PARTNERSHIP HEALTHPLAN OF CALIFORNIA
QUALITY/UTILIZATION ADVISORY COMMITTEE MEETING NOTICE

FROM: Leslie Erickson, Program Coordinator II, Quality & Performance Improvement (QI)
DATE: May 15, 2026
SUBJECT: Quality/Utilization Advisory Committee (Q/UAC) Meeting

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

Meeting Time/Date: 7:30 – 9:00 a.m., Wednesday, May 20, 2026
Meeting Locations:

Partnership HealthPlan of California
4665 Business Center Drive, Fairfield, CA 94534 | Napa/Solano
2525 Airpark Drive, Redding, CA 96002 | Trinity Alps
495 Tesconi Circle, Santa Rosa, CA 95401 | Santa Rosa Huddle
1000 Fortress Street, Chico, CA 95973 | Stony Creek
1036 5th St. Suite E, Eureka, CA 95503 | Grizzly Creek

Other Locations:
Chapa-de Indian Health: 11670 Atwood Road, Auburn
Open Door Community Health Center, 770 10th St., Arcat0
Kaiser Permanente, 5820 Owens Drive, Pleasanton

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

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

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

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

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

Date: May 20, 2026 **Time: 7:30 – 9:10 a.m.**

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

Other Locations:
Open Door Community Health Center, 770 10th St., Arcata
Chapa-de Indian Health: 11670 Atwood Road, Auburn
Kaiser Permanente, 5820 Owens Drive, Pleasanton

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

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

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

	Item	Lead	Time	Page #
I.	**Call to Order – Welcome/Introductions/Announcements/Approval/Acceptance of Minutes**			
1	*Approval of* April 15, 2026 Quality/Utilization Advisory Committee (Q/UAC) Minutes	Robert Moore, MD, MPH, MBA	7:30	5 – 21
2	*Acknowledgment and acceptance of draft minutes of the* • April 7 Internal Quality Improvement (IQI) Committee			23 – 40
3	Announcements			--
II.	**Standing Updates**			
1	Quality and Performance Improvement Program Update	Isaac Brown, MHA/MBA	7:36	41 – 52
2	HealthPlan Update	Robert Moore, MD	7:41	--
III.	**Old Business – None**			
IV.	**New Business – Consent Calendar**			
	Consent Calendar	All	7:46	53
	Proposed 2027 Perinatal Quality Improvement Program (PQIP) Measures Summary – *refer questions to Troy Foster*			55 – 58
Health Services Policies	**Behavioral Health**			
	MPBP8005 – Dispute Resolution Between Partnership and BHPs in Delivery of Mental Health			59 – 63
	Care Coordination			
	MPCP2026 – Diabetes Prevention Program			65 – 70
	MPCP2034 – Transitional Care Services			71 – 83
	Enhanced Health Services			
	MPAP7004 – Community Health Worker (CHW) Services Benefit			85 – 95
	MPAP7005 – Street Medicine			97 – 104
	Quality Improvement			

	Item	Lead	Time	Page #
	MPQP1038 – Physician Orders for Life-Sustaining Treatment (POLST)			105 – 109
	MPQP1047 – Advance Directives			111 – 113
	MPQP1055 – Provider Preventable Condition (PPC) Reporting			115 – 119
	Utilization Management			
	MPUP3137 – Palliative Care: Intensive Program (Adult)			121 – 140
	MPUP3144 – Residential Substance Use Disorder Treatment Authorization			141 – 146
Non HS	**Network Services - Compliance**			
	MPNET101 – Wellness and Recovery Access Standards and Monitoring			137 – 149
V.	**New Business – Discussion Policies**			
	Synopsis of Changes		--	151 – 153
Health Services Policies	**Behavioral Health**			
	MPBP8003 – Mental Health Services – *the three DHCS attachment forms are unchanged since recent Q/UAC policy review and are not included in this packet.*	Jeff DeVido, MD	7:50	155 – 172
	Care Coordination			
	MPCP2023 – New Members Needs Assessment	Aryana Cunningham	7:55	173 – 187
	Quality Improvement (manager) / **Behavioral Health** (owner)			
	MPXG5003 – Major Depression in Adults Clinical Practice Guidelines	Jeff DeVido, MD	8:00	189 – 191
	Utilization Management			
	MPUP3136 – Microbiota-Based Therapeutics (MBT) **NEW TITLE** *formerly Fecal Microbiota Transplant*	Kermit Jones, MD, JD	8:05	193 – 195
	MCUP3104 – Transplant Authorization Process	Tony Hightower, CPhT	8:10	197 – 202
	MPUP3047 – Tuberculosis Related Treatment	Mark Netherda, MD	8:15	203 – 207
VI.	**Presentations**			
1	IHA- Claims & Encounters Summary	Rachel Newman, RN	8:20	209 – 219
2	Behavioral Health Overview and Grand Analysis: ME7 E&F Member Experience	Mark Bontrager Jeffrey DeVido, MD Nicole Escobar	8:30	221 – 246
3	Quality Improvement Health Equity Committee (QIHEC) Charter	Mohamed Jalloh, Pharm.D	8:50	247 – 249
VII.	**Adjournment scheduled for 9:00 a.m. Q/UAC next meets 7:30 a.m. Wednesday, June 17, 2026**			

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
MEETING MINUTES

Quality and Utilization Advisory Committee (Q/UAC) Meeting
Wednesday, Apr. 15, 2025 / 7:30 a.m. – 9:30 a.m. - Napa/Solano Room, Airpark,
Chico – Story Creek

Voting Members Present:
Gwiazdowski, Steven, MD, FAAP
Hackett, Emma, MD, FACOG
Montenegro, Brian, MD
Mulligan, Meagen, FNP-BC
Murphy, John, MD
Quon, Robert, MD, FACP
Strain, Michael, PHC Consumer Member
Swales, Chris, MD
Wilson, Jennifer, MD, MPH

Voting Members Absent: Luu, Phuong, MD; Thomas, Randolph, MD; Sara Choudhry, MD; Brandy Lane, Consumer Member

Partnership *Ex-Officio* Members Present:
Bides, Robert, RN, BSN, Mgr, Member Safety – Quality Investigations, QI
Bontrager, Mark, Senior Director of Behavioral Health
Brown, Isaac, MBA/MHA, Interim Senior Director of Q & P Improvement
Cox, Bradley, DO, Regional Medical Director (Northeast)
DeVido, Jeff, MD, Behavioral Health Clinical Director
Esget, Heather, RN, BSN, ACM, Director of Utilization Management
Gast, Brigid, MSN, BS, RN, NEA-BC, Senior Director, Care Management
Glickstein, Mark, MD, Associate Medical Director
Hightower, Tony, CPhT, Associate Director, UM Regulations
Jalloh, Mohamed “Moe”, Pharm.D, Dir. of Health Equity (Health Equity Officer)
Jensen, Annika, RN, Assoc Dir. of Clinical Integration, Care Coordination
Jones, Kermit, MD, JD, Medical Director for Medicare Services
Leung, Stan, Pharm.D, Director of Pharmacy Services
Moore, Robert, MD, MPH, MBA, Chief Medical Officer – Chair
Netherda, Mark, MD, Medical Director for Quality – Vice Chair
Newman, Rachel, RN, BSN, Mgr, Clinical Compliance – Quality Inspections
O’Connell, Lisa, Director, Enhanced Health Services
Randhawa, Manleen, Senior Health Educator, Population Health
Ribordy, Jeff, MD, Regional Medical Director (Northwest)
Ruffin, DeLorean, DrPH, MPH, Director of Population Health
Townsend, Colleen, MD, Regional Medical Director (Southeast)
Ward, Lisa, MD, Regional Medical Director (Southwest)
Watkins, Kory, MBA-HM, Director, Grievance & Appeals

Partnership *Ex-Officio* Members Absent:
Barresi, Katherine, RN, BSN, PHN, NE-BC, CCM, Chief Health Services Officer
Guillory, Ledra, Senior Manager of Provider Relations Representatives
Katz, Dave, MD, Associate Medical Director
O’Connell, Lisa, Director, Enhanced Health Services
Spiller, Bettina, MD, Associate Medical Director
Thornton, Aaron, MD, Associate Medical Director

Guests:
Beard, Alyssa, RN, Manager of CC Regulatory Performance
Booth, Garnet, Senior Program Manager, Provider Relations
Brunkal, Monika, RPh, Associate Director, Population Health
Campbell, Anna, MPH, Health Policy Analyst, Utilization Management
Cunningham, Aryana, Policy Analyst, Care Coordination
Devan, James, Director of Quality Management
Durst, Jennifer, Manager of Performance Improvement (Santa Rosa)
Frankovich, Terry, MD, Associate Medical Director
Gual, Kristine, Director of Quality Measurement
Katz, Dave, MD, Associate Medical Director
Kubota, Marshall, MD, Associate Medical Director
Matthews, Richard, MD, Regional Medical Director (Chico)
Molteni-Casper, Sarah, Program Manager ll, QI
Morris, Matthew, MD, Regional Medical Director (Auburn)
Ocampo, Andrea, Pharm. D, Clinical Pharmacist, Pharmacy
O’Leary, Hannah, MPH, Manager of Population Health, Pop Health
Quichocho, Sue, Manager of Quality Measurement, QI
Rushing, Eric, Manager of Mental Health Programs, Behavioral Health
Smith, Christine, Community Health Needs Liaison, Pop Health
Stites, Jaylyn, Program Manager ll, Provider Relations
Ungaro, Chloe, Senior Program Manager, Provider Relations
Vo, Kathleen, Pharm. D, Clinical Pharmacist, Pharmacy
Williams, Joanie, RN, Manager of UM
YoungStone, Kelly, RN, Director of Care Coordination

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
I. Call to Order Public Comment – *none made* Introductions Approval/ Acceptance of Minutes	Chief Medical Officer and Committee Chair Robert Moore, MD, MPH, MBA, called the meeting to order at 7:30 a.m. The Jan. 21, 2026 and Mar. 18, 2026 Q/UAC Minutes were approved without any corrections. *Acknowledgment and acceptance of draft meeting minutes of the* • March 10 Internal Quality Improvement (IQI) Committee • Feb. 26 Member Grievance Review Committee (MGRC) • March 12 Population Needs Assessment (PNA) Committee – *(Committee is now disbanded – these are the final minutes for this committee).*	Motion to **approve the Q/UAC minutes:** Steven Gwiazdowski, MD, FAAP Second: Robert Quon, MD, FACP *Approved unanimously* Motion to **accept the other minutes:** Robert Quon, MD, FACP Second: Steven Gwiazdowski, MD, FAAP *Accepted unanimously*
II. Standing Updates		
1. Quality Improvement (QI) Department Update *Isaac Brown, Senior Director of Quality and Performance Improvement, QI*	• Primary Care Provider Quality Incentive Program (PCP QIP) payment for measurement year 2025 is currently underway with the final payment being distributed by the end of May 2026. The PCP QIP Team is working with EDW to process manual adjustments. Providers will be asked to complete validation of their updated scores during the third week of March. Once this validation has been completed, final payment files will be drafted and validated then reviewed with the executive team for final sign off. • The organization, as a whole, has been through kind of an end-to-end assessment of our member experience with a consultant, and they're going to be giving us recommendations and gaps to fill on our own member experience. Final recommendations and prioritized action roadmap will be presented later this year. • Currently have 40 Mobile Mammography event days scheduled with limited availability left. If you know anyone who is interested please have them reach out to mobilemammography@partnershiphp.org.	*For information only.*
2. HealthPlan Update *Robert Moore, MD, MPH, MBA Chief Medical Officer*	• Regional Medical Directors Meetings are currently underway for 2026 with 4 completed and 3 left with Santa Rosa this Friday, Chico in a couple weeks, and then wrapping up in Truckee. The main topics covered will be about health policy, health plan and state updates, public health measures, and then quality. Folks are encouraged to attend as it will be a comprehensive review of everything related to Partnership and anything adjacent to the health plan. • April 1st the State changed the GLP1 prior auth criteria to not require a TAR for metabolic dysfunction-associated steatohepatitis (MASH). Just putting the right diagnosis code on the prescription will work, although a TAR is still required for other diagnoses. • Partnership is currently watching closely from a health policy perspective the rural health transformation grants coming through the California Department of Health Care Access and Information (HCAI). $3	*There were no questions for Dr. Moore nor any action items.*

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	million will be distributed this first year with 20% of that being used up by the consultants and HCAI people they hire. Those grants will be sent out most likely in June plus or minus a month. Our regional directors will be working with our providers and organizations that may not have the desire or skills to submit a federal grant. One of the grants will be reviewed by CMS who tend to be meticulous with their budgetary review. Areas of focus will be the workforce pipeline, recruitment and retention of clinical staff, IT system enhancements, and OB access. • Currently looking at doing a periodic review of Partnership's Medical Equipment Distribution Services (PMEDS) program where blood pressure cuffs, scales, nebulizers, and so on are sent directly through partners because they are low cost and it can be hard to get the pharmacies to do it. Please send any frontline stories of how these devices are being used and how they may have benefitted a member to Dr. Moore.	
III. Old Business – None		
IV. New Business – Consent Calendar (Committee Members as Applicable)		
Proposed 2027 Palliative Care QIP Measure Set – *direct any questions to Eva Lopez, CPhT* Proposed 2026 Hospital QIP 6-month Bridge Measure Set - *direct any questions to Troy Foster* **Health Services Policies** Care Coordination MCCP2036 – Memorandum of Understanding (MOU) Requirements For Medi-Cal Managed Care Plans and Third-Party Entities - *Attachments A-L (unchanged from last review) are available on Partnership's external website. Attachment M is the new template added to the policy.* Quality Improvement MPQP1006 – Clinical Practice Guidelines MPXG5001 – Clinical Practice Guidelines for the Diagnosis & Management of Asthma MPXG5002 – Clinical Practice Guidelines for Diabetes Mellitus Utilization Management MPUP3026 – Inter-Rater Reliability Policy MCUP3037 – Appeals of Utilization Management/Pharmacy Decisions		*No questions were asked.* Motion to **approve the slate:** Robert Quon, MD, FACP Second: Steven Gwiazdowski, MD, FAAP *Approved unanimously* Next Steps: May 13, 2026 Physician Advisory Committee (PAC)
V. New Business – Discussion Policies		
Policy Owner: Behavioral Health – *Presenter: Jeffrey DeVido, MD, Behavioral Health Clinical Director*		
MPBP8003 – Mental Health Services	**Synopsis of changes reviewed:** • Added, "and dyadic Behavioral Health Services" to section I. 1. Changes were made to align with APL 26-002 wording. • Changed wording "medications" to "drugs" in section I. 5. Changes were made to align with APL 26-002 wording.	*There were no questions for Dr. DeVido.* Motion to **approve as presented:** Robert Quon, MD, FACP

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	• Updated DHCS BHIN 21-073 reference to updated BHIN 26-002. DHCS updated BHIN. • Added wording "Partnership covers NSMHS without prior authorization requirements.". This aligns with Partnerships NCQA requirements for no authorization required for MH services. • Added section K. Youth Trauma Screening Tools. Section added to align with new Youth Trauma Screening Tool requirements in DHCS APL 26-002 • Updated and Added wording related to EPSDT benefit to section H 1. Changes were made to align with APL 26-002 guidance. • Added wording "Partnership covers clinically relevant laboratory and radiologic studies…" to align with wording in APL 26-002. • Removed "up to 20" limitation on individual and/or group counseling sessions for pregnant and postpartum Members. Changes were made to align with APL 26-002 guidance. • Added sections N and O in Partnership is responsible for: SABIRT services and Preventive screenings for tobacco, alcohol and drugs. Changes were made to align with APL 26-002 guidance. • Updated wording in section R. 1. "and Partnership will notify members of such applicable policies." to align with wording in APL 26-002 • Removed superseded references and added reference to APL 26-002.	Second: John Murphy, MD *Approved unanimously* Next Steps: May 13 PAC
MPBP8011 – Scope of Primary Care – Behavioral Health Indications for Referral Guidelines	**Synopsis of changes reviewed:** • Added, "and dyadic Behavioral Health Services" to section A. 1. Changes were made to align with APL 26-002 wording. • Changed wording "medications" to "drugs" in section A. 5. Changes were made to align with wording in APL 26-002. • Updated BHIN 21-073 reference to updated BHIN 26-002. DHCS updated BHIN. • Added wording "If a PCP cannot perform the mental health assessment, they must refer the Member to the appropriate Provider and delivery system for mental health services…". Changes made to align with APL 26-002. • Added section e. Reference to Youth Mental Health Screening Tools in Policy MPBP8003. Changes made to align with APL 26-002. • Added sections a, b, c and d. PCPs should screen and refer members with SUD as follows: SABIRT services, Preventive screenings for tobacco, MAT services, and Emergency and Post-Stabilization service. Changes were made to align with APL 26-002. • Removed superseded references and added reference to APL 26-002. **Discussion:**	Motion to **approve as presented:** Robert Quon, MD, FACP Second: Steven Gwiazdowski, MD, FAAP *Approved unanimously* Next Steps: May 13 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	• Associate Medical Director Dave Katz, MD, asked who is responsible for administering these screenings? Are they county mental health or primary care providers or behavioral health providers? Who is qualified to do the screenings to get this pathway started? o Dr. DeVido said that the intent here is that the PCP in the primary care setting would do the screening.	
Policy Owner: Quality Improvement – *Presenter: Rachel Newman, RN, BSN, Manager of Clinical Compliance – Quality Inspections*		
MPQP1022 – Site Review Requirements and Guidelines	**Synopsis of changes reviewed:** This policy is coming back ahead of its annual review in large part to align with Partnership's Urgent Care Services updates as recently described in UM policy MCUP3044. Accordingly, MCQP1022's attachments will now include review tools relevant to urgent care. Additional changes have been made to improve the workflow of the policy and be more inclusive of the additional reviews performed by the Site Review team. Policy number changed from MCQP1022 to MPQP1022 to reflect its applicability to the future Partnership Advantage D-SNP program. **Section III Definitions added:** "Supplemental Facility, Free Standing Urgent Care Provider, Free-Standing Urgent Care Center, Shared Medical Record Practice" to add clarification throughout the policy. **Attachment F –** the Non-Accredited Facility Site Review Tool – has minor updates on questions for flow and process. **Note: this Tool will no longer be used for Urgent Care.** **Attachments are being reordered and thus re-lettered Attachments J-N below are new additions:** J. Free Standing Urgent Care Clinic Facility Site Review Tool K. Urgent Care Medical Record Tool L. PCP Providing Urgent Care Facility Site Review Tool M. Palliative Care Facility Site Review Tool N. Palliative Care Medical Record Review Tool **Section VI Policy /Procedure is entirely reformatted for ease of reading**. Therein, these additions or changes have been made: • "Supplemental Sites" added as language to be more inclusive in required site reviews. (p.5) • Sites with a failed review will be placed on an annual review. • "Any site review concerns that reveal significant quality of care issues will be forwarded to the Chief Medical Officer or the Quality Medical Director for Quality for further guidance." (p. 5) • Partnership expanding to a new service area. Language is removed and now points to APL 20-017 for guidance. • Facility Site Review (FSR) Scoring language on Critical Elements (CEs) is updated (p. 7) • Medical Record Review (MRR) Scoring language is updated (p. 8): "If the minimum number of records is not available, Partnership will document the rationale and complete the MRR with the available records." • Obstetric Specialists and Non-Accredited Sites have been bundled and FSR and MRR language augmented under section "Specialized Site Reviews" (pp. 12) These are followed by additional MMR language pertaining to Free Standing Urgent Care Clinics (p. 12), and "PCP providing Urgent Care	*There were no questions for Rachel.* Motion to **approve as presented:** Jennifer Wilson, MD, MPH Second: Steven Gwiazdowski, MD, FAAP *Approved unanimously* <u>Next Steps</u>: May13 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Services” (p. 12) “A Palliative Care report is run monthly by the Inspections Site Review Team.” (p. 13) • Removed section under Non-Accredited site reviews. These reviews do not fit within the Site Review scope. Sites removed include Hospitals, Skilled Nursing Facilities, Ambulatory Behavioral Health Facilities, Free Standing Surgical Centers. Originally was going to place a “rural section” but felt it was more accurate to completely remove. These sites will require accreditation.	
Policy Owner: Utilization Management – *Presenter: Tony Hightower, CPhT, Associate Director of UM Regulations*		
MCUP3133 – Wheelchair Mobility, Seating and Positional Components	**Synopsis of changes reviewed:** **Section VI.A.3.a. and b.:** This policy was updated to include language for Charpentier billing as follows: • Partnership will process a TAR for a dually eligible Member in the same manner as it would process a TAR for a Medi-Cal-only Member, regardless of whether Medicare (or any other health coverage) has authorized the equipment or been billed. • A TAR for such requests must include all medical justification and documentation that would normally accompany a Medi-Cal-only TAR and include the message “Medi/Medi: Charpentier/Rates”, “Medi/Medi: Charpentier/Benefit Limitation”, or “Medi/Medi: Charpentier/Both Rates and Benefit Limitation” in the Medical Justification section. **Discussion:** • Dr. Gwiazdowski asked why did they take out the provision for the denial? ○ Tony stated that Medicare won’t necessarily issue an explanation of benefits (EOB) or evidence of denial for services that they do not cover, and Partnership needs to make sure that, in the case of wheelchair requests, if the Medicare rate is lower than what Medi-Cal will reimburse, that it doesn’t get stuck on a provider with that lower reimbursement rate, and that Partnership would consider the service and pay if the Medi-Cal rate was high than the Medicare reimbursement rate.	Motion to **approve as presented:** Steven Gwiazdowski, MD, FAAP Second: Robert Quon, MD, FACP *Approved unanimously* <u>Next Steps</u>: May 13 PAC
MPUD3001 – Utilization Management Program Description	*Utilization Management Program Description is included in the Presentation section as part of our Annual UM Program Evaluation (see below).*	*See below*
VI. Presentations		
MPUD3001 – Utilization Management Program Description – *Tony Hightower, Associate Director of UM Regulation*		
<u>Pages 406 - 448</u> **<u>Synopsis of Changes reviewed (page 403):</u>** Annual updates to our UM Program Description for both UM and Pharmacy activities were made in conjunction with our annual UM Program Evaluation.		*Voting was combined for UM Program Description and UM Program Evaluation. Please see below.*

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
Page 1: In the Program Purpose section, "Enhanced Health Services" was added as the eighth Health Services team. **Pages 2 - 19:** Program Staff descriptions were reorganized into sections as follows: OCMO, UM, BH, and Pharmacy. **Page 3:** Added Program Staff description for the new position of Deputy Chief Medical Officer. In the assigned responsibilities for the Medical Director of Quality, added that this position serves as Chair for the Credentials Committee, Directs the two Member Safety Teams for Clinical Compliance and Quality Investigations, and Works with the Grievance and Appeals team to review Member Grievances with possible clinical care elements. **Page 5:** Removed Program Staff description for Director of Health Equity as that position is now described in the QIHETP Program Description, MCED6001. **Page 6:** Updated Program Staff description for the Director of UM to clarify duties and remove responsibility for reporting to Q/UAC on UM activity. **Page 7:** Updated Program Staff description for the Director of EHS. **Page 8:** Updated Program Staff description for the Associate Director of Utilization Management Regulations to state that this position gathers UM program information and incorporates updates into the annual UM evaluation and program description. **Page 9:** Updated Program Staff description for the Associate Director of EHS. **Page 10:** Added new Program Staff description for Manager of Enhanced Health Services Operations. **Page 11:** Updated Program Staff description for the Clinical Supervisor of Enhanced Health Services to include participation in oversight and audit of CalAIM providers. **Pages 12-13:** Updated Program Staff descriptions for Nurse Auditor, Nurse Coordinator II, and Nurse Coordinator I. **Pages 13-14:** Added new Program Staff description for Program Manager II and Program Coordinator II in UM Regulations. Also updated Program Staff description for Program Manager I – (EHS). **Page 15:** Updated Program Staff descriptions for Project Coordinator II - (EHS), Project Coordinator I - (EHS), Health Services Analyst I, and Health Services Administrative Assistant II – UM, EHS. Added a new Program Staff Description for Program Coordinator I - (Training & Education). **Pages 16 - 17:** Updated Program Staff description for Behavioral Health Clinical Director to reflect only MD as that is the credential for the person currently in this position. Other options of DO, PhD, and PsyD were deleted for now. Other updates were made to clarify changes since Carelon was de-delegated. **Pages 17-18:** In the Behavioral Health section, added new Program Staff descriptions for Senior Manager of Behavioral Health, Sr. Manager of Behavioral Health Access, Sr. Manager of Child Welfare Program, Manager of First 5 Commissions, Manager of Mental Health Programs, and County Child Welfare Liaison. **Page 20:** Updated information on attendees for the PAC Committee. **Pages 20-21:** Updated information on attendees for the Q/UAC Committee and specified that the committee activities include annual review of UM rates and identification of actions to address opportunities identified. Also updated information on attendees for the QIHEC committee. **Page 22:** Corrected definition of BHT to reflect Behavioral Health Treatment instead of "therapy" services. **Page 24:** Updated information on APL 22-012 to reflect APL 25-013 Medi-Cal Rx Pharmacy Benefits and Cell and Gene Therapy Coverage. **Page 25:** Updated policy number MPCP2017 to reflect MPBP8011 because the *Scope of Primary Care - Behavioral Health and Indications for Referral Guidelines* policy has been transferred from Care Coordination to the Behavioral Health department.		

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Page 27: In the Utilization Manager Process section, added statement to say that "Appropriately licensed professionals supervise all medical necessity decisions as described in the UM Program Staff section starting on page four (4)." This was a recommendation from our NCQA consultant. Consultant also added clarification to last statement on the page to specify that UM considers the "local" delivery system and the availability of services with "their ability to meet the Member's specific health care needs." **Page 31:** In the UM chart for Non-Behavioral Healthcare Decisions and Behavioral Healthcare Decisions, the time frame for Non-urgent pre-service decisions was changed from 5 business days to 7 calendar days as per DHCS regulations. A new time frame chart was added to describe Pharmacy Decisions that must be made within 24 hours of receipt of request for Urgent Concurrent, Urgent Pre-service, and Non-urgent pre-service decisions. **Post-Meeting Note:** *We also reduced the time frame for a non-urgent preservice extension from 28 to 14 calendar days which will be updated in the PAC meeting packet.* **Page 33:** In the Availability of Criteria section, language was updated to say that the Provider Relations department notifies providers in writing "and electronically" regarding availability of UM criteria. Per our NCQA consultant, this statement was also added to describe our upcoming D-SNP program: "Partnership's UM Program plans include development and implementation of its CMS Final Rule Interoperability plan during CY 2026. This plan will include steps for the implementation of practitioner access to criteria electronically at point of service. Implementation is planned for January 2027." **Page 35:** The section on Appeals was updated per recommendation from our NCQA consultant. The title of the section was changed to specify "Process for ***a Member or a*** Provider ***on Behalf of a Member*** to Appeal an Adverse Benefit Determination," and the following language was added to this section. "The Member or their authorized representative may submit a request for appeal verbally or in writing. The Member or the authorized representative may submit additional information for review and may request copies of all documents considered as part of the review. The time for resolution begins when the request is received, even if the information provided is incomplete. Partnership makes appropriate attempts to obtain any needed information for review within the required timelines, in order to make an informed decision within required timeframes based on clinical urgency and according to our policies and procedures." **Page 39:** The Annual Program Evaluation section was updated to specify that the Behavioral Health department participates in the evaluation, and the following additional positions were added for leadership who contribute: Senior Director of Care Management, Senior Director of Behavioral Health, and the Director of Enhanced Health Services. **<u>Discussion:</u>** • Dr. Gwiazdowski asked why the DO, PhD, and PsyD credentials would be removed from the Program Staff description title for the Behavioral Health Clinical Director (leaving only MD), but then all of the credentials are included in the next sentence in the policy? o Tony answered that when this policy was being reviewed by the National Quality Assurance Committee (NCQA) consultant, they requested that we align that credential with the actual medical director that we have in place for that position now. The intent was not necessarily to exclude other credentials from that particular position. Dr. Moore added that the Program Staff descriptions provide a list of individuals that are currently in our department and it's a requirement that the policy states this. o Dr. Gwiazdowski said that this breaks from how we format everything else and may cause confusion..	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	○ Dr. Moore agreed and noted that listing only the current staff credentials for each position in the policy would also cause more work in the future, because if someone leaves, then we would have to update the Program Description each time. He wondered if we should list current staff with their credentials in an addendum or an appendix. ○ Anna pointed out that we are consistent where we describe all other types of medical directors in the CMO section. We list both MD and DO for each Medical Director position because they could hold either credential, but Dr DeVido's position appears at the start of the Behavioral Health Staff section and the NCQA consultant was very insistent that the description for Behavioral Health Clinical Director had to specify only MD as the qualifying credential because the current person in that role is an MD. ○ Dr. Moore said that doesn't make sense because this is a program description intended to describe the necessary qualifications for the staff position and not necessarily the specific person who holds the position now. Dr. Quon agreed and said a more typical place to list specific people and their positions is in an addendum. ○ Dr. Moore suggested removing "MD" in the title of "Behavioral Health Clinical Director ~~MD~~" and then including an addendum to list the people who are actually hold each role. This would be consistent with how staff are listed in the QI Program Description. An entire policy should not have to be changed when a new person switches in. ○ Anna asked if the addendum would list staff for the entire UM program including Pharmacy, UM, BH, EHS, and CMO? Dr. Moore confirmed yes, it will be a very long list. ○ Anna expressed concern about including full names, titles, and credentials in a public-facing policy. Dr. Netherda said that we are supposed to be transparent so it shouldn't matter. Dr. Quon said that at Kaiser, it is available in their public policy. ○ Anna asked if we would need to list all MD's and nurses? Dr. Moore said it should only be the leadership, with Dr. Quon agreeing. ○ **Dr. Moore proposed that documentation of more specific clinical staff information should be presented at a future meeting (i.e. an org chart, list of clinical staff leadership, both, or neither) for the committee to review.**	
Annual 2025 Utilization Management (UM) Program Evaluation - NCQA UM Standard 1 Element G –*Tony Hightower, Associate Director of UM Regulation and Andrea Ocampo, Pharm.D.*		
	UM 1G Annual UM Program Evaluation (Page 450) Tony Hightower led the presentation by stating that the Q/UAC packet was distributed to committee members in advance and it included the following documents: policy MPUD3001 UM Program Description (summarized above), the 2025 Annual UM Program Evaluation Report (UM 1G) and the UM rates Evaluation Report (UM 1F) which analyzes data using a new NCQA workbook. • **UM Rates** ○ *The 2025 results, along with the interventions and ongoing activities by UM and Pharmacy to address identified gaps and opportunities are detailed in the UM 1F Evaluation of Utilization Management Rates Report which was reviewed and discussed with the committee* ***(Appendix A – Page 469)****.* ○ <u>UM Non-behavioral Health Rates</u>: The aggregate approval rate for UM TARs in 2025 was 77.58% and the aggregate denial rate was 22.42%. Within the reporting specs provided by NCQA these rates do include all administrative decisions. When looking at just medical necessity denials, the denial rate was at 6% which is significantly lower than the combined (Administrative and Medical Necessity) denial rate. ○ UM Behavioral Health Rates: Partnership does not require any prior authorization for Behavioral healthcare services. Partnership ran the rates to confirm no behavioral healthcare services were prior authorized during the measurement period. No results were noted.	Motion to **approve MPUD3001 UM Program Description and the UM 1G Annual UM Program Evaluation as presented:** Robert Quon, MD, FACP *Second:* Jennifer Wilson, MD, MPH <u>Next Steps for both MPUD3001 UM Program Description and UM 1G Annual Program Evaluation</u>: May13 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	○ Pharmacy Rates: The aggregate approval rate for Pharmacy TARs in 2025 was 86.34% and the aggregate denial rate was 19.46%. This reporting also included all operational and administrative decisions and excluded retrospective decisions. Quarterly reports showed that the approval and denial rates remained stable and consistent throughout the year. When considering only medical necessity denials, the denial rate was 10.49%. Quarterly reports were reviewed showing a 2% denial rate increase from Q3 to Q4. This increase was due to introduction of new preferred product requirement. After reviewing the rest of the denials, there were no other noticeable trends. ○ Appeal rates: These are a combination of UM, Pharmacy, and G&A teams. Overall appeals rate was 2.91% with an overturn rate of all appeals being 29.41%. When evaluating these rates with the G&A team, it was determined that most of the overall appeals overturn volume was due to UM receiving a large influx of appeals related to disagreements on level of care decisions for post discharge and patient stays. These primarily came from 2 large hospital providers within our network. G&A also reported that a large portion of their appeals were focused on the medically-tailored meals benefit that is processed by the EHS team. ○ Timeliness: Rates are evaluated for both Non-Behavioral and Behavioral decisions, although Partnership does not require any prior authorization for Behavioral healthcare, so we report none in that section. Both Non-Behavioral and Pharmacy decisions met the 90th percentile timeliness threshold for the year. ○ **Conclusion:** • Thresholds for all review categories were met based on the evaluation of the 2025 UM rates. As a result, no opportunities and interventions were identified by the committee. • TAR timeliness will be an area of focus for 2026 – 2027 due to the updates that UM has encountered with application of the CMS final rule and the planned transition from the current legacy TAR processing platform to a JIVA platform. These changes pose a risk to timeliness, and the UM team plans to increase the cadence of monitoring timeliness from a weekly cadence to a daily cadence for the first 30 – 60 days of the go-live of JIVA implementation. • The annual review for the UM program of CY 2025 report assesses the following: ○ Program Structure ○ Program scope, processes, and information sources used to determine benefit coverage and medical necessity. ○ UM criteria, prior authorization requirements, and level of involvement of the senior-level physician and designated behavioral healthcare practitioner in the UM program ○ Member and Practitioner experience with the UM program • **Program Structure: Staffing Oversight (Page 453)** ○ Currently Partnership established a minimum threshold of Medical Directors to Nurses and Medical Directors to Pharmacists at 1:5 at 1:5 (20%). Partnership's Physician to Pharmacist ratios were met for all months in 2025 but Physician to Nurse ratios did not meet the threshold goal from July through December 2025. ○ Partnership received about 12,000 Pharmacy Treatment Authorization Requests (TARs) which was a 9.43% increase from 2024. ○ Also monitored the TAR per pharmacist and TAR per tech ratios month to month to assess for adequate staffing. The TAR per pharmacist did exceed the 20% month to month threshold in July and October due to fluctuations in TAR volume and staff retirement. Hired new staff in Q4 to address the staffing gaps and daily workflow demands. • **Program Structure: Staffing Workload (Page 454)** ○ Annual TAR volume was 327,639 which represented a 4.95% decrease from calendar year 2024.	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	o Nurse to medical director ratio also operates on the 1:5 20% threshold. Q3 and Q4 exceeded the threshold due to an influx of nursing hires that was out of proportion to the hiring of medical director staff. **Suggested interventions are as follows:** • Continuing to assess and monitor staffing ratios • Continuing to assess opportunities for increased efficiency in evaluating TAR requirements. • Increase staff ratio threshold from 1:5 (0.20) to 1:6 (0.167) based on 2025 process improvement and operational assessment o TAR to nurse ratio was met for all quarters. This was a reflection of interventions that were made in 2024 and indicates that interventions were effective. • **Program Structure: Evaluation of the Partnership Advisory Committee Structure (Pages 456-458)** o All advisory committees were within quorum threshold. • **Program Process: Consistency of Applying UM Criteria (Page 459)** o Inter-rater reliability (IRR) is the measure of how we apply our criteria for our nursing, pharmacy, and medical director staff. Our threshold for concurrence is set at 90%. For the UM team, it was identified that outpatient nurses, LTSS nurses, and medical director reviewers met the 90% threshold. For Inpatient Nurse Reviewers, the concurrence rate for Q2-Q4 fell slightly below the 90% threshold with an overall rate of 89%. **Suggested interventions are as follows:** • Tracking and trending for repeated deficiencies to be observed and acted upon by UM Leadership on a quarter-by-quarter basis. • Conduct team-wide discussions on consistency in applying medical necessity criteria during internal Inpatient Rounds • Conduct annual training on InterQual® for UM Nurses. • UM Nurse Scorecard template updated to include IRR components. The scorecard is used to score IRR and other competencies for each nurse on a monthly basis. • Transition quarterly IRR monitoring process from nurse staff at large to the UM Training & Education team to focus and standardize the application of inter-rater reviews and ensure that secondary reviews are consistent. o Threshold of concurrence for Pharmacy staff is set at 90%. This was exceeded for both pharmacists and pharmacy technician reviewers. • **Program Process: Appropriate Care: Monitoring for Over/Underutilization (Page 459)** o This is a summary of over/underutilization activities for the year that were evaluated by the Over/Under Committee. o Evaluation of Over/Under utilization is performed across various groups and committees in the organization including HEDIS reviews, IQI committee, QUAC committee, through our Site Review process, and through the Access and Availability Grand Analysis that is performed by the Quality team. Additional analyses and remediation actions for potential areas of noncompliance for over/underutilization are typically handled by the Plan via quality improvement programs as well as the standard UM process and review. • **Prior Authorization Requirements, UM Criteria, and Information Sources Used to Determine Benefit Coverage and Medical Necessity (Page 463)**	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	○ Partnership uses the most currently available InterQual® Criteria sets as the primary review guidelines for UM medical necessity decisions. For the calendar year 2025, UM used the 2024 InterQual decision criteria until the 2025 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 MPUP3139 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®. ○ 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 Community Advisory Committee (CAC), external providers, State policy letters, or medical literature among other sources. ○ Partnership's Pharmacy & Therapeutics (P&T) Committee determines whether or not a particular drug or pharmaceutical class shall be absent of TAR requirements based on therapeutic advantages in safety and efficacy, standards of care, and generally accepted place in therapy. Cost, utilization, and approval rates are also considered. • **Involvement of Senior Level Physicians in the UM Process (Page 463)** ○ Partnership looks at the involvement of the CMO and medical directors including the Behavioral Health clinical director in the UM process. The CMO and medical directors participate in the review and approval policies via QUAC and PAC and, for the pharmacy team, via the P&T workgroups and committees. They also perform daily UM review and decision making and participate in internal and external clinical rounds. • **Assessing Experience with the UM Process: Improving Practitioner Experience with the UM Process (Page 464)** ○ *Please see Appendix B: Physician Satisfaction Survey for a breakout of the practitioner experience.* ○ On an annual basis, Provider Relations engages with a third-party surveyor, Press Ganey, to survey our network of primary care physicians and specialists to gauge their satisfaction with Partnership's UM and Pharmacy processes. ○ UM was able to meet the threshold goal of 90% satisfaction for primary care physicians. ○ UM was unable to meet the threshold goal of 90% satisfaction for the specialists. 6 UM questions that were posed to our network specialists did not meet the goal. ○ Pharmacy was unable to meet the threshold goal with primary care physicians. 1 question did not meet the goal. ○ Pharmacy was able to meet the threshold goal with specialists. ○ Analysis of these results identified that there was a potential gap in provider education in both Eastern and Southern regions. These results were driven by the recently added Eastern region, with this being their first survey. **Suggested interventions are as follows:** • Collaborate with the Provider Relations (PR) team to participate in clinic site visits to share information about the Partnership Pharmacy program and the services available to providers. • Collaborate with the PR team to educate PCPs on the differences between the Partnership Pharmacy program and Medi-Cal Rx • **Assessing Experience with the UM Process: Member Experience with the UM and Pharmacy Process (Page 466)** ○ *Please refer to Appendix C for further details of Member satisfaction data for 2025.*	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION

- This portion of the program evaluation was provided by the Grievance and Appeal
- s (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).
- In 2025, there was an overall increase in grievances received when compared to 2024. The majority of areas that did not meet goal centered around provider-related concerns. The primary issues reported concerning the UM process were access-related issues. Notably, 57.3% of these access-related issues were associated with Partnership's Referral Authorization Form (RAF) process, while the remaining 42.7% were linked to the Treatment Authorization Request (TAR) process. Among the reported issues within the referral process, delays by providers (162) 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 Members alleging that their providers delayed submission of TARs to Partnership (87 reported concerns).
- **Suggested interventions are as follows:**
  - Collaborate with the G&A team to include additional data points in the PULSE report for "Member Experience with the UM Program" - adding data for Member "County" and "Provider Substantiation" (Yes or No). This additional information will allow UM to further stratify the data and gain insights into trends in Member concerns.
  - Collaborate with the PR team in pursuing educational opportunities with our provider network on Partnership processes and resources to improve Member satisfaction with the authorization process.

Supplemental TAR Report to the 2025 UM Program Evaluation (Page 484)

- This includes a TAR breakdown of each UM team's respective TAR numbers by category and status type.
- Also includes a summary breakdown of the percentage of TARs that were approved, modified and approved, denied, and admin denied.
- Summary of the percentage of appeals that were upheld, overturned, and partially overturned.

Conclusion

Overall, Partnership's UM Leadership concludes there are no significant changes required for the UM program. Activities addressing the improvement opportunities will continue to be monitored, measured, and reported in future evaluations. We find that 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.

Summary of Opportunities and Proposed Interventions by UM for Approval

Priority	Opportunities Identified	Barriers	UM Program Evaluation Component	Interventions
1	**IRR concurrence rate for**	Lack of consistency in applying	UM Program Processes	• Tracking and trending for repeated deficiencies to be observed and acted upon by UM Leadership on a quarter-by-quarter basis.

AGENDA ITEM	DISCUSSION				RECOMMENDATIONS / ACTION
	inpatient nurse reviewers	inpatient criteria by UM Nurses		• Conduct team-wide discussions on consistency in applying medical necessity criteria during internal Inpatient Rounds • Conduct annual training on InterQual for UM Nurses. • UM Nurse Scorecard template updated to include IRR components. The scorecard is used to score IRR and other competencies for each nurse on a monthly basis. • Transition quarterly IRR monitoring process to the UM Training & Education team to focus and standardize the application of inter-rater reviews and ensure that secondary reviews are consistent.	
2	**Physician to Nurse staffing ratios**	Uncertain fiscal climate at State and Federal levels	UM Program Structure	• Continuing to assess and monitor staffing ratios • Continuing to assess opportunities for increased efficiency in evaluating TAR requirements. Increase staff ratio threshold from 1:5 (0.20) to 1:6 (0.167) based on 2025 process improvement and operational assessment	
3	**Provider Experience with the UM Process**	Negative provider perceptions of Medi-Cal Rx may be conflated with Partnership's Pharmacy processes.	UM Program Scope	• Collaborate with the Provider Relations (PR) team to participate in clinic site visits to share information about the Partnership Pharmacy program and the services available to providers. • Collaborate with the PR team to educate PCPs on the differences between the Partnership Pharmacy program and Medi-Cal Rx	
4	**Member Experience with the UM Process**	Absence of year-over-year comparative data for recent Eastern Region expansion counties con-strains analysis of factors	UM Program Processes	• Collaborate with the G&A team to include additional data points in the PULSE report for "Member Experience with the UM Program" — adding data for Member "County" and "Provider Substantiation" (Yes or No). This additional information will allow UM to further stratify the data and gain insights into trends in Member concerns.	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION

		contributing to lower Member satisfaction scores.		• Collaborate with the PR team in pursuing educational opportunities with our provider network on Partnership processes and resources to improve Member satisfaction with the authorization process.

Tony invited the Committee to review the above opportunities and interventions and provide feedback on their prioritization and offer any additional recommendations they may have for consideration. Q/UAC did not request any changes to the prioritization of actions which were accepted as presented.

Discussion

- Dr. Quon asked if the ratio between the nurses and medical directors is dictated or a regulatory requirement by DHCS?
  - Tony said that it's not necessarily at that strict level and is left to Partnership's best judgement. What Partnership is required to do by NCQA is to establish a threshold and ensure that all processes and staffing align with that goal.
  - Dr. Quon made a suggestion to remove the ratio goal altogether, as the focus should be on making good decisions in a timely manner, and not that we have "X" number of nurses and "X" number of doctors. This would avoid Partnership pigeon-holing itself into a specific number that is unrealistic and unnecessary. Dr. Moore said this was a good thought, and although it can't be changed in this round, it can be taken back to NCQA to look at what the regulatory requirements are, as opposed to what the recommendation was. If all they require is the monitoring of the amount of work being done, then that would be easier to report..
- Dr. Murphy asked if there are ways to automate parts of the claims review process? How is Partnership looking at automating review of claims that get rejected from a billing standpoint? Right now, there is a bifurcated approach where if the claim is not denied, then you don't have a TAR anymore. Another branch point would be that some sets of claims need an in-depth review while other sets do not need to be reviewed at all and don't require a TAR, and others that can be automated. He was wondering if there were vendor solutions?
  - Dr. Moore said on the claims side, we will be implementing a claims editor system. Currently we are under-utilizing efficient processes because we are in the process of changing our core system and don't want to build out some of the automation based on the older system that is on its way out. Our new system is scheduled to go live at the end of this year. Our new vendor has certain efficiency aspects built out for us based on extensive evaluation of Partnership processes. Automations will be implemented where it makes sense to automate, but without making them deny people inappropriately or subjecting claims to medical review decision-making that we can't have the machine make.
- Dr. Gwiazdowski (page 452) pointed out several items that are leading to confusion:
  - Under the Methodology/Data: Program Structure section, there are 3 bullet points (Physician to Nurse ratio, Physician to Pharmacist ratio, and then Staff to TAR ratio). Is staff meaning RNs or nurses? The tables that follow it look as though they're nurses, so he was curious as to how staff are defined. **Tony replied this would be our clinical nursing staff to medical director ratio. This will be updated for clarification.**
  - (Page 452) The third bullet under Program Structure says it was Staff to Treatment Authorization Ratio which suggests the staff is in the numerator and the TAR is in the denominator, but then in the tables it has TARs per nurse. **Dr. Moore said in order to avoid redoing the entire table, the wording on page 452 should be flipped to say "Treatment Authorization Request to Clinical Nurse Staff ratio."**

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	○ Where we say “Physician to Nurse ratio,” it has MD as it was before MD/DO. Should that be maintained from the bullet points down to the rest of what you are doing to avoid any confusion or do you think that will not be an issue? **Tony said he will change this for consistency.** • Associate Medical Director Marshall Kubota, MD, asked if the nurses are RNs? **Tony replied that only clinical nurses are included in the ratios and it excludes anyone who is non-clinical. The nurses include RNs and LVNs.** • Dr. Gwiazdowski (page 475) asked if the overturned rate of appeals of 29% is considered high, low, or great? ○ Dr. Moore said the biggest reason for denial is because the proper documents were never submitted and then they submit them during the appeal process. Dr. Moore said the sweet spot is somewhere between 20% to 80% and that there is some legislation that says it should be between 10% to 90%. ○ Tony emphasized that these particular rate evaluations are a new part of the UM program evaluation, so we will now be able to track it year over year to determine what our overall performance is.	
Population Needs Assessment Presentation – *Hannah O’Leary, Manager of Population Health*		
	The Population Needs Assessment takes place every year and looks at the needs of our members from the past calendar year, 2025. • Key findings included economic instability, lack of access to quality health care, neighborhood and built environmental challenges, limited access to quality education, and social and community context changes. • Other community challenge findings included access to care, differences in health outcomes, transportation, environmental concerns (wildland fires), and chronic conditions. • Chico region had the greatest percentage of members accessing mental health services. • Continuing to struggle in some areas with breast cancer and cervical cancer screenings. • Reported some health disparities in a particular set of ethnic and racial categories in clinical measures. • Opportunity areas included organizational structure, social and environmental needs, member health and wellness, access to care, health disparities, and health education. • **Organization structure:** ○ Hired a handful of different positions that will support their health equity department. ○ Fully staffed health needs liaison team to cover all 24 counties. • **Social and environmental needs:** ○ Has been some opportunities to distribute CalAIM distribute payment program: awarded over $52 million in grants. To local entities to build out our enhanced care management and community supports programs. ○ Many of the households in our counties reported having insufficient income. Partnership is continuing to work on increasing workforce opportunities. ○ Partnership continues to support its Asthma Emergency Department Visit Outreach Program • **Access to Care:** ○ Some great work around working with our schools to increase behavioral health access ○ Continued working with Alinea for mobile mammography ○ Continued to work on providing education regarding the cervical cancer self-swab program ○ Continued growing together program that focuses on getting kids into well visits and to get vaccinated ○ Continued working on the provider recruitment and retention programs to increase access	*Motion to* ***approve as presented:*** Steven Gwiazdowski, MD, FAAP *Second:* Robert Quon, MD, FACP *Approved unanimously*

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION

- **Health Disparities:**
  - Continued our tribal health connections to support our tribal members who may not have great access to perinatal care
- **Health Education:**
  - Continued with our basic health population management programs
  - Community resource pages are still available and are a great resource for those who need support with identifies available resources in their area.
  - Wonderful member education events where members who were new to Partnership were able to ask questions and receive support.

Discussion:

- Dr. Gwiazdowski, page 540, noticed that the prevalence of anxiety translates to over 80% and wondered how this relates to use of social media. Other countries are doing it and wonders if Partnership can participate or spearhead a grant for giving money towards social media education. Schools can get involved to get kids to limit use. There's a big opportunity that we could do better.
  - Dr. Moore said it seems like it needs to be a policy intervention. It's not just kids, but also young adults and pregnant patients. Anxiety is one of the highest symptoms among pregnant patients. Policy is local and state level, which should be a systematic change, not just an individual choice.
- Jennifer Wilson, MD (page 548) asked if it's weird to have COPD and dementia listed under the conditions that children suffer from?
  - Hannah commented that it's a screenshot of a data dashboard that we are referring to with Dr. Netherda saying that it's based off of coding. Dr. Moore said this would be worth a follow up with the data analytics team to look at the underlying diagnoses that are feeding into the dashboard.

VII. Adjournment

Dr. Moore adjourned the meeting at 9:18 a.m.

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

Signature of Approval: ______________________________ Date:

Robert Moore, MD, MPH, MBA
Chief Medical Officer

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA
INTERNAL QUALITY IMPROVEMENT (IQI) COMMITTEE MEETING MINUTES
Tuesday, Apr.. 7, 2026 / 1:30 – 3:24 PM

Members Present:
Andrews, Leigha, Regional Director (SW)
Barresi, Katherine, RN, BSN, PHN, Chief Health Services Officer
Bides, Robert, RN, BSN, Mgr, Member Safety – Quality Investigations
Bontrager, Mark, Senior Director of Behavioral Health, Health Services
Brincko, Aaron, Director of Provider Relations
Brown, Isaac, MHA/MBA, Senior Director, Q & PI
Brunkal, Monika, RPh, Associate Director of Population Health
Campbell, Anna, MPH, Policy Analyst, Utilization Management
DeVido, Jeffrey, MD, Behavioral Health Clinical Director
Esget, Heather, RN, MSN, ACM, Director of Utilization Management
Gast, Brigid, MSN, BS, RN, NEA-BC, Senior Director, Care Management
Gual, Kristine, PMP, CPHQ, Director of Quality Measurement, QI
Hightower, Tony, CPhT, Associate Director, UM Regulations
Innes, Latrice, Compliance Manager, Grievance & Appeals
Jalloh, Mohamed, Pharm.D, Dir. of Health Equity (Health Equity Officer)
Jones, Kermit, MD, JD, Deputy CMO/Medical Director for Medicare Srvcs
Leung, Stan, Pharm.D, Director of Pharmacy Services
Moore, Robert, MD, MPH, MBA, Chief Medical Officer (Chair)
Netherda, Mark, MD, Medical Director for Quality (Vice Chair)
Newman, Rachel, RN, BSN, Mgr, Clinical Comp. – Quality Inspections
O'Connell, Lisa Brundage, MHA, Director, Enhanced Health Services
Randhawa, Manleen, Senior Health Educator, Population Health
Ruffin, DeLorean, DrPH, Director of Population Health
Townsend, Colleen, MD, Regional Medical Director (SE-Fairfield)
Villasenor, Edna, Senior Director, Member Services and Grievance
Ward, Lisa, MD, Regional Medical Director (SW-Santa Rosa)

Members Absent:
Ayala, Priscila, Director of Network Services
Bjork, Sonja, JD, Chief Executive Officer
Boyle, Shannon, RN, Manager of CC Regulatory Performance
Davis, Wendi, Chief Operating Officer
Klakken, Vicky, Regional Director (NW-Eureka)
Matthews, R. Douglas, "Doug," MD, Regional Medical Director (Chico)
Sharp, Tim, Regional Director (NE-Redding)
Turnipseed, Amy, Chief Strategy and Government Affairs Officer
Vaisenberg, Liat, Director of Health Analytics
YoungStone, Kelly, RN, Director of Care Coordination

Guests:
Akintan, Folo, Epidemiologist, Pop Health
Allen, Angier, Sr. Data Scientist I, Finance
Arguello, Amanda, Lead Trainer, Network Services
Banuelos, Anna, Nurse Case Manager II, Care Coordination
Beard, Alyssa, RN, Manager of CC Regulatory Performance
Bikila, Dejene, Manager of Data Science, Finance
Brown, Evangeline, RN, Manager of Utilization Management
Chebolu, Radha, Sr. Data Scientist II, Finance
Clark, Kristen, Manager of Qlty. & Training, Member Services
Cunningham, Aryana, Policy Analyst, Care Coordination
Devan, James, Director of Quality Improvement, QI
Diaz, Alondra, Project Coordinator I, Care Coordination
Durst, Jennifer, Senior Manager of Performance Improvement, QI
Foster, Troy, Program Manager II, QI
Hanusiak, Kenzie, Associate Director of Reg. Affairs/Compliance
Harris, Vander, Sr. Health Data Analyst I, Finance
Hazel, Jerry, RN, Supervisor of UM
Ling, Samuel, Sr. Health Data Analyst I, Finance
Lopez, Eva, CPhT, Program Manager I, QI
Lopez, Rosalee, Manager of UM Operations
Moore, Jordan, Education Specialist, Provider Relations
Morris, Matthew, MD, Regional Medical Director
Muncy, Kellie, Manager of Change Management & Configuration
Nguyen, Tom, Manager of Health Analyt., Finance
Ogren, Danielle, Sr. Director of Reg. Affairs & Compliance
Quichocho, Sue, Manager of Quality Measurement, QI
Rathnayake, Rasitha, Sr. Health Data Analyst I, Finance
Robertello, Kimberly, Manager of Medicare Quality, QI
Rodriguez, Cindy, Project Coordinator II, QI
Rushing, Eric, Manager of Mental Health Programs
Salehi, Tiphanie, Sr. Health Data Analyst I, Finance
Seale, J'aime, PR Lead, Network Services
Sivasankar, Shivani, Sr. Data Scientist, Finance
Smith, Christine, Community Health Needs Liaison, Pop Health

Hostesttler, Rebekah, RN, Supervisor of UM Isola, Brandy, Manager of Performance Improvement, QI Jensen, Annika, RN, Assoc. Dir. of Clinical Integration, Care Coordination Kubota, Marshall, MD, Associate Medical Director Kulkarni, Shreya, Policy Analyst, Regulatory Affairs & Compliance Lee, Donna, Manager of Claims	Spiller, Bettina, MD, Associate Medical Director Thomas, Penny, Sr. Health Data Analyst I, Finance Ungaro, Chloe, Sr. Program Manager, Provider Relations Vance, Brooke, Program Manager, Network Services Williams, Joanie, RN, Manager of UM

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
I. Call to Order • Introductions • Approval / Acceptance of Minutes	Chief Medical Officer Robert Moore, MD, MPH, MBA called the meeting to order at 1:30 p.m. from the Fairfield-West office. 1. Approval of the Mar. 10, 2026 IQI Minutes 2. Acknowledgment and Acceptance of the draft minutes of: • Jan. 29, 2026 Over/Under Utilization Workgroup Meeting Minutes • March 12, 2026 Population Needs Assessment (PNA) Committee minutes	*Motion to* ***approve IQI Minutes****: Kristine Brown, PMP, CPHQ* *Second: Isaac Brown, MHA/MBA* *Motion to* ***approve Over/Under Utilization Workgroup Minutes and PNA Minutes****:* *Kristine Gual, PMP, CPHQ* *Second: Lisa Ward, MD*

II. Old Business

MPCR700- Assessment of Organizational Providers (page 32)

- Edits were made after the March IQI meeting regarding accreditation and were approved by Dr. Moore. This topic is being brought back to notify the IQI committee before it goes to the final approving body the credentials committee. Brooke confirmed removed accreditation piece and left the site review.
- Informational only topic with no further questions.

Policy Workflow

- Dr. Moore gave the reminder that starting in June in preparation for the August IQI meeting we will be doing reviews of the policies earlier than normal through PowerDMS. The goal is to have both individual business owners, assigned medical directors, and RAC to review the policies a little more than 2 months prior than they are due. The timeline is that for August IQI reviews would start in June. 2 weeks before submissions are due to IQI (3 weeks before August IQI) they should be reconciling their edits with RAC so by the time it gets to the August IQI the experts have already weighed in.
- Kenzie from RAC added that she and Shreya will be presenting **CMP44** Policy on Policies which will entail the workflow on how these should be handled to Ops next week. Once that has been approved it will be uploaded into PowerDMS. This policy will also outline the roles and responsibilities for the policy workflow. They will also share a list soon of who currently has access to PowerDMS and can begin using it now versus who will need access. If you have any questions or in the future, please reach out to Kenzie and/or Shreya for support.

III. New Business Consent Calendar (Committee Members as applicable)

Health Services Policies Care Coordination MCCP2036 – Memorandum of Understanding (MOU) Requirements For Medi-Cal Managed Care Plans and Third-Party Entities Health Equity MCEO6003 – Race/Ethnicity, Language, Gender Identity, and Sexual Orientation Individual Member Data Collection/Storage	*Motion to* ***approve the slate without the one pulled policy****:* *Isaac Brown, MHA/MBA* *Second: Lisa Ward, MD* Next Steps:

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
/Retrieval MCEO6003-A – Attachment A Quality Improvement MPQP1006 – Clinical Practice Guidelines MPXG5001 – Clinical Practice Guidelines for the Diagnosis & Management of Asthma MPXG5002 – Clinical Practice Guidelines for Diabetes Cellulitis Utilization Management MPUP3026 – Inter-Rater Reliability Policy MCUP3037 – Appeals of Utilization Management/Pharmacy Decisions **Non-Health Services Policies** Network Services – Credentialing MPCR13D – Registered Pharmacist for AB1114 Credentialing MPCR602 – Reporting Actions to Authorities MPPR200 – Partnership Network Providers and Contracts MPPR210 – Long Term Support Services Liaison ***– Pulled – held from this meeting and will be added to May's IQI meeting.*** MPCR301 – Non-Physician Clinician Credentialing and Re-credentialing Requirements		*Apr. 15 Q/UAC* *May 13 PAC*
IV. New Business – Discussion Policies		
Policy Owner: Behavioral Health – *Presenter: Jeffrey DeVido, Behavioral Health Clinical Director*		
MPBP8003 – Mental Health Services	**Synopsis of Changed reviewed (page 156):** • Added, "and dyadic Behavioral Health Services" to section I. 1. Changes were made to align with APL 26-002 wording. • Changed wording "medications" to "drugs" in section I. 5. Changes were made to align with APL 26-002 wording. • Updated DHCS BHIN 21-073 reference to updated BHIN 26-002. DHCS updated BHIN. • Added wording "Partnership covers NSMHS without prior authorization requirements.". This aligns with Partnerships NCQA requirements for no authorization required for MH services. • Added section K. Youth Trauma Screening Tools. Section added to align with new Youth Trauma Screening Tool requirements in DHCS APL 26-002 • Updated and Added wording related to EPSDT benefit to section H 1. Changes were made to align with APL 26-002 guidance. • Added wording "Partnership covers clinically relevant laboratory and radiologic studies…" to align with wording in APL 26-002. • Removed "up to 20" limitation on individual and/or group counseling sessions for pregnant and postpartum Members. Changes were made to align with APL 26-002 guidance. • Added sections N and O in Partnership is responsible for: SABIRT services and Preventive screenings for tobacco, alcohol and drugs. Changes were made to align with APL 26-002 guidance. • Updated wording in section R. 1. "and Partnership will notify members of such applicable policies." to align with wording in APL 26-002 • Removed superseded references and added reference to APL 26-002.	*Motion to **approve as amended:** Mark Bontrager* *Second: Isaac Brown, MHA/MBA* Next Steps: *Apr. 15 Q/UAC* *May 13 PAC*

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION

	• Changed "sound" to "current evidence based" and changed "principles and processes" to "practice guidelines". Changes made to align with wording in APL 26-002
	
	Discussion:
	• Anna noticed that there were edits to the medical disclaimer on page 188 and recalled that due to an audit in the past they had to include the medical disclaimer as it was. She asked if DHCS had requested this change and if so if the changes need to be run by compliance and then updated on all other policies that use the medical disclaimer.
	  o Eric said that the new wording is the exact wording from APL 26-002. Anna asked if it should be updated everywhere?
	  o Dr. DeVido shared the policy on the screen and it was determined that the language was referencing a different policy. Dr. Moore recommended the medical disclaimer language be reverted to its original state with no changes.	

MPBP8011 – Scope of Primary Care – Behavioral Health Indications for Referral Guidelines	**Synopsis of Changes reviewed:** • Added, "and dyadic Behavioral Health Services" to section A. 1. Changes were made to align with APL 26-002 wording. • Changed wording "medications" to "drugs" in section A. 5. Changes were made to align with wording in APL 26-002. • Updated BHIN 21-073 reference to updated BHIN 26-002. DHCS updated BHIN. • Added wording "If a PCP cannot perform the mental health assessment, they must refer the Member to the appropriate Provider and delivery system for mental health services…". Changes made to align with APL 26-002. • Added section e. Reference to Youth Mental Health Screening Tools in Policy MPBP8003. Changes made to align with APL 26-002. • Added sections a, b, c and d. PCPs should screen and refer members with SUD as follows: SABIRT services, Preventive screenings for tobacco, MAT services, and Emergency and Post-Stabilization service. Changes were made to align with APL 26-002. • Removed superseded references and added reference to APL 26-002. • Changed "sound" to "current evidence based" and changed "principles and processes" to "practice guidelines". Changes made to align with wording in APL 26-002 **Discussion:** • *The discussion regarding medical disclaimer language for policy **MPBP8003** – Mental Health Services also reflected this policy with one conversation happening for both policies. Please refer to the minutes for policy **MPBP8003**, with no further discussion happening for policy **MPBP8011**.*	*Motion to **approve as amended:** Anna Campbell, MPH* *Second: Kristine Gual, PMP, CPHQ* Next Steps: *Apr. 15 Q/UAC* *May 13 PAC*
Policy Owner: Network Services – *Presenter: Mark Netherda, MD, Medical Director for Quality*		

<table>
<tr><th>AGENDA ITEM</th><th>DISCUSSION</th><th>RECOMMENDATIONS / ACTION</th></tr>
<tr><td>MPCR17 – Standards for Contracted Primary Care and Urgent Care Physicians</td><td><u>Synopsis of Changes reviewed:</u>
Added language – VI. A. 3. h. - Resident physicians, in the process of completing residency training within a primary care specialty (Pediatrics, Internal Medicine, or Family Medicine) may apply to start the credentialing process upon documented, successful completion of two (2) years of post-graduate training, within a primary care specialty residency. This will facilitate credentialing of physicians wishing to begin working in Partnership contracted practices or groups immediately upon completion of residency requirements.

