PARTNERSHIP HEALTHPLAN OF CALIFORNIA
QUALITY/UTILIZATION ADVISORY COMMITTEE MEETING NOTICE

FROM: Cindy Rodriguez, Project Coordinator II, Quality & Performance Improvement (QI)
DATE: March 18, 2026
SUBJECT: Quality/Utilization Advisory Committee (Q/UAC) Meeting

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

Meeting Time/Date: 7:30 – 9:00 a.m., Wednesday, March 18, 2026
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
1000 Fortress Street, Chico, CA 95973 | Temp Conf Room
1036 5th St. Suite E, Eureka, CA 95503 | Grizzly Creek

Other Locations:
Chapa-de Indian Health: 11670 Atwood Road, Auburn
H&HS Dept.,5730 Packard Ave., Suite 100, Marysville
Open Door Community Health Center, 770 10th St., Arcata

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, Behavioral Health
Brown, Isaac, MHA/MBA, Sr. Dir. of Quality & Perf. Improvement
Cox, Bradley, DO, Regional Medical Director, Northeast
Devan, James, Director of Quality Management
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
Guillory, Ledra, Senior Manager of Provider Relations Representatives
Hightower, Tony, CPhT, Associate Director, UM Regulations
Jalloh, Mohamed "Moe," Pharm.D, Health Equity Officer
Jensen, Annika, RN, Associate Director of Clinical Integration, CC
Jones, Kermit, MD, JD, Medical Director for Medicare Services
Katz, Dave, MD, Associate Medical Director
Leung, Stan, PharmD., Director of Pharmacy Services
Matthews, R. Douglas, MD, Regional Medical Director, Chico
George, Michael, MD, Associate Medical Director
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
Thornton, Aaron, MD, Associate Medical Director
Townsend, Colleen, MD, Regional Medical Director, Southeast
Ward, Lisa, MD, Regional Medical Director, Southwest
Watkins, Kory, MBA-HM, Director, Grievance & Appeals

cc:
Andrews, Leigha, Regional Director, Southwest
Bjork, Sonja, JD, Chief Executive Officer
Blake, Jill, Regional Director, Auburn
Brincko, Aaron, Director of Provider Relations
Brunkal, Monika, RPh, Associate Director of Population Health
Campbell, Anna, MPH, Policy Analyst, UM Regulations
Cunnigham, Aryana, policy Analyst, Care Coordination
Davis, Wendi, Chief Operations Officer
Durst, Jennifer, Sr. Mgr. of Performance Improvement, QI (SE/SW)
Foster, Troy, Program Manager II, QI (HQIP)
George, Michael "Mike," MD, Associate Medical Director
Gual, Kristine, Director of Quality Measurement, QI
Isola, Brandy, Mgt of Performance Improvement, QI (Chico/Auburn)
Jarrett-Lee, Kevin, RN, Associate Director, UM
Klakken, Vicki, Regional Director, Northwest
Kubota, Marshall, MD, Associate Medical Director
Mercer, Renee, Sr. Exec. Dir. of Operations, Administration
Morris, Matthew, MD, Regional Medical Director, Auburn
Nakatani-Phipps, Stephanie, Manager of Provider Relations Reps
Power, Kathryn, Regional Director, Southeast
Quichocho, Sue, Manager of Quality Improvement, QI
Sharp, Tim, Regional Director, Northeast
Sivasankar, Shivani, Sr. Data Scientist, Finance
Stark, Rebecca, Regional Director, Chico
Trosky, Renee, Manager of Provider Relations, Compliance
Vaisenberg, Liat, Director of Health Analytics, Finance
Villasenor, Edna, Sr. Dir., Member Services and Grievances
Youngstone, Kelly, RN, Dir. Of Care Coordination

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

Date: Mar. 18, 2026 **Time: 7:30 – 9:00 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
1000 Fortress Street, Chico, CA 95973 | Stony Creek Conf Room
1036 5th St. Suite E, Eureka, CA 95503 | Grizzly Creek

Other Locations:
Chapa-de Indian Health: 11670 Atwood Road, Auburn
H&HS Dept.,5730 Packard Ave., Suite 100, Marysville
Open Door Community Health Center, 770 10th St., Arcata

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 Partnership locations

	Item	Lead	Time	Page #
I.	**Call to Order – Welcome/Introductions/Announcements/Approval/Acceptance of Minutes**			
1	*Approval of Feb. 18, 2026* Quality/Utilization Advisory Committee (Q/UAC) Minutes	Robert Moore, MD, MPH, MBA	7:30	6 - 12
2	*Acknowledgment and acceptance of draft minutes of the* • Feb. 10, 2026 Internal Quality Improvement (IQI) Committee • Jan. 29.2026 Over/Under Utilization Workgroup			14 - 18
II.	**Standing Updates**			
1	Quality and Performance Improvement Program Update	Isacc Brown, MHA/MBA	7:35	25 - 38
2	HealthPlan Update	Robert Moore, MD	7:42	--
III.	**Old Business – None**			
IV.	**New Business – Consent Calendar**			
	Consent Calendar	All	7:47	40
	G&A Pulse Report/ Issue 20/ March 2026			42 - 55
	Proposed 2026 Perinatal QIP 6-month Bridge Measure Set			57 - 59
Health Services Policies	**Care Coordination**			--
	MCCP2014 – Continuity of Care – *The Adult Expansion population and associated attachments have been removed and archived, as references to populations and immigration status are considered protected language and are not appropriate for inclusion in policy content. The policy is bundled here without Attachment C (400 pages of codes).*			61 - 400
	Quality Improvement			--
	MPQP1002 – Quality/Utilization Advisory Committee			102 – 106
	MPQP1003 – Physician Advisory Committee (PAC) Policy			108 - 110

	Item	Lead	Time	Page #
	MPQP1004 – Internal Quality Improvement Committee			112 – 115
	Utilization Management			--
	MCUP3124 – Referral to Specialist (RAF) Policy			117 – 120
	MCUP3126 – Behavioral Health Treatment (BHT) for Members Under the Age of 21			122 – 129
	MCUP3121 – Neonatal Circumcision			131 – 132
	MPUG3031 – Nebulizer Guidelines			134 – 136
	MPUP3110 – Evaluation and Management of Obstructive Sleep Apnea in Adults			138 – 142
	MPUP3059 – Negative Pressure Wound Therapy (NPWT) Device/Pump			144 – 148
Non HS	**Provider Relations**			--
	MPPRGR210 – Provider Grievance			150 – 152
V.	**New Business – Discussion Policies**			
	Synopsis of Changes		--	154 – 158
Non -HS	**Transportation**			
	MPTP2503 – Transportation-Related Travel Expenses, Lodging, Meals, Attendants, Parking and Tolls	Danielle Biasotti, RPht,	7:54	160 – 167
HS	**Quality Improvement**			
	MPQG1005 – Adult Preventive Health Guidelines	Lisa Ward, MD	7:59	169 – 184
	Utilization Management			
	MPUG3019 – Hearing Aid Guidelines	Anna Campbell	8:04	186 – 193
	MCUG3024 – Inpatient Utilization Management	Tony Hightower	8:09	195 - 206
	Population Health			
	The annual Cultural & Linguistic Workplan, the annual Cultural & Linguistic Program Description, and the annual Cultural & Linguistic Evaluation will be presented for voting approval under the "Presentation" section.			See below
VI.	**Presentations**			
1	Site Review & PARS Reports	Rachel Newman, RN	8:14	208 – 222
2	Cultural & Linguistic Grand Analysis Presentation MPND9002 2026 C&L Program Description 2025 C&L/QIHETP Work Plan Final Update 2026 C&L Work Plan 2025 C&L Program Evaluation	Hannah O'Leary	8:21	224 – 362
3	Community Reinvestment- Review of Requirements and Funding Options	Mohamed Jollah, Pharm.D.	8:36	364 – 387
VI. FYI & Close	2025-2026 QI Work Plan Update	*Questions?:* Isaac Brown	--	389 - 400
	Adjournment scheduled for 9:00 a.m. Q/UAC next meets 7:30 a.m. Wednesday, Apr. 15, 2026			

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA
MEETING MINUTES

Quality and Utilization Advisory Committee (Q/UAC) Meeting
Wednesday, Feb. 18, 2025 / 7:30 a.m. – 9:30 a.m. - Napa/Solano Room, Airpark, Chico – Story Creek

Voting Members Present:		
Choudhry, Sara, MD	Luu, Phuong, MD	Swales, Chris, MD
Gwiazdowski, Steven, MD, FAAP	Montenegro, Brian, MD	Wilson, Jennifer, MD, MPH
	Quon, Robert, MD, FACP	

Voting Members Absent: Sara Choudhry, MD; Emma Hackett, MD, FACOG; Brandy Lane, Consumer Member; MD; Meagen Mulligan, FNP-BC; John Murphy, MD; Randolph Thomas, MD; Strain, Michael, PHC Consumer Member

Partnership *Ex-Officio* Members Present:

Bides, Robert, RN, BSN, Mgr, Member Safety – Quality Investigations, QI
Bontrager, Mark, Senior Director of Behavioral Health
Brown, Isaac, MBA/MHA, Interim Senior Director of Q & P Improvement
Cox, Bradley, DO, Regional Medical Director (Northeast)
DeVido, Jeff, MD, Behavioral Health Clinical Director
Esget, Heather, RN, BSN, ACM, Director of Utilization Management
Glickstein, Mark, MD, Associate Medical Director
Hightower, Tony, CPhT, Associate Director, UM Regulations
Jensen, Annika, RN, Assoc Dir. of Clinical Integration, Care Coordination
Jones, Kermit, MD, JD, Medical Director for Medicare Services
Katz, Dave, MD, Associate Medical Director
Moore, Robert, MD, MPH, MBA, Chief Medical Officer – Chair
Netherda, Mark, MD, Medical Director for Quality – Vice Chair
Newman, Rachel, RN, BSN, Mgr, 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, MPH, Director of Population Health
Thornton, Aaron, MD, Associate Medical Director
Townsend, Colleen, MD, Regional Medical Director (Southeast)
Ward, Lisa, MD, Regional Medical Director (Southwest)
Watkins, Kory, MBA-HM, Director, Grievance & Appeals

Partnership *Ex-Officio* Members Absent:

Barresi, Katherine, RN, BSN, PHN, NE-BC, CCM, Chief Health Services Officer
Gast, Brigid, MSN, BS, RN, NEA-BC, Senior Director, Care Management
Guillory, Ledra, Senior Manager of Provider Relations Representatives
Jalloh, Mohamed "Moe", Pharm.D, Dir. of Health Equity (Health Equity Officer)
Leung, Stan, Pharm.D, Director of Pharmacy Services
Spiller, Bettina, MD, Associate Medical Director

Guests:

Boyle, Shannon, RN, Manager of Care Coordination Regulatory Performance
Brunkal, Monika, RPh, Associate Director, Population Health
Campbell, Anna, Health Policy Analyst, Utilization Management
Chiang, Yeun, Project Manager I, UM
Chishty, Shahrukh, Sr. Mgr., Child Welfare Programs, Behavioral Health
Cunningham, Aryana, Policy Analyst, Care Coordination
Devan, James, Associate Director of Quality Improvement
Durst, Jennifer, Manage of Performance Improvement (Fairfield)
Frankovich, Terry, MD, Associate Medical Director
Gual, Kristine, Director of Quality Measurement
Hardwick, Curtis, Executive Assistant to the Chief Health Services Officer
Jarrett-Lee, Kevin, RN, Assoc. Dir., Utilization Management (Auburn)
Krznarich, Jackie, RN, Supervisor of Clinical Compliance
Matthews, Richard "Doug," MD, Regional Medical Director (Chico)
Morris, Matthew, MD, Regional Medical Director (Auburn)
O'Leary, Hannah, Manager of Population Health, Pop Health
Sivasankar, Shivani, Sr Data Scientist, Health Analytics, Finance
Trosky, Renee, Mgr of Provider Relations Compliance, Network Services
Vo, Kathleen, Pharm.D., Clinical Pharmacist
YoungStone, Kelly, RN, Director of Care Coordination

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
I. Call to Order Public Comment – *none made* Introductions Approval/ Acceptance of Minutes	Chief Medical Officer and Committee Chair Robert Moore, MD, MPH, MBA, called the meeting to order at 7:30 a.m. There was no quorum as yet, so the meeting began with the standing updates and an introduction. Dr. Moore introduced Michael George, MD, the new Associate Medical Director. The Jan. 21 Q/UAC Minutes will be proposed for approval in the next Mar. 18 Q/UAC meeting.	*There were no questions.*
II. Standing Updates		
1. Quality Improvement (QI) Department Update *Isaac Brown, Senior Director of Quality and Performance Improvement, QI*	• PCP QIP is going through their end of the year / beginning of the year activities. Preliminary periods are coming up for non-clinical measures where providers get to take a look at their numbers. • Retinal eye camera grant project is wrapping up. All providers who were awarded the grant money to purchase this device have officially done so and are putting best practices into place. We found that purchase and putting best practices into play were a bit more time consuming than originally thought. Program evaluation is under way. • The Quality Improvement Project Training Program is launching with its first cohort and has over 100 registrants to learn more about project management with 6 sessions over 12 weeks. • The Mobile Mammography program has done 21 event days from June – December 2025 with the goal to do at least 60 each fiscal year. Currently looking to turn these event days into Wellness Days to expand and address multiple health measures. o Dr. Townsend confirmed that Quest and LabCorp provide self swabs to any provider who is interested.	*For information only*.
2. HealthPlan Update *Robert Moore, MD, MPH, MBA Chief Medical Officer*	• Dr. Michael George is a new Associate Medical Director. • Currently updating our hospice, provider network, and some of the utilization management requirements for hospice that was required by APL 24-008. Hospice is not allowed to require pre-authorization. The mandate is to narrow our network and provide greater insight over any non-contracted hospice providers who are servicing our members. • SB912 bill is to reform perinatal services program. There was a required paper form to be filled out by every pregnant patient on Medicaid and submitted to DCHS that has been removed, but the new part added this year eliminates the PPS reimbursement for most perinatal services provided at FQHC's, RHC's, and tribal health centers across the state. Partnership is trying to raise awareness of what implications this	*There were no questions.*

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	language has on our region. • There is a drafted APL out from the Office of Healthcare Affordability that requires every healthplan in the state to have alternative payment methodology. • The Annual Regional Directors Forum is starting next week with registration currently open. Fairfield: March 6, 2026; Eureka: March 20, 2026; Redding: March 27, 2026; Ukiah: April 3, 2026: Santa Rosa: April 17, 2026; Chico: May 1, 2026; Truckee: May 8, 2026	
III. Old Business – None		
IV. New Business – Consent Calendar (Committee Members as Applicable)		
Health Services Policies Care Coordination MPCP2024 – Whole Child Model for California Children's Services Quality Improvement MCQP1021 – Initial Health Appointment MCQP1022 – Site Review Requirements and Guidelines – *coming back from January policy approval with reordered and re-lettered attachments* MPQG1011 – Non-Physician Medical Practitioners & Medical Assistants Practice Guidelines MPQP1016 – Potential Quality Issue Investigation and Resolution Utilization Management **ARCHIVE** MCUP3064 – Communications Services – *subsumed into the UM Program Description* MPUD3001 – Utilization Management Program Description MPUG3002 – Acupuncture Services Guidelines MPUG3011 – Criteria for Home Health Services MPUP3048 – Dental Services (including Dental Anesthesia) **Non-Health Services Policies** Member Services MC305 – Distribution of Member Rights and Responsibilities Network Services – Compliance MPNET102 – DHCS Network Certification Requirements	*No questions were asked.* Motion to **approve slate as presented:** Steven Gwiazdowski, MD Second: Chris Swales, MD *Approved unanimously* Next Steps: All policies go to the Mar. 11, 2026 PAC	
V. New Business – Discussion Policies		
Policy Owner: Network Services – Compliance – *Presenter: Renee Trosky, Manager of Provider Relations Compliance, Network Services*		

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
MPNET100 – Access Standards and Monitoring	**Language has been updated to comply with All Plan Letter (APL) 25-006 Timely Access Requirements** (revised Nov. 18, 2025). This update covers the process for psychiatric emergencies (VI.B.3.b.), appointment standards for primary care urgent care appointments requiring prior authorization, and appointment standards for urgent specialty care (with and without prior authorization). Changes in accordance with NCQA NET 1D – access standards for Behavioral Health – have been approved both by Dr. Moore and our NCQA consultant MHR: • Removed language referring to high-volume behavioral health • Added definition of Prescribers and Non-Prescribers. • Added provider-to-member ratios for prescribers and non-prescribers. • Added number of practitioners accepting new members, separated by prescribers and non-prescribers. • Reformatted the geographic distribution of practitioners graph to include access standards for each specialty **Sections I and III:** MCUP3044 Urgent Care Services has been added as a Related Policy, and that policy's definition of urgent care services has been added to this policy. MPBP8003 Mental Health Services and MPUP2014 Emergency Services have also been added as Related Policies. **Reference C:** APL 23-001 – Network Certification Requirements (Jan. 6, 2023) supersedes APL 21-006 **Reference D:** APL 25-006 (revised Nov. 18, 2025) supersedes April 25 version Dr. Swales felt like many of the time requirements in this APL are unattainable. Dr. Moore agreed but that it's a state requirement, and where we feel like we won't be able to meet it, we apply for an exception.	Motion to **approve as presented:** Chris Swales, MD Steven Gwiazdowski, MD *Approved unanimously* Next Steps: Mar. 11 PAC
Policy Owner: Utilization Management – *Presenter: Colleen Townsend, MD, Regional Medical Director (Southeast)*		
MPUP3018 – Health Services Review of Observation Code Billing	During the annual review of this policy, updates were made to clarify the conditions under which observation codes should be used. **Section I:** Policy MCUP3014 Emergency Services was updated to reflect MPUP3014. **Section III.A and C:** A definition was added for Acute Inpatient Care, and the definition of Observation Stay was updated. **Section V:** The Purpose section was updated to include Partnership Advantage enrollees. **Sections VI.B.1. and 2.** were added to provide details of the conditions under which Observation Status should be billed, namely, "when a Member's medical condition requires continuous monitoring for an additional period of time beyond what is usual and customary for Emergency Services and is provided up to a	No questions for Colleen Townsend, MD. Motion to **approve as presented:** Brian Montenegro, MD Second: Steven Gwiazdowski, MD *Approved unanimously* Next Steps: Mar. 11 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	maximum of 48 hours." **Sections VI.B.3. and 4.** detail when a Member may be admitted for Acute Inpatient Level of Care if they require more than 48 hours of monitoring (Observation Status).	

VI. Presentations

Care Coordination Grand Analysis (MPCD2013 – Care Coordination Program Description, Complex Case Management (CCM) Program Evaluation for CY 2024, CCM Program Evaluation CY 2924) **–** *Shannon Boyle, RN, Manager of Care Coordination Regulatory Performance; Kelly YoungStone, RN, Director of Care Coordination; Shivani Sivasankar, Sr Data Scientist, Health Analytics- Finance*

Care Coordination Background

Kelly provided an introduction to Care Coordination with a background of the department. CC is comprised of regional associate directors, managers, social workers, and health care guides. This team coordinates 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 their benefit. The responsibilities include assessing needs, coordinating services, and conducting outreach to targeted specific populations. The team works with multidisciplinary care groups to meet member needs, reduce duplication, and address challenges such as chronic illness, fragmented care, and complex health issues. They create individualized care plans and interventions aimed at education, timely care access, and connecting members with resources to minimize care gaps during transitions. The department supports members deeming care coordination and builds with complex needs using evidence based practices to achieve desired health outcomes.

MPCD2014 – Care Coordination Program Description and Complex Case Management (CCM) Program Evaluation for CY 2024

Shannon reviewed the policy edits due to Annual Review and NCQA edits:

Department Objectives & Goals (Page 4)
Added: Partnership Advantage Enrollees (Effective January 1st, 2027), in Partnership's Dual Eligible Special Needs Plan (D-SNP), who require integrated care coordination to address complex medical, behavioral, and social needs.

Updated footnote (Page 6)
MCCP2032 updated to reflect new policy number MCAP7002 CalAIM Enhanced Care Management (ECM)

Transitional Care Services (TCS) (Page 8)
Revised: Transitions may also occur across benefit structures (e.g. exhausting residential treatment service benefits for substance use disorder, or transitioning from curative care to hospice care). These members are vulnerable to lost information across the care continuum, fragmented care, difficulty navigating the health care system, or challenges to a transition plan being executed as intended.
Added: When a member's Partnership-covered benefits are exhausted and ongoing care is still needed, Care Coordination staff inform the member of available alternatives and provide guidance on how to access appropriate services.
Updated the most common sources of referral:
- Daily Hospital Discharge reports
- Referrals from other internal departments (Utilization Management, etc.)

Interventions updated to include:
- Ensuring necessary prior authorizations are in place and offering Treatment Authorization Request (TAR) support (e.g. home health, shift nursing, medical supplies, DME, etc.)

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION

Updated footnote (Page 8)
MCCP2034 updated to reflect new policy number MPCP2034 Transitional Care Services (TCS)
Abbreviated Transitional Care Services to TCS throughout Transitional Care Services (TCS) section

Non-Discrimination Statement (Page 20)
Updated to include Medicare beneficiaries

Complex Case Management Program Evaluation for CY 2024

Kelly provided background that complex case management focuses on meeting the needs of the most fragile members through clinical interventions and case management services. This is done through an evidence based approach. These may be members with multiple chronic conditions or they may have fragmented care, have difficulty navigating the health care system, or have other challenges that threaten to compromise their well being if not supported through an individualized care plan. Kelly highlighted that there was a reduction in enrollment year over year with high utilization across other programs in 2024. This is a volunteered program so it does impact enrollment. Shivani shared the program evaluation for CY 2024 powerpoint with it being found on page 202 with the report found on 223.

Discussion

Steven Gwiazdowski, MD, FAAP inquired what the ROI was for this program with Dr. Moore confirming that since this is a state requirement the ROI is not something they have looked into although this program is a little above the minimum for what is required.

Dr. Montenegro made an observation that the greatest impact was on the emergency department (ED) visits and asked what percentage of ED's, as far as Partnership is aware, has some kind of labelled frequent flyer program? Kelly YoungStone responded that we receive that information through a few different modalities with one of them being our monthly utilization reports and the other through community partners who bring members to our attention. Dr. Montenegro clarified that his question was more specific to what the ED's do to help intervene without Partnerships intervention, and if so what percentage have that? Dr. Townsend stated that Partnership does not have insight into which hospitals in each region have what services because its such a variable. Some of them do have structured programs but its not uniform across all of them although this is an area we could probably look into since that direct service would be so valuable since they can refer their own patients into our case management program and/or into enhanced care programs within their communities. Dr. Luu stated that sometimes it's confusing to know when to reach for the care coordination team and when to focus solely on the ECM side, often having to pull in both. Dr. Moore agreed that sometimes DHCS expects the ECM teams to be doing clinical stuff in their assumptions and that's not the way the program was structured or financed. Dr. Ward added that ED's in her region generate lists of patients who have visited the emergency room and send it to the PCP for them to follow up on, and did not realize this was not a universal thing. Dr. Swales added that after hearing from many ED providers needing more beds and more staff that if there is any way to target that partnership or the state should target, that it would be a high value item to improve both quality and costs through something like CCM that is targeted specifically for those high utilizers.

Dr. Moore asked for a motion and second to accept and approve: Robert Quon / Chris Swales, MD

Ensuring Access and Quality in Perinatal Care Presentation – *Colleen Townsend MD, Regional Medical Director (Southeast)*

Dr. Townsend stated that she is hopeful this presentation will help identify where and how Partnership is actually focusing on some of our perinatal services and our quality metrics to really ensure that we are meeting our accreditation mandate, but also our desire to really ensure that individuals who are pregnant and their infants get the highest quality of care and great access as well. She reviewed the presentation that starts on page 239.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION

Dr. Moore stated that Dr. Townsend is being called upon by a number of state agencies to help advise them when they see the work that we are doing.

Due to time questions were limited with direction to follow up with Dr. Townsend after the meeting if you want to dive into the topic deeper.

Q3 & Q4 and CY 2025 Potential Quality Issue (PQI) Report – *Robert Bides, RN, Quality Investigations, QI*

CY 2025: 291 referrals. Compared to last year (CY 2024: 247 referrals) there was a 17.8% increase in referrals and have been seeing a steady increase over the past few years showing. Most referrals tend to come from grievance but last year there was a significant increase from non-grievance sources including UM, CCM, and Medical Directors and as a result there were more PQI referrals. Closed 291 cases. 40% increase from 2024.

Peer Review Committee (PRC) have members that consist of non-Partnership primary and specialist clinicians who serve on Partnerships Quality/Utilization Advisory Committee (Q/UAC) and meet each month to review cases. Action and next steps depend on the severity level of the individual case.

Peer Review Committee (PRC) in Q1/Q2 reviewed a total of 9 cases and in Q3/Q4 total of 5 cases.

Subject Matter Expert Medical reviews had a total of 15 cases.

Q1/Q2 had eight providers with multiple PQIs however there were no reoccurring concerns that required additional actions.

Q3/Q4 had eight providers with multiple PQIs however there is only one provider and one facility that may need additional actions as a result of a reoccurring concern.

Any questions please follow up with Robert Bides.

VII. Adjournment

Dr. Moore adjourned the meeting at 9 a.m.

Respectfully submitted by: Chandler Ackerman, Program Manager I, QI

Signature of Approval: Date:

Robert Moore, MD, MPH, MBA
Chief Medical Officer

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA
INTERNAL QUALITY IMPROVEMENT (IQI) COMMITTEE MEETING MINUTES
Tuesday, Feb. 10, 2026 / 1:32 – 3:09 PM

Members Present:

Ayala, Priscila, Director of Network Services
Barresi, Katherine, RN, BSN, PHN, NE-BC, CCM, Chief Health Services Officer
Bides, Robert, RN, BSN, Manager of Member Safety – Quality Investigations, QI
Bjork, Sonja, JD, Chief Executive Officer
Bontrager, Mark, Sr. Director of Behavioral Health, Behavioral Health
Brown, Isaac, MHA/MBA, Sr. Dir. of Q & P Improvement
Brunkal, Monika, RPh, Assoc. Dir., Population Health
Campbell, Anna, MPH, Policy Analyst, Utilization Management
Esget, Heather, RN, BSN, ACM, Director of Utilization Management
Gast, Brigid, MSN, BS, RN, NEA-BC, Sr. Director, Care Management
Gual, Kristine, PMO, CPHQ, Director of Quality Measurement, QI
Hightower, Tony, CPhT, Associate Director, UM Regulations
Innes, Latrice, Manager of Grievance & Appeals Compliance
Jones, Kermit, MD, JD, Deputy CMO & Medical Director for Medicare Services
Leung, Stan, Pharm.D, Director of Pharmacy Services
Matthews, Richard "Doug," MD, Regional Medical Director (Chico)
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
Ruffin, DeLorean, DrPH, MPH, Director of Population Health
Vaisenberg, Liat, Director of Health Analytics, Finance
Villasenor, Edna, Senior Director, Member Services and G&A
Ward, Lisa, MD, Regional Medical Director (Southwest)
YoungStone, Kelly, RN, Director of Care Coordination, Care Coordination

Members Absent:

Andrews, Leigha, MBA, Regional Director (Southwest)
Brincko, Aaron, Director, Provider Relations
Brundage O'Connell, Lisa, MHA, Director of Enhanced Health Services
Davis, Wendi, Chief Operating Officer
Jalloh, Mohamed "Moe," Pharm.D, Health Equity Officer
Klakken, Vicki, Regional Director (Northwest)
Sharp, Tim, Regional Director (Northeast)
Townsend, Colleen, MD, Regional Medical Director (Southeast)
Turnipseed, Amy, Senior Director of External and Regulatory Affairs

Guests:

Ackerman, Chandler, Project Manager I, Quality Improvement
Akintan, Folo, MBBS/MD MPH MBA, Epidemiologist, Population Health
Allen, Angier, Senior Data Scientist I, Finance
Almanza, Mark, Director of Provider Contracts
Bikila, Dejene, Manager of Data Science, Finance
Boyle, Shannon, RN, Manager, Care Coordination Regulatory Performance
Chebolu, Radha, Sr. Health Data Analyst II
Clark, Kristen, Manager, Quality & Training, Member Services
Cunningham, Aryana, Policy Analyst, Care Coordination
Diaz, Alondra, Project Coordinator I, Care Coordination
Devan, James, Sr. Mgr. of Performance Improvement, QI (Redding)
DeVido, Jeff, MD, Behavioral Health Clinical Director
Foster, Troy, Program Manager II, QI
Hanusiak, Kenzie, Associate Director of Reg. Affairs/Compliance
Harris, Vander, Senior Health Data Analyst I, Finance
Isola, Brandy, Manager of Performance Improvement, QI (Chico/Auburn)
Jensen, Annika, RN, Associate Director of Clinical Integration
Kulkarni, Shreya, JD, Policy Analyst, Regulatory Affairs & Compliance (RAC)
Kung, Jen, Senior Health Data Analyst II, Finance
O'Leary, Hannah, Manager of Population Health, Population Health
Ogren, Danielle, Sr. Director of Reg. Affairs & Compliance
Moore, Jordan, Education Specialist, Provider Relations
Moraghebi, Roudabeh, Manager of Health Analyst
Muncy, Kellie, Mgr of Change Management & Configuration, Configuration
Nguyen, Tom, Manager of Health Analytics, Finance
Puga, Jose, Ops. & Systems Technician III, IT
Quichocho, Sue, Manager of Quality Measurement, QI
Rathnayake, Russ, Senior Health Data Analyst I, Finance
Rednic, Hanny, Program Manager I, UM
Roach, Erika, Program Manager II, Network Services
Moraghebi, Roudabeh, Manager of Health Analyst
Salehi, Tiphanie, Sr. Health Data Analyst I, Finance
Seale, J'aime, PR Lead, Network Services
Selig, Barbara, Manager of Qlty. Improvement Programs
Sivasankar, Shivani, Sr Data Scientist, Health Analytics, Finance
Stark, Rebecca, Regional Director
Thomas, Penny, Senior Health Data Analyst I, Finance
Trosky, Renee, Manager of Provider Relations Compliance

Lee, Donna, Manager of Claims, Claims	Vance, Brooke, Program Manager I, Network Services
Ling, Samuel, Sr. Health Data Analyst I, Finance	Yu, Fei, Senior Data Scientist I, Finance
O'Connell, Lisa, Director of Enhanced Health Services	Zhao, Li, Senior Health Data Analyst I, Finance

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
I. Call to Order • Introductions • Approval / Acceptance of Minutes	Chief Medical Officer Robert Moore, MD, MPH, MBA called the meeting to order at 1:32 p.m. from the Fairfield-West office. Approval of the Jan. 13, 2026 IQI Minutes •	Motion to **approve IQI Minutes**: Isaac Brown Second: Katherine Barressi
II. Old Business		
None		
III. New Business Consent Calendar (Committee Members as applicable)		
Health Services Policies Care Coordination MCCP2024 – Whole Child Model for California Children's Services (CCS) Quality Improvement MCQP1021 – Initial Health Appointment – ***pulled*** MCQP1022 – Site Review Requirements and Guidelines – ***pulled*** MPQG1011 – Non Physician Medical Practitioners & Medical Assistants Practice Guidelines MPQP1016 – Potential Quality Issue Investigation and Resolution Utilization Management **ARCHIVE** MCUP3064 – Communications Services – *subsumed into the UM Program Description* MPUD3001 – Utilization Management Program Description MPUG3002 – Acupuncture Services Guidelines MPUG3011 – Criteria for Home Health Services MPUP3048 – Dental Services (including Dental Anesthesia) **Non-Health Services Policies** Member Services MC305 – Distribution of Members Rights and Responsibilities Network Services – Compliance MPNET102 – DHCS Network Certification Requirements – ***pulled*** Network Services - Credentialing MPCR16 – Lactation Consultant Credentialing Policy MPCR301 – Non Physician Clinician Credentialing and Re-credentialing Requirements – ***pulled*** MPCR400 – Provider Credentialing and Re-credentialing Verification Process and Record Security MPCR602 – Reporting Actions to Authorities **Anna Campbell pulled** MCQP1021, MCQP1022, MPNET102, MPCR301 to comment or ask clarifying questions. • MCQP1021: Update by 2027 to match the handbook. No objective to keeping preventative services taskforce. *Kristine Gual/Lisa O'Connell*	*Motion to **approve the slate without the four pulled policies**: Anna Campbell* *Second: Brigid Gast* Next Steps: All Health Services and Non-Health Services policies but Network Services - Compliance will go to the Feb. 18 Quality/ Utilization Advisory Committee (Q/UAC) and thereafter to the Mar. 11 Physician Advisory Committee (PAC). MPNET102 – Follow up with Compliance department to clarify the process for routing policies to DHCS and follow back up in March IQI meeting to report back on the DHCS policy routing process.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	• MCQP1022: Same mention of USTSPF. On page 61 non-members should be corrected to non-assigned members. *Lisa Ward/Katherine Barresi* • MPNET102: Marked as an external policy but could not be found in the Provider Manual. Dr. Moore and Renee confirmed it should be marked as an internal policy. Attachment A: DHCS approval notice from an APL in 2021 but this is now superseded by another APL – is this still needed as an attachment? Renee confirmed it can be removed. Clarified that Compliance ownership is through Net Services Compliance, not the centralized Compliance department. Section 14 can be deleted and Section 6 follow-up language should be removed. *Katherine Barresi/Anna Campbell* • MPCR301: On page 346 section F-2 can be removed: language can be removed for addendums but leave in language referring to policy 342b. On page 347 update the APL 18-023-ACS to possibly APL 24-015. Removed outdated references on pages 347-348. Add clarification regarding NP supervision and applicability. *Anna Campbell/Kristine Gual*	
IV. New Business – Discussion Policies		
Policy Owner: Network Services - Compliance – *Presenter: Renee Trosky, Manager of Provider Relations Compliance, NS*		
MPNET100 – Access Standards and Monitoring	Synopsis of Changed reviewed. Policy edits to meet the requirements under NCQA Net 1D. Dr. Moore provided additional information/background on how the standards were created. Anna questioned on page 387 where it states Carelon is a delegated provider who members can contact. Dr. Moore added that this is in reference to what do we do with emergencies. It is a "No Wrong Door" approach. Mark Bontrager proposed amendments regarding Urgent versus Emergent request for appointments and gave how these request are processed.	**Motion to approve as amended:** Lisa O'Connell Second: Isaac Brown Next Steps: Feb. 18 Q/UAC Mar. 11 PAC
Policy Owner: Utilization Management – *Presenter: Kermit Jones, MD, JD, Deputy Chief Medical Officer, MD's*		
MPUP3018 – Health Services Review of Observation Code Billing	**Synopsis of Changed reviewed.**	*There were no questions.* **Motion to approve as presented:** Katherine Barresi Second: Heather Esget Next Steps: Feb. 18 Q/UAC Mar. 11 PAC
V. Presentations		
QI Update – *Isaac Brown, MPH/MBA, Senior Director, Quality Improvement and Performance*		
Couple different medical equipment pilots have taken place in the last year or two where Partnership has provided medical equipment to providers to help increase both their QIP and HEDIS measure scores. The idea was not to give the entire network the medical equipment but to see if provided the equipment if it would help them earn their QIP dollars thereby giving encouragement to other providers that they are worth that investment. These pilots are wrapping up with evaluations being developed. Partnership continues to collaborate with some of our largest providers through Joint Leadership Initiative (JLI's) meetings to help them increase their PCP QIP scores. Several have taken place lately with a majority of the work happening in Auburn and Chico. Providers leadership is met with to collaborate with our chief staff including Dr. Moore, Sonia, and others.		

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION

Annual regulated CAHPS was launched in February. With new additions in the last several years of members and providers, hopeful to learn more about how well they are receiving our services through the member experience survey.

In CY Q1 2026, 21 event days took place across 20 different provider sites. The goal is to reach around 70 event days throughout the year. Currently looking to expand these event days to close other care gaps. Pilot is being worked on to expand those out to Women's Wellness Days, along with some other versions.

Care Coordination Grand Analysis *–Kelly YoungStone, RN, Director of CC, Aryana Cunningham, Shivani*

Kelly provided an introduction to Care Coordination with a background of the department. CC is comprised of regional associate directors, managers, social workers, and health care guides. This team coordinates 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 their benefit. The responsibilities include assessing needs, coordinating services, and conducting outreach to targeted specific populations. The team works with multidisciplinary care groups to meet member needs, reduce duplication, and address challenges such as chronic illness, fragmented care, and complex health issues. They create individualized care plans and interventions aimed at education, timely care access, and connecting members with resources to minimize care gaps during transitions. The department supports members deeming care coordination and builds with complex needs using evidence based practices to achieve desired health outcomes.

MPCD2014 – Care Coordination Program Description and Complex Case Management (CCM) Program Evaluation for CY 2024

Dr. Moore questioned what is the minimum number of CCM patients needed for the period? Shannon indicated it is 40 cases within the look back period and we have 52. Folo Akintan noted that several test were used, however, questioned if there were any test of the analysis and most of the tests were small or insignificant. Shaivani indicated she used Ankover which could have been significant with a greater sample size, but even with this small sample size, we found that the CCM program had a significant impact on the ED visits which was very profound with this small sample size. Dr. Moore added that an increase in visits is not unexpected, good case management usually results in increased. Expect a decrease in utilization would be ED visits and inpatient. Things expected to go up would be medication compliance, and visits. Less inpatient, less ED visits, higher specialty and higher primary care would be expected. This is a mandatory program. Last year there were 189 members and in this year 52. Kelly YoungStone added that the reduction was a result of multiple factors.

Motion to approve as presented: Isaac Brown

Second: Kristine Gual

2024-2025 Perinatal Quality Incentive Program Evaluation *–Troy Foster, Program Manager ll, QI*

Reference slide presentation for content reviewed.
Dr. Moore added that this includes two withhold measures and all the rest are sanctioned measures. The performance is improving. No questions asked.

Q3 & Q4 and CY 2025 Potential Quality Issue (PQI) Report – *Robert Bides, RN, Manager of Member Safety Quality Investigations, QI*

Reference slide presentation for content reviewed. No questions asked.

VI. Adjournment

Dr. Moore adjourned the meeting at 3:09 p.m. IQI will meet next Tuesday, Mar. 10, 2026.

Respectfully Submitted by Chandler Ackerman, Project Manager I, Quality Improvement

Approval Signature: *Date:*

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION

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

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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, 2026 **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	☒ Brigid Gast
☒ Jeff Ribordy	☐ Melissa Perez	☐ Doreen Crume
☒ Kermit Jones	☐ Wendi Davis	☐ Sharon Hoffman-Spector
☐ James Cotter	☒ Stan Leung	☒ Lisa Malvo
☐ Mary Kerlin	☐ Nancy Steffen	☐ Melanie Lam
☒ Dejene Bikila	☒ Brian Spiker	☐ Cody West
☒ Liat Vaisenberg	☒ Shivani Sivasankar	☐ Angela Guevarra
☒ Kristine Gual	☒ Radha Chebolu	☒ Renee Trosky
☐ Amber Newell	☒ Tiphanie Salehi	☐ Lisa O'Connell
☐ Athena Beltran-Nampraseut	☐ Kim Palfini	☒ Jen Kung
☐ Garnet Booth	☐ Mark Aguirre	☒ James Devan
☐ Kim Fillette	☒ Shell Swift	☒ Isaac Brown
☐ Lindsey Bushey	☐ Stephanie Nakatani Phipps	☐ Katherine Barresi
☐ Sarah Browning	☐ David Lopez	☐ Deanna Watson
☐ Emily Stoller	☒ Candis Flournoy	☐ Kristina Coester
☒ Monika Brunkal	☒ Alex Brito	☐ David Lavine
☒ Penny Thomas	☐ Ruth Hood	☐ Elijah Allen
☐ Christopher Triolo	☐ Derick Stacy	☐ Erin Hall
☐ Jeffrey DeVido	☒ Mark Bontrager	☐ Dominic Salido
☒ Anthony Sackett	☐ Greg Allen Friedman	☐ Mohamed Jalloh
☐ Tim Sharp	☐ Akshay Sharma	☐ Florentina Torres
☒ Rasitha Rathnayake	☐ Danielle Ogren	☒ Qi Yao
☐ DeLorean Ruffin	☐ Hanh Hoang	☐ Kareena Rodriquez
☒ Vander Harris	☐ Amber Acosta	☐ Jennifer Lopez
☐ Michelle Rodriguez	☐ Tasha Krongard	☐ Robert Ducay
☐ Cheng Saechao	☒ Heather Esget	☐ Kevin Jarrett-Lee
☐ Benjamin Amparo	☐ Amanda Federico	☐ Migdalia Liboy
☐ Heather Coronado	☒ Roudabeh Moraghebi	☒ Brandy Isola
☒ Jennifer Durst	☒ Paul Leung	☒ Tom Nguyen
☒ Angier Allen	☒ Folo Akintan	☒ Fei Yu
☒ Samuel Ling	☒ Winnie Chen	☒ Garvin Lum
☒ Li Zhao	☒ Leslie Warner	☒ Tony Sengdara

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 The overall PCP office visit rate showed a decline from 2025 Q1 through 2025 Q3. The Eureka, Redding, and Fairfield regions experienced slight increases, while the remaining regions saw modest decreases from 2025 Q2 to 2025 Q3. In 2025 to date, Colusa, Del Norte, and Glenn counties have had the highest visit rates, whereas Placer, Lassen, and Solano counties have had the lowest visit rates and did not meet the target. Sierra and Nevada counties also fell short of the target, while the remaining counties met or exceeded the expected visit rate. In reviewing the Primary Care practitioners to members ratio; Butte, Glenn, and Tehama counties observed highest provider-to-member ratios for Family Medicine. For Internal Medicine, the highest ratios were observed in Glenn, Placer, and Nevada counties. Del Norte, Lassen, and Mendocino counties saw the highest Pediatric Medicine ratios. At the provider level, Shasta Community Health Center, Ampla Health Chico Medical, and Solano County Health Services continued to be among the clinics in 2025 that did not meet the target visit rate. In the Auburn Region, the top three clinics with higher membership but still below target were WellSpace Health Roseville, Western Sierra Medical Clinic, and Chapa-De Indian Health. WellSpace Health Roseville, in particular, had most of its members receiving visits elsewhere. A leakage report shows that majority of members assigned to WellSpace Health clinics saw providers within the Wellspace Health system, but not their assigned PCPs. Although members remained within the WellSpace system for PCP visits, the overall PCP visit rate for WellSpace continues to be low. Action item: Prepare a list of Family Med specialty providers in the Humboldt County
2) Flu and Advance Directives *Speaker: Dr. Moore*	Discuss Findings According to the CGHPS 2025 report, the top three counties with the highest flu vaccination rates were Marin, Solano, and Yolo, while the counties with the lowest rates were Sierra, Siskiyou, and Del Norte. Smoking prevalence was highest in Lassen, Siskiyou, and

	Butte counties, whereas Solano, Placer, and Marin counties had the lowest smoking rates. For Advance Directive completion, Trinity County reported a significantly higher rate (60%) compared to all other counties, which remained below 40%. The counties with the lowest completion rates included Yuba, Tehama, Placer, and Lassen.
3) Colorectal Cancer Screening *Speaker: QI*	Discuss Findings Measure Definition The percentage of continuously enrolled assigned members 45–75 years of age who had appropriate screening for colorectal cancer. Partnership is involved in the below core activities for cancer screening – • QMSI Chronic Disease Workgroup is collaborating with the American Cancer Society to co-brand educational materials on screening options • Leveraging county-level data to identify gaps and deliver targeted education, in partnership with UC Davis Comprehensive Cancer Center • Continue to streamline bulk ordering of Cologuard tests to ensure timely colorectal cancer screening for patients in need Next Steps – The QMSI Chronic Disease Workgroup is partnering with Web & Communications team to build a dynamic, resource driven hub to achieve the following goals- • Centralized resource center for providers and members • Comprehensive education materials on screening modalities • Increase awareness and support informed decision making • Clear, accessible information on available screening options • Promote early detection and preventive care • Strengthen provider engagement • Improve health literacy • Drive better outcomes across communities
Overutilization Analysis Discussion Topics	
1) Tobacco Screening report *Speaker:* HA	Discuss Findings In 2025, 51,194 members received TSR, of which 67% were adults. The rate of members who received TSR increased by 25% compared to last year, especially in the pediatric population and in females. In adults, members aged 61 and above have a higher rate of TSR compared to other age groups. In 2025, Cambodian-speaking adults and Punjabi-speaking pediatric population have a higher rate of TSR compared to other languages. Asian

	population have a higher rate of TSR compared to other ethnic groups. The Santa Rosa region recorded the highest TSR rate, primarily driven by Sonoma, which ranks among the top counties. Marin, on the other hand, continues to report the lowest rates across all counties. The Chico, Redding, and Auburn regions each have a TSR rate of 8%, followed by Eureka at 2.7% and Fairfield at 1.7%. Counties showing an increase in rates include Placer, Nevada, Sierra, Shasta, Tehama, Sutter, and Yuba with the highest rate among all counties. Declining rates were seen in Solano, Modoc, Napa, Del Norte, Humboldt, and Plumas. 355 PCP sites (85%) had at least one assigned member who received TSR. Peach Tree Healthcare reported the highest number of TSR members, followed by Vista Family Health Center, which saw increases in both rates and numbers compared to last year. SRCH Lombardi and Dutton campuses followed, though both experienced declines in rates and numbers from the previous year. From 2024 to 2025, Wellspace Health Roseville saw the largest TSR rate increase, jumping from 154 (1.4%) to 1,875 (21.1%) members, with other Wellspace sites—San Juan, Sierra Gardens, and South Valley—also rising. Ampla Health Yuba City Med followed, increasing from 148 to 1,553 members. The steepest decline occurred at Harvest Pediatrics, dropping from 9.2% to 0.6%, while Ampla Health Yuba City Peds fell from 533 (6.5%) to 10 (2.8%).
1) Genetic testing report *Speaker:* HA	Discuss Findings Genetic test referrals increased gradually throughout 2024 and early 2025, followed by a sharp surge in mid-2025 that peaked at around 300 referrals by December of 2025. Gendex Llc, Variantyx Inc, and Natera Inc are the top 3 genetic testing providers. Overall, Unlisted Molecular Pathology was genetic test that had highest number of referrals. Gendex had the greatest volume of referrals for genetic tests, including Exome Sequence Analysis and Whole Mitochondrial Genome. Referral rates for specific genetic tests increased across most counties, with the greatest growth observed in Placer, Butte and Humbolt. Plumas, Colusa, and Trinity were the only counties showing a decline in referrals.
Future Agenda Items	PCP visit rates will continue to be monitored
Next Meeting Date: TBD	

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PARTNERSHIP HEALTHPLAN of CALIFORNIA

QI Department Update
February 2026
Prepared by Isaac Brown
Senior Director, Quality and Performance Improvement

Quality Incentive Programs (QIPs)

PROGRAM	UPDATE
Primary Care Provider Quality Incentive Program (PCP QIP)	**Program Overview** Pay for performance program incentivizing improved performance on Clinical, Non-Clinical, and Unit of Service (UOS) measures in the Primary Care setting. **Program Update** • Measurement Year 2025 has formally concluded. Clinical validation took place February 1, 2026 – February 8, 2026. Non-Clinical validation will take place March 9, 2026 – March 13, 2026. UOS preliminary period will take place March 16, 2026 – March 20, 2026. The PCP QIP team will continue next steps with determining final payment, pending time for claims lag prior to finalization of Non-Clinical scores and application of manual adjustments to all final scores. • The Quarter 1 newsletter was sent February 23, 2026 • The PCP QIP team is preparing for the MY2025 eReport upload audit. There will be two measures of focus: Clinical Measure - Child and Adolescent Well Care Visit (WCV) and Unit of Service Measure - Advanced Care Planning (ACP). • Measurement Development for 2027 will begin earlier, starting in March 2026. • Provider notification for qualification status for the Optional Clinical Measure - Reducing Healthcare Disparity will be sent via email between March 2 – 6, 2026 and providers must indicate intent of participation by EOB, Tuesday, March 31, 2026.
Palliative Care Quality Incentive Program (Palliative Care QIP)	**Program Overview** Pay for performance program which offers significant financial incentives to support and improve the access to and quality of palliative care provided by our contracted palliative care providers. **Program Update** • Payment processing for 2025 Measure Period II (July-December) has begun. All survey and POLST reporting templates have been received. The Palliative QIP team will be working to analyze the data to calculate payment. Payment is to be distributed in May.
Perinatal Quality Incentive Program (PQIP)	**Program Overview** The Perinatal QIP offers financial incentives to participating Comprehensive Perinatal Services Program (CPSP) and select non-CPSP providers providing quality and timely prenatal and postpartum care to Partnership members Program Update

	Program Update • The Perinatal QIP will have 6-month bridge measurement set covering the period of July 1, 2026 through December 31, 2026 and will then transition to a calendar year QIP January 2027. The proposed measurement set for the 6-month bridge is being presented at March's IQI, PAC and QU/AC meetings. No new measures are being added. The set will be an abbreviated 6 month version with mainly timeframes and due dates adjusted.
Enhanced Care Management quality Incentive program (ECM QIP)	**Program Overview** The ECM QIP offers financial incentives to motivate, modify, and improve the health outcomes of seven identified groups of individuals by standardizing a set of care management services and interventions **Program Update** • The ECM QIP Team is working with Contracting and Enhanced Care Services to develop a workflow for new contract amendments to ensure newly ECM-contracted providers receive and sign the amendment to meet eligibility for ECM QIP participation.
Hospital Quality Incentive Program (HQIP)	**Program Overview** The Hospital QIP offers financial incentives to improve performance related to Readmissions, Advance Care Planning, Clinical Quality, Patient Safety, Operations and Efficiency, and Patient Experience **Program Update** • The following eight hospitals received recognition plaques as Top performers at Partnership's February 25, 2026 Board Meeting: Adventist Health Howard Memorial, Banner Lassen Medical Center, MarinHealth Medical Center, Petaluma Valley Hospital, Providence St. Joseph Hospital Eureka, Queen of the Valley, Sonoma Valley, and Surprise Valley. • The 6 -month bridge measurement set has been developed and will be presented in April's committee meetings. Three measures will be removed for the abridged set. • Of note Partnership will not host a Hospital Quality Symposium this summer but will host in 2027.
Extended Care Facility Incentive Program (EXT QIP)	**Program Overview** The EXT QIP offers financial incentives to support and improve the quality of long-term care provided to our members, with measures in the following domains: Clinical, Functional Status, Resource Use, and Operations / Satisfaction. **Program Update** • Provider outreach will begin soon to promote the importance of QAPI plan submission to meet the gateway measure to remain eligible for participation in the program's other measures.

QUALITY DATA TOOLS

TOOL	UPDATE
PARTNERSHIP QUALITY DASHBOARD (PQD)	**Program Overview** The Partnership Quality Dashboard (PQD) is a Tableau designed to inform, prioritize, and evaluate quality improvement efforts. Dashboards and performance metrics built into the PQD provide the ability to track and trend QIP data. **Program Update** • MY2026 PQD development is in process, launch date TBD
EREPORTS	**Program Overview** eReports is a web application that allows providers to see their quality metrics in Partnership's PCP QIP program. eReports updates twice a week for near real-time visibility to quality metrics while PQD refreshes monthly for historical trending. **Program Update** • MY2026 eReports launched on March 2, 2026

PERFORMANCE IMPROVEMENT (PI)

ACTIVITY	UPDATE

STATE MANDATED WORK: *PERFORMANCE IMPROVEMENT PROJECT (PIP) & PLAN-TO-DO-STUDY-ACT (PDSA) CYCLE*	**Program Overview**
	All plans in California are required to conduct PIPs as part of their agreements. Currently DHCS has assigned Partnership two PIPs: a non-clinical PIP for BH and a disparity PIP. DHCS can also require plans to do mandated improvement PDSA projects
	Program Update
	• **Clinical Performance Improvement Projects (PIP):**
	  ○ DHCS has not yet provided instruction on a mandated clinical PIP for 2026.
	• **Non-Clinical PIP (Follow-up After Emergency Department Visit for Mental Illness (FUM):**
	  ○ Partnership is seeking a health center to collaborate with on an improvement project in 2026.
	  ○ Partnership met with two health centers between January and February to discuss a potential collaboration on the FUM project for MY2026 but have not confirmed collaboration.

QUALITY MEASURE SCORE IMPROVEMENT	**Program Overview** Internal measure-focused workgroups, which bring together perspectives across Partnership's services delivery continuum with the goal of strategically improving HEDIS measures that align with the strategic priorities of Partnership HealthPlan. **Program Update** • **Pediatrics:** No updates.

	• **Women's Health & Perinatal:** No updates. • **Chronic Disease:** Partnership conducted an evaluation of its pilot program which funded nine (9) diabetic retinal cameras in optometry deserts. Results showed that clinics who were able to acquire cameras early in the measurement year all exceeded the 50th national percentile for the first time in 2025. There were observed delays in acquiring cameras from the vendor, so those looking to purchase cameras for MY2026 should consider purchasing early to account for shipping times. • **Behavioral Health:** No updates.
Improvement Academy	**QI Project Management Training Program** **Program Overview** The Quality Improvement (QI) Project Training Program is designed to help provider organizations and community partners strengthen their skills to lead and manage QI initiatives by offering training and use of standardized tools, templates, and best practices. The program features a 6-session webinar series delivered over 12 weeks, covering all phases of the project life cycle and focuses on applying those methods to real-world QI efforts. **Program Update** • **Pilot cohort evaluation:** A formal evaluation of the pilot cohort was distributed on 2/10/2026 and can be found here. • **QI Project Training Series (Spring 2026 cohort**): The inaugural cohort started on 02/24/2026 and will end 05/05/2026. Enrollment is officially closed with 122 total registrants; Eighty-five (85) of the registrants attended the first session in the series. **Improving Measure Outcomes Webinar Series** **Program Overview** This series is designed to help Quality Improvement teams turn knowledge into action. These sessions focus on Partnership's Primary Care and Perinatal Provider Quality Incentive Program (QIP) measures, offering practical strategies to close care gaps, advance health equity, and improve clinical outcomes. Each session highlights proven strategies and best practices from peer clinics that are actively achieving measurable improvements in patient care. **Program Update** **Registration review:** • The first two sessions of the six-part Improving Measure Outcomes webinar series were offered in February. o Preventive Care for Children Ages 0 – 30 Months

	○ Preventive Care for Children and Adolescents Ages 3 – 17 Years **March webinars include:** • 03/11/2026 - **Preventive Cancer Screenings:** Improving Outcomes through Early Detection • 03/25/2026 - **Managing Chronic Disease:** Strategies for Blood Pressure and Diabetes Control • Following the February pediatric webinars, an ad hoc webinar was held on 03/03/2026 - **Vaccine Hesitancy in the Current Climate.** Featuring panelists from Communicare+OLE, Lake County Tribal Health Consortium, Marin Clinic, and Santa Rosa Community Health, the webinar highlighted strategic blueprints for achieving benchmark-setting vaccination rates and effectively overcoming patient concerns. **ABCs of Quality Improvement** **Program Overview** The ABCs of Quality Improvement (QI) is a training designed to introduce participants to key QI methodologies with a specific focus on the Model for Improvement – a widely used framework for driving measurable change in health care settings. **Program Update** • The second offering of the ABCs of QI training is scheduled for 03/19/2026 in Redding.
Joint Leadership Initiative (JLI)	**Program Overview** The Performance Improvement team is scheduling 2026 Joint Leadership Initiative meetings with seven parent organizations across the Partnership network. Four of the seven organizations are in our expansion counties (Chico and Auburn Regions). This is a quality improvement strategy to collaborate with the largest parent organizations providing primary care who did not earn at least 75% of their PCP QIP scores in the previous year. This number could change once final 2025 PCP QIP scores are finalized. **Program Update** A JLI meeting will be held in the Fairfield region on 3/25/2026 with Solano Family Health Services.
Regional Improvement Meetings	**Program Overview**

	Regional Quality Improvement meetings are held quarterly at each of our 6 regional offices (Eureka, Redding, Chico, Auburn, Fairfield, and Santa Rosa) or online with the goal of bringing together regional health center quality leaders to share and discuss strategies to improve measures that regionally important and learn from Partnership regarding any program changes and/or priorities. **Program Update** • **Santa Rosa Region** o The Regional Quality Meeting was held on 2/24/26 and a related meeting for small & medium sized health centers was held on 3/5/26 • **Fairfield Region** o The next Fairfield Regional Quality Meeting is scheduled for 3/17/26 • **Chico Region** o The next meeting is scheduled for 3/12/26. • **Auburn Region** o The next Auburn Regional Quality meeting is scheduled for 3/9/26. • **Eureka Region** o Humboldt/Del Norte/Mendocino/Lake Counties Q1 Regional Quality Meeting is scheduled for 03/04/2026. • **Redding Region** o Shasta/Tehama/Trinity/Siskiyou/Modoc and Lassen Counties Q1 Regional Quality Improvement Q1 Meeting is scheduled for 04/07/2026.

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 – FY 25/26 Member Experience*	**Program Overview** Oversees NCQA Accreditation requirements for Member Experience (ME) 7 (Elements C and D). Conducts annual regulated CAHPS® surveys for Medi-Cal members and non-regulated surveys to assess patient experiences. Results drive improvements in care quality and member experience. **Program Updates** ***CAHPS® Regulated Measurement Year (MY) 2025 / Report Year (RY) 2026 Survey***

- Progress on the regulated survey remains on track. A second survey was distributed to select members on 03/20/2026, followed by reminder letters on 03/27/2026 for those who have not yet responded.

Consultant Work

Enhancing CAHPS® Survey & Reporting Framework

In partnership with Press Ganey, we finalized the consulting engagement focused on strengthening our non-regulated CAHPS survey design and reporting approach. This work establishes a scalable framework to support more precise root cause analysis and targeted quality improvement efforts moving forward.

Three core assets were produced:

- Developed a master catalog of validated survey questions for Adult and Child populations to ensure alignment and consistency.
- Created a modular survey instrument that can be adapted to specific improvement goals
- Built standardized reporting templates to ensure future survey results are consistent, comparable, and immediately actionable for leadership

CAHPS® Member Experience Gap Assessment:

Rex Wallace Consulting (RWC) was engaged to conduct a comprehensive, rapid end-to-end assessment. Target completion date: April 4

Progress To Date:

- Weeks 1–3: Discovery and data review were completed, including an in depth CAHPS® performance and experience assessment.
- Weeks 4–5 (current): Member Experience Initiative review and deep-dive analysis are currently underway.

Next Milestone:

- Final Recommendations and prioritized action roadmap

Fiscal Year 2025/2026 Organizational Goal 5: Member Experience (MX)

Fiscal Quarter 3 (On-Track): Q3 goal activities continue through the end of this month, led by champions from four departments: Transportation, Member Services, Population Health, and Quality Improvement.

Milestone updates will be posted internally on the OpEx|PMO goal dashboard the week of April 6.

Equity & Practice Transformation Project	**Program Overview**
	The DHCS Equity and Practice Transformation (EPT) Program is a statewide initiative aimed at advancing health equity while reducing COVID-19 driven care disparities. During the three (3) year program, practices receive payments for achieving population health milestones that enable the implementation of improvements across their infrastructure, data capabilities and care management processes to promote patient well-being, health equity and whole-person care.
	
	Currently, 23 providers are participating in the EPT Program, with total estimated funding of $13.3 million over the three-year project period. These providers are expected to receive payments tied to milestone achievements that support sustainable practice transformation.
	
	Program Updates
	• PHLC established minimum requirements for providers to remain in the program, due May 2026, which include:
	  ○ 2026 PhmCAT
	  ○ Milestone 3: Empanelment Policy & Procedure
	  ○ Milestone 4: Data Governance & HEDIS Policy & Procedure
	  ○ Milestone 6: Data Implementation Plan
	  ○ Milestone 8: Disparity Reduction Plan
	• One Model of Care Document (Milestones 9-12) United Indian Health Services has submitted a request to be terminated from the EPT program and Department of Healthcare Services (DHCS) has processed that request on 02/19/2026.
	• November 2025 deliverable submissions have been reviewed by PHLC; awaiting DHCS funding instructions to distribute provider payments.
	
	The next quarterly CaTS report for MY 04/01/24 - 03/31/25 is scheduled to be completed by the due date, January 31, 2026.

Preventive Care Bridge Project (Formerly: Locum Pilot Initiative)	**Overview of the Preventive Care Bridge Project** The Preventive Care Bridge Project was developed as a short-term solution to address access challenges by providing targeted locum support with the goal of improving performance on preventive care measures, specifically well-child visits and cervical cancer screenings. By proactively guiding providers to maximize the locum resources through clear onboarding, scope alignment, and data tracking, the pilot explores a potential model for supporting improved measure performance, reducing withholds and sanctions associated with unmet benchmarks, and enhancing the overall member experience. **Project Update** The Project Management Team is now developing a Locum Implementation Guide, including a storyboard, ROI calculator, implementation checklist, best-practice reference,

<table>
<tr><td></td><td>and training assets, all set to be finalized and posted by the end of April, with presentations planned at QI Regional Meetings this summer.</td></tr>
<tr><td>Mobile Mammography Program</td><td>

Program Overview

Aims to boost breast cancer screening (BCS) rates for providers performing below the 50th percentile benchmark. Partnership collaborates with Alinea Medical Imaging and providers to host Mobile Mammography events, helping members complete preventive screenings.

Program Updates

- Event Days for FY 25/26 Q3 (January – March)

<table>
<tr><th colspan="4">Current Event Days
01/01/2026 – 03/21/2026</th></tr>
<tr><th>Region</th><th># of Provider Organizations</th><th># of Provider Sites</th><th># of Event Days</th></tr>
<tr><td>Auburn</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>Chico</td><td>1</td><td>3</td><td>4</td></tr>
<tr><td>Eureka</td><td>2</td><td>2</td><td>2</td></tr>
<tr><td>Fairfield</td><td>3</td><td>6</td><td>6</td></tr>
<tr><td>Redding</td><td>5</td><td>5</td><td>5</td></tr>
<tr><td>Santa Rosa</td><td>5</td><td>5</td><td>5</td></tr>
<tr><td>Plan Wide</td><td>16</td><td>21</td><td>22</td></tr>
</table>

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

Program Overview

Provides LeadCare II POC devices to qualified providers and enrolls them in a year-long program with coaching and education. Offers lead poisoning prevention education to all and collaborates with local agencies.

Program Updates

- No new updates

</td></tr>
<tr><td>Exact Sciences: Promoting Colorectal Cancer Screenings</td><td>

Offering Overview

Provides LeadCare II POC devices to qualified providers and enrolls them in a year-long program with coaching and education. Offers lead poisoning prevention education to all and collaborates with local agencies.

Program Updates

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

	• No new updates
QI TRILOGY PROGRAM	**Program Overview** Annually, the Quality Improvement (QI) department updates three core documents – often referred to as the QI Trilogy Documents, that collectively describe the program structure, priorities and performance. The Program Description outlines the overall QI framework, the Work Plan details active and planned initiatives aligned with strategic priorities, and the Program Evaluation assesses progress, outcomes and opportunities for improvement. **Program Updates** • Initial notices for the 2026-2027 QI Program Description were sent to Business Owners on 02/10/2026 and a reminder email was sent on 02/24/26 with submissions due on 03/03/2026. • Initial notices for the 2026-2027 QI Work Plan will be sent to Business Owners on 04/21/2026 with submissions due on 05/12/2026.QI Trilogy live trainings have been scheduled with invites sent to Sponsors, Business Owners, and Contributors: ▪ 2025-2026 QI Program Evaluation: 05/13/2026 at noon ▪ 2026-2027 QI Work Plan (Goal Submissions): 06/04/2026 at noon
SAGE GRANT	**Program Overview** The *Systems Advancement for General EHR* (SAGE) Grant is designed to assist healthcare providers in implementing or upgrading their EHR systems, to help modernize and enhance their ability to deliver high-quality, efficient, and member-centered care. This grant will help providers overcome common barriers to EHR adoption by offering financial support and implementation guidance. The recipient of the SAGE grant, Kimaw Medical Center, signed the agreement on 12/5/2025. The first payment installment of $125,000 was initiated. The SAGE Grant team will continue to conduct regular check-ins and monitor implementation milestones. The SAGE Grant Timeline can be found here. **Program Updates** • No new updates
D-SNP MEDICARE	**D-SNP** **Program Overview** The D-SNP Quality team is responsible for 1) Development and finalization of the Model of Care document, 2) Management of Partnership's CMS Medicare Star quality program, and 3) Developing D-SNP readiness for all Quality Improvement teams. **Program Update**

	• Partnership has begun the process of preparing the Medicare Model of Care (MOC) for submission to DHCS and CMS for the launch of Partnership Advantage, Partnership's D-SNP product, in eight (8) counties on 01/01/2027.
ACTIVITY	**UPDATE**
QUALITY ASSURANCE AND PATIENT SAFETY	
ACTIVITY	**UPDATE**
POTENTIAL QUALITY ISSUES (PQI) FOR THE PERIOD: 1/28/2026 TO 2/25/2026	**Program Overview** To identify, report, and manage Potential Quality Issues (PQI), to determine opportunities for improvement in the provision of care and services to our members, and to direct appropriate actions for improvement based upon outcome, risk, frequency, and severity. **Program Update** • 27 PQI referrals were received with 23 coming from Grievance and Appeals, 3 from Utilization Management and 1 from an Associate Medical Director. • 28 PQI cases were processed and closed. • 91 cases are currently open. • One case was discussed at Peer Review Committee (PRC) on 02/18/2026 and there is one case awaiting PRC review.
FACILITY SITE REVIEWS (FSR) & MEDICAL RECORD REVIEWS (MRR) FOR FEB 2026	**Program Overview** Site Review and Medical Record Review performed for monitoring of providers. **Program Update** • No update at this time.
HEALTHCARE EFFECTIVENESS DATA INFORMATION SET (HEDIS)	
ACTIVITY	**UPDATE**
Annual HEDIS® Projects	**Program Overview** HEDIS is used to evaluate clinical quality in a standardized way. This program shares performance measurement rates with the intent of improving the quality of care delivered to members. **Program Update** • The MY2025 HEDIS Annual project has begun for DHCS Managed Care Accountability Set (MCAS) and NCQA Health Plan Accreditation (HPA) measure sets.

	• HEDIS Hybrid Medical Record Review will occur between 03/10/2026 – 04/23/2026
	• The HEDIS MY2025 Annual Audits were conducted in February with no audit findings:
	  ○ DHCS Managed Care Accountability Set (MCAS) – 02/12/2026
	  ○ NCQA Health Plan Accreditation (HPA) – 02/26/2026
	• Preparation is underway to receive and integrate all data to support the HEDIS MY2025 regulatory required reporting; this includes all non-standard supplemental data sources that will require Primary Source Verification (PSV), which must be approved by both auditors.
	• Supplemental Data – Requiring PSV
	  ○ Year-Round Medical Record Review (YRMRR) was conducted for MY2025 for W30, PPC and WCC-BMI
	  ○ DataLink
	  ○ Sac Valley Med Share (SVMS)
	  ○ Inovalon – Electronic Record on Demand (ERD)
	• As in MY2024, DHCS and NCQA will require plan-wide rate reporting for MY2025. In addition, DHCS continues to require county level rate reporting for MY2025 and plans to sanction MCPs at the county level for MCAS measure rates that perform below the 50th percentile benchmark.

HEDIS® Program Overall	**Program Updates**
	Measure Rate Generation for DHCS Programs: Partnership participates in three (3) DHCS programs that require quarterly quality rate production using the California Technical Specifications (CaTS) measure specifications, which are HEDIS-like measure specifications. Partnership provides all participating practices member-level data for all CaTS measure rates on request through each program's dedicated inbox.
	
	• Equity and Practice Transformation (EPT)
	  • Data provided in January 2026 for April 2024 – March 2025 time period for the twenty-three (23) EPT practices.
	• Designated Public Hospitals QIP (QIP)
	  • Reports submitted to DHCS in January 2026 for the (11) QIP hospitals participating.
	• Alternative Payment Model (APM)
	  • Winters Healthcare APM MY2024 Scorecard submitted to DHCS on 01/16/26

NATIONAL COMMITTEE FOR QUALITY ASSURANCE (NCQA) ACCREDITATION	
ACTIVITY	**UPDATE**

NCQA Health Plan Accreditation	**Program Overview** • The State of California requires all Managed Care Plans (MCPS) to be both Health Plan (HP) and Health Outcome (HO) Accredited. The process involves completing a Renewal Survey every three (3) years, and reporting HEDIS and CAHPS results every year for a Health Plan Rating (HRP) score. Partnership's next HPA Renewal Survey is scheduled for 09/15/2026. **Program Update** • The NCQA Program Management Team sent out calendar invites for the NCQA HPA File Review Virtual Survey, which will take place on 11/02-11/03/2026. Attendees for each department were confirmed during the February 2026 Business Owner (BO) check-in meetings. BOs were told to contact the NCQA Program Management Team should they have any additional attendees they would like added to the calendar invite. The NCQA Program Management Team also sent out calendar invites for the NCQA Renewal Survey Closing Session, which will take place on 11/03/2026. • After Kim Petit's departure from our NCQA Consultant Firm, Managed Healthcare Resources (MHR), Sharon Castro stepped in as our MHR lead consultant on NCQA accreditation renewals. Partnership will host mock file reviews sessions with UM, Pharmacy, Grievance and Appeals, Network Services and Care Coordination between February to April 2026. The mock ensures a timely assessment of performance and allows for rapid process improvement if issues are identified. The NCQA Program Management Team began scheduling BO check-in meetings for the month of May. BOs were asked to notify the PM team with any scheduling conflicts.
NCQA Health Outcome Accreditation	**Program Overview** The State of California requires all Managed Care Plans (MCPs) to be both Health Plan (HP) and Health Outcome (HO) Accredited. The process involves completing a Renewal Survey every three (3) years. Partnership's next HOA Renewal Survey is tentatively scheduled for 05/16/2028. **Program Update** • The NCQA Program Management Team distributed the 2026 HOA Workbook to Business Owners (BOs) on 02/17/2026, with a submission due date of 03/06/2026. Delay in HOA Workbook submission may pose risks to Accreditation, due to lack of transparency in preparing survey evidence per the look-back period or at the frequency specified by NCQA. It is important to plan ahead as NCQA may no longer allow the use of Implementation Plans or they may expand the look-back period under various requirements. Partnership will be held accountable to the

	2027 HOA Standards and Guidelines, with an anticipated release date of August 2026. • All BOs have been notified to implement revisions of the documented processes by April 2026, including timely review by the NCQA Consultant and approval at committee meetings, to meet the 24-month look-back period requirement, starting in May 2026. The impacted BOs are required to submit screenshots in April 2026. A lack of compliant documentation with date/time stamp can result in a score of Not Met and zero points. • The NCQA Program Management continues to work with the key stakeholders in assessing gap based on changes from 2026 HOA Standards and Guidelines. This includes collaboration between departments, clarifying functions by different business units, and determining roles and responsibilities for NCQA requirements.

