Quality Improvement Program Evaluation

2024-2025

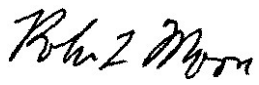
EVALUATION PERIOD

(JULY 1, 2024 – JUNE 30, 2025)

PARTNERSHIP HEALTHPLAN of CALIFORNIA

A Public Agency

Approval of Quality Improvement Program Evaluation

	**08/12/2025**

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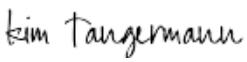	**10/22/2025**

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Quality Improvement Overview and Program Oversight

QI TRILOGY

Scope of Data and Results Reported in the 2024-2025 Quality Improvement (QI) Program Evaluation

Partnership HealthPlan of California's (Partnership) Quality and Performance Improvement (QI) program provides a systematic process to monitor the quality of clinical care and health care service delivery to all Partnership members. It includes an organized framework for ongoing review of activities to identify opportunities to improve the quality of health care services provided, promote efficient and effective use of health plan financial resources, and partner with internal and external stakeholders to support performance improvement and to improve health outcomes and advance health equity. The program promotes consistency in application of quality assessment and improvement functions for the full scope of health care services while providing a mechanism to:

- Ensure integration with current community health priorities, standards, and goals that impact the health of the Partnership member population
- Ensure alignment with DHCS' Comprehensive Quality Strategy Report
- Identify and act upon opportunities to improve care and service
- Identify overuse, misuse, and underuse of health care services
- Identify and act on opportunities to improve processes to ensure member safety
- Identify and act on opportunities to address disparities in health access and outcomes
- Address potential or tangible quality issues
- Review data for trends that suggest variations in health care service delivery processes or disparities in care

The QI Program adheres to the following goals to improve the quality and effectiveness of clinical care and service to Partnership members:

- Improve the health of the populations Partnership serves
- Enhance the member care experience
- Support the delivery of high-quality clinical care
- Reduce disparities in health access and outcomes
- Ensure member safety
- Measure and encourage appropriate use of clinical resources
- Strengthen a culture of continuous quality improvement throughout the Partnership network

The QI Program accomplishes these goals by:

- Systematically monitoring and evaluating service and care provided
- Continuously improving data and analytics to validate care outcomes
- Actively pursuing opportunities for improvement in areas that are relevant and important to Partnership members' health
- Implementing strong interventions when opportunities for improvement are identified
- Addressing overall member experience by improving provider access and member awareness of the health plan's role and responsibilities

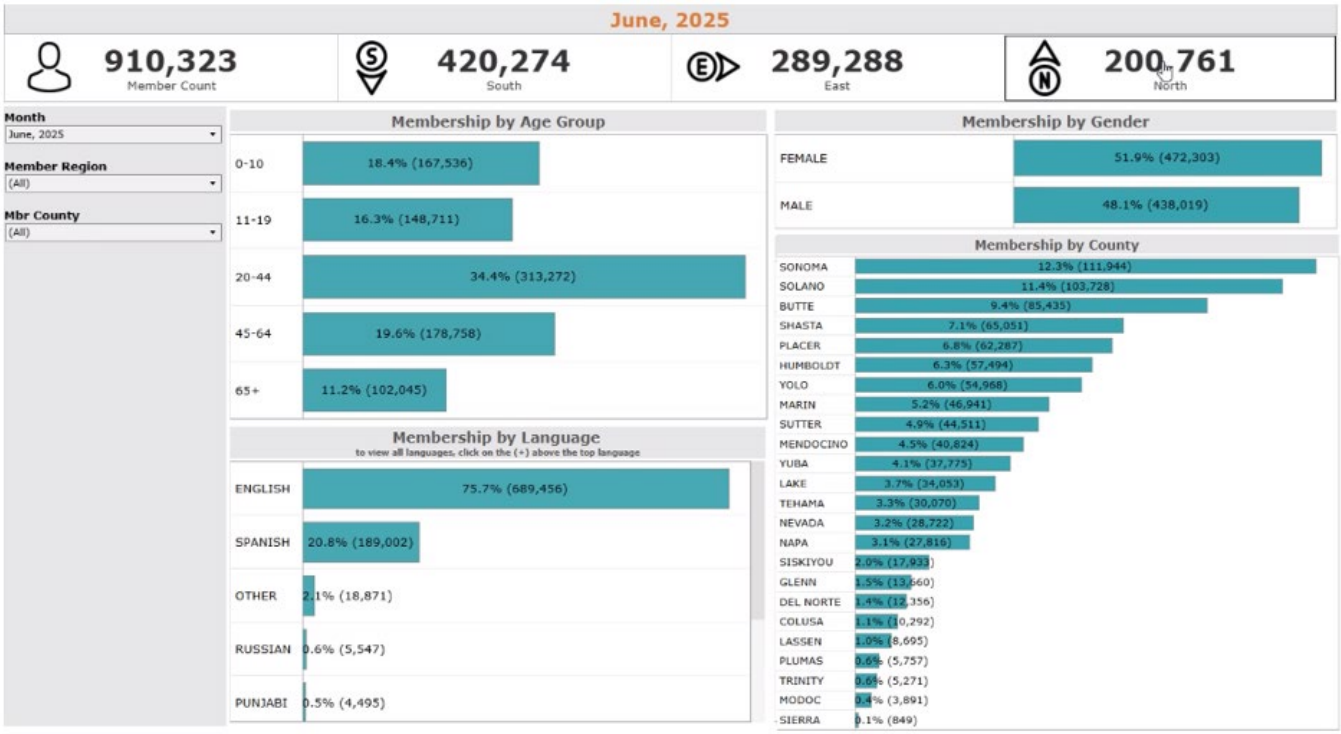
Detailed results of projects, programs, and quality assurance activities regulated by the Department of Health Care Services (DHCS) were presented to the various quality committees throughout the year. This evaluation provides highlights of activities led by or in partnership with the Quality and Performance Improvement department. The evaluation does not include detailed results from the Grievance and Appeals Department, Pharmacy Department, Utilization Management, Care Coordination, or Population Health Departments. Separate evaluations address these functional areas. Additionally, the Quality and Performance Improvement Department partners closely with its Health Equity and Population Health Departments, as defined in Partnership's Quality Improvement and Health Equity Transformation Program (QIHETP) Description. The QIHETP is designed to develop, implement, monitor, and maintain a health equity transformation system to address improvements in the quality of care delivered by all its providers in any setting, and take appropriate action to improve upon the health equity and health care delivered to members. The Quality Improvement and Health Equity Committee (QIHEC) oversees the QIHETP, and the program's overall effectiveness is evaluated in a separate annual evaluation, which complements this overall program evaluation.

The 2024-2025 QI program covers Medi-Cal lines of business across 24 counties: 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. Associated quality improvement initiatives and programs are designed to encourage appropriate care at the right time while being cognizant of resource utilization. Initiatives target areas of under-use, misuse, and overuse in addition to exploring different strategies and payment models for improving access to care and the care of medically complex patients.

The time period of this evaluation is July 1, 2024, to June 30, 2025. This is the first annual QI Program evaluation representing a complete year of experience in counties joining Partnership's service region as part of its most recent geographical expansion, effective January 1, 2024. This expansion included the addition of Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, and Yuba counties. While these 10-counties have previously been referred to as the East Region, Partnership has since operationally re-organized itself and now designates the expansion counties as part of either the Chico Region or the Auburn Region. Similarly, the legacy counties are now designated operationally across the Fairfield, Santa Rosa, Eureka, and Redding Regions. This shift in regional references reflects the location of Partnership's six Regional Offices and corresponding leadership and staff who are in roles regionally allocated. Similarly, QI staff are aligned by region, where appropriate, to fulfill quality programs and initiatives designated under the overall QI Program. Since Partnership's last evaluation (fiscal year 2023-2024), Partnership's total membership has increased from 900,432 (as of July 1, 2024) to 910,323 (as of June 1, 2025).

Across all 24 counties, 51.9% of Partnership members are female and 48.1% are male. Caucasians represent (37.9%); Hispanic (34.1%); Unknown (13.9%); members who identify as "Other" (4.4%); Black (3.6%); Asian (2.5%); Native American (1.7%); Asian Indian (1.6%); and Native Hawaiian or other Pacific Islander (0.2%). English speakers comprise 75.7%; followed by Spanish (20.8%); Other (2.1%); Russian (0.6%) and Punjabi (0.5%). Members ages 0-10 comprise 18.4%; members ages 11-19 comprise 16.3% of the population; followed by members ages 20-44 (34.4%); members ages 45-64 (19.6%); and 11.2% of Partnership's membership is 65 or older.

Below is a summary of membership by county.



Quality Improvement Program Structure

This section outlines the structure of the Quality Improvement Program, including executive leadership, departmental organization, collaboration mechanisms, and operational capabilities for FY 2024 2025, in accordance with NCQA QI 1 Element C.

To address evolving priorities and increasing operational complexity, the following structural highlights illustrate how the Quality Improvement Program was organized and mobilized throughout FY 2024–2025.

The QI Program operates under the executive leadership of the Chief Medical Officer (CMO) and Senior Director of QI, supported by the leadership team that includes Directors of Quality Management, Quality Measurement, and the Medical Director for Quality. Together this team guided execution of the 5-Star Quality Strategy and objectives outlined in the QI Tactical Plan.

Department managers led teams focused on: Member Safety-Quality Investigations and Clinical Compliance; Accreditation; Quality Measurement; Performance Improvement (PI); Quality Incentive Programs (QIP); and Quality Improvement Programs and Project Management. Within these teams, there are efforts to support data quality and validation in collaboration with IT and Finance – Health Analytics. The department periodically utilizes external consultants to support QI training for provider organizations and internal staff and National Committee for Quality Assurance (NCQA) Accreditation and contract employees for Healthcare Effectiveness Data and Information Set (HEDIS®)-related data collection and reviews.

Programmatic and Operational Highlights

- **Support for Geographical Expansion**: A cross-section of representatives under the QI program continued efforts to ensure regulatory alignment and high-quality services within its expanded provider network for new members gained through the 10-county geographic expansion. These activities included expanding the scope of quality measurement in HEDIS and QIP, proactive provider engagement, onboarding, and strategic support to promote quality program success in the newly integrated counties. This work contributed to sustaining Partnership's regional support overall and resulted in allocating additional resources across QI teams.

- **Expansion and Roles of the Program and Project Management Team**: The Quality Improvement Program and Project Management Team (PPMT) formed in 2023 continued work in FY 24-25, including program activities central to fulfilling DHCS Quality regulatory requirements and NCQA Health Plan Accreditation deliverables. This spectrum also includes transitioning successful pilots from the regional Performance Improvement Teams for further scaling. Then, with continued results, this team leads conversion to sustained program offerings plan wide. They are also the QI Team tasked with providing project management structure, accountability, and urgency to new initiatives and work brought forward by DHCS, internal customers, the provider network, and community partners.

- **Enhanced Regional PI Team Capacity**: In FY 2024-2025, the growth of the PPMT allowed greater focus on regionally driven activities led by the Performance Improvement Teams. This was particularly needed given the geographical expansion coupled with continued focus in legacy counties on driving quality measure score improvement interventions and initiatives, inclusive of new efforts to identify and reduce health disparities within quality measure performance. In early FY 2024–2025, executive leadership restructured regional operations from three to six regions for improved local support. QI's PI teams were realigned accordingly, and a new regional PI Manager role was introduced, along with additional staff positions, to ensure sufficient capacity and alignment with the expanded regional model.

- **Sustained Leadership of QMSI Workgroups**: Performance Improvement Teams continue to lead measure-focused improvement workgroups under the Quality Measure Score Improvement Initiative (QMSI). Each workgroup is responsible for a specified measure domain and has 1-2 designated leaders to facilitate cross-departmental analysis and review of quality measure performance, assess and initiate new interventions to address prioritized care gaps. This year included developing a new QMSI workgroup focused on Elder Care, which represents measures unique to members enrolling in Partnership's forthcoming D-SNP offering.

- **Enhanced Provider Engagement (EPE) and Modified PCP QIP**: In 2024-2025, Partnership continued its EPE and Modified PCP QIP coaching programs focused on providers facing significant infrastructure and workforce challenges, serving members in communities with historical healthcare disparities, and reporting low performance in the PCP QIP. Provider organizations demonstrating improvement transitioned to coaching and collaboration activities that are elective and less prescriptive, while new participants were onboarded based on low performance in priority quality measures.

Cross-Functional Alignment and Special Projects

- **CAHPS / Member Experience Efforts**: In Fiscal Year 2024-2025, CAHPS® / Member Experience goal efforts continued. As a result, implementation of new improvement activities and interventions that targeted workforce development, improved access to care, transportation services, direct-to-member activities, and increased Partnership branding and awareness were the focus and thus supported stronger linkage to Partnership's 5-Star Strategy and the stated objectives of the Engaging Members focus area in the corresponding QI Tactical Plan.

- **NCQA Health Plan Accreditation and Health Equity Accreditation (HEA) Readiness:** In FY 2024-2025, the Accreditation Program maintained Partnership's health plan accreditation and continued work in preparation for NCQA Health Equity Accreditation (HEA). The team led readiness activities across departments and conducted a full mock HEA survey in August 2024, with its first HEA survey scheduled for June 2025.

- **Support for D-SNP Implementation**: In FY 2024-2025, significant progress was made in implementation planning for the future launch of Partnership's Dual Eligible Special Needs Plan (D-SNP), defined as an Exclusively Aligned Enrollment (EAE) model. The Senior Medicare QI Program Manager was fully integrated into the QI Program structure over the course of 2024-2025. Reporting into the Senior Director of QI, this position worked closely with the Medicare Medical Director, Medicare Program Manager, QI leaders, and other Health Services leaders to develop, implement, and sustain the Model of Care and lead organization-wide implementation of Partnership's CMS Medicare STARS Quality strategy, which is crucial to the organization achieving an optimal STARS rating. QI added new resources across QI teams to support implementation planning activities central to the QI Program. QI also facilitated cross-functional collaboration with internal and external stakeholders to prepare for program launch activities, including quality strategy alignment, readiness assessments, and infrastructure planning key to the long-term needs of the QI Program.

- **HRP Implementation**: In fiscal year 2024-2025, QI resources continued supporting the development and testing related to the transition from Partnership's prior core claims processing system, Amisys, to the new core claims processing system, HealthRules Payer® (HRP®). The QI Department remains actively engaged in ongoing work to ensure quality and compliance alignment throughout the system implementation lifecycle and will continue supporting this work through its launch.

Conclusion and Structural Growth

In response to organizational expansion and increasing program complexity, the QI Department added multiple new roles, aligned regional operations, and refined team responsibilities to support sustained quality oversight and performance improvement across all regions. Additional details on personnel changes are provided in the Quality Improvement Departmental Changes section.

Quality Improvement Governance

Partnership HealthPlan of California maintains a comprehensive and well-integrated Quality Improvement (QI) governance structure designed to ensure strong oversight, accountability, and collaboration across all levels of the organization. The QI governance framework brings together diverse specialties and expertise through multiple committees and advisory groups. These committees work in alignment to oversee, monitor, and continuously improve the quality of care and services provided to members.

The organization is satisfied with the number and types of specialties represented across its governance bodies including the Board of Commissioners, Physician Advisory Committee (PAC), Quality and Utilization Advisory Committee (Q/UAC), Internal Quality Improvement (IQI) Committee, and the Quality Incentive Program (QIP) Advisory Groups — each playing a critical role in supporting Partnership's mission and advancing quality initiatives.

Board of Commissioners

The purpose of the Commission is to arrange for the provision of health care services to qualifying individuals, as well as other purposes set forth in the enabling ordinances established by the respective counties. The Commission promotes, supports, and has ultimate accountability, authority, and responsibility for a comprehensive and integrated QI Program. The Commission is ultimately accountable for the quality of care and services provided to members. The Commission has delegated direct supervision, coordination, and oversight of the QI Program to the Physician Advisory Committee (PAC), which serves as the main Quality Improvement committee. PAC is supported by two (2) other quality committees – the Quality and Utilization Advisory Committee (Q/UAC) and the Internal Quality Improvement (IQI) Committee, which are described in more detail below. The county Boards of Supervisors for each geographic area appoints members of the Commission, which include representation from the community, consumers, business, physicians, providers, hospitals, community clinics, HMOs, local government, and County Health departments. The Commission meets six (6) times per year.

Internal Quality Improvement Committee

The Internal Quality Improvement (IQI) Committee is comprised of appropriate Partnership department directors and staff that track progress towards successful completion of quality initiatives, surveys, audits, and accreditation. The IQI Committee under the leadership of the Chief Medical Officer, Medical Director for Quality, and Senior Director for Quality and Performance Improvement, meets 10 times per year, with the option to add additional meetings if needed, and reviews approximately 185 or more external-facing policies owned by the various Health Services department, including QI, and a few non-HS departments (i.e., Credentialing, Network Services, Provider Relations, Member Services, and Grievance & Appeals). IQI also considers QI initiatives spearheaded by Performance Improvement staff ; reviews annual evaluations of the various Quality Incentive Programs (QIPs) and hears annual "Grand Analysis" presented by various Health Services departments. IQI is also the initial committee to receive and provide feedback on the monitoring of Initial Health Assessment trends and actions, site review results, and trends in potential quality of care issues. Multidisciplinary improvement teams may be designated to complete analysis and intervention recommendations for quality improvement issues and activities. The IQI Committee serves to integrate quality activities organization wide. Activities and progress are reported to the Quality and Utilization Advisory Committee (Q/UAC) and then the Physician Advisory Committee (PAC).

The IQI Committee met 10 times during fiscal year 2024-2025. Partnership's IQI Committee agenda remained heavy throughout the year, due to the volume of policy changes related to NCQA Accreditation and DHCS requirements. To date, Partnership addressed all agenda items timely. The IQI Committee membership remained stable, consisting of a multi-departmental team that included the necessary level of leadership across departments impacted by policies and procedures moving through the IQI Committee. The meeting structure included a policy pre-review process and dedicated policy review time during the meeting, both of which ensure there is adequate time for policy discussion. Discussion topics were presented to the committee, and Partnership leveraged these presentations and reports for IQI Committee members to provide input and qualitative feedback. Overall, the IQI Committee structure has been sufficient to provide adequate oversight and support in tracking quality initiatives and providing health plan and/or clinical expertise into policy and procedure review.

Partnership's IQI Committee agenda grew heavier this year, not least because of increasing volume of policy changes related to NCQA Accreditation and DHCS requirements. (For example, the IQI Committee twice this fiscal year considered a new internal Health Equity policy for the purpose of helping to obtain initial NCQA Health Equity Accreditation (HEA) in June 2025.) Volume also increased this fiscal year over last as departments reorganized and existing policies were reassigned from one department to another and new Medi-Cal policies were born. In Health Services, the emerging Enhanced Health Services and Behavioral Health sub-departments or "business units" assumed policies that had previously belonged to Administration, Care Coordination, or Utilization Management. (The expansion of Health Services sub-departments sparked a reformatting of the general policy template. Whereas only the "Lead Department" was once specified, now the "business unit" is as well: e.g., Health Services/Quality Improvement. This innovation makes it easier to ascertain who owns what policy.) Tracking non-HS department policies was made more difficult by the August 2024 Provider Relations split into Provider Relations and Network Services, the latter of which assumed the Credentialing policies. Finally, in the fall of 2024, work began in earnest on policy requirements to meet the needs of the new Dual-Eligible Special Needs Program (D-SNP) "Partnership Advantage," Partnership's Medicare product line that will take effect Jan. 1, 2027, and the volume of policy review at IQI increased accordingly beginning in February 2025. Staff anticipates that the IQI Committee workload will remain heavy in FY 2025-2026 as preparations continue for the coming Medicare product. The policy pool could grow from approximately 185 to well above 200 distinct documents.

Quality and Utilization Advisory Committee

The Quality and Utilization Advisory Committee's (Q/UAC) role is to assure that quality, comprehensive health care and services are provided to Partnership members through an ongoing, systematic evaluation and monitoring process that facilitates continuous quality improvement. This responsibility includes providing significant input on the QI Program Description, Annual Evaluation, and Work Plan. The committee is required to meet at least 10 times per year, with the option of adding meetings if needed. Present Q/UAC voting membership includes two consumer representatives, one physician currently serving as a county Public Health Officer, and 10 external clinicians whose specialties are internal medicine, family medicine, pediatrics, OB/GYN, neonatology, or behavioral health, among others. The Partnership CMO (chair of the committee), Medical Director for Quality (vice-chair), and leadership from the Health Service departments (i.e. QI, CMO Office, Utilization Management, Care Coordination, Pharmacy, Population Health, Health Equity, Behavioral Health, and Enhanced Health Services) and non-HS departments (e.g., Member Services and Grievance & Appeals) regularly attend Q/UAC meetings. Q/UAC activities and recommendations are reported monthly to PAC and at least quarterly to the Commission.

Q/UAC met 10 times during fiscal year 2024-2025. Partnership's Q/UAC agenda remained heavy due to the volume of policy changes related to maintaining NCQA Accreditation and new DHCS requirements largely associated with California Advancing & Innovating Medi-Cal (Cal-AIM) and other All Plan Letters. Furthermore, Partnership's addition of 10 new counties to its service area, effective January 2024, continued to impact the QI Program at large and Q/UAC discussions particularly.

Committee membership remained steady, and quorum was met each meeting. Partnership was able to address all agenda items timely, although at times, reports on QI initiatives had to move from verbal presentation to directing committee members to refer to written reports in their meeting packets in soliciting feedback. This was a result of accommodating the increased discussion corresponding to the growing policy load. (See Internal Quality Improvement (IQI) Committee above for details.) In Fall 2024, QI staff took an informal straw poll of Q/UAC voters and received no support to increase monthly meeting time from 90 minutes to two hours. This and other remedies, however, may need to be considered in the future. Overall, in 2024-2025, the Q/UAC committee structure was sufficient and provided adequate oversight and support to the Quality Improvement program and sufficient clinical expertise to support informing policy and procedure. Moreover, the medical expertise of Q/UAC's clinicians is deemed sufficient to meet Medicare's requirements, that those whose practices care for the elderly and disabled are involved.

Physician Advisory Committee Oversight Program

Physician Advisory Committee (PAC) and voting membership included external PCPs, board certified high-volume specialists, and advanced practice clinicians such as certified nurse midwives, nurse practitioners, or physician assistants. A voting provider member of the committee chaired PAC. Per Partnership policy, the committee met monthly, at least 10 times during fiscal year 2023-2024. PAC monitored and evaluated all Health Services activities and was directly accountable to the Commission for the oversight of the QI Program. The parameters for membership and meeting frequency were met for the fiscal year 2023-2024, and activities including review and approval of policies and procedures, QI activities, and evaluations of projects and programs were addressed by an appropriate mix of Primary Care and Specialty physician members who attended. Quorum requirements were met for nine of the ten convened meetings. The Partnership CMO, Medical Director for Quality, Clinical Director of Behavioral Health, and leadership from QI, Provider Relations, Utilization Management, Care Coordination, and Pharmacy Departments attended PAC meetings regularly.

Quality Incentive Program Advisory Groups

As detailed later, Partnership has several incentive programs called Quality Incentive Programs (QIPs). QIP Advisory Groups are made up of appropriate Partnership staff and representative provider network staff to ensure ongoing collaboration in Partnership's value-based program offerings. Each year they review and recommend measures for the QIPs in which they participate, with each member of the QIP Advisory Group serving for a two-year time frame. The QIP Team manages the Advisory Group member list and is responsible for inviting new participants at the conclusion of the two-year service period. Advisory Group meetings are held once per quarter throughout a measurement year for most QIPs and less frequently but no less than twice per measurement year for smaller programs.

Physician Advisory Committee (PAC) oversees the QIP Advisory Groups and the QIP Team is responsible for hosting the meeting and creating the Advisory Group meeting agenda in collaboration with the Partnership Chief

Medical Officer. Each QIP Advisory Group formulates recommendations generated by internal QIP Technical Working Groups, in the form of draft measures which are released to their respective provider networks during a "public comment period." Feedback from the public comment period is shared with the QIP Advisory Groups, who assimilate them into a set of measure recommendations that are forwarded to PAC for review and approval. The current committee structure supports the QIPs and allows for valuable feedback from appropriate stakeholders, in a fashion that helps Partnership meet its goals. The QIP Advisory Group includes representation from all Partnership regions, including invitees from smaller organizations to diversify feedback and increase stakeholder buy-in.

Quality Improvement Leadership Engagement & Commitment

Partnership HealthPlan of California's executive leadership team provides essential oversight, accountability, and strategic guidance to support the Quality Improvement (QI) Program. Through active participation in key committees, workgroups, and strategic initiatives, these leaders ensure alignment between organizational priorities and quality goals. Each executive brings unique expertise and plays a distinct role in advancing quality management, supporting NCQA accreditation, meeting regulatory requirements, and driving performance improvement initiatives that enhance member care. The following describes the roles and contributions of executive leaders key to the governance and success of the QI Program.

Chief Executive Officer

The Partnership Chief Executive Officer's (CEO) primary roles in quality management and improvement were four-fold:

- Maintained a working knowledge of clinical and service issues targeted for improvement
- Provided organizational leadership and direction
- Participated in prioritization and organizational oversight of quality improvement activities
- Ensured availability of resources necessary to implement the approved QI Program

The CEO is a member of the Internal Quality Improvement (IQI) Committee and is a standing attendee and presenter at the Physician Advisory Committee (PAC). Along with other members of the Executive Team, the CEO further supports the QI Program through participation in the NCQA Steering Committee and Executive Quality Measure Score Improvement meetings. The Executive Team provides oversight, accountability and support for NCQA, HEDIS®, and related quality improvement initiatives.

In recognition of the need to better engage provider executive leadership at practice sites primarily responsible for driving quality measure performance, the CEO and CMO (or their senior leadership designees) meet with the executive and senior leadership of our largest primary care provider sites. One (1) to three (3) meetings are held annually with each of the participating provider organizations. These meetings have been an effective engagement strategy over the past several years and will continue in the next FY. The CEO was also a member of the Board Quality Advisory Group and partnered with the CMO in the consideration of topics and areas to gain further insights and recommendations from Board members who are also leaders at some of our largest participating network provider sites. The CEO's level of involvement in quality improvement activities was appropriate to ensure executive level accountability in support of the department and organizational wide goals and responsibilities.

Chief Operating Officer

The Chief Operating Officer (COO) provides strategic leadership and guidance in all health plan operations. The COO has purview over the Member Services, Claims, Configuration, Grievance and Appeals, Transportation, Provider Relations, Contracting, Network Services, and the Regional Leadership departments and ensures that these departments incorporate and prioritize quality improvement work and processes in coordination with standing work. The COO is a regular attendee and ad hoc member of PAC and an engaged participant at NCQA Steering Committee and Executive Quality Measure Score Improvement meetings. The COO's level of involvement fulfilled the need for executive support and accountability for operations key to successful quality improvement interventions, initiatives, and related organization wide goals and responsibilities.

Chief Medical Officer

The Chief Medical Officer (CMO), with the assistance of the members of the PAC, Q/UAC, and IQI Committees, is responsible for providing professional judgment regarding matters of quality of care, peer review, clinical services, and medical procedures. The CMO is the chair of the IQI Committee and Q/UAC and has significant involvement in all QI, Pharmacy, Population Health Management, and Health Services activities. The CMO facilitates the Board Quality Advisory Group and presents a report on quality at each Board of Commissioners meeting.

The CMO and the QI Program senior leadership team provide oversight for QI programs on a day-to-day basis. The team is comprised of:

- Associate Medical Directors - Assists CMO with utilization management review, review of appeal decisions, and review of Potential Quality Issues (PQI). The level of involvement of the associate medical directors was sufficient for reconciliation of PQIs via the peer review process.
- Medical Director for Quality - Assists CMO by providing physician support for varying activities within the Department, including Performance Improvement, Member Safety, Peer Review, and the Quality Improvement Programs, as well as assisted with utilization management review activities. This role also has management oversight of the Member Safety Teams within the Quality Department. The time allocated and scope of responsibilities of the Medical Director for Quality is set appropriately to meet the evolving needs of the QI Department.
- Regional Medical Directors - Works closely with respective counties on quality improvement activities including: liaison to physician leaders, serve as medical leadership at community meetings, support process improvement activities, author/ edit provider and member QI newsletter articles, drive improvements on adult and child quality measures and foster further collaboration and engagement with providers through regional meetings.
- Medical Director of Medicare Services – This new role was added in 2023-2024 to assure physician leadership in preparations for implementing the Medicare Dual Special Needs Plan (D-SNP). This medical director works closely with the CMO and Quality Department to develop policy, strategy, and tactical activities with Medicare leads designated in other departments across the organization. As D-SNP is implemented, this role will provide medical leadership for Partnership's Medicare activities, including utilization management, quality, care coordination, pharmacy, grievances, and compliance activities. Also assists CMO, as requested, in supporting broader needs to oversee appropriateness and quality of care delivered through Partnership and for the cost-effective utilization of services.

- Chief Health Services Officer - Reports to the CEO but works in close collaboration with the CMO and QI Program senior leadership. Responsible for the day-to-day implementation of Partnership's Utilization Management, Care Coordination and Health Equity Programs. This position has the authority to make decisions on coverage not relating to medical necessity. This role serves as a standing Member of PAC, Q/UAC and the Peer Review Committee and provides oversight, guidance, and evaluations of ongoing UM activities and programs under their oversight.
- Senior Director of Quality and Performance Improvement - Works collaboratively with the CMO to define strategy, develop programs and services, and evaluate the effectiveness of the QI Program. Together with the QI management team, including the Medical Director for Quality, provides oversight of Facility Site Reviews, investigation of potential quality issues, compliance with NCQA standards, HEDIS® and other performance measure data collection and performance reporting, value based payment programs (QIPs), performance improvement initiatives and programs, external and internal QI training, provider education on the QIPs and HEDIS®, grant application and grant management. This role works to foster greater cross collaboration of QI staff and strategic involvement of other departments to support the execution of tactics defined and maintained under Partnership's 5-Star Quality Strategy.

The number of associated Health Services staff and level of involvement of the CMO was appropriate for meeting the objectives of the Quality Improvement Program.

Chief Health Services Officer

The Chief Health Services Officer (CHSO) works closely with leaders in Utilization Management to provide accountability for delegates to meet necessary NCQA accreditation requirements and provide strategic leadership and guidance in the review and revision of provider contracts to ensure QI reporting requirements and value-based program contingencies are met. The CHSO also has purview over the Care Coordination, Utilization Management, Enhanced Health Services, Behavioral Health, and Health Equity Departments and ensures that these departments incorporate and prioritize quality improvement work and processes in coordination with standing work. The CHSO's level of involvement fulfills the need for executive support and accountability for improvements with data quality, and coordination of activities between QI and these departments. Collaborates with the Chief Medical Officer and members of PAC, Q/UAC, and IQI in matters involving quality of care, clinical, and medical procedures.

Chief Strategy & Government Affairs Officer

The Chief Strategy and Government Affairs Officer (CSGAO) reports to the Chief Executive Officer and is a peer to the other executive team members. The CSGAO leads the overall strategic direction of the HealthPlan in consultation with the CEO and Governing Board.

This position is responsible for the operations and executive management of Regulatory Affairs and Compliance (RAC); Communications, Legal, and Project Management/Operational Excellence (PMO) departments. This executive leader is also overseeing the organizational implementation of the Partnership Advantage (D-SNP) product line.

Quality Improvement Departmental Changes

The structure of the QI Department, including committee structure (inclusive of leadership and practitioner participation), position changes, staff and team roles and responsibilities, are periodically assessed. The results of these assessments can lead to major operational and structural changes to the department or related QI functions. Consideration is given to new state directives, local and national events, general business needs, staff growth and development and fiscal responsibility when making a determination on whether to make structural or operational changes.

Based on the considerations noted above and the evaluation and assessment of the 2023-2024 QI Program, the following changes were made during fiscal year 2024-2025:

Changes within QI Department

Key personnel changes and Program restructuring in fiscal year 2024-2025:**Member Safety**

- Two Project Coordinator Is were added to the Member Safety-Inspections team to address logistics and site review scheduling associated with increasing DHCS regulatory requirements integrated in the site review process. These requirements include: oversight of Comprehensive Perinatal Services Programs (CPSP), supporting CPSP-like services, and absorbing Child Health and Disability Prevention (CHDP) provider training responsibilities. The Inspections team is also working to prepare provider sites in Partnership's recent 10-county expansion region for increased site review requirements before their next periodic review. This has led to these newer staff arranging focused trainings, led by certified site review nurses, in the expansion counties on DHCS Site Review Tool changes to ensure providers are prepared for the significant changes in Medical Record Review and CAP requirements. Simultaneously, the Inspections team is relied upon to maintain an expanded periodic site review schedule post-geographic expansion.
- A new role was created and added to the Inspections team: Quality Training Specialist and Dental Liaison. This position is responsible for maintaining and delivering provider education, required previously of the counties, under the Child Health and Disability Prevention (CHDP) Program. In anticipation of the sunset of the CHDP Program, Partnership has re-branded its newly implemented program as CHILD (Comprehensive Health Interventions for Lifelong Development) trainings. This role also serves providers as Partnership's designated Dental Liaison. As Dental Liaison, this position is responsible for collaborating with providers, internal departments, and other stakeholders to identify process improvements and other improvement activities for enhancing the quality of dental and oral health care our members received. This position maintains current knowledge of related benefit changes from DHCS and standards of care to help improve member health status and quality outcomes while establishing a positive provider experience and rapport.

Quality Improvement Program and Project Management Team (PPMT)

- Two Project Manager Is were added to support new and expanding program and project management needs within the overall QI Program. This includes adapting QI programs for D-SNP integration, scaling successful measure improvement pilots transitioning from the Performance Improvement teams, expanding established performance improvement programs and scaling initiatives into Partnership's expansion region, supporting county partners focused on quality measure performance improvement under DHCS required Community Health Assessments and Community Health Improvement Plans, and assuring timely completion of increasing deliverables under DHCS' Equity and Practice Transformation Program.

Performance Improvement

- Over the last two years, as Partnership prepared for and completed its 10-county geographic expansion, QI leadership opted to add new Performance Improvement (PI) staff, namely Improvement Advisors and improvement-focused Project Managers, versus adding a new regional PI Manager. The Northern Region PI Team integrated Tehama County into their workloads, while the Southern Region PI Team integrated the remaining nine new counties. The NR PI and SR PI Teams worked closely together over 2023-2024 and the first half of 2024-2025 to provide boots on the ground support to the provider network, with emphasis in primary care. In early 2024-2025, the executive leadership of Partnership opted to re-structure Partnership's regional operations from 3 to 6 regions for improved local coverage and impact in all its counties. Similarly, the CMO and Senior Director of QI worked to align QI's regionally designated PI teams. A new regional PI Manager role was added, and the existing NR and SR PI teams were re-structured to reflect the new regional structure. This resulted in the former NR PI Team being allocated to the Redding and Eureka Regions which include: Lassen, Modoc, Shasta, Siskiyou, Tehama, Trinity, Del Norte, Humboldt, Lake, and Mendocino counties. The former SR PI Team was allocated to the Fairfield and Santa Rosa Regions which include: Marin, Napa, Solano, Sonoma, and Yolo. The new regional PI Manager and team were allocated to the Chico and Auburn Regions which include: Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Sutter, and Yuba. This resulted in several changes within PI including role and reporting changes for existing staff and the addition of new staff and leaders. In addition to the new regional PI Manager role, a new Project Coordinator II position and another Improvement Advisor position were added to ensure adequate capacity in PI across all regions.

HEDIS

- QI added a new role, the Director of Quality Measurement in 4Q 2024. For several years, QI had a designated Associate Director of Quality Measurement to fulfill a role like this one. Due to the departure of this leader in 2021 and budget limitations, the Medical Director for Quality added the HEDIS team to his oversight responsibilities in 2022. Given increasing risks of sanctions and quality withholds, increasing complexity in the HEDIS projects, and expanding measure sets, additional leadership focus was needed in HEDIS. Simultaneously, this addition permitted the Medical Director for Quality to focus his leadership, clinical expertise and strengths in directing QI's Member Safety teams, supporting grievances, and increasing needs (due to impending medical director retirements) in credentialing. The Director of Quality Measurement is responsible for establishing data sources that are integrated and validated for optimal clinical quality measurement and reporting across both Medicaid/Medi-Cal and Medicare D-SNP product lines. This includes directing analyses of quality outcomes and reporting required per DHCS MCAS, NCQA HPA, DHCS D-SNPs, and CMS Medicare Stars. This position provides the primary strategic and management/supervisory support for the current Manager of Quality Measurement, the HEDIS projects and HEDIS team. This leader is key in identifying and driving strategies with IT, Health Analytics, and others in QI for enhancing data quality central to quality measurement that informs Performance Improvement priorities, namely ongoing quality measure score improvement activities. This position was filled by the former SR PI Manager, who has the analytical qualifications and related work experience to step into this new role. Her Partnership experience as a PI leader positions her very well in driving strategies essential to improving measure outcomes.
- Another QI Analyst was added to the HEDIS team due to the increasing workload brought forward with the 2024 Geographic Expansion, effective on Measurement Year (MY) 2024 HEDIS reporting. This position supports an estimated increase of 200k members to our current HEDIS eligible population in both DHCS MCAS and NCQA HPA Annual projects. This role is also key to assuring successful Primary Source Verification (PSV) of Electronic Clinical Data Systems (ECDS) sourced data through our NCQA-certified Data Aggregator as well as supplemental data from regional HIEs and other non-standard data sources.

- The HEDIS team also added another Program Coordinator II to support the growth of the HEDIS eligible population and the additional county-level oversampling required to support ongoing DHCS Quality Reporting. Both increase the team's non-clinical, medical records management workload substantially.
- Lastly, a Program Manager I was added to the HEDIS team focused on preparing for the D-SNP HEDIS projects. This role serves as the team's point of contact to collect the D-SNP Reporting requirements, understand and identify the new data sources that will be needed to capture the data, and create business requirements to integrate into existing systems key to fulfilling regulatory-based measure reporting requirements and inform Partnership's STAR strategy.

Quality Improvement Executive Summary

QI TRILOGY

Executive Summary

Partnership has identified three (3) strategic priorities in its 2024-2027 Strategic Plan – 1) Champion Local Partnerships, Provide Statewide Leadership, 2) Be a Catalyst for Health Equity and Quality and 3) Extend Our Reach, Transform Our Role.

Partnership's Quality Improvement (QI) Program was successful over the course of fiscal year 2024-2025 in achieving its quality improvement goals and commitments. The structure of the QI Program and its associated work planning process included ongoing monitoring of planned objectives and activities dedicated to improving quality of clinical care, safety of clinical care, quality of service and members' experience.

Key accomplishments and highlighted learnings, further detailed in this annual QI Evaluation, include:

- The NCQA Accreditation Program Management Team worked with business owners across Partnership to maintain compliance with all assigned and current NCQA Health Plan Accreditation (HPA) Standards and Guidelines. Confidence in maintaining compliance was primarily achieved through applicable departments' participation in quarterly file review audits and scheduled Mock File Reviews in the spring of 2025. All Business Owners addressed resulting findings and recommendations shared by Partnership's external NCQA Consultant. The HPA Report schedule was also fulfilled, with timely analysis reports deemed compliant by the NCQA Consultant.
- Business owners across the organization also continued working with the NCQA Program Management Team in achieving NCQA Health Equity Accreditation survey readiness. The 2024-2025 HEA goal aimed at readiness of all assigned HEA Standards and Guidelines for Initial Survey, scheduled for June 17, 2025. Confidence in readiness was achieved through the completion of a full scope HEA Mock Survey in August 2024 and the subsequent completion of all resulting corrective actions. Business owners also on confirming documented processes are in compliance with all evidence and analysis reports submitted timely for NCQA Consultant review. At the close of 2024-2025, an overall compliance rate of 100% is estimated.
- In FY 2024-2025, significant progress was made in implementation planning for the future launch of Partnership Advantage, a Dual Eligible Special Needs Plan (D-SNP) which is defined as an Exclusively Aligned Enrollment (EAE) model. QI worked closely with the Medicare Medical Director, Medicare Program Manager, and other Health Services leaders to develop, implement, and sustain its Model of Care. QI also led organization-wide implementation of Partnership's CMS Medicare STARS Quality strategy. QI added new resources across QI teams to support implementation planning activities central to the QI Program. QI also facilitated cross-functional collaboration with internal and external stakeholders to prepare for program launch activities, including quality strategy alignment, readiness assessments, and infrastructure planning key to the long-term needs of the QI Program.
- Partnership achieved an NCQA Health Plan Rating (HPR) of 3.5 in September 2024, reflecting Measurement Year 2023 health plan performance. NCQA assessed Partnership as a 3.5 Star accredited health plan, considered a slightly better than average rating on the five-point scale used nationally. The HPR methodology used by NCQA represents a composite metric of health plan performance under HPA HEDIS® measures and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey measures. As such, Partnership's QI Program has adapted in recent years to incorporate greater focus on improving both the quality measures defined by the Department of Health Care Services (DHCS) Managed Care Accountability Set (MCAS), NCQA HPA, and CAHPS® surveys, as each are used to assess the quality of healthcare provided to our members. Partnership continues to evaluate its QI Program under its 5-Star Quality Strategy (last updated in February 2020) and corresponding tactical plan, which is updated quarterly. This framework is reflected in detailed goals and

deliverables within Partnership's annual QI Work Plan. This approach has aided Partnership in demonstrating continued organizational focus on improving HEDIS® and CAHPS® scores over 2024-2025, which will continue as a multi-year effort and focus across the health plan. At the close of 2024-2025, Partnership estimates its HPR will be maintained as a 3.5 Star rating, given recently submitted HEDIS® and CAHPS® rates for Measurement Year 2024. The final HPR is pending NCQA assessment and reporting in September 2025.

- In 2024, DHCS implemented several new contract deliverables for managed care plans, emphasizing enhanced quality, access, accountability, and health equity. These contracts introduced requirements such as improved integration of physical and mental health services, culturally competent care, and mandates for plans to reinvest a portion of their profits into community health initiatives. At the same time, DHCS revised its sanctions methodology to assess annual MCAS performance at the county-level (vs regional or plan-wide level), while in parallel constructing its new Quality Withhold and Incentive Program, effective on MY2024 MCAS and CAHPS results. These new accountability deliverables and revised assessment criteria represent increasing pressure to optimize quality measure performance. In 2024-2025, Partnership continued its focus on corresponding priority quality measures and initiatives to meet these state goals and minimize financial sanctions and withholds that may impact how we serve our communities in the future. In addition to maintaining focus on driving quality measure score improvement through a variety of performance improvement initiatives and quality incentive programs, we also worked to enhance data completeness in reporting quality measure performance. Our goals are to enhance data completeness to better represent the actual care and services being delivered to our members that is increasingly not reflected in the reported quality measure performance rates. First, a new leadership role was inserted in the QI Program, the Director of Quality Measurement. This role oversees the HEDIS team and is key in identifying and driving strategies with IT, Health Analytics, and others in QI for enhancing data quality central to quality measurement. Key efforts in 2024-2025 to enhance data quality and completeness include:
    - Partnership worked with the DHCS Data team to better understand how it receives fluoride varnish claims and encounters that can be counted towards the Topical Fluoride for Children (TFL-CH) MCAS measure, most of which are billed to Denti-Cal from FQHC, RHC, and Tribal Health Dental Centers and then sent to Partnership. As a result, Partnership was able to identify fluoride varnish services completed by FQHC, RHC, and Tribal Health Dental Centers and receive approval from our HSAG HEDIS auditor to include in the MY2024 HEDIS Annual Project. These Dental Centers must follow specific coding requirements for their fluoride varnish services to be successfully sent to Partnership via DHCS, and in 2025 Partnership is actively working with Dental Centers throughout its network to implement the coding requirements and monitor progress.
    - Partnership piloted the use of Datalink, an NCQA Certified Data Aggregator Validation vendor, to more fully address the ongoing transition of several NCQA HEDIS measures to require data collection by Electronic Clinical Data Systems (ECDS) methodology. Learnings from this successful pilot in MY2024 HEDIS projects has identified adaptations for expanded use of DataLink in MY2025 HEDIS projects.
    - Partnership gained auditor approval to integrate a supplemental Medical Record Review project to improve measurement of the entire MY2024 W30 measure eligible population in MCAS. This supplemental Medical Record Review addressed numerous known points of failure in the Medi-Cal eligibility and enrollment process that have been limiting administrative data capture of newborn visits. The results of this pilot had a dramatic impact on the rates for both W30 sub measures, resulting in both rates scoring above the 75th percentile for MY2024. The W30 Medical Record Review is being adopted within the HEDIS Annual Project going forward.

- Considerable efforts were dedicated to building relationships with expansion providers and evaluating emerging quality data and performance trends in 2024-2025. In early FY 2024–2025, executive leadership restructured regional operations from three to six regions for improved local support. QI's Performance Improvement teams were realigned accordingly to ensure sufficient capacity and alignment with the expanded regional model. These regional interactions helped Partnership quality improvement staff support organizations in identifying improvement opportunities going forward, upon using their MY2024 QIP results with anticipated MY2024 HEDIS results soon to follow.
- In Partnership's legacy counties, QI continued coaching efforts across its lowest performing PCP practice tier through coupling our Enhanced Provider Engagement (EPE) and PCP Modified QIP programs. Performance Improvement staff assessed, supported, and coached lower-performing sites, developing tailored interventions designed to address foundational issues, including financial support to purchase equipment, increase short term access, and addressing health disparities. At the conclusion of MY2024, some provider organizations graduated from the Modified QIP back to full participation in the PCP QIP. At the same time, several providers remained, with a few provider organizations joining these programs for the first time. Improvement advising and project management support were also extended to low through mid-performing practice tiers in pursuit of funding through DHCS' Equity and Practice Transformation (EPT) program, which launched in 2023-2024.
- Performance improvement interactions with providers largely leveraged Partnership's Quality Incentive Programs (QIPs), targeting measures reflecting priorities from the DHCS MCAS and NCQA HPA measure sets. In FY 2024-2025, the Hospital QIP measure set was revised to include the introduction of the 7-day Clinical Visit Follow-Up measure, in anticipation of corresponding HPA measures and continued DHCS focus on managing transitions between care settings. Refinements to the measure are planned for 2025-2026. Additionally, the 2024-2025 measure set included a new measure encouraging hospitals to begin expanding their delivery privileges to midwives and family physicians given continued access constraints in OB services.
- Our steadfast commitment to provider technical assistance was also demonstrated through Improvement Academy trainings, regular joint leadership and operational meetings with larger provider organizations, regionally focused quality meetings with local primary care provider organizations, and state-mandated performance improvement collaborations. Improvement Academy trainings, along with a dedicated series of webinars, highlighting best practices in improving priority MCAS measures were very well attended and received. In local meetings and collaborative interactions, provider teams and coaches focused on closing care gaps through interventions within clinical and operational workflows, fostering a culture of quality within provider leadership, and building capacity for quality improvement.
- Quality Measure Score Improvement (QMSI) workgroups were expanded and optimized to address evolving DHCS MCAS and NCQA Health Plan Accreditation (HPA) measure sets in Pediatrics, Chronic Diseases (including medication management), Behavioral Health, Women's Health, and Perinatal Care. Through local collaboration, Partnership piloted, scaled, or spread improvements across measures including breast cancer screening, cervical cancer screening, chlamydia screening, perinatal care, colorectal cancer screening, controlling high blood pressure, diabetes care management, follow-up after emergency department visits with members having mental health illness or substance use, childhood immunizations, adolescent immunizations, lead screening, and well-child visits. New intervention opportunities continue to be investigated and implemented on an ongoing basis to address lagging measure performance across Partnership's service region. In anticipation of the new Dual Special Needs Plans (D-SNP) launch, a new Elder Care QMSI workgroup was formed in early 2025 to proactively educate staff on quality measures in order to start identifying and planning improvement efforts.
- The QI and Health Equity teams, along with other collaborating departments, continue to partner under its QI and Health Equity Transformation Program (QIHETP). In completing the required NCQA HEA grand analysis

on reducing health care disparities, Partnership used MY2023 HEDIS measure performance to identify potential disparities through an analysis of race and ethnicity, language, and gender data. Partnership prioritized the following as areas of focus and identified corresponding goals, targets, and ongoing interventions to reduce these targeted disparities.

  - Timeliness of Prenatal Care (PPC-Pre): Black/African American Members
  - Timeliness of Prenatal Care (PPC-Pre): American Indian/Alaska Natives
  - Timeliness of Postpartum Care (PPC-Post): American Indian/Alaska Natives
  - Well Care Visits (WCV): All Pediatric Members

- The most recent CAHPS® Composite Scores from 2023-2024 warrant continued focus and expanding improvement efforts on behalf of the health plan and within the provider network. In 2024-2025, CAHPS® Score Improvement activities targeted workforce development, improved access to care, transportation services, direct-to-member activities, and increased Partnership branding and awareness. These activities and interventions are being adapted based on the first ever drilldown CAHPS® survey Partnership completed at the end of 2023-2024 and received results for early 2024-2025. This unregulated drilldown survey provided greater insight into member responses in low performing CAHPS® survey questions. Partnership recognizes continued investments and scaling of successful interventions are necessary to enhance member experience and access to care, which are also key to achieving an improved NCQA Health Plan Rating (HPR).
- The Member Safety – Investigations Team observed an 8% increase in PQI care referrals in 2024 versus 2023, which is largely attributed to the 10-county geographical expansion. The team was staffed adequately to effectively absorb this increased workload. Physician and nurse participation in Peer Review Committee and PQI rounds, inclusive of Partnership medical directors and network providers from diverse specialties, was sufficient to meet the requirements for reviewing and making determinations about PQIs
- The Member Safety – Inspections Team integrated oversight of CPSP requirements and delivery of CHDP-designated provider trainings within its site review process. In anticipation of the sunset of the CHDP Program, Partnership has re-branded its newly implemented training program as the CHILD (Comprehensive Health Interventions for Lifelong Development) trainings. A Quality Training Specialist and Dental Liaison role was created and filled in 2024-2025 to deliver CHILD trainings and serve as Partnership's designated Dental Liaison.
- The structure and function of the quality committees remained stable. Overall, the quality committee structure was sufficient and provided adequate oversight and support to the QI Program and provided sufficient health plan and/or clinical expertise to inform and maintain policies and procedures. In 2024-2025, the overall volume of policy and procedure updates increased. These updates were primarily focused on maintaining NCQA Health Plan Accreditation, preparing for NCQA Health Equity Accreditation, and integrating new and changing DHCS requirements. Some of the increased volume was also associated with the re-organization of departments and functions due to Partnership's recent expansion and increasing regulatory requirements. In the fall of 2024, Partnership started to integrate the new Partnership Advantage (i.e. D-SNP) product line into its policies and procedures, which will continue into 2025-2026. In addition to reporting HEDIS® and CAHPS® annual results, the quality committee structure also received and provided feedback on results from provider access studies, monitoring of grievances and appeals, Initial Health Assessment trends and actions, monitoring of site review results and corrective actions trends, monitoring of potential quality of care issues, evaluations of performance improvement interventions and pilots, and outcomes of the Partnership Improvement Academy activities.
- There were sufficient resources to support the QI Program overall. Given the growing complexity and scope of requirements between DHCS MCAS and NCQA accreditations, sustaining quality improvement support in legacy and expansion counties, and preparing for the launch of Partnership Advantage (D-SNP), several QI Teams within the QI Program grew in staffing with restructuring of resources within select QI teams.

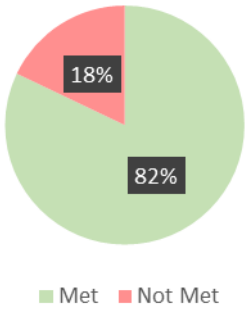
2024-2025 QI Work Plan Summary

Background

Background: The QI Work Plan is designed to track progress on key Quality Improvement (QI) activities and initiatives throughout the year. Approved by our Board of Commissioners and quality committees, it includes progress updates on planned activities and objectives for improving quality of clinical care, safety of clinical care, quality of service and members' experience. The Work Plan is set on a fiscal year (FY) 2024-2025 schedule. This update includes progress on activities included in the FY 2024-2025 QI Work Plan from July 1, 2024, to June 30, 2025.

Of the 67 goals outlined in the 24-25 QI Work Plan, 56 are "Met" and 11 are "Not Met".

Goal Status July 1, 2024 – June 30, 2025		
Status	**Total Number:**	**%**
Met	55	82.09%
Not Met	12	17.91%



QI Major Milestones and Activities

- `The Dual Eligible Special Needs Plan (D-SNP) Strategy Work Group was formed and met with representatives from across the organization. All Medicare D-SNP measures were reviewed including those in Part C, Part D and Display measures, along with DHCS D-SNP measures for which Partnership will be accountable. Each measure was reviewed to identify measure ownership, data collection and intervention/actions. This information was documented for all measures across the organization. The shared document will be used for other projects to identify business needs by department.
- A new Primary Care Provider (PCP) Incentive Program for organizations contracting to serve Partnership Advantage members has been developed and gained executive approval. The approved proposal included program goals and principles, member and provider eligibility criteria, the measure set, scoring methodology, and payment mechanisms.
- External vendors and internal IT resource capacity were both explored to identify a system solution for performance tracking of the Dual Eligible Special Needs Plan (D-SNP) PCP QIP program. After opting to buy versus build, several external vendors were considered through detailed responses to Partnership's Request for proposal (RFP). A vendor with experience delivering provider-based measure performance solutions was identified as the preferred option and recommended to Partnership's Project Review Board (PRB) in May 2025. The recommendation was accepted, and contracting is underway at the close of 24-25.

- A CAHPS D-SNP programmatic work plan and timeline have been developed with framework informed by research into survey methodologies and conversation with other local health plans in California. Ongoing coordination with the identified survey vendor and CAHPS team will help further implementation planning.
- A detailed review of D-SNP requirements was completed by the Member Safety Quality Investigation team. No changes are needed to Partnership's current Peer Review Committee (PRC) policy or to the current Potential Quality Investigation (PQI) process to accommodate D-SNP.
- The Member Safety Quality Investigation team completed UAT testing and upgraded its PQI process tool to Sugar, Version 14. This tool is used to maintain PQI cases end-to-end through the process and for storage.
- The Member Safety Inspections Team piloted a "Quality Management Overview" document that is completed prior to each scheduled site review. Each Overview details recent QI interactions, status check on sites, and updates on HEDIS, QIP, and Performance Improvement programs and initiatives. These details are reviewed with the site's staff during the completion of the Medical Record Review (MRR). Post review surveys of Site Review nurses revealed mixed feedback. Most nurses found sharing this additional quality information beneficial to conducting the site review. A few warm hand-offs to the PI and QIP teams also resulted.
- The Inspections Team developed provider training materials to reflect Child Health and Disability Program (CHDP) requirements. The delivery of these training materials is now the responsibility of managed care plans. Training topics include: vision, hearing, fluoride varnish application, anthropometric screenings and information on vaccines for children (VFC). These materials have been distributed to the provider network with issuance of certificates upon staff completion.
- Pharmacy conducted concurrent review of Latent Tuberculosis Infection (LTBI) medication treatments and provided timely provider notification to all identified potential LTBI treatment regimen gaps, which results from late refill, non-adherence, inappropriate prescribing, and/or inappropriate dispensing.
- The Primary Care Provider Quality Incentive Program (PCP QIP) reviewed its existing Data Validation framework to identify areas for improvement, based on learnings over the past year. The team added a dedicated Non-Clinical Measure Preliminary Period for providers to review and validate their final data before Partnership completes scoring and payment. The team also detailed key steps in the existing eReports clinical validation period and updated the process for verifying HIE connections by provider organization.
- A designated QIP Workgroup developed provider education materials to inform and influence Member Experience improvement activities. The MY2025 specifications now include a URL resource link within the Patient Experience Unit of Service measure description.
- The Quality Measure Score Improvement (QMSI) initiative successfully engaged five measure-specific workgroups. Each workgroup monitored and reviewed measure performance, as data was available, identified and completed score improvement activities for all stated deliverables by the end of the fiscal year. Highlights include:

  1. Pediatrics
     - Expanded promotion of Healthy Babies Growing Together Program to include Partnership's Provider Network and specific messaging on an expanded $100 member incentive offering for timely completion of childhood immunizations required by HEDIS measure, CIS-10
     - Launched a new Human Papillomavirus (HPV) 2nd Dose Reminder Program Pilot to affect HEDIS immunization measure performance under IMA-2
     - Launched a new provider educational webinar on Developmental Screening in the First Three Years of Life (DEV) in preparation for more focused DEV measure improvement work in the provider network

- Extended the PCP QIP Unit of Service (UOS) group well care visits' measure to include members eligible under either the Well Child Visits in the First 15 Months (W15) or Well Child Visits for ages 15-30 months (W30) measure
- Conducted Topical Fluoride for Children (TFL-CH) data investigation to identify and better address known data source gaps in related MCAS measure reporting
- Completed a Child and Adolescent Well Care Visits (WCV) Disparity Sprint Campaign focused on improving well child visit completion in 4Q 2024 among disparate populations identified by DHCS from MY2022 MCAS Annual HEDIS reporting.
- Continued work on the DHCS-mandated Performance Improvement Project (PIP) to improve W15 completion rates in African American members in Solano County, while looking for spread opportunities in other areas of Partnership's service region.

2. Behavioral Health
   - As part of the DHCS-mandated Non-Clinical PIP, implemented a pilot to track and improve the follow up care for patients with mental health (FUM) and substance abuse disorder (FUA) after emergency department (ED) discharge aiming to increase the percentage of PCP notifications for a provider partner's assigned members (DHCS Non-Clinical PIP)
   - Executed the DHCS-mandated IHI Behavioral Health Collaborative Project in partnership with Nevada County
   - Engaged County Departments of Behavioral Health (DBH) to utilize Sac Valley Med Share Data Exchange for follow-up after mental illness (FUM) data
   - Facilitated collaboration amongst several departments, including: Behavior Health, Care Coordination, Population Health, Pharmacy, Health Equity's Tribal Health Liaison, and Quality Improvement. This collaborative group monitored and evaluated interventions aiming to improve FUM and FUA measures scores.
   - Increased embedded Community Health Workers (CHWs) in hospital Emergency Departments
3. Management of Chronic Diseases
   - Monitored, evaluated, and improved the use of the Diabetes management program offered by TeleMed2U
   - Implemented a pilot of a comprehensive, service-intensive diabetes management program with Gojji
   - Brought the blood pressure control strategies into alignment with best practices of at least one primary care practice
   - Implemented a retinal eye exam grant to support providers in improving the rate of diabetic members receiving an annual retinal eye exam
   - Implemented improvements to the Cologuard bulk ordering program to better serve a broader group of Primary Care providers
4. Women's Health
   - Facilitated integration of cervical cancer screening HPV Self Swab across our network to affect the corresponding measure (CCS) rate
   - Identified 3 practices in counties with Chlamydia Screening in Women (CHL) rates below the minimum performance level (MPL) and conducted 1 on 1 provider education
   - Promoted incentives for "Increasing Screening Mammogram Capacity" in the Hospital Quality Incentive Program (H-QIP)
   - Elevated promotion of the Growing Together Program's increased incentive to impact postpartum rates

- Identified counties with race/ethnicity disparities for post-partum visits and supported connection to Enhanced Care Management (ECM) Birth Equity (BE) providers to support members accessing post-partum care

5. Elder Care
   - Identified all D-SNP measures which fall within the QMSI workgroups by work group domain for further focus in D-SNP implementation planning.

- The Performance Improvement (PI) team collaborated with the far northern consortia to bring QI awareness and education to providers serving members in Partnership's Redding and Eureka Regions through several activities and forums.
- Four (4) new expansion provider organizations were added to the Joint Leadership Initiative (JLI) series.
- Improvement Academy offered six (6) virtual trainings in 2025 highlighting priority MCAS measures including Pediatric Preventative Care for Ages 0 - 30 Months, Pediatric Preventative Care for Ages 3 - 17 years, Chronic Disease and Colorectal Cancer Screening, Perinatal Care and Chlamydia Screening, Breast and Cervical Cancer Screenings, and Diabetes Control. Improving Member Outcomes webinar attendance ranged from 53 to 90 attendees, with each session representing 28 to 45 unique organizations. Of attendees who completed the post-session evaluations for all six webinars, 99% selected "strongly agree" or "agree" when asked if the webinar was relevant and useful.
- Improvement Academy hosted three (3) ABCs of Quality Improvement in-person trainings with 100% of survey respondents, representing 37 unique provider organizations, reporting being extremely satisfied/satisfied with this course.
- The Healthy Kids Growing Together Program conducted two (2) cohorts focused on contacting any 3-6 year-old who has never had a well-child visit in a set timeframe and offered an incentive to complete a well-child visit within 90 days prior to their 4th, 5th, and 6th birthday. Over 2600 children participated and received member incentives.
- The Primary Care Provider Quality Incentive Program (PCP) QIP Breast Cancer 50th percentile benchmark has been met in the legacy Southeast, Southwest, and Northeast regions. This improvement was largely influenced by 77 Mobile Mammography event days, resulting in 2,162 completed breast cancer screenings.
  - 15 Mobile Mammography event days were held at Tribal Health Centers.
  - 14 Mobile Mammography event days were held at Enhanced Provider Engagement (EPE) provider organizations.

FY24/25 Final Goal Status: Delayed/Terminated

Project or Program	Goal	Status Details	Next Steps
2.g. Partnership Quality Dashboard (PQD)	**Goal #1**: By June 30, 2025, apply annual development updates of the MY2025 HEDIS® Monthly Exploratory Dashboard in accordance with identified stakeholder needs (Contingent on	Delayed	Delay due to revised HRP® launch date. Deliverable 4 will be completed in CY Q3 of 2025.

	HRP® implementation). **Goal #2:** By June 30, 2025, apply annual development updates of the PCP QIP Provider and Internal View Dashboards in accordance with identified stakeholder needs.		Delay due to revised HRP® launch date. Deliverables 4-5 will be completed following the implementation of HRP®.
2.h. Enterprise Information Management	**Goal #1:** By December 31, 2024, integrate the HRP® version of the HEDIS® monthly project data into the Enterprise Data Warehouse and use this data to create the HRP® version of the HEDIS® PQD modules.	Delayed	Delay due to revised HRP® launch date. Deliverable 3 will be completed following the implementation of HRP®.
3.c. Palliative Care Quality Incentive Program (PC QIP)	**Goal #2:** By June 30, 2025, complete CY 2024 PC QIP evaluation.	Delayed	Payment processing for the Palliative Care QIP 2024 measure period II (July-December) did not begin until March 2025. This goal is on track to be completed, but not until July 2025.
3.e. Enhanced Care Management Quality Incentive Program (ECM QIP)	**Goal #2:** By December 31, 2024, complete CY 2023 ECM QIP evaluation.	Delayed	Due to this program only offering one measure from its inception spanning from 4th quarter CY 2022 to 4th quarter CY 2023, an evaluation of CY 2025 will be completed to provide a robust evaluation of the present program's five measures with year over year performance trend analysis. This goal is scheduled to be

			completed during the 2025-2026 QI Work Plan.
4.b. Missed Opportunities and Member Engagement	**Goal #1:** By June 30, 2025 Incorporate missed opportunity data and feedback from the 23/24 goal and include in the member engagement dashboard currently in development and publish externally for providers to use.	Delayed	Delay due to revised HRP® launch date. Deliverables 2 and 3 will be completed following the implementation of HRP®.
5.b. Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Dual Eligible Special Needs Plan (D-SNP)	**Goal #1:** By June 30, 2025, select and contract with a Medicare Dual Eligible Special Needs Plan (D-SNP) Consumer Assessment of Healthcare Providers and Systems (CAHPS®) CMS-approved vendor.	Terminated	A survey vendor has been identified. However, it was determined that contracting with a survey vendor is not required during this fiscal year (24-25) and will be addressed at a later date if or when the need arises.
8.d. Provider Coaching and Engagement	**Goal #2:** By June 30, 2025, the Performance Improvement teams will engage with practices in the 10 incoming counties joining Partnership in 2024. We will engage with practices holding 70% of assigned membership for incoming counties around PCP QIP performance.	Delayed	Due to heightened organization sensitivity to requesting too many meetings with our contracted providers, the Chico regional meeting has been rescheduled to July 2025. Deliverable 2 will be completed during the 25-26 QI Work Plan.
8.e. Expansion of Regional Quality Meetings	**Goal #1:** By June 30, 2025, Partnership will implement regional quality meetings in all six (6) operational regions to offer forums	Delayed	Redding, Fairfield, and Eureka regional meetings continue. Santa Rosa, Chico, and Auburn regional offices are currently in planning for

	for regional dialogue to address quality improvement opportunities or barriers.		Quarterly Quality meetings. Deliverable 2 on track to be completed by end of CY 2025.
14.a. Grand Analysis - Continuity and Coordination of Medical Care (QI3) Report	**Goal #1:** By June 30, 2025, Quality Improvement will complete as much as possible of the annual Continuity and Coordination of Medical Care Grand Analysis (QI3) report, given the complete data sets that are available. (The delay for full document completion past June 30, 2025 is required to allow appropriate analysis of all of the data required for the report, some of which is not anticipated to be available for review by June 30th.)	Terminated	Grand Analysis - Continuity and Coordination of Medical Care (QI3) Report is retired under 2025 HPA standards.
14.a. Grand Analysis - Continuity and Coordination of Behavioral Health (QI4) Report	**Goal #1:** By June 30, 2025, Behavioral Health will complete the annual Continuity and Coordination of Behavioral Health Grand Analysis (QI4).	Terminated	Grand Analysis - Continuity and Coordination of Behavioral Health (QI4) Report is retired under 2025 HPA Standards.

National Committee for Quality Assurance (NCQA) Accreditation

QI TRILOGY

NCQA Overview

(National Committee for Quality Assurance)

Partnership strives to improve the health status of members and their care experience to become one of the highest quality health plans in California. The NCQA Health Plan Accreditation (HPA) and Health Equity Accreditation (HEA) support Partnership's vision, mission, and strategic goals and fulfill Partnership's contractual obligations with the Department of Health Care Services (DHCS).

NCQA Health Plan Accreditation (HPA) and Health Equity Accreditation (HEA) Key Activities

During fiscal year 2024-2025, Partnership focused on advancing key activities and achieving important goals related to NCQA Accreditation. Including:

1) Maintaining compliance of all assigned NCQA Health Plan Accreditation (HPA) Standards and Guidelines, as they became available.
2) Preparing for readiness and maintaining compliance of all assigned NCQA Health Equity Accreditation (HEA) Standards and Guidelines, in preparation for the Initial Survey in June 2025.
3) Report HEDIS® and CAHPS® results to NCQA for HPA requirements by June 2025.

Compliance with NCQA Survey Standards

Per the 2024 DHCS contract, all Managed Care Plans (MCPs), including Partnership, will be mandated to achieve both NCQA Health Plan Accreditation (HPA) and NCQA Health Equity Accreditation (HEA) by January 1, 2026.

Partnership successfully achieved NCQA HPA reaccreditation on December 28, 2023. NCQA requires health plans to undergo reaccreditation every three (3) years, and Partnership's next HPA Renewal Survey is scheduled for September 22, 2026. A three (3)-year Renewal Survey timeline has been developed which outlines all key activities to achieve HPA in 2026. In preparation for Partnership's HPA Renewal Survey in 2026, Partnership will conduct a Mock Renewal Survey in October 2025. The Mock Renewal Survey will be a full-scope review of all "Year 1" evidence by our NCQA consultant, who will provide recommendations and address findings on the evidence submitted. Business Owners can also clarify issues and seek guidance during this time. A final report and scoring will be distributed after the conclusion of the Mock Renewal Survey. Activities are currently underway in FY 24-25 to prepare for the Mock Renewal Survey.

NCQA HEA is a relatively new standards program focused on advancing the delivery of more equitable and culturally and linguistically appropriate services across member populations. The NCQA Program Management Team worked closely with Partnership's NCQA Consultant, and key stakeholders across the organization to estimate Partnership's current performance and develop a readiness timeline to achieve the new NCQA HEA by the mandated deadline of January 1, 2026. Partnership's HEA Initial Survey was submitted on June 17, 2025, and formal Accreditation status from NCQA is anticipated September 2025.

The NCQA Program Management Team attended two (2) HEA Town Hall meetings that took place in February and May 2025 respectively. During the Town Hall meetings, the NCQA Program Management Team gained additional knowledge regarding best practices, compliance tips, and NCQA Policy Clarification Support (PCS) frequently asked questions.

Additionally, in April 2025 NCQA released Modifications to Scoring for NCQA Accredited Surveys due to the executive orders issued in January 2025. These modifications are in place until June 2026. The NCQA Program Management Team shared the modifications with Partnership's leadership team and Business Owners, and ensured all appliable modifications were in place for our HEA Initial Survey submission in June 2025. The NCQA Program Management Team continues to monitor for the next update from NCQA, scheduled for release by December 31, 2025, for impact related to HPA and HEA surveys beginning July 1, 2026.

The NCQA Program Management Team strives to maintain up-to-date knowledge of the NCQA Standards and Guidelines, and monitors NCQA's public comment, triannual policy updates and monthly FAQs closely, notifying Business Owners of any impact to their standards and/or approved evidence. The NCQA Program Management Team also maintains a compliance dashboard, which outlines key reporting accreditation metrics, and tracks plan-wide compliance rates. Communications provided by the NCQA Program Management Team were shared via different forums, including newsletters, business owner check-in meetings, and Steering Committee meetings with the executive leadership. Input and direction received from the executive leadership help to define Partnership's NCQA program vision and success for accreditation.

NCQA Health Equity Accreditation Initial Survey

The NCQA Program Management Team has built a solid HEA Program structure to ensure compliance with the HEA requirements which prepared Partnership for our formal HEA Initial Survey, submitted in June 2025. The HEA Program structure mimics that of the HPA Program structure, which has proven to be successful in achieving accreditation. The HEA Program structure includes, but is not limited to, the following activities:

- Host bi-quarterly check-in meetings with all Business Owners to ensure tasks are completed as planned.
- Distribute work plans to Business Owners to identify assigned requirements.
-
- Track all HEA evidence by developing an Evidence Submission Library for each Business Owner.
- Maintain HEA Report Schedules for each Business Owner to track data sources, approving bodies and due dates.
- Maintain the HEA Compliance Dashboard to monitor overall compliance by department and the applicable points achieved by month.

In preparation for Partnership's Formal HEA Initial Survey, Partnership conducted a Mock Initial Survey in August 2024. The Mock Initial Survey was a full scope review of all evidence by our NCQA consultant, who provided recommendations and addressed findings on the evidence submitted. A final report and scoring was distributed after the conclusion of the Mock Initial Survey and Business Owners developed Action Plans to address the gaps and recommendations identified by our consultant. Throughout this time, the NCQA Program Management Team continued to work with Business Owners to ensure all evidence met compliance in accordance with NCQA's look-back period, timelines, and/or expectations.

The HE 2 Workgroup that was formed in Fiscal Year 23/24 continued in Fiscal Year 24/25. Key participants of the Workgroup included: IT, Quality Improvement, and Health Equity. Other departments, including Member Services, Care Coordination, Population Health, and Compliance, also participated based on the selected topics. The HE 2 Workgroup was able to close the gaps on required evidence, ensuring necessary policies, materials and systems were in place prior to our survey submission and an implementation plan is in place for future activities. The HE 2 Workgroup concluded activities in May 2025 and Business Owners were identified to lead the HE 2 requirements going forward.

The activities completed in the HEA key activities and HE 2 Workgroup along with the actions taken following the Mock Initial Survey kept Partnership moving forward with compliance reaching 100% in May 2025. Formal survey results are expected to be received from NCQA in September 2025.

Preparation for HPA Renewal Survey and HEA Initial Survey

The plan-wide NCQA-related HPA and HEA key activities were approved by the NCQA Steering Committee for fiscal year 2024-2025. The HPA key activities included five (5)milestones aimed at ensuring continuous compliance of HPA requirements in preparation for Partnership's next HPA renewal survey, scheduled for September 22, 2026. For the HEA key activities, there were four (4) milestones aimed at readiness of all assigned HEA Standards and Guidelines for Initial Survey, scheduled for June 17, 2025. A summary of the key activities and outcomes towards obtaining NCQA HPA Renewal Survey and HEA Initial Survey are presented below. The HPA and HEA key activities were met, and all milestones were completed, with the exception of one (1) milestone under HPA, which was no longer applicable for fiscal year 2024-2025.

HPA Key Activities: Departments will maintain compliance with all assigned NCQA HPA Standards and Guidelines, following the most up-to-date Standards and Guidelines once available as measured by five (5) milestones:

Milestone 1: Milestone 1 was achieved by Business Owners completing both components timely:

1. All Business Owners provided their acknowledgement by July 25, 2024, due date confirming all documented processes were in compliance with current NCQA HPA Standards and Guidelines. Departments that had revisions to documented processes completed the revisions timely and received approval from our NCQA consultant.
   Applicable Business Owners submitted their screenshots by August 8, 2024, due date. For Business Owners with no screenshot evidence, their acknowledgement was received confirming there is no screenshot evidence.

Milestone 2: Milestone 2 was achieved by Business Owners completing the annual HPA Workbooks. This included:

1. Review of the HPA Work Plan, identifying new Business Owners, Business Sponsors, and Contributors as needed.
2. Review of the Evidence Submission Library, confirming evidence documents and planned target production dates.
3. Obtaining attestations, discussing questions, and evaluating impact among Business Owners and Contributors, as needed..

Milestone 3: Milestone 3 was achieved by Business Owners submitting edits to the HPA Report Schedule and providing their analysis reports timely. All edits were incorporated, and the analysis reports were deemed compliant by the NCQA Consultant

Milestone 4: Milestone 4 was achieved by applicable departments completing the three components related to file review and oversight.

1. Applicable departments participated in a Mock File Review with our consultant in April or May 2025. Audit findings and recommendations were shared with Business Owners and Action Plans were completed and submitted timely by the Business Owners. Risks identified and next steps were presented to the NCQA Steering Committee in May 2025. A targeted mock audit will be held prior to the start of look-back period in September 2025, with the selected departments where the file review requirements were scored "not met". Additional mock audits are recommended within three (3) months of implementation of the new system, Jiva. Additionally, selected teams participated in a Mock File Review for upheld appeals files in December 2024. Findings were addressed via a Corrective Action Plan and discussed at the December CMO/MD meeting, where the NCQA consultant, the pharmacy department and the medical directors discussed NCQA's expectation regarding same-or-similar specialist review of appeals, which the medical directors must demonstrate specific clinical knowledge and experience of the condition, service or procedure in question, when determining if an appeal meets criteria for medical necessity and clinical appropriateness.
2. Applicable departments completed quarterly file review audits of Partnership files. Issues identified, were discussed and addressed, as needed. The UM Team implemented weekly reviews of denial letters and focused on education via a newly formed work group. In addition, the Pharmacy Department updated the letter template to comply with the requirements of appeal notifications. Due to the new credentialing requirements, the Network Services (NS) Team also confirmed the internal audit tools for Partnership files have already been updated and are currently being used to ensure compliance by July 2025. The final quarterly audit in May 2025 was optional as all departments had just completed the full scope Mock File Review with our new NCQA consultant in April or May 2025. The G&A, Pharmacy, and Care Coordination Departments opted not to participate in the May 2025 quarterly audit. NS and UM completed the May 2025 audit timely and issues were addressed, as needed.
3. The NS and UM teams monitored the non-NCQA accredited delegates throughout the goal period. The annual delegation audits for credentialing delegates were conducted in February-March 2025, with no issues identified. Due to the new credentialing requirements, NS also confirmed they will review the Health Industry Collaboration Effort (ICE) Credentialing Audit tool, scheduled to be released by the end of year, to ensure all new NCQA elements and updates are present for 2026 annual delegation audit. The UM team monitored the UM hospital denials weekly and completed the annual delegation audits between March-April 2025. One (1) preliminary finding was addressed with one (1) delegate, and the issue was closed during the preliminary CAP process.

Milestone 5: Milestone 5 was related to evidence submission for the HPA Mock Renewal Survey, which is now scheduled in October 2025, rather than the originally planned date in August 2025. With the change in timing, this milestone no longer applies for FY 24/25. Details for evidence submission will be updated for FY 25/26.

HEA Key Activities: Departments will maintain compliance of all assigned NCQA Health Equity Accreditation (HEA) Standards and Guidelines and prepare for the HEA Initial Survey, in June 2025, as measured by four (4) milestones:

Milestone 1: Milestone 1 was achieved by Business Owners submitting a completed Corrective Action Plan (CAP) to address all applicable recommendations from the Mock Initial Survey.

Milestone 2: Milestone 2 was achieved by Business Owners completing the annual HEA Workbooks. This included:

1. Review of the HEA Work Plan, identifying new Business Owners, Business Sponsors, and Contributors as needed.
2. Review of the Evidence Submission Library, confirming evidence documents and planned target production dates.
3. Obtaining attestations, discussing questions, and evaluating impact among Business Owners and Contributors, as needed.

Milestone 3: Milestone 3 was achieved by Business Owners completing the three (3) components timely:

1. All Business Owners confirmed Documented Processes were in compliance prior to the start of the look-back period. Any edits that were required to bring Documented Processes in compliance were completed by November 2024.
2. All Business Owners submitted their applicable screenshots or provided their confirmation that no screenshots are required prior to the established due dates.
3. All applicable teams have submitted their analysis reports timely; all edits were incorporated, and the analysis reports were deemed compliant by the NCQA Consultant. In May 2025, NCQA announced survey accommodations to support implementation of the executive orders issued in January 2025. These accommodations went into effect for all accreditation surveys submitted on or after February 12, 2025, and will remain in effect until June 30, 2026. Due to the new guidance, Partnership did not submit a subset of evidence, including analysis reports with our HEA Initial Survey in June 2025.

Milestone 4: The NCQA Program Management Team hosted an evidence collection training on January 23, 2025. Submission instructions along with an Evidence Submission Tracker were sent to all Business Owners on January 28, 2025. Business Owners submitted their annotated and bookmarked evidence by the March 28, 2025 due date, with a few known exceptions. These exceptions had later submission dates due to committee review, publication and distribution of newsletters, and select delegation activities. The NCQA Program Management Team collaborated with the Business Owners to ensure all evidence followed the plan-wide submission guidelines. All evidence was uploaded to NCQA's web-based portal, the IRT, prior to our submission date of June 17, 2025.

Overall, the activities outlined above, along with staff that serve as the NCQA Program Management Team, were sufficient and provided strong oversight to achieve the fiscal year 2024-2025 key activities and objectives for NCQA HP and HE Accreditation included in the QI Work Plan.

CAHPS® and HEDIS® Reporting for Health Plan Accreditation

Partnership was required to formally report MY2023 HEDIS® and CAHPS® for HPA by June 2025. HEDIS® and CAHPS® reporting is a requirement that must be fulfilled annually by accredited health plans in order to maintain their accredited status. A health plan may choose the results of the CAHPS® survey to be reported: Adult CAHPS® or Child CAHPS®. For MY2024/RY2025, Partnership chose to submit the Child CAHPS® rates. Partnership also successfully reported HEDIS® HPA rates by the May 23, 2025, mandated deadline. Additionally, Partnership submitted the NCQA Healthcare Organization Questionnaire (HOQ) for the required CAHPS® surveys by the December 29, 2024, required deadline.

NCQA uses the annual HEDIS®/CAHPS® reporting to calculate the Health Plan Rating (HPR) that is released on NCQA's website every September. The HPR is the weighted average of a plan's HEDIS® and CAHPS® measure ratings, plus bonus points for plans with current Accreditation status.

During the next fiscal year, Partnership will continue to work on sustaining compliance of all Renewal Survey requirements through key defined activities, as well as its NCQA Program Management and NCQA Steering Committee structure to assure our readiness for Renewal Survey Accreditation in September 2026.

Partners in Quality

As of November 2021, Partnership became an NCQA Recognition Program Partner in Quality (PIQ) and has been awarded the PIQ stamp by NCQA. The PIQ program recognizes organizations that provide financial incentives or support services to practices seeking recognition through a subset of NCQA programs, including Patient-Centered Medical Home (PCMH) Recognition. This distinction was awarded to Partnership based upon the incentive payment offered to practices who are PCMH providers as well as technical assistance provided for gap analysis or assessment to assist practices with identifying areas to focus transformation. As of November 2021, Partnership is also listed on NCQA's Resource Directory of Incentives website as a PIQ organization. NCQA will reassess our PIQ status on a yearly basis via survey shared with our organization, and update their database accordingly based on our response.

As a result of this recognition, provider practices that are first time applicants and are supported by Partnership will also be eligible for a 20% discount for NCQA Recognition programs. This discount opportunity was shared with the Provider network through articles included in Partnership newsletters throughout FY 2024 – 2025. Further support and motivation for the Provider network to achieve and maintain the PCMH recognition is the PCMH Unit of Service measure included in the PCP QIP. Each measurement year, the Provider network has the chance to earn $1,000 per PCP site for achieving or maintaining PCMH accreditation from NCQA, or equivalent from Accreditation Association for Ambulatory Health Care (AAAHC) or The Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

Key Benefits of Being a Partners in Quality (PIQ) Recognized Organization:

- NCQA will grant auto-credit on a small subset of HPA Standards and Guidelines
- NCQA offers provider quality data at a discounted rate to organizations seeking to integrate validated quality ratings into their information tools.
- Provider Practices supported by Partnership that are first time applicants will be eligible for a 20% discount off the initial Recognition submission fee when submitting their NCQA application.

Preparations for Partnership Advantage (D-SNP)

QI TRILOGY

Preparations for Partnership Advantage (D-SNP)

During fiscal year 2024-2025, Partnership dedicated significant effort to preparing for the launch of its Medicare Dual-Eligible Special Needs Plan (D-SNP), known as Partnership Advantage, whose go-live date is planned for eight counties in January of 2027. These preparations focused on meeting regulatory requirements, establishing a comprehensive Model of Care (MOC), and integrating Medicare-specific goals and structures into existing Quality Improvement (QI) processes. The work reflects a coordinated, organization-wide commitment to ensuring that Partnership Advantage delivers high-quality, patient-centered care while aligning with CMS Star Rating expectations and other federal and state performance requirements. The following section highlights key activities and initiatives undertaken by the QI Department in preparation for a successful D-SNP launch and ongoing performance monitoring.

Model of Care

Partnership is required by DHCS to implement an Exclusive Aligned Enrollment (EAE) Dual-enrollment Special Needs Plan (D-SNP). Each D-SNP is required to draft a Model of Care (MOC) document which specifies how members receive care, how that care is coordinated, and how the plan intends to ensure that care is accessible, efficient and patient-centered. The MOC was drafted and submitted to DHCS and NCQA for approval in February 2025. Both agencies approved the MOC and Partnership Advantage is anticipated to launch within the following eight counties: Del Norte, Humboldt, Lake, Marin, Mendocino Napa, Solano and Sonoma. The MOC addresses four specific areas: 1) identifying and defining the needs of our most vulnerable population, 2) care coordination, 3) the primary care and specialty care network, and 4) quality improvement and monitoring. The QI Department assumed the lead in continuously updating and formatting the MOC for future submissions by the Regulatory and Compliance Department.

Within the Quality section of the MOC, Partnership defines the processes for monitoring and evaluating D-SNP performance. This process aligns closely with the annual QI Program Description in terms of existing committee structure, quality improvement program structure and overlapping data reporting needs. This structure and additions to the QI Program will supplement Partnership's overall efforts to achieve a high CMS Star Rating.

Integrating Partnership Advantage D-SNP

The QI Department integrated Medicare focused goals throughout the department. The Quality team has specifically focused on adapting to needs in the Quality Incentive Program, HEDIS and CAHPS data monitoring and Potential Quality Issues. An Operational Gap Analysis was performed to assess program needs within the fiscal year and beyond in preparation for program launch. Several projects were executed this fiscal year to supplement existing QI work, including:

- Developing the structure and vendor support for a D-SNP Quality Incentive program
- Addressing PQI issues and developing workflows to incorporate CMS specific requirements
- Developing methods for data capture and analysis for HEDIS as part of a larger Medicare Star Strategy
- Assessing vendor needs for the Medicare CAHPS and HOS surveys

Additionally, new projects included developing the structure and internal support to address overall Medicare Quality reporting needs including CMS Stars, DHCS and MOC reporting. Overall, the QI Department has focused significant efforts to ensure a successful program launch and the ability to monitor and analyze Medicare program data to optimize the quality of member care.

HealthPlan Quality Performance

QI TRILOGY

Overall Summary

In addition to HEDIS® reporting, updates on the following activities were presented to the IQI and physician committees annually: CAHPS®, summary results from specific access studies, Grievances & Appeals, Initial Health Assessments, facility site and medical record reviews, potential quality issues, targeted improvement projects, and the Partnership Improvement Academy. Project measures were reviewed during improvement team meetings. Partnership completed a robust, comprehensive evaluation annually for major programs and quality improvement projects and initiatives.

Partnership HEDIS Reporting Populations – MY2024

The addition of 10 incoming counties to Partnership's network coincides with changes to Partnership's HEDIS Reporting Populations for both DHCS's Managed Care Accountability Set (MCAS) measure set and NCQA's Health Plan Accreditation (HPA). Starting in MY2024, Partnership reported one Plan-Wide rate for all 24 counties in its network for the MCAS measure set to its DHCS auditor, Health Services Advisory Group (HSAG). The Reporting Unit configuration of Partnership regions used until MY2023 (i.e.: Southeast, Southwest, Northeast, and Northwest) has been sunset.

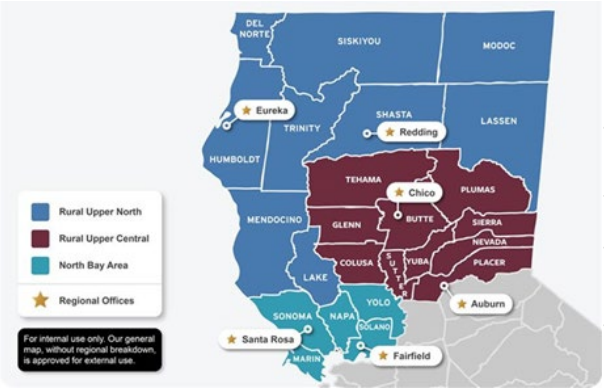
For NCQA reporting, Partnership also reported one Plan-Wide rate for all 24 counties in its network. Rates for each HPA measure are reported to Partnership's NCQA auditor, Advent Advisory.

Population	Description	Purpose
NCQA HEDIS Reporting - DHCS Populations		
Plan Wide	All 24 counties - Plan wide reported rates	DHCS-published HEDIS rates for MCP
County	County level measure rates for each of Partnership's 24 counties	County-level sanctions Withhold measure reimbursement (compiled into Rating Regions by DHCS)
NCQA HEDIS Reporting - HPA Population		
Plan Wide	All 24 counties - Plan wide reported rates	NCQA Star Rating

Population	Description	Purpose
NCQA HEDIS Reporting - DHCS Populations		
Plan Wide	All 24 counties - Plan wide reported rates	DHCS-published HEDIS rates for MCP
County	County level measure rates for each of Partnership's 24 counties	Geographic sanctions and withholds will be applied at DHCS's discretion (applied only to 14 legacy counties in MY2024)
NCQA HEDIS Reporting - HPA Population		
Plan Wide	All 24 counties - Plan wide reported rates	NCQA Star Rating

Starting in 2025, Partnership also reported county-wide MY2024 rates for all MCAS measures and their respective sub-measures to DHCS directly. DHCS intends to hold all California Managed Care Plans accountable for sanctions for all MCAS Accountable measures that did not reach the 50th percentile benchmark at the county level for Partnership's 14 legacy counties. (The 10 incoming counties are not held to performance sanctions for MY2024.)

Starting in 2025, using MY2024 results, DHCS intends to launch its DHCS Quality Withhold and Incentive Program. This program requires Partnership to earn back a percentage of its withheld revenue from DHCS based on performance of a subset of MCAS measures and two (2) CAHPS measures. The Quality Withhold program measures MCAS measure rates aggregated by DHCS Quality Rating Regions. The Rural Upper Central Rating Region, which is made up of the 10 incoming counties to Partnership in 2024, was excluded from this program for MY2024. An illustration of Partnership's network organized by DHCS Quality Rating Regions is shown below.



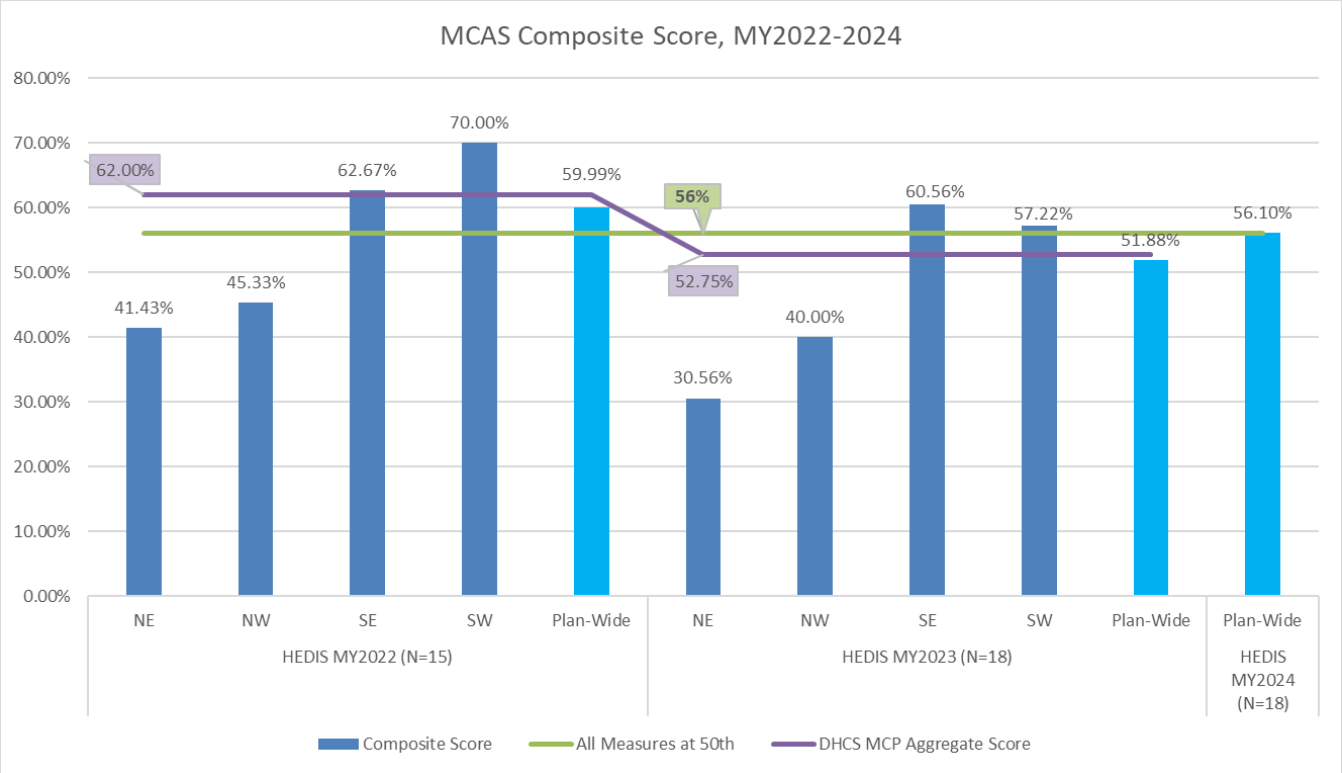
DHCS Quality Rating Region	Counties
North Bay	Marin, Napa, Sonoma, Solano, Yolo
Rural Upper North	Del Norte, Humboldt, Lassen, Lake, Mendocino, Modoc, Shasta, Siskiyou, Trinity
Rural Upper Central	Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Yuba

Overall Health Plan Ranking: DHCS Managed Care Accountability Set (MCAS)

DHCS uses a scoring methodology to determine an aggregated Quality Factor Score (QFS), which ranks health plan performance relative to California Medicaid reporting health plans. Partnership adopts DHCS' scoring methodology to determine Partnership's regional and plan-wide composite scores year over year. Each plan-wide measure is given a score from one to ten (1-10) based on performance relative to national benchmarks. A plan-wide composite score is then calculated by dividing total earned points by total possible points.

The Quality Compass 2024 Benchmarks, which were developed based on national MY2023 performance, are the most currently available benchmarks. These benchmarks were used by Partnership to determine percentile rankings and the following composite scoring year over year analysis. Every fall, DHCS releases a dashboard indicating the plan's regional Quality Factor Scores and associated rankings with other health plans. The results of this ranking will be published upon the release of this information and will be utilized by DHCS to assess mandated improvement activities and any sanctions.

MY2024 HEDIS® Composite Performance Year Over Year Comparison: DHCS Managed Care Accountability Set (MCAS)



➢**Reported Measures held to MPL MY2019:** ABA, AMM-Acute, AMM-Cont, AMR, AWC, BCS, CBP, CCS, CDC-H9, CDC-HT, CHL, CIS-10, IMA-2, PPC-Pre, PPC-Post, W15, W34, WCC-BMI, PCR

➢**Reported Measures held to MPL MY 2022:** BCS, CBP, CCS, CHL, CIS-10, HBD-H9, IMA-2,FUM-30, FUA-30, LSC, PPC-Pre, PPC-Post, W30-0-15, W30-15-30, WCV

➢**Reported Measures held to MPL MY 2023:** AMR, BCS-E, CBP, CCS, CHL, CIS-10, HBD-H9, IMA-2,FUM-30, FUA-30, LSC, PPC-Pre, PPC-Post, W30-0-15, W30-15-30, WCV

Reported Measures held to MPL MY2022: BCS, CBP, CCS, CHL, CIS-10, HBD-H9, IMA-2, FUM-30, FUA-30, LSC, PPC-Pre, PPC-Post, W30-6, W30-2, WCV
Reported Measures held to MPL MY2023: AMR, BCS-E, CBP, CCS, CHL, CIS-10, DEV, HBD-H9, IMA-2, FUM-30, FUA-30, LSC, PPC-Pre, PPC-Post, TFL-CH, W30-6, W30-2, WCV
Reported Measures held to MPL MY2024: AMR, BCS-E, CBP, CCS, CHL, CIS-10, DEV, HBD-H9, IMA-2, FUM-30, FUA-30, LSC, PPC-Pre, PPC-Post, TFL-CH, W30-6, W30-2, WCV

Note: *MY2024/RY2025: Total Points Earned: 101 Points out of 180 Total Points (18 measures included)*

- Because MY2024 marks a transition year in terms of reporting regions, only a plan-wide composite score is displayed for MY2024. Year-over-year trending of the plan-wide composite score will begin in MY2025.
- In MY2024 there were 18 measures held accountable to the MPL.
- The increase in Composite Score between MY2024 and prior years reflects significant improvement in several pediatric MCAS measure rates, including Well Child Visits Birth – 15 Months (W30-6), Well Child Visits 15-30 Months, and Lead Screening in Children (LSC). Interventions to support these rate increases are described below in the *Supplemental Data within the HEDIS Annual Project* section.

MY2024 continued to host two (2) required separate audits:

- DHCS / MCAS required reporting: Health Service Advisory Group Auditor (this report's focus)
- NCQA HEDIS® Health Plan Accreditation / HPA: Advent Advisory Auditor

In MY2024, Partnership observed an increase in overall membership by approximately 36.7%, to 906,964 assigned members in December 2024. The changes in membership reflect the addition of 10 new counties to the Partnership network, as well as the departure of members assigned to Kaiser sites, who moved to Kaiser as their Medi-Cal Managed Care Plan.

- Incoming counties added approximately 316,000 members to Partnership.

- Approximately 82,000 members assigned to Kaiser departed from Partnership. The decrease in membership primarily impacted Solano, Sonoma, Napa and Yolo Counties.

The impact of population shifts in Partnership's network impacts HEDIS measure eligible populations differently, depending on each measure's continuous enrollment requirements as defined in the NCQA HEDIS MY2024 Technical Specifications. A subset of measures require continuous enrollment greater than 1 year for a member to be included in the measure's eligible population, which meant that very few members from incoming counties met the criteria to be included in the measure in MY2024. For the MCAS measure set, these measures with very small eligible populations for incoming counties in MY2024 are:

- Asthma Medication Ratio (AMR)
- Breast Cancer Screening, ECDS (BCS-E)
- Well-Child Visits in the First 30 Months of Life (W30)

Supplemental Data Within MY2024 HEDIS Annual Project

Partnership was able to use a number of new supplemental data sources in the MY2024 HEDIS Annual project. Two of the additional supplemental data sources piloted approaches that will continue in MY2025.

Supplemental Data Pilots within MY2024 HEDIS Annual Project:

Electronic Clinical Data Systems (ECDS) Vendor Pilot: Partnership piloted the use of Datalink, an NCQA Certified Data Aggregator software, in MY2024, and received auditor approval to include records from two (2) EMR vendors (eClinical Works and Nextgen) in the MY2024 HEDIS Project. Records from six (6) provider organizations, within Partnership's provider network, were included in the MY2024 HEDIS Annual Project. Our analysis shows promising results from the Datalink pilot:

- The MCAS (Report Only) and HPA measure sets include seven (7) Depression Screening measures. Datalink was the sole source of data for six (6) of the seven (7) Depression Screening measures.
- Five (5) of the seven (7) Depression Screening measures exceeded the 50th percentile as a result of the inclusion of Datalink data.
- Datalink also made a positive impact on administrative rates for MCAS and HPA measures, including Controlling Blood Pressure (CBP) and Glycemic Status Assessment for Patients with Diabetes (GSD).

The HEDIS team will adapt the Datalink Data Aggregator project in MY2025 to add additional EMR's and practices. Priority will be given to Perinatal QIP practices, for which Datalink data submission will be a gateway measure in the 2025-26 Perinatal QIP; and Equity Practice Transformation funding awardees, who must report HEDIS-like Depression Screening rates bi-annually to meet program milestones and earn incentive dollars.

Medical Record Review for Well-Child Visits in the First 30 Months of Life (W30) Pilot: Partnership has historically scored below the 50th percentile on both W30 measures, though our PCP QIP rates for the W15 measure (Well Child Visits Birth – 15 Months) have been above the 50th percentile since MY2022. The QI department devoted time and resources to researching root causes for the discrepancy between HEDIS and QIP rates in 2024 and identified numerous points of failure for newborn visits to be counted towards the HEDIS rate using administrative data.

As a result of this analysis, the HEDIS team piloted a supplemental Medical Record Review of the entire W30 measure eligible population in early 2025, which was accepted as a supplemental data source by our HSAG auditor. The supplemental Medical Record Review made a dramatic impact on the rates for both W30 sub-measures, and both W30 sub-measure rates scored above the 50th percentile for MY2024.

The HEDIS team will adopt the W30 Medical Record Review within the HEDIS Annual Project going forward. The team will also look for additional opportunities to use the Medical Record Review process to improve measure rates in MY2025.

New Supplemental Data Sources within MY2024 HEDIS Annual Project:

Sacramento Valley MedShare (SVMS): SVMS is a Health Information Exchange used by practices and health systems throughout Northern California. In MY2024, Partnership received auditor approval to use Immunization, Pharmacy, and Measurement (blood pressure data) records towards the HEDIS Annual Project. In previous years, not all three record categories were approved for use in the HEDIS Annual Project.

Root cause analysis of fluoride varnish coding: Partnership worked with DHCS in 2024-2025 to better understand how it receives fluoride varnish claims and encounters that can be counted towards the Topical Fluoride for Children (TFL-CH) MCAS measure, most of which are billed to Denti-Cal from FQHC, RHC, and Tribal Health Dental Centers and then sent to Partnership. As a result, Partnership was able to identify fluoride varnish services completed by FQHC, RHC, and Tribal Health Dental Centers and receive approval from our HSAG auditor to include in the MY2024 HEDIS Annual Project. These Dental Centers must follow specific coding requirements for their fluoride varnish services to be successfully sent to Partnership via DHCS, and in 2025 Partnership is actively working with Dental Centers throughout its network to implement the coding requirements and monitor progress.

- NCQA released changes to two existing clinical measures used in DHCS MCAS for MY2024:The former Hemoglobin A1c (HbA1c) Control for Patients with Diabetes (HBD) measure was revised to Glycemic Status Assessment for Patients with Diabetes (GSD).
- Colorectal Cancer Screening (COL-E) using ECDS methodology replaced Colorectal Cancer Screening (COL), which was an administrative measure.

Partnership successfully launched our HEDIS® MY2024/RY2025 data collection and reporting audits incorporating all changes as noted above.

DHCS MCAS Accountable Measures

In MY2024/RY2025 HEDIS® Annual Final Reporting, DHCS is holding managed care plans (MCPs) accountable and imposing financial sanctions on 18 selected Hybrid and Administrative measures performing below the minimum performance level (MPL -50th national Medicaid percentile) by county, as described above.

Results of an additional 20 MCAS measures were reported but were not part of the accountability measure set in MY2024 ("reporting only measures"). The full list of MY2024 MCAS measures can be found on the DHCS website: https://www.dhcs.ca.gov/dataandstats/reports/Documents/Managed-Care-Accountability-Set-Reporting-Year-2025.pdf Finally, Partnership also reports to DHCS three (3) Long Term Care (LTC) measures designated as reporting only:

- Number of Outpatient ED Visits per 1,000 Long Stay Resident Days (HFS)
- Skilled Nursing Facility Healthcare Associated Infections Requiring Hospitalization (SNF-HAI)
- Potentially Preventable 30-Day Post Discharge Readmission (PPR)

The 18 MCAS Accountable measures did not change between MY2023 and MY2024, with the exception of the replacement of the former Hemoglobin A1c (HbA1c) Control for Patients with Diabetes (HBD) measure with Glycemic Status Assessment for Patients with Diabetes (GSD). As in MY2023, two (2) non-HEDIS® measures were included in the MCAS Accountable measure set, based on the 2023 CMS Core Measure Set: Developmental Screening in the First Three (3) Years of Life (DEV), an administrative measure specified by CMS and Topical Fluoride for Children (TFL-CH), an administrative measure specified by the Dental Quality Alliance (DQA). Per APL 24-004, DHCS designates MPLs for CMS Core Set measures in the current MY using previous Federal Fiscal Year (FFY) benchmarks as its basis.

The measure performance analysis that follows is based on the performance of the 18 accountable MCAS measures per NCQA Quality Compass 2024 Benchmarks, developed from MY2023 performance.

MY2024 MCAS Plan-Wide Rates

The table below shows Partnership's MY2024 rates for the MCAS measure set at the Plan-Wide level. These are the measure rates that were used to calculate the estimated MY2024 Composite Score shown above.

MCAS Accountable Measure Rates, MY2024, Plan-Wide (24 counties)

Domain	Measure Description	Acronym	Measure Type	Rate	Benchmark Percentile
Pediatric	Childhood Immunization Status—Combination 10 only	CIS	Hybrid	28.22%	50th
	Developmental Screening in the First Three Years of Life (Total, All Ages)	DEV	Admin	29.65%	<50th
	Immunizations for Adolescents—Combination 2 (Meningococcal, Tdap, HPV) only	IMA	Hybrid	40.39%	66.67th
	Lead Screening in Children	LSC	Hybrid	71.78%	75th
	Topical Fluoride for Children, Numerator 1 Total - Dental or Oral Health Services	TFL	Admin	12.40%	<50th
	Well-Child Visits in the First 30 Months of Life - 2+ visits 15-30 months	W30-2+	Admin	72.22%	66.67th
	Well-Child Visits in the First 30 Months of Life - 6+ visits in 0-15 months	W30-6+	Admin	67.05%	75th
	Child and Adolescent Well-Care Visits	WCV	Admin	48.83%	33.33rd
Cancer Prevention	Breast Cancer Screening, Non-Medicare Total	BCS-E	ECDS	56.29%	50th
	Cervical Cancer Screening	CCS	Hybrid	59.12%	50th
Reproductive	Chlamydia Screening in Women	CHL	Admin	55.58%	33.33rd
	Postpartum Care— and Postpartum Care	PPC-POST	Hybrid	89.54%	95th
	Prenatal - Timeliness of Prenatal Care	PPC-PRE	Hybrid	85.40%	50th
Chronic Disease	Asthma Medication Ratio, Total 5 to 64 Ratios > 0.50	AMR	Admin	64.71%	33.33rd
	Controlling High Blood Pressure, Total	CBP	Hybrid	69.59%	75th
	Glycemic Status Assessment for Patients With Diabetes—Glycemic Status (>9%), Non-Medicare Poor Control	GSD>9	Hybrid	32.60%	50th
Behavioral Health	Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up	FUA-30	Admin	33.27%	33.33rd
	Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up	FUM-30	Admin	29.01%	<10th

Key:
Above HPL MEASURES (>90th)
Below MPL MEASURES (<50th)

Hybrid Measures: Measure rates are calculated using a systematic sample drawn from the eligible population

GSD - HbA1c Poor Control is an inverted measure; a lower rate results in a better performance.

Some highlights of MY2024 Plan-Wide MCAS performance include:

Measures above the High-Performance Level (90th percentile):

- One (1) measure, Prenatal and Postpartum Care: Postpartum Care, scored above the 90th percentile at the Plan-Wide level.

Measures above the Minimum-Performance Level (50th percentile) :

- The two Well Child Visits in the First 30 Months of Life (W30) measures improved dramatically as a result of the W30 Medical Record Review. The W30-6 measure improved 24.96% from MY2023, to the 75th percentile; W30-2 improved 7.67% to the 62.5th percentile.
- The Lead Screening for Children (LSC) measure also improved dramatically between MY2023 and MY2024, gaining 12.66% to the 75th percentile in MY2024.
- Two immunization measures - Childhood Immunization Series (CIS-10) and Immunizations for Adolescents (IMA-2) - have Plan-Wide rates above the 50th percentile; these measures have been challenging measures for the Plan in past years.
- Other measures above the 50th percentile include: Breast Cancer Screening (BCS-E), Cervical Cancer Screening (CCS), Controlling High Blood Pressure (CBP), Glycemic Status Assessment for Patients with Diabetes (GSD), and Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-Pre).

Measures below the Minimum Performance Level (50th percentile):

- Three (3) measures – Asthma Medication Ratio (AMR), Chlamydia Screening for Women (CHL), and Child and Adolescent Well Care Visits (WCV) scored below the 50th percentile and are opportunities for performance improvement for Partnership in MY2025 onward.
- Four additional (4) measures – Developmental Screening in the First Three Years of Life (DEV), Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up (FUA-30), Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up (FUM-30), and Topical Fluoride for Children (TFL-CH) - have rates below the 50th percentile that are partially due to significant data completeness issues. Three of the four measures (FUA-30, FUM-30, TFL-CH) are dependent on data exchange between DHCS and Partnership, and Partnership has documented and DHCS has acknowledged that completeness issues still exist in the data exchange. The fourth measure, DEV, has an ambiguous value set directory and is challenging for PCP's to code accurately, which leads to incomplete claims and encounters data from Partnership's provider network. Partnership intends to appeal any sanctions received from DHCS on these four measures, since data received is insufficient to represent these measures' true performance within our provider network.

NCQA Health Plan Accreditation (HPA) – Health Plan Rating (HPR) Methodology

As an NCQA-Accredited Health Plan, Partnership is required to report HEDIS® and CAHPS® data annually. This reporting started in June 2022 for MY2021. Reporting for MY2024/RY2025 will be formally assessed by NCQA for Partnership's publicly reporting Health Plan Rating (HPR).

- Health Plans are given the option to choose to report the Adult CAHPS® survey results or Child CAHPS® survey results.
- Partnership chose to report the Child CAHPS® survey results for MY2024.

- In addition to CAHPS measures, there were 43 clinical HEDIS® measures requiring plan-wide level reporting for the HPA Annual Project.
- At the close of 2024-2025, Partnership awaits NCQA's formal assessment and final HPR for MY2024.

NCQA has released the current Health Plan Rating Methodology: (Plan-wide)

- NCQA ratings are based on three (3) types of quality measures:
  - Measures of clinical quality from NCQA's Healthcare Effectiveness Data and Information Set (HEDIS®); and
  - Health Outcomes Survey (HOS); measures of patient experience using the Consumer Assessment of Healthcare Providers and Systems (CAHPS®); and
  - Results from NCQA's review of a health plan's health quality processes (NCQA Accreditation). NCQA rates health plans that choose to report measures publicly.
- The overall rating is the weighted average of a plan's HEDIS®, HOS, and CAHPS® measure ratings added to any Accreditation bonus points (if the plan is accredited by NCQA), which is then rounded to the nearest half point and displayed as stars.
- The overall rating is based on performance tied to dozens of measures of care. The rating is calculated on a 0–5 scale including half points with five (5) being the highest. Performance includes three (3) subcategories (also scored 0–5 in half points):
  1. Patient Experience
  2. Rates for Clinical Measures
  3. NCQA Health Plan Accreditation

- MY2024 HPA Star Rating Results

NCQA's Projected HPA Star Rating Results with the Child CAHPS® Survey Results:

Projected Star Rating with Child CAHPS® Survey Results: 3.0 Stars

HEDIS HealthPlan Accreditation Star Rating Scoring MY2024 With Child CAHPS Survey Results	TOTAL Weight	TOTAL ACCRD Score MY2024	TOTAL Measure Score (Weight*Score)	Calculated Score (Not-Rounded)	Star Rating (Rounded) + 0.5 Bonus points overall
Overall Rating (CAHPS + Accreditation Measures)	60	135	164.5	2.741666667	3.0
Patient Experience	7.5	12	18	2.400	2.5
Prevention and Population	19.5	52	61.5	3.154	3.0
Treatment	33	71	85	2.576	2.5

Projected Star Rating with Adult CAHPS® Survey Results: 3.0 Stars

HEDIS HealthPlan Accreditation Star Rating Scoring MY2024 With Adult CAHPS Survey Results	TOTAL Weight	TOTAL ACCRD Score MY2024	TOTAL Measure Score (Weight*Score)	Calculated Score (Not-Rounded)	Star Rating (Rounded) + 0.5 Bonus points
Overall Rating (CAHPS + Accreditation Measures)	60	133	161.5	2.691666667	3.0
Patient Experience	7.5	10	15	2.000	2.0
Prevention and Population	19.5	52	61.5	3.154	3.0
Treatment	33	71	85	2.576	2.5

For Partnership's full HPA performance, refer to Star Rating Score Dashboard, Appendix (F).

Summary of HEDIS Measures in the Primary Care Provider Quality Incentive Program (PCP QIP)

The table below provides a summary of Measures Managed Care Accountability Sets (MCAS) for Medi-Cal Managed Care Plans Measurement Year 2024 | Reporting Year 2025 included in Partnership's Quality Incentive Program (QIP) measure sets.

	Measurement Year 2024 | Reporting Year 2025			
HEDIS® Measures	**MCAS Accountable/Reporting**	**MY2023 PCP QIP Measures**	**MY2024 PCP QIP Measures**	**QIP Program**
Asthma Medication Ration (AMR)*	Accountable	X		PCP QIP – removed from QIP in MY2024
Breast Cancer Screening (BCS-E)*	Accountable	X	X	PCP QIP
Controlling High Blood Pressure (CBP)	Accountable	X	X	PCP QIP
Cervical Cancer Screening (CCS)	Accountable	X	X	PCP QIP
Childhood Immunization Status (CIS) – Combo 10	Accountable	X	X	PCP QIP
Colorectal Cancer Screening (COL-E)	Reporting	X	X	PCP QIP
Eye Exam for Patients with Diabetes (EED)	Reporting	X	X	PCP QIP
Glycemic Status Assessment for Patients with Diabetes—Glycemic Status (>9%), Poor Control (GSD)	Accountable	X	X	PCP QIP QIP uses the inverse of this measure: Good Control, HbA1c Good Control <9%

	Measurement Year 2024 | Reporting Year 2025			
HEDIS® Measures	**MCAS Accountable/Reporting**	**MY2023 PCP QIP Measures**	**MY2024 PCP QIP Measures**	**QIP Program**
Immunizations for Adolescents (IMA) – Combo 2	Accountable	X	X	PCP QIP
Lead Screening in Children (LSC)	Accountable	X	X	PCP QIP MY2023: UOS measure MY2024: Clinical
Postpartum Depression Screening (PDS-E)	Reporting	X	X	Perinatal QIP
Prenatal Depression Screening (PND-E)	Reporting	X	X	Perinatal QIP
Prenatal and Postpartum Care (PPC) – Postpartum Care	Reporting	X	X	Perinatal QIP
Prenatal and Postpartum Care (PPC) – Timeliness of PrenatalCare	Reporting	X	X	Perinatal QIP
Prenatal Immunization Status – combo (PRS-E)	Reporting	X	X	Perinatal QIP
Well-Child Visits in the First 30 Months of Life—0 to 15 Months—Six or More Well-Child Visits (W30-6)	Accountable	X	X	PCP QIP
Child and Adolescent Well-Care Visits (WCV)	Accountable	X	X	PCP QIP

**Administrative Measures. The entire eligible population is used in calculating performance (versus a systematic sample drawn from the eligible population for the hybrid measures).*
PCP QIP Measurement Set:
http://www.partnershiphp.org/Providers/Quality/Pages/PCPQIPLandingPage.aspx

For Partnership's full summary of HEDIS® MY2024 performance, please refer to Appendix (E).

Quality in Data Governance

QI TRILOGY

Data Governance, Stewardship, and Analytics Integration

Partnership continues to strengthen its data and analytics infrastructure through the combined efforts of its Data Governance framework, Data Stewardship program, and Analytics Center of Excellence (ACE). Together, these initiatives ensure that organizational data is reliable, well-managed, and strategically applied to support quality improvement activities.

The Data Governance and Stewardship functions provide oversight, accountability, and structure for managing critical data assets, while ACE builds on this foundation to advance analytics maturity, promote data literacy, and drive innovation through cross-department collaboration. This integrated approach supports Partnership's goal of delivering data-driven insights to improve member care and organizational performance.

Data Governance

The QI, IT, and Health Analytics Departments play a key role in supporting the Data Governance framework across the organization. Data Governance involves the planning, oversight, and management of data and related resources to ensure they are used effectively and responsibly.

The main goal of Data Governance is to make data available, more reliable, well-understood, and easy to use. There is an important emphasis on partnering with each department to solve data related problems.

The Enterprise Data Warehouse (EDW) Team, within IT, has made significant progress in building a data warehouse system that integrates data from HealthRules Payor® (HRP®) (the new claims system), bringing together member, claims, and provider data into the Data Warehouse and DataMarts. Departments across the organization, including QI, rely on this data to support critical applications and processes.

Following the development of this infrastructure, the Provider Quality Dashboard (PQD) for the Quality Incentive Program (QIP) was developed and tested using data sourced from HRP®. Building the PQD database was successful, and this data was able to be fed into the HRP® version of the dashboards. Going forward into the next year the data will continue to be thoroughly tested in preparation for HRP® go live.

Data Stewardship

The Data Stewardship program is one key process under the Data Governance framework. In preparation for the introduction of HRP®, the team partnered with several departments to identify the data stewards for some of the data domains and established roles and responsibilities.

The goals and deliverables set for FY 2024-2025 included the following:

- Integrate the data from the new claims systems (HRP®) into all QI processes. This would include both HEDIS® and PQD.
- Integrate membership, claims, and provider data from the HRP® claims system into the EDW DataMart.
- Integrate Sutter supplemental data into the QI processes including the HEDIS® project.

The EDW Team was able to successfully integrate data from the new claims system, HRP®, into all QI processes. This included the HEDIS® project, the PQD, and EDW DataMart's which are provided to end users to use for reporting and analyzing data. By doing this it will allow for the QI processes to seamlessly switch sources of data for their projects, dashboards, and reporting when the new claims system goes live. Multiple iterations of testing have been performed to ensure the data from the new system will meet quality standards and the EDW Team will continue to oversee this as the go live date approaches.

A successful connection was made with Sutter to ingest their supplemental data, which could be used toward their quality measurements. In the past fiscal year, this data was able to successfully be included in Sutter's PCP QIP measurement scores and assisted us in gaining more data on our members while they were able to improve their program scores. The current connection was a one-time feed and further process improvement will take place next year to gather this data more frequently and use it in the HEDIS® project.

Analytics Center of Excellence

Partnership's Analytics Center of Excellence (ACE) was established in January 2024 as a virtual, cross-functional entity designed to integrate IT, business, and analytics functions across the organization. Its purpose is to align analytics initiatives with organizational strategy and to guide the development of analytics maturity, governance, and innovation.
ACE was created with the following core objectives:

- Operationalize the organization's analytics strategy
- Drive data governance and promote data literacy
- Identify and coordinate cross-functional analytics projects
- Standardize data management practices and data products
- Foster innovation in analytics
- Enhance collaboration across departments and reduce duplication of effort

ACE comprises several interconnected groups, each playing a distinct role:

- Analytics Steering Committee: Oversees the activities of the ACE groups and reports to the existing Data Governance Council. It is formed by representatives of the business units, IT and the Lead Team, and meets every other month, or as needed.
- Lead Team: Responsible for coordinating ACE operations and for realizing its functions. The Lead Team works closely with Governance Personnel, the Analytics Council, and business stakeholders to perform its functions.
- Analytics Council: Cross-departmental forum for analysts to discuss data issues, inform of new data or tools, contribute to the development of data standards, identify training, knowledge sharing, and prevent duplication of effort.
- Data Governance Council: Involved in developing and maintaining the data stewardship program.

Despite organizational constraints, ACE has delivered several important achievements:

- Data Literacy: Launched learning modules via the Learning Management System (LMS), supporting a foundational goal of improving data fluency across departments.
- Develop Advanced Analytics Capability**:** Established a Data Science function to support complex analysis, such as applying machine learning to provider network gap analysis and using RAND's Bayesian surname geocoding to address missing demographic data—critical for improving equity analysis.

- Cross-Team Integration: The integration of a long-standing Senior Quality Improvement (QI) Analyst into the Health Analytics (HA) team, along with enhanced collaboration between QI, HA, and Enterprise Information Management (EIM), has improved both operational efficiency and the integrity of analytics in QI projects.
- Data Standardization: Initiated a data catalog and glossary while also defining consistent classifications for race and ethnicity across datasets.
- Artificial Intelligence Governance Awareness: Developed a draft Artificial Intelligence policy. While the draft policy is still pending finalization and formal approval by leadership, it demonstrates early recognition of the need for governance around emerging technologies.
- Analytics Council Engagement: With 42 active participants from departments including IT, Finance, Grievance and Appeals, Quality Improvement, Care Coordination, and Population Health, the Council has become a key platform for sharing projects, addressing data quality concerns, and promoting standard practices.

While progress has been made, ACE's development has been hindered by several structural and cultural challenges. Leadership turnover and loss of key Lead personnel have stalled strategic momentum, and proliferation of several key initiatives requiring organizational priority have reduced the attention and resources available for ACE activities.

To ensure long-term success and impact, the following recommendations are proposed at the close of 2024-2025:

1. Update the ACE charter to reflect lessons learned, redefine the roles of each group with clarified deliverables, and consider more agile, outcome-oriented governance practices. Through this charter update, re-establish executive sponsorship given changes in executive leadership and immense organizational growth since the original charter was developed and adopted.
2. Position innovation as a core part of ACE's function, supported by leadership and cross-functional input
3. Enhance communications and visibility by improving internal awareness of ACE activities through regular updates, success stories, and shared outcomes.

Partnership Quality Dashboard

The Partnership Quality Dashboard (PQD) is one of many dashboard projects that can be accessed on Partnership's Tableau server landing page. This page houses multiple healthcare quality measure data dashboards and supports Partnership's data and analytics objectives. Dashboards visualize key performance indicators for multiple Partnership department stakeholders, including behavioral health, population health, care coordination, data quality, cost avoidance, member access and utilization projects. The PQD dashboards focus their scope on visualization of source data maintained by the Quality Improvement (QI) Department, HEDIS®, and Quality Incentive Program (QIP). These dashboards enable providers and Partnership staff to prioritize, inform, and evaluate quality improvement efforts. PQD supports year-over-year performance trending and enables analysis across geographic regions and demographic aggregates.

The PQD is maintained by staff in Partnership's QI, IT, and Finance departments. Annual dashboard development involves evaluation of project data needs, documentation of business requirements, data and dashboard development, and user acceptance testing. Data Governance principles are applied throughout the development and maintenance

process to ensure accuracy, consistency and responsible use of the data. Ongoing maintenance of dashboards throughout the year involves monthly warehousing of both HEDIS® and QIP source data and issue resolution. PQD training is a key project activity conducted throughout the year.

The majority of PQD project goals and deliverables outlined under the 2024-2025 QI Department Work Plan were successfully accomplished during the fiscal year. Delayed PQD goals have dependencies on the HealthRules Payor® (HRP®) integration and will continue into next year. Business rules for mapping primary care provider identification numbers under the new HRP® provider data structure were identified and shared with stakeholders. Other business rules defining data linkages were identified for source data projects (eReports, Inovalon) and tested, to help minimize delays during implementation. Source data validation and user acceptance testing was completed and continues, where needed. PQD dashboards are expected to be updated based on HRP® source data, following implementation. (Note, exact timing of refreshing PQD dashboards is contingent on the final implementation timing of HRP®, which remains pending as of the close of 2024-2025.)

The use of data to identify health inequities is a key organizational focus and was identified as a new goal under the PQD 2024-2025 QI Work Plan.

A health disparity dashboard was soft launched internally in November 2024. The dashboard allows various internal stakeholders to easily see the disparities by measure and by region. This dashboard is a critical step toward changing systems and decreasing disparities. Future phases of this dashboard include further upgrades and giving access to external stakeholders to inform effective collaboration.

Summary of FY 24-25 PQD Dashboards

Dashboard Name	Data Source	Brief Description	Major 2024-2025 Reporting Enhancements
MY2023 HEDIS® Annual Static -Summary of Performance	HEDIS® Annual Measurement Year 2023	MCAS measure performance by Sub-Region and County and color-coded against benchmarks; 16 of 18 MCAS Accountable measures included.	Measurement Year 2023 HEDIS® Final Performance
MY2024 HEDIS® Annual Static -Summary of Performance	HEDIS® Annual Measurement Year 2024	MCAS measure performance by Plan-Wide, DHCS Quality Rating Region, Partnership Region, and County and color-coded against benchmarks. 18 MCAS Accountable measures included.	MY2024 dashboard reflects DHCS transition to Plan-Wide rate reporting and replacement of legacy Reporting Units with County and Rating Regions for DHCS Accountability programs.
MY2023 HEDIS® Annual Exploratory	HEDIS® Annual Measurement Year 2023	MCAS measure performance by Sub-Region, County and Provider. Color-coded against	Measurement Year 2023 HEDIS® Final Performance

Dashboard Name	Data Source	Brief Description	Major 2024-2025 Reporting Enhancements
		benchmarks. Stratification by member demographics such as race and gender. Member-level drilldown reports by measure.	(MY 2024 dashboard expected Q3, 2025)
MY2023 HEDIS® Scatterplot	HEDIS® Annual Exploratory Measurement Year 2023	Bubble chart displays measure performance against population size, with break out by various demographic indicators.	Measurement Year 2023 Final Performance (MY2024 dashboard expected Q3, 2025)
MY2024 NCQA Health Plan Accreditation (HPA) Annual Static – Summary and Star Rating Estimation	HEDIS® Annual Measurement Year 2024	HPA measure performance (including 2024 Child and Adult CAHPS scores) by Plan-Wide and County, including year-over-year measure performance. Star Rating calculations displayed based on HPA measure scoring.	New Tableau dashboard. Displays Star Rating using Child and Adult CAHPS scoring scenarios.
MY2023 HEDIS® Monthly Exploratory – Internal View	HEDIS® Monthly 2023	MCAS and NCQA Health Plan Accreditation measure performance by various geographic and demographic aggregates, color-coded against benchmarks. Member-level drilldown reports by measure.	2024 Rolling Year and Year-to-Date Performance (MY2024 dashboard expected Q3 2025)
PCP QIP Internal and Provider View	Monthly eReports Clinical data and QIP Non-Clinical calculated data	Payout by measure for the PCP QIP program, with gaps to target, member drilldown, performance against targets and regional averages.	December-2024 final PCP QIP performance. The QIP Stoplight and Final Statement dashboards are also available on PQD.
Disparity Analysis	2024 PCP QIP Monthly Clinical Data	Breakout of QIP performance by measure at the plan-wide level, and stratified by ethnicity group. View top 10 providers with largest population size for selected ethnicity groups	December-2024 Geographic View dashboard to display measure performance across updated categories for race and ethnicity. Dashboard is available to the provider network through eReports.
Maximizing Visibility of Quality Data	2024 PCP QIP Year-end Score	Rank PCPs year-end QIP total score by county and display	December-2024 PCP QIP Final Data

Dashboard Name	Data Source	Brief Description	Major 2024-2025 Reporting Enhancements
		population size, increase or decrease over previous year score.	PCP-level stars ratings added to ranked performance chart.
QIP Stoplight Dashboard	2024 PCP QIP Monthly Data	Member gap-to-target analysis, color coded against benchmarks at the parent organization level.	December-2024 PCP QIP Final Data.
PCP QIP Final Statement	2024 PCP QIP Year-end Score	Payment, points and performance by measure for individual providers. Used for PCP QIP payment.	December-2024 PCP QIP Final Data. This dashboard was updated for Modified QIP providers for 2024.
Perinatal QIP Dashboard	Perinatal QIP supplemental measure data and custom claims and membership calculations	Perinatal QIP measure performance is updated quarterly for provider statements.	
Hospital QIP (HQIP) Final Statement	Supplemental HQIP Performance data	Calculates payment for the Hospital QIP year-end provider payment.	2023-2024 fiscal year-end performance
PQD User Activity	Monthly HEDIS® and QIP dashboard clicks, internal and external (PCP QIP)	Monitors internal and external provider user clicks in HEDIS® and QIP PQD dashboards.	N/A
Well Care Dashboard – Internal View	Custom table for well-care claims for members in measure age ranges	Reports by provider for well visit dates of service for assigned and special members. Internal staff access through PQD.	N/A
Preventive Care Reports – Provider View	Custom table for well care claims and CIS and IMA claims and California Immunization Registry (CAIR) data	Member-level contact information includes all well care, IMA and CIS DOS for assigned members. Priority flags for member outreach based on age.	Daily refresh starting in January of each measurement year.

Provider Network Quality Improvement Support and Initiatives

QI TRILOGY

Quality & Performance Improvement Initiatives and Projects

Overview

In 2024-2025, our Quality Improvement (QI) Team continued to focus on priority measures for Partnership HealthPlan of California, guided by performance indicators from the Department of Health Care Services (DHCS) Managed Care Accountability Set (MCAS) and the National Committee for Quality Assurance (NCQA) accreditation measures. DHCS encouraged prioritized improvement efforts related to Health Equity, as well as measures where significant financial incentives/penalties were introduced or enforced.

We made significant strides in understanding Health Equity (HE) accreditation readiness, laying the groundwork to address identified gaps in care, while aiming for 2025 Health Equity Accreditation. We developed a Health Equity playbook that we now share with providers so they can better identify and understand their own Health Equity related challenges. Additionally, we began developing a Dual Eligible Special Needs Plan (D-SNP) product line, its accompanying Model of Care (MOC), as well as its associated Quality Incentive Program (QIP).

Considerable efforts were dedicated to building relationships, understanding gaps, and producing data in Partnership's geographic expansion. QI and Regional cross-functional staff engaged with providers in the Auburn and Chico Operational Regions, assessing sites and orienting them to data tools and program specifications. This engagement prepared organizations and managed expectations as they receive their initial QIP results and payment summaries for MY2024, with additional HEDIS data to follow, pending finalization of MY2024 results.

California's health care system underwent significant transformations, particularly regarding Quality within Medi-Cal. The state implemented new standardized contracts for managed care plans, emphasizing enhanced quality, access, accountability, and health equity. These contracts introduced requirements such as improved integration of physical and mental health services, culturally competent care, and mandates for plans to reinvest a portion of their profits into community health initiatives. Partnership focused on quality measures and initiatives that moved us in the direction of meeting those goals, with some seeing significant improvement, in large part due to data quality enhancements. Other measures such as vaccination rates, continue to decline due to shifting public messaging on efficacy and importance.

Our QI Team continued efforts related to engagement of lower performing providers, with several graduating back to full participation in our PCP QIP measure sets.. We assessed, supported, and coached lower-performing sites, developing tailored interventions designed to address foundational issues. Some of these efforts included financial support to purchase equipment, increase access, and reduce disparities. Support was also extended to organizations seeking state-directed payment funding for equity and practice transformation initiatives. Our commitment to the Improvement Academy trainings, joint leadership meetings with major provider organizations, practice coaching, mandated work collaborations, and other ad hoc support increased to meet provider needs. The focus of this support was on closing care gaps through clinical and operational workflows, fostering a culture of quality within provider leadership, and building capacity for quality improvement within provider teams.

Internally, QI collaborated closely with key stakeholders, including Population Health, Pharmacy, Behavioral Health, Medical Directors, Health Equity and regional leadership on strategic efforts, such as direct member engagement. Particular emphasis was placed on ensuring proper support for the Local Engagement Teams (LETs) in better understanding local issues and sharing region-specific intelligence within each Operational Region.

Collaboration with Population Health led to alignment and improvement of the CHA/CHIP goals established by counties within the Partnership footprint.

Quality Measure Score Improvement (QMSI) workgroups were expanded and optimized to address evolving DHCS MCAS and NCQA Health Plan Accreditation (HPA) measure sets and anticipated Medicare STARs measures. The QMSI workgroups focused on measure domains specific to Pediatrics, Chronic Diseases, Elder Care, Medication Management, Behavioral Health, Women's Health, and Perinatal Care. These workgroups evaluated opportunities under priority measures included in the DHCS Quality Withholds and Incentive Program, as well as those subject to DHCS sanctions, such as Topical Fluoride for Children and well-child visit measures. Through collaboration with internal staff and external partners, such as Aliados, the Health Alliance of Northern California (HANC), and North Coast Clinics Network (NCCN) consortia, we piloted, scaled, and spread improvements across measures including breast cancer screening, childhood immunizations, adolescent immunizations, and well-child visits.

Partnership incentivized improved performance and the adoption of best practices through Quality Incentive Programs (QIPs), targeting Clinical and Non-Clinical measures aligned with NCQA Health Plan Accreditation (HPA) and DHCS Managed Care Accountability (MCAS) sets. Enhancements to data tools improved visibility and transparency into QIP performance gaps. Financially, Partnership paid out more incentives within the QIPs than any previous year.

These combined efforts have positioned Partnership HealthPlan of California and our provider network to deliver high levels of care and support to our members, amidst challenging national headwinds and potential budget cuts.

Quality Measure Score Improvement

The Quality Measure Score Improvement (QMSI) effort continues to better coordinate service and performance across the organization and to raise Partnership's overall performance in quality measures, as defined under DHCS MCAS and NCQA Health Plan Accreditation (HPA). This effort involved team formation under QMSI to encompass all current and potentially future accountable measures by measure family within each workgroup team: Pediatric, Chronic Diseases (including medication management), Behavioral Health, Women's Health and Perinatal Care. Each workgroup monitored and reviewed all measure performance where data was available, assessed current improvement efforts, identified gaps and initiated new performance improvement activities. In anticipation of the new Dual Special Needs Plans (D-SNP) launch , a new Elder Care QMSI workgroup was formed in early 2025 to proactively educate staff on quality measures in order to anticipate potential improvement efforts needed in the following year.

QMSI workgroups consisted of cross-functional teams led by Quality and included representation from across the organization, such as: Care Coordination, Claims, Health Education, Office of the CMO, Pharmacy, Population Health, Provider Relations, Health Equity, Quality and/or regional leadership. The following summaries include what each measure-family QMSI Workgroup Team achieved in 2024-2025.

Improvement Team Workgroups

Chronic Disease

Expand Exact Sciences Cologuard Bulk Order Program

In 2023 Partnership conducted a pilot project with Exact Sciences who produces the Cologuard Fit DNA colorectal cancer screening product. During the pilot Partnership observed notable improvements in colorectal cancer screening rates with participating providers. Partnership has turned this effort into an ongoing program and has worked closely with Exact Sciences to spread awareness and access to the bulk ordering program. Partnership has created a resources page on its public website to aggregate lessons learned and details on the bulk ordering process. Partnership's Quality team has biweekly check-ins with Exact Sciences to address questions from providers, review data, and facilitate upcoming orders. Exact Sciences has a minimum number of patients required for bulk orders since it is resource intensive for them to do outreach and messaging for patients with an order. Partnership has offered to help facilitate bulk orders for smaller practices who do not have large enough denominators to do bulk orders on their own, with orders going out every few months.

The Chronic Disease workgroup will continue to monitor colorectal cancer screening rates, and specifically modalities to track screening rates by screening type to look for opportunities where Cologuard bulk order may be appropriate based on availability of other screening methods.

Diabetic Retinopathy Camera Grant

In March 2025 Partnership launched a grant program that allowed a select group of providers to apply for a grant up to $10,000 to purchase a diabetes retinal camera. Partnership targeted rural primary care providers who are performing low with higher volumes of patients needing to be screened for diabetic retinopathy. The goal of the grant was not to eventually fund every practice with a retinal camera, but to instead serve as a proof of concept to show practices how to operationalize cameras to earn funds in the PCP QIP program where diabetic eye exams is a clinical measure.

Partnership offered the grant opportunity to 12 practices meeting the criteria above and had nine (9) practices respond with an interest to participate. One provider requested two (2) devices because they have two very rural locations, which Partnership was able to accommodate. To date only one provider has yet to submit their application for funding while the remaining eight (8) providers have executed contracts to purchase devices. Partnership hosted a kickoff webinar outlining the grant program, as well as including a provider practice who successfully implemented retinal cameras who spoke to best practices.

For the remainder of calendar year 2025 Partnership will monitor the participating provider practices to ensure they reach the required thresholds of the contract which is the 50th national Medicaid percentile. Partnership is offering monthly check-ins to ensure there are no unmet needs from the participating provider practices. Partnership will survey providers after the close of the measurement year to understand barriers and best practices to be shared more globally for practices so they can feel confident in purchasing their own cameras and using earned QIP dollars to make themselves whole.

VSP Telephonic Outreach Campaign (as it relates to Retinopathy)

Partnership members are provided with vision benefits through their regular medical coverage and with Vision Service Plan (VSP). The member's general vision coverage includes one eye examination with refraction every 24 months. A second eye examination with refraction will be covered if the member has a sign or symptom indicating medical necessity (Partnership Policy MCUP3102 Vision Care, 2023). Given the current trend in eye care and the

vision care benefits available to Partnership members, Partnership has partnered with VSP to share data on members who are identified as diabetic and are still in need of a retinal or dilated eye exam by an eye care professional (optometrists or ophthalmologist) in the measurement year. Partnership provides a list of members diagnosed with diabetes to VSP, so they may be flagged in VSP's system. A Partnership Quality Improvement (QI) Improvement Advisor collaborates with a Partnership QI Data Analyst to pull a member list that is shared and sent to VSP.

This triggers three primary actions:

1. Will enroll the member in their established 'reminder' program where the member receives an eye exam reminder in the mail AND
2. When a member presents at a VSP provider, the provider will know to ask about their condition and provide a dilated eye exam AND
3. Send the primary care provider the exam findings and follow-up recommendations via the VSP Primary Care Physician Communication Form

Gojji Pilot with Telemed2U

TeleMed2U, Partnership's vendor for adult specialty care, has proposed a diabetes management pilot, partnering with Gojji and Partnership. Gojji will fulfill orders for continuous glucose monitors and medications placed by TeleMed2U and use technology to make managing chronic conditions, such as diabetes, easier by monitoring patients' glucose levels, providing education and ensuring adherence. For the pilot, it has been proposed to begin with a group of 50 patients we have identified based on certain criteria. The initially suggested criteria were A1C> 10 for >6 months, chronic, comorbid conditions (HTN), frequent hospitalizations, existing home health/case management support and hypoglycemia.

We formed a subcommittee consisting of our Telehealth team, QMSI leads and our data analyst to research which provider would fit the criteria for this pilot. We looked at past performance of a particular group of providers and narrowed it down to two health centers that could potentially benefit the most from this pilot and extra level of care around HbA1c Good Control.

Currently, this pilot is on hold. TeleMed2U has encountered logistical issues working with the vendor and another provider they would like to work through prior to expanding the pilot and sharing across the health care continuum.

Academic Detailing Sessions Through Partnership Pharmacy Team

For measurement year 2025 Partnership added a Unit of Service (UOS) measure to the PCP QIP program. The purpose of this new unit of service measure is to incentivize provider organizations to host a two-part academic detailing meeting with PHC Pharmacy Team/Medical Director. Pharmacy academic detailing helps clinicians improve medication management, improve quality measure performance, and achieve better clinical outcomes for their patients. The UOS measure applies to practices with at least 1,000 assigned members and requires an initial training as well as a follow-up session to review any changes in prescribing practices following the initial training. Provider practices are offered up to $2,500 to help cover costs to get prescribers out of clinic for education.

Pharmacy academic detailing meetings focused on improving medication management through pharmacy claims analysis within the following disease states:

- CBP: Controlling High Blood Pressure
- HbA1c Good Control
- AMR: Asthma Medication Ratio

- Statin therapy in:
    - Cardiovascular disease
    - Diabetes
- Opioid Disorder Measure (only if providers are interested in opioids and MAT)

To date four (4) initial academic detailing sessions have been completed and have been well received, and follow-up sessions will be conducted after providers have ingested and operationalized the recommended practices. Several noteworthy best practices include identifying patients with chronic diseases with no medication fill history or who are on suboptimal therapies. The Chronic Disease workgroup will continue to monitor these measures for positive rate changes for the remainder of the 2025 measurement year to determine if future changes to the QIP UOS measure are warranted.

Asthma ED Visit Follow-Up

The objective for this program is to prevent them from returning to the emergency room because of their asthma by providing asthma related education to members who had an ED visit for asthma in the last two weeks. Population Health will send mailings to these members that contain basic information about asthma and instruct members to call PHC if they wish to speak to a pharmacist for further consultation on their asthma management. These efforts will improve overall health and quality of life and lower the cost of care by:

- Reducing asthma exacerbations
- Addressing medication gaps
- Improving self-management, the member's AMR / medication adherence, communication and coordination of care with PCP and adherence with asthma action plan
- Screening for tobacco use and offering referral to Kick-it California

Scope definition:

- Members that are between the ages of 5 and 64 who have been identified through Collective Medical with an asthma ED event report, with an ED discharge within the last two weeks. (Members will be deemed out of scope if they: do not have Partnership HealthPlan as primary insurance, only have Wellness & Recovery benefits, are on Hospice, are admitted to the hospital, or have a COPD or lung cancer diagnosis.)
- Members will receive a letter after their ED visit informing them that our pharmacists can assist them with managing their asthma as well as how they can obtain an asthma handbook.
- Members wanting to consult with a pharmacist will call Member Services and ask to speak to a pharmacist. From there, Member Services will connect them to the Pharmacy Department, and pharmacists will speak with the members. Pharmacists will obtain a history and answer any questions the member may have. Pharmacist reviews pharmacy fill history for 6 months (Medi-Cal Rx) noting rescue inhaler fill frequency verses controller frequency and calculate the Asthma Medication Ratio (AMR) over the last 6 months for each member. The pharmacist will review items taken from GINA and NIH content points for asthma education provided to patients that have been shown to improve patient outcomes. The talking points could include asthma disease state information, roles of medication, correct use of inhalers, medication adherence, medication side effects, preventing flare-ups / avoiding triggers and having / using an Asthma Action Plan. As part of this program members may be referred to services such as: CHW, CCM, ECM, or other services.
- Members with repeated emergency room visits will be referred to Care Coordination.

Criteria for referring members for case management and providing additional information on asthma:

- Members with 2+ visits within 30 days of each other, regardless of case management history
- Members with 2+ visits in any time frame who have never been case managed or have not been case managed for 6 or more months.

The Care Coordination team is instructed to work the cases with the following goal and interventions:

- Goal: Verbalizes understanding of asthma disease process and management options
- Any relevant Intervention/s
- Assess/address barriers affecting medications/vitamins
- Assist member to access needed medications
- Communicate with provider any concerns/issues related to medication adherence
- Follow up on member's adherence to medication regimen
- Teach/reinforce the actions/importance of prescribed medications

In summary and to-date for 2025 (from January to May), a total of thirty referrals were received by Care Coordination. Partnership attempted to contact all thirty members and eight members agreed to case management. Upon speaking to those members, our population health and pharmacy team set up a total of twenty-three interventions to keep track of their Asthma Diagnosis.

Best Practices for at-home Blood Pressure Monitoring and Member Engagement

The Partnership Medical Equipment Distribution Services (PMEDS) program distributes medical devices to eligible members based on diagnosis of related conditions. This program has been distributing blood pressure monitors to members with diagnoses of hypertension and other related conditions since 2020. Research from the Million Hearts Self-Monitored Blood Pressure Program (SMPBP) indicates blood pressure monitors can be effective in reducing blood pressure rates when used alongside patient education, timely monitoring, medication control, and related nutrition, smoking or lifestyle interventions. We analyzed data from CY2024 comparing end of year Controlling Blood Pressure (CBP) measure compliance (values less than 140/90) for members with and without blood pressure monitors. Evaluation of this data presented barriers in documentation, availability of usable data from multiple sources, manual adjustments to data, and data volume. Upon analyzing data from PQD (Partnership Quality Dashboard) and a more comprehensive data set from electronic data warehouse (EDW), a significantly higher number of members without blood pressure monitors had numerator compliance for the CBP measure compared to a sample population of members who have blood pressure (BP) monitors. The work group has collaborated with a PCP who has experienced success in this measure by utilizing the PMEDS program. When reviewing the data, anecdotal feedback indicates that providers will often prescribe their high complexity patients a home BP monitor compared to those who are managing their hypertension through traditional means. Further evaluation is required to look at member comorbidities and visit histories to confirm this hypothesis. Their workflows and interdisciplinary care approach have been documented and will be ongoing throughout 2025. The work group will consider piloting a similar interdisciplinary approach with interested PCP Quality Incentive Program (QIP) organizations to increase measure success annually. This may increase measure success by implementing workflow best practices alongside the PMEDS program.

The workgroup will continue to meet with this provider on best practices as they will continue to audit quarterly to see the success of the PMEDS program, as well as what they are implementing around new and improved workflows when the patient is coming in for a visit and has hypertension. New processes and best practices consist of re-

checking blood pressure if they are presenting with a value of 140/90, requesting a follow up appointment as soon as one month after being seen if medication is increased at the given appointment and making sure at every appointment contact information is being updated to prevent missed opportunities.

Behavioral Health

DHCS Mandated Non-Clinical PIP: Improving Provider Notifications and Follow-Up for Members with Serious Mental Health Diagnoses (QI)

The Department of Health Care Services (DHCS) has mandated a non-clinical Performance Improvement Project (PIP) focused on enhancing the timeliness and consistency of provider notifications for members with Serious Mental Health (SMH) diagnoses following emergency department (ED) visits. The primary goal of this initiative is to improve the percentage of notifications sent to providers within seven days of an ED visit, thereby increasing the likelihood of timely follow-up care for affected members.

Timely and accurate provider notifications are essential to bridge the gap between emergency care and outpatient follow-up. By promoting greater visibility and utilization of existing alert systems, providers can be better equipped to respond within the crucial seven-day window. Ensuring that providers opt to receive these ED alerts on an instant or daily basis, rather than at less frequent intervals, is critical to achieving this objective.

In 2024, the QI team at Partnership identified an additional tool with the potential to significantly improve provider notification processes: PointClickCare. Partnership subscribes to this platform, which serves as a centralized hub for real-time Admission, Discharge, and Transfer (ADT) messages from EDs and hospitals across California. These ADT messages provide rich, actionable data, including dates and times of ED events, member demographics, assigned Primary Care Providers (PCPs), and associated diagnoses—specifically highlighting members with SMH conditions.

Leveraging the "ED Visits – Mental Health Diagnosis" report within PointClickCare, providers gain enhanced visibility into ED utilization patterns among their assigned members. This enables earlier outreach and intervention, positively impacting follow-up not only within the targeted 7-day window but also within 30 days, when clinically appropriate.

To operationalize this data, Partnership has proposed a targeted intervention in the Northwest region, routing daily PointClickCare reports to a large provider organization. These reports flag assigned members with recent ED visits for SMH diagnoses. In response, the provider organization is developing integrated clinical and operational workflows across its sites to proactively conduct outreach, schedule appointments, and ensure follow-up care is completed within 30 days of the ED event.

A key component of this strategy involves PCP notification workflows based on ADT message access. This proactive approach allows care teams to connect with members who may not typically seek follow-up due to cultural stigma, lack of awareness, or historical mistrust of healthcare systems. Importantly, the ADT messages often include the specific mental health diagnosis from the ED encounter—information that PCPs may not have previously received. Without these details, providers risk addressing only the medical concerns from the ED visit, overlooking critical mental health needs unless the patient self-reports them. This enhanced data empowers care teams to deliver more comprehensive and informed follow-up, increasing the likelihood of effective patient engagement.

This strategy was initially piloted through a collaboration between the Quality Improvement department at Partnership and Open Door in Humboldt and Del Norte counties. A follow-up tracking tool was developed and implemented, supported by weekly data exchanges to promote timely provider engagement and care coordination. Due to the success of the pilot, the collaboration with Open Door has been formally extended for another year. Additionally, based on the promising results, Partnership is now working to expand this approach to additional provider organizations across the region. Ongoing support will include bi-monthly coordination meetings and weekly data sharing to ensure effective implementation and continuous quality improvement.

Key Outcomes and Learnings:

- Regular data exchange to promote shared learning, pattern recognition, and continuous quality improvement.
- Real-time data analysis to support agile adjustments and maintain program responsiveness.
- Focused efforts on increasing the rate of timely notifications and achieving compliance with follow-up targets.

By building upon these learnings and expanding access to real-time data through PointClickCare, this initiative aims to close the loop on care for members with serious mental health needs—ensuring they receive the support and continuity of care necessary for improved health outcomes.

DHCS/IHI Behavioral Health Collaborative: Partnership HealthPlan of California and Nevada County (BH)

Beginning June 3, 2024, the Behavioral Health and Quality Improvement departments at Partnership HealthPlan of California (PHC) embarked on a 15-month collaborative initiative facilitated by the Department of Health Care Services (DHCS) and the Institute for Healthcare Improvement (IHI). This partnership, in coordination with the Nevada County Department of Behavioral Health, aims to improve Follow-Up After Emergency Department Visit for Mental Illness (FUM) and Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) measures.
Key Outcomes and Learnings:

- The collaboration has significantly strengthened the working relationship between PHC and Nevada County, laying the foundation for ongoing partnership and communication.
- Despite ongoing data misalignment between the County and PHC, the collaborative has initiated efforts to identify data gaps, establish a shared baseline, and apply data-driven strategies to guide targeted quality improvement interventions.
- Piloted standardized screening procedures for bedside.

Sac Valley MedShare Data Exchange: Partnership HealthPlan of California and SacValley MedShare (SVMS) (BH)

To improve data sharing capabilities between Behavioral Health Plans (BHPs) and Partnership HealthPlan of California (PHC), the partnership with SacValley MedShare (SVMS) was expanded to include county participation. Over the course of a 12-month collaboration, 22 out of 24 counties signed participation agreements with SVMS, which allowed various levels of data use and sharing to be integrated into county operations.
Key Outcomes and Learnings:

- The collaboration facilitated the provision of medical data, including real-time admissions, discharges, and transfers, from participating hospitals.
- Some counties implemented opt-in procedures for data sharing, which have limited the number of beneficiaries included in the data.
- Substance use disorder data has not yet been included in the exchange due to varying levels of regulatory uncertainty across counties.

Community Health Worker (CHW) & Emergency Department: Partnership HealthPlan of California (BH)

To bridge the gap between existing Substance Use Navigation (SUN) grants and the implementation of community health workers (CHWs), Partnership HealthPlan of California (PHC) offered a grant of up to $100,000 to promote the use of CHWs in emergency departments. A total of 24 hospitals expressed interest, and 17 followed through during the grant year.
Key Outcomes and Learnings:

- Most emergency department EHRs (Electronic Health Records) were not capturing non-clinical interactions, which made it difficult to promote CHW work as a billable service.
- Staffing challenges arose at some hospitals, including engaging HR to create new job descriptions, adding positions late in budget cycles, and dealing with workforce shortages in certain areas.
- Many hospitals felt that longer grant periods would be necessary to fully capture the impact of the new CHW role

Community Health Assessment- Community Health Improvement Plan (CHA-CHIP) (Pop Health)

As part of the CHA-CHIP initiative, a key project launched in December 2024 in Trinity County aims to improve follow-up care for individuals presenting to Emergency Departments (EDs) with substance use disorder (SUD) diagnoses. The focus is on streamlining and strengthening referral pathways from EDs to County Behavioral Health services to ensure timely, coordinated, and effective connections to care for patients with SUD.

This project involves developing a comprehensive referral system that facilitates direct, consistent communication between EDs and County Behavioral Health. In parallel, it expands outreach and education efforts to increase community awareness of available behavioral health services, substance use programs, and the Partnership transportation benefit that supports access to care. Together, these strategies aim to reduce barriers, promote patient engagement, and improve health outcomes for individuals on the path to recovery.

Although the project is currently on pause due to ongoing restructuring within the County, the work in Trinity County remains an important part of the broader CHA-CHIP initiative. It reflects a continued commitment to improving behavioral health systems, with additional initiatives actively being developed in other jurisdictions to promote system-wide improvements and ensure equitable access to care.