<u>Discussion:</u>
• Dr. Netherda added that there will be one additional change that has not been implemented yet but would like approval on it. Under section IV. Attachments, A - Primary Care and Urgent Care Provider Criteria Form, this is actually a misnomer due to it being a list of procedures or practices that the provider is asking to be credentialed for. Due to it not being an actual criteria they will be replacing the word Criteria to Procedures, Primary Care and Urgent Care Provider Procedures Form.
○ The current link is not attached to the most up to date form. The updated form now has a box where the provider can write in and describe anything else they would like to be approved for if it falls out of the current options since this happens quite often. Attachment A is not included in the packet and is linked within the policy. Brooke is working on getting this updated within PowerDMS so it goes to the newest version.</td><td>Motion to approve as amended: Isaac Brown, MHA.MBA
Second: Aaron Brincko
<u>Next Steps</u>:
May 13 Credentials Committee</td></tr>
<tr><td colspan="3">Policy Owner: Care Coordination – Presenter: Aryana Cunnigham, Policy Analyst – Care Coordination</td></tr>
<tr><td>MPCP2034 – Transitional Care Services (TCS)</td><td>Pulled from the packet for this month and will come back at a later time.</td><td><u>Next Steps:</u>
This policy will return at to a later IQI meeting after further review.</td></tr>
<tr><td colspan="3">Policy Owner: Pharmacy – Presenter: Andrea Ocamp, Pharm.D., Clinical Pharmacist – Pharmacy</td></tr>
<tr><td>MCRP4068 – Medical Benefit Medication TAR Policy</td><td>• This policy is coming back ahead of its annual review to meet NCQA requirements.
<u>Synopsis of Changes reviewed:</u>
Section VI.C-Members or their authorized representative may request a PAD that is not on the list of covered drugs or exceptions to the UM requirements based on medical necessity
Section VI.C.1.-Effective June 1, 2026, prescribers submitting TARs for PADs must be enrolled in Medi-Cal FFS using a Type 1 NPI through PAVE. TARs associated with non-enrolled prescribers may be administratively denied.
Section VI.D.1.-Providers are expected to include ICD-10 CM codes when applicable to support medical necessity determination</td><td>Motion to approve as presented: Kristine Gual, PMP, CPHQ
Second: Isaac Brown, MHA/MBA
<u>Next Steps</u>:
Apr. 15 Q/UAC
May 13 PAC</td></tr>
</table>

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION

	Section VI.I.1.f-Drug exclusions, restrictions, or PA requirements implemented under Medi-Cal Rx effective January 1, 2026 remain outside the scope of Partnership medical benefit review unless DHCS guidance explicitly assigns responsibility to the MCP
	
	<u>Discussion:</u>
	• Mark asked if managed care plans will be fielding grievances regarding the June 1, 2026 deadline?
	   ○ Dr. Moore said that typically grievances are handed over to Magellan to be handled but Partnership does serve as the backup if they do not resolve it well. Since this is regarding provider enrollment the idea is that there will be collaboration to enforce it. A list was provided with 2/5ths of the gigantic list having only filled 1 prescription. The two top prescribers were pharmacists, not outside prescribers. Pharmacists have the ability to prescribe certain things. This last was sent to RAC for investigation. Pharmacy can prescribe nicotine replacement therapy, birth control, and travel health meds directly.
	   ○ Dr. Jalloh added that pharmacists have to go through various trainings to be able to provide prescriptions directly to patients. For example the state has their own naloxone training that they require for it to be provided.	

Policy Owner: Quality Improvement– *Presenter: Rachel Newman, RN, Manager of Clinical Compliance*		
MPQP1022 – Site Review Requirements and Guidelines	**<u>Synopsis of Changes reviewed:</u>** This policy is coming back ahead of its annual review in large part to accommodate UM's MCUP2033 – Urgent Care Services policy. Accordingly, MCQP1022's attachments will now include review tools relevant to urgent care. Additional changes have been made to improve the workflow of the policy and be more inclusive of the additional reviews performed by the Site Review team. Policy title changed from MCQP1022 to MPQP1022 due reflect applicability to Partnership Advantage, effective January 1, 2027." **Section III Definitions added:** "Supplemental Facility, Free Standing Urgent Care Provider, Free-Standing Urgent Care Center, Shared Medical Record Practice" to add clarification throughout the policy. **Attachment F –** the Non-Accredited Facility Site Review Tool – has minor updates on questions for flow and process. **Note: this Tool will no longer be used for Urgent Care.** **Attachments are being reordered and thus re-lettered Attachments J-N below are new additions:** J. Free Standing Urgent Care Clinic Facility Site Review Tool K. Urgent Care Medical Record Tool L. PCP Providing Urgent Care Facility Site Review Tool M. Palliative Care Facility Site Review Tool N. Palliative Care Medical Record Review Tool	*Motion to* ***approve as presented:*** *Mark Netherda, MD* *Second: Lisa O'Connell, MHA* *<u>Next Steps</u>:* *Apr. 15 Q/UAC* *May 13 PAC*

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Section VI Policy /Procedure is entirely reformatted for ease of reading. Therein, these additions or changes have been made: • "Supplemental Sites" added as language to be more inclusive in required site reviews. (p.5) • Sites with a failed review will be placed on an annual review. • "Any site review concerns that reveal significant quality of care issues will be forwarded to the Chief Medical Officer or the Quality Medical Director for Quality for further guidance." (p. 5) • Partnership expanding to a new service area. Language is removed and now points to APL 20-017 for guidance. • Facility Site Review (FSR) Scoring language on Critical Elements (CEs) is updated (p. 7) • Medical Record Review (MRR) Scoring language is updated (p. 8): "If the minimum number of records is not available, Partnership will document the rationale and complete the MRR with the available records." • Obstetric Specialists and Non-Accredited Sites have been bundled and FSR and MRR language augmented under section "Specialized Site Reviews" (pp. 12) These are followed by additional MMR language pertaining to Free Standing Urgent Care Clinics (p. 12), and "PCP providing Urgent Care Services" (p. 12) "A Palliative Care report is run monthly by the Inspections Site Review Team." (p. 13) • Removed section under Non-Accredited site reviews. These reviews do not fit within the Site Review scope. Sites removed include Hospitals, Skilled Nursing Facilities, Ambulatory Behavioral Health Facilities, Free Standing Surgical Centers. Originally was going to place a "rural section" but felt it was more accurate to completely remove. These sites will require accreditation. **Discussion:** *No questions or discussion regarding this policy.*	
Policy Owner: Utilization Management – *Presenter: Tony Hightower, Associate Director of UM Regulation*		
MCUP3133 – Wheelchair Mobility, Seating and Positional Components	**Synopsis of Changes reviewed:** **Section VI.A.3.a. and b.:** This policy was updated to include language for Charpentier billing as follows: • Partnership will process a TAR for a dually eligible Member in the same manner as it would process a TAR for a Medi-Cal-only Member, regardless of whether Medicare (or any other health coverage) has authorized the equipment or been billed. • A TAR for such requests must include all medical justification and documentation that would normally accompany a Medi-Cal-only TAR and include the message "Medi/Medi: Charpentier/Rates", "Medi/Medi: Charpentier/Benefit Limitation", or "Medi/Medi: Charpentier/Both Rates and Benefit Limitation" in the Medical Justification section. **Discussion:** • Dr. Spiller expressed concern that if we are saying we are processing the Medi/Medi claims the same as MediCare's decision because often when they are processing the claim MediCare has not made	*Motion to* ***approve as presented:*** *Katherine Barresi, RN, BSN, PHN* *Second: Lisa O'Connell, MHA* *Next Steps:* *Apr. 15 Q/UAC* *May 13 PAC*

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION

	their decision yet. She suggested removing this language from the policy and instead having it be on an internal workflow.
	    ○ Dr. Moore asked if MediCare typically approve the various wheelchair items? Dr. Spiller said they will approve the wheelchair but then deny some of the components, the same as Partnership. Depending on the member, if appropriate, it could go to a QHP eval.
	    ○ Dr. Moore confirmed that we do not have to define this workflow within the policy and instead will develop a desktop.
	• Rosalee expressed a concern that if they receive a TAR and the patient is Medi/Medi. If we cannot determine if it was approved and/or paid by MediCare. Would they request the periscope review or would we approve and hope that our Claims stops it? Dr. Moore said that if we do an independent review, then they would need to do the periscope review, along with confirming this is also a workflow issue and not a policy one.
	• Kellie asked who will be on point for the workflow development to ensure it gets completed. Rosalee and Dr. Spiller will work on it together. Kellie confirmed to also include claims so they are informed on how to process them.	

V. Presentations

QI Update – *Isaac Brown, MPH/MBA, Senior Director, Quality Improvement and Performance*

- The Perinatal Symposium will be held on April 13th out of Fairfield and broadcast to Auburn, Eureka and Redding offices for providers to attend in person. Topics covered will include:
  - Nutrition education and treatment in the perinatal period
  - Comprehensive assessments: Integrating effective strategies to understand and meet your patient's needs during and after pregnancy
  - Maternal mood disorders: Screening, diagnosis, and treatment
  - Substance use disorders during and after pregnancy
  - Vascular disease: Who is at risk?
- Our CAHPS program administers our annual survey with progress on the regulated survey remaining on schedule, with the telephone interviewing phase currently underway. The survey window is expected to close in May, marking the end of the data collection period.
- For the upcoming quarter we currently have 40 mobile mammography events scheduled with 19 of those being in Eureka. The calendar is quickly being filled so if there are any providers who are interested please have them reach out to mobilemammography@partnershiphp.org
- In the period of 02/26/2026 to 04/01/2026 there were 39 referrals for Potential Quality Issues (PQI) were received with 34 coming from Grievance and Appeals, 3 from Utilization Management, 1 from Care Coordination and 1 from QI Member Safety. There is a training for Grievance and UM coming up so there will likely be an uptick in referrals. If any other department is interested in having this training, please reach out to Robert Bides.
- NCQA released the March HPA and HOA Triannual Policy Updates on 3/30/2026. The NCQA Project Management Team has provided updates on impacted standards with respective Business Owners (BOs). BOs are asked to review the updates, assess impact, and/or request clarification to ensure the evidence documentation is aligned with NCQA's scope of review, or must implement/finalize edits within 90 calendar days of the release date for any policy changes or clarifications.

Discussion:

- *No questions or discussion regarding this update.*

MPUD3001 – Utilization Management Program Description – *Tony Hightower, Associate Director of UM Regulation*

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
Pages 449 - 657 **Synopsis of Changes reviewed (page 446):** Annual updates to our UM Program Description for both UM and Pharmacy activities were made in conjunction with our annual UM Program Evaluation. **Page 1:** In the Program Purpose section, "Enhanced Health Services" was added as the eighth Health Services team. **Pages 2 - 19:** Program Staff descriptions were reorganized into sections as follows: OCMO, UM, BH, and Pharmacy. **Page 3:** Added Program Staff description for the new position of Deputy Chief Medical Officer. In the assigned responsibilities for the Medical Director of Quality, added that this position serves as Chair for the Credentials Committee, Directs the two Member Safety Teams for Clinical Compliance and Quality Investigations, and Works with the Grievance and Appeals team to review Member Grievances with possible clinical care elements. **Page 5:** Removed Program Staff description for Director of Health Equity as that position is now described in the QIHETP Program Description, MCED6001. **Page 6:** Updated Program Staff description for the Director of UM to clarify duties and remove responsibility for reporting to Q/UAC on UM activity. **Page 7:** Updated Program Staff description for the Director of EHS. **Page 8:** Updated Program Staff description for the Associate Director of Utilization Management Regulations to state that this position gathers UM program information and incorporates updates into the annual UM evaluation and program description. **Page 9:** Updated Program Staff description for the Associate Director of EHS. **Page 10:** Added new Program Staff description for Manager of Enhanced Health Services Operations. **Page 11:** Updated Program Staff description for the Clinical Supervisor of Enhanced Health Services to include participation in oversight and audit of CalAIM providers. **Pages 12-13:** Updated Program Staff descriptions for Nurse Auditor, Nurse Coordinator II, and Nurse Coordinator I. **Pages 13-14:** Added new Program Staff description for Program Manager II and Program Coordinator II in UM Regulations. Also updated Program Staff description for Program Manager I – (EHS). **Page 15:** Updated Program Staff descriptions for Project Coordinator II - (EHS), Project Coordinator I - (EHS), Health Services Analyst I, and Health Services Administrative Assistant II – UM, EHS. Added a new Program Staff Description for Program Coordinator I - (Training & Education). **Pages 16 - 17:** Updated Program Staff description for Behavioral Health Clinical Director to reflect only MD as that is the credential for the person currently in this position. Other options of DO, PhD, and PsyD were deleted for now. Other updates were made to clarify changes since Carelon was de-delegated. **Pages 17-18:** In the Behavioral Health section, added new Program Staff descriptions for Senior Manager of Behavioral Health, Sr. Manager of Behavioral Health Access, Sr. Manager of Child Welfare Program, Manager of First 5 Commissions, Manager of Mental Health Programs, and County Child Welfare Liaison. **Page 20:** Updated information on attendees for the PAC Committee. **Pages 20-21:** Updated information on attendees for the Q/UAC Committee and specified that the committee activities include annual review of UM rates and identification of actions to address opportunities identified. Also updated information on attendees for the QIHEC committee. **Page 22:** Corrected definition of BHT to reflect Behavioral Health Treatment instead of "therapy" services.		*Motion to **approve as presented:** Lisa O'Connell, MHA* *Second: Kristine Gual, PMP, CPHQ*

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
Page 24: Updated information on APL 22-012 to reflect APL 25-013 Medi-Cal Rx Pharmacy Benefits and Cell and Gene Therapy Coverage. **Page 25:** Updated policy number MPCP2017 to reflect MPBP8011 because the *Scope of Primary Care - Behavioral Health and Indications for Referral Guidelines* policy has been transferred from Care Coordination to the Behavioral Health department. **Page 27:** In the Utilization Manager Process section, added statement to say that "Appropriately licensed professionals supervise all medical necessity decisions as described in the UM Program Staff section starting on page four (4)." This was a recommendation from our NCQA consultant. Consultant also added clarification to last statement on the page to specify that UM considers the "local" delivery system and the availability of services with "their ability to meet the Member's specific health care needs." **Page 31:** In the UM chart for Non-Behavioral Healthcare Decisions and Behavioral Healthcare Decisions, the time frame for Non-urgent pre-service decisions was changed from 5 business days to 7 calendar days as per DHCS regulations. A new time frame chart was added to describe Pharmacy Decisions that must be made within 24 hours of receipt of request for Urgent Concurrent, Urgent Pre-service, and Non-urgent pre-service decisions. **Page 33:** In the Availability of Criteria section, language was updated to say that the Provider Relations department notifies providers in writing "and electronically" regarding availability of UM criteria. Per our NCQA consultant, this statement was also added to describe our upcoming D-SNP program: "Partnership's UM Program plans include development and implementation of its CMS Final Rule Interoperability plan during CY 2026. This plan will include steps for the implementation of practitioner access to criteria electronically at point of service. Implementation is planned for January 2027." **Page 35:** The section on Appeals was updated per recommendation from our NCQA consultant. The title of the section was changed to specify "Process for ***a Member or a*** Provider ***on Behalf of a Member*** to Appeal an Adverse Benefit Determination," and the following language was added to this section. "The Member or their authorized representative may submit a request for appeal verbally or in writing. The Member or the authorized representative may submit additional information for review and may request copies of all documents considered as part of the review. The time for resolution begins when the request is received, even if the information provided is incomplete. Partnership makes appropriate attempts to obtain any needed information for review within the required timelines, in order to make an informed decision within required timeframes based on clinical urgency and according to our policies and procedures." **Page 39:** The Annual Program Evaluation section was updated to specify that the Behavioral Health department participates in the evaluation, and the following additional positions were added for leadership who contribute: Senior Director of Care Management, Senior Director of Behavioral Health, and the Director of Enhanced Health Services. **<u>Discussion:</u>** • *No questions or discussion regarding this policy.*		
Annual 2025 Utilization Management (UM) Program Evaluation - NCQA UM Standard 1 Element G –*Tony Hightower, Associate Director of UM Regulation and Andrea Ocampo, Pharm.D.*		
UM 1G Annual UM Program Evaluation (Page 493) • Annual review for the UM program of CY 2025 report assesses the following: o Program Structure		*Motion to* ***approve as presented:*** *Mark Netherda, MD*

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	○ Program scope, processes, and information sources used to determine benefit coverage and medical necessity. ○ Level of involvement of the senior-level physician and designated behavioral healthcare practitioner in the UM program ○ Member and Practitioner experience with the UM program • **Program Structure: Staffing Oversight (Page 496)** ○ Currently Partnership established a minimum threshold of Medical Directors to Nurses and Medical Directors to Pharmacists at 1:5 at 1:5 (20%). Partnership's Physician to Pharmacist ratios were met for all months in 2025 but Physician to Nurse ratios did not meet the threshold goal from July through December 2025. ○ Partnership received about 12,000 pharmacy Treatment Authorization Requests (TARs) which was a 9% increase from 2024. ○ Also monitored the TAR per pharmacist and TAR per tech ratios month to month to assess for adequate staffing. The TAR per pharmacist did exceed the 20% month to month threshold in July and October due to fluctuations in TAR volume and staff retirement. Hired new staff in Q4 to address the staffing gaps and daily workflow demands. • **Program Structure: Staffing Workload (Page 497)** ○ Annual TAR volume was 327,639 which represented a 4.95% decrease from calendar year 2024. ○ Nurse to medical director ratio also operates on the 20% threshold. For quarter 3 and quarter 4 fell below the 20% threshold due to an influx of nursing hires that was out of proportion to the hiring of medical director staff. **Suggested interventions are as follows:** • Continuing to assess and monitor staffing ratios • Continuing to assess opportunities for increased efficiency in evaluating TAR requirements. • Increase staff ratio threshold from 1:5 (0.20) to 1:6 (0.167) based on 2025 process improvement and operational assessment ○ TAR to nurse ratio was met for all quarters. This was a reflected of interventions that were made in 2024 and indicators of the interventions that were put forward were effective. • **Program Structure: Evaluation of the Partnership Advisory Committee Structure (Page 499)** ○ All advisory committees were within quorum threshold. • **Program Process: UM Rates (Page 501)** ○ *The 2025 results, along with the interventions and ongoing activities by UM and Pharmacy to address identified gaps and opportunities are detailed in the UM 1F Evaluation of Utilization Management Rates Report (Appendix A – Page 512) – see below for minutes.* • **Program Process: Consistency of Applying UM Criteria (Page 502)** ○ For inter-rate reliability (IRR), this is the measure of how we apply our criteria for our nursing and medical director staff. NCQA threshold of concurrence is set at 90%. For the UM team it was identified that for the outpatient, LTSS, and medical directors reviewers they were able to meet the 90% threshold. For Inpatient Nurse Reviewers, the concurrence rate for Q2-Q4 fell below the 90% threshold with an overall rate of 89%. **Suggested interventions are as follows:** • Tracking and trending for repeated deficiencies to be observed and acted upon by UM Leadership on a quarter-by-quarter basis. • Conduct team-wide discussions on consistency in applying medical necessity criteria during internal Inpatient Rounds • Conduct annual training on InterQual for UM Nurses. • UM Nurse Scorecard template updated to include IRR components. The scorecard is used to score IRR and other competencies for each nurse on a monthly basis.	*Second: Kristine Gual, PMP, CPHQ*

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION

- Transition quarterly IRR monitoring process to the UM Training & Education team to focus and standardize the application of inter-rater reviews and ensure that secondary reviews are consistent.
    - NCQA threshold of concurrence is set at 90%. This was exceeded for both pharmacists and pharmacy technician reviewers.

- **Program Process: Appropriate Care: Monitoring for Over/Underutilization (Page 502)**
    - This is a summary of over/underutilization activities for the year that were evaluated by the Over/Under Committee.
    - Evaluation of Over/Under is performed across various groups and committees across the organization along with conducting over/underutilization reviews on HEDIS reviews, IQI committee, QUAC committee through sire review process and through the access and availability grand analysis that is performed by the quality team. Additional analysis and remediation actions for potential areas of noncompliance for over/underutilization are typically handled by the plan via quality improvement programs as well as the standard UM process and review.
- **Program Process: Information Source Used to Determine Benefit Coverage and Medical Necessity (Page 506)**
    - Partnership uses the most currently available InterQual® Criteria sets as the primary review guidelines for UM medical necessity decisions. For the calendar year 2025, UM used the 2024 InterQual decision criteria until the 2025 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 MPUP3139 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®.
    - 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 Community Advisory Committee (CAC), external providers, State policy letters, or medical literature among other sources.
- **Program Process: Prior Authorization Requirements (Page 506)**
    - Partnership's Pharmacy & Therapeutics (P&T) Committee determines whether or not a particular drug or pharmaceutical class shall be absent of TAR requirements based on therapeutic advantages in safety and efficacy, standards of care, and generally accepted place in therapy. Cost, utilization, and approval rates are also considered.
- **Program Process: Involvement of Senior Level Physicians in the UM Process (Page 506)**
    - Partnership looks at the involvement of the CMO and medical directors including the Behavioral Health clinical director in the UM process. The CMO and medical directors participate in the review and approval policies via PAC and QUAC and for the pharmacy team the PNT workgroups and committees. They also perform daily UM review, decision making, and participate in internal and external clinical rounds.
- **Program Process: Assessing Experience with the UM Process: Improving Practitioner Experience with the UM Process (Page 507)**
    - *Please see Appendix B: Physician Satisfaction Survey for a breakout of the practitioner experience.*
    - On an annual basis Provider Relations engages with a third party surveyor, Press Ganey, to survey our network of primary care physicians and specialists to gauge their satisfaction with Partnership's UM and Pharmacy processes.
    - UM was able to meet the threshold goal of 90% with primary care physicians.
    - UM was unable to meet the threshold goal of 90% with the specialists. 6 UM questions that were posed to our network specialists did not hit the goal.
    - Pharmacy was unable to meet the threshold goal with primary care physicians. 1 question did not hit the goal.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	○ Pharmacy was able to meet the threshold goal with specialists. ○ Analysis of these results it was identified that there was a potential gap in provider education in both Eastern and Southern regions. These results were driven by the Eastern region with this being their first survey. **Suggested interventions are as follows:** • Collaborate with the Provider Relations (PR) team to participate in clinic site visits to share information about the Partnership Pharmacy program and the services available to providers. • Collaborate with the PR team to educate PCPs on the differences between the Partnership Pharmacy program and Medi-Cal Rx • **Program Process: Assessing Experience with the UM Process: Member Experience with the UM and Pharmacy Process (Page 509)** ○ *Please refer to Appendix C for further details of Member satisfaction data for 2025.* ○ 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). ○ In 2025 there was an overall increase in grievances received when compared to 2024. Majority of areas that did not meet goals centered around provider related concerns. The primary issue reported concerning the UM process was access-related issues. Notably, 57.3% of these access-related issues were associated with Partnership's Referral Authorization Form (RAF) process, while the remaining 42.7% were linked to the Treatment Authorization Request (TAR) process. Among the reported issues within the referral process, delays by providers (162) 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 Members alleging that their providers delayed submission of TARs to Partnership (87 reported concerns). ○ **Suggested interventions are as follows:** • Collaborate with the G&A team to include additional data points in the PULSE report for "Member Experience with the UM Program" — • adding data for Member "County" and "Provider Substantiation" (Yes or No). This additional information will allow UM to further stratify the data and gain insights into trends in Member concerns. • Collaborate with the PR team in pursuing educational opportunities with our provider network on Partnership processes and resources to improve Member satisfaction with the authorization process. **Supplemental TAR Report to the 2025 UM Program Evaluation (Page 526)** • Tis includes a TAR breakdown of each departments respective TAR numbers by category and status type. • Also includes a summary breakdown of the percentage of TARs that were approved, modified and approved, denied, and admin denied. • Summary of the percentage of appeals that were upheld, overturned, and partially overturned. **Appendix A: Evaluation of Utilization Management Rates – NCQA UM Standard 1 Element F (Page 512)** • UM Rates: The aggregate approval rate was 77.58% and the aggregate denial rate was 22.42%. Within the reporting specs provided by NCQA these rates do include all administrative decisions including duplicate tar or no tar required denials. When looking at just medical necessity denials the denial rate was at 6% which is significantly lower than the combined denial rate.	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION

- Pharmacy Rates: The aggregate approval rate was 86.34% and the aggregate denial rate was 19.46%. This reporting also included all operational and administrative decisions and exclude retrospective decisions. Quarterly report showed that the approval and denial rates remained stable and consistent throughout the year. When looking at just medical necessity denials the denial rate was at 10.49%. Quarterly reports were reviewed showing a 2% denial rate increase from quarter 3 to quarter 4. This increase was due to introduction of new preferred product requirement but after reviewing the rest of the denials there were no other noticeable trends.
- Appeal rates: These are a combination of UM, pharmacy, and GNA teams. Overall appeals rate was 2.91% with an overturn rate of all appeal rates being 29.41%. When evaluating these rates with the GNA team it was determined that most of the overall appeals overturn volume was due to UM receiving a large influx of appeals related to disagreements on level of care decisions for post discharge and patient stays. These primarily came from 2 large hospital providers within our network. GNA also reported that a large proportion of their appeals were focused on medically tailored meals benefit that is processed by the EHS team.
- Timeliness: Rates are evaluated for both Non-Behavioral and Behavioral decisions, although Partnership does not require any prior authorization for Behavioral healthcare so we report none in that section and therefore do not have any data to present on. For both Non-Behavioral and Pharmacy decisions both met the 90th percentile threshold for the year. Due to the updates that UM has encountered with applications of the CMS final rule and that they have a planned transition from the current legacy TARE processing platforms to JIVA platform. This poses a significant risk to timeliness in the later part of 2026 and into 2027. THE UM team will; be increasing the cadence of monitoring timeliness from weekly cadence to a daily cadence in that 30 – 60 day period post go live of JIVA implementation.

Conclusion
Overall, Partnership's UM Leadership concludes there are no significant changes required for the UM program. Activities addressing the improvement opportunities will continue to be monitored, measured, and reported in future evaluations. We find that 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.

Summary of Opportunities and Proposed Interventions by UM for Approval

Priority	Opportunities Identified	Barriers	UM Program Evaluation Component	Interventions
1	**IRR concurrence rate for inpatient nurse reviewers**	Lack of consistency in applying inpatient criteria by UM Nurses	UM Program Processes	• Tracking and trending for repeated deficiencies to be observed and acted upon by UM Leadership on a quarter-by-quarter basis. • Conduct team-wide discussions on consistency in applying medical necessity criteria during internal Inpatient Rounds • Conduct annual training on InterQual for UM Nurses. • UM Nurse Scorecard template updated to include IRR components. The scorecard is used to score IRR and other

AGENDA ITEM	DISCUSSION				RECOMMENDATIONS / ACTION
				competencies for each nurse on a monthly basis. • Transition quarterly IRR monitoring process to the UM Training & Education team to focus and standardize the application of inter-rater reviews and ensure that secondary reviews are consistent.	
2	**Physician to Nurse staffing ratios**	Uncertain fiscal climate at State and Federal levels	UM Program Structure	• Continuing to assess and monitor staffing ratios • Continuing to assess opportunities for increased efficiency in evaluating TAR requirements. Increase staff ratio threshold from 1:5 (0.20) to 1:6 (0.167) based on 2025 process improvement and operational assessment	
3	**Provider Experience with the UM Process**	Negative provider perceptions of Medi-Cal Rx may be conflated with Partnership's Pharmacy processes.	UM Program Scope	• Collaborate with the Provider Relations (PR) team to participate in clinic site visits to share information about the Partnership Pharmacy program and the services available to providers. • Collaborate with the PR team to educate PCPs on the differences between the Partnership Pharmacy program and Medi-Cal Rx	
4	**Member Experience with the UM Process**	Absence of year-over-year comparative data for recent Eastern Region expansion counties con-strains analysis of factors contributing to lower Member satisfaction scores.	UM Program Processes	• Collaborate with the G&A team to include additional data points in the PULSE report for "Member Experience with the UM Program" — adding data for Member "County" and "Provider Substantiation" (Yes or No). This additional information will allow UM to further stratify the data and gain insights into trends in Member concerns. • Collaborate with the PR team in pursuing educational opportunities with our provider network on Partnership processes and resources to improve Member satisfaction with the authorization process.	

Discussion

- Dr. Netherda commended the evaluation.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
• Isaac asked that regarding the physicians to nurse threshold being lowered due to more nursing staff added, does the additional staff cause any other complications like more work for the physicians? ○ Tony said that there is work currently being done to better evaluate requirements and identify opportunities where TAR requirements could be relaxed especially in areas where they ae not showing value. This work requires collaboration with the CMOs. • Isaac wanted to know if there was anything that could be done on the Quality or PR side to help address the dissatisfaction from the East Region through the provider survey. ○ Tony said it was difficult to say as there s an assumption this is their first time being surveyed and seeing these questions. Being that they went through the expansion they also left a two plan model. It was expressed to Partnership that there were certain levels of dissatisfaction with the 2 plan model but it was something that they were used to. QI continuing to engage with providers and helping them become familiar with our plans benefits and programs would be most beneficial.		
Population Needs Assessment Presentation – *Hannah O'Leary, Manager of Population Health*		
• Presentation begins on page 521 with the full report beginning on page 531. • The Population Needs Assessment takes place every year and looks at the needs of our members from the past calendar year, 2025. • Key findings included economic instability, lack of access to quality health care, neighborhood and built environmental challenges, limited access to quality education, and social and community context changes. • Other community challenge findings included access to care, differences in health outcomes, transportation, environmental concerns (wildland fires), and chronic conditions. • Chico region had the greatest percentage of members accessing mental health services. • Continuing to struggle in some areas with breast cancer and cervical cancer screenings. • Reported some health disparities in a particular set of ethnic and racial categories in clinical measures. • Opportunity areas included organizational structure, social and environmental needs, member health and wellness, access to care, health disparities, and health education. • **Organization structure:** ○ Hired a handful of different positions that will support their health equity department. ○ Fully staffed health needs liaison team to cover all 24 counties. • **Social and environmental needs:** ○ Has been some opportunities to distribute CalAIM distribute payment program: awarded over $52 million in grants. To local entities to build out our enhanced care management and community supports programs. ○ Many of the households in our counties reported having insufficient income. Partnership is continuing to work on increasing workforce opportunities. ○ Partnership continues to support its Asthma Emergency Department Visit Outreach Program • **Access to Care:** ○ Some great work around working with our schools to increase behavioral health access ○ Continued working with Alinea for mobile mammography ○ Continued to work on providing education regarding the cervical cancer self-swab program ○ Continued growing together program that focuses on getting kids into well visits and to get vaccinated ○ Continued working on the provider recruitment and retention programs to increase access • **Health Disparities:**		*Motion to* ***approve as presented:*** *Isaac Brown, MHA/MBA* *Second: Mark Netherda, MD*

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	○ Continued our tribal health connections in order to support our tribal members who may not have great access to perinatal care • **Health Education:** ○ Continued with our basic health population management programs ○ Community resource pages are still available and are a great resource for those who need support with identifies available resources in their area. ○ Wonderful member education events where members who were new to Partnership were able to ask questions and receive support. **Discussion:** • *No questions or discussion regarding this policy.*	

Proposed 2027 Palliative Care QIP Measure Set – Eva Lopez, Program Manager I, Quality Improvement

- No approval needed from IQI as it is going to PAC for approval, this is serving as an FYI.
- No changes to the measure set, all 3 measures will remain the same for 2027.
- If you have any questions please send them to Eva for consideration before it goes in front of PAC next month.

Discussion:
- *No questions or discussion regarding this policy.*

Proposed 2026 Hospital QIP 6-month Bridge Measure Set – Troy Foster, Program Manager II, Quality Improvement

- No approval needed from IQI as it is going to PAC for approval, this is serving as an FYI.
- Three measures that are being proposed for extension while staying within their current phase:
  - **Expanding Delivery Privileges**
    - Will move into the next phase in 2027.
  - **Doula Support**
    - Will move into the next phase in 2027.
  - **Vaccines for Children Enrollment**
    - Extended for providers to get enrolled.
    - If already enrolled this measure will be N/A for them.
    - This measure will retire in 2027.
- Three measures are being proposed for removal from this 6 month set:
  - **QI Capacity**
    - Hospital Quality Symposium has already been offered for the 25-26 measurement year. The plan is for this measure to return for the full 2027 calendar year HQIP.
  - **Cal Hospital Compare**
    - Scores for the 25-26 measurement year would have just been delivered meaning there would be no new information to score the hospitals. The plan is for this measure to be return for the full 2027 calendar year HQIP.
  - **Health Equity**
    - Hospitals would have just submitted their annual report to Partnership in August of 2026 and because CMS removed its requirement for Commitment to Health Equity Attestation, which is what this measure was based upon. The plan is to develop a new Health Equity measure that will be added to the full 2027 calendar year HQIP.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
• If you have any questions please send them to Troy for consideration before it goes in front of PAC next month. **Discussion:** • *No questions or discussion regarding this policy.*		
VI. Adjournment		
Dr. Moore adjourned the meeting at 3:24 p.m. IQI will meet next Tuesday, May 12, 2026.		
Respectfully Submitted by Chandler Ackerman, Project Manager I, Quality Improvement *Approval Signature:* *Date:* *Robert Moore, MD, MHA, MBA* *Chief Medical Officer and Committee Chair*		

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

Quality Incentive Programs (QIPs)	
PROGRAM	**UPDATE**
Primary Care Provider Quality Incentive Program (PCP QIP)	**Program Overview** Pay for performance program incentivizing improved performance on Clinical, Non-Clinical, and Unit of Service (UOS) measures in the Primary Care setting. **Program Update** • Payment for PCP QIP is expected to happen later this month
Palliative Care Quality Incentive Program (Palliative Care QIP)	**Program Overview** Pay for performance program which offers significant financial incentives to support and improve the access to and quality of palliative care provided by our contracted palliative care providers. **Program Update** • No Update
Perinatal Quality Incentive Program (PQIP)	**Program Overview** The Perinatal QIP offers financial incentives to participating Comprehensive Perinatal Services Program (CPSP) and select non-CPSP providers providing quality and timely prenatal and postpartum care to Partnership members Program Update **Program Update** ○ No Update
Enhanced Care Management quality Incentive program (ECM QIP)	**Program Overview** The ECM QIP offers financial incentives to motivate, modify, and improve the health outcomes of seven identified groups of individuals by standardizing a set of care management services and interventions **Program Update** • No Update
Hospital Quality Incentive Program (HQIP)	**Program Overview** The Hospital QIP offers financial incentives to improve performance related to Readmissions, Advance Care Planning, Clinical Quality, Patient Safety, Operations and Efficiency, and Patient Experience **Program Update** • No Update

EXTENDED CARE FACILITY INCENTIVE PROGRAM (EXT QIP)	**Program Overview** The EXT QIP offers financial incentives to support and improve the quality of long-term care provided to our members, with measures in the following domains: Clinical, Functional Status, Resource Use, and Operations / Satisfaction. **Program Update** • No Update

QUALITY DATA TOOLS

TOOL	UPDATE
PARTNERSHIP QUALITY DASHBOARD (PQD)	**Program Overview** The Partnership Quality Dashboard (PQD) is a Tableau designed to inform, prioritize, and evaluate quality improvement efforts. Dashboards and performance metrics built into the PQD provide the ability to track and trend QIP data. **Program Update** • PQD is expected to launch this month (May)
EREPORTS	**Program Overview** eReports is a web application that allows providers to see their quality metrics in Partnership's PCP QIP program. eReports updates twice a week for near real-time visibility to quality metrics while PQD refreshes monthly for historical trending. **Program Update** • No Update

PERFORMANCE IMPROVEMENT (PI)

ACTIVITY	UPDATE
STATE MANDATED WORK: *PERFORMANCE IMPROVEMENT PROJECT (PIP) & PLAN-TO-DO-STUDY-ACT (PDSA) CYCLE*	**Program Overview** All plans in California are required to conduct PIPs as part of their agreements. DHCS has assigned Partnership two PIPs: a non-clinical PIP for BH and a disparity PIP. DHCS can also require plans to do mandated improvement PDSA projects **Program Update** • No update
QUALITY MEASURE SCORE IMPROVEMENT	**Program Overview** Internal measure-focused workgroups, which bring together perspectives across Partnership's services delivery continuum with the goal of strategically improving measures that align with the strategic priorities of Partnership HealthPlan. Current Priority Measures: 1. Child and Adolescent Well Care Visits (WCV) 2. Adolescent Immunizations (IMA-2) 3. Controlling High Blood Pressure (CBP)

	4. Glycemic Status Assessment for People with Diabetes (GSD) 5. Timely Prenatal Care (PPC-Pre) **Workgroup Updates** • **Pediatrics:** The process of spreading measure-specific best practices from high performing practices to lower performing practices is ongoing. • **Women's Health & Perinatal:** Partnership's Enhancing Perinatal Support and Services Webinar is occurring monthly through June 2026. • Fostering Connections provider meeting planning is underway with a focus on Timely Prenatal Care (PPC Pre). One session has been completed with Dr. Townsend and a large prenatal care provider in Shasta County. More are being scheduled with focus on the Redding region. • One on One provider training on hrHPV self-collect is ongoing. Our lab vendors have informed us that a completely at-home sample collection option should be available in 2027. • **Chronic Disease:** At the April 2026 meeting, the group welcomed Dr. Matthew Morris as the new clinical lead. The group is focusing on three measures that have high impact and a high need for improvement across the network: Blood Pressure control, Blood Sugar Control, and Colorectal Cancer Screening. We are conducting root cause analyses of each measure and will aim for change ideas and any project work to begin mid-year. • **Behavioral Health:** There are new (as of April 1) state mandates for real-time data sharing as a key strategy to maintain ongoing data access.
IMPROVEMENT ACADEMY	**Program Overview** The Partnership Improvement Academy launched in 2014 to offer various programs which provide training and technical assistance designed to help practices optimize population health, enhance the patient experience, promote provider and care team satisfaction, and foster a culture of continuous quality improvement. These programs are designed for a variety of audiences, including clinicians, administrators, and staff to gain quality improvement expertise from industry leaders and peers. **Current Offerings** **QI Project Management Training Program** The Quality Improvement (QI) Project Training Program is designed to help provider organizations and community partners strengthen their skills to lead and manage QI initiatives by offering training and use of standardized tools, templates, and best practices. The program features a 6-session webinar series delivered over 12 weeks, covering all phases of the project life cycle and focuses on applying those methods to real-world QI efforts. **Program Update** • Registration for the Fall 2026 cohort is open through 08/25/26. • Following the successful conclusion of the Spring, a comprehensive evaluation is currently underway. The final analysis is slated for completion by 06/30/2026, and

	those findings will be leveraged to drive modifications for the upcoming Fall cohort beginning 09/01/2026. **Improving Measure Outcomes Webinar Series** This series is designed to help Quality Improvement teams turn knowledge into action. These sessions focus on Partnership's Primary Care and Perinatal Provider Quality Incentive Program (QIP) measures, offering practical strategies to close care gaps, advance health equity, and improve clinical outcomes. Each session highlights proven strategies and best practices from peer clinics that are actively achieving measurable improvements in patient care. **Program Update** • The 2026 webinar series was completed on April 22nd. **ABCs of Quality Improvement** **Program Overview** The ABCs of Quality Improvement (QI) is a full day in-person training designed to introduce participants to key QI methodologies with a specific focus on the Model for Improvement – a widely used framework for driving measurable change in health care settings. **Program Update** • The third and final 2026 ABCs of QI training is scheduled for May 14th in Auburn. The Auburn Regional team has been actively recruiting participants for this training and there are 32 registered participants from 15 Provider Organizations and 1 Public Health Department. **Microlearning** **Program Overview** These short, focused modules deliver key concepts in easily digestible formats. **Program Update** • Launched: Clinical Care Team Huddle microlearning. This targeted resource focuses on key huddle elements that improve team communication, anticipate patient needs, and reduce day-of surprises, setting teams up for smoother workflows and better patient outcomes.
JOINT LEADERSHIP INITIATIVE (JLI)	**Program Overview** The Performance Improvement team facilitates Joint Leadership Initiative meetings with seven parent organizations across the Partnership network. Four of the seven organizations are in our expansion counties (Chico and Auburn Regions). This is a quality improvement strategy to collaborate with the largest parent organizations providing primary care who did not earn at least 75% of their PCP QIP scores in the previous year. This number could change once final 2025 PCP QIP scores are finalized.

	Update • There are 2 Joint Leadership Initiative meetings planned in May.
REGIONAL IMPROVEMENT MEETINGS	**Program Overview** Regional Quality Improvement meetings are held quarterly at each of our 6 regional offices (Eureka, Redding, Chico, Auburn, Fairfield, and Santa Rosa) or online with the goal of bringing together regional health center quality leaders to share and discuss strategies to improve measures that are regionally important and learn from Partnership regarding any program changes and/or priorities. **Update** • **Santa Rosa and Fairfield Regions –** Next meetings in June • **Chico and Auburn Regions –** Next meetings are in July • **Redding and Eureka Regions –** Next meetings in June

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

QI PROGRAM & PROJECT MANAGEMENT

ACTIVITY	UPDATE
CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEMS® (CAHPS) PROGRAM -MEDI-CAL PRODUCT LINE & ORG GOALS – FY 24/25 MEMBER EXPERIENCE AND ACCESS | *ORG GOALS – FY 25/26 MEMBER EXPERIENCE*	**Program Overview** Oversees NCQA Accreditation requirements for Member Experience (ME) 7 (Elements C and D). Conducts annual regulated CAHPS® surveys for Medi-Cal members and non-regulated surveys to assess patient experiences. Results drive improvements in care quality and member experience. **Program Updates** ***CAHPS® Regulated Measurement Year (MY) 2025 / Report Year (RY) 2026 Survey*** • The data collection phase for the 2026 regulated survey cycle has officially concluded. The final validated results are expected to be released mid-to-late August. ***CAHPS® Member Experience Gap Assessment:*** Rex Wallace Consulting (RWC) completed a comprehensive, rapid end-to-end assessment of our CAHPS® performance and overall member experience framework, with a focus on identifying key drivers, gaps, and opportunities for improvement across the organization.

<table>
<tr><td></td><td>We extend our sincere thanks to all participants for their engagement, flexibility, and collaboration, which helped ensure a smooth and efficient process. RWC has repeatedly noted their strong impression of our health plan and the quality of work produced.

This month, the project will move into the executive engagement phase, during which RWC will present their comprehensive report to Executive Leadership and facilitate discussions on key findings, priorities, and next steps.

Fiscal Year 2025/2026 Organizational Goal 5: Member Experience (MX)
• Fiscal Quarter 4: Goal activities continue, led by champions from four departments: Transportation, Member Services, Population Health, and Quality Improvement.
• All goals are on-track to be completed by the end of the goal period.

For more insights on goal progress and milestone accomplishments, please visit the OpEx|PMO internal goal dashboard (Partnership4Me, under Smart Links).</td></tr>
<tr><td>EQUITY & PRACTICE TRANSFORMATION PROJECT</td><td>Program Overview
The DHCS Equity and Practice Transformation (EPT) Program is a statewide initiative aimed at advancing health equity while reducing COVID-19 driven care disparities. During the three (3) year program, practices receive payments for achieving population health milestones that enable the implementation of improvements across their infrastructure, data capabilities and care management processes to promote patient well-being, health equity and whole-person care.

Currently, 22 providers are participating in the EPT Program, with total estimated funding of $13.3 million over the three-year project period. These providers are expected to receive payments tied to milestone achievements that support sustainable practice transformation. The last and final opportunity to submit eligible deliverables for milestone achievement is in November 2026 when the program concludes. Payments for the November 2026 successfully completed milestones will be paid out early 2027.

Program Updates
• PHLC established minimum requirements for providers to remain in the program. Deliverables, due 05/01/2026, include:
    o 2026 PhmCAT
    o Milestone 3: Empanelment Policy & Procedure
    o Milestone 4: Data Governance & HEDIS Policy & Procedure
    o Milestone 6: Data Implementation Plan
    o Milestone 8: Disparity Reduction Plan
    o One Model of Care Document (Milestones 9-12)
• Provider Portal was open for deliverable submissions beginning 04/01/26 and closed on 05/01/26 at 5:00 PM PST.</td></tr>
</table>

	• The next quarterly CaTS report for MY 07/31/24-06/30/25 was completed and submitted, by Partnership, to Pop Health Learning Center (PHLC) by the due date, 04/30/2026.
PREVENTIVE CARE BRIDGE PROJECT (FORMERLY: LOCUM PILOT INITIATIVE)	**Overview of the Preventive Care Bridge Project** The Preventive Care Bridge Project was developed as a short-term solution to address access challenges by providing targeted locum support with the goal of improving performance on preventive care measures, specifically well-child visits and cervical cancer screenings. By proactively guiding providers to maximize the locum resources through clear onboarding, scope alignment, and data tracking, the pilot explores a potential model for supporting improved measure performance, reducing withholds and sanctions associated with unmet benchmarks, and enhancing the overall member experience. **Project Update** No new updates
MOBILE MAMMOGRAPHY PROGRAM	**Program Overview** Aims to boost breast cancer screening (BCS) rates for providers performing below the 50th percentile benchmark. Partnership collaborates with Alinea Medical Imaging and providers to host Mobile Mammography events, helping members complete preventive screenings. **Program Updates** • Event Days for FY 25/26 Q4 (April – June)

Current Event Days 04/01/2026 – 06/30/2026				
Region	**# of Provider Organizations**	**# of Provider Sites**	**# of Provider Event Days**	**# of Community Event Days**
Auburn	1	2	2	0
Chico	2	7	7	0
Eureka	9	16	19	0
Fairfield	1	2	2	0
Redding	10	11	11	1
Santa Rosa	2	2	2	0
Plan Wide	**22**	**37**	**43**	**1**

	* Totals may not match across columns due to provider orgs hosting event days at multiple sites and regions within the quarter. ** Community event days are reported separately and not included in provider totals.
PARTNERING FOR PEDIATRIC LEAD PREVENTION PROGRAM (PPLP)	**Program Overview** Provides LeadCare II POC devices to qualified providers and enrolls them in a year-long program with coaching and education. Offers lead poisoning prevention education to all and collaborates with local agencies. **Program Updates** No new updates
EXACT SCIENCES: PROMOTING COLORECTAL CANCER SCREENINGS	**Offering Overview** Providers can place care-gap orders for Cologuard kits directly through Exact Sciences or via facilitated orders through Partnership to eliminate the minimum requirement of 200 members. Any provider interested in more information can fill out the Partnership's Cologuard Facilitated Order Interest Form on our Cologuard Care-Gap Orders page. **Program Updates** **Partnership Facilitated Orders** • Five provider orgs participated in the most recent Facilitated Order that aligned with Colorectal Cancer Awareness Month in March. A total of 196 kits shipped on 03/30/2026. • The next Facilitated Order is scheduled to launch on 07/20/2026 and is aligned with QIP's timeline for addressing 2026 and 2027 PCP QIP Measures .
QI TRILOGY PROGRAM	**Program Overview** Annually, the Quality Improvement (QI) department updates three core documents – often referred to as the QI Trilogy Documents, that collectively describe the program structure, priorities and performance. The Program Description outlines the overall QI framework, the Work Plan details active and planned initiatives aligned with strategic priorities, and the Program Evaluation assesses progress, outcomes and opportunities for improvement. **Program Updates** • Updates and internal review of the 2026–2027 QI Program Description have been completed. The Program Description has been submitted to the NCQA Consultant (MHR), and feedback has been provided. Final edits are underway in preparation for Committee and Board review. • Submissions for the 2025-2026 QI Work Plan are due on 05/12/2026.

	• Initial notices for the 2025-2026 QI Program Evaluation will be sent on 05/12/2026 with submissions due on 05/29/2026. • Sponsor Business Owner Tracker update request for the 2026-2027 QI Work Plan will be sent to Business Owners on 05/19/2026. Initial notices will be sent on 06/02/2026 with submissions due on 06/18/2026. • QI Trilogy live trainings have been scheduled with invites sent to Sponsors, Business Owners, and Contributors: ▪ 2025-2026 QI Program Evaluation: 05/13/2026 at noon ▪ 2026-2027 QI Work Plan (Goal Submissions): 06/04/2026 at noon • The updated QI Trilogy LMS training launched on 04/29/2026 and will be advertised during the live training sessions as another resource.
SAGE Grant	**Program Overview** The *Systems Advancement for General EHR* (SAGE) Grant is designed to assist healthcare providers in implementing or upgrading their EHR systems, to help modernize and enhance their ability to deliver high-quality, efficient, and member-centered care. This grant will help providers overcome common barriers to EHR adoption by offering financial support and implementation guidance. The recipient of the SAGE grant, Kimaw Medical Center, signed the agreement on 12/5/2025. The first payment installment of $125,000 was initiated. The SAGE Grant team will continue to conduct regular check-ins and monitor implementation milestones. The SAGE Grant Timeline can be found here. **Program Updates** • Coordination activities are underway to prepare for the January-June Progress Check-In with Kimaw and Partnership to be scheduled in June.
D-SNP Medicare	**D-SNP** **Program Overview** The D-SNP Quality team is responsible for 1) Development and finalization of the Model of Care document, 2) Management of Partnership's CMS Medicare Star quality program, and 3) Developing D-SNP readiness for all Quality Improvement teams. The team has revised QI Department D-SNP Project plans to reflect the launch postponement with vendor-related projects TBD.
ACTIVITY	**UPDATE**
Quality Assurance and Patient Safety	

<table>
<tr><th>ACTIVITY</th><th>UPDATE</th></tr>
<tr><td>Potential Quality Issues (PQI) for the period: 4/02/2026 to 4/26/2026</td><td>Program Overview
To identify, report, and manage Potential Quality Issues (PQI), to determine opportunities for improvement in the provision of care and services to our members, and to direct appropriate actions for improvement based upon outcome, risk, frequency, and severity.

Program Update
• 33 referrals were received with 30 coming from Grievance and Appeals, 1 from Utilization Management, 1 from other (Regulator) and 1 from QI Member Safety
• 18 cases were processed and closed
• 115 cases are currently open
• One case was discussed at Peer Review Committee (PRC) on 04/15/2026 and there are three cases awaiting PRC review.</td></tr>
<tr><td>Facility Site reviews (FSR) & Medical record reviews (MRR) For Jan-march 2026</td><td>Program Overview
Site Review and Medical Record Review performed for monitoring of providers.

Program Update
• As of 4/27/2026, we have a total of 538 reviews including PCP, OB, Multiple check-in's and delegated reviews
• Primary and OB Reviews:
<table><tr><th>Region</th><th># of FSR conducted</th><th># of MRR conducted</th><th># of FSR CAP issued</th><th># of MRR CAP issued</th></tr><tr><td>Auburn</td><td>1</td><td>0</td><td>0</td><td>0</td></tr><tr><td>Chico</td><td>7</td><td>6</td><td>0</td><td>1</td></tr><tr><td>Eureka</td><td>5</td><td>3</td><td>1</td><td>2</td></tr><tr><td>Fairfield</td><td>13</td><td>9</td><td>2</td><td>4</td></tr><tr><td>Redding</td><td>11</td><td>12</td><td>2</td><td>7</td></tr><tr><td>Santa Rosa</td><td>5</td><td>5</td><td>1</td><td>4</td></tr></table>
• New sites opened this period →
  ○ 4 new sites were reviewed</td></tr>
</table>

Healthcare Effectiveness Data Information Set (HEDIS)

ACTIVITY	UPDATE
Annual HEDIS® Projects	**Program Overview** HEDIS is used to evaluate clinical quality in a standardized way. This program shares performance measurement rates with the intent of improving the quality of care delivered to members. **Program Update** • No Update

HEDIS® Program Overall	**Program Updates** • **No Update**

NATIONAL COMMITTEE FOR QUALITY ASSURANCE (NCQA) ACCREDITATION

ACTIVITY	UPDATE
NCQA Health Plan Accreditation (HPA)	**Program Overview** The State of California requires all Managed Care Plans (MCPS) to be both Health Plan (HP) and Health Outcome (HO) Accredited. The process involves completing a Renewal Survey every three (3) years, and reporting HEDIS and CAHPS results every year for a Health Plan Rating (HRP) score. Partnership's next HPA Renewal Survey is scheduled for 09/15/2026. **Program Update** • The NCQA Project Management Team hosted an HPA Renewal Survey evidence preparation and collection training on 03/25/2026. The team also distributed communications for evidence collection process, which began on 03/31/2026. All annotated and bookmarked evidence is due 05/22/2026 unless otherwise discussed with the NCQA Program Management Team. • HPA Mock File Reviews were held with our NCQA consultant, Managed Healthcare Resources (MHR), in February and March 2026 with the Utilization Management, Grievance and Appeals, and Pharmacy departments. Mock File Reviews will also take place in April 2026 with Care Coordination and Network Services. Most file review requirements are Must-Pass requirements, and an organization must receive a MET score on all Must-Pass requirements to achieve or maintain accreditation. These Mock File Reviews will help to ensure Partnership remains in compliance throughout the look-back period. Some risks and opportunities for improvement were identified by MHR and results were shared with the applicable Business Owners (BOs). BOs have submitted Action Plans to address each finding/recommendation. • The HPA Compliance Dashboard is updated monthly and available on the Y:Drive. The NCQA Program Management Team presents the dashboard monthly to the NCQA Steering Committee and quarterly to BOs, with an intent to create project transparency, track key activities and facilitate timely escalation. The NCQA Program Management Team is working closely with the BOs to ensure all applicable evidence is revised or finalized to sustain compliance in accordance with NCQA's look-back periods, timelines, and expectations.
NCQA Health Outcome Accreditation (HOA)	**Program Overview** The State of California requires all Managed Care Plans (MCPs) to be both Health Plan (HP) and Health Outcome (HO) Accredited. The process involves completing a Renewal Survey every three (3) years. Partnership's next HOA Renewal Survey is tentatively scheduled for 05/16/2028. **Program Update**

	• The NCQA Program Management Team distributed the 2026 HOA Workbook to Business Owners (BOs) on 02/17/2026. BOs submitted their 2026 HOA Workbooks by or shortly after the due date, 03/06/2026. The NCQA Program Management Team continues to work with the selected departments to complete their annual HOA Workbook, clarify the agreed upon evidence documentation, analysis reports and production timeline, and to ensure no previously unknown issues are identified. The NCQA Program Management Team also facilitates collaboration between departments to deep dive into subsets of NCQA requirements, clarify functions, and determine roles and responsibilities. Due to competing priorities, activities have been prioritized based on the requirements' look-back periods and the scopes of review. • BOs responsible for implementing revisions of the documented processes by April 2026 to meet the 24-month look-back period requirement (starting in May 2026) are working on their respective updates with the NCQA Program Management Team assisting as needed. The documented processes will require timely review by the NCQA Consultant and approval at committee meetings prior to May 2026. • Impacted BOs were sent an email on 03/26/2026 regarding submission of required screenshots, which are due by 04/17/2026. A lack of compliant documentation with date/time stamp can result in a score of Not Met and zero points. • The NCQA Program Management Team created an HOA Renewal Survey Timeline, which was shared with the NCQA Steering Committee on 03/24/2026. The Timeline is available on the Y:Drive and will be reviewed with the BOs during the May 2026 NCQA BO Check-in Meetings.
NCQA Health Plan Accreditation (HPA) and Health Outcomes Accreditation (HOA)	• NCQA released the March HPA and HOA Triannual Policy Updates at the end of March 2026. The NCQA Project Management Team has provided updates on impacted standards with respective Business Owners (BOs). BOs are asked to review the updates, assess impact, and/or request clarification to ensure the evidence documentation is aligned with NCQA's scope of review, or must implement/finalize edits within 90 calendar days of the release date for any policy changes or clarifications.

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

Consent Calendar
May 20, 2026
Items on the Consent Calendar have minor or no changes and are recommended by staff for approval.

		Pages
	Proposed 2027 Perinatal Quality Improvement Program (PQIP) Measures Summary –*refer questions to Troy Foster*	55 – 58
Health Services Policies	**Behavioral Health**	
	MPBP8005 – Dispute Resolution Between Partnership and BHPs in Delivery of Mental Health	59 – 63
	Care Coordination	
	MPCP2026 – Diabetes Prevention Program	65 – 70
	MPCP2034 – Transitional Care Services	71 – 83
	Enhanced Health Services	
	MPAP7004 – Community Health Worker (CHW) Services Benefit	85 – 95
	MPAP7005 – Street Medicine	97 – 104
	Quality Improvement	
	MPQP1038 – Physician Orders for Life-Sustaining Treatment (POLST)	105 – 109
	MPQP1047 – Advance Directives	111 – 113
	MPQP1055 – Provider Preventable Condition (PPC) Reporting	115 – 119
	Utilization Management	
	MPUP3137 – Palliative Care: Intensive Program (Adult)	121 – 140
	MPUP3144 – Residential Substance Use Disorder Treatment Authorization	141 – 146
Non-HS Policies	**Network Services - Compliance**	
	MPNET101 – Wellness and Recovery Access Standards and Monitoring	137 – 149

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PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

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

Proposed 2027
Perinatal Quality Improvement Program (PQIP)
Measurement Set

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

(A) Gateway Measure – Measure 1

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

(B) Clinical Measures – Measures 2-6

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

Key:
New Proposed Measures || Change to Measure Design

Current 2026 6-month Bridge Measures	Proposed CY 2027 Measures
ECDS & Clinical Domains	
Perinatal Medicine: 1. Electronic Clinical Data Systems (ECDS) 2. Prenatal Immunization 3. Timely Prenatal Care 4. Depression Screening 5. Timely Postpartum Care 6. Timely Comprehensive (Monitoring Only)	**Perinatal Medicine:** 1. Electronic Clinical Data Systems (ECDS) 2. Prenatal Immunization 3. Timely Prenatal Care 4. Depression Screening 5. Timely Postpartum Care 6. Timely Comprehensive Assessments

PROPOSED CHANGES FOR THE PQIP 2027 MEASURE SET

Programmatic Changes:

Due to a new federal regulation that went into effect at the end of 2025, the Perinatal Quality Incentive Program must transition to a calendar year program by January 2027. Therefore, the proposed changes below pertain to the proposed 2027 Measurement Year covering the period of January 1, 2027, through December 31, 2027.

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

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

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

Proposal: It is proposed that contracting and connection with DataLink remain a gateway measure for 2027. It is recommended that a June 30th deadline be set to give any new providers adequate time to complete the extraction process.

Measure Requirements

All providers with existing DataLink connectivity must maintain those connections and extractions throughout the measurement year to be eligible to receive their 2027 PQIP incentive payment.

All participants new to the PQIP in 2027 must complete all ***Implementation Phases*** and ***Participation Requirement Steps*** by **June 30, 2027**, to be eligible to receive their 2027 PQIP incentive payment.

B. CLINICAL MEASURES

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

Measure Summary:

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

Proposal:

Since DataLInk connections and extractions have occurred for PQIP providers during the previous year, it is proposed to add monthly DataLink extractions be the only option for submitting visit and depression screening data. The manual submission option would be removed, but Partnership would retain the right to request manual submissions as a means of data validation if needed. Below is the suggested language change for the reporting section of the measure.

Reporting (Applies to Measures 3 & 4)

Monthly DataLink Extractions

Counts of qualifying prenatal visits will be gathered through the DataLink extraction process. Partnership reserves the right to periodically request manual submissions to validate extracted data.

A timely prenatal visit is a comprehensive ***FIRST*** prenatal visit with a clinical provider of obstetrics services (MD/DO/CNM/LM/NP/PA-c) that occurs in the first trimester of the pregnancy or within 42 days of Partnership enrollment.

Note: New providers entering the PQIP in 2027 that are not yet connected to DataLink may provide manual submissions on the provided Excel template by the tenth of each month for January through June but must complete the implementation process by June 30, 2027, to be eligible to receive incentive payment. To request a template and instructions, email perinatalqip@partnershiphp.org.

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

Measure Summary:

Prenatal care visits to an OB/GYN or other perinatal care practitioner or PCP after the first trimester (equal to or greater than 14 weeks of gestation, as documented in the medical record) will be eligible for the incentive payment. A diagnosis of pregnancy must be present.

Proposal:

It is also proposed that Measure 4 have the same changes as noted in Measure 3.

III. Measure 6: Timely Comprehensive Assessments

Measure summary

Providers will perform Comprehensive Health Assessments that included psychosocial, nutrition and health education assessments at the initiation of care, in each trimester and in the post-partum period.

Proposal

It is proposed that this measure move from a monitoring measure to an incentivized measure as noted below.

Measure Target Specifications

Providers will earn a $100 incentive for members who gave birth during the measurement year and received the following assessments:

1. Initial Assessment with code Z6500 or code Z6200 + Z6300 + Z6402 billed on claim(s)
   And
2. Three subsequent follow-up visits: one in the second trimester, one in third trimester and one postpartum. No incentive earned if all visits are not completed.