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

QUALITY/UTILIZATION ADVISORY COMMITTEE (Q/UAC)

Consent Calendar

Mar. 18, 2026

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

		Pages
	G&A Pulse Report/ Issue 20/ March 2026	42 - 55
	Proposed 2026 Perinatal QIP 6-month Bridge Measure Set	57 - 59
Health Services Policies	**Care Coordination**	--
	MCCP2014 – Continuity of Care – *The Adult Expansion population and associated attachments have been removed and archived, as references to populations and immigration status are considered protected language and are not appropriate for inclusion in policy content. The policy is bundled here without Attachment C (400 pages of codes).*	61 - 400
	Quality Improvement	--
	MPQP1002 – Quality/Utilization Advisory Committee	102 – 106
	MPQP1003 – Physician Advisory Committee (PAC) Policy	108 - 110
	MPQP1004 – Internal Quality Improvement Committee	112 – 115
	Utilization Management	--
	MCUP3124 – Referral to Specialist (RAF) Policy	117 – 120
	MCUP3126 – Behavioral Health Treatment (BHT) for Members Under the Age of 21	122 – 129
	MCUP3121 – Neonatal Circumcision	131 – 132
	MPUG3031 – Nebulizer Guidelines	134 – 136
	MPUP3110 – Evaluation and Management of Obstructive Sleep Apnea in Adults	138 – 142
	MPUP3059 – Negative Pressure Wound Therapy (NPWT) Device/Pump	144 – 148
Non-HS Policies	**Provider Relations**	--
	MPPRGR210 – Provider Grievance	150 – 152

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Our Mission

To help our members, and the communities we serve, be healthy

GRIEVANCE & APPEALS
Pulse Report

INSIDE THIS ISSUE

G&A PULSE REPORT

Issue 20 | March 2026

The purpose of this report is to provide objective updates to all stakeholders regarding trends in member experience as expressed through Appeals, Grievances, Exempt Grievances, and State Hearings. The report contains data from the fourth quarter of 2025.

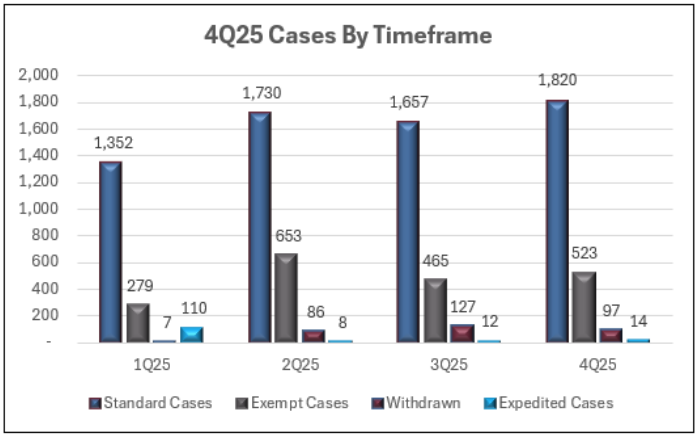
Partnership HealthPlan of California (Partnership) is committed to member satisfaction. When members understand their Partnership Medi-Cal benefits and how to access them, and the service they receive meets expectations, we believe members are likely to seek care and maintain their health. We invite all members to share their concerns or challenges.

4Q25 HIGHLIGHTS

OVERALL NUMBERS

In 4Q25, G&A investigated 2,454 cases. The chart below shows a breakdown of the cases investigated this quarter. Of the 1,907 cases subject to DHCS-mandated timeframes, 98.3% were closed within the 30-day timeframe. This did not meet our goal of 98.6%. G&A met the timeliness goals for October and November. December presented several challenges that impacted our case timeliness. Subordinate changes within the Medical Director team led to some cases requiring external medical review, which extended processing time frames. We also experienced delays related to late receipt of provider referral responses and medical records. Several unexpected staff leave of absences occurred, which placed additional strain on caseloads and affected overall timeliness. Underperforming staff also impacted timeliness. Relevant feedback has been provided, and corrections have been implemented to prevent recurrence.

4Q25 TOTAL # INVESTIGATED CASES		
Case Type	**# Cases**	**% Grand TTL**
Grievance	1,623	66.1%
Appeal	284	11.6%
Exempt	523	21.3%
State Hearing	24	1.0%
Grand Total	**2,454**	**100.0%**



KEY POINTS & TRENDS

Transportation – Transportation-related cases were the most frequently reported concern, making up 48.7% of the total concerns reported. Late drivers and missed rides were the highest reported concerns, at 24.9% and 24.6% of transportation-related concerns, respectively.

Appeals account for 6.6% of all transportation concerns reported. Meal denials were the most commonly appealed service, making up 65.8% of the transportation appeals, followed by lodging denials at 59.2%.

Provider Service – This category accounted for 20.3% of the total case concerns. The most common issue was treatment plan disputes, at 32.6% of total provider service complaints. This was followed by communication and poor attitude/service, each at 22.3% of total provider service complaints.

Appeals – There was a significant increase in Appeals closed in 4Q25, compared to 1Q25. This number has increased each quarter through 2025. There were 284 Appeals closed in 4Q25, compared to 198 closed in 1Q25. This is primarily attributed to an increase in Community Supports-related appeals, specifically the Medically Tailored Meals benefit. There were 78 appeals identified for the Community Supports benefits. These cases were originally not differentiated, but updates were made to our reporting in October 2025 to allow for more precise tracking.

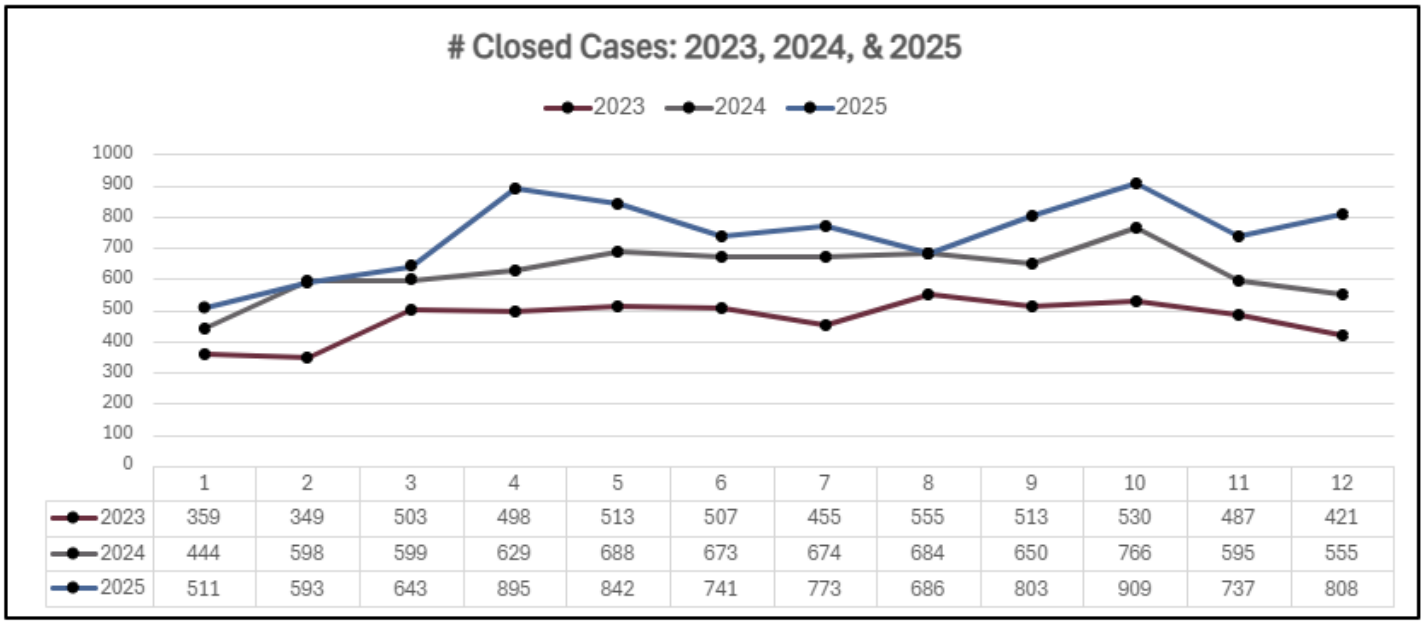
DHCS CATEGORIES

Non-Medical Transportation (NMT) was the most frequently reported Benefit Type at 37.4% of cases, followed by Outpatient Physical Health Services at 25.7% of cases.

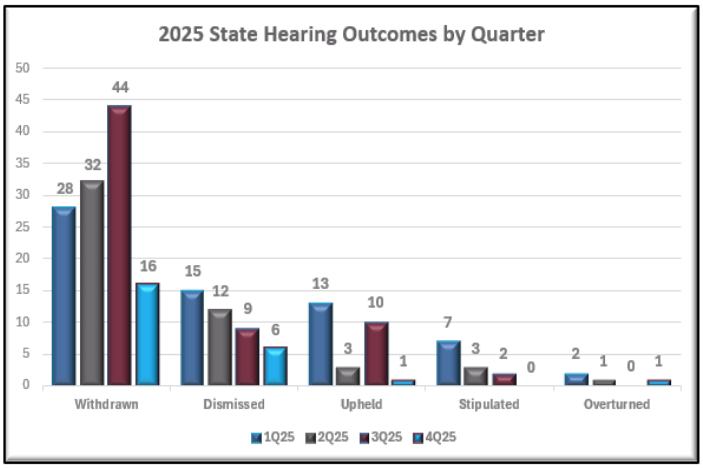
KEY STATISTICS

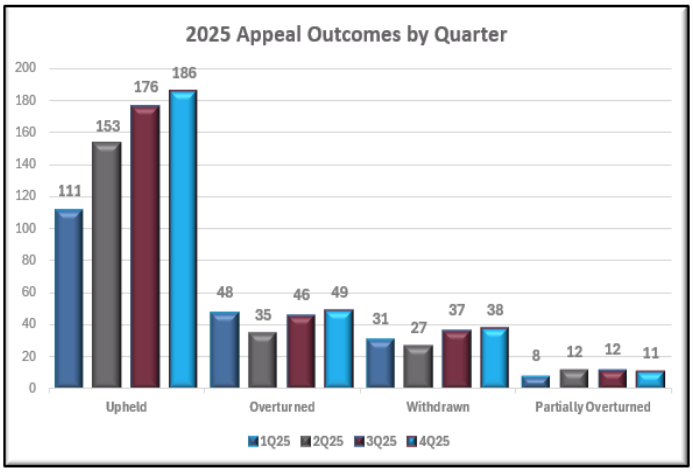
CHARTS OF KEY CASE TRENDS

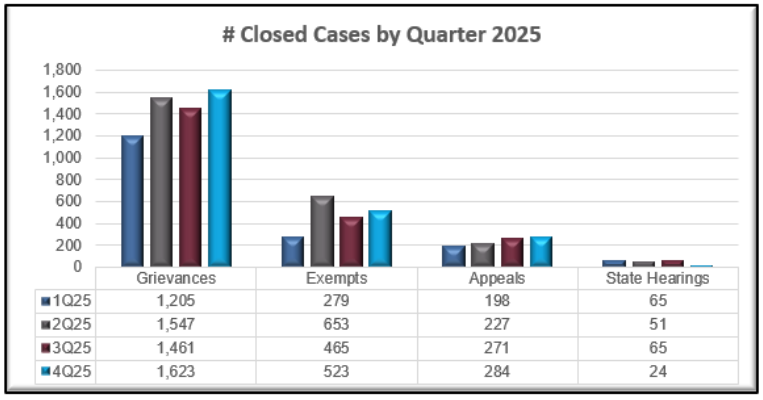
The following charts represent key data metrics used to track and trend Appeals, Grievances, and State Hearings over time.



	1	2	3	4	5	6	7	8	9	10	11	12
2023	359	349	503	498	513	507	455	555	513	530	487	421
2024	444	598	599	629	688	673	674	684	650	766	595	555
2025	511	593	643	895	842	741	773	686	803	909	737	808







	Grievances	Exempts	Appeals	State Hearings
1Q25	1,205	279	198	65
2Q25	1,547	653	227	51
3Q25	1,461	465	271	65
4Q25	1,623	523	284	24

STATISTICS BY REGION

"Deija helped obtain my reimbursement. I was very pleased with her service. She did a great job!"

– Partnership Member

CHARTS OF CASE STATISTICS BY REGION

The following charts illustrate the distribution of closed cases across each region, providing a breakdown of the total number of cases closed, the average yearly membership, and the percentage per 1,000 members.

4Q25 Cases by County			
AUBURN			
County	# of Cases	Avg Membership	Cases p/1,000
Nevada	89	28,310	3.14
Placer	202	61,454	3.29
Plumas	17	5,505	3.09
Sierra	2	818	2.44
Total	310	96,087	3.23

4Q25 Cases by County			
CHICO			
County	# of Cases	Avg Membership	Cases p/1,000
Butte	216	84,362	2.56
Colusa	18	10,022	1.80
Glenn	19	13,500	1.41
Sutter	67	44,204	1.52
Yuba	76	37,204	2.04
Total	396	189,292	2.09

4Q25 Cases by County			
REDDING			
County	# of Cases	Avg Membership	Cases p/1,000
Lassen	37	8,376	4.42
Modoc	8	3,767	2.12
Shasta	269	64,823	4.15
Siskiyou	63	17,773	3.54
Tehama	75	29,196	2.57
Trinity	21	5,101	4.12
Total	473	129,036	3.67

4Q25 Cases by County			
EUREKA			
County	# of Cases	Avg Membership	Cases p/1,000
Del Norte	52	12,171	4.27
Humboldt	207	56,133	3.69
Lake	84	33,261	2.53
Mendocino	83	40,161	2.07
Total	426	141,726	3.01

4Q25 Cases by County			
FAIRFIELD			
County	# of Cases	Avg Membership	Cases p/1,000
Solano	332	101,379	3.27
Napa	43	27,466	1.57
Yolo	142	54,091	2.63
Total	517	182,936	2.83

4Q25 Cases by County			
SANTA ROSA			
County	# of Cases	Avg Membership	Cases p/1,000
Sonoma	223	109,644	2.03
Marin	109	45,988	2.37
Total	332	155,632	2.13

DEMOGRAPHICS

CHARACTERISTICS OF FILING MEMBERS

The following charts represent key demographic data of members who filed an Appeal, Grievance, or State Hearing during 4Q25.

4Q25 CASES BY COUNTY			
County	# of Cases	Avg Membership	Cases p/1,000
Sonoma	9.1%	12.3%	0.25
Solano	13.5%	11.3%	0.37
Butte	8.8%	9.4%	0.24
Shasta	11.0%	7.2%	0.30
Placer	8.2%	6.9%	0.23
Humboldt	8.4%	6.3%	0.23
Yolo	5.8%	6.0%	0.16
Marin	4.4%	5.1%	0.12
Sutter	2.7%	4.9%	0.07
Mendocino	3.4%	4.5%	0.09
Yuba	3.1%	4.2%	0.08
Lake	3.4%	3.7%	0.09
Tehama	3.1%	3.3%	0.08
Nevada	3.6%	3.2%	0.10
Napa	1.8%	3.1%	0.05
Siskiyou	2.6%	2.0%	0.07
Glenn	0.8%	1.5%	0.02
Del Norte	2.1%	1.4%	0.06
Colusa	0.7%	1.1%	0.02
Lassen	1.5%	0.9%	0.04
Plumas	0.7%	0.6%	0.02
Trinity	0.9%	0.6%	0.02
Modoc	0.3%	0.4%	0.01
Sierra	0.1%	0.1%	0.00
Grand Total	100.0%	100.0%	2.74

4Q25 CASES BY ETHNICITY		
Member Ethnicity	% Cases	% Membership
White	57.1%	37.9%
Other/Unknown	15.8%	19.8%
Hispanic	16.5%	34.3%
Black	5.8%	3.6%
Asian	1.8%	2.5%
Native American	2.0%	1.7%
Hawaiian/Pacific Islander	1.0%	0.2%
Grand Total	100.0%	100.0%

4Q25 CASES BY LANGUAGE		
Member Language	% Cases	% Membership
English	91.6%	75.7%
Spanish	7.0%	20.8%
Other	0.9%	2.1%
Russian	0.1%	0.6%
Tagalog	0.2%	0.3%
Punjabi	0.2%	0.5%
Grand Total	100.0%	100.0%

4Q25 CASES BY GENDER		
MBR Gender	% Cases	% Membership
Female	63.1%	51.9%
Male	36.9%	48.1%
Grand Total	100.0%	100.0%

4Q25 CASES BY AGE		
Member Age	% of Cases	% of Membership
Age 0-10	5.9%	18.4%
Age 11-19	3.7%	16.3%
Age 20-44	26.2%	34.1%
Age 45-64	42.0%	19.6%
Age 65+	22.2%	11.6%
Grand Total	100.0%	100.0%

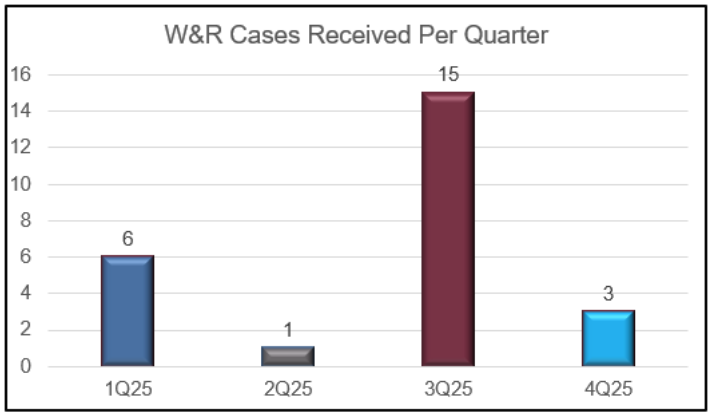
W&R RELATED

REPORTING PERIOD

This section covers quarterly statistics and trends in cases related to Wellness & Recovery (W&R) during 4Q25. It should be noted that W&R cases are measured based on the number of cases received per quarter, rather than the number of cases closed per quarter due to unique reporting by DHCS.

4Q25 NUMBERS

Three (3) W&R cases were received in 4Q25. Fifteen cases were closed. There were 25 Grievances and zero (0) Appeals reported in the calendar year 2025.



TRENDING ISSUES

There were two (2) cases received in 4Q25 related to Interpersonal Relationship Issues. G&A received one (1) case related to Program Requirements. Overall, 2025 cases have mostly fallen into the categories of Access to Care issues, Program Requirements and Interpersonal Relationship issues.

The increase in W&R cases for 2025 is primarily due to one (1) member filing eight (8) grievances against different providers. The member reported none of the eight (8) facilities were able to accommodate him. Upon investigation, it was determined the member did not contact four (4) of the facilities named. Those four (4) facilities had capacity to treat the member. The member contacted three (3) of the facilities. Those three (3) facilities did not have capacity to treat the member. The member was admitted to one (1) facility but left by his own choice and did not return.

DHCS REPORTING

DHCS requires quarterly reporting of W&R cases. The tables below provide the specific number of W&R cases and the case categories Partnership reported to DHCS for 4Q25 and for all of 2025. All the cases received in 2025 were closed within the 30-day DHCS regulatory timeframe.

4Q25 DHCS Grievance Categories	
Access to Care	0
Quality of Care	0
Program Requirements	1
Failure to Respect Enrollee's Rights	0
Interpersonal Relationship Issues	2
Other	0

2025 DHCS Grievance Categories	
Access to Care	11
Quality of Care	3
Program Requirements	6
Failure to Respect Enrollee's Rights	0
Interpersonal Relationship Issues	5
Other	0

WCM RELATED

REPORTING PERIOD

This section covers quarterly statistics and trends in cases related to Whole Child Model (WCM) during 4Q25.

4Q25 STATISTICS

During 4Q25, a total of 28 WCM-related cases were closed and reported to DHCS, representing 1.1% of the total of 2,454 closed cases for this quarter. These cases are divided into 21 Grievances (Standard and Exempt) and seven (7) Appeals. There were no State Hearings reported in this quarter related to WCM.

TRENDING ISSUES

The top complaints in 4Q25 were related to Non-Medical Transportation (NMT), Quality of Service, and Timely Access. NMT cases accounted for 39.3% and Quality of Service and Timely Access accounted for 28.6% of the total WCM-related cases. The top NMT concerns reported were driver behavior, drivers arriving late, unsafe drivers, and gas-mileage reimbursement. The top WCM provider service concerns reported were related to communication and poor attitude.

There were five (5) cases related to durable medical equipment (DME) in 4Q25 which included four (4) Appeals and one (1) Grievance. The DME cases were related to wheelchairs, baby formula, a cubby bed, a vest airway clearance system and an activity stroller. Out of the four (4) Appeals, two (2) denials were upheld, one (1) denial was overturned and one (1) was partially approved due to receiving additional information. The overturned Appeal was regarding the denial of a pediatric stroller. The denial was overturned because records received showed the member had outgrown their previous pediatric stroller. The partially approved Appeal was regarding a vest airway clearance system. The provider requested a 10-month rental. The appeal was partially approved to allow a three (3) month trial period.

DISCRIMINATION AGAINST WCM MEMBERS

G&A reviews all allegations of discrimination to determine if they fall under civil rights law. There was one (1) grievance that reported discrimination against a WCM member. It was determined that discrimination did not occur.

ETHNICITY AND PREFERRED LANGUAGE

G&A provides ethnicity and language data specific to WCM members through the charts below.

4Q25 WCM CASES BY ETHNICITY		
Member Ethnicity	**# of Cases**	**% of Cases**
White	12	42.9%
No response	6	21.4%
Hispanic	5	17.9%
Black (African American)	2	7.1%
Declined	1	3.6%
Guamanian	1	3.6%
Other Asian	1	3.6%
Grand Total	**28**	**100.0%**

Members provide Partnership with their language preferences for communication. Below is a breakdown of the member's reported languages.

4Q25 WCM CASES BY LANGUAGE		
Member Language	**# of Cases**	**% of Cases**
English	23	82.1%
Spanish	5	17.9%
Grand Total	**28**	**100.0%**

DISCRIMINATION

REPORTING PERIOD

This section covers quarterly statistics and trends in cases related to discrimination during 4Q25. Because a member may report multiple discrimination allegations in a single Grievance, a case may fall into multiple categories. As a result, the number of concerns may exceed the total number of cases.

4Q25 DISCRIMINATION STATISTICS

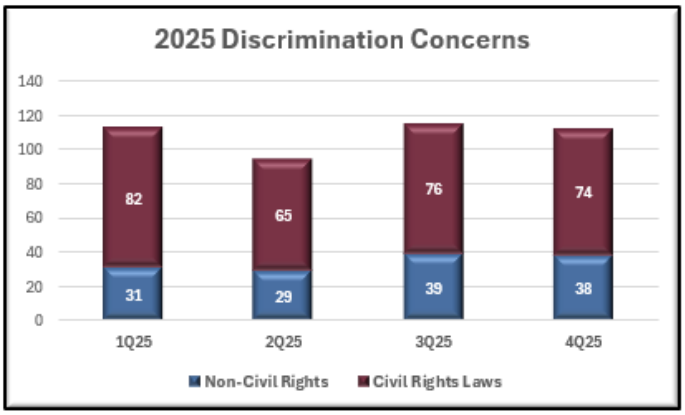
G&A investigated 112 cases related to discrimination allegations in 4Q25. This represented 4.6% of all cases closed. Of the 112 cases, 74 fell under an applicable federal or state civil rights law. This accounts for 66.1% of 4Q25 discrimination cases.

After investigation, it was determined that discrimination likely occurred in 12 cases, representing 10.7% of discrimination cases. This included a total of 17 concerns: four (4) for limited English skills, three (3) for language assistance services, two (2) for gender expression, two (2) for gender identity, and one (1) each for race or ethnicity, disability, sexual orientation, religion, auxiliary aids and services, and basis of sex.

Discrimination allegations that do not fall under a civil rights law accounted for 38 of the 112 alleged discrimination cases filed. This accounts for 33.9% of 4Q25 discrimination cases. Members alleged discrimination based on reasons such as being labeled a medication/drug seeker or having Medi-Cal.

4Q25 DISCRIMINATION TRENDS

A member reported being denied care by an Emergency Room physician based on their gender identity. The member was not examined before being sent to a higher-level hospital. The provider shared this is a common occurrence as they are a small, rural facility. Discrimination was found likely based on the member's gender identity, as it was found the provider could have completed an exam before sending the member to a higher level of care.



4Q25 CASES BY CATEGORY

The chart below shows a breakdown of cases wherein discrimination was found to be likely by the reported civil rights law.

Discrimination Found Likely	
Civil Rights Category	# of Concerns
Limited English Skills	4
Language Assistance Services	3
Gender Expression	2
Gender Identity	2
Auxilliary Aids and Services	1
Basis of Sex	1
Disability	1
Race or Ethnicity	1
Religion	1
Sexual Orientation	1
Total	17

QUALITY ASSURANCE

INTER-RATER RELIABILITY DEFINED

The quarterly Inter-Rater Reliability (IRR) audit provides physician oversight over clinical decisions made by Partnership's Grievance Registered Nurse team. A list of cases that were not previously reviewed by a Partnership Medical Director is forwarded to Partnership's Chief Medical Officer (CMO) or designated representative, of which a sample size is selected and evaluated. The Compliance Manager and Quality & Training Supervisor complete a subsequent comprehensive review to identify opportunities for operational improvements. Due to the timing of report generation, the data discussed reflects cases closed in 3Q25.

THE RESULTS

Forty-nine (49) Grievances were evaluated for the 3Q25 IRR review. There were no findings for cases that could have been sent for Potential Quality Issue (PQI) review. There were three (3) cases which had processing errors made by Grievance & Appeals staff.

The first case was a discrimination case. The case was deemed not likely to have been discriminatory due to the provider not responding to the request for information. Medical records could have been requested to determine if the members' concerns were substantiated in their records.

The second case involved a complaint against Kaiser. The case was closed without investigation, and the member was encouraged to file their complaint directly with Kaiser. The member was a Partnership member on the date of service, and their concerns should have been investigated.

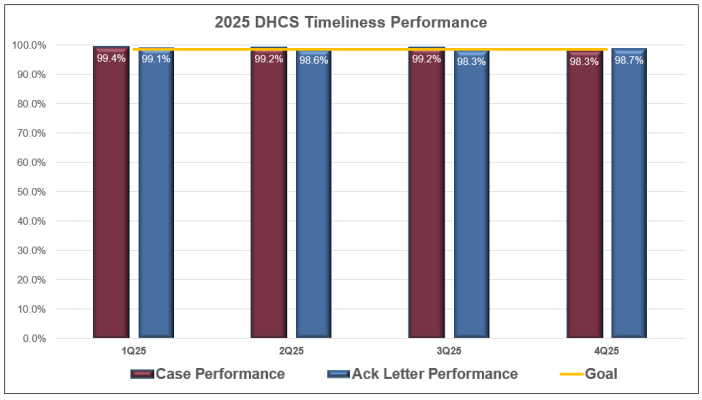
The third case was related to a treatment plan dispute. There was an opportunity to advocate for the member during the investigation. The member should have been contacted for clarification of the details of their grievance, and more research could have been conducted. The provider submitted a general response to the grievance and was not asked to clarify information.

TIMELINESS

The target timeliness goal for investigations and acknowledgement letters (ack-letters) is 98.6%. For 4Q25, 1,907 cases were subject to DHCS Turnaround Times (TAT). Thirty-two (32) cases closed outside of the time frame. The timeliness for investigations was 98.3%, which does not meet the threshold. There were 25 late ack-letters, achieving 98.7% timeliness. Investigations did not meet the timeliness goal in 4Q25 due to an increase in case load, subordinate changes within the Medical Director team, and several unexpected staff leave of absences on the G&A team in December 2025. G&A met the timeliness goals for October and November.

4Q25 DHCS Timeliness Performance

Performance Category	Performance Goal	# Late	Performance Result	Status
Investigations	98.6%	32	98.3%	
Ack-Letters	98.6%	25	98.7%	



TRANSPORTATION

REPORTING PERIOD

This section covers quarterly statistics and trends in cases related to Transportation during 4Q25.

4Q25 STATISTICS

Transportation cases in 4Q25 accounted for 1,194 cases of the 2,454 cases closed. This represented 48.7% of all cases closed in 4Q25. There were 1,134 Grievances (Exempt and Standard), 58 Appeals, and two (2) State Hearings.

TRENDING ISSUES

Lyft, North Bay Transit, Budget Friendly, Wheelcare Express and Redline Transit were the top five (5) providers with complaints in 4Q25. The top four (4) issues that members had during this time period were: missed rides, drivers arriving late, driver behavior and vendor customer service. There were 973 Non-Medical Transportation (NMT) cases and 221 Non-Emergency Medical Transportation (NEMT) cases in 4Q25.

There were 312,665 completed trips in 4Q25 as per Partnership's NMT & NEMT Transportation Dashboard dated February 2, 2026. Transportation Grievances accounted for 0.4% of the total rides completed in 4Q25. There were 240,986 NMT rides completed. This brings the percentage of NMT rides with concerns to 0.4%. There were 70,390 NEMT rides completed. This makes the total percentage of NEMT rides with concerns 0.3%. The number of NMT and NEMT grievances increased by 32.1% in 4Q25 as compared to 3Q25. This was primarily due to a new hire class training held in 4Q25. Complaints such as missed rides and drivers arriving late were the top common concerns in NMT and NEMT grievances.

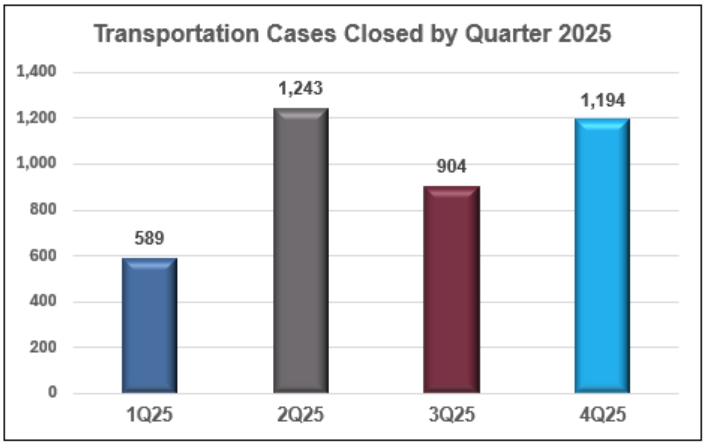
G&A identified multiple complaints against Partnership's Transportation Services department. The top three (3) complaints against the Transportation Services department included: scheduling issues with 91 cases or 7.6% of transportation cases, reimbursement of lodging with 57 cases or 4.8% of transportation cases and denied transportation with 55 cases or 4.6% of transportation cases.

PROCESS IMPROVEMENTS

Transportation Services is currently working on a pilot program where they connect directly with transportation providers with high grievance rates to improve the member experience.

Transportation Services created a new process to identify specific drivers using G&A data, to provide more specific feedback to the transportation providers. The goal of both process improvements is to improve the overall member experience and decrease the number of grievances received for providers who have higher grievance rates.

The chart below shows the total number of transportation cases that closed every quarter during 2025.



MEMBER EXPERIENCE

REPORTING PERIOD

As required by the National Committee for Quality Assurance (NCQA), this section reports member dissatisfaction globally in 2025 compared to 2024. For more details, please reference the attached NCQA ME.7 Member Experience Threshold Report.

OVERVIEW

The Member Experience Report tracks increases in cases across five (5) specific categories defined by NCQA. Those categories are Access, Attitude/Service, Billing/Financial, Quality of Care, and Quality of Provider's Office. The threshold for significant change is set at a 10% increase. This report provides insight into which categories experience fluctuations, reflecting the impact of membership changes and overall case filings.

There were 6,486 Grievances, Second Level Grievances, and Appeals closed in 2025, compared to 6,149 in 2024. This reflects a 5.5% increase in cases. Grievances accounted for 5,638 cases. Appeals and Second Level Grievances accounted for 848 cases. There was one (1) Second Level Grievance closed in 2025. This is no longer a case type and will not be reported on in 2026.

Partnership membership decreased by 0.4% from 905,570 to 901,645. The total number of grievances filed per 1,000 members increased to 6.25 from 6.05, a 3.3% increase. For Appeals and Second Level Grievances, the total number of cases filed per 1,000 members increased from 0.74 to 0.94, a 27.0% increase.

GRIEVANCES

G&A met the threshold for Grievances in the following categories: Access, Attitude and Service, Billing and Financial, Quality of Provider Office, and Overall. The threshold was not met for Grievances with Quality of Care concerns.

Quality of Care-related cases rose from 196 cases in 2024 to 223 cases in 2025 marking a 13.8% increase leading to missing the threshold by 0.01 cases per 1,000 members.

Like 2024, Attitude/Service issues and Access issues were the most frequently reported concerns in 2025, with 2,718 and 2,570 cases respectively.

Over 43.4% of the reported concerns pertained to transportation services. Common complaints include missed rides, delayed driver arrivals, and scheduling inconsistencies.

APPEALS & SECOND LEVEL GRIEVANCES

G&A met the threshold for Appeals and Second Level Grievances in the following categories: Attitude and Service, Billing and Financial, Quality of Care, and Quality of Provider Office. G&A did not meet the threshold for Access, and overall Appeals and Second Level Grievances received.

Access-related cases rose from 442 cases in 2024 to 634 cases in 2025 marking a 43.4% increase leading to missing the threshold by 0.16 cases per 1,000 members. The total cases rose from 672 in 2024 to 848 in 2025 marking a 26.2% increase leading to missing the threshold by 0.12 cases per 1,000 members.

Like 2024, Access issues and Billing/Financial issues were the most frequently reported concerns, with 634 and 213 cases in 2025 respectively.

THE UM EXPERIENCE

REPORTING PERIOD

As required by NCQA, this section reports G&A findings about members who encountered problems with the Utilization Management (UM) processes involving authorizations or referrals in 2025 compared to 2024. For more details, please reference the attached NCQA UM 1B: Member Experience-UM Threshold Report.

OVERVIEW

There were 426 reported concerns regarding the UM process in 2025 compared to 270 in 2024. The Grievance rate per 1,000 members for 2025 increased to 0.47, compared to 0.30 in 2024. This does not meet the overall threshold of 0.30. We have met the threshold in the Quality of Provider Office and Billing/Financial categories. We did not meet the threshold in the Access, Attitude/Service, or Quality of Care categories. There continues to be communication issues between members and their providers regarding referrals. This resulted in providers delaying or refusing to submit Treatment Authorization Requests (TARs) or Referral Authorization Forms (RAFs).

DISSATISFACTION WITH RAF PROCESS

Of the 426 UM concerns, 244 of them were related to the RAF process. Of those, 162 of the concerns were related to a member's primary care provider allegedly delaying their RAF request, which caused delays in getting appointments with specialists. There were 39 cases referred to Quality Improvement for further research.

RAF Process	
# of Reported Concerns	
Delayed by Provider	162
Refused by Provider	36
Member dislikes overall	19
Other	14
Delayed by PHC	8
Refused by PHC	5
Total	244

DISSATISFACTION WITH TAR PROCESS

Member's concerns related to the TAR process account for 182 of the 426 cases reported. The most significant driver was members alleging their provider delayed submission of their TAR to Partnership, which was reported in 87 of the concerns. There were 12 cases referred to Quality Improvement for further research.

TAR Process	
# of Reported Concerns	
Delayed Provider	87
Delayed by PHC	36
Member dislikes overall	21
Refused by Provider	17
Other	16
Med nec unmet by med recs	5
Total	182

PROVIDER FOCUSED

REPORTING PERIOD

This section highlights trends discovered from January 1, 2025, through December 31, 2025.

APPOINTMENTS

The Partnership Medi-Cal Handbook defines timely access to care as the following:

Urgent Care	48 hours
Non-urgent: w/PCP	10 Business Days
Non-urgent: w/Specialist	15 Business Days
Non-urgent: w/Mental Health	10 Business Days
Non-urgent: w/Ancillary Service	15 Business Days
Telephone Wait Times	10 minutes

G&A regularly reviews member concerns regarding timely access to care. Typically, members are not aware of these timeframes until educated during the Grievance process.

APPOINTMENT DELAYS WITH PROVIDERS

Primary Care Providers – Members reported a total of 175 concerns in 2025. These concerns were primarily directed at their primary care providers (PCP) or office staff regarding access to appointments, either in person or by phone. Members expressed dissatisfaction with long wait-times for appointments, difficulties in reaching staff when calling, a lack of return calls from providers, and instances where providers refused to see them.

Specialists – Partnership approves access to specialists through the RAF process. High-volume and high-impact providers include cardiologists, dermatologists, ophthalmologists, orthopedists, general surgeons, and OB/GYNs. These providers are closely monitored to ensure our members can access timely appointments. Members reported 14 concerns involving specialists in 4Q25. We received 13 reports regarding appointment availability, showing that members encountered difficulties promptly scheduling appointments. Among these 14 cases, eight (8) involved a high-impact provider.

MEETING CULTURAL & LINGUISTIC NEEDS

Partnership monitors our provider network to ensure it effectively meets the diverse cultural, ethnic, racial, gender, and linguistic needs of our membership. There were 23 total concerns reported against medical groups or individual doctors. Solano County had five (5) concerns reported. Shasta and Yolo Counties had three (3) concerns reported. Butte, Placer, Siskiyou, and Tehama Counties had two (2) concerns reported. Humboldt, Mendocino, Nevada, and Sonoma Counties each had one (1) case filed.

Partnership is a non-profit community-based health care organization that contracts with the State to administer Medi-Cal benefits through local care providers to ensure Medi-Cal recipients have access to high-quality comprehensive cost-effective health care. Partnership is available to Medi-Cal-qualifying residents 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, and Yuba.

CONTACT US
Partnership HealthPlan of California

4665 Business Center Drive
Fairfield, CA 94534

2525 Airpark Drive
Redding, CA 96001

www.PartnershipHP.org

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Quality Improvement Department
Partnership HealthPlan of California
4665 Business Center Dr., Fairfield CA 94534

Proposed 2026 6-Month Perinatal Quality Improvement Program (PQIP) Measurement Set

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

(A) Gateway Measure – Measure 1

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

(B) Clinical Measures – Measures 2-6

PHPS practices and select perinatal providers who provide quality and timely prenatal and postpartum care to PARTNERSHIP members have the option to earn additional financial incentives. The PQIP framework offers a simple and meaningful measurement set developed for PCPs and OB/GYNs and includes the following clinical measures: Timely Immunization Status - Tdap and Influenza Vaccine, Timely Prenatal Care, Late Entry to Care with Depression Screening ≥14 weeks gestation, Timely Postpartum Care and Timely Assessments (monitoring only measure).

Key:

New Proposed Measures || Change to Measure Design

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

PROPOSED CHANGES FOR THE PQIP 2026 6-MONTH MEASURE SET

Programmatic Changes:

Due to a new federal regulation that went into effect at the end of 2025, the Perinatal Quality Incentive Program must transition to a calendar year program by January 2027. Therefore, the proposed changes below pertain to the proposed abbreviated six-month bridge measurement set covering the period of July 1, 2026, through December 31, 2026. There are no new measures proposed for this set, but some revisions are suggested

In general, all the reporting timelines for any measures included in this set have been adjusted to correlate to the six-month period. Those revisions are not presented here. What follows are the proposed measure changes with their rationales.

A. GATEWAY MEASURE 1: ELECTRONIC CLINICAL DATA SYSTEMS (ECDS) – DATALINK IMPLEMENTATION

This measure supports the allowance of data exchange from provider Electronic Health Records to Partnership to capture clinical screenings, follow-up care and outcomes. ECDS participation is a vital component of furthering the quality of care for covered Partnership members. Note that NCQA is converting most hybrid measures to ECDS measures in the coming years. DHCS continues to make Partnership accountable for several ECDS measures. Partnership partnered with DataLink (a qualified HEDIS data aggregator) who can pull a much larger scope of measures than what is currently required for the Perinatal QIP. The DataLink process will continue to increase in emphasis and is now a gateway measure to the Perinatal QIP.

Proposal: It is proposed to keep the gateway measure the same except for changing the dates to align with the 6-month period of July 1, 2026 – December 31, 2026. This means contracting and connecting would still be a gateway to earning perinatal incentive.

B. CLINICAL MEASURES

I. Measure 3. Timely Prenatal Care (<14 Weeks of Gestation)

Measure Summary:

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

Proposal:

Since DataLInk connections and extractions have occurred for many PQIP providers, it is proposed to add monthly DataLink extractions as **Option 1** to submit monthly perinatal visits and depression screening data. The current process for manual

submissions would become **Option 2**. Below is the suggested language change for the reporting section of the measure.

Reporting (Applies to Measures 3 & 4)

There are two options for submitting monthly visits with depression screenings to Partnership.

Option 1: Monthly DataLink Extractions
PQIP providers must have an active connection with DataLink and have successfully completed the extraction process to utilize this option. Counts of qualifying prenatal visits will be gathered through the DataLink extraction process. Partnership reserves the right to periodically request manual submissions to validate extracted data.

Option 2: Monthly Manual submissions

II. **Measure 4: Depression Screening at First Prenatal Visit with Late Entry to Care (≥14 weeks Gestation)**

Measure Summary:
Prenatal care visits to an OB/GYN or other perinatal care practitioner or PCP in the first trimester (less than 14 weeks of gestation, as documented in the medical record) will be eligible for the incentive payment.

Proposal:
It is proposed to change the title of this measure to add the words "**with Late Entry to Care**". This helps clarify the intent of the measure for providers.

It is also proposed that Measure 4 have the same **Option 1** and **Option 2** as noted in the Measure 3 proposal.

III. **Measure 5: Timely Postpartum Care**

Measure Summary: Timely postpartum care is a measure of quality care and can contribute to healthier outcomes for women after delivery. Postpartum visits are an important opportunity to educate new mothers on expectations about motherhood, address concerns, and reinforce the importance of routine preventive health care.

Proposal: It is proposed to adjust the Index period by which women with live births are identified from an April through April date to April through October date as noted below. This allows for consistency in our data collection and will avoid gaps in the measure.

Measurement Period

April 7, 2026, to October 7, 2026: Index period by which women with live births are identified.

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

Policy/Procedure Number: MPCP2014 (previously MCCP2014)			**Lead Department: Health Services** Business Unit: Care Coordination	
Policy/Procedure Title: Continuity of Care			☒ **External Policy** ☐ **Internal Policy**	
Original Date: 08/19/2015 **Effective Date:** 12/29/2014 per DHCS		**Next Review Date:** 04/08/2027~~08/13/2026~~ **Last Review Date:** 04/08/2026~~08/13/2025~~		
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:** ~~08/13/2025~~04/08/2026	

I. RELATED POLICIES:

A. MPUP3039 – Direct Members
B. MCUP3126 – Behavioral Health Treatment (BHT) for Members Under the Age of 21
C. MP~~C~~CP2007 – Complex Case Management
D. MCCP2024 – Whole Child Model for California Children's Services (CCS)
E. MPBP8003 – Mental Health Services
F. CGA024 – Medi-Cal Member Grievance System
G. MCAP7002~~MCCP2032~~ – CalAIM Enhanced Care Management (ECM)
H. MCUP3041 – Treatment Authorization Request (TAR) Review Process
I. MCAP7001 - CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS)
J. MP~~C~~AP7003 – CalAIM Community Supports (CS)
K. MPTP2501~~MCCP2016~~ – Transportation Policy for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT)
L. MCUP3104 – Transplant Authorization Process

II. IMPACTED DEPTS:

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

III. DEFINITIONS:

~~A. **Adult Expansion Population:** Senate Bill (SB) 184 (Chapter 47, Statutes of 2022) amended Welfare and Institutions Code (W&I) section 14007.8 to expand eligibility for full scope Medi-Cal to individuals who are 26 through 49 years of age, and who do not have satisfactory immigration status (SIS) as required by W&I section 14011.2. SB 184 took effect on January 1, 2024. Impacted populations include:~~

~~1. **New Enrollee Population**: The new enrollee population consists of individuals who are 26 through 49 years of age in January 2024, who are not currently enrolled in full scope or restricted scope Medi-Cal, but who may apply for Medi-Cal after implementation of the Age 26-49 Adult Expansion and meet all eligibility criteria for full scope Medi-Cal, under any eligibility group, including Modified Adjusted Gross Income (MAGI) and Non-MAGI, except for SIS.~~

~~1. **Transition Population**: The transition population consists of individuals who are 26 through 49 years of age and are currently enrolled in restricted scope Medi-Cal because they do not have SIS or~~

~~are unable to establish SIS for full scope Medi-Cal under any eligibility group, including MAGI and Non-MAGI, before implementation of this expansion.~~

~~D.~~A. **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.

~~E.~~B. **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.

~~F.~~C. **Dual Eligible Special Needs Plans (D-SNPs):** A type of Medicare Advantage (MA) plan designed specifically for individuals who qualify for both Medicare and Medi-Cal. These plans offer specialized care that addresses the unique health needs of dual-eligible beneficiaries, providing enhanced care coordination, comprehensive services, and additional benefits not typically covered by standard Medicare or Medi-Cal. D-SNPs aim to integrate and streamline medical, behavioral, and long-term care services to improve health outcomes and reduce costs for individuals with complex care needs.

~~G.~~D. **Existing Relationship with Provider (for services other than Behavioral Health Treatment [BHT]):** is defined as the situation where a Member has seen an out of network Primary Care Provider (PCP) or specialist at least once during the 12 months prior to the date of their initial enrollment into Partnership HealthPlan of California (Partnership) for a non-emergency visit.

~~H.~~E. **Existing Relationship with Provider (for individuals receiving BHT):** is defined as the situation where a Member has seen the out-of-network BHT provider at least one time during the six months prior to either the transition of responsibility for BHT services from the Regional Center to Partnership, or the date of the Member's initial enrollment with Partnership if enrollment occurred on, or after, July 1, 2018.

~~I.~~F. **Managed Care Plan (MCP):** Partnership HealthPlan of California (Partnership) is contracted as a Department of Health Care Services (DHCS) Managed Care Plan (MCP). MCPs are required to provide and cover all medically necessary physical health and non-specialty mental health services

~~J.~~G. **Medical Exemption Request (MER):** A request for a Medi-Cal beneficiary to be temporarily exempt from mandatory enrollment into an MCP, and to instead remain in fee for service (FFS) Medi-Cal. This allows the beneficiary to maintain access to providers who are not enrolled as network providers with the MCP until the Member's medical condition has stabilized to a level that would enable the Member to transfer to a network provider of the same specialty without deleterious medical effects.

~~K.~~H. **Medical Necessity for EPSDT Services**: For individuals under 21 years of age, a service is medically necessary if the service meets the standards set for in Section 1396d(r)(5) of Title 42 of the United States Code and is necessary to correct or ameliorate defects and physical and mental illnesses that are discovered by screening services.

~~L.~~I. **Partnership Advantage:** Effective January 1, 2027, 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 Enrollees~~Members~~ will be qualified to receive both Medi-Cal and Medicare services as described in the Partnership Advantage Member Handbook.

~~M.~~J. **Risk of Harm:** An imminent and serious threat to the health of the Member.

K. **Special Populations:** Members most at risk for harm from disruptions in care or who are least able to access COC protections by request and who are identifiable in DHCS data or Previous MCP data.

~~N.~~

~~O.~~L. **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 with CCS eligible conditions insured by Partnership.

IV. ATTACHMENTS:

~~A. Continuity of Care Data Sharing Information~~
~~B. Continuity of Care (CoC) Data Template – 1) Data Elements for All Members~~
~~C. Continuity of Care (CoC) Data Template – 2a) Special Populations Specifications~~
~~D. Continuity of Care (CoC) Data Template – 2b) Special Population Member File~~
~~E.~~A. ~~Continuity of Care (CoC) Data Template – 2c) Special Populations Accompanying Data~~N/A

V. PURPOSE:

The purpose of this guideline is to define the process by which a Member may request to be allowed to continue to receive services by an out-of-network provider in the event that the Member has an established relationship with the provider who is providing ongoing care to the Member prior to their enrollment or re-enrollment into Partnership HealthPlan of California (Partnership). This policy applies to the following populations:

A. Medi-Cal Members assigned a mandatory aid code that transitions them from Medi-Cal fee-for-service into a Medi-Cal managed care plan (Partnership), i.e. Covered California to Partnership
B. Members newly enrolled directly into Partnership
C. Members from MCPs with contracts expiring or terminating into Partnership (Implemented ~~on or after~~ January 1, 2023)
D. Members newly enrolled and eligible for the Seniors and Persons with Disabilities aid code
E. Members receiving BHT services
F. Members with CCS-eligible conditions transitioning into WCM
G. Members receiving non-specialty (mild-to-moderate) mental health services
H. Members who have been denied for a Medical Exemption Request (MER)
I. Members who transitioned~~ding~~ to new MCPs on January 1, 2024 ~~(Partnership will ensure that transitioning members are able to access assistance from Partnership's call center starting November 1, 2023 and will be offering the same level of support for transitioning Members who seek assistance before January 1, 2024 while not enrolled in Partnership)~~
~~J. Members classified as Adult Expansion Population, which includes New Enrollee and Transition Populations~~
~~K.~~J. Enrollees~~Members~~ newly enrolled in Partnership Advantage's Dual Eligible Special Needs Plans (D-SNP), effective January 1, 2027.

VI. POLICY/ PROCEDURE:

A. Medi-Cal Members assigned a mandatory aid code who are transitioning into a Medi-Cal managed care plan (MCP) have the right to request continuity of care in accordance with federal and California law and managed care plan contracts with some exceptions.
   1. Consistent with federal law, Members must:
      a. Have access to services consistent with the access they previously had
      b. Be permitted to have continued access to services during a transition from FFS to Partnership, or a transition from a different MCP to Partnership
      c. Be permitted to retain their current provider for a period of time if that provider is not in

Partnership's network when the Member, in the absence of continued services, would suffer serious detriment to health or be at risk of hospitalization or institutionalization.

2. All Partnership Members with verifiable pre-existing provider relationships who make a continuity of care request to Partnership must be given the opportunity to continue treatment for up to 12 months with an out-of-network Medi-Cal provider. These eligible Members may require continuity of care for services they have been receiving through Medi-Cal FFS or through another MCP.
3. At the Member's request, Partnership will provide continuity of care for the completion of treatment by a terminated provider or by a non-participating provider, if the Member has one of the following conditions listed under Knox-Keene Health Care Service Plan Act (California Health and Safety Code (H&S) section 1373.96):
    a. An acute condition – a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention that has a limited duration.
        1) Completion of covered services shall be provided for the duration of the acute condition
    b. A serious chronic condition – a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration.
        1) Completion of the covered services shall not exceed 12 months from the contract termination date or 12 months from the effective date of coverage for newly covered Member.
    c. A pregnancy – the three trimesters of pregnancy and the immediate postpartum period (which is 12 months).
        1) Completion of covered services shall be provided for the duration relating to the pregnancy
    d. A terminal illness – an incurable or irreversible condition that has high probability of causing death within one year or less
        1) Completion of covered services shall be provided for the duration of a terminal illness, which may exceed 12 months from the contract termination date of 12 months from effective date of coverage for a new Member.
    e. The care of a newborn between birth and age 36 months.
        1) Completion of covered services under this paragraph shall not exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a newly covered Member.
    f. Performance of a surgery or other procedure that is authorized by the MCP as part of a documented course of treatment and has been recommended and documented by the provider to occur within 180 days of the contract's termination date or within 180 days of the effective date of coverage for a newly covered Member.
4. Partnership must review all available data to identify eligible providers that provided services to Special Populations during the 12 months preceding (Implemented January 1, 2024) or within 30 calendar days of receiving data for Special Populations. To minimize the risk of harm for disruptions in care, Partnership will focus their attention, resources, and provide continuity of care for transitioning Members in the following Special Populations that include:
    a. Adults and children with authorizations to receive ECM service
    b. Adults and children with authorizations to receive CS
    c. Adults and children receiving CCM
    d. Enrolled in 1915(c) wavier programs
    e. Receiving In-Home Supportive Services (IHSS)
    f. Children and youth enrolled in CCS/CCS Whole Child Model
    g. Children and youth receiving foster care, and former foster youth through age 25

h. In active treatment for the following chronic communicable diseases: HIV/AIDS, Tuberculosis, Hepatitis B and C
i. Taking immunosuppressive medications, immunomodulators, and biologics
j. Receiving treatment for end-stage renal disease (ESRD)
k. Living with an intellectual or developmental disability (I/DD) diagnosis
l. Living with a dementia diagnosis
m. In the transplant evaluation process, on any waitlist to receive a transplant, undergoing a transplant, or received a transplant in the previous 12 months
n. Pregnant or postpartum (within 12 months of the end of a pregnancy or maternal mental health diagnosis)
o. Receiving specialty mental health services (adults, youth, and children)
p. Receiving treatment with pharmaceuticals whose removal risks serious withdrawal symptoms or mortality
q. Receiving hospice care (for duration of the terminal illness)
r. Receiving home health
s. Residing in Skilled Nursing Facilities (SNF)
t. Residing in Intermediate Care Facilities for individuals with Developmental Disabilities (ICF/DD)
u. Receiving hospital inpatient care (for duration of the acute condition)
v. Post-discharge from inpatient hospital, SNF or sub-acute facility (Implemented ~~on or after~~ December 1, 2023)
w. Newly prescribed DME (Implemented January 1, 2024)
x. Members receiving Community-Based Adult Services

5. Enhanced protections for Members accessing the Transplant benefit
   a. If the MCP is unable to bring a Transplant Program in Network, the Receiving MCP must make a good faith effort to:
      1) Enter into a CoC for Providers agreement with the hospital where a Transplant Program is located as described in Section V.C and according to the following terms:
         a) Make explicit the existing statutory requirement that Receiving MCPs must pay, and transplant providers must accept, FFS rates (section 14184.201(d)(2) of the Welfare and Institutions Code.
         b) Permit the CoC for Providers agreement to continue for the duration of the Member's access to the transplant benefit.
      2) If the MCP is unable to enter into a CoC for Providers agreement, the MCP must:
         a) Arrange for the hospital where the Transplant Program is located to continue to deliver services to a Member as an out-of-network (OON) provider, in accordance with the timeline in 2024 Medi-Cal Managed Care Plan Transition Policy Guide.
         b) Explain in writing to DHCS why the provider and the MCP could not execute a CoC for Provider agreement, per guidance in the Transition Monitoring and Related Reporting Requirements, of the 2024 Medi-Cal Managed Care Plan Transition Policy Guide.

B. For Members with written documentation of being diagnosed with a maternal mental health condition from the treating health care provider, completion of covered services for the maternal mental health condition shall not exceed 12 months from the diagnosis or from the end of pregnancy, whichever occurs later.
C. Partnership is not required to provide continuity of care for services that are not covered by Medi-Cal.
D. Continuity of care protections extend to primary care providers (PCPs), specialists, ECM providers, CS Providers, Skilled Nursing Facilities (SNFs), Intermediate Care Facilities for Individuals with Developmental Disabilities (ICF/DD), Community-Based Adult Services (CBAS) providers, and select

ancillary providers, including dialysis centers, physical therapist, occupational therapists, respiratory therapists, mental health providers, behavioral health treatment (BHT) providers, speech therapy providers, doulas, and community health workers (CHW). They do not extend to all other ancillary providers such as radiology, laboratory, non-emergency medical transportation (NEMT), non-medical transportation (NMT), and non-enrolled or carved-out service providers.

E. Partnership will provide continuity of care with an out-of-network provider when the following criteria are met:
   1. Partnership is able to determine that the Member has an ongoing relationship with the provider (defined as at least one non-emergency visit during the preceding 12 months or prior to the date of the Members' initial enrollment in the D-SNP for a non-emergency visit).
      a. Self-attestation is not sufficient to provide proof of an established relationship with a provider.
   2. The provider is providing a service that is eligible for COC, and
   3. The provider is willing to accept the higher of Partnership's contract rates or Medi-Cal Fee For Service (FFS) rates or current Medicare fee schedule, and
   4. The provider meets Partnership's applicable professional standards and has no disqualifying quality of care issues and,
   5. The provider is a California State Plan approved provider, and
   6. The provider supplies Partnership with all relevant treatment information, for the purposes of determining medical necessity, as well as a current treatment plan, as long as it is allowable under federal and state privacy laws and regulations.
   7. Partnership Advantage Enrollees~~Members~~:
      a. D-SNPs are network based for Partnership Advantage Enrollees~~Members~~, with the following exceptions:
         1) Partnership Advantage Enrollees~~Members~~ are allowed to continue receiving care from an out of network provider for up to 12 months after enrolled if they have an acute or serious chronic medical condition as referenced in VI.A.3.
         2) Partnership Advantage Enrollees~~Members~~ must submit a request to Partnership including documentation from current medical provider.

F. If a Member/Enrollee changes managed care plans or D-SNP by choice following the initial enrollment into Partnership, or if a Member/Enrollee loses or leaves D-SNP and then later regains Partnership eligibility or rejoins D-SNP, the 12-month continuity of care period may start over one time. If the Member/Enrollee changes managed care plans or D-SNP or loses and regains Partnership eligibility a second time or more, the continuity of care (COC) period does not start over and the Member/ ~~does~~Enrollee does not have the right to a new 12-month period of continuity of care. If the Member returns to Medi-Cal fee-for-service and later re-enrolls in Partnership, the COC period does not start over.
   1. Partnership must accept COC requests made over the telephone, electronically, or in writing, according to the requester's preference.
   2. Partnership informs Members of their continuity of care protections through the Member welcome packet and the Partnership provider website. This information includes how the Member, Member's authorized representative, and/or provider may initiate continuity of care requests with Partnership. All information provided is made available in threshold languages and alternative formats upon request.
   3. Partnership also provides on-going training regarding continuity of care to both the Care Coordination and Member Services staff who interact regularly with Members and/or providers.

G. Behavioral Health Treatment
   1. For Members under 21 years of age transitioning from a Regional Center (RC), Partnership must automatically generate a continuity of care request. Members do not have to independently request continuity of care from Partnership. The State of California Department of Health Care Services

(DHCS) will provide Partnership with a list of transitioning Members whose services will transfer from the Regional Center to Partnership. Partnership will make a good faith effort to proactively contact the current treating provider(s) to begin the continuity of care process. For all Members assigned to Partnership on or after July 1, 2018, who were not receiving BHT services from a Regional Center, Partnership will offer the same continuity of care as outlined below.

2. Continuity of Care for an out-of-network BHT provider can be granted for a Member for up to 12 months when all the following DHCS criteria is met:
   a. The Member has an existing relationship with a qualified provider of BHT services. An existing relationship means the 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 RC to Partnership or the date of the Member's initial enrollment with Partnership if enrollment occurred on or after July 1, 2018.
   b. The provider and Partnership can agree to a rate, with the minimum rate offered by Partnership being the established Medi-Cal 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 Partnership's network.
   d. The provider is a California State Plan approved provider.
   e. The BHT provider supplies Partnership with relevant treatment information, including the current treatment plan, for the purpose of determining medical necessity, provided it complies with federal and state privacy laws and regulations.
3. If Partnership and the existing Member's provider are unable to reach a continuity of care agreement by the date of transition to Partnership, Partnership will reach out to the Member to transition through a warm handoff to an in-network BHT provider to ensure no gaps in services will apply.
4. Additionally, if a Member has an existing relationship (as defined above) with an in-network BHT service provider, Partnership will allow the Member to continue BHT services with that provider.
5. BHT services will not be discontinued or changed during the continuity of care period until a new behavioral treatment plan has been completed and approved by Partnership, regardless of whether the services are provided by the RC provider under continuity of care or a new, in-network Partnership provider.
6. Retroactive requests for BHT service continuity of care reimbursement are limited to services that were provided after a Member's transition date to Partnership, or the date of the Member's enrollment into Partnership, if the enrollment date occurred after the transition.

H. Specialty Mental Health Services to Non-Specialty Mental Health Services Transition:
   1. Partnership provides outpatient non-specialty mental health services for Members with mild to moderate impairment of mental, emotional, or behavioral functioning resulting from a mental health condition as defined by the current Diagnostic and Statistical Manual.
   2. County Behavioral Health Plans (BHPs) are required to provide specialty mental health services (SMHS) for Members who have significant impairment or reasonable probability of functional deterioration due to a diagnosed or suspected mental health disorder as described in Behavioral Health Information Notice (BHIN) 21-073. These criteria are less stringent for Members under the age of 21 under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit so children with a lower level of impairment may meet medical necessity criteria for SMHS services (see III.G. above).
   3. Partnership will provide continuity of care with an out-of-network SMHS provider in instances where a Member's mental health condition has stabilized such that the Member no longer qualifies for SMHS service from the county BHP. Continuity of Care for SMHS services applies only to psychiatrists and/or mental health provider types permitted though California's Medicaid State Plan to provide outpatient non-specialty mental health services.

4. Continuity of care requests for non-specialty mental health services must meet all criteria outlined in section VI.A-F.
5. If the Member later requires additional SMHS services from the county BHP to treat a serious mental illness and subsequently experiences sufficient improvement to be referred back to Partnership for non-specialty mental health services, the 12-month continuity of care period may start over one time.
6. If the Member requires subsequent SMHS services from the county BHP after the continuity of care period has ended, the continuity of care period does not start over when the Member returns to Partnership or changes managed care plans (i.e., the Member does not have the right to a new 12 months of continuity of care).

I. WCM and CCS Members:
1. Please see policy MCCP2024 Whole Child Model for California Children's Services for continuity of care guidelines.

J. Pregnancy and Post-Partum Members:
1. Pregnant and post-partum Medi-Cal Members ~~who are~~ assigned a mandatory aid code and who ~~are~~ transitioned~~ing~~ from Medi-Cal FFS into Partnership, or from MCPs with contracts that expired~~ing~~ or terminated~~ing~~ ~~to Partnership~~ on or after January 1, 2023, have the right to request continuity of care per criteria outlined in VI.A.3. These requirements also ~~will~~ apply to~~for~~ pregnant and postpartum Members and newborn children who transitioned from Covered California to Medi-Cal due to eligibility requirements.

~~K. Adult Expansion Population Members:~~
~~0. For Adult Expansion Population Members with an existing PCP that is in-Network with the receiving MCP, Partnership is required to maintain that assignment. Adult Expansion Population Members are not required to request COC to maintain their PCP assignment with PCPs that are in Partnership's Network. If the PCP is out-of-Network, Partnership is not expected to maintain that assignment; however, Partnership must adhere to all Continuity of Care requirements in accordance with APL 23-022.~~

~~M.~~K. Continuity of Care (COC) Process:
1. Members, their authorized representative, or their provider may make a direct request to Partnership for continuity of care. Partnership will begin to process the request within five (5) business days of receipt of the request. The COC process begins when Partnership starts to determine if the Member meets the criteria outlined in section VI.A-K and has a pre-existing relationship with the provider. Partnership will complete non-urgent request within 30 calendar days from the date Partnership receives the request, or 15 calendar days if an immediate request or if the Member's medical condition requires more immediate action such as upcoming appointments or other pressing care needs, or three (3) calendar days if this is an urgent request or if there is risk of harm to the Member (as defined above).
2. For Members that have one of the following conditions listed under Knox-Keene Health Care Service Plan Act (California Health and Safety Code (H&S) section 1373.96), once Partnership has established a COC for Providers agreement with an eligible provider, Partnership must reimburse the provider for covered services for the appropriate duration (as defined above) and as agreed upon with the provider.
3. For Members under the Special Population (as defined above), Partnership will initiate the COC process within 30 calendar days from receipt of the Special Populations data.
4. If a~~the~~ COC request ~~is made in advance of~~was submitted prior to January 1, 2024, Partnership ~~will~~ provided the same level of support and ~~d will~~ processed the request by January 1, 2024 or according to the timeframes in VI.K.1, whichever is later.
5. Partnership will accept requests for COC over the telephone, electronically, or in writing, according to the requester's preference and will not require that the requester complete and/or submit paper or

computer form if the requester prefers to make the request by telephone. Partnership will collect any necessary information from the requester over the telephone. Partnership will consider any Medical Exception Request (MER) that has been denied as an automatic COC request.

6. Partnership will utilize the following criteria to determine if a relationship exists:
   a. FFS utilization data provided by DHCS, or
   b. FFS utilization or claims data from an MCP with its contract expiring or terminating, or
   c. Documentation from the Member and/or provider which demonstrates a pre-existing relationship, or
   d. Partnership claims data
7. If a pre-existing relationship has been established with an out-of-network provider, Partnership will contact the provider and make a good faith effort to enter into a contract, letter of agreement, single-case agreement, or other form of relationship to establish a COC relationship for the Member. Specifically, for ECM and CS Providers, if Partnership does not come to an agreement, Partnership must explain in writing to DHCS why Partnership and the ECM Provider could not execute a contract, letter of agreement, single-case agreement, or other form of relationship to establish a COC relationship. Refer to policy MCAP7001 CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS) and MP~~C~~AP7003 CalAIM Community Supports (CS) for more details.
8. Partnership will accept and review retroactive COC requests for services that were already provided if the request meets all the COC requirements in VI.A.- J. and the services that are subject to the request meet the following requirements:
   a. Have dates of service that occur after the Member's assignment to Partnership or dates of service that have occurred after July 1, 2018.
   b. Have dates of services within 30 calendar days of the first date of service for which the provider is requesting, or the date from which they have previously requested COC retroactive reimbursement, and
   c. Are submitted to Partnership within 30 calendar days of the first date of service for which retroactive continuity of care is being requested.
   d. D-SNP retroactive requests for Partnership Advantage Enrollees~~Members~~ must be accepted if submitted more than 30 days after the first service if the provider can document that the reason for the delay is that the provider unintentionally sent the request to the incorrect entity and the request is sent within 30 days of the denial from the other entity. Examples include, but are not limited to, situations where the provider sent the claim to CMS (as a Medicare Fee-for-Service (FFS) claim), a Medicare Advantage plan, another D-SNP, or the primary plan instead of the delegate.
9. Each COC request is considered complete when the Member is notified of the COC decision via Member's preferred method of communication or by telephone. A written notice will also be mailed to the Member within seven calendar days of the COC decision when:
   a. Partnership and the out-of-network FFS or prior plan provider are unable to agree to a rate
   b. Partnership has documented quality of care issues; or
   c. Partnership makes a good faith effort to contact the provider and the provider is non-responsive for 30 calendar days
10. Member Notifications
    a. Partnership will provide acknowledgment of the COC request within the time frames specified below, advising the Member that the COC request has been received, the date of receipt, whether the request was considered urgent, immediate, or non-urgent (as defined in Section VI.L.1.), and the estimated timeframe of resolution. Partnership will notify the Member using the Member's known preference of communication or by using one of these methods in the

following order: telephone call, email and then notice by mail.

1) For non-urgent, immediate, and Special Population requests, acknowledgment of the COC request will be provided within seven calendar days of the decision.
2) For urgent requests, acknowledgment of the COC request will be provided within the shortest applicable timeframe that is appropriate for the Member's condition, but no longer than three calendar days of the decision.

b. Member Notification of Denial
   1) When a COC request is denied, the Member will be offered an in-network alternative. If the Member does not make an alternate choice, the Member will be referred or assigned to an in-network provider. When a COC request is denied and/or a Member disagrees with the result of the process, a notice by mail will be sent within seven calendar days of the COC decision to include the following information:
      a) A statement of Partnership's decision
      b) A clear and concise explanation of the reason for denial
      c) The Member's right to pursue a grievance and/or appeal (please see policy CGA024 – Medi-Cal Member Grievance System).

c. Member Notification of Approval
   1) If a provider meets all the necessary requirements, including agreeing to a letter of agreement or contract with Partnership, Partnership will grant the COC request to allow access to that provider for the length of the continuity of care period unless the provider is only willing to work with Partnership for a shorter time frame. Upon approval, a notice by mail will be sent within seven calendar days of the COC decision including the following information:
      a) A statement of Partnership's decision
      b) The duration of the COC agreement
      c) The process that will occur to transition the Member's care at the end of the continuity of care period and
      d) The Member's right to choose a different provider from Partnership's provider network
   2) When the COC agreement has been established, Partnership will work with the provider to establish a plan of care for Member.
   3) At any time, Members may change their provider to a network provider regardless of whether or not a COC relationship has been established.

d. Member Notification Prior to End of COC Period
   1) 30 days prior to the expiration of the COC approval, Partnership will notify the Member using member's preferred method of communication about the process that will occur to transition the Member to a network provider at the end of the COC period. Partnership will engage with the Member and provider, including the transferring of the Member's record, before the COC period ends to ensure continuity of services through the transition to a new provider. This serves as the notification that continuity of care will not be extended past the expiration date unless the Member reaches out to Partnership prior to the date on the COC approval letter.
      a) Any request for extension of a COC request may be subject to Medical Director Review.
      b) Although not required by DHCS, Partnership may continue to work with the Member's out-of-network provider past the 12-month COC period.
   2) For Members falling under the transition as outline in V.I, the notification timeframe is 60 days prior to the expiration of the COC approval.

11. Referrals
    a. An approved out-of-network provider must work with Partnership and its contracted network

and cannot refer the Member to another out-of-network provider without authorization from Partnership. In such cases, Partnership will make the referral if the request meets medically necessity criteria and Partnership does not have an appropriate provider within its network.

b. At the request of the Member, the Member's authorized representative, or the provider, Partnership will allow transitioning Members to keep authorized and scheduled specialist appointments with out-of-network providers when COC has been established and the appointments occur during the COC period.
   1) If a Member, their authorized representative, or their provider contacts Partnership to request to keep an authorized and scheduled specialist appointment with an out-of-network provider that the Member has not seen in the previous 12 months and there is no established relationship, Partnership may arrange for the Member to keep the appointment or may schedule an appointment with a network provider on or before the Member's scheduled appointment with the out-of-network provider.
   2) If Partnership is unable to arrange a specialist appointment with a network provider on or before the Member's scheduled appointment with the out-of-network provider, Partnership will make a good faith effort to allow the Member to keep their appointment; however, since the appointment occurs after the transition into Partnership, it does not meet criteria for a pre-existing relationship to request COC.

