process through the agenda. The Chair will guide and lead discussion to ensure all participants are provided equal opportunity for participation.

The role of the Vice Chair is to preside at the meetings of the FAC in the absence of the Chair.
If both Chair and Vice Chair are absent, the WCM FAC members present will select one member to act as Chair for the meeting.

The FAC shall elect a Chair and Vice Chair for a two-year term.

Meetings:

The WCM FAC shall meet four (4) times per year (i.e., quarterly).

These meetings will be on the 3rd Tuesday of every third month. This time can be changed at any time by a vote of the Committee.

These meetings will be located at Partnership offices, and remotely. Partnership will provide technical support for remote meeting access. When feasible, meetings could be held at alternative locations with prior approval by the organizers.

Meeting Compensation:

Appointed Members are eligible to receive a stipend for meeting attendance.

Agendas, Minutes, Reports:

Partnership staff will work in collaboration with the Committee, to develop the agenda for each meeting.

Partnership staff are responsible for agenda and meeting material production and distribution.

Partnership staff will record minutes of meetings which will be approved by the FAC members at each subsequent meeting.

Review of Charter:

The FAC shall review this charter as needed. Any proposed changes shall be submitted to the CEO for approval.

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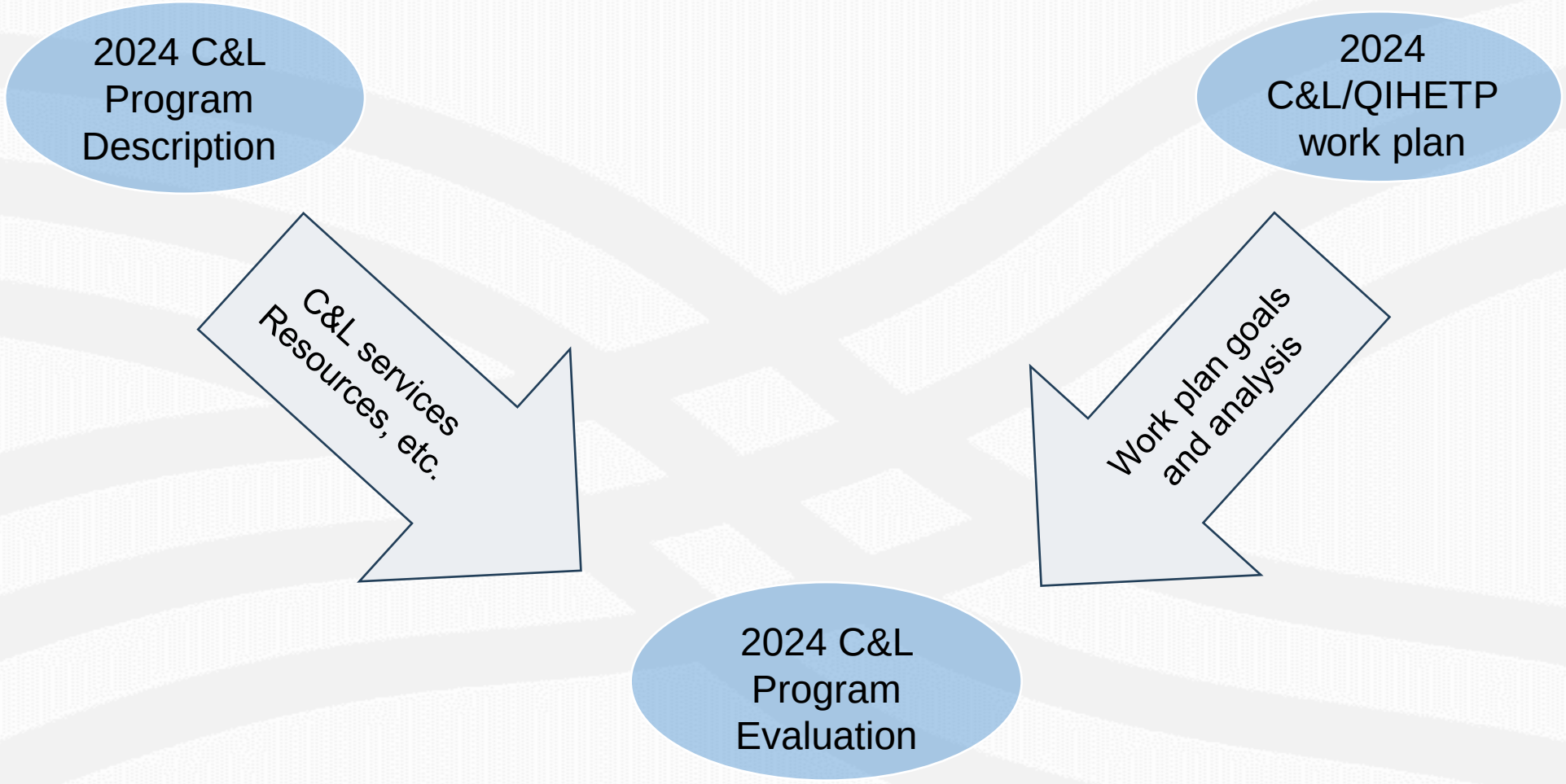
Cultural and Linguistic (C&L) Trilogy Presentation

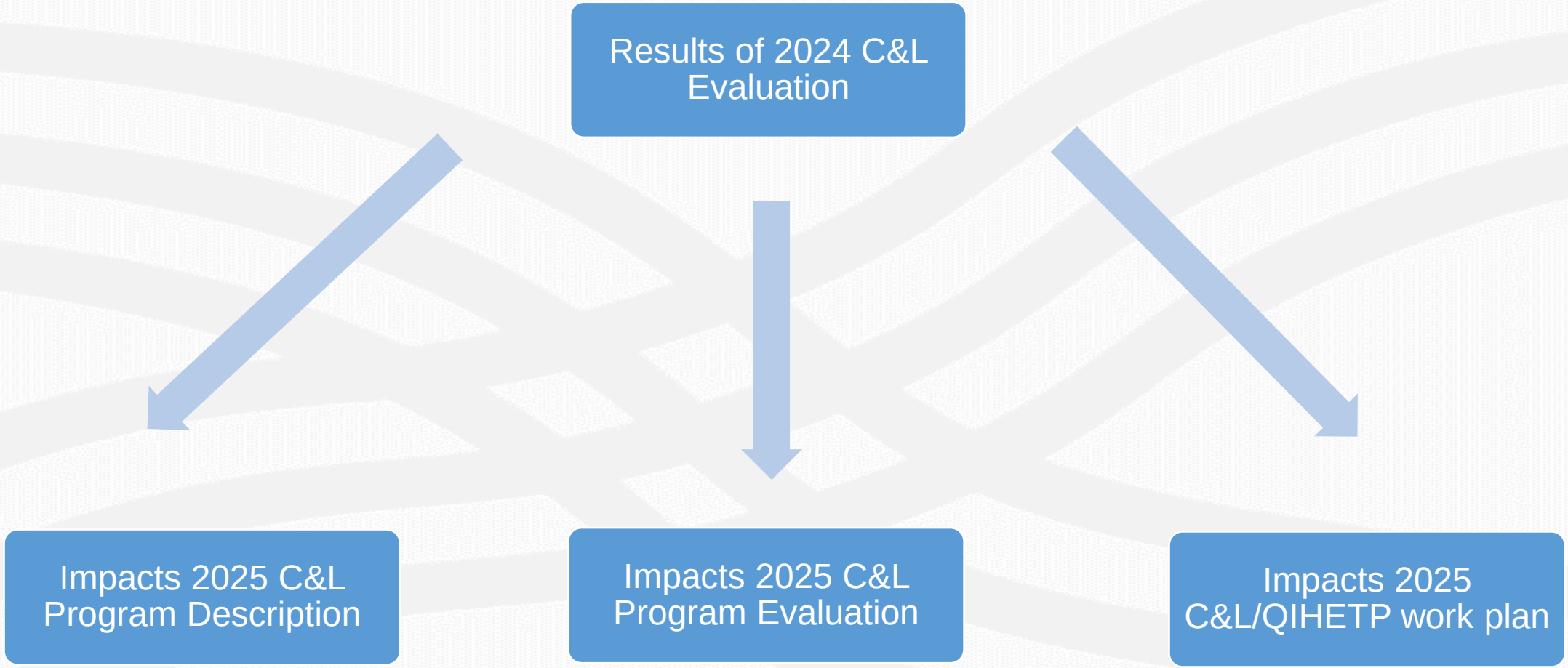
Hannah O’Leary, MPH, CHES

Part 1: Cultural and Linguistic Trilogy Documents: Background

2024 C&L Program Evaluation: Overview



Results Feed Future Documents



Part 2: 2024 Cultural & Linguistic Program Evaluation: Findings

2024 C&L Program Evaluation: C&L Program Findings (part 1)

In 2024, there were…

1,113 translation requests (2023 = 720)

*800 on time
*1 late

320,760 interpreter calls (2023 = 133,191)

689 alternate format requests (2023 = 1,820)

2024 C&L Program Evaluation: C&L Program Findings (part 2)

In 2024, there were…

32+ languages spoken

Top languages: English, Spanish, Russian, Tagalog, and Punjabi

Over 35 attendees at each QIHEC meeting

Each quarterly CAC meeting met quorum

2024 C&L Program Evaluation: C&L Program Findings (part 3)

In 2024

All policies reviewed and approved

Hiring new health equity staff to support

*Discrimination cases

*DEI regulatory requirements

2024 C&L Program Evaluation: C&L/QIHETP Work Plan Goal Findings

Goal 1 Goal is delayed, but will be met

- By August 31, 2024, define the framework and processes by which the QIHETP program description, C&L/QIHETP work plan, and QIHETP evaluation will be initiated in 2024 and maintained through approval of corresponding 2025 versions needed for HEA Initial Survey in June 2025.

Goal 2 Goal delayed, but was met

- By September 30, 2024, submit DEI training to DHCS for review to fulfill Phase I APL-23-025 deliverables.

Goal 3 Goal was met

- By December 31, 2024, 90% of members who asked for materials in an alternate format will receive one or more mailings in their preferred format.

2024 C&L Program Evaluation: C&L/QIHETP Work Plan Goal Findings (Cont'd)

Goal 4 Goal was met

- By December 31, 2024, increase the number of bilingual member service representative (MSR) staff hired by 1% to move closer to organizational goal of 75% of bilingual MSR staff.

Goal 5 Goal undetermined

- By December 31, 2024, improve controlled blood pressure rates among American Indian/Alaska Native members by 5% in at least one region.

Part 3: 2025 C&L/QIHETP Work Plan

2025 C&L/QIHETP Work Plan

8 goals total

Goal 1

- By June 30, 2025, develop and propose a multi-year health equity strategic and tactical plan.

Goal 2

- By December 31, 2025, distribute the DEI training to the provider network and MCP staff and submit the final version to DHCS.

2025 C&L/QIHETP Work Plan

Goal 3

- By December 31, 2025, 91% of members who have requested materials in an alternative format will be mailed in their preferred format.

Goal 4

- By December 31, 2025, increase the number of bilingual MSR staff hired by 2% to move closer to organizational goal of 75% of bilingual MSR staff.

2025 C&L/QIHETP Work Plan

Goal 5

- By December 31, 2025, improve controlled blood pressure rates among American Indian/Alaska Native members by 5% in at least two regions.

Goal 6

- By December 31, 2025, improve the rate of timely translations in the Utilization Management and/or Care Coordination department to achieve the threshold of at least 90%.

2025 C&L/QIHETP Work Plan

Goal 7

- By December 31, 2025, improve timely prenatal visit rates by at least 5% in Eureka region (Del Norte, Humboldt, Lake, and Mendocino), or Redding region (Lassen, Modoc, Shasta, Siskiyou, Tehama, and Trinity) in the American Indian/Alaska Native Member Population within 12 months with the global goal of improvement by 22% in the next five years.

Goal 8

- By December 31, 2025, improve Well Care Visits rate among Black, White, and/or American Indian/Alaska native members by 5% overall or in at least 1.25% in at least one region.

Part 4: 2025 C&L Program Description

2025 C&L Program Description

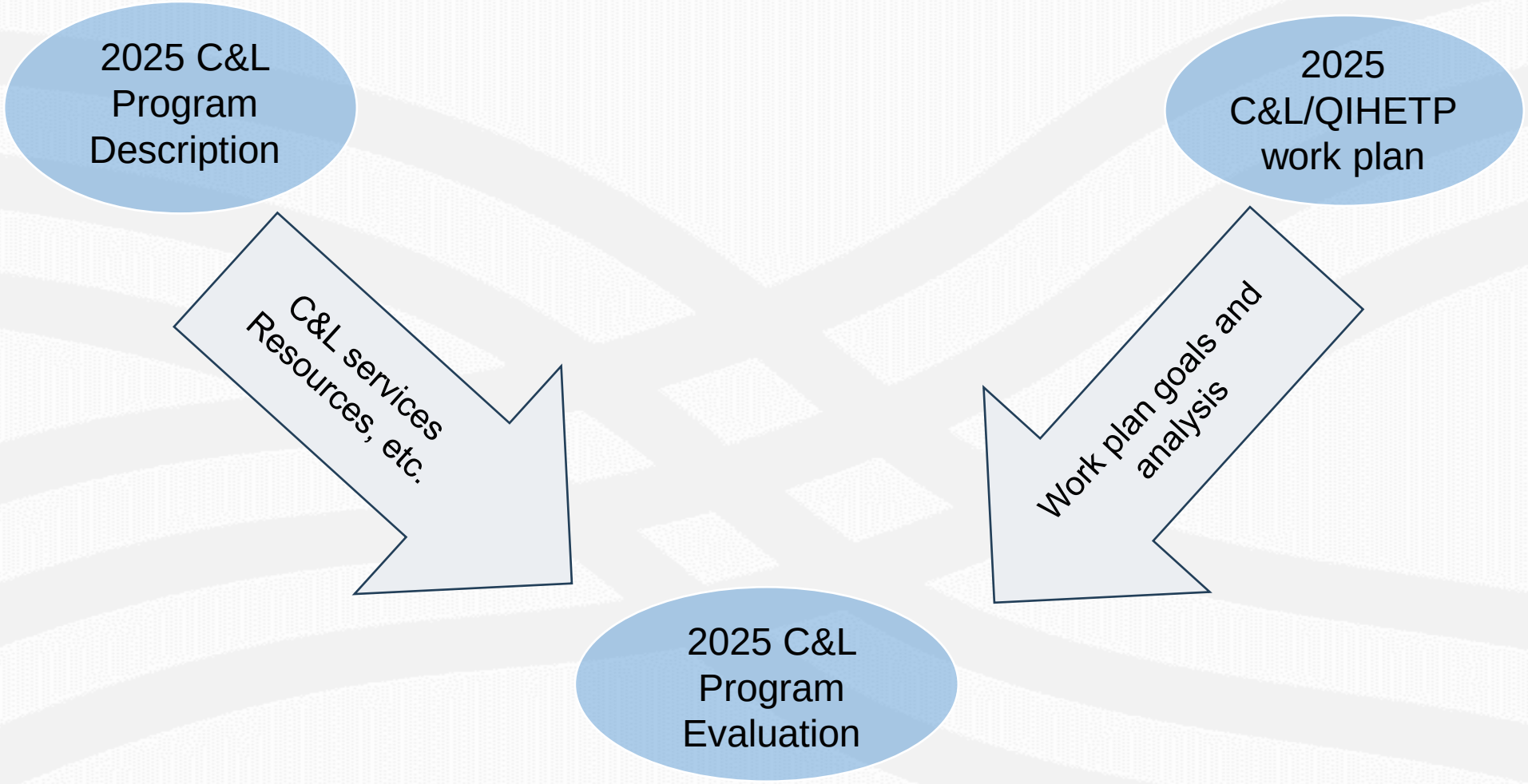
- Partnership cultural and linguistic services include:
  - Language data collection
  - Translation
  - Interpreters
  - Alternate formats
  - Auxiliary aids
  - Trainings for staff
  - Compliance monitoring
  - Goals for 2025 around cultural and linguistic services
  - C&L team structure

Summary

Today we reviewed:

- C&L trilogy document background
- Results of the 2024 C&L program evaluation, made up of:
  - The final 2024 C&L/QIHETP work plan
  - The 2024 C&L program description
- The 2025 C&L program description
- The 2025 C&L/QIHETP work plan

Summary (Cont'd)



Questions?