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

Policy/Procedure Number: MPBP8005 (previously ADM52, MCUP3127)			**Lead Department: Health Services** Business Unit: Behavioral Health	
Policy/Procedure Title: Dispute Resolution Between Partnership and BHPs in Delivery of Mental Health Services			☒ **External Policy** ☐ **Internal Policy**	
Original Date: 02/21/2015		**Next Review Date:** ~~06/11/2026~~06/10/2027 **Last Review Date:** ~~06/11/2025~~06/10/2026		
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**	
Reviewing Entities:	☒ **IQI**	☐ **P & T**	☒ **QUAC**	
	☐ **OPERATIONS**	☐ **EXECUTIVE**	☐ **COMPLIANCE**	☐ **DEPARTMENT**
Approving Entities:	☐ **BOARD**	☐ **COMPLIANCE**	☐ **FINANCE**	☒ **PAC**
	☐ **CEO** ☐ **COO**	☐ **CREDENTIALS**	☐ **DEPT. DIRECTOR/OFFICER**	
Approval Signature: *Robert Moore, MD, MPH, MBA*			**Approval Date:** ~~06/11/2025~~06/10/2026	

I. RELATED POLICIES:

A. MPBP8003 – Mental Health Services
B. CMP36 – Delegation Oversight and Monitoring
C. CMP30 – Records Retention and Access Requirements

II. IMPACTED DEPTS:

A. Health Services
B. Finance

III. DEFINITIONS:

A. Behavioral Health Plan (BHP) is a county behavioral health plan that is responsible for providing mental health services outlined in Title 9 CCR and Title 22 CCR.
B. Dispute: is a formal disagreement between a Medi-Cal managed care plan (MCP) and a county behavioral health plan (BHP) regarding the provision of and/or payment for mental health services that has not been resolved through informal measures and occurs when either plan makes a formal written request for a Plan Level Dispute Resolution and/or Department of Health Care Services (DHCS) Dispute Resolution.
C. Expedited Dispute Resolution Process: means a resolution more expeditious than what is expected for a standard resolution and shall be resolved within one business day when Partnership HealthPlan of California (Partnership) and the BHP determine that the Routine Dispute Resolution timeframe would result in serious jeopardy to the Member's life, health, or the ability of the Member to attain, maintain or regain maximum function.
D. Member is an eligible beneficiary who is a member of Partnership HealthPlan of California (Partnership), under either the Medi-Cal or Partnership Advantage program.
E. Memorandum of Understanding (MOU): where no reimbursement is to be made, Partnership shall negotiate in good faith an MOU for services provided by said agency. MOU shall describe the scope and responsibilities of both parties in the provision of services to Members; billing and reimbursements; reporting responsibilities; and how services are to be coordinated.
F. Plan Level Dispute Resolution: means good faith efforts, which shall include a meeting to remedy coverage disputes as formally communicated via written notice by either Partnership or a BHP to either respective party
G. Request for Resolution: means Partnership's written request to DHCS for aid in resolving a dispute between Partnership and a BHP when the dispute could not be rectified via the Plan Level Dispute Resolution.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

Pursuant to the Department of Health Care Services (DHCS) All Plan Letter (APL) 21-013 and any future related DHCS guidance as communicated in writing, the purpose of this policy is to provide a process that allows for a formal system of resolving disputes between Partnership and a BHP when traditional communications are unable to resolve disputes. This policy also clarifies the requirement that medically necessary services will not be delayed during this dispute process.

VI. POLICY / PROCEDURE:

A. Basis for Partnership and BHP relationship
   1. As an MCP, Partnership shall negotiate in good faith and execute memorandum of understanding (MOU) with county BHPs across Partnership's service area to ensure for coordination of Medi-Cal mental health services, delineate the responsibilities of each respective party, and afford for a dispute resolution process.
      a. MOUs shall be entered into and maintained consistent with DHCS APL 23-029 and any future related DHCS guidance as communicated in writing.

B. Guiding Principles
   1. Emphasis on Timely, Collaborative Resolution
      a. The provision of medically necessary services for members will not be delayed during the pendency of any dispute.
      b. Partnership and BHP staff will make a good faith effort to agree to resolutions that are in the best interest of members and are agreeable to all parties involved.
      c. Proactive and timely communication is expected between Partnership and the BHP.

C. Plan Level Dispute Resolution Process is outlined in this policy and referenced in Partnership and BHP MOUs
   1. Partnership or the BHP may seek to remedy a dispute informally through discussion and dialogue. If this fails to resolve the dispute, either plan may request, in writing, a formal meeting between the two plans to identify issues and possible solutions. The receipt of the written request will initiate the Plan Level Dispute timeline in which the dispute must be resolved within 15 business days.
      a. A Request for Plan Level Resolution can be submitted via secure email to either Partnership's Senior Director of Behavioral Health or CEO.
   2. Within 10 business days, the meeting will be conducted at a mutually agreeable time. Representatives from both Partnership and the BHP must participate in the meeting.
   3. Within 5 business days from the date of the meeting, Partnership will issue to the BHP a written final position on the matter in dispute signed by the Chief Executive Officer (CEO) or their designee.
   4. Members will continue to receive medically necessary services while the disagreement or dispute is being resolved in accordance with Title 9, CCR, §1850.525(a).
   5. The Partnership Behavioral Health team will maintain records of Plan Level Dispute Resolutions consistent with applicable Partnership record retention policy.
   6. The Expedited Dispute Resolution Process as outlined in Section E below will be followed if a Member has not received a disputed service (s) and Partnership or the BHP determines that the Routine Dispute Resolution timeframe would result in serious jeopardy to the Member's life, health, or the ability of the Member to attain, maintain or regain maximum function.

D. DHCS Dispute Resolution Process (For further details, refer to DHCS APL 21-013 Dispute Resolution Process Between BHPs and MCPs)

1. The parties are required to document attempts to resolve the disputed issue(s), including results of the Plan Level Dispute Resolution (Title 9, CCR, §1850.505 (d) (2))
2. If Partnership and the BHP are unable to resolve a dispute at the Plan Level, Partnership may submit a written Request for Resolution to DHCS and signed by Partnership's CEO or their designee. The Request for Resolution must be submitted within 3 business days from the completion of the Plan Level Dispute Resolution process that didn't result in a satisfactory resolution. A Request for Resolution should be submitted via secure email to the DHCS Managed Care Quality and Monitoring Division (MCQMD), at MCQMD@dhcs.ca.gov. Conversely, the BHP may exercise the same process to escalate the dispute to DHCS for resolution.
3. A Request for Resolution submitted to DHCS must contain all of the following:
   a. Summary of disputed issue(s) and a statement of the desired remedies, including any disputed services that have been or are expected to be delivered to the beneficiary by either party;
   b. History of attempts to resolve the issue with the BHP;
   c. Justification for Partnership's desired remedy: and
   d. If applicable, any additional documentation that Partnership deems relevant to resolve the disputed issue(s)
4. Within three (3) business days after DHCS' receipt of a Request for Resolution from Partnership or the BHP, a copy of the Request for Resolution will be forwarded by DHCS to the other party via secure email ("Notification").
   a. Both parties will have three (3) business days to submit a response and any relevant documents to support their position; and
   b. If the responding party fails to respond within three (3) business days, DHCS will decide on the disputed issue(s) based solely on the documentation submitted by the requesting party.
5. At its discretion, DHCS may allow both Partnership and BHP representatives the opportunity to present oral arguments.
6. Within 20 business days from the third business day of the Notification date, DHCS will issue its final decision and communicate it via secure email to both Partnership's CEO or their designee and the BHP Director.
   a. DHCS' decision will state the reasons for the decision, the determination of rates of payment (if rates of payment were disputed), and any actions Partnership and the BHP are required to take to implement the decision.
   b. If DHCS' dispute resolution determination includes a finding that the unsuccessful party has a financial liability to the other party for services rendered by the successful party, Partnership or the BHP is required to follow the financial liability criteria set forth in Title 9, CCR § 1850.530, which specify the provisions regarding financial liability rates and proof of reimbursement.
      1) If necessary, DHCS shall enforce the decision, including withholding funds to meet any financial liability established pursuant to Title 9, CCR, §1850.530 (Title 9, CCR, §1850.520(c)).
7. The provision of medically necessary specialty and other mental health services, physical health care services, or other services shall not be delayed during the dispute.

E. Expedited Dispute Resolution Process
1. Either Partnership or the BHP may seek to enter an Expedited Dispute Resolution Process if a Member has not received a disputed service(s) and Partnership or the BHP determine that the Routine Dispute Resolution timeframe would result in serious jeopardy to the Member's life, health, or the ability of the Member to attain, maintain, or regain maximum function.
2. Under this process, both Partnership and the BHP will have one business day to resolve the dispute at the Plan level.
3. If Partnership and the BHP fail to resolve an Expedited dispute within one business day, each party

must file a Request for Resolution with DHCS within one business day. The request must include an affirmation of the Member's stated jeopardy.
4. If either plan fails to submit a Request for Resolution and/or documentation to DHCS, DHCS will base its decision upon the documentation submitted.
5. DHCS will render a decision within one business day upon receipt of said request.

F. To ensure there is not a delay in the provision of medically necessary services to a member during a dispute, the following actions will apply:
1. When the dispute concerns Partnership's contention that the BHP is required to deliver specialty mental health services to a beneficiary either because the beneficiary's condition would not be responsive to physical health care based treatment or because the BHP has incorrectly determined the beneficiary's diagnosis to be a diagnosis not covered by the BHP, Partnership shall manage the care of the beneficiary under the terms of its contract with the State until the dispute is resolved, pursuant to Title 9, CCR, §1850.525 (Title 9, CCR, §1850.525(b)).
2. When the dispute concerns the BHP's contention that Partnership is required to deliver physical health care based treatment of a mental illness, or to deliver prescription drugs or laboratory, radiological, or radioisotope services required to diagnose or treat the mental illness, the BHP shall be responsible for providing or arranging and paying for those services to the beneficiary until the dispute is resolved, pursuant to Title 9, CCR, §1850.525 (Title 9, CCR, §1850.525(c)).

G. Delegation of Plan Level Dispute Resolution
1. Partnership does not delegate the responsibility of MCP and BHP dispute resolution, including the handling of Plan Level Dispute Resolution, to any Subcontractor and as such, is directly responsible for facilitating the Plan Level Dispute Resolution.
2. Where Partnership has delegated responsibility for the provision of Covered Services, consistent with its DHCS Medi-Cal managed care contract, Partnership may seek data, documentation, and information from Subcontractors to support satisfactory dispute resolution.

VII. REFERENCES:

A. Title 9, California Code of Regulations (CCR) Sections §1810.370, §1850.505, §1850.520, §1850.525, and §1850.530
B. Title 22 CCR Section 53855
C. DHCS APL 23-029 Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans and Third Party Entities (10/11/2023)
1. Specialty Mental Health Services Memorandum of Understanding Template
D. DHCS APL 21-013 Dispute Resolution Process Between Mental Health Plans and Medi-Cal Managed Care Health Plans (10/04/2021)
E. DHCS Behavioral Health Information Notice BHN 21-034 Dispute Resolution Process Between Mental Health Plans and Medi-Cal Managed Care Plans (10/04/2021)
F. DHCS APL 26-002 MediCal Managed Care Plan Responsibilities for Non-Specialty Mental Health Services (02/02/2026) *Supersedes APL 22-006*
~~E.~~G. DHCS APL 26-004 Medi-Cal Managed Care Plan Responsibilities for Behavioral Health Data-Sharing (03/16/2026)

VIII. DISTRIBUTION:

A. Partnership Provider Manual
B. Partnership Department Directors

IX. PERSON RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Senior Director of Behavioral Health

X. REVISION DATES:

Medi-Cal
MPBP8005: 06/11/25; 06/10/26

Partnership Advantage (effective Jan. 1, 2028)
N/A

PREVIOUSLY APPLIED TO:

Medi-Cal (ADM52 12/07/21 to 06/11/2025)
12/07/21; ARCHIVED 06/11/25

Medi-Cal (MCUP3127 01/21/2015 to 02/09/2022)
01/21/15; 06/17/15; 04/20/16; 04/19/17; *06/13/18; 06/12/19; 06/10/20; 06/09/21; ARCHIVED 12/07/2021

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

Policy/Procedure Number: MPCP2026 (previously MCCP2026)					**Lead Department: Health Services** Business Unit: Care Coordination	
Policy/Procedure Title: Diabetes Prevention Program					☒**External Policy** ☐ **Internal Policy**	
Original Date: 03/13/2019 **Effective Date: 01/01/2019 per DHCS**			**Next Review Date:** ~~06/11/2026~~06/10/2027 **Last Review Date:** ~~06/11/2025~~06/10/2026			
Applies to:	☐ **Employees**		☒ **Medi-Cal**		☒ **Partnership Advantage**	
Reviewing Entities:	☒ **IQI**		☐ **P & T**	☒ **QUAC**		
	☐ **OPERATIONS**		☐ **EXECUTIVE**	☐ **COMPLIANCE**	☐ **DEPARTMENT**	
Approving Entities:	☐ **BOARD**		☐ **COMPLIANCE**	☐ **FINANCE**	☒ **PAC**	
	☐ **CEO**	☐ **COO**	☐ **CREDENTIALS**	☐ **DEPT. DIRECTOR/OFFICER**		
Approval Signature: *Robert Moore, MD MPH MBA*				**Approval Date:** ~~06/11/2025~~06/10/2026		

I. **RELATED POLICIES**:
   A. MCUP3052 – Medical Nutrition Services
   B. MPCR701 – Ancillary Care Services Provider Credentialing and Re-credentialing Requirements

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

III. **DEFINITIONS**:
   A. Diabetes Prevention Program (DPP): An evidence-based lifestyle change program, taught by lifestyle coaches designed to prevent or delay the onset of type 2 diabetes among individuals diagnosed with pre-diabetes.
   B. Lifestyle Coach (also known as Peer Coaches): A person formally trained in Centers for Disease Control and Prevention (CDC) approved curriculum for a minimum of 12 hours or approximately two days. A lifestyle coach may have credentials [e.g. Physician, Registered Dietician (RD), and Registered Nurse (RN)], but they are not required. The CDC approved training may be provided by one of the following:
      1. A training entity listed on the CDC website
      2. A private organization with a national network of CDC recognized program sites
      3. A CDC recognized virtual organization with national reach or
      4. A Master Trainer, as designated by the CDC recognized program, who has delivered that lifestyle change program for at least one year and has completed a Master Trainer program offered by a training entity listed on the CDC website.
   C. Medicare Diabetes Prevention Program (MDPP): An evidence-based lifestyle change program for individuals eligible for Medicare, available to Partnership Advantage ~~members~~Enrollees, taught by lifestyle coaches designed to prevent or delay the onset of type 2 diabetes among individuals diagnosed with pre-diabetes.
   D. Partnership Advantage: Effective January 1, 202~~7~~8, Partnership HealthPlan of California will operate a Centers for Medicare & Medicaid Services (CMS) - approved Dual-Eligible Special Needs Plan (D-SNP) in specific counties as described in the Department of Health Care Services (DHCS) CalAIM Dual Eligible Special Needs Plan Policy Guide. This line of business will be known as Partnership Advantage and will be a Medicare Advantage plan offered to all full-benefit, dual-eligible beneficiaries 21 years of age or older who reside in the applicable counties. Partnership Advantage Enrollees~~Members~~ will be qualified to receive both Medi-Cal and Medicare services as described in the Partnership Advantage Member Handbook.

Policy/Procedure Number: MPCP2026 (previously MCCP2026)			**Lead Department:** Business Unit: Care Coordination
Policy/Procedure Title: Diabetes Prevention Program			☒ **External Policy** ☐ **Internal Policy**
Original Date: 03/13/2019 **Effective Date:** 01/01/2019 per DHCS			**Next Review Date:** 06/10/202706/11/2026 **Last Review Date:** 06/10/202606/11/2025
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**

IV. ATTACHMENTS:

A. NA

V. PURPOSE:

To provide an overview of these external programs; Diabetes Prevention Program and Medicare Diabetes Prevention Program, including eligibility requirements and participation processes.

VI. POLICY / PROCEDURE:

A. Program Description

The Diabetes Prevention Program (DPP) and Medicare Diabetes Prevention Program (MDPP) are evidence-based lifestyle change programs established by the CDC, taught by lifestyle coaches and designed to prevent or delay the onset of type 2 diabetes among individuals diagnosed with pre-diabetes. Members/Enrollees must meet certain criteria to join, reference the Member Handbook for more information. https://www.partnershiphp.org/Members/Medi-Cal/Pages/Member-Handbooks.aspx

B. Eligibility Criteria

1. DPP Eligibility Criteria:

   Medi-Cal Members must meet the CDC Diabetes Prevention Program eligibility requirements to qualify for participation in the DPP benefit. The requirements are as follows:

   a. Must be 18 years or older
   b. Must not be pregnant at the time of enrollment. (A participant who becomes pregnant during the program may continue at the discretion of their health care provider and the program delivery organization.)
   c. Must have a body mass index (BMI) of ≥ 25 kg/m^2 (≥ 23 kg/m^2 if Asian American)
   d. Participants cannot have a previous diagnosis of type 1 or type 2 diabetes prior to enrollment.
   e. Must have a positive screening for pre-diabetes based on the CDC Prediabetes Screening Test
   f. Clinically diagnosed gestational diabetes mellitus (GDM) during a previous pregnancy (allowed for CDC recognition and may be self-reported; not allowed for MDPP participants)

2. MDPP Specific Eligibility Criteria:

   a. Partnership Advantage EnrolleesMembers must meet the CDC Medicare Diabetes Prevention Program (MDPP) eligibility requirements to qualify for participation in the MDPP benefit. The requirements are as follows:

      1) Must be enrolled as a Partnership Advantage EnrolleeMember.
      2) Participants cannot have end-stage renal disease (ESRD) at any point during the MDPP services period. A Member who previously had ESRD may be eligible to participate in MDPP if:

         a) It has been 12 months after the month the EnrolleeMember stops dialysis treatments, or
         b) It has been 36 months after the month the EnrolleeMember had a kidney transplant.

      3) Participants cannot have received MDPP services previously.
      4) All other requirements for MDPP are listed above in VI.B.1.b-e for reference.

3. All DPP & MDPP program eligible MMembers/Enrollees must also meet one of the following clinical requirements:

   a. A blood test within the past year meeting one of the following specifications:

      1) Fasting glucose of 1100 to 125 mg/dl
      2) Plasma glucose reading of 140 to 199 mg/dl measured 2 hours after a 75 g glucose load
      3) HbA1c of 5.7 to 6.4%

   b. Clinically diagnosed gestational diabetes mellitus (GDM) during a previous pregnancy
   c. Received a high-risk result (score of 5 or higher) on the Prediabetes Risk Test.
   d. A health care professional may refer potential participants to the program, but a referral or

treatment authorization are not required for participation. Members/Enrollees meeting the eligibility criteria may self-refer.

C. Provider Requirements
   1. Diabetes Prevention Program and Medicare Diabetes Prevention Program providers must comply with the most current CDC Diabetes Prevention Recognition Program (DPRP) guidelines and obtain pending, preliminary or full CDC recognition.
   2. DPP and MDPP Providers must use a CDC approved lifestyle change curriculum that includes all of the following;
      a. Emphasizes self-monitoring, self-efficiency and problem solving
      b. Facilitates ~~Provides for~~ coach feedback
      c. Includes participant materials to support program goals
      d. Requires participant weigh-ins to track and achieve program goals

D. Program Structure
   1. DPP Program Structure
      a. The core DPP benefit includes a minimum of 22 DPP sessions for the first 12 months of the DPP benefit. These visits are typically once a week for the first 6 months.
      b. The core benefit is followed by maintenance sessions once a month for the next 6 months.
      c. Thereafter, Partnership will cover 12 months of ongoing maintenance sessions to qualified M~~m~~embers to promote continued healthy behavior. A M~~m~~ember qualifies for the ongoing maintenance sessions if:
         1) The M~~m~~ember achieves and/or maintains a minimum weight loss of 5% from the first core session, and
         2) The M~~m~~ember meets the attendance requirement as outlined in the Medi-Cal Manual in accordance with Department of Health Care Services (DHCS) All Plan Letter (APL) 18-018 Diabetes Prevention Program (11/16/2018) and Diabetes Prevention Program: The Medi-Cal Provider Manual section.~~(March 2022)~~
         3) Weigh-ins are required, but may be obtained in these ways:
            1) In person at a DPP Session or DPP Provider location
            2) Remote weigh-in at the M~~m~~ember's home using scales with digital or Bluetooth communications ability
               i. MDPP Enrollees can submit weight within five (5) days of a MDPP session
      d. Self-reported weigh-ins with or without confirmatory documentation
   2. MDPP Program Structure
      a. The core MDPP benefit includes 16 weekly core sessions over months 1-6, and 6 monthly core maintenance sessions in months 7-12.
      b. The remaining details of the MDPP Program Structure are listed above in VI.D.1.c-d~~e~~ for reference.

E. Delivery Methods for DPP and MDPP Sessions
   Partnership will cover the following methods for DPP sessions and MDPP sessions (for Partnership Advantage Enrollees~~members~~) as deemed clinically appropriate:
   1. In-Person: Members / or Enrollees must be physically present in a classroom or classroom-like setting with a lifestyle coach.
   2. Distance Learning: Distance learning occurs when lifestyle coach(es) deliver sessions via remote classroom or telehealth. The lifestyle coach is present in one location while participants call in or participate by videoconference from another location.
   3. Online: Online delivery can be conducted either through synchronous real-time interactive audio and video telehealth communication or through asynchronous store and forward telehealth communication.

4. Combination: Members/or Enrollees may use a combination of in-person, distance learning or online delivery methods.

F. DPP Frequency
The DPP benefit for Medi-Cal Members only may be offered as often as necessary, but the Member's medical record must indicate that the Member's medical condition or circumstance warrants repeat or additional participation in the DPP benefit. Examples of circumstance that may warrant repeat or additional participation include:
1. Member switched enrollment from one Managed Care Plan (MCP) to a different MCP
2. Member transitioned from Fee for Service Medi-Cal into an MCP
3. Member moved to a different county
4. Member experienced a lapse in Medi-Cal enrollment
5. Member has or had medical conditions that hinder DPP session attendance

G. Curriculum and Translations
1. Partnership will ensure that MDPP & DPP providers use a CDC approved curriculum. MDPP & DPP Providers may use either the official CDC curriculum or a modified curriculum that has been approved by the CDC.
2. Partnership will monitor the MDPP & DPP providers to ensure that the MDPP & DPP services are provided in a culturally and linguistically appropriate manner and that the curriculum materials are translated and made available to Mmembers/Enrollees in a timely manner and meet all the requirements per Welfare and Institutions Code (WIC) Section 14029.91, Part 92 of Title 45 of the Code of Federal Regulations (CFR) and Section 1557 of the federal Patient Protection and Affordable Care Act [42 United States Code (USC) Section 18116].

H. Documentation of Performance-Based Codes
Partnership will ensure that any MDPP and DPP providers are informed and comply with all applicable state and federal laws and regulations, contract requirements and other Department of Health Care Services (DHCS) guidance, including All Plan Letters (APLs) and Policy Letters.

I. Ancillary Care Services Provider
Partnership credentials and re-credentials all the types of ancillary care service providers which includes MDPP and DPP, refer to Partnership Policy MPCR701 - Ancillary Care Services Provider Credentialing and Re-credentialing Requirements for more details.

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

VII. REFERENCES:

A. DHCS All Plan Letter (APL) 18-018 Diabetes Prevention Program (11/16/2018)
A.B. DHCS Diabetes Prevention Program https://www.dhcs.ca.gov/services/medi-cal/Pages/Diabetes-Prevention-Program.aspx
B.C. Medi-Cal Provider Manual/Guidelines: Diabetes Prevention Program (*diabetes*)
C.D. Welfare and Institutions Code (WIC) Section 14029.91
D.E. Part 92 of Title 45 of the Code of Federal Regulations (CFR)
F. Section 1557 of the federal Patient Protection and Affordable Care Act [42 United States Code (USC) Section 18116]

E.G. Medicare and Medicaid Programs CY 2026 https://www.federalregister.gov/documents/2025/11/05/2025-19787/medicare-and-medicaid-programs-cy-2026-payment-policies-under-the-physician-fee-schedule-and-other (11/05/2025)

F.H. Prediabetes Risk Test Sheet https://www.cdc.gov/diabetes/prevention/pdf/Prediabetes-Risk-Test-Final.pdf

G.I. Centers for Disease Control and Prevention, Diabetes Prevention Recognition Program Standards and Operating Procedures (03/01/202106/01/2024) 2024 DPRP Standards and Operating Procedureshttps://www.cdc.gov/diabetes-prevention/media/pdfs/legacy/dprp-standards.pdfhttps://nccpa.org/sites/default/files/2021-05/2021-DPRP-Standards-and-Operating-Procedures.pdf

H.J. National Diabetes Prevention Program, Preventing Type 2 Diabetes with Medicare (05/15/2024) https://www.cdc.gov/diabetes-prevention/lifestyle-change-program/ndpp-medicare-program.html

I.K. Medicare Diabetes Prevention Program (MDPP) Expanded Model Fact Sheet https://www.cms.gov/priorities/innovation/Files/x/MDPP_Overview_Fact_Sheet.pdf

J.L. Medicare Diabetes Prevention Program (MDPP) Medicare Advantage Fact Sheet https://www.cms.gov/priorities/innovation/files/fact-sheet/mdpp-ma-fs.pdf

K.M. Medicare Diabetes Prevention Program (MDPP) Basics (04/30/2024) https://coveragetoolkit.org/medicare/mdpp-basics/

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

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

X. REVISION DATES:

Partnership Advantage (Program effective January 1, 20287)
06/11/25; 06/10/26

Medi-Cal
06/12/19; 06/10/20; 06/09/21; 06/08/22; 06/14/23; 06/12/24; 06/11/25; 06/10/26

PREVIOUSLY APPLIED TO:

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

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

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

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

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

Policy/Procedure Number: MPCP2034 (previously MCCP2034)			**Lead Department: Health Services** Business Unit: Care Coordination	
Policy/Procedure Title: Transitional Care Services (TCS)			☒**External Policy** ☐ **Internal Policy**	
Original Date: **06/12/2024** **Effective Date: 01/01/2023**		**Next Review Date:** ~~06/11/2026~~06/10/2027 **Last Review Date:** ~~06/11/2025~~06/10/2026		
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**	
Reviewing Entities:	☒ **IQI**	☐ **P & T**	☒ **QUAC**	
	☐ **OPERATIONS**	☐ **EXECUTIVE**	☐ **COMPLIANCE**	☐ **DEPARTMENT**
Approving Entities:	☐ **BOARD**	☐ **COMPLIANCE**	☐ **FINANCE**	☒ **PAC**
	☐ **CEO** ☐ **COO**	☐ **CREDENTIALS**	☐ **DEPT. DIRECTOR/OFFICER**	
Approval Signature: *Robert Moore, MD, MPH, MBA*			**Approval Date:** ~~06/11/2025~~06/10/2026	

I. **RELATED POLICIES**:
   A. MPCD2013 – Care Coordination Program Description
   B. MP~~C~~CP2019 – Identification and Care Coordination for Seniors and Persons with Disabilities and/or California Children's Services
   C. MP~~C~~CP2007 – Complex Case Management
   D. MCAP7002 ~~MCCP2032~~ – CalAIM~~:~~ Enhanced Care Management (ECM)
   E. MP~~C~~AP7003 – CalAIM Community Supports (CS)
   F. MCAP7001 – CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS)
   G. MP~~C~~ND9001 – Population Health Management Strategy & Program Description
   H. MCUP3041 – Treatment Authorization Request (TAR) Review Process
   I. MPUD3001 – Utilization Management Program Description
   J. MCUP3106 – Waiver Programs
   K. MPUG3011 – Criteria for Home Health Services
   L. MPBP8003 – Mental Health Services
   M. MPBP8007~~MCUP3101~~ – Screening and Treatment for Substance Use Disorders
   ~~N.~~ MCUP3013 – Durable Medical Equipment (DME) Authorization
   ~~O.~~N. ~~MCUP3064 – Communications Services~~
   ~~P.~~O. MP~~C~~CP2018 – Advice Nurse Program
   P. MPAP7004 – Community Health Worker (CHW) Services Benefit
   Q. MCUP3012 – Discharge Planning (Non-capitated Members)
   ~~Q.~~R. MCUP3141 – Delegation of Inpatient Utilization Management

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

III. **DEFINITIONS**:
   A. Accountable Care Organizations (ACO): These are groups of hospitals, doctors, and other health care providers that come together voluntarily to provide coordinated high-quality care to assigned groups of

patients.

B. Admission, Discharge, and Transfer (ADT) data: Feeds providing notifications of Member admission, discharge, and transfer data in standardized formats.

C. California Integrated Care Management (CICM): California-specific requirements for integrated care coordination for specific vulnerable populations covered by D-SNPs as determined by the state

D. Closed Loop Referral: A closed loop referral means bidirectional information sharing between two or more parties to communicate requests for services and the associated outcomes of the requests. The frequency and format of this information sharing varies by service provider and by the degree of formality that may be required according to local community norms. Depending on the type of service needed, this process may include referral to medical, dental, behavioral, and/or social services or community agencies. While a warm hand off may occasionally be appropriate, a closed loop referral does not imply that a warm hand off is required.

E. Community Health Worker (CHW): Individuals known by a variety of job titles, such as promotores, community health representatives, navigators, and other non-licensed public health workers, including violence prevention professionals, who connect and engage with their community to provide equitable health care through culturally competent services. CHWs are trusted Members of their community who help address chronic conditions, preventive health care needs, and health related social needs within their communities.

F. Community Health Worker (CHW) Services: CHW services are preventive health services as defined in 42 CFR health 440.130(c) delivered by a CHW to prevent disease, disability, and other health conditions or their progression; to prolong life; and to promote physical and mental health and well-being. CHW services can help Members receive appropriate services related to perinatal care, preventive care, sexual and reproductive health, environmental and climate-sensitive health issues, oral health, aging, injury, and domestic violence and other violence prevention services.

G. Community Supports (CS): Pursuant to 42 CFR 438.3(e)(2), In-Lieu of Services (ILOS) are optional services or settings that are offered in place of services or settings covered under the California Medicaid State Plan (Medi-Cal) and are medically appropriate, cost-effective alternatives to services or settings under the State Plan. These services or settings require Department of Health Care Services (DHCS) approval. Under CalAIM, these services are known as Community Supports (CS).

H. Complex Case Management (CCM): The process of applying evidence-based practices to individual Members to assist them with the coordination of their care and promote their well-being.

I. Drug Medi-Cal Organized Delivery System (DMC-ODS): An opt-in 1115 waiver program available in California since 2015 that provides the opportunity for counties to expand substance use disorder treatment options outside of traditional Medicaid substance use disorder treatment offerings. In the DMC-ODS, opted-in counties provide a continuum of care modeled after the American Society of Addiction Medicine (ASAM) Criteria for substance use disorder treatment services which enables more local control and accountability, provides greater administrative oversight, creates utilization controls to improve care and efficient use of resources, implements evidenced based practices in substance use treatment, and coordinates with other systems of care. Of Partnership's 24 counties, 7 participate in Partnership's Regional Model or DMC-ODS program (aka as Partnership's "Wellness ~~and~~ & Recovery ~~P~~program" see III.Q.): Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, and Solano counties. ~~Five~~ Seven other counties have organized their own county-managed DMC-ODS programs (over which Partnership has no regulatory oversight responsibilities): Lake, Marin, Napa, Nevada, Placer, Sonoma, and Yolo counties. The remaining counties have not opted into the DMC-ODS program and therefore abide by the county-managed "State Plan" DMC program.

J. Enhanced Care Management (ECM): A whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-need and/or high-cost Members through systematic coordination of services and comprehensive care management that is community-based,

interdisciplinary, high-touch, and person-centered.

K. HCBS: Home and Community Based Services

L. Individualized Care Plan (ICP): A Member-focused care plan designed to optimize the Member's health, function, and well-being.

M. Interdisciplinary Care Team (ICT): -ICT will only be applicable for Partnership Advantage ~~(PA)~~ Enrollees~~Members~~. A group of key stakeholders including, at minimum, the Enrollee~~Member~~, their Primary Care Provider (PCP), and case manager. This core group is responsible for developing, implementing, and evaluating the Member's individualized care plan. This includes the oversight and coordination of care for D-SNP Members and may include additional specialists and family Members if relevant to the Member's care needs. The extended ICT may also include other stakeholders who provide support as required across transitions and care settings.

N. Longitudinal Support: This means that a single relationship must span the whole transition.

O. Long-Term Services & Supports (LTSS): These services and supports are designed to enable a Member with functional limitations and/or chronic illnesses to live or work in the setting of their choice. This may include the Member's home, a worksite, a provider-owned or controlled residential setting, a nursing facility, or other institutional setting. LTSS encompasses both Long-Term Care (LTC) and Home and Community Based Services (HCBS), and includes both carved-in and carved-out services.

P. Medicare Medi-Cal Plans (MMPs): Medicare Medi-Cal Plans (MMPs or Medi-Medi Plans) are integrated Dual Eligible Special Needs Plans (D-SNPs) for people with both Medicare and Medi-Cal. Members are enrolled in aligned plans under one organization, which coordinates care across both benefits.

~~P.~~Q. Partnership Advantage: Effective January 1, 2028~~7~~, Partnership HealthPlan of California will operate a Centers for Medicare & Medicaid Services (CMS)-approved Dual-Eligible Special Needs Plan (D-SNP) in specific counties as described in the Department of Health Care Services (DHCS) CalAIM Dual Eligible Special Needs Plan Policy Guide. This line of business will be known as Partnership Advantage and will be a Medicare Advantage plan offered to all full-benefit, dual-eligible beneficiaries 21 years of age or older who reside in the applicable counties. Partnership Advantage Enrollees~~Members~~ will be qualified to receive both Medi-Cal and Medicare services as described in the Partnership Advantage Member Handbook.

~~Q.~~R. PointClickCare (PCC) formerly Collective Medical Technologies (CMT): A contracted external vendor platform designated as Partnership HealthPlan of California (Partnership)'s data sharing and information exchange system. This platform provides Admission, Discharge, and Transfer data on members from providers, facilities, and community partners that is reportable or integrated in Partnership systems.

~~R.~~S. Population Health Management (PHM) Service: A State-wide service that collects and links Medi-Cal beneficiary information from disparate sources and performs risk stratification and segmentation (RSS) and risk-tiering functions, conducts analytics and reporting, identifies gaps in care, performs other population health functions, and allows for multiparty data access and use in accordance with state and federal law and policy.

~~S.~~T. Risk Stratification and Segmentation (RSS)**:** Partnership's Risk Stratification/Segmentation (RSS) and Risk Tier process leverages data from multiple data sources to separate its Member populations into different risk groups and/or meaningful subsets using information collected through a proprietary algorithm and other data sources that include population and Member assessments, demographic data, and utilization data. Partnership's RSS results in the categorization of Members with care needs at all levels and intensities. When available, Partnership will also incorporate the standardized risk tier criteria provided through DHCS's PHM Service, ~~(defined in III.M. above),~~ which will include a single, statewide, open-source RSS methodology for risk stratification that will place all Medi-Cal Members into high, medium-rising, and low-risk tiers.

U. Specialty Mental Health Services (SMHS): *aka Serious and Persistent Mental Health Services* County Behavioral Health Plans (BHPs) are contractually required to provide or arrange for the provision of SMHS for Medi-Cal Members who have significant impairment or reasonable probability of functional deterioration due to a diagnosed or suspected mental health disorder as described in Behavioral Health Information Notice. ~~are those provided by County Mental Health Plans, generally for members who have significant impairment or reasonable probability of functional deterioration due to a diagnosed or suspected mental health disorder as described in Behavioral Health Information Notice (BHIN) 21-073.~~(BHIN) 26-002~~*aka Serious and Persistent Mental Health Services County* Mental Health Plans (MHPs) are contractually required to provide or arrange for the provision of SMHS for Members who have significant impairment or reasonable probability of functional deterioration due to a diagnosed or suspected mental health disorder as described in Behavioral Health Information Notice (BHIN) 21-073.~~

1. For Partnership Advantage Enrollees who meet criteria for SMHS and/or substance use disorder treatment services provided by a county BHP, Partnership will coordinate with BHP providers to ensure members have access to and are connected with medically necessary services delivered by the BHP.

~~T.~~V. Transitional Care Services (TCS): A set of activities and interventions provided to Members transferring from one institutional care setting or level of care to another institution or lower level of care, including home settings.

~~U.~~W. TCS Care Manager: Regardless of organizational setting or job title, an individual who shall serve as the identified single point of contact who is responsible for the provision of transitional care services for a Member

~~V.~~X. Wellness & Recovery ~~p~~Program (W&R): Partnership's regional Drug Medi-Cal-~~-~~Organized Delivery System ~~waivered~~ program serving ~~in~~ seven counties within Partnership's service area.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

To describe and define Partnership HealthPlan of California (Partnership~~s~~) Transitional Care Services (TCS) in accordance with the Department of Health Care Services (DHCS) Population Health Management (PHM) Policy Guide. This policy outlines the roles and collaboration among Partnership's Health Services staff, provider network, and Members to support continuity of care and coordinated care planning before, during, and after transitions across health care settings and levels of care. This policy is established pursuant to DHCS PHM program requirements and applicable CalAIM Dual Eligible Special Needs Plan (D-SNP) guidance. ~~To describe and define Partnership HealthPlan of California (Partnership's) Transitional Care Services (TCS) as required by the DHCS Population Health Management (PHM) Policy Guide. This policy shall also outline the collaboration between Partnership's Health Services staff, provider network, and Members to ensure safe, effective, quality coordination of care and planning across health care settings. This policy was written based on the request by DHCS as part of their PHM Policy Guide and the CalAIM Dual Eligible Special Needs Plan Policy Guide.~~

VI. POLICY / PROCEDURE:

A. Transitional Care Services (TCS):

1. Partnership shall ensure Transitional Care Services are provided to Members/Enrollees transferring from one setting, or level of care, to another in accordance with 42 CFR section 438.208, other applicable federal and state laws and regulations, and DHCS guidance. Settings include, but are not

limited to, discharges from hospitals, institutions, acute care facilities, and Skilled Nursing Facilities (SNFs) to home or community-based settings, Community Supports (CS) placements (including Sobering Centers, Recuperative Care, and Short-Term Post Hospitalization), post-acute care facilities, or Long-Term Care (LTC) settings. Across these settings, TCS shall prioritize member-centered care by:

a. Ensuring Members are supported with discharge planning until they have been successfully connected to all needed services and supports.
b. Ensuring that a single point of contact, herein referred to as a TCS Care Manager, can assist throughout all high-risk Members' transitions, providing longitudinal support, and ensuring all required services are completed.
c. Ensuring that a dedicated TCS Team and a phone number is available to support lower-risk transitioning Members telephonically when needed.
d. Ensuring Members receive timely follow-up care after emergency department (ED) visits for mental health or Substance Use Disordersubstance use disorder (SUD) issuesneeds.
e. Ensuring Members receive timely follow-up after ED visits for pregnant and postpartum individuals (through 12 months postpartum), given the association of ED visits and maternal morbidity and mortality.
f. Updating a Partnership Advantage EnrolleeMember's Individualized Care Plan (ICP) as appropriate and distributing the updated ICP to the ICT.

B. TCS Member Eligibility & Identification:

1. As part of Partnership's Risk Stratification/Segmentation (RSS) and Risk Tier process, Partnership Members shall be proactively identified for TCS services.
   a. For more information on Partnership's Population Health Management Program and/or Risk Stratification/Segmentation process, see Partnership policy MPCND9001 Population Health Management Strategy & Program Description.
   b. All Partnership Advantage Eenrolleesd members.
      1) For the purpose of identifying TCS for Partnership Advantage, Enrolleesmembers receive all services in Section VI.B. and VI.C. required for High Risk members.
   c. All Non-Partnership Advantage members receiving TCS are differentiated by High- and Low-risk designations.
   d. High-risk transitioning Members means all Members that meets criteria under MPCCP2019 Identification and Care Coordination for Seniors and Persons with Disabilities and/or California Children's Services Section VI.D.1 and other Members assessed as high-risk by RSS and Risk Tier Process. Noting for TCS purposes, pregnant individuals include individuals hospitalized during pregnancy, admitted during the 12-month period post-partum, and discharges related to the delivery.
   e. In addition to these groups, and in recognition of high-risk of poor outcomes in transition for Partnership Members enrolled in multiple payors, those transitioning from SNFs, and those at high-risk who are potentially not captured in criteria mentioned in section VI.C.1.e, Partnership must also consider the following Members high-risk for the purpose of TCS:
      1) Any Member who has been served by county Special Mental Health Services (SMHS) and/or DMC or DMC-ODS (if known) within the last 12 months, or any Member who has been identified as having a specialty mental health need or substance use disorder by Partnership or discharging facility
      2) Any Member transitioning to or from a SNF
      3) Any Member that is identified as high-risk by the discharging facility and thus is referred or recommended by the facility for high-risk TCS
   f. Lower-risk transition Members are defined as those not included in the high-risk transitioning

Members noted above.

2. Partnership utilizes Admission, Discharge and Transfer (ADT) data feeds to assist in Member identification for TCS services and for assistance with timely authorizations for services that require prior authorization (e.g. acute in-patient care setting requests, etc.).
3. Partnership utilizes the ADT feed, PointClickCare (PCC) formerly Collective Medical Technologies (CMT), to receive timely notifications within 24 hours of a Member's admission, transfer or discharge.
   a. When ADT feeds are not available, Partnership shall utilize other mechanisms to identify Members who may be eligible for TCS. This includes but is not limited to: fax notifications from facilities/institutions, Treatment Authorization Requests (TAR) for services, existing data-sharing agreements with providers/vendors, direct referrals to the Health Services department, and/or internal reports. Notification is necessary within 24 hours of Partnership being aware of any planned admission, or of any admissions, discharges, or transfers. However, this notification time frame will not apply if the care manager responsible for TCS is notified of the admission, discharge, or transfer through an ADT feed directly.

C. Transitional Care Services shall include the following:
1. Ensuring collaboration and partnership with discharging facilities, including ensuring hospitals provide patient-centered discharge planning as required by federal and state requirements. Partnership must ensure discharging facilities complete a discharge planning process that:
   a. Engages the Member/legal guardian/caregiver(s)/legal representative/authorized representative , as appropriate, when being discharged from a hospital, institution, or facility.
   b. Focuses on the Member's goals and treatment preferences during the discharge process, and that these goals and preferences are documented in the medical record.
   c. Uses a consistent assessment process and/or assessment tools to identify Members who are likely to suffer adverse health consequences upon discharge without adequate discharge planning, in alignment with hospitals' current processes. Hospitals are currently required to identify these Members and complete a discharge planning evaluation on a timely basis, including identifying the need and availability of appropriate post-hospital services and documenting this information in the medical record for establishing a discharge plan.
      1) For high-risk Members, Partnership must ensure the discharging facility shares this information with Partnership's TCS Care Manager and that the discharging facilities have processes in place to refer Members to Enhanced Care Management (ECM) or CS, as needed. Partnership will include those who are Partnership Advantage Enrollees~~Members~~ in California Integrated Care Management (CICM)
      2) For Members not already classified as high-risk by Partnership per Section VI.C.1, the discharging facility must have processes in place to leverage the assessment to identify Members who may benefit from high-risk TCS services. This process must include referrals to Partnership for:
         a) Any Member who has a specialty mental health or substance use disorder need ~~need or SUD~~.
         b) Any Member who is eligible for an ECM Population of Focus.
         c) Any Partnership Advantage Enrollee~~Member~~ who is eligible for CICM Population of Focus.
         d) Any Member whom the clinical team feels is high-risk and may benefit from more intensive transitional care support upon discharge.
   d. Ensures appropriate arrangements for post-discharge care are made, including needed services, transfers, and referrals, in alignment with facilities' current requirements.
2. As defined above in Section III.C, closed loop referrals to CS and/or coordination with county social

service agencies and waiver agencies for In-Home Support Services (IHSS), Long Termm ~~Support~~ Services and Supports (LTSS) and/or Home and Community Based Waiver (HCBS) services and programs.

3. Ensuring that medication reconciliation is conducted both pre- and post-transition, including education and counseling about the Member's medications.
4. Ensuring all necessary prior authorizations required for a Member's discharge are completed in timeframes consistent with the Member's condition and regulatory requirements. Examples include, but are not limited to, authorizations for:
   a. Therapy
   b. Home care / Home Health
   c. Medical supplies
   d. Prescription medications
   e. Durable Medical Equipment (DME)
5. Coordination to ensure appropriate follow-ups are completed for post-discharge appointments includes:
   a. Ensuring the post-discharge providers are notified and receive necessary clinical information, including a discharge summary in the medical record that outlines the care, treatment, and services provided, the patient's condition and disposition at discharge, information provided to the patient and family, and provisions for follow-up care.
   b. Confirming hospital has secured necessary follow-up appointments prior to discharge.
   c. Assisting with scheduling/arranging transportation when necessary for follow-up appointments.
   d. Ensuring needed post-discharge services are provided and follow-up visits are scheduled, including, but not limited to, follow-up provider appointments, SUD and/or mental health treatment initiation.
6. Follow-up with Member and/or their legal guardian/caregiver(s)/legal representative/authorized representative to ensure that services are coordinated and post-discharge needs have been met.
7. Members may choose to have limited or no contact with the identified TCS Care Manager. In such cases, the TCS Care Manager must, at a minimum, act as a liaison to coordinate care among the discharging facility, the Primary Care Provider (PCP), and Partnership.
8. Coordination and verification that the Member is receiving all appropriate services regardless of setting.
9. Ensuring collaboration, communication and coordination with the Member, their legal guardian/caregiver(s)/legal representative/authorized representative and the care team including, but not limited to, hospitals, physicians (including the Member's PCP), LTSS providers, discharge planners, social workers, and/or other case managers to ensure and facilitate a safe and successful transition.
10. A core responsibility of the TCS Care Manager is to coordinate with discharging facilities to fully understand the Member's potential needs and follow-up plans. Additionally, the TCS Care Manager must ensure the Member participates in the care plan and receives and comprehends the information about their required care. To achieve this, the TCS Care Manager must complete the following:
    a. Risk Assessment: The TCS Care Manager must assess Members' risk for adverse outcomes to inform needed TCS. This must include reviewing information from the discharging facility's assessment(s) and discharge planning process (e.g., the discharge summary). The TCS Care Manager may supplement this risk assessment through Member engagement as needed. During this process, the TCS Care Manager must also identify Members who may be newly eligible for ongoing care management (ECM/CCM), or for PA Members (CICM), and/or Community Supports and make appropriate referrals.
    b. Discharge Instructions: The TCS Care Manager must receive and review a copy of the

discharging facility's discharge instructions given to the Member, including the medication reconciliation completed upon discharge by the discharging facility. After discharge, upon Member engagement, the TCS Care Manager must review the discharge instructions with the Member and ensure that Member can have any questions answered. A best practice (not required) is for the TCS Care Manager to work with the facility to ensure that the TCS Care Manager's name and contact information are integrated into the discharge documents.

c. Discharge Summary and Clinical Information Sharing: The TCS Care Manager must receive and review a copy of the discharging facility's discharge summary once it is complete. The TCS Care Managers must ensure all follow-up providers have access to the clinical information needed from the discharging facility, including the discharge summary.
d. Preadmission Status: Includes living arrangements, physical and mental function, SUD needs, social support, DME usage, and other services received prior to admission.
e. Pre-discharge Support Needs: Includes the Member's medical condition, physical and mental function, financial resources, and social supports at the time of discharge.
f. Discharge Location: The hospital, institution, or facility to which the Member was admitted.
g. Specific Agency or Home: Recommended by the hospital, institution, or facility after the Member's discharge based on the Member's needs and preferences.
h. Specific Services Needed After the Member's Discharge: A specific description of the type of placement preferred by the Member, the type of placement agreed to by the Member, the agency or Member's return to home agreed to by the Member, and recommended pre-discharge counseling.
i. Summary of Participation in the Discharge Planning Process: A summary of the nature and outcome of the participation of the Member/legal guardian/caregiver(s)/legal representative/authorized representative in the discharge planning process.
j. Anticipated Problems and Further Actions: Anticipated problems in implementing post-discharge plans and further actions contemplated by the hospital, institution, or facility to be included in the Member's Medical Record.
k. Information on Post-Discharge Care and Services: Information regarding available care, services, and supports that are in the Member's community once the Member is discharged from a hospital, institution or facility, including the scheduled outpatient appointment or follow-up with the Member.
l. TCS Care Manager Information: The TCS Care Manager's name and contact information, along with a description of TCS, should also be included.

11. Ensures that the Discharge Planning Document shall use language that is culturally, linguistically and literacy-level appropriate, and be shared with the Member, their legal guardian/caregiver(s)/legal representative/authorized representative, treating providers, PCPs, discharging facility and the receiving provider.

D. TCS Care Manager, Care Manager Assignment, & TCS Team
1. Once a high-risk Member has been admitted, Partnership shall identify a TCS Care Manager who shall serve as the single point of contact for the Member to provide longitudinal support and who ensures completion of all TCS services outlined in section VI.A.
a. For Members enrolled in Partnership's Complex Case Management (CCM) program, the Partnership Case Manager shall serve as the TCS Care Manager and perform all TCS services for the Member.
b. For Members enrolled in the ECM benefit, the ECM Lead Care Manager shall serve as the TCS Care Manager and perform all ECM services for the Member. For more information regarding the ECM benefit, see Partnership Policy ~~MCCP2032~~ MCAP7002 CalAIM Enhanced Care Management (ECM).

2. For high-risk Members identified for TCS, the Member shall be referred to Partnership's CCM program, ECM benefit, or for PA Members; CICM benefit, as appropriate.
3. Partnership Advantage Enrolleesmembers are assigned a Primary Case Manager for all of the member's Enrollees care coordination, including TCS. The PA primary case manager is the primary responsible person for longitudinal support and to collaborate with the staff involved with member transitions and will invite participation to the ICT based on a prioritized and active need in the ICP addressing transitions. Transitions of care involved staff (not all inclusive of inpatient review nurse coordinators, LTSS nurse coordinators, for example) provide clinical support and expertise related to transitions between care settings including LTSS.
4. For lower-risk Members identified for TCS, Partnership is required:
    a. To ensure Member has access to a dedicated contact to provide assistance for any TCS need (at Partnership or a delegate) for a period of at least 30 days from discharge.
    b. To ensure Member can reach a dedicated telephonic support service. See Partnership Policy MCUP3064 Communication Services, MPCCP2018 Advice Nurse Program , and latest Member Handbook for more details.
    c. To facilitate Members' ambulatory follow-up within 30 days of discharge for necessary post-discharge service, as needed.
5. For all other Members identified for TCS, Partnership shall evaluate and identify an appropriate TCS Care Manager. Examples include, but are not limited to, Partnership Health Services staff, hospital staff, PCPs, and/or other contracted agencies.
    a. Facility staff who help with discharge planning should work with, but not take the place of the responsible TCS Care Manager, unless Partnership has formally assigned the facility to act as the TCS Care Manager.
6. The TCS Care Manager is notified of the Member's admission, discharge and/or transfer status including the location of admission and facility contact information.
7. Partnership will notify the discharging facility of the name and contact information, including phone number, of the identified TCS Care Manager for the facility to include in the discharge planning document.
8. Partnership will provide the TCS Care Manager's contact information to the Member, legal guardian/caregiver(s)/legal representative/authorized representative, as part of the TCS engagement.
9. The TCS Care Manager must obtain permission from the Member, legal guardian/caregiver(s)/legal representative/authorized representative, as appropriate, to share information with providers to facilitate transitions, in accordance with federal and state privacy laws and regulations (ex: Release of Information (ROI), etc.)
10. The TCS Care Manager must also ensure non-duplication of services provided through other programs such as ECM, CCM, CICM Targeted Case Management, etc.
11. The assigned TCS Care Manager shall ensure that all TCS are provided in a culturally and linguistically appropriate manner for the duration of the transition, including follow-up and post-discharge.
12. High-Risk Member Outreach: The identified TCS Care Manager is responsible for contacting the Member within 7 calendar days of discharge and supporting the Member in all needed TCS care identified at discharge, as well as addressing any new needs identified through engagement with the Member or their care providers.
13. Low-Risk Member Outreach: Partnership must make best efforts to ensure Members receive direct communication about the dedicated TCS team and phone line, and how to access it, no later than 24 hours after the plans are notified of the discharge. Acceptable methods of communication include automated phone calls, incorporating information into discharge documents, and letters (either as supplemental to other efforts or if no other effort was effective). More than one method of

notification can be utilized.

E. End of TCS
   1. High-Risk Members
      a. TCS will end once the Member has been connected to needed services as identified in the discharge risk assessment or in the discharge planning document. TCS should extend at least 30 days post-discharge.
      b. If Partnership has delegated TCS to another contracted entity (e.g. hospital, PCP), Partnership will ensure that the delegate follows and coordinates services for the Member until all aforementioned activities are completed. A monitoring plan would be in place to ensure all required TCS are completed.
         1) This arrangement for managed care plan (MCP) contracted entities to provide TCS is not considered formal delegation. Therefore, Partnership is not subject to the requirements outlined in APL 23-006 "Delegation and Subcontractor Network Certification."
      c. For those Members who have ongoing unmet needs post-TCS, eligibility for ECM or CCM should be reconsidered.
      d. If the Member is enrolled in ECM, CCM, or CICM and if the TCS Care Manager responsible for TCS will not continue as their ECM, CCM, or CICM Lead Care Manager, the Member should be connected to their new TCS Care Manager through a referral.
      e. For Members who are unresponsive to Partnership's outreach attempts or did not attend scheduled follow-up ambulatory visits, Partnership must make reasonable effort to ensure Members:
         1) Are aware that TCS support is available for at least 30 days.
         2) Are engaged and that follow-up ambulatory visits are completed.
      f. For Members with multiple care transitions within a 30-day period, Partnership must ensure the same TCS Care Manager is assigned to support the Member through all transitions. If the second transition occurs within 7 days of the first transition, the TCS Care Manager must facilitate, as needed, a follow-up visit to be completed within 7 days post-discharge after the last transition. The TCS Care Manager must also provide TCS support for at least 30 days after the last transition. These Members should be considered for ECM/CCM/CICM and/or CS eligibility.
   2. Lower-Risk Members
      a. Partnership must continue to offer TCS support through a dedicated telephonic team for at least 30 days post-discharge.
      b. In addition to accepting referrals to longer term care management at any point during the transition, Partnership will use data including any information from admission, to identify newly qualified Members for outreach and enrollment into ECM/CCM/CICM and/or CS as appropriate.
   3. Partnership may utilize Community Health Worker~~'~~s (CHW~~'~~s) when available through the CHW benefit to facilitate Member outreach and engagement. Refer to Partnership policy MPAP7004 ~~MCCP2033~~ Community Health Worker (CHW) Services Benefit for details.

F. Prior Authorization and Timely Discharge
   1. Partnership adheres to regulatory prior authorization processing timeframes. The timely processing of authorizations supports Partnership's contracted providers in discharge planning and ensuring necessary services and supports are in place prior to discharge. Partnership policy MCUP3041 Treatment Authorization Request (TAR) Review Process describes how Partnership monitors performance and complies with regulatory prior authorization processing timeframes and standards as well as APL 21-011 "Grievance and Appeal Requirements, Notice and "Your Rights" Templates".

2. As described in Partnership policy MPUD3001 Utilization Management Program Description, Members are evaluated for appropriateness of care setting pursuant to medical necessity and the documented discharge plan. The discharge plan shall take into account the continuing care needs and initiation of arrangements for services or placement needed after discharge.
   a. Partnership shall collaborate with hospital discharge planners, case managers, admitting/attending physicians and ancillary service providers to assist in making necessary arrangements for post-discharge needs.
3. To support effective discharge planning practices, Partnership shall ensure all network providers (e.g. hospitals, acute care facilities, institutions, etc.) educate their discharge staff on the services, supplies, medications, and DME that require a Treatment Authorization Request (TAR). A list of items that require prior authorization is attached to Partnership policy MCUP3041 Treatment Authorization Request (TAR) Review Process as Attachment A. The policy is made available on Partnership's website for further education and to support the provider network and discharge planning staff.
4. Partnership maintains mutually agreed upon policies and procedures for Discharge Planning and Transitional Care Services that apply to each of our Network Providers and Out-of-Network Provider hospitals within our Service Area.

G. TCS For Partnership Members with Other Health Insurance/ Multiple Payers
1. Partnership is responsible for providing TCS to Partnership assigned Members even for services or benefits carved-out from Partnership's Medi-Cal contract. (e.g., hospitalization for a Medicare FFS dual-eligible Member, in-patient acute psychiatric admissions, etc.)
2. For Members who have multiple payers (other health insurance) and are undergoing any transition, Partnership will make a good faith attempt to obtain necessary ADT information from the corresponding facility. For these Members, Partnership shall notify existing CCM and/or ECM care managers of the admission, discharge and/or transfer in the manner outlined above in section VI. C.
3. For Members who are admitted for an acute psychiatric hospital, psychiatric health facility, adult residential or crisis residential stay where the county Mental Health Plan is the primary payer, the county Mental Health Plan has the primary responsibility to coordinate the Member's care upon discharge. Partnership and the county Mental Health Plan must share necessary data and information to coordinate care for TCS per APL 23-029 Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans and Third-Party Entities (08~~10~~/11/2025~~3~~).
   a. Partnership will be responsible for all TCS during the transfer/discharge to the behavioral health facility.
   b. Partnership shall identify a TCS Care Manager for these Members to coordinate with county behavioral health and/or county case managers to ensure physical health follow-up needs are met, assessed for, and additional care management needs such as CCM, ECM, CICM, or CS are addressed.
   c. TCS for this transfer/discharge end once the Member is admitted to the behavioral health facility and connected to all needed services, including care coordination.
4. After the Member's treatment at the behavioral health facility is complete and the Member is ready to be discharged or transferred, Partnership must follow the same transitional care requirements as either psychiatric admission or residential SUD treatment facility admission listed above. For Partnership members who have Medicare as primary coverage for inpatient, acute, and/or skilled nursing services:
   a. The M~~m~~ember's Medicare Medi-Cal Plan (MMP) or the M~~m~~ember's Dual-Eligible Special Needs ~~Program~~ Plan (D-SNP) is responsible for coordinating the delivery of all benefits covered by both Medicare and Partnership. Partnership ~~shall not~~is not responsible for providing~~e~~ TCS or

assigning a transitional care manager for Members enrolled in a Medicare Medi-Cal Plan or Dual-Eligible Special Needs Program (D-SNP).

1) Effective January 1, 2028, members enrolled in Partnership's Partnership Advantage program for D-SNP will have transitions of care coordinated under the Partnership Advantage plan.

5. Drug Medi-Cal Organized Delivery System (DMC-ODS) or Partnership's Wellness and Recovery services:
   a. For Members needing SUD services in counties participating in Partnership's Wellness & Recovery program (Regional Model), Partnership will be responsible for all TCS during the transfer/discharge to the behavioral health facility.
   b. For Members needing SUD services in the counties not participating in Partnership's Wellness & Recovery program, Partnership shall identify a TCS Care Manager for these Members to coordinate with county behavioral health and/or county case managers to ensure physical health follow-up needs are met, assessed for, and additional care management needs such as CCM, ECM, CICM or Community Supports (CS) are addressed.
   c. TCS for this transfer/discharge end once the Member is admitted to the behavioral health facility and connected to all needed services, including care coordination.
   d. After the Member's treatment at the behavioral health facility is complete and the Member is ready to be discharged or transferred, Partnership must follow the same transitional care requirements as either psychiatric admission or residential SUD treatment facility admission listed above.

H. DHCS Monitoring of TCS
   1. If Partnership contracts with or delegates to facilities or providers to provide full scope or specific components of TCS, Partnership must have robust monitoring and enforcement process in place to hold facilities or providers accountable for providing all required TCS outlined above.
   2. For more details on what DHCS will monitor with Partnerships' TCS implementation through specific PHM Monitoring Key Performance Indicators (KPIs), refer to the CalAIM Population Health Management Policy Guide for more details.

VII. REFERENCES:

A. DHCS Contract Exhibit A, Attachment III – 4.3, Population Health Management and Coordination of Care
B. DHCS APL 22-024 Population Health Management Policy Guide (11/28/2022)
C. DHCS APL 23-006 Delegation and Subcontractor Network Certification (03/28/2023)
D. DHCS APL 21-011 Grievance and Appeal Requirements, Notice and "Your Rights" Templates (*Revised* 08/31/2022)
E. DHCS APL 23-029 Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans and Third-Party Entities (*Revised* 08/11/2025~~01/08/2025~~)
   1. Specialty Mental Health Services MOU template (DHCS contract Attachment E)
F. Title 42 Code of Federal Regulations (CFR) Section 438.208
G. CalAIM Dual Eligible Special Needs Plans Policy Guide - Contract 2026 (February 20265)
H. CalAIM Population Health Management Policy Guide (January 20264)
I. DHCS Birthing Care Pathway
J. Medicare Advantage Options for Dual Eligible Beneficiaries
K. DHCS BHIN 26-001 Inpatient Criteria SMHS https://www.dhcs.ca.gov/Documents/BHIN-26-001-Inpatient-Criteria.pdf
L. DHCS BHIN 26-002 Criteria for Medi-Cal Member Access to SMHS https://www.dhcs.ca.gov/Documents/BHIN-26-002-Access-Criteria.pdf

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

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

X. REVISION DATES:

Medi-Cal
06/11/25; 06/10/26

Partnership Advantage (Program effective January 1, 2028~~7~~)
06/10/26~~N/A~~

PREVIOUSLY APPLIED TO:

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

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

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

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

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

Policy/Procedure Number: MPAP7004 (*previously MCCP2033***)**			**Lead Department:** Health Services Business Unit: EHS	
Policy/Procedure Title: Community Health Worker (CHW) Services Benefit			☒**External Policy** ☐ **Internal Policy**	
Original Date: 02/08/2023 (MCCP2033) **Effective Date:** 07/01/2022 vs. DHCS		**Next Review Date:** **Last Review Date:**	~~06/10/2026~~06/09/2027 ~~06/11/2025~~06/10/2026	
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒**Partnership Advantage**	
Reviewing Entities:	☒ **IQI**	☐ **P & T**	☒ **QUAC**	
	☐ **OPERATIONS**	☐ **EXECUTIVE**	☐ **COMPLIANCE**	☐ **DEPARTMENT**
Approving Entities:	☐ **BOARD**	☐ **COMPLIANCE**	☐ **FINANCE**	☒ **PAC**
	☐ **CEO** ☐ **COO**	☐ **CREDENTIALS**	☐ **DEPT. DIRECTOR/OFFICER**	
Approval Signature: *Robert Moore, MD, MPH, MBA*			**Approval Date:** 06/11/2025	

I. RELATED POLICIES:

A. MCND9001 – Population Health Management Strategy & Program Description
B. MCCP2032 – CalAIM Enhanced Care Management (ECM)
C. MCAP7003 – CalAIM Community Supports (CS)
D. MCAP7001 – CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS)
E. MCUP3041 – Treatment Authorization Request (TAR) Review Process
F. MCUP3113 – Telehealth Services
G. MPCR11 – Credentialing of Community Health Worker (CHW) Supervising Providers
H. MPAP7005 – Street Medicine
~~H.~~I. MCCP2024 Whole Child Model for California Children's Services

II. IMPACTED DEPTS:

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

III. DEFINITIONS:

A. California Children's Services (CCS): A state program for children up to 21 years of age, who have been determined eligible for the CCS program due to the presence of certain diseases or health problems.
~~A.~~B. California Integrated Care Management (CICM): California-specific requirements for integrated care coordination for specific vulnerable populations covered by Dual-Eligible Special Needs Plans (D-SNPs) as determined by the State.
~~B.~~C. Closed loop referral: A closed loop referral means bidirectional information sharing between two or more parties to communicate requests for services and the associated outcomes of the requests. The frequency and format of this information sharing varies by service provider and by the degree of formality that may be required according to local community norms. Depending on the type of service needed, this process may include referral to medical, dental, behavioral, and/or social services or community agencies. While a warm hand off may occasionally be appropriate, a closed loop referral does not imply that a warm hand off is required.
~~C.~~D. Community-Based Organization (CBO): A public or private non-profit organization dedicated to the overall health, well-being, and functions of their community.
~~D.~~E. Community Health Worker (CHW): Individuals known by a variety of job titles, such as ~~promotores~~promotors, community health representatives, navigators, and other non-licensed public

health workers, including violence prevention professionals, who connect and engage with their community to provide equitable health care through culturally competent services. CHWs are trusted members of their community who help address chronic conditions, preventive health care needs, and health related social needs within their communities.