M. Continuity of Covered Services and Prior Treatment Authorizations:
1. Active prior treatment authorizations for services remain in effect for 6 months and must be honored without a request by the Member, Member's authorized representative, or provider. Partnership will arrange for services authorized under the active prior treatment authorization with a network provider, or, if there is no network provider, with an out-of-network provider. Utilization data of Special Populations will be examined to identify active courses of treatment and the MCP will contact providers as needed to establish any necessary prior authorizations.
2. After 6 months, the active treatment authorization remains in effect for the duration of the treatment authorization or until a new assessment is completed, whichever is shorter.
3. If a new assessment is not completed, the active treatment authorization remains in effect. After 6 months, the prior treatment authorization may be reassessed at any time. Reassessments for clinical necessity for Members to continue accessing the transplant benefit will start no sooner than six months after the transition date. A new assessment is considered complete if the Member has been seen in-person and/or via synchronous telehealth by a network provider who has reviewed the Member's current condition and completed a new treatment plan that includes assessment of the services specified by the pre-transition active prior treatment authorization.
4. If reassessing Enhanced Care Management (ECM) authorizations after 6 months, the reassessment must be against ECM discontinuation criteria and not the ECM Population of Focus eligibility criteria. Please refer to policy MCAP7002~~MCCP2032~~ – CalAIM Enhanced Care Management (ECM), MCAP7001 CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS) and MP~~C~~AP7003 CalAIM Community Supports (CS) for more details.
5. Durable Medical Equipment (DME): Partnership will allow transitioning Members to keep their existing DME rentals and medical supplies from their existing provider under the criteria above (VI.L.1- 3). Additionally, if the DME or medical supplies have been arranged for a transitioning Member but have not yet been delivered, Partnership will allow the delivery and permit the Member to keep the equipment or supplies for a minimum of 6 months following Partnership enrollment and until reassessed.
6. Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT): Partnership will allow Members to keep the modality of transportation under the previous prior authorization with a network provider until Member's continued transportation needs are reassessed.

Refer to policy MPTP2501~~MCCP2016~~ – Transportation Policy for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT) for details.

7. Treatment Authorization Request (TAR) data or prior authorization data will be used to identify prior treatment authorizations, including authorized procedures and surgeries, and existing authorizations for DME and medical supplies. Partnership will pay claims for prior authorizations or existing authorizations when data is incomplete.

N. Reporting
1. Partnership will report metrics related to COC provisions to DHCS. DHCS may request additional reporting on COC at any time and in a manner determined by DHCS.

VII. REFERENCES:

A. 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)
B. DHCS All Plan Letter 23-010 *Revised*: Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21 (11/22/2023)
C. Welfare and Institutions Code Sections 14132.03 and 14189
D. Knox-Keene Health Care Service Plan Act (California Health and Safety Code (H&S) section 1373.96)
E. DHCS All Plan Letter 24-015: California Children's Services Whole Child Model Program (12/02/2024)
F. DHCS All Plan Letter 23-018: Managed Care Health Plan Transition Policy Guide (06/23/2023)
~~G. DHCS All Plan Letter 23-031: Medi-Cal Managed Care Plan Implementation of Primary Care Provider Assignment for the Age 26-49 Adult Expansion Transition (12/20/2023)~~
~~H.~~G. DHCS CalAIM Dual Eligible Special Needs Plans Policy Guide- Contract Year 2026 (2025)
~~I.~~H. Medicare Managed Care Manual: Chapter 11 – Medicare Advantage Application Procedures and Contract Requirements, Rev. 83 (04/25/2007)

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE:

Chief Health Services Officer, Health Services

X. REVISION DATES:

Partnership Advantage (Program effective January 1, 2027~~6~~)
08/13/25; 04/08/26

Medi-Cal
8/19/15 effective 12/29/14 per DHCS; 11/18/15; 08/17/16; 08/16/17; *06/13/18; 11/14/18; 11/13/19; 09/09/20, 09/08/21; 09/14/22; 09/13/23; 08/14/24; 08/13/25; 04/08/26

*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

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

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

MPCP2014 – A Continuity of Care Data Sharing Information: Successful data sharing among DHCS, Previous MCPs, and Receiving MCPs, will be critical to effectuate 2024 MCP Transition. Receiving MCPs must have access to ingestible, complete, accurate, and timely data from Previous MCPs and DHCS. Receiving MCPs must receive confirmation from Previous MCP to ensure that they completed all data transfer sharing activities. DHCS will require Previous MCPs to transmit utilization data, authorization data, member information, including preferred form of communication, supplemental accompanying data for Special Populations, and any additional data elements identified by DHCS for data transfer directly to Receiving MCPs.

I. DHCS Provided Data Files

Partnership HealthPlan of California (Partnership) must utilize information provided in the standard monthly Plan Data Feed to implement COC protections. DHCS will share the data outlined below which represents a subset of all Special Populations that can be identified by DHCS held data in eligibility and claims/encounters data.

Figure A: Summary of DHCS Provided Data Files

File	Description	Data Recipient	Refresh Frequency	Data Elements
Plan Transfer Status Report	Pending MCP enrollment for transitioning members.	Previous MCPs	Weekly, Beginning October 20, 2023	Refer to Figure 1: Plan Transfer Status Report Data Elements

Figure A.1: Plan Transfer Status Report Data Elements

Data Element	Format
Medi-Cal Member CIN	Alpha-Numeric 9-digit, Text
Member Date of Birth	MM/DD/YYYY, Date
Member First Name	Alpha-Numeric, Text
Member Last Name	Alpha-Numeric, Text
Choice Plan	Alpha-Numeric, Text
Default Plan	Alpha-Numeric, Text

Figure B: Member Level Data

File	Description	Data Recipient	Refresh Frequency
Member Level Data	For transitioning members in November 2023: 1. Plan Data Feed historical utilization data 2. Treatment Authorization Request (TAR) data	Receiving MCPs	One-Time in November

Figure C: Plan Data Feed

File	Description	Data Recipient	Refresh Frequency
Plan Data Feed	Utilization information for all enrolled members	Receiving MCPs	Monthly (First of Each Month)

Figure D: Special Populations Member File

File	Description	Data Recipient	Refresh Frequency
Special Populations Member File	Member-level information, specifically CINs for transitioning members who meet Special Populations criteria (see MPCP2014 Continuity of Care (Medi-	Receiving MCPs must use both the DHCS-provided Special Populations Member File and the Previous MCP-provided Transitioning Member Special Population	Monthly for All Special Population Members from November 2023 through March 2024

	Cal) Policy for details), indicating the members' Special Population group(s)	Information Data file to identify Special Populations members' providers and begin outreach, a key tenet of the COC policies for Special Populations.	

II. Previous MCP Provided Data Files

DHCS is requiring Previous MCPs to share data with Receiving MCPs to ensure access to the most timely, accurate, and comprehensive member-level information to effectuate COC protections. The Previous MCP must complete all data sharing requirements outlined below (Figure E) that reflects a standardized set of "minimum necessary" data elements for data shared from the Previous MCP to Receiving MCPs, as well as standard file formats, transmission methods, and transmission frequencies.

Figure E: Summary of MCP Provided Data Files

File	Description	Data Recipient	Refresh Frequency
Transitioning Member Identifying Data	Identifying information (e.g., name, date of birth) and contact information for transitioning members	Receiving MCPs and DHCS	Initial transfer November 2, weekly refreshes beginning in December
Transitioning Member Utilization Data	Claims and encounter information for transitioning members	Receiving MCPs and DHCS	Initial transfer November 2, weekly refreshes beginning in December
Transitioning Member Authorization Data	Prior authorization information for transitioning members	Receiving MCPs and DHCS	Initial transfer November 2, weekly refreshes beginning in December
Transitioning Member NEMT/NMT Schedule and Physician Certification Statement Data	Scheduled transportation information for transitioning members	Receiving MCPs and DHCS	Initial transfer November 2, weekly refreshes beginning in December
Transitioning Member Special Populations Information Data	Transitioning members who meet Special Populations criteria and relevant accompanying data elements	Receiving MCPs and DHCS	Initial transfer November 2, weekly refreshes beginning in December
Special Populations Member Supportive Information Data	Transitioning member screening and assessment findings, and member Care Management Plans	Receiving MCPs and DHCS	Within 15 days of member changing to a new Care Manager or by January 1, 2024, whichever is later

Figure F: Accompanying Excel Attachments for Previous MCP Provided Data

DHCS has compiled the outlined data elements into four accompanying Excel workbooks for Previous MCPs to prepare data files to transmit to Receiving MCPs to enable implementation of Continuity of Care policies. Refer to Figure F table for details. Refer to policy MPCP2014 – Continuity of Care (Medi-Cal) for attachment details.

Excel Attachment File	Description
Continuity of Care (CoC) Data Template - 1) Data Elements for All Members	Previous MCPs must use this template to prepare member level data files for transitioning members outlined in Figures G-J

Continuity of Care (CoC) Data Template - 2a) Special Populations Specifications	Previous MCPs must use these specifications to identify relevant members and prepare Transitioning Member Special Populations Data files
Continuity of Care (CoC) Data Template – 2b) Special Population Member File	Previous MCPs must use this template to prepare a file identifying members that meet the outlines criteria
Continuity of Care (CoC) Data Template – 2c) Special Populations Accompanying Data	Previous MCPs must use this template to prepare Special Populations accompanying data for certain Special Population groups for transmittal to Receiving MCPs

Figure G: Transitioning Member Identifying Data

Previous MCPs will share Transitioning Member Identifying Data files with Receiving MCPs and DHCS in accordance with the required transmission method and frequency outlined below in Figure G.1 and G.2.

Figure G.1: Transitioning Member Identifying Data

Data Element	Format
Medi-Cal Member CIN	Alpha-Numeric 9 digit, Text
Member First Name	Alpha-Numeric, Text
Member Last Name	Alpha-Numeric, Text
Member Date of Birth	MM/DD/YYYY, Date
Member Gender Code	Numeric 3-digit, Text
Member Homelessness Indicator	Numeric, 1 digit, Text
Member Residential Address	Alpha-numeric, Text
Member Residential City	Alpha-numeric, Text
Member Residential Zip Code	Alpha-numeric, Text
Member Mailing Address	Alpha-numeric, Text
Member Mailing City	Alpha-numeric, Text
Member Mailing Zip Code	Numeric, 5-digit
Member Phone Number	Numeric, 10-digit
Member Email Address	Alpha-Numeric, Text
Member's Preferred Form of Contact	Alpha-Numeric, Text
Description of Member's Selected Alternative Format	Alpha-Numeric, Text
Member's Preferred Language (Spoken)	Alpha-Numeric, Text
Member's Preferred Language (Written)	Alpha-Numeric, Text

Figure G.2: Transitioning Member Primary Care Provider Information

Data Element	Format
Medi-Cal Member CIN	Alpha-Numeric 9-digit, Text
Primary Care Provider/Name (Assigned PCP)	Alpha-numeric, Text
Primary Care Provider/National Provider Identifier (NPI)	Numeric, 10-digit, Text
Primary Care Provider/Phone Number	Numeric, 10-digit
Primary Care Facility Name	Alpha-numeric, Text
Primary Care Facility NPI	Numeric, 10-digit, Text
Primary Care Facility Phone Number	Numeric, 10-digit
Primary Care Facility Address	Alpha-numeric, Text
Medical Group	Alpha-numeric, Text
Medical Group TIN	Numeric, 9-digit
Last Visit Date	MM/DD/YYYY, Date

Figure H: Transitioning Member Utilization Data
Previous MCPs must share Transitioning Member Utilization Data files directly with Receiving MCPs and DHCS in accordance with the required transmission method and frequency outlined in Section I (A-D) and Section II (E-F). Previous MCPs must share Transitioning Member Utilization Data files with Receiving MCPs and DHCS in accordance with the required data elements and format outlined in the transitioning member claims/encounter information outlined below in Figure H.1.

Figure H.1: Transitioning Member Claims / Encounter Information

Data Element	Format
Medi-Cal Member CIN	Alpha-Numeric 9-digit, Text
Detail Service Date	MM/DD/YYYY, Date
Procedure Code	Alpha-Numeric, Text
HCPCS Modifier	Alpha-Numeric, Text
Revenue Code	Numeric, 4-digit, Text
Place of Service	Numeric, 2-digit, Text
Bill Type	Alpha-Numeric, Text
Billed Units	Numeric, 6-digit, Text
Tax Identification Number	Numeric, 9-digit, Text
Billing Provider NPI	Numeric, 10-digit, Text
Billing Provider First Name	Alpha-Numeric, Text
Billing Provider Last Name	Alpha-Numeric, Text
Billing Provider Phone Number	Numeric, 10-digit
Rendering Provider Taxonomy Code	Alpha-Numeric 9-digit, Text
Rendering Provider NPI	Alpha-Numeric, Text
Rendering Provider First Name	Alpha-Numeric, Text
Rendering Provider Last Name	Numeric, 10-digit
Rendering Provider Phone Number	Alpha-Numeric, Text
Rendering Provider Specialty Type	Alpha-Numeric, Text
Admittance Low Service Date	MM/DD/YYYY, Date
Discharge High Service Date	MM/DD/YYYY, Date
Diagnosis Code 1	Alpha-Numeric, Text
Diagnosis Code 2	Alpha-Numeric, Text
Diagnosis Code 3	Alpha-Numeric, Text
Diagnosis Code 4	Alpha-Numeric, Text

Figure I: Transitioning Member Authorization Data
Previous MCPs will share Transitioning Member Authorization Data files with Receiving MCPs and DHCS in accordance with the required transmission method and frequency outlined below in Figure I.1.

Figure I.1: Transitioning Member Authorization Information

Data Element	Format
Medi-Cal Member CIN	Alpha-Numeric 9-digit, Text
Requesting Provider Name	Alpha-numeric, Text
Requesting Provider NPI	Numeric, 10-digit, Text
Requesting Provider Phone Number	Numeric, 10-digit
Requesting Facility Name	Alpha-numeric, Text
Requesting Facility NPI	Numeric, 10-digit, Text
Requesting Facility Phone Number	Numeric, 10-digit
Rendering Provider Name	Alpha-numeric, Text
Rendering Provider NPI	Numeric, 10-digit, Text
Rendering Provider Phone Number	Numeric, 10-digit

Rendering Facility Name	Alpha-numeric, Text
Rendering Facility NPI	Numeric, 10-digit, Text
Rendering Facility Phone Number	Numeric, 10-digit
Authorization Begin Date	MM/DD/YYYY, Date
Authorization End Date	MM/DD/YYYY, Date
Units (as applicable)	Numeric 7-digit, Text
Service Code	Alpha-Numeric, 5-digit, Text
Service Code Description	Alpha-Numeric, Text
Diagnosis Code	Alpha-Numeric, Text
Diagnosis Description	Alpha-Numeric, Text
Authorization Status	Alpha-Numeric, Text
Authorization Type	Alpha, 2-digit, Text
Previous MCP Authorization Number	Alpha-Numeric, Text
Discharge Status	Alpha-Numeric, Text

Figure J: Transitioning Member NEMT/NMT Schedule and Physician Certification Statement Data
Receiving MCPs must identify scheduled NEMT/NMT services for which there is no provider scheduled or the provider is OON and either schedule a Network provider or an OON provider to transport the member. See policy MPCP2014 – Continuity of Care (Medi-Cal) for details and refer to Figure J.1 and J.2 for outlined data elements and format.

Figure J.1: Transitioning Member NEMT/NMT Schedule Data

Data Element	Format
Medi-Cal Member CIN	Alpha-Numeric 9-digit, Text
Level Of Transportation Service	Numeric, 1 digit, Text
Date of Scheduled Transportation Service	MM/DD/YYYY, Date
Time of Scheduled Transportation Service	hh:mm:ss, Time
Recurring Transportation Service Indicator	Numeric, 1 digit, Text
Member Phone Number	Numeric, 10-digit
Pickup Location	Alpha-Numeric, Text
Pickup Address	Alpha-Numeric, Text
LTC/SNF Phone Number	Numeric, 10-digit
Mode of Transport	Alpha-Numeric, Text
Transportation Provider Name	Alpha-Numeric, Text
Transportation Provider Phone Number	Numeric, 10-digit
Dropoff Provider Name	Alpha-Numeric, Text
Dropoff Provider Address	Alpha-Numeric, Text
Dropoff Provider Phone Number	Numeric, 10-digit
Current NMT/NEMT Vendor	Alpha-Numeric, Text
Transportation Notes	Alpha-Numeric, Text

Figure J.2: Transitioning Member PCS Information

Data Element	Format
Medi-Cal Member Client Index Number (CIN)	Alpha-Numeric 9-digit, Text
Level Of Service	Alpha-Numeric, Text
Authorization Begin Date	MM/DD/YYYY, Date
Authorization End Date	MM/DD/YYYY, Date
Start Date of Standing Order	MM/DD/YYYY, Date
Mode of Transportation	Alpha-Numeric, Text
Requesting Provider Name	Alpha-Numeric, Text
Requesting Provider NPI	Numeric, 10-digit, Text
Requesting Provider Phone Number	Numeric, 10-digit
Rendering Provider Name	Alpha-numeric, Text

Rendering Provider NPI	Numeric, 10-digit, Text
Rendering Provider Phone Number	Numeric, 10-digit
PCS Notes	Alpha-numeric, Text

Figure K: Transitioning Member Special Populations Information Data

Previous MCPs must share Transitioning Member Special Populations Information Data files with Receiving MCPs in accordance with the required transmission method and frequency outlined in Section I (A-D) and Section II (E-F). Previous MCPs must also share a copy of this data to DHCS to facilitate DHCS' oversight of the transition. For transitioning members not captured in the subset of members included in the *Special Populations Member File* provided by DHCS, including transitions involving subcontracted MCP terminations, the MCP and its subcontracted MCP are required to identify **both** Figure K.1 and Figure K.2 members and share all data elements outlined in this section.

Figure K.1: Special Populations for which DHCS Data is Primary Source of Information

Members Who Are:
• Children and youth receiving foster care and former foster youth through age 25
• Children and youth enrolled in CCS/CCS Whole Child Model
• Enrolled in Assisted Living Waiver
• Enrolled in HIV/AIDS waiver
• Enrolled in Home and Community-Based Services (HCBS) Waiver for Developmental Disabilities (DD)
• Enrolled in in Home and Community-Based Alternatives (HCBA) Waiver
• Enrolled in Multipurpose Senior Services Program MSSP
• Enrolled in Self-determination program for intellectual and DD
• Receiving In Home Supportive Services (IHSS)
• Residing in Intermediate Care Facilities for individuals with Developmental Disabilities (ICF/DD)
• Receiving Community-Based Adult Services

Figure K.2: Special Populations for which Previous MCP Data is Primary Source of Information

Members Who Are:
• In active treatment for the following chronic communicable diseases: HIV/AIDS, tuberculosis, hepatitis B and C
• Living with an Intellectual or Developmental Disability (I/DD) diagnosis
• Newly prescribed DME (within 3 months prior to January 1, 2024)
• Accessing the transplant benefit
• Post-discharge from inpatient hospital, SNF, or sub-acute facility on or after December 1, 2023
• Receiving hospital inpatient care
• Receiving treatment with pharmaceuticals whose removal risks serious withdrawal symptoms or risk of mortality
• Taking immunosuppressive medications, immunomodulators and biologics
• Adults and children with authorizations to receive Enhanced Care Management services
• Adults and children with authorizations to receive Community Supports
• Living with a dementia diagnosis
• Pregnant or post-partum (within 12 months of the end of a pregnancy or maternal mental health diagnosis)
• Receiving home health
• Receiving hospice care
• Receiving Specialty Mental Health Services (adults, youth, and children)
• Receiving treatment for End Stage Renal Disease (ESRD)
• Residing in Skilled Nursing Facilities (SNF)
• Adults and children receiving Complex Care Management

Figure K.3: Previous MCP-Provided Special Population Accompanying Data Elements

Data Element	Format
Adults and children receiving Complex Care Management	
Medi-Cal Member CIN	Alpha-Numeric 9-digit, Text
Reason for Care Management or Program type	Alpha-Numeric, Text
Care Management Open Date	MM/DD/YYYY, Date

Plan Contact Name	Alpha-Numeric, Text
Plan Contact Phone Number	Numeric, 10-digit
Assessment Completion Date	MM/DD/YYYY, Date
Care Plan Date	MM/DD/YYYY, Date
Members accessing the transplant benefit	
Medi-Cal Member CIN	Alpha-Numeric 9 digit, Text
Transplant Stage	Alpha-Numeric, Text
Eligibility Plan Code	Alpha-Numeric, Text
Organ	Alpha-Numeric, Text
Transplant Date	MM/DD/YYYY, Date
Request Type	Alpha-Numeric, Text
Authorization Begin Date	MM/DD/YYYY, Date
Authorization End Date	MM/DD/YYYY, Date
Transplant Waitlisting Date	MM/DD/YYYY, Date
Transplant Evaluation Date	MM/DD/YYYY, Date
Transplant Date	MM/DD/YYYY, Date
Request Type	Alpha-Numeric, Text
Facility Name	Alpha-Numeric, Text
Facility NPI	Numeric, 10-digit, Text
Facility Phone Number	Numeric, 10-digit
Living Donor Indicator	Numeric, 1 digit, Text
Transplant SAR Number	Numeric, 10 digit
Post-discharge from inpatient hospital, SNF, or sub-acute facility on or after December 1, 2023	
Medi-Cal Member CIN	Alpha-Numeric 9-digit, Text
Admission Date	MM/DD/YYYY, Date
Admission Diagnosis	Alpha-Numeric, Text
Discharge Date	MM/DD/YYYY, Date
Discharge Disposition	Numeric, 2 digit, Text
Facility Name	Alpha-Numeric, Text
Facility Type	Numeric, 1 digit, Text
Facility NPI	Numeric, 10 digit, Text
Facility Phone Number	Numeric, 10 digit
Receiving hospital inpatient care	
Medi-Cal Member CIN	Alpha-Numeric 9-digit, Text
Admission Date	MM/DD/YYYY, Date
Admission Diagnosis	Alpha-Numeric, Text
Authorization Determination	Alpha-Numeric, Text
Authorization Status	Alpha-Numeric, Text
Bed Type Code	Alpha-Numeric, Text
Level of Care	Alpha-Numeric, Text
Facility Name	Alpha-Numeric, Text
Facility NPI	Numeric, 10-digit, Text
Facility Phone Number	Numeric, 10-digit
Adults and children with authorizations to receive Community Supports	
Medi-Cal Member CIN	Alpha-Numeric 9-digit, Text
Member's Servicing CS Provider Name	Alpha-Numeric, Text
Member's Servicing CS Provider NPI	Numeric, 10-digit, Text
Member's Servicing CS Provider Phone Number	Numeric, 10-digit
Authorization Begin Date	MM/DD/YYYY, Date
Authorization End Date	MM/DD/YYYY, Date
Member received Community Supports	Numeric, 1 digit, Text

Community Supports approved: **Housing Transition/Navigation Services**	Numeric, 1 digit, Text
Community Supports approved: **Housing Deposits**	Numeric, 1 digit, Text
Community Supports approved**: Housing Tenancy and Sustaining Services**	Numeric, 1 digit, Text
Community Supports approved**: Short-Term Post-Hospitalization Housing**	Numeric, 1 digit, Text
Community Supports approved**: Recuperative Care (Medical Respite)**	Numeric, 1 digit, Text
Community Supports approved: **Respite Services**	Numeric, 1 digit, Text
Community Supports approved: **Day Habilitation Programs**	Numeric, 1 digit, Text
Community Supports approved: **Nursing Facility Transition/Diversion to Assisted Living Facilities**	Numeric, 1 digit, Text
Community Supports approved: **Nursing Facility Transition to a Home**	Numeric, 1 digit, Text
Community Supports: **Personal Care and Homemaker Services**	Numeric, 1 digit, Text
Community Supports: **Environmental Accessibility Adaptations**	Numeric, 1 digit, Text
Community Supports approved: **Medically Supportive Food/Meals/Medically Tailored Meals**	Numeric, 1 digit, Text
Community Supports approved: **Asthma Remediation**	Numeric, 1 digit, Text
Community Supports approved: **Other**	Numeric, 1 digit, Text
Adults and children with authorizations to receive Enhanced Care Management services	
Medi-Cal Member CIN	Alpha-Numeric 9-digit, Text
Member's Assigned ECM Provider Name	Alpha-Numeric, Text
Member's Assigned ECM Provider NPI	Numeric, 10-digit, Text
Member's Assigned ECM Provider Phone Number	Numeric, 10-digit
Member's Servicing ECM Provider Name	Alpha-Numeric, Text
Member's Servicing ECM Provider NPI	Numeric, 10-digit, Text
Member's Servicing ECM Provider Phone	Numeric, 10-digit
ECM Population of Focus: Individuals Experiencing Homelessness: Adults without Dependent Children/Youth Living with Them Experiencing Homelessness	Numeric, 1 digit, Text
ECM Population of Focus: Individuals Experiencing Homelessness: Homeless Families or Unaccompanied Children/Youth Experiencing Homelessness	Numeric, 1 digit, Text
ECM Population of Focus: Individuals At Risk for Avoidable Hospital or ED Utilization	Numeric, 1 digit, Text
ECM Population of Focus: Individuals with Serious Mental Health and/or SUD Needs	Numeric, 1 digit, Text
ECM Population of Focus: Individuals Transitioning from Incarceration	Numeric, 1 digit, Text
ECM Population of Focus: Adults Living in the Community and At Risk for LTC Institutionalization	Numeric, 1 digit, Text
ECM Population of Focus: Adult Nursing Facility Residents Transitioning to the Community	Numeric, 1 digit, Text

ECM Population of Focus: Children and Youth Enrolled in CCS or CCS WCM with Additional Needs Beyond the CCS Condition	Numeric, 1 digit, Text
ECM Population of Focus: Children and Youth Involved in Child Welfare	Numeric, 1 digit, Text
ECM Population of Focus: Birth Equity Population of Focus	Numeric, 1 digit, Text
ECM Benefit Date Assessed/Approved	MM/DD/YYYY, Date
ECM Benefit Start Date	MM/DD/YYYY, Date
Residing in Skilled Nursing Facilities (SNF)	
Medi-Cal Member CIN	Alpha-Numeric 9-digit, Text
Facility Name	Alpha-Numeric, Text
Facility NPI	Numeric, 10-digit, Text
Facility Phone Number	Numeric, 10-digit, Text
Level of Care	Alpha-Numeric, Text
Authorization Start Date	MM/DD/YYYY, Date
Authorization End Date	MM/DD/YYYY, Date

III. Continuity of Care Coordination and Management Information

Transitioning members in Special Populations who are receiving care management services from their Previous MCP will change to a new Care Manager on January 1, 2024, upon transitioning to Receiving MCPs. The Previous MCP must transfer supportive information that includes, but is not limited to, results of available member screening and assessment findings, and member Care Management Plans. Transitioning members receiving CCM services are expected to continue receiving these services from Receiving MCPs. To facilitate the sharing of supportive information important for members' care coordination and management for these transitioning members, the Previous MCP shall designate key staff with appropriate training and experience to serve as the plan-level contact(s). The Previous MCP must provide to Receiving MCPs, by November 2, 2023, contact information for plan-level staff and for the Care Managers (program level contact information) who served transitioning members. Receiving MCPs must proactively contact the Previous MCP's point of contact(s) for Care Managers in order to obtain information to mitigate gaps in members' care. Previous MCPs must share supportive data for these members before January 1, 2024 or within 15 calendar days of the member changing to a new Care Manager, whichever is later.

Figure L:

Members in Inpatient Hospital Care	Members Accessing the Transplant Benefit
The Previous MCP must inform the Receiving MCP of members known to be receiving inpatient care by December 22, 2023, and must refresh that information daily through January 9, 2024, including holidays and weekends. It is possible that Previous MCPs may stop receiving ADT feeds after December 31, 2023. MCP must also contact inpatient member's Primary Care Physician responsible for the member's care while they are admitted. Refer to MPCP2014 Continuity of Care (Medi-Cal) Policy for more details.	For members accessing the transplant benefit on January 1, 2024, Receiving MCPs are responsible for ensuring coordination of care between all providers, organ donation entities, and Transplant Programs. Receiving MCPs must ensure that members accessing the transplant benefit are provided services and/or treatments as expeditiously as possible.

Department of Health Care Services
2024 MCP Transition Policy Guide
Continuity of Care (CoC) Data Template - 1) Data Elements for All Members

Last Updated: 8/7/2023
Version: 1

This template is an attachment to the 2024 Managed Care Transition Policy Guide. MCPs must use this template to prepare member level data files for **all** transitioning members in accordance with requirements outlined in Sections VIII of the Policy Guide. Receiving MCPs will utilize the resulting member level data to implement Continuity of Care policies in Section V. of the Policy Guide.

File	Data Elements	Required Naming Convention	Field Description	Format	Notes
Transitioning Member Identifying Data	Transitioning Member Identifying Data	C01_INFO	Medi-Cal Member CIN	Alpha-Numeric 9 digit, Text	
			Member First Name	Alpha-Numeric, Text	
			Member Last Name	Alpha-Numeric, Text	
			Member Date of Birth	MM/DD/YYYY, Date	
			Member Gender Code	Numeric 3-digit, Text	This will be limited to the Medi-Cal 834 file acceptable values.
			Member Homelessness Indicator	Numeric, 1-digit, Text	Identifier for if the member is experiencing "homelessness," as defined in the ECM Policy Guide (pgs. 11-12). If "homeless," enter "2", if not, enter "1", if unknown, enter "0".
			Member Residential Address	Alpha-numeric, Text	MCPs may complete data element as "99999" if the member is identified as homeless by the "Member Homelessness Indicator" and another zip code is not available.
			Member Residential City	Alpha-numeric, Text	MCPs may complete data element as "99999" if the member is identified as homeless by the "Member Homelessness Indicator" and Residential City is not available.
			Member Residential Zip Code	Alpha-numeric, Text	MCPs may complete data element as "99999" if the member is identified as homeless by the "Member Homelessness Indicator" and another zip code is not available.
			Member Mailing Address	Alpha-numeric, Text	MCPs may complete field as "HOMELESS" if the member is identified as homeless by the "Member Homelessness Indicator" and another address is not available.
			Member Mailing City	Alpha-numeric, Text	MCPs may complete field as "HOMELESS" if the member is identified as homeless by the "Member Homelessness Indicator" and another address is not available.
			Member Mailing Zip Code	Numeric, 5-digit	MCPs may complete data element as "99999" if the member is identified as homeless by the "Member Homelessness Indicator" and another zip code is not available.
			Member Phone Number	Numeric, 10-digit	Numbers only, no dashes, character limit of ten. If number not available to the MCP, MCP may report "0000000000".
			Member Email Address	Alpha-Numeric, Text	
			Member's Preferred Form of Contact	Alpha-Numeric, Text	Member's Preferred Form of Contact, as known by MCP (e.g., "CALL", "TEXT", "EMAIL", "MAIL"). If not known, MCP may report "UNKNOWN".
			Description of Member's Selected Alternative Format	Alpha-Numeric, Text	If applicable, member's selected alternative format, as known by MCP (e.g., "LARGE PRINT", "AUDIO CD", "DATA CD", "BRAILLE"). If not known, MCP may report "UNKNOWN".
Transitioning Member Identifying Data	Primary Care Provider Information	C02_PCP	Medi-Cal Member CIN	Alpha-Numeric 9-digit, Text	
			Primary Care Provider/Clinic Name (Assigned PCP)	Alpha-numeric, Text	
			Primary Care Provider/Clinic National Provider Identifier (NPI)	Numeric, 10-digit, Text	
			Primary Care Provider/Clinic Phone Number	Numeric, 10-digit	Numbers only, no dashes, character limit of ten. If number not available to the MCP, MCP may report "0000000000".
			Medical Group	Alpha-numeric, Text	
			Medical Group TIN	Numeric, 9-digit	
			Last Visit Date	MM/DD/YYYY, Date	As known by the MCP; if no visits on record, MCP should enter "00/00/0000".
Transitioning Member Utilization Data	Transitioning Member Claims / Encounter Information	C03_CLAIMS	Medi-Cal Member CIN	Alpha-Numeric 9-digit, Text	
			Detail Service Date	MM/DD/YYYY, Date	
			Procedure Code and Description	Alpha-Numeric, Text	
			HCPCS Modifier	Alpha-Numeric, Text	
			Revenue Code and Description	Alpha-Numeric, Text	
			Place of Service	Numeric, 2-digit, Text	
			Bill Type	Alpha-Numeric, Text	
			Billed Units	Numeric, 6-digit, Text	
			Tax Identification Number	Numeric, 9-digit, Text	
			National Provider Identifier (NPI)	Numeric, 10-digit, Text	
			Provider First Name	Alpha-Numeric, Text	
			Provider Last Name	Alpha-Numeric, Text	
			Provider Phone Number	Numeric, 10-digit	Numbers only, no dashes, character limit of ten. If number not available to the MCP, MCP may report "0000000000".
			Provider Specialty Type	Alpha-Numeric, Text	
			Admittance Low Service Date	MM/DD/YYYY, Date	
			Discharge High Service Date	MM/DD/YYYY, Date	
			Diagnosis Code 1	Alpha-Numeric, Text	

			Diagnosis Code 2	Alpha-Numeric, Text	
			Diagnosis Code 3	Alpha-Numeric, Text	
			Diagnosis Code 4	Alpha-Numeric, Text	
Transitioning Member Authorization Data	Transitioning Member Authorization Information	C04_PA	Medi-Cal Member CIN	Alpha-Numeric 9-digit,	
			Referring Provider Name	Alpha-numeric, Text	
			Referring Provider NPI	Numeric, 10-digit, Text	
			Referring Provider Phone Number	Numeric, 10-digit	Numbers only, no dashes, character limit of ten. If number not available to the MCP, MCP may report "0000000000".
			Authorization Begin Date	MM/DD/YYYY, Date	
			Authorization End Date	MM/DD/YYYY, Date	
			Units (as applicable)	Numeric 7-digit, Text	
			Level of Service	Alpha-Numeric, Text	
			Service Code	Alpha-Numeric, 5-digit,	
			Service Code Description	Alpha-Numeric, Text	
			Diagnosis Code	Alpha-Numeric, Text	
			Diagnosis Description	Alpha-Numeric, Text	
			Prior Authorization Status	Alpha-Numeric, Text	
			Authorization Type	Alpha, 2-digit, Text	
Transitioning Member NEMT/NMT Schedule and Physician Certification Statement Data	NEMT/NMT Schedule Data	C05_NEMTNMT	Medi-Cal Member CIN	Alpha-Numeric 9-digit,	
			Level Of Service	Alpha-Numeric, Text	
			Days of Week of Scheduled Service	Alpha-Numeric, Text	
			Time of Scheduled Service	Alpha-Numeric, Text	
			Member Phone Number	Numeric, 10-digit	Numbers only, no dashes, character limit of ten. If number not available to the MCP, MCP may report "0000000000".
			Pickup Location	Alpha-Numeric, Text	Indicates NEMT/NMT pickup locations (e.g., "MEMBER HOME", "SNF", "LTC").
			Pickup Address	Alpha-Numeric, Text	
			LTC/SNF Phone Number	Numeric, 10-digit	If applicable. Numbers only, no dashes, character limit of ten. If number not available to the MCP, MCP may report "0000000000".
			Mode of Transport	Alpha-Numeric, Text	Member's Mode of Transportation, as known by MCP (e.g., "AMBULANCE", "ADVANCED LIFE SUPPORT AMBULANCE", "BASIC SUPPORT AMBULANCE", "GURNEY VAN/LITTER VAN", "WHEELCHAIR VAN", "AIR TRANSPORT").
			Transportation Provider Name	Alpha-Numeric, Text	
			Transportation Provider Phone Number	Numeric, 10-digit	Numbers only, no dashes, character limit of ten. If number not available to the MCP, MCP may report "0000000000".
			Dropoff Provider Name	Alpha-Numeric, Text	
			Dropoff Provider Phone Number	Numeric, 10-digit	Numbers only, no dashes, character limit of ten. If number not available to the MCP, MCP may report "0000000000".
			Current NMT/NEMT Vendor	Alpha-Numeric, Text	
			Transportation Notes	Alpha-Numeric, Text	
Transitioning Member NEMT/NMT Schedule Data and Physician Certification Statement Data	Physician Certification Statement (PCS) Data	C06_PCS	Medi-Cal Member Client Index Number (CIN)	Alpha-Numeric 9-digit, Text	
			Level Of Service	Alpha-Numeric, Text	
			Authorization Begin Date	MM/DD/YYYY, Date	
			Authorization End Date	MM/DD/YYYY, Date	
			Standing Orders	Alpha-Numeric, Text	
			Mode of Transportation	Alpha-Numeric, Text	Member's Mode of Transportation, as known by MCP (e.g., "AMBULANCE", "ADVANCED LIFE SUPPORT AMBULANCE", "BASIC SUPPORT AMBULANCE", "GURNEY VAN/LITTER VAN", "WHEELCHAIR VAN", "AIR TRANSPORT").
			Requesting Provider Name	Alpha-Numeric, Text	
			Requesting Provider NPI	Numeric, 10-digit, Text	
			Requesting Provider Phone Number	Numeric, 10-digit	Numbers only, no dashes, character limit of ten. If number not available to the MCP, MCP may report "0000000000".

Medi-Cal Member CIN	Member First Name	Member Last Name	Member Date of Birth	Member Gender Code	Member Homelessness Indicator	Member Residential Address	Member Residential City	Member Residential Zip Code	Member Mailing Address	Member Mailing City	Member Mailing Zip Code	Member Phone Number	Member Email Address	Member's Preferred Form of Contact	Description of Member's Selected Alternative Format

Medi-Cal Member CIN	Primary Care Provider/Clinic Name (Assigned PCP)	Primary Care Provider/Clinic National Provider Identifier (NPI)	Primary Care Provider/Clinic Phone Number	Medical Group	Medical Group TIN	Last Visit Date

Medi-Cal Member CIN	Detail Service Date	Procedure Code and Description	HCPCS Modifier	Revenue Code and Description	Place of Service	Bill Type	Billed Units	Tax Identification Number	National Provider Identifier (NPI)	Provider First Name	Provider Last Name	Provider Phone Number	Provider Specialty Type	Admittance Low Service Date	Discharge High Service Date	Diagnosis Code 1	Diagnosis Code 2	Diagnosis Code 3	Diagnosis Code 4

Medi-Cal Member CIN	Referring Provider Name	Referring Provider NPI	Referring Provider Phone Number	Authorization Begin Date	Authorization End Date	Units (as applicable)	Level of Service	Service Code	Service Code Description	Diagnosis Code	Diagnosis Description	Prior Authorization Status	Authorization Type

Medi-Cal Member CIN	Level Of Service	Days of Week of Scheduled Service	Time of Scheduled Service	Member Phone Number	Pickup Location	Pickup Address	LTC/SNF Phone Number	Mode of Transport	Transportation Provider Name	Transportation Provider Phone Number	Dropoff Provider Name	Dropoff Provider Phone Number	Current NMT/NEMT Vendor	Transportation Notes

Medi-Cal Member Client Index Number (CIN)	Level Of Service	Authorization Begin Date	Authorization End Date	Standing Orders	Mode of Transportation	Requesting Provider Name	Requesting Provider NPI	Requesting Provider Phone Number

Department of Health Care Services
2024 MCP Transition Policy Guide
Continuity of Care (CoC) Data Template - 2b) Special Populations Member File

Last Updated: 8/7/2023
Version: 1

This template is an attachment to the 2024 Managed Care Transition Policy Guide. Previous MCPs must use this template to identify transitioning members who meet Special Populations criteria outlined in *Continuity of Care (CoC) Data Template - 2a) Special Populations Specifications* . For certain populations, Previous MCPs must also provide accompanying data elements using the *Continuity of Care (CoC) Data Template – 2c) Special Populations Accompanying Data.* Receiving MCPs will utilize the resulting member level data to implement Continuity of Care policies in Section V. of the Policy Guide.

Required Naming Convention	Data Type	Field Name	Field Description	Format	Notes
B01_MEM	*Member Special Populations Information*	Medi-Cal Member CIN	Medi-Cal Member CIN	Alpha-Numeric 9 digit, Text	
		CCM	Adults and children receiving Complex Care Management	Numeric, 1 digit, Text	Identifier for if the member meets Special Populations criteria. If "yes," enter "1", if no enter "0"
		CHRONIC_DX	In active treatment for the following chronic communicable diseases: HIV/AIDS, tuberculosis, hepatitis B and C	Numeric, 1 digit, Text	Identifier for if the member meets Special Populations criteria. If "yes," enter "1", if no enter "0"
		IDD	Living with an intellectual or developmental disability (I/DD) diagnosis	Numeric, 1 digit, Text	Identifier for if the member meets Special Populations criteria. If "yes," enter "1", if no enter "0"
		NEW_DME	Newly Prescribed DME (within 30 days of January 1, 2024)	Numeric, 1 digit, Text	Identifier for if the member meets Special Populations criteria. If "yes," enter "1", if no enter "0"
		TP	In the transplant evaluation process, or any waitlist to receive a transplant, undergoing a transplant, or received a transplant in the previous 12 months	Numeric, 1 digit, Text	Identifier for if the member meets Special Populations criteria. If "yes," enter "1", if no enter "0"
		DIS	Post-discharge from inpatient hospital, SNF, ICF/DD, or sub-acute facility on or after December 1, 2023	Numeric, 1 digit, Text	Identifier for if the member meets Special Populations criteria. If "yes," enter "1", if no enter "0"
		IP	Receiving hospital inpatient care	Numeric, 1 digit, Text	Identifier for if the member meets Special Populations criteria. If "yes," enter "1", if no enter "0"
		TX_WITH_MORT	Receiving treatment with pharmaceuticals whose removal risks serious withdrawal symptoms or mortality	Numeric, 1 digit, Text	Identifier for if the member meets Special Populations criteria. If "yes," enter "1", if no enter "0"
		TX_IMMUNE_BIO	Taking immunosuppressive medications, immunomodulators, and biologics	Numeric, 1 digit, Text	Identifier for if the member meets Special Populations criteria. If "yes," enter "1", if no enter "0"
		CS	Adults and children with authorizations to receive Community Supports	Numeric, 1 digit, Text	Identifier for if the member meets Special Populations criteria. If "yes," enter "1", if no enter "0"
		ECM	Adults and children with authorizations to receive Enhanced Care Management services	Numeric, 1 digit, Text	Identifier for if the member meets Special Populations criteria. If "yes," enter "1", if no enter "0"
		DEM_DX	Living with a dementia diagnosis	Numeric, 1 digit, Text	Identifier for if the member meets Special Populations criteria. If "yes," enter "1", if no enter "0"
		MAT_MH_PRE_POST	Pregnant or postpartum (within 12 months of the end of a pregnancy or maternal mental health diagnosis)	Numeric, 1 digit, Text	Identifier for if the member meets Special Populations criteria. If "yes," enter "1", if no enter "0"
		HH	Receiving home health	Numeric, 1 digit, Text	Identifier for if the member meets Special Populations criteria. If "yes," enter "1", if no enter "0"
		HOSPICE	Receiving hospice care	Numeric, 1 digit, Text	Identifier for if the member meets Special Populations criteria. If "yes," enter "1", if no enter "0"
		SMHS	Receiving specialty mental health services (adults, youth, and children)	Numeric, 1 digit, Text	Identifier for if the member meets Special Populations criteria. If "yes," enter "1", if no enter "0"
		END_STAGE_RENAL	Receiving treatment for end-stage renal disease (ESRD)	Numeric, 1 digit, Text	Identifier for if the member meets Special Populations criteria. If "yes," enter "1", if no enter "0"
		SNF	Residing in Skilled Nursing Facilities (SNF)	Numeric, 1 digit, Text	Identifier for if the member meets Special Populations criteria. If "yes," enter "1", if no enter "0"

Medi-Cal Member CIN	CCM	CHRONIC_DX	IDD	NEW_DME	TP	DIS	IP	TX_WITH_MORT	TX_IMMUNE_BIO	CS	ECM	DEM_DX	MAT_MH_PRE_POST	HH	HOSPICE	SMHS	END_STAGE_RENAL	SNF

Department of Health Care Services
2024 MCP Transition Policy Guide
Continuity of Care (CoC) Data Template - 2c) Special Populations Accompanying Data

Last Updated: 8/7/2023
Version: 1

This template is an attachment to the 2024 Managed Care Transition Policy Guide. MCPs must use this template in conjunction with the template *2a) Special Populations Specifications* to prepare the accompanying data elements listed below to share with Receiving MCPs, in accordance with requirements outlined in Section VIII of the Policy Guide. Receiving MCPs will utilize the resulting member level Special Populations data to implement Continuity of Care policies in Section V. of the Policy Guide.

File	Required Naming Convention	Special Population	Field Description	Format	Notes
Transitioning Member Special Populations Information	M01_CCM	Adults and children receiving Complex Care Management	Medi-Cal Member CIN	Alpha-Numeric 9-digit, Text	
			Reason for Care Management or Program type	Alpha-Numeric, Text	
			Care Management Open Date	MM/DD/YYYY, Date	
			Plan Contact Name	Alpha-Numeric, Text	
			Plan Phone Number	Numeric, 10-digit	Numbers only, no dashes, character limit of ten. If number not available to the MCP, MCP may report "0000000000".
Transitioning Member Special Populations Information	M02_TP	In the transplant evaluation process, or any waitlist to receive a transplant, undergoing a transplant, or received a transplant in the previous 12 months	Medi-Cal Member CIN	Alpha-Numeric 9-digit, Text	
			Transplant Stage	Alpha-Numeric, Text	Indicates which phase of the transplant process the member is in ("CONSULTATION/PRE-SCREEN", "EVALUATION", " PRE-TRANSPLANT/WAITLIST", "TRANSPLANT EPISODE", "POST TRANSPLANT", or "UNKNOWN").
			Eligibility Plan Code	Alpha-Numeric, Text	
			Organ	Alpha-Numeric, Text	
			Transplant Date	MM/DD/YYYY, Date	
			Request Type (Outpatient, Inpatient)	Alpha-Numeric, Text	
			Facility Notify Date	MM/DD/YYYY, Date	
			Facility Name	Alpha-Numeric, Text	
			Facility NPI	Numeric, 10 digit, Text	
			Facility Phone Number	Numeric, 10 digit	Numbers only, no dashes, character limit of ten. If number not available to the MCP, MCP may report "0000000000".
Transitioning Member Special Populations Information	M03_DIS	Post-discharge from inpatient hospital, SNF, ICF/DD, or sub-acute facility on or after December 1, 2023	Medi-Cal Member CIN	Alpha-Numeric 9-digit, Text	
			Facility Name	Alpha-Numeric, Text	
			Facility Type	Numeric, 1 digit, Text	Indicates member facility type, ("INPATIENT", "SNF", "SUB-ACUTE").
			Facility NPI	Numeric, 10 digit, Text	
			Facility Phone Number	Numeric, 10 digit	Numbers only, no dashes, character limit of ten. If number not available to the MCP, MCP may report "0000000000".
Transitioning Member Special Populations Information	M04_IP	Receiving hospital inpatient care	Medi-Cal Member CIN	Alpha-Numeric 9-digit, Text	
			Facility Name	Alpha-Numeric, Text	
			Facility NPI	Numeric, 10 digit, Text	

Medi-Cal Member CIN	Reason for Care Management or Program type	Care Management Open Date	Plan Contact Name	Plan Phone Number

Medi-Cal Member CIN	Transplant Stage	Eligibility Plan Code	Organ	Transplant Date	Request Type (Outpatient, Inpatient)	Facility Notify Date	Facility Name	Facility NPI	Facility Phone Number

Medi-Cal Member CIN	Facility Name	Facility Type	Facility NPI	Facility Phone Number

Medi-Cal Member CIN	Facility Name	Facility NPI	Facility Phone Number

Medi-Cal Member CIN	Member's CS Provider Name	Member's CS Provider NPI	Member's CS Provider Phone	Member received Community Supports	Community Supports approved: Housing Transition/Navigation Services	Community Supports approved: Housing Deposits	Community Supports approved: Housing Tenancy and Sustaining Services	Community Supports approved: Short-Term Post-Hospitalization Housing	Community Supports approved: Recuperative Care (Medical Respite)	Community Supports approved: Respite Services	Community Supports approved: Day Habilitation Programs	Community Supports approved: Nursing Facility Transition/Diversion to Assisted Living Facilities	Community Supports approved: Nursing Facility Transition to a Home	Community Supports: Personal Care and Homemaker Services	Community Supports: Environmental Accessibility Adaptations	Community Supports approved: Medically Supportive Food/Meals/Medically Tailored Meals	Community Supports approved: Asthma Remediation	Community Supports approved: Other

Medi-Cal Member CIN	Member's Assigned ECM Provider Name	Member's Assigned ECM Provider NPI	Member's Assigned ECM Provider Phone	ECM Population of Focus	ECM Benefit Date Assessed/Approved	ECM Benefit Start Date

Medi-Cal Member CIN	Facility Name	Facility NPI	Facility Phone Number	Dates Authorized

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="4">Policy/Procedure Number: MPQP1002 (previously QP100102)</td><td colspan="2">Lead Department: Health Services
Business Unit: Quality Improvement</td></tr>
<tr><td colspan="4">Policy/Procedure Title: Quality/Utilization Advisory Committee</td><td colspan="2">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 12/1998</td><td colspan="4">Next Review Date: ~~04/09/2026~~04/08/2027
Last Review Date: ~~04/09/2025~~04/08/2026</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="4">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="2">Approval Date: ~~04/09/2025~~04/08/2026</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:

A. ~~N/A~~Partnership Advantage: Effective Jan. 1, 2027, 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 enrollees will be qualified to receive both Medi-Cal and Medicare services as described in the Partnership Advantage Member Handbook.

~~A.~~

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

[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: MPQP1002 (previously QP100102 & MPQP1002)			**Lead Department: Health Services** Business Unit: Quality Improvement
Policy/Procedure Title: Quality/Utilization Advisory Committee			☒**External Policy** ☐**Internal Policy**
Original Date: 12/1998		**Next Review Date: ~~04/09/2026~~04/08/2027** **Last Review Date: ~~04/09/2025~~04/08/2026**	
Applies to:	☐ **Employees**	☒**Medi-Cal**	☒**Partnership Advantage**

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 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
	Deputy Chief Medical Officer
	Medical Director for Medicare Services
	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 taken at all meetings. Approved minutes are submitted monthly to Regulatory Affairs and Compliance (RAC) inbox. RAC submits these minutes quarterly to the Department of Health Care Services (DHCS) and forwards the tracking documentation to the designated QI staff. ~~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~~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. Approve and ensure implementation of evidence-based guidelines and policies of medical practice including preventive, chronic care, and behavioral health initiatives.
~~9.~~10. 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.~~11. Develops and/or approves clinical criteria used by UM staff to perform prospective and concurrent inpatient, ambulatory review or other utilization activities.
~~11.~~12. Reviews utilization, financial, and other staff reports that display the utilization of services and outcomes of quality within the delivery system.
~~12.~~13. Serves as a review body to assist in the interpretation of medical benefit coverage based on medical necessity and appropriateness issues.
~~13.~~14. Provides oversight of delegated utilization management and quality improvement activities.
~~14.~~15. Reviews performance dashboards and make recommendations for corrective action on indicators that fall below established thresholds; ensures follow-up on corrective actions where identified.
~~15.~~16. 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.
~~16.~~17. 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 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:

Policy/Procedure Number: MPQP1002 (previously QP100102 & MPQP1002)			**Lead Department: Health Services** Business Unit: Quality Improvement
Policy/Procedure Title: Quality/Utilization Advisory Committee			☒**External Policy** ☐**Internal Policy**
Original Date: 12/1998		**Next Review Date: ~~04/09/2026~~04/08/2027** **Last Review Date: ~~04/09/2025~~04/08/2026**	
Applies to:	☐ **Employees**	☒**Medi-Cal**	☒**Partnership Advantage**

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; 04/08/26

Partnership Advantage (effective January 1, 2027)
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
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

Policy/Procedure Number: MPQP1003 (previously QP100103)			**Lead Department: Health Services** Business Unit: Quality Improvement	
Policy/Procedure Title: Physician Advisory Committee (PAC) Policy			☒ **External Policy** ☐ **Internal Policy**	
Original Date: 07/19/1993 - Medi-Cal (Charter)		**Next Review Date:** ~~04/09/2026~~04/08/2027 **Last Review Date:** 04/09/2025~~04/08/2026~~		
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**[1]	
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:** ~~04/09/2025~~04/08/2026		

I. RELATED POLICIES:

A. MP~~C~~UP3042 – Technology Assessment
B. MPQP1002 – Quality/Utilization Advisory Committee (Q/UAC)
C. MPRP4001 – Pharmacy & Therapeutics (P&T) Committee
D. MPCR200 – ~~The~~ Credentials Committee and CMO Credentialing Program Responsibilities

II. IMPACTED DEPTS:

N/A

III. DEFINITIONS:

A. Partnership Advantage: Effective Jan. 1, 2027, 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 enrollees will be qualified to receive both Medi-Cal and Medicare services as described in the Partnership Advantage Member Handbook. ~~N/A~~

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

The Physician Advisory Committee (PAC) is responsible for oversight and monitoring of the quality and cost-effectiveness of medical care provided to Partnership HealthPlan of California's members. The PAC reviews the activities of the Quality/Utilization Advisory Committee (Q/UAC), Provider Engagement & Networking Meeting (PEN) ~~Group (PEG)~~, Pharmacy and Therapeutics (P&T) Committee, the Quality Improvement Program Advisory Group, the Pediatric Quality Committee, the Quality Improvement Health Equity Committee (QIHEC) and the Credentials Committee, makes recommendations, and assists Partnership in other ways as defined in this policy.

[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: MPQP1003 (previously QP100103)		**Lead Department: Health Services** Business Unit: Quality Improvement	
Policy/Procedure Title: Physician Advisory Committee		**☒External Policy** **☐Internal Policy**	
Original Date: 07/19/1993 - Medi-Cal (Charter)		**Next Review Date: ~~04/09/2026~~04/08/2027** **Last Review Date: ~~04/09/2025~~04/08/2026**	
Applies to:	**☐ Employees**	**☒ Medi-Cal**	**☒ Partnership Advantage**

VI. POLICY / PROCEDURE:

A. Committee Structure

1. Membership:
   a. The PAC is comprised of the Partnership Chief Executive Officer, Chief Operating Officer, Chief Financial Officer, Chief Medical Officer (CMO), Deputy CMO, Chief Health Services Officer (CHSO), Medical Director for Quality, Medical Director for Medicare Services, Regional Medical Director(s), Behavioral Health Clinical Director, leadership from the Quality and Performance Improvement, Provider Relations, Care Coordination, Utilization Management, and Pharmacy departments, and 15-25 other members who may include:
      1) Participating physician representatives from primary and specialty care, including at least one behavioral health provider.
      2) Advanced practice clinicians such as certified nurse midwives, nurse practitioners or physician assistants.
      3) Members representing active medical staffs of hospitals, community-based practices, and medical groups in the Partnership service area.
   b. Members with annual attendance of <50% are evaluated for termination from the PAC.
   c. Other health plan staff may make special or periodic reports to the committee or may attend selected meetings ex-officio at the discretion of Partnership's CEO or CMO. All attendees are otherwise expected to present from a location posted in the meeting notice.
2. Minutes:Minutes are taken at all meetings. Approved minutes are submitted monthly to Regulatory Affairs and Compliance (RAC) inbox. RAC submits these minutes quarterly to the Department of Health Care Services (DHCS) and forwards the tracking documentation to the designated QI staff. ~~Meetings are recorded for the purpose of preparing minutes, but recordings are not retained past 30 days after the meeting date, in accordance with Brown Act regulations.~~
3. Chair: An external physician committee member chairs the meeting. Partnership's CMO chairs in the absence of the chair.
4. Meetings: The Committee meets at least ten (10) times a year, and may elect to pause in the months of July or December, with the option to conduct meetings if needed.
5. Voting: Only committee members who are not Partnership staff may vote. The CMO serves in a tie breaking capacity as necessary. Quorum is 50% or more of voting members.

B. Committee Responsibilities

1. Reviews and makes recommendations for corrective action based upon other committee and workgroup reports including:
   a. Q/UAC
   b. P&T Committee
   c. Credentials Committee
   d. PEN~~G~~
   e. QIHEC
2. Annually reviews, recommends and approves the Quality Improvement department's Program ~~Description, Program~~Description, Program Evaluation and~~-~~ Work Plan (aka "QI Trilogy"), along with the Utilization Management and Care Coordination Program Descriptions, the Population Health Management Strategy & Program Description, the Cultural & Linguistic (C&L) Program Description, and the Quality Improvement and Health Equity Transformation Program (QIHETP) Program Description. Performance in utilization management activities is included in the annual Quality Improvement Evaluation.
3. Provides medical opinion regarding technological advances in consideration of benefit enhancements, inclusions, and exclusions.
4. Technology Review: The CMO or physician designee may request input from an appropriate specialist within the community prior to presenting the request to P&T, Q/UAC, or PAC.. This

specialist must have expertise in the technology under review. The decision to consult a specialist will depend on the nature of the technology being considered, and will be made on a case-by-case basis.

5. Makes recommendations for HealthPlan policy and protocol changes based on guidelines and standards of practice, and select Partnership policies that affect quality improvement, clinical care, or provider issues.
6. Oversees responsibility for utilization, quality, and other staff reports, which monitor the utilization of services and outcomes of quality within the delivery system.
7. Reviews and approves Partnership's adopted Clinical Practice Guidelines.
8. Provides oversight to the Primary Care Provider (PCP) and Quality Improvement Programs (QIPs) for providers and hospitals, which includes approval of the measures and payment methodologies, in addition to overseeing the implementation and evaluation of the QIPs.
9. Advises and assists in the selection of the CMO, as needed.

C. Committee Accountability
   1. PAC has oversight responsibility for the above listed committees (see VI.B.1.) and is accountable to the Partnership Board of Commissioners.

VII. REFERENCES:
N/A

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

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Committee Chair

X. REVISION DATES:
Medi-Cal
10/14/98; 06/14/00; 03/14/01; 06/12/02; 10/13/04; 02/8/06; 04/11/07; 05/14/08; 05/13/09; 06/09/10; 10/10/12; 10/09/13; 04/09/14; 05/13/15; 06/8/16; 06/14/17; 06/13/18; 03/13/19; 09/11/19; 04/08/20; 09/09/20; 09/08/21; 09/14/22; 09/13/23; 09/11/24; 04/09/25; 04/08/26

Partnership Advantage (effective January 1, 2027)
N/A

PREVIOUSLY APPLIED TO:
PartnershipAdvantage
MPQP1003 - 04/11/2007 to 01/01/2015

Healthy Families
MPQP1003 - 10/10/2012 to 03/01/2013

Healthy Kids
04/11/2007; 05/14/08; 05/13/09; 06/09/10; 10/10/12; 10/09/13; 04/09/14; 5/13/15; 5/11/16 to 12/01/16
(Healthy Kids program ended 12/01/2016)

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MPQP1004 (previously QP100104)</td><td colspan="3">Lead Department: Health Services
Business Unit: Quality Improvement</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Internal Quality Improvement Committee</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 05/17/2000</td><td colspan="4">Next Review Date: ~~08/12/2026~~04/08/2027
Last Review Date: ~~08/13/2025~~04/08/2026</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>☐ 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: ~~08/13/2025~~04/08/2026</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
H. Partnership Advantage: effective Jan. 1, 2027, 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~~ enrollees 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:

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

Policy/Procedure Number: MPQP1004 (previously QP100104)			**Lead Department: Health Services** Business Unit: Quality Improvement
Policy/Procedure Title: Internal Quality Improvement Committee			☒**External Policy** ☐**Internal Policy**
Original Date: 05/17/2000		**Next Review Date: ~~08/13/2026~~04/08/2027** **Last Review Date: ~~08/13/2025~~04/08/2026**	
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**

(i.e., 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, Network Services, Transportation, and Member Services policies. IQI reports to the Quality/Utilization Advisory Committee (Q/UAC), which ensures that P~~p~~lan activities comply with all state and regulatory requirements and meet~~s~~ 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 Directors
	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
	Deputy Chief Medical Officer
	Medical Director for Medicare Services
	Regional Medical Director(s)
	Associate Medical Director(s)
	Chief Health Services Officer
	Senior Director of Quality and Performance Improvement
	Senior Director of Care Management
	Behavioral Health Clinical Director
	Senior Director, Behavioral Health
	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

	Policy Analyst, Utilization Management Regulations
	Senior Health Educator
Member Services	Senior Director of Member Services & Grievance
	Senior Director, Provider Relations
Provider Relations/Network Services	Director of Network Services

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 are taken at all meetings. Approved minutes are submitted monthly to Regulatory Affairs and Compliance (RAC) inbox. RAC submits these minutes quarterly to the Department of Health Care Services (DHCS) and forwards the tracking documentation to the designated QI staff.

~~2. 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 Members, including the Regional Medical Directors and Associate Medical Directors specifically assigned by the CMO to sit on this committee, 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 and behavioral health 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) and the Quality Dual Special Needs Plan (D-SNP) Subcommittee.

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

Policy/Procedure Number: MPQP1004 (previously QP100104)			**Lead Department: Health Services** Business Unit: Quality Improvement
Policy/Procedure Title: Internal Quality Improvement Committee			☒**External Policy** ☐**Internal Policy**
Original Date: 05/17/2000		**Next Review Date: ~~08/13/2026~~04/08/2027** **Last Review Date: ~~08/13/2025~~04/08/2026**	
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**

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

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; 08/13/25; 04/08/26

Partnership Advantage (effective Jan. 1, 2027)
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)

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MCUP3124</td><td colspan="3">Lead Department: Health Services
Business Unit: Utilization Management</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Referral to Specialists (RAF) Policy</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: (UM-1) 12/27/1995
(Effective 08/21/2013 - RAF Review Policy split from TAR/RAF Review)</td><td colspan="4">Next Review Date: ~~04/09/2026~~04/08/2027
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<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: 04/0~~89~~/2026~~5~~</td></tr>
</table>

I. RELATED POLICIES:

A. MCUP3041 – Treatment Authorization Request (TAR) Review Process
B. MP~~C~~UP3039 – Direct Members
C. ~~MCCP2016~~ MPTP2501 – 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. Partnership Provider Network: Providers that are contracted with Partnership HealthPlan.
C. Referral Authorization Form (RAF) process: ~~is defined as~~T ~~t~~he process by which the primary care provider (PCP) submits a request to Partnership HealthPlan of California to refer a Partnership Member ~~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 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

Partnership Claims Department to reimburse the specialist for elective/scheduled services rendered. RAFs are not required for Mmembers who have another insurance plan as their primary carrier or are assigned a Partnership Direct Member status (see policy MPCUP3039 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 Mmember's PCP to submit to Partnership

C. Obstetric/Gynecological (OB/GYN) Services
   1. OB/GYN services do not require a RAF.
      a. During obstetrical care, the Member 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 Member requires specialty services outside of perinatal subspecialties.

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

E. Complex Cancer Treatment
   1. The California Cancer Care Equity Act allows Mmembers 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 Mmembers directly to network providers without requiring a referral from a network PCP or prior authorization.

G. Referral to a Specialist Outside of Partnership's Network
   1. PCPs are expected to make every effort to direct the Member to an in-network specialist within Partnership's service area. Partnership also may have contracting specialists outside its service area. The PCP and/or their referral coordinator can find contracting provider information on Partnership's Provider Online Services (OLS) 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 Partnership's contracted specialists in the provider network (e.g. denial letters, referral denials) within the Mmember's county of residence or 60 miles driving distance (whichever is greatest). Partnership may provide transportation if the referral is approved and Member meets criteria for transportation benefit. See policy MCCP2016 MPTP2501 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 (H&P), PCP progress notes, letter from PCP.
      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, Partnership's clinical staff will

review the request to determine if an in-network specialist is available. If an in-network specialist is identified, the case is reviewed by Partnership's Chief Medical Officer (CMO) or Physician Designee to determine if redirection to the in-network specialist is medically appropriate. If the determination is made that the Member should be redirected to an in-network specialist, the PCP is notified and provided with possible alternative in-network specialist(s). The Member is also notified of the determination, and both the Member and PCP are provided the right to file a grievance or appeal (refer to Partnership policies CGA024 Medi-Cal Member Grievance System and MCUP3037 Appeals of Utilization Management/ Pharmacy Decisions).

4. 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 meets criteria as per Welfare and Institutions Code (WIC) 14197.04 and/or Partnership policy ~~MCCP2016~~ MPTP2501 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), Partnership will authorize and arrange for out-of-network access to appointments.

H. Referral to a Tertiary Care Center Outside of Partnership's Network
1. If a PCP submits a request to refer a Member to an out-of-network tertiary care center, the medical records are reviewed by 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 is notified of the determination and provided with information on how to file a grievance or appeal (refer to Partnership policies CGA024 Medi-Cal Member Grievance System and MCUP3037 Appeals of Utilization Management/ Pharmacy Decisions).

I. Standing Referrals
1. A 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.

J. Referral Authorization Process
1. A PCP should submit the RAF electronically using Partnership's Provider 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 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.~~.~~G.2.~~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 a local specialist or if a pattern of over-utilization is noted on retrospective review, ~~then~~ Partnership may impose limits on the number of visits or time period covered by the RAF. At the end of the approved time period, a new RAF from the PCP will be required.

K. Treatment Authorization Requirements
1. If the services to be rendered require a Treatment Authorization Request (TAR) from Partnership, it

is the responsibility of the rendering provider (specialist and/or facility) to submit a TAR to Partnership for review. See policy MCUP3041 Treatment Authorization Request (TAR) Review Process.

L. Monitoring Referrals
   1. Partnership monitors referrals to specialists, including open or unused referrals, using data from 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. 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. Partnership Department Directors
B. 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; 04/08/26

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

PREVIOUSLY APPLIED TO: N/A

****

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

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

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

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

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MCUP3126 (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: ~~04/09/2026~~04/08/2027
Last Review Date: ~~04/09/2025~~04/08/2026</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>
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<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: 04/0~~9~~8/2026~~5~~</td></tr>
</table>

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. MP~~C~~CP2014 - 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 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. **Medi-Cal Rx:** The program title established by the State of California Department of Health Care Services (DHCS) for the new system of administering Medi-Cal pharmacy benefits through the fee-for-service (FFS) delivery system effective January 1, 2022.

M. **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.

N. **Release of Information (ROI) Consent Form** is a form valid one calendar year from the date of signature of the 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.

O. **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.)

P. **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 responsibilities to provide Behavioral Health Treatment (BHT) services to Partnership Medi-Cal eligible Members under age 21 covered by the Early and Periodic Screening Diagnostic and Treatment (EPSDT) Supplemental Services benefit.

VI. POLICY / PROCEDURE:

A. Partnership is responsible for providing Early and Periodic Screening, Diagnostic and Treatment services

for 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 Partnership Medi-Cal 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. Partnership utilizes current clinical criteria and guidelines when determining what BHT services covered under Medicaid are medically necessary and ensures appropriate independent review of 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 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, 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 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 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,

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 Partnership-approved behavioral treatment plan developed by a BHT Service Provider for the specific 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. Partnership permits and encourages (but does not require) the 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'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's progress is measured 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's age, school attendance requirements, and other daily activities when determining the number of hours of medically necessary direct service and supervision.
    a. Partnership must not limit BHT services on the basis of school attendance or other categorical

BHT, and Attachment 3.1-A, Supplement 6.

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. BHT hours delivered across settings, including during school, must be proportionate to the 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 require~~s~~ that the BHT provider indicates a transition plan for the 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'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. Partnership is not contractually responsible for educationally necessary BHT services covered by a LEA and provided pursuant to a Member's IFSP, IEP, or IHSP. However, if medically necessary and covered under Medicaid, 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 Partnership may coordinate any needed BHT services in a school-linked setting.
      b. When school is not in session, Partnership must cover medically necessary BHT services that were being provided by the LEA when school was in session.

I. Coordination of Care
   1. Partnership has primary responsibility for ensuring that EPSDT Members receive all medically necessary BHT services covered under Medicaid. 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, Partnership must assess the medical needs of the 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. Partnership will coordinate the provision of all services including durable medical equipment (DME) and medication with the other entities to ensure that Partnership and the other entities are not providing duplicative services.
c. Partnership will ensure that all of the 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.

2. Medically necessary BHT must not be considered duplicative when 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. 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, Partnership must authorize any remaining medically necessary services. 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, Partnership must not assume that BHT services included in a Member's IEP/IHSP/IFSP are actively being provided by the LEA. 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's IEP team concludes that Partnership-approved BHT services are necessary to the Member's education, the IEP team must determine that Partnership-approved BHT services must be included in the Member's IEP. Services in a Member's IEP must not be reduced or discontinued without formal amendment of the IEP. If the Partnership-contracted Provider determines that BHT services included in a Member's IEP are no longer medically necessary, Partnership is not authorized to use Medi-Cal funding to provide such services.
    a. Partnership is solely financially responsible for providing, or coordinating with the LEA to provide any BHT services included in a Member's IEP until such time that the IEP is amended.
    b. 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 Partnership-provided services upon amendment of the IEP.
5. In the event that BHT services are no longer medically necessary, Partnership will attempt to obtain written agreement from the LEA to oversee the provision of services included in the IEP.
    a. 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. 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. 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. 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, Partnership is responsible for covering any gap in medically necessary services for the Member. 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 Members under the age of 21 years of age transitioning BHT services from a Regional Center, 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 has an existing relationship with a qualified provider of BHT services. An existing relationship means the 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 Partnership or the date of the Member's initial enrollment with Partnership if enrollment occurred on or after July 1, 2018.
      b. The provider and Partnership can agree to a rate, with the minimum rate offered by 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 Partnership's network.
      d. The provider is a California State Plan approved provider
      e. The BHT provider supplies 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 Partnership's Continuity of Care policy and BHT, please refer to policy MP~~C~~CP2014 Continuity of Care.
   4. Partnership will not provide continuity of care for services not covered by Medi-Cal.