<u>Pediatric Preventive Care</u>

Continue State-Mandated Performance Improvement Project (PIP) Focused on Early Well-Care in Black/African American Members in Solano County

The California Department of Healthcare Services (DHCS) assigned Partnership a Health Equity PIP focused on the Well Child Visit Birth-15 Months (W30-6) HEDIS® Measure for the 2023-2026 time period, based on not

meeting the Minimum Performance Level (MPL) of 50th percentile for the W30-6 measure in any Reporting Unit. Partnership and DHCS agreed to focus the PIP on African American rates of completion of the W30-6 measure. Partnership selected Solano County as the population of focus for this measure based on several factors. Solano County has the highest member population of any of Partnership's counties with a total of 141,387 members as of July 2023. Solano County's Black/African American population represents 17.5% of total members (24,757), the highest Black/African American population of any county served by Partnership. The HEDIS® denominator population represented in Solano County's 0-15 months' age for Black/African American members was 168 in 2022.

This PIP's initial intervention addressed delays in Medi-Cal enrollment, which have a significant impact on all families, including African American families, continuity of care with their chosen PCP and on Partnership's ability to capture all well-child visits in babies' first 15 months of life. Since the W30-6 HEDIS® measure is an administrative measure by NCQA's definition, Current Procedural Terminology (CPT) codes on claims are the only way for Partnership to count a well-child visit as completed. One barrier to success with the W30-6 HEDIS® measure is that most newborns are not enrolled in Medi-Cal until their second month of life and often later. Often times, Managed Care Plans (MCPs) have a difficult time linking a baby's Medi-Cal ID with data about their early care captured under Mom's Medi-Cal ID. This can also result in babies being auto assigned to a PCP that they have not been seeing up to that point, causing disruptions in care. The delays in Medi-Cal enrollment do not only cause undercounts for well child visits within the W30-6 HEDIS® measure but also have a disruptive impact on babies' healthcare throughout our provider network, and erode the relationship between the family, clinical team, and health plan.

During this fiscal year, Partnership formed the W15 Taskforce, a cross-departmental team charged with planning, implementing, and evaluating new initiatives aimed at increasing W15 rates among African American newborns in Solano County. On August 17th, 2024, the taskforce launched a six-week phone outreach pilot project in collaboration with NorthBay Health. NorthBay Health was identified as a key partner due to its unique position as the only labor and delivery hospital in Solano County currently serving Medi-Cal members.

Pilot Design:
The Phone Outreach Pilot Project focused on supporting birthing parents at NorthBay Health with newborn Medi-Cal enrollment, selection of their newborn's primary care provider (PCP), and coordination of early pediatric follow-up.

Upon discharge, NorthBay staff informed Partnership members that they would receive a call from PHC. Patients were told what the call would be about, the number the call would be coming from, and were given the Growing Together Program flyer. NorthBay then emailed Partnership a daily list of members that had been discharged from their Labor and Delivery unit. Partnership staff would then reach out to these members within 72 hours of discharge.

During these calls, Partnership staff covered five key areas:

1. Medi-Cal Enrollment - Inquired if the member completed a Medi-Cal Enrollment Form. If they had not, a form was sent to them.
2. Newborn PCP Selection - Completed a PCP selection form for the newborn. Forms are kept on file while we wait for the baby to be enrolled. The form collects mother's CIN to help us capture well baby visits occurring within the first 2 months of life.
3. Well Baby Visit Scheduling - Assisted moms with scheduling their next well baby visit.

4. Resources - Connected mother to resources as needed (e.g.: transportation to well-baby visit or postpartum visits)
5. Growing Together Program - Encouraged them to enroll in the Growing Together Program.

Pilot Results

- Total number of unique participants:126
    - 81% reach rate
    - 51.6% engagement rate (65 participants)
    - 48 newborn PCP selection forms
    - 55 families enrolled in the Growing Together Program.
- Number of African American Participants: 13
    - 76.92% reach rate
    - 38.46% engagement rate (5 participants)

Key Takeaways

- The warm handoffs by NorthBay staff at discharge played a critical role in establishing trust and improving participation rates.
- The PCP selection process not only supported immediate care coordination but also enhanced PHC's ability to track well-baby visits by linking maternal and newborn records—a common barrier to early pediatric care monitoring.
- Compared to a similar phone outreach campaign running concurrently (which achieved a 25.3% reach rate and a 14.9% engagement rate), the NorthBay pilot's results represent a significant improvement in both reach and engagement.

This pilot demonstrated that targeted, collaborative outreach in a centralized delivery setting—coupled with warm handoffs and structured follow-up—can meaningfully improve newborn enrollment, care coordination, and health program engagement among Medi-Cal families in Solano County. The insights from this pilot will directly inform scalable strategies for broader regional implementation. The taskforce continues to explore new solutions to help overcome barriers in completing timely well-child visits and measuring well-child visits completion.

Increase HPV Vaccine Completion Rates Through 2nd Dose Reminder Mailers

Human papillomavirus (HPV) vaccination is a critical public health measure that protects against several types of cancer, including cervical, oropharyngeal, and other genital cancers. Completing the HPV vaccine series is essential to ensuring long-term immunity and maximum effectiveness. However, national and regional data continue to show gaps in series completion rates.

To address this, the HPV 2nd Dose Reminder Pilot was developed to test a targeted strategy aimed at increasing completion of the HPV vaccination series. Reminder and recall strategies are widely recognized as best practices for improving adherence to vaccination schedules. Research demonstrates that these strategies, especially when automated, can increase HPV vaccination series completion by up to 15%. The Centers for Disease Control and Prevention (CDC), the American Cancer Society, and the National HPV Vaccination Roundtable all recommend integrating parent reminders into overall HPV vaccination plans, especially in managed care settings.

The HPV 2nd Dose Pilot Project identified children under age 13 who are due for their second dose of the HPV

vaccine and mailed a reminder notice to their homes to encourage timely completion. This three-month initiative aims to assess whether mailed reminders can improve HPV vaccine series completion rates.
The evaluation of this pilot project is scheduled for completion just before the close of FY24/25. We hope that the findings from this initiative will help inform broader efforts to close gaps in HPV vaccination and improve health outcomes across pediatric and adolescent populations.

Promote Pediatric Group Well-Care Visits Through Expanded Provider Incentive

Group Well-Care Visits is one (1) proven strategy to increase completion of these important pediatric preventative care services early in a child's life. Last year a new unit of service measure was approved and added to Partnership's PCP QIP to incentivize providers to conduct group well-visit cohorts in the 2024 calendar year, focusing on the 0-15-month old population.

To further support comprehensive well-child care, the UOS measure has been expanded from the 0–15-month period to 0–30 months of life. This extension allows us to capture the two additional well-care visits recommended between 15–30 months, helping ensure children receive all recommended pediatric preventative services through their second birthday. This incentive was approved and is currently part of the 2025 PCP QIP unit-of-service measure, as an expansion of the existing "Peer-Lead Group Visits" measure.

Pediatric and Family practices will continue to be incentivized $1,000 for each cohort of group well-care visits. Each group cohort must meet at least four (4) times across the 30-month timeframe and have at least 16 members in total attendance. The maximum number of cohorts (groups) per year for reimbursement remains at 15.

Develop a Plan-Wide Strategy for Well-Child Visits in the First 15 Months of Life (W15)

From the introduction of the Managed Care Plan (MCP) accountable measure for early baby well-care visits within the first 15 months of life (W15), Partnership has consistently under performed on this measure by approximately twenty percentage points from the Minimum Performance Level (MPL). Over the last several years, Partnership has undertaken many performance improvement efforts focused on completion of early well-baby visits.

While there have been many unique approaches for improving W15, Partnership recognized that the significant efforts were lacking a strategic vision for addressing the complexities that exist in W15 and decided to form a W15 Plan-Wide Strategy Committee. The purpose of this committee was to develop a concerted approach to understanding the current state and strategically planning for future improvement efforts.

The committee launched in October 2024 with a cross-functional stakeholder group including leadership from Population Health, Health Equity, Office of the CMO, Regional Operations Leadership, Quality Incentive Programs, Member Safety, Performance Improvement and Quality Measurement. The purpose of the committee was to develop and implement a guiding strategy for improving performance of well-baby visit across Partnership's service area:

- Link all improvement efforts and provide a more strategic and streamlined approach
- Ensure thoughtful investment of time and resources
- Raise awareness and increase engagement across all stakeholders, both internal and external

The committee developed the following framework for W15 improvement work across the organization:

- Strategy Objective (Multi-Year): Achieve significant annual plan-wide performance increases in W15, initially meeting minimum performance thresholds ,eading to achieving high performance.
- AIM for Calendar Year 2025: Increase Partnership Members' completion rate of 6 well-care visits for babies 0-15 months of age from baseline to goal by December 2025 in established 14-county service region and establish baseline performance in Partnership's new 10-county region in the East:

Geo 14 County	Baseline	Goal
Plan	**42.09**	**50.24**
NE	40.68	48.82
NW	45.26	51.82
SE	36.83	47.61
SW	46.28	52.33

- Pillars for Improvement:
  - Conduct Process and Operational Improvements (within Partnership's control)
  - Improve Encounter Data Capture of Early Well-Child Visits
  - Enhance Provider and Member Engagement and Education Around Early Well-Care Visits
  - Educate and Engage Partnership Staff, Leading to Meaningful Improvement, Plan-Wide
- Driver Diagram for Analysis of W15:
  - Brainstormed challenges and drivers for low performance
  - Centrally documented existing improvement efforts
  - Identified potential new improvement efforts

With a centralized, focused committee focusing on understanding the challenges and current efforts, a path has been established to better identify potential opportunities for improvement and determine the best path forward for success on this important preventative care activity for our most vulnerable population of babies!

Expand Promotion of Healthy Babies Growing Together Program to Provider Network to Increase W15 and CIS10 Rates

Member incentives are widely known as a best practice for improving patient appointment completion rates. Population Health's rebranding of the Growing Together Program (GTP) led to member incentives directly aligning with the CIS-10 and W30+6 MCAS Accountable measures. Improvement advisors, through their engagement with sites, recommended promotion of this program beyond the member population to the provider network.

In close partnership and collaboration with the Population Health team, improvement advisors began promoting the GTP through various modalities including provider coaching, Regional Quality meetings, Joint Leadership Initiative meetings, Improvement Academy Trainings, and leveraging the Provider Relations representatives to promote through site communication.

The impact on CIS-10 and W30+6 rates is pending as this activity will continue into the FY25/26 when the 2025 Measure Year has completed. Population Health is tracking member enrollment to include the referral source of enrollment which will be used during the activity evaluation.

Increase WCV Rates Among Special Populations through WCV Sprint Project

In late August 2024 DHCS notified plans of an opportunity to mitigate losses in Quality withhold dollars by closing disparities in the Child and Adolescent Well-Care Visits (WCV) measure for the top two disparate groups in each of the four legacy reporting regions. The disparities were based on MY2022 HEDIS data which included the White, African American or Black, American Indian/Alaskan Native, Asian, and Native Hawaiian/Other Pacific Islander populations. Plans had until the end of the 2024 measurement year to close these gaps to qualify for points toward the withhold.

Partnership's QI team developed multiple iterations of proposals based on the disparate populations while analyzing the data and seeking input from key provider partners. In October 2024 Partnership's executive team approved the final proposal which offered a $200 incentive for each member of the population who received a well visit and was billed correctly. The incentive was to be used in whatever means the provider saw fit if it contributed toward getting visits completed. Given the tight time and resource constraints, Partnership elected to include a cohort of nine (9) providers who collectively held roughly 42 percent of the target populations. Five (5) of the nine (9) providers agreed to participate in the project with the other four (4) declining for various reasons. Partnership also opted to not include the white population given the large volume of members and instead focused on the smaller populations.

Partnership created custom gap lists because providers could not leverage their existing QIP lists for several reasons: the WCV measure includes ages 3-21 while the QIP only includes 3-17, HEDIS rates include direct members while QIP only includes members assigned to the provider, etc. QI's analysts generated these gap lists which were shared with providers, and updates were distributed showing what claims Partnership had received so that providers could compare their encounter data with the administrative claims.

Upon completion of the project, only 48 of the 380 members in the five (5) participating provider cohort completed well visits before the end of the measurement year for a total incentive payout of $9,600. This is 2% of the 2,459-member cohort for the four reporting regions. Upon closure of the project Partnership surveyed providers to gather feedback on the project. Demographic data was a consistent issue for the providers. The state demographic data for members was less accurate than what providers had in their systems. The timeline was too short for practices to thoroughly plan and subsequently outreach members and complete visits. The end of year holidays also had an impact on both members and staffing. All participants showed commitment to closing disparities for their members and expressed interest in future incentive opportunities, but with the requirement that issues were resolved.

Seeing the desire for incentives to address disparities, Partnership has elected to continue the use of incentives by leveraging the QIP program that providers are accustomed to. Partnership has included a Reducing Healthcare Disparity optional measure in the 2025 PCP QIP. Providers are invited by the QIP team and must reply with their intent to participate in the measure. Those that apply will have a specific population of focus chosen by both the QIP team and Health Equity Officer. Providers will have until the end of the 2025 measurement year to close disparities for those populations to be eligible for up to a 7% enhancement of their total QIP earnings.

Improve Data Capture of Topical Fluoride Application by Conducting a Data Investigation

In the measurement year 2023 Partnership observed a shockingly low rate for fluoride application for the TFL measure, less than 1% across all reporting regions. Partnership solicited providers and dental practices who all said that fluoride was consistently being applied when patients were seeking dental care. Open Door Community Health Centers provided a claims report showing claims were in fact being sent to Denti-Cal for Partnership members with

the fluoride varnish procedure code. When reviewing Partnership's DHCS dental claims data the majority of these claims were visible but there was no record of fluoride application. This was reviewed with DHCS and its data team and it was discovered that DHCS cannot receive the procedure codes for FQHCs, RHCs, and IHS providers. The solution offered was to use a Z29.3 diagnosis code which the state can ingest and share with plans

This prompted Partnership to launch a multi-pronged messaging campaign to providers. Partnership outreached the providers through various channels such as provider operations meetings, regional quality meetings, regional medical director forums, emails, coaching calls, and fax blasts. Following the messaging campaign, QI coaches followed up with practices during coaching calls to see if the codes had been implemented. Some providers had implemented the codes and had no issues while others had reported challenges. Coaches have worked with these practices to try and find solutions and have also leveraged Partnership's new Dental Liaison to assist. As of May, Partnership has started receiving claims with the Z29.3 code from providers who were quick to implement the code into their processes. Partnership will continue to monitor claims and work with practices who have not implemented the code.

Facilitate Educational Webinar for Providers Regarding Developmental Screening in Children

On April 3rd, Partnership HealthPlan hosted a well-attended and informative webinar on **Developmental Screening in** Children, drawing 55 participants from a variety of roles including clinicians, practice managers, and quality improvement (QI) teams. The session provided essential education on the importance of developmental screening in early childhood and practical guidance for implementation in clinical settings.

Developmental screening is a critical component of pediatric care, enabling early identification of developmental delays and allowing for timely intervention. By using standardized tools, providers can better support a child's long-term health and developmental outcomes. Early detection and intervention are key to promoting optimal growth and reducing the impact of potential developmental challenges.
The webinar focused on two main areas:

- Overview of Developmental Screening Tools: Presenters reviewed screening tools that align with guidelines established by the American Academy of Pediatrics (AAP) and the Centers for Medicare and Medicaid Services (CMS), ensuring providers can confidently select appropriate and validated instruments.
- Billing Guidelines: Attendees also received a practical review of billing codes and processes to support accurate and efficient claim submissions for developmental screening services.

Despite the importance of developmental screening, the plan-wide screening rate decreased from 30.03% in 2023 to 29.36% in 2024, highlighting the continued need for provider engagement and support in improving screening rates.

Participant feedback was overwhelmingly positive:

- 100% of respondents strongly agreed the topics were relevant and useful.
- 100% strongly agreed the content was clearly communicated by the presenters.
- 90% rated the educational session as excellent; 10% rated it as good.
- 100% strongly agreed they could now identify at least one AAP-approved developmental screening tool.
- 90% strongly agreed—and 10% agreed—that they could identify appropriate billing codes for developmental screenings.

This session reinforced the value of developmental screening and provided actionable knowledge to improve screening practices across pediatric and family care settings.

Women's Health and Perinatal Care

The Women's Health and Perinatal Quality Measure Score Improvement workgroup began the year analyzing the MY2023 HEDIS® performance for the 8 measures that are assigned to the group: Breast Cancer Screening, Cervical Cancer Screening, Chlamydia Screening, Timeliness of Prenatal Care, Postpartum Care, Prenatal Depression Screening, Postpartum Depression Screening, and Prenatal Immunization Status. The group looked at the change from the previous year and compared the performance in each sub region to the benchmarks set by NCQA. This analysis led the group to prioritize work on the following measures: Breast Cancer Screening, Cervical Cancer Screening, Chlamydia Screening, Timeliness of Prenatal Care, Postpartum Care, and Prenatal Immunization Status.

Breast Cancer Screening

In MY2024 The NCQA's Quality Compass Medicaid 50th percentile rate (52.6%) for Breast Cancer Screening was met in Partnership's Southeast and Southwest region. Partnership's Northeast and Northwest region did not meet the NCQA's Quality Compass Medicaid 50th percentile rate. Activities to improve this measure in the past year included Mobile Mammography events and sponsorships, a new measure in the Hospital Quality Incentive Program, and a new monitoring measure in the Primary Care Provider Quality Incentive Program.

Partnership's Mobile Mammography program continued as a strategy to increase Breast Cancer Screening performance. Partnership collaborates with Alinea Medical Imaging and providers to host Mobile Mammography events, helping members complete preventive screenings at their primary care provider sites. Partnership supports the event days with event coordination support on behalf of the Mobile Mammography Program Management Team, event attendance by our Population Health Team, and support from the Performance Improvement team. The goals for this year included: scheduling 60 event days and completing 1500 screenings, focusing engagement efforts on Tribal Health Centers and providers in the Modified primary care provider quality incentive program, and piloting innovative strategies to engage Tribal Health Center patients. In MY24/25 the program completed 77 mobile mammography event days resulting in 2,162 completed screenings. Mobile Mammography events were held at seven Tribal Health Centers, and Partnership led talking circles on screening importance at three Tribal Health Center's Mobile Mammography events.

The Hospital Quality Incentive Program (HQIP) added the 'Increasing Screening Mammogram Capacity' measure to the clinical quality domain for MY24/25. Hospitals were incentivized to increase breast cancer screening access/capacity for Partnership members by at least 5% for partial points and 10% for full points. Data to evaluate the effectiveness of this measure is not yet available and will be analyzed once finalized.

Breast Cancer Screening remains an incentivized quality measure in the Primary Care Provider Quality Incentive Program (PCP QIP) under the clinical domain for ages 50-74 years in MY2024 and MY2025. In MY2025 PCP QIP has added Breast Cancer Screening with an age group of 40-51 years as a monitoring measure. The Monitoring measurement set does not have any points assigned and is intended to provide visibility into performance and access to the member gap-in-care list throughout the measurement year.

Cervical Cancer Screening

In MY2024 The NCQA's Quality Compass Medicaid 50th percentile rate (57.11%) for Cervical Cancer Screening (CCS) was met in Partnership's Southeast, Southwest, and Northwest regions. Partnership's Northeast and region did not meet the NCQA's Quality Compass Medicaid 50th percentile rate. Activities to improve this measure in the past year included conducting an hrHPV Self Swab Pilot, integration of the FDA approved hrHPV self-swab for cervical cancer screening, and continued measure inclusion in the PCP QIP.

A Cervical Cancer self-swab pilot launched in January 2024 with five strategically selected primary care clinics in all four sub-regions of different sizes. The pilot's scale was 200 kits across the five sites. The objective of the pilot is to develop lessons learned and workflows for allowing patients to collect their own cervical cancer screening swabs in conjunction with clinic staff. The criteria for patient inclusion: a current Partnership member, at least 30 years old, and have declined a clinician collected CCS in the past. The self-swab test environments included a normal office visit (55%), mobile mammography event (3%), and field/street medicine (42%). The pilot was called to a close September 2024.

The most common barrier to using the test kits reported by the clinics is the process to register the self-swab kit for testing using a vendor. While some patients are still reluctant to be screened, the pilot showed patients and providers are ready for this option. Learnings from the pilot continue to be shared in provider education.

In May 2024, the U.S. Food and Drug Administration approved two HPV self-collect vaginal tests for cervical cancer screening. In March 2025 Quest and LabCorp launched the Roche Molecular Systems, Inc Cobas HPV test for self-collection with a new CPTII code 87626. Instructions on how to complete the self-swab were developed. In the March 2025 release of HEDIS MY 2025 Value Set Directory CPT code 87626 was included in the High-Risk HPV Lab Test Value Set. In May 2025, the CPT code was added to the CCS code set in eReports. We worked closely with Quest and LabCorp to facilitate integration of the self-swab in our network. An HPV Self-Swab Webinar was held April 1, 2025, with 100+ attendees and the webinar is available on Partnership's website. Information on the self-swab has been shared across the network at Medical Directors Forums, Regional Meetings, Newsletters, 1-on-1 provider education sessions, and during community partner engagements with Aliados Health in Napa, Sonoma, Yolo, and Solano counties, and at Napa's sexual and reproductive health coalition.

Cervical Cancer Screening remains an incentivized quality measure in the Primary Care Provider Quality Incentive Program under the clinical domain for ages 21-64 years in MY2024 and MY2025.

Chlamydia Screening

In MY2024 The NCQA's Quality Compass Medicaid 50th percentile rate (56.04%) for Chlamydia Screening was met in Partnership's Southeast and Southwest regions. Partnership's Northeast and Northwest region did not meet the NCQA's Quality Compass Medicaid 50th percentile rate. Activities to improve this measure in the past year included data analysis, measure inclusion in the Primary Care Provider Quality Incentive Program, CHL Provider education, and development of Measure Best Practices.

In MY2025 Primary Care Provider Quality Incentive Program added Chlamydia Screening (CHL) as an incentivized quality measure under the pediatric practice clinical domain for ages 16-20 years. In MY2025 PCP QIP also added Chlamydia Screening as a monitoring measure for family medicine (ages 16-24 years) and internal

medicine (ages 21-24 years). The Monitoring measurement set does not have any points assigned and is intended to provide visibility into performance and access to the member gap-in-care list throughout the measurement year.

CHL Provider Education An analysis of MY2023 HEDIS region rates and county rates was completed to identify parent organizations and practice sites with CHL rates below the 50th MPL. Practices were selected based on this criteria and PCP QIP participation with over 100 members in the MY2025 PCP QIP denominator. High CDPH reported county CHL incidence rates among females was also factored in. 8 practices were identified for targeted provider training. Outreach to sites begun April 2025. Goal is to provide training to 3 practices and engage 1 in a pilot project. Training sessions have been completed with Ampla Health, and Shasta Community Health is in the planning stages for a CHL pilot.

Prenatal and Postpartum Care:
(Timeliness of Prenatal Care, Postpartum Care, Prenatal Immunization Status)

In MY2024 The NCQA's Quality Compass Medicaid 90th percentile rate (91.07%) for Timeliness of Prenatal Care was met in Partnership's Southwest region. NCQA's Quality Compass Medicaid 50th percentile rate (84.23%) was met in Partnership's Northeast and Southeast regions. Partnership's Northwest region did not meet the NCQA's Quality Compass Medicaid 50th percentile rate. In MY2024 The NCQA's Quality Compass Medicaid 90th percentile rate (84.59%) for Postpartum Care was met in Partnership's Southeast and Southwest region. NCQA's Quality Compass Medicaid 50th percentile rate (78.1%) was met in Partnership's Northeast and Northwest regions. Activities to improve perinatal measures in the past year included Tribal Perinatal Program, Provider Education and Engagement, Perinatal Growing Together Program, Perinatal Provider Quality Incentive Program, Population Health activities, Community Health Assessments/Community Health Improvement Plans, dashboard enhancements from Health Analytics, and the Solano Perinatal Clinical Collaborative.

Partnership's pay-for-performance Perinatal Quality Improvement Program (PQIP) summary of measures for MY24/25 includes: (1) Prenatal Immunization status (TDaP and Influenza Vaccinations), (2) Timely Prenatal Care, (3) Timely Postpartum Care, (4) Prenatal Care-Depression Screening at First Prenatal Visit and (5) Electronic Clinical Data System (ECDS) use. The financial incentives: $100 for Timely Prenatal Care, $50.00 for receiving TDaP and Influenza vaccines, $25 for Depression Screening, and $25 for the 1st postpartum visit and $50 for the 2nd visit. In MY24/25 PQIP had 32 parent organizations encompassing 70 clinics, across 18 of 24 Partnership counties actively participate in the program. PQIP reached more members with perinatal services this year than any other year due to adding seven new providers through our Eastern County Expansion. Evaluating provider performance year-over-year shows and increase in average incentive dollars earned per site.

Tribal Perinatal Program (TPP) aims to improve perinatal health outcomes among California Indian community through a comprehensive approach encompassing training, curriculum development, evaluation, and continuous improvement initiatives. The project scope: Training program development, Curriculum customization, Evaluation framework establishment, Healthcare system education and sensitization education and activities, Pre-conception care optimization, Perinatal support enhancement, Prenatal medical care access improvement. TPP started in April 2024 and has 6 Tribal Health Centers enrolled across 3 cohorts. Core curriculum trainings include: Family Spirit Program, Mental Health First Aid, Motivational Interviewing, and Trauma Informed Care. TPP has also developed a TPP newsletter and resources for members covering various health and perinatal topics. This program addresses disparities identified in prenatal care and postpartum care for American Indian/Alaskan Native members.

The Perinatal Growing Together Program (Perinatal GTP) aims to improve early access to prenatal care and completion of a timely T-dap immunization between 27 weeks and delivery, improve regular post-partum care and complete 2 post-partum visits prior to 84 days following delivery, complete a flu shot if appropriate, and improve well-baby care. Population Health will achieve this goal by encouraging birthing individuals to attend recommended scheduled visits and complete required immunizations. Programmatic goals include improving birth outcomes, reducing maternal/infant complications, and promoting the overall medical, behavioral health, and health habits of parents/guardians/authorized representatives and their babies. In FY24/25 the Perinatal GTP made 23,234 contacts across both the Prenatal and Postpartum Growing Together Program campaigns, outreaching to 12,117 unique members. Of the 4,144 unique members outreached for the Prenatal program, 60.4% agreed to participate. Of the 7,973 outreached for the Postpartum program, 58.5% agreed to participate. Note that the data is present as of May 27, 2025, since at the time of this summary, the fiscal year is still in progress. In addition, The Population Health team conducted a W15 Pilot Project in the fall of 2024 with North Bay Health where staff connected with new parents, asking about the birthing member's experience with their provider, birthing experience, and if they were connected to postpartum appointments. These members were seamlessly transitioned into the GTP Postpartum program for targeted conversations post-birth.

Population Health participates in face-to-face member engagement including attending mobile mammography events, community baby showers, and the Partnership Maternal Photo Shoot. Over the 24/25 fiscal year, Population Health attended a total of 188 events; 59 of those were mobile mammography events and 13 were community events specific to women's health, breastfeeding, or maternal health. The Population Health and Health Equity teams partnered together to host a Maternal Photo Shoot for African American and Hispanic members in December 2024 and May 2025. The event showcased local community partners such as Doula Doula, WIC, Solano HEALS, Partnership staff, and more. This project was the result of a health disparities analysis that informed the organization of disparities among African American/Black and Hispanic pregnant and postpartum members. These events aim to empower mothers and birthing individuals while addressing maternal health disparities in Solano County through meaningful engagement, providing community resources, health education, and support for workforce development.

Healthy Living Coaches within the Population Health team attend multiple counties' Breastfeeding Coalitions, Perinatal Service Coalitions, and Maternal and Child Adolescent Health Advisory Board meetings. At these meetings, they connect with the community, learn about challenges or barriers, as well as educate and share information regarding Partnership and Population Health's perinatal offerings.

Provider Education and Engagement Informational materials have been developed in collaboration with Population Health related to women's health and perinatal health: Doula Services flyer, breast pump guide, WIC resources for GTP, cervical cancer self-swab screening instructions, and presentations with information about Perinatal GTP for the Fostering Connections series and Doula education series. Webinars and Presentations included: Improving Measure Outcomes-Perinatal Care and CHL screening, Raising Quality and Improving Outcomes in Women's Health and Perinatal Care for PQIP Participating Providers, Doula Pathway Webinar, Medical Director Forums, Regional Meetings, Partnership Health Perinatal Services Webinar, and the Perinatal Symposium. Presentations with and without continuing education credits were offered to practices throughout FY24/25. The intended audience for the educational opportunities were practices that provide perinatal women's health services. Recruitment for this education focused on practices who had either not participated in a prior year's training or those who expressed an interest in this education event. The objective was to educate providers about the PQIP and PCP QIP measures and Partnership resources to support members and practices in accessing the Partnership perinatal resources.

Community Health Needs Liaisons within the Population Health department work with all 24 counties to discuss their Community Health Assessments/Community Health Improvement Plans (CHA CHIP), shared SMART goals, and formulate objectives. A goal in Modoc County is to increase access to early entry into prenatal care for Modoc residents, to include Native American residents. Activities towards this goal started August 2024 and include providing transportation education to members via flyer distribution at provider offices and social media posts, and Partnership's Growing Together Program. January 2025 pilot planning began with activities to enhance member education around the necessity of early prenatal care through media outreach campaigns (social media, flyers, Modoc Public Health's provider newsletter, Partnership's provider and member newsletter) and Modoc's home visiting programs or partnering agencies that work with perinatal population. Charter approval was received in May 2025, and the pilot will begin July 2025 with a run time of one year.

The Health Analytics team continued to support initiatives by enhancing existing data reports and developing new recurring reports that provide insights into utilization patterns, enabling targeted outreach and quality improvement efforts. Additions made to the Tableau Maternal Health Dashboard this year included: updates to the Deliveries dataset with a Doula Flag and ECM flag, addition of a Doula Tab and ECM Tab to existing pages, and the creation of a new Doula Services Dataset. As a part of our Health Equity work the Health Analytics team created weekly reporting of currently pregnant and recently delivered Alaskan Native/American Indian members with complicated pregnancies with referrals to care coordination.

The Solano Perinatal Clinical Collaborative continues for FY24/25. The collaborative focuses on addressing health disparities in prenatal care for African Americans in Solano County. They have identified operational and communication barriers that were impeding access. They developed better systems of care across organizations and improved the standards and methods of patient related and professional communication. Meeting every 8 weeks with Partnership Medical Director attending.

Elder Care

In anticipation of the new Dual Special Needs Plans (D-SNP) launch, a new Elder Care QMSI workgroup was formed in early 2025 to proactively educate staff on quality measures in order to anticipate potential improvement efforts needed in upcoming years.

Workgroup participants were identified in January 2025 and monthly workgroup meetings initiated in March 2025. Workgroup meetings were conducted monthly through June 2025 and comprised of the following:

- Workgroup participant expectations and commitments
- Workgroup purpose:
    - Mission: To promote improvement efforts for measures related specifically to the care of older adults
    - Establish workgroup priorities and measure focus
    - Identify and execute new improvement interventions
- 2025 Timeline – Areas of Focus:
    - D-SNP measure education (April – May)
    - Data review (June)
    - Existing interventions and repository development (planned July)

- Measure prioritization (planned August-September)
- CY 2026 goal development and planning for new improvement work (planned October-December)

New Dashboards in Development

During FY2024-25, the Missed Opportunities and Member Engagement dashboards were prepared for final development and deployment in the production environment. Resources needed to complete the deployment were reassigned to finish out the HealthRules Payor (HRP) deployment. After go-live of HRP, the system is expected to go through a period of stabilization, after which resources will be reassessed, reprioritized, and redeployed. This may result in continuation of work on these two dashboards in FY2025-26.

Quality Improvement Coaching

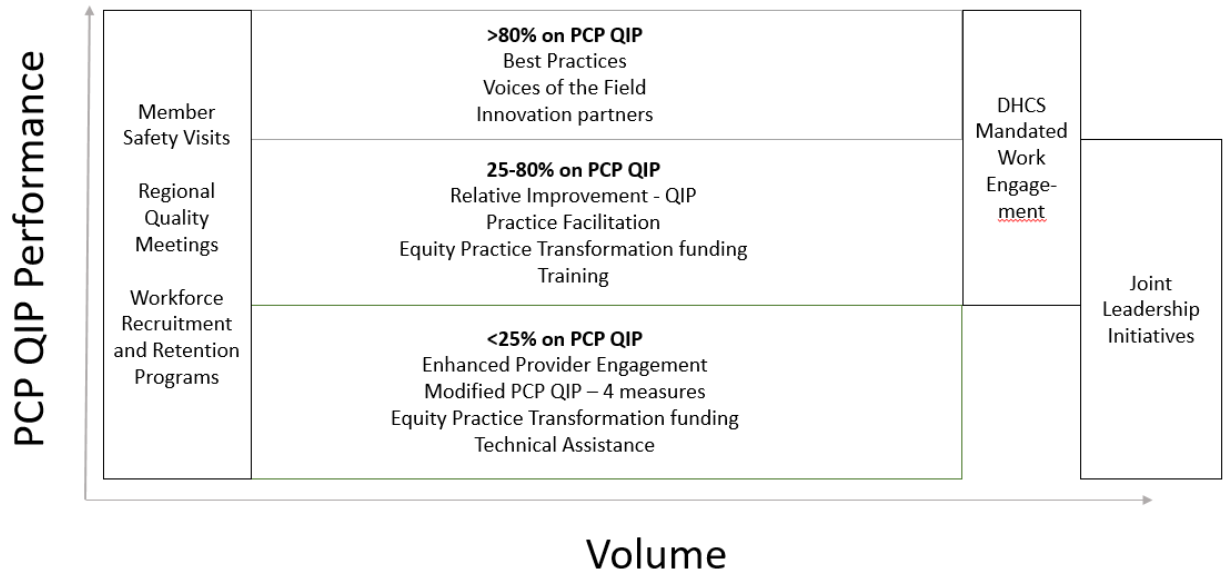
Partnership uses a practice's Primary Care Provider Quality Incentive Program (PCP QIP) scores on clinical measures as a proxy for assessing the strength of a practice's quality program. Each practice is assigned into one (1) of three (3) tiers based on their PCP QIP performance in the previous year, and each tier is associated with coaching and collaborative programs meant to maximize the capacity of the practice for success with the PCP QIP.

The diagram below visualizes the three (3) tiers of PCP practices based on past PCP QIP performance, and the coaching and collaboration programs associated with each tier.

The three (3) PCP practice tiers are:

1. Highest tier: Scoring over 80% of clinical points on previous year's PCP QIP
2. Middle tier: Scoring between 25-80% of clinical points on previous year's PCP QIP
3. Lowest tier: Scoring under 25% of clinical points on previous year's PCP QIP

PCP Practice tiers based on PCP QIP scores, and associated coaching/collaboration programs



In January 2024, Partnership expanded into ten (10) additional counties. Primary care providers in those ten (10) counties participated in the PCP QIP for the first time. For the purposes of this evaluation, coaching with these providers will be discussed separately from the ongoing efforts in our legacy counties. See the **"Expansion Region Coaching"** for an evaluation of that project.

Enhanced Provider Engagement and Modified PCP QIP

Enhanced Provider Engagement (EPE) and Modified PCP QIP are two (2) programs centered around Provider Organizations (PO) who are in the Low Performing Tier. These PO's often have significant infrastructure and workforce challenges and are more likely to be located in rural or frontier areas with inadequate health system infrastructure, and to be serving communities who have historically had less access to healthcare resources. Practices in the Low Performing tier are more likely to have higher rates of leadership and workforce turnover, and a lack of dedicated quality resources and structures. Tribal health organizations are overrepresented in this tier, partially because these health centers center their quality work around the Government Performance and Results Act (GPRA), a quality measure set that is not fully aligned with Partnership's QIP.

In 2023, Partnership launched two (2) new tactics to improve the performance of POs who scored less than 25% of possible clinical points in the previous year's PCP QIP:

Enhanced Provider Engagement (EPE): Recognizing that practices who fall into the Low Performing Tier of the QIP often have significant core challenges with infrastructure, leadership, and funding, the EPE coaching methodology centers around the Building Blocks from UCSF's Center for Excellence in Primary Care. The EPE coaching program focuses on interventions that will impact core areas of a practice such as leadership engagement, use of data systems, empanelment, and clinical team formation.

Enhanced Provider Engagement consists of several stages:

- Completion of a Needs Assessment tool and corresponding Supplemental Survey
- Partnership summary and recommendation for impactful quality interventions, based on Needs Assessment and Supplemental Survey
- Coaching with planning and implementation of interventions designed to impact core quality improvement capacity and measure performance

Modified PCP QIP for Low Performing Providers: Partnership developed and implemented consequences for Primary Care Provider Organizations with persistent low performance in Partnership's PCP QIP. Provider Organizations who are assigned more than 1,000 Partnership members and who earned less than 25% of their clinical points for the previous year's PCP QIP are assigned the Modified QIP. The Modified QIP assignment includes several requirements for Provider Organizations qualifying, including:

- Reduction of QIP clinical domain measure set from 11 to 4 measures
- Required Executive meeting with PO's Board
- Required participation in Enhanced Provider Engagement coaching with PI Team
- Demonstrated improvement in QIP measures to 50% or more of clinical measure points to return to fill QIP measure set by next MY

2024 EPE and Modified QIP Goals:

- 80% participation by POs assigned EPE and Modified QIP
- Coach two high-volume practices in each region and conduct at least one intervention in a measure of focus

2024 EPE and Modified QIP Outcomes: Partnership assigned 14 Provider Organizations to Enhanced Provider Engagement and Modified QIP. Seven (7) of the Parent Organizations continued from last year because they did not earn at least 50% of their clinical points in the QIP which was the graduation criteria. The 2024 cohort had the following outcomes:

81% of POs assigned EPE and Modified QIP engaged with Partnership and completed at least one (1) of the program activities – GOAL ACHIEVED

- 71% of the new POs completed a Needs Assessment
- 100% of POs also participated in coaching activities around opportunities identified by their Needs Assessment
- 43% of POs had a Partnership executive or senior leader present on Partnership's quality program to their Board

POs improved their 2023 PCP QIP scores by an average of 7.29%.

- Providers participating in EPE had an average increase in points earned year-over-year of 7.29% compared to non-EPE providers improvement in Partnership's legacy counties of 2.57%
- Five (5) out of 12 POs earned fewer points than the previous year.

The PI Team continued the EPE and Modified QIP Team in 2025, although it was decided to include POs who scored less than 33% (vs. 25%) of possible clinical points in the previous year's PCP QIP. The 2025 Modified QIP cohort consists of:

- Two (2) POs graduating from the program
- Ten (10) POs continuing the program
- Three (3) POs entering the program
- Two (2) POs exited the program due to membership falling below the required thresholds
- Two (2) POs graduated from their CAP and returned to the program

Expansion Region Coaching

Partnership expanded into ten (10) additional counties beginning January 1, 2024. Between July 1, 2024, and June 30th 2025 performance improvement efforts focused on prioritizing large provider organizations who were most receptive to and could benefit most from improvement coaching. During this time period, an organizational restructuring established a dedicated Performance Improvement team, including a manager and three Improvement Advisors, to focus exclusively on nine (9) of the ten (10) expansion counties. The tenth county was integrated into an already established performance improvement region with other legacy counties.

Of the 220,300 members in incoming counties with a PCP assignment, Improvement Advisors successfully engaged with practices holding 154,150 members (70% of assigned members). Initial outreach was conducted with nine (9) practices in these counties; eight (8) practices were elected to participate in regular coaching sessions in 2024

(though some struggled to establish a regular coaching cadence). An additional three (3) practices, while not participating in regular coaching, engaged through the Equity Practice Transformation (EPT) program, which included Learning Community sessions around QI methodologies and best practices. This participation brought them into regular contact with QI team members.

By the end of the reporting period, coaching is ongoing with ten (10) of the original twelve (12) mentioned previously. The PI Manager has regular touchpoints, with the two other practices to offer assistance and resources as they become available. Initial touchpoints were made with an additional five (5) previously unengaged providers representing an additional 15,197 members during the first five (5) months of 2025. Three more practices began regular coaching in 2025 representing an additional 5,800 members.

In Tehama County specifically, the one expansion county assigned to a separate regional performance improvement team, there are 22,260 members assigned to a primary care provider. Improvement coaching is ongoing with six (6) providers in Tehama County and many providers outside of Tehama County that represent over 75 percent of the Tehama County members assigned to a primary care provider.

Final PCP QIP data for measurement year 2024 showed that approximately 41% of members in the nine (9) eastern expansion counties were assigned to one of six (6) providers earning at least 50% (or more) of their total PCP QIP points. Conversely, thirty-three percent (33%) of members were assigned to 17 provider organizations that earned less than twenty-five (25%) of their total PCP QIP points. The highest performance achieved in this region was 67.85 percent of total available points. (See the table below for full results in this region.)

Performance Category	Number of Providers*	Percent of Members assigned to a Provider in this Performance Category
Earned 50% or more PCP-QIP points	6	41
Earned between 26 and 49.9% of PCP-QIP Points	16	26
Earned 25% or below of total PCP-QIP Points	17	33

* Represents provider organizations except for two (2) Adventist Health sites

Based on established criteria of the modified QIP, twelve (12) provider organizations from these nine (9) counties would have been added to the modified QIP program. Many factors led to the decision to not have expansion county providers enter the modified QIP for 2025. As of June, 2025, the performance improvement team has two new Improvement Advisors adding necessary resources to support the full network in these nine (9) counties. Outreach and engagement of all practices will continue to be the primary focus for the performance improvement team in the expansion region. These practices will continue to see improvement with robust support from the performance improvement team and Partnership's portfolio of supportive resources.

Equity and Practice Transformation (EPT) Program

In January 2024, the Department of Healthcare Services (DHCS) launched the Equity and Practice Transformation (EPT) Program, as a state-wide initiative focused on advancing health equity while reducing COVID-19 driven care disparities. Partnership leveraged this funding opportunity to prioritize organizations with the greatest need for infrastructure and capacity-building support. The EPT funding is divided between three (3) programs; the Initial Planning Incentives Payments (IPIP), the Provider Directed Payment Program (PDPP), and the Statewide Learning Collaborative (SLC).

Initial Planning Incentive Payments (IPIP)

Through the IPIP, Partnership awarded $10,000 to 23 qualifying provider organizations, primarily geared toward small and medium-sized independent practices, to support their PDPP planning and application process. Ten of these provider organizations were already engaged under Partnership's Enhanced Provider Engagement (EPE) strategy in 2023. The remaining $1.2 million IPIP funds have been allocated to two strategic initiatives; updating outdated Electronic Health Record Systems (led by the QI Project Management Team) and the development and implementation of a Primary Care Physician (PCP) Leadership Training Program, (led by the Work Force Development Team). .

Provider Directed Payment Program (PDPP)

A total of 56 provider organizations applied to participate in the PDPP under Partnership. Of those, 27 were invited by DHCS to participate, giving Partnership the third-highest acceptance rate among managed care plans (49%, compared to a statewide average of 29%). These providers span across all Partnership's regions and include five (5) provider organizations contracted with Partnership through the 2024 10-county expansion, eight (8) tribal health centers, and seven (7) provider organizations already engaged through Partnership's EPE program.

Based on the updated funding criteria, there is a possible draw-down of $13M for Partnership's contracted provider organizations upon meeting the practice transformation activities over the program's three-year (3) timeline (January 1, 2024 – December 31, 2026).

All 27 practices successfully submitted their first deliverable, the Year 1 PhmCAT in May 2024. The Year 1 PhmCAT is a practice self-assessment tool designed to help sites reflect on their current performance across key quality domains, identify strengths and gaps, and set priorities for improvement. Completion rates in subsequent cycles, have declined.

Of the 198 practices participating statewide, 85% (169) practices met the criteria for at least one of the five (5) milestone deliverables focused on building empanelment, access, and cycles governance. In comparison, 92% (25) of Partnership's 27 practices met the criteria for at least one of the milestone deliverables. As of June 2025, 78% (21) of Partnership's practices met the criteria for at least one of the May 2025 deliverables, which focused on data implementation, stratifying their assigned HEDIS-like measures based on their population of focus, and completing a second Population Health Management Capabilities Assessment Tool (PhmCAT) to track their foundational progress from the year prior.

Statewide data for recent submission periods is still pending, so it remains unclear whether the decline in submission rates reflects a broader trend. However, several practices have reported challenges in sustaining participation, citing limited staffing, organizational transitions, and shifting internal priorities. In response, Partnership's QI Program

Management and Performance Improvement teams met with these practices to better understand their needs and encourage their continued participation. These conversations revealed that many practices were already actively implementing transformation activities but struggled with translating and aligning their data and responses to complete the milestone deliverables. Partnerships coaching support helped bridge this gap and promote continued engagement.

Statewide Learning Collaborative (SLC)

The Statewide Learning Collaborative (SLC) is designed to support the PDPP awardees in implementing transformation goals, sharing and spread of best practices, practice coaching activities, and achieving the quality and equity goals outlined in their PDPP applications. Participation in the SLC is mandatory for all PDPP participants.

The Population Health Learning Center (PHLC) is facilitating the Technical Assistance strategy within the SLC for practices. They launched three (3) forms of Technical Assistance:

- PopHealth + eLearning curriculum – An eLearning platform with short (10-15) minute training videos and resources available to all practices.
- Peer Learning Cohorts – Practices are grouped into two cohorts (health centers, tribal health and public hospitals in one and private practices in the other) based on region, and size to encourage peer-to-peer learning and application of the curriculum.
- Coaching Pool – This optional offering provides tailored coaching to support implementation of the EPT curriculum. Unlike the common curriculum and the peer learning components, the Coaching Pool is optional and is not funded by DHCS. Practices may purchase a coaching package using their own funds, directed payment dollars, or financial support from their sponsored managed care plan.

In lieu of PHLC's coaching pool, Partnership has a team of coaches dedicated to EPT awardees and may draw on outside experts for specific transformation topics as needed. The success of participating practices is dependent on the collaboration between Managed Care Plans (including Partnership's QI Performance Improvement team, who act as their dedicated coaches and the organization and management from the Program Management team), the guidance and open communication from PHLC and DHCS, and how engaged a practice is with the Technical Assistance activities and the rate of completing EPT milestone deliverables. Through our coaching efforts, we have seen firsthand how aligned support from all parties can drive meaningful practice transformation. Partnership anticipates more data and trends will emerge as the program matures.

Practice Facilitation and Provider Coaching

Practice Facilitation centers around POs who are in the Mid Performing Tier. These POs have demonstrated engagement and some success with the QIP but have opportunities to improve their performance on clinical measures.

Practice Facilitation uses the Institute for Healthcare Improvement's (IHI) Model for Improvement framework to build capacity for provider organizations to implement impactful interventions via Plan-Do-Study-Act (PDSA) cycles and other tools and promote a culture of quality throughout the provider organizations. Improvement Advisors serve as Practice Facilitation Coaches, and their role includes the following duties:

- Provide guidance on QI Project Team make-up and management
- Work with practice's leadership team on QI infrastructure development

- Provide consultative support and tools for project management of QI projects
- Train and support application of the Model for Improvement methodology. Enable workgroup members to implement changes by providing tools, guiding them through rapid-cycle tests of change, and assisting when obstacles are identified
- Provide best practice change ideas and build capacity for brainstorming
- Build capacity for collection and use of measurement data, assess the effectiveness of changes made
- Support change management aspects of QI projects

In 2024, two (2) provider organizations participated in Practice Facilitation, consisting of one (1) provider in the Southwest Region, and one (1) in the Southeast Region. Each provider organization met with a Practice Facilitator at least once a month, including site-specific QI Team members as well as QI leadership. Multiple provider included team members such as clinicians and clinical support team members in their Practice Facilitation team structure. Providers selected at least one (1) PCP QIP measure to focus on throughout the calendar year.

2025 Engagement in Practice Facilitation

In 2025, there were several changes in the POs participating in Practice Facilitation:

- The remaining Southeast Region PO is now in the Modified QIP and is focusing on the four (4) measures of focus.
- The Southwest PO that was working with an Improvement Advisor for Practice Facilitation in 2024, no longer needed this level of coaching, however, remains engaged with their coach in an advising capacity.

Outcomes for the Practice Facilitation program in 2024:

Considering vast improvements that were made to the 2024 HEDIS reported rates for both W30 and CIS measures using supplemental data submissions and lack of practice engagement in the Practice Facilitation structure through 2023 and 2024, the PI Team recommended abandoning the Practice Facilitation program as a stand-alone form of coaching going forward. The structure of Practice Facilitation can be used for any practice who would benefit from additional training and support using the IHI model for improvement. Thus, coaches will use their relationship and individual judgement to employ Practice Facilitations strategies with any practice identified as needing this level of support.

Joint Leadership Initiative

In 2019 the Joint Leadership Initiative (JLI) was implemented in an effort to increase executive level engagement with large, contracted provider organizations that have significant room for improvement on quality metrics.

In FY 2024-2025 the following provider organizations participated in the JLI: Adventist Health, Mendocino Community Health Center, Fairchild Medical Center, Shasta Community Health Centers, Solano County Family Health Services, Oroville Hospital, Wellspace Health, Ampla Health, and Western Sierra Medical Center. Communicare+Ole and Open Door Community Health Center both graduated out of the JLI program due to high performance in 2024. Collectively these organizations are responsible for the care of approximately 209,486 Partnership members, which is about 23% of the health plan's membership as of December 2024. the JLI aimed to provide mutual benefits for these organizations and Partnership, including:

- Significant improvement of quality scores for Partnership
- Maximization of QIP dollars, giving significant additional resources to the organizations

- Improved performance, leading to significant improvement in quality outcomes for members/patients

The FY 2024-2025 QI Work Plan goals for this initiative included:

- Meeting with participating providers in accordance with the tier frequency identified in the prior year, which ranged from a single annual check-in for high performers and up to quarterly meetings for lower performers.
- Transferring responsibility for JLI meetings from Improvement Advisors to Performance Improvement Managers to better align to updated regional structures within Partnership. PI Managers have better visibility to regional activities across their territories.
- Engaging new JLI partners in the expansion counties following their first QIP measurement year.

Overall, the JLI meetings have been well received and have helped improve the relationships with the provider entities. Feedback from participants has also cited that the meetings have allowed focused time to discuss quality issues and provided a platform to discuss provider concerns. When evaluating 2024 QIP performance of JLI providers, it was determined that JLI providers earned 63.90% of possible QIP points on average, which is 5% higher than the non-JLI provider average of 58.90%. When reviewing year-over-year data comparing 2023 and 2024 QIP data, JLI providers increased 2.62% year-over-year compared to non-JLI providers in Partnership's legacy counties who increased by 3.10%. The table below shows performance changes from MY2023 to MY2024 for JLI providers. Two providers, Shasta Community Health Center and Solano County Health & Social Services, declined in 2024 while the others improved compared to the prior year.

Provider Organization	YoY Difference
Adventist Health	5.19%
Fairchild Medical Clinic	14.50%
Mendocino Community Health	7.00%
Open Door Community Health Centers	3.11%
Shasta Community Health Centers	-6.25%
Solano County Health & Social Services	-10.25%
Grand Total	**2.62%**

Expansion of Regional Quality Meetings

For FY 2024-2025, the QI Team continued to expand regional quality meetings to the Chico and Auburn Regions. Following the expansion of regional quality meetings in the Redding and Eureka regions, quality observed increased collaboration within the Northern County provider network which mirrored practices in the Southern Region. These meetings serve as an opportunity to address regional quality improvement topics with local stakeholders. Existing regional meetings include:

Solano Quality Improvement Program Initiative (SQIP-I): This monthly meeting is co-sponsored by Partnership and Aliados Health, the Federally Qualified Health Center (FQHC) consortium that is active in Solano County. The SQIP-I Workgroup engages four (4) of the largest PCPs in Solano County as a collaborative forum for collective learning and for partnership on quality measures that are best addressed on a systems level. In 2023-2024, the SQIP-I Workgroup's projects included:

- Planning activities, including root cause analysis activities, around the DHCS assigned Health Equity Performance Improvement Project (PIP) around the Well Child Visits Birth – 15 Months (W30-6)

measure. The PIP will be focused on increasing the completion rate for the visit series for African American children in Solano County.
- Sharing of best practices around Lead Screening for Children (LSC) measure.
- Presentation on Cologuard bulk ordering program to increase Colorectal Cancer Screening (COL) rates.
- Focused collaborative work on newborn visit workflows, featuring analysis on newborn transitions of care by Solano County's primary inpatient labor and delivery unit and discussion of newborn Medi-Cal enrollment and PCP assignment.

Southeast Regional Meeting: This quarterly meeting engages all PCPs in the Southeast Region. In 2024-2025, the Southeast Regional Meeting's topics included:

- Voices from the Field presentations by PCP quality teams describing best practices for measures such as Cervical Cancer Screenings (CCS) and Unit of Service measures.
- Overview of Partnership programs such as the transportation benefit, member redetermination tools, and the Electronic Blood Pressure Monitor program.
- Presentations by community partners such as First 5 Yolo, presenting on their Welcome Baby program.
- Health Equity Data presentation regarding disparities within QIP outcomes
- Telehealth Services available to members

Lake and Mendocino Quality Meeting: This bi-annual meeting engages PCPs in Lake and Mendocino Counties around quality improvement topics. Following the organizational region restructuring, QI is working with the Eureka Regional Director to determine if this meeting will get integrated into the Eureka Region quarterly virtual format or if it will remain its own bi-annual in-person meeting.

East Region Quarterly Quality Meetings/Monthly Office Hours: The PI and QIP Teams held four (4) sessions for incoming practices in the expansion counties from July 1 through December 31, 2024. This forum, titled "How to Succeed in the PCP QIP", engaged quality teams from incoming practices and helped orient them to Partnership's QIP program and measures, analytic tools, and best practices for success with QIP measures. Topics at these four (4) sessions included:

- Gaining access to eReports and understanding the eReports and Partnership Quality Dashboard interface and features.
- Troubleshooting common problems faced by incoming practices, such as member assignment issues and incomplete data issues.
- Understanding the QIP Equity Adjustment and best practices for acuity coding.
- Strategies and best practices for success with QIP measures.

Regional quality meetings for both the Chico and Auburn regions have been scheduled to start in July, 2025. They will follow the structure of the other regional quality meetings and include a survey of participants to ensure maximum value for our provider network.

Partnership, HANC, and NCCN continue to collaborate to maintain a QI Measurement Systems Toolkit, initially developed and launched in 2017. The QI Measurement Systems Toolkit provides background information on the measures defined under HEDIS®, Uniform Data Set (UDS), Site Reviews, and the PCP QIP. This toolkit also includes measure by measure data sets reflective of consortia member performance across the varying measurement sets. And, recommended best practices from national change packages and regional interventions are also included by measure. A key component of the toolkit is a measure crosswalk that indicates which measures fall under each measure set, as well as what criteria constitutes denominator and numerator compliance, and any exclusions that exist for the measure. The scope of the crosswalk is primarily determined by the PCP QIP measure set versus attempting to offer a fully inclusive view of all the new measures Partnership has taken on via MCAS and NCQA accreditation. The crosswalk acknowledges when a comparable HEDIS® measure exists but does not detail the measure specs, given sensitivity around licensing agreements with NCQA. These tools allow organizations to potentially target measures for performance improvement that affect multiple measure sets. The Northern consortia also continue to cite this toolkit as a key onboarding tool for health center staff either new to QI or taking on new responsibilities under the PCP QIP.

HANC and NCCN offer great avenues for communicating with the largest PCP organizations serving Partnership members in the Redding and Eureka Regions. In the past year, Partnership has leveraged the consortia QI and CMO Peer Networks, which each meet monthly, to share key changes in measure sets, HEDIS®/QIP measure education, HEDIS®/QIP performance results, and emerging best practices from ongoing regional performance improvement projects. It is also a forum by which barriers to achieving improved HEDIS® performance can be openly discussed, informing Partnership's HEDIS® Score Improvement tactical strategies and dialog with DHCS. Historically, HANC and NCCN member organizations perform higher than non-members.

Other QI Provider Resource Updates and Changes

The Performance Improvement (PI) Team publishes a set of Measure Best Practices for each PCP QIP measure on an annual basis. 2025 Measure Best Practices feature Partnership programs and tools, and include best practices around data and coding, member care, and health equity best practices for each PCP QIP measure.

Frequently Asked Questions (FAQs) documents were developed by the QIP Team to support newly enhanced dashboards in the Partnership Quality Dashboard (PQD) called Preventive Care Reports. Each dashboard includes supplemental data for three (3) measures included in the PCP QIP core clinical measure set: Immunization for Adolescents, Childhood Immunization Status – Combo 10, and Well Care Visits in support of the Well Child First 15 Months measure, with well visits between 15-30 months coming later in 2025. The Preventive Care Report FAQs document provides descriptive highlights of each measure dashboard including guidance on how to use the data in support of measure score improvement. The QIP Team also distributes an educational, bi-monthly email DRIP campaign focusing on helpful tips for using the Preventive Care Reports dashboard and other QIP basics to reinforce on-going performance education provided by the PI Team.

Quality Improvement Training

Improving Measure Outcomes

In conjunction with Partnership medical directors, the Performance Improvement Team offered six (6) virtual Improving Measure Outcomes (IMO) sessions to primary care provider organizations between February - April 2025. The webinars aimed to provide clinical background and best practices related to 2025 Primary Care Provider Quality Incentive Program (PCP QIP) measures. Each session was approved for Continuing Medical Education (CME)/Continuing Education (CE) credits through the American Academy of Family Physicians and the California Board of Registered Nursing for 1.0 contact hours per session.

The focus of the webinars and attendance rates are included below:

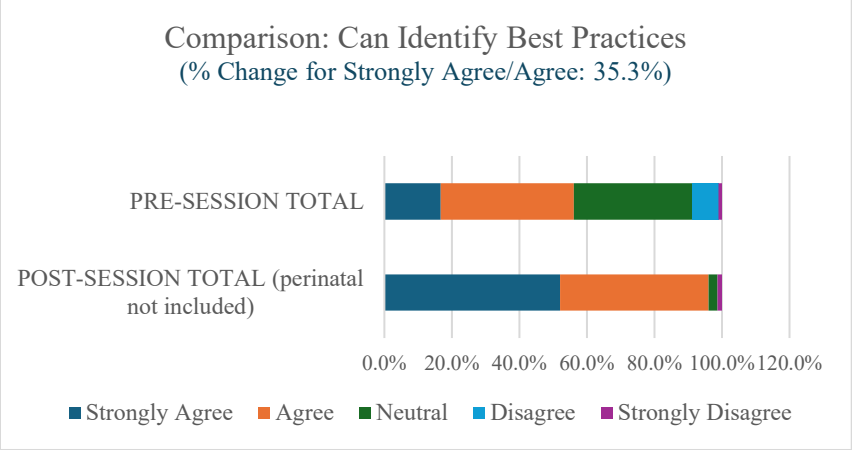
- 02/12/2025 - Pediatric Preventative Care for Ages 0 - 30 Months
  - 90 attendees, representing 36 unique organizations, 12 requests for CME/CEs
    (Webinar covered Well-Child Visits for the First 30 Months of Life, Childhood Immunizations Status, Blood Lead Screening, and Topical Fluoride in Children measures)
- 02/26/2025 - Pediatric Preventative Care for Ages 3 - 17 Years
  - 65 attendees, representing 33 unique organizations, 11 requests for CME/CEs
    (Webinar covered Child and Adolescent Well-Care Visits, Immunizations for Adolescents, Blood Lead Screening, and Topical Fluoride in Children measures)
- 03/12/2025 - Chronic Disease and Colorectal Cancer Screening
  - 79 attendees, representing 45 unique organizations, 9 requests for CME/CEs
    (Webinar covered Controlling High Blood Pressure and Colorectal Cancer Screening measures)
- 03/26/2025 - Perinatal Care and Chlamydia Screening
  - 53 attendees, representing 28 unique organizations, 15 requests for CME/CEs
    (Webinar covered Women and Timely Postpartum Care screening measure)
- 04/09/2025 - Breast and Cervical Cancer Screenings
  - 85 attendees, representing 37 unique organizations, 10 requests for CME/CEs
    (Webinar covered Cervical and Breast Cancer Screening measures)
- 04/23/2025 - Diabetes Control
  - 57 attendees, representing 31 unique organizations, 13 requests for CME/CEs
    (Webinar covered Comprehensive Diabetes Management - HbA1c Good Control, Retinal Eye Exam, and Blood Pressure Control for Patients with Diabetes measures)

Of attendees who completed the post-session evaluations for all six webinars, 99% selected *Strongly Agree* or *Agree* when asked if the webinar was relevant and useful.

All six (6) Improving Measure Outcomes trainings featured one to two leaders from a high-performing provider organization as a "Voices from the Field" presenter, allowing these providers to share their best and promising practices with their peers throughout the provider network.

The target audience for Improving Measure Outcomes trainings were quality improvement staff at primary care physician offices within the Partnership geographic footprint. Marketing strategies for trainings included the following:

- Targeted eblasts for all trainings were sent using the Primary Care Provider contact list and the Improvement Academy contact list.
- QR registration codes were added to all training flyers. This offered additional ease for individuals to register. The total number of scans for IMO webinars was 535.
- Event listing on Partnership website for all trainings.
- Distribution of training flyers to Leadership staff.
- Promotional training event slides were sent to internal Quality Teams (QIP, HEDIS® and Improvement Advisors) to incorporate in upcoming provider trainings/meetings.
- Provider Relations fax blast of training flyers.
- Provider Relations Representatives asked to distribute training flyers.
- Training opportunities included in Quality Improvement, Provider Relations, and Medical Director Newsletters.
- The Patient Safety Team was asked to share training flyers when conducting on-site visits with providers. Additionally, IMO training PowerPoints were shared to ensure on-site education by the Patient Safety Team was consistent with educational messaging.
- Members of the Performance Improvement Team added a customized IMO banner ad to their Outlook signature. The ad touted the webinar series and offered a hyperlink to allow potential attendees to register for the series.



A strategy was implemented at the conclusion of the series to measure the impact of the training offerings whereby an evaluation was sent to participants who attended three (3) or more IMO webinars. The survey was distributed to 49 participants and had a total of 7 responses (14%). The majority of responses to this survey was positive.

Responses were rated on a Likert scale (strongly agree=5, agree=4, neutral=3, disagree=2, and strongly disagree=1). The average for each response was calculated to understand participants' perceived improvements for the following questions. The following table lists each question and Likert score.

Improving Measure Outcomes Webinar Series Evaluation Questions	Likert Score

I can locate appropriate Partnership resources that define measure specifications for the 2025 Primary Care Provider Quality Improvement Program.	4.3
I can identify and implement best practices to improve clinical outcomes for the specific Improvement Measure Outcomes webinar(s) I attended.	4.1
I can apply specific measure outcome performance strategies to a variety of quality improvement (QI) work in several content areas.	4.3
I am able to evaluate our current QI program and assess future needs or gaps.	4.3
I am able to identify care gaps attributed to health inequities, develop strategies to address those care gaps, and successfully implement those strategies.	4.0
I can communicate to interdisciplinary team members (clinical and non-clinical) about QI best practices to improve measure performance.	4.3
Does offering continuing education credits (CMEs/CEs) influence your attendance.	4.0

Overall, respondents indicated their ability to locate resources for measure best practices, quality improvement strategies, and identify and influence care gaps. Based on participant response, CME/CEs credit continue to be valuable to attendees.

ABCs of Quality Improvement

In FY 2024-2025, Partnership offered three (3) in-person ABCs of Quality Improvement (QI) training series for its provider network. The purpose of the ABCs of QI training is to introduce quality improvement concepts to clinical and non-clinical provider staff to improve performance in the PCP QIP.

The all-day trainings covered a range of topics, including:

- What is Quality Improvement?
- Introduction to the Model for Improvement
- How to create an aim statement
- How to use data for improvement
- Why and how to establish outcome and process measures
- Tips for developing change ideas that lead to improvement
- Testing changes with the Plan-Do-Study-Act (PDSA) cycle

Significant collaborative efforts among seasoned Improvement Advisors were brought together to align the ABCs of QI curriculum into a single, cohesive training deck. This was designed to not only ensure that any Improvement Advisor, regardless of region, could effectively deliver the training, but also to provide a consistent and valuable training to all participants across the network.

Attendance and overall training satisfaction were as follows:

- 11/07/2024 – Fairfield: 48 attendees, representing 14 unique provider organizations with 100% of respondents reporting being extremely satisfied/satisfied with this course.
- 01/30/2025 – Ukiah: 21 attendees, representing 8 unique provider organizations with 100% of respondents reporting being extremely satisfied/satisfied with this course.
- 03/25/2025 – Redding: 28 attendees, representing 15 unique provider organizations with 100% of respondents reporting being extremely satisfied/satisfied with this course.

Participants in the trainings included clinicians, front-line staff, quality improvement staff, administrators, and public health professionals. Continuing Medical Education (CME)/Continuing Education (CE) credits through the American Academy of Family Physicians and the California Board of Registered Nursing were offered for each training.

To evaluate the effectiveness of the ABCs of QI training, pre- and post-session knowledge check questions were administered at the beginning and end of each training section, respectively. Each post-session evaluation revealed higher percentages of *Strongly Agree* and *Agree* as compared to pre-session evaluations. Aggregated evaluation results are shown below.

ABCs of QI Evaluation Question	Pre-Session % of Participants Choosing *Strongly Agree* or *Agree*	Post-Session % of Participants Choosing *Strongly Agree* or *Agree*
I understand the Model for Improvement as it relates to health care quality improvement efforts.	54% N=101	98% N=102
I am able to construct an aim statement/differentiate between effective/ineffective aim statements.	29% N=101	94% N=101
I understand when to use a driver diagram and how it contributes to developing change concepts.	12% N=86	96% N=101
I am able to develop a process map for a workflow that is commonly used in our practice.	33% N=86	93% N=101
I am able to identify/design process/outcome/ balance measures relevant to QI projects.	37% N=83	80% N=94
I can identify and implement the components of a run chart to monitor improvement.	34% N=83	79% N=94
I am able to design and implement a PDSA cycle.	39% N=83	89% N=95
I have ideas that I would like to put into action in my workplace that I can test with a PDSA cycle.	45% N=83	86% N=95

Additionally, all post session evaluations asked if the information presented directly related to participant's work. Participants choosing *Strongly Agree* or *Agree* ranged from 76% to 94%.

Several provider sites attending the ABCs of QI agreed to post-training follow-up meetings to track the progress of the AIM Statement developed during the Plan-Do-Study-Act portion of the training.

One example of session outputs includes a Mendocino County provider site whose focused measure was Colorectal Cancer Screening. From the aim statement and driver diagram developed during the ABCs of QI training, this team was able to test their change ideas by utilizing the Plan-Do-Study-Act (PDSA) framework. The provider site shared their PDSA success of accelerating improvement, which included:

- Cologuard patient education
- Offer UPS shipping of Cologuard kits for completed samples
- Offer incentives for returned kits
- Promotion of standing orders for Cologuard
- Outreach/follow-up on outstanding orders

Further check-ins have been established to continue to monitor this provider's successes in driving improvement.

Microlearnings

After informally polling several provider sites on beneficial training types, microlearning modules - intended as short tutorials - were introduced this fiscal period. The first microlearning developed focused on ePrompts, an online tool within Provider Online Services that allows provider office staff to easily access members' preventive screenings due while simultaneously checking their eligibility. The second microlearning, currently in production, will focus on the Preventative Care Dashboard. This tool enhances visibility of well-child visits and immunization status and can be particularly helpful for staff to identify operational processes contributing to pediatric well care completion trends for performance improvement.

Both offerings will be promoted to the provider network through eblasts, newsletters, regional meetings and by posting them to the Improvement Academy web page.

Value Based Pay-for-Performance Programs

Partnership's Quality Incentive Programs (QIP) provided financial incentives, data reporting and technical assistance to providers for improving in key domains of quality: clinical care, patient experience, access and operations, and resource use. The total pay-out for the MY2023-2024 QIP was approximately $51,493,633.57 across the five (5) QIP programs managed within the Quality Improvement (QI) Department. The total payout for MY2023-2024 is reflective of payouts distributed for Fiscal and Calendar year programs. The following is a breakdown of the QIP measurement year ranges included in the total payout of $51,493,633.57:

- Hospital QIP: full measurement year (FY2023-2024)
- Perinatal QIP: full measurement year (FY2023-2024)
- PCP QIP: full measurement year (CY2023)
- ECM QIP: Two partial measurement years (Q3 - Q4 2023 and Q1 - Q2 2024)
- Palliative Care QIP: Two bi-annual payments (Q3 - Q4 2023 and Q1 - Q2 2024)

Primary Care Provider Quality Incentive Program

The Primary Care Provider (PCP) Quality Incentive Program (QIP) Core Measurement Set evaluated four (4) domains of quality: Prevention and Screening, Chronic Disease Management,, Appropriate Use of Resources, Patient Experience, and Access & Operations. The Unit of Service measures provided additional dollars for providing specific services such as Tobacco Use Screening, Advance Care Planning, etc. All primary care providers who have Medi-Cal members capitated to them are automatically enrolled in the PCP QIP.

Program Goals

The PCP program goals and activities outlined in the FY 2024-2025 QI Work Plan were completed and are highlighted below.

- Development of measures for the 2025 PCP QIP by December 31, 2024.
- Partnership adhered to DHCS guidance regarding this program by including a performance threshold for measures that rewarded providers for conducting activities they may already be compensated for through capitation payments.

- Supported providers enrolled in the program by hosting webinars, distributing quarterly newsletters & surveys, provider notifications/reminders, and responding to provider inquiries via phone and email in a timely manner.
- Continued provider engagement and program activities to support quality (HEDIS®) measure score improvement, including monitoring changes to relative improvement methodology, payment methodology, and continuous enrollment requirement.
- Supported provider network and respective sites/clinics in their efforts to use data to improve reporting and performance improvement activities through FY 2024-25.
- Implement process improvement which includes documenting and updating current and new program protocols based on lessons learned.

The PCP QIP program performs annual evaluations. The 2023 Measurement Year evaluation was completed during the fiscal year 2024-2025 and is highlighted below.

MY2023 PCP QIP Program Evaluation Summary

The PCP QIP offers pay-for-performance (P4P) financial incentives. The intent of P4P is to improve access and quality of care across all clinical domains. The PCP QIP, designed in collaboration with Partnership providers, offers substantial financial incentives, data resources, and technical assistance to primary care providers who serve our capitated Medi-Cal members so that significant improvements can be made in the following areas: 1) Prevention and Screening, 2) Chronic Disease Management, 3) Appropriate Use of Resources, 4) Primary Care Access and Operations, and 5) Patient Experience. This evaluation is an analysis of the January 1, 2023 – December 31, 2023, Measurement Year.

Program Performance

PCP QIP performance observed incremental year-over-year recovery from 2022 to 2023 in the following clinical measures:

- Asthma Medication Ratio
- Controlling High Blood Pressure
- Diabetes HbA1c Good Control (<= 9.0%)
- Well-Care Visit (First 15 months)
- Child & Adolescent Well Care Visits
- Breast Cancer Screenings
- Immunization for Adolescents

Provider Experience

In 2023, the annual PCP provider engagement survey was retired due to a lack of participation. This survey was administered to the entire network and received poor response rate year over year. In efforts to continue provider engagement, the PCP QIP team shifted its focus towards offering a higher level of support to its identified low performing providers and newly enrolled providers by administering specific surveys towards these audiences. The intent of these surveys is to evaluate their knowledge of the program & its performance measure tools, provide programmatic reminders and offer education & training. With the administration of these targeted surveys, we have seen a better response rate with 27-53% of the targeted Parent Organizations participating in quarters 3 & 4 of measurement year 2024. These surveys have created a space for the PCP QIP team to have more engagement with these targeted providers and offering additional support. These surveys have been well perceived by the targeted provider network.

PCP QIP eReports System

The eReports system is an online tool provided to PCP participants in the PCP QIP. It serves as a means for providers to track their performance under the clinical care domain of the Core Measurement set at both an organizational level and individual site level. Under the 2024-2025 QI Work Plan, the eReports system was successfully enhanced to support the 2025 PCP QIP clinical measure set and released to providers on-time, in March 2025.

The information from eReports presents providers with member-level data corresponding to eligibility and compliance status under each measure. eReports data sources are: claims, lab data, pharmacy data, California immunization registry (CAIR) data, and the eReports user supplemental upload data. eReports supplemental upload functionality gives the provider the opportunity to upload medical record data to substantiate member compliance where administrative data is unavailable.

In the second quarter of 2025, the PCP QIP Team conducted its annual eReports Upload Audit for measurement year 2024. The QIP Team selected to audit the Child and Adolescent Well Care Visits (WCV) measure. A random sampling was performed, and we identified 34 Parent Organizations who uploaded WCV data into eReports. Sampling results were used to compile the audit list and request supporting medical records. During the 2023 PCP QIP eReports Upload Audit analysis we transitioned our audit approach from penalizing providers with a loss of members in the numerator or denominator to focusing on provider education based on our results. This approach allowed us to take more time with our audit analysis and identify opportunities for improving the quality of our audit through education. Our 2024 analysis will be completed by the end of June 2025.

Hospital Quality Incentive Program

The Hospital Quality Incentive Program (HQIP) is a pay-for-performance incentive program that began in 2012 for selected hospitals in the Partnership network. The purpose of the HQIP is twofold: 1) To help improve the health outcomes of Partnership members served by its contracted hospitals and 2) to help participating hospitals assess the quality of care provided to their patients by serving as a guide to their existing quality improvement efforts. To do this, the program offers substantial financial incentives for hospitals that meet specific performance targets, connects HQIP hospitals with regular training opportunities and resources, and hosts an annual Hospital Quality Symposium (HQS). The HQS supports HQIP participants' work in quality by bringing stakeholders together from each hospital entity across two Partnership regions for thoughtful discussion on high-priority, hospital related topics.

Program Goals

The HQIP program goals and activities outlined in the FY 2024-2025 QI Work Plan were completed and are highlighted below. Partnership completed development of the 2024/2025 measurement year measurement set. Partnership also provided ongoing technical assistance to providers throughout the year and conducted an evaluation of the program for the 2023-2024 measurement year which is summarized below. Through Partnership's geographical expansion the number of hospitals participating in the HQIP increased from 26 to 33 hospitals.

During the 2024-2025 measurement year, Partnership conducted ongoing measure performance monitoring on participating hospitals while providing as needed technical support and updating them on performance status through operations meetings and mid-year performance reports.

Completed Goals

Goal #1: By June 30, 2025, develop the 2025-2026 measurement year Hospital Quality Incentive Program (H-QIP) Measurement Set to support Hospital Performance Improvement.

The 2025-2026 measurement year will include focus areas in the following domains: readmissions, advanced care planning, clinical quality: maternity care, patient safety and operations & efficiency, and patient experience. Measurement set development is informed by insights from the annual evaluation, regulatory needs, and trends in care. In the previous measurement year, two new measures were added, one was removed due to regulatory requirements and several targets were adjusted to encourage continuous quality improvement. This included the introduction of the 7-day Clinical Visit Follow-up measure, which was added in preparation of future DHCS requirements. The measure was refined during the 2024-2025 measurement year as data reports showing follow-up rates and adjustments were made to both the 2024-25 measure set and the proposed 2025-26 measurement set. The 2024-25 measure set also included "phase one" of a measure encouraging hospitals to begin expanding their delivery privileges to midwives and family physicians and another measure incentivizing increased screening mammography capacity.

The 2025-26 measurement set continues down the path of expanding delivery privileges by moving into "phase 2", where hospitals will be required to show evidence of recruitment or hiring of midwives and family physicians. The measure set also introduces a Doula Support measure encouraging hospitals to allow doulas to be part of the birthing process. Additionally, the new Vaccines For Children Program enrollment measure encourages hospitals to take advantage of the resources from the CDPH. Targets were adjusted in response to challenges observed during the 2024-25 MY. This resulted in continuing to place emphasis on follow-up visits and adjusting the Health Equity measure to align with CMS requirements for health equity.

The 2025-2026 measurement set includes the following 17 quality measures:

1. Risk Adjusted Readmissions
2. 7-day Clinical Visit Follow-up
3. Palliative Care Capacity
4. Rate of Elective Delivery Before 39 Weeks
5. Exclusive Breast Mild Feeding Rate
6. Nulliparous, Term, Singleton, Vertex Cesarean Rate
7. Vaginal Birth After Cesarean
8. Increased Screening Mammography Capacity
9. Doula Support
10. Expanded Delivery Privileges
11. Vaccines for Children Program Enrollment
12. California Hospital Patient Safety Organization (CHPSO) Patient Safety Organization Participation
13. Substance Use Disorder – Medication Assisted Treatment
14. Quality Improvement Capacity
15. Hospital Quality Incentive Platform
16. Cal Hospital Compare – Patient Experience
17. Health Equity

Goal #2: Develop Partnership's Hospital Quality Symposium for the 2025-26 HQIP measurement year.

The HQIP Program Manager, Manager of Quality Incentive Programs and the Medical Director for Quality analyzed the August 2024 event by reviewing attendee surveys to help inform the development of the 2025-26

event. The HQIP Program Manager and the Medical Director for Quality also attended an external hospital quality conference in October to look for potential speakers, topics and coordination of ideas for this year's event. Between January and June 2025, the venues, dates and times were solidified. The HQS will take place on July 29, 2025, at Partnership's Fairfield office and on July 31, 2025 at the Sheraton Hotel in Redding. Both events occur from 8:30 – 4:30 with the same agenda and speakers. The speaker engagement process was completed with the selected presenters. The events will include topics on: Health Equity, Substance Abuse Treatment, a Top Performer Panel discussing How to succeed in the QIP, Efficient PointClickCare Workflows to improve follow-ups and Enhanced Care Management, and Data Analytics with the Hospital Quality Institute. Continuing Education Credits will be available for attendees who request them.

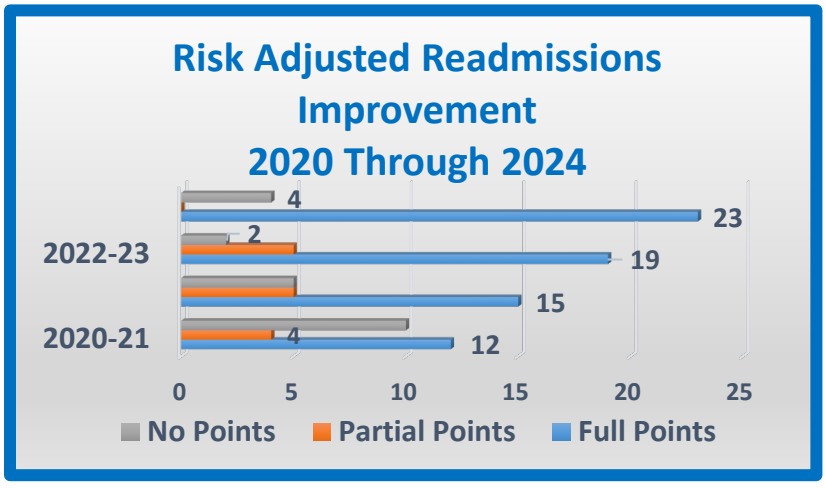
Goal #3: By January 31, 2025, complete evaluation of the 2023-24 HQIP and deliver summary to the Partnership Quality Committee meetings (IQI, QUAC, PAC).

Annually, the HQIP compiles a year-end evaluation utilizing performance relative to targets and performance points distributed by measure. The goal was completed in January 2025. This year's summary and presentation highlighted the addition of 6 new hospitals to the HQIP, as well as the continued increase in hospitals meeting the Risk Adjusted Readmissions measure.

The evaluation summary The evaluation summary included comparison scores from FY2022-23 and FY2023-24. Analysis showed that most of the decrease in scores was due to hospitals who did not meet the Health Equity measure, while increases were due to improved Risk Adjusted Readmission rates, and improved HQI Platform participation. Other notable performances included 15 hospitals earning Top Performer Status of greater than 90%, which included Tahoe Forest Hospital, a first-time participant from the geographic expansion region.

It was determined that the CAIR Utilization measure could be removed due to consistent high performance. The evaluation suggested that other measure targets could be increased in FY2025-26 to encourage continued quality improvement. Most hospitals improved scores in the RAR and Cal Hospital Compare measures.

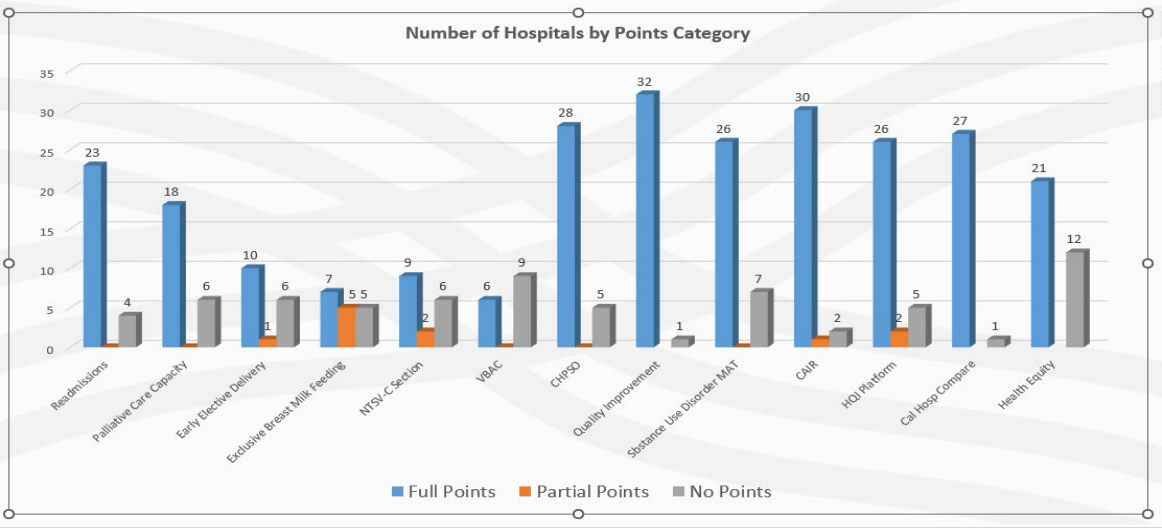
Chart: Risk Adjusted Readmissions Improvement



The FY2024-25 evaluation demonstrated the significant improvement hospitals have continued to make in Risk Adjusted Readmissions scores over the past three measurement years with a 12% positive increase of hospitals earning full points for RAR in 23/24 MY over 22/23 MY. In the 2024-25 measurement set, small hospitals were not held accountable to RAR, therefore rates next year may look different.

The chart below shows the count of hospitals falling into full, partial, and no points categories for each measure. Of note, 12 hospitals did not earn points for the Health Equity measure, which was due to many smaller hospitals not meeting reporting requirements. Several very small-size hospitals expressed their difficulty identifying a significant population with disparities to their overall low volume of patients.

Table: 2023-24 Performance Relative to Targets - Point Distribution by Measure



Perinatal Quality Incentive Program

The Perinatal Quality Incentive Program (PQIP) is a pay-for-performance program offering financial incentives to participating Partnership Health Perinatal Services Program (PHPS), formerly Comprehensive Perinatal Service Program (CPSP) providers and select non-PHPS providers administering quality and timely prenatal and postpartum care to Partnership members.

Program Goals

The PQIP goals and activities outlined in the FY 2024-2025 QI Work Plan were completed and highlighted are below. These goals revolve around the development of the PQIP measurement set for the 2025-26 measurement year, continuing to support provider on-boarding and ECDS implementation to satisfy programmatic gateway measure (ECDS), and annual program evaluation. All three goals were met during the measurement period as noted below.

Completed Goals

Goal #1: 2025-26 Measurement Set Completion

Throughout the measurement period, particularly between January and May, work was completed on the development of the 2025-26 Perinatal QIP Measurement Set. The measure set was developed with direct input from Partnership Medical Directors, perinatal subject matter experts, program managers and feedback from perinatal providers. The PQIP measures tend to maintain a comprehensive yet simple measure set with the intent to improve HEDIS® performance among providers offering prenatal and postpartum services often occurring outside of a PCP visit. While the 2024-25 measure set incentivized providers to contract and connect with DataLink, the 2025-26 measurement set now includes a gateway measure requiring perinatal providers to contract and connect with DataLink an approved HEDIS data aggregator that Partnership is using for data extraction to help meet NCQA requirements for ECDS. The PQIP is also looking to the future in the area of comprehensive assessment. During

2025-26, the PQIP has added a measure to monitor timely prenatal comprehensive assessments. There are no incentives tied to this measure this year, but in future years it will likely be incentivized.

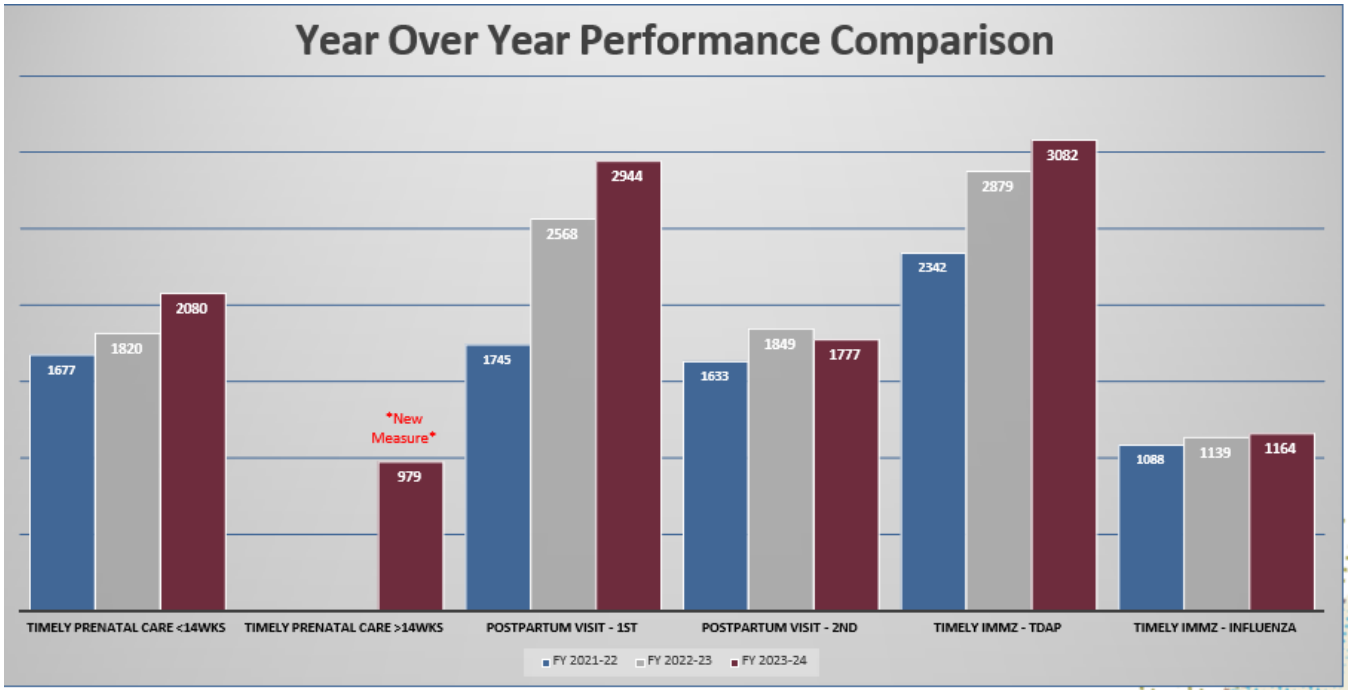
- Electronic Clinical Data System (ECDS) DataLink Implementation
- Timely Tdap and Influenza Vaccine
- Timely Prenatal Care
- Timely Postpartum Care
- Timely Comprehensive Assessments - Monitoring measure

Goal #2: By June 30, 2025, continue to support provider on-boarding and ECDS implementation to satisfy programmatic gateway measure (ECDS).

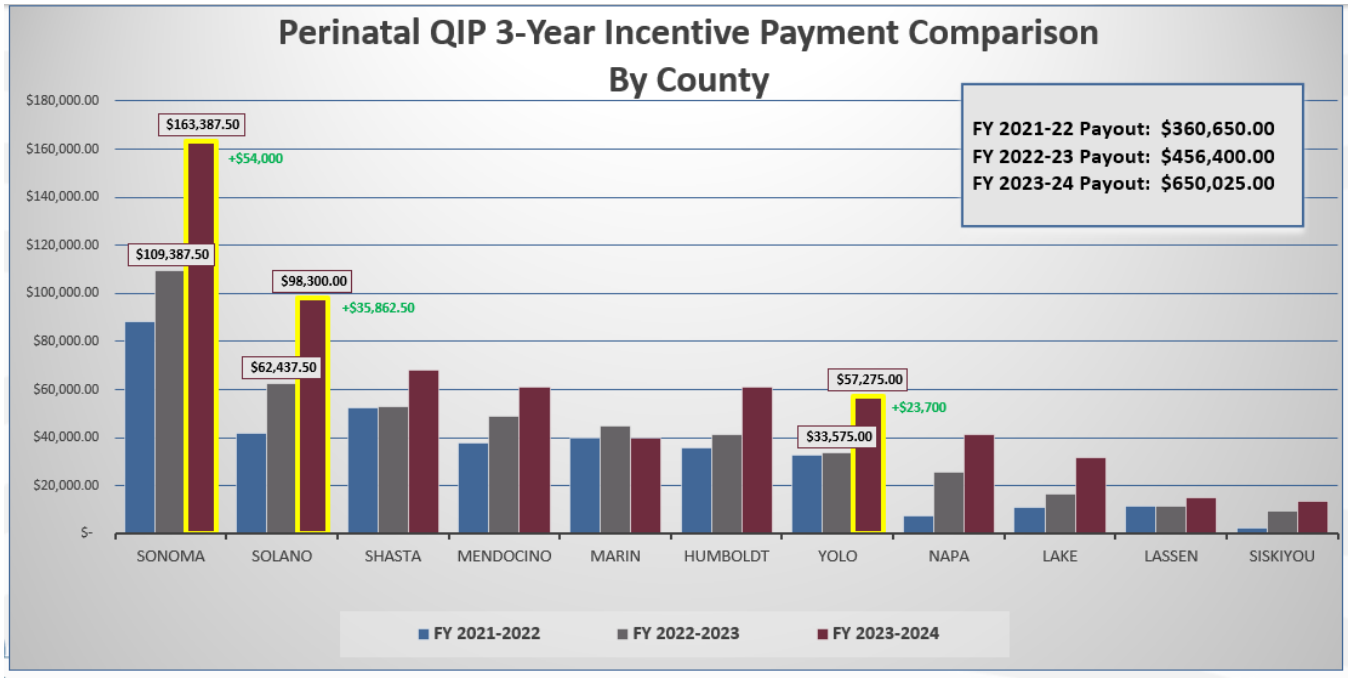
During the measurement year, the ECDS measure data collection process changed to include DataLink, an approved HEDIS Data Aggregator, as the vendor responsible for extracting data from participating provider Electronic Medical Records (EMR) vs. requiring providers to submit data via Partnership Secure File Transfer Protocol (sFTP) for use by the PHC HEDIS team. This process was newly outlined in the specifications for the Perinatal QIP and the PCP QIP with ground level support offered to all providers to coordinate DataLink contract completion, DataLink integration and data extraction. All contract and data extraction was expected to be completed by 12/31/2024 for Perinatal QIP providers to qualify for 2024/2025 ECDS incentive. There were 19 Parent Organizations who completed the contracting process and had successful data extractions. The goal is for the rest of the providers to complete the process in the 2025-26 measurement year.

Goal #3: By June 30, 2025, complete PQIP program evaluation for FY 23-24.

FY 2023-24 Program Evaluation was written in December 2024, and presented to IQI, QU/AC, and PAC in January 2025. The evaluation is a year-over-year measure comparison between the 2020-21 year through the 2023-24 measurement years. As seen in the first chart below, the program evaluation highlighted that most of the measures saw improvement over the previous two years, with the exception being a slight drop in the number of 2nd postpartum visits. There was an increase for Approved Timely Prenatal Visits and Tdap immunization counts. Contributing factors included: increased provider engagement, follow-ups and training with providers, and Partnership/provider workgroups focusing on improving overall perinatal performance.



The annual Perinatal QIP program evaluation included the three-year comparison of payment across 11 Partnership counties seen in the second chart below, which compares performance by county. All counties except Marin showed improved performance and an increase in overall incentive payments for this fiscal year. It's important to note that the number of participating clinics in 2022-23 and 2023-24 were nearly the same at 98 and 97, respectively. Therefore, the increase represents a true improvement in the number of visits, screenings and immunizations provided to our members.



Palliative Care Quality Incentive Program

In 2017, Partnership began a pay-for-performance program for Palliative Care Quality Improvement Program (PC QIP) providers. The Palliative Care QIP offers sizeable financial incentives to support and improve the quality of palliative care provided to Partnership members. In collaboration with Palliative Care providers, Partnership has developed a simple, meaningful measurement set to measure quality of care using two (2) measures: Avoiding hospitalization and emergency room visits, Completion of POLST (Physician Orders for Life-Sustaining Treatment), and Completion of Standardized PCQC Assessments and use of the Palliative Care Quality Collaborative (PCQC).

The PC QIP program goals and activities outlined in the FY 2024-2025 QI Work Plan were completed. Partnership conducted ongoing performance evaluation of the participants, continued to use the most meaningful and feasible measures available, offered technical assistance to providers throughout the year, tracked all submissions, validated them, and gave participants updates on their performance

The Palliative Care QIP runs on a calendar year, from January 1 – December 31. Providers are paid based on their performance during two (2) six-month measurement periods. In 2024, the program had 10 participants, and a total payout of $2,485,280. Major program activities during 2024 included: new participant outreach and onboarding; webinars, technical assistance, and program communications; work with providers to coordinate data validation and collection for the Palliative Care Quality Collaborative (PCQC) measure; work with analytics to coordinate data collection and validation for avoiding hospitalization and ED visits measure; and distribution of reports to providers.

In mid-February 2025, the Executive Director of Palliative Care Quality Collaborative (PCQC) notified the Palliative Care QIP team of the dissolution of PCQC due to lack of funding to maintain operations. PCQC officially closed their doors on April 17, 2025. In preparation, the Palliative Care QIP team met with PCQC leadership to secure final data needed for the 2024 measurement period II (July – December) payment processing. Providers were notified that March 15, 2025 was the last day to submit critical data via the PCQC platform,

Following PCQC's closure April 2, 2025, Palliative Care Clinician Workgroup meeting was repurposed as an advisory session to discuss the impact on data collection and explore ideas for replacing Measure III, which relied on PCQC assessments. Providers supported introducing a Palliative Care Patient Satisfaction survey as a replacement measure, development of the new measure is underway, with implementation targeted by late summer 2025.
Program strengths include an opportunity for Partnership to decrease utilization and improve quality of care provided to members, strong provider engagement, and connecting providers with useful quality monitoring resources such as PCQC.

Partly due to the aligned incentives of the Palliative Care QIP, the overall financial savings of this program has continued, and the data from PCQC have demonstrated the average performance better than other, non-Partnership palliative care programs.

Enhanced Care Management (ECM) Quality Incentive Program

The Enhanced Care Management Quality Incentive Program (ECM QIP) debuted on January 1, 2022. ECM is a statewide benefit which is part of the California Advancing and Innovating Medi-Cal (CalAIM) initiative organized by the Department of Health Care Services (DHCS). This pay-for-reporting program utilizes Incentive Payment Program (IPP) funds to incentivize providers to present Partnership with quality data tied to the timeliness of required ECM program reporting.

ECM QIP measures are developed based on DHCS directives as well as through collaboration with internal and external stakeholders. ECM data is captured through provider submitted reports and templates, and internal TAR data captured and sorted administratively.

The program's measurement set for the 2024-2025 measurement periods include:

- Timely Reporting (Gateway Measure)
- ECM Care Plans and Release of Information (ROI) Forms uploaded into PointClickCare (PCC)
- PHQ-9 Depression Screening
- Blood Pressure Screening
- Timely Review of ED/Admissions Notifications in PointClickCare

The ECM QIP program goals and activities outlined in the 2024-2025 FY QI Work Plan were completed. . With contribution from the CalAIM/ECM Team, program activities included:

- Ongoing provider outreach and onboarding through annual kick-off webinar and one-on-one virtual meetings
- Clear and concise program communications to share program changes, best practices and measure deadline reminders
- Quarterly measure auditing and scoring, incentive payment calculation and final payment distribution
- Successful collaboration with the CalAIM/ECM Team

The ECM QIP runs on a calendar year, from January 1 – December 31, and ECM contracted providers are automatically enrolled anytime throughout the measurement year. All ECM providers are paid quarterly. The 2024 measurement year included 155 participating provider sites with 124 provider sites earning $5.1 million. This represents an increase of $3.2 million compared to $1.9 million earned by 74 provider sites in the 2023 measurement year.

Program strengths include an opportunity for Partnership to improve quality of care provided to members and encourage provider engagement. Continued data collection will support potential future quality measures for this program.

Long-Term Care Quality Assurance Performance Improvement (QAPI) Monitoring

In 2016, Partnership began a value-based performance program targeting long-term care facilities. The Long-Term Care (LTC) QIP was designed to offer sizeable financial incentives to support and improve the quality of long-term care provided to Partnership members. On December 31, 2023, the LTC QIP was sunset due to the implementation of the State's Workforce & Quality Incentive Program (WQIP).

Assembly Bill 186 (Chapter 46, Statutes of 2022), Nursing Facility Financing Reform, amended the Medi-Cal Long-Term Reimbursement Act to reform the financing methodology applicable to subacute care facilities and intermediate care facilities. The finance methodology authorized the implementation of three (3) major programs, one (1) of which was the Workforce & Quality Incentive Program (WQIP). As a part of the implementation of the State's WQIP, guidance released under *APL 24-009: Skilled Nursing Facilities –LTC Benefit Standardization & Transition of Members to Managed Care* created a requirement for managed care plans (MCPs) to be responsible for maintaining a comprehensive Quality Assurance Performance Improvement (QAPI) program for LTC services provided. MCPs must also have a system in place to collect quality assurance and improvement findings from CDPH. MCPs are also required to annually submit QAPI program reports with outcomes and trending data as specified by DHCS.

There are five (5) mandatory elements that an MCPs QAPI program must incorporate. Partnership has developed a framework to demonstrate fulfillment of the LTC QAPI plan requirements as outlined in APL 24-009and is monitoring QAPIs for each of the five (5) DHCS require QAPI elements:

Element 1: Design and Scope
Element 2: Governance and Leadership
Element 3: Feedback, Data Systems and Monitoring
Element 4: Performance Improvement Projects (PIPs)
Element 5: Systematic Analysis and Systemic Action

Working with the Partnership Long Term Support Services (LTSS) Liaison, we continuously work to obtain evidence of QAPI programs currently in effect at each contracted LTC facility. To support this effort, the Partnership Quality Improvement team works with the LTSS Liaison and newly formed Skilled Nursing Facility (SNF) Quality Workgroup to design and maintain a documented Managed Care Plan (MCP) LTC QAPI Program. The Quality Improvement team supports the LTSS Liaison in completing any requested secondary reviews of QAPI attestations determined to be insufficient or incomplete regarding the required Five (5) Key Elements identified by CMS and required for MCP monitoring by DHCS. QAPI deficiencies are tracked internally by the LTSS Liaison and key findings are used as education opportunities during LTC provider luncheons and on-site training with the goal of improving the quality of LTC facilities' QAPI programs.

The Partnership LTSS Liaison also serves as a primary contact for facilities with questions or concerns in post-acute and extended care settings by assisting with TAR processing, claims, grievances, appeals, contracting and many other issues. The addition of the LTSS team and the LTSS Liaison have added increased support to facilities to help them meet designated goals within their QAPI plans.

D-SNP Quality Incentive Program

The Dual Eligible Special Needs (D-SNP) Quality Incentive Program (QIP) is a pay-for-performance program set to launch in parallel with Partnership Advantage. The D-SNP program offers financial incentives to support and improve the quality of our Partnership Advantage members. The program focuses on rewarding high performing providers, 3 STARs and above, that meet our proposed measure set and our Medicare STAR performance metrics. The D-SNP program will roll-out in eight (8) Partnership counties initially and as we continue to refine the D-SNP QIP more counties will be added.

D-SNP QIP measures closely mirror the PCP QIP measure set with the intention of promoting provider familiarity and with the addition of measures reflecting D-SNP enrollee needs. Our quality metric alignment measures are Breast Cancer Screening, Colorectal Cancer Screening, Eye Exam for Patient with Diabetes, Diabetes Care - Blood Sugar Controlled, Controlling Blood Pressure, Statin therapy for Patients with Cardiovascular Disease, and Annual Wellness Visits. D-SNP QIP measures are weighted using CMS metrics and provide flexibility in measure weighting; permitting Partnership to adjust throughout the year to target performance gains where needed.

The review of our current QIP systems show there is more advanced technology available in today's vendor market, offering a higher level of support and responsiveness than what we currently offer in our Medi-Cal QIPs. A new technology system will provide our clinicians with better structure for incentives by offering user-friendly support and a more responsive QIP overall. The D-SNP QIP program will be contracting with a system vendor to perform and maintain payment and performance tracking for the D-SNP QIP.

Our selected system vendor is able to provide payment calculations and offer direct payment to our providers, if needed. The D-SNP program will run on a calendar year, from January 1- December 31st and our contracted D-SNP providers are able to utilize our contracted vendor system starting day one (1) of go-live.

Year 1 Program Focus

Partnership's expansion into Medicare provides the D-SNP QIP team an opportunity to connect with newly contracted Medicare providers and engage them in the D-SNP QIP. In collaboration with our Quality colleagues and Medical Directors, the D-SNP QIP will offer traditional QIP programmatic offerings such as Kick Off webinars, newsletters, provider check-ins and any other support needed in the introductory year of this program,

Member Safety and Quality Compliance Activities

QI TRILOGY

Member Safety and Quality Compliance Activities

Quality Assurance and Member Safety activities include investigation of Potential Quality Issues (PQIs), Site Reviews (including facility site and medical record reviews), Physical Accessibility Review Surveys (PARS) (which assess the level of physical accessibility of provider sites including specialist and ancillary providers that serve a high volume of seniors and persons with disabilities), and monitoring Initial Health Appointment (IHA) rates.

Potential Quality Issues

A PQI is defined as a possible adverse variation from expected clinician performance, clinical care, or outcome of care which requires further investigation to determine whether an actual quality of care concern or opportunity for improvement exists. The PQI investigation and Peer Review process provide a systematic method for the identification, reporting, and processing of a PQI to determine opportunities for improvement in the provision of care and services to Partnership members and to direct appropriate actions for improvement based upon outcome, risk, frequency, and severity. Actions include sending letters with recommendations, issuing Corrective Action Plans (CAP), Focused Reviews, and referral to the Credentials Committee or other oversight entities.

Partnership identifies PQIs through the systematic review of a variety of data sources, including but not limited to: 1) Grievances and Appeals; 2) UM (utilization review); 3) Claims and encounter data; 4) Care Coordination; 5) Medical Record Review; 6) Referrals from other health plan staff, providers and members of the community; 7) HEDIS® medical record abstraction process; and 7) Facility and Medical Record Site Reviews.

The top three (3) referral sources were Grievance and Appeals, Utilization Management and referrals from Partnership Medical Directors. The rest of the PQI cases were referred by other sources such as the Care Coordination Pharmacy departments, and external providers. The top three (3) Referral Types were Assessment/Treatment/Diagnosis, Continuity of Care, and Communication. The top three (3) Provider Types were Primary Care Provider (PCP), Hospital/ER, and Specialist.

Table: A

Region-wide Report (includes expansion region, as of 2024	2023		Grand Total	2024		Grand Total
PQI Referral Rate, Count and Membership	Q1/Q2	Q3/Q4		Q1/Q2	Q3/Q4	
PQI Count	116	111	227	97	150	247
Members Months	4,944,385	4,216,811	8,493,104	5,932,733	5,684,834	11,470,123
Rate per 1,000 Members	0.28	0.32	0.32	0.20	0.32	0.26

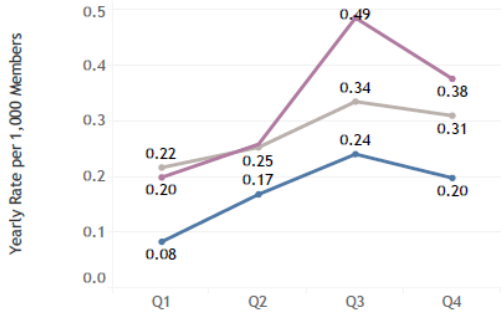
Table: B

Potential Quality Issues
Referral Dates: 2024

PQI Rate, Count and Membership

	EASTERN	NORTHERN	SOUTHERN	Grand Total
Member Months	3,411,853	2,589,914	5,468,356	11,470,123
PQI Count	49	71	127	247
Yearly Rate per 1,000 Members	0.17	0.33	0.28	0.26

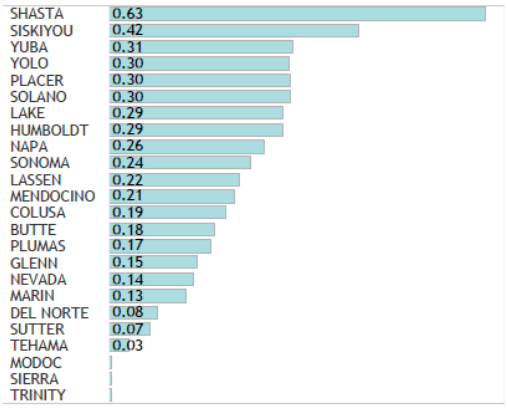
Trend of PQI Rate



Count, Membership and Rate per 1,000 Members by County

Mbr County	Member Months	PQI Count	Yearly Rate per 1,000 Members
SHASTA	862,345	45	0.63
SISKIYOU	230,895	8	0.42
YUBA	432,356	11	0.31
YOLO	643,601	16	0.30
PLACER	716,269	18	0.30
SOLANO	1,674,441	42	0.30
LAKE	415,501	10	0.29
HUMBOLDT	750,672	18	0.29
NAPA	324,264	7	0.26
SONOMA	1,327,491	26	0.24
LASSEN	111,425	2	0.22
MENDOCINO	522,451	9	0.21
COLUSA	124,258	2	0.19
BUTTE	1,026,586	15	0.18
PLUMAS	71,119	1	0.17
GLENN	164,285	2	0.15
NEVADA	342,782	4	0.14
MARIN	560,607	6	0.13
DEL NORTE	149,155	1	0.08
SUTTER	523,801	3	0.07
TEHAMA	369,178	1	0.03
TRINITY	66,483		
SIERRA	10,397		
MODOC	49,761		

PQI Rate per 1,000 Members by County



Yearly Rate per 1,000 is defined as: [(Number of PQIs)/(Membermonths)]*12,000
Created by: Liat Vaisenberg (lvaisenberg@partnershiphp.org)

As illustrated in the preceding tables A & B, in 2024, 247 cases were referred for PQI investigation compared to 128 in 2020, 113 in 2021, 156 in 2022, and 227 in 2023. As expected, PQIs case referrals increased as a result of the expansion to 10 additional counties in January 2024. There was an 8% increase in PQI case referrals in 2024 compared to 2023. Cases from the expansion region accounted for 49 (20%) of the 247 cases referred. A total of 207 cases were processed and closed to completion compared to 151 in 2020, 126 in 2021, 156 in 2022, and 235 in 2023. Closed cases included seven (7) Provider Preventable Conditions (PPC). Providers must report potential PPCs directly via online reporting to the DHCS Audits & Investigation Unit (A&I) after discovery of the event and confirmation that the patient is a Medi-Cal beneficiary.

In accordance with Partnership policy, cases score as P2 or P3 or S2 or S3 (refer to the grid below: *Assignment of Practitioner Performance and Systems Scores), by the CMO/physician designee during the internal weekly PQI rounds,* are reviewed by Partnership's Peer Review Committee (PRC) to determine what actions on the part of the health plan are indicated. A total of 16 cases were reviewed by the PRC in 2024. Assignment of practitioner performance and system scores are based on the reviewed medical records, responses from the facility or provider, other information submitted by the provider, independent Subject Matter Expert reviews, and additional supporting documentation as needed to thoroughly review the case.

A PQI may involve both a practitioner performance issue and system issue. In addition, some cases involve multiple providers who are scored individually. Physician oversight of the PQI/Peer Review process includes weekly PQI rounds attended by an internal team consisting of the Medical Director for Quality, Regional Medical Directors, Associate Medical Directors, the Behavioral Health Clinical Director, a Clinical Pharmacist, the Manager of Member Safety Quality Investigations, the RN Quality Investigators, some RN Clinical Compliance Inspectors, and the Project Coordinator. In addition to the internal PQI team, the PRC committee is comprised of external primary cre physicians and specialists who are currently practicing in hospitals, clinics, and medical groups within the Partnership provider network. Cases with significant concerns are communicated to the Credential Committee at the recommendation of the PRC. Physician and nurse participation in PRC and PQI rounds, inclusive of Partnership medical directors and network providers from diverse specialties was sufficient to meet the requirements for reviewing and making determinations regarding PQIs. In January 2024, a Nurse Practitioner from a network provider facility joined the PRC and subsequently, the PRC policy was updated to include Non-Physician Medical Practitioners as voting members.

One of our main goals for the 2024-2025 growth and improvement strategy was our outreach program focusing on educating acute care hospitals on Provider Preventable Conditions (PPC) reporting to DHCS and Partnership. This is a continuation of our 2023-2024 goal. Four (4) in-service sessions were completed with hospital Quality Staff to ensure they are familiar with the reporting requirements via the DHCS secure online reporting portal. We published an article on PPCs in the Provider Relations Spring 2024 Provider Newsletter. We also conducted several PQI presentations to other internal departments at Partnership.

In an effort to standardize our processes, we implemented new processes, enhanced existing processes and updated our policies and procedures to be aligned with business operations, regulatory requirements, technological advancement and internal practices. By focusing on these key aspects, we increased our efficiency, reduced costs, and improved quality.

Assignment of Practitioner Performance and Systems Scores

Practitioner Performance Severity Scores		
P Score	**Definition**	**Action/Follow-up**
P0	Care is appropriate.	No action required.
P1	Minor opportunity for improvement. Potential for or actual, minor adverse outcome to member.	The reviewer will send a letter and/or secure email to the provider. Response may or may not be required.
P2	Moderate opportunity for improvement and/or care deemed inappropriate. Potential for minor or moderate adverse outcome to member.	Send a certified letter and/or secure email to provider of concern, requiring a response. May impose a CAP and/or other interventions.
P3	Significant opportunity for improvement and/or care deemed inappropriate. Potential for significant adverse outcome to member.	ASAP communication by certified letter, secure email and/or direct phone call to the provider of concern requiring a response. Requires a CAP and/or other interventions. May be referred to

Practitioner Performance Severity Scores		
P Score	**Definition**	**Action/Follow-up**
		the Credentials Committee with recommendations from the PRC.
PUTD	Use whenever the PQI cannot be leveled prior to referral to the Peer Review Organization (PRO) of the Facility of Concern (FOC) or the Provider of Concern (POC).	Referral to the Peer Review Organization (PRO) of the Facility of Concern (FOC) or the Provider of Concern (POC). If none identified, it may be through direct contact with the management of the FOC or with oversight of the POC. Refer to the appropriate licensing entity, if indicated.

System Issue Severity Scores		
S Score	**Definition**	**Action/Follow-up**
S0	No system issue.	No action required.
S1	Minor opportunity for improvement. Potential for or actual, minor adverse outcome to member.	The reviewer will send a letter and/or secure email to the provider. Response may or may not be required.
S2	Moderate opportunity for improvement and/or care deemed inappropriate. Potential for or actual minor or moderate adverse outcome to member,	Send a certified letter and/or secure email to the provider of concern, requiring a response. May impose a CAP and/or other interventions.
S3	Significant opportunity for improvement and/or care deemed inappropriate. Potential for or actual significant adverse outcome to member.	ASAP communication by a certified letter, secure email and/or direct phone call to FOC/POC, requiring a response. Requires a CAP and/or other interventions. May be referred to the Credentials Committee with recommendations from the PRC.
SUTD	Use whenever the PQI cannot be leveled prior to referral to the Peer Review Organization (PRO) of the Facility of Concern (FOC) or the System of Concern (SOC).	Referral to the PRO of the FOC or the System of Concern (SOC). If none identified, it may require direct contact with the management of the FOC or with oversight of the SOC. Refer to the appropriate licensing entity, if indicated.

Site Reviews

Partnership conducts Site Reviews to ensure that primary care providers have the capacity to maintain member safety standards and practices. Each PCP site is required to pass an Initial Facility Site Review prior to joining Partnership's network. Site Reviews are conducted, at least every three (3) years. DHCS requires that a DHCS Certified Site Reviewer (Registered Nurse) conduct these reviews. Since April 2024, Partnership has maintained two (2) Master Trainers on the Inspections Team along with seven (7) Certified Site Reviewers (CSR). Partnership follows standards and guidelines outlined in APL 22-017 as it was issued on September 2, 2022 and revised September 9, 2022.

DHCS issued updated Facility Site Review (FSR) and Medical Record Review (MRR) Tools that went live on July 1, 2022. Effective July 1, 2022 providers were scored on the newest tools (2022 Version). DHCS later released updated FSR/MRR tools (2024 Version) with additional requirements that were implemented on January 1, 2024 as required. Any additional DHCS updates are disseminated to site review nurses and primary care providers as they are published.

Currently, Partnership continues to educate sites on the 2024 FSR/MRR Tools to assist sites in understanding the new requirements. Best practices are shared with sites to help drive improvement. Education is provided onsite during the exit interview process of site reviews and is additionally offered as separate educational sessions to all sites. Each site receives an educational packet during the exit interview that consists of information such as: Initial Health Appointment (IHA), Adverse Childhood Experiences (ACES)/Developmental Screening, Blood Lead Testing, Interpretive Services, CalAIM Enhanced Case Management (ECM), Doula Services, Telemed Program, Medical Equipment Distribution, Transportation Benefits, and Potential Quality Issues (PQI).

Certified Site Reviewers address areas identified from the review tool that do not meet the DHCS guidelines at the time of discovery during the Site Review. Partnership nurses also use this time to provide educational feedback to provider staff (i.e., handouts on TB risk assessments, reviewing IHA/Blood Lead Screening [BLS] and any other identified problem areas faced by the provider). For some areas, as required by the Site Review APL, corrective action plans (CAPs) are issued to the provider. If the site is issued a Critical Element corrective action plan (CE CAP), the site is scheduled to have a virtual CE verification with a nurse to validate all CE's were corrected appropriately. An interim assessment is also conducted at the halfway point between periodic reviews. The interim assessment addresses all Critical Elements and any additional CAP criteria from the sites last review (if applicable). Sites are supported throughout the entire CAP process to ensure site success.

Facility Site Reviews

Reviews completed from 7/1/2024-5/19/2025

Overall, the Facility Site Review domain scores remained very high in 2024. There are some areas in need of improvement. Through the Facility Site Review process, Partnership identified and communicated to providers where specific improvement is needed, with the following areas commonly cited:

- Emergency Medications and Dosage Chart
- Documentation of education/training for Non-Licensed Medical Personnel is maintained on site
- Eye Charts
- PPE in rooms with autoclaving
- Non-Safety Needles
- Spore Testing Monthly
- Management of a positive spore test

FSR Performance	2022-2023	2023-2024	2024-2025
Access & Safety	95%	96%	96%
Personnel	92%	94%	93%
Office Management	98%	98%	98%

Clinical Services	97%	98%	99%
Preventive Services	97%	99%	97%
Infection Control	95%	98%	98%

Medical Record Reviews

Reviews completed from 7/1/2024-5/19/2025

Format and documentation domain scores for the Medical Record Review (MRR) remained fairly high – within the 90th percentile range. The number of Adult and Pediatric Preventative measures were greatly increased with the release of the 2022 and 2024 MRR Tools. Partnership has been working with sites to understand the new guidelines and where specific improvement is needed.

Areas for improvement:

- All entries are signed, dated, and legible
- Member Risks Assessment/Subsequent Risk Assessment (IHA)
- Certified Screening Tools
- Advance Healthcare Directive
- All Preventative Healthcare Measures

MRR Performance	2022-2023	2023-2024	2024-2025
Format	97%	98%	98%
Documentation	94%	93%	94%
Coordination of Care	97%	96%	98%
Pediatric Preventive	81%	81%	80%
Adult Preventive	77%	76%	72%
OB Preventive	97%	90%	89%

Provider Billing Guide

As part of the FY 22/23 Department SMART Goals, the Inspections Team joined with the Claims Team to create a new provider billing guide to assist sites in correctly coding for preventative services. The guide covers Adult and Pediatric preventative services. The billing guide lists the preventative services from the Medical Record Review (MRR) Site Review tool and includes demographics along with the corresponding billing codes. By supporting providers to use the proper billing codes, providers will be able to better demonstrate completion of preventative services required by quality measures and the DHCS Site Review Tools. PCP sites and OB sites are provided with laminated copies of this guide at the Site Review exit interview. (Providers have given us positive feedback and have asked for additional copies of the billing guides to assist their site in better billing practices). Partnership continues to utilize this tool and updates the document quarterly or as needed.

Provider Educational Trainings

Site review measures correspond to priority quality measures defined under the DHCS Managed Care Accountability Set (MCAS) as well as those required for reporting and scoring under NCQA Health Plan Accreditation. Providers are encouraged to engage in educational sessions to drive improvement throughout the communities they serve. Partnership offers educational sessions as needed to our provider network through various forums.

Providers are offered one-to-one educational training sessions with a Certified Site Review Nurse (CSR RN) at every Site Review. Education is provided as requested. Educational offerings are provided through multiple forums such as provider newsletters, the Partnership website and regional meetings. Trainings are tailored to each specific site to assist sites with overcoming barriers and to provide best practices.

In anticipation to the new Site Review tools, Partnership emailed and offered education to PCP offices focusing on the new 2022 and 2024 Site Review Tool changes as well as the Initial Health Appointment (IHA) and Blood Lead Screening. This is in addition to the education provided at every Site Review exit interview. Partnership will continue to offer one-to-one educational sessions to sites to help support our provider network to be successful.

In anticipation of the sunset of the Child Health and Disability Prevention (CHDP) Program, Partnership has taken on the responsibility of training providers and staff on CHILD (Comprehensive Health Interventions for Lifelong Development) trainings, rebranding CHDP. As of May 2024, Partnership has been offering CHILD trainings to primary care provider (PCP) offices. Training topics include hearing and vision screening, anthropometric measurements, BMI calculation, fluoride varnish application, and immunizations, all in alignment with the DHCS CHDP Transition Plan. PowerPoint training materials were developed using CHDP references provided by the California Department of Health Care Services (DHCS) and in collaboration with CHDP offices across the counties served by Partnership. We currently offer training via Webex with an education specialist or through videos that are available on our website.

We have added an additional role to the Inspections Team: Quality Training Specialist and Dental Liaison. This position is responsible for delivering provider education such as the above-mentioned CHILD trainings.

This role also serves providers as Partnership's designated Dental Liaison. As Dental Liaison, this position is responsible for collaborating with providers, internal departments, and other stakeholders to identify process improvements and other improvement activities for enhancing the quality of dental and oral health care our members received. This position maintains current knowledge of related benefit changes from the Department of Health Care Services and standards of care to help improve member health status and quality outcomes while establishing a positive provider experience and rapport.

Improving Blood Lead Screening

Consistent with APL 20-016, Partnership's Facility Site Review (FSR) and Performance Improvement Teams have regularly educated providers on Blood Lead Screening (BLS) and anticipatory guidance for all children ages 6 months to 6 years. Partnership was able to collaborate with some Partnership network county Public Health offices

in order to better support our communities in increasing awareness and testing for Blood Lead. This is an ongoing relationship.

As of May 2023, the Inspections Team (Site Review Team) was able to work with Provider Relations (PR) and join their Operational meetings between Partnership and clinics. These customized meetings with providers and practice staff allow for direct interaction with Partnership staff from multiple departments. They provide a forum for Partnership to present updates on specific topics, review identified gaps in care and to field questions directly from providers about various topics of concern. The Inspections Team is now presenting on BLS and the Initial Health Appointment (IHA) during these meetings.

Blood Lead Screening flyers are given as part of an educational packet at every Site Review. Education is provided 1:1 while on-site during the Site Review exit interview process. Formal education is also offered through various avenues such as provider newsletters, member facing newsletters, webinars, Regional Directors Forums, Partnership's website, etc. Providers receive quarterly lists of members eligible for BLS testing with the expectation they will contact and schedule members to receive the required services they are due for. BLS testing is monitored through the medical record review (MRR) process.

Member Engagement:
Members also receive notifications and reminders through various sources such as member newsletters, Partnership's member website, mailings, community events, etc. Partnership has multiple member programs such as "Growing Together" prenatal and postpartum programs, "Healthy Toddlers and Healthy Kids- Growing Together." These programs help create awareness on multiple topics including blood lead screening.

Physical Accessibility Review Survey

(PARS), aka Part C Review

The purpose of the Physical Accessibility Review Survey (PARS) is to assess provider sites' physical accessibility for Partnership's seniors and persons with disabilities (SPDs) using a set of standards approved by DHCS. Results from the reviews are made available to Partnership's members through its website and provider directories. The findings of these reviews are informational only. Providers are designated as having either "Basic Access" or "Limited Access."

- Basic Access: Indicates that the facility met all 29 critical elements that identify a site's capability of accommodating SPDs
- Limited Access: Indicates that the facility does not meet one (1) or more critical element related to the six (6) indicators listed below:
  - Parking
  - Interior Building
  - Exterior Building
  - Restroom
  - Exam Room
  - Medical Equipment
- Medical Equipment Access: PCP sites only. Demonstrates if a site has a height adjustable exam table and patient accessible weight scales per guidelines (for wheelchair/scooter plus patient)

PARS Results for PCP and Specialist Offices July 1, 2024-May 23, 2025

Count of PARS-Level	OB	PCP	Spec	Grand Total
Basic	2	72	6	80
Limited	8	82	5	95
Grand Total	10	154	11	175

Initial Health Appointment

In FY 2024/25, Partnership continued its efforts to support and monitor compliance against DHCS requirements for the Initial Health Appointment (IHA). The DHCS contract mandates that each new member receive an IHA within 120 days of enrollment in the health plan. The IHA includes a comprehensive history of the member's physical and mental health, identification of risks, an assessment of needed preventive screenings or services and health education, and development of any necessary diagnosis or treatment plan.

Effective January 1, 2024, one additional requirement was added to the Initial Health Appointment. Now, along with the completion of a history and physical within 120 days of enrollment, providers are required to complete a Member Risk Assessment as part of the IHA.

The initial Member Risk Assessment identifies health and social needs of members including cultural, linguistic, and health education needs; health disparities and inequities; lack of coverage/access to care; and social drivers of health (SDOH).An assessment of at least one of the following risk assessment domains meets the standard:

- *Social Determinants of Health (SDOH):* The conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Examples of SDOH include housing instability, food insecurity, transportation needs, utility needs, interpersonal safety, etc. Documented assessments of SDOH in the progress notes or use of an SDOH screening tool meet the standard (ex: Social Needs Screening Tool).
- *Adverse Childhood Experiences (ACEs)* (birth to 64 years old): Potentially traumatic experiences, such as neglect, experiencing or witnessing violence, having a family member attempt or die by suicide, household with substance use problems, mental health problems and other experiences that occur in childhood that can affect individuals for years and impact their life opportunities. Examples of validated screening tools that meet the standards include:
  - The Pediatric ACEs and Related Life-Events Screener (PEARLS), used to screen children and adolescents ages 0-19 for ACEs
  - The ACE Questionnaire for Adults, used to screen adults 18 years and older for ACEs
- *Cognitive Health Assessment*

A Subsequent Risk Assessment shall be completed annually, or more frequently, if any significant changes in health status are identified. This consists of at least one (1) of the risk assessment domains listed above.

Performance and Oversight Activities (FY 2024/2025)
Partnership focused on strengthening provider education, outreach and monitoring.

- Continued provider education through newsletters, regional meetings, site reviews and exit interviews
- Monitored IHA compliance via the medical record review process and site reviews, providing targeted feedback and support
- Enhanced outreach strategies by encouraging providers to regularly access lists of newly enrolled members via the provider portal and to proactively schedule IHA appointments
  Provided members with IHA reminder through new member packets, letter, and the Wellcare Guide.

Internal and external QI committees review the results of completed Site Reviews, including the review of IHA compliance, at least annually. This allows an opportunity to provide constructive feedback regarding the existing processes.

Partnership is currently working on strengthening our internal data analysis by reviewing coding and reporting procedures. This has proven to be a large task and continues to be a topic of discussion.

Recognizing the challenges in achieving high rate of success in this measure, Partnership continues efforts to influence performance on a provider-by-provider basis through the site review process.

Improvement Activities

Efforts Made During Site Reviews:

a. Sites receive a monthly reminder to outreach to their new members and are educated to document their outreach attempts to new members. Partnership provides spreadsheets for the sites to document their efforts, as many sites do not wish to open a new chart before the member is actually located and establishes care. These spreadsheets are reviewed and discussed during the Site Reviews.

Miscellaneous Continuous Efforts:

a. A multi departmental collaborative meeting is held biannually to discuss IHA efforts and opportunities. Participating departments include: Quality, Claims, Provider Relations, Utilization Management, Care Coordination, Member Services, Population Health, and Regional Directors, as available.
b. Newsletter articles: Information continues to be shared through our Provider and Member Newsletters. These articles are available on the Partnership website.
c. IHA Provider education is available on the Partnership website including a webinar for Providers.
d. Newly credentialed providers are educated on the IHA requirement, and a new member packet is sent to members informing them of the importance of an IHA.
e. Member Services mails an initial letter encouraging members to schedule a PCP appointment and will remind members to schedule an IHA if the member calls Partnership.
f. Partnership currently contracts with a vendor to call all newly assigned members to complete Partnership mandated assessments along with recommending an IHA visit (tracked by Care Coordination). Partnership implemented a script change to add the statement “Reminder -Please contact your Primary Care Provider to schedule your important Initial Health Appointment within 90 days of becoming a Partnership member.”
g. Partnership has a “Healthy Growing Together” program and mailers/outreach goes out to babies from birth to 18 months with outbound calls and incentives. This activity particularly focuses on members newly enrolled with the plan, so it provides the opportunity to promote IHAs.

h. IHA is discussed at Operational Meetings with sites along with BLS (see BLS section for further details- page 108.

Delegation Oversight

Partnership's oversight of QI activities delegated to DHCS subcontractors/NCQA Delegates is reviewed and approved at least annually by the Delegation Oversight, IQI, and Q/UAC Committees. Designated leaders within the Member Safety team serve as primary reviewers of Carelon's QI program and distinct quality functions it carries out on behalf of Partnership. A delegation agreement, including a detailed list of delegated activities and reporting requirements, is mutually agreed upon by Partnership and the entity. Currently Partnership contracts with Carelon Behavioral Health (formerly known as Beacon Health Options) to administer non-specialty mental health consistent with NCQA standards.

Latent TB Infection – 12 Dose Treatment

The Pharmacy Department led an intervention to track, monitor, and evaluate member adherence to Latent Tuberculosis Infection (LTBI) treatment regimen. The goal was to create a Business Object Report utilizing Medi-Cal Rx Contractor pharmacy claims data whereby the health plan clinical pharmacist can timely and proactively identify members who are at risk of becoming non-adherent to their LTBI regimen. Prescribers are notified at Day 16 and Day 20 of members late on their refills and out of medication. The objective is to inform the prescribers so they can reach out to members to refill their medications before the adherence gap exceeds the CDC allowed gap which would requires the member to restart the regimen.

Since July 2023, a total of 148 notification letters were sent for identified treatment gaps from 314 members (28 members had two (2) or more treatment gap notifications sent to their prescribers). Of the 314 members, 120 members (~38%) completed a refill of their LTBI medications after the prescriber notification and 66 (~21%) completed their prescribed LTBI regimen by the recommended timeframe.

For notification timeliness, 84% of notifications were sent by Day 16 and 6% by Day 20. 10% were beyond Day 20 due to claim reversals, delay in confirmed LTBI diagnosis, or missed tracking.

The Day 16 and Day 20 notifications provide an opportunity for the prescriber to engage the member on continuing their LTBI regimen rather than being informed the member did not complete their regimen and would require a restart. Additionally, the monitoring to cover all LTBI regimens identified more treatment gaps, as well as provided an opportunity to educate prescribers and pharmacies on the different LTBI regimens and common mistakes that occur with prescribing and dispensing LTBI regimens. Lastly, we are working with county public health by sharing information on instances of LTBI treatment gap and collaborate with public health on improving LTBI treatment completion rates. Currently, we are sending our LTBI pharmacy claim information to public health officers of 7 counties.

As needed, the health plan pharmacy technician or clinical pharmacist will also contact the dispensing pharmacy to assist with coordinating Isoniazid and Rifapentine refills or identified inappropriate dispensing. The clinical pharmacist will continue to track LTBI therapy gap and non-adherence as well as validate pharmacy claim data from Medi-Cal Rx. Partnership continues to advocate to the California Department of Public Health (CDPH) for

consideration of an interface between the Medi-Cal Rx prescription data with CalREDIE, the health information and management system used by County Public Health departments and CDPH. If CDPH and Medi-Cal Rx can effectuate this interface, it will allow public health agencies to actively monitor, track, and trend LTBI detection and treatment.

Quality in Member Experience

QI TRILOGY

Care for Members with Complex Needs and Community Partnerships

Partnership HealthPlan of California is committed to supporting members with complex health and social needs through coordinated care, strong community partnerships, and focused quality improvement initiatives. During FY 2024-2025, these efforts centered on advancing equitable, high-quality care and improving member experience across our regions. This section highlights our work to enhance care for members with complex needs, including maternal and child health, complex case management, and transitions of care, to ensure services are safe, coordinated, and effective. It also describes our collaboration with counties and community organizations to expand provider capacity and strengthen local resources to improve access to care. In addition, it reflects our efforts under the CAHPS® / Member Experience Program, which evaluates member feedback to identify opportunities for improvement in access, service delivery, and overall satisfaction. Together, these initiatives demonstrate Partnership's ongoing commitment to addressing health disparities, improving outcomes, and enhancing the experience of care for the communities we serve.

Care for Members with Complex Needs

With the goal of improving HEDIS® rates for PPC-Pre, PPC-Post, W15, and to comply with California AB2193 (Maternal Mental Health Screening, 2018), Partnership's Population Health Department decided to review and revise the Growing Together Program by conducting an assessment that asks questions on a variety of topics, including social determinants of health and mental health. Efforts of this revision also consisted of continued focus on HEDIS® measures to support and reinforce maternal participation in prenatal and postpartum appointments, obtaining well-child exams for children within the first 15 months of life, and encourage members to take advantage of mental health services during and after pregnancy. Assessment tools were developed in 2021 to work with members who are progressing with a healthy pregnancy and well babies, and the team worked to improve early identification of pregnant women in 2022. Over the 24/25 fiscal year, the percentage of participation across programs is a follows: Prenatal 59.8% and Healthy Babies 64.7%*. When the team identifies a pregnant, postpartum, or baby that might need additional services, the team will submit a referral into Care Coordination for case management.

*All percentages are current as of May 21, 2025; date range is July 1, 2024-May 21,2025.

Complex Case Management

Partnership's Care Coordination (CC) Department has continued to monitor for any updates in Complex Case Management (CCM) activities to meet DHCS and NCQA requirements and strive for continuous compliance and improvement. The CC Department has been using the online NCQA Auditing Tool to keep track of CCM Cases. CCM Cases are continuously audited to ensure compliance with NCQA standards and to identify opportunities for additional training and tools to support the staff—primarily Nurse Case Managers and Social Workers—who conduct CCM assessments. We are collaborating closely to finalize our plan for the CCM Assessment in preparation for Jiva's go-live implementation. The CC Department recently had a mock audit with our NCQA Consultant in April 2025, and we are working on getting the necessary recommendations integrated in our current practices. Ongoing efforts are being made to ensure the assessment, audit tool, staff training, and any additional necessary activities are successfully completed to maintain continuous compliance with our CCM program. With the implementation of D-SNP, we are proactively ensuring that our CCM policy remains current and undergoes a

thorough review to maintain compliance and alignment with program requirements. The CC Department has decided to implement a CCM Close-Out Letter to be issued upon case closure, once all goals have been successfully met. We initiated the draft in May 2025 and are collaborating with the Communications Department to obtain the necessary approvals, ensuring the letter is finalized in time for Jiva's go-live. The CC Department is expanding with the addition of new Nurse Case Managers and Social Workers. To support their integration, CCM new hire trainings are conducted as needed, offering comprehensive guidance on program requirements to ensure staff proficiency and regulatory compliance. The department remains committed to maintaining survey readiness across the CCM program and services and continues to actively promote the CCM program to members.

Community Resource Web Pages

Partnership has recognized that community resources provide significant support to its member population and their health and well-being. In December 2018, Partnership's Population Health Team created web-based community resource pages that show the various resources available in each county by resource type. New resources are added to the existing pages as they are identified. The community resources pages are organized by county and use pictographs and titles to be mindful of readability and education-level, ensuring easy access for all literacy levels. Over the past year, the Population Health Team has partnered with Communications to add new resource pages for the 10 expansion counties and ensure they have all twenty-five categories available and populated. Additionally, in September 2024, the Population Health team launched a new category for all twenty-four counties – Tribal Health and Wellness. This resource category showcases resources that are specific to tribal communities or members of American Indian/Alaska Native (AI/AN) descent. The creation of this category is an acknowledgement of the unique health challenges faced by AI/AN communities and is also a step towards equitable healthcare but providing culturally relevant and easily accessible local resources. The Population Health Team validates all resources in each page no less than annually, and shares county resource page web links with providers, members, and community-based organizations to promote the programs and services offered within a member's community.

Services and Patient Experience

A vulnerable time for a member is when they are transitioning across settings. The Transitions of Care (TOC) Assessment/Survey was archived on April 21, 2025, following the revision and implementation of the Transitions of Care (TCS) Assessment/Survey, which replaced the TOC Assessment/Survey in Care Coordination. The Care Coordination Department continues to assist members in transitioning across different settings (hospital to home or other levels of care), across benefits (exhausting residential treatment service benefits for substance use disorder or transitioning from curative care to hospice care), or transitioning from pediatric to adult care. Members are often vulnerable to information loss across the care continuum, fragmented care, and challenges navigating the health care system. Case leads provide support by connecting members with outpatient resources, clarifying prescriptions, educating them on benefits and available services, and helping to establish or re-establish care with providers. The program-specific assessment is utilized to ensure all needs are effectively identified and addressed, preventing any gaps in support. Previous TOC reports in Care Coordination identified members that had been discharged from the hospital with a length of stay longer than five days, and complex members that were transitioning from pediatric to adult care. Daily TCS reports indicate members within any DHCS-defined High Risk TCS population who is transferring from one setting or level of care to another.) Members who have been identified and/or are part of Complex Case Management (CCM)/Enhanced Care Management (ECM) have their Transitional Care Services rendered by the same case manager.

As we transition to Jiva, we are ensuring the seamless integration of the TCS workflow. Moving forward, the TCS Assessment/Survey will fully replace the TOC Assessment/Survey. We remain committed to ensuring the accurate and timely completion of the TCS Assessment/Survey while continuing our efforts to provide comprehensive support to our members. There were 157 adult members who completed TOC services, and 155 completed Adult TOC Satisfaction Surveys between January 1 and December 31, 2024: a survey completion rate of 99%. The goal is at least 75% of members surveyed agree with the statement, which translates to an average score of 2.5 or greater for each response. The average score for each satisfaction measure exceeded the goal of at least 75% of members surveyed agreeing with each statement of the Adult TOC Satisfaction Survey. The average score ranged from the lowest at 2.64 to the highest at 2.98, which exceeds the goal average of 2.5. The results of the Adult TOC surveys and the many positive comments left reveal a high satisfaction rate among the members surveyed. Our adult members report good outcomes with this program, and we will continue providing this benefit under the TCS program.

Survey Questions	Average Response	Goal Met
I am satisfied with the case management program that has helped me manage my health issues.	2.97	Yes
I am confident in the abilities of the team members who contacted me; (the team could have included: health care guide, social worker, and/or nurse case manager)	2.98	Yes
My team referred me to medical and community resources that were valuable and helped me.	2.91	Yes
After working with the case management team, I feel my ability to manage my healthcare needs is better.	2.92	Yes
My health has improved since working with my case management team	2.71	Yes
I was able to safely transition between Providers with the help of my Care Team	2.78	Yes
The relationship that I have with the PCP and/or Specialist offices has improved since working with my case management team.	2.64	Yes
I was provided the available equipment, medication and/or services that were needed.	2.87	Yes

There were 62 pediatric members who completed TOC interventions, and 37 of them provided responses for the Pediatric TOC Satisfaction Surveys between January 1 and December 31, 2024: a response rate of 60%. The goal is at least 75% of members surveyed agree with the statement, which translates to an average score of 2.5 or greater for each response. The average score for each satisfaction measure exceeded the goal of at least 75% of members surveyed agreeing with each statement of the Pediatric TOC Satisfaction Survey. The average score ranged from the lowest at 2.58 to the highest at 2.95; well above the goal average of 2.5. The results of the Pediatric TOC surveys and the many positive comments left reveal a high satisfaction rate among the members surveyed. Families report

good outcomes with this program for our pediatric members, and we will continue providing this benefit under the TCS program.

Survey Questions	Average Response	Goal Met
I am satisfied with the case management program that has helped me manage my child's health issues.	2.86	Yes
I am confident in the abilities of the team members who contacted me; (the team could have included: health care guide, social worker, and/or nurse case manager).	2.92	Yes
My team referred me to medical and community resources that were valuable and helped me.	2.78	Yes
After working with the case management team, I feel my ability to manage my child's healthcare needs is better	2.76	Yes
My child's health has improved since working with our case management team	2.56	Yes
I was able to safely transition my child between Providers with the help of my Care Team.	2.69	Yes
The relationship that my child and I have with the PCP and/or Specialist offices has improved since working with our case management team.	2.58	Yes
My child and I were provided with the available equipment, medication and/or services that were needed.	2.95	Yes

There were 17 adult members who completed TCS services, and 16 completed Adult TCS Satisfaction Surveys between January 1 and May 27, 2025: a survey completion rate of 94%. The goal is at least 75% of members surveyed agree with the statement, which translates to an average score of 2.5 or greater for each response. The average score for each satisfaction measure exceeded the goal of at least 75% of members surveyed agreeing with each statement of the Adult TCS Satisfaction Survey. The average score ranged from the lowest at 2.50 to the highest at 3.00, which exceeds the goal average of 2.5. The results of the Adult TCS Surveys and the many positive comments left reveal a high satisfaction rate among the members surveyed. Our adult members report good outcomes with this program, and we will continue providing this benefit.

Survey Questions	Average Response	Goal Met
I am satisfied with the case management program that has helped me manage my health issues.	3.00	Yes
I am confident in the abilities of the team members who contacted me; (the team could have included: health care guide, social worker, and/or nurse case manager)	3.00	Yes
My team referred me to medical and community resources that were valuable and helped me.	2.88	Yes
After working with the case management team, I feel my ability to manage my healthcare needs is better.	2.75	Yes
My health has improved since working with my case management team	2.50	Yes
I was able to safely transition between Providers with the help of my Care Team	2.88	Yes
The relationship that I have with the PCP and/or Specialist offices has improved since working with my case management team.	2.63	Yes
I was provided the available equipment, medication and/or services that were needed.	2.69	Yes

There were two (2) pediatric members who completed TCS interventions, and two (2) of them provided responses for the Pediatric TCS Satisfaction Surveys between January 1 and May 27, 2025: a response rate of 100%. The goal is at least 75% of members surveyed agree with the statement, which translates to an average score of 2.5 or greater for each response. The average score for each satisfaction measure exceeded the goal of at least 75% of members surveyed agreeing with each statement of the Pediatric TCS Satisfaction Survey. The average score ranged from a low of 2.50 to a high of 3.00, both exceeding the target average of 2.5. The results of the Pediatric TCS Surveys and the many positive comments reveal a high satisfaction rate among the members surveyed. Families report good outcomes with this program for our pediatric members, and we will continue providing this benefit.

Survey Questions	Average Response	Goal Met
I am satisfied with the case management program that has helped me manage my child's health issues.	3.00	Yes
I am confident in the abilities of the team members who contacted me; (the team could have included: health care guide, social worker, and/or nurse case manager).	3.00	Yes
My team referred me to medical and community resources that were valuable and helped me.	3.00	Yes
After working with the case management team, I feel my ability to manage my child's healthcare needs is better	3.00	Yes
My child's health has improved since working with our case management team	3.00	Yes
I was able to safely transition my child between Providers with the help of my Care Team.	2.50	Yes
The relationship that my child and I have with the PCP and/or Specialist offices has improved since working with our case management team.	3.00	Yes
My child and I were provided with the available equipment, medication and/or services that were needed.	3.00	Yes

Access to Care

Annually, Partnership collects data from a variety of sources to evaluate all aspects of information related to Network Adequacy to ensure Partnership provides members with adequate network access for needed healthcare services. The provider types covered include primary care clinicians, medical specialists, pharmacies and hospitals. Partnership follows both the DHCS and NCQA requirements. A detailed analysis of access to care data is included in the Assessment of Access and Availability (NET 3) Grand Analysis Report. The following provides a preliminary high-level summary of the data available to date.

Analysis was conducted in collaboration between the Quality Improvement, Network Services, and Health Analytics Teams. Based on opportunities identified, interventions are defined, and measurable goals are set, to improve network adequacy.

The following access to care findings reflect information included for the calendar year 2024 in the 2025 Network Management Grand Analysis Report.

- **Member Grievances**

  For the reporting period of January 1, 2024 through December 31, 2024, Partnership did not meet the established goal of 2.47 grievances per 1,000 member threshold, having recorded 2.83 grievances per 1,000 members in 2024. This number represented an increase in grievances per 1,000 members when compared to the 2.25 grievances per 1,000 members in 2023. An increase in the total submission of grievances was to be expected due to the ten-county expansion Partnership undertook in 2024. A national shortage of healthcare workers combined with an aging provider population has contributed to ongoing access challenges; however, Partnership did experience a decrease in the percentage of access related grievances. In 2024, there were a total of 5,477 grievances submitted by our members and the analysis attributes 42% of all cases to access related issues. In comparison to the 2023 reporting period, there were a total of 3,572 grievances submitted by our members and the analysis attributes 43% of all cases to access related issues.

- **Member Appeals**

  For the reporting period of January 1, 2023 – December 31, 2023, as well as the reporting period of January 1, 2024 – December 2024, Partnership met the threshold of less than or equal to 0.57 per 1,000 members for access to care appeals and second level grievances. Partnership had 15 less total Appeals and Second Level Grievances in 2024 than in 2023 resulting in a decrease of 2%.

- **Out of Network (OON) Requests**

  For the period of January 2024 – December 2024, as a plan, Partnership met the goal of less than 20 per 1,000 members for referrals. Out of 5,916 OON Referral requests submitted in 2024, 3,803 were approved with equal distribution throughout the service regions.

  A deeper look shows that Modoc county failed to meet the threshold with 37.3 referrals per 1,000 members. Access in Modoc county is much harder due to rural terrain and a patient population that is typically too small for a specialist to maintain viable practices. Placer county had the highest number of referrals overall; however, the threshold was met at 18.7 per 1,000 members.

  The three specialties with the highest OON referrals included: Oncology/Hematology with 64.7% of approved referrals used, Dermatology with only 12.5% of approved referrals used, and Optometry with only 1.2% of approved referrals used. Of the 3,803 approved referrals plan-wide, 1,377 (36.2%) were used.

- **Practitioner Availability (Ratio and Geographic Availability)**
  - *Measured through the 2024 Network Adequacy Report Availability of Practitioners (NET 1, Element B, C).* Primary Care Practitioners overall, Family Practice, and Pediatrics all achieved a "met" score for number of practitioners to members for the reporting period. Partnership expanded into 10 new rural counties in 2024 and experienced a 38.8% increase in total membership compared to 2023. We have been able to maintain access to primary care for all ages by having a stable Family Medicine network. The Provider Recruitment Program provides incentives for Primary Care practitioners to join our network. Partnership is actively recruiting for all categories of Primary Care, specifically in our rural areas that traditionally have a lower number of providers.
  - The six (6) high volume specialties utilized by members remained unchanged from 2023 to 2024. The six (6) specialties include Obstetrics/Gynecology, Cardiology, General Surgery, Orthopedic,

Ophthalmology, and Dermatology. Plan-wide, the provider ratio standards and geographic distribution for all high-volume specialist providers were met. No plan-wide interventions are indicated.
  - Plan-wide, the provider ratio standards and geographic distribution for our high impact Oncology/Hematology specialty providers were met. No plan-wide interventions are indicated.

- **Practitioner Accessibility (Appointment Time Standard)**
  Measured through the 2024 Third Next Available Appointment Provider Survey
  - As a plan, one (1) of the four categories of primary care appointments fell below the established median 10-day appointment goal in 2024. Non-urgent adult primary care appointments fell short with a 6.7 decrease from 2023
  - As a plan, two (2) high-volume specialties fell below the established median 15-day appointment goal in 2024 as compared to three (3) in 2023. Dermatology fell short of the goal in both the southern and eastern regions. Obstetrics Gynecology fell short across all regions.

- **Member Experience**
  The 2022-2023 Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Composite Scores taken from the ME7 CAHPS® Results Report revealed the Adult Composite score for getting needed care and getting care quickly both had a slight decrease as compared to 2023. Both failed to meet the benchmark. In Year 2023-2024, we received 130 more complete surveys than in Year FY 2022-2023 giving us an increase in response rate of 1%. All questions met the 100 sample size criteria for both measurement periods. The CAHPS program raised the plan performance benchmark to the 33rd percentile from the 25th. The Child composite scores for both measures experienced a slight increase from 2023, however, both measures failed to meet the benchmark. In Year 2023-2024, we received 48 more complete surveys than in Year FY 2022-2023 giving us an increase in response rate of 1.2%. All questions met the 100 sample size criteria for both measurement periods. The CAHPS program raised the plan performance benchmark to the 33rd percentile from the 25th.

Member Services Access

The Member Services Department monitors and analyzes internal Call Center performance as well as the performance of our contracted delegates. Performance is based on Partnership's established service level(s) below:

- 80% of Calls Answered within 30 Seconds
- 30 Second Average Speed of Answer
- 10% or less Abandonment Rate

To monitor delegate performance, Partnership requires delegates to submit a monthly performance report in which Partnership tracks and trends results against the established service levels on a quarterly basis. Delegate performance is reported out through our Delegation Oversight Review Subcommittee (DORS). The delegates that are currently within Member Services' purview are Carenet, and Carelon. With that said, it is important to note that Carelon's Call Center function will transition in-house and no longer be delegated. While the transition date is still fluid, internal efforts are targeting Fall 2025.

At the department level, Member Services also track quarterly delegate Call Center performance through inter/intradepartmental collaboration and reporting.

Additionally, the Carenet/Partnership Joint Operations Quarterly meeting provides an open forum for both entities to collaborate and discuss areas of opportunities. Carenet's participation and efforts in this collaboration have led to continued progress around sustaining service level standards memorialized through their respective Master Service Agreement.

Opportunities for Improvement

Partnership operates in a broad service area encompassing urban, suburban, and rural settings. Partnership's provider network is challenged by a national shortage of providers, competition from other entities, and an aging provider community. Because of this, Partnership has developed a multi-pronged approach to recruit and retain providers.

Activities to Improve Access

Opportunity

Increase the number of contracted primary care and high-volume specialty care practitioners.

- Partnership has updated the Provider Recruitment Program (PRP) that offers a sign-on bonus for providers that are new to the Partnership network. If they are a currently practicing provider, they must come from outside of the Partnership 24 county service area. Providers completing a training program within the Partnership service area qualify for consideration for an award from the program. This updated program is active between January 2024 – June 2025 with the bonuses being paid out over multiple payments over a 60-month term for physicians, NPs, and PAs, 24 months for behavioral health clinicians, and 12 months for certified SUD counselors. The strategy is to recruit and hold providers in place longer term. To date there has been an increase in accepted offers with 168 awards approved on average over 12 months, (as compared to a historical average going back to 2014 of 86 awards per year). Family Medicine has been the majority provider specialty awarded, representing nearly 57% of the program awards to date. Partnership was able to recruit 208 new primary care practitioners to the network between January 2024 – April 2025, with 5 of them recruited to 4 of our most rural counties, including Sierra, Modoc, Plumas, and Trinity, whose geographic area is 75% or more rural (according to the US Census Bureau definition). Initial recruitment and retention details look favorable, but we may not know completely until the 60-month time period and further payments take place.
- Partnership continued to expand its efforts to strengthen recruitment for specialty providers, including obstetrics providers (physicians, women's health nurse practitioners, certified nurse midwives) whose clinical care focuses on perinatal care, including labor and delivery, to the 2024 PRP. Fifteen obstetrics providers have been awarded since January 2024.
- Partnership added a physician medical resident retention bonus to the 2024 PRP. The bonus is intended to help retain resident graduates to the region if they committed in their third year of residency to stay in practice with a Partnership-contracted provider organization following graduation from their training program. Since January 2024, 8 residents have qualified for the resident retention bonus and accepted offers to practice in northern California following their graduation.
- Partnership launched a provider retention initiative (PRI) pilot in January 2024. The PRI is intended to recognize primary care clinicians, those who offer perinatal services (including labor and delivery) and/or obstetrics/gynecology, and psychiatrists who have devoted their careers to the safety net, while helping to incentivize additional years of service from them. Our hope is that the PRI will help preserve institutional knowledge and clinical leadership and mentorship within our network, while an emerging generation of

providers can learn from and train with these committed health professionals. Since January 2024, 65 providers have been awarded and have committed to practice for 3 additional years.

- Partnership conducted a survey of specialty providers in 2024 to better understand our specialty network. Partnership's workforce team continues to analyze the data to learn what strategies and tactics could help increase access to specialty care.
- Partnership's workforce development team continues to complete environmental scans with partners and analyze data from our access studies. We will continue to use this information to engage with our leadership to inform and recommend strategies for FY 2025-2026, which include the PRP and PRI.