E.F. Community Health Worker (CHW) Services: CHW services are preventive health services as defined in 42 CFR health 440.130(c) delivered by a CHW to prevent disease, disability, and other health conditions or their progression; to prolong life; and to promote physical and mental health and well-being. CHW services can help members receive appropriate services related to perinatal care, preventive care, sexual and reproductive health, environmental and climate-sensitive health issues, oral health, aging, injury, and domestic violence and other violence prevention services.

F.G. Enhanced Care Management (ECM): A whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-need and/or high-cost members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered.51532).

G.H. Enhanced Care Management (ECM) Provider: A Provider of ECM. ECM Providers are community-based entities with experience and expertise providing intensive, in-person care management services to individuals in one or more of the Populations of Focus for ECM.

H.I. Licensed Practitioner of the Healing Arts (LPHA): For the purposes of this policy, an individual who, within the scope of State law, has the ability and appropriate state licensure to independently make a clinical assessment, certify a diagnosis and recommend treatment.

I.J. Managed Care Plan (MCP): Partnership HealthPlan of California (Partnership) is contracted as a Department of Health Care Services (DHCS) Managed Care Plan (MCP).

J.K. Partnership Advantage: Effective January 1, 2027, Partnership HealthPlan of California will operate a Centers for Medicare & Medicaid Services (CMS)-approved Dual-Eligible Special Needs Plan (D-SNP) in specific counties as described in the Department of Health Care Services (DHCS) CalAIM Dual Eligible Special Needs Plan Policy Guide. This line of business will be known as Partnership Advantage and will be a Medicare Advantage plan offered to all full-benefit, dual-eligible beneficiaries 21 years of age or older who reside in the applicable counties. Partnership Advantage Members will be qualified to receive both Medi-Cal and Medicare services as described in the Partnership Advantage Member Handbook.

K.L. Street Medicine: Refers to a set of health and social services developed specifically to address the unique needs and circumstances of individuals experiencing unsheltered homelessness, delivered directly to them in their own environment.

M. Supervising Providers: The organizations with which Partnership HealthPlan of California (Partnership) contracts that employ or otherwise oversee the CHWs. The Supervising Provider must be a licensed provider, a hospital including the Emergency Department (ED), outpatient clinic, local health jurisdiction (LHJ), or community-based organization (CBO). The Supervising Provider ensures that CHWs meet Department of Health Care Services (DHCS) qualifications as listed in APL 24-006, oversees CHWs and the services delivered to Partnership Members, and submits claims for services provided by CHWs.

L.N. Whole Child Model (WCM): A comprehensive program for the whole child encompassing providing comprehensive diagnostic and treatment services and care coordination in the areas of primary, specialty, and behavioral health for any pediatric Member with CCS eligible conditions insured by Partnership

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

To define the Community Health Worker (CHW) Medi-Cal benefit (effective July 1, 2022), including categories of service and pathways to CHW certification.

VI. POLICY / PROCEDURE:

A. Partnership recognizes the CHW benefit as a means to ensure that members have improved access to culturally competent services that link health and social resources with the intent to improve the overall quality of health and wellbeing of the member population. CHW services may be provided through multiple entities including contracted primary care providers (PCPs), community-based organizations (CBOs), as well as via health plan staff trained to perform services normally provided by CHWs

B. CHW Qualifications

1. Per APL 24-006 Community Health Worker Services Benefit, CHWs must have lived experience that aligns with and provides a connection between the CHW and the Member or population served. This may include, but is not limited to, experience related to incarceration, military service, pregnancy and birth, disability, foster system placement, homelessness, mental health conditions or substance use, or being a survivor of domestic or intimate partner violence or abuse and exploitation. Lived experience may also include shared race, ethnicity, sexual orientation, gender identity, language, or cultural background with one or more linguistic, cultural, or other groups in the community for which the CHW is providing services.

2. CHWs must demonstrate, and Supervising providers must maintain evidence of, minimum qualifications that may be met through one of the following means:

   a. Certificate Pathway: CHWs demonstrating qualifications through the Certificate Pathway must provide proof of completion of at least one of the following certificates:

      1) CHW Certificate: A CHW Certificate allows a CHW to provide all covered CHW services including violence prevention services. It must be a valid certificate of completion of a curriculum that attests to demonstrated skills and/or practical training in the following areas as determined by the Supervising Provider:

         a) communication
         b) interpersonal and relationship building
         c) service coordination and navigation
         d) capacity building
         e) advocacy
         f) education and facilitation
         g) individual and community assessment
         h) professional skills and conduct
         i) outreach
         j) evaluation and research, and
         k) basic knowledge in public health principles and Social Drivers of Health (SDOH), as determined by the Supervising Provider.
         l) Certificate programs must also include field experience as a requirement. A CHW Certificate allows a CHW to provide all covered CHW services described in APL 24-006, including violence prevention services.

      2) Violence Prevention Professional Certificate: For individuals providing CHW violence prevention services only, a Violence Prevention Professional (VPP) Certificate issued by Health Alliance for Violence Intervention or a certificate of completion in gang intervention training from the Urban Peace Institute.

         a) A VPP Certificate allows a CHW to provide CHW violence prevention services only. A CHW providing services other than violence prevention services must demonstrate qualification through either the Work Experience Pathway or completion of a general

CHW Certificate.

b. Work Experience Pathway: Individuals having at least 2,000 hours working as a CHW in paid or volunteer positions within the previous three years and who demonstrate skills and practical training in the areas described above (as determined and validated by the Supervising Provider) may provide CHW services without a certificate for a maximum period of 18 months.

1) A CHW who does not have CHW certification must earn certification, as described above, within 18 months of the first CHW visit provided to a Member.

3. Supervising Providers will maintain evidence of CHWs completing a minimum of six hours of additional relevant training annually, which can be in core competencies or a specialty area.

C. Provider Responsibilities for CCS Members:

1. For CCS members residing in a WCM County and enrolled in a MCP, the WCM MCP is responsible for CHW services.
2. For CCS members in Classic Counties enrolled in a MCP, the MCP is responsible for CHW services.
3. For CCS members in Classic County Fee-For-Service, County CCS Program staff are responsible for CHW services.

C.D. Supervising Provider Responsibilities

1. The Supervising Provider ensures that CHWs meet all required qualifications, maintains evidence of the CHW's experience (as mentioned in section VI.B.2.) and training, and oversees CHWs and the services delivered to Partnership Members.
2. The Supervising Provider does not need to be the same entity as the Provider who made the referral for CHW services, nor do they need to have a licensed provider on staff in order to contract with Partnership to provide CHW services.
3. Supervising Providers do not need to be physically present at the location when CHWs provide services to Members. Management and day-to-day supervision of CHWs as employees may be delegated as determined by the Supervising Provider. However, the Supervising Provider is responsible for ensuring the provision of CHW services complies with all applicable requirements.
4. Supervising Providers must provide direct or indirect oversight to CHWs.
   a. Supervising providers (or their Subcontractors contracting with or employing CHWs to provide covered CHW services to the MCP's Members) must ensure CHWs have adequate supervision and training.
   b. Direct oversight includes, but is not limited to, guiding CHWs in providing services, participating in the development of the care plan, and following up on the progression of CHW services to ensure that services are provided in compliance with all applicable requirements.
   c. Indirect oversight includes, but is not limited to, ensuring connectivity of CHWs with the ordering entity and ensuring appropriate services are provided in compliance with all applicable requirements.
   c.d. Oversight of CHW services for CCS members must be done by one or more CCS paneled pediatric specialty physicians at a CCS approved special care center or other outpatient facility.
5. See policy MPCR11 Credentialing of Community Health Worker (CHW) Supervising Providers for further information on credentialing requirements for Supervising Providers.

D.E. Partnership CHW Workforce Initiative

1. Partnership actively supports local partnerships and CHW training across our network, including funding by the Health Resources and Services Administration (HRSA).
2. Partnership encourages providers to integrate CHWs into basic Population Health Management (PHM) and preventive care, and to give anticipatory guidance in support of the primary care team, Enhanced Care Management (ECM) teams, and perinatal care teams.
3. Partnership surveys our provider network periodically to get an understanding of how many CHWs are providing services, what area of focus/training the CHWs have, and if they have capacity for

referrals from outside agencies.

4. Partnership is actively building a mechanism for Partnership staff and outside providers to search for organizations with CHW capacity for outside referrals, so they can make referrals to CHWs matched to the needs of individual members.

E.F. Informing providers about the CHW benefit

1. Partnership publicizes our current understanding of the regulatory framework for CHWs with our provider network and community-based organizations in community meetings, provider meetings, and in provider newsletters.
2. Partnership's Provider Relations department educates providers on CHW services through the Medical Director's newsletter, Provider quarterly newsletters, bulletins, and other mechanisms of education to ensure providers know how to leverage this benefit on behalf of their members.

F.G. Informing members about the CHW benefit

1. Partnership's Health Education team crafts communications that are culturally and linguistically appropriate and explain CHW services to our members. Details of the CHW benefit and services are outlined in Partnership's Evidence of Coverage (EOC), which is distributed annually to Partnership members by Member Services.
2. Partnership's Health Education team and Communications department collaborate to ensure there are written notices in the member newsletter and that the Partnership webpage is updated with these new services.
3. CHW can provide qualifying members with specific support and offer tailored communication about how these services can support their health and wellbeing. Members referred to these services can be provided with materials explaining the services and are given the option to opt out of CHW services.

G.H. Member Eligibility for CHW services

a. Members who meet the eligibility criteria for receiving CHW services have a standing recommendation issued by DHCS. For CHW services rendered in the ED, the treating Provider may document the recommendation in the Member's medical record of the ED visit.

2. CHW services are considered medically necessary for Members with one or more chronic health conditions (including behavioral health and CCS eligible conditions) or exposure to violence and trauma, who are at risk for a chronic health condition or environmental health exposure, who face barriers in meeting their health or health-related social needs, and/or who would benefit from preventive services. The recommending Provider, whom does not need to be Medi-Cal enrolled, must determine whether a Member meets eligibility criteria based on the presence of one or more of the following before recommending CHW services:
   a. Diagnosis of one or more chronic health (including behavioral health and CCS eligible conditions) conditions, or a suspected mental disorder or substance use disorder that has not yet been diagnosed.
   b. Presence of medical indicators of rising risk of chronic disease (e.g., elevated blood pressure, elevated blood glucose levels, elevated blood lead levels or childhood lead exposure, etc.) that indicate risk but do not yet warrant diagnosis of a chronic condition.
   c. Any stressful life event presented via the Adverse Childhood Events (ACEs) screening.
   d. Presence of known risk factors, including domestic or intimate partner violence, tobacco use, excessive alcohol use, and/or drug misuse.
   e. Results of a SDOH screening indicating unmet health-related social needs, such as housing or food insecurity.
   f. One or more visits to a hospital emergency department (ED) within the previous six months.
   g. One or more hospital visits or hospital inpatient stays, including stays at a psychiatric facility, within the previous six months, or being at risk of institutionalization.
   h. One or more stays at a detox facility within the previous year.
   i. Two or more missed medical appointments within the previous six months.

j. Member expressed need for support in health system navigation or resource coordination services.

k. Need for recommended preventive services, including updated immunizations, annual dental visit, and well-child care visits for children.

k.l. Services are medically necessary to correct or ameliorate CCS eligible conditions.

3. CHW violence prevention services are specific to community violence (e.g. gang violence) and are available to Members who meet any of the following circumstances as determined by a licensed practitioner:
   a. The Member has been violently injured as a result of community violence.
   b. The Member is at significant risk of experiencing violent injury as a result of community violence.
   c. The Member has experienced chronic exposure to community violence.
4. CHW services can be provided to Members for interpersonal/domestic violence through the other pathways with training/experience specific to those needs.

H.I. Assessing and Identifying Member Needs for CHW Services

1. In addition to recommending that Providers identify member needs for CHW services, Partnership also assesses member needs for services and determines priority populations using a data driven approach. Partnership attempts outreach to identified members and their Providers and offers to connect the qualifying Members to needed CHW services. Data sources may include, but are not limited to, using past and current Member utilization/encounters, Partnership's proprietary risk score model, risk stratification and segmentation methodology, utilization reports showing member hospitalizations and ED visits, data on health risks and clinical core gaps, demographic and SDOH data, referrals from the community (including Provider referrals) for services, member self-referral to identify members who may benefit from CHW services, and needs assessments.
2. Populations of special focus include:
   a. Children who need preventive care
   b. Members who under-utilize primary care
   c. Pregnant or newly delivered members
   d. Members who have behavioral health needs, substance use disorders (SUD), or conditions requiring integration of physical and behavioral health.
   e. Members newly released from incarceration.

I.J. Documentation Requirements

1. CHWs are required to document the dates and time/duration of services provided to Members, which should also reflect information on the nature of the service provided and support the length of time spent with the patient that day.
2. Documentation must be accessible to the Supervising Provider upon their request.
3. Documentation should be integrated into the Member's medical record and available for encounter data reporting.

J.K. Authorization for CHW Services and Care Plans

1. Partnership does not require prior authorization for CHW services as preventive care for the first 12 units with a limit of four (4) units a day.
2. For Members who need multiple CHW services or continued CHW services in excess of 12 units, a prior authorization request (TAR) is required (see Partnership Policy MCUP3041 Treatment Authorization Request (TAR) Review Process for requirements and procedures).
   a. Documentation to be provided with the TAR includes a written care plan that must be written by one or more individual licensed providers (with the exception of services provided in the ED) which may include the recommending Provider and other licensed Providers affiliated with the CHW Supervising Provider.
      1) The care plan must state the following:

a) Specify the condition that the service is being ordered for and be relevant to the condition
b) Include a list of other health care professionals providing treatment for the condition or barrier
c) Contain written objectives that specifically address the recipient's condition or barrier affecting their health
d) List the specific services required for meeting the written objectives
e) Include the frequency and duration of CHW services (not to exceed the Provider's order) to be provided to meet the care plan's objectives

2) The Provider submitting the care plan does not need to be the same Provider who initially recommended CHW services or the Supervising Provider for CHW services.
3) CHWs may participate in the development of the care plan and may take a lead role in drafting the care plan if done in collaboration with the Member's care team and/or other Providers.
4) The plan of care may not exceed a period of one year.
5) The care plan must state the following:
   a) Specify the condition that the service is being ordered for and be relevant to the condition
   b) Include a list of other health care professionals providing treatment for the condition or barrier
   c) Contain written objectives that specifically address the recipient's condition or barrier affecting their health
   d) List the specific services required for meeting the written objectives; and
   e) Include the frequency and duration of CHW services (not to exceed the Provider's order) to be provided to meet the care plan's objectives.
6) A licensed Provider must review the member's care plan at least every six months from the effective date of the initial care plan. The licensed Provider must determine if progress is being made toward the written objective and whether services are still medically necessary.
   a) TARs will be authorized for 6 monthsmonths, and reauthorization will be contingent upon submission of a reviewed/updated care plan.
   b) If there is a significant change in the member's condition, Providers should consider amending the plan for continuing care or discontinuing services if the objectives have been met.

K.L. Partnership's CHW Program Standards

1. Partnership will not establish unreasonable or arbitrary barriers for accessing coverage.
2. Partnership complies with all reporting and oversight requirements including monitoring for fraud, waste and abuse of CHW services through committees that review for over and under-utilization of services.
3. Partnership uses CHWs to help address basic population health management, improve engagement, quality and health equity, and to improve efficiencies.
4. Partnership encourages providers to integrate CHWs into basic population health management and preventive care activities. This may include:
   a. Referrals for families with children requiring preventive care
   b. Referrals for vulnerable pregnant members who may benefit from added support through pregnancy and the first year of a child's life
   c. Referrals for members with Limited English Proficiency (LEP) or members who are not familiar with Medi-Cal benefits.
5. Partnership will encourage recruitment of CHWs who have lived experience with incarceration, behavioral health concerns, homelessness, and other vulnerable populations to provide CHW

services to members facing these challenges.

6. Partnership will track quality indicators for those members who use CHW services compared to a matched sample of members who do not agree to CHW services. For example:
   a. HEDIS compliance with well-child visits for families requiring preventive care
   b. HEDIS compliance with prenatal, post-partum, and well-baby visits for pregnant mothers
   c. Member satisfaction post benefit-utilization for a representative sample of those using the CHW benefit.
7. Partnership will assess the CHW workforce through several means:
   a. Surveying providers known to be using CHWs to determine the number of CHWs engaged by ~~provider~~providers, the particular population of focus for each CHW, and a percentage of population covered calculated by provider and by county.
   b. Tracking utilization rates using the DHCS-designated CPT/HCPCS billing codes for CHW services that are not billed under global services (such as ECM or perinatal services).
   ~~b.~~c. Partnership will cover, ensure and monitor sufficient provider networks for CHW services.

~~L.~~M. CHW Services Provided

1. CHW services can be provided as individual or group sessions and can also be provided virtually or in-person with locations in any setting including, but not limited to, outpatient clinics, hospitals, homes, or community settings. Services may also be provided via telehealth (see policy MCUP3113 Telehealth Services). There are no service location limits.
2. Services may be provided to a parent or legal guardian of Members under age 21 for the direct benefit of the Member, in accordance with a recommendation from a licensed Provider. Services for the direct benefit of the Member must be billed under the Member's Medi-Cal ID. If the parent or legal guardian of the Member is not enrolled in Medi-Cal or Partnership Advantage, the Member must be present during the session. Covered services do not require a license.
3. CHWs may render street medicine, and the Supervising Provider would bill Partnership for any appropriate and applicable services within the scope of the CHW benefit. (Street Medicine services are defined by DHCS in APL 24-001 *Street Medicine Provider: Definitions and Participation In Managed Care* dated 01/12/2024)
4. Covered CHW services do not include any service that requires a license.
5. CHW Services include:
   a. Health Education: Promoting a Member's health or addressing barriers to physical and mental health care, such as through providing information or instruction on health topics. Health Education content must be consistent with established or recognized health care standards and may include coaching and goal setting to improve a Member's health or ability to self-manage their health conditions.
   b. Health Navigation: Providing information, training, referrals, or support to assist Members to access health care, understand the health care delivery system, or engage in their own care, including, and communicating cultural and language preferences to providers. Health navigation includes connecting Members to community resources necessary to promote health; addressing barriers to care, including connecting to medical translation/interpretation or transportation services; or address health-related social needs. Under Health Navigation, CHWs can also:
      1) Serve as a cultural liaison or assist a licensed health care Provider to participate in the development of a plan of care, as part of a health care team;
      2) Perform outreach and resource coordination to encourage and facilitate the use of appropriate preventive services; or
      3) Help a Member enroll or maintain enrollment in government or other assistance programs related to improving their health, if such navigation services are provided pursuant to a plan of care.
   c. Screening and Assessment: Providing screening and assessment services that do not require a

license and assisting Members with connecting to appropriate services to improve their health, including connecting individuals and families with community-based resources.

d. Individual Support or Advocacy: Assisting Members in preventing the onset or exacerbation of a health condition, or preventing injury or violence. This includes peer support as well if not duplicative or other covered benefits.

~~M.~~N. Non-Covered CHW Services

1. Non-covered CHW services include, but are not limited to:
   a. Clinical case management/care management that requires a license
   b. Child care
   c. Chore services, including shopping and cooking meals
   d. Companion services
   e. Employment services
   f. Helping a Member enroll in government or other assistance programs that are not related to improving their health as part of a plan of care
   g. Delivery of medication, medical equipment, or medical supply
   h. Personal care services/Homemaker services
   i. Respite care
   j. Services that duplicate another covered Medi-Cal service already being provided to a Member
   k. Socialization
   l. Transporting members
   m. Services provided to individuals not enrolled in Medi-Cal, except as noted above
   n. Services that require a license
   o. Peer Support Services as covered under the Drug Medi-Cal, Drug Medi-Cal Organized Delivery System, and Specialty Mental Health Services programs. (CHW services are distinct and separate from Peer Support Services.)

~~N.~~O. Partnership is actively working towards establishing closed loop referrals for services provided by CHWs, peer counselors (peer support not duplicative of other covered Medi-Cal or Medicare D-SNP benefits), and local community organizations, as defined at III.B. above. Closed loop referrals are currently accomplished through:

1. Tracking member referrals through Partnership's case management system and sharing access to this system with providers.
2. Leveraging Community Information Exchanges (CIEs) to allow community-based organizations and their staff to have insight into services and referrals made on behalf of shared members/clients.
3. Establishing protocols for documenting and sharing referral data in shared systems.

~~O.~~P. Billing, Claims, and Payments

1. CHW services will be reimbursed through a CHW Supervising Provider in accordance with its Provider contract.
2. Claims processes must adhere to contractual requirements related to claims processing and encounter data submissions including use of approved codes pursuant to the Medi-Cal Provider Manual for CHW Preventive Services.
3. Claims for CHW services will be submitted by the Supervising Provider with allowable current procedural terminology (CPT) codes as outlined in the Medi-Cal Provider Manual at Community Health Worker (CHW) Preventive Services (*chw prev*).
4. Partnership does not require prior authorization for CHW services; however, quantity limits can be applied based on goals detailed in the care plan as described in section VI.J.2.
5. Encounter data:
   a. Partnership shall submit all CHW encounters to DHCS using national standard specifications and code sets to be defined by DHCS.
   b. Partnership shall be responsible for submitting to DHCS all CHW encounter data, including

encounter data for CHW generated under subcontracting arrangements.

6. Providers must not double bill, as applicable, for CHW services that are duplicative to services that are reimbursed through other benefits such as ECM or CICM, which is inclusive of the services within the CHW benefit.
   a. If a member who is not already enrolled in ECM but meets ECM criteria, then the member chooses which benefit to receive.
   b. CHW/ECM providers must document member choice in the member record.
   -.c. Through Partnership's Claims process, Partnership shall ensure that members shall not receive duplicative services through CHW and/or ECM or CICM. Please see Partnership policies MCCP2032 CalAIM Enhanced Care Management and MCAP7001CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS).
7. Tribal clinics may bill Partnership for CHW services at the Fee-for-Service rates using the CPT codes as outlined in the Medi-Cal Provider Manual.
8. For purposes of the services rendered by CHWs, FQHC and Rural Health Clinic (RHC) providers are not authorized as supervising providers in the Medi-Cal State Plan. Although FQHC and RHC providers may use CHWs to provide covered CHW preventive services, CHWs are not considered to be FQHC and RHC billable providers.

VII. REFERENCES:

A. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-006 Community Health Worker Services Benefit (05/13/2024) supersedes APL 22-016
B. State Plan Amendment (SPA) 22-0001
C. Title 42 Code of Federal Regulations (CFR) Section 440.130(c)
C.D. CCS Information Notice 25-05 (12/22/2025)
D.E. Welfare and Institutions Code (WIC) 14087.325(d)
E.F. Medi-Cal Provider Manual/ Guidelines: Community Health Worker (CHW) Preventive Services (*chw prev*)
F.G. DHCS APL 24-001 Street Medicine Provider: Definitions and Participation in Managed Care (01/12/2024) supersedes APL 22-023
G.H. DHCS Standing Order

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

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

X. REVISION DATES:

Medi-Cal
MPAP7004: 6/11/26; 06/10/26:

Partnership Advantage (effective Jan. 1, 2028)
N/A

PREVIOUSLY APPLIED TO:
Medi-Cal MCCP2033:
02/14/24; 10/09/24; ARCHIVED 06/11/25

****

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

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

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

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

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

Policy/Procedure Number: MPAP7005 (previously MCUP3146)			**Lead Department: Health Services** Business Unit: EHS	
Policy/Procedure Title: Street Medicine			☒**External Policy** ☐ **Internal Policy**	
Original Date: 04/12/2023 (MCUP3146)		**Next Review Date:** ~~06/11/2026~~06/09/2027 **Last Review Date:** ~~06/11/2025~~06/10/2026		
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**	
Reviewing Entities:	☒ **IQI**	☐ **P & T**	☒ **QUAC**	
	☐ **OPERATIONS**	☐ **EXECUTIVE**	☐ **COMPLIANCE**	☐ **DEPARTMENT**
Approving Entities:	☐ **BOARD**	☐ **COMPLIANCE**	☐ **FINANCE**	☒ **PAC**
	☐ **CEO** ☐ **COO**	☐ **CREDENTIALS**	☐ **DEPT. DIRECTOR/OFFICER**	
Approval Signature: *Robert Moore, MD, MPH, MBA*			**Approval Date:** ~~6/11/2025~~6/10/2026	

I. RELATED POLICIES:

A. ~~MCCP2032~~ MCAP7002 – -CalAIM Enhanced Care Management (ECM)
B. MCAP7003 – CalAIM Community Supports (CS)
C. MCAP7001 – CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS)
D. MPAP7004 – Community Health Worker (CHW) Services Benefit
E. MCUP3124 – Referral to Specialists (RAF) Policy
F. MCUP3041 – Treatment Authorization Request (TAR) Review Process
G. MPCR300 – Physician Credentialing and Re-Credentialing Requirements
H. MPCR301 – Non-Physician Clinician Credentialing and Re-Credentialing Requirements
I. MPCR302 – Behavioral and Mental Health Practitioner Credentialing and Re-Credentialing Requirements
J. MPCR17 – Standards for Contracted Primary Care Providers
K. MPCR11 – Credentialing of Community Health Worker (CHW) Supervising Providers
L. MPNET100 – Access Standards and Monitoring
M. MPQP1022 – Site Review Requirements and Guidelines

II. IMPACTED DEPTSM

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

III. DEFINITIONS:

A. Authorized Representative: An adult Member has the right to designate a friend, family member, or other person to have access to certain protected health information (PHI) to assist the Member with making medical decisions. The Member will need to provide appropriate legal documentation as defined in CMP26 Verification of Caller Identity and Release of Information and submit to Partnership HealthPlan of California (Partnership) for review prior to releasing PHI. Until the form has been submitted and validated by Partnership staff, the Member can give verbal consent to release non-sensitive PHI to a designated person. Verbal consent expires at close of business the following business day. The Member can give additional Verbal Consent when the prior Verbal Consent window of time has expired.
B. Certified Nurse Midwife (CNM): A CNM is licensed as a Registered Nurse and certified as a Nurse Midwife by the California Board of Registered Nursing.
C. Community Health Worker (CHW): Individuals known by a variety of job titles, such as

promotorespromoters, community health representatives, navigators, and other non-licensed public health workers, including violence prevention professionals, who connect and engage with their community to provide equitable health care through culturally competent services. CHWs are trusted members of their community who help address chronic conditions, preventive health care needs, and health related social needs within their communities.

D. Community Supports Services (CS): Pursuant to 42 CFR 438.3(e)(2), In-Lieu of Services (ILOS) are optional services or settings that are offered in place of services or settings covered under the California Medicaid State Plan (Medi-Cal) and are medically appropriate, cost-effective alternatives to services or settings under the State Plan. These services or settings require Department of Health Care Services (DHCS) approval. Under CalAIM, these services are known as Community Supports (CS).

E. Community Supports Provider: A contracted provider experienced and/or trained in providing one or more of the Community Supports

F. Enhanced Care Management (ECM): A whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-need and/or high-cost Members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered.

G. Enhanced Care Management (ECM) Provider: A Provider provider of ECM. ECM Providers providers are community-based entities with experience and expertise providing intensive, in-person care management services to individuals in one or more of the Populations of Focus for ECM.

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

I. Medical Home: The provider identified as the Member's medical home or primary care provider (PCP) is responsible for managing the Member's primary care needs

J. Mobile Medicine: Health care services provided at shelters, mobile units/recreational vehicles (RV), or other sites with a fixed and specified location. Note that this is not considered street medicine as it requires people experiencing unsheltered homelessness to visit a health care provider at the provider's fixed, specified location.

K. Partnership Advantage: Effective January 1, 20272028, Partnership HealthPlan of California will operate a Centers for Medicare & Medicaid Services (CMS)-approved Dual-Eligible Special Needs Plan (D-SNP) in specific counties as described in the Department of Health Care Services (DHCS) CalAIM Dual-Eligible Special Needs Plan Policy Guide. This line of business will be known as Partnership Advantage and will be a Medicare Advantage plan offered to all full-benefit, dual-eligible beneficiaries 21 years of age or older who reside in the applicable counties. Partnership Advantage Members will be qualified to receive both Medi-Cal and Medicare services as described in the Partnership Advantage Member Handbook.

L. Street Medicine: Street medicine refers to a set of health and social services developed specifically to address the unique needs and circumstances of individuals experiencing unsheltered homelessness, delivered directly to them in their own environment. Note that mobile units/RVs that go to the individual experiencing unsheltered homelessness in their lived environment ("on the street") is considered street medicine.

M. Unsheltered Homelessness: Situations in which individuals are not regularly accessing shelters or transitional housing programs and are instead often sleeping in encampments, under underpasses, in their vehicles, or other locations not meant for human habitation.

IV. **ATTACHMENTS**:

A. N/A

V. **PURPOSE:**
To define the opportunities for street medicine providers to address the clinical and non-clinical needs of Partnership HealthPlan Members experiencing unsheltered homelessness.

VI. **POLICY / PROCEDURE**:

A. The fundamental approach of street medicine is to engage people experiencing unsheltered homelessness exactly where they are and on their own terms to maximally reduce or eliminate barriers to care access and follow-through. The Department of Health Care Services (DHCS) recognizes the benefit that street medicine can provide, and with this in mind, encourages Managed Care Plans (MCPs) to adopt requirements for street medicine providers as outlined in APL 24-001 Street Medicine Provider: Definitions and Participation In Managed Care that allow for maximum provider participation while maintaining high quality care.
   1. The Department of Health Care Services (DHCS) does not require a street medicine provider to be affiliated with a brick-and-mortar facility.
   2. DHCS does not prescribe any particular contracting type for MCPs (i.e., Partnership) and street medicine providers.

B. Partnership covers the provision of medical services for their Members experiencing unsheltered homelessness through street medicine providers acting in the following ways:
   1. In the role of the Member's assigned primary care provider (PCP)
   2. In a direct contracting arrangement with Partnership
   3. As a referring or treating contracted provider directly contracted with Partnership
   4. As an ECM provider (as defined in III.F. and G.) or as a Community Supports ~~Provider~~ provider (as defined in III.D. and E.)

C. DHCS has outlined provisions for various street medicine scenarios as follows:
   1. Street Medicine Provider as a Member's Assigned Primary Care Provider (PCP)
      a. "Street medicine provider" refers to a licensed medical provider (e.g., Doctor of Medicine (MD), Doctor of Osteopathic Medicine (DO), Physician Assistant (PA), Nurse Practitioner (NP), Certified Nurse Midwife (CNM)) who conducts patient visits outside of the four walls of clinics or hospitals and directly on the street, in environments where unsheltered individuals may be (such as those living in a car, RV, abandoned building, or other outdoor areas).
         1) A non-physician medical practitioner (PA, NP, and CNM), must have a supervising Physician who is a practicing street medicine provider.
      b. Contracted street medicine providers may choose to serve as the Member's assigned PCP upon Member election. In order to serve as a PCP, the street medicine ~~Provider~~ provider must meet Partnership's eligibility criteria for being a PCP per policy MPCR17 Standards for Contracted Primary Care Providers, be qualified and capable of treating the full range of health care issues served by PCPs within their scope of practice and agree to serve in a PCP role.
         1) Street medicine providers willing to serve in a PCP capacity are advised to assess and examine the level and quality of the establishment of the treatment relationship at the time of initial engagement when considering an agreement to be a Member's assigned PCP, as DHCS envisions dynamic and exceptional Provider-Member patient interactions.
         2) If the street medicine provider is willing to be the Member's assigned PCP, the provider must initiate the request via telephone call to Partnership's Member Services department (800) 863-4155 with the Member on the line, and both parties must confirm to

Partnership the Member's choice in selecting the street medicine provider to be their assigned PCP. The street medicine provider will then be assigned as the Member's PCP and will be responsible for overseeing the Member's care.

c. Street medicine providers, when elected by Members to act as their assigned PCP, are responsible for providing the full array of primary care services, including but not limited to, preventive services, and the treatment of acute and chronic conditions. Thus, street medicine providers who choose to act as a Member's assigned PCP must agree to provide the essential components of the Medical Home in order to provide comprehensive and continuous medical care, including but not limited to:
   1) Care coordination and health promotion, such as those services offered under Basic Population Health Management (BPHM)
   2) Support for Members, their families, and their authorized representatives
   3) Referral to specialists, including behavioral health, community, and social support services, when needed
   4) The use of health information technology to link services, as feasible and appropriate; and
   5) Provision of primary and preventative services to assigned Members

d. Street medicine providers who are serving in an assigned PCP capacity are required to undergo the appropriate level of site review process, which is either a full or a condensed review as follows:
   1) For street medicine providers serving as an assigned PCP, and that are affiliated with a brick-and-mortar facility or that operate a mobile unit/RV, Partnership will conduct the full review process of the street medicine provider and affiliated facility in accordance with APL 22-017: Primary Care Provider Site Reviews: Facility Site Review and Medical Record Review and policy MPQP1022, Site Review Requirements and Guidelines.
   2) For street medicine providers serving as an assigned PCP in the unsheltered environments, and that are not affiliated with a brick-and-mortar facility or mobile unit/RV, Partnership will conduct a condensed Facility Site Review (FSR) and Medical Record Review (MRR) of the street medicine provider to ensure Member safety. The condensed FSR and MRR requirements will be based on, and reflective of, the full FSR and MRR requirements as outlined in APL 22-017.

e. Street medicine providers who elect to be PCPs are required to develop and maintain protocols for identifying and transferring Members to a higher level of care if needed when the Member's service needs are beyond the capabilities and/or qualifications of the street medicine ~~Provider~~provider. This includes access to urgent and emergency care, specialty care, mental health and substance use disorder treatment, ancillary services, and appropriate Non-Emergency medical and Non-Medical Transportation services as well as expeditious referrals to ECM and Community Supports.

f. Licensed providers must follow Partnership credentialing requirements as per Partnership policies MPCR300 Physician Credentialing and Re-Credentialing Requirements, MPCR301 Non-Physician Clinician Credentialing and Re-Credentialing Requirements, and MPCR302 Behavioral and Mental Health Practitioner Credentialing and Re-credentialing Requirements.

g. Licensed providers must be enrolled as a Medi-Cal provider in accordance with APL 22-013: Provider Credentialing/Re-Credentialing and Screening/Enrollment.
   1) If there is not a state-level enrollment pathway, the street medicine provider is not required to meet the credentialing requirements in APL 22-013 in order to become an "in-network" ~~Provider~~provider. But in that case, Partnership must vet the qualifications of the street medicine provider to ensure they can meet Partnership's standards of participation, similar

to the credentialing process and requirements outlined in APL 22-013 and in accordance with Partnership policies MPCR300 Physician Credentialing and Re-Credentialing Requirements, MPCR301 Non-Physician Clinician Credentialing and Re-Credentialing Requirements, and MPCR302 Behavioral and Mental Health Practitioner Credentialing and Re-credentialing Requirements.

h. Providers elected as a Member's assigned PCP are exempt from PCP time and distance standards (as part of Annual Network Certification requirements) because the Member does not have a permanent residential address and the street medicine provider is meeting the Member at their lived environment. Additionally, service location requirement for PCPs, as specified in the MCP Contract, is not applicable to street medicine providers serving as PCPs, as they are not rendering services at a brick-and-mortar location

2. Street Medicine Provider in a Direct Contracting Arrangement with Partnership
   a. To facilitate direct access, DHCS encourages Partnership to contract directly with street medicine providers. This is an option even if the provision of health care services is delegated to a Subcontractor.
      1) Direct contracts with street medicine providers can allow ready access to health care services for individuals experiencing unsheltered homelessness and reduce contracting complexity for street medicine providers.
      2) The street medicine provider would be subject to the same Partnership administrative processes (e.g. billing protocols, credentialing requirements, authorization guidelines, etc.) rather than having multiple processes and requirements under each subcontracting entity.
      3) The payment arrangement would be between the MCP and the street medicine ~~Provider~~provider.
      4) Under a direct contracting arrangement, the street medicine provider must have the ability to refer Members to medically necessary covered services within Partnership's network, and must coordinate care with Partnership, the Subcontractor, and/or Independent Physician/Provider Association (IPA) as appropriate.
3. Street Medicine Providers Serving Solely as Referring or Treating Contracted Provider
   a. The contracted street medicine provider has the right to decline the additional responsibilities of an assigned PCP, and instead, care for Members in a non-PCP capacity as a referring or treating contracted provider working with individuals experiencing unsheltered homelessness. To provide care in this capacity, street medicine providers must have processes in place to work with Partnership, the Member's PCP, and/or the ECM Care Manager to ensure the Member has referrals to primary care, Community Supports, behavioral health services, and other social services as needed.
   b. Licensed providers must follow Partnership credentialing requirements as per Partnership policies MPCR300 Physician Credentialing and Re-Credentialing Requirements, MPCR301 Non-Physician Clinician Credentialing and Re-Credentialing Requirements, and MPCR302 Behavioral and Mental Health Practitioner Credentialing and Re-credentialing Requirements.
   c. Licensed providers must be enrolled as a Medi-Cal provider in accordance with APL 22-013 Provider Credentialing/Re-Credentialing and Screening/Enrollment.
4. Street Medicine Provider as an ECM and/or Community Supports Provider
   a. A street medicine provider can be contracted to provide both PCP and ECM or Community Supports services to a Member but must avoid duplication of services. Street medicine providers that are also ECM or Community Support providers are required to do the following:
      1) Enroll in Medi-Cal if there is a state-level enrollment pathway
      2) Fulfill all ECM or Community Supports requirements per policies ~~MCCP2032~~ MCAP7002 CalAIM Enhanced Care Management (ECM), MCAP7003 CalAIM Community Supports

(CS) and MCAP7001 CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS)
3) Have the capacity to provide culturally appropriate and timely in-person care management activities; and
4) Have formal agreements, data systems, and processes in place with entities across sectors to support care coordination and care management

D. Billing/Reimbursement Street medicine
1. Contracted street medicine providers rendering services to Medi-Cal and/or Partnership Advantage eligible members are to bill Partnership based on the eligibility of the individual, for appropriate and applicable services within their scope of practice. Street medicine providers rendering services to beneficiaries eligible for fee-for-service (FFS) Medi-Cal, not assigned to Partnership, should bill Medi-Cal FFS consistent with the requirements set forth in the FFS provider manual.
2. Street medicine providers must comply with the billing provisions for street medicine providers as applicable to Partnership policies and procedures.
3. If a street medicine provider is a Federally Qualified Health Clinic (FQHC), they can still be reimbursed at their applicable Prospective Payment System (PPS) rate when such services are being provided outside the four walls and where the Member is located. The FQHC would be paid their applicable PPS rate when the street medicine provider is a billable clinic provider.
4. Street medicine providers can also be reimbursed for providing other State Plan benefits (e.g . Community Health Worker (CHW) services are often provided in street medicine programs and can be billed by the contracted CHW supervising provider organization).
a. Partnership is responsible for ensuring non-duplication of services with any other covered benefit, program, and/or delivery system.

E. Eligibility
1. Street medicine ~~Providers~~ providers are required to verify the Member's eligibility with Partnership of individuals they encounter in the provision of health care services.

F. Authorizations
1. No Prior Authorization is needed for a Member to see a street medicine provider if the Member seeks services directly from a street medicine provider related to the Member's primary care. This means that a Partnership-contracted street medicine provider that meets all of Partnership's required administrative processes could provide services to a Member and receive payment for those services, even if the Member is assigned to another PCP.
2. If a Member needs medical services that do require prior authorization, all Partnership contracted street medicine providers must follow the requirements of Partnership policies MCUP3124 Referral to Specialists (RAF) Policy and MCUP3041 Treatment Authorization Request (TAR) Review Process.

G. Data Sharing, Reporting and Administration
1. Contracted street medicine providers must comply with all applicable Partnership administration requirements in accordance with federal and state laws as well as Partnership data sharing and reporting requirements and the provider's contract with Partnership, based on provider contracting type.
2. Partnership ensures street medicine providers are given the necessary provider training and manuals and have adequate systems in place to adhere to administration requirements, such as grievances and appeals, referrals, after-hours and timely access, prior authorizations, quality improvement, performance measures, and electronic health records.

VII. REFERENCES:

A. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-001 Street Medicine Provider:

Definitions and Participation in Managed Care (01/12/2024)

B. DHCS APL 22-017 Primary Care Provider Site Reviews: Facility Site Review and Medical Record Review (09/22/2022)
C. DHCS APL 22-013 Provider Credentialing/Re-Credentialing and Screening/Enrollment (07/19/2022) *revised 01/02/2025*
D. DHCS APL 22-016 Community Health Worker Services Benefit (09/09/2022) *revised 09/18/2023*
E. State Plan Amendment (SPA) 22-0001
F. Title 42 Code of Federal Regulations (CFR) Section 440.130(c)
G. Medi-Cal Provider Manual/ Guidelines: Community Health Worker (CHW) Preventive Services (*chw prev*)
H. Street Medicine Institute: https://www.streetmedicine.org/
I. "Addressing Unsheltered Homelessness in California" (August 2021): A report by the Division of Social Work and the Center for Health Practice, Policy & Research at the California State University, Sacramento prepared for the Homelessness Coordinating and Financing Council in the California Business, Consumer Services, and Housing Agency https://bcsh.ca.gov/calich/documents/2021_heap_case_study1.pdf

VIII. **DISTRIBUTION**:

B. Partnership Department Directors
C. Partnership Provider Manual

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

REVISION DATES:

Medi-Cal
MPAP7005: 06/11/25; 06/10/26

Partnership Advantage (ffective Jan. 1, 2028)
N/A

PREVIOUSLY APPLIED TO:

MCUP3146
(04/12/23; 05/08/24; ARCHIVED 6/11/25)

****

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

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

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

Partnership's authorization requirements comply with the requirements for parity in mental health and substance

use disorder benefits in 42 CFR 438.910.

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

Policy/Procedure Number: MPQP1038				**Lead Department: Health Services** Business Unit: Quality Improvement	
Policy/Procedure Title: Physician Orders for Life-Sustaining Treatment (POLST)				☒**External Policy** ☐ **Internal Policy**	
Original Date: 08/28/2008		**Next Review Date:** ~~06/11/2026~~06/09/2027 **Last Review Date:** ~~06/11/2025~~06/10/2026			
Applies to:	☐ **Employees**		☒ **Medi-Cal**	☒ **Partnership Advantage**	
Reviewing Entities:	☒ **IQI**		☐ **P & T**	☒ **QUAC**	
	☐ **OPERATIONS**		☐ **EXECUTIVE**	☐ **COMPLIANCE**	☐ **DEPARTMENT**
Approving Entities:	☐ **BOARD**		☐ **COMPLIANCE**	☐ **FINANCE**	☒ **PAC**
	☐ **CEO**	☐ **COO**	☐ **CREDENTIALS**	☐ **DEPT. DIRECTOR/OFFICER**	
Approval Signature: *Robert Moore, MD, MPH, MBA*				**Approval Date:** ~~06/11/2025~~06/10/2026	

I. RELATED POLICIES:
N/A

II. IMPACTED DEPTS:
A. Health Services

III. DEFINITIONS:
N/A

IV. ATTACHMENTS:
A. California Physician Orders for Life-Sustaining Treatment (POLST) Revised Form effective April 1, 2017 and available at: https://capolst.org/.

V. PURPOSE:
To establish Partnership HealthPlan of California's policy for use of the Physician Orders for Life-Sustaining Treatment (POLST) form.

VI. POLICY / PROCEDURE:
The Physician Orders for Life-Sustaining Treatment (POLST) is a physician order sheet. The POLST translates a person's wishes for medical treatment at the end of life into a set of physician orders that are followed throughout the medical system, including during transport between medical facilities. It constitutes a uniform document which implements a person's wishes in all health care settings.

A. The POLST is not an Advance Directive and does not take the place of one. Patients should still be encouraged to complete an Advance Directive if they do not have one. The POLST translates the Advance Directive into physician orders. It also replaces the emergency medical services (EMS) form that gives resuscitation directions to emergency response staff in a patient's home or any residential care facility.
   1. The POLST is optional and not required. It can be an alternative to the "Pre-Hospital Do Not Resuscitate," "Preferred Intensity of Care" and "Preferred Intensity of Treatment" forms, although POLST is more comprehensive in that it addresses other life-sustaining treatment in addition to resuscitative measures.
   2. The primary population for completion of a POLST form is anyone with a life-limiting illness who is appropriate for end-of-life planning. However, the POLST form is valid for any patient.
   3. The POLST may be changed by the patient, surrogate decision-maker (if patient is incapable of expressing their wishes), or the physician.

4. A physician, nurse practitioner, or physician assistant must sign the POLST. It also should be signed by the patient or legally recognized decision-maker.
5. If the possibility of resuscitation arises (patient has no pulse and no respiration), Part A: Attempt Resuscitation or Do Not Attempt Resuscitation orders are followed.
6. If any section of the POLST is not completed, the highest level of treatment must be provided until further discussion with physician, nurse practitioner, or physician assistant. As with other physician orders, new orders can supersede the initial POLST.
7. The physician, nurse practitioner, or physician assistant will be notified if the patient or legally recognized decision-maker requests a change in the POLST treatment decisions.
8. In the skilled nursing setting, the POLST may be used in place of other facility cardiopulmonary resuscitation (CPR) treatment decision forms; dual forms are not necessary.

B. Recommendations for completing a POLST form with the patient:
1. If the patient or surrogate decision maker chooses to complete a POLST form, the physician, nurse practitioner, or physician assistant or designated staff member will discuss the treatment options in the POLST form. Discussion will also include the patient's Advance Directive (if done) or other statements the patient has made regarding their wishes for end of life care and treatments. The likelihood of treatment success and the potential for causing suffering should be discussed when deciding upon CPR and medical interventions. Additional information about medical interventions is available for patients and families in the POLST Patient Handout.
2. The POLST form is completed according to the patient's expressed wishes.
3. The physician, nurse practitioner, or physician assistant and the patient or his/her legally recognized decision-maker will sign the POLST form.
4. The POLST instructions and form are available at capolst.org/polst-for-healthcare-providers/forms/. Members needing assistance with translation should contact Partnership's Member Services department.

C. Review of POLST form:
1. The physician, nurse practitioner, or physician assistant and patient or legally recognized decision-maker may review or revise the POLST at any time.
2. During care plan conferences or discharge planning, the physician may review the POLST to see if the patient's condition warrants review or revision.
3. The POLST can also be marked "VOID" and a new POLST completed. The original POLST marked "VOID" should be signed and dated. A copy of POLST marked "VOID" is kept in medical record directly behind the current POLST.
4. As the patient moves from one health care setting to another or to home, the most current, original POLST form (including copies of any Advance Directive) should accompany the patient.

D. Recommendations for when a patient with a POLST form is admitted to a health care facility:
1. The physician, nurse practitioner, or physician assistant, nurse, social worker or designated staff member will review the contents of the POLST form with the patient or surrogate decision maker.
2. POLST orders will be honored by the staff. Resuscitation orders will be transcribed into the patient's medical orders.
3. If the POLST is signed by a physician, nurse practitioner, or physician assistant who is not a member of the medical staff, POLST orders will be followed until reviewed by a credentialed member of the medical staff. POLST orders are continued, unless the attending physician writes new orders.
4. The POLST form is copied for the medical record (or scanned into the electronic medical record).At the time of discharge, the Discharge Summary should note that patient has a POLST form. The original POLST should be sent with the patient at discharge or transfer from the facility.

VII. REFERENCES:
California Physician Orders for Life-Sustaining Treatment https://capolst.org/

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

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Medical Officer

X. REVISION DATES:
Medi-Cal
08/19/09; 11/17/10; 10/17/12; 10/16/13; 10/15/14; 10/21/15; 01/20/16; 01/18/17; *02/14/18; 02/13/19, 02/12/20; 02/10/21; 02/09/22; 02/08/23; 02/14/24; 02/12/25; 06/11/25; 06/10/26

Partnership Advantage (effective Jan. 1, 202~~7~~8)
N/A

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

PREVIOUSLY APPLIED TO:
PartnershipAdvantage:
MPQP1038 - 08/20/2008 to 01/01/2015

Healthy Families:
MPQP1038 - 11/17/2010 to 03/01/2013

Healthy Kids (Healthy Kids program ended 12/01/2016)
MPQP1038 - 08/28/08; 08/19/09; 11/17/10; 10/17/12; 10/16/13; 10/15/14; 10/21/15; 01/20/16 to 12/01/16

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

EMSA #111 B
(Effective 4/1/2017)*

Physician Orders for Life-Sustaining Treatment (POLST)

First follow these orders, then contact Physician/NP/PA. A copy of the signed POLST form is a legally valid physician order. Any section not completed implies full treatment for that section. **POLST complements an Advance Directive and is not intended to replace that document.**

Patient Last Name:	Date Form Prepared:
Patient First Name:	Patient Date of Birth:
Patient Middle Name:	Medical Record #: *(optional)*

A — Check One

CARDIOPULMONARY RESUSCITATION (CPR): ***If patient has no pulse and is not breathing. If patient is NOT in cardiopulmonary arrest, follow orders in Sections B and C.***

☐ **Attempt Resuscitation/CPR** (Selecting CPR in Section A **requires** selecting Full Treatment in Section B)

☐ **Do Not Attempt Resuscitation/DNR** (Allow Natural Death)

B — Check One

MEDICAL INTERVENTIONS: ***If patient is found with a pulse and/or is breathing.***

☐ **Full Treatment – primary goal of prolonging life by all medically effective means.**
In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated.

☐ ***Trial Period of Full Treatment.***

☐ **Selective Treatment – goal of treating medical conditions while avoiding burdensome measures.**
In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.

☐ ***Request transfer to hospital only*** *if comfort needs cannot be met in current location.*

☐ **Comfort-Focused Treatment – primary goal of maximizing comfort.**
Relieve pain and suffering with medication by any route as needed; use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. ***Request transfer to hospital only if comfort needs cannot be met in current location.***

Additional Orders: ______________________________

____

C — Check One

ARTIFICIALLY ADMINISTERED NUTRITION: ***Offer food by mouth if feasible and desired.***

☐ Long-term artificial nutrition, including feeding tubes.
☐ Trial period of artificial nutrition, including feeding tubes.
☐ No artificial means of nutrition, including feeding tubes.

Additional Orders: ______________________________

D

INFORMATION AND SIGNATURES:

Discussed with: ☐ Patient (Patient Has Capacity) ☐ Legally Recognized Decisionmaker

☐ Advance Directive dated _______, available and reviewed →
☐ Advance Directive not available
☐ No Advance Directive

Health Care Agent if named in Advance Directive:
Name: ______________________________
Phone: ______________________________

Signature of Physician / Nurse Practitioner / Physician Assistant (Physician/NP/PA)
My signature below indicates to the best of my knowledge that these orders are consistent with the patient's medical condition and preferences.

Print Physician/NP/PA Name:	Physician/NP/PA Phone #:	Physician/PA License #, NP Cert. #:
Physician/NP/PA Signature: *(required)*		Date:

Signature of Patient or Legally Recognized Decisionmaker
I am aware that this form is voluntary. By signing this form, the legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of the form.

Print Name:		Relationship: *(write self if patient)*
Signature: *(required)*	Date:	Your POLST may be added to a secure electronic registry to be accessible by health providers, as permitted by HIPAA.
Mailing Address (street/city/state/zip):	Phone Number:	

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

*Form versions with effective dates of 1/1/2009, 4/1/2011,10/1/2014 or 01/01/2016 are also valid

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Patient Information		
Name (last, first, middle):	Date of Birth:	Gender: **M F**

NP/PA's Supervising Physician	**Preparer Name** (if other than signing Physician/NP/PA)	
Name:	Name/Title:	Phone #:

Additional Contact ☐ None		
Name:	Relationship to Patient:	Phone #:

Directions for Health Care Provider

Completing POLST

- **Completing a POLST form is voluntary.** California law requires that a POLST form be followed by healthcare providers, and provides immunity to those who comply in good faith. In the hospital setting, a patient will be assessed by a physician, or a nurse practitioner (NP) or a physician assistant (PA) acting under the supervision of the physician, who will issue appropriate orders that are consistent with the patient's preferences.
- **POLST does not replace the Advance Directive.** When available, review the Advance Directive and POLST form to ensure consistency, and update forms appropriately to resolve any conflicts.
- POLST must be completed by a health care provider based on patient preferences and medical indications.
- A legally recognized decisionmaker may include a court-appointed conservator or guardian, agent designated in an Advance Directive, orally designated surrogate, spouse, registered domestic partner, parent of a minor, closest available relative, or person whom the patient's physician/NP/PA believes best knows what is in the patient's best interest and will make decisions in accordance with the patient's expressed wishes and values to the extent known.
- A legally recognized decisionmaker may execute the POLST form only if the patient lacks capacity or has designated that the decisionmaker's authority is effective immediately.
- To be valid a POLST form must be signed by (1) a physician, or by a nurse practitioner or a physician assistant acting under the supervision of a physician and within the scope of practice authorized by law and (2) the patient or decisionmaker. Verbal orders are acceptable with follow-up signature by physician/NP/PA in accordance with facility/community policy.
- If a translated form is used with patient or decisionmaker, attach it to the signed English POLST form.
- Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid. A copy should be retained in patient's medical record, on Ultra Pink paper when possible.

Using POLST

- Any incomplete section of POLST implies full treatment for that section.

Section A:

- If found pulseless and not breathing, no defibrillator (including automated external defibrillators) or chest compressions should be used on a patient who has chosen "Do Not Attempt Resuscitation."

Section B:

- When comfort cannot be achieved in the current setting, the patient, including someone with "Comfort-Focused Treatment," should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).
- Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP), bi-level positive airway pressure (BiPAP), and bag valve mask (BVM) assisted respirations.
- IV antibiotics and hydration generally are not "Comfort-Focused Treatment."
- Treatment of dehydration prolongs life. If a patient desires IV fluids, indicate "Selective Treatment" or "Full Treatment."
- Depending on local EMS protocol, "Additional Orders" written in Section B may not be implemented by EMS personnel.

Reviewing POLST

It is recommended that POLST be reviewed periodically. Review is recommended when:

- The patient is transferred from one care setting or care level to another, or
- There is a substantial change in the patient's health status, or
- The patient's treatment preferences change.

Modifying and Voiding POLST

- A patient with capacity can, at any time, request alternative treatment or revoke a POLST by any means that indicates intent to revoke. It is recommended that revocation be documented by drawing a line through Sections A through D, writing "VOID" in large letters, and signing and dating this line.
- A legally recognized decisionmaker may request to modify the orders, in collaboration with the physician/NP/PA, based on the known desires of the patient or, if unknown, the patient's best interests.

This form is approved by the California Emergency Medical Services Authority in cooperation with the statewide POLST Task Force. For more information or a copy of the form, visit **www.caPOLST.org**.

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

Policy/Procedure Number: MPQP1047 (previously MCQP1047)				**Lead Department: Health Services** Business Unit: Quality Improvement	
Policy/Procedure Title: Advance Directives				☒**External Policy** ☐ **Internal Policy**	
Original Date: 06/17/2009			**Next Review Date:** ~~06/11/2026~~06/09/2027 **Last Review Date:** ~~06/11/2025~~06/10/2026		
Applies to:	☐ **Employees**		☒ **Medi-Cal**	☒ **Partnership Advantage**	
Reviewing Entities:	☒ **IQI**		☐ **P & T**	☒ **QUAC**	
	☐ **OPERATIONS**		☐ **EXECUTIVE**	☐ **COMPLIANCE**	☐ **DEPARTMENT**
Approving Entities:	☐ **BOARD**		☐ **COMPLIANCE**	☐ **FINANCE**	☒ **PAC**
	☐ **CEO**	☐ **COO**	☐ **CREDENTIALS**	☐ **DEPT. DIRECTOR/OFFICER**	
Approval Signature: *Robert Moore, MD, MPH, MBA*				**Approval Date:** ~~06/11/2025~~06/10/2026	

I. RELATED POLICIES:

A. MPQP1038 – Physician Orders for Life-Sustaining Treatment
B. MPQP1022 – Site Review Requirements and Guidelines

II. IMPACTED DEPTS:

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

III. DEFINITIONS:

A. Partnership Advantage: Effective Jan. 1, 2028~~7~~, Partnership HealthPlan of California will operate a Centers for Medicare & Medicaid Services (CMS)-approved Dual-Eligible Special Needs Plan (D-SNP) in specific counties as described in the Department of Health Care Services (DHCS) CalAIM Dual Eligible Special Needs Plan Policy Guide. This line of business will be known as Partnership Advantage and will be a Medicare Advantage plan offered to all full-benefit, dual-eligible beneficiaries 21 years of age or older who reside in the applicable counties. Partnership Advantage Members will be qualified to receive both Medi-Cal and Medicare services as described in the Partnership Advantage Member Handbook.
B. Advance Directives include two parts:
   1. A health care proxy (sometimes called "durable power of attorney"), which names someone the member trusts to make decisions about their health care if the member cannot.
   2. A living will describes which treatment(s) the member wants if the member's life is threatened, including dialysis, breathing machines, resuscitation, and tube feeding.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

To define member rights to have an Advance Health Care Directive (aka Advance Directive), and define practitioner and health plan responsibility to provide Advance Directive information to Partnership HealthPlan of California (Partnership) members who are adults or emancipated minors.

VI. POLICY / PROCEDURE:

A. Regarding Members

1. Partnership advises members about Advance Health Care Directives and their right to execute one. The Advance Directive form enables the individual to express his or her preferences for life-sustaining treatment and to elect an individual to make health care decisions in a situation where the individual is unable to make decisions for themselves. Members receive this information from Partnership in the Evidence of Coverage document on enrollment and information about Advance Directives is available on the Partnership website. Partnership will notify members within 90 days if there are changes in state or federal law regarding Advance Directives. Partnership acknowledges that members have the right to not fill out part or all of the Advance Directive form as a matter of conscience. Partnership will not discriminate in any way against a member who chooses to not fill out part or all of an Advance Directive form. If a member is incapacitated at the time of initial enrollment and unable to receive information (due to the incapacitating condition or to a mental disorder) or articulate whether they have executed an Advance Directive, Partnership will give Advance Directive information to the member's family or surrogate in the same manner that we issue other materials about policies and procedures. When the incapacity has resolved, Partnership Care Coordination staff will discuss advance care planning with the member, including the recommendation to complete an Advance Directive.

B. Regarding Partnership Advantage Members: Medicare covers and utilizes advance care planning, as part of the annual wellness visit or as a separate medically necessary service. Medicare Part B covers voluntary advance care planning, including discussions about end-of-life care preferences. The member may update their Advance Directive at any time.

B.C. Regarding Practitioners

1. Partnership regularly provides education on Advance Directives to all contracted providers for whom advance care planning is an appropriate part of their scope of practice. Partnership encourages its clinicians to discuss the right to execute an Advance Directive and to honor the Advance Directive of any individual who completes the form. The primary care provider (PCP) and/or specialist should periodically review the Advance Directive with the patient to ensure the elections made on the form continue to reflect the current wishes of the individual. The PCP should keep a copy of an executed Advance Directive in the medical record. PCPs should not condition the provision of care or discriminate against an individual based on whether the patient has executed an Advance Directive or on the contents of that Advance Directive. Partnership acknowledges that health care providing organizations, and individual clinicians practicing in each organization, may conscientiously object to implementing parts of executed Advance Directives. In such cases, it is expected that the organization and/or individual practitioner will inform the member that they cannot implement those portions of the Advance Directive to which there is conscientious objection. The member should be offered the right to switch their care to an organization or practitioner who will follow the requests in their Advance Directive.
2. Medicare reimburses healthcare providers for advance care planning discussions with Medicare beneficiaries. Utilize CPT codes 99497 and 99498 for billing advance care planning services. When billing for multiple advance care planning services, a change in the patient's health status or wishes regarding end-of-life care must be documented.
3. Partnership Facility Site and Medical Record Review (see MPQP1022) on primary care provider sites determines if providers offer Advance Directive information. Documentation in the medical record should indicate if the PCP discussed Advance Directives with the patient and/or if the patient executed or refused an Advance Directive. Evidence of a discussion of the Advance Directive is sufficient to meet site review requirements.

C.D. Regarding Partnership Staff

1. Partnership provides education of its staff regarding our policies and procedures about Advance Directives.

D.E. Regarding the Community

1. Partnership, in partnership with various community organizations, encourages community education regarding Advance Directives, emphasizing that they are designed to enhance individual's control over their medical treatment plans.