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

VI. REFERENCES:

A. Medi-Cal Provider Manual/Guidelines: EPSDT (*epsdt*) section "Behavioral Health Treatment"

~~A.~~B. Council of Autism Service Providers [CASP] (2024). *Applied behavior analysis practice guidelines for the treatment of Autism Spectrum Disorder: Guidance for healthcare funders, regulatory bodies, service providers, and consumers* [Clinical practice guidelines]. https://www.casproviders.org/asd-guidelines ~~Behavior Analyst Certification Board, Inc (BCBA): *Guidelines – Health Plan Coverage of Applied Behavior Analysis Treatment for Autism Spectrum Disorder* (2012)~~

~~B.~~C. 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.~~D. California Department of Developmental Services, *Autism Spectrum Disorders- Best Practice Guidelines Screening, Diagnosis and Assessment*, (2002)

~~D.~~E. 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.~~F. Diagnostic and Statistical Manual (DSM) V

~~F.~~G. Title 22, California Code of Regulations (CCR), Sections 51184 *(EPSDT Program Definitions)*; 51242 *(EPSDT Diagnosis and Treatment Provider and EPSDT Supplemental Services Provider)*; 51340 *(EPSDT Services and EPSDT Supplemental Services)*; 51532 *(EPSDT Services)*

~~G.~~H. 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.~~I. DHCS State Plan Amendment (SPA) 14-026 01/21/2016

~~I.~~J. 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*~~25-013 ~~– Governor's Executive Order N-01-19 Regarding Transitioning~~ Medi-Cal Rx Pharmacy Benefits and Cell and Gene Therapy Coverage ~~From Managed Care to Medi-Cal Rx~~ (~~12/30/2022~~09/18/2025)

VII. DISTRIBUTION:

A. Partnership Department Directors
B. 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; 04/08/26

*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

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MCUP3121</td><td colspan="3">Lead Department: Health Services
Business Unit: Utilization Management</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Neonatal Circumcision</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 11/28/2012
Effective Date: 01/01/2013</td><td colspan="4">Next Review Date: ~~05/14/2026~~04/08/2027
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<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: ~~05/14/2025~~04/08/2026</td></tr>
</table>

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

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

III. DEFINITIONS:
N/A

IV. ATTACHMENTS:
A. N/A

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

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

Policy/Procedure Number: MCUP3121		Lead Department: Health Services Business Unit: Utilization Management	
Policy/Procedure Title: Neonatal Circumcision		☒ **External Policy** ☐ **Internal Policy**	
Original Date: 11/28/2012 Effective 01/01/2013		**Next Review Date: 05/14/202604/08/2027** **Last Review Date: 05/14/202504/08/2026**	
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☐ **Partnership Advantage**

VII. REFERENCES:

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

B. InterQual® criteria

VIII. DISTRIBUTION:

A. Partnership Department Directors

B. Partnership Provider Manual

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

X. REVISION DATES: 01/20/16; 11/16/16; 11/15/17; *02/13/19; 03/11/20; 03/10/21; 05/11/22; 05/10/23; 05/08/24; 05/14/25; 04/08/26

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

PREVIOUSLY APPLIED TO: N/A

****

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

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

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

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

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

GUIDELINE / PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MPUG3031 (previously UG100331)</td><td colspan="3">Lead Department: Health Services
Business Unit: Utilization Management</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Nebulizer Guidelines</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 05/30/1995</td><td colspan="4">Next Review Date: ~~06/11/2026~~04/08/2026
Last Review Date: ~~06/11/2025~~04/08/2027</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>
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<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALING</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: 04/08/2026~~6/11/2025~~</td></tr>
</table>

I. RELATED POLICIES:

A. MCUP3041 - Treatment Authorization Request (TAR) Review Process
B. MCUP3013 - Durable Medical Equipment (DME) Authorization
C. MP~~C~~UP3039 - Direct Members
D. MPXG5001 - Clinical Practice Guidelines for the Diagnosis & Management of Asthma

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 is 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.
B. Partnership Advantage: Effective January 1, 2027, 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~~ enrollees 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:

The following guidelines are used by the Utilization Management (UM) staff when reviewing a Treatment Authorization Request (TAR) request for a nebulizer.

Policy/Procedure Number: MPUG3031 (previously UG100331)		**Lead Department: Health Services** **Business Unit: Utilization Management**	
Policy/Procedure Title: Nebulizer Guidelines		☒ **External Policy** ☐ **Internal Policy**	
Original Date: 05/30/1995		**Next Review Date: 06/11/202604/08/2026** **Last Review Date: 06/11/202504/08/2027**	
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**

VI. GUIDELINE / PROCEDURE:

A. A nebulizer must be ordered by the primary care provider (PCP) or specialist who is treating the Member. For Direct Members, the nebulizer must be ordered by the provider who is currently managing the medical care for the Member.

B. A nebulizer can be ordered for a Member when it is reasonable and necessary to improve a condition related to breathing such as:
   1. Chronic Lung Disease
   2. Cystic Fibrosis
   3. Asthma
   4. Bronchopulmonary Dysplasia (Pediatric)

C. For Medicare criteria specific to Partnership Advantage ~~Members~~enrollees, refer to the Medicare National Coverage Determinations (NCD) Manual 100-03: Chapter 1, Part 4 and Medicare Local Coverage Determination (LCD) L33370 Nebulizers.

D. A nebulizer does not require a TAR when the billed price is less than $200 including tax. A diagnosis of respiratory need is still required for medical justification of a nebulizer.

E. When the billed price including tax is $200 or more, a TAR is required and it must include documentation of medical necessity of chronic home use of nebulizer therapy and the following information related to the condition:
   1. Description of the severity and frequency of the symptoms
   2. Frequency of emergency visits if present
   3. Frequency of hospitalizations if present
   4. Trial and failure of treatment with a metered dose inhaler (MDI)

F. The physician order must include:
   1. Medications to be administered with the nebulizer
      a. Partnership Medi-Cal Members: The pharmacy (prescription) benefit was carved-out to State Medi-Cal as of January 1, 2022. For State Medi-Cal authorization requirements, please refer to the State Medi-Cal Rx Education & Outreach page at this website https://medi-calrx.dhcs.ca.gov/home/education/
      b. Partnership Advantage ~~Members~~Enrollees: Effective January 1, 2027~~6~~, the pharmacy benefit for Partnership Advantage ~~Members~~ enrollees is delegated to a pharmacy benefit manager.
         1) Note that Medicare prohibits Part D (pharmacy) coverage when Part B (DME) is available.
   2. Frequency of administration
   3. Length of time the Member requires the nebulizer

G. The TAR should include information or assessment regarding the patient/caretaker's ability to use the equipment properly.

H. Nebulizers may be purchased for Partnership Members who have a chronic or non-reversible respiratory condition. Otherwise, authorization of rental equipment will be reviewed on an individual basis for Members with a short term illness.

I. Members may be able to obtain a nebulizer (and certain other medical devices that do not require a TAR) through the Partnership Medical Equipment Distribution Services (PMEDS) program when their Provider submits a request form on their behalf. The PMEDS program serves all Partnership Members as an efficient means of fulfilling orders for certain home medical devices that are prescribed by medical providers. Form and information can be found on the Partnership website at https://www.partnershiphp.org/Providers/Medi-Cal/Pages/PMEDS%20Program.aspx

VII. REFERENCES:

A. Medi-Cal Provider Manual/ Guidelines

B. DHCS All Plan Letter (APL) ~~22-012 *Revised*~~25-013 ~~– Governor's Executive Order N-01-19 Regarding Transitioning~~ Medi-Cal Rx Pharmacy Benefits and Cell and Gene Therapy Coverage ~~From Managed Care to Medi-Cal Rx 12/30/2022~~(09/18/2025)

C. Medicare National Coverage Determinations (NCD) Manual 100-03: Chapter 1, Part 4, Sections 200.2 Nebulized Beta Adrenergic Agonist Therapy for Lung Diseases (Revision 173 Issued 09/04/14 effective upon Implementation of ICD-10) and 280.1 Durable Medical Equipment Reference List (Revision effective 05/16/2023)
D. Medicare Local Coverage Determination (LCD) L33370 Nebulizers Revision Effective Date 01/01/2024 or any subsequent updates published by CMS.

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

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

X. REVISION DATES:
04/28/00; 06/20/01; 09/18/02; 10/20/04; 10/19/05; 08/20/08; 11/18/09; 05/18/11; 02/20/13; 01/21/15; 01/20/16; 01/18/17; *02/14/18; 02/13/19; 03/11/20; 02/10/21; 03/09/22; 04/12/23; 05/08/24; 06/11/25; 04/08/26

*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 MPUG3031 (Healthy Kids program ended 12/01/2016)
01/21/15 to 12/01/2016

****

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

GUIDELINE / PROCEDURE

<table>
<tr><td colspan="3">Guideline/Procedure Number: MPUG3110 (previously MCUG3110, MPUG3110)</td><td colspan="3">Lead Department: Health Services
Business Unit: Utilization Management</td></tr>
<tr><td colspan="3">Guideline/Procedure Title: Evaluation and Management of Obstructive Sleep Apnea in Adults (Medi-Cal)</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 11/18/2009</td><td colspan="4">Next Review Date: ~~06/11/2026~~04/08/2027
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I. RELATED POLICIES:

A. MCUP3041 – Treatment Authorization Request (TAR) Review Process
B. MCUP3124 – Referral to Specialists (RAF)
C. MCUP3013 – Durable Medical Equipment (DME) Authorization

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

A. Obstructive Sleep Apnea (OSA) is a disorder that is characterized by obstructive apneas, obstructive hypopneas, and/or respiratory related arousals caused by repetitive collapse of the upper airway during sleep.
B. Partnership Advantage: Effective January 1, 2027, 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~~ enrollees 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:

The following guideline discusses the current recommendations for the evaluation and management of obstructive sleep apnea (OSA) in adults.

VI. GUIDELINE / PROCEDURE:

A. OSA is an important disorder because it is common, and patients with OSA are at increased risk for poor neurocognitive performance and organ system dysfunction due to repeated arousals or hypoxemia during sleep over months to years. The severity and duration of OSA necessary for these sequelae likely varies among individuals. Despite its importance, medical practitioners often under-recognize OSA. Cardinal

features of obstructive sleep apnea (OSA) in adults include:

1. Perturbations of a regular respiratory pattern during sleep, including obstructive apneas, hypopneas, or respiratory effort related arousals.
2. Daytime symptoms attributable to disrupted sleep, such as sleepiness, fatigue, or poor concentration.
3. Signs of disturbed sleep, such as snoring with restlessness. Simple snoring alone does not require a work up. If patients who have significant snoring have additional findings, such as obesity, daytime sleepiness, witnessed apneas, or morning headaches, further evaluation for obstructive sleep apnea should be considered.

B. RISK FACTORS

1. Risk factors for OSA include obesity and craniofacial or upper airway soft tissue abnormalities, while potential risk factors include heredity, smoking, and nasal congestion.
   a. Obesity is the best documented risk factor for OSA.
   b. Craniofacial or upper airway soft tissue abnormalities increase the likelihood of having or developing OSA.
   c. A family history of OSA
   d. Current smoking
   e. Nasal congestion
   f. Diabetes or insulin resistance
   g. Older age

C. DIAGNOSIS

1. If patients are suspected of having sleep apnea based on the history or if the patient is at high risk for the condition, evaluation with a sleep study should be considered.
2. Overnight pulse oximetry study (Current Procedural Terminology [CPT] 94762)
   a. Partnership Medi-Cal: Code 94762 is not a Medi-Cal benefit.
   b. Partnership Advantage: Code 94762 may by covered for Partnership Advantage ~~Members~~ enrollees according to Medicare criteria. See Medicare National Coverage Determination (NCD) 240.4.1. Sleep Testing for Obstructive Sleep Apnea (OSA).
3. A Treatment Authorization Request (TAR) is not required for CPT 95782 (polysomnography for Members younger than 6 years of age).
4. Unattended Sleep Study:
   a. A home unattended portable multimodal monitoring (CPT codes 95800, 95801, and 95806 or HCPCS codes G0398, G0399, and G0400) is required prior to having a facility-based attended diagnostic sleep study in the following circumstances:
      1) When there is a high pre-test probability of moderate to severe obstructive sleep apnea on clinical grounds (excessive daytime drowsiness AND at least one of the following: habitual loud snoring, hypertension, nocturnal gasping or choking, witnessed apnea, or frequent awakenings) OR
      2) The patient has had a screening overnight pulse ox study which showed likely OSA, AND
      3) If there are no co-morbid conditions that would impact the accuracy of the sleep study (e.g. neuromuscular disease, history of stroke, significant cardiopulmonary disease, chronic opioid use, severe insomnia, impaired dexterity or mobility, cognitive impairment),
   b. This diagnostic evaluation should only be interpreted by a specialist with experience in administering and interpreting this test.
   c. No prior authorization is required for home sleep studies. Unattended sleep studies are not covered for diagnoses other than OSA. Reimbursement for home sleep studies is limited to one per year. Reimbursement for home sleep studies beyond 1 per year requires a TAR for medical necessity.
5. An attended diagnostic sleep study (CPT 95808, 95810 or 95811) is generally indicated when one or more of the following conditions are diagnosed or suspected:

a. Narcolepsy
b. Idiopathic CNS Hypersomnia
c. Sleep disordered breathing due to central sleep apnea
d. Parasomnia
e. Nocturnal Oxygen Desaturation
f. Disorders of REM Sleep
g. Suspicion of OSA in mission critical workers such as airline pilots, bus drivers, truck drivers, taxi drivers, rideshare service company drivers, and others in whom falling asleep at work could have a major negative impact

6. Attended sleep studies must be ordered by the primary care provider (PCP) or by the specialist who is treating the Member. For Direct Members, the study must be ordered by the physician who is currently managing the medical care for the Member. Prior authorization is required by Partnership for an attended sleep study, and Partnership utilizes InterQual® criteria to determine the medical necessity of this service. For Partnership Advantage ~~Members~~enrollees, Medicare criteria will be considered including, but not limited to, Medicare National Coverage Determination (NCD) 240.4.1. Sleep Testing for Obstructive Sleep Apnea (OSA).
7. The use of polysomnography for a complaint of insomnia is not considered medically necessary and is not covered because there is no convincing evidence that polysomnography is useful or improves outcome results for this symptom.
8. If there is some question about the need for sleep study, a specialist consultation should be obtained.

D. TREATMENT: -Correct diagnosis is the foundation for a treatment plan for sleep disorders. This section focuses on the treatment of obstructive sleep apnea.
1. Many options exist for treatment of obstructive sleep apnea. These include behavior modification (including weight loss, exercise, sleep position, alcohol avoidance), surgical options, pharmacologic treatment and Continuous Positive Airway Pressure (CPAP).
2. For the initial approval of CPAP, InterQual® Criteria (*noninvasive airway assistive devices*) must be met and a sleep study performed within the past 12 months and documented OSA is required. When CPAP is selected as the treatment modality, it may be titrated in a sleep study laboratory (CPT 95810) or at home, with a self-titrating CPAP device (Healthcare Common Procedure Coding System [HCPCS] code: E0601). Determination of which titration method is needed is made by the treating physicians. Both titration methods require prior diagnosis of OSA and should only be done under the supervision of a clinician with experience coaching a patient on the use of CPAP.
3. For approval of renewal of CPAP authorization, InterQual® Criteria *(noninvasive airway assistive devices*) apply.

E. EQUIPMENT REQUIREMENTS: Partnership follows Centers for Medicare and Medicaid Services (CMS) standards for specifications for equipment permissible for diagnosis of obstructive sleep apnea, interpretation of sleep studies, and titration of CPAP as per Medicare National Coverage Determinations (NCD) Manual 100-03: Chapter 1, Part 4, Section 240.4.1. Sleep Testing for Obstructive Sleep Apnea (OSA), implementation date 08/10/2009 or any subsequent updates published by CMS and Local Coverage Determinations (LCD) L33718 Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea, Revision Effective Date 01/01/2024 or any subsequent updates published by CMS.

F. No TAR is required for CPAP supplies for a CPAP machine owned by the Member (as per Medi-Cal guidelines for ordering/quantity limits).

VII. REFERENCES:

A. Medi-Cal Provider Manual/ Guidelines including Medicine: Neurology and Neuromuscular (*medne neu*)
B. InterQual® criteria: Durable Medical Equipment: Non-invasive airway assistive devices, ~~July 2023~~Oct. 2025 Release

C. InterQual® criteria: Procedures: Sleep studies, ~~July 2023~~2025 Release
D. Kline, Lewis R. MD et al. Clinical Presentation and Diagnosis of OSA in Adults; UpToDate: published online ~~10/05/2023~~11/25/2025.
E. Medicare National Coverage Determinations (NCD) Manual 100-03: Chapter 1, Part 4, Section 240.4.1. Sleep Testing for Obstructive Sleep Apnea (OSA). Implementation date 08/10/2009 or any subsequent updates published by CMS.
F. Medicare Local Coverage Determination (LCD) L33718 Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea. Revision Effective Date 01/01/2024 or any subsequent updates published by CMS.

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

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

X. REVISION DATES:
Partnership Advantage (Program effective January 1, 2027)
06/11/25; 04/08/26

Medi-Cal
10/01/10; 04/18/12; 02/20/13; 10/15/14; 01/20/16; 11/16/16; 11/15/17; *02/13/19; 02/12/20; 01/13/21; 02/09/22; 05/11/22; 06/14/23; 06/12/24; (MPUG3110) 06/11/25; 04/08/26

*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
MPUG3110 - 11/18/09; 10/01/10; 04/18/12 to 2/20/2013

PartnershipAdvantage:
MPUG3110 - 11/18/09; 10/01/10; 04/18/12 to 2/20/2013
PAUG3123 – 02/20/13 to 01/01/15 (PA program ended 01/01/2015)

Healthy Families:
MPUG3110 - 10/01/10; 04/18/12 to 02/20/2013

****

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Guideline/Procedure Number: MPUG3110 (previously MCUPG3110, MPUG3110)			**Lead Department: Health Services** **Business Unit: Utilization Management**
Guideline/Procedure Title: Evaluation and Management of Obstructive Sleep Apnea in Adults (Medi-Cal)			☒ **External Policy** ☐ **Internal Policy**
Original Date: 11/18/2009		**Next Review Date: 06/11/202604/08/2027** **Last Review Date: 06/11/202504/08/2026**	
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MPUP3059 (previously UP100359)</td><td colspan="3">Lead Department: Health Services
Business Unit: Utilization Management</td></tr>
<tr><td colspan="3">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="3">Next Review Date: ~~04/09/2026~~04/08/2027
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<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: ~~04/09/2025~~04/08/2026</td></tr>
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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.
B. Partnership Advantage: Effective January 1, 2027, 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~~ enrollees 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 Members.

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: 04/089/2026** **Last Review Date: 04/089/2025**	
Applies to:	**☐ Employees**	**☒ Medi-Cal**	**☒ Partnership Advantage**

VI. POLICY / PROCEDURE:

A. Initial Coverage:

Partnership will approve the use of NPWT when either criterion A.1. or ~~,~~ A.2. ~~or A.3.~~ AND InterQual® Durable Medical Equipment (DME) criteria 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. 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.C~~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.D~~C~~. below).

B. 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. Written order must include:
   a. ~~Documentation of the~~Patient history, previous treatment regimens (if applicable), and current wound management orders ~~must be documented.~~
   b. ~~Additionally,~~Any concurrent measurements ~~must also be submitted~~ to support the need for NPWT~~.~~
   c. Duration of the time the patient is expected to require the NPWT
2. Documentation of the treatment plan must also be submitted with the TAR to include the following:
   a. Detailed wound evaluation ~~and treatment,~~including ~~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).

b. Comorbid conditions

2.3. Documentation of wound status indicating progress of healing must be entered at least weekly (using quantitative measurements described in VI.B.2.a. above). 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.

C. 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

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

E. When Coverage Ends:

1. For wounds and ulcers described under VI.A. or VI.CB. above, NPWT will be denied as not medically necessary with any of the following, whichever occurs earliest:
   a. Criteria DC.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 [HbgA1cC]).

F. 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.~~1. 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.

~~Documentation:~~

~~3. 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.~~

~~4.~~3. ~~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
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. Partnership Department Directors
B. Partnership Provider Manual

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

X. REVISION DATES:

Partnership Advantage (Program effective January 1, 2027)
04/09/25; 04/08/26

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; 04/089/~~20~~26

*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

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: 04/089/2026** **Last Review Date: 04/089/2025**	
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**

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

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

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

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

Policy/Procedure Number: MPPRGR210				**Lead Department: Provider Relations**	
Policy/Procedure Title: Provider Grievance				☒ **External Policy** ☐ **Internal Policy**	
Original Date: 04/25/1994			**Next Review Date:** ~~08/13/2025~~04/08/2027 **Last Review Date:** ~~08/14/2024~~04/08/2026		
Applies to:	☒ **Medi-Cal**		☐ **Employees**	☐ **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:** ~~08/14/2024~~04/08/2026	

I. RELATED POLICIES:

A. MCUP3037 – Appeals of Utilization Management/Pharmacy Decisions
B. MPQP1053 – Peer Review Committee
C. MPQP1016 – Potential Quality Issue Investigation and Resolution
D. CGA024 – Medi-Cal Member Grievance System

II. IMPACTED DEPTS:

A. Provider Relations
B. Health Services

III. DEFINITIONS:

Provider Grievance: For the purposes of this policy, a Provider Grievance is defined as an expression of dissatisfaction from a provider that, after exhausting all Plan appeal processes, requests to have their complaint, appeal or dispute submitted to the Provider Grievance Review Committee for final review of the medical or pharmacy decision or how the Plan implemented a regulatory requirement.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

To describe the process for resolving provider grievances related to determinations of medical or pharmacy decisions made by Partnership HealthPlan of California, the Plan's implementation of DHCS Regulatory or other State and Federal requirements, or contractual disputes between the Health Plan and providers. The provider grievance process is not applicable to provider appeals filed on behalf of members and as such, is separate and distinct from the member grievance and appeal process. A provider may request a grievance after all applicable Partnership Appeal processes have been exhausted.

VI. POLICY / PROCEDURE:

A. The Partnership HealthPlan of California, (Partnership) Chief Executive Officer is ultimately responsible for the provider grievance process and has primary responsibility for maintenance, review, formulation of policy changes and procedural improvements of the grievance review system. The CEO is assisted by the Partnership Chief Medical Officer, Chief health Services Officer and Senior Director of Provider Relations. The provider grievance process is managed and monitored by the Provider Relations department.
B. Providers must be given an opportunity to have their grievance heard and evaluated. Two mechanisms, an informal and a formal grievance procedure, have been established for that purpose.

Policy/Procedure Number: MPPRGR210		Lead Department: Provider Relations	
Policy/Procedure Title: Provider Grievance		☒ External Policy ☐ Internal Policy	
Original Date: 04/25/1994		**Next Review Date:** ~~8/13/2024~~04/08/2027 **Last Review Date:** 04/08/2026~~08/14/2024~~	
Applies to:	☒ Medi-Cal	☐ Employees	☐ Partnership Advantage

1. Informal grievances may be registered by the provider, by telephone, letter or visit to the Partnership office. The provider should contact the Provider Relations department to register a grievance. The grievance is immediately recorded. If a satisfactory solution has not been reached through discussion with the parties within ten (10) working days after an informal grievance is registered, the grievance automatically becomes a formal grievance.
2. Formal grievance is filed in writing at the Partnership offices or by mail within 45 working days of the determination or action that is the subject of the grievance. There is a fifteen (15) working-day resolution period during which time the Partnership staff proposes a resolution to the provider. If the proposed resolution is not satisfactory, the provider may request in writing a Provider Grievance Review Committee (PGRC) hearing.
3. The PGRC will meet within forty-five (45) working days of receipt of the written provider request for a meeting. PGRC decisions are binding unless reversed by Partnership's Board of Commissioners.

C. The Provider Grievance Review Committee (PGRC) has been established to provide a formal grievance mechanism.

1. The PGRC consists of the members of the Peer Review Committee (PRC) who are not Partnership medical directors, excluding any members of the PRC who have a potential conflict of interest. Potential conflict of interest for provider grievances includes being a member of the active medical staff on a hospital if the hospital is the grieving party and otherwise working for a hospital or institution if the grieving party is a physician on the active medical staff of that hospital or institution. PGRC will meet on the same date as the Peer Review Committee.
2. The Committee's meeting is documented in minutes. The provider and Partnership are advised in writing of the Committee's decision within ten (10) working days of the meeting.

D. Providers appealing utilization management or pharmacy decisions on behalf of members must follow the procedure outlined in Health Services policy MCUP3037, Appeals of Utilization Management/Pharmacy Decisions prior to filing a request for a PGRC hearing.

E. Providers retrospectively appealing a decision to deny or limit payment for a service based on application of UM criteria, for which the member is not financially responsible, should first submit an appeal (which is not on behalf of a member, but on behalf of the billing provider), with additional documentation responding to the reason for the initial denial or limitation. A provider grievance may not be filed until an initial appeal has been completed, which the provider disagrees with.

F. If during the review process, the PGRC determines that a provider may be deficient in rendering or managing care, or problem areas are discovered, this information is referred to the Performance Improvement Clinical Specialist as a Potential Quality Issue (PQI); see MPQP1016 - Potential Quality Issue Investigation and Resolution.

G. The plan or the plan's capitated provider shall not discriminate or retaliate against a provider (including but not limited to the cancellation of the provider's contract) because the provider filed a contracted provider grievance or a non-contracted provider grievance.

VII. REFERENCES:

A. California Department of Health Care Services (DHCS) All Plan Letter (APL) 21-011 Grievance and Appeal Requirements, Notice and "Your Rights" Templates (Aug. 31, 2021 supersedes APL 17-006)

B. National Committee for Quality Assurance (NCQA) Guidelines (effective July 1, 2024) UM 7 Element C, Written Notification of Non-Behavioral Healthcare Appeal Rights/Process and Element I, Written Notification of Pharmacy Appeal Rights/Process

VIII. DISTRIBUTION:

A. Partnership Provider Manual

B. Partnership Department Directors

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE:
Senior Director of Provider Relations

X. REVISION DATES:
08/23/1996, 10/10/1997, 03/29/2000, 07/24/2000, 09/13/2000, 07/17/2002, 11/17/2003, 2/11/2004, 02/09/2005, 03/08/2006, 07/11/2007, 03/12/2008, 04/08/2009, 07/08/2009, 08/11/2010, 08/10/2011, 08/08/2012, 08/14/2013, 08/13/2014, 08/12/2015, 08/10/2016, 08/09/2017, 08/08/2018, 01/09/2019, 01/08/2020, 08/12/2020, 08/11/2021, 08/10/2022, 08/09/2023, 08/14/2024, 04/08/2026

PREVIOUSLY APPLIED TO:
N/A

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Synopsis of Changes to Discussion Policies

Below is an overview of the policies that will be discussed at the Mar. 18, 2026 Quality/Utilization Advisory Committee (Q/UAC) meeting.
It is recommended that you 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 #**	**Summary of Revisions** (include why the changes were made, *i.e.,* NCQA, APL, Medi-Cal guidelines, clarification, *etc.*)	**External Documentation** (Notice required outside of originating department)
Policy Owner: Transportation – *Presenter: Danielle Biasotti, RPht, Director of Transportation Services*			
MPTP2503 – Transportation-Related Travel Expenses, Lodging, Meals, Attendants, Parking and Tolls	**160 – 167**	• Updated related policies revised MCCP2016 to new policy number MPTP2503 and added MPTP2501 • Updated Partnership Advantage go live to January 1, 2027 • Partnership advantage members changed to enrollees • Changed member to Member throughout the policy • Updated WCM definition based on aligning with other PHC policies • Transportation-Related Travel Expenses Benefit • Revising the milage requests for transportation-related travel expenses within 150 miles of the member's residence may be subject to additional review, up to and including Medical Director review for necessity. This is to align with our current processes. Change from 50 to 150 miles. • Updated the Lodging section to include: • Receipts must be itemized • The member will not be reimbursed if they choose to lodge outside of the prebooked hotel and do not notify Partnership in advance. • Partnership is not responsible for fees such as early check in, late check out, incidentals, pet fees, protection coverage, and/or cleaning fees. • Updated the Meals section with the following: • To require a minimum of five calendar days prior to the date of service to align with processes. • Breastfeeding moms with a child two or younger may qualify for meals but not to exceed fifteen (15) days of meals for each thirty (30) days of the member's hospitalization. Beginning with the day of member's admission. Each new hospitalization shall begin a new thirty (30) day benefit period. • Updated Parking and Tolls section with the following: • Express lanes are not covered • Hand-written parking receipts will only be accepted if they are from a bank or credit card company showing proof of payment. • Parking and tolls will only be approved if there is a coinciding Travel Related Expense or Gas Millage Reimbursement request and the member cannot submit parking and/or toll receipts without a valid request on file to support it.	Health Services Claims Member Services Grievance & Appeals Finance Provider Relations

Synopsis of Changes to Discussion Policies

Policy Number & Name	Page #	Summary of Revisions (include why the changes were made, *i.e.,* NCQA, APL, Medi-Cal guidelines, clarification, *etc.*)	External Documentation (Notice required outside of originating department)
		• Millage to Mileage • MCCP2016 to MPTP2501	
Policy Owner: Quality Improvement – *Presenter: Mark Netherda, MD, Medical Director for Quality*			
MPQG1005 – Adult Preventive Health Guidelines	**169 – 184**	In addition to correcting some typos and attempting to standardize capitalizations, etc., the following significant changes were made to the policy. Section V. Purpose Added new professional sources used in creating this document, specifically, the American Society for Colposcopy and Cervical Pathology (ASCCP) and the California Department of Public Health (CDPH). Section VI. Guideline/ Procedure: B. 2. Which addresses immunizations, we replaced "the Advisory Committee on Immunization Practices (ACIP) with the California Department of Public Health as the source for recommended immunizations for all members. B.3. We clarified the language regarding the Cognitive Health Assessment (CHA) requirement for members who are 65 years of age or older and who do not have Medicare coverage. Retaining the recommendation for providers to complete the DHCS Dementia Care Aware training before administering the CHA, adding that this training is no longer required for providers to be able to bill for this service. Note that this is in anticipation of a change to APL 22-025, which is currently being updated to add some clarification, while removing the training requirement. Section VII. References: We added References – the California Department of Public Health and the American Society for Colposcopy and Cervical Pathology (ASCCP). SYNOPSIS OF CHANGES – Attachment A – Adult Preventive Health Screening Guidelines In addition to ensuring we have the most current version of each policy, we added a couple of references that were missing and had the following significant changes: • Vaccination - Based on age and risk factors. For updated schedule, reference the	Health Services Claims Provider Relations

Policy Number & Name	Page #	Summary of Revisions (include why the changes were made, *i.e.,* NCQA, APL, Medi-Cal guidelines, clarification, *etc.*)	External Documentation (Notice required outside of originating department)
		CDPH guidelines. CDPH Vaccination Guidelines • *NEW* Cognitive Health Assessments (CHA) for Members 65 years of age and older – The USPSTF (February 2020 – currently under review) concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for cognitive impairment in older adults. DHCS, however, per APL 22 025, REQUIRES an annual cognitive health assessment (CHA) for Medi-Cal Members 65 years of age and older if they are otherwise ineligible for a similar assessment as part of an Annual Wellness Visit through the Medicare Program. The annual CHA is intended to identify whether the patient has signs of Alzheimer's disease or related dementias, consistent with the standards for detecting cognitive impairment under the Medicare Annual Wellness Visit and the recommendations by the American Academy of Neurology (AAN). (The additional requirement that Medi-Cal Providers must complete the DHCS Dementia Care Aware CHA training to be eligible for billing for this service is expected to be eliminated in 2026.) • **Screening for Perinatal Depression** - Risk factors include low socio-economic status. Consequently, all pregnant Partnership members should be referred for at least one counseling session. The Partnership HealthPlan Perinatal Services (PHPS) Program includes provision of counseling services. If a PHPS program is available, all eligible Partnership members should be referred to a PHPS program for counseling and other services. (CPSP was replaced with PHPS) • **Cervical Cancer Screening** – Additional notes: The American Society for Colposcopy and Cervical Pathology (ASCCP) recommends the use of vaginal swab collection for high-risk HPV testing in cervical cancer (April 2025) o Clinician collected specimens are preferred and self-collected vaginal specimens are acceptable o Vaginal swab collection is recommended for primary HPV screening in asymptomatic, average-risk people with a cervix ages 25-65 years o Repeat testing each 3 years following a negative HPV test using self-collected vaginal specimens o Self-collected vaginal specimens resulting in HPV positive results require a follow-up visit for clinician-collected cervical specimen o Self-collection is not recommended for high-risk individual, including	

Synopsis of Changes to Discussion Policies

Policy Number & Name	Page #	Summary of Revisions (include why the changes were made, *i.e.,* NCQA, APL, Medi-Cal guidelines, clarification, *etc.*)	External Documentation (Notice required outside of originating department)
		those with immunosuppression o Use only FDA-approved collection devices and HPV assays	
Policy Owner: Utilization Management – *Presenter: Anna Campbell, Policy Analyst and Tony Hightower, Associate Director of UM Regulations*			
MPUG3019 – Hearing Aid Guidelines	**186 – 193**	During the annual review of this policy, updates were made to clarify the conditions under which hearing aids will be authorized. **Section VI.A.2. S**entence deleted which previously stated "Routing authorizations will be for one hearing aid only. Per discussion with Medical Directors, we are dropping the binaural restriction. **Section VI.A.4.a.** The hearing loss level at which a hearing aid may be authorized was changed from 25 dB to 26 dB to align with InterQual criteria® **Section VI.A.4.d.** Added statement to specify that "InterQual® criteria for *Durable Medical Equipment: Hearing Aids* will be used to approve hearing aids. **Section VI.A.6.** This entire section regarding binaural hearing aids was deleted as per discussion with Medical Directors that we are dropping the binaural restriction. **Section VI.A.5.** Reference to "Attachment A" was deleted. **Section VI.B.2.** Clarified that a trial period for hearing aids is 30 days. **Section VI.B.8.** Add criteria for the authorization of Contralateral Routing of Signals (CROS)-type hearing aids. **Section VI.B.9.** Add criteria for the authorization of Bilateral Contralateral Routing of Signals (BiCROS) hearing aids **Section VII.B. – D:** Added further description and hyperlinks for Title 22 references. At Reference D., the Title 22 CCR code was updated from 51340.1(b)(2) to 51340.1(c) as (b)(2) currently refers to Orthodontic services but (c) refers to Hearing Services. **Section VII.E.:** Added further description and hyperlink for WIC reference.	Claims Provider Relations Network Services Member Services
MCUG3024- Inpatient Utilization Management	**195 - 206**	This policy was updated off-cycle to clarify processes for achieving placements for Members at the appropriate level of care and for providers seeking Reconsideration of Inpatient UM Determinations. **Section I.** Policy MPUP3018 - Health Services Review of Observation Code Billing was added as a Related Policy. **Section III.G.3. thru 5.** The Definitions of Long Term Acute Care, Subacute Care and Skilled Nursing Facilities were updated. **Section IV.** Attachment A document title was updated to "Request for Reconsideration of Inpatient UM Determination (RRIU): Post Discharge Review for Inpatient Services."	Health Services Claims Member Services Provider Relations

Synopsis of Changes to Discussion Policies

Policy Number & Name	Page #	Summary of Revisions (include why the changes were made, *i.e.,* NCQA, APL, Medi-Cal guidelines, clarification, *etc.*)	External Documentation (Notice required outside of originating department)
		Section VI.D.1.b. Language was added in the Elective/Scheduled Admission Authorization Process section to say "*For elective surgeries in which a post-operative admission directly to an acute inpatient rehabilitation facility is recommended instead of an initial inpatient stay, the prior authorization should be submitted prior to surgery to ensure timely placement*." **Section VI.E.5.b.** Concurrent review time frame for continued review was corrected to be *72* hours instead of 24 hours. **Section VI.E.5.i.** Language clarified to reflect that a provider will be notified verbally, "*via telephone*," if an inpatient stay is determined to be not medically necessary and the facility stay is denied. **Section VI.E.5.j. and k.** Language updated to reflect that attending clinicians of inpatient facilities may request a Peer to Peer for a Member currently admitted to the facility "*or within 3 business days of discharge*." At VI.E.5.k., title of dispute from was changed from provider dispute resolution request to "*Request to Reconsider an Inpatient UM Determination*." **Section VI.G.2.** Added additional facility types: "*Long Term Care Facility (LTC), Medical Respite, Acute Inpatient Rehabilitation, Subacute Rehabilitation*" to the list of facilities where an inpatient facility might make outreach for placement of a Member who no longer requires acute inpatient level of care. **Section VI.G.3.b.** Added this specification for the process when acute inpatient facilities seek placement for Members: "*Once begun, a daily assessment of placement status is expected, summarized in progress notes no less frequently than every 3 calendar days*." **Section VI.G.3.d.** Added specification for acute inpatient admin days as follows: "*If a member meets the criteria for acute inpatient administrative days (as defined in this section), but no placement is achieved and the patient ends up being discharged to a non-covered setting (e.g. home, congregate living, homeless shelter), administrative days can still be assigned those days that met criteria while outreach efforts were being made.*" **Section VI.G.4.** Added specification for acute inpatient admin days as follows: "*For Members with a terminal illness, administrative days may be considered while the facility finalizes an appropriate discharge disposition (SNF with hospice, home with hospice) for a patient with a terminal illness who, when admitted, met acute inpatient criteria, and the records show that the goals of care for the Member have transitioned to comfort care measures*." **Section VI.L.1.** Updated policy reference for UM Communications Services to reflect MPUD3001 UM Program Description.	

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

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**	
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: 04/09/2025**	

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~~ MPTP2501 - Transportation Guidelines for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT)
D. MPTP2502 Emergency Medical Transportation
~~D.~~E. CMP09 - Investigating & Reporting Fraud, Waste and Abuse
~~E.~~F. 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 (Partnership'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 M~~m~~embers 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. Partnership Advantage: Effective January 1, 2027~~6~~, 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~~ enrollees will be

qualified to receive both Medi-Cal and Medicare services as described in the Partnership Advantage Member Handbook.

~~E.~~ 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 with CCS eligible conditions insured by Partnership.~~care coordination in the areas of primary, specialty, and behavioral health for any pediatric member insured by Partnership.~~

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

To outline the circumstances by which Partnership HealthPlan of California (Partnership) 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, M~~m~~embers 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 M~~m~~ember 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 150 miles of the M~~m~~ember'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, M~~m~~ember 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.
   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 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, an itemized 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 is decided by Partnership 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.
   3) If Member chooses to not lodge at prebooked hotel, they will not be reimbursed if they choose to lodge elsewhere without notifying Partnership in advance.

~~2)~~e. Partnership is not responsible for early check in and/or late check out fees, incidentals, pet fees, protection coverage, and/or cleaning fees.

2. If multiple ~~m~~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 M~~m~~embers 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 M~~m~~ember'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 will review the request for reimbursement.
   c. For M~~m~~embers who have diagnoses that prevent them from traveling in a vehicle for the above length of time, Partnership 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 M~~m~~embers 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 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 ~~m~~Member's bedside, Partnership 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 Mmember's circumstances.

b. For non-intensive care settings when the parent/legal guardian is able to stay at the Mmember's bedside, Partnership may authorize one (1) night of lodging for one (1) parent/legal guardian after every six (6) nights of Mmember hospitalization.

c. The total maximum authorization when the Mmember is in an inpatient setting shall be fifteen (15) nights of lodging for each thirty (30) days of mMember hospitalization, beginning with the day of the Mmember'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~~ five (5~~2~~) ~~business~~ calendar days prior to the date of service, meals payments can be issued in advance by Partnership 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 is decided by Partnership 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 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 Mmember and their one (1) accompanying attendant.
   a. For Mmembers 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 Mmember can be reimbursed to the hospital when billed via invoice. The value of the provided meal vouchers will be deducted from the Mmember's meal reimbursement.
6. Members seeking outpatient care are eligible to receive meals if the Mmember'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 will review the request for reimbursement.

c. For Mmembers who have diagnoses that prevent them from traveling in a vehicle for the above length of time, Partnership 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 Mmembers 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 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 Mmember's bedside, Partnership 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 Mmember's circumstances.
   b. For non-intensive care settings when the parent/legal guardian is able to stay at the Mmember's bedside, Partnership may authorize one (1) day of meals for one (1) parent/legal guardian after every six (6) nights of Mmember 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 Mmember'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. Not to exceed fifteen (15) days of meals for each thirty (30) days of the Member's hospitalization. Beginning with the day of member's admission. Each new hospitalization shall begin a new thirty (30) day benefit period.
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 Mmember 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 Mmember 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 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, in advance, regardless of the mode of transport provided.

c. Attendant salary will not be reimbursed if the attendant is related to the Mmember.
d. In order for reimbursement to be issued, a receipt including proof of payment must be supplied to Partnership within ninety (90) days of the date of service.
e. The form of reimbursement offered by Partnership is decided by Partnership 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 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 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.
   e. Express lanes are not covered under tolls reimbursement.
   f. Parking receipts may not be hand-written receipts unless they are supported by a bank or credit card statement showing proof of payment.
   ~~d.~~g. Parking and tolls are only reimbursable if Member has a coinciding Travel Related Expense or Gas Mileage Reimbursement request and the Member cannot submit parking and/or toll receipts without a valid request on file to support it.

F. **RETROACTIVE REQUESTS**

1. Partnership will review retroactive reimbursement requests for the services listed in this policy if the ~~m~~Member paid out of pocket for the services during a month in which retroactive eligibility to Medi-Cal and Partnership has been assigned. Partnership'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 Whole Child Model (WCM) Mmembers, 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 policies MCCP2024 Whole Child Model for California Children's Services (CCS) and ~~MCCP2016~~ MPTP2501 Transportation Policy for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT).
2. For a CCS/WCM-eligible Mmember 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 Mmember and parent(s)/legal guardian(s).

3. A CCS/WCM eligible Mmember and/or the Mmember'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 Mmember's CCS-eligible condition are the responsibility of the CCS/WCM eligible Mmember and/or the mMember's parent(s)/legal guardian(s).
4. Parking, toll(s), meal(s) and/or lodging may be a benefit for CCS/WCM mMembers for whom Partnership 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 24-015: California Children's Services Whole Child Model Program (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)
G. DHCS APL 22-013 Provider Credentialing / Recredentialing and Screening / Enrollment (07/19/2022 and *Revised for FAQs 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 Department Directors
B. Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Director of Transportation Services

X. REVISION DATES:

Medi-Cal
N/A
Partnership Advantage
N/A

PREVIOUSLY APPLIED TO:

MCCP2030 (Archived 04/09/2025)
02/10/21; 02/09/22; 10/12/22; 02/08/23; 04/12/23; 02/14/24

****

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

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

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

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

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

GUIDELINE / PROCEDURE

<table>
<tr><td colspan="3">Guideline/Procedure Number: MPQG1005 (previously MCQG1005 & QG1001050)</td><td colspan="3">Lead Department: Health Services
Business Unit: Quality Improvement</td></tr>
<tr><td colspan="3">Guideline/Procedure Title: Adult Preventive Health Guidelines</td><td colspan="3">☒External Guideline
☐ Internal Guideline</td></tr>
<tr><td colspan="2">Original Date: 04/25/1994</td><td colspan="4">Next Review Date: 03/11/2027
Last Review Date: 03/11/2026</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
MPQG1005 Attachment A.pdf
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: 03/11/2026</td></tr>
</table>

I. RELATED POLICIES:

A. MCQP1021 – Initial Health Appointment
B. MCQP1022 – Site Review Requirements and Guidelines
C. MPUP3047 – Tuberculosis Related Treatment
D. MCUP3052 – Medical Nutrition Services
E. MCUP3101 – Screening and Treatment for Substance Use Disorders E. MPCP2026 – Diabetes Prevention Services

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Provider Relations

III. DEFINITIONS:

A. Partnership Advantage: Effective January 1, 2027, 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 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. Adult Preventive Health Screening Guidelines
B. TB Screening Recommendations (Flowcharts)

V. PURPOSE:

To specify and define Partnership Health Plan of California (Partnership) guidelines for adult health screening and preventive services provided by primary care providers to adults aged 18 and over, as recommended by the United States Preventive Services Task Force (USPSTF) and other national and State of California~~ly~~ recognized standards of practice. These include the American Academy of Family Physicians

(AAFP), the American College of Obstetricians and Gynecologists (ACOG), the American Society for Colposcopy and Cervical Pathology (ASCCP), ~~and~~ the American College of Physicians (ACP) and the California Department of Public Health (CDPH). These guidelines address periodic health and behavioral risk screening and preventive services for average risk asymptomatic adults.

Individuals identified as being at high risk for a given condition may require screening at intervals that are more frequent or the performance of additional screening tests specific to the condition. High-risk individuals are defined as those individuals whose risk behaviors, family history, socioeconomic status, or lifestyle is associated with a higher tendency towards a specific disease. "Required" and "recommended" screening interventions for various conditions as adapted from the USPSTF guidelines and other resources are listed in Attachment A. (See VI.C below for Preventive Care for Medicare recipients.) Required interventions are an integral component of primary care. Partnership audits the compliance of each primary care provider (PCP) performing these services at least once every three years during Medical Record Review (MRR). Recommended interventions are considered to constitute good clinical care but are not required by Partnership and are not considered as audit criteria.

VI. GUIDELINE / PROCEDURE:

A. An Initial Health Appointment (IHA) must be completed for all m~~M~~embers within 120 days of assignment to Partnership and periodically re-administered per Department of Health Care Services' Contract and CalAIM: Population Health Management (PHM) Policy Guide requirements.
   1. An IHA must be performed by a provider within the primary care medical setting.
   2. An IHA is not necessary if the m~~M~~ember's PCP determines that the m~~M~~ember's medical record contains complete information that was updated within the previous 12 months.
      a. If a member is new to a PCP's practice and received health-screening services from another provider within the past 12 months, the new PCP should request those medical records from the former provider.
   3. If a member has not been seen for an IHA or for a periodic health-screening visit, the PCP should perform the indicated screening, behavioral risk assessment, and preventive interventions during episodic visits or recommend that the m~~M~~ember schedule a health-screening appointment.
   4. An IHA must be provided in a manner culturally and linguistically appropriate to the m~~M~~ember.
   5. An IHA must be documented in the m~~M~~ember's medical record and include all of the following:
      a. A history of the m~~M~~ember's physical and mental health;
      b. An identification of risks;
      c. An assessment of need for preventive screenings or services;
      d. Health education offered, and
      e. The diagnosis of and plan for treatment of any diseases.
   6. A subsequent risk assessment should be completed annually or as indicated by the m~~M~~ember's needs
      and according to the provider's clinical judgment.

B. Documentation
   1. Preventive services offered and/or performed, as well as health education provided either verbally or in writing, must be documented in the m~~M~~ember's medical record. Completed and outstanding preventive services should be easily identifiable.
   2. Providers must ensure timely provision of immunizations to m~~M~~embers in accordance with the most recent schedule and recommendations published by ~~the Advisory Committee on Immunization Practices (ACIP),~~California Department of Public Health (CDPH) regardless of the m~~M~~ember's age, sex, or medical condition, including pregnancy. Providers must document each m~~M~~ember's need for

~~ACIP~~CDPH-recommended immunizations as part of all regular health visits. All provided immunizations must be documented in the California Immunization Registry (CAIR2).

3. PCPs are required to provide annual cognitive health assessments (CHAs) for m~~M~~embers who are 65 years of age or older and who do not have Medicare coverage. (Reference APL 22-025.) While recommended, ~~Partnership verifies whether providers have completed the required DHCS Dementia Care Aware cognitive health assessment training, using the list of providers who have completed the training provided by DHCS. Providers must complete the~~providers are no longer required to complete the DHCS Dementia Care Aware training to bill and receive reimbursement from Partnership for providing the CHA. ~~As part of new provider training,~~ Partnership educates its providers to bill appropriately for an annual ~~cognitive health~~cognitive health assessment ~~-~~according to the Provider billing requirements outlined in APL 22-025.

~~a. To receive reimbursement for this assessment, providers must complete the DHCS Dementia Care Aware cognitive health assessment training **prior to** billing for the annual cognitive assessments.~~

~~b. Once certified, providers~~Providers will perform the annual cognitive health assessment as a part of an
Evaluation and Management (E&M) visit and have readily available documentation based on
a. APL guidelines in the m~~M~~ember's medical record. Approved assessment screening tools include the General Practitioner assessment of Cognition (GPCOG) and the Mini-Cog. Informant tools for family members and close friends, which include the Eight-item Informant Interview to Differentiate Aging and Dementia, the GPCOG, and the Short Informant Questionnaire on Cognitive Decline in the Elderly.

~~c.~~b. Providers who bill for the annual cognitive assessment must provide appropriate follow-up care based on assessment scores including, but not limited to, additional assessments or specialist referrals.

~~d.~~c. P~~Certified p~~roviders should use the CPT code 1494F for billing. ~~**Partnership is not required to reimburse non-certified providers.**~~

C. Medicare Preventive Care
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 who meet Medicare and Medi-Cal criteria:
   a. Medical Nutrition Services (MNT) as outlined in Partnership policy MCUP3052 – Medical Nutrition Services.
   b. Diabetes Prevention Services (DPP) as outlined in Partnership policy MPCP2026 – Diabetes Prevention Services.
4. Medicare-specific preventive care visits as outlined on the Medicare website for eligible members* at http://www.medicare.gov/coverage/preventive-screening-services including, but not limited to
   a. A "Welcome to Medicare" visit
   b. An annual "A~~a~~dult W~~w~~ellness V~~v~~isit" (AWV)
   c. A cardiovascular behavioral therapy visit (performed by the PCP)
   d. An obesity behavioral therapy visit (performed by the PCP).

* Eligible members – added because criteria for who gets 4a. and 4b. are mutually exclusive.

~~d.~~

D. Monitoring and Quality Improvement

1. Documentation of adult preventive health services is reviewed as a component of the Medical Record Review.

VII. REFERENCES:

A. Department of Managed Health Care All Plan Letter (APL) 25-015 Assembly Bill 144 and Coverage of Preventive Care Services (Sept. 18, 2025)
B. California Department of Health Care Services' (DHCS) CalAIM: Population Health Management (PHM) Policy Guide (updated July 2025) https://www.dhcs.ca.gov/CalAIM/Documents/PHM- Policy-Guide.pdf
C. DHCS All Plan Letter (APL) 24-008 Immunization Requirements (June 21, 2024, supersedes APL 18004)
D. DHCS APL 22-030, Initial Health Appointment (Dec. 22, 2022, supersedes APL 13- 017)
E. DHCS APL 22-025, Responsibilities for Annual Cognitive Health Assessment for Eligible Members 65 Years of Age or Older (Nov. 28, 2022)
F. DHCS APL 21-014 Alcohol and Drug Screening, Assessment, Brief Intervention and Referral to Treatment (Oct. 11, 2021 supersedes APL 18-014)
G. American Cancer Society Screening Guidelines: https://www.cancer.org/health-careprofessionals/american-cancer-society-prevention-early-detection-guidelines.html
H. American Academy of Family Physicians (AAFP) 2023 list of assessments that differ from USPSTF: Clinical Preventive Services Recommendations https://www.aafp.org/family-physician/patient-care/clinical-recommendations/aafp-cps.html
D. American College of Obstetricians & Gynecologists (ACOG): http://www.acog.org/ (requires subscription)
E. American College of Physicians (ACP): https://www.acponline.org/clinical-information/clinical-guidelinesrecommendations
F. Centers for Disease Control, Vaccines and Immunizations https://www.cdc.gov/vaccines/?CDC_AAref_Val=http s://www.cdc.gov/vaccines/schedules/index.html
G. American Society for Colposcopy and Cervical Pathology: https://www.asccp.org/guidelines/screeningguidelines/
~~K.~~ CDPH Adult Vaccination Schedule; https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/publichealth4all/vaccines.aspx ~~https://www.cdc.gov/vaccines/schedules/downloads/adult/adult-combined- schedule-bw.pdf~~
~~L.~~K. United States Preventive Services Task Force (USPSTF) https://uspreventiveservicestaskforce.org/uspstf/home
~~M.~~L. California Welfare and Institutions Code 14132.171, Annual cognitive health assessment
~~N.~~M. Medicare Preventive & Screening Services – https://www.medicare.gov/coverage/preventive-screeningservices 42 CFR § 410.16, 42 CFR § 410.15, 42 CFR § 410.64, 42 CFR § 410.73, 42 CFR § 410.79.
~~O.~~N. California Assembly Bill 2132 Health Care Services: Tuberculosis (Sept. 29, 2024) https://leginfo.legislature.ca.gov/
O. Department of Health Care Services-vaccine schedules pending guidance.
P. The American Society for Colposcopy and Cervical Pathology (ASCCP)- https://www.asccp.org/wp-content/uploads/2026/01/ASCCP-Practice-Advisory-WPSI-HRSA_FINAL.pdf

~~P.~~

VIII. DISTRIBUTION:

A. Partnership Department Directors

B. Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Medical Officer

X. REVISION DATES:

Medi-Cal

HS-4 - 12/27/95; 08/05/97; 10/10/97 [name change only]; 02/10/99; 06/21/00, 06/20/01; 06/19/02; 10/30/02; 10/20/04; 05/17/06; 09/19/07; 03/18/09; 10/20/10; 03/21/12; 04/17/13; 04/16/14; 04/15/15; 05/18/16;

04/19/17; *06/13/18; 06/12/19; 06/10/20; 06/09/21; 02/09/22; 09/14/22; 03/08/23; 04/10/24; 03/12/25; 03/11/26

*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 meeting date.

PREVIOUSLY APPLIED TO:

Partnership Advantage

MPQG1005 - 09/19/2007 to 01/01/2015

Healthy Families

MPQG1005 - 10/20/2010 to 03/01/2013

Healthy Kids

MPQG1005 - 09/19/2007 to 04/17/2013

ADULT PREVENTIVE HEALTH SCREENING GUIDELINES

These guidelines for adult health screening and preventive services are derived from the most recent United States Preventive Services Task Force (USPSTF) and other nationally recognized standards of practice from organizations such as American Academy of Family Physicians (AAFP), American College of Obstetricians and Gynecologists (ACOG), American Cancer Society (ACS), American College of Physicians (ACP), and others. Age, sex and risk factor specific USPSTF recommendations can be found using the ePSS app found on the USPSTF website.

Required interventions are italicized and considered to be an integral component of primary care. Consequently, Partnership HealthPlan of California (Partnership) audits the compliance of each PCP performing these services at least once every three years during the Medical Record Review (MRR).

*The USPSTF recommends clinicians discuss these preventive services with eligible patients and offer them as a priority. All these services have received an "A" (strongly recommended) or a "B" (recommended) grade from the Task Force.

PREVENTIVE CARE	FREQUENCY/DETAILS
Aspirin for the Primary Prevention of Cardiovascular Events *	~~A meta-analysis in the Jan. 22, 2019 issue of JAMA concluded that there was no net benefit for use of aspirin for primary prevention of cardiovascular disease.~~ The USPSTF (April 2022) recommends for adults aged 40 to 59 years with a 10% or greater 10-year cardiovascular disease (CVD) risk, the decision to initiate low-dose aspirin for the primary prevention of CVD should be an individual one. Evidence indicates that the net benefit of aspirin use in this group is small. ~~Persons~~ Persons who are not at increased risk ~~for~~of bleeding and are willing to take low-dose aspirin daily are more likely to benefit. (Grade C) For adults 60 years or older, the USPSTF recommends against initiating low-dose aspirin use for the primary prevention of CVD. (Grade D) A meta-analysis in the Jan. 22, 2019 issue of JAMA concluded that there was no net benefit for use of aspirin for primary prevention of cardiovascular disease. Cardiovascular risk can be calculated by the heart risk calculator found at PREVENT Online Calculator – Professional Heart Daily / American Heart Association or the ASCVD Risk Calculator Plus for mobile devices.
Assessment for Hearing Impairment	The USPSTF (March 2021) concludes current evidence is insufficient re: screening for hearing loss in older adults (asymptomatic adults aged 50 years or older). . ~~Age 65+ at the time of the periodic health examination. O~~ Perceived hearing loss (symptomatic patients) can be assessed by single-question screening (asking "Do you have difficulty with your hearing?") or longer patient questionnaires such as the Hearing Handicap Inventory for the Elderly–Screening (HHIE-S) questionnaire.~~best screen for individuals likely to take action based on abnormal testing results, consider a three-question screening: 1. Do you have difficulty with your hearing? 2. How bothered are you by your hearing loss? 3. How motivated are you to do something about it? (Affirmative responses to all three warrants referral for diagnostic evaluation and possible treatment.)~~ Reference: *JAMA March 23/30, 2021, pp. 1162-1163.* ~~The USPSTF concludes current evidence is insufficient re: screening for hearing loss in older adults.~~
High Blood Pressure Screening *	Upon initial entry into PCP practice, then at least every two years. If elevated, the USPSTF (April 2021) recommends obtaining measurements outside of the clinical setting for diagnostic confirmation before starting treatment, when feasible.

Hypertensive Disorders of Pregnancy Screening	The USPSTF (September 2023) recommends screening for hypertensive disorders in pregnant persons with blood pressure measurements at each prenatal visit. This includes all pregnant ~~persons~~ persons without a known diagnosis of a hypertensive disorder of pregnancy or chronic hypertension. (Grade B)

PREVENTIVE CARE	FREQUENCY/DETAILS
Colorectal Cancer Screening *	The USPSTF (May 2021) recommends performing screening for colorectal cancer in adults aged 50 to 75 (Grade A) and ages 45 to 49. (Grade B) • Modalities include Fecal Occult Blood Test (FOBT) or Fecal Immunochemical Test (FIT) annually, OR colonoscopy every 10 years; OR flexible sigmoidoscopy every five years OR FIT –DNA test every three years. (See USPSTF for other variations.) CT colonoscopy is technically ~~difficult~~difficult, and Partnership requires a Treatment Authorization Request (TAR). • Recommendations for adults aged 50 to 75 (Grade A) differ from those aged 76 to 85. For adults aged 76 to 85 years, the decision to screen for colorectal cancer is an individual one, ~~taking into account~~considering a patient's overall health and prior screening for colorectal cancer are more likely to benefit. • The USPSTF does not comment on screening for colorectal cancer in adults older than 85 years of age.
Height & Weight (BMI)	• Upon i~~I~~nitial entry into PCP practice, then annually, is the generally accepted standard, but no evidence is found for appropriate intervals for ~~.~~screening. • AAFP, *Am Fam Physician.* 2012;86(10):online • ~~Age 18 to 64: weight at least every two years.~~ • ~~Age 65+: weight at least annually.~~
HIV Screening, ~~and~~ nonpregnant persons HIV Screening – pregnant persons Pre-exposure Prophylaxis to Prevent Acquisition of HIV *	The USPSTF (June ~~2018~~ 2019 – currently under review) recommends that each adolescent and adult ages 15 to 65 without risk factors be tested for HIV once in their lifetime. In addition, all ~~individuals~~ persons at increased risk for HIV, regardless of age, should be tested every year. Pregnant ~~persons~~ persons should be tested with each pregnancy, including those presenting in labor or ~~at~~ at delivery whose HIV status is unknown. The Centers for Disease Control and Prevention (CDC) recommends prenatal testing for ~~syphilis and~~ HIV (and syphilis) during a pregnant ~~person's~~ person's first prenatal visit and repeat testing for "high-risk" pregnant ~~persons~~ persons during the third trimester (preferably 28-32 weeks~~)~~. CDC, April 19, 2022) ~~(CDC, April 19, 2022)~~ The USPSTF (August 2023) also recommends that clinicians prescribe preexposure prophylaxis using effective antiretroviral therapy to ~~persons~~ persons who are at increased risk of HIV acquisition to decrease the risk of acquiring HIV.
Hepatitis C Screening*	The USPSTF (March 2020) recommends a one-time screening for average risk adults ages 18 to 79. In addition, adults at increased risk of contracting Hepatitis C (e.g., those using injectable drugs of abuse), should be screened periodically (ungraded recommendation). There is limited evidence to determine how often to screen ~~persons~~ persons at increased risk.

Lung Cancer Screening *	The USPSTF (March 2021) recommends annual screening for lung cancer with low-dose computed tomography (LCDT; CPT code 71211) in adults ages 50 to 80 years who have a 20+ pack-year smoking history and IN ADDITION currently smoke or have quit within the past 15 years or develop a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery. (Grade B) Full-dose CT scans are not approved for screening.
Syphilis Infection, Screening – Nonpregnant personsand Syphilis infection screening - Pregnant Persons *	The USPSTF (September 2022) recommends screening ~~persons~~ persons at increased risk for syphilis. (Grade A) At highest risk are men who have sex with men and persons living with HIV. Other risk factors are history of incarceration, history of commercial sex work, males younger than 29 years old, and (in Partnership regions) current homelessness and current use of methamphetamines. The USPSTF (~~September 2018~~May 2025) recommends early, universal screening for syphilis infection in all pregnant ~~persons~~persons. If an individual is not screened early in pregnancy, screening should be done at the first available opportunity. ~~Those presenting in labor or at delivery whose syphilis status is unknown should be tested at that time.~~ (Grade A)

	~~The Centers for Disease Control and Prevention (CDC) recommends prenatal testing for syphilis and HIV during a pregnant person's first prenatal visit and repeat testing for "high-risk" pregnant persons during the third trimester (preferably 28-32 weeks). (CDC April 19, 2022)~~ Screen and confirm - Options for testing include traditional screening algorithm: Screen with an initial nontreponemal test (e.g., Venereal Disease Research Laboratory (VDRL) or rapid plasma regain [RPR] test). If positive, confirm with a treponemal antibody detection test (e.g., *T pallidum* particle automated treponemal test (e.g., enzyme-linked or chemiluminescence immunoassay). If positive, confirm with a ~~nontreponemal~~non-treponemal test.
Latent Tuberculosis Infection (LTBI) Screening	The USPSTF (May 2023) recommends screening for latent tuberculosis infection (LTBI) in populations at increased risk. (Grade B) (See ~~MPQG1004~~ MPQG1005 Attachment B – TB Screening Overview for more specifics.) This recommendation meets the requirements of California's new Tuberculosis screening law, Assembly Bill 2132, which was signed into law Sept. 29, 2024, and took effect Jan. 1, 2025.
Glaucoma Screening	AAFP and USPSTF (May 2022) find insufficient evidence for or against screening for glaucoma. (Grade I) Medicare recommends screening for those in these high-risk categories: 1. Persons with diabetes, 2. Family history of glaucoma, 3. African American and age 50 or older, or 4. Hispanic and age 65 or older.
Hyperlipidemia Screening (needed for full cardiovascular risk factor evaluation)	The USPSTF recommendations covering lipid screening in adults are archived. UpToDate® ("Screening for lipid disorders in adults" Aug. 2, 2021) recommends obtaining a fasting or non-fasting lipid profile when an adult enters care at a new practice to screen for familial hypercholesterolemia and for cardiovascular risk assessment, with rescreening as part of a cardiovascular risk analysis every five years. Earlier re-screening may be indicated depending on patient-specific factors.

Statin Use for Primary Prevention of Cardiovascular Disease (CVD)	The USPSTF (August 2022) recommends prescribing statins for the primary prevention of CVD for adults ages 40 to 75 years with one or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension or smoking), AND a 10-year cardiovascular risk of ≥10% (Grade B) or 7.5% to <10%. (Grade C) Current evidence is insufficient to assess benefits versus harms in adults > 75 years of age. (Grade I) Cardiovascular risk can be calculated by the heart risk calculator found at PREVENT Online Calculator – Professional Heart Daily / American Heart Association or the ASCVD Risk Calculator Plus for mobile devices.
Vaccination	Based on age and risk factors. For the updated schedule, reference the ~~CDC~~ CDPH guidelines. CDPH Vaccination Guidelines
Diabetes Mellitus in Adults, Screening for Type 2 and Prediabetes *	The USPSTF (August 2021) recommends screening all adults ages 35 to 70 years who are overweight or obese. (Grade B) The screening interval is uncertain, but every three years "may be reasonable." 2023 Standards of the American Diabetes Association: 1. Testing for prediabetes and DM2 in asymptomatic people should be considered in any overweight adult (BMI ≥25)[1] with one or more risk factors. Risk factors include a first-degree relative with diabetes, high-risk race/ethnicity (e.g., African American, Latino, Native American, Asian American, Pacific Islander), history of CVD, hypertension, HDL cholesterol level < 35 mg/dL (0.90 mmol/L) and triglyceride level > 250 mg/dL (2.82 mmol/L), polycystic ovary syndrome, physical inactivity, and/or other clinical conditions associated with insulin resistance (e.g., severe obesity, acanthosis nigricans).

	2. Screen all adults beginning at age 35 years. 3. If test results are normal, screen every three years. 4. Acceptable screening tests include fasting plasma glucose, 2-h plasma glucose during a 75-g GTT, and HgbA1c. 5. ~~Persons~~ Persons with HIV should be screened using a fasting glucose test before starting antiretroviral therapy, when switching therapies, and 3-6 months after starting therapy, and then annually, if screening results are normal. [1] *The ADA suggests different BMI parameters for Asian Americans; however, Partnership does not endorse this differentiation.*
Dental Disease and referral to dental provider	The USPSTF (November 2023) concludes that the current evidence is insufficient to assess the balance of benefits and harms of routine screening performed by primary care clinicians for oral health conditions, including dental caries or periodontal-related disease, in adults. The AAFP recognizes the PCP may act as a first line of defense by promoting good oral health during patient visits. Their recommendation is to assess for and promote oral health. Ask about brushing and flossing, use of tobacco and other smoked products, consumption of sugary drinks and advocating and assisting with identifying a primary dental office. Frequency includes entry into PCP practice, then yearly or as indicated by the PCP and/or dental care provider.