2024 Cultural and Linguistic Program Evaluation

April 9, 2025

Table of Contents

Executive Summary

The purpose of this report is to describe and evaluate the Cultural and Linguistic (C&L) program structure and interventions performed during 2024 in accordance with PHM and other Partnership efforts of the year. Key elements in this annual evaluation include program structure/processes, goals for completed activities, a plan for trending measures, review of Consumer Advisory Committee (CAC) feedback, overall program effectiveness, and opportunities for improvement.

In 2024, Partnership convened a group of multidiscipline stakeholders to collect and provide data. The Population Health and Health Equity 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
Director of Population Health	Population Health
Director of Health Equity	Health Equity

Methodology/Data

Partnership HealthPlan of California (Partnership) collects aspects of data related to the Cultural and Linguistic (C&L) Program, evaluates key elements and resources, and measures performance indicators of the C&L Program against its established goals. 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 C&L program in order to better serve our members. The evaluation was conducted by the Population Health department.

Program Structure and Process

Partnership's key Cultural and Linguistic program components will be evaluated in this report. Ongoing program components include:

- Translation Services
- Interpreter Services
- Auxiliary Aids and Services

- Alternative Formats
- Language Data Collection
- Committee Review of QIHEC and CAC
- Policy Review
- Staffing

Activity Goals from the 2024 Cultural and Linguistics work plan that will be evaluated in this report include:

- **Goal #1a:** By August 31, 2024, define the framework and processes by which the QIHETP Program Description, C&L/QIHETP Work Plan, and QIHETP Evaluation will be initiated in 2024 and maintained through approval of corresponding 2025 versions needed for HEA Initial Survey in June 2025.
- **Goal #1b:** By September 30, 2024, submit DEI training to DHCS for review to fulfill Phase I of APL-23-025 deliverables.
- **Goal #1c:** By December 31, 2024, 90% of members who have requested materials in an alternate format will receive one or more mailings in their preferred format.
- **Goal #1d:** By December 31, 2024, increase the number of bilingual Member Service Representative (MSR) staff hired by 1% to move closer to the organizational goal of 75% of bilingual MSR staff.
- **Goal #2a**: By December 31, 2024, improve controlled blood pressure rate among American Indian/Alaska Native members by 5% in at least one region.

I. CLAS Program Evaluation

A. Evaluation of Culturally and Linguistically Appropriate Services

1. Description of C&L Program Activates and Analysis

a) Translation Services

As part of standard procedures, and in alignment with Partnership's regulatory body the Department of Health Care Services (DHCS), Partnership utilizes United Language Group (ULG) as the certified translation service of all member-facing materials (including vital written materials) for LEP and monolingual members and potential Members who speak Threshold or Concentration Standard Languages. Partnership's

current threshold languages are Spanish, Tagalog, Russian, and Punjabi as defined by DHCS.[1]

If a member speaks a language other than Partnership's Threshold or Concentration Standard Languages, they can request written translations of Partnership member materials in their preferred language. ULG's services are provided at no cost to the member; written content is typically translated by ULG within 2-5 business days. Fully translated materials are sent to members in a timely manner. Other, less common languages may take longer depending on the availability of a translator.

Analysis/Discussion

In 2023, Partnership fulfilled 720 translation requests in a variety of languages, of which many were in Partnership's threshold and/or concentration languages (see Table 1). Three hundred and thirty-eight requests were for materials to be translated into Spanish, 99 requests were for Russian translations, 100 requests were for Tagalog translations, and 19 requests were for Punjabi. In 2024, Partnership fulfilled 1,113 total member translation requests (see Table 1), primarily in non-threshold and/or concentration languages; this is almost double the number of requests fulfilled in 2023. Of those fulfilled requests, 877 requests were for threshold languages. One hundred and forty-five requests were for Russian, 557 were for Spanish, 139 were for Tagalog, and 36 requests were for Punjabi. This data is reflective of all Partnership's translation requests through Partnership's language vendor, ULG for 2024.

Table 1: Translation Requests Fulfilled by ULG for 2024

Number of Fulfilled Translation Requests by Year				
Language	**2024**	**Percentage of Total Request**	**2023**	**Percentage of Total Request**
Amharic	0	0.00%	1	0.13%
Arabic	25	2.25%	12	1.66%
Bengali	0	0.00%	1	0.13%
Braille	3	0.27%	0	0
Cambodian	11	0.99%	9	1.25%
Chinese	20	1.80%	22	3.05%
Chuukese	0	0.00%	1	0.13%
Danish	0	0.00%	1	0.13%
Dari	4	0.36%	2	.27%
Dutch	6	0.54%	0	0

[1] APL 25-005 Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services

Farsi	31	2.79%	16	2.22%
French	10	0.90%	1	0.13%
Gujarati	0	0.00%	1	0.13%
Haitian	2	0.18%	1	0.13%
Hindi	7	0.63%	5	.69%
Hmong	19	1.71%	13	1.8%
Iu Mein	6	0.54%	12	1.66%
Japanese	1	0.09%	6	0.83%
Korean	2	0.18%	3	0.41%
Lao	12	1.08%	12	1.66%
Nepali	0	0.00%	1	0.13%
Pashto	8	0.72%	2	0.277%
Portuguese	21	1.89%	12	1.66%
Punjabi*	36	3.23%	19	2.63%
Romanian	0	0.00%	1	0.13%
Russian*	145	13.03%	99	13.75%
Serbian-Cyrillic	0	0.00%	2	0.27%
Spanish*	557	50.04%	338	46.95%
Swahili	0	0.00%	1	0.13%
Tagalog*	139	12.49%	100	13.88%
Thai	8	0.72%	10	1.38%
Tigrinya	1	0.09%		
Turkish	6	0.54%	1	0.13%
Twi	1	0.09%	0	0
Ukrainian	13	1.17%	0	0
Vietnamese	19	1.71%	15	2.08%
Total	**1,113**		**720**	

Source: ULG Records, 2024.
*Note: The * indicates a language is one of Partnership's threshold languages as defined by DHCS*

Table 2 shows a year-over-year comparison of the timeliness of turnaround times for translation requests. Timeliness is defined as returning a translation request within 2 business days. In 2024, there were more on time requests completed when compared to 2023 and 2022 (800 compared to 478 and 294 requests, respectively). The upward trend in on-time requests may be due in part to Partnership's growing membership base as a result of expanding into 10 new counties. In 2023, there were more late requests completed when compared to 2022 (7 requests compared to 3 requests, respectively). In 2024, there was 1 late request, which may be due in part to competing priorities.

Please note, some translation requests were bundled in which one piece of material was translated into multiple languages. This data is reflective of all Partnership's translation requests through Partnership's language vendor, ULG for 2024.

Table 2: Translation Request Fulfillment Status by Year through ULG for 2024

Year-Over-Year Status					
2024		2023		2022	
On time	Late	On time	Late	On time	Late
800	1	478	7	294	3

Source: Partnership Records, 2024

While there is currently no established goal for an acceptable number of late translation requests fulfilled, the data seems to show that translation requests are generally being fulfilled in a timely manner (i.e. within 2-5 business days). There is a future opportunity to define a threshold for the number of acceptable late requests in order to improve Partnership's systems. Partnership will continue to provide this service to its members at no cost to ensure they receive the highest quality healthcare.

2. Interpreter Services

Partnership provides equal access to high quality, oral and non-oral (such as American Sign Language) interpretation services to monolingual members or members with Limited English Proficiency from a qualified interpreter on a 24-hour, 7 days a week basis at all key points of contact and at no cost to all members and potential members. Oral and non-oral interpreter services are available for languages spoken by the member. Interpreter services are available in all of Partnership's threshold languages, over 140 additional languages, including American Sign Language, and are available upon member request through Partnership's contracted language service provider, AMN HealthCare.

Analysis/Discussion

In 2023, there were 133,191 total interpreter calls, of which 107,264 calls were in the threshold languages of Russian, Spanish, Tagalog, and Punjabi. Spanish came in at 98,844 calls, 4,984 calls were in Russian, 838 calls were for Tagalog, and 2,598 requests were in Punjabi (see Table 3). Other languages of note were the 1,210 calls in Arabic, the 732 calls for American Sign Language (ASL), the 2,640 calls in Dari, the 1,057 calls in Farsi, the 1,530 in Haitian Creole, the 2,247 in Mandarin, the 974 calls in Pashto, the 2,427 calls in Portuguese, the 280 in Ukrainian, and the 5,036 calls in Vietnamese.

In 2024, there were 320,760 interpreter calls, more than double the number of calls compared to 2023. Of the 320,760 calls, 269,908 calls were in the threshold languages of Russian, Spanish, Tagalog, and Punjabi. Spanish came in at 246,799 calls, 15,161 calls were in Russian, 1,099 calls were for Tagalog, and the 6,849 requests in Punjabi (see Table 3). This significant increase in languages from 2023 to 2024 may be due in part to Partnership's recent expansion to 10 new counties. Other languages of note were the 2,599 calls in Arabic, the 1,661 calls for American Sign Language (ASL), the 6,559 calls in Dari, the 2,093 calls in Farsi, the 6,164 in Haitian Creole, the 3,732 calls in Mandarin, the 1,949 calls in Pashto, the 4,021 calls in Portuguese, the 1,556 in Ukrainian, and the 7,965 calls in Vietnamese. There is a future opportunity for Partnership to work towards refining its interpreter services reporting process.

Table 3: Number of Interpreter Calls for 2024

Number of Interpreter Calls per Language				
Language	**2024**	**Percentage of Total Request**	**2023**	**Percentage of Total Request**
Achi	53	0.02%	38	0.03%
Acholi	11	0.00%	8	0.01%
Afar	3	0.00%	2	0.00%
Afrikaans	1	0.00%	1	0.00%
Akan	0	0.00%	4	0.00%
Akateko	0	0.00%	2	0.00%
Albanian	18	0.01%	2	0.00%
Amharic	73	0.02%	61	0.05%
Arabic	2,599	0.81%	1,210	0.91%
Armenian	100	0.03%	45	0.03%
ALS	1,661	0.52%	732	0.55%
Bengali	70	0.02%	33	0.02%
Bosnian	12	0.00%	10	0.01%
Bulgarian	32	0.01%	29	0.02%
Burmese	297	0.09%	105	0.08%
Cambodian	696	0.22%	645	0.48%
Cantonese	1464	0.46%	888	0.67%
Cape Verdean	12	0.00%	9	0.01%
CDI	59	0.02%	38	0.03%
Cebuano	1	0.00%	0	0.00%
Chuukese (Trukese)	8	0.00%	8	0.01%
Croatian	35	0.01%	9	0.01%
CST	1	0.00%	3	0.00%
Danish	0	0.00%	1	0.00%
Dari	6,559	2.04%	2,640	1.98%

Dutch	1	0.00%	0	0.00%
Ewe	1	0.00%	0	0.00%
Falam	0	0.00%	1	0.00%
Farsi	2,093	0.65%	1,057	0.79%
Filipino	0	0.00%	1	0.00%
French	588	0.18%	309	0.23%
Fujianese	0	0.00%	3	0.00%
Georgian	14	0.00%	21	0.02%
Greek	11	0.00%	2	0.00%
German	9	0.00%	17	0.01%
Gujarati	70	0.02%	39	0.03%
Haitian Creole	6,164	1.92%	1,530	1.15%
Hakha Chin	1	0.00%	1	0.00%
Hausa	0	0.00%	2	0.00%
Hebrew	5	0.00%	4	0.00%
Hindi	935	0.29%	716	0.54%
Hmong	1186	0.37%	375	0.28%
Hungarian	4	0.00%	11	0.01%
Ilonggo	1	0.00%	4	0.00%
Indonesian (Bahasa Indonesian)	9	0.00%	5	0.00%
Italian	16	0.00%	22	0.02%
Japanese	137	0.04%	51	0.04%
Kanjobal	1	0.00%	2	0.00%
Karen	37	0.01%	6	0.00%
Karenni	1	0.00%	0	0.00%
Khmer	948	0.30%	602	0.45%
Kinyarwanda	2	0.00%	1	0.00%
Korean	611	0.19%	439	0.33%
Krio	1	0.00%	0	0.00%
Kumam	0	0.00%	1	0.00%
Kurdish	2	0.00%	3	0.00%
Lao	582	0.18%	324	0.24%
Lautu	0	0.00%	1	0.00%
Lingala	7	0.00%	2	0.00%
Luganda	0	0.00%	1	0.00%
Malay (Bahasa Malaysia)	1	0.00%	0	0.00%
Malayalam	12	0.00%	3	0.00%
Mam	59	0.02%	131	0.10%
Mandarin	3,732	1.16%	2,247	1.69%
Marshallese	3	0.00%	3	0.00%

Maay Maay	0	0.00%	1	0.00%
Mien	62	0.02%	79	0.06%
Mien (or Lao/Thai)	9	0.00%	11	0.01%
Mixteco Alto	1	0.00%	6	0.00%
Mixteco Bajo	6	0.00%	14	0.01%
Mongolian	44	0.01%	30	0.02%
Moroccan Arabic	12	0.00%	4	0.00%
Nepali	763	0.24%	340	0.26%
Nigerian Pidgin	1	0.00%	1	0.00%
Oromo	1	0.00%	1	0.00%
Pashto	1,949	0.61%	974	0.73%
Persian	287	0.09%	183	0.14%
Polish	13	0.00%	29	0.02%
Pohnpeian	0	0.00%	2	0.00%
Portuguese	4,021	1.25%	2,427	1.82%
Punjabi*	6,849	2.14%	2,598	1.95%
Quiche	13	0.00%	10	0.01%
Romanian	721	0.22%	605	0.45%
*Russian	15,161	4.73%	4,984	3.74%
Sinahala (Sinhalese)	1	0.00%	0	0.00%
Serbian	9	0.00%	18	0.01%
Samoan	2	0.00%	4	0.00%
Somali	3	0.00%	3	0.00%
*Spanish	246,799	76.94%	98,844	74.21%
Swahili	23	0.01%	12	0.01%
*Tagalog	1099	0.34%	838	0.63%
Taishanese	7	0.00%	3	0.00%
Taiwanese	1	0.00%	3	0.00%
Tamil	129	0.04%	47	0.04%
Tedim	0	0.00%	10	0.01%
Telugu	7	0.00%	15	0.01%
Thai	443	0.14%	260	0.20%
Tibetan	5	0.00%	2	0.00%
Tigre	0	0.00%	1	0.00%
Tigrinya	347	0.11%	362	0.27%
Tongan	1	0.00%	0	0.00%
Triqui	1	0.00%	4	0.00%
Turkish	570	0.18%	149	0.11%
Ukrainian	1,556	0.49%	280	0.21%
Unknown	21	0.01%	8	0.01%
Urdu	830	0.26%	518	0.39%
Uzbek	6	0.00%	4	0.00%