CAHPS® Program | Member Experience

Overview

At Partnership HealthPlan of California (Partnership), our commitment to members goes beyond policy or compliance, it is rooted in purpose. As of December 2023, we proudly served over 663,822 members across our legacy 14-county service area. While Partnership expanded to serve an additional 10 Northern California counties (as of January 2024), this evaluation focuses exclusively on our legacy regions to ensure consistent year-over-year trend analysis. It reflects our ongoing commitment to listen, learn and lead work that improve our members' healthcare experience. As a member-centered organization, we recognize that member experience fundamentally shapes our healthcare delivery success.

What We Measured and Why it Matters

Through coordinated efforts across departments, we capture member feedback through two primary channels:

- Annual regulated and non-regulated surveys (Calendar Years: 2022-2023)
- Grievance and appeals reporting (Calendar Years: 2023-2024)

We maintain a comprehensive view of our performance by evaluating both historical trends and current National Committee for Quality Assurance (NCQA) Member Experience data. This analysis drives our continuous improvement efforts and supports our commitment to delivering high-quality healthcare services. Detailed trending analyses and supporting documentation can be found in Appendix C: Member Experience (ME 7) Report.

Together, these data sources offer a more complete picture of how our members truly feel. From survey responses to the concerns raised through appeals, each insight helps us better understand what matters most to the people we serve.

Accreditation Compliance

NCQA requires accredited health plans to conduct an annual Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey. The Agency of Healthcare Research and Quality (AHRQ) designed and governs this survey.

CAHPS® Survey Objectives

The CAHPS® survey captures member-reported experiences with their healthcare, through three key focus areas:

1. Measuring how effectively plans meet member expectations and goals

2. Determining which service areas most impact overall member satisfaction
3. Identifying opportunities for quality improvement in care delivery

The structured evaluation process below highlights the disciplined approach that Partnership applies to quality improvement efforts to continuously enhance service quality and member care experience.

I. Introduction

This evaluation provides retrospective performance analysis that links previous fiscal year (FY) reporting period (FY 2023-24) outcomes to FY 2024-25 Organizational Goal activities. This comprehensive review enables us to assess historical performance while informing strategic quality improvement initiatives.

This analysis evaluates plan-covered members' experience and quality metrics for Measure Year 2023, Reporting Year 2024, and Fiscal Year 2024-2025.

Note: In this evaluation, "Partnership" and "Plan" refer to Partnership HealthPlan of California.

II. Scope of Evaluation

The FY 2024-25 QI Evaluation draws on a comprehensive, evidence-based methodology to assess member experience and inform targeted strategies. This multi-dimensional evaluation integrates both qualitative and quantitative insights to guide meaningful improvements in service delivery and member outcomes.

Key Components:

1. Member Experience Data	2. Grievances and Appeals Data
• CAHPS® survey results • Service quality metrics • Member satisfaction indicators	• 2024 Annual Report • Ongoing complaint monitoring • Trend analysis

The evaluation process follows an evidence-based methodology incorporating:

3. Quantitative Analysis	4. Qualitative Analysis
• Year-over-year CAHPS® survey results • Statistical trending of key metrics • Benchmark comparisons against national standards • Internal performance indicators	• Member narrative feedback • Contextual assessment of survey responses • Process evaluation findings • Implementation effectiveness review

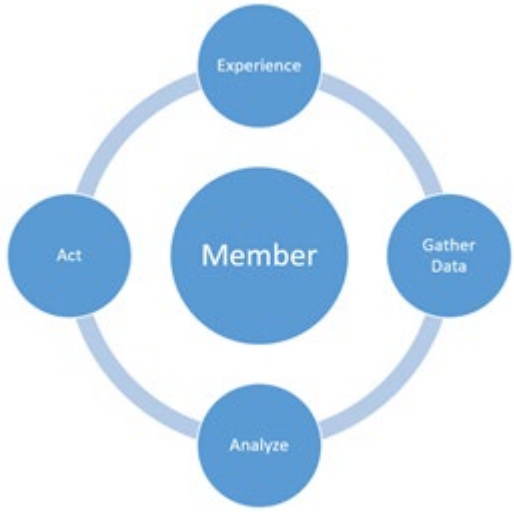
This integrated analytical approach enables Partnership to:

- Identify statistically significant trends
- Pinpoint high-impact improvement opportunities
- Develop data-driven action plans
- Track progress against strategic objectives
- Demonstrate alignment with organizational mission

Ultimately, these insights drive informed, decision making to enhance member experience and health outcomes, and reinforces Partnership's commitment to delivering high-quality, equitable, and responsive managed care delivery.

III. CAHPS® Program Framework and Methodology

The CAHPS® program operates on a comprehensive member-centric Continuous Quality Improvement (CQI) framework that drives evaluation and enhancement of member experience. This framework encompasses:

Core Components	CQI Diagram
• Member experience assessment	
• Performance analytics	
• Outcome measurement	
• Data collection and validation	
• Targeted improvement initiatives	

CAHPS® Regulated Survey Methodology

The plan contracts with an NCQA-certified vendor annually to administer the CAHPS® Regulated survey from February to May. It employs a multi-protocol engagement strategy in English and Spanish to enhance outreach and inclusivity by utilizing mail, phone, and digital options. The protocol begins with a mailed questionnaire, followed by a reminder letter and a second questionnaire in the second month. Phone outreach includes a reminder call before the second mailing and up to three follow-up calls in the third month for non-responders. Members can also complete the survey online through a secure portal or by scanning a QR code.

CAHPS®

The survey sample frame size includes qualifying Adult and Child member populations. Each member must have continuous Partnership primary coverage for the prior year, six (6) months (July 1 – Dec 31), and have been treated by a contracted provider within our network. Annual survey results provide a retrospective data set on key NCQA ratings and composite measures (Tables I and II).

Grievances and Appeals

The Grievance & Appeals (G&A) Department is responsible for investigating, monitoring, and reporting member dissatisfaction regarding their experience with Partnership's Medi-Cal plan. Routine G&A reports shared internally and externally provide real-time insight into service dissatisfaction.

Evaluation Summary

Grievances

Partnership experienced a 6.3% growth in membership, rising from 638,303 members in 2022 to 678,546 members in 2023. Alongside our membership increase, there was a rise in Grievances received in 2023, leading to an increase in Grievances filed per 1,000 members from 4.00 to 5.26, Table VI. The analyses observed a decrease in the number

of Appeals and Second Level Grievances filed in 2023, resulting in a decline in Second Level Grievances filed per 1,000 members from 1.19 to 1.02, Table VII.

An observed 6.3% increase in membership in 2023 may have contributed to a 28.5% increase in Grievances filed, that led to three (3) Grievance thresholds not being met: Access, Attitude/Service, and Quality of Care. Access issues mainly consisted of long wait times for providers and transportation issues such as the driver arriving late and missed rides. Attitude/Service issues were mostly regarding insufficient communication between the member and the provider's office. Communication and treatment plan disputes were the most frequently reported Quality of Care concerns. Two (2) categories, Billing/Financial and Quality of Provider Office, did meet the threshold for 2023, Table VI.

Table: VI

Grievances Only Reporting Period: Annual 2022 vs. 2023								
	Previous Period: 2022			Current Period: 2023				
NCQA Category	Avg PHC Membership	Grievances	Grievances p/1,000	Avg PHC Membership	Grievances	Grievances p/1,000	Threshold	Threshold Met?
Access	638,303	1,055	1.65	678,546	1,526	2.25	1.82	No
Attitude/Service		1,278	2.00		1,752	2.58	2.20	No
Billing/Financial		113	0.18		106	0.16	0.19	Yes
Quality of Care		106	0.17		186	0.27	0.18	No
Quality of Provider Office		4	0.01		2	0.00	0.01	Yes
TOTAL		2,556	4.00		3,572	5.26	4.40	No

Appeals & Second Level Grievances

The Appeals and Second Level Grievances saw an overall decrease in numbers. While four (4) categories (Access, Attitude/Service, Billing/Financial, and Quality of Provider Office) successfully maintained stability by not exceeding the 10% threshold. One (1) category, Quality of Care, saw an increase from one (1) case in 2022 to nine (9) cases in 2023, surpassing the threshold. These cases consisted of treatment plan disputes that caused delay in the care the members received and communication issues such as the provider not returning the members' calls, Table VII.

Table: VII

Appeals & Second Level Grievances Reporting Period: Annual 2022 vs. 2023								
	Previous Period: 2022			Current Period: 2023				
NCQA Category	Avg PHC Membership	Appeals & SLG	Appeals & SLGs p/1,000	Avg PHC Membership	Appeals & SLG	Appeals & SLGs p/1,000	Threshold	Threshold Met?
Access	638,303	332	0.52	678,546	350	0.52	0.57	Yes
Attitude/Service		47	0.07		33	0.05	0.08	Yes
Billing/Financial		382	0.60		297	0.44	0.66	Yes
Quality of Care		1	0.00		9	0.01	0.00	No
Quality of Provider Office		0	0.00		0	0.00	0.00	Yes
TOTAL		762	1.19		689	1.02	1.31	Yes

CAHPS® Measure Year 2023 | Reporting Year 2024 Plan Performance

A summary of the MY 2023 CAHPS® survey performance for Adult and Child, identified barriers, Fiscal Year (FY) 2024-2025 intervention and improvement focus are outlined below

Adult

Measured performance compared to the plan's 33rd percentile benchmark ranking indicates member dissatisfaction in the following measures. In comparison to MY 2022 ranking performance, MY 2023 demonstrates an overall ranking decline in seven (7) of nine (9) measures, Table I.

Table: I

Measure Attribute	Plan Performance		
	MY 2023 HEDIS QC Ranking	Plan Benchmark Target ≥33rd Percentile Ranking	MY 2023 Ranking Compared to MY 2022
Rating of Health Plan (% 8, 9, 10)	<5th	Not Met	Decline
Rating of Health Care (% 8, 9, 10)	5th	Not Met	Decline
Rating of Personal Doctor (% 8, 9, 10)	51st	Met	Improvement
Rating of Specialist Seen Most Often (% 8, 9, 10)	41st	Met	Improvement
Getting Needed Care (% Always or Usually)	7th	Not Met	Decline
Getting Care Quickly (% Always or Usually)	<5th	Not Met	Decline
Care Coordination (% Always or Usually)	11th	Not Met	Decline
How Well Doctors Communicate (% Always or Usually)	48th	Met	Decline
Customer Service (% Always or Usually)	18th	Not Met	Decline

Healthcare Effectiveness Data and Information Set (HEDIS) Quality Compass (QC) Benchmarks

Child

Measured performance compared to the plan's 33rd percentile benchmark ranking indicates member dissatisfaction in the following measures. In comparison to MY 2022 ranking performance, MY 2023 demonstrated an overall ranking improvement in seven (7) of nine (9) measures, and one noted as maintaining similar ranking, with a marginal decline of 3.5% in score performance with Rating of Health Care, Table II.

Table: II

Measure Attribute	Plan Performance		
	MY 2023 HEDIS QC Ranking	Plan Benchmark Target ≥33rd Percentile Ranking	MY 2023 Ranking Compared to MY 2022

Rating of Health Plan (% 8, 9, 10)	45th	Met	Improvement
Rating of Health Care (% 8, 9, 10)	<5th	Not Met	No Change
Rating of Personal Doctor (% 8, 9, 10)	55th	Met	Improvement
Rating of Specialist Seen Most Often (% 8, 9, 10)	21st	Not Met	Decline
Getting Needed Care (% Always or Usually)	14th	Not Met	Improvement
Getting Care Quickly (% Always or Usually)	9th	Not Met	Improvement
Care Coordination (% Always or Usually)	40th	Not Met	Improvement
How Well Doctors Communicate (% Always or Usually)	22nd	Met	Improvement
Customer Service (% Always or Usually)	89th	Met	Improvement

Healthcare Effectiveness Data and Information Set (HEDIS) Quality Compass (QC) Benchmarks

Identification of Opportunities and Priority

Throughout fiscal year 2024-2025, the focus of Organizational Goal # 4 Access to Care and Member Experience Improvement was to develop and, when applicable, revise existing strategies and tactics by understanding the landscape of the primary care provider and specialty provider networks, identifying gaps, and developing targeted actions (see Appendix C: Member Experience (ME 7) Report).

The QI CAHPS® programmatic framework helping to drive and influence a multi-disciplinary approach to improve the member experience through long and short-term strategies. The team priority this year will pilot a smaller focus at the county and region level to target low performing composite and rating measures linked to access.

Member Experience (ME) – Priority Flag

Partnership determines ME through the analysis of multiple CAHPS® rating and composite measures. The previously noted performance tables demonstrate a continuation of member dissatisfaction. The QI CAHPS® Team intends to shepherd organizational guidance on the measures marked with a priority flag. These measures are considered influence drivers and when those scores improve member experience, the Rating of Health Plan and Rating of Healthcare measures improve.

Causal Factors

While CAHPS® is a retrospective survey, the CAHPS team hypothesizes that the most recent member experiences, whether positive or negative, heavily influence reported satisfaction. Key factors that likely led to member dissatisfaction and subsequent declines in NCQA rating and composite measures, during the measurement period include:

- **County Expansion - HealthPlan Growth**

In January of 2024, Partnership expanded into ten (10) new counties, now serving twenty-four (24) Northern California counties. It is relevant to note the new county members were not included in the HEDIS

CAHPS® sample frame member for MY 2023. The membership growth coupled with the regional service disruption mentioned below created unforeseen operational delays that impacted members requiring plan or service support during this period.

- **Regional Service Disruption**

In April of 2024, contract negotiations and renewal was not reached with Dignity Health. This matter is presently resolved, but while the CAHPS® survey was in the field, thousands of members were impacted through the initial notification and subsequent actions of provider reassignment among many others.

Rating of Health Plan

Partnership focused on two (2) additional barriers outside of the FY 2024-2025 Org. Goals (see Appendix C: Member Experience (ME 7) Report, page 25). The CAHPS® Team used non-regulated survey results to validate and link benefit literacy gaps and themes gathered through members surveyed at in-person community events by Population Health Management (PHM). Benefit themes point to coverage confusion between Partnership and state carve out coverage (Medi-Cal Dental/Pharmacy), vision, and Partnership administered transportation services, and 2) Customer Service calls related to covered benefit or service questions. Member shared comments including calling plan multiple times about the same issue, calls being transferred multiple times, customer service representative provided unclear or incomplete information making it challenging for the members to understand, (see Appendix C: Member Experience (ME 7), page 41).

Access To Care – Priority Flag

Member access to primary and specialty care remained a key focus and priority for Partnership. Through various data sources and the Association for Community Affiliated Plans CAHPS® Collaborative, Partnership recognized a national and regional shortage of clinical professionals, along with many aging professionals nearing retirement (QI Evaluation, see Appendix C: Member Experience (ME 7), page 56). The fluctuations in performance measures for access identified below, combined with the lack of improvement to pre-COVID levels, indicated inconsistencies in access to care and service delivery.

Getting Needed Care (GNC)

Partnership observed a general decline in Adult and Child GNC composite questions (Q9 and Q20), measures, and overall summary rate score. Performance analysis by population is highlighted below.

Adult: The GNC measure declined by -2.4% and did not meet or exceed the plan 33rd percentile benchmark ranking target. The HEDIS Quality Compass (QC) benchmark ranking decline to the 7th percentile ranking from the 14th percentile ranking compared to MY 2022. The highest noted summary rate score of 81.60% occurred in the reporting year (RY) 2021 for MY 2020. The marked -5.6% decline of GNC trend began in the RY 2022, for MY 2021 survey results. Continuing the performance trend, Partnership observed a minimal increase of 0.4% of a percentage point in the RY 2023 for MY 2022, followed by another decline of -2.4% performance in the RY 2024 for MY 2023.

Child: The GNC measure marginally improved by 0.4% of a percentage point, and did not meet or exceed the plan 33rd percentile benchmark ranking target. The HEDIS QC benchmark ranking also improved to the 14th percentile ranking from the 10th percentile ranking compared to MY 2022. Similar yet dissimilar to the Adult trend performance, the highest summary rate score for Child was 83.20% and occurred in the RY 2020 for MY 2019. The marked -2.5% decline of GNC trend began in the RY 2021, for MY 2020 survey

results. Continuing the performance trend, Partnership observes the following: -1.1% (MY 2021) and -2.9% (MY 2022).

Getting Care Quickly (GCQ)

Partnership continued to observe a general decline with Adult and Child GCQ composite (Q4 and Q6.), measures, and overall summary rate score. Performance analysis by population is highlighted below.

Adult: The GCQ measure declined by -1.4% and did not meet or exceed the plan 33rd percentile benchmark ranking target. The HEDIS QC benchmark ranking MY 2023 declined below the 5th percentile ranking established in MY 2022. The highest summary rate score of 80.30% occurred in the RY 2021 for MY 2020. The marked -7.4% decline of GQC trend began in the RY 2022, for MY 2021 survey results. Continuing the performance trend, Partnership observed the following decline of -3.40% for MY2022.

Child: Although the GCQ measure saw a marked improvement score of 2.6%, the measure did not meet or exceed the plan's 33rd percentile benchmark target. The HEDIS QC benchmark ranking mirrored the score performance by increasing MY 2022 below the 5th percentile ranking to 9th percentile ranking in MY 2023. The highest summary rate score for Child was 88.80% and occurred in the RY 2020 for MY 2019. The marked -7.7% decline of GQC trend began in the RY 2021, for MY 2020 survey results. Continuing the performance trend, Partnership observes summary rate fluctuations ranging from an increase of 3% in MY 2021 and another decline of -7.8% in MY 2022.

Rating of Specialist (Rating)

Partnership continued to observe survey performance variations related to the Rating of Specialist measure, GNC, and GQC composite measures linked to specialty providers seen most often. As previously noted, improving member access to Primary Care Providers (PCP) and Specialists Providers was a top priority. Access interventions had been a continued organization focus and is covered in prior Member Experience (ME 7) Grand Analysis reporting periods. The complete details of actions taken during the FY 2023-2024 goal period are available in Appendix C: Member Experience (ME 7) Report, page 27). The trending overview and qualitative analysis by population is provided below.

Adult: The Rating of Specialist (Q22.) measure improved by 5.1%, meeting the plan's 33rd percentile benchmark target and increased the HEDIS QC benchmark ranking to the 41st percentile from the 26th percentile. The highest summary rate score of 71.50% occurred in the RY 2021 for MY 2020. The marked -4.8% decline of rating trend began in the RY 2022 for MY 2021 survey results. Continuing the performance trend, Partnership observed another decline of -2.3% for MY2022.

Child - Priority Flag: The Rating of Specialist (Q22.) measure saw a marked decline -5.7%. The measure did not meet or exceed the plan's 33rd percentile benchmark target. The HEDIS QC benchmark percentile ranking also declined to the 24th percentile ranking from the 34th percentile in MY 2022. The highest summary rate score for Child was 74.4% and occurred in the RY 2020

for MY 2019. The marked -10.8% rating measure decline began in the RY 2021 for MY 2020 survey results. Continuing the performance trend, Partnership observes summary rate fluctuations ranging from an increase of 6.8% in MY 2021 and another marginal decline of -0.9% of a percentage point in MY 2022.

Causal Factors

The ME 7 qualitative analysis also includes findings detailed in the Network Adequacy Assessment Report (NET 3) aligned with MY 2023 CAHPS® survey results. A summary below captures factors that link to member dissatisfaction on respective declines with priority flagged measures.

- Membership 6.3% annual growth.
- Grievance notable findings:
  - As previously noted, the leading filed Grievances in 2023 were Access at 1,526 (43%), almost half of 3,572 closed grievance cases.
  - Grievance cases filed per 1,000 members increased to 5.26 from 4.00, a notable 28.5% increase.
  - Partnership did not meet the access grievance threshold for 2023.
- Geographic impacts
  - Northern county members are experiencing greater travel distance and time to access primary care and specialty care.
  - Northern and Southern County assigned members observed longer wait times to be seen for the following specialists: Cardiology, Dermatology, and Ophthalmology.

FY 2023-2024 Summary of Activities and Interventions

The detailed activities for the FY 2023-2024 Quality Improvement Department Goal CAHPS® Score Improvement (CSI) demonstrated cross-department action focused on interventions (see Appendix C: Member Experience (ME 7) Report, page 27, Table XV). The highlighted examples below showcase completed goals/actions targeting Access and, furthermore, document continuous improvement.

- **Human Resource/Workforce Development Department**
  - **Completed Action:** Improve Access with Provider Recruitment Support. Contracted with a third-party talent search firm to partner and support recruitment and placement of multiple clinical vacancies within the Partnership contracted primary care and specialty care provider network.
  - **Completed Action**: Improve Access with Provider Retention. Successfully added and facilitated a retention bonus to the 2024 Provider Recruitment Program (PRP).

Organizational Goal #4 | FY 2024-2025 Summary

Access & Member Experience

The summary table below includes improvement focus based on the outcome of MY 2023-2024 quantitative, qualitative, causal analysis, and highlights organization priority of member barriers identified through the mentioned (see table: III).

Table: III

INTERVENTION &	IMPROVEMENT FOCUS	GOAL MILESTONE	INTERDEPARTMENTAL COLLABORATION	DEFINITIONS

Improvement Status		#	Yes / No	# of Depts.	
Continue	Access	1,2	Yes	4	• **Adjust:** a lean approach or pivot. A continued focus and intent. • **Continue:** a continuation of intervention or improvement activity and focus. • **Maintain:** score or intervention met. • **Monitor:** intervention or improvement assessment period. • **New:** a new action or intervention.
Continue	Member Experience	2,3,4,5,6,7	Yes		
Continue	Customer Service	3,8			
Continue	Attitude/Service	3,5			
Continue	Health Care Rating	1,2,4,5,6,7	Yes		
Continue	Health Plan Rating	All	Yes		

The two (2) workgroups Access and Member Experience will collaborate through FY 2024-2025 to implement short and long-term strategies and plan development focused on the identified barriers and milestone summaries listed below.

- **Milestone 1:** The **Access Workgroup** will develop and propose a multi-year Access Strategy plan that is inclusive of understanding the landscape of our specialty care and primary care provider network and identifying gaps.
- **Milestone 2:** The **Access Workgroup** will develop and propose a multi-year Access Tactical plan that outlines targeted actions to drive Milestone 1 objectives.
- **Milestone 3:** The **Member Experience (ME) Workgroup** will drive CSI FY 2023-2024 pilot from analysis phase to Strike-Team "action" phase. The enhanced ME improvement strategy is continuous, with the intent to leverage quarterly data (G&A, PHM) sources to drive proactive interventions throughout FY 2024-2025.
- **Milestone 4:** The **Member Experience (ME) Workgroup** will focus on developing and proposing member communication and engagement enhancements through existing platforms or new tool development.
- **Milestone 5:** The **Member Experience (ME) Workgroup** will define and develop Member Informative Session (MIS) program strategy and framework.
- **Milestone 6:** The **Member Experience (ME) Workgroup** will implement Year 1 of the texting program as approved by the monthly texting workgroup.
- **Milestone 7:** The **Member Experience (ME) Workgroup** will continue with Your Partner in Health branding campaign to develop a Partnership Awareness - grassroots communications strategy.
- **Milestone 8:** The **Member Experience (ME) Workgroup** will collaborate with the Quality Improvement Pay-for-Performance Team to explore Unit-of-Service measure development opportunities.

Organizational Goal #4 | FY 2024-2025 Outcomes

Below are the milestone outcomes for the Access and Member Experience workgroups, organized sequentially and showing requirement status and goal completion.

Final Goal Status		
☒ Goal Completed at Full Credit	☐ Goal Completed at Partial Credit	☐ Goal Not Completed

Milestone 1: Access Strategy Development

The Access Workgroup successfully completed Milestone 1 of developing a comprehensive multi-year Access Strategy for specialty and primary care provider networks. Key accomplishments included creating a strategic

framework with defined metrics, implementing advanced network visualization tools, and engaging 15 departments through 22 stakeholder interviews. The team delivered technical solutions including provider exit scoring, network gap analysis tools, and enhanced data reporting capabilities. The strategy incorporated critical elements such as workforce retention, telehealth integration, health equity, and transportation services, while establishing the foundation for tactical implementation in Milestone 2. This milestone met all requirements for framework development, stakeholder validation, and technical infrastructure establishment.

Required Milestone: ☑ Yes **Status:** ☑ Completed

Milestone 2: Access Tactical Plan

The Access Workgroup successfully executed Milestone 2 by developing a comprehensive tactical plan for improving specialty and primary care network access. Through extensive stakeholder engagement across 8 key departments, the team produced a detailed multi-year implementation framework with defined timelines and success metrics. Key deliverables included a Provider Gap Analysis Tool, resource allocation framework, and integration strategies for existing services. The plan incorporated lessons from existing quality initiatives while addressing critical implementation factors such as staff capacity, technological infrastructure, and community partnerships. This milestone successfully established the operational blueprint for enhancing provider network accessibility.

Required Milestone: ☑ Yes **Status:** ☑ Completed

Milestone 3: Member Experience Improvement Strike Team

The Member Experience Workgroup successfully implemented the CAHPS® Score Improvement (CSI) initiative through a Strike-Team approach, focusing on transportation services and benefit awareness enhancement. Key achievements included implementing Kinetik trip tracking, analyzing 154 grievances, and establishing NCQA-aligned incident thresholds for transportation services. The team strengthened benefit awareness through comprehensive staff training, enhanced communication channels, and strategic partnerships, particularly with DHCS's Smile, California program. Significant improvements were made in data analysis, G&A reporting, and cross-departmental collaboration, resulting in enhanced member service delivery and monitoring capabilities. The milestone exceeded original deliverables across stakeholder engagement, operational enhancement, data analysis, transportation provider accountability, and system-wide benefit awareness.

Required Milestone: ☑ Yes **Status:** ☑ Completed

Milestone 4a: Digital Platform Enhancements

The Member Experience Workgroup completed preliminary planning for digital communication enhancements through the Member Portal platform. While the team successfully completed initial requirements gathering, system testing, and stakeholder engagement for SOGI data collection and CAC application integration, implementation has been strategically postponed to align with the upcoming HRP/JIVA platform launch. Key preparatory work included C2 platform testing, SOGI module development, and CAC application framework design. This milestone established the technical groundwork and documentation necessary for future implementation while ensuring seamless integration with the new HRP system.

Required Milestone: ☑ Yes ☐ **Status:** Not Complete AND/OR

Milestone 4b: Mobile Application Assessment

The Member Experience Workgroup completed a comprehensive assessment for Partnership's mobile application initiative through extensive stakeholder engagement and strategic analysis. The team gathered valuable insights from Family Advisory Committee (FAC), Community Advisory Committee (CAC), and Member Services, resulting in a detailed operational assessment framework and requirements inventory. Key deliverables included developing vendor evaluation criteria, establishing feature prioritization methodology, and creating

implementation recommendations based on member feedback. This milestone successfully laid the groundwork for mobile application development by aligning stakeholder needs with operational feasibility and integration requirements.

Required Milestone: ☐ No **Status:** ☑ Completed

Milestone 5: Member Informative Session (MIS) Program

The Member Experience Workgroup successfully established the Member Informative Session (MIS) program framework, securing both executive approval and resources for regional implementation. Key achievements included creating five new positions (4 Member Engagement Specialists and 1 CAC Coordinator), developing partnerships across 24 counties, and implementing a comprehensive cross-departmental collaboration system. The team completed the initial phase by staffing four regional offices (Fairfield, Redding, Auburn, and Chico) and establishing the infrastructure for 48 annual sessions. The milestone delivered a scalable framework for future expansion to Eureka and Santa Rosa offices, supported by robust event tracking systems and sustainable budget planning.

Required Milestone: ☑ Yes **Status:** ☑ Completed

Milestone 6: Text Messaging Program Implementation

The Member Experience Workgroup successfully implemented Year 1 of the text messaging program, establishing comprehensive infrastructure, and launching multiple targeted campaigns. The team created a cross-departmental texting workgroup, developed operational parameters, and successfully executed campaigns reaching approximately 100,000 members with remarkably low opt-out rates (0.013%). Notable achievements included rapid emergency response deployment for the Park Fire, implementation of the Welcome Campaign, and execution of multiple health initiative campaigns across three quarters. The program established robust KPI tracking mechanisms and demonstrated operational success through high delivery rates and engagement metrics. This milestone created a scalable foundation for future messaging campaigns while proving the effectiveness of text-based member communication.

Required Milestone: ☑ Yes **Status:** ☑ Completed

Milestone 7: Partnership Awareness Communications Strategy

The Member Experience Workgroup launched the "Your Partner in Health" branding campaign, establishing a comprehensive grassroots communications strategy. Working with NKE Strategies, the team developed and secured executive approval for a Strategic Communications Plan focused on community-centered messaging. Key achievements included creating targeted messaging for Congressional visits, advancing immigration-focused communications, and establishing a grassroots engagement framework. The milestone successfully delivered messaging architecture and presentation materials while laying the groundwork for Year One implementation. With strategic planning and executive approval phases completed, the initiative is positioned to move into active implementation.

Required Milestone: ☐ No **Status:** ☑ Completed

Milestone 8: CAHPS® Integration Strategy

The Member Experience Workgroup successfully established an integrated approach to patient experience measurement by connecting clinic-level CG-CAHPS® with health plan CAHPS® scoring. Working with the Quality Improvement Pay-for-Performance team, the group developed unified measurement standards and specific improvement targets, which were successfully incorporated into the 2025 PCP specifications. Key achievements included gaining Technical Work Group consensus on measure modifications, creating comprehensive resource documentation, and establishing clear connections between provider and health plan performance metrics. The

milestone completed all planned implementation steps through July 2024, positioning the program for ongoing stakeholder education and support.

Required Milestone: ☑ Yes **Status:** ☑ Completed

Lessons Learned

ACAP CAHPS® Collaborative: Year 2 Summary

The CAHPS® Team partnered with 10 sister plans through the Association for Community Affiliated Plans (ACAP) CAHPS Collaborative to improve survey performance and member experience.

Key Initiatives and Findings

1. Member Experience Projects

The cornerstone of our work was knowledge sharing between sister plans. Through collaboration, we developed solutions to optimize access to care, enhance needed care scores, and streamline durable medical equipment access.

2. Health Plan Operational Assessment

Our operational assessment uncovered key insights about structure and performance. Through systematic evaluation, we identified organizational strengths in quality metrics and cross-functional collaboration, while noting opportunities to enhance member contact systems, provider experience, and regional access consistency. Priority improvement areas emerged in pharmacy services, healthcare access, and transportation.

3. Enhanced Engagement

To facilitate ongoing learning and collaboration, the team implemented monthly "Office Hours" sessions. These forums proved value by offering real-time problem-solving and best practice sharing among peer organizations.

4. Benefit Literacy Initiative

Perhaps the most significant finding from our MY 2023/RY 2024 surveys was the widespread challenge in benefit comprehension. The most common areas of confusion included transportation, vision, behavioral health, and dental services. This discovery prompted a series of targeted interventions in FY 24/25, including.

- **Targeted Interventions:**
    - **Transportation:** Improved tracking tools, data analysis, and alignment with NCQA standards.
    - **Dental:** Formed a dedicated workgroup, expanded member education, and planned outreach events.
    - **Organizational Support:** Increased staff training, multilingual communication efforts, and digital engagement strategies.

Looking Ahead

The initiatives implemented through this collaborative have laid a strong foundation for continued improvement in member experience. The combination of structural changes, enhanced communication channels, and targeted service improvements positions us to better serve our member population. Moving forward, we will continue to monitor these initiatives' effectiveness and adapt our strategies based on member feedback and performance metrics.

Organizational Goal # 5 | FY 2025-2026 Summary

Member Experience

Building on our FY 2024-25 progress, the Member Experience teams will advance our continuous improvement efforts through FY 2025-26, implementing strategic initiatives to address evolving challenges and achieve the key milestones outlined below.

- **Milestone 1:** The Transportation Department will continue its FY 2024-2025 pilot program connecting member Grievance and Appeal cases with driver performance to enhance service quality and develop data-driven improvement targets.
- **Milestone 2:** The QI CAHPS® team will lead the MX Strike Team pilot by analyzing real-time internal influence drivers to identify and address member dissatisfaction sources, focusing on line staff engagement and causal factors to enhance service delivery effectiveness.
- **Milestone 3:** The Member Services Department will implement one new initiative to improve member experience through operational and service delivery enhancements.
- **Milestone 4:** The QI CAHPS® team will advance dental coverage initiatives to improve member experience through enhanced education, access, and service delivery.
- **Milestone 5:** The Quality Improvement Department will lead a cross-departmental initiative to enhance potential (future-state) Partnership Advantage (Medicare) members' benefit understanding by developing targeted education channels, delivering accessible content that supports effective benefit utilization.
- **Milestone 6:** The Population Health Management Department, in collaboration with the Health Equity team, will advance equitable member engagement by integrating diverse cultural, linguistic, and social perspectives into member experience initiatives.

Conclusion

The FY 2024–2025 Quality Improvement Evaluation reflects Partnership's continued commitment to advancing member experience, access to care, and health outcomes through data-driven, cross-functional collaboration. This year's findings reaffirm the importance of listening to member voices—whether through survey results, grievances, or community engagement—and translating those insights into targeted, meaningful action.

Despite challenges such as workforce shortages, regional access disparities, and growing member needs, the organization has made measurable progress. Improvements in provider ratings and select CAHPS® measures, alongside successful interventions in benefit literacy, transportation, and dental access, underscore the impact of our collective efforts.

Looking ahead, Partnership remains focused on equity, responsiveness, and continuous learning. The insights gained from this evaluation will shape the next cycle of strategic priorities, with an emphasis on sustained improvement, community trust, and alignment with our organizational mission to help the members of our communities be healthy.

Please see Appendix (C) Member Experience (ME 7) Report for a complete review of the FY 2023-2024 analysis, and interventions implemented and proposed FY 2025-2026 programmatic interventions.

Purpose & Overview

The Quality and Accuracy of Information Report tracks the quality results of the information provided to Partnership members received during the following:

- Telephonic inquiry call(s) to the Member Services Department
- General inquiry(s) sent electronically (email) to the Member Services Department
- Partnership's website (self-service, Member Portal) online tools at https://member.partnershiphp.org/.

Member Services reviews the quality and accuracy of information monthly. On an annual basis, we document our findings through the production of this Quality and Accuracy of Information Report. The analysis of results and publishing of this report was a Member Services led initiative. The report was authored by the Member Services Manager of Quality & Training in collaboration with the Associate Director of Member Services. All Partnership department contributors for this report are listed below:

Title / Department	Role
Sr. Director, Member Services & Grievance	Analysis Contributor
Associate Director, Member Services	Analysis Contributor
Manager of Quality & Training, Member Services	Author
Director, Grievance & Appeals	Analysis Contributor
Compliance Manager, Grievance & Appeals	Data Contributor

Methodology

Telephonic Response

Data Source: *Annual Telephone Quality and Accuracy Evaluation*

Member Service Representatives (MSR) are annually tested on the quality and accuracy of telephone support as it relates to "Referrals and Authorizations," "Eligibility and Benefits," and "Member Financial Responsibilities."

The Member Services management team assesses the quality and accuracy of telephonic support provided by an MSR through the administration of the "*Eligibility and Financial Responsibility Knowledge Check"* test. Testing is administered through Partnership's online Learning Management System (LMS) training tool. This tool tracks and trends both individual and overall results. Member Services supervisors review individual MSR testing results and provide a departmental summary for review by the Member Services management team. Through this review, the management team identifies deficiencies and determines appropriate next steps.

In terms of performance standards, a minimum score of 90% is required for individual MSRs and a minimum score of 95% for the collective department. If the management team identifies any departmental trend(s) within the deficiencies, they may place the individual(s) and/or the department on a Corrective Action Plan (CAP). Additionally, the management team provides their analysis to the Member Services Manager of Quality & Training to develop tailored training material that may include, but not limited to:

- Updated desktop procedures/materials
- Instructive and informative email correspondence
- Focused departmental training

In addition, results are summarized annually and documented in the Analysis section of the Quality and Accuracy of Information Report. This report is also presented to the Member Experience Sub-Committee for review and approval.

Quality & Accuracy Member Complaints

Data Source: *Member Phone Call/Email*

Member complaints received against Partnership staff are documented by Member Services supervisors. Other member facing department supervisors also have the ability to file complaints against Partnership staff. This includes complaints filed due to staff providing misinformation or not enough information related to a member's financial responsibility, referrals, and/or authorizations. If a supervisor identifies a training opportunity, they provide tailored support and conduct additional training for the staff member.

Partnership's Grievance & Appeals (G&A) Department provides Member Services with an annual report that includes details on all Partnership staff-related complaints. If trend(s) are identified, the Member Services Manager of Quality & Training may develop tailored training materials that includes, but are not limited to:

- Updated desktop procedures/materials
- Instructive and informative email correspondence
- Focused departmental training

In addition to the annual reporting and analysis, there is an established feedback loop to address any instance of misinformation closer to real time. If the G&A Department identifies that misinformation was provided, the staff member's supervisor is notified and provides feedback, coaching, and monitoring.

Website Self-Service Quality

Data Source: *PartnershipHP.org*

Ten (10) of Partnership's newest Member Services staff audit the functionality and ease of use of Partnership's website. This audit is conducted on an annual basis through the use of a web-based survey tool. Partnership utilizes new employees as their lack of experience in navigating the Member Portal provides a true gauge of what a member would experience as it relates to the ease of use and the quality of information provided.

Performance is measured on a five-point rating scale, where one (1) indicates a poor experience and five (5) signifies an excellent experience with Member Portal's functionality. To ensure consistent evaluation, a performance threshold of 3.0 has been established for each question/activity. Staff members assess the quality and accuracy of the web functionality based on the following:

Changing Primary Care Practitioner:
Was it easy to do?
Was the staff member able to change a PCP?
Was it completed in one attempt?

Determine How/When to obtain Referrals/Authorization:
Was it easy to find?
Was the staff member able to determine how and when to obtain referrals and authorizations for specific services?
Was it completed in one attempt?
Was the information provided useful?

Determine benefits and financial responsibility of a service:
Was it easy to find?
Was the staff member able to find the language that stated that members have no financial responsibility?
Was it completed in one attempt?

Audit findings are summarized and reviewed annually. In the event that the results of a specific question/activity have an average score below 3.0, the Member Services management team shall engage Partnership's Web Development team. These efforts will include recommendations and/or potential enhancements needed for improvement. Similar to the above, the annual report is presented to the Member Experience Sub-Committee for review and approval.

Email

Data Source: Emails submitted via https://member.partnershiphp.org

A designated Member Services auditor selects either 10% of all email inquiries or ten (10) inquiries (whichever is fewer) per month to audit. The auditor determines the quality, accuracy, and timeliness of the email response to the member's inquiry through the following categories:

Email Etiquette
- Identified themselves to the member
- Response protects Member(s) Personal Health Information (PHI)
- Response projects professionalism and politeness
- Correct spelling, grammar, and punctuation

Resolution
- Appropriately identified member reason for email inquiry
- Offered the most appropriate and accurate solution to meet the members' needs
- Communicated at a level that the member would understand

Timeframes and Documentation
- Delivered appropriate acknowledgment or resolution response within one business day of receipt of the Member's request.
- Resolutions are completed by the end of the following business day
- Member's record is documented according to policy

Audit findings are recorded in the Member Services Department audit log, which tracks and trends individual and overall results. Individual audit results are reviewed with the staff member's supervisor and overall departmental results are reviewed by the Member Services management team. Through this review, the department aims to address any deficiencies identified as well as determine appropriate next steps. If the auditor identifies any trends within the deficiencies (meaning an aggregate score that falls below the performance threshold of 95%), they will provide their analysis to the Member Services Supervisor of Quality & Training to develop tailored training which may include, but not limited to:

- Updated desktop procedures/materials
- Instructive and informative email correspondence
- Focused departmental training

Annually, the results are summarized in a formal analysis that is presented to the Member Experience Sub-Committee for review and approval.

Results & Analysis

Telephonic

Member Services Call Center staff completed the Annual Eligibility and Financial Responsibility training and test. The results of this year's testing exceeded the established threshold of 95% as the department scored 98% overall, while a slight improvement over our 2024 results (+.05%) was experienced, it was down 2% compared to our 2023 results. To illustrate the trend, we have organized our findings below which include a comparison of results, year over year (Table 1).

Table 1

	2023	2024	2025
	Quality & Accuracy Question Scores		
Question 1	99%	100%	99%
Question 2	99%	97%	99%
Question 3	100%	100%	99%
Question 4	100%	100%	100%
Question 5	100%	100%	100%
Question 6	100%	100%	100%
Question 7	100%	100%	99%
Question 8	100%	100%	100%
Question 9	100%	97%	100%
Question 10	100%	100%	100%
Question 11	100%	100%	100%
Question 12	98%	77%	83%
Question 13	100%	100%	99%
Question 14	100%	100%	100%
Total:	***100%**	***98%**	***98%**

** Percentages are rounded*

While we met our established threshold, the Manager of Quality & Training collaborated with departmental supervisors to provide one-on-one refresher training. This training focuses on helping staff identify all useful and relevant information a member may need when seeking care from a specialty provider. The additional training was completed in March 2025 and specifically addressed the deficiency reflected in the results for Question 12 (83%). It is worth reiterating that, while we observed a positive shift in the results for Question 12, this area will remain a focal point in the coming year. Below is an overview of our findings as we compared our performance against the previous period:

- Three (3) questions achieved a higher score in comparison to last year (2025 vs. 2024)
  - Question 12: +6%Question 9: +3%Question 2: +2%
- 39/40 staff tested, one (1) leave of absence, four (4) staff members retook the test and passed with a 100% score after the refresher training)
- 67.5% of respondents scored 100% compared to 70.5% in 2024
- 32.5% of respondents scored 93% compared to 29.4% in 2024

Quality & Accuracy Member Complaints

For the 2024-2025 evaluation period, Partnership experienced a total of 306 member complaints against Partnership staff. Of the 306, only one (1) was related to misinformation regarding either "Referrals and Authorizations",

"Eligibility and Benefits", and "Member Financial Responsibilities" (0 in the 2022 – 2023 period). For the purpose of this report, our G&A Department references these types of complaints as an "RAFR" complaint. When comparing this result to the previous evaluation period (2023 – 2024) there were 147 total complaints, with four (4) related to the RAFR reasoning. Upon review, the sole RAFR complaint in this reporting period was identified as a potential coaching opportunity for a Care Coordination staff member. The coaching and other resolution details are documented within the Resolution Column of Table 2.

It is important to highlight that Partnership remained below our established threshold of three (3) total complaints, reducing the total number of RAFR grievances by 75%. While this is a favorable outcome, Member Services will continue annual monitoring of member complaints related to the RAFR reasoning to ensure performance levels are maintained.

Table 2
2024-2025

2024-2025			
Date Received	**Date Closed**	**Issue**	**Resolution**
4/13/2024	5/9/2024	The member is unhappy with her care coordinator and feels she is not helpful and did not return her call. Feels she was given wrong information regarding one of the providers not accepting her as a patient/ The member is needing a referral to specialists for ophthalmology and rheumatology.	The care coordinator's supervisor states the specialist provider would accept the member only if the member was also assigned there for PCP, however, also documents there were training opportunities found in that the care coordinator could benefit from. The supervisor was able to get the 2 referrals approved and reassigned the member to a new care coordinator.

Table 3
2023-2024

2023-2024			
Date Received	**Date Closed**	**Issue**	**Resolution**
2/14/2023	2/16/2023	The member is upset because he feels he is receiving conflicting information regarding a TAR from different people at PHC. The Grievance staff said it was approved and the CC staff said it was denied.	The MSR educated the member regarding the denial of the TAR in question, advised him that his CM in CC would follow up with him, and offered to file a Grievance. The member declined to file a standard Grievance, so an exempt Grievance was filed.
7/31/2023	8/15/2023	Member was unhappy with the TS Unit representative who provided her information about the GMR process. Member had a long trip scheduled, which would include a hotel and meal reimbursement. The representative did not specifically tell member that the meal is something they must pay for and request a reimbursement for. Member usually has very little money and she was under the impression PHC would send meal ticket/vouchers.	PHC TS Unit listened to recorded call and agreed the rep did not explain the process well enough. They provided education and feedback to their staff so that better explanations of the process are given to members. Member asked for help on how to get her receipts to PHC. She lives in Eureka, so I shared the physical address. Member stated she would drop these off at the office.
9/22/2023	10/17/2023	Member dissatisfied that it took 10 months for billing issue to be resolved. Staff member did not know the correct information.	MS Enrollment unit reviewed the concerns. They have implemented a process to monitor timeframes for billing issues. Staff member has been counseled. The process will be reviewed at their department trainings and added to their desktops.
10/6/2023	10/9/2023	The member had communication issues with the MSR who initially assisted her with her referral issue.	The member declined to file a standard Grievance. An exempt Grievance was filed. Supervisor reviewed call and found a training opportunity around referrals / authorizations for palliative care. Feedback was given.

Table 4
2022-2023

2022 - 2023			
Date Received	**Date Closed**	**Issue**	**Resolution**
N/A	N/A	N/A	N/A

In addition, Member Services has introduced a new tracking mechanism to monitor the trend of RAFR complaints. Moving forward, RAFR complaints per 1,000 members will be assessed and reviewed. The membership used for this calculation was obtained through our internal analytics platform, Tableau, and reflects membership data as of December 31, 2024. This new tracking method will continue to be assessed and included in the analysis of our Quality and Accuracy of Information Report.

	# Of Grievances	Membership Base	# of Grievances - Per 1,000 Members
RAFR Grievances	1	906,993	**0.001**
	1	**906,993**	**0.001**

Website Self-Service Quality and Accuracy

As for the results of the current reporting period, it is evident that our overall performance continues to exceed the predetermined categorical threshold of 3.00. However, there was a slight decline of -0.39%, which is primarily attributed to challenges in locating referral, authorization, and financial responsibility information.

Table 5
Year 2025

Changing Primary Care Practitioner:	Surveyor 1	Surveyor 2	Surveyor 3	Surveyor 4	Surveyor 5	Surveyor 6	Surveyor 7	Surveyor 8	Surveyor 9	Surveyor 10	Avg. Rating
Was it easy to do?	4.00	4.00	5.00	2.00	5.00	3.00	5.00	5.00	2.00	5.00	4.00
Was the staff member able to change a PCP?	5.00	4.00	5.00	4.00	5.00	3.00	5.00	5.00	4.00	5.00	4.50
Was it completed in one attempt?	5.00	4.00	5.00	3.00	5.00	3.00	5.00	5.00	3.00	5.00	4.30

Determine How/When to obtain Referrals/Authorization:	Surveyor 1	Surveyor 2	Surveyor 3	Surveyor 4	Surveyor 5	Surveyor 6	Surveyor 7	Surveyor 8	Surveyor 9	Surveyor 10	Avg. Rating
Was it easy to find?	1.00	3.00	5.00	1.00	5.00	4.00	5.00	5.00	3.00	5.00	3.70
Was the staff member able to determine how and when to obtain referrals and authorizations for specific services?	2.00	3.00	5.00	2.00	4.00	3.00	3.00	5.00	3.00	5.00	3.50
Was it completed in one attempt?	4.00	3.00	5.00	2.00	4.00	3.00	5.00	5.00	3.00	5.00	3.90
Was the information provided useful?	3.00	3.00	5.00	2.00	5.00	3.00	5.00	5.00	3.00	5.00	3.90

Determine benefits and financial responsibility of a service:	Surveyor 1	Surveyor 2	Surveyor 3	Surveyor 4	Surveyor 5	Surveyor 6	Surveyor 7	Surveyor 8	Surveyor 9	Surveyor 10	Avg. Rating
Was it easy to find?	3.00	3.00	5.00	5.00	3.00	4.00	5.00	3.00	2.00	5.00	3.80
Was the staff member able to find the language that stated that members have no financial responsibility?	3.00	3.00	5.00	5.00	3.00	3.00	4.00	4.00	4.00	5.00	3.90
Was it completed in one attempt?	3.00	3.00	5.00	5.00	3.00	3.00	5.00	4.00	2.00	5.00	3.80

Table 6
Year 2024

Changing Primary Care Practitioner:	Surveyor 1	Surveyor 2	Surveyor 3	Surveyor 4	Surveyor 5	Surveyor 6	Surveyor 7	Surveyor 8	Surveyor 9	Surveyor 10	Avg. Rating
Was it easy to do?	5.00	5.00	4.00	3.00	3.00	5.00	5.00	5.00	5.00	3.00	4.30
Was the staff member able to change a PCP?	5.00	5.00	5.00	3.00	5.00	5.00	5.00	4.00	5.00	3.00	4.50
Was it completed in one attempt?	5.00	5.00	4.00	3.00	4.00	5.00	5.00	4.00	4.00	3.00	4.20

Determine How/When to obtain Referrals/Authorization:	Surveyor 1	Surveyor 2	Surveyor 3	Surveyor 4	Surveyor 5	Surveyor 6	Surveyor 7	Surveyor 8	Surveyor 9	Surveyor 10	Avg. Rating
Was it easy to find?	2.00	5.00	4.00	4.00	4.00	5.00	5.00	5.00	5.00	5.00	4.40
Was the staff member able to determine how and when to obtain referrals and authorizations for specific services?	2.00	5.00	4.00	4.00	5.00	5.00	5.00	4.00	5.00	5.00	4.40
Was it completed in one attempt?	1.00	5.00	4.00	4.00	5.00	5.00	5.00	4.00	5.00	5.00	4.30
Was the information provided useful?	4.00	5.00	4.00	4.00	5.00	5.00	5.00	5.00	5.00	5.00	4.70

Determine benefits and financial responsibility of a service:	Surveyor 1	Surveyor 2	Surveyor 3	Surveyor 4	Surveyor 5	Surveyor 6	Surveyor 7	Surveyor 8	Surveyor 9	Surveyor 10	Avg. Rating
Was it easy to find?	1.00	5.00	5.00	4.00	2.00	5.00	5.00	5.00	5.00	5.00	4.20
Was the staff member able to find the language that stated that members have no financial responsibility?	1.00	5.00	4.00	4.00	3.00	5.00	5.00	5.00	5.00	5.00	4.20
Was it completed in one attempt?	1.00	5.00	4.00	1.00	4.00	5.00	5.00	5.00	5.00	5.00	4.00

Upon thorough analysis of the results across all categories, it is evident that each reporting category experienced a negative trend compared to the previous year. Additionally, the decline in scoring appears to be linked to the Help page feature on the Member Portal and the format of the current survey questions. Some respondents reported challenges navigating to the Help page, and their feedback on locating referrals, authorization, and financial responsibility information varied due to the structure of the survey question.

To enhance the user experience of the Member Portal, Member Services will partner with IT Web Team to update the instructional language that guides users on the "Help" screen icon. Additionally, to improve the Website Self-Service Quality and Accuracy process for the 2025-2026 review period, Member Services will collaborate with the NCQA Accreditation Team to refine the survey layout, breaking down the questions to ensure responses are accurately captured for both Member Portal and the member-facing website. In addition to the above, we have organized additional year-over-year comparisons, as shown below:

- Total average rating decreased by 9% (2025: 3.92 vs. 2024: 4.32)
- Changing Primary Care Practitioner: -2% (2025: 4.27 vs. 2024: 4.33)
- Determine How/When to obtain Referrals/Authorization: -16% (2025: 3.77 vs. 2024: 4.47)
- Determine Benefits and Financial Responsibility of a Service: -8% (2025: 3.82 vs. 2024: 4.13)
- Total average rating experienced a 1.3% increase over our 2023 results (2025: 3.92 vs. 2023: 3.87)

Email Accuracy and Timeliness

During our recent assessment, we reviewed results of the current period and compared them to the previous period (Table 7-9). Through this review, we noted a continued rise in total volume of email inquiries received. We logged an annual increase of 141 email inquiries compared to the prior period. We attributed the increase to Partnership's membership growth across our 24-county service area.

Table 7

		2024								2025				
Email Inquiries	**Goal**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**Total**
Total Email Inquiries Received	N/A	101	89	89	85	73	93	50	52	97	62	72	71	934
# of Submissions Audited Per Month	10 or 10% of # Inquiries Received	10	10	10	10	10	10	10	10	10	10	10	10	120
% of Accuracy of Information	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
% of Emails Responded to Within 1 Business Day	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Table 8

		2023								2024				
Email Inquiries	**Goal**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**Total**
Total Email Inquiries Received	N/A	57	41	56	57	55	53	30	35	113	124	67	105	793
# of Submissions Audited Per Month	10 or 10% of # Inquiries Received	5	5	5	5	5	9	9	9	11	12	8	10	93
% of Accuracy of Information	95%	100%	100%	100%	100%	100%	100%	100%	99%	100%	100%	100%	98%	99.8%
% of Emails Responded to Within 1 Business Day	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Table 9

		2022								2023				
Email Inquiries	**Goal**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**Total**
Total Email Inquiries Received	N/A	22	39	28	35	30	26	39	26	46	33	64	55	443
# of Submissions Audited Per Month	10 or 10% of # Inquiries Received	5	5	5	5	5	5	5	5	5	5	10	5	65
% of Accuracy of Information	95%	100%	100%	98%	100%	100%	100%	100%	100%	98%	100%	100%	100%	99.7%
% of Emails Responded to Within 1 Business Day	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100.0%

Despite the increase in volume of email inquiries since the 2022-2023 period, we observed positive results across all aspects of email communication with our members. This includes response timeliness, and the accuracy of resolutions provided. Our Quality and Training team will continue to conduct monthly audits and report the findings to the intra-departmental workgroup as part of the annual assessment. Additional quantitative findings are presented below:

- Total Email Inquiries Received
  - +18% over the previous reporting period
    - 2024-2025: 934 vs. 2023-2024: 793
  - +111% over the 2022-2022 period
- % of Accuracy of Information
  - +.02% over the previous reporting period
    - 2024-2025: 100% vs. 2023-2024: 99.8%
  - +.03% over the 2022-2022 period

- # of Emails Responded to within 1 Business Day
  - Results (100%) remained stable with no change observed during the previous reporting periods

Summary

Barriers

Our results in accuracy and quality speak to Partnership's continued focus. While no barriers have been identified, we do understand that our performance results have shifted slightly, which has prompted our workgroup to implement an update to Partnership's Member Portal.

Opportunities for Improvement

Similar to the Barriers section, no major areas of opportunity were identified. That said, our internal teams will continue to monitor key areas, with a focus on process improvement and sustainability to ensure continued success. For the 2025-2026 review period, our focus will be to improve the Website Self-Service Quality and Accuracy annual survey results. At the department level, we remain committed to maintaining a strong focus on process improvement and will continue to identify potential opportunities for improvement. Our priorities center on increasing efficiency and upholding high-quality standards to ensure the quality and accuracy of all information provided to members is clear, consistent, and accurate.

Prioritization and Next Steps

Given the results of the current period, our focus will place strong emphasis on the Website Self Service Quality and Accuracy portion. To re-establish our performance levels, the Member Services Manager of Quality & Training will work with the IT Web Team to initiate updates to Partnership's Member Portal. Additionally, the Member Services management team will continue to closely monitor individual employee scorecards, new hire training, and process improvement efforts related to the quality and accuracy of "Referrals and Authorizations", "Eligibility and Benefits", and "Member Financial Responsibilities." The team will also evaluate the need for additional staff-level refresher training on an as-needed basis.

Quality in Grand Analysis

QI TRILOGY

NCQA - Grand Analyses

Partnership has established a strong foundation and framework to engage and build community partnerships with our members, health providers and organizations that serve the tenets of our organizational mission of ***"To help our members, and the communities we serve, be healthy,"*** and vision of ***"To be the most highly regarded managed care plan in California."*** Our commitment of continuous quality improvement is summarized within the six (6) Grand Analyses herein and in addition the complete analyses are provided in the appendices.

Under the 2025 NCQA Health Plan Accreditation Standards, the Continuity and Coordination of Behavioral Health (QI4) report and the Continuity and Coordination of Medical Care (QI3) Report are retired.

Access and Availability (NET3) Report

Partnership is meeting access standards for primary care (adult/pediatrics, newborn, urgent appointments, and telephone and after-hours accessibility) and four of six specialty care, high-volume and high-impact specialties (urgent, telephone, and after hours), based on data from our provider surveys and additional internal analysis. Partnership has experienced a downward trend for adult and pediatric primary care as well as specialty care appointments meeting the appointment standard across both regions since 2020. This coincides with the start of the pandemic. We are experiencing a continued trend of decreasing numbers of providers for multiple reasons including retirement of the baby boomer generation, decreased enrollment into medical schools across the nation, and higher burnout of physicians leading to reduction in available office hours.

While Partnership failed to meet the 15-day appointment standard for Dermatology and Obstetrics Gynecology, this is not due to a lack of contracting with an available service provider. Currently there are no additional qualified providers who are enrolled in Medi-Cal practicing in these geographic areas with whom to contract. Partnership monitors appointment access each quarter and works with individual providers who fail to meet the standard to identify strategies for improvement. Partnership requests and receives approval from DHCS for Alternative Access Standards (AAS) on an annual basis for the geographical areas that fail to meet the standard. If a member lives in an area where services are not covered, Partnership will help those members with making the appointment and arrange transportation to see the specialists that are not within the time or distance standard.

Opportunity

Appointment access to non-urgent primary care decreased by 13% in the southern region. Appointment access for obstetrics and gynecology in the southern region decreased by 19.5%. Partnership has identified the need to increase the number of contracted primary care and women's health specialty care practitioners to the network, particularly in the southern region.

Partnership has chosen primary care and women's health provider recruitment as equal high priority opportunities.

- *Planned Action:* Partnership has updated the Provider Recruitment Program (PRP) that offers a sign-on bonus for providers that are new to the Partnership network. If they are a currently practicing provider, they must come from outside of the Partnership 24 county service area. Providers completing a training program within the Partnership service area qualify for consideration for an award from the program. This

updated program is active between January 2024 – June 2025 with the bonuses being paid out over multiple payments over a 60-month term for physicians, NPs, and PAs, 24 months for behavioral health clinicians, and 12 months for certified SUD counselors. The strategy is to recruit and hold providers in place longer term.
    - Effectiveness of Action: To date there has been an increase in accepted offers with 168 awards approved on average over 12 months, (as compared to a historical average going back to 2014 of 86 awards per year). Family Medicine has been the majority provider specialty awarded, representing nearly 57% of the program awards to date. Partnership was able to recruit 208 new primary care practitioners to the network between January 2024 – April 2025, with 5 of them recruited to 4 of our most rural counties, including Sierra, Modoc, Plumas, and Trinity, whose geographic area is 75% or more rural (according to the US Census Bureau definition). Initial recruitment and retention details look favorable, but we may not know completely until the 60-month time period and further payments take place.
- *Planned Action:* Partnership continued to expand its efforts to strengthen recruitment for specialty providers, including obstetrics providers (physicians, women's health nurse practitioners, certified nurse midwives) whose clinical care focuses on perinatal care, including labor and delivery, to the 2024 PRP.
    - Effectiveness of Action: Fifteen obstetrics providers have been awarded since January 2024.
- *Planned Action:* Partnership launched a provider retention initiative (PRI) pilot in January 2024. The PRI is intended to recognize primary care clinicians, those who offer perinatal services (including labor and delivery) and/or obstetrics/gynecology, who have devoted their careers to the safety net, while helping to incentivize additional years of service from them. Our hope is that the PRI will help preserve institutional knowledge and clinical leadership and mentorship within our network, while an emerging generation of providers can learn from and train with these committed health professionals.
    - Effectiveness of Action: Since January 2024, 65 providers have been awarded and have committed to practice for 3 additional years.

Opportunity

Partnership has identified a need to improve member experience associated with access to care. The Adult Composite score for getting needed care decreased from 76.4% to 74.0% and getting care quickly decreased from 69.5% to 68.1%. Both failed to meet the benchmark for the second year in a row.

- *Planned Action:* To leverage more real time data (i.e., Grievance & Appeals [G&A] and Population Health Management [PHM] community engagement responses) on a quarterly basis to examine and respond timelier to topical themes identified directly from our members, including complaints about the health plan and providers. This enhanced method will provide the CAHPS Goal Team more real-time opportunity to measure intervention effectiveness against targeted barriers

Please see Appendix (A) Access and Availability (NET3) Report for a complete review of the quantitative and qualitative analyses for the learnings while trying to meet the stated goals for each measure noted above.

Pharmacy & Utilization Management (UM1B) Report: Utilization Management

The Annual Utilization Management (UM) Program Evaluation analyzes all aspects of data related to the UM program, identifies gaps and opportunities for improvement, and updates the program as necessary to ensure the program remains current and appropriate.

Key elements in this annual evaluation include program structure, program scope, processes, and information sources, as well as level of involvement of senior-level physicians and designated behavioral healthcare practitioners in the UM program.

In addition, data for member and practitioner experience with the UM process is evaluated to identify improvement and actionable opportunities. This report does not contain Kaiser Permanente or Carelon Behavioral Health data for evaluation of the UM program. Kaiser Permanente and Carelon Behavioral Health are NCQA accredited, and as such, reports from Kaiser Permanente and Carelon Behavioral Health are reviewed through the delegation oversight process.

Please see Appendix (B) Pharmacy & Utilization Management – UM1B Report: Utilization Management for a complete review of the quantitative and qualitative analyses for the learnings while trying to meet the stated goals for each measure noted above. AND Appendix (B) Pharmacy & Utilization Management (UM1B) Supplemental TAR Report.

Member Experience (ME7) Report

At Partnership HealthPlan of California (Partnership), our commitment to members goes beyond policy or compliance, it is rooted in purpose. As of December 2023, we proudly served over 663,822 members across our legacy 14-county service area. While Partnership expanded to serve an additional 10 Northern California counties (as of January 2024), this evaluation focuses exclusively on our legacy regions to ensure consistent year-over-year trend analysis. It reflects our ongoing commitment to listen, learn and lead work that improve our members healthcare experience. As a member-centered organization, we recognize that member experience fundamentally shapes our healthcare delivery success.

What We Measured and Why it Matters

Through coordinated efforts across departments, we capture member feedback through two primary channels:

- Annual regulated and non-regulated surveys (Calendar Years: 2022-2023)
- Grievance and appeals reporting (Calendar Years: 2023-2024)

The FY 2024–2025 Quality Improvement Evaluation reflects Partnership's continued commitment to advancing member experience, access to care, and health outcomes through data-driven, cross-functional collaboration. This year's findings reaffirm the importance of listening to member voices—whether through survey results, grievances, or community engagement—and translating those insights into targeted, meaningful action.

Despite challenges such as workforce shortages, regional access disparities, and growing member needs, the organization has made measurable progress. Improvements in provider ratings and select CAHPS® measures, alongside successful interventions in benefit literacy, transportation, and dental access, underscore the impact of our collective efforts.

Looking ahead, Partnership remains focused on equity, responsiveness, and continuous learning. The insights gained from this evaluation will shape the next cycle of strategic priorities, with an emphasis on sustained improvement, community trust, and alignment with our organizational mission to help the members of our communities be healthy.

Please see Appendix (C) Member Experience (ME 7) Report for a complete review of the FY 2024-2025 analysis, and interventions implemented and proposed FY 2025-2026 programmatic interventions.

Health Equity (HE6) Report

The HE 6: Reducing Health Care Disparities is an NCQA standard that examines how Partnership stratifies measures by race, ethnicity, language, and sexual orientation, as well as the prioritization and action taken, as necessary, to improve identified inequities. More specifically, the HE 6 report summarizes the work of Partnership to analyze potential disparities within the member population through an analysis of race and ethnicity, language, and gender data, as well as Partnership's effort to implement impactful interventions to reduce inequities and improve any Culturally and Linguistically Appropriate Services (CLAS) identified through the analysis. The measures of focus for the Grand Analysis report are:

1. Controlling High Blood Pressure (CBP)
2. Hemoglobin A1c Control for Patients with Diabetes (HBD)
3. Prenatal and Postpartum Care (PPC)
4. Child and Adolescent Well Care Visits (WCV)

Partnership completed this Grand Analysis in September 2024 as an element of Health Equity Accreditation (HEA), utilizing MY2023 Health Plan Accreditation (HPA) and MY2023 Managed Care Accountability Set (MCAS) final rates.

After Partnership's assessment for statistically significant inequities for the measures of focus, the following disparity classification system was developed to aid in prioritizing disparities based upon measure findings. This is based upon the Strength of recommendation taxonomy used in various clinical guidelines to stratify recommendations:

Disparity Classification

Strong Disparity (Disparity is clearly present when compared to comparator group or goal)
• Meets at least three (3) of any of following factors below
  ○ MCAS Sample Measure
  ▪ One group is performing statistically worse in at least one region when compared to the comparator group
  ▪ Absolute average percentage deficit between group and comparator (minimum performance level) is at least 10% (multiple regions) or 15% in single region in MCAS/HEA measure.
  ▪ Multiple regions (≥2) where specific group falls below 25th percentile per MCAS measure
  ▪ At least 1 region where group falls below 25th percentile
  ▪

Moderate Disparity (Disparity is moderately present when compared to comparator group or goal)
• Meets at least three (3) of any of the following factors
  ○ MCAS Sample Measure
  ▪ Absolute Average Percentage deficit between group and comparator (minimum performance level) is at least 10% (multiple regions) or 15% in single region
  ▪ No group is performing significantly better than comparator group yet at least one (1) group is performing significantly worse per MCAS measure
  ▪ Multiple regions (≥2) where group falls below 50th percentile

- At least one (1) region where group falls below 25th percentile

Weak Disparity (Disparity is uncertain when compared to comparator group or goal)

- Meets at least two (2) of any of the following factors:
  - MCAS Sample Measure
    - No statistical difference between groups in a region
    - Absolute Average Percentage deficit between group and comparator (minimum performance level) is at least 5% (multiple regions) or 7% in single region
    - Only one (1) region where group falls below 50th percentile and no group falls below 25th percentile

No inequities were identified when stratifying the measures of focus by language or gender. After developing this disparity classification system, Partnership identified the following areas of focus:

HEALTH INEQUITIES AREAS OF FOCUS							
Group	Key Measure	MCAS Number of Regions with Statistically Worse Disparity	MCAS Number of Regions with disparity (below 25th)	MCAS Number of additional Regions with disparity (below MPL – 50th)	Absolute Percent Average BELOW MPL across regions below 50th percentile	Category of Dsparity	Number of Years with Same Disparity
White	Controlling Blood Pressure	-	1	0	-1.21%	WEAK	N/A
	Poor HbA1c Control (>9%)	-	0	1	-6%	WEAK	N/A
	Postpartum Care	-	0	0		N/A	N/A
	Timeliness of Prenatal Care	-	0	1	-4.33%	WEAK	N/A
	Well Child Visits (WCV)	-	1	3	-6.02%	MODERATE	N/A
Native Hawaiian and Other Pacific Islander	Controlling Blood Pressure	0	1	0	-61.00%	MODERATE	N/A
	Poor HbA1c Control (>9%)	0	2	0	-12%	STRONG	N/A
	Postpartum Care	0	-	-	-	N/A	N/A
	Timeliness of Prenatal Care	0	-	-	-	N/A	N/A
	Well Child Visits (WCV)	1	3	1	-11.16%	STRONG	N/A

Hispanic or Latino	Controlling Blood Pressure	0	0	1	4.22%	WEAK	N/A
	Poor HbA1c Control (>9%)	0	0	1	-1%	WEAK	N/A
	Postpartum Care	0	0	0	N/A	NONE	N/A
	Timeliness of Prenatal Care	0	0	0	N/A	NONE	N/A
	Well Child Visits (WCV)	0	0	1	-3.08%	WEAK	N/A

HEALTH INEQUITIES AREAS OF FOCUS							
Group	**Key Measure**	**MCAS Number of Regions with Statistically Worse Disparity**	**MCAS Number of Regions with disparity (below 25th)**	**MCAS Number of additional Regions with disparity (below MPL – 50th)**	**Absolute Percent Average BELOW MPL across regions below 50th percentile**	**Category of Dsparity**	**Number of Years with Same Disparity**
Black or African American	Controlling Blood Pressure	0	0	0	N/A	NONE	N/A
	Poor HbA1c Control (>9%)	0	1	1	12%	STRONG	N/A
	Postpartum Care	0	0	0	N/A	NONE	N/A
	Timeliness of Prenatal Care	0	2	0	-30.12%	STRONG	N/A
	Well Child Visits (WCV)	1	2	2	-6.57%	STRONG	N/A
Asian	Controlling Blood Pressure	0	0	2	-0.17%	WEAK	N/A
	Poor HbA1c Control (>9%)	0	0	0	N/A	NONE	N/A
	Postpartum Care	0	0	1	-6.71%	WEAK	N/A
	Timeliness of Prenatal Care	0	1	0	-30.12%	WEAK	N/A
	Well Child Visits (WCV)	0	0	4	-6.57%	WEAK	N/A

American Indian and Alaska Native	Controlling Blood Pressure	0	2	0	-11.26%	MODERATE	N/A
	Poor HbA1c Control (>9%)	1	1	2	N/A	STRONG	N/A
	Postpartum Care	1	0	2	-15.57%	STRONG	N/A
	Timeliness of Prenatal Care	1	3	0	-21.78%	STRONG	N/A
	Well Child Visits (WCV)	1	1	3	-5.91%	MODERATE	N/A

While all of the above were identified as areas of focus, Partnership prioritized the following:

1. Timeliness of Prenatal Care (PPC-Pre): Black/African American Members
2. Timeliness of Prenatal Care (PPC-Pre): American Indian/Alaska Natives
3. Timeliness of Postpartum Care (PPC-Post): American Indian/Alaska Natives
4. Well Care Visits (WCV): All Pediatric Members

Partnership first conducted a barrier and root cause analysis for these measures and populations and also identified interventions to reduce the disparities. This is highlighted in the table below:

Timeliness of Prenatal Care (PPC – Pre)	
Group(s) of Focus	Black/African American Members
Percentage Below Minimum Performance Level (MPL)	*NE Region: 9.28% below* *NW Region:50.97* % below Non-Weighted Average: 30.12%
Goal for Specific Group	Improve prenatal visits by at least 5% in the NE or NW region in the Black/African American Member Population within 12 months with the global goal of improvement by 30% in the next 5 years.
Root Cause Analysis	Timely prenatal care is recommended to promote healthy pregnancies via screening and preventative management of a woman's risk factors. Unfortunately, various studies have suggested that fewer timely prenatal visits are associated with poorer pregnancy outcomes such as severe maternal morbidity, maternal death, and infant mortality (Howell, 2018). Research has suggested that insurance availability, transportation, and access to specific providers are key driving factors for receiving timely prenatal care. Partnership identified inequities for Black/African American members in the Northeast and Northwest regions for Timeliness of Prenatal Care.
Barrier Analysis	For prenatal care, researchers found that policy changes that improved eligibility for individuals, made insurance coverage more comprehensive, and improved maternity reimbursement rate was associated with greater attendance in postpartum visits (Saldanha et al., 2023). There has been limited research evaluating prenatal care and postpartum interventions in specific patient groups—namely Black/African American patients.

	Currently, Black/African American women are at least 3x more likely to experience a pregnancy-related death when compared to White women and have the largest disparity among all the conventional population perinatal health measures (Howell, 2018). However, partnership is currently exploring interventions to positively impact their prenatal and postpartum care. In 2023, the Department of Health Care Services (DHCS) added doula services as a covered benefit. In 2023, Sobczak et al. conducted a literature review of 16 studies (cohort and randomized trials) to evaluate the benefits of utilizing a doula. Their findings suggested that doula support decreased incidence of cesarean or premature labor, low birth weight, and epidural/medical pain management. Finally, Partnership conducted a focus-group-like survey of Black prenatal and postpartum members (n=12) to conduct a survey to better understand if the member attended their appointments, as well as to understand the barriers faced, if any at the Solano County Family Health Services site—which has the largest population of Black/African American members. Overall, the members highlighted that they didn't attend their visits due to one of the following three categories: (1) Incorrect Staff Actions, (2) Schedule Unavailability, (3) Lack Of Transportation. This has motivated Partnership to explore utilizing group visits to streamline staff actions, schedule availability, and coordinate transportation. In 2017, Byerley and Hass conducted a systematic review of 38 studies (8 randomized trials, 23 nonrandomized studies, 6 reports of group outcomes without controls) to evaluate group prenatal care in 20,000+ women. Overall, Byerley et al. (2017) found a significant increase in rates of breastfeeding and satisfaction in Black/African American members after implementing group prenatal care interventions. Partnership may explore whether clinical site locations will be interested in conducting a pilot to validate the efficacy of utilizing such group visits with Doulas. Long-term, Partnership will explore utilizing a combination of interventions to likely meet the large threshold of members who are not meeting the goal.
Actions for Direct Clinical/Service Measure Improvement	**<u>Intervention #1: Contracting Doulas in Partnership Network:</u>** Partnership is also investigating what education doulas share with utilizing members, to ensure members are receiving appropriate information on the importance of early access to prenatal care as well as postpartum care. Partnership has worked to add doulas to the network and has at least one doula in each region of the network. The health equity officer and other staff have ventured into various community events to help with recruiting various Doulas. **<u>Intervention #2: Increase Diversity of OB GYNs:</u>** Partnership is investigating how to improve the diversity among Obstetrics-Gynecology doctors. To this, Partnership is exploring how to do a baseline assessment of the race and ethnicity demographics of OBs within the network to assess. Partnership will then share this information with respective HR departments to provide guidance to the provider recruitment team at Partnership and incentivize increasing diversity hiring throughout the network to reflect the populations served. Partnership has launched a new provider retention

	initiative. Specifically, partnership will provide $45,000 award to a Doctor of Medicine/Doctor of Osteopathic Medicine (DO) or $30,000 award to a nurse practitioner/physician assistant for a 3-year commitment. This intervention will be applicable to all clinical sites—especially OB/GYN sites that inhabit locations that serve a large Black/African American population. **<u>Intervention #3: Encourage Clinical Sites to Utilize Dyadic Care Models</u>** Dyadic care models are considered effective for optimizing the care of both the mother and infant. Dyadic care is considered when a provider provides care for a birthing mother and their infant during the same visit. Specifically, the American Academy of Pediatrics recommends prenatal visits to establish pediatric medical homes and postnatal depression screening for the birthing person during pediatric visit (Choy et al. *PLoS One*. 2024 Apr 16;19(4):e0298927). This is based upon the postnatal period being seen as a critical time to support and improve health outcomes of birthing people and their infants. Unfortunately, pregnancy-related morbidity and mortality often occurs within the 6-week postpartum period, and this has been attributed to difficulty in accessing care. Partnership will continue to advocate for sites to adopt dyadic care models—especially in regions where there are limited OB/GYNs and primary care providers.

Prenatal and Postpartum Care (PPC)	
Group(s) of Focus	American Indian/Alaska Native
Prenatal Percentage Below Minimum Performance Level (MPL)	*NE Region: 9% Below* *NW Region:* 22% below *SW Region:* 34% below *Non-Weighted Average:* 21.78% Below
Goal for Specific Group	Improve prenatal visits by at least 5% in the NE or NW region in the American Indian/Alaska Native Member Population within 12 months with the global goal of improvement of 22% in the next 5 years.
Postpartum Percentage Below Minimum Performance Level (MPL)	*NE Region: 28% Below* *NW Region:* 3% below *SW Region:* 3% below *Non-Weighted Average:* 11.4% Below
Goal for Specific Group	Improve postpartum visits by at least 5% in the NE region in the American Indian/Alaska Native Member Population within 12 months with the global goal of improvement by 12% in the next 5 years.
Root Cause Analysis	Currently, majority of our American Indian/Alaska Native members are located in Humboldt, Mendocino, and Shasta Counties in our NW and NE regions. Tertiary research has suggested that there is a significantly higher rate of maternal morbidity and mortality among this group due to centuries of human rights violations (e.g. massacres, forced relocation, boarding schools)

	which has translated into generational trauma via epigenetics (Burns et al. *Soc Sci Med*. 2023 Jan;317:115584.). In addition, researchers has identified the following predictors of maternal mortality: older maternal age, pre-existing conditions, prior cesarean section, transportation issues, travel time, administrative burdens which limit Medicaid enrollment and prenatal care update; and various structural racism incidents during healthcare interactions.
Barrier Analysis	Research suggests that there are structural barriers that are exacerbating poor outcomes in our American Indian/Alaska Native community. For example, there are purported to be transportation infrastructure, family welfare system, poor prenatal care infrastructure, and blatant racism that are the key upstream factors that are acting as barriers for improving disparities. Within Partnership's service landscape, the region that is experiencing the greatest disparity for this measure is the NW rural region. Currently, many of Partnership's AI/AN members inhabit this area and likely are experiencing lack of clinic access for all providers. Also, various tribal centers utilize various are held financially accountable to government performance and results act (GPRA) versus HEDIS measures—which are considered less stringent. Therefore, various tribal centers do not have the financial incentive to be intensive with hypertension treatments versus non-tribal health centers. To improve relations, Manage Care Organizations (MCOs) and Partnership specifically, has explored hiring tribal health center liaisons to improve the collaboration between MCOs and tribal centers.
Actions for Direct Clinical/Service Measure Improvement	**<u>Intervention #1: Tribal Health Liaison Hiring and Hosting Tribal Center Event</u>** Partnership has hired a full-time Tribal health liaison to positively impact relationships with tribal health centers, tribal health community members, and provide guidance to help support Tribal member needs. Partnership has recognized partnering with the Tribal community as an organizational initiative and is working to positively impact all care received by Tribal members through this partnership and communication with Tribal Health Centers within the network at this time. This work has the potential to improve the member experience of American Indian/Alaska Native members, ensure they are receiving culturally appropriate care, and positively impacting the care received by members who identify with this group. Also, the tribal health liaison will be able to conduct various focal group interviews and possibly identify community-based organizations to able to provide tele-nutrition counseling sessions, funds for delivery of DASH-diet aligned foods. **<u>Intervention #2: Contracting Doulas in Partnership Network:</u>** Partnership is also investigating what education doulas share with utilizing members, to ensure members are receiving appropriate information on the importance of early access to prenatal care as well as postpartum care. Partnership has worked to add doulas to the network and has at least one doula in each region

	of the network. The health equity officer and other staff have ventured into various community events to help with recruiting various Doulas. In addition, Partnership is trying to contract with doulas in the NE/NW regions to ensure that we are able to outreach to our Tribal community members. **Intervention #3: Advertisements of Transportation Benefit with Translation into Tribal Languages:** Partnership is also investigating what education we can share with utilizing members, to ensure members are receiving appropriate information on the importance of early access to prenatal care as well as postpartum care. For example, partnership has recognized that many members are unaware of the transportation benefit afforded to them. Therefore, they may be unaware that Partnership is able to pay for the lodging fees and transportation for a tribal member anywhere they would like to go if they are seeking prenatal/postpartum care in a separate county. Finally, Partnership would like to engage with and survey members to assess whether they should advertise certain education materials into different languages to ensure they are receptive to our various tribal communities.

Well Care Visits (WCV)	
Group(s) of Focus	American Indian/Alaska Native Black/African American White
Goal for Specific Group	Improve Well Care Visit attendance by at least 2.5% across multiple regions or at least 5% in 1 single region in any group (e.g.) Black/African American, American Indian/Alaska Native, White within 12 months with global goal of improvement by 5% in the next 5 years.
Root Cause Analysis	Per the DHCS Bold goals, the state is looking to close all racial/ethnic disparities in WCVs by 50% by 2025. Currently, WCVs are low for all populations. A proposed hypothesis of the root cause is that there is a significant shortage of pediatrician providers—who are able to conduct the WCVs. Therefore, there is a limitation in conducting the absolute number of visits for all pediatric members—regardless of race/ethnicity/gender identity. Also, by having certain members miss at least 1 visit, this will likely cause a shift to make it impossible to attain the key number of visits by a certain age. Currently, the American Academy of Pediatrics recommends at least 13 well-child visits between birth and 6 years of life.
Barrier Analysis	Overall, researchers found that Well Care Visits (WCV) was the clinical measure that majority of race/ethnic groups have a disparity of not meeting the minimum performance threshold throughout the regions. This suggests that the low WCV rate is more of a quality concern versus a demographic specific concern.

	Within the American Indian/Alaska Native community, there is a community concern of children being reported for child protective services referrals. Historically, AI/AN children were consistently removed from their homes to adopt western cultures. This has resulted in various family members being concerned with exposing their child to unfamiliar members of the community. Also, Partnership tribal health centers have a challenge with engaging with members due to the ongoing difficulties with recruitment and consistent retention of health workers and leadership. This is due to the Indian health serves being consistently underfunded, leading to rationing of needed services and a crumbling infrastructure. Therefore, Partnership may consider helping with provider recruitment and retention since tribal centers are unlikely to financially compete with other centers. Within the Black/African American community, there is an association with low well child visit attendance due to low levels of maternal education, low income, and poor prenatal care (Wolfe et al., 2018). Partnership can explore implementing interventions to improve tailored interventions to improve well-child care in African American/Black groups. For example, in a systematic review of well care visit redesigns researchers highlighted the efficacy of doing group WCVs. (Coker et al., 2013)
Actions for Direct Clinical/Service Measure Improvement	**Intervention #1: Provider Recruitment Program and Provider Retention Initiatives** Partnership has launched a new provider retention initiative. Specifically, Partnership will provide $45,000 award to a Doctor of Medicine/Doctor of Osteopathic Medicine (DO) or $30,000 award to a nurse practitioner/physician assistant for a 3-year commitment. This intervention will be applicable to all of clinical sites—especially Partnership's tribal centers and sites that inhabit locations that serve a large Black/African American population. **Intervention #2: Group Well Child Visits** Partnership is conducting a pilot with a clinical site to start group well-child visits in a clinical site in Solano county—which has the greatest diversity among Partnership's 14 counties. Long-term, Partnership can explore utilizing a combination of interventions to likely meet the large threshold of members who are not meeting the goal throughout the network. **Intervention #3: Increase Access to BIPOC-related children's book regarding improving immunizations and attending WCVs** Partnership's HEO previously published a children's book, Andres Armor, which teaches BIPOC children the importance of vaccines using knight and dragon analogies. He is exploring donating copies of the book and videos to clinical sites to hopefully increase the number of children wanting to attend WCVs and watching the free information play during their provider visits.

In Partnership's assessment of opportunities to improve Culturally and Linguistically Appropriate Services (CLAS), Partnership met or performed better than the member satisfaction target of maintaining member abrasion or dissatisfaction below 1/10th of one percent (0.10%). The 2023 case filings yielded a score of 0.03% relative to language service utilization and were slightly above the threshold target of (1/10th of one percent) 0.10%. The

analysis workgroup established a priority ranking based on the number of case filings by category. The Language Barrier/Limited English Proficiency category type resulted in roughly 60% of the total grievances within the 2023 Annual Grievance & Appeals Priority by Category Type, which highlights an opportunity for improvement.

Based on member satisfaction with language-related services and the HE 6 Case Analyses, Member Services and Quality Improvement will implement an intervention in the form of an inter/intradepartmental workgroup. This workgroup will place an emphasized focus on analyzing the leading causes of member dissatisfaction as it relates to CLAS. As a result of the associated grievance volume, the Language Barrier/Limited English Proficiency category type will serve as the basis through which Partnership's intervention workgroup will develop improvement activities.

Furthermore, Partnership's Population Health Department will address this unmet goal by addressing the need to provide written materials to members in their choice of format (such as large print, Braille, audio format, or other) to ensure vision-impaired members are able to understand the information Partnership shares. This goal is monitored through the annual C&L Work Plan. This will be done to provide a more proactive approach for language services.

The completed Grand Analysis report will be submitted with all other Health Equity Accreditation documents for review in June 2025. Partnership will continue completing a Grand Analysis report each year, adjusting to meet the needs of the organization's missing and Health Equity Accreditation standards.

Please see Appendix (D) Health Equity (HE 6) Report for a complete review of the assessment for statistically significant inequities for the measures of focus.

Evaluation

Conclusion

QI TRILOGY

Evaluation Conclusion

This concludes the FY 2024-2025 Quality Improvement Program Evaluation, which provides an assessment on performance work outlined in the FY 2024-2025 QI Program Description and Work Plan. Partnership's Quality Improvement (QI) Program was successful over the course of fiscal year 2024-2025 in achieving its quality improvement goals and commitments. Partnership has maintained its NCQA Health Plan Rating (HPR) as 3.5 Star health plan. Partnership continues to leverage its 5-Star Quality Strategy and corresponding tactical and work plans to demonstrate an increased organizational focus on improving quality measure and CAHPS® scores now and into the future. In 2024-2025, Partnership has been able to engage fully in existing and expanding performance improvement and pay-for-performance strategies and programming, including priorities to advance health equity. While, at the same time, Partnership has worked diligently through its QI Program to engage with providers in its 10-county expansion region to help our members in these new communities be healthy. As Partnership moves into 2024-2025, Partnership's QI Program remains committed to striving for its long-term goal of achieving a 5-Star HPR, while also preparing to implement its new D-SNP and achieve NCQA Health Equity Accreditation .

Appendices

QI TRILOGY

NETWORK ADEQUACY REPORT

ASSESSMENT OF NETWORK ADEQUACY

NET 3, ELEMENT A, B: ASSESSMENT OF MEMBER EXPERIENCE ACCESSING THE NETWORK & OPPORTUNITIES TO IMPROVE ACCESS TO NON-BEHAVIORAL HEALTHCARE SERVICES

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Section 1: Objective

The purpose of this report is to evaluate all aspects of data related to Network Adequacy to ensure Partnership HealthPlan of California (Partnership) provides members with adequate network access for needed healthcare services. The provider types covered include primary care clinicians, medical specialists, and hospitals. Partnership follows the NCQA Network Management Standard requirements, and this report will present those findings.

Partnership HealthPlan of California (PARTNERSHIP) is a managed Medi-Cal Health Plan in Northern California. PARTNERSHIP expanded from 14 counties in 2023 to 24 counties in 2024. Our service area is divided into 6 regions with 13 counties designated as rural, 7 designated as small, and 4 designated as medium by DHCS.

Utilizing access data from our current network, this report evaluates and summarizes the following:

- Member Grievance (Complaints) appeals and member experience about network adequacy for non-behavioral healthcare services from ME7: Element C and D.
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey results from the ME 7 report.
- Utilization of out-of-network services.
- Practitioner Availability summarized results for practitioner ethnicity/race to member ethnicity/race data and provider to member ratio for the top three threshold languages identified in (Net 1 Element A Cultural Needs and Preferences).
- High Volume and High Impact specialty geographic distribution and Practitioner Ratios (NET 1 Practitioner Availability of Services - Elements B and C).
- Routine Primary Care, Urgent Care, Non- Urgent Specialty Care Practitioner (NET 2 - Accessibility of Services - Elements A and C).
- Analysis from factors 1-3 to determine if there are gaps in the network specific to particular geographic areas or types of practitioners or providers.

The Network Services Manager of Compliance, Associate Directory of Workforce Development, and the Workforce Development Liaison, are responsible for conducting and summarizing the qualitative analysis.

The report is reviewed and approved by a multi-disciplinary team made up of the Chief Medical Officer, Senior Director of Provider Relations, Senior Director of Member Services, Director of Grievance and Appeals, Senior Director of Quality and Performance HS Quality Improvement, Network Services Director, Network Services Manager of Compliance, and Network Services Compliance Program Managers.

Opportunities for improvement are identified by the Chief Medical Officer, Associate Director of Workforce Development, and the Workforce Development Liaison. Decisions and actions are reviewed and approved by the Quality Committee.

Section 2: Methodology

The following data sources were used to evaluate Network Adequacy:

***MEMBER GRIEVANCE*:** From the full volume of member grievances evaluated annually, this analysis includes a subset of those grievances that are specifically focused on network adequacy or access to care. Grievance category used was "access", which includes all grievances related to appointment access or availability within the network.

MEMBER APPEALS: Member appeals and second level grievances data.

2023-2024 CAHPS: Survey results from the ME 7 report for Adult and Child.

***OUT OF NETWORK (OON) REQUEST/REFERRAL AND UTILIZATION*:** Partnership has two distinct types of members, Direct and Non-Direct. For Non-Direct Members, a request for a referral to see an OON specialist must be submitted and prior authorization (approval) are required prior to seeing the specialist. Direct Members do not need to submit a request for a referral or receive prior authorization (approval) before seeing an OON specialist. The ability of Direct Members to self-refer accounts for the number of OON requests and approved referrals being lower than the number of OON claims. Claims data is pulled to determine utilization. Out of network request and claims are analyzed per 1, 000 members. Requests and claims counts are analyzed at the Plan level.

PRACTITIONER AVAILABILITY: (NET 1, ELEMENT A: CULTURAL AND LINGUISTIC NEEDS AND PREFERENCES): Partnership collects data every year on language, culture and ethnicity/race of our members and compares the data against practitioners to determine if there is adequate practitioner coverage to meet our members' needs. Member Ethnicity/Race – all self-reported member race/ethnicity is identified and assessed against provider ethnicity/race. Provider Ethnicity/Race – data from the Medical Board of California's Physician Survey of allopathic physicians and surgeons (licensees) is to analyze practitioner ethnicity/race. Member Grievance Reports: data is collected and analyzed for member concerns regarding discrimination and linguistic needs. Cultural Preference is assessed utilizing the Health Education and Cultural and Linguistic Population Needs Assessment (PNA). The PNA investigates member health status and behavior, cultural and linguistic needs, community health education and cultural and linguistic programs and resources, health disparities, and gaps in services.

PRACTITIONER AVAILABILITY: (NET 1, ELEMENT B, C: PRACTITIONERS PROVIDING PRIMARY CARE & SPECIALTY CARE RATIO, GEOGRAPHIC DISTRIBUTION OF PRACTITIONERS):

Partnership obtained data for contracted primary care, high volume, and high impact specialties from our Data Warehouse which then populates Quest Analytics software to evaluate geographic distribution compared to our established geographic standards set forth in policy (MPNET 100) that were in effect at the time of production. Additionally, practitioner ratios were evaluated for primary

care, high volume, and high-impact specialty practitioners. The analysis is based on a comparison to our established standards.

PRACTITIONER ACCESSIBILITY: (NET 2 ELEMENT A, C: ACCESS TO PRIMARY CARE & SPECIALTY CARE):

The Third Next Available (3NA) survey is a cross-sectional, one-time call during business hours, to provider offices, to evaluate access. This survey is used to evaluate primary care and high volume/high impact specialty appointment access using the following performance standards:

Routine Primary Care Appointments	**< 10 Business Days of Request**
Prenatal Care Appointments	**< 10 Business Days of Request**
Newborn Appointments	**< 48 hours of Discharge of Request**
Urgent Care Appointments	**< 48 hours of Request of Request**
Non-Urgent Specialty Care Appointments	**< 15 Business Days of Request**

The survey is administered by Partnership's provider relations staff annually during the months of February and March and includes all PCP sites and identified high volume/high impact specialists that meet a set threshold of 200 unique member visits a year. The 2022 3NA surveyed 254 primary-care provider sites, 255 specialty provider sites, and 110 prenatal provider sites. Partnership's Well-managed benchmark analysis to evaluate specialty use trends within our network.

Member Grievances: from the full volume of member grievances evaluated annually, this analysis includes a subset of those grievances that are specifically focused on network adequacy or access to care. The grievance category is used as the "access" category, which includes all grievances related to appointment access for primary care and specialty care providers. Grievance data utilized for the analysis is data from January 1, 2023, through December 31, 2023.

***BEHAVIORAL HEALTH PRACTITIONER AVAILABILITY AND ACCESSIBILITY*:** Behavioral health data is analyzed in the Annual Behavioral Health Report. Additionally, Carelon Health Options is Partnership's delegated entity, and are NCQA accredited.

Section 3: Quantitative Analysis:

MEMBER GRIEVANCES:

TOTAL ACCESS MEMBER GRIEVANCES:

The trending data includes reporting periods; January 1, 2024 – December 31, 2024, and the previous year, January 1, 2023 – December 31, 2023.

In 2024, there were a total of 5,477 grievances submitted by our members. The analysis attributes 42% of all cases to Access.

In comparison to the 2023 reporting period, there were a total of 3,572 grievances submitted by our members. The analysis attributes 43% of all cases to Access.

Grievances Only Reporting Period: Annual 2023 vs 2024								
	Previous Period: 2023			Current Period: 2024				
NCQA Category	Grievances	Avg Mship	Grievances p/1,000	Grievances	Avg Mship	Grievances p/1,000	Threshold	Threshold Met?
ACCESS	1,526	678,546	2.25	2,567	905,570	2.83	2.47	No

- **Notable Findings:** Partnership did not meet the established 2.47 grievances per 1,000 member threshold, having 2.83 grievances per 1,000 members in 2024. This number represented an increase in grievances per 1,000 members when compared to the 2.25 grievances per 1,000 members in 2023.

MEMBER APPEALS:

The trending data includes reporting periods; January 1, 2023 – December 31, 2023, and the previous year, January 1, 2022 – December 31, 2022.

In 2024, the health plan received 674 Appeals and Second Level Grievance cases, a 2% decrease in case filings from 2023, with Access contributing 34% of the total.

In comparison to the 2023 reporting period, the health plan received a total of 689 Appeals and Second Level Grievances cases with Access contributing 43% of the total.

Appeals & Second Level Grievances Reporting Period: Annual 2023 vs 2024								
	Previous Period: 2023			Current Period: 2024				
NCQA Category	Appeals & SLG	Avg Mship	Appeals & SLG p/1,000	Appeals & SLG	Avg Mship	Appeals & SLG p/1,000	Threshold	Threshold Met?
ACCESS	350	678,546	0.52	442	905,570	0.49	0.57	Yes

Notable Findings: Partnership met the access Appeals and Second Level Grievances threshold for 2024.

There were 6,149 Grievances, Second Level Grievances, and Appeals closed in 2024 compared to 4,261 in 2023. These cases are broken into two (2) groups – Grievances accounted for 5,477 and Appeals and Second Level Grievances accounted for 672.

Our membership experienced a 33.5% growth, rising from 678,546 in 2023 to 905,570 members in 2024. Alongside our membership increase, there was a rise in Grievances received in 2024, leading to an increase in access related Grievances filed per 1,000 members from 2.25 to 2.83. We saw a decrease in the number of Appeals and Second Level Grievances filed in 2024.

With an increase in membership and a 28.5% increase in Grievances filed, three thresholds for Grievances were not met, one of which was Access. Access issues mainly consisted of long wait times for providers and transportation issues such as the driver arriving late and missed ride issues.

Partnership was able to meet the minimum threshold for Appeals & SLGs regardless of a 31% increase from 2023. The total number of cases filed per 1,000 members decreased from 0.52 to 0.49 and was well within the threshold.

In 2023, DHCS eliminated Second Level Grievance as a case type. Effective January 1, 2025, the process was replaced with the appeal process to satisfy DHCS guidelines.

PRIMARY CARE ACCESS MEMBER GRIEVANCE

Partnership analyzes total access grievances by region and practitioner group to determine if there are access trends. Grievance data utilized for the analysis is for the calendar year, January 1st - December 31st.

Partnership had 14 counties and two distinct regions in 2023

Region	Appt. Availability	Office Availability	Telephone Availability	Total
Northern	29	0	0	30
Southern	51	1	8	60
Totals	81	1	8	90

Partnership had 24 counties and six distinct regions in 2024

Region	Appt. Availability	Office Availability	Telephone Availability	Total
Auburn	18	0	4	22
Chico	23	1	2	26
Eureka	13	0	2	15
Fairfield	65	0	13	78
Redding	18	1	4	23
Santa Rosa	17	0	2	19
Totals	154	2	27	183

The threshold for review is based on the total number of grievances of two or more in any one category and a rate of 4/1000 members.

Primary Care Access Grievance Data (January 1, 2024 – December 31, 2024)								
Region	**County**	**Provider Name**	**Appt. Availability**	**Office Availability**	**Telephone Availability**	**Total**	**Total Members Assigned to Provider**	**Rate per 1000 Members**
Auburn	Placer	Wellspace Health Roseville	3			3	7,985	0.37
Chico	Butte	Ampla Health Chico Medical & Pediatric	3			3	15,536	0.19
Fairfield	Solano	Jayesh Patel, MD			3	3	927	3.31
Fairfield	Solano	Solano County Health & Social Service	7			7	31,098	0.23
Redding	Shasta	Shasta Community Health Center	2		1	3	18,773	0.16

Member Complaints Primary Care (Everest Data, 2024)

Notable findings: In 2024, the access to primary care member complaints increased from 90 to 183. The increase is not surprising with the inclusion of 10 new counties. Appointment availability remains the most common type of grievance.

- Jayesh Patel, MD had the highest telephone availability grievances and a rate of 3.31 per 1000 members. However, the rating is within the standard and requires no further action.
- Solano County Health and Social Service had the most grievances in appointment availability as well as overall. Despite the number of grievances, the rating per 1000 members was within the standard. No further action is currently required.

A trend could not be established due to the low number of member grievances over the course of a year. No further action is currently required.

SPECIALTY CARE MEMBER GRIEVANCE:

Partnership analyzes total access complaints by region and practitioner group to determine if there are access trends. Grievance data utilized for the analysis is for the calendar year, January 1st - December 31st.

Partnership had 14 counties and two distinct regions in 2023

Region	**Appt. Availability**	**Office Availability**	**Telephone Availability**	**Total**
Northern	2			2
Southern	2			2
Totals	4			4

Member Complaints Specialty Care (Everest Data, 2023)

Partnership had 24 counties and six distinct regions in 2024

Region	Appt. Availability	Office Availability	Telephone Availability	Total
Auburn	2			2
Chico	6			6
Eureka	1			1
Fairfield	4			4
Redding	2			2
Santa Rosa	1			1
Totals	16			16

Member Complaints Specialty Care (Everest Data, 2024)

The threshold for review is based on the total number of grievances of two or more in any one category.

Specialty Care Access Grievance Data (January 1, 2024 – December 31, 2024)							
Region	**County**	**Provider Name**	**Appt. Availability**	**Office Availability**	**Telephone Availability**	**Total**	**High Volume or High Impact Specialty**
Chico	**Butte**	Ampla Health Chico Medical	**2**			**2**	**High Volume Specialty** Pediatrics
Santa Rosa	**Sonoma**	Santa Rosa Orthopedic Medical Group	**2**			**2**	**High Volume Specialty** Physical Therapy
Santa Rosa	**Sonoma**	Santa Rosa Orthopedic Medical Group	**2**			**2**	**High Volume Specialty** Orthopedic Surgery

Specialty Care Access Grievance Data (Everest, 2024)

Notable findings: In 2024, the access to specialty care member complaints increased from 4 to 16. The increase is not surprising with the inclusion of 10 new counties. Appointment availability remains the most common type of grievance. Twelve high-volume specialties had one appointment complaint each for the reporting year and two had two appointment complaints.

- Ampla Health: Despite having two grievances for appointment availability, Ampla was within appointment standards with the 3NA survey. A trend could not be established. No further action is currently required.
- Santa Rosa Orthopedic: Despite having two grievances for appointment availability in physical therapy and orthopedic surgery, Santa Rosa Orthopedic was within the standards with the 3NA survey. A trend could not be established. No further action is currently required.

CULTURAL, ETHNIC, RACIAL, LGBTQ+ DISCRIMINATION GRIEVANCES

Partnership looks at network adequacy for issues pertaining to race, ethnicity, and language to ensure practitioners are meeting member needs. This report identifies member-reported grievances

which are classified into four discrimination categories which include: Cultural, Ethnic, Racial, and LGBTQ+. For Language grievances, we identify language discrimination and language barriers.

The table below outlines the summary of discrimination grievances for 2023

Discrimination Grievances (January 1, 2023 - December 31, 2023)							
Region	County	Provider	Specialty	Discrimination Grievances			
				CE&R Discrim	Language Discrim	Language Barrier	LGBTQ+ Discrim
South	Mendocino	Adventist Health Ukiah Valley	Nutrition Services	1	0	0	0
South	Solano	DaVita Dialysis - Napa	Renal Dialysis Clinic	1	0	0	0
South	Lake	Elhakim, Samer MD	Family Medicine	0	1	0	0
South	Solano	La Clinica - Vallejo	Pediatrics	1	0	0	0
South	Mendocino	North Coast Family Health Center-Clinic	Pain Management	1	0	0	0
South	Solano	Solano County Health & Social Services	Internal Medicine	1	0	0	0
South	Solano	Sutter Medical Foundation	Orthopedic Surgery	0	1	0	0
South	Sonoma	Sutter Medical Group of the Redwoods	General Surgery	0	1	0	0
South	Solano	Sutter Solano Medical Center	General Medicine	1	0	0	0
South	Marin	Marin Health Network	ENT (Family Practice)	0	1	0	0
South	Solano	Vacaville Urgent Care Medical Group	Urgent Care	1	0	0	0
North	Shasta	Fletscher, Walter Lyle, MD	Cardiovascular Disease/Internal Medicine	0	1	0	0
North	Lassen	Lassen Indian Health Center	Family Practice	2	0	0	0
North	Shasta	Mercy Medical Center-Redding	Emergency Medicine	0	1	0	0
North	Trinity	Meredith, Randall John, MD	Family Medicine	0	0	0	1
North	Shasta	Shasta Regional Medical Center	Psychiatry	0	2	0	0
North	Humboldt	Southern Humboldt Community Clinic	Family Practice	0	0	1	0

Source: 2023 Discrimination Grievances Data: 1Q24 Grievance and Appeals PULSE Report

The table below outlines the summary of discrimination grievances for 2024. The 2023 categories of language and language barrier were combined into one category of linguistic.

Discrimination Grievances (January 1, 2024 - December 31, 2024)						
Region	County	Provider	Specialty	Discrimination Grievances		
				CE&R	Linguistic	LGBTQ+
Auburn	Placer	Baird, Rowan Chantel MD	Family Medicine		1	
Auburn	Placer	Jahangir Mahmoudi, MD	Endocrinology	1		
Chico	Yuba	Angeli Duran, MD	Internal Medicine	1		
Chico	Butte	Enloe General & Colorectal Surgery	Multi-Specialty Group		1	
Fairfield	Solano	Bay Area Ortho Surgery	Orthopedic Surgery		1	
Fairfield	Solano	Rashid Iqbal Gastro Office	Gastroenterology	1		
Redding	Siskiyou	Nicholas Schulack, DO	Emergency Medicine	1		
Redding	Shasta	Hill Country – Center of Hope	Family Medicine		1	
Redding	Shasta	Lassen Medical Center-Red Bluff	Family Medicine			1

Source: 2024 Discrimination Grievances Data: 1Q25 Grievance and Appeals PULSE Report

- **Notable Findings:** The most common reported problem was alleged discrimination due to race or ethnicity. The second most common was alleged discrimination due to language. All concerns were addressed by the usual grievance process. Further action is not required.

  An examination of discrimination cases from 2023 to 2024 showed a significant reduction of 47%. This decline is particularly noteworthy given the overall year-over-year increase of 28.5% in total grievance cases. This follows the same pattern from 2022 to 2023.

  One contributing factor to this decline could be attributed to our comprehensive approach in handling cases of alleged discrimination. Upon identifying instances where discrimination is likely to have occurred by a provider, G&A initiates a proactive measure of implementing a Soft-Warning Letter aimed at fostering awareness and corrective action within the provider community. These letters serve as a formal communication channel providing educational resources that are tailored to assist in understanding and implementing practices that promote inclusiveness and prevent discrimination against our members.

2022- 2023 CAHPS Composite Scores:

CAHPS Results from ME7 Report: Adult Response

Below is a year-by-year comparison of the Composite scores for measurement year 2022 and measurement year 2023 for the Adult Survey. In Year 2023-2024, we received 130 more complete surveys than in Year FY 2022-2023. All questions met the 100 sample size criteria for both measurement periods. The CAHPS program raised the plan performance benchmark to the 33rd percentile from the 25th percentile for measurement period 2023-2024.

	ADULT CAHPS Composite	2022-2023 (14.3% Response Rate) Sample Size 2700 Total Returns 380	2022 Percentile Rate	Partnership Benchmark	PHC Benchmark Met?	2023-2024 (15.3% Response Rate) Sample Size 2700 Total Returns 510	2023 Percentile Rate	Partnership Benchmark	PHC Benchmark Met?
Composite Measure	Getting Needed Care (% Always or Usually)	76.4%	14th	≥ 25th	No	74.0%	7th	≥ 33rd	No
	Getting Care Quickly (% Always or Usually)	69.5%	5th	≥ 25th	No	68.1%	<5th	≥ 33rd	No

Notable Findings: The Adult Composite score for getting needed care decreased from 76.4% to 74.0% and getting care quickly decreased from 69.5% to 68.1%. Both failed to meet the benchmark.

The Adult survey response relative to Partnership covered members indicates we continue to have dissatisfaction with member access which influences health plan ratings. Stakeholders determined that continued intervention focused on; Getting Needed Care and Getting Care Quickly composite measures and Rating of Health Plan would be in scope for the CAHPS® Score Improvement (CSI) Goal for FY 2024-2025.

CAHPS Results from ME7 Report: Child Response

Below is a year-by-year comparison of the Composite scores for measurement year 2022 and measurement year 2023 for the Child Survey. In Year 2023-2024, we received 48 more complete surveys than in Year FY 2022-2023. All questions met the 100 sample size criteria for both measurement periods. The CAHPS program raised the plan performance benchmark to the 33rd percentile from the 25th.

	CHILD CAHPS Composite	2022-2023 (14.9% Response Rate) Sample Size 4,125 Total Returns 611	MY 2022 Percentile Rate	Partnership Benchmark	Benchmark Met?	2022-2023 (16.1% Response Rate) Sample Size 4,125 Total Returns 659	MY 2023 Percentile Rate	Partnership Benchmark	Benchmark Met?
Composite	Getting Needed Care (% Always or Usually)	76.7%	10th	≥ 25th	No	77.1%	14th	≥ 33rd	No

	CHILD CAHPS Composite	2022-2023 (14.9% Response Rate) Sample Size 4,125 Total Returns 611	MY 2022 Percentile Rate	Partnership Benchmark	Benchmark Met?	2022-2023 (16.1% Response Rate) Sample Size 4,125 Total Returns 659	MY 2023 Percentile Rate	Partnership Benchmark	Benchmark Met?
	Getting Care Quickly (% Always or Usually)	76.3%	<5th	≥ 25th	No	78.9%	9th	≥ 33rd	No

- **Notable Findings:** The Child composite score for Getting Needed Care increased from 76.7% to 77.1% and Getting Care Quickly increased from 76.3% to 78.9%. However, both measures failed to meet the benchmark.

  The Child survey responses relative to Partnership covered members indicate we continue to have dissatisfaction with member access and correlating impact to member experience which influences health plan ratings. Stakeholders determined that continued intervention focused on; Getting Needed Care and Getting Care Quickly composite measures would be in scope for the CAHPS® Score Improvement (CSI) Goal for FY 2024-2025.

QUALITATIVE ANALYSIS FOR MEMBER SATISFACTION: GRIEVANCE, APPEALS, AND CAHPS

The healthcare system in California and throughout the country has continued to grapple with workforce shortages for both clinical and non-clinical staff. This has resulted in greater difficulty in obtaining timely appointments. Access and Attitude/Service remain the most frequently reported concerns. In 2023, there were two cases related to the Quality of a Provider's Office, while in 2024, this number increased to five cases. Members reported 181 concerns against their primary care provider (PCP) or provider's office staff regarding access to appointments in person or by phone, compared to 139 in 2023. 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.

The CAHPS® Team concludes that while the survey is structured as a retrospective, it is hypothesized there is a high probability that experiences whether satisfactory or unsatisfactory may influence survey results by present experiences. Highlighted below are events that occurred while the regulated survey was in the field, and likely led to member dissatisfaction and subsequent declines in NCQA rating and composite measures.

• **COUNTY EXPANSION - HEALTHPLAN GROWTH:** In January of 2024, Partnership expanded into ten (10) new counties, now serving twenty-four (24) Northern California counties. *It is relevant to note the new county members were not included in the HEDIS CAHPS® sample frame member for MY 2023*. The membership growth coupled with the below disruption created unforeseen operational delays that impacted members requiring plan or service support during this period.

• **REGIONAL SERVICE DISRUPTION:** In April of 2024, contract negotiations and renewal was not reached with Dignity Health. This matter is presently resolved, but while the CAHPS® survey was in the field, thousands of members were impacted through the initial notification and subsequent actions of provider reassignment among many others.

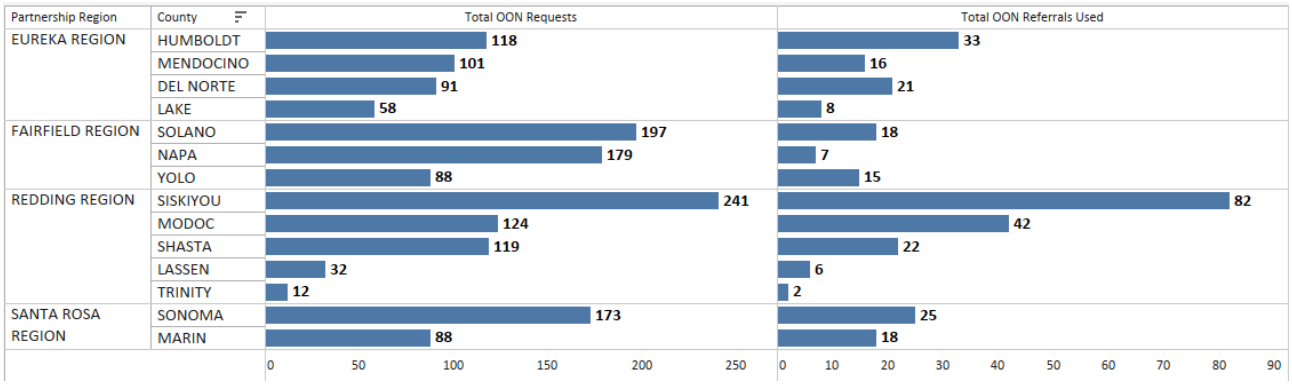
Barriers identified: Partnership is aware there is a national and regional shortage of clinical professionals and aging clinical professionals retiring. The fluctuation of Access measure performance identified coupled with performance not improving to pre-COVID, indicates inconsistency with access to care and service delivery.

Out-of-Network Requests and Utilization:

The out of network requests per 1,000 members' threshold is less than or equal to 20. The Threshold for out of network utilization is less than or equal to 10 per 1,000 members.

Partnership had 14 counties in 2023.

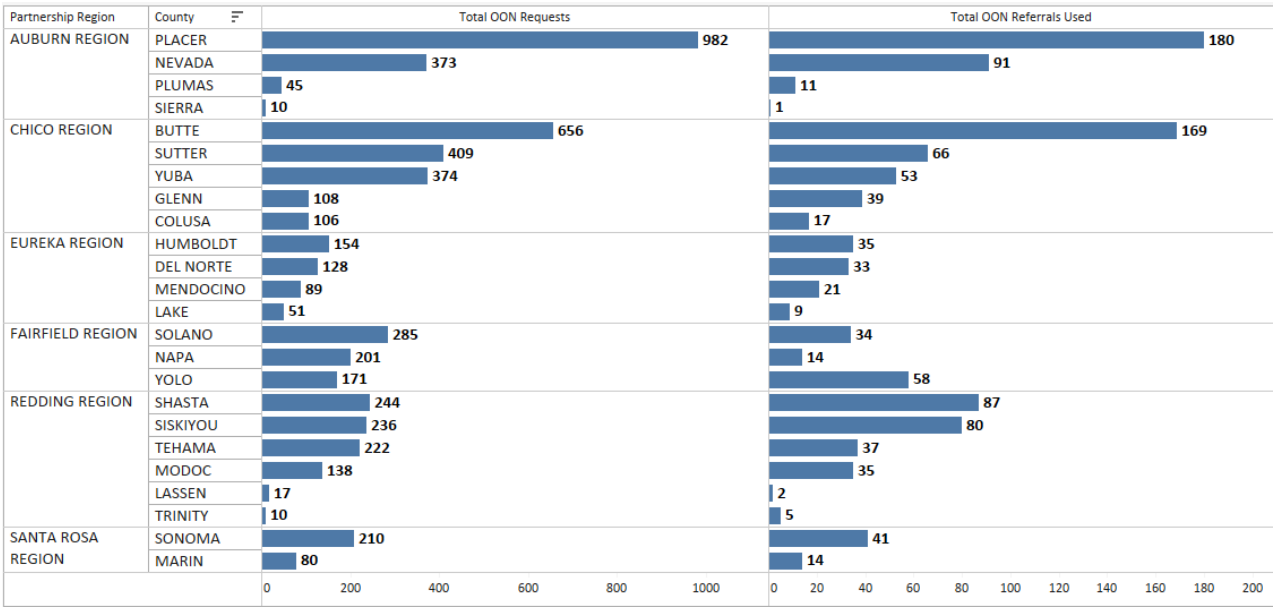
	EUREKA REGION	FAIRFIELD REGION	REDDING REGION	SANTA ROSA REGION	Grand Total
Distinct Members	147,060	229,942	108,230	178,592	663,824
Total OON Requests	368	464	528	261	1,621
OON Requests per 1,000 Members	2.5	2.0	4.9	1.5	2.4
Approved OON Requests	163	296	374	110	943
Approved OON Requests per 1,000 M..	1.1	1.3	3.5	0.6	1.4
Denied OON Requests	205	168	154	151	678
Denied OON Requests per 1,000 Members	1.4	0.7	1.4	0.8	1.0
Total OON Referrals Used	78	40	154	43	315
Total OON Claims	525	323	802	253	1,903
OON Claims per 1,000 Members	3.6	1.4	7.4	1.4	3
Approved OON Claims	383	226	671	145	1,425
% Approved OON Claims	73.0%	70.0%	83.7%	57.3%	74.9%
Denied OON Claims	142	97	131	108	478
% Denied OON Claims	27.0%	30.0%	16.3%	42.7%	25.1%



Notable findings: For the period of January 2023 – December 2023, Partnership met performance goals for requests and utilization.

Partnership had 24 counties in 2024

	AUBURN REGION	CHICO REGION	EUREKA REGION	FAIRFIELD REGION	REDDING REGION	SANTA ROSA REGION	Grand Total
Distinct Members	95,974	189,666	146,315	183,081	133,122	158,709	906,867
Total OON Requests	1,410	1,653	422	657	867	290	5,299
OON Requests per 1,000 Members	14.7	8.7	2.9	3.6	6.5	1.8	5.8
Approved OON Requests	996	1,089	268	508	672	166	3,699
Approved OON Requests per 1,000 M..	10.4	5.7	1.8	2.8	5.0	1.0	4.1
Denied OON Requests	414	564	154	149	195	124	1,600
Denied OON Requests per 1,000 Members	4.3	3.0	1.1	0.8	1.5	0.8	1.8
Total OON Referrals Used	283	344	98	106	246	55	1,132
Total OON Claims	1,546	1,341	538	466	1,426	339	5,656
OON Claims per 1,000 Members	16.1	7.1	3.7	2.5	10.7	2.1	6
Approved OON Claims	1,126	1,075	322	386	729	219	3,857
% Approved OON Claims	72.8%	80.2%	59.9%	82.8%	51.1%	64.6%	68.2%
Denied OON Claims	420	266	216	80	697	120	1,799
% Denied OON Claims	27.2%	19.8%	40.1%	17.2%	48.9%	35.4%	31.8%



Notable findings: For the period of January 2024 – December 2024, Partnership met performance goals for requests and utilization.

The number of OON Requests increased from 1,621 in 2023, to 5,299 in 2024. The number of OON Claims increased from 1,903 in 2023, to 5,656 in 2024. An increase was expected due to the addition of 10 counties to the service area.

January 2023 – December 2023:

Requests: Partnership met the goal of less than 20 per 1,000 members for requests. Out of the 1,621 OON Requests submitted (2.4 per 1,000 members) in 2023, 943 (58%) were approved and 678 (42%) of requests were denied. The counties with the highest number of requests included Solano County with 12%, Siskiyou County with 15%, and Sonoma County with 11%. Some requests were due to excessive appointment wait times or excessive driving distance, and approvals were allocated in those instances. Where services were available in network, those requests were denied.

Utilization: There was 1,903 OON Claims submitted (3 per 1,000 members) meeting the 10 or less per 1,000 members performance goal for utilization. Of the 1,902 OON Claims submitted, 1,425 (75%) were approved and 478 (25%) were denied. This appears to demonstrate that authorization review processes are effectively identifying and redirecting out-of-network requests to qualified in-network providers and practitioners. Of the 943 approved requests Plan wide, 315 (33%) were used. The three specialties with the highest OON requests included: Cardiovascular Disease/Internal Medicine with 48% of requests used, Gastroenterology with 15% of requests used, and Rheumatology with 44% of requests used. Analysis of data on paid claims did not reveal additional insights related to the practitioner network.

January 2024 – December 2024:

Requests: As a plan, Partnership met the goal of less than 20 per 1,000 members for requests. Out of 5,299 OON Referral submitted (5.8 per 1,000 members) in 2024, 3,699 (70%) were approved. The counties with the highest number of requests included Placer County with 19%, Butte County with 12%, and Sutter County with 8%. Some requests were due to excessive appointment wait times or excessive driving distance, and approvals were allocated in those instances. Where services were available in network, those requests were denied. Of the 5,299 requests submitted, 1,600 (30%) of requests were denied.

Utilization: There was 5,656 OON Claims submitted (6 per 1,000 members) meeting the 10 or less per 1,000 members performance goal for utilization. This appears to demonstrate that authorization review processes are effectively identifying and redirecting out-of-network requests to qualified in-network providers and practitioners. The three specialties with the highest OON requests included: Oncology/Hematology with 48% of requests used, Dermatology with 7% of requests used, and Optometry with only .8% of requests used. Of the 5,656 OON Claims submitted, 3,857 (68%) were approved and 1,799 (32%) were denied. Of the 3,699 approved requests Plan wide, 1,132 (31%) were used. A closer look at the Auburn Region shows that Placer County had the highest utilization with the total OON Claims per 1.000 members at 17.7. The most requested referral was Gastroenterology with 3.7% being Out of Network.

PRACTITIONER AVAILABILITY RESULTS: (NET 1, ELEMENT A: CULTURAL AND LINGUISTIC NEEDS AND PREFERENCES)

Availability standards and detailed analysis are provided in the annual Network Adequacy Report Availability of Practitioners reports. For this grand analysis, we have summarized the results for practitioner ethnicity/race to member ethnicity/race data and provider to member ratio for the top three threshold languages identified in 2024. Practitioner to member ratios and geographic distribution data for primary care, high volume specialties, and high impact specialties.

ETHNICITY/RACE COMPARISON:

Partnership collects race and ethnicity information on both members and practitioners. However, the collection of that information is voluntary. Since Partnership implemented the collection of race and ethnicity information through the credentialing process, the voluntary disclosure of that information has been very low with the majority of practitioners declining to answer leaving the organization with an incomplete and non-useful data set. In order to get an idea of what the race/ethnicity comparison is in our network, Partnership utilized the information gathered by the Medical Board of California for physicians licensed in the counties we serve.

The table below summarizes our findings in 2023

PHC Member Data Ethnicity/Race Percentages to Physician/Surgeon Ethnicity/Race Percentages and Ratio Report				
Race/Ethnicity	**PHC Members 686,844**	**Physician 14,283**	**Physician to Member Ratio**	**Goal 1:2000**
White	37.5%	60.97%	1:30	Met
Hispanic	30.9%	7.62%	1:195	Met
Other	11.1%	2.01%	1:265	Met
Unknown	8.8%	2.01%	1:199	Met
Black	5.3%	4.44%	1:50	Met
Native American	2.2%	1.17%	1:90	Met
Filipino	1.8%	4.52%	1:15	Met
Asian/Pacific Islander	1.0%	1.17%	1:27	Met
Asian Indian	0.8%	6.37%	1:6	Met
Vietnamese	0.6%	1.42%	1:21	Met

PHC Member Data Ethnicity/Race Comparison Analysis to Physician/Surgeon Ethnicity/Race (Amysis Data, April 2023 / Medical Board of California Data, June 2021)

- **Notable Finding:** The self-reported ethnicity/race comparison indications plan wide we met our ratio performance goal of 1:2000

The table below summarizes our findings in 2024

PHC Member Data Ethnicity/Race Percentages to Physician/Surgeon Ethnicity/Race Percentages and Ratio Report				
Race/Ethnicity	**PHC Members 902,734**	**Physician 14,608**	**Physician to Member Ratio**	**Goal 1:2000**
White	39.1%	60.97%	1:40	Met
Hispanic	33.6%	7.62%	1:272	Met
Other	4.4%	2.01%	1:135	Met
Unknown	13.3%	2.01%	1:408	Met
Black	3.6%	4.44%	1:50	Met
Native American	1.8%	1.17%	1:95	Met
Asian	2.5%	4.52%	1:34	Met
Asian Indian	1.5%	1.17%	1:79	Met
Native Hawaiian or other Pacific Islander	0.2%	6.37%	1:2	Met

PHC Member Data Ethnicity/Race Comparison Analysis to Physician/Surgeon Ethnicity/Race (Tableau Data, June 2024 / Medical Board of California Data, June 2021)

- **Notable Findings:** The self-reported ethnicity/race comparison indicates that plan-wide we met our ratio performance goal of 1:2000.

Partnership Assessing Practitioner and Member Language:

Partnership has applied a general standard for PCP to member ratio, which is 1:500 for all threshold languages to establish a point of comparison. The standard is considered compliant if the member to provider ratio is less than 1:500 for each threshold language. For this study, we will look at Partnership 's top three (3) threshold languages, which are Spanish, Tagalog, and Russian.

The following table summarizes our findings for 2023

Practitioner Language					
Threshold Language	**Provider**	**Member**	**2023 Ratio**	**Performance Goal**	**Goal Met?**
Spanish	360	135,827	1:377	1:500	Met
Tagalog	71	3,269	1:46	1:500	Met
Russian	29	2,205	1:76	1:500	Met

Practitioner Language to Member Language (SUGAR Data, Amisys Data, April 2023)

The following table summarizes our findings for 2024

Practitioner Language					
Threshold Language	Provider	Member	2023 Ratio	Performance Goal	Goal Met?
Spanish	1943	186,842	1:96	1:500	Met
Tagalog	113	2,319	1:21	1:500	Met
Russian	80	5,237	1:65	1:500	Met

Practitioner Language to Member Language (SUGAR Data, Amisys Data, December 2024)

- **Notable Finding:** As a plan Partnership met the overall ratio of 1:500 (provider to member) standard for all three threshold languages (Spanish, Tagalog and Russian).

To further assess how Partnership is meeting member language needs, we looked at office staff languages spoken at provider sites as it compares to the top three (3) threshold languages of Spanish, Tagalog, and Russian. The following table summarizes our finds for 2023

Practitioner Office Staff Language				
Threshold Language	Provider Sites	Member	Performance Goal	2023 Ratio
Spanish	326	135,827	1:500	1:416
Tagalog	96	3,269	1:500	1:34
Russian	28	2,205	1:500	1:78

Practitioner Language to Member Language (SUGAR Data, Amysis Data, April 2023)

The following table summarizes our findings for 2024

Practitioner Office Staff Language					
Threshold Language	Provider Sites	Member	Ratio	Performance Goal	Goal Met?
Spanish	402	186,842	1:464	1:500	Met
Tagalog	108	2,319	1:21	1:500	Met
Russian	32	5,237	1:163	1:500	Met

Practitioner Language to Member Language (SUGAR Data, December 2024)

- **Notable Finding:** Provider site language to member language ratios meets the performance goal. Office staff capabilities for threshold languages are sufficient to meet member needs.

LINGUISTIC NEEDS

As a plan, Partnership met the overall ratio of 1:500 (provider to member) standard for all three threshold languages (Spanish, Tagalog, and Russian). When comparing our linguistic data to grievances, there was a decrease in language discrimination from eight in 2023 to four in 2024. Shasta, Solano, and Placer Counties had the highest reported grievances, however, none of the providers within the counties had more than one grievance, and therefore, there is no trend to address.

Partnership offers no-cost linguistic services which include, oral interpreters, and sign language interpreters. Many practices have providers and medical staff who speak languages spoken by plan members. Written informing materials are fully translated into the threshold languages upon request.

PRACTITIONER AVAILABILITY RESULTS: (NET 1, ELEMENT B, C: PRACTITIONERS PROVIDING PRIMARY CARE & SPECIALTY CARE RATIO, GEOGRAPHIC DISTRIBUTION OF PRACTITIONERS

The following table summarizes the findings for Primary Care practitioners for 2023.

Practitioner Ratios: Primary Care – Standards and Performance Goals						
Practitioner Type	**Practitioner Count**	**Membership**	**Measure: Ratio**	**Results**	**Performance Goal**	**Goal Met?**
Primary Care Practitioner Overall	833	616,313	Primary Care Practitioner to Member (adult and children)	1:739	1:≤ 2,000	MET
Family or General Practice	517	616,313	Family or General Practice Practitioner to Member (adult and children)	1:1,192	1:≤ 2,000	MET
Pediatrics	171	193,201	Pediatricians to Members (children)	1:1,129	1:≤ 2,000	MET
Internist	145	423,112	Internists to Members (adult)	1:2,918	1:≤ 3,000	MET

Practitioner Ratios: Primary Care (April 2023)

The following table summarizes the findings for Primary Care practitioners for 2024.

Practitioner Ratios: Primary Care – Standards and Performance Goals						
Practitioner Type	**Practitioner Count**	**Membership**	**Measure: Ratio**	**Results**	**Performance Goal**	**Goal Met?**
Primary Care Practitioner Overall	1,272	915,046	Primary Care Practitioner to Member (adult and children)	1:719	1:≤ 2,000	MET

Family or General Practice	**741**	**915,046**	**Family or General Practice Practitioner to Member (adult and children)**	**1:1,235**	**1:≤ 2,000**	**MET**
Pediatrics	**296**	**334,640**	**Pediatricians to Members (children)**	**1:1,130**	**1:≤ 2,000**	**MET**
Internist	**235**	**580,406**	**Internists to Members (adult)**	**1:2,469**	**1:≤ 3,000**	**MET**

Practitioner Ratios: Primary Care (April 2024)

Notable findings: The Plan met the standard for all Primary Care Practitioners in 2024 without any significant changes from 2023. Interventions are not currently indicated

- The primary care overall ratio exceeded the performance goal. There was slight improvement from 2023.
- The family or general practice care ratio exceeded the performance goal. There was a slight decrease from 2023.
- The pediatric primary care ratio exceeded the performance goal without change from 2023 to 2024.
- The internal medicine ratio exceeded the performance goal. There was an improvement from 2023.

The DHCS standard for primary care is a provider to member ratio of 1:2000 that combines Family Medicine with Internal Medicine for adults and Family Medicine with Pediatric Medicine for children. NCQA looks at all three types of primary care providers separately.

Partnership expanded into 10 new rural counties in 2024 and experienced a 38.8% increase in total membership compared to 2023. We have been able to maintain access to primary care for all ages by having a stable Family Medicine network.

The following table summarizes the findings for High Volume Specialists for 2023.

Practitioner Ratios: High Volume Specialists - Standards and Performance Goals						
Practitioner Type	**Practitioner Count**	**Membership**	**Measure Ratio**	**Results**	**Performance Goal**	**Goal Met?**
Obstetrics/Gynecology	**479**	**254,936**	**OB-GYN to Member**	**1:287**	**1:≤ 5,000**	**MET**
Cardiology	**574**	**616,313**	**Cardiologist to Member**	**1:1,074**	**1:≤ 10,000**	**MET**
General Surgery	**427**	**616,313**	**General Surgery to Member**	**1:1,443**	**1:≤ 10,000**	**MET**

Orthopedic	**335**	**616,313**	**Orthopedic Surgeon to Member**	**1:1,840**	**1:≤ 10,000**	**MET**
Ophthalmology	**248**	**616,313**	**Ophthalmologist to Member**	**1:2,485**	**1:≤ 10,000**	**MET**
Dermatology	**204**	**616,313**	**Dermatologist to Member**	**1:3,021**	**1:≤ 15,000**	**MET**

Practitioner Ratios: Tableau Dashboard -High Volume Specialist (April 2023)

The following table summarizes the findings for High Volume Specialists for 2024.

Practitioner Ratios: High Volume Specialists - Standards and Performance Goals						
Practitioner Type	**Practitioner Count**	**Membership**	**Measure Ratio**	**Results**	**Performance Goal**	**Goal Met?**
Obstetrics/Gynecology	**523**	**379,253**	**OB-GYN to Member**	**1:725**	**1: ≤ 5,000**	**MET**
Cardiology	**459**	**915,046**	**Cardiologist to Member**	**1:1,994**	**1: ≤ 10,000**	**MET**
General Surgery	**413**	**915,046**	**General Surgery to Member**	**1:2,216**	**1: ≤ 10,000**	**MET**
Orthopedic	**356**	**915,046**	**Orthopedic Surgeon to Member**	**1:2,570**	**1: ≤ 10,000**	**MET**
Ophthalmology	**261**	**915,046**	**Ophthalmologist to Member**	**1:3,506**	**1: ≤ 10,000**	**MET**
Dermatology	**212**	**915,046**	**Dermatologist to Member**	**1:4,316**	**1: ≤ 15,000**	**MET**

Practitioner Ratios: Tableau Dashboard - High Volume Specialist (April 2024)

- **Notable findings**: The six high-volume specialties remained unchanged from 2023. Partnership comfortably met the provider ratio standards for all high-volume specialist providers. Interventions are not currently indicated.

- The obstetrics/gynecology provider ratio exceeded the performance goal despite a decrease from 2023.
- The cardiology provider ratio exceeded the performance goal despite a decrease from 2023.
- The general surgery provider ratio exceeded the performance goal despite a decrease from 2023.
- The orthopedic provider ratio exceeded the performance goal despite a decrease from 2023.

- The ophthalmology provider ratio exceeded the performance goal despite a decrease from 2023.
- The dermatology provider ratio exceeded the performance goal despite a decrease from 2023.

The following table summarizes the findings for High Impact Specialists for 2023.

Practitioner Ratio: High Impact Specialists - Standards and Performance Goals						
Practitioner Type	**Practitioner Count**	**Membership**	**Measure: Ratio**	**Results**	**Performance Goal**	**Goal Met?**
Oncology Hematology	428	616,313	Oncology Hematology to Member	1:1,440	1: ≤ 25,000	MET

The following table summarizes the findings for High Impact Specialists for 2024.

Practitioner Ratio: High Impact Specialists - Standards and Performance Goals						
Practitioner Type	**Practitioner Count**	**Membership**	**Measure: Ratio**	**Results**	**Performance Goal**	**Goal Met?**
Oncology Hematology	230	915,046	Oncology Hematology to Member	1:3,978	1: ≤ 25,000	MET

Practitioner Ratio: Tableau Dashboard -High Impact Specialists (April 2024)

- **Notable findings:** The provider ratio for oncology/hematology dropped plan wide as well as the total number of network practitioners. Despite this drop, the practitioner -to- member ratio for oncology/hematology practitioners stayed comfortably within the performance standard. No plan-wide interventions are currently indicated.

GEOGRAPHIC DISTRIBUTION: PRIMARY CARE PRACTITIONERS

The following table summarizes the 2023 findings for Primary Care Practitioners

Geographic Distribution of Primary Care – Standards and Performance Goals				
Practitioner Type	**Standard: Geographic Distribution**	**Results**	**Performance Goal**	**Goal Met?**
Primary Care Practitioner Overall	1 within 10 miles or 30 minutes from the member's residence	97.9%	≥ 95%	MET
Family Medicine or General Practitioner	1 within 10 miles or 30 minutes from the member's residence	99.8%	≥ 95%	MET
Pediatrics	1 within 10 miles or 30 minutes from the member's residence	97.4%	≥ 95%	MET

Internist	**1 within 10 miles or 30 minutes from the member's residence**	**96.6%**	**≥ 95%**	**MET**

Geographic Distribution of Primary Care (Quest Analytics, December 2023)

The following table summarizes the 2024 findings for Primary Care Practitioners

Geographic Distribution of Primary Care – Standards and Performance Goals				
Practitioner Type	**Standard: Geographic Distribution**	**Results**	**Performance Goal**	**Goal Met?**
Primary Care Practitioner Overall	**1 within 10 miles or 30 minutes from the member's residence**	**97.59%**	**≥ 95%**	**MET**
Family Medicine or General Practitioner	**1 within 10 miles or 30 minutes from the member's residence**	**99.9%**	**≥ 95%**	**MET**
Pediatrician	**1 within 10 miles or 30 minutes from the member's residence**	**96.0%**	**≥ 95%**	**MET**
Internal Medicine	**1 within 10 miles or 30 minutes from the member's residence**	**96.6%**	**≥ 95%**	**MET**

Geographic Distribution of Primary Care (Quest Analytics, December 2024)

- **Notable findings:** Partnership met the plan-wide geographic distribution of "Primary Care Practitioner Overall" standard and the individual performance standard for each PCP specialty. No interventions are currently indicated.
  - The primary care practitioner overall geographic distribution remained stable from 2023 to 2024 without significant change.
  - The family medicine practitioner geographic distribution remained stable from 2023 to 2024 without significant change.
  - The pediatrician geographic distribution had a 1.4% decrease while meeting the standard.
  - The internal medicine geographic distribution remained stable without any change.

Geographic Distribution of Primary Care by County – Standards and Performance Goals						
Region	**County**	**Specialty Type**	**Standard: Geographic Distribution**	**Result**	**Performance Goal**	**Goal Met?**
Redding	**Lassen**	**Primary Care**	**1 within 10 miles or 30 minutes**	**89.3%**	**≥ 95%**	**Not MET**
	Modoc	**Primary Care**	**1 within 10 miles or 30 minutes**	**99.0%**	**≥ 95%**	**MET**
	Shasta	**Primary Care**	**1 within 10 miles or 30 minutes**	**99.9%**	**≥ 95%**	**MET**
	Siskiyou	**Primary Care**	**1 within 10 miles or 30 minutes**	**99.9%**	**≥ 95%**	**MET**
	Trinity	**Primary Care**	**1 within 10 miles or 30 minutes**	**98.4%**	**≥ 95%**	**MET**
	Tehama	**Primary Care**	**1 within 10 miles or 30 minutes**	**99.9%**	**≥ 95%**	**MET**
Eureka	**Humboldt**	**Primary Care**	**1 within 10 miles or 30 minutes**	**100%**	**≥ 95%**	**MET**
	Del Norte	**Primary Care**	**1 within 10 miles or 30 minutes**	**100%**	**≥ 95%**	**MET**
	Mendocino	**Primary Care**	**1 within 10 miles or 30 minutes**	**100%**	**≥ 95%**	**MET**
	Lake	**Primary Care**	**1 within 10 miles or 30 minutes**	**100%**	**≥ 95%**	**MET**

Geographic Distribution of Primary Care by County – Standards and Performance Goals						
Region	**County**	**Specialty Type**	**Standard: Geographic Distribution**	**Result**	**Performance Goal**	**Goal Met?**
Chico	Butte	Primary Care	1 within 10 miles or 30 minutes	100%	≥ 95%	MET
	Sutter	Primary Care	1 within 10 miles or 30 minutes	100%	≥ 95%	MET
	Yuba	Primary Care	1 within 10 miles or 30 minutes	100%	≥ 95%	MET
	Glenn	Primary Care	1 within 10 miles or 30 minutes	99.7%	≥ 95%	MET
	Colusa	Primary Care	1 within 10 miles or 30 minutes	99.7%	≥ 95%	MET
Auburn	Placer	Primary Care	1 within 10 miles or 30 minutes	100%	≥ 95%	MET
	Nevada	Primary Care	1 within 10 miles or 30 minutes	100%	≥ 95%	MET
	Plumas	Primary Care	1 within 10 miles or 30 minutes	100%	≥ 95%	MET
	Sierra	Primary Care	1 within 10 miles or 30 minutes	100%	≥ 95%	MET
Fairfield	Napa	Primary Care	1 within 10 miles or 30 minutes	100%	≥ 95%	MET
	Solano	Primary Care	1 within 10 miles or 30 minutes	100%	≥ 95%	MET
	Yolo	Primary Care	1 within 10 miles or 30 minutes	100%	≥ 95%	MET
Santa Rosa	Marin	Primary Care	1 within 10 miles or 30 minutes	100%	≥ 95%	MET
	Sonoma	Primary Care	1 within 10 miles or 30 minutes	100%	≥ 95%	MET

Geographic Distribution of Primary Care by County (Quest Analytics, December 2024)

- Notable findings: A breakdown of the data at the county level shows Lassen County as not meeting the time or distance standard for primary care for both children and adults. Out of 8219 Partnership members in Lassen County, 879 do not meet the time or distance standard despite the Family Practice to member ratio in Lassen County being 1:663.

County	Family Medicine	Pediatrics	Internal Medicine
Modoc	99.0%	0%	68.4%
Siskiyou	99.9%	86.3%	60.3%
Trinity	98.4%	12.8%	13.5%
Plumas	100%	1.1%	39.5%
Sierra	100%	75.3%	88.4%

Geographic Distribution of Primary Care by County (Quest Analytics, December 2024)

- **Notable findings:** A deeper dive into the three categories of Primary Care shows that despite a ≥95% coverage by Family Practice Physicians, there are five counties that lack Pediatricians and Internal Medicine providers. This is indicative of a rural county, where the population is widely dispersed, and the providers are in, or near, towns and cities.

  Rural areas generally have family physicians that serve as primary care physicians, as the population is not sufficient to sustain pediatric and internal medicine specialists. Taking the presence of family physicians into account, there is sufficient access to primary care physicians.

Continued general support of the primary care workforce, like our primary care recruitment program and our primary care Quality Incentive Program, are prudent to maintain and grow our current primary care network.

PART V: GEOGRAPHIC ACCESS: SPECIALISTS

County Size Categories by Population			
Size Category	**Population Density**	**# of Counties**	**PARTNERSHIP Counties**
Rural	**≤50 people per square mile**	**13**	**Colusa, Del Norte, Glenn, Humboldt, Lassen, Mendocino, Modoc, Plumas, Shasta, Sierra, Siskiyou, Tehama, and Trinity**
Small	**51 to 200 people per square mile**	**7**	**Butte, Lake, Napa, Nevada, Sutter, Yolo, and Yuba**
Medium	**201 to 599 people per square mile**	**4**	**Marin, Placer, Solano, and Sonoma**

County Size Categories by Population (DHCS, Standard for County Size by Population, 2024)

The following table summarizes the 2023 findings for High Volume and High Impact Specialists

Geographic Distribution of Specialty Care – Standards and Performance Goals				
High Volume Practitioner Type	**Standard: Geographic Distribution**	**Results**	**Performance Goal**	**Goal Met?**
Cardiology	**Standard: % of members whose residence is within a distance (miles) or time (minutes) from a specialist's office.** **Rural = 60 miles or 90 minutes** **Small= 45 miles or 75 minutes** **Medium= 30 miles or 60 minutes**	**100%**	**≥90%**	**MET**
Dermatology		**100%**	**≥90%**	**MET**
General Surgery		**100%**	**≥90%**	**MET**
Obstetrics/Gynecology		**100%**	**≥90%**	**MET**
Ophthalmology		**98.5%**	**≥90%**	**MET**
Orthopedics		**100%**	**≥90%**	**MET**
High Impact Practitioner Type		**Results**	**Performance Goal**	**Goal Met?**
Oncology/Hematology		**97.8%**	**≥80%**	**MET**

Geographic Distribution of Specialty Care - High Volume and High Impact (Quest Analytics, May 2023)

The following table summarizes the 2024 findings for High Volume and High Impact Specialists

Geographic Distribution of Specialty Care – Standards and Performance Goals				
High Volume Practitioner Type	**Standard: Geographic Distribution**	**Results**	**Performance Goal**	**Goal Met?**
Cardiology	Standard: % of members whose residence is within a distance (miles) or time (minutes) from a specialist's office. Rural = 60 miles or 90 minutes Small= 45 miles or 75 minutes Medium= 30 miles or 60 minutes	100%	≥90%	MET
Dermatology		100%	≥90%	MET
General Surgery		100%	≥90%	MET
Obstetrics/Gynecology		99.9%	≥90%	MET
Ophthalmology		99.3%	≥90%	MET
Orthopedics		99.3%	≥90%	MET
High Impact Practitioner Type		**Results**	**Performance Goal**	**Goal Met?**
Oncology/Hematology		99.1%	≥80%	MET

Geographic Distribution of Specialty Care - High Volume and High Impact (Quest Analytics, Nov 2024)

➢ **Notable findings:** The geographic distribution of all High Volume and High Impact Specialties met the access standard plan wide. Interventions are not currently indicated.

- The geographic distribution for cardiology remained at 100% exceeding the standard
- The geographic distribution for dermatology remained at 100% exceeding the standard
- The geographic distribution for general surgery remained at 100% exceeding the standard
- The geographic distribution for obstetrics/gynecology was 99.9% exceeding the standard. This represented a decline from 2023 of 0.1%.
- The geographic distribution for ophthalmology was 99.3% exceeding the standard. This represented a increase from 2023 of 0.8%.
- The geographic distribution for orthopedics was 99.3% exceeding the standard. This represented a decline from 2023 of 0.7%.
- The geographic distribution for oncology/hematology was 99.1%. exceeding the standard. This represented an increase from 2023 of 1.3%.

When the data is broken down to the county level, one rural county did not meet the 60 miles, or 90 minutes standard for access to specialists.

Geographic Distribution of Specialty Care – Standards and Performance Goals						
Region	**County**	**Specialty Type**	**Standard: Geographic Distribution**	**Result**	**Performance Goal**	**Goal Met?**
Redding	Modoc	Ophthalmology	Rural standard: % of members' residence	14.1%	≥ 80%	Not MET

	Modoc	Hematology/Oncology	is 60 miles or 90 minutes from a specialist's office.	0.8%	≥ 80%	Not MET
	Modoc	Physical Medicine and Rehabilitation		0.9%	≥ 80%	Not MET

Geographic Distribution of Specialty Care - Not Met Score by County (Quest Analytics, Nov 2024)

Partnership contracts with all available high-volume specialists that practice within Modoc county. Modoc is sparsely populated and has an insufficient population to sustain a practice for many specialties. Currently, there are no qualified specialists who are enrolled in Medi-Cal practicing in these geographic areas with whom to contract. Partnership will assist members in making appointments and arrange transportation for members to see a specialist that is outside of the time or distance standards.

Partnership continues to review all sources of data related to access to specialty care, for monitoring trends and implementing focused strategies on the area of greatest need. This includes a robust telemedicine and e-Consult program. Many telehealth specialties are available to members via video appointments arranged at primary care offices. In addition, direct-to-member video telehealth between specialist providers and members is available through Partnership's contract with TeleMed2U.

PRACTITIONER ACCESSIBILITY RESULTS: (NET 2 ELEMENT A, C: ACCESS TO PRIMARY CARE & SPECIALTY CARE)

The data for assessing regular and routine care, urgent care, and after-hours care is collected by Partnership's Provider Relations staff using the Third Next Available (3NA) methodology for appointment access and the after-business hours' survey for telephone and triage services. All PCPs are surveyed (no sampling).

Third Next Available (3NA) Survey Results - Primary Care Routine Appointment Accessibility The following table summarizes the findings of the Third Next Available Survey for 2023.

Third Next Available (3NA) Survey Findings									
Provider Type	Standard	Median Days for Established PCP Appt.			Percentage of Clinics Meeting PCP Standards			Goal	2023 Goal Met?
		North	South	Plan	North	South	Plan		
Primary Care Adult	Non-urgent care primary care appointments within 10 business days of request	3.0	3.0	3.0	94%	91.7%	92.9%	≥ 90%	Met
Primary Care Pediatrics	Non-urgent care primary care appointments within 10 business days of request	3.0	3.0	3.0	94.4%	90.4%	92.4%	≥ 90%	Met
Newborn Appointments	Newborn appointments within 48 hours of discharge	1.0	1.0	1.0	96.9%	100.0%	98.5%	≥ 90%	Met

Primary Care Urgent Care	**Urgent care appointments within 48 hours of request**	**0.0**	**0.0**	**0.0**	**95.3%**	**96.9%**	**96.1%**	**≥ 90%**	**Met**

The following table summarizes the findings of the Third Next Available Survey for 2024.

Third Next Available (3NA) Survey Findings											
Provider Type	**Standard**	**Median Days for Established PCP Appt.**				**Percentage of Clinics Meeting PCP Standards**				**Goal**	**Goal Met?**
		North	**South**	**East**	**Plan**	**North**	**South**	**East**	**Plan**		
Primary Care Adult	**Non-urgent care primary care appointments within 10 business days of request**	**3.0**	**5.0**	**2.5**	**3.0**	**94.4%**	**78.7%**	**91.3%**	**86.2%**	**≥ 90%**	**Not Met**
Primary Care Pediatrics	**Non-urgent care primary care appointments within 10 business days of request**	**3.0**	**4.0**	**2.5**	**3.0**	**93.6%**	**85.1%**	**96.4%**	**91.3%**	**≥ 90%**	**Met**
Newborn Appointments	**Newborn appointments within 48 hours of discharge**	**1.0**	**1.0**	**1.0**	**1.0**	**100%**	**99.0%**	**93.2%**	**97.4%**	**≥ 90%**	**Met**
Primary Care Urgent Care	**Urgent care appointments within 48 hours of request**	**1.0**	**1.0**	**0.0**	**0.0**	**97.9%**	**97.4%**	**95.4%**	**96.9%**	**≥ 90%**	**Met**

Third Next Available (3NA) Primary Care Survey Findings (PR Reps Survey, 2024).

- **Notable findings:** The 3NA survey results show that as a plan we did not meet our 2024 performance goal across all areas.
- Non-urgent Adult Primary Care Provider appointments fell short of the goal with a 6.7% decrease from 2023.
- Non-urgent Pediatric appointment access exceeded the performance goal despite a 1.1% decrease from 2023.
- Newborn appointment access exceeded the performance goal despite a 1.1% decrease from 2023.
- Urgent primary care access exceeded the performance goal. There was 0.8% improvement from 2023.

THIRD NEXT AVAILABLE (3NA) SURVEY RESULTS - PRIMARY CARE TELEPHONE ACCESSIBILITY:

Third Next Available (3NA) Survey Findings (Primary Care)											
Measurements	**Standard**	**Median Performance Rates**				**Percentage of Clinics Meeting PCP Standards**				**Goal**	**Goal Met?**
		North	**South**	**East**	**Plan**	**North**	**South**	**East**	**Plan**		

# Rings before phone answered	**≤ 5 rings**	**2.0**	**1.0**	**1.0**	**1.0**	**100%**	**100%**	**100%**	**100%**	**≥ 90%**	**Met**
Minutes on hold	**≤ 5 minutes**	**0.0**	**1.0**	**1.0**	**0.0**	**100%**	**92.8%**	**94.5%**	**95.2%**	**≥ 90%**	**Met**
Average wait time before seeing a provider	**≤ 30 minutes**	**10.0**	**10.0**	**10.0**	**10.0**	**100%**	**100%**	**99.1%**	**99.7%**	**≥ 90%**	**Met**
Return call within 30 minutes	**≤ 30 minutes**	**Yes**	**Yes**	**Yes**	**Yes**	**98.9%**	**100%**	**96.4%**	**98.6**	**≥ 90%**	**Met**

Third Next Available (3NA) Primary Care Telephone Accessibility (PR Rep Survey, 2024).

- **Notable findings:** The 3NA survey results show that as a plan we met our 2024 performance goal of 90% telephone accessibility and wait time measurements.

SURVEY RESULTS - PRIMARY CARE AFTER BUSINESS HOURS

After Business Hours Survey Findings Primary Care															
Measurements	**Standard**	**Q1 2024**			**Q2 2024**			**Q3 2024**			**Q4 2024**			**Goal**	**Goal Met?**
		North	**South**	**East**	**North**	**South**	**East**	**North**	**South**	**East**	**North**	**South**	**East**		
Answering Machine/ Answering Services	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**≥ 90%**	**Met**
Instructions to call 911/ER	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**≥ 90%**	**Met**
Instructions to reach MD or Advice Nurse	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**≥ 90%**	**Met**
Wait time for screening or triage services	**≤ 30 minutes**	**100%**	**100%**	**99%**	**100%**	**100%**	**99%**	**100%**	**100%**	**99%**	**100%**	**100%**	**100%**	**≥ 90%**	**Met**

Survey Results Primary Care After Business Hours (PR Rep Survey, 2024).

- **Notable findings:** The 3NA survey results show that as a plan Partnership met 2024 goals for Primary Care After Business Hours Accessibility measurements.

3NA SURVEY RESULTS - ACCESS TO PRIMARY CARE BY COUNTY

The data for assessing access to care by county is pulled from the 3NA survey results. The 2024 3NA findings below summarize the access by county.