Alcohol and Drug Misuse and Behavioral Counseling Interventions *	The USPSTF (November 2018 currently under review – public comment closed June 2025) recommends screening for unhealthy alcohol use in primary care settings in adults 18 years and older, including pregnant persons. Screen all adults annually; if present, offer behavioral interventions to reduce unhealth alcohol use. (Grade B) The USPSTF (June 2020) recommends asking about unhealthy drug use in adults aged 18 years or older. When screening is positive, offer or refer for appropriate treatment. California Department of Health Care Services (DHCS) All Plan Letter (APL) 21-014 – Alcohol and Drug Screening, Assessment, Brief Intervention and Referral to Treatment – Oct. 11, 2021)
Diet, Behavioral Counseling in Primary Care to Promote a Healthy Lifestyle – Recommendations for adults **with and without** known CVD risks *	The USPSTF (July 2022 - currently under review) recommends for adults **without** known CVD risk factors individualizing the decision to offer to refer to behavioral counseling interventions to promote a healthy diet and physical activity. The USPSTF (November 2020 – currently under review) recommends offering or referring adults **with** one of the following: 1. Hypertension 2. Dyslipidemia 3. Mixed multiple risk factors such as metabolic syndrome or a ≥ 7.5% estimated 10year CVD risk to intensive behavioral/counseling interventions to promote a healthy diet and physical activity for CVD prevention. This recommendation no longer includes adults with other known modifiable CVD risk factors such as abnormal blood glucose levels, obesity, and smoking, as these populations are covered by other USPSTF recommendations. Person~~Individual~~s with a diagnosis of prediabetes should be referred to participate in a Diabetes Prevention Program, if available.
BEHAVIORAL HEALTH CONDITIONS	**DETAILS**
Screening for Depression and Suicide Risks * in Adults and Perinatal Depression	The USPSTF (June 2023) recommends screening for **depression** on the general adult population, including pregnant persons and post-partum persons. (Grade B) Screening should be implemented with adequate systems in place to ensure accurate diagnoses, effective treatment, and appropriate follow up. There is little evidence regarding optimal timing for screening. The USPSTF (October 2022) concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for **suicide risk** in the adult population, including pregnant and post-partum persons, as well as older adults. (Grade I) The USPSTF (February 2019 – currently under review) also recommends that **pregnant and postpartum ~~persons~~ persons** at risk of depression should be referred for counseling even if not currently depressed. (Grade B) Risk factors include low socio-economic status. Consequently, all pregnant Partnership members should be referred for at least one counseling session. The Partnership HealthPlan Perinatal Services (PHPS) Program includes provision of counseling services. If a PHPS program is available, all eligible Partnership members should be referred to a PHPS program for counseling and other services.~~The~~

	~~California Perinatal Services Program (CPSP) includes provision of counseling services. If a CPSP program is available, all eligible Partnership members should be referred to a CPSP program for counseling and other services.~~
~~BEHAVIORAL CONDITIONS~~	**~~DETAILS~~**
Anxiety *	The USPSTF (June 2023) recommends screening for anxiety disorders in adults 64 years or younger, including pregnant and post-partum ~~persons~~ persons who have no recognized signs of symptoms of anxiety. (Grade B) The USPSTF (June 2023) concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for anxiety disorders in older adults 65 years or older. (Grade I)
Obesity *	The AAFP recommends screening all adults for obesity (using BMI >30). ~~This is a 2012 statement based on what were once current but are since retired USPSTF recommendations.~~ The current USPSTF (September 2018~~ – currently under review~~) recommendation is clinicians should offer or refer patients with a BMI of 30 or more to intensive, multicomponent behavioral interventions. (Grade B) $BMI = \left(\frac{\text{Weight in Pounds}}{(\text{Height in inches}) \times (\text{Height in inches})} \right) \times 703$
Tobacco Use and Tobacco Caused Disease Counseling, including for Pregnant Persons *	For all adults who are not pregnant, the USPSTF (January 2021) recommends that clinicians ask all adults about tobacco use, advise them to stop using tobacco, and provide behavioral interventions and USDA (FDA) approved pharmacotherapy for cessation. (Grade A) For all pregnant ~~persons~~persons, the USPSTF recommends that clinicians ask about tobacco use, advise them to stop using tobacco, and provide behavioral interventions for cessation to pregnant persons who use tobacco. (Grade A)
Unintended Pregnancy *	Screen all reproductive aged persons at risk for unintended pregnancy (and males who may cause unintended pregnancy); offer counseling and access to contraceptives, including emergency contraception. (ACOG 2019) Recommended screening question: "with a modified O~~o~~ne K~~k~~ey Q~~q~~uestion" method: "Do you, or any of your sensual or sexual partners, want to become pregnant in the coming year?" (AAFP 2021)
OTHER SCREENINGS	**DETAILS**

Abdominal Aortic Aneurysm Screening*	The USPSTF (December 2019) recommends one-time screening for abdominal aortic aneurysm by ultrasound in persons aged 65 to 75 who have ever smoked and were assigned as male at birth. (Grade B)
Prostate Cancer Screening (Prostate Specific Antigen blood test) *	USPSTF recommendations (~~May 2018~~December 2023 – currently under review): • Asymptomatic average risk persons with a prostate aged 65 to 69 years should have shared decision making with their clinician about the pros and cons of screening. (Grade C) • ~~Persons~~ Persons with a prostate aged 70 and older should not be screened. (Grade D) • ~~Persons with a prostate~~Persons with prostate symptoms may have a PSA as part of their diagnostic evaluation.
Screening for Intimate Partner Violence *	Adapted~~*~~ from USPSTF (~~October~~ June ~~2018~~ 2025)~~ – currently under review)~~ recommendations: Screen all patients of childbearing age for intimate partner violence when a routine health maintenance exam is performed, including those who are pregnant and postpartum. (Grade B) Providers should refer patients who screen positive to ongoing support services. * *Language updated to be non-gender specific.*
Breast Cancer Screening by Mammography *	The USPSTF (April 2024) recommends biennial mammography for persons aged 40 to 74 years with breasts and assigned as female at birth who are asymptomatic. (Grade B) Transgender and Gender Diverse persons: The "Standards of Care for the Health of Transgender and Gender Diverse People, Version 8" from the World Professional Association for Transgender Health (WPATH) recommends "… health care professionals follow local breast cancer screening guidelines developed for cisgender women in their care of transgender and gender diverse people who have received estrogens, taking into consideration length of time of hormone use, dosing, current age, and the age at which hormones were initiated." Shared decision making is recommended.
Breast Cancer, Chemoprevention *	The USPSTF (September 2019 – currently under review) recommends clinicians offer to prescribe risk reducing medications, such as tamoxifen, raloxifene or aromatase inhibitors, to persons at high risk for breast cancer and at low risk for adverse effects of chemoprevention. (Grade B) A breast cancer risk assessment toll is available at www.cancer.gov/bcrisktool
Breast and Ovarian Cancer Susceptibility, Genetic Risk Assessment and BRCA Mutation Testing *	Adapted* the USPSTF (August 2019 – currently under review) recommends assessment with an appropriate brief family risk assessment tool for persons at high risk of breast and ovarian cancer. Persons with a positive result should be offered genetic counseling and, if indicated after counseling, genetic testing. (Grade B) See MCUP3131 – Genetic Testing policy for details.
Breastfeeding, ~~Behavioral Interventions to Promote *~~Promotion*	The USPSTF (~~October 2016~~April 2025) ~~– update in progress)~~ recommends interventions or referrals during pregnancy and after birth to promote and support breastfeeding. (Grade B)

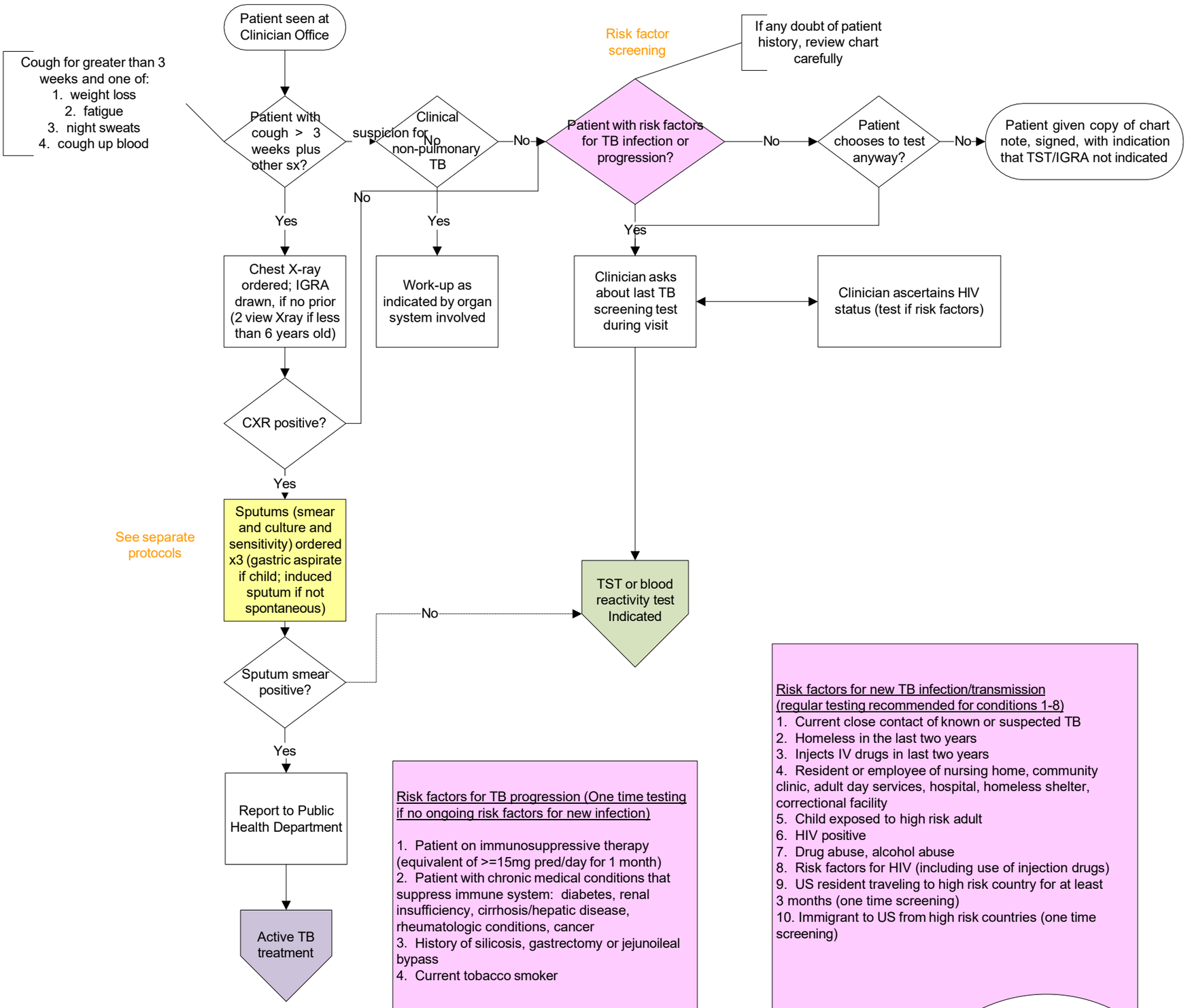
Cervical Cancer Screening*~~Cervical Cancer Screening *~~	USPSTF recommendations (~~August 2018~~December 2024 – currently under review) • Persons with a cervix aged 21 to 29 should have cytology screening every three years. Persons with a cervix aged 30 to 65 may have cytology screening every three years or may have high-risk HPV testing every five years. (Grade A) • Persons with a cervix under aged 21 should not be screened. (Grade D)
	• The USPSTF recommends against screening for cervical cancer in women who have had a hysterectomy with removal of the cervix and do not have a history of a high-grade precancerous lesion (i.e., cervical intraepithelial neoplasia [CIN] grade 2 or 3) or cervical cancer. (Grade D) • The USPSTF recommends against screening for cervical cancer in women older than 65 years who have had adequate prior screening and are not otherwise at high risk for cervical cancer. (Grade D) ~~•Persons with a cervix over age 65 should only be screened if they have never been previously screened, or if one of their last three screenings had any type of cervical atypia. (Grade D)~~ ~~•Routine cervical cytology testing should be discontinued (regardless of age) in persons with a history of a total hysterectomy (removal of the cervix along with the uterus) for noncancerous reasons, as long as they have no history of high-grade CIN. (Grade D)~~ Note: although the American Cancer Society changed its recommendations in 2020 to recommend later initiation of screening, less frequent screening, and use of HPC screening only under age 30, Partnership continues to recommend following the recommendations of USPSTF / ACOG. Additional Notes: The American Society for Colposcopy and Cervical Pathology (ASCCP) recommends the use of vaginal swab collection for high-risk HPV testing in cervical cancer (April 2025) • Clinician collected specimens are preferred and self-collected vaginal specimens are acceptable • Vaginal swab collection is recommended for primary HPV screening in asymptomatic, average-risk people with a cervix ages 25-65 years • Repeat testing each 3 years following a negative HPV test using self-collected vaginal specimens • Self-collected vaginal specimens resulting in HPV positive results require a follow-up visit for clinician-collected cervical specimen • Self-collection is not recommended for high-risk individual, including those with immunosuppression • Use only FDA-approved collection devices and HPV assays •

~~Chlamydia Screening * Gonorrhea Screening~~Chlamydia and Gonorrhea Screening* *	USPSTF recommendations (September 2021): Annual screening recommended for sexually active women 24 years or younger and for women aged 25 years or older at increased risk for infection. Risks include previous or current STI, a sex partner with a STI, inconsistent condom use when indicated, a history of exchanging sex for money or drugs, and a history of incarceration. (Grade B) Transgender and gender-diverse persons – Gonorrhea and chlamydia screening recommendations should be adapted based on anatomy (i.e., screening recommendations for cisgender females should be extended to all transgender males and gender-diverse persons with a cervix.) Screening at the pharyngeal and rectal site for gonorrhea and chlamydia should be considered based on reported sexual behaviors and exposure. (UpToDate®, March 2024)
Osteoporosis in Postmenopausal Persons Assigned as Female at Birth Screening *	USPSTF recommendation (January 2025): Screen persons assigned as female at birth age 65 and older with bone measurement testing to prevent osteoporotic fractures. (Grade B) For post-menopausal persons assigned as female at birth younger than 65 years, apply a formal clinical risk assessment tool such as the FRAX tool, found at https://www.sheffield.ac.uk/FRAX/tool.aspx?country=9 to determine the appropriate need for bone measurement testing. (Grade B) The USPSTF does not speak to the frequency of, or interval between, testing. ACOG (September 2021) recommends repeat testing no earlier than two years after initial screening in those with a borderline result of a change in risk factors. A ~~oneyear~~one-year follow-up test is recommended for patients on chronic glucocorticoid treatment. WPATH's "Standards of Care for the Health of Transgender and Gender Diverse People, Version 8" provides osteoporosis screening recommendations based on surgical and hormonal histories of transgender and gender diverse ~~individuals~~persons.
Vitamin D, Calcium or Combined Supplementation for the Primary Prevention of Fractures in Postmenopausal Persons Assigned as Female at Birth	The USPSTF (April 2018 – currently under review) recommends against daily supplementals with 400 IU or les of Vitamin D and 1000 mg or les of Calcium for the primary prevention of fractures in postmenopausal persons assigned as female at birth. (Grade D) The USPSTF (April 2018) finds inconclusive evidence that the benefits outweigh the risks for daily Calcium doses greater than 1000 mg of Vitamin D supplementation greater than 400 IU to prevent fractures. (Grade I) WPATH's "Standards of Care for the Health of Transgender and Gender Diverse People, Version 8" provides osteoporosis prevention recommendations based on surgical and hormonal histories of transgender and gender diverse ~~individuals~~persons.

Resources: United States Preventive Services Task Force recommendations, American Academy of Family Physicians (AAFP), American College of Obstetricians & Gynecologists (ACOG), American College of Physicians (ACP), UpToDate®, the American Diabetes Association, "Standards of Care for the Health of Transgender and Gender Diverse People, Version 8," Centers for Disease Control and Prevention (CDC), the American Society for Colposcopy and Cervical Pathology, the California Department of Public Health (CDPH).

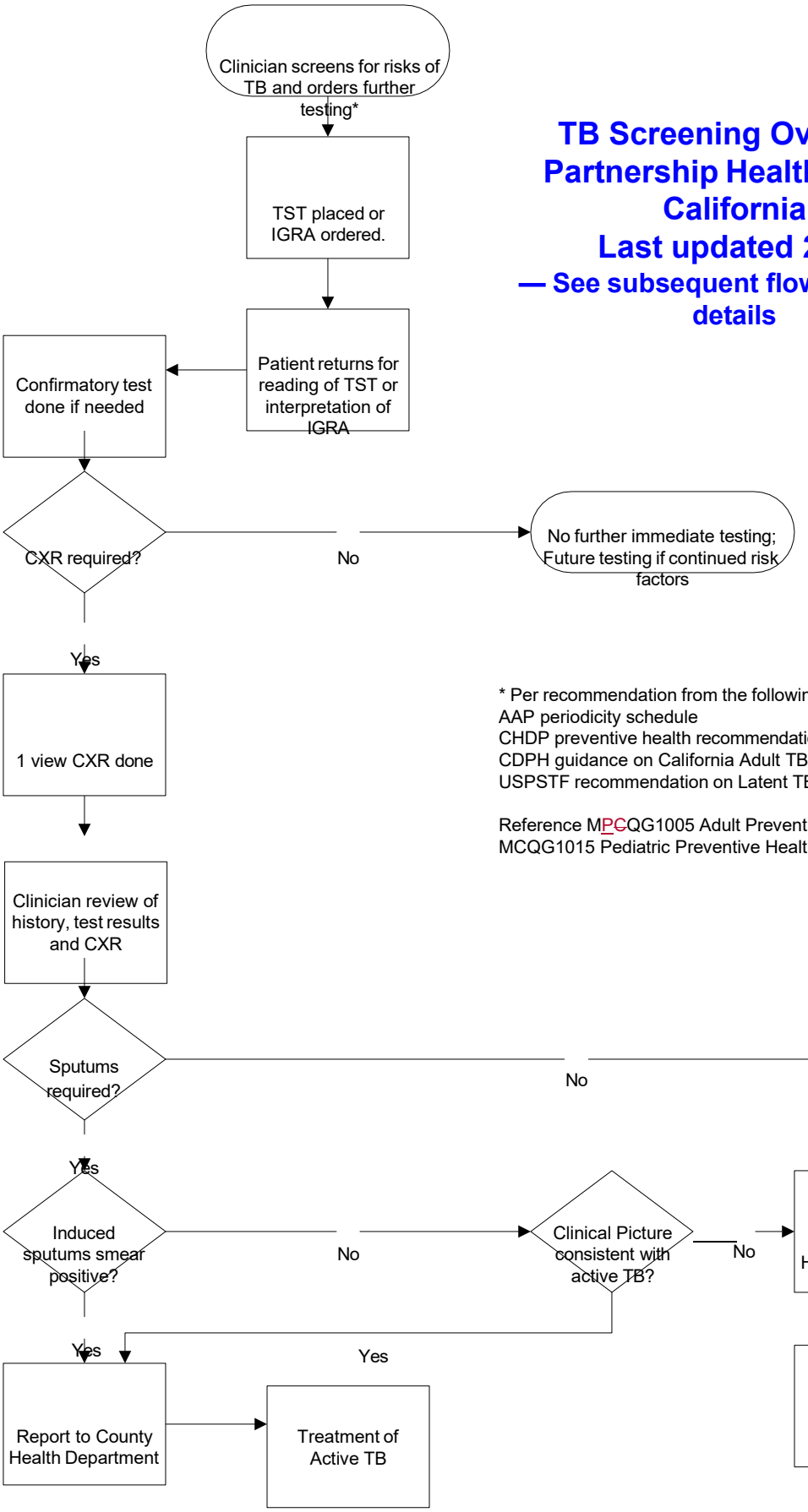
Distribution: Partnership Provider Manual, Department Heads

TB Screening Guidelines
Partnership HealthPlan of California
Last updated:2024



TB Screening Overview Partnership HealthPlan of California Last updated 2024

— See subsequent flow charts for details



* Per recommendation from the following agencies:
AAP periodicity schedule
CHDP preventive health recommendations
CDPH guidance on California Adult TB Risk Assessment
USPSTF recommendation on Latent TB infection screening

Reference MPCQG1005 Adult Preventive Health Guidelines and MCQG1015 Pediatric Preventive Health Guidelines

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

GUIDELINE / PROCEDURE

Guideline/Procedure Number: MPUG3019 (previously MCUG3019, UG100319)			**Lead Department: Health Services** Business Unit: Utilization Management	
Guideline/Procedure Title: Hearing Aid Guidelines			☒ **External Policy** ☐ **Internal Policy**	
Original Date: 01/19/1995		**Next Review Date:** ~~03/12/2026~~04/08/2027 **Last Review Date:** ~~03/12/2025~~04/08/2026		
Applies to:	☒ **Medi-Cal**	☐ **Employees**	☒ **Partnership Advantage**	
Reviewing Entities:	☒ **IQI**	☐ **P & T**	☒ **QUAC**	
	☐ **OPERATIONS**	☐ **EXECUTIVE**	☐ **COMPLIANCE**	☐ **DEPARTMENT**
Approving Entities:	☐ **BOARD**	☐ **COMPLIANCE**	☐ **FINANCE**	☒ **PAC**
	☐ **CEO** ☐ **COO**	☐ **CREDENTIAL~~SING~~**	☐ **DEPT. DIRECTOR/OFFICER**	
Approval Signature: *Robert Moore, MD, MPH, MBA*		**Approval Date:** ~~03/12/2025~~04/08/2026		

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

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

III. DEFINITIONS:
A. ASHA: American Speech-Language-Hearing Association
B. Medically necessary: 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. Partnership Advantage: Effective January 1, 2027, ~~-~~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~~ Enrollees will be qualified to receive both Medi-Cal and Medicare services as described in the Partnership Advantage Member Handbook.

IV. ATTACHMENTS:
A. Documentation for Authorization of Hearing Aids

V. PURPOSE:
To describe the process by which Partnership HealthPlan of California authorizes medically necessary hearing aids for Partnership-eligible Members or Partnership Advantage Enrollees.

VI. GUIDELINE / PROCEDURE:
A. General Hearing Aid Guidelines
~~1.~~ A Treatment Authorization Request (TAR) is required (see policy MCUP3041 TAR Review Process.)
~~2.~~1. ~~Routine authorization will be for one hearing aid only.~~

~~3.~~2. Hearing aids are a covered benefit of Partnership when supplied by a hearing aid dispenser with a prescription from an otolaryngologist or, for Members age 17 and older, the Member's primary care provider (PCP) (in consultation with the evaluating otolaryngologist if possible), when no otolaryngologist is available in the community.

a. An audiological evaluation, including a hearing aid evaluation, must be performed by, or under the supervision of, the above provider or by a licensed audiologist.

b. If pure conductive hearing loss or any concerning symptoms or "red flags" (e.g., visible deformity; evidence of fluid, pus, or blood; sudden or fluctuating hearing loss; feeling of canal blockage; pain) are observed during the audiological evaluation, a complete ear, nose, and throat examination by an otolaryngologist or the Member's PCP is required. The patient should be evaluated by a licensed healthcare provider that specializes in ear disease (i.e., otologist, otolaryngologist) prior to proceeding with the hearing aid evaluation.

c. Hearing loss criteria considered during the authorization review process is specified in VI.A.4 and 5. below.

~~4.~~3. Medi-Cal recipients younger than 21 years of age must be referred to California Children's Services (CCS) for determination of eligibility for CCS hearing services. (Reference CCS Numbered Letters noted in sections VII.I. – M. of this policy.) For children younger than 17 years of age, the prescribing physician must be an otolaryngologist.

~~5.~~4. Generally, authorization for hearing aids may be granted only when:

a. ~~Tests of the better ear,~~ Aafter treatment of any condition contributing to the hearing loss, an audiogram reveals an average hearing loss level of 2~~6~~5 dB or greater, American National Standards Institute (ANSI), 1969, for 500, 1000, 2000, and 4000 Hertz (Hz) by pure tone air conduction, or

b. Speech communication is effectively improved or auditory contact is necessary for sound awareness (personal safety) in the environment in which the recipient exists.

c. Specialized hearing aids for Members with an unusual pattern of hearing loss must be authorized for medical necessity as a CCS-eligible condition for children under age 21 or by the Chief Medical Officer (CMO) or physician designee for adults. Digital hearing aids may be authorized if the Treatment Authorization Request (TAR) is submitted with a standard code (V5050 or V5060). Aids requested with an unlisted code require approval by the CMO/~~Chief Medical Officer or P~~physician designee.

~~e.~~d. InterQual® criteria for *Durable Medical Equipment: Hearing Aids* will be used to approve hearing aids.

~~6. Binaural hearing aids may be authorized under the following conditions:~~

~~a. For Medi-Cal recipients 20 years of age or under, under either of the following conditions:~~

~~1) Tests of each ear reveal a hearing loss level of 25 dB or greater, ANSI, 1969, for 500, 1000, 2000, and 4000 Hz by pure tone air conduction.~~

~~2) The hearing loss is associated with legal blindness~~

~~b. For Medi-Cal recipients 21 years of age or over:~~

~~1) Tests of each ear reveal a hearing loss level of 25 dB or greater, ANSI, 1969, for 500, 1000, 2000, and 4000 Hz by pure tone air conduction and~~

~~a) The hearing loss is associated with legal blindness~~

~~b) There is documentation that binaural aids are medically necessary for the safety of the Member, or~~

~~7.~~5. Documentation for hearing aid requests shall be presented to Partnership in a format acceptable per Title 22 CCR Section 51319(e). Providers must submit documentation containing the following information:

a. For the purchase of new hearing aids: ~~Attachment A, a~~ A signed prescription from an

otolaryngologist or from the Member's PCP submitted with the following:

1) Appropriately signed and completed ear, nose, and throat examination
2) Appropriately signed and completed audiological evaluation including a hearing aid evaluation performed by or under the supervision of the above physician or by a licensed audiologist. This examination report must include the results of the following tests:
   a) Pure tone air conduction threshold and bone conduction tests of each ear at 500, 1,000, 2,000, 3,000 and 4,000 Hz with effective masking as indicated.
   b) Speech tests, aided and unaided, shall include the following:
      i. Speech Reception Threshold (SRT) using Spondee words.
      ii. A Word Discrimination Score (WDS) derived from testing at 40 dB above the SRT or at the Most Comfortable Loudness (MCL) using standard discrimination word lists (such as PB or W22) utilizing either recorded or live voice.
      iii. Sound Field Aided and Unaided Speech Scores (SRT or WDS) shall be established.
      iv. For the non-English speaking client, the provider must submit a description of alternative testing and the results of such testing.
      v. The ear to be fitted must be specified.

b. For the replacement of lost, stolen, or irreparably damaged hearing aids, the following is required:
   1) A statement describing the circumstances of the loss, theft, or destruction of the hearing aid, signed by the recipient and the otolaryngologist or the PCP.
   2) A completed audiometric report dated within the last 12 months is required unless the request is for the replacement of a recently purchased hearing aid within the last three months. [
c. For the replacement of a hearing aid that no longer meets the needs of the recipient whose hearing impairment requires amplification or correction not within the capabilities of the recipient's present hearing aid, the provider must submit documentation consistent with that required for the purchase of new hearing aids as detailed above.
d. For hearing aid repairs that exceed the cost of $50.00 per repair service, the provider shall submit all of the following:
   1) Description of the problem requiring repair.
   2) Hearing aid manufacturer's name, unit, model designation, date of purchase, and serial number.
   3) Ear to which the aid is fitted.

8. An authorization for a hearing aid takes into account the needs of individual Member and the characteristics of the local delivery system.
9. Partnership may consult an independent otolaryngologist on an as-needed basis to assist with the review of a hearing aid request for a Member.

B. External Hearing Aids

1. Total hearing aid cost is limited to $1510.00 per fiscal year (July 1 through June 30 of the following year) per Member, including sales tax as per Welfare and Institutions Code Section 14131.05. The following are excluded from the $1510 maximum benefit cap:
   a. Pregnancy-related benefits and benefits for the treatment of other conditions that might complicate the pregnancy.
   b. Recipients under the Early and Periodic Screening Diagnosis and Treatment Program.
   c. Recipients who are receiving long-term care in a licensed skilled nursing facility or intermediate care facility (NF-A and NF-B). Recipients who are receiving long-term care in a licensed intermediate care facility for the developmentally disabled (ICF/DD), including ICF/DD Habilitative and ICF/DD Nursing.

d. Recipients in the Program for All-Inclusive Care for the Elderly (PACE).
e. Replacement of hearing aids that are lost, stolen or irreparably damaged due to circumstance beyond the recipient's control.

2. Prior authorization is required for ~~the~~ a 30-day trial period of a hearing aid and for hearing aid repairs which exceed a cost of $50.00 per item (an item is defined as all related components of a given device) or service repair. Hearing aid cords, receivers, ear molds, and hearing aid garments do not require prior authorization.
3. Binaural external hearing aids must be authorized and billed using the appropriate Healthcare Common Procedure Coding System (HCPCS) codes (V5120 – V5150) and a quantity of "1" not "2". V5298 quantity 1 = 1 set hearing aids
4. All external hearing aids shall be guaranteed for at least one year exclusive of ear piece, cord and batteries. The guarantee is to cover the repair or replacement of any or all defective parts and labor on a new hearing aid (out-of-guarantee repairs are to have a minimum guarantee of at least six months). A separate charge is payable for postage and handling during the guarantee period.
5. Hearing aid maximum allowances are for new instruments and include up to six post-sale visits for training, adjustments and fitting, a cord, receiver, and other components normally required to use the instrument. An additional allowance is included for one standard package of batteries.
6. Hearing aid replacement may be authorized only if:
   a. The prior hearing aid has been lost, stolen, or irreparably damaged due to circumstances beyond the recipient's control.
   b. The hearing impairment of the recipient requires amplification or correction not within the capabilities of the recipient's present hearing aid. The new aid shall be prescribed and authorized in accordance with the above guidelines described for the purchase of a new hearing aid.
7. Initial hearing aid batteries supplied with the hearing aid are covered by Partnership when supplied with a hearing aid that has been prior authorized. Replacement batteries are not covered under Partnership except for children under age 21 as noted below.
   a. Under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program, per Title 22 CCR Section 51340.1(c)(2), children under the age of 21 years may receive one package of batteries, size 675, 13, 312, or 10A, on a quarterly basis without prior authorization. Batteries in sizes other than those listed, and hearing aid batteries provided at more frequent intervals, may be obtained with prior authorization.
8. Contralateral Routing of Signals (CROS)-type hearing aids may be approved for Members who require binaural hearing, but one ear has a sensorineural hearing loss that cannot be corrected by normal hearing aid amplification.
~~8.~~9. Bilateral Contralateral Routing of Signals (BiCROS) hearing aids may be approved for Members with bilateral hearing loss where the hearing in one ear can be corrected by amplification, but the other ear is not able to be corrected by hearing aid amplification.

C. Cochlear Implants
1. Cochlear implant candidates must meet all of the following criteria:
   a. Diagnosis of bilateral sensorineural deafness, established by audiologic and medical evaluation
   b. If recipient is a child, age appropriateness, as per current Food and Drug Administration (FDA) recommendations, up to age 20
   c. Post-lingual deafness (if recipient is 21 years or older)
   d. For post-lingual candidates, a score of less than 30 percent on an open-set sentence recognition test (tape-recorded speech comprehension) as well as indications of cognitive ability to use auditory cues.
   e. An accessible cochlear lumen structurally suited to implantation, with no lesions in the auditory

nerve and acoustic areas of the central nervous system, as demonstrated by a computerized tomography (CT) scan or other appropriate radiologic evaluation

f. No infection or other active disease of the middle ear
g. No contraindications to anesthesia/surgery
h. Cognitive ability to use auditory clues
i. Motivation of candidate, and/or commitment of family/care-giver(s), to undergo a program of prosthetic fitting, training and long-term rehabilitation
j. Realistic expectations of candidate, and/or family/caregiver(s), for post-implant educational/vocational rehabilitation, as appropriate
k. Reasonable anticipation by treating providers that cochlear implant will confer awareness of speech at conversational levels

2. Cochlear implant in the contralateral ear (that is, a second implant) is not a Medi-Cal benefit.
3. Batteries and accessories for cochlear implants require a TAR and may be supplied as noted below:
   a. L8615 Headset/headpiece for use with cochlear implant device, replacement. (Frequency Limit: May be supplied up to two times in a rolling 12-month period)
   b. L8616 Microphone for use with cochlear implant device, replacement. (Frequency Limit: May be supplied up to two times in a rolling 12-month period)
   c. L8617 Transmitting coil for use with cochlear implant device, replacement (Frequency Limit: May be supplied up to two times in a rolling 12-month period)
   d. L8618 Transmitter cable for use with cochlear implant or auditory osseointegrated device, replacement. (Frequency Limit: May be supplied up to eight times in a rolling 12-month period)
   e. L8619 Cochlear implant external speech processor and controller, integrated system, replacement. (Frequency Limit: 1 replacement every 5 years is covered)
   f. L8621 Zinc air replacement battery, disposable/single use battery for use with cochlear implant device and auditory osseointegrated sound processors, replacement. (Frequency Limit: Up to 900 batteries may be supplied in a rolling 12-month period)
   g. L8622 Alkaline battery for use with cochlear implant device, any size, replacement, each. (Frequency: Up to 900 batteries may be supplied in a rolling 12-month period)
   h. L8623 Lithium ion battery - rechargeable. For use with cochlear implant device speech processor, other than ear level, replacement, each. (Frequency: May be supplied up to four times in a rolling 12-month period)
   i. L8624 Lithium ion battery - rechargeable. For use with cochlear implant or auditory osseointegrated device speech processor, ear level, replacement, each. (Frequency: May be supplied up to four times for each device/side in a rolling 12-month period)
   j. L8625 External recharging system for battery for use with cochlear implant or auditory osseointegrated device, replacement only, each. Modifiers LT or RT are required when billing this code. (Frequency: May be supplied one time in a rolling 12-month period)
   k. L8627 Cochlear implant; external speech processor, component, replacement
   l. L8628 Cochlear implant; external controller component, replacement
   m. L8629 Transmitting coil and cable, integrated, for use with cochlear implant device, replacement
   n. L9900 Orthotic and prosthetic supply, accessory, and/or service component of another L Code. Specifically, cochlear implant accessories such as ear hooks, ear bands, harnesses and magnets. (Frequency: May be supplied up to three times in a rolling 12-month period)

D. Bone Anchored Hearing Aids
   1. Bone Anchored Hearing Aids (BAHA) may be covered for individuals with moderate to severe conductive or mixed hearing loss if there is a medical reason involving the external or middle ear

such that air conducted hearing aids and/or contralateral routing of signal (CROS) devices cannot be used.

2. Binaural BAHA may be considered for individuals who have moderate to severe conductive or mixed hearing loss in both ears if bone conduction thresholds are symmetrical and do not exceed 10 dB average difference at 0.5, 1, 2, and 3 kHz. Binaural hearing aid criteria as stated earlier in section VI.A.5 of this policy also applies.

3. BAHA Covered Conditions:
   a. Congenital or surgically induced middle ear malformation of the external or middle ear
   b. Otosclerosis in patients who cannot undergo stapedectomy
   c. Severe chronic otitis externa precluding use of air conducted hearing aids
   d. Chronic otitis media with drainage that precluding use of air conducted hearing aids
   e. Tumors of the external ear canal or tympanic cavity
   f. Other anatomic or medical condition that contraindicates use of an air conduction hearing aid
   g. Unilateral sensorineural hearing loss (single sided deafness) is a covered condition for CCS Members.
4. BAHA Coverage Exclusions:
   a. Children younger than 5 years of age
   b. Bilateral sensorineural hearing loss
   c. Pure tone average bone conduction threshold exceeds 65 dB at 0.5, 1, 2, and 3 kHz.
5. BAHA Replacement:
   a. Component is no longer functional and cannot be repaired.
   b. The replacement is not solely for better technology or improved aesthetics.
   c. It has been at least five years since implantation and the processor is not functional.
   d. The original processor was being used daily until it became non-functional.

VII. REFERENCES:

A. Medi-Cal Provider Manual/ Guidelines: Audiological Services (*audio*); Hearing Aids (*hear aid*)
B. Title 22 California Code of Regulations (CCR) Section 51014 *Vocational Rehabilitation Services*
C. Title 22 California Code of Regulations (CCR) Section 51319(e) *Hearing Aids (test results format)*
D. Title 22 California Code of Regulations (CCR) Section 51340.1~~(b)(2)~~(c) *Requirements Applicable to EPSDT Supplemental Services (Hearing Services)*
E. Welfare and Institutions Code (W&I Code), Section 14131.05 *The Medi-Cal Benefits Program*
F. Clark, J. G. (1981). Uses and abuses of hearing loss classification. ASHA, 23, 493–500.
G. InterQual® criteria
H. Chandrasekhar, Sujana,S. MD and Kohan, Darius, MD. *Implantable Auditory Devices.* Otolaryngologic Clinics of North America Volume 52, Number 2 -April 2019.
I. California Children's Services (CCS) Numbered Letter (NL) 11-0807 Hearing Aid Supplies and Maintenance 08/30/2007
J. CCS NL 07-1011 Hearing Aids 10/17/2011
K. CCS NL 12-0818 Cochlear Implant Updated Candidacy Criteria and Authorization Procedure 08/24/2018
L. CCS NL 01-0616 Cochlear Implant Batteries and Parts 06/28/2016
M. CCS NL 12-1120 Bone Conduction Hearing Devices 11/19/2020
N. U.S. Food and Drug Administration (FDA) recommendations for Cochlear Implants
O. Medicare National Coverage Determinations (NCD) Manual 100-03: Chapter 1, Part 1, Section 50.3 Cochlear Implantation

Guideline/Procedure Number: MPUG3019 (previously MCUG3019, UG100319)			**Lead Department: Health Services** **Business Unit: Utilization Management**
Guideline/Procedure Title: Hearing Aid Guidelines			☒**External Policy** ☐**Internal Policy**
Original Date: 01/19/1995		**Next Review Date: ~~03/12/2026~~04/08/2027** **Last Review Date: ~~03/12/2025~~04/08/2026**	
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

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

X. REVISION DATES: 09/07/95; 03/08/00; 11/28/01 vs. 11/21; 10/16/02; 04/21/04; 02/16/05; 08/16/06; 08/20/08; 01/18/12; 08/20/14; 01/20/16; 04/20/16; 08/17/16; 08/16/17; *09/12/18; 03/13/19; 02/12/20; 02/10/21; 03/09/22; 03/08/23; 03/13/24; **MPUG** 03/12/25; 04/08/26

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

PREVIOUSLY APPLIED TO: N/A

****

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

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

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

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

DOCUMENTATION FOR AUTHORIZATION OF HEARING AIDS
To be filled out by a licensed clinician and submitted with the TAR

1. Name of Patient: _____ Medi-Cal ID#: _____
2. Age_____ Sex: _____ DOB: _____ Examination Date: _____
3. Diagnosis (Otological):_____ Place of Exam: _____
4. Hearing loss: AS _____ AD _____ Onset _____
5. Has the patient ever worn a hearing aid? YES ____ NO _____
   If Yes, Patient has worn a hearing aid for _____ years on the _____ ear.
6. If the request is to replace a current hearing aid, please clarify why a new hearing aid is needed at this time:

   _____

   _____

   _____

   _____
7. The patient has had a complete examination of the ear, nose and throat by me and the patient has the requisite psychological and physical well-being to successfully wear and care for a hearing aid. YES ____ NO ____
8. The audiological evaluation was performed by me _____, or by a licensed audiologist _____under my personal supervision.
9. SIGNATURE: _____ MD/ DO/ NP/ PA

   Name: _____

   Address: _____

   City/State/Zip: _____

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA
GUIDELINE / PROCEDURE

Guideline/Procedure Number: MCUG3024 (previously UG100324)			**Lead Department: Health Services** **Business Unit:** Utilization Management	
Guideline/Procedure Title: Inpatient Utilization Management			☒ **External Policy** ☐ **Internal Policy**	
Original Date: 04/25/1994		**Next Review Date:** ~~09/10/2026~~04/08/2027 **Last Review Date:** ~~09/10/2025~~04/08/2026		
Applies to:	☒ **Medi-Cal**		☐ **Employees**	
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:** ~~09/10/2025~~04/08/2026	

I. RELATED POLICIES
A. MCUP3037 - Appeals of Utilization Management/Pharmacy Decisions
B. MCUP3041 - Treatment Authorization Request (TAR) Review Process
C. MPUP3139 - Criteria and Guidelines for Utilization Management
D. MCUP3124 - Referral to Specialists (RAF) Policy
E. MCUG3058 - Utilization Review Guidelines ICF/DD, ICF/DD-H, ICF/DD-N Facilities
F. MCUG3038 - Review Guidelines for Member Placement in Extended Care (Custodial/Long Term Care, Skilled or Subacute)~~(LTC)~~ Facilities
~~F.~~G. MPUP3018 - Health Services Review of Observation Code Billing
~~G.~~H. MP~~C~~AP7003 - CalAIM Community Supports (CS)
~~H.~~I. MPUP3078 - Second Medical Opinion
~~I.~~J. MPUP3138 - External Independent Medical Review
~~J.~~K. MPUD3001 - Utilization Management Program Description
~~K.~~L. MPBP8003 - Mental Health Services
~~L.~~M. MCUP3141 - Delegation of Inpatient Utilization Management
~~M.~~N. CMP36 - Delegation Oversight and Monitoring

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

III. DEFINITIONS:
A. Acute inpatient administrative days are days approved at an acute inpatient facility, which provides a higher level of medical care than currently needed by the Member, or when a Member is awaiting placement in a transitional care setting, such as a Skilled Nursing Facility (SNF), Subacute Facility, or Intermediate Care Facility (ICF).
B. Acute inpatient care is defined as that care provided to persons sufficiently ill or disabled who require the following:
1. Constant availability of medical supervision by the attending physician or other professional medical staff
2. Constant availability of licensed professional nursing personnel
3. The availability of other diagnostic or therapeutic services and equipment which are ordinarily immediately available only in a hospital setting to ensure proper medical management

C. Elective as a guideline for admission is defined as planned treatment that can be delayed without risk to permanent health. Also known as a scheduled admission.

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

E. Inpatient admission locations include:
   1. Acute Hospitals: These hospitals treat patients with severe or brief illnesses, injuries, or during recovery from surgery. They often have specialized units like ICUs, trauma centers, and emergency departments.
   2. Acute Rehabilitation Centers (ARUs): Inpatient facilities that provide~~s~~ intensive rehabilitation services to individuals who need to regain maximum independent function after a physical or cognitive impairment. These centers focus on restoring mobility, self-care, and independent living skills, enabling patients to return home or transition to a lower level of care.
   3. Long Term Acute Care (LTAC) Facility: A type of ~~hospital~~ healthcare setting or facility that provides extended, intensive medical care for patients with serious, complex conditions who require ongoing treatment and monitoring with a longer recovery period than typically provided in a traditional acute care hospital. ~~These facilities are designed for patients who no longer require the intensive diagnostic procedures of a traditional hospital but still need acute inpatient level of care.~~
   4. Subacute Care Facilities: Facilities with a level of care that is less intensive than acute care, but more intensive than skilled nursing care (e.g. Members who require ventilators at stable settings, tracheostomies, total parenteral nutrition, tube feeding, complex wound management care, etc.).
   5. Skilled Nursing Facility (SNFs): A ~~special~~ facility or part of a hospital that provides short-term medically necessary skilled services provided by nurses, therapists, and/or physicians.
   6. Hospice Facility: A licensed facility providing care for terminally ill individuals 24 hours per day, 7 days per week, that is focused on comfort and symptom management rather than curative treatment. Medi-Cal hospice providers must be Medicare-certified and enrolled with Medi-Cal.

F. 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.

G. Urgent as a guideline for admission is defined as:
   1. Patient requires immediate attention for the care and treatment of a physical disorder. An unscheduled admission.
   2. Medical situations that require prompt medical attention, but do not endanger the patient's life or risk permanent health if care is not obtained in a reasonable period of time.
   3. The immediate treatment of a medical condition that requires prompt medical attention, but where a reasonable lapse of time before medical care is obtained would not endanger life or cause significant impairment.
   4. A non-emergency admission that is neither life threatening nor elective, but requires immediate attention for optimal outcome.

H. Utilization Management (UM) is the process of reviewing medical services prior to and during confinement to evaluate the following:
   1. Medical necessity - meaning reasonable and necessary service to protect life, prevent significant illness or disability or alleviate severe pain through the diagnosis or treatment of disease, illness or injury
   2. Ongoing review of patient response to treatment
   3. Appropriate level of care

4. Therapeutic decisions to determine if more effective, efficient avenues are available.
5. Use of Partnership HealthPlan of California (Partnership) contracted providers and facilities

IV. ATTACHMENTS:

A. ~~Provider Dispute Resolution (PDR)~~ Request for Reconsideration of Inpatient UM Determination (RRIU): Post Discharge Review for Inpatient ~~Admission~~Services

V. PURPOSE:

To provide guidelines for the Partnership HealthPlan of California's inpatient utilization management activities. These activities are performed by the Utilization Management Department under the direction of the Chief Medical Officer (CMO) or Physician Designee.

VI. GUIDELINE / PROCEDURE:

A. The Objectives of the Utilization Management Program are as follows:
   1. Reduce unnecessary or inappropriate admissions
   2. Ensure that services are provided in the appropriate setting or manner required for the patient's medical condition - the right care at the right time, in the right setting
   3. Reduce medically unnecessary inpatient days
   4. Identify and report potential quality of care issues
   5. Evaluate the anticipated course of treatment and length of stay for appropriateness and efficiency
   6. Integrate second opinion guidelines when appropriate
   7. Ensure participating providers who are contracted with Partnership are appropriately utilized
   8. Collaborate with facility staff and Member's physician to address, plan, and coordinate needs of the patient prior to discharge, including identification of cases appropriate for referral to an appropriate case management program. The Nurse Coordinator utilizes the historical information provided by the facility in the decision making process as well as InterQual® which is the department's evidenced-based practice tool. Some of the information utilized includes but is not limited to:
      a. Age
      b. Comorbidities
      c. Complications
      d. Progress of treatment
      e. Psychosocial situations
      f. Home environment, when applicable

B. CRITERIA
   1. Acute inpatient cases are reviewed according to guidelines set forth by the California Department of Health Care Services (DHCS), the Centers for Medicare & Medicaid Services (CMS), clinical guidelines such as InterQual® and National Comprehensive Cancer Network (NCCN) and other broadly accepted standards of care. Please see policy MPUP3139 Criteria and Guidelines for Utilization Management for further information.
   2. If a request is received for review of services that varies from such guidelines, or for which review criteria have not been developed, the CMO/Physician Designee will use clinical judgment and discussion using a specialty matched board certified specialist as necessary to make a determination based on medical appropriateness.
      a. Utilization management staff will provide the InterQual® information, as well as a patient summary developed from the facility's discharge planning or UM staff (including the applicable policies), for the Medical Director to reference.
      b. Information from the attending physician will also be considered. The attending physician can be the primary care physician, hospitalist, or the specialist physician (or all three as necessary).

3. The needs of individual patients and the characteristics of the local delivery system are taken into account when determining the medical necessity of an inpatient hospitalization.

C. URGENT AND NEWBORN ADMISSION AUTHORIZATION PROCESS

1. Urgent or Emergency Admission
   a. In the case of an urgent or emergent admission, the hospital is required to notify the Health Services Department within 1 business day of the admission.
   b. All declared emergency admissions will be followed by a Nurse Coordinator who will perform the initial review within 72 hours of notification to Partnership. The Nurse Coordinator will then follow concurrent review procedures.
   c. Refer to III.G. and III.D. above for definitions of urgent and emergency.
2. Newborn Admissions
   a. All initial inpatient newborn care is automatically authorized if care rendered to the mother is approved. The neonate is assigned the same number as the mother if the mother and baby are discharged on the same day. If mother is discharged and the infant remains in the hospital, a new authorization number will be assigned for the baby.
   b. If the newborn is admitted to the intensive care nursery, an authorization number must be assigned at the time of admission to NICU and the appropriate capitated provider, if applicable, notified.

D. ELECTIVE/SCHEDULED ADMISSION AUTHORIZATION PROCESS

1. This type of review requires justification of medical necessity before a patient can be admitted to an acute care facility. It is a process to assure that elective or non-emergency hospitalization is medically necessary and arranged in the appropriate facility. Authorization is required for all elective/scheduled admissions as follows:
   a. Prior authorization should be obtained by the admitting physician as soon as possible but not less than five (5) to ten (10) days prior to the planned admission.
   b. Preadmission authorization is the process in which the Nurse Coordinator evaluates a request for an elective admission to a health care facility. The procedure involves the admitting physician furnishing the pertinent information such as diagnosis, age, indication for admission, and any planned surgical procedure. For elective surgeries in which a post-operative admission directly to an acute inpatient rehabilitation facility is recommended instead of an initial inpatient stay, the prior authorization should be submitted prior to surgery to ensure timely placement.
   c. If a specialist is planning to admit the Member, a Referral Authorization from the Primary Care Physician is required. (see policy MCUG3102~~0~~24 Referral to Specialists (RAF) Policy)
   d. Preadmission testing will be performed prior to elective admissions.
   e. Early morning admission on the day of a proposed surgical procedure should be utilized. If the patient's problem precludes such utilization, the admitting physician must document the need for a preoperative review and a determination of medical necessity and appropriateness will be included in the prior authorization of the proposed admission. Using established criteria, most confinements can be pre-approved by the Nurse Coordinator. If a less expensive but equally effective care alternative is available and the patient's condition permits, Partnership's CMO/Physician Designee will approve treatment at that level of care. If medical necessity is not clear, the request will be escalated to the CMO/Physician Designee for review.
   f. It is the admitting facility's responsibility to verify (prior to admission) that the required prior authorization has been completed and approved. The admitting facility is required to notify Partnership of the actual admission within one business day of the admission, even though the admission has been pre-approved. (In the event that a prior-authorization request is not submitted for an elective procedure, a review for medical necessity is still performed.)
   g. The purpose of this process is to arrive at the most cost efficient manner for Partnership HealthPlan's patients to obtain quality care as well as screen patients for medical necessity and appropriateness of admission to an acute care facility.

h. Refer to III.C. above for definition of elective.

E. CONTINUED STAY REVIEW/CONCURRENT REVIEW AUTHORIZATION PROCESS

1. Concurrent review is the process of review for the assessment of ongoing medical necessity and appropriateness of continued hospitalization in an inpatient facility. All hospital admissions are subject to the concurrent review process.
2. All patients in acute or subacute facilities are reviewed concurrently, either telephonically, electronically, or via faxed reviews, for appropriateness of care and use of hospital services in an effort to assure cost efficient delivery of care as well as medical necessity and quality of care.
3. Objectives of Concurrent Review
   a. Evaluate medical necessity
   b. Monitor and ensure the efficient us of health care services
   c. Determine if the hospital setting is consistent with care being rendered
   d. To evaluate the course of treatment and length of stay
   e. To identify and report any potential quality of care issues
   f. To reduce length of stay by proactively working with hospital discharge planners and Case Managers to facilitate timely discharge planning and needed follow up
   g. Identify cases requiring CCMO/Physician Designee review and/or intervention
4. CMO/Physician Designee referrals include but are not limited to cases:
   a. Which appear to fail to meet criteria
   b. For which medical information provided is insufficient to make a decision
   c. For which a level of care determination may be required
   d. For which physician to physician consultation is deemed necessary, e.g., procedures that may not be considered standard medical practice, questionable procedures/treatment
5. Continued Stay/Concurrent Review Process
   a. Partnership maintains electronic records on all hospital admissions and monitors the Member's care throughout the length of stay using established criteria as defined in Section VI. B, the Nurse Coordinator determines the medical necessity and appropriateness of continued hospitalization.
   b. Partnership will render a decision (approve, modify, defer/pend, deny) within 72 hours of receipt of notification of admission. The Nurse Coordinator will continue to concurrently review the authorization within ~~24~~ 72 hours of receipt each time clinical information is received throughout the remainder of the stay.
   c. If continued hospitalization meets InterQual criteria, the next/frequency of review is determined by the Member's acuity level, individual circumstances, and InterQual criteria.
   d. If the stay does not meet the criteria due to lack of documentation/information, further information from the nursing staff/appropriate departments/personnel may be requested.
   e. If, after all available information has been reviewed, and the stay does not appear to meet criteria, the authorization is escalated by the Nurse Coordinator to the CMO/Physician Designee for review of medical necessity.
   f. The CMO/Physician Designee reviews the medical record documentation and makes the decision to approve or deny continued hospitalization within 24 hours (1 calendar day).
   g. If the CMO/Physician Designee approves continued stay, the Nurse Coordinator will continue the concurrent review process.
   h. The CMO/Physician Designee may contact the attending physician to discuss the case. The result of the review is documented on the appropriate review form and includes the rationale for the decision.
   i. If the CMO/Physician Designee determines the stay is not medically necessary, the provider is notified verbally, via the telephone, that the ~~patient's~~ facility stay is ~~not approved and the Nurse Coordinator verbally notifies the facility that the stay is~~ denied, followed by electronic or written notice of denial within 24 hours from the verbal notification. The CMO/Physician Designee signs the denial letter.

j. Attending clinicians of inpatient facilities may request a Peer to Peer for a Member currently admitted to the facility or within 3 business days of discharge if the determination of the case in concurrent review by the CMO/Physician designee does not meet criteria for medical necessity for the level of care requested, and the stay is not approved.

k. After 3 business days after a member is discharged from the hospital, if a hospital has a disagreement with a denial of medical necessity for a hospital admission, or one or more inpatient days of an admission, the hospital should submit a- Request to Reconsider an Inpatient UM Determination~~provider dispute resolution request~~. Please see Attachment A for the information we require to consider.

F. INTER-FACILITY TRANSFERS OF MEMBERS

1. Partnership UM staff may facilitate the transfer of a Member from a non-contracted hospital to a contracted hospital. Criteria for consideration of transfer include:
   a. A benefit analysis of care offered for the patient.
   b. The Member is medically stable for transfer.
   c. There is a contracted facility available that can meet the Member's medical needs.
   d. The estimated length of stay at the receiving hospital is greater than three days.
   e. The attending physician at the transferring hospital is agreeable to the transfer and willing to sign the necessary documents.
   f. The attending physician and the hospital staff at the accepting hospital are willing to accept the Member in transfer.
   g. There is agreement of agencies responsible for authorizing services (e.g. California Children's Services [CCS] or the Genetically Handicapped Persons Program [GHPP]).
   h. The consent of the parent or authorized caregiver for children under the age of 21 hospitalized under the CCS program is required prior to the transfer.
   i. In each of the above situations, the utilization management forms and appropriate electronic record screens are documented as applicable.
2. Partnership may coordinate other inter-facility transfers of Members when deemed medically necessary.
3. For further discussion of services for Members capitated to contracted hospitals, please see policy MCUP3141 Delegation of Inpatient Utilization Management.

G. ACUTE INPATIENT ADMINISTRATIVE DAYS

1. A Partnership Member may be approved for acute inpatient administrative days when, after review of information from the attending physician and the medical record, it is the professional judgment of the Partnership CMO/physician designee that the Member's care no longer meets acute inpatient criteria, and medical and nursing care is required at a lower level of care, but placement is not available at the present time.
2. Inpatient acute facilities must provide documentation to demonstrate that active inquiries are being made to potential facilities for the appropriate level of care as determined by medical necessity. The Member's record must reflect the outreach efforts to achieve placement at a SNF, Subacute facility, Long Term Care Facility (LTC), Medical Respite, Acute Inpatient Rehabilitation, Subacute Rehabilitation or ICF.
3. For Members who require placement for continued management, the acute inpatient facility must initiate inquiries and contact with facilities that are appropriate for the Member's needs.
   a. The acute inpatient facility must continue placement efforts until placement occurs.
   b. The Member's record must reflect the outreach efforts to achieve placement. Once begun, a daily assessment of placement status is expected, summarized in progress notes no less frequently than every 3 calendar days.
   c. Partnership will review documentation of placement efforts on a regular basis for ongoing approval of acute inpatient administrative days.
   ~~c.~~d. If a member meets the criteria for acute inpatient administrative days (as defined in this section), but no placement is achieved and the patient ends up being discharged to a non-covered setting (e.g.

home, congregate~~ive~~ living, homeless shelter), administrative days can still be assigned for those days that met criteria while outreach efforts were being made.

4. For Members with a terminal illness, administrative days may be considered while the facility finalizes an appropriate discharge disposition (SNF with hospice, home with hospice) for a patient with a terminal illness who, when admitted, met acute inpatient criteria, and the records show that the goals of care for the Member have transitioned to comfort care measures.

~~4.~~5. If the Member is pending placement at a level of care that is not Partnership's responsibility, acute inpatient administrative days do not apply. Examples include, but are not limited to, Members who are the responsibility of the criminal justice system or being discharged home or to a board and care facility.

H. INPATIENT PSYCHIATRIC ADMISSIONS

1. For Partnership Medi-Cal Members: Specialty mental health services are not a Partnership covered benefit.
   a. Partnership Medi-Cal Members determined to have moderate to severe mental health conditions which require specialty mental health services are referred to the County Behavioral Health Plan in the Member's county of residence. The administration of such referrals is addressed in the respective Memorandum of Understanding (MOU) with each County Mental Health Plan, consistent with California statutes and regulations.
   b. Acute inpatient administrative days do not apply when the Partnership Medi-Cal Member is pending evaluation on a psychiatric hold or awaiting placement at a mental health facility. Specialty mental health services are not a Partnership responsibility.
2. For further information, see policy MPBP8003 Mental Health Services.

I. CASE REVIEW CONFERENCES

1. Case Review Conferences provide a forum to promote and ensure consistent application of criteria and decision-making between and among Nurse Coordinators and the CMO/Physician Designee. They are also used as an educational tool for research, discussion of unique and difficult cases, and pertinent, new treatment innovations and pharmaceuticals. The goal is to keep the staff up to date on current medical care.
2. Case Review Conferences occur weekly, at a minimum and often include facility care management staff (e.g. case managers, discharge planners).
3. The meetings are conducted in a private area, either an office or conference room. This serves to encourage frank discussion of cases while protecting and preserving patient confidentiality.
4. The meetings are conducted by the Director of UM or Designee, and attended by the Health Services Nurse Coordinator staff and Managers involved in the in-patient review process, appropriate Care Coordination staff and the CMO/Physician Designee.
5. Identified cases (e.g. patients with long lengths of stay, typically over seven (7) calendar days from the date of admission are discussed in detail by the team with a focus on creative, innovative solutions and remedies to move patients through the health care continuum in the most efficient manner.
6. Nurse Coordinators are expected to follow the review guidelines outlined in this policy.
7. The objectives of case conferences are to:
   a. Reduce unnecessary or inappropriate admissions and inpatient days.
   b. Ensure that services are provided in the appropriate setting or manner required for the patient's medical condition
   c. Improve the quality of care rendered
   d. Evaluate the anticipated course of treatment and length of stay
   e. Evaluate Members for transfer from non-contracted to contracted hospitals
   f. Ensure participating providers who are contracted with Partnership are appropriately utilized
   g. Address, plan, and coordinate needs of the patient upon discharge, including identification of cases appropriate to case management intervention

h. Ensure the provision of efficient, quality care and assist in assessing alternative treatments
i. Provide appropriate support and recommendations to the Inpatient UM Nurse Coordinators

J. PROCESS FOR A PROVIDER TO APPEAL AN ADVERSE BENEFIT DETERMINATION ON BEHALF OF A MEMBER
1. Refer to Partnership's policy MCUP3037 Appeals of Utilization Management/ Pharmacy Decisions.

K. POST-SERVICE OR RETROSPECTIVE REVIEW
Retrospective review applies the same process and criteria as continued stay/concurrent review, only AFTER the patient has been discharged.
1. Objective
Retrospective review is used to identify medically unnecessary admissions and bed days that have been incurred.
2. Process
a. For post-service/retrospective review, Partnership will render a decision (approve, modify, defer/pend, deny) no later than 30 calendar days from the receipt of the request.
b. When the clinical information is received, the acute care hospitalization is evaluated, day by day, to determine the appropriateness of admission and length of stay given the patient's clinical status and the course of treatment.
c. Identified problem areas are presented to the CMO/Physician Designee as with continued stay review/concurrent review.
d. Electronic or written notification of the decision and how to initiate a ~~routine or expedited appeal~~reconsideration or provider appeal ~~if applicable~~ is communicated to the provider within 24 hours of decision, but no later than 30 calendar days from the date of the receipt of the request. Written notification is mailed to the Member within two (2) business days of the decision.

L. COMMUNICATION SERVICES
1. Partnership provides access to staff for Members and practitioners seeking information about the UM process and the authorization of care as described in the Communication Services section of policy MPUD3001 Utilization Management Program Description~~MCUP3064 Communication Services~~.
2. Note that Partnership also has a dedicated after-hours local phone number (707) 430-4808 or toll free number (866) 828-2304 to receive calls from physicians and hospital staff for addressing post-stabilization care and inter-facility transfer needs 24 hours per day, 7 days per week. Calls are returned within 30 minutes of the time the call was received. Partnership's CMO/physician designee is on call 24 hours per day 7 days per week to authorize medically necessary post-stabilization care services and to respond to hospital inquiries within 30 minutes. Partnership clinical staff are available 24 hours per day 7 days per week to coordinate the transfer of a Member whose emergency medical condition is stabilized.

M. DELEGATION OVERSIGHT AND MONITORING
1. Partnership delegates UM functions to select contracted hospitals. Please see policy MCUP3141 Delegation of Inpatient Utilization Management.

VII. REFERENCES:

A. InterQual® criteria
B. Medi-Cal Provider Manual/ Guidelines
C. National Committee for Quality Assurance (NCQA) Guidelines ~~(Effective July 1, 2025) UM 5~~ for Timeliness of UM Decisions ~~Elements A and E~~
D. DHCS All Plan Letter (APL) 21-011 *Revised* Grievance and Appeals Requirements, Notice and "Your Rights" Templates (08/31/2022)

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

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

X. REVISION DATES:

03/23/95; 08/98; 06/21/00; 06/20/01; 09/18/02; 04/16/03; 05/21/03; 10/20/04; 02/16/05; 08/20/08; 11/18/09; 05/18/11; 05/20/15; 08/19/15; 05/18/16; 04/19/17; *08/08/18; 04/10/19; 04/08/20; 04/14/21; 06/09/21; 06/08/22; 08/09/23; 09/11/24; 09/10/25; 04/08/26

*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:
MCUP3053 Acute Inpatient Administrative Days (06/20/2001 – 09/10/2025)

****

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

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

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

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

REQUEST FOR RECONSIDERATION OF INPATIENT UM DETERMINATION (RRIU)
~~PROVIDER DISPUTE RESOLUTION (PDR) REQUEST~~
Post Discharge Review for Inpatient Services

INSTRUCTIONS

- Please complete the below form. Fields with an asterisk (*) are required.
- Be specific when completing the DESCRIPTION OF DISPUTE and NARRATIVE. Use additional pages if needed.
- Provide additional information to support the description of the dispute.
- Do not include a copy of a claim that was previously processed.
- Mail or Fax the completed form to: **Partnership HealthPlan of California**
  Attn: Utilization Management Department
  4665 Business Center Drive
  Fairfield, CA 94534
  Fax: (707) 863-4118

Has A Claim Been Submitted? ☐ **Y** ☐ **N** **If Yes, please submit a Provider Claims Dispute Resolution Request (Link)**
If No, please complete this form

***DISPUTE TYPE:**

☐ **~~PDR~~ RRIU to ~~appeal~~ Reconsider for Medical Necessity.** Please check this box if you received a Notice of Action ~~denial~~ letter from our Utilization Management (UM) Department and you would like to appeal the ~~denial for~~ medical necessity of the Level of Care authorization.

☐ Other _____

MEMBER INFORMATION:

***Member Name:**		***Date of Birth:**
***CIN/Mem ID Number:**	**Patient Account Number:**	***TAR Number:**
***Primary Reason for Admission:**		
Date ED Visit Began (If Admitted from ED):	**Observation Dates/Times** (If applicable):	***Date of Member Admission:**
Date of Primary Surgery (if applicable):	***Date of Discharge:**	***Patient Disposition Upon Discharge:**

PROVIDER INFORMATION:

***PROVIDER NPI:**	***PROVIDER TAX ID:**
***PROVIDER NAME:**	
***PROVIDER ADDRESS:**	
***PROVIDER TELEPHONE:**	***PROVIDER FAX:**

SUBMISSION INFORMATION:

***NAME OF PERSON SIGNING THIS ~~PDR~~ RRIU SUBMISSION:**	***TITLE**
***TELEPHONE:**	***FAX:**
***NAME OF ASSISTANT HELPING PREPARE THIS ~~PDR~~ RRIU SUBMISSION:**	***TITLE**
***TELEPHONE:**	***FAX:**

REQUEST FOR RECONSIDERATION OF INPATIENT UM DETERMINATION (RRIU) ~~PROVIDER DISPUTE RESOLUTION (PDR) REQUEST~~

Post Discharge Review for Inpatient Services

INSTRUCTIONS:
- Attach any supporting clinical documentation.
- Please only send clinical records that are pertinent for the DOS you are contesting.
- Provide a clear explanation as to why the denial decision should be overturned in the space provided below.

***DESCRIPTION OF DISPUTE**:
- List days on which Partnership denied inpatient status for not meeting criteria for inpatient admission (Note: The date of discharge does not count as a billable/paid date.)
- Of these days, which dates does hospital want to have re-evaluated?

~~Please list the name(s) and title(s) of the hospitalist(s) who rounded on the patient on the specified days~~

***NARRATIVE:**
- Summarize the reasons given by Partnership for lack of meeting criteria for inpatient coverage
- Please give a narrative of the ~~hospitalist's~~ description of circumstances that the reviewing Physician ~~they~~ feels justify acute inpatient level of care, for each day they wish to contest.

REQUEST FOR RECONSIDERATION OF INPATIENT UM DETERMINATION (RRIU) ~~PROVIDER DISPUTE RESOLUTION (PDR) REQUEST~~

Post Discharge Review for Inpatient Services

***ATTACHMENTS REQUIRED:**

Please attach, for this hospitalization:

- The Admission and Physical note
- The Discharge summary note
- The hospital progress notes (including notes from consultants and primary rounding hospitalist) and any other supporting evidence for the contested days of care

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Site Review Compliance Report-March 2026
Prepared By: Leah Imhoff, Program Manager I
Presented By: Rachel Newman, RN, Manager of Clinical Compliance
Reporting Period: 1/1/2025-12/31/2025

Overview

A Site Review (SR) is comprised of a Facility Site Review (FSR) and a Medical Records Review (MRR) using tools developed by the California Department of Health Care Services (DHCS) and Managed Care Plans collectively. Contracted sites are reviewed as a condition of participation in our provider network and are conducted for credentialing and re-credentialing purposes.

There are two components of a Site Review:

Facility Site Review (FSR)

This is an assessment of the facility's physical site including the building, accessibility, equipment, and policies/procedures for all contracted sites at the time of initial contracting and up to every three years thereafter. This assessment is conducted by a registered nurse, who is a DHCS-certified site reviewer. The site review tool is used to determine compliance with the standards set by DHCS. The FSR portion looks at areas ranging from Access and Safety to Infection Control If any of the six domains fall below 80%, a Corrective Action Plan is required for the entire review.

1. Access/Safety
2. Personnel
3. Office Management
4. Clinical Services
5. Preventative Services
6. Infection Control

Medical Record Review (MRR)

This is a review of randomly selected medical records of members assigned to a practice site. This type of review is conducted three to six months after an initial FSR has been completed and is repeated up to every three years thereafter. The DHCS approved tool and standards are used by the DHCS-certified site reviewer. The site can operate as usual during the review. An 80% overall score is required to pass. If any of the six domains fall below 80%, a Corrective Action Plan is required for the entire review.

1. Format
2. Documentation
3. Coordination of Care
4. Pediatric Preventive Care
5. Adult Preventive Care
6. OB/CPSP Preventive Care (if applicable)

Reviews are conducted in the following Regions

Eureka (Del Norte, Humboldt, Mendocino, Lake)
Redding (Siskiyou, Modoc, Trinity, Shasta, Lassen, Tehama)
Chico (Glenn, Butte, Yuba, Sutter, Colusa)
Fairfield (Napa, Solano, Yolo)
Auburn (Plumas, Sierra, Nevada, Placer)
Santa Rosa (Marin, Sonoma)

Site Review Compliance Report-March 2026
Prepared By: Leah Imhoff, Program Manager I
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Reporting Period: 1/1/2025-12/31/2025

2025 Average FSR Scores by Region and County						
	Access & Safety	Personnel	Office Management	Clinical Services	Preventive Services	Infection Control
Auburn	95%	90%	98%	98%	96%	98%
Nevada	95%	91%	97%	99%	97%	99%
Sierra	*	*	*	*	*	*
Placer	94%	86%	98%	97%	95%	96%
Plumas	97%	98%	100%	99%	95%	100%
Chico	98%	98%	99%	100%	97%	99%
Butte	98%	99%	98%	100%	98%	99%
Colusa	98%	96%	99%	99%	96%	100%
Glenn	96%	99%	99%	98%	100%	100%
Sutter	99%	99%	99%	100%	97%	99%
Yuba	99%	97%	100%	100%	97%	100%
Eureka	97%	94%	99%	99%	96%	99%
Del Norte	100%	100%	100%	100%	100%	100%
Humboldt	98%	93%	99%	99%	98%	100%
Lake	97%	93%	100%	100%	97%	100%
Mendocino	96%	95%	99%	98%	94%	99%
Fairfield	95%	91%	97%	96%	97%	97%
Napa	95%	92%	97%	97%	95%	97%
Solano	93%	94%	96%	95%	98%	97%
Yolo	97%	84%	99%	96%	98%	96%
Redding	98%	93%	99%	98%	98%	97%
Lassen	*	*	*	*	*	*
Modoc	87%	65%	100%	100%	92%	92%
Shasta	99%	92%	98%	97%	99%	97%
Siskiyou	97%	95%	100%	97%	97%	97%
Tehama	98%	99%	97%	98%	96%	94%
Trinity	100%	100%	100%	100%	96%	100%
Santa Rosa	98%	97%	98%	99%	97%	99%
Marin	98%	98%	98%	99%	96%	99%
Sonoma	98%	97%	98%	99%	97%	98%
Grand Total	97%	95%	98%	99%	97%	98%
*No reviews during the time period.						