Vietnamese	7,965	2.48%	5,036	3.78%
Wolof	2	0.00%	6	0.00%
Yemini Arabic	4	0.00%	2	0.00%
Yoruba	6	0.00%	0	0.00%
Zapoteco	1	0.00%	1	0.00%
Zomi	0	0.00%	2	0.00%
Total	**320,760**		**133,191**	

Source: AMN records, Number of Interpreter Calls for 2024.
*The * indicates a threshold language*

3. Alternate Format/Auxiliary Aids and Services:

In accordance with APL 25-005 and APL 22-002, Partnership provides alternative formats and auxiliary aids to members in a timely fashion and at no cost; alternative formats include Braille, audio and electronic format, large print no less than 20 point and in Arial font, and accessible electronic format such as a data CD. Also in accordance with APL 25-005 and APL 22-002, Partnership must provide the following auxiliary aids and services to members, to a family member, friend, or their authorized representative (AR) or someone with whom it is appropriate for Partnership to communicate with ("companion") by request, and at no cost to the member:

- Qualified oral and sign language interpreters on-site or through VRI services; note takers; real-time computer-aided transcription services; written materials; exchange of written notes; telephone handset amplifiers; assistive listening devices; assistive listening systems; telephones compatible with hearing aids; closed caption decoders; open and closed captioning, including real-time captioning; voice, text, and video-based telecommunication products and systems, text telephones/telephone typewriters (TTYs) or Telecommunication Devices for the Deaf (TDD), videophones, captioned telephones, or equally effective telecommunications devices; videotext displays; accessible information and communication technology; or other effective methods of making aurally delivered information available to individuals who are deaf or hard of hearing.
- Qualified readers; taped texts; audio recordings; Braille materials and displays; may screen reader software; magnification software; optical readers; secondary auditory programs; large print materials (no less than 20-point font); accessible information and communication technology; or other effective methods of making visually delivered materials available to individuals who are blind or have low vision.

Analysis/Discussion

Partnership collects data on requests for alternative formats. An analysis was conducted on this activity to review the number of members who have requested materials in an alternate format. This analysis showed that in 2023, Partnership received 286 requests for materials to be sent as audio/data CD, 1,443 requests for materials to be sent in large print font, and 91 requests for materials to be sent in braille (see Table 4). This activity resulted in a total of 1,820 requests for alternative formats. In 2024, Partnership received 188 requests for materials to be sent as audio/data CD, 437 requests for materials to be sent in large print font, and 64 requests for materials to be sent in braille (see Table 4). This service resulted in a total of 689 requests for alternative formats in 2024, which is significantly less than the requests for 2023. One barrier to note with the data provided is that, due to data collection challenges, it is limited to requests made from one department. As such, the total number of alternate format requests at an organizational wide level may be significantly higher than what is reported in this evaluation. This is due in part to challenges with internal organizational systems, as Partnership currently lacks a unified infrastructure to track requests for alternative formats at an organizational wide level. An opportunity arose to resolve this issue by convening with other member-facing departments to discuss operationalizing a centralized and/or unified tracking mechanism for alternative format requests at the organizational level. Results of this discussion will be reviewed in 2025. Partnership will continue to provide this service to its members at no cost to ensure they receive the highest quality healthcare.

Table 4: Alternative Format Requests for 2024

Requests for Materials in Alternative Formats					
2024			2023		
Audio/Data CD	Large Font	Braille	Audio/Data CD	Large Font	Braille
188	437	64	286	1,443	91
Total: 689			Total: 1,820		

Source: Partnership Records, 2024

4. Language Data Collection

Partnership regularly collects language data on its members to better understand the cultural and linguistic needs of the member population. Based on its membership demographics in 2024, DHCS identified English, Punjabi, Spanish, Tagalog, and

Russian as Partnership's main languages. However, many languages are spoken among the member population (see Figure 3).

Analysis/Discussion

As of December 2024, the most common languages spoken among Partnership's member population is English (76.1%), Spanish (20.6%), Russian (.6%), Punjabi (.5%), and Tagalog (.3%). See Figure 1 for a full list of languages.

Figure 1: Member Languages by County and Language as of December 2024

Membership by Language

to view all languages, click on the (+) above the top language

ENGLISH	76.1% (680,887)
SPANISH	20.6% (183,966)
OTHER NON ENGLISH	0.4% (3,825)
HMONG	0.3% (2,589)
NO VALID DATA REPO.	0.2% (2,236)
VIETNAMESE	0.2% (2,045)
FARSI	0.2% (1,723)
MANDARIN	0.1% (1,019)
ARABIC	0.1% (734)
CANTONESE	0.1% (541)
LAO	0.1% (517)
PORTUGUESE	0.1% (489)
MIEN	0.0% (438)
CAMBODIAN	0.0% (297)
ASL AMERICAN SIGN ..	0.0% (288)
KOREAN	0.0% (286)
FRENCH	0.0% (150)
THAI	0.0% (124)
TURKISH	0.0% (104)
CHINESE	0.0% (96)
SAMOAN	0.0% (68)
NO RESPONSE, CLIEN.	0.0% (66)
ARMENIAN	0.0% (58)
	0.0% (37)
ILACANO	0.0% (32)
OTHER SIGN LANGUA..	0.0% (30)
JAPANESE	0.0% (30)
ITALIAN	0.0% (19)
POLISH	0.0% (12)
HEBREW	0.0% (12)
UNKNOWN	0.0% (5)
RUSSIAN	0.6% (5,132)
PUNJABI	0.5% (4,183)
TAGALOG	0.3% (2,284)
UKRAINIAN	0.0% (325)
HINDI	0.0% (162)

Source: Partnership Tableau Dashboard, December 2024

While Partnership's threshold and/or concentration languages of Spanish, Tagalog, and Russian were constant for quite some time, as Partnership grows, the DHCS-defined threshold and concentration languages are subject to change. March 2024 data from DHCS revealed Punjabi as a new concentration language. If any languages are deemed to be a threshold language, there is an opportunity to regularly print Partnership materials in said added languages in the way we do for currently established threshold languages. As such, Partnership will update its standard material translation process by printing all future member facing materials in Punjabi as part of standard practices. Partnership will continue to collect language data to ensure members receive the highest quality healthcare in their own language.

5. Evaluation of Partnership Committees

a) Quality Improvement Health Equity Committee (QIHEC)

The Quality Improvement Health Equity Committee (QIHEC) is a DHCS-mandated committee that is part of the larger Quality Improvement Health Equity Transformation Program (QIHETP). In alignment with the Department of Health Care Services, Partnership's chief governing body, the QIHEC is co-chaired by the Director of Health Equity/Health Equity Officer (HEO) and Chief Medical Director/Officer (CMO). It is comprised of various stakeholders including but not limited to community-based organizations, academic institutions, clinical staff, and Partnership staff members.

QIHEC is responsible for analyzing and evaluating the results of quality improvement and health equity activities including an annual review of the results of performance measures, utilization data, consumer satisfaction surveys, and findings and activities of internal Partnership specific committee. This committee is also responsible for developing actions to address performance deficiencies and ensuring appropriate follow-up of identified performance deficiencies. Furthermore, the QIHEC meets bi-monthly to align interdepartmental efforts promoting health equity through both member-facing and systemic interventions outlined in the C&L/QIHETP Work plan. Lastly, the QIHEC provides recommendations to the Quality/Utilization Advisory Committee (Q/UAC) (see policy MPQP1002). For more details on QIHETP and the QIHEC, refer to MCED6001 and MCEP6002.

Analysis/Discussion

In 2023, the following activities were accomplished:

- The HEO recruited medical providers and health equity leaders from clinical sites and Community Based Organizations (CBO's) by means of conducting informal presentations at various clinical sites.
- The QIHEC's goal for formal voting members was set at 9-15 representatives from a broad range of network providers, including but not limited to, hospitals, county partners, physicians, subcontractors, and/or downstream subcontractors, as well as PHC members. The QIHEC may also include members from the California Department of Public Health (CDPH), members from academic institutions, ethnic services coordinators, community-based organization leaders, and tribal health liaisons.

The QIHEC officially kicked off in 2024 with the first meeting occurrence in February 2024. Each scheduled meeting met a quorum; quorum refers to the minimum number of members of an assembly or society that must be present at any of its meetings to make the proceedings of that meeting valid. Meetings were scheduled on a quarterly basis but switched to bi-monthly (see Table 5). All planned topics were discussed at the first meeting. The QIHEC planned to review the following topics in 2024:

- Analyze and evaluate the results of clinical quality performance measures related to Health Plan Ratings (HPR), as specified by NCQA Health Equity Accreditation standards, as mandated by DHCS, or due to poor performance trending on the DHCS Managed Care Accountability Set (MCAS) (with stratification by race/ethnicity and language):
    - b. Consumer Assessment of Healthcare Providers and Systems (CAHPS)
- Analyze utilization data (Types of services, denials, deferrals, modifications) with stratification by race/ethnicity and language.
- Analyze utilization data of language services and experience with language services with stratification by language.
- Analyze and evaluate the results of member satisfaction surveys, Grievance and Appeal surveys, and care coordination-based surveys with stratification by race/ethnicity and language

Table 5: QIHEC Meeting Schedule

Meeting Date	Number of Attendees	Number of Members that Voted	Quorum Met
February 20, 2024	46	10	Yes
May 21, 2024	39	9	Yes
August 20, 2024	45	7	Yes
September 24, 2024	37	8	Yes
November 19, 2024	44	10	Yes

Source: Partnership Records, 2024
Note: quorum refers to the minimum number of members of an assembly or society that must be present at any of its meetings to make the proceedings of that meeting valid.

Partnership has the opportunity to fully represent its member population through the equitable distribution of QIHEC voting members. Despite successful meetings, Partnership has experienced barriers which include operating in its 24-county service area with a 900,000 plus membership base. In addition, several topics from the list above were not discussed at QIHEC as planned. The goal to analyze utilization data was not reviewed because Partnership is currently exploring which types of services and decisions need to be stratified by race/ethnicity and language. The goal to analyze utilization data of language services was also not reviewed; this is because the QIHEC did not have enough time to review this data point. However, there are plans and opportunities to review this data in the upcoming year as QIHEC will now meet 6 times per year. Partnership's QIHEC meetings are sufficient and will continue to meet to ensure members are receiving the highest quality and equitable healthcare.

b) Consumer Advisory Committee (CAC)

The purpose of the Consumer Advisory Committee (CAC) is to act as a liaison between Partnership HealthPlan of California (Partnership) and its members. The CAC provides Partnership members with a forum to discuss common issues of interest and importance, while creating a supportive and informative environment. Partnership's CAC is primarily composed of members, advocates, and stakeholders. The CAC may also include participation from select providers within the service area. Partnership values the input received through the CAC and considers the feedback during annual reviews and policy/procedural updates that affect cultural and linguistic services, as well as quality improvement and health equity initiatives. Additionally, Partnership provides relevant updates to the CAC on how their input is incorporated. The CAC also advocates for Partnership members by ensuring that the health plan is responsive to the diversity of health care needs of all members. Partnership will make a good faith effort

to ensure that CAC members feel supported in their role and may provide resources to help educate CAC members so they can effectively participate in CAC meetings. For more information on this committee, please see MCND9002 attachment E.

Analysis/Discussion

In order for CAC meetings to be carried out, it must meet quorum. For the purpose of the CAC, a quorum is defined as the minimum number of members in attendance required to conduct the business of the committee. The CAC quorum shall consist of at least 1/2 (one half) of the CAC membership seats held. Every act or decision done or made by a quorum is an act of the CAC as a whole. The CAC carries out duties and/or provides input in the following ways:

- Culturally and linguistically appropriate service or program design, including culturally and linguistically appropriate health education;
- Priorities for health education and outreach program;
- Member satisfaction survey results;
- Plan marketing materials and campaigns.
- Communication of needs for Network development and assessment;
- Community resources and information;
- Population Health Management (including wellness and prevention strategies) and Quality Interventions;
- Health Delivery Systems Reforms to improve health outcomes;
- Carved Out Services;
- Coordination of Care;
- Health Equity;
- Accessibility of Services; Development of covered, Non-Specialty Mental Health Services (NSMHS) outreach and education plan;
- Input on Quality Improvement and Health Equity and the Population Needs Assessment;
- Health related initiatives; Reforms to improve health outcomes, accessibility, and coordination of care for Members; and
- Inform the development of the MCP’s Provider Manual.
- Resource allocation; and
- Other community-based initiatives

CAC is held on a quarterly basis. In 2024, all 4 scheduled CAC meetings took place. There were 15 attendees at the March meeting, 23 attendees at the July meeting, 18 attendees at the September meeting, and 20 attendees at the December meeting. Quorum was met at 4 of 4 meetings (see Table 6).