VII. REFERENCES:

A. Title 42, Code of Federal Regulations, Sections 422.128 and 489.100
B. California Probate Code, Sections 4670 through 4743
C. Medi-Cal Handbook / Evidence of Coverage
D. Medicare Managed Care Manual
E. https://www.medicare.gov/coverage/advance-care-planning
F. Partnership website: http://www.partnershiphp.org/Members/Medi-Cal/Pages/California-Advance-Health-Care-Directive.aspx
G. Multiple Advanced Directive options can be found on the California Coalition for Compassionate Care website: https://coalitionccc.org/CCCC/Resources/ACP-Tools-Resource-List.aspx

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Medical Officer

X. REVISION DATES:

Medi-Cal
08/18/10; 05/21/08; 05/20/09; 10/17/12; 10/16/13; 10/15/14; 10/21/15; 10/19/16; 04/19/17; *06/13/18; 06/12/19; 06/10/20; 06/09/21; 06/08/22; 06/14/23; 6/12/24; 06/11/25; 06/10/26

Partnership Advantage (effective Jan. 1, 20287)
N/A

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

PREVIOUSLY APPLIED TO:

Partnership*Advantage*:
PAQI 101 – 06/21/2006 to 05/21/2008
PAQP1036 – 05/21/2008 to 10/17/2012
MPQP1047 – 10/17/2012 to 01/01/2015

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA
POLICY/ PROCEDURE

Policy/Procedure Number: MPQP1055				**Lead Department: Health Services** Business Unit: Quality Improvement	
Policy/Procedure Title: Provider Preventable Condition (PPC) Reporting				☒ **External Policy** ☐ **Internal Policy**	
Original Date: 09/03/2012 (CMP-36)			**Next Review Date: ~~06/11/2026~~06/09/2027** **Last Review Date: ~~06/11/2025~~06/10/2026**		
Applies to:	☐ **Employees**		☒ **Medi-Cal**	☒ **Partnership Advantage**	
Reviewing Entities:	☒ **IQI**		☐ **P & T**	☒ **QUAC**	
	☐ **OPERATIONS**		☐ **EXECUTIVE**	☐ **COMPLIANCE**	☐ **DEPARTMENT**
Approving Entities:	☐ **BOARD**		☐ **COMPLIANCE**	☐ **FINANCE**	☒ **PAC**
	☐ **CEO**	☐ **COO**	☐ **CREDENTIALS**	☐ **DEPT. DIRECTOR/OFFICER**	
Approval Signature: *Robert Moore, MD, MPH, MBA*				**Approval Date: ~~06/11/2025~~06/10/2026**	

I. RELATED POLICIES:

A. MPQP1016 – Potential Quality Issue Investigation and Resolution
B. FIN 405 – Treatment of Recoveries of Overpayments to Providers
C. CMP30 – Records Retention and Access Requirements

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Finance
D. Provider Relations
E. Regulatory Affairs & Compliance

III. DEFINITIONS:

A. Partnership Advantage: Effective Jan. 1, 202~~7~~8, Partnership HealthPlan of California will operate a Centers for Medicare & Medicaid Services (CMS)-approved Dual-Eligible Special Needs Plan (D-SNP) in specific counties as described in the Department of Health Care Services (DHCS) CalAIM Dual Eligible Special Needs Plan Policy Guide. This line of business will be known as Partnership Advantage and will be a Medicare Advantage plan offered to all full-benefit, dual-eligible beneficiaries 21 years of age or older who reside in the applicable counties. Partnership Advantage Members will be qualified to receive both Medi-Cal and Medicare services as described in the Partnership Advantage Member Handbook.

B. Provider Preventable Condition (PPC): specified and defined Health Care Acquired Condition (HCAC or HAC) or Other Provider Preventable Condition (OPPC), which is a medical condition or complication that a patient develops during a hospital stay or ambulatory surgical encounter that was not present at admission. See Title 42 of the Code of Federal Regulations Sections §447.26, 434.6, 438.3 and Welfare and Institutions Code Section 14131.11 for original documentation related to these terms.

C. Potential PPC: An incident or activity reported to Partnership HealthPlan of California (Partnership), or flagged during internal Partnership encounter data audits, as a possible PPC, before it has been investigated and confirmed.

D. OPPC and HCAC definitions, according to the Department of Health Care Services (DHCS), can be found here: http://www.dhcs.ca.gov/individuals/Pages/AI_PPC.aspx)

E. Other Provider Preventable Conditions (OPPC) for purposes of Medicaid include the following (may occur in any health care setting):
   1. Wrong surgery or wrong invasive procedure
   2. Surgery or invasive procedure on the wrong body part
   3. Surgery or invasive procedure on the wrong patient

F. Health Care Acquired Condition (HCAC or HAC) for purposes of Medicaid include the following (for inpatient hospital settings only):
   1. Air embolism
   2. Blood incompatibility transfusion
   3. Catheter-associated urinary tract infection (UTI)
   4. Falls and trauma that result in fractures, dislocations, intracranial injuries, crushing injuries, burns and electric shock
   5. Foreign object retained after surgery
   6. Iatrogenic pneumothorax with venous catheterization
   7. Manifestations of poor glycemic control
      a. Diabetic ketoacidosis
      b. Nonketotic hyperosmolar coma
      c. Hypoglycemic coma
      d. Secondary diabetes with ketoacidosis
      e. Secondary diabetes with hyperosmolarity
   8. Stage III and IV pressure ulcers that developed during the patient's hospital stay
   9. Surgical site infection following:
      a. Mediastinitis following coronary artery bypass graft (CABG)
      b. Bariatric surgery, including laparoscopic gastric bypass, gastroenterostomy and laparoscopic gastric restrictive surgery
      c. Orthopedic procedures for spine, neck, shoulder, and elbow
      d. Cardiac implantable electronic device (CIED) procedures
   10. Vascular catheter-associated infection
   11. Deep vein thrombosis (DVT)/pulmonary embolism (PE) (excluding pregnant women and children under 21 years of age) resulting from:
      a. Total knee replacement
      b. Hip replacement

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

Title 42 of the Code of Federal Regulations, Sections 447.26, 434.6 and 438.3 and Welfare and Institutions Code Section 14131.11 prohibit the payment of Medicaid/Medi-Cal funds to a provider for the treatment of a PPC except when the PPC existed prior to the initiation of treatment for that beneficiary by that provider. Furthermore, the F~~f~~ederal Centers for Medicare & Medicaid Services (CMS) specified that managed care organizations must participate in reporting PPC-related encounters.

This policy serves to define the mechanism for screening, investigating, processing and reporting of PPCs.

VI. POLICY / PROCEDURE:

A. Reporting Requirements
   1. Providers must report potential PPCs directly to the DHCS Audits & Investigations (A&I) Unit after discovery of the event and confirmation that the patient is a Medi-Cal beneficiary. Online reporting guidance at: http://www.dhcs.ca.gov/individuals/Pages/AI_PPC.aspx. Reporting is required for all Medi-Cal beneficiaries, including those eligible for Medicare or other insurance coverage.

2. Any potential PPC pertaining to a Partnership member must also be reported directly to Partnership. Providers should forward potential PPCs to the Quality Improvement (QI) department via a secure email at PQI@partnershiphp.org. The email must be encrypted through a secure messaging system.
3. Partnership follows up on all provider self-reported potential PPCs to ensure that appropriate notification has also been sent by the provider to the DHCS A&I Unit.
4. Potential PPCs may also be reported to the QI department by Partnership staff or community members, per the PQI identification methods identified in MPQP1016 Potential Quality Issue Investigation and Resolution.
5. Request for information about the PPC process or how to report a PPC may be referred to the QI department's Member Safety & Clinical Investigations team via PQI@partnershiphp.org.

B. Partnership Screening for PPCs
   1. Partnership's Claims department on a monthly basis screens encounter data, including data received from network providers, for the presence of PPC-specific billing codes. The Claims department on a monthly basis in a report format forwards identified encounters to PQI@partnershiphp.org. The Clinical Investigations team will review these reports.

C. Clinical Review of Potential PPCs
   1. Potential PPCs are investigated according to the PQI investigation processes outlined in MPQP1016 – Potential Quality Issue Investigation and Resolution.
   2. The scope of review includes both a medical record and claims history review.
   3. All potential PPCs are forwarded to the Chief Medical Officer (CMO) or physician designee for secondary review.
   4. Potential PPC cases may be reviewed by the Partnership Peer Review Committee for additional potential actions/remedies, as noted in MPQP1016.

D. Reporting Confirmed PPCs
   1. The QI department reports all confirmed PPCs previously unreported to the DHCS A&I unit via the online reporting module: http://www.dhcs.ca.gov/individuals/Pages/AI_PPC.aspx.
   2. Notification of the reported incident is also sent to Partnership's internal Regulatory Affairs & Compliance department at RAC_Inbox@partnershiphp.org.

E. Payment Recoupment for Confirmed PPCs
   1. If the case is determined to be a PPC, the medical record will be reviewed to determine which, if any extra procedures, length of hospitalization, medications or other items/ actions were provided to the member exclusively because of the PPC. Documentation of this review will be placed in the QI department PQI case file.
   2. The CMO or physician designee will discuss the case with a representative of Claims, Finance – Cost Avoidance Unit and Financial Analysis team, Provider Relations and ~~and~~ Utilization Management departments who are well versed in provider reimbursement. Using the results of the PPC clinical review, and a review of the federal code, this group will recommend which, if any, charges are recommended for recoupment. Partnership's CMO and Chief Financial Officer (CFO) will review and act upon this recommendation.
   3. The Finance – Cost Avoidance Unit will process any recoupment in accordance with Partnership Policy FIN-405 – Treatment of Recoveries of Overpayments to Providers.
   4. Contractor, Subcontractor, Downstream Subcontractor, or Network Provider and shall not pay any Provider claims nor reimburse a Provider for a PPC in accordance with 42 CFR section 438.3(g)

F. Communication
   1. The QI department will notify the provider of the results of the potential PPC clinical investigation

according to MPQP1016.
2. For confirmed PPCs, the Finance – Cost Avoidance Unit will communicate with the provider the recommendations of the PPC financial review and the mechanism of recoupment proposed, if indicated.
3. Any objections raised by the provider regarding final case determinations will be escalated to the CFO and CMO for review.

G. Training and Notification
1. Provider training: The Provider Relations department provides routine education of the contracted provider network through provider newsletters and bulletins on the requirement to report PPCs for Partnership members directly to D~~P~~HCS and Partnership.
2. Employee training: Partnership staff that review hospital records and hospital inpatient quality issues will be trained on this policy. This includes the QI staff involved in medical record review, Claims staff reviewing hospital claims, and Utilization Management and Care Coordination staff reviewing hospital care. These trainings will be conducted at the department level during the orientation process and when the policy is updated.
3. Delegate notification: Each year, as part of the delegate oversight process, each delegated health care provider will be notified of their responsibility to report PPCs as they are identified to Partnership via PQI@partnershiphp.org.

H. Document Retention
1. Copies of all PPC submissions to DHCS by Partnership or Partnership providers and supporting medical record evidence will be maintained by Partnership in accordance with Partnership document retention policy CMP30.

I. Oversight
1. An annual summary PPC report will be presented to Partnership's Internal Quality Improvement (IQI) Committee, Quality and Utilization Advisory Committee (Q/UAC), and Compliance Committee.

VII. REFERENCES:

A. Department of Health Care Services All Plan Letter 17-009 (DHCS APL 17-009): Reporting Requirements Related to Provider Preventable Conditions (05/23/2017)
B. DHCS Medi-Cal Guidance on Reporting PPCs (last modified 03/23/2021)
C. DHCS PPC Frequently Asked Questions (last modified 03/23/2021)
D. DHCS PPC Online Reporting System
E. Department of Health and Human Services, Centers for Medicare & Medicaid Services, 42 CFR Parts 434, 438, and 447 - Medicaid Program; Payment Adjustment for Provider Preventable Conditions including Health Care-Acquired Conditions, effective July 1, 2011 https://www.govinfo.gov/content/pkg/FR-2011-06-06/pdf/2011-13819.pdf,
Centers for Medicare & Medicaid Services, Hospital-Acquired Conditions https://www.cms.gov/medicare/payment/fee-for-service-providers/hospital-aquired-conditions-hac

VIII. DISTRIBUTION:

A. Partnership Provider Manual
B. Partnership Department Directors

IX. PERSON RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Medical Officer

X. REVISION DATES:

Medi-Cal
10/19/16, 06/14/17, *03/14/18; 03/13/19; 03/11/20; 06/10/20; 06/09/21; 06/08/22; 06/14/23; 06/12/24; 06/11/25; 06/10/26

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

Partnership Advantage (effective Jan. 1, 2028~~7~~)
N/A

PREVIOUSLY APPLIED TO:
CMP 36, Provider Preventable Conditions – 09/03/2013 to 10/19/2016, now archived.

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA
POLICY/ PROCEDURE

Policy/Procedure Number: MPUP3137 (previously MCUP3137)				**Lead Department: Health Services** **Business Unit:** Utilization Management	
Policy/Procedure Title: Palliative Care: Intensive Program (Adult)				☒**External Policy** ☐ **Internal Policy**	
Original Date: 06/21/2017			**Next Review Date:** ~~06/11/2026~~06/~~11~~10/2027 **Last Review Date:** ~~06/11/2025~~06/10/2026		
Applies to:	☐ **Employees**		☒ **Medi-Cal**	☒ **Partnership Advantage**	
Reviewing Entities:	☒ **IQI**		☐ **P & T**	☒ **QUAC**	
	☐ **OPERATIONS**		☐ **EXECUTIVE**	☐ **COMPLIANCE**	☐ **DEPARTMENT**
Approving Entities:	☐ **BOARD**		☐ **COMPLIANCE**	☐ **FINANCE**	☒ **PAC**
	☐ **CEO**	☐ **COO**	☐ **CREDENTIALS**	☐ **DEPT. DIRECTOR/OFFICER**	
Approval Signature: *Robert Moore, MD, MPH, MBA*				**Approval Date:** ~~06/11/2025~~06/10/2026	

I. RELATED POLICIES:

A. MCUP3020 – Hospice Service Guidelines
B. MCUP3041 – Treatment Authorization Request (TAR) Review Process
C. MCUP3124 – Referral to Specialists (RAF) Policy
D. MPCR13A – Credentialing of Hospice and Palliative Care Medicine Specialist
E. MPCR300 – Physician Credentialing and Re-credentialing Requirements
F. MPCR301 – Non-Physician Clinician Credentialing and Re-credentialing Requirements
G. CGA024 – Medi-Cal Member Grievance System
H. MPQP1022 – Site Review Requirements and Guidelines
I. MPQP1038 – Physician Orders for Life-Sustaining Treatment (POLST)

II. IMPACTED DEPTS:

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

III. DEFINITIONS:

A. ED: Emergency Department
B. Hospice Care: Services provided to a terminally ill patient with a prognosis of life of 6 months or less, if the disease follows its normal course.
C. Interdisciplinary Care Team (ICT): ICT will only be applicable for Partnership Advantage Members. A group of key stakeholders including, at minimum, the Member, their Primary Care Provider (PCP), and case manager. This core group is responsible for developing, implementing, and evaluating the Member's individualized care plan. This includes the oversight and coordination of care for Partnership Advantage Members and may include additional specialists and family members if relevant to the Member's care needs. The extended ICT may also include other stakeholders who provide support as required across transitions and care settings. For Partnership Advantage Members with a serious illness participating in the palliative care program, Partnership will use a palliative care ICT.
D. Medical Necessity: Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury.
E. Partnership Advantage: Effective January 1, 2028~~7~~, Partnership HealthPlan of California will operate a Centers for Medicare & Medicaid Services (CMS)-approved Dual-Eligible Special Needs Plan (D-SNP) in specific counties as described in the Department of Health Care Services (DHCS) CalAIM Dual Eligible Special Needs Plan Policy Guide. This line of business will be known as Partnership Advantage and will be a Medicare Advantage plan offered to all full-benefit, dual-eligible beneficiaries 21 years of

age or older who reside in the applicable counties. Partnership Advantage ~~Members~~ enrollees will be qualified to receive both Medi-Cal and Medicare services as described in the Partnership Advantage Member Handbook.

F. Palliative Care: Patient and family-centered care that optimizes qualify of life by anticipating, preventing, and treating suffering.

G. Palliative Care Team: A group of healthcare individuals such as a Doctor of Medicine (MD) or Osteopathy (DO), Physician Assistant (PA), Nurse Practitioner (NP), Registered Nurse (RN), Medical Social Worker (MSW) and/or Chaplain who work together to meet the physical, medical, psychological, emotional and spiritual needs of a Member and the Member's family and assist in identifying sources of pain and discomfort.

H. RAF: Referral Authorization Form – The primary care provider (PCP) submits a RAF to Partnership HealthPlan of California (Partnership) to refer a Partnership Member to a specialist for evaluation and/or treatment.

I. TAR: Treatment Authorization Request – A request for a treatment, procedure, or service to be performed by a requested specialist or professional services in a health care setting, normally outside the requesting practitioner's office.

IV. ATTACHMENTS:

A. Adult Palliative Care Eligibility Assessment
B. Palliative Care Patient Summary
C. Engagement and Enrollment Process for Outpatient Palliative Care
D. Application to be a Contracted Outpatient Palliative Care Provider

V. PURPOSE:

To define Partnership HealthPlan of California's Palliative Care services for eligible beneficiaries ages 21 or older.

VI. POLICY / PROCEDURE:

A. ADULT GENERAL ELIGIBILITY CRITERIA

1. In order to receive payment for services described in this policy, provider organizations must submit an application for approval (Attachment D) and have a palliative care contract in place with Partnership.
2. The Intensive Palliative Care Management benefit is limited to Members who have Partnership HealthPlan of California as their primary insurance, either for Medi-Cal, or as a Partnership Advantage Member.
3. A Member must meet all criteria below and at least one of the covered disease-specific criteria outlined in Section VI.B.6~~5~~ to be eligible for Intensive Palliative Care services. Exceptions for other diagnoses will be made on a case-~~-~~by-~~-~~case basis as described below:
   a. The Member is likely to, or has started to, use the hospital or emergency department as a means to manage unanticipated decompensation in their late stage of illness.
   b. Member is in a late stage of illness (section VI.B.1.a.) and is not eligible for, or declines, hospice enrollment.
   c. The Member's death within a year would not be unexpected based on clinical status, as documented on the patient summary (Attachment B)
   d. Member has received maximum Member-desired medical therapy, or for whom treatment is no longer effective. Member should be evaluated in their best compensated state after receiving or being offered appropriate treatments to manage their underlying illnesses. Member is not in reversible acute decompensation.

e. Patient has a Palliative Performance Scale or Karnofsky Performance Scale score of 70 or less or an Eastern Cooperative Oncology Group (ECOG) score of 3 or 4.

f. Member, and if applicable, family/patient-designated support person, agree to both of the following:

1) Willing to attempt in-home, residential or outpatient disease management as recommended by the Palliative Care team (and Palliative Care ICT for Partnership Advantage Members) instead of first going to the emergency department.

2) Willing to participate in Advance Care Planning discussions.

B. ADULT MEMBER ENGAGEMENT AND ENROLLMENT PROCESS

1. Patient Palliative Care Assessment and Consultation (Engagement):

a. No prior authorization is required for the engagement process before speaking with a Member who meets one or more of the following diagnostic categories.

1) Congestive Heart Failure (CHF)
2) Pulmonary Disease
3) Advanced Cancer
4) Advanced Liver Disease
5) Progressive Degenerative Neurologic Disorder
6) Hematologic Disease
7) Cerebrovascular Accident
8) Renal Disease
9) Acquired Immunodeficiency Syndrome
10) Other Conditions

b. If the Member has one of the covered diagnoses listed above~~,~~ and does not meet the general or specific criteria or life expectancy for enrollment, submit a retroactive TAR for the engagement only. ~~.~~Engagement requires a comprehensive evaluation to include:

1) Goals of care discussion and assessment of the Member's emotional and social support

~~1)~~2) Advance care planning discussion including POLST discussion if appropriate

~~b.~~c. If the Member meets the criteria for engagement AND enrollment criteria, submit a TAR for engagement along with the TAR for enrollment. Submit the TAR for engagement with progress or consultation notes documenting the following:

1) One of the ~~five~~ covered diagnoses or other pre-terminal conditions as defined in section VI.B.6~~5~~

2) Date of face~~-~~-to~~-~~-face or telemedicine visit with Doctor of Medicine (MD) or Osteopathy (DO), Nurse Practitioner (NP), Physician Assistant (PA), or Registered Nurse (RN)

3) Advance~~d~~ care planning discussion with goals of care document

4) Care Plan addressing medical, social, emotional and spiritual needs

5) Include consultation or hospital discharge notes that confirm the Member's diagnosis, extent of disease, prognosis, functional status and goals of care

~~c.~~d. A multidisciplinary comprehensive assessment is required.

~~d.~~e. Engagement will occur after discharge from the hospital.

~~e.~~f. When requested, Partnership will generate regional lists of Members who may qualify for palliative care services, providing these to community primary care and specialty providers to evaluate for potential referral to locally available palliative care clinicians and/or intensive palliative care providers. If Partnership determines that an intensive palliative care provider has the demonstrated capacity and capability to do active direct outreach to potential recipients of palliative care, Partnership will provide the list of local Members potentially qualifying for intensive palliative care services to the intensive palliative care provider, for the provider to perform this direct engagement coordinated with the Member's primary providers.

~~f.~~g. Partnership intensive care management teams may identify and refer care managed Members

who are potentially eligible for this benefit, to a contracted Partnership palliative care provider

2. Adult Enrollment Criteria (see Attachment C for detailed requirements)
   a. For Members who meet the disease specific criteria (VI.B.6~~5~~)
      1) Submit a TAR for the Member's enrollment into the Intensive Home-Based Palliative Care program to Partnership in accordance with Partnership policy MCUP3041 TAR Review Process. With an enrollment TAR, the Provider must submit the information required for the engagement TAR [VI.B.1.c. 1) thru 4)] as well as:
         a) Eligibility Assessment Form (Attachment A)
         b) Patient Summary document (Attachment B)
   b. For Members in the hospital, enrollment will take place after discharge. The Palliative Care Management TAR will be approved for three months.
   c. Enrolled Members must have at minimum:
      1) One in-person or video visit by an RN every month
         a) The registered nurse must see the patient face to face a minimum of once in every 12-week period
         b) If face-to-face visits with the RN are not possible due to distance or other operation issues, palliative care providers may submit charges under the "virtual only care" billing code T2025 GT.
      2) One in-person or video visit by a social worker every month
      3) Standardized assessments of symptoms must be done approximately every 14 days. Assessments may be completed face to face, via telemedicine or telephonically.
3. Adult Re-Enrollment Criteria
   A new TAR is required every 3 months for all patients receiving Intensive Outpatient Palliative Care services. The TAR must include documentation and submission of the following items:
   a. Palliative Care Patient Summary (Attachment B) completed by the palliative care physician, nurse practitioner or physician's assistant
   b. Detailed progress notes completed by the palliative care physician, nurse practitioner or specialist documenting relevant specific clinical information showing continued decline in functional status and clinical condition as evidenced by decreasing palliative performance scale scores, weight loss or other specific documentation of decline in function and health (e.g. labs and imaging, include results if completed in the previous 3 months)
   c. Medical records must include a recent face to face visit by the registered nurse, medical provider (MD or DO, nurse practitioner, or physician assistant) that documents the patient's current clinical condition.
   d. For remote Members seen only through telemedicine visits, the medical records must include a recent detailed visit by the RN, NP or physician that clearly documents the patient's current clinical condition and functional status.
4. Remote Hospice Level Care
   A Member who lives in an area remote from Medi-Cal Hospice providers may be cared for under the intensive palliative care benefit at a higher reimbursement rate. The Member must be pre-approved via Partnership's TAR review process for palliative care to allow for billing under code T2025-TN.
   a. The Member must live more than 30 miles from the nearest Medi-Cal Hospice, or the palliative care provider must submit documentation that, although the Member meets hospice criteria, the local hospice is not able to enroll the Member for non-medical reasons.
   b. The Member must be seen in-person at least once a month by the palliative care RN.
5. Adult Disenrollment Criteria
   a. Member is not eligible for Partnership for more than 30 days
   b. Member moves out of the service area

c. Member declines participation after enrollment
d. Member refuses to be contacted
e. Member cannot be reached or is lost to follow-up for 30 days
f. Member exhibits inappropriate or threatening behavior towards staff
g. Member is under the influence or illegal drugs or alcohol during visits
h. Member poses a safety or security risk to staff, other patients or clinic property
i. Member is deceased
j. Member is incarcerated for more than 30 days
k. Member enters a different equally intensive care management program
l. Member enters hospice
m. Member's condition stabilizes and/or is unlikely to meet 1 year life expectancy criteria
n. Member enrolls in Medicare with another health plan: A Member who becomes eligible for Medicare after enrollment into Partnership Medi-Cal may continue to receive palliative care services until the current TAR expires.
   1) Members who enroll into the Partnership Advantage (Medicare) plan are eligible for Intensive Palliative Care through Partnership.

6. Adult Disease Specific Criteria
   a. **Congestive Heart Failure (CHF)**:
      1) The Member has been hospitalized with a primary diagnosis of CHF with no further invasive interventions planned OR meets criteria for New York Heart Association (NYHA) heart failure classification III or higher, AND
         a) The Member has an ejection fraction of < 30% for systolic failure OR
         b) Significant comorbidities such as stage IV renal disease, coronary artery disease with persistent angina, severe lung disease, diabetes with significant vascular or neurologic complications, severe dementia OR
         c) Heart failure due to advanced diastolic dysfunction with preserved ejection fraction OR
         d) Other severe cardiomyopathy or non-operable severe valvular heart disease.
   b. **Pulmonary Disease:**
      1) **Chronic Obstructive Pulmonary Disorder (COPD)**: Member must meet 1) or 2)
         a) The Member has a Forced Expiratory Volume (FEV)1 less than 35% predicted and 24-hour oxygen requirement of less than 3 Liters (L) per minute, OR
         b) The Member has a 24-hour oxygen requirement of greater than or equal to 3L per minute.
      2) Other Progressive Pulmonary Disease:
         a) Idiopathic Pulmonary fibrosis, Primary Pulmonary Hypertension, or Cystic Fibrosis WITH
            i. Disabling dyspnea at rest AND
            ii. Hypoxemia (oxygen saturation < 88%) on 2 LPM AND
            iii. Poorly response or unresponsive to standard treatment.
   c. **Advanced Cancer**: Member must meet 1) and 2)
      1) The Member has a diagnosis of stage III or IV cancer, AND
      2) The Member has a Palliative Performance Scale (PPS) or Karnofsky Performance Scale (KPS) score less than or equal to 70, Eastern Cooperative Oncology Group (ECOG) score of 3 or 4 OR has failure of two lines of standard of care therapy (chemotherapy or radiation therapy) OR
      3) Member refuses further treatment for the cancer
   d. **Advanced Liver Disease**: Member must meet 1) and 2) combined, or 3) alone
      1) The Member has evidence of irreversible liver damage, serum albumin less than 3.0, and Internal Normalized Ratio (INR) greater than 1.3, AND

2) The Member has a history of ascites, bacterial peritonitis, hepatic encephalopathy, hepatorenal syndrome, or recurrent esophageal varices, OR
3) The Member has evidence of irreversible liver damage and has a Model for End Stage Liver Disease (MELD) score of greater than 19.

e. **Progressive Degenerative Neurologic Disorder**
1) Neurodegenerative condition such as multiple sclerosis, muscular dystrophy, end-stage myasthenia gravis, Parkinson's disease or other progressive neurologic condition with significant deterioration as evidenced by dysphagia, aspiration pneumonia, unintentional weight loss of 10% or more, recurrent infections, significant cognitive decline or dependency on ventilator support.
2) Amyotrophic Lateral Sclerosis (ALS) with a PPS score of 70 or less and a vital capacity of less than 55% predicted.
3) Late~~-~~stage dementia with progressive decline with both:
   a) FAST scale score of 7a or more AND
   b) Complications such as unintentional weight loss, dysphagia, aspiration pneumonia or a PPS score of 40% or less.

f. **Hematologic Disease**
1) Myelodysplastic syndrome dependent on transfusion and unresponsive to treatment **OR**
2) Sickle cell disease with organ failure, severe pulmonary hypertension, stage IV or worse renal disease, or other significant severe vascular disease.

g. **Cerebrovascular Accident**
1) PPS score of 50% or less **AND**
2) Progressive unintentional weight loss of 10% or more, **OR**
3) Recurrent infections such as aspiration pneumonia or sepsis.

h. **Renal Disease:**
1) Creatinine clearance of 15 ml/min or less **AND**
2) Discontinuing or declining dialysis and not seeking kidney transplant

i. **Acquired Immunodeficiency Syndrome (AIDS):** A patient with a CD4 count less than 200 or a positive HIV test and an AIDS defining condition who chooses to forego antiviral treatment or has one of these AIDS related conditions:
1) Advanced AIDS dementia complex
2) CNS lymphoma or systemic lymphoma unresponsive to treatment
3) Kaposi's sarcoma unresponsive to treatment
4) Mycobacterium avium complex infection unresponsive to treatment
5) Progressive wasting syndrome

j. **Other patients may be considered for the palliative care benefit on a case-by-case basis.** Consideration will depend upon the patient's functional status, pre-terminal condition and disease trajectory, hospital and emergency department utilization or the patient declining hospice services.

7. Providers of Services
   a. Partnership will contract with qualified palliative care providers such as hospitals, long-term care facilities, clinics, hospice agencies, home health agencies, and Community Based Adult Service (CBAS) facilities ~~who~~ that utilize providers with current palliative care training and/or certification to deliver authorized palliative care services to Members in accordance with this policy, existing Medi-Cal contracts and/or All Plan Letters. Certification of qualified palliative care providers shall occur in accordance with Partnership policies MPCR300 Physician Credentialing and Re-credentialing Requirements and MPCR301 Non-Physician Clinician Credentialing and Re-credentialing Requirements. Partnership will authorize palliative care

services to be provided in a variety of settings including, but not limited to, inpatient, outpatient or community-based settings. Palliative care provided in a Member's home must comply with existing Partnership policies and Medi-Cal requirements for in-home providers, services, and authorization such as physician assessments and care plans.

b. All approved Palliative Care service providers shall be listed in Partnership's Provider Directory.

c. Partnership- contracted intensive palliative care providers will contact Members referred to their program for evaluation within 7 calendar days to arrange an evaluation and assessment.

d. Provider organization must submit an application to become a contracted Intensive Home-Based Palliative Care Providers (See Attachment D for application). Criteria for consideration includes the following:
   1) Completed application (Attachment D)
   2) Organization or all providers are contracted Medi-Cal providers
   3) Organization must have the capacity to bill Partnership for services provided
   4) Organizations that are already contracted with Partnership for other services must be providers in good standing
   5) Clinical staff are trained in palliative care. Minimum training is the California State University San Marcos/ Shiley Haynes Institute for Palliative Care tTraining cCurriculum, or equivalent, which must be completed by a staff Member no later than 3 months after beginning to work for the Intensive Outpatient Palliative Care Organization. Medical Director may be board certified, board eligible or have one year (at least 200 hours) in hospice or palliative care experience.
   6) Core staffing identified (hired or contracted to be hired by contract start date):
      a) Medical Director
      b) Registered Nurse
      c) Social Worker
      d) Administrator
   7) Organization or Medical Director already providing services in the region for at least 6 months prior to contracting.

e. Submission of an application does not guarantee that Partnership will contract with an organization. Submitted applications will be evaluated based on a variety of criteria including, but not limited to, the quality and completeness of the application, geographic network adequacy, and history of the organization submitting the application.

f. Contracted sites must pass a Partnership facility and medical record site audit within 3 months of contract start date, and every 3 years afterwards. Sites which do not pass the audit may have their contract terminated for cause, or may be required to submit and complete a corrective action plan. Timelines and appeals process for this audit will follow the general standards defined in Partnership policy MPQP1022 Site Review Requirements and Guidelines.

VII. REFERENCES:

A. Section 2302 of the Patient Protection and Affordable Care Act (ACA)
B. Centers for Medicare & Medicaid Services (CMS) *Medicare Benefit Policy Manual*
C. Title 22, California Code of Regulations (CCR) / Hospice Care 51349
D. Social Security Act 1812(d)(1)
E. Welfare and Institutions Code Section 14132.75
F. Department of Health Care Services (DHCS) All Plan Letter (APL) 18-020 Palliative Care (12/07/2018)
G. Medi-Cal Provider Manual/ Guidelines: Palliative Care *(palli care)*
H. DHCS "CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide - Contract Year 2026" (February 2026Re-release date 12/20/2024)

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

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

X. REVISION DATES:

Partnership Advantage (Program effective January 1, 2028~~7~~)
06/11/25; 06/10~~1~~/26

Medi-Cal
11/15/17; *02/14/18; 02/13/19; 02/12/20; 02/10/21; 05/11/22: 06/14/23; 01/10/24; 01/08/25; (MPUP3137) 06/11/25; 06/10~~1~~/26

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

PREVIOUSLY APPLIED TO:
MCUP3122 - Palliative Care policy was archived 06/21/2017

****

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

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

The materials provided are guidelines used by Partnership to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under Partnership.Partnership's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.

Partnership HealthPlan of California
Palliative Care Eligibility Assessment Form
ADULTS

Name: ________________________________

DOB: ____________

CIN: ____________

Type of Insurance: ________________________

Name of Palliative Care Program: ________________________

General criteria: Check each of the following that apply (All needed for eligibility).

☐ Patient who is likely to or has started to use the hospital as a means to manage unanticipated decompensation in their late stage of illness. This refers to unplanned 'decompensation,' not elective procedures.

☐ Patient evaluated in their best compensated state

☐ The patient's death within a year would not be unexpected based on clinical status.

☐ Patients and Families are both:

a. Willing to attempt in-home disease management by the palliative care team instead of first going to the emergency department AND

b. Willing to participate in Advance Care Planning

☐ At least one of the following is true for their palliative qualifying condition:

a. Patient is intolerant to further therapy

~~a.~~b. Patient's disease is progressing despite current therapy

~~b.~~c. Patient declines further disease directed therapy

~~c.~~d. Patient repeatedly decompensates due to severe non-compliance

☐ Palliative Performance Scale (PPS) or Karnofsky Performance Score (KPS) less than or equal to 70% or an Eastern Cooperative Oncology Group (ECOG) score of 3 or 4 (refer to pages 4~~5~~ -6~~7~~ of this document for these scales)

In addition, one of the following diagnoses must be selected, and the associated severity criteria met:

1. **Congestive Heart Failure (CHF)**

☐ The member has been hospitalized with a primary diagnosis of CHF with no further invasive interventions planned OR

☐ New York Heart Association (NYHA) heart failure classification III or higher NYHA (Patients with cardiac disease resulting in marked limitation of physical activity. They are comfortable at rest. Less than ordinary activity causes fatigue, palpitation, dyspnea or angina pain.)

AND one of the following:

☐ The member has an ejection fraction of < 30 for systolic failure

☐ Significant comorbidities such as stage IV renal disease, coronary artery disease with persistent angina, severe lung disease, diabetes with significant vascular or neurologic complications, severe dementia

☐ Heart failure due to advanced diastolic dysfunction with preserved ejection fraction

☐ Other severe cardiomyopathy or non-operable severe valvular heart disease

2. **Pulmonary Disease:**

Chronic Obstructive Pulmonary Disorder (COPD): Member must meet 1 or 2

☐ The member has a Forced Expiratory Volume (FEV)1 less than 35% predicted and 24-hour oxygen requirement of less than 3 Liters (L) per minute, OR

☐ The member has a 24-hour oxygen requirement of greater than or equal to 3L per minute.

3. **Progressive Pulmonary Disease:**
   Idiopathic Pulmonary fibrosis, Primary Pulmonary Hypertension, or Cystic Fibrosis
   All of the following:
   - ☐ Disabling dyspnea at rest AND
   - ☐ Hypoxemia (oxygen saturation < 88%) on 2 LPM AND
   - ☐ Poorly response or unresponsive to standard treatment.

4. **Advanced Cancer:** Member must meet 1 and 2
   - ☐ The member has a diagnosis of stage III or IV cancer

   AND
   - ☐ The member has an Eastern Cooperative Oncology Group (ECOG) score of 3 or 4 or Karnofsky Performance Score (KPS) less than or equal to 70%, OR
   - ☐ The member has failed ~~of~~ two lines of standard of care therapy (chemotherapy or radiation therapy) OR
   - ☐ The member refuses further cancer treatment

5. **Advanced Liver Disease:** Member must meet 1 and 2 combined or 3 alone
   - ☐ The member has evidence of irreversible liver damage, serum albumin <3.0, and Internal Normalized Ratio (INR) > 1.3 AND
   - ☐ The member has a history of ascites, bacterial peritonitis, hepatic encephalopathy, hepatorenal syndrome, or esophageal varices

   OR
   - ☐ The member has evidence of irreversible liver damage and has a Model for End Stage Liver Disease (MELD) score of greater than 19.

6. **Progressive Degenerative Neurologic Disorder**
   - ☐ Neurodegenerative condition such as multiple sclerosis, muscular dystrophy, end-stage myasthenia gravis, Parkinson's disease or other progressive neurologic condition with significant deterioration as evidenced by any of the following:
     - ☐ dysphagia
     - ☐ aspiration pneumonia
     - ☐ unintentional weight loss of 10% or more
     - ☐ recurrent infections
     - ☐ significant cognitive decline
     - ☐ dependency on ventilator support
   - ☐ Amyotrophic Lateral Sclerosis (ALS) with a PPS score of 70 or less and a vital capacity of less than 55% predicted
   - ☐ Late stage dementia with progressive decline with both:
     - ☐ FAST scale score of 7a or more AND
     - ☐ Complications such as unintentional weight loss of 10% or more, dysphagia, aspiration pneumonia or a PPS score of 40% or less.

7. **Hematologic Disease**
   - ☐ Myelodysplastic syndrome dependent on transfusion and unresponsive to treatment **OR**
   - ☐ Sickle cell disease with organ failure, severe pulmonary hypertension, stage IV or worse renal disease, or other significant severe vascular disease.

8. **Cerebrovascular Accident**
   - ☐ PPS score of 50% or less

   AND
   - ☐ Progressive unintentional weight loss of 10% or more, **OR**
   - ☐ Recurrent infections such as aspiration pneumonia or sepsis.

9. **Renal Disease:**
   - ☐ Creatinine clearance of 15 ml/min or less **AND**
   - ☐ Discontinuing or declining dialysis and not seeking kidney transplant

10. **Acquired Immunodeficiency Syndrome (AIDS):** A CD4 count less than 200 or a positive HIV test and an AIDS defining condition
    - ☐ Chooses to forego antiviral treatment

    Or has one of these AIDS related conditions:
    - ☐ Advanced AIDS dementia complex
    - ☐ CNS lymphoma or systemic lymphoma unresponsive to treatment
    - ☐ Kaposi's sarcoma unresponsive to treatment
    - ☐ Mycobacterium avium complex infection unresponsive to treatment
    - ☐ Progressive wasting syndrome

11. **Other Covered Conditions may be considered on a case to case basis:**
    - ☐ Serious pre-terminal medical condition with a life expectancy of one year or less
    - ☐ PPS score of 70% or less
    - ☐ Member has received maximal member-desired treatment or treatment is no longer effective
    - ☐ Member is using inpatient or emergency department utilization for symptom management

Palliative Performance Scale (PPSv2)

PPS Level %	Ambulation ~~1~~	Activity & Evidence of Disease ~~2~~	Self-Care 3	Intake 4	Conscious Level ~~5~~
100%	Full	Normal Activity & Work, No Evidence of Disease	Full	Normal	Full
90%	Full	Normal Activity & Work, Some Evidence of Disease	Full	Normal	Full
80%	Full	Normal Activity & Work with e~~E~~ffort, Some e~~E~~vidence of d~~D~~isease	Full	Normal or Reduced	Full
70%	Reduced	Unable to do ~~to do~~ normal activity & work, Significant disease	Full	Normal or Reduced	Full
60%	Reduced	Unable to do hobby/ house work, ~~for most activities~~ ~~,~~ Significant Disease	Occasional Assistance	Normal or Reduced	Full or Confusion
50%	Mainly sit/ lie~~Chair~~	Unable to do any work, ~~Minimal Activity,~~ Extensive Disease	Considerable Assistance	Normal or Reduced	Full or Drowsy or ~~±~~ Confusion
40%	Mainly in b~~B~~ed	~~As Above~~Unable to do most activity, Extensive disease	Mainly Assisted	Normal or Reduced	Full or Drowsy ± Confusion
30%	Totally b~~B~~ed b~~B~~ound	~~As Above~~Unable to do any activity, Extensive disease	Total Care	Normal or Reduced	Full or Drowsy ± Confusion
20%	Totally bed bound~~Moribund~~	~~As Above~~Unable to do any activity, Extensive disease	Total Care	Minimal s~~S~~ips	Full or Drowsy ± Confusion
10%	Totally bed bound~~Moribund~~	Unable to do any activity, Extensive disease~~As Above~~	Total Care	Mouth c~~C~~are o~~O~~nly	Drowsy or Coma
0%	Death	—	—	—~~0~~	—~~0~~

Instructions: PPS level is determined by reading left to right to find a 'best horizontal fit.' Begin at left column reading downwards until current ambulation is determined, then, read across to next and downwards until each column is determined. Thus, 'leftward' columns take precedence over 'rightward' columns.

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Victoria Hospice Society, Michael Downing, MD
https://victoriahospice.org/wp-content/uploads/2020/08/PPSv2-QA-Instructions-and-Definitions-updated-July-2020.pdf

Karnofsky Performance Status Scale

Able to carry on normal activity and to work; no special care needed	100	Normal, no complaints, no evidence of disease
	90	Able to carry on normal activity; minor signs or symptoms of disease
	80	Normal activity with effort; some signs or symptoms of disease
Unable to work; able to live at home and care for most personal needs; varying amount of assistance needed	70	Cares for self; unable to carry on normal activity or to do active work
	60	Requires occasional assistance but is able to care for most of his/her personal needs
	50	Requires considerable assistance and frequent medical care
Unable to care for self; requires equivalent of institutional or hospital care; disease may be progressing rapidly	40	Disabled; requires special care and assistance
	30	Severely disabled; hospitalization is indicated;~~hospital admission necessary; active supportive treatment~~ although death not imminent
	20	Very sick, hospital admission necessary; active supportive treatment necessary
	10	Moribund; fatal processes progressing rapidly
	0	Deceased

Karnofsky, D.A., Abelmann, W.H., Craver, L.F. and Burchenal, J.H. (1948), The use of the nitrogen mustards in the palliative treatment of carcinoma. With particular reference to bronchogenic carcinoma. Cancer, 1: 634-656. https://doi.org/10.1002/1097-0142(194811)1:4<634::AID-CNCR2820010410>3.0.CO;2-L

Eastern Cooperative Oncology Group (ECOG) Performance Status Scale

Grade	ECOG Performance Status
0	Fully Active, able to carry on all pre-disease performance without restriction
1	Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g. light house work, office work
2	Ambulatory and capable of all self-care but unable to carry out any work activities.; up and about more than 50% or waking hours
3	Capable of only limited self-care; confined to bed or chair more than 50% of waking hours
4	Completely disabled; cannot carry on any self-care. Totally confined to bed or chair
5	Dead

Oken MM, Creech RH, Tormey DC, Horton J, Davis TE, McFadden ET, Carbone PP. Toxicity and response criteria of the Eastern Cooperative Oncology Group. *Am J Clin Oncol.* 1982 Dec;5(6):649-655. PMID: 7165009.

Credit: The ECOG Performance Status Scale was developed by the Eastern Cooperative Oncology Group (ECOG), now the ECOG-ACRIN Cancer Research Group, and published in 1982. To learn more, visit ecog-acrin.org/scale.

Palliative Care Patient Summary

Patient Name: ____

Patient DOB: ___________________________

Document the specific clinical factors, functional capacity and complicating conditions that affect the patient's life expectancy:

____
____
____
____
____

☐ The patient's death within a year would not be unexpected based on clinical status.

I confirm that I composed this narrative statement and that it is based on my review of the patient's medical record and/or my personal examination of the patient.

____

Physician Date

Data Requirements:

Initial Enrollment:

1. Please include specialist consultation notes that document the diagnosis, extent of disease, prior treatments and outcomes and the options remaining to the member.
2. Please include specific information about the member's functional capacity including ambulation, activity level, and capacity for self-care.

Re-enrollment:

1. Please include specific information to document that the member continues to meet the general and specific criteria for the Partnership palliative care benefit.
2. Please include specific information about the member's functional capacity including ambulation, activity level, capacity for self-care and extent of disease.

**Engagement and Enrollment Process for
Outpatient Palliative Care**

Partnership does not require a Referral Authorization Form (RAF) from a primary care provider (PCP) to refer patients for palliative care services. A Treatment Authorization Request (TAR) will be required for all Palliative Care Services (engagement and enrollment) and should be faxed or electronically submitted from the palliative care provider to the Health Services Department for review, no less than once every three months, based upon medical necessity criteria and in accordance with Partnership policy MCUP3041 Treatment Authorization Request (TAR) Review Process. The TAR request for Palliative Care services must include, at a minimum, documentation and/or treatment plan addressing the following:

1. Advanced Care Planning: includes discussions about advance directives and Physicians Authorization for Life Sustaining Treatment (POLST) forms. These discussions take place between a physician and other qualified healthcare professional and a Member, family member or surrogate in counseling. See also policy MPQP1038 Physician Orders for Life-Sustaining Treatment (POLST).

2. Assessment and Consultation: palliative care assessment and consultation services may be provided at the same time as advanced care planning, or in subsequent patient conversations. The goal of the palliative care consultation is to collect both routine medical data and additional personal information not regularly included in a medical history or Health Risk Assessment. During an initial and/or subsequent palliative care consultation or assessment, topics may include but are not limited to:
   a) Treatment plans, including palliative care and curative care
   b) Pain control, medication side effects, symptom control
   c) Emotional and/or social challenges
   d) Spiritual concerns
   e) Patient goals
   f) Advance Directives, including POLST forms

3. Plan of Care: a plan of care should be developed with the engagement of the Member and/or his/her healthcare representative. If a Member already has a plan of care in place, that plan should be updated to reflect any changes resulting from the palliative care consultation. A Member's plan of care must include all authorized palliative care including, but not limited to, symptom management and curative care.

If a Member continues to meet the above minimum eligibility criteria, he/she may continue to access both palliative care services and curative care until the condition improves, stabilizes, or results in death. Partnership will review treatment plan notes with TAR submission to assess for changes in the Member's condition and continued palliative care needs. Partnership may discontinue palliative care for Members for whom palliative care is no longer medically necessary.

Partnership HealthPlan of California

Application to be a Contracted Outpatient Palliative Care Provider

Please submit the following to contracting@partnershiphp.org

Organization Information

1. **Name of Organization**

2. **Contact Information:**
   Administrative Contact of Parent Organization (if applicable)
   Name
   Title
   Phone
   e-mail

   Billing Department
   Name
   Title
   Phone
   e-mail

   Palliative Care Program Director
   Name
   Title
   Phone
   e-mail

   Palliative Care Medical Director
   Name
   Title
   Phone
   e-mail

3. Does your organization currently contract with Partnership HealthPlan of California?

   Yes ____ No___

4. Medi-Cal provider number:

5. Describe any palliative care services *currently provided* by your organization. Include current volume of services, the service delivery model, outcomes and the criteria for enrollment.

6. Number of patients enrolled annually in your organization's palliative care program (if applicable)

   Medicare:

   Medi-Medi:

   Medi-Cal only:

   Uninsured:

   Total:

   Not applicable

7. Number of patients enrolled annually in your organization's ___hospice or ___home care program (if applicable)

   Medicare:

   Medi-Medi:

   Medi-Cal only:

   Uninsured:

   Total:

   Not applicable

8. Does your organization provide palliative care services to children? ___ Yes ___No
   If Yes, please describe level of experience and training in pediatric palliative care:

Program Information

9. What strategies will your organization use to identify patients who may be eligible and interested in community-based palliative care?

10. What geographic areas will your palliative care program serve?

11. Describe how your organization will partner with local hospice agency(s) and/or home health agencies.

12. Provide a narrative outlining:
(1) Staff disciplines and FTE your organization will use to provide 24/7 telephonic care (with access to a nurse), assessments, pain/symptom management, advance care planning, POLST, acute management plan, assess caregiver support, transition support, case management and medical oversight? If your organization will contract for some of these services, please describe the contractual arrangements. Include description of current and planned training and/or certification in palliative care.

13. How will your palliative care program be distinct from chronic disease case management and hospice programs? How will this distinction be communicated to providers and patients?

14. Attachments:

    a. C.V. of Medical Director of program
    b. Letter of commitment from applicant's parent organization or major funder of a new organization not affiliated with a larger corporate sponsor
    c. Letters of support from major expected referral sources (hospitals, health centers, at least one oncologist, at least one other specialist from this group: gastroenterology, pulmonology, cardiology)
    d. If organization is not a hospice organization, a letter or memorandum of understanding with local hospice organizations who can accept patients who need hospice care.
    e. Annual Audited Financial Statements

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
POLICY/ PROCEDURE

Policy/Procedure Number: MPUP3144 (previously MCUP3144, MCCP2028)			**Lead Department: Health Services** **Business Unit:** Utilization Management	
Policy/Procedure Title: Residential Substance Use Disorder Treatment Authorization			☒**External Policy** ☐ **Internal Policy**	
Original Date: 11/13/2019 (MCCP2028) Effective Date: 07/01/2020 (MCCP2028)		**Next Review Date:** ~~06/11/2026~~06/10/2027 **Last Review Date:** ~~06/11/2025~~06/10/2026		
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**	
Reviewing Entities:	☒ **IQI**	☐ **P & T**	☒ **QUAC**	
	☐ **OPERATIONS**	☐ **EXECUTIVE**	☐ **COMPLIANCE**	☐ **DEPARTMENT**
Approving Entities:	☐ **BOARD**	☐ **COMPLIANCE**	☐ **FINANCE**	☒ **PAC**
	☐ **CEO** ☐ **COO**	☐ **CREDENTIALING**	☐ **DEPT. DIRECTOR/OFFICER**	
Approval Signature: *Robert Moore, MD, MPH, MBA*			**Approval Date:** ~~06/11/2025~~06/10/2026	

I. RELATED POLICIES:

A. MCCP2022 – Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services
B. MCUP3037 – Appeals of Utilization Management/Pharmacy Decisions
C. MPUD3001 – Utilization Management Program Description
D. CGA024 – Medi-Cal Member Grievance System
E. MPQP1016 – Potential Quality Issue Investigation and Resolution
F. MCUP3113 – Telehealth Services
G. CMP41 – Wellness and Recovery Records

II. IMPACTED DEPTS:

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

III. DEFINITIONS

A. American Society of Addiction Medicine (ASAM) Criteria - As defined in the Department of Health Care Services (DHCS) Drug Medi-Cal Organized Delivery System Intergovernmental Agreement, pertains to necessary care for biopsychosocial severity and is defined by the extent and severity of problems in all six multidimensional assessment areas of the patient. Currently using ASAM Criteria 3rd Edition.

B. Discharge – The process to prepare the program beneficiary for referral into another level of care, post treatment return or re-entry into the community, and/or the linkage of the individual to essential community treatment, housing, and human services.

C. Behavioral Health Clinical Director – The Partnership HealthPlan of California (Partnership) Behavioral Health Clinical Director is a Doctor of Medicine (MD), Doctor of Osteopathic Medicine (DO), clinical Doctor of Philosophy (PhD), or Doctor of Psychology (PsyD) who is actively involved in the behavioral health aspects of Partnership activities. This Director provides clinical oversight of Partnership's behavioral health activities including substance use services and the activities of Partnership's delegated ~~managed behavioral health~~ organization~~(s)~~ for the administration of certain mental health services. The Behavioral Health Clinical Director has the authority to make decisions based on medical necessity which result in the approval or denial of coverage for ~~behavioral health or~~ substance use disorder treatment related services.

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

E. Medical Necessity – Medical Necessity means those treatment services that are reasonable and necessary to protect life, prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness or injury consistent with Title 42 Code of Federal Regulations (CFR) 438.210 (a) (4).

F. Medical Necessity for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services: (California refers to the EPSDT benefit as *Medi-Cal for Kids & Teens*.) For individuals under 21 years of age, a service is medically necessary if the service meets the standards set for in Section 1396d(r)(5) of Title 42 of the United States Code and is necessary to correct or ameliorate defects and physical and mental illnesses that are discovered by screening services

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

H. Partnership Advantage: Effective January 1, 2028~~7~~, Partnership HealthPlan of California will operate a Centers for Medicare & Medicaid Services (CMS)-approved Dual-Eligible Special Needs Plan (D-SNP) in specific counties as described in the Department of Health Care Services (DHCS) CalAIM Dual Eligible Special Needs Plan Policy Guide. This line of business will be known as Partnership Advantage and will be a Medicare Advantage plan offered to all full-benefit, dual-eligible beneficiaries 21 years of age or older who reside in the applicable counties. Partnership Advantage enrollees~~Members~~ will be qualified to receive both Medi-Cal and Medicare services as described in the Partnership Advantage Member Handbook.

I. Program Beneficiary – A person who: (1) has been determined eligible for full scope Medi-Cal; (2) is not institutionalized; (3) meets criteria for authorization as described in section VI. A. below; (4) meets the admission criteria to receive Drug Medi-Cal (DMC) covered services; and (5) resides in Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, or Solano County.

J. Residential Treatment – As defined for Drug Medi-Cal (DMC) purposes, Residential Treatment means a non-institutional, 24-hour non-medical, short-term residential program of any size that provides rehabilitation services to beneficiaries. Each program beneficiary shall live on the premises and shall be supported in their efforts to restore, maintain, and apply interpersonal and independent living skills and access community support systems. Programs shall provide a range of activities and services. Residential treatment shall include 24-hour structure with available trained personnel, seven days a week, including a minimum of five hours of clinical service a week to prepare beneficiary for outpatient treatment.

K. Urgent Request – A request for medical care or services where application of the timeframe for making routine or non-life threatening care determinations:
   1. Could seriously jeopardize the life, health or safety of the Member or others, due to the Member's psychological state, or
   2. In the opinion of a practitioner with knowledge of the Member's medical or behavioral condition, would subject the Member to adverse health consequences without the care or treatment that is the subject of the request.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

The purpose of this policy is to describe the procedures used by Partnership HealthPlan of California (Partnership) to process Treatment Authorization Requests (TARs) for residential substance use disorder

treatment services.

VI. POLICY / PROCEDURE:

A. Criteria for Authorization of Residential Treatment Services for Substance Use Disorders (SUD)

1. Partnership HealthPlan of California (Partnership) authorizes residential treatment services for substance use disorders according to the specific terms of the contract with the provider and in accordance with the medical necessity requirements specified in Title 22, Section 51303 and the coverage provisions of the approved State Medi-Cal Plan for Medi-Cal eligible beneficiaries as described below:
    a. Adults (Age 21 or older)
        1) Must have at least one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) for Substance-Related and Addictive Disorders (with the exception of Tobacco Related Disorders and Non-Substance Related Disorders).
        2) Must meet the ASAM criteria definition of medical necessity for services based on the ASAM Criteria, 3rd Edition. An LPHA at the residential facility (provider) will assess the Medi-Cal eligible beneficiary using a multi-dimensional assessment based on the ASAM criteria. A summary of the assessment findings must be submitted with the Treatment Authorization Request (TAR) to Partnership.
    b. Adolescents up to the twenty-first [21st] birthday)
        1) These Medi-Cal eligible beneficiaries are also eligible to receive Medicaid services under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program. Under the EPSDT mandate, they are eligible to receive all appropriate and medically necessary services needed to correct and ameliorate health conditions that are coverable under section 1905(a) Medicaid authority.
        2) Must meet the ASAM criteria definition of medical necessity for services based on the ASAM adolescent criteria. An LPHA at the residential facility (provider) will assess the Medi-Cal eligible beneficiary using a multi-dimensional assessment based on the ASAM adolescent criteria. A summary of the assessment findings must be submitted with the TAR to Partnership.
    c. Program beneficiaries (as defined in III.I.) who are also Partnership Advantage Members (as defined in III.H), are eligible for residential SUD treatment under their Medi-Cal benefit as described in this policy.
2. Partnership utilizes InterQual® Behavioral Health Criteria to ensure that the services are medically necessary and provided in sufficient amount, duration, or scope to reasonably achieve the purpose for which the services are furnished.
3. Partnership shall not arbitrarily deny or reduce the amount, duration, or scope of a medically necessary service solely because of the diagnosis, type of illness, or condition of the beneficiary. This does not exclude use of industry standard utilization management practices.

B. Initial Authorization Process Overview

1. When the Medi-Cal eligible beneficiary) presents to the residential substance use disorder treatment facility (provider), an LPHA will conduct an assessment to determine if the Medi-Cal eligible beneficiary meets medical necessity criteria for admission.
2. Within one business day of the intake, the residential provider shall submit a TAR with a summary of the assessment findings and a treatment plan to the Partnership Health Services Department for review.
    a. TAR determinations cannot be made by Partnership until all required documents and information are received.
    b. TARs should be submitted electronically via Partnership's Online Services portal as electronic submission will allow for more expedient processing. If online submission is not possible, the TAR may be submitted via fax number (707) 863-4118 to Partnership's Health Services

Department for review.

3. Partnership's Utilization Management (UM) staff reviews the documentation submitted with the TAR using the non-urgent preservice review time frame and notifies the provider of the determination within ~~5 business~~7 calendar days of receipt of the request.
   a. Partnership's UM staff includes nurse coordinators who are Registered Nurses (RNs) with specialized ASAM training who can approve and defer (pend) the TAR, or deny the TAR for administrative reasons (e.g. TAR not required, duplicate request, or invalid code). Any decision requiring medical necessity determination will be referred to a Physician as per 3.b. below. The nurse coordinator reviews the information received from the residential treatment provider utilizing the approved review guidelines as described in section VI.A. above.
   b. Requests that do not meet review guidelines are referred to the Behavioral Health Clinical Director (described in section III.C. above) or Physician Designee for further evaluation. When a TAR requires clinician review, the nurse coordinator attaches all relevant documentation, InterQual~~®~~ criteria and the Medical Director Worksheet.
   c. Notification of approved TARs will be provided to the provider at the time of decision, but no later than 24 hours from the date of decision.
4. A TAR submission may be initially approved from date of intake up to 30 days for adults and up to 15 days for adolescents.

C. Continued Stay/Reauthorization Process
1. Partnership will review the program beneficiary's progress periodically throughout their length of stay as appropriate.
2. The provider submits a summary of the updated assessment findings, an updated treatment plan and a TAR or discharge plan to Partnership no later than five business days prior to the expiration of the previous authorization.
   a. Continued stay residential SUD treatment authorizations do not meet the definition of "urgent care." These requests are classified as non-urgent preservice review, and Partnership will review and notify the provider of the determination (approved, modified, deferred/pended, or denied) within ~~5 business~~7 calendar days of receipt of the request.
2. Adults (Age 21 or older)
   a. The duration of stay in a residential treatment center is not expected to exceed 90 days. Any length of stay beyond 90 days requires prior approval from Partnership.
   b. After completing 90 days of treatment, Partnership may approve extensions of the stay based upon medical necessity and the treatment plan.
3. Adolescents up to the twenty-first [21st] birthday)
   a. Adolescent beneficiaries receiving residential treatment shall be stabilized as soon as possible and moved down to a less intensive level of treatment.
   b. EPSDT beneficiaries may receive a longer length of stay based on medical necessity.
4. Pregnant/Post-Partum Beneficiaries
   a. Pregnant beneficiaries may receive residential treatment services during pregnancy and up to 60 days during the post-partum period (which begins on the last day of pregnancy). Extension beyond 60 days will require prior approval from Partnership and must be to a non-perinatal level of care.
   b. Providers will be required to provide proof of pregnancy or delivery date ~~for~~ with each new TAR submitted to Partnership.

D. Notification of Denials/Modifications/Appeals Process
1. Only the Behavioral Health Clinical Director or Physician Designee can deny for reasons of medical necessity.
2. For any decision to deny a TAR or to authorize a service in an amount, duration, or scope that is less than requested, electronic or written notification of the decision and how to initiate an appeal, if

applicable, is communicated to the provider within 24 hours of the decision and written notification is mailed to the Medi-Cal eligible beneficiary within two (2) business days of the decision. Please refer to policy MCUP3037 Appeals of Utilization Management/ Pharmacy Decisions for further information on the appeals process.

E. Behavioral Health Clinical Director Residential SUD TAR Reviews
   1. The Behavioral Health Clinical Director may be consulted by UM nurses to review any case for which their expertise may be necessary, as determined by UM nurses upon review of case materials from provider.
   2. The Behavioral Health Clinical Director will review for medical necessity any request for residential SUD treatment episode exceeding 3 episodes in the prior 365 days.
   3. The Behavioral Health Clinical Director will review for medical necessity any request for extension of residential SUD treatment exceeding 90 contiguous days (adults), or 45 days (adolescents).

VII. REFERENCES:

A. Department of Health Care Services (DHCS) Intergovernmental Agreement for Drug Medi-Cal Organized Delivery System (DMC-ODS) Services
B. Drug Medi-Cal Organized Delivery System (DMC-ODS) webpage
C. Title 42 Code of Federal Regulations (CFR) Section 438.210 (a)(4)
D. Title 22 California Code of Regulations (CCR) Sections 51303 and 51340.1
E. Department of Health Care Services (DHCS) Behavioral Health Information Notice (BHIN) No: 21-021 Drug Medi-Cal Organized Delivery System – Updated Policy on Residential Treatment Limitations (May 14, 2021)
F. InterQual® Behavioral Health Criteria
G. National Committee for Quality Assurance (NCQA) Guidelines ~~(Effective July 1, 2025)~~ UM 1 Program Structure Element A, UM 2 Clinical Criteria for UM Decisions Element A and UM 4 Appropriate Professionals Element A
H. DHCS All Plan Letter (APL) 21-011 Grievance and Appeals Requirements, Notice and "Your Rights" Templates (08/31/2021)
I. DHCS "CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide - Contract Year 2026" (Re-release date ~~12/20/2024~~February 2026) https://www.dhcs.ca.gov/provgovpart/Documents/DHCS-CalAIM-D-SNP-Policy-Guide.pdf ~~https://www.dhcs.ca.gov/provgovpart/Documents/CY2026-D-SNP-Policy-Guide.pdf~~

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

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Behavioral Health Clinical Director

X. REVISION DATES:
MPUP3144 (06/11/2025)
06/11/25; 06/10~~1~~/26

PREVIOUSLY APPLIED TO:
Medi-Cal MCUP3144 (05/11/2022 – 06/10/2025):
05/11/22; 06/14/23; 06/12/24

MCCP2028 (11/13/2019 – 05/10/2022)

04/08/20;, 04/14/21; 09/08/21

****

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

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

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

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

Policy/Procedure Number: MPNET101				**Lead Department: Network Services** Business Unit: Compliance	
Policy/Procedure Title: Wellness and Recovery Access Standards and Monitoring				☒**External Policy** ☐ **Internal Policy**	
Original Date: 08/12/20			**Next Review Date:** ~~09/10/2026~~06/10/2027 **Last Review Date:** ~~09/10/2025~~06/10/2026		
Applies to:	☐ **Employees**		☒ **Medi-Cal**	☒ **Partnership Advantage**	
Reviewing Entities:	☒ **IQI**		☐ **P & T**	☒ **QUAC**	
	☐ **OPERATIONS**		☐ **EXECUTIVE**	☐ **COMPLIANCE**	☐ **DEPARTMENT**
Approving Entities:	☐ **BOARD**		☐ **COMPLIANCE**	☐ **FINANCE**	☒ **PAC**
	☐ **CEO**	☐ **COO**	☐ **CREDENTIALS**	☐ **DEPT. DIRECTOR/OFFICER**	
Approval Signature: *Robert Moore, MD, MPH, MBA*				**Approval Date:** ~~09/10/2025~~06/10/2026	

I. RELATED POLICIES:

A. MPNET100 – Access Standards and Monitoring

II. IMPACTED DEPTS:

A. Member Services
B. Provider Relations
C. Health Services
D. Finance
E. Behavioral Health

III. DEFINITIONS:

A. Rural Counties: Counties with a population density of <50 people per square mile (according to current Department of Health Care Services (DHCS) standards), includes Del Norte, Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, and Trinity counties.
B. Suburban or Small Counties: Counties with a population density of 51 to 200 people per square mile (according to current DHCS standards), includes Lake, Napa, and Yolo counties.
C. Urban or Medium Counties: Counties with a population density of 201 to 600 people per square mile (according to current DHCS standards), includes Marin, Solano, and Sonoma counties.
D. Triage or Screening: The assessment of a member's health concerns and symptoms via communication, with a physician, registered nurse, or other qualified health professional acting within his or her scope of practice and who is trained to screen or triage a member who may need care, for the purpose of determining the urgency of the member's need for care.