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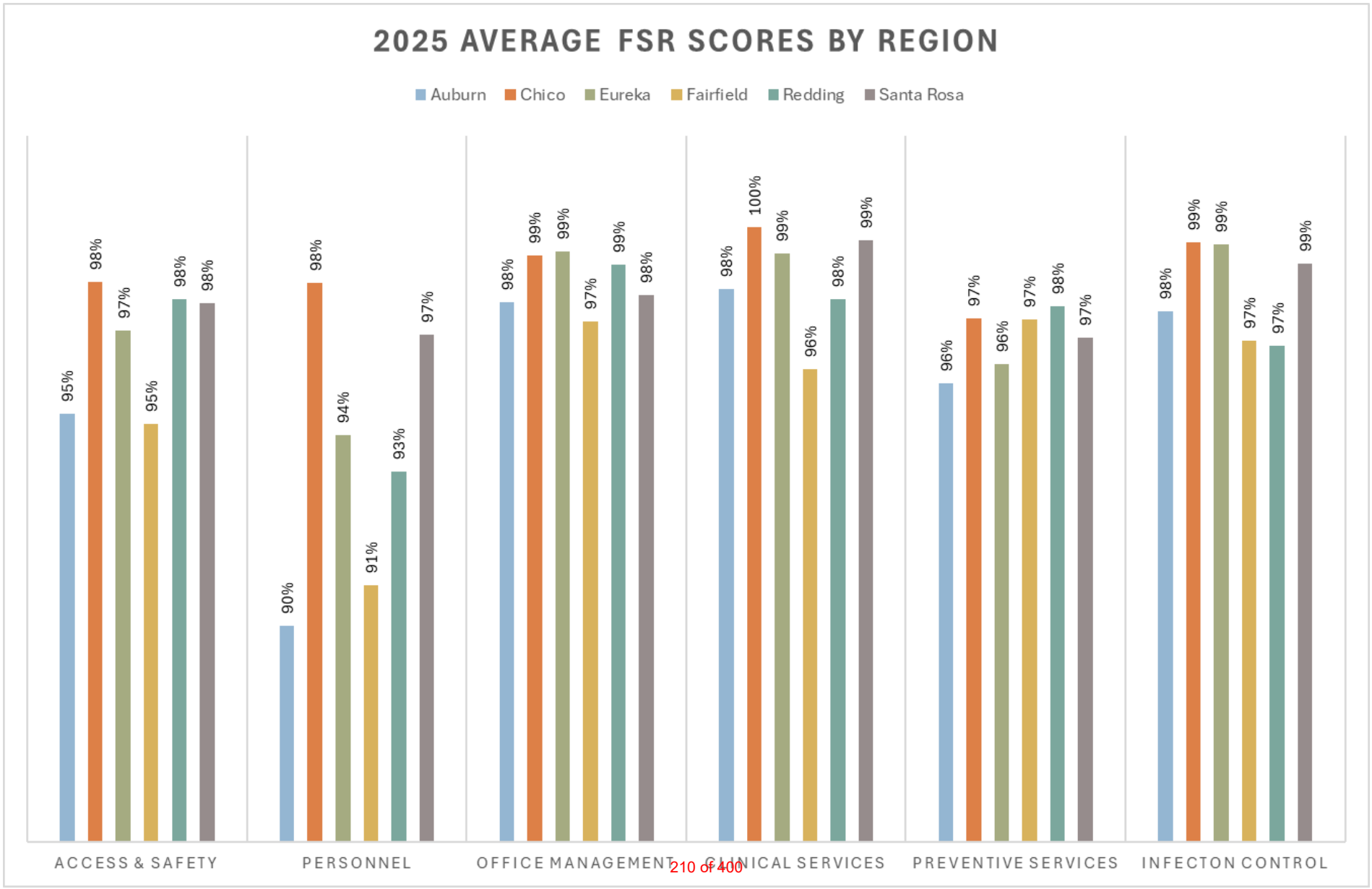

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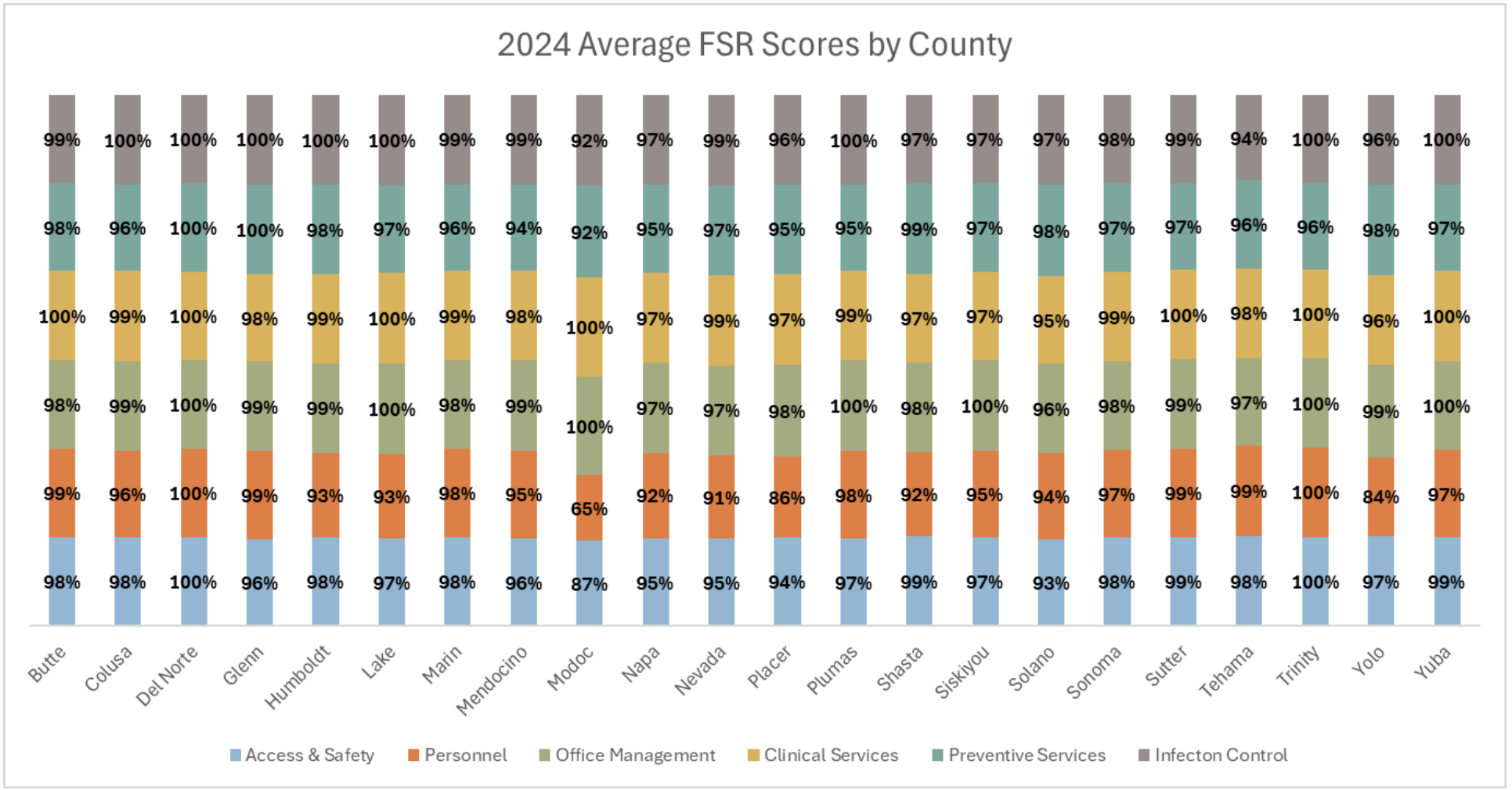

Site Review Compliance Report-March 2026
Prepared By: Leah Imhoff, Program Manager I
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Reporting Period: 1/1/2025-12/31/2025

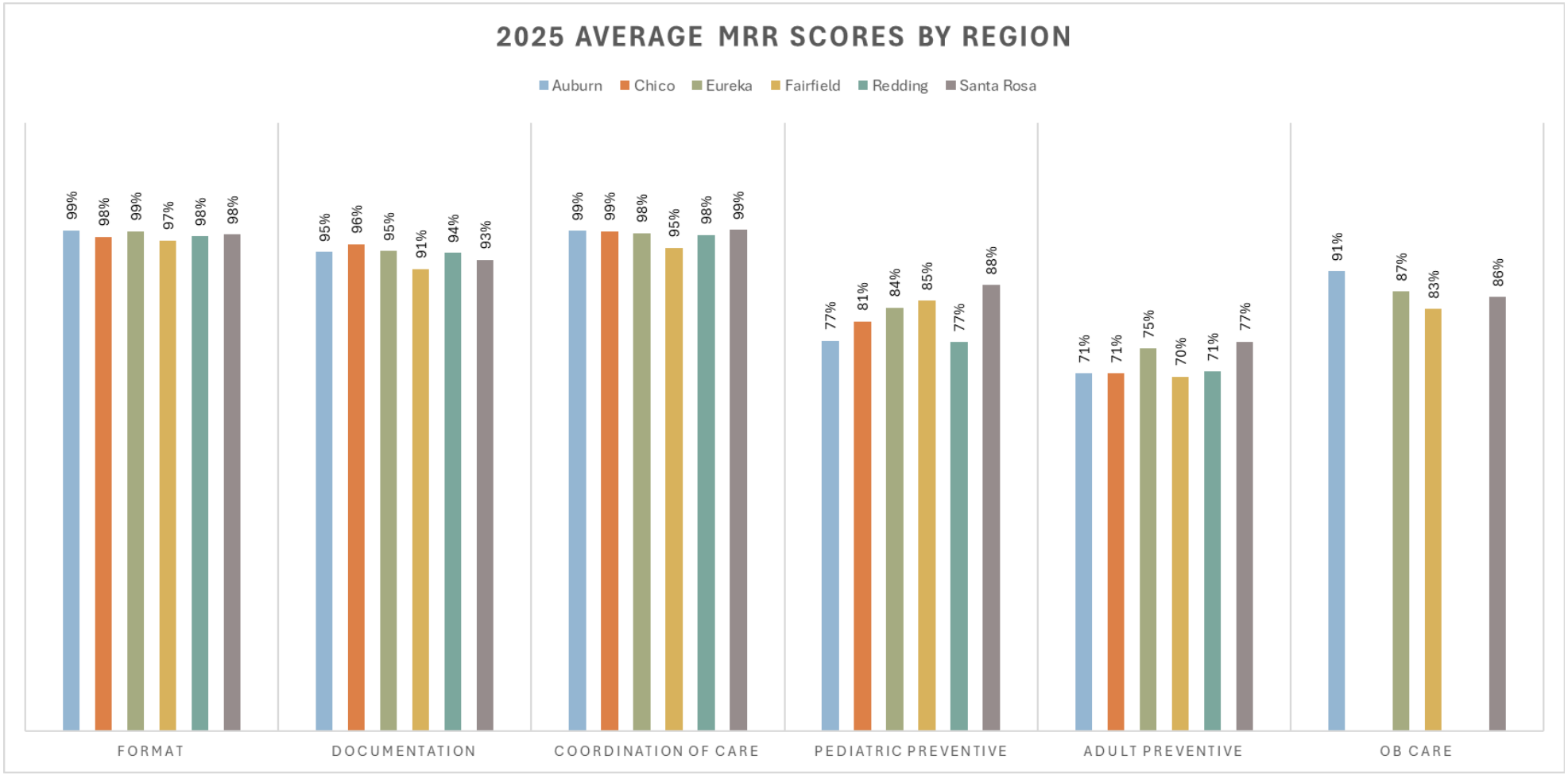
Year to Year Comparison of Average FSR Section Scores by Region						
	Auburn	**Chico**	**Eureka**	**Fairfield**	**Redding**	**Santa Rosa**
Number of Reviews						
2024	9	27	30	31	41	29
2025	22	47	35	24	23	40
Difference from 24-25	13	20	5	-7	-18	11
Access & Safety						
2024	96%	95%	96%	95%	97%	96%
2025	95%	98%	97%	95%	98%	98%
Difference from 24-25	-1%	3%	1%	0%	1%	2%
Personnel						
2024	92%	89%	96%	90%	95%	95%
2025	90%	98%	94%	91%	93%	97%
Difference from 24-25	-2%	**9%**	-2%	1%	-2%	2%
Office Management						
2024	97%	99%	100%	98%	99%	99%
2025	98%	99%	99%	97%	99%	98%
Difference from 24-25	1%	0%	-1%	-1%	0%	-1%
Clinical Services						
2024	98%	98%	99%	97%	98%	99%
2025	98%	100%	99%	96%	98%	99%
Difference from 24-25	0%	2%	0%	-1%	0%	0%
Preventive Services						
2024	97%	96%	99%	98%	99%	98%
2025	96%	97%	96%	97%	98%	97%
Difference from 24-25	-1%	1%	-3%	-1%	-1%	-1%
Infection Control						
2024	97%	98%	99%	96%	97%	98%
2025	98%	99%	99%	97%	97%	99%
Difference from 24-25	1%	1%	0%	1%	0%	1%

- ***Facility Site Review Opportunities for Improvement:***
    - All regions have opportunities for improvement in a couple different sections. The lowest scoring criteria weren't necessarily contained in one domain. Identified opportunities for improvement include: having appropriate emergency medications (critical element), staff training in disability rights and provider obligations (newer requirement), and having proper tools for vision testing (new requirement for height adjustable vision charts).
    - The Chico region has made a significant improvement in the Personnel section. Overall there were minor changes in each section for the regions, but happy to report that all sections are scoring an average of 90% and above.

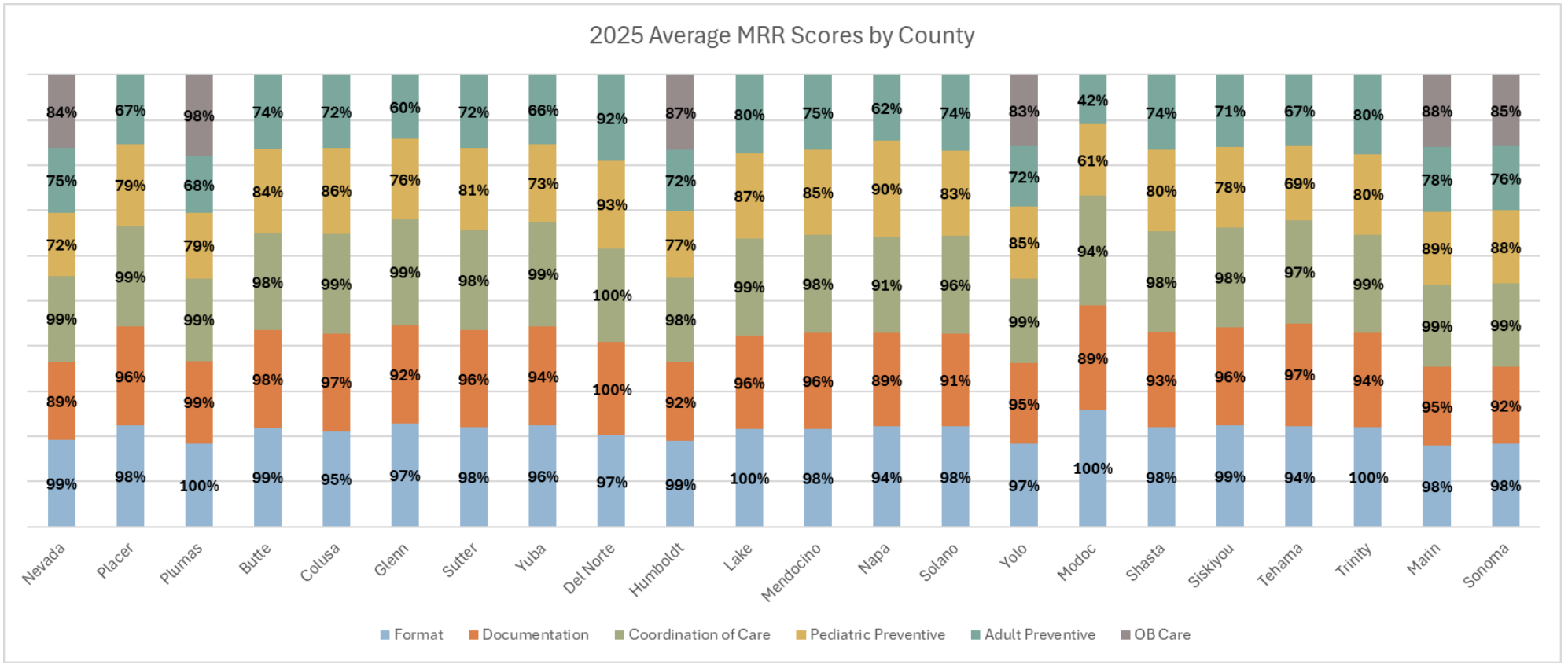
Site Review Compliance Report-March 2026
Prepared By: Leah Imhoff, Program Manager I
Presented By: Rachel Newman, RN, Manager of Clinical Compliance
Reporting Period: 1/1/2025-12/31/2025

2025 Average MRR Scores by Region and County						
	Format	Documentation	Coordination of Care	Pediatric Preventive	Adult Preventive	OB Care
Auburn	99%	95%	99%	77%	71%	91%
Nevada	99%	89%	99%	72%	75%	84%
Sierra	*	*	*	*	*	*
Placer	98%	96%	99%	79%	67%	*
Plumas	100%	99%	99%	79%	68%	98%
Chico	98%	96%	99%	81%	71%	*
Butte	99%	98%	98%	84%	74%	*
Colusa	95%	97%	99%	86%	72%	*
Glenn	97%	92%	99%	76%	60%	*
Sutter	98%	96%	98%	81%	72%	*
Yuba	96%	94%	99%	73%	66%	*
Eureka	99%	95%	98%	84%	75%	87%
Del Norte	97%	100%	100%	93%	92%	*
Humboldt	99%	92%	98%	77%	72%	87%
Lake	100%	96%	99%	87%	80%	*
Mendocino	98%	96%	98%	85%	75%	*
Fairfield	97%	91%	95%	85%	70%	83%
Napa	94%	89%	91%	90%	62%	*
Solano	98%	91%	96%	83%	74%	*
Yolo	97%	95%	99%	85%	72%	83%
Redding	98%	94%	98%	77%	71%	*
Lassen	*	*	*	*	*	*
Modoc	100%	89%	94%	61%	42%	*
Shasta	98%	93%	98%	80%	74%	*
Siskiyou	99%	96%	98%	78%	71%	*
Tehama	94%	97%	97%	69%	67%	*
Trinity	100%	94%	99%	80%	80%	*
Santa Rosa	98%	93%	99%	88%	77%	86%
Marin	98%	95%	99%	89%	78%	88%
Sonoma	98%	92%	99%	88%	76%	85%
Grand Total	98%	94%	98%	82%	73%	86%
* No records were reviewed during this time period.						

Site Review Compliance Report-March 2026
Prepared By: Leah Imhoff, Program Manager I
Presented By: Rachel Newman, RN, Manager of Clinical Compliance
Reporting Period: 1/1/2025-12/31/2025



Site Review Compliance Report-March 2026
Prepared By: Leah Imhoff, Program Manager I
Presented By: Rachel Newman, RN, Manager of Clinical Compliance
Reporting Period: 1/1/2025-12/31/2025



Site Review Compliance Report-March 2026
Prepared By: Leah Imhoff, Program Manager I
Presented By: Rachel Newman, RN, Manager of Clinical Compliance
Reporting Period: 1/1/2025-12/31/2025

Year to Year Comparison of Average MRR Section Scores by Region						
	Auburn	**Chico**	**Eureka**	**Fairfield**	**Redding**	**Santa Rosa**
Number of Reviews						
2024	12	26	28	31	31	23
2025	17	43	29	22	24	32
Difference from 24-25	5	17	1	-9	-7	9
Format						
2024	98%	97%	98%	98%	99%	98%
2025	99%	98%	99%	97%	98%	98%
Difference from 24-25	1%	1%	1%	-1%	-1%	0%
Documentation						
2024	95%	96%	95%	94%	93%	92%
2025	95%	96%	95%	91%	94%	93%
Difference from 24-25	0%	0%	0%	-3%	1%	1%
Coordination of Care						
2024	99%	98%	98%	97%	97%	98%
2025	99%	99%	98%	95%	98%	99%
Difference from 24-25	0%	1%	0%	-2%	1%	1%
Pediatric Preventive						
2024	81%	71%	78%	82%	78%	83%
2025	77%	81%	84%	85%	77%	88%
Difference from 24-25	-4%	**10%**	**6%**	3%	-1%	**5%**
Adult Preventive						
2024	70%	72%	75%	76%	72%	74%
2025	71%	71%	75%	70%	71%	77%
Difference from 24-25	1%	-1%	0%	**-6%**	-1%	3%
OB Preventive						
2024	*	95%	87%	89%	85%	94%
2025	91%	*	87%	83%	*	86%
Difference from 24-25	*	*	0%	**-6%**	*	**-9%**
* No records were reviewed during this time period.						

- ***Medical Record Review Opportunities for Improvement:***
    - All regions have opportunities for improvement in Adult and Pediatric Preventive Health.
        - Multiple regions have made significant improvements in Pediatric Preventive Health section this year.
        - Since the release of the 2022 Site Review Tools, we have seen a decline in scores. The new tool includes many additions to adult and pediatric preventative sections. We are currently offering education to our providers regarding these new requirements.
        - Only 9 PCP providing OB care reviews in 4 regions were completed during this reporting period. This makes a difficult comparison from year to year.

Site Review Compliance Report-March 2026
Prepared By: Leah Imhoff, Program Manager I
Presented By: Rachel Newman, RN, Manager of Clinical Compliance
Reporting Period: 1/1/2025-12/31/2025

Continued Efforts and Upcoming Changes

- Monitor and report trended data to IQI and QUAC annually.
- Continually refining the logic for the IHA report to ensure its accuracy and reliability.
- Educate sites during Site Review Exit Interview on the following:
  - Initial Health Appointment (IHA), including a 2-attempt tracker
  - Blood Lead Screening/Testing
  - Developmental Screening Tools (Prop 56/96110 Billing)
  - Billing Guide for Preventive Criteria
  - CHILD Trainings
  - Fluoride Varnish Trainings
  - Including any other criteria that need to be reviewed
- WebEx Trainings on Preventive Criteria, Site Review, CHILD, and IHA upon request
- Utilizing new Site Review Software (KSB)
  - Creates "Staff Writer" which consists of all Corrective Action Plan (CAP) criteria/standards for Sites deficiencies related to MRR. This allows the sites to better educate their staff.
  - Ability to create an FYI CAP to help educate sites on preventative standards.
- Virtual Medical Record Review
  - Virtual MRRs have proven a more efficient use of time with providers, per their feedback, and lessened risks of disagreement over deficiencies at the exit interview because the provider's staff was present during the entire MRR.
  - Virtual MRRs also provide a tailored 1:1 educational opportunity with the site and less time spent onsite to complete the overall review.

Reporting Period: 01/01/2025-12/31/2025
Prepared by: Leah Imhoff, Program Manager I
Presented by: Rachel Newman, RN, Manager of Clinical Compliance

Physical Accessibility Review Survey (PARS) Report

A Physical Accessibility Review Survey 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. PHC'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:

Level of Access / Domains:	**Definition**
Basic • Parking • Exterior Building • Interior Building • Restroom • Exam room	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.**
Limited • Missing one or more domains above	Demonstrates that the facility is deficient in one or more areas.
Medical Equipment • This is noted in addition to access level of Basic or Limited as appropriate.	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.

Reporting Period: 01/01/2025-12/31/2025
Prepared by: Leah Imhoff, Program Manager I
Presented by: Rachel Newman, RN, Manager of Clinical Compliance

Accessibility Level by Region/County

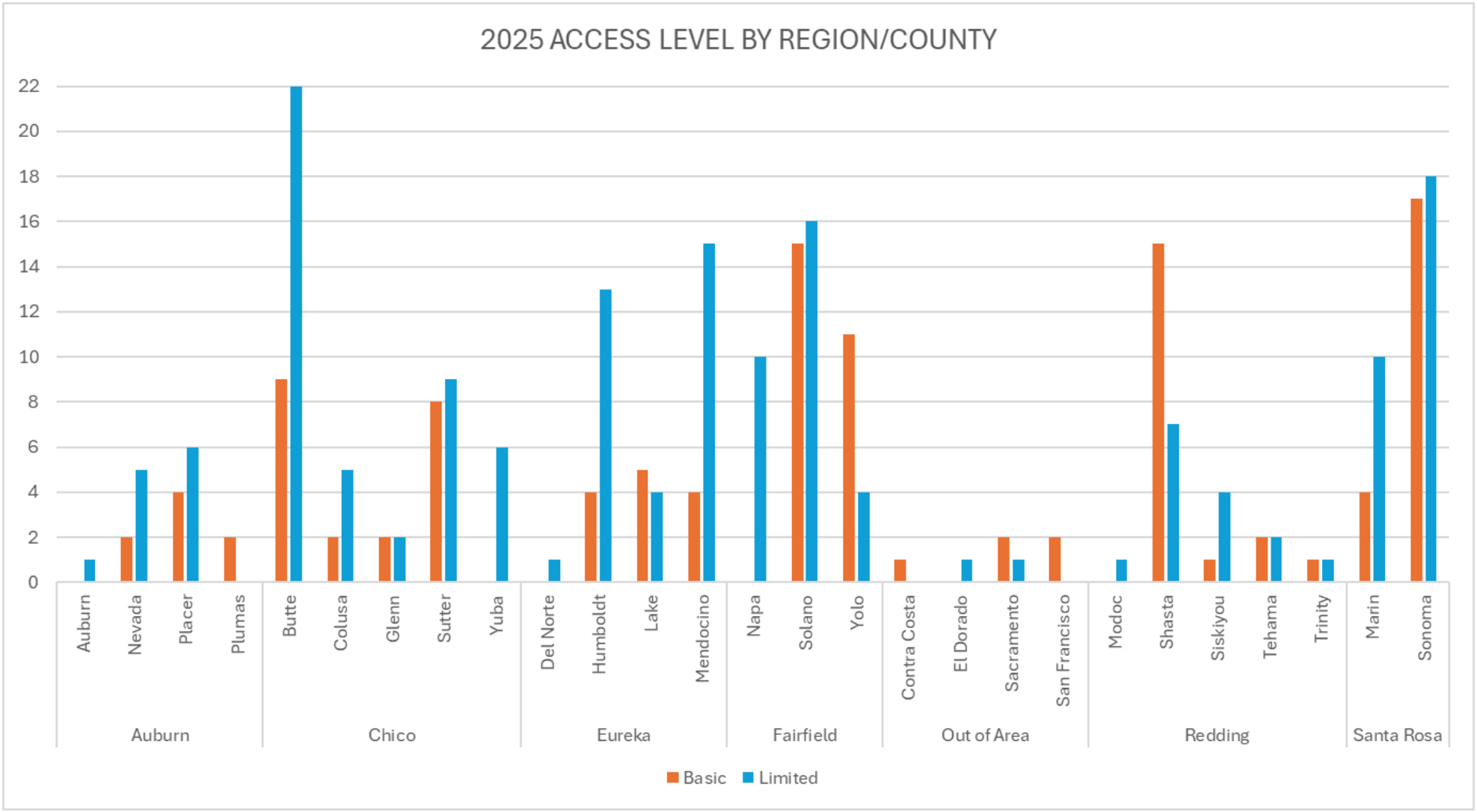
Access Level	Basic	Limited	Total
Auburn	8	12	20
Auburn	NA	1	1
Nevada	2	5	7
Placer	4	6	10
Plumas	2	NA	2
Chico	21	44	65
Butte	9	22	31
Colusa	2	5	7
Glenn	2	2	4
Sutter	8	9	17
Yuba	NA	6	6
Eureka	13	33	46
Del Norte	NA	1	1
Humboldt	4	13	17
Lake	5	4	9
Mendocino	4	15	19
Fairfield	26	30	56
Napa	NA	10	10
Solano	15	16	31
Yolo	11	4	15
Out of Area	5	2	7
Contra Costa	1	NA	1
El Dorado	NA	1	1
Sacramento	2	1	3
San Francisco	2	NA	2
Redding	19	15	34
Modoc	NA	1	1
Shasta	15	7	22
Siskiyou	1	4	5
Tehama	2	2	4
Trinity	1	1	2
Santa Rosa	21	28	49
Marin	4	10	14
Sonoma	17	18	35
Grand Total	113	164	277

Reporting Period: 1/1/2025-12/31/2025
Prepared by: Leah Imhoff, Program Manager I
Presented by: Rachel Newman, RN, Manager of Clinical Quality and Patient Safety

Domain Level Accessibility by Region/County

	Parking			Exterior Building			Interior Building			Restroom			Exam Room			Med. Equip.		
	Deficient	Criteria Met	Avg % Passing	Deficient	Criteria Met	Avg % Passing	Deficient	Criteria Met	Avg % Passing	Deficient	Criteria Met	Avg % Passing	Deficient	Criteria Met	Avg % Passing	Deficient	Criteria Met	Avg % Passing
Auburn	2	18	90%	5	15	75%	3	17	85%	5	15	75%	2	18	90%	12	8	40%
Auburn	1	NA	0%	NA	1	100%	NA	1	100%	NA	1	100%	NA	1	100%	1	NA	0%
Nevada	1	6	86%	1	6	86%	1	6	86%	3	4	57%	1	6	86%	5	2	29%
Placer	NA	10	100%	4	6	60%	2	8	80%	2	8	80%	1	9	90%	6	4	40%
Plumas	NA	2	100%	NA	2	100%	NA	2	100%	NA	2	100%	NA	2	100%	NA	2	100%
Chico	9	56	86%	19	46	71%	11	54	83%	27	38	58%	6	59	91%	44	21	32%
Butte	4	27	87%	11	20	65%	4	27	87%	13	18	58%	2	29	94%	24	7	23%
Colusa	3	4	57%	2	5	71%	NA	7	100%	4	3	43%	2	5	71%	6	1	14%
Glenn	NA	4	100%	1	3	75%	NA	4	100%	2	2	50%	NA	4	100%	2	2	50%
Sutter	NA	17	100%	3	14	82%	4	13	76%	7	10	59%	2	15	88%	10	7	41%
Yuba	2	4	67%	2	4	67%	3	3	50%	1	5	83%	NA	6	100%	2	4	67%
Eureka	7	39	85%	22	24	52%	9	37	80%	18	28	61%	6	40	87%	32	14	30%
Del Norte	NA	1	100%	NA	1	100%	NA	1	100%	1	NA	0%	NA	1	100%	NA	1	100%
Humboldt	3	14	82%	8	9	53%	2	15	88%	6	11	65%	1	16	94%	11	6	35%
Lake	2	7	78%	4	5	56%	3	6	67%	2	7	78%	NA	9	100%	5	4	44%
Mendocino	2	17	89%	10	9	47%	4	15	79%	9	10	53%	5	14	74%	16	3	16%
Fairfield	7	49	88%	10	46	82%	11	45	80%	19	37	66%	3	53	95%	32	24	43%
Napa	4	6	60%	4	6	60%	5	5	50%	5	5	50%	1	9	90%	9	1	10%
Solano	3	28	90%	5	26	84%	4	27	87%	12	19	61%	2	29	94%	17	14	45%
Yolo	NA	15	100%	1	14	93%	2	13	87%	2	13	87%	NA	15	100%	6	9	60%
Out of Area	1	6	86%	1	6	86%	1	6	86%	1	6	86%	NA	7	100%	4	3	43%
Contra Costa	NA	1	100%	NA	1	100%	NA	1	100%	NA	1	100%	NA	1	100%	NA	1	100%
El Dorado	1	NA	0%	NA	1	100%	NA	1	100%	1	NA	0%	NA	1	100%	1	NA	0%
Sacramento	NA	3	100%	1	2	67%	1	2	67%	NA	3	100%	NA	3	100%	2	1	33%
San Francisco	NA	2	100%	NA	2	100%	NA	2	100%	NA	2	100%	NA	2	100%	1	1	50%
Redding	2	32	94%	8	26	76%	5	29	85%	7	27	79%	NA	34	100%	22	12	35%
Modoc	NA	1	100%	NA	1	100%	NA	1	100%	1	NA	0%	NA	1	100%	1	NA	0%
Shasta	1	21	95%	3	19	86%	3	19	86%	3	19	86%	NA	22	100%	15	7	32%
Siskiyou	1	4	80%	3	2	40%	1	4	80%	1	4	80%	NA	5	100%	3	2	40%
Tehama	NA	4	100%	1	3	75%	1	3	75%	1	3	75%	NA	4	100%	2	2	50%
Trinity	NA	2	100%	1	1	50%	NA	2	100%	1	1	50%	NA	2	100%	1	1	50%
Santa Rosa	5	44	90%	11	38	78%	8	41	84%	19	30	61%	5	44	90%	33	16	33%
Marin	3	11	79%	3	11	79%	1	13	93%	6	8	57%	2	12	86%	11	3	21%
Sonoma	2	33	94%	8	27	77%	7	28	80%	13	22	63%	3	32	91%	22	13	37%
Grand Total	33	244	88%	76	201	73%	48	229	83%	96	181	65%	22	255	92%	179	98	35%

Reporting Period: 1/1/2025-12/31/2025
Prepared by: Leah Imhoff, Program Manager I
Presented by: Rachel Newman, RN, Manager of Clinical Quality and Patient Safety



Reporting Period: 1/1/2025-12/31/2025
Prepared by: Leah Imhoff, Program Manager I
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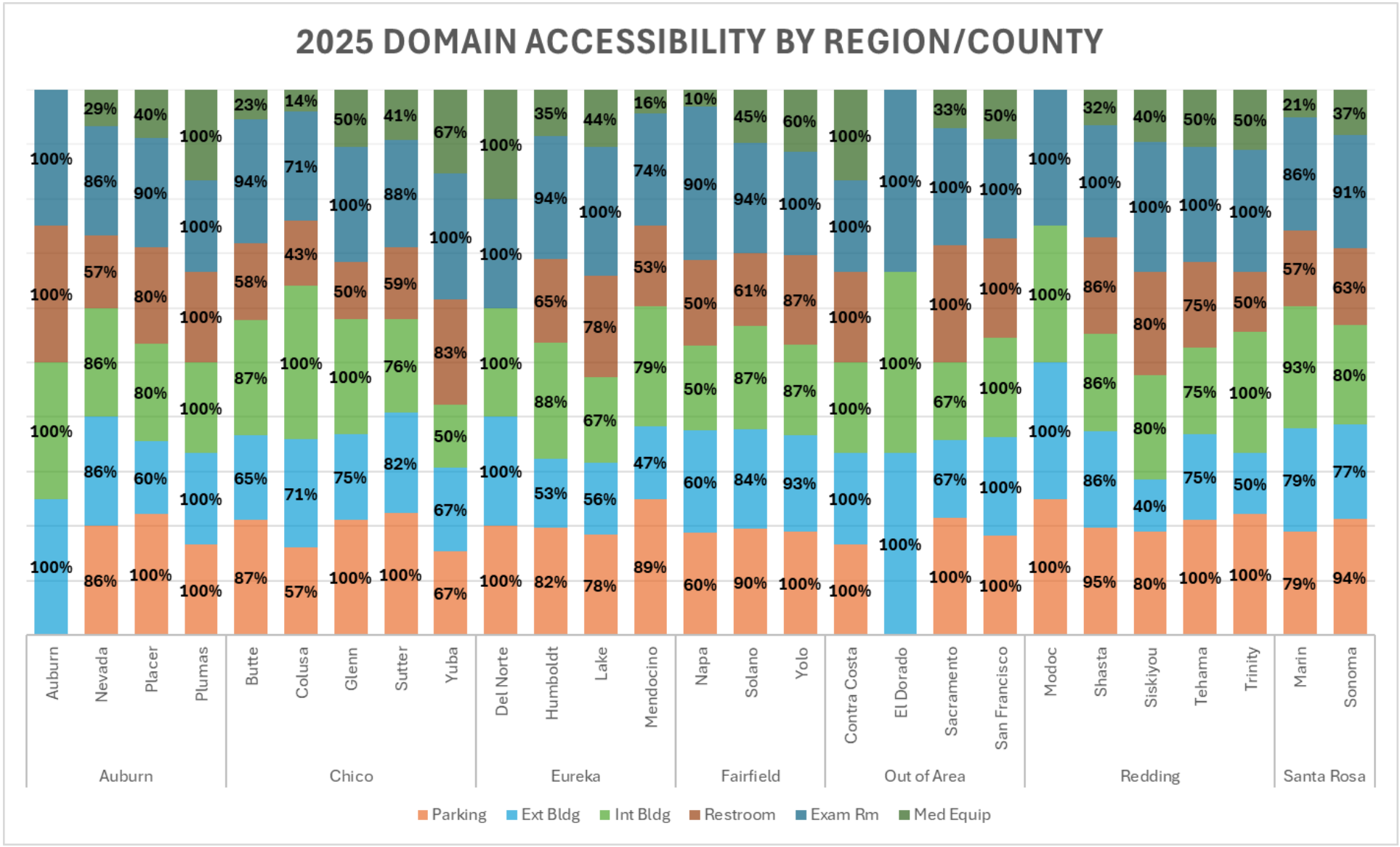

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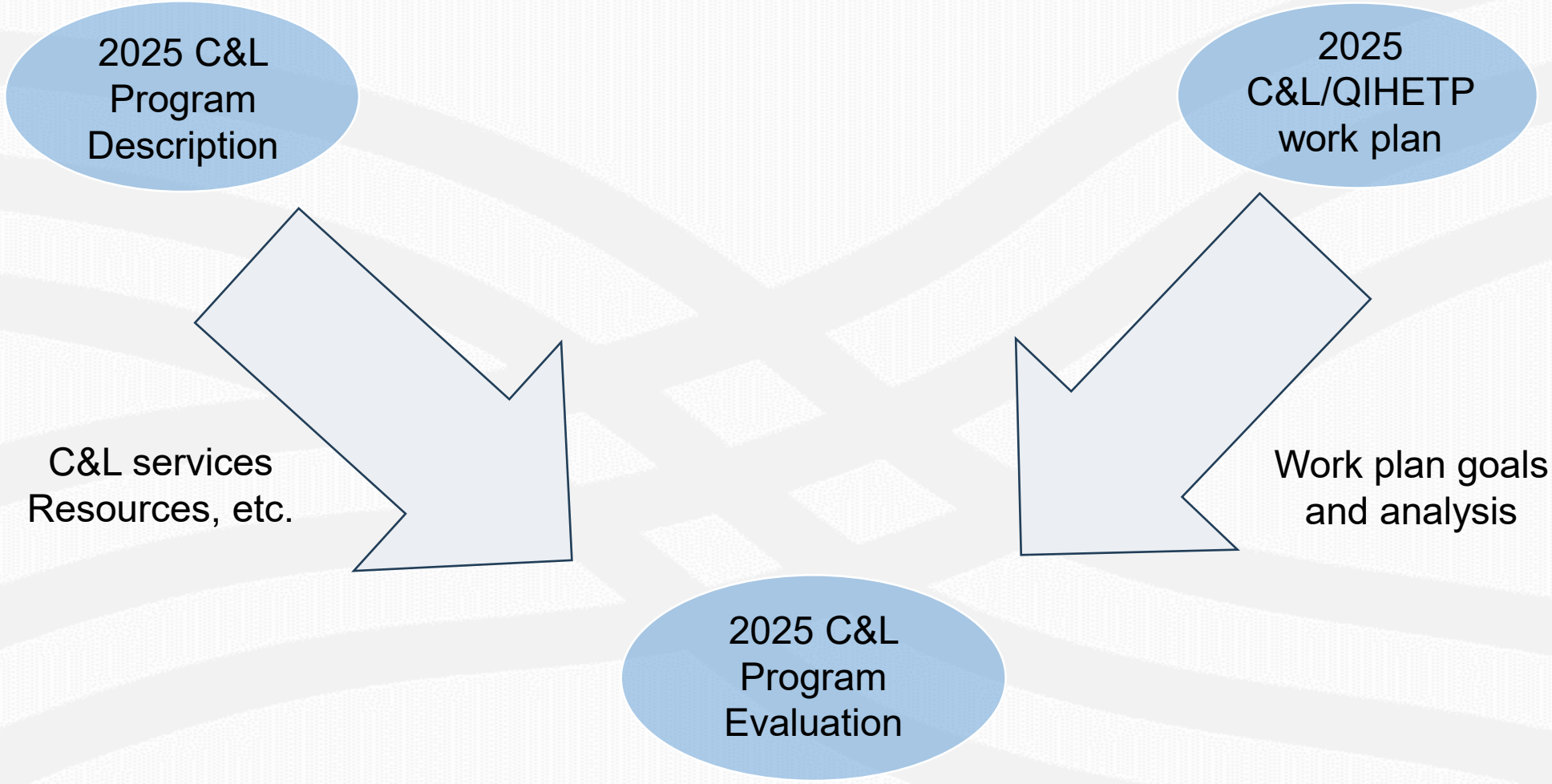
Cultural and Linguistic (C&L) Trilogy Presentation

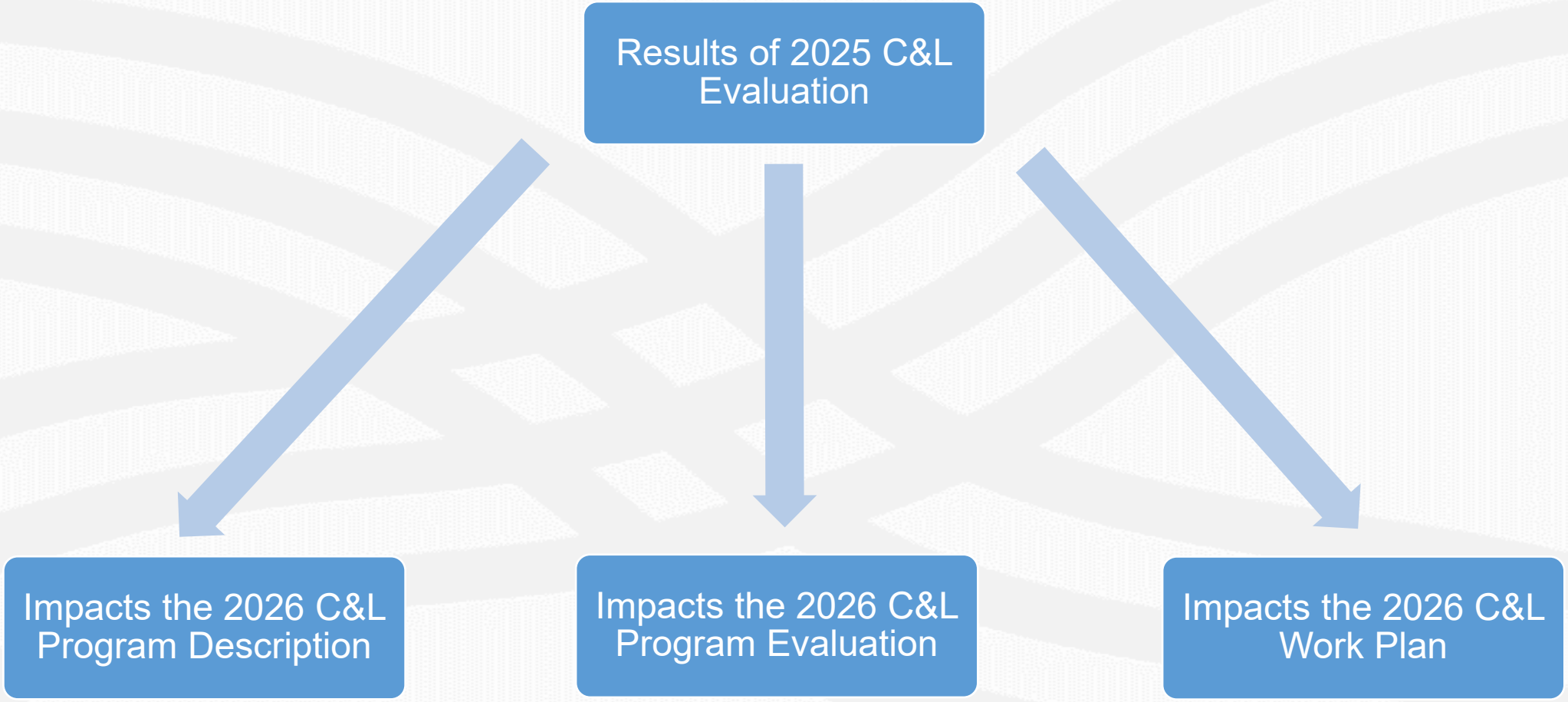
Hannah O'Leary, MPH, CHES

Part 1: Cultural and Linguistic Trilogy Documents: Background

2025 C&L Program Evaluation: Overview



Results Feed Future Documents



Part 2: 2025 Cultural & Linguistic Program Evaluation: Findings

2025 C&L Program Evaluation: C&L Program Findings (Part 1)

In 2025, there were:

1,864 translation requests (2024 = 1,113)

*1,790 on time
*26 late

444,134 interpreter calls (2024 = 320,760)

13,790 alternate format requests fulfilled (2024 = 689)

2025 C&L Program Evaluation: C&L Program Findings (Part 2)

In 2025, there were:

32+ languages spoken

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

Over 47 attendees at each QIHEC meeting

Each quarterly CAC meeting met quorum

2025 C&L Program Evaluation: C&L Program Findings (Part 3)

In 2025:

All C&L policies reviewed and approved

Health Equity hired staff to support

*Discrimination cases

*DEI regulatory requirements

*Addressing key health disparities

2025 C&L Program Evaluation: C&L/QIHETP Work Plan Goal Findings

Goal 1 Met

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

Goal 2 Met

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

Goal 3 Met

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

2025 C&L Program Evaluation: C&L/QIHETP Work Plan Goal Findings

Goal 4 Not met

- 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.

Goal 5 Met

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

Goal 6 Met

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

2025 C&L Program Evaluation: C&L/QIHETP Work Plan Goal Findings (Cont'd)

Goal 7 Not met

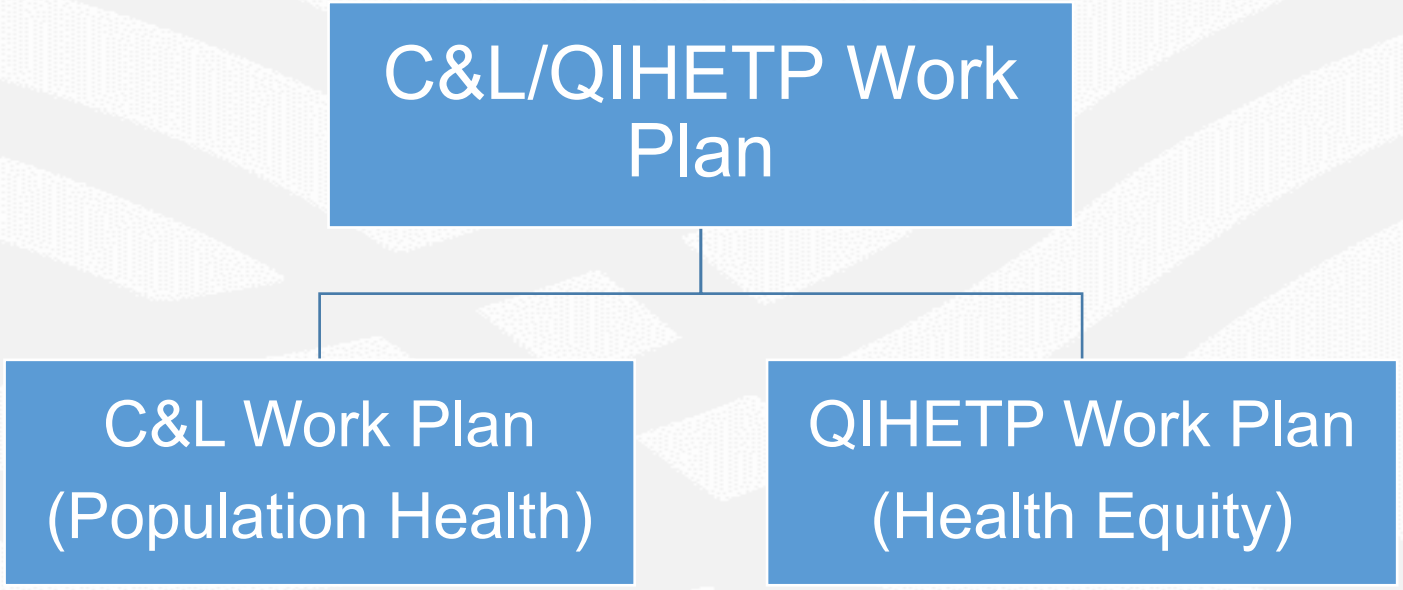
- By December 31, 2025, improve timely prenatal visit rates by at least 5% in the American Indian/Alaska Native Member Population within 12 months, in the Eureka region (Del Norte, Humboldt, Lake, and Mendocino), or Redding region (Lassen, Modoc, Shasta, Siskiyou, Tehama, and Trinity), with the global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

Goal 8 Met

- By December 31, 2025, improve timely Well Care Visit rates 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 3: 2026 C&L Work Plan

Splitting C&L/QIHETP Work Plan in 2026



2026 C&L Work Plan

Goal 1

- By December 31, 2026, 92% of members who have requested materials in an alternative format will be mailed in their preferred format.

Goal 2

- By December 31, 2026, increase the percentage of bilingual MSR staff by 2% to move closer to organizational goal of 75% of bilingual MSR staff.

Goal 3

- By December 31, 2026, improve the rate of timely translations in the Utilization Management and/or Care Coordination department by 1% from baseline of 96% or 98.5%, respectively.

Goal 4

- By March 31, 2026, complete the 2025 C&L Program Evaluation.

Part 4: 2026 C&L Program Description

2026 C&L Program Description

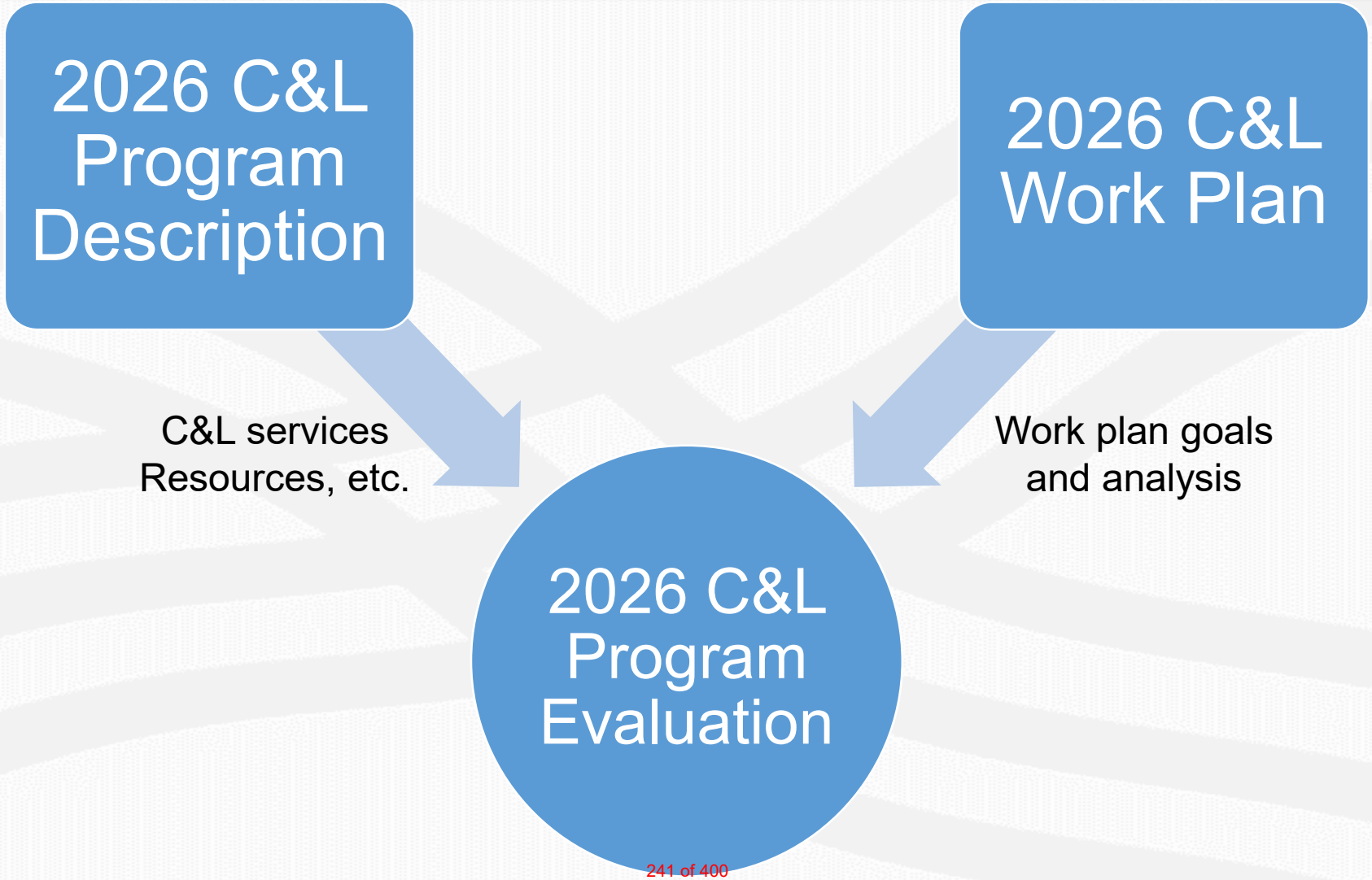
- Partnership cultural and linguistic services include:
  - Translation services
  - Interpreter services
  - Alternative formats and/or auxiliary aids and services
  - Language data collection
  - Trainings for staff
  - Compliance monitoring
  - Goals for 2026 around C&L services
  - C&L team structure

Summary

Today we reviewed:

- C&L trilogy document background
- Results of the 2025 C&L program evaluation, made up of:
  - The final 2025 C&L/QIHETP work plan
  - The 2025 C&L program description
- The 2026 C&L program description
- The 2026 C&L work plan

Summary (Cont'd)



PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

Questions?

Synopsis of Changes to Discussion Policies

Below is an overview of the policies that will be discussed at the March 10, 2026 Internal Quality Improvement (IQI) Committee meeting.
It is recommended that you 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 #**	**Summary of Revisions** (include why the changes were 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, MPH, CHES, Manager of Population Health*	
MPND9002 Cultural & Linguistic Program Description		This program description was updated to reflect changes per NCQA HOA standards, APL 25-016 *Alternative Format Selection for Members with Visual Impairments*, and organizational changes. Includes minor grammar, formatting, and hyperlink updates. **Policy Codes** • Removed APL 22-022 references throughout document and updated to APL 25-016. **Auxiliary Aids (pg. 16)** • Clarified requirements for providing auxiliary aids and services to the Member's Authorized Representative (AR) or other individuals authorized by the Member or as designated by law. **Alternative Formats (pg. 17-18)** • Clarified that Members may request an encrypted (password-protected) electronic format; if not requested, an unencrypted electronic format will be provided. • Removed references to MCP receipt of weekly AFS extracts; MCPs will rely on 834 membership data. • Added language describing Partnership's reasonable efforts to direct Members to BenefitsCal or local county offices for AFS updates. **Team Roles and Responsibilities (pg. 26)** • Updated existing Partnership position descriptions (across PHM, Health Equity, and G&A) to cover staff dedicated to C&L activities. **Updated Attachment A: Criteria for Interpreter Services** • In Telephonic or Video Remote Interpreter Services section, added extra possible context in which a request could be made, "calling Partnership HealthPlan of California." • Removed last paragraph describing referral to Carelon for Face-to-Face Interpreter Services, due to changes in Behavioral Health operations (de-delegation of Carelon). **Updated Attachment B: Providing Auxiliary Aids and Services for Persons with Disabilities**	Grievance & Appeals, Health Equity, Member Services, Pharmacy, Utilization Management, Communications, Quality Improvement

Synopsis of Changes to Discussion Policies

Policy Number & Name	Page #	Summary of Revisions (include why the changes were made, *i.e.,* NCQA, APL, Medi-Cal guidelines, clarification, *etc.*)	External Documentation (Notice required outside of originating department)
		• Edits to update from "language assistance taglines" to the newer "Notice of Availability" name. • Edits clarify that a Partnership representative will help the requester fill out the Auxiliary Aid Request Form **Updated Attachment E: CAC Guiding Principles** • Edits made to align with DHCS APL 25-009 Community Advisory Committee. • Added details around what resources may be shared to help educate CAC members. • Added additional points to the list of CAC's responsibilities. • Clarified the role of both Partnership's Board of Commissioners and Health Equity in the CAC member selection process. • Clarified that interpretation and translation services are available to all CAC members upon request, and that the CAC organizing team will ensure all locations where meetings are held are accessible to all members.	

Cultural & Linguistic Program Description

MPND9002

~~August~~ April 202~~5~~6

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; MPND9002 08/13/25; 04/08/~~20~~26~~Hannah~~

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. In alignment with the National CLAS standards, tThis 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 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 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 specified in APL 25-005. Partnership maintains, continually monitors, improves, and evaluates cultural and linguistic services that support covered services for all members, including members less than 21 years of age.

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~~Member-facing materials are routinely distributed in all of Partnership's threshold languages, meeting the requirements of APL 18-016 Readability and Suitability of

[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 and Threshold and Concentration Languages
[3] Penal Code 422.56
[4] ACA 1557
[5] Americans with Disabilities Act of 1990

Written Health Education Materials,[6] 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, and other relevant needs, such as age-related needs, 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.[7,8,9,10,11]
- 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.
- 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. Starting in 2026, the C&L/QIHETP annual work plan will be renamed as the C&L annual work plan.

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

Programs and Services

Partnership's C&L programs and servi~~-aids~~

ces 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 ~~-~~action as appropriate 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 MPND9002 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 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 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.[12] 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 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 individuals, whichever is less. For more details on this process, please refer to the separate Community Language Assessment report.

At the time of the writing of this document, Partnership's concentration standard and/or threshold languages are Russian, Tagalog, Spanish, and Punjabi, as determined by

[12] APL 25-005 and Threshold and Concentration Languages

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~~retains a list of the DHCS-~~-~~provided threshold and concentration languages (see MPND9002 attachment C for threshold languages), 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 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.[13] Partnership 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 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 the goals of Partnership's Population Health Management Strategy, the Cultural & Linguistics Program, and their associated work plans. Both of these work plans are part of the driving force by which Partnership responds to the cultural and linguistic diversity and needs of Partnership's member population. The annual 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).

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

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.[14] 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 Community 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 Goals~~, health equity efforts, 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.[15]~~ 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, Behavioral Health, and Transportation Services). Members using TTY/TDD can also call a toll-free number ~~with TTY/TDD~~.

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

In alignment with APL 25-005[16] and other DHCS requirements, Partnership provides nondiscrimination notices and Language Assistance Notice of Availability. Nondiscrimination notices are provided 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 is also provided in a visible font size in English and 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

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[14] ~~DHCS Basic Population Health Management Policy Guide~~DHCS Population Health Management Policy Guide

[15] ~~DHCS Comprehensive Quality Strategy~~

[16] APL 25-005

services at no cost to them as well as how to access them (including written translation and interpretation). To see these two notices in detail please refer to attachment A & B in MCNP9004 Regulatory Required Notices.

The Language Assistance Notice of Availability and nondiscrimination notices are provided in a font size no smaller than 12-point and are available in all Threshold Languages/Concentration Standard Languages and in an ~~ADA-compliant,~~ accessible format. Alternative formats available to members include~~s~~ b~~B~~raille, 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. Although quick response codes, otherwise known as QR code may be used alongside the nondiscrimination notice and notice of availability, they are not to be replaced by the use of QR codes.

Nondiscrimination notices and the Notice of Availability of Language Assistance Services are also sent with all member correspondences, which 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
- Notices of Organization and Coverage Determinations
- 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.

In alignment with APL 25-005, Standards for Determining Threshold Languages, Nondiscrimination Requirements, Language Assistance Services and Alternative

Formats, the nondiscrimination notice and the Notice of Availability includes Partnership's toll-free and/or Telephone Typewriters (TTY)/Telecommunication Devices for the Deaf (TDD) telephone number for obtaining these services. The nondiscrimination notice also includes information on how to file a discrimination grievance directly with Partnership, DHCS' OCR, and HHS' OCR. The regulatory notices are posted in the following places in a clear and prominent manner:[17]

a) In the Member Handbook/EOC and other electronic and written communications,
b) In all physical locations in 20-point font sans serif where Partnership interacts with the public and where members seeking health programs or activities would be able to read or hear the notice;
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
d) In all Member information and other informational notices, in accordance with federal and state law and this APL.

Partnership maintains a library of member-facing materials in all Partnership threshold languages, including ~~the~~ vital information such as major correspondence, health education materials, and other benefit-related member informing materials. 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, and ~~are translated and~~ are sent in the member's preferred language (including Partnership's threshold languages) and format; translation of member facing materials are provided at no cost to members ~~at no cost to member~~~~them~~. Member informing materials are approved by DHCS before distribution, while health education materials are approved by a Qualified Health E~~e~~ducator as defined by APL 18-016.[18] ~~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 include b~~B~~raille, 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 materials in all Partnership threshold languages, including the major correspondence, health education materials,~~

[17] APL 25-005
[18] APL 18-016 Readability and Suitability of Written Health Education Materials

~~and other benefit-relaterelated member informing materials.~~ Any mailed correspondence is sent according to the member's preferred threshold language or format (as described above) as requested. ~~. Other~~D ~~d~~ocuments~~, such as~~like letters or utilization review determinations are typically translated within 2 business days after submission of request~~2 business days~~; m~~. M~~embers may also request translation of other documents. ~~Translated materials are completed within 2 business days of the request~~ ~~and~~ M~~m~~embers receive their fully translated materials in a timely manner and in alignment with department-specific timelines, but no later than 30 days after the request was made.

Translation Service

Partnership utilizes Propio (formerly 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 designated 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.

If a member has requested to receive translated written information in either traditional or simplified Chinese characters, Partnership must provide written information in the member's preferred characters. If member does not indicate a preference, Partnership will provide translations in Traditional Chinese characters. Only upon member request, Partnership is required to provide translated written information in Simplified Chinese characters.

Member requests are fulfilled in a timely manner. ~~ULG~~ Translation services are provided at no cost to the member. Partnership aims to have written member information translated within 2-5 business days; however, ~~-~~turnaround times may vary depending on the complexity and rarity of the language requested and dependent on specific departmental turnaround times, but no more than 30 days from the request; ~~;~~ this includes requests for braille and large font (see table 1 below).

Table 1: Department Specific Translation Turnaround Times for Vital Documents

Department Specific Translation Turnaround Times for Vital Documents	
Type of Document	**Department Turnaround Time**
Information about eligibility, benefits and coverage (e.g., welcome packets, benefit summary,	Translation times vary depending on the size of materials. Small to medium size materials range from 2 to 14 business days. Larger

	items such as an Evidence of Coverage (EOC) may take up to 30 days.
Explanation of benefits (EOB)	2-30 days depending on complexity.
Notifications pertaining to denial, reduction, modification or termination of services and benefits.	Notice oOf Action (NOA) translations: 48 hours. ~~from the time of the request to when the material is mailed to the member~~
Information about the right to file a complaint, grievance or appeal (e.g., the portion of the notice that does not contain individual-specific information).	Non-Discrimination Notices contain information about the right to file a complaint, grievance or appeal. These are part of our acknowledgement and resolution letters. Those follow regulatory timeframes set by DHCS as stated below. No additional time for translated documents is given. • Acknowledgement Letter - 5 calendar days from the receipt date of the case. • Resolution Letter - 30 calendar days from the receipt date of the case.
Notification of practitioner termination.	Practitioner termination notice: 2-4 business days for translation depending on the length of the notice.

Tthreshold and concentration languages are defined by DHCS APL 25-005. All translations are verified by separate, additional ~~ULG~~ Propio translators to ensure cultural and linguistic accuracy as well as appropriate grammar and context (see MPND9002 attachment D Process for Culturally and Linguistically Appropriate Translations for further translation explanation).

Partnership has adopted the definition of a qualified translator/vendor as delineated in APL 25-005.[19] Per this APL, a translator ~~interpreting~~ translating 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.

[19] APL 25-005

Partnership has requirements for their translator certification process, as set forth by ~~ULG~~ Propio Translations in MPND9002 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. Points of contact may 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~~member services, orientations, and appointment scheduling. Oral interpreter services are available for any language spoken by the member. ~~(see MPND9002 attachment A for criteria and authorization requirements for interpreting services).~~ Oral i~~I~~nterpreter services are available in all of Partnership's threshold languages, and over 140 additional languages are available upon member request through Partnership's contracted language service provider, AMN HealthCare (see MPND9002 attachment A for criteria and authorization requirements for interpreting services). 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 staff who are qualified interpreters are also available for interpreter services in select languages. 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. Furthermore, ~~The member'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 APL 25-005.~~[20] a~~A~~s 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 when members need a document translated immediately during medical appointments, when connecting with health plan staff, or in other necessary circumstances. Member'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

[20] ~~APL 25-005~~

members with disabilities) in accordance with APL 25-005.[21] ~~The member'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 APL 25-005.[22]Partnership will not require Members with LEP or members with a disability to provide their own interpreters or pay for the cost of their own interpreter or rely on staff who are not qualified interpreters or qualified bilingual/multilingual staff.~~

~~Partnership will not require Members with LEP or members with a disability to provide their own interpreters or pay for the cost of their own interpreter or rely on staff who are not qualified interpreters or qualified bilingual/multilingual staff. 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. 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 25-005 in vendor selection and to define a qualified interpreter as an interpreter who:

- 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.

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[21] APL 25-005
~~[22] APL 25-005~~

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 in alignment with the requirements stated in 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 will not require Members with LEP or members with a disability to provide their own interpreters, ~~or~~ pay for the cost of their own interpreter, or rely on staff who are not qualified interpreters or ~~qualified~~ bilingual/multilingual qualified~~staff~~. 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.

Prior to using a family member, friend, or in an emergency only, a minor child, for interpretation services, the MCP will inform the Member they have the right to free interpreter services and ensure that the use of an interpreter will not compromise the effectiveness of services or violate the individual's confidentiality. Partnership will make a good faith effort to ensure that the refusal of free interpreter services and the member's request to use a family member, friend or minor child as an interpreter is documented in the medical record.

Auxiliary Aids and Services

In accordance with APL 25-005 and APL 25-~~-~~016 ~~22-022~~, Partnership provides the following auxiliary aids and services to members in an accessible format, in a timely manner, and at no cost to the member, including qualified interpreters and written materials in alternative formats, to a family member, friend, ~~members~~ their authorized representative (AR) or someone with whom it is appropriate for Partnership to communicate with according to the member or as designated by law. ~~with ("companion") by request or as needed, 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 may 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 (TTYs), 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 MPND9002 attachment B to learn more about how Partnership provides auxiliary aids and services for persons with disabilities.

Alternate Formats

In accordance with APL 25-005 and APL 25-~~---~~016, ~~22-002,~~ Partnership provides member information ~~to members and potential members~~ in alternate formats to meet the cultural and linguistic needs of members and potential enrollees~~members~~, including Braille, large print text (20 point or larger), audio, and accessible electronic formats (such as data CDs~~cd~~), 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~~ updated thereafter, using data provided by DHCS, received via the 834 enrollment data ~~or~~file, or reported to Partnership by the member and/or their AR, or by s~~S~~ubcontractors. Partnership also collects and stores member's ~~the~~ alternative format selections (AFS) for receiving written materials in accessible formats. Partnership will make reasonable efforts to direct m~~M~~embers ~~are directed~~ to make or update their AFS through BenefitsCal~~,~~ ~~Covered California,~~ or their local county office~~e~~. ~~The California Statewide Automated Welfare System (CalSAWS) and California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS) transmit updated AFS information to the Medi-Cal Eligibility Data System (MEDS), which serves as the system of record for AFS data. .~~AFS information is shared with subcontractors and network providers, as appropriate, to ensure accessibility of communications~~. Partnership no longer uses the DHCS web-based AFS Screens or receives weekly AFS extracts from DHCS.~~

~~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 25-016 ~~22-002,~~ when a member contacts Partnership about electronic alternative formats, Partnership also informs the member that, unless they request an encrypted ~~password-protected~~ format, the requested member information will be provided in an electronic format that is not password protected. Partnership then communicates to the member that they may request an encrypted electronic format with unencrypted instructions on how the m~~M~~ember can access the encrypted information in their requested format.[23]

~~Also, in alignment with APL 25-016, Partnership must ensure that a member receives an adequate notice explaining the reasons for proposed suspension or termination of the member's benefits within legal timeframes and issued in the member's chosen alternative format. Partnership is required to calculate the deadline for a member to take action from the date of the notice including all deadlines for appeals and aid paid pending. A member may immediately request a state hearing if Partnership fails to provide adequate notice within federal or state required timeframes. Partnership is prohibited from requesting dismissal of a state hearing based on failure to exhaust internal appeal process in these cases.~~

Trainings

In alignment with APL 24-016 and the DHCS contract, 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. This training is referred to as CARES: Community, Access, Respect, Engagement, Service. 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.

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

[23] ~~APL 22-002 Alternative Format Selection for Members with Visual Impairments~~APL 25-~~-~~016 Alternative Format Selection for Members with Visual Impairments

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 MCEP6004 DEI/Cultural Connection Training policy~~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.

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 MCEP6004 DEI/Cultural Connection Training policy~~forthcoming policy Diversity, Equity, and Inclusion Training Program Requirements for External Practitioners~~.

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 a certified ADA Coordinator, who advises Partnership on how and when accommodation requests should be honored.

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:

- Staff
- Leadership
- Governing bodies
- Committees
- Providers

Assessment and Evaluation

Cultural and Linguistic Program Evaluation

On an annual basis, Partnership writes a Cultural and Linguistic Program ~~n~~ E~~e~~valuation ~~report~~as part of a larger set of linked documents, referred to as the Cultural and Linguistic Trilogy documents. This Trilogy of documents consists of the MPND~~DP~~9002 Cultural and Linguistic Program Description, the Annual Cultural and Linguistic Workplan, and the Annual Cultural and Linguistic Program Evaluation. The Annual Cultural and Linguistic Program Evaluation ~~detailing~~details the performance of the Cultural and Linguistic ~~(C&L)~~ program. ~~structure and interventions performed in accordance with PHM and other Partnership efforts of the given year.~~ This ~~report~~ evaluation is drafted using elements and findings from ~~this~~ the Cultural and Linguistic P~~p~~rogram D~~d~~escription and the A~~a~~nnual Cultural and Linguistic ~~C&L/QIHETP~~ Workplan~~workplan~~. Key elements in this annual evaluation include review and analysis of key program structure/processes, review and assessment of progress towards workplan goal~~ss for completed activities~~, annual trending of data, gaps and/or barriers, review of the Community 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 delegated cultural and linguistic services providers 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 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:

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

Administrative Oversight & Compliance Monitoringg

Internal Oversight

Within Partnership's Population Health department, the Senior Health Educator (a masters-prepared or MCHES-certified professional) monitors and oversees select regulatory requirements related to Cultural & Linguistics programs and requirements for compliance purposes and to ensure the delivery of culturally and linguistically appropriate health care services. Other key departments within Partnership also support the Cultural and Linguistic program and program compliance.

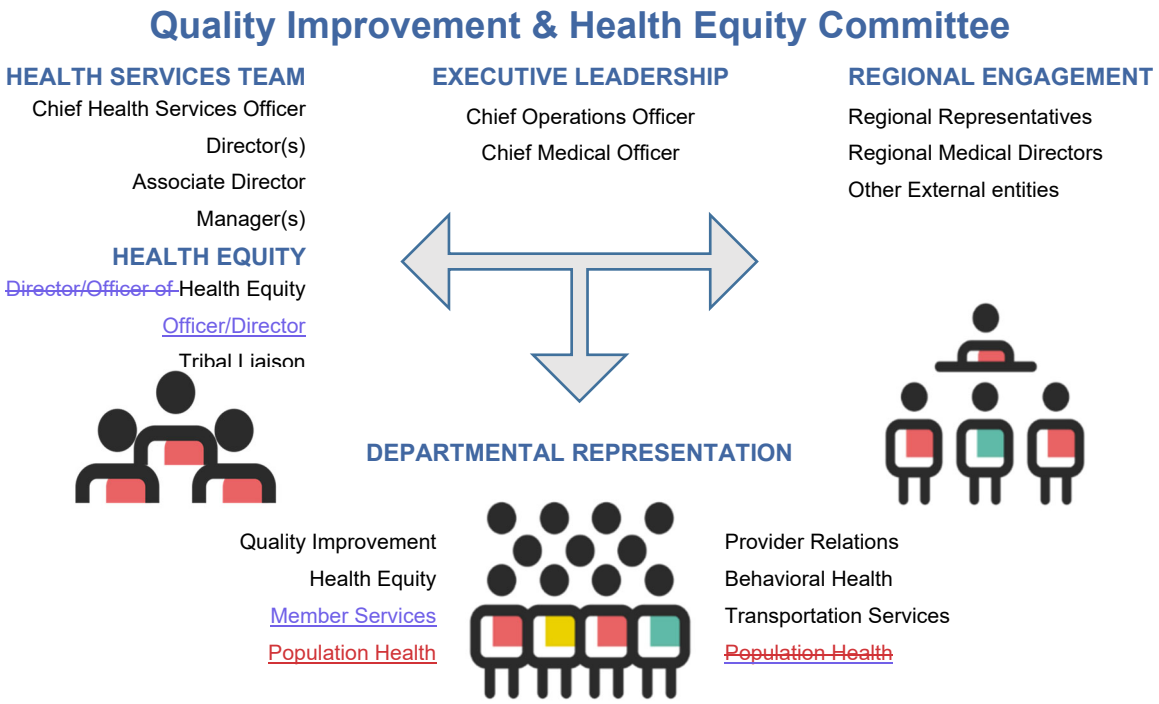
Partnership also created the Population Needs Assessment Committee to review findings and strategies, as needed, to address C&Lcultural and linguistic needs identified in the collaborative work referred to as the CHA and CHIP process (please refer to MPND9001 for more detail). Please note, in 2026, this committee will be disbanded. 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 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. 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, in accordance with MPND9001 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 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 wW~~o~~rk ~~p~~lan (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).



Community Engagement

Partnership's Community Advisory Committee (CAC) and Whole Child Model Family Advisory Committee (FAC) serves as a linkage between Partnership and the community (see attachment MPND9002-E CAC Guiding Principles and Policy MCCP2024 for more details on these committees). The CAC and FAC consists of culturally and linguistically diverse Partnership members and community advocates. ~~These advisory committees~~

~~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 ~~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;
- Annual C&L Program Evaluation
- 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~~ Tthe MCP's Provider Manual.
- Resource allocation; and
- Other community-based initiatives

To learn more about the CAC, please refer to MPND9002 attachment E CAC Guiding Principles.

In addition to CAC, Partnership also has dedicated staff to gather input and participation from the communities it serves in order to ensure that it meets the needs of its members. The Cultural Community Manager leads engagement with communities experiencing health disparities across 24 counties and oversees reinvestment liaisons, who will collaborate with local counties to implement future reinvestment projects addressing disparities identified through community and partner input. The role also seeks input from individuals with relevant experience and expertise to meet the diverse cultural, linguistic, and other needs of members by:

- Conducting interviews and focus groups to elicit feedback from members of various local communities, including Partnership members, on key health disparities in order to improve health outcomes.
- Disseminating community feedback to internal departments, external workgroups, and committees to inform and enhance programs and initiatives.
- Building and maintaining relationships with community-based organizations, translating community needs into actionable recommendations for the health plan.–
- Advising on Partnership's community engagement across multiple departments.
- Leading engagement with network providers/practitioners, subcontractors, and downstream subcontractors to implement focus groups or individual 1:1 meetings, across the network, to directly gather direct feedback from members.

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 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.

Furthermore, Partnership will make reasonable efforts to report activities that aim to ensure members are aware of their right to receive effective communication, what requests for auxiliary aids and services have been made by members, if any, how Partnership has responded to those requests, and Partnership's response to any complaints regarding the receipt of effective communication.

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 (the improvement of service appropriateness or accessibility) and/or for the reduction of health care inequities that are presented annually in the C&L/QIHETP wWork pPlan; these goals may differ year to year. This annual work plan describes 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/or reduction of health care inequities Partnership invests in the C&L program and goals as part of increasing access to care in order to improve member health outcomes; these efforts ultimately align with our mission to help our members, and the communities we serve, be healthy.

; This annual plan is reviewed and/or approved by various committees, including:

- The Quality Improvement and Health Equity Committee (QIHEC)
- 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/QIHETP wWork p Plan to all stakeholders, and constituents as appropriate.

20265 Goals

Partnership identified multiple goals for 20265. Several Multiple goals will carry over from 20254 to track trends data from year to year; goals 1-2 and 6-8 are new goals. Goals carried over from 20254 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 wWork pPlan:

- ~~Goal 1: By June 30, 2025 develop and propose a multi-year health equity strategic and tactical plan.~~
    - ~~This goal was chosen to strategize and streamline 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.~~
    - ~~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 1~~3~~: By December 31, 2026~~5~~, 92~~1~~% of members who have requested materials in an alternative format will be mailed in their preferred format.
    - This goal was chosen to ensure members receive information in a way that they can understand.
- Goal 2~~4~~: By December 31, 2026~~5~~, increase the ~~number~~ percentage of bilingual Member Service Representative (MSR) staff hired by 2~~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, 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 3~~6~~: By December 31, 2026~~5~~, improve the rate of timely translations in the Utilization Management and/or Care Coordination by 1% from baseline of 96% or 98.5%, respectively. ~~department to achieve the threshold of at least 90%.~~
    - ~~Goal~~ This goal~~6~~ was chosen due to the recognized need for quality translation services and an overall positive member experience.

- Goal 4: By March 31, 2026, complete the 2025 C&L Program Evaluation.
    - This goal was chosen to ensure the complete evaluation took place.

- ~~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.~~

- ~~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 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.~~

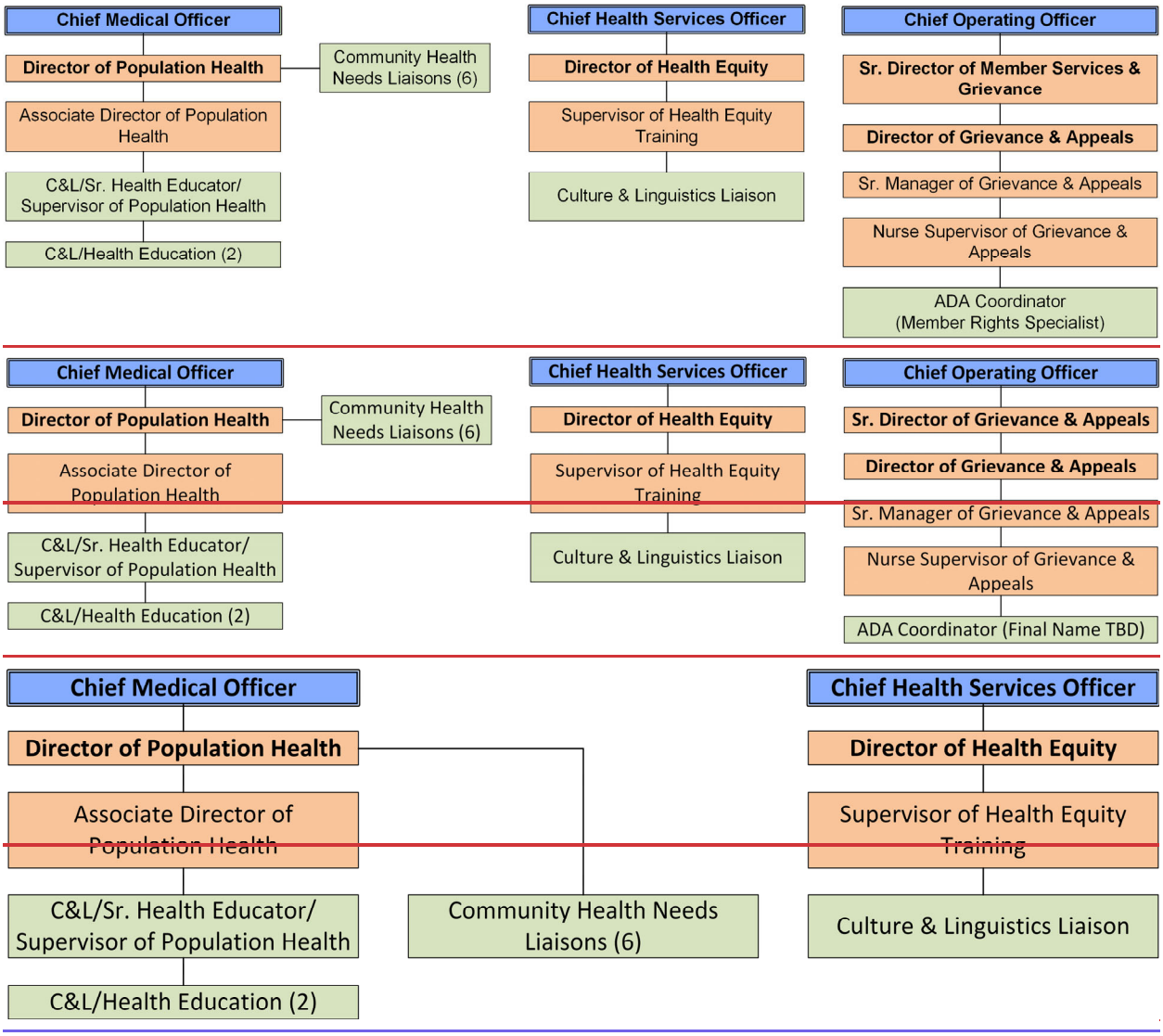
Partnership will continue to monitor these goals through the annual C&L~~/QIHETP~~ w~~W~~ork p~~P~~lan to ensure the goals are met. Progress toward these goals will be reviewed by appropriate Population Health staff on a quarterly basis. Progress toward these~~is~~ goal ~~will be also be~~will also be reviewed and/or approved no less than annually by the committees described above, with PAC having the final approval. The C&L work plan describes in more detail the measures that will be collected, frequency of monitoring, and staff responsible for goal progress.

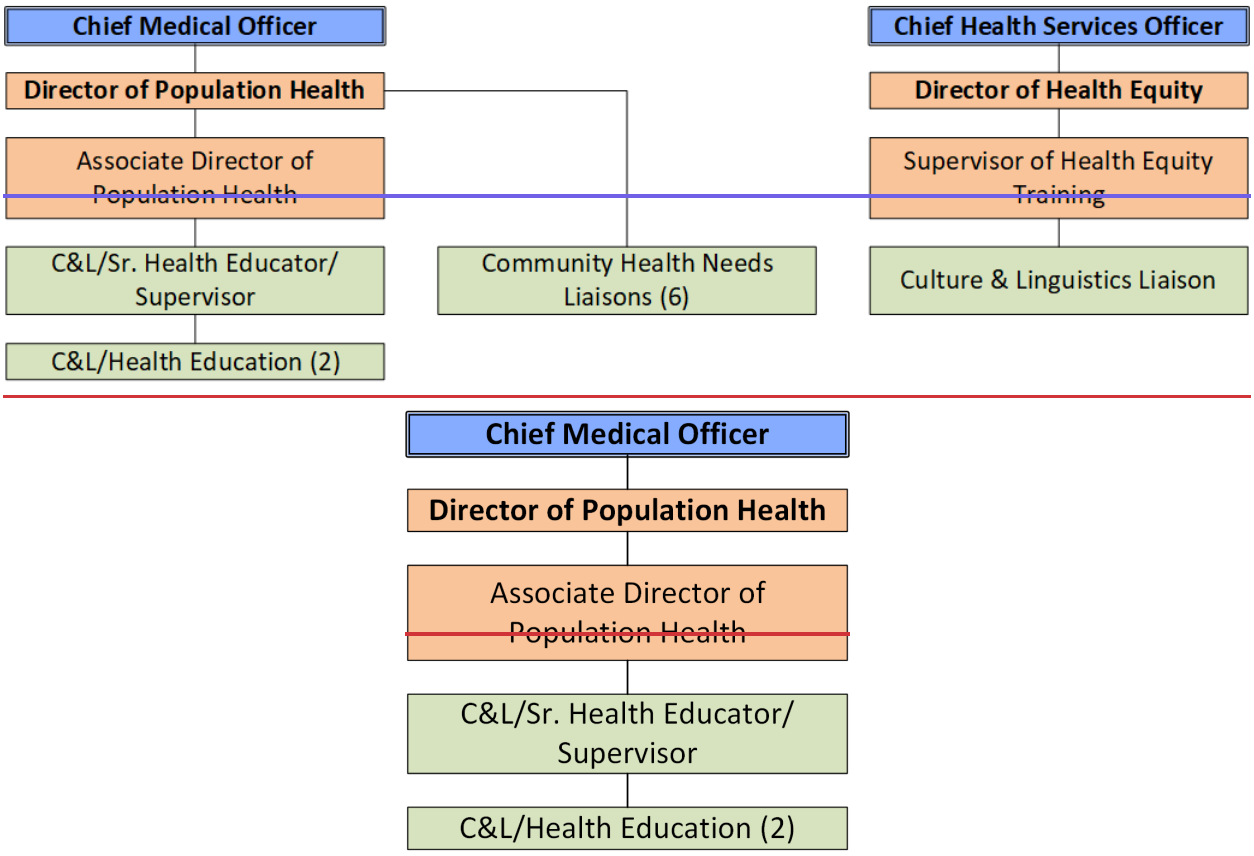
~~Population Health Department~~Cultural and Linguistic Team Structure

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 (MPND9001), 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~~departments and include making referrals to culturally and linguistically appropriate community service programs and aligning organizational and community efforts to meet these needs, in accordance with DHCS, NCQA, and CMS requirements. 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. Below is an overview of Partnership staff who support key Cultural and Linguistic services. While other Partnership teams also support the cultural and linguistic services that make up the C&L

program as needed, the graphic below depicts the main reporting structure of key staff who support the C&L program.





Team Roles and Responsibilities by Department

Population Health Department

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. Required education includes an MD/DO degree from an accredited program preferably in a primary care specialty required; minimum 2 years' experience in a managed care plan preferred, and experience administering medical programs. This role also requires board certification in a specialty and a minimum of 7 years' clinical/medical practice experience.

Director of Population Health

The Director of Population Health is the key business leader who oversees the organization's Population Health Management strategy and is responsible for providing leadership, alignment, support, strategic development and implementation of associated

activities and interventions. Provides clinical guidance and strategic direction for departmental activities by applying their understanding of population health management priorities, health care policy, financing, and regulations to promote optimal health outcomes for members. A Bachelor of Science Nursing or Doctorate in Public Health is required. At least 5 years of experience in a leadership/management role is also required. Experience in a managed care, health care provider network and/or working with Medi-Cal population is preferred.

Associate Director of Population Health

Under the leadership of the Director of Population Health, manages and provides direction to the Population Health team managers and supervisors to ensure Basic Population Health Management activities are performed in compliance with DHCS and NCQA requirements. Participates in the development, implementation, and maintenance of Population Health programs and achievement of department goals and objectives in a fast paced, dynamic environment. This role ensures compliance with established operational criteria, NCQA, and DHCS Standards, and PHC policies and procedures. A bachelor's degree is required, but an RN license is preferred. A minimum of 5 years of relevant experience in health care operations, a minimum of 3 years of management experience with effective problem solving, or equivalent combination of education and experience is required.

Supervisor of Population Health

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. Bachelor's degree in business, Communication, Healthcare Administration, or a related field, or 3-5 years of managed care experience; or equivalent combination of education and experience is required. General knowledge of managed care and principles of population health management is preferred.

Senior Health Educator

The Senior Health Educator is a public health masters-prepared (or MCHES-certified) professional who maintains administrative oversight of health education and supports oversight of cultural and linguistic services. This role also implements health education activities that promote member wellness, understanding of benefits, and access to care. This position is responsible for health education programs and cultural and linguistic services. Plans, implements and evaluates health education activities; analyzes and coordinates cultural and linguistic services; Supports the development of the annual Population Needs Assessment (PNA) according to DHCS and NCQA guidelines; and

collaborates in developing and implementing organizational interventions identified in the PNA in conjunction with health promotion and equity programs. The Senior Health Educator may also perform supervisor responsibilities. This role requires a Master of Public Health (MPH) degree with a health education or health promotion emphasis, or master's degree in Community Health with a specialization in health education or health promotion, or Master Certified Health Education Specialist (MCHES) awarded by the National Commission for Health Education Credentialing, Inc. This role must have a minimum of 2 years' experience developing health education programs. Previous experience in a supervisory capacity, and/or experience or capacity to manage audit activities in our provider network, and experience or equivalent academic training on identifying health disparities within different cultures is preferred.

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 of 2 years of health education experience is preferred.

Community Health Needs Liaison(s)

Collaborates with internal staff in the development of Partnership's Population Needs Assessment (PNA) through active participation in the Local Health Department's Community Health Assessment (CHA) and/or Community Health Improvement Plan (CHIP) processes. Identifies and support key strategic activities and interventions that promote efforts to encourage members' health outcomes. Works with Health Educator team to identify appropriate member educational materials to share with community partners, providers, and members. Required education includes bachelor's degree in public health, Community Health or related field; A minimum of 2 years of experience in public health is preferred.

Health Equity Department

Chief Health Services Officer:

This position is responsible for the executive management and operational leadership of the following Partnership Health Plan of California Health Services departments: Utilization Management (UM), Care Coordination (CC), Population Health Management (PHM), Health Equity, and associated initiatives under CalAIM. This position provides executive leadership in organizing the health plan's operations, interdepartmental

communication, and participates in goal setting and strategic organizational planning in the development of new business lines and programs. A master's degree in nursing, Public Health or Health Administration or a related field is preferred; a bachelor's degree is required. This role must have a minimum of 10 years' experience in healthcare, with 7 years of management experience in healthcare organization, preferably leading and managing major clinical programs & initiatives, general and fiscal operations, or equivalent combination of education and experience.

Director of Health Equity

The Director of Health Equity will partner with other Partnership leaders to develop and drive forward the key strategies to be a diverse, equitable, and inclusive organization. They will be responsible for driving systemic change to increase diversity and representation as well as building programs that foster an inclusive culture of belonging. This position will promote pathways towards raising awareness of health inequities within our membership and concrete plans for addressing them. This will include working to track, trend and improve disparities in care, recognizing the diverse cultural, language, economic, education and health status needs of those in our service area and organization. A bachelor's degree in social work, health care, public policy, business, or related field, 5 years of experience advocating for and implementing change within a multi-cultural environment, with at least 3 years' experience developing and implementing diversity, equity, and inclusion programs, or equivalent combination of education and experience is required.

Supervisor of Health Equity Training

The Supervisor of Health Equity Training is responsible for executing and managing diversity, equity, and inclusion (DEI) training programs and initiatives to enhance the skills, knowledge and performance of the company, network provider, subcontractors, downstream subcontractors, etc. This role also participates in DEI training meetings, supports DEI Training all plan letter requirements set forth by DHCS, and supports monitoring of training completion of Partnership staff, network providers, subcontractors, downstream subcontractors etc. A bachelor's degree is preferred. At least a minimum of 3 years of experience working directly in DEI initiatives with a proven track record of developing and implementing successful training programs; or any combination of education, training, and 4 years of experience which provides the required knowledge and abilities is required. This role must also be knowledgeable in the use of Learning Management Systems (LMS), Electronic Learning platforms, online learning programs, and industry leading virtual learning programs.

Cultural and Linguistic Liaison(s)

The Cultural and Linguistic Liaison is responsible for overseeing grievance and appeal reviews, as well as conducting cultural and linguistic reviews for our subcontractors to ensure alignment with our commitment to diversity and inclusion. This role will provide support to the department on promoting health equity within our organization and in the community, ensuring fair and just access to healthcare services for all members. A bachelor's degree in public health, Community Health or related field preferred, 2-4 years of experience in Health Equity, or equivalent combination of education and experience is required.

Grievance & Appeals Department

~~Chief Health Services Officer:~~

~~This position is responsible for the executive management and operational leadership of the following Partnership Health Plan of California Health Services departments: Utilization Management (UM), Care Coordination (CC), Population Health Management (PHM), Health Equity, and associated initiatives under CalAIM. This position provides executive leadership in organizing the health plan's operations, interdepartmental communication, and participates in goal setting and strategic organizational planning in the development of new business lines and programs. A master's degree in nursing, Public Health or Health Administration or a related field is preferred; a bachelor's degree is required. This role must have a minimum of ten (10) years' experience in healthcare, with seven (7) years of management experience in healthcare organization, preferably leading and managing major clinical programs & initiatives, general and fiscal operations, or equivalent combination of education and experience.~~

~~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~~years' ~~clinical/medical practice experience.~~

Chief Operating Officer:

This position is responsible for the oversight of operations and executive management of the Claims, Member Services, Health Services (Utilization Management and Care Coordination), and Provider Relations Departments, the Project Management/Operational Excellence unit, Partnership's Northern Region regional office, and the Administration Department within the Southern Region, within Partnership. This position provides leadership in organizing the Health Plan's operations, interdepartmental communication, and participates in goal setting and strategic organizational planning in the development of new business lines and programs. Required education includes a master's degree in business, Public Health, Health Administration, Communication, Marketing, Government, Political Science, or related field; a minimum of seven (7) years of management experience within a health care organization (managed care or prepaid health system experience preferred); general and fiscal operations; or equivalent combination of education and experience is required.

Sr. Director of Member Services & Grievance

The Senior Director of Member Services and Grievance is responsible for leading, planning, organizing, and managing all operational functions of the Member Services and Grievance departments organization- wide. This role ensures efficient operations, compliance with policies and procedures and achievement of department goals and objectives. A bachelor's degree in business or related field required; minimum ten (10) years of experience at a manager level or above in a managed care environment and/or call center; or equivalent combination of education and experience is required.

~~Director of Health Equity~~

~~The Director of Health Equity will partner with other PartnershipHC leaders to develop and drive forward the key strategies to be a diverse, equitable, and inclusive organization. They will be responsible for driving systemic change to increase diversity and representation as well as building programs that foster an inclusive culture of belonging. This position will promote pathways towards raising awareness of health inequities within our membership and concrete plans for addressing them. This will include working to track, trend and improve disparities in care, recognizing the diverse cultural, language, economic, education and health status needs of those in our service area and organization. A bachelor's degree in social work, health care, public policy, business, or related field, 5five years of experience advocating for and implementing change within a multi-cultural environment, with at least 3 years' experience developing and implementing diversity, equity, and inclusion programs, or equivalent combination of education and experience is required.~~

Director of Grievance and Appeals

This Director of Grievance and Appeals has the overall responsibility for leading, organizing, and directing the Grievance & Appeals (G&A) Department. This role provides strategic direction and oversight to ensure Partnership HealthPlan of California meets its regulatory and contractual obligations related to G&A. This role oversees the Investigation Team, which is responsible for end-to-end investigations of member grievances, appeals, and state hearing cases. They ensure all casework is compliant with applicable state and federal requirements, the Department of Healthcare Services (DHCS), and the National Committee for Quality Assurance (NCQA) credentialing standards. They oversee the G&A Compliance & Strategy Team, which monitors the impact of regulatory changes to G&A, extracts data for DHCS-mandated reporting, performs internal auditing of G&A casework, completes quantitative and qualitative NCQA reporting, and implements all G&A-related initiatives. The Director represents G&A in all external DHCS and NCQA regulatory audits, and is a key speaker on G&A trends at internal and external committees. They are responsible for organizing and facilitating the internal quality committee — the Member Grievance Review Committee (MGRC). They also hold budgetary responsibilities. A bachelor's degree from an accredited institution is required; an MBA or equivalent is preferred. At least seven (7) years of experience in the managed care industry is required; a minimum three (3) years' experience in Grievance & Appeals is preferred. A minimum of five (5) years in a leadership role is also required.

Sr. Manager of Grievance and Appeals

The Senior Manager of Grievance & Appeals serves as a key departmental leader who will be responsible for strategic oversight and continuous improvement of all grievance, appeal, state hearing, and expedited case processes. This role leads and mentors a multidisciplinary team including Grievance Clinical Nurse Supervisors, State Hearing Representatives, Grievance Clinical Nurse Specialists, Supervisors, Grievance Case Analysts, Grievance Resolution Specialists, and Grievance Associates, ensuring excellence in case quality, regulatory compliance, timeliness, and member experience. In partnership with the Director, the Senior Manager drives the development and implementation of department wide goals, and quality improvement initiatives. This position represents the department in cross functional work groups, enterprise-wide projects, and external regulatory engagements, serving as a leader and advocating for equitable member resolution. The Senior Manager champions professional development, cultivates a high performance culture, leads efforts that contribute to organizational growth and member satisfaction, and provides strategic leadership, training and direction to staff.

A Mmaster's or Bachelor's degree in Business, Nursing, Healthcare Management, or other related field and 4-5 years experience in the healthcare industry, of which at least 3 years are in a leadership capacity, and/or equivalent combination of education and experience is required. Experience in Grievance & Appeals, case management, customer service, account management, or experience in de-escalation is preferred. This role must be willing to manage onsite and teleworking staff and have excellent written and interpersonal communication skills. Demonstrated conflict resolution and mediation skills are also required. This role must be confident, autonomous, solution driven, proactive, detail oriented, have high standards of excellence, be nonjudgmental, diplomatic, resourceful, intuitive, dedicated, and resilient.

Director of Population Health

The Director of Population Health is the key business leader who oversees the organization's Population Health Management strategy and is responsible for providing leadership, alignment, support, strategic development and implementation of associated activities and interventions. Provides clinical guidance and strategic direction for departmental activities by applying their understanding of population health management priorities, health care policy, financing, and regulations to promote optimal health outcomes for membersThe 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. A Bachelor of Science Nursing or Doctorate in Public Health is required. At least five (5) years of experience in a leadership/management role is also required. Experience in a managed care, health care provider network and/or working with Medi-Cal population is preferred.

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.Under the leadership of the Director of Population Health, manages

and provides direction to the Population Health team managers and supervisors to ensure Basic Population Health Management activities are performed in compliance with DHCS and NCQA requirements. Participates in the development, implementation, and maintenance of Population Health programs and achievement of department goals and objectives in a fast paced, dynamic environment. This role ensures compliance with established operational criteria, NCQA, and DHCS Standards, and PHC policies and procedures. A bachelor's degree is required, but an RN license is preferred. A minimum of five (5) years of relevant experience in health care operations, a minimum of three (3) years of management experience with effective problem solving, or equivalent combination of education and experience is required.

ADA Coordinator (Member Rights Specialist)

The Member Rights Specialist serves as the Plan's designated ADA Coordinator. This role is responsible for overseeing compliance with federal and state nondiscrimination and accessibility requirements, including the investigation, tracking, and resolution of ADA and discrimination related grievances. The Member Rights Specialist ensures appropriate review of reasonable accommodation requests, provides subject matter expertise to internal departments, and supports regulatory reporting related to member rights and accessibility standards. In addition, the Member Rights Specialist represents the Plan in State Fair Hearings. The Member Rights Specialists will reports to the G&A Nurse Supervisor (RN).

Nurse Supervisor of Grievance and Appeals

The Grievance and Appeals (G&A) Nurse Supervisor provides clinical and operational supervision to the Grievance & Appeals nursing team, including Nurse Specialists, Sr. Nurse Specialists, and State Hearing Representatives. The Nurse Supervisor maintains an active clinical caseload while overseeing the daily operations, workload distribution, and performance of the clinical team. The Nurse Supervisor ensures that casework meets all regulatory and quality standards, including DHCS guidelines, CMS regulations, NCQA standards, and internal best practices. This position supports management in driving team performance, upholding productivity and accuracy standards, and ensuring a cohesive and collaborative team environment. The Nurse Supervisor exercises advanced clinical judgment to assess, guide, and resolve complex cases and provides direct support and mentorship to staff. The role represents the department clinically in internal and external settings, including participation in hearings and key committees, and plays a central role in the department's clinical oversight and continuous improvement initiatives. -A bachelor's degree in healthcare administration, Business Bachelor's degree in Nursing, 3-5 years' experience to include at least one (1) year of case management experience and one (1) year in an acute care setting; or

equivalent combination of education and experience is required; CCM is desired. Knowledge of Partnership Grievance & Appeals processes is also desired. General knowledge of managed care with emphasis in UM or CM is preferred.

ADA Coordinator (Member Rights Specialist)

The Member Rights Specialist serves as the Plan's designated ADA Coordinator. This role is responsible for overseeing compliance with federal and state nondiscrimination and accessibility requirements, including the investigation, tracking, and resolution of ADA and discrimination related grievances. The Member Rights Specialist ensures appropriate review of reasonable accommodation requests, provides subject matter expertise to internal departments, and supports regulatory reporting related to member rights and accessibility standards. In addition, the Member Rights Specialist represents the Plan in State Fair Hearings. The Member Rights Specialists will reports to the G&A Nurse Supervisor (RN).

~~Sr. Manager of Grievance and Appeals~~

~~The Senior Manager of Grievance & Appeals serves as a key departmental leader who will be responsible for strategic oversight and continuous improvement of all grievance, appeal, state hearing, and expedited case processes. This role leads and mentors a multidisciplinary team including Grievance Clinical Nurse Supervisors, State Hearing Representatives, Grievance Clinical Nurse Specialists, Supervisors, Grievance Case Analysts, Grievance Resolution Specialists, and Grievance Associates, ensuring excellence in case quality, regulatory compliance, timeliness, and member experience. In partnership with the Director, the Senior Manager drives the development and implementation of department wide goals, and quality improvement initiatives. This position represents the department in cross functional work groups, enterprise-wide projects, and external regulatory engagements, serving as a leader and advocating for equitable member resolution. The Senior Manager champions professional development, cultivates a high performance culture, leads efforts that contribute to organizational growth and member satisfaction, and provides strategic leadership, training and direction to staff.~~

~~A master's or Bachelor's degree in Business, Nursing, Healthcare Management, or other related field and 4-5 years experience in the healthcare industry, of which at least 3 years are in a leadership capacity, and/or equivalent combination of education and experience is required. Experience in Grievance & Appeals, case management, customer service, account management, or experience in de-escalation is preferred. This role must be willing to manage onsite and teleworking staff and have excellent written and interpersonal communication skills. Demonstrated conflict resolution and~~

mediation skills are also required. This role must be confident, autonomous, solution driven, proactive, detail oriented, have high standards of excellence, be nonjudgmental, diplomatic, resourceful, intuitive, dedicated, and resilient.

Supervisor of Population Health

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.

Bachelor's degree in business, Communication, Healthcare Administration, or a related field, or 3-5 years of managed care experience; or equivalent combination of education and experience is required. General knowledge of managed care and principles of population health management is preferred.Supports and assists 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.

Supervisor of Health Equity Training

The Supervisor of Health Equity Training is responsible for executing and managing diversity, equity, and inclusion (DEI) training programs and initiatives to enhance the skills, knowledge and performance of the company, network provider, subcontractors, downstream subcontractors, etc. This role also participates in DEI training meetings, supports DEI Training all plan letter requirements set forth by DHCS, and supports monitoring of training completion of Partnership staff, network providers, subcontractors, downstream subcontractors etc. A bachelor's degree is preferred. At least a minimum of three (3) years of experience working directly in DEI initiatives with a proven track record of developing and implementing successful training programs; or any combination of education, training, and four (4) years of experience which provides the required knowledge and abilities is required. This role must also be knowledgeable in the use of Learning Management Systems (LMS), Electronic Learning platforms, online learning programs, and industry leading virtual learning programs

Cultural and Linguistic Liaison(s)

The Cultural and Linguistic Liaison is responsible for overseeing grievance and appeal reviews, as well as conducting cultural and linguistic reviews for our subcontractors to ensure alignment with our commitment to diversity and inclusion. This role will provide

support to the department on promoting health equity within our organization and in the community, ensuring fair and just access to healthcare services for all members. A bachelor's degree in public health, Community Health or related field preferred, two (2) to four (4) years of experience in Health Equity, or equivalent combination of education and experience is required.

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 materials for Partnership members, and community members as appropriate 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. The Senior Health Educator is a public health masters-prepared (or MCHES-certified) professional who maintains administrative oversight of health education and supports oversight of cultural and linguistic services. This role also implements health education activities that promote member wellness, understanding of benefits, and access to care. This position is responsible for health education programs and cultural and linguistic services. Plans, implements and evaluates health education activities; analyzes and coordinates cultural and linguistic services; Supports the development of the annual Population Needs Assessment (PNA) according to DHCS and NCQA guidelines; and collaborates in developing and implementing organizational interventions identified in the PNA in conjunction with health promotion and equity programs. The Senior Health Educator may also perform supervisor responsibilities. This role requires a Master of Public Health (MPH) degree with a health education or health promotion emphasis, or master's degree in Community Health with a specialization in health education or health promotion, or Master Certified Health Education Specialist (MCHES) awarded by the National Commission for Health Education Credentialing, Inc. This role must have a minimum of two (2) years' experience developing health education programs. Previous experience in a supervisory capacity, and/or experience or capacity to manage audit activities in our provider network, and experience or equivalent academic training on identifying health disparities within different cultures is preferred.

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 Educationbachelor’s degree in health education, Public Health, Community Health or related field;field, experience in Public Health Education. A minimumminimum of two (2) years of health education experience is preferred.

Community Health Needs Liaison(s)

Collaborates with internal staff in the development of Partnership’s Population Needs Assessment (PNA) through active participation in the Local Health Department’s Community Health Assessment (CHA) and/or Community Health Improvement Plan (CHIP) processes. Identifies and support key strategic activities and interventions that promote efforts to encourage members’ health outcomes. Works with Health Educator team to identify appropriate member educational materials to share with community partners, providers, and members. Required education includes Bachelor’s Degree in Public Healthbachelor’s degree in public health, Community Health or related field; A minimum of two (2) years of experience in public health is preferred.

Cultural & Linguistic Program Description Approval

	0X/XX/2026

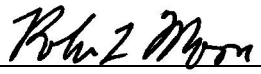
Robert Moore, MD, MPH, MBA *Date Approved*
Quality/Utilization Advisory Committee Chairperson

	0X/XX/2026

Angela Brennan, DO *Date Approved*
Physician Advisory Committee Chairperson

	0X/XX/2026

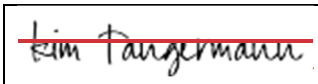
Kim Tangermann *Date Approved*
Board of Commissioners Chairperson

	~~06/18/2025~~

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

	~~08/13/25~~

~~*Angela Brennan, DO* *Date Approved*~~
~~*Physician Advisory Committee Chairperson*~~

	~~08/27/2025~~

~~*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 Partnership contracted provider site or is calling Partnership HealthPlan of California.
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 Partnership's Member Services.

Sign Language Interpreters

a. Member is enrolled in Partnership at the point the service is required.
b. Member does not have OHC that is primary to Partnership, that covers the requested/required interpreting service.
c. Appointment is for a service that is covered by Partnership.
d. Member has hearing and/or speech impairment.
e. Sign Language Interpretation services require prior authorization through Partnership'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 Partnership at the point the service is required.
b. Member does not have OHC that is primary to Partnership, that covers the requested/required interpreting service.
~~c.~~ The appointment is for a service that is covered by Partnership.
c.
~~f.~~d. Face-to-face interpretation services require prior authorization through Partnership's Member Services department. Requests can be made by calling Member Services in advance at (800) 863-4155.
~~d.~~e. 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 Partnership benefit and fall under Partnership responsibility to arrange and schedule face-to-face interpreter services.
~~e.~~f. If face-to-face interpreter services are being requested at a hospital, Partnership staff contacts the Patient Services department at the hospital for these services. If the hospital refuses to provide these services, Partnership 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 Partnership 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. Partnership provides notice of the availability of and procedure for requesting auxiliary aids and services through our language assistance taglines Notice of Availability and Nnon-Ddiscrimination notices.
    b. When a member, their authorized representative (AR), or someone with whom it is appropriate for Partnership 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 Partnership representative will help the member/AR/companion can fill out and submit an Partnership's Auxiliary Aid Request Form
            1. Partnership 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 Partnership staff over the phone about their auxiliary aids or services request.
            1. Partnership staff will notate this request at time of call.
            2. Partnership 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. Partnership 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 Partnership 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
A Propio Company

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

May 28, 2025

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 to 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.

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 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.

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

Authorized Certification and/or Accreditation Marks. This certificate is property of NSF-ISR and must be returned upon request.

***Company is audited for conformance at regular intervals. To verify certification call (888) NSF-9000 or visit our web site at www.nsf-isr.org**

ANAB ACCREDITED ISO/IEC 17021-1 MANAGEMENT SYSTEMS CERTIFICATION BODY

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

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

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 is composed of a single committee that provides Partnership members with a forum that allows meaningful engagement and the ability to discuss common issues of interest and importance, while creating a supportive and informative environment. Partnership has determined that it would be most effective to operate a single committee, providing visibility to Partnership's service area as a whole. The CAC is composed of Partnership members, advocates, and stakeholders who represent the diversity and geographic regions of Partnership's membership~~,~~ including hard-to-reach populations. The CAC may also include participation from select providers within the service area. Partnership ensures that all Subcontractors and Network Providers comply with all applicable state and federal law and regulations. 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 diverse 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~~them so they can effectively participate in CAC meetings. These resources may include, but are not limited to, onboarding materials for CAC members and additional support to assist them in their CAC activities.

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

- Identify member concerns that may influence Partnership policies and practices
- 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, operational, and cultural competency issues that may affect groups who speak a primary language other than English
- Make recommendations regarding the cultural appropriateness of communications, partnerships, and/or services
- Annually review the results of the C&L program evaluation to provide feedback and recommendations on root causes and possible interventions.
- Provide input on necessary member/provider targeted services, programs, and trainings including but not limited to diversity, equity, and inclusion.

Community Advisory Committee Guiding Principles

- Review Population Needs Assessment findings and discuss improvement opportunities related to Population Health Management (PHM), Health Equity and ~~Social Drivers of~~ Health Disparities
- Contribute feedback and suggestions on Community Health Assessments (~~CHAs~~CHA)/Community Health Improvement Plans (~~CHIPs~~CHIP) and other health education and community focused initiatives
- Validate Community Reinvestment Plans prior to submission to DHCS to ensure investments are adequately targeted toward the needs of the community
- Making recommendations on Quality of Care and children services
- 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, Partnership marketing materials, and campaigns
- Annually review grievance and appeal data
- Review and make recommendations regarding Quality Improvement activities, including but not limited to the Member Satisfaction Survey results
- Review communication of needs for Network development, assessment, and provider manual
- Development of Non-Specialty Mental Health Services (NSMHS), outreach, and education plan
- Priorities for health education and outreach programs
- Community resources information
- Reforms to improve health outcomes, accessibility of services, and coordination of care for members

To manage the operations of this committee, Partnership has designated CAC ~~facilitators~~Facilitators and a ~~coordinator~~Coordinator. The CAC ~~coordinator~~Coordinator, in partnership with the Facilitators, are responsible for managing the operations of the CAC. Together, they ensure compliance with all statutory, rule, and DHCS contractual requirements. Partnership ensures that the CAC program team, including the CAC Coordinator and Facilitators, are neither Partnership members nor members of the committee.

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.

Community Advisory Committee Guiding Principles

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~~To ensure that the ~~committee~~CAC is composed of representatives that bring different perspectives, ideas, and views to the committee~~. These~~, Partnership has enacted a CAC Selection Committee, tasked with the selection of new CAC members.

Partnership's Board of Commissioners serves as our Selection Committee and is made up of representatives ~~may reflect~~from Partnership's service area, including representation at the county, provider, and member level. The CAC Program Team consults with Partnership's Health Equity Officer, prior to the Selection Committee's appointment of new CAC members.

Partnership's Selection Committee ensures that the composition of the committee reflects 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, and age backgrounds (including parents/caregivers of adolescents/foster youth and representatives from Indian Health Care Providers [IHCP]).
- Limited English Proficient (LEP) Members
- Members who receive Long-Term Supports Services (LTSS), and/or individuals representing those members

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 ensure appropriate representation, our internal teams established a membership

Community Advisory Committee Guiding Principles

baseline and corresponding committee capacity. Our CAC membership baseline shall align with the Board of Commissioner seats per county. The ratio selected for each county is defined as one (1) times the number of Partnership Board of Commissioner seats per county, whereas the membership capacity will be two (2) times the baseline.

The CAC ~~coordinator, facilitators~~Coordinator, Facilitators, and the CAC selection committee are responsible for selecting new CAC members and/or replacing former CAC members whose position has been vacated. If a CAC member resigns or is asked to resign, the CAC ~~coordinator, facilitators~~Coordinator, Facilitators, and the CAC selection committee must make their best effort to promptly replace a vacant seat within 60 calendar days. The CAC Team will continue to ensure that Partnership is responsive to the diverse health care needs of all members and is reflective of Partnership's service area.

Member Responsibilities

- Regularly attend scheduled meetings
  - If a member of Partnership's Board (or committees) has an ADA-qualifying disability that prevents in-person attendance, the member may participate in a public meeting remotely as reasonable accommodation.
- Arrive in a timely manner
- Actively ~~participate~~engage in CAC meetings by providing opinions and feedback to improve Partnership services
- Provide updated contact information to the CAC ~~coordinator~~Coordinator and/or ~~facilitators~~Facilitators for the purpose of meeting notices
- Notify the CAC ~~coordinator~~Coordinator and/or ~~facilitators~~Facilitators 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 ~~if~~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,

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emailing, or sending a letter to the CAC ~~coordinator~~Coordinator and/or ~~facilitators~~Facilitators. The CAC ~~coordinator, facilitators~~Coordinator, Facilitators, and the CAC selection committee will make a good-faith effort to promptly replace any vacancy due to member resignations (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 the Department of ~~Healthcare~~Health Care Services (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, CHA/CHIP initiatives, resource allocation, and other community-based initiatives, including examples of how CAC input impacted and shaped Contractor initiatives and/or policies
- The data sources used to validate that CAC membership aligns with member demographics
- 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. Three representatives throughout Partnership's regions will be selected every two years to represent the CAC on the Board of Commissioners.

~~**Department of Healthcare Services (DHCS)**~~

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DHCS Statewide Medi-Cal Member Advisory Committee (MMAC)
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 MMAC. Partnership shall compensate the representative for time and participation within the Statewide MMAC, 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:

County	Address
Butte	2760 Esplanade Avenue, Suite 130, Chico, CA 95973
Humboldt	1036 5th St., Suite E, Eureka, CA 95501
Placer	281 Nevada Street, Auburn, CA 95603
Shasta	2525 Airpark Drive, Redding, CA 96001
Solano	4605 Business Center Drive, Fairfield, CA 94534
Sonoma	495 Tesconi Circle, Santa Rosa, CA 95401

All CAC meetings are open to the public and ~~we welcome and encourage attendance~~held in locations that are easily accessible to all members. 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 calendar days, and no later than 72 hours prior to the meeting. Video conferencing equipment is used when members from multiple locations participate. Interpretation and translations services are available to all members upon request.

Community Advisory Committee Guiding Principles

Facilitation of Meetings

CAC meetings are conducted in compliance with the Ralph M. Brown Act. The CAC ~~facilitator~~Facilitator(s) are responsible for the facilitation of all CAC meetings. The CAC ~~coordinator~~team will arrange interpretation and translation for our members upon request and ensure all locations where the meetings are held are accessible to all members. 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:

- CAC meeting minutes that include the date, time, attendee list, and place of CAC meetings
- A copy of the Guiding Principles and any modifications to date, which shall be open to inspection

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	Yes
					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	Yes
					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 February 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	Yes
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	No
					Deliverable #2: Conduct recruiting 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	Oct 1 - Dec 31 ☑ Complete ☐ On Track ☐ Delayed ☐ Terminated	Yes
					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	Yes
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 service (Del Norte, Humboldt, Lake, and	**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	**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	No
					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	☐ 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	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.	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 #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	**No**
					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	**No**
					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	

2026 Cultural and Linguistic Goals

Program Scope: In alignment with the objectives outlined in the C&L program description, this annual Cultural and Linguistic (C&L) work plan describes the planned activities for the coming year, along with the strategy and rubrics for monitoring against the measurable goals for the improvement of CLAS (Program to Improve Service Appropriateness and Accessibility). The goals for 2026 focus on four key metrics to improve CLAS standards. The first three goals include timely translations, mailing member's prefererred alternative formats, and increasing bilingual member services representatives, and are all aligned with content in the 2026 C&L program description. The last goal focuses on completing the C&L Evaluation to assess the program and any gaps. Partnership invests in the C&L program and C&L work plan as part of increasing access to care in order to improve member health outcomes which ultimately align with our mission to help our members, and the communities we serve, be healthy.

Goal #	Project/Program	Type of Goal	Goal	Outcome Measure(s)	Deliverables	Start Date	Due Date	Sponsor	Business Owner (Responsible Staff)	Deliverable Evaluation Status (Frequency of Monitoring)				Goal Met (Yes No)
										Jan 1 - Mar 31	Apr 1 - June 30	July 1 - Sep 30	Oct 1 - Dec 31	
1. C&L Program Measures	Providing materials to members in large print, Braille, audio format, or other, per member request	Continued with modification from 2025	**Goal #1:** By December 31, 2026, 92% 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 2026 C&L Program Evaluation based on 2026 C&L Program Description and Final 2026 C&L Work Plan in preparation for submission to the NCQA Consultant for review in February 2027.	1/1/2026	12/31/2026	Title: Chief Medical Officer Name: Robert Moore, MD	Title: Manager of Population Health Name: Hannah O'Leary, MPH, CHES Title: Sr. Manager of Member Services Name: Cyress Mendiola	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	
2. C&L Program Measures	Hiring of bilingual member services representatives	Continued with modification from 2025 (to monitor a previously identified issue)	**Goal #2:** By December 31, 2026, increase the percentage of bilingual MSR staff by 2% to move closer to organizational the 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.	1/1/2026	12/31/2026	Title: Chief Medical Officer Name: Robert Moore, MD	Title: Sr. Manager of Member Services Name: Cyress Mendiola Title: Supervisor of Member Services Name: Maria Cabrera	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	
					Deliverable #2: Conduct recruiting efforts to hire additional bilingual staff.	1/1/2026	12/31/2026	Title: Chief Medical Officer Name: Robert Moore, MD	Title: Sr. Manager of Member Services Name: Cyress Mendiola Title: Supervisor of Member Services Name: Maria Cabrera	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	
3. C&L Program Measures	Timely translation requests	Continued with modification from 2025 (to monitor a previously identified issue)	**Goal #3:** By December 31, 2026, improve the rate of timely translations in the Utilization Management and/or Care Coordination department by 1% from baseline of 96% or 98.5%, respectively.	**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.	1/1/2026	12/31/2026	Title: Chief Medical Officer Name: Robert Moore, MD	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	
4. Completion of C&L Evaluation	Reporting	Continued with modification	**Goal #4:** By March 31, 2026, complete the 2025 C&L Program Evaluation.	**Measure**: Completion of report.	**Deliverable #1:** Generate a report based on 2025 C&L Program Description and Final 2025 C&L Work Plan.	10/1/2025	3/31/2026	Title: Chief Medical Officer Name: Robert Moore, MD	Title: Manager of Population Health Name: Hannah O'Leary, MPH, CHES	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	N/A	N/A	N/A	

2025 Cultural and Linguistic Program Evaluation

April 9, 2026

Table of Contents

Executive Summary

The purpose of this report is to describe and evaluate the Cultural and Linguistic (C&L) program structure and planned goals for 2025 in accordance with Population Health Management and other Partnership HealthPlan of California (Partnership) efforts of the year. Key elements in this annual evaluation include analysis of cultural and linguistic program structure/processes, review and assessment of progress towards C&L/QIHETP workplan goals, annual trending of data, gaps and/or barriers, review of the Community Advisory Committee (CAC) feedback on program and evaluation results, opportunities for program improvement, and overall program effectiveness.

In 2025, 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 collects aspects of data related to the Cultural and Linguistic (C&L) Program, evaluates key elements and resources, and assesses performance indicators of the C&L Program (including the C&L/QIHETP work plan) against its established benchmarks and/or goals. From this evaluation, Partnership then determines if any gaps exist in particular program activities or structure, identifies any opportunities for improvement, prioritizes those opportunities, and takes appropriate 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
- Alternative Formats and/or Auxiliary Aids and Services
- Language Data Collection
- Committee Review of QIHEC and CAC

- Policy Review
- Staffing

Activity Goals from the 2025 Cultural and Linguistic/Quality Improvement Health Equity Transformation (C&L/QIHETP) work plan that will be evaluated in this report include:

- **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.
- **Goal 3:** By December 31, 2025, 91% of members who have requested materials in an alternative format will receive one or more mailings in their preferred format.
- **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.
- **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%.
- **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.
- **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.

I. Evaluation of Program to Improve Service Appropriateness and Accessibility

A. Description and Analysis of Cultural and Linguistical Program Components

1. Translation Services

As part of standard procedures, and in alignment with Partnership's regulatory body, the Department of Health Care Services (DHCS), Partnership utilizes Propio (previously United Language Group or ULG) as the certified translation service of all member-facing materials (including vital written materials) for Limited English Proficient (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. Propio's services are provided at no cost to the member; written content is typically translated by Propio within 2-5 business days, but can vary depending on the project or requirements of the requester. 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

Partnership collects data on translation services. An analysis was conducted on this activity to review the number of fulfilled translation requests for various years. 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.

In 2025, Partnership fulfilled 1,864 translation requests in a variety of languages, of which 1,561 requests were in Partnership's threshold and/or concentration languages (see Table 1). This is a moderate increase from 2024. There were 966 requests for materials to be translated into Spanish, 236 requests were for Russian translations, 184 requests were for Tagalog translations, and 175 requests were for Punjabi. This data is reflective of Partnership's translation requests through Partnership's language vendor, Propio for 2023, 2024, and 2025 and demonstrates the variety of languages available for translating materials.

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

Table 1: Translation Requests Fulfilled by Propio/ULG by Year

Number of Fulfilled Translation Requests						
	2025		2024		2023	
Language	Count	Percent	Count	Percent	Count	Percent
Amharic	0	0.00%	0	0.00%	1	0.13%
Arabic	19	1.02%	25	2.25%	12	1.66%
Bengali	0	0.00%	0	0.00%	1	0.13%
Braille	0	0.00%	3	0.27%	0	0.00%
Chinese	40	2.15%	20	1.80%	22	3.05%
Chuukese	1	0.05%	0	0.00%	1	0.13%
Croatian	4	0.21%	0	0.00%	0	0.00%
Danish	0	0.00%	0	0.00%	1	0.13%
Dari	14	0.75%	4	0.36%	2	0.27%
Dutch	0	0.00%	6	0.54%	0	0.00%
English	34	1.82%	0	0.00%	0	0.00%
Farsi	29	1.56%	31	2.79%	16	2.22%
French	8	0.43%	10	0.90%	1	0.13%
Gujarati	1	0.05%	0	0.00%	1	0.13%
Haitian	0	0.00%	2	0.18%	1	0.13%
Hindi	11	0.59%	7	0.63%	5	0.69%
Hmong	19	1.02%	19	1.71%	13	1.80%
Indonesian	1	0.05%	0	0.00%	0	0.00%
Iu Mien	10	0.54%	6	0.54%	12	1.66%
Japanese	2	0.11%	1	0.09%	6	0.83%
Khmer (Cambodian)	10	0.54%	11	0.99%	9	1.25%
Korean	5	0.27%	2	0.18%	3	0.41%
Lao	14	0.75%	12	1.08%	12	1.66%
Mongolian	1	0.05%	0	0.00%	0	0.00%
Nepali	2	0.11%	0	0.00%	1	0.13%
Pashto	3	0.16%	8	0.72%	2	0.28%
Portuguese	11	0.59%	21	1.89%	12	1.66%
Punjabi	175	9.39%	36	3.23%	19	2.63%
Romanian	2	0.11%	0	0.00%	1	0.13%
Russian	236	12.66%	145	13.03%	99	13.75%
Serbian-Cyrillic	0	0.00%	0	0.00%	2	0.27%
Spanish	966	51.82%	557	50.04%	338	46.95%
Swahili	0	0.00%	0	0.00%	1	0.13%
Tagalog	184	9.87%	139	12.49%	100	13.88%
Thai	11	0.59%	8	0.72%	10	1.38%
Tigrinya	0	0.00%	1	0.09%	0	0.00%

Turkish	3	0.16%	6	0.54%	1	0.13%
Twi	0	0.00%	1	0.09%	0	0.00%
Ukrainian	7	0.38%	13	1.17%	0	0.00%
Unknown	16	0.86%	0	0.00%	0	0.00%
Urdu	1	0.05%	0	0.00%	0	0.00%
Vietnamese	24	1.29%	19	1.71%	15	2.08%
Total:	**1,864**		**1,113**		**720**	

Source: Propio Records, 2023-2025.
*Note: The * indicates a language is one of Partnership's threshold languages as defined by DHCS*

Transitioning to a different metric, Table 2 shows a year-over-year comparison of the timeliness of turnaround times for translation requests on behalf of Partnership, which can in turn affect the timeliness of a member receiving their material. Timeliness is generally defined as within 2-5 business days, but no more than 30 days from the time of the member request to when the material is mailed to the member; exact turnaround times may depend on the complexity and rarity of the language requested and are dependent on specific departmental turnaround times. In 2024, there were more on time requests completed when compared to 2023 and 2022 (800 compared to 478 and 294 requests, respectively). The increase 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 2024. In 2025, there were significantly more on time requests completed when compared to 2024, 2023, and 2022.

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. In 2025, the number of late requests rose to 26, which is significantly higher than the previous years. This may be due to having more complete data compared to 2023 and 2024. Other barriers to timely translations include translating highly technical assignments requiring additional review, adding last minute additional content or changes to existing projects, taking extra time to confirm project details to ensure the final translations are accurate, file formatting, and unforeseen circumstances. This data is reflective of all Partnership's translation requests through Partnership's language vendor, Propio, for the years listed in the table below.

Table 2: Propio Translation Request Fulfillment Status by Year

Year-Over-Year Status							
2025		2024		2023		2022	
On time	Late	On time	Late	On time	Late	On time	Late
1,790	26	800	1	478	7	294	3

Source: Partnership Records, 2025

While there is currently no established benchmark 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. Given the upward trend in late requests, there are plans to better 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 qualified staff or Partnership's contracted language service provider, AMN HealthCare. The next section's analysis will focus on data from AMN HealthCare.

Analysis/Discussion

Partnership collects data on interpreter services. An analysis was conducted on this activity to review the number of interpreter calls for various years. 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.

In 2025, there were 444,134, interpreter calls, a moderate increase from 2024. Of the total calls, 365,513 calls were in the threshold languages of Russian, Spanish, Tagalog, and Punjabi. Spanish came in at 328,034 calls, 23,787 calls were in Russian, 1,685 calls were for Tagalog, and the 12,007 requests in Punjabi (see Table 3). Other languages of note were the 3,982 calls in Arabic, the 2,258 calls for American Sign Language (ASL), the 1,820 calls for Cantonese, 20,288 calls in Dari, the 3,191 calls in Farsi, the 5,651 in Haitian Creole, the 2,384 for Hmong, the 4,962 calls in Mandarin, the 5,179 calls in Pashto, the 4,150 calls in Portuguese, the 3,002 in Ukrainian, the 1,566 in Urdu, and the 9,062 calls in Vietnamese. This data demonstrates Partnership has a vast array of available languages for interpretation service.

In addition to quantity, Partnership also considers the quality of its interpreter calls. As such, it was also identified after each Video Remote Imaging (VRI) call conducted through AMN, the provider using the service is asked to complete a survey to rate the interpreter and the video quality. In 2025, the average interpreter rating for AMN was 4.83 out of 5 and the average video quality rating was 4.77 out of 5. Barriers to reaching a rating of 5 for interpreter rating included the interpreter being inattentive during the call, the interpreter was not interpreting the provider verbatim, issues with the volume of the interpreter (either too quiet or too loud), or background noise from the interpreter during the call. Barriers to reaching a rating of 5 for video quality included unstable connection, poor quality video, and longer than expected wait times for the interpreter. To address ongoing quality improvement, AMN conducts annual interpreter performance evaluations and trainings.

One concern with the data table presented above is that it only captures interpreter calls conducted through our vendor, AMN. The data also does not differentiate between phone calls and VRI interpreter calls. Thus, any direct interpreter calls conducted by Partnership staff are not included. As such, there is a future opportunity for Partnership to work towards refining its interpreter services reporting process. Improvement activities to consider include exploring how to collect data on Partnership staff provided interpreter services, and/or increasing the number of bilingual providers in a specific region.

Table 3: Number of Interpreter Sessions by Year

Number of Interpreter Sessions						
	2025		2024		2023	
Language	Count	Percent	Count	Percent	Count	Percent
Achi	59	0.01%	53	0.02%	38	0.03%
Acholi	3	0.00%	11	0.00%	8	0.01%
Afar	12	0.00%	3	0.00%	2	0.00%
Afrikaans	0	0.00%	1	0.00%	1	0.00%
Akan	0	0.00%	0	0.00%	4	0.00%
Akateko	2	0.00%	0	0.00%	2	0.00%
Albanian	43	0.01%	18	0.01%	2	0.00%
Algerian	2	0.00%	0	0.00%	0	0.00%
Amharic	150	0.03%	73	0.02%	61	0.05%
Arabic	3,982	0.90%	2,599	0.81%	1,210	0.91%
Armenian	176	0.04%	100	0.03%	45	0.03%
ASL	2,258	0.51%	1,661	0.52%	732	0.55%
Bengali	163	0.04%	70	0.02%	33	0.02%
Berber	1	0.00%	0	0.00%	0	0.00%
Bosnian	22	0.00%	12	0.00%	10	0.01%
Bulgarian	53	0.01%	32	0.01%	29	0.02%
Burmese	445	0.10%	297	0.09%	105	0.08%
Cantonese	1,820	0.41%	1,464	0.46%	888	0.67%
Cape Verdean	29	0.01%	12	0.00%	9	0.01%
CDI	81	0.02%	59	0.02%	38	0.03%
Cebuano	0	0.00%	1	0.00%	0	0.00%
Chuukese (Trukese)	37	0.01%	8	0.00%	8	0.01%
Croatian	46	0.01%	35	0.01%	9	0.01%
CST	2	0.00%	1	0.00%	3	0.00%
Czech	2	0.00%	0	0.00%	0	0.00%
Danish	1	0.00%	0	0.00%	1	0.00%
Dari	20,288	4.57%	6,559	2.04%	2,640	1.98%
Dutch	0	0.00%	1	0.00%	0	0.00%
English	5	0.00%	0	0.00%	0	0.00%
Ewe	0	0.00%	1	0.00%	0	0.00%
Falam	0	0.00%	0	0.00%	1	0.00%
Farsi	3,191	0.72%	2,093	0.65%	1,057	0.79%
French	327	0.07%	588	0.18%	309	0.23%
Fujianese	4	0.00%	0	0.00%	3	0.00%
Fuzhou	3	0.00%	0	0.00%	0	0.00%
Georgian	19	0.00%	14	0.00%	21	0.02%

Number of Interpreter Sessions						
	2025		2024		2023	
Language	Count	Percent	Count	Percent	Count	Percent
German	5	0.00%	9	0.00%	17	0.01%
Greek	18	0.00%	11	0.00%	2	0.00%
Gujarati	142	0.03%	70	0.02%	39	0.03%
Haitian Creole	5,651	1.27%	6,164	1.92%	1,530	1.15%
Hakha Chin	8	0.00%	1	0.00%	1	0.00%
Hakka	1	0.00%	0	0.00%	0	0.00%
Hausa	0	0.00%	0	0.00%	2	0.00%
Hebrew	4	0.00%	5	0.00%	4	0.00%
Hindi	1,096	0.25%	935	0.29%	716	0.54%
Hmong	2,384	0.54%	1,186	0.37%	375	0.28%
Hunan	1	0.00%	0	0.00%	0	0.00%
Hungarian	7	0.00%	4	0.00%	11	0.01%
Igbo	4	0.00%	0	0.00%	0	0.00%
Ilonggo	0	0.00%	1	0.00%	4	0.00%
Ilocano	3	0.00%	0	0.00%	0	0.00%
Indonesian (Bahasa Indonesian)	14	0.00%	9	0.00%	5	0.00%
Italian	28	0.01%	16	0.00%	22	0.02%
Japanese	147	0.03%	137	0.04%	51	0.04%
Kabba (Dialect from Yoruba)	1	0.00%	0	0.00%	0	0.00%
Kanjobal	0	0.00%	1	0.00%	2	0.00%
Karen	9	0.00%	37	0.01%	6	0.00%
Karenni	0	0.00%	1	0.00%	0	0.00%
Khmer (Cambodian)	1,601	0.36%	1,644	0.51%	1,247	0.94%
Kinyarwanda	1	0.00%	2	0.00%	1	0.00%
Kirundi	1	0.00%	0	0.00%	0	0.00%
Korean	838	0.19%	611	0.19%	439	0.33%
Krio	0	0.00%	1	0.00%	0	0.00%
Kumam	2	0.00%	0	0.00%	1	0.00%
Kurdish	1	0.00%	2	0.00%	3	0.00%
Lao	632	0.14%	582	0.18%	324	0.24%
Lautu	0	0.00%	0	0.00%	1	0.00%
Lingala	3	0.00%	7	0.00%	2	0.00%
Luganda	0	0.00%	0	0.00%	1	0.00%
Maay Maay	0	0.00%	0	0.00%	1	0.00%

Number of Interpreter Sessions						
	2025		2024		2023	
Language	Count	Percent	Count	Percent	Count	Percent
Malay (Bahasa Malaysia)	0	0.00%	1	0.00%	0	0.00%
Malayalam	19	0.00%	12	0.00%	3	0.00%
Mam	143	0.03%	59	0.02%	131	0.10%
Mandarin	4,962	1.12%	3,732	1.16%	2,247	1.69%
Marshallese	20	0.00%	3	0.00%	3	0.00%
Mien	91	0.02%	71	0.02%	90	0.07%
Mixteco	1	0.00%	0	0.00%	0	0.00%
Mixteco Alto	9	0.00%	1	0.00%	6	0.00%
Mixteco Bajo	13	0.00%	6	0.00%	14	0.01%
Mizo	2	0.00%	0	0.00%	0	0.00%
Mongolian	123	0.03%	44	0.01%	30	0.02%
Moroccan Arabic	1	0.00%	12	0.00%	4	0.00%
Nepali	1,121	0.25%	763	0.24%	340	0.26%
Nigerian Pidgin	2	0.00%	1	0.00%	1	0.00%
Norwegian	1	0.00%	0	0.00%	0	0.00%
Oromo	1	0.00%	1	0.00%	1	0.00%
Pashto	5,179	1.17%	1,949	0.61%	974	0.73%
Persian	421	0.09%	287	0.09%	183	0.14%
Pohnpeian	0	0.00%	0	0.00%	2	0.00%
Polish	13	0.00%	13	0.00%	29	0.02%
Portuguese	4,150	0.93%	4,021	1.25%	2,427	1.82%
Punjabi	12,007	2.70%	6,849	2.14%	2,598	1.95%
Quechua	1	0.00%	0	0.00%	0	0.00%
Quiche	7	0.00%	13	0.00%	10	0.01%
Rohingya	3	0.00%	0	0.00%	0	0.00%
Romanian	681	0.15%	721	0.22%	605	0.45%
Russian	23,787	5.36%	15,161	4.73%	4,984	3.74%
Samoan	1	0.00%	2	0.00%	4	0.00%
Serbian	31	0.01%	9	0.00%	18	0.01%
Sichuanese	1	0.00%	0	0.00%	0	0.00%
Sinhala (Sinhalese)	1	0.00%	1	0.00%	0	0.00%
Slovak	2	0.00%	0	0.00%	0	0.00%
Somali	7	0.00%	3	0.00%	3	0.00%
Spanish	328,034	73.86%	246,799	76.94%	98,844	74.21%
Sudanese	1	0.00%	0	0.00%	0	0.00%
Swahili	45	0.01%	23	0.01%	12	0.01%

Number of Interpreter Sessions						
	2025		2024		2023	
Language	Count	Percent	Count	Percent	Count	Percent
Tagalog	1,685	0.38%	1,099	0.34%	839	0.63%
Taishanese	0	0.00%	7	0.00%	3	0.00%
Taiwanese	2	0.00%	1	0.00%	3	0.00%
Tajik	3	0.00%	0	0.00%	0	0.00%
Tamil	103	0.02%	129	0.04%	47	0.04%
Tedim	0	0.00%	0	0.00%	10	0.01%
Telugu	12	0.00%	7	0.00%	15	0.01%
Thai	739	0.17%	443	0.14%	260	0.20%
Tibetan	0	0.00%	5	0.00%	2	0.00%
Tigre	0	0.00%	0	0.00%	1	0.00%
Tigrinya	329	0.07%	347	0.11%	362	0.27%
Toishanese	1	0.00%	0	0.00%	0	0.00%
Tongan	10	0.00%	1	0.00%	0	0.00%
Triqui	4	0.00%	1	0.00%	4	0.00%
Turkish	803	0.18%	570	0.18%	149	0.11%
Twi	1	0.00%	0	0.00%	0	0.00%
Ukrainian	3,002	0.68%	1,556	0.49%	280	0.21%
Unknown	29	0.01%	21	0.01%	8	0.01%
Urdu	1,566	0.35%	830	0.26%	518	0.39%
Uzbek	58	0.01%	6	0.00%	4	0.00%
Vietnamese	9,062	2.04%	7,965	2.48%	5,036	3.78%
Visayan	5	0.00%	0	0.00%	0	0.00%
Wolof	0	0.00%	2	0.00%	6	0.00%
Yemini Arabic	3	0.00%	4	0.00%	2	0.00%
Yoruba	8	0.00%	6	0.00%	0	0.00%
Zapoteco	0	0.00%	1	0.00%	1	0.00%
Zomi	0	0.00%	0	0.00%	2	0.00%
Total	**444,134**		**320,760**		**133,191**	

Source: Partnership records, Number of Interpreter Calls for 2023-2025.
*The * indicates a threshold language.*

3. Alternate Format:

In accordance with APL 25-005 Standards For Determining Threshold Languages,[2] Nondiscrimination Requirements, Language Assistance Services, And Alternative Formats and APL 25-016 Alternative Format Selection for Members with Visual

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

Impairments,[3] 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 materials no less than 20 point and in Arial font, and accessible electronic format such as a data CD, or other auxiliary aids and services that may be appropriate. Also in accordance with APL 25-005 and APL 25-016, Partnership must provide the 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.

Analysis/Discussion

Partnership collects data on requests for materials in alternative formats. An analysis was conducted on this activity to review the number of requests members had for materials in an alternate format. This analysis showed that in 2023, Partnership received 286 requests for materials to be sent as audio/CD, 1,443 requests for materials to be sent in large print font, 91 requests for materials to be sent in braille, and 0 requests for a USB drive (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/CD, 437 requests for materials to be sent in large print font, 64 requests for materials to be sent in braille, and 0 requests for a USB drive (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.

In 2025, Partnership received 103 requests for materials to be sent as audio/CD, 13,612 requests for materials to be sent in large print font, 67 requests for materials to be sent in braille, and 8 requests for USB drives (see Table 4). This service resulted in a total of 13,790 requests for alternative formats in 2025, which is significantly higher than the requests for 2023 and 2024.

Table 4: Alternative Format Requests by Year

Requests for Materials in Alternative Formats											
2025				2024				2023			
Audio/ CD	Large Font	Braille	USB	Audio/ CD	Large Font	Braille	USB	Audio/ CD	Large Font	Braille	USB
103	13,612	67	8	188	437	64	0	286	1,443	91	0
Total: 13,790				**Total: 689**				**Total: 1,820**			

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

Source: Partnership Records, 2025

Table 5 and Table 6 below further breaks down requests for Alternative Formats into fulfilled requests and the unfulfilled requests. Table 7 shows a fulfillment rate, thus demonstrating that the fulfillment request rate is slightly lower in 2025 compared to 2024 (99.4% vs 100% respectively).

Table 5: Fulfilled Requests for Alternative Format Requests for 2025

Fulfilled requests for Materials in Alternative Formats			
Type	**2025**	**2024**	**2023**
Audio/CD	100	188	286
Large Font	13,612	437	1,443
Braille	67	64	91
USB	8	0	0
Total	13,787	689	1,820

Source: Partnership Records, 2025

Table 6: Unfulfilled Requests for Alternative Format as of 2025

Unfulfilled requests for Materials in Alternative Formats			
Type	**2025**	**2024**	**2023**
Audio/CD	3	0	0
Large Font	0	0	0
Braille	0	0	0
USB	0	0	0
Total	3	0	0

Source: Partnership Records, 2025

Table 7: Rate of Fulfillment Requests Year over Year

Fulfilled requests rate for Materials in Alternative Formats			
Type	**2025**	**2024**	**2023**
Audio/CD	97.1%	100.0%	100.0%
Large Font	100.0%	100.0%	100.0%
Braille	100.0%	100.0%	100.0%
USB	100.0%	N/A	N/A
Total	99.97%	100%	100%

Source: Partnership Records, 2025

One barrier to note with the data provided for 2023 and 2024 is that, due to data collection challenges, it was limited to requests made from one department. As such, the total number of alternate format requests at an organizational-wide level would likely have been significantly higher than what was reported. This was due in part to challenges with internal organizational systems, as Partnership lacked a unified infrastructure to track requests for alternative formats at an organizational wide level.

This also led to incomplete data for unfulfilled requests, resulting in 0 unfulfilled requests, or a 100% fulfillment rate as noted in Table 7.

In early 2025, 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. This updated tracking system resulted in substantially more requests in 2025 (1,820 requests in 2023 and 689 in 2024 and vs. 13,790 in 2025) as noted in Table 4. Establishing this mechanism also provided a way to track fulfilled and unfulfilled alternative requests, resulting in a truer baseline of 3 unfulfilled requests (or a 99.97% fulfillment rate) as noted in Tables 5-7. However, since this updated tracking mechanism was not fully rolled out at the beginning of 2025, the data remains incomplete. Thus, an opportunity remains to refine the tracking mechanism in 2026 for data completeness. Despite these challenges, Partnership will continue to provide this service to its members at no cost to ensure they receive the highest quality healthcare.

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, Spanish, Punjabi, Tagalog, and Russian as Partnership's main languages. However, many languages are spoken among the member population (see Figure 1). Per DHCS requirements, Partnership officially added Punjabi as a threshold language in 2025.

Analysis/Discussion

As of December 2024, the most common languages spoken among Partnership's member population was 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

As of December 2025, the most common languages spoken among Partnership's member population is English (75.9%), Spanish (20.5%), Russian (0.6%), Punjabi (0.5%), and Tagalog (0.3%). See Figure 2 for a full list of languages. Minimal changes ensued when comparing 2024 data to 2025 data for all 5 threshold languages. However, the most significant change was a decrease in the number of English speakers (3,030 less people in 2025 compared to 2024).

Figure 2: Member Languages by County and Language as of December 2025

ENGLISH	ENGLISH	75.9% (677,857)
SPANISH	SPANISH	20.5% (183,154)
OTHER	OTHER NON ENGLISH	0.5% (4,514)
	HMONG	0.3% (2,410)
	VIETNAMESE	0.2% (2,167)
	FARSI	0.2% (1,912)
	NO VALID DATA REPO.	0.2% (1,905)
	MANDARIN	0.1% (1,047)
	ARABIC	0.1% (783)
	CANTONESE	0.1% (546)
	PORTUGUESE	0.1% (497)
	LAO	0.1% (485)
	MIEN	0.0% (419)
	CAMBODIAN	0.0% (307)
	ASL AMERICAN SIGN .	0.0% (272)
	KOREAN	0.0% (267)
	TURKISH	0.0% (148)
	FRENCH	0.0% (141)
	THAI	0.0% (130)
	CHINESE	0.0% (88)
	NO RESPONSE, CLIEN.	0.0% (76)
	SAMOAN	0.0% (62)
	ARMENIAN	0.0% (61)
		0.0% (54)
	ILACANO	0.0% (34)
	OTHER SIGN LANGUA..	0.0% (30)
	JAPANESE	0.0% (29)
	ITALIAN	0.0% (29)
	HEBREW	0.0% (14)
	POLISH	0.0% (9)
RUSSIAN	RUSSIAN	0.6% (5,524)
PUNJABI	PUNJABI	0.5% (4,634)
TAGALOG	TAGALOG	0.3% (2,289)
UKRAINI..	UKRAINIAN	0.1% (448)
HINDI	HINDI	0.0% (215)

Source: Partnership Tableau Dashboard, December 2025

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. As such, Punjabi became an official threshold language in 2025.

Given the addition of Punjabi as a threshold language, Partnership continues to ensure past and future member-facing materials are translated into Punjabi as part of standard practices. If any additional languages are deemed to be a threshold language, there is a future opportunity to incorporate the additional language into Partnership's standard translation practices for member-facing materials. 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)

Established in 2024, 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). As required by 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, hospitals, clinics, county partners, physicians, subcontractors, and/or downstream subcontractors, Partnership members, members from the California Department of Public Health (CDPH), members from academic institutions, ethnic services coordinators, community-based organization leaders, and tribal health liaisons, and health system leaders.

QIHEC is responsible for analyzing and evaluating the results of quality improvement and health equity activities including annual reviews 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. Lastly, the QIHEC committee 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

QIHEC is held on a bi-monthly basis. In 2024, all 5 scheduled QIHEC meetings took place. There were 46 attendees at the February meeting, 39 at the May meeting, 45 attendees at the August meeting, 37 attendees at the September meeting, and 44 attendees at the November meeting. Quorum was met at 5 out of 5 total meetings. Meetings were originally scheduled on a quarterly basis but switched to bi-monthly (see Table 8). As such, there was no meeting scheduled for November.

In 2025, all 6 scheduled QIHEC meetings took place. There were 47 attendees at the January meeting, 57 attendees at the March meeting, 56 attendees at the May meeting, 53 attendees at the July meeting, 48 attendees at the September meeting, and 55 attendees at the November meeting. Quorum was met at 6 out of 6 total meetings (see Table 8). Overall, there were more attendees per meeting in 2025 when compared to the number of attendees per meeting in 2024.

Table 8: QIHEC Meeting Schedule

2025 Meeting Date	# of Attendees	# of Members that Voted	Quorum Met	2024 Meeting Date	# of Attendees	# of Members that Voted	Quorum Met
January 21, 2025	47	8	Y	February 20, 2024	46	10	Y
March 18, 2025	57	9	Y	May 21, 2024	39	9	Y
May 27, 2025	56	7	Y	August 20, 2024	45	7	Y
July 22, 2025	53	8	Y	September 24, 2024	37	8	Y
September 16, 2025	48	6	Y	November 19, 2024	44	10	Y
November 16, 2025	55	7	Y	N/A	N/A	N/A	N/A

Source: Partnership Records, 2025. 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.

The QIHEC planned to review the following topics in 2025 (see Table 9):

Table 9: 2025 QIHEC Quarterly Meeting Agenda Topics

Meeting Date	Planned Topics	Skipped /Condensed Agenda Items
January 21, 2025	• Introductions • Renaming QIHEC • CMO Partnership HealthPlan Updates • Community Updates from ALIADOS and HANC • Meeting minutes • Grand Analysis: Disparity Analysis (Language Stratification) • Health Equity Integration Policy • Disparity Discussions: Prenatal and Postpartum Care in AI/AN • Disparity Discussions: Well-Care Visits in Rural Community • Disparity Discussions: Controlling Blood Pressure in AA Community • Next Meeting	None
March 18, 2025	• Introductions • Health Equity updates • Meeting Minutes • CMO Health Plan Updates • CA Association Updates	None

Meeting Date	Planned Topics	Skipped /Condensed Agenda Items
	• Grand Analysis: Population Needs Assessment, 2024 C&L Evaluation • Community Information • Key Policy Discussion • Health Equity Playbook • Disparity Discussions: Policy Changes • Disparity Discussions: QI/PHM • Next Meeting	
May 27, 2025	• Introductions • Health Equity updates • CMO Health Plan Updates • CA Association Updates • Meeting Minutes • Grand Analysis: • Community Information • Key Policy Discussion • DEI Policy • Disparity Discussions: Interventions • Next Meeting	None
July 22, 2025	• Introductions • Health Equity updates • CMO Health Plan Updates • CA Association Updates • Meeting Minutes • PHM Grand Analysis • Key Policy Discussion: QIHETP and QIHEC Policy • Disparity Discussions: Community Engagement • Open Forum – External Member Updates and Requests • New Committee Member(s) • Next Meeting	None
September 16, 2025	• Introductions/Roll Call/Meeting minutes • Health Equity updates • CMO Health Plan Updates • CARES Training Updates • Grand Analysis: HEDIS/MCAS/QIP Disparity Analysis (Race and Language Stratifications) • Community Feedback • Disparity Discussions: Systemic Concerns • Next Meeting	None

Meeting Date	Planned Topics	Skipped /Condensed Agenda Items
November 16, 2025	• Introductions/Roll Call/Meeting minutes • Health Equity updates • CMO Health Plan Updates • CARES Training Updates • Grand Analysis: HEDIS/MCAS/QIP Disparity Analysis (Race and Language Stratifications) • Community Feedback • Disparity Discussions: • Systemic Concerns • Next Meeting	None

Source: Partnership Records, 2025

In 2024, Partnership had the opportunity to fully represent its member population through the equitable distribution of QIHEC voting members. Despite successful meetings, Partnership experienced barriers which included operating in its 24-county service area with a 900,000 plus membership base. In addition, several planned topics 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.

In 2025, all planned topics in Table 9 were discussed, indicating there were no barriers. However, there is room for improvement in 2026. Opportunities include structural improvements to the QIHEC meetings, such as the creation QIHEC workgroup to address ongoing disparities and provide interventions and recommendations to vote on during the QIHEC meetings. Partnership's QIHEC meetings are sufficient and will continue to meet to ensure members are receiving the highest quality and equitable healthcare.

b. Community Advisory Committee (CAC)

The purpose of the Community Advisory Committee (CAC) is to act as a liaison between Partnership and its members. The CAC is composed of a single committee that provides Partnership members with a forum that allows meaningful engagement and the ability to discuss common issues of interest and importance, while creating a supportive and informative environment. Partnership has determined that it would be most effective to operate a single committee, providing visibility to Partnership's service area as a whole. The CAC is composed of members, advocates, and stakeholders who represent the diversity and geographic regions of Partnership's membership including hard-to-reach populations. The CAC may also include participation from select

providers within the service area. Partnership ensures that all Subcontractors and Network Providers comply with all applicable state and federal law and regulations. 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.

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.

Analysis/Discussion

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 June meeting, 18 attendees at the September meeting, and 20 attendees at the December meeting. Quorum was met at 4 of 4 meetings in 2024 (see Table 10). In 2025, all 4 scheduled CAC meetings took place. There were 25 attendees at the March meeting, 20 attendees at the June meeting, 26 attendees at the September meeting, and 20 attendees at the December meeting. There were more attendees per meeting in March 2025 and September 2025 when compared to the number of attendees per meeting in the same months in 2024. This was likely due to recruiting efforts of CAC members for Partnership's 10 newer counties. Compared to 2024, the June 2025 meeting had less attendees per meeting and the December 2025 meeting had the same number of attendees per meeting. Quorum was met at 4 of 4 meetings in 2025 (see Table 10).

Table 10: CAC Quarterly Meeting Schedule

2025 Meeting Date	Number of Attendees	Quorum Met	2024 Meeting Date	Number of Attendees	Quorum Met
March 13, 2025	25	Y	March 14, 2024	15	Y
June 12, 2025	20	Y	July 11, 2024	23	Y
September 11, 2025	26	Y	September 12, 2024	18	Y
December 11, 2025	20	Y	December 12, 2024	20	Y

Source: Partnership Records, 2025 and 2024

In 2025, the following agenda items were planned for review and discussion by CAC (see Table 11):

Table 11: 2025 CAC Quarterly Meeting Agenda Topics

Meeting Date	Planned Topics	Skipped /Condensed Agenda Items
March 13, 2025	• Welcome / Purpose of Meeting • Introductions • Approval of December 2024 Minutes • Follow Up from December 2024 CAC Meeting • Report on Board Meeting • Partnership Update • CAC Name Change • Update on CAC Events • Population Needs Assessment (PNA) • Partnership Texting Program • Partnership Advantage • 2024 Cultural and Linguistics Evaluation • Member Experience Annual Review • Open Forum • Next Meeting	Member Experience Annual Review (Was postponed until the December 2025 meeting)
June 12, 2025	• Welcome / Purpose of Meeting • Introductions • Approval of March 2025 Minutes • Follow Up from March 2025 CAC Meeting • CAC Member Seat Changes • Report on Board Meeting • Partnership Update • Announcement of CAC Coordinator CAC in the community • Community Health Assessment (CHA)/Community Health Improvement Plans (CHIP) Update • Transportation Overview • Open Forum Next Meeting	None
September 11, 2025	• Welcome / Purpose of Meeting • Introductions • Approval of July 2025 Minutes • Follow Up from July 2025 CAC Meeting • Report on Board Meeting • Partnership Update • Annual Grievance and Appeals Report	Children's Services Overview (Was postponed until December 2025 Meeting)

Meeting Date	Planned Topics	Skipped /Condensed Agenda Items
	• Health Disparities Data Review • Partnership in the Community • Member Outreach and Education Plan for Mental Health • Children's Services Overview • Open Forum • Next Meeting	
December 11, 2025	• Welcome / Purpose of Meeting • Introductions • Approval of September 2025 Minutes • Follow Up from September 2025 CAC Meeting • Report on Board Meeting • Community Board Representative Update • Partnership Update • Member Accomplishments or CAC Achievements • Children's Services Overview • Community Reinvestment Plan • CHA/CHIP Update • Member Experience Annual Review • Medi-Cal Dental Overview • Provider Manual Updates • Open Forum • Next Meeting	None

Source: Partnership Records, 2025

While most of the planned agenda items were discussed, the following items were either condensed or postponed in 2025:

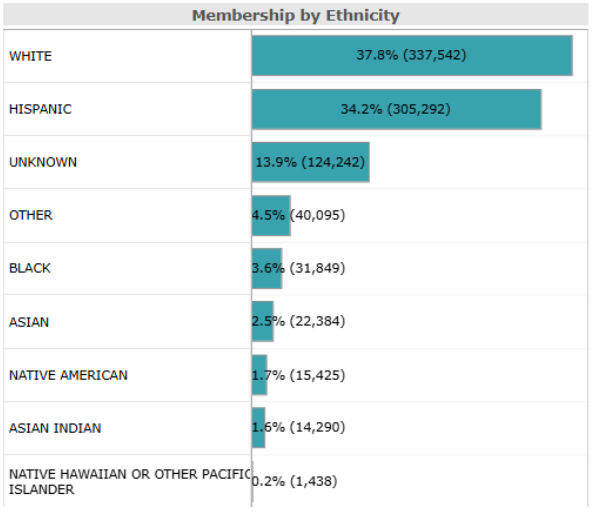
- Member Experience Annual Review (postponed until the December 2025 meeting)
- Children's services overview (postponed until December 2025 meeting)

Despite the delays, all planned agenda items were eventually covered by the end of 2025. Barriers to holding sufficient discussions of the planned agenda items mentioned in Table 11 included not having enough time allotted for the number of planned topics. Partnership is working internally to ensure all topics are discussed as scheduled for future meetings.

Furthermore, Partnership's CAC is reflective of 5% of its linguistic and racial/ethnic member population. Similar to 2024, Partnership's 2025 member data shows the known racial/ethnic groups that are reflective of at least 5% of Partnership's membership base

are White and Hispanic (see Figure 3). In addition, CAC also consists of Black, Asian, and Native American members which represent 3.6%, 2.5%, and 1.7%, respectively, of our membership population; these percentages closely align with 2024 data, which were 3.5% Black, 2.5% Asian, and 1.8% Native American. Other groups that CAC consisted of in 2025 were Chinese and Filipino.

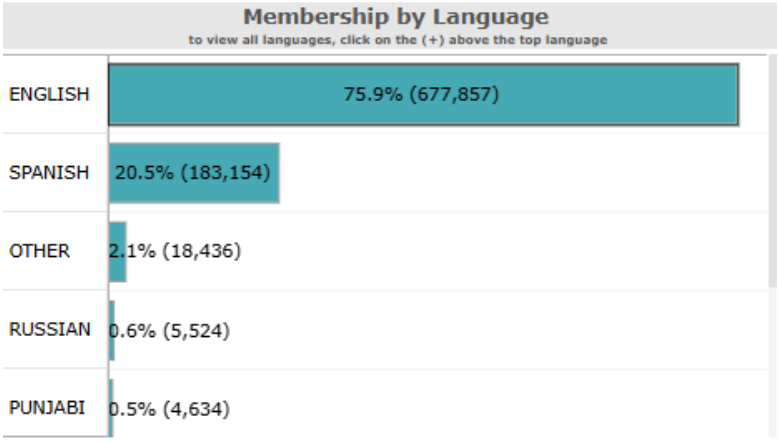
Figure 3: Partnership Membership by Ethnicity



Source: Partnership Records, December 2025

Also similar to 2024, English and Spanish are the only two linguistic groups representing at least 5% of the membership base (see Figure 4).

Figure 4: Partnership Membership by Language



Source: Partnership Records, December 2025

While Partnership has met a 5% linguistic and racial/ethnic reflection of its member population, recruitment efforts continue in order to fill vacant seats. There is a specific focus on filling seats in the 9 Partnership counties that currently have no CAC member representation. As of late 2025, Partnership had nine applications in progress for

onboarding new members, 3 of which are from non-represented counties. Barriers to filling vacant seats 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; however, transportation assistance is available to ensure participation. As part of recruitment efforts, Partnership continues to actively work with its regional leadership and provider network 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 12). In 2025 Partnership added a third and fourth report due for review and approval. All items were reviewed and approved. No barriers were identified in this process in any of the approval years. These policy reviews are sufficient. Partnership will continue to annually review and update as appropriate policies and reports to ensure regulatory compliance.

Table 12: Policy Review for 2023-2025

Department	Year	Policies/ Reports	Policies/Reports Reviewed for Consent	Policies/Reports Approved
Population Health	2023	1	1	1
Population Health	2024	2	2	2
Population Health	2025	4	4	4

Source: Partnership Records, 2025

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 primarily responsible for developing, maintaining, and overseeing implementation of Partnership's overall PHM strategy (MPND9001). This strategy, along with the support of other Partnership departments, helps 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, NCQA, and CMS requirements. 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 key 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
- Promote collaboration of effort
- 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 of Population Health, a Senior Health Educator, and health educators (see Table 13 for more details). Due to changes in department structure and changes in oversight of key cultural and linguistic activities, in 2025 the Chief Medical Officer, the Director of Health Equity, Cultural and Linguistic Liaisons, and a Supervisor of Health Equity Training position were hired and/or were brought into this work. The Health Equity team hired 2 Cultural and Linguistic Liaisons to help support the growing number of discrimination cases (further described below). Health Equity also hired 1 Supervisor of Health Equity Training to support the department's requirements to create a Diversity, Equity, and Inclusion (DEI) Training, as well as to improve community engagement initiatives based on disparities found in Partnership's local communities. A Manager of Cultural Community was also added in

2025 to support specific initiatives aimed at addressing key disparities in specific Partnership regions. The Chief Medical Officer, and the Director of Health Equity are not new roles but added to reflect changes in organizational structure.

Table 13: Number of Staff

Position Title	2025 Number of Positions	2024 Number of Positions
Associate Director of Population Health	1	1
Chief Health Services Officer	1	1
Chief Medical Officer	1	1
Community Health Needs Liaisons	6	6
Cultural and Linguistic Liaison	2	1
Director of Health Equity	1	1
Director of Population Health	1	1
Health Educator	2	2
Manager of Cultural Community	1	0
Senior Health Educator	1	1
Supervisor of Health Equity	1	0
Supervisor of Population Health	2	2

Source: Partnership data, 2025

In addition to having staff who support Cultural and Linguistic activities, 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, key Partnership staff are tasked with reviewing these time-intensive discrimination cases to provide third party input that ultimately helps determine if discrimination occurred or not. In early 2025, the Health Education team transferred this cultural and linguistic activity to the Health Equity department. This decision has allowed for more dedicated support of this activity and frees up the Health Education team to participate in future Cultural and Linguistic activities as needed.

The Health Education team reviewed 105 cases in 2023 and 204 cases in 2024, almost double the amount (see Table 14 for more details). This jump in cases may be due in part to Partnership's addition of 10 new counties in 2024. The Health Education team and the Health Equity team collectively reviewed 275 cases in 2025, a significant increase from 2023 and a moderate increase from 2024. Root causes of this jump in cases included provider access concerns due to not being able to see specific providers, an increase in cases due to ethnicity/nationality as well as disability discrimination claims, and cases with complaints around transportation options, and approvals of additional drivers. The number of staff for cultural and linguistic activities

was sufficient for 2025. Partnership will continue to dedicate staff to key cultural and linguistic activities.

Table 14: Number of Discrimination Cases Reviewed

2025	2024	2023
275	204	105

Source: Partnership data, 2024

B. Description and Analysis of Goals from the 2025 C&L/QIHETP Workplan

Partnership focused on eight measurable activities to improve upon in 2025 to address cultural and/or linguistic activities or health disparities seen in our member population. The tables below are a description of completed and ongoing goals for culturally and linguistically appropriate activities and services and/or health disparities.

1. Goal 1: Health Equity Strategic Plan

Goal 1 was “By June 30, 2025, develop and propose a multi-year health equity strategic and tactical plan.” The outcome measure was to track completion rates for all deliverables. Departments involved in the outcome of this activity included Health Equity, Quality Improvement, and Population Health. This goal started on 7/1/2024 and had an end date of 6/30/2025.

Analysis/Discussion

Evaluating the development of the Health Equity Strategic Plan analysis was completed through measuring progress against the stated goal. The Health Equity department team collaborated with the Quality Improvement Department, and the Population Health department to identify and implement these activities. Regular updates to the 2025 C&L/QIHETP work plan were made to track progress of goals. Table 15 provides a visual of the goal in more detail.

Table 15: Description of Goal and Measure

Goal	Outcome Measures	Deliverables	Start Date	Due Date	Completion Status
Goal 1: By June 30, 2025 develop and propose a multi-year health equity strategic and tactical plan.	Track completion rate for all deliverables.	**#1:** Update department activities to include health equity activities.	7/1/2024	6/30/2025	Complete
		#2: Update incentive models for employees.	7/1/2024	6/30/2025	Complete

Goal	Outcome Measures	Deliverables	Start Date	Due Date	Completion Status
		#3: Update incentive models for PCP QIP.	7/1/2024	6/30/2025	Complete
		#4: Create a list of interventions for addressing the disparities.	7/1/2024	12/31/2024	Complete
		#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	Complete

Source: Partnership 2025 C&L/QIHETP Work Plan

A review of this work plan took place towards the end of 2025 to see if each deliverable was completed; this was done ultimately to evaluate completion of this goal. This review showed that in 2025, Partnership completed all of the deliverables**, ultimately meeting the goal.** In 2024, Goal 1A 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." The 2024 goal was modified in 2025 to be more encompassing. As a note, at the time of writing the 2024 evaluation, Deliverable 5 for Goal 1A from the 2024 C&L/QIHETP workplan was delayed, but it has since been completed. As such, these overlapping goals for 2024 and 2025 were ultimately met.

2. Goal 2: DEI Training Distribution

Goal 2 was "By December 31, 2025 distribute the DEI training to the provider network and MCP staff and submit the final version to DHCS." The outcome measure was the DEI Training completion rate. Departments involved in the outcome of this activity included Health Equity. This goal started on 1/1/2025 and had an end date of 12/31/2025.

Analysis/Discussion

Evaluating the goal of providing DEI Training for staff and network providers to fulfill DHCS All Plan Letter (APL) requirements was completed through measuring progress against the stated goal. The Health Equity team identified and implemented these

activities. Regular updates to the 2025 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 2: By December 31, 2025 distribute the DEI training to the provider network and MCP staff and submit the final version to DHCS.	DEI Training completion rate.	**#1:** Conduct pilot with one of our provider networks.	1/1/2025	3/31/2025	Complete
		#2: Review feedback from pilot and make changes as appropriate.	4/1/2025	5/31/2025	Complete
		#3: Distribute the final training throughout the provider network and to MCP staff.	7/1/2025	12/31/2025	Complete

Source: Partnership 2025 C&L/QIHETP Work Plan

A review of this work plan took place towards the end of 2025 to see if each deliverable was completed; this was done ultimately to evaluate completion of this goal. This review showed that in 2025, Partnership completed all three deliverables on time, **thus meeting the goal**. As a note, Deliverable 1 carried over from 2024 to 2025, and while it was delayed at the time of writing the 2024 evaluation, it has since been completed. As such, when comparing the 2025 Goal 2 to a similar 2024 goal, it was determined both goals were ultimately met.

3. Goal 3: Services for Vision-Impaired Members

Goal 3 was “By December 31, 2025, 91% of members who have requested materials in an alternative format will be mailed in their preferred format.” Departments involved in the outcome of this activity included Member Services, and Population Health. The outcome measure was the percentage of members requesting materials in an alternative format who received a mailing in their preferred format. The numerator was the number of members who have been sent one or more mailings of materials in their preferred format, and the denominator was the number of members who have requested an alternate format. This goal started on 1/1/2025 and had an end date of 12/31/2025.

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 17 provides a visual of the goal in more detail.

Table 17: Description of Goal and Measure

Goal	Outcome Measures	Deliverable	Start Date	End Date	Completion Status
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.	**#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 February 2026.	1/1/2025	12/31/2025	Complete

Source: Partnership 2025 C&L/QIHETP Work Plan

A review of this work plan took place towards the end of 2025 to see if each deliverable was completed; this was done ultimately to evaluate completion of this goal. This review showed that in 2025, Partnership completed the deliverable for this goal.

A data analysis was also conducted on this activity to measure the percentage of members requesting materials in an alternative format compared to who was sent a mailing in their preferred format against the stated goal (otherwise known as the fulfillment rate). This analysis showed that in 2025, Partnership received 13,790 total requests for alternate formats (see Table 18). Partnership had 13,787 fulfilled requests and 3 unfulfilled requests which means of the 13,790 total requests received for alternate formats, 99.9% of requests were fulfilled (see Tables 19, 20, and 21). Thus, Partnership has **met** its goal of 91% of members receiving materials in their preferred alternate format requests.

Table 18: Alternative Format Requests by Year

Requests for Materials in Alternative Formats											
2025				2024				2023			
Audio/ CD	Large Font	Braille	USB	Audio/ CD	Large Font	Braille	USB	Audio/ CD	Large Font	Braille	USB
103	13,612	67	8	188	437	64	0	286	1,443	91	0
Total: 13,790				**Total: 689**				**Total: 1,820**			

Source: Partnership Records, 2025

Table 19: Requests for Alternative Format Requests for 2025

Fulfilled requests for Materials in Alternative Formats			
Type	**2025**	**2024**	**2023**
Audio/CD	100	188	286
Large Font	13,612	437	1,443
Braille	67	64	91
USB	8	0	0
Total	13,787	689	1,820

Source: Partnership Records, 2025

Table 20: Unfulfilled Requests for Alternative Format as of 2025

Unfulfilled requests for Materials in Alternative Formats			
Type	**2025**	**2024**	**2023**
Audio/CD	3	0	0
Large Font	0	0	0
Braille	0	0	0
USB	0	0	0
Total	3	0	0

Source: Partnership Records, 2025

When comparing the results of the 2024 goal to the 2025 goal, Partnership surpassed the goal for both years of ensuring member requests for alternative formats were appropriately honored; however, it is worth noting that the 2024 Goal 5, which was to 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, was delayed but ultimately completed.

In addition, in 2024 Partnership's data for unfulfilled alternative format requests was incomplete due to insufficient tracking mechanisms, resulting in 0 unfulfilled requests, or a 100% fulfillment rate. In 2025, Partnership established a mechanism to track unfulfilled alternative format requests, resulting in a truer baseline of 3 unfulfilled requests, or a 99.9% fulfillment rate. While this data demonstrates that the fulfillment request rate is slightly lower compared to 2024, it represents a more accurate baseline compared to the previous year. See Table 21 below.

Table 21: Rate of Fulfillment Requests for Alternative Formats Year over Year

Fulfilled requests rate for Materials in Alternative Formats			
Type	**2025**	**2024**	**2023**
Audio/CD	97.1%	100.0%	100.0%
Large Font	100.0%	100.0%	100.0%
Braille	100.0%	100.0%	100.0%

USB	100.0%	N/A	N/A
Total	99.97%	100%	100%

Source: Partnership Records, 2025

4. Goal 4: Bilingual Member Service Representatives

Goal 4 was “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.” The outcome measure for this goal was the percentage of member services representatives who are considered bilingual. The numerator for this goal was the number of bilingual MSR department staff that have passed Partnership’s bilingual competency examination with a minimum rating of "Advanced." The denominator for this goal is the total number of Member Services Representative department staff. Departments involved in the outcome of this activity included Member Services. This goal started on 1/1/2025 and had an end date of 12/31/2025.

Analysis/Discussion

Evaluation of the focused hiring of additional bilingual member services representative efforts was completed through measuring progress against the stated goal. The Member Services department identified and implemented these activities. Regular updates to the 2025 C&L/QIHETP work plan were made to track progress of goals. Table 22 provides a visual of the goal in more detail.

Table 22: Description of Goal and Measure

Goal	Outcome Measures	Deliverables	Start Date	Due Date	Completion Status
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"	**#1:** Conduct assessment of number of bilingual representatives needed to reach a 2% increase.	1/1/2025	12/31/2025	Complete

	Denominator: Total number of MSR department staff	**#2:** Conduct recruiting efforts to hire additional bilingual staff.	1/1/2025	12/31/2025	Complete

Source: Partnership 2025 C&L/QIHETP Work Plan

A review of the progress on this work plan took place towards the end of 2025 to see if each deliverable was completed; this was done ultimately to evaluate completion of this goal. This review showed that in 2025, Partnership completed all the deliverables. A data analysis was also conducted on this activity to measure the percentage of member services representatives who are considered bilingual against the stated goal. This analysis showed that the percentage of Partnership bilingual staff increased from 65.96% to 67%, a percentage increase of 1.04%; as a result, Partnership **did not meet** its goal of increasing the number of bilingual Member Service Representative (MSR) staff hired by 2% to move closer to the organizational goal of 75% of bilingual MSR staff (see Table 23 for percentage of bilingual staff). When comparing the results of the 2024 goal to 2025 goal, Partnership met its goal in 2024 but did not meet its goal in 2025 to move closer to the organizational goal of 75% of bilingual MSR staff**.** Barriers to meeting the 2025 goal include 4 bilingual MSR staff leaving Partnership, 2 bilingual MSR staff transitioning into a non-MSR role within the department, and 6 bilingual non-MSR staff were cross trained to take member calls in Spanish. Partnership will continue to prioritize bilingual candidates to ensure the diverse needs of our members are met. Internal referrals continue to be a successful avenue of recruitment.

Table 23: Year over Year Percentage Increase of Bilingual Member Services Staff

Year	Number of Bilingual Member Service Representatives	Number of Total Member Service Representatives	Percentage of Bilingual Member Service Representatives
2023	28	44	63.64%
2024	31	47	65.96%
2025	32	48	67%

Source: Partnership Records, 2025

5. Goal 5: Controlled Blood Pressure Rate

Goal 5 was “By December 31, 2025, improve controlled blood pressure rates among American Indian/Alaska Native members by 5% in at least two regions.” The outcome measure for this goal was the percentage of members with controlled blood pressure per HEDIS measures. 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 6/1/2024 and had an end date of 12/31/2025.

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 2025 C&L/QIHETP work plan were made to track progress of goals. Table 24 provides a visual of the goal in more detail.

Table 24: Description of Goal and Measure

Goal	Outcome Measures	Deliverables	Start Date	Due Date	Completion Status
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.	**#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	Complete
		#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	Complete
	Numerator: Number of members who are considered controlled for blood pressure.	**#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	Complete
	Denominator: Total number of eligible members with essential hypertension diagnosis.				

A review of this work plan took place towards the end of 2025 to see if each deliverable was completed; this was done ultimately to evaluate completion of this goal. This review showed that in 2025, Partnership completed all the deliverables for this goal. A data

analysis was also conducted on this activity to measure the percentage of Partnership members with controlled blood pressure per HEDIS measures against the stated goal. This analysis showed that in 2025, Auburn, Chico, Redding, and Santa Rosa regions had a 17.99% increase, a 12.96% increase, a 11.24% increase, and a 16.28% increase respectively, compared to 2024 (see Table 25 below); this indicates that 4 of 6 Partnership Regions had an increase over 5% in controlled blood pressure rates compared to 2024. Therefore, Partnership **met** its goal to improve controlled blood pressure rates among American Indian/Alaska Native Partnership members by 5% in at least two regions. Due to data issues, the analysis for this goal was completed using data from January 2025 to November 2025.

At the time of writing the 2024 Cultural and Linguistic evaluation report, the HEDIS data for 2024 was not available for analysis, rendering the goal status as undetermined. In 2025, Partnership attempted to analyze the data to determine if the 2024 goal was met. However, due to data challenges, the goal status remains undetermined and no baseline was established. As such, it is not possible to compare the results of the 2024 goal to that of the 2025 goal at this time.

Table 25: Rate Change Controlled Blood Pressure in Partnership Regions, Jan. 2025 to Nov. 2025

Region	Rate Difference	Increase/Decrease
Auburn	17.99	Increase
Chico	12.96	Increase
Eureka	-3.75	Decrease
Fairfield	-5.38	Decrease
Redding	11.24	Increase
Santa Rosa	16.28	Decrease

Source: Partnership Records, 2025

6. Goal 6: Timely Translation Requests

Goal 6 was “By December 31, 2025, improve the rate of timely translations in the Utilization Management (UM) and/or Care Coordination (CC) department to achieve the threshold of at least 90%.” The outcome measure for this goal was the percentage of translations fulfilled in a timely manner. The numerator was the number of translations completed in 48 hours (for UM) and 14 business days (for CC). The denominator was the total number of translations in either department. Departments involved in the outcome of this activity included Care Coordination and/or Utilization Management. This goal started on 1/1/2025 and had an end date of 12/31/2025.

Analysis/Discussion

Evaluating the improvement of timely translations in the Utilization Management and/or Care Coordination department was completed through measuring progress against the

stated goal. The Care Coordination and/or Utilization Management department worked to identify and implement these activities. Regular updates to the 2025 C&L/QIHETP work plan were made to track progress of goals. Table 26 provides a visual of the goal in more detail.

Table 26: Description of Goal and Measure

Goal	Outcome Measures	Deliverables	Start Date	Due Date	Completion Status
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.	**#1:** Generate a report showing the rate of timely translations for UM and/or CC.	1/1/2025	12/31/2025	Complete

A review of this work plan took place towards the end of 2025 to see if each deliverable was completed; this was done ultimately to evaluate completion of this goal. This review showed that in 2025, Partnership completed the deliverables for this goal. A data analysis was also completed to measure the percentage of translations fulfilled in a timely manner against the stated goal. This analysis showed that in 2025, both Care Coordination and Utilization Management achieved a threshold of 98.5% and 96%, respectively, of timely (or on-time) translation requests, which is well above the threshold goal of 90% (see Table 27 below). Therefore, Partnership **met** its goal to improve the rate of timely translations in the Utilization Management and/or Care Coordination department to achieve the threshold of at least 90%. This goal was new for 2025; therefore, there is no goal comparison between 2024 and 2025.

Table 27: On-time vs. Late Requests for Translations by Department

Department	Status	Number of Requests	Rate
Care Coordination	On-time	74	98.7%
	Late	1	1.3%
Utilization Management	On-time	384	96.0%
	Late	16	4.0%

Source: Partnership Records, 2025

7. Goal 7: Prenatal Care

Goal 7 was "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." The outcome measure for this goal was 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. The numerator was the total number of prenatal care visits a woman had in the first trimester. The denominator was the total number of eligible deliveries, such as all live births between certain dates or all women who meet certain enrollment criteria. Departments involved in the outcome of this activity included the Health Equity department and the Population Health Department to identify and implement these activities. This goal started on 10/1/2024 and had an end date of 12/31/2025.

Analysis/Discussion

Evaluating the improvement of timely prenatal visit rates among the American Indian/Alaska Native Member population was completed through measuring progress against the stated goal. The Health Equity department and the Population Health Department worked to identify and implement these activities. Regular updates to the 2025 C&L/QIHETP work plan were made to track progress of goals. Table 28 provides a visual of the goal in more detail.

Table 28: Description of Goal and Measure

Goal	Outcome Measures	Deliverables	Start Date	Due Date	Completion Status
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,	**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.	**#1:** Conduct Root Cause Analysis to identify sites and zip codes with highest likelihood of not completing prenatal care visits.	10/1/2024	10/31/2024	Completed
		#2: Interview at least 10 members in the Northern Region to identify barriers for conducting prenatal visits.	11/1/2024	3/31/2025	Completed

Goal	Outcome Measures	Deliverables	Start Date	Due Date	Completion Status
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.	**Numerator:** The total number of prenatal care visit a woman had in the first trimester.	**#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	Delayed
	Denominator: The total number of eligible deliveries, such as all live births between certain dates or all women who meet certain enrollment criteria.	**#4:** Execute internal PHM campaign, QMSI generated intervention, and/or Population Health Community event to address disparity.	5/1/2025	12/31/2025	Delayed

A review of this work plan took place towards the end of 2025 to see if each deliverable was completed; this was done ultimately to evaluate completion of this goal. This review showed that in 2025, Partnership did not complete all the deliverables for this goal. There were several barriers to completing deliverables for this goal. Deliverable 3 was delayed because the QMSI workgroup supporting this work was unable to identify at least one intervention to address the prenatal care disparity in the tribal community, especially in the Eureka Region. A major concern is that there isn't a significant amount of tribal members to warrant investing in a large project that would result in a marginal impact on key organizational measures. Deliverable 4 was delayed due to its contingency on completing Deliverable 3.

A data analysis was also conducted on this activity to measure the percentage of deliveries in which American Indian/Alaska Native Partnership members 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 against the stated goal. This analysis showed that in 2025, the Eureka region increased by 3.58% and the Redding region showed a drop in prenatal care rates by 3.46% (see Table 29 below). Although the Eureka region showed an increase, it was less than 5%. Therefore, Partnership **did not meet** its goal to 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. Barriers to meeting this goal may be due in part to not completing all deliverables. Furthermore, Goal 7 was added to the C&L/QIHETP workplan in 2025. Therefore, it is not possible to demonstrate any trending at this time for Goal 7.

Table 29: Rate Change for Prenatal Care Visit by Select Region Jan. 2025 to Nov. 2025

Region	Rate Difference	Increase/Decrease
Eureka	3.58	Increase
Redding	-3.46	Decrease

Source: Partnership Records, 2025

8. Goal 8: Well Care Visits

Goal 8 was “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.” The outcome measure for this goal is the 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. The numerator was the number of members who attend at least one well-care visit with a primary care practitioner. The denominator was the total number of eligible members in age range. Departments involved in the outcome of this activity included the Health Equity department and the Population Health Department to identify and implement these activities. This goal started on 10/1/2024 and had an end date of 12/31/2025.

Analysis/Discussion

Evaluating the improvement of timely Well Care Visits rate among Black, White, and/or American Indian/Alaska native members was completed through measuring progress against the stated goal. The Health Equity department and the Population Health Department worked to identify and implement these activities. Regular updates to the 2025 C&L/QIHETP work plan were made to track progress of goals. Table 30 provides a visual of the goal in more detail.

Table 30: Description of Goal and Measure

Goal	Outcome Measures	Deliverables	Start Date	Due Date	Completion Status
Goal 8: By December 31, 2025, improve timely Well Care Visit rates 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.	**#1:** Conduct Root Cause Analysis to identify sites that have the largest number of members who are not attending WCVs.	10/1/2024	10/31/2024	Complete
		#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.	11/30/2024	12/31/2024	Terminated
		#3: Identify interventions for QMSI workgroup in collaboration with other departments and teams (Conduct	1/1/2025	3/31/2025	Delayed

Goal	Outcome Measures	Deliverables	Start Date	Due Date	Completion Status
		in-service presentation on benefit of group WCV and mother-child dyadic appointments to clinical sites.			
		#4: Execute internal PHM campaign, QMSI generated intervention, and/or Population Health Community event to address disparity.	6/1/2025	12/31/2025	Delayed

A review of this work plan took place towards the end of 2025 to see if each deliverable was completed; this was done ultimately to evaluate completion of this goal. This review showed that in 2025, Partnership did not complete all the deliverables for this goal. Deliverable 2 was terminated; barriers to completing Deliverable 2 included a lack of having a significant number of pediatricians available to be interviewed largely because of the low number of Primary Care Providers and a growing member population. Deliverable 3 was delayed; barriers to meeting Deliverable 3 on time were because the organization needed to determine the key enterprise quality measures of focus. In 2026, key leaders are planning to identity the measures of focus; another Partnership team will designate a key disparity or disparities of focus to guide the Pediatrics QMSI workgroup. Deliverable 4 was delayed due to its contingency on completing Deliverables 2 and 3.

A data analysis was also conducted on this activity to measure the 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 against the stated goal. This analysis showed that in 2025, when looking at the regions, the American Indian/Alaska Native group showed a 1.10% drop overall, but increased more than 1.25% in the Chico, Redding, and Santa Rosa regions. The Black population showed a 5.34% increase overall but increased more than 1.25% in all regions except the Eureka region and the Santa Rosa region. The White group showed a 4.46% drop

overall, but over a 1.25% increase in all regions except the Santa Rosa region. See Tables 31 and 32 for full details.

Therefore, all groups demonstrated at least a 1.25% increase in at least one region (see Table 32 below). As a result, Partnership **met** its goal to improve timely Well Care Visits rate among Black, White, and/or American Indian/Alaska native members by 5% overall, or at least 1.25% in at least one region. Furthermore, goal 8 was added to the C&L/QIHETP workplan in 2025. Therefore, it is not possible to demonstrate any trending at this time for Goal 8. See Tables 31 and 32 for full details.

Table 31: Rate Change for Timely Well Care Visits by Select Race/Ethnicity, Jan. 2025 to Nov. 2025

Race/Ethnicity	Rate Difference
American Indian and Alaska Native	-1.10
Black	5.34
White	4.46

Source: Partnership Records, 2025

Table 32: Rate Change for Timely Well Care Visits by Region and by Select Race/Ethnicity, Jan. 2025 to Nov. 2025

Race/Ethnicity	Region	Rate Difference	Increase/Decrease
American Indian and Alaska Native	Auburn	-0.43	Decrease
	Chico	5.60	Increase
	Eureka	-4.17	Decrease
	Fairfield	-2.33	Decrease
	Redding	2.28	Increase
	Santa Rosa	3.64	Increase
Black	Auburn	3.91	Increase
	Chico	8.35	Increase
	Eureka	-1.48	Decrease
	Fairfield	6.71	Increase
	Redding	3.30	Increase
	Santa Rosa	-1.42	Decrease
White	Auburn	5.34	Increase
	Chico	4.67	Increase
	Eureka	4.25	Increase
	Fairfield	4.00	Increase
	Redding	5.37	Increase
	Santa Rosa	0.48	Decrease

Source: Partnership Records, 2025

C. Review of the 2025 C&L Evaluation Results at the Community Advisory Committee

Partnership maintains a Community 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 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. This committee meets on a quarterly basis (see MCND9002-E CAC Guiding Principles for a full description of Partnership's CAC).

In Q1 of 2026, Partnership shared the analysis of the evaluation and overall C&L program performance, including the root cause and/or barrier analysis of select findings, to the CAC committee members for review, feedback, as well as their perspectives on the root causes of barriers, and possible solutions. This was conducted via survey due to timing constraints. Partnership received robust feedback from CAC members, but the content below highlights key themes for various program components where there were either notable findings or where a C&L/QIHETP workplan goal was not met:

a. Feedback on Translation Services

- Barriers
    - Inconsistent follow-through with members; need call logs so people don't have to re-explain.
    - Need shared rules across departments to avoid siloed outcomes.
    - Need culturally responsive staff who can interpret, not just translate, especially over the phone.
- Solutions
    - Time management improvements.
    - Centralized requests, better transparency to reduce delays; clearer escalation options and notifying members when delays occur, especially for translated materials.
    - Expedite materials when [sent] via email, mail, and if possible, use AI.
    - Translators need to self-identify and request translated materials when contacting Partnership.

b. Feedback on Language Data Collection

- Barriers
    - Need more staff who speak members' native languages and can communicate openly and respectfully.
    - A key challenge is that enrollment and provider workflows don't always capture accurate or complete language information, so some members' true language needs are missed.
    - One barrier might be a lack of general public awareness of the need for bilingual staff in Member Services. Also, an email reminder to CAC members and staff to say you're needing more bilingual Member Services Representatives.
    - Barrier can include being afraid to ask for help in a member's preferred

language due to the political climate.

- Solutions
    - Improving how language data is collected, updated, and verified can reduce gaps. Stronger outreach in communities can reveal additional high-need languages that aren't showing up in current records. Doing these together helps close language access gaps and better meet members' needs.

c. Feedback on CAC Meetings

- Barriers
    - Meetings include too many agenda items, with long explanations, which limits time for member questions and feedback.
    - Meetings often run overtime, and members want to meet more frequently and with increased stipends.
- Solutions
    - Prioritizing agenda items and assigning time limits can help keep meetings focused.
    - Non-urgent topics can be moved to pre-reads or follow-up Webex groups.
    - Streamlined presentations plus dedicated time for discussion ensure all voices are heard and all planned items are addressed.

d. Feedback on Goal 5

- Barriers
    - Communities benefit when needed equipment is consistently provided so people can fully participate in programs and activities.
- Solutions
    - Access to nutritious food is essential for health, and creating community gardens can increase fresh, local food availability.
    - Hosting community events can inspire healthier living and strengthen connections among residents.
    - Sharing practical information on healthy lifestyle habits helps people make informed choices.

e. Feedback on Goal 7

- Barriers
    - Members want more transparency about why things didn't work out; the lack of clear communication creates frustration and confusion.
    - Transportation is a major barrier and having on call transportation options can make a real difference in members' ability to participate.

    - Delays in care often happen because of transportation challenges, limited trust in healthcare systems, lack of culturally aligned services, or balancing childcare and work responsibilities.
- Solutions
    - Groups should continue to be formed even when earlier attempts didn't succeed, consistency shows commitment.
    - Practicing cultural humility is essential when working with BIPOC communities; do not assume you already know their needs or experiences; listen first and build trust through respect.
    - Find ways to make prenatal [care] incorporated in popular culture.

f. Feedback on Goal 8

- Barriers
    - Members may feel discomfort answering certain questions and can feel tokenized, especially when they're asked to share experiences without fair compensation.
    - Many members aren't fully aware of the health benefits of preventive care, so building understanding and trust is important.
- Solutions
    - Using culturally responsive education and partnering with trusted community or tribal organizations can help explain why preventive care matters.
    - Offering flexible scheduling, transportation support, and personalized outreach can increase timely well care visits and help close care gaps, including ECM when needed.
    - Coordinate efforts with clinics that accept Partnership to inform clients of important preventative care needs based on their demographics.

By Q2 of 2027**,** Partnership will make a good faith effort to consider and incorporate CAC's feedback as appropriate into any future planned actions or interventions.

II. 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 2025 Partnership had a total of 1,864 individual language translation requests, of which 1,790 were considered timely and 26 was considered late; this was significantly more translation services requests compared to 2024. Despite having more late submissions of translation requests in 2025 compared to 2024 and 2023, 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 444,134 interpreter calls to members from January-December 2025, significantly more than the volume from 2024. While services seem to be running smoothly and are sufficient, Partnership will explore ways to improve performance concerns as they come up and will consider ways to better track interpreter services administered through Partnership staff. 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 13,790 requests for alterative formats, of which 103 were for Audio/CD, 13,612 were for large font, 67 were for Braille, and 8 were for USB drive. Member requests seemed to be fulfilled in a timely manner, but there are opportunities to improve tracking mechanisms and processes for late requests. 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 2025, Punjabi was added as a threshold languages. Partnership will continue to incorporate new threshold languages into their services when identified. Partnership has also updated its standard material translation process and will print all current and future member-facing materials in newly identified threshold languages, including Punjabi, as part of standard practices. Partnership will continue to perform this activity to ensure our members receive the highest quality healthcare.

E. Partnership Committees: QIHEC and CAC

In 2025, all scheduled QIHEC meetings took place and a variety of initiatives and topics were reviewed. 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 also recruiting additional CAC members to ensure the remaining open seats are filled. Barriers to filling all seats include finding members that can regularly attend in-person CAC meetings; key activities are taking place to address this. The CAC committee will continue to meet and will work to ensure members receive the highest quality healthcare.

F. Policy Review for Oversight and Compliance

In 2025, Partnership reviewed and approved 4 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. Cultural and Linguistic Program Staffing

In 2025, 275 discrimination cases were reviewed by the health education team, and the Cultural and Linguistic Liaisons; this is more than the amount in 2024. While the number of staff for cultural and linguistic activities was mostly sufficient for 2025, there are opportunities to consider hiring more staff, including additional Population Health supervisors and managers for 2026. Health Equity hired two Cultural and Linguistic Liaisons positions and one Supervisor of Health Equity Training. Partnership will continue to track this data to ensure members are receiving high quality health care.

H. 2025 C&L/QIHETP Workplan Goals

Partnership had eight goals associated with this program component. The Goal 1 was “by June 30, 2025 develop and propose a multi-year health equity strategic and tactical plan.” All of the deliverables for this goal were completed on time. As such, the goal was met by the intended date. Goal 2 was “by December 31, 2025 distribute the DEI training to the provider network and MCP staff and submit the final version to DHCS.” All of the deliverables were completed on time. As such, the goal was met by the intended date. Goal 3 was “By December 31, 2025, 91% of members who have requested materials in an alternative format will be mailed in their preferred format.” The deliverable for this goal was completed on time and the goal was met. Goal 4 was “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.” Each deliverable was completed on time but the goal was not met. Goal 5 was “By December 31, 2025, improve controlled blood pressure rates among American Indian/Alaska

Native members by 5% in at least two regions." The deliverables for this goal were completed on time and the goal was met. Goal 6 was "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%." The deliverable was completed on time and the goal was met. Goal 7 was "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." Several deliverables were delayed and the goal was not met. Goal 8 was "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." Several deliverables were either terminated or delayed but the goal was met.

III. 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 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 multiple areas, including a high, on-time return rate for translation requests, a vast array of available languages for interpretation services, a high rate of fulfilled alternative format requests, meeting quorum for the whole year at both CAC and QIHEC meetings, all the C&L policies/reports for compliance purposes that were approved by their internal governing bodies, meeting most of the C&L/QIHETP workplan goals set for 2025, and appropriate practitioner participation and leadership involvement in the program as demonstrated by appropriate committee attendance and the approval of all C&L related policies and reports.

Based on the results from the 2025 C&L Program Evaluation, Partnership concludes there are no significant changes required for the program. However, opportunities were identified, including: establishing a standard metric for how often translation requests can be late; structural improvements to the QIHEC meetings, such as the creation QIHEC workgroups to address ongoing disparities and provide interventions and recommendations to vote on during the QIHEC meeting; establishing a strategy to ensure none of the planned CAC meeting agenda items are delayed; and opportunities to adjust workplan goals for 2026 to ensure they are achievable. Issues and barriers

that made the C&L/QIHETP Work Plan goals more difficult to achieve included organizing multiple departments to achieve the work plan goals, and staff turnover. 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 reviewed for future evaluations.

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Community Reinvestment

Review of Requirements and Funding Options

Mohamed Jalloh, PharmD

Health Equity Officer

mjalloh@partnershiphp.org

Agenda Overview

- Review methodology of idea solicitation
- Review finalized list of ideas
- Discuss strategies for mitigating paying for 10 county expansion via MY2024 calculations

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What is Community Reinvestment Initiative?

101 and Funding

What is Community Reinvestment?

- The **Department of Health Care Services** is requiring that all health plans **reinvest a portion of their net income into their local communities** to address unmet health-related social needs and support community wellbeing per their calculations

What Are The Minimum Funding Calculations?

Base Community Reinvestment Requirement

MCPs **and** Qualifying Subcontractors with positive net income must contribute:

- 5% of annual income if **net revenue is less than or equal to 7.5%**
- 7.5% of annual income if **net revenue is greater than 7.5%**

**Annual net revenue for initial cycle must come from their Medi-Cal contract revenues for 2024.*

Quality Achievement Requirement

MCPs with positive net income must contribute:

- **An additional 7.5%** of their annual net income for counties with an Enforcement Tier 2 or 3 assignment
  - *Tier 2: assigned to any county where MCP has 2 or more measures below MPL in any 1 MCAS domain*
  - *Tier 3: assigned to any county where MCP has 3 or more measures below MPL in 2 or more MCAS domains*

**Funding will be 100% allocated to improving quality measures below target for counties within Enforcement Teir 2 or 3*

Which Counties Will Receive Funding?

2024, 2025, and 2026 Funding Calculations per APL

- 14 Original Counties

2025, 2026, and 2027 Funding Calculations per APL***

- 10 Expansion Counties

What Are We Allowed to Fund?

DHCS will require MCPs to allocate Community Reinvestment funds toward a defined set of categories tailored to the specific needs of their communities.

Cultivating Neighborhoods & Built Environment
(e.g., neighborhood revitalization, affordable housing, new wing of a rural health clinic)

Cultivating a Health Care Workforce
(e.g., training programs to address workforce shortages and establish career pipeline for Medi-Cal members; additional staffing to support weekend hours at a community clinic)

Cultivating Well-Being for Priority Populations *(e.g., tailored support for foster children & youth, justice-involved, maternal/child populations, individuals experiencing homelessness)*

Cultivating Local Communities
(e.g., education initiatives, employment & training programs, wellness initiatives to address social isolation)

Cultivating Improved Health Outcomes
(e.g., initiatives to address immediate and long-term health outcomes by targeting improvements in quality measures in which the MCP underperformed)

How Much?


Sometimes you think you know
but then you don't know.
371 of 400
quickmeme.com

How Much Will My County Get?

- **DHCS will calculate** Partnership's **annual net income** as a statewide aggregate based on various factors and notify plans in **Q2 2026 and stratify per county (Per APL and FAQ sheet).**
  - Contingent on **Positive Net Income**
  - Adjusted for Quality Achievement
  - Adjusted for **Medi-Cal membership size**

DHCS Examples (High Level SDOH)

"Yays"

- Funding for **scholarships** for allied health professions
- Funding for **Park development** in a community
- Funding for **Hospital development** in a community

"Nays"

- Funding for clinical services at a clinic or hospital
- Funding for **Expanding Provider Networks** for the delivery of services covered under the MCP Contract
- Funding **street medicine services** for persons experiencing unsheltered homelessness.

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Reinvestment Methodology

Review of How Parntership Determined Current Investment Ideas

Who was "Required" to Be Involved in Community Reinvestment Planning and Decision-Making Process?

2025 Methodology Review

Partnership team reviewed APL and developed preliminary list of ideas

Partnership surveyed internal leaders (Regional Directors, Department Directors, etc) for additional feedback and ideas after reviewing CHA/CHIP data and other sources

Partnership emailed and surveyed our Former CDPH officers, BH Directors, Public Health Directors, an CAC members and presented their data at their respective meetings

Partnership hosted a special December meeting for additional external community members and leaders (e.g. QIHEC members), CAC members, PAC members, BH Leaders, PT members etc)

Q1 2026 Methodology

Partnership Collated Information and Presented to Internal Leaders in 1st week of January

Internal Leaders voted and recommended top 1-2 funding options per category

Integrated feedback of combining funding options

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Review of Funding Options

Key Factors Considered for Determining Reinvestment Options

- DHCS APL requirements
- Annual Health Disparities Assessment
- CHA Analysis
- CHIP Analysis
- Access Improvement Assessment
- Community Support
  - CAC Support via Survey
  - BHT Director Support via Survey
  - LHJ Director Support Via Survey

Impact

50+ IDEAS

30+ IDEAS

10 SOLUTIONS

List of Reinvestment Options

Cultivating Neighborhood

Option #1: Funding To Support Expansion of RHC or FQHC facility to meet community needs

Option #2: Funding to Support Expansion of Mobile Health Services to meet community needs

Cultivating Healthcare Workforce

Option #1: Funding to Support Specialty Provider Recruitment

Option #2: Funding to Support Expansion of Residency Slots, Programs, and Development

Option #3: Funding to Support Expansion of Student Slots, Programs, and Development

Cultivating Wellbeing

Option #1: Funding to Support Community Wellness and Resource Centers

Option #2: Funding To Support Accountable Communities for Health (ACH) initiatives and programming

Option #3: Funding to Support Community Fitness Programs

Cultivating Local Communities

Option #1: Funding to Support the development and funding of CHW programs in each county

Option #2: Funding to Support the development and funding of doula programs in each county

Example Payment Workflow for funding expansion of local FQHC who is awarded $40,000

Reinvestment Idea Selection

- County leaders select using their entire **40k for FQHC** to build new wing

Reinvestment Idea Process

- Partnership receives and processes **application form**

Reinvestment Fund Disperse

- **Partnership sends check directly to FQHC or building contactor**
- Partnership will request KPI for annual reporting requirements

What we still don't know?

- How much each **county will receive each year?**
- What is the exact date of when DHCS **will clarify county amounts?**
- What are the exact dates of when funds need to be **dispersed?**
- Will DHCS approve submissions in a **timely manner? Can Partnership dispense payment pending approval?**

What Counties Can Start Doing Now

- To Prepare for the potential community reinvestment application process:

1. **Identify ONE Central Point of Contact for reinvestment application per county**
2. Review **9 potential reinvestment options** with local stakeholders involved with the County's Community Health Improvement Plan.
3. Review the county's current performance on the DHCS bold quality goals to identify intersecting priorities or additional priorities to consider.
4. **Narrow done options to one or two areas** which stakeholders agree best aligns with the goals and objectives of the County Health Improvement Plan, as well as the DHCS bold quality goals.

Note for 10 Expansion Counties

- The Board of Commissioners has approved a focused reinvestment for the 10 expansion counties to be allocated starting in 2026 only (when the other 14 counties will be receiving their 2024 reinvestment allocations).
- The details of this **one-year reinvestment fund** are being developed and will be discussed in future communications.

Questions

- Communityreinvestment@partnershiphp.org

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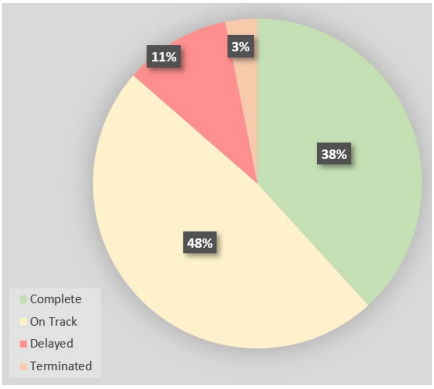
QI TRILOGY PROGRAM

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) 2025-2026 schedule. This update includes progress on activities included in the FY 2025-2026 QI Work Plan from 07/01/2025 - 12/31/2025.

Results: Of the 191 deliverables outlined in the QI Work Plan, 73 are "Complete"; 92 are "On Track"; 20 are "Delayed"; and 6 have been "Terminated."

Deliverable Status 07/01/2025 - 12/31/2025		
Status	**Total Number: 191**	**%**
Complete	73	38%
On Track	92	48%
Delayed	20	10%
Terminated	6	3%



QI Major Milestones and Activities:

- Framework has been developed to create D-SNP education topics within the QI department with feedback from multiple sources regarding the level of education intervention needed by the team.
- The D-SNP Model of Care (MOC) document has been reviewed for initial changes and is expected to enter the formal editing process and be finalized by May 29, 2026.
- A project plan for the D-SNP Stars analytics tool development and related HEDIS D-SNP data analysis has been outlined with vendor HMA Wakely. Initial steps have been completed with completing data sharing by the end of the year.

- Dual Eligible Special Needs Plan Quality Incentive Program (DSNP QIP) continues development for Partnership Advantages launch date of January 2027.
    - Contracting discussions with Cozeva have been approved by leadership to continue.
    - The measures Advance Care Planning (ACP) and Annual Wellness Visit (AWV) will be presented to the executive team for approval after Cozeva contracting is finalized by June 30, 2026.
- The Primary Care Provider Quality Improvement Program (PCP QIP) reviewed the Data Validation Framework document to help identify any areas of revision and improvement.
    - Due to the new 2026 federal contracting requirements related to participation in the QIP's, several measurement years deliverables were adjusted to earlier due dates.
    - PCP QIP is currently drafting several check lists that will be used in conjunction with the PCP QIP Data Validation Framework document.
    - Based off of feedback from the Executive walk through, Finance executive leadership's review during the payment validation process for final sign off will be added.
- The Palliative Care Quality Improvement Program (PC QIP) reviewed the Data Validation Framework document to include the payment process for the new measure Palliative Care Survey that will be replacing the Completion of Assessments and Use of the PCQC Tool and enhanced validation for payment processing accuracy for the measures Avoiding Hospital and Emergency Room Admissions and Completion of a POLST.
    - Revisions have been completed and were implemented in the payment processing for 2025 measure period I (January – June), which was completed early December.
- Perinatal Quality Improvement Program (PQIP) continues to provide ECDS education and onboarding for existing PQIP providers to meet gateway measure compliance. As of January 1, 2026, 24 out of 34 providers had signed a data sharing contract with DataLink with 13 out of those 24 having actively implemented data pulls with the rest on track to complete by June 30, 2026. Outreach continues to providers who have not contracted and/or connected with DataLink.
- Enhanced Care Management Quality Improvement Program (ECM QIP) met in Technical Workgroup meeting and with PointClickCare and have determined no new measures will be added to the 2026 measurement year.
- The Improvement Academy has scheduled 6 virtual trainings highlighting priority MCAS measures relative to each webinar topic, 3 in-person ABCs of QI trainings, and are developing 2 microlearning topics.

- The Quality Measure Score Improvement (QMSI) group, formed to improve Quality performance over measurement years 2023, 2024, and 2025 with 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
     - Facilitate two Pediatric Preventative Care Improving Measure Outcomes webinars
     - Interview high-performing providers in WCV (Well Care Visit), CIS (Childhood Immunization Status), and IMA (Immunization for Adolescents) to identify best practices and utilize findings to improve performance across the network
     - Develop and implement new one-on-one Provider Education on Developmental Screening in the First Three Years of Life to improve DEV (Developmental Screening) rates
     - Evaluate expansion Healthy Babies Growing Together Program to Provider Network ($100 for completion of CIS-10)
     - Add W30-2+ as a new monitoring measure in QIP to improve completion rates
     - Launch newborn pilot project with Fairchild Medical Clinic to improve W30-6+ completion rates in Siskiyou County
  2. Behavioral Health
     - Facilitate collaboration among Partnership's Behavior Health (BH), Care Coordination, Population Health, Pharmacy and Quality Improvement to monitor and evaluate the implemented interventions by the respective departments aiming to improve the BH measures scores
     - Improve the percentage of provider notifications and follow-up for members with Serious Mental Health (SMH) diagnoses within 7 days of an Emergency Department (ED) visit (DHCS-Non-Clinical PIP)
     - Work with County Department of Behavioral Health (DBH) to utilize Sac Valley Med Share (SVMS) for Follow-up After Mental Illness (FUM) data
     - Extend the Community Health Workers (CHWs) in Partner hospitals' Emergency Departments to the end of 2025.
     - Partner with Counties to increase the percentage of members who receive Peer Support Services (DHCS-Clinical PIP)
     - Improve the Follow-Up After Emergency Department Visit for Substance use (FUA) measure rate (DHCS Non-Clinical PIP)
  3. Management of Chronic Diseases
     - Monitor, evaluate and improve the use of the diabetes management program offered by TeleMed2U.
     - Educate providers on Colorectal Cancer screening modalities (such as FIT testing, Cologuard, Colonoscopy) to serve their unique population

- Bring the blood pressure control strategies into alignment with best practices of one primary care practice and build a storyboard to spread across the health care continuum
- Work with UC Davis Cancer comprehensive center on a collaborative around strategies engaging clinics by county data around Colorectal Cancer to provide support and education for improvements to their workflows.
- Implement Kidney Health Evaluation for Patients with Diabetes as a QIP measure for the PCP QIP MY2026.

4. Women's Health
   - Explore aligning Prenatal and Postpartum Care (PPC) Pre timeliness of prenatal care across Partnership's Perinatal QIP, HEDIS, and Clinical Compliance.
   - Continue providing support and education to our network to promote the hrHPV Self-Collect option for patients in clinic.
   - Explore and implement opportunities for provider education and resources on chlamydia screening and adolescent sexual and reproductive health.
   - Partner with Improvement Advisors to discuss PPC Pre: timeliness of prenatal care measure requirements with Perinatal QIP providers to strengthen staff awareness and improve adherence.

- Regional Quality Meetings within the date span of 07/01/2024 – 12/31/2024 were hosted twice in all regions: Chico and Auburn, Eureka, Redding, Fairfield, and Santa Rosa.
- In collaboration with Northern Redding and Eureka regions consortia's Health Alliance of Northern California (HANC) and North Coast Clinics Network (NCCN), a storyboard was developed with Redwoods Rural Health Center outlining their cervical cancer screening improvement project that leveraged workflow changes, outreach methodologies, and self-swab modalities.
- Health Alliance of Northern California (HANC) and North Coast Clinics Network (NCCN) collaborated with Redwoods Rural Health Center to develop a storyboard outlining their Cervical Cancer Screening improvement project that leveraged workflow changes, outreach methodologies, and self-swab modalities.
- The QI Project Toolkit & Training Program first cohort is scheduled to launch February 24, 2026, with 61 participants currently registered representing over 30 provider and community based organizations.
- 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 eleven (11) months and offer an incentive to those who have birthdays coming within the upcoming 120 days to complete a well-child visit within 90 days of outreach. The Wellness Guide team has been consistently reviewing each members claims' section on Call Center to verify if the member had a well child visit. If there is no claim, Population Health Management staff will make a follow-up call to the providers'

office to confirm if an appointment took place, then mail out an incentive card if an appointment was completed.

- 41 Mobile Mammography event days have been completed resulting in 1,402 completed breast cancer screenings.
    1. 6 Mobile Mammography event days were held at Tribal Health Centers.
    2. 5 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
2d Primary Care Provider Quality Incentive Program (PCP QIP) Payment Processing Report **Goal 1:** By June 30, 2026, PCP QIP will continue to revise and ensure that the Data Validation Framework documents comprehensively support a robust and effective verification of payment accuracy. This involves confirming that data sources are clearly defined, with proper lineage and ownership established, and that validation procedures include thorough checks for data completeness, accuracy, consistency, and timeliness.	**Deliverable 1:** Evaluate Data Validation Framework documents and examine the QIP specific validation procedures outlined in the documents to ensure they are robust and effective in verifying payment accuracy based on prior measurement years "lessons learned". Any enhancements to the process will be incorporated into the document as they are identified.	Delayed	Due to the new 2026 federal contracting requirements the PCP QIP is currently drafting new check lists that will be used in junction with the PCP QIP Data Validation Framework document with an expected completion date of June 30, 2026.
3e Enhanced Care Management Quality Incentive Program (ECM QIP) **Goal 2:** By December 31, 2025, complete CY 2024 ECM QIP evaluation.	**Deliverable 1:** Complete evaluation of the program's CY 2024 measurement year to monitor performance	Delayed	Measurement years 2024 and 2025 have been combined for a two-year evaluation with an expected completion date of June 30, 2026.

Project / Program	Deliverable	Status Detail	Next Steps
3f Dual Eligible Special Needs Plan (D-SNP) Quality Incentive Program (QIP) Development **Goal 1:** By October 31, 2025, complete the Advance Care Planning and Annual Wellness Visit (AWV) measure development for inclusion in the 2027 D-SNP QIP measurement year.	**Deliverable 1:** Evaluate the current framework for Advance Care Planning (ACP) and Annual Wellness Visit (AWV) for inclusion in the D-SNP QIP. **Deliverable 2:** Present proposed ACP and AWV measures to Executive Leadership for approval.	Delayed	ACP and AWV measures will be presented to the Executive Team after Cozeva contracting is finalized with an expected completion date of June 30, 2026.
3f Dual Eligible Special Needs Plan (D-SNP) Quality Incentive Program (QIP) Development **Goal 2:** By October 31, 2025, obtain a signed contract agreement with Partnership HealthPlan of California and our selected D-SNP system vendor, Cozeva.	**Deliverable 3:** Pricing and negotiation will be conducted by Finance, I.T., and Executive Leadership team. Cozeva will provide a detailed price breakdown for additional system enhancement which may include Advance Care Planning (ACP) and Annual Wellness Visit (AWV). **Deliverable 4:** Finalize contract agreement will be signed by Partnership HealthPlan of California (PHC) and Cozeva on or before October 31, 2025.	Delayed	D-SNP program was paused following the new Partnership Advantage launch date of January 2027. Contracting discussions have now continued but with an expected completion date for all deliverables of June 30, 2026.
3f Dual Eligible Special Needs Plan (D-	**Deliverable #1:** Project scoping will	Delayed	D-SNP program was paused following the

Project / Program	Deliverable	Status Detail	Next Steps
SNP) Quality Incentive Program (QIP) Development **Goal 3:** By June 30, 2026, develop a detailed implementation plan and timeline (Project kick-off, Pre-Implementation phase, Implementation phase) with internal PHC teams and Cozeva.	begin after a executed contract has been signed. Scoping meetings with D-SNP IT stakeholders, QIP and Cozeva to begin November 1, 2025 through December 31, 2025. **Deliverable #2:** Pre-implementation phase: includes, but not limited to, setup SFTP/ECG file transfer, Data kick-off & requirement, finalization of key business decisions and hierarchy design, provide finalized measure set, QIP incentive data logic, and submission & validation of all transactional files. **Deliverable #3:** Implementation phase: includes, but not limited to, incremental file delivery, weekly inbound & outbound feed days, QA testing, user access, scheduled training, deployment of incentive, regression testing, and UAT in CERT/PROD.		new Partnership Advantage launch date of January 2027. Contracting discussions have now continued happen but with an expected completion date for all deliverables of November 30, 2026.

Project / Program	Deliverable	Status Detail	Next Steps
3f Dual Eligible Special Needs Plan (D-SNP) Quality Incentive Program (QIP) Development **Goal 4:** By June 30, 2026, the D-SNP Quality Incentive Program (QIP) will prepare Cozeva systems for the anticipated 2027 go-live.	**Deliverable #1:** Cozeva will complete each requirement for go-live: 1) Generate outbound extract post historic load 2) Registries enable Cozeva UI 3) Analytics enable in Cozeva UI 4) Enterprise and Practice level Resource Page configured **Deliverable #2:** Deployment of Quality Incentive Program to production, along with payment extract generation. Cozeva will perform measure set validation and score comparison against legacy system data, user training, utilizer interface walk-through, features & measures visibility and go-live sign-off. **Deliverable #3:** Post Go-Live phase. To include: incremental file self-validation by PHC Data warehouse team, configure time capsule, validate and load 2nd and 3rd incremental files, and automate	Delayed	D-SNP program was paused following the new Partnership Advantage launch date of January 2027. Contracting discussions have now continued but with an expected completion date for all deliverables of November 30, 2026.

Project / Program	Deliverable	Status Detail	Next Steps
	load of subsequent weekly feeds. **Deliverable #4:** Begin Provider Rollout/Onboarding in conjunction with EHR integration. EHR framework will consist of confirmation of configuration capabilities, embedded App, chart retrieval, diagnosis Writeback, and browser extension overlay.		
5b Complex Case Management **Goal 1:** By June 30, 2026, We will ensure that Partnership remains compliant with the National Committee for Quality Assurance (NCQA) Population Health Management Standard PHM5, Standards A-E, in preparation for our NCQA Renewal Survey in November 2026 and beyond. This will be demonstrated through the results of our upcoming NCQA renewal audit, as well as through ongoing quarterly internal compliance audits of Complex Case Management to maintain overall file compliance.	**Deliverable 3:** Obtain a "yes" score on all assigned elements during the HPA Mock Renewal Survey. • Business Owners to submit an Action Plan to address recommendations. Note: Evidence to be corrected by the applicable look-back period, timelines, and/or expectations by NCQA. Any revised evidence will be reviewed by MHR for approval.	Delayed	Care Coordination gap assessment included required edits and recommended annotations. They are working closely with the NCQA Team on the submission of corrected documentation and remain in ongoing communication to monitor status updates. Expected to complete by June 30, 2026.

Project / Program	Deliverable	Status Detail	Next Steps
6a Potential Quality Issues (PQI) (safety) **Goal 3:** By June 30, 2026, the Member Safety Investigations Team will have an effective Corrective Action Plan (CAP) monitoring tool.	**Deliverable 1:** Review and edit the current CAP desktop policy including the CAP template for providers/facilities and the CAP Monitoring Tool to align with current and more directive CAP procedures.	Delayed	Expected to be revised, update, and approved by January 30, 2026.
7c Provider Coaching and Engagement **Goal 1:** By June 30, 2026, the Performance Improvement teams will launch interventions with 80 percent of provider organizations identified as low performing providers on the 2024 Primary Care Provider Quality Incentive Program (PCP QIP) assigned to Enhanced Provider Engagement or a Corrective Action Plan, aimed at improving performance on the Modified QIP.	**Deliverable 1:** By September 30, 2025, the Performance Improvement team will complete a Needs Assessment with 80 percent of provider organizations newly assigned to Enhanced Provider Engagement (EPE) OR Corrective Action Plan in 2025.	Delayed	Performance Improvement will continue to engage the last new EPE provider and conduct a needs assessment with an expected completion date of June 30, 2026.
7c Provider Coaching and Engagement **Goal 2:** By June 30, 2026, the Performance Improvement teams will engage with at least two lower performing, mid-volume providers in each of the three regions on a high-	**Deliverable 2:** By December 31, 2025, the Performance Improvement team will plan and begin implementation of at least one intervention to impact at least one measure of focus with the six	Delayed	Performance Improvement continues to engage providers in the Chico and Auburn regions with monthly coaching. Collaborative interventions with measure prioritization for at least 2 providers is expected to be completed by June 30, 2026.

Project / Program	Deliverable	Status Detail	Next Steps
priority HEDIS and PCP-QIP measure.	identified providers.		
7c Provider Coaching and Engagement **Goal 3:** By December 31, 2025, the Performance Improvement teams will engage with all high-volume (greater than 15,000 members) Primary Care Provider (PCP) practices in each quality region on high-priority measures.	**Deliverable 2:** By December 31, 2025, the Performance Improvement teams will establish a coaching relationship with two high-volume PCP practices in each sub-region and plan and implement at least one intervention to address high-priority measures. The intervention can be measure-specific or focused on foundational elements in the organization.	Delayed	Performance Improvement continues to establish and build relationships with high-volume PCP's in the Auburn and Chico regions with monthly coaching meetings. Collaborative planning and implementation of interventions have been delayed.
2h Enterprise Information Management **Goal 1:** By June 30, 2026, integrate the HRP® version of the HEDIS® project data into the Enterprise Data Warehouse and use this data to create the HRP® version of the HEDIS® PQD modules.	**Deliverable 1:** Integrate HEDIS® Health Rules Payor data in to Enterprise Data Warehouse environment and make necessary programming changes to populate Provider Quality Dashboard-HEDIS® tables. **Deliverable 2:** Develop the HEDIS® PQD dashboards using the HRP® data and complete User Acceptance Testing (UAT).	Terminated	The priority of this task has changed with work shifting towards implementing an automated solution on the Inovalon datalake.
2j HEDIS Reporting to Support D-SNP Data	**Deliverable 1:**	Terminated	This goal has been terminated due to the

Project / Program	Deliverable	Status Detail	Next Steps
Collection and Analysis **Goal 1:** By August 29, 2025 provide first set of data for D-SNP Monthly MY2025 data to the QI D-SNP Team and, send data monthly thereafter after each data refresh.	By August 29, 2025, send first set of Monthly MY2025 data exports to the EDW & HA team's to create the PQD Monthly Dashboard, send the Monthly data to the QI D-SNP team. **Deliverable 2:** By June 30, 2026, perform a comparative analysis of preliminary and final HEDIS MY 2025 data for the D-SNP baseline population against comparable Wakely HEDIS MY 2025 Medicare baseline data.		decision to report DSNP data collection and analysis using a new third party vendor, Wakely.