Table 6: CAC Quarterly Meeting Schedule

Meeting Date	Number of Attendees	Quorum Met
March 14, 2024	15	Y
July 11, 2024	23	Y
September 12, 2024	18	Y
December 12, 2024	20	Y

Source: Partnership Records, 2024

In 2024, the following agenda items were planned for review and discussion by CAC (see Table 7):

Table 7: CAC Quarterly Meeting Agenda Topics

Meeting Date	Planned Topics	Skipped /Condensed Agenda Items
March 14, 2024	• Welcome / Purpose of Meeting • Introductions • Approval of December 2023 Minutes • Follow Up from December2023 CAC Meeting • Welcome New CAC Members • Report on Board Meeting • Partnership Update • Consumer Board Member Position • Insuring the Uninsured Project (ITUP) Conference • Member Experience Annual Review • Partnership - Branded Pill Boxes • Health Disparity Data Review • Population Needs Assessment (PNA) and CHA/CHIP Efforts • 2024 CHW Program and Scholarship Opportunity Flyer • Open Forum • Next Meeting	None
July 11, 2024	• Welcome / Purpose of Meeting • Introductions • Approval of March 2024 Minutes • Follow Up from March 2024 CAC Meeting • Report on Board Meeting • Consumer Board Position • Partnership Update • CHA / CHIP Updates	• Schools and Mental Health Services

	• A Member Story • Partnership ID Card Sleeve Pilot • Schools and Mental Health Services • Open Forum • Next Meeting	
September 12, 2024	• Welcome / Purpose of Meeting • Introductions • Approval of July 2024 Minutes • Follow Up from July 2024 CAC Meeting • CAC Member Seat Changes Consumer Board Representative Update • Report on Board Meeting • Partnership Update • Preparing for Medicare • Outreach and Education Campaign for Mental Health • CHA/CHIP Update • Partnership in the Community • Open Forum • Next Meeting	None
December 12, 2024	• Welcome / Purpose of Meeting • Introductions • Approval of September 2024 Minutes • Follow Up from September2024 CAC Meeting • Report on Board Meeting • Partnership Update • Partnership Logo • 2024 Grievance & Appeals Annual Report • Partnership Advantage • Partnership Member Scholarship Prog Community Health Assessment (CHA)/Community Health Improvement Plans (CHIP) Updates • CAC Achievements • Open Forum • Next Meeting	• Partnership Advantage (Partnership's forthcoming Medicare line of business) • Community Health Assessment (CHA)/Community Health Improvement Plans (CHIP) Update • Community events or open houses the CAC members can attend and report back on • Updates from the Transportation department

Source: Partnership Records, 2024

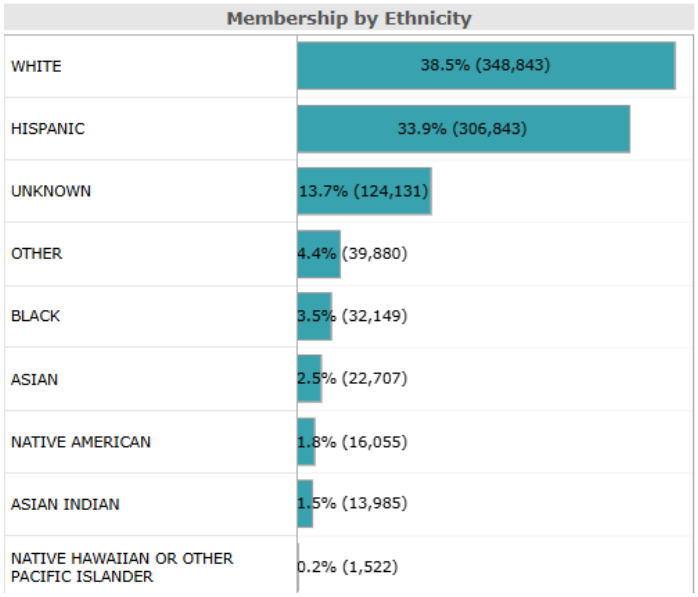
While most of the planned agenda items were discussed, the following items were either condensed or skipped:

- Community Health Assessment (CHA)/Community Health Improvement Plan (CHIP) updates
- Mental health services at schools
- Partnership Advantage (Partnership's forthcoming Medicare line of business)

- Community events or open houses the CAC members can attend and report back on
- Updates from the Transportation department

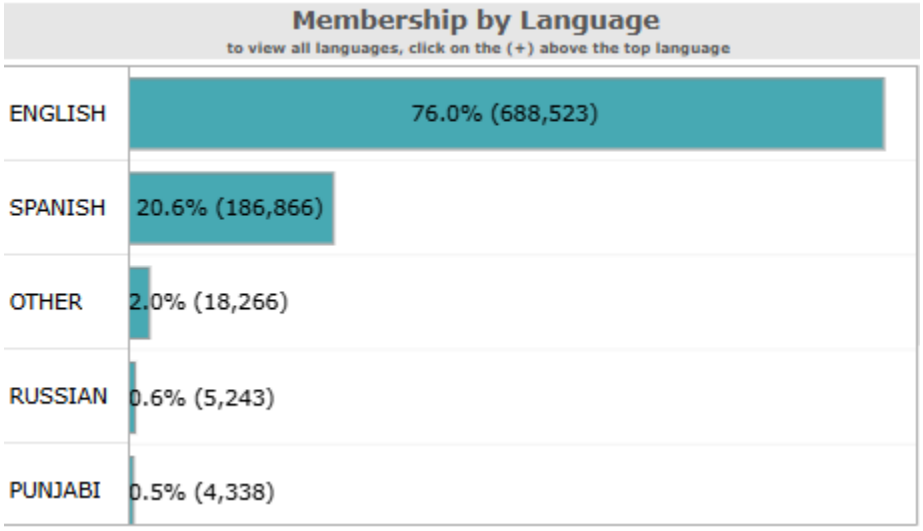
Furthermore, Partnership's CAC is reflective of 5% of its linguistic and racial/ethnic member population. Partnership's 2024 Member data shows the racial/ethnic groups that are reflective of at least five (5) percent of Partnership's membership base include White and Hispanic (see Figure 2). English and Spanish are the only two (2) linguistic groups representing at least five (5) percent of the membership base (see Figure 3). In addition, CAC also consists of Black, Asian, and Native American members which represents 3.5%, 2.5%, and 1.8% respectively, our membership population.

Figure 2: Partnership Membership by Ethnicity



Source: Partnership Records, December 2024

Figure 3: Partnership Membership by Language



Source: Partnership Records, December 2024

Barriers to holding sufficient discussion of the planned agenda items mentioned in Table 7 included not having enough time allotted for the length of the meeting. For 2025, Partnership plans to make each meeting as interactive as possible with the goal of more member collaboration. In 2025, Partnership is also exploring hosting additional ad hoc CAC meetings for planned agenda items that were skipped over or condensed. Furthermore, while Partnership has met a 5% linguistic and racial/ethnic reflection of its member population, recruitment efforts continue in order to fill 30 of the 37 seats available. Barriers to achieving this goal include finding members that can regularly attend in-person CAC meetings. Meetings must be held in person due to regulatory requirements and some members struggle to attend due in part to geographical challenges. As part of recruitment efforts, Partnership is actively working with its regional leadership to secure additional locations so members can attend in-person CAC meetings. Partnership will continue to host CAC meetings to listen to members' voices and ultimately to ensure equitable healthcare for the member population.

6. Policy Review for Oversight and Compliance Monitoring

At least annually, Population Health reviews its policies and procedures to reflect the most current regulatory requirements, as DHCS will periodically release new requirements that may warrant updates. Any updates made to policies or procedures require approvals from Partnership's internal governing committees (IQI, Q/UAC, and PAC). Population Health reviews each of its policies at least annually as part of Partnership's policy and regulatory requirements.

Analysis/Discussion

In 2023, Population Health had 1 Cultural and Linguistic report due for review and approval. This report was reviewed and approved. In 2024, Population Health had 2 Cultural and Linguistic reports/policies due for review and approval. Both items were reviewed and approved (see Table 8). No barriers were identified in this process. Partnership expects to add a third report in 2025. These policy reviews are sufficient. Partnership will continue to annually review policies and reports to ensure regulatory compliance.

Table 8: Policy Review for 2023-2024

Department	Year	Policies/Reports	Policies/Reports Reviewed for Consent	Policies/Reports Approved
Population Health	2023	1	1	1
Population Health/	2024	2	2	2

Source: Partnership Records, 2024

7. Cultural and Linguistic Staffing

Partnership's cultural and linguistic service operations are supported by a leadership team and administrative staff that recruits, promotes, and supports a culturally and linguistically diverse structural and organizational environment that is responsive to the Partnership membership. Partnership's Population Health department is responsible for developing, maintaining, and overseeing implementation of Partnership's overall PHM strategy. This strategy, along with the support of other Partnership departments, help to identify the health disparities and wellness needs of Partnership's members, including making referrals to culturally and linguistically appropriate community service programs, and aligning organizational and community efforts to meet these needs, in accordance with DHCS and NCQA requirements. In order to accomplish these objectives, Population Health departmental resources are leveraged to engage internal stakeholders, external stakeholders, and members, aligning existing projects and efforts to promote health equity for Partnership's population, including the provision of cultural and linguistic services. Population Health department staff are allocated to:

- Develop and share member education materials,
- Ensure all member subpopulations have resources specific to their needs,
- Identify and refer to culturally and linguistic appropriate community service programs when available,
- Engage with the community,

- Educate community partners on Partnership programs and interventions,
- Learn about resources available within communities, and
- Promote collaboration of effort and
- Reduce duplication of services.

Analysis/Discussion

In 2024, there were multiple staff dedicated to this work, including the Chief Health Services Officer, the Director of Population Health, the Associate Director of Population Health, Managers of Population Health, Supervisors, a Senior Health Educator, and health educators (see Table 9 for more details).

Table 9: Number of Staff

Position Title	Number of Positions
Chief Health Services Officer (changed to Chief Medical Officer):	1
Director of Population Health	1
Associate Director of Population Health	1
Supervisor	2
Senior Health Educator	1
Health Educator	2

Source: Partnership data, 2024

Partnership also has a member grievance review process which allows members to share their complaints about their quality of care. Occasionally grievance cases are converted to discrimination cases when certain criteria are met. When this occurs, the case becomes a discrimination case, and therefore a cultural and linguistic activity. As a result, the Health Education team is tasked with reviewing these time-intensive discrimination cases to provide third party input that ultimately helps determine if discrimination occurred or not. The Health Education team reviewed 105 cases in 2023 and 204 cases in 2024, almost double the amount (see Table 10 for more details). This jump in cases may be due in part to Partnership's addition of 10 new counties in 2024.

Table 10: Number of Discrimination Cases Reviewed

2024	2023
204 cases	105 cases

Source: Partnership data, 2024

As a result of an increasing case load, the Health Education team has transferred this cultural and linguistic activity to the Health Equity department. This decision will allow for more dedicated support of this activity and allows the Health Education team to participate in other Cultural and Linguistic activities. While the number of staff for cultural and linguistic activities was mostly sufficient for 2024, there are opportunities to hire more staff, including additional Health Equity staff, and additional Population Health supervisors and managers for 2025. Plans for 2025 include filling roles for 2 Cultural and Linguistic Liaisons to help support the growing number of discrimination cases and 1 Supervisor of DEI Training to support the Health Equity department's requirements to create a Diversity, Equity, and Inclusion (DEI) Training.

II. Evaluation of Goals from the C&L/QIHETP Workplan

Partnership focused on five measurable activities to improve upon in 2024 to address cultural and linguistic disparities seen in our member population. The tables below are a description of completed and ongoing activities for culturally and linguistically appropriate services.

A. Goal 1A: Health Equity Strategic Plan and Health Disparities Analysis

Goal 1 focused on the development of the Health Equity Strategic Plan and Health Disparities analysis. The outcome measure was the completion of the Disparity Analysis Report and Health Equity Strategic Plan Completion (QIHETP Program Description). The goal was "by August 31, 2024, define the framework and processes by which the QIHETP Program Description, C&L/QIHETP Work Plan, and QIHETP Evaluation will be initiated in 2024 and maintained through approval of corresponding 2025 versions needed for HEA Initial Survey in June 2025." Departments involved in the outcome of this activity included Health Equity, Quality Improvement, and Health Analytics. This goal started on 1/1/2024 and had an end date of 10/30/2024.

Analysis/Discussion

Evaluating the development of the Health Equity Strategic Plan and Health Disparities analysis was completed through measuring progress against the stated goal. The Health Equity department team collaborated with the Quality Improvement Department, and the Health Analytics department to identify and implement these activities. Regular updates to the 2024 C&L/QIHETP work plan were made to track progress of goals. Table 11 provides a visual of the goal in more detail.

Table 11: Description of Goal and Measure

Goal	Outcome Measures	Deliverables	Start Date	Due Date	Completion Status
Goal 1A: By August 31, 2024, define the framework and processes by which the QIHETP Program Description, C&L/QIHETP Work Plan, and QIHETP Evaluation will be initiated in 2024 and maintained through approval of corresponding 2025 versions needed for HEA Initial Survey in June 2025	Disparity Analysis Report and Health Equity Strategic Plan Completion (QIHETP Program Description)	**#1:** Submit 2023 HE 6 Disparity Analysis to External Consultant	1/1/2024	2/24/20024	Complete
		#2: Submit updated 2024 C&L/QIHETP Work Plan for QIHEC approval	1/1/2024	2/20/2024	Complete
		#3: Health Disparities Statistical Analysis for 2024 data (2025 HE 6 Analysis)	7/1/2024	7/30/2024	Complete
		#4: Submit 2025 HE 6 Disparity Analysis to External Consultant	9/1/2024	9/15/2024	Complete
		#5: Submit Final 2024 C&L/QIHETP Work Plan and proposed 2025 C&L/QIHETP Work Plan for IQI / Q/UAC review and approval for HEA Initial Survey in 2025	9/1/2024	10/30/2024	Delayed – to be finalized in March 2025

Source: Partnership 2024 C&L/QIHETP Work Plan

A review of this work plan took place towards the end of 2024 to see if each deliverable was completed; this was done ultimately to evaluate completion of this goal. This review showed that in 2024, Partnership completed most of the deliverables but did not meet its goal, as deliverable 5 was delayed. One barrier to completing this deliverable was due to changes in internal logistics and schedules. While this goal was not met by the deadline, the projected end date for deliverable 5 is March 2025. Therefore, Partnership intends to meet this goal soon.

B. Goal 1B: DEI Training Development

Goal 1B focused on providing DEI Training Development for Staff and Network Providers, and Subcontractors to fulfill DHCS All Plan Letter (APL) Requirements. The outcome measure was obtaining a DEI Training Submission Receipt from DHCS. The goal was "By Sep 30 2024, submit DEI training to DHCS for review to fulfill Phase I APL-23-025 deliverables." Departments involved in the outcome of this activity included Project Management Oversite, and Health Equity. This goal started on 1/1/2024 and had an end date of 9/30/2024.

Analysis/Discussion

Evaluating the provision of DEI Training Development for Staff and Network Providers, and Subcontractors to fulfill DHCS All Plan Letter (APL) Requirements was completed through measuring progress against the stated goal. The Health Equity department team collaborated with the Project Management Oversight department to identify and implement these activities. Regular updates to the 2024 C&L/QIHETP work plan were made to track progress of goals. Table 12 provides a visual of the goal in more detail.

Table 12: Description of Goal and Measure

Goal	Outcome Measures	Deliverables	Start Date	Due Date	Completion Status
Goal 1B: By Sep 30 2024, submit DEI training to DHCS for review to fulfill Phase I APL-23-025 deliverables	DEI Training Submission Receipt from DHCS	**#1:** Create and submit RFP for DEI training	1/1/2024	2/1/20024	Complete
		#2: Execute Contract for RFP after decision from Exec Team and PRB	3/1/2024	4/30/2024	Complete (was delayed)
		#3: Review DEI training Content and conduct pilot with 5 to 10 practitioners to validate training practicality	4/30/2024	8/31/2024	Delayed (scheduled for January-June 2025)
		#4: Submit training to DHCS for review and approval to fulfill Phase I of APL	9/1/2024	9/30/2024	Complete (was delayed)

Source: Partnership 2024 C&L/QIHETP Work Plan

A review of this work plan took place towards the end of 2024 to see if each deliverable was completed; this was done ultimately to evaluate completion of this goal. This review showed that in 2024, Partnership completed three of the four deliverables on time. While three deliverables were completed by the deadline, there were several goals that were delayed along the way. Deliverable number 2 was scheduled to be finished by the end of April 2024 but was delayed and instead finished in the third quarter of 2024. Deliverable 3 is scheduled to be completed by June 2025; the original August 2024 deadline for this deliverable was mistaken; as such this deliverable is still scheduled to be completed on time. While deliverable four was also delayed, it was completed by the end of 2024. One barrier to completing this overall goal on time was due to the need to work out additional logistics with the project vendor before submission to DHCS for approval (Partnership's regulatory body).

C. Goal 1C: Services for Vision-Impaired Members (Disability)

Goal 1C focused on improving services for Vision-Impaired Members (i.e. those with a Disability), specifically by providing materials to members in large print, Braille, audio format or another format per member request. The outcome measure was the percentage of members requesting materials in an alternate format who received a mailing in their preferred format. The goal was by Dec 31, 2024, 90% of members who have requested materials in an alternate format will receive one or more mailings in their preferred format. Departments involved in the outcome of this activity included Member Services, and Population Health. The denominator was the number of members who have requested an alternate format, and the numerator was the number of members who have been sent one or more mailings of materials in their preferred format. This goal started on 11/1/2024 and had an end date of 12/31/2024.