IV. ATTACHMENTS:

N/A

V. PURPOSE:

To define access standards for substance use disorder treatment through the Partnership HealthPlan of California (Partnership) Wellness and Recovery Program.

VI. POLICY / PROCEDURE:

Partnership is committed to ensuring that its members have the availability of and accessibility to providers to meet their health care needs. Partnership has established standards for the numbers and types of clinicians and facilities, as well as for their geographic distribution, appointment accessibility and office and telephone

availability. Partnership monitors provider availability and accessibility on an annual basis.

A. Access to Providers
1. Established measurable standards for the geographic distribution of each type of wellness and recovery program.

GEOGRAPHIC DISTRIBUTION OF WELLNESS AND RECOVERY PROVIDERS		
Practitioner Type	**Standard: Geographic Distribution**	**Performance Goal**
Outpatient Services	• Rural Counties: 60 miles or 90 minutes from the beneficiary's residence • Small Counties: 60 miles or 90 minutes from the beneficiary's residence • Medium Counties: 30 miles or 60 minutes from the beneficiary's residence • Large Counties: 15 miles or 30 minutes from the beneficiary's residence	≥ 80%
Opioid Treatment Programs	• Programs Rural Counties: 60 miles or 90 minutes from the beneficiary's residence • Small Counties: 45 miles or 75 minutes from the beneficiary's residence • Medium Counties: 30 miles or 60 minutes from the beneficiary's residence • Large Counties: 15 miles or 30 minutes from the beneficiary's residence	≥ 80%

2. Established measurable standards for timely access of each type of wellness and recovery program.

TIMELY ACCESS STANDARD		
Provider Type	**Standard**	**Performance Goal**
Outpatient Services	Within 10 business days from request to appointment	≥ 80%
Opioid Treatment	Within 3 business days from request to appointment	≥ 80%

B. Communication
1. Partnership communicates access standards to:
   a. Members through newsletters, Evidence of Coverage (EOC) and other education materials. Provider directories are also available to members online or upon request.
   b. Providers through the Provider Manual, provider newsletter and/or bulletins, initial provider training and during monthly provider training sessions.

VII. REFERENCES:

A. Master Agreement between Partnership and Wellness and Recovery Counties BHIN (Behavioral Health Information Notice) 21-023 2021 Federal Network Certification Requirements for County Mental Health Plans (MHPs) and Drug Medi-Cal Organized Delivery Systems (DMC-ODS). (May 24, 2021)

VIII. DISTRIBUTION:

A. Partnership Department Directors

B. Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE:
Director, Network Services

X. REVISION DATES:
Medi-Cal
08/11/2021, 08/10/2022, 08/09/2023, 08/14/2024, 09/10/25, 06/10/26

Partnership Advantage (effective Jan. 1, 2028~~7~~)
N/A

PREVIOUSLY APPLIED TO:
N/A

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Synopsis of Changes to Discussion Policies

Below is an overview of the policies that will be discussed at the May 20, 2026 Quality/Utilization Advisory Committee (Q/UAC) meeting.
It is recommended that you look over the changes to each and note any questions or comments you may have to help keep a progressive meeting agenda.

Policy Number & Name	**Page #**	**Summary of Revisions** (include why the changes were made, *i.e.,* NCQA, APL, Medi-Cal guidelines, clarification, *etc.*)	**External Documentation** (Notice required outside of originating department)
Policy Owner: Behavioral Health – *Presenter: Jeffrey DeVido, MD, Behavioral Health Clinical Director*			
MPBP8003 – Mental Health Services	155 - 172	**Seen recently in this committee, this policy is back today for updates in compliance with All Plan Letter (APL) 26-004** (3/16/26) "Medi-Cal Managed Care Plan Responsibilities For Behavioral Health Data-Sharing." Added related policy: MPBP8007 - Screening and Treatment for Substance Use Disorders Section B. 1. a. – Added "should Partnership impose any authorization requirements, Partnership must ensure authorization determinations are based on the requested medically necessary health care services and are consistent with current evidence-based clinical guidelines." to align with wording from APL 26-002. Section I. G. - Re-Added "through the diagnosis or treatment of disease, illness or injury" per request from Policy Analyst Section I. N. – Added "should be performed by PCP." Section I. O. – Added "as outlined in APL 21-014." Section S. – Added "Data sharing" section to align with APL 26-004. Section S.4 – Added "ASCMI" initiative update noted in APL 26-004. Updated all Partnership Advantage effective dates to Jan. 1, 2028. Updated references to include APL 26-002 and APL 26-004.	Health Services Claims Member Services
Policy Owner: Care Coordination – *Presenter: Aryana Cunnigham, Policy Analyst – Care Coordination*			
MPCP2023 – New Member Needs Assessment	173 – 187	**Policy edits due to APL 26-001 Initial Health Appointment. Pursuant to May 12 IQI discussion regarding suggested revisions to the HRA form, the IQI-requested SPD (Seniors/Persons with Disabilities) updates therein are paused until the Department of Health Care Services (DHCS) may respond, at which time this policy may come back to committee.** (At this time, each of the three DCHS form attachments remains the same.) Throughout the policy Partnership Advantage effective date has been updated to reflect January 1, 2028. The body of the policy has been updated to reflect Partnership Advantage "Enrollee" instead of Partnership Advantage "Member."	Health Services Information Technology Member Services

Synopsis of Changes to Discussion Policies

<table>
<tr><th>Policy Number & Name</th><th>Page #</th><th>Summary of Revisions
(include why the changes were made, i.e., NCQA, APL, Medi-Cal guidelines, clarification, etc.)</th><th>External Documentation
(Notice required outside of originating department)</th></tr>
<tr><td></td><td></td><td>Related Policies added: MCQP1021 – Initial Health Appointment
Definition Added: Initial Health Appointment (IHA)
Added VI.C. Initial Health Appointment (IHA)
1. For Members/Enrollees, Partnership must ensure Members engage in primary care consistent with IHA requirements. This requirement may be met by confirming the Member's/Enrollee's engagement with their PCP and documenting that the member was seen by a PCP within the past 12 months.
a. If the Member/Enrollee was not seen by a PCP within the past 12 months. The requirement may be met by assisting in identifying and connecting with a PCP who accepts Member's or Enrollees coverage or by conducting a warm handoff to a care coordination entity affiliated with the Medicare Enrollee's plan, if applicable.
b. For more information regarding IHA please review Partnership's policy MCQP1021 Initial Health Appointment.
References added: DHCS All Plan Letter 26-001: Initial Health Appointment (01/07/2026)</td><td></td></tr>
<tr><td colspan="4">Policy Owner: Quality Improvement (manager) / Behavioral Health (owner0 – Presenter: Jeffrey DeVido, MD, Behavioral Health Clinical Director</td></tr>
<tr><td>MPXG5003 – Major Depression in Adults Clinical Practice Guidelines</td><td>189 - 191</td><td>Changes to Fow Chart (Attachment A):
• Added reference to 2023 ACP guidelines, against which this Partnership Clinical Guideline was reviewed.
• Added bubble to remind of the importance of considering pregnancy status and substance use, as these can impact pharmacotherapy decision making.
• Added bubble to remind of the need to continue to consider suicidality throughout the duration of treatment, as suicidality can emerge throughout treatment.</td><td>Health Services
Provider Relations</td></tr>
<tr><td colspan="4">Policy Owner: Utilization Management – Presenter: Kermit Jones, MD, JD, Deputy Chief Medical Officer / Director for Medicare Services</td></tr>
<tr><td>MPUP3136 – Microbiota-Based Therapeutics (MBT) NEW TITLE formerly Fecal Microbiota Transplant [FMT)</td><td>193 – 195</td><td>During the annual review of this policy, the title was updated from Fecal Microbiota Transplant (FMT) to Microbiota-Based Therapeutics (MBT) to reflect coverage of lab-grown microbial consortia.
Section I.C.: MCRP4068 Medical Benefit Medication TAR Policy was added as a Related Policy because lab-grown microbial consortia is covered as a Physician Administered Drug.</td><td>Provider Relations</td></tr>
</table>

Synopsis of Changes to Discussion Policies

Policy Number & Name	Page #	**Summary of Revisions** (include why the changes were made, *i.e.,* NCQA, APL, Medi-Cal guidelines, clarification, *etc.*)	**External Documentation** (Notice required outside of originating department)
		Section III.A.: Definition of FMT was updated to MBT (which includes FMT). **Sections V. and VI.:** Acronym FMT was updated to MBT throughout the policy. **Section VII.** Minor updates were made to existing References to reflect most-current article information.	
Policy Owner: Utilization Management – *Presenter: Tony Hightower, CPhT, Associate Director of UM Regulations*			
MCUP3104 – Transplant Authorization Process	197 - 202	This policy was updated to address a revision to APL 21-015. **Section I.** Related Policy H. which was formerly numbered MCCP2016, was updated to MPTP2501 *Transportation Policy for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT)* to reflect its transfer of ownership from Care Coordination to the Transportation department. **Sections V. and VI.A.** The purpose statement and policy was updated to reflect the new DHCS term, "Organ and Bone Marrow Transplant (OBMT)" in lieu of previous terminology, "Major Organ Transplant (MOT). **Section VI.B.4.:** Per a revision to Attachment 2 of APL 21-015, this statement was added to the policy: "Initial denial determinations will have a second review by the CMO (or designees Deputy Chief Medical Officer or supervising Medical Director if CMO is unavailable)."	Compliance
Policy Owner: Utilization Management – *Presenter: Mark Netherda, MD. Medical Director for Quality*			
MPUP3047 – Tuberculosis Related Treatment	203 – 207	**Section VI.B:** Guidance for Directly Observed Therapy was updated, and a link was provided to a CDPH guidance document titled, "Information for Physicians Regarding Directly Observed Therapy (DOT) for Active Tuberculosis (TB)." **Section VII.G and I.:** Minor updates were made in the References section to combine two Title 17 citations and to update former Medi-Cal Rx APL number 22-012 to the current number 25-013. **Attachment A:** The TB Screening Guidelines were combined into one flow chart, instead of two, and a clarification was made at the end to say that "Consideration of Treatment of Latent TB" would be "by PCP."	Providers

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

Policy/Procedure Number: MPBP8003 (previously MCUP3028, UP100328)			**Lead Department: Health Services** Business Unit: Behavioral Health	
Policy/Procedure Title: Mental Health Services			☒**External Policy** ☐ **Internal Policy**	
Original Date: 04/25/1994		**Next Review Date:** ~~05/13/2027~~06/10/2027 **Last Review Date:** ~~05/13/2026~~06/10/2026		
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**	
Reviewing Entities:	☒ **IQI**	☐ **P & T**	☒ **QUAC**	
	☐ **OPERATIONS**	☐ **EXECUTIVE**	☐ **COMPLIANCE**	☐ **DEPARTMENT**
Approving Entities:	☐ **BOARD**	☐ **COMPLIANCE**	☐ **FINANCE**	☒ **PAC**
	☐ **CEO** ☐ **COO**	☐ **CREDENTIALS**	☐ **DEPT. DIRECTOR/OFFICER**	
Approval Signature: *Robert Moore, MD, MPH, MBA*			**Approval Date:** ~~05/13/2026~~06/10/2026	

I. RELATED POLICIES:

A. MPBP8011 – Scope of Primary Care – Behavioral Health and Indications for Referral Guidelines
B. MPBP8005 – Dispute Resolution Between Partnership and BHPs in Delivery of Mental Health Services
~~B.~~C. MPBP8007 - Screening and Treatment for Substance Use Disorders
~~C.~~D. CMP36 – Delegation Oversight and Monitoring
~~D.~~E. MCUG3024 – Inpatient Utilization Management
~~E.~~F. MPUP3014 – Emergency Services
~~F.~~G. MPBP8007 – Screening and Treatment for Substance Use Disorders
~~G.~~H. MCUG3118 – Prenatal & Perinatal Care
~~H.~~I. MCCP2022 – Early & Periodic Screening, Diagnostic and Treatment (EPSDT) Services
~~I.~~J. MCQG1015 – Pediatric Preventive Health Guidelines
~~J.~~K. MCUP3041– Treatment Authorization Request (TAR) Review Process

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

A. (BHP) Behavioral Health Plan: A county Behavioral Health Plan in Partnerships' service area. BHPs are required to provide and cover all medically necessary Specialty Mental Health Services (SMHS) and Substance Use Disorder (SUD) treatment services in accordance with their contracts with the Department of Health Care Services (DHCS).
B. Closed Loop Referral: A closed loop referral means bidirectional information sharing between two or more parties to communicate requests for services and the associated outcomes of the requests. The frequency and format of this information sharing varies by service provider and by the degree of formality that may be required according to local community norms. Depending on the type of service needed, this process may include referral to medical, dental, behavioral, and /or social services or community agencies. While a warm hand off may occasionally be appropriate, a closed loop referral does not imply that a warm hand off is required.
C. Dyad: A dyad refers to a child and their parent(s) or caregiver(s). Dyadic care refers to serving both parent(s) or caregiver(s) and child together as a dyad.
D. Dyadic Services Benefit is a family and caregiver-focused model of care intended to address developmental and behavioral health conditions of children as soon as they are identified and is designed to support the implementation of comprehensive models of dyadic care that work within the pediatric

clinic setting to identify and address caregiver and family risk factors for the benefit of the child.

E. (MBHO) Managed Behavioral Healthcare Organization: Partnership HealthPlan of California's delegated managed behavioral healthcare organization is Carelon Behavioral Health

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

G. Medical Necessity: Medically necessary services are reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury.

H. Medical Necessity for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services: (California refers to the EPSDT benefit as *Medi-Cal for Kids & Teens*.) For individuals under 21 years of age, a service is medically necessary if the service meets the standards set for in Section 1396d(r)(5) of Title 42 of the United States Code and is necessary to correct or ameliorate defects and physical and mental illnesses that are discovered by screening services

I. Non-Specialty Mental Health Services (NSMHS): *aka Mild to Moderate Mental Health Services*
Managed Care Plans (MCPs) are required to provide or arrange for provision of the following NSMHS:
1. Mental health evaluation and treatment, including individual, group and family psychotherapy, and dyadic Behavioral Health Services.
2. Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition.
3. Outpatient services for the purposes of monitoring drug therapy
4. Psychiatric consultation
5. Outpatient laboratory, drugs[1], supplies, and supplements

J. Partnership Advantage: Effective January 1, 2028~~7~~, Partnership HealthPlan of California will operate a Centers for Medicare & Medicaid Services (CMS)-approved Dual-Eligible Special Needs Plan (D-SNP) in specific counties as described in the Department of Health Care Services (DHCS) CalAIM Dual Eligible Special Needs Plan Policy Guide. This line of business will be known as Partnership Advantage and will be a Medicare Advantage plan offered to all full-benefit, dual-eligible beneficiaries 21 years of age or older who reside in the applicable counties. Partnership Advantage enrollees will be qualified to receive both Medi-Cal and Medicare services as described in the Partnership Advantage Member Handbook.

K. Professional Person: A "professional person" in Family Code section 6924 means either (1) a professional person as defined in H&S section 124260 or (2) a chief administrator of an agency referred to in Fam. Code section 6924, subdivision (a)(1) and (3). AB 665 added several professionals to the definition of a "professional person," including a registered psychologist, a registered psychosocial assistant, an associate clinical social worker, and a board-certified or board eligible psychiatrist.

L. Specialty Mental Health Services (SMHS): *aka Serious and Persistent Mental Health Services*
County Behavioral Health Plans (BHPs) are contractually required to provide or arrange for the provision of SMHS for Medi-Cal Members who have significant impairment or reasonable probability of functional deterioration due to a diagnosed or suspected mental health disorder as described in Behavioral Health Information Notice (BHIN) 21-073
1. For Partnership Advantage enrollees who meet criteria for SMHS and/or substance use disorder treatment services provided by a county BHP, Partnership will coordinate with BHP providers to

[1] As per APL 25-013, the pharmacy (prescription) benefit was carved-out to State Medi-Cal as of January 1, 2022. Please refer to the State Medi-Cal Rx Education & Outreach page at this website: *https://medi- calrx.dhcs.ca.gov/home/education/*
Effective January 1, 2028~~7~~, the pharmacy benefit for Partnership Advantage enrollees is delegated to a pharmacy benefit manager.

ensure members have access to and are connected with medically necessary services delivered by the BHP as described in section VI.T. of this policy.

M. Wellness & Recovery Program: Partnership's regional Drug Medi-Cal Organized Delivery System waivered program (substance use treatment services) in seven counties within Partnership's service area.

IV. ATTACHMENTS:

A. Adult Screening Tool (DHCS form 8765 A)
B. Youth Screening Tool (DHCS form 8765 C)
C. Transitions of Care Tool (DHCS form 8765 B)

V. PURPOSE:

To describe the means for providing mental health services to Members of Partnership HealthPlan of California (Partnership).

VI. POLICY / PROCEDURE:

A. Partnership HealthPlan of California provides mental health services for Medi-Cal Members. Effective January 1, 2028~~7~~, Partnership will also provide mental health services for Partnership Advantage enrollees who are eligible to receive both Medi-Cal and Medicare services.
   1. For services specific to Partnership Advantage enrollees, see section VI.T. of this policy below.

B. Mental health services for Members with Medi-Cal as their primary insurance are provided as follows:
   1. Members determined to require Non-Specialty Mental Health Services (NSMHS) are served by contacting Partnership at (855) 765-9703.
      a. Partnership covers NSMHS without prior authorization requirements. ~~, s~~Should Partnership impose any authorization requirements, Partnership will ensure prior authorization, concurrent authorization, and retrospective authorization determinations are based on the requested medically necessary health care services and are consistent with current evidence-based clinical guidelines. Partnership will disclose the utilization management or utilization review policy and procedures to the DHCS, ~~its~~ network providers, and any subcontractors involved in these processes under the benefits.
      ~~a.~~b. Partnership maintains a Member Outreach & Education Campaign for Non-Specialty Mental Health Services (NSMHS) which details how NSMHS utilization assessments and population assessments are used to inform NSMHS outreach and education to enhance Member understanding of access to covered NSMHS. This document can be located on Partnership's website.
   2. Members determined to require Specialty Mental Health Services (SMHS) are referred to the County Behavioral Health Plan in the Member's county of responsibility. The administration of such referrals is addressed in the respective Memorandum of Understanding (MOU) with each County Behavioral Health Plan (BHP), consistent with California statutes and regulations.
   3. DHCS requires MCPs and BHPs to use the Screening and Transition of Care Tools (Attachments A, B & C) for Members under age 21 (youth) and for Members age 21 and over (adults) to determine the appropriate mental health delivery system referral for Members who are not currently receiving mental health services when they contact the MCP or BHP seeking mental health services. The contents, including the specific wording and order of fields in the Adult and Youth Screening Tools and Transition of Care Tool, must remain intact and unchanged
      a. The Screening Tools (Attachments A & B) identify initial indicators of Member needs in order to make a determination for referral to either the Member's MCP (Partnership) for a clinical assessment and medically necessary NSMHS or the BHP for a clinical assessment and medically necessary SMHS.
         1) The Adult Screening Tool includes screening questions that are intended to elicit

information about the following topics:
   a) Safety: Information about whether the Member needs immediate attention and the reason(s) a Member is seeking services
   b) Clinical Experiences: Information about whether the Member is currently receiving treatment, if they have sought treatment in the past, and their current or past use of prescription mental health medications.
   c) Life Circumstances: Information about challenges the Member may be experiencing such as issues related to school, work, relationships, housing, or other circumstances.
   d) Risk: Information about suicidality, self-harm, emergency treatment, and hospitalizations.
   e) Questions related to substance use disorders (SUD): If a Member responds affirmatively to these SUD questions, they must be offered a referral to the county behavioral health plan or Partnership (for Members residing in one of the 7 counties participating in the Wellness and Recovery regional DMC-ODS program administered by Partnership) for SUD assessment. (*See also policy MPBP8007 Screening and Treatment for Substance Use Disorders*) The Member may decline this referral without impacting their mental health delivery system referral.
2) The Youth Screening Tool includes screening questions that are intended to elicit information about the following topics:
   a) Safety: Information about whether the Member needs immediate attention and the reason(s) a Member is seeking services
   b) System Involvement: Information about whether the Member is currently receiving treatment, and if they have been involved in foster care, child welfare services, or the juvenile justice system.
   c) Life Circumstances: Information about challenges the Member may be experiencing such as issues related to school, work, relationships, housing, or other circumstances.
   d) Risk: Information about suicidality, self-harm, emergency treatment, and hospitalizations.
   e) SMHS access and referral of other services

b. Adult and Youth Screening Tool questions must be asked in full using the specific wording provided in the tool and in the specific order the questions appear in the tools, to the extent that the Member is able to respond.

c. The scoring methodology provided in the Adult Screening Tool and the Youth Screening Tool will determine whether the Member must be referred to the MCP or the BHP for clinical assessment and medically necessary services.
   1) Scoring methodologies within the Adult and Youth Screening Tools must be used to determine an overall score for each screened Member.
   2) MCPs must use the scoring methodology and follow the referral determination generated by the score unless the MCP overrides the score consistent with the guidance outlined in DHCS APL 25-010 *Adult and Youth Screening and Transition of Care Tools for Medi-Cal Mental Health Services*.
      a) For all referrals, the Member must be engaged in the process and appropriate consents must be obtained in accordance with accepted standards of clinical practice.
      b) Referral coordination must include sharing the completed Adult or Youth Screening Tool and following up to ensure a timely clinical assessment has been made available to the Member.
      c) The MCP must coordinate Member referrals with BHPs or directly to BHP providers delivering SMHS. MCPs may only refer directly to a BHP provider of SMHS if policies and procedures have been established and MOUs are in place with the BHP to ensure a timely clinical assessment with an appropriate in-network provider is made available to the Member.

3) MCPs may override the Screening Tool score when the result is inconsistent with Member's clinical presentation (e.g. the Screening Tool does not capture the need for SMHS in Members who are unable to respond to the Screening Tool questions due to serious mental health symptoms).
   a) Overriding the Screening Tool score must be conducted only by qualified practitioners of NSMHS. MCP practitioner types that may override the Screening Tool score include Licensed Clinical Social Workers, Licensed Professional Clinical Counselors, Licensed Marriage and Family Therapists, Licensed Psychologists, Psychiatric Physician Assistants, Psychiatric Nurse Practitioners. Licensed Physicians, and waivered Registered, or Clinical Trainee counterparts. MCPs are responsible for ensuring that all Practitioners deliver services within their score of practice under California law.
   b) MCP Practitioners must provide their rationale and information supporting the rationale for overriding the Screening Tool score based on the following:
      i. Information provided during screening indicates a higher level of services than NSMHS in needed. MCP should refer members to BHP for a timely assessment.
      ii. Information provided during screening indicates a lower level of services than SMHS in needed. BHP should refer members to MCP for a timely assessment.
   c) MCP must record overrides as well as the Practitioner's rationale through the MCP's preferred monitoring system (EHR, Excel spreadsheet) and share this information when referring a member to the appropriate Medi-Cal mental health delivery system following the administration of the Screening Tool. Overrides of the Screening Tool are subject to auditing and MCPs must provide the records, including the override rationale, to DHCS upon request.

d. The Adult and Youth Screening Tools are administered by Partnership's staff, and may be administered in a variety of ways, including in person, by telephone, or by video conference.
   1) The Screening Tools can be administered by designated staff, licensed and unlicensed, who are trained by the MCP to administer the Screening Tools in alignment with MCP protocols and in accordance with APL 25-010.

e. The Screening Tools are not required or intended for use with Members who are currently receiving mental health services.

f. The Screening Tools are also not required for use with Members who contact mental health providers directly to seek mental health services. Contracted mental health providers who are contacted directly by Members seeking mental health services may begin the assessment process and provide services during the assessment period without using the Screening Tools.

g. The Screening Tools are also not required to be used when a Practitioner refers a member specifically to the MCP for NSMHS based on an understanding of the member's needs and using their own clinical judgment. If a Practitioner refers a member directly to the MCP for NSMHS, the MCP should follow existing protocols for referrals in these scenarios.

h. The Adult and Youth Screening Tools do not replace:
   1) MCP policies and procedures that address urgent or emergency care needs, including protocols for emergencies or urgent and emergent crisis referrals
   2) MCP protocols that address clinically appropriate, timely, and equitable access to care
   3) MCP clinical assessments, level of care determinations and service recommendations.
   4) MCP requirements to provide EPSDT services.

i. Completion of the Adult or Youth Screening Tool is not considered an assessment. Once a Member is referred to the MCP or BHP, they must receive an assessment from a provider in that system to determine medically necessary mental health services.

j. During the assessment period for both youth and adult Members, provision of and payment for NSMHS remain the responsibility of Partnership, even if Member is found to meet criteria for

SMHS.

k. Youth Trauma Screening Tools
   1) DHCS has approved a list of youth trauma screening tools to identify if a Partnership Member under the age of 21 has a condition placing them at high risk for a mental health disorder due to the experience of trauma, or needs further assessment.
   2) If youth trauma is identified or screened during a clinical assessment, clinicians may use their judgment to decide whether further assessment is needed and/or whether the Member qualifies for SMHS.
   3) Standard tool-specific scoring methodology must be used to establish whether a Member scores in the “high risk” range on a youth trauma screening tool.
   4) If there is no clearly defined “high-risk” score, Partnership will ensure a process in place to decide whether the Member qualifies for SMHS.
   5) If a Provider decides that youth trauma screening is needed to determine SMHS eligibility, only DHCS-approved tools may be used.
      a) ACEs Questionnaire
      b) Standard Child and Adolescent Needs and Strengths (CANS) Trauma Module (also referred to as the National Child Traumatic Stress Network CANS – Trauma Comprehensive)
      c) California Integrated Practice-Child and Adolescent Needs and Strengths (IP-CANS) tool
      d) Child and Adolescent Trauma Screen (CATS)
      e) Child Post-Traumatic Stress Disorder (PTSD) Symptom Scale – 6-item Screening Version (CPSS-5-Screen)
      f) Child Trauma Screening (CTS)
      g) Life Events Checklist for DSM-V Standard Version (LEC-5)
      h) Pediatric ACEs and Related Life-Events Screener (PEARLS), including Parent-Caregiver report and self-report versions.
      i) UCLA Child/Adolescent PTSD Reaction Index for DSM-5 Brief Form (UCLA PTSD RI-5 BF)

4. MCPs are required to administer the Transition of Care Tool (Attachment C) to facilitate transitions of care to BHPs for all Members, including adults age 21 and older and youth under age 21, when their service needs change, unless the member is currently receiving mental health services through the MCP or BHP; or referred directly to a mental health delivery system by Practitioner based on an understanding of the Member’s needs and using their own clinical judgment; or the member reaches out directly to the mental health delivery system. When there is a need to refer a Member between levels of care (SMHS and NSMHS), the Transition of Care Tool shall be completed by the treating clinical provider and submitted as part of the referral.
   a. The Transition of Care Tool is used for both adults and youth and is intended to document the Member’s information and provide information from the entity making the referral to the receiving delivery system to begin the Member's care transition.
   b. The Transition of Care Tool may be completed in a variety of ways, including in person, by telephone, or by video conference, and is utilized to ensure Members that are receiving mental health services from one delivery system receive timely and coordinated care when their existing services are transitioned to another delivery system or when services need to be added to their existing mental health treatment from another delivery system.
   c. The Transition of Care Tool includes specific fields to document the following elements:
      1) Referring plan contact information and care team
      2) Member demographics and contact information
      3) Member behavioral health diagnosis, cultural and linguistic requests, presenting behaviors/symptoms, environmental factors, behavioral health history, medical history,

and medications
4) Requested services and plan contact information

d. Following the completion of the Transition of Care Tool, Partnership shall:
1) Refer the Member to the BHP, or directly to a BHP provider delivering SMHS if appropriate processes have been established in coordination with BHPs.
2) Coordinate Member care services with BHPs to facilitate care transitions or additions of services, including ensuring that the referral process has been completed, the Member has been connected with a provider in the new system, the new provider accepts the care of the Member, and medically necessary services have been made available to the Member.
3) All appropriate consents must be obtained in accordance with accepted standards of clinical practice.
4) When Closed Loop Referrals (see section III.B.) are made for behavioral health services between NSMHS, SMHS or county level SUD treatment services, Partnership will ensure that that there is an appointment in the other system of care, along with tracking the outcome of that appointment. If Partnership is unable to confirm with the other system of care or provider that the appointment was fulfilled, Partnership will seek to confirm with the member or to further understand what barriers to care the member may experience. At all times, parties involved will adhere to relevant privacy regulations for the sharing of mental health and SUD information. Obtaining appropriate releases of information (with appropriate Member consent) is recommended to allow information exchange for facilitating exchange of pertinent clinical information.
5) Outcomes of referrals are monitored through monthly referral trackers between Partnership (and/or its delegate) and each BHP.

e. The determination to transition services to and/or add services from the BHP delivery system must be made by a clinician via a patient-centered, shared decision-making process in alignment with the plan's protocols?
1) Once a clinician has made the determination to transition care or refer for additional services, the Transition of Care Tool may be filled out by a clinician or a non-clinician.
2) Members must be engaged in the process and appropriate consents must be obtained in accordance with accepted standards of clinical practice

f. The Transition of Care Tool is not considered an assessment and does not replace:
1) MCP policies and procedures that address urgent or emergency care needs, including protocols for emergencies or urgent and emergent crisis referrals
2) MCP protocols that address clinically appropriate, timely, and equitable access to care
3) MCP clinical assessments, level of care determinations, and service recommendations
4) MCP requirements to provide EPSDT services

C. Members may self-refer for mental health services to an appropriate mental health provider. Members do not need a referral from their Primary Care Provider (PCP) to receive mental health services.

D. In an effort to coordinate medical and mental health care, providers should ask Members to sign a release of information so that the Member's providers can best coordinate care. However, the release of information is not a condition for services to be provided.

E. California Health and Safety Code (HSC) section 124260(b)(1) allows minors 12 and older to consent to mental health treatment if they are mature enough to participate.
1. Effective July 1, 2024, without consent from a parent or legal guardian, minors 12 years of age or older may consent to non-specialty outpatient Medi-Cal mental health treatment or counseling if, in the opinion of the attending professional person, the minor is mature enough to participate intelligently in the outpatient services.
2. The professional person must use their clinical judgment and expertise to make a determination regarding the minor's maturity to participate intelligently in these services.

3. MCPs are responsible for ensuring that minors can consent to non-specialty outpatient Medi-Cal mental health treatment or counseling and county Behavioral Health Plans (BHPs) are responsible for ensuring that minors can consent to specialty mental health outpatient treatment or counseling in accordance with Family Code section 6924 and DHCS guidance. Minors already eligible for full scope Medi-Cal can consent to outpatient mental health services without applying to enroll in limited scope Medi-Cal for Minor Consent Services.
4. The professional person treating or counseling the minor must consult with the minor before determining whether involvement of the parent or guardian would be appropriate.
5. State law requires that the parent or guardian of a minor receiving outpatient mental health treatment or counseling be involved in the treatment unless, after consulting with the minor, the professional person determines that the involvement of the minor's parent or guardian would be inappropriate.
6. MCPs, Network Providers, Subcontractors, or Downstream Subcontractors must establish and ensure safeguards are in place to suppress confidential information and prevent appointment notifications, Notice of Adverse Benefit Determination documents, and any other communication that would violate the minor's confidentiality from being inappropriately delivered to the minor's parent or guardian. MCPs, Network Providers, Subcontractors, or Downstream Subcontractors are prohibited from disclosing any information relating to Minor Consent Services without the express consent of the minor.
7. Following consultation with the minor, the professional person must note their determination regarding the appropriateness of involvement of the parent or guardian in the Member record, stating either:
   a. Whether and when the person attempted to contact the minor's parent or guardian, and whether the attempt to contact was successful; or
   b. The reason why, in the professional person's opinion, it would be inappropriate to contact the minor's parent or guardian.

F. The County Behavioral Health Plan's (BHP's) role in providing mental health services:
   1. County BHPs provide crisis assessments, SMHS and authorizations for acute in-patient psychiatric care for Members in their counties who meet access criteria as described in Behavioral Health Information Notice ~~(BHIN) 21-073.~~ (BHIN) 26-002.
      a. Immediate access to the crisis service remains an option throughout all phases of treatment by any provider.
      b. The County crisis stabilization service acts as a backup after hours and on weekends as well as at other times of provider unavailability.
      c. Members may call the County crisis line directly, without a referral.
      d. Members eligible for mental health services from Partnership delegated managed behavioral health organizations will be re-directed to appropriate County crisis services as needed.
      e. Should services be rendered concurrently in both the NSMHS and SMHS systems for both Members who are under the age of 21 and those 21 years and older, Partnership and County Mental Health Plans shall coordinate care as mutually agreed upon, while ensuring Member's choice is considered. This collaboration shall continue through transitions between systems of care.

G. The PCP's role in providing mental health services:
   1. A certain level of mental health services is appropriately dealt with in a primary care practice, including screening and referrals to services. ~~Primary Care Providers may contact each county's Mental Health Plan or Partnership's delegated managed behavioral health organization, Carelon Behavioral Health, for telephone consultation.~~ For detailed screening, referral and consultation procedures, PCPs can refer to Partnership Policy MPBP8011 Scope of Primary Care - Behavioral Health and Indications for Referral Guidelines.

a. If a Member's screening is positive and indicates further assessment, the assessment may be performed either by the PCP or by referral to a network mental health provider.
b. If the Member's PCP cannot perform the mental health assessment, they must refer the Member to the appropriate provider and ensure referral to the appropriate delivery system for mental health services, either in the MCPs provider network or the county BHP's network
c. Members may then be treated by the PCP within the PCP's scope of practice; or
d. When the condition is beyond the PCP's scope of practice, the PCP must refer the Member to a mental health provider, first attempting to refer within the MCP network
e. At any time, Members can choose to seek and obtain a mental health assessment from a licensed mental health provider within the MCPs provider network.

H. Managed Care Plan's responsibility for providing NSMHS:
1. Partnership is responsible for the delivery of NSMHS (as defined in III.I.) for the following populations:
   a. Members who are 21 year of age and older with mild to moderate distress, or mild to moderate impairment of mental, emotional, or behavioral functioning resulting from mental health disorders, as defined by the current Diagnostic and Statistical Manual of Mental Disorders;
   b. Members who are under the age of 21, to the extent they are eligible for services through the Medicaid EPSDT benefit, regardless of the level of distress or impairment, or the presence of a diagnosis;
   c. Members who are under the age of 21, with specified risk factors or with persistent mental health symptoms in the absence of a mental health disorder, are subject to psychotherapy; and
   d. Members of any age with potential mental health disorders not yet diagnosed.
   e. MCPs must provide psychotherapy to MCP members under the age of 21 with specified risk factors or with persistent mental health symptoms in the absence of a diagnosed mental health disorder.
2. NSMHS may be delivered by PCPs within their scope of practice, or through Partnership's provider network which shall provide a full range of covered NSMHS to its pediatric and adult Members.
3. In accordance with California Welfare and Institutions Code (WIC) sections 14059.5 and 14184.402, services that are "medically necessary" or a "medical necessity" (see III.H.) to correct or ameliorate health conditions for Members under the age of 21 shall be in accordance with the standards set forth in Section 1396d(r)(5) of Title 42 of the United States Code (U.S.C.), which also includes NSMHS. These services are covered by Partnership as Early & Periodic Screening, Diagnostic and Treatment (EPSDT) Services (per policy MCCP2022) regardless of whether the services are covered in the state's Medicaid State Plan.
   a. Consistent with federal guidance from Centers for Medicare & Medicaid Services (CMS), behavioral health services, including NSMHS, need not be curative or completely restorative to ameliorate a behavioral health condition. Services that sustain, support, improve, or make more tolerable a behavioral health condition are considered to ameliorate the condition and are thus medically necessary and are covered as EPSDT services.
4. Consistent with W&I Code section 14184.402(f), clinically appropriate and covered NSMHS are covered by Partnership even when:
   a. Services are provided prior to determination of a diagnosis, during the assessment period, or prior to a determination of whether NSMHS or SMHS access criteria are met;
   b. Services are not included in an individual treatment plan;
   c. The Member has a co-occurring mental health condition and substance use disorder (SUD); OR
   d. NSMHS and SMHS services are provided concurrently, if those services are coordinated and not duplicated.

I. Partnership provides or arranges for the provision of NSMHS including outpatient laboratory tests, drugs, supplies and supplements prescribed by NSMHS mental health providers in-network and PCPs as follows:
   1. Partnership covers physician administered drugs administered by a health care professional in a clinic, physician's office, or outpatient setting through the medical benefit, to assess and treat mental health conditions
   2. Partnership does not cover pharmacy benefits and services pursuant to APL 25-013 and the Medi-Cal Rx program. All drugs (Rx and OTC) which are provided by a pharmacy must be billed to the State Medi-Cal/ DHCS contracted pharmacy administrator instead of Partnership. Please refer to the State Medi-Cal Rx Education & Outreach page at this website: https://medi-calrx.dhcs.ca.gov/home/education/
   3. Partnership covers clinically relevant laboratory and radiologic studies which are determined to be clinically necessary to clarify diagnosis and/or inform treatment, including (but not limited to) endocrinologic or metabolic studies, toxicology screening, radiographic studies, or other necessary procedures (i.e., EKG).
   4. Partnership covers Transcranial Magnetic Stimulation (TMS) under NSMHS.[2]

J. Partnership covers individual and/or group counseling sessions for pregnant and postpartum Members with specified risk factors for perinatal depression when sessions are delivered during the prenatal period and/or during the 12 months following childbirth. (*see also policy MCUG3118 Prenatal & Perinatal Care*)

K. Partnership provides medical case management and covers and pays for all medically necessary Medi-Cal- covered physical health care services, not otherwise excluded by contract, for Partnership beneficiaries receiving SMHS. Partnership coordinates care with the BHP, and is responsible for the appropriate management of a Member's mental and physical health which includes, but is not limited to, medication reconciliation and the coordination of all medically necessary, contractually required Medi-Cal covered services, including mental health services, both within and outside the MCPs provider network.

L. Partnership covers family therapy under Medi-Cal's NSMHS benefit, including for Members ages 20 or below who are at risk for behavioral health concerns and for whom clinical literature would support that the risk is significant such that family therapy is indicated, but may not have a mental health diagnosis. Family therapy is composed of at least two family members receiving therapy together provided by a mental health provider to improve parent/child or caregiver/child relationships and encourage bonding, resolving conflicts, and creating a positive home environment.
   1. All family members do not need to be present for each service.
   2. Members ages 20 or below may receive up to five family therapy sessions before a mental health diagnosis is required.
   3. Family therapy is delivered without regard to the five session limit for Members under age 21 with any of the following risk factors:
      a. mental health disorders or parents/caregivers with related risk factors, including separation from a parent/caregiver due to incarceration, immigration, or death
      b. foster care placement
      c. food insecurity
      d. housing instability

[2] Note that some mental health treatment services, such as TMS, may be available in both SMHS and NSMH systems of care. Partnership's coverage of these treatment services through NSMH is, therefore, not intended to duplicate, supplant, or exclude the potential of those treatment services being offered in the SMHS system of care. As with all mental health treatment services, Partnership will coordinate care with the relevant SMHS systems of care to ensure Members receive clinically indicated care in the most appropriate mental health system of care.

e. exposure to domestic violence or trauma
f. maltreatment
g. severe/persistent bullying
h. discrimination

M. Partnership is responsible for emergency room professional services as described in Section 53855 of Title 22 of the California Code of Regulations (CCR). This includes all professional physical, mental, and substance use treatment services, including screening examinations necessary to determine the presence or absence of an emergency medical condition and, if an emergency medical condition exists, for all services medically necessary to stabilize the Member. Emergency services include facility and professional services and facility charges claimed by emergency departments.

N. SABIRT services including alcohol and drug use screening, assessment, brief interventions, and referral to treatment (SABIRT) for Members ages 11 and older, including pregnant Members, should be performed by PCP.

O. Preventive Screenings including tobacco, alcohol, and illicit drug screenings for adults and children, conducted in accordance with UPSTF grade A and B recommendations and AAP Bright Futures recommendations as outlined in APL 21-014.

~~N.~~P. Partnership is responsible for the provision of Medications for Addiction Treatment (MAT) in primary care, inpatient hospital, emergency departments, and other contracted medical settings as well as for emergency services necessary to stabilize the Member. *(see also policy MPBP8007 Screening and Treatment for Substance Use Disorders)*

~~O.~~Q. Clinically appropriate and covered Drug Medi-Cal (DMC) services delivered by DMC providers whether delivered through the Drug Medi-Cal Organized Delivery System (DMC-ODS) model or the DMC State Plan model are covered by the counties respectively, whether or not the Member has a co-occurring mental health condition. *(See also policy MPBP8007 Screening and Treatment for Substance Use Disorders.)*

~~P.~~R. The Parity in Mental Health and Substance Use Disorder Benefits requirements of Subpart K of Part 438 of Title 42 of the Code of Federal Regulations (CFR) stipulate that treatment limitations for mental health benefits may not be more restrictive than the predominant treatment limitations applied to medical or surgical benefits. Therefore, Partnership ensures direct access to an initial mental health assessment by a licensed mental health provider within the Partnership provider network, and no referral from a PCP or prior authorization is required for an initial mental health assessment to be performed by a network mental health provider.

1. Partnership provides information regarding mental health services for Members in the Partnership Medi-Cal Member Handbook as well as through Partnership's website www.partnershiphp.org. Applicable Member informing materials state that referral and prior authorization are not required for a Member to seek an initial mental health assessment from a network mental health provider and Partnership will notify members of such applicable policies.
2. Partnership covers the cost of an initial mental health assessment completed by an out-of-network provider only if there are no in-network providers that can complete the necessary service within the applicable timely access to care requirements.
3. Pursuant to DHCS requirements and the Memorandums of Understanding (MOU) template, Partnership will execute MOUs with County Mental Health Plans for the purpose of sharing clinical data in order to better coordinate care of Members, improve quality and meet the requirements of the Behavioral Health Quality Incentive Program (BHQIP). To the extent permitted by law, Partnership will exchange with county partners, member demographic information, behavioral and physical health information, diagnoses, assessments, medications prescribed, laboratory results, referrals/discharges to/from inpatient or crisis services and known changes in condition that may adversely impact the Member's health.

~~Q.~~S. Dyadic Services Benefit

Partnership reimburses for all medically necessary mental health services pursuant to the Non-Specialty Mental Health Services: Psychiatric and Psychological Services section of the Medi-Cal Provider Manual. Dyadic Services is a new benefit pursuant to the Medi-Cal Provider Manual, APL 22-029 *Revised* and California Welfare and Institutions Code section 14132.755. Tribal health programs (THPs), Rural Health Clinics (RHCs), and Federal Qualified Health Centers (FQHCs) are eligible to receive their All-Inclusive Rate from the plans if Dyadic Care services are provided by a billable Provider.

1. Dyadic Services Provider Requirements and Qualifications
   a. Provider Types:
      Dyadic caregiver services may be provided by the medical well-child provider in addition to the provider types listed below.
      1) Dyadic Services may be provided by Licensed Clinical Social Workers, Licensed Professional Clinical Counselors, Licensed Marriage and Family Therapists, Licensed Psychologists, Psychiatric Physician Assistants, Psychiatric Nurse Practitioners, and Psychiatrists.
      2) Associate Marriage and Family Therapists, Associate Professional Clinical Counselors, Associate Clinical Social Workers, and Psychology Assistants may render services under a supervising clinician.
      3) Appropriately trained nonclinical staff, including Community Health Workers (CHWs), are not precluded from screening Members for issues related to Social Drivers of Health (SDOH) or performing other nonclinical support tasks as a component of the Dyadic Behavioral Health (DBH) visit, as long as the screening is not separately billed.
   b. Provider Requirements:
      1) Providers of Dyadic Services must be enrolled as a Medi-Cal provider AND
      2) Possess a National Provider Identifier (NPI) number that is entered in the 274 Network Provider File.
   c. Reimbursement for Services:
      1) The delivery of these services and family therapy are considered non-specialty mental health services and are billable to Partnership's contracted MBHO (Carelon Behavioral Health).
      2) There are no prior authorization requirements nor will there be any unreasonable barriers to access and services.
      3) All Dyadic Services must be billed under the Medi-Cal ID of the Member ages 20 or below.
2. Member Eligibility Criteria for Dyadic Services
   a. Children (Members ages 20 or below) and their parent(s)/caregiver(s) are eligible for Dyadic Behavioral Health (DBH) well-child visits when delivered according to the Bright Futures/American Academy of Pediatrics periodicity schedule for behavioral/social/emotional screening assessment, and when medically necessary, in accordance with Medi-Cal's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standards.
      1) Under EPSDT standards, a diagnosis is not required to qualify for services.
      2) DBH well-child visits are intended to be universal per the Bright Futures periodicity schedule for behavioral/social/emotional screening assessment. The DBH well-child visits do not need a particular recommendation or referral and must be offered as an appropriate service option even if the Member does not request them.
      3) The family is eligible to receive Dyadic Services so long as the child is enrolled in Medi-Cal. The parent(s) or caregiver(s) does not need to be enrolled in Medi-Cal or have other coverage so long as the care is for the direct benefit of the child.
3. Covered Dyadic Services
   a. MCPs may offer the Dyadic Services benefit through telehealth or in-person with locations in any setting including, but not limited to, pediatric primary care settings, doctor's offices or clinics, inpatient or outpatient settings in hospitals, the Member's home, school-based sites, or

community settings.

b. Encounters for Dyadic Services must be submitted with allowable current procedural terminology codes as outlined in the Medi-Cal Provider Manual.

c. Multiple Dyadic Services are allowed on the same day and may be reimbursed at the fee-for-service (FFS) rate.

d. Dyadic Services rendered by behavioral health staff are reimbursed when they have not been previously completed as part of the medical well child visit.

e. Dyadic Caregiver Services, including screening, assessment, and brief intervention, may be billed either by the medical well child provider or the DBH provider, but not by both when rendered on the same day.

f. Covered Dyadic Services are behavioral health services for children (Members ages 20 or below) and/or their parent(s) or caregiver(s), and include:

1) DBH Well-Child Visits
   a) DBH well-child visits are provided for the child and caregiver(s) or parent(s) at medical visits. The DBH portion of the well-child visit must be limited to those services not already covered in the medical well-child visit.
   b) When possible and operationally feasible, the DBH well-child visit should occur on the same day as the medical well-child visit. When this is not possible, MCPs must ensure the DBH well-child visit is scheduled as close as possible to the medical well-child visit, consistent with timely access requirements.
   c) MCPs may deliver DBH well-child visits as part of the HealthySteps program, a different DBH program, or in a clinical setting without a certified DBH program as long as all of the following components are included:
      i. Behavioral health history for child and parent(s) or caregiver(s), including parent(s) or caregiver(s) interview addressing child's temperament, relationship with others, interests, abilities, and parent or caregiver concerns.
      ii. Developmental history of the child.
      iii. Observation of behavior of child and parent(s) or caregiver(s) and interaction between child and parent(s) or caregiver(s).
      iv. Mental status assessment of parent(s) or caregiver(s).
      v. Screening for family needs, which may include tobacco use, substance use, utility needs, transportation needs, and interpersonal safety, including guns in the home.
      vi. Screening for SDOH such as poverty, food insecurity, housing instability, access to safe drinking water, and community level violence.
      vii. Age-appropriate anticipatory guidance focused on behavioral health promotion/risk factor reduction, which may include:
         a. Educating parent(s) or caregiver(s) on how their life experiences (e.g., Adverse Childhood Experiences (ACEs) impact their child's development and their parenting.
         b. Educating parent(s) or caregiver(s) on how their child's life experiences (e.g., (ACEs) impact their child's development.
         c. Information and resources to support the child through different stages of development as indicated.
      viii. Making essential referrals and connections to community resources through care coordination and helping caregiver(s) prioritize needs.
2) Dyadic Comprehensive Community Supports Services, separate and distinct from California Advancing and Innovating Medi-Cal's (CalAIM) Community Supports, help the child (Member ages 20 or below) and their parent(s) or caregiver(s) gain access to needed medical, social, educational, and other health-related services, and may include any of the following:

a) Assistance in maintaining, monitoring, and modifying covered services, as outlined in the dyad's service plan, to address an identified clinical need.
b) Brief telephone or face-to-face interactions with a person, family, or other involved member of the clinical team, for the purpose of offering assistance in accessing an identified clinical service.
c) Assistance in finding and connecting to necessary resources other than covered services to meet basic needs.
d) Communication and coordination of care with the child's family, medical and dental health care Providers, community resources, and other involved supports including educational, social, judicial, community and other state agencies.
e) Outreach and follow-up of crisis contacts and missed appointments.
f) Other activities as needed to address the dyad's identified treatment and/or support needs.

3) Dyadic Psychoeducational Services for psychoeducational services provided to the child age 20 or below and/or parent(s) or caregiver(s). These services must be planned, structured interventions that involve presenting or demonstrating information with the goal of preventing the development or worsening of behavioral health conditions and achieving optimal mental health and long-term resilience.
4) Dyadic Family Training and Counseling for Child Development for family training and counseling provided to both the child age 20 or below and parent(s) or caregiver(s). These services include brief training and counseling related to a child's behavioral issues, developmentally appropriate parenting strategies, parent/child interactions, and other related issues.
5) Dyadic Parent or Caregiver Services: Dyadic parent or caregiver services are services delivered to a parent or caregiver during a child's visit that is attended by the child and parent or caregiver, including the following assessment, screening, counseling, and brief intervention services provided to the parent or caregiver for the benefit of the child (Member ages 20 or below) as appropriate:
a) Brief Emotional/Behavioral Assessment
b) ACEs Screening
c) Alcohol and Drug Screening, Assessment, Brief Interventions, and Referral to Treatment
d) Depression Screening
e) Health Behavior Assessments and Interventions
f) Psychiatric Diagnostic Evaluation
g) Tobacco Cessation Counseling

R. Dispute Resolution
1. If a dispute occurs between the local County Behavioral Health Plan (BHP) and Partnership HealthPlan of California (Partnership) or its delegated managed behavioral healthcare organization, Carelon Behavioral Health, the BHP and Partnership will participate in a dispute resolution process as defined in Partnership Policy MPBP8005 Dispute Resolution Between Partnership and BHPs in Delivery of Mental Health Services.
a. Partnership does not delegate the responsibility of MCP and BHP dispute resolution to any Subcontractor.

S. Data sharing
1. Managed Care Plans (MCPs) and Behavioral Health Plans (BHPs) shall support real-time data sharing to advance care coordination, continuity of care, and whole-person care, consistent with Cal AIM, AB 133, and the California Health and Human Services Data Exchange Framework, in compliance with federal and state law and HIPAA's minimum necessary standard.
2. PHC will share data in "real time" with MHPs, either directly or through a Qualified Health

Information Organization (QHIO).

3. MCP and BHP Joint Responsibilities:
   a. Support real-time, bidirectional behavioral health data exchange
   b. MCP and BHP will bidirectionally share up to date member rosters on a monthly basis.
   c. Share only minimum necessary information
   d. Support care coordination and referrals by sharing key referral, eligibility, and clinical MH/SUD information for timely access to services
   e. Support transitions of care by exchanging Admission, Discharge, and Transfer (ADT) notifications to ensure continuity of services
   f. Maintain electronic data exchange capability by sustaining policies, procedures, and technical infrastructure to electronically send, receive, and use standardized behavioral health data
   g. Ensure privacy, security, and confidentiality by protecting behavioral health data in compliance with HIPAA, 42 C.F.R. Part 2, state confidentiality laws, and information security requirements
   h. Manage consent and disclosure by implementing policies to obtain, document, honor, and revoke member data-sharing consent
   i. Formalize data sharing relationships through MOUs or equivalent agreements defining purpose, roles, responsibilities, permitted disclosures, and compliance obligations
   j. Use shared data to support CalAIM initiatives, including ECM, care coordination, referrals, member engagement, and whole-person care integration
   k. Partnership (MCP) and County BHP will share encounter data to meet state and federal quality, accountability, and monitoring reporting requirements, including DHCS accountability reporting, CMS Core Set measures, and Comprehensive Quality Strategy performance measures.
4. Authorization to Share Confidential Member Information (ASCMI): A DHCS CalAIM initiative that standardizes member consent to securely share sensitive health and social services data to support care coordination, interoperability, and person-centered care, including ECM and Community Supports. Managed care plans and county BHPs are required to adopt this authorization form and participate in the statewide patient consent platform once it goes live.

~~S.~~T. Delegation Oversight and Monitoring

1. Partnership delegates the administration of certain mental health services to a managed behavioral health organization.
2. A formal agreement is maintained and inclusive of all delegated functions.
3. Oversight/Regular monitoring activities include, but are not limited to, an audit conducted no less than annually.
4. Results from the annual delegation oversight audit shall be presented to Partnership's Delegation Oversight Review Sub-Committee (DORS) for review and approval and reviewed by the Chief Medical Officer (CMO) or physician designee.

~~T.~~U. Partnership Advantage Mental Health Services (Effective January 1, 2028~~7~~)

1. Availability: Partnership maintains a telephone line for behavioral health assistance 24 hours per day, 7 days a week, to provide information, referral to treatment for conditions pursuant to 42 CFR § 438.3(q). Behavioral-health services are available 24 hours a day, 7 days a week, when medically necessary, per 42 CFR § 438.206(c)(1)(iii)
2. Non-Discrimination: In accordance with 42 CFR § 422.110(a), Partnership ensures that Partnership Advantage enrollees may self-refer for an outpatient mental health assessment or service with a contracted in-network mental health provider without prior authorization requirements and does not deny or limit service if medical necessity requirements are met.
3. Coordination: For Partnership Advantage enrollees who meet criteria for Specialty Mental Health Services (SMHS) and/or substance use disorder treatment services provided by a county BHP,

Partnership will coordinate with BHP providers to ensure enrollees have access to and are connected with medically necessary services delivered by the BHP.

4. Access: Partnership includes providers specializing in behavioral health in its network and meets the appointment-wait-time standards pursuant to 42 CFR § 422.112(a)(6)(i) as follows: emergency services immediately and routine/preventative services within 30 business days. However, where Medi-Cal timely access standards are more strict than Medicare requirements, Partnership will default to those timely access requirements. When required behavioral health services are unavailable or inadequate in-network, Partnership arranges for and covers medically necessary services through non-contracted providers at in-network cost-sharing per 42 CFR § 422.112(a)(1)(iii) and Medicare Managed Care Manual, Ch. 4 § 110.1.1.
5. Screenings: Partnership ensures for Partnership Advantage enrollees that the primary care providers in its network incorporate the following behavioral health screenings as part of every Annual Wellness Visit (first and subsequent) under 42 C.F.R. § 410.15, Depression & Substance Use Disorder screenings among others.
6. Coverage: Partnership shall cover behavioral health services in accordance with Medicare Advantage requirements, including:
   a. Inpatient psychiatric hospital services as a basic Medicare Part A benefit, subject to the 190-day lifetime maximum on inpatient psychiatric care (42 CFR § 422.100(c)(1); 42 CFR § 409.62).
      1) Coverage for inpatient psychiatric services beyond the lifetime maximum will be the responsibility of the Member's county BHP.
   b. Outpatient behavioral health services under Medicare Part B including diagnostic and therapeutic services, incident-to-physician services, and mental health counselor services (42 CFR § 410.10; 42 CFR § 410.54).
      1) Covered services also include Electroconvulsive Therapy (ECT), whether delivered in an inpatient or outpatient setting, hospital incurred medical costs for ECT (i.e., anesthesia), partial hospitalization and intensive outpatient treatment.[3]
      2) Additionally, the treatment of Opioid Use Disorder is a covered service in Partnership Advantage as provided by Opioid Treatment Programs (OTPs). Some services are subject to a Treatment Authorization Request (TAR) and approval.
   c. Residential treatment for substance use disorders is not a covered service under Medicare, and Partnership Advantage enrollees in need of this level of care will be provided care coordination and referral to their county BHP for services.

VII. REFERENCES:

A. DHCS Contract Exhibit A, Attachment 10, Section 10.8.D
B. Medi-Cal Provider Manual/ Guidelines: Non-Specialty Mental Health Services: Psychiatric and Psychological Services *(non spec mental)*
C. Title 9 of the California Code of Regulations (CCR) Chapter 11
D. Title 9 CCR Sections 1820.205, 1830.205, 1830.210, 1850.505, 1850.515, 1850.525, 1850.535
E. Title 22 CCR Section 53855
F. Subpart K of Part 438 of Title 42 of the Code of Federal Regulations (CFR)
G. Title 42 United States Code (USC) § 1396d(r)(5)
H. Welfare and Institutions Codes (WIC) § 14059.5, 14132.03, 14184.402 § 14189
I. DHCS APL 23-029 Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans and Third Party Entities (10/11/2023)

[3] For Partnership Medi-Cal Members, County BHPs are responsible for covering administration of ECT. Hospital incurred medical costs for ECT (i.e., anesthesia) for Partnership Medi-Cal Members are covered by Partnership.

a. Specialty Mental Health Services Memorandum of Understanding Template
b. Substance Use Disorder Treatment Services Memorandum of Understanding Template

J. DHCS APL 21-013 Dispute Resolution Process Between Mental Health Plans and Medi-Cal Managed Care Health Plans (10/04/2021)
K. DHCS APL 22-005 No Wrong Door for Mental Health Services Policy (03/30/2022)
L. DHCS APL 22-029 *Revised* Dyadic Services & Family Therapy Benefit (03/20/2023)
M. California Welfare and Institutions Code section 14132.755, Dyadic Behavioral Health Visits
N. Behavioral Health Information Notice (BHIN) 26-002 (01/20/2026) *Supersedes (BHIN) 21-073*
O. California Health Care Foundation explanation of The Drug Medi-Cal Organized Delivery System
P. DHCS APL 24-012 Non-Specialty Mental Health Services: Member Outreach, Education, and Experience Requirements (09/17/2024)
Q. DHCS APL 24-019 Minor Consent to Outpatient Mental Health Treatment or Counseling (12/31/2024)
R. DHCS APL 25-010 Adult and Youth Screening and Transition of Care Tools for Medi-Cal Mental Health Services (6/3/2025) *Supersedes APL 22-028*
S. DHCS APL 26-002 MediCal Managed Care Plan Responsibilities for Non-Specialty Mental Health Services (02/02/2026) *Supersedes APL 22-006*
T. DHCS APL 26-002 Attachment A Approved Youth Trauma Screening Tools for Specialty Mental Health Services Access Criteria.
U. DHCS Screening and Transition of Care Tools for Medi-Cal Mental Health Services
   1. Adult Screening Tool for Medi-Cal Mental Health Services (DHCS 8765A 01/2023)
   2. Youth Screening Tool for Medi-Cal Mental Health Services (DHCS 8765C 01/2023)
   3. Transition of Care Tool for Medi-Cal Mental Health Services (Adult & Youth) (DHCS 8765B 01/2023)

V. DHCS All Plan Letter APL 25-013 "Medi-Cal Rx Pharmacy Benefits, and Cell and Gene Therapy Coverage" (09/18/2025)
~~V.~~W. DHCS All Plan Letter (APL) 26-004 "Medi-Cal Managed Care Plan Responsibilities for Behavioral Health Data-Sharing" (03/16/2026)
~~W.~~X. California Family Code section 6924
~~X.~~Y. State Medicare Advantage Contract, Exhibit A, Exclusively Aligned Enrollment D-SNP, currently in draft (2025).
~~Y.~~Z. Code of Federal Regulations: 42 CFR § 422.100(c)(1); 42 CFR § 409.62; 42 CFR § 410.10; 42 CFR § 410.54; 42 CFR § 422.100(c)(1); 42 CFR § 409.62; 42 C.F.R. § 410.15; 42 CFR § 422.112(a)(1)(iii); 42 CFR § 438.3(q); 42 CFR § 438.206(c)(1)(iii)
~~Z.~~AA. Medicare Managed Care Manual, Ch. 4 § 110.1.1

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

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

X. REVISION DATES:

MPB~~H~~P8003
06/11/25; 11/12/25; 02/11/26; 05/13/2026; 06/10/2026

Partnership Advantage (effective Jan. 1, 2028)
N/A

Policy/Procedure Number: **MPBP8003** (previously MCUP3028, UP100328)			Lead Department: Health Services Business Unit: Behavioral Health
Policy/Procedure Title: Mental Health Services			☒ **External Policy** ☐ **Internal Policy**
Original Date: 04/25/1994	**Next Review Date:** ~~05/13/2027~~ 06/10/2027 **Last Review Date:** ~~05/13/2026~~ 06/10/2026		
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**

PREVIOUSLY APPLIED TO:
MCUP3028: 10/18/2006 – 06/11/2025
08/11/95; 10/10/97 (name change only); 06/21/00; 12/19/2001; 08/20/03, 10/20/04; 10/19/05; 10/18/06; 10/17/07; 10/15/08; 04/21/10; 03/16/11; 08/15/12; 05/20/15; 04/20/16; 04/19/17; *06/13/18; 06/12/19; 06/10/20; 06/09/21; 06/08/22; 10/12/22; 06/14/23; 04/10/24; 08/14/24; 01/08/25; Transferred to MPBP8003 06/11/25

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

UP100328: 04/25/1994 – 10/18/2006

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

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

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

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

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

Policy/Procedure Number: MPCP2023 (previously MCCP2023)			**Lead Department: Health Services** Business Unit: Care Coordination	
Policy/Procedure Title: New Member Needs Assessment			☒**External Policy** ☐ **Internal Policy**	
Original Date: 08/16/2017		**Next Review Date:** ~~01/14/2027~~06/10/2027 **Last Review Date:** ~~01/14/2026~~06/10/2026		
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**	
Reviewing Entities:	☒ **IQI**	☐ **P & T**	☒ **QUAC**	
	☐ **OPERATIONS**	☐ **EXECUTIVE**	☐ **COMPLIANCE**	☐ **DEPARTMENT**
Approving Entities:	☐ **BOARD**	☐ **COMPLIANCE**	☐ **FINANCE**	☒ **PAC**
	☐ **CEO** ☐ **COO**	☐ **CREDENTIALS**	☐ **DEPT. DIRECTOR/OFFICER**	
Approval Signature: *Robert Moore, MD, MPH, MBA*			**Approval Date:** ~~01/14/2026~~06/10/2026	

I. RELATED POLICIES:

A. MPCD2013 – Care Coordination Program Description
B. MPCP2019 – Identification and Care Coordination for Seniors and Persons with Disabilities and/or California Children's Services
C. MCCP2024 – Whole Child Model for California Children's Services (CCS)
~~C.~~D. MCQP1021 – Initial Health Appointment

II. IMPACTED DEPTS:

A. Health Services
B. Information Technology
C. Member Services

III. DEFINITIONS:

A. California Children's Services (CCS): A state program for children up to 21 years of age, who have been determined eligible for the CCS program due to the presence of certain diseases or health problems.
B. Care Coordination (CC) Staff: Partnership's CC staff members have either experience in health care fields (e.g., Medical Assistant, Emergency Medical Technician, etc.) or are licensed and possess the appropriate skills and training to assist Members. All staff are trained in care coordination and motivational interviewing.
C. Health Information Form (HIF)/Member Evaluation Tool (MET): Screening tool sent to newly enrolled Members to identify Members needing expedited care.
D. Health Risk Assessment (HRA): An assessment form mailed to newly enrolled adult Members (ages 21 and over) with corresponding Seniors and Persons with Disabilities (SPD) aid codes who may be at risk for adverse health outcomes without support from an Individualized Care Plan (ICP).
~~D.~~E. Initial Health Appointment (IHA): is defined as a Member's visit to their Primary Care Provider (PCP) or other provider of primary care services, within stipulated timelines for an evaluation that consists of a history and physical examination sufficient to assess and manage the acute, chronic and preventive health needs of the member. The IHA must be documented in the member's medical record.
~~E.~~F. Partnership Advantage: Effective January 1, 2028~~7~~, Partnership HealthPlan of California will operate a Centers for Medicare & Medicaid Services (CMS)-approved Dual-Eligible Special Needs Plan (D-SNP) in specific counties as described in the Department of Health Care Services (DHCS) CalAIM Dual Eligible Special Needs Plan Policy Guide. This line of business will be known as Partnership Advantage and will be a Medicare Advantage plan offered to all full-benefit, dual-eligible beneficiaries 21 years of age or older who reside in the applicable counties. Partnership Advantage Enrollees~~Members~~ will be qualified to receive both Medi-Cal and Medicare services as

described in the Partnership Advantage Member Handbook.