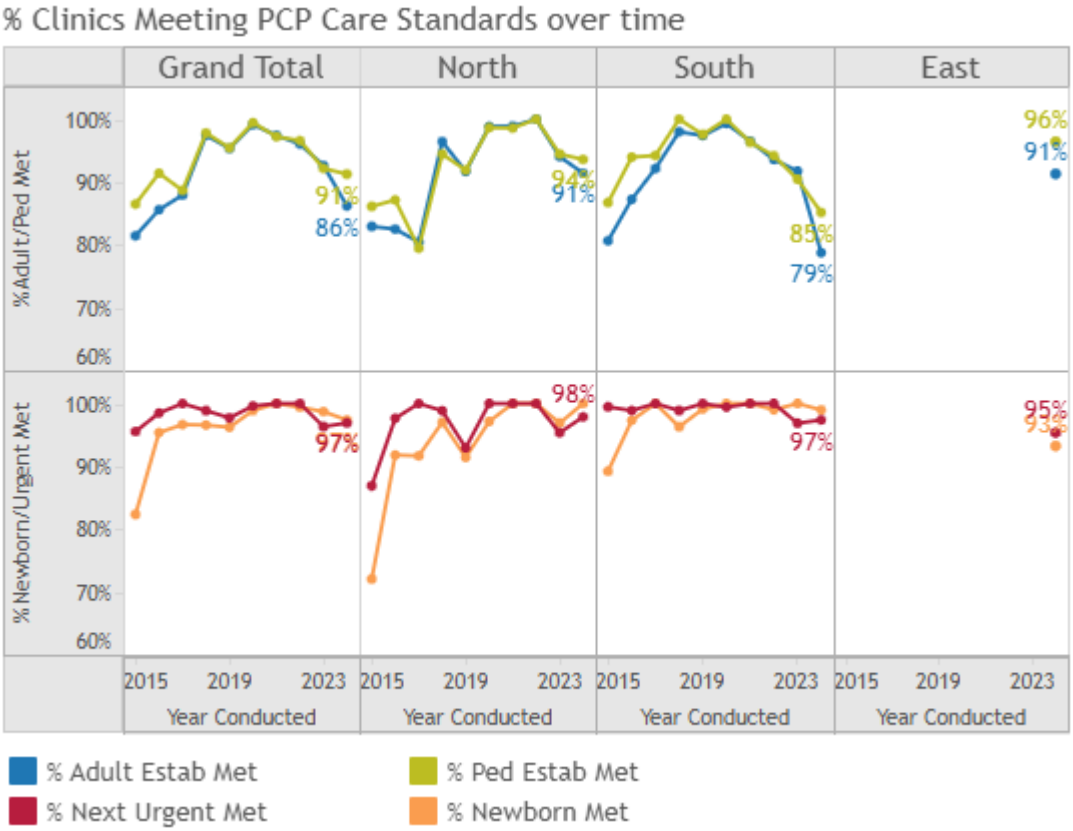
The following table summarizes the findings of the Third Next Available Survey for 2024.

Primary Care Appointment Access by County- 3NA Results (Outside Performance Standards)			
Region	**County**	**Service Location**	**Days to Adult Primary Care**
Chico	Butte	Ampla Health Chico	18
		Oroville Premier Health Practice	13
	Sutter	Harmony Health Medical Clinic	19
		Sutter North Medical Group	12
		Peach Tree Healthcare	11
Eureka	Humboldt	UIHS Potawot Health Village	13
		Fortuna Family Medical Clinic	12
	Mendocino	Adventist Health Ukiah Valley	37
		Hillside Health Center	22
		Dora Street Health Clinic	21
		Point Arena Community Health Clinic	19
		Adventist Health Ukiah Valley – Hospital Dr.	11
	Lake	Adventist Health Clear Lake	11
Redding	Siskiyou	Karuk Tribal Health Clinic	35
		Staszel, Michael Zbigniew	11
	Lassen	Westwood Family Practice	22
		Northeastern Rural Health Clinic	12
Fairfield	Napa	Ole Health – Hartle Clinic	30
		Ole Health – Pear Tree Clinic	28
	Solano	Solano County Health	40
		Ole Health Fairfield	37
		La Clinica – Vallejo	21
		La Clinica – N Vallejo	14
		Community Medical Centers – Vacaville	11
Santa Rosa	Marin	Marin Community – Campus Clinic	52
		Marin Community – S Novato	39
		Marin Community – Greenbrae	29
		Marin Community – Larkspur	23

Primary Care Appointment Access by County- 3NA Results (Outside Performance Standards)			
Region	**County**	**Service Location**	**Days to Adult Primary Care**
	Sonoma	**Sutter Medical Group of the Redwoods**	**19**

- **Notable Findings:** When the 3NA data is broken down by county we find 29 sites failed to meet the appointment standards. All sites that failed to meet the standard were surveyed 30 days later. 20 passed upon resurvey, 9 were escalated to the Chief Medical Officer.
  - Marin Community Clinics-Larkspur Clinic- The Compliance director stated MCC is actively recruiting and participating in our physician recruitment program. They have 12 open positions for Physicians and 6 open positions in the call center. They passed the resurvey for urgent appointment but are still under cap for 3na Adult appointment. Provider was escalated to CMO.
  - Marin Community Clinics-Greenbrae The Compliance director stated MCC is actively recruiting and participating in our physician recruitment program. The have 12 open positions for Physicians and 6 open positions in the call center. Provider was escalated to CMO
  - Marin Community – Campus Clinic- The Compliance director stated MCC is actively recruiting and participating in our physician recruitment program. The have 12 open positions for Physicians and 6 open positions in the call center. Provider was escalated to CMO
  - Solano County Family Health & Social Service: Provider in process of clinician recruitment. Escalated to CMO
  - Adventist Health Ukiah Valley PCP-260 Hospital Dr Ste 103 Family Med Response from Kristi Adams, office manager stated that Adventist has lost quite a number of providers and is actively recruiting. Escalated to CMO
  - Adventist Health Ukiah Valley PCP (850 Sequoia Circle, Fort Bragg) – Received email from the interim director of the clinic. They will be having a new provider start in the next few months which will help alleviate the backlog. Resurveyed and provider failed standards. Provider was escalated to CMO.
  - Point Arena Community Health Center- Followed up with Maryann Watts, clinic manager, on April 3. They are doing their best to accommodate everyone but are currently having longer wait times than normal. Escalated to CMO
  - Dora Street Health Center-Clinic PCP- CAP response from the clinic manager stated they have a lack of providers and are actively recruiting. Resurveyed on and provider failed standards. Provider escalated to CMO
  - Westwood Family Practice CAP response stated they currently only have one provider and are actively recruiting for more. Escalated to CMO.

Trends for PCP Appointments Meeting Targets



- **Notable Finding:** There has been a downward trend for adult and pediatric PCP appointments across the Partnership service area since 2020. A baseline for the expansion counties was established in 2024.

3NA SURVEY RESULTS - ACCESS TO PRENATAL CARE[1]

The data for assessing access to prenatal care by county is also pulled from the 3NA survey results.

The following table summarizes the findings of the Third Next Available Survey for 2023.

Third Next Available (3NA) Survey Findings									
Provider Type	Standard	Median Days for Established PCP Appt			% of Clinics Meeting Prenatal Standards			Goal	Goal Met?
		North	South	Plan	North	South	Plan		
Prenatal Care	Appointments within 10 business days of request	2.5	3.9	3.2	87.1%	93.2%	90.2%	≥ 90%	Met

3NA Survey Results Prenatal Care Region and Plan (PR Rep 3NA Survey, 2023)

The following table summarizes the findings of the Third Next Available Survey for 2024.

Third Next Available (3NA) Survey Findings											
Provider Type	Standard	Median Days for Established PCP Appt				% of Clinics Meeting Prenatal Standards				Goal	Goal Met?
		North	South	East	Plan	North	South	East	Plan		
Prenatal Care	Appointments within 10 business days of request	2.5	5.0	3.0	3.0	96.9%	73.7%	90.6%	82.9%	≥ 90%	Not Met

3NA Survey Results Prenatal Care Region and Plan (PR Rep 3NA Survey, 2024)

- **Notable Findings:** The 3NA survey results show that as a plan we did not meet the 2024 performance goal for prenatal care appointments with the southern counties experiencing a 19.5% decrease from 2023.

Prenatal Appointment Access by County- 3NA Results (Outside Performance Standards)			
Region	County	Service Location	Days to Prenatal Appointment
Chico	Butte	Enloe Women's Services - Esplanade	15
		Oroville Women's Health-Midwifery	14
Eureka	Humboldt	UIHS-Potawot Health Village	20
	Lake	Adventist Health Clearlake	19
	Mendocino	Adventist Health Ukiah Valley	37
		Adventist Health Ukiah Valley-1050 N State	18
		Hillside Health Center	13
		Little Lake Health Center	16
		Point Arena Community Health Center	19
Fairfield	Solano	Center for Primary Care-Vacaville	37
		Community Medical Centers-Vacaville	14
		NorthBay Women's Health - Fairfield	43
	Yolo	Sutter Medical Group Yolo-2020 Sutter Pl Ste 203	20
		Woodland Clinic-1321 Cottonwood St	16

- **Notable Findings:** When breaking down Prenatal Appointment Access by County we find that fourteen providers failed to meet the standard within 10 business days. All sites were re-surveyed and were found to be compliant. No further action was taken

ACCESS TO SPECIALTY CARE

The data for assessing access to specialty care is collected by Partnership's Provider Relations staff using the 3NA methodology for appointment access and the After Business Hours survey for telephone and triage services. Data results for urgent care and after business hours' survey findings are not required by NCQA, however, they are included in this report to meet DHCS requirements. The 3NA high-volume, high-impact specialists are selected from a list of all specialty offices that served 200 or more unique members in the measurement year. If a county does not meet the 200 unique members seen, the provider with the highest unique members seen is selected to ensure we account for all counties.

The following tables summarize the findings for specialty care providers.

The following table summarizes the findings of the Third Next Available Survey for 2023.

Third Next Available (3NA) Survey Findings									
Provider Type	Standard	Median Days for Established Specialty Appointment			% of Sites Meeting Specialty Care Standards			Goal	2023 Goal Met?
		North	South	Plan	North	South	Plan		
Specialty Care	Non-urgent specialty care appointments within 15 business days	9.0	8.0	7.0	78.8%	82.0%	80.4%	≥ 80%	Met
Specialty Care	Next urgent appointment ≤ 48 hours	0.0	1.0	1.0	92.9%	95.8%	94.4%	≥ 90%	Met

3NA Survey Specialty Care Overall (PR Rep Survey, 2023)

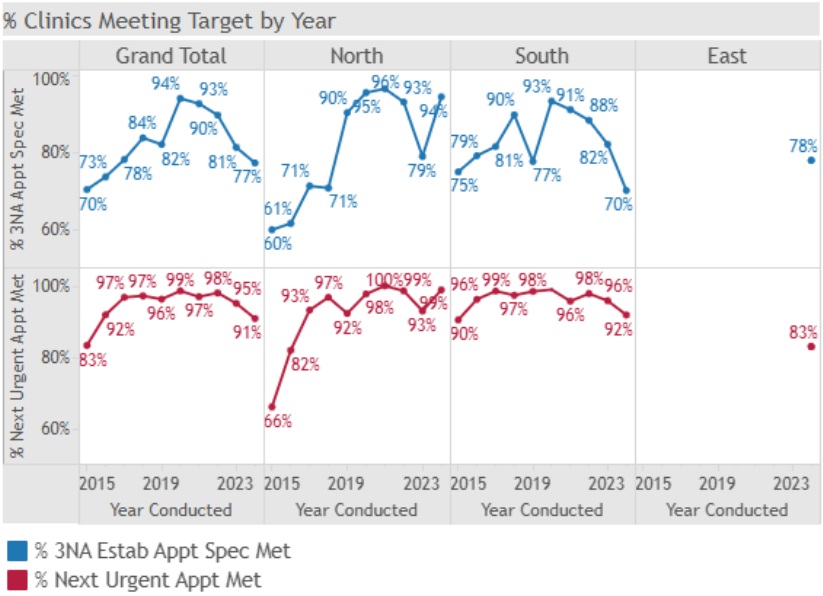
The following table summarizes the findings of the Third Next Available Survey for 2024.

Third Next Available (3NA) Survey Findings											
Provider Type	Standard	Median Days for Established Specialty Appointment				% of Sites Meeting Specialty Care Standards				Goal	Goal Met?
		North	South	East	Plan	North	South	East	Plan		
Specialty Care	Non-urgent specialty care appointments within 15 business days	7.0	10.0	5.0	8.0	94.3%	70.0%	77.8%	77.8%	≥ 80%	Not Met
Specialty Care	Next urgent appointment ≤ 48 hours	1.0	1.0	1.0	1.0	98.9%	91.8%	82.9%	90.8%	≥ 90%	Met

3NA Survey Specialty Care Overall (PR Rep Survey, 2024)

- **Notable Finding:** As a Plan, we did not meet the 2024 goal for non-urgent and urgent specialty care appointments. Partnership met the goal in 2023, but data also showed that all regions had suffered an overall decrease in the number of sites meeting both the non-urgent and urgent appointment goal. In 2024 we experienced further decreases that dropped us below the overall goal.

Trends for Specialty Appointments Meeting Targets



- Notable Finding: There had been a downward trend for routine and urgent specialty care appointments across the Southern and Northern regions between 2020 and 2023. In 2024 we saw improvement in the Northern Region while the Southern Region has continued to decrease. A baseline was established for the expansion counties of the Eastern Region.

High Volume Specialties Third Next Available Survey Results

The following table summarizes the findings of the Third Next Available Survey for 2023.

3NA Survey Results – Specialty Care: Routine Non-Urgent Care (Standard = 15 Days)								
High Volume Specialties	Median Days for Established Specialist Appointment			% of Clinics Meeting Specialty Care Standards			Goal	2023 Goal Met?
	North	South	Plan	North	South	Plan		
Cardiology	7	8	7	63%	81%	77%	≥ 80.0%	Not Met
Dermatology	9.5	17	12	100%	50%	67%	≥ 80.0%	Not Met
General Surgery	7	5	5	100%	89%	93%	≥ 80.0%	Met
Obstetrics Gynecology	5	6	4	100%	90%	94%	≥ 80.0%	Met
Ophthalmology	18	9	8	60%	78%	73%	≥ 80.0%	Not Met
Orthopedic Surgery	7.5	7.5	7.5	89%	93%	92%	≥ 80.0%	Met

3NA Survey High Volume Specialties (PR Rep Survey, 2023)

The following table summarizes the findings of the Third Next Available Survey for 2024.

3NA Survey Results – Specialty Care: Routine Non-Urgent Care (Standard = 15 Days)										
High Volume Specialties	Median Days for Established Specialist Appointment				% of Clinics Meeting Specialty Care Standards				Goal	Goal Met?
	North	South	East	Plan	North	South	East	Plan		
Cardiology	8	10	2	5	89%	71%	86%	80%	≥ 80.0%	Met
Dermatology	3	27	15	14	100%	33%	75%	57%	≥ 80.0%	Not Met
General Surgery	5	5	7.5	5	100%	95%	83%	95%	≥ 80.0%	Met
Obstetrics Gynecology	7	9.5	9	8	100%	61%	67%	71%	≥ 80.0%	Not Met
Ophthalmology	5	9	10	8.5	83%	85%	85%	85%	≥ 80.0%	Met
Orthopedic Surgery	5	8	5	7	100%	90%	80%	90%	≥ 80.0%	Met

3NA Survey High Volume Specialties (PR Rep Survey, 2024)

Notable finding: As a plan, two high-volume specialties fell below the established median 15-day appointment goal in 2024 as compared to 3 in 2023.

- Cardiology met the 2024 goal with a 3% increase from 2023
- Dermatology did not meet the goal two years in a row with a 10% decrease from 2023
- General Surgery met the 2024 goal and had a 2% increase from 2023
- Obstetrics Gynecology did not meet the 2024 goal with a decrease of 23% from 2023
- Ophthalmology met the 2024 goal with a 12% improvement from 2023
- Orthopedic Surgery met the 2024 goal despite a 2% decrease from 2023

High Volume: Cardiology 3NA Results (Outside Performance Standards)			
Region	**County**	**Service Location**	**Days to Cardiology Appointment**
Redding	Shasta	Dignity Health Medical Group North State-Eureka Way	25
Eureka	Mendocino	Adventist Health Ukiah Valley	41
	Lake	Adventist Health Clearlake-15230 Lakeshore Dr	19
Fairfield	Solano	Sutter Medical Group Solano-2720 Low Ct	27
	Yolo	Sutter Medical Group Yolo-2030 Sutter Pl Ste 1000	86
	Napa	Adventist Health Physicians Network-475 N Forbes St	25
Santa Rosa	Sonoma	Providence Medical Group, Sonoma-141 Lynch Creek Way Ste C	65
		Providence Medical Group, Sonoma-500 Doyle Park Dr Ste 103	19
Auburn	Plumas	Adventist Health Physicians Network-481 Plumas Blvd Ste 201	40
Chico	Butte	Enloe Cardiology Services & Structural Heart & Valve Center	20
		Northstate Cardiology Consultants	44

- **Notable finding:** When breaking down the Cardiology Appointment Access by County we found that eleven providers failed to meet the standard within 15 business days. All sites that failed were resurveyed after 30 days with all passing except one.
  - Providence Medical Group failed to meet the standard upon resurvey. Office staff reported there are a total of 3 MDs and 1NP at the office, the reason for appointments being pushed back is not all MDs are in office every day and NP only sees patients for intake. The Provider CAP and reported barrier to timely access was shared with the CMO and the information was taken to the Partnership Specialty Access Group for discussion.

High Volume: Dermatology 3NA Results (Outside Performance Standards)			
Region	**County**	**Service Location**	**Days to Dermatology Appointment**
Santa Rosa	Marin	Marin Health Medical Network Dermatology- 5000 Civic Center	56
	Sonoma	Redwood Family Dermatology-Santa Rosa	35
Chico	Colusa	Oroville Dermatology	37
Fairfield	Napa	Loftis, Brent, DO	28
	Yolo	Woodland Clinic-2440 W Covell Blvd Ste 100	45
		Sutter Medical Group Yolo-2030 Sutter Pl Ste 2200	112
	Solano	Solano Dermatology Associates-Vallejo	18
		Jiva Health, Inc-Vacaville	26
		Sutter Medical Group Solano-2720 Low Ct Dermatology	96

- **Notable finding:** When breaking down the Dermatology Appointment Access by County we find that two providers in the Santa Rosa region, one provider in the Chico region, and three

providers in the Fairfield region failed to meet the standard within 15 business days. All sites that failed were resurveyed after 30 days with all passing except 1 site.

- Sutter Medical Group Yolo failed to meet the standard upon resurvey. The staff did not offer a specific reason for the appointment backlog. The CAP for timely access was shared with the CMO and the information was taken to the Partnership Specialty Access Group for discussion.

High Volume: General Surgery 3NA Results (Outside Performance Standards)			
Region	**County**	**Service Location**	**Days to General Surgery Appointment**
Chico	**Butte**	**Oroville Surgical Specialists**	**26**

- **Notable finding:** When breaking down the General Surgery Appointment Access by County we find that one provider in the Chico region failed to meet the standard within 15 business days. The provider was re-surveyed and found to be compliant with the access standard. No further action was taken.

High Volume: Obstetrics Gynecology 3NA Results (Outside Performance Standards)			
Region	**County**	**Service Location**	**Days to Obstetrics Gynecology Appointment**
Fairfield	**Napa**	**Adventist Health Physicians Network**	**60**
	Solano	**NorthBay Women's Health**	**45**
	Yolo	**Sutter Medical Group Yolo**	**32**
		Woodland Clinic	**26**
Sonoma	**Marin**	**Marin Health Medical Network**	**29**
Eureka	**Lake**	**Little Lake Health Center**	**16**
		Adventist Clearlake	**19**
Chico	**Butte**	**Enloe Women's Services**	**36**
		Oroville Women's Health-Midwifery	**39**
	Yuba	**Sutter North Medical Group-969 Plumas St Ste 103**	**37**

- **Notable finding:** When breaking down the OB GYN Appointment Access by County we find that 10 providers failed to meet the standard of 15 business days. All sites that failed were re-surveyed after 30 days with all but 4 having passed.
  - Adventist Health Physicians Network staff stated that the reason for the appointment backlog is the fact that they do not have as many physicians in their office as other Adventist locations within the county. CAP and barrier reported the CMO.
  - NorthBay Women's Health reported there are a high number of referrals to the office, however the referrals are appropriate. The provider is in the process of recruiting. CAP and barrier reported to the CMO
  - Little Lake Health Center CAP response stated they have a lack of providers and are actively recruiting. The provider stated they are also working with staff processes as they felt there might be a scheduling issue. CAP and barrier reported to the CMO

- Enloe Women's Services CAP response stated that they are currently experiencing a shortage of providers. CAP and barrier reported to the CMO.

High Volume: Ophthalmology 3NA Results (Outside Performance Standards)			
Region	**County**	**Service Location**	**Days to Ophthalmology Appointment**
Redding	Tehama	Northridge Eye Care	56
	Shasta	Robert C. Fox MD, Inc	21
Chico	Butte	Kirstiane Ransbarger MD	92
		Oroville Premier Health Center	38

- **Notable finding:** When breaking down the Ophthalmology Appointment Access by County we find that two providers in the Redding Region and two providers in the Chico region failed to meet the standard within 15 business days. All sites that failed were resurveyed after 30 days with all 4 having passed. No direct barriers were identified.

High Volume: Orthopedic Surgery 3NA Results (Outside Performance Standards)			
Region	**County**	**Service Location**	**Days to Orthopedic Surgery Appointment**
Chico	Yuba	Adventist Health Physicians Network-370 Del Norte Ave Ste 201	53
Auburn	Placer	Sutter Medical Group Placer-3 Medical Plaza Dr Ste 110	19

- **Notable finding:** When breaking down the Orthopedic Surgery Appointment Access by County we find that one provider in the Chico Region and one provider in the Auburn region failed to meet the standard within 15 business days. Both sites were resurveyed after 30 days with both having passed. No direct barriers were identified.

HIGH IMPACT SPECIALTY THIRD NEXT AVAILABLE SURVEY RESULTS

The following table summarizes the findings of the Third Next Available Survey for 2023.

Third Next Available (3NA) Survey Findings									
Provider Type	**Standard**	**Median Days for Established PCP Appt**			**% of Clinics Meeting Prenatal Standards**			**Goal**	**2023 Goal Met?**
		North	**South**	**Plan**	**North**	**South**	**Plan**		
Prenatal Care	Appointments within 10 business days of request	2.5	3.9	3.2	87.1%	93.2%	90.2%	≥ 90%	Met

3NA Survey Results Prenatal Care Region and Plan (PR Rep 3NA Survey, 2023)

- **Notable Findings:** The 3NA survey results show that as a plan we met the 2023 performance goal for prenatal care appointments.

The following table summarizes the findings of the Third Next Available Survey for 2024.

3NA Survey Results – Specialty Care: Routine Non-Urgent Care (Standard = 15 Days)										
High Impact Specialty	Median Days for Established Specialist Appointment				% of Clinics Meeting Specialty Care Standards				Goal	Goal Met?
	North	South	East	Plan	North	South	East	Plan		
Oncology Hematology	5.5	4.5	2	4	100%	93%	75%	89%	≥ 80.0%	Met

3NA Survey High Impact Specialty (PR Rep Survey, 2024)

Notable finding: The 3NA survey results show that as a plan we met the 2024 performance goal for prenatal care appointments despite a 1.2% decrease from 2023.

3NA SURVEY RESULTS: SPECIALTY CARE ACCESSIBILITY

Specialty Care Accessibility Survey Findings											
Measurements	Standard	Median Performance Rates				% of Sites Meeting Standards				Goal	Goal Met?
		North	South	East	Plan	North	South	East	Plan		
# rings before phone answered	≤ 5 rings	2	2		2	100%	100%		100%	≥ 90%	Met
Minutes on hold	≤ 5 minutes	0.0	1.0		1.0	100%	98.9%		99.2	≥ 90%	Met
Average wait time before seeing a provider	≤ 30 minutes	5	10		10	100%	100%		100%	≥ 90%	Met
Return call	≤ 30 minutes	1	1		1	100%	99.5%		99.6%	≥ 90%	Met

3NA Survey Specialty Care Accessibility Survey Results (PR Rep Survey, 2024)

- **Notable Findings:** As a plan, we met our 2023 goal for appointments and telephone access to specialty care providers.

Survey Results: After Business Hours Specialty Care

The after-business hour's survey includes all specialty care providers (no sampling).

After-Business Hours Survey Findings Specialty Care															
Measurements	Standard	Q1 2024			Q2 2024			Q3 2024			Q4 2024			Goal	Goal Met?
		North	South	East	North	South	East	North	South	East	North	South	East		
Answering Machine/ Answering Services	100%	100%	100%		100%	100%		99%	100%		100%	100%		≥ 90%	Met
Instructions to call 911/ER	100%	100%	99%		100%	100%		100%	100%		100%	100%		≥ 90%	Met

Instructions to reach MD or Advice Nurse	**100%**	**100%**	**99%**		**100%**	**100%**		**94%**	**99%**		**100%**	**99%**		**≥ 90%**	**Met**
Wait times for screening or triage services	**≤ 30 minutes**	**100%**	**99%**		**100%**	**100%**		**90%**	**99%**		**100%**	**99%**		**≥ 90%**	**Met**

Table 1: Survey Results: After Business Hours Specialty Care Accessibility (PR Rep Survey, 2024)

- **Notable Findings:** Partnership met the After Business Hours Accessibility Specialty Care goals for each quarter in 2023. No action is currently required.

Section 4: Qualitative Analysis

ACCESS TO PRIMARY CARE

As a plan, Partnership met the ≥90% performance goal for all Primary Care Provider appointments including, adult, pediatrics, newborn, prenatal, and urgent care. When breaking down the primary care access standard 3NA survey data by percentages of clinics in the county that meet the standard we find one county in the northern region, one in the eastern region, and two in the southern region had lower percentages of appointment compliance. This is a decrease from seven counties last year. All sites that fail to meet the standard were resurveyed and issued a corrective action plan if needed.

The total number of member complaints regarding access increased between 2023 and 2024 with appointment availability being the most common type of access grievance. Primary care grievances increased by 32% compared to 2023. However, an increase is to be expected with the addition of 10 new counties. Despite the number of grievances, the rating per 1000 members was within the standard. No further action is currently required.

ACCESS TO SPECIALTY CARE

As a Plan, we met our ≥ 80% appointment access performance goal for four of the six identified high-volume specialties and the identified high-impact specialty. Two high-volume specialties fell below the established median 15-day appointment goal in 2024 as compared to 3 in 2023. Dermatology demonstrated a 10% decrease while Ophthalmology demonstrated a 12% improvement. Obstetrics Gynecology had the largest decrease with a drop of 23%. Providers who failed re-survey were issued a CAP and their reported barrier to timely access was shared with the CMO for Specialty Access Group discussion.

Access to specialty care member complaints were low. Twelve high-volume specialties had one appointment complaint each for the reporting year and three had two appointment complaints. A trend could not be established due to low member complaints. No further action is currently required.

Section 5: Summary of Findings

Partnership is meeting access standards for primary care (adult/pediatrics, newborn, urgent appointments, and telephone and after-hours accessibility) and four of six specialty care, high-volume

and high-impact (urgent, telephone, and after hours), based on data from our provider surveys and additional internal analysis.

Partnership has experienced a downward trend for adult and pediatric primary care as well as specialty care appointments meeting the appointment standard across both regions since 2020. This coincides with the start of the pandemic. We are experiencing a continued trend of decreasing numbers of providers for multiple reasons including retirement of the baby boomer generation, decreased enrollment into medical schools across the nation, and higher burnout of physicians leading to reduction in available office hours.

While Partnership failed to meet the 15-day appointment standard for Dermatology and Obstetrics Gynecology, this is not due to a lack of contracting with an available service provider. Currently there are no additional qualified providers who are enrolled in Medi-Cal practicing in these geographic areas with whom to contract. Partnership monitors appointment access each quarter and works with individual providers who fail to meet the standard to identify strategies for improvement.

The 2024 CAHPS data from the ME7 (Member Experience) report indicates performance below the thirty-third percentile benchmark for getting care quickly and getting care needed for Adult and Child. This is a decrease from 2023. The benchmark was raised from the twenty-fifth in 2022 to the thirty-third in 2023. The previously noted performance tables demonstrate a continuation of member dissatisfaction. The CAHPS® Team concludes that while the survey is structured as a retrospective, it is hypothesized there is a high probability that experiences whether satisfactory or unsatisfactory may influence survey results by present experiences. Highlighted below are events that occurred while the regulated survey was in the field and likely led to member dissatisfaction and subsequent declines in NCQA rating and composite measures.

- County Expansion – HealthPlan Growth: Previously noted in January of 2024, Partnership expanded into ten (10) new counties, now serving twenty-four (24) Northern California counties. *It is relevant to note the new county members were not included in the HEDIS CAHPS® sample frame member for MY 2023*. The membership growth coupled with the below disruption created unforeseen operational delays that impacted members requiring plan or service support during this period.

- Regional Service Disruption: In April of 2024, contract negotiations and renewal was not reached with Dignity Health. This matter is presently resolved, but while the CAHPS® survey was in the field, thousands of members were impacted through the initial notification and subsequent actions of provider reassignment among many others.

There were 6,149 Grievances, Second Level Grievances, and Appeals closed in 2024 compared to 4,261 in 2023. These cases are broken into two (2) groups – Grievances accounted for 5,477 and Appeals and Second Level Grievances accounted for 672.

Our membership experienced a 33.5% growth, rising from 678,546 in 2023 to 905,570 members in 2024. Alongside our membership increase, there was a rise in Grievances received in 2024, leading

to an increase in access related Grievances files per 1,000 members from 2.25 to 2.83. We saw a decrease in the number of Appeals and Second Level Grievances filed in 2024.

With an increase in membership and 28.5% increase in Grievances filed, three thresholds for Grievances were not met, one of which was Access. Access issues mainly consisted of long wait times for providers and transportation issues such as the driver arriving late and missed ride issues.

Partnership was able to meet the minimum threshold for Appeals & SLGs regardless of a 31% increase from 2023. The total number of cases filed per 1,000 members increased from 0.52 to 0.49 and was well within the threshold.

There were no identified gaps in the provider ratios overall. Although Partnership experienced an 38.8%% increase in total membership compared to 2023 due to our expansion into 10 additional counties. We have been able to maintain access to primary care for all ages by having a stable Family Medicine network. The Provider Recruitment Program provides incentives for Primary Care practitioners to join our network and Partnership is continuously recruiting for all categories of Primary Care, specifically in our rural counties that traditionally have a lower number of providers.

While some members were outside the time or distance standards for primary care, specialty care, and hospital services, this is not due to lack of contracting with available service providers. There are no new provider sites in these geographic areas with whom to contract as the geography and lack of larger towns limits the ability to reduce time or distance to a provider office. Partnership requests and receives approval for Alternative Access Standards (AAS) from the Department of Health Care Services on an annual basis for the geographical areas that fail to meet the standard. If a member lives in an area where services are not covered, Partnership will help those members with making the appointment and arrange transportation to see the specialists that are not within the time or distance standard.

Section 5: Opportunities for Improvement

Partnership operates in a broad service area encompassing urban, suburban, and rural settings. Improving member access to care is consistently the number one opportunity for improvement and top priority for leadership. Partnership's provider network is challenged by a national shortage of providers, competition from other entities, and an aging provider community. Because of this, Partnership has developed a multi-pronged approach to recruit and retain providers.

Effectiveness of Prior Actions: Partnership started a sponsored workforce development program that offered a sign-on bonus for providers when they contracted with Medi-Cal for the first time, and if they came from a county outside of the 14 counties that partnership served. The updated program took place between January 2021 and January 2024 with the bonuses being paid out over multiple payments over a 36-month period for physicians, nurse practitioners, physician assistants and 12 months for licensed behavioral health clinicians including substance use disorder counselors. The result of the program was an increase in accepted offers with 84 the first year and 89 the second with Family Medicine being the majority provider specialty. Partnership was able to recruit 66 new primary care practitioners to the network between May 1 2023 and December 1 2023 with 27 of those practicing in 6 of the Partnership's most rural northern counties.

The results of increased primary care recruitment resulted in a 0.4% increase in non-urgent primary care access in our rural northern region.

Opportunity: Appointment access to non-urgent primary care decreased by 13% in the southern region. Appointment access for obstetrics and gynecology in the southern region decreased by 19.5%. Partnership has identified the need to increase the number of contracted primary care and women's health specialty care practitioners to the network, particularly in the southern region.

Partnership has chosen primary care and women's health provider recruitment as equal high priority opportunities.

- *Planned Action:* Partnership has updated the Provider Recruitment Program (PRP) that offers a sign-on bonus for providers that are new to the Partnership network. If they are a currently practicing provider, they must come from outside of the Partnership 24 county service area. Providers completing a training program within the Partnership service area qualify for consideration for an award from the program. This updated program is active between January 2024 – June 2025 with the bonuses being paid out over multiple payments over a 60-month term for physicians, NPs, and PAs, 24 months for behavioral health clinicians, and 12 months for certified SUD counselors. The strategy is to recruit and hold providers in place longer term.
    - Effectiveness of Action: To date there has been an increase in accepted offers with 168 awards approved on average over 12 months, (as compared to a historical average going back to 2014 of 86 awards per year). Family Medicine has been the majority provider specialty awarded, representing nearly 57% of the program awards to date. Partnership was able to recruit 208 new primary care practitioners to the network between January 2024 – April 2025, with 5 of them recruited to 4 of our most rural counties, including Sierra, Modoc, Plumas, and Trinity, whose geographic area is 75% or more rural (according to the US Census Bureau definition). Initial recruitment and retention details look favorable, but we may not know completely until the 60-month time period and further payments take place.
- Planned Action: Partnership continued to expand its efforts to strengthen recruitment for specialty providers, including obstetrics providers (physicians, women's health nurse practitioners, certified nurse midwives) whose clinical care focuses on perinatal care, including labor and delivery, to the 2024 PRP.

    Effectiveness of Action: Fifteen obstetrics providers have been awarded since January 2024.

- Planned Action: Partnership launched a provider retention initiative (PRI) pilot in January 2024. The PRI is intended to recognize primary care clinicians, those who offer perinatal services (including labor and delivery) and/or obstetrics/gynecology, who have devoted their careers to the safety net, while helping to incentivize additional years of service from them. Our hope is that the PRI will help preserve institutional knowledge and clinical leadership and mentorship within our network, while an emerging generation of providers can learn from and train with these committed health professionals.

- Effectiveness of Action: Since January 2024, 65 providers have been awarded and have committed to practice for 3 additional years.

Opportunity: Partnership has identified a need to improve member experience associated with access to care. The Adult Composite score for getting needed care decreased from 76.4% to 74.0% and getting care quickly decreased from 69.5% to 68.1%. Both failed to meet the benchmark for the second year in a row.

- Planned Action: To leverage more real time data (i.e., Grievance & Appeals [G&A] and Population Health Management [PHM] community engagement responses) on a quarterly basis to examine and respond timelier to topical themes identified directly from our members, including complaints about the health plan and providers. This enhanced method will provide the CAHPS Goal Team more real-time opportunity to measure intervention effectiveness against targeted barriers

Annual Utilization Management (UM) Program Evaluation

NCQA UM Standard 1 Element B

Evaluation Period
January 1, 2024 – December 31, 2024

Production Date: March 21, 2025

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Related Reports:

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

Executive Summary:

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

Methodology / Data:

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

Program Structure

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

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

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

Level of involvement of senior level physician in the UM determination

- Advisory committee structure and participation

Member and Practitioner experience with the UM program

- Member Grievance and Appeals Pulse Report
- Provider Satisfaction Survey

I. PROGRAM EVALUATION

A. PROGRAM STRUCTURE

1. STAFFING OVERSIGHT

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

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

[1]Includes only Pharmacists who perform TAR reviews.

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

2. STAFFING WORKLOAD

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

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

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

Utilization Management:

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

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

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

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

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

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

Pharmacy:

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

[1]Includes only staff who perform TAR reviews.

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

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

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

3. EVALUATION OF THE PHC ADVISORY COMMITTEE STRUCTURE

Physician Advisory Committee (PAC)

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

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

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

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

Quality/Utilization Advisory Committee (Q/UAC)

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

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

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

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

Pharmacy & Therapeutics Committee (P&T)

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

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

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

B. PROGRAM SCOPE

1. POLICY REVIEW

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

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

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

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

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

C. PROGRAM PROCESS

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

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

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

Summary of Results:

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

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

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

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

Pharmacy:

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

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

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

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

2. CONSISTENCY OF APPLYING UM CRITERIA

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

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

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

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

3. APPROPRIATE CARE: MONITORING FOR OVER/UNDERUTILIZATION

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

Overview:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Other evaluations for potential under-utilization included:

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

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

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

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

Evaluations of potential areas of over-utilization

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

Areas of over-utilization with ongoing activities

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

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

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

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

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

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

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

E. INVOLVEMENT OF SENIOR LEVEL PHYSICIANS IN THE UM PROCESS

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

F. ASSESSING EXPERIENCE WITH THE UM PROCESS

1. IMPROVING PRACTITIONER EXPERIENCE WITH THE UM PROCESS

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

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

Please refer to Appendix I for Physician Satisfaction Survey Data.

Summary of PCP Outcomes:

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

agree or agree. No further interventions needed.

Summary of Specialist Outcomes:

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

2. MEMBER EXPERIENCE WITH THE UM AND PHARMACY PROCESS

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

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

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

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

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

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

II. Conclusion:

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

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

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

APPENDIX I: Improving Practitioner Experience with the UM process

Key:

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

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

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

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

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

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

APPENDIX II: Member Experience with the UM process

THE UM EXPERIENCE

REPORTING PERIOD

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

OVERVIEW

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

DISSATISFACTION WITH RAF PROCESS

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

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

DISSATISFACTION WITH TAR PROCESS

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

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

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

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

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

Published March 2025

CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS & SYSTEMS (CAHPS®) PROGRAM

2023-2024

MEMBER EXPERIENCE GRAND ANALYSIS (NCQA ME 7 REPORT)

PERIOD

(JULY 1, 2023 – JUNE 30, 2024)

PRODUCTION DATE

SEPTEMBER 2024

PARTNERSHIP HEALTHPLAN of CALIFORNIA

A Public Agency

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EXECUTIVE SUMMARY

CAHPS® PROGRAM

SUMMARY

Partnership experienced a season of change this reporting period. There was executive level changes to include a new Chief Executive Officer, Chief Operating Officer, and Chief Technology Officer. Additionally in January of 2024, Partnership expanded its service area by ten (10) additional northern counties. It is important to note the ten (10) new county members are not included in the Measure Year (MY) 2023 survey results but will be included in the MY 2024 survey sample frame.

QUALITY IMPROVEMENT

The Quality Improvement Department's Consumer Assessment of Healthcare Providers & Systems (CAHPS®) program provides programmatic structure and resource commitment to effectively administer National Committee for Quality Assurance (NCQA) requirements and influence organizational change to improve member experience and the health plan rating.

Our approach and discipline to leverage team strengths will provide the necessary skill set to apply a mixed methodology, including quality improvement tools and program management principles of plan-do-study-act (PDSA); lean; root-causal-analysis; data analytics; qualitative and quantitative analysis . As the team identifies new opportunities or lessons learned, we are continuously exploring and identifying pathways to improve. The established program is designed to be flexible, allowing us to adapt and pivot between each fiscal year.

ANNUAL ASSESSMENT OF NONBEHAVIORAL HEALTHCARE COMPLAINTS AND APPEALS

GRIEVANCES

Partnership experienced a 6.3% growth in membership, rising from 638,303 members in 2022 to 678,546 members in 2023. Alongside our membership increase, there was a rise in Grievances received in 2023, leading to an increase in Grievances filed per 1,000 members from 4.00 to 5.26, Table VI. The analyses observed a decrease in the number of Appeals and Second Level Grievances filed in 2023, resulting in a decline in Second Level Grievances filed per 1,000 members from 1.19 to 1.02, Table VII.

An observed 6.3% increase in membership may have contributed to a 28.5% increase in Grievances filed, that led to three (3) Grievance thresholds not being met: Access, Attitude/Service, and Quality of Care. Access issues mainly consisted of long wait times for providers and transportation issues such as the driver arriving late and missed rides. Attitude/Service issues were mostly regarding insufficient communication between the member and the provider's office. Communication and treatment plan disputes were the most frequently reported Quality of Care concerns. Two (2) categories, Billing/Financial and Quality of Provider Office, did meet the threshold for 2023, Table VI.

APPEALS & SECOND LEVEL GRIEVANCES

The Appeals and Second Level Grievances saw an overall decrease in numbers. While four (4) categories (Access, Attitude/Service, Billing/Financial, and Quality of Provider Office) successfully maintained stability by not exceeding the 10% threshold. One (1) category, Quality of Care, saw an increase from one

(1) case in 2022 to nine (9) cases in 2023, surpassing the threshold. These cases consisted of treatment plan disputes that caused delay in the care the members received and communication issues such as the provider not returning the member's calls, Table VII.

CAHPS® Measure Year 2023 | Reporting Year 2024 Plan Performance

A summary of the MY 2023 CAHPS® survey performance for Adult and Child, identified barriers, Fiscal Year (FY) 2024-2025 intervention and improvement focus are outlined below.

Adult

Measured performance compared to the plan's 33rd percentile benchmark ranking indicates member dissatisfaction in the following measures. In comparison to MY 2022 ranking performance, MY 2023 demonstrates an overall ranking decline in seven (7) of nine (9) measures, Table I.

Table: I

Measure Attribute	Plan Performance		
	MY 2023 HEDIS QC Ranking	Plan Benchmark Target ≥33rd Percentile Ranking	MY 2023 Ranking Compared to MY 2022
Rating of Health Plan (% 8, 9, 10)	<5th	Not Met	Decline
Rating of Health Care (% 8, 9, 10)	5th	Not Met	Decline
Rating of Personal Doctor (% 8, 9, 10)	51st	Met	Improvement
Rating of Specialist Seen Most Often (% 8, 9, 10)	41st	Met	Improvement
Getting Needed Care (% Always or Usually)	7th	Not Met	Decline
Getting Care Quickly (% Always or Usually)	<5th	Not Met	Decline
Care Coordination (% Always or Usually)	11th	Not Met	Decline
How Well Doctors Communicate (% Always or Usually)	48th	Met	Decline
Customer Service (% Always or Usually)	18th	Not Met	Decline

Healthcare Effectiveness Data and Information Set (HEDIS) Quality Compass (QC) Benchmarks

Child

Measured performance compared to the plan's 33rd percentile benchmark ranking indicates member dissatisfaction in the following measures. In comparison to MY 2022 ranking performance, MY 2023 demonstrates an overall ranking improvement in seven (7) of nine (9) measures, and one noted as maintaining similar ranking, with a marginal decline of 3.5% in score performance with Rating of Health Care, Table II.

Table: II

Measure Attribute	Plan Performance		
	MY 2023 HEDIS QC Ranking	Plan Benchmark Target ≥33rd Percentile Ranking	MY 2023 Ranking Compared to MY 2022
Rating of Health Plan (% 8, 9, 10)	45th	Met	Improvement
Rating of Health Care (% 8, 9, 10)	<5th	Not Met	No Change
Rating of Personal Doctor (% 8, 9, 10)	55th	Met	Improvement
Rating of Specialist Seen Most Often (% 8, 9, 10)	21st	Not Met	Decline
Getting Needed Care (% Always or Usually)	14th	Not Met	Improvement
Getting Care Quickly (% Always or Usually)	9th	Not Met	Improvement
Care Coordination (% Always or Usually)	40th	Not Met	Improvement
How Well Doctors Communicate (% Always or Usually)	22nd	Met	Improvement
Customer Service (% Always or Usually)	89th	Met	Improvement

Healthcare Effectiveness Data and Information Set (HEDIS) Quality Compass (QC) Benchmarks

IDENTIFICATION OF OPPORTUNITIES AND PRIORITY

Over the next fiscal year, the focus of Organizational Goal # 4 Access to Care and Member Experience Improvement is to develop and when applicable, revise existing strategies and plan tactics through the actions of understanding the landscape of the primary care provider and specialty provider networks, identify gaps, and develop targeted actions, Appendix A.

The QI CAHPS® programmatic framework is helping to drive and influence a multi-disciplinary approach to improve the member experience through long and short-term strategies. The team priority this year will pilot a smaller focus at the county and region level to target low performing composite and rating measures linked to access.

MEMBER EXPERIENCE (ME) – PRIORITY FLAG

Partnership determines ME through the analysis of multiple CAHPS® rating and composite measures. The previously noted performance tables demonstrate a continuation of member dissatisfaction. The QI CAHPS® Team intends to shepherd organizational guidance on the measures marked with a priority flag. These measures are considered influence drivers and when those scores improve member experience, the Rating of Health Plan and Rating of Healthcare measures improve.

Causal Factors

The CAHPS® Team concludes that while the survey is structured as a retrospective, it is hypothesized there is a high probability that experiences whether satisfactory or unsatisfactory may influence survey results by present experiences. Highlighted below are events that occurred while the regulated survey was in the field, and likely led to member dissatisfaction and subsequent declines in NCQA rating and composite measures.

- **County Expansion - HealthPlan Growth**
  - Previously noted in January of 2024, Partnership expanded into ten (10) new counties, now serving twenty-four (24) Northern California counties. *It is relevant to note the new county members were not included in the HEDIS CAHPS® sample frame member for MY 2023*. The membership growth coupled with the below disruption created unforeseen operational delays that impacted members requiring plan or service support during this period.
- **Regional Service Disruption**
  - In April of 2024, contract negotiations and renewal was not reached with Dignity Health. This matter is presently resolved, but while the CAHPS® survey was in the field, thousands of members were impacted through the initial notification and subsequent actions of provider reassignment among many others.

❖ Rating of Health Plan

Partnership is focused on two (2) additional barriers outside of the FY 2024-2025 Org. Goals (Appendix A): 1) Benefit literacy. The CAHPS® Team used non-regulated survey results to validate and link benefit literacy gaps and themes gathered through members surveyed at in-person community events by Population Health Management (PHM). Benefit themes point to coverage confusion between Partnership and state carve out coverage (Medi-Cal Dental/Pharmacy), vision, and Partnership administered transportation services, and 2) Customer Service calls related to covered benefit or service questions. Member shared comments including: calling plan multiple times about the same issue, calls being transferred multiple times, customer service representative provided unclear or incomplete information making it challenging for the members to understand, Appendix C.

Access To Care – Priority Flag

Member access to primary and specialty care continues to be a top focus and priority for Partnership. Through several data sources and Association for Community Affiliated Plans CAHPS® Collaborative. Partnership is aware there is a national and regional shortage of clinical professionals and aging clinical professionals retiring, Appendix E. The fluctuation of Access measure performance identified below coupled with performance not improving to pre-COVID, indicates inconsistency with access to care and service delivery.

❖ Getting Needed Care (GNC)

Partnership continues to observe a general decline with Adult and Child GNC composite questions (Q9. & Q20.), measures, and overall summary rate score. Performance analysis by population is highlighted below.

ADULT: The GNC measure declined by -2.4% and did not meet or exceed the plan 33rd percentile benchmark ranking target. The HEDIS Quality Compass (QC) benchmark ranking decline to the 7th percentile ranking from the 14th percentile ranking compared to MY 2022. The highest noted summary rate score of 81.60% occurred in the reporting year (RY) 2021 for MY 2020. The marked -5.6% decline of GNC trend began in the RY 2022, for MY 2021 survey results. Continuing the performance trend, Partnership observed a minimal increase of 0.4% of a percentage point in the RY 2023 for MY 2022, followed by another decline of -2.4% performance in the RY 2024 for MY 2023.

CHILD: The GNC measure marginally improved by 0.4% of a percentage point, and did not meet or exceed the plan 33rd percentile benchmark ranking target. The HEDIS QC benchmark ranking also improved to the 14th percentile ranking from the 10th percentile ranking compared to MY 2022. Similar yet dissimilar to the Adult trend performance, the highest summary rate score for Child was 83.20% and occurred in the RY 2020 for MY 2019. The marked -2.5% decline of GNC trend began in the RY 2021, for MY 2020 survey results. Continuing the performance trend, Partnership observes the following: -1.1% (MY 2021) and -2.9% (MY 2022).

❖ GETTING CARE QUICKLY (GCQ)

Partnership continues to observe a general decline with Adult and Child GCQ composite (Q4 & Q6.), measures, and overall summary rate score. Performance analysis by population is highlighted below.

ADULT: The GCQ measure declined by -1.4% and did not meet or exceed the plan 33rd percentile benchmark ranking target. The HEDIS QC benchmark ranking MY 2023 declined below the 5th percentile ranking established in MY 2022. The highest summary rate score of 80.30% occurred in the RY 2021 for MY 2020. The marked -7.4% decline of GQC trend began in the RY 2022, for MY 2021 survey results. Continuing the performance trend, Partnership observed the following decline of -3.40% for MY2022.

CHILD: Although the GCQ measure saw a marked improve score of 2.6%, the measure did not meet or exceed the plan 33rd percentile benchmark target. The HEDIS QC benchmark ranking mirrored the score performance by increasing MY 2022 below the 5th percentile ranking to 9th percentile ranking in MY 2023. The highest summary rate score for Child was 88.80% and occurred in the RY 2020 for MY 2019. The marked -7.7% decline of GQC trend began in the RY 2021, for MY 2020 survey results. Continuing the performance trend, Partnership observes summary rate fluctuations ranging from an increase of 3% in MY 2021 and another decline of -7.8% in MY 2022.

❖ RATING OF SPECIALIST (RATING)

Partnership continues to observe survey performance variations related to the Rating of Specialist measure, GNC, and GQC composite measures linked to specialty providers seen most often. As previously noted, improving member access to Primary Care Providers (PCP) and Specialists Providers are a top priority. Access interventions has been a continued organization focus and is covered in prior Member Experience (ME 7) Grand Analysis reporting periods. The complete details of actions taken during the

FY 2023-2024 goal period are available in Appendix B. The trending overview and qualitative analysis by population is provided below.

ADULT: The Rating of Specialist (Q22.) measure improved by 5.1%, meeting the plan's 33rd percentile benchmark target and increased the HEDIS QC benchmark ranking to the 41st percentile from the 26th percentile. The highest summary rate score of 71.50% occurred in the RY 2021 for MY 2020. The marked -4.8% decline of rating trend began in the RY 2022 for MY 2021 survey results. Continuing the performance trend, Partnership observed another decline of -2.3% for MY2022.

CHILD - PRIORITY FLAG: The Rating of Specialist (Q22.) measure saw a marked decline -5.7%. The measure did not meet or exceed the plan's 33rd percentile benchmark target. The HEDIS QC benchmark percentile ranking also declined to the 24th percentile ranking from the 34th percentile in MY 2022. The highest summary rate score for Child was 74.4% and occurred in the RY 2020 for MY 2019. The marked -10.8% rating measure decline began in the RY 2021 for MY 2020 survey results. Continuing the performance trend, Partnership observes summary rate fluctuations ranging from an increase of 6.8% in MY 2021 and another marginal decline of -0.9% of a percentage point in MY 2022.

CAUSAL FACTORS

The ME 7 qualitative analysis also includes findings detailed in the Network Adequacy Assessment Report (NET 3) aligned with MY 2023 CAHPS® survey results. A summary below captures factors that link to member dissatisfaction on respective declines with priority flagged measures.

- Membership 6.3% annual growth.
- Grievance notable findings:
  - As previously noted, the leading filed Grievances in 2023 were Access at 1,526 (43%), almost half of 3,572 closed grievance cases.
  - Grievance cases filed per 1,000 members increased to 5.26 from 4.00, a notable 28.5% increase.
  - Partnership did not met the access grievance threshold for 2023.
- Geographic impacts
  - Northern county members are experiencing greater travel distance and time to access primary care and specialty care.
  - Northern and Southern county assigned members observed longer wait times to beseen for the following specialists: Cardiology, Dermatology, and Ophthalmology.

SUMMARY OF ACTIVITIES AND INTERVENTIONS

The detailed activities for the FY 2023-2024 Quality Improvement Department Goal CAHPS® Score Improvement (CSI) available in Appendix B, Table XV demonstrates cross-department action focused on interventions. The highlighted examples below showcase completed goals/actions targeting Access and, furthermore, document continuous improvement.

❖ **HUMAN RESOURCE/WORKFORCE DEVELOPMENT DEPARTMENT**

- **Completed Action:** Improve Access with Provider Recruitment Support. Contracted with a third-party talent search firm to partner and support recruitment and placement of multiple clinical vacancies within the Partnership contracted primary care and specialty care provider network.
- **Completed Action:** Improve Access with Provider Retention. Successfully added and facilitated a retention bonus to the 2024 Provider Recruitment Program (PRP).

❖ **ORGANIZATIONAL GOAL #4 | FY 2024-2025**

ACCESS & MEMBER EXPERIENCE

The summary table below includes improvement focus based on the outcome of MY 2023-2024 quantitative, qualitative, causal analysis, and highlights organization priority of member barriers identified through the mentioned, Table: III.

Table: III

INTERVENTION & IMPROVEMENT STATUS	IMPROVEMENT FOCUS	GOAL MILESTONE #	INTERDEPARTMENTAL COLLABORATION		DEFINITIONS
			YES / NO	# OF DEPTS.	
Continue	Access	1,2	Yes	4	• **Adjust:** a lean approach or pivot. A continued focus and intent. • **Continue:** a continuation of intervention or improvement activity and focus. • **Maintain:** score or intervention met. • **Monitor:** intervention or improvement assessment period. • **New:** a new action or intervention.
Continue	Member Experience	2,3,4,5,6,7	Yes		
Continue	Customer Service	3,8			
Continue	Attitude/Service	3,5			
Continue	Health Care Rating	1,2,4,5,6,7	Yes		
Continue	Health Plan Rating	All	Yes		

The two (2) workgroups Access and Member Experience will collaborate through FY 2024-2025 to implement short and long-term strategies and plan development focused on the identified barriers and milestone summaries listed below.

- **Milestone 1:** The **Access Workgroup** will develop and propose a multi-year Access Strategy plan that is inclusive of understanding the landscape of our specialty care and primary care provider network and identifying gaps.
- **Milestone 2:** The **Access Workgroup** will develop and propose a multi-year Access Tactical plan that outlines targeted actions to drive Milestone 1 objectives.

- **Milestone 3:** The **Member Experience (ME) Workgroup** will drive CSI FY 2023-2024 pilot from analysis phase to Strike-Team "action" phase. The enhanced ME improvement strategy is continuous, with the intent to leverage quarterly data (G&A, PHM) sources to drive proactive interventions throughout FY 2024-2025.
- **Milestone 4:** The **Member Experience (ME) Workgroup** will focus on developing and proposing member communication and engagement enhancements through existing platforms or new tool development.
- **Milestone 5:** The **Member Experience (ME) Workgroup** will define and develop Member Informative Session (MIS) program strategy and framework.
- **Milestone 6:** The **Member Experience (ME) Workgroup** will implement Year 1 of the texting program as approved by the monthly texting workgroup.
- **Milestone 7:** The **Member Experience (ME) Workgroup** will continue with Your Partner in Health branding campaign to develop a Partnership Awareness - grassroots communications strategy.
- **Milestone 8:** The **Member Experience (ME) Workgroup** will collaborate with the Quality Improvement Pay-for-Performance Team to explore Unit-of-Service measure development opportunities.

MEMBER EXPERIENCE

2023-2024 GRAND ANALYSIS

Partnership HealthPlan of California (Partnership) measures the Members' Experience through monitoring of annual regulated and non-regulated surveys and grievance and appeals reporting. The Member Experience and respective quality outcomes are driven and measured by interdepartmental health plan coordinated efforts that support operational and strategic member and provider-focus activities. Our commitment to ensuring our members receive high-quality healthcare services and excellent customer service directly aligns with Partnership's mission and vision. In 2021, Partnership achieved NCQA Health Plan Accreditation and in September of 2023 another organizational milestone was reached with our first official NCQA Health Plan Star Rating of 3.5 out of 5 Stars. These two achievements demonstrate 30 years of organizational commitment to cultivate a culture of quality, and purpose to our mission, "To help our members and the communities we serve, be healthy." The method and accreditation requirement for how our member's rate our service is through the administration of the CAHPS® regulated survey, and the collection of various member data resources used to assess member satisfaction with Partnership and the provider network.

Partnership maintains a multidisciplinary approach to improve the member experience through the administration of the QI Department CAHPS® Program and organizational goal alignment intended to improve the health plan member engagement and service experience.

Organizational efforts to improve member experience is included in the ME 7 Grand Analyses and covers both fiscal year and CAHPS® MY 2023 and RY 2024. The evaluation period highlights fiscal year improvement that directly aligns with Partnership's NCQA Member Experience Priority Ranking: 1) Access, 2) Health Equity, 3) Rating of Health Plan, and 4) Attitude and Service. The analyses herein will interchangeably reference this period as a measure year or MY 2023-2024 and includes the 2023 Grievances and Appeals Annual Report and the continuous monitoring of complaints, grievances, and appeals data for calendar year 2022.

OBJECTIVE

The intent of this report is to meet the requirements of NCQA standards ME7: Element C and D. The objectives are to assess member experience through G&A Department and CAHPS® scores QI Department quantitative and qualitative analyses, identify opportunities for improvement and set priorities.

The primary ME 7 report contributors include:

1. Nancy Steffen, Senior Director of Quality and Performance Improvement
2. Isaac Brown, Director of Quality and Performance Improvement
3. Barbara Selig, Manager of Quality Improvement Programs
4. Anthony Sackett, Program Manager II, Quality Improvement Programs
5. Andrea Thomas, Project Manager I, Quality Improvement Programs
6. Kory Watkins, Director of Grievance & Appeals
7. Latrice Innes, Manager of Grievance & Appeals Compliance

DEPARTMENT OVERVIEW:

GRIEVANCE AND APPEALS

The G&A Department is responsible for the execution of Department of Healthcare Services (DHCS) APL 21-011, also known as the "Final Rule", which mandates that members have a right to report any problem(s) while using their Partnership Medi-Cal plan and Partnership has an obligation to investigate objectively.

The G&A analysts are responsible for investigating, monitoring, and reporting on members' dissatisfaction experiences related to Partnership, health plan delivery, and services provided within a clinical and non-clinical setting. The role G&A serves on behalf of our member is to advocate, mediate, educate, and ensure each member receives high-quality healthcare services across the healthcare continuum. The G&A Department performs quarterly and annual reporting, and through their analyses, they provide insight into service dissatisfaction. Through continuous monitoring and reporting, the G&A Team makes data-driven decisions to address, improve, and transform member dissatisfaction into innovative system-wide changes with the purpose to improve the overall member experience.

QUALITY IMPROVEMENT | CAHPS® PROGRAM

The Quality Improvement Department - CAHPS® Program manages the contract administration of conducting an annual Consumer Assessment of Healthcare Providers and Systems (CAHPS®) regulated survey designed and governed by the Agency of Healthcare Research and Quality (AHRQ). The team is also responsible for:

- Leading the ME 7 report production, performing quantitative and qualitative analyses on survey results and other plan delivery data aligned with NCQA ME 7 Standards C and D and elements intended to drive continuous improvement activities and interventions.

- CAHPS® programmatic alignment with two (2) of the five (5) FY 24-25 Organizational Metrics, 1) Achieve a 4.0 Star NCQA Health Plan Rating (HPR), 2) Achieve a 2.5 Star NCQA, Patient Experience (CAHPS®) HPR.
- Presenting annual survey results, HEDIS Quality Compass benchmarks, and NCQA reportable measures.
- Leading goal activities, discussion, and collaboration with program charter members.

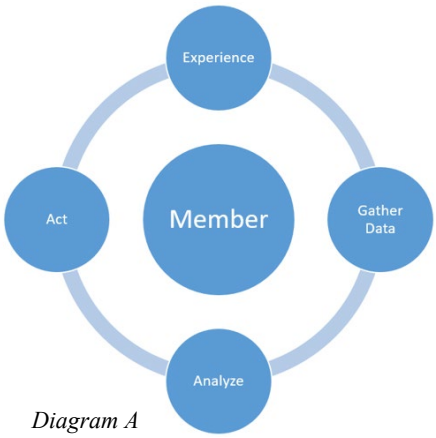


Diagram A

PROGRAM FRAMEWORK

The CAHPS® programmatic framework is rooted in the discipline of continuous quality improvement (CQI). A combined member-centric and CQI process illustrates continuous purpose, *Diagram A*. Action that is focused on listening to member experiences, collecting data, performing analyses, and data-driven improvements to target or influence the member experience, health outcomes, perception of the health plan, and score performance. The outcome of these improvement activities align with the Partnership mission and vision.

METHODOLOGY

ANALYSIS WORKGROUP

As noted in ME7: Element C & D, the health plan is required to conduct a side-by-side annual quantitative and qualitative analysis of our data sources and make recommendations for interventions to ultimately improve our healthcare delivery system and most importantly, overall member experience. Partnership established internal thresholds and benchmarks as a strategy to set realistic goals for underperforming measures.

The QI CAHPS® Team leads continuous activities and organizational influence focused on CAHPS® score improvement. Partnership relies on various internal and external data sources to manage health plan and health service delivery that includes the annual G&A and CAHPS® data sources as a guide to evaluate member satisfaction and improvement effectiveness. Program administration relies on two key documents: 1) CAHPS® Program Charter and 2) Organizational Goal #4 Charter. These documents are used to drive stakeholder commitment, outline specific actions to improve service delivery and experience, and serves as communication and strategic guiding tools.

DATA SOURCES

GRIEVANCE AND APPEALS: Partnership utilized NCQA's required data sources, which are G&A reporting and CAHPS® scores. The G&A analysts provided reporting from January 1, 2023, through December 31, 2023. Also shown is the previous year, 2022 G&A data. It's important to note that multiple reporting categories can apply to any given grievance, appeal, or second-level grievance. Therefore, the stated metrics herein reflect the number of concerns expressed by our members during the reporting periods,

rather than actual case counts. In addition, please note that internally, Partnership refers to a member's dispute of a denied grievance as a "Second Level Grievance". Throughout this document, we will reference appeals as "Appeals" and "Second Level Grievances".

CAHPS® SURVEY: Partnership contracts with an NCQA-certified vendor, PressGaney to administer the annual regulated survey and provide results of our CAHPS® survey on a yearly basis. The CAHPS® regulated survey results is one of several sources used to complete the ME 7 analysis for MY 2023-2024 and includes the last two survey cycles, MY 2023 and MY 2022 surveys.

DATA MAPPING

GRIEVANCE AND APPEALS: NCQA standards ME7: Element C & D requires that the organization aggregate G&A data into five (5) specific categories (Quality of Care, Quality of Practitioner Office Site, Attitude and Service, Billing/Financial Issues, and Access). Since Partnership's categorization is structured to meet DHCS requirements, the team (consisting of key individuals from impacted departments, including Member Services, Health Services, G&A, Quality Improvement, and Communications) mapped Partnership reporting categories to that of the five (5) NCQA required categories.

CAHPS® SURVEY: Partnership reports on the eight (8) CAHPS® NCQA rating and composites measures including: Rating of Health Plan, Rating of Health Care, Rating of Personal Doctor, Rating of Specialist, Getting Needed Care, Getting Care Quickly, Care Coordination, and Customer Service.

THRESHOLDS & BENCHMARKS

As part of the NCQA process and to better evaluate member experience, thresholds, and benchmarks have been set to measure our performance.

- GRIEVANCES AND APPEALS

  For each category, a ratio of the number of grievances per 1,000 members is used as a performance metric. Our numerator will be the total amount of Grievances or Appeals/Second Level Grievances for the reporting period, and our denominator will be the monthly average member base of each reporting period. If we see a 10% increase in any of the five (5) categories, it is flagged for discussion based on the number of grievances per 1,000 members.

- CAHPS® SURVEY

  The CAHPS® Team in collaboration with program charter stakeholders established methods to measure member satisfaction through continuous monitoring, analyses, improvement activities and interventions. The annual analyses is centered on evaluating improvement effectiveness through the actions of quantitative and qualitative analyses. To achieve this, Partnership relies on the Healthcare Effectiveness Data and Information Set (HEDIS) Quality Compass benchmarks and internal performance targets.

In addition to the mentioned eight (8) NCQA rating and composite summary measures, the CAHPS® program also includes, *How Well Doctors Communicate* as an additional monitoring and performance measure. It should be mentioned the CAHPS® program increased the prior year's 25th percentile performance levels to the 33rd percentile, Table IV. Summary measures performing below the 33rd percentile target are flagged for review and discussion.

Table: IV

CAHPS® COMPOSITE MEASURES	CAHPS® PROGRAM TARGET
Getting Needed Care	Rating and composite measures ≥ 33rd percentile
Getting Care Quickly	
Getting Care Coordination	
Customer Service	
CAHPS® RATING MEASURES	
Rating of Health Plan	
Rating of All Health Care	
Rating of Specialist Seen Most Often	
Rating of Personal Doctor	

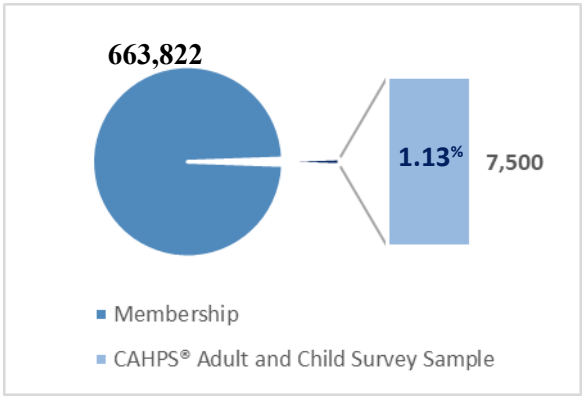
SURVEY METHODOLOGY

The CAHPS® survey is administered to capture accurate and complete information about HealthPlan member-reported experiences and specifically aims to measure how well plans are meeting covered member expectations. It also determines which areas of service have the greatest influence on member overall satisfaction and identifies areas of opportunity to improve the quality of care and service delivery.

SURVEY SAMPLE SIZE

Survey sample size includes Adult and Children populations based on NCQA member sample frame eligibility requirements. The annual survey results provide a retrospective performance on key NCQA ratings and composite measures. Typically the regulated survey is conducted in February of each calendar year, and members are asked to share their experiences over the past six (6) months that consists of dates-of-service between the months of July 1st and December 31st of the prior year. Survey questions target member experiences and engagement with a physician, non-emergent clinical setting, health plan, and health plan delivery of covered benefits within Partnership's fourteen (14) county service area.

In January of 2024, Partnership expanded its service area by ten (10) additional northern counties. ***As noted the ten (10) new-county-members are not included in the MY 2023 survey results but will be included in the MY 2024 survey sample frame.***



OVERSAMPLE STRATEGY

Analyses of MY 2022 survey responses identified low Adult responses for reportable measures requiring a plan to obtain at least 100 responses for a related rating and composite measures.

As a proactive strategy, the QI CAHPS® Team increased the MY 2023 Adult sample size from 100% to 150% above the required minimum sample frame with the intent to improve reportable survey responses (denominators) in the CAHPS® domain and, moreover, mitigate risk of not meeting the minimum requirement. The QI CAHPS® Team has maintained an over-sampling strategy for several survey cycles. The combined Adult and Child sample size of 7,500 represent 1.13% of DHCS eligible member assignment for December 2023 (663,822). An over sample comparison table by population highlights the minimum sample requirement, over sample percentage, and samples size for each respective measure year, Table V.

Table: V

Measure Year	Minimum Sample Size	Oversample %	Survey Sample Size		Minimum Sample Size	Oversample %	Survey Sample Size
	Adult				Child		
2023-2024	1,350	150%	3,375		1,650	150%	4,125
2022-2023		100%	2,700			150%	4,125

ANNUAL ASSESSMENT OF NON-BEHAVIORAL HEALTHCARE COMPLAINTS AND APPEALS

GRIEVANCES | APPEALS & SECOND LEVEL GRIEVANCES

The G&A data and quantitative analysis are grouped by 1) Grievances and 2) Appeals & Second Level Grievances (SLG) and include the total cases filed for current and prior reporting periods. Data is further stratified by the five (5) defined NCQA service categories; includes threshold calculations by reported cases; (category/average monthly member base); and denotes if the threshold is met or not met.

The G&A performance thresholds are set based on prior year's performance, and targets are set at the level of each NCQA grievance and appeal category. A summary threshold for annual performance is also provided, reference Table VI and Table VII. This data represents all member filings within the 2023 calendar year.

Table: VI

Grievances Only Reporting Period: Annual 2022 vs. 2023								
	Previous Period: 2022			Current Period: 2023				
NCQA Category	Avg PHC Membership	Grievances	Grievances p/1,000	Avg PHC Membership	Grievances	Grievances p/1,000	Threshold	Threshold Met?
Access	638,303	1,055	1.65	678,546	1,526	2.25	1.82	No
Attitude/Service		1,278	2.00		1,752	2.58	2.20	No
Billing/Financial		113	0.18		106	0.16	0.19	Yes
Quality of Care		106	0.17		186	0.27	0.18	No
Quality of Provider Office		4	0.01		2	0.00	0.01	Yes
TOTAL		2,556	4.00		3,572	5.26	4.40	No

RESULTS & THRESHOLDS – GRIEVANCES ONLY

The trending data in Table VI includes annual reporting periods between January 1, 2023, and December 31, 2023, and the previous year, January 1, 2022, and December 31, 2022.

There were a total of 4,261 closed G&A cases in calendar year 2023, compared to 3,318 in calendar year 2022. The two (2) case types that comprise the leading filed Grievances were Attitude/Service at 1,752 (49%) followed by Access at 1,526 (43%) of 3,572 closed grievance cases.

Table: VII

Appeals & Second Level Grievances Reporting Period: Annual 2022 vs. 2023								
	Previous Period: 2022			Current Period: 2023				
NCQA Category	Avg PHC Membership	Appeals & SLG	Appeals & SLGs p/1,000	Avg PHC Membership	Appeals & SLG	Appeals & SLGs p/1,000	Threshold	Threshold Met?
Access	638,303	332	0.52	678,546	350	0.52	0.57	Yes
Attitude/Service		47	0.07		33	0.05	0.08	Yes
Billing/Financial		382	0.60		297	0.44	0.66	Yes
Quality of Care		1	0.00		9	0.01	0.00	No
Quality of Provider Office		0	0.00		0	0.00	0.00	Yes
TOTAL		762	1.19		689	1.02	1.31	Yes

RESULTS & THRESHOLDS – APPEALS & SECOND LEVEL GRIEVANCES

The trending data in Table VII includes annual reporting periods between January 1, 2023, and December 31, 2023, and the previous year January 1, 2022, and December 31, 2022. In 2023, the health plan received 689 Appeals and Second Level Grievance cases, an observed 9.6% decrease compared to 762 cases filed in 2022. A noted decrease in two (2) NCQA categories: Attitude/Service, and Billing/Financial.

SUMMARY HIGHLIGHTS:

GRIEVANCES AND APPEALS & SECOND LEVEL GRIEVANCES

GRIEVANCES SUMMARY: Partnership met two out of the five (5) grievance thresholds for 2023, including Billing/Financial and Quality of Provider Office. The three threshold not met include: Access, Attitude/Service, and Quality of Care (QOC). Comparing results to 2022, all threshold were met except QOC, marking an overall decline of NCQA category thresholds.

APPEALS & SECOND LEVEL GRIEVANCES SUMMARY: One (1) out of five (5) thresholds were not met in 2023, Quality of Care. Although the threshold for QOC was not met in the current reporting period, it is important to call attention that QOC cases went from one (1) case in 2022 to nine (9) cases in 2023.

IDENTIFICATION OF OPPORTUNITIES

- Access related issues continue to impact our members as the provider network, in particular in our more rural service areas, struggles to attract and retain clinical staff.

GRIEVANCES AND SECOND LEVEL GRIEVANCES BY NCQA CATEGORY

  - Access: long wait times for providers.
  - Service and Attitude: transportation late arrivals or missed ride issues.
  - Quality of Care concerns: Treatment plan disputes causing delays in care and provider communication.
- 6.3% annual growth in Partnership's membership.
- Grievance cases filed per 1,000 members increased to 5.26 from 4.00, a notable 28.5% increase.
- Appeals and Second Level Grievances filed per 1,000 members decreased from 1.19 to 1.02.

QUANTITATIVE ANALYSIS

MY 2023 CAHPS® SURVEY

PLAN PERFORMANCE

Previously noted, the CAHPS® Program evaluates plan performance against an internal plan benchmark set at the 33rd percentile for both rating and composite measures. It should be noted that the difference between the plan benchmark and NCQA ratable measures is that for each rating measures, the CAHPS® workgroup includes the percent of ratings (8, 9 or 10) as another target to use for team-oriented goal activities, whereas HPR only includes rating (% of 9 or 10) scores.

Additionally, the annual evaluation takes into consideration survey trends from PressGaney portfolio of business, and/or book-of-business (BoB), and AHRQ 2023 CAHPS® Chart Book. The CAHPS® Team considers industry trends as another measurement to evalute the plan against other member survey engagement, and NCQA rating measure peformance relative to other Medicaid Managed Care Plans, Appendix E.

The CAHPS® survey plan performance for MY 2023-2024, MY 2022-2023, and comparable analyses are included in each section by population and illustrated within Table VIII and Table IX. ***As referenced above in Section Methodology, the CAHPS® Program raised the plan performance benchmark to the 33rd percentile from the 25th percentile.***

ADULT CAHPS® PLAN PERFORMANCE

The comparison table illustrates Adult CAHPS® survey scores by MY 2022 and MY 2023.

Table: VIII

	ADULT CAHPS Composite	2022-2023 (14.3% Response Rate) Sample Size 2,700 Total Returns 380	MY 2022 Percentile Ranking	Partnership (PHC) Benchmark	Partnership Benchmark Met?	2023-2024 (15.3.% Response Rate) Sample Size 3,375 Total Returns 510	MY 2023 Percentile Ranking	Partnership (PHC) Benchmark	Partnership Benchmark Met?
Rating Measure	Rating of Health Plan (% 8, 9, 10)	73.8%	18th	PHC ≥ 25th	No	68.4%	<5th	PHC ≥ 33rd	No
	Rating of All Health Care (% 8, 9, 10)	74.9%	40th	PHC ≥ 25th	Yes	66.9%	5th	PHC ≥ 33rd	No
	Rating of Personal Doctor (% 8, 9, 10)	81.5%	42nd	PHC ≥ 25th	Yes	82.8%	51st	PHC ≥ 33rd	Yes
	Rating of Specialist Seen Most Often (% 8, 9, 10)	81.1%	26th	PHC ≥ 25th	Yes	81.0%	41st	PHC ≥ 33rd	Yes
Composite Measure	Getting Needed Care (% Always or Usually)	76.4%	14th	PHC ≥ 25th	No	74.0%	7th	PHC ≥ 33rd	No
	Getting Care Quickly (% Always or Usually)	69.5%	5th	PHC ≥ 25th	No	68.1%	<5th	PHC ≥ 33rd	No
	Care Coordination (% Always or Usually)	86.6%	73rd	PHC ≥ 25th	Yes	78.8%	11th	PHC ≥ 33rd	No
	How Well Doctors Communicate (% Always or Usually)	92.9%	51st	PHC ≥ 25th	Yes	92.6%	48th	PHC ≥ 33rd	Yes
	Customer Service (% Always or Usually)	88.6%	38th	PHC ≥ 25th	Yes	87.0%	18th	PHC ≥ 33rd	No

Plan Performance Target: 33rd Percentile

RATING MEASURES

- In MY2023, there was a noted decline of two (2) measures, ***Rating of Health Plan*** and ***Rating of All Health Care,*** and an observed improvement in benchmark rates for ***Rating of Personal Doctor and Rating of Specialist Seen Most Often*** compared to MY 2022.
- Plan Performance MET: ***Rating of Personal Doctor and Rating of Specialist Seen Most Often*** (% 8, 9, 10).

COMPOSITE MEASURES

- In MY2023, there was a noted decline of all five (5) composite measures, and only one (1) measure exceeded the 33rd percentile performance target.
- Plan Performance MET: ***How Well Doctors Communicate*** *(% always or usually).*

CHILD CAHPS® PLAN PERFORMANCE

The comparison table illustrates Child CAHPS® survey scores by measure years; MY 2022, and MY 2023.

Table: IX

	CHILD CAHPS Composite	2022-2023 (14.9% Response Rate) Sample Size 4,125 Total Returns 611	MY 2022 Percentile Ranking	Partnership (PHC) Benchmark	Partnership Benchmark Met?	2023-2024 (16.1% Response Rate) Sample Size 4,125 Total Returns 659	MY 2023 Percentile Ranking	Partnership (PHC) Benchmark	Partnership Benchmark Met?
Rating Measure	Rating of Health Plan (% 8, 9, 10)	84.7%	33rd	PHC ≥ 25th	Yes	86.5%	45th	PHC ≥ 33rd	Yes
	Rating of All Health Care (% 8, 9, 10)	80.4%	<5th	PHC ≥ 25th	No	76.9%	<5th	PHC ≥ 33rd	No
	Rating of Personal Doctor (% 8, 9, 10)	90.5%	51st	PHC ≥ 25th	Yes	89.9%	55th	PHC ≥ 33rd	Yes
	Rating of Specialist Seen Most Often (% 8, 9, 10)	85.2%	34th	PHC ≥ 25th	Yes	81.5%	21st	PHC ≥ 33rd	No
Composite Measure	Getting Needed Care (% Always or Usually)	76.7%	10th	PHC ≥ 25th	No	77.1%	14th	PHC ≥ 33rd	No
	Getting Care Quickly (% Always or Usually)	76.3%	<5th	PHC ≥ 25th	No	78.9%	9th	PHC ≥ 33rd	No
	How Well Doctors Communicate (% Always or Usually)	92.7%	26th	PHC ≥ 25th	Yes	93.0%	40th	PHC ≥ 33rd	Yes
	Care Coordination (% Always or Usually)	81.1%	19th	PHC ≥ 25th	No	80.4%	22nd	PHC ≥ 33rd	No
	Customer Service (% Always or Usually)	89.9%	73rd	PHC ≥ 25th	Yes	91.2%	89th	PHC ≥ 33rd	Yes

Plan Performance Target: 33rd Percentile

Rating Measures

- In MY2023, there was a noted decline of two (2) measures, ***Rating of All Health Care and Rating of Specialist Seen Most Often,*** and an observed improvement in benchmark rates for ***Rating of Health Plan and Rating of Personal Doctor*** compared to MY 2022.
- Plan Performance MET: ***Rating of Health Plan and Rating of Personal Doctor*** *(% 8, 9, 10).*

Composite Measures

- In MY2023, there was a noted improvement of four (4) composite measures, and only two (2) measures exceeded the plan 33rd percentile performance target.
- Plan Performance MET: ***How Well Doctors Communicate and Customer Service*** *(% always or usually).*

Partnership CAHPS® Survey Results–NCQA Patient Experience Star Rating

Rating and Composite Summary Rate Performance

Table: X

ADULT
HEDIS/CAHPS® Measures Required for Health Plan Accreditation
Quality Compass Reporting Year Summary Rate Trend

Patient Experience	RY 2022	RY 2023	RY 2024	Performance Trend
	Summary Rate Performance			
Getting Care				
Getting Needed Care (% Always or Usually)	76.0%	76.4%	73.9%	
Getting Care Quickly (% Always or Usually)	72.9%	69.5%	68.0%	
Satisfaction with Plan Physicians				
Rating of Personal Doctor (% 9 + 10)	61.8%	66.9%	70.0%	
Satisfaction with Plan and Plan Services				
Rating of Health Plan (% 9 + 10)	54.5%	56.8%	54.4%	
Rating of Health Care (% 9 + 10)	51.5%	55.7%	46.3%	

Table: X
Summary Rates are defined by NCQA in the HEDIS 2024 CAHPS® 5.1H guidelines and generally represent the most favorable response percentages.

Adult Notable Findings for RY 2024

- Adult oversampling strategy contributed to meeting the 100 survey response threshold for all NCQA Reportable measures.
- RY 2024 Patient Experience Star Rating Estimate: 1.5, ***no change from prior year.***
- Getting Care (% Always or Usually): ***A decrease in Access related measures has an overall impact to Rating of Health Plan and Rating of Health Care measures.***
    - Getting Needed Care - Score decline of -2.4 compared to RY 2023
    - Getting Care Quickly - Score decline of -1.4 compared to RY 2023
- Satisfaction with Plan Physicians (% 9+10):
    - Rating of Personal Doctor - Score increase of +3.1 compared to RY 2023
- Satisfaction with Plan and Plan Services (% 9 + 10):
    - Rating of Health Plan - Score decline of -2.3 compared to RY 2023
    - Rating of Health Care - Significant decline of -9.4 compared to RY 2023

Table: XI

CHILD HEDIS/CAHPS® Measures Required for Health Plan Accreditation Quality Compass Reporting Year Summary Rate Trend				
Patient Experience	RY 2022	RY 2023	RY 2024	Performance Trend
	Summary Rate Performance			
Getting Care				
Getting Needed Care (% Always or Usually)	79.6%	76.7%	77.0%	
Getting Care Quickly (% Always or Usually)	84.1%	76.3%	78.9%	
Satisfaction with Plan Physicians				
Rating of Personal Doctor (% 9+10)	74.6%	74.4%	75.5%	
Satisfaction with Plan and Plan Services				
Rating of Health Plan (% 9 + 10)	66.9%	68.0%	68.1%	
Rating of Health Care (% 9 + 10)	65.6%	64.2%	58.8%	

Table: XI
Summary Rates are defined by NCQA in the HEDIS 2024 CAHPS® 5.1H guidelines and generally represent the most favorable response percentages.

CHILD NOTABLE FINDINGS FOR RY 2024:

- Child oversampling strategy contributed to meeting the 100 survey response threshold for all NCQA reportable measures.
- RY 2024 Patient Experience Star Rating Estimate: 2.0, ***an increase of +.5 from prior year.***
- Getting Care (% Always or Usually): ***An increase in Access related measures has an overall impact to Rating of Health Plan and Rating of Health Care measures.***
    - Getting Needed Care - Score increase of +0.4 compared to RY 2023
    - Getting Care Quickly - Score increase of +2.6 compared to RY 2023
- Satisfaction with Plan Physicians (% 9+10):
    - Rating of Personal Doctor - Score increase of +1.1 compared to RY 2023
- Satisfaction with Plan and Plan Services (% 9 + 10):
    - Rating of Health Plan - Score increase of +0.1 compared to RY 2023
    - Rating of Health Care - Significant decline of -5.3 compared to RY 2023

APPENDIX

MEMBER EXPERIENCE

APPENDIX A

2024-2025 ORGANIZATION GOAL #4

The CAHPS® Program Manager has been appointed to lead ***Goal 4: Access to Care and Member Experience Improvement***. The Access to Care/Member Experience Improvement organizational goal will focus on three (3) main areas:

1. Understanding the landscape of our specialty provider network, identifying gaps, and developing targeted action plans
2. Understanding the landscape of our primary care provider network, identifying gaps, and developing targeted action plans
3. Expanding the "Your Partner in Health" branding campaign and implementing an action plan to improve and increase member awareness

Goal Overview and Impact Summary

Improving access to care and enhancing member experience are pivotal for fostering a healthcare system that prioritizes both quality and member experience.

The CAHPS® regulated survey measures adult and child (member/patient) experience or perception of key aspects of their care. As an accredited health plan, we may designate which CAHPS® survey we want scored, either adult or child population. Last measure year, we chose child survey results that earned us 2.0 Patient Experience (CAHPS®) rating and an overall NCQA 3.5 Star Health Plan rating. This measure year Partnership designated adult survey results to be included in the scoring.

This fiscal year Partnership aims to achieve or exceed a 2.5 Star NCQA Patient Experience (CAHPS®) rating and achieve or exceed a 4.0 Star NCQA Health Plan rating. The Goal #4 Team will continue to build on the prior year's interventions and improvement activities. The established FY 2024-2025 goals are intended to impact or influence positive change on the key focus areas:

Access to Care: Improving access to care serves as the gateway to improve patient/member experience and health outcomes. As an organization, Partnership must plan to navigate through access obstacles linked to ever-changing membership levels, clinical staffing shortages, and economic climate at state, county and federal levels. Over the next fiscal goal period, our plan is to broaden our approach with the stewardship of Workforce Development leadership. In scope is to incorporate the past four (4) years of implemented access improvements and lessons learned through the 5-Star Quality Strategic and Tactical Plans, and, where applicable, adjust them as we develop a comprehensive Access Strategy and Tactical Plan fully dedicated to access moving forward.

Member Experience: Advancing the Quality Improvement (QI) CAHPS® programmatic framework will require implementing interventions rooted in present barriers and before eligible members participate in the regulated CAHPS® survey. Lessons learned through CSI activities over the past two (2) fiscal goal periods have paved the path forward. The plan is to leverage more real time data (i.e., Grievance & Appeals [G&A] and Population Health Management [PHM] community engagement responses) on a quarterly basis to examine and respond timelier to topical themes identified directly from our members, including complaints about the health plan and providers. This enhanced method will provide Goal #4 Team more real-time opportunity to measure intervention effectiveness against targeted barriers

Positive Reputation and Brand Identity: Continue to distinguish Partnership as a Managed Care Plan leader that is committed to member-centered care, leading to a positive reputation and member awareness, "our story" within the communities we serve.

Effective Communication: Enhance member communication through texting, email, and Partnership mobile application designed to centralize and simplify all member-facing online websites/tools/platforms. This will help drive usability and value by engaging members through various communication modalities in delivering proactive resources that promote health education, covered benefits literacy, wellness, and preventative care resources.

Member Engagement and Adherence: Empower members with knowledge and resources intended to lead to greater engagement in their own care and increased adherence to treatment plans, resulting in better long-term health outcomes.

Enhanced Digital Experience: Develop a user-friendly mobile app and enhance member portal functionality and methods to empower members to self-serve and inform Partnership how they would prefer to engage with us. The plan is to build upon member demographic collection integration through existing C-Square enhancements.

APPENDIX B

IMPROVEMENT ACTIVITIES & ACTIONS TAKEN

In FY 2022-2023, CAHPS® stakeholders continued the established FY 2021-2022 process to evaluate data sources, including CAHPS® MY 2022 survey results and the 2022 Annual G&A and Second Level Grievances data. This included the analysis of said sources, improvement recommendations and NCQA Steering Committee approval to proceed with intervention activities focused on improving Access to Care and Member Experience.

The goal-setting approach this reporting period was slightly different to account for organizational change from a team goal to a department goal structure. The FY 2023-2024 QI CAHPS® Score Improvement (CSI) Department goal aimed to address overall member experience with an emphasis on improving equitable access to care as evaluated using MY 2022 / RY 2023 CAHPS® survey results and G&A data. The approach will include implementation of short and long term interventions[1] that target workforce development, expand primary care access and favorable member experience, and increased HealthPlan branding and promotion.

CAHPS® SCORE IMPROVEMENT (CSI) PARTICIPANTS

The FY 2023-2024 QI Department CSI Goal cross-department workgroup participants illustrate organization-wide participants involved in a multi-disciplinary approach focused on improvement activities and strategic CSI planning during the reporting and evaluation period, Table: XII.

Table: XII

GOAL WORKGROUP PARTICIPANTS	
WORKGROUP	**DEPARTMENT | NAME**
CAHPS® SCORE IMPROVEMENT OVERSIGHT WORKGROUP/GOAL LEAD: ANDREA THOMAS CO-LEAD: ANTHONY SACKETT	**ADMIN – SANTA ROSA:** Lynn Scuri
	COMMUNICATIONS: Dustin Lyda
	GRIEVANCE & APPEALS: Kory Watkins
	HR/WORKFORCE DEVELOPMENT: Cody Thompson, David Lavine
	MEMBER SERVICES: Edna Villasenor
	OFFICE OF THE CMO: Jeff Ribordy, MD, Mohammed Jalloh, PharmD
	PMO/OPEX: Hannah Petersen, Matt Hintereder, William Kinder
	POPULATION HEALTH MANAGEMENT: Monika Brunkal, Nicole Curreri
	PROVIDER RELATIONS: Ledra Guillory, Garnet Booth, Stephanie Nakatani
	QI: Anthony Sackett, Andrea Thomas, Barb Selig, Isaac Brown, Nancy Steffen
	TRANSPORTATION SERVICES: Melissa McCartney, Michelle Mootz

CAHPS® SCORE IMPROVEMENT (CSI) INTERVENTIONS

It should be highlighted that through continuous discovery our program has consistently evolved since CAHPS® program inception. To this point, our team placed more emphasis on analyzing existing delivery of services and covered benefits to gain a different perspective of member perception and linkage to satisfied and dissatisfied experiences.

The table below represents potential improvement focus to known member barriers, intervention ideas referenced in the FY 2023-2024 QI Program Evaluation and a status check mark indicates an influence of change, adoption, or linkage to department goal activities this fiscal year.

Table: XIV

IMPROVEMENT FOCUS	IDEAS	STATUS
Member Experience (ME)	Listen more through all established member engagement channels and determine whether these are adequate. Member focus groups are a potential intervention under evaluation.	
Rating of Health Plan	Operational awareness of member-supporting activities and internal/external communication. An operational improvement to remove work silos between departments is under review and consideration.	
ME	Continue to support Partnership branding and broader member and community awareness of the importance of CAHPS® survey participation.	✓
ME & Service/Attitude	Partnership Transportation, support, collaborate, and evaluate member experience with the Transportation Services Department and take timely action with what we learn.	✓
Access	Workforce Development, Partner with Workforce Development Associate Director and regional staff to: • Support local activities to bolster residency programs by engaging residents to help improve retention • Provide resources to help update and analyze PCP vacancy data and support other Workforce Development tactics linked to improving Access	✓
Access	Telehealth, where applicable support PMO regional-based telehealth to improve member and provider utilization and the influence of improving access and member experience.	✓
Rating of Health Plan	Develop key preventative indicators (KPI) to resolve service line issues quickly. An operational improvement pilot is under review and consideration.	
Access & Service/Attitude	• G&A complaints to identify member service delivery dissatisfaction themes. • PHM community member engagement survey and call campaign data. • Transportation member satisfaction data collection, analysis and, if applicable, proposed interventions. • Develop a process to quickly identify service delivery issues through real-time data with the intent to proactively investigate, validate, and implement solutions to improve member satisfaction.	✓ ✓ ✓

	• Remove operational barriers, Treatment Authorization Request denials and provider training opportunities.	

FY 2023-2024 SUMMARY OF ACTIVITIES AND INTERVENTIONS

The summary table below includes improvement focus based on the outcome of MY 2022-2023 quantitative and qualitative analyses, and root casual analysis. This table also highlights organizational priority of member barriers identified through the actions outlined in the CAHPS® Program Description and goal specific within the FY 2023-2024 CAHPS® Program Charter. Further the improvement or intervention focus status may include: New, Continue, Adjust, Monitor or Maintain. A summary of each improvement focus, accomplishment or outcome maybe referenced in Table XV.

Table: XV

INTERVENTION & IMPROVEMENT STATUS	IMPROVEMENT FOCUS	INTERDEPARTMENTAL COLLABORATION		DEFINITIONS
		YES / NO	# OF DEPTS.	• **Adjust:** a lean approach or pivot. A continued focus and intent. • **Continue:** a continuation of intervention or improvement activity and focus. • **Maintain:** score or intervention met. • **Monitor:** intervention or improvement assessment period. • **New:** a new action or intervention.
Continue	Access	Yes	7	
Continue	Member Experience	Yes		
New	Customer Service			
New	Attitude/Service			
Continue	Health Care Rating	Yes		
Continue	Health Plan Rating	Yes		

Drawing on new discoveries and lessons learned in FY 2022-2023 CSI, goal efforts pivoted in FY 2023-2024 from four (4) distinct workgroups into one (1) collaborative Oversight Workgroup. This change afforded our team the ability to remove cross-department work silos and improve department leader collaboration by linking to external QI Department goal activities that directly and indirectly influence member experiences, Appendix D.

Further, restructuring allowed external departments to adopt or align with the CSI goal. As a result, implementation of new improvement activities and interventions that targeted workforce development, improved access to care, transportation services, direct-to-member activities, and increased Partnership branding and awareness were the focus of this collaborative workgroup. Seven (7) departments officially adopted the CSI goal and three (3) departments closely aligned their goals with CSI.

Additionally, an opportunity presented itself mid-year where the CAHPS® Team was invited to a webinar brainstorming session in order to fulfill Partnership's Northern Region Consortia partners, Health Alliance of Northern California (HANC) and North Coast Clinics Network (NCCN), contractual agreement. The CAHPS® Team suggested a Patient Experience webinar, which stemmed from the team's CG-CAHPS® / Provider Network – Improve Communications Scores Pilot referenced above. The outcome was a

webinar entitled *Incorporating Patient Experience in Quality Improvement Projects and Plans,* which was held on May 7, 2024. The learning objectives for participants viewing this webinar were as follows:

- Describe how patient experience impacts clinical outcomes, patient satisfaction, provider/staff satisfaction, and healthcare quality.
- Identify opportunities to assess patient experience data from a Quality Improvement (QI) perspective.
- Apply QI methodology to patient experience improvement activities.
- Discuss strategies for involving patients and their families in the QI process.

There were 53 external individuals, representing 34 unique organizations, who attended this webinar. The webinar recording is posted under "On-Demand" webinars on the Quality page of Partnership's website. An article in the summer 2024 edition of the Partnership Provider Relations newsletter focusing on CAHPS® and Member Experience as a true partnership between the health plan and providers highlighted this webinar and encouraged providers to view the recording.

In FY 2023-2024 Partnership restructured the former fiscal goal to a department goal process with metric alignment to measure effectiveness of improvement. The CAHPS® Program will still maintain our annual programmatic focus but owning the responsibility of delivery is shared among four (4) departments: Communications, Member Services, HR/Workforce Development, and Quality Improvement.

Table: XVI

CSI GOAL OVERSIGHT WORKGROUP PARTICIPANTS		
Department | Action	**Goal | Milestones**	**Accomplishments**
HR/Workforce Development QI CSI Department Goal adopted: yes	**Intervention/Improvement Status: New** Intervention: Contract with Third Party Recruiter Impact on CSI: Improve Access with Provider Recruitment Barrier: Access to Care	Successfully facilitated the execution of a contingency search firm agreement with CompHealth as wells as creating a contingency search firm Letter of Agreement for partners and provided to sites in Solano County. Five (5) of the six (6) partners (Communicare+Ole, Winters Health, Community Medical Center, LaClinica, and Northbay) signed the agreement. The remaining site is currently in the contracting phase as of the date of this update. Additionally, four (4) sites have provided open position details. • Three (3) openings with Community Medical Centers (Family medicine positions in Dixon, Internal Medicine in Vacaville, and a Pediatric opening in Vacaville) • Two (2) openings with La Clinica de La Raza (Family medicine positions in North Vallejo and Vallejo Medical)

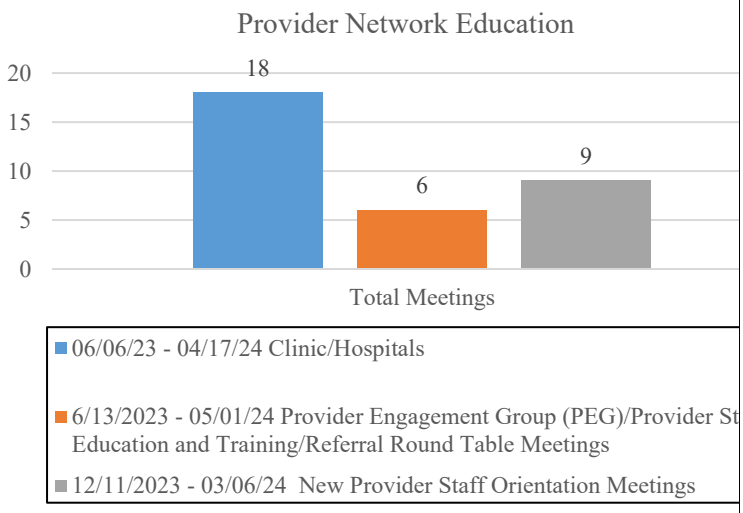
CSI GOAL OVERSIGHT WORKGROUP PARTICIPANTS		
Department | Action	**Goal | Milestones**	**Accomplishments**
		• Five (5) openings with NorthBay Medical (Family medicine positions in American Canyon, Dixon, Fairfield, Green Valley, and Vacaville) • One (1) opening with Winters Healthcare (Family medicine position in Winters/Esparto) With this information, CompHealth works to market the positions to candidates searching for opportunities. There have been 14 candidates formally introduced by CompHealth to three (3) provider organizations (Community Medical Centers, La Clinica de La Raza, and NorthBay). Four (4) interviews have taken place with candidates in the month of April 2024 (three (3) with Community Medical Centers and one (1) with NorthBay).
	Intervention/Improvement Status: Continue Intervention: Provider Resident Retention Program Impact on CSI: Improve Access with Provider Retention Barrier: Access to Care	Successfully facilitated adding the resident retention bonus to the 2024 Provider Recruitment Program (PRP) Agreement, which launched the first week of January 2024. Of the 65 grant requests submitted to the program as of May 1, 2024, six (6) requests included the additional $20,000 resident retention bonus. To date, one (1) of the offers made, including the $20,000 bonus, has been accepted. There is a possibility that the five (5) remaining requests for program support, including a resident bonus, could be accepted and the resident bonus payment facilitated before graduation. Since the 2024 recruitment program launched in January and physician residents graduate in late June, the opportunity for provider sites to be able to align the bonus successfully may have been difficult. With continued promotion of PRP in the upcoming fiscal year, higher utilization and retention of additional regional residents is expected.
	Intervention/Improvement Status: Continue Improvement Activity: Provider Network Vacancy Survey Impact on CSI: Improve Access with Provider Recruitment Barriers: Access to Care	The Provider Network Vacancy survey for Report Year 2024 was successfully launched to partner sites with 500 or more assigned members. The survey was completed between April 1, 2024 and April 19, 2024. Compared to the Measurement Year (MY) 2022/2023 site survey where there was a 74% response rate, initial review of the MY2023/2024 survey results showed nearly an 80% response rate from organizations polled. The increase in response rate can be attributed to initial engagement from the Partnership team with executives at provider sites as well as multiple follow-ups with clinic managers, Human Resource departments, and recruiters. Final survey results are being compiled.

CSI GOAL OVERSIGHT WORKGROUP PARTICIPANTS		
Department | Action	**Goal | Milestones**	**Accomplishments**
OpEx/PMO Telehealth Program QI CSI Department Goal Adopted: No	**Intervention/Improvement Status: New** Intervention: Increase DTM utilization by 25% through DTM grant Impact on CSI: Member Experience / Specialty Access / Health Care / Health Plan Ratings Barrier: Access to Care	In FY 2022-2023, Direct-to-Member (DTM) utilization spiked significantly over the prior fiscal year to 1,974 from 543 visits in FY 2021-2022. For FY 2023-2024, the goal was to increase DTM by 25%. Through March, or nine (9) months, DTM utilization has 4,373 completed visits representing a 122% increase. DTM Grant executed with five (5) organizations: Alliance Medical; Redwood Coast Medical Services (RCMS); Redwood Rural Health Center (RRHC); Stallant Health; and Sutter Coast. All five (5) are set to achieve their goals. • Alliance – 143/200 visits completed through March. 117% increase over FY 2022-2023 • RCMS – 63/50 visits completed through March. Did zero (0) visits in FY 2022-2023 • RRHC – 150/100 visits completed through March. 217% increase over FY 2022-2023 • Stallant – 429/150 visits completed through March. 1,489% increase over FY 2022-2023 • Sutter Cost – 127/150 visits completed through March. 75% increase over FY 2022-2023 Collectively these organizations represent 101 completed DTM visits per month over nine (9) months, which is a 290% increase collectively over their collective 26 visits per month in FY 2022-2023.
Communications QI CSI Department Goal Adopted: No	**Intervention/Improvement Status: New** Improvement Activity: Your Partner in Health: Partnership Branding/Awareness Strategy Impact on CSI: Knowing who Partnership is relative to health plan administrator/Managed Care Plan (MCP)	The new Your Partner in Health campaign officially launched on October 1, 2023 in all 24 counties Partnership serves. The goal of the campaign is to reiterate to members that Partnership is here to help them with all their Medi-Cal needs. Your Partner in Health is the organization's slogan and branding campaign/initiative to ultimately raise awareness of who Partnership is and what the organization does for members and the broader community. Strategies included outdoor, radio, social media, streaming, and digital with messaging aimed to target specific populations.

CSI Goal Oversight Workgroup Participants		
Department | Action	**Goal | Milestones**	**Accomplishments**
	Barriers: Health Plan Rating / Health Care Rating	
	Intervention/Improvement Status: New Improvement Activity: Member Texting Engagement Platform Impact on CSI: Improve member connection with the plan by communicating through preferred channels Barriers: Health Plan Rating / Health Care Rating	Partnership's newly appointed Chief Information Officer is taking the necessary steps to re-evaluate the predecessor's work related to the vendor selection and cyber security considerations. The unforeseen activities affect the ability to execute a contract and submit a texting plan to Department of Healthcare Services (DHCS) for review and approval. In conclusion, the member texting platform is unlikely to launch by June of 2024.
Member Services QI CSI Department Goal Adopted: No	Improvement Activity: Member Texting Engagement Impact on CSI: Improve member connection with the plan by communicating through preferred channels Barriers: Health Plan Rating / Health Care Rating	See Communication's update above.

CSI GOAL OVERSIGHT WORKGROUP PARTICIPANTS		
Department | Action	**Goal | Milestones**	**Accomplishments**
	Intervention/Improvement Status: New Intervention: Optimizing Translation Services Impact on CSI: Member Experience / Health Plan Ratings Barriers: Health Plan Rating / Health Care Rating	Conducted two (2) webinars in November 2023 for providers to engage with AMN vendor to introduce the phone/video remote interpreting (VRI) services and how to utilize. Two (2) additional webinars were completed in January and February 2024. Additionally, covered options of obtaining the AMN platform for video remote interpreting (license [using the provider's owned devices] or securing tablets and stands).
Population Health Management QI CSI Department Goal Adopted: yes	Improvement Activity: Member Texting Engagement Platform Impact on CSI: Improve member connection with the plan by communicating through preferred channels Barriers: Health Plan Rating / Health Care Rating	See Communication's update above.
Transportation Services QI CSI Department Goal Adopted: yes	**Intervention/Improvement Status: New** Improvement Activity: Transportation Gas Mileage Reimbursement Service Recovery Impact on CSI: Member Experience / Health Plan Ratings Barriers: Customer Service / Health Plan Rating	During the course of this fiscal cycle, the Transportation Team worked to automate Gas Mileage Reimbursement payments. Process improvements were identified and implemented, which should increase satisfaction and timely payments moving forward. Out of 40,629 gas mileage reimbursement trips, there were a total of 122 related grievances filed between May 1, 2023 – April 1, 2024. Findings are being reviewed and methods for identifying improvements to increase Customer Service ratings are being developed. One such metric being used to measure improvements in processes is the Gas Mileage Reimbursement Service Recovery Outcall Project. During this pilot project, the Transportation Team will attempt making two (2) calls to members having filed a gas mileage reimbursement grievance to gauge if the member is now satisfied as to receiving timely gas mileage reimbursements. The goal is to achieve successfully connecting with 20% (or 25) members.

CSI Goal Oversight Workgroup Participants		
Department | Action	**Goal | Milestones**	**Accomplishments**
	Intervention/Improvement Status: New Improvement Activity: Transportation Active Utilizer Survey Impact on CSI: Access to Care / Member Experience / Health Plan Ratings / Health Care Barrier: Access to Care	This activity was abandoned due to Transportation Team being severely understaffed this fiscal year and prioritization of gas mileage reimbursement service recovery efforts.
Grievance & Appeals QI CSI Department Goal Adopted: yes	**Intervention/Improvement Status: Continue** Improvement Activity: Participate in dialogue channel to provide real-time member satisfaction data and methods to drive key preventive indicators (KPIs). A KPI will have defined risk thresholds, which will provide Partnership more real-time opportunities prior to the survey. G&A will evaluate trends through grievance and appeal data and provide to the workgroup. Impact on CSI: Access to Care / Member Experience / Health Plan Ratings / Health Care / Specialty Care Barriers: Health Plan Rating	Grievance & Appeals (G&A) participated in regular meetings with key stakeholders to discuss intervention ideas and opportunities. Through regular evaluation of trends using G&A data, the team provided the workgroup with analyses to be used for data-driven recommendations. This enabled informed decision-making and targeted interventions.
	Intervention/Improvement Status: New Improvement Activity: Participate in analysis	G&A effectively participated in activities aimed at understanding and improving areas of opportunity within the plan. By actively engaging in the analysis process, the team gained insights into the plan's strengths and areas for improvement. Through collaborative efforts within the

CSI Goal Oversight Workgroup Participants		
Department | Action	**Goal | Milestones**	**Accomplishments**
	activity to better understand where the plan's areas of opportunity are. Participate in workgroup to write summaries to track relative milestones G&A participates in. Impact on CSI: Access to Care / Member Experience / Health Plan Ratings / Health Care / Specialty Care Barriers: Health Plan Rating	workgroup, G&A added valuable contributions to summaries related to CSI.
Provider Relations QI CSI Department Goal Adopted: yes	**Intervention/Improvement Status: New** Improvement Activity: Provider Network Education Impact on CSI: Health Plan Ratings / Member Experience Barriers: Health Plan Rating	Throughout this fiscal cycle, the Provider Relations Team reviewed flyers, PowerPoint presentations, and hosted meetings with providers in support of educating the network on Transportation Services and Benefits and Work Force Development Programs (Provider Recruitment and Provider Retention Initiatives). These meetings included, and not limited to, Operations, Provider Staff Education and  Trainings, Provider Engagement, and Referral Roundtables.
Admin – Santa Rosa Office	**Intervention/Improvement Status: New** Intervention: Identify primary care providers in	Using Primary Care Tableau Utilization reports, four practices were identified in the Southwest region providing > 25% of primary care visits via telehealth. Organizations included in the study were: West County Health Centers, Long Valley Health Center, Marin Community Clinics, and

CSI GOAL OVERSIGHT WORKGROUP PARTICIPANTS		
Department | Action	**Goal | Milestones**	**Accomplishments**
QI CSI Department Goal Adopted: yes	the Southwest Region that are providing a significant percent of visits via telehealth (>10% of total); interview providers and summarize the ways telehealth is being used and perceived impact on access to care. Impact on CSI: Member Experience / Specialty Access / Health Care / Health Plan Ratings Barrier: Access to Care	Alliance Health Centers. A survey was developed and meetings scheduled with leaders from each primary care organization to administer survey and discuss use of primary care telehealth. Information gleaned from surveys was used to create one-page summary documents for each organization. A meeting was scheduled with all participants on May 30, 2024 to share details from each organization and jointly develop primary care telehealth best practices. **Study Participants**: The four (4) health centers in the study provide between 26 – 43% of their primary care visits via telehealth, most often as audio visits rather than video visits. **Common Uses of Primary Care Telehealth**: Telehealth visits are most commonly used for same day appointments and triage and follow-up visits to review imaging and lab results. One provider routinely uses telehealth for Emergency Department and hospital patient follow-up. Follow-up to eConsults also noted as a potential use for primary care telehealth visits. **Telehealth Staffing**: The staffing and structure used to provide primary care telehealth services varies quite a bit from one organization to another. Some rely exclusively on current staff, others contract with remote staff. **Member Satisfaction**: While most organizations have not done a formal telehealth member satisfaction survey, all sites stated that telehealth is well received by their patients, though many still prefer in-office visits, depending on the nature and scope of the visit. For example, one clinic noted patients receiving medication assisted treatment are grateful for the telehealth option, thereby reducing the need for frequent visits to the clinic. **Provider Satisfaction**: Providers appreciate the flexibility afforded by telehealth to work remotely or even with telehealth visits integrated into their daily in-office schedule. One (1) provider sites that telehealth helps with provider satisfaction and retention. **Primary Care Telehealth**: All health centers participating in the study state that primary care telehealth is an important tool to help address access to care. One (1) organization emphasized “Telehealth is here to stay”.
	Intervention/Improvement Status: New	The Southwest Direct-to-Member (DTM) workgroup was formed to include staff from the Telehealth Team, Provider Relations, and Regional staff to assess current use of DTM

CSI Goal Oversight Workgroup Participants		
Department | Action	**Goal | Milestones**	**Accomplishments**
	Intervention: Engage at least two providers in the Southwest Region to implement DTM or increase DTM physician visits to at least 50 visits for FY 2023-24. Impact on CSI: Member Experience / Specialty Access / Health Care / Health Plan Ratings Barrier: Access to Care	by provider and develop joint outreach and promotional strategies. A dashboard was developed to monitor progress. Specific strategies were reviewed and refreshed at each quarterly meeting. As a result, there was a significant increase in the use of DTM services by provider offices in the Southwest, with an average increase of over 101% from the previous six (6) months. Eight (8) providers met the goal of greater than 50 DTM visits in the goal period.
Office of the CMO – Northern Region QI CSI Department Goal adopted: yes	**Intervention/Improvement Status: New** Intervention: Engagement with Tribal Health Organizations Impact on CSI: Member Experience / Health Care / Health Plan Ratings Barriers: Access to Care / Member Experience	This intervention aimed to support engagement with tribal health providers in an effort to improve the health and well-being of tribal communities. A Tribal Conference was successfully held in October of 2023. 14 tribal health providers were in attendance in addition to representatives from Department of Healthcare Services, Indigenous Pact, Indian Health Organizations, and Partnership leaders. Also occurring in October 2023 were Better Birthing Coalition site visits to K'ima:w Medical Center and ceremony sites on Hoopa Reservation and Sue-Meg village. In February 2024, a successful workshop was led by Indigenous Pact, a tribal healthcare consultant, for key Partnership staff. The intent of the workshop was to increase Partnership staff and leadership's knowledge around tribal history, beliefs and practices, which in turn would improve relationships and communication between organizations. Upcoming meetings, not yet scheduled as of this update, with K'ima:w Medical Center leadership will be centered around CalAIM and quality work.
	Intervention/Improvement Status: New Intervention: Work Collaboratively with Telehealth Team and TeleMed2U to Promote DTM Model	Throughout the fiscal year, worked collaboratively with Telehealth Team and provided Subject Matter Expert support for provider outreach to increase use of DTM and other telehealth services.

<table>
<tr><th colspan="3">CSI Goal Oversight Workgroup Participants</th></tr>
<tr><th>Department | Action</th><th>Goal | Milestones</th><th>Accomplishments</th></tr>
<tr><td></td><td>Impact on CSI: Member Experience / Specialty Access / Health Care / Health Plan Ratings

Barriers: Access to Care / Member Experience</td><td></td></tr>
<tr><td rowspan="2">Quality Improvement</td><td>Intervention/Improvement Status: New

Improvement Activity: Implement CAHPS® Drill Down Survey, and gather all member-centric data points to include but not limited to; community/member-facing engagement activities, and call campaign data points

Impact on CSI: Member Experience / Health Plan Ratings

Barriers: Member Experience / Health Plan Ratings</td><td>Implementation of the non-regulated CAHPS® Drill Down Survey for the Adult population was completed. The purpose of the non-regulated survey was to help identify potential root causes and/or qualitative insight to responses garnered in the regulated Measurement Year 2023 Report Year 2024 CAHPS® survey. To incentivize members to complete the Drill Down survey, a $30 Walmart gift card was offered. The survey timeline and methodology were as follows.
<table>
<tr><th>Task Name</th><th>Date</th></tr>
<tr><td>Survey Mailed (First attempt)</td><td>March 18, 2024</td></tr>
<tr><td>Survey Mailed (Second attempt)</td><td>April 3, 2024</td></tr>
<tr><td>Telephonic Reminders Begin</td><td>April 17, 2024</td></tr>
<tr><td>Drill Down Survey Concludes</td><td>May 29, 2024</td></tr>
</table>
A total of 694 surveys were completed; incentives are in the process of being administered to members. Survey results and analysis are pending and will be outlined in the MY2023-2024 Member Experience Grand Analysis.</td></tr>
<tr><td>Intervention/Improvement Status: Continue

Improvement Activity: Analysis and Risk Identification of Grievance and Appeals Data

Impact on CSI: Health Care Rating / Health Plan Rating / Rating of Personal Doctor / How Well Doctors</td><td>As part of a pilot program, 2023 G&A data and Population Health Management member surveys were reviewed / analyzed. For Population Health Management, themes/requests among members were identified, some of which pointed to third parties (i.e., mental health, dental, etc.) The various grievance and appeals data was categorized and aligned with National Committee for Quality & Assurance's (NCQA) defined categories of Access; Attitude and Service; Billing and Financial; Quality of Care; and Quality of Practitioner Site. The intent was to identify an on-going method to capture member feedback (active listening) that may demonstrate network wide or health plan wide</td></tr>
</table>

CSI GOAL OVERSIGHT WORKGROUP PARTICIPANTS		
Department | Action	**Goal | Milestones**	**Accomplishments**
	Communicate / Customer Service Barriers: Health Care Rating / Health Plan Rating / Rating of Personal Doctor / How Well Doctors Communicate / Customer Service	themes requiring adjustments in member-facing communications, branding, and educational activities. This activity would provide active listening in real time as opposed to waiting for yearly CAHPS® survey results. The intent is to effect change and/or implement steps to address barriers sooner rather than later. Support of the CAHPS® Oversight Workgroup was garnered to move the pilot forward into the next fiscal year and establish a small group of Subject Matter Experts to provide further guidance on what other data sets could be identified pointing to themes of member dissatisfaction; data/interventions to be accessed on a quarterly basis. Ongoing meetings with G&A and other key stakeholders will continue in the next fiscal year.
	Intervention/Improvement Status: New Intervention: CG-CAHPS® / Provider Network – Improve Communications Scores Pilot (*Select at least one mid-to-large Parent Organizations, ≥ 1,200 assigned members*) Impact on CSI: Health Care Rating / Health Plan Rating / Rating of Personal Doctor / How Well Doctors Communicate / Customer Service Barriers: Health Care Rating / Health Plan Rating / Rating of Personal Doctor / How Well Doctors Communicate / Customer Service	This intervention was implemented with a provider located in Partnership's Southwest region. Part one involved contracting with the Crossroads Group to establish a system of continuous patient experience surveying and reporting. The Crossroads Group is a well-established company, with extensive experience serving Federally Qualified Health Centers (FQHCs), which offers comprehensive patient experience surveying, data analysis and reporting. The intent was for this provider to use patient experience data provided by the Crossroads group to carry out at least two (2) Quality Improvement Projects addressing patient satisfaction, with specific aims and defined Plan-Do-Study-Act cycles by June 30, 2024. Part two entailed a four-hour, interactive training on patient-centered communication in the primary care setting for all providers and clinical staff. The training would be specifically tailored to strengthen team-based communication techniques to increase patient satisfaction and clinical efficiency. A sustainability plan and training materials for providers and staff who onboard in the future would also be developed. As of the date of this update, this provider successfully launched their post-visit patient experience survey program and collected survey data via live phone interviews from over 1,000 patients in Q1 2024. In addition to receiving an executive summary, the provider also has access to a real-time dashboard displaying up-to-the-minute data, which allows data to be filtered/analyzed in multiple ways.

APPENDIX C

CAHPS® NON-REGULATED SURVEY

BACKGROUND

As a strategy, the CAHPS® Program contracted with PressGaney to administer a CAHPS® Adult non-regulated drill down (DD) survey at the same time of the CAHPS® regulated survey. The intent behind the strategic approach offers Partnership another mode to collect member experience data linked to NCQA CAHPS® reportable rating and composite measures.

SURVEY KEY DIFFERENCES

- The plan's ability to modify questions to better understand member survey responses is an alternate means of providing the health plan with potential root causes of why or how a member is feeling related to the asked question.

- The DD survey is modeled after the previously described regulated survey and includes similar mixed survey protocols, methodology, and the same HEDIS survey sample frame. However, a de-duplication process is in place to mitigate over surveying, survey-confusion, or unintended abrasion.

- An option to offer survey participants a thank you gift in the form of a $30 Walmart card to incentivize members to participate and complete the survey in its entirety.

- The DD survey questions are different by design and, therefore, survey results will not exactly align with regulated questions or HEDIS Quality Compass benchmarks.

SURVEY QUESTION DEVELOPMENT

The CAHPS® Team, in collaboration with key internal stakeholders developed survey questions linked to Partnership covered benefits and health care delivery services. The outcome of cross-department survey question collaboration is included in the tables below. Including department, attribute (focus), and questions, Tables: XIII[a-d].

ADULT DD SURVEY ADMINISTRATION HIGHLIGHTS

The gift card administration was managed by the QI Department, who partnered with the PHM Department to conduct outreach efforts to non-English, Spanish speaking members. The highlighted outcomes are listed below.

- Adult population (18 years or older)
- Total Survey Responses: 554 | English
- 5,000 sample frame
- Total Survey Responses: 140 | Spanish
- Language format: English and Spanish
- Response rate: 694-16 ineligible, survey completes = (678/5,000), 13.6%

- 673 Gift cards mailed

ADULT DD SURVEY RESULTS
CORRELATION TO REGULATED NCQA REPORTABLE RATING AND COMPOSITE MEASURES

As previously noted, the DD survey completes (n=678), combined with the regulated survey completes (n=510) is a combined total of 1,188 completed surveys. To date, this is the largest single member population and experience data collection within a survey measure year for Partnership.

QUANTITATIVE ANALYSIS

The quantitative analysis displayed in the tables below aligns key rating and composite measure questions with DD member survey responses and other survey questions considered to be key drivers that influence and impact the overall NCQA Health Plan Star Rating.

QUALITATIVE ANALYSIS

The qualitative analysis will include comparing the results of the DD survey to those of the CAHPS® regulated survey and provide key findings regarding how our members think and feel about key questions or attributes.

The quantitative and qualitative analysis tables when applicable will include Adult CAHPS® regulated rating or composite measure MY 2023 performance, followed by similar or influenced DD questions, highlight survey responses, and offer comparative key findings. ***Survey questions where applicable are developed into DD questions by asking key subsequent questions. The survey includes several gate questions, which when applicable advances members to the next question. Therefore the noted sample size will change.***

DD SURVEY NOTABLE FINDINGS

- **MEMBER SATISFACTION**
  - Members shared they are 87% (n=678), very or somewhat satisfied with Partnership Health Plan of California.
- **PLAN COVERED BENEFITS AND SERVICES**
  - More than a third of respondents 36% (n=678), ask either their provider or clinical staff questions related to benefit coverage or health services. While another 29% prefer to contact Partnership Member Services, and the remaining are self-reliant and choose to reference Partnership printed materials or website.
- **COVERED BENEFIT LITERACY**
  - Over 53% consider their understanding of benefits and coverage at excellent or very good, while 47% of members scored less than excellent or very good regarding understanding benefits. The CAHPS® Team has used DD results to validate and link benefit literacy gaps and themes gathered through members surveyed at in-person community events by PHM. Benefit themes point to coverage confusion between Partnership and state carve out coverage, Medi-Cal

(Dental/Pharmacy), vision, and transportation services. Although only 18% consider benefits and coverage confusing, the CAHPS® Team believes this number is higher given the complexity and distinction between state and Partnership covered benefits.

- **PARTNERSHIP CUSTOMER SERVICE**
  - Partnership prides itself with providing professional, courteous, respectful and top-notch member-facing customer service (Q25). In addition to our internal methods to monitor satisfaction levels, we also evaluate CAHPS® regulated survey performance. Over the past three CAHPS® regulated measure years, Adult and Child results scored in the lower (Adult) to mid (Child) 90th percentile. In comparison to providing information or help, our scores are in the low (Adult) to mid (Child) 80th percentile over the same measure period.
- **MEMBER SUPPORT AND ISSUE RESOLUTION**
  - Although only 16% (n=678) indicate they called Partnership customer service (Q25) only 25% (n=102) answered somewhat or strongly disagree with the posed survey question (Q27), "Question or issue was resolved." Additional comments shared include members called multiple times regarding the same issue, members placed on hold too long, and some members felt the phone system was confusing to navigate.
- **HEALTH EQUITY | HEALTH PLAN RATING – INTERPRETER EXPERIENCE**
  - As previously noted, the CAHPS® and DD Survey is only offered in two language formats, English and Spanish. Members answering the following questions represent Hispanic and Latino members.
  - The non-English speaking members (n=158), who relied on interpreter and language services while speaking with Partnership staff, shared that 69% (%9 + 10) had the best possible experience, while 31%, worst possible experience. Also important to note, the Adult CAHPS® regulated survey received a similar rating score related health plan interpreter services (n=171) 67.3%.
- **GETTING CARE QUICKLY**
  - Almost 40% of members participating in the DD survey experienced an illness, injury or condition requiring care right away (Q2), and 12.5% indicated experiencing a life-threating emergency (Q3. Member reported responses demonstrate less than half (n=263) required services in a non PCP setting.
- **KIND OF CARE NEEDED AND CLINICAL SETTING**
  - The correlating survey emergent care options (Q3 - Q5) indicate that one-third (39%) of surveyed respondents sought care within an Emergency Department (ED) setting for non-emergent, life-threating services. It is worth mentioning, the CAHPS® Team and internal stakeholders do not rely on DD survey data to inform Partnership of ED over-utilization of non-emergent care. It does, however, align with the intent to tease out and elevate learnings (Q5) as to the why. The collected data will serve to facilitate discussions and to drive quality improvement activities.

HOW WELL DOCTORS COMMUNICATE

- Members (n=678) responded favorably with posed DD questions (Q11a-d). This aligns with the CAHPS® regulated survey Rating of Personal Doctor summary composite score of 70% and HEDIS Quality Compass ranking 64th percentile.
  - 90% of members (Q11d) felt their personal doctor spoke in a way that was easy to understand, ***whereas 97% shared their personal doctor used medical words they did not understand (Q12).***

- 80% of members (Q11a, Q11c) felt their personal doctor spent enough time and encouraged them to talk about health problems or concerns.
- 85% of members felt their personal doctor answered all their questions.

Table: XIII-[a]

DEPARTMENT: TRANSPORTATION SERVICES ATTRIBUTE / FOCUS: ACCESS, BENEFIT LITERACY, MEMBER EXPERIENCE
QUESTIONS
Q9. If you had a challenge in the last 6 months getting care right away or as soon as needed for an illness, injury or condition, what was the problem? *(Mark all that apply):* ***Option, Did not have transportation to the appointment***
Q26. What was the reason you called customer service? (Mark all that apply): ***Option, Request transportation services.***
Q35. Are you aware that help with transportation to your medical appointments is available through your health plan?
Q36. In the past 6 months, has lack of transportation kept you from medical appointments?
Q37. Some health plans help with transportation to a doctor's offices or clinics. This help can be a shuttle bus, tokens or vouchers for a bus or taxi, or payments for mileage. In the last 6 months, did you phone your health plan to get help with transportation?

Table: XIII-[b]

DEPARTMENT: OPEX/PMO – TELEHEALTH PROGRAM ATTRIBUTE / FOCUS: ACCESS, BENEFIT LITERACY, MEMBER EXPERIENCE
QUESTIONS
Q30. In the past 6 months, did you have a telehealth visit?
Q31. Please indicate why you did NOT have any Telehealth visits in the last 6 months. *(Mark all that apply)*
Q32. If you had a choice, how likely would you be to choose a telehealth visit with your provider instead of having an in person visit with your provider?
Q33. You indicated that you had a telehealth visit in the last 6 months. *(Mark all that apply)*
Q34. What do you view as the main benefit to telehealth services? *(Mark only one)*

Table: XIII-c

DEPARTMENT: MEMBER SERVICES ATTRIBUTE / FOCUS: CUSTOMER SERVICE, BENEFIT LITERACY, MEMBER EXPERIENCE
QUESTIONS
Q22. Which of the following resources do you prefer to use when you need to find information about your health benefits and coverage?
Q23. Overall, how would you rate your understanding of your health care benefits and the coverage provided by your health plan?
Q24. Is the information about your health plan's coverage and benefits confusing?
Q25. In the past 6 months, did you call your health plan's customer service?
Q26. What was the reason you called customer service? (Mark all that apply.)
Q27. My question and or issue was resolved to my complete satisfaction.
Q28. If you answered question #27 with Somewhat Disagree or Strongly Disagree, please provide reason. (Mark all that apply.)
Q29. In the last 6 months, if you needed an interpreter (non-English speaker) or language services to help communicate with your Health Plan, how would you rate your experience (with 0 being the worst possible experience, and 10 being the best possible experience)?

Table: XIII-d

DEPARTMENT: HEALTH EQUITY ATTRIBUTE / FOCUS: CLAS SERVICES, MEMBER & PATIENT EXPERIENCE
QUESTIONS
Q11. In the last 6 months, how often did your personal doctor do each of the following? Option d) Spoke to you in a way that was easy to understand.
Q12. In the last 6 months, did your personal doctor use medical words you did not understand?
Q13. In the last 6 months, have you had problems communicating with your doctor or other cultural, personal, or religious beliefs?
Q14. In the last 6 months, have you had a hard time speaking with or understanding your doctor or other health care provider because you spoke different languages?
Q15. In the last 6 months, have you been treated unfairly at your personal doctor's office because of your race or ethnicity?

Q18. In the last 6 months, if you needed an interpreter (non-English speaker) or language services to help communicate with your doctor or other healthcare providers, how would you rate your experience (with 0 being the worst possible experience, and 10 being the best possible experience)?

Q29. In the last 6 months, if you needed an interpreter (non-English speaker) or language services to help communicate with your Health Plan, how would you rate your experience (with 0 being the worst possible experience, and 10 being the best possible experience)?

CAHPS® Regulated Survey		
Rating Measure		
Rating of Health Care (% 9 + 10) Respondents (n=326)	Score: 46.3% ⬇	HEDIS Quality Compass Ranking: 5th Percentile
Non-Regulated - DD Survey		
Questions that Influence Rating Measure	Member Insight – How members feel and what they're saying	
Q2. In the last 6 months, did you have an illness, injury, or condition that needed care right away?	Response (n=678): ▪ *61%: No* ▪ *39%: Yes*	
Q3. What kind of care did you need?	Response (n=263): *The question format is multiple choice; therefore, percentages do not equal 100%.* ▪ *48.3%: Lab tests or treatments.* ▪ *43.0%: Urgent care needed right away, such as for the flu virus, back pain, fever or sprain.* ▪ *40.3%: Appointment with a specialist.* ▪ *31.9%: Annual wellness exam or checkup.* ▪ *30.8%: Non-urgent care for illness/sick visit (for example, cough, sore throat, flu symptoms, etc.)* ▪ *16%: Other.* ▪ *12.5%: Life-threatening emergency.*	
Q4. Where did you go to get the care you needed right away for an illness, injury or condition?	Response (n=263): ▪ *42.1%: Hospital emergency room.* ▪ *22.2%: Personal doctor's office.* ▪ *15.4%: Walk-in clinic.* ▪ *10.4%: Specialist Office.* ▪ *8.1%: Other.* ▪ *1.8%: Did not get care needed for illness, injury or condition.*	
Q5. If you had to be seen in the hospital emergency room, why?	Response (n=263): ▪ *46.9%: Does not apply.*	

	▪ *14.8%: Other* ▪ *12.3%: Personal doctor's office was closed.* ▪ *11.1%: Personal doctor's office told me to go to the emergency room.* ▪ *7.8%: Life-threatening emergency.* ▪ *4.1%: I do not have a personal doctor.* ▪ *2.9%: I always go to the emergency room for care.*

CAHPS® Regulated Survey		
Rating Measure		
Rating of Health Plan (% 9 + 10) Respondents (n=490)	Score: 54.5% ⬇	HEDIS Quality Compass Ranking: 13th Percentile

Non-Regulated - DD Survey	
Questions that Influence Measure	Member Insight – How members feel and what they're saying
Q20. Satisfaction with Partnership.	Response (n=678): ▪ *87%: Very or somewhat satisfied.* ▪ *13%: Somewhat dissatisfied or very dissatisfied.*
Q22. Which of the following resources do you prefer to use when you need to find information about your health benefits and coverage.	Response (n=678): ▪ *35.7% Ask provider or someone at my provider's office.* ▪ *29.1%: Call the health plan's customer service department.* ▪ *23.1%: My health plan's web site.* ▪ *7.9%: Look first in the health plan's member handbook.* ▪ *4.2%: Other.*
Q23. Rating of understanding of benefits and coverage.	Response (n=678): ▪ *53%: Excellent or very good understanding of health benefits and coverage.* ▪ *47%: Fair or poor understanding of health benefits and coverage.*
Q24. Is the information about your health plan's coverage and benefits confusing?	Response (n=678): ▪ *81.8%: No, do not find coverage and benefits confusing.* ▪ *11.1%: Yes, find coverage and benefits confusing.* ▪ *7.1%: Other.*
Q25. Called customer service.	Response (n=678): ▪ *84%: No, member did not call plan customer service.* ▪ *16%: Yes, member called plan customer service.*
Q26. Reason for calling customer service.	Response (n=100): *The question format is multiple choice; therefore, percentages do not equal 100%.*

	▪ *33%: Coverage or benefit information (i.e. dental, vision).* ▪ *26%: Referral information.* ▪ *18%: Prior authorization, find a provider, medication coverage information.* ▪ *15%: Request new member ID card.* ▪ *11%: Request transportation services.* ▪ *9%: File a complaint, grievance or appeal.* ▪ *8%: Change my personal doctor.*
Q27. Question and or issue was resolved.	Response (n=102): ▪ *75%: Member strongly or somewhat agrees that issue was resolved.* ▪ *25%: Member somewhat or strongly disagrees that issue was resolved.*
Q28. If you answered question #27 with Somewhat Disagree or Strongly Disagree, please provide reason.	Response (n=28) *The question format is multiple choice; therefore, percentages do not equal 100%.* ▪ *50%: Other, please specify.* ▪ *35.7%: Called customer service several times about the same issue.* ▪ *32.1%: Call was transferred multiple times.* ▪ *28.6%: Placed on hold too long.* ▪ *21.4%: Customer service representative provided unclear or incomplete information.* ▪ *17.9%: Customer service representative spoke in a way that was unclear and hard to understand.* ▪ *14.3%: Member confused by recorded message on how to navigate to a customer service representative.* ▪ *10.7%: Customer service representative was not knowledgeable.* ▪ *3.6%: Medication coverage information.*
Q29. Rating of experience with interpreter with Health Plan.	Response (n=158): ▪ *69%: Plan interpreter (non-English speaker), best possible experience, % 9 +10.* ▪ *31%: Plan interpreter (non-English speaker), worst possible experience.*

CAHPS® REGULATED SURVEY		
COMPOSITE MEASURE		
Getting Needed Care **% Always + Usually** Respondents (n=271)	Score: 74.0% ⬇	HEDIS Quality Compass Ranking: 7th Percentile
NON-REGULATED - DD SURVEY		

Questions that Influence Measures	Member Insight – How members feel and what they're saying
Q7. In the last 6 months, how long did you have to wait between making an initial appointment and being seen by your personal doctor?	Response (n=541): ▪ *19.6%: 4 to 7 days.* ▪ *18.3%: 15 to 30 days.* ▪ *14.6%: 31 to 60 days.* ▪ *12.6%: 8 to 14 days.* ▪ *10.2%: More than 60 days.* ▪ *9.2%: Same day.* ▪ *6.7%: 3 days.* ▪ *5.0%: 2 days.* ▪ *3.9%: 1 day.*
Q8. Did you feel that the amount of time you had to wait for your appointment was reasonable?	Response (n=556): ▪ *66%: Yes, members felt the wait time to be seen was reasonable.* ▪ *34%: No, members did not feel the wait time to be seen was reasonable.*
Q9. If you had a challenge in the last 6 months getting care right away or as soon as needed for an illness, injury or condition, what was the problem?	Response (n=289): *The question format is multiple choice; therefore, percentages do not equal 100%.* ▪ *68.5%: Scheduling an appointment right away.* ▪ *24.2%: Receiving approval from my health plan.* ▪ *23.5%: Finding a location near me.* ▪ *15.6%: Other* ▪ *12.5%: Did not have transportation to the appointment.* ▪ *11.1%: Appointment with a specialist.*
Q10. In thinking about your experiences in the last 6 months, how sure are you that you will be able to get an appointment as soon as you need it for healthcare services, tests or treatments?	Response (n=678): ▪ *59%: Very sure or sure, members feel their able to get an appointment as soon as needed for healthcare services, tests and treatments.* ▪ *41%: Somewhat sure or not at all sure.*
Q38. Made Specialist Appointment	Response (n=678): ▪ *63%: No, in the last 6 months, member did not make an appointment with a specialist.* ▪ *37%: Yes, in the last 6 months, member made an appointment with a specialist.*
Q39. Had problems getting Specialty Care, tests or treatments	Response (n=253): ▪ *76%: No, member did not have problems getting specialty care, tests or treatments.* ▪ *24%: Yes, member had problems getting specialty care, tests or treatments.*

Q40. If you had challenges scheduling a specialist appointment, what type of appointment were you looking for?	Response (n=58): *The question format is multiple choice; therefore, percentages do not equal 100%.* ▪ *70.7%: Scheduling an appointment with a specialist they want to see.* ▪ *27.6%: Dental.* ▪ *24.1%: Other.* ▪ *20.7%: Scheduling radiology services (for example, X-rays, MRI, CT scan) appointment.* ▪ *20.7%: Lab work (for example, blood tests).* ▪ *12.1%: Annual check-up appointment.* ▪ *12.1%: Mental health services (for example, counseling or therapy).* ▪ *12.1%: Vision services.* ▪ *1.7%: Obtaining vaccinations or shots.*
Q41. What was the challenge when you tried to get an appointment with a specialist?	Response (n=58): *The question format is multiple choice; therefore, percentages do not equal 100%.* ▪ *50.9%: Getting an appointment as soon as I needed.* ▪ *42.1%: Untimely referral.* ▪ *38.6%: Finding a specialist near me.* ▪ *26.3%: Finding a specialty I needed.* ▪ *22.8%: Specialist did not accept my health insurance.* ▪ *21.1%: Unable to be seen by selected specialist.*

CAHPS® Regulated Survey Question		
Rating Measure		
Rating of Personal Doctor Respondents (n=320)	Score: 70.0% ⬆	HEDIS Quality Compass Ranking: 64th Percentile
Non-Regulated - DD Survey Questions		
Questions that Influence Rating Measure	Member Insight – How members feel and what they're saying	
Q11 (a-d). In the last 6 months, how often did your personal doctor do each of the following?		
Q11a. Spend enough time with you	Response (n=678): ▪ *80%: Always or Usually* ▪ *20%: Sometimes or Never*	
Q11b. Answer all your questions to your satisfaction	Response (n=678): ▪ *85%: Always or Usually* ▪ *15%: Sometimes or Never*	
Q11c. Encourage you to talk about all health problems or concerns	Response (n=678): ▪ *80%: Always or Usually* ▪ *20%: Sometimes or Never*	

Q11d. Spoke to you in a way that was easy to understand	Response (n=678): ▪ *90%: Always or Usually* ▪ *10%: Sometimes or Never*
Q12. In the last 6 months, did your personal doctor use medical words you did not understand?	Response (n=561): ▪ *93%: Always or Usually* ▪ *7%: Sometimes or never*
Q13. In the last 6 months, have you had problems communicating with your doctor or other cultural, personal, or religious beliefs?	Response (n=678): ▪ *95%: No* ▪ *5%: Yes*
Q14. In the last 6 months, have you had a hard time speaking with or understanding your doctor or other health care provider because you spoke a different language?	Response (n=678): ▪ *95%: No* ▪ *5%: Yes*
Q15. In the last 6 months, have you been treated because of your race or ethnicity?	Response (n=678): ▪ *98%: Never* ▪ *2%: Sometimes*
Q16. If you answered question #15 with Sometimes, Usually, Always, did you share your experience with your health plan (Member Services or Grievance & Appeals Department)?	Response (n=135): ▪ *84%: No* ▪ *16%: Yes*
Q17. If yes to question #16, how would you rate your Health Plan experience (with 0 being the worst possible experience, and 10 being the best possible experience)?	Response (n=131): ▪ *48%: % 9 + 10* ▪ *52%: % 0 - 8*
Q18. In the last 6 months, if you needed an interpreter (non-English speaker) or language services to help communicate with your doctor or other healthcare providers, how would you rate your experience (with 0 being the worst possible experience, and 10 being the best possible experience)?	Response (n=179): ▪ *73%: % 9 + 10* ▪ *27%: % 0 - 8*

COVERED BENEFIT – OPEX/PMO - TELEHEALTH PROGRAM	
NON-REGULATED - SUPPLEMENTAL QUESTIONS	
INFORMING QUESTIONS	MEMBER INSIGHT – HOW MEMBERS FEEL AND WHAT THEY'RE SAYING
Q30. In the past 6 months, did you have a telehealth visit?	Response (n=678): ▪ *72%: No* ▪ *28%: Yes*
Q31. Please indicate why you did NOT have any telehealth visits in the last 6 months.	Response (n=434): *The question format is multiple choice; therefore, percentages do not equal 100%.*

	▪ *41.9%: Medical situation was not appropriate for telehealth.* ▪ *38.0% Unaware doctor or specialist offered telehealth/video visits.* ▪ *25.3% Unaware health plan covered telehealth/video visits.* ▪ *14.5%: Do not own technology (laptop, tablet, smartphone).* ▪ *12.0%: Do not feel comfortable using telehealth for medical, behavioral or specialist health visits.* ▪ *10.8%: No internet access* ▪ *7.8%: Lack technical knowledge or private space for visit.* ▪ *2.3%: Limited phone minutes, and do not want to use them for telehealth visit.*
Q32. If you had a choice, how likely would you be to choose a telehealth visit with your provider instead of having an in person visit with your provider?	Response (n=471): ▪ *68%: Very Likely* ▪ *32%: Likely*
Q33. You indicated that you had a telehealth visit in the last 6 months.	Response (n=206): *The question format is multiple choice; therefore, percentages do not equal 100%.* ▪ *83.5%: Yes, and open to more telehealth visits in the future.* ▪ *16.5%: Yes, but the process is too hard, I prefer in-person.* ▪ *10.7%: Yes, but I do not want to have more telehealth visits in the future.* ▪ *6.8%: Yes, but the doctor's office had technical issues.*
Q34. What do you view as the main benefit to telehealth services?	Response (n=388): ▪ *41.0%: Quicker access.* ▪ *21.9%: No need for transportation.* ▪ *14.9%: Ability to receive care from home, avoid crowded waiting rooms.* ▪ *9.5%: Greater access to care in remote areas.* ▪ *8.5%: Ability to take less time off work.* ▪ *4.1%: Greater privacy.*

Covered Benefit – Transportation Services	
Non-Regulated - DD Survey Questions	
Informing Questions	Member Insight – How members feel and what they're saying
Q35. Are you aware that help with transportation to your medical appointments is available through your health plan?	Response (n=678): ▪ *56%: No* ▪ *44%: Yes*
Q36. In the past 6 months, has lack of transportation kept you from medical appointments?	Response (n=678): ▪ *94%: Never* ▪ *6%: Sometimes*
Q37. Some health plans help with transportation a shuttle bus, tokens or vouchers for a bus or taxi, or payments for mileage. In the last 6 months, did you phone your health plan to get help with transportation?	Response (n=678): ▪ *94%: No* ▪ *6%: Yes*

APPENDIX D

FY 2023-2024 Lessons Learned

- ❑ Cross-Department Collaboration: Direct dialogue with Senior Leadership this past fiscal year was of particular importance in order to maintain operational awareness of member-supporting activities. This was accomplished through regular attendance at monthly NCQA Steering Committee meetings. Oversight Workgroup attendees were invited to join on an ad-hoc basis when their Subject Matter Expertise relative to their interventions/activities was needed.

  This level of organizational integration helped Partnership:

  1) Leverage improvement activities and interventions to meet regulatory requirements
  2) Collaborate, strategize, and optimize when and how joint improvement activities were approached
  3) Optimize internal allocation of staff to improvement activities

  - One example of successful cross-department collaboration was OpEx's intervention of increasing Direct-to-Member (DTM) telehealth utilization and the Admin-Santa Rosa Team's efforts. For additional details reference, Appendix B, Table XIV.
  - The Admin-Santa Rosa Team directly targeted their Southwest (SW) Region interventions.
    - Engagement of two (2) SW providers to implement / increase DTM visits to at least 50 visits and identify SW providers utilizing a significant percent of telehealth visits and jointly develop a primary care telehealth best practice document to share among providers experiencing barriers with access.
  - At Oversight meetings, the Op/Ex Team continually asked for workgroup attendee's partnership in promoting DTM and provided an excellent forum to provide further collaboration on each department's telehealth efforts, all aimed at influencing improving access and member experience.
- ❑ Oversight Workgroup participants agreed to move the operational improvement pilot aimed at identifying key preventative indicators (KPI) forward into the next fiscal cycle. The intent of the pilot was to identify an on-going method to capture member feedback that may demonstrate network wide or health plan wide themes (KPIs) requiring adjustments in member-facing communications, branding, and educational activities.
  - Activity would provide active listening in real time as opposed to waiting for yearly CAHPS® survey results in an effort to implement changes to address barriers sooner rather than later. For the purposes of this pilot, 2023 Grievance and Appeals data and Population Health member engagement surveys were analyzed. The results of the pilot garnered support from the CAHPS® Score Improvement (CSI) Oversight Workgroup. As a next step, it was agreed upon to move the pilot forward into the next fiscal cycle establishing a small group of Subject Matter Experts to provide further guidance on what other possible data sets could be identified pointing to themes of member dissatisfaction.
- ❑ The CAHPS® Team began attending the 2024 Consumer Advisory Committee (CAC) quarterly meetings. CAC acts as a liaison group between members and Partnership and provides another mechanism to obtain feedback on existing/proposed CAHPS® interventions and activities.

- As an example, a small pilot for Partnership branded ID card sleeves is currently taking place. The sleeve would allow members to keep both their state issued Department of Health Care Services (DHCS) Medi-Cal card and their Partnership card together. Results of the pilot will be shared at an upcoming CAC meeting as well as requesting their input before concluding the pilot.

❑ Association for Community Affiliated Plans (ACAP). The CAHPS® Team and several Senior Leaders participated in the first ACAP sponsored CAHPS® Collaborative. This provided the opportunity to engage with nine (9) plans in several markets across the nation.

- **Medicaid Child Data Observations**
  - The member respondent population is of similar health status and slightly more diverse than other ACAP collaborative participants.
  - Partnership has performance results similar to other plans.
  - Rating measures tend relatively to be lower than other measures.
  - Those with fair/poor mental health status gave lower scores on the rating measures.
- **Medicaid Adult Data Observations**
  - Overall CAHPS® scores are lower than other Medicaid plans.
  - Most rates are trending down as well.
  - Those with fair/poor mental health status appear to have a much worse care experience.
- **Network Management**
  - The Plan must understand provider network coverage and availability. Sometimes time and distance can be adequate while access still is poor.
- **Provider Network**
  - Most of the members' experience with health care is going to be with the providers in a care setting. Without affecting this, plans have limited ability to move CAHPS® rates overall.
- Defining impactful interventions can be difficult to develop based on the results of the CAHPS® survey.
- **CAHPS® Response Rates**
  - Response rates have decreased and administrative costs have increased. Plans are looking for alternative means to assess member experience on a more real-time basis.
- **Influencing Member Experience**
  More complex operationally compared to influencing many clinical measures.

APPENDIX E

MEDICAID HEALTHCARE HEALTH PLAN TRENDS

PressGaney, an NCQA certified vendor is a an industry leader with more than 30 years of CAHPS® survey project management, and analytic reporting experience. Managing a Health Plan company Book-of-Business (BoB) portfolio includes more than 80% of our nation's Medicare, Medicaid, and Managed Care Health Plans (MCP) products.

PressGaney completed a thorough CAHPS® 5.1 H portfolio data analysis of their administered MY 2023 Medicaid Adult and Child samples. Survey responses include 200 Plans / 50,297 respondents. Their analysis compares the current Partnership HealthPlan of California (Partnership) respondent rate and measures performance against Partnership's year-over-year performance, HEDIS®, and PressGaney BoB benchmarks. The Press Ganey BoB is used to monitor health plan trends by comparing side-by-side aggregate scores over the past four years.

MY 2023-2024 TREND HIGHLIGHTS

AHRQ-CAHPS® Health Plan Survey Database[1]

The AHRQ 2023 Chart Book continues to indicate a national Medicaid downward trend in all four (4) composite measures, reference source below. It is significant to recognize the impact of a post-COVID disruption to healthcare delivery and key to underscore the 2023 U.S. healthcare industry and American Hospital Association (AHA) linkage to severe workforce shortages at every level. The AHA estimated the healthcare industry was likely to experience a shortage of up to 124,000 physicians by the end of 2023.[2]

Key observation include: 1) all composite measures were relatively stable or slightly increasing until 2021, 2) Getting Needed Care and Getting Care Quickly showed large declines from 2021-2023, and 3) How Well Doctors Communicate and Health Plan Information and Customer Service showed smaller declines from, 2021-2023, reference source below.

PRESSGANEY BOB

- The BoB average respondent rates (174 - 200 Plans) for both populations had a noticeable downward trend between reporting years 2020 - 2024. Relative to Partnership respondent rates, the health plan performed above the average Press Ganey BoB.
- The BoB response rate aligns with the noted industry downward trend through the same reporting period.

MEDICAID TRENDS

- Medicaid Adult Population: Among the Medicaid Adult population, no measures declined by more than 1% compared to 2023. Rating of Personal Doctor (% 9 or 10) and Rating of Specialist (% 9 or 10) have increased by more than 1%. All scores have decreased overall since 2020. Rating of Health Care Quality and Getting Care Quickly are the largest decrease of at least 2% lower than the 2020 scores

- Medicaid Child Population: Among the Medicaid Child population, no measures declined by more than 1% compared to 2023. Rating of Specialist, Getting Needed Care, and Getting Care Quickly have increased by more than 1% since 2023. All scores have decreased overall since 2020. Rating of Health Care Quality and Getting Care Quickly are the largest decrease of at least 2% lower than the 2020 scores

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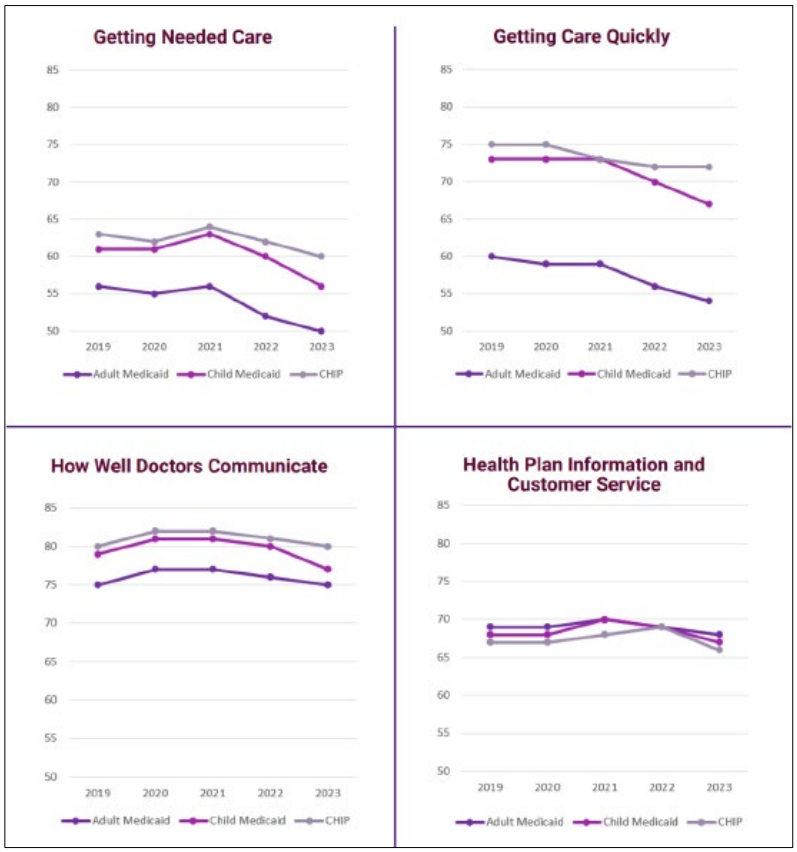
[1]AHRQ-CAHPS® Health Plan Survey Database
AHRQ 2023 CAHPS® CHART BOOK.

2023 Chart Book
https://www.ahrq.gov/sites/default/files/wysiwyg/cahps/cahps-database/2023-hp-chartbook.pdf

[2] American Hospital Association (AHA) Fact Sheet: Strengthening the Health Care Workforce https://www.aha.org/fact-sheets/2021-05-26-fact-sheet-strengthening-health-care-workforce



Health Equity Standards –
HE 6: Reducing Healthcare Disparities

September 2024

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Introduction

The HE 6 report summarizes the work of Partnership HealthPlan of California (Partnership) to analyze potential disparities within the member population through an analysis of race and ethnicity, language, and gender data, as well as Partnership's effort to implement impactful interventions to reduce inequities and improve any culturally and linguistically appropriate services (CLAS) identified through the analysis.

For the purposes of this grand analysis, health inequities are significant differences in health between racial or ethnic groups, gender groups, sexual orientation, age, disability status, socioeconomic status, geographic location, etc. For most groups, health disparities result in significantly higher rates of chronic disease and/or premature death when compared to a historically dominant group, which is why positively impacting these inequities is important (National Academies Press, 2017). The current demographics of Partnership members are listed below:

Table I: Partnership Demographic Information per Race (as of August 2024)

Race/Ethnicity	Membership (n, %)
African American/Black	31,327 (3.50%)
American Indian/Alaska Native	15,947 (1.78%)
Asian Indian	14,072 (1.57%)
Asian or Pacific Islander	12,419 (1.39%)
Filipino	9,961 (1.11%)
Hispanic/Latino	300,739 (33.57%)
Other	36,713 (4.10%)
Unknown	122,361 (13.66%)
Vietnamese	3,707 (.41%)
White	348,514 (38.91%)

Objective

In 2024, Partnership convened a multidisciplinary team to collect and review the data, prioritize the findings, recommend interventions, and prioritize opportunities for improvement in specific groups.

The primary HE 6 team members include:

1. Robert Moore, MD MPH MBA, Chief Medical Officer
2. Mohamed Jalloh, Pharm.D. BCPS, Health Equity Officer
3. Nancy Steffen, Senior Director of Quality and Performance Improvement
4. Dorian Roberts, Senior Project Manager, Performance Improvement
5. Anthony Sackett, Program Manager II, Performance Improvement
6. Cyress Mendiola, Senior Manager of Member Services
7. Latrice Innes, Manager of Grievance and Appeals
8. Sue Quichocho, Manager of Quality Measurement
9. Margarita Garcia-Hernandez, Director of Health Analytics
10. Shivani Sivasankar Ph.D., M.S, Senior Health Data Analyst II

The measures of focus for this report are:

1. Controlling High Blood Pressure (CBP).
2. Hemoglobin A1c Control for Patients with Diabetes (HBD).
3. Prenatal and Postpartum Care (PPC).
4. Child and Adolescent Well Care Visits (WCV).