Analysis/Discussion

Evaluating the effectiveness of providing members with alternate formats was completed through measuring progress against the stated goal. The Population Health team collaborated with the Member Services Department to identify and implement these activities. Table 13 provides a visual of the goal in more detail.

Table 13: Description of Goal and Measure

Goal	Outcome Measures		Deliverable	Start Date	End Date	Completion Status
Goal 1C: By Dec 30 2024, 90% of members who have requested materials in an alternate format will receive one or more mailings in their preferred format	**Measure**	Percentage of members requesting materials in an alternate format who received a mailing in their preferred format	**#1**: Complete draft 2024 C&L Program Evaluation based on 2024 C&L Program Description and Final 2024 C&L/QIHETP Work Plan in preparation for submission to the NCQA Consultant for review in January 2025	11/1/2024	12/31/2024	Complete
	Numerator	Number of members who have been sent one or more mailings of materials in their preferred format				
	Denominator	Number of members who have requested an alternate format				

Source: Partnership 2024 C&L/QIHETP Work Plan

A review of this work plan took place towards the end of 2024 to see if each deliverable was completed; this was done ultimately to evaluate completion of this goal. This review showed that in 2024, Partnership completed the deliverable for this goal. An analysis was also conducted on this activity to compare the number of members who requested an alternate format to the number of members who have been sent one or more mailings of materials in their preferred format. This analysis showed that in 2023, Partnership fulfilled 286 requests for materials to be sent as audio/data CD, 1,443 requests for materials to be sent in large print font, and 91 requests for materials to be sent in braille (see Table 14). This activity resulted in a total of 1,820 fulfilled requests for alternative formats. In 2024, Partnership fulfilled 188 requests for materials to be sent as audio/data CD, 437 requests for materials to be sent in large print font, and 64 requests for materials to be sent in braille (see Table 14). This activity resulted in a total of 689 fulfilled requests for alternative formats, which is significantly less than the number of alternative format requests in 2023.

Table 14: Requests for Alternative Format Requests for 2024

Requests for Materials in Alternative Formats					
2024			2023		
Audio/Data CD	Large Font	Braille	Audio/Data CD	Large Font	Braille
188	437	64	286	1,443	91
Total: 689			Total: 1,820		

Source: Partnership Records, 2024

At the time of writing this report, we did not have the ability to track the percentage of members who received their alternative requests in the way they preferred. Instead, we looked at the number of unfulfilled requests for alternative formats to determine if the goal was met. In 2024, Partnership received 689 total requests for alternate formats. Similar to 2023, Partnership had 0 unfulfilled requests which means of the 689 total requests received for alternate formats, 100% of requests were fulfilled (see Table 15). Thus, Partnership has met its goal of 90% of members receiving materials in their preferred alternate format requests.

Table 15: Unfulfilled Requests for Alternative Format as of 2024

Unfulfilled Requests for Materials in Alternative Formats					
2024			2023		
Audio/Data CD	Large Font	Braille	Audio/Data CD	Large Font	Braille
0	0	0	0	0	0
Total: 0			Total: 0		

Source: Partnership Records, 2024

While this overall goal was achieved, one barrier with the unfulfilled alternate format requests data is that it is primarily from one department. As such, the total number of unfulfilled alternate format requests at an organizational wide level may be significantly higher than the data presented above. This finding is further compounded by a barrier identified in this service, namely the lack of an established mechanism to confirm if members received their alterative materials. Thus, while the data showed 0 unfulfilled requests, it is likely that there are cases of unfulfilled requests. Partnership is still working to understand the barriers and implementation of actions necessary for this work.

Partnership will consider future ways to potentially track unfulfilled requests at the organizational level to establish a true baseline for unfulfilled requests; this includes exploring avenues to confirm member receipt of alternative formats per their request. Possible strategies may include a call campaign surveying a sample of members with alternative formats, from which fulfillment rates can be inferred. Alternative strategies may include renewing each member-facing department's attestation that their staff are trained on and incorporate alternate formats into their processes as needed.

D. Goal 1D: Bilingual Member Service Representatives

Goal 1D focused on hiring additional bilingual member services representatives. The outcome measure for this goal was percentage of members who are considered bilingual. The numerator for this goal was the number of bilingual MSR department staff that have passed Partnership bilingual competency examination with a minimum rating of "Advanced." The denominator for this goal was the total number of MSR department staff. The goal was "By Dec 31, 2024, increase the number of bilingual Member Service Representative (MSR) staff hired by 1% to move closer to organizational goal of 75% of bilingual MSR staff. Departments involved in the outcome of this activity included Health Equity, and Member Services. This goal started on 1/1/2024 and had an end date of 8/1/2024.

Analysis/Discussion

Evaluation of the focused hiring of additional bilingual member services representative efforts was completed through measuring progress against the stated goal. The Health Equity department team collaborated with the Member Services department to identify and implement these activities. Regular updates to the 2024 C&L/QIHETP work plan were made to track progress of goals. Table 16 provides a visual of the goal in more detail.

Table 16: Description of Goal and Measure

Goal	Outcome Measures	Deliverables	Start Date	Due Date	Completion Status
Goal 1D: By Dec 31, 2024, increase the number of bilingual Member Service Representative (MSR) staff hired by 1% to move	**Measure:** Percentage of members who are considered bilingual	**#1:** Conduct baseline assessment of number of bilingual representatives needed to reach 1% increase	1/1/2024	2/24/20024	Complete

closer to organizational goal of 75% of bilingual MSR staff.	**Numerator:** Number of bilingual MSR department staff that have passed Partnership bilingual competency examination with a minimum rating of "Advanced"	**#2:** Conduct internal evaluation of bilingual salary adjustment recommendations to promote MSR retention in the MS department	3/1/2024	6/30/2024	Complete
	Denominator: Total number of MSR department staff	**#3:** Conduct internal focus group to discuss strategies for recruiting bilingual staff members	3/1/2024	6/30/2024	Completed
		#4: Complete draft 2025 C&L/QIHETP Work Plan	7/1/2024	8/1/2024	Complete

Source: Partnership 2024 C&L/QIHETP Work Plan

A review of the progress on this work plan took place towards the end of 2024 to see if each deliverable was completed; this was done ultimately to evaluate completion of this goal. This review showed that in 2024, Partnership completed all of the deliverables. In addition to completing the goal deliverables, the percentage of Partnership bilingual staff increased from 63.64% to 65.96%, a percentage increase of 3.6%; as a result, Partnership also met its goal of increasing the number of bilingual Member Service Representative (MSR) staff hired by 1% to move closer to organizational goal of 75% of bilingual MSR staff (see Table 17 for percentage of bilingual staff).

Table 17: Percentage of Bilingual Member Services Staff as of October 2024

	Number of Bilingual Member Service Representatives	Number of Total Member Service Representatives	Percentage of Bilingual Member Service Representatives
Baseline	28	44	63.64%
As of Report Date	31	47	65.96%

Source: Partnership Records, 2024

E. Goal 2a: Improve Controlled Blood Pressure Rate

Goal 2a focused on improving controlled blood pressure rate among American Indian/Alaska Native. The goal was "By Dec 31, 2024, improve controlled blood pressure rates among American Indian/Alaska Native members by 5% in at least one region." The outcome measure for this goal was the percentage of members with controlled blood pressure per HEDIS. The numerator was the number of members who are considered controlled for blood pressure. The denominator was the total number of eligible members with essential hypertension diagnosis. Departments involved in the outcome of this activity included Health Equity, and Population Health. This goal started on 3/1/2024 and had an end date of 12/31/2024.

Analysis/Discussion

Evaluating the improvement of controlled blood pressure rates among American Indian/Alaska Native members was completed through measuring progress against the stated goal. The Health Equity department team collaborated with the Population Health Department to identify and implement these activities. Regular updates to the 2024 C&L/QIHETP work plan were made to track progress of goals. Table 18 provides a visual of the goal in more detail.

Table 18: Description of Goal and Measure

Goal	Outcome Measures	Deliverables	Start Date	Due Date	Completion Status
Goal 2A: By Dec 31, 2024, improve controlled blood pressure rate among American Indian/Alaska Native members by 5% in at least one region	**Measure:** Percentage of members with controlled blood pressure per HEDIS	**#1:** Conduct Root Cause Analysis to identify sites that have largest number of American Indian/Alaska Native Members with lowest blood pressure control per region	3/1/2024	3/30/2024	Complete
		#2: Conduct coordinated site visit with Performance Improvement and/or Equity Transformation Project teams to at least 60 to 80% of previously identified sites to provide	4/1/2024	6/30/2024	Delayed

		education and solicit feedback			
	Numerator: Number of members who are considered controlled for blood pressure	**#3:** Provide recommendations to QIP workgroup to incentivize blood pressure reduction in specific target community to model other health plans	4/1/2024	6/30/2024	Complete
	Denominator: Total number of eligible members with essential hypertension diagnosis	**#4:** Execute PHM campaign to prioritize group during outreach calls and identify community events to conduct hypertension community outreach	4/1/2024	12/31/2024	Complete (Ongoing)

A review of this work plan took place towards the end of 2024 to see if each deliverable was completed; this was done ultimately to evaluate completion of this goal. This review showed that in 2024, Partnership completed most of the deliverables; deliverable 2 was delayed. Deliverable 4 was technically complete, however, it is an ongoing activity. At the time of writing this report, the HEDIS data for 2024 was not available for analysis. Therefore, we were unable to determine if the goal was met. Full analysis of this goal will take place after the HEDIS data is available which is scheduled for Q3 of 2025. Partnership is still working to understand additional barriers and implementation of actions necessary for this work; Partnership will consider ways to improve data tracking in the future. Partnership will consider removing or modifying this goal from its workplan in the future due to the data tracking challenges.

III. Review of Results for 2024 at the Consumer Advisory Committee

Partnership maintains a community advisory committee, known as the Consumer Advisory Committee (CAC), which serves to inform its Cultural and Linguistic (C&L) Services Program. The purpose of the CAC is to act as a liaison between Partnership Health Plan of California (Partnership) and our members. The CAC provides Partnership members with a forum to discuss common issues of interest and importance, while creating a supportive and informative environment.

Population Health and/or Health Equity will plan to share the results and findings of the 2024 C&L Program Evaluation with the CAC in Q1 of 2025; this committee meets on a quarterly basis (see MCND9002-E CAC Guiding Principles for a full description of Partnership's CAC). Partnership will also plan to present the analysis to CAC committee members for review, feedback, as well as their perspectives on the root causes of barriers, and possible solutions. Any comments or concerns will be considered and incorporated as appropriate into any future planned actions or interventions.

IV. Overall Program Effectiveness

All in all, the C&L program has demonstrated it is effective in both its goals and in other C&L program elements, as they have shown that they are meeting the needs of our members. The effectiveness of each program component and goal completion status is described next.

A. Translation Services

In 2024 Partnership had a total of 1,113 individual language translation requests, of which 800 were considered timely and 1 was considered late; this was close to double the amount of translation services requests compared to 2023. Please note, some requests were bundled in which one piece of material was translated into multiple languages. Despite having more late submissions of translation requests in 2024 compared to 2023 and 2022, Partnership is generally fulfilling requests in a timely manner (i.e. receiving translations from the translator within 2-5 days) and this service has sufficient resources. However, there is a future opportunity to define a threshold for late requests to improve Partnership's systems. Partnership will continue to provide this service to its members at no cost to ensure they receive the highest quality healthcare.

B. Interpreter Services

Partnership provided 320,760 interpreter calls to members from January-December 2024, more than double the volume from 2023. While services seem to be running

smoothly and are sufficient, Partnership will explore ways to improve any performance concerns as they come up. This service will continue to be provided to its members at no cost to ensure they receive the highest quality healthcare.

C. Alternative Formats/Auxiliary Aids and Services

Partnership had a total of 689 requests for alterative formats, of which 188 were for Audio/CD, 437 were for large font, and 64 were for Braille. While member requests seemed to be fulfilled in a timely manner, there were challenges with data collection that arose, preventing Partnership from being able to confirm this. As such, Partnership has a future opportunity to improve its internal systems through convening with other member-facing departments to discuss and operationalize a unified mechanism to track alternative format requests at the organizational level. Partnership will continue to provide this service to its members at no cost to ensure they receive the highest quality healthcare.

D. Language Data Collection

Partnership collects data on its member population. This information is used to better understand the cultural and linguistic needs of the member population and to tailor interventions to best address their needs. In 2024, Punjabi was added as a threshold language. Partnership incorporates new threshold languages into their services when identified. As such, Partnership plans to update its standard material translation process and will begin printing all future member facing materials in Punjabi as part of standard practices. Partnership will continue to perform this activity to ensure our members receive the highest quality healthcare.

E. QIHEC and CAC Review

Partnership’s QIHEC focused primarily on member recruitment in 2023. In 2024, the committee hosted its first year of meetings in February, May, August, September and November. These meetings were scheduled on a quarterly basis but will now meet bi-monthly. A variety of initiatives were reviewed at QIHEC over the last 12 months. CAC also met for each of the scheduled meetings and reviewed a variety of topics, but several were skipped or condensed due to time constraints. Partnership is exploring ways to ensure CAC meetings are truly collaborative with its members and topics that were skipped over or condensed are reviewed by CAC members. Partnership is also recruiting additional CAC members to ensure the remaining 7 of 37 total seats are filled. This committee will continue to meet and will work to ensure members receive the highest quality healthcare.

F. Policy Review

In 2024, Partnership reviewed and approved 2 C&L policies and/or reports. These processes are sufficient. Partnership will continue to conduct annual reviews of policy and reports to ensure regulatory compliance.

G. Review of Staffing

In 2024, 204 discrimination cases were reviewed by the health education team, almost double (105) the amount in 2023. While the number of staff for cultural and linguistic activities was mostly sufficient for 2024, there are opportunities to hire more staff, including additional Health Equity staff, and additional Population Health supervisors and managers for 2025. Health Equity plans to fill 2 Cultural and Linguistic Liaisons positions and 1 Supervisor of DEI training. Partnership will continue to track this data to ensure members are receiving high quality health care.

H. Goals for Completed Activities

Partnership had five goals associated with this program component. The first goal (goal 1A) was that by August 31, 2024, Partnership would define the framework and processes by which the QIHETP Program Description, C&L/QIHETP Work Plan, and QIHETP Evaluation will be initiated in 2024 and maintained through approval of corresponding 2025 versions needed for HEA Initial Survey in June 2025. While most of the deliverables were completed on time, one deliverable was delayed. As such, the goal was not met by the intended date; however, Partnership intends to meet this goal by March 2025. The second goal (goal 1B) was that by Sep 30, 2024, Partnership would submit the DEI training to DHCS for review to fulfill Phase I APL-23-025 deliverables. Two deliverables were delayed, however, Partnership still plans to meet this goal by the end of 2024. The third goal (goal 1C) was that 90% of members who have requested materials in an alternate format will receive one or more mailings in their preferred formal. The deliverable for this goal was completed on time and the goal was met. The fourth goal (goal 1D) was that by Dec 31, 2024, increase the number of bilingual Member Service Representative (MSR) staff hired by 1% to move closer to organizational goal of 75% of bilingual MSR staff. Each deliverable was completed on time and the goal was met. The fifth and final goal (goal 2A) was that by Dec 31, 2024, Partnership would improve controlled blood pressure rate among American Indian/Alaska Native members by 5% in at least one region. One deliverable was delayed while the other deliverable is an ongoing effort. Due to delays in data collection, it is unknown at this time if this goal was met.