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

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

IV. ATTACHMENTS:

A. Health Information Form (HIF)/Member Evaluation Tool (MET)
B. Health Risk Assessment (HRA)
C. Pediatric HRA

V. PURPOSE:

This policy describes the process Partnership HealthPlan of California (Partnership) will follow to assess new plan enrollees in order to identify those Members who may need expedited services.

VI. POLICY / PROCEDURE:

A. New Member Outreach Process
   1. All newly enrolled Members designated with an SPD aid code and/or CCS identifier are sent the HRA (Attachment B) or PHRA (Attachment C) via mail within 10 calendar days of enrollment into the plan along with a postage-paid envelope for response. The HRA includes both questions from the HIF tool as well as additional questions appropriate for assessing the need for expedited services for high-risk Members. (See policy MPCP2019 for the full process of screening of Seniors and Persons with Disabilities and/or California Children's Services beneficiaries, and risk assignment process.)
   2. For more information on the assessment, outreach and case management activities for CCS Members, please see Partnership policy MCCP2024 Whole Child Model for California Children's Services.
   3. All newly enrolled Members who are designated with neither an SPD aid code nor a CCS identifier are sent the HIF/MET form (Attachment A) via mail within 10 days of enrollment into the plan along with a postage-paid envelope for response.
   4. Each new Member will also receive up to two telephone calls reminding them to review and return the assessment form. This telephonic outreach can be made to head of household for Members under the care of parents or other authorized representatives. At least two attempts will be made to contact the Member or their authorized representative within 45 days of enrollment.

B. Initial Screening
   1. Returned forms will be reviewed to determine if the Member requires expedited care within 30 days of receipt of a completed HRA form for SPD/CCS Members, or within 90 days of return of the HIF/MET for all other newly enrolled Members. If the Member is found to require expedited care, a CC staff member will contact the Member or Member's authorized representative.
      a. The role of CC staff member in the HRA or HIF/MET process is to expedite access to care for new Members. Examples include, but are not limited to:
         1) Facilitate referrals for Long Term Services and Supports (LTSS) needs identified
         2) Contact durable medical equipment (DME) vendors to facilitate timely delivery of appropriate medical equipment
         3) Work with the primary care provider (PCP) and/or specialists' offices to coordinate

appointments
4) Arrange transportation as appropriate
5) Provide support and encouragement to the Member and caregiver
6) Identify Members who may benefit from mental health services and refer to appropriate agencies for services
7) Work with Member to identify any psychosocial needs and refer to community-based organizations as appropriate
8) Assist with facilitating referrals to appropriate resources and/-or services outside of the Plan's benefits (i.e., personal care, and/or energy assistance programs)
9) Screen and refer new Members who may benefit from Basic Care Management or Complex Case Management Services

C. Initial Health Appointment (IHA)
1. For Members/Enrollees, Partnership must ensure Mmembers engage in primary care consistent with IHA requirements. This requirement may be met by confirming the Member's/Enrollee's engagement with their PCP and documenting that the member was seen by a PCP within the past 12 months.
   a. If the Member/Enrollee was not seen by a PCP within the past 12 months. The requirement may be met by assisting in identifying and connecting with a PCP who accepts Member's or Enrollee's coverage or by conducting a warm handoff to a care coordination entity affiliated with the Medicare Enrollee's plan, if applicable.
   a.b. For more information regarding IHA please review Partnership's policy MCQP1021 Initial Health Appointment.

C.D. Disenrollment
1. Upon disenrollment from Partnership and when requested, Partnership will make the results of the HRA or HIF/MET assessment available to the new Medi-Cal Managed Care Health Plan.

VII. REFERENCES:
A. Title 42 Code of Federal Regulations (CFR) 438.208(b)
A.B. DHCS All Plan Letter 26-001: Initial Health Appointment (01/07/2026)

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

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

X. REVISION DATES:
Medi-Cal
10/18/17; *11/14/18; 11/13/19; 09/09/20; 09/08/21; 10/12/22; 10/11/23; 10/09/24; 02/12/25; 01/14/26; 06/10/26

Partnership Advantage (Program effective January 1, 202887)
01/14/26; 06/10/26

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

PREVIOUSLY APPLIED TO: N/A

Health Information Form

You are receiving this form because you are newly assigned to Partnership HealthPlan of California. Partnership will use this form to make sure you get the care that you need.

Please circle each answer that applies to you. Complete one form for each person in your family who is newly assigned to Partnership.

If you have questions, please call Partnership at **(800) 863-4155** Monday – Friday, 8 a.m. – 5 p.m. TTY users can call **(800) 735-2929**.

Please return this completed form in the (yellow) envelope provided or mail to:

Q&A Research Inc
#357, 22052 W 66th Street
Shawnee KAS 66226-9905

Filling out this form is voluntary. You will not be denied care based on your confidential answers.

Name of Partnership Member:____

Date of Birth: ____________________ **Medi-Cal ID Number:**____________________

1. Do you need to see a doctor within the next 60 days?	YES	NO
2. Do you take 3 or more prescription medications each day?	YES	NO
3. Do you see a doctor regularly for a mental health condition such as depression, bipolar disorder, or schizophrenia?	YES	NO
4. Have you been to the emergency room two (2) or more times in the last twelve (12) months?	YES	NO
5. Have you been admitted to the hospital in the last twelve (12) months?	YES	NO
6. Have you needed help with personal care such as bathing, getting dressed, or changing bandages in the last six (6) months?	YES	NO
7. Are you using medical equipment or supplies such as a hospital bed, wheelchair, walker, oxygen or ostomy bags?	YES	NO
8. Do you have a condition that limits your activities or what you can do?	YES	NO
9. Are you pregnant?	YES	NO
9a. *If yes, are you currently seeing a doctor for this pregnancy*?	YES	NO
10. Do you see a doctor for a chronic medical condition?	YES	NO

If yes, circle all that apply:

a. Asthma / Lung Problems	b. Heart Problems	c. Diabetes
d. HIV or AIDS	e. Kidney Disease	f. Seizures

g. Other ____

These answers will be sent to Partnership. If you think you need to see a doctor before Partnership contacts you, you should go to the doctor or hospital at that time.

Please note, if you change to another health plan and we get a request, Partnership will share this health information form with your new plan.

Signature:______________________________ Date: __________________

If not signed by member, specify relationship: Parent/ Guardian/ Other Representative

CONFIDENTIAL

MC1191E
DHCS approved 06212017

Partnership HealthPlan of California
Health Risk Assessment Form
Seniors and Persons with Disabilities (SPD)

This form will help Partnership HealthPlan of California learn about your health and wellness needs and find ways we can help you. Please take a few minutes to fill out this form and send it back as soon as possible.

If you think you need to see a doctor before Partnership calls you, you should go to the doctor or hospital at that time.

If you have questions, please call Partnership at **(800) 809-1350**, Monday – Friday, 8 a.m. to 5 p.m. TTY users can call **(800) 735-2929**.

Please return your completed form in the green envelope.
Partnership HealthPlan of California
4665 Business Center Drive
Fairfield, CA 94534

Filling out this form is voluntary. We will not deny your care because of how you respond.

Name of Partnership Member: ______________________________

Date of Birth: ____________________ **Medi-Cal ID Number:** ________________

1. What is your preferred language?
   ☐ English ☐ Spanish ☐ Russian ☐ Mandarin ☐ Tagalog ☐ Other

2. What was your gender at birth?
   ☐ Male ☐ Female ☐ Other

3. What do you like to be called?
   ☐ He/Him/His ☐ She/Her/Hers ☐ They/Them/Their ☐ Other

4. Do you have trouble communicating due to hearing, vision, or speech problems? ☐Yes ☐No
   If yes, do you need special materials/equipment? ☐Yes ☐No

5. Do you have a regular doctor? ☐Yes ☐No

6. Do you see a specialist(a doctor who specializes in health problems, like heart, kidney, cancer or other health problems)? ☐Yes ☐No

7. Do you feel your doctor(s) understand your medical needs? ☐Yes ☐No

8. Do you need to see a doctor in the next 60 days? ☐Yes ☐No
   If yes, do you have the appointment scheduled? ☐Yes ☐No

9. Do you get services or care from a regional center that cares for people with developmental disabilities? ☐Yes ☐No

10. Are you pregnant? ☐Yes ☐No

11. Have you been to the emergency room 2 or more times in the last 12 months?
☐Yes ☐No

12. Have you been admitted to the hospital in the last 12 months?
☐Yes ☐No

13. Are you using medical equipment or supplies such as a hospital bed, wheelchair, walker, or ostomy bags? ☐Yes ☐No
If yes, do you need help getting more supplies? ☐Yes ☐No

14. Do you smoke or use tobacco products? ☐Yes ☐No
If yes, would you like help quitting? ☐Yes ☐No

15. Do you use home oxygen? ☐Yes ☐No

16. How many prescription medicines do you take each day?
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 or more

17. Have you ever been told you have any of these health problems?
(check yes or no for each of the problems below)
California Children's Services (CCS) condition ☐Yes ☐No
Asthma/Lung problems ☐Yes ☐No
Heart problems ☐Yes ☐No
Diabetes ☐Yes ☐No
HIV or AIDS ☐Yes ☐No
Kidney Disease ☐Yes ☐No
Seizures ☐Yes ☐No
Cancer ☐Yes ☐No
Medical Therapy Program or Unit (MTP/MTU) condition ☐Yes ☐No
If yes to any, do you see a doctor or specialist for any of these problems?
☐Yes ☐No
If yes to any, have you ever had any surgeries for these problems?
☐Yes ☐No
Do you need help finding a doctor to help you with these problems?
☐Yes ☐No

18. Have you ever been told you have a mental or behavioral health problem such as depression, bipolar disorder, or schizophrenia? ☐Yes ☐No
If yes, do you need help finding a doctor to help you with a mental or behavioral health problem?
☐Yes ☐No

19. Would like more information about how to improve your health or stay healthy?
☐Yes ☐No

20. Do you need help with any of these actions? (**Yes** or **No** to each individual action, choose **N/A** if this is something you have never done)
Taking a bath or shower ☐Yes ☐No ☐N/A

Going up stairs	☐Yes	☐No	☐N/A
Eating	☐Yes	☐No	☐N/A
Getting dressed	☐Yes	☐No	☐N/A
Brushing teeth, brushing hair, shaving	☐Yes	☐No	☐N/A
Making meals or cooking	☐Yes	☐No	☐N/A
Getting out of a bed or a chair	☐Yes	☐No	☐N/A
Shopping and getting food	☐Yes	☐No	☐N/A
Using the toilet	☐Yes	☐No	☐N/A
Making it to the toilet on time/without an "accident"	☐Yes	☐No	☐N/A
Walking	☐Yes	☐No	☐N/A
Washing dishes or clothes	☐Yes	☐No	☐N/A
Writing checks or keeping track of money	☐Yes	☐No	☐N/A
Getting a ride to the doctor or to see your friends	☐Yes	☐No	☐N/A
Doing house or yard work	☐Yes	☐No	☐N/A
Going out to visit family or friends	☐Yes	☐No	☐N/A
Using the phone	☐Yes	☐No	☐N/A
Keeping track of appointments	☐Yes	☐No	☐N/A

If yes, are you getting all the help you need with these actions?
☐Yes ☐No ☐N/A

21. Can you live safely and move easily around your home?
☐Yes ☐No ☐N/A

If ***no***, does the place where you live have:
(Yes, No, or N/A to each individual item)

Good lighting	☐Yes	☐No	☐N/A
Good heating	☐Yes	☐No	☐N/A
Good cooling	☐Yes	☐No	☐N/A
Rails for any stairs or ramps	☐Yes	☐No	☐N/A
Hot water	☐Yes	☐No	☐N/A
Indoor toilet	☐Yes	☐No	☐N/A
A door to the outside that locks	☐Yes	☐No	☐N/A
Stairs to get into your home or stairs inside your home	☐Yes	☐No	☐N/A
Elevator	☐Yes	☐No	☐N/A
Space to use a wheelchair	☐Yes	☐No	☐N/A
Clear ways to exit your home	☐Yes	☐No	☐N/A

22. I would like to ask you about how you think you are managing your health conditions

Do you need help taking your medications?	☐Yes	☐No	☐N/A
Do you need help filling out health forms?	☐Yes	☐No	☐N/A
Do you need help answering questions during a doctor's visit?	☐Yes	☐No	☐N/A

23. Which of the following answers best describes how you feel with your medical needs? (check all that apply)
    - ☐ I sometimes forget what I am supposed to do for my health
    - ☐ I can't afford all of things I need to take care of myself
    - ☐ It's hard to read or understand directions at times
    - ☐ I'm confused about what I really need to do for my health

- ☐ I don't think it is necessary to do what my doctor says all of the time
- ☐ I don't understand my medical needs
- ☐ I feel confident that I know how to take care of what I need

24. Do you have family members or others willing and able to help you when you need it?
☐Yes ☐No ☐N/A

25. Do you ever think your caregiver has a hard time giving you all the help you need?
☐Yes ☐No ☐N/A

26. Are you afraid of anyone or is anyone hurting you?
☐Yes ☐No ☐N/A

27. Is anyone using your money without your ok? ☐Yes ☐No ☐N/A

28. Have you had any changes in thinking, remembering, or making decisions? ☐Yes ☐No ☐N/A

29. Have you fallen in the last month? ☐Yes ☐No ☐N/A
Are you afraid of falling? ☐Yes ☐No ☐N/A

30. Do you sometimes run out of money to pay for food, rent, bills, and medicine?
☐Yes ☐No ☐N/A

31. Over the past month (30 days), how many days have you felt lonely?
☐None – I never feel lonely
☐Less than 5 days
☐More than half the days (more than 15)
☐Most days – I always feel lonely

32. In general, would you say that your health is
☐Excellent ☐Very Good ☐Good ☐Fair ☐Poor

Signature of person
filling out the form: ____

Date: ______________________________

If not signed by member, what is your relationship to the member:
Parent/ Guardian/ Other Representative

Thank you for your time filling out this form.
CONFIDENTIAL

Partnership HealthPlan of California
Pediatric Health Risk Assessment Form

Please take a few minutes to complete this form to help us learn about your child's health and wellness needs. We want to use these answers to help you get the right care as soon as possible.

If you think you need to see a doctor before Partnership calls you, you should go to the doctor or hospital at that time.

If you have questions, please call Partnership at **(800) 809-1350** Monday – Friday, 8 a.m. – 5 p.m. TTY users can call **(800) 735-2929**.

Please return this completed form in the green envelope
To: Partnership HealthPlan of California
4665 Business Center Drive
Fairfield, CA 94534

Filling out this form is voluntary. We will not deny your care because of how you respond.

Name of Partnership CCS Member: ______________________________

Date of Birth: ________________ **Medi-Cal ID Number:** ________________

1. Who is answering the questions on this survey?
☐ Mother ☐ Father ☐ Grandparent ☐ Foster Parent ☐ Self
☐ Other Family Member: ________________ ☐ Other: ________________

2. What is your preferred language?
☐ English ☐ Spanish ☐ Tagalog ☐ Russian ☐Other: ________________

3. Does your child have difficulty with any of the following? (Choose **N/A** if you would not expect other children of this age to be able to do this on his/her own)

Taking care of him/herself, such as:			
Feeding him/herself (feeding)	☐Yes	☐No	☐N/A
Taking a bath or shower (bathing)	☐Yes	☐No	☐N/A
Getting dressed (dressing)	☐Yes	☐No	☐N/A
Going to the toilet (toileting)	☐Yes	☐No	☐N/A
Making it to the toilet on time/without an "accident" (continence)	☐Yes	☐No	☐N/A
Being active, like:			
Walking (mobility)	☐Yes	☐No	☐N/A
Getting out of a bed or a chair (transferring)	☐Yes	☐No	☐N/A
Going up or down stairs	☐Yes	☐No	☐N/A
Showing independence by:			
Going out to visit family or friends	☐Yes	☐No	☐N/A
Going to school or work	☐Yes	☐No	☐N/A
Making doctor or dentist appointments	☐Yes	☐No	☐N/A
Using the phone, tablet, or computer	☐Yes	☐No	☐N/A
Other ________________	☐Yes	☐No	☐N/A

4. Does your child get services or care from a Regional Center that provides care for people with developmental disabilities? ☐Yes ☐No ☐Not sure
   What is the name of the center where you go?____________________________________

5. Does your child receive any of the following services? (Check all that apply)
   - ☐ Speech Therapy
     Where is this received? ☐Home ☐School ☐Medical Therapy Program (MTP) or Medical Therapy Unit (MTU)
     ☐Other ____________________________________
   - ☐ Physical Therapy
     Where is this received? ☐Home ☐School ☐MTP/MTU
     ☐Other ____________________________________
   - ☐ Occupational Therapy
     Where is this received? ☐Home ☐School ☐MTP/MTU
     ☐Other ____________________________________
   - ☐ Respiratory Therapy
     Where is this received? ☐Home ☐School
     ☐Other ____________________________________
   - ☐ Nursing Services
     Where is this received? ☐Home ☐School Hours/days per week? __________
     ☐Other ____________________________________
   - ☐ Mental or Behavioral Therapy
     Where is this received? ☐Home ☐School
     ☐Other ____________________________________
   - ☐ Individualized Education Plan (IEP) or 504 Plan or other learning support?
     Which one(s)? ☐IEP ☐504
     ☐School Name____________________________________
   - ☐ Other supportive services (Respite Care, Palliative Care, etc.)
     Please explain ____________________________________
     Where is this received? ☐Home ☐School
     ☐Other____________________________________

6. In general, would you say that your child's health is
   ☐Excellent ☐Very Good ☐Good ☐Fair ☐Poor

7. Does your child have any allergies?
   - ☐ Food(s) (please specify) ______________________________

   Environmental (seasonal, dust, pollution, etc.)
   (please specify) ______________________________
   - ☐ Medication(s) (please specify) ______________________________
   - ☐ No Known Allergies

8. Does your child use durable medical equipment (DME) or supplies that were ordered for your child's specific needs?

☐ Yes (check all that apply)
- ☐ Glasses
- ☐ Hearing Aids
- ☐ Cochlear Implant
- ☐ Wheelchair
- ☐ Brace
- ☐ Orthotics
- ☐ Walker
- ☐ Car Seat
- ☐ Bed
- ☐ Ventilator/breathing machine
- ☐ Oxygen
- ☐ Percussion Vest
- ☐ Insulin Pump/Continuous Glucose Monitor
- ☐ Intravenous pump/Infusion device
- ☐ Feeding pump/Gastrostomy Tube (GT)/Jejunostomy Tube (JT)/ Gastrojejunostomy Tube (GJT)
- ☐ Other (please specify) ______________________________

Who ordered it? ______________________________

Date of last order ______________________________

Who was the vendor? ______________________________

Vendor Phone: ______________________________

9. What is your child's current:

Height ____________________ Weight ________________

10. Has your child ever had surgery?

☐ Yes ☐ No ☐ Don't Know

Please list each surgery	**Date or Year**

Please list each surgery	**Date or Year**
☐ **More than can fit here**	

11. Has your child been to the emergency room (ER) in the last 6 months?
    ☐ Yes ☐ No ☐ Don't know
    i. How many times?______________________
    ii. When?_______________________________

12. Has your child been in the hospital overnight in the last 6 months?
    ☐ Yes ☐ No ☐ Don't know
    i. How many times?_________________________
    ii. When?__________________________________

13. What medications does your child take? Please include prescriptions, over-the-counter medications, vitamins, herbal supplements and other remedies. **Start with the medications your child is taking now, and then add medications your child has taken in the past**.

Medication/Vitamin/Supplement Name	**Current**	**Past**
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

Medication/Vitamin/Supplement Name	Current	Past
	☐	☐
	☐	☐
☐ More than can fit here	☐	☐

14. Have you ever been told by a medical professional you that your child has any of the following problems? For each problem, check whether it is a problem now or was a problem in the past.

	Current	Past
Asthma	☐	☐
Cystic Fibrosis	☐	☐
Ventilator Dependent	☐	☐
Other Lung Conditions	☐	☐
What is/are the conditions(s)?	☐	☐
Congenital Heart Disease	☐	☐
Heart Murmur	☐	☐
Other Heart Conditions	☐	☐
What is/are the conditions(s)?	☐	☐
Para/Quadriplegia	☐	☐
Seizures/Epilepsy	☐	☐
Cerebral Palsy	☐	☐
Other Neurological Conditions	☐	☐
What is/are the conditions(s)?	☐	☐
Muscular Dystrophy	☐	☐
Broken bone(s)	☐	☐
Scoliosis	☐	☐
Other bone or muscle disorders	☐	☐
What is/are the conditions(s)?	☐	☐
Ostomy/G Tube /Colostomy/Urostomy	☐	☐
Crohn’s Disease/Ulcerative Colitis	☐	☐
Celiac Disease	☐	☐
Other gastrointestinal (GI)/stomach/digestion conditions	☐	☐
What is/are the conditions(s)?	☐	☐
Sickle Cell Anemia	☐	☐
Hemophilia	☐	☐
Other Blood Conditions	☐	☐
What is/are the conditions(s)?	☐	☐

	Current	Past
Diabetes	☐	☐
Immune Disorder	☐	☐
What is/are the conditions(s)?	☐	☐
Kidney Disease	☐	☐
Is your child on dialysis?	☐	☐
Liver Condition	☐	☐
Genetic Conditions, i.e. Down Syndrome	☐	☐
What is/are the conditions(s)?	☐	☐
Growth / Developmental Delays	☐	☐
Birth Defects	☐	☐
What is/are the conditions(s)?	☐	☐
Underweight / Failure to Thrive	☐	☐
Hearing Problems	☐	☐
Vision Problems	☐	☐
Speech Problems	☐	☐
Migraines / Headaches	☐	☐
Poisoning	☐	☐
Other	☐	☐
What is/are the conditions(s)?	☐	☐
	☐	☐

15. Does your child need a specialist to provide care for any of these conditions?
    - ☐ Yes
      - ☐ Which condition(s) ________________________________
    - ☐ No – my child already has provider(s) for all his/her needs
      - ☐ Name/Specialty ________________________________
      - ☐ Name/Specialty ________________________________
      - ☐ Name/Specialty ________________________________
    - ☐ No – my child does not need a specialist for his/her condition

16. Who are your child's medical providers?
    - ◊ Primary Care Provider (PCP) in your community
      - ☐ Do not have one
    - ☐ Provider Name: ________________________________
    - ☐ Provider Phone: ________________________________
    - ☐ Last Appointment: Date:________________________________
    - ☐ Next Appointment: Date:________________________________

- ◊ Specialty Care Center
  - ☐ N/A
  - ☐ Facility Name: ________________________________
  - ☐ Facility Phone: ________________________________
  - ☐ Last Appointment: Date:____________________________
  - ☐ Next Appointment: Date:____________________________
- ◊ Regular Dental Care
  - ☐ Do not have one
  - ☐ Provider Name: ________________________________
  - ☐ Provider Phone: ________________________________
  - ☐ Last Appointment: Date:____________________________
- ◊ Regular Vision Care
  - ☐ Do not have one
  - ☐ Provider Name: ________________________________
  - ☐ Provider Phone: ________________________________
  - ☐ Last Appointment: Date:____________________________
- ◊ Ongoing care from Mental or Behavioral Health Specialist
  - ☐ N/A
  - ☐ Provider Name: ________________________________
  - ☐ Provider Phone: ________________________________
  - ☐ Condition(s) being treated for:

    ____

☐ My child does not get regular care from any provider

- ◊ Do you need help choosing a provider for your child?

  ☐ Yes ☐ No ☐ Don't know

17. Have your child's medical conditions caused him/her to miss activities, work, or school in the past year? If yes, please describe:

    ____

    ____

    ____

18. What is the best time of day (Monday to Friday, 7:30 a.m. to 5:30 p.m.) to call you to discuss your child's needs in more detail?

    ____

Signature of Person
Filling Out the Form: ____________________________________ Date:______________

Thank you for your time filling out this form.

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MPXG5003</td><td colspan="2">Lead Department: Health Services
Business Unit: Quality Improvement</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Major Depression in Adults Clinical Practice Guidelines</td><td colspan="2">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 04/19/2000</td><td colspan="3">Next Review Date: ~~: 06/11/2026~~06/09/2027
Last Review Date: ~~06/11/2025~~06/10/2026</td></tr>
<tr><td>Applies to:</td><td>☐ Employees</td><td>☒ Medi-Cal</td><td colspan="2">☒ Partnership Advantage</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td>☒ IQI</td><td>☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
<tr><td>☐ OPERATIONS</td><td>☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td>☐ BOARD</td><td>☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO ☐ COO</td><td>☐ CREDENTIALS</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="2">Approval Date: ~~06/11/2025~~06/10/2026</td></tr>
</table>

I. RELATED POLICIES:

A. MPCP2017 – Scope of Primary Care – Behavioral Health and Indication for Referral Guidelines

II. IMPACTED DEPTS:

A. Health Services

B. Provider Relations

III. DEFINITIONS:

A. N/A

IV. ATTACHMENTS:

A. Clinical Decision Flow Chart

V. PURPOSE:

To define the appropriate diagnostic criteria and therapy for patients with major depression.

This guideline is meant to be a basic guideline, not an enforceable standard, and is intended to assist the primary care professional in caring for Partnership HealthPlan of California (Partnership) adult members with major depression. Recommendations are not intended to replace sound clinical judgment in caring for individual patients.

VI. POLICY / PROCEDURE:

A. Overview

Nationally accepted clinical practice guidelines for depression are created and updated regularly. Pharmacologic choices for depression also continually change as new products enter the market. For these reasons, and upon the recommendation of Partnership's Physician Advisory Committee, this clinical practice guideline (CPG) will be annually updated with the appropriate internet references, which will provide timely guidelines for the management of major depression in adults.

VII. REFERENCES:

A. From the American Psychiatric Association: Practice Guideline for the Treatment of Patients with Major Depressive Disorder (2010) https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/mdd.pdf

B. From the American Psychological Association: APA Clinical Practice Guideline for the Treatment of Depression Across Three Age Cohorts (February 2019) https://www.apa.org/depression-guideline/guideline.pdf

C. From the US Preventive Services Task Force (USPSTF) Final Recommendation Statement (June 20, 2023) Depression and Suicide Risk in Adults: Screening: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/screening-depression-suicide-risk-adults
D. National Institute of Mental Health: Sequenced Treatment Alternatives to Relieve Depression (STAR*D) Study (2006): https://www.nimh.nih.gov/funding/clinical-research/practical/stard
E. U.S. Department of Veterans Affairs. VA/DoD Clinical Practice Guideline: Assessment and Management of Patients at Risk for Suicide (2024): https://www.healthquality.va.gov/guidelines/mh/srb/index.asp
F. VA/DoD Clinical Practice Guidelines: Management of Major Depressive Disorder (2022) https://www.healthquality.va.gov/guidelines/MH/mdd/VADoDMDDCPGFinal508.pdf
G. Qaseem A, et al. Nonpharmacologic and Pharmacologic Treatments of Adults in the Acute Phase of Major Depressive Disorder: A Living Clinical Guideline From the American College of Physicians. Ann Intern Med. 2023 Feb. 176 (2):239-252. https://www.acpjournals.org/doi/10.7326/M22-2056~~https://www.healthquality.va.gov/guidelines/MH/mdd/VADoDMDDCPGFinal508.pdf~~

VIII. DISTRIBUTION:

A. Partnership Provider Manual
B. Partnership Department Directors

VIII. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Medical Officer

IX. REVISION DATES:

Medi-Cal

09/18/02; 10/20/04; 11/15/06; 05/18/11; 06/19/13; 7/27/15; 08/19/15; 08/19/16; 11/15/17; *10/10/18; 11/13/19; 11/11/20; 04/14/21; 06/08/22; 06/14/23; 06/12/24; -10/09/24; 06/11/25; 06/10/26

Partnership Advantage (effective Jan. 1, 202~~7~~8)

N/A

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

IX. PREVIOUSLY APPLIED TO:

Healthy Families

05/18/11

Partnership*Advantage*

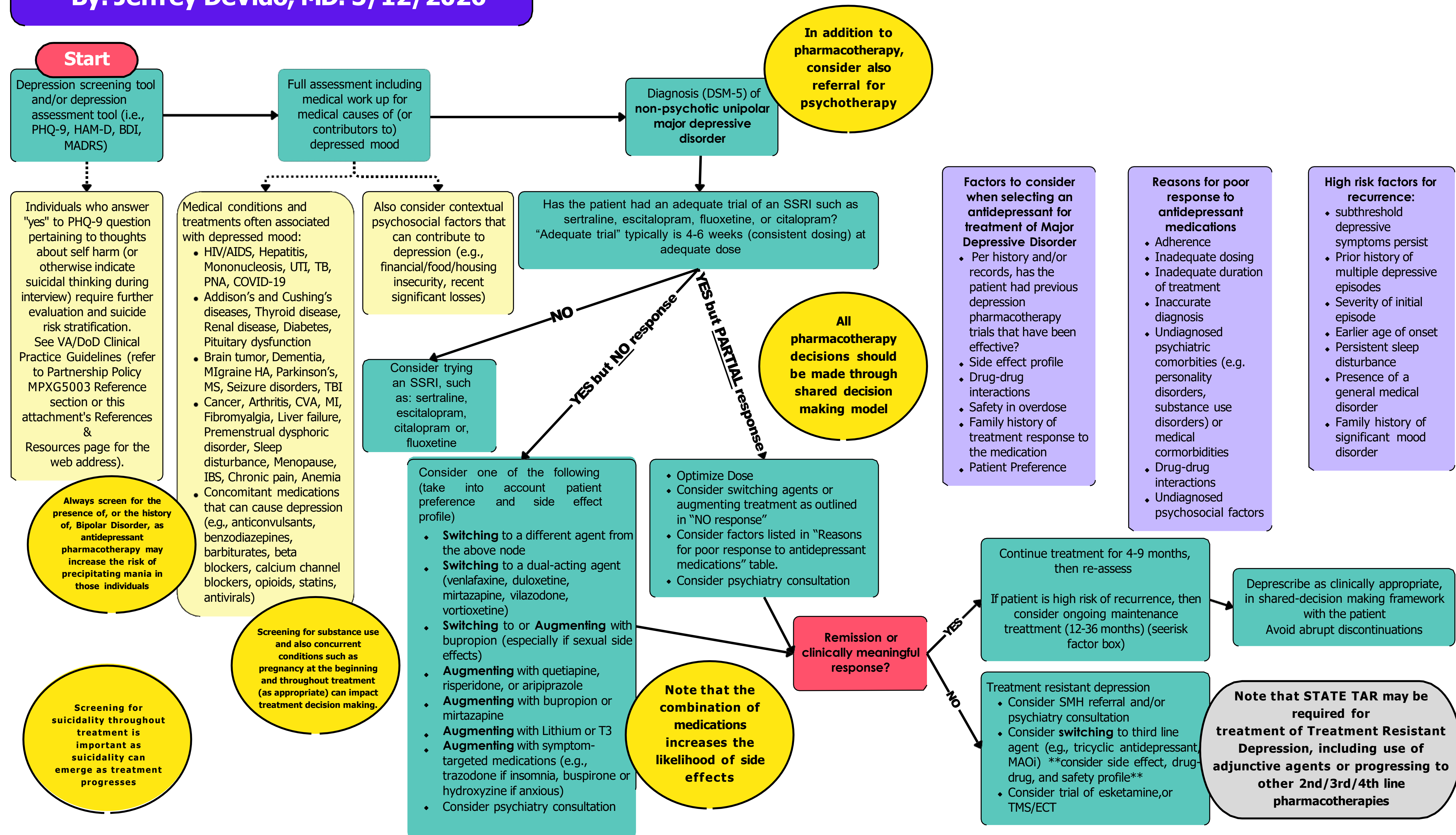
11/15/06; 05/18/11

Healthy Kids

11/15/06; 05/18/11; 08/19/15, 08/19/16 (Healthy Kids Program ended 12/01/2016)

Adult Depression Treatment Flow Diagram
(MPXG5003 Policy Attachment A)
By: Jeffrey DeVido, MD: 5/12/2026

PROVIDERS PLEASE NOTE:
Medi-Cal mental health treatment services are divided between county specialty mental health (SMH) and managed care plan non-specialty mental health (NSMH) programs. The differentiation is based on clinical severity, with higher severity patients being preferentially routed to SMH systems of care.



This algorithm is drawn from several sources listed below. This algorithm is not intended to be comprehensive or definitive; rather, it aims to provide one possible approach to depression pharmacotherapy that could be considered in primary care practice settings.

- Osser, DN (ed). Psychopharmacology Algorithms: Clinical Guidance from the Psychopharmacology Algorithm Project at the Harvard South Shore Psychiatry Residency Program. Wolters Kluwer, New York, 2021.
- Schatzberg, AF and Nemeroff CB (eds). The American Psychiatric Association Publishing Textbook of Psychopharmacology, 5th Ed. APA Publishing, Arlington, VA, 2017.
- Qaseem A, et al. Nonpharmacologic and Pharmacologic Treatments of Adults in the Acute Phase of Major Depressive Disorder: A Living Clinical Guideline From the American College of Physicians. Ann Intern Med. 2023 Feb. 176 (2):239-252.

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

Policy/Procedure Number: MPUP3136 (previously MCUP3136)			**Lead Department: Health Services** **Business Unit:** Utilization Management	
Policy/Procedure Title: ~~Fecal Microbiota Transplant (FMT)~~ Microbiota-Based Therapeutics (MBT)			☒**External Policy** ☐ **Internal Policy**	
Original Date: 05/17/2017		**Next Review Date:** ~~06/11/2026~~06/10/2027 **Last Review Date:** ~~06/11/2025~~06/10/2026		
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**	
Reviewing Entities:	☒ **IQI**	☐ **P & T**	☒ **QUAC**	
	☐ **OPERATIONS**	☐ **EXECUTIVE**	☐ **COMPLIANCE**	☐ **DEPARTMENT**
Approving Entities:	☐ **BOARD**	☐ **COMPLIANCE**	☐ **FINANCE**	☒ **PAC**
	☐ **CEO** ☐ **COO**	☐ **CREDENTIALS**	☐ **DEPT. DIRECTOR/OFFICER**	
Approval Signature: *Robert Moore, MD, MPH, MBA*			**Approval Date:** ~~06/11/2025~~06/10/2026	

I. RELATED POLICIES:

A. MCUP3041 —Treatment Authorization Review (TAR) Review Process
B. MP~~C~~UP30~~1~~42 —Technology Assessment
~~B.~~C. MCRP4068 Medical Benefit Medication TAR Policy

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

~~Fecal microbiota transplantation (FMT) – the transfer of a processed stool specimen from a healthy donor to a diseased recipient for the purpose of restoring a normal population of bacteria to the colon of the recipient. Also known as fecal biotherapy, fecal bacteriotherapy, stool or fecal transplant, fecal transfusion, fecal enema and human probiotic infusion.~~ Microbiota-Based Therapeutics (MBT) (including Fecal Microbiota Transplantation or [FMT]) – The transfer of a prepared microbial community, either derived from the processed stool of a healthy donor or synthesized from defined, lab-grown microbial consortia, to a recipient. The purpose of this therapy is to restore a healthy and diverse microbial ecosystem to the recipient's gastrointestinal tract. This procedure is also known as fecal biotherapy, fecal bacteriotherapy, stool or fecal transplant, fecal transfusion, fecal enema and human probiotic infusion.

A.
B. *Clostridioides* (formerly *Clostridium*) *difficile* infection (CDI) - confirmed stool test positive for toxigenic *C. difficile* and patient currently has symptoms of watery diarrhea.
C. Non-severe CDI – CDI with documented White Blood Cell Count ≤15,000 cells/ml and serum creatinine <1.5 mg/dL. [E]
D. Severe CDI - CDI with WBC >15,000 cells/mL and/or serum creatinine ≥1.5 mg/dL. [E]
E. Complicated/fulminant CDI – CDI associated with hypotension or shock, ileus or megacolon. [E]
F. Recurrent or relapsing CDI (RCDI) – a second or greater episode of documented CDI.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

The purpose of the ~~F~~MBT policy is to assist Utilization Management (UM) staff with decision making when reviewing Treatment Authorization Requests (TARs) for ~~FMT~~ MBT to treat confirmed recurrent CDI that has failed standard CDI treatment.

VI. POLICY / PROCEDURE:

A. A Treatment Authorization Request (TAR) is required for all ~~FMT~~ MBT procedures.

B. Partnership HealthPlan of California (Partnership) considers ~~FMT~~ MBT medically indicated in cases of recurrent CDI as follows:

1. Eligibility Criteria:
   a. Member must be 18 years of age or older.
   b. Documentation of current symptomatic recurrent CDI.
   c. Documentation of at least a moderate **second or more** episode of RCDI (as defined above) which is a third episode or more of CDI, unresponsive to standard AND alternate treatments.
      1) ~~FMT~~ MBT is no longer recommended as first line treatment for fulminant CDI.[E]
   d. Patient is not immunocompromised (including neutropenia).
   e. Severe or fulminant CDI in the hospital and the patient is not improving after completing standard antimicrobial therapy for CDI.
   f. All other uses of MBT~~FMT~~ are considered experimental or investigational, including first line treatment of CDI and the treatment of inflammatory bowel disease.
2. Methodology
   a. MBT~~FMT~~ is limited to centers of expertise.
   b. ~~FMT~~ MBT may be administered by colonoscopy, nasogastric or jejunal tube, enema, or oral route, as available from the provider performing the procedure.
   c. The provider performing the ~~FMT~~ MBT and facility providing the transplant materials must comply with the U.S. Food and Drug Administration's regulations regarding MBT~~FMT~~[A].

VII. REFERENCES:

A. U.S. FDA Vaccines, Blood and Biologics Bulletin- Guidance for Industry: Enforcement Policy Regarding Investigational New Drug Requirements for Use of Fecal Microbiota for Transplantation to Treat *Clostridium difficile* Infection Not Responsive to Standard Therapies November 2022

B. ~~TJ Borody, MD~~Ramrakha S, Agrawal G~~ et al~~. Fecal microbiota transplantation for treatment of *Clostridioides difficile* infection; UpToDate. ~~Accessed~~ Last updated ~~03/21/2025~~04/09/2026.~~04/12/2024~~

C. Moore T, Rodriguez A, Bakken J~~et al~~. Fecal Microbiota Transplantation: A Practical Update for the Infectious Disease Specialist; Clin Infect Dis ~~(~~2014 Feb 15;~~)~~ 58 (4) 541-545; doi.org/10.1093/CID/cit950~~. Accessed March 24, 2017~~

D. Cho, Janice M. *et al*. Update on Treatment of *Clostridioides difficile* Infection; Mayo Clin Proc. April 2020; 95(4): 758-769. https://www.mayoclinicproceedings.org/ ~~Accessed March 23, 2021.~~

E. Johnson, Stuart et al. Clinical Practice Guideline by the Infectious Diseases Society of America (IDSA) and Society for Healthcare Epidemiology of America (SHEA): 2021 Focused Update Guidelines on Management of *Clostridioides difficile* Infection in Adults *Clinical Infectious Diseases*, Volume 73, Issue 5, 1 September 2021, Pages e1029–e1044, https://doi.org/10.1093/cid/ciab549~~ Accessed March 30, 2022.~~

F. Consideration for Use of Fecal Microbiota-Based Therapies in Adults With GI Disorders. Gastroenterology, Volume 166, Issue 3, p.435. March 2024. DOI: 10.1053/S0016-5085(24)00075-1

G. Shapiro, M. (2024, February 21). AGA now recommends fecal microbiota transplant for the majority of recurrent C. diff patients. American Gastroenterological Association. https://gastro.org/press-releases/aga-recommends-fecal-transplant-for-recurrent-cdiff-patients/

VIII. DISTRIBUTION:

A. Partnership Provider Manual
B. Partnership Department Directors

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

X. REVISION DATES:

Partnership Advantage (Program effective January 1, 2028)
06/11/25; 6/10/26

Medi-Cal
*06/13/18; 06/12/19; 06/10/20; 06/09/21; 06/08/22; 06/14/23; 06/12/24; (MPUP3136) 06/11/25; 6/10/26

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

PREVIOUSLY APPLIED TO:
N/A

****

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

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

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

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

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

<table>
<tr><td colspan="4">Policy/Procedure Number: MCUP3104</td><td colspan="2">Lead Department: Health Services
Business Unit: Utilization Management</td></tr>
<tr><td colspan="4">Policy/Procedure Title: Transplant Authorization Process</td><td colspan="2">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 04/21/2010</td><td colspan="3">Next Review Date: ~~02/11/2027~~06/10/2027
Last Review Date: ~~02/11/2026~~06/10/2026</td></tr>
<tr><td>Applies to:</td><td colspan="2">☐ Employees</td><td></td><td colspan="2">☒ Medi-Cal</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td>☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td>☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALS</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="4">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="2">Approval Date: ~~02/11/2026~~06/10/2026</td></tr>
</table>

I. RELATED POLICIES:

A. MCUP3124 – Referral to Specialists (RAF) Policy
B. MCUP3041 – Treatment Authorization Request (TAR) Review Process
C. MPUP3137 – Palliative Care: Intensive Program (Adult)
D. MCUP3140 – Palliative Care: Pediatric Program for Members Under the Age of 21
E. MPUP3039 – Direct Members
F. MP~~C~~UP3138 – External Independent Medical Review
G. MCCP2024 – Whole Child Model for California Children's Services (CCS)
H. ~~MCCP2016~~ MPTP2501 – Transportation Policy for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT)
I. MPTP2503 –Transportation-Related Travel Expenses: Lodging, Meals, Attendants, Parking and Tolls
J. MPCR700 – Assessment of Organizational Providers
K. MPPR200 – Provider Contracts

II. IMPACTED DEPTS:

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

III. DEFINITIONS:

A. Center of Excellence (COE): A Medi-Cal-approved transplant program which operates within a hospital setting, is certified and licensed through the Centers for Medicare and Medicaid Services (CMS), and meets Medi-Cal state and federal regulations consistent with 42 CFR, parts 405, 482, 488, 498 and Section 1138 of the Social Security Act (SSA) [42 USC section 1230b-8].
B. Direct Member: Direct Members are those whose service needs are such that Primary Care Provider (PCP) assignment would be inappropriate. Assignment to Direct Member status is based on the Member's aid code, prime insurance, demographics or administrative approval based on qualified circumstances. A Referral Authorization Form (RAF) is not required for Direct Members to see Partnership network providers and/or certified Medi-Cal providers willing to bill Partnership for covered services. However, many specialists will still request a RAF from the PCP to communicate background patient information to the specialist and to maintain good communication with the PCP.
C. Organ Procurement and Transplantation Network (OPTN): The OPTN is operated under contract with the Health Resources & Services Administration (HRSA) of the U.S. Department of Health and Human

Services by the United Network for Organ Sharing (UNOS). OPTN maintains the National Waitlist but only a Transplant Program can register patients on the National Wait list or remove them from the list.

D. Transplant Program: A unit within a hospital that has received approval from CMS to perform transplants for a specific type of organ and is a current beneficiary of the Organ Procurement and Transplantation Network (OPTN), which is administered by the United Network for Organ Sharing (UNOS).

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

A. The purpose of this policy is to describe the Partnership HealthPlan of California treatment authorization process for medically necessary Organ and Bone Marrow Ttransplant (OBMT)s procedures including the following:
   1. Bone Marrow (stem cell)*
   2. Heart*
   3. Lung*
   4. Heart/lung*
   5. Liver*
   6. Combined liver/kidney*
   7. Simultaneous Pancreas/Kidney (SPK)*
   8. Pancreas After Kidney (PAK)*
   9. Small Bowel (Intestinal) Transplant*
   10. Combined liver/small bowel(intestinal)*
   11. Kidney+
   12. Corneal transplant+
   13. Autologous islet cell+
   14. Chimeric Antigen Receptor T-Cell (CAR T-cell) therapy

   * These transplants can only be approved when performed by a Medi-Cal approved Center of Excellence (COE) as defined in III.A.

   + Programs that perform corneal, autologous islet cell or kidney transplants are not required to be a Medi-Cal approved COE.

VI. POLICY / PROCEDURE:

A. Partnership authorizes, refers, and coordinates the delivery of the Medi-Cal Major Organ and Bone Marrow Transplant (MOBMT) benefit and all medically necessary services associated with MOBMTs, including, but not limited to, pre-transplantation assessments and appointments, organ procurement costs, hospitalization, surgery, discharge planning, readmissions from complications, post-operative services, medications[1], and care coordination for transplants. All medically necessary adult and pediatric major organ transplants are covered as outlined in the Medi-Cal Provider Manual, including all updates and amendments to the Provider Manual. The Transplant section of the Medi-Cal Provider Manual is available at: https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/8B313A4A-3B84-49DB-B98B-6A51BECCF01C/transplant.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO.
   1. Transplants will only be authorized to be performed in an approved transplant program located within a hospital that meets the Department of Health Care Services' (DHCS) criteria.

[1] As per APL 25-013, the pharmacy (prescription) benefit was carved-out to State Medi-Cal as of January 1, 2022. Please refer to the State Medi-Cal Rx webpage: https://medi-calrx.dhcs.ca.gov/home/cdl/.

2. As noted in V.A. above, certain transplants are only covered when performed by Medi-Cal approved Centers of Excellence (COE).
3. Bone marrow transplant programs must have current accreditation by the Foundation for the Accreditation of Cellular Therapy.
4. Major organ transplants for pediatric beneficiaries are required to be performed only in a Special Care Center (SCC) as approved by California Children's Services (CCS). A directory of SCCs can be found here: https://www.dhcs.ca.gov/services/ccs/scc/Pages/SCCType.aspx
5. Total pancreatectomy with autologous islet cell transplantation (TPIAT) is reimbursable by Medi-Cal when the patient has chronic pancreatitis or relapsing acute pancreatitis and meets medical necessity criteria as stated in the Transplants section of the Medi-Cal Provider Manual.
6. Kidney transplants must be performed by transplant programs approved by the Centers for Medicare & Medicaid (CMS) and the program must have current membership in the Organ Procurement and Transplantation Network (OPTN). Patients must meet medical necessity criteria as stated in the Transplants section of the Medi-Cal Provider Manual.
7. CAR T-cell therapy must meet drug-specific requirements. For more information, refer to Medi-Cal Provider Manual Guidelines for chemotherapy drugs as Referenced in VII.F.- P. below.
   a. While all CAR T-cell therapies previously had mandated Risk Evaluation and Mitigation Strategy (REMS) requirements, the U.S. Food and Drug Administration (FDA) announced on June 26, 2025 that the approved REMS for the following products should be eliminated because a REMS is no longer necessary to ensure that the benefits of the autologous CAR T-cell immunotherapies outweigh their risks.
      1) Abecma (idecabtagene vicleucel)
      2) Breyanzi (lisocabtagene maraleucel)
      3) Carvykti (ciltacabtagene autoleucel)
      4) Kymriah (tisagenlecleucel)
      5) Tecartus (brexucabtagene autoleucel)
      6) Yescarta (axicabtagene ciloleucel)

B. Members Age 21 and Over
   1. When a Member is identified as a potential candidate for a transplant, the Member should be referred to a Partnership-contracted Medi-Cal approved Transplant Center for evaluation as described in VI.A. Consistent with Partnership policy MCUP3124 Referral to Specialists (RAF) Policy, referrals to contracted specialists are auto-adjudicated and written approval is generated to the requesting primary care provider (PCP) and the specialist within one working day of the receipt of the request (not to exceed 72 hours).
   2. Members remain assigned to their primary care provider (PCP) during the evaluation process.
   3. Upon completion of the evaluation, if the Transplant Center Team confirms the Member is appropriate for transplant, the transplant program is responsible for placing the beneficiary on the National Waitlist maintained by The Organ Procurement and Transplantation Network OPTN. A Treatment Authorization Request (TAR) must then be submitted to Partnership. The request may be submitted electronically through Partnership's Oonline ServicesProvider (OLS) pPortal, or by fax to 707-863-4118. The complete medical record, including the MMember's medical and treatment history (including, starting in January 2020, either a palliative care consultation or equivalent documentation of discussion of options, prognosis, goals of care, and completion of advance care planning documents), pertinent lab studies, current condition and treatment, and requested procedure, must accompany the TAR.
   4. Partnership will review the transplant request for medical necessity using the most up-to-date InterQual® criteria and DHCS medical and procedural guidelines. Transplant requests are reviewed by Partnership's Chief Medical Officer (CMO) or Physician designee and may be sent for external independent medical review as appropriate. Initial denial determinations will have a second review

by the CMO (or designees Deputy Chief Medical Officer or supervising Medical Director if CMO is unavailable) in accordance with Section IV.1. of Attachment 2 of APL 21-015.

5. Once the TAR is approved, the Member, physician and facility are notified in writing.
6. When the TAR for a transplant is approved, Partnership assigns the Member to a Direct Member status, Health Plan 5 (H5), to ensure continuity of care. Re-evaluation of the continued need for Direct Member status will be reviewed at the end of 12 months or as follows:
   a. Heart transplant recipients are granted H5 Direct Member status for plan lifetime.
   b. Bone Marrow transplant Members (including CAR T-cell therapy and gene therapy) become eligible for assignment to a PCP two years after receiving the transplant, but may qualify for continued Direct Member H5 status based on continuity of care criteria as detailed in policy MPUP3039 Direct Members.

C. Members Under Age 21
1. For members under age 21, the procedures noted in sections VI.B.1 through VI.B.4 remain the same. However, these members will also be evaluated for eligibility under the California Children's Services (CCS) program (see VI.C.3 for additional authorization criteria).
2. If the Member has not already been determined eligible under the CCS program, Partnership will work with the member's physician, parents/legal guardians and refer the case to the designated County CCS office for a financial and residential eligibility determination.
3. If the Member is determined eligible for CCS, Partnership will review the transplant request for medical necessity using a combination of the most up-to-date InterQual® criteria as well as the medical and procedural guidelines as directed in the DHCS "Numbered Letters" for CCS (some of which have not been updated for current standards of medical care). Medical Directors may obtain outside expert advice for complex cases or those where the Numbered Letters seem to conflict with current standards of care.
4. Members under age 21 with coverage under CCS are assigned to a Partnership Direct Member status called "Whole Child Model" (WCM) and will remain in that status until they reach their 21st birthday, as long as they retain residential, financial and medical eligibility with CCS. This status allows for direct referral to a specialist, without being subject to Partnership's Referral Authorization Form (RAF) process. (See policy MCCP2024 Whole Child Model for California Children's Services and MPUP3039 Direct Members).
5. Partnership will provide ongoing case management services and continue to coordinate care and transition of services for these members regardless of age, for as long as they remain eligible for coverage under Partnership. In the event that a WCM Member moves outside of Partnership's services area, Partnership will collaborate with the receiving county CCS staff to facilitate continuity of care.

D. Donors
1. Per DHCS policy, Partnership will cover designated donor related hospital services associated with the transplant, including organ procurement for cadaver organ transplants or living donor care and related transportation expenses, if not covered by other insurance. (see also policy MPTP2501Transportation Policy for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT) as well as policy MPTP2503 Transportation-Related Travel Expenses: Lodging, Meals, Attendants, Parking and Tolls).

VII. REFERENCES:

A. In compliance with the California Department of Health Care Services (DHCS) contract
B. In compliance with DHCS "Numbered Letters" for California Children's Services (CCS)
C. InterQual® Criteria
D. Medi-Cal Provider Manual/ Guidelines: Transplants
E. Medi-Cal Provider Manual/ Guidelines: Surgery: Eye and Ocular Adnexa

F. Medi-Cal Provider Manual/ Guidelines: Chemotherapy: Drugs A Policy
G. Medi-Cal Provider Manual/ Guidelines: Chemotherapy: Drugs B Policy
H. Medi-Cal Provider Manual/ Guidelines: Chemotherapy: Drugs C Policy
I. Medi-Cal Provider Manual/ Guidelines: Chemotherapy: Drugs D Policy
J. Medi-Cal Provider Manual/ Guidelines: Chemotherapy: Drugs E-H Policy
K. Medi-Cal Provider Manual/ Guidelines: Chemotherapy: Drugs I-L Policy
L. Medi-Cal Provider Manual/ Guidelines: Chemotherapy: Drugs M Policy
M. Medi-Cal Provider Manual/ Guidelines: Chemotherapy: Drugs N-O Policy
N. Medi-Cal Provider Manual/ Guidelines: Chemotherapy: Drugs P-Q Policy
O. Medi-Cal Provider Manual/ Guidelines: Chemotherapy: Drugs R-S Policy
P. Medi-Cal Provider Manual/ Guidelines: Chemotherapy: Drugs T-Z Policy
Q. Title 42 Code of Federal Regulations (CFR) parts 405 *Federal Health Insurance for the Aged and Disabled*;, 482 *Conditions of Participation for Hospitals*;, 488 *Survey, Certification, and Enforcement Procedures*; 498 *Appeals Procedures for Determinations that Affect Participation in the Medicare Program and for Determinations that Affect the Participation of ICFs/IID and Certain NFs in the Medicaid Program*
R. Section 1138 of the Social Security Act (42 U.S.C. 1320b–8)(SSA): *Hospital Protocols for Organ Procurement and Standards for Organ Procurement Agencies*.
S. DHCS APL 21-015 Benefit Standardization and Mandatory Managed Care Enrollment Provisions of the California Advancing and Innovating Medi-Cal Initiative (10/18/2021) Attachment 2 Major Organ Transplant Requirements. (*Revised* 10/14/2022)
T. DHCS APL 25-013 Medi-Cal Rx Pharmacy Benefits, and Cell and Gene Therapy Coverage (09/18/2025)
U. DHCS APL 22-008 Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses (05/18/2022)
V. FDA Safety Communication: FDA Eliminates Risk Evaluation and Mitigation Strategies (REMS) for Autologous Chimeric Antigen Receptor (CAR) T cell Immunotherapies. June 26, 2025

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

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

X. REVISION DATES:

01/18/12; 02/18/15; 02/17/16; 02/15/17; *03/14/18; 09/11/19; 09/09/20; 02/10/21; 02/09/22; 02/08/23: 02/14/24; 02/12/25; 02/11/26; 06/10/26

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

PREVIOUSLY APPLIED TO:
N/A

****

In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with

involvement from actively practicing health care providers and meets these provisions:

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

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

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

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

Policy/Procedure Number: MPUP3047 (previously MCUP3047, UP100347)			**Lead Department:** Health Services **Business Unit:** Utilization Management	
Policy/Procedure Title: Tuberculosis Related Treatment			☒**External Policy** ☐ **Internal Policy**	
Original Date: 07/31/2000		**Next Review Date:** **Last Review Date:**	~~06/11/2026~~06/10/2027 ~~06/11/2025~~06/10/2026	
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**	
Reviewing Entities:	☒ **IQI**	☐ **P & T**	☒ **QUAC**	
	☐ **OPERATIONS**	☐ **EXECUTIVE**	☐ **COMPLIANCE**	☐ **DEPARTMENT**
Approving Entities:	☐ **BOARD**	☐ **COMPLIANCE**	☐ **FINANCE**	☒ **PAC**
	☐ **CEO** ☐ **COO**	☐ **CREDENTIALS**	☐ **DEPT. DIRECTOR/OFFICER**	
Approval Signature: *Robert Moore, MD, MPH, MBA*			**Approval Date:** ~~06/11/2025~~06/10/2026	

I. RELATED POLICIES:

A. MPQG1005 – Adult Preventive Health Guidelines
B. MCQG1015 – Pediatric Preventive Health Guidelines
C. MPQP1048 – Reporting Communicable Diseases
D. MCCP2035 – Local Health Department (LHD) Coordination

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

A. DOT: Directly Observed Therapy or the Direct Observation of the ingestion of prescribed anti-Tuberculosis medications by tuberculosis (TB) infected persons. DOT includes:
   1. Delivering of prescribed medications
   2. Assisting with the means to ingest prescribed medications
   3. Observing the ingestion of prescribed medications
   4. Monitoring for signs of non-adherence or adverse side effects
   5. Documenting that prescribed medications have been ingested and
   6. Reporting compliance and/or other problems

B. Partnership Advantage: Effective January 1, 2028~~7~~, Partnership HealthPlan of California will operate a Centers for Medicare & Medicaid Services (CMS)-approved Dual-Eligible Special Needs Plan (D-SNP) in specific counties as described in the Department of Health Care Services (DHCS) CalAIM Dual Eligible Special Needs Plan Policy Guide. This line of business will be known as Partnership Advantage and will be a Medicare Advantage plan offered to all full-benefit, dual-eligible beneficiaries 21 years of age or older who reside in the applicable counties. Partnership Advantage ~~Members~~ enrollees will be qualified to receive both Medi-Cal and Medicare services as described in the Partnership Advantage Member Handbook.

C. Tuberculosis (TB) related treatment means all outpatient services necessary for the medical management and follow-up of TB infection and/or active disease. This may include medical therapy, Targeted Case Management (as defined in Title 22, CCR, Section 51276) and DOT when provided by a provider meeting the qualifications (as defined in section 51276.)

IV. ATTACHMENTS:

A. TB Screening Guidelines (Flowcharts)

V. PURPOSE:

To define the roles of Partnership HealthPlan of California (Partnership) in providing TB Control and DOT for Medi-Cal and Partnership Advantage beneficiaries.

VI. POLICY / PROCEDURE:

A. Program Guidelines:
   1. Partnership covers the screening, diagnosis, and follow-up care related to tuberculosis.
      a. Partnership Medi-Cal: Effective January 1, 2022 with the implementation of Medi-Cal Rx, the pharmacy benefit is carved-out to Medi-Cal Fee-For-Service as described in All Plan Letter (APL) ~~22-012~~23-015 ~~*Revised*~~ and all medications (Rx and OTC) which are provided by a pharmacy must be billed to the State Medi-Cal/ DHCS-contracted pharmacy administrator instead of Partnership. This includes medications used for the treatment of tuberculosis.
      b. Partnership Advantage: Effective January 1, 2028~~7~~, the pharmacy benefit for Partnership Advantage ~~Members~~ enrollees is delegated to a pharmacy benefit manager that will provide medications used for the treatment of tuberculosis.
   2. Partnership will reference the current guidelines from the Center for Disease Control and Prevention (CDC), and the American Thoracic Society (ATS). For TB screening, Partnership network providers will use guidelines from the American Academy of Pediatrics (AAP) for persons age 0-20 years and from the United States Preventative Services Taskforce (USPSTF) for adults age 21 or over. The California Department of Public Health (CDPH) TB Risk Assessment Tools should be used to identify adult and pediatric patients at risk for TB.
   3. Partnership network providers use laboratories that conform to Title 17, CCR, Section 2505 and CDC and ATS requirements.
   4. Partnership Providers shall report all cases of confirmed or suspected active tuberculosis (TB) to the local county health department (LHD) within one day of identification in accordance with Title 17, CCR, Section 2500.

B. Directly Observed Therapy (DOT)
   1. Per the California Department of Public Health (CDPH), Directly Observed Therapy (DOT) is a technique of delivering TB treatment to ensure timely completion of treatment, prevent further TB transmission, and prevent development of drug resistance.
   2. National guidelines recommend DOT as standard treatment for TB disease.
   3. In the event of limited available DOT resources, CDPH provides guidance on groups to be considered for DOT prioritization in their document titled, "Information for Physicians Regarding Directly Observed Therapy (DOT) for Active Tuberculosis (TB)."
   ~~1. Partnership Providers shall refer members with active tuberculosis (TB) to the local health department for DOT if the Member has any of the following risk categories:~~
      ~~a. Member with demonstrated multidrug-resistant tuberculosis (MDR-TB)~~
      ~~b. Member whose treatment has failed or who has relapsed after completing a prior regimen~~
      ~~c. Member is a child or adolescent~~
      ~~d. Member has demonstrated failed adherence/failure to keep appointments~~
   ~~2. Members in the following categories shall be referred if, in the opinion of the providers, the Member is at risk for non-adherence:~~
      ~~a. Substance users~~
      ~~b. Members with mental illness~~
      ~~c. Elderly members~~
      ~~d. Child and adolescent members~~
      ~~e. Members with unmet housing needs~~

~~f. Members with complex medical needs (e.g. end-stage renal disease, diabetes mellitus)~~
~~g. Members with language and/or cultural barriers~~
~~h. Members who have demonstrated any other reason to suspect non-adherence~~

~~3.~~4. In addition, Partnership Providers are expected to follow any local county health department regulations and instructions regarding the treatment of identified or suspected cases of active tuberculosis not covered by the above language.

~~4.~~5. Since DOT services are provided outside of Partnership's contract with the California Department of Health Care Services (DHCS), a Partnership Referral Authorization Form (RAF) is NOT required, and services will be reimbursed directly by the State of California.