The stratifications of the quality measures include:

1. Race/Ethnicity
2. Language
3. Gender Identity

Methodology

Step 1: Sample Selection to Evaluate Disparities

Partnership initially utilized Measurement Year 2023 (MY 2023) Health Plan Accreditation final measure samples (n=186 to 167,450 members) to evaluate each of the clinical measures of focus. The rates for each measure are comprised of the members included in each measure's audit for Partnership's Health Plan Accreditation Plan-wide summary of performance report. The random member sample that was generated for each hybrid measure and full member denominator along with member race/ethnicity demographic information, was provided by Partnership's HEDIS vendor, Inovalon. Inovalon has been classified is a direct data source.

Through the initial analysis of MY 2023 Health Plan Accreditation sample, Partnership identified no statistically significant lower rates of performance for many of the race-stratified measures highlighted in Element A that aligned with our internal quality improvement data and state health managed care accountability final rate samples. These consistent insignificant findings were likely secondary due to the small sample sizes included in each hybrid measure sample when trying to evaluate and compare groups to the White, English-speaking, and Male populations, respectively.

As a result of the limited findings from the analysis of the NCQA Final rates and the limitations of the NCQA Final data, and to truly identify and evaluate other inequities, Partnership chose to evaluate the MY 2023 Managed Care Accountability Set (MCAS) final rate samples (n=812 to 167,450 members) for the measures included in the Grand Analysis report to provide a more meaningful analysis for the measures of focus for this report. The MCAS samples may be theoretically more consistent with current Partnership member demographics due to their included region stratifications. However, this is relative to the comparison to the Health Plan Accreditation sample. Finally, the MCAS rates have a greater denominator in the hybrid measure samples for the represented race and ethnicity groups and Partnership is able to evaluate rates per region—which provides a more comprehensive and tailored approach to prioritizing disparities.

Step 2: Statistical Analysis to Identify Key Disparities

After receiving the data from Inovalon, members from Partnership's Health Analytics team conducted various statistical analyses. The Chi-Square and Fisher's Exact statistical tests were utilized, based upon sample size, to determine if there were significant differences for the various categorical measure outcomes.

When analyzing disparities based upon race/ethnicity, Partnership conducted various statistical analyses using the White group as the key comparator group. When analyzing disparities based upon language, Partnership conducted various statistical analyses using the English language group as the key comparator group. Finally, when analyzing disparities based upon gender, Partnership conducted various statistical analyses using the Male gender identity group as the key comparator group. A statistically significant difference was classified as a p value less than 0.05 when comparing the categorical outcomes of one group versus the key comparator group, respectively (i.e. White, English-speaking, Male).

These comparators were identified based upon various literature suggesting that such groups, respectively, have had significantly more political, economic, and/or social advantages within the United States (Malat et al., 2018). Data, that were excluded from the evaluation, were findings from patients who reported "Unknown" in race, language, and gender identity.

Step 3: Analysis of Measures

Due to the low sample sizes for the hybrid measures included in the Health Plan Accreditation data (n=186 to 368), a lack of statistically significant inequities identified for all measures, and low number of disparities found through this analysis, Partnership again chose to also evaluate the MCAS final sample measures (at sub region level) to assess, identify, and prioritize any disparities identified through this additional analysis.

Partnership also reviewed the performance of each race/gender identity/linguistic group in comparison to the MCAS benchmarks to asses not only how each group performed statistically in comparison to the White/Male/English speaking group, but in comparison to the national Medicaid benchmarks. In MY 2023, DHCS is holding managed care plans (MCPs) accountable and imposing sanctions on selected Hybrid and Administrative measures performing below the minimum performance level (MPL) (50th national Medicaid percentile) by reporting region, and as a result, Partnership thought it valuable to assess how each group is performing in comparison to that benchmark to assess whether group performance could also have an impact on accountable measures.

As a result, Element A and the prioritization of activities to address and reduce disparities is based on the MCAS samples for the measures of focus. The HPA final rate stratifications can be found in the Appendix of the report, however it is not included in the classification table or the prioritization of activities to address and reduce disparities for the limitations mentioned above.

Step 4: Presentation of Data

After the first data analysis was completed, members of the primary HE 6 team placed the data points in graphs and included various percentile targets per various National benchmarks. To aid in the evaluation of outcomes, Partnership color coded the bar graphs with the color orange indicate a group percentile performance below the MPL; bars highlighted in green indicated groups performed above the 90th percentile.

Finally, Partnership created a table (Table XXXI) to classify and provide guidance to help prioritize inequities identified through this analysis. While these classifications are referenced in the measure descriptions below, this table can be found in Element D, Factors 1 & 3.

Element A: Reporting Stratified Measures

Element Summary: Partnership found statistically significant lower rates when comparing each race/ethnicity group to the white group while using the NCQA Health Plan Accreditation generated sample for WCV, CBP, and PPC - Prenatal, and HBD – Poor Control per the analysis that was produced on July 24th, 2024. PPC – Postpartum included statistically significant higher rates for the Hispanic or Latino group. When comparing each group to the Health Plan Accreditation National Medicaid Benchmarks, The Asian group had the lowest performance and was the only group below the 33.33rd percentile for CBP. Interestingly, the American Indian and

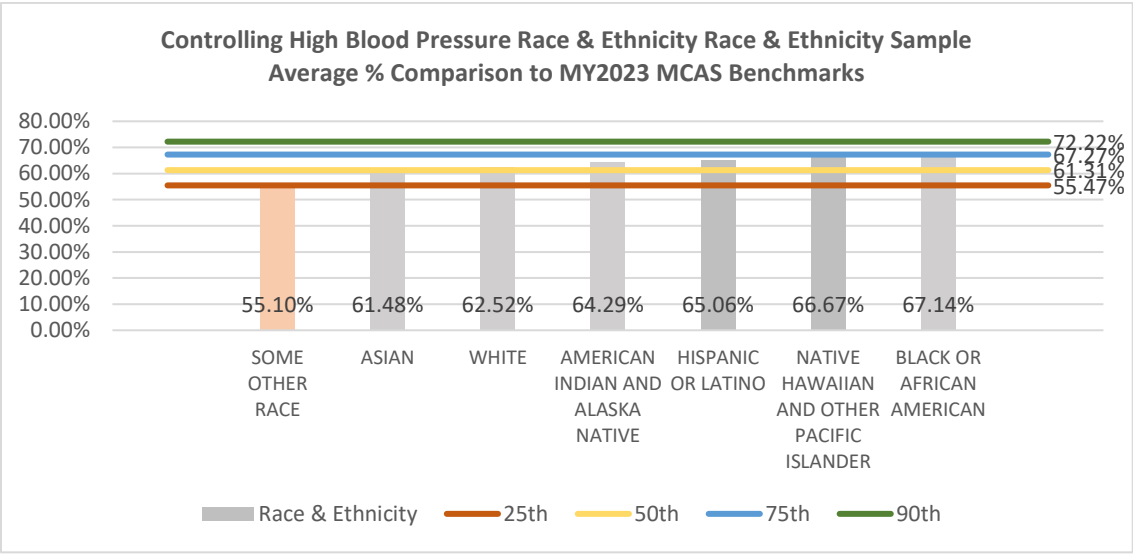
Alaska Native group had the lowest performance and was the only group below the 10th percentile for PPC – Prenatal, PPC Postpartum, and HBD – Poor Control. The Native Hawaiian and Pacific Islander group was the lowest performing and only group below the 10th percentile for WCV.

*Due to the low sample sizes for the hybrid measures included in the Health Plan Accreditation data (*n=186 to 368*), a lack of statistically significant inequities identified for all measures, and low number of disparities found through this analysis, Partnership chose to also evaluate the MCAS final sample measures (at sub region level) to assess, identify, and prioritize any disparities identified through this additional analysis.*

Element Key Methodology: The sections below highlight the results of the statistical significance testing done for each measure by race for the MCAS samples. "Unknown" and "some other race group" data were excluded from the evaluation. Additional analysis of the HPA samples can be found in the Appendix.

Controlling High Blood Pressure (CBP):

Partnership found that no group had a statistically significantly lower rate of CBP when compared to the White group while using the MCAS generated hybrid sample in all four reporting regions (n=1,395) (Table III). Overall, groups performed at average across respective regions, or above the Minimum Performance Level (MPL – 50th). However, when comparing each group's performance in comparison to the National Medicaid benchmarks in each of Partnership's regions (Graphs II – V), the American Indian/Alaska Native population had rates below the 25th percentile in 2 of 4 regions (Southeast and Southwest). The Asian group performed below the Minimum Performance Level (MPL – 50th) in 2 regions (Northeast and Southeast), and the 'Some Other Race' Group in 3 (Northeast, Northwest, and Southwest). The Native Hawaiian and Other Pacific Islander, Hispanic or Latino, and White groups only performed below the MPL in 1 region respectively (Northeast for Hispanic or Latino and Native Hawaiian and Other Pacific Islander, Northwest for White group). Interestingly, the Black/African American group performed better than the White group in 3 of the 4 regions (Northeast, Northwest, and Southeast).

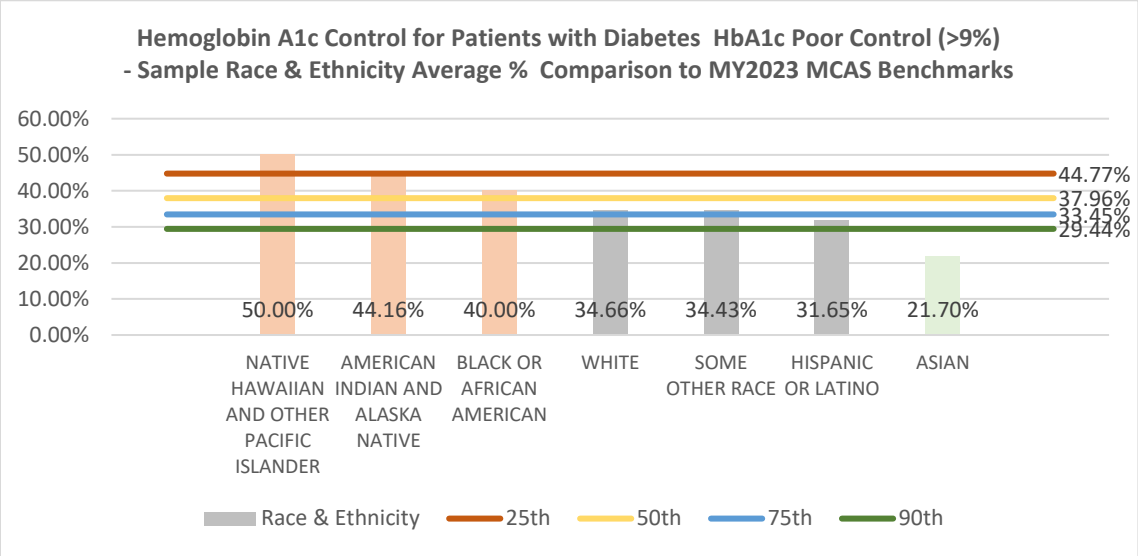


Note: Bars highlighted orange indicate group performed below the MPL (50th percentile). Bars highlighted green indicate groups performed above the 90th percentile.

When taking the average rate for each race/ethnicity group in comparison to the MCAS benchmarks, Partnership found that the 'Some Other Race' group was the only group that performed below the MPL – 50th, and no group performed above the 90th percentile.

Hemoglobin A1c Control for Patients with Diabetes (HBD) HbA1c Poor Control (>9.0%):

Partnership found that the American Indian and Alaska Native group in the Southwest region performed significantly worse than the White population and the Asian population performed significantly better in the Southeastern region (Table V) when reviewing the MCAS data. It was identified that although there was a small sample of Native Hawaiian and Other Pacific Islander members included in the sample, this group did not meet the MPL percentile in 2 regions (Northwest, Southeast) in which they were included. Also, the American Indian/Alaska Native did not meet the MPL in 3 regions (Northwest, Southeast, Southwest). The Black/African American population also did not meet the MPL in 2 regions (Northwest and Southeast). Finally, the White population in the Northeast region was the lowest performing group, and did not meet the MPL (1.54% away from MPL) in comparison to the benchmarks, with the Hispanic or Latino group performing only marginally better in the region (.22% away from MPL), the only region in which they did not meet the MPL for the measure (Graphs VII – X).

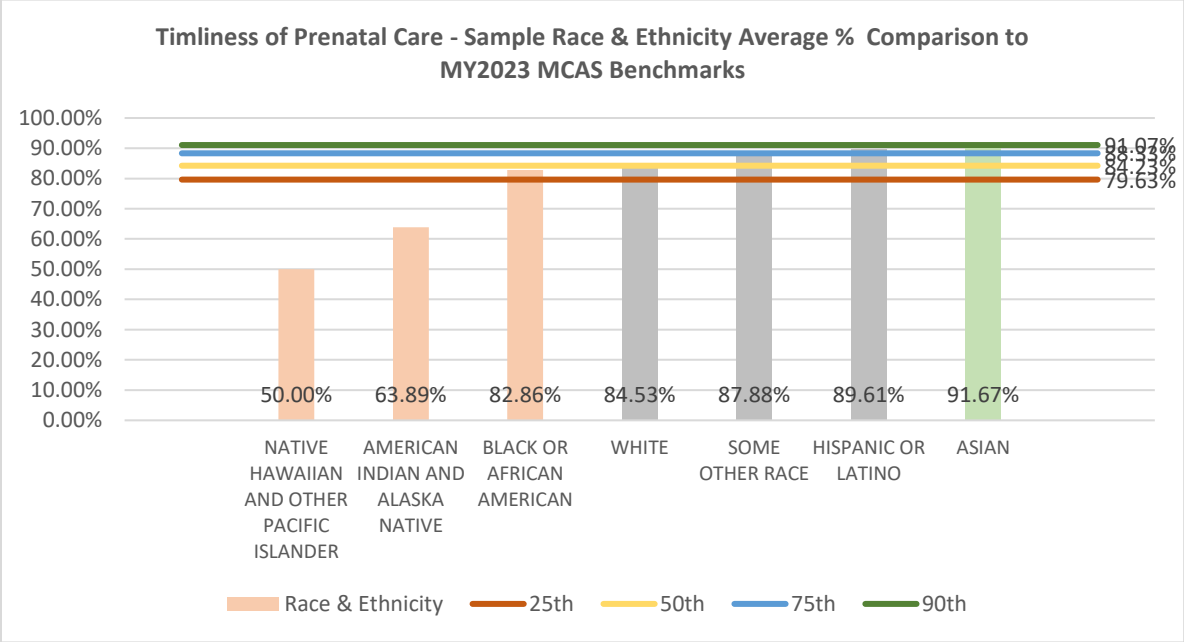


Note: Bars highlighted orange indicate group performed below the MPL (50th percentile). Bars highlighted green indicate groups performed above the 90th percentile.

When comparing the sample's average rate for each race/ethnicity group to the MCAS benchmarks, Partnership found that the Native Hawaiian and Other Pacific Islander, American Indian and Alaska Native, and Black or African American groups all performed below the MPL – 50th, and only the Asian group performed above the 90th percentile.

Timeliness of Prenatal Care (PPC – Pre):

Partnership found that only the American Indian and Alaska Native group in the Southwest region performed significantly worse than the White population (Table VII) per the MCAS sample. However, the Black/African American group was well below the 25th performing percentile in 2 of 4 regions (Northeast, Northwest). This is likely due to the very small sample size of Black/African American group members within these regions (n=7). In the Northeast region, 4 groups performed below the MPL (Black or African American, American Indian and Alaska Native, Asian, and 'Some Other Race'), and in the Northwest, 4 different groups performed below the MPL (Black or African American, American Indian and Alaska Native, 'Some Other Race', and White). Also, the American Indian and Alaska Native group performed numerically worse than the White population, and was below the MPL in 3 regions (Northeast, Northwest, Southwest). In the Southeast region, only the Native Hawaiian and Other Pacific Islander group performed below the 25th (n=1) (Graphs XII – XV).



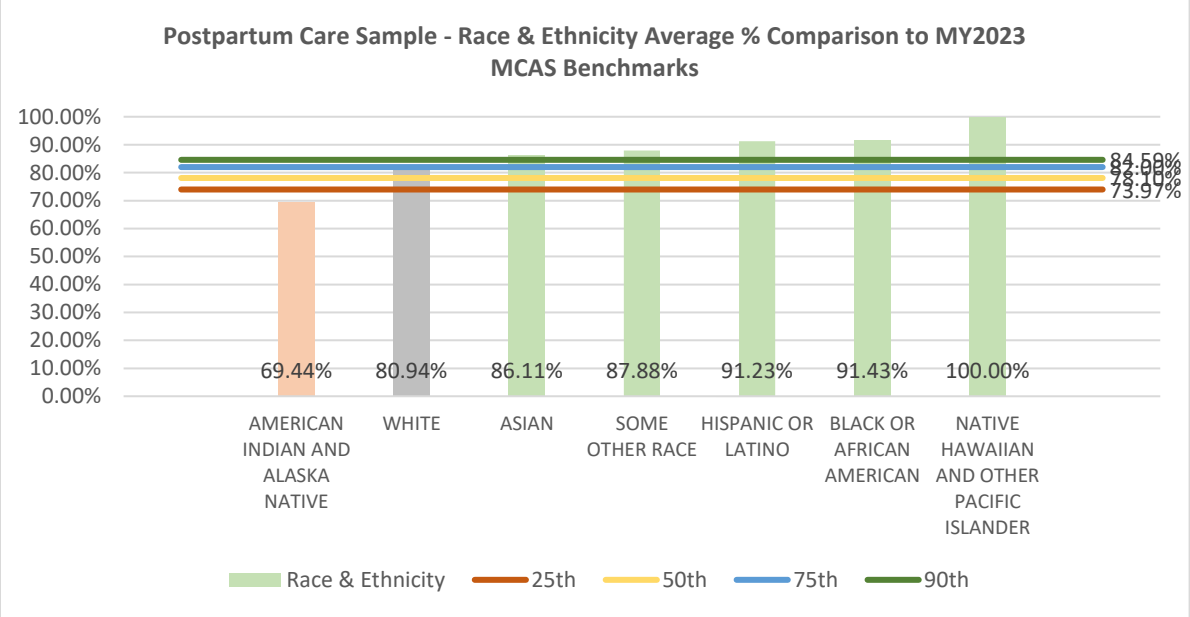
Note: Bars highlighted orange indicate group performed below the MPL (50th percentile). Bars highlighted green indicate groups performed above the 90th percentile.

When comparing the sample's average rate for each race/ethnicity group to the MCAS benchmarks, Partnership found that the Native Hawaiian and Other Pacific Islander, American Indian and Alaska Native, and Black or African American groups all performed below the MPL – 50th, and only the Asian group performed above the 90th percentile.

Postpartum Care (PPC – Post):

Partnership found that only the American Indian and Alaska Native group in the Northeast region performed significantly worse than the White population (Table IX) per the MCAS sample. However, when comparing each group to the MCAS benchmarks, the American Indian and Alaska Native population performed below the MPL in 3 out of 4 regions (Northeast,

Northwest, Southwest). The Asian population also performed below the MPL in 2 regions (Northeast and Northwest), and the 'Some Other Race' group performed below the MPL in 1 region (Southeast). It is also worth noting that the Black or African American and Hispanic or Latino groups were the only groups to perform above the 90th percentile in all regions (Graphs XVII – XX).

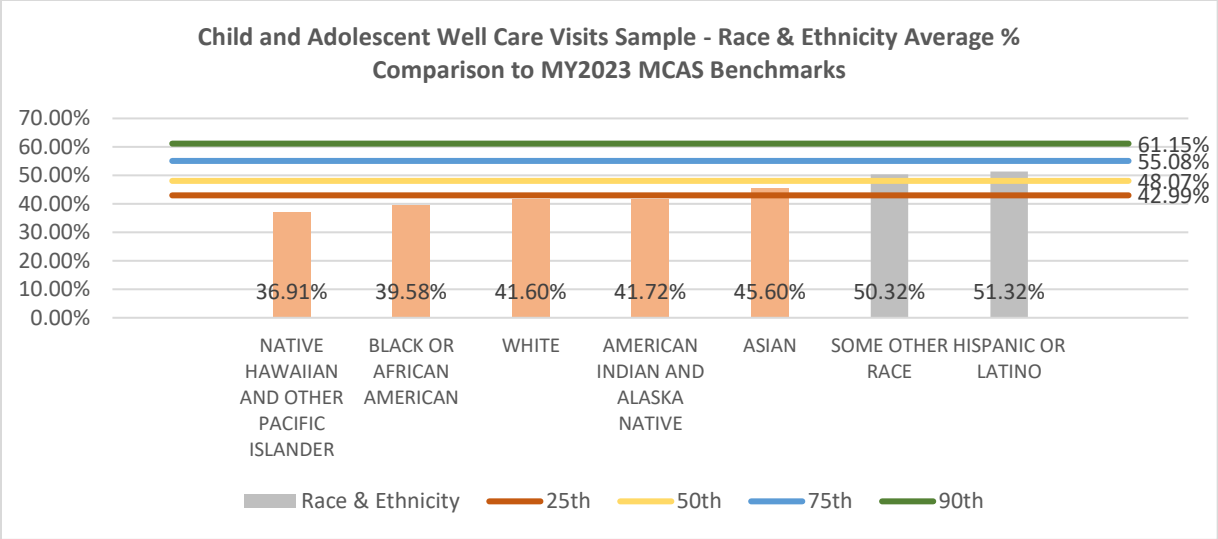


Note: Bars highlighted orange indicate group performed below the MPL (50th percentile). Bars highlighted green indicate groups performed above the 90th percentile.

When comparing the sample's average rate for each race/ethnicity group to the MCAS benchmarks, Partnership found that the American Indian and Alaska Native groups was the only group that performed below the MPL – 50th, and the Asian , 'Some Other Race', Hispanic or Latino, Black or African American, and Native Hawaiian and Other Pacific Islander groups all performed above the 90th percentile.

Child and Adolescent Well Care Visits (WCV):

When reviewing the MCAS sample for the measure, Partnership found that the majority of groups did not perform to the Minimum Performance Level (MPL – 50th) for WCVs throughout all 4 regions suggesting a greater concern in the infrastructure for attending WCVs. Interestingly, various groups performed statistically significantly better than the White group in the MCAS sample in all four reporting regions (n=167,450) despite still performing below the MPL. The American Indian and Alaska Native population had a significantly lower rate in the Southwest, and were even below the 25th percentile in 2 of 4 regions (Southeast and Southwest. The Black/African American and Native Hawaiian and Other Pacific Islander group had a significantly lower rate in comparison to the White group in the Southeast region, and both were also below the 25th percentile in the region. (Graphs XXII – XXV).



Note: Bars highlighted orange indicate group performed below the MPL (50th percentile). Bars highlighted green indicate groups performed above the 90th percentile.

When comparing the sample's average rate for each race/ethnicity group to the MCAS benchmarks, Partnership found that the Native Hawaiian and Other Pacific Islander, Black or African American, White, American Indian and Alaska Native, and Asian groups all performed below the MPL – 50th, and no group performed above the 90th percentile.

Appendix 1: Table II: Controlling High Blood Pressure (CBP) HPA Statistical Significance Results

Appendix 2: Graph I: Controlling High Blood Pressure - Race & Ethnicity Comparison to MY2023 NCQA Benchmarks

Appendix 3: Table III: Controlling High Blood Pressure (CBP) MCAS Statistical Significance Results

Appendix 4: Graph II: Controlling High Blood Pressure in Northeast Region - Race & Ethnicity Comparison to MY2023 MCAS Benchmarks

Appendix 5: Graph III: Controlling High Blood Pressure in Northwest Region - Race & Ethnicity Comparison to MY2023 MCAS Benchmarks

Appendix 6: Graph IV: Controlling High Blood Pressure in Southeast Region - Race & Ethnicity Comparison to MY2023 MCAS Benchmarks

Appendix 7: Graph V: Controlling High Blood Pressure in Southwest Region - Race & Ethnicity Comparison to MY2023 MCAS Benchmarks

Appendix 8: Table IV: Hemoglobin A1c Control for Patients with Diabetes (HBD) HbA1c Poor Control (>9.0%) HPA Statistical Significance Results

Appendix 9: Graph XI: Hemoglobin A1c Control for Patients with Diabetes -- HbA1c Poor Control (>9%) - Race & Ethnicity Comparison to MY2023 NCQA Benchmarks

Appendix 10: Table IV: Hemoglobin A1c Control for Patients with Diabetes (HBD) HbA1c Poor Control (>9.0%) MCAS Statistical Significance Results

Appendix 11: Graph VII: Hemoglobin A1c Control for Patients with Diabetes in Northeast Region -- HbA1c Poor Control (>9%) - Race & Ethnicity Comparison to MY2023 MCAS Benchmarks
Appendix 12: Graph VIII: Hemoglobin A1c Control for Patients with Diabetes in Northwest Region -- HbA1c Poor Control (>9%) - Race & Ethnicity Comparison to MY2023 MCAS Benchmarks
Appendix 13: Graph IX: Hemoglobin A1c Control for Patients with Diabetes in Southeast Region -- HbA1c Poor Control (>9%) - Race & Ethnicity Comparison to MY2023 MCAS Benchmarks
Appendix 14: Graph X: Hemoglobin A1c Control for Patients with Diabetes in Southwest Region -- HbA1c Poor Control (>9%) - Race & Ethnicity Comparison to MY2023 MCAS Benchmarks
Appendix 15: Table VI: Timeliness of Prenatal Care (PPC-Pre) HPA Statistical Significance Results
Appendix 16: Graph XI: Timeliness of Prenatal Care - Race & Ethnicity Comparison to MY2023 NCQA Benchmarks
Appendix 17: Table VII: Timeliness of Prenatal Care (PPC – Pre) MCAS Statistical Significance Results
Appendix 18: Graph XII: Timeliness of Prenatal Care in Northeast Region - Race & Ethnicity Comparison to MY2023 MCAS Benchmarks
Appendix 19: Graph XIII: Timeliness of Prenatal Care in Northwest Region - Race & Ethnicity Comparison to MY2023 MCAS Benchmarks
Appendix 20: Graph XIV: Timeliness of Prenatal Care in Southeast Region - Race & Ethnicity Comparison to MY2023 MCAS Benchmarks
Appendix 21: Graph XV: Timeliness of Prenatal Care in Southwest Region - Race & Ethnicity Comparison to MY2023 MCAS Benchmarks
Appendix 22: Table VIII: Postpartum Care (PPC – Post) HPA Statistical Significance Results
Appendix 23: Graph XVI: Postpartum Care in Northeast Region - Race & Ethnicity Comparison to MY2023 NCQA Benchmarks
Appendix 24: Table IX: Postpartum Care (PPC – Post) MCAS Statistical Significance Results
Appendix 25: Graph XVII: Postpartum Care in Northeast Region - Race & Ethnicity Comparison to MY2023 MCAS Benchmarks
Appendix 26: Graph XVIII: Postpartum Care in Northwest Region - Race & Ethnicity Comparison to MY2023 MCAS Benchmarks
Appendix 27: Graph XIX: Postpartum Care in Southeast Region - Race & Ethnicity Comparison to MY2023 MCAS Benchmarks
Appendix 28: Graph XX: Postpartum Care in Southwest Region - Race & Ethnicity Comparison to MY2023 MCAS Benchmarks
Appendix 29: Table X: Child and Adolescent Well Care Visits (WCV) HPA Statistical Significance Results
Appendix 30: Graph XXI: Child and Adolescent Well Care Visits in Northeast Region - Race & Ethnicity Comparison to MY2023 NCQA Benchmarks
Appendix 31: Table XI: Child and Adolescent Well Care Visits (WCV) MCAS Statistical Significance Results
Appendix 32: Graph XXII: Child and Adolescent Well Care Visits in Northeast Region - Race & Ethnicity Comparison to MY2023 MCAS Benchmarks

Appendix 33: Graph XXIII: Child and Adolescent Well Care Visits in Northwest Region - Race & Ethnicity Comparison to MY2023 MCAS Benchmarks
Appendix 34: Graph XXIV: Child and Adolescent Well Care Visits in Southeast Region - Race & Ethnicity Comparison to MY2023 MCAS Benchmarks
Appendix 35: Graph XXV: Child and Adolescent Well Care Visits in Southwest Region - Race & Ethnicity Comparison to MY2023 MCAS Benchmarks

Element B: Use of Data to Assess Disparities

Element Methodology: Partnership conducted the same steps highlighted in the Methodology section, however, stratifying based on preferred language and gender identity versus race/ethnicity. The sections below highlight the results of the statistical significance testing done for each measure stratified by language and gender identity. Each language was statistically compared to English. In addition, each language group was compared with the Minimum Performance Level (MPL – 50th). "Other" language data were excluded from the evaluation. For gender identity, Partnership is only able to assess comparisons between the Male and Female gender identities due to only being able to receive such information from the state member files. The Male group was designated as the dominant group, and both the Male and Female groups were compared with the Minimum Performance Level (MPL – 50th).

Element Summary: Partnership only found a statistically significant lower rate when comparing the Hmong language group to the English group while using the NCQA Health Plan Accreditation generated sample for WCV, per the analysis that was produced on July 24th, 2024. The Spanish and Farsi groups had significantly higher rates for this measure. The were no additional statistically significant differences for any additional groups in comparison to the English group for all other measures.

Partnership also found no statistically significant differences between the Female and Male gender identities for all measures.

Due to the low sample sizes for the hybrid measures included in the Health Plan Accreditation data (n=205 to 394 for language, n=205 to 405 for gender identity), a lack of statistically significant inequities identified for measures, and low number of disparities found through this analysis, Partnership chose to also evaluate the MCAS final sample measures (at sub region level) to assess, identify, and prioritize any disparities identified through this additional analysis for both language and gender identity.

Factor 1: Analyzing clinical performance measures by race/ethnicity

NA. Included in Element A.

Factor 2: Analyzing clinical performance measures by preferred language

Factor Summary: Overall, Partnership found that no linguistic group had a statistically significantly worse rate of CBP, PPC – Pre, PPC – Post when compared to the English-speaking group while using the MCAS generated hybrid sample in all four reporting regions

(n=885 to 1,489). The English-speaking group had worse HBD in at least 2 regions, when compared to the Spanish speaking population. Also, the English-speaking group had worse WCVs when compared to the Spanish speaking population in all 4 regions. The Vietnamese population had a significantly worse WCV in the SE region, however majority of the linguistic groups (except the Spanish population) were below the Minimum Performance Level (MPL – 50th).

Factor Methodology: The sections below highlight the results of the statistical significance testing done for each measure stratified by language. Each language was statistically compared to English. In addition, each language group was compared with the Minimum Performance Level (MPL – 50th). "Other" language data were excluded from the evaluation.

Controlling High Blood Pressure (CBP):

Partnership found that no linguistic group had a statistically significantly lower rate of CBP when compared to the English-speaking group while using the MCAS generated hybrid sample in all four reporting regions (Table XXIII). When comparing each group's performance in comparison to the National Medicaid benchmarks in each of Partnership's regions, the Spanish-speaking group had rates below the MPL – 50th in 2 regions (5.75% below in Northeast, 11.31% below in Northwest). The Tagalog speaking population also performed below the MPL – 50th in 2 regions (6.76% below in Southeast, 11.31% below in Southwest).

Hemoglobin A1c Control for Patients with Diabetes (HBD) HbA1c Poor Control (>9.0%):

Partnership found that the Spanish group performed significantly better than the English speaking group in the Northeast and Southwest regions respectively using the MCAS generated hybrid sample in all four reporting regions (Table XXV). Specifically, the Spanish-speaking group performed 14.40% above the MPL – 50th in the Northeast and 7.55% above the MPL – 50th in the Southwest.

Timeliness of Prenatal Care (PPC – Pre):

Partnership found that no linguistic group had a statistically significantly lower rate for PPC – Prenatal when compared to the English-speaking group while using the MCAS generated hybrid sample in all four reporting regions (Table XXVII). All regions had at least 1 linguistic group who had achieved 100% of timeliness in the prenatal care. The Spanish speaking group had the highest performance while the Southeast and Southwest regions had the highest number of linguistic groups who achieved the 100% of timeliness in the prenatal care.

Postpartum Care (PPC – Post):

Partnership found that no linguistic group had a statistically significantly lower rate of PPC – Postpartum when compared to the English-speaking group while using the MCAS generated hybrid sample in all four reporting regions (Table XXIX). The Spanish speaking group had a significantly higher performance postpartum care in the SW region and had the highest number of regions that achieved 100% of postpartum care.

Child and Adolescent Well Care Visits (WCV):

Partnership found that the Spanish speaking community performed significantly better in WCV in all four regions when compared to the English-speaking community with an average rate of 53.40% versus 44.98% in the English-speaking community. The English speaking community was below the MPL – 50th in all four regions with an average absolute percentage below of 3.09%. The Farsi speaking community also had a significantly higher rate of completion of WCVs in the SE region in comparison to the English community. Specifically, the Russian community (n=372) had a 25.41% higher rate when compared to the English-speaking community. Finally, the Vietnamese-speaking community had a significantly lower rate of WCV in the SE region. The Vietnamese-speaking community had a 9.35% lower rate when compared to the English community and was 12.21% below the MPL.

Appendix 36: Table XII: Controlling High Blood Pressure (CBP) Language HPA Statistical Significance Testing
Appendix 37: Table XIII: Controlling High Blood Pressure (CBP) Language MCAS Statistical Significance Testing
Appendix 38: Table XIV: Hemoglobin A1c Control for Patients with Diabetes (HBD) HbA1c Poor Control (>9.0%) Language HPA Statistical Significance Testing
Appendix 39: Table XV: Hemoglobin A1c Control for Patients with Diabetes (HBD) HbA1c Poor Control (>9.0%) Language MCAS Statistical Significance Testing
Appendix 40: Table XVI: Timeliness of Prenatal Care (PPC-Pre) Language HPA Statistical Significance Testing
Appendix 41: Table XVII: Timeliness of Prenatal Care (PPC-Pre) Language MCAS Statistical Significance Testing
Appendix 42: Table XVIII: Postpartum Care (PPC – Post) Language HPA Statistical Significance Testing
Appendix 43: Table XIX: Postpartum Care (PPC – Post) Language MCAS Statistical Significance Testing
Appendix 44: Table XX: Child and Adolescent Well Care Visits (WCV) Language HPA Statistical Significance Testing
Appendix 45: Table XXI: Child and Adolescent Well Care Visits (WCV) Language MCAS Statistical Significance Testing

Factor 3: Analyzing clinical performance measures by gender identity and/or sexual orientation

*Factor Summary**:** In analyzing each measure based on gender identity and comparing each gender identity to the Male group, Partnership found that no significant difference between the two genders for CBP. Partnership did identify a significant difference between the Male and Female group for HBD and WCS with the Female group performing significantly better than Male group in the Southeast for HBD, and the Female group performing significantly better than the Male group in the Southwest for WCV.*

Table XVII: Partnership Demographic Information per Gender Identity and/or Sexual Orientation

Estimated Total Population: 895,760 (As of August 2024)

Gender Identity	Membership (n, %)
Female	466,464 (55.1%)
Male	429,136 (47.9%)

Factor Methodology: Partnership stratified the clinical measures included in this report by using individual-level data to identify the members captured in the measures numerators and denominators, and stratified by individual's self-identified gender and/or sexual orientation. Partnership collects gender identity utilizing the two gender options of Male and Female. Therefore, analysis was conducted utilizing those two gender options with the Male population listed as the dominant group. Currently, Partnership does not directly collect sexual orientation data directly from members, as of 2024. As a result, Partnership only had Female members in the Timeliness of Prenatal Care and Postpartum Care measures, and therefore did not include the statistical significance testing outlined for the measure. The information below highlights the results of the statistical significance testing done for each measure by the two gender identities.

Controlling High Blood Pressure (CBP):

Partnership found no statistically significant difference when comparing each gender identity group to the Male gender identity group while using the MCAS generated sample (drawn from the eligible population) for Controlling High Blood Pressure (n=1,534) (Table XXIII).

Hemoglobin A1c Control for Patients with Diabetes (HBD) HbA1c Poor Control (>9.0%):

Partnership found no statistically significant difference when comparing each gender identity group to the Male gender identity group while using the MCAS generated sample (drawn from the eligible population) for HbA1c Poor Control in the Northeast, Northwest, and Southwest. Partnership found the Female group performed significantly better than Male group, with a rate 13% better than the Male group and 12.55% above the MPL – 50th, while the Male group performed below the MPL – 50th in the region (Table XXV).

Child and Adolescent Well Care Visits (WCV):

Partnership found that the Female group performed significantly better than the Male group in the Southwest region while using the MCAS generated sample (drawn from the eligible population) for Child and Adolescent Well Care Visits. Specifically, the Female population had a .77% higher rate of Child and Adolescent Well Care when compared to the Male population in the region. However, Partnership found no statistically significant difference between the Male and Female group for Child and Adolescent Well Care Visits in the remaining 3 regions. (Table XXVII).

Appendix 46: Table XXII: Controlling High Blood Pressure (CBP) Gender Identity HPA Statistical Significance Testing

Appendix 47: Table XXIII: Controlling High Blood Pressure (CBP) Gender Identity MCAS Statistical Significance Results

Appendix 48: Table XXIV: Hemoglobin A1c Control for Patients with Diabetes (HBD) HbA1c Poor Control (>9.0%) Gender Identity HPA Statistical Significance Testing

Appendix 49: Table XXV: A1c Control for Patients with Diabetes (HBD) HbA1c Poor Control (>9.0%) Gender Identity MCAS Statistical Significance Results

Appendix 50: Table XXVI: Child and Adolescent Well Care Visits (WCV) Gender Identity HPA Statistical Significance Testing

Appendix 51: Table XXVII: Child and Adolescent Well Care Visits (WCV) Gender Identity MCAS Statistical Significance Results

Factor 4: Analyzing individual experience measures by race/ethnicity or preferred language

Factor Summary Findings: At the conclusion of the 2022 CAHPS® survey period, Partnership received 372 completed adult surveys, representative of a 14% survey completion rate for Partnership's adult member population. White adult members (n=246) reported lowest score in care coordination; African American/Black members reported the lowest score in customer service; Asian members reported the lowest score in getting needed care; Native Hawaiian members reported the lowest score in rating of health care, American Indian/Alaska Native reported the lowest score in rating of personal doctor and health plan; and Hispanic/Latino reported the lowest score in rating of customer service.

Factor Methodology: Partnership measured members' experience through monitoring of annual regulated and non-regulated surveys, and grievance and appeals reporting. The member experience and respective quality outcomes are driven and measured by interdepartmental health plan coordinated efforts that support operational and strategic member and provider-focused activities. For the analysis of individual experience by race and ethnicity, Partnership utilized MY 2022 annual CAHPS® survey for both adults and children to analyze individual experience measures for Partnership members by race and ethnicity.

Partnership contracts with an NCQA-certified vendor, PressGaney to administer the annual regulated survey and provide results of CAHPS® survey on a yearly basis, which are the data points used throughout this evaluation. Partnership reports on the eight CAHPS® composites categories, including Rating of Health Plan, Rating of Health Care, Rating of Personal Doctor, Rating of Specialist, Getting Needed Care, Getting Care Quickly, Care Coordination, and Customer Service. PressGaney provided category responses stratified by race and ethnicity in comparison to the overall health plan score (percentage in grey at top of table). The brighter red shading (highlighted in key below) indicates a larger disparity.

The Adult survey had the most completed surveys from the White population, with 246 member responses. All other groups had less than 100 responses respectively (Black/African American: 26, Asian: 34, Native Hawaiian and Other Pacific Islander: 8, American Indian/Alaska Native: 27, Other: 58, Hispanic/Latino: 90), which limits the applicability of the data.

In addition, the following limitations exists.

The CAHPS® regulated and non-regulated surveys provided insight, albeit some of the response data was limited. This fiscal year we created the foundation to continue to monitor member

satisfaction within the Health Equity framework. The established performance threshold is a starting point to observe year-over-year progress.

Important to note, the regulated and drill-down surveys are only offered in English and Spanish language formats, which limits Partnership's ability to proactively solicit members for all threshold languages. Partnership is actively exploring the option for adult population only that will include adding Chinese (Mandarin and Cantonese) as another threshold language to regulated and non-regulated surveys. Presently, Partnership's DHCS assigned Chinese population relative to all threshold languages is low. The 2021 DHCS Threshold and Concentration Languages report demonstrates lower Chinese population within Partnership's 24 county service area. The return on investment to include Chinese language format for CAHPS® surveys may be cost-prohibitive relative to the insight low response may offer. The CAHPS® program team will continue to evaluate and explore alternative options to measure member satisfaction for all threshold languages.

Since the survey response rate for [1]CAHPS® Non-Regulated Survey is low, and linked to 28 fewer survey field days, Partnership surmised the low performance gap to be an outlier and therefore we excluded this data set while focusing on improvement activity discussions. The performance for CAHPS® regulated survey noted, the plan service delivery for adult population is marginally below the 70th percentile threshold. Comparing both populations, the team concludes that members in general are satisfied with Partnership's service delivery. Moving forward, the internal team will continue to refine and facilitate transparent and consistent benefit coverage communication and training with Partnership's contracted providers.

The Quality Improvement (QI) CAHPS® program team in collaboration with key stakeholders are leading a process improvement that carried forward from prior fiscal year to this fiscal year 2023-2024. The premise is to use real-time operational data sources to proactive identify member abrasion, through theme related categories that link to provider network or health plan delivery barriers.

Table XXVII: Adult CAHPS® Survey Findings

		Rating of Health Plan	Rating of Health Care	Getting Needed Care	Getting Care Quickly	Coordination of Care
Demographic	**Total**	**54.5%**	**51.5%**	**76.0%**	**72.9%**	**81.3%**
White	*n =246*	-1%	-1%	1%	5%	-7%
Black / African American	*n =26*	-1%	7%	4%	-6%	19%
Asian	*n =34*	8%	6%	-18%	-15%	8%
Native Hawaiian/Pacific Islander	*n =8*	3%	-52%	24%	-6%	19%
American Indian/Alaska Native	*n =27*	-27%	-22%	-2%	-4%	19%

Other	*n =58*	13%	11%	10%	8%	19%
Hispanic/Latino	*n =90*	7%	13%	0%	3%	2%

		Rating of Personal Doctor	Rating of Specialist	Customer Service	How Well Doctors Communicate	Ease of Filling Out Forms
Demographic	**Total**	**61.8%**	**66.7%**	**87.2%**	**88.5%**	**91.8%**
White	*n =246*	-7%	-3%	1%	-3%	0%
Black / African American	*n =26*	16%	17%	-9%	3%	4%
Asian	*n =34*	21%	-3%	0%	4%	-1%
Native Hawaiian/Pacific Islander	*n =8*	-29%	-17%	NA	12%	8%
American Indian/Alaska Native	*n =27*	-29%	-22%	0%	-2%	-1%
Other	*n =58*	12%	22%	5%	12%	5%
Hispanic/Latino	*n =90*	9%	-4%	-3%	6%	0%

Group is performing…

- **Above the plan score by 5 or more points**
- **Above the plan score**
- **Below the plan score**
- **Below the plan score by 5 or more points**
- **Above/below plan score but has low base (<30)**

Factor Summary Findings: At the conclusion of the CAHPS® survey period, Partnership received 587 completed child surveys, representative of a 14.5% survey completion rate for Partnership's pediatric member population. The Hispanic/Latino group had the largest amount of survey completions (n=323) and did not have any low scores. The White group, had lowest scores in coordination of care—comparable to adult group; the Black/African American group and reported lowest scores in 'rating of health plan'; the Asian and American Indian/Alaska Native groups had lowest scores in rating of personal doctor; Native Hawaiian members reported the lowest score in rating of health plan.

Table XXVIII: Child CAHPS® Survey Findings

		Rating of Health Plan	Rating of Health Care	Getting Needed Care	Getting Care Quickly	Coordination of Care
Demographic	**Total**	**66.9%**	**65.6%**	**79.6%**	**84.1%**	**85.3%**
White	*n =312*	-3%	-4%	-1%	1%	-5%
Black / African American	*n =46*	-20%	-10%	9%	6%	4%
Asian	*n =57*	10%	14%	-7%	-9%	8%
Native Hawaiian/Pacific Islander	*n =16*	-11%	-2%	10%	7%	15%

American Indian/Alaska Native	*n =37*	-2%	-3%	-5%	9%	-4%
Other	*n =145*	5%	5%	8%	-3%	7%
Hispanic/Latino	*n =323*	7%	7%	4%	0%	6%

		Rating of Personal Doctor	Rating of Specialist	Customer Service	How Well Doctors Communicate	Ease of Filling Out Forms
Demographic	**Total**	**74.6%**	**70.4%**	**89.4%**	**94.7%**	**95.4%**
White	*n =312*	-3%	-6%	1%	1%	-1%
Black / African American	*n =46*	-2%	5%	-1%	-1%	2%
Asian	*n =57*	-5%	17%	-4%	-4%	3%
Native Hawaiian/Pacific Islander	*n =16*	10%	-10%	11%	2%	5%
American Indian/Alaska Native	*n =37*	-11%	-25%	-8%	-2%	2%
Other	*n =145*	4%	12%	-1%	1%	3%
Hispanic/Latino	*n =323*	6%	11%	3%	1%	0%

Element C: Use of Data to Monitor and Assess Services

Partnership conducts an annual Utilization and Experience review to identify potential areas of opportunity at the organizational level. At a health plan level, the annual member experience is monitored through various data sources. These data sources include Language Service Utilization Reports, Internal Satisfaction Survey, Member Satisfaction, Grievance and Appeals data, CAHPS® regulated and non-regulated[1] survey ratings for health plan and personal doctor encounters.

Factors 1 & 3: Utilization of language services for organization functions and staff experience with language services for organization functions

<u>Factors 1 & 3 Summary Findings:</u> Interpreting sessions increased by 10,372 sessions or a +13% growth, period over period. Spanish was the top requested language and accounted for 79.9% of total interpreting sessions reported within the current period. Vietnamese, Russian, Dari, and Punjabi rounded out the top 5 requested languages for interpreting. One thing to note is that one of Partnership's threshold language, Tagalog was not represented within the top 5 most requested languages. In regards to translations, Partnership experienced -19% or 80 less translation requests period over period. Similar to our interpreting results, Spanish as a whole (Latin America + Mexico) was the most requested language, contributing to 48% of total translation requests. Russian, Tagalog, Hmong made up the remaining top 5 languages requested for the current period. This slightly differs from the previous period in which Lao was represented in the top 5.

Overall, internal employee surveys suggested that Member Services (48%), Transportation (17%), and Care Coordination (13%) employees were the heaviest utilizers of translation / interpreter services within the organization. Of the 5 reporting categories, Partnership exceeded our internal threshold for the "An interpreter(s) was available at the time of request" and the

"Overall, the interpreter(s) met the interpreting needs of the member" categories. Partnership experienced either a positive trend or flat to last year for 2 of the categories that did not meet the established threshold. Additionally, the number of respondents increased by 69%.

Methodology: Language Services utilization reports are extracted through Partnership's vendor(s) reporting portal on a quarterly basis. In addition, Partnership administers an annual internal satisfaction survey to all member-facing positions. The objective of this survey is to assess staff experience with obtaining Language Services through Partnership's contracted providers. For transparency, all member-facing positions flow into the following departments:

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

To track and trend Partnership's Language Service utilization, the team established a ratio of the number of translations and interpreting sessions per 1,000 members. The numerator will be the total amount of interpreting sessions or translations requests for the reporting period, and the denominator will be the average membership base of each reporting period. Note that Kaiser Members were excluded from this reporting as Kaiser was a delegated entity within our lookback period and Language Services fall under the scope of services that Kaiser provides. Additionally, the membership base is representative of members that have indicated a primary language other than English.

In regards to the reporting period, Partnership referenced reporting data from January 2023 through December 2023. The reporting data is divided into two periods. The "Previous Period" will include data from Quarter 1 and 2 (January – June) whereas the "Current Period" will include data from Quarter 3 and 4 (July – December). Note that for the purpose of this report, we observed the traditional calendar year, not fiscal.

To establish a threshold, Partnership determined that the interpreting and translation ratio would increase/decrease proportionally with any shift in the quarterly average member base of members who have indicated a primary language other than English. To meet the intent of this deliverable, Partnership identified the percentage shift in membership between the Previous and Current Period and compared that against the percentage shift in Language Services utilization. Moving forward, Partnership will implement a yearly look back period where the previous year ratio will be compared to the current year ratio. Partnership may re-evaluate utilization on a yearly basis and adopt a new threshold for the purpose of this deliverable. Table XXIX lists the membership base whereas Table XXX illustrates the established Current Period threshold for this initiative:

Table XXIX: Membership Base

*Membership Base		
Previous Period	**Current Period**	**% Difference**
130,905	132,345	+ 1.1%

** Representative of members that have indicated a primary language other than English*

Table XXX: Language Service Type

Language Service Type	Current Period Threshold
Interpreting	≥ 618.21
Translation	≥ 3.19

In addition, Partnership administers an internal satisfaction survey to gauge staff experience with language service providers. This internal survey contains five experience/service based questions with a five-point rating scale ("Strongly Disagree", "Disagree", "Neutral", "Agree", and "Strongly Agree"). To assess staff experience with the services received, Partnership established an internal threshold in which 80% of Partnership staff provide a favorable response for each of the experience/service based questions. Note that a favorable response is defined as a response that is either "Agree" or "Strongly Agree".

To assess the utilization of language services and staff experience, select staff conducted analysis work groups. Through these work groups, contributors reviewed the aforementioned data sources to understand the current state of Partnership's Language Service utilization and staff experience levels. The Member Services team compared the utilization data of the Current Period against the Previous Period and monitored any shifts in the utilization. As evidenced in Table XXIX, Partnership experienced a 1.1% increase in the analysis membership figures between periods. When looking at the results, Partnership exceeded the threshold established for the interpreting category only. When comparing the utilization ratio between periods, interpreting saw a 13% increase, whereas as translation requests experienced a 19% decrease in utilization (Table XXXI).

Table XXXI: Language Service Utilization Data

Category	# of Sessions / Requests - Per 1,000 Members		Threshold	Partnership ≥ Threshold
	Previous Period	Current Period		
Interpreting	611.48	683.20	≥ 618.21	**YES**
Translation	3.15	2.52	≥ 3.19	**NO**

Category	Total # of Sessions / Requests		
	Previous Period	Current Period	% Diff
Interpreting	80,046	90,418	**+13%**
Translation	413	333	**-19%**

Notable Findings – Utilization / Staff Experience

To better understand the utilization data, the team took a closer look at each Language Service category (Table XXXII) in an effort to understand the composition of the utilization data. While the demand for interpreting continues to grow, we noticed a significant percentage shift in the amount of translation requests. We attributed this decrease to timing of events in which Partnership provides translations. It's worth noting that Q1 typically sees an increase in translation requests as new member material may be distributed more frequently during the start of the year. This is evidenced through the data captured as Q1 2023 contributed 31% to the total number of translations in 2023 and 56% of translations for the reporting period. In addition, we saw an uptick in both interpreting and translation requests during Q4. This was primarily driven by the increase in call volume into our Call Center (+15%, Q4 2024 vs. Q4 2022) and a result of Partnership's expansion into 10 additional counties.

Table XXXII: Utilization Demographics

Interpreting - Previous Period			
	Language	# of Trans.	% to Total
1.	Spanish	63,852	79.8%
2.	Russian	2,524	3.2%
3.	Vietnamese	2,392	3.0%
4.	Punjabi	1,252	1.6%
5.	Dari	1,242	1.6%

Interpreting - Current Period			
	Language	# of Trans.	% to Total
1.	Spanish-Lat.Am	72,165	79.9%
2.	Spanish-Mexico	2,644	2.9%
3.	Russian	2,460	2.7%
4.	Tagalog	1,398	1.5%
5.	Hmong	1,346	1.5%

Translation - Previous Period			
	Language	# of Trans.	% to Total
1.	Spanish-Lat.Am	95	23.0%
2.	Spanish-Mexico	81	19.6%
3.	Tagalog	50	12.1%
4.	Russian	47	11.4%
5.	Lao	14	3.4%

Translation - Current Period			
	Language	# of Trans.	% to Total
1.	Spanish-Lat.Am	93	27.9%
2.	Spanish-Mexico	67	20.1%
3.	Russian	52	15.6%
4.	Tagalog	50	15.0%
5.	Hmong	8	2.4%

When reviewing the results of the internal survey, Partnership exceeded the internal threshold for two out of the five survey questions (Table XXXIV). While the "Overall, the interpreter(s) was professional, respectful, and polite" category did not meet our internal threshold, we saw a positive increase of 2% over last year's result. The most glaring opportunity was seen in the "The turnaround time in obtaining interpreting services was acceptable" category in which 12 additional respondent provided a neutral response over last year. The increase in neutral respondents led to the overall decrease in performance for the category. In an effort to mitigate further timeliness issues, Partnership will incorporate additional collaborative sessions

throughout the year with our contracted vendor. These collaborative sessions with have an emphasized focus on workforce planning as well as identifying potential process improvement efforts around our intake process.

Table XXXIV: Internal Survey Results

Internal Survey Question	Favorable Rating % to Total	Threshold Met?
An interpreter(s) was available at the time of request.	85%	YES
The turnaround time in obtaining interpreting services was acceptable.	77%	NO
Overall, the interpreter(s) was professional, respectful, and polite.	76%	NO
Overall, the interpreter(s) met the interpreting needs of the member.	84%	YES
Overall, I was satisfied with the level of services that the interpreter(s) provided.	79%	NO

Factors 2 & 4: Individual experience with language services for organization functions and during health care encounters

Factors 2 & 4 Summary Findings: In comparing Grievance & Appeals (G&A) 2023 to 2022 cases, Language Assistance Services decreased by 22 cases in 2023 compared 2022. Language Barrier / Limited English Proficiency case filings increase by five (5) cases. Non-Threshold Language case type consisted of an increase of one (1) new case for 2023 compared to zero (0) in 2022. Auxiliary Aids and Services had eight (8) cases in 2023, four (4), from prior year. CAHPS® Regulated Survey for Measure Year 2022 sample frame consisted of 2,700 Adults, and 4,125 Child, achieving are response rate of 14.3% (380) Adult, and 14.9% Child (611).

In comparing survey performance by health plan target at or above 70th percentile threshold, Adult satisfaction was -2.3% below target and Child performed slightly above the target at 0.7%. Comparing survey performance by provider at or above 70th percentile threshold, Adult satisfaction was 1% above the target and 4.8% for Child satisfaction.

Methodology: In addition to the quantitative analysis above, we evaluated utilization data and results of the internal satisfaction survey and CAHPS® regulated and non-regulated[1] member experience survey questions specific to interpreting and translation language services. Qualitative findings and observations are detailed within this section. Grievance and Appeals (G&A) data is another source the analysis workgroup uses to evaluate real time member abrasion or dissatisfaction. Custom G&A reports provide case filings by type, category, status, outcome and whether grievances involve the health plan or provider network. The following category types and definitions support the intent to reduce healthcare disparities.

Category Type	Definition
Language Assistance Services	Case involves interpretation services that help people with a Limited English Proficiency communicate in English.
Language Barrier / Limited English Proficiency	Case involves a person whose first language is not English and has trouble reading, writing, speaking, or understanding English.
Non-threshold Language	Case involves a non-threshold spoken language. Threshold languages are; English, Armenian, Cambodian, Chinese, Farsi, Korean, Tagalog, Russian, Spanish and Vietnamese.
Auxiliary Aids and Services	Case involving services used by a member who is deaf, blind, hard of hearing or seeing to help them communicate. These services include sign language, text telephones, or other such devices to get information. This also includes any effective method to improve reading such as large print.

Notable Findings - Grievance & Appeals (G&A)

The analysis workgroup observed two notable findings while comparing year-over-year covered member benefit and G&A case filings: One) an increase in 2023 member utilization of interpreter or language services (UILS), and 2) a decrease in Culturally and Linguistically Appropriate Services (CLAS) member filed G&A cases compared to 2022. The overall assessment is the member UILS rate relative to the G&A CLAS case filings are low.

Referenced below is a year-over-year case comparison by category type.

Language Assistance Services

- 2023 - 2 Cases
- 2022 - 24 Cases
- - 22 Cases
- Noted improvement

Non-threshold Language

- 2023 - 1 Case
- 2022 - 0 Cases
- + 1 Case
- Noted increase

Language Barrier / Limited English Proficiency

- 2023 - 15 Cases
- 2022 - 10 Cases
- + 5 Cases
- Noted increase

Auxiliary Aids and Services

- 2023 - 8 Cases
- 2022 - 4 Cases
- + 4 Cases
- Noted increase

The 2023 case filings yielded a score of 0.03% relative to language service utilization and was below the threshold target of (1/10th of one percent) 0.10%. Although the goal was met the analysis workgroup established a priority ranking based the on number of case filings by category (Table XXXV).

Table XXXV

2023 Annual Grievance & Appeals Priority By Category Type	
Language Barrier / Limited English Proficiency	15
Auxiliary Aids and Services	8
Language Assistance Services	2

The workgroup focused on the top three case category types to identify service abrasion/dissatisfaction themes. Partnership further compiled case filings by service delivery and identified correlating themes (italicized) for Health Plan and Provider/Network (Table XXXVI) and NCQA Health Equity (HE) 6 Case Analyses (Table XXXVII).

Table XXXVI: Member Dissatisfaction Theme

Service Delivery	Member Dissatisfaction Theme
Partnership	• Service provider - technical/connectivity issues • *Service provider - dialect/translation issues* • *Covered member - translation and interpreter benefit literacy*
Provider/Network	• Customer service/cultural sensitivity training • *Covered benefit awareness and training* • *Service provider - dialect/translation issues*

Table XXXVII: NCQA Health Equity (HE) 6 Case Analyses

Case Category Type	2023 Grievance & Appeals Case Totals	NCQA Health Equity (HE) 6 Case Analyses
Language Assistance Services	2	Case filings offer different perspectives specific to Language Assistance Services. Theme: Familiarity of benefit literacy and breakdown in communication.
Language Barrier / Limited English Proficiency	15	Case filings offer a combination of unconfirmed and confirmed perceptions of discrimination associated with language barriers. Case filing themes: benefit literacy, scheduling, and communication breakdown. Per the Partnership Member Hand-book, members are encouraged to schedule interpreter services when confirming a medical appointment. In some instances, provider sensitivity training, and reminders of CLAS-covered benefits are warranted.

Non-threshold Language	1	Partnership Member Services (MS) employee created an unintended abrasion/experience while following procedure to authenticate plan covered member over the phone. The language barrier occurred between member ad hoc interpreter (family member) and MS employee. Assessment: Although plan MS employee adhered to procedure, there is an employee lesson learned/training opportunity. Learn to take verbal/conversation ques to know when to transfer to a bilingual MS employee or qualified interpreter services (AMN) delegated vendor.
Auxiliary Aids and Services	8	Case filings offer different perspectives specific to Auxiliary Aids and Services. Theme: Familiarity with covered benefits (varied clinical settings) literacy and breakdown in communication.

CAHPS® Survey Data

The CAHPS® program added NCQA approved supplemental questions specific to interpreting and translation language services for adult and child 2022 Measure Year (MY) CAHPS® regulated survey. Important to note, the survey is only available in two language formats, English and Spanish. A targeted focus to improve child survey scores, and to address regulated survey limitations, we included additional questions in English and Spanish in the child non-regulated[1] CAHPS® drill-down survey. Partnership has implemented this strategic step to align with NCQA standards and NCQA Health Equity Accreditation requirements. The survey oversample frame for the CAHPS® regulated consisted of; Adult 2,700, and Child 4,125, members survey and for the CAHPS® non-regulated[1] survey, Child 2,000. The following regulated supplemental questions were assessed:

Adult Experience with Language Services

Question
Q42. In the last 6 months, if you utilized an interpreter or language services to help speak with your Health Plan, how would you rate your experience (with 0 being the worst possible experience, and 10 being the best possible experience)?
Q43. In the last 6 months, if you utilized an interpreter or language services to help speak with your doctors or other healthcare providers, how would you rate your experience (with 0 being the worst possible experience, and 10 being the best possible experience)?

Medicaid Adult Regulated Survey		Category Responses Based on Valid Responses Per Question			MY 2022 Performance Target
Valid Responses (n= 99)	Q42. Overall experience with interpreter/language services utilized with plan (% 9 or 10 - Best possible experience)	9 or 10 - Best possible experience	7-8	0-6	70th Percentile
Not Applicable 244		67.7%	25.3%	7.1%	
Valid Responses (n= 100)	Q43. Overall experience with interpreter/language services utilized with Dr. (% 9 or 10 - Best possible experience)	9 or 10 - Best possible experience	7-8	0-6	
Not Applicable 240		71.0%	21.0%	8.0%	

Child Experience with Language Services

Question
Q43. In the last 6 months, if you utilized an interpreter or language services to help speak with your Health Plan, how would you rate your experience (with 0 being the worst possible experience, and 10 being the best possible experience)?
Q44. In the last 6 months, if you utilized an interpreter or language services to help speak with your child's doctors or other healthcare providers, how would you rate your experience (with 0 being the worst possible experience, and 10 being the best possible experience)?

Medicaid Child Regulated Survey		Category Responses Based on Valid Responses Per Question			MY 2022 Performance Target
Valid Responses (n= 239)	Q43. Overall experience with interpreter/language services utilized with plan (% 9 or 10 - Best possible experience)	9 or 10 - Best possible experience	7-8	0-6	70th Percentile
Not Applicable 308		70.7%	17.6%	11.7%	
Valid Responses (n= 238)	Q44. Overall experience with interpreter/language services utilized with Dr. (% 9 or 10 - Best possible experience)	9 or 10 - Best possible experience	7-8	0-6	
Not Applicable 304		74.8%	16.8%	8.4%	

Survey Section: Your Child's Personal Doctor

Question
Q13. In the last 6 months, have you ever had a hard time speaking with or understanding your child's doctor or other health care provider because you spoke different languages?
Q14. In the last 6 months, if you used an interpreter or language services to help speak with your child's doctors or other healthcare providers, how would you rate your experience (with 0 being the worst possible experience, and 10 being the best possible experience)?
14a. Please share more about your rating.

Survey Section: Your Child's Health Plan

Question
21. In the last 6 months, if you used an interpreter or language services to help speak with your child's Health Plan, how would you rate your experience (with 0 being the worst possible experience, and 10 being the best possible experience)?
21a. Please share more about your rating.

Performance Summary by Survey and Service Delivery

The analyst workgroup evaluated the CAHPS® Regulated and [1]CAHPS® Non-Regulated Drill-Down Surveys (Section II) results against the Plan 70th percentile performance threshold (Section III) to determine if we met or exceeded the performance target (Table XXXVIII).

Located below is a summary of the survey findings:

Table XXXVIII

Population	Survey Type	Plan Satisfaction Rating Score (% 9 or 10)	Performance Target Met?	Provider Satisfaction Rating Score (% 9 or 10)	Performance Target Met?
Adult	Regulated	67.7%	NO	71.0%	YES
Child		70.7%	YES	74.8%	YES
Child	Non-Regulated	62.5%	NO	57.1%	NO

- Adult Population:
  - Plan Satisfaction: Performance -2.3% below threshold target
  - Provider Satisfaction: Performance 1% above threshold target
- Child Population
  - Plan Satisfaction: Performance 0.7% above threshold target
  - Provider Satisfaction: Performance 4.8% above threshold target

[1]CAHPS® Non-Regulated Survey

- Child Population
  - Plan Satisfaction: Performance -8.5% below threshold target
  - Provider Satisfaction: Performance -12.9% below threshold target

CAHPS® Regulated Survey

Survey scores for adult and child questions (Table XXXIX) and (Table XL).

- **Adult CAHPS® Regulated Survey (Table XXXIX)**
  - **Q42** (utilization with plan) 244 chose "not applicable"
  - Valid response (n = 99)
  - Experience rating scale 0 - 10 (0=worst 10=best)

        - 9 or 10 (67.7%), 7-8 (25.3%), 0-6 (7.1%)
        - Target Met: **No**
    - **Q43** (utilization with provider) 240 chose “not applicable”
    - Valid response (n=100)
    - Experience rating scale 0 - 10 (0=worst 10=best)
        - 9 or 10 (71.0%), 7-8 (21.0%), 0-6 (8.0%)
        - Target Met: **Yes**

Table XXXIX

Medicaid Adult Regulated Survey		Category Responses Based on Valid Responses Per Question			MY 2022 Performance Target
Valid Responses (n= 99)	Q42. Overall experience with interpreter/language services utilized with plan (% 9 or 10 - Best possible experience)	9 or 10 - Best possible experience	7-8	0-6	70th Percentile
Not Applicable 244		67.7%	25.3%	7.1%	
Valid Responses (n= 100)	Q43. Overall experience with interpreter/language services utilized with Dr. (% 9 or 10 - Best possible experience)	9 or 10 - Best possible experience	7-8	0-6	
Not Applicable 240		71.0%	21.0%	8.0%	

- **Child CAHPS® Regulated Survey (Table XL)**
    - **Q43** (utilization with plan) 308 chose “not applicable”
    - Valid response (n = 239)
    - Experience rating scale 0 - 10 (0=worst 10=best)
        - 9 or 10 (70.7%), 7-8 (17.6%), 0-6 (11.7%)
        - Target Met: **Yes**
    - **Q44** (utilization with provider) 240 chose “not applicable”
    - Valid response (n=304)
    - Experience rating scale 0 - 10 (0=worst 10=best)
        - 9 or 10 (74.8%), 7-8 (16.8%), 0-6 (8.4%)
        - Target Met: **Yes**

Table XL

Medicaid Child Regulated Survey		Category Responses Based on Valid Responses Per Question			MY 2022 Performance Target
Valid Responses (n= 239)	Q43. Overall experience with interpreter/language services utilized with plan (% 9 or 10 - Best possible experience)	9 or 10 - Best possible experience	7-8	0-6	70th Percentile
Not Applicable 308		70.7%	17.6%	11.7%	
Valid Responses (n= 238)	Q44. Overall experience with interpreter/language services utilized with Dr. (% 9 or 10 - Best possible experience)	9 or 10 - Best possible experience	7-8	0-6	
Not Applicable 304		74.8%	16.8%	8.4%	

The child MY 2022 [1]CAHPS® non-regulated drill-down survey (Section III) sample frame of 2,000 members, of the surveyed we had a respondent rate of 9.5% and/or 189 completed surveys.

[1]CAHPS® Non-Regulated Survey
Survey scores by child questions only (Table XL).

- **Child [1]CAHPS® Non-Regulated Drill-Down Survey**
  - **Q14** (utilization with provider)
  - Valid response (n=8)
  - Experience rating scale 0 - 10 (0=worst 10=best)
    - 9 or 10 (62.5%), 7-8 (0%), 0-6 (37.5%)
    - Target Met: **No**
  - **Q21** (utilization with plan)
  - Valid response (n=14)
  - Experience rating scale 0 - 10 (0=worst 10=best)
    - 9 or 10 (57.1%), 7-8 (29%), 0-6 (13.9%)
    - Target Met: **No**

Table XL

Medicaid Child Non-regulated Drill Down Survey		Category Responses Based on Valid Responses Per Question			MY 2022 Performance Target
Valid Responses (n= 8)	Q14. Overall experience with interpreter/language services utilized with Dr. (% 9 or 10 - Best possible experience)	9 or 10 - Best possible experience	7-8	0-6	70th Percentile
Not Applicable 181		62.5%	--	37.5%	
Valid Responses (n = 14)	Q21. Overall experience with interpreter/language services utilized with plan (% 9 or 10 - Best possible experience)	9 or 10 - Best possible experience	7-8	0-6	
Not Applicable 175		57.1%	29%	13.9%	

Grievance & Appeals
The workgroup priority to evaluate Language Assistance Services case filings started with causal factor analysis. Through the discovery process, we identified linked dissatisfaction themes between the Health Plan and Provider/Network service delivery. Additionally, Partnership's analysis includes specific examples of service abrasion (Table XLI).

Table XLI

Service Delivery	Member Dissatisfaction Theme	Examples
Partnership	• Service provider - dialect/interpreter issues • Covered member - translation and interpreter benefit literacy	• Interpreter is not adequately communicating because of dialect grammar, word usage/ variations.

Provider/Network	• Covered benefit awareness and training • Service provider - dialect/interpreter issues	• Provider education. Not aware of covered benefit. Members misinformed or general communication barriers.

The concept of inverse logic was used while evaluating G&A case filings as a method to measure member satisfaction for all language thresholds. The logical premise is low G&A-CLAS case filings relative to the utilization of interpreter and translation services demonstrates satisfaction (26/85,605[+]).

[+]Language Service Utilization includes services for Language or Interpreter. Threshold (Combined Category Total / Annual Utilization Average)

Element D: Use of Data to Measure CLAS and Inequities

Factor 1: Identifies and prioritizes opportunities to reduce health care inequities

Factor Summary:

Overall, researchers found that Well Care Visits (WCV) was the clinical measure with a majority of race/ethnic groups not meeting the minimum performance threshold in all of Partnership's regions. The American Indian/Alaska Native, African American/Black, and White groups had a Strong Disparity for this measure. The Black/African American group, the additional disparity of focus is Timeliness of Prenatal Care due to some findings that were statistically significant and having an average percentage below the MPL across various regions. The American Indian/Alaska Native group, had a Strong Disparity in prenatal care, postpartum care due to having an average rate of performance 13% below the MPL across 3 regions.

Methodology:

Partnership's original goal in defining and prioritizing disparities to reduce health care disparities was to utilize statistical significance to identify measures with an opportunity for improvement. Currently, there are no gold standards for evaluating disparities, therefore Partnership developed the following disparity classification system to aid in prioritizing disparities based upon measure findings. This is based upon the Strength of recommendation taxonomy used in various clinical guidelines to stratify recommendations. Partnership identified opportunities to reduce health care inequities after evaluating both Health Plan Accreditation and MCAS final rates for the measures of focus for the Grand Analysis Report. Identified opportunities to reduce inequities were then prioritized using the strong/moderate/weak disparity classification system referenced in Table XLII, with Partnership ultimately prioritizing opportunities classified as a Strong Disparity.

Table XLII: Strength of Disparity Classification

Disparity Classification

Strong Disparity (Disparity is clearly present when compared to comparator group or goal)
• Meets at least three of any of following factors below
  ○ MCAS Sample Measure
  ▪ Group is performing statistically worse in at least one region when compared to the comparator group
  ▪ Absolute Average Percentage Difference between specific group and minimum performance level is at least 10% (multiple regions) or 15% in single region in MCAS/HEA measure
  ▪ Multiple regions (≥2) where specific group falls below 25th percentile per MCAS measure

Moderate Disparity (Disparity is moderately present when compared to comparator group or goal)
• Meets at least three of any of the following factors
  ○ MCAS Sample Measure
  ▪ Absolute Average Percentage deficit between group and comparator (minimum performance level) is at least 10% (multiple regions) or 15% in single region
  ▪ No group is performing significantly better than comparator group yet at least one group is performing significantly worse per MCAS measure
  ▪ Multiple regions (≥2) where group falls below 50th percentile
  ▪ At least 1 region where group falls below 25th percentile

Weak Disparity (Disparity is uncertain when compared to comparator group or goal)
• Meets at least two of any of the following factors:
  ○ MCAS Sample Measure
  ▪ No statistical difference between groups in a region
  ▪ Absolute Average Percentage deficit between group and comparator (minimum performance level) is at least 5% (multiple regions) or 7% in single region
  ▪ Only 1 region where group falls below 50th percentile and no region fall below 25th percentile

Partnership created the table below (Table XLII) to not only highlight the disparities identified from all analyses, but to classify the level of priority for each identified disparity based on the utilization of the Strength of Disparity Classification table (Table XLIII). The table below lists the overall disparity findings with prioritization for each race/ethnicity group included in this Grand Analysis.

Table XLIII: Health Inequities Areas of Focus

Group	Key HEA Measure	MCAS Number of Regions with Statistically Worse Disparity	MCAS Number of Regions with disparity (below 25th)	MCAS Number of additional Regions with disparity (below MPL – 50th)	Absolute % Average BELOW MPL across regions below 50th Percentile	Category of Disparity (S/M/W)	Number of Years with Same Disparity from 2024
White	Controlling High Blood Pressure (CBP)	-	1	0	-1.21%	WEAK	N/A
	Poor HbA1c Control (>9%)	-	0	1	-5.54%	WEAK	N/A
	Postpartum Care	-	0	0	-----	N/A	N/A
	Timeliness of Prenatal Care	-	0	1	-4.33%	WEAK	N/A
	Well Child Visits (WCV)	-	1	3	-6.02%	MODERATE	N/A
Native Hawaiian and Other Pacific Islander	Controlling High Blood Pressure (CBP)	0	1	0	-61%	MODERATE	N/A
	Poor HbA1c Control (>9%)	0	2	0	-12.04%	STRONG	N/A
	Postpartum Care**	0	-	-	---	N/A	N/A
	Timeliness of Prenatal Care**	0	-	-	---	N/A	N/A
	Well Child Visits (WCV)	1	3	1	-11.16%	STRONG	N/A
Hispanic or Latino	Controlling High Blood Pressure (CBP)	0	0	1	4.22%	WEAK	N/A
	Poor HbA1c Control (>9%)	0	0	1	-1%	WEAK	N/A
	Postpartum Care	0	0	0	N/A	NONE	N/A
	Timeliness of Prenatal Care	0	0	0	N/A	NONE	N/A
	Well Child Visits (WCV)	0	0	1	-3.08%	WEAK	N/A
Black or African American	Controlling High Blood Pressure (CBP)	0	0	0	N/A	NONE	N/A
	Poor HbA1c Control (>9%)	0	1	1	12%	STRONG	N/A
	Postpartum Care	0	0	0	N/A	NONE	N/A
	Timeliness of Prenatal Care	0	2	0	-30.12%	STRONG	N/A
	Well Child Visits (WCV)	1	2	2	-6.57%	STRONG	N/A
Asian	Controlling High Blood Pressure (CBP)	0	0	2	-0.17%	WEAK	N/A
	Poor HbA1c Control (>9%)	0	0	0	N/A	NONE	N/A
	Postpartum Care	0	0	1	-6.71%	WEAK	N/A

	Timeliness of Prenatal Care	0	1	0	-6.53%	WEAK	N/A
	Well Child Visits (WCV)	0	0	4	-2.81%	WEAK	N/A
American Indian and Alaska Native	Controlling High Blood Pressure (CBP)	0	2	0	-11.26%	MODERATE	N/A
	Poor HbA1c Control (>9%)	1	1	2	-33%	STRONG	N/A
	Postpartum Care	1	0	2	-15.57%	STRONG	N/A
	Timeliness of Prenatal Care	1	3	0	-21.78%	STRONG	N/A
	Well Child Visits (WCV)	1	1	3	-5.91%	MODERATE	N/A

Native Hawaiian and other pacific islander measures not evaluated due to lack of sample size in each region to be sufficient

From the table above, Partnership prioritized the following identified health inequities (highlighted in orange) based on their inclusion in the "strong" disparity category:

1. Timeliness of Prenatal Care (PPC – Pre): Black/African American Members
2. Timeliness of Prenatal Care (PPC – Pre): American Indian/Alaska Natives
3. Timeliness of Postpartum Care (PPC – Post): American Indian/Alaska Natives
4. Well Care Visits (WCV): All Pediatric Members

However, there are some significant limitations to note in Partnership's analysis. The major limitation is the lack of a gold standard to evaluate and quantify disparities between various groups. Experts have debated and have not developed a consensus on how to effectively measure disparities between groups. While team members reviewed this information, we developed modifications of such systems of evaluating the disparities, which may produce bias. Also, the system and metrics previously used have not been tested to validate their accuracy. For example, in utilizing the scoring model and analyzing findings, Partnership prioritized Controlling High Blood Pressure, Hemoglobin A1c Control, and Prenatal and Postpartum Care for Black members. While a disparity was identified for the Black/African American population for CBP, only 20 members identified as Black/African American were included in the MCAS hybrid sample, and of those 20, only 8 (40%) were noncompliant in the measure over all four regions. The small denominator for this group made the Black population a larger priority in addressing inequities identified for this measure.

Additionally, Partnership's utilization of state data for the race and ethnicity information included in this analysis was done to provide the most up to date member demographic information for members included in each measure sample. However, members where race or ethnicity were unknown fell into the "Unknown" category, and as such, these members were not included in the final analysis. As shown in Element A, 59,918 (8.9%) of Partnership members have "Unknown" listed for their race and ethnicity demographic information. Partnership is exploring ways to strengthen race and ethnicity demographic information for members in this category, to more appropriately impact them in future analysis and create more tailored interventions.

Another major limitation was evaluating and integrating CAHPS® responses. In addition to the prioritized opportunities listed above, Partnership also identified a need to explore potential

solutions to impact CAHPS® responses. Partnership recognizes that the CAHPS® response rate from members is low, and is exploring options to increase survey access, and acknowledge the diverse language demographics of Partnership members. As such, Partnership is also exploring how to ensure the survey is available in additional languages to Spanish and English to encourage responses are being received from a diverse population of eligible survey recipients, findings are more representative of the communities served, and can be acted upon.

Finally, as highlighted previously, a major limitation of all of these findings is that the sample sizes were significantly smaller, therefore significantly lowering the likelihood of finding significant differences. NCQA team auditors may want to suggest threshold demographic sample sizes for each measure to improve likelihood of validity when comparing stratified languages while working with plans that utilize the MCAS measures.

Factor 2: Identifies and prioritizes opportunities to improve CLAS

When reviewing the utilization data, Spanish was the most requested language for both interpreting sessions and translation requests. To continue to support the demand for Spanish Language Services, Partnership's Member Services Call Center strives to ensure Member Service Representatives (MSR) are bilingual. At the department level, there is an internal goal to maintain ¾ or 75% of Partnership's MSR's are bilingual. To be considered a "bilingual" employee, applicable staff must pass a Partnership administered language competency exam. Upon completion, bilingual staff are able to provide customer support in the language in which they exemplified competency. With that said, the Department is currently at 70% and will continue to work towards achieving and sustaining this internal goal.

In regard to Partnership's threshold languages, we noticed that Tagalog was not within the top seven requested languages for interpreting. Although the volume was small, Tagalog accounted for 12.9% of the translation requests in the Current Period. Another language that is gaining adoption is Vietnamese. Vietnamese was the second most requested language for interpreting. In terms of translation requests. Knowing that Vietnamese is not a threshold language, there may be future opportunities for Partnership to further understand the demand for this language through the continued analysis of utilization data.

When looking at the results of the Internal Satisfaction Survey, Partnership provided staff with the opportunity to provide candid feedback through an open-ended/optional question. Through this question, we were able to understand some of the challenges that Partnership staff experienced. One of the leading causes of staff dissatisfaction was that interpreters disconnected from the session prematurely. To address this opportunity, Partnership will collaborate with contracted vendors to reiterate expectations and ensure that the interpreters are adequately trained on closing each interpreting session. Another common concern was that select languages had a longer hold time than usual. This typically happens with languages of lesser diffusion, such as Samoan and Mixteco. This concern has been thoroughly discussed with Partnership's provider base. Contracted providers will continue to make a good-faith effort to ensure that their internal workforce-planning department is aware of these deficits. Another solution is that Partnership has the ability to pre-schedule interpreting sessions for the

languages of lesser diffusion. Partnership will continue to assess staff experience and work with contracted providers on areas of opportunities in an effort to improve staff experience with the interpreting services received.

In identifying opportunities to improve CLAS, Partnership utilized measure performance stratified by language and sexual orientation, CAHPS® and Grievance and Appeals data. Partnership's original goal when assessing opportunities to improve CLAS was defined as:

Goal: There will be no statistically significant lower performance for each measure included in this report for each language group in comparison to the English group.

Status: Goal Met.

Goal: There will be no statistically significant lower performance for each measure included in this report for the Female group in comparison to the Male group.

Status: Goal Met.

As each of these goals was met, Partnership reviewed the CAHPS® data findings. Although the CAHPS® survey yields insight into the interpreting and translation language services, respondent samples specific to each supplemental question in the CAHPS® regulated and non-regulated survey are statistically insignificant relative to the non-English speaking surveyed member population. Important to note, the regulated and drill-down surveys are only offered in English and Spanish language formats, which limits Partnership's ability to proactively solicit members for all threshold languages. As a result of the barriers identified, Partnership did not identify any opportunities based on responses to CAHPS® questions.

Partnership also created a goal to evaluate member satisfaction relative to language service utilization. This goal was defined as:

Goal: Maintain member abrasion or dissatisfaction below 1/10th of one percent (0.10%).

Status: Goal Met.

As outlined in Element C, Partnership met or performed better than the member satisfaction target. The 2023 case filings yielded a score of 0.03% relative to language service utilization and was slightly above the threshold target of (1/10th of one percent) 0.10%. The analysis workgroup established a priority ranking based the on number of case filings by category (Table XLIV). As illustrated in Table XLIV, the Language Barrier/Limited English Proficiency category type resulted in roughly 60% of the total grievances within the 2023 Annual Grievance & Appeals Priority by Category Type, which highlights an opportunity for improvement.

Table XLIV

2023 Annual Grievance & Appeals Priority By Category Type	
Language Barrier / Limited English Proficiency	15
Auxiliary Aids and Services	8

Language Assistance Services	2

Based on the priority, the workgroup approached each Language Assistance Service case (TTL: 26) with the purpose to identify service abrasion/dissatisfaction themes. Partnership further compiled case filings by service delivery and identified correlating themes (italicized) for Health Plan and Provider/Network (Table XLV) and NCQA Health Equity (HE) 6 Case Analyses (Table XLVI).

Table XLV

Service Delivery	Member Dissatisfaction Theme
Partnership	• Service provider - technical/connectivity issues • *Service provider - dialect/translation issues* • *Covered member - translation and interpreter benefit literacy*
Provider/Network	• Customer service/cultural sensitivity training • *Covered benefit awareness and training* • *Service provider - dialect/translation issues*

Table XLVI: NCQA Health Equity (HE) 6 Case Analyses

Case Category Type	2023 Grievance & Appeals Case Totals	NCQA Health Equity (HE) 6 Case Analyses
Language Assistance Services	2	Case filings offer different perspectives specific to Language Assistance Services. Theme: Familiarity of benefit literacy and breakdown in communication.
Language Barrier / Limited English Proficiency	15	Case filings offer a combination of unconfirmed and confirmed perceptions of discrimination associated with language barriers. Case filing themes: benefit literacy, scheduling, and communication breakdown. Per the Partnership Member Handbook, members are encouraged to schedule interpreter services when confirming a medical appointment. In some instances, provider sensitivity training, and reminders of CLAS-covered benefits are warranted.
Non-threshold Language	1	Partnership Member Services (MS) employee created an unintended abrasion/experience while following procedure to authenticate plan covered member over the phone. The language barrier occurred between member ad hoc interpreter (family member) and MS employee. Assessment: Although plan MS employee adhered to procedure, there is an employee lesson learned/training opportunity. Learn

		to take verbal/conversation ques to know when to transfer to a bilingual MS employee or qualified interpreter services (AMN) delegated vendor.
Auxiliary Aids and Services	8	Case filings offer different perspectives specific to Auxiliary Aids and Services. Theme: Familiarity with covered benefits (varied clinical settings) literacy and breakdown in communication.

Factor 3: Implements at least one intervention to address an inequity

In addressing disparities and impacting health equity at a global scale, Partnership has worked to improve tools used both internally and externally to ensure they address disparities at the plan-wide level. Race and ethnicity data has been added to external tools to allow network practitioners to facilitate targeted outreach, and understand demographic information for members seen at their clinics. Demographic information has been added to Partnership's eReports (an online system built by Partnership's Web team for the PCP QIP Clinical measures; it is the mechanism by which providers can monitor their performance and submit supplemental medical record data to Partnership to enhance their performance), and member lists available to providers like Partnership's Preventive Care dashboard.

Furthermore, Partnership is adding race and ethnicity data to internal tools like the Maternity Services dashboard to bring more visibility to this data, and facilitate targeted outreach when tools are utilized. Health equity has also been added to the *Improving Measure Outcomes* webinar series Partnership hosts to QI teams within the network to ensure teams understand measure specifications and performance, and best practices for each of the measures included. The addition of health equity focus and member demographic information to these externally facing webinars was done to help QI teams within Partnership's network develop strategies for measure improvement with this information in mind. This has been added to webinars that address all measures of focus included in this report.

Lastly, Partnership identified a number of opportunities to improve health and CLAS inequities based on the analysis included in Factor 1 (Table XLIII). Opportunities to address inequities have been highlighted below by measure category.

Timeliness of Prenatal Care (PPC – Pre)	
Group(s) of Focus	Black/African American Members
Percentage Below Minimum Performance Level (MPL)	*NE Region: 9.28% below* *NW Region:50.97* % below Non-Weighted Average: 30.12%
Goal for Specific Group	Improve prenatal visits by at least 5% in the NE or NW region in the Black/African American Member Population within 12 months with the global goal of improvement by 30% in the next 5 years.
Root Cause Analysis	Timely prenatal care is recommended to promote healthy pregnancies via screening and preventative management of a woman's risk factors. Unfortunately, various studies have suggested that fewer timely prenatal visits are associated with poorer pregnancy outcomes such as severe maternal morbidity, maternal death, and infant mortality (Howell, 2018). Research has suggested that insurance availability, transportation, and access to specific providers are key driving factors for receiving timely prenatal care. Partnership identified inequities for Black/African American members in the Northeast and Northwest regions for Timeliness of Prenatal Care.
Barrier Analysis	For prenatal care, researchers found that policy changes that improved eligibility for individuals, made insurance coverage more comprehensive, and improved maternity reimbursement rate was associated with greater attendance in postpartum visits (Saldanha et al., 2023). There has been limited research evaluating prenatal care and postpartum interventions in specific patient groups—namely Black/African American patients. Currently, Black/African American women are at least 3x more likely to experience a pregnancy-related death when compared to White women and have the largest disparity among all the conventional population perinatal health measures (Howell, 2018). However, partnership is currently exploring interventions to positively impact their prenatal and postpartum care. In 2023, the Department of Health Care Services (DHCS) added doula services as a covered benefit. In 2023, Sobczak et al. conducted a literature review of 16 studies (cohort and randomized trials) to evaluate the benefits of utilizing a doula. Their findings suggested that doula support decreased incidence of cesarean or premature labor, low birth weight, and epidural/medical pain management. Finally, Partnership conducted a focus-group-like survey of Black prenatal and postpartum members (n=12) to conduct a survey to better understand if the member attended their appointments, as well as to understand the barriers faced, if any at the Solano County Family Health Services site—which has the largest population of Black/African American members. Overall, the members highlighted that they didn't attend their visits due to one of the following three categories: (1)

	Incorrect Staff Actions, (2) Schedule Unavailability, (3) Lack Of Transportation. This has motivated Partnership to explore utilizing group visits to streamline staff actions, schedule availability, and coordinate transportation. In 2017, Byerley and Hass conducted a systematic review of 38 studies (8 randomized trials, 23 nonrandomized studies, 6 reports of group outcomes without controls) to evaluate group prenatal care in 20,000+ women. Overall, Byerley et al. (2017) found a significant increase in rates of breastfeeding and satisfaction in Black/African American members after implementing group prenatal care interventions. Partnership may explore whether clinical site locations will be interested in conducting a pilot to validate the efficacy of utilizing such group visits with Doulas. Long-term, Partnership will explore utilizing a combination of interventions to likely meet the large threshold of members who are not meeting the goal.
Actions for Direct Clinical/Service Measure Improvement	**<u>Intervention #1: Contracting Doulas in Partnership Network:</u>** Partnership is also investigating what education doulas share with utilizing members, to ensure members are receiving appropriate information on the importance of early access to prenatal care as well as postpartum care. Partnership has worked to add doulas to the network, and has at least one doula in each region of the network. The health equity officer and other staff have ventured into various community events to help with recruiting various Doulas. **<u>Intervention #2: Increase Diversity of OB GYNs:</u>** Partnership is investigating how to improve the diversity among Obstetrics-Gynecology doctors. To this, Partnership is exploring how to do a baseline assessment of the race and ethnicity demographics of OBs within the network to assess. Partnership will then share this information with respective HR departments to provide guidance to the provider recruitment team at Partnership and incentivize increasing diversity hiring throughout the network to reflect the populations served. Partnership has launched a new provider retention initiative. Specifically, partnership will provide $45,000 award to a doctor of medicine/doctor of osteopathic medicine (DO) or $30,000 award to a nurse practitioner/physician assistant for a 3-year commitment. This intervention will be applicable to all clinical sites—especially OB/GYN sites that inhabit locations that serve a large Black/African American population. **<u>Intervention #3: Encourage Clinical Sites to Utilize Dyadic Care Models</u>** Dyadic care models are considered effective for optimizing the care of both the mother and infant. Dyadic care is considered when a provider provides care for a birthing mother and their infant during the same visit. Specifically, the American Academy of Pediatrics recommends prenatal visits to establish pediatric medical homes and postnatal depression screening for the birthing person during pediatric visit (Choy et al. *PLoS One*. 2024 Apr 16;19(4):e0298927). This is based upon the

	postnatal period being seen as a critical time to support and improve health outcomes of birthing people and their infants. Unfortunately, pregnancy-related morbidity and mortality often occurs within the 6-week postpartum period and this has been attributed to difficulty in accessing care. Partnership will continue to advocate for sites to adopt dyadic care models—especially in regions where there are limited OB/GYNs and primary care providers.

Prenatal and Postpartum Care (PPC)	
Group(s) of Focus	American Indian/Alaska Native
Prenatal Percentage Below Minimum Performance Level (MPL)	*NE Region: 9% Below* *NW Region:* 22% below *SW Region:* 34% below *Non-Weighted Average:* 21.78% Below
Goal for Specific Group	Improve prenatal visits by at least 5% in the NE or NW region in the American Indian/Alaska Native Member Population within 12 months with the global goal of improvement of 22% in the next 5 years.
Postpartum Percentage Below Minimum Performance Level (MPL)	*NE Region: 28% Below* *NW Region:* 3% below *SW Region:* 3% below *Non-Weighted Average:* 11.4% Below
Goal for Specific Group	Improve postpartum visits by at least 5% in the NE region in the American Indian/Alaska Native Member Population within 12 months with the global goal of improvement by 12% in the next 5 years.
Root Cause Analysis	Currently, majority of our American Indian/Alaska Native members are located in Humboldt, Mendocino, and Shasta Counties in our NW and NE regions. Tertiary research has suggested that there is a significantly higher rate of maternal morbidity and mortality among this group due to centuries of human rights violations (e.g. massacres, forced relocation, boarding schools) which has translated into generational trauma via epigenetics (Burns et al. *Soc Sci Med*. 2023 Jan;317:115584.). In addition, researchers has identified the following predictors of maternal mortality: older maternal age, pre-existing conditions, prior cesarean section, transportation issues, travel time, administrative burdens which limit Medicaid enrollment and prenatal care update; and various structural racism incidents during healthcare interactions.
Barrier Analysis	Research suggests that there are structural barriers that are exacerbating poor outcomes in our American Indian/Alaska Native community. For example, there are purported to be transportation infrastructure, family welfare system, poor prenatal care infrastructure, and blatant racism that are the key upstream factors that are acting as barriers for improving disparities.

	Within Partnership's service landscape, the region that is experiencing the greatest disparity for this measure is the NW rural region. Currently, many of Partnership's AI/AN members inhabit this area and likely are experiencing lack of clinic access for all providers. Also, various tribal centers utilize various are held financially accountable to government performance and results act (GPRA) versus HEDIS measures—which are considered less stringent. Therefore, various tribal centers do not have the financial incentive to be intensive with hypertension treatments versus non-tribal health centers. To improve relations, Manage Care Organizations (MCOs) and Partnership specifically, has explored hiring tribal health center liaisons to improve the collaboration between MCOs and tribal centers.
Actions for Direct Clinical/Service Measure Improvement	**Intervention #1: Tribal Health Liaison Hiring and Hosting Tribal Center Event** Partnership has hired a full-time Tribal health liaison to positively impact relationships with tribal health centers, tribal health community members, and provide guidance to help support Tribal member needs. Partnership has recognized partnering with the Tribal community as an organizational initiative, and is working to positively impact all care received by Tribal members through this partnership and communication with Tribal Health Centers within the network at this time. This work has the potential to improve the member experience of American Indian/Alaska Native members, ensure they are receiving culturally appropriate care, and positively impacting the care received by members who identify with this group. Also, the tribal health liaison will be able to conduct various focal group interviews and possibly identify community based organizations to able to provide tele-nutrition counseling sessions, funds for delivery of DASH-diet aligned foods. **Intervention #2: Contracting Doulas in Partnership Network:** Partnership is also investigating what education doulas share with utilizing members, to ensure members are receiving appropriate information on the importance of early access to prenatal care as well as postpartum care. Partnership has worked to add doulas to the network, and has at least one doula in each region of the network. The health equity officer and other staff have ventured into various community events to help with recruiting various Doulas. In addition, Partnership is trying to contract with doula's in the NE/NW regions to ensure that we are able to outreach to our Tribal community members. **Intervention #3: Advertisements of Transportation Benefit with Translation into Tribal Languages:** Partnership is also investigating what education we can share with utilizing members, to ensure members are receiving appropriate information on the importance of

	early access to prenatal care as well as postpartum care. For example, Partnership has recognized that many members are unaware of the transportation benefit afforded to them. Therefore, they may be unaware that Partnership is able to pay for the lodging fees and transportation for a tribal member anywhere they would like to go if they are seeking prenatal/postpartum care in a separate county. Finally, Partnership will like to engage with and survey members to assess whether they should advertise certain education materials into different languages to ensure they are receptive to our various tribal communities.

Well Care Visits (WCV)	
Group(s) of Focus	American Indian/Alaska Native Black/African American White
Goal for Specific Group	Improve Well Care Visit attendance by at least 2.5% across multiple regions or at least 5% in 1 single region in any group (e.g.) Black/African American, American Indian/Alaska Native, White within 12 months with global goal of improvement by 5% in the next 5 years.
Root Cause Analysis	Per the DHCS Bold goals, the state is looking to close all racial/ethnic disparities in WCVs by 50% by 2025. Currently, WCVs are low for all populations. A proposed hypothesis of the root cause is that there is a significant shortage of pediatrician providers—who are able to conduct the WCVs. Therefore, there is a limitation of conducting the absolute number of visits for all pediatric members—regardless of race/ethnicity/gender identity. Also, by having certain members miss at least 1 visit, this will likely cause a shift to make it impossible to attain the key number of visits by a certain age. Currently, the American Academy of Pediatrics recommends at least 13 well-child visits between birth and 6 years of life.
Barrier Analysis	Overall, researchers found that Well Care Visits (WCV) was the clinical measure that majority of race/ethnic groups have a disparity of not meeting the minimum performance threshold throughout the regions. This suggests that the low WCV rate is more of a quality concern versus a demographic specific concern. Within the American Indian/Alaska Native community, there is a community concern of children being reported for child protective services referrals. Historically, AI/AN children were consistently removed from their homes to adopt western cultures. This has resulted in various family members being concerned with exposing their child to unfamiliar members of the community. Also, Partnership tribal health centers have a challenge with engaging with members due to the ongoing difficulties with recruitment and consistent retention of health

	workers and leadership. This is due to the Indian health serves being consistently underfunded, leading to rationing of needed services and a crumbling infrastructure. Therefore, Partnership may consider helping with provider recruitment and retention since tribal centers are unlikely to financially compete with other centers. Within the Black/African American community, there is an association with low well child visit attendance due to low levels of maternal education, low income, and poor prenatal care (Wolfe et al., 2018). Partnership can explore implementing interventions to improve tailored interventions to improve well-child care in African American/Black groups. For example, in a systematic review of well care visit redesigns researchers highlighted the efficacy of doing group WCVs. (Coker et al., 2013)
Actions for Direct Clinical/Service Measure Improvement	**Intervention #1: Provider Recruitment Program and Provider Retention Initiatives** Partnership has launched a new provider retention initiative. Specifically, partnership will provide $45,000 award to a doctor of medicine/doctor of osteopathic medicine (DO) or $30,000 award to a nurse practitioner/physician assistant for a 3-year commitment. This intervention will be applicable to all of clinical sites—especially Partnership's tribal centers and sites that inhabit locations that serve a large Black/African American population. **Intervention #2: Group Well Child Visits** Partnership is conducting a pilot with a clinical site to start group well child visits in a clinical site in Solano county—which has the greatest diversity among Partnership's 14 counties. Long-term, Partnership can explore utilizing a combination of interventions to likely meet the large threshold of members who are not meeting the goal throughout the network. **Intervention #3: Increase Access to BIPOC-related children's book regarding improving immunizations and attending WCVs** Partnership's HEO previously published a children's book, Andres Armor, which teaches BIPOC children the importance of vaccines using knight and dragon analogies. He is exploring donating copies of the book and videos to clinical sites to hopefully increase the number of children wanting to attend WCVs and watching the free information play during their provider visits.

Factor 4: Implements at least one intervention to improve CLAS

The CLAS team will continue to focus on continued root-cause analyses and improvement activities specific to Grievance & Appeals categories related to language. As illustrated in Table XLIV, the Language Barrier/Limited English Proficiency category type resulted in roughly 60% of the total grievances within the 2023 Annual Grievance & Appeals Priority by Category Type, which highlights an opportunity for improvement.

Table XLIV

2023 Annual Grievance & Appeals Priority by Category Type	
Language Barrier / Limited English Proficiency	15
Auxiliary Aids and Services	8
Language Assistance Services	2

Based on member satisfaction with language related services and the HE 6 Case Analyses (Table XLVI), Member Services and Quality Improvement will implement an intervention in the form of an inter/intradepartmental workgroup. This workgroup will place an emphasized focus on analyzing the leading causes of member dissatisfaction as it relates to CLAS. As a result of the associated grievance volume, the Language Barrier/Limited English Proficiency category type will serve as the basis through which Partnership's intervention workgroup will develop improvement activities.

Table XLVI: NCQA Health Equity (HE) 6 Case Analyses

Case Category Type	2023 Grievance & Appeals Case Totals	NCQA Health Equity (HE) 6 Case Analyses
Language Assistance Services	2	Case filings offer different perspectives specific to Language Assistance Services. Theme: Familiarity of benefit literacy and breakdown in communication.
Language Barrier / Limited English Proficiency	15	Case filings offer a combination of unconfirmed and confirmed perceptions of discrimination associated with language barriers. Case filing themes: benefit literacy, scheduling, and communication breakdown. Per the Partnership Member Hand-book, members are encouraged to schedule interpreter services when confirming a medical appointment. In some instances, provider sensitivity training, and reminders of CLAS-covered benefits are warranted.
Non-threshold Language	1	Partnership Member Services (MS) employee created an unintended abrasion/experience while following procedure to authenticate plan covered member over the phone. The language barrier occurred between member ad hoc interpreter (family member) and MS employee. Assessment: Although plan MS employee adhered to procedure, there is an employee lesson learned/training opportunity. Learn to take verbal/conversation ques to know when to transfer to a bilingual MS employee or qualified interpreter services (AMN) delegated vendor.
Auxiliary Aids and Services	8	Case filings offer different perspectives specific to Auxiliary Aids and Services. Theme: Familiarity with covered benefits (varied clinical settings) literacy and breakdown in communication.

Member Services and Quality Improvement stakeholders will design, assemble, and implement the workgroup that will be comprised of key stakeholders within the organization. The overall deliverable will be focused on addressing and identifying commonalties associated with CLAS member grievances with the intent of reducing the number of member grievances associated with Language Barrier/Limited English Proficiency. This will be accomplished through addressing the Member Dissatisfaction Themes related to translation and interpreter benefit literacy and covered benefit awareness and training, which were both highlighted in the Partnership and Provider/Network service delivery categories in Table XLV.

Through this workgroup, Partnership will engage the impacted stakeholders to understand current state and offering of informative material for both members and providers. This intervention workgroup will also focus on CLAS benefit literacy, educational material, and provider education/communication cadence. Additionally, this workgroup may work with external stakeholders to solicit feedback as we look to refine our communication/education approach while identifying any pertinent causal factors lined to CLAS member dissatisfaction. This intervention also allows internal stakeholders the opportunity to provide direct education and feedback to external stakeholders in an effort to mitigate related grievances in the future.

Measure	Intervention	Goal	Stakeholders
Member Grievances Filed	Internal workgroup to lead intervention efforts centered around CLAS Member Grievances and Provider Education	10% reduction in Member Grievances associated with the *Language Barrier / Limited English Proficiency* filed, using CY2023 Q3/Q4 as the baseline. Results will be assessed no later than July 2025, in which the workgroup will determine the future state of the intervention workgroup and may identify additional areas of opportunity.	Internal: • Member Services • Quality Improvement • Grievance & Appeals • Provider Relations External: • Provider Network • Interpreting Vendor

Partnership will evaluate the effectiveness of the workgroup and its goal of a 10% reduction in Member Grievances associated with the Language Barrier / Limited English Proficiency filed, no later than July 2025. The workgroup will evaluate the effectiveness of the intervention work related to CLAS benefit literacy, educational material, and provider education/communication cadence. This evaluation will determine the future state of the intervention workgroup and may identify additional areas of opportunity.

Furthermore, Partnership's Population Health department will address this goal by addressing the need to provide written materials to members in their choice of format (such as large print, Braille, audio format, or other) to ensure vision-impaired members are able to understand the information Partnership shares. This goal is monitored through the annual C&L Work Plan. This will be done to provide a more proactive approach for language services.

Factor 5: Evaluates the effectiveness of an intervention to reduce an inequity

Partnership has not previously evaluated the effectiveness of an intervention to improve CLAS and reduce inequities in a specific group. Listed below is the plan to evaluate the effectiveness of certain interventions in the future, and these evaluations will be completed by July 2025.

Partnership's Population Health team will evaluate the effectiveness of their hosted events. This will be done through an analysis of the number of members who attended each event, the number of blood pressure cuffs distributed and diabetes checks conducted, the number of members enrolled in Population Health's Healthy Living Tools program, as well as an evaluation of member surveys conducted at these events. Analysis of event impact and member engagement and satisfaction will be used to evaluate if these events should be adapted, spread to additional counties within the network, or abandoned for more impactful events and interactions to address within this population of focus. However, the Population Health team will collaborate with the Health Equity Officer and Quality Improvement Department to identify and implement these activities.

Prenatal and Postpartum Care (PPC):

Partnership will be evaluating the current utilization of the doula benefit, as highlighted in Factor 3. Partnership will also explore additional intervention opportunities to impact the Black population, and will conduct interventions for at least 3 months.

Population	Key Intervention(s)	Effectiveness to Improve Culture and Linguistically Appropriate Services (CLAS)	Effectiveness of Intervention to Reduce Inequities
American Indian/Alaska Native	Tribal Health Liaison Appointment	**Measure (Indirect):** Number of Community Events Attended Number of American Indian/Alaska Native Members Interviewed **Goal:** Engagement with at least 20% of American Indian/Alaska Native attendees **Measure:** Not Collected During Event	**Measure (Direct):** PPC-Pre visit rate in AI/AN community **Preliminary Goal:** 5% Improvement from baseline in 12 months **Global Goal:** Improve prenatal visits by at least 5% in the NE or NW region in the American Indian/Alaska Native Member Population within 12 months with the global goal of improvement by 22% in the next 5 years.

Black/African American	Doula Appointments in Regions	**Measure (Indirect):** Number of Events Attended Number of Black/African American Members engaged during Community Screening Event **Goal:** Engagement with at least 20% of Black/African American attendees **Measure:** Not Collected During Event	**Measure (Direct):** Percentage of Black/African American members with adequately controlled BP (<140/90) during measurement year **Goal:** Improve prenatal visits by at least 5% in the NE or NW region in the Black/African American Member Population within 12 months with the global goal of improvement by 30% in the next 5 years. **Measure:** Not Collected During Event

Factor 6: Evaluates the effectiveness of an intervention to improve CLAS

Partnership has not previously evaluated the effectiveness of an intervention to improve CLAS and reduce inequities in a specific group. Listed below is the plan to evaluate the effectiveness of certain interventions in the future.

Partnership will evaluate the effectiveness of the workgroup and its goal of a 10% reduction in Member Grievances associated with the Language Barrier / Limited English Proficiency filed, no later than July 2025. The workgroup will evaluate the effectiveness of the intervention work related to CLAS benefit literacy, educational material, and provider education/communication cadence. This evaluation will determine the future state of the intervention workgroup and may identify additional areas of opportunity.

Partnership's Population Health team will also evaluate member satisfaction with materials received. Grievances can also be evaluated to see if there is a reduction in grievances received related to format.

Measure	Intervention	Effectiveness to Improve Culture and Linguistically Appropriate Services (CLAS)
Member Grievances Filed	Internal workgroup to lead intervention efforts centered around CLAS Member Grievances and Provider Education	**Goal:** 10% reduction in Member Grievances associated with the Language Barrier / Limited English Proficiency filed, using CY2023 Q3/Q4 as the baseline.

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Appendix

1. *Table II: Controlling High Blood Pressure (CBP) HPA Statistical Significance Results*

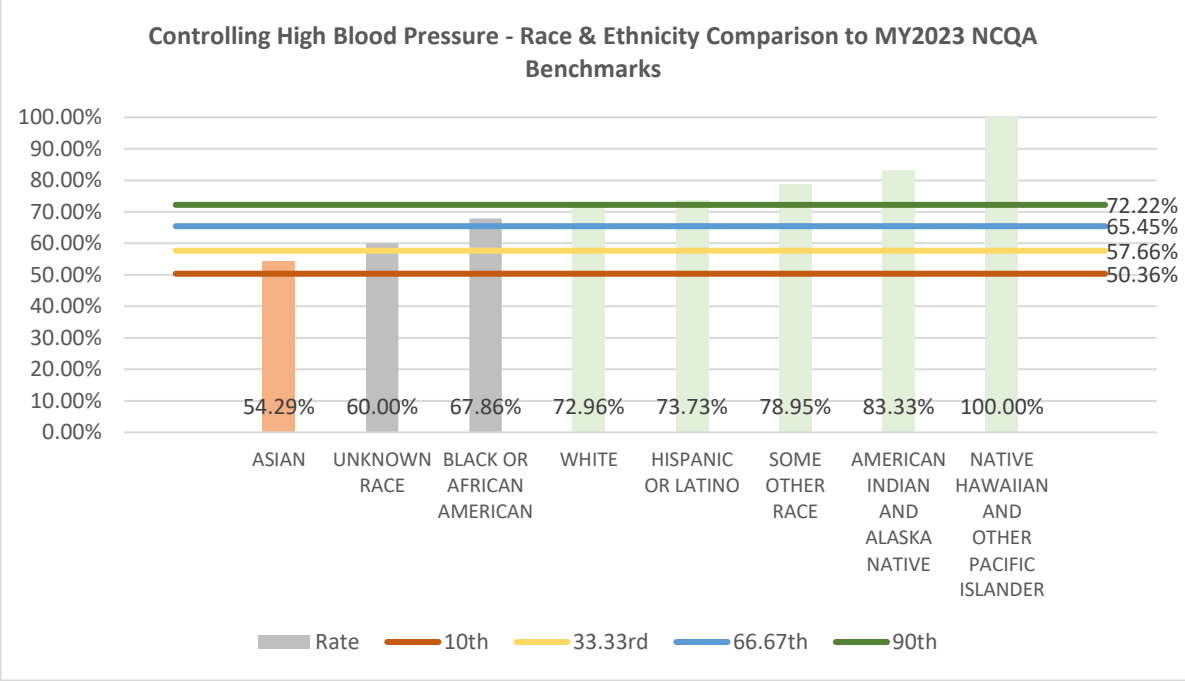
   MY 2023, Run Date: 7/24/2024

   Sample Size: 401

   Contact: Shivani Sivasankar, Sr. Health Data Analyst II

Race	Numerator	Denominator	Rate	Interpretation
WHITE	116	159	73%	Reference
HISPANIC OR LATINO	87	118	74%	There is no statistically significant difference in rates between the WHITE population, (72.93%), and the `HISPANIC OR LATINO` population, (Rate =73.70%, Chi-Square=0.021, p=.8857)
AMERICAN INDIAN AND ALASKA NATIVE	5	6	83%	There is no statistically significant difference in rates between the WHITE population, (72.93%), and the `AMERICAN INDIAN AND ALASKA NATIVE` population, (Rate =83.38%, Chi-Square=0.342, p=1.000)
ASIAN	19	35	54%	The WHITE population had a statistically significantly higher rate, (72.93%), compared to the `ASIAN` population, (Rate =54.34%, Chi-Square=4.725, p=.0297)
BLACK OR AFRICAN AMERICAN	19	28	68%	There is no statistically significant difference in rates between the WHITE population, (72.93%), and the `BLACK OR AFRICAN AMERICAN` population, (Rate =67.87%, Chi-Square=0.308, p=.5787)
NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER	1	1	100%	There is no statistically significant difference in rates between the WHITE population, (72.93%), and the `NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER` population, (Rate =99.99%, Chi-Square=0.731, p=1.000)
SOME OTHER RACE	15	19	79%	There is no statistically significant difference in rates between the WHITE population, (72.93%), and the `SOME OTHER RACE` population, (Rate =78.98%, Chi-Square=0.314, p=.5755)

2. *Graph I*



Note: Bars highlighted orange indicate a group had lowest percentile performance of all groups included in measure sample, and were only group to fall into the percentile. Bars highlighted green indicate groups performed above the 90th percentile.

Partnership only found a statistically significant difference in compliance when comparing the Asian group to the White group while using the NCQA Health Plan Accreditation generated sample for Controlling High Blood Pressure (CBP) (n=401) (Table II). Furthermore, after reviewing stratified data in comparison to the National All Lines of Business benchmarks, the Asian population had a numerically lower rate for CBP and was the only racial group that scored below the 33.33rd percentile for the measure. All of the other groups were able to achieve at least the 33.33rd percentile defined by the National Medicaid benchmarks (Graph I).

3. *Table III: Controlling High Blood Pressure (CBP) MCAS Statistical Significance Results*

   MY 2023, Run Date: 7/24/2024

   Sample Size: 1,395

   Contact: Shivani Sivasankar, Sr. Health Data Analyst II

Northeast

Race	Numerator	Denominator	Rate	Interpretation
WHITE	172	274	63%	
HISPANIC OR LATINO	24	42	57%	There is no statistically significant difference in rates between the WHITE population, (62.81%), and the `HISPANIC OR LATINO` population, (Rate =57.09%, Chi-Square=0.490, p=.4838)
AMERICAN INDIAN AND ALASKA NATIVE	6	9	67%	There is no statistically significant difference in rates between the WHITE population, (62.81%), and the `AMERICAN INDIAN AND ALASKA NATIVE` population, (Rate =66.66%, Chi-Square=0.057, p=.8120)
ASIAN	9	16	56%	There is no statistically significant difference in rates between the WHITE population, (62.81%), and the `ASIAN` population, (Rate =56.21%, Chi-Square=0.274, p=.6005)
BLACK OR AFRICAN AMERICAN	7	9	78%	There is no statistically significant difference in rates between the WHITE population, (62.81%), and the `BLACK OR AFRICAN AMERICAN` population, (Rate =77.77%, Chi-Square=0.197, p=.4932)
NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER	0	1	%	There is no statistically significant difference in rates between the WHITE population, (62.81%), and the `NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER` population, (Rate =0.000%, Chi-Square=0.375, p=.3745)
SOME OTHER RACE	1	2	50%	There is no statistically significant difference in rates between the WHITE population, (62.81%), and the `SOME OTHER RACE` population, (Rate =50.05%, Chi-Square=0.470, p=1.000)

Northwest

Race	Numerator	Denominator	Rate	Interpretation
WHITE	155	261	59%	
HISPANIC OR LATINO	31	45	69%	There is no statistically significant difference in rates between the WHITE population, (59.40%), and the `HISPANIC OR LATINO` population, (Rate =68.86%, Chi-Square=1.454, p=.2279)
AMERICAN INDIAN AND ALASKA NATIVE	11	16	69%	There is no statistically significant difference in rates between the WHITE population, (59.40%), and the `AMERICAN INDIAN AND ALASKA NATIVE` population, (Rate =68.75%, Chi-Square=0.550, p=.4582)
ASIAN	11	17	65%	There is no statistically significant difference in rates between the WHITE population, (59.40%), and the `ASIAN` population, (Rate =64.68%, Chi-Square=0.188, p=.6648)

BLACK OR AFRICAN AMERICAN	9	13	69%	There is no statistically significant difference in rates between the WHITE population, (59.40%), and the `BLACK OR AFRICAN AMERICAN` population, (Rate =69.19%, Chi-Square=0.499, p=.4798)
NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER	1	1	100%	There is no statistically significant difference in rates between the WHITE population, (59.40%), and the `NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER` population, (Rate =99.99%, Chi-Square=0.595, p=1.000)
SOME OTHER RACE	2	4	50%	There is no statistically significant difference in rates between the WHITE population, (59.40%), and the `SOME OTHER RACE` population, (Rate =50.05%, Chi-Square=0.352, p=1.000)

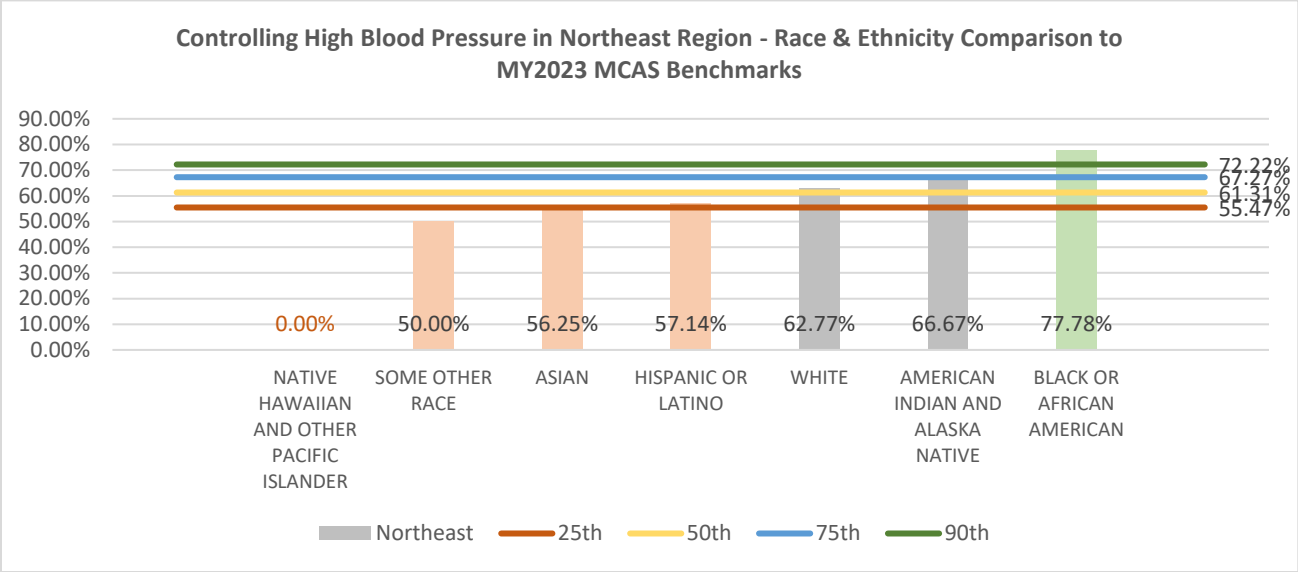
Southeast

Race	Numerator	Denominator	Rate	Interpretation
WHITE	57	88	65%	
HISPANIC OR LATINO	84	130	65%	There is no statistically significant difference in rates between the WHITE population, (64.79%), and the `HISPANIC OR LATINO` population, (Rate =64.57%, Chi-Square=0.001, p=.9810)
AMERICAN INDIAN AND ALASKA NATIVE	0	1	%	There is no statistically significant difference in rates between the WHITE population, (64.79%), and the `AMERICAN INDIAN AND ALASKA NATIVE` population, (Rate =0.000%, Chi-Square=1.801, p=.1795)
ASIAN	45	75	60%	There is no statistically significant difference in rates between the WHITE population, (64.79%), and the `ASIAN` population, (Rate =59.95%, Chi-Square=0.394, p=.5303)
BLACK OR AFRICAN AMERICAN	26	40	65%	There is no statistically significant difference in rates between the WHITE population, (64.79%), and the `BLACK OR AFRICAN AMERICAN` population, (Rate =65.01%, Chi-Square=0.001, p=.9801)
NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER	1	1	100%	There is no statistically significant difference in rates between the WHITE population, (64.79%), and the `NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER` population, (Rate =99.99%, Chi-Square=0.652, p=1.000)
SOME OTHER RACE	6	9	67%	There is no statistically significant difference in rates between the WHITE population, (64.79%), and the `SOME OTHER RACE` population, (Rate =66.66%, Chi-Square=0.285, p=1.000)

Southwest

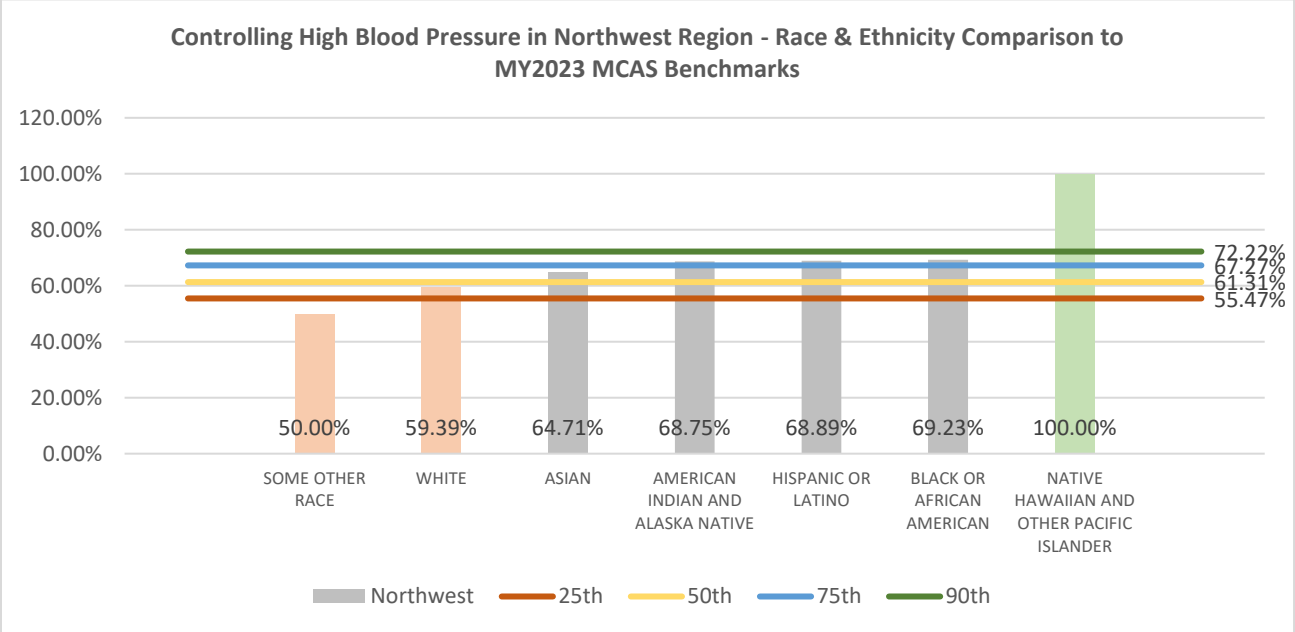
Race	Numerator	Denominator	Rate	Interpretation
WHITE	98	148	66%	
HISPANIC OR LATINO	90	135	67%	There is no statistically significant difference in rates between the WHITE population, (66.22%), and the `HISPANIC OR LATINO` population, (Rate =66.66%, Chi-Square=0.006, p=.9361)
AMERICAN INDIAN AND ALASKA NATIVE	1	2	50%	There is no statistically significant difference in rates between the WHITE population, (66.22%), and the `AMERICAN INDIAN AND ALASKA NATIVE` population, (Rate =50.05%, Chi-Square=0.231, p=.6306)
ASIAN	10	14	71%	There is no statistically significant difference in rates between the WHITE population, (66.22%), and the `ASIAN` population, (Rate =71.39%, Chi-Square=0.222, p=.7758)
BLACK OR AFRICAN AMERICAN	5	8	62%	There is no statistically significant difference in rates between the WHITE population, (66.22%), and the `BLACK OR AFRICAN AMERICAN` population, (Rate =62.48%, Chi-Square=0.283, p=1.000)
SOME OTHER RACE	18	34	53%	There is no statistically significant difference in rates between the WHITE population, (66.22%), and the `SOME OTHER RACE` population, (Rate =52.91%, Chi-Square=2.108, p=.1465)

4. *Graph II*



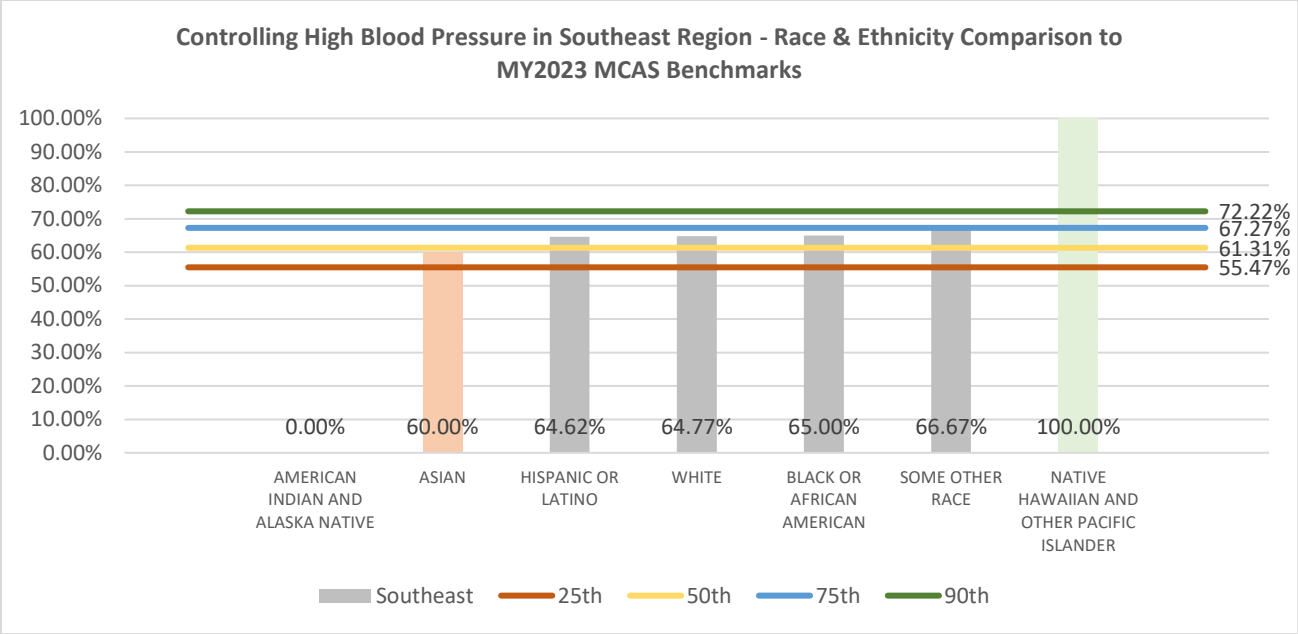
Note: Bars highlighted orange indicate group performed below the MPL (50th percentile). Bars highlighted green indicate groups performed above the 90th percentile.

5. *Graph III*



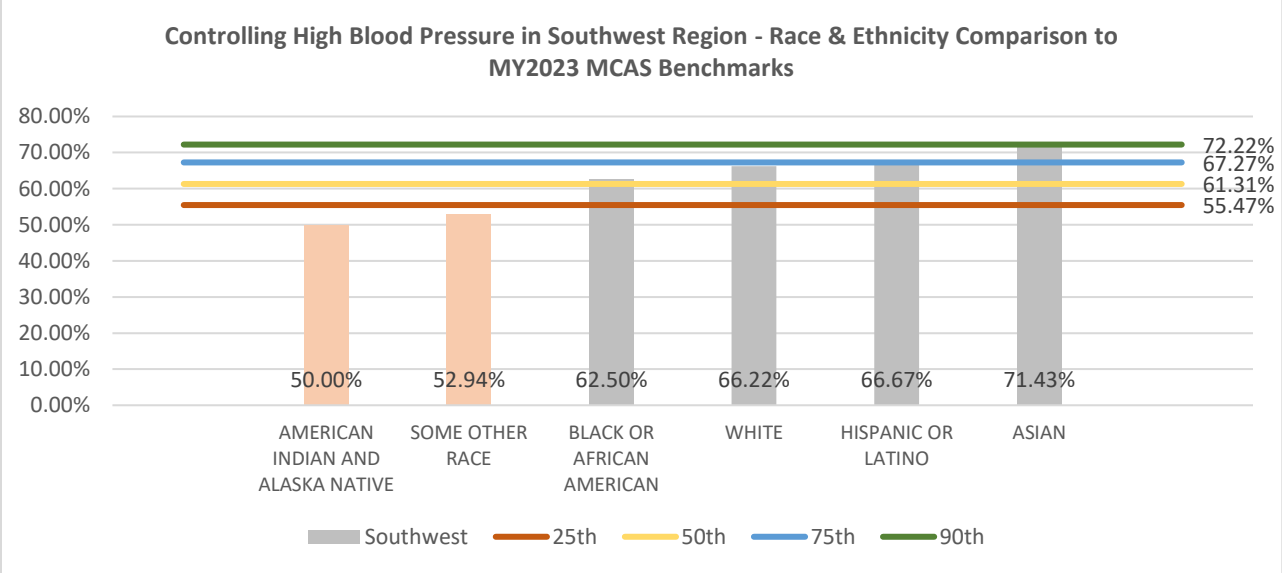
Note: Bars highlighted orange indicate group performed below the MPL (50th percentile). Bars highlighted green indicate groups performed above the 90th percentile.

6. *Graph IV*



Note: Bars highlighted orange indicate group performed below the MPL (50th percentile). Bars highlighted green indicate groups performed above the 90th percentile.

7. *Graph V*



Note: Bars highlighted orange indicate group performed below the MPL (50th percentile). Bars highlighted green indicate groups performed above the 90th percentile.

8. *Table IV: Hemoglobin A1c Control for Patients with Diabetes (HBD) HbA1c Poor Control (>9.0%) HPA Statistical Significance Results*

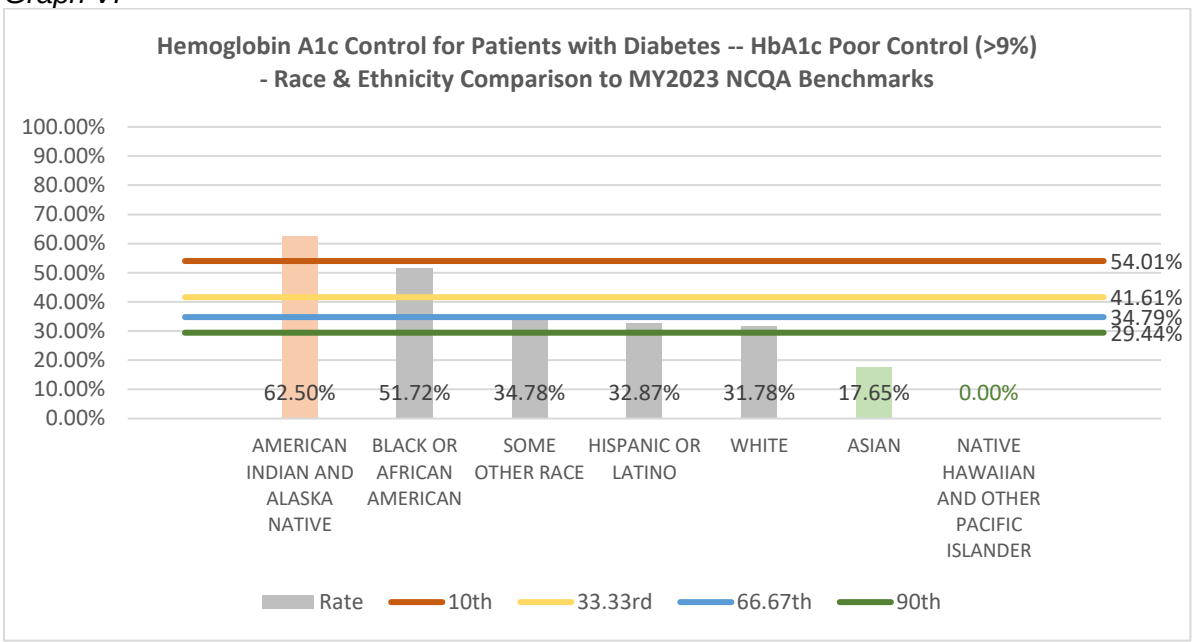
MY 2023, Run Date: 7/24/2024

Sample Size: 405

Contact: Shivani Sivasankar, Sr. Health Data Analyst II

Race	Numerator	Denominator	Rate	Interpretation
WHITE	41	129	32%	Reference
HISPANIC OR LATINO	47	143	33%	There is no statistically significant difference in rates between the WHITE population, (31.79%), and the `HISPANIC OR LATINO` population, (Rate =32.89%, Chi-Square=0.036, p=.8486)
AMERICAN INDIAN AND ALASKA NATIVE	5	8	62%	There is no statistically significant difference in rates between the WHITE population, (31.79%), and the `AMERICAN INDIAN AND ALASKA NATIVE` population, (Rate =62.48%, Chi-Square=0.067, p=.1180)
ASIAN	6	34	18%	There is no statistically significant difference in rates between the WHITE population, (31.79%), and the `ASIAN` population, (Rate =17.60%, Chi-Square=2.620, p=.1055)
BLACK OR AFRICAN AMERICAN	15	29	52%	The WHITE population had a statistically significantly lower rate, (31.79%), compared to the `BLACK OR AFRICAN AMERICAN` population, (Rate =51.70%, Chi-Square=4.115, p=.0425)
NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER	0	2	%	There is no statistically significant difference in rates between the WHITE population, (31.79%), and the `NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER` population, (Rate =0.000%, Chi-Square=0.470, p=1.000)
SOME OTHER RACE	8	23	35%	There is no statistically significant difference in rates between the WHITE population, (31.79%), and the `SOME OTHER RACE` population, (Rate =34.76%, Chi-Square=0.080, p=.7768)

9. *Graph VI*



Note: Bars highlighted orange indicate a group had lowest percentile performance of all groups included in measure sample, and were only group to fall into the percentile. Bars highlighted green indicate groups performed above the 90th percentile.

The Native Hawaiian and Other Pacific Islander group had the lowest rate of HbA1c Poor Control, however the sample size (n=2) was too small for their performance to be

considered statistically significant using Fishers Exact. Therefore, the Asian population was the next group with a lower rate of HbA1c Poor Control (suggesting high rate of good control) when compared to the White population per the NCQA Health Plan Accreditation associated sample (n=405) (Table IV). The White population had a higher rate of poor control when compared to the Asian population, but the American Indian and Alaska Native population was the worst performing group. Specifically, the rate of poor control was 30% higher in the American Indian or Alaska Native population when compared to the White population, however, the sample size (n=8) was too small for their performance to be considered statistically significant. The only group with a statistically significant difference in compliance in comparison to the White group was the Black or African American group, with a rate of 51.72%. The Hispanic or Latino, White, and 'Some Other Race' groups performed above the 66.67th, While the Black or African American population performed at the 10th, and the American Indian and Alaska Native population performed below the 10th.

10. *Table V: Hemoglobin A1c Control for Patients with Diabetes (HBD) HbA1c Poor Control (>9.0%)MCAS Statistical Significance Results*

    MY 2023, Run Date: 7/24/2024

    Sample Size: 1,352

    Contact: Shivani Sivasankar, Sr. Health Data Analyst II

Northeast

Race	Numerator	Denominator	Rate	Interpretation
WHITE	94	238	39%	
HISPANIC OR LATINO	21	55	38%	There is no statistically significant difference in rates between the WHITE population, (39.49%), and the `HISPANIC OR LATINO` population, (Rate =38.17%, Chi-Square=0.032, p=.8573)
AMERICAN INDIAN AND ALASKA NATIVE	6	20	30%	There is no statistically significant difference in rates between the WHITE population, (39.49%), and the `AMERICAN INDIAN AND ALASKA NATIVE` population, (Rate =30.03%, Chi-Square=0.701, p=.4025)
ASIAN	7	19	37%	There is no statistically significant difference in rates between the WHITE population, (39.49%), and the `ASIAN` population, (Rate =36.85%, Chi-Square=0.052, p=.8197)
BLACK OR AFRICAN AMERICAN	4	13	31%	There is no statistically significant difference in rates between the WHITE population, (39.49%), and the `BLACK OR AFRICAN AMERICAN` population, (Rate =30.80%, Chi-Square=0.394, p=.5300)
NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER	0	1	%	There is no statistically significant difference in rates between the WHITE population, (39.49%), and the `NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER` population, (Rate =0.000%, Chi-Square=0.607, p=1.000)
SOME OTHER RACE	0	4	%	There is no statistically significant difference in rates between the WHITE population, (39.49%), and the `SOME OTHER RACE` population, (Rate =0.000%, Chi-Square=0.138, p=.1596)

Northwest

Race	Numerator	Denominator	Rate	Interpretation
WHITE	58	198	29%	
HISPANIC OR LATINO	22	60	37%	There is no statistically significant difference in rates between the WHITE population, (29.26%), and the `HISPANIC OR LATINO` population, (Rate =36.63%, Chi-Square=1.170, p=.2793)
AMERICAN INDIAN AND ALASKA NATIVE	20	46	43%	There is no statistically significant difference in rates between the WHITE population, (29.26%), and the `AMERICAN INDIAN AND ALASKA NATIVE` population, (Rate =43.45%, Chi-Square=3.454, p=.0631)

ASIAN	4	17	24%	There is no statistically significant difference in rates between the WHITE population, (29.26%), and the `ASIAN` population, (Rate =23.54%, Chi-Square=0.203, p=.7831)
BLACK OR AFRICAN AMERICAN	5	9	56%	There is no statistically significant difference in rates between the WHITE population, (29.26%), and the `BLACK OR AFRICAN AMERICAN` population, (Rate =55.55%, Chi-Square=0.075, p=.1346)
NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER	1	1	100%	There is no statistically significant difference in rates between the WHITE population, (29.26%), and the `NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER` population, (Rate =99.99%, Chi-Square=0.297, p=.2965)
SOME OTHER RACE	2	4	50%	There is no statistically significant difference in rates between the WHITE population, (29.26%), and the `SOME OTHER RACE` population, (Rate =50.05%, Chi-Square=0.263, p=.5837)

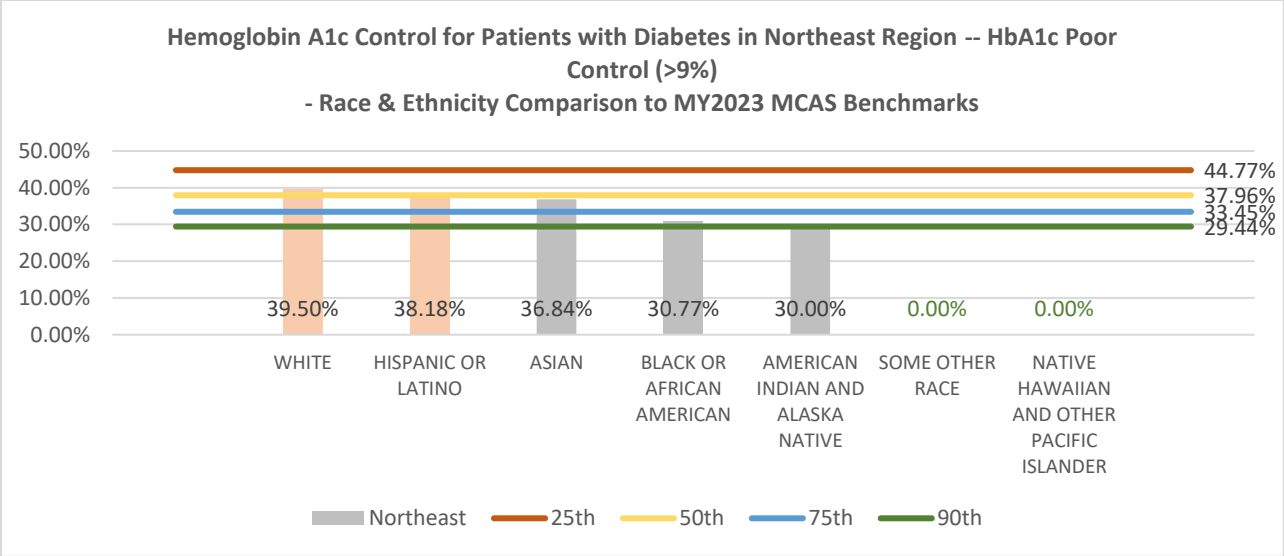
Southeast

Race	Numerator	Denominator	Rate	Interpretation
WHITE	23	69	33%	
HISPANIC OR LATINO	46	155	30%	There is no statistically significant difference in rates between the WHITE population, (33.33%), and the `HISPANIC OR LATINO` population, (Rate =29.70%, Chi-Square=0.299, p=.5843)
AMERICAN INDIAN AND ALASKA NATIVE	1	1	100%	There is no statistically significant difference in rates between the WHITE population, (33.33%), and the `AMERICAN INDIAN AND ALASKA NATIVE` population, (Rate =99.99%, Chi-Square=1.944, p=.1632)
ASIAN	11	62	18%	The WHITE population had a statistically significantly higher rate, (33.33%), compared to the `ASIAN` population, (Rate =17.71%, Chi-Square=4.131, p=.0421)
BLACK OR AFRICAN AMERICAN	14	32	44%	There is no statistically significant difference in rates between the WHITE population, (33.33%), and the `BLACK OR AFRICAN AMERICAN` population, (Rate =43.78%, Chi-Square=1.022, p=.3121)
NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER	1	1	100%	There is no statistically significant difference in rates between the WHITE population, (33.33%), and the `NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER` population, (Rate =99.99%, Chi-Square=0.343, p=.3429)
SOME OTHER RACE	6	16	38%	There is no statistically significant difference in rates between the WHITE population, (33.33%), and the `SOME OTHER RACE` population, (Rate =37.51%, Chi-Square=0.100, p=.7514)

Southwest

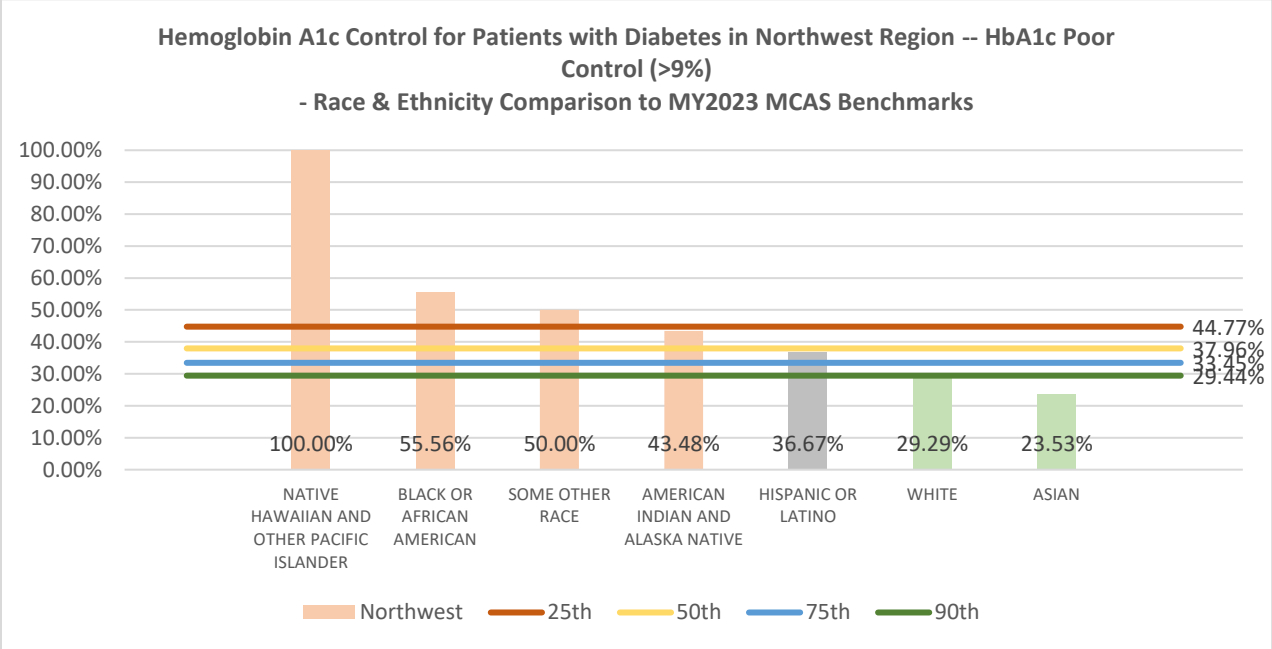
Race	Numerator	Denominator	Rate	Interpretation
WHITE	34	98	35%	
HISPANIC OR LATINO	49	166	29%	There is no statistically significant difference in rates between the WHITE population, (34.65%), and the `HISPANIC OR LATINO` population, (Rate =29.48%, Chi-Square=0.766, p=.3815)
AMERICAN INDIAN AND ALASKA NATIVE	7	10	70%	The WHITE population had a statistically significantly lower rate, (34.65%), compared to the `AMERICAN INDIAN AND ALASKA NATIVE` population, (Rate =69.96%, Chi-Square=4.803, p=.0284)
ASIAN	1	8	13%	There is no statistically significant difference in rates between the WHITE population, (34.65%), and the `ASIAN` population, (Rate =12.54%, Chi-Square=0.154, p=.2662)
BLACK OR AFRICAN AMERICAN	3	11	27%	There is no statistically significant difference in rates between the WHITE population, (34.65%), and the `BLACK OR AFRICAN AMERICAN` population, (Rate =27.28%, Chi-Square=0.242, p=.7464)
NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER	0	1	%	There is no statistically significant difference in rates between the WHITE population, (34.65%), and the `NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER` population, (Rate =0.000%, Chi-Square=0.657, p=1.000)
SOME OTHER RACE	13	37	35%	There is no statistically significant difference in rates between the WHITE population, (34.65%), and the `SOME OTHER RACE` population, (Rate =35.09%, Chi-Square=0.002, p=.9617)

11. *Graph VII*



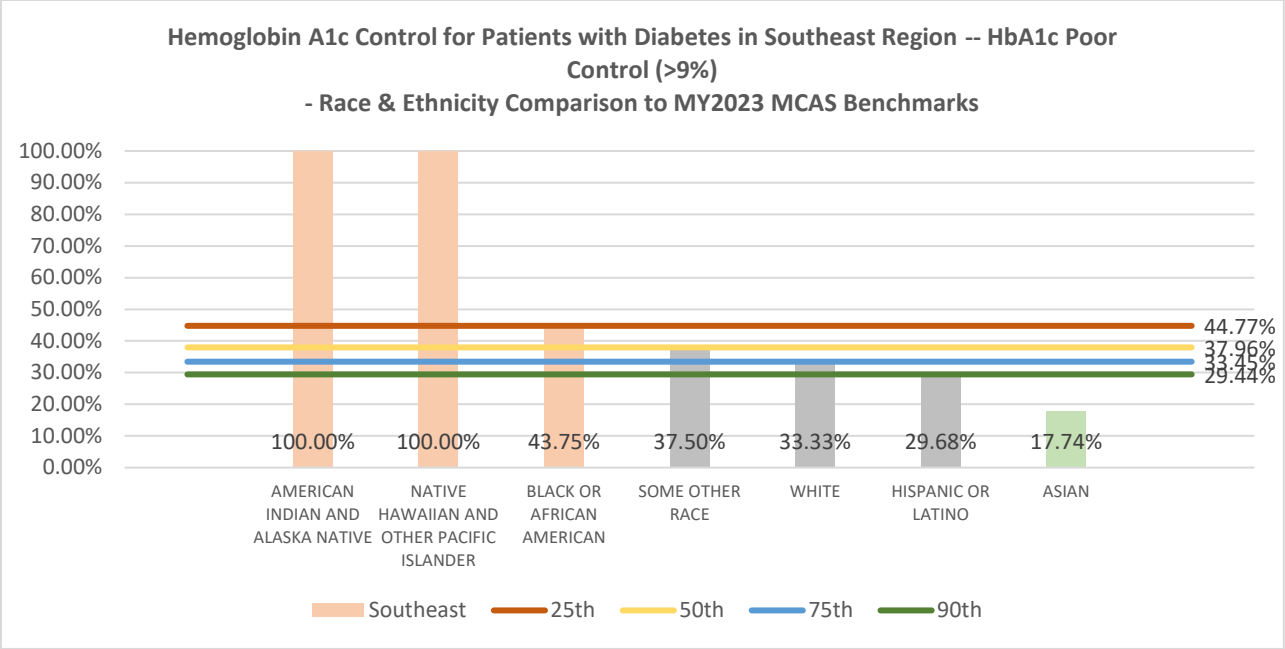
Note: Bars highlighted orange indicate group performed below the MPL (50th percentile). Bars highlighted green indicate groups performed above the 90th percentile.

12. *Graph VIII*



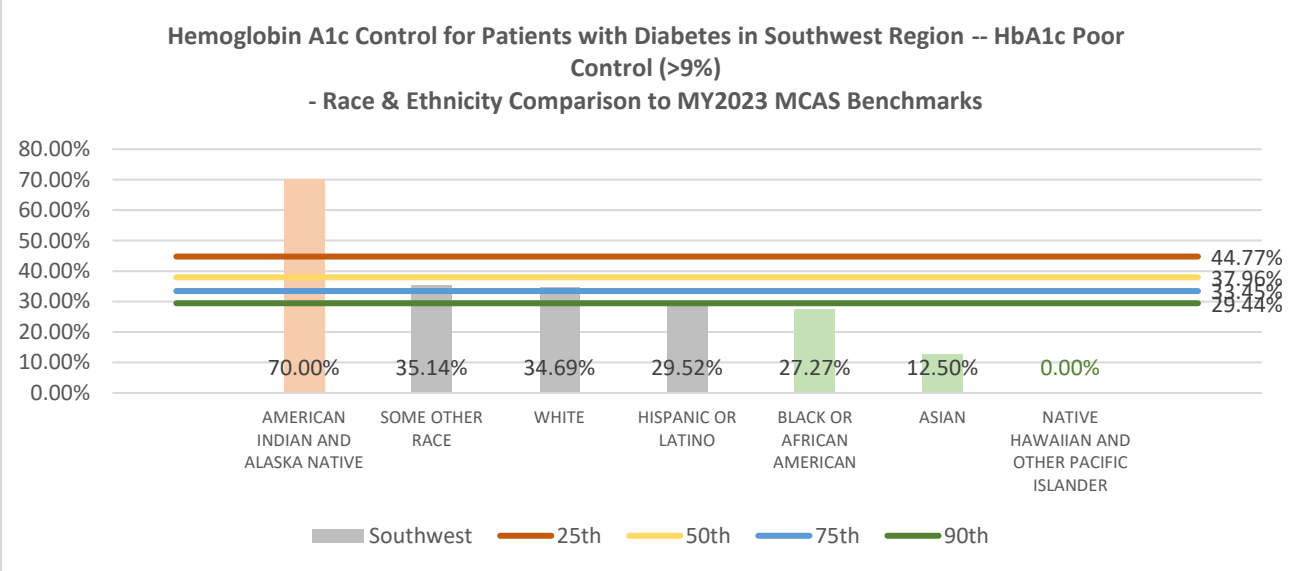
Note: Bars highlighted orange indicate group performed below the MPL (50th percentile). Bars highlighted green indicate groups performed above the 90th percentile.

13. *Graph IX*



Note: Bars highlighted orange indicate group performed below the MPL (50th percentile). Bars highlighted green indicate groups performed above the 90th percentile.

14. *Graph X*



Note: Bars highlighted orange indicate group performed below the MPL (50th percentile). Bars highlighted green indicate groups performed above the 90th percentile.

15. *Table VI: Timeliness of Prenatal Care (PPC – Pre) HPA Statistical Significance Results*

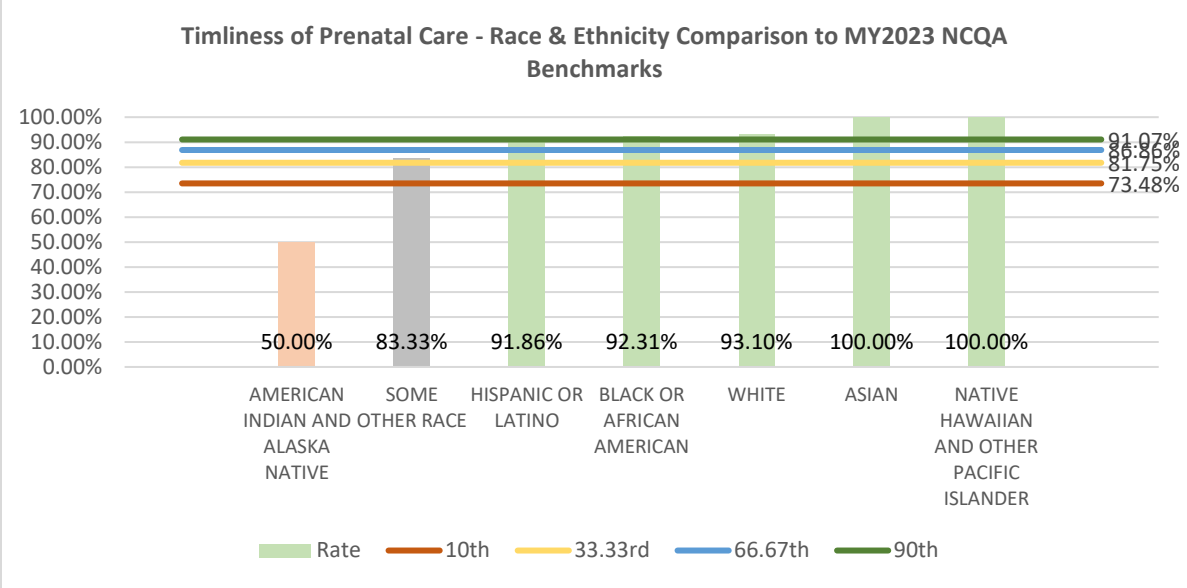
MY 2023, Run Date: 7/24/2024

Sample Size: 186

Contact: Shivani Sivasankar, Sr. Health Data Analyst II

Race	Numerator	Denominator	Rate	Interpretation
WHITE	54	58	93%	Reference
HISPANIC OR LATINO	79	86	92%	There is no statistically significant difference in rates between the WHITE population, (93.06%), and the `HISPANIC OR LATINO` population, (Rate =91.85%, Chi-Square=0.244, p=1.000)
AMERICAN INDIAN AND ALASKA NATIVE	4	8	50%	The WHITE population had a statistically significantly higher rate, (93.06%), compared to the `AMERICAN INDIAN AND ALASKA NATIVE` population, (Rate =50.05%, Chi-Square=0.005, p=.0055)
ASIAN	8	8	100%	There is no statistically significant difference in rates between the WHITE population, (93.06%), and the `ASIAN` population, (Rate =99.99%, Chi-Square=0.589, p=1.000)
BLACK OR AFRICAN AMERICAN	12	13	92%	There is no statistically significant difference in rates between the WHITE population, (93.06%), and the `BLACK OR AFRICAN AMERICAN` population, (Rate =92.29%, Chi-Square=0.424, p=1.000)
NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER	1	1	100%	There is no statistically significant difference in rates between the WHITE population, (93.06%), and the `NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER` population, (Rate =99.99%, Chi-Square=0.932, p=1.000)
SOME OTHER RACE	10	12	83%	There is no statistically significant difference in rates between the WHITE population, (93.06%), and the `SOME OTHER RACE` population, (Rate =83.38%, Chi-Square=0.214, p=.2719)

16. *Graph XI*



Note: Bars highlighted orange indicate a group had lowest percentile performance of all groups included in measure sample, and were only group to fall into the percentile. Bars highlighted green indicate groups performed above the 90th percentile.

Partnership found the American Indian and Alaska Native group performed significantly worse when compared to the White group in PPC – Pre rates per the Health Plan Accreditation Timeliness of Prenatal Care sample (n=207) (Table VI). When comparing each group's performance to the NCQA benchmarks (Graph XI), all groups achieved at least the 33.33rd percentile or greater, except the American Indian and Alaska Native population (n=8). The Native Hawaiian and Other Pacific Islander and Asian populations had the highest rates, surpassing the 90th percentile with 100% compliance, indicating all members

included in the Health Plan Accreditation sample for this measure within these groups successfully completed a timely prenatal care visit during the measurement year.

17. *Table VII: Timeliness of Prenatal Care (PPC – Pre) MCAS Statistical Significance Results*

MY 2023, Run Date: 7/24/2024

Sample Size: 812

Contact: Shivani Sivasankar, Sr. Health Data Analyst II

Northeast

Race	Numerator	Denominator	Rate	Interpretation
WHITE	157	182	86%	
HISPANIC OR LATINO	49	58	84%	There is no statistically significant difference in rates between the WHITE population, (86.24%), and the `HISPANIC OR LATINO` population, (Rate =84.48%, Chi-Square=0.115, p=.7348)
AMERICAN INDIAN AND ALASKA NATIVE	6	8	75%	There is no statistically significant difference in rates between the WHITE population, (86.24%), and the `AMERICAN INDIAN AND ALASKA NATIVE` population, (Rate =75.02%, Chi-Square=0.797, p=.3718)
ASIAN	7	9	78%	There is no statistically significant difference in rates between the WHITE population, (86.24%), and the `ASIAN` population, (Rate =77.77%, Chi-Square=0.254, p=.6173)
BLACK OR AFRICAN AMERICAN	3	4	75%	There is no statistically significant difference in rates between the WHITE population, (86.24%), and the `BLACK OR AFRICAN AMERICAN` population, (Rate =75.02%, Chi-Square=0.361, p=.4553)
SOME OTHER RACE	4	5	80%	There is no statistically significant difference in rates between the WHITE population, (86.24%), and the `SOME OTHER RACE` population, (Rate =79.97%, Chi-Square=0.388, p=.5311)

Northwest

Race	Numerator	Denominator	Rate	Interpretation
WHITE	92	115	80%	
HISPANIC OR LATINO	41	47	87%	There is no statistically significant difference in rates between the WHITE population, (79.97%), and the `HISPANIC OR LATINO` population, (Rate =87.23%, Chi-Square=1.188, p=.2757)
AMERICAN INDIAN AND ALASKA NATIVE	15	24	62%	There is no statistically significant difference in rates between the WHITE population, (79.97%), and the `AMERICAN INDIAN AND ALASKA NATIVE` population, (Rate =62.48%, Chi-Square=3.431, p=.0640)
ASIAN	6	7	86%	There is no statistically significant difference in rates between the WHITE population, (79.97%), and the `ASIAN` population, (Rate =85.69%, Chi-Square=0.377, p=1.000)
BLACK OR AFRICAN AMERICAN	1	3	33%	There is no statistically significant difference in rates between the WHITE population, (79.97%), and the `BLACK OR AFRICAN AMERICAN` population, (Rate =33.33%, Chi-Square=0.105, p=.1131)
NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER	1	1	100%	There is no statistically significant difference in rates between the WHITE population, (79.97%), and the `NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER` population, (Rate =99.99%, Chi-Square=0.802, p=1.000)
SOME OTHER RACE	3	4	75%	There is no statistically significant difference in rates between the WHITE population, (79.97%), and the `SOME OTHER RACE` population, (Rate =75.02%, Chi-Square=0.418, p=1.000)

Southeast

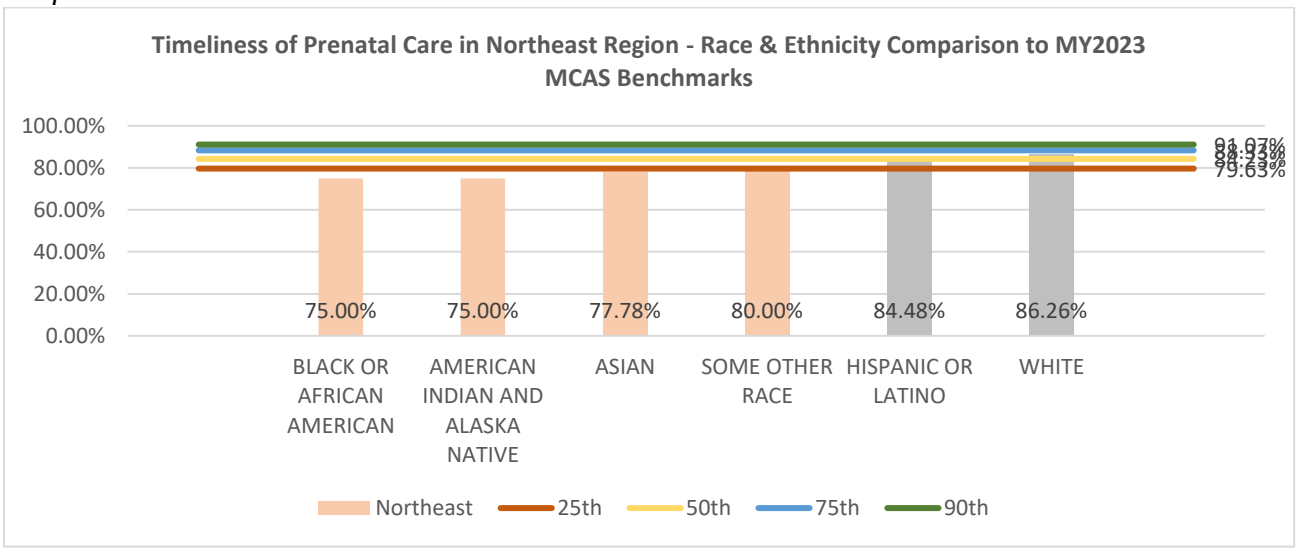
Race	Numerator	Denominator	Rate	Interpretation
WHITE	31	36	86%	

HISPANIC OR LATINO	110	123	89%	There is no statistically significant difference in rates between the WHITE population, (86.13%), and the `HISPANIC OR LATINO` population, (Rate =89.43%, Chi-Square=0.191, p=.5591)
ASIAN	16	16	100%	There is no statistically significant difference in rates between the WHITE population, (86.13%), and the `ASIAN` population, (Rate =99.99%, Chi-Square=0.145, p=.3077)
BLACK OR AFRICAN AMERICAN	22	25	88%	There is no statistically significant difference in rates between the WHITE population, (86.13%), and the `BLACK OR AFRICAN AMERICAN` population, (Rate =88.00%, Chi-Square=0.294, p=1.000)
NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER	0	1	%	There is no statistically significant difference in rates between the WHITE population, (86.13%), and the `NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER` population, (Rate =0.000%, Chi-Square=0.162, p=.1622)
SOME OTHER RACE	11	13	85%	There is no statistically significant difference in rates between the WHITE population, (86.13%), and the `SOME OTHER RACE` population, (Rate =84.59%, Chi-Square=0.342, p=1.000)

Southwest

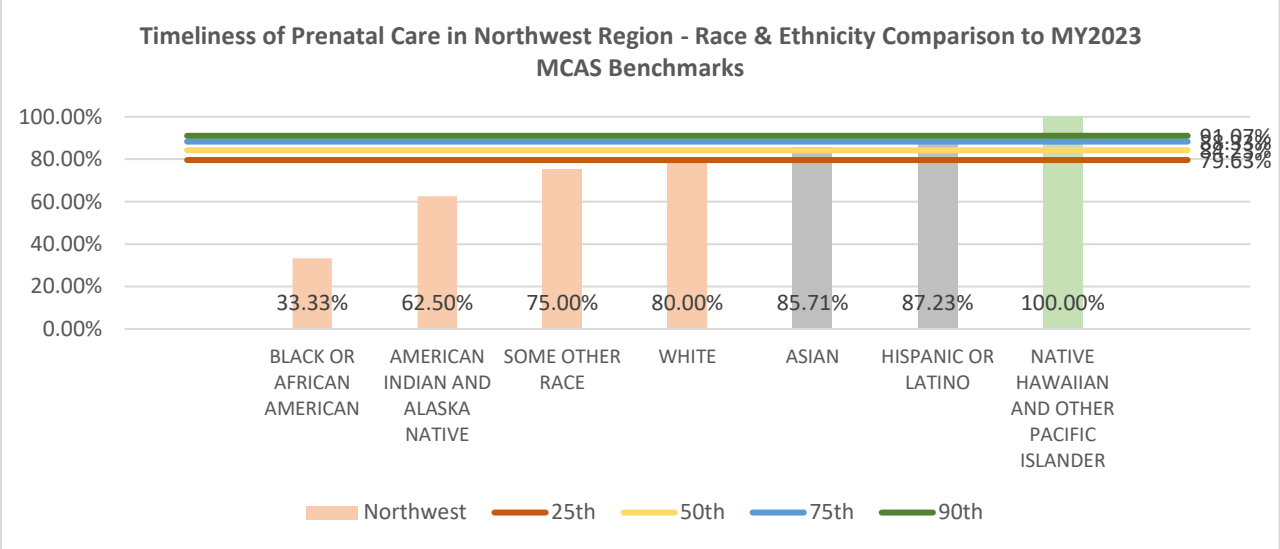
Race	Numerator	Denominator	Rate	Interpretation
WHITE	26	29	90%	
HISPANIC OR LATINO	76	80	95%	There is no statistically significant difference in rates between the WHITE population, (89.65%), and the `HISPANIC OR LATINO` population, (Rate =95.04%, Chi-Square=0.194, p=.3800)
AMERICAN INDIAN AND ALASKA NATIVE	2	4	50%	The WHITE population had a statistically significantly higher rate, (89.65%), compared to the `AMERICAN INDIAN AND ALASKA NATIVE` population, (Rate =50.05%, Chi-Square=4.300, p=.0381)
ASIAN	4	4	100%	There is no statistically significant difference in rates between the WHITE population, (89.65%), and the `ASIAN` population, (Rate =99.99%, Chi-Square=0.670, p=1.000)
BLACK OR AFRICAN AMERICAN	3	3	100%	There is no statistically significant difference in rates between the WHITE population, (89.65%), and the `BLACK OR AFRICAN AMERICAN` population, (Rate =99.99%, Chi-Square=0.737, p=1.000)
SOME OTHER RACE	11	11	100%	There is no statistically significant difference in rates between the WHITE population, (89.65%), and the `SOME OTHER RACE` population, (Rate =99.99%, Chi-Square=0.370, p=.5480)

18. *Graph XII*



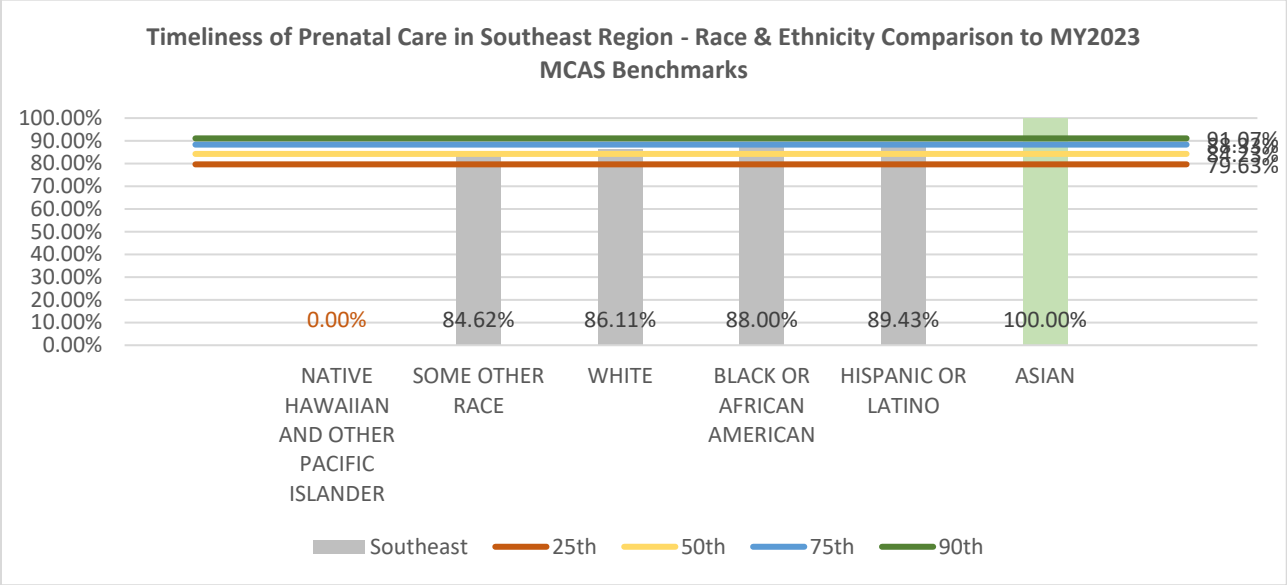
Note: Bars highlighted orange indicate group performed below the MPL (50th percentile). Bars highlighted green indicate groups performed above the 90th percentile.

19. *Graph XIII*



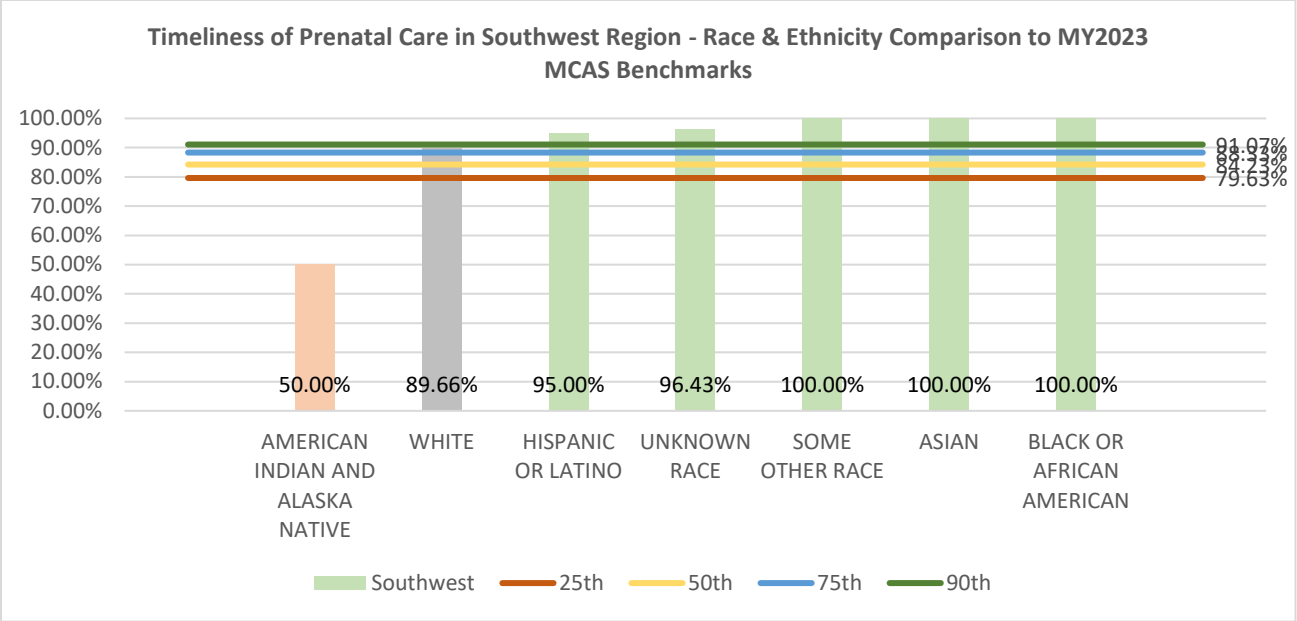
Note: Bars highlighted orange indicate group performed below the MPL (50th percentile). Bars highlighted green indicate groups performed above the 90th percentile.

20. *Graph XIV*



Note: Bars highlighted orange indicate group performed below the MPL (50th percentile). Bars highlighted green indicate groups performed above the 90th percentile.

21. *Graph XV*



Note: Bars highlighted orange indicate group performed below the MPL (50th percentile). Bars highlighted green indicate groups performed above the 90th percentile.

22. *Table VII: Postpartum Care (PPC – Post) HPA Statistical Significance Results*

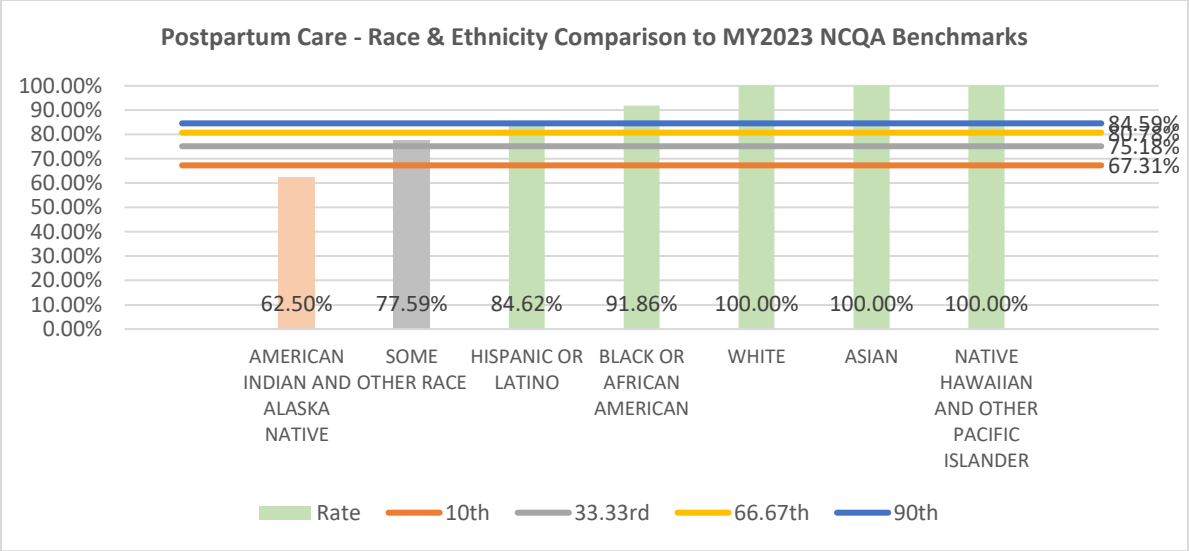
MY 2023, Run Date: 7/24/2024

Sample Size: 186

Contact: Shivani Sivasankar, Sr. Health Data Analyst II

Race	Numerator	Denominator	Rate	Interpretation
WHITE	45	58	78%	Reference
HISPANIC OR LATINO	79	86	92%	The WHITE population had a statistically significantly lower rate, (77.55%), compared to the `HISPANIC OR LATINO` population, (Rate =91.85%, Chi-Square=5.901, p=.0151)
AMERICAN INDIAN AND ALASKA NATIVE	5	8	62%	There is no statistically significant difference in rates between the WHITE population, (77.55%), and the `AMERICAN INDIAN AND ALASKA NATIVE` population, (Rate =62.48%, Chi-Square=0.207,p=.3897)
ASIAN	8	8	100%	There is no statistically significant difference in rates between the WHITE population, (77.55%), and the `ASIAN` population, (Rate =99.99%, Chi-Square=0.154, p=.3393)
BLACK OR AFRICAN AMERICAN	11	13	85%	There is no statistically significant difference in rates between the WHITE population, (77.55%), and the `BLACK OR AFRICAN AMERICAN` population, (Rate =84.59%, Chi-Square=0.269, p=.7212)
NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER	1	1	100%	There is no statistically significant difference in rates between the WHITE population, (77.55%), and the `NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER` population, (Rate =99.99%, Chi-Square=0.780, p=1.000)
SOME OTHER RACE	12	12	100%	There is no statistically significant difference in rates between the WHITE population, (77.55%), and the `SOME OTHER RACE` population, (Rate =99.99%, Chi-Square=0.067, p=.1050)

23. *Graph XVI*



Note: Bars highlighted orange indicate a group had lowest percentile performance of all groups included in measure sample, and were only group to fall into the percentile. Bars highlighted green indicate groups performed above the 90th percentile.

Researchers found no group performed statistically significantly worse than the White group, although the Hispanic or Latino group performed significantly better than the White population in Postpartum care rates in the Health Plan Accreditation Postpartum Care sample (n=207) (Table VIII). When comparing groups to the NCQA benchmarks (Graph XVI), only the American Indian and Alaska Native and 'Some Other Race' groups did not surpass the 90th percentile benchmark as all other groups, with the American Indian and Alaska Native being the only group below the 10th.

24. *Table VIV: Postpartum Care (PPC – Post) MCAS Statistical Significance Results*

MY 2023, Run Date: 7/24/2024

Sample Size: 812

Contact: Shivani Sivasankar, Sr. Health Data Analyst II

Northeast

Race	Numerator	Denominator	Rate	Interpretation
WHITE	145	182	80%	
HISPANIC OR LATINO	50	58	86%	There is no statistically significant difference in rates between the WHITE population, (79.64%), and the `HISPANIC OR LATINO` population, (Rate =86.24%, Chi-Square=1.234, p=.2667)
AMERICAN INDIAN AND ALASKA NATIVE	4	8	50%	The WHITE population had a statistically significantly higher rate, (79.64%), compared to the `AMERICAN INDIAN AND ALASKA NATIVE` population, (Rate =50.05%, Chi-Square=3.986, p=.0459)
ASIAN	7	9	78%	There is no statistically significant difference in rates between the WHITE population, (79.64%), and the `ASIAN` population, (Rate =77.77%, Chi-Square=0.311, p=1.000)
BLACK OR AFRICAN AMERICAN	4	4	100%	There is no statistically significant difference in rates between the WHITE population, (79.64%), and the `BLACK OR AFRICAN AMERICAN` population, (Rate =99.99%, Chi-Square=0.409, p=.5859)

SOME OTHER RACE	5	5	100%	There is no statistically significant difference in rates between the WHITE population, (79.64%), and the `SOME OTHER RACE` population, (Rate =99.99%, Chi-Square=0.328, p=.5848)

Northwest

Race	Numerator	Denominator	Rate	Interpretation
WHITE	94	115	82%	
HISPANIC OR LATINO	41	47	87%	There is no statistically significant difference in rates between the WHITE population, (81.73%), and the `HISPANIC OR LATINO` population, (Rate =87.23%, Chi-Square=0.725, p=.3944)
AMERICAN INDIAN AND ALASKA NATIVE	18	24	75%	There is no statistically significant difference in rates between the WHITE population, (81.73%), and the `AMERICAN INDIAN AND ALASKA NATIVE` population, (Rate =75.02%, Chi-Square=0.576, p=.4478)
ASIAN	5	7	71%	There is no statistically significant difference in rates between the WHITE population, (81.73%), and the `ASIAN` population, (Rate =71.39%, Chi-Square=0.270, p=.6152)
BLACK OR AFRICAN AMERICAN	3	3	100%	There is no statistically significant difference in rates between the WHITE population, (81.73%), and the `BLACK OR AFRICAN AMERICAN` population, (Rate =99.99%, Chi-Square=0.552, p=1.000)
NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER	1	1	100%	There is no statistically significant difference in rates between the WHITE population, (81.73%), and the `NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER` population, (Rate =99.99%, Chi-Square=0.819, p=1.000)
SOME OTHER RACE	4	4	100%	There is no statistically significant difference in rates between the WHITE population, (81.73%), and the `SOME OTHER RACE` population, (Rate =99.99%, Chi-Square=0.455, p=1.000)

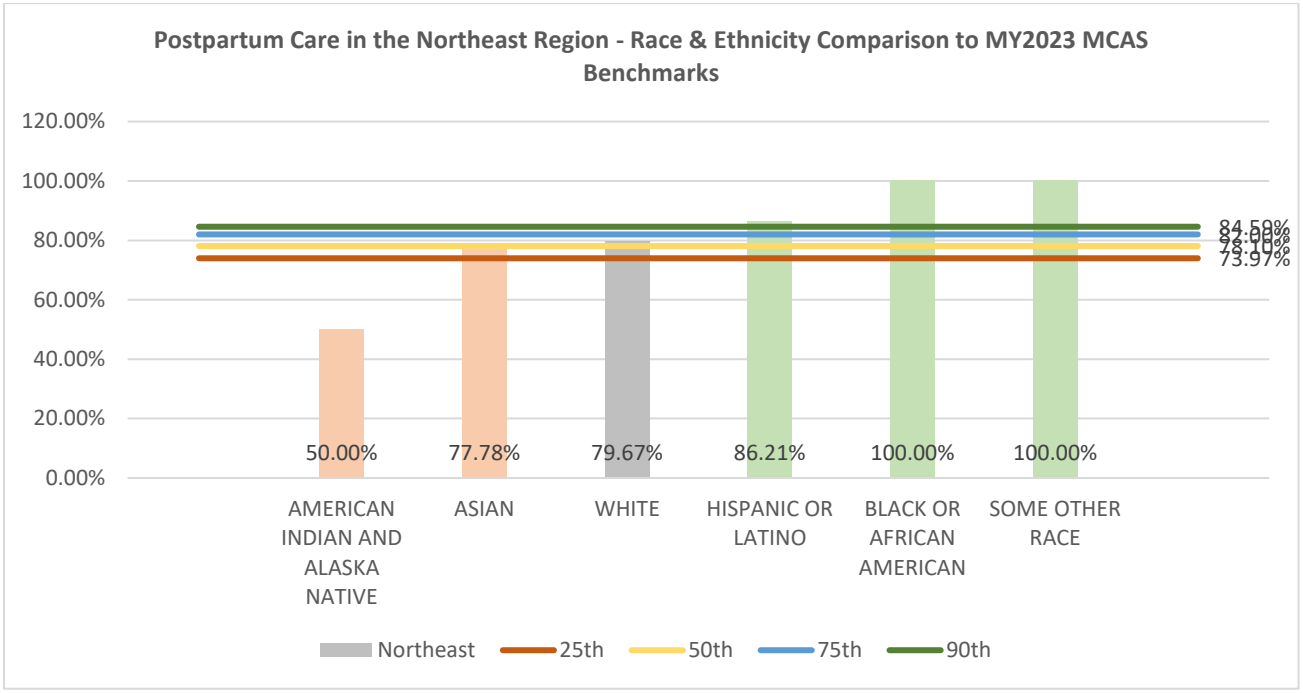
Southeast

Race	Numerator	Denominator	Rate	Interpretation
WHITE	30	36	83%	
HISPANIC OR LATINO	111	123	90%	There is no statistically significant difference in rates between the WHITE population, (83.38%), and the `HISPANIC OR LATINO` population, (Rate =90.20%, Chi-Square=0.116, p=.2452)
ASIAN	15	16	94%	There is no statistically significant difference in rates between the WHITE population, (83.38%), and the `ASIAN` population, (Rate =93.72%, Chi-Square=0.233, p=.4153)
BLACK OR AFRICAN AMERICAN	22	25	88%	There is no statistically significant difference in rates between the WHITE population, (83.38%), and the `BLACK OR AFRICAN AMERICAN` population, (Rate =88.00%, Chi-Square=0.258, p=.7250)
NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER	1	1	100%	There is no statistically significant difference in rates between the WHITE population, (83.38%), and the `NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER` population, (Rate =99.99%, Chi-Square=0.838, p=1.000)
SOME OTHER RACE	10	13	77%	There is no statistically significant difference in rates between the WHITE population, (83.38%), and the `SOME OTHER RACE` population, (Rate =76.89%, Chi-Square=0.271, p=.6831)

Southwest

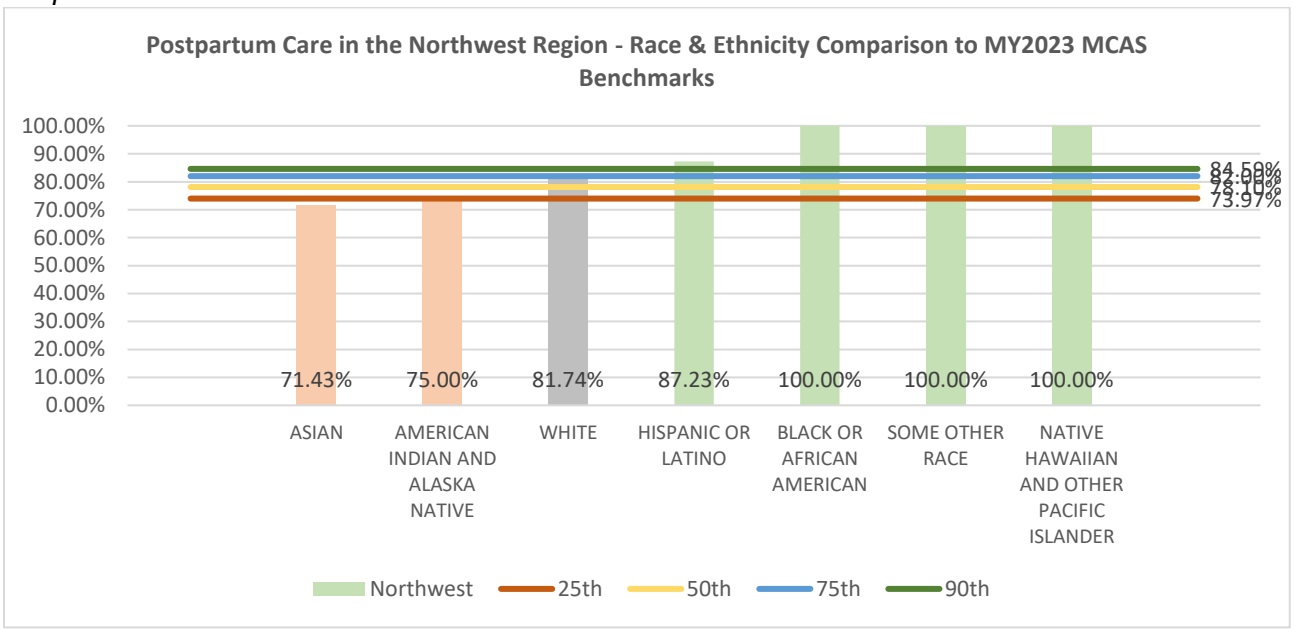
Race	Numerator	Denominator	Rate	Interpretation
WHITE	24	29	83%	
HISPANIC OR LATINO	79	80	99%	The WHITE population had a statistically significantly lower rate, (82.72%), compared to the `HISPANIC OR LATINO` population, (Rate =98.78%, Chi-Square=0.005, p=.0049)
AMERICAN INDIAN AND ALASKA NATIVE	3	4	75%	There is no statistically significant difference in rates between the WHITE population, (82.72%), and the `AMERICAN INDIAN AND ALASKA NATIVE` population, (Rate =75.02%, Chi-Square=0.142, p=.7061)
ASIAN	4	4	100%	There is no statistically significant difference in rates between the WHITE population, (82.72%), and the `ASIAN` population, (Rate =99.99%, Chi-Square=0.500, p=1.000)
BLACK OR AFRICAN AMERICAN	3	3	100%	There is no statistically significant difference in rates between the WHITE population, (82.72%), and the `BLACK OR AFRICAN AMERICAN` population, (Rate =99.99%, Chi-Square=0.590, p=1.000)
SOME OTHER RACE	10	11	91%	There is no statistically significant difference in rates between the WHITE population, (82.72%), and the `SOME OTHER RACE` population, (Rate =90.86%, Chi-Square=0.340, p=1.000)

25. *Graph XVII*



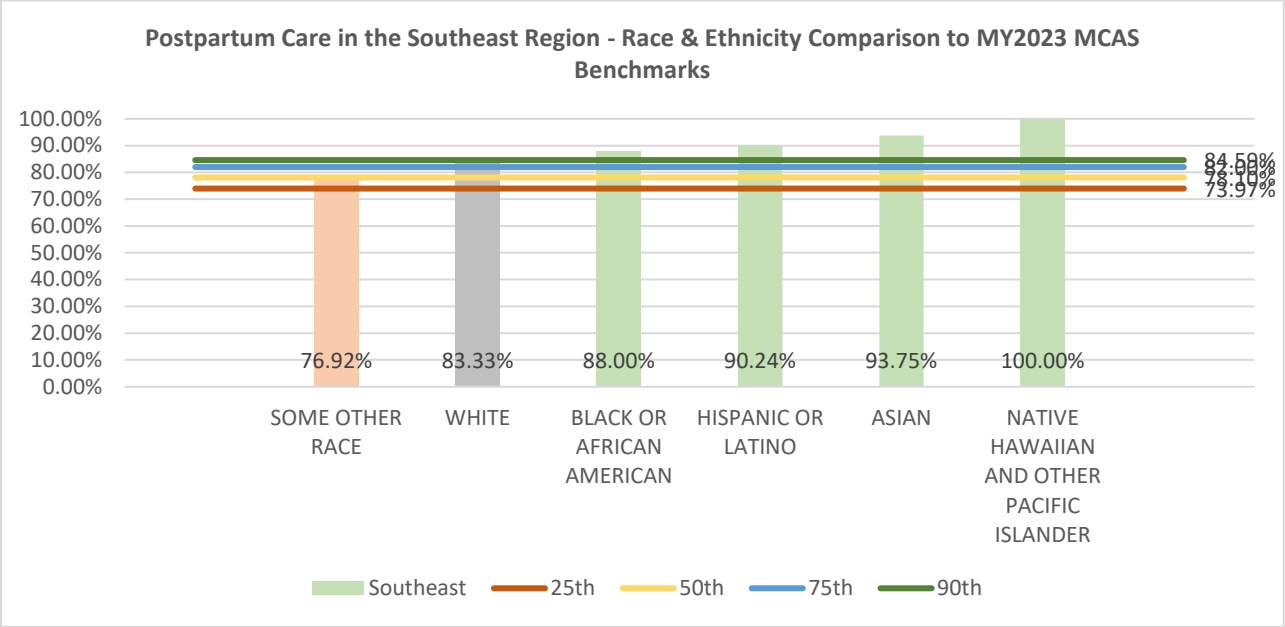
Note: Bars highlighted orange indicate group performed below the MPL (50th percentile). Bars highlighted green indicate groups performed above the 90th percentile.

26. *Graph XVIII*



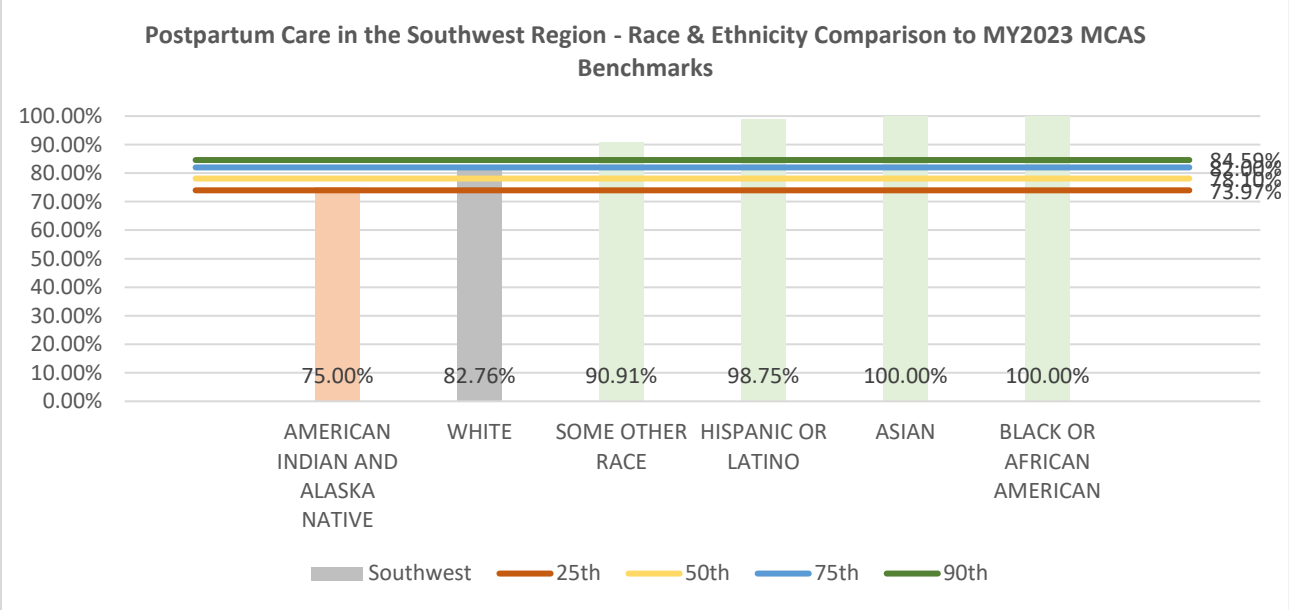
Note: Bars highlighted orange indicate group performed below the MPL (50th percentile). Bars highlighted green indicate groups performed above the 90th percentile.

27. *Graph XIX*



Note: Bars highlighted orange indicate group performed below the MPL (50th percentile). Bars highlighted green indicate groups performed above the 90th percentile.

28. *Graph XX*



Note: Bars highlighted orange indicate group performed below the MPL (50th percentile). Bars highlighted green indicate groups performed above the 90th percentile.

29. *Table VIV: Child and Adolescent Well Care Visits (WCV) HPA Statistical Significance Results*

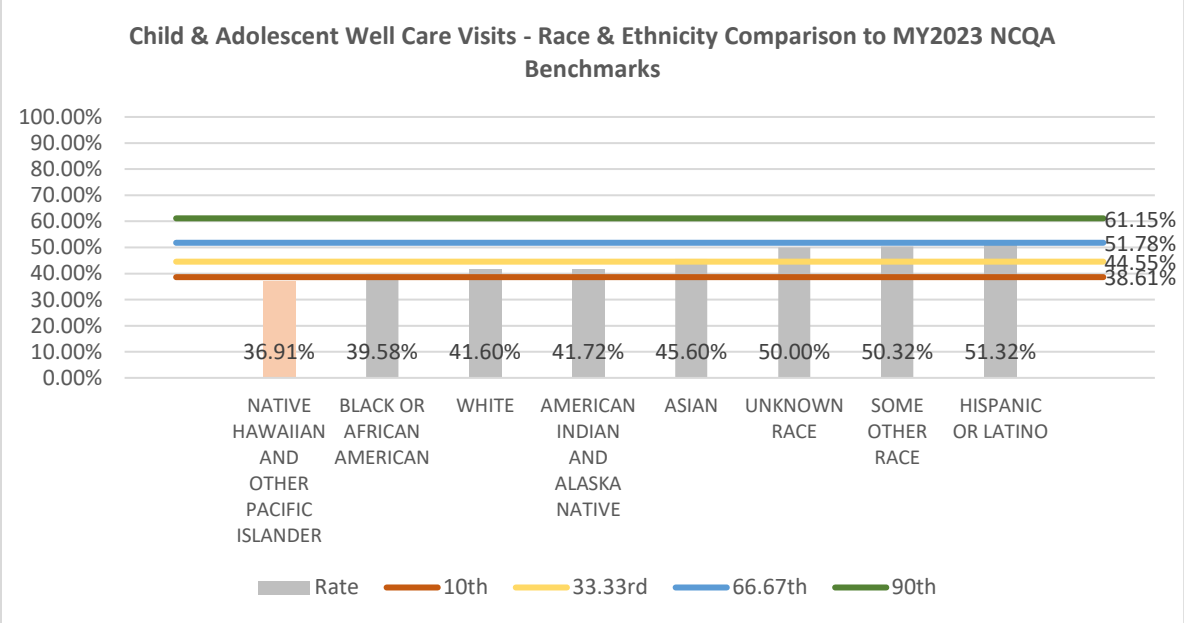
MY 2023, Run Date: 7/24/2024

Sample Size: 167,450

Contact: Shivani Sivasankar, Sr. Health Data Analyst II

Race	Numerator	Denominator	Rate	Interpretation
WHITE	22119	53167	42%	Reference
HISPANIC OR LATINO	44145	86027	51%	The WHITE population had a statistically significantly lower rate, (41.58%), compared to the `HISPANIC OR LATINO` population, (Rate =51.37%, Chi-Square=1242.7, p=.0000)
AMERICAN INDIAN AND ALASKA NATIVE	1853	4442	42%	There is no statistically significant difference in rates between the WHITE population, (41.58%), and the `AMERICAN INDIAN AND ALASKA NATIVE` population, (Rate =41.69%, Chi Square=0.021, p=.8837)
ASIAN	2998	6574	46%	The WHITE population had a statistically significantly lower rate, (41.58%), compared to the `ASIAN` population, (Rate =45.65%, Chi-Square=38.436, p=.0000)
BLACK OR AFRICAN AMERICAN	3256	8226	40%	The WHITE population had a statistically significantly higher rate, (41.58%), compared to the `BLACK OR AFRICAN AMERICAN` population, (Rate =39.60%, Chi-Square=12.000, p=.0005)
NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER	148	401	37%	There is no statistically significant difference in rates between the WHITE population, (41.58%), and the `NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER` population, (Rate =36.96%, Chi-Square=3.612, p=.0574)
SOME OTHER RACE	4334	8613	50%	The WHITE population had a statistically significantly lower rate, (41.58%), compared to the `SOME OTHER RACE` population, (Rate =50.27%, Chi-Square=230.01, p=.0000)

30. *Graph XXI*



Note: Bars highlighted orange indicate a group had lowest percentile performance of all groups included in measure sample, and were only group to fall into the percentile. Bars highlighted green indicate groups performed above the 90th percentile

The Hispanic/Latino, Asian, and 'Some Other Race' groups had a significantly higher rate of Child and Adolescent Well Care Visits (WCV) completions when compared to the White population per the HPA sample. Specifically, the Hispanic/Latino group had the highest rate

of completion with a rate of 51.32%. The Black/African American had a statistically significantly lower rate of completed WCV in comparison to the White group, and numerically had the lowest rate of completion. They were also the only group below the 10th percentile (Graph XXI) (n=167,450) (Table X).

31. *Table VIV: Child and Adolescent Well Care Visits (WCV) MCAS Statistical Significance Results*

    MY 2023, Run Date: 7/24/2024

    Sample Size: 167,450

    Contact: Shivani Sivasankar, Sr. Health Data Analyst II

Northeast

Race	Numerator	Denominator	Rate	Interpretation
WHITE	7084	18461	38%	
HISPANIC OR LATINO	2245	4986	45%	The WHITE population had a statistically significantly lower rate, (38.39%), compared to the `HISPANIC OR LATINO` population, (Rate=44.99%, Chi-Square=72.537, p=.0000)
AMERICAN INDIAN AND ALASKA NATIVE	441	1079	41%	There is no statistically significant difference in rates between the WHITE population, (38.39%), and the `AMERICAN INDIAN AND ALASKA NATIVE` population, (Rate =40.92%, Chi-Square=2.687, p=.1012)
ASIAN	398	926	43%	The WHITE population had a statistically significantly lower rate, (38.39%), compared to the `ASIAN` population, (Rate =43.01%, Chi-Square=7.900, p=.0049)
BLACK OR AFRICAN AMERICAN	160	428	37%	There is no statistically significant difference in rates between the WHITE population, (38.39%), and the `BLACK OR AFRICAN AMERICAN` population, (Rate =37.40%, Chi-Square=0.173, p=.6772)
NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER	9	33	27%	There is no statistically significant difference in rates between the WHITE population, (38.39%), and the `NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER` population, (Rate =27.28%, Chi-Square=1.717, p=.1901)
SOME OTHER RACE	237	498	48%	The WHITE population had a statistically significantly lower rate, (38.39%), compared to the `SOME OTHER RACE` population, (Rate =47.63%, Chi-Square=17.381, p=.0000)

Northwest

Race	Numerator	Denominator	Rate	Interpretation
WHITE	4261	9519	45%	
HISPANIC OR LATINO	1919	3733	51%	The WHITE population had a statistically significantly lower rate, (44.77%), compared to the `HISPANIC OR LATINO` population, (Rate=51.37%, Chi-Square=47.551, p=.0000)
AMERICAN INDIAN AND ALASKA NATIVE	779	1813	43%	There is no statistically significant difference in rates between the WHITE population, (44.77%), and the `AMERICAN INDIAN AND ALASKA NATIVE` population, (Rate =43.01%, Chi-Square=1.988, p=.1585)
ASIAN	257	552	47%	There is no statistically significant difference in rates between the WHITE population, (44.77%), and the `ASIAN` population, (Rate =46.53%, Chi-Square=0.680, p=.4098)
BLACK OR AFRICAN AMERICAN	103	224	46%	There is no statistically significant difference in rates between the WHITE population, (44.77%), and the `BLACK OR AFRICAN AMERICAN` population, (Rate =45.98%, Chi-Square=0.132, p=.7169)
NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER	12	30	40%	There is no statistically significant difference in rates between the WHITE population, (44.77%), and the `NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER` population, (Rate =40.04%, Chi-Square=0.274, p=.6004)
SOME OTHER RACE	158	315	50%	There is no statistically significant difference in rates between the WHITE population, (44.77%), and the `SOME OTHER RACE` population, (Rate =50.16%, Chi-Square=3.588, p=.0582)

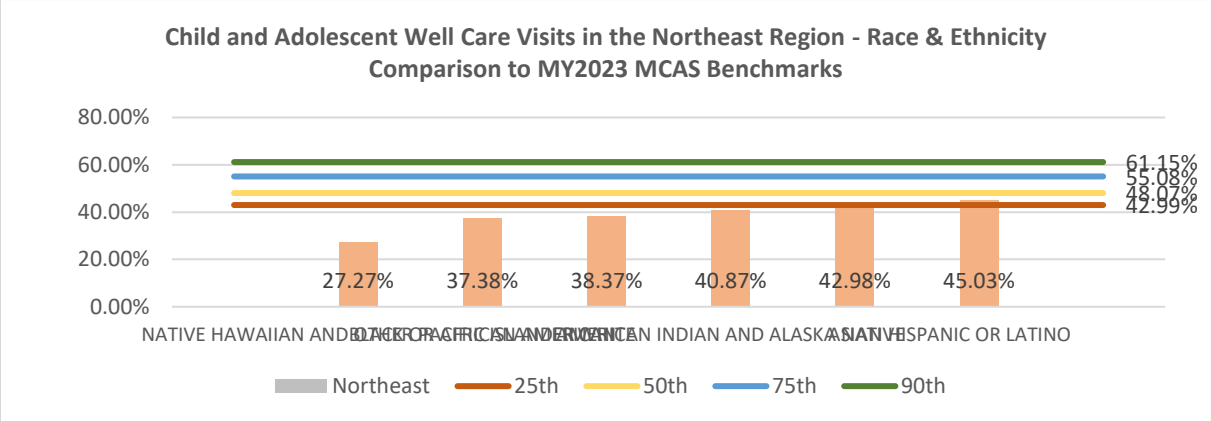
Southeast

Race	Numerator	Denominator	Rate	Interpretation
WHITE	3327	7949	42%	
HISPANIC OR LATINO	17716	34611	51%	The WHITE population had a statistically significantly lower rate, (41.80%), compared to the `HISPANIC OR LATINO` population, (Rate=51.15%, Chi-Square=225.20, p=.0000)
AMERICAN INDIAN AND ALASKA NATIVE	79	178	44%	There is no statistically significant difference in rates between the WHITE population, (41.80%), and the `AMERICAN INDIAN AND ALASKA NATIVE` population, (Rate =44.33%, Chi-Square=0.457, p=.4991)
ASIAN	1760	3809	46%	The WHITE population had a statistically significantly lower rate, (41.80%), compared to the `ASIAN` population, (Rate =46.20%, Chi-Square=19.870, p=.0000)
BLACK OR AFRICAN AMERICAN	2508	6469	39%	The WHITE population had a statistically significantly higher rate, (41.80%), compared to the `BLACK OR AFRICAN AMERICAN` population, (Rate =38.72%, Chi-Square=14.087, p=.0002)
NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER	86	249	35%	The WHITE population had a statistically significantly higher rate, (41.80%), compared to the `NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER` population, (Rate =34.54%, Chi-Square=5.318, p=.0211)
SOME OTHER RACE	1526	3094	49%	The WHITE population had a statistically significantly lower rate, (41.80%), compared to the `SOME OTHER RACE` population, (Rate=49.28%, Chi-Square=50.409, p=.0000)

Southwest

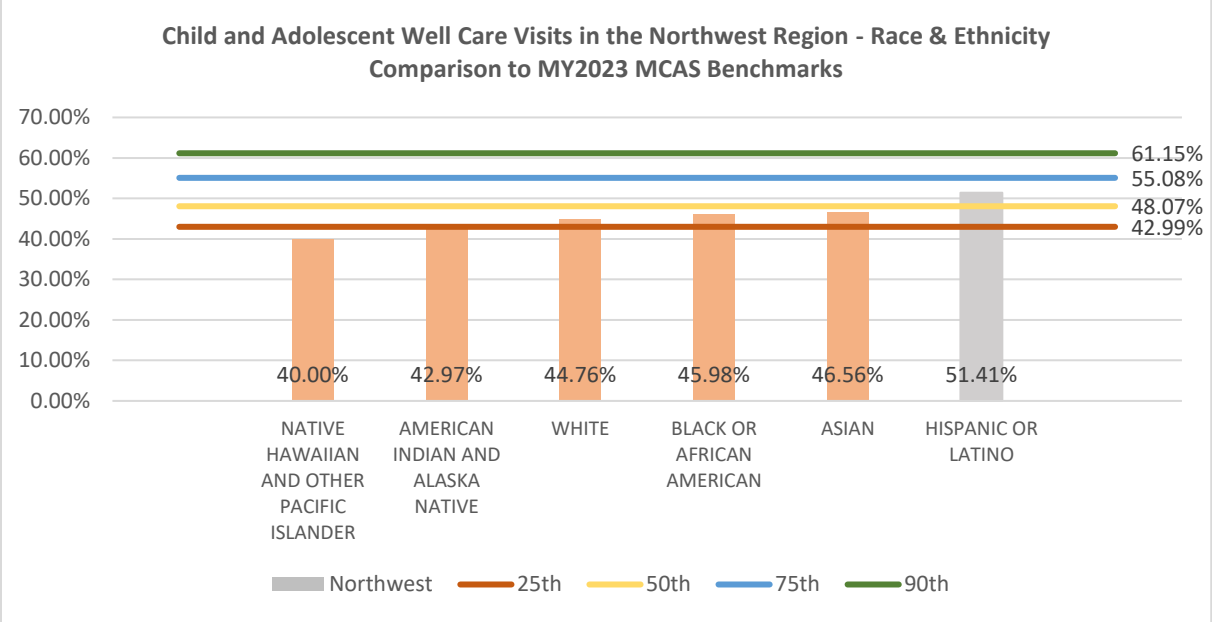
Race	Numerator	Denominator	Rate	Interpretation
WHITE	7447	17238	43%	
HISPANIC OR LATINO	22265	42697	52%	The WHITE population had a statistically significantly lower rate, (43.23%), compared to the `HISPANIC OR LATINO` population, (Rate=52.14%, Chi-Square=393.10, p=.0000)
AMERICAN INDIAN AND ALASKA NATIVE	554	1372	40%	The WHITE population had a statistically significantly higher rate, (43.23%), compared to the `AMERICAN INDIAN AND ALASKA NATIVE` population, (Rate =40.37%, Chi-Square=4.130, p=.0421)
ASIAN	583	1287	45%	There is no statistically significant difference in rates between the WHITE population, (43.23%), and the `ASIAN` population, (Rate =45.32%, Chi-Square=2.147, p=.1429)
BLACK OR AFRICAN AMERICAN	485	1105	44%	There is no statistically significant difference in rates between the WHITE population, (43.23%), and the `BLACK OR AFRICAN AMERICAN` population, (Rate =43.89%, Chi-Square=0.202, p=.6534)
NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER	41	89	46%	There is no statistically significant difference in rates between the WHITE population, (43.23%), and the `NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER` population, (Rate =46.09%, Chi-Square=0.296, p=.5861)
SOME OTHER RACE	2413	4706	51%	The WHITE population had a statistically significantly lower rate, (43.23%), compared to the `SOME OTHER RACE` population, (Rate=51.26%, Chi-Square=97.394, p=.0000)

32. *Graph XXII*



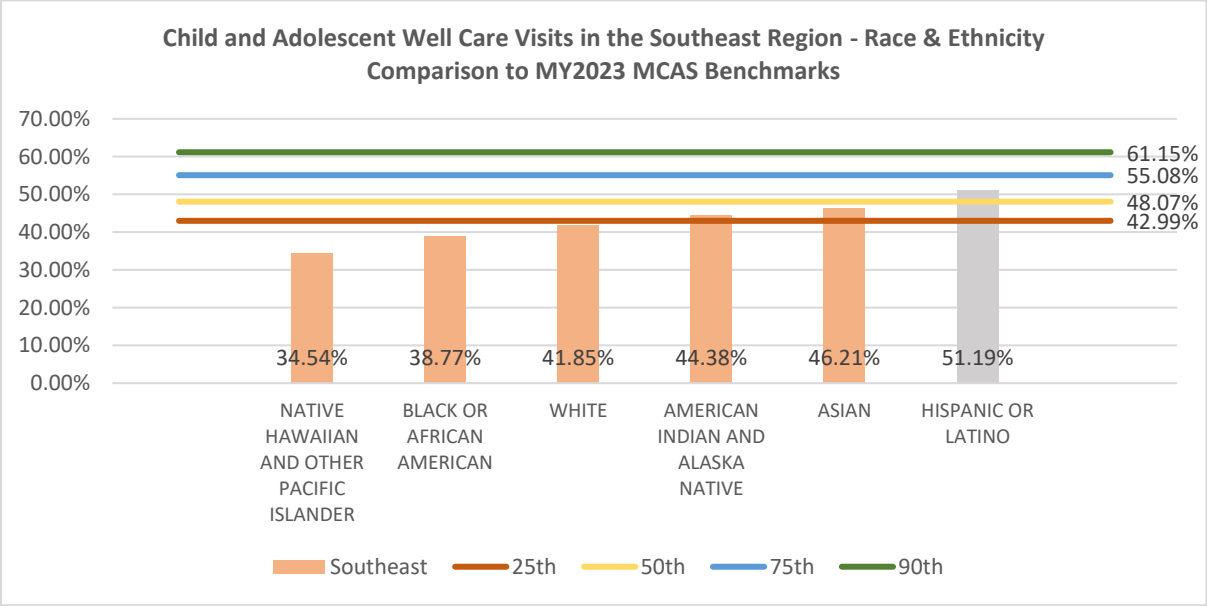
Note: Bars highlighted orange indicate group performed below the MPL (50th percentile). Bars highlighted green indicate groups performed above the 90th percentile.

33. *Graph XXIII*



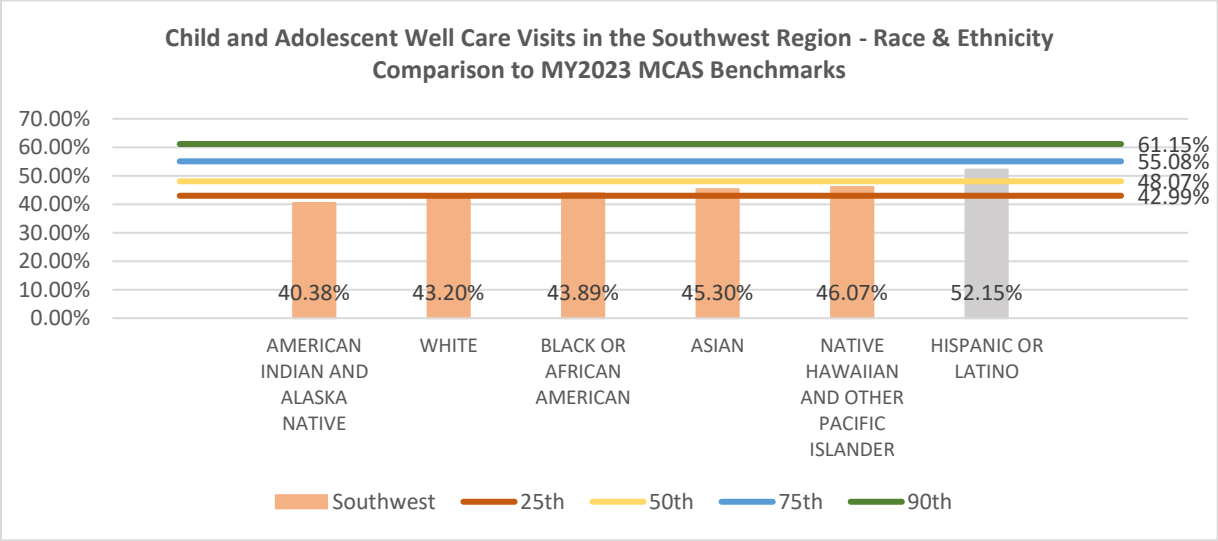
Note: Bars highlighted orange indicate group performed below the MPL (50th percentile). Bars highlighted green indicate groups performed above the 90th percentile.

34. *Graph XXIV*



Note: Bars highlighted orange indicate group performed below the MPL (50th percentile). Bars highlighted green indicate groups performed above the 90th percentile.

35. *Graph XXV*



Note: Bars highlighted orange indicate group performed below the MPL (50th percentile). Bars highlighted green indicate groups performed above the 90th percentile.

36. *Table XII: Controlling High Blood Pressure (CBP) Language HPA Statistical Significance Testing*

Sample Size: 392

Contact: Shivani Sivasankar, Sr. Health Data Analyst II

Language	Numerator	Denominator	Rate	Interpretation
ENGLISH	204	289	71%	Reference
SPANISH	70	95	74%	There is no statistically significant difference in rates between the ENGLISH population, (70.62%), and the `SPANISH` population, (Rate=73.70%, Chi-Square=0.335, p=.5626)
TAGALOG	3	6	50%	There is no statistically significant difference in rates between the ENGLISH population, (70.62%), and the `TAGALOG` population, (Rate=50.05%, Chi-Square=0.184, p=.3677)
RUSSIAN	1	2	50%	There is no statistically significant difference in rates between the ENGLISH population, (70.62%), and the `RUSSIAN` population, (Rate=50.05%, Chi-Square=0.418, p=.5044)

37. *Table XIII: Controlling High Blood Pressure (CBP) Language MCAS Statistical Significance Testing*

Sample Size: 1,489

Contact: Shivani Sivasankar, Sr. Health Data Analyst II

Northeast

Language	Numerator	Denominator	Rate	Interpretation
ENGLISH	223	359	62%	
SPANISH	10	18	56%	There is no statistically significant difference in rates between the ENGLISH population, (62.15%), and the `SPANISH` population, (Rate=55.55%, Chi-Square=0.313, p=.5761)

Northwest

Language	Numerator	Denominator	Rate	Interpretation
ENGLISH	234	366	64%	
SPANISH	6	12	50%	There is no statistically significant difference in rates between the ENGLISH population, (63.91%), and the `SPANISH` population, (Rate=50.05%, Chi-Square=0.144, p=.3675)

Southeast

Language	Numerator	Denominator	Rate	Interpretation
ENGLISH	166	265	63%	
SPANISH	66	98	67%	There is no statistically significant difference in rates between the ENGLISH population, (62.59%), and the `SPANISH` population, (Rate=67.32%, Chi-Square=0.687, p=.4073)
TAGALOG	6	11	55%	There is no statistically significant difference in rates between the ENGLISH population, (62.59%), and the `TAGALOG` population, (Rate=54.56%, Chi-Square=0.209, p=.7523)
RUSSIAN	3	5	60%	There is no statistically significant difference in rates between the ENGLISH population, (62.59%), and the `RUSSIAN` population, (Rate=59.95%, Chi-Square=0.346, p=1.000)

Southwest

Language	Numerator	Denominator	Rate	Interpretation
ENGLISH	150	237	63%	
SPANISH	76	116	66%	There is no statistically significant difference in rates between the ENGLISH population, (63.25%), and the `SPANISH` population, (Rate=65.56%, Chi-Square=0.168, p=.6823)
TAGALOG	1	2	50%	There is no statistically significant difference in rates between the ENGLISH population, (63.25%), and the `TAGALOG` population, (Rate=50.05%, Chi-Square=0.467, p=1.000)

38. *Table XIV: Hemoglobin A1c Control for Patients with Diabetes (HBD) HbA1c Poor Control (>9.0%) Language HPA Statistical Significance Testing*

    Sample Size: 394

    Contact: Shivani Sivasankar, Sr. Health Data Analyst II

Language	Numerator	Denominator	Rate	Interpretation
ENGLISH	97	276	35%	Reference
SPANISH	34	114	30%	There is no statistically significant difference in rates between the ENGLISH population, (35.09%), and the `SPANISH` population, (Rate=29.81%, Chi-Square=1.024, p=.3116)
TAGALOG	0	2	%	There is no statistically significant difference in rates between the ENGLISH population, (35.09%), and the `TAGALOG` population, (Rate=0.000%, Chi-Square=0.423, p=.5440)
RUSSIAN	2	2	100%	There is no statistically significant difference in rates between the ENGLISH population, (35.09%), and the `RUSSIAN` population, (Rate=99.99%, Chi-Square=0.126, p=.1260)

39. *Table XV: Hemoglobin A1c Control for Patients with Diabetes (HBD) HbA1c Poor Control (>9.0%) Language MCAS Statistical Significance Testing*

Sample Size: 1,441

Contact: Shivani Sivasankar, Sr. Health Data Analyst II

Northeast

Language	Numerator	Denominator	Rate	Interpretation
ENGLISH	138	338	41%	
SPANISH	4	21	19%	The ENGLISH population had a statistically significantly higher rate, (40.81%), compared to the `SPANISH` population, (Rate =19.03%, Chi-Square=3.923, p=.0476)

Northwest

Language	Numerator	Denominator	Rate	Interpretation
ENGLISH	116	346	34%	
SPANISH	5	14	36%	There is no statistically significant difference in rates between the ENGLISH population, (33.55%), and the `SPANISH` population, (Rate =35.75%, Chi-Square=0.220, p=1.000)

Southeast

Language	Numerator	Denominator	Rate	Interpretation
ENGLISH	87	248	35%	
SPANISH	29	112	26%	There is no statistically significant difference in rates between the ENGLISH population, (35.09%), and the `SPANISH` population, (Rate =25.85%, Chi-Square=2.982, p=.0842)
TAGALOG	0	7	%	There is no statistically significant difference in rates between the ENGLISH population, (35.09%), and the `TAGALOG` population, (Rate =0.000%, Chi-Square=0.052, p=.0991)
RUSSIAN	0	1	%	There is no statistically significant difference in rates between the ENGLISH population, (35.09%), and the `RUSSIAN` population, (Rate =0.000%, Chi-Square=0.651, p=1.000)

Southwest

Language	Numerator	Denominator	Rate	Interpretation
ENGLISH	82	214	38%	
SPANISH	36	139	26%	The ENGLISH population had a statistically significantly higher rate, (38.28%), compared to the `SPANISH` population, (Rate =25.85%, Chi-Square=5.840, p=.0157)
TAGALOG	1	1	100%	There is no statistically significant difference in rates between the ENGLISH population, (38.28%), and the `TAGALOG` population, (Rate =99.99%, Chi-Square=0.386, p=.3860)

40. *Table XVI: Timeliness of Prenatal Care (PPC – Pre) Language HPA Statistical Significance Testing*

Sample Size: 205

Contact: Shivani Sivasankar, Sr. Health Data Analyst II

Language	Numerator	Denominator	Rate	Interpretation
ENGLISH	143	158	91%	Reference
SPANISH	42	47	89%	There is no statistically significant difference in rates between the ENGLISH population, (90.53%), and the `SPANISH` population, (Rate=89.32%, Chi-Square=0.208, p=.7837)

41. *Table XVII: Timeliness of Prenatal Care (PPC – Pre) Language MCAS Statistical Significance Testing*

Sample Size: 885

Contact: Shivani Sivasankar, Sr. Health Data Analyst II

Northeast

Language	Numerator	Denominator	Rate	Interpretation
ENGLISH	224	265	84%	
SPANISH	12	12	100%	There is no statistically significant difference in rates between the ENGLISH population, (84.48%), and the `SPANISH` population, (Rate =99.99%, Chi-Square=0.140, p=.2243)

Northwest

Language	Numerator	Denominator	Rate	Interpretation
ENGLISH	163	208	78%	
SPANISH	8	9	89%	There is no statistically significant difference in rates between the ENGLISH population, (78.32%), and the `SPANISH` population, (Rate =88.88%, Chi-Square=0.284, p=.6880)

Southeast

Language	Numerator	Denominator	Rate	Interpretation
ENGLISH	159	177	90%	
SPANISH	44	52	85%	There is no statistically significant difference in rates between the ENGLISH population, (89.87%), and the `SPANISH` population, (Rate =84.59%, Chi-Square=1.086, p=.2973)
TAGALOG	1	1	100%	There is no statistically significant difference in rates between the ENGLISH population, (89.87%), and the `TAGALOG` population, (Rate =99.99%, Chi-Square=0.899, p=1.000)
RUSSIAN	2	2	100%	There is no statistically significant difference in rates between the ENGLISH population, (89.87%), and the `RUSSIAN` population, (Rate =99.99%, Chi-Square=0.809, p=1.000)

Southwest

Language	Numerator	Denominator	Rate	Interpretation
ENGLISH	100	108	93%	
SPANISH	48	50	96%	There is no statistically significant difference in rates between the ENGLISH population, (92.62%), and the `SPANISH` population, (Rate =96.03%, Chi-Square=0.216, p=.5059)
RUSSIAN	1	1	100%	There is no statistically significant difference in rates between the ENGLISH population, (92.62%), and the `RUSSIAN` population, (Rate =99.99%, Chi-Square=0.927, p=1.000)

42. *Table XVIII: Postpartum Care (PPC – Post) Language HPA Statistical Significance Testing*

Sample Size: 205

Contact: Shivani Sivasankar, Sr. Health Data Analyst II

Language	Numerator	Denominator	Rate	Interpretation

ENGLISH	134	158	85%	Reference
SPANISH	44	47	94%	There is no statistically significant difference in rates between the ENGLISH population, (84.81%), and the `SPANISH` population, (Rate=93.61%, Chi-Square=2.457, p=.1170)

43. *Table XIX: Postpartum Care (PPC – Post) Language MCAS Statistical Significance Testing*

Sample Size: 885

Contact: Shivani Sivasankar, Sr. Health Data Analyst II

Northeast

Language	Numerator	Denominator	Rate	Interpretation
ENGLISH	213	265	80%	
SPANISH	12	12	100%	There is no statistically significant difference in rates between the ENGLISH population, (80.41%), and the `SPANISH` population, (Rate=99.99%, Chi-Square=0.078, p=.1312)

Notheast

Language	Numerator	Denominator	Rate	Interpretation
ENGLISH	169	208	81%	
SPANISH	9	9	100%	There is no statistically significant difference in rates between the ENGLISH population, (81.29%), and the `SPANISH` population, (Rate=99.99%, Chi-Square=0.162, p=.3684)

Southeast

Language	Numerator	Denominator	Rate	Interpretation
ENGLISH	154	177	87%	
SPANISH	46	52	88%	There is no statistically significant difference in rates between the ENGLISH population, (87.01%), and the `SPANISH` population, (Rate=88.44%, Chi-Square=0.077, p=.7814)
TAGALOG	1	1	100%	There is no statistically significant difference in rates between the ENGLISH population, (87.01%), and the `TAGALOG` population, (Rate=99.99%, Chi-Square=0.871, p=1.000)
RUSSIAN	2	2	100%	There is no statistically significant difference in rates between the ENGLISH population, (87.01%), and the `RUSSIAN` population, (Rate=99.99%, Chi-Square=0.759, p=1.000)

Southwest

Language	Numerator	Denominator	Rate	Interpretation
ENGLISH	98	108	91%	
SPANISH	50	50	100%	The ENGLISH population had a statistically significantly lower rate, (90.75%), compared to the `SPANISH` population, (Rate =99.99%, Chi-Square=0.019, p=.0313)
RUSSIAN	1	1	100%	There is no statistically significant difference in rates between the ENGLISH population, (90.75%), and the `RUSSIAN` population, (Rate=99.99%, Chi-Square=0.908, p=1.000)

44. *Table XX: Child and Adolescent Well Care Visits (WCV) Language HPA Statistical Significance Testing*

Sample Size: 187,458

Contact: Shivani Sivasankar, Sr. Health Data Analyst II

Language	Numerator	Denominator	Rate	Interpretation
ENGLISH	59368	131999	45%	Reference
SPANISH	28864	54051	53%	The ENGLISH population had a statistically significantly lower rate, (44.99%), compared to the `SPANISH` population, (Rate =53.35%, Chi-Square=1091.8, p=.0000)
TAGALOG	61	155	39%	There is no statistically significant difference in rates between the ENGLISH population, (44.99%), and the `TAGALOG` population, (Rate=39.38%, Chi-Square=1.977, p=.1597)
RUSSIAN	197	424	46%	There is no statistically significant difference in rates between the ENGLISH population, (44.99%), and the `RUSSIAN` population, (Rate=46.42%, Chi-Square=0.377, p=.5391)
FARSI	121	172	70%	The ENGLISH population had a statistically significantly lower rate, (44.99%), compared to the `FARSI` population, (Rate =70.40%, Chi-Square=44.679, p=.0000)
HMONG	45	125	36%	The ENGLISH population had a statistically significantly higher rate, (44.99%), compared to the `HMONG` population, (Rate =35.97%, Chi-Square=4.066, p=.0438)
MANDARIN	51	123	41%	There is no statistically significant difference in rates between the ENGLISH population, (44.99%), and the `MANDARIN` population, (Rate=41.47%, Chi-Square=0.613, p=.4338)
PORTUGUESE	50	102	49%	There is no statistically significant difference in rates between the ENGLISH population, (44.99%), and the `PORTUGUESE` population, (Rate =49.06%, Chi-Square=0.673, p=.4119)
VIETNAMESE	131	307	43%	There is no statistically significant difference in rates between the ENGLISH population, (44.99%), and the `VIETNAMESE` population, (Rate =42.68%, Chi-Square=0.658, p=.4174)

45. Table XXI: Child and Adolescent Well Care Visits (WCV) Language MCAS Statistical Significance Testing

Sample Size: 187,070

Contact: Shivani Sivasankar, Sr. Health Data Analyst II

Northeast

Language	Numerator	Denominator	Rate	Interpretation
ENGLISH	12748	31029	41%	
SPANISH	658	1179	56%	The ENGLISH population had a statistically significantly lower rate, (41.03%), compared to the `SPANISH` population, (Rate =55.77%, Chi-Square=101.37, p=.0000)
RUSSIAN	4	8	50%	There is no statistically significant difference in rates between the ENGLISH population, (41.03%), and the `RUSSIAN` population, (Rate =50.05%, Chi-Square=0.240, p=.7243)

Northwest

Language	Numerator	Denominator	Rate	Interpretation
ENGLISH	9087	19045	48%	
SPANISH	662	1233	54%	The ENGLISH population had a statistically significantly lower rate, (47.74%), compared to the `SPANISH` population, (Rate =53.68%, Chi-Square=16.572, p=.0000)
TAGALOG	3	4	75%	There is no statistically significant difference in rates between the ENGLISH population, (47.74%), and the `TAGALOG` population, (Rate =75.02%, Chi-Square=0.227, p=.3538)

Southeast

Language	Numerator	Denominator	Rate	Interpretation
ENGLISH	17893	39571	45%	
SPANISH	10631	20118	53%	The ENGLISH population had a statistically significantly lower rate, (45.21%), compared to the `SPANISH` population, (Rate =52.80%, Chi-Square=310.85, p=.0000)
TAGALOG	52	135	39%	There is no statistically significant difference in rates between the ENGLISH population, (45.21%), and the `TAGALOG` population, (Rate =38.50%, Chi-Square=2.438, p=.1185)
RUSSIAN	170	372	46%	There is no statistically significant difference in rates between the ENGLISH population, (45.21%), and the `RUSSIAN` population, (Rate =45.65%, Chi-Square=0.034, p=.8527)
FARSI	113	160	71%	The ENGLISH population had a statistically significantly lower rate, (45.21%), compared to the `FARSI` population, (Rate =70.62%, Chi-Square=41.512, p=.0000)
VIETNAMESE	56	156	36%	The ENGLISH population had a statistically significantly higher rate, (45.21%), compared to the `VIETNAMESE` population, (Rate =35.86%, Chi-Square=5.450, p=.0196)

Southwest

Language	Numerator	Denominator	Rate	Interpretation
ENGLISH	19639	42354	46%	
SPANISH	16914	31521	54%	The ENGLISH population had a statistically significantly lower rate, (46.42%), compared to the `SPANISH` population, (Rate =53.68%, Chi-Square=384.28, p=.0000)
TAGALOG	6	16	38%	There is no statistically significant difference in rates between the ENGLISH population, (46.42%), and the `TAGALOG` population, (Rate =37.51%, Chi-Square=0.506, p=.4769)
RUSSIAN	23	44	52%	There is no statistically significant difference in rates between the ENGLISH population, (46.42%), and the `RUSSIAN` population, (Rate =52.25%, Chi-Square=0.616, p=.4325)
VIETNAMESE	61	125	49%	There is no statistically significant difference in rates between the ENGLISH population, (46.42%), and the `VIETNAMESE` population, (Rate =48.84%, Chi-Square=0.296, p=.5862)

46. *Table XXII: Controlling High Blood Pressure (CBP) Gender HPA Statistical Significance Testing*

Gender	Numerator	Denominator	Rate	Interpretation
MALE	133	178	75%	Reference
FEMALE	150	223	67%	There is no statistically significant difference in rates between the Male population, (74.69%), and the Female population, (Rate =67.21%, Chi-Square=2.649, p=.1036)

Partnership found no statistically significant difference when comparing each gender identity group to the Male gender identity group while using the NCQA Health Plan Accreditation generated sample (drawn from the eligible population) for Controlling High Blood Pressure (n=401) (Table XXII).

47. *Table XXIII: Controlling High Blood Pressure (CBP) Gender Identity MCAS Statistical Significance Results*

Northeast

Gender	Numerator	Denominator	Rate	Interpretation
MALE	99	173	57%	
FEMALE	139	215	65%	There is no statistically significant difference in rates between the Male population, (57.20%), and the Female population, (Rate =64.68%, Chi-Square=2.229, p=.1354)

Northwest

Gender	Numerator	Denominator	Rate	Interpretation
MALE	133	209	64%	
FEMALE	112	179	63%	There is no statistically significant difference in rates between the Male population, (63.69%), and the Female population, (Rate =62.59%, Chi-Square=0.047, p=.8281)

Southeast

Gender	Numerator	Denominator	Rate	Interpretation
MALE	104	161	65%	
FEMALE	148	231	64%	There is no statistically significant difference in rates between the Male population, (64.57%), and the Female population, (Rate =64.02%, Chi-Square=0.011, p=.9147)

Southwest

Gender	Numerator	Denominator	Rate	Interpretation
MALE	106	167	63%	
FEMALE	131	199	66%	There is no statistically significant difference in rates between the Male population, (63.47%), and the Female population, (Rate =65.78%, Chi-Square=0.221, p=.6384)

48. *Table XXIV: Hemoglobin A1c Control for Patients with Diabetes (HBD) HbA1c Poor Control (>9.0%) Gender HPA Statistical Significance Testing*

Gender	Numerator	Denominator	Rate	Interpretation
MALE	68	189	36%	Reference
FEMALE	66	216	31%	There is no statistically significant difference in rates between the Male population, (35.97%), and the Female population, (Rate=30.58%, Chi-Square=1.339, p=.2472)

Partnership found no statistically significant difference when comparing each gender identity group to the Male gender identity group while using the NCQA Health Plan Accreditation generated sample (drawn from the eligible population) for HbA1c Poor Control (n=405) (Table XXIV).

49. *Table XXV: A1c Control for Patients with Diabetes (HBD) HbA1c Poor Control (>9.0%) Gender Identity MCAS Statistical Significance Results*

Northeast

Gender	Numerator	Denominator	Rate	Interpretation
MALE	71	170	42%	
FEMALE	73	201	36%	There is no statistically significant difference in rates between the Male population, (41.80%), and the Female population, (Rate =36.30%, Chi-Square=1.150, p=.2835)

Northwest

Gender	Numerator	Denominator	Rate	Interpretation
MALE	60	156	39%	
FEMALE	63	215	29%	There is no statistically significant difference in rates between the Male population, (38.50%), and the Female population, (Rate =29.26%, Chi-Square=3.422, p=.0643)

Southeast

Gender	Numerator	Denominator	Rate	Interpretation
MALE	66	171	39%	
FEMALE	53	209	25%	The Male population had a statistically significantly higher rate, (38.61%), compared to the Female population, (Rate =25.41%, Chi-Square=7.662, p=.0056)

Southwest

Gender	Numerator	Denominator	Rate	Interpretation
MALE	57	172	33%	
FEMALE	62	188	33%	There is no statistically significant difference in rates between the Male population, (33.11%), and the Female population, (Rate =33.00%, Chi-Square=0.001, p=.9742)

50. *Table XXVI: Child and Adolescent Well Care Visits (WCV) Gender Identity HPA Statistical Significance Testing*

Gender	Numerator	Denominator	Rate	Interpretation
MALE	45513	96466	47%	Reference
FEMALE	43714	91730	48%	The Female population had a statistically significantly higher rate, (47.63%), compared to the Male population, (Rate =47.19%, Chi-Square=4.250, p=.0393)

Partnership found that the Female gender identity significantly performed better to the Male-group while using the NCQA Health Plan Accreditation generated sample (drawn from the eligible population) for Child and Adolescent Well Care Visits (n=188,196, Table XXVI). Specifically, the Female population had a 1% higher rate of Child and Adolescent Well Care when compared to the Male population.

51. *Table XXVII: Child and Adolescent Well Care Visits (WCV) Gender Identity MCAS Statistical Significance Results*

Northeast

Gender	Numerator	Denominator	Rate	Interpretation
MALE	6964	16665	42%	
FEMALE	6520	15719	41%	There is no statistically significant difference in rates between the Male population, (41.80%), and the Female population, (Rate =41.47%, Chi-Square=0.319, p=.5720)

Northwest

Gender	Numerator	Denominator	Rate	Interpretation

MALE	4952	10440	47%	
FEMALE	4840	9948	49%	There is no statistically significant difference in rates between the Male population, (47.41%), and the Female population, (Rate =48.62%, Chi-Square=3.038, p=.0813)

Southeast

Gender	Numerator	Denominator	Rate	Interpretation
MALE	14866	31164	48%	
FEMALE	14320	29908	48%	There is no statistically significant difference in rates between the Male population, (47.74%), and the Female population, (Rate =47.85%, Chi-Square=0.193, p=.6603)

Southwest

Gender	Numerator	Denominator	Rate	Interpretation
MALE	18731	38198	49%	
FEMALE	18034	36154	50%	The Female population had a statistically significantly higher rate, (49.83%), compared to the Male population, (Rate =49.06%, Chi-Square=5.299, p=.0213)

Healthcare Effectiveness Data and Information Set (HEDIS®)

Measurement Year 2024 / Reporting Year 2025

Managed Care Accountability Set (MCAS)
Summary of Performance
August 2025

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1.0 Notable Changes to the MY2024 Annual Summary of Performance Report

MY2024 continued to host two required separate audits:

- DHCS / MCAS required reporting: Health Service Advisory Group (HSAG) Auditor (this report's focus)
- NCQA HEDIS Health Plan Accreditation / HPA: Advent Advisory Auditor

Partnership HEDIS Reporting Populations – MY2024

In MY2024, Partnership observed an increase in overall membership by approximately 36.7%, to 906,964 assigned members in December 2024. The changes in membership reflect the addition of 10 new counties to the Partnership network, as well as the departure of members assigned to Kaiser sites, who moved to Kaiser as their Medi-Cal Managed Care Plan.

- Incoming counties added approximately 316,000 members to Partnership.
- Approximately 82,000 members assigned to Kaiser departed from Partnership. The decrease in membership primarily impacted Solano, Sonoma, Napa and Yolo Counties.

	Dec 2023	Dec 2024
Total Membership	**663,919**	**906,964**
10 Incoming Counties	**0**	**316,096**
New membership	0	316,096
14 Legacy Counties	**663,919**	**590,868**
Kaiser assigned Partnership members	82,033	0
Non-Kaiser membership	581,886	590,868

The addition of 10 incoming counties to Partnership's network coincides with changes to Partnership's HEDIS Reporting Populations for both DHCS's MCAS measure set and NCQA's Health Plan Accreditation (HPA). Starting in MY2024, Partnership reported one Plan-Wide rate for all 24 counties in its network for the MCAS measure set to its DHCS auditor, HSAG. The Reporting Unit configuration of Partnership regions used until MY2023 (i.e.: Southeast, Southwest, Northeast, and Northwest) has been retired.

The impact of population shifts in Partnership's network impacts HEDIS measure eligible populations differently, depending on each measure's continuous enrollment requirements as defined in the NCQA HEDIS MY2024 Technical Specifications. A subset of measures require continuous enrollment greater than one (1) year for a member to be included in the measure's eligible population, which meant that very few members from incoming counties met the criteria to be included in the measures' plan-wide rates in MY2024. For the MCAS measure set, these measures with very small eligible populations for incoming counties in MY2024 are:

- Asthma Medication Ratio (AMR)
- Breast Cancer Screening, ECDS (BCS-E)
- Well-Child Visits in the First 30 Months of Life (W30)

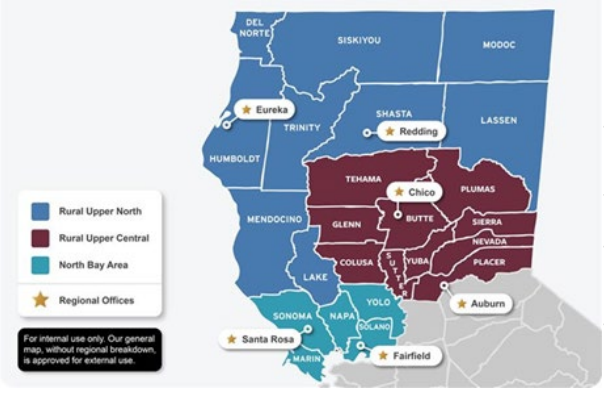
Changes to DHCS Sanctioning Methodology – MY2024

Starting in MY2024, Partnership also reported county-wide rates for all MCAS measures and their respective sub-measures to DHCS directly. DHCS intends to hold all California Managed Care Plans accountable for sanctions for all MCAS Accountable measures that did not reach the 50th percentile benchmark at either the county level or at the level of groups of counties. Details have not been finalized at the time of this report.

Of note, sanctions do not apply to counties newly covered by a Managed Care Plan. For Partnership, this includes the Plan's 14 legacy counties; the 10 incoming counties are not held to performance sanctions in MY2024.

Population	Description	Purpose
NCQA HEDIS Reporting - DHCS Populations		
Plan Wide	All 24 counties - Plan wide reported rates	DHCS-published HEDIS rates for MCP
County	County level measure rates for each of Partnership's 24 counties	Geographic sanctions and withholds will be applied at DHCS's discretion (applied only to 14 legacy counties in MY2024)
NCQA HEDIS Reporting - HPA Population		
Plan Wide	All 24 counties - Plan wide reported rates	NCQA Star Rating

Starting in MY2024, DHCS also intends to use its Withhold/Incentives accountability program for Partnership to earn back a percentage of its withheld income from DHCS based on performance of a subset of MCAS measures and two (2) CAHPS measures. The Withhold accountability program measures MCAS measure rates aggregated by DHCS Quality Rating Regions. The Rural Upper Central Rating Region, which is made up of the 10 incoming counties to Partnership in 2024, is excluded from the Withhold/Incentives accountability program for MY2024. An illustration of Partnership's network organized by DHCS Quality Rating Regions is shown below.



DHCS Quality Rating Region	Counties
North Bay	Marin, Napa, Sonoma, Solano, Yolo
Rural Upper North	Del Norte, Humboldt, Lassen, Lake, Mendocino, Modoc, Shasta, Siskiyou, Trinity
Rural Upper Central	Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Yuba

Changes to NCQA HEDIS Measures – MY2024

NCQA released changes to two existing clinical measures used in DHCS MCAS for MY2024:

- The former Hemoglobin A1c (HbA1c) Control for Patients with Diabetes (HBD) measure was revised to Glycemic Status Assessment for Patients with Diabetes (GSD).
- Colorectal Cancer Screening (COL-E) using ECDS methodology replaced Colorectal Cancer Screening (COL), which was an administrative measure.

Partnership's Efforts to Improve Data Quality – MY2024

Partnership was able to use a number of new supplemental data sources in the MY2024 HEDIS Annual project.

Electronic Clinical Data Systems (ECDS) Vendor Pilot: Partnership piloted the use of Datalink, an NCQA Certified Data Aggregator software, in MY2024, and received auditor approval to include records from two (2) EMR vendors (eClinical Works and Nextgen) in the MY2024 HEDIS Project. Records from six (6) practices within Partnership's provider network were included in the MY2024 HEDIS Annual Project. The analysis shows promising results from the Datalink pilot:

- The MCAS (Report Only) measure set includes seven (7) Depression Screening measures. Datalink was the sole source of data for six (6) of the seven (7) Depression Screening measures.
- Five (5) of the seven (7) Depression Screening measures exceeded the 50th percentile as a result of the inclusion of Datalink data.
- Datalink also made a positive impact on administrative rates for MCAS Accountable measures, including Controlling Blood Pressure (CBP) and Glycemic Status Assessment for Patients with Diabetes (GSD).

Medical Record Review for Well-Child Visits in the First 30 Months of Life (W30) Pilot:
Partnership has historically scored below the 50th percentile on both W30 measures, though the rates for the W15 measure (Well Child Visits Birth – 15 Months) within the Primary Care Provided Quality Incentive Program (PCP QIP) have been above the 50th percentile since MY2022. The QI department devoted time and resources to researching root causes for the discrepancy between HEDIS and QIP rates in 2024 and identified numerous points of failure for newborn visits to be counted towards the HEDIS rate using administrative data. The major issue identified was a temporary member ID number that could not automatically be matched to the child's final permanent membership ID.

As a result of this analysis, the HEDIS team piloted a supplemental Medical Record Review of the entire W30 measure eligible population in early 2025, which was accepted as a supplemental data source by HSAG's auditor. The supplemental Medical Record Review made a dramatic impact on the rates for both W30 submeasures, and both W30 submeasure rates scored above the 50th percentile for MY2024.

Sacramento Valley MedShare (SVMS): SVMS is a Health Information Exchange used by practices and health systems throughout Northern California. In MY2024, Partnership received auditor approval to use Immunization, Lab, and Measurement (i.e.: blood pressure readings) records towards the HEDIS Annual Project, which had a significant impact on several MCAS measures in MY2024. In previous years not all three record categories were approved for use in the HEDIS Annual Project.

Root cause analysis of fluoride varnish coding: Partnership worked with DHCS in 2024-2025 to better understand how it receives fluoride varnish claims and encounters that can be counted towards the Topical Fluoride for Children (TFL-CH) MCAS measure, most of which are billed to Denti-Cal from Federally Qualified Health Center (FQHC), Rural Health Center (RHC), and Tribal Health Dental Centers and then sent to Partnership. As a result, Partnership was able to identify dental visits completed by FQHC, RHC, and Tribal Health Dental Centers and receive approval from HSAG's auditor to include in the MY2024 HEDIS Annual Project. Unfortunately, the dental visit data for the FQHC, RHC, and Tribal Health Dental Centers that Partnership receives from DHCS does not include procedure codes for dental fluoride varnish applications; only diagnosis codes for fluoride varnish are included. In 2025 Partnership is actively working with Dental Centers throughout its network to expand the use of dental fluoride varnish diagnosis coding to help with next year's MY2025 HEDIS audit.

HEDIS Annual Project Outcomes

Partnership successfully launched our HEDIS® MY2024/RY2025 data collection and reporting audits incorporating all changes as noted above.

DHCS MCAS Accountable Measures

In MY2024/RY2025 HEDIS® Annual Final Reporting, DHCS announced that it is planning to hold managed care plans (MCPs) accountable and imposing financial sanctions on 18 selected Hybrid and Administrative measures performing below the minimum performance level (MPL - 50th national Medicaid percentile). In prior years, the final list of sanctionable measures was changed just before sanctions were announced, so the final number of sanctionable measures may change late in 2025.

Results of an additional 20 MCAS measures were reported but were not part of the accountability measure set in MY2024 ("reporting only measures"). The full list of MY2024 MCAS measures can be found on the DHCS website: https://www.dhcs.ca.gov/dataandstats/reports/Documents/Managed-Care-Accountability-Set-Reporting-Year-2025.pdf

The same 18 MCAS accountable measures from MY2023 continued into MY2024, although two of the MY2023 measures (FUA and FUM) were removed from being accountable for MY2023 sanctions after the annual analysis was complete, due to data incompleteness transmitted from DHCS to Managed Care Plans.

Much of the measure performance analysis that follows is based on the performance of the 18 accountable MCAS measures per NCQA Quality Compass 2024 Benchmarks, developed on MY2023 performance.

2.0 Plan-Wide MCAS Performance Relative to Quality Compass® Medicaid Benchmarks

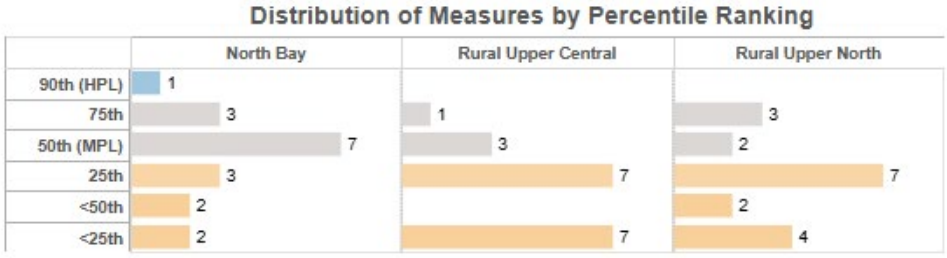
- **Above HPL** (high performance level, based on NCQA's Quality Compass Medicaid 90th percentile)
- **Below MPL** (minimum performance level,based on NCQA's Quality Compass Medicaid 50th percentile)

	Plan Wide Performance	National Medicaid Benchmarks			
Measures	**Plan Wide**	**25TH**	**50TH**	**75TH**	**90TH**
Asthma Medication Ratio (AMR) - Total, 5 to 64 Ratios > 0.50	64.71%	59.47%	66.24%	72.22%	76.65%
Breast Cancer Screening ECDS (BCS-E) - Non-Medicare Total	56.29%	47.93%	52.68%	59.51%	63.48%
Cervical Cancer Screening (CCS) - *	59.12%	49.64%	57.18%	61.56%	67.46%
Childhood Immunization Status (CIS) - Combination 10*	28.22%	22.87%	27.49%	34.79%	42.34%
Chlamydia Screening in Women (CHL) - Total	55.58%	49.65%	55.95%	64.37%	69.07%
Controlling High Blood Pressure (CBP) - Non-Medicare Total*	69.59%	59.73%	64.48%	69.37%	72.75%
#Developmental Screening in the First Three Years of Life (DEV-CH) - Total All Ages	29.65%		35.70%		
Follow-Up After Emergency Department Visit for Mental Illness (FUM) - 30 Days Total	29.01%	46.05%	53.82%	63.06%	73.12%
Follow-Up After Emergency Department Visit for Substance Use (FUA) - 30 Days Total	33.27%	26.79%	36.18%	41.86%	49.40%
**Hemoglobin A1c Poor Control for Patients With Diabetes (GSD) - HbA1c Poor Control (>9%)*	32.60%	40.15%	33.33%	29.93%	27.01%
Immunizations for Adolescents (IMA) - Combination 2*	40.39%	29.72%	34.30%	41.61%	48.66%
Lead Screening in Children (LSC) - *	71.78%	53.12%	63.84%	71.11%	79.51%
Prenatal and Postpartum Care (PPC) - Postpartum care*	89.54%	75.67%	80.23%	83.33%	86.62%
Prenatal and Postpartum Care (PPC) - Timeliness of Prenatal Care*	85.40%	79.81%	84.55%	88.58%	91.85%
#Topical Fluoride for Children (TFL - CH) - Numerator 1 Total	12.40%		19.30%		
Well Care Visits (WCV) - Total	48.83%	46.57%	51.81%	58.07%	64.74%
^Well Child 30 (W30) - Well child visits for age15-30 months	72.22%	65.53%	69.43%	73.09%	79.94%
^Well Child 30 (W30) - Well child visits in the first 15 months	67.05%	54.46%	60.38%	64.99%	69.67%

** Hybrid Measures: Measure rates are calculated using a systematic sample drawn from the eligible population. ** GSD is an inverted measure: a lower rate results in better performance. Before MY2024, the GSD measure was referred to as Hemoglobin A1c Poor Control for Patients with Diabetes (HBD) *** BCS-E in historical measurement years was named BCS. MY2023 onwards uses ECDS data collection method. ^ W30-6+ and W30-2+ measure rates were calculated using Supplemental Medical Records Review combined with administrative data in MY2024. # The Developmental Screening for Children (DEV) and Topical Fluoride for Children (TFL-CH) measures are CMS Child Core Set measures, and only have one (1) benchmark, the 50th percentile, which is the FFY 2023 State Median. NOTE: Report excludes measures reported to DHCS where DHCS does not hold Managed Care plans accountable for meeting specific performance targets.*

3.0 MCAS Summary of Performance by Region

Regional Distribution of Measures by Percentile Ranking



● Above HPL (high performance level, based on NCQA's Quality Compass Medicaid 90th percentile)

● Below MPL (minimum performance level,based on NCQA's Quality Compass Medicaid 50th percentile)

3.1 MCAS Measures at or Above the High Performance Level (HPL) – 90th Percentile

Measures	North Bay
Prenatal and Postpartum Care (PPC) - Postpartum care*	●

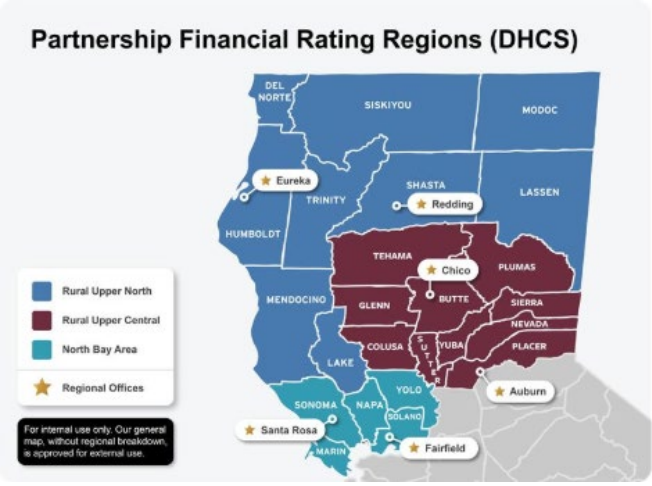
3.2 MCAS Measures below the Minimum Performance Level (MPL) - 50th Percentile

Measures	North Bay	Rural Upper Central	Rural Upper North
Asthma Medication Ratio (AMR) - Total, 5 to 64 Ratios > 0.50		●	●
***Breast Cancer Screening ECDS (BCS-E) - Non-Medicare Total		●	●
Cervical Cancer Screening (CCS)*		●	●
Childhood Immunization Status (CIS) - Combination 10*		●	●
Chlamydia Screening in Women (CHL) - Total		●	●
Controlling High Blood Pressure (CBP) - Non-Medicare Total*		●	●
#Developmental Screening in the First Three Years of Life (DEV-CH) - Total All Ages	●		●
Follow-Up After Emergency Department Visit for Mental Illnes (FUM) - 30 Days Total	●	●	●
Follow-Up After Emergency Department Visit for Substance Use (FUA) - 30 Days Total	●	●	●
**Hemoglobin A1c Poor Control for Patients With Diabetes (HBD) - HbA1c Poor Control (>9%)*	●	●	
Immunizations for Adolescents (IMA) - Combination 2*		●	●
Prenatal and Postpartum Care (PPC) - Timeliness of Prental Care*	●	●	●
#Topical Fluoride for Children (TFL - CH) - Numerator 1 Total	●		●
Well Care Visits (WCV) - Total	●	●	●
^Well Child 30 (W30) - Well child visits for age15-30 months		●	
^Well Child 30 (W30) - Well child visits in the first 15 months		●	

** Hybrid Measures: Measure rates are calculated using a systematic sample drawn from the eligible population. ** GSD is an inverted measure: a lower rate results in better performance. Before MY2024, the GSD measure was referred to as Hemoglobin A1c Poor Control for Patients with Diabetes (HBD) *** BCS-E in historical measurement years was named BCS. MY2023 onwards uses ECDS data collection method. ^ W30-6+ and W30-2+ measure rates were calculated using Supplemental Medical Records Review combined with administrative data in MY2024. # The Developmental Screening for Children (DEV) and Topical Fluoride for Children (TFL-CH) measures are CMS Child Core Set measures, and only have one (1) benchmark, the 50th percentile, which is the FFY 2023 State Median. NOTE: Report excludes measures reported to DHCS where DHCS does not hold Managed Care plans accountable for meeting specific performance targets.*

4.0 MCAS Summary of Performance by County

4.1 MCAS Distribution of Percentile Rankings by County



DHCS_ Financial_ Rating_Region	County	<25th	<50th(DEV and TFL-CH only)	25th	50th (MPL)	75th	90th (HPL)
North Bay	MARIN	1	1	3	5	2	6
	NAPA	4	2	2	2	1	7
	SOLANO	4	2	4	3	3	2
	SONOMA	1	2	4	5	3	3
	YOLO	4		4	7	3	
Rural Upper Central	BUTTE	10	2	3	2		1
	COLUSA	5		3	5		4
	GLENN	2	1	4	5	3	1
	NEVADA	7	1	2	2	2	2
	PLACER	6		3	5	1	
	PLUMAS	9	2	2		2	1
	SIERRA	8	2				1
	SUTTER	2		3	7	1	2
	TEHAMA	9	2	4		2	1
	YUBA	3		5	6		1
Rural Upper North	DEL NORTE	8	2	5	2	1	
	HUMBOLDT	3	1	4	2	5	3
	LAKE	6	2	4	2	2	2
	LASSEN	8	2	2	5	1	
	MENDOCINO	2	2	6	3	3	2
	MODOC	8	2	5		2	1
	SHASTA	9	2	2	3	2	
	SISKIYOU	6	2	7	1	1	1
	TRINITY	9	2	5		2	

- **Above HPL** (high performance level, based on NCQA's Quality Compass Medicaid 90th percentile)
- **Below MPL** (minimum performance level,based on NCQA's Quality Compass Medicaid 50th percentile)

NOTE: The Developmental Screening for Children (DEV) and Topical Fluoride for Children (TFL-CH) measures are CMS Child Core Set measures, and only have one (1) benchmark, the 50th percentile, which is the FFY 2023 State Median. Performance below the 50th percentile is indicated by the <50th column in the graph.

4.2 MCAS Percentile Ranking Change from Prior Year

Where measures remained in the MCAS in MY2024, the next set of tables show that Partnership observed a number of measures within the fourteen (14) legacy counties that declined or improved in percentile ranking relative to prior year. The NCQA Quality Compass 2024 Benchmarks, which were developed based on MY2023 performance, result in the percentile rankings below.

At the County level, a comparison of county-level performance between MY2023 and MY2024 in Partnership's 14 legacy counties shows:

- 67 county-level measures, or 26.59% of 252 county-level measures, improved in performance and moved to a higher benchmark in MY2024.
- 126 county-level measures, or 50.39% of 252 county-level measures, stayed at their same benchmark as MY2023 in MY2024.
- 58 county-level measures, or 23.02% of 252 county-level measures, declined in performance and moved to a lower benchmark in MY2024.

4.2.1 MCAS Percentile Ranking Change MY2023-2024 – Eureka Region: Del Norte, Humboldt, Lake, Mendocino Counties

- Measure percentile ranking improved from Prior Year
- Measure percentile ranking decreased from Prior Year

	DEL NORTE		HUMBOLDT		LAKE		MENDOCINO	
Measure	**MY2023**	**MY2024**	**MY2023**	**MY2024**	**MY2023**	**MY2024**	**MY2023**	**MY2024**
Asthma Medication Ratio (AMR) - Total, 5 to 64 Ratios > 0.50	<25th	25th	25th	25th	<25th	<25th	25th	25th
***Breast Cancer Screening ECDS (BCS-E) - Non-Medicare Total	<25th	<25th	25th	25th	25th	25th	25th	50th
Cervical Cancer Screening (CCS)*	<25th	<25th	50th	75th	<25th	25th	<25th	75th
Childhood Immunization Status (CIS) - Combination 10*	<25th	<25th	<25th	<25th	25th	<25th	<25th	25th
Chlamydia Screening in Women (CHL) - Total	<25th	<25th	25th	25th	25th	25th	25th	25th
Controlling High Blood Pressure (CBP) - Non-Medicare Total*	<25th	<25th	50th	75th	50th	<25th	75th	25th
#Developmental Screening in the First Three Years of Life (DEV-CH) - Total All Ages	<50th	<50th	<50th	50th	<50th	<50th	<50th	<50th
Follow-Up After Emergency Department Visit for Mental Illness (FUM) - 30 Days Total	<25th	<25th	<25th	<25th	<25th	<25th	<25th	<25th
Follow-Up After Emergency Department Visit for Substance Use (FUA) - 30 Days Total	<25th	25th	25th	75th	25th	<25th	25th	25th
**Hemoglobin A1c Poor Control for Patients With Diabetes (GSD) - HbA1c Poor Control (>9%)*	75th	25th	75th	90th	50th	<25th	50th	50th
Immunizations for Adolescents (IMA) - Combination 2*	<25th	50th	50th	50th	50th	75th	25th	<25th
Lead Screening in Children (LSC)*	25th	<25th	50th	90th	<25th	50th	75th	75th
Prenatal and Postpartum Care (PPC) - Postpartum care*	<25th	25th	90th	90th	25th	90th	90th	90th
Prenatal and Postpartum Care (PPC) - Timeliness of Prenatal Care*	25th	<25th	<25th	<25th	90th	50th	90th	50th
#Topical Fluoride for Children (TFL - CH) - Numerator 1 Total	<50th	<50th	<50th	<50th	<50th	<50th	<50th	<50th
Child and Adolescent Well Care Visits (WCV) - Total	25th	25th	50th	25th	25th	25th	25th	25th
^Well Child 30 (W30) - Well child visits for age15-30 months	<25th	50th	25th	75th	<25th	75th	50th	75th
^Well Child 30 (W30) - Well child visits in the first 15 months	<25th	75th	<25th	75th	<25th	90th	25th	90th

** Hybrid Measures: Measure rates are calculated using a systematic sample drawn from the eligible population. ** GSD is an inverted measure: a lower rate results in better performance. Before MY2024, the GSD measure was referred to as Hemoglobin A1c Poor Control for Patients with Diabetes (HBD) *** BCS-E in historical measurement years was named BCS. MY2023 onwards uses ECDS data collection method. ^ W30-6+ and W30-2+ measure rates were calculated using Supplemental Medical Records Review combined with administrative data in MY2024. # The Developmental Screening for Children (DEV) and Topical Fluoride for Children (TFL-CH) measures are CMS Child Core Set measures, and only have one (1) benchmark, the 50th percentile, which is the FFY 2023 State Median. NOTE: Report excludes measures reported to DHCS where DHCS does not hold Managed Care plans accountable for meeting specific performance targets.*

4.2.2 MCAS Percentile Ranking Change MY2023-2024 – Fairfield Region: Napa, Solano, Yolo Counties

- Measure percentile ranking improved from Prior Year
- Measure percentile ranking decreased from Prior Year

	NAPA		SOLANO		YOLO	
Measure	**MY2023**	**MY2024**	**MY2023**	**MY2024**	**MY2023**	**MY2024**
Asthma Medication Ratio (AMR) - Total, 5 to 64 Ratios > 0.50	90th	90th	50th	25th	50th	50th
***Breast Cancer Screening ECDS (BCS-E) - Non-Medicare Total	90th	90th	75th	50th	75th	75th
Cervical Cancer Screening (CCS)*	90th	90th	25th	75th	50th	25th
Childhood Immunization Status (CIS) - Combination 10*	90th	90th	75th	75th	75th	50th
Chlamydia Screening in Women (CHL) - Total	25th	<25th	50th	50th	25th	25th
Controlling High Blood Pressure (CBP) - Non-Medicare Total*	50th	25th	75th	50th	25th	25th
#Developmental Screening in the First Three Years of Life (DEV-CH) - Total All Ages	<50th	<50th	50th	<50th	50th	50th
Follow-Up After Emergency Department Visit for Mental Illness (FUM) - 30 Days Total	<25th	<25th	<25th	<25th	<25th	<25th
Follow-Up After Emergency Department Visit for Substance Use (FUA) - 30 Days Total	25th	<25th	25th	25th	<25th	<25th
**Hemoglobin A1c Poor Control for Patients With Diabetes (GSD) - HbA1c Poor Control (>9%)*	90th	50th	50th	<25th	90th	25th
Immunizations for Adolescents (IMA) - Combination 2*	90th	90th	90th	90th	75th	75th
Lead Screening in Children (LSC)*	50th	90th	25th	75th	50th	50th
Prenatal and Postpartum Care (PPC) - Postpartum care*	90th	90th	90th	90th	90th	50th
Prenatal and Postpartum Care (PPC) - Timeliness of Prenatal Care*	90th	<25th	50th	25th	90th	<25th
#Topical Fluoride for Children (TFL - CH) - Numerator 1 Total	<50th	<50th	<50th	<50th	<50th	50th
Well Care Visits (WCV) - Total	75th	50th	<25th	<25th	50th	50th
^Well Child 30 (W30) - Well child visits for age15-30 months	75th	75th	<25th	<25th	75th	75th
^Well Child 30 (W30) - Well child visits in the first 15 months	<25th	25th	<25th	25th	<25th	<25th

** Hybrid Measures: Measure rates are calculated using a systematic sample drawn from the eligible population. ** GSD is an inverted measure: a lower rate results in better performance. Before MY2024, the GSD measure was referred to as Hemoglobin A1c Poor Control for Patients with Diabetes (HBD) *** BCS-E in historical measurement years was named BCS. MY2023 onwards uses ECDS data collection method. ^ W30-6+ and W30-2+ measure rates were calculated using Supplemental Medical Records Review combined with administrative data in MY2024. # The Developmental Screening for Children (DEV) and Topical Fluoride for Children (TFL-CH) measures are CMS Child Core Set measures, and only have one (1) benchmark, the 50th percentile, which is the FFY 2023 State Median. NOTE: Report excludes measures reported to DHCS where DHCS does not hold Managed Care plans accountable for meeting specific performance targets.*

4.2.3 MCAS Percentile Ranking Change MY2023-2024 – Redding Region: Lassen, Modoc, Shasta, Siskiyou, Trinity Counties

Tehama County is excluded from the Redding Region table, since the County joined Partnership in 2024.

- Measure percentile ranking improved from Prior Year
- Measure percentile ranking decreased from Prior Year

	LASSEN		MODOC		SHASTA		SISKIYOU		TRINITY	
Measure	**MY2023**	**MY2024**	**MY2023**	**MY2024**	**MY2023**	**MY2024**	**MY2023**	**MY2024**	**MY2023**	**MY2024**
Asthma Medication Ratio (AMR) - Total, 5 to 64 Ratios > 0.50	<25th	<25th	<25th	25th	<25th	<25th	<25th	25th	<25th	<25th
***Breast Cancer Screening ECDS (BCS-E) - Non-Medicare Total	<25th	<25th	<25th	25th	25th	50th	25th	25th	<25th	25th
Cervical Cancer Screening (CCS)*	<25th	25th	<25th	<25th	<25th	25th	25th	<25th	<25th	25th
Childhood Immunization Status (CIS) - Combination 10*	<25th	<25th	<25th	<25th	<25th	<25th	<25th	25th	<25th	<25th
Chlamydia Screening in Women (CHL) - Total	<25th	<25th	<25th	<25th	25th	25th	<25th	<25th	<25th	<25th
Controlling High Blood Pressure (CBP) - Non-Medicare Total*	25th	50th	<25th	<25th	25th	<25th	90th	50th	50th	<25th
#Developmental Screening in the First Three Years of Life (DEV-CH) - Total All Ages	<50th	<50th	<50th	<50th	<50th	<50th	<50th	<50th	<50th	<50th
Follow-Up After Emergency Department Visit for Mental Illness (FUM) - 30 Days Total	<25th	<25th	<25th	<25th	<25th	<25th	<25th	<25th	<25th	<25th
Follow-Up After Emergency Department Visit for Substance Use (FUA) - 30 Days Total	<25th	<25th	25th	75th	75th	75th	25th	25th	50th	25th
**Hemoglobin A1c Poor Control for Patients With Diabetes (GSD) - HbA1c Poor Control (>9%)*	75th	50th	90th	75th	25th	50th	25th	90th	75th	75th
Immunizations for Adolescents (IMA) - Combination 2*	<25th	<25th	<25th	<25th	<25th	<25th	<25th	<25th	<25th	<25th
Lead Screening in Children (LSC)*	<25th	75th	50th	90th	25th	50th	<25th	25th	50th	75th
Prenatal and Postpartum Care (PPC) - Postpartum care*	75th	25th	90th	25th	50th	<25th	50th	75th	50th	<25th
Prenatal and Postpartum Care (PPC) - Timeliness of Prenatal Care*	25th	50th	90th	25th	25th	<25th	90th	<25th	50th	<25th
#Topical Fluoride for Children (TFL - CH) - Numerator 1 Total	<50th	<50th	<50th	<50th	<50th	<50th	<50th	<50th	<50th	<50th
Well Care Visits (WCV) - Total	<25th	<25th	<25th	25th	<25th	<25th	<25th	25th	25th	25th
^Well Child 30 (W30) - Well child visits for age15-30 months	<25th	50th	25th	<25th	<25th	<25th	<25th	25th	<25th	<25th
^Well Child 30 (W30) - Well child visits in the first 15 months	<25th	50th	<25th	<25th	<25th	75th	<25th	<25th	<25th	25th

** Hybrid Measures: Measure rates are calculated using a systematic sample drawn from the eligible population. ** GSD is an inverted measure: a lower rate results in better performance. Before MY2024, the GSD measure was referred to as Hemoglobin A1c Poor Control for Patients with Diabetes (HBD) *** BCS-E in historical measurement years was named BCS. MY2023 onwards uses ECDS data collection method. ^ W30-6+ and W30-2+ measure rates were calculated using Supplemental Medical Records Review combined with administrative data in MY2024. # The Developmental Screening for Children (DEV) and Topical Fluoride for Children (TFL-CH) measures are CMS Child Core Set measures, and only have one (1) benchmark, the 50th percentile, which is the FFY 2023 State Median. NOTE: Report excludes measures reported to DHCS where DHCS does not hold Managed Care plans accountable for meeting specific performance targets.*

4.2.4 MCAS Percentile Ranking Change MY2023-2024 – Santa Rosa Region: Marin, Sonoma Counties

- Measure percentile ranking improved from Prior Year
- Measure percentile ranking decreased from Prior Year

	MARIN		SONOMA	
Measure	**MY2023**	**MY2024**	**MY2023**	**MY2024**
Asthma Medication Ratio (AMR) - Total, 5 to 64 Ratios > 0.50	50th	25th	75th	50th
***Breast Cancer Screening ECDS (BCS-E) - Non-Medicare Total	75th	75th	75th	50th
Cervical Cancer Screening (CCS)*	90th	75th	90th	75th
Childhood Immunization Status (CIS) - Combination 10*	75th	50th	75th	50th
Chlamydia Screening in Women (CHL) - Total	90th	90th	25th	25th
Controlling High Blood Pressure (CBP) - Non-Medicare Total*	75th	50th	50th	75th
#Developmental Screening in the First Three Years of Life (DEV-CH) - Total All Ages	50th	50th	50th	<50th
Follow-Up After Emergency Department Visit for Mental Illness (FUM) - 30 Days Total	<25th	<25th	<25th	<25th
Follow-Up After Emergency Department Visit for Substance Use (FUA) - 30 Days Total	25th	25th	25th	25th
**Hemoglobin A1c Poor Control for Patients With Diabetes (GSD) - HbA1c Poor Control (>9%)*	75th	25th	75th	90th
Immunizations for Adolescents (IMA) - Combination 2*	75th	90th	90th	75th
Lead Screening in Children (LSC)*	90th	90th	<25th	25th
Prenatal and Postpartum Care (PPC) - Postpartum care*	90th	90th	90th	90th
Prenatal and Postpartum Care (PPC) - Timeliness of Prenatal Care*	50th	50th	90th	25th
#Topical Fluoride for Children (TFL - CH) - Numerator 1 Total	<50th	<50th	<50th	<50th
Well Care Visits (WCV) - Total	75th	50th	50th	50th
^Well Child 30 (W30) - Well child visits for age15-30 months	75th	90th	25th	50th
^Well Child 30 (W30) - Well child visits in the first 15 months	<25th	90th	<25th	90th

** Hybrid Measures: Measure rates are calculated using a systematic sample drawn from the eligible population. ** GSD is an inverted measure: a lower rate results in better performance. Before MY2024, the GSD measure was referred to as Hemoglobin A1c Poor Control for Patients with Diabetes (HBD) *** BCS-E in historical measurement years was named BCS. MY2023 onwards uses ECDS data collection method. ^ W30-6+ and W30-2+ measure rates were calculated using Supplemental Medical Records Review combined with administrative data in MY2024. # The Developmental Screening for Children (DEV) and Topical Fluoride for Children (TFL-CH) measures are CMS Child Core Set measures, and only have one (1) benchmark, the 50th percentile, which is the FFY 2023 State Median. NOTE: Report excludes measures reported to DHCS where DHCS does not hold Managed Care plans accountable for meeting specific performance targets.*

4.3 MY2024 MCAS Annual Performance by County

4.3.1 MCAS Auburn Region: Nevada, Placer, Plumas, Sierra Counties

- Above HPL (high performance level, based on NCQA's Quality Compass Medicaid 90th percentile)
- Below MPL (minimum performance level,based on NCQA's Quality Compass Medicaid 50th percentile)

	Partnership Region - Auburn				National Medicaid Benchmarks			
Measures	NEVADA	PLACER	PLUMAS	SIERRA	25TH	50TH	75th	90th
Asthma Medication Ratio (AMR) - Total, 5 to 64 Ratios > 0.50			100.00%		59.47%	66.24%		
***Breast Cancer Screening ECDS (BCS-E) - Non-Medicare Total	66.67%	0.00%		0.00%	47.93%	52.68%	59.51%	63.48%
Cervical Cancer Screening (CCS)*	40.21%	39.39%	32.63%	43.43%	49.64%	57.18%	61.56%	67.46%
Childhood Immunization Status (CIS) - Combination 10*	15.22%	21.67%	12.50%		22.87%	27.49%	34.79%	42.34%
Chlamydia Screening in Women (CHL) - Total	48.06%	60.67%	23.26%	27.27%	49.65%	55.95%	64.37%	69.07%
Controlling High Blood Pressure (CBP) - Non-Medicare Total*	56.00%	53.00%	34.00%		59.73%	64.48%	69.37%	72.75%
#Developmental Screening in the First Three Years of Life (DEV-CH) - Total All Ages	39.51%	44.12%	0.00%	0.00%		35.70%		
Follow-Up After Emergency Department Visit for Mental Illness (FUM) - 30 Days Total	36.81%	23.45%	25.00%	0.00%	46.05%	53.82%	63.06%	73.12%
Follow-Up After Emergency Department Visit for Substance Use (FUA) - 30 Days Total	38.31%	34.08%	32.69%	100.00%	26.79%	36.18%	41.86%	49.40%
**Hemoglobin A1c Poor Control for Patients With Diabetes (GSD) - HbA1c Poor Control (>9%)*	34.00%	36.00%	73.00%		40.15%	33.33%	29.93%	27.01%
Immunizations for Adolescents (IMA) - Combination 2*	17.54%	36.00%	0.00%	0.00%	29.72%	34.30%	41.61%	48.66%
Lead Screening in Children (LSC)*	76.09%	65.00%	75.00%		53.12%	63.84%	71.11%	79.51%
Prenatal and Postpartum Care (PPC) - Postpartum care*	83.84%	84.00%	77.78%	25.00%	75.67%	80.23%	83.33%	86.62%
Prenatal and Postpartum Care (PPC) - Timeliness of Prenatal Care*	82.83%	68.00%	88.89%	75.00%	79.81%	84.55%	88.58%	91.85%
#Topical Fluoride for Children (TFL - CH) - Numerator 1 Total	7.38%	20.20%	5.44%	5.45%		19.30%		
Well Care Visits (WCV) - Total	42.02%	47.93%	28.19%	30.90%	46.57%	51.81%	58.07%	64.74%
^Well Child 30 (W30) - Well child visits for age15-30 months	100.00%		33.33%		65.53%	69.43%	73.09%	79.94%
^Well Child 30 (W30) - Well child visits in the first 15 months					54.46%	60.38%	64.99%	69.67%

** Hybrid Measures: Measure rates are calculated using a systematic sample drawn from the eligible population. ** GSD is an inverted measure: a lower rate results in better performance. Before MY2024, the GSD measure was referred to as Hemoglobin A1c Poor Control for Patients with Diabetes (HBD) *** BCS-E in historical measurement years was named BCS. MY2023 onwards uses ECDS data collection method. ^ W30-6+ and W30-2+ measure rates were calculated using Supplemental Medical Records Review combined with administrative data in MY2024. # The Developmental Screening for Children (DEV) and Topical Fluoride for Children (TFL-CH) measures are CMS Child Core Set measures, and only have one (1) benchmark, the 50th percentile, which is the FFY 2023 State Median. NOTE: Report excludes measures reported to DHCS where DHCS does not hold Managed Care plans accountable for meeting specific performance targets.* ***Blank cells indicate an Eligible Population of 0 members within a County for the measure.***

4.3.2 MCAS Chico Region: Butte, Colusa, Glenn, Sutter, Yuba Counties

- **Above HPL** (high performance level, based on NCQA's Quality Compass Medicaid 90th percentile)
- **Below MPL** (minimum performance level,based on NCQA's Quality Compass Medicaid 50th percentile)

	Partnership Region - Chico					National Medicaid Benchmarks			
Measures	BUTTE	COLUSA	GLENN	SUTTER	YUBA	25TH	50TH	75th	90th
Asthma Medication Ratio (AMR) - Total, 5 to 64 Ratios > 0.50	66.67%		100.00%			59.47%	66.24%	72.22%	76.65%
***Breast Cancer Screening ECDS (BCS-E) - Non-Medicare Total	26.32%	20.00%	0.00%	0.00%	100.00%	47.93%	52.68%	59.51%	63.48%
Cervical Cancer Screening (CCS)*	46.94%	60.61%	50.51%	54.08%	42.00%	49.64%	57.18%	61.56%	67.46%
Childhood Immunization Status (CIS) - Combination 10*	15.00%	21.88%	27.78%	37.84%	23.19%	22.87%	27.49%	34.79%	42.34%
Chlamydia Screening in Women (CHL) - Total	55.64%	53.02%	51.47%	57.24%	57.89%	49.65%	55.95%	64.37%	69.07%
Controlling High Blood Pressure (CBP) - Non-Medicare Total*	66.00%	64.00%	71.00%	67.68%	61.00%	59.73%	64.48%	69.37%	72.75%
#Developmental Screening in the First Three Years of Life (DEV-CH) - Total All Ages	10.10%	40.68%	36.17%	57.22%	56.33%		35.70%		
Follow-Up After Emergency Department Visit for Mental Illness (FUM) - 30 Days Total	20.40%	33.33%	28.57%	26.09%	24.72%	46.05%	53.82%	63.06%	73.12%
Follow-Up After Emergency Department Visit for Substance Use (FUA) - 30 Days Total	34.49%	26.92%	34.78%	29.85%	30.13%	26.79%	36.18%	41.86%	49.40%
**Hemoglobin A1c Poor Control for Patients With Diabetes (GSD) - HbA1c Poor Control (>9%)*	43.00%	32.00%	33.00%	36.00%	43.00%	40.15%	33.33%	29.93%	27.01%
Immunizations for Adolescents (IMA) - Combination 2*	22.00%	60.00%	37.93%	39.51%	37.14%	29.72%	34.30%	41.61%	48.66%
Lead Screening in Children (LSC)*	53.00%	87.50%	77.78%	83.78%	63.77%	53.12%	63.84%	71.11%	79.51%
Prenatal and Postpartum Care (PPC) - Postpartum care*	90.00%	92.94%	85.00%	90.00%	81.82%	75.67%	80.23%	83.33%	86.62%
Prenatal and Postpartum Care (PPC) - Timeliness of Prenatal Care*	82.00%	74.12%	83.00%	87.00%	87.88%	79.81%	84.55%	88.58%	91.85%
#Topical Fluoride for Children (TFL - CH) - Numerator 1 Total	18.62%	28.95%	9.77%	39.49%	28.17%		19.30%		
Well Care Visits (WCV) - Total	41.84%	55.53%	53.91%	55.93%	47.65%	46.57%	51.81%	58.07%	64.74%
^Well Child 30 (W30) - Well child visits for age15-30 months	50.00%	100.00%				65.53%	69.43%	73.09%	79.94%
^Well Child 30 (W30) - Well child visits in the first 15 months	0.00%	0.00%				54.46%	60.38%	64.99%	69.67%

** Hybrid Measures: Measure rates are calculated using a systematic sample drawn from the eligible population. ** GSD is an inverted measure: a lower rate results in better performance. Before MY2024, the GSD measure was referred to as Hemoglobin A1c Poor Control for Patients with Diabetes (HBD) *** BCS-E in historical measurement years was named BCS. MY2023 onwards uses ECDS data collection method. ^ W30-6+ and W30-2+ measure rates were calculated using Supplemental Medical Records Review combined with administrative data in MY2024. # The Developmental Screening for Children (DEV) and Topical Fluoride for Children (TFL-CH) measures are CMS Child Core Set measures, and only have one (1) benchmark, the 50th percentile, which is the FFY 2023 State Median. NOTE: Report excludes measures reported to DHCS where DHCS does not hold Managed Care plans accountable for meeting specific performance targets.* ***Blank cells indicate an Eligible Population of 0 members within a County for the measure.***

4.3.3 MCAS Eureka Region: Del Norte, Humboldt, Lake, Mendocino Counties

- **Above HPL** (high performance level, based on NCQA's Quality Compass Medicaid 90th percentile)
- **Below MPL** (minimum performance level,based on NCQA's Quality Compass Medicaid 50th percentile)

	Partnership Region - Eureka				National Medicaid Benchmarks			
Measures	DEL NORTE	HUMBOLDT	LAKE	MENDOCINO	25TH	50TH	75th	90th
Asthma Medication Ratio (AMR) - Total, 5 to 64 Ratios > 0.50	60.83%	63.41%	57.84%	62.50%	59.47%	66.24%	72.22%	76.65%
***Breast Cancer Screening ECDS (BCS-E) - Non-Medicare Total	46.83%	51.35%	48.55%	56.75%	47.93%	52.68%	59.51%	63.48%
Cervical Cancer Screening (CCS)*	49.00%	63.00%	56.25%	62.63%	49.64%	57.18%	61.56%	67.46%
Childhood Immunization Status (CIS) - Combination 10*	6.00%	19.00%	21.00%	25.00%	22.87%	27.49%	34.79%	42.34%
Chlamydia Screening in Women (CHL) - Total	47.33%	54.61%	53.93%	52.00%	49.65%	55.95%	64.37%	69.07%
Controlling High Blood Pressure (CBP) - Non-Medicare Total*	58.59%	70.00%	52.00%	63.00%	59.73%	64.48%	69.37%	72.75%
#Developmental Screening in the First Three Years of Life (DEV-CH) - Total All Ages	27.71%	38.89%	6.03%	8.12%		35.70%		
Follow-Up After Emergency Department Visit for Mental Illness (FUM) - 30 Days Total	27.68%	35.36%	35.75%	30.66%	46.05%	53.82%	63.06%	73.12%
Follow-Up After Emergency Department Visit for Substance Use (FUA) - 30 Days Total	27.06%	42.26%	23.51%	30.15%	26.79%	36.18%	41.86%	49.40%
**Hemoglobin A1c Poor Control for Patients With Diabetes (GSD) - HbA1c Poor Control (>9%)*	35.00%	23.00%	49.00%	31.00%	40.15%	33.33%	29.93%	27.01%
Immunizations for Adolescents (IMA) - Combination 2*	36.00%	38.00%	42.00%	28.00%	29.72%	34.30%	41.61%	48.66%
Lead Screening in Children (LSC)*	53.00%	89.00%	71.00%	79.00%	53.12%	63.84%	71.11%	79.51%
Prenatal and Postpartum Care (PPC) - Postpartum care*	79.00%	93.00%	91.00%	92.00%	75.67%	80.23%	83.33%	86.62%
Prenatal and Postpartum Care (PPC) - Timeliness of Prenatal Care*	78.00%	79.00%	86.00%	86.00%	79.81%	84.55%	88.58%	91.85%
#Topical Fluoride for Children (TFL - CH) - Numerator 1 Total	0.68%	1.11%	1.69%	3.86%		19.30%		
Well Care Visits (WCV) - Total	49.25%	50.11%	48.82%	47.59%	46.57%	51.81%	58.07%	64.74%
^Well Child 30 (W30) - Well child visits for age15-30 months	71.79%	74.89%	78.92%	75.15%	65.53%	69.43%	73.09%	79.94%
^Well Child 30 (W30) - Well child visits in the first 15 months	68.47%	68.89%	79.34%	74.19%	54.46%	60.38%	64.99%	69.67%

** Hybrid Measures: Measure rates are calculated using a systematic sample drawn from the eligible population. ** GSD is an inverted measure: a lower rate results in better performance. Before MY2024, the GSD measure was referred to as Hemoglobin A1c Poor Control for Patients with Diabetes (HBD) *** BCS-E in historical measurement years was named BCS. MY2023 onwards uses ECDS data collection method. ^ W30-6+ and W30-2+ measure rates were calculated using Supplemental Medical Records Review combined with administrative data in MY2024. # The Developmental Screening for Children (DEV) and Topical Fluoride for Children (TFL-CH) measures are CMS Child Core Set measures, and only have one (1) benchmark, the 50th percentile, which is the FFY 2023 State Median. NOTE: Report excludes measures reported to DHCS where DHCS does not hold Managed Care plans accountable for meeting specific performance targets.*

4.3.4 MCAS Fairfield Region: Solano, Yolo, and Napa Counties

- **Above HPL** (high performance level, based on NCQA's Quality Compass Medicaid 90th percentile)
- **Below MPL** (minimum performance level,based on NCQA's Quality Compass Medicaid 50th percentile)

Measures	Partnership Region - Fairfield			National Medicaid Benchmarks			
	NAPA	SOLANO	YOLO	25TH	50TH	75th	90th
Asthma Medication Ratio (AMR) - Total, 5 to 64 Ratios > 0.50	79.82%	65.79%	67.84%	59.47%	66.24%	72.22%	76.65%
***Breast Cancer Screening ECDS (BCS-E) - Non-Medicare Total	66.84%	54.14%	60.29%	47.93%	52.68%	59.51%	63.48%
Cervical Cancer Screening (CCS)*	70.00%	64.95%	52.53%	49.64%	57.18%	61.56%	67.46%
Childhood Immunization Status (CIS) - Combination 10*	47.00%	38.00%	33.00%	22.87%	27.49%	34.79%	42.34%
Chlamydia Screening in Women (CHL) - Total	49.58%	62.14%	51.37%	49.65%	55.95%	64.37%	69.07%
Controlling High Blood Pressure (CBP) - Non-Medicare Total*	63.00%	67.00%	63.00%	59.73%	64.48%	69.37%	72.75%
#Developmental Screening in the First Three Years of Life (DEV-CH) - Total All Ages	3.77%	33.92%	61.20%		35.70%		
Follow-Up After Emergency Department Visit for Mental Illness (FUM) - 30 Days Total	26.09%	24.53%	26.73%	46.05%	53.82%	63.06%	73.12%
Follow-Up After Emergency Department Visit for Substance Use (FUA) - 30 Days Total	26.11%	29.24%	26.46%	26.79%	36.18%	41.86%	49.40%
**Hemoglobin A1c Poor Control for Patients With Diabetes (GSD) - HbA1c Poor Control (>9%)*	32.00%	41.00%	35.00%	40.15%	33.33%	29.93%	27.01%
Immunizations for Adolescents (IMA) - Combination 2*	53.00%	49.00%	46.00%	29.72%	34.30%	41.61%	48.66%
Lead Screening in Children (LSC)*	84.00%	72.00%	71.00%	53.12%	63.84%	71.11%	79.51%
Prenatal and Postpartum Care (PPC) - Postpartum care*	93.00%	89.00%	82.00%	75.67%	80.23%	83.33%	86.62%
Prenatal and Postpartum Care (PPC) - Timeliness of Prenatal Care*	74.00%	82.00%	65.00%	79.81%	84.55%	88.58%	91.85%
#Topical Fluoride for Children (TFL - CH) - Numerator 1 Total	13.87%	16.40%	19.73%		19.30%		
Well Care Visits (WCV) - Total	55.43%	43.99%	52.25%	46.57%	51.81%	58.07%	64.74%
^Well Child 30 (W30) - Well child visits for age15-30 months	75.50%	63.84%	73.35%	65.53%	69.43%	73.09%	79.94%
^Well Child 30 (W30) - Well child visits in the first 15 months	54.79%	55.26%	49.82%	54.46%	60.38%	64.99%	69.67%

** Hybrid Measures: Measure rates are calculated using a systematic sample drawn from the eligible population. ** GSD is an inverted measure: a lower rate results in better performance. Before MY2024, the GSD measure was referred to as Hemoglobin A1c Poor Control for Patients with Diabetes (HBD) *** BCS-E in historical measurement years was named BCS. MY2023 onwards uses ECDS data collection method. ^ W30-6+ and W30-2+ measure rates were calculated using Supplemental Medical Records Review combined with administrative data in MY2024. # The Developmental Screening for Children (DEV) and Topical Fluoride for Children (TFL-CH) measures are CMS Child Core Set measures, and only have one (1) benchmark, the 50th percentile, which is the FFY 2023 State Median. NOTE: Report excludes measures reported to DHCS where DHCS does not hold Managed Care plans accountable for meeting specific performance targets.*

4.3.5 MCAS Redding Region: Lassen, Modoc, Shasta, Siskiyou, Tehama, Trinity Counties

- Above HPL (high performance level, based on NCQA's Quality Compass Medicaid 90th percentile)
- Below MPL (minimum performance level,based on NCQA's Quality Compass Medicaid 50th percentile)

	Partnership Region - Redding						National Medicaid Benchmarks			
Measures	LASSEN	MODOC	SHASTA	SISKIYOU	TEHAMA	TRINITY	25TH	50TH	75th	90th
Asthma Medication Ratio (AMR) - Total, 5 to 64 Ratios > 0.50	58.70%	63.16%	57.28%	59.62%	0.00%	50.00%	59.47%	66.24%	72.22%	76.65%
***Breast Cancer Screening ECDS (BCS-E) - Non-Medicare Total	43.08%	48.52%	54.90%	52.64%	38.46%	49.39%	47.93%	52.68%	59.51%	63.48%
Cervical Cancer Screening (CCS)*	50.52%	46.46%	52.53%	49.49%	44.00%	55.79%	49.64%	57.18%	61.56%	67.46%
Childhood Immunization Status (CIS) - Combination 10*	13.00%	9.76%	14.00%	26.00%	16.00%	7.25%	22.87%	27.49%	34.79%	42.34%
Chlamydia Screening in Women (CHL) - Total	41.55%	32.89%	52.12%	45.38%	54.34%	34.72%	49.65%	55.95%	64.37%	69.07%
Controlling High Blood Pressure (CBP) - Non-Medicare Total*	66.00%	56.00%	58.00%	67.00%	64.00%	47.00%	59.73%	64.48%	69.37%	72.75%
#Developmental Screening in the First Three Years of Life (DEV-CH) - Total All Ages	11.91%	27.27%	26.09%	28.95%	32.26%	8.67%		35.70%		
Follow-Up After Emergency Department Visit for Mental Illness (FUM) - 30 Days Total	18.75%	11.76%	35.70%	37.50%	14.81%	12.50%	46.05%	53.82%	63.06%	73.12%
Follow-Up After Emergency Department Visit for Substance Use (FUA) - 30 Days Total	25.81%	45.45%	43.80%	32.53%	31.60%	32.56%	26.79%	36.18%	41.86%	49.40%
**Hemoglobin A1c Poor Control for Patients With Diabetes (GSD) - HbA1c Poor Control (>9%)*	32.00%	29.00%	30.00%	27.00%	41.00%	28.00%	40.15%	33.33%	29.93%	27.01%
Immunizations for Adolescents (IMA) - Combination 2*	9.00%	24.00%	23.00%	17.00%	17.54%	20.37%	29.72%	34.30%	41.61%	48.66%
Lead Screening in Children (LSC)*	76.00%	80.49%	71.00%	55.00%	76.00%	72.46%	53.12%	63.84%	71.11%	79.51%
Prenatal and Postpartum Care (PPC) - Postpartum care*	79.76%	77.42%	69.00%	84.00%	80.00%	75.47%	75.67%	80.23%	83.33%	86.62%
Prenatal and Postpartum Care (PPC) - Timeliness of Prenatal Care*	86.90%	83.87%	71.00%	78.00%	72.00%	67.92%	79.81%	84.55%	88.58%	91.85%
#Topical Fluoride for Children (TFL - CH) - Numerator 1 Total	3.23%	3.06%	5.05%	1.25%	9.96%	2.39%		19.30%		
Well Care Visits (WCV) - Total	36.95%	48.59%	44.19%	47.51%	46.42%	48.35%	46.57%	51.81%	58.07%	64.74%
^Well Child 30 (W30) - Well child visits for age15-30 months	70.16%	56.10%	65.41%	69.10%	75.00%	61.40%	65.53%	69.43%	73.09%	79.94%
^Well Child 30 (W30) - Well child visits in the first 15 months	63.64%	45.83%	65.20%	37.63%	75.00%	59.38%	54.46%	60.38%	64.99%	69.67%

** Hybrid Measures: Measure rates are calculated using a systematic sample drawn from the eligible population. ** GSD is an inverted measure: a lower rate results in better performance. Before MY2024, the GSD measure was referred to as Hemoglobin A1c Poor Control for Patients with Diabetes (HBD) *** BCS-E in historical measurement years was named BCS. MY2023 onwards uses ECDS data collection method. ^ W30-6+ and W30-2+ measure rates were calculated using Supplemental Medical Records Review combined with administrative data in MY2024. # The Developmental Screening for Children (DEV) and Topical Fluoride for Children (TFL-CH) measures are CMS Child Core Set measures, and only have one (1) benchmark, the 50th percentile, which is the FFY 2023 State Median. NOTE: Report excludes measures reported to DHCS where DHCS does not hold Managed Care plans accountable for meeting specific performance targets.*

4.3.6 MCAS Santa Rosa Region: Marin, Sonoma Counties

- Above HPL (high performance level, based on NCQA's Quality Compass Medicaid 90th percentile)
- Below MPL (minimum performance level,based on NCQA's Quality Compass Medicaid 50th percentile)

	Partnership Region - Santa Rosa		National Medicaid Benchmarks			
Measures	MARIN	SONOMA	25TH	50TH	75th	90th
Asthma Medication Ratio (AMR) - Total, 5 to 64 Ratios > 0.50	61.27%	70.42%	59.47%	66.24%	72.22%	76.65%
***Breast Cancer Screening ECDS (BCS-E) - Non-Medicare Total	63.44%	59.17%	47.93%	52.68%	59.51%	63.48%
Cervical Cancer Screening (CCS)*	64.00%	66.67%	49.64%	57.18%	61.56%	67.46%
Childhood Immunization Status (CIS) - Combination 10*	34.00%	30.00%	22.87%	27.49%	34.79%	42.34%
Chlamydia Screening in Women (CHL) - Total	77.63%	51.89%	49.65%	55.95%	64.37%	69.07%
Controlling High Blood Pressure (CBP) - Non-Medicare Total*	69.00%	70.00%	59.73%	64.48%	69.37%	72.75%
#Developmental Screening in the First Three Years of Life (DEV-CH) - Total All Ages	48.23%	26.47%		35.70%		
Follow-Up After Emergency Department Visit for Mental Illness (FUM) - 30 Days Total	37.27%	33.66%	46.05%	53.82%	63.06%	73.12%
Follow-Up After Emergency Department Visit for Substance Use (FUA) - 30 Days Total	34.63%	31.17%	26.79%	36.18%	41.86%	49.40%
**Hemoglobin A1c Poor Control for Patients With Diabetes (GSD) - HbA1c Poor Control (>9%)*	37.00%	27.00%	40.15%	33.33%	29.93%	27.01%
Immunizations for Adolescents (IMA) - Combination 2*	49.00%	48.00%	29.72%	34.30%	41.61%	48.66%
Lead Screening in Children (LSC)*	89.00%	54.00%	53.12%	63.84%	71.11%	79.51%
Prenatal and Postpartum Care (PPC) - Postpartum care*	98.00%	98.00%	75.67%	80.23%	83.33%	86.62%
Prenatal and Postpartum Care (PPC) - Timeliness of Prenatal Care*	88.00%	81.00%	79.81%	84.55%	88.58%	91.85%
#Topical Fluoride for Children (TFL - CH) - Numerator 1 Total	0.55%	6.17%		19.30%		
Well Care Visits (WCV) - Total	56.18%	55.42%	46.57%	51.81%	58.07%	64.74%
^Well Child 30 (W30) - Well child visits for age15-30 months	90.11%	71.03%	65.53%	69.43%	73.09%	79.94%
^Well Child 30 (W30) - Well child visits in the first 15 months	86.53%	70.70%	54.46%	60.38%	64.99%	69.67%

** Hybrid Measures: Measure rates are calculated using a systematic sample drawn from the eligible population. ** GSD is an inverted measure: a lower rate results in better performance. Before MY2024, the GSD measure was referred to as Hemoglobin A1c Poor Control for Patients with Diabetes (HBD) *** BCS-E in historical measurement years was named BCS. MY2023 onwards uses ECDS data collection method. ^ W30-6+ and W30-2+ measure rates were calculated using Supplemental Medical Records Review combined with administrative data in MY2024. # The Developmental Screening for Children (DEV) and Topical Fluoride for Children (TFL-CH) measures are CMS Child Core Set measures, and only have one (1) benchmark, the 50th percentile, which is the FFY 2023 State Median. NOTE: Report excludes measures reported to DHCS where DHCS does not hold Managed Care plans accountable for meeting specific performance targets.*

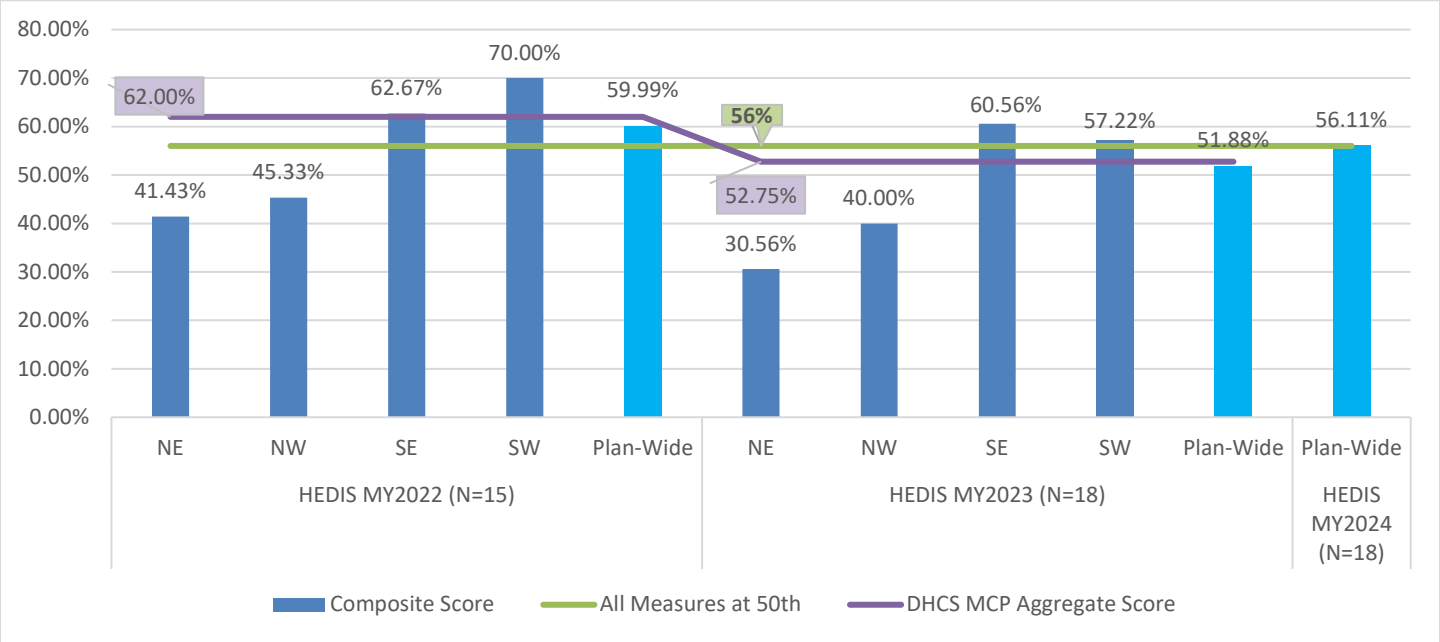
5.0 Overall Health Plan Ranking: DHCS Managed Care Accountability Set (MCAS)

DHCS uses a scoring methodology to determine an aggregated Quality Factor Score (QFS), which ranks health plan performance relative to California Medicaid reporting health plans. Partnership adopts DHCS' scoring methodology to determine Partnership's composite scores year over year. In prior years, Partnership's composite score was calculated for each of the four (4) legacy Reporting Units (Southeast, Southwest, Northeast, and Northwest). In MY2024, since Partnership transitioned to one (1) Plan-Wide Reporting Unit, a single Plan-Wide composite score is calculated.

To calculate the composite score, each measure is given a score from one to ten (1-10) based on performance relative to national benchmarks. A composite score is then calculated by dividing total earned points by total possible points.

The Quality Compass 2024 Benchmarks, which were developed based on national MY2023 performance, are the most currently available benchmarks. These benchmarks were used by Partnership to determine percentile rankings and the following composite scoring year over year analysis. Annually each fall, DHCS releases a dashboard displaying the plan's Quality Factor Scores and associated rankings to other health plans. The results of this ranking will be published upon the release of this information and will be utilized by DHCS to assess mandated improvement activities and any sanctions.

MY2024 HEDIS® Composite Performance Year over Year Comparison: DHCS Managed Care Accountability Set (MCAS)



Note: MY2024/RY2025: Total Points Earned: 101 Points out of 180 Total Points (18 measures included)

- In MY2024 18 measures were held accountable to the MPL.
- Three (3) measures were added to the MCAS Accountable Measure Set in MY2023: Asthma Medication Ratio (AMR), Developmental Screening for Children (DEV), and Topical Fluoride for Children (TFL-CH).
- MY2022-MY2023 represents DHCS's Quality Factor Scores, which are publicly available and issued in year following the Reporting Year.
- For MY2022-MY2023, Partnership received four (4) Quality Factor Scores from DHCS for each of its legacy Reporting Units. Partnership calculates its Plan-Wide score across all four DHCS MCAS reporting regions by factoring in eligible populations by region, given membership is significantly greater in the Southern region reporting populations than Northern.

6.0 Year-over-year Performance Trends and Initial Assessment of Results

6.1 Year-over-year Performance Trends

The MY2024 HEDIS® Composite Performance Year-Over-Year Comparison is based on NCQA Quality Compass 2024 (MY2023) Benchmarks. To date, DHCS has only established state-wide MPLs for the two newly accountable CMS Core set measures, Developmental Screening in the First Three Years of Life (DEV) and Topical Fluoride for Children (TFL-CH). Therefore, the maximum points for these two (2) measures is 6 points. All other measures in the MCAS Accountable Measure Set can earn up to 10 points.

Overall, the MY2024 HEDIS® Composite Performance Year over Year Comparison indicates a 4.22% increase in aggregate plan-wide performance from MY2023 to MY2024.

Plan-Wide, Partnership saw the following Year over Year changes in Plan-Wide rates between MY2023 and MY2024:

- 9 of 18 measures improved in performance and moved to a higher benchmark in MY2024.
- 6 of 18 measures stayed at their same benchmark as MY2023 in MY2024.
- 3 of 18 measures declined in performance and moved to a lower benchmark in MY2024.

6.2 Plan-Wide Strengths: Measure Performing Above MPL

Eleven (11) of the 18 measures in the MCAS Accountable set exceeded the Minimum Performance Level in MY2024.

Six (6) measures are newly above the Minimum Performance Level in MY2024, as seen in the Table below.

Table: MCAS Measures Newly Above MPL in MY2024

Measure	MY2023 Plan-Wide Benchmark	MY2024 Plan-Wide Benchmark YOY points gained
Breast Cancer Screening (BCS-E)	37.5th	50th +0.77%
Cervical Cancer Screening (CCS)	37.5th	50th +2.77%
Childhood Immunization Status—Combination 10 only (CIS-10)	25th	50th +0.97%
Lead Screening in Children (LSC)	25th	75th +12.66%
Well-Child Visits in the First 30 Months of Life - 2+ visits 15-30 months (W30-2)	37.5th	62.5th +7.67%
Well-Child Visits in the First 30 Months of Life - 6+ visits in 0-15 months (W30-6)	<10th	75th +24.96%

- Breast Cancer Screening (BCS): Partnership achieved a Plan-Wide score above the MPL for the first time in MY2024. These gains are largely attributed to initiatives cited in Section 9, focused on creating greater access through mobile mammography events. This measure continues in the PCP QIP to bring continued PCP focus on utilizing available access to mammography services on an ongoing basis.

  Of note, performance in this measure is expected to drop in MY2025 and in the following few years, as the BCS-E measure lowered the age range for beginning breast cancer screening from age 50 years to 40 years. As this is a national change to the HEDIS measure, an adjustment in the benchmarks for this measure may follow, but some negative impact on performance is anticipated. Because the measure has long continuous enrollment requirements for members to be included in the measure, MY2024's measure included very few members from the incoming 10 counties. Since the incoming counties showed significant data completeness issues in their measure performance, Partnership also anticipates a drop in performance in MY2025 when the full cohort of members are included in the BCS-E measure.

- Cervical Cancer Screening (CCS): In MY2024 Partnership received approval on all of its supplemental data sources, including Health Information Exchange lab data that captures screenings outside the primary care setting. Strong performance in legacy counties counterbalanced data completeness challenges in incoming counties for this measure with a five-year lookback period. As noted in Section 9, Partnership is promoting self-swab testing to members through PCPs, now that this method has received FDA approval and can be counted towards this HEDIS measure in MY2025 and onward.

- Childhood Immunizations (CIS): Partnership met the MPL benchmark Plan-Wide on this measure for the first time in MY2024. The improvement in performance is partially due to a 3% decline in the national percentiles between MY2023 and MY2024. Fairfield and Santa Rosa Region counties had significantly stronger measure performance than Auburn, Chico, Eureka, and Redding Region counties. In review of HEDIS sampled medical records, the second required influenza immunization was observed as the most common missing immunization. In cases where the immunizations were administered, the dates of service were often outside the measurement compliance timeframe. Additionally, high rates of parental refusal continue to be a major factor in measure performance, which even when documented in the record is not a permitted exclusion under the HEDIS measure.

- Lead Screening for Children (LSC): Partnership showed dramatic improvement on the LSC measure, gaining over 12% on its Plan-Wide rate between MY2023-2024. Improvement is related to the inclusion of the measure in the PCP QIP, which allows practices to measure their improvement throughout the measurement year. Partnership spearheaded extensive provider education efforts throughout the provider network as a component of Facility Site Reviews and with dedicated Lead Screening training webinars. The Lead Screening Point of Care (POC) Distribution Program, in which PCP sites could receive a POC device from Partnership for real-time lead screening, made a significant contribution to improved rates for this measure.

- Well Child Visits in the First 30 Months of Life (W30): As described in Section 1, Partnership addressed the known data completeness issues around the W30 measure by completing a Medical Record Review (MRR) of the entire eligible population for the W30 measure in MY2024. By requesting charts from PCP's and completing a Medical Record Review, Partnership treated the measure as a hybrid measure and received auditor approval to include the W30 MRR as a supplemental data source. As a result, both W30 submeasures improved dramatically in performance, and are now both above the 50th percentile for the first time in MY2024. Partnership intends to continue completing a MRR on the W30 measure in future HEDIS Projects.

Five (5) additional measures have sustained Plan-Wide performance above the MPL since MY2023.

Table: MCAS Measures With Sustained Performance above the MPL MY2023-2024

Measure	MY2023 Plan-Wide Benchmark	MY2024 Plan-Wide Benchmark YOY points gained
Controlling High Blood Pressure (CBP)	50th	75th +6.23%
Glycemic Status Assessment for Patients With Diabetes (>9%) (GSD)	62.5th	50th +1.48%
Immunizations for Adolescents—Combination 2 (IMA-2)	50th	62.5th +2.43%
Prenatal and Postpartum Care: Postpartum Care (PPC-Post)	90th	90th +4.14%
Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-Pre)	50th	50th -0.78%

- Controlling High Blood Pressure (CBP) and Glycemic Status Assessment for Patients with Diabetes (>9%) (GSD): Both measures benefitted greatly from the approval of all supplemental data sources by Partnership's HEDIS auditor in MY2024. Partnership's Health Information Exchange, Sacramento Valley MedShare (SVMS) is a clearinghouse for lab and measurement data, which helps support the Medical Record Review for this measure. Additionally, Partnership piloted use of an NCQA Data Aggregator, Datalink, in MY2024 – as described in Section 1, Datalink is a promising new source of blood pressure readings and Hemoglobin A1c results. Finally, the increased use of OCHIN Epic within the PCP network means that more practices have the ability to automate the CPTII coding that is required to support these measures.

  Though GSD's Plan-Wide rate improved by 1.48% in MY2024 (as an inverse measure, improvement is reflected as a lower rate), Partnership's drop in percentile for GSD reflects an over 4.5% benchmark movement between MY2023 and MY2024, making a high benchmark harder to obtain.

- Immunizations for Adolescents (IMA-2): Because some of the vaccinations included in this measure are required for public school enrollment, this is historically a higher performing childhood vaccination measure than Childhood Immunization Series (CIS-10). Encouragingly, MY2024 shows several counties in Rural Upper North and Rural Upper Central regions exceeding the MPL for this measure along with all North Bay Area counties. The predominant causes of low rates are missing or late secondary doses of the HPV immunization series and high rates of parental refusal.

- Timeliness of Prenatal Care (PPC-Pre): Partnership just met the MPL for the Plan-Wide rate for this measure in MY2024. Because of variations in Eligible Populations within regional rates (calculated from county rates, which use a larger random sample of charts from each county than plan-wide rates), none of Partnership's Financial Rating Regions met the 50th percentile for this measure. The HEDIS team observed several performance issues around prenatal visits, including that many members receive their first prenatal visit outside of the measure timeline, and that visits do not include all of the required components of a prenatal visit. Prenatal visits will be a measure of increased focus in MY2025 onwards to reverse declining rates on this measure throughout Partnership's network.

- Postpartum Care (PPC-Post): Postpartum Care visits continue to be a source of strength for Partnership, with sustained performance over the 90th percentile. Interventions to maintain high postpartum care rates are described in Section 9 and include refinements to the Growing Together Program and equity focused programs centered on communities with lower prenatal and postpartum visit rates.

6.3 Plan-Wide Opportunities for Improvement

After analyzing the MY2024 annual results and year over year performance comparisons, measures below the MPL can be categorized across three primary drivers.

1.) Performance – Members qualifying under a measure did not receive the required care per measure specifications and designated timeframes

2.) **Data Completeness** – Data used to generate reported rates has gaps, decreasing confidence that reported rates accurately reflect performance.

3.) Measure Limitations – Measure specifications determine how data is collected through the reporting of rate performance. Measure specifications can detract from a measure's intended purpose. In these cases, specifications can limit accurate representation of performance as well as detection of recent improvements that are in alignment with the measure's purpose and clinical practice.

6.3.1 MCAS Measures with Performance Opportunities

Three (3) measures are performance improvement opportunities for Partnership's provider network. These measures have sustained performance below the MPL, and data completeness issues are not the primary driver of low measure rates.

Table: MCAS Measures with Performance Opportunities

Measure	MY2023 Plan-Wide Benchmark	MY2024 Plan-Wide Benchmark YOY points gaine
Asthma Medication Ratio (AMR)	37.5th	37.5th +0.70%
Chlamydia Screening in Women (CHL)	50th	37.5th -0.42%
Child and Adolescent Well-Care Visits (WCV)	37.5th	37.5th +1.42%

- Asthma Medication Ration (AMR): Partnership removed AMR from its PCP QIP at the conclusion of MY2023, given continued year-over-year performance gains in recent years. The HEDIS team reviewed updates to its AMR custom code mapping frequently during the MY2024 Annual Project and requested several custom code mappings from their auditor. In MY2025, Partnership added a Unit of Service (UOS) measure to its PCP QIP, to incentivize practices to host Academic Detailing sessions with Partnership's Pharmacy team. The Pharmacy team reviews pharmacy claims data to improve medication management for asthma and other chronic conditions. The AMR measure is being retired at the end of MY2025, with a new measure of follow up after ED visits for Asthma replacing it.

- Chlamydia Screening in Women (CHL): Chlamydia Screening rates declined Plan-Wide in MY2024, despite the use of all supplemental data sources for the MY2024 HEDIS Annual Project, including Health Information Exchange lab data that captures screenings outside the primary care setting. In MY2025, Partnership added the CHL measure to its PCP QIP, which will allow practices to monitor their performance on this measure.

- Child and Adolescent Well Care Visits (WCV): This measure requires an annual well care visit for children and adolescents between the ages of 3-21. While Plan-Wide performance improved in MY2024, it was not sufficient to meet the MPL benchmark, which increased in MY2024. Given this measure's demand, performance is largely impacted by access constraints. Rates drop significantly for children in older age bands for the WCV measure. When providers face capacity challenges, they prioritize babies and toddlers for visits versus older adolescents. Young adults in the 18-21 years age band are more likely to be reliant on episodic care, live away from family (out

of Partnership's coverage area or out of state), and access care in settings such as student health centers, episodic telehealth services, and urgent care centers that are not part of Partnership's PCP network. For these reasons, Partnership has opted to exclude young adults ages 18-21 years from its PCP QIP WCV measure.

6.3.2 MCAS Measures with Data Completeness and Measure Limitation Issues

Finally, four (4) measures have sustained performance below the MPL primarily because of data completeness and measure limitation issues. Partnership has documented and escalated data completeness issues around all four measures directly to DHCS and is engaged in interventions and activities meant to improve the quality and completeness of data.

Table: MCAS Measures with Data Completeness and Measure Limitation Issues

Measure	MY2023 Plan-Wide Benchmark	MY2024 Plan-Wide Benchmark YOY points gained
Developmental Screening in the First Three Years of Life (DEV)	>50th	<50th -0.38%
Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up (FUA-30)	25th	37.5th +1.25%
Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up (FUM-30)	>10th	<10th -2.47%
Topical Fluoride for Children (TFL-CH)	<50th	<50th +12.15%

- Developmental Screening (DEV): Starting in 2019, Partnership's Site Review team incorporated chart audits for this measure into their workflow. The results from these and other chart audits suggest that more screenings are occurring than what this measure's performance reflects. Along with the chart audits, the Site Review team includes counseling of providers performing these screenings to update their coding practices. This resulted in very limited success, due to struggles to gain provider adoption of coding these screenings properly to capture compliance.

  Accurate measurement of this developmental screening is significantly limited by prescriptive coding requirements, and the measure uses a CPT code that does not have standardized coding rules. Partnership was sanctioned for performance below the MPL in MY2023 and is in the process of appealing the sanctions.

  In MY2025, DHCS transitioned the DEV measure from administrative to hybrid, which is recommended by CMS, the measure steward. As a hybrid measure, Partnership will have the

opportunity to complete a Medical Record Review on this measure in MY2025, which will help overcome the measure limitations described above.

- Follow-up After Emergency Department (ED) Visit for Mental Illness (FUM-30) or Substance Use (FUA-30): Unlike other state Medicaid systems (which drive national benchmarks), Medi-Cal divides mental health benefits from medical benefits, and then further divides these benefits between managed care plans and "County Mental Health Plans (MHPs)". Benefits for those requiring "Specialty Mental Health Services (SMHS): aka Serious and Persistent Mental Health Services" are the responsibility of the County MHPs, while the benefits for those requiring Non-Specialty Mental Health Services (NSMHS) are the responsibility of Partnership. This complicated dual delivery system limits Partnership's ability to capture, through internal means, all follow-up visits, as it relies on reporting from the state, which currently provides this data on behalf of counties in SMHS cases (where the county is responsible for follow-up visits). MCP's are dependent on DHCS to provide the MHP data, and Partnership has documented significant drops in monthly data provided by DHCS. In MY2023, DHCS declined to sanction any California Managed Care Plan for performance below the MPL on both measures because of data completeness issues.

  To address data completeness issues, Partnership actively pursued data agreements with all of its counties to improve capturing follow-up visits from county mental health providers through SVMS; to date, 22 of 24 counties are contracted with SVMS. Interventions with large PCP organizations are also underway, focused on timely referral processing and/or timely follow-up to ED discharge reporting. Incomplete data is the largest driver, but Measure Limitations and Performance drivers are also contributing to the low reported rates. Partnership also acknowledges there is significant performance improvement potential under both measures, which can be more fully addressed once data is more complete.

- Topical Fluoride for Children (TFL-CH): The largest driver of low rates on this measure is incomplete dental claims data provided by DHCS. This measure can be fulfilled through services provided in either the primary care or dental setting – over 90 percent of dental services for Partnership members are completed in a FQHC, Rural Health Center, or Tribal Health Dental Center. These services, including fluoride varnish applications, are billed to Denti-Cal; Denti-Cal then sends data to DHCS, and DHCS sends data to MCP's in a monthly data feed. DHCS has admitted that their system does not have the capacity to store or exchange the dental codes that indicate fluoride varnish was applied; they are only capable of sending codes indicating a dental service was completed. Partnership was sanctioned for performance below the MPL in MY2023 and is in the process of appealing the sanctions.

  Partnership is closely engaged with DHCS's Data Team around improving the completeness of data around this measure. DHCS's Data Team provided a work-around for their inability to send dental codes, which is to use an ICD-10 code indicating fluoride varnish application with Dental Center claims. Partnership received auditor approval to map the ICD code towards the TFL-CH measure in MY2024, which resulted in a significant year-over-year improvement in rates in MY2024.

6.4 Comparing MY2024 MCAS Results to MY2024 PCP QIP Results

The clinical measures included in the PCP QIP are designed to reflect HEDIS measure priorities. Most PCP QIP clinical measures have very similar definitions to their HEDIS measure counterparts, and strong performance on PCP QIP measures should be reflected in strong HEDIS measure performance. Differences between PCP QIP and HEDIS measures are designed to improve providers' ability to impact the population in the measure. Some examples include:

- Partnership relaxes the strict continuous enrollment requirements in PCP QIP measures that are present in many HEDIS measures. Several measures (AMR, BCS-E, and W30) require members be continuously enrolled with a MCP for eleven (11) months to be included in the HEDIS measure; Partnership relaxed this requirement so that incoming members could be included in their PCP QIP cohorts.

- Partnership allows PCP's to upload supplemental data for all PCP QIP measures. HEDIS administrative and ECDS measures only allow claims and encounter data, as well as auditor approved supplemental data, to be applied to a HEDIS measure.

Overall, plan-wide performance declined on seven (7) of ten (10) continuous measures on the PCP QIP between MY2023 and MY2024. The primary factor in the decline in PCP QIP performance was the addition of over 100 PCP sites to Partnership in the ten (10) incoming counties in 2024. Incoming PCP's were challenged by data completeness issues described in Section 1, which gave them limited historical data for multi-year measures. Incoming PCP's also experienced significant member assignment mismatches at the beginning of 2024, which limited their ability to impact the members on their panels – this impacted both their PCP QIP scores and their local HEDIS measure rates.

The MY2024 MCAS measure performance trends for North Bay and Rural Upper North Rating Regions (DHCS's Rating Regions for the fourteen (14) legacy counties) were consistent with corresponding MY2024 PCP QIP results for the fourteen (14) legacy counties.

In MY2024, Partnership's HEDIS rates for Well Child Visits Birth – 15 Months (W30-6) was closely aligned with PCP QIP performance on the Well Child First 15 Months (W15) measure, which permits submission of supplemental data – this is thanks to the W30 Medical Record Review described in Section 1.

For reasons noted in Section 6.3.1, the PCP QIP Child and Adolescent Well Care Visits (WCV) measure only includes members 3-17 years of age. This, combined with permitting supplemental medical records not allowed under HEDIS measure Child and Adolescent Well Care Visits (WCV), influenced the higher achievement of 55.48% in PCP QIP plan-wide performance.

With the exception of WCV, all other HEDIS measures that are aligned with PCP QIP measures showed slightly higher plan wide performance in the HEDIS measure than in the plan wide PCP QIP.

6.6 Next Steps in Finalizing Assessment of Results

- DHCS will finalize Quality Factor Scoring of all managed care plans, based on composite scoring per reporting region, in fall or winter 2025.
- DHCS has not yet announced its final methodology for sanctioning managed care plans for performance below the MPL. Once methodologies are finalized, DHCS will share mandated performance improvement activities and sanctions with plans including Partnership.
- Final assessment of results will be used to adapt quality measure score improvement strategies and tactics in 2025-2026.

7.0 Summary of Measures in the Primary Care Provider Quality Improvement Program (PCP QIP)

The table below provides a summary of Primary Care Provider Quality Improvement Program measures included in the Measures Managed Care Accountability Sets (MCAS) for Medi-Cal Managed Care Plans Measurement Year 2024 | Reporting Year 2025.

HEDIS® Measures	MCAS Accountable/Reporting	MY2023 PCP QIP Measures	MY2024 PCP QIP Measures	QIP Program
Asthma Medication Ration (AMR)*	Accountable	X		PCP QIP – removed from QIP in MY2024
Breast Cancer Screening (BCS-E)*	Accountable	X	X	PCP QIP
Controlling High Blood Pressure (CBP)	Accountable	X	X	PCP QIP
Cervical Cancer Screening (CCS)	Accountable	X	X	PCP QIP
Childhood Immunization Status (CIS) – Combo 10	Accountable	X	X	PCP QIP
Colorectal Cancer Screening (COL-E)	Reporting	X	X	PCP QIP
Eye Exam for Patients with Diabetes (EED)	Reporting	X	X	PCP QIP
Glycemic Status Assessment for Patients with Diabetes—Glycemic Status (>9%), Poor Control (GSD)	Accountable	X	X	PCP QIP QIP uses the inverse of this measure: Good Control, HbA1c Good Control <9%
Immunizations for Adolescents (IMA) – Combo 2	Accountable	X	X	PCP QIP
Lead Screening in Children (LSC)	Accountable	X	X	PCP QIP MY2023: UOS measure MY2024: Clinical
Postpartum Depression Screening (PDS-E)	Reporting	X	X	Perinatal QIP
Prenatal Depression Screening (PND-E)	Reporting	X	X	Perinatal QIP
Prenatal and Postpartum Care (PPC) – Postpartum Care	Reporting	X	X	Perinatal QIP

HEDIS® Measures	MCAS Accountable/Reporting	MY2023 PCP QIP Measures	MY2024 PCP QIP Measures	QIP Program
Prenatal and Postpartum Care (PPC) – Timeliness of Prenatal Care	Reporting	X	X	Perinatal QIP
Prenatal Immunization Status – combo (PRS-E)	Reporting	X	X	Perinatal QIP
Well-Child Visits in the First 30 Months of Life—0 to 15 Months—Six or More Well-Child Visits (W30-6)	Accountable	X	X	PCP QIP
Child and Adolescent Well-Care Visits (WCV)	Accountable	X	X	PCP QIP

PCP QIP Measurement Set: http://www.partnershiphp.org/Providers/Quality/Pages/PCPQIPLandingPage.aspx

8.0 Measurement Year 2024 Managed Care Accountability Site (MCAS) Measurement Set Descriptions-Accountable Measures

HEDIS Measure	Measure Indicator	Measure Definition
*Asthma Medication Ratio (AMR)	• Total	• The percentage of members 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.
*Breast Cancer Screening (BCS-E)	• Non-Medicare Total	• The percentage of women 52–74 years of age who had a mammogram to screen for breast cancer as of December 31 of the measurement year.
Cervical Cancer Screening (CCS)	• Total	• The percentage of women 21–64 years of age who were screened for cervical cancer using either of the following criteria: o Women 21–64 years of age who had cervical cytology performed within the last 3 years o Women 30–64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years • Women 30–64 years of age who had cervical cytology/high-risk human papillomavirus (hrHPV) cotesting within the last 5 years
*Child and Adolescent Well-Care Visits (WCV)	• Total	• The percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year. • Total. The sum of the age stratifications (ages 3–21) as of December 31 of the measurement year.

HEDIS Measure	Measure Indicator	Measure Definition
Childhood Immunization Status (CIS)	• Combination 10	• The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and three combination rates.
*Chlamydia Screening in Women (CHL)	• Total	• The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year. o Total: The sum of the age stratifications.
Controlling High Blood Pressure (CBP)	• Total	• The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90 mm Hg) during the measurement year.
*Developmental Screening in the First Three Years of Life (DEV_CH)	• Total All Ages	• Percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding or on their first, second, or third birthday. • This measure is a CMS FFY 2023 Child Core Set Measure, held to the DHCS designated MPL.
*Follow-Up After ED Visit for Mental Illness – 30 days (FUM)	• Total	• The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness. • The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).

HEDIS Measure	Measure Indicator	Measure Definition
*Follow-Up After ED Visit for Substance Abuse – 30 days (FUA)	• Total	• The percentage of emergency department (ED) visits among members age 13 years and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up. • The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).
Immunizations for Adolescents (IMA)	• Combination 2	• The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. The measure calculates a rate for each vaccine and two combination rates. • Combination 2. Adolescents who have had all three indicators (meningococcal, Tdap and HPV).
Hemoglobin A1c Control for Patients With Diabetes (HBD)	• HbA1c poor control (>9.0%)	• The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had each of the Measure Indicators performed. ○ HbA1c poor control (>9.0%). The most recent HbA1c level is >9.0% or is missing a result, or if an HbA1c test was not done during the measurement year.
Lead Screening in Children (LSC)	• Total	• The percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday. • At least one lead capillary or venous blood test (Lead Tests Value Set) on or before the child's second birthday.

HEDIS Measure	Measure Indicator	Measure Definition
Prenatal and Postpartum Care (PPC)	• Timeliness of Prenatal Care • Postpartum Care	• The percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care. o Timeliness of Prenatal Care. The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization. o Postpartum Care. The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.
*Topical Fluoride for Children (TFL-CH)	• Total ages 1 through 20	• Percentage of enrolled children ages 1 through 20 who received at least two topical fluoride applications as: (1) dental or oral health services, (2) dental services, and (3) oral health services within the measurement year. • This measure is a CMS FFY 2023 Child Core Set Measure, held to the DHCS designated MPL.
*Well-Child Visits in the First 30 Months of Life (W30)	• Well-Child Visits in the First 15 Months • Well-Child Visits for Age 15 Months–30 Months.	• The percentage of members who had the following number of well-child visits with a PCP during the last 15 months. The following rates are reported: • Well-Child Visits in the First 15 Months. Children who turned 15 months old during the measurement year: Six or more well-child visits. • Well-Child Visits for Age 15 Months–30 Months. Children who turned 30 months old during the measurement year: Two or more well-child visits.

**-Administrative Measures. The entire eligible population is used in calculating performance (versus a systematic sample drawn from the eligible population for the hybrid measures*

9.0 Quality Improvement Initiatives - HEDIS Score Improvement

Partnership's Quality Improvement organization-wide goals for 2024-2025 focused on four measure domains similar to those defined under the DHCS Managed Care Accountability Set (MCAS) measures:

1. **Chronic Diseases**
2. **Behavioral Health**
3. **Pediatrics**
4. **Women's Health and Perinatal**

The Quality Measure Score Improvement (QMSI) effort continues to better coordinate service and performance across the organization and to raise Partnership's overall performance in quality measures, as defined under DHCS MCAS and NCQA Health Plan Accreditation (HPA). This effort involved team formation under QMSI to encompass all current and potentially future accountable measures by measure family within each workgroup team: Pediatric, Chronic Diseases, Behavioral Health, Women's Health and Perinatal Care. A fifth QMSI Workgroup, Medication Management, was disbanded in July 2024 and its measures were absorbed into the Chronic Disease and Behavioral Health Workgroups. Each workgroup monitored and reviewed all measure performance where data was available, assessed current improvement efforts, identified gaps and initiated new performance improvement activities.

QMSI workgroups consisted of cross-functional teams led by Quality and included representation from across the organization, such as: Care Coordination, Claims, Health Education, Office of the CMO, Pharmacy, Population Health, Provider Relations, Quality and/or regional leadership. The following summaries include what each measure-family QMSI Workgroup Team achieved in 2024-2025.

9.2 Chronic Disease Measure Activities

Colorectal Cancer Screening: Cologuard: In 2023 Partnership conducted a pilot project with Exact Sciences who produces the Cologuard Fit DNA colorectal cancer screening product. During the pilot Partnership observed notable improvements in colorectal cancer screening rates with participating providers. Partnership has turned this effort into an ongoing program and has worked closely with Exact Sciences to spread awareness and access to the bulk ordering program. Partnership has created a resources page on its public website to aggregate lessons learned and details on the bulk ordering process. Exact Sciences has a minimum number of patients required for bulk orders since it is resource intensive for them to do outreach and messaging for patients with an order. Partnership has offered to help facilitate bulk orders for smaller practices who do not have large enough denominators to do bulk orders on their own, with orders going out every few months.

Academic Detailing Sessions Through Partnership Pharmacy Team: For MY2025 Partnership added a Unit of Service (UOS) measure to the PCP QIP program. The purpose of this new unit of service measure is to incentivize provider organizations to host a two-part academic detailing meeting with Partnership's Pharmacy Team/Medical Director. Pharmacy academic detailing helps clinicians improve medication management, improve quality measure performance, and achieve better clinical outcomes for their patients. The UOS measure applies to practices with at least 1,000 assigned members and requires an initial training as well as a follow-up session to review any changes in prescribing practices following the initial training. Provider practices are offered up to $2,500 to help cover costs to get prescribers out of clinic for education.

Pharmacy academic detailing meetings focused on improving medication management through pharmacy claims analysis within the following disease states:

- CBP: Controlling High Blood Pressure
- HbA1c Good Control
- AMR: Asthma Medication Ratio
- Statin therapy in:
    - Cardiovascular disease
    - Diabetes
- Opioid Disorder Measure (only if providers are interested in opioids and MAT)

9.3 Behavioral Health Measure Activities

Sac Valley MedShare Data Exchange: Partnership HealthPlan of California and SacValley MedShare (SVMS): To improve data sharing capabilities between Behavioral Health Plans (BHPs) and Partnership, the partnership with SacValley MedShare (SVMS) was expanded to include county participation. Over the course of a 12-month collaboration, 22 out of 24 counties signed participation agreements with SVMS, which allowed various levels of data use and sharing to be integrated into county operations.

Key Outcomes and Learnings:

- The collaboration facilitated the provision of medical data, including real-time admissions, discharges, and transfers, from participating hospitals.
- Some counties implemented opt-in procedures for data sharing, which have limited the number of beneficiaries included in the data.
- Substance use disorder data has not yet been included in the exchange due to varying levels of regulatory uncertainty across counties.

DHCS Mandated Non-Clinical PIP: Improving Provider Notifications and Follow-Up for Members with Serious Mental Health Diagnoses: The Department of Health Care Services (DHCS) has mandated a

non-clinical Performance Improvement Project (PIP) focused on enhancing the timeliness and consistency of provider notifications for members with Serious Mental Health (SMH) diagnoses following emergency department (ED) visits. The primary goal of this initiative is to improve the percentage of notifications sent to providers within seven days of an ED visit, thereby increasing the likelihood of timely follow-up care for affected members.

In 2024, the QI team at Partnership identified a tool with the potential to significantly improve provider notification processes: PointClickCare. Partnership subscribes to this platform, which serves as a centralized hub for real-time Admission, Discharge, and Transfer (ADT) messages from EDs and hospitals across California. To operationalize this data, Partnership launched a targeted intervention in the Northwest region, routing daily PointClickCare reports to a large provider organization. These reports flag assigned members with recent ED visits for SMH diagnoses. In response, the provider organization is developing integrated clinical and operational workflows across its sites to proactively conduct outreach, schedule appointments, and ensure follow-up care is completed within 30 days of the ED event.

Key Outcomes and Learnings:

- Regular data exchange to promote shared learning, pattern recognition, and continuous quality improvement.
- Real-time data analysis to support agile adjustments and maintain program responsiveness.
- Focused efforts on increasing the rate of timely notifications and achieving compliance with follow-up targets.

<u>DHCS/IHI Behavioral Health Collaborative: Partnership HealthPlan of California and Nevada County:</u>
Beginning June 3, 2024, the Behavioral Health and Quality Improvement departments at Partnership embarked on a 15-month collaborative initiative facilitated by the Department of Health Care Services (DHCS) and the Institute for Healthcare Improvement (IHI). This partnership, in coordination with the Nevada County Department of Behavioral Health, aims to improve Follow-Up After Emergency Department Visit for Mental Illness (FUM) and Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) measures.

Key Outcomes and Learnings:

- The collaboration has significantly strengthened the working relationship between Partnership and Nevada County, laying the foundation for ongoing partnership and communication.
- Despite ongoing data misalignment between the County and Partnership, the collaborative has initiated efforts to identify data gaps, establish a shared baseline, and apply data-driven strategies to guide targeted quality improvement interventions.
- Piloted standardized screening procedures for Emergency Department bedside.

<u>Community Health Worker (CHW) & Emergency Department: Partnership HealthPlan of California:</u>

To bridge the gap between existing Substance Use Navigation (SUN) grants and the implementation of community health workers (CHWs), Partnership offered a grant of up to $100,000 to promote the use of CHWs in emergency departments. A total of 24 hospitals expressed interest, and 17 followed through during the grant year.

Key Outcomes and Learnings:

- Most emergency department EHRs (Electronic Health Records) were not capturing non-clinical interactions, which made it difficult to promote CHW work as a billable service.
- Staffing challenges arose at some hospitals, including engaging HR to create new job descriptions, adding positions late in budget cycles, and dealing with workforce shortages in certain areas.
- Many hospitals felt that longer grant periods would be necessary to fully capture the impact of the new CHW role

9.4 Pediatric Medicine Measure Activities

State-Mandated Performance Improvement Project (PIP) Focused on Early Well-Care in Black/African American Members in Solano County: This PIP's initial intervention addressed delays in Medi-Cal enrollment, which have a significant impact on all families, including African American families. The team launched a six-week phone outreach pilot project in collaboration with NorthBay Health. Upon discharge, NorthBay staff informed Partnership members that they would receive a call from Partnership. NorthBay then emailed Partnership a daily list of members that had been discharged from their Labor and Delivery unit. Partnership staff would then reach out to these members within 72 hours of discharge, educating new parents on Medi-Cal enrollment, newborn PCP selection, well baby visit scheduling, and connection to resources. The pilot had an 81% reach rate and a 51.6% engagement rate, which is significantly higher than similar outreach programs within Partnership.

Increase HPV Vaccine Completion Rates Through 2nd Dose Reminder Mailers: The HPV 2nd Dose Pilot Project identified children under age 13 who are due for their second dose of the HPV vaccine and mailed a reminder notice to their homes to encourage timely completion. This three-month initiative aims to assess whether mailed reminders can improve HPV vaccine series completion rates.

Develop a Plan-Wide Strategy for Well-Child Visits in the First 30 Months of Life – Birth to 15 Months (W30-6): While there have been many unique approaches for improving W30-6, Partnership recognized that the significant efforts were lacking a strategic vision for addressing the complexities that exist in W30-6 and decided to form a W30-6 Plan-Wide Strategy Committee. The purpose of this committee was to develop a concerted approach to understanding the current state and strategically planning for future improvement efforts.

The committee launched in October 2024 with a cross-functional stakeholder group. The purpose of the committee was to develop and implement a guiding strategy for improving performance of well-baby visits across Partnership's service area:

- Link all improvement efforts and provide a more strategic and streamlined approach
- Ensure thoughtful investment of time and resources
- Raise awareness and increase engagement across all stakeholders, both internal and external

Expand Promotion of Healthy Babies Growing Together Program to Provider Network to Increase W30-6 and CIS-10 Rates: Member incentives are widely known as a best practice for improving member appointment completion rates. Population Health's rebranding of the Growing Together Program (GTP) led to member incentives directly aligning with the CIS-10 and W30+6 MCAS Accountable measures. Improvement advisors, through their engagement with sites, recommended promotion of this program beyond the member population to the provider network.

Improve Data Capture of Topical Fluoride Application: Partnership launched a multi-pronged messaging campaign to providers to evangelize the use of the Z29.3 ICD code to indicate fluoride varnish application in FQHC, RHC, and Tribal Health Dental Centers. Following the messaging campaign, QI coaches and Partnership's new Dental Liaison followed up with practices during coaching calls to see if the codes had been implemented. As of May 2025, Partnership has started receiving claims with the Z29.3 code from providers who were quick to implement the code into their processes. Partnership will continue to monitor claims and work with practices who have not implemented the code.

9.5 Women's Health and Perinatal Care Measure Activities

Improve Breast Cancer Screening by Engaging Mobile Mammography: Partnership's Mobile Mammography program continued as a strategy to increase Breast Cancer Screening performance. Partnership collaborates with Alinea Medical Imaging and providers to host Mobile Mammography events, helping members complete preventive screenings at their primary care provider sites. In FY2024/2025 the program completed 77 mobile mammography event days resulting in 2,162 completed screenings. Mobile Mammography events were held at seven Tribal Health Centers, and Partnership led talking circles on screening importance at three Tribal Health Center's Mobile Mammography events.

Cervical Cancer Screening Self-Swab Pilot: A Cervical Cancer self-swab pilot launched in January 2024 with five strategically selected primary care clinics. The cervical cancer self-swabs were piloted in provider clinics and mobile settings to increase screening access for patients who previously declined clinician-administered exams. Early learning suggests broad provider and patient interest.

In May 2024, the U.S. Food and Drug Administration approved two HPV self-collect vaginal tests for cervical cancer screening. In March 2025 Quest and LabCorp launched the Roche Molecular Systems, Inc Cobas HPV test for self-collection with a new CPTII code 87626. Instructions on how to complete the self-swab were developed. In the March 2025 release of HEDIS MY 2025 Value Set Directory CPT code 87626 was included in the High-Risk HPV Lab Test Value Set. In May 2025, the CPT code was added to the CCS code set in eReports. Partnership worked closely with Quest and LabCorp to facilitate integration of the self-swab in its network. An HPV Self-Swab Webinar was held April 1, 2025, with 100+ attendees and the webinar is available on Partnership's website.

Perinatal Growing Together Program (Perinatal GTP): This program aims to improve early access to prenatal care and improve timely well-baby care. In FY24/25 the Perinatal GTP made 23,234 contacts across both the Prenatal and Postpartum Growing Together Program campaigns, outreaching to 12,117 unique members. Of the 4,144 unique members outreached for the Prenatal program, 60.4% agreed to participate. Of the 7,973 outreached for the Postpartum program, 58.5% agreed to participate. These members were transitioned into the GTP Postpartum program for targeted conversations post-birth.

Maternal Events: Population Health organized maternal photo shoots and baby showers to build trust and engagement with Black and Hispanic members. These events promoted health education and connected families to local and Partnership resources.

Tribal Perinatal Program (TPP) aims to improve perinatal health outcomes among California Indian communities through a comprehensive approach encompassing training, curriculum development, evaluation, and continuous improvement initiatives. TPP started in April 2024 and has 6 Tribal Health Centers enrolled across 3 cohorts. This program addresses disparities identified in prenatal care and postpartum care for American Indian/Alaskan Native members.

The Solano Perinatal Clinical Collaborative continues for FY24/25. The collaborative focuses on addressing health disparities in prenatal care for African Americans in Solano County. They have identified operational and communication barriers that were impeding access. They developed better systems of care across organizations and improved the standards and methods of patient related and professional communication.

Healthcare Effectiveness Data and Information Set (HEDIS®)

Measurement Year 2024 / Reporting Year 2025

NCQA HealthPlan Accreditation (HPA) Summary of Performance

Partnership – HPA Star Rating

August 2025

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1.0 Introduction

As a Medi-Cal Managed Care Plan, Partnership provides health care coverage for 24 counties in Northern California – the largest geographic footprint of any Medi-Cal Managed Care Plan in California. The health plan covers over 900,000 members who qualify for coverage based on low household income, and who make up a substantial portion of Northern California's total population. The annual measure performance analysis contained in this Annual Summary of Performance, centered on Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures selected by the National Committee for Quality Assurance (NCQA), supports Partnership's Health Plan Accreditation and is intended to give the best possible understanding of the status of quality outcomes for the low-income population served in these counties.

Partnership generates a detailed Annual Summary of Performance and distributes it widely so that stakeholders in Northern California – local governments, county public health, medical and behavioral health providers, hospitals, and community foundations - can use current, local, accurate, and audited data to prioritize activities to meet the health care needs of their communities. The Summary of Performance contains regional and county-level data that show local strengths and opportunities for preventative health care, based on national benchmarks. Behind each measure are many community members who were able to access the preventative services they needed to stay healthy, or who faced challenges or struggles to receive care.

In the end, it takes the entire health care delivery system working together to improve the health outcomes contained in this report. Partnership encourages everyone reading this report to review their local data closely, and look for a handful of ways their organization, alone or with others, can drive improvement on one or more measure that is important to them.

Partnership is always happy to connect organizations and community members within our network to resources and activities to help our members, and the communities we serve, be healthy. Please reach out to our Performance Improvement team at ImprovementAcademy@partnershiphp.org if you would like to learn more about activities in your area.

Thank you for your dedication to improving the health of our communities.

2.0 Notable Changes to the MY2024 Annual Summary of Performance Report

MY2024 continued to host two required separate audits:

- DHCS / MCAS required reporting: Health Service Advisory Group (HSAG) Auditor
- NCQA HEDIS Health Plan Accreditation / HPA: Advent Advisory Auditor (this report's focus)

Partnership HEDIS Reporting Populations – MY2024

In MY2024, Partnership observed an increase in overall membership by approximately 36.7%, to 906,964 assigned members in December 2024. The changes in membership reflect the addition of 10 new counties to the Partnership network, as well as the departure of members assigned to Kaiser sites, who moved to Kaiser as their Medi-Cal Managed Care Plan.

- Incoming counties added approximately 316,000 members to Partnership.
- Approximately 82,000 members assigned to Kaiser departed from Partnership. The decrease in membership primarily impacted Solano, Sonoma, Napa and Yolo Counties.

	Dec 2023	Dec 2024
Total Membership	**663,919**	**906,964**
10 Incoming Counties	**0**	**316,096**
New membership	0	316,096
14 Legacy Counties	**663,919**	**590,868**
Kaiser assigned Partnership members	82,033	0
Non-Kaiser membership	581,886	590,868

The addition of 10 incoming counties to Partnership's network changes Partnership's HEDIS Reporting Populations for NCQA's Health Plan Accreditation (HPA). Starting in MY2024, Partnership reported one Plan-Wide rate for all 24 counties in its network for the HPA measure set to its NCQA auditor, Advent Advisory.

Changes to NCQA HEDIS Measures – MY2024

NCQA released changes to several existing clinical measures used in NCQA HPA for MY2024:

Clinical Measure Changes for MY2024 HPA Required Reporting:

- New Measures:
  - Colorectal Cancer Screening (COL-E) is a new HPA measure
  - Language Diversity of Membership (LDM) is a new HPA measure
- Changed Measures:
  - The former Hemoglobin A1c (HbA1c) Control for Patients with Diabetes (HBD) measure was revised to Glycemic Status Assessment for Patients with Diabetes (GSD).

  - Metabolic Monitoring for Children and Adolescents on Antipsychotics – Blood Glucose and Cholesterol Testing (APM-E) is now an Electronic Clinical Data Systems (ECDS) measure.
  - Follow-Up Care for Children Prescribed ADHD Medication – Continuation & Maintenance Phase (ADD-E) is now an Electronic Clinical Data Systems (ECDS) measure.

- Removed Clinical Measures:
  - Follow-up After Hospitalization for Mental Illness, 7 Days (FUH) was approved by the Advent Advisory auditor for removal from the HPA measure set as Not a Benefit, since psychiatric hospitalizations are not a Partnership benefit.

Partnership successfully launched our HEDIS® MY2024/RY2025 data collection and reporting audits incorporating all changes as noted above.

In July 2021, NCQA released the HealthPlan Rating Methodology: (Plan-wide):
As an NCQA Accredited plan, Partnership was required to report HEDIS and CAHPS annually, starting June 2022, for measurement year 2021 (MY2021). The overall Health Plan Rating (HPR) is the weighted average of a plan's HEDIS and CAHPS measure ratings, plus bonus points for plans with current Accreditation status. In MY2024 Partnership chose to be formally scored utilizing the Child CAHPS results.

3.0 HPA Summary of Performance Plan-wide Relative to National All Lines of Business Benchmarks

3.1 HPA Plan-wide Performance Child CAHPS Results – Patient Experience:

This table shows the results of the MY2023 - MY2024 performance on the Patient Experience NCQA Accreditation measures relative to the MY2022 and MY2023 National All Lines of Business 10th, 33.33rd, 66.67th and 90th benchmarks and percentiles that are used for ratings, calculated as whole numbers on a 1–5 scale.

4-5 points 3 points 1-2 points

NCQA Accreditation Measures: Child CAHPS Survey Results MY2023-MY2024

NCQA Accreditation Measures - Planwide Performance w/Child CAHPS Survey Results						
Year	Measure	Plan-level Performance	National Medicaid Benchmarks			
			10th	33.33rd	66.67th	90th
Patient Experience						
Getting Care						
MY 2023	***Getting Needed Care (Usually + Always)	77.06%	74.98%	79.83%	83.11%	86.50%
MY 2024		77.87%	76.79%	81.10%	85.70%	89.41%
MY 2023	Getting Care Quickly (Usually + Always)	78.92%	73.36%	77.73%	83.78%	86.94%
MY 2024		80.04%	78.92%	84.62%	89.35%	92.10%
Satisfaction with Plan Physicians						
MY 2023	Rating of Personal Doctor (9+10)	75.51%	61.79%	65.38%	70.59%	74.03%
MY 2024		78.64%	70.66%	74.42%	78.53%	82.63%
Satisfaction with Health Plan Services						
MY 2023	Rating of All Health Care (9+10)	68.13%	48.00%	53.48%	58.27%	62.50%
MY 2024		66.40%	62.29%	67.49%	71.90%	76.27%
MY 2023	***Rating of Health Plan (9+10)	58.89%	52.72%	59.30%	64.02%	68.70%
MY 2024		72.87%	64.03%	69.01%	73.76%	78.19%

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

3.2 HPA Plan-wide Performance Adult CAHPS Results – Patient Experience:

This table shows the results of the MY2023 - MY2024 baseline performance on the Patient Experience NCQA Accreditation measures relative to the MY2022 and MY2023 National All Lines of Business10th, 33.33rd, 66.67th and 90th benchmarks and percentiles that are used for ratings, calculated as whole numbers on a 1–5 scale.

4-5 points 3 points 1-2 points

NCQA Accreditation Measures: Adult CAHPS Survey Results MY2023-MY2024

NCQA Accreditation Measures - Planwide Performance w/Adults CAHPS Survey Results						
Year	Measure	Plan-level Performance	National Medicaid Benchmarks			
			10th	33.33rd	66.67th	90th
Patient Experience						
Getting Care						
MY 2023	***Getting Needed Care (Usually + Always)	73.98%	74.98%	79.83%	83.11%	86.50%
MY 2024		74.54%	75.52%	79.75%	83.73%	86.12%
MY 2023	Getting Care Quickly (Usually + Always)	68.09%	73.36%	77.73%	83.78%	86.94%
MY 2024		74.02%	73.26%	78.80%	82.98%	86.40%
Satisfaction with Plan Physicians						
MY 2023	Rating of Personal Doctor (9+10)	70.00%	61.79%	65.38%	70.59%	74.03%
MY 2024		65.75%	63.01%	67.32%	71.05%	74.42%
Satisfaction with Health Plan Services						
MY 2023	Rating of All Health Care (9+10)	54.49%	48.00%	53.48%	58.27%	62.50%
MY 2024		54.43%	50.00%	55.07%	59.47%	63.36%
MY 2023	***Rating of Health Plan (9+10)	46.62%	52.72%	59.30%	64.02%	68.70%
MY 2024		55.76%	53.41%	59.44%	64.05%	68.54%

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

3.3 HPA HEDIS Plan-wide Performance – Prevention and Population

This table shows the MY2023 – MY2024 baseline performance on the **Prevention and Population** NCQA Accreditation measures relative to the MY2022 and MY2023 National All Lines of Business10th, 33.33rd, 66.67th and 90th measure benchmarks and percentiles that are used for ratings, calculated as whole numbers on a 1–5 scale.

4-5 points 3 points 1-2 points Administrative measures: The entire eligible population is used in calculating performance (versus a systematic sample drawn from the eligible population for the hybrid measures)

NCQA Accreditation Measures - Planwide Performance w/Child CAHPS Survey Results						
Year	Measure	Plan-level Performance	National Medicaid Benchmarks			
			10th	33.33rd	66.67th	90th
Prevention and Population						
Children and Adolescent Well-Care						
MY 2023	***CIS - Childhood Immunization Status (Combination 10)	29.68%	20.68%	26.76%	35.04%	45.26%
MY 2024		28.22%	18.25%	24.39%	31.32%	42.34%
MY 2023	***IMA - Immunizations for Adolescents (Combination 2)	43.07%	24.82%	30.66%	38.93%	48.80%
MY 2024		39.66%	25.41%	31.39%	38.69%	48.66%
MY 2023	WCC - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total	85.99%	62.77%	74.70%	83.21%	89.72%
MY 2024		76.16%	66.91%	76.89%	86.20%	91.24%
Women's Reproductive Health						
MY 2023	***PPC - Prenatal and Postpartum Care—Timeliness of Prenatal Care	90.34%	73.48%	81.75%	86.86%	91.07%
MY 2024		84.43%	73.48%	81.94%	86.89%	91.85%
MY 2023	***PPC - Prenatal and Postpartum Care—Postpartum Care	86.96%	67.31%	75.18%	80.78%	84.59%
MY 2024		88.81%	68.63%	77.37%	82.48%	86.62%
MY 2023	PRS-E - Prenatal Immunization Status - Combination Rate	35.40%	7.94%	15.17%	25.81%	37.75%
MY 2024		29.36%	8.42%	15.96%	24.92%	35.60%
Cancer Screening						
MY 2023	BCS-E - Breast Cancer Screening	55.52%	42.98%	48.33%	54.94%	62.67%
MY 2024		56.29%	42.86%	49.24%	56.66%	63.48%
MY 2023	CCS - Cervical Cancer Screening	58.04%	43.50%	53.37%	59.85%	66.48%
MY 2024		58.64%	43.31%	52.07%	60.10%	67.46%
MY 2023	COL-E - Colorectal Cancer Screening	NR	NR	NR	NR	NR
MY 2024		32.99%	27.27%	34.30%	41.59%	49.35%
Description of Membership						
MY 2023	RDM - Race/Ethnicity Diversity of Membership (Reporting Only)	100.00%	63.20%	95.91%	100.00%	100.00%
MY 2024		100.00%	100.00%	100.00%	100.00%	100.00%
MY 2023	LDM - Language Diversity of Membership	NR	NR	NR	NR	NR
MY 2024		100.00%	0.00%	0.00%	13.07%	100.00%

NCQA Accreditation Measures - Planwide Performance w/Child CAHPS Survey Results						
Year	Measure	Plan-level Performance	National Medicaid Benchmarks			
			10th	33.33rd	66.67th	90th
Prevention and Population						
Other Preventive Services						
MY 2023	**CHL - Chlamydia Screening in Women—Total**	56.00%	42.61%	51.39%	61.07%	67.39%
MY 2024		55.58%	43.53%	52.40%	61.46%	69.07%
MY 2023	AIS-E - Adult Immunization Status -- Influenza	17.61%	6.50%	10.82%	16.32%	21.05%
MY 2024	Immunizations for Adults	14.33%	7.39%	12.55%	17.91%	26.40%
MY 2023	AIS-E - Adult Immunization	49.15%	N/A	N/A	N/A	N/A
MY 2024	Status—Pneumococcal	44.03%	21.04%	38.73%	55.03%	68.07%
MY 2023	AIS-E - Adult Immunization Status—Td/Tdap	36.43%	18.67%	29.84%	41.54%	56.53%
MY 2024	Immunizations for Adults	32.96%	21.26%	33.40%	47.30%	57.67%
MY 2023	AIS-E - Adult Immunization Status—Zoster	14.63%	1.72%	4.42%	10.27%	14.54%
MY 2024	Immunizations for Adults	14.47%	2.23%	7.15%	13.49%	20.56%

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

NB Not a Benefit - Auditor Approval required
NR Not Rated - Not included in the MY's measurement set
N/A No NCQA benchmark to apply in Measurement Year
* RDM and LDM are reporting only measures, full credit received for reporting.
** Inverted measures, a lower rate results in better performance
*** DHCS Withhold Measures
BOLD Indicates MCAS measures held to the MPL

3.4 HPA HEDIS Plan-wide Performance – Treatment: Respiratory, Diabetes, Heart Disease

This table shows the MY2024 baseline performance on the **Treatment** NCQA Accreditation measures relative to the MY2022 and MY2023 National All Lines of Business10th, 33.33rd, 66.67th and 90th measure benchmarks and percentiles that are used f whole numbers on a 1–5 scale.

4-5 points 3 points 1-2 points

NCQA Accreditation Measures - Planwide Performance w/Child CAHPS Survey Results						
Year	Measure	Plan-level Performance	National Medicaid Benchmarks			
			10th	33.33rd	66.67th	90th
Treatment						
Respiratory						
MY 2023	**AMR - Asthma Medication Ratio- Total**	64.01%	55.09%	61.81%	69.41%	75.92%
MY 2024		64.71%	54.56%	62.35%	70.56%	76.65%
MY 2023	CWP - Appropriate Testing for	71.45%	57.41%	68.76%	77.56%	82.40%
MY 2024	Pharyngitis—Total	70.27%	61.35%	76.71%	85.11%	89.17%
MY 2023	**AAB - Avoidance of Antibiotic Treatment for	74.30%	50.05%	57.16%	66.19%	77.11%
MY 2024	Acute Bronchitis/Bronchiolitis—Total	56.00%	49.48%	56.76%	67.03%	77.66%
MY 2023	PCE - Pharmacotherapy Management of COPD	73.71%	56.05%	68.39%	75.79%	82.43%
MY 2024	Exacerbation - Systemic Corticosteroid	70.93%	55.28%	66.86%	74.78%	82.88%
MY 2023	PCE - Pharmacotherapy Management of COPD	88.15%	72.88%	82.35%	86.96%	90.53%
MY 2024	Exacerbation - Bronchodilator	86.18%	67.25%	80.19%	86.54%	89.96%
Diabetes						
MY 2023	EED - Eye Exams for Patients with Diabetes	52.59%	36.74%	46.96%	56.20%	63.33%
MY 2024		52.31%	40.39%	49.15%	57.09%	64.06%
MY 2023	BPD -Blood Pressure Control (<140/90) for	67.50%	52.07%	59.85%	68.61%	74.56%
MY 2024	Patients with Diabetes	70.56%	58.15%	65.32%	71.78%	77.37%
MY 2023	HBD -Hemoglobin A1c Control for Patients with Diabetes-- HbA1c Control (<8%)	54.81%	38.93%	49.39%	55.72%	60.34%
MY 2024	**GSD -Glycemic Status Assessment for Patients with Diabetes-- HbA1c Control (<8%)**	54.26%	44.25%	54.50%	59.64%	63.50%
MY 2023	SPD - Statin Therapy for Patients With	63.12%	54.15%	62.58%	67.07%	72.15%
MY 2024	Diabetes—Received Statin Therapy	64.93%	51.96%	62.66%	67.01%	71.41%
MY 2023	SPD - Statin Therapy for Patients With	94.76%	52.67%	62.50%	70.37%	77.97%
MY 2024	Diabetes—Statin Adherence 80%	67.90%	53.23%	64.18%	70.91%	79.73%
MY 2023	KED - Kidney Health Evaluation for Patients with	42.13%	22.73%	29.42%	38.80%	47.55%
MY 2024	Diabetes	40.88%	26.79%	33.00%	42.10%	49.72%

NCQA Accreditation Measures - Planwide Performance w/Child CAHPS Survey Results						
Year	Measure	Plan-level Performance	National Medicaid Benchmarks			
			10th	33.33rd	66.67th	90th
Treatment						
Heart Disease						
MY 2023	SPC - Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy—Total	81.90%	70.02%	78.80%	81.64%	85.04%
MY 2024		81.06%	66.64%	79.82%	83.00%	85.89%
MY 2023	SPC - Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%—Total	95.45%	56.67%	66.48%	73.63%	80.95%
MY 2024		70.33%	59.20%	66.84%	73.75%	81.25%
MY 2023	***CBP - Controlling High Blood Pressure	70.57%	50.36%	57.66%	65.45%	72.22%
MY 2024		61.80%	54.61%	61.43%	67.40%	72.75%

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

NB Not a Benefit - Auditor Approval required
NR Not Rated - Not included in the MY's measurement set
N/A No NCQA benchmark to apply in Measurement Year
* RDM and LDM are reporting only measures, full credit received for reporting.
** Inverted measures, a lower rate results in better performance
*** DHCS Withhold Measures
BOLD Indicates MCAS measures held to the MPL

3.5 HPA HEDIS Plan-wide Performance – Behavioral Health

This table shows the MY2024 baseline performance on the **Behavioral Health** NCQA Accreditation measures relative to the MY2022 and MY2023 National All Lines of Business10th, 33.33rd, 66.67th and 90th measure benchmarks and percentiles that are used for ratings, calculated as whole numbers on a 1–5 scale.

4-5 points 3 points 1-2 points Administrative measures: The entire eligible population is used in calculating performance (versus a systematic sample drawn from the eligible population for the hybrid measures).

NCQA Accreditation Measures - Planwide Performance w/Child CAHPS Survey Results						
Year	Measure	Plan-level Performance	National Medicaid Benchmarks			
			10th	33.33rd	66.67th	90th
Treatment						
Behavioral Health--Care Coordination						
MY 2023	FUH - Follow-Up After Hospitalization for Mental Illness-7 days	29.05%	21.77%	31.23%	41.03%	52.90%
MY 2024		NB	23.55%	32.71%	42.86%	57.69%
MY 2023	**FUM - Follow-UP After Emergency Department Visit for Mental Illness 7 days total**	18.92%	23.74%	33.61%	46.35%	61.68%
MY 2024		13.39%	21.19%	33.01%	44.33%	59.95%
MY 2023	**FUA - Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence—7 days—Total**	22.68%	13.83%	20.00%	27.73%	38.15%
MY 2024		22.88%	12.73%	18.76%	27.62%	37.47%
MY 2023	FUI - Follow-Up After High-Intensity Care for Substance Use Disorder—7 days—Total	32.29%	15.16%	23.12%	37.31%	49.55%
MY 2024		29.83%	15.91%	26.90%	37.64%	50.80%
Behavioral Health--Medication Adherence						
MY 2023	AMM - Antidepressant Medication Management—Effective Continuation Phase Treatment	81.49%	31.59%	40.01%	46.74%	58.06%
MY 2024		48.04%	31.52%	41.00%	48.16%	61.06%
MY 2023	POD - Pharmacotherapy for Opioid Use Disorder—Total	41.53%	14.94%	23.38%	31.93%	40.34%
MY 2024		15.84%	12.05%	21.36%	29.01%	36.71%
MY 2023	SAA - Adherence to Antipsychotic Medications for Individuals With Schizophrenia	73.46%	41.24%	57.79%	64.90%	72.61%
MY 2024		68.58%	44.65%	58.60%	66.15%	74.83%

NCQA Accreditation Measures - Planwide Performance w/Child CAHPS Survey Results						
Year	Measure	Plan-level Performance	National Medicaid Benchmarks			
			10th	33.33rd	66.67th	90th
Treatment						
Behavioral Health-- Access, Monitoring and Safety						
MY 2023	APM - Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	32.80%	26.36%	31.97%	40.50%	53.58%
MY 2024	APM-E - Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total (ECDS)	32.18%	25.86%	30.92%	41.41%	52.57%
MY 2023	ADD -Follow-Up Care for Children Prescribed ADHD Medication—Continuation & Maintenance Phase	31.45%	40.38%	50.98%	57.90%	63.92%
MY 2024	ADD-E -Follow-Up Care for Children Prescribed ADHD Medication—Continuation & Maintenance Phase (ECDS)	40.36%	37.19%	48.94%	56.83%	63.49%
MY 2023	SSD - Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	81.90%	72.83%	77.40%	80.86%	85.52%
MY 2024		83.85%	75.46%	79.51%	83.51%	87.27%
MY 2023	APP - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total	25.95%	36.65%	55.19%	63.89%	73.87%
MY 2024		41.38%	41.57%	54.55%	64.10%	74.14%
MY 2023	IET - Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Engagement - Total	8.50%	7.05%	11.11%	16.94%	24.37%
MY 2024		7.63%	6.08%	10.51%	16.78%	26.72%

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

NB Not a Benefit - Auditor Approval required
NR Not Rated - Not included in the MY's measurement set
N/A No NCQA benchmark to apply in Measurement Year
* RDM and LDM are reporting only measures, full credit received for reporting.
** Inverted measures, a lower rate results in better performance
*** DHCS Withhold Measures
BOLD Indicates MCAS measures held to the MPL

3.6 HPA HEDIS Plan-wide Performance – Risk Adjusted / Other

This table shows the MY2024 baseline performance on the **Risk Adjusted** / Other NCQA Accreditation measures relative to the MY2022 and MY2023 National All Lines of Business10th, 33.33rd, 66.67th and 90th measure benchmarks and percentiles that are used for ratings, calculated as whole numbers on a 1–5 scale.

4-5 points 3 points 1-2 points Administrative measures: The entire eligible population is used in calculating performance (versus a systematic sample drawn from the eligible population for the hybrid measures).

NCQA Accreditation Measures - Planwide Performance w/Child CAHPS Survey Results						
Year	Measure	Plan-level Performance	National Medicaid Benchmarks			
			10th	33.33rd	66.67th	90th
Risk-Adjusted Utilization						
MY 2023	PCR - Plan All-Cause Readmission - Observed to	0.8951	No Bench Marks Use for Scoring			
MY 2024	- Expected Ratio (18-64 years)	0.9944				
Other Treatment Measure						
MY 2023	**LBP - Use of Imaging Studies for Low Back	76.71%	67.72%	71.32%	75.44%	79.96%
MY 2024	Pain	73.67%	64.77%	67.84%	72.74%	78.72%

Note: PCR calculations are based on the scoring algorithm for risk-adjusted utilization measures as defined by NCQA. NCQA calculates the Confidence Limits (CLs) for all health plans.

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

NB Not a Benefit - Auditor Approval required
NR Not Rated - Not included in the MY's measurement set
N/A No NCQA benchmark to apply in Measurement Year
* RDM and LDM are reporting only measures, full credit received for reporting.
** Inverted measures, a lower rate results in better performance
*** DHCS Withhold Measures
BOLD Indicates MCAS measures held to the MPL

4.0 MY 2024 HPA HEDIS Rate Performance by County

The following tables show MY2024 county-level performance on HPA HEDIS measures in Partnership's six (6) Regions. For the fourteen (14) legacy counties in Partnership's Eureka, Fairfield, Redding and Santa Rosa Regions, MY2023 county-level performance is also included, showing year-over-year performance trends by county.

HPA measures not included in the county-level performance tables are:

- CAHPS Measures, which only have plan-wide rates;
- Description of Membership measures, which only have plan-wide rates

All tables show the MY2024 baseline performance on NCQA Accreditation measures relative to the MY2022 and MY2023 National All Lines of Business 10th, 33.33rd, 66.67th and 90th measure benchmarks and percentiles that are used for ratings, calculated as whole numbers on a 1–5 scale.

4.1 HPA HEDIS Rate Performance by County, Auburn Region: Nevada, Placer, Plumas, Sierra Counties

4-5 points ○ 3 points 1-2 points Administrative measures: The entire eligible population is used in calculating performance (versus a systematic sample drawn from the eligible population for the hybrid measures).

Year	Measure	County Performance				National Medicaid Benchmarks			
		Nevada	Placer	Plumas	Sierra	10th	33.33rd	66.67th	90th
Prevention and Population									
Children and Adolescent Well-Care									
MY 2024	***CIS - Childhood Immunization Status (Combination 10)	100.00%	0.00%	0.00%	0.00%	18.25%	24.39%	31.32%	42.34%
MY 2024	***IMA - Immunizations for Adolescents (Combination 2)	0.00%	12.50%	0.00%	0.00%	25.41%	31.39%	38.69%	48.66%
MY 2024	WCC - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total	73.33%	90.48%	0.00%	0.00%	66.91%	76.89%	86.20%	91.24%
Women's Reproductive Health									
MY 2024	***PPC - Prenatal and Postpartum Care—Timeliness of Prenatal Care	100.00%	75.00%	100.00%	73.33%	73.48%	81.94%	86.89%	91.85%
MY 2024	***PPC - Prenatal and Postpartum Care—Postpartum Care	100.00%	83.33%	100.00%	86.67%	68.63%	77.37%	82.48%	86.62%
MY 2024	PRS-E - Prenatal Immunization Status - Combination Rate	11.28%	21.29%	31.11%	25.00%	8.42%	15.96%	24.92%	35.60%
Cancer Screening									
MY 2024	BCS-E- Breast Cancer Screening	66.67%	0.00%	0.00%	0.00%	42.86%	49.24%	56.66%	63.48%
MY 2024	CCS - Cervical Cancer Screening	62.50%	50.00%	33.33%	50.00%	43.31%	52.07%	60.10%	67.46%
MY 2024	COL-E - Colorectal Cancer Screening	18.18%	0.00%	33.33%	0.00%	27.27%	34.30%	41.59%	49.35%
Other Preventive Services									
MY 2024	CHL - Chlamydia Screening in Women—Total	48.06%	60.67%	23.26%	27.27%	43.53%	52.40%	61.46%	69.07%
MY 2024	AIS-E-Adult Immunization Status—Influenza - Total	8.48%	11.84%	10.38%	12.12%	7.39%	12.55%	17.91%	26.40%
MY 2024	AIS-E-Adult Immunization Status—Pneumococcal - 66+	35.21%	30.02%	31.25%	0.00%	21.04%	38.73%	55.03%	68.07%
MY 2024	AIS-E-Adult Immunization Status—Td/Tdap - Total	26.37%	24.48%	30.03%	37.12%	21.26%	33.40%	47.30%	57.67%
MY 2024	AIS-E-Adult Immunization Status—Zoster - Total	13.02%	14.60%	6.87%	8.60%	2.23%	7.15%	13.49%	20.56%

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Year	Measure	County Performance				National Medicaid Benchmarks			
		Nevada	Placer	Plumas	Sierra	10th	33.33rd	66.67th	90th
		Treatment							
		Respiratory							
MY 2024	**AMR - Asthma Medication Ratio- Total**	0.00%	0.00%	100.00%	0.00%	54.56%	62.35%	70.56%	76.65%
MY 2024	CWP - Appropriate Testing for Pharyngitis—Total	77.18%	72.08%	80.74%	100.00%	61.35%	76.71%	85.11%	89.17%
MY 2024	**AAB - Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total	76.67%	65.22%	57.69%	0.00%	49.48%	50.98%	67.03%	77.66%
MY 2024	PCE - Pharmacotherapy Management of COPD Exacerbation - Systemic Corticosteroid	81.25%	62.00%	87.50%	100.00%	55.28%	66.86%	74.78%	82.88%
MY 2024	PCE - Pharmacotherapy Management of COPD Exacerbation - Bronchodilator	75.00%	82.00%	87.50%	0.00%	67.25%	80.19%	86.54%	89.96%
		Diabetes							
MY 2024	EED - Eye Exams for Patients with Diabetes	20.00%	44.44%	0.00%	0.00%	40.39%	49.15%	57.09%	64.06%
MY 2024	BPD -Blood Pressure Control (<140/90) for Patients with Diabetes	70.00%	72.22%	0.00%	0.00%	58.15%	65.32%	71.78%	77.37%
MY 2024	GSD -Glycemic Status Assessment for Patients with Diabetes-- HbA1c Control (<8%)	50.00%	44.44%	0.00%	0.00%	44.25%	54.50%	59.64%	63.50%
MY 2024	SPD - Statin Therapy for Patients With Diabetes—Received Statin Therapy	100.00%	0.00%	50.00%	0.00%	51.96%	62.66%	67.01%	71.41%
MY 2024	SPD - Statin Therapy for Patients With Diabetes—Statin Adherence 80%	0.00%	0.00%	100.00%	0.00%	53.23%	64.18%	70.91%	79.73%
MY 2024	KED - Kidney Health Evaluation for Patients with Diabetes	45.34%	49.73%	14.62%	0.00%	26.79%	33.00%	42.10%	49.72%
		Heart Disease							
MY 2024	SPC - Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy—Total	100.00%	0.00%	0.00%	0.00%	66.64%	79.82%	83.00%	85.89%
MY 2024	SPC - Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%—Total	100.00%	0.00%	0.00%	0.00%	59.95%	67.42%	74.07%	81.79%
MY 2024	***CBP - Controlling High Blood Pressure	71.43%	50.00%	0.00%	0.00%	54.61%	61.43%	67.40%	72.75%

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Year	Measure	County Performance				National Medicaid Benchmarks			
		Nevada	Placer	Plumas	Sierra	10th	33.33rd	66.67th	90th
Treatment									
Behavioral Health - Care Coordination									
MY 2024	**FUH - Follow-Up After Hospitalization for Mental Illness-7 days**	NB	NB	NB	NB	23.74%	33.61%	46.35%	61.68%
MY 2024	**FUM - Follow-UP After Emergency Department Visit for Mental Illness 7 days total**	17.58%	9.04%	10.71%	0.00%	21.19%	33.01%	44.33%	59.95%
MY 2024	**FUA - Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence—7 days—Total**	22.25%	22.72%	17.31%	87.50%	12.73%	18.76%	27.62%	37.47%
MY 2024	FUI - Follow-Up After High-Intensity Care for Substance Use Disorder—7 days—Total	13.46%	12.05%	33.33%	50.00%	15.91%	26.90%	37.64%	50.80%
Behavioral Health - Medication Adherence									
MY 2024	AMM - Antidepressant Medication Management—Effective Continuation Phase Treatment	38.71%	46.34%	0.00%	100.00%	31.52%	41.00%	48.16%	61.06%
MY 2024	POD - Pharmacotherapy for Opioid Use Disorder—Total	9.76%	12.50%	0.00%	0.00%	12.05%	21.36%	29.01%	36.71%
MY 2024	SAA - Adherence to Antipsychotic Medications for Individuals With Schizophrenia	65.45%	79.66%	72.73%	100.00%	44.65%	58.60%	66.15%	74.83%

Behavioral Health - Access, Monitoring and Safety									
MY 2024	APM - Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	39.29%	35.92%	38.46%	0.00%	25.86%	30.92%	41.41%	52.57%
MY 2024	ADD -Follow-Up Care for Children Prescribed ADHD Medication—Continuation & Maintenance Phase	0.00%	0.00%	0.00%	0.00%	37.19%	48.94%	56.83%	63.49%
MY 2024	SSD - Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	85.08%	85.07%	89.29%	80.00%	75.46%	79.51%	83.51%	87.27%
MY 2024	APP - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total	80.00%	6.25%	0.00%	0.00%	41.57%	54.55%	64.10%	74.14%
MY 2024	IET - Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Engagement - Total	3.82%	5.83%	3.08%	14.29%	6.08%	10.51%	16.78%	26.72%
Risk-Adjusted Utilization									
MY 2024	PCR - Plan All-Cause Readmission - Observed to - Expected Ratio (18-64 years)	2.0801	1.7290	0.0000	12.8852	No Bench Marks Use For Scoring			
Other Treatment Measures									
MY 2024	**LBP - Use of Imaging Studies for Low Back Pain	70.18%	71.43%	79.17%	40.00%	64.77%	67.84%	72.74%	78.72%

Note: PCR calculations are based on the scoring algorithm for risk-adjusted utilization measures as defined by NCQA.
NCQA calculates the Confidence Limits (CLs) for all health plans.

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

NB Not a Benefit - Auditor Approval required
NR Not Rated - Not included in the MY's measurement set
N/A No NCQA benchmark to apply in Measurement Year
* RDM and LDM are reporting only measures, full credit received for reporting.
** Inverted measures, a lower rate results in better performance
*** DHCS Withhold Measures
BOLD Indicates MCAS measures held to the MPL

4.2 HPA HEDIS Rate Performance by County, Chico Region: Butte, Colusa, Glenn, Sutter, Yuba Counties

4-5 points 3 points 1-2 points Administrative measures: The entire eligible population is used in calculating performance (versus a systematic sample drawn from the eligible population for the hybrid measures).

Year	Measure	County Performance					National Medicaid Benchmarks			
		Butte	Colusa	Glenn	Sutter	Yuba	10th	33.33rd	66.67th	90th
		Prevention and Population								
		Children and Adolescent Well-Care								
MY 2024	***CIS - Childhood Immunization Status (Combination 10)	0.00%	0.00%	0.00%	0.00%	0.00%	18.25%	24.39%	31.32%	42.34%
MY 2024	***IMA - Immunizations for Adolescents (Combination 2)	0.00%	0.00%	100.00%	40.00%	37.50%	25.41%	31.39%	38.69%	48.66%
MY 2024	WCC - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total	64.52%	100.00%	77.78%	63.33%	58.82%	66.91%	76.89%	86.20%	91.24%
		Women's Reproductive Health								
MY 2024	***PPC - Prenatal and Postpartum Care—Timeliness of Prenatal Care	93.33%	33.33%	83.33%	92.00%	90.00%	73.48%	81.94%	86.89%	91.85%
MY 2024	***PPC - Prenatal and Postpartum Care—Postpartum Care	96.67%	100.00%	100.00%	88.00%	80.00%	68.63%	77.37%	82.48%	86.62%
MY 2024	PRS-E - Prenatal Immunization Status - Combination Rate	19.02%	24.19%	25.82%	18.15%	17.99%	8.42%	15.96%	24.92%	35.60%
		Cancer Screening								
MY 2024	BCS-E- Breast Cancer Screening	26.32%	20.00%	0.00%	0.00%	100.00%	42.86%	49.24%	56.66%	63.48%
MY 2024	CCS - Cervical Cancer Screening	53.19%	75.00%	30.00%	55.56%	60.00%	43.31%	52.07%	60.10%	67.46%
MY 2024	COL-E - Colorectal Cancer Screening	26.67%	20.00%	25.00%	50.00%	50.00%	27.27%	34.30%	41.59%	49.35%
		Other Preventive Services								
MY 2024	CHL - Chlamydia Screening in Women—Total	55.64%	53.02%	51.47%	57.24%	57.89%	43.53%	52.40%	61.46%	69.07%
MY 2024	AIS-E-Adult Immunization Status—Influenza - Total	11.00%	17.54%	13.04%	12.57%	9.16%	7.39%	12.55%	17.91%	26.40%
MY 2024	AIS-E-Adult Immunization Status—Pneumococcal - 66+	39.50%	43.21%	32.31%	51.35%	36.51%	21.04%	38.73%	55.03%	68.07%
MY 2024	AIS-E-Adult Immunization Status—Td/Tdap - Total	28.86%	30.82%	32.27%	30.26%	27.31%	21.26%	33.40%	47.30%	57.67%
MY 2024	AIS-E-Adult Immunization Status—Zoster - Total	13.42%	15.10%	17.50%	14.44%	9.08%	2.23%	7.15%	13.49%	20.56%

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Year	Measure	County Performance					National Medicaid Benchmarks			
		Butte	Colusa	Glenn	Sutter	Yuba	10th	33.33rd	66.67th	90th
		Treatment								
		Respiratory								
MY 2024	**AMR - Asthma Medication Ratio- Total**	66.67%	0.00%	100.00%	0.00%	0.00%	54.56%	62.35%	70.56%	76.65%
MY 2024	CWP - Appropriate Testing for Pharyngitis—Total	61.62%	46.31%	37.55%	38.27%	44.70%	61.35%	76.71%	85.11%	89.17%
MY 2024	**AAB - Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total	20.23%	46.67%	24.29%	42.38%	31.59%	49.48%	50.98%	67.03%	77.66%
MY 2024	PCE - Pharmacotherapy Management of COPD Exacerbation - Systemic Corticosteroid	71.58%	62.50%	75.00%	79.69%	55.00%	55.28%	66.86%	74.78%	82.88%
MY 2024	PCE - Pharmacotherapy Management of COPD Exacerbation - Bronchodilator	83.68%	62.50%	93.75%	95.31%	84.00%	67.25%	80.19%	86.54%	89.96%
		Diabetes								
MY 2024	EED - Eye Exams for Patients with Diabetes	59.09%	100.00%	60.00%	39.13%	52.94%	40.39%	49.15%	57.09%	64.06%
MY 2024	BPD -Blood Pressure Control (<140/90) for Patients with Diabetes	79.55%	100.00%	60.00%	65.22%	70.59%	58.15%	65.32%	71.78%	77.37%
MY 2024	GSD -Glycemic Status Assessment for Patients with Diabetes-- HbA1c Control (<8%)	68.18%	50.00%	60.00%	56.52%	52.94%	44.25%	54.50%	59.64%	63.50%
MY 2024	SPD - Statin Therapy for Patients With Diabetes—Received Statin Therapy	63.64%	75.00%	50.00%	0.00%	0.00%	51.96%	62.66%	67.01%	71.41%
MY 2024	SPD - Statin Therapy for Patients With Diabetes—Statin Adherence 80%	57.14%	0.00%	100.00%	0.00%	0.00%	53.23%	64.18%	70.91%	79.73%
MY 2024	KED - Kidney Health Evaluation for Patients with Diabetes	33.96%	37.39%	28.71%	32.35%	29.28%	26.79%	33.00%	42.10%	49.72%
		Heart Disease								
MY 2024	SPC - Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy—Total	100.00%	100.00%	100.00%	0.00%	0.00%	66.64%	79.82%	83.00%	85.89%
MY 2024	SPC - Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%—Total	100.00%	100.00%	100.00%	0.00%	0.00%	59.95%	67.42%	74.07%	81.79%
MY 2024	***CBP - Controlling High Blood Pressure	72.00%	75.00%	66.67%	61.11%	37.50%	54.61%	61.43%	67.40%	72.75%

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Year	Measure	County Performance					National Medicaid Benchmarks			
		Butte	Colusa	Glenn	Sutter	Yuba	10th	33.33rd	66.67th	90th
Treatment										
Behavioral Health - Care Coordination										
MY 2024	FUH - Follow-Up After Hospitalization for Mental Illness-7 days	NB	NB	NB	NB	NB	23.74%	33.61%	46.35%	61.68%
MY 2024	FUM - Follow-UP After Emergency Department Visit for Mental Illness 7 days total	10.45%	22.22%	10.71%	12.32%	10.11%	21.19%	33.01%	44.33%	59.95%
MY 2024	FUA - Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence—7 days—Total	26.69%	15.38%	28.26%	23.38%	22.71%	12.73%	18.76%	27.62%	37.47%
MY 2024	FUI - Follow-Up After High-Intensity Care for Substance Use Disorder—7 days—Total	15.91%	30.00%	33.33%	17.65%	16.67%	15.91%	26.90%	37.64%	50.80%
Behavioral Health - Medication Adherence										
MY 2024	AMM - Antidepressant Medication Management—Effective Continuation Phase Treatment	43.28%	28.57%	66.67%	36.84%	35.00%	31.52%	41.00%	48.16%	61.06%
MY 2024	POD - Pharmacotherapy for Opioid Use Disorder—Total	14.88%	0.00%	28.57%	25.00%	11.63%	12.05%	21.36%	29.01%	36.71%
MY 2024	SAA - Adherence to Antipsychotic Medications for Individuals With Schizophrenia	67.83%	83.33%	87.50%	86.96%	69.81%	44.65%	58.60%	66.15%	74.83%
Behavioral Health - Access, Monitoring and Safety										
MY 2024	APM - Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	35.56%	50.00%	25.81%	28.26%	34.44%	25.86%	30.92%	41.41%	52.57%
MY 2024	ADD -Follow-Up Care for Children Prescribed ADHD Medication—Continuation & Maintenance Phase	0.00%	0.00%	0.00%	0.00%	0.00%	37.19%	48.94%	56.83%	63.49%
MY 2024	SSD - Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	86.90%	90.91%	86.36%	89.57%	85.26%	75.46%	79.51%	83.51%	87.27%
MY 2024	APP - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total	45.16%	100.00%	44.44%	33.33%	29.63%	41.57%	54.55%	64.10%	74.14%
MY 2024	IET - Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Engagement - Total	4.59%	5.77%	3.28%	6.01%	5.12%	6.08%	10.51%	16.78%	26.72%

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Year	Measure	County Performance					National Medicaid Benchmarks			
		Butte	Colusa	Glenn	Sutter	Yuba	10th	33.33rd	66.67th	90th
Treatment										
Risk-Adjusted Utilization										
MY 2024	PCR - Plan All-Cause Readmission - Observed to - Expected Ratio (18-64 years)	2.6863	1.3132	0.0000	1.5553	2.337	No Bench Marks Use For Scoring			
Other Treatment Measures										
MY 2024	**LBP - Use of Imaging Studies for Low Back Pain	72.62%	67.92%	75.58%	75.72%	77.56%	64.77%	67.84%	72.74%	78.72%

Note: PCR calculations are based on the scoring algorithm for risk-adjusted utilization measures as defined by NCQA.
NCQA calculates the Confidence Limits (CLs) for all health plans.

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

NB Not a Benefit - Auditor Approval required
NR Not Rated - Not included in the MY's measurement set
N/A No NCQA benchmark to apply in Measurement Year
* RDM and LDM are reporting only measures, full credit received for reporting.
** Inverted measures, a lower rate results in better performance
*** DHCS Withhold Measures
BOLD Indicates MCAS measures held to the MPL

4.3 HPA HEDIS Rate Performance by County, Eureka Region: Del Norte, Humboldt, Lake, Mendocino Counties

4-5 points 3 points 1-2 points Administrative measures: The entire eligible population is used in calculating performance (versus a systematic sample drawn from the eligible population for the hybrid measures). Denominators less than 20 at the county level are suppressed.

Year	Measure	County Performance				National Medicaid Benchmarks			
		Del Norte	Humboldt	Lake	Mendocino	10th	33.33rd	66.67th	90th
		Prevention and Population							
		Children and Adolescent Well-Care							
MY 2023	***CIS - Childhood Immunization Status (Combination 10)	10.00%	19.44%	18.75%	21.88%	20.68%	26.76%	35.04%	45.26%
MY 2024		0.00%	26.47%	26.09%	31.43%	18.25%	24.39%	31.32%	42.34%
MY 2023	***IMA - Immunizations for Adolescents (Combination 2)	50.00%	40.48%	28.57%	33.33%	24.82%	30.66%	38.93%	48.80%
MY 2024		16.67%	36.36%	50.00%	35.71%	25.41%	31.39%	38.69%	48.66%
MY 2023	WCC - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total	100.00%	88.89%	92.86%	91.67%	62.77%	74.70%	83.21%	89.72%
MY 2024		85.71%	88.00%	100.00%	80.00%	66.91%	76.89%	86.20%	91.24%
		Women's Reproductive Health							
MY 2023	***PPC - Prenatal and Postpartum Care—Timeliness of Prenatal Care	100.00%	80.00%	100.00%	92.31%	25.86%	30.92%	41.41%	52.57%
MY 2024		55.56%	76.00%	86.67%	90.91%	73.48%	81.94%	86.89%	91.85%
MY 2023	***PPC - Prenatal and Postpartum Care—Postpartum Care	100.00%	80.00%	85.71%	92.31%	67.31%	75.18%	80.78%	84.59%
MY 2024		44.44%	88.00%	93.33%	90.91%	68.63%	77.37%	82.48%	86.62%
MY 2023	PRS-E - Prenatal Immunization Status - Combination Rate	19.67%	19.46%	32.27%	38.89%	7.94%	15.17%	25.81%	37.75%
MY 2024		14.05%	20.24%	28.69%	37.32%	8.42%	15.96%	24.92%	35.60%
		Cancer Screening							
MY 2023	BCS-E- Breast Cancer Screening	38.88%	47.35%	47.56%	50.43%	42.98%	48.33%	54.94%	62.67%
MY 2024		46.83%	51.35%	48.55%	56.75%	42.86%	49.24%	56.66%	63.48%
MY 2023	CCS - Cervical Cancer Screening	30.00%	48.78%	65.52%	66.67%	43.50%	53.37%	59.85%	66.48%
MY 2024		50.00%	75.00%	30.00%	50.00%	43.31%	52.07%	60.10%	67.46%
MY 2023	COL- Colorectal Cancer Screening	NR	NR	NR	NR	NR	NR	NR	NR
MY 2024	COL-E - Colorectal Cancer Screening	25.14%	28.05%	33.41%	31.50%	27.27%	34.30%	41.59%	49.35%

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Year	Measure	County Performance				National Medicaid Benchmarks			
		Del Norte	Humboldt	Lake	Mendocino	10th	33.33rd	66.67th	90th
		Treatment							
		Respiratory							
MY 2023	AMR - Asthma Medication Ratio- Total	46.79%	60.64%	51.71%	60.71%	55.09%	61.81%	69.41%	75.92%
MY 2024		60.83%	63.41%	57.84%	62.50%	54.56%	62.35%	70.56%	76.65%
MY 2023	CWP - Appropriate Testing for Pharyngitis—Total	68.86%	72.81%	60.75%	69.21%	57.41%	68.76%	77.56%	82.40%
MY 2024		63.05%	78.86%	58.17%	80.02%	61.35%	76.71%	85.11%	89.17%
MY 2023	**AAB - Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total	73.28%	71.76%	58.58%	68.16%	50.05%	57.16%	66.19%	77.11%
MY 2024		56.25%	56.86%	55.52%	62.08%	49.48%	50.98%	67.03%	77.66%
MY 2023	PCE - Pharmacotherapy Management of COPD Exacerbation - Systemic Corticosteroid	75.76%	79.26%	75.20%	74.47%	56.05%	68.39%	75.79%	82.43%
MY 2024		62.75%	68.84%	74.82%	74.00%	55.28%	66.86%	74.78%	82.88%
MY 2023	PCE - Pharmacotherapy Management of COPD Exacerbation - Bronchodilator	87.88%	88.89%	83.20%	87.94%	72.88%	82.35%	86.96%	90.53%
MY 2024		82.35%	84.06%	92.09%	88.00%	67.25%	80.19%	86.54%	89.96%

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Year	Measure	County Performance				National Medicaid Benchmarks			
		Del Norte	Humboldt	Lake	Mendocino	10th	33.33rd	66.67th	90th
		Treatment							
		Diabetes							
MY 2023	EED - Eye Exams for Patients with Diabetes	22.22%	44.12%	56.52%	44.00%	36.74%	46.96%	56.20%	63.33%
MY 2024		0.00%	33.33%	50.00%	70.00%	40.39%	49.15%	57.09%	64.06%
MY 2023	BPD -Blood Pressure Control (<140/90) for Patients with Diabetes	75.00%	59.09%	68.00%	75.00%	52.07%	59.85%	68.61%	74.56%
MY 2024		66.67%	66.67%	92.86%	60.00%	58.15%	65.32%	71.78%	77.37%
MY 2023	HBD -Hemoglobin A1c Control for Patients with Diabetes-- HbA1c Control (<8%)	77.78%	55.88%	52.17%	44.00%	38.93%	49.39%	55.72%	60.34%
MY 2024	GSD -Glycemic Status Assessment for Patients with Diabetes-- HbA1c Control (<8%)	33.33%	59.26%	78.57%	60.00%	44.25%	54.50%	59.64%	63.50%
MY 2023	SPD - Statin Therapy for Patients With Diabetes—Received Statin Therapy	54.32%	54.86%	58.43%	53.94%	54.15%	62.58%	67.07%	72.15%
MY 2024		59.47%	59.20%	61.94%	55.91%	51.96%	62.66%	67.01%	71.41%
MY 2023	SPD - Statin Therapy for Patients With Diabetes—Statin Adherence 80%	95.45%	96.36%	92.39%	92.45%	52.67%	62.50%	70.37%	77.97%
MY 2024		73.25%	70.16%	61.03%	65.32%	53.23%	64.18%	70.91%	79.73%
MY 2023	KED - Kidney Health Evaluation for Patients with Diabetes	25.32%	31.69%	19.91%	19.26%	22.73%	29.42%	38.80%	47.55%
MY 2024		29.02%	37.62%	35.38%	31.95%	26.79%	33.00%	42.10%	49.72%
		Heart Disease							
MY 2023	SPC - Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy—Total	77.78%	83.72%	80.12%	83.33%	70.02%	78.80%	81.64%	85.04%
MY 2024		69.44%	75.83%	85.71%	77.78%	66.64%	79.82%	83.00%	85.89%
MY 2023	SPC - Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%—Total	91.43%	95.37%	92.70%	96.25%	56.67%	66.48%	73.63%	80.95%
MY 2024		64.00%	74.73%	71.67%	61.04%	59.95%	67.42%	74.07%	81.79%
MY 2023	***CBP - Controlling High Blood Pressure	37.50%	78.13%	72.22%	74.07%	50.36%	57.66%	65.45%	72.22%
MY 2024		83.33%	48.00%	68.18%	78.95%	54.61%	61.43%	67.40%	72.75%

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Year	Measure	County Performance				National Medicaid Benchmarks			
		Del Norte	Humboldt	Lake	Mendocino	10th	33.33rd	66.67th	90th
Treatment									
Behavioral Health - Care Coordination									
MY 2023	**FUH[1] - Follow-Up After Hospitalization for Mental Illness-7 days**	0.00%	0.00%	0.00%	0.00%	23.74%	33.61%	46.35%	61.68%
MY 2024		NB	NB	NB	NB	23.74%	33.61%	46.35%	61.68%
MY 2023	**FUM - Follow-UP After Emergency Department Visit for Mental Illness 7 days total**	10.89%	22.04%	10.78%	5.69%	23.74%	33.61%	46.35%	61.68%
MY 2024		11.61%	17.14%	10.36%	12.77%	21.19%	33.01%	44.33%	59.95%
MY 2023	**FUA - Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence—7 days—Total**	14.97%	26.22%	19.35%	22.27%	13.83%	20.00%	27.73%	38.15%
MY 2024		18.24%	31.70%	13.33%	21.08%	12.73%	18.76%	27.62%	37.47%
MY 2023	FUI - Follow-Up After High-Intensity Care for Substance Use Disorder—7 days—Total	20.00%	35.39%	8.00%	53.69%	15.16%	23.12%	37.31%	49.55%
MY 2024		15.79%	37.24%	6.67%	52.52%	15.91%	26.90%	37.64%	50.80%
Behavioral Health - Medication Adherence									
MY 2023	AMM - Antidepressant Medication Management—Effective Continuation Phase Treatment	86.96%	82.99%	73.58%	79.39%	31.59%	40.01%	46.74%	58.06%
MY 2024		53.62%	52.91%	40.89%	44.49%	31.52%	41.00%	48.16%	61.06%
MY 2023	POD - Pharmacotherapy for Opioid Use Disorder—Total	61.90%	40.96%	48.40%	47.30%	14.94%	23.38%	31.93%	40.34%
MY 2024		16.95%	20.75%	13.82%	17.47%	12.05%	21.36%	29.01%	36.71%
MY 2023	SAA - Adherence to Antipsychotic Medications for Individuals With Schizophrenia	76.92%	73.83%	67.38%	71.65%	41.24%	57.79%	64.90%	72.61%
MY 2024		67.57%	68.39%	68.12%	62.81%	44.65%	58.60%	66.15%	74.83%

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Year	Measure	County Performance				National Medicaid Benchmarks			
		Del Norte	Humboldt	Lake	Mendocino	10th	33.33rd	66.67th	90th
Treatment									
Behavioral Health - Access, Monitoring and Safety									
MY 2023	APM - Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	54.05%	21.32%	29.52%	37.04%	26.36%	31.97%	40.50%	53.58%
MY 2024		45.95%	21.14%	26.47%	29.09%	25.86%	30.92%	41.41%	52.57%
MY 2023	ADD -Follow-Up Care for Children Prescribed ADHD Medication—Continuation & Maintenance Phase	55.00%	36.00%	25.00%	43.33%	40.38%	50.98%	57.90%	63.92%
MY 2024		18.18%	43.24%	50.00%	33.33%	37.19%	48.94%	56.83%	63.49%
MY 2023	SSD - Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	88.76%	81.56%	78.73%	86.96%	72.83%	77.40%	80.86%	85.52%
MY 2024		81.11%	79.15%	80.07%	88.03%	75.46%	79.51%	83.51%	87.27%
MY 2023	APP - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total	40.00%	30.36%	16.67%	11.11%	36.65%	55.19%	63.89%	73.87%
MY 2024		0.00%	48.98%	33.33%	75.00%	41.57%	54.55%	64.10%	74.14%
MY 2023	IET - Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Engagement - Total	6.85%	10.11%	8.55%	10.44%	7.05%	11.11%	16.94%	24.37%
MY 2024		5.94%	8.06%	3.82%	8.25%	6.08%	10.51%	16.78%	26.72%
Risk-Adjusted Utilization									
MY 2023	PCR - Plan All-Cause Readmission - Observed to - Expected Ratio (18-64 years)	0.7160	0.8959	0.9614	0.7823	No Bench Marks Use For Scoring			
MY 2024		0.6596	0.9967	0.9747	0.9901				
Other Treatment Measures									
MY 2023	**LBP - Use of Imaging Studies for Low Back Pain	66.82%	82.27%	72.25%	79.77%	67.72%	71.32%	75.44%	79.96%
MY 2024		69.04%	78.28%	70.45%	74.30%	64.77%	67.84%	72.74%	78.72%

Note: PCR calculations are based on the scoring algorithm for risk-adjusted utilization measures as defined by NCQA. NCQA calculates the Confidence Limits (CLs) for all health plans.

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

NB Not a Benefit - Auditor Approval required
NR Not Rated - Not included in the MY's measurement set
N/A No NCQA benchmark to apply in Measurement Year
* RDM and LDM are reporting only measures, full credit received for reporting.
** Inverted measures, a lower rate results in better performance
*** DHCS Withhold Measures
BOLD Indicates MCAS measures held to the MPL

4.4 HPA HEDIS Rate Performance by County, Fairfield Region: Solano, Yolo, and Napa Counties

4-5 points 3 points 1-2 points Administrative measures: The entire eligible population is used in calculating performance (versus a systematic sample drawn from the eligible population for the hybrid measures). Denominators less than 20 at the county level are suppressed.

Year	Measure	County Performance			National Medicaid Benchmarks			
		Napa	Solano	Yolo	10th	33.33rd	66.67th	90th
Prevention and Population								
Children and Adolescent Well-Care								
MY 2023	***CIS - Childhood Immunization Status (Combination 10)	45.00%	33.33%	41.38%	20.68%	26.76%	35.04%	45.26%
MY 2024		47.06%	34.85%	21.62%	18.25%	24.39%	31.32%	42.34%
MY 2023	***IMA - Immunizations for Adolescents (Combination 2)	70.37%	39.13%	37.93%	24.82%	30.66%	38.93%	48.80%
MY 2024		50.00%	38.03%	55.56%	25.41%	31.39%	38.69%	48.66%
MY 2023	WCC - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total	100.00%	97.22%	69.23%	62.77%	74.70%	83.21%	89.72%
MY 2024		100.00%	80.65%	45.00%	66.91%	76.89%	86.20%	91.24%
Women's Reproductive Health								
MY 2023	***PPC - Prenatal and Postpartum Care—Timeliness of Prenatal Care	90.91%	90.70%	89.47%	25.86%	30.92%	41.41%	52.57%
MY 2024		88.24%	87.76%	76.00%	73.48%	81.94%	86.89%	91.85%
MY 2023	***PPC - Prenatal and Postpartum Care—Postpartum Care	81.82%	93.02%	94.74%	67.31%	75.18%	80.78%	84.59%
MY 2024		100.00%	85.71%	68.00%	68.63%	77.37%	82.48%	86.62%
MY 2023	PRS-E - Prenatal Immunization Status - Combination Rate	35.87%	41.85%	38.39%	7.94%	15.17%	25.81%	37.75%
MY 2024		38.62%	37.70%	40.00%	8.42%	15.96%	24.92%	35.60%
Cancer Screening								
MY 2023	BCS-E- Breast Cancer Screening	67.20%	58.12%	59.99%	42.98%	48.33%	54.94%	62.67%
MY 2024		66.84%	54.14%	60.29%	42.86%	49.24%	56.66%	63.48%
MY 2023	CCS - Cervical Cancer Screening	77.27%	66.07%	48.78%	43.50%	53.37%	59.85%	66.48%
MY 2024		75.00%	64.71%	47.62%	43.31%	52.07%	60.10%	67.46%
MY 2023	COL- Colorectal Cancer Screening	NR	NR	NR	NR	NR	NR	NR
MY 2024	COL-E - Colorectal Cancer Screening	38.24%	31.74%	32.50%	27.27%	34.30%	41.59%	49.35%

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Year	Measure	County Performance			National Medicaid Benchmarks			
		Napa	Solano	Yolo	10th	33.33rd	66.67th	90th
Prevention and Population								
Other Preventive Services								
MY 2023	CHL - Chlamydia Screening in Women—Total	55.05%	62.67%	53.32%	42.61%	51.39%	61.07%	67.39%
MY 2024		49.58%	62.14%	51.37%	43.53%	52.40%	61.46%	69.07%
MY 2023	AIS-E-Adult Immunization Status—Influenza - Total	24.34%	19.23%	22.72%	6.50%	10.82%	16.32%	21.05%
MY 2024		21.99%	16.50%	21.83%	7.39%	12.55%	17.91%	26.40%
MY 2023	AIS-E-Adult Immunization Status—Pneumococcal - 66+	51.43%	56.30%	50.46%	N/A	N/A	N/A	N/A
MY 2024		51.67%	51.11%	47.74%	21.04%	38.73%	55.03%	68.07%
MY 2023	AIS-E-Adult Immunization Status—Td/Tdap - Total	39.23%	38.95%	41.62%	18.67%	29.84%	41.54%	56.53%
MY 2024		35.69%	34.58%	39.96%	21.26%	33.40%	47.30%	57.67%
MY 2023	AIS-E-Adult Immunization Status—Zoster - Total	21.55%	17.94%	18.53%	1.72%	4.42%	10.27%	14.54%
MY 2024		24.27%	17.30%	19.20%	2.23%	7.15%	13.49%	20.56%
Treatment								
Respiratory								
MY 2023	**AMR - Asthma Medication Ratio- Total**	78.34%	68.85%	65.93%	55.09%	61.81%	69.41%	75.92%
MY 2024		79.82%	65.79%	67.84%	54.56%	62.35%	70.56%	76.65%
MY 2023	CWP - Appropriate Testing for Pharyngitis—Total	65.48%	62.85%	89.19%	57.41%	68.76%	77.56%	82.40%
MY 2024		74.40%	71.69%	88.25%	61.35%	76.71%	85.11%	89.17%
MY 2023	**AAB - Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total	76.10%	81.13%	78.71%	50.05%	57.16%	66.19%	77.11%
MY 2024		68.79%	80.34%	80.77%	49.48%	50.98%	67.03%	77.66%
MY 2023	PCE - Pharmacotherapy Management of COPD Exacerbation - Systemic Corticosteroid	69.70%	74.00%	75.00%	56.05%	68.39%	75.79%	82.43%
MY 2024		78.26%	76.19%	68.35%	55.28%	66.86%	74.78%	82.88%
MY 2023	PCE - Pharmacotherapy Management of COPD Exacerbation - Bronchodilator	100.00%	89.50%	84.52%	72.88%	82.35%	86.96%	90.53%
MY 2024		91.30%	87.07%	84.81%	67.25%	80.19%	86.54%	89.96%

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Year	Measure	County Performance			National Medicaid Benchmarks			
		Napa	Solano	Yolo	10th	33.33rd	66.67th	90th
Treatment								
Diabetes								
MY 2023	EED - Eye Exams for Patients with Diabetes	69.57%	58.76%	43.24%	36.74%	46.96%	56.20%	63.33%
MY 2024		46.67%	59.65%	44.83%	40.39%	49.15%	57.09%	64.06%
MY 2023	BPD -Blood Pressure Control (<140/90) for Patients with Diabetes	66.67%	71.23%	67.86%	52.07%	59.85%	68.61%	74.56%
MY 2024		86.67%	84.21%	68.97%	58.15%	65.32%	71.78%	77.37%
MY 2023	HBD -Hemoglobin A1c Control for Patients with Diabetes-- HbA1c Control (<8%)	52.17%	56.70%	48.65%	38.93%	49.39%	55.72%	60.34%
MY 2024	GSD -Glycemic Status Assessment for Patients with Diabetes-- HbA1c Control (<8%)	66.67%	52.63%	55.17%	44.25%	54.50%	59.64%	63.50%
MY 2023	SPD - Statin Therapy for Patients With Diabetes—Received Statin Therapy	69.71%	69.35%	68.62%	54.15%	62.58%	67.07%	72.15%
MY 2024		67.58%	68.90%	69.47%	51.96%	62.66%	67.01%	71.41%
MY 2023	SPD - Statin Therapy for Patients With Diabetes—Statin Adherence 80%	94.88%	96.63%	94.49%	52.67%	62.50%	70.37%	77.97%
MY 2024		65.16%	70.86%	71.09%	53.23%	64.18%	70.91%	79.73%
MY 2023	KED - Kidney Health Evaluation for Patients with Diabetes	59.81%	55.47%	47.04%	22.73%	29.42%	38.80%	47.55%
MY 2024		48.46%	50.53%	39.00%	26.79%	33.00%	42.10%	49.72%
Heart Disease								
MY 2023	SPC - Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy—Total	85.26%	82.35%	84.31%	70.02%	78.80%	81.64%	85.04%
MY 2024		87.84%	77.89%	82.48%	66.64%	79.82%	83.00%	85.89%
MY 2023	SPC - Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%—Total	97.53%	96.94%	93.80%	56.67%	66.48%	73.63%	80.95%
MY 2024		64.62%	69.87%	81.42%	59.95%	67.42%	74.07%	81.79%
MY 2023	***CBP - Controlling High Blood Pressure	86.67%	65.71%	63.64%	50.36%	57.66%	65.45%	72.22%
MY 2024		52.38%	62.75%	78.13%	54.61%	61.43%	67.40%	72.75%

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Year	Measure	County Performance			National Medicaid Benchmarks			
		Napa	Solano	Yolo	10th	33.33rd	66.67th	90th
Treatment								
Behavioral Health - Care Coordination								
MY 2023	**FUH[1] - Follow-Up After Hospitalization for Mental Illness-7 days**	16.67%	58.10%	0.00%	23.74%	33.61%	46.35%	61.68%
MY 2024		NB	NB	NB	23.74%	33.61%	46.35%	61.68%
MY 2023	**FUM - Follow-UP After Emergency Department Visit for Mental Illness 7 days total**	20.59%	19.43%	15.58%	23.74%	33.61%	46.35%	61.68%
MY 2024		13.04%	9.98%	10.69%	21.19%	33.01%	44.33%	59.95%
MY 2023	**FUA - Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence—7 days—Total**	17.37%	24.81%	17.45%	13.83%	20.00%	27.73%	38.15%
MY 2024		10.83%	20.83%	17.30%	12.73%	18.76%	27.62%	37.47%
MY 2023	FUI - Follow-Up After High-Intensity Care for Substance Use Disorder—7 days—Total	17.39%	36.08%	11.76%	15.16%	23.12%	37.31%	49.55%
MY 2024		12.90%	32.17%	15.07%	15.91%	26.90%	37.64%	50.80%
Behavioral Health - Medication Adherence								
MY 2023	AMM - Antidepressant Medication Management—Effective Continuation Phase Treatment	86.92%	84.74%	79.92%	31.59%	40.01%	46.74%	58.06%
MY 2024		49.62%	51.75%	50.22%	31.52%	41.00%	48.16%	61.06%
MY 2023	POD - Pharmacotherapy for Opioid Use Disorder—Total	38.46%	42.53%	39.68%	14.94%	23.38%	31.93%	40.34%
MY 2024		3.57%	13.07%	3.85%	12.05%	21.36%	29.01%	36.71%
MY 2023	SAA - Adherence to Antipsychotic Medications for Individuals With Schizophrenia	78.02%	73.23%	67.11%	41.24%	57.79%	64.90%	72.61%
MY 2024		65.67%	65.96%	64.89%	44.65%	58.60%	66.15%	74.83%

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Year	Measure	County Performance			National Medicaid Benchmarks			
		Napa	Solano	Yolo	10th	33.33rd	66.67th	90th
Treatment								
Behavioral Health - Access, Monitoring and Safety								
MY 2023	APM - Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	47.73%	33.57%	21.18%	26.36%	31.97%	40.50%	53.58%
MY 2024		40.00%	41.57%	23.88%	25.86%	30.92%	41.41%	52.57%
MY 2023	ADD -Follow-Up Care for Children Prescribed ADHD Medication—Continuation & Maintenance Phase	37.50%	16.22%	38.78%	40.38%	50.98%	57.90%	63.92%
MY 2024		28.57%	25.00%	48.84%	37.19%	48.94%	56.83%	63.49%
MY 2023	SSD - Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	82.55%	85.45%	83.85%	72.83%	77.40%	80.86%	85.52%
MY 2024		83.85%	87.32%	80.00%	75.46%	79.51%	83.51%	87.27%
MY 2023	APP - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total	28.00%	20.37%	17.39%	36.65%	55.19%	63.89%	73.87%
MY 2024		9.09%	58.33%	28.00%	41.57%	54.55%	64.10%	74.14%
MY 2023	IET - Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Engagement - Total	6.32%	9.24%	4.34%	7.05%	11.11%	16.94%	24.37%
MY 2024		4.79%	8.85%	3.50%	6.08%	10.51%	16.78%	26.72%
Risk-Adjusted Utilization								
MY 2023	PCR - Plan All-Cause Readmission - Observed to - Expected Ratio (18-64 years)	1.0566	0.8160	0.9892	No Bench Marks Use For Scoring			
MY 2024		0.8874	1.1087	1.0775				
Other Treatment Measures								
MY 2023	**LBP - Use of Imaging Studies for Low Back Pain	75.78%	77.01%	76.37%	67.72%	71.32%	75.44%	79.96%
MY 2024		65.19%	71.39%	74.62%	64.77%	67.84%	72.74%	78.72%

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

NB Not a Benefit - Auditor Approval required
NR Not Rated - Not included in the MY's measurement set
N/A No NCQA benchmark to apply in Measurement Year
* RDM and LDM are reporting only measures, full credit received for reporting.
** Inverted measures, a lower rate results in better performance
*** DHCS Withhold Measures
BOLD Indicates MCAS measures held to the MPL

Note: PCR calculations are based on the scoring algorithm for risk-adjusted utilization measures as defined by NCQA.
NCQA calculates the Confidence Limits (CLs) for all health plans.

4.5 HPA HEDIS Rate Performance by County, Redding Region: Lassen, Modoc, Shasta, Siskiyou, Tehama, Trinity Counties

4-5 points 3 points 1-2 points Administrative measures: The entire eligible population is used in calculating performance (versus a systematic sample drawn from the eligible population for the hybrid measures). Denominators less than 20 at the county level are suppressed.

Year	Measure	County Performance						National Medicaid Benchmarks			
		Lassen	Modoc	Shasta	Siskiyou	Tehama	Trinity	10th	33.33rd	66.67th	90th
		Prevention and Population									
		Children and Adolescent Well-Care									
MY 2023	***CIS - Childhood Immunization Status (Combination 10)	10.00%	0.00%	13.95%	20.00%	N/A	0.00%	20.68%	26.76%	35.04%	45.26%
MY 2024		50.00%	0.00%	16.00%	18.18%	0.00%	25.00%	18.25%	24.39%	31.32%	42.34%
MY 2023	***IMA - Immunizations for Adolescents (Combination 2)	0.00%	50.00%	21.82%	18.18%	N/A	33.33%	24.82%	30.66%	38.93%	48.80%
MY 2024		12.50%	0.00%	21.57%	10.00%	0.00%	33.33%	25.41%	31.39%	38.69%	48.66%
MY 2023	WCC - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total	66.67%	100.00%	86.67%	66.67%	N/A	66.67%	62.77%	74.70%	83.21%	89.72%
MY 2024		100.00%	100.00%	95.12%	66.67%	56.25%	0.00%	66.91%	76.89%	86.20%	91.24%
		Women's Reproductive Health									
MY 2023	***PPC - Prenatal and Postpartum Care—Timeliness of Prenatal Care	100.00%	75.00%	93.75%	66.67%	N/A	0.00%	25.86%	30.92%	41.41%	52.57%
MY 2024		100.00%	100.00%	84.38%	100.00%	61.54%	50.00%	73.48%	81.94%	86.89%	91.85%
MY 2023	***PPC - Prenatal and Postpartum Care—Postpartum Care	100.00%	25.00%	83.38%	33.33%	N/A	0.00%	67.31%	75.18%	80.78%	84.59%
MY 2024		100.00%	50.00%	0.00%	100.00%	92.31%	75.00%	68.63%	77.37%	82.48%	86.62%
MY 2023	PRS-E - Prenatal Immunization Status - Combination Rate	11.70%	15.63%	14.29%	20.00%	N/A	8.51%	7.94%	15.17%	25.81%	37.75%
MY 2024		26.67%	17.14%	24.12%	27.33%	22.51%	15.38%	8.42%	15.96%	24.92%	35.60%
		Cancer Screening									
MY 2023	BCS-E- Breast Cancer Screening	45.98%	45.65%	50.90%	51.66%	N/A	43.46%	42.98%	48.33%	54.94%	62.67%
MY 2024		43.08%	48.52%	54.90%	52.64%	38.46%	49.39%	42.86%	49.24%	56.66%	63.48%
MY 2023	CCS - Cervical Cancer Screening	33.33%	0.00%	39.47%	66.67%	N/A	66.67%	43.50%	53.37%	59.85%	66.48%
MY 2024		50.00%	100.00%	53.85%	72.73%	36.84%	100.00%	43.31%	52.07%	60.10%	67.46%
MY 2023	COL- Colorectal Cancer Screening	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
MY 2024	COL-E - Colorectal Cancer Screening	23.17%	31.51%	32.16%	27.63%	25.00%	27.13%	27.27%	34.30%	41.59%	49.35%

Year	Measure	County Performance						National Medicaid Benchmarks			
		Lassen	Modoc	Shasta	Siskiyou	Tehama	Trinity	10th	33.33rd	66.67th	90th
Prevention and Population											
Other Preventive Services											
MY 2023	CHL - Chlamydia Screening in Women—Total	37.37%	30.39%	53.06%	46.15%	N/A	35.96%	42.61%	51.39%	61.07%	67.39%
MY 2024		41.55%	32.89%	52.12%	45.38%	54.34%	34.72%	43.53%	52.40%	61.46%	69.07%
MY 2023	AIS-E-Adult Immunization Status—Influenza - Total	7.70%	9.76%	9.31%	9.63%	N/A	7.89%	6.50%	10.82%	16.32%	21.05%
MY 2024		12.02%	10.14%	8.49%	10.20%	9.42%	8.18%	7.39%	12.55%	17.91%	26.40%
MY 2023	AIS-E-Adult Immunization Status—Pneumococcal - 66+	30.00%	25.00%	32.17%	33.33%	N/A	0.00%	N/A	N/A	N/A	N/A
MY 2024		30.00%	46.15%	36.81%	32.43%	27.00%	9.09%	21.04%	38.73%	55.03%	68.07%
MY 2023	AIS-E-Adult Immunization Status—Td/Tdap - Total	28.52%	29.97%	31.04%	29.73%	N/A	27.09%	18.67%	29.84%	41.54%	56.53%
MY 2024		28.42%	31.51%	33.87%	31.68%	29.20%	31.10%	21.26%	33.40%	47.30%	57.67%
MY 2023	AIS-E-Adult Immunization Status—Zoster - Total	3.76%	8.95%	9.25%	4.65%	N/A	5.99%	1.72%	4.42%	10.27%	14.54%
MY 2024		4.50%	10.87%	10.49%	5.84%	9.87%	6.96%	2.23%	7.15%	13.49%	20.56%

Year	Measure	County Performance						National Medicaid Benchmarks			
		Lassen	Modoc	Shasta	Siskiyou	Tehama	Trinity	10th	33.33rd	66.67th	90th
Treatment											
Respiratory											
MY 2023	**AMR - Asthma Medication Ratio- Total**	54.64%	46.88%	49.94%	49.05%	N/A	48.00%	55.09%	61.81%	69.41%	75.92%
MY 2024		58.70%	63.16%	57.28%	59.62%	0.00%	50.00%	54.56%	62.35%	70.56%	76.65%
MY 2023	CWP - Appropriate Testing for Pharyngitis—Total	83.33%	74.39%	60.26%	52.12%	N/A	47.44%	57.41%	68.76%	77.56%	82.40%
MY 2024		77.47%	75.18%	63.34%	64.94%	50.37%	43.96%	61.35%	76.71%	85.11%	89.17%
MY 2023	**AAB - Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total	71.01%	46.67%	69.48%	67.18%	N/A	72.41%	50.05%	57.16%	66.19%	77.11%
MY 2024		59.62%	60.00%	61.78%	65.66%	53.05%	64.71%	49.48%	50.98%	67.03%	77.66%
MY 2023	PCE - Pharmacotherapy Management of COPD Exacerbation - Systemic Corticosteroid	90.48%	75.00%	66.06%	61.11%	N/A	77.78%	56.05%	68.39%	75.79%	82.43%
MY 2024		58.62%	30.77%	74.31%	70.83%	77.00%	81.82%	55.28%	66.86%	74.78%	82.88%
MY 2023	PCE - Pharmacotherapy Management of COPD Exacerbation - Bronchodilator	95.24%	75.00%	87.27%	86.11%	N/A	88.89%	72.88%	82.35%	86.96%	90.53%
MY 2024		86.21%	84.62%	85.42%	83.33%	90.00%	81.82%	67.25%	80.19%	86.54%	89.96%
Diabetes											
MY 2023	EED - Eye Exams for Patients with Diabetes	100.00%	100.00%	68.42%	85.71%	N/A	50.00%	36.74%	46.96%	56.20%	63.33%
MY 2024		20.00%	100.00%	58.33%	71.43%	30.77%	0.00%	40.39%	49.15%	57.09%	64.06%
MY 2023	BPD -Blood Pressure Control (<140/90) for Patients with Diabetes	66.67%	80.00%	73.81%	70.00%	N/A	66.67%	52.07%	59.85%	68.61%	74.56%
MY 2024		20.00%	0.00%	62.50%	57.14%	30.77%		58.15%	65.32%	71.78%	77.37%
MY 2023	HBD -Hemoglobin A1c Control for Patients with Diabetes-- HbA1c Control (<8%)	0.00%	100.00%	65.79%	42.86%	N/A	25.00%	38.93%	49.39%	55.72%	60.34%
MY 2024	GSD -Glycemic Status Assessment for Patients with Diabetes-- HbA1c Control (<8%)	60.00%	50.00%	54.17%	42.86%	38.46%	0.00%	44.25%	54.50%	59.64%	63.50%
MY 2023	SPD - Statin Therapy for Patients With Diabetes—Received Statin Therapy	55.29%	64.13%	54.82%	56.68%	N/A	47.73%	54.15%	62.58%	67.07%	72.15%
MY 2024		53.90%	60.61%	57.12%	61.60%	46.15%	51.09%	51.96%	62.66%	67.01%	71.41%
MY 2023	SPD - Statin Therapy for Patients With Diabetes—Statin Adherence 80%	93.62%	98.31%	93.45%	93.50%	N/A	97.62%	52.67%	62.50%	70.37%	77.97%
MY 2024		67.47%	73.33%	71.68%	67.71%	66.67%	82.98%	53.23%	64.18%	70.91%	79.73%
MY 2023	KED - Kidney Health Evaluation for Patients with Diabetes	18.15%	25.00%	38.24%	26.56%	N/A	24.83%	22.73%	29.42%	38.80%	47.55%
MY 2024		17.08%	24.22%	42.26%	38.86%	37.70%	31.72%	26.79%	33.00%	42.10%	49.72%

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Year	Measure	County Performance						National Medicaid Benchmarks			
		Lassen	Modoc	Shasta	Siskiyou	Tehama	Trinity	10th	33.33rd	66.67th	90th
Treatment											
Heart Disease											
MY 2023	SPC - Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy—Total	72.73%	50.00%	75.22%	87.50%	N/A	78.57%	70.02%	78.80%	81.64%	85.04%
MY 2024		78.95%	100.00%	80.65%	76.67%	66.67%	78.95%	66.64%	79.82%	83.00%	85.89%
MY 2023	SPC - Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%—Total	100.00%	100.00%	96.46%	91.43%	N/A	100.00%	56.67%	66.48%	73.63%	80.95%
MY 2024		60.00%	57.14%	68.00%	60.87%	50.00%	73.33%	59.95%	67.42%	74.07%	81.79%
MY 2023	***CBP - Controlling High Blood Pressure	100.00%	75.00%	80.65%	80.00%	N/A	100.00%	50.36%	57.66%	65.45%	72.22%
MY 2024		54.55%	0.00%	51.52%	50.00%	33.33%		54.61%	61.43%	67.40%	72.75%
Behavioral Health - Care Coordination											
MY 2023	**FUH[1] - Follow-Up After Hospitalization for Mental Illness-7 days**	0.00%	0.00%	0.00%	0.00%	N/A	0.00%	23.74%	33.61%	46.35%	61.68%
MY 2024		NB	NB	NB	NB	NB	NB	23.74%	33.61%	46.35%	61.68%
MY 2023	**FUM - Follow-UP After Emergency Department Visit for Mental Illness 7 days total**	10.00%	0.00%	17.44%	13.58%	N/A	21.05%	23.74%	33.61%	46.35%	61.68%
MY 2024		9.38%	5.88%	18.90%	23.61%	6.67%	6.25%	21.19%	33.01%	44.33%	59.95%
MY 2023	**FUA - Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence—7 days—Total**	6.67%	35.29%	34.58%	18.37%	N/A	21.05%	13.83%	20.00%	27.73%	38.15%
MY 2024		14.52%	27.27%	34.01%	22.29%	22.94%	20.93%	12.73%	18.76%	27.62%	37.47%
MY 2023	FUI - Follow-Up After High-Intensity Care for Substance Use Disorder—7 days—Total	26.09%	40.00%	31.27%	40.00%	N/A	0.00%	15.16%	23.12%	37.31%	49.55%
MY 2024		37.04%	31.25%	36.40%	39.29%	25.00%	0.00%	15.91%	26.90%	37.64%	50.80%

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Year	Measure	County Performance						National Medicaid Benchmarks			
		Lassen	Modoc	Shasta	Siskiyou	Tehama	Trinity	10th	33.33rd	66.67th	90th
Treatment											
Behavioral Health - Medication Adherence											
MY 2023	AMM - Antidepressant Medication Management—Effective Continuation Phase Treatment	81.05%	72.41%	81.78%	86.41%	N/A	86.36%	31.59%	40.01%	46.74%	58.06%
MY 2024		54.29%	22.22%	46.21%	44.66%	44.00%	55.56%	31.52%	41.00%	48.16%	61.06%
MY 2023	POD - Pharmacotherapy for Opioid Use Disorder—Total	52.94%	66.67%	33.63%	37.63%	N/A	46.15%	14.94%	23.38%	31.93%	40.34%
MY 2024		5.56%	55.56%	16.40%	27.83%	4.00%	10.00%	12.05%	21.36%	29.01%	36.71%
MY 2023	SAA - Adherence to Antipsychotic Medications for Individuals With Schizophrenia	75.00%	73.68%	72.43%	84.38%	N/A	50.00%	41.24%	57.79%	64.90%	72.61%
MY 2024		73.91%	46.15%	66.19%	57.58%	60.53%	70.00%	44.65%	58.60%	66.15%	74.83%
Behavioral Health - Access, Monitoring and Safety											
MY 2023	APM - Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	30.43%	11.11%	29.11%	34.78%	N/A	37.50%	26.36%	31.97%	40.50%	53.58%
MY 2024		31.03%	0.00%	29.56%	29.73%	29.52%	50.00%	25.86%	30.92%	41.41%	52.57%
MY 2023	ADD -Follow-Up Care for Children Prescribed ADHD Medication—Continuation & Maintenance Phase	15.38%	25.00%	32.43%	37.50%	N/A	37.50%	40.38%	50.98%	57.90%	63.92%
MY 2024		20.00%	50.00%	48.53%	53.85%	0.00%	40.00%	37.19%	48.94%	56.83%	63.49%
MY 2023	SSD - Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	67.92%	96.15%	78.12%	87.62%	N/A	76.47%	72.83%	77.40%	80.86%	85.52%
MY 2024		80.43%	90.48%	81.42%	82.76%	84.08%	88.89%	75.46%	79.51%	83.51%	87.27%
MY 2023	APP - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total	20.83%	14.29%	31.97%	18.18%	N/A	20.00%	36.65%	55.19%	63.89%	73.87%
MY 2024		6.25%	33.33%	54.55%	50.00%	20.69%	50.00%	41.57%	54.55%	64.10%	74.14%
MY 2023	IET - Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Engagement - Total	6.51%	2.59%	9.95%	11.13%	N/A	5.00%	7.05%	11.11%	16.94%	24.37%
MY 2024		9.57%	8.94%	12.24%	11.41%	4.96%	2.87%	6.08%	10.51%	16.78%	26.72%

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		Risk-Adjusted Utilization									
MY 2023	PCR - Plan All-Cause Readmission - Observed to - Expected Ratio (18-64 years)	0.7435	1.2776	0.8396	0.9745	N/A	0.8752	No Bench Marks Use For Scoring			
MY 2024		0.9224	0.9456	0.8900	0.4606	2.7723	0.6961				
		Other Treatment Measures									
MY 2023	**LBP - Use of Imaging Studies for Low Back Pain	68.93%	73.91%	76.68%	61.90%	N/A	75.76%	67.72%	71.32%	75.44%	79.96%
MY 2024		71.59%	57.78%	75.10%	63.19%	76.58%	64.44%	64.77%	67.84%	72.74%	78.72%

Note: PCR calculations are based on the scoring algorithm for risk-adjusted utilization measures as defined by NCQA.
NCQA calculates the Confidence Limits (CLs) for all health plans.

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

NB Not a Benefit - Auditor Approval required
NR Not Rated - Not included in the MY's measurement set
N/A No NCQA benchmark to apply in Measurement Year
* RDM and LDM are reporting only measures, full credit received for reporting.
** Inverted measures, a lower rate results in better performance
*** DHCS Withhold Measures
BOLD Indicates MCAS measures held to the MPL

4.6 HPA HEDIS Rate Performance by County, Santa Rosa Region: Marin, Sonoma Counties

Note: CAHPS is not captured by County

4-5 points ○ 3 points 1-2 points Administrative measures: The entire eligible population is used in calculating performance (versus a systematic sample drawn from the eligible population for the hybrid measures). Denominators less than 20 at the county level are suppressed.

Year	Measure	County Performance		National Medicaid Benchmarks			
		Marin	Sonoma	10th	33.33rd	66.67th	90th
Prevention and Population							
Children and Adolescent Well-Care							
MY 2023	***CIS - Childhood Immunization Status (Combination 10)	28.13%	44.74%	20.68%	26.76%	35.04%	45.26%
MY 2024		35.14%	34.25%	18.25%	24.39%	31.32%	42.34%
MY 2023	***IMA - Immunizations for Adolescents (Combination 2)	64.29%	65.43%	24.82%	30.66%	38.93%	48.80%
MY 2024		57.14%	53.85%	25.41%	31.39%	38.69%	48.66%
MY 2023	WCC - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total	89.47%	77.50%	62.77%	74.70%	83.21%	89.72%
MY 2024		90.91%	69.49%	66.91%	76.89%	86.20%	91.24%
Women's Reproductive Health							
MY 2023	***PPC - Prenatal and Postpartum Care—Timeliness of Prenatal Care	88.89%	91.67%	25.86%	30.92%	41.41%	52.57%
MY 2024		100.00%	90.00%	73.48%	81.94%	86.89%	91.85%
MY 2023	***PPC - Prenatal and Postpartum Care—Postpartum Care	100.00%	88.89%	67.31%	75.18%	80.78%	84.59%
MY 2024		100.00%	96.67%	68.63%	77.37%	82.48%	86.62%
MY 2023	PRS-E - Prenatal Immunization Status - Combination Rate	57.21%	45.31%	7.94%	15.17%	25.81%	37.75%
MY 2024		46.87%	39.15%	8.42%	15.96%	24.92%	35.60%
Cancer Screening							
MY 2023	BCS-E- Breast Cancer Screening	58.02%	61.94%	42.98%	48.33%	54.94%	62.67%
MY 2024		63.44%	59.17%	42.86%	49.24%	56.66%	63.48%
MY 2023	CCS - Cervical Cancer Screening	75.00%	58.62%	43.50%	53.37%	59.85%	66.48%
MY 2024		71.43%	68.00%	43.31%	52.07%	60.10%	67.46%
MY 2023	COL- Colorectal Cancer Screening	NR	NR	NR	NR	NR	NR
MY 2024	COL-E - Colorectal Cancer Screening	34.44%	38.68%	27.27%	34.30%	41.59%	49.35%

Year	Measure	County Performance		National Medicaid Benchmarks			
		Marin	Sonoma	10th	33.33rd	66.67th	90th
Prevention and Population							
Other Preventive Services							
MY 2023	CHL - Chlamydia Screening in Women—Total	72.34%	54.05%	42.61%	51.39%	61.07%	67.39%
MY 2024		77.63%	51.89%	43.53%	52.40%	61.46%	69.07%
MY 2023	AIS-E-Adult Immunization Status—Influenza - Total	24.30%	23.75%	6.50%	10.82%	16.32%	21.05%
MY 2024		21.41%	18.25%	7.39%	12.55%	17.91%	26.40%
MY 2023	AIS-E-Adult Immunization Status—Pneumococcal - 66+	48.51%	44.70%	N/A	N/A	N/A	N/A
MY 2024		49.58%	40.21%	21.04%	38.73%	55.03%	68.07%
MY 2023	AIS-E-Adult Immunization Status—Td/Tdap - Total	41.23%	35.03%	18.67%	29.84%	41.54%	56.53%
MY 2024		40.27%	31.66%	21.26%	33.40%	47.30%	57.67%
MY 2023	AIS-E-Adult Immunization Status—Zoster - Total	22.92%	15.55%	1.72%	4.42%	10.27%	14.54%
MY 2024		27.44%	13.98%	2.23%	7.15%	13.49%	20.56%

Year	Measure	County Performance		National Medicaid Benchmarks			
		Marin	Sonoma	10th	33.33rd	66.67th	90th
Treatment							
Respiratory							
MY 2023	**AMR - Asthma Medication Ratio- Total**	65.65%	71.78%	55.09%	61.81%	69.41%	75.92%
MY 2024		61.27%	70.42%	54.56%	62.35%	70.56%	76.65%
MY 2023	CWP - Appropriate Testing for Pharyngitis—Total	77.41%	75.36%	57.41%	68.76%	77.56%	82.40%
MY 2024		80.68%	82.89%	61.35%	76.71%	85.11%	89.17%
MY 2023	**AAB - Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total	87.50%	79.66%	50.05%	57.16%	66.19%	77.11%
MY 2024		88.02%	77.33%	49.48%	50.98%	67.03%	77.66%
MY 2023	PCE - Pharmacotherapy Management of COPD Exacerbation - Systemic Corticosteroid	72.22%	75.00%	56.05%	68.39%	75.79%	82.43%
MY 2024		55.26%	71.52%	55.28%	66.86%	74.78%	82.88%
MY 2023	PCE - Pharmacotherapy Management of COPD Exacerbation - Bronchodilator	86.11%	91.88%	72.88%	82.35%	86.96%	90.53%
MY 2024		86.84%	87.42%	67.25%	80.19%	86.54%	89.96%

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		Diabetes					
MY 2023	EED - Eye Exams for Patients with Diabetes	50.00%	41.77%	36.74%	46.96%	56.20%	63.33%
MY 2024		63.16%	65.52%	40.39%	49.15%	57.09%	64.06%
MY 2023	BPD -Blood Pressure Control (<140/90) for Patients with Diabetes	66.67%	59.76%	52.07%	59.85%	68.61%	74.56%
MY 2024		89.47%	67.24%	58.15%	65.32%	71.78%	77.37%
MY 2023	HBD -Hemoglobin A1c Control for Patients with Diabetes-- HbA1c Control (<8%)	73.08%	49.37%	38.93%	49.39%	55.72%	60.34%
MY 2024	GSD -Glycemic Status Assessment for Patients with Diabetes-- HbA1c Control (<8%)	52.63%	44.83%	44.25%	54.50%	59.64%	63.50%
MY 2023	SPD - Statin Therapy for Patients With Diabetes—Received Statin Therapy	65.65%	65.80%	54.15%	62.58%	67.07%	72.15%
MY 2024		67.69%	68.61%	51.96%	62.66%	67.01%	71.41%
MY 2023	SPD - Statin Therapy for Patients With Diabetes—Statin Adherence 80%	95.35%	93.54%	52.67%	62.50%	70.37%	77.97%
MY 2024		69.25%	62.65%	53.23%	64.18%	70.91%	79.73%
MY 2023	KED - Kidney Health Evaluation for Patients with Diabetes	43.55%	44.30%	22.73%	29.42%	38.80%	47.55%
MY 2024		50.23%	47.24%	26.79%	33.00%	42.10%	49.72%

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Measurement Year 2024 - Reporting Year 2025

Year	Measure	County Performance		National Medicaid Benchmarks			
		Marin	Sonoma	10th	33.33rd	66.67th	90th
		Treatment					
		Heart Disease					
MY 2023	SPC - Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy—Total	87.74%	83.18%	70.02%	78.80%	81.64%	85.04%
MY 2024		89.01%	82.29%	66.64%	79.82%	83.00%	85.89%
MY 2023	SPC - Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%—Total	100.00%	93.38%	56.67%	66.48%	73.63%	80.95%
MY 2024		72.84%	70.46%	59.95%	67.42%	74.07%	81.79%
MY 2023	***CBP - Controlling High Blood Pressure	62.07%	71.64%	50.36%	57.66%	65.45%	72.22%
MY 2024		62.07%	62.67%	54.61%	61.43%	67.40%	72.75%
		Behavioral Health - Care Coordination					
MY 2023	**FUH[1] - Follow-Up After Hospitalization for Mental Illness-7 days**	11.11%	15.79%	23.74%	33.61%	46.35%	61.68%
MY 2024		NB	NB	23.74%	33.61%	46.35%	61.68%
MY 2023	**FUM - Follow-UP After Emergency Department Visit for Mental Illness 7 days total**	28.49%	26.91%	23.74%	33.61%	46.35%	61.68%
MY 2024		20.50%	16.83%	21.19%	33.01%	44.33%	59.95%
MY 2023	**FUA - Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence—7 days—Total**	22.95%	17.08%	13.83%	20.00%	27.73%	38.15%
MY 2024		21.33%	18.89%	12.73%	18.76%	27.62%	37.47%
MY 2023	FUI - Follow-Up After High-Intensity Care for Substance Use Disorder—7 days—Total	17.81%	13.57%	15.16%	23.12%	37.31%	49.55%
MY 2024		10.53%	22.86%	15.91%	26.90%	37.64%	50.80%

Partnership HealthPlan of California
Measurement Year 2024 - Reporting Year 2025

Year	Measure	County Performance		National Medicaid Benchmarks			
		Marin	Sonoma	10th	33.33rd	66.67th	90th
Treatment							
Behavioral Health - Medication Adherence							
MY 2023	AMM - Antidepressant Medication Management—Effective Continuation Phase Treatment	82.33%	80.13%	31.59%	40.01%	46.74%	58.06%
MY 2024		49.81%	45.43%	31.52%	41.00%	48.16%	61.06%
MY 2023	POD - Pharmacotherapy for Opioid Use Disorder—Total	47.22%	46.89%	14.94%	23.38%	31.93%	40.34%
MY 2024		5.19%	12.62%	12.05%	21.36%	29.01%	36.71%
MY 2023	SAA - Adherence to Antipsychotic Medications for Individuals With Schizophrenia	85.71%	73.57%	41.24%	57.79%	64.90%	72.61%
MY 2024		77.88%	68.80%	44.65%	58.60%	66.15%	74.83%
Behavioral Health - Access, Monitoring and Safety							
MY 2023	APM - Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	40.00%	41.84%	26.36%	31.97%	40.50%	53.58%
MY 2024		51.72%	35.29%	25.86%	30.92%	41.41%	52.57%
MY 2023	ADD -Follow-Up Care for Children Prescribed ADHD Medication—Continuation & Maintenance Phase	27.03%	33.74%	40.38%	50.98%	57.90%	63.92%
MY 2024		50.00%	31.82%	37.19%	48.94%	56.83%	63.49%
MY 2023	SSD - Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	79.34%	81.45%	72.83%	77.40%	80.86%	85.52%
MY 2024		78.61%	85.90%	75.46%	79.51%	83.51%	87.27%
MY 2023	APP - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total	22.73%	32.47%	36.65%	55.19%	63.89%	73.87%
MY 2024		77.78%	31.48%	41.57%	54.55%	64.10%	74.14%
MY 2023	IET - Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Engagement - Total	6.69%	7.17%	7.05%	11.11%	16.94%	24.37%
MY 2024		5.39%	8.69%	6.08%	10.51%	16.78%	26.72%

Risk-Adjusted Utilization							
MY 2023	PCR - Plan All-Cause Readmission - Observed to - Expected Ratio (18-64 years)	0.9021	0.9640	No Bench Marks Use For Scoring			
MY 2024		0.9704	0.8308				
Other Treatment Measures							
MY 2023	**LBP - Use of Imaging Studies for Low Back Pain	75.28%	78.80%	67.72%	71.32%	75.44%	79.96%
MY 2024		72.67%	77.55%	64.77%	67.84%	72.74%	78.72%

Note: PCR calculations are based on the scoring algorithm for risk-adjusted utilization measures as defined by NCQA.
NCQA calculates the Confidence Limits (CLs) for all health plans.

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

NB Not a Benefit - Auditor Approval required
NR Not Rated - Not included in the MY's measurement set
N/A No NCQA benchmark to apply in Measurement Year
* RDM and LDM are reporting only measures, full credit received for reporting.
** Inverted measures, a lower rate results in better performance
*** DHCS Withhold Measures
BOLD Indicates MCAS measures held to the MPL

5.0 HEDIS HealthPlan Accreditation (HPA) – Healthplan Rating Methodology

Health plans are rated in three categories: private/commercial plans in which people enroll through employers or on their own; plans that serve Medicare beneficiaries in the Medicare Advantage program (not supplemental plans); and plans that serve Medicaid beneficiaries.

NCQA ratings are based on three types of quality measures: 1) measures of clinical quality from NCQA's Healthcare Effectiveness Data and Information Set (HEDIS®) and Health Outcomes Survey (HOS); 2) measures of patient experience using the Consumer Assessment of Healthcare Providers and Systems (CAHPS®); and 3) results from NCQA's review of a health plan's health quality processes (NCQA Accreditation). NCQA rates health plans that choose to report measures publicly.

The overall rating is the weighted average of a plan's HEDIS, HOS and CAHPS measure ratings, plus Accreditation bonus points (if the plan is Accredited by NCQA), rounded to the nearest half point displayed as stars.

The overall rating is based on performance on dozens of measures of care and is calculated on a 0–5 scale in half points (5 is highest). Performance includes three subcategories:

1. **Patient Experience:** Patient-reported experience of care, including experience with doctors, services and customer service (measures in the Patient Experience category).

2. **Rates for Clinical Measures:** The proportion of eligible members who received preventive services (prevention measures) and the proportion of eligible members who received recommended care for certain conditions (treatment measures).

3. **NCQA Health Plan Accreditation:** For a plan with an Accredited or Provisional status, 0.5 bonus points are added to the overall rating before rounding to the nearest half point and displayed as stars.

6.0 HEDIS/CAHPS Measures Required for HP Accreditation—Medicaid

Measure Name		Display Name	Weight
PATIENT EXPERIENCE			
Getting Care			
Getting Needed Care (Usually + Always)		Getting care easily	1.5
Getting Care Quickly (Usually + Always)		Getting care quickly	1.5
Satisfaction With Plan Physicians			
Rating of Personal Doctor (9 + 10)		Rating of primary care doctor	1.5
Satisfaction With Plan and Plan Services			
Rating of Health Plan (9 + 10)		Rating of health plan	1.5
Rating of All Health Care (9 + 10)		Rating of care	1.5
PREVENTION AND POPULATION			
Children and Adolescent Well-Care			
CIS	Childhood Immunization Status—Combination 10	Childhood immunizations	3
IMA	Immunizations for Adolescents—Combination 2	Adolescent immunizations	3
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total	BMI percentile assessment	1
Women's Reproductive Health			
PPC	Prenatal and Postpartum Care—Timeliness of Prenatal Care	Prenatal checkups	1
	Prenatal and Postpartum Care—Postpartum Care	Postpartum care	1
PRS-E	Prenatal Immunization Status—Combination Rate	Prenatal immunizations	1
Cancer Screening			
BCS-E	Breast Cancer Screening	Breast cancer screening	1
COL-E	Colorectal Cancer Screening—Total *(NEW MEASURE)*	Colorectal cancer screening	1
CCS	Cervical Cancer Screening	Cervical cancer screening	1
Description of Membership			
RDM	Race/Ethnicity Diversity of Membership	Race and ethnicity of members	1
LDM	Language Diversity of Membership *(NEW MEASURE)*	Language preferences of members	0.5
Other Preventive Services			
CHL	Chlamydia Screening in Women—Total	Chlamydia screening	1
AIS-E	Adult Immunization Status—Influenza—Total	Influenza immunizations for adults	1
	Adult Immunization Status—Td/Tdap—Total	Td/Tdap immunizations for adults	1
	Adult Immunization Status—Zoster—Total	Zoster immunizations for adults	1
	Adult Immunization Status—Pneumococcal—66+	Pneumococcal immunizations for adults	1

TREATMENT			
Respiratory			
AMR	Asthma Medication Ratio—Total	Asthma control	1
CWP	Appropriate Testing for Pharyngitis—Total	Appropriate testing and care for a sore throat	1
AAB	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total	Appropriate antibiotic use for acute bronchitis/bronchiolitis	1
PCE	Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid	Steroid after hospitalization for acute COPD	1
	Pharmacotherapy Management of COPD Exacerbation—Bronchodilator	Bronchodilator after hospitalization for acute COPD	1
Diabetes			
BPD	Blood Pressure Control for Patients With Diabetes	Patients with diabetes—blood pressure control (140/90)	3
EED	Eye Exam for Patients With Diabetes	Patients with diabetes—eye exams	1
GSD	Glycemic Status Assessment for Patients With Diabetes—Glycemic Status (<8%) ***(NEW MEASURE)***	Patients with diabetes—glycemic status	3
SPD	Statin Therapy for Patients With Diabetes—Received Statin Therapy	Patients with diabetes—received statin therapy	1
	Statin Therapy for Patients With Diabetes—Statin Adherence 80%	Patients with diabetes—statin adherence 80%	1
KED	Kidney Health Evaluation for Patients With Diabetes—Total	Patients with diabetes—kidney health evaluation	1
Heart Disease			
SPC	Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy—Total	Patients with cardiovascular disease—received statin therapy	1
	Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%—Total	Patients with cardiovascular disease—statin adherence 80%	1
CBP	Controlling High Blood Pressure	Controlling high blood pressure	3

Measure Name		Display Name	Weight
Behavioral Health—Care Coordination			
FUM	Follow-Up After Emergency Department Visit for Mental Illness—7 days—Total	Follow-up after ED for mental illness	1
FUA	Follow-Up After Emergency Department Visit for Substance Use—7 days—Total	Follow-up after ED for substance use disorder	1
FUI	Follow-Up After High-Intensity Care for Substance Use Disorder—7 days—Total	Follow-up after high-intensity care for substance use disorder	1
Behavioral Health—Medication Adherence			
SAA	Adherence to Antipsychotic Medications for Individuals With Schizophrenia	Adherence to antipsychotic medications for individuals with schizophrenia	1
AMM	Antidepressant Medication Management—Effective Continuation Phase Treatment	Patients with a new episode of depression—medication adherence for 6 months	1
POD	Pharmacotherapy for Opioid Use Disorder—Total	Patients with opioid use disorder—medication adherence for 6 months	1
Behavioral Health—Access, Monitoring and Safety			
APM-E	Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total ***(NEW REPORTING METHOD)***	Cholesterol and blood sugar testing for youth on antipsychotic medications	1
ADD-E	Follow-Up Care for Children Prescribed ADHD Medication—Continuation & Maintenance Phase ***(NEW REPORTING METHOD)***	Continued follow-up after ADHD diagnosis	1
SSD	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	Diabetes screening for individuals with schizophrenia or bipolar disorder	1
APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total	First-line psychosocial care for youth on antipsychotic medications	1
IET	Initiation and Engagement of Substance Use Disorder Treatment—Engagement of SUD Treatment—Total	Substance use disorder treatment engagement	1
Risk-Adjusted Utilization			
PCR	Plan All-Cause Readmissions—Observed-to-Expected Ratio—18-64	Plan all-cause readmissions	1
Other Treatment Measures			
LBP	Use of Imaging Studies for Low Back Pain—Total	Appropriate use of imaging studies for low back pain	1

7.0 HEDIS/CAHPS MY2024 / RY2025 HPA Overall Star Rating Results: with Child CAHPS Survey Results (Projected)

On August 15, 2025, Partnership received NCQA's projected MY2024 HPA Star Rating of 3.0 Stars. This rating is calculated based on the MY2024 Child CAHPS® (regulated) survey results and plan-wide HEDIS rates per the NCQA Health Plan scoring methodology. Final scores will be published by NCQA in Fall of 2025. Because NCQA's scoring methodology uses rates that are proprietary to NCQA and will not be published until Fall 2025, Partnership's scoring calculations are not published in the MY2024 Annual Summary of Performance at this time.

As the MY2024 scoring summary below shows, Partnership's score was very close to a 3.5 Star Rating and missed the 3.5 Star Rating cut-point by 8/1000 of a point.

Rounding Rules	
0.000–0.249 → 0.0	2.750–3.249 → 3.0
0.250–0.749 → 0.5	3.250–3.749 →3.5
0.750–1.249 → 1.0	3.750–4.249 → 4.0
1.250–1.749 → 1.5	4.250–4.749 → 4.5
1.750–2.249 → 2.0	≥4.750 → 5.0
2.250–2.749 → 2.5	

Overall Rating Source	
Measure points	164.5
Overall Rating Not Rounded	2.741666667
Final Overall Rating +.5 Bonus	3.242
Final Score Rounded	3.0

7.1 Factors in MY2024 HPA Star Rating

Partnership's Star Rating declined from 3.5 Stars in MY2023 to 3.0 Stars in MY2024. The following factors were important drivers of Partnership's performance on the MY2024 HPA measures:

Improved Performance on CAHPS Surveys: Both the Child and Adult CAHPS survey scores

improved plan-wide between MY2023 and MY2024. Partnership saw significant improvements in year-over-year scores on the questions “Rating of Health Plan” and “Rating of Personal Doctor” on both surveys. This reflects Partnership’s sustained focus on improving the Partnership member experience in several key areas, including staff trainings to improve member benefits literacy; improvements in the transportation benefit; and digital platform enhancements such as the launch of a member texting platform. Partnership has also invested significant resources into a Healthcare Access Strategy and Tactical Plan, which includes provider recruitment and retention initiatives, network gap analyses, and telehealth integration strategies. All of these efforts combined led to survey results that show an improvement in reported member experience within the provider network.

Population Shifts within the Network: As described in Section 2, Partnership grew its membership by 36.7 percent in January, 2024, by adding ten additional counties to its network. Neither of the legacy Managed Care Plans departing these counties were NCQA Accredited Health Plans before 2024, so HPA HEDIS measures were less familiar and less prioritized for these incoming primary care providers. Additionally, incoming PCP’s were challenged by data completeness issues, which gave them limited historical data for multi-year measures. Incoming PCP’s also experienced significant member assignment mismatches at the beginning of 2024, which limited their ability to impact the members on their panels and impacted their HEDIS measure rates.

Approximately 82,000 Partnership members assigned to Kaiser also departed Partnership in January, 2024. These members have had high rates on the HPA HEDIS measures, and their departure impacted measure rates in Solano, Sonoma, Napa and Yolo Counties.

Finally, the disruption in Partnership’s contract with Dignity Health in early 2024 impacted members in Nevada, Shasta, Siskiyou, Tehama, and Yolo Counties. Though these 64,000 members were assigned to other PCP’s in their regions, the disruption in their primary care impacted many of the chronic condition and behavioral health management measures that make up the HPA measure set.

Resolution of Medi-Cal Rx Data Issues: In late 2024, Partnership identified and resolved several prescription duplication issues within the Medi-Cal Rx dataset, provided to Partnership by DHCS pharmacy benefit administrator Magellen. These issues had the effect of inflating the reported rates for several HPA measures centered on medication management during MY2022 and MY2023, including Antidepressant Medication Management—Effective Continuation Phase Treatment (AMM), Pharmacotherapy for Opioid Use Disorder (POD), Statin Therapy for Patients with Cardiovascular Disease – Adherence (SPC), and Statin Therapy for Patients with Diabetes – Adherence (SPD). The MY2024 measure rates reflects a more accurate Medi-Cal Rx prescription dataset, but also reflects a drop in reported rates between MY2023 – MY2024.

Annual Changes to NCQA HEDIS Benchmarks: Partnership uses the most recent NCQA published benchmarks available to project measure scores and calculate a Projected Star Rating. For

MY2024, the most recently published benchmarks available are the Quality Compass MY2023 Medicaid National Benchmarks. NCQA, however, uses the MY2024 rates they receive from Medicaid plans nationwide in June 2025 to produce a more recent set of benchmarks based on MY2024 rates, that they then use to calculate the MY2024 Star Ratings for Medicaid plans. For MY2024, Partnership saw several measure benchmarks increase significantly, which resulted in a lower Star Rating projection than Partnership calculated internally using the MY2023 benchmarks. The HPA measures with benchmarks that increased most significantly in MY2024 include:

- Immunizations for Adolescents - Combination 2 (IMA-2)
- Prenatal and Postpartum Care - Timeliness of Prenatal Care (PPC-Pre)
- Adult Immunization Status - Zoster (Total) (AIS-E)
- Eye Exam for Patients With Diabetes (EED)
- Controlling High Blood Pressure (CBP)
- Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SSA)
- Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (Total) (APM-E)
- Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

7.2 MY2024 HEDIS HealthPlan Accreditation (HPA) – HealthPlan Rating Score Child CAHPS - Change from Prior Year

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

Rounding Rules	
0.000–0.249 → 0.0	2.750–3.249 → 3.0
0.250–0.749 → 0.5	3.250–3.749 →3.5
0.750–1.249 → 1.0	3.750–4.249 → 4.0
1.250–1.749 → 1.5	4.250–4.749 → 4.5
1.750–2.249 → 2.0	≥4.750 → 5.0
2.250–2.749 → 2.5	

MY2024 Projected Star Rating w/Child CAHPS survey results (submitted for HPA):

Final Overall Rating +.5 Bonus	3.24166667

HEDIS HealthPlan Accreditation Star Rating Scoring MY2024 With Child CAHPS Survey Results	TOTAL Weight	TOTAL ACCRD Score MY2024	TOTAL Measure Score (Weight*Score)	Calculated Score (Not-Rounded)	Star Rating (Rounded) + 0.5 Bonus points overall
Overall Rating (CAHPS + Accreditation Measures)	60	135	164.5	2.741666667	3.0
Patient Experience	7.5	12	18	2.400	2.5
Prevention and Population	19.5	52	61.5	3.154	3.0
Treatment	33	71	85	2.576	2.5

MY2023 Star Rating w/Child CAHPS survey results (not submitted for HPA):

Final Overall Rating +.5 Bonus	3.752101

HEDIS HealthPlan Accreditation Star Rating Scoring MY2023 With Child CAHPS Survey Results	TOTAL Weight	TOTAL ACCRD Score MY2022	TOTAL ACCRD Score MY2023	TOTAL Measure Score (Weight*Score)	Calculated Score (Not-Rounded)	Star Rating (Rounded) + 0.5 Bonus points
Overall Rating (CAHPS + Accreditation Measures)	59.5	153	155	193.5	3.252101	4.0
Child CAHPS Rating	7.5	12	9	13.5		
Patient Experience	7.5	12	9	13.5	1.800	2
Prevention and Equity	18	39	52	66	3.667	3.5
Treatment	34	102	94	114	3.353	3.5

7.3 MY2024 HEDIS HealthPlan Accreditation (HPA) – HealthPlan Rating Score Adults CAHPS - Change from Prior Year

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

Rounding Rules	
0.000–0.249 → 0.0	2.750–3.249 → 3.0
0.250–0.749 → 0.5	3.250–3.749 →3.5
0.750–1.249 → 1.0	3.750–4.249 → 4.0
1.250–1.749 → 1.5	4.250–4.749 → 4.5
1.750–2.249 → 2.0	≥4.750 → 5.0
2.250–2.749 → 2.5	

MY2024 Projected Star Rating w/Adult CAHPS survey results (not submitted for HPA):

Final Overall Rating +.5 Bonus	3.19166667

HEDIS HealthPlan Accreditation Star Rating Scoring MY2024 With Adult CAHPS Survey Results	MY 2024 Final Rate	TOTAL Weight	TOTAL ACCRD Score MY2024	TOTAL Measure Score (Weight*Score)	Calculated Score (Not-Rounded)	Star Rating (Rounded) + 0.5 Bonus points
Overall Rating (CAHPS + Accreditation Measures)		60	133	161.5	2.691666667	3.0
Patient Experience		7.5	10	15	2.000	2.0
Prevention and Population		19.5	52	61.5	3.154	3.0
Treatment		33	71	85	2.576	2.5

MY2023 Final Health Plan Rating w/Adult CAHPS survey results (submitted for HPA):

Final Overall Rating +.5 Bonus	3.62605042

HEDIS HealthPlan Accreditation Star Rating Scoring MY2023 With Adult CAHPS Survey Results	TOTAL Weight	TOTAL ACCRD Score MY2023	TOTAL Measure Score (Weight*Score)	Calculated Score (Not-Rounded)	Star Rating (Rounded) + 0.5 Bonus points
Overall Rating (CAHPS + Accreditation Measures)	59.5	148	186	3.12605042	3.5
Patient Experience	7.5	8	12	1.600	1.5
Prevention and Equity	18	50	64	3.556	3.5
Treatment	34	90	110	3.235	3.5

8.0 MY2024 HEDIS HealthPlan Accreditation (HPA) – Measurement Set Descriptions

HEDIS Measure	Measure Indicator	Measure Definition
Antidepressant Medication Management (AMM)	• Continuation Phase Treatment • Acute Phase Treatment	• The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment. ○ Effective Acute Phase Treatment. The percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks). ○ Effective Continuation Phase Treatment. The percentage of members who remained on an antidepressant medication for at least 180 days (6 months).
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)	• Total	• The percentage of episodes for members ages 3 months and older with a diagnosis of acute bronchitis/ bronchiolitis that did not result in an antibiotic dispensing event. ***Note**: This measure is reported as an inverted rate [1–(numerator/eligible population)]. A higher rate indicates appropriate acute bronchitis/bronchiolitis treatment (i.e., the proportion for episodes that did not result in an antibiotic dispensing event).*
Adult Immunization Status (AIS-E)	• Influenza immunizations for adults • Td/Tdap immunizations for adults • Zoster immunizations for adults • Pneumococcal immunizations for adults	• The percentage of members 19 years of age and older who are up to date on recommended routine vaccines for influenza, tetanus and diphtheria (Td) or tetanus, diphtheria and acellular pertussis (Tdap), zoster and pneumococcal.

HEDIS Measure	Measure Indicator	Measure Definition
Follow-Up Care for Children Prescribed ADHD Medication—Continuation & Maintenance Phase (ADD-E)	• Initiation Phase • Continuation and Maintenance (C&M) Phase	• The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported. ○ Initiation Phase. The percentage of members 6–12 years of age with a prescription dispensed for ADHD medication, who had one follow-up visit with a practitioner with prescribing authority during the 30-day Initiation Phase. ○ Continuation and Maintenance (C&M) Phase. The percentage of members 6–12 years of age with a prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.
Asthma Medication Ratio (AMR)	• 5–64 years • Total	• The percentage of members 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total (APP)	• Total	• The percentage of children and adolescents 1–17 years of age who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment.
Breast Cancer Screening (BCS-E)	• Total	• The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.

HEDIS Measure	Measure Indicator	Measure Definition
Cervical Cancer Screening (CCS)	• Total	• The percentage of women 21–64 years of age who were screened for cervical cancer using either of the following criteria: ○ Women 21–64 years of age who had cervical cytology performed within the last 3 years ○ Women 30–64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years ○ Women 30–64 years of age who had cervical cytology/high-risk human papillomavirus (hrHPV) cotesting within the last 5 years
Childhood Immunization Status (CIS)	• Combination 10	• The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates. ○ Combination 10. Children who have had all ten indicators (DTaP, IPV, MMR, HiB, HepB, VZV, PCV, HepA, RV and Influenza).
Chlamydia Screening in Women (CHL)	• Total	• The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.
Colorectal Cancer Screening (COL-E)	• Total	• The percentage of members 45–75 years of age who had appropriate screening for colorectal cancer.
Controlling High Blood Pressure (CBP)	• Total	• The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90 mm Hg) during the measurement year.

HEDIS Measure	Measure Indicator	Measure Definition
Appropriate Testing for Pharyngitis(CWP)	• Total	• The percentage of episodes for members 3 years and older where the member was diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode.
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	• Diabetes Screening	• The percentage of members 18–64 years of age with schizophrenia, schizoaffective disorder or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	• 7 days • Total	• The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness. ○ The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse Dependence (FUA)	• 7 days • Total	• The percentage of emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD. ○ The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)	• 7 days • Total	• The percentage of acute inpatient hospitalizations, residential treatment or detoxification visits for a diagnosis of substance use disorder among members 13 years of age and older that result in a follow-up visit or service for substance use disorder. ○ The percentage of visits or discharges for which the member received follow-up for substance use disorder within the 7 days after the visit or discharge.

HEDIS Measure	Measure Indicator	Measure Definition
Blood Pressure Control (<140/90) for Patients With Diabetes (BPD)	• Total	• The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement year.
Glycemic Status Assessment for Patients With Diabetes (GSD)	• HbA1c Control (<8%)	• The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose hemoglobin A1c (HbA1c) was at the following levels during the measurement year: ○ HbA1c Control (<8%) ○ HbA1c poor control (>9.0%). ***Note:*** *Organizations must use the same data collection method (Administrative or Hybrid) to report these indicators.*
Eye Exam for Patients With Diabetes (EED)	• Eye Exam for Patients With Diabetes	• The percentage of members 18–75 years of age with diabetes (types 1 and 2) who had a retinal eye exam.
Kidney Health Evaluation for Patients with Diabetes (KED)	• Kidney Health Evaluation for Patients With Diabetes—Total	• The percentage of members 18–85 years of age with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR), during the measurement year.

HEDIS Measure	Measure Indicator	Measure Definition
Initiation and Engagement of Substance Use Disorder Treatment—(IET)	• Engagement of SUD Treatment • Total	• The percentage of new substance use disorder (SUD) episodes that result in treatment initiation and engagement. Two rates are reported: ○ Initiation of SUD Treatment. The percentage of new SUD episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth visits or medication treatment within 14 days. ○ Engagement of SUD Treatment. The percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation.
Use of Imaging Studies for Low Back Pain (LBP)	• Imaging for Low Back Pain	• The percentage of members with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis. ○ The measure is reported as an inverted rate [1–(numerator/eligible population)]. A higher score indicates appropriate treatment of low back pain (i.e., the proportion for whom imaging studies did not occur).
Immunizations for Adolescents (IMA)	• Combination 2	• The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. The measure calculates a rate for each vaccine and two combination rates. ○ Combination 2. Adolescents who have had all three indicators (meningococcal, Tdap and HPV).
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E)	• Total	• The percentage of children and adolescents 1–17 years of age who had two or more antipsychotic prescriptions and had metabolic testing. Three rates are reported, the percentage of children and adolescents on antipsychotics who received blood glucose testing, cholesterol testing, and both blood glucose and cholesterol testing. ○ Total. The sum of the age stratifications (1-17) as of December 31 of the measurement year.

HEDIS Measure	Measure Indicator	Measure Definition
Prenatal and Postpartum Care (PPC)	• Timeliness of Prenatal Care • Postpartum Care	• The percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care. ○ Timeliness of Prenatal Care. The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization. ○ Postpartum Care. The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.
Prenatal Immunization Status (PRS-E)	• Combination Rate	• The percentage of deliveries in the Measurement Period in which women had received influenza and tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccinations.
Pharmacotherapy Management of COPD Exacerbation (PCE)	• Systemic Corticosteroid • Bronchodilator	• The percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED visit on or between January 1–November 30 of the measurement year and who were dispensed appropriate medications. Two rates are reported: 1. Dispensed a systemic corticosteroid (or there was evidence of an active prescription) within 14 days of the event. 2. Dispensed a bronchodilator (or there was evidence of an active prescription) within 30 days of the event. ○ ***Note:*** *The eligible population for this measure is based on acute inpatient discharges and ED visits, not on members. It is possible for the denominator to include multiple events for the same individual.*
Pharmacotherapy for Opioid Use Disorder (POD)	• Total	• The percentage of new opioid use disorder (OUD) pharmacotherapy events with OUD pharmacotherapy for 180 or more days among members age 16 and older with a diagnosis of OUD. ○ A 12-month period that begins on July 1 of the year prior to the measurement year and ends on June 30 of the measurement year.

HEDIS Measure	Measure Indicator	Measure Definition
Plan All-Cause Readmissions— (PCR)	• Observed-to-Expected Ratio • 18-64 years • Total	• For members 18 years of age and older, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. ***Note**: For commercial and Medicaid, report only members 18–64 years of age.*
Race/Ethnicity Diversity of Membership- (RDM)	• Race/Ethnicity Direct	• An unduplicated count and percentage of members enrolled any time during the measurement year, by race and ethnicity.
Language Diversity of Membership (LDM)	• Spoken Language Preferred • Preferred Language for Written Materials	• An unduplicated count and percentage of members enrolled at any time during the measurement year by spoken language preferred for health care and preferred language for written materials.
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)	• Non-Medicare 80% Coverage	• The percentage of members 18 years of age and older during the measurement year with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.
Statin Therapy for Patients With Cardiovascular Disease (SPC)	• Total. • Statin Therapy • Statin Adherence 80%	• The percentage of males 21–75 years of age and females 40–75 years of age during the measurement year, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria. The following rates are reported: ○ Received Statin Therapy. Members who were dispensed at least one high-intensity or moderate-intensity statin medication during the measurement year. ○ Statin Adherence 80%. Members who remained on a high-intensity or moderate-intensity statin medication for at least 80% of the treatment period.

HEDIS Measure	Measure Indicator	Measure Definition
Statin Therapy Statin Therapy for Patients With Diabetes (SPD)	• Received Statin Therapy • Statin Adherence 80%	• The percentage of members 40–75 years of age during the measurement year with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) who met the following criteria. Two rates are reported: ○ Received Statin Therapy. Members who were dispensed at least one statin medication of any intensity during the measurement year. ○ Statin Adherence 80%. Members who remained on a statin medication of any intensity for at least 80% of the treatment period.
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)	• BMI Percentile Documentation	• The percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following during the measurement year. ○ BMI Percentile Documentation. Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value.

2024-25 Quality Improvement Work Plan											Deliverable Complete On Track Delayed Terminated
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**	**Goal Met (Yes No)**	
1. QI Program Infrastructure											
1.a.	QI Program Documents	Continued	**Goal #1:** By July 2025, complete draft QI Program Description, QI Work Plan and QI Evaluation revisions in preparation for August Quality Committee meetings.	**Deliverable #1:** Finalize 2025 - 2026 QI Program Description.	10/1/2024	7/30/2025	Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Project Manager I Name: Francesca Bautista	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
1.a.				**Deliverable #2:** Finalize 2024 - 2025 QI Work Plan.	10/1/2024	7/30/2025	Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Project Manager I Name: Francesca Bautista	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
1.a.				**Deliverable #3:** Finalize 2024 - 2025 QI Evaluation.	10/1/2024	7/30/2025	Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Project Manager I Name: Francesca Bautista	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
1.a.				**Deliverable #4:** 2025 - 2026 QI Work Plan – Complete Draft.	5/1/2025	7/30/2025	Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Project Manager I Name: Francesca Bautista	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
1.b.	Physician Advisory Committee (PAC) Oversight of QI Program	Continued	**Goal #1:** By June 30, 2025, Ensure PAC oversight of Partnership's QI Program through semi-annual monitoring of the QI Work Plan.	**Deliverable #1:** By September 30, 2024, QI Trilogy Documents to be reviewed for approval by PAC in September 2024, post-review of other Quality committees to include but not limited to: * FY 2024-25 - Work Plan * FY 2024-25 - Program Descriptions * FY 2023-24 - QI Program Evaluation	9/11/2024	9/30/2024	Title: Chief Medical Officer Name: Robert Moore	Title: Executive Assistant Name: Sarah Browning	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
2. Measurement, Analytics and Reporting											
2.a.	HEDIS® Reporting	Continued	**Goal #1:** By June 30, 2025, report HEDIS® MY2024 final rate performance as required annually for NCQA Health Plan Accreditation (HPA) and the DHCS Managed Care Accountability Set (MCAS).	**Deliverable #1:** • Monthly Project Work Plan updated by 09/30/2024 to accommodate HPA and MCAS unique activities/deliverables. • Annual Project Work Plans updated by 10/31/2024 to accommodate HPA and MCAS unique activities/deliverables.	9/1/2024	10/31/2024	Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen Title: Director of Quality Measurement Name: Kristine Gual	Title: Manager of Quality Measurement Name: Sue Quichocho	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
2.a.				**Deliverable #2:** By October 31, 2024, build HEDIS® MY2024 Monthly Project which includes all populations for DHCS, HPA and Dual Eligible Special Needs Plan (D-SNP). (Contingent on HRP production implementation in 2024)	9/1/2024	10/31/2024	Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen Title: Director of Quality Measurement Name: Kristine Gual	Title: Manager of Quality Measurement Name: Sue Quichocho	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
2.a.				**Deliverable #3:** • By February 1, 2025 build production environments for the Annual project and collect, prepare and integrate administrative data, inclusive of new Electronic Clinical Data Systems (ECDS) data sources. • By May 31, 2025, conclude the HEDIS® Annual Medical Record projects for MCAS and HPA required reporting in support of the HEDIS® MY2023 Annual Project. • By June 30, 2025, report HEDIS® MY2024 final rate performance as required annually for NCQA Health Plan Accreditation (HPA) and the DHCS Managed Care Accountability Set (MCAS).	1/1/2025	6/30/2025	Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen Title: Director of Quality Measurement Name: Kristine Gual	Title: Manager of Quality Measurement Name: Sue Quichocho	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
2.b.	Member Experience Data	Continued	**Goal #1:** By June 30, 2025, gather, analyze and highlight areas of opportunity for the plan using the CAHPS® survey and Grievances & Appeals (G&A) data as it relates to NCQA requirements.	**Deliverable #1:** By December 30, 2024, present measure year (MY) 2023 CAHPS® and Member Experience results to internal and external committees.	7/1/2024	12/30/2024	Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen Title: Director of Quality Management Name: Isaac Brown	Title: Program Manager II Name: Anthony Sackett	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
2.b.				**Deliverable #2:** By June 30, 2025, continue the fiscal/quarterly year process to collect and analyze G&A data. Ensure stakeholders at a minimum meet quarterly or as needed to review data compared to prior and current year CAHPS® survey results.	7/1/2024	6/30/2025	Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen Title: Director of Quality Management Name: Isaac Brown	Title: Program Manager II Name: Anthony Sackett	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
2.b.				**Deliverable #3:** By June 30, 2025, collect and analyze CAHPS®-regulated measure year (MY) 2024 survey results, 2024 G&A annual filings, and other data sources (inclusive of Adult Drill Down survey dependent upon execution date).	7/1/2024	6/30/2025	Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Program Manager II Name: Anthony Sackett	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
2.b.		New	**Goal #2**: By June 30, 2025, Org. Goal # 4 Access & Member Experience (Milestone 3), Member Experience (ME) Workgroup will drive CAHPS® Score Improvement (CSI) fiscal year 2023-2024 pilot from analysis phase to Strike-Team "action" phase. The enhanced ME improvement strategy is continuous, with the intent to leverage quarterly data (G&A, PHM) sources to drive proactive interventions throughout fiscal year 2024-2025. Outcome(s)/Deliverable(s): • Workgroup will adhere to Quality Improvement Model: Plan, Do, Study, and Act (PDSA) • Collaborate with subject matter experts to review prior fiscal year quarter interventions against new quarter datasets • Analyze new quarterly data sets (G&A, PHM) against pilot ME abrasion thresholds* o Access o Attitude and Service o Billing and Financial o Quality of Care o Quality of Practitioner Office Site	**Deliverable #1:** By August 31, 2024 - Analyze 2024 Q2 Quarterly G & A Pulse Report data against established member experience abrasion thresholds that target at least three areas intended to improve service delivery and member experience. The action includes and is not limited to root-cause analysis, and operational research/investigation to determine Plan or provider gaps. Action to influence experience or service improvement requires cross-department resources dedicated to this pilot. Department Leadership in the FY 23-24 pilot continuation is essential to drive improvement.	7/1/2024	8/31/2024	Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Program Manager II Name: Anthony Sackett	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**
2.b.				**Deliverable #2:** By November 30, 2024 - Analyze 2024 Q3 Quarterly G & A Report data against established member experience abrasion thresholds that target at least three areas intended to improve service delivery and member experience. The action includes and is not limited to root-cause analysis, and operational research/investigation to determine Plan or provider gaps. Action to influence experience or service improvement requires cross-department resources dedicated to this pilot. Department Leadership in the FY 23-24 pilot continuation is essential to drive improvement.	8/1/2024	11/30/2024	Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Program Manager II Name: Anthony Sackett	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
2.b.				**Deliverable #3:** By January 31, 2025 - Analyze 2024 Q4 Quarterly G & A Pulse Report data against established member experience abrasion thresholds that target at least three areas intended to improve service delivery and member experience. The action includes and is not limited to root-cause analysis, and operational research/investigation to determine Plan or provider gaps. Action to influence experience or service improvement requires cross-department resources dedicated to this pilot. Department Leadership in the FY 23-24 pilot continuation is essential to drive improvement.	11/1/2024	1/31/2024	Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Program Manager II Name: Anthony Sackett	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☒ Terminated	**Yes**
2.b.				**Deliverable #4:** By May 30, 2025 - Analyze 2025 Q1 Quarterly G & A Pulse Report data against established member experience abrasion thresholds that target at least three areas intended to improve service delivery and member experience. The action includes and is not limited to root-cause analysis, and operational research/investigation to determine Plan or provider gaps. Action to influence experience or service improvement requires cross-department resources dedicated to this pilot. Department Leadership in the FY 23-24 pilot continuation is essential to drive improvement.	2/3/2025	5/30/2024	Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Program Manager II Name: Anthony Sackett	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☒ Terminated	
2.b.				**Deliverable #5:** By June 30, 2025 - Evaluate pilot strike-team quarterly outcomes and effectiveness. Use evaluation to inform and propose recommendations.	4/1/2025	6/30/2025	Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Program Manager II Name: Anthony Sackett	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	
2.c.	Member Services Access	Continued	**Goal #1:** By June 30, 2025, ensure compliance of internal and delegated access standards as it relates to inbound call handling.	**Deliverable #1:** Monitor, Analyze and Recommend Corrective Action Plan(s) (CAP) when appropriate which includes: • Review internal call center performance stats monthly (performance benchmarks tracked quarterly) on several service level agreements (SLAs) • Plan to continue to track quarterly delegate call center performance (submitted quarterly by each respective delegate) against established performance thresholds (based on SLAs above) during Delegate Oversight quarterly meetings	7/1/2024	6/30/2025	Title: Senior Director of Member Services and Grievances Name: Edna Villasenor	Title: Associate Director of Member Services Name: Cyress Mendiola	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**

2024-25 Quality Improvement Work Plan												Deliverable Complete On Track Delayed Terminated
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**	
2.d.	Primary Care Provider Quality Inceptive Program (PCP QIP) Payment Processing Report	New	**Goal #1:** By June 30, 2025, PCP QIP will continue to refine the Data Validation Framework documents which includes identifying areas for improvement in efficiency and accuracy, ensuring that the updated documents provide clear guidance on each step of the payment process, strengthening the validation processes to enhance the accuracy of payment calculations, establishing clear timelines for each stage of the payment process and continuing to monitor the effectiveness of the refined process and make adjustments as needed going forward.	**Deliverable #1:** Evaluate Data Validation Framework documents and examine the validation procedures outlined in the documents to ensure they are robust and effective in verifying payment accuracy.	7/1/2024	12/31/2024	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager I Name: Amber Newell Title: Program Manager II Name: Athena Beltran Namprasuet Title: Program Manager I Name: Eva Lopez	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**	
2.d.				**Deliverable #2:** Engage in collaboration with a sister plan to Partnership (Alameda Alliance) to understand their payment processing methods and to possibly integrate best practices into our own payment process.	7/1/2024	12/31/2024	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager I Name: Amber Newell Title: Program Manager II Name: Athena Beltran Namprasuet Title: Program Manager I Name: Eva Lopez	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated		
2.d.				**Deliverable #3:** Maintain ongoing collaboration with contributing teams and executive leadership to enhance payment processes to ensure future payment accuracy.	7/1/2024	5/31/2024	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager I Name: Amber Newell Title: Program Manager II Name: Athena Beltran Namprasuet Title: Program Manager I Name: Eva Lopez	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated		
2.e.	Web Based Member Information Assessment	Continued	**Goal #1:** By June 30, 2025, complete annual evaluation of the quality and accuracy of information provided to members via e-mail and telephone as stated in NCQA Standard ME 6 Element C: Quality and Accuracy of Information.	**Deliverable #1:** Complete annual evaluation of the quality and accuracy of information provided to members via e-mail and telephone as stated in ME 6 C: Quality and Accuracy of Information.	7/1/2024	6/30/2025	Title: Senior Director of Member Services and Grievances Name: Edna Villasenor Title: Associate Director of Member Services Name: Cyress Mendiola	Title: Supervisor of Quality and Training, Member Services Name: Kristen Clark	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**	
2.f.	Primary Care Provider Quality Incentive Program (PCP QIP) eReports System	Continued *(Monitoring of previous issue)*	**Goal #1:** By June 30, 2025, PCP QIP will continue collaborating with the Partnership Web Team to align 2025 eReports with HRP® (Health Rules Payor) data elements in preparation for the launch of HRP®.	**Deliverable #1:** Review 2025 eReports scoping and development with Web Team to identify any remaining areas within eReports needing integration with HRP®. Finalize via annual Business Requirement Documents (BRD) approved by QI and IT management.	7/1/2024	11/1/2024	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager I Name: Amber Newell Title: Program Manager II Name: Athena Beltran Namprasuet Title: Program Manager I Name: Eva Lopez	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**	
2.f.				**Deliverable #2:** Complete User Acceptance Testing (UAT), inclusive of HRP® integration testing, per approved 2025 eReports BRD, for on-time release to provider network.	11/1/2024	3/1/2025	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager I Name: Amber Newell Title: Program Manager II Name: Athena Beltran Namprasuet Title: Program Manager I Name: Eva Lopez	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated		
2.f.				**Deliverable #3:** Conduct weekly eReports check-in meetings with the Partnership Web Team to discuss project timeline, BRD revisions, application logic, UAT testing timelines, progress and bugs.	10/1/2024	3/15/2025	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager I Name: Amber Newell Title: Program Manager II Name: Athena Beltran Namprasuet Title: Program Manager I Name: Eva Lopez	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated		
2.g.	Partnership Quality Dashboard (PQD)	Continued	**Goal #1:** Goal #1: By June 30, 2025, apply annual development updates of the MY2025 HEDIS® Monthly Exploratory Dashboard in accordance with identified stakeholder needs (Contingent on HRP® implementation).	**Deliverable #1:** Complete development of PQD of HEDIS® MY2024 Monthly Exploratory dashboard (Contingent on HRP® production implementation) **Complete project status denotes completion of previous year's PQD Work Plan Goal	10/1/2024	11/29/2024	Title: Director of Quality Management Name: Kristine Gual Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Title: Manager of Quality Measurement Name: Sue Quichocho	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**No**	
2.g.				**Deliverable #2:** Complete an annual HEDIS® Monthly data user needs assessment for MY2025 Monthly Exploratory dashboard in PQD. In collaboration with the HEDIS® team and QMSI workgroup's leads and through use of the updated Master Measure List to confirm applicable measures..	7/1/2024	3/30/2025	Title: Director of Quality Management Name: Kristine Gual Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Title: Manager of Quality Measurement Name: Sue Quichocho	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated		
2.g.				**Deliverable #3:** Complete updated HEDIS® Monthly Exploratory business requirements documentation for MY2025 Monthly Exploratory dashboard in PQD in collaboration with the HEDIS® team.	7/1/2024	3/30/2025	Title: Director of Quality Management Name: Kristine Gual Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Title: Manager of Quality Measurement Name: Sue Quichocho	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated		
2.g.				**Deliverable #4:** Timely publication of the MY2025 HEDIS® Monthly Exploratory dashboard (Contingent on HRP® production implementation).	4/1/2025	6/30/2025	Title: Director of Quality Management Name: Kristine Gual Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Title: Manager of Quality Measurement Name: Sue Quichocho	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☒ Delayed ☐ Terminated		
2.g.	Partnership Quality Dashboard (PQD)	Continued *(Monitoring of previous issue)*	**Goal #2:** By June 30, 2025, apply annual development updates of the PCP QIP Provider and Internal View Dashboards in accordance with identified stakeholder needs.	**Deliverable #1:** Work with representatives of the provider network to review all enhancement requests to be included in the Business Requirements Document (BRD) to be reviewed and approved by the Enterprise Data Warehouse (EDW) team for the new measurement year (MY).	7/1/2024	12/31/2024	Title: Director of Quality Management Name: Isaac Brown Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Title: Manager of Quality Incentive Programs Name: Amy McCune	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**No**	
2.g.				**Deliverable #2:** Work with stakeholders to submit updated annual dashboard business requirements document (BRD) to developers for review and approval.	7/1/2024	2/29/2024	Title: Director of Quality Management Name: Isaac Brown Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Title: Manager of Quality Incentive Programs Name: Amy McCune	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated		
2.g.				**Deliverable #3:** Work with developers and business owners to finalize which proposed new business requirements/enhancements will be deemed in scope for dashboard updates in 2025. Escalate to QI and IT senior leadership if consensus cannot be reached to finalize prioritization	2/1/2025	3/31/2025	Title: Director of Quality Management Name: Isaac Brown Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Title: Manager of Quality Incentive Programs Name: Amy McCune	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated		
2.g.				**Deliverable #4:** Completion of user acceptance testing (UAT) of dashboards	4/1/2025	6/30/2025	Title: Director of Quality Management Name: Isaac Brown Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Title: Manager of Quality Incentive Programs Name: Amy McCune	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☒ Delayed ☐ Terminated		

2024-25 Quality Improvement Work Plan												Deliverable Complete On Track Delayed Terminated
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**	
2.g.				**Deliverable #5:** Timely publication of the dashboards in PQD for internal and external use.	1/1/2025	6/30/2025	Title: Director of Quality Management Name: Isaac Brown Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Title: Manager of Quality Incentive Programs Name: Amy McCune	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☒ Delayed ☐ Terminated		
2.h.	Enterprise Information Management	Continue *(Monitoring of previous issue)*	**Goal #1:** By December 31, 2024, integrate the HRP® version of the HEDIS® monthly project data into the Enterprise Data Warehouse and use this data to create the HRP® version of the HEDIS® PQD modules.	**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.	9/1/2024	10/15/2024	Title: Director of Enterprise Information Management Name: Thenn Subramanian	Title: Director of Data Warehouse Name: Arun Saligame	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**No**	
2.h.				**Deliverable #2:** Develop the HEDIS® PQD dashboards using the HRP® data and complete UAT.	10/15/2024	11/30/2024	Title: Director of Enterprise Information Management Name: Thenn Subramanian	Title: Director of Data Warehouse Name: Arun Saligame	**July 1 - Dec 31** ☐ Complete ☐ On Track ☒ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☒ Delayed ☐ Terminated		
2.h.		New	**Goal #2:** By December 31, 2024, develop, test, and have the 2024 HEDIS® monthly project live in production with the data available to users via the HEDIS® PQD modules.	**Deliverable #1:** Complete development and testing to deliver 2024 HEDIS® monthly files to the Quality Improvement (QI) Team. This might require building new medi-medi population and catalogs on the Inovalon side.	7/1/2024	9/15/2024	Title: Director of Enterprise Information Management Name: Thenn Subramanian	Title: Director of Data Warehouse Name: Arun Saligame	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**	
2.h.				**Deliverable #2:** Integrate 2024 HEDIS® data from monthly project into the Enterprise Data Warehouse.	9/15/2024	10/1/2024	Title: Director of Enterprise Information Management Name: Thenn Subramanian	Title: Director of Data Warehouse Name: Arun Saligame	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated		
2.h.				**Deliverable #3:** Develop and test PQD HEDIS® dashboards using the 2024 HEDIS® monthly project data and support D-SNP processes.	10/1/2024	10/31/2024	Title: Director of Enterprise Information Management Name: Thenn Subramanian	Title: Director of Data Warehouse Name: Arun Saligame	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated		
2.h.		Continue *(Monitoring of previous issue)*	**Goal #3:** By December 31, 2024, integrate Electronic Clinical Data Systems data (behavioral health, depression screening, various clinical measures) from Data Link and Sutter into the Enterprise Data Warehouse environments, and use as a source for various QI programs and processes.	**Deliverable #1:** Establish a connection to receive clinical data from Data Link.	7/1/2024	7/30/2024	Title: Director of Enterprise Information Management Name: Thenn Subramanian	Title: Director of Data Warehouse Name: Arun Saligame	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**	
2.h.				**Deliverable #2:** Integrate clinical data from Data Link into the Enterprise Data Warehouse environments and integrate the data to HEDIS® Monthly project and various QI processes.	8/30/2024	11/15/2024	Title: Director of Enterprise Information Management Name: Thenn Subramanian	Title: Director of Data Warehouse Name: Arun Saligame	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated		
2.h.				**Deliverable #3:** Incorporate clinical data from Sutter into the HEDIS® program and various QI processes.	8/15/2024	9/30/2024	Title: Director of Enterprise Information Management Name: Thenn Subramanian	Title: Director of Data Warehouse Name: Arun Saligame	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated		
2.i.	Dual Eligible Special Needs Plan (D-SNP)	New	**Goal #1**: By June 30, 2025, develop systems to manage data sourcing, analysis and stakeholder communication for the proposed D-SNP population and associated CMS Part C&D and DHCS measure sets.	**Deliverable #1:** By December 31, 2024, develop an interdepartmental D-SNP Stars Strategy Work Group to manage and assess data needs pertaining to the Medicare D-SNP product line and reportable measures.	7/1/2024	12/31/2024	Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Title: Senior Medicare QI Program Manager Name: Kimberly Robertello	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**	
2.i.				**Deliverable #2:** By February 1, 2025, complete Chapter 4 of the Model of Care document for submission to DHCS	7/1/2024	2/1/2025	Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Title: Senior Medicare QI Program Manager Name: Kimberly Robertello	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated		
2.i.				**Deliverable #3:** By June 30, 2025, develop the process for integration of MOC-related goals and re-evaluation into the QI Trilogy.	7/1/2024	6/30/2025	Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Title: Senior Medicare QI Program Manager Name: Kimberly Robertello	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated		
2.i.				**Deliverable #4:**By June 30, 2025, develop communication strategies through appropriate committee structure to inform stakeholders of D-SNP goals and progress with defined ongoing communication frequency.	7/1/2024	6/30/2025	Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Title: Senior Medicare QI Program Manager Name: Kimberly Robertello	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated		
2.j.	D-SNP HEDIS Reporting	New	**Goal #1:** By June 30, 2025, Develop systems and processes for analysis of Stars and DHCS HEDIS® data for proposed D-SNP population of focus.	**Deliverable #1:** By 10/31/2024, Create Monthly Project Work Plan to accommodate D-SNP unique activities/deliverables.	8/1/2024	10/31/2024	Title: Director of Quality Measurement Name: Kristine Gual Title: Senior Medicare QI Program Manager Name: Kimberly Robertello Title: Senior Director of Quality and Performance Improvement	Title: Manager of Quality Measurement Name: Sue Quichocho	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**	
2.j.				**Deliverable #2:** By 10/31/2024, build HEDIS® MY2024 Monthly Project which includes all populations for DHCS, HPA and D-SNP. (Contingent on HRP production implementation in 2024)	9/1/2024	10/31/2024	Title: Director of Quality Measurement Name: Kristine Gual Title: Senior Medicare QI Program Manager Name: Kimberly Robertello Title: Senior Director of Quality and Performance Improvement	Title: Manager of Quality Measurement Name: Sue Quichocho	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated		
2.j.				**Deliverable #3:** By 03/31/2025, collect, analyze, validate, and disseminate HEDIS® MY2024 D-SNP preliminary results for the required D-SNP Measure Sets.	11/1/2024	3/31/2025	Title: Director of Quality Measurement Name: Kristine Gual Title: Senior Medicare QI Program Manager Name: Kimberly Robertello Title: Senior Director of Quality and Performance Improvement	Title: Manager of Quality Measurement Name: Sue Quichocho	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated		
3. Value Based Payment Programs - QIP												
3.a.	Primary Care Provider Quality Incentive Program (PCP QIP)	New	**Goal #1:** By June 30, 2025, the PCP QIP Program will be leveraged to support existing and newly added low performing providers in the Modified QIP measure set. This support will include provider education and encouragement to increase on-line data platform usage and monitoring and result in improved reporting and performance improvement activities.	**Deliverable #1:** For new Modified QIP provider, a warm hand-off is made to the QIP team as the result of the work completed by initial PI Needs Assessment, the QIP team will meet with individual modified QIP providers and perform a PCP QIP specific needs assessment to determine QIP tools skill-set level amongst modified QIP staff. Assessment will inform the QIP team how to move forward and what level of engagement/training is needed. May include monthly or quarterly check-ins meetings.	7/1/2024	6/30/2025	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager I Name: Amber Newell Title: Program Manager II Name: Athena Beltran Namprasuet Title: Program Manager I Name: Eva Lopez	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**	
3.a.				**Deliverable #2:** For existing Modified QIP provider, the QIP team will continue to conduct and offer monthly or quarterly check-ins meetings.	7/1/2024	6/30/2025	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager I Name: Amber Newell Title: Program Manager II Name: Athena Beltran Namprasuet Title: Program Manager I Name: Eva Lopez	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated		
3.a.				**Deliverable #3:** Create a survey specifically for Modified QIP provider which includes questions to check-in, assess needs and important reminders. Survey will be distributed on quarterly basis. Answers will be reviewed and followed-up with a 1:1 email.	7/1/2024	6/30/2025	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager I Name: Amber Newell Title: Program Manager II Name: Athena Beltran Namprasuet Title: Program Manager I Name: Eva Lopez	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated		
3.a.		Continued	**Goal #2:** By June 30, 2025, the PCP QIP Program will be leveraged to support new Eastern	**Deliverable #1:** Partner with the Performance Improvement (PI) Team to conduct welcome and/or on going check-in meetings. Check-ins will create an opportunity for both the PI and QIP team to assess how to move forward and what level of engagement/training is needed. Monthly or quarterly check-ins meetings may be required.	7/1/2024	12/31/2024	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager I Name: Amber Newell Title: Program Manager II Name: Athena Beltran Namprasuet Title: Program Manager I Name: Eva Lopez	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**	

2024-25 Quality Improvement Work Plan												Deliverable Complete On Track Delayed Terminated
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**	
3.a.		~~Continued~~	Region PCPs in their efforts to use data to improve reporting and performance improvement activities.	**Deliverable #2:** Create a survey specifically for expansion provider which includes questions to check-in, assess needs and important reminders. Survey will be distributed on quarterly basis. Answers will be reviewed and followed-up with a 1:1 email.	7/1/2024	6/30/2025	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager I Name: Amber Newell Title: Program Manager II Name: Athena Beltran Namprasuet Title: Program Manager I Name: Eva Lopez	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**	
3.b.	Hospital Quality Incentive Program (H-QIP)	New	**Goal #1:** By June 30, 2025, develop the 2025-2026 measurement year Hospital Quality Incentive Program (H-QIP) Measurement Set to support Hospital Performance Improvement.	**Deliverable #1:** Complete development of measures for 2025-26 H-QIP.	7/1/2024	6/30/2025	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager II Name: Troy Foster	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**	
3.b.		New	**Goal #2:** Develop Partnership's Hospital Quality Symposium for the 2025-2026 H-QIP measurement year.	**Deliverable #1:** Select dates, venues, theme, topics, and tentative speakers for the event.	7/1/2024	4/1/2025	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager II Name: Troy Foster	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**	
3.b.				**Deliverable #2:** Finalize agenda, complete speaker engagement, promote event with hospitals.	1/1/2025	6/30/2025	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager II Name: Troy Foster	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated		
3.b.		New	**Goal #3:** By January 31, 2025, complete evaluation of the 2023-2024 HQIP and deliver summary to the Partnership's Quality Committee meetings (IQI, QUAC, PAC).	**Deliverable #1:** Evaluate 2023-2024 hospital program performance by measure in comparison to prior measurement year.	7/1/2024	1/31/2025	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager II Name: Troy Foster	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**	
3.b.				**Deliverable #2:** Provide Evaluation summary to the Partnership Quality Committee meetings (IQI, QUAC, PAC).	7/1/2024	1/31/2025	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager II Name: Troy Foster	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated		
3.c.	Palliative Care Quality Incentive Program (PC QIP)	New	**Goal #1:** By December 31, 2024, develop a measurement set for the calendar year (CY) 2025 Palliative Care Quality Incentive Program (PC QIP), that supports quality improvement.	**Deliverable #1:** Complete measure development for CY 2025 PC QIP.	7/1/2024	12/31/2024	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager I Name: Eva Lopez	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**	
3.c.		Continued *(Monitoring of previous issue)*	**Goal #2:** By June 30, 2025, complete CY 2024 PC QIP evaluation.	**Deliverable #1:** Complete evaluation of the program's CY 2024 measurement year to monitor performance	7/1/2024	6/30/2025	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager I Name: Eva Lopez	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☒ Delayed ☐ Terminated	**No**	
3.d.	Perinatal Quality Incentive Program (PQIP)	Continued	**Goal #1:** By June 30, 2025, continue to develop Perinatal QIP Measurement set to support HEDIS® Score Improvement through May 30, 2025, and leverage support from Partnership's Population Health team and the Growing Together Program to improve scores for the Timely Prenatal Care measures.	**Deliverable #1:** Develop Perinatal QIP Measurement set to support HEDIS® Score Improvement through May 30, 2025 and leverage support from Partnership's Population Health team and the Growing Together Program to improve scores for the Timely Prenatal Care measure.	7/1/2024	6/30/2025	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager II Name: Troy Foster	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**	
3.d.		Continued	**Goal #2:** By June 30, 2025, continue to support provider on-boarding and ECDS implementation to satisfy programmatic gateway measure (ECDS).	**Deliverable #1:** For existing PQIP providers: Continue ECDS education and on-boarding for gateway measure compliance.	7/1/2024	6/30/2025	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager II Name: Troy Foster	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**	
3.d.				**Deliverable #2:** For new PQIP providers: Support implementation of ECDS by providing education and one-on-one meetings with provider staff.	7/1/2024	6/30/2025	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager II Name: Troy Foster	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated		
3.d.		Continued	**Goal #3:** By June 30, 2025, complete PQIP program evaluation for FY 23-24	**Deliverable #1:** Complete FY 23-24 PQIP program evaluation	7/1/2024	6/30/2025	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager II Name: Troy Foster	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**	
3.e.	Enhanced Care Management Quality Incentive Program (ECM QIP)	Continued	**Goal #1:** By December 31, 2024, develop a measurement set for the calendar year (CY) 2025 Enhanced Care Management Quality Incentive Program (ECM QIP) that supports quality improvement and aligns with DHCS' CalAIM initiatives.	**Deliverable #1:** Complete measure development for CY 2025 ECM QIP	7/1/2024	12/31/2024	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager I Name: Deanna Watson	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**	
3.e.		Continued	**Goal #2:** By December 31, 2024, complete CY 2023 ECM QIP evaluation.	**Deliverable #1:** Complete evaluation of the program's CY 2023 measurement year to monitor performance.	7/1/2024	12/31/2024	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager I Name: Deanna Watson	**July 1 - Dec 31** ☐ Complete ☐ On Track ☒ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☒ Delayed ☐ Terminated	**No**	
3.e.		Continued	**Goal #3:** By June 30, 2025, improve provider engagement through Advisory Group and offering one-on-one assistance through meetings and trainings.	**Deliverable #1:** Facilitate Advisory Group meeting for providers to review proposed CY 2025 measurement set and offer their feedback and suggestions for improvement.	7/1/2024	12/31/2024	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager I Name: Deanna Watson	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**	
3.e.				**Deliverable #2:** Outreach to low-performing ECM providers immediately after payment processing and offer one-on-one meetings to review the areas needing improvement, re-review relevant areas in the specifications, and share best practices for success.	7/1/2024	6/30/2025	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager I Name: Deanna Watson	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated		
3.e.				**Deliverable #3:** Outreach to new ECM providers and offer one-on-one meetings to include an overview of the ECM QIP, review the detailed specifications and answer questions.	7/1/2024	6/30/2025	Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Incentive Programs Name: Amy McCune	Title: Program Manager I Name: Deanna Watson	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated		
3.f.	Dual Eligible Special Needs Plan (D-SNP) Quality Incentive Program (QIP) Development	New	**Goal #1:** Explore vendor options and Partnership options for the development of system solution for performance tracking of D-SNP QIP launch in January 2026.	**Deliverable #1:** Evaluate external vendor system solution products. Gather feedback from sister Healthplans on systems used for D-SNP QIPs.	7/1/2024	12/31/2024	Title: Director of Quality Management Name: Isaac Brown Title: Manager of PCP QIP Name: Amy McCune Title: Senior Medicare QI Program Manager	Title: Program Manager II Name: Tony Sengdara	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**	
3.f.				**Deliverable #2:** Evaluate in-house system solution. Gather feedback from Web Team on feasibility of development for 2026 launch of D-SNP QIP.	7/1/2024	12/31/2024	Title: Director of Quality Management Name: Isaac Brown Title: Manager of PCP QIP Name: Amy McCune Title: Senior Medicare QI Program Manager	Title: Program Manager II Name: Tony Sengdara	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated		
3.f.				**Deliverable #3:** Provide an update to the executive team on available options for decision on which vendor or in-house solution will be used to manage D-SNP QIP starting January 2026.	1/1/2025	3/30/2025	Title: Director of Quality Management Name: Isaac Brown Title: Manager of PCP QIP Name: Amy McCune Title: Senior Medicare QI Program Manager	Title: Program Manager II Name: Tony Sengdara	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated		
3.f.				**Deliverable #4:** Develop and gain approval of a project plan, with a scope including execution of provider contracting for an external solution or executive approval for in-house solution through go-live.	1/1/2025	6/30/2025	Title: Director of Quality Management Name: Isaac Brown Title: Manager of PCP QIP Name: Amy McCune Title: Senior Medicare QI Program Manager	Title: Program Manager II Name: Tony Sengdara	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated		
3.f.				**Deliverable #5:** Demonstrate timely progress against approved project plan by June 30, 2025.	1/1/2025	6/30/2025	Title: Director of Quality Management Name: Isaac Brown Title: Manager of PCP QIP Name: Amy McCune Title: Senior Medicare QI Program Manager	Title: Program Manager II Name: Tony Sengdara	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated		
3.f.			**Goal #2:** Develop a Primary Care Provider (PCP) Incentive Program for the provider network	**Deliverable #1:** By December 31, 2024, develop D-SNP PCP Incentive Program (D-SNP QIP) measure set with methodology for setting thresholds and scoring to assure organizational goals are achieved relative to Partnership's STARs strategy and demonstrating feasibility of its D-SNP product line. Any measure set variation will be considered, if applicable, across PCP Incentive Program Groups defined within the D-SNP QIP Portfolio.	7/1/2024	12/31/2024	Title: Director of Quality Management Name: Isaac Brown Title: Manager of PCP QIP Name: Amy McCune Title: Senior Medicare QI Program Manager	Title: Program Manager II Name: Tony Sengdara	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated		

2024-25 Quality Improvement Work Plan												Deliverable Complete On Track Delayed Terminated
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**	
3.f.		New	contracting with Partnership to serve the D-SNP member population as of its D-SNP implementation in January 2026.	**Deliverable #2:** By June 30, 2025, define D-SNP PCP Incentive Program's (D-SNP QIP's) framework including (but not limited to): program goals and principles, member eligibility criteria, provider participant eligibility criteria, performance reporting solution, scoring methodology, and payment mechanisms, and governance structure for each PCP Incentive Program Group selected by Execs for go-live in January 2026	7/1/2024	6/30/2025	Title: Director of Quality Management Name: Isaac Brown Title: Manager of PCP QIP Name: Amy McCune Title: Senior Medicare QI Program Manager Name: Kimberly Robertello	Title: Program Manager II Name: Tony Sengdara	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**	
3.g.	Patient Experience Unit of Service (UOS) Measure Development	New	**Goal #1:** By December 31, 2024, Org. Goal # 4 Access & Member Experience (Milestone 8), Member Experience (ME) Workgroup will collaborate with the Quality Improvement Pay-for-Performance team to explore Unit-of-Service measure development opportunities.	**Deliverable #1:** Complete and propose Unit-of-Service - Patient Experience Measure Development aligned with CAHPS® Scores / NCQA Health Plan Rating. (Access, Communication, Customer Service).	7/1/2024	12/31/2024	Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Improvement Programs Name: Barbara Selig	Title: Program Manager II Name: Anthony Sackett Title: Manager of Quality Incentive Programs name: Amy McCune	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**	
4. Improvement Projects, Clinical Quality												
4.a.	Quality Measure Score Improvement (QMSI)	Continued	**Goal #1:** By June 30, 2025, the Quality Measure Score Improvement group will complete all defined deliverables for each measure-specific workgroup. The goal the Quality Measure Score Improvement group is to improve Partnership's Quality performance over measurement years 2024 and 2025 under all required accountable and reportable quality measure sets (DHCS MCAS, DHCS D-SNP, CMS Part C and Part D, HEDIS®) There are 4 measure-specific workgroups: 1. Pediatrics 2. Behavioral Health 3. Chronic Diseases 4. Women's Health	**Deliverable #1:** Define five (5) specific deliverables for each measure-specific workgroup by December 1, 2024.	7/1/2024	12/1/2024	Title: Director of Quality Management Name: Isaac Brown Title: Senior Director of Quality and Performance Name: Nancy Steffen Title: Senior Medicare QI Program Manager Name: Kimberly Robertello	Title: Manager of Performance Improvement (NR) Name: James Devan Title: Improvement Advisor Name: Amanda Kim	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**	
4.a.				**Deliverable #2:** • Successfully complete all required deliverables for each measure-specific workgroup by June 30, 2025. • By June 30, 2025, identify all D-SNP measures which fall within the QMSI workgroups by work group domain.	7/1/2024	6/30/2025	Title: Director of Quality Management Name: Isaac Brown Title: Senior Director of Quality and Performance Name: Nancy Steffen Title: Senior Medicare QI Program Manager Name: Kimberly Robertello	Title: Manager of Performance Improvement (NR) Name: James Devan Title: Improvement Advisor Name: Amanda Kim	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated		
4.b.	Missed Opportunities and Member Engagement	Continued	**Goal 1:** By June 30, 2025 Incorporate missed opportunity data and feedback from the 23/24 goal and include in the member engagement dashboard currently in development and publish externally for providers to use.	**Deliverable #1:** By November 30, 2024, meet with provider stakeholders to solicit input on updated dashboard use and determine scope of requirements for making the dashboard provider-facing.	7/1/2024	11/30/2024	Title: Manager of Performance Improvement (ER) Name: Brandy Isola Title: Manager of Performance Improvement (NR) Name: James Devan	Title: Director of Quality Management Name: Isaac Brown	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**No**	
4.b.				**Deliverable #2:** By January 1, 2025, submit provider-facing dashboard business requirements for development team review.	7/1/2024	1/1/2025	Title: Manager of Performance Improvement (ER) Name: Brandy Isola Title: Manager of Performance Improvement (NR) Name: James Devan	Title: Director of Quality Management Name: Isaac Brown	**July 1 - Dec 31** ☐ Complete ☐ On Track ☒ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☒ Delayed ☐ Terminated		
4.b.				**Deliverable #3:** By June 30, 2025, publish dashboard for provider on-demand use.	1/1/2025	6/30/2025	Title: Manager of Performance Improvement (ER) Name: Brandy Isola Title: Manager of Performance Improvement (NR) Name: James Devan	Title: Director of Quality Management Name: Isaac Brown	**July 1 - Dec 31** ☐ Complete ☐ On Track ☒ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☒ Delayed ☐ Terminated		
4.c.	Healthy Kids Growing Together Program	New	**Goal #1:** By June 30, 2025, modify the Healthy Kids Growing Together Program to include any 3 - 6 year old who has never had a well-child visit in the last nine (9) months and offer an incentive to complete a well-child visit within 90 days prior to 4th, 5th and 6th birthday.	**Deliverable #1:** Campaign lists showing members identified for the Healthy Kids Growing Together Program	7/1/2024	9/30/2024	Title: Associate Director of Population Health Name: Monika Brunkal	Title: Manager of Population Health Name: Nicole Curreri Title: Supervisor of Population Health Name: Cynthia Galicia-Huizar	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**	
4.c.				**Deliverable #2:** Program Impact Analysis report showing results of this intervention.	5/1/2025	6/30/2025	Title: Associate Director of Population Health Name: Monika Brunkal	Title: Manager of Population Health Name: Nicole Curreri Title: Supervisor of Population Health Name: Cynthia Galicia-Huizar	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated		
4.d.	Mobile Mammography Program	New	**Goal #1**: By June 30, 2025, the Mobile Mammography Program Team will have scheduled 60 Mobile Mammography event days throughout the provider network, resulting in at least 1,500 completed breast cancer screenings towards meeting the 50th percentile benchmark.	**Deliverable #1:** • Complete at least 10 event days in the legacy Eastern Region. • Complete at least 40 event days in the legacy Northern Region. • Complete at least 10 event days in legacy Southern Region.	7/1/2024	6/30/2025	Title: Manager of Quality Improvement Name: Barbara Selig	Title: Program Manager II Name: Arelí Carrillo Title: Project Manager I Name: Chandler Ackerman	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**	
4.d.				**Deliverable #2**: By December 31 2024, reach the Primary Care Provider Quality Incentive Program (PCP QIP) Breast Cancer Screening 50th percentile benchmark (52.20%) in the Northwest, Northeast, Southwest and Southeast legacy regions.	7/1/2024	12/31/2024	Title: Manager of Quality Improvement Name: Barbara Selig	Title: Program Manager II Name: Arelí Carrillo Title: Project Manager I Name: Chandler Ackerman	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated		
4.d.		New	**Goal #2**: By June 30, 2025, focus efforts on engaging Enhanced Provider Engagement (EPE) provider organizations and Tribal Health Centers.	**Deliverable #1:** By June 30, 2025, schedule at least five (5) event days with at least five (5) eligible Tribal Health Centers.	7/1/2024	6/30/2025	Title: Manager of Quality Improvement Name: Barbara Selig	Title: Program Manager II Name: Arelí Carrillo Title: Project Manager I Name: Chandler Ackerman	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**	
4.d.				**Deliverable #2**: By June 30, 2025, schedule at least five (5) event days with at least five (5) eligible EPE provider organizations.	7/1/2024	6/30/2025	Title: Manager of Quality Improvement Name: Barbara Selig	Title: Program Manager II Name: Arelí Carrillo Title: Project Manager I Name: Chandler Ackerman	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated		
4.d.		New	**Goal #3:** By June 30, 2025 pilot a new innovation to engage Tribal Health Center patients at mobile event days.	**Deliverable #1:** By June 30, 2025 pilot one (1) new innovation at three (3) Tribal Health Center mobile event days.	7/1/2024	6/30/2025	Title: Manager of Quality Improvement Name: Barbara Selig	Title: Program Manager II Name: Arelí Carrillo Title: Project Manager I Name: Chandler Ackerman	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**	
5. Service and Patient Experience												
5.a.	Collect Member Experience Data	Continued	**Goal #1:** By June 30, 2025, launch the annual CAHPS® survey for Measure Year (MY) 2024 Reporting Year (RY) 2025 and collect data results	**Deliverable #1:** By June 30, 2025, confirm HEDIS® team Measure Year (MY) 2024 sample frame submission to Press Ganey, launch survey, and collect results as part of the NCQA member experience process	11/1/2024	6/30/2024	Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen Title: Director of Quality Management Name: Isaac Brown	Title: Program Manager II Name: Anthony Sackett	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**	
5.b.	Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Dual Eligible Special Needs Plan (D-SNP)	New	**Goal #1:** By June 30, 2025, select and contract with a Medicare Dual Eligible Special Needs Plan (D-SNP) Consumer Assessment of Healthcare Providers and Systems (CAHPS®) CMS-approved vendor.	**Deliverable #1:** By December 31, 2025 execute RFP process with Medicare D-SNP CAHPS® CMS approved vendors.	7/1/2024	12/31/2024	Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Improvement Programs Name: Barbara Selig Title: Senior Medicare QI Program Manager Name: Kimberly Robertello	Title: Project Manager I Name: Tasha Krongard	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☒ Terminated	**No**	
5.b.		New	**Goal #2**: By June 30, 2025 develop D-SNP CAHPS® programmatic work plan and timeline.	**Deliverable #1**: By December 31, 2024 conduct interviews with at least three (3) sister plans regarding their D-SNP programs in an effort to help inform the D-SNP CAHPS® programmatic work plan and timeline.	7/1/2024	12/31/2024	Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen Title: Director of Quality Management Name: Isaac Brown Title: Manager of Quality Improvement Programs Name: Barbara Selig Title: Senior Medicare QI Program Manager Name: Kimberly Robertello	Title: Project Manager I Name: Tasha Krongard	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**	
6. Care for Members with Complex Needs												
6.a.				**Deliverable #1:** Documented Processes: Provide acknowledgement that documented processes meet the scope of review throughout the look-back period. Any revisions that impact NCQA requirements must be finalized in August 2024, including timely review by the NCQA Consultant and approval at committee meetings.	7/1/2024	7/25/2024	Title: Sr. Director of Care Management Name: Brigid Gast	Title: CC Regulatory Performance Manager Name: Shannon Boyle	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated		

2024-25 Quality Improvement Work Plan												Deliverable Complete On Track Delayed Terminated
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**	
6.a.	Complex Case Management	Continued	**Goal #1:** By June 30, 2025, we will ensure Partnership remains compliant with meeting the National Committee for Quality Assurance (NCQA) Population Health Management Standard PHM5, A-E, standards for our NCQA Renewal Survey in November 2026 and thereafter as evidenced in the results of our upcoming NCQA renewal audit and continuous quarterly internal compliance audits of Complex Case Management to meet overall compliance of files.	**Deliverable #2:** Materials: Submit all applicable screenshots as indicated under the Evidence Submission Library to demonstrate the compliance is met.	8/1/2024	8/8/2024	Title: Sr. Director of Care Management Name: Brigid Gast	Title: CC Regulatory Performance Manager Name: Shannon Boyle	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**	
6.a.				**Deliverable #3:** August 2024 Quarterly Internal Audit (Audit Period 05/01/2024-07/31/2024)	8/1/2024	8/15/2024	Title: Sr. Director of Care Management Name: Brigid Gast	Title: CC Regulatory Performance Manager Name: Shannon Boyle	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated		
6.a.				**Deliverable #4:** Review and update the annual HPA Workbook (Work Plan and Evidence Submission Library)	10/1/2024	10/18/2024	Title: Sr. Director of Care Management Name: Brigid Gast	Title: CC Regulatory Performance Manager Name: Shannon Boyle	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated		
6.a.				**Deliverable #5:** November 2024 Quarterly Internal Audit (Audit Period 08/01/2024-10/31/2024)	11/1/2024	11/15/2024	Title: Sr. Director of Care Management Name: Brigid Gast	Title: CC Regulatory Performance Manager Name: Shannon Boyle	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated		
6.a.				**Deliverable #6:** Continue to maintain strict oversight of Partnership and non-NCQA Accredited delegates' files to ensure compliance and participate in a Mock File Review with the NCQA Consultant. This review will include files from Partnership and non-NCQA Accredited delegates.	4/1/2025	4/30/2025	Title: Sr. Director of Care Management Name: Brigid Gast	Title: CC Regulatory Performance Manager Name: Shannon Boyle	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated		
6.a.				**Deliverable #7:** February 2025 Quarterly Internal Audit (Audit Period 11/01/2024-01/31/2025)	2/1/2025	2/14/2025	Title: Sr. Director of Care Management Name: Brigid Gast	Title: CC Regulatory Performance Manager Name: Shannon Boyle	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated		
6.a.				**Deliverable #8:** May 2025 Quarterly Internal Audit (Audit Period 02/01/2025-04/30/2025)	5/1/2025	5/15/2025	Title: Sr. Director of Care Management Name: Brigid Gast	Title: CC Regulatory Performance Manager Name: Shannon Boyle	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated		
6.a.				**Deliverable #9:** Business Owners will submit all annotated evidence for the Mock Renewal Survey based on the dates listed in the Evidence Submission Library for Year 1 of the look-back period, and the submission guidelines provided by the NCQA Program Management Team	6/1/2025	6/20/2025	Title: Sr. Director of Care Management Name: Brigid Gast	Title: CC Regulatory Performance Manager Name: Shannon Boyle	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated		
	7. Quality Assurance and Patient Safety											
7.a.	Potential Quality Issues (PQI) (safety)	New	**Goal #1:** By June 30, 2025, QI Member Safety Quality Investigation Team will provide in-services to other Partnership Departments educating on Potential Quality Issues (PQI) and how to refer. In addition, the team will monitor referral track and trending reports to determine if inservice training results in an increase in PQI referrals from respective departments.	**Deliverable #1:** Review and update power point presentation on PQI for internal staff.	7/1/2024	12/31/2024	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Member Safety Quality Investigations Name: Robert Bides	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**	
7.a.				**Deliverable #2:** Reach out to departments Managers/Directors for potential inservice dates. Schedule and provide in-services.	7/1/2024	12/31/2024	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Member Safety Quality Investigations Name: Robert Bides	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated		
7.a.				**Deliverable #3:** Develop a survey monkey feedback questionnaire. Send survey monkey to attendees for feedback on areas to consider for improvement.	7/1/2024	5/31/2025	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Member Safety Quality Investigations Name: Robert Bides	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated		
7.a.				**Deliverable #4:** Monitor referral track and trending reports to determine if inservice training results in an increase in PQI referrals from respective departments.	7/1/2024	6/30/2025	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Member Safety Quality Investigations Name: Robert Bides	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated		
7.a.		New	**Goal #2**: By June 30, 2025, QI Member Safety Quality Investigation Team will assess SugarCRM Potential Quality Issues (PQI) application and determine potential enhancements or replacement options.	**Deliverable #1:** Review and list issues/areas in SugarCRM PQI app that require an enhancement or upgrade. Consult with IT to determine best action.	7/1/2024	8/31/2024	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Member Safety Quality Investigations Name: Robert Bides	**July 1 - Dec 31** ☐ Complete ☐ On Track ☒ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**	
7.a.				**Deliverable #2:** Reach out to other Managed Care Plans for feedback on using JIVA/ZeOmega system to monitor and manage PQI cases.	7/1/2024	9/30/2024	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Member Safety Quality Investigations Name: Robert Bides	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated		
7.a.		Continued	**Goal #3**: By June 30, 2025, QI Member Safety Quality Investigation Team will continue to provide Provider Preventable Conditions (PPC) trainings to Partnership network acute inpatient hospitals.	**Deliverable #1:** Reach out to at least five (5) acute care inpatient hospitals and provide an inservice to at least three (3) regarding PPC and reporting requirements.	7/1/2024	6/30/2025	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Member Safety Quality Investigations Name: Robert Bides	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**	
7.a.				**Deliverable #2:** Continue to monitor track and trend reports to determine if inservice training results in an increase in PPC reporting to Partnership.	7/1/2024	6/30/2025	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Member Safety Quality Investigations Name: Robert Bides	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated		
7.a.		New	**Goal #4:** By June 30, 2025, QI Member Safety Quality Investigation Team will investigate/research requirements for the Dual Special Needs Plan (D-SNP) program related to Partnership's Potential Quality Issues process and modify/update related policies.	**Deliverable #1:** Develop a project plan that includes identifying P&P and system changes required to be ready for D-SNP implementation.	7/1/2024	6/30/2025	Title: Medical Director for Quality Name: Mark Netherda Title: Senior Medicare QI Program Manager Name: Kimberly Robertello	Title: Manager of Member Safety Quality Investigations Name: Robert Bides	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**	
7.a.				**Deliverable #2:** Continue discussions with Senior Medicare QI Program Manager and obtain any D-SNP documents and resources related to Potential Quality Issues (PQI). Review documents to determine potential impact to PQI process and reporting.	7/1/2024	6/30/2025	Title: Medical Director for Quality Name: Mark Netherda Title: Senior Medicare QI Program Manager Name: Kimberly Robertello	Title: Manager of Member Safety Quality Investigations Name: Robert Bides	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated		
7.a.				**Deliverable #3:** Review and update related policies.	7/1/2024	6/30/2025	Title: Medical Director for Quality Name: Mark Netherda Title: Senior Medicare QI Program Manager Name: Kimberly Robertello	Title: Manager of Member Safety Quality Investigations Name: Robert Bides	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated		
7.a.				**Deliverable #4:** Contact other Managed Care Plans for information on D-SNP impact on their PQI process.	7/1/2024	6/30/2025	Title: Medical Director for Quality Name: Mark Netherda Title: Senior Medicare QI Program Manager Name: Kimberly Robertello	Title: Manager of Member Safety Quality Investigations Name: Robert Bides	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated		
7.b.	QI Collaboration	New	**Goal #1:** By June 30, 2025, the Site Review Inspections Team currently conducts Medical Record Reviews (MRR) that can take between 5-16 hours side by side with staff/ providers at Primary Care Provider (PCP) sites. In an effort to better utilize that 1:1 time with the site, the Inspections Team will incorporate additional Quality Improvement (QI) department knowledge with the PCP site thereby improving patient care.	**Deliverable #1:** Develop and implement a process to open up communication and share areas of focus between Partnership Quality Department teams (e.g., Performance Improvement (PI), Quality Incentive Programs (QIP), etc.) prior to scheduled site reviews.	7/1/2024	6/30/2025	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Clinical Compliance Name: Rachel Newman	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**	
7.b.				**Deliverable #2:** In an effort to be collaborative, the Site Review Nurse will research recent QI communications with 15 PCP sites prior to the Site Review. Using the knowledge gleaned from the other QI teams' contacts with a PCP site, topics discussed will be reviewed with the site during the 1:1 time spent conducting the MRR to further drive quality improvements.	7/1/2024	6/30/2025	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Clinical Compliance Name: Rachel Newman	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated		
7.b.				**Deliverable #3:** Develop a post MRR survey to be completed by the Site Review Nurses to obtain a subjective evaluation to determine if the additional information assisted in making the site review more informative on a broader scope of quality topics (i.e. QIP/PI Plan-Do-Study-Act (PDSAs), Mammo or Immunization clinics, etc.)	7/1/2024	6/30/2025	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Clinical Compliance Name: Rachel Newman	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated		

2024-25 Quality Improvement Work Plan												Deliverable Complete On Track Delayed Terminated
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**	
7.c.	CHDP	New	**Goal #1:** Due to Child Health and Disability Program (CHDP) sun setting effective July 1, 2024, the Site Review Inspections Team will be taking over CHDP mandated trainings for the following topics: vision, hearing, fluoride varnish application, anthropometric screenings and information on Vaccines for Children (VFC), per the CHDP Transition Plan (March 2024).	**Deliverable #1:** By December 31, 2024, create Child Health and Disability Program (CHDP) training materials covering the following topics: vision, hearing, fluoride varnish application, anthropometric screenings and information on Vaccines for Children (VFC).	7/1/2024	12/31/2024	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Clinical Compliance Name: Rachel Newman	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**	
7.c.				**Deliverable #2:** By December 31, 2024, implement a process to roll out CHDP training to the Partnership network.	7/1/2024	12/31/2024	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Clinical Compliance Name: Rachel Newman	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated		
7.c.				**Deliverable #3:** Develop a monitoring process for sites regarding their CHDP training status.	7/1/2024	6/30/2025	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Clinical Compliance Name: Rachel Newman	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated		
7.d.	Latent TB Infection Treatment (safety)	Continued	**Goal #1:** By June 30, 2025, a clinical pharmacist will conduct concurrent review of Latent Tuberculosis Infection (LTBI) medication treatments and provide timely notification of all identified potential LTBI treatment regimen gaps, which result from late refill, non-adherence, inappropriate prescribing, and/or inappropriate dispensing. The regimens to be monitored will include 30-doses of isoniazid/rifapentine (1HP), 12-doses of isoniazid/rifapentine (3HP), 90-doses of isoniazid/rifampin (3HR), and 120-doses of rifampin (4R).	**Deliverable #1:** Pharmacist will identify potential treatment gaps and provide notification to prescribers within two timeframes: day 16 and day 20. • Pharmacist will identify and notify providers (via fax) whose members are ≥14 days late in refilling their prescribed LTBI medication. • ≥ 80% of identified potential non-adherence cases will receive provider notification (via fax) no later than day 16 of their member not having their LTBI medication based on the last refill date. • ≤ 20% of the identified potential non-adherence cases will receive provider notification (via fax) no later than day 20 of their member not having their LTBI medication based on the last refill date. Pharmacist will verify gap and confirm member's prescribed LTBI regimen was not completed in the accepted timeframe. • Pharmacist will provide notification to prescribers (via fax) of their member's potential non-adherence to their prescribed LTBI regimen.	7/1/2024	6/30/2025	Title: Director of Pharmacy Services Name: Stan Leung	Title: Clinical Pharmacist Name: Kathleen Vo	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**	
7.d.				**Deliverable #2:** Pharmacist will monitor for inappropriate prescribing / dispensing of 100-dose rifampin (4R regimen). • Pharmacist will identify and provide information for correct prescribing of 4R regimen. • Pharmacist will notify prescriber (via fax) that 100-dose rifampin is insufficient and is not considered completion of 4R regimen.	7/1/2024	6/30/2025	Title: Director of Pharmacy Services Name: Stan Leung	Title: Clinical Pharmacist Name: Kathleen Vo	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated		
7.d.		New	**Goal #2:** By June 30, 2025, a clinical pharmacist will provide Latent Tuberculosis Infection (LTBI) summary updates to Partnership's Medical Directors and to the County Public Health Officers.	**Deliverable #1:** Pharmacist will provide semi-annual LTBI summary updates to Partnership's Medical Directors for tracked LTBI regimens (identified late fills, identified possible non-adherence to regimen, actions taken, and results of provider outreach).	7/1/2024	6/30/2025	Title: Director of Pharmacy Services Name: Stan Leung	Title: Clinical Pharmacist Name: Kathleen Vo	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**	
7.d.				**Deliverable #2:** Pharmacist will provide quarterly update of Partnership members who are prescribed a LTBI regimen and the current status of that LTBI regimen to the County Public Health Officers.	7/1/2024	6/30/2025	Title: Director of Pharmacy Services Name: Stan Leung	Title: Clinical Pharmacist Name: Kathleen Vo	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated		
	8. Quality Improvement Training and Coaching											
8.a.	QI Technical Assistance in Partnership with Northern Region Consortia	Continued	**Goal #1:** By June 30 2025, collaborate with Northern Region consortia to bring QI awareness and education to Northern Region providers: • Develop and post storyboards and infographics to demonstrate successful QI improvement projects over time • Host recurring forums for QI engagement • Develop measure best practices to share with Northern Region consortia members • Complete annual comprehensive organizational profiles for each member to inform and support Partnership and provider partnering in improvement activities	**Deliverable #1:** Develop at least two project storyboards outlining regional Quality Improvement (QI) projects and post on consortia websites.	7/1/2024	6/30/2025	Title: Director of Quality Improvement Name: Isaac Brown	Title: Manager of Performance Improvement (NR) Name: James Devan	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**	
8.a.				**Deliverable #2:** Present Partnership updates and timely provider education at least 4 times via monthly QI and Chief Medical Officer (CMO) Peer Network Calls and in-person Rural Round Table events.	7/1/2024	6/30/2025	Title: Director of Quality Improvement Name: Isaac Brown	Title: Manager of Performance Improvement (NR) Name: James Devan	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated		
8.a.				**Deliverable #3:** Develop materials that highlight best practices for focus HEDIS®/Quality Incentive Program measures and proactively share with Northern Region consortia members via consortia hosted webinars, its eNews, or its Peer Network.	7/1/2024	6/30/2025	Title: Director of Quality Improvement Name: Isaac Brown	Title: Manager of Performance Improvement (NR) Name: James Devan	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated		
8.a.				**Deliverable #4:** Complete comprehensive organizational profiles (i.e. inclusive of QI, PCMH, Workforce, and Finance updates) for each Federally Qualified Health Center (FQHC) member to support Partnership's assessment of current performance and identification of key areas for partnering in improvement.	7/1/2024	6/30/2025	Title: Director of Quality Improvement Name: Isaac Brown	Title: Manager of Performance Improvement (NR) Name: James Devan	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated		
8.b.	Performance Improvement Training Offerings	Continued	**Goal #1:** By June 30, 2025, the Improvement Academy will offer multiple forms of Quality Improvement education to the Partnership provider network.	**Deliverable #1:** By June 30, 2025, offer at least four (4) virtual training sessions on priority MCAS measures between January 2025 and June 2025 across the provider network.	1/1/2025	6/30/2025	Name: Brandy Isola Title: Manager of Performance Improvement (ER) Name: James Devan Title: Manager of Performance Improvement (NR)	Title: Improvement Advisor Name: Tiffany Tryan Title: Project Manager I Name: Andrea Thomas	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**No**	
8.b.				**Deliverable #2:** By June 30, 2025, offer at least two (2) virtual or in-person ABCs of Quality Improvement training series across the provider network	7/1/2024	6/30/2025	Name: Brandy Isola Title: Manager of Performance Improvement (ER) Name: James Devan Title: Manager of Performance Improvement (NR)	Title: Improvement Advisor Name: Tiffany Tryan Title: Project Manager I Name: Andrea Thomas	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated		
8.b.				**Deliverable #3:** By June 30, 2025, offer at least two (2) Microlearnings focused on improving outcomes around priority measures for the provider network.	7/1/2024	6/30/2025	Name: Brandy Isola Title: Manager of Performance Improvement (ER) Name: James Devan Title: Manager of Performance Improvement (NR)	Title: Improvement Advisor Name: Tiffany Tryan Title: Project Manager I Name: Andrea Thomas	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☒ Delayed ☐ Terminated		
8.b.				**Deliverable #4:** By June 30, 2025, develop a strategy to align ABCs of Quality Improvement curriculum for all regions.	7/1/2024	6/30/2025	Name: Brandy Isola Title: Manager of Performance Improvement (ER) Name: James Devan Title: Manager of Performance Improvement (NR)	Title: Improvement Advisor Name: Tiffany Tryan Title: Project Manager I Name: Andrea Thomas	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated		
8.b.		Continued	**Goal #2:** By June 30, 2025, the Improvement Academy will develop a strategy to measure the impact of trainings on both MCAS rates and provider network foundational knowledge.	**Deliverable #1:** By June 30, 2025, offer at least four (4) virtual training sessions on priority MCAS measures between January 2025 and June 2025 across the provider network.	7/1/2024	6/30/2025	Name: Brandy Isola Title: Manager of Performance Improvement (ER) Name: James Devan Title: Manager of Performance Improvement (NR)	Title: Improvement Advisor Name: Tiffany Tryan Title: Project Manager I Name: Andrea Thomas	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**No**	
8.b.				**Deliverable #2:** By June 30, 2025, continue to measure effectiveness of the ABCs of Quality Improvement trainings by evaluating knowledge pre and post training and develop a mechanism to track implementation of concepts.	7/1/2024	6/30/2025	Name: Brandy Isola Title: Manager of Performance Improvement (ER) Name: James Devan Title: Manager of Performance Improvement (NR)	Title: Improvement Advisor Name: Tiffany Tryan Title: Project Manager I Name: Andrea Thomas	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated		
8.b.				**Deliverable #3:** By June 30, 2025, develop a strategy to evaluate Microlearnings and guide further build out of Microlearning development.	7/1/2024	6/30/2025	Name: Brandy Isola Title: Manager of Performance Improvement (ER) Name: James Devan Title: Manager of Performance Improvement (NR)	Title: Improvement Advisor Name: Tiffany Tryan Title: Project Manager I Name: Andrea Thomas	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☒ Delayed ☐ Terminated		
8.c.	Joint Leadership Initiative	Continued	**Goal #1:** Continue Joint Leadership Initiative (JLI) meetings structure plan-wide as Partnership's strategic program for engaging executive teams of high-volume provider organizations around quality improvement. Revisit Partnership attendees to ensure proper alignment given organizational title and role changes, and adapting to updated regional structure.	**Deliverable #1:** By September 30, 2024, review prior year JLI evaluation to assess program effectiveness, and identify update Partnership attendees to reflect new regional structure.	7/1/2024	9/30/2024	Title: Director of Quality Management Name: Isaac Brown Title: Senior Director of Quality & Performance Name: Nancy Steffen	Name: Brandy Isola Title: Manager of Performance Improvement (ER) Name: James Devan Title: Manager of Performance Improvement (NR)	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**	
8.c.				**Deliverable #2:** By June 30, 2025, conduct all JLI meetings in accordance with new tier structure. The number of JLI meetings by parent organization can range from zero to four meetings during the calendar year, based on MY2023 and MY2024 Quality Incentive Program (QIP) performance.	7/1/2024	6/30/2025	Title: Director of Quality Management Name: Isaac Brown Title: Senior Director of Quality & Performance Name: Nancy Steffen	Name: Brandy Isola Title: Manager of Performance Improvement (ER) Name: James Devan Title: Manager of Performance Improvement (NR)	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated		

2024-25 Quality Improvement Work Plan												Deliverable Complete On Track Delayed Terminated
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**	
8.c.				**Deliverable #3:** By June 30, 2025, conduct a qualitative and quantitative evaluation of JLI providers for MY 2024 to determine effectiveness of JLI series.	7/1/2024	6/30/2025	Title: Director of Quality Management Name: Isaac Brown Title: Senior Director of Quality & Performance Name: Nancy Steffen	Name: Brandy Isola Title: Manager of Performance Improvement (ER) Name: James Devan Title: Manager of Performance Improvement (NR)	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated		
8.d.		Continued	**Goal #1:** By June 30, 2025, the Performance Improvement teams will launch interventions with 80 percent of provider organizations identified as low performing providers on the 2023 Primary Care Provider Quality Incentive Program (PCP QIP) (<25% of clinical points earned) assigned to Enhanced Provider Engagement or a Corrective Action Plan, aimed at improving performance on the Modified QIP.	**Deliverable #1:** By December 31, 2024, the Performance Improvement team will complete a Needs Assessment with 80 percent of provider organizations newly assigned to Enhanced Provider Engagement OR Correction Action Plan in 2024.	7/1/2024	12/31/2024	Title: Director of Quality Management Name: Isaac Brown	Name: Brandy Isola Title: Manager of Performance Improvement (ER) Name: James Devan Title: Manager of Performance Improvement (NR) Name: Jennifer Durst Title: Sr. Manager of Performance Improvement (SR)	**July 1 - Dec 31** ☐ Complete ☐ On Track ☒ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☒ Delayed ☐ Terminated	**Yes**	
8.d.				**Deliverable #2:** By December 31, 2024, 80 percent of provider organizations with a completed Needs Assessment will select and implement at least one (1) intervention aligned with a Needs Assessment recommendation provided by Partnership.	7/1/2024	12/31/2024	Title: Director of Quality Management Name: Isaac Brown	Name: Brandy Isola Title: Manager of Performance Improvement (ER) Name: James Devan Title: Manager of Performance Improvement (NR)	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated		
8.d.				**Deliverable #3:** By June 30, 2025, the Performance Improvement team will evaluate the Enhanced Provider Engagement program in 2024, including the use of Corrective Action engagement and advance of QIP dollars for Phase 2 Modified QIP practices.	1/1/2025	6/30/2025	Title: Director of Quality Management Name: Isaac Brown	Name: Brandy Isola Title: Manager of Performance Improvement (ER) Name: James Devan Title: Manager of Performance Improvement (NR)	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated		
8.d.				**Deliverable #4:** By March 31, 2025, the Performance Improvement team will partner with senior leadership to develop a strategy for evaluating practices new to Partnership in 2024 for inclusion in the Enhanced Provider Engagement and Modified QIP programs.	1/1/2025	3/31/2025	Title: Director of Quality Management Name: Isaac Brown	Name: Brandy Isola Title: Manager of Performance Improvement (ER) Name: James Devan Title: Manager of Performance Improvement (NR) Name: Jennifer Durst Title: Sr. Manager of Performance Improvement (SR)	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated		
8.d.	Provider Coaching and Engagement	New	**Goal #2:** By June 30, 2025, the Performance Improvement teams will engage with practices in the 10 incoming counties joining Partnership in 2024. We will engage with practices holding 70% of assigned membership for incoming counties around PCP QIP performance.	**Deliverable #1:** By December 31, 2024, the Performance Improvement teams will engage primary care practices holding 70% of assigned membership for the 10 incoming counties in regular coaching meetings with assigned Improvement Advisor.	7/1/2024	12/31/2024	Title: Director of Quality Management Name: Isaac Brown	Name: Brandy Isola Title: Manager of Performance Improvement (ER) Name: James Devan Title: Manager of Performance Improvement (NR) Name: Jennifer Durst Title: Sr. Manager of Performance Improvement (SR)	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**No**	
8.d.				**Deliverable #2:** By June 30, 2025, the Performance Improvement teams will engage primary care practices holding 60% of assigned membership for incoming counties in regional meetings in partnership with regional leadership.	7/1/2024	6/30/2025	Title: Director of Quality Management Name: Isaac Brown	Name: Brandy Isola Title: Manager of Performance Improvement (ER) Name: James Devan Title: Manager of Performance Improvement (NR)	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☒ Delayed ☐ Terminated		
8.d.				**Deliverable #3:** By June 30, 2025, the Performance Improvement team, in partnership with regional leadership, will evaluate incoming practices' performance on the 2024 PCP QIP.	7/1/2024	6/30/2025	Title: Director of Quality Management Name: Isaac Brown	Name: Brandy Isola Title: Manager of Performance Improvement (ER) Name: James Devan Title: Manager of Performance Improvement (NR)	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated		
8.d.		New	**Goal #3:** By December 31, 2024, the Performance Improvement teams will engage with two high-volume Primary Care Provider (PCP) practices in each DHCS reporting sub-region around improvement on high-priority HEDIS® and PCP QIP measures.	**Deliverable #1:** By July 31, 2024, the Performance Improvement team will identify the high-volume PCP practices of focus in each sub-region and measures of focus for engagement.	7/1/2024	7/31/2024	Title: Director of Quality Management Name: Isaac Brown	Name: Brandy Isola Title: Manager of Performance Improvement (ER) Name: James Devan Title: Manager of Performance Improvement (NR)	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**	
8.d.				**Deliverable #2:** By December 31, 2024, the Performance Improvement team will establish a coaching relationship with two (2) high-volume PCP practices in each sub-region and plan and implement at least one intervention to impact at least one measure of focus.	7/1/2024	12/31/2024	Title: Director of Quality Management Name: Isaac Brown	Name: Brandy Isola Title: Manager of Performance Improvement (ER) Name: James Devan Title: Manager of Performance Improvement (NR)	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated		
8.e.	Expansion of Regional Quality Meetings	Continued	**Goal #1:** By June 30, 2025, Partnership will implement regional quality meetings in all six (6) operational regions to offer forums for regional dialogue to address quality improvement opportunities or barriers.	**Deliverable #1:** By September 30, 2024, Quality Improvement (QI) will evaluate existing regional quality meeting structure and the new expansion counties to determine roles and attendees to ensure alignment with Partnership operations.	7/1/2024	9/30/2024	Title: Director of Quality Management Name: Isaac Brown	Name: Brandy Isola Title: Manager of Performance Improvement (ER) Name: James Devan Title: Manager of Performance Improvement (NR)	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**No**	
8.e.				**Deliverable #2:** By June 30, 2025 Quality Improvement (QI) will conduct at least four (4) quarterly meetings in each of the respective regions. The meetings may be comprised of different modalities such as regional quality meetings, the Solano Quality Improvement Program - Improvement workgroup (SQIP-I), How to Succeed sessions, etc.	7/1/2024	6/30/2025	Title: Director of Quality Management Name: Isaac Brown	Name: Brandy Isola Title: Manager of Performance Improvement (ER) Name: James Devan Title: Manager of Performance Improvement (NR)	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☒ Delayed ☐ Terminated		
8.e.				**Deliverable #3:** By June 30, 2025 QI will survey attendees for feedback on quality forums as well as inventory projects and activities identified through the regional forums to possibly leverage for scale and spread of successful activities.	7/1/2024	6/30/2025	Title: Director of Quality Management Name: Isaac Brown	Name: Brandy Isola Title: Manager of Performance Improvement (ER) Name: James Devan Title: Manager of Performance Improvement (NR)	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated		
8.f.	Implementation of Plan Wide HEDIS Week in 2023	Continued	**Goal #1:** By June 30, 2025, the HEDIS® team will develop content and conduct a HEDIS® Week to include plan wide activities focused on HEDI®S education. HEDIS® Week is planned to occur in mid-October 2024.	**Deliverable #1:** By August 31, 2024, develop a work plan and materials to conduct a virtual HEDIS® week. Material will be solicited from the HEDIS®, Performance Improvement, Quality Incentive, and NCQA accreditation teams.	7/1/2024	8/31/2024	Title: Director of Quality Measurement Name: Kristine Gual	Title: Manager of Quality Measurement Name: Sue Quichocho	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**	
8.f.				**Deliverable #2:** By December 30, 2024: • Conduct the virtual HEDIS® week utilizing LMS created modules, online presentations and email communications. • Develop a survey and distribute to staff to solicit feedback on HEDIS® week. • Review survey feedback to determine any changes or adjustments required for future events. • Develop a sustainability plan to ensure HEDIS® week remains an annual event.	7/1/2024	12/30/2024	Title: Director of Quality Measurement Name: Kristine Gual	Title: Manager of Quality Measurement Name: Sue Quichocho	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated		
	9. Cultural and Linguistics Services (See Partnership's 2020 Population Health and Health Education Work Plan)											
	10. Delegation Oversight											
10.a	QI Delegation Oversight	Continued	**Goal #1:** By June 30, 2025, demonstrate strong delegation oversight process in support of delegation standards and Partnership policies and procedures.	**Deliverable #1:** Quarterly and yearly review of delegation committee reports and delegated activities based on submitted documents. Present findings at the Delegation Oversight Committee (DORS) meetings with recommendations.	7/1/2024	6/30/2025	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Member Safety Quality Investigations Name: Robert Bides	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**	
10.a				**Deliverable #2:** Participation with the annual delegation audits by Partnership Compliance department. Submit audit findings within required timeframe.	7/1/2024	6/30/2025	Title: Medical Director for Quality Name: Mark Netherda	Title: Manager of Member Safety Quality Investigations Name: Robert Bides	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated		
	11. NCQA Program Management											

2024-25 Quality Improvement Work Plan												Deliverable Complete On Track Delayed Terminated
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**	
11.a.	[Compliance with NCQA HEA and Preparation for Initial Survey]	New	**Goal #1:** By June 30, 2025, departments will maintain compliance of all assigned NCQA Health Equity Accreditation (HEA) Standards and Guidelines and prepare for the HEA Initial Survey in June 2025, as measured by the four (4) deliverables listed.	**Deliverable #1:** Obtain a "yes" score on all assigned requirements during the HEA Mock Initial Survey. If gaps are identified, Business Owners will: • Submit a Corrective Action Plan (CAP) to address all applicable recommendations by September 20, 2024. • All revised evidence must be submitted to the NCQA Consultant for review and approval. • All evidence must be corrected by the date indicated on the CAP in accordance to NCQA's look-back period, timelines, and/or expectations. • Documented processes (policies and/or program descriptions) that require committee's approval must be edited and approved by the NCQA Consultant on or before September 23, 2024.	7/1/2024	9/27/2024	Title: Chief Medical Officer Name: Robert Moore, MD Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Compliance, Health Equity, Population Health, Quality Improvement, Human Resources, Provider Relations, Member Services Primary Contact: Title: Manager of Quality Performance and Accreditation Name: Sue Lee	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**	
11.a.				**Deliverable #2:** By October 25, 2024, Business Owners will update the annual HEA Workbook (Work Plan and Evidence Submission Library). • Review and/or update the HEA Work Plan information based on the 2024 HEA Standards and Guidelines (finalized by July 2024); collect attestations from newly identify key stakeholders and contributors if applicable. • Review and/or update the Evidence Submission Library based on the 2024 HEA Standards and Guidelines (finalized by July 2024) and recommendations from the HEA Mock Initial Survey. All evidence must be produced and dated based on the date(s) listed under the Evidence Submission Library. Any date changes or document revisions must be reviewed and agreed upon by the NCQA Program Management Team in collaboration with the NCQA Consultant. • Contributors identified from FY 23-24 should share their questions with Business Owners for further evaluation and discussion. Submissions of the HEA Workbook that do not follow the instructions are considered incomplete. The NCQA Program Management Team will request the Business Owner make corrections and resubmit, which may cause a delay in meeting the submission deadline. The NCQA Program Management Team will share the annual HEA Workbook by September 27, 2024.	9/27/2024	10/25/2024	Title: Chief Medical Officer Name: Robert Moore, MD Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Compliance, Health Equity, Population Health, Quality Improvement, Human Resources, Provider Relations, Member Services Primary Contact: Title: Manager of Quality Performance and Accreditation Name: Sue Lee	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated		
11.a.				**Deliverable #3:** All Business Owners must confirm and/or submit the following to meet the look-back period for each assigned standard: • Documented Processes: By October 25, 2024, provide acknowledgement that documented processes meet the scope of review throughout the look-back period. Any revisions that impact NCQA requirements must be finalized in November 2024, including timely review by the NCQA Consultant and approval at committee meetings. No edits should be made without review and/or assessment by the NCQA Consultant. • Materials: By November 15, 2024, submit all applicable screenshots as indicated under the Evidence Submission Library to demonstrate	7/1/2024	6/30/2025	Title: Chief Medical Officer Name: Robert Moore, MD Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Compliance, Health Equity, Population Health, Quality Improvement, Human Resources, Provider Relations, Member Services Primary Contact: Title: Manager of Quality Performance and Accreditation Name: Sue Lee	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated		
11.a.				**Deliverable #4:** By March 28, 2025, Business Owners will submit all annotated evidence for HEA Initial Survey based on the dates listed in the Evidence Submission Library and the submission guidelines provided by the NCQA Program Management Team.	2/3/2025	3/28/2025	Title: Chief Medical Officer Name: Robert Moore, MD Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Compliance, Health Equity, Population Health, Quality Improvement, Human Resources, Provider Relations, Member Services Primary Contact: Title: Manager of Quality Performance and Accreditation Name: Sue Lee	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated		
11.b.				**Deliverable #1:** All Business Owners must confirm and/or submit the following to meet the look-back period for each assigned standard: • Documented Processes: By July 25, 2024, provide acknowledgement that documented processes meet the scope of review throughout the look-back period. Any revisions that impact NCQA requirements must be finalized in August 2024, including timely review by the NCQA Consultant and approval at committee meetings. No edits should be made without review and/or assessment by the NCQA Consultant. • Materials: By August 8, 2024, submit all applicable screenshots as indicated under the Evidence Submission Library to demonstrate the compliance is met.	7/1/2024	8/8/2024	Title: Chief Medical Officer Name: Robert Moore, MD Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Behavioral Health, Compliance, Grievance & Appeals, Care Coordination, Population Health, Utilization Management, Pharmacy, Quality Improvement, Human Resources, Provider Relations, Member Services Primary Contact: Title: Manager of Quality Performance and Accreditation Name: Sue Lee	**July 1 - Dec 31** ☒ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated		
11.b.				**Deliverable #2:** By October 18, 2024, Business Owners will update the annual HPA Workbook (Work Plan and Evidence Submission Library) • Review and/or update the HPA Work Plan information based on the 2025 HPA Standards and Guidelines; collect attestations from newly identify key stakeholders and contributors if applicable. • Review and/or update the Evidence Submission Library based on the 2025 HPA Standards and Guidelines changes. All evidence must be produced and dated based on the date(s) listed under the Evidence Submission Library. Any date changes or document revisions must be reviewed and agreed upon by the NCQA Program Management Team in collaboration with the NCQA Consultant. • Contributors identified from FY 23-24 should share their questions with Business Owners for further evaluation and discussion. Submissions of the HPA Workbook that do not follow the instructions are considered incomplete. The NCQA Program Management Team will request the Business Owner make corrections and resubmit, which may cause a delay in meeting the submission deadline. The NCQA Program Management Team will share the annual HPA Workbook by September 20, 2024.	9/20/2024	10/18/2024	Title: Chief Medical Officer Name: Robert Moore, MD Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Behavioral Health, Compliance, Grievance & Appeals, Care Coordination, Population Health, Utilization Management, Pharmacy, Quality Improvement, Human Resources, Provider Relations, Member Services Primary Contact: Title: Manager of Quality Performance and Accreditation Name: Sue Lee	**July 1 - Dec 31** ☐ Complete ☐ On Track ☒ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated		
11.b.	[Compliance with NCQA HPA and Sustain Performance]	New	**Goal #1:** By June 30, 2025, departments will maintain compliance of all assigned NCQA Health Plan Accreditation (HPA) Standards and Guidelines, following the most up-to-date Standards and Guidelines once available, as measured by the five (5) deliverables listed.	**Deliverable #3**:Complete subset of analysis reports based on the approval dates outlined under the 2024-2026 HPA Report Schedule: • By October 18, 2024, submit edits to the 2024-2026 HPA Report Schedule, if applicable. This would include any changes relative to the reporting period of the data sources, when data sources will become available, and the targeted approval date of the analysis reports. • Submit the analysis reports based on the draft report date provided under the 2024-2026 HPA Report Schedule. All reports must be submitted to the NCQA Consultant for review. All edits must be incorporated in a timely manner prior to any committee review and/or approval, or by the production date as agreed upon under the 2024-2026 HPA Report Schedule	7/1/2024	6/30/2025	Title: Chief Medical Officer Name: Robert Moore, MD Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Behavioral Health, Compliance, Grievance & Appeals, Care Coordination, Population Health, Utilization Management, Pharmacy, Quality Improvement, Human Resources, Provider Relations, Member Services Primary Contact: Title: Manager of Quality Performance and Accreditation Name: Sue Lee	**July 1 - Dec 31** ☐ Complete ☐ On Track ☒ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**	
11.b.				**Deliverable #4**: Departments that oversee file review requirements will maintain strict oversight of Partnership and non-NCQA Accredited delegates' files to ensure compliance. The departments are Provider Relations, Utilization Management, Pharmacy, Grievance and Appeals, and Care Coordination. • By April 2025, participate in a Mock File Review with the NCQA Consultant. This review will include files from Partnership and non-NCQA Accredited delegates. Submit a detailed Corrective Action Plan (CAP) for files that do not score "yes" on each factor within 10 business days from the date of Mock File Review. ▪ The CAP will indicate detailed steps on how to improve file review performance. Business Owners must assess risks and propose a timeline in collaboration with the NCQA Program Management Team. Additional follow-up activities and subsequent monitoring may be required. ▪ At the discretion of the NCQA Steering Committee, ad hoc file review audits with the NCQA Consultant may follow before June 30.	7/1/2024	6/30/2025	Title: Chief Medical Officer Name: Robert Moore, MD Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Behavioral Health, Compliance, Grievance & Appeals, Care Coordination, Population Health, Utilization Management, Pharmacy, Quality Improvement, Human Resources, Provider Relations, Member Services Primary Contact: Title: Manager of Quality Performance and Accreditation Name: Sue Lee	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated		
11.b.				**Deliverable #5:** By June 20, 2025, Business Owners will submit all annotated evidence for the Mock Renewal Survey based on the dates listed in the Evidence Submission Library for Year 1 of the look-back period, and the submission guidelines provided by the NCQA Program Management Team.	5/5/2025	6/20/2025	Title: Chief Medical Officer Name: Robert Moore, MD Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Behavioral Health, Compliance, Grievance & Appeals, Care Coordination, Population Health, Utilization Management, Pharmacy, Quality Improvement, Human Resources, Provider Relations, Member Services Primary Contact: Title: Manager of Quality Performance and Accreditation Name: Sue Lee	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☒ Terminated		
	12. Contracting											
	13. Population Health Management: See Partnership's 2020 Population Health Work Plan											

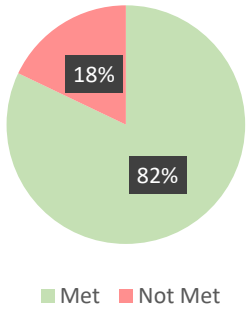
2024-25 Quality Improvement Work Plan												Deliverable Complete On Track Delayed Terminated
Item #	**Project/Program**	**Type of Goal**	**Goal**	**Deliverables**	**Start Date**	**Due Date**	**Sponsor**	**Business Owner**	**Deliverable Evaluation Status**		**Goal Met (Yes No)**	
	14. Grand Analysis											
14.a.	Grand Analysis - Member Experience (ME7) Report	Continued	**Goal #1:** By August 31, 2025, complete the annual Member Experience Grand Analysis (ME7) report. (Note, the ME 7 report is dependent on CAHPS® data results, which are managed by an external vendor (Press Ganey) and not available until after the goal period ends).	**Deliverable #1:** By August 31, 2025, complete the Member Experience Grand Analysis Report (ME7).	6/1/2025	8/31/2025	Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen Title: Director of Quality Management Name: Isaac Brown	Title: Project Manager II Name: Anthony Sackett	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**	
14.a.	Grand Analysis - Pharmacy and Utilization Management (UM1B) Report	Continued	**Goal #1:** By June 30, 2025, complete annual Pharmacy & Utilization Management Grand Analysis (UM1B) report per NCQA Health Plan Accreditation standards.	**Deliverable #1:** Complete 2024 UM1B report.	7/1/2024	6/30/2025	Title: Chief Health Services Officer Name: Katherine Barresi	Title: Clinical Pharmacist Name: Andrea Ocampo Title: Associate Director of UM Regulations Name: Tony Hightower	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**	
14.a.	Grand Analysis - Continuity and Coordination of Medical Care (QI3) Report	Continued	**Goal #1:** By June 30, 2025, Quality Improvement will complete as much as possible of the annual Continuity and Coordination of Medical Care Grand Analysis (QI3) report, given the complete data sets that are available. (The delay for full document completion past June 30, 2025 is required to allow appropriate analysis of all of the	**Deliverable #1:** Complete those sections of the Continuity and Coordination of Medical Care Annual Grand Analysis Report (QI3) for which all needed data is available, including a quantitative and qualitative analysis by June 30, 2025.	7/1/2024	6/30/2025	Title: Senior Director of Quality and Performance Improvement Name: Nancy Steffen	Title: Improvement Advisor Name: Emily Wellander Title: Medical Director for Quality Name: Mark Netherda	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☒ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☒ Terminated	**No**	
14.a.	Grand Analysis - Continuity and Coordination of Behavioral Health (QI4) Report	Continued	**Goal #1:** By June 30, 2025, Behavioral Health will complete the annual Continuity and Coordination of Behavioral Health Grand Analysis (QI4).	**Deliverable #1:** Complete- QI4 Grand Analysis as measured by completion of report, review and approval by NCQA consultant, and presentation at IQI and QUAC.	9/1/2024	6/30/2025	Title: Chief Health Services Officer Name: Katherine Barresi	Title: Behavioral Health Administrator Name: Mark Bontrager	**July 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☒ Terminated	**Jan 1 - June 30** ☐ Complete ☐ Delayed ☒ Terminated	**No**	
14.a.	Grand Analysis - Access and Availability (NET3) Report	Continued	**Goal #1:** By June 30, 2025, the 2024 NET 3 Report will be complete.	**Deliverable #1:** Complete the NET 3 Report	7/1/2024	6/1/2025	Title: Associate Director of Provider Relations Compliance Name: Priscila Ayala	Title: Manager of Provider Relations Compliance Name: Renee Trosky	**July 1 - Dec 31** ☐ Complete ☒ On Track ☐ Delayed ☐ Terminated	**Jan 1 - June 30** ☒ Complete ☐ Delayed ☐ Terminated	**Yes**	

QI TRILOGY PROGRAM

Background: The QI Work Plan is designed to track progress on key QI activities and initiatives throughout the year. Approved by our Board of Directors and quality committees, it includes progress updates on planned activities and objectives for improving quality of clinical care, safety of clinical care, quality of service and members' experience. The Work Plan is set on a fiscal year (FY) 2024-2025 schedule. This update includes progress on activities included in the FY 2024-2025 QI Work Plan from July 1, 2024 to June 30, 2025.

Results: Of the 67 goals outlined in the QI Work Plan, 55 are "Met"; 12 are "Not Met".

Goal Status July 1, 2024 – June 30, 2025		
Status	**Total Number:**	**%**
Met	55	82.09%
Not Met	12	17.91%



QI Major Milestones and Activities:

- The Dual Eligible Special Needs Plan (D-SNP) Strategy Work Group was formed and met with representatives from across the organization. All Medicare D-SNP measures were reviewed including those in Part C, Part D and Display measures, along with DHCS D-SNP measures for which Partnership will be accountable. Each measure was reviewed to identify measure ownership, data collection and intervention/actions. This information was documented for all measures across the organization. The shared document is available will be used for other projects to identify business needs by department.
- A new Primary Care Provider (PCP) Incentive Program for organizations contracting to serve Partnership Advantage members has been developed and gained executive approval. The approved proposal included program goals and principles, member

and provider eligibility criteria, the measure set, scoring methodology, and payment mechanisms.

- External vendors and internal IT resource capacity were both explored to identify a system solution for performance tracking of the Dual Eligible Special Needs Plan (D-SNP) PCP QIP program. After opting to buy versus build, several external vendors were considered through detailed responses to Partnership's Request for proposal (RFP). A vendor with experience delivering provider-based measure performance solutions was identified as the preferred option and recommended to Partnership's Project Review Board (PRB) in May 2025. The recommendation was accepted and contracting is underway at the close of 24-25.
- A CAHPS D-SNP programmatic work plan and timeline have been developed with framework informed by research into survey methodologies and conversation with other local health plans in California. Ongoing coordination with the identified survey vendor and CAHPS team will help further implementation planning.
- A detailed review of D-SNP requirements was completed by the Member Safety Quality Investigation team. No changes are needed to Partnership's current Peer Review Committee (PRC) policy or to the current Potential Quality Investigation (PQI) process to accommodate D-SNP.
- The Member Safety Quality Investigation team completed UAT testing and upgraded its PQI process tool to Sugar, Version 14. This tool is used to maintain PQI cases end-to-end through the process and for storage.
- The Member Safety Inspections Team piloted a "Quality Management Overview" document that is completed prior to each scheduled site review. Each Overview details recent QI interactions, status check on sites, and updates on HEDIS, QIP, and Performance Improvement programs and initiatives. These details are reviewed with the site's staff during the completion of the Medical Record Review (MRR). Post review surveys of Site Review nurses revealed mixed feedback. Most nurses found sharing this additional quality information beneficial to conducting the site review. A few warm hand offs to the PI and QIP teams also resulted.
- The Inspections Team developed provider training materials to reflect Child Health and Disability Program (CHDP) requirements. The delivery of these training materials is now the responsibility of managed care plans. Training topics include: vision, hearing, fluoride varnish application, anthropometric screenings and information on vaccines for children (VFC). These materials have been distributed to the provider network with issuance of certificates upon staff completion.
- Pharmacy conducted concurrent review of Latent Tuberculosis Infection (LTBI) medication treatments and provided timely provider notification to all identified potential LTBI treatment regimen gaps, which results from late refill, non-adherence, inappropriate prescribing, and/or inappropriate dispensing.
- The Primary Care Provider Quality Incentive Program (PCP QIP) reviewed its existing Data Validation framework to identify areas for improvement, based on

learnings over the past year. The team added a dedicated Non-Clinical Measure Preliminary Period for providers to review and validate their final data before Partnership completes scoring and payment. The team also detailed steps key in the existing eReports clinical validation period and updated the process for verifying HIE connections by provider organization. A designated QIP Workgroup developed provider education materials to inform and influence Member Experience improvement activities. The MY2025 specifications now include a URL resource link within the Patient Experience Unit of Service measure description.

- The Quality Measure Score Improvement (QMSI) initiative successfully engaged five measure-specific workgroups. Each workgroup monitored and reviewed measure performance, as data was available, identified and completed score improvement activities for all stated deliverables by the end of the fiscal year. Highlights include:

  1. Pediatrics
     - Expanded promotion of Healthy Babies Growing Together Program to include Partnership's Provider Network and specific messaging on an expanded $100 member incentive offering for timely completion of childhood immunizations required by HEDIS measure, CIS-10
     - Launched a new Human Papillomavirus (HPV) 2nd Dose Reminder Program Pilot to affect HEDIS immunization measure performance under IMA-2
     - Launched a new provider educational webinar on Developmental Screening in the First Three Years of Life (DEV) in preparation for more focused DEV measure improvement work in the provider network
     - Extended the PCP QIP Unit of Service (UOS) group well care visits' measure to include members eligible under either the Well Child Visits in the First 15 Months (W15) or Well Child Visits for ages 15-30 months (W30) measure
     - Conducted Topical Fluoride for Children (TFL-CH) data investigation to identify and better address known data source gaps in related MCAS measure reporting
     - Completed a Child and Adolescent Well Care Visits (WCV) Disparity Sprint Campaign focused on improving well child visit completion in 4Q 2024 among disparate populations identified by DHCS from MY2022 MCAS Annual HEDIS reporting.
     - Continued work on the DHCS-mandated Performance Improvement Project (PIP) to improve W15 completion rates in African American members in Solano County, while looking for spread opportunities in other areas of Partnership's service region.

  2. Behavioral Health
     - As part of the DHCS-mandated Non-Clinical PIP, implemented a pilot to track and improve the follow up care for patients with mental health (FUM) and substance abuse disorder (FUA) after emergency department (ED) discharge aiming to increase the percentage of PCP notifications for a provider partner's assigned members.

- Executed the DHCS-mandated IHI Behavioral Health Collaborative Project in partnership with Nevada County
- Engaged County Departments of Behavioral Health (DBH) to utilize Sac Valley Med Share Data Exchange for follow-up after mental illness (FUM) data
- Facilitated collaboration amongst several departments, including: Behavior Health, Care Coordination, Population Health, Pharmacy, Health Equity's Tribal Health Liaison, and Quality Improvement. This collaborative group monitored and evaluated interventions aiming to improve FUM and FUA measures scores.
- Increased embedded Community Health Workers (CHWs) in hospital Emergency Departments

3. Management of Chronic Diseases
   - Monitored, evaluated, and improved the use of the Diabetes management program offered by TeleMed2U
   - Implemented a pilot of a comprehensive, service-intensive diabetes management program with Gojii
   - Brought the blood pressure control strategies into alignment with best practices of at least one primary care practice
   - Implemented a retinal eye exam grant to support providers in improving the rate of diabetic members receiving an annual retinal eye exam
   - Implemented improvements to the Cologuard bulk ordering program to better serve a broader group of Primary Care providers
4. Women's Health
   - Facilitated integration of cervical cancer screening HPV Self Swab across our network to affect the corresponding measure (CCS) rate
   - Identified 3 practices in counties with Chlamydia Screening in Women (CHL) rates below the minimum performance level (MPL) and conducted 1 on 1 provider education
   - Promoted incentives for "Increasing Screening Mammogram Capacity" in the Hospital Quality Incentive Program (H-QIP)
   - Elevated promotion of the Growing Together Program's increased incentive to impact postpartum rates
   - Identified counties with race/ethnicity disparities for post-partum visits and supported connection to Enhanced Care Management (ECM) Birth Equity (BE) providers to support members accessing post-partum care
5. Elder Care
   - Identified all D-SNP measures which fall within the QMSI workgroups by work group domain for further focus in D-SNP implementation planning.

- The Performance Improvement (PI) team collaborated with the far northern consortia to bring QI awareness and education to providers serving members in Partnership's Redding and Eureka Regions through several activities and forums.

- Four (4) new Eastern region providers were added to the Joint Leadership Initiative (JLI) series.
- Improvement Academy offered six (6) virtual trainings in 2025 highlighting priority MCAS measures including Pediatric Preventative Care for Ages 0 - 30 Months, Pediatric Preventative Care for Ages 3 - 17 years, Chronic Disease and Colorectal Cancer Screening, Perinatal Care and Chlamydia Screening, Breast and Cervical Cancer Screenings, and Diabetes Control. Improving Member Outcomes webinar attendance ranged from 53 to 90 attendees, with each session representing 28 to 45 unique organizations. Of attendees who completed the post-session evaluations for all six webinars, 99% selected “strongly agree” or “agree” when asked if the webinar was relevant and useful.
- Improvement Academy hosted three (3) ABCs of Quality Improvement in-person trainings with 100% of survey respondents, representing 37 unique provider organizations, reporting being extremely satisfied/satisfied with this course.
- The Healthy Kids Growing Together Program conducted two (2) cohorts focused on contacting any 3 -6 year old who has never had a well-child visit in a set timeframe and offered an incentive to complete a well-child visit within 90 days prior to their 4th, 5th, and 6th birthday. Over 2600 children participated and received member incentives.
- The Primary Care Provider Quality Incentive Program (PCP) QIP Breast Cancer 50th percentile benchmark has been met in the legacy Southeast, Southwest, and Northeast regions. This improvement was largely influenced by 77 Mobile Mammography event days, resulting in 2,162 completed breast cancer screenings.
    - 15 Mobile Mammography event days were held at Tribal Health Centers.
    - 14 Mobile Mammography event days were held at Enhanced Provider Engagement (EPE) provider organizations.

FY24/25 Final Goal Status: Delayed/Terminated

Project or Program	Goal	Status Details	Next Steps
2.g. Partnership Quality Dashboard (PQD)	**Goal #1**: By June 30, 2025, apply annual development updates of the MY2025 HEDIS® Monthly Exploratory Dashboard in accordance with identified stakeholder needs (Contingent on HRP® implementation).	Delayed	Delay due to revised HRP® launch date. Deliverable 4 will be completed in CY Q3 of 2025.

Project or Program	Goal	Status Details	Next Steps
	Goal #2: By June 30, 2025, apply annual development updates of the PCP QIP Provider and Internal View Dashboards in accordance with identified stakeholder needs.		Delay due to revised HRP® launch date. Deliverables 4-5 will be completed following the implementation of HRP®.
2.h. Enterprise Information Management	**Goal #1:** By December 31, 2024, integrate the HRP® version of the HEDIS® monthly project data into the Enterprise Data Warehouse and use this data to create the HRP® version of the HEDIS® PQD modules.	Delayed	Delay due to revised HRP® launch date. Deliverable 3 will be completed following the implementation of HRP®.
3.c. Palliative Care Quality Incentive Program (PC QIP)	**Goal #2:** By June 30, 2025, complete CY 2024 PC QIP evaluation.	Delayed	Payment processing for the Palliative Care QIP 2024 measure period II (July-December) did not begin until March 2025.This goal is on track to be completed, but not until July 2025.
3.e. Enhanced Care Management Quality Incentive Program (ECM QIP)	**Goal #2:** By December 31, 2024, complete CY 2023 ECM QIP evaluation.	Delayed	Due to this program only offering one measure from its inception spanning from 4th quarter CY 2022 to 4th quarter CY 2023, an evaluation of CY 2025 will be completed to provide a robust evaluation of the

Project or Program	Goal	Status Details	Next Steps
			present program's five measures with year over year performance trend analysis. This goal is scheduled to be completed during the 2025-2026 QI Work Plan.
4.b. Missed Opportunities and Member Engagement	**Goal #1:** By June 30, 2025 Incorporate missed opportunity data and feedback from the 23/24 goal and include in the member engagement dashboard currently in development and publish externally for providers to use.	Delayed	Delay due to revised HRP® launch date. Deliverables 2 and 3 will be completed following the implementation of HRP®.
5.b. Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Dual Eligible Special Needs Plan (D-SNP)	**Goal #1:** By June 30, 2025, select and contract with a Medicare Dual Eligible Special Needs Plan (D-SNP) Consumer Assessment of Healthcare Providers and Systems (CAHPS®) CMS-approved vendor.	Terminated	A survey vendor has been identified. However, it was determined that contracting with a survey vendor is not required during this fiscal year (24-25) and will be addressed at a later date if or when the need arises.
8.d. Provider Coaching and Engagement	**Goal #2:** By June 30, 2025, the Performance Improvement teams will engage with practices in the 10 incoming counties joining Partnership in 2024. We will engage	Delayed	Due to heightened organization sensitivity to requesting too many meetings with our contracted providers, the Chico regional meeting has been rescheduled to July 2025. Deliverable 2 will

Project or Program	Goal	Status Details	Next Steps
	with practices holding 70% of assigned membership for incoming counties around PCP QIP performance.		be completed during the 25-26 QI Work Plan.
8.e. Expansion of Regional Quality Meetings	**Goal #1:** By June 30, 2025, Partnership will implement regional quality meetings in all six (6) operational regions to offer forums for regional dialogue to address quality improvement opportunities or barriers.	Delayed	Redding, Fairfield, and Eureka regional meetings continue. Santa Rosa, Chico, and Auburn regional offices are currently in planning for Quarterly Quality meetings. Deliverable 2 on track to be completed by end of CY 2025.
14.a. Grand Analysis - Continuity and Coordination of Medical Care (QI3) Report	**Goal #1:** By June 30, 2025, Quality Improvement will complete as much as possible of the annual Continuity and Coordination of Medical Care Grand Analysis (QI3) report, given the complete data sets that are available. (The delay for full document completion past June 30, 2025 is required to allow appropriate analysis of all of the data required for the report, some of which is not anticipated to be available for review by June 30th.)	Terminated	Grand Analysis - Continuity and Coordination of Medical Care (QI3) Report is retired under 2025 HPA standards.
14.a.	**Goal #1:** By June 30, 2025, Behavioral	Terminated	Grand Analysis - Continuity and

Project or Program	Goal	Status Details	Next Steps
Grand Analysis - Continuity and Coordination of Behavioral Health (QI4) Report	Health will complete the annual Continuity and Coordination of Behavioral Health Grand Analysis (QI4).		Coordination of Behavioral Health (QI4) Report is retired under 2025 HPA Standards.

Grievance & Appeals Department Annual Report

CY 2024

June 2025

Kory Watkins, MBA-HM

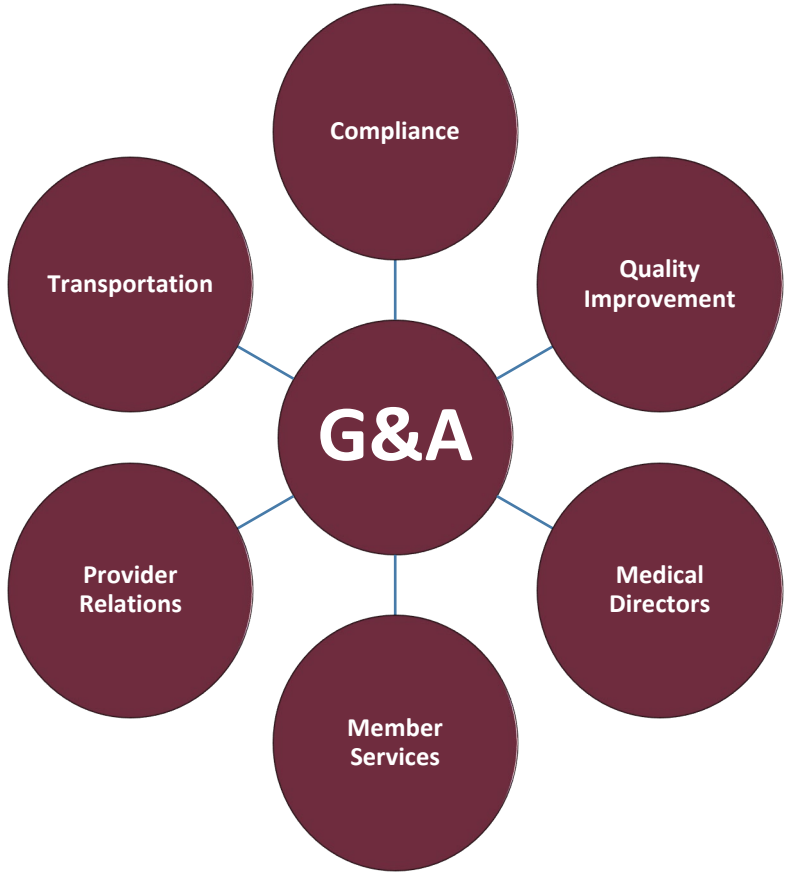
Director, Grievance & Appeals

Agenda

- Department Overview
- Case Volume and Trends
- Case Intake and Classification
- Member Demographics
- Grievance Trends and Categories
- Civil Rights Allegations
- Appeals and Outcomes
- Performance Metrics
- Challenges and 2025 Goals

Department Overview

The Grievance & Appeals (G&A) department ensures that members concerns are heard, addressed, and resolved in alignment with regulatory standards and health plan policies. We manage member grievances and appeals with a focus on timeliness, fairness, and improving the overall member experience.

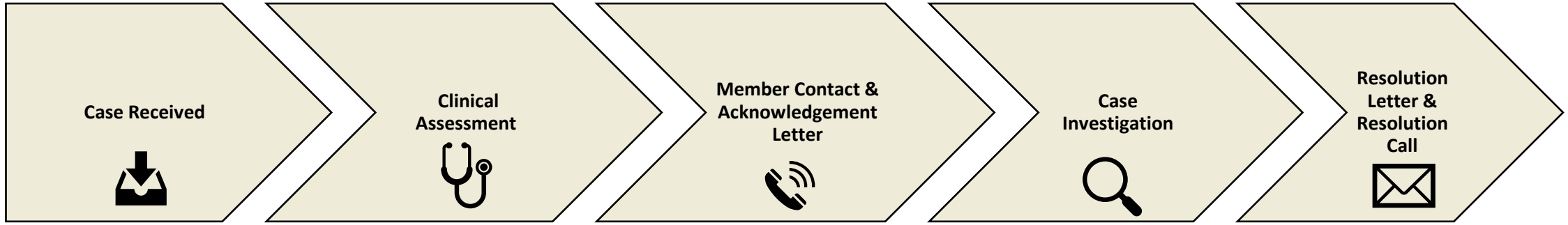


Interdepartmental Collaboration

- **Collaboration with the Quality Improvement Department** – G&A works closely with the Medical Director for Quality, who reviews all clinical grievances flagged by nurses for potential quality issues (PQI). The Medical Director determines whether each case should be referred to the PQI process. Additionally, quarterly interrater reliability reviews (IRR) are conducted to assess the appropriateness of cases not referred. In 2024, 207 grievances were referred to the quality department for PQI review.

- **Collaboration with the Transportation Department** – In 2024, we partnered with the transportation department to enhance our grievance process by capturing the names of individual drivers involved in transportation-related concerns. Previously, only the transportation company was identified. This change allows for more precise data analysis and better identification of driver specific trends.

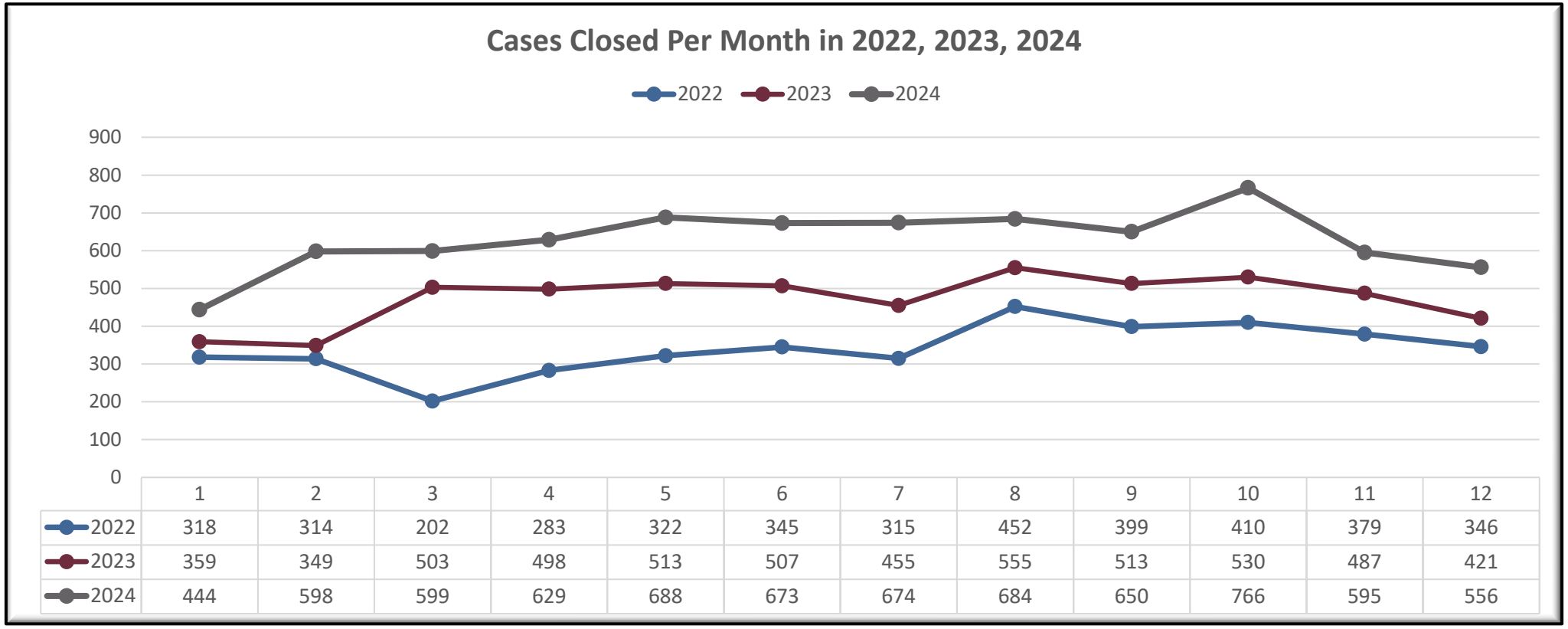
Overview of Process



Case Types We Process:

- **Standard Grievances -** Member complaints about dissatisfaction with services, care, or experiences
- **Exempt Grievances -** Member concerns that are resolved quickly without the formal grievance process
- **Appeals -** Member disagreement with a denied service or treatment
- **State Fair Hearings -** Formal requests for a hearing before an administrative law judge regarding a denied service

Annual Case Volume – 3 Year Comparison



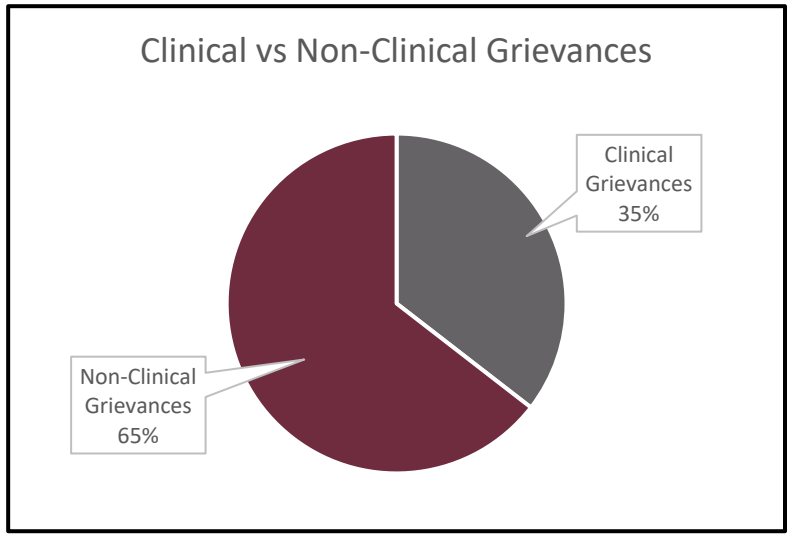
	1	2	3	4	5	6	7	8	9	10	11	12
2022	318	314	202	283	322	345	315	452	399	410	379	346
2023	359	349	503	498	513	507	455	555	513	530	487	421
2024	444	598	599	629	688	673	674	684	650	766	595	556

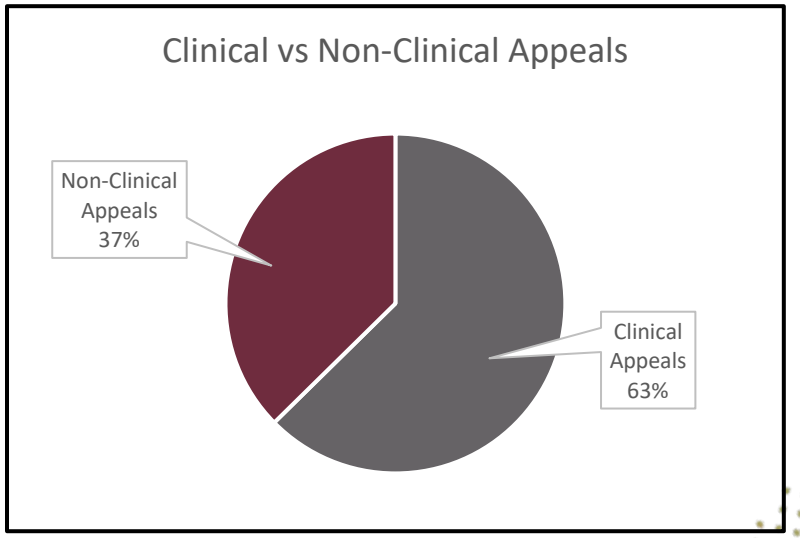
Annual Cases Closed/Cases per 1,000 Members:
2024 – 7,556/8.34
2023 – 5,690/8.39
2022 – 4,085/6.40

Case Intake and Classification

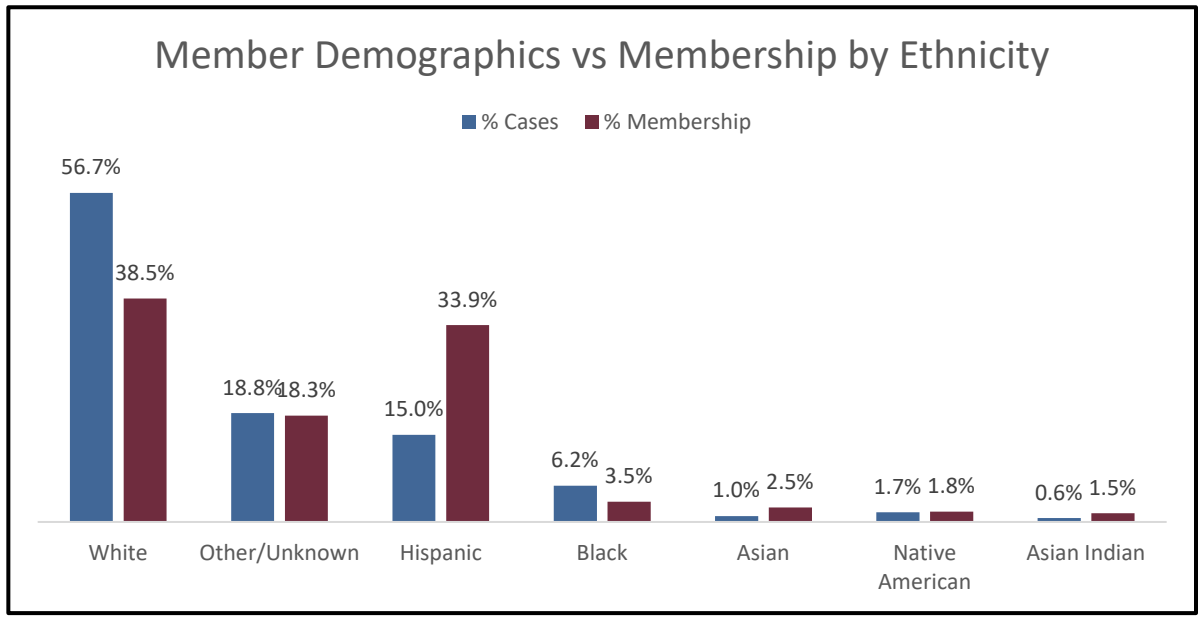
How Cases Were Received		
Phone	6843	91%
Online/Email	509	7%
Mail	129	2%
Fax	65	1%
In-Person	7	0.1%

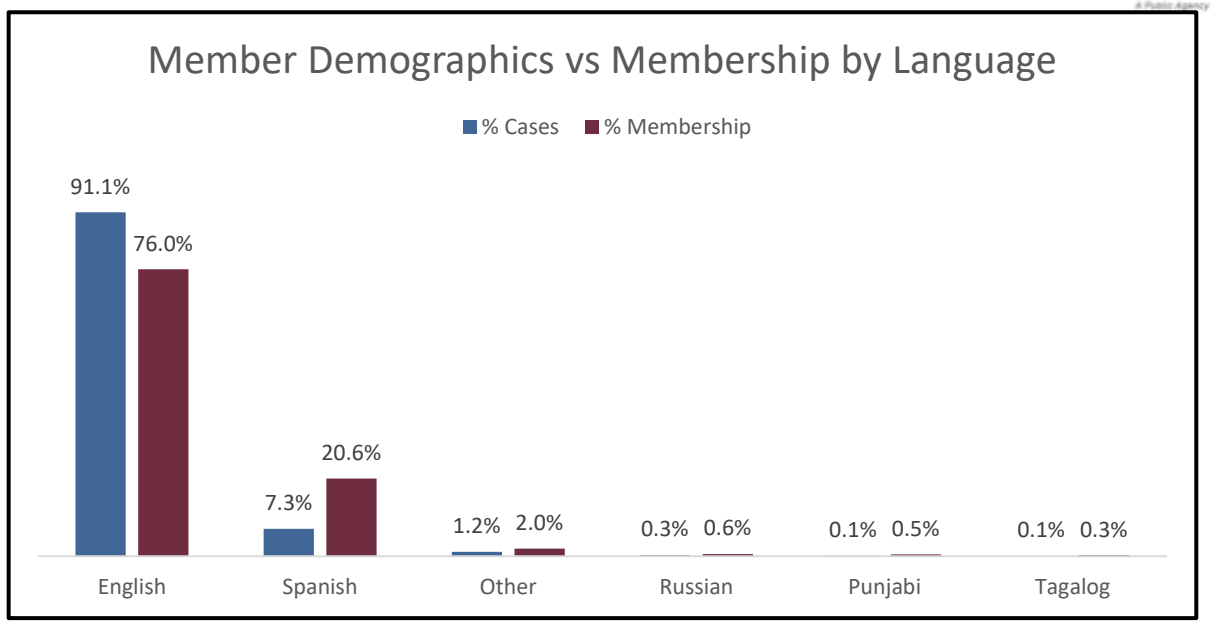
213 cases were requested to be expedited, but only 28 met the criteria

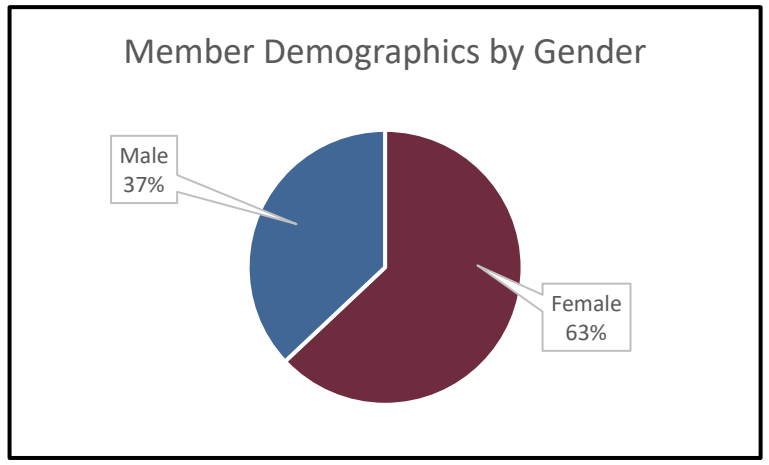


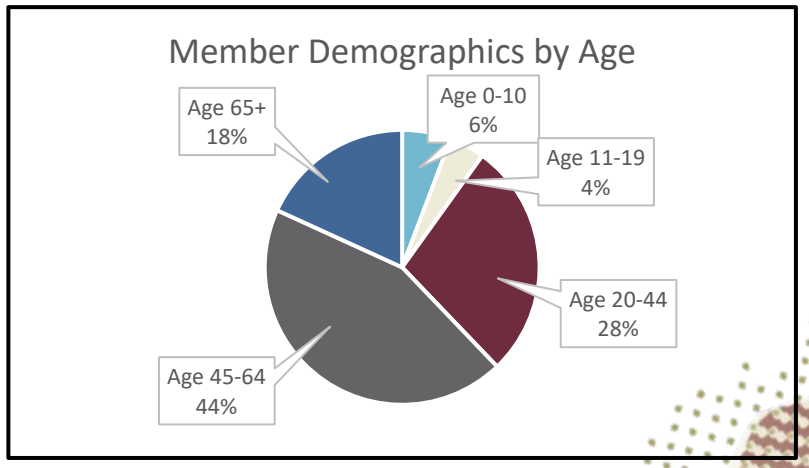


Member Demographics





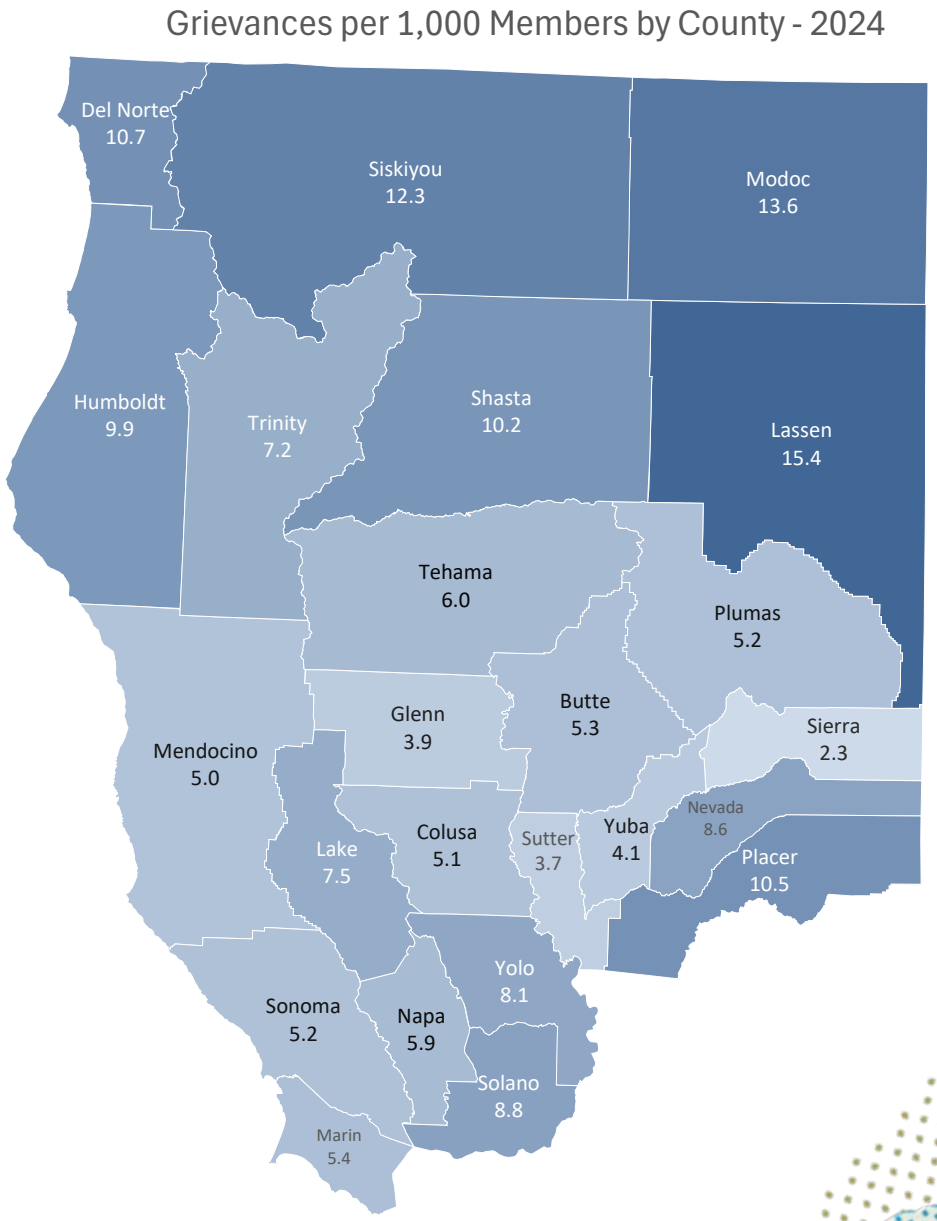




Where Members File Grievances

Top 3 Counties by Grievances Per 1,000 members:

- Lassen – 15.4
- Modoc – 13.6
- Siskiyou – 12.3



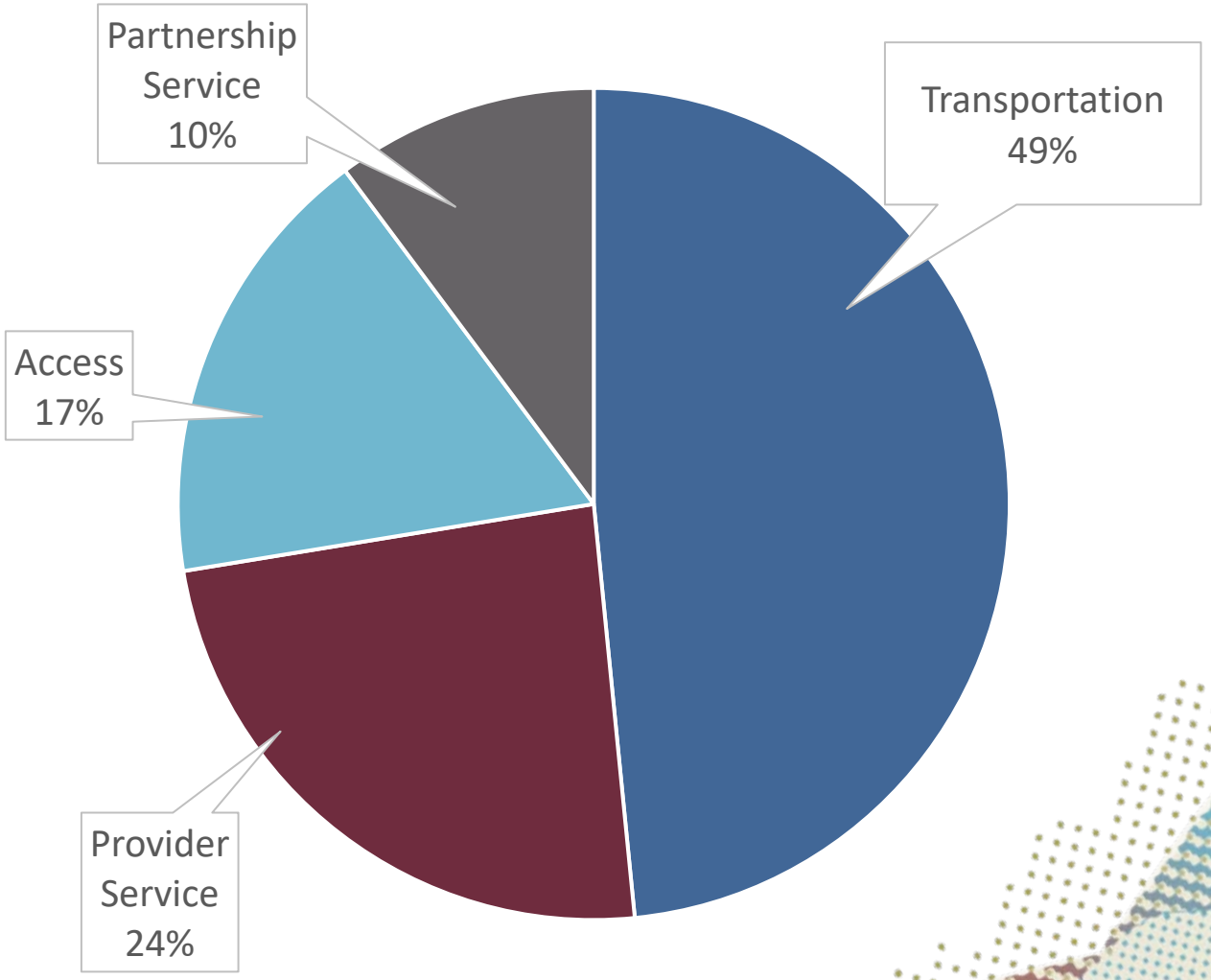
Top Grievance Concerns by Category

Transportation* – includes missed rides, driver arriving late, driver behavior, scheduling issues, and vehicle conditions

Provider Service – includes treatment plan disputes, communication issues, poor attitude, office conditions, and allegations of misconduct

Access – includes long wait times to be seen, delayed referrals/authorizations, and lack of provider availability

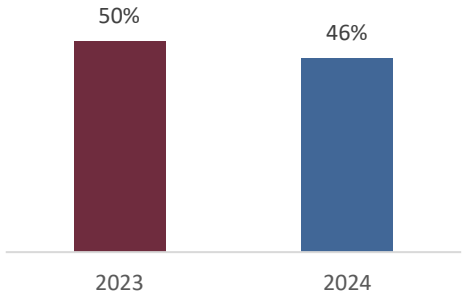
Partnership Service – includes staff complaints, advise nurse line, escalation process, website, phone system, and member mailings



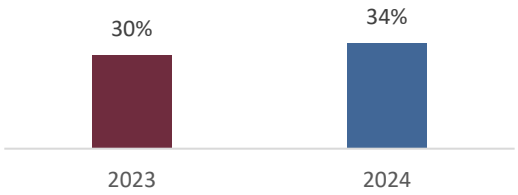
* Partnership provided 1,166,701 rides in 2024 and received 4,472 transportation related concerns – representing less than 0.4% of total rides (down from 0.6% in 2023)

Breakdown of Service-Related Grievances (Excluding Transportation)

Provider Services (46%) ↓
- Treatment Plan Disputes (39%)
- Communication (29%)
- Poor Attitude (29%)



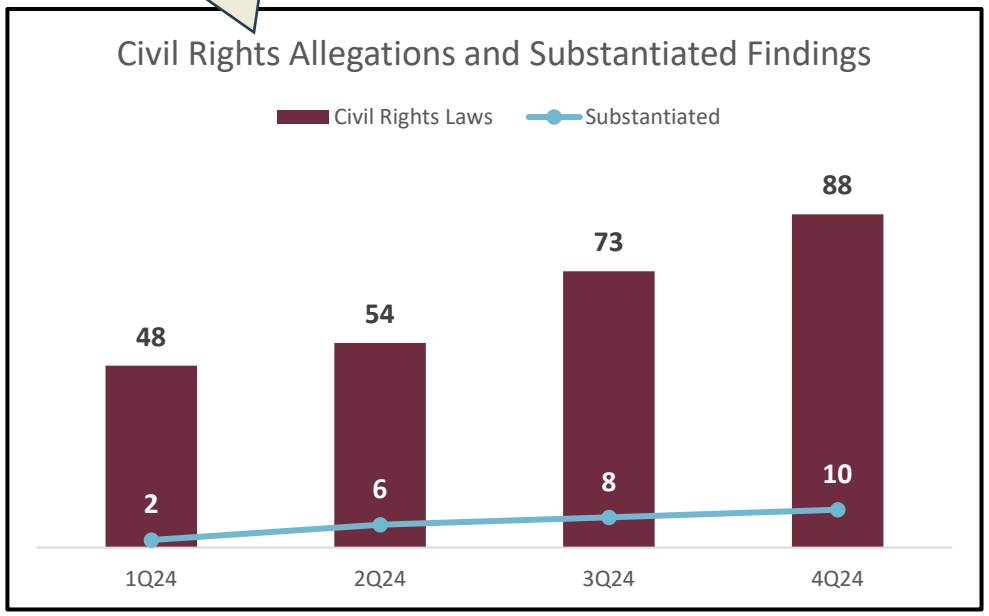
Access Issues (34%) ↑
- Long Wait Time for Appointments (37%)
- Provider Refusal of Care (13%)
- Provider Network Adequacy (13%)



Partnership Services (20%)

Discrimination Allegations - Civil Rights Focus

Only 10% of civil rights allegations were substantiated in 2024, down from 22% in 2023



Type of Civil Rights Concern	Total Concerns Reported
Disability	89
Race or Ethnicity	72
Language Assistance Services	26
Limited English Skills	22
Gender	16
Age	15
Sexual Orientation	7
Auxiliary Aids and Services	5
Religion	5
Nationality	2
Basis of Sex	1
Character Associations	1
Gender Identity	1
Sex Stereotypes	1
Total	**263**

Note: Members May allege discrimination for many reasons. This slide only reflects allegations that fall under federally protected civil rights laws

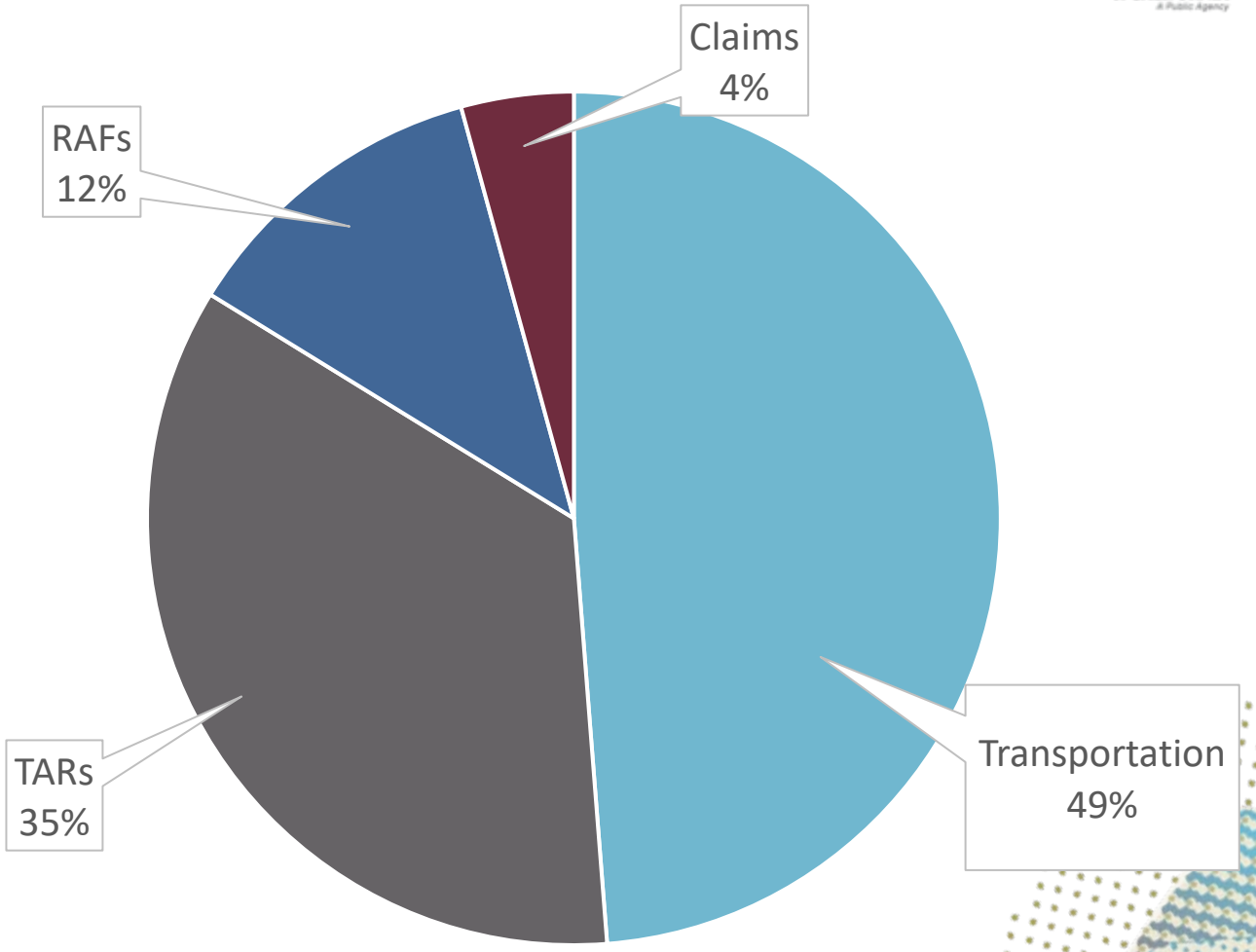
Top Appeals by Category

Transportation – includes meals, lodging, rides, and gas mileage reimbursement

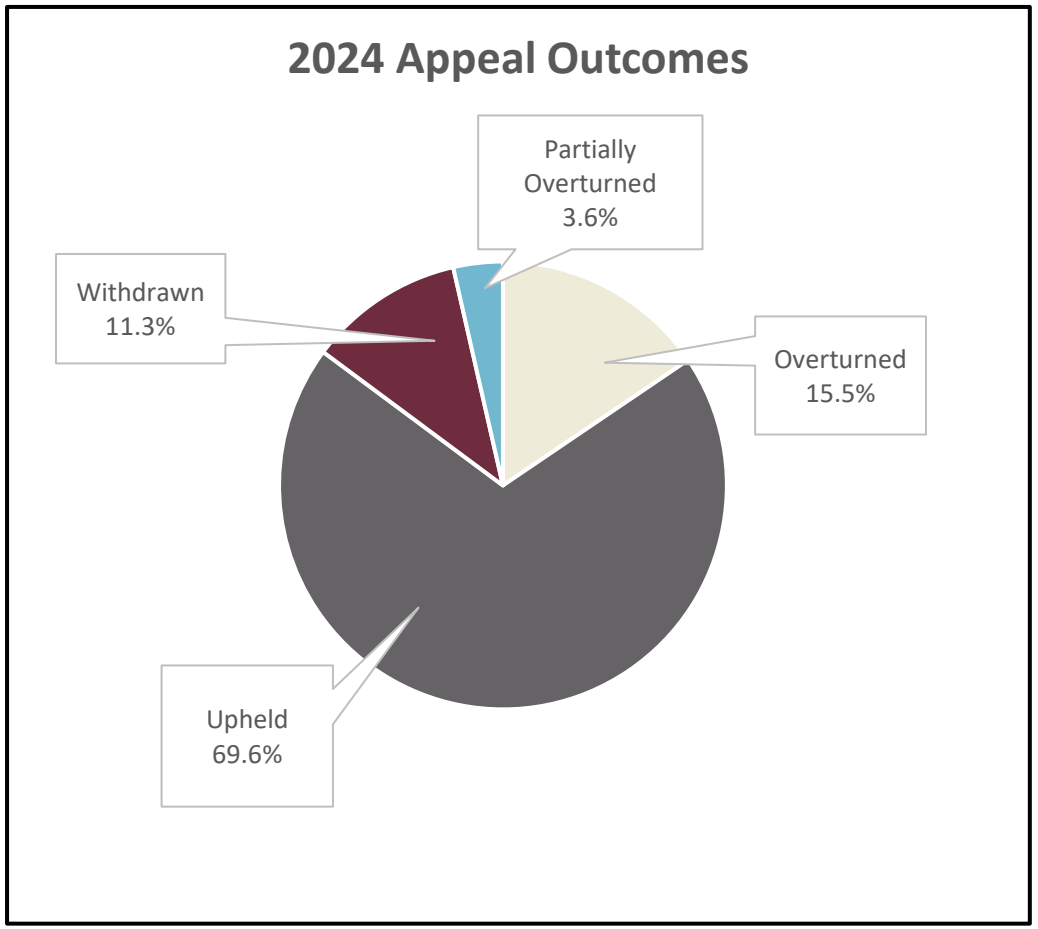
Treatment Authorization Request (TARs) – includes DME, surgery, diagnostic testing, and ancillary services

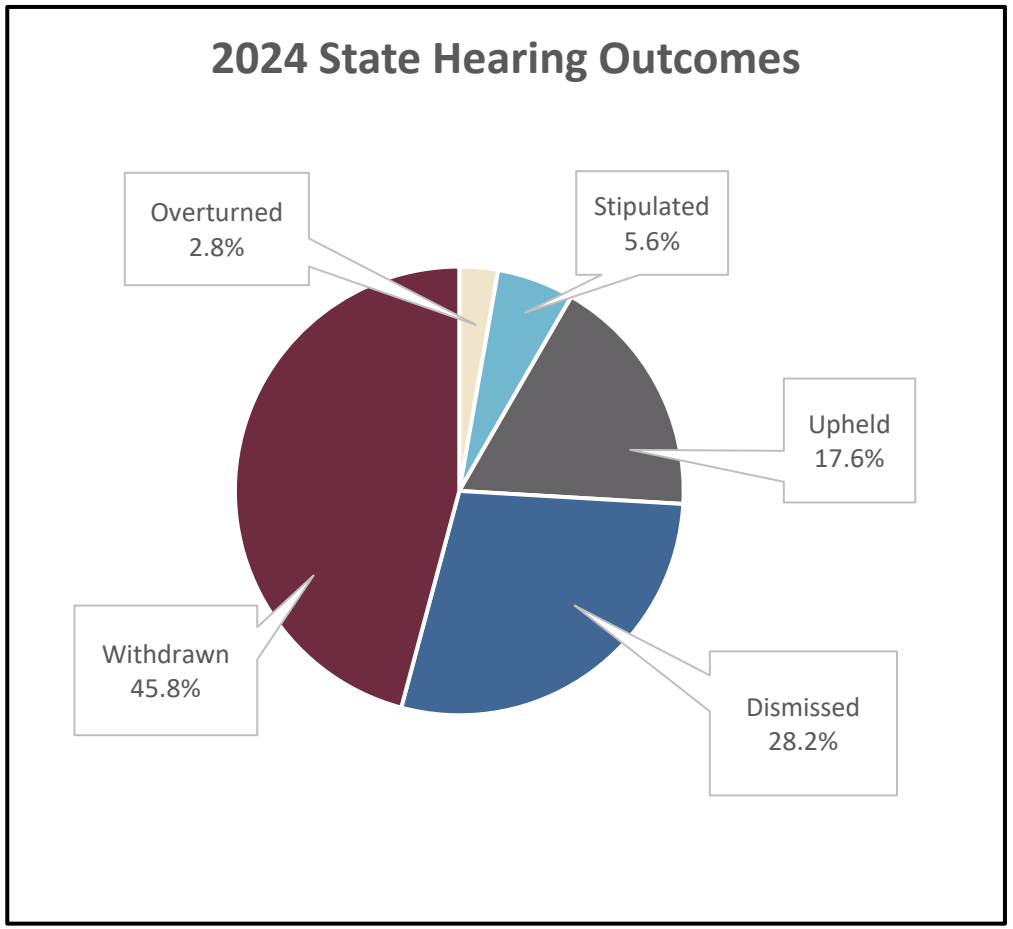
Referral Authorization Forms (RAFs) – includes out-of-network requests

Claims – includes requests for reimbursement of services paid out of pocket



Outcomes and Dispositions





2024 Department Performance

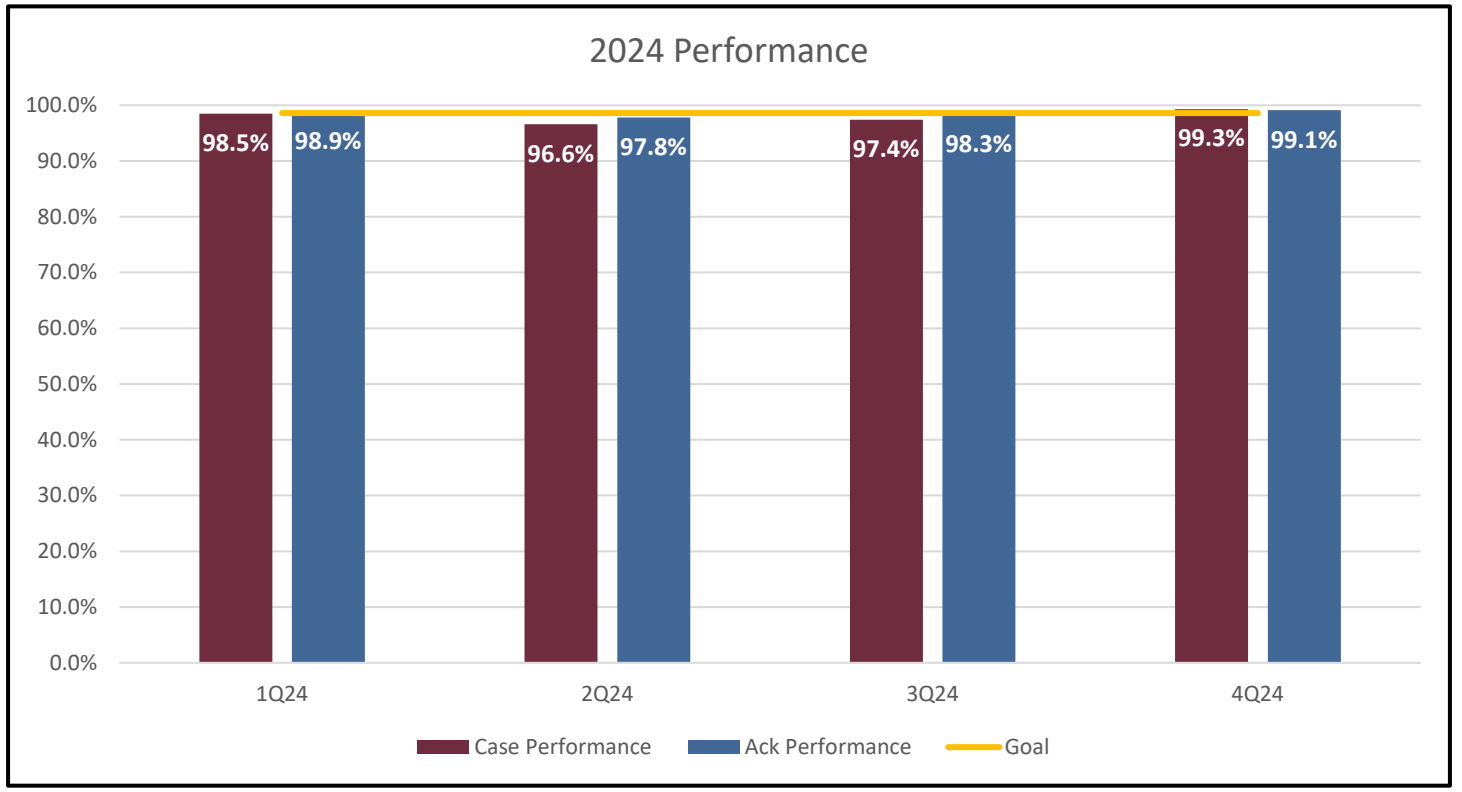
Performance Goals

Case Closure

- Expedited Cases – Investigate 98.6% of cases within 72 hours
- Standard Cases – Investigate 98.6% of cases within 30 days

Acknowledgment Letters

- Letters sent on or before the fifth calendar day after case received



Challenges and Lessons Learned

Challenge	Lesson Learned
Timeliness Goals Were Not Met Across the Year • Due to increased caseloads and limited staffing capacity, the department struggled to consistently meet the 30-day resolution timeline.	• Lack of accountability metrics made it difficult to manage timeliness performance. • **Action Taken**: Implemented new metrics to monitor staff performance and flag cases approaching noncompliance.

Delays Caused by Awaiting External Documentation
• Cases frequently exceeded the timeframe due to outstanding medical records or provider responses.
	• Needed a stronger review process to validate whether delays were clinically justified.
	• Action Taken: Developed a multi-step nurse review protocol:
	  • When one nurse determines documentation is essential, a second nurse confirms or disagrees.
	  • If disagreement, the case is escalated to a Medical Director for final decision
	• This process ensures only necessary cases are pended and improves oversight on delayed resolutions.

Voice of the Member

"Deija has worked with me on a few discrimination cases. She is always very kind, helpful and knowledgeable whenever I have any questions."

"I had an appeal with you [Amanda], that you fought hard on my behalf and the denial was successfully overturned. I had the surgery, and it changed my life. Thank you so much because you were a key person to make this all happen. I really appreciate you and want to offer you a very sincere thank you."

"We had a hearing this morning with Robert. He was so collaborative and supportive and went over and beyond to give me information and help me navigate some systems an alternatives. It is nice to run across people within the system who are so compassionate and supportive."

Goals and Focus Areas for 2025

- **Jiva Implementation** – Launching a new case management platform in Q3 to enhance case tracking, oversight, and reporting.
- **Behavioral Health Transition** – Transitioning mental health and substance use disorder related grievances in-house in Q3 as we end delegation with Carelon.
- **Operational Growth** – Continuing to grow operational staffing while expanding focus on quality assurance and data reporting.
- **Partnership Advantage Prep** – Preparing for January 2026 launch of the new D-SNP line of business with new processes, policies, and CMS reporting requirements.

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Questions?