V. Summary

The C&L Program Evaluation assesses the program's effectiveness, capacity, and integrity in managing the delivery of C&L Services to our members. It also helps to ensure our members receive the necessary quality and quantity of care in a way that is culturally and linguistically appropriate. In addition, the evaluation identifies gaps and improvement opportunities for which interventions can be developed.

In this evaluation, the results demonstrated strengths in the areas of program structure. Based on the results from the 2024 C&L Program Evaluation, Partnership concludes there are no significant changes required for the program. However, opportunities were identified to reduce the number of discrimination cases and move towards centralizing data collection for specific services. Issues and barriers that make the C&L/QIHETP Work Plan goals more difficult to achieve included organizing multiple departments to achieve the work plan goals. Partnership's C&L program functions effectively and efficiently through a solid program structure, comprehensive set of policies, and robust support, guidance, and engagement from its advisory committee members. Activities addressing improvement opportunities will be monitored, measured, and reported in future evaluations.

VI. Implementation Plan for the 2025 Program Evaluation

A. Trending of Measures

In 2024, Partnership had limited data available to draft a full evaluation report of C&L activities based on existing programmatic components and the 2024 C&L-QIHETP Work Plan. While Partnership was able to identify some initial findings among certain programmatic components in 2024, by the end of 2025, Population Health and/or Health Equity will plan to compare the 2024 data of the following C&L program components to available 2025 data:

- Translation Services
- Interpreter Services
- Auxiliary Aids and Services
- Alternative Formats
- Language Data Collection
- QIHEC and CAC Review
- Policy Review
- Staffing

By the end of 2025, Partnership will also compare the 2024 baseline data of the goals from 2024 C&L-QIHETP Work Plan to the 2025 C&L-QIHETP Work Plan to track

trending of measures as part of this annual report. The 2024 C&L-QIHETP Work Plan goals are as follows:

- By August 31, 2024, defining the framework and processes by which the QIHETP Program Description, C&L/QIHETP Work Plan, and QIHETP Evaluation will be initiated in 2024 and maintained through approval of corresponding 2025 versions needed for HEA Initial Survey in June 2025. This goal will be measured through the completion of the Disparity Analysis Report and Health Equity Strategic Plan Completion (QIHETP Program Description).
- By September 30, 2024 submitting the DEI training to DHCS for review to fulfill Phase I of APL-23-025 deliverables. This goal will be measured through obtaining a DEI Training submission receipt from DHCS.
- By December 31, 2024, increasing the number of members who have received one or more mailings in their preferred format by 90% as its base line for the following years. This goal will be measured by calculating the percentage of members requesting materials in an alternate format who received a mailing in their preferred format.
- By December 31, 2024, increasing the number of bilingual Member Service Representative (MSR) staff hired by 1% to move closer to organizational goal of 75% of bilingual MSR staff. This goal will be measured through calculating the percentage of member services staff members who are considered bilingual.
- By December 31, 2024, improving controlled blood pressure rates among American Indian/Alaska Native members by 5% in at least one region. This goal will be measured by calculating the percentage of members with controlled blood pressure per HEDIS measures.

This annual, year-over-year tracking and analysis will be an ongoing and iterative process. The date range for data collection for each cultural and linguistic programmatic activity and goal is January 1, 2025-December 31, 2025. Quantitative analysis will take place in Q1 of 2026 to allow for access to the most complete data records for 2025. Data will be displayed using charts, graphs, or tables to display information and to trend data. The 2025 Cultural and Linguistic evaluation will be presented for committee approval at IQI, Q/UAC, and PAC, as well as QIHEC for review only from March 2026 through April 2026. Proposals for additional efforts, modifications, or interventions will take place at the committees and approved proposals will take effect between Q2-Q4 of 2026. Partnership will also plan for future evaluation efforts.

B. Analysis of Results of C&L Initiatives

In Quarter 1 of 2026 Partnership will analyze changes in outcomes from 2024 to 2025. Partnership will determine whether performance is improving, declining, or remaining stable as it relates to the cultural and linguistic program components and goals identified in the C&L QIHETP/ Work Plan. If the performance goals are not met, or if program components are showing gaps, Population Health and/or Health Equity will conduct a root cause analysis or barrier analysis to identify any and all barriers; analysis may include both quantitative data, and qualitative data derived from member experience feedback, which may include CAHPS results and/or member satisfaction surveys, and/or other methods as appropriate. Partnership will plan appropriate actions and interventions to address any gaps or concerns with services, including working with appropriate staff who have appropriate knowledge of and expertise with the processes proven to be barriers to improvement.

C. Review of Results at the Consumer Advisory Committee

Partnership maintains a community advisory committee, known as the Consumer Advisory Committee (CAC), which serves to inform its Cultural and Linguistic (C&L) Services Program. The purpose of the CAC is to act as a liaison between Partnership Health Plan of California (Partnership) and our members. The CAC provides Partnership members with a forum to discuss common issues of interest and importance, while creating a supportive and informative environment.

Partnership will plan to present the analysis of the evaluation and overall C&L program performance, including the root cause and/or barrier analysis, to the CAC committee members for review, feedback, as well as their perspectives on the root causes of barriers, and possible solutions. This may include garnering feedback from CAC members via feedback tools such as surveys and/or meetings minutes and/or verbal feedback from CAC members. Any comments or concerns will be considered and incorporated as appropriate into any planned actions or interventions. Population Health and/or Health Equity will plan to share the results and findings of the C&L Program Evaluation with the CAC in Q1 of 2025 and in Q1 2026; this committee meets on a quarterly basis (see MCND9002-E CAC Guiding Principles for a full description of Partnership’s CAC).

Partnership will consider the adequacy of the program’s structure and resources, including participation of practitioners, community representatives, and leadership as applicable. This information will be used to determine whether to restructure or change the program for improvement for the subsequent year based on its findings. Changes will be implemented and assessed for effectiveness as appropriate. Restructuring of the

following Cultural and Linguistic program activities will be undertaken if there is a need for it:

- Translation Services
- Interpreter Services
- Auxiliary Aids and Services
- Alternative Formats
- Language Data Collection
- QIHEC and CAC Review
- Policy Review
- Staffing

Partnership will also assess if the workplan goals listed below were effective or if adjustments to work plan activities are required to improve future outcomes. These goals were effective in 2024 and were modified or added on to in 2025. The goals are as follows:

1. By June 30, 2025, develop and propose a multi-year health equity strategic and tactical plan. Distribute the DEI training to the provider network and MCP staff and submit the final version to DHCS. This goal's completion status will be measured by tracking the DEI Training completion rate.
2. By December 31, 2025 distribute the DEI training to the provider network and MCP staff and submit the final version to DHCS.
3. By December 31, 2025, 91% of members who have requested materials in an alternative format will be mailed in their preferred format
4. December 31, 2025, increase the number of bilingual Member Service Representative (MSR) staff hired by 2% to move closer to organizational goal of 75% of bilingual MSR staff.
5. By December 31, 2025, improve controlled blood pressure rates among American Indian/Alaska Native members by 5% in at least two regions.
6. By December 31, 2025, improve the rate of timely translations in the Utilization Management and/or Care Coordination department to achieve the threshold of at least 90%.
7. By December 31, 2025, improve timely prenatal visit rates by at least 5% in the American Indian/Alaska Native Member Population within 12 months, in the Eureka region (Del Norte, Humboldt, Lake, and Mendocino), or Redding region (Lassen, Modoc, Shasta, Siskiyou, Tehama, and Trinity), with the global goal of improvement by 22% in the next 5 years.
8. By December 31, 2025, improve timely Well Care Visits rate among Black, White, and/or American Indian/Alaska native members by 5% overall or in at least 1.25% in at least one region.

For a visual of the 2025 Program Evaluation implementation plan, please see appendix A.

Appendix A – 2025 CLAS Program Evaluation Implementation Plan

2025 CLAS Program Evaluation Implementation Plan									
Measure	**Type of Goal**	**CLAS Evaluation Category (Goal/C&L Service)**	**Deliverables**	**Start Tracking**	**End Tracking**	**Responsible Department**	**Committee Approval Timeline**	**CAC Review**	**QIHEC Review**
Health Equity Strategic Plan Development and Health Disparities Analysis (HE6)	New	**Goal #1:** By June 30, 2025 develop and propose a multi-year health equity strategic and tactical plan.	• Trending of measures to assess performance. • Analysis of results of initiatives, including barrier analysis. • Review and evaluation of the results by community representatives. • Evaluation of the overall effectiveness of the program.	1/1/2025	2/1/2026	Population Health and/or Health Equity Departments	March - April 2026 (IQI, Q/UAC, PAC)	3/12/2026	3/17/2026
Providing DEI Training Development for Staff and Network Providers, Subcontractors, etc. to fulfill DHCS All Plan Letter (APL) Requirements.	New	**Goal #2:** By December 31, 2025 distribute the DEI training to the provider network and MCP staff and submit the final version to DHCS.	• Trending of measures to assess performance. • Analysis of results of initiatives, including barrier analysis. • Review and evaluation of the results by community representatives. • Evaluation of the overall effectiveness of the program.	1/1/2025	2/1/2026	Population Health and/or Health Equity Departments	March - April 2026 (IQI, Q/UAC, PAC)	3/12/2026	3/17/2026
Providing materials to members in large print, Braille, audio format, or other, per member request	Continued with modification	**Goal #3:** By December 31, 2025, 91% of members who have requested materials in an alternative format will be mailed their preferred format.	• Trending of measures to assess performance. • Analysis of results of initiatives, including barrier analysis. • Review and evaluation of the results by community representatives. • Evaluation of the overall effectiveness of the program.	1/1/2025	2/1/2026	Population Health and/or Health Equity Departments	March - April 2026 (IQI, Q/UAC, PAC)	3/12/2026	3/17/2026
Hiring of bilingual member services representatives	Continued with modification	**Goal #4:** By December 31, 2025, increase the number of bilingual Member Service Representative (MSR) staff hired by 2% to move closer to organizational goal of 75% of bilingual MSR staff.	• Trending of measures to assess performance. • Analysis of results of initiatives, including barrier analysis. • Review and evaluation of the results by community representatives. • Evaluation of the overall effectiveness of the program.	1/1/2025	2/1/2026	Population Health and/or Health Equity Departments	March - April 2026 (IQI, Q/UAC, PAC)	3/12/2026	3/17/2026
Controlling Blood Pressure	Continued with modification	**Goal #5:** By December 31, 2025, improve controlled blood pressure rate among American Indian/Alaska Native members by 5% in at least two regions.	• Trending of measures to assess performance. • Analysis of results of initiatives, including barrier analysis. • Review and evaluation of the results by community representatives. • Evaluation of the overall effectiveness of the program.	1/1/2025	2/1/2026	Population Health and/or Health Equity Departments	March - April 2026 (IQI, Q/UAC, PAC)	3/12/2026	3/17/2026
Timely translation requests	New	**Goal #6**: By December 31, 2025, improve the rate of timely translations in the Utilization Management and/or Care Coordination department to achieve the threshold of at least 90%.	• Trending of measures to assess performance. • Analysis of results of initiatives, including barrier analysis. • Review and evaluation of the results by community representatives. • Evaluation of the overall effectiveness of the program.	1/1/2025	2/1/2026	Population Health and/or Health Equity Departments	March - April 2026 (IQI, Q/UAC, PAC)	3/12/2026	3/17/2026
Prenatal Care	New	**Goal #7:** By December 31, 2025, improve timely prenatal visit rates by at least 5% in the American Indian/Alaska Native Member Population within 12 months, in the Eureka region (Del Norte, Humboldt, Lake, and Mendocino), or Redding region (Lassen, Modoc, Shasta, Siskiyou, Tehama, and Trinity), with the global goal of improvement by 22% in the next 5 years.	• Trending of measures to assess performance. • Analysis of results of initiatives, including barrier analysis. • Review and evaluation of the results by community representatives. • Evaluation of the overall effectiveness of the program.	1/1/2025	2/1/2026	Population Health and/or Health Equity Departments	March - April 2026 (IQI, Q/UAC, PAC)	3/12/2026	3/17/2026
Well Care Visits	New	**Goal #8:** By December 31, 2025, improve Well Care Visits rate among Black, White, and/or American Indian/Alaska native members by 5% overall or in at least 1.25% in at least one region.	• Trending of measures to assess performance. • Analysis of results of initiatives, including barrier analysis. • Review and evaluation of the results by community representatives. • Evaluation of the overall effectiveness of the program.	1/1/2025	2/1/2026	Population Health and/or Health Equity Departments	March - April 2026 (IQI, Q/UAC, PAC)	3/12/2026	3/17/2026
Trend yearly data, 2024-2025	Continued CLAS Services	Translation Services Interpreter Services Auxiliary Aids and Services Alternative Formats Language Data Collection QIHEC and CAC Review Policy Review Staffing	• Trending of measures to assess performance. • Analysis of results of initiatives, including barrier analysis. • Review and evaluation of the results by community representatives. • Evaluation of the overall effectiveness of the program.	1/1/2025	2/1/2026	Population Health and/or Health Equity Departments	March - April 2026 (IQI, Q/UAC, PAC)	3/12/2026	3/17/2026

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Item #	Project/Program	Type of Goal	Goal	Outcome Measure(s)	Deliverables	Start Date	Due Date	Sponsor	Business Owner	Deliverable Evaluation Status				Goal Met (Yes No)
										Jan 1 - Mar 31	Apr 1 - June 30	July 1 - Sep 30	Oct 1 - Dec 31	
1.a. (Health Equity Foundation)	Health Equity Strategic Plan Development and Health Disparities Analysis (HE6)	Continued	**Goal #1:** By August 31 , 2024, define the framework and processes by which the QIHETP Program Description, C&L/QIHETP Work Plan, and QIHETP Evaluation will be initiated in 2024 and maintained through approval of corresponding 2025 versions needed for HEA Initial Survey in June 2025	**Measure:** Disparity Analysis Report and Health Equity Strategic Plan Completion (QIHETP Program Description)	**Deliverable 1:** Submit 2023 HE 6 Disparity Analysis to External Consultant (Diane Williams)	1/1/2024	2/24/2024	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Improvement Advisor (QI) Name: Dorian Roberts	☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	No - delayed
					Deliverable #2: Submit updated 2024 C&L/QIHETP Work Plan for QIHEC approval	1/1/2024	2/20/2024	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Director of Health Equity Name: Mohamed Jalloh, PharmD	☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	
					Deliverable #3: Health Disparities Statistical Analysis for 2024 data (2025 HE 6 Analysis)	7/1/2024	7/30/2024	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Senior Health Data Analyst II Name: Shivani Sivasankar	☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	
					Deliverable #4: Submit 2024 HE 6 Disparity Analysis to External Consultant (Diane Williams)	9/1/2024	9/15/2024	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Improvement Advisor (QI) Name: Dorian Roberts	☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	
					Deliverable #5: Submit Final 2024 C&L/QIHETP Work Plan and proposed 2025 C&L/QIHETP Work Plan for IQI / QUAC review and approval for HEA Initial Survey in 2025	9/1/2024	10/30/2024	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Director of Health Equity Name: Mohamed Jalloh, PharmD	☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☒ Delayed ☐ Terminated	
1.b. (Health Equity Foundation)	Providing DEI Training Development for Staff and Network Providers, Subcontractors, etc. to fulfill DHCS All Plan Letter (APL) Requirements. Training will be tailored per Network Cultural Responsiveness and Community Needs	New	**Goal #1:** By Sep 30 2024, submit DEI training to DHCS for review to fulfill Phase I APL-23-025 deliverables	**Measure:** DEI Training Submission Receipt from DHCS	**Deliverable #1:** Create and submit RFP for DEI training	1/1/2024	2/1/2024	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Director of Health Equity Name: Mohamed Jalloh, PharmD	☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	No - delayed
					Deliverable #2: Execute Contract for RFP after decision from Exec Team and PRB	3/1/2024	4/30/2024	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Project Manager I Name: Anabel Castro	☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☒ Delayed ☐ Terminated	☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	
					Deliverable #3: Review DEI training Content and conduct pilot with 5 to 10 practitioners to validate training practicality	4/30/2024	8/31/2024	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Director of Health Equity Name: Mohamed Jalloh, PharmD	☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐On Track ☒ Delayed ☐ Terminated	☐ Complete ☐ On Track ☒ Delayed ☐ Terminated	☐ Complete ☐ On Track ☒ Delayed ☐ Terminated	
					Deliverable #4: Submit training to DHCS for review and approval to fulfill Phase I of APL	9/1/2024	9/30/2024	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Director of Health Equity Name: Mohamed Jalloh, PharmD	☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	☐Complete ☒ On Track ☐ Delayed ☐ Terminated	☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	
1.c. (CLAS)	Providing materials to members in large print, Braille, audio format, or other, per member request	Continued	**Goal #1:** By Dec 31, 2024, 90% of members who have requested materials in an alternate format will receive one or more mailings in their preferred format	**Measure:** Percentage of members requesting materials in an alternate format who received a mailing in their preferred format **Numerator:** Number of members who have been sent one (1) or more mailings of materials in their preferred format **Denominator:** Number of members who have requested an alternate format	**Deliverable #1:** Complete draft 2024 C&L Program Evaluation based on 2024 C&L Program Description and Final 2024 C&L/QIHETP Work Plan in preparation for submission to the NCQA Consultant for review in January 2025	11/1/2024	12/31/2024	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Manager of Population Health Name: Hannah O'Leary, MPH, CHES Title: Sr. Manager of Member Services Name: Cyress Mendiola (MS)	☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	☒Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	Yes
1.d (CLAS)	Hiring of bilingual member services representatives	New	**Goal #1:** By Dec 31, 2024, increase the number of bilingual Member Service Representative (MSR) staff hired by 1% to move closer to organizational goal of 75% of bilingual MSR staff.	**Measure:** Percentage of members who are considered bilingual **Numerator:** Number of bilingual MSR department staff that have passed Partnership bilingual competency examination with a minimum rating of "Advanced" **Denominator:** Total number of MSR department staff	**Deliverable #1:** Conduct baseline assessment of number of bilingual representatives needed to reach 1% increase	1/1/2024	2/24/2024	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Director of Health Equity Name: Mohamed Jalloh, PharmD	☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	Yes
					Deliverable #2: Conduct internal evaluation of bilingual salary adjustment recommendations to promote MSR retention in the MS department	3/1/2024	6/30/2024	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Sr. Manager of Member Services Name: Cyress Mendiola (MS) Title: Supervisor of Member Services Name: Maria Cabrera (MS)	☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	☒Complete ☐ On Track ☐ Delayed ☐ Terminated	☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	
					Deliverable #3: Conduct internal focus group to discuss strategies for recruiting bilingual staff members	3/1/2024	6/30/2024	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Sr. Manager of Member Services Name: Cyress Mendiola (MS) Title: Supervisor of Member Services Name: Maria Cabrera (MS)	☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	
					Deliverable #4: Complete draft 2025 C&L/QIHETP Work Plan	7/1/2024	8/1/2024	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Director of Health Equity Name: Mohamed Jalloh, PharmD	☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	
2.a (Disparity)	Controlling Blood Pressure	Continued	**Goal #1:** By Dec 31, 2024, improve controlled blood pressure rates among American Indian/Alaska Native members by 5% in at least one region.	**Measure:** Percentage of members with controlled blood pressure per HEDIS **Numerator:** Number of members who are considered controlled for blood pressure **Denominator:** Total number of eligible members with essential hypertension diagnosis	**Deliverable #1:** Conduct Root Cause Analysis to identify sites that have largest number of American Indian/Alaska Native Members with lowest blood pressure control per region	3/1/2024	3/30/2024	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Director of Health Equity Name: Mohamed Jalloh, PharmD	☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	TBD
					Deliverable #2: Conduct coordinated site visit with Performance Improvement and/or Equity Transformation Project teams to at least 60 to 80% of previously identified sites to provide education and solicit feedback	4/1/2024	6/30/2024	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Director of Health Equity Name: Mohamed Jalloh, PharmD	☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☒ Delayed ☐ Terminated	☐ Complete ☐ On Track ☒ Delayed ☐ Terminated	☐ Complete ☐ On Track ☒ Delayed ☐ Terminated	
					Deliverable #3: Provide recommendations to QIP workgroup to incentivize blood pressure reduction in specific target community to model other health plans	4/1/2024	6/30/2024	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Director of Health Equity Name: Mohamed Jalloh, PharmD	☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	
					Deliverable #4: Execute PHM campaign to prioritized group during outreach calls and identify community events to conduct community outreach	4/1/2024	12/31/2024	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Associate Director of Population Health Name: Monika Brunkal, RPH	☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	

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2025 Goals

Goal #	Project/Program	Type of Goal	Goal	Outcome Measure(s)	Deliverables	Start Date	Due Date	Sponsor	Business Owner	Deliverable Evaluation Status				Goal Met (Yes No)
										Jan 1 - Mar 31	Apr 1 - June 30	July 1 - Sep 30	Oct 1 - Dec 31	
1. (Health Equity Foundation)	Health Equity Strategic Plan	New	**Goal 1:** By June 30, 2025 develop and propose a multi-year health equity strategic and tactical plan.	**Measure:** Track completion rate for all deliverables.	**Deliverable #1:** Update department activities to include health equity activities.	7/1/2024	6/30/2025	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Director of Health Equity Name: Mohamed Jalloh, PharmD	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	
					Deliverable #2: Update incentive models for employees.	7/1/2024	6/30/2025	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Director of Health Equity Name: Mohamed Jalloh, PharmD	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	
					Deliverable #3: Update incentive models for PCP QIP.	7/1/2024	6/30/2025	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Director of Health Equity Name: Mohamed Jalloh, PharmD	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	
					Deliverable #4: Create a list of interventions for addressing the disparities. **Note:** This deliverable was kept to demonstrate steps and ongoing progress around a goal tied to the 2024 C&L/QIHETP Work Plan.	7/1/2024	12/31/2024	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Manager of QI Name: Brandy Isola	☐ Complete ☐On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	
					Deliverable #5: Establish a pilot for addressing a single disparity utilizing an MCO-Health System-Pub Health-CBO ecosystem model in a single community.	7/1/2024	6/30/2025	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Manager of Population Health Name: Nicole Curreri	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	
2. (Health Equity Foundation)	Provide DEI Training for Network Providers and MCP staff to fulfill DHCS All Plan Letter (APL) Requirements	New	**Goal 2**: By December 31, 2025 distribute the DEI training to the provider network and MCP staff and submit the final version to DHCS.	**Measure:** DEI Training completion rate.	**Deliverable #1:** Conduct pilot with one of our provider networks.	1/1/2025	3/31/2025	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Director of Health Equity Name: Mohamed Jalloh, PharmD	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	
					Deliverable #2: Review feedback from pilot and make changes as appropriate.	4/1/2025	5/31/2025	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Director of Health Equity Name: Mohamed Jalloh, PharmD	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	
					Deliverable #3: Distribute the final training throughout the provider network and to MCP staff.	7/1/2025	12/31/2025	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Director of Health Equity Name: Mohamed Jalloh, PharmD	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	
3. (CLAS)	Providing materials to members in large print, Braille, audio format, or other, per member request	Continued with modification	**Goal #3:** By December 31, 2025, 91% of members who have requested materials in an alternative format will be mailed in their preferred format.	**Measure:** Percentage of members requesting materials in an alternative format who received a mailing in their preferred format. **Numerator:** Number of members who have been sent one (1) or more mailings of materials in their preferred format. **Denominator:** Number of members who have requested an alternative format.	**Deliverable #1:** Complete 2025 C&L Program Evaluation based on 2025 C&L Program Description and Final 2025 C&L/QIHETP Work Plan in preparation for submission to the NCQA Consultant for review in Febrary 2026.	1/1/2025	12/31/2025	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Manager of Population Health Name: Hannah O'Leary, MPH, CHES Title: Sr. Manager of Member Services Name: Cyress Mendiola (MS)	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	
4. (CLAS)	Hiring of bilingual member services representatives	Continued with modification	**Goal #4:** By December 31, 2025, increase the number of bilingual Member Service Representative (MSR) staff hired by 2% to move closer to organizational goal of 75% of bilingual MSR staff.	**Measure:** Percentage of member services representatives who are considered bilingual. **Numerator:** Number of bilingual MSR department staff that have passed Partnership bilingual competency examination with a minimum rating of "Advanced." **Denominator:** Total number of MSR department staff.	**Deliverable #1:** Conduct assessment of number of bilingual representatives needed to reach a 2% increase.	1/1/2025	12/31/2025	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Sr. Manager of Member Services Name: Cyress Mendiola (MS) Title: Supervisor of Member Services Name: Maria Cabrera (MS)	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	
					Deliverable #2: Conduct recruitng efforts to hire additional bilingual staff.	1/1/2025	12/31/2025	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Sr. Manager of Member Services Name: Cyress Mendiola (MS) Title: Supervisor of Member Services Name: Maria Cabrera (MS)	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	
5. (Disparity)	Controlling Blood Pressure	Continued with modification	**Goal #5:** By December 31, 2025, improve controlled blood pressure rates among American Indian/Alaska Native members by 5% in at least two regions.	**Measure:** Percentage of members with controlled blood pressure per HEDIS measures. **Numerator:** Number of members who are considered controlled for blood pressure. **Denominator:** Total number of eligible members with essential hypertension diagnosis.	**Deliverable #1:** Conduct Root Cause Analysis to identify sites that have the largest number of American Indian/Alaska Native Members with lowest blood pressure control per region.	6/1/2025	12/31/2025	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Director of Health Equity Name: Mohamed Jalloh, PharmD	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	
										Jan 1 - Mar 31	Apr 1 - June 30	July 1 - Sep 30	Oct 1 - Dec 31	
										☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	
					Deliverable #2: Provide recommendations to QIP workgroup to incentivize blood pressure reduction in specific target community to model other health plans.	6/1/2025	12/31/2025	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Director of Health Equity Name: Mohamed Jalloh, PharmD	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	
					Deliverable #3: Execute PHM campaign to prioritize group during outreach calls and identify community events to conduct hypertension community outreach.	6/1/2025	12/31/2025	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Associate Director of Population Health Name: Monika Brunkal, RPH	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	
6. C&L Program Measures	Timely translation requests	New	**Goal #6**: By December 31, 2025, improve the rate of timely translations in the Utilization Management and/or Care Coordination department to achieve the threshold of at least 90%.	**Measure**: Percentage of translations fulfilled in a timely manner. **Numerator**: Translations completed in 48 hours (for UM) and 14 business days (for CC). **Denominator**: Total translations in either department.	**Deliverable #1:** Generate a report showing the rate of timely translations for UM and/or CC.	1/1/2025	12/31/2025	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Supervisor of Quality and Training, Care Coordination Name: Jaz Hernandez and Jennifer Osborn Title: Program Manager I, Utilization Management Name: Kandice Dixon	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	
					Deliverable #1: Conduct Root Cause Analysis to identify sites and zipcodes with highest likelihood of not completing prenatal care visits. **Note:** This deliverable was kept to demonstrate steps and ongoing progress for this goal.	10/1/2024	10/31/2024	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Director of Health Equity Name: Mohamed Jalloh, PharmD	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	

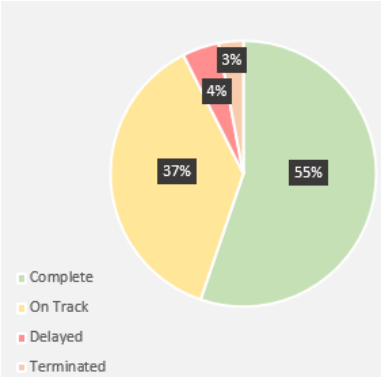
7. (Disparity)	Prenatal Care	New	**Goal #7:** By December 31, 2025, improve timely prenatal visit rates by at least 5% in the American Indian/Alaska Native Member Population within 12 months, in the Eureka region (Del Norte, Humboldt, Lake, and Mendocino), or Redding region (Lassen, Modoc, Shasta, Siskiyou, Tehama, and Trinity), with the global goal of improvement by 22% in the next 5 years.	**Measure:** The percentage of deliveries in which women had a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization. **Numerator:** The total number of prenatal care visit a woman had in the first trimester. **Denominator:** The total number of eligible deliveries, such as all live births between certain dates or all women who meet certain enrollment criteria.	**Deliverable #2:** Interview at least 10 members in the Northern Region to identify barriers for conducting prenatal visits. **Note:** This deliverable was kept to demonstrate steps and ongoing progress for this goal.	11/1/2024	3/31/2025	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Director of Health Equity Name: Mohamed Jalloh, PharmD	**Jan 1 - Mar 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Apr 1 - June 30** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**July 1 - Sep 30** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Oct 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	
					Deliverable #3: Identify and recommend interventions for QMSI workgroup in collaboration with other departments and teams. QMSI to submit at least 1 intervention agreed upon by the QMSI team.	1/1/2025	4/30/2025	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Director of Health Equity Name: Mohamed Jalloh, PharmD	**Jan 1 - Mar 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Apr 1 - June 30** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**July 1 - Sep 30** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Oct 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	
					Deliverable #4: Execute internal PHM campaign, QMSI generated intervention, and/or Population Health Community event to address disparity.	5/1/2025	12/31/2025	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Associate Director of Population Health Name: Monika Brunkal, RPH	**Jan 1 - Mar 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Apr 1 - June 30** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**July 1 - Sep 30** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Oct 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	
8. (Disparity)	Well Care Visits	New	**Goal #8:** By December 31, 2025, improve timely Well Care Visits rate among Black, White, and/or American Indian/Alaska native members by 5% overall or in at least 1.25% in at least one region.	**Measure:** Percentage of members 3–21 years of age who received one or more well-care visit with a primary care practitioner or an OB/GYN practitioner during the measurement year. **Numerator:** Number of members who attend at least one well-care visit with a primary care practitioner. **Denominator:** Total number of eligible members in age range.	**Deliverable #1:** Conduct Root Cause Analysis to identify sites that have the largest number of members who are not attending WCVs. **Note:** This deliverable was kept to demonstrate steps and ongoing progress for this goal.	10/1/2024	10/30/2024	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Director of Health Equity Name: Mohamed Jalloh, PharmD	**Jan 1 - Mar 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Apr 1 - June 30** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**July 1 - Sep 30** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Oct 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	
					Deliverable #2: Interview available pediatricians to assess current workload of seeing members for well care visits and interview at least 10 parents to identify barriers for going to well-care visits. **Note:** This deliverable was kept to demonstrate steps and ongoing progress for this goal.	11/30/2024	12/21/2024	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Director of Health Equity Name: Mohamed Jalloh, PharmD	**Jan 1 - Mar 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Apr 1 - June 30** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**July 1 - Sep 30** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Oct 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	
					Deliverable #3: Identify interventions for QMSI workgroup in collaboration with other deptartments and teams (Conduct in-service presentation on benefit of group WCV and mother-child dyadic appointments to clinical sites.	1/1/2025	3/30/2025	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Director of Health Equity Name: Mohamed Jalloh, PharmD	**Jan 1 - Mar 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Apr 1 - June 30** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**July 1 - Sep 30** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Oct 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	
					Deliverable #4: Execute internal PHM campaign, QMSI generated intervention, and/or Population Health Community event to address disparity.	6/1/2025	12/312025	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Associate Director of Population Health Name: Monika Brunkal, RPH	**Jan 1 - Mar 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Apr 1 - June 30** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**July 1 - Sep 30** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Oct 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	

QI TRILOGY PROGRAM

Background: The QI Work Plan is designed to track progress on key QI activities and initiatives throughout the year. Approved by our Board of Directors and quality committees, it includes progress updates on planned activities and objectives for improving quality of clinical care, safety of clinical care, quality of service and members' experience. The Work Plan is set on a fiscal year (FY) 2024-2025 schedule. This update includes progress on activities included in the FY 2024-2025 QI Work Plan from 07/01/2024 - 12/31/2024.

Results: Of the 67 deliverables outlined in the QI Work Plan, 37 are "Complete"; 25 are "On Track"; 3 are "Delayed"; and 2 have been "Terminated."

Deliverable Status 07/01/2024 - 06/30/2025		
Status	**Total Number: 67**	**%**
Complete	37	55.2
On Track	25	37.3
Delayed	3	4.5
Terminated	2	3.0



QI Major Milestones and Activities:

- The D-SNP Strategy Work Group was formed and met through July 2024 with representatives from across the organization. All Medicare D-SNP measures were reviewed including those in Part C, Part D and Display measures, along with DHCS D-SNP measures for which Partnership will be accountable. Each measure was reviewed to identify measure ownership, data collection and intervention/actions. This information was documented for all measures across all departments in the organization. The shared document is available on the Partnership Advantage SharePoint site and will be used for other projects to identify business needs by department.

- A measure set has been developed for the D-SNP incentive program while QIP model for payment and STAR performance is currently being developed with an estimated completion date of June 2025.
- Evaluations of external vendors for the development of system solution for performance tracking of Dual Eligible Special Needs Plan (D-SNP) QIP have been concluded. Request for proposal (RFP) have been received from vendors and are currently being conducted. Currently on track to choose an external vendor and start contracting process.
- No changes needed to current PRC policy or to current PQI process to accommodate D-SNP.
- The Primary Care Provider Quality Improvement Program (PCP QIP) reviewed the Data Validation framework document to help identify any areas of revision and improvement.
    - Within the document, the Non-Clinical Preliminary Period was added to give providers the opportunity to review and validate their final non clinical data.
    - For the eReports clinical validation period, the necessary steps were taken to document this process within the Data Validation framework document.
    - For Health Information Exchange (HIE) data validation, this process was updated to include the steps of a program manager using the clinical viewer dashboard to verify HIE connection.
- QIP Workgroup developed a provider education document to inform and influence Member Experience improvement activities. The MY 2025 specifications will include a URL resource link within the Patient Experience Unit of Service measure description.
- The Quality Measure Score Improvement (QMSI) group, formed to improve Quality performance over measurement years 2023 and 2024, has four measure-specific workgroups of which each has identified deliverables to focus on during the current fiscal year. Activities to complete all stated deliverables by the end of the fiscal year are either complete or on-track.

  1. Pediatrics
    - Expand Promotion of Healthy Babies Growing Together Program to also include our Provider Network (including update member incentive of $100 for completion of CIS-10)
    - Launch a new Human Papillomavirus (HPV) 2nd Dose Reminder Program Pilot
    - Facilitate two Pediatric Preventative Care Improving Measure Outcomes webinars
    - Extend current Quality Incentive Program (QIP) Unit of Service (UOS) group well care visits' measure to include members eligible under either the W15 or W30 clinical measure

- Launch a Provider Educational Webinar on Developmental Screening in the First Three Years of Life in preparation for provider network Developmental Screening in the First Three Years of Life (DEV) measure improvement work
- Conduct Topical Fluoride Varnish (TFL-CH) data investigation to identify data source gaps
- Complete State Withhold Well Child Visit (WCV) Disparity Sprint Project focused on improving well child visit completion among direct members.
- Continue work on the State Mandated Performance Improvement Project (PIP) to improve Well Child in First 15 Months (W15) completion rates in African American members in Solano County

2. Behavioral Health
   - Implement a pilot with a provider to track and improve the follow up care for patients with mental health and substance abuse disorder after emergency department (ED) discharge aiming to increase the percentage of provider notification for the respective members (DHCS Non-Clinical PIP)
   - Execute the DHCS-mandated IHI Behavioral Health Collaborative Project
   - Engage County Department of Behavioral Health (DBH) to utilize Sac Valley Med Share Data Exchange for follow-up after mental illness (FUM) data
   - Facilitate collaboration among departments (Behavior Health, Care Coordination, Population Health, Pharmacy, Tribal Health Liaison and Quality Improvement) to monitor and evaluate the implemented interventions by the respective departments aiming to improve the FUM and follow up after emergency visit for substance use (FUA) measures scores.
   - Increase embedded Community Health Workers (CHWs) in hospital Emergency Departments (up to 26)
3. Management of Chronic Diseases
   - Monitor, evaluate, and improve the use of the Diabetes management program offered by TeleMed2U
   - Implement a pilot of a comprehensive, service-intensive diabetes management program with Gojii
   - Bring the blood pressure control strategies into alignment with best practices of at least one primary care practice
   - Implement a retinal eye exam grant to support providers to improve their percentage of Partnership members with diabetes who receive an annual retinal eye exam
   - Implement improvements to the Cologuard bulk ordering program to better serve a broader group of Primary Care providers
4. Women's Health
   - Facilitate integration of cervical cancer screening HPV Self Swab across our network

    - Identify 3 practices in counties with chlamydia screening rates below 50th minimum performance level (MPL) and offer 1 on 1 education
    - Monitor BCS rates/improvements following the hospital quality incentive program (H-QIP) incentive “Increasing Screening Mammogram Capacity”
    - Monitor Postpartum rates/improvements in regions below the 50th MPL following the Growing Together Program’s increased incentive
    - Identify counties with race/ethnicity disparities for post-partum visits and support connection to enhanced care management (ECM) birth equity (BE) providers to support members accessing post-partum care
- Regional Quality Meetings within the date span of 07/01/2024 – 12/31/2024 were hosted in the Northeast twice, Northwest twice, Fairfield twice, Santa Rosa once, and Chico/Auburn collectively 4 times.
- HEDIS Week was held 10/21/2024 – 10/25/2024. In collaboration with key stakeholders across the organization, the HEDIS team created five (5) LMS training modules for staff to complete each day, along with a video from Leadership outlining what HEDIS means to them.
- The Healthy Kids Growing Together Program focused on contacting any 3 -6 year old who has never had a well-child visit in the last nine (9) months and offer an incentive to complete a well-child visit within 90 days prior to their 4th, 5th, and 6th birthday. This initial cohort identified 6,930 members that met the criteria and resulted in 2,257 successful outreaches. 1,601 children agreed to participate while 656 declined to participate. 967 gift cards have been distributed to date.
- The Primary Care Provider Quality Incentive Program (PCP) QIP Breast Cancer 50th percentile benchmark has been met in the legacy Southeast, Southwest, and Northeast regions.
- 43 Mobile Mammography event days have been completed resulting in 1,153 completed breast cancer screenings.
    - 7 Mobile Mammography event days were held at Tribal Health Centers.
    - 7 Mobile Mammography event days were held at Enhanced Provider Engagement (EPE) provider organizations.

Current Goal Status: Delayed/Terminated

Project / Program	Deliverable	Status Detail	Next Steps
2h Enterprise Information Management **Goal 1:** By June 30, 2025, integrate the Health Rules Payor (HRP®)	**Deliverable 1:** Develop the HEDIS® PQD dashboards using the HRP® data and complete User Acceptance Testing (UAT).	Delayed	This deliverable is delayed due to HRP delay.

Project / Program	Deliverable	Status Detail	Next Steps
version of the HEDIS® monthly project data into the Enterprise Data Warehouse and use this data to create the HRP® version of the HEDIS® PQD modules.			
3e Enhanced Care Management Quality Incentive Program (ECM QIP) **Goal 2:** By December 31, 2024, complete CY 2023 ECM QIP evaluation.	**Deliverable 1:** Complete evaluation of the program's CY 2023 measurement year to monitor performance.	Delayed	Because of competing deliverables in 2024, including the shifting of programs between program managers, the CY 2023 ECM QIP Evaluation is delayed. Evaluation completion is scheduled to be completed by March 31, 2025.
4b Missed Opportunities and Member Engagement **Goal 1:** By June 30, 2025 Incorporate missed opportunity data and feedback from the 23/24 goal and include in the member engagement dashboard currently in development and publish externally for providers to use.	**Deliverable 2:** By January 1, 2025, submit provider-facing dashboard business requirements for development team review.	Delayed	While BRD is developed and is ready to be shared with providers, discussions with development team have been delayed due to HRP implementation and competing priorities. Dashboard is currently available (and refreshed monthly) in Tableau Prod for internal users.
7a Potential Quality Issues (PQI) (safety) **Goal 2:** By June 30, 2025, QI Member Safety Quality Investigation Team will assess SugarCRM Potential Quality Issues (PQI) application and determine potential enhancements or replacement options.	**Deliverable 1:** Review and list issues/areas in SugarCRM PQI app that require an enhancement or upgrade. Consult with IT to determine best action.	Delayed	Discussed with IT and determined upgrading SugarCRM versus changing over to JIVA PQI system was more ideal. Tentative start date for upgrade was mid November 2024 with a completion by end of December 2024. A change freeze was placed on all systems on 11/14/24 but Tina Buop, CIO, agreed on

Project / Program	Deliverable	Status Detail	Next Steps
			11/27/24 that the upgrade was critical and approved it, with a request to continue evaluating whether JIVA can be used in the future. Demos for JIVA application were held in November/December while ongoing conversation continues regarding the Sugar upgrade including the plan and timeline.
8d Provider Coaching and Engagement **Goal 1:** By June 30, 2025, the Performance Improvement teams will launch interventions with 80 percent of provider organizations identified as low performing providers on the 2023 Primary Care Provider Quality Incentive Program assigned to Enhanced Provider Engagement or a Corrective Action Plan.	**Deliverable 1:** By December 31, 2024, the Performance Improvement team will complete a Needs Assessment with 80 percent of provider organizations newly assigned to Enhanced Provider Engagement OR Correction Action Plan in 2024.	Delayed	5 of the 7 providers who were newly assigned to the Modified QIP had completed a needs assessment, or the more comprehensive phmCAT assessment used in the DHCS Equity and Practice Transformation (EPT) program. Fortuna Family Medical has moved to a new facility which took up their leadership team's capacity but would ideally be engaged after they settle in their new facility. Prime Healthcare lacked engagement after initial contact given Partnership members are a small portion of their overall patient mix. Although, they have since committed to capturing preventative services when patients present in clinic. Both of the providers who were put on a corrective action plan have

Project / Program	Deliverable	Status Detail	Next Steps
			completed needs assessments. This brings the total assessment to 7 out of 9 (77.78%).
11b. Compliance with NCQA HPA and Sustain Performance **Goal 1:** By June 30, 2025, departments will maintain compliance of all assigned NCQA Health Plan Accreditation (HPA) Standards and Guidelines, following the most up-to-date Standards and Guidelines once available, as measured by the five (5) deliverables listed.	**Deliverable 2:** By October 18, 2024, Business Owners will update the annual HPA Workbook • Review and/or update the HPA Work Plan information; collect attestations from newly identify key stakeholders and contributors if applicable. • Review and/or update the Evidence Submission Library • The NCQA Program Management Team will share the annual HPA Workbook by September 20, 2024. **Deliverable 3:** Complete subset of analysis reports based on the approval dates outlined under the 2024-2026 HPA Report Schedule: • By October 18, 2024, submit edits to the 2024-2026 HPA Report	Delayed	**Deliverable 2:** All Business Owners but one completed the annual HPA Workbooks by the October 18, 2024 due date. The NCQA Program Management Team continues to work with the Health Equity Department to complete their annual HPA Workbook, and to ensure no issues are identified due to the late submission. **Deliverable #3:** There are two components to this deliverable: • All applicable Business Owners except one submitted their HPA Report Schedule timely. The NCQA Program Management Team continues to work with the Health Equity Department to complete their annual HPA Report Schedule, and to ensure no issues identified due to the late submission. • Applicable teams are on track to submit their analysis reports timely; no issues or concerns have been identified. This component will

Project / Program	Deliverable	Status Detail	Next Steps
	Schedule, if applicable. • Submit the analysis reports based on the draft report date provided under the 2024-2026 HPA Report Schedule.		remain in progress through June 2025 as annual reports are completed as scheduled.
14a Grand Analysis - Continuity and Coordination of Medical Care (QI3) Report **Goal 1:** By June 30, 2025, Quality Improvement will complete as much as possible of the annual Continuity and Coordination of Medical Care Grand Analysis (QI3) report, given the complete data sets that are available.	**Deliverable 1:** Complete those sections of the Continuity and Coordination of Medical Care Annual Grand Analysis Report (QI3) for which all needed data is available, including a quantitative and qualitative analysis by June 30, 2025.	Terminated	Grand Analysis - Continuity and Coordination of Medical Care (QI3) Report is retired under 2025 HPA standards.
14a Grand Analysis - Continuity and Coordination of Behavioral Health (QI4) Report **Goal 1:** By June 30, 2025, Behavioral Health will complete the annual Continuity and Coordination of Behavioral Health Grand Analysis (QI4).	**Deliverable 1:** By June 30, 2025, Behavioral Health will complete the annual Continuity and Coordination of Behavioral Health Grand Analysis (QI4).	Terminated	Grand Analysis - Continuity and Coordination of Behavioral Health (QI4) Report is retired under 2025 HPA Standards.

Updated Billing Instructions

(Urgent Request for Help)

Attention Dental Centers

Fluoride varnish services completed in FQHC, RHC, and Tribal Health Dental Centers count toward DHCS measure rates!

Dental Centers ***must*** use ICD code Z29.3 (Encounter for prophylactic fluoride administration)

Combined with CDT/CPT code (DI206, DI208, 99188)

The Topical Fluoride Varnish for Children measure includes children, ages 1-20 years. The measure requires a minimum of two fluoride varnish applications per year.

Please partner with us in this endeavor, as this measure greatly affects Partnership and, in turn, your health centers.

For questions contact: dentalsupport@partnershiphp.org