~~5.~~6. The Local Health Department TB Control Program for DOT shall inform the HealthPlan of any changes to policy or of providers failing to refer members needing services.

~~6.~~7. Partnership maintains Memoranda of Understanding (MOUs) with each county it serves to ensure joint case management and care coordination with LHD TB Control Programs. Partnership provides all medically necessary covered services to members with TB on DOT.

VII. REFERENCES:

A. Center for Disease Control (CDC) guidelines https://www.cdc.gov/tb
B. Center for Disease Control (CDC) "TB 101for Health Care Workers https://www.cdc.gov/tb/webcourses/TB101/page16489.html
C. American Thoracic Society (ATS) guidelines https://www.thoracic.org/statements/tuberculosis-pneumonia.php
D. American Academy of Pediatrics (AAP) guidelines https://www.aap.org/
E. United States Preventative Services Taskforce (USPSTF) guidelines https://www.uspreventiveservicestaskforce.org/uspstf/
F. Medi-Cal Provider Manual/ Guidelines: Tuberculosis Program (*tuber*)
~~G.~~ Title 17, California Code of Regulations (CCR) Section 2500 and
~~H.~~G. ~~Title 17, California Code of Regulations (CCR)~~ Section 2505
~~I.~~H. Title 22, California Code of Regulations (CCR) Section 51276
~~J.~~I. DHCS All Plan Letter (APL) ~~22-012~~25-013 *Revised* ~~Governor's Executive Order N-01-19 Regarding Transitioning~~ Medi-Cal Rx Pharmacy Benefits and Cell and Gene Therapy Coverage ~~From Managed Care to Medi-Cal Rx~~ (~~12/30/2022~~09/18/2025)
~~K.~~J. DHCS All Plan Letter (APL) 23-029 *Revised* Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans and Third-Party Entities (~~10/11/2023~~08/11/2)
   1. Local Health Department Memorandum of Understanding template (DHCS Contract Attachment F)
~~L.~~K. California Department of Public Health (CDPH) TB Risk Assessment Tools
~~M.~~L. California Department of Public Health (CDPH) Information for Physicians Regarding Directly Observed Therapy (DOT) for Active Tuberculosis (TB)
~~N.~~M. California Tuberculosis Controllers Association (CTCA), Latent Tuberculosis Infection Guidance for Preventing Tuberculosis in California, available at: https://ctca.org/guidelines/guidelines-latent-tuberculosis-infection-guideline/

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

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

X. **REVISION DATES:**

Partnership Advantage (Program effective January 1, 20287)
06/11/25; 6/10/26

Medi-Cal:
09/19/01; 10/16/02; 10/20/04; 10/19/05, 10/18/06; 10/17/07; 10/15/08, 01/20/10; 01/18/12; 05/20/15; 04/20/16; 04/19/17; *06/13/18; 05/08/19; 05/13/20; 05/12/21; 05/11/22; 04/12/23; 05/08/24; 06/11/25; 06/10/26

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

PREVIOUSLY APPLIED TO: N/A

****

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

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

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

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

TB Screening Guidelines
Partnership HealthPlan of California
Last updated:2026

MPUP3047 - Attachment A
MPQG1005 - Attachment B
MCQG1015 - Attachment B
06/10/2026

Legend:

CXR: Chest X-Ray

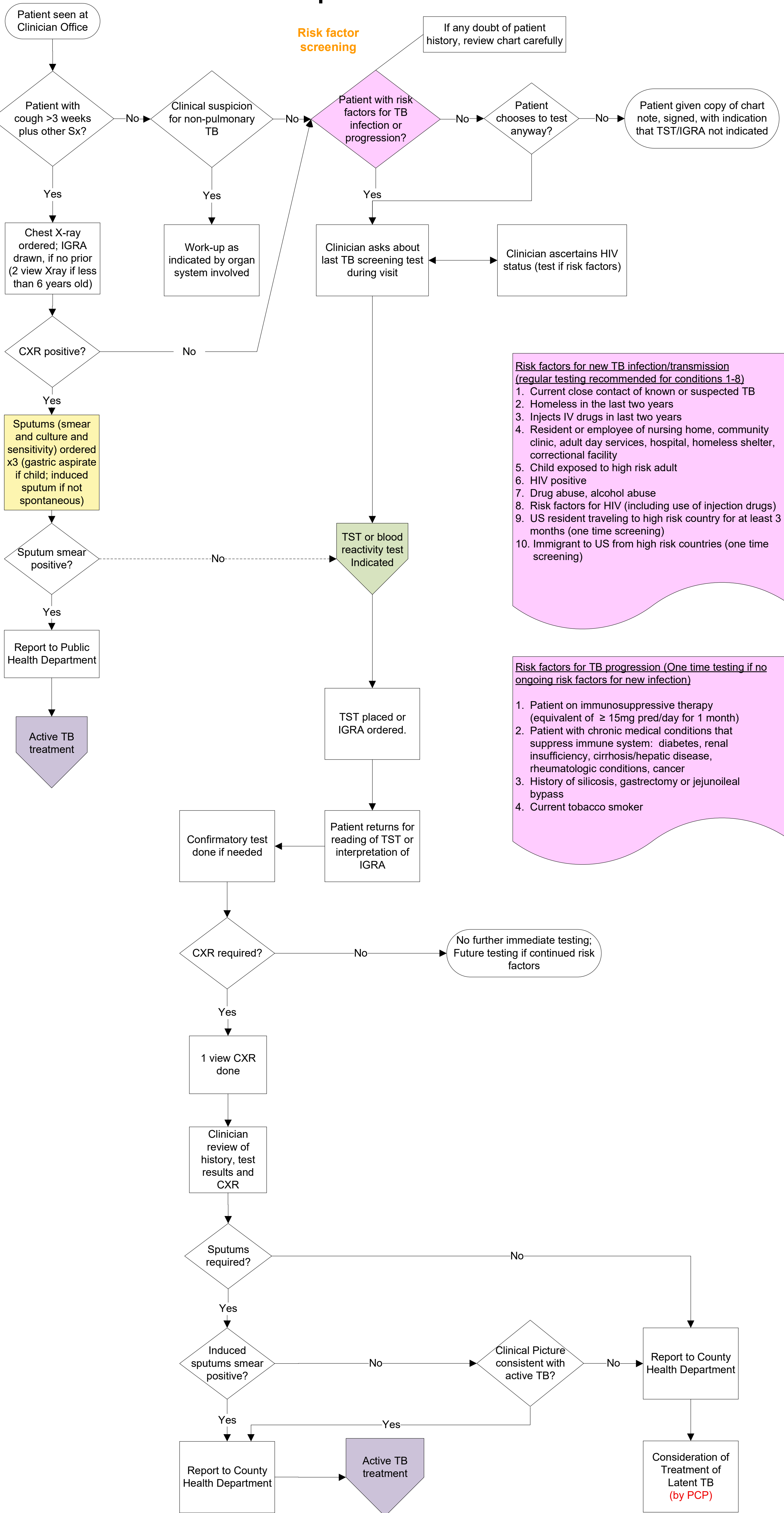
IGRA: Interferon-gamma Release Assays

TB: Tuberculosis

TST: Tuberculin Skin Test

Cough for greater than 3 weeks and one of:
1. weight loss
2. fatigue
3. night sweats
4. cough up blood

See separate protocols



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

Initial Health Appointment

Overview

In January 2026, DHCS issued APL 26-001 which added that members who are dually eligible for Medi-Cal and Medicare must adhere to the IHA requirements, this change is also notated in the recent update of the CALAIM Population Health Management Policy Guide. The Staying Health Assessment (SHA) was replaced by the Member Risk Assessment effective January 1, 2024.

The initial Member Risk Assessment is related to 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) shall be conducted. An assessment of at least one of the following risk assessment domains meets the standard: Social Determinants of Health (SDOH), Adverse Childhood Experiences (ACEs), and/or Pediatric ACEs and Related Life Events Screener (PEARLs).

Partnership ensures that network providers will complete an Initial Health Appointment (IHA) for new members within 120 days of a member's enrollment in Partnership HealthPlan of California (Partnership) or within 90 days of a member's assignment to a PCP (whichever is most recent). The Initial Health Appointment (IHA) is not necessary if the Member's Primary Care Physician (PCP) determines that the Member's medical record contains complete information that was updated within the previous 12 months. Partnership abides by DHCS guidance for member screening and assessment, and monitors assessments through the Site Review process.

Requirements for an Initial Health Appointment (IHA):

- Must be performed by a Provider within the primary care medical setting.
- Must be provided in a way that is culturally and linguistically appropriate for the Member.
- Must be documented in the Member's medical record.

An IHA must include all of the following:

- A history of the member's physical and mental health;
- An identification of risks;
- An assessment of need for preventive screens or services;
- Health education
- The diagnosis and plan for treatment of any diseases.
- Member risk assessment
- Must bring members up to date with all currently recommended preventive services, including immunizations, blood lead screening, or arrange to have the member brought up to date if, for any reason, this objective cannot be fully accomplished at the time of the IHA.

If the provider is unable to complete an IHA within the appropriate timeframe, providers are encouraged to outreach to the member with a minimum of 2 documented attempts. This is monitored through the Site Review process.

Methodology – see attached data report

Our IHA compliance report captures encounter data for members enrolled in Partnership between January 1, 2024, and December 31, 2024. Additional criteria were built into the report to accommodate claims lag of approximately three months. The report looks for 4 months of continuous enrollment.

With continuous efforts over the last year and a half of editing the report to capture an IHA approved visit, we feel as we are closer to the most accurate a report can be without a DHCS approved IHA procedure code. These efforts have included shifting our focus to the fourth month for new enrollees whereas before members that started as Direct members were excluded from this report. This has brought our enrollment numbers from the hundreds up to the thousands for each month. We have also included a more claims-centric approach to help capture these members, that includes when the visit happened, where the visit was completed, and what procedure and diagnosis codes are attached to the visit. For a more detailed list of the changes made to the report, information can be provided upon request.

Potential IHA Scores Based on Claims Submission:

Partnership uses an array of codes that were most probable to represent the completion of an IHA. These codes can be found on Attachment B of our IHA Policy.

- 2023 53.02%
- 2024 40.07%
- 2025 42.20%

The data with the most accuracy comes from our Site Review process since these records are reviewed individually by our DHCS Certified Site Review Nurses. For MY 2024 2,763 records qualified for IHA during the Medical Record Review (MRR) Process. Out of these records, 92.2% were compliant. These members either met the history and physical requirements and the timeline standards for the IHA or a documented refusal.

Barriers

1. The ability to efficiently capture IHA-related elements from code sets is another large barrier to gleaning this information from medical records. During the FY 2021-2022 audit, Partnership discussed with DHCS the difficulties we face in data capture due to the lack of a singular billing code to capture IHA compliance. The released APL 22-030 does

not offer guidance on data capture or coding for completion of IHA or member refusal of IHA's.

2. Previously, we used billing data to represent Partnerships potential IHA compliance rates. However, without the use of a singular billing code, the data needs to be validated at the medical record level to verify accuracy. The best way to validate this is through our Site Review process until DHCS is able to assign a single billing code for data tracking purposes.
3. The release of the CalAim Population Health Management Strategy Guide Update in August of 2023 states that DHCS will leverage Managed Care Accountability Sets (MCAS) measure focused on preventative services as a proxy for monitoring IHA. This is currently being discussed at the Site Review MCP Workgroups and is on hold for further guidance as DHCS Population Health and DHCS Site Review Team work through the details of monitoring compliance.

DHCS

We are currently in our 24-25 DHCS FY Audit period, we submitted more than 800 documents related to Initial Health Appointment.

We are happy to announce our 23-24 DHCS FY Audit was successful, and no corrective action plan was issued.

Partnership was under a DHCS Corrective Action Plan (CAP) for IHA for FY 2021-2022. As a result of these findings, Partnership was under this CAP for the entire audit period of FY 2022-2023. We worked closely with the DHCS Audit Monitoring Unit and were able to close the Initial Health Appointment CAP portion as of October 2023.

Improvement Activities

Miscellaneous Continuous Efforts:

1. Sites receive a monthly email reminding them to retrieve the list of new enrollees and are educated to document their outreach attempts to new members. If they have outreached two times and documented each, they are compliant for that member. We are providing spreadsheets for the sites to document their efforts, as many sites do not wish to open a new chart before the member is located and makes an appointment. This was changed from a three-attempt outreach to a two-attempt outreach based off the Population Health Management Policy Guide and APL 22-030.
2. Starting in late 2025 an IHA Attestation was created to ensure Partnership's Primary Care Provider offices are making all the necessary efforts to schedule and/or complete an Initial Health Appointment for all newly assigned members. This attestation is sent along with the pre-site documentation for an upcoming review.

3. A collaborative meeting is held quarterly which includes Care Coordination, Claims, Health Education, Quality, Utilization Management, Population Health, Provider Relations and Member Services departments to increase efforts to inform members and providers of the need for members to come in for the IHA. The diversity of departments represented by this workgroup allows for unique perspectives on the opportunities and barriers to IHA performance.
4. Newsletter Articles: Information continues to be shared through our Provider and Member Newsletters. These articles are available on the Partnership website.
5. Provider education is available on the Partnership website including a webinar for new Providers.
6. Newly credentialed providers are educated on IHA process, and a new member packet is sent out to members informing them of the importance of an IHA. This information is also provided in the member handbook.
7. Monthly mailers are sent to Providers along with address labels for newly enrolled members so providers can reach out to members to schedule an IHA.
8. Currently researching to include Robo Calls to members as a reminder to schedule IHA.
9. Providers are able to run reports of their newly assigned members in Partnership's Provider Online Services portal. QI will be researching with IT to see if a module can be created for providers to submit their outreach efforts through Provider Online Services. This is a long-term goal as IT has multiple competing projects.
10. Members are reminded when calling in by member services to reach out to their PCP for an IHA with prerecorded hold messages and again when speaking to a member services representative.
11. With the change of vendor for our Site Review process in April 2023, we now have a staff writer that is attached to our CAP process that informs providers on ways to improve their compliance in all areas of the tool which includes IHA.
12. The Site Review Team offers 1:1 educational training about IHA requirements at every site review exit interview. This educational piece is also posted on the Partnership Website. Partnership Billing Guide and IHA education PowerPoint are provided as an educational piece. This is provided during the site review exit interview process. IHA PowerPoint is used for 1:1 or group education with providers.
13. Internal and external quality improvement committees review the results from completed Site Reviews, including review of Initial Health Assessments, at least annually. Provide constructive feedback regarding existing processes.
14. In January of 2026 Partnership joined multiple other Managed Care Plans in California in a workgroup collaborative to discuss Initial Health Appointment coding. This collaboration's main objective is to establish a robust baseline for what qualifies as a "Comprehensive" Initial Health Appointment.

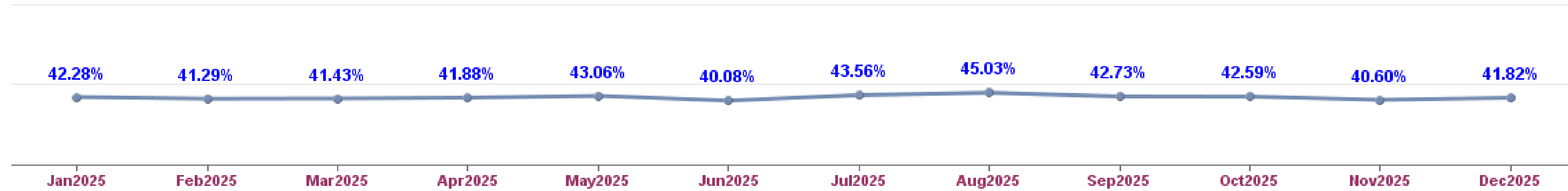
MEDICAL PROGRAM - INITIAL HEALTH ASSESSMENT COMPLIANCE REPORT : NEW ENROLLEES CONTINUOUSLY ENROLLED (CE)

Claims and Eligibility Date 01/01/2025 thru 12/31/2025 Report Run Date: 4/27/26

Methodology: This report captures encounter data for all members continusously enrolled at PHC for 4 months during the period noted below. Take note that members newly enrolled for each month are not eligible for prior month. For multiple visits encountered by a member, only the first visit date was captured. ICD-10 and CPT codes for an initial health assessment were used to identify the applicable visit. Excluding Kaiser, Direct Members and Medi-Cal Members only with no other insurance.

All Region

		Eligibility Year 2025												
		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Totals
A	New Eligibility	9966	11420	10383	10826	10664	12766	10119	9328	10069	9763	10184	8865	**124353**
B	IHA Visits <= 120 Days	4214	4715	4302	4534	4592	5117	4408	4200	4302	4158	4135	3707	**52384**
C	New enrollees With Visits > 120 Days	1839	1983	1759	1788	1613	1874	1245	1022	989	734	546	142	**15534**
D	New Enrollment With No Visits	3913	4722	4322	4504	4459	5775	4466	4106	4778	4871	5503	5016	**56435**
E	% New enrollees With Visits <= 120 Days	42.28%	41.29%	41.43%	41.88%	43.06%	40.08%	43.56%	45.03%	42.73%	42.59%	40.60%	41.82%	**42.20%**
F	% New enrollees With Visits > 120 Days	18.45%	17.36%	16.94%	16.52%	15.13%	14.68%	12.30%	10.96%	9.82%	7.52%	5.36%	1.60%	**12.22%**
G	% New enrollees With No Visits	39.26%	41.35%	41.63%	41.60%	41.81%	45.24%	44.13%	44.02%	47.45%	49.89%	54.04%	56.58%	**45.58%**



MEDICAL PROGRAM - INITIAL HEALTH ASSESSMENT COMPLIANCE REPORT : NEW ENROLLEES CONTINUOUSLY ENROLLED (CE)

Claims and Eligibility Date 01/01/2025 thru 12/31/2025 Report Run Date: 4/27/26

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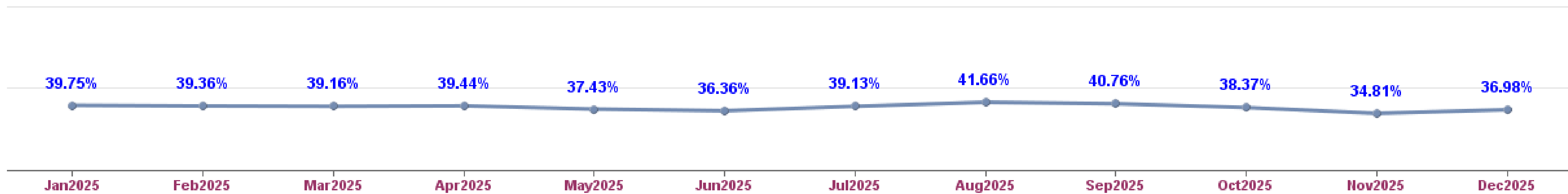
Auburn

		Eligibility Year 2025												
		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Totals
A	New Eligibility	1381	1730	1448	1544	1392	1950	1385	1325	1428	1303	1313	1233	**17432**
B	IHA Visits <= 120 Days	549	681	567	609	521	709	542	552	582	500	457	456	**6725**
C	New enrollees With Visits > 120 Days	256	315	248	256	225	300	153	157	144	78	67	22	**2221**
D	New Enrollment With No Visits	576	734	633	679	646	941	690	616	702	725	789	755	**8486**
E	% New enrollees With Visits <= 120 Days	39.75%	39.36%	39.16%	39.44%	37.43%	36.36%	39.13%	41.66%	40.76%	38.37%	34.81%	36.98%	**38.60%**
F	% New enrollees With Visits > 120 Days	18.54%	18.21%	17.13%	16.58%	16.16%	15.38%	11.05%	11.85%	10.08%	5.99%	5.10%	1.78%	**12.32%**
G	% New enrollees With No Visits	41.71%	42.43%	43.72%	43.98%	46.41%	48.26%	49.82%	46.49%	49.16%	55.64%	60.09%	61.23%	**49.08%**



MEDICAL PROGRAM - INITIAL HEALTH ASSESSMENT COMPLIANCE REPORT : NEW ENROLLEES CONTINUOUSLY ENROLLED (CE)

Claims and Eligibility Date 01/01/2025 thru 12/31/2025 Report Run Date: 4/27/26

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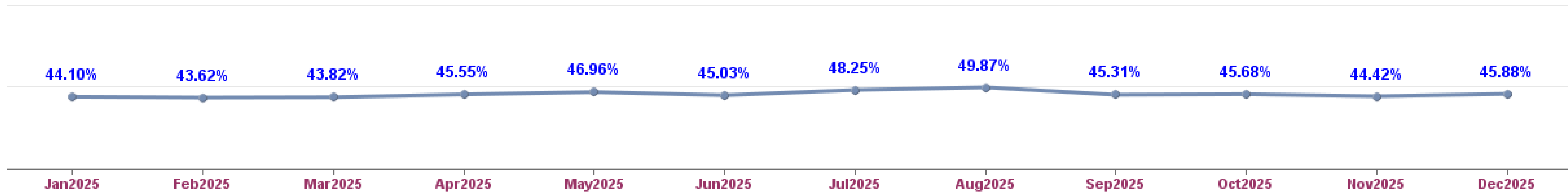
Chico

		Eligibility Year 2025												
		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Totals
A	New Eligibility	1925	2162	2063	2301	2008	2294	1940	1861	1865	1771	1943	1820	**23953**
B	IHA Visits <= 120 Days	849	943	904	1048	943	1033	936	928	845	809	863	835	**10936**
C	New enrollees With Visits > 120 Days	330	355	366	349	300	328	237	183	195	137	109	24	**2913**
D	New Enrollment With No Visits	746	864	793	904	765	933	767	750	825	825	971	961	**10104**
E	% New enrollees With Visits <= 120 Days	44.10%	43.62%	43.82%	45.55%	46.96%	45.03%	48.25%	49.87%	45.31%	45.68%	44.42%	45.88%	**45.71%**
F	% New enrollees With Visits > 120 Days	17.14%	16.42%	17.74%	15.17%	14.94%	14.30%	12.22%	9.83%	10.46%	7.74%	5.61%	1.32%	**11.91%**
G	% New enrollees With No Visits	38.75%	39.96%	38.44%	39.29%	38.10%	40.67%	39.54%	40.30%	44.24%	46.58%	49.97%	52.80%	**42.39%**



MEDICAL PROGRAM - INITIAL HEALTH ASSESSMENT COMPLIANCE REPORT : NEW ENROLLEES CONTINUOUSLY ENROLLED (CE)

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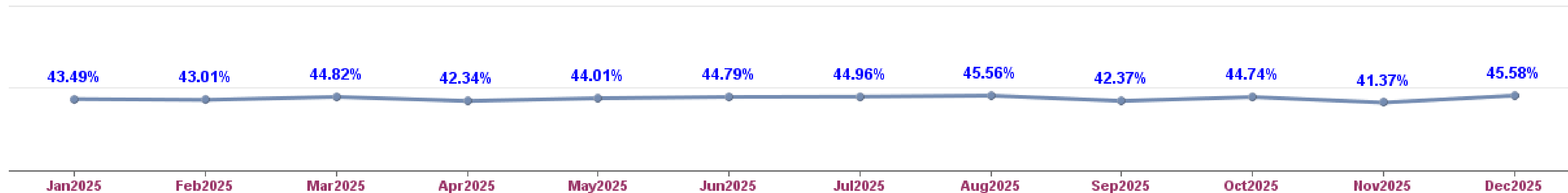
	Eureka	Eligibility Year 2025												
		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Totals
A	New Eligibility	1283	1460	1428	1410	1486	1239	1241	1273	1343	1265	1368	1132	**15928**
B	IHA Visits <= 120 Days	558	628	640	597	654	555	558	580	569	566	566	516	**6987**
C	New enrollees With Visits > 120 Days	253	272	249	223	222	174	166	160	136	90	78	17	**2040**
D	New Enrollment With No Visits	472	560	539	590	610	510	517	533	638	609	724	599	**6901**
E	% New enrollees With Visits <= 120 Days	43.49%	43.01%	44.82%	42.34%	44.01%	44.79%	44.96%	45.56%	42.37%	44.74%	41.37%	45.58%	**43.92%**
F	% New enrollees With Visits > 120 Days	19.72%	18.63%	17.44%	15.82%	14.94%	14.04%	13.38%	12.57%	10.13%	7.11%	5.70%	1.50%	**12.58%**
G	% New enrollees With No Visits	36.79%	38.36%	37.75%	41.84%	41.05%	41.16%	41.66%	41.87%	47.51%	48.14%	52.92%	52.92%	**43.50%**



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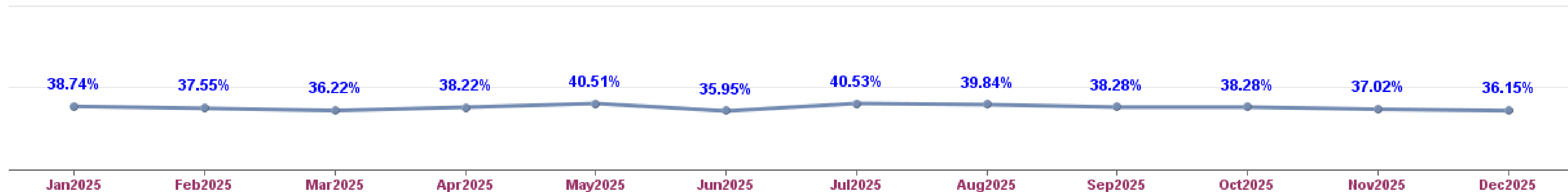
Fairfield

		Eligibility Year 2025												
		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Totals
A	New Eligibility	2238	2578	2424	2410	2518	3394	2095	1983	2265	2111	2307	2058	**28381**
B	IHA Visits <= 120 Days	867	968	878	921	1020	1220	849	790	867	808	854	744	**10786**
C	New enrollees With Visits > 120 Days	405	444	403	416	360	484	256	222	216	193	124	38	**3561**
D	New Enrollment With No Visits	966	1166	1143	1073	1138	1690	990	971	1182	1110	1329	1276	**14034**
E	% New enrollees With Visits <= 120 Days	38.74%	37.55%	36.22%	38.22%	40.51%	35.95%	40.53%	39.84%	38.28%	38.28%	37.02%	36.15%	**38.11%**
F	% New enrollees With Visits > 120 Days	18.10%	17.22%	16.63%	17.26%	14.30%	14.26%	12.22%	11.20%	9.54%	9.14%	5.37%	1.85%	**12.26%**
G	% New enrollees With No Visits	43.16%	45.23%	47.15%	44.52%	45.19%	49.79%	47.26%	48.97%	52.19%	52.58%	57.61%	62.00%	**49.64%**



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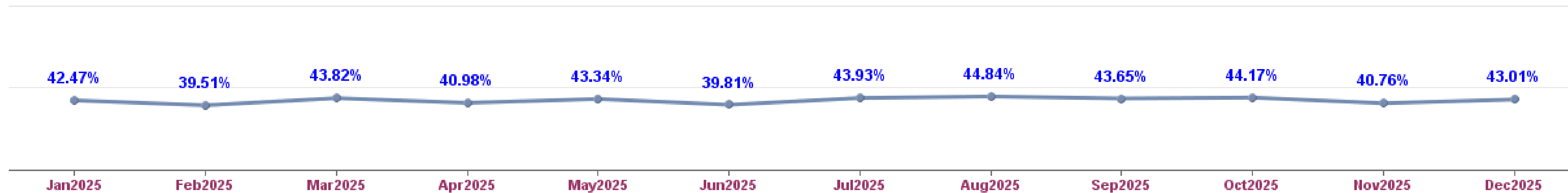
Redding

		Eligibility Year 2025												
		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Totals
A	New Eligibility	1342	1359	1189	1303	1373	1404	1391	1251	1434	1354	1423	1151	**15974**
B	IHA Visits <= 120 Days	570	537	521	534	595	559	611	561	626	598	580	495	**6787**
C	New enrollees With Visits > 120 Days	242	220	167	209	203	194	167	121	136	78	55	13	**1805**
D	New Enrollment With No Visits	530	602	501	560	575	651	613	569	672	678	788	643	**7382**
E	% New enrollees With Visits <= 120 Days	42.47%	39.51%	43.82%	40.98%	43.34%	39.81%	43.93%	44.84%	43.65%	44.17%	40.76%	43.01%	**42.52%**
F	% New enrollees With Visits > 120 Days	18.03%	16.19%	14.05%	16.04%	14.79%	13.82%	12.01%	9.67%	9.48%	5.76%	3.87%	1.13%	**11.24%**
G	% New enrollees With No Visits	39.49%	44.30%	42.14%	42.98%	41.88%	46.37%	44.07%	45.48%	46.86%	50.07%	55.38%	55.86%	**46.24%**



MEDICAL PROGRAM - INITIAL HEALTH ASSESSMENT COMPLIANCE REPORT : NEW ENROLLEES CONTINUOUSLY ENROLLED (CE)

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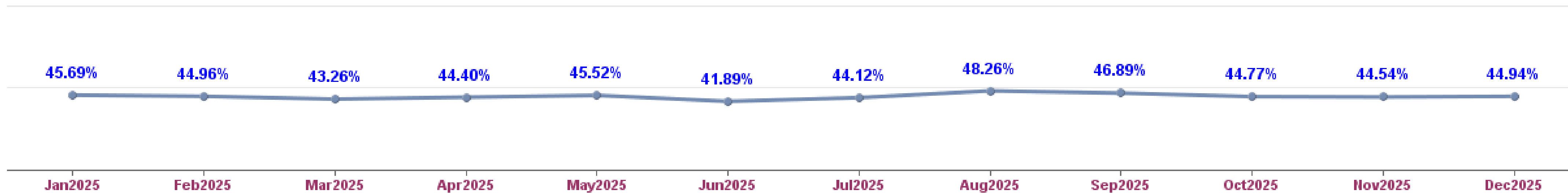
Santa Rosa

		Eligibility Year 2025												
		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Totals
A	New Eligibility	1797	2131	1831	1858	1887	2485	2067	1635	1734	1959	1830	1471	**22685**
B	IHA Visits <= 120 Days	821	958	792	825	859	1041	912	789	813	877	815	661	**10163**
C	New enrollees With Visits > 120 Days	353	377	326	335	303	394	266	179	162	158	113	28	**2994**
D	New Enrollment With No Visits	623	796	713	698	725	1050	889	667	759	924	902	782	**9528**
E	% New enrollees With Visits <= 120 Days	45.69%	44.96%	43.26%	44.40%	45.52%	41.89%	44.12%	48.26%	46.89%	44.77%	44.54%	44.94%	**44.93%**
F	% New enrollees With Visits > 120 Days	19.64%	17.69%	17.80%	18.03%	16.06%	15.86%	12.87%	10.95%	9.34%	8.07%	6.17%	1.90%	**12.87%**
G	% New enrollees With No Visits	34.67%	37.35%	38.94%	37.57%	38.42%	42.25%	43.01%	40.80%	43.77%	47.17%	49.29%	53.16%	**42.20%**



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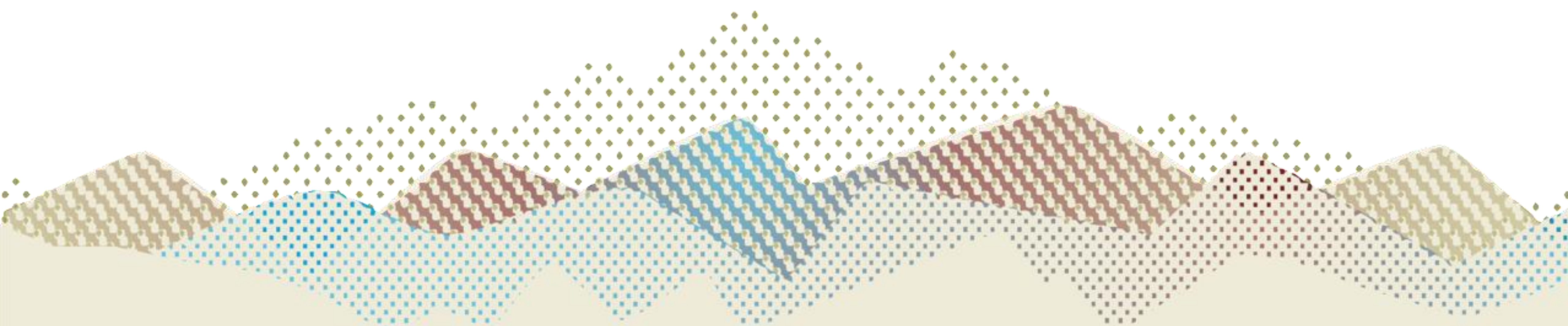
Behavioral Health Overview & Grand Analysis of Member Experience

May 2026



Behavioral Health Overview

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- Mental Health Overview & Utilization
- Significant Changes
- Member Outreach & Education Plan 2026
- Grand Analysis of Member Experience
- Regional Model Transition
- Stakeholder Engagement

Medi-Cal Shared Responsibilities in Behavioral Health

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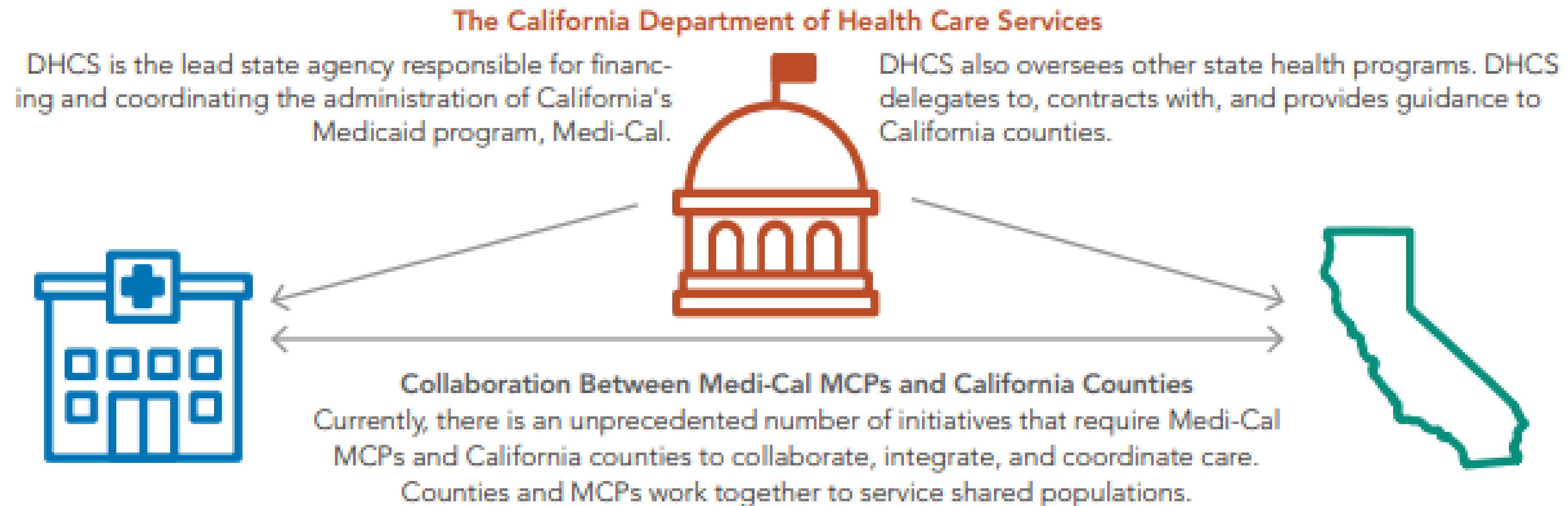

Medi-Cal Managed Care Plans

MCPs are responsible for arranging for the delivery of Medi-Cal covered benefits in accordance with the MCP contract held with DHCS and in accordance with federal and state statutory and regulatory requirements.

California Counties

Responsible for delivering care to county indigent populations; administering special programs; owning and/or operating public health care systems; and providing services to Medi-Cal members who require specialty mental health services (SMHS) and substance use disorder (SUD) services as well as non-Medi-Cal behavioral health services in accordance with DHCS contracts and federal and state law.

How is Mental Health Carved Up in Medi-Cal

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Managed Care Plans (Non-Specialty Mental Health)	County Behavioral Health Plans (Specialty Mental Health)
Eligibility: Individuals with **mild to moderate** distress or impairment resulting from a mental health disorder or a suspected mental health disorder.	**Eligibility:** Individuals with **significant** impairment or distress/dysfunction and due to a mental disorder or suspected mental disorder
Covered Services: • Mental Health Evaluation & Treatment • Individual, Group, Dyadic Services and Family Therapy • Psychiatric Consultation • Neuropsychological Testing • Outpatient laboratory, drugs and supplies • Transportation for both MCP and County BHP services	**Covered Services:** • Assessment • Therapy • Psychiatric • Inpatient Psychiatric • Mobile Crisis • Crisis Residential and Stabilization • Day Treatment Intensive • Day Rehabilitation • Targeted Case Management **Broader Provider types (e.g. Peers, Trainees, etc.)*

No Wrong Door
Screening & Transition Tools

Concurrent Services
Closed Loop Referrals

MOUs
Non-Duplication

How is Substance Use Treatment Offered in Medi-Cal?

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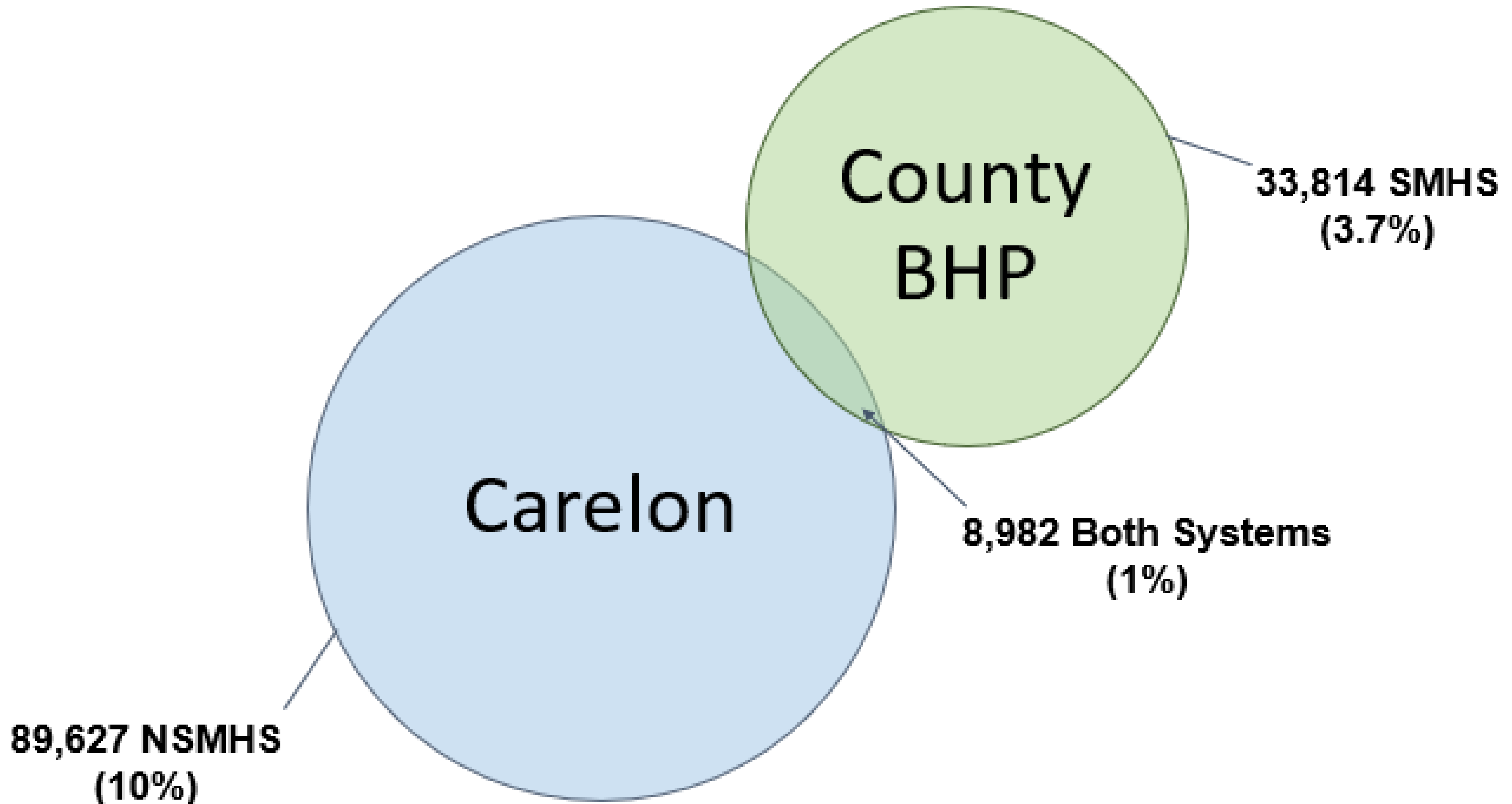
Managed Care Plans	County Behavioral Health (DMC/DMC-ODS)
Covered Services: • Screening – SABIRT • Medication Assisted & Treatment (MAT) • Care Coordination & Referral • Transportation for both MCP and County BHP services	**Covered Services:** • Assessment • Outpatient (ASAM level 1.0) • Intensive Outpatient (ASAM 2.1) • Residential Treatment (ASAM 3.1-3.5)* • Case Management* • Narcotic Treatment Program (NTP) • Peer Support • Traditional Healthcare Practices* **DMC-ODS counties only*

Mental Health Utilization 2025

* Approximately 896K Members



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Insourcing Member Facing Activities

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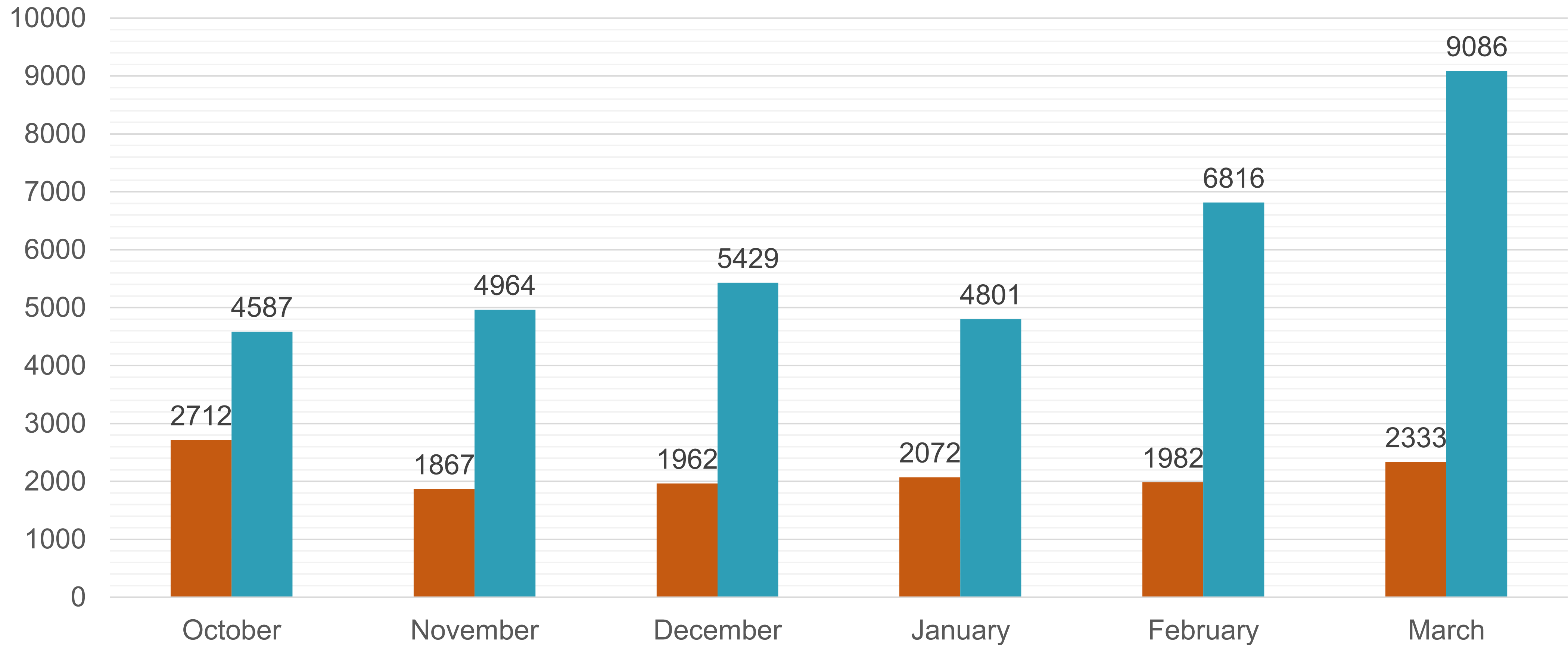
- Contracted with Carelon since 2014 to administer Mental Health benefit
- October of 2025 Insourced:
  - Call Center
  - Care Coordination
  - Grievances and Appeals
  - Utilization Management
- Carelon retains Network Management and Claims Processing

Call Volume



PARTNERSHIP HEALTHPLAN of CALIFORNIA

Service Level Agreements

Month	Average Speed of Answer	Service Level	% Abandoned
October	0:00:10	89.38%	1.25%
November	0:00:11	90.40%	2.04%
December	0:00:14	88.35%	2.96%
January	0:00:20	88.32%	2.75%
February	0:00:12	90.74%	2.17%
March	0:00:07	94.59%	1.11%
Total	**0:00:12**	**90.30%**	**2.05%**

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2026 Q1 Referral Data

County	County to PHC	PHC to County	TOCs to County	Screenings to County	PHC to NSMHS
Butte	21	17	3	14	254
Colusa	1	1	0	1	4
Del Norte	0	4	0	4	38
Glenn	16	4	0	4	18
Humboldt	43	17	0	17	215
Lake	8	3	0	3	44
Lassen	3	5	0	5	38
Marin	31	19	2	17	194
Mendocino	0	1	0	1	90
Modoc	0	0	0	0	1
Napa	23	7	0	7	77
Nevada	74	16	1	15	120
Placer	42	33	5	28	316
Plumas	1	0	0	0	11
Shasta	14	8	3	5	126
Sierra	0	0	0	0	0
Siskiyou	17	7	0	7	55
Solano	99	110	0	110	517
Sonoma	34	32	2	30	328
Sutter	0	2	1	1	47
Tehama	0	0	0	0	42
Trinity	9	1	0	1	14
Yolo	16	20	2	18	215
Yuba	0	1	0	1	63
Total	**452**	**308**	**19**	**289**	**2827**

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Member Feedback

Compassionate Care	"I can tell in your voices that you all have compassion." "Your team shows urgency and concern" to connect members with services.
Appreciation and Gratitude	"I wish I could give you a hug to say thanks for everything you have done for me." "I'd give you 10 stars for all the time and services you assisted with."
Support and Guidance	"You are a great team, and I'd give you all a 5-star review. You helped me respond in a crisis and I was able to follow your guidance, which allowed everything to work out."

Majority of Members (52%) leave call with a scheduled appointment

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Transcranial Magnetic Stimulation (TMS): Severe Depression, Treatment Resistant Depression

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- Newly covered benefit in NSMHS (18+)—no TAR required by Partnership
- Historically (and still) covered by county BHPs (SMHS)
- Some complexities: Myriad FDA-approved machines with myriad different protocols.
- Growing Network Providers

Non-Specialty Mental Health Member Outreach and Education Plan (SB1019)

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Requirement: annually conduct a non-specialty mental health utilization assessment, identifying trends in low utilization and develop an outreach and education intended to support closing gaps in service delivery.

Partnership's 2026 DHCS approved Outreach & Education included feedback from Community Advisory Committee, Quality Improvement Health Equity Committee, Primary Care Provider (via engagement survey) and Tribal partners. Target strategies include the following:

- PCP engagement and education intended to provide insight into Partnership's new BH Access Line
- Perinatal MH outreach highlighting awareness and resources
- MH Awareness month where staff will participate in community events
- Promoting direct referral opportunities for Modoc County youth through school-based coordination
- Sierra County will be exploring leveraging MH telehealth services through County Office of Education
- Social media outreach, text messaging campaigns, amongst other community-based engagement will be supported throughout the year

The O&E plan is available publicly on our external website.

Member Outreach: Race, Ethnicity & Disparity Targeting

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Data Capture

- Race & ethnicity stratification across utilization metrics.
- Social Determinants of Health (SDoH) and demographic data collection.
- Member survey data disaggregated by population.

Targeting Strategy

- Underutilization rates in demographics and county-level disparities.
- Tribal member outreach & annual convening.
- Language and cultural responsiveness in messaging.

OEP Interventions

- Text messaging pilot targeting Solano & Modoc.
- Follow-up outreach supports continuity post-discharge from ED.
- Quarterly social media outreach and presence in in-person MH fairs
- Monthly COE meetings and Tribal Outreach continuation.

Grand Analysis Member Experience

(NCQA – ME7)

ME-7: Member Experience of Behavioral Health Access

What is ME-7?

ME-7 is an NCQA accreditation standard that evaluates how well a health plan ensures members can access behavioral health services specifically addressing **perceived barriers to care.**

ME-7 has six elements (A–F). Partnership's Behavioral team is responsible for Element E & F.

Elem. E	**Member Perception Survey** NCQA-approved survey measuring whether members feel they can access timely BH care
Elem. F	**Interventions** Action plans addressing identified barriers; includes both plan-level and delegation oversight

PHC Delegation Context

Carelon Behavioral Health

Partnership delegated BH vendor responsible for managing mental health.

Delegation Oversight

Partnership oversees Carelon's compliance with ME-7 standards, including review of their member survey methodology and G&A data

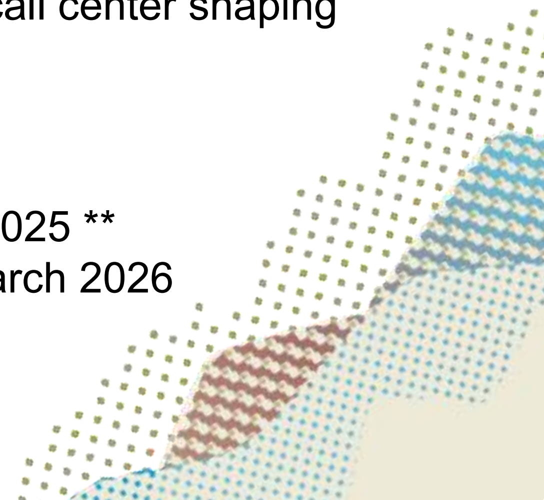
In-House Transition

Partnership is actively insourcing call center shaping this reporting cycle

Reporting Cycle

Carelon: April 2025 – September 2025 **
Partnership: September 2025 – March 2026

** *Auto-credit due to delegation*



ME-7: Efforts & Next Steps

PARTNERSHIP HEALTHPLAN of CALIFORNIA

Call Center Insourcing

Ongoing

Partnership is insourcing call center functions previously delegated to Carelon. This directly addresses member-reported communication issues in improving responsiveness and tracking outcomes.

Closed-Loop Referral Tracking

Ongoing

Implementing systematic tracking of referrals from initial request through appointment completion ensuring members who are referred to BH services are receiving care.

County Coordination & Network Strengthening

Ongoing

Strengthening relationships with county BH agencies to reduce hand-off gaps. Particularly important for Medi-Cal members in rural PHC counties where county-plan coordination is critical.

Element F Intervention Planning

In Progress

Developing structured interventions in response to Element E including provider network adequacy improvements, member navigation supports, and PCP data sharing processes.

ME-7 Analysis: What Was Seen

PARTNERSHIP HEALTHPLAN of CALIFORNIA

889
Medi-Cal members responded to Member Experience Survey

161
G&A cases reviewed (Apr 2025 – March 2026)

Member Experience Survey

- Member satisfaction is strong and staff interactions are highly rated.
- Provider access is the most significant gap in the survey.
  - Wait times and appointment availability were the most frequently cited barriers to care.
- Members who called Carelon's care management line reported varied experiences with follow-through.

G&A Case Analysis

- 161 G&A cases reviewed (April 2025 – March 2026).
- Partnership met the establish goal of ≤1 grievances per thousand members.
- Attitude/Service grievances was the leading category particularly around communication issues both administratively and clinical.
- Cases reflected member difficulty navigating the BH system from initial contact through care initiation.

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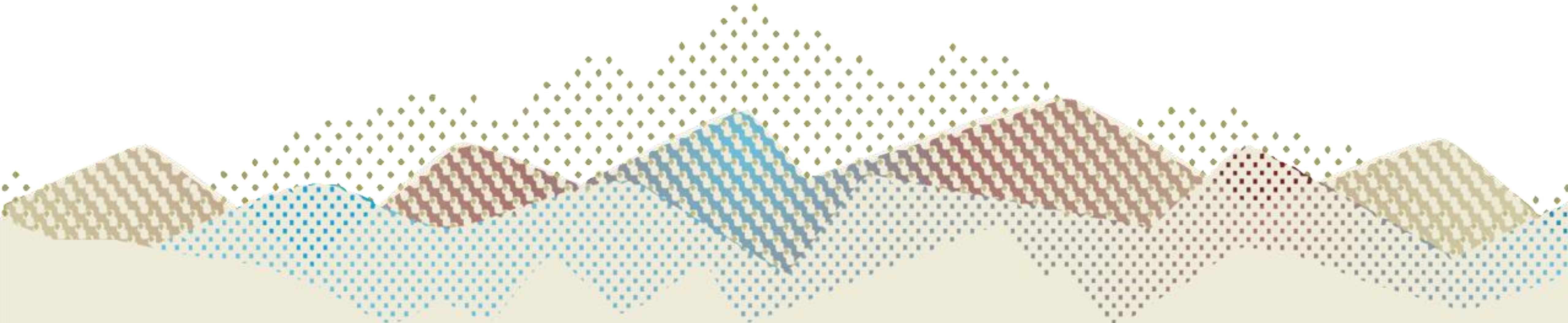
Regional Model

Aka Wellness & Recovery



What is the Regional Model?

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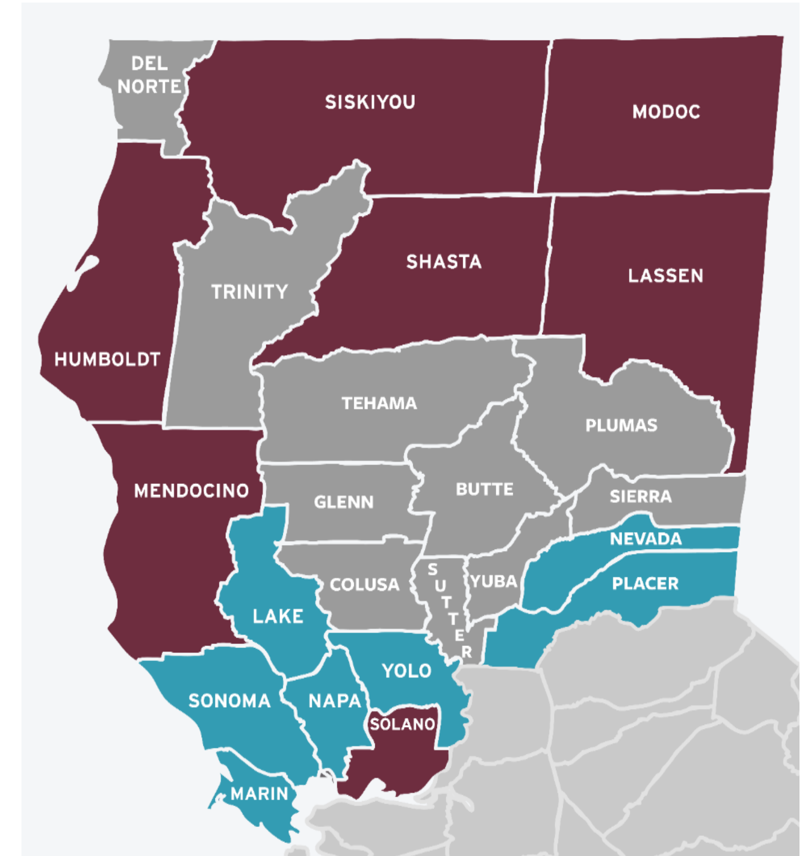
- **Drug Medi-Cal Organized Delivery System (DMC-ODS)** is an enhanced substance use benefit under Medi-Cal that county Behavioral Health Plans can opt-in
- 40 of 58 County Behavioral Plans have opted –in
- **Regional Model**: Partnership Administers this benefit on behalf of seven counties (Humboldt, Mendocino, Shasta, Solano, Lassen, Siskiyou and Modoc)
- Served over 20,000 individuals served since inception (July 2020)

Wellness & Recovery - 2025

- Timely access- 96% screening to treatment episodes occur within 2 days
- 68% of members self refer to services
- Transitions to lower levels of care occur on average within 2 days, 5 days for higher LOC
- Utilization increased significantly in 2025 over previous year:
    - 8.5% increase in members accessing services
    - 15.3% increase in services rendered



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Administrative Challenges

- Integrated Contract:

  New contract between state and counties for both SMHS/DMC-ODS effective 1/1/2027

- Fiscal Model
- Compliance Challenges
- Managed Care Plan Responsibilities

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Regional Model Transition

Partnership will no longer administer this benefit as of 1/1/2027

- Meeting weekly with impacted counties
- Informed DHCS, Providers and Staff
- Meeting weekly with a perspective administrator
- All counties indicated to state their intention of continuing the DMC-ODS benefit

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Behavioral Health Department MOUs

Mental Health Plan

Child Welfare MOU

First 5

DMC State

DMC ODS

LEAs (2027)

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COUNTY	Child Welfare	First 5	LEAs (2027)	MHP	DMC State Plan	DMC ODS
Butte	Not Received	Executed		Executed	Executed	
Colusa	County Review	County Review		Executed	Executed	
Del Norte	County Review	Executed		Executed	Executed	
Glenn	County Review	County Review		Executed	Executed	
Humboldt	County Review	Executed		Executed		Executed
Lake	County Review	County Review		Executed		Executed
Lassen	Executed	County Review		Executed		Executed
Marin	Executed	Country Review		Executed		Executed
Mendocino	Executed	Executed		Executed		Executed
Modoc	County Review	Our for Signature		Executed		Executed
Napa	Executed	County Review		Executed		Executed
Nevada	Executed	Executed		Executed		Executed
Placer	Executed	Executed		Executed		Executed
Plumas	Executed	County Review		Executed	Executed	
Shasta	County Review	Executed		Not Received		Not Received
Sierra	Executed	County Review		Executed	Executed	
Siskiyou	Executed	Executed		Executed		Executed
Solano	Sent to NPC	County Review		Executed		Executed
Sonoma	Executed	Executed		Executed		Executed
Sutter	Sent to NPC	Out for Signature		Sent to NPC	Sent to NPC	
Tehama	Out for Signature	County Review		Executed	Executed	
Trinity	County Review	County Review		Executed	Executed	
Yolo	Executed	Executed		Executed		Executed
Yuba	County Review	County Review		Sent to NPC	Sent to NPC	

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Questions?

Quality Improvement and Health Equity Committee (QIHEC) Charter

Updated: 05/07/2026

Last Ratified: TBD

Purpose:

The QIHEC is an external advisory group that is led by the Health Equity Officer (HEO) and Chief Medical Officer (CMO). The QIHEC is responsible for analyzing and evaluating the results of quality improvement and health equity activities including annual review of the results of performance measures, utilization data, consumer satisfaction surveys, training completion rates, and findings activities of internal Partnership specific committees.

The QIHEC is responsible for developing actions to address health equity-related performance deficiencies (e.g., policy recommendations, action plans) and ensuring appropriate follow-up of identified performance deficiencies)

Authority and Responsibility:

The QIHEC provides recommendations to the Quality/Utilization Advisory Committee (Q/UAC) (see policy MPQP1002). The Q/UAC is responsible to assure that quality, comprehensive health care and services are provided to Partnership members through an ongoing, systematic evaluation and monitoring process that facilitates continuous quality improvement. The Q/UAC provides recommendations and is overseen by the Physician Advisory Committee (PAC) (see policy MPQP1003), which subsequently reports to Partnership's governing Board of Commissioners. PAC is responsible for oversight and monitoring of the quality and cost-effectiveness of medical care provided to Partnership members and is comprised of the CMO and participating clinician representatives from primary and specialty care disciplines.

Committee Staff:

The QIHEC is co-chaired by Partnership's CMO and Health Equity Officer (HEO). A current voting committee member will be designated as a temporary chair, in the absence of both the CMO and HEO per the majority votes of current external committee members. The HEO is to provide meeting facilitation and direct the meeting process thought the agenda. In addition, the HEO will guide and lead discussion to ensure all participants are provided an equal opportunity to participate. The CMO, or their designee, is to provide executive health plan updates and preside over the meetings in the absence of the HEO.

Health Equity department staff will be responsible for agenda and meeting material production and distribution. Finally, department staff will record minutes of meetings, which will be reviewed and approved by the QIHEC members at each subsequent meeting.

Membership:

Membership includes representatives from a broad range of network providers, including but not limited to, hospitals, clinics, county partners, physicians, subcontractors, and/or downstream subcontractors, as well as Partnership members. Also, the QIHEC may include members from the California Department of Public Health (CDPH), members from academic institutions, ethnic services coordinators, community based organization leaders, and tribal health liaisons, and health system leaders. Membership status will be reviewed and approved by this committee. Interested members must attend a meeting, submit their CV/resume, then receive a vote to be included. Each committee member signs an annual Conflict of Interest statement prepared and retained by Partnership. (See policy MPQP1008 Conflict of Interest Policy for QI Activities.) QIHEC committee members who are not Partnership staff are eligible to receive a financial stipend for each meeting attended (unless otherwise compensated by Partnership for management responsibilities). This stipend may be in addition to other compensation when a committee member serves as a clinical consultant/physician adviser. For further information, refer to Partnership policy ADM21 Stipends for Committee Members.

Meeting Cadence

QIHEC shall meet bimonthly (every other month) to total at least four (4) to six (6) times per year. The meetings are to be held every 3rd Tuesday of every odd numbered month. These meetings will be located at Partnership offices, and remotely. Only committee members who are not Partnership staff may vote. The CMO and/or HEO serves in a tie breaking capacity as necessary. A quorum is 50% or more of the total voting members (e.g.,. 5 to 8 members) and presence of the HEO.

Review and Approval of Charter

The QIHEC shall review this charter an annual basis in combination with its corresponding policy MCEP6002.

REFERENCES

1. Department of Health Care Services (DHCS) standards
2. **Original Date:** 05/12/2026 Effective Date: 05/20/2026

	05/20/2026

Robert Moore, MD, MPH, MBA *Date Approved*

CEO and Quality Improvement Health Equity Advisory Committee Co-Chair

	05/20/2026

Mohamed Jalloh, PharmD *Date Approved*

HEO and Quality Improvement Health Equity Advisory Committee Co-